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“BEHAVIORAL SPACE THERAPY”: AN ALTERNATIVE APPROACH TO ‘HANDICAPPED’ CHILDREN

Emiko Gotoh

I. Introduction

In recent years need for intervention to handicapped children has been pointed out by various groups of people. In Hokkaido, there is now emerging a new direction for this end. And there is an increasing number of commuting institutions for those children. Reported here is the result of the efforts for establishing a systematic approach in improving children’s communication ability.

Particularly intended in this report is to describe the physical and the psychological environments designed to promote children’s communication ability that are based upon the experiences and the practices at two training centers in Eniwa and Hiroshima.

The primary and initial concern among the staffs at the centers in their efforts to build such environment was what kind of perspectives should take toward target children. In this connection, however, the author believes that there gradually emerged a particular approach as we attempted to implement our basic understanding of human beings. Such an approach may allow to dispel a risk of having a gap between the therapists and the handicapped children that is so often observed when therapists are too much concerned with the children’s handicaps and treat them as “special”. Rather often people tend to distinguish the “healthy” and the “handicapped” in order to articulate the significant points in training and education. However, this very distinction, as many of the therapeutic programs and case reports made at various conferences have shown, has worked rather as a barrier and hindered the relationship between the therapists and the children. Most important, be it in care-taking or in education, is an approach that rejects the position to postulate unrealistic “boundary” between the normal and the abnormal.

That is to say, what is asked for a therapist is to see and accept the child as he/she is, and to have an appropriate understanding of human nature, instead of being captured only by the handicaps. In that sense, our therapeutic job will mark the first step when a therapist has come to understand the handicapped child as an individual just like an healthy normal child having an independent personality.

In many cases, people who are working with those children tend to pay too much attention only to “problematic characteristics” and are concerned with improving the “problems”. Consequently, most therapists are inclined to separate themselves from the children, weakening their own “raison d’etre”, thus tend to produce a phenomenon

of so-called "functional isolation of therapist".

In the past, behavioral characteristics of the handicapped children have been categorized in various ways, and sometimes attempts have been made to get clearer pictures of handicaps, only by giving names to each handicap. Based on our experience, however, we have come to believe that each child we have worked with can be grasped on the same dimensions as all the other children, in that he/she has human characteristics for performing full functioning as an independent human existence. What we have to take more importantly is rather that to what extent stabilized and functionalized are the foundations of interactional behavior with various things and people in the environment which are fundamentals for living a life as social existence. The point we have to look at is whether the handicapped children are performing adequately their functions in the interrelational systems with objects and people in these social settings.

When we look at handicapped children, we are liable to focus on lowness of their ability characteristics of the children. The concept of the "handicap" should not be defined only by their ability characteristics, instead it should be found out in their "interrelationship" with the environment. From this perspective, it would be important to identify the developmental tasks for the handicapped children in order for finding an answer to the question, "what kind of interactions we could have with those children who are living their lives and continue to live as social existence hereafter too".

In the following sections I would like to describe what we have practiced at the training centers in two towns in greater Sapporo district, keeping in mind the points of view mentioned above.

II. Clinical Practices at the Training Centrs for Handicapped Children

Our clinical activities at the centers gave us opportunities to meet children with various problematic behavior. Those who came for counseling indeed seemed to have problems of various kind in their behavior as their mothers claimed. However, as we observed, we came to recognize that most of such claimed behaviors were associated with impediments in their communication to a great extent and that was among the causes to delay their development.

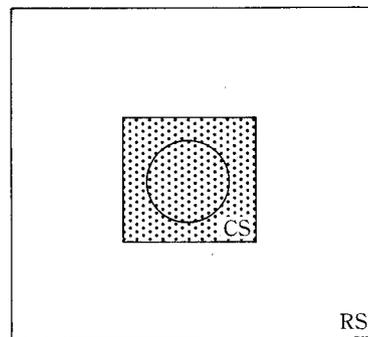
The unique aspect of our clinical activities is to look at the children from another perspective in broader terms as having communicative disability, and are provided programs in accordance with our perspective. Communicative behavior refers to not only giving and receiving information. It also includes expressing emotions and desires to be associated with others as well as letting out their egos and even accepting others, in other words, the whole expressive behavior. And this communicative behavior strengthens its meaningfulness as the children come in to contact with others. Therefore we attached importance to events and objects as well as people that surrounded the children with great attention and tried to find significance to each of their behaviors for possible improvement. This was the primary theme of our program.

The behavior through which the children share the time and space with others is the "associated behavior". The "behavioral space therapy", a therapy we devised, focuses upon this associated behavior (Gotoh, Gotoh, and Miyajima, 1980). This ther-

apy was applied at the Hiroshima Welfare Center and is now in the process of further improvement (Gotoh, Ogasawara, Gotoh, Fukuhara, 1984). The background that led to the “behavioral space therapy” is as follows.

What we had to do first in our initiative for a group therapy for the purpose described above was creating the situation with a workable environment that would induce a certain possible direction not only for individual children but also for the group as a whole. It had to be an environment that would encourage the child to get interested in things and people around him/her and motivate him/her for a further action. The scheme also had to have therapists organically involved. Thus came the physical set-up of a “gathering place”.

A “gathering place” was designed in such a way to encourage the children to share the time and space with others. The so-called “stage” with two layers, a square bottom (244 by 244cm) of about 25cm’s height and a round top with a diameter of 180 cm was prepared. Fig. 1 shows the physical setting of this stage.



Notes :
 CS : Communicative Space
 RS : Round Space

FIG. 1 Behavioral Space

Secondly, toys were selected that would inevitably bring the children to come into contact with others. Toys actually used were such as large blocks that could be made into a locomotive with wheels, colored balls and fancy tunnels. Other things such as trampoline and play house set, picture books and mini cars with which children could play alone were excluded for the reason that they would not encourage them to involve in group activity.

Thirdly, we applied a time control scheme by introducing music. The music would give a sign to the children to prepare themselves for an intermittence for a change in activity.

Fourthly, a chief therapist was placed with a distinct role to regulate the activities which otherwise might be too diffuse without direction, although spontaneity was crucial. The chief therapist would work to overcome incoherence that has been so often observed among the therapists in a group therapy. Important as well is coherence among the children, which was also to be promoted by the chief therapist, together with expanding interface between the children and the therapists themselves to give a certain direction to their activities. The other therapists would be required to

act in line with the chief therapists in order to give a focus to their activities.

Our group therapy at the centers consisted of two main programs, the image expression learning in the nursery room and the behavioral space therapy in a play room. The image expression learning can be divided into four settings. The first setting is the "gathering place". Here chairs are placed in circle. Children and therapists sit like "sandwiches" with the chief therapist at the center. Intended in this phase is to activate children's expressive behaviors through hand play, greetings, and responding to others. Reflecting the actual processes in the therapy, therapists tended to force children to sit down on the chairs right after they entered the room hand in hand with children, probably because that they were overconscious of the beginning of therapy and too much concerned with letting children sit down. This is one of the problems that need to be overcome, since the program is intended to focus upon children's feelings and bring about spontaneity in their activities. This was one of the issues that were often taken up at the case conference.

The kind of problem was often found when we formed a group of emotionally disturbed children. They often preferred to stay in the corner, or by the wall, or near the window. When the children did not have enough experience in therapy, there were only therapists at the "gathering place". Mentally retarded children seemed to react and adapt more easily to this situation.

All these experiences led us to consider more about the make-up of the group members. When children with various behavioral characteristics were grouped together, we found there was more interaction among them, which subsequently brought some toward the "gathering place" with others following them. The therapists' role in such a situation was how to react toward their movement. They were never to direct them with a direct gesture like inviting them to gather at the center. The make-up of the group seemed quite significant, since it affected and sometimes fortified, the functional linkage of the members.

In general, members of the group are decided by the therapists on the basis of similarity in their ability or behavioral characteristics. However, our findings were that a group with varied characteristics worked better to reciprocate their differences and induce qualitative change.

Grouping of children based on homogeneity or similarity is very unnatural in daily situations, and the groups of such kind should be idiosyncratic organizations constrained by special purposes. Taken this idea, there will appear peculiar groups which are exclusively of the elderly or of handicapped children. Therefore we included in the program joint activities with the children from the near-by nursery school. The program at the Hiroshima Welfare Center had mothers work together with the therapists.

The very term of handicap contains in itself a negative evaluation on children with particular behavioral characteristics which are some how deviant from development and behavioral standard is in "normal" children. This type of position is hard to come with our approach. We take handicaps as certain types of behavioral characteristics, and we have kept seeking for common values through working on those characteristics. This is analogous to the efforts made when one learns about foreign culture,

where differences are respected and similarities sympathized. Through these interactions we will be able to find the ways to appreciate the properties of individual person's behaviors.

The second setting is intended to develop images of environment around the children. It was designed in such a way to make it easier for them to react and retain the images of people and objects they were likely to see in every day life, i. e. telephones, TVs, or wooden blocks and large balls they played with during the therapy, or people they came in contact with, i. e. mothers, themselves, therapists, and friends, or various events in which they were also involved. These were all made into slides and were shown to them, not individually but as a group. The room was kept dark to make it easier for them to concentrate. Very often children who were reluctant to come to the "gathering place" were found to show interest in this setting. The atmosphere became lively with their spontaneous verbal and vocal responses to the therapists' remarks.

The third setting is for expression learning. Expression learning was to stimulate the children's desire to express feelings, to let their egos out and to increase their expressive ability, whereas image learning focused on learning to be attentive to objects and people around them and on their cognitive activities to take in stimuli from outside. Materials used and the setting were designed to meet this purpose. More specifically, picture painting and rhythmic expression were introduced. These two have a common characteristic of using objects. A similar idea was also applied in the play room where toys instead were offered as a means to help extend their awareness of the outside world. Activities such as finger painting that would have children touch paints directly were intentionally excluded. Rather, having them use intermediaries such as paint brushes was thought to work on their unintentional expressive activities and thus give them a behavioral direction because of the very nature of the brushes. We had tried this idea before and empirically found that it is useful for activating children's motivation.

Picture expression learning focuses on activity to use paint brushes. And, rhythmic expression learning is intended to induce activity in which the static and dynamic processes supplement each other, by devising the sequence of the activity.

In practice children listen to the musical pieces which are arranged in accordance with the above mentioned idea, engaging in free expressive activity with the therapists. Thus, there are provided them with the opportunity to develop the attentiveness to listen to particular targets.

The other half of the activities here comprises mainly of beating various things with drum sticks, resulting in spontaneous production of sounds.

In the picture expression learning, the children sat on their chairs at the table. They receive from the therapists drawing papers and brushes, which prepared them for the coming activity. The paints used here are boiled wheat powder with poster colors, and are made rather thick in order for making it responsive to the activity of painting by children.

There were some children who would take up the brushes but were reluctant to start painting, or others who had difficulty to start with, being afraid of making their clothes messy. But once they had brushes with plenty of paints with the therapists'

help and saw a drop of paint fall on the paper, they became eager and were motivated for a next try. Through the tactile feeling of drawing a line with brush and the vividness of the new lines they draw, they have come to challenge the task again and again spontaneously.

We found that the hand-made paints were better than crayons or felt-tip pens, because the act of putting the paint on the brush itself excited and interested them. Furthermore, one thing which should be stressed here is that through these activities the therapists can have chances to intervene in more natural ways.

After children were through this task, all the paintings were put on the wall, and some children were observed gazing at their own, while eating cookies in the snack time. It is, however, partly observed that children failed to strengthen motivation to engage in this activity and to develop their skills of drawing, and rather weakened the liveliness of their awareness for this task. This should be a task for us to pursue in our future endeavor. Examination of the appropriateness of the materials is left as a task for us.

As described earlier, rhythmic expression learning, on the other hand, was set in an environment with the specifically arranged music played on the piano. Hula-hoops and a mattress were prepared so that the children could easily move about with images they would get from the music which was usually repeated. Their reactions were varied. Some listened intently, coming close to the speaker. Others were attracted by hula-hoops and the mattress but remained there without engaging in any actual activity. There were still others who kept running with the therapists, jumping or were just lying on the mattress. In the light of the whole sequence of the therapeutic procedures, all these seem to have happened rather abruptly and the setting here has come to lack the necessity in the planned sequence of activities. Children were often found not fully active. As for beating with drumsticks, it was an activity the therapists found difficult to take part intently. They went about beating various things and listened, and just remained in a state they cannot find the directions toward which they should bring the children to develop the activity.

The fourth setting was a dining place. They sat together around the table and had snacks. They were inclined to remain at the "gathering place" longest with their lively vocal and verbal expressions.

Described so far are the flows of activity for the image expression learning. And from the beginning point of time of the fourth setting, children moved into a play room. Music was played until all the activities there were over. The music had different melodies to give signs and to coordinate the activities there. Music with lyrics such as "Sekken-san" (Mr. Soap) or "Pajama-man" was played when there was going to be a clear change in the activity. Also included were various classical pieces, each arranged to be three or four minutes long.

The effect of the background music is not yet unanimously supported, although it has been recognized to be effective in coordinating the activities. As to its effect on the children, there have been no opportunities to well look into except that it worked in such a way to prepare them for the next phase of the program.

III. Discussions

Image expression learning is one form of the behavioral space therapy, which would be ranked in higher order of "taskfulness". On the other hand, those activities conducted in the play room had instructive forms that were already well established in the behavioral space therapy and allowed more freedom in the children's movement. Image expression learning and the program in the play room share a common characteristic in that they prepared a setting where the time and the space were shared and that both are devised for transforming children's behavior into the more meaningful behaviors in social contexts through their expressive activities. Reflecting what we have done so far, we can see that there still remain many problems we have to tackle with. The most important is that we should not keep the behavioral space therapy, which has been developed from intervention through the direct contacts with the children in an efforts to find appropriate directions, in a confined realm of training techniques.

In order to refine further this therapy, an educational philosophy based on human understandings such as how to regard disabled children and relate to them must be established through clinical practices. It means that what is really awaited is further growth of awareness on the part of therapists.

Here is a summary of what I found in this approach, particularly in the play-room setting as the chief therapist. One distinct feature of this is that there is placed a stage at the center of the room. This indeed worked to bring about changes in the children's behaviors. Children who had kept standing by the wall, leaning on it with their back, or just wandered around at the corners, or kept looking out of the windows, have come to approach the stage, and run or walk around it. They also began to show the behaviors such as sitting or standing on it, thus more spontaneous actions around the became more conspicuous. Therapists were also observed to be involved in the activities centering around the stage and eventually began orienting more activities toward and around it. By making the stage as a pivotal place, I myself began to find consistency and direction in the locus of my behaviors as the chief therapist.

Furthermore, because of the fact that in this therapy the toys are selected in the ways that allow interrelatedness among the members, and by using the toys effectively, each therapist has come to show indirectly relating behaviors toward children and it has become much easier for therapist to create settings where appeared more spontaneous sharings of toys along with the streams of activities. Their recognition of the toys having similar roles as theirs increased flexibility and depth in their relations with the children.

Therapist's behaviors like this seem very effective in decreasing forcible unilateral relating behaviors of the therapists, just like their direct trespassing into the children's inner world. Through indirect relating, behaviors such as placing a toy ostentatiously by the child, the therapist keeps waiting for spontaneous behaviors to occur, and once they occur the therapist accept and situate them in the streams of the whole activities. It should be noted that the very presence of the toy and play things has had great significance in that it allowed to produce conditions for this type of "therapy of waiting" to operate naturally. And of course the provision of the play room

specifically designed for the purpose contributed a great deal.

One last point that I want to add is that this is a program through which therapists themselves have had the chance to grow through the encounter with those children in this approach. This approach does not leave a room for therapists to indulge themselves in irresponsible position, thus this should have been extremely strenuous and sometimes perplexing for those therapists who have been accustomed to the position of "stimulus-giver". The most significant part of this therapeutic program is that the sequence of activities always reminded the therapists that their roles can be meaningful only when they involved themselves in the process and moved forward together with the children. To onlookers' eyes our approach may look not so different from the ordinary ones at the nursery school. There is, however, no doubt that this approach played an important role in preparing a scaffold for proceeding to further steps in the job of helping those children develop the communicative behaviors, and in activating the programs at the local community centers for handicapped children.

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