BEHAVIOURAL DISORDERS IN CHILDREN AND ADOLESCENTS: A CONCEPTUAL REVIEW ABOUT THE THERAPEUTIC ALLIANCE WITH FAMILY AND SCHOOL

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ABSTRACT

Aim*: In disruptive behavioral disorders, given the wide range of symptomatic manifestations and the complexity of the socio-familiar contexts in which they develop, it is now proven that more visible and more stable results can be achieved over time through multimodal and multidimensional interventions. These are accomplished through the integration of psychotherapeutic interventions for the child and parents, counseling interventions for all the various practitioners who come into contact with the child in school, sports, and social settings, through the possibility of organizing multiple settings in patient can be followed by several health professionals such as child and adolescent neuropsychiatrist, neuropsychomotricist, occupation therapist, psychologist.*

Keywords*: Behavioural disorders, Family alliance, therapeutic program.*

DOI: 10.19193/0393-6384_2017_2s_184

Received *November 30, 2016;* ***Accepted*** *May 20, 2017*

Introduction

In disruptive behavioral disorders, given the wide range of symptomatic manifestations and the complexity of the socio-familiar contexts in which they develop, it is now proven that more visible and more stable results can be achieved over time through multimodal and multidimensional interventions. These are accomplished through the integration of psychotherapeutic interventions for the child and parents, counseling interventions for all the various practitioners who come into contact with the child in school, sports, and social settings, and through the possibility of organizing multiple settings in The patient can be followed by several health professionals such as child and adolescent neuropsychiatrist, neuropsychomotricist, occupation therapist, psychologist[1-8].

Multiple settings allow a comprehensive approach to the problem by acting on the multiple risk factors that contribute to the emergence of child's behavioral problems and allowing them to respond more appropriately to their needs[9-12].

All the diagnostic process and, subsequently, the therapeutic process are largely influenced at every stage by the quality of the therapeutic rela-

tionship built with the child and his family. The alliance reflects three basic aspects of therapeutic work: the bond or the feelings that participants share with each other (in particular the perception of acceptance, confidence and positive feelings in the session), their degree of agreement on therapy And sharing the strategies that will be used to reach them. The quality of the therapeutic alliance, both with the child and with his parents, correlates not only with significant changes in the child but also with a marked increase in parental skills and perceived improvements in the problematic situation of the parent.

Therefore, in order for the therapeutic pathway to be more likely to give tangible results over time it will be important for the therapist to establish true therapeutic alliances not only with children but also with parents and with the school[13-18].

Working alliance with parents

The therapist should try to establish a more collaborative and equal climate with patient's parents; and establishing together the goals to be achieved, the schedules, the ways and their roles. To maintain a good therapeutic relationship with families of children and adolescents with serious behavioral problems, it may be useful to refer to a list of strategies:

1. Focus on strengths in the different relational and life spans of the child, rather than on individual and / or family difficulties.

2. Use reflective listening techniques that will re-formulate what the patient said in an accurate and supportive way for the patient. This means emphasizing the importance of the patient's point of view by communicating that we understand what he is saying to us. Especially in the early stages of therapy, this type of re-formulation is a valid method to offer patients the opportunity to share their thoughts and emotions on the therapist.

3. Maintaining an empathic attitude during the treatment, monitoring your moods and thoughts especially with those families who, by their clinical features, do not evoke a spontaneous empathy from the therapist. To do this, it may be useful to assume a perspective attitude towards the patients and to constantly monitor the possible emergence of negative attributions to families in the mind of the therapist.

4. Maintaining an authentic and genuine positive hope and positive reinforcement.

5. Preparing and possibly anticipating or reassuring families that the therapeutic pathway may be sore, trigger intense emotional reactions, such as anger and avoidance, in order to normalize fluctuations in motivation to treatment. On the other hand, the therapist must be prepared to use various strategies to resume any withdrawal from the therapy (to offer parents a brief update, even telephone, engage them at some party of the therapeutic group just to greet them, and be happy to meet them again when resumed after long absences).

6. Maintaining the therapeutic focus on the family, giving priority to the goals proposed by each member of the family and adapting from time to time to the needs the family shows, rather than to those that would seem to prioritize the therapist's clinical skills[19-35].

It is important that the therapist is not seen as the one who corrects educational errors by providing quick solutions or as a judge over The behavior of family members. In fact, the therapist must not only focus on behavioral behavior, but also on mentalization processes and on the search for connections between the symptoms and the quality of the relationships and emotions present, to offer family opportunities for internal processing that allow to connect The symptoms of internal processes that support them. In disruptive behavioral disorders, even more so than in other psychopathological areas, it is important to be able to transmit to family members an attitude of suspending action by trying to stop thinking, to reflect on why, and only after making a plan together. By supporting the idea that the symptom is not an enemy to fight at all costs or be kept under control, but a signal with a strong emotional value and its role in family dynamics, one can solicit a sense of cooperation and curiosity In the family members[36-50].

Working alliance with patients

This point is very important because as long as the boy does not hear the therapist as a figure to trust, which is there only for him without judging it, the therapeutic alliance will struggle to take off. In order for this to happen, the therapist must first find the right distance in the relationship, avoiding to stimulate too early the attachment system through too cautious or naively empathetic attitudes, as these cause critical emotions of vulnerability, fear, pain, sadness That the boy is unable to hold and that he usually passes through agitated rage.

You should also avoid going early to explore what they think, their inner scenarios, or trying to tell what parents or others think about because these children have disconnected the action plan and the internal representations with a self-protective, vital purpose , Derived from their primary learning context, and going to investigate this too prematurely means triggering aggressive defensive reactions. The construction of the relationship must then develop from procedural domination, that is, by the concreteness of their "doing" everyday, by sharing some of their small interests, keeping on an outside rather internal level, more on what is done than on what You think and feel. The therapist will then have to exploit those areas of childhood emotional accessibility resulting from the inevitable activation of the attachment system that takes place during the meetings and which must be recognized and used in terms of tuning and building the therapeutic alliance. These areas of emotional accessibility represented by the agonistic motivation system, from the sexual and the care-cure, result from the fact that the child perceives the activation of the attachment system as something unsustainable and dangerous. The agonistic system can be exploited by looking for areas of possible sharing and tuning with the most obstinately strong and invulnerable part of the boy, using more toned games.

The care-cure system being also of this hierarchical type, allows the child to maintain a position of relative superiority and control, but connotating her emotional tonality; You can try, for example, to involve the child in the game asking for his help (eg "Marco but how do these legos come together? Please give me a hand!"). With adolescent or preadolescent boys, the sexual system can also be an initial tuning channel that the therapist must treat with the utmost delicacy and explore some aspects of sharing, such as the interests of children and / or sexuality for How can they be lived in this age. The goal will be to move gradually from what is external to the internal states, even through the game, which becomes an opportunity to work with ideas and to recognize and discriminate different meanings, by providing the basis for the Development of mentality skills[51-70].

Working landscape with school

Also the alliance with the school is a very important element, as the school itself is one of the areas in which the various symptomatic manifestations of DCs are revealed in their gravity; In addition, it is often the school that requires parents to take special care as they are unable to handle the child's behavioral difficulties. What unfortunately often arises is a conflict between families and school, which take on totally different points of view. A climate of tension and mutual accusations makes it necessary, before any kind of intervention is initiated, that the therapist finds some area of agreement between the school and the to family, pending the failure of therapy. In fact, only a strong sharing of goals and strategies between the various child's reference figures can make the therapeutic intervention effective. As with parents, teachers will be invited to focus attention on observing and understanding the aggressive behavior of the child in the classroom.

In the light of this, it will be possible to plan an intervention with the school, taking into account the availability in the school context, to which the parent should show interest and attention, on which he will be constantly updated in relation to the child's progress and to which he will be actively involved[71-100].

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