

## **Suggesting a resilient and systemic oriented psychodynamic model to include students with behavioural problems: Theoretical issues and practical challenges**

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### *Abstract*

This paper presents an overview of available research data on the functioning of children with behavioural problems, and also discusses school-based risk and protective factors, and school problems in children with conduct problems. Additionally, emphasis has been placed on the presentation of key features of a psychoeducational counselling and psychodynamic resilient based intervention model which aims to address disruptive and disturbing behaviours within the school setting in partnership with school staff and in a systemic perspective. A case vignette is presented in order to better illustrate the basic tenets of this model.

*Keywords:* children's behavioural problems; school-based interventions; ecosystemic psychodynamic counselling model.

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## ***Introduction***

Many children at US or European schools face significant academic difficulties and/or have emotional and behavioural problems that place them at high risk of school and social exclusion (Simpson & Mundschenk, 2012; Kauffman & Landrum, 2013; Roeser & Eccles, 2000). One in ten children in the UK presents at least one DSM-IV disorder, such as conduct problems or emotional and behavioural disruptions, involving clinically significant levels of distress or impairment sufficient to warrant specialized intervention and the involvement of the school community and professionals (Ford, Goodman, & Meltzer, 2003).

According to a report from the Office of the Surgeon General, 10.3% of children in the United States aged 9–17 display some form of disruptive behaviour (see Mash & Wolfe, 2012). In fact, the U.S. Department of Health and Human Services estimates that between 6 and 16 percent of males and 2 to 9 percent of females aged under 18 have a conduct disorder that ranges in severity from mild to severe.

In addition, between 12% and 30% of all children in many European countries and in the United States experience moderate to severe social-emotional difficulties, and their needs and problems remain unmet or inadequately dealt with (Mash & Wolfe, 2012; Kauffman & Landrum, 2013; Simpson & Mundschenk, 2012). Children in elementary schools with social, emotional and behavioral problems are three times more likely to be suspended or expelled than their peers (Kauffman & Landrum, 2013; Simpson & Mundschenk, 2012). Almost 50 percent of adolescents in high school with social, emotional and behavioural problems drop out of school (Simpson & Mundschenk, 2012).

These and other issues emerging from recent research findings urgently invite professionals to develop community- or school-based services and practices that focus on effectively responding to these children's needs and difficulties (Adelman & Taylor, 2010).

In fact, traditional medical services seem to be unable to deal successfully with the high numbers of childhood disorders, adopting as they do an exclusively individual-centred treatment protocol which risks losing sight of the wide range of personal and contextual risks that may be relevant, and which thus fails to promote factors that might foster the resilience of children and families at risk. In addition, separating the child from his/her context and locating the problems exclusively within the individual is an epistemological and methodological approach which is - or at least should be - contestable.

Children's social, emotional and behavioural problems represent a complex phenomenon which challenges traditional psychiatric approaches and calls for the adoption of innovative conceptual frameworks and systematic and coordinated efforts from all stakeholders and experts. School must be considered the ideal site to implement comprehensive and successful interventions that can address a wide range of social, educational, emotional, behavioural and adjustment problems concurrently in a large number of students. However, designing and implementing effective intervention strategies within school and family settings remains a complex issue for parents, teachers and clinicians.

## ***Shifting from a deficit- to a strength-based model***

School and family environments are the most important settings in which to promote protective factors and address contextual risks for children (Goldstein & Rider, 2013; Felner & Devries, 2013). Multi-setting interventions have been found to be successful in positively impacting upon children's outcomes (Fraser & Williams, 2004). Resilience-based interventions have been demonstrated to create more protective environments for children facing various risks (Doll, 2013; Hart & Blincow 2007; Winslow, Sandler, Wolchik, & Carr, 2013). In fact, a considerable shift in school and educational-psychology practice and research has been realized during the last decade. The strength-based approach represents a shift from medical and individual-based models of treatment to more systemic, resilience-based and less expertise-oriented approaches, which foster families', schools' and teachers' potential and focus on positive aspects of their functions (e.g., abandoning punishment-based treatment techniques for defiant children in favour of more supportive and (internal or external) conflict-resolution strategies; avoiding pathologizing *in extremis* families; and building on parents' knowledge and intuitions as built up from their relational and interactional experience with the "problem" child) (Banton & Timmerman, 2011; Brehm & Doll, 2009; Galassi & Akos, 2007; Kourkoutas & Wolhuter, 2013). In fact, a strength-based approach has been promoted by researchers

and practitioners as one of the most comprehensive models that can bring about essential transformations in the way professionals work and how they impact schools, families and children.

Within school contexts, a series of intervention programs referring to the principles of strength-based models have been implemented with significant positive results for the students and schools concerned. Specifically, the implementation of social-emotional learning programs can help students with problematic behaviours to reduce their rates of emotional and behavioural disruptions. In fact, a major implication of the findings of a very recent study is that well-implemented multiyear social-emotional learning programs can have significant and meaningful preventive effects on population-level rates of aggression, social competence and academic engagement in the elementary school years (Adelman & Taylor, 2010).

Overall, such programs strongly contribute to helping students achieve high rates of classroom adjustment and avoid school exclusion or drop out, which is one of the key targets of inclusive projects. In addition, schools can be transformed so as to adopt a more positive, resilience-based and inclusive perspective in dealing with such children.

### ***Forms of aggressive or disruptive behaviour in school, and related social and individual dynamics***

There are several key aggressive behaviours which are apparent in school settings. These vary in seriousness and intensity, and may be associated with one gender more often than the other (Burke, Loeber, & Birmaher, 2002). In terms of sex, male students may display moderately serious aggressive behaviours including *hostile teasing, pushing, and bullying*, whereas female students are known to use *indirect* forms of aggression, including *ostracism* and *relational bullying* (Hawker & Boulton, 2000). Studies have revealed a principal dimension of disruptive behaviour, with overt problem behaviours (e.g., temper tantrums and physical attacks) clustering at one pole, and covert problem behaviours (e.g., theft and setting fires) at the other (Frick & Kimonis, 2008). Disobedience and misbehaviour within the classroom, often a source of anxiety for teachers, are situated in the middle of the overt–covert continuum (Kourkoutas & Wolhuter, 2013), and the destructive–nondestructive dimension is another important aspect of aggressive behaviours (Frick & Kimonis, 2008).

There is general agreement that both overt and covert antisocial acts reflect the failure to successfully resolve distinct normative developmental tasks, to effectively achieve transitional phases, and to establish forms of emotional and behavioural regulation in order to deal with extreme or intense internal tensions and painful feelings related to past traumatic experiences (Dunn, 2001). In fact, all available data show a strong connection between conduct problems or aggressive behaviour and some form of family dysfunction or even mental health problems in parents, especially in extreme cases of isolated or disrupted family environment (Dishion & Patterson, 2006).

There is of course some relationship between aggressive or antisocial patterns and overall social inequality and poverty, although research has yet to uncover how precisely to delineate the different mechanisms involved. In fact, social inequalities, social exclusion and economic crisis might be some of the most significant factors creating conditions of extreme risk and, thus, contributing to the exacerbation of existing family and individual problems. Compared with the general youth population, youth with behavioural or antisocial problems are more likely to live in poverty, have a head of household with no formal education past high school, and live in a single-parent household.

It is usually suggested that overt aggressive or antisocial acts (e.g., physical violent behaviour) pertains to children who have not successfully acquired control of their emotions or developed the necessary social skills (e.g., the use of *non-confrontational/conflicting forms of interpersonal problem solving*) to deal with social and interpersonal challenges (Casey, 2012; Kauffman & Landrum, 2013). This is a standard interpretation of behavioural problems when they are perceived as being the result of a within-child deficit. Indeed, many studies have showed that children who have not acquired these general skills then fail to develop the necessary skills to establish and maintain positive relationships with peers and adults. Many of these children seem to struggle with strong negative and resentful or even hostile and sadistic emotions, which lie beneath their antisocial or violent behaviours (Kourkoutas, 2012; Levine, 2007). In fact, however, resentful and negative emotions such as anger, rage, fury or hostile-depressive feelings, may be associated with or generated by accumulated experiences of rejection or traumatic relationships problems within the family and in school contexts (Kourkoutas, 2012; Schmidt, 2010).

### ***Key features of children exhibiting a wide range of behavioural problems***

In general, children with behavioural problems may display aggressive or defiant oppositional behavioural patterns, low or inflated self-esteem, distorted self-conceptions, inappropriate play, hostile talk, insecure internal working models, limited positive interpersonal skills, restricted prosocial patterns and relationships, and poor academic skills (Kauffman & Landrum, 2013; Mash & Wolfe, 2012). They also exhibit more resentful and negative feelings, a high propensity to impulsive behaviours, anxiety and depressive tendencies, a limited capacity in expressing and verbalizing emotions, deficient or limited psychosocial skills, and problems in attachment patterns, which may in turn lead to a restricted capacity to negotiate and resolve interpersonal disputes with peers and adults, and difficulty maintaining satisfying relationships with peers and adults (Kourkoutas, 2012; Mash & Wolfe, 2012).

Behavioural problems in children are associated with negative outcomes including impaired educational achievements, high rates of school failure and school drop-out, poor social relationships, high rates of emotional distress, conflicts with parents and teachers, and social rejection or isolation (Fiese, Wilder, & Bichham, 2000; Frick & Dickens, 2006; Mash & Wolfe, 2012). Not surprisingly, studies have shown high rates of rejection by peers and teachers in the school setting for children with behavioural and conduct issues (Kauffman & Brigham, 2009). Defiant, oppositional, challenging and aggressive behaviour usually elicits strong negative emotional reactions on the part of classmates and teachers, which in turn may intensify the trauma of rejection and school reprimands, and amplify the negative emotions and behaviour towards others (Kourkoutas, 2012; Levine, 2007). Repeated traumatic rejections and reprimands may therefore create a vicious cycle of recurring acting-out, leading to a breakdown in the pupil–school relationship during adolescence. Excluded youth are more likely to identify with marginal values and strengthen their self-esteem by affiliating with antisocial groups such as gangs, and building an antisocial identity at odds with more mainstream social norms.

Contemporary psychodynamic approaches view childhood symptomatology and children's oppositional, defiant, challenging and aggressive behaviours as resulting from internal conflicts, emotional ambivalence, and incapacity to bear and metabolize distressing feelings related to trauma or extreme socioeconomic and emotional deprivation; it may also be an indicator of the child's inability to deal with external challenges, often because they have not been supported or educated to manage complex social-emotional and interpersonal situations. Systems-oriented approaches consider childhood disorders as reflecting family dysfunction and conflict, problematic, rigid, violent, or chaotic dynamics and lack of boundaries, or even unresolved mourning and losses. Family or systemic theorists suggest that children's problem behaviours are often locked up in family incoherencies, deficits, dysfunctions, and coercive rearing practices, which undermine the development of the child's internal capacities and mentalization skills (Dishion & Patterson, 2006; Fonagy, 2006). In any case, these children are not in a position to build a repertory of adequate social-emotional skills and behaviours and become successfully adjusted within school context without substantial help and assistance from the educational staff, and often from specialists.

In summary, from our own perspective, behavioural problems are seen as the result of a series of internal/intrapsychic and interpersonal transactions and processes, which take place within the frame of the wider family and social context. Within contemporary psychodynamic theory, therefore, behavioural problems are thought to reflect a variety of meanings and functions, depending on the child's psychological organization and developmental stage, and the family structure and dynamics.

Moreover, more holistic and ecological approaches, rooted in understandings of (individual) internal dynamics, family relationships and wider socio-economic forces, appreciate the role that structural inequalities, including poverty and educational disadvantages, have to play in the development of children's conduct problems (Hart & Blincow, 2007). Such models speak in favour of a school–community partnership in order to establish networks and “Communities of Practice” that successfully support and help those children or youth in developing the necessary skills and overcome the barriers in their everyday life.

### ***Traumatic family experiences and relationships, and childhood disruptive or aggressive and violent behaviour***

The evidence strongly supports the hypothesis that parental rearing practices and family dynamics (family structure, organization, communicational patterns, family emotional climate, specific members' relationships, relational patterns, etc.) seriously impact the way children construct their self-schemas, their mental representations about themselves and significant others, their attachment and behavioural repertory, their coping and self-protecting strategies, as well as the way they interpret social cues and how they approach and relate to other people. So too do the wider social and neighbourhood environments through which they navigate in daily life.

Moreover, some relationships within a family context can be oppressing, coercive, or frightening and disruptive for the child, destabilizing his or her internal world (representations, working models, secure feeling, etc.) and, therefore, jeopardizing the development of adequate social, emotional and interpersonal capacities. In such cases, if the child is exposed to recurring experiences of parental rejection or unstable behaviour, or persistent psychological violence or maltreatment, they are likely to develop maladaptive behaviours (e.g., acting-out) or inappropriate emotional reactions (e.g., temper tantrums), and thus face serious future problems at school and as regards social adjustment more generally.

In addition, distressing events and complex or adverse family experiences that parents cannot adequately face up to themselves, may also have a traumatic dimension. These may contribute to the development of deficient or conflicting self-representations, disordered or confusing emotions, and problematic behavioural and attachment patterns. The way parents deal with complex, stressful experiences is likely to impact upon the way children learn to manage their own internal stresses or painful emotions. Parental inability to deal with complex, conflicting situations or exceptional experiences (intrafamily conflicts, father's absence, divorce, child's school failure, etc.) may therefore be an additional source of stress, causing further anxiety and confusion for children, and may hold them back in developing their internal capacities and interpersonal skills. Childhood traumatic or harmful experiences are considered a fundamental source of negative, ambivalent and painful emotions, which may lie behind and reinforce oppositional, aggressive and antisocial behaviours.

Studying traumatic relationships and victimisation in childhood, Ford (2002) has elaborated and proposed the following model, which postulates a chronological sequence from (a) victimisation in childhood, to (b) escalating dysregulation of emotion and social information processing, to (c) severe and persistent problems with oppositional-defiance and overt or covert aggression, which may be compounded by post-traumatic symptoms. Unfortunately, classical medical and symptom-oriented clinical assessments may be insufficient to fully evaluate the underlying causes and emotional forces, as well as the socio-ecological contextual factors, that may generate opposition, aggressive or antisocial behaviour in children and youths. Traditional clinical diagnosis is focused on a syndrome perspective, which lacks a transactional developmental orientation, and often fails to gain insight into children's potentially disordered lives or suggest which risk factors really need to be addressed. Interventions informed by a medical model may prove meaningless or inadequate, both in terms of responding to the challenges of the psychosocial development of such children, and in promoting the resilient or protective factors related to their social and school inclusion.

In summary, trauma is considered by many authors to be one of the key factors in understanding the development and persistence of conduct disorders and behavioural problems in childhood (Greenwald, 2002). Within this model, trauma is thought to be related to the affect dysregulation and the consequent acting-out that is characteristic of many traumatised children and adults. Affect dysregulation is suggested by the literature to be a powerful predictor of oppositional and antisocial behaviour, and parental reinforcement of coercive practice (Greenwald, 2002). Trauma-related affect dysregulation may increase hypersensitivity to potential threats, and trigger reactivity to a variety of situations and stimuli perceived as trauma-related (Greenwald, 2002). From our perspective, many incidents relating to family life or dynamics may be experienced as traumatic or emotionally destabilising for the child.

### *School-related risk and protective factors*

The schooling process can lead to significant risks for students' development and adjustment, which may contribute to and/or maintain social, behavioural and conduct problems (Morrison, Furlong, & Morrison, 1998). Additionally, school has an important role to play in assessing children's emotional and behavioural problems. Research suggests that diagnoses of conduct disorders and ADHD may be missed if information is not sought from teachers about children's functioning in school (Ford et al., 2003).

Given that many countries lack appropriate mental health services in schools, pupils with "untreated" behavioural problems or who remain unsupported and without assistance to develop their potential, present a daily challenge for teachers (Roeser & Eccles, 2000) and are at risk of developing additional and more serious emotional and interpersonal problems, school exclusion or drop out, and life-long antisocial personality difficulties (Farrington, Ullrich, & Salekin, 2010).

Teachers' pedagogical beliefs, as well as their classroom instructional practices, conceptions about the origin of behavioural problems, and their ability to relate to students and accept external help in critical situations, can all influence children's cognitive and social-emotional development within the school context (Kourkoutas, 2012). Empirical studies have shown that, among some children, academic difficulties can cause subsequent feelings of frustration, inferiority, anger and aggression that may result in behaviour problems in and out of school (Roeser & Eccles, 2000). In any case, school failure is a strong predictor of later psychological disturbance, internalising difficulties, behavioural disruptions, delinquency, substance abuse and dropping-out (Kracher, 2004).

Children who are struggling with family difficulties or death, who lack boundaries and support, who are struggling with painful feelings, and who tend to adopt aggressive behavioural patterns in school, are quickly rejected by non-aggressive peers and risk direct or indirect rejection by teachers (Kourkoutas, 2012). Overt or covert rejection by peers and teachers (e.g., negative expectations) seem to be an important risk factor for children's psychosocial outcomes, especially for children who have already encountered difficulties in school adjustment or who come from conflicting and disruptive family environments (Mash & Wolfe, 2012). Negative expectations for students, as communicated by school staff members, have been noted as a further risk factor (Kauffman & Landrum, 2013).

As regards the teacher-child relationship, it seems that children with antisocial behaviour are much less likely to get encouragement from teachers for appropriate behaviour, and more likely to be punished for negative behaviour than well-behaved children (Simpson & Mundschenk, 2012). Other studies suggest that students perceived to be at risk of antisocial conduct, particularly boys and impoverished minority students, are more likely to be punished, excluded and controlled than to have their problems addressed in a therapeutic manner.

It is widely accepted that difficult behaviours which have already manifested by preschool age, tend to worsen and become generalised in primary school because of school-climate-related factors (Levine, 2007; Roaeser & Eccles, 2000). Researchers focusing on very disruptive children have described escalating spirals of negative teacher-pupil interchanges, strongly reminiscent of coercive relationships within families (Maughan, 2001; Dishion & Patterson, 2006).

There is general agreement that early peer rejection within the school context is a risk factor for both early- or late-onset behavioural problems; for example, peer rejection at school appears to be a significant predictor of adolescent disorder. Children with antisocial behaviour tend to be rejected by prosocial peers because of their aversive social behaviour. Thus a child's antisocial behaviour within the school setting induces peer rejection, and peer rejection may contribute to further behavioural problems in a reciprocal relationship. According to recent findings, the experience of being systematically rejected and victimised within the school setting may lead some children to become bullies themselves by relating to an aggressive peer group.

In contrast, peer acceptance in school-age children and adolescents has been revealed to be a highly protective factor for children and youths at risk for antisocial behaviour. The use of peer mentors or systems of peer support in schools may increase feelings of peer acceptance and reduce problem behaviour; however, research reveals that very careful attention needs to be paid to how they are set up and to the skills and abilities of those involved (Schmidt, 2010).

Summarizing the literature on school-based risks, Morrison and colleagues (1994) provide a detailed delineation of the risk factors associated with school violence. Their basic risk categories include, among others, (a) risks of child isolation and rejection, (b) risks related to lack of educational opportunities and

psychosocial or professional support (where otherwise needed), (c) risks of personal and social intimidation, (d) risks relating to school failure and low academic performance, (e) risks relating to low self-esteem and deficient self-conceptions or lack of social self-determination, and (f) victims of teachers' rejection and aggressive reactions, or systematic extreme punishments. Moreover, the lack of competent professionals who intermediate between parents and teachers and support both of them in collaborating and developing more mindful and effective attitudes or practices towards at-risk or vulnerable students is another important deficiency of many educational systems.

Another conclusion of researchers who have a broad ecological-systemic perspective is that problematic behaviour and academic failure reinforce each other within the context of ineffective school practices and ineffective parenting strategies (McEvoy & Welker, 2000). Kassen, Johnson and Cohen (1990) found that low levels of school conflict (e.g., teachers rarely shouting at pupils) were associated with a decline in attentional and behavioural problems in adolescence. Three key elements of the curriculum and instructional process which may help prevent school-related critical situations are: (a) a curriculum that is relevant and connected to children's life experiences, (b) instructional approaches that build on the learning styles and previous experiences of the children, and (c) opportunities to achieve reflective thinking.

In summary, the findings of research into school climate suggest that affirming interpersonal relationships and providing opportunities for children to achieve mastery can increase academic achievement levels and reduce antisocial behaviours (Levine, 2007; McEvoy & Welker, 2000; Schmidt, 2010). In addition, receptive and caring school contexts can represent an embracing ("holding") and helpful environment for many children who have experienced extreme frustrations or obstacles in developing social-emotional skills. Adequately trained professionals, working alongside teachers, can provide facilitative learning environments and develop therapeutic relationships to assist children who have suffered trauma, maltreatment or deprivation, so that they can manage their internal conflicts or dysregulation and so prevent them from developing more disorganised patterns of behaviour and attachment.

### ***Multisetting prevention and intervention programs based on resilience and systemic theory***

School may be considered an ideal site in which to implement comprehensive and successful interventions that address a wide range of social, educational, emotional, behavioural and adjustment problems, in a large number of students concurrently. However, designing and implementing effective intervention strategies within the school and family settings remains a complex issue for parents, teachers and clinicians or other school professionals.

School and family environments seem to be the most important settings in which to promote protective factors and address contextual risk factors (Goldstein & Brooks, 2007; Cooper & Jacobs, 2011). Multi-setting interventions have been reported to be successful in positively impacting upon children's outcomes (Kourkoutas, 2012). Resilience-based interventions have been demonstrated to create more protective and emotionally receptive and embracing environments for children facing various risks (Hart & Blincow, 2007; Schmidt, 2010; Urquhart, 2009).

As mentioned above, a considerable shift in school and educational-psychology practice and research has taken place in recent years, notably regarding abandoning punishment-based treatment techniques for defiant children in favour of more supportive strategies, and avoiding pathologising families. Programs and interventions that utilize a strength-based approach often combine this framework with other approaches such as wraparound service models, resilient models, family systems frameworks, social, parenting and teaching skills programs for students, parents, teachers, and various types of cognitive-behavioral therapies including solution-focused therapy or conflict-resolution programs (see Banton & Timmerman, 2011). Thus, rather than viewing the strength-based approach as one method of working with children and families, the strength-based approach can be seen as a conceptual framework within which many practitioners already do work (Banton & Timmerman, 2011; Kourkoutas & Raul Xavier, 2010). While implementation of the strength-based approach may vary, practitioners using a strength-based approach tend to emphasize individual and family functioning and strengths (Adelman & Taylor, 2010; Banton & Timmerman, 2011; Galassi & Akos, 2007; Kourkoutas, 2012).

From our own perspective, one of the key elements alongside resilience, inclusive education framework and taking a systems perspective, is "psychodynamic thinking and practice". Psychodynamic thinking allows

counsellors and teachers to go beyond the child's symptomatic reactions and see the "real" child and his/her family behind the problem behaviour. Within this model, in fact, teachers and school counsellors are encouraged and helped to gain insight into or distinguish the complex emotional needs and problematic family processes (conflicting, ambivalent or destructive feelings such as anger; feeling lost, confused or depressive; a lack of boundaries within the family, etc.) that might lie behind or generate early disruptive or "antisocial" behaviour. Despite the fact that many teachers tend to make a rather easy identification of specific behaviour as pathologic, many others tend to "suffer" from what Elliott and Place have termed "selective myopia"; namely, the teacher's inability to appropriately estimate the severity of less disruptive cases of children or understand the internal conflicts or struggle with depressive tendencies that some children are experiencing (Elliott & Place, 2012).

Likewise, this perspective can be very useful in counselling work with teachers, as it focuses on the emotional aspects of the teachers' functioning, their internal confusion or stress, their struggle to identify the meaning of the child's situation, or their own guilt about not providing enough help to "difficult" children. Teachers also experience frustration or anger when they are unable to contain their students' disruptive feelings and reactions. The counselling process may provide this real and metaphoric (psychic) space to help teachers reinforce their self-awareness and self-confidence, explore the meaning of the problematic reaction, and, therefore, start to think and react in more "reasonable" ways. In fact, when teachers and counsellors work within a collaborative perspective, they participate in the establishment of a co-constructed holding space (a space of learning and professional development) and a dialogue that allows them to strengthen their critical thinking, as experience and knowledge are shared and discussed (Goldstein & Brooks, 2007; Kourkoutas & Giovazolias (in press); Schmidt, 2010).

Successful examples of resilience-based programs and those focused on skill-development include the Child Development Program and the Family Schools Together programs, or programs that share similar principles, targets and philosophy (Casey, 2012; Conduct Problems Prevention Research Group, 2011).

The programs with the highest level of positive developmental outcomes have been those interventions that targeted three levels: teacher emotional support and guidance; individual or group support and treatment for children; and training, support and guidance for parents (Middlemis, 2005).

The combination of a social-ecological model with resilience theory, and the use of specific techniques for working with antisocial children in the schooling context, allows professionals to simultaneously address numerous problems within the school environment (Cohen, 2013; Kourkoutas, 2012; Lerner et al., 2013; Taub & Pearrow, 2013). These include chaotic classrooms, inadequate teacher support, poor administrative leadership, inappropriate or unclear expectations concerning students with learning disabilities and psychosocial problems, as well as inadequate strategies for handling problem behaviours. Regarding the teacher's role in the implementation of preventive or targeted programs (e.g., social-emotional skills development, conflict resolution, anti-violence or anti-bullying interventions, and social inclusion), it has been demonstrated that teachers can significantly contribute to the positive outcome of those programs or interventions (Cooper & Jacobs, 2011; Fleming, Mackrain, & LeBuffe, 2013).

In conclusion, research data very clearly suggest that interventions are more effective if the environmental factors that reinforce the problem behaviour are identified and manipulated in specific and holistic ways (Adelman & Taylor, 2010; McEvoy & Welker, 2000). In addition, providing teachers with emotional support and strategies to deal with challenging or aggressive behaviour is an essential part of the more successful school-based programs (Kourkoutas & Giovazolias, in press). Professionals should help parents and teachers to overcome their respective emotional resistances and defences and develop more understanding and mutual recognition of each other's difficulties and qualities. Professionals should also assist parents both in gaining insight into their child's "internal and external struggles", and by guiding them to develop more meaningful and appropriate child-rearing practices and attitudes. Interventions aimed at helping parents to creatively resolve family problems and use positive parenting techniques are now considered important aspects of holistic school-based programs (Weare, 2005).

### ***Classroom interventions***

Teachers often play a substantial role in identifying developmental problems and other issues affecting students, and in taking action to prevent at-risk students from developing further psychological problems. Of



course, teachers are not trained to be experts in psychological difficulties and interventions; however, they are often involved in intense (personal and professional) interaction with their students, and it has been suggested that after proper training they are able to recognise the early signs of psychological problems or acknowledge the variety of children's difficulties. Similarly, it has been noted that because teachers spend a substantial amount of time with students, their observations of students and evaluation of their cognitive and emotional status can provide vital information when designing interventions to promote a healthy school environment (Kauffman & Landrum, 2013). With the help and guidance of counsellors, who provide them with the necessary theoretical and practical tools and means (background) to better analyse, de-codify and understand their vulnerable or "difficult" students' behaviours, teachers can acquire confidence in their capacity to relate to and deal with such students by linking these behaviours with intrapersonal, family or school parameters (Hanko, 2002; Urquhart, 2009).

More specifically, as regards classroom practices the literature suggests that personalized classroom interventions for children with aggressiveness and conduct problems can be effective in enhancing positive behaviour, reducing ACP tendencies, and promoting social and emotional skills (Weare, 2000). When schools actively combine effective emotional and academic learning, and school-wide, classroom and targeted individual interventions, they can significantly reduce oppositional or aggressive behaviours (Bloomquist & Schnell, 2002; Cooper & Jacobs, 2011). When treating certain aspects of child behaviour, there is always the danger of isolating these aspects from their context and thus missing the developmental and transactional processes at work in the problematic situations (Sameroff, 2000).

Overall, the therapeutic role of teachers who are well-trained, skilled, and committed to inclusive values, has been highlighted by many researchers and practitioners (see Kourkoutas, 2012; Urquhart, 2009). Teachers can operate as facilitators in the positive development of "problematic children", and work in a therapeutic direction by being receptive, supportive, and providing a stable framework with clear limits and positive expectations (Fell, 2002; Kourkoutas & Raul Xavier, 2010; Urquhart, 2009). Teachers are more likely to reframe disordered children's disruptive behaviours when they are actively involved, use appropriate teaching and psychoeducational practices inside and outside the classroom by taking into consideration the internal (emotional) and social dynamics of the classroom, and when they use resilience-based methods to engage all students (Cohen, 2013; Cooper & Jacobson, 2011). Obtaining sufficient assistance from skilled and experienced professionals who are trained both in childhood education and in systemic and psychodynamic practice, is also a crucial aspect of comprehensive and meaningful psychoeducational intervention programs (Hanko, 2002; Kourkoutas, 2012; Kourkoutas & Giovazolias, in press).

Alongside this, it is important to encourage teachers to develop an 'inequalities imagination' – that is to say, a thorough understanding of the dynamics of inequality and how children's behaviour is shaped in relation to them (Hart & Blicow, 2007). This will ensure that some of the basic issues in relation to child behaviour are dealt with – for example, ensuring that a child has appropriate nutritional intake both before and during the school day in order to regulate blood sugars and reduce mood swings.

Overall, system- and community-based resilience approaches and research suggest that school should also ensure partnership coalitions with the community. School professionals should care about and focus on creating "Communities of Practices" and "Communities (spaces) of Learning" that enhance all stakeholders, though with emphasis on parents and teachers, to produce and share new forms of understanding of their problems and potential, as well as practices that successfully boost the emotional and academic resilience of at-risk or vulnerable children.

Analogous to the "therapeutic space" in the psychodynamic model, school and community professionals can provide such "micro-spaces" of support to families experiencing social exclusion and poverty, enabling them to face up to these critical situations in a less "traumatic" or disorganizing way. Childhood disability may place additional burden on such families. In fact, many of these families may need intense social and medical support that guarantees favourable elementary conditions of living.

### ***School-based psychosocial and targeted psychotherapeutic interventions***

The school-wide interventions considered here fall into three broad groups: (a) programs to enhance social competence and social problem-solving, (b) programs specifically targeted at the reduction of aggressive behaviour, and (c) programs to reduce bullying (Burke, Loeber, & Birmaher, 2002).

Although several critiques have been made concerning the efficacy and methodology of alternative educational interventions (e.g., social-emotional learning programs, conflict-resolution programs, anger management programs, etc.) implemented in schools (Jones, 2004; McEvoy & Welker, 2000; Weare, 2000), there is an additional number of studies that show promising results (Bloomquist & Shnell, 2002; Jones, 2004; Tolbin & Sprague, 2000). For instance, the implementation of the Resolving Conflict Creatively Program (RCCP) in a highly representative sample of 1,160 children in grades 1–6 from New York City public elementary schools showed that children were less likely to make hostile attributions to peers in provocative but ambiguous social situations; were less likely to be aggressive in interpersonal negotiations; and reported fewer conduct problems, depressive symptoms and aggressive fantasies, and fewer teacher-reported aggressive behaviours (Aber, Jones, Brown, Chaudry, & Samples, 1998). Promoting Alternative Thinking Strategies (PATHS) is another universal school-based prevention program, designed to reduce aggression and behaviour problems by promoting social-emotional competence, which has been shown to lower internalising and externalising behavioural problems in 2<sup>nd</sup> and 3<sup>rd</sup> graders, whilst training and supporting the teachers involved in delivering the curriculum (Greenberg, 2006).

The principal critique made against school-based interventions and alternative educational programs concerns: (a) the limited time and resources allocated to staff development and program implementation; (b) the lack of data on implementation of interventions (partial implementation of the interventions); (c) the lack of monitoring and methodical assessment of the interventions; (d) the lack of follow-up studies regarding the long-term efficacy of interventions (Gresham, 2004); (e) the success measure, which is based mostly on cognitive modification concerning violence rather than on long-term behavioural effects (McEvoy & Welker, 2000); (f) the failure to target specific risk factors; (g) the lack of an individualized and specific intervention strategy (having instead a rather universal and preventative character); (h) the lack of a coordinated strategy for the implementation of alternative educational programs. Adelman and Taylor (2010) suggest that many programs for students with emotional and behavioural problems (EBP) are fragmented and reflect a narrow view of the nature of the student's disability. It is also worth pointing out that a lot of them are very costly.

Greenberg (2003) reviewed school-based interventions and concluded that programs in this area are most beneficial when they simultaneously enhance students' personal and social assets, as well as improving the quality of the environments in which students are educated. They also argue that optimal delivery of programs is through trained teachers who integrate the concepts into their regular teaching and do so over a long period of time. Added to this, we would point to the need for an inbuilt awareness of poverty and other social inequalities in any such intervention, especially in countries in which economic crisis has had a dramatic impact on families, although we note that there are as yet few such programmes specifically designed for school populations.

The eco-systemic resilience model of intervention draws on the resources of the different systems that affect the developmental and academic outcomes of children. If the problems occur in school, professionals will support and strengthen the teacher; if the problems are within the peer group, then they may either work with the peer group directly, or collaborate with the available educational staff to re-direct the student to more pro-social activities and groupings in order to reinforce ties with classmates. If the problem is related to issues of poverty and inequality then community-based interventions in cooperation with schools are needed. Besides specific psychosocial and psychoeducational activities, the interdisciplinary team (comprising school psychologists, special educators, teachers, or educators trained in alternative psychosocial methods) may target the promotion and strengthening of pro-social behaviours and interpersonal skills. If the parents are not involved and find it hard to frame and guide their child, then therapists together with the interdisciplinary team will support the parents in assuming a more involved parental role. The systemic approach recognises that problems (and solutions) exist within many different systems and the more inclusive and flexible a practitioner can be, the better it is for the young person. Moreover, resilience models emphasise the strengthening of the child's innate capacities and inner or outer resources.

Furthermore, school counsellors or educational psychologists who work within the school context from a psychodynamic systemic perspective may mediate in parent–teacher conflicts and facilitate family–school communication and teacher–child relationships. Consequently, they can act as a buffer and prevent the escalation of mutual overreactions or intense behaviours. More specifically, school psychologists may help parents and teachers gain better insights into their children's problems, and work with the parents' and the educational staff's negative emotions around children's behaviours.

Schools should try to create a *holding* environment for counselling and psychotherapeutic purposes in cooperation with flexible, school-based teams of professionals who work from a psychodynamic, resilient and systemic perspective to address risks and strengthen vulnerable students against future mental health disorders. Well-trained professionals can address pupils' intrapsychic issues, enabling them to resolve major internal conflicts; accordingly, interpersonal and contextual issues can be addressed with the cooperation of parents and teachers, and by the use of psychoeducational interventions. Dealing with contextual factors that hinder pupils' psychosocial functioning, and promoting positive facilitating factors, are essential targets for any ecosystemic resiliency-oriented program.

### ***A case study of working from a psychodynamic, resilient and systemic perspective in a primary school on the island of Crete***

#### *A brief overview of the Greek referral system*

School educational psychologists are lacking in the Greek educational system. As a result, most pupils with problems in mainstream schools, who are in need of specialised and targeted interventions, are missing out on the type of comprehensive service discussed thus far in this paper. Pupils may be referred to Centres for Diagnosis and Support (KEDDY). These small, regional units are staffed by teachers, special educators, social assistants, and psychologists, and are often chronically under-resourced with respect to the huge number of referrals received. Their aim is to assess pupils' educational needs and facilitate their reintegration into mainstream school, usually via a traditional psychiatric assessment and a strict behavioural program. In actual fact, this often proves to be too large a task for children with emotional and conduct disorders, who are unable to adjust to the behavioural requirements of mainstream school. Furthermore, psychologists working in KEDDYs usually lack specialised training in family support, system-level interventions, or advanced individual psychotherapy, and in most cases have limited access to academic resources, training and research.

Within this context, researchers from the Educational Department at the University of the Crete, together with local and foreign professionals and academics, are implementing experimental action research intervention programs in schools to target cases of challenging behaviour.

#### *Theoretical background and purposes of the (psychosocial-psychoeducational) intervention*

In brief, the rationale behind these intervention programs draws on the following theoretical models and approaches: a) the contemporary psychodynamic approach and resilience therapy; b) the ecosystemic/risk and protective factor perspectives; c) trauma-related theory; d) inclusive psychology and critical pedagogy.

In practical terms, what is proposed is a whole-school model which encompasses a multilevel, multidimensional intervention plan; namely, interventions at the individual, family, teacher, classroom, and school levels, including a variety of techniques – educational, learning-instructional and clinical-psychosocial. The duration, intensity and extent of the intervention depends on the pupil's issues, challenges, and requirements, as well as the environmental (school and family) reactions.

Ensuring a working alliance between teachers and special educators to provide reliable educational and psychosocial support for the “disordered” pupil is an essential component of the successful implementation of an intervention program. In general, two major goals should be included: addressing the children's personal intrapsychic difficulties, and addressing the contextual factors that may impede those children in unfolding their innate potential and building the necessary social, emotional, and academic skills.

More specifically, the following key principles shape and guide our school-based practice (see also Kourkoutas, 2012; Schmidt, 2010):

- Recognition that each case of “problematic” behaviour has meaning and represents an effort, direct or indirect, conscious or unconscious, to communicate disturbing or unprocessed emotions in order to affect the child's proximal environment;
- The centrality of advocacy for the child and young person (a child-centered approach);

- Understanding and working with the parental and family context: understanding how the child “speaks” within the family;
- Promoting a therapeutic process for children, parents and teachers that provides containment and empowerment and focuses on enabling parents and teachers to become more resilient;
- Understanding the importance of the setting: working towards the implementation of an inclusive and holding “therapeutic” environment that promotes socio-emotional skills and focuses on the strength of relationships and the child’s social and academic inclusion;
- Working towards a broader conception of child and family wellbeing, and of the intervention and inclusive processes within the school context;
- Accepting that challenging, problematic and disturbing behaviours may represent acting-out of uncontrolled internal impulses and strong negative feelings that the child can neither bear nor work through emotionally and cognitively.

Overall, our intervention program is integrated within the framework of recent work on developmental trends in the onset of problematic and antisocial behaviour, which has focussed on early starter pathways and on family and social parameters. Therefore, the proposed studies implement a family-based intervention program as early as possible. If they are not treated appropriately, pupils entering school with serious unresolved emotional, family, behavioural or self-regulation problems are at increased risk of more severe emotional, behavioural and learning disorders. In addition, if these children are labelled as pathologically disturbed and excluded from the school system, their emotional deficits and extreme or pathological defences and reactions are more likely to be reinforced. The studies draw attention to the importance of early implementation of comprehensive school-based interventions in parallel to interventions at the family level for those pupils.

#### *Child and family history: strategies and goals of the intervention plan*

In this specific case study we encountered a boy (referred to as P), aged 6.5 years (first grade), with hyperactivity and conduct problems. He was the eldest child of a low-socioeconomic-level family with two other children who lived in the city. His father, who worked in the fields breeding animals, had had a stroke two years earlier, which seemed to have caused significant problems in family functioning.

The intervention plan included a series of initial meetings (two) with teachers (including the school head, classroom teacher, and special educator) and parents, in order to outline the main issues and questions regarding the way in which the child was functioning and behaving in school, as well as teachers’ interventions and perceptions of child’s difficulties.

The school head considered P a very disturbed and pathological case, from a highly problematic family environment. P was diagnosed as hyperactive, and as exhibiting significant emotional immaturity and conduct problems. In the first grade of primary school, he exhibited significant adjustment problems, displayed non-compliant, oppositional reactions and passive-aggressive behaviours toward his classroom teacher, as well as sporadic aggressive behaviours and explosions toward his peers in the school yard. Although he was able to play with his classmates for a while without any serious problems, he was also exhibiting unpredictable mood swings that were keeping him away from his mates’ games.

The classroom teacher had developed a number of strategies and techniques to help P integrate into the classroom. She acknowledged feeling overwhelmed and distressed at times, but also very frustrated and disappointed with the P case, as she felt that he hadn’t made any serious progress. She admitted having done a lot of things for him, but she felt impotent and unable really to help P escape his “*emotional confusion*” and stop him from being aggressive. P became very challenging and disruptive, even with the teacher, when he felt frustrated or when she tried to exert limits on him in an effort to maintain the classroom rules. She felt “*confused*” by P’s disruptive behaviours and intuitively believed that he was a sensitive but unhappy boy. She also mentioned that often, instead of feeling angry, she felt rather sad for him. She finally admitted to not being able to handle the situation, despite her considerable efforts during the last four months to use positive methods to reduce P’s disruptions and aggression, and enhance his classroom integration. The rest of

the educational staff didn't have a clear idea of his problems, but most of them were convinced that P needed a specialised treatment for his aggressive and unpredictable behaviour.

A number of family sessions were conducted with the mother and one with the father. P was presented by the parents, and especially by the father, as a boy with significant problems during the preschool period relating to his impulsivity, his inability to self-regulate and problematic relationships with his peers. He was described by the mother as a *lonely*<sup>1</sup>, *sensitive* and *resigned* boy, who was extremely affected by the father's illness, despite being presented by some school teachers as "*aggressive and mean*".

The Achenbach System of Empirically Based Assessment (ASEBA), including the Inattention and Hyperactivity-Impulsivity subscale, was administered to capture objective data on the child's psychosocial functioning. High rates of anxiety and depressive feelings were revealed, as well as emotional self-regulation and disruptive problems, in agreement with the initial diagnosis.

The major goal at this stage was to formulate a hypothesis about the factors contributing to P's problematic behaviours. Therefore, from the initial family sessions with the mother, the following issues were considered by all the involved professionals as crucial for understanding the family's functioning and its impact on the development of the child's problem behaviours:

- a) A very problematic couple relationship: a father who has been described by the mother as *a hard working and active, but not always easy man*, emotionally quite *tough, reserved, distant* and *uninvolved with the children*; the mother seemed from the beginning of the marriage to suffer from the father's character; she was not satisfied with the couple's emotional tie and the climate in the family, though she expressed her admiration for her husband several times and from many aspects;
- b) The father's stroke had occurred some years ago (P was 4.5 years old at the time) and caused him serious medical and physical limitations, which at their worst left him immobilised; the stroke seemed to have had a dramatic impact on his functioning; he couldn't work anymore, and he became very nervous and verbally violent towards others, as he was emotionally unable to face the situation and overcome his disability;
- c) The father's stroke seems to have been as a crucial turning point in family life, as it had had a tremendous effect on the family dynamics and function; the father's reactions generated a "*painful and sick climate*" inside the family, as he was lying in bed suffering, *shouting* at or *insulting* the children about the minimal noise they made; and according to the mother, the children had been severely disturbed by their fathers' disability and the image of a father who was stuck in his bed and shouting incessantly;
- d) P seemed devastated by his father's anger and the escalation of his aggressive behaviour towards him; the father's behaviour produced the opposite effect on the children, especially P, who became very distressed and nervous and started to exhibit disruptive, non-compliant behaviour;
- e) During the period before the father's stroke, P was described by the mother as a very *lively* and sometimes *overactive*, though very *sensitive*, boy;
- f) Despite the fact that she was very caring and protective, and emotionally devoted to her children, the mother was unable to sufficiently protect them from the shock of their father's reactions; she was also suffering from his illness and his behaviour, but she was quite dependent on him and powerless to exert any kind of influence over him in order to modify his behaviour, or even to help her husband process the traumatic effect the stroke had had on him.

Based on additional data from the initial session with P, a primary hypothesis was formulated by the intervention team: that P was profoundly traumatized by his father's illness and subsequent aggressive reactions. In actual fact, P was considered by the professionals to be a maltreated child, despite the caring and protective relationship he had with his mother. Furthermore, it was proposed that during a developmental period (4–6 years) which is crucial for the growth of the sense of self, self-esteem and self-value, the boy was not sufficiently contained and supported by his parents to overcome his infantile anxieties and to better respond to the challenges of the socialisation process (interpersonal relationships, school requirements, etc.); in contrast, he was permanently faced with distressing and destabilising behaviour stemming from his father. Instead of functioning as an attractive and supportive "identification" model to help P unfold his emotional potential and develop psychosocial skills, his father was threatening, entrapping P in a stressful and

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<sup>1</sup> The terms in italic are exact reproduction of the parents' or teachers' narrative.

conflicting position. According to the mother, P was attached to his father, permanently seeking his approval and encouragement; yet his father was totally indifferent to his needs and expectations. Even before the stroke, P was suffering from his father's absence, his emotional resignation and his distant behaviour. The father believed that the mother was highly overprotective; for his part, he was trying to avoid P becoming a weak or "*feminized*" boy. Overall, the team was convinced that the incessant family conflicts, and the fact that the mother was also subjected to the father's verbal and non-verbal aggression and threats, had seriously jeopardised the children's socio-emotional development during the last few years.

During the individual sessions, although very resigned and resistant in the beginning, and refusing to talk about his father, P admitted that his father's shouting and attacks against his mother made him "*feel really sad*". The children were witnessing the father's persistent violent explosions and threatening behaviours against their mother. P's teachers were aware of the family conflict, but could not imagine the degree to which this family was destabilised, and how the children were affected by the father's critical and rejecting behaviour. Research team members strongly believed that the father's behaviour was debilitating for P's cognitive, emotional and behavioural development, leading to his oppositional behaviours and explosive aggression at school.

In fact, studies demonstrate that parents who are rejecting, uninvolved, and often angry, and who frequently employ physical or psychological punishment to enforce limits, are more likely to have children who are disruptive or aggressive with their peers (Campbell, 2002). Many researchers have found a linear relationship between parents' use of physical punishment and children's reactive aggression and bullying (Simpson & Mundschenk, 2012). Evidence thus exists that a father's rejecting, aggressive or violent behaviour may have a dramatic impact on children of both genders' social, emotional, behavioural, and school adjustment.

In our case, P was emotionally supported by his mother, a relationship which protected him from even being more emotionally disorganised and behaviourally disruptive and aggressive than he was. It is believed that this relationship also prevented him from exhibiting sadistic tendencies toward other children. This is supported by research which shows that children who experience abuse may also display sadistic behaviour toward vulnerable peers, and that a relationship with a supportive adult can help them develop more prosocial behaviour.

Concerning the individual therapeutic intervention with the child, and the goals of this intervention, it was considered essential to provide P with a "containing framework" that would help him "put an order inside", and sort out of the conflicting and confusing emotional states caused by his family situation, notably his father's behaviour. A containing framework would be provided through the "relational presence" and accompaniment of an experienced professional, who recognises through talking and alternative ways of expression (e.g., playing) his unbearable, contradicting and ambivalent feelings towards his father (anger together with sadness and pain). The relational process and framework would help him "voice" (through verbal and non-verbal means) his internal struggle and confusion, his deepest sadness and depressive feelings related to the father's rejection, and the pain he was experiencing by seeing him suffer.

It was suggested that the relationship with his teacher, though supportive and caring, was not sufficient to help P sort out his internal confusion and become less disruptive and aggressive. P was suffering from strong contradictory emotions (the individual sessions brought to the surface his pain and anger) that he was unable to handle; such strong and painful emotions were considered a source of disruptive and aggressive acting-outs.

Overall, the proposed hypotheses were based on strong research evidence which associates conduct problems in childhood both with inconsistent, harsh or aggressive parenting, and traumatising or coercive practices (Kauffman & Landrum, 2013; Levine, 2007; Mash & Wolfe, 2012). Victimized children are much more likely to develop defiant, challenging or non-compliant and aggressive behaviours, as they are also suffering from strong emotional disorders that underlie their behavioural explosions. In addition, many of these children (and this also was the case for P) display very contradictory "inner dynamics", as from the one side they have extreme dependency needs, probably due to their deficient self-conceptions and lack of emotional fulfilment, and from the other side they show rejecting or aggressive behaviour that keeps others away.

To effectively address these behaviours, it is important to establish a comprehensive and holistic therapeutic plan that encompasses family, individual, and school aspects, and which also targets emotional and social behavioural issues.

### *The individual work with the child*

The individual work with P primarily focused on building a trusting and accepting relationship with him. A key component of this work is the provision to the child of a stable relational environment which is protected from the conflicts, frustrations and even traumatic experiences of reality. Many “aggressive” children are emotionally unreachable, as they tend to use strong defences to cover for their internal vulnerability and protect their fragile self-conception. P was also difficult to reach because he was depressed, disruptive and sometimes stubborn and reactive. For a series of sessions the therapist attempted to be “with the child”, to gain his trust rather than trying to immediately disclose him. Psychodynamic and resilience-oriented interventions attempt to go beyond the symptoms: to meet the suffering child, enhance their mentalizing processes, enable them to better handle the challenges of his internal and external reality, and stop enacting painful and distressing feelings and experiences.

A combination of talk and innovative techniques (e.g., direct talk, mutual storytelling, self-created stories, combining talk and playing, drawings, games, and other transitional or projective techniques) were employed to overcome P’s reticence and allow the establishment of a trusting relationship and the expression of painful experiences.

The individual work aimed at helping the child “put words” on what was “unspeakable” and painful, or internally conflicting or puzzling. After a series of sessions, P started to verbally and non-verbally express his negative emotions, especially his anger towards both his parents. His initial drawings and games reflected a narrative full of violence, anger, fear and distress. The therapist helped him articulate and give expression to his confusion and contradicting emotions: he admitted being very *sad* for his father’s illness and *terrified* by his behaviour, even though he was disobedient and disruptive. He was *like that* because his father *didn’t love him* and was incessantly shouting and trying to hit him, breaking things inside the house and trying *to hit mommy*. He was also scared that his mother would fall *ill* and *die*. He liked his teacher but was not sure *that he wants to go school every day*. There were teachers that were *nice* and others that were really *mean* and *nuts*. He had a lot of friends but was not sure he’d like to be with them. Although P started to get attached to his therapist, he remained quite introverted until the end of the intervention process.

Based on his drawings and his narratives in the Cognitive Analytic Therapy (CAT) sessions, it was concluded that P was *emotionally extremely dependent* (also taking into account his relationship with the teacher and his incessant demands for attention and support, often expressed in disruptive or non-conventional ways). It was therefore believed that some of his disruptive behaviours and acting-outs were related to the fact that he was not able to draw the teacher’s attention and care, or his classmates’ interest, with pro-social means. His learning difficulties increased his problems with classroom and academic integration, and put him at risk of more disruptive or challenging behaviours in the classroom.

The ultimate goal of the individual intervention was to enhance therapeutic communication and address all the issues which came to light in the verbal or non-verbal material. Through individual sessions, and the containing and positive relationship with the therapist, it was attempted to help the child gain better self-perception and emotional reassurance; furthermore, it was aimed to enable the child to work through his troublesome emotions, which were pushing him to behavioural explosions and acting-outs, and show him how concerned he was with his teacher’s and his peers’ acceptance and how frustrated he was by his inability to associate with them in a satisfying way. The classroom teacher’s availability was not sufficient to fulfil his profound needs and expectations for emotional soothing and self-assertiveness. Besides, she reported always being *challenged* and *requested*, which made her feel *exhausted* and often *impotent*. The relationship with a number of peers and teachers was rather conflictual and problematic, putting him in a position of extreme frustration and even anger. It was in fact the same kind of frustration and rejection he was experiencing with his father at home.

The therapist integrated verbal interventions into a frame of dynamic and creative communication and exchanges with the child through playing or storytelling and direct talk. This kind of work recognises and verbalises the child’s profound and often neglected needs for self-recognition and approval, and activates a reflective process that could help them gain better control over their emotions and behaviours. Moreover, when employed with care and caution, the technique of verbalising stressful family experiences (for example, the father’s hostile behaviour and his illness), and the child’s subsequent emotions, may be very soothing for the child’s trauma. Though it is usually believed that more targeted behavioural interventions might produce better results, recent studies have shown that psychodynamic and systemic interventions

could be very helpful for children's emotional and behavioural problems (Kourkoutas, 2012; Levine, 2007); besides, the classical behavioural interventions are not as successful as previously thought, as they are not so effective in real "clinical populations" (Kourkoutas, 2012).

It was considered essential for P to participate in a series of psycho-educational programs which would allow him to unfold his psychic potential, reinforce his interpersonal skills and ameliorate his relationships with his classmates. It was also suggested that he be provided with learning support from the special educator, a procedure that his father had refused at the start of the year; it was thought that part of his disruptive behaviours could be activated by his inability to appropriately follow the lesson and participate in classroom activities.

Almost three months later, during an evaluation meeting at the school, the classroom teacher noted that P was much less hyperactive, and not at all aggressive, less dependent and demanding, though he had become more *introvert and sometimes quite reserved*.

### *The work with the parents*

The intervention assigned a central role to taking a family history and asking parents to relate their own story, talk about their relationships and their family reality, their own experiences, beliefs, attitudes and practices toward the child, their ways of dealing with their children's problems, and what they perceive as problems. This was not merely an administrative process or a forerunner to therapeutic intervention; rather, it was a dynamic and transformative experience in which, thanks to the professionals' specific interventions, the parents began to articulate their own narrative and were encouraged to realise the "unknowable" parts of their child, his or her needs and expectations and the associated developmental challenges and requirements, as well as the consequences for the child of parental behaviours and rearing practices. In fact, parents were invited to gain a better insight into their own couple relationship, the family climate and communication, and their child's behaviour and development. Regardless of the quality of the working alliance, and the resistances parents may display, they were confronted by the professionals with the inner reality of their child, which is often misunderstood, underestimated or even ignored.

In our case, we outlined the following issues and discussed them with P's parents:

- a) How affected P was by his father's behaviour, which he was experiencing as open rejection;
- b) How affected he was by his father's illness and pain;
- c) How disturbed P was by the whole situation, and how these emotional states produced disruption, over-activity and disobedience;
- d) How impotent P was to approach his father and find ways to communicate and relate to him;
- e) How vital it was for P to have a positive and supportive relationship with his father, which could reinforce his self-conception, self-esteem and gender identity;
- f) How children may "incorporate" and reproduce or transfer to other contexts the aggressive behaviours they are experiencing at home;
- g) How difficult it was for P under these circumstances to adjust in school and adequately respond to the first-grade challenges and requirements;
- h) How school failure and his inability to properly relate to his classmates frustrated and depressed him;
- i) How some teachers' and peers' rejection reinforced his feeling of frustration, anger and depression, generating more disruption or aggressive behaviours.

The father was really surprised to realise that P was so affected by his illness and his subsequent disability and suffering, which had also made P suffer. He was also surprised to hear that behind P's non-compliant and disruptive behaviour might lie very difficult and painful feelings related to his father's illness. His father was shown that P reacted to pain and distress in the same ways that he personally did (anger and aggression). It was outlined that the father's violent explosions increased P's inability to self-regulate, and to develop appropriate coping strategies. In addition, P was overwhelmed by feelings of impotence, stress, sorrow and pain for his father. As a child he was in a more vulnerable position emotionally, since he was both highly dependent on his parents and feeling powerless to help his father cope with so much stress and pain. Fears about death and losing his mother emotionally overburdened him. His learning difficulties and relational problems, which led to a lack of acceptance by his classmates and the rest of the educational staff, increased the risk of him being more disruptive and emotionally withdrawn. It was also explained to the parents that P



was transferring the same problems of acceptance, self-recognition, self-belonging and assertiveness that he was experiencing in the family, to his school. Parental sessions focussed on the trauma of the stroke, and the pain and confusion that this had caused for the father.

The work with P's parents, which lasted several months (five sessions in total), focussed on helping them, notably the father, recognise P's suffering, overcome their debilitating negative emotional reactions, and find ways to better relate to P and treat him better in everyday life. Though the work with the family was quite short, the mother reported in an evaluation meeting some months later that P's father *had changed a lot after the sessions*. Although he continued to *suffer* and was depressed, he was *less aggressive* and *less brutal* with P. For the next year, the parents were referred to the regional hospital psychological services in order to ensure their emotional support and guidance.

The family treatment was focussed on helping the parents deal with and resolve their own emotional ambivalence, inconsistency and/or negativity toward their child, overcome the couple conflicts that caused emotional unavailability and inadequate practices, and promote their own parental skills.

### *The work with the educational staff, the classroom teacher and the special educator*

The educational staff, especially the classroom teacher, sought help and guidance, and three months later the classroom teacher was trying to help P stop his disruptive behaviours and integrate into the classroom. She thought she had done everything she could, although she felt overwhelmed, desperate and sometimes very sad about the final result. It has been argued that these children's distressing experiences may almost incapacitate staff, who themselves seem to internalise the powerful, unmanageable feelings these children display (Hanko, 2002).

The proposed work with the educational staff had a twofold aim: a) inform teachers how parental practices and specific family events affect the child's functioning, and how these problems are transferring into the school, with the aim of modifying their negative perception of the child; b) provide a meaningful intervention plan to help the classroom teacher deal with the disruptive behaviours, and to provide emotional support, as she was feeling at the point of burning out.

Long-term psychodynamic work with teachers can allow them to work with their distressing emotions and gain better control of the situation by increasing their awareness as professionals. It can sharpen teachers' recognition and deepen their understanding of children's emotional and behavioural needs, and augment their ability to respond to them more appropriately (Hanko, 2002). In addition, it can help them learn to develop their support, consultancy and negotiating skills through a supervisory process.

Indeed, through regular meetings teachers were helped to gain a more thorough insight into P's internal confusion and the pain he was experiencing in relation to his father. It was important to show teachers how emotionally unprepared and unskilled P was to face the challenges of social and school adjustment.

The classroom teacher felt really relieved when she was shown that, because of the strong emotional attachment and dependence P had developed with respect to her, he was continuously transferring to her the unresolved conflicts and needs that related to his family. It was also suggested that she be less emotionally involved and try to maintain a certain distance with P, without losing the careful and attentive stance she was displaying. She felt grateful for having been helped to clearly perceive her limits (i.e., that she could not fulfil his deep emotional needs), and the suggestion that she could help him more effectively in the classroom by focussing on academic support. In the final evaluation meeting, five months later, she reported that P was less withdrawn, more attentive, and much more integrated in the classroom, and much less disruptive, demanding, reactive and aggressive, even if he still remained an introverted boy.

The special educator supported P to gain better control of the learning material and to be more adequately prepared for the classroom requirements (as the mother was unable to do this). The special educator reported that over a period of four months, she established a good relationship with P, and that P was proving very receptive and cooperative. She also focused on strengthening his self-esteem and academic self-competence through continued praise and the implementation of attractive instructional techniques.

### *Summary of the intervention report*

The final report at the end of the academic year, based on data collected from a series of measures and from interviews with the classroom teacher and the mother, showed significant improvement in P's psychosocial functioning. Furthermore, there was a considerable decrease in behavioural problems, as well as better classroom integration.

The interdisciplinary partnership work that encompassed the interventions at individual, family and school level seemed to really help P better handle both his internal distress and disruptive behaviours, and helped the teachers to be more effective with him.

### **Conclusions**

The available evidence shows that successful interventions for children with behavioural problems should include the following: (a) individual treatment or therapeutic counselling for the child; (b) family training and counselling, or therapeutic family interventions; (c) counselling guidance and supportive supervision for teachers and other education staff. More specifically, evidence indicates that interventions need to be multimodal, multidisciplinary, precise and flexible at the same time, focussing on specific goals and combining a range of educational and therapeutic techniques (Young, Marchant, & Wilder, 2004).

Finally, the choice of intervention should be guided by the particular developmental context of the child and his or her unique needs, and ought to address the plethora of contextual and personal risk and protective factors (Adelman & Taylor, 2010; Fraser & Williams, 2004). Comprehensive and continuous assessment of whole-child functioning seems to be an important dimension of any meaningful intervention (Schmidt, 2010; Young, Marchant, & Wilder, 2004).

In conclusion, there is now strong evidence that multimodal intervention strategies can be effective for a range of children with various conduct problems, and that schools can play an important role by putting health, counselling, recreational and training skills programs under one roof (McNab, 2009). Schools and professionals who are trained in inclusive psychology, resilience and psychodynamic systemic approaches should be able to cooperate with the educational staff, aiming to creating a caring environment for all students, but also developing specific targeted interventions for the most vulnerable or disordered. Authors should also adhere to the social model of childhood disability, which constitutes a paradigm shift away from the traditional disease and medical-based models, so that they are aware of the importance of the implementation of professional interventions for children who struggle with emotional and behavioural difficulties. In addition, to address the student's challenging behaviours, schools should close the gap between life-learning and curriculum-learning, and place the emotional development of children and adolescents at the core of their practice (Schmidt, 2010; Urquhart, 2009). Teacher's role and capacity to develop meaningful and supportive relationships with vulnerable or challenging students remains critical. School psychologists or counsellors have a crucial role to play in supporting them fulfilling this goal (Hanko, 2002; Kourkoutas & Giovazolias, in press).

Even though such programs may seem to be complex or expensive in their implementation, their practicability and overall low cost have been proved and tested, as they involve small flexible teams that can work with a number of schools (e.g., 4–5) in a specific area. One of the most challenging issues for academic institutions and theorists remains how to reach a consensus and train prospective teachers and school psychologists in theories and practices that combine clinical with resilience and school inclusion approaches, which have been proved to be meaningful and helpful for teachers and families at risk (Lunt & Norwich, 2009; Rhodes, 2007).

Last but not least, regarding inclusive education it has been argued that both professionals and parents all too often, and unthinkingly, collaborate in protecting disabled children (in terms of traditional categories of disability) from risk-taking and personal responsibility (Finkelstein & Stuart, 1996). A consequence is that disabled children can grow into adulthood poorly equipped with the social skills necessary to form meaningful relationships, compete for jobs, and sustain their own independent household. This is the vicious circle of dependence and over-protection in which disabled children are often trapped by parents and professionals (Miller, 2000).

In our inclusive model, a strong emphasis is put on how to help all “problematic” or vulnerable students develop their own resources and skills through various systems of relationships and networks, or specific practices that focus on these elements. Indeed, we strongly believe that inclusion is about genuine relationships, and about the intentional building of meaningful relationships wherein difference is welcomed and all benefit (Miller, 2000).

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