CHAPTER II
PROVIDING HELP

1. INTRODUCTION

Deviant behavior is as old as human beings. From the previous chapter, it seems that there is no simple answer to be found regarding accepted norms and criteria by which deviant behavior can be evaluated or even essential characteristics by which it can be recognized.

As divergent as the views regarding the nature of deviant behavior are, so also are the opinions regarding its origins. For the sake of systematizing, the opinions about the origins of child deviancies are arranged into seven categories, i.e.:

- the behavioral view
- the psychodynamic view
- the biophysical view
- the sociological view
- the ecological view
- the "anti-theoretical" view
- the pedagogical view

Each of these approaches begins from the standpoint that there are denotable originative factors at the foundation of child deviant behaviors. With respect to pronouncements about the nature of these behaviors, globally viewed, there are fewer specific indications. From each of these views, pronouncements also are made about the intervention needed to eliminate the deviancy. The nature of the deviancy determines the helping aim; the criteria implemented to determine the degree or state of deviancy also serve as criteria for evaluating the progress or success of the intervention; the view of the underlying cause determines the nature of the therapy.

2. LAWS AND THEORIES AS FOUNDATIONS FOR THERAPY

Rhodes (1977, Vol. 2, P. 24) indicates directly that a specific theory results in a practice because it brings about a delimited aim. However, it is not reflected so much in the method, technique, or approach. Proponents of conflicting theories often carry out the same activities.

From an exploration of prevailing practices, it seems that, e.g., a pedagogically oriented therapist rewards a specific child activity with verbal approval. He/she uses the term "assent" to typify his/her action and has in view educating a child to adulthood. A behavioral therapist also continually attaches verbal approval to a specific behavioral expression and calls it "positive reinforcement". His/her aim is to condition a child to a particular reaction. In both cases, the result of the intervention is to observe change in the child's behavior. Thus, both appeal to the same law, i.e., that verbal approval by an adult influences a child's behavior. The law is the same in both cases, but the theoretical explanation differs.

An additional example which appears in practice in this country (R.S.A.) is the following: a psychoanalytically oriented therapist, who is going to work decisively, uses child play to explore the child's subconscious. His/her aim is to eliminate anxiety and feelings of guilt. A non-directive, psychodynamic Ally oriented therapist also uses child play with the aim of giving the child an opportunity to him/herself find a solution to his/her problem. Both appeal to the same law, i.e., children explore via play. However, their theoretical explanation of the matter differs.

According to "The Encyclopedia of Philosophy," edited by Paul Edwards (1972), the fundamental difference between a law and a theory is that laws only contain terminology which refers to what is perceptible, while theories contain terminology which also refers to what is not perceptible, and what is not operationally definable. Laws remain true irrespective of the theory in terms of which they are explained.

The fact that a specific law is often explained by more than one theory, gives rise to the fact that therapists who endorse different theories avail themselves of the same technique based on a specific law. Thus, a therapeutic direction does not have a monopoly on methods, and overlapping often occurs. In this context, compare the use of the guided imaginary journey in pedotherapy, and in psychoanalysis.

3. WHAT IS THERAPY?

3.1 The difference between therapy and therapeutic

The concept "therapy" has its origin in medical terminology. Originally, the word "therapeutic" is used to indicate the treatment of a physical condition with an eye to alleviating, healing, or preventing an illness (Warren, 1962; English, 1958; Drever, 1968). With the rise of psychiatry and related sciences, the term "therapy" found acceptance and, today, it is generally used in non-medical contexts.

More often, there is reference to therapy as "treatment" (See English's definition: Therapy is "treatment intended to cure or alleviate a disordered condition, so that normal functioning is brought about"). All steps taken to eliminate a bad condition also are subsumed under the term therapy. To contrast "therapy" with "therapeutic", John Drever (1968) says that the term therapy "... emphasizes the practical measures employed in alleviating disorders".

Thus, it seems that the term therapy has undergone an expansion of meaning and has found acceptance in non-medical circles.

3.2 Psychotherapy

When the term psychotherapy is used for providing help to children and adults, the situation is extremely complicated and nearly every author gives his/her own meaning to the word. In trying to capture the term in a definition, the definition becomes so broad that it fades into being meaningless. In this connection, compare the definition included in the *Dictionary of Psychology*

edited by H. C. Warren (1962): "Psychotherapy – the treatment of disorders by psychological methods; these methods differ widely, including making suggestions, hypnotic suggestion, reeducation, persuasion, psychoanalysis, Christian Science".

In an attempt at clarity, Bergin and Strupp (1972, pp. 7-8) have made a comprehensive survey of the prevailing meanings of the term "psychotherapy". They conclude that there are so many divergent views about the aims and nature of psychotherapy that no simple answer can be provided to the question of what it is.

3.3 Intervention

An exploration of the literature on child deviant behavior indicates that there are a large variety of terms used to label the elimination of the deviancy, such as therapeutic, therapy, psychotherapy, interference, rehabilitation, remedial help, and reeducation. In an attempt to typify these practices on behalf of the deviant child, Rhodes and Tracy (1972, Vol. 2, p. 27) use the term "intervention" and describe it as follows: Intervention is that act of intervening in the interaction between a child and his/her world which aims at changing this interaction such that the resulting change is different from what would be expected if the act of intervention had not occurred. This action can be directed to an adjustment of the child's experiencing, to his/her behaving, in general, or in specific situations, to other persons in his/her world, and to his/her physical surroundings.

Rhodes and Tracy specify, however, that the intervention does not aim for outcome for the good. According to them, the aim of the intervention is only an adjustment or a modification.

3.4 Conclusion

After considering the variety of terms used to typify the act of providing help on behalf of a child with deviant behavior, it is concluded that the most useful term for the aim of the present study is *therapy.*

By this is meant that when a child deviates from the accepted to such an extent that he/she no longer can be helped to recover from his/her everyday situatedness, he/she is dependent on specialized help. This specialized help which is provided in an ordered, purposeful way with the aim of eliminating the child's deviancy is therapy.
In what follows, the term therapy is used in this context.

4. METHOD FOR EXPLORING THERAPEUTIC PRACTICE

4.1 Introduction

Experience shows that therapists often their practice reflects the theories, views, and anthropologies with which they have been made familiar in their training. Also, regarding techniques and methods, they are inclined to remain with the tried ways. Thus, a practitioner reflects, to a high degree, the nature and quality of his/her training.

This is not a denial that individual talent or aptitude, insight, and experience of the therapist in practice have not made a great contribution to expanding existing knowledge about therapy with children. On the contrary, training of however a high degree of quality cannot replace aptitude or talent. No talent, however distinctive, can replace experience. The distinctive therapist has all three at his/her disposal: talent, training, and experience.

When it does happen that an individual therapist, in practice, makes a great breakthrough, and a new insight appears, training organizations quickly recognize and incorporate it into the training program. In doing so, each new generation benefits from the knowledge and experience of their predecessors. However, revolutionary, new breakthroughs seldom arise. The usual course of matters is that a reinterpretation of an existing insight occurs, more useful variations replace the old theories. Thus, there is a continual course of renewal and broadening of knowledge, but this is a deliberate event which occurs gradually.

The institutes involved with gathering knowledge and making it available to the new generation is the universities. It is their task

to keep abreast of new developments in the specific subject area and to make the new knowledge available to the students.

Thus, based on these arguments, there is a decision to involve universities in this exploratory study, rather than to select from the many private practices, as well as private and state organizations.

4.2 Choice of sources of information

The motivation for choosing universities as the source of information is in the above argument.

In the Republic of South Africa, there are now thirteen universities which have child guidance centers. These centers are spread over the Country's four provinces, i.e., six in the Transvaal, one in the Orange-Free State, four in the Cape Province, and two in Natal (See appendix 2). Together, they serve all ethnic groups, i.e., Blacks, Coloreds, Indians, and Whites irrespective of socio-economic status.

The function of these child guidance centers at the universities is three-fold: research, training, and providing services. As such, they meet the demands of this study in an outstanding way, i.e., provide information which serves as an overview of the entire practice of child therapy, the determination of gaps, and the possible establishment of an alternative.

4.3 The compilation of a questionnaire

Since the area of study does not lend itself to a statistical analysis of the data (Bergin and Strupp, 1972, and Van den Berg, 1972), it is decided to do a qualitative study of the practices of the various child guidance centers.

To avoid only an individual view of a specific therapist being expressed, the exploratory conversation is carried on with the director or head of the center. This approach ensures an overview of the activities of the entire personnel of the institute.

Comparable data for the different centers are obtained in terms of a questionnaire which serves as a conversational guide.

With reference to the study of the literature, as contained in Chapter I, the following areas are selected as conversational themes:

- Explanation of reasons for derailment
- Which intervention is necessary to rectify problem
- Delimiting aim of the program to provide help
- Preparation of a session
- Therapeutic content
- Therapeutic relationship
- Form of the therapeutic sequence
- Techniques and methods
- Evaluating
- Therapy for parents and the use of other experts.

The data obtained generally relate to the practical situation as it is found in the specific community served by the center, and not to what the ideal situation ought to be, as theoretically discussed.

4.4 Ordering the research data

In the following, the conversational themes mentioned are considered and a summary of the findings provided by the thirteen heads of the university child guidance clinics are presented under the heading of each theme.

Finally, there is an indication of gaps which appear to exist in contemporary practice.

5. THE PREVAILING THERAPEUTIC PRACTICE IN THE R.S.A.

The thirteen university clinics involved serve all races and ethnic groups of the Republic of South Africa. The areas where service is provided extend from rural as well as city populations representing poor socio-economic circumstances to prosperous communities. The conclusions reached are thus representative of the state of practice during May and June 1979.

5.1 Explanation of reasons for derailment

5.1.1 The behavioral theoretical view

At two of the thirteen centers, the opinion is that the derailment of children who show deviancies can be partly attributed to faulty learning. However, no one believes this to be the exclusive factor. According to proponents of this line of thought, everything which is learned, and then appears to be undesirable, can be unlearned (De Villiers, 1975, p.4). The aim of their therapy also is to substitute, via learning, undesirable behavior with acceptable behavior.

However, behavioral theoreticians give a specific meaning to learning. According to their view, learning in its essence is conditioning (Bondesio, 1977, pp. 64-72). There is a denotable, predictable connection between stimulus and response. The therapeutic intervention thus is a manipulation of the stimuli that influence a child. To bring this about, the following principles are used:

5.1.1.1 Desired behavior leads to positive consequences for a child. For example, there is a smile, words of approval expressed or he/she obtains money, food, extrinsic privileges, etc. The form that the positive consequences have on a child's behavior depends on the preferences of the child and the resourcefulness of the therapist. In doing so, certain behaviors are encouraged and reinforced.

5.1.1.2 The desired behavior brings about the elimination of the unacceptable. For example, by carrying out the desired behavior, a child avoids a reprimand, loss of privileges, punishment and even physical shock. In doing so, the behavior is also reinforced.

5.1.1.3 The behavior does not lead to the expected positive consequence. This is brought about by manipulating a child's environment so that what previously was a pleasant result is now absent. For example, a child is ignored or removed from the room. The consequence of

such action is a weakening and eventual extinction of the behavior.

5.1.1.4 The behavior does not avoid the unpleasant consequences and thus appears to be ineffective. The unpleasant consequences that a child wants to avoid are brought about. The result is a weakening and eventual absence of the behavioral expression.

5.1.1.5 The behavior brings about unpleasant consequences. By ensuring that each time a child occupies him/herself with a behavioral expression it has an unpleasant consequence for him/her, he/she associates the specific behavior with the unpleasantness and purposefully avoids it.

5.1.1.6 The behavior brings about a temporary or permanent loss of pleasant consequences. This is accomplished, e.g., by not giving approval, candy, pocket money or gifts and by denying trips. The aim also is that the behavior disappears.

According to this division by Gardner, as quoted by Kameya (1977, p. 166), the first two techniques are directed at reinforcing and encouraging the behavioral expression and the latter four at discouraging and working against the specific behavior. Many permutations are possible by combining two or more of these techniques and their variations.

Because of the relatively quick results that are obtained with behavior therapy, with rapid strides it has gained ground and found application in related areas of science, and especially teaching. However, it was quickly realized that the initial claims of earlier exponents were overoptimistic. Thompson (1975) asserts that contemporary practice is far removed from Skinner's boxes and Watson's excessive claim: "Give me a dozen healthy infants ... and I'll guarantee to take any one at random and turn him to become ... doctor, lawyer, artist, merchant-chief, and yes, even beggar man and thief". According to Thompson, behavior therapy has great possibility for application, e.g., with respect to social problems and, indeed, it is not the "frightening menace" it is regarded to be by the uninformed, provided its "integral humanism" comes forth more strongly. With this, Thompson

recognizes that behavior therapy often does violence to the humanity of a person.

With this, he suddenly brings to light the errors in judgment of behavior therapy, i.e.:

a) all persons lend themselves to manipulation by a fellow person;
b) an individual person's world can be controlled over the long term;
c) giving personal meaning and taking a position play no role in willful behaving;
d) the individual has no possibility of choice and thus is a puppet in the hands of a therapist who decides for him/her;
e) a person takes no responsibility for his/her behavior, it is manipulated by the therapist;
f) the striving for pleasure and avoidance of the unpleasant are the underlying driving forces that direct all human behavior;
g) above all, they misunderstand the complexity of human behavior, especially in the case of the simultaneous presence of a variety of strivings or motives (Bondesio, 1977; Van der Merwe, 1974).

The reason for the degree of success achieved with this therapeutic technique possibly is that behaviorists have disclosed a truth about human behavior, i.e., that a person often behaves such that his/her behaving brings about pleasant consequences. Most certainly this is one of the dimensions of human behavior. However, to generalize this insight and make it applicable to all human behavior is an oversimplification of a complex phenomenon. This is evidence of a misunderstanding of the fact that a human being always remains a mystery and is never totally knowable.

This then also explains the relatively short duration of the success of the behavior therapeutic intervention. A child behaves acceptably, if this is meaningful. As soon as the situation changes and a new or changed hierarchy of values emerges, especially the adequacy of the therapeutically acquired behavior declines and a new choice, taking a new position, a new willful

choice and new task of responsibility arise. This complexity of demands that now address a child from the new or changed situation compel him/her to a new response.

Critics of behavior therapy point out that the mere treatment of symptoms often result in symptom substitution. Behavior therapists profess that such new unacceptable behavior is then treatable by the same method.

Owing to the misunderstanding of willful child choices, his/her own sense of identity, as well as the fact that a child, in personal ways, gives sense and meaning to his/her world on affective, cognitive and normative levels, genuine learning that results in possessed experience (Ferreira, 1973) does not occur during behavior therapy.

5.1.2 The psychodynamic view

Of the thirteen institutes involved, six hold the view that child deviant behavior is attributable to the consequences of adopting one's own, unique innate dispositional factors or that this at least is a contributing factor.

After an overview of the most authoritative literature on the psychodynamic nature of child deviancy, Cheney and Morse (1977, p. 268) conclude that there are two structures recognized, i.e.:

a) Individual development in accordance with innate dispositional factors. Derailment early in a child's life is mainly the consequence of defective, innate propensities.
b) Development of the growing child in interaction with his/her environment. Development later in a child's life is a consequence of defects in this interaction.

From the psychodynamic theory regarding child deviant behavior. the therapeutic aim then is also two-fold, i.e., healthy development according to disposition and balanced interpersonal relationships as results of the interaction between the individual and his/her environment. Both facets must be maintained "... so

that the individual can cope without excessive defense", according to Cheney and Morse (1977, p. 292). Thus, it seems that the avoidance of tension is an overarching therapeutic aim.

The techniques and methods applied by psychodynamic oriented therapists also fall into two main classes:

5.1.2.1 Biological intervention – through medical treatment, such as medications, diet-change- and physio-therapy changes are brought about in the child's behavior. Especially symptoms such as tension, hyperactivity and aggression are controlled medicinally such that the child can resume a favorable course of development. However, this intervention is seldom done without being paired with conversing with the child with the aim of making the treatment cognitively knowable to him/her through information and clarification, and also to stabilize him/her emotionally by eliminating distrust, guilt feelings and shame.

5.1.2.2 The second type of intervention is interfering with the "normal process of growth". It is accepted that each child has innate patterns of behaving, but its tempo can be influenced by extrinsic factors. The way a child expresses his/her instincts can be changed. Environmental change generally is freely applied to bring a child's instincts to acceptable expression. Roger's non-directive, client-centered therapy is an example of this approach. His therapy rests on the assumption that a child is self-sufficient. Everything is given with being human for an individual to maintain him/herself and evolve to a higher level of existence. All that is necessary is an opportunity to do this and the therapist ensures this. Therapy is an opportunity for a child to be what he/she is (Rogers, 1939, and Axline, 1977).

This therapy, whether individual or group, is extremely time consuming. The therapy is continued until a child him/herself, at his/her own tempo and in his/her own way has arrived at a solution that he/she him/herself is satisfied with.

In contrast to behavior therapy, where disapproval, criticism and punishment figure prominently, they are entirely inappropriate with psychodynamic therapy; on the contrary, any form of maintaining norms or evaluating is deliberately avoided. This results in a therapeutic situation, and especially the therapeutic relationship, being foreign to life. The already derailed child becomes confused because of the discrepancy between the therapeutic situation and life reality, and this impedes the transfer of insight.

The fundamental not-yet-responsibility of the child is misunderstood because he/she is forced to accept full responsibility as an adult for his/her own decisions and the consequences of his/her deeds. Indeed, a child is surrendered to him/herself and his/her own limited life experiences. Acceptance of responsibility for a child is one of the essences of educating that is highly valued by pedagogues (Landman, 1972).

5.1.3 The biophysical view

Only three of the institutes hold the view that child deviancy mainly is attributable to origins of a biophysical nature such as genetic and neurological problems, and even nutritional matters.

To bring about a change in a child's behavior, it is necessary to identify and eliminate the underlying originative factors. The intervention is of a medical nature and mainly includes the administration of medicines and control of a child's diet.

Proponents of this view not only define themselves by the therapy for the individual. In cases where heredity plays a role, appropriate information is acquired on the entire family, and even blood relatives. In the case of a genetic deviation, emphasis is on the responsibility of the individual in contrast to the community, and on making responsible choices about future expectations, vocational practice and having children (Kameya, 1977).

Recent research (Denhoff, Davis and Hawkins, 1971) shows that with the help of medications, dramatic results are obtained with

respect to symptoms such as hyperactivity, fluctuating attention, impulsive behaviors, low frustration tolerance and lack of interest in school activities.

The assumption is that the therapy is continued until a child has "outgrown the condition" (Kameya, 1977, p. 114). There are no criteria by which the success of the intervention can be evaluated, other than the satisfaction of parents and teachers that the child has improved. Thus, the exclusive aim of such therapy is the elimination of those ways of behaving that make a child "difficult to handle" for his/her parents and teachers.

Little if any attention is given to matters such as a child's own role in his/her unique situation, the cognitive meaning of the difficult situation, the normative task that stems from physical handicaps, the acquisition of a self-image and identity, and acceptance of co-responsibility for his/her own becoming. A child is viewed and treated as an object that can be manipulated by his/her parents, teachers and doctors.

That the administration of medications can greatly illuminate his/her difficult situation, and his/her educators cannot be doubted. However, this is and remains only a helpful aid at the therapist's disposal and, as a rule, ought to be supplemented by educative help to the parents and child to smooth over the gap (in becoming) that has arisen because of the biophysical impediments, and to support the child in re-signifying him/herself and his/her world.

5.1.4 The sociological and ecological views

This view of the originative factors of child deviant behaviors is by far the most general. Nine of the institutes consulted are of the opinion that matters such as family problems, too high aspirations and too much pressure to achieve from the family and school give rise to child deviant behavior.

One institute considers ecological factors such as over-population, pollution and malnutrition to be co-determinants of child deviant behavior.

In the case of those of other color in white areas, child derailment is largely caused by socio-pathological phenomena such as alcoholism, drug use and illegitimacy. Paired with this are the frustration of political aspirations (that foster a fatalistic attitude toward life), as well as inadequate housing, healthcare, day and night school centers and recreational areas for children in urbanized areas.

In colored as well as Indian communities, the children are involved in moving away from established systems of norms and values previously accepted as generally valid in their communities. They reject the norms and values of their parents but have not yet arrived at an acceptable alternative.

These problems are further forced to a head by the fact that the language of instruction at school is not necessarily the mother tongue. Many young Indian children no longer understand the language of their parents and can only speak English. Also, for coloreds, the tendency is to see to it that the younger generation lends itself to English, the language of the world, and to distance themselves from their Afrikaans speaking parents, their customs and habits. In these communities there is a high percentage of working mothers. Thus, as soon as a child is placed in a nursery school, he/she meets a language different from that in his/her home and his /her cultural alienation begins.

Several children are not sufficiently cared for during the time that their parents are working for hourly wages and, thus, are exposed to the social evils of asocial neighborhoods.

Pressure to achieve is an originative factor that generally arises with both whites and non-whites. For whites, this especially arises with middle and well-off socioeconomic levels of the population where high academic achievement is sought and ranks high in the parents' hierarchy of aspirations for their children.

With Indians, it is found that families often are large and not all the children in the family have an equal opportunity to enjoy

schooling and teaching. Then a family invests in one specific child. This tendency places the favored child under great pressure to achieve, awakens feelings of frustration in the other children and leads to a decay in communication in the family.

The therapy prescribed by proponents of the sociological and ecological ways of thinking is diverse, but has one matter in common, i.e., one or another form of environmental change. This often is paired with providing individual help to a child showing the symptoms of deviance (Wagner, 1977). In both cases, the emphasis is on the situatedness of a child, the fact that he/she and his/her world are not separable and are in continual interaction with each other. The environment asks demands of a child, but being a child with dignity also puts demands on the environment. The aim of this kind of therapy thus is two-fold, i.e., to help a child acquire a standpoint in his/her social environment, and to manipulate or rearrange the environment such that he/she can arrive at adulthood in it with dignity.

Therapeutic techniques applied on behalf of a child can be divided into the following four classes (Wagner, 1977, pp. 562-567):

5.1.4.1 Techniques focused on bringing home his/her own worth and the human dignity of others.
5.1.4.2 Techniques which bring about greater acceptance of a child, as such, in his/her own environment.
5.1.4.3 Techniques which help a child restore disturbed relationships.
5.1.4.4 Techniques which aim to make community activities function smoothly.

The spectrum covered by these techniques is extremely wide and ranges from help with interpersonal relationships to the smooth functioning of the community in its breadth.

The unique nature and needs of a child are valued highly. His/her reliance on help and support to become adult, by implication, is recognized, although no specific attention is given to his/her home educative situatedness. His/her school

educative situatedness gets much more attention in the form of placement in special schools, boarding houses, clinic schools and enrolment in extramural activities, youth clubs, etc.

Indeed, there is a synoptic overview of the parent-child relationship, but no analysis of its essential nature is made to enable a therapist to provide purposeful, specialized educative help to parents and child in the problematic situation.

5.1.5 The anti-theoretical view

The term "anti-theory" is applied to a group of theories that differ from each other and from other lines of thought. However, the one thing they have in common is their dissatisfaction with existing school systems.

They advocate for a more humanistic approach to teaching children, greater participation of pupils in their own education and less control by state authorities. They are unanimous in their criticism of the existing order, but when it comes down to an alternative, they differ so much from each other about the established, accepted, tried systems of teaching.

According to Burke (1977), their views of deviancy can be divided into three groups:

5.1.5.1 Those who maintain that "deviation" is admirable, since it is evidence of individuality and shows that the individual is not ready to conform.

5.1.5.2 A second group believes it does not matter at all if the community sees a child as "deviant". What is important is that his/her behavior is effective with respect to his/her own situation and criteria.

5.1.5.3 A third group thinks that there is something such as normality and mental health, but they do not necessarily correspond to the community's expectations.

Only one of the institutes holds the view that the contemporary school system is a contributing factor in causing child deviant behavior in the Republic of South Africa. The view held

corresponds to that described in 5.1.5.3. This institute holds the view that a child is basically good and inclined to develop positively. Because of the restrictive school system, his/her individuality is largely kept in check, he/she is compelled to conform to stereotyped roles as prescribed by the community. A child is a seeker of support and will gladly be accepted by his/her educators. Consequently, he/she accepts the desired behavior codes and ways presented to him/her. Often this conflicts with his/her innate disposition and leads to derailment.

Proponents of the anti-theoretical view advocate changes in school curriculum, greater emphasis on practice rather than theory, doing away with labeling pupils, greater intimacy between pupil and teacher and mutual pupils, greater role of the pupils in exercising authority and a doing away with the system of compulsory attendance.

A revolution in the established education system will remain an ideal for the foreseeable future. Several private schools experiment to a greater or lesser degree with the "open classroom" system, but beyond experiments on a limited scale, this has not yet arrived in this country. Even A. S. Neil's famous "free" school, Summerhill, which has existed for decades and is known worldwide, has not yet gotten adherents elsewhere worth mentioning.

In the R. S. A., at this moment, the therapeutic intervention advocated by the anti-theories exists only as an ideal.

5.1.6 The pedagogical view

At the completion of the investigation of the state of the practice of providing help to children in this country, it has seemed that, in addition to the above views of the origin of child deviant behavior that are in use in America, Britain and Europe, and all of which are more or less held in the R. S. A., there is yet an alternative, i.e., the pedagogical view.

This view is especially in vogue in the Transvaal and to a lesser extent in the Cape Province and Natal. Seven of the thirteen

institutes believe that problematic educating is an originating factor in child deviance. One of these seven maintains that the family problematic, in which parent-child relationship is included, is the main originating factor.

In addition to sociological factors, educative problems are seen as the most general reason why children derail these days.

As indicated in the previous chapter, there are diverse norms by which "normal" (and by implication also "deviant") is recognizable. Each people, community and even small group holds its own view of what can be expected of a child at a particular stage of life. Deviance is a human phenomenon that has various forms of expression.

In terms of the models mentioned, it is said that a child who deviates from the normal is one whose psychodynamic development and/or biophysical growth do not progress uniformly, or who is not sociologically engaged or is not in ecological harmony with his/her environment or has learned erroneously.

When child deviance is seen where the phenomenon itself occurs in life reality, it appears that it reveals itself in only one way, i.e., in behaving. It is only when a child as a person actively functions that it can be concluded that he/she has actualized his/her psychic life potentialities, that he/she continually becomes different because he/she has learned, has lived experienced, has experienced and has willed. From his/her behavior, it is read that he/she is engaged in a relationship with him/herself, fellow persons, things of the world and God. Also, it is read from his/her behavior that he/she continually establishes different relationships, gives different sense and meaning to his/her lifeworld. In addition, it also is knowable from his/her behavior that it has become inadequate or deviant.

Ecological harmony, sociological engagement, biophysical health, psychodynamic equilibrium, and adequate learning can only appear when a child announces him/herself in life as a person, when he/she behaves as a totality-in-function, when he/he

presents him/herself as a knowable behaving being to his/her fellow persons.

Irrespective of the originative factors which are at the foundation of the deviance, deviancy is only knowable through behavior. This implies that deviating children behave differently from what is considered proper, and that they are to be distinguished from children who satisfy these expectations.

The following question arises: How does a child behave such that he/she, in his/her behaving presents him/herself as deviant? Moustakas (1959) asserts that the difference between children labeled as normal and those who are deviant is in the degree of difference in the intensity and frequency of the expression of their negative behavior. Accordingly, a deviant child does nothing different than what other children do; there are only differences in frequency and intensity in behaving. However, Moustakas does not consider the level of becoming. He does not contrast the achievable level from that achieved (Van Niekerk, 1978). Irrespective of the frequency or intensity of a behavioral expression, it certainly is to be expected that specific behaviors will permanently fall by the wayside as a child progresses. For example, it is expected that all children will feed and dress themselves if they are physically able to. If a child in puberty insists on being cared for like a baby, this is deviant, despitef its frequency or intensity.

If Moustakas would explain that as far as form is concerned, deviant behavior is the same as adequate behavior, it must be granted that he is right. A child, deviant or not, is able to behave in no other way than as a human. He/she has nothing else at his/her disposal than generally human ways of expression – what he/she has in common with other beings of his/her species.

However, a person is a temporal being. His/her existence progresses in time. His/her estimation and understanding of time are also shown in his/her behaving. If the behavioral expression of the coherence of time is inappropriate, according to the judgment of adult members of the community, it also is seen as deviant.

Finally, it is stated that child deviance is knowable in behavioral expressions that, according to the judgment of the adults in the community, is labeled as inappropriate with respect to intensity, frequency and temporal coherence. In other words, a child, from whose behavior it seems that he/she is not becoming a proper adult, and shows restraints in his/her becoming, is viewed as deviant. It is expected that each child at a given time must have reached a specific level of becoming. This is known as the pedagogically attainable level. If he/she falls short in one or more facets of his/her being a person, his/her attained level of becoming is lower than the level possibly achievable. There is a deviation from the expected; a gap in becoming exists (Koster, 1972; Sonnekus et al., 1971; Prtorius, 1972). In the language of Van Niekerk (1978, p. 10): "Briefly, there is a difference between what the child, *as a person, is* and what he *ought to be".*

As soon as it is stated that child deviance, seen from a pedagogical point of view, can be described as a handicap in becoming, the following question arises: how does a gap in becoming occur, or what is the origin of child deviancy?

"The most original person-to-person relationship is expressed in educating, the primordial function of being human" (Landman and Gous, 1969, p. 1). With this, Landman and Gous state that, at birth, each child is immediately situated educatively; that is, the educative situation is given with being a child. For a child to become adult and be able to transform his/her potentialities into realities, he/she is committed to education (Langeveld, 1959; Oberholzer, 1968). In other words, adequate educating is a precondition for becoming a full-fledged adult.

Educating occurs or takes its course from a specific relationship between an adult and a child. As with any other human relationship, a mutual contribution is a requirement. The educator(s) and the child both have a role in the event of educating so that the educative aim (the full-fledged adulthood of the child) can be reached. If the contribution of the adult, the child, or both is inadequate, the result of the educating also will be inadequate. Then, the child does not *become* adult as he/she

should. His/her becoming progresses disharmoniously, the tempo of his/her becoming is delayed or restrained, he/she stagnates or even regresses. The child deviates.

When there is mention of personal potentialities, this does not mean a collection of "psychic functions" but the totality of a person's attributes as they are functionalized in communicating with his/her world. Thus, this includes corporeal, cognitive, affective and normative potentialities.

Thus, viewed pedagogically, it seems that child deviance follows the inadequate [self-]realization of personal potentialities by a child and/or inadequate accompaniment by his/her educators.

To eliminate child deviant behavior, pedagogues advocate a specific type of therapy, i.e., educative help. This educative help includes both poles of the educative event, i.e., the adults and the child. Since they are co-involvers in the educative event, they are co-committed to therapy in the case of educative failure. Educative help then falls into two distinguishable (but not separable) matters:

Educative help for a child (pedotherapy) and

educative help for the parents (parental accompaniment).

From the data obtained during the investigation about the state of child therapy, it seems that this co-involvement of parent and child in a child's becoming is a generally accepted fact. All thirteen institutes participating involve parent and child in their attempts to provide help. However, this occurred in very divergent and often ill-considered and haphazard ways.

Thanks to the work of phenomenological pedagogue, the fundamental nature of educating is today knowable in its essentials. Psychopedagogics has disclosed the nature of a child's actualization of his/her psychic life and didactic pedagogics has illuminated the ways in which knowledge, insight, skills and dispositions are transferred from one situation to another. This fundamental knowledge is primarily available – however,

purposeful acts of providing help that begin with a convergence of these insights still is less frequent than desired.

5.2 Therapeutic aim

The therapeutic aim is formulated depending on the view of the origin of the child deviance. Those who believe deviance arises through biophysical factors aim for a healthy physical state for a child. The proponents of the psychodynamic view set themselves the aim of allowing the child's psychic development to proceed harmoniously. Advocates of the sociological view have the aim of allowing interpersonal relationships and joining groups to progress smoothly. Those who believe that ecological factors give rise to deviance aim for a harmonious linking up of child with his/her environment. Where learned inappropriate behavior patterns are viewed as underlying the deviance, learning favorable behaviors is the therapeutic aim. If an objectionable school system is the cardinal originating factor, environmental manipulations are the aim to compensate for systems that practically are not changeable. The advocates of the pedagogical view aim to eliminate education-restraining factors so the child can become adult.

When the concern is delimiting an aim for an individual child in a unique situation, the matter becomes much more complicated. It seems that such delimitation mainly occurs in four ways. However, none of the institutes made use only of one method. All used combinations of the following.

5.2.1 Aim formulation stemming from a demarcated, clearly denotable beginning diagnostic phase

Five of the institutes had beginning contact with a child and his/her family, with at least one session devoted to an exploratory conversation with a child and his/her parents separately, followed by observing and testing the child. After this diagnostic phase that can stretch over several sessions, the results are presented to a panel. Then therapeutic aims are formulated according to the findings of the panel.

5.2.2 Acceptance conversation

This method was followed by four of the thirteen institutes. First contact occurred by conversing with all involved, i.e., parents, children, and other occupants of the family residence, where applicable. Under the lead of the therapist, the problem is clearly formulated. The parents, mutually, and the child are thus aware of the nature of the problem and how each family member feels about it. There is a collective choice of aims regarding the problem. All anonymity of the problem is disposed of, and it is clearly spelled out to the child why he/she was brought to therapy and what is planned for him/her.

5.2.3 Statement of the announced problem

Four institutes accept the stated problem announced by the parents as an indication of their "here-and-now" experience of their situation. The elimination of the symptoms that compelled the parents to state and announce as problems were then accepted as the therapeutic aim. With two of the four which followed this method, subsequently, the child underwent diagnostic testing to disclose other possible problems. The results of these tests were then considered in delimiting the therapeutic aim.

5.2.4 Delimiting problem areas

In five cases, the course of the diagnostic and helping phases are intertwined and gradually arrive at knowledge of the child and his/her situation. Then problem areas are identified and ordered hierarchically. This gives an indication of the greater urgency of one aim compared to another. Short- and long-term aims are then formulated.

In two of these cases, greater emphasis is placed on the diagnostic beginning phase that can occur simultaneously with or slightly isolated from providing help. In these two cases, the results of the diagnosis were ordered in terms of

a structured theoretical frame of reference. Then there also is the formulation of a hierarchy of aims in terms of the theoretical structure.

In one case, where a strong biophysical approach to child deviance is maintained, the aims are presented to the child as exactly formulated prospects in terms of skills and abilities. In the other case, there is an attempt to not rigidly delimit so that a degree of change is possible as the therapy requires.

5.3 Preparation

As far as planning and preparation for the therapeutic event, there are a great variety of opinions. Indeed, nearly all institutes used their own approach. On closer investigation, it seems that there are mainly four approaches that make variations and combinations possible. In essence the following are approaches to planning therapy:

5.3.1 No specific planning

Only one of the institutes that was approached believe that they should work non-directive to such an extent that the therapist did not delimit aims, choose conversational themes, select content, or anticipate specific techniques. Thus, there is no mention of structuring the therapy.

5.3.2 Planning the total therapeutic course

Five institutes made overarching plans before the therapy began for the total course of the therapy. Aims were delimited, priorities set and techniques were selected in connection with the nature of the problem, the potentialities of the child and the unique talents of the involved therapist. Direction was indicated only in broad strokes. In no sense was the therapy structured. This overarching planning took no specific form. Also, no use of any fixed approaches or methods was suggested in such preparation and planning.

5.3.3 Short-term planning

Three of the institutes did no comprehensive planning and preparation of the therapy. For each individual session there indeed was planning according to progress. The motivation for this approach is that, via the therapy, a therapist learns to know the child better and might find that his/her initial planning is over-optimistic or erroneous, or that he/she has underestimated the child. During a session, matters might arise that give a new turn to the course different from what the therapist had initially anticipated. Based on the the results of each session, the subsequent one is planned.

Also, in this case there are no clearly denotable approaches or methods that hold for the preparation. Specific techniques and content are only foreshadowed.

5.3.4 Overall planning in combination with planning from session to session

Five institutes plan from the beginning which course the therapy will take in order to attain the planned aim. However, there is also a continual reconsideration of the original planning based on the results of the specific session. Changes are brought about with respect to media, methods, tempo and even therapeutic content as what might seem to be necessary to attain the eventual aim as this was proposed in the initial preparation and planning.

Three of the institutes that use this preparatory way make use of a structured, precisely formulated approach. In this case, it is carefully determined what the contribution is of the therapist, the child and, where necessary, the parent in reaching the specific immediate aim proposed for this specific session. The therapeutic content is then selected such that there is a high probability that the child will make the desired breakthrough. Although the approach is generally directive, the therapy occurs in a non-authoritarian way and the child is given maximum possibility of choice and is consulted within predetermined limits.

To facilitate the planning of one session according to the other to promote continuity, and to bring about change in the long-term comprehensive planning, in four cases use was made of a system of verification. Comments can be recorded by the child him/herself as a "homework" assignment, the parents and/or teachers can be asked to keep an account of their observations of the child, or the therapist him/herself can note the progress or its lack.

These written reports can then be taken account of in planning the subsequent session.

5.3.5 Deliming aims for the therapist

In addition to the above case where the contribution of the therapist is specifically planned, there are two institutes whose preparation exists exclusively in the therapist delimiting aims for him/herself for the specific session. Both boast of their non-directive approach but find that it is particularly time consuming. Because the therapist previous content, he/she is going to allow to play a role, he/she can accelerate the course of the therapy. Thus, he/she indeed violates the basic principles of nondirective therapy, but maintains the spirit of the Rogerian approach.

5.3.6 Making a contract

In six cases, use is made of a system of contracting between the therapist and the child. This has implications for planning and preparing each session.

Beforehand, there is agreement between the therapist and the child about how many sessions the provision of help will extend and what the therapeutic aim will be. Indeed, therapist and child plan together what the aim, duration and sometimes what the content will be for the therapy. Then the therapist alone plans additionally about the technique and tempo of the therapy.

At the conclusion the contract can be renewed if it is deemed desirable.

5.4 Therapeutic content

With respect to the choice of therapeutic content, i.e., the design of themes to be broached during the sessions, there is remarkable agreement among the participants.

One institute chose not to provide an answer to this part of the questionnaire. The answers the others provided are classified under the following headings:

5.4.1 Free choice of the child

Three institutes said that there are no limits imposed or indications given by the therapist. The choice of content rests exclusively with the child. Also, the therapist then follows a nondirective approach in his/her dealing with the content brought up by the child. The therapist identifies, names and reflects, but takes no part in the choice of therapeutic content.

Naturally, this is an extremely time-consuming approach and places great responsibility on the child. The therapist assures him/her that he/she will not accept co-responsibility for the choice of content. Indeed, the child is not accepted as a child – i.e., as not yet morally independent. Thus, he/she is overburdened.

5.4.2 Therapist and child choose together

In one case, the following approach to the choice of content is followed. The therapist and child discuss the announced problem that is then also verbalized, with all its implications. Then, the therapist and child jointly select themes that will more closely illuminate the problem. These themes are then brought up in the subsequent sessions. The aim is to give the child an opportunity to be co-responsible for the results of the therapy, and to recognize him/her as someone who has a role in his/her

own becoming, to support and lead him/her to make responsible choices and to encourage him/her to independence.

5.4.3 Symbolic treatment of the problem

In one other case, a similar approach is followed. Indeed, both therapist and child are involved in the choice of content as in the above case. However, there are methodological differences worthy of separate consideration.

During the diagnostic phase, the child is prompted to project. In this way, on his/her own initiative, he/she chooses symbols in terms of which he/she concretizes his/her problem. Then, the therapist selects from these symbols in connection with the aim resulting from a panel discussion. In the subsequent sessions, the problem is then presented symbolically as therapeutic content. The choice of a symbol is the child's role. Announcing it as therapeutic content is the role of the therapist.

An important point of difference between this approach and that followed in the above institute is that here the problem always remains anonymous unless the child him/herself chooses to refer to it. In that case, it is verbalized and presented as therapeutic content by the therapist.

The motivation for this approach is the following:

- Young children usually are not able to verbalize their difficult situation.
- A child who experiences serious emotional problems finds it difficult to arrive at cognitive order and, thus, to objectify, identify and name his/her feelings, wishes, thoughts, fears, etc.
- The child who is stuck often finds it painful to openly discuss his/her problems. Via the symbolic handling of them, a degree of distance is created, and the child has greater confidence to proceed with them.
- When a child explores the problem situation symbolically and assimilates it, he/she is often affectively stabilized to such an extent, and has arrived

> at such a degree of cognitive ordering and structuring that he/she him/herself, without embarrassment or injuring his/her self-respect, can be openly talkative about the problem.

It seems that this way of selecting content often leads to other ways of doing so.

However, the drawback is that not all behaviorally deviant children readily project. The therapist then is often tempted to see mere expressions as projections. When erroneous interpretations of symbols occur because the therapist reads meanings into the symbols that the child has not necessarily attributed to them, the entire further course of the therapeutic conversation fails. Then, therapist and child do not understand each other.

A therapist who proceeds to a symbolic interpretation of a child's projections must be able to support them with a thorough knowledge of and insight into the child and his/her entire historicity. This includes his/her past situatedness as this appears in his/her giving meaning, his/her present situatedness in its full complexity and his/her future expectations and anticipations.

5.4.4 Selection by the therapist

Most institutes, i.e., nine, follow an approach where the therapist selects and announces the content. However, there is no unanimity about the content chosen. In three cases, the announced problem is presented as the first conversational theme. Then the theme is amplified or repeated in subsequent sessions according to what seems to be necessary. In the other cases, a series of themes connected with the problem, and the hierarchy of aims are raised one after the other by the therapist.

This approach leaves little room for a child to choose and decide. The therapist is going to work in a directive way and in a somewhat authoritarian manner. Because this is a directive method, it has the important benefit of saving time.

The relatively short duration of the course of therapies that follow this approach to content selection, however, includes the danger that a child is confronted with a series of choices, insights and their implications at a tempo that is beyond his/her control. Modifying possessed experience and changing meaning attributed to him/herself and his/her world are matters of intentionality. A child must open him/herself, show a readiness for this and, through actualizing his/her own potentialities, to assimilate and add new meanings to his/her already existing frame of reference. This is an event that no one other than the child him/herself can accomplish. At most, a therapist can make this possible and easier for the child. A disadvantage to this method is that the therapist can progress in such a concentrated way that superficial change or change of a short duration might be the result. Once again, it is the inexperienced therapist who runs the danger of becoming trapped in this pothole.

5.5 The therapeutic relationship

There was a great deal of agreement in the answers to the question about the therapeutic relationship.

This had to do with a search for the essences of the relationship established in a therapeutic relationship, and how this differs from an everyday relationship between an adult and a child. The following essential characteristics came to light:

5.5.1 Confidentiality

This is a concept that includes mutual trust but also emphasizes secrecy. Only when a child is convinced of the confidentiality of the situation can he/she confide in the therapist, who a short time before was a stranger to him/her and provide him/her access to his/her problem situation.

5.5.2 Sincerity

This concept, that also is known as congruency, includes that the therapist take care that he/she presents no “mask” to the child during therapy. He/she must present him/herself as what he/she is

as knowable. The child must not be misled. The therapist must not represent him/herself as other than what he/she really is. He/she is a person with certain merits and shortcomings, and he/sje must present him/herself to the child just as he/she is without any pretenses.

5.5.3 Empathy

At all times the therapist shows empathy in his/her relationship with the child while maintaining limits and a degree of distance. He/she never becomes involved in the situation such that his/her empathizing is converted into mere sympathy. At all times there must be understanding and insight, but never the therapist's own possessiveness and emotional involvement.

5.5.4 Respect for human dignity

Especially, a bogged down child shows a heightened sensitivity for signs of respect for his/her dignity. This obliges the therapist, in establishing his/her relationship with the child, to take care that the child is unconditionally respected and highly regarded as a person. This entails that the therapist genuinely takes note of the child's opinions and standpoints, and refrains from a superior attitude by which it is conveyed that the therapist can solve all of the child's problems.

5.5.5 Helpfulness

The purpose of establishing a relationship between therapist and child certainly is that the former will provide help to the child in distress. The therapeutic relationship is of such a nature that the child lives (experiences) that the therapist him/herself is available and willing to intervene with him/her.

5.5.6 Acceptance

When the therapist respects the child as worthy as a person, he/she also accepts him/her with all his/her defects as what he/she is. This is a precondition for eliminating the deviancy. At all times, the

therapist restrains him/herself from blaming the child in his/her relationship with the child who is bogged down.

5.5.7 Purposefully establishing a relationship

The therapeutic relationship is not a haphazard or informal relationship that arises spontaneously. It is purposefully established with forethought by the therapist. He/she takes the initiative for this and is responsible for its maintenance and unfolding.

However, there was one aspect of the therapeutic relationship about which there are large differences of opinion. Four of the institutes typified the therapeutic relationship as similar to an educative relationship. The therapist maintains authority and establishes a relationship of authority with the child. He/she sets limits and maintains norms and intervenes when needed. It was emphasized that such a relationship of authority was not authoritarian, but nevertheless constitutes an unmistakable part of the adult-child relationship during therapy.

Eight other institutes, however, had the opinion that the therapeutic relationship is unique and not comparable with an educative relationship. The therapist is not a substitute or surrogate parent and, as such, he/she does not assume the educator's disciplinary role. However, everyone agreed that definite limits must be set and maintained in the therapeutic relationship, as is the case in other interpersonal relationships.

5.6 The course of therapy

With respect to the course of the therapy, the methods of all the institutes showed a describable structure. In only one case the therapy progresses so diffusely that only an intervention and a follow-up phase are clearly distinguishable. As far as the others are concerned, the following phases of the course of therapy are distinguished.

5.6.1 A diagnostic phase

In ten cases, they begin with one or more sessions devoted to testing and exploring the situation. The parents, child, family and teacher can all be involved individually or jointly. There is a divergence of opinion regarding procedures and methods. The preference of the involved therapist seems to be a co-determining factor. In all ten of these cases, the diagnosis is carried on during the rest of the therapy, but gradually tapers off.

Diagnosis also occurs in the other institutes, but there are no sessions devoted exclusively to exploration. Thus, the phase is more diffuse and entwined with the rest of the therapeutic course.

Implementing tests and media seem to vary according to the nature of the therapy and the therapeutic methods planned. Those who avail themselves of the Rogerian nondirective method purposefully implement no media [tests] in their exploration, while a method such as audio-psycho-phonology requires a considerable amount of testing.

Although the nature and duration of the exploratory phase thus varies, all the institutes are in agreement that penetrating, exploring and, flowing from these, a phase of diagnosis is indicated in the therapeutic course.

5.6.2 Verification

Verification occurs at nine of the institutes. However, there is no agreement about its place in the therapeutic course. Often it occurs when one has arrived at a clear image or diagnosis. It takes the form of cross-referencing and verifying with other experts. Usually, panel discussions occur where there is reliance on the insight of therapists from a variety of fields. The following experts were consulted at the participating institutes regarding a deviant child:

Social workers	11
Physicians	9
Clinical psychologists	9
Speech therapists	7
Remedial teachers	6
Occupational therapists	6

Vocational orienters	5
Orthodidacticians	4
Pastoral psychologists	3
Eye specialists	3
Psychiatric social workers	2
Sociopedagogues	2
Sociologists	2
Audio-psycho-phonologist	1
Physical education specialist	1

Recommendations arise from the panel discussion about supplemental teaching as well as delimiting aims for the therapy.

5.6.3 Intervening

This is that phase of the therapy during which attributing meaning, clarifying, illuminating and assimilating new insights occur. The results of this are then perceived in the child's behaving. It is the phase that takes the most time in the total course of therapy. Ten institutes distinguish such a phase. In only three cases is the phase structured with two endorsing the pedagogical view of child deviancy while the third maintains the psychodynamic view. In the latter case, audio-psycho-phonology was used often as a therapeutic method. This requires a highly specialized, structured, carefully defined method where there is lots of time for using electronic equipment.

In the case of audio-psycho-phonology, a total of 100 sessions occurs over a period of three weeks. In the other cases, the intervention phase extends on the average over 3 months during which the child and/or the family is seen once a week for approximately 30 to 45 minutes.

5.6.4 Evaluating

From the investigation it seems that a considerable amount of vagueness and even confusion reign about the entire matter of evaluating the success of the therapy.

Only two institutes mentioned that they avail themselves of specific criteria in terms of which they can determine if the original aims had been attained and, if so, to what degree.

Those institutes that entered a contract with the family regarding the number of sessions the help would last do not distinguish an evaluation phase in their therapy. When the contract limit is reached, the provision of help is discontinued.

The other institutes do distinguish an evaluation phase at the end of the course of therapy. To be able to make a judgment about the degree of success of the therapy, the following mattes are taken into consideration:

a) The satisfaction of the reporting person. When the person who initially recommended the child and/or family to the institute is satisfied that the symptoms indicating distress have been eliminated, the therapy is labeled a success.
b) The therapy is discontinued as being successful when the child "functions normally", i.e., when he/she no longer is labeled problematic.
c) Favorable accounts by parents and teachers are seen as an indication that the therapy has succeeded and can be discontinued.
d) If the child in conversation with the therapist indicates that he/she no longer lives (experiences) him/herself as bogged down by his/her situation, the therapy is ended.
e) From the observations of the therapist him/herself, he/she infers whether the deviancy has been eliminated.
f) The same media (tests) used in the diagnosis phase once again are presented. Based on the child's achievement, the therapist decides whether to end the therapy.

However, three institutes have an organized follow-up system according to which the evaluation is continued after ending contact with the family. In one case, the parents were asked to report back in two months and in another case the clinic again contacted the family after six months to determine how successful and permanent the changes were.

None made use of an ordered evaluation system or method. The decision rests exclusively on the judgment of the therapist. Personal insight and experience of the therapist, thus seem to be decisive factors in this matter. There is no way in which the insight (or its lack) of parents and others involved can be evaluated. If the person, for whatever reason, assumes that the problem is removed, this is accepted, as such, and the therapist treats his/her intervention as a success. In addition to the subjective judgment of the therapist involved, the layman insight of the parent and other family members carry great weight in evaluating therapy with children.

With respect to evaluating each individual session, a lesser degree of vagueness reigns. Seven institutes use an assignment or "homework" system that is checked weekly by the therapist and is annotated. According to this, it then can be determined if the child and his/her family have succeeded in transferring the insight they have acquired during the session to their everyday life situation. In other words, it is determined if generalizing has occurred and to what degree. The evaluation of the previous session that is made at the beginning of each new session is an indication of the progress being made and serves as an aid for delimiting the subsequent aims.

5.7 Methods and techniques

There are a variety of therapeutic techniques and methods found to be highly useful by almost all the institutes, those that are very generally applicable, a series of supplementary or alternative methods of less general use and those methods that are beneficial only in isolated cases or that are unique to a specific institute.

In the following, attention is given to the techniques and methods that were applied at the participating institutes to eliminate child deviancies.

5.7.1 Methods generally applied

5.7.1.1 Behavior modification

Eleven institutes report that they often use this method. It is found by the institutes that made use of this method assess it highly because of the quick and dramatic results obtained with it. A further reason for the attractiveness of this method is that parents, teachers, family members and other persons outside of the surrounding effort can cooperate. Thus, this therapeutic method is not merely limited to sessions with the therapist. Indeed, a reason for its popularity is the fact that it lends itself to quantification and recordkeeping. Parents and child can experience the progress they are making in a variety of ways. Because of its abroad spectrum of techniques, the method is applicable in a laboratory with sophisticated electronic equipment or under the most limited circumstances. The technique is relatively simple and easy to master.

According to Morris (1976), behavior therapy rests on the following suppositions:

a) Problematic behavior is learned and thus it can be unlearned.
b) Behavior problems arise individually and independently of each other and can thus once again be unlearned
c) Undesired behavior can be eliminated by therapeutic techniques.
d) The problematic behavior that a child shows only indicates how he/she usually behaves under specific circumstances. Morris (1976, p. 7) explains: "It is therefore presumed, unless there is contradictory evidence, that a child's particular behavior problem is specific to the conditions in which it has been learned and does not generalize to other situations".
e) Problems are treated as they arise here and now. Historicity is not important.
f) The aim is specific and exclusively directed to eliminating the disturbed behavior for now. "... the goal of each treatment procedure is to change a particular behavior of the child, rather than to achieve a more general goal for 'helping the child get better' or 'helping the child reach his highest level of adjustment'" (Morris, 1976, p. 8).
g) As a rule, substitute symptoms do not arise. According to Morris they only arise when faulty modification procedures

are followed and/or when the causative stimuli are not correctly identified.

The types of behavior that can be eliminated by this therapeutic method are three-fold: acts seldom engaged in; unacceptable behaviors that must be refrained from.; and new ways of behaving that must be unlearned.

The principle at the foundation of all behavior modification procedures is that people and animals exhibit predictable behaviors under experimental conditions and that learning under similar circumstances occurs in accordance with fixed principles.

During the diagnostic phase the therapist delimits specific problematic behavior and makes a list of priorities of which behaviors urgently need to be changed. Then a tally is kept of how often and under what circumstances the behavior occurs. The therapist then decides if he/she will eliminate the negative behavior via de-conditioning or if it will be replaced by already positive behaviors by reinforcing the latte, or to change over to an entirely new behavioral pattern. Then a conditioning program is planned. The desired behavior is rewarded while reward is withheld in the case of undesired behavior. By some techniques, reward is not only withheld but punishment is administered to deter the objectionable. Albert Bandura (1962, p. 452) contends that research has indicated that punishment alone is ineffective for changing behavior; "... parental use of physical punishment provides the child an aggressive model for imitation." In addition to the weak example the adult presents, punishment stimulates conditioned anxiety.

Programs for treating several negative behavioral patterns are already designed and the assumption is that what holds true for one, also will be successful for the other. Consequently, the uniqueness of the child and the unrepeatability of his/her situation are completely overlooked. No room is allowed for the personal attribution of meaning, or intentionality, or intelligence actualization. Overlooking the humanness of a person, what distinguishes him/her from an animal, is one of the reasons this therapeutic method often fails. This compels Morris (1976, p. 60) to express the following: "But rewards have limits. No matter how

attractive a reward is to a child, it will not be useful unless the child is developmentally and physically ready to perform the target behavior". With this, then, he acknowledges that a child's state of becoming, or level of readiness is a decisive factor. However, it can be added that his/her own willingness, meaning giving and directedness, as well as state of his/her educating, at least are co-determining factors.

5.7.1.2 Directive play therapy

Equally as popular as behavior modification as a therapeutic method is directive play therapy where nine institutes reported applying it.

The reason for the general acceptance of this therapeutic method certainly is that it is so eminently suited for children up to ten years of age. Many therapists find it difficult to carry on a verbal conversation with young children and few young children in problematic situations are able to do so. In addition, a small child is not yet sufficiently able to express him/herself graphically and because of his/her relatively limited possessed experience, limited vocabulary and general knowledge, he/she does not readily establish a relationship with a stranger such that his/her unique attribution of meaning and attunement can be fathomed. Child play bridges these gaps.

Child play is one of those human ways of being that does not allow itself to be grasped by a definition. Many researchers have tried to verbalize the phenomenon with a greater or lesser degree of success. Child play shows a great diversity with respect to its nature and level. Not all forms of play are equally useful therapeutically. Jackson and Todd (1950, p. 3) give the following description of child play that can be beneficial therapeutically: "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 free from the keen sense of rivalry which enters into most games". Ter Horst (1972, p. 7) calls play "the ground form, par excellence, of orthopedagogics".

Play, itself, is not therapeutic in nature, it is a medium in terms of which a therapist can fathom a child's world (Ross, 1950. P. iii), communicate with him/her (Moustakas, 1959) and is a way in which a bridge can be built between the world of the child and society (Van der Stoep and Louw, 1978, p. 77).

In his insightful article, "Persuasive doll play: a technique of directive psychotherapy for use with children", Mann (1957) illuminates the underlying dynamic of this therapeutic method: The use of dolls bridges the child's distrust and defensiveness about discussing his own knotty situation. Commonly there is talk in the third person. For the child, it is "his" or "her" problem that is brought up and "I" am not delivered to a painful confrontation with the confusing situation. A high degree of transferring and accepting solutions and interpretations occur because the child appropriates the behavior of the "I doll" as his/her own. Mann even finds that changing behavior via play can occur when direct persuasion fails. Via play, the therapist transfers to the child in direct ways the meanings needed to alleviate his/her situation of distress.

A disadvantage of this method is that with repetition, the child subsequently rejects the procedure and takes away its effectiveness. "This limitation, however, seems to be a general one for all directive approaches to children", according to Mann (1957, p. 19). Another limitation is that play therapy is not suitable for children older than approximately 10 years, and not for seriously psychotic or intellectually retarded children.

5.7.1.3 Parental guidance

As are the above two methods, parental guidance is a popular therapeutic method. Thirteen institutes report that they commonly used it. Those who do not provide specific guidance to parents do involve them in a behavior modification program, family therapy and, in one case, audio-psycho-phonological therapy.

Thus, in all cases, it seems that parent(s) and child are involved jointly in the program of providing help. Not one institute took only the child into therapy. This is splendid evidence of the fact that currently in the R.S.A. there is general acceptance that a child

continually is educatively situated. He/she is continually in education as long as he.she is a child. If a child can be helped to recover and take responsibility for him/herself and be educated to adulthood, it must be considered that such recovery only is possible from within that relationship that a child has with the adult(s) who vouches for him/her.

Irrespective of the fact that parental guidance is used so generally, it proceeds mostly in unstructured and haphazard ways. Often the "here-and-now" problem of the child is chosen as a theme and the guidance provided the parents simply is to give practical advice on "handling" the child during problem situations. As reflected in the literature (Ginott, 1972; Adler, 1971; De Rossie, 1974), the guidance conversation with the parents mainly revolves around the following themes: communication between parent and child; discipline; sex education, jealousy, and rivalry between the children, learning problems and similar disturbing behaviors.

At present, in parental guidance, no penetrating attention is given to the essential nature of parenthood in connection with the essences of educating. No systematic, purposeful training in parenthood is provided. Therapists simply start from the knotty situation of the moment and providing the parents with practical pointers and expanding the conversation according to the interests and demands of the parent. In cases where the parent is involved in a behavior modification program, they carry out very specific assignments at specific times, tallying the progress and reporting it back. There is little room allowed for the individuality of the parent (Bandura, 1962).

Because of the limited time and methodical training program, therapists assume that simple insight during a therapeutic conversation will change a parent's entire attunement and possessed experience that extend over years (Rogers, 1939, p. 184). Practice has taught that as soon as a parent again is placed, unguided, in his/her knotty situation, a distortion of insights occurs. He/she is under the delusion that he/she is following the new approach, but his/her new insights are so twisted that they fit into his/her old frame of reference. Changing meaning in parents is a complicated

and lengthy event. After care and follow-up evaluation are extremely important.

The ideal would be that systematic training would be given to the parental pair so that they not only can arrive at bettering the present problem but self-confidently can further bring their child up to adulthood.

5.7.1.4 The guidance conversation

This therapeutic method is mentioned in nine cases as of great practical value. As alternatives or supplemental methods for modifying behavior, play therapy is done with younger children and the guidance conversation is used with older children. This method lends itself to accommodating a wide variation of the nature of a child and his/her problem as well as the personal prefence, ability and therapeutic style of the therapist. The technique can vary from reflection, clarification, identification of the problem and giving support for making his/her own decision for a more didactic teaching conversation where, in direct ways, alternatives are shown for a child.

Although this method is extremely popular in handling teenager problems, it is not limited to use with older children. Expert therapists carry on conversations with young and even very small children, especially in addition to play therapy.

According to Stewart and his co-workers (1978), the guidance conversation is realized within a relationship characterized by:

a) active communication in a verbal as well as non-verbal way,
b) non-possessive warmth and acceptance,
c) sincerity and
d) readiness to concretize.

The technique the therapist applies to bring the therapeutic event into motion is subject to his/her personal preference, the nature of the problem and the potentialities of the child. The methods followed mainly amount to the following:

(i) The coordination of background data, reports and own perceptions.
(ii) Analysis and ordering of data.
(iii) The establishment of a therapeutic relationship and orienting the child. The nature and scope of the provision of help are elucidated and, if desired, an agreement can be reached about the duration of the help given.
(iv) Mutual aim delimitation by therapist and child.
(v) Exposition of the new. This can occur in terms of an example, or by offering opportunities for practice under safe circumstances or even by a situation analysis that results in cognitive ordering and affective stabilizing.
(vi) Evaluation of the functionalizing of the newly acquired insights.
(vii) Re-guiding or following up if needed.
(viii) Ending the therapeutic support.

With respect to this method, Rogers (1939) warns against the temptation to "preach" to the child and says if the solution is presented in a one-sided way by the therapist, it has little value. He adds, however, that if the therapist's solution coincides with the choices and adjustments that are present in the child, "it may serve to hasten and strengthen the re-educative process". Thus already in 1939 Rogers had arrived at the insight that, in essence, the therapeutic event is a learning event. Just as no parent or teacher can force a child to learn if he/she doesn't want to, no therapist can *let* a child *learn* if it is not meaningful to him/her. A therapist cannot force solutions on a child. "A wrong interpretation or one which is prematurely forced on the child may definitely set him back in his personality development", according to Rogers (1939, p. 332). This leaves a child feeling more discouraged and hopeless about his/her situation.

Despite objections that can be made against a directive method, it seems that the guidance discussion is extremely useful in the practice of providing help to children with problems becoming adult.

5.7.2 Supplementary methods

There are a variety of methods that mainly are applied as complementary to those mentioned above. However, they are equally well applied alone. It seems that these methods are less generally used than those mentioned in section *5.7.1.* The reason is not always clear. It might be that these methods have fewer possibilities for application. An additional reason, however, might be that they also are relatively specialized and require specific skills from the therapist. That they are relatively unknown might also be a relevant reason. This is a question that requires further penetrating research that falls beyond the scope of the present study.

5.7.2.1 Language enrichment therapy

This therapeutic method was applied at six institutes. It is especially institutes that serve children's homes that often use this method.

To do justice to this method, it is a precondition that the therapist has mastered the language used in an exemplary way, and is completely familiar with the culture it reflects. For example, it is doubtful if a white therapist can help an Indian child in this way or that a colored therapist can really do justice with a Zulu child.

This method is applied, par excellence, in cases where children are from limited milieus such as asocial neighborhoods, children's homes, residential and/or from environments where they have been so educatively neglected that they have an attenuated experiential residue and an impoverished language (Grove, 1975).

Language is seen as much more than a sound-symbol system. It is, par excellence, a communication system unique to humans and includes a spoken as well as a written component. In and through language, a child establishes a world, strengthens his/her grip on reality and expands his/her life horizon (Sander, 1967, pp. 56-81). In his/her language, a child presents him/herself as knowable. An impoverished language affects a child-as-totality unfavorably. Language defects wreak havoc over the entire range of child being.

In language enrichment therapy, attention is not only given to vocabulary, grammar and articulation, but to the development of a child's personal potentialities. Help is provided regarding affective stabilizing, cognitive ordering, normative giving meaning, interpersonal relationships, as well as perceptual and motor skills. Particular attention is given to good listening habits (Grove, 1972; Blignaut, 1967).

The techniques applied vary from taking excursions, sightseeing tours, to playing dexterity games, and putting on plays, reading and discussing literature, writing compositions and giving speeches, and holding discussions (Barnard, 1973, Chapter VI).

Language enrichment therapy is a method that is not location-bound, and also requires no specific equipment. Improvisational skill of the therapist is the most important requirement. The method lends itself to a great variety of forms of progression. The method also is useful with children of all ages, individually or in groups.

5.7.2.2 Psychomotor therapy

This method is known by a variety of names, such as developmental therapy, perceptual training and physical therapy. It is used at six institutes for eliminating child deviancies grounded in a physical defect. Very often this method is combined with language enrichment techniques and orthodidactic help.

This provision of help is opened by a diagnostic phase during which a child's physical skills and the state of sensory perception are carefully inspected. Often the results are expressed as a score indicating a child's achievement in relation to the average achievement of his/her age group. Chronological age and physical maturity are of great importance. This therapeutic method emphasizes the coherence of the psychic life and bodiliness.

At the end of the diagnostic phase, a therapeutic program is planned with firmly described aims and a relatively structured course. Marianne Frostig has achieved groundbreaking work in this regard. In her practical handbook, *Move – Grow – Learn,* she says:

"This program is not designed to teach only skills, although that is a very important part of it. It is designed to help children express themselves through movement to become more aware of themselves and others and to become more aware of feelings and how feelings are aroused by movement" (Frostig, 1969, p. 61). The program takes the form of a series of exercises focused on the optimal attainment of knowledge of bodily positions, bodily experiences, actualizing language, perception, motor skillfulness and a sense of rhythm. Braley, Konicke and Leedy (1968) mention that Piaget, Montessori, Gesell and others have found that the development of physical skills paves the way to successful learning within as well as outside of a school context. This therapeutic program is viewed as beneficial for helping children with neurological problems, children from environments which physically limit them, traumatized children and children overprotected by their parents, as well as preparing them for receiving school teaching, i.e., making them school ready.

5.7.2.3 Orthodidactic help

This is a highly specialized method for helping children who get bogged down in school with learning problems. However, an orthodidactician concerns him/herself not only with a child's problems with school subjects, but considers a child as a totality in helping him/her. The problems a child experiences with non-school content are rarely considered. Hence, this method is suitable exclusively for use with school children.

Four of the thirteen institutes turned to this method. At the other institutes, a child with learning problems in school is confronted directly with the therapist's use of other methods and supplemental help by a teacher.

In view of the large numbers of children who are bogged down in the school situation, it seems desirable that this method gain greater acquaintance.

In broad strokes, the method is summarized as follows: a historicity conversation is carried on with both parents, the child him/herself and his/her teachers to gauge his/her current situatedness, to

fathom his/her attribution of sense and meaning and future hopes, and to trace his/her physical development. All relevant medical data are obtained.
Subsequently, the child is observed pedagogically to determine his/her affective, cognitive and normative personal potentialities. In the third place, a child is subjected to a diagnostic evaluation to identify the nature and scope of his/her learning problem, as well as the actualization of his/her modes of learning (Sonnekus, 1968; Van Niekerk and Sonnekus, 1979). The results of the orthodidactic investigation are a person-image of the child from which is expressed his/her own unique nature. The findings are provided about the state of his/her becoming, the nature and scope of his/her learning problem and the modes of learning that he/she is best able to utilize.

Subsequently, a therapeutic program is compiled that progresses in structured, purposeful sessions during which the child is supported directly in eliminating his/her learning-restraining moments. The results of the therapy are evaluated in terms of pedagogical criteria. Thus, there is not only an attempt to eliminate the symptoms, but to assist the learning child on his/her way to adulthood.

The techniques used to bring about a transfer of meaning embrace, e.g., remedial teaching, perception exercises, motor-exercise play, conversing, articulation and speech exercises, acquiring knowledge of bodily positions (Bannantyne and Bannantyne, 1973) and changing the attribution of meaning via pedagogical techniques of projection. Thus, orthodidactics, as a method of providing educative help, incorporates many of the techniques also found in other therapeutic methods. However, the emphasis usually falls on the defectively learning child in contrast merely to treating symptoms.

5.7.2.4 Art therapy

Five institutes make use of this method, but only on a limited scale, and exclusively as a supplementary method.

This therapeutic method sets high demands on the insight, intuition, sensitivity and empathy of the therapist, and assumes a

basic knowledge of usable materials, their possibilities and limitations. Use is made of techniques such as sketching, painting, modeling, woodcutting, etc. Often there is an evasion from applying this method because of the faulty assumption that the therapist and child must possess talents that will place the end product in the framework of "fine arts". The only justification for placing the method under this heading is the fact that the media used (paint, clay, brush, paper, etc) are the same as used by an artist in his/her artistic expression. With respect to the aim, method and result, there are conspicuous differences between the therapist and the artist.

With respect to art therapy, Naumberg (1961, p. 33) says: "... every individual, whether trained or untrained in art, has a latent capacity to project his inner conflicts into visual form". The purpose then is to draw the child out to expression and projection. In doing so, he/she concretizes his/her feelings and thoughts. He/she represents them by giving them visual form. Because the child expresses him/herself graphically, he/she tunes the therapist into the matter in order to explore his/her experiential world, and also to communicate with him/her via the image. Cheney and Morse (1977) indicate that art therapy mainly is applied to

a) explore the non-conscious contents, and
b) as a way of communicating.

However, it is important to indicate that the therapist does not interpret the image for the child, but encourages the child to do so him/herself via verbalizing. As soon as he/she names his/her image, distancing and objectifying occur and the therapist can further support him/her to cognitive ordering. For the most part, non-directive techniques are used and the course of the therapeutic sessions largely is unstructured.

Van Lennep (1958) indicates that although this method is very suitable for children who find it difficult to verbally express themselves, its utility is limited to children who fantasize easily. The phase of a child's becoming also is of great importance. For a toddler, graphic expression is manipulative play. It has little communicative significance. An older child can create something

that can withstand his/her own and other's criticism. He/she will make a true to life rendering or, in adequate ways, give form to his/her lived experiences. This demands high technical skillfulness. A child in the realistic phase strives for a representation that is true to life. He/she no longer gives personal form to his/her drawings but strives spasmodically to give a photographic representation. He/she fails at this. Child drawings proceed to adult drawings when a child is aware that his/her product must meet higher demands than merely being a form of expression.

Art expression, in themselves, are cathartic and in this sense, they also have therapeutic value, but art expressions also can be of further therapeutic benefit as a medium of communication.

5.7.2.5 Drama therapy

This method was applied at six institutes. The same presumptions hold as for art therapy. Once again, it is to be lamented that the name has undesirable connotations because the method has broad possibilities of application. It is usable with small children from the age when they can readily fantasize, imagine and verbalize up to and including adulthood.

Drama therapy progresses largely in an unstructured way. The therapist takes a directive part, especially at the beginning of the help, with the aim of bringing the child to elicit verbal and non-verbal expressions. Use is made of a great variety of techniques such as, e.g., making glove puppets available, music, prints, toys or the widely know "Tell-a-story" technique where the therapist begins a story and the child is asked to continue it. The child is continually encouraged to arrive at expressions through gestures, bodily movements, mimicry, or words. The success of the method is closely connected with the quality of the child's emotional expressions and his/her readiness to explore. The ending phase places high demands on the sensitivity and empathy of the therapist. Via the relationship he/she establishes with the child, the therapist insures him/her that he/she sympathizes emotionally with him/her and that he/she will not be delivered to the frightening image that looms from his/her fantasy world.

It usually requires a few practice sessions before he/she will proceed to projection. Because the therapist gets involved and plays with the child by playing one or more roles, the opportunity is offered to transfer meanings. In subtle, non-authoritarian ways he/she gives direction to the little dramas, stories or doll play and, in doing so, to lead the child to situation analysis and the disclosure of a possible solution. Even a variety of solutions can be tried out.

This method also offers an opportunity to play out the role of the other. However, this requires a relative degree of skillfulness of the child to distance him/herself from his/her feelings such that he/she can imagine for him/herself how another would behave, feel and think under the same circumstances. If the child succeeds with this, he/she acquires insight that enables him/her to order and systematize his/her own lived experiences cognitively. In its turn, this works to stabilize his/her affect.

Rogers (1939, pp. 314-318) reports that in 1937 Dr. Howard Potter and Dr. Louise Despert of the New York City Psychiatric Institute had applied dramatic play as a way of expression that has cathartic results, but also provided an opportunity for a directive treatment in terms of the play symbol used in transferring meanings.

When it is considered that drama therapy with children is an old method, it is regrettable that, in the R.S.A., it has not received greater familiarity. Research and re-interpretation in terms of modern scientific insights would be a great contribution to filling this gap.

5.7.2.6 Family therapy

Six institutes reported that they applied this method for eliminating child deviancy.

The opinion that the family is a functional unity, that mutual family relationships influence the educative relationship, and that the child cannot be helped outside of his/her situatedness to get the best of his/her deviancy, is readily admitted by all the institutes. It is an experiential fact that a child very often is brought to the clinic as being the deviant member of the family, while he/she is the only

one who shows symptoms of a deeper-lying family pathology. Nevertheless, in the R.S.A., family therapy as a method, is still in its infancy.

Mainly two methods of family therapy are distinguished. The first rests on Bowen's (1971) view that the family exists out of a fusion of individuals and that, as long as the family members remain fused with the preservation of individuality, the family is fundamentally sound. Deviancy arises when the lives of the family members become so entwined that the stability of one is threatened by a change in the other. Klugman (1976, p. 322) describes this as follows: "When people are fused, any change in one is a threat to the other, since fusion contains the notion that the emotional security of one is dependent upon the constancy of his relationship to the other".

Bowen's therapy also includes a restoration of the individuality of each family member by means of maintaining contact. This requires that the therapist establish individual relationships with each family member to look at and listen to the other. Initially, there is an inclination of the parents to speak in the name of the child(ren) or to chip in and be complimentary. The therapist acts as a conversation leader, but remains an outsider. As soon as the family highly esteems each other's self-wanting-to-be-someone and allows this to be expressed in their family life, the therapist's task is completed.

The second method of family therapy is that of Salvador Minuchin. He views the family as individuals existing as a system. Each family shows its own structure that leaves its stamp on the behavior of its members. "Therapy based on this framework is directed toward changing the organization of the family. When the structure of the family group is transformed, the positions of the members in that group are altered accordingly. As a result, each individual experiences change" (Minuchin, 1974, p. 21).

To bring this change about, the therapist connects with the family. He/she tries to re-establish communication within the family, and then observes the ways of communication, verbal and/or non-verbal. Then he/she presents a diagram of the structure the family

shows. It is indicated who the family member is, who is the spokesman, who takes the initiative, who shows aggression against whom and when, who covers for whom and who withdraws or moves to the periphery. Then, the therapist clearly delimits aims that he/she arranged hierarchically. Through directive participation in the family discussion in a concerned way, he/she tries to bring about a change in the family structure. "Change is seen as occurring through the process of the therapist's affiliation with the family and his restructuring of the family in a carefully planned way, so as to transform dysfunctional transactional patterns", according to Munuchin (1974, p. 91).

To set family therapy in motion, a variety of techniques are applied. Fellner (1976, pp. 427-431) uses fables and legends as starting points, while Anderson and Malloy (1976) report that they used the family photo-album therapeutically. Shifting often is made of the sitting places that the family had assumed during the session, or the therapist directly asks two or more of the members to discuss a theme.

There are considerable differences in opinions in family therapists about the presence of young children at such re-structuring sessions. Dismantling the existing family structure and replacing it with a new one can be a confusing and even painful experience for adults. When such changes are brought about in the presence of young children who are in a dependent relationship with their parents and do not yet have the insight and understanding of the older children in the family, it is doubtful if the event will result in stabilizing their emotional life.

The result of structural family therapy on the educative relationship is a matter that demands further investigation before a finding can be provided about its value as a therapeutic method on behalf of a child in distress.

5.7.2.7 Environmental change

Four institutes mention that they used changing the child's physical environment in their provision of help. However, all four institutes

emphasize that they view this as a drastic intervention and only is applied when it seems to be the only way out.

The method mostly amounts to temporarily or permanently removing the child from his /herexisting educative situation and placing him/her in a substitute one when there are educatively impeding aspects present in the original situatedness that cannot be eliminated. With this, not only is the structure of the original situation drastically changed, but also is the new family or group. Rogers (1939) cautions that it must be kept in mind that no child can permanently disregard his/her family of origin. Only the impact of their daily influence is lessened. The new situation does not negate the old, the child always enters the new one with established possessed experience,and he/she is received there by adults who entertain specific expectations regarding his/her changing for the good. Thus, it is not an uncomplicated, relaxed situation that lies ahead.

Traditionally, this method of providing help mainly was used with juvenile delinquents (Burt, 1943, and Tappan, 1949). These days, however, the divorce rate is so high that drastic changes in home circumstances are not unusual. The following placements most generally are made: living with another parent (in the case of divorce), foster care (whether with family or strangers), boarding house, clinic schools, hospitalization and homes for children.

A less drastic intervention regarding the child's educative situatedness is to keep the primary or home educative situation intact and to bring about change in the school educative situation. Changes of this nature would include: preschool, day centers or play groups, changing a classroom teacher, courses or schools, entering an after school center, youth group or club. The value of the latter changes is that temporarily an opportunity for distancing provides an opportunity for objectifying. This results in cognitive ordering and affective stability.

Tappan (1949, p. 308) believes that everything in this struggle must try to keep the child in his/her original environment and to help him/her and his/her parents as the other possibilities for change

are scanty. Experience has taught that the prognosis for institutional and foster care is poor.

5.7.3 Methods used less generally

5.7.3.1 Rogerian non-directive client-centered therapy

Use was made of this method at three institutes.

At the foundation of this method is the assumption that a human being has a personal core that is positively directed. He/she can and will get the best of his/her problems him/herself if he/she is given the opportunity to do so (Rogers, 1951; Axline, 1977, p. 10). It is the therapist's task to provide such an opportunity. Because the client him/herself exclusively takes the initiative, the therapist indeed is client centered. This principle holds even in the case of a child. The bogged down child might initially shrink from taking such initiative. This, then, is one of the reasons this therapeutic method is extremely time consuming.

The therapy is not just client-centered but also non-direction giving. Rogers and his followers assume that if the therapist completely refrains from presenting norms and values, a child necessarily will make the correct choice (Rogers, 1964, and 1965). If he/she is left free to learn at his/her own tempo, on his/her own initiative, following his/her own interests and, in his/her own way, (Rogers, 1969) he will him/herself discover the solution to his/her problems and learn how to behave him/herself such that he/she is accepted by others.

To bring isbout the situation, the therapist uses several techniques that are not peculiar to this therapeutic method, but really a specific relationship is used in a particular way, and with a specific aim. The approach is briefly summarized as follows:

a) The therapist enters the therapy in a relationship that evidences unconditional acceptance, regard for the person, empathy and congruence.

b) No historicity conversation, observation or exploration is carried out before the therapy. The child is met as what he/she is, here and now.
c) Strong limits are placed on time, but in addition, the child may do and say what he/she wants whenever he/she wants.
d) The therapist identifies the child's feelings, thoughts and aims, and names them. He/she verbalizes for the child, but restrains him/herself from any value judgments, assignments or suggestions. The therapist reflects, but gives no direction to the course of the event.

This therapeutic approach places high demands on the skillfulness of the therapist and is time consuming. It also places high demands on the intelligence of the child. It is expected of the child, who is not-yet adult and thus not-yet morally independent, to accept the consequences of his/her deeds and decisions. Owing to his/her being a child, he/she still has limited possessed experience and cannot yet fully anticipate and judge these consequences. In this respect, child and adult are placed on the same level about non-directive client-centered therapy.

5.7.3.2 Audio-psycho-phonological therapy

Only one clinic in the R.S.A. avails itself of this method. Indeed, in this country, it is still largely unknown, mainly because it is based on very recent research.

"Audio-psycho-phonology is the study of the mutual connections and interactions among a human's listening and hearing abilities (audio), his/her psychological attunement (psycho) and his/her control of speech and language" (Van Jaarsveld, 1979). It is a new science that has its origin in the pioneering work of the French phonetician, Alfred Tomatis.

According to audio-psycho-phoneticians, many human inabilities are attributable to perceptual deprivation, e.g., speech, language, hearing, balance, laterality, memory and attention problems, tension, depression aggression and psychosomatic conditions. "With perceptual deprivation *listening* to *hearing* are impoverished.

An affective shock can change an acoustic encounter into a painful and exhausting experience" says Van Jaarsveld. The underlying connections and coherence of the auditory organ, affect and language are emphasized and have central relevance for therapy.

For the child not only to hear but also be able to listen authentically, resistances that block perception must be eliminated. This is not an exclusively somatic matter. Auditory-psycho-phoneticians recognizes the totality of a person in function. Van Jaarsveld stresses that a person is not a stimulus-response-organism, but that he/she continually is in relation to and has a role to play in his/her psychic becoming. The child is educatively situated and continually is in a relationship with his/her educators. Also, his/her parents usually are situated in an educative relationship with their child. The being-there of a child makes a woman a mother, a man a father. When a child manifests problems, the parents also are co-involved with the problems. For this reason, the child is never only involved with the therapist, but always is accompanied by at least one educator. Audio-psycho-phonological therapy is directed to parent and child.

The resistances that prevent a child from listening authentically and, thus, communicating with his/her fellow persons in his/her human way via language can be placed on different levels. During the diagnostic phase of the therapy, the investigation is attuned to the state of:

a) the physico-chemical level
b) the biotic-physical level
c) the biotic-psychic level, and
d) the psychic-spiritual level.

After determining the level of malfunctioning, a remediation program is compiled for parent and child. In its therapeutic program, particular emphasis is placed on the trilogy of verticality, laterality and language. Use is made of electronic equipment and tape recorders. By restoring the listening function, not only is the way to language opened, but with this also are the physical-acoustical and cognitive-affective interwoven characteristics of language, according to Van Jaarsveld.

Aristotle has said that the ear is the portal to the soul, but thanks to the pioneering work of Tomatis, and Prof. Van Jaarsveld from Potchefstroom in South Africa, children with listening problems such as the autistic and neurological handicapped can benefit from a therapy that is hardly known after a decade of neglect in the R.S.A. Because of the high demands placed on training and technical equipment, by its nature, this method only is possible in a well-equipped center where the necessary technology is available.

5.7.3.3 Ellis' Rational-Emotive Therapy (RET)

Only one institute used this method.

In contrast to the more traditional forms of psychotherapy, Ellis' RET is a relatively short-term procedure. Within an average of 30 sessions, it is possible not only to improve the announced symptom but also bring about favorable results with many less conspicuous problems. Ellis also mentions good long-term results.

His method is an offspring of his [philosophical] anthropology, i.e., a human being is not merely a stimulus-response being, but he/she has possibilities of choosing, of actualizing his/her willing, living normatively and holding his/her own view of life and of persons. The behavior that an individual shows in answer to the appeal that his/her world directs to him/her can be modified via didactic intervention in a directive way when his/her life philosophy is deficient and ought to be changed or supplemented. With respect to RET, Ellis (1971, p. 6) says: "It shows the individual that whenever he upsets himself at point C (the emotional consequence), it is not (as he almost always thinks is the case) because of what is happening at point A (the activating event). Rather it is because of his own irrational and unvalidatable suppositions at point B (his belief system)." When a person realizes he/she has choice possibilities regarding his/her personal taking a position, he/she transfers this insight to the broader spectrum of his/her personal being, and not only to the specific problem.

To bring about this insight, Ellis makes use of various familiar techniques such as homework assignments, role-playing, dramatic

expressions, conditioning and direct confrontation. Unique to this type of therapy, however, is the use of "a Socratic-type dialogue through which the client is calmly, logically, forcefully taught that he'd better stop telling himself nonsense, accept reality, desist from condemning himself and others, and actively persist at making himself as happy as he can be in a world that is far from ideal". This Socratic method to which Ellis (1971, p. 4) refers is direction giving via question and answer, verbal reasoning and drawing logical conclusions.

In contrast with most other therapeutic approaches, where the emphasis falls on the quality of the therapeutic relationship, Ellis believes that his success is just as ascribable to the fact that the therapist pays minimal attention to the relationship and maximal attention to his/her teaching task. Ellis criticizes Rogers and his followers who state unconditional acceptance as a therapeutic prerequisite. A person leaves the therapy with the impression that he/she is worthy of being human because his/jer therapist has respected him/her, and very likely other people will feel the same about him/her. Ellis tries to bring a person to self-acceptance, irrespective of the opinions of others.

Ellis makes a plea that his view must influence child educating and must even be introduced at school. It is hardly imaginable that this sort of verbal reasoning and use of logic is attainable with a young child who still distances, objectifies and reasons inadequately, especially if such a child is emotionally shocked and his/her cognitive potentialities are used inadequately. To hold one's own view of life and of human beings is an essential characteristic of adulthood. The child, also the bogged down child, must yet acquire this. By definition, a child is not yet morally independent and cannot yet accept responsibility for his/her own choices. His/her possessed experiences limited. It is not possible for him/her to arrive at self-understanding, self-insight and to make room for his/her own standpoint in life in any other way than by interacting with his/her educators. A young child's self-image is influenced greatly by what his/her parents think of him/her. He/she unconditionally accepts their value judgments about his/her deeds. This primordial trust in the correctness of their judgment is an indispensable source of (living) experiencing security. To expect a

young child to arrive at self-acceptance in opposition to the opinions of his/her educators is to ask too much and to overlook his/her being a child.

Ellis (1971, pp. 7-8) adds: "Even if his rejection by another indicates that this other person finds him completely valueless, he would still be wrong if he concluded 'Because I am totally worthless to this *other,* I have to consider myself totally worthless to me'". To acquire insight with such a faulty attitude, and to replace it with a more acceptable alternative, requires a generous degree of adulthood, experience, intelligence and verbal expression. It is possible that these attributes can be present in children in puberty, adolescents and some in the pre-puberty phase.

It appears as if Ellis' RET has limited possibilities of application to child deviancy.

5.7.3.4 Gestalt therapy

The one institute that availed itself of this therapeutic method used it alone and/or alternatively with Rogerian client-centered therapy and Ellis' RET in one and the same session.

F. S. Perls is the founder of gestalt therapy as a method for eliminating deviancy. According to him, deviancy arises when there is stagnation in the growth process. Such stagnation arises when a person becomes alienated from him/herself and his/her environment, when the person-world gestalt is disrupted. Under pressure from society, authorities, educators and other authority figures, a person tries to be other than what he/she is. "The basic principle underlying these disturbances is the environmental demand to be what he is not, the demand to actualize an ideal rather than to actualize himself" (Perls, Hefferline and Goodman, 1976, p. 10).

The therapist tries to bring the child to think in terms of *my* self, instead of myself. His/her interventions are focused on disclosing the self as a gestalt of which the whole is greater than the sum of its constituents. According to Perl's [philosophical] anthropology, this

is possible in that person and world are not separate but form a unity.

To bring about this becoming aware of self, a person is advised to engage in different "experiments" rather than carrying out assignments. "In this process, which is the process of growth and maturing, the patient experiences and develops his 'self' ... via the means at his disposal: his available amount of awareness in experimental situations" (Perls, Hefferline and Goodman, 1976, pp. 18-19; and Prinsloo, 1976). The therapist designs subsequent experimental situations in which a person proceeds to perceive his/her senses, perceiving, intuiting, remembering, verbalizing, becoming aware of bodiliness, introspecting, meditating, etc.

Paul Goodman (Perls, Hefferline and Goodman, 1976, p. 354) believes that children are still not responsible, not because they are children, but because their parents force them to irresponsibility through their disciplining and punishing: "A child's irresponsibility follows from his dependency; to the extent that he is closely part of the parental field, he is not answerable to himself for his behaviour". According to this way of seeing, the therapist must deliver the child from his/her deficient insights, limited life experiences and still not realized potentialities. The primordial trust a child shows in the adult that the latter will accompany, support, sponsor and protect him/her against grief is violated.

Some techniques of gestalt therapy, however, can be of great value if applied by a pedagogically accountable therapist on behalf of children from a limited milieu, educatively neglected children who are harmed in their wanting-to-be-someone-themselves, children who, because of physical defects or limitations, have become alienated from their environment and children who live (experience) their bodiliness unfavorably.

5.7.3.5 Group play therapy

Only one institute used this method. During group play therapy two or more children in the presence of a therapist are together in the playroom. There are no specific limitations for age differences, gender or the nature and scope of the problem.

Virginia May Axline (1977, pp. 199-208), the founder of this therapeutic method, points out that the same fundamental principles hold for group play therapy as for individual, non-directive play therapy, namely:

a) The therapist establishes a warm, friendly relationship with the children.
b) He/she accepts the children just as they are at this given moment.
c) The therapist ensures a permissive atmosphere so the children will feel inclined to express their emotions.
d) The therapist identifies the children's feelings and intentions and verbalizes them in such a way that they acquire insight into their behavior.
e) The therapist trusts that each child can and will solve his/her own problems. He/she restrains him/herself from making choices.
f) The therapist him/herself does not give direction to the event; he/she lets all initiative come from the children.
g) No attempt is made to accelerate the event.
h) The therapist only sets limits that ensure that the therapy remains bound to reality and to make the child aware of his/her responsibility for the relationship.

Because the therapist remains in contact with all of the children in the group, he/she provides a running commentary of what each feels anticipates, intends and aims at. Thus, the child not only acquires insight into his/her own behavior, but also into that of the other children involved in the situation. Axline believes children understand each other, that they speak the same language. The group experience accelerates the child's acceptance of the permissive therapeutic relationship. When one takes the lead and ventures. the others are co-involved, and this spurs them on to expression. This seems to be an important benefit from this method since it is just this matter that is time-consuming in the case of individual non-directive play therapy.

The therapist makes no attempt to settle any conflict or aggression among the children. In true Rogerian style, he/she trusts that each

child eventually will make the correct choice because each person, and also each child, eagerly wants to be accepted by the others (Axline, 1977; Rogers, 1964).

Since each child has his/her own knotty situation, a variety of themes and emotions arise within a few sessions. Suggestions also play a prominent role. An incidental remark by one member of the group stimulates a response from another member who, now, was involved with something else. The encouragement given by the therapist lessens while the interaction among the children gains momentum during the session. A characteristic of non-directive group play therapy is the fluctuating emotions each child lives (experiences) during a session.

This therapeutic method places particularly high demands on the skillfulness of the therapist, especially in cases where one child dominates the course of events, where his/her negative behavior finds favor with other members of the group and each does not take the opportunity to explore and assimilate the situation at his/her own tempo and discretion.

The ending of a group session often is a problematic matter since it seldom occurs that all group member's conversations and activities simultaneously reach such a state where the session can be conveniently ended.

In addition to the critique of Rogerian non-directive client centered therapy raised in section *5.7.3.1* and that also holds for non-directive group play therapy, it is added that it is doubtful if a child who already is bogged down in his/her own knotty situation can distance him/herself from it enough to benefit from the insight acquired about the problems of another. The quality of the relationship with the therapist, that is seen to be of decisive importance during non-directive therapy, becomes shallow because he/she takes turns with the others or competes with them for the adult's attention. The therapist refrains from making value pronouncements and judgments about a child's behavior, but this restraint is freely supplemented by commentary by the other children. Deviant children are less permissive with each other than

a highly trained adult with respect to an individual child in non-directive therapy.

The relationship with the therapist becomes shallow, the permissive situation becomes diluted because of limits from the group, the emotionally unstable child becomes absorbed in the problems of others and the less expressive child is dominated by the tempo and skillfulness of the leader of the group. Thus, it seems that the relative unpopularity of this method in the R.S.A. is attributable to multiple stumbling blocks and practical problems that therapist and children in distress face with this method.

5.7.3.6 Final considerations

The great variety of techniques that now are applied on behalf of a derailed child with more or less success has compelled Skuy (1975, p. 111) to say: "In fact, there do not seem to be any techniques which are always associated with people who are effective in the helping relationship". It must be granted that he is right.

Technical skillfulness does not seem to be the determining factor in providing help. Moustakas (1959, p. 23) refers to Jessy Tuft who indicates that therapy is not something that one person does to another. There really is no verb for *therapy*. The event that plays itself out when a child in distress encountered by an adult fellow person who accepts responsibility to provide help, is a complex event that requires closer study and theorizing.

5.8 Parental accompaniment

With respect to helping parents, there is a clear distinction to be made regarding the service provided a parent as a co-concerned person. Two approaches are distinguished here:

5.8.1 Help with [personal] adulthood problems

Six of the institutes provide help to parents regarding their own problematic situations. The underlying idea is to enable the parent, as person, to be an adequate parent for his/her child, and to benefit

from training in parenting that is provided as a service that complements the first. Of the six institutes affirming that they provide help regarding [personal] problems of a parent that are not directly applicable to the educative situation, only two are prepared to involve the adult in long-term, intensive psychotherapy. The help offered by the other four institutes frequently takes the form of guidance conversations. If it appears a parent is not benefitting from such help, he/she is referred to another institute that can be of help.

5.8.2 Training in parenting

All of the institutes provide training in parenting to the parents, in addition to help for their child. This training in parenting can occur in the form of group sessions with parents, during family sessions where the children are present and in conversation with a few of the pairs of parents or alone with an individual parent.

This help in parenting largely is determined by the nature of the child's problem. In cases where behavior modification is used, the provision of help takes the form of direct, firmly prescribed instructions and directions. In the case of family therapy, the matte is discussed under the guidance of the therapist and a solution is reached in response to the unique situation of the individual family.

What is held by a pedagogical view of the deviant child allows parental accompaniment to proceed according to a fixed structure. The essentials of being a parent are highlighted and presented. The essentials of parental input, ehivh are preconditions for child becoming, are indicated. In doing so, the parent acquires an insight, not only into his/her child's current troubled situation, and he is not only supported in eliminating the existing bottlenecks. He/she also acquires such insight that he/she, since these insights into the fundamentals of educating, can decide on a plan of action in the future in response to changing circumstances. The aim is that, via training in parenting, the parent will acquire insight such that he/she is not "recipe" bound but that he/she is able to improvise and make changes, as the situation requires.

The basic difference between the provision of help to parents from a pedagogical perspective and the parental accompaniment offered from the other lines of thought, is that the pedagogical is not merely directed to symptoms or to the "here-and-now". In contrast, the pedagogical also is future directed. One of the aims of providing this help is to restore the parent's confidence and future perspective such that once again he/she can look to the future with his/her child.

One institute that holds the pedagogical view makes use of the services of an after-care official who visited the parents at home during the parental training and on site after it ended to evaluate what kind of improvement occurred or if transfer had occurred from the sessions to the life situation, or to check on whether distortion occurred or not. It is found that often parents show insight during a session, but that at home, where once again they are confronted with the full complexity of the problem, the new insights are distorted such that they now fits into their old frame of reference and behaviors. They then mistakenly think that they are applying the new insights, but they become discouraged because it is apparent that no change is brought about.

An additional problem that can arise with home visits is that matters that the parent has deemed to be trivial or has underestimated are noticed by a trained observer and put into perspective.

When a parent is encountered in his/her original situatedness and asks for help, he/she is immediately led back to his/her problem.

The institutes ehich follow this method, unfortunately, did no follow-up studies that can give an indication of success of this approach. Indeed, it is still in the experimental phase.

Further research on this and other aspects of parental accompaniment, however, seem to be pressing, given the number of services provided, and the relative deficiency in theoretical grounding and in establishing an accountable practice.

5.9 Findings

After exploring the prevailing therapeutic practice with children in the R.S.A., the following findings are attained:

a) With respect to the reasons for derailment, seven different views are distinguished. There is a relative degree of overlap among them.

However, it is conspicuous that less than half of the institutes mention problems in educating as a principal factor in child deviancy. Even so, with respect to the intervention necessary to eliminate the deviancy, all institutes make use of one form or another of parental accompaniment. Thus, from their practice, it seems that the parent-child problematic or educative problems assume a more prominent place than what is generally acknowledged.

b) Problems that flow from the unique situation in the R.S.A., such as cultural intermingling among population groups, urbanization and the transition to a technological society disrupt established value systems that result in educative problems.

c) With respect to delimiting aims in terms of changing what is aimed for in the child's becoming, there are many gaps. It seems that intervention largely is directed at treating symptoms that, at best. only bring about temporary improvement.

In the light of the larger number of children who yearly depend on help, and the urgency of youth preparedness under current circumstances, the reality of this matter is nothing short of distressful, and the ineffective use of resources can no longer be afforded.

d) Arising from the diffuse delimitation of aims, the planning of and preparation for the therapy also is going to be extremely lame. With respect to eliminating specific symptoms, there indeed is purposeful and planned work being done. With

respect to the progress of a child on the way to adulthood, little attention is given to its planning and such a result merely is haphazard.

e) Just as the formulation of the aim influences the planning and the subsequent course of the therapy, it also influences the therapeutic content. Where a great majority of the institutes more or less worked in a directive way and the therapist at least had input regarding the therapeutic content, there is a glaring absence of criteria for selecting the content, or, at least an ordered procedure by which it can be selected.

f) Thanks to the pioneering work of Carl Rogers, there is somewhat more clarity about the nature of the therapeutic relationship. However, Roger's excellent contributions deserve to be supplemented in the light of modern pedagogical insights. As already shown, there is disagreement about whether the therapeutic relationship between the adult therapist and the troubled child, in essence is an educative relationship. This matter deserves closer examination.

g) It seems that there are methods and techniques which enjoy wide respect, irrespective of the therapist's theoretical foundation. There is a variety of techniques and methods that justify broad application, provided they are re-interpreted in accordance with new insights.

h) Finally, it deserves to be indicated that the importance and place of parental accompaniment is recognized everywhere, but ought to be considered in a more ordered, purposeful way in the overarching planning of the therapy.

APPENDIX 1

EXPLORATORY QUESTIONNAIRE

1. According to your experience, what are the most general causative factors for childlike deviancy?

i) biophysical factors
ii) social factors

iii) ecological factors
iv) psychodynamic factors
v) faulty learning
vi) other.

2. What intervention is necessary to bring about repair?
3. How do you determine the therapeutic aim for an individual child?
4. What methods and techniques do you use?
5. How long does the therapy last in total and per session?
6. How do you plan for a session and for the therapy as a whole?
7. How do you evaluate if the therapy was a success?
8. Do you work directively or indirectively?
9. Do you hold a specific anthropology?
10. How would you typify the therapeutic relationship?
11. What phases do you distinguish in the therapy?
12. What content is relevant (how do you select it)?
13. How does stating a problem figure in the therapy?
14. What role does repetition and exercising play and how do you bring it about?
15. How do you verify if transfer has occurred from the therapeutic situation to life reality?
16. Do you involve other experts in the therapy?
17. What is the nature of your parental accompaniment?

APPENDIX 2

LIST OF UNIVERSITY INSTITUTES IN THE REPUBLIC OF SOUTH AFRICA, 1979

1. Child Guidance Institute
   University of Pretoria
2. Institute for Child Guidance
   University of Western Cape
3. Child Guidance Clinic
   University of Orange Free State
4. Child Guidance Clinic
   University of Port Elizabeth
5. Child Guidance Clinic
   University of the North

6. Institute for Psychological/Educational Services
   Potchefstroom University for Christian Higher Education
7. Education/Psychology Clinic
   University of Stellenbosch
8. Institute for Behavioral Sciences
   University of South Africa
9. Child Guidance Clinic
   University of Natal
10. Institute for Child- and Adult Guidance
    Rand Afrikaans University
11. Child Guidance Clinic
    University of Cape Town
12. Center of Clinical Studies
    Witwatersrand University
13. Child Guidance and Research Center
    University of Durban-Westville

Appendix 3

Methods followed by the thirteen university clinics

(The number of each clinic in Appendix 2
corresponds to the institute numbers below)

	Institutes following:	Total
REASONS FOR DERAILMENT		
Behavior theory view	3, 4	2
Psychodynamic view	1, 3, 4, 5, 6, 8	6
Biophysical view	3, 6, 8	3
Sociological/ecological view	2, 3, 5, 7, 9, 10, 11, 12, 13	9
Pedagogical view	1, 2, 7, 9, 10, 11, 13	7
STATING THERAPEUTIC AIM		
Formulated on basis of a clearly specified diagnostic phase	1, 2, 4, 5, 7	5
Inclusive discussion	6, 9, 12, 13	4
Announcing problem statement	9, 10, 11, 12	4
Delimitation of problem areas	1, 3, 6, 11, 12	5
PREPARATION		
No specific planning	8	1
Planning total therapeutic course	1, 3, 6, 11, 13	5
Short-term planning	2, 4, 9	3
Comprehensive planning combined		

with planning from session to session	1, 5, 6, 7, 10	5
Aim delimitation of therapist	12, 13	2
Contract closure	4, 6, 7, 9, 12, 13	6
THERAPEUTIC CONTENT		
Free choice of child	3, 4, 13	3
Joint choice by therapist and child	12	1
Symbolic dealing with problem	1	1
Selected by therapist	2, 5, 6, 7, 9, 10, 11	7
THERAPEUTIC RELATIONSHIP		
Similar to educative relationship	1, 2, 7, 10	4
Doesn't correspond at all to educative relationship	3, 4, 5. 6, 9, 11, 12, 13	8
THERAPEUTIC COURSE		
Diagnostic phase	1, 2, 4, 5, 6, 7, 9, 10, 11, 13	10
Verification	1, 2, 6, 7, 9, 10, 11, 12, 13	9
Intervention	1, 2, 3, 4, 5, 6. 7, 9, 11, 13	10
Evaluating	1, 3, 6, 7, 9, 11, 13	7
Follow-up	2, 4, 6	3
METHODS AND TECHNIQUES		
Behavior modification	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12	11
Directive play therapy	1, 2, 6, 7, 9, 10, 11, 12, 13	9
Parental guidance	all	13
Guidance conversation	1, 2, 3, 4, 6, 7, 9, 10, 12	9
Language enrichment therapy	1, 2, 6, 7, 10, 13	6
Psychomotor therapy	1, 2, 6, 7, 10, 13	6
Orthodidactic help	1, 2, 6, 7	4
Art therapy	1, 6, 7, 10, 13	5
Drama therapy	1, 3, 7, 10, 12, 13	6
Family therapy	4, 5, 7, 9, 10, 11	6
Environmental change	1, 2, 9, 13	4
Rogerian client-centered therapy	4, 11, 12	3
Audio-psycho-phonology	6	1
Gestalt therapy	4	1
Ellis' RET	4	1
Group play therapy	4	1
PARENTAL ACCOMPANIMENT		
Help with adulthood problems	6. 8, 10, 11, 12, 13	6
Training in parenting	all	13

TEAM COMPILATION

Social worker	1, 2, 4, 5, 6, 8, 9, 10, 11, 12, 13	11
Physician	**1, 2, 3, 6, 7, 9, 10, 12,** 13	9
Clinical psychologist	1, 2, 3, 4, 5, 6, 8, 9, 13	9
Speech therapist	1, 2, 7, 9, 10, 12, 13	7
Remedial teacher	2, 4, 8, 11, 12, 13	6
Occupational therapist	2, 5, 7, 9, 11, 13	6
Vocational orienter	1, 2, 6, 9, 10	5
Orthodidactician	1, 2, 6, 7	4
Pastoral psychologist	1, 2, 7	3
Sociopedagogue	1, 10	2
Sociologist	8, 10	2
Audio-psycho-phonologist	6	1
Physical educationist	1	1

i)