CHAPTER 3

SOME PSYCHOTHERAPEUTIC PRACTICES FOR ASSISTING THE AFFECTIVELY DISTURBED CHILD

1. INTRODUCTION

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

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

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

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

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

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

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

All related theories should

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

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

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

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

2. THEORETICAL MODELS AND "METHODS OF TREATMENT"

2.1 The biophysical model

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

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

Since the biophysical model mainly is adhered to by medical practitioners, this therapeutic approach is cast in a medical model. Use is made of the following methods, among others: various

medications, chemotherapy, diet, surgery and hormone injections. Because of the strong medical flavor of this model, it will not be considered any further.

2.2 Behavioral model

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

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

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

2.3 The psychodynamic model

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

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

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

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

2.3.1 The psychoanalysis of Sigmund Freud

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

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

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

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

The task of the ego, then, is to maintain a balance between the id's demand to satisfy desires, on the one hand, and the demands of

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

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

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

In light of Freud's theory concerning the influence of the different "developmental stages" on adult behavior, it is correct to understand that even "normal" progression through these psychosexual stages clearly ought to entail a considerable degree of tension for the child (31, 201).

2.3.1.1 Freud's "methods of treatment"

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

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

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

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

2.3.1.2 Psychodynamic model: contemporary status and methods

A gradual shift in emphasis has occurred in the psychoanalytic approach from an emphasis of the **id** to an emphasis of the **ego**. This change has not given rise to an entirely new theory or methods; rather, it should be viewed as a logical extension of Freud's main ideas (49, 319). New contributions to this school of thought have mainly arisen from points of disagreement with Freud. Especially, there is disagreement with the following points of the original perspective:

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

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

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

Since the neo-psychoanalysts have preserved Freud's main ideas and mainly extended them, the role of the therapist, his techniques and aims also have remained largely the same. Because of the change in emphasis, disturbed behavior now is viewed as having its main source in **disturbed interpersonal relationships**. In this

connection, Brammer and Shostrom (1, 44) indicate that disturbed behavior arises because the person experiences a set-back in his attempts to attain affective bonding and understanding and this requires the therapist to establish a relationship within which the patient can acquire sufficient self-confidence to be able to handle any situation.

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

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

2.4 The sociological model

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

of view, deviant or disturbed behavior is seen as the violation of societal rules and norms.

The sociological view is that societal norms limit and regulate the individual's needs. Without these norms, the individual can so extend his needs that they cannot be satisfied. This leads to frustration which gives rise to all sorts of deviant behavior. According to Jarlais (16, 275), social pathology arises as a result of the absence of appropriate group norms or as a consequence of the presence of norms that no longer are applicable to changed social circumstances. This leads to a high incidence of individual pathology which, in turn, is an indication of social pathology.

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

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

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

Any provision of assistance in the sense of therapy from the sociological model is directed at preparing the individual so he can maintain himself in a complex society. In the work of Rhodes and Tracy (32) there are few distinctions made between sociological and ecological ways of giving assistance. They distinguish among different types of assistance, depending on where the particular form of assistance will bring about change, namely: (i) changes in the child; (ii) changes in the environment; (iii) changes in the child and the environment and (iv) changes in the level of separation between child and environment (47, 401).

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

2.5 The ecological model

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

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

parents is lessened by using the child as a scapegoat. In this way, the child comes to represents the parents' problem to themselves.

Since disturbed behavior is viewed as a disturbance in the ecosystem, it only can be eliminated by treating the ecosystem as well as the individual in his natural surroundings. As already mentioned, some ecologists are of the opinion that the **family** is responsible for the origin of the child's disturbed behavior. Therefore, use has to be made of **family therapy** (see below) by a team of psychologists, psychiatrists, social workers and other human scientists (47, 484).

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

2.6 Contra-theories

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

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

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

The above pronouncements were an attempt to erect a broad framework of the existing approaches to disturbed behavior. However, in no sense is there a claim of completeness. The aim was merely to acknowledge these different approaches and as far as possible to indicated the place of the affective and of educating in each. For the sake of more completeness, in the following sections each of the schools of thought and their methods that currently enjoy the largest number of adherents are described.

3. A CLOSER VIEW OF SOME PSYCHOTHERAPEUTIC PRACTICES

3.1 The client-centered therapy of Carl Rogers

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

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

3.1.1 Rogers' theory of personality

Although Rogers does not emphasize personality structures, still a few basic concepts, principles or constructs can be identified that form the basis of his theory, namely the **organism**, the **phenomenal field** and the **self**.

The organism is the total individual and its one basic aim is to actualize, maintain and enhance itself. This disposition to self-actualization is described by Rogers as "the inherent tendency of the

organism to develop all its capacities in ways that serve to maintain or enhance the organism". Thus, in therapy, it is this aim that is stressed.

The phenomenal field is the world as it is perceived and experienced by the individual. It is the totality of experiences of which he is the center. This also can be described as a private world because only the individual knows this world as the meaning he attributes to it. His experiencing and perceiving of this phenomenal field is reality for him.

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

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

Together with the "growth" and "development" of the child, he begins to differential between "experience itself and awareness of that experience" (30, 237). This awareness of existence and awareness of functioning lead to the development of a **self concept** or **self image**. The formation of the self concept is a dynamic process that is largely dependent on how the individual perceives his environmental experiences (21, 130). Thus, the self

concept originates out of the interaction between the child and his environment and especially his interactions with what is important to him. Healthy personality development depends on the degree of **congruence** between his experiences and his self-image. If experiences are acceptable to the self-image, they become **symbolized**, i.e., they are allowed into awareness. Experiences not congruent with the self-image are not acceptable and can be denied symbolization. This view of Rogers clearly is in agreement with Freud's view of defense mechanisms and especially of repression.

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

3.1.2 The origin of disturbed behavior

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

Rogers greatly emphased the **role of the parents** in establishing a child's system of self regard. Healthy personality development only can take place in a climate where the child **feels accepted** and where he can accept himself. Of particular importance is how he experiences his parents' judgments of him. If he experiences that they judge him positively he will find satisfaction in himself and in how his body looks, but if he experiences their judgments as negative, a negative self judgment will arise and he will feel uncertain and insecure (27, 301). An experience of positive regard leads the child to feel that a state of congruence between his experiences and his self image is achieved. If the child experiences that his behavior is congruent with his self image, he experiences **feelings of adequacy, security and worth** (1, 49).

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

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

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

3.1.3 Client-centered therapy

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

Rogers' therapeutic aim is not so much to solve specific problems but rather to support the individual to "grow" so that he can handle his current problems and also successfully face his future problems. According to him, through therapy the individual is "liberated" so he can "grow" and "develop" "normally" and by this all obstacles on the way to adulthood are removed (34, 29). Rogers believes that each individual has in himself the potentiality and disposition to move in the direction of adulthood. This disposition might be buried under his defensive behavior but it is present in each individual and only waits for the appropriate circumstances to become liberated and expressed (50, 35). In order to allow the therapy to succeed in this

aim, the therapist needs to create a situation that offers the individual the freedom to be himself (13, 524). This view of Rogers is clearly summarized in the following words of Heine [in English] (14, 128): "An individual may be pushed off the path of self-actualization by unfortunate early experiences, but if the pressure is released, his natural response is to return to the trajectory of life that is intuitively right for him".

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

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

As for the therapeutic situation, as such, Rogers particularly stresses the **relationship** with and the **attitude** of the therapist rather than the knowledge, theory or technique he employs. He believes that the individual will solve his problems himself as he gradually reorganizes his self-structure (39, 438). Since he is of the opinion

that the individual himself is in a position to deal with his problems, he gives as much responsibility and guidance as possible to the client in the therapeutic situation. The therapist's task mainly is to make the occurrence easier, and he takes the role of the client's "other self" in order to put him in a position to perceive his phenomenal field more frankly and accurately (39, 432). In describing the relationship between therapist and client, Rogers emphasizes that there is no evaluation, no interpretation, no interrogation and no "reaction" by the therapist. It is in such a relationship that the individual realizes that since the therapist accepts him for what he is, he too can accept himself.

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

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

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

Although clearly defined phases in the course of client-centered therapy with an individual cannot be distinguished, Heine (14, 134-136) nonetheless contends that it takes a somewhat predictable course. At first, the client mainly deals with his problems and symptoms and his reference to himself is critical and negative. Later in the therapy, he shows an understanding of the relationship between his behavior in the past and his present behavior. However, during this stage this understanding might be prevented if the child's situation degenerates because he easily becomes upset, but it also can be promoted by the great pleasure drawn from personal successes. During the final phase of therapy, the client talks more about current events and future expectations. He now views himself as master of his life rather than as a perpetual victim of it (14, 135).

The following is a brief summary of Rogers' client-centered approach: he views self-actualization as the one basic striving at a person's disposal. If, however, his experiences are not conducive to self-actualization, incongruencies arise between his experiences and his self-image, and this leads to feelings of threat and anxiety. In order to protect himself against this anxiety, he makes use of defense mechanisms and as a consequence his behavior becomes more disturbed.

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

3.2 The behaviorist approach and methods

3.2.1 Theoretical foundations

As already mentioned in the first part of this chapter there is not merely one comprehensive theory of learning and behavior but rather a group of theories that show particular similarities and since

there are just as many theories as thinkers, each theory also has a distinctive character. The behaviorist insights rest largely on the works of men such as Pavlov, Thorndike, Watson, Hull, Guthrie, Skinner, Tolman, Mowrer, Miller, Wolpe, Bandura, Eysenck, and Bijou. As a school of thought, this approach in many respects is radically different from most others in the human sciences.

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

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

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

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

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

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

On the basis of his experiments with dogs, Pavlov described the process of **classical conditioning** (see 39, 283-284). He had found that if a light is turned on or bell is rung **just before** food is placed in the dog's mouth, then the dog's secretion of saliva will show a tendency to become connected with the light or bell after several such pairings of the **unrelated stimulus** (light, bell) with the food stimulus. In behaviorist terms, the food is known as an **unconditioned stimulus** and the natural tendency to secrete saliva correlated with this is known as the **unconditioned response**. The unrelated stimulus (light, bell) is the **conditioned stimulus** and if it stimulates the secretion of saliva, such behavior is described as a **conditioned response**. This way of forming (learning) a connection between the stimulus and the response is known as classical conditioning.

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

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

In describing operant conditioning, Skinner greatly emphasizes **reinforcement**. Here the focus is on the response and if it is followed by a reinforcer, the probability is increased that the

response will manifest itself again. Skinner is of the opinion that behavior is determined by the reinforcers that daily influence responses. In this way, a person's behavior is formed step-by-step until the desired mode of behavior is achieved. Thus, a person is formed each day by the reinforcers arising from his environment. Skinner [in English] (43, 91) describes operant conditioning as follows: "Operant conditioning shapes behavior as a sculptor shapes a lump of clay ... At no point does anything emerge which is very different from what preceded it ... An operant is not something which appears full grown in the behavior of the organism. It is the result of a continuous shaping process".

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

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

3.2.2 The origin of disturbed behavior

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

inappropriate response to a stimulus. This means that the person either has failed to learn a particular response or that he has learned a maladaptive response (27, 468).

Dollard and Miller (5, 127) show much agreement with Freud in that they understand disturbed behavior as an unconscious conflict that has its origin in **early childhood**. They say [in English]: "Neurotic conflicts are taught by parents and learned by children". According to this view, the child "develops" intense feelings of anxiety or guilt if he is "incorrectly" handled by his parents in the satisfaction of his basic needs. These feelings of anxiety and shame lead to forming a conflict that serves as the basis for later disturbed behavior. As long as the conflict remains unconscious, it continues to exist and gives rise to certain symptoms. According to Hall and Lindsey (13, 448), these symptoms are the direct consequence of the emotional unrest caused by the conflict, but often these symptoms are behaviors that enable the individual to temporarily escape his anxieties and fears. Thus the disturbed behavior actually is a means for reducing or eliminating anxiety. In other words, the anxiety serves as a **stimulus** for the arousal of an avoidance **response** by which the anxiety is lessened and the particular pattern of behavior is **reinforced**.

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

3.2.3 Therapeutic methods

It follows from the above that behaviorists make use of techniques to correct disturbed behaviors that are based on **laws of learning**. A study of the literature on these techniques shows that two hierarchically related concepts stand out, namely, **behavior therapy** and **behavior modification**. Although some authors use these two concepts interchangeably and synonymously, others are of the opinion that, all the same, unmistakable differences exist between these two therapeutic methods. Martin and Pear (20, 422) contend that behavior therapy more often is used by followers of Pavlov, Hull and Wolpe while behavior modification is used by the adherents of operant conditioning. For Goldman (9, 207), behavior therapy focuses on "emotional learning" and behavior modification

on "observable behavior and change through contingent reinforcement". On the contrary, for Graziano [in English] (11, 28) behavior modification is the more comprehensive concept "referring to a large area of research and application involving the systematic, empirical study of behavior, its development, maintenance and change"; behavior therapy is the "application of behavior modification to clinical problems". It thus seems that since there is no unanimity about the differences between these two concepts, it is likely that there will be a tendency to use them interchangeably and synonymously (see 20, 421). For the purpose of this study, behavior therapy will be based on Graziano's discussion of it.

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

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

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

Systematic desensitization is a form of behavior therapy developed by Wolpe (51). According to his view, neuroses arise by means of classical conditioning by which a strong anxiety response is aroused by general stimuli. The aim of his therapy is to break the connection between the conditioned stimulus and the anxiety response (11, 33). To succeed at this he pairs stimuli that arouse anxiety with a relaxing situation until the connection between the original stimulus and the anxiety response is eliminated (20, 215).

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

Assertiveness training is a technique mainly used with adults, and it is one of the most valuable methods of behavior therapy. It is very appropriate for persons who are inclined to be too polite and apologetic, avoid confrontations, allow others to take advantage of them but who, at the same time, show feelings of vindictiveness, harbor rage and fear toward others or exhibit psychosomatic disturbances or depression (9, 229). According to Lange and Jakubowski (19, 38), the name of this form of therapy means the following: to stand up for personal rights and to express thoughts, feelings and convictions in a direct, honest and appropriate way and with due respect for the rights of others. Thus, in this form of

therapy, the client is taught to express his feelings in appropriate ways and in this way to validate himself, yet without harming another by this.

According to Graziano (11, 34), assertiveness training consist, first, of a specification of the circumstances within which the client cannot maintain himself and, second, in learning self-assertive behaviors. This can take the form of a general **discussion** of the handling of problematic situations, **practicing behavior** or **role-playing** after which the client can apply his newly learned self-assertive behavior to real situations. It is expected that the client compile a diary of all situations that he handled well and all cases that he could not handle himself. How he feels during and after such situations serves as a criterion for compiling the diary (see 9, 229). During therapy, the details of the different situations are analyzed and the therapist suggests alternative behaviors where necessary. The therapist also might exemplify a particular situation and offer the client the opportunity to practice his behavior in such a situation until it **awakens a feeling of satisfaction.** In doing this, the client learns to maintain himself in different situations and his anxiety makes room for self-confidence.

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

The work of Skinner was not so much directed to changing behavior, yet his method of **operant conditioning** is widely used in behavior therapy. As in the case of all operant conditioning, the

emphasis in its therapeutic use also is on reinforcement in order to shape the desired behavior (27, 484). Also this form of behavior therapy requires the specification of problematic behavior as well as the desired behavior aimed for. In addition, it requires thorough planning regarding the stimuli, responses and reinforcers that are going to be used (11, 35).

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

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

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

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

In spite of the fact that the behaviorist approach is not always acceptable from a phenomenological point of view, still the author recommends a reinterpretation of this view from a pedagogic perspective as a future research task.

3.3 Family therapy*

3.3.1 Introduction

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

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

3.3.2 The origin of disturbed behavior

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

As a **system**, the family is always in balance (see section **2.5**) but because a person in the system can be disturbed, the system is "sick"--the balance is "sick". The person who shows the disturbed

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

behavior is merely the "identified patient" whose symptoms manifest the pathology of the entire family. These symptoms arise because of **disturbed relationships** among the different family members. Thus, to help the person, the "sick" balance in the family has to be corrected and, therefore, the aim of family therapy is to **view the family itself as the patient.** It is directed at correcting the disturbed relationships and especially the disturbed communication in the family "with the aim of a better family organization, so that the growth potential of each member can be optimally developed" [in Afrikaans] (2, 139). Also, Minuchin (23, 2) indicates that family therapy is directed to a change in the organization of the family. If the structure of the family is changed, the position of each member in the family changes accordingly and consequently the experiences of each individual change.

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

3.3.3 Aims of family therapy

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

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

In general, this involves "positive changes in the total family system which is shared by all members rather than intra-psychic changes in one individual. The improved family functioning is not only reflected in the disappearance of the individual member's symptoms, but also in the entire family's more dynamic interaction with wider society" (2, 146).

3.3.4 Family therapeutic methods

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

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

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

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

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

otherwise would remain suppressed or irrupt into inappropriate activities" (2, 140) (my emphasis).

The first session or two is more **diagnostic** in nature and special attention is given to **communication problems** in the family. As soon as a disturbed pattern of communication emerges, it is **identified** and pointed out to the family. The therapist arranges his findings into particular themes that then are brought up in later therapy sessions. However, he allows himself to be guided in this by the family. He holds the different themes in mind and the first problem related to them, and which is manifested in a particular therapy session, serves as a theme for the session of concern. Thus the family provides the **content** about which there is a discussion while the therapist merely gives **structure** to it.

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

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

4. CONCLUSION

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

of **educating** in their "methods of treatment", still the following deserve mention.

It seems that all of these different approaches, often even unconsciously, make provision for stabilizing emotional lived-experiences. The role of educating and the family enjoy wide recognition in the origin of disturbed behavior. Even so, little or no attention is given to educating in the therapy. In client-centered therapy, a great deal of emphasis is placed on the relationship between the client and the therapist. However, here there is no really authentic pedagogic relationship since no actual guidance is given to the child and thus it is not "education". This relationship also is deficient in pedagogic authority. Mainly, the child is guided to accept himself as he is and not as what he ought to be. Thus, it is not expected of him that he adequately actualize his potentialities and live in accordance with the norms of adulthood. Behavior therapy largely is directed at eliminating symptoms. Little attention is given to the causative factors and to the re-establishment of disturbed educative relationships. In spite of the fact that family therapy works exclusively with the family, and is directed to re-establishing patterns of communication, the guidance offered does not take place within a pedagogic framework and situations can arise that, e.g., undermine the authority of the parents and thus are pedagogically unacceptable. Thus, it appears that the success of the existing forms of psychotherapy mainly can be attributed to the fact that the anxiety that lies at the foundation of the symptoms is more or less alleviated.

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

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