Emidio Tribulato

THE CHILD AND THE ENVIRONMENT

Volume Two

-Influence of the affective-relational environment in development
and in the psychic pathology of the child-

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We saw in the first volume how important the influence of the environment can be in the child's psychic life.

Ultimately, all environments, when they carry *pathogenic* elements, can easily provoke potentially harmful situations such as: *psychogenic reactions, stress, frustration and trauma*.

The psychogenic reaction

To understand psychogenic reactions, we need only think of what happens in each of us when we are suddenly offended or insulted. In such cases, without thinking about it, we immediately respond with facial expressions and behaviour from which it is easy to understand our immediate, deep displeasure, or we retaliate with equally offensive and heavy-handed words and gestures. On the other hand, if the other person has had a sudden and unexpected expression of affection towards us, our immediate reaction may be that of a broad smile and a heartfelt 'thank you'.

The psychogenic reaction to an environmental stimulus therefore contains a strong affective charge and deep emotional involvement, without the restraint of judgement or rational reflection (Galimberti, 2006, p. 310). Psychogenic reactions are usually of short duration and consist of elementary responses, such as sudden displays of affection or, conversely, such as anger and aggression. Positive reactions made up of displays of affection may arise from the tender and warm words or gestures that significant persons have towards the child, but also as inner needs for protection, cuddles and tenderness, such as when the child, who is playing, suddenly feels the need to get close to his mother and hugs her

and covers her with kisses, and then returns more serene and happy to his usual games.

Negative reactions can be provoked by behaviour that is not acceptable to the child. For example, when the mother interrupts the child in his play or when she dresses or undresses him in an ungentlemanly manner, without waiting for his willingness, and the child stamps his feet protesting angrily (De Ajuriaguerra, 1993, p. 479).

Stress

Different from the psychogenic reaction is stress. This is defined by Galimberti (2006, vol. 3, p. 553) as the ″intense emotional reaction to a series of external stimuli that set in motion physiological and psychological responses of an adaptive nature. If the subject's efforts fail because the stress exceeds the capacity to respond, the individual is subjected to a vulnerability to psychic illness, somatic illness, or both'.

External stimuli, and thus stressful agents, can be numerous. There can be *physical stress* due to stimuli such as heat and cold or excessive muscular exertion; there can be *psychological stress*, due to emotional stimuli (Galimberti, 2006, vol. 3, p. 553), such as having to cope with the demands of the people living next door, for example, when family members demand irreproachable behaviour from the child: excessively polite, tidy, obedient, punctual or a school commitment disproportionate to the child's possibilities. There are also *psychosocial stresses,* in which the child is forced to cope with an external situation characterised by interpersonal, social or individual difficulties (Galimberti, 2006, vol. 3, p. 554). For Clancy Blair (2003, p. 45): "Stress influences the brain development of even very young children, probably even before birth". "Stress hormones can modify developing brain circuits. In particular, they affect neural connections in the prefrontal cortex, which presides over executive functions'. These brain

areas are crucial for reasoning, planning and problem-solving and for regulating emotions and attention, and are essential for academic success (Clancy Blair, 2013, p. 45). While stress in children can prevent the development of important cognitive skills, it is dangerous at any age. In adults, for example, it can also disrupt and wreak havoc on their interpersonal and concentration skills. If stress occurs chronically, it can damage a person physically, emotionally and intellectually. With serious psychological consequences, such as depression and chronic anxiety.

Stress can be well coped with and managed, when it is not frequent, not excessively intense or when the person experiencing it is strong, solid and mature enough to be able to bear it. Otherwise, it can provoke, in the person suffering it, psychological as well as physical consequences, more or less serious.

Early exposure to stressful environmental stimuli, such as a child's separation from his or her mother, the presence of intense conflict within the family, parental depression or anxiety, bad relationships with teachers or peers, is capable of altering, in a negative sense, the individual's sensitivity to subsequent stressful stimuli; thus, at later times and moments, even very modest and trivial stimuli can cause considerable anxiety.

Therefore, a mild stress on a person who is old enough, mature enough and psychologically robust enough to cope with it and tolerate it well, produces positive effects, such as greater joy and gratification, which are followed by greater maturity and inner robustness, given by the pleasure of facing, with good results, a more impervious and difficult path than usual. If, on the other hand, the stressful situation is repeated frequently, is too intense or acts on a child already tried by early and excessive stress, the latter, in spite of good will and in spite of all attempts to cope well with the request, is forced to give in. In these cases there is the

phase of exhaustion and collapse of the defences, with heavy repercussions on the physical and psychological level (Meazzini, 1997, p. 33).

This type of stress with negative effects is called *distress*. Prolonged distress produces increased heart rate, increased blood pressure and respiratory rate, deficits in the immune system and decreased reasoning abilities, resulting in difficulty in dealing with problems that arise from time to time. Moreover, in the case of prolonged and intense distress, both memory and perception of reality outside the individual are impaired (Meazzini, 1997, p. 39).

Usually, stresses are environmental in origin. Only occasionally, however, are they the result of unrecognised constitutional impediments (Wolff, 1970, p. 37). Sometimes stresses arise from good intentions. For example, often, in our society, parents, driven by the fashion of the moment and being afraid of not stimulating their child sufficiently and depriving him or her of something, stimulate their children by involving them in a thousand activities: music, dancing, swimming, English classes, skating. This without taking into account the real needs of their children.

As we have already mentioned, the ability to withstand and cope well with one or more stressful situations depends on various factors:

- *the age of the individual*. The younger the individual's age, the less chance he or she has of coping well with stressors (Meazzini, 1997, p. 32);

- *the frequency, duration, intensity and severity of the stressor*. The greater the frequency, duration and severity of the stressful element, the less chance we have of coping effectively;

- *the psychological robustness or fragility of the person*. The more psychologically healthy and robust a person is,

> the more easily he or she withstands stress; the more fragile he or she is, the more easily he or she becomes a victim of stress (Meazzini, 1997, p. 32).

Unfortunately, when the psychological pressure levels are considerably high, very few people are able to resist without giving in.

All children encounter minor difficulties in the course of their development, as they may experience accidents, illness, the birth of a sibling, a change of home, school or living environment, demands for greater self-control, particularly strict or grumpy teachers. Mostly, these children react to these stresses with temporary alterations in behaviour, episodes of nocturnal enuresis, outbursts of violent anger or the presence of night terrors, intense and excessive fears. Fortunately, if parents are able to interpret these symptoms of malaise correctly and quickly, so as to take immediate action, trying to relieve the pressure on the child, the symptoms caused by the stress diminish, until they disappear. Serious difficulties arise when the stresses are overwhelming or when adults are uncaring, too busy or excessively superficial, so that they do not pay attention to the signs of distress and difficulty expressed by the child. In these cases, the child's symptoms worsen, and specialist help is needed, even though the child's reactions are 'normal', in the sense that any child under those conditions would have reacted in the same way (Wolff, 1970, p. 7).

It can be worse, when on the part of parents or adults, this type of child's reaction to stress is not only not understood and accepted, but is actually judged as capricious and bratty behaviour: 'He has become incontentatible, always whining and restless. He does these things deliberately, to make me suffer and to tire me out'. In these cases, the symptoms of dif ficulty and discomfort expressed by the child, not dealt with in the correct way, trying to discover the causes, and then to eliminate or reduce them, triggers a real psychological disorder.

Frustration

Substantially different is frustration. This is defined by Galimberti (2006, vol. 2, p. 203) as an 'internal or external situation that does not allow a satisfaction or goal to be achieved'. We therefore experience this feeling when an expectation is in vain, when something or someone disappoints us. The expectation, and thus the disappointment, may concern an attitude, a behaviour, a response to a need of ours, which we imagined and anticipated, but failed to obtain. Sense of frustration also occurs when what we imagined came to pass, but did not fulfil our desire and expectation at all.

The non-achievement or non-satisfaction can result not only from the external world, but also from the inner world, when, for example, the superego does not allow us to obtain a satisfaction that is deemed unjust or reprehensible.

Frustration is made up of initial suffering, which is followed by sadness and, after sadness, often comes closure. This can only concern the relationship with the one who has disappointed us, but it can extend to anything and everything. As if to say: 'If this person, if this feeling has let me down, I not only want nothing to do with this person but I also close and defend my life from everything it represents: friendship, love, hope, trust, pleasure'.

Distrust spreads in our souls like the waves caused by a stone thrown on a pond. These do not stop at the point in the water where the stone has fallen but spread out to the shore. If one person betrays us, the distrust resulting from the disappointment will not only affect that person but is likely to spread to all people. And if a feeling such as love or friendship betrays us, the risk is that we will no longer believe in these feelings.

Childhood disappointments are considerably more serious, as the still immature human being has not developed efficient defence mechanisms. The child's frustrations go hand in hand and follow the quantity and quality of the expectations he or she has

of reference persons. The most serious concern the mother, followed by the father, grandparents, siblings, teachers, friends and so on.

Since the world of the newborn and infant is made almost exclusively of the mother, when the mother betrays it in its expectations, it is as if the whole world has betrayed it. Therefore, the depression and closure that follow can be very intense and long-lasting. Fortunately, the reaction that follows is not always total closure. Often the child manifests other types of reaction than the passivity of closure, such as anger, rage and aggression.

Implicit in frustration is a subjective feeling, so that the same episode may be experienced by different children, in different ways, depending on their personality characteristics, the experiences of the moment, their age and the stage of development they are experiencing at that time. Children differ not only in their heterogeneous tolerance to frustration, but also in a different elective way of reacting. Some respond by shutting down or regressing to a lower stage of development, others react by showing aggression and anger, and still others express their distress by crying.

Of course, the most serious frustrations are those of an affective-relational nature, which can leave relics even for a lifetime. Such are the frustrations caused by the continuous or frequent absence of parents, which prevents the desire for care, affective manifestations and stable attention from being satisfied. Such are the frustrations suffered by a child due to parents in whom significant psychological disorders are present. For example, very anxious or depressed parents who make their children's lives particularly painful, preventing them from satisfying their needs for play, discovery and sharing. Such are the frustrations present in a family that suffers frequent and intense conflicts that prevent the child from enjoying the necessary peace, tranquillity and security.

As far as age is concerned, the postponement of an affective satisfaction, such as the pleasure and sense of well-being given by

a mother's or father's affectionate hug or word, is more serious the younger the child, since he has little chance of replacing the person who let him down with another.

These considerations have considerable implications and explain why the disappointments experienced in very early childhood, when the child is entering into life, can lead to very serious symptomatological pictures, both of depression and of closure.

Ultimately, the quantity, quality and duration of the frustrations, as well as the age of the sufferer and the manner in which they are administered, are of considerable importance in the process of affective maturation and character development of the child.

Acute or chronic frustrations

If a child is reprimanded, beaten, denied something he cares about, or is laughed at, insulted, or suffers other types of violence at a given time, the event suffered results in *acute frustration*. *Chronic frustration*, on the other hand, occurs when the events causing the suffering are prolonged over time. We can compare acute frustration to a wound. The child suffers, cries, the pain lingers for a few days, but then the wound heals and heals. If, on the other hand, the same child constantly lives in a polluted environment and does not have the opportunity to get away from this environment, he or she will have much greater and longer-lasting consequences. On the other hand, a child with a bleeding wound immediately attracts the attention of those around him: family members or strangers. This is not the case when the same child lives for years in a polluted environment!

The reasons that lead to chronic frustration can be many:

- ❖ total or partial institutionalisation;
- ❖ affective deficiencies of a parental or parental nature;
- ❖ poor or impaired dialogue;

- ❖ educational misbehaviour;
- ❖ excessive limitations, misunderstandings, reprimands and punishments;
- ❖ limited possibilities for autonomy or expression of the needs for play, movement and care;
- ❖ the frequent and constant conflicts present in the parental couple or family.

The child copes much better when faced with *acute frustration*, since it allows him to express anger and rage and stimulates him to seek remedy, mediation, help or external support. In *chronic frustration*, on the other hand, the child's possibilities of defence are reduced, since it is the environment in which he or she permanently lives that excessively and continuously limits the fulfilment of his or her needs and desires. Often, unfortunately, the effects of chronic frustration, which are the most frequent and numerous, do not create any social alarm or family alarm, despite the fact that they have a considerable negative impact on the serene development of the child.

It should be noted that we are born into a situation of basic optimism whereby human babies instinctively tend to see the positive aspects of a situation, rather than the negative ones. Therefore, when the child is overwhelmed by sadness and discouragement, the causes must have been so heavy and long-lasting that it defeats its innate optimism.

The consequences

The positive aspects of frustrations, when they are not excessive in quantity and severity, are due to the fact that they foster greater awareness, give a clearer and sharper sense of limits to the

child's ego, stimulate his strength and determination, improve his ability to adapt to the world around him, and stimulate him to find the most suitable strategies to overcome disappointments. For these reasons, a *non-excessive frustration* can lead to a positive reaction, since it stimulates the subject to intensify his commitment and efforts with a view to solving the problem or the goal to be achieved.

Excessive frustration, on the other hand, can lead to psychic disorganisation, which will be evidenced by various symptoms: inner tension and conflict, anxieties, fears, inhibition, disesteem of oneself, of others and of the world around the child, behavioural disorders, aggression towards others, animals or objects, but also sometimes towards oneself.

Frustration *is either excessive or not excessive* depending on multiple personal and environmental factors, so it can be well coped with and managed when it is not frequent, not excessively intense, and when the person experiencing it is strong, solid and mature enough to cope.

Psychic trauma

Just as physical trauma can result in a wound or laceration of the body, which almost always leaves indelible scars, in the same way psychological trauma can cause an injury 'to the psychic organism as a result of events that erupt abruptly in a destructive manner without the subject being able to respond appropriately (Galimberti, 2006, vol. 3, p. 639)'. Such an injury can be determined either by a single event or by an accumulation of excitations, singularly tolerable, that the subject is unable to suppress or let out (*abreaction*) by venting or processing them (Galimberti, 2006, vol. 3, p. 639). "The traumatic effect depends on the susceptibility of the subject, on the psychological conditions in which he finds himself at the time of the event, on the factual situations that pre-

vent an adequate reaction, and on the psychic conflict that prevents the subject from integrating the experience that comes to him from outside (Galimberti, 2006, vol. 3, p. 640)".

Simple and multiple traumas

When we review the history of a child with more or less serious disorders for clinical reasons, we realise that only rarely is the pathogenic environmental situation unique, whereas, more often than not, a constellation of negative events, due to organic and/or psychic factors that, together, contribute to the child's malaise, thickens over the child's psychic life.

Many of these causes relate to *the past*, others are still *current* and tend to maintain or worsen an environment that is not suitable for the child's personality development.

Particularly in the most severe cases, such as in situations of Generalised Developmental Disorder, we find a multiplicity of negative elements that succeed one another over time, but are often still active and thus still able to maintain a more or less severe state of malaise in the child.

The case of forty-four-month-old Francesco is representative of these situations. Upon observation, the child presented a psychotic regression: he would rock in his cot, contact with adults was inconstant, and his attention appeared very labile. According to his parents, he 'fixated' on the same game for months on end, experienced fits of terror, refused his mother's presence, and did not socialise with other peers in the kindergarten. These classmates, in turn, teased him because of his strange way of speaking (his speech development did not exceed 20 months) and because of his gesticulating with his fingers when he felt embarrassed.

His story was made up of a series of traumas, stresses and frustrations that had begun even before he came into the world. He was born into a family consisting of a highly cultured mother,

described by her husband as 'over-anxious, protective and nagging', both towards her son and her spouse, as extremely precise and tidy. The father, in turn, was described by his wife as "a sociable but inconstant, irritable and distracted man". Arguments were frequent between the parents, as neither of them was willing to back down from their ideas and intentions. During Francesco's pregnancy, his mother had been very nervous: she did not feel understood by her husband and was prey to many intense fears. Above all, she feared losing the child she was expecting due to a previous miscarriage.

Francesco was born in the eighth month due to the onset of gestosis in his mother. In addition, the woman, due to a subsequent illness, had been unable to breastfeed him. In the first months of life, the child already showed easy irritability, with frequent and unmotivated crying. Communication with the parents was still discreet, however: the child appeared lively and was affectionate towards them. Around the age of nine months, however, the mother, for study and work reasons, was forced to leave her son for a few months. When she returned, she noticed that he tended to reject her. This behaviour, rather than making her reflect on her son's needs and the psychological problems he was already beginning to present, irritated her and made her even more nervous, so she accentuated her repressive attitudes towards Massimo rather than sympathetic and affectionate ones.

Despite this, no real regression was yet present in the child at that time. This appeared after the first year of life, coinciding with the mother's return to work.

The woman describes that period as follows: 'He sought my cuddles and my arms as if he were a few months old and, like a baby only a few months old, he cried at the slightest thing. Moreover, although he had already been weaned for a while, he wanted to latch onto the breast again'. However, until around the age of thirty months, his social skills appeared discreet: 'he would call

out to the other children from the balcony, he wanted to play with them, he would greet them from afar'. During this period, however, the parents carried out a very laborious move and, at the same time, placed the child in nursery school, despite the fact that he showed clear signs of impatience with the separation from the family nest. It was only at this point, after the move and the forced insertion into the nursery school, that a series of serious autistic symptoms appeared: the child increasingly distanced himself from the real world and closed in on himself; the development of language was blocked; at night the little one woke up crying, while, the parents said: 'He often moves his fingers in a strange way, without any reason'.

After giving the parents initial suggestions as to how best to deal with the child, we dismissed them, making clear the absolute necessity of systematic interviews, both with the child and with them, in order to try to improve the child's serious psychological condition. In spite of this, and no given the gratuitousness of our interventions, it was only after two months that they asked us for the first and only check-up. The mother reported that she saw the child more serene. His speech had improved and he was better understood. At school her son was now learning songs and poems. The crying fits had been greatly reduced. However, he continued to sleep in his parents' bed and tended to seek out his grandmother more than his mother. However, despite the obvious improvements and our full willingness, the parents stopped monitoring the child, of whom we have had no news since then.

We have reported this case because it is indicative of many realities.

Meanwhile, we find many possible concauses for the disorders presented by little Massimo:

- the psychological characteristics of the parents who had negatively influenced the child's developmental environment even before his birth. Psychological characteristics

with clear elements of anxiety and obsessiveness that, in turn, had been accentuated due to the fear of a new miscarriage and the illness that occurred immediately after Massimo's birth;

- ❖ frequent marital conflicts;
- ❖ the premature birth of the child;
- ❖ the lack of maternal breastfeeding, with probable difficulties in building an effective mother-child bond;
- ❖ his mother's estrangement from Massimo for a few months for work reasons;
- ❖ the unwillingness on the part of the mother to reconnect with the child upon his or her return to the family;
- ❖ a stressful family environment, due to the move;
- ❖ inclusion in the kindergarten, despite the fact that the child was clearly showing signs of fear and uneasiness;
- ❖ Massimo's suffering and sense of exclusion at this school, accentuated by rejection by other peers.

It is as if a cascade of negative events, difficult if not impossible for the still fragile and immature child's ego to cope with, had cascaded onto this child, one after the other.

On the other hand, we cannot but note a series of inappropriate behaviours in the management and relationship with the child on the part of the parents, who manifested considerable difficulties in recognising and satisfying his needs, and misinterpreted the signs of his suffering as 'tantrums' and therefore did not act correctly and promptly to address and resolve his suffering, but

tended to inflict further trauma on the child. The parents also failed to commit to correcting their own mistakes when these were pointed out, nor did they accept the help offered to them, except for a very short time.

Ultimately, this case well illustrates how psychological problems that afflict parents often spill over not only directly into the child's psyche, but also into the subsequent correct handling of the problems they present.

The consequences

In order to understand the consequences of stressful, frustrating or traumatic psychological experiences on a child's psyche, it must be borne in mind that all feelings and events in the environment, whether positive or negative, tend to leave indelible traces in the soul of children, which can become generalised, extended and enlarged not only in space but also in time.

Therefore, when a child experiences feelings of joy, love or security, they also expand to unfamiliar people and environments. Similarly, the sadness, distrust, anxiety, fears and pain experienced can be projected onto absolutely innocent and harmless people, animals or things.

If the child, for example, fears, given past experiences with one or both parents, that his or her needs for tenderness will not be met, but rather anticipates that his or her dissatisfaction and pain will be accentuated, he or she will react, at least for a time, with malevolence towards anyone who approaches him or her. The same happens with regard to time. If for a time his trust in others has been well accepted, recognised and rewarded, he is likely to continue to trust others in the future. Conversely, if his openness and willingness towards others has left him disillusioned and suffering in his soul, he expects the same to happen in the future.

The younger the child is and the more severely he or she has been hurt, the more easily he or she will realise and maintain this extension of his or her negative experiences. Therefore, while a child with mild psycho-affective problems, when he meets trustworthy people, will easily and quickly open his heart to trust, hope and love, a child with severe psychological disorders will have great difficulty trusting others. Therefore, when the frustrations and traumas he has suffered and perhaps still suffers are felt with great intensity, the task of those who want to approach him, to bring help and support, will be very difficult, although always possible. This is because stressful, frustrating or traumatic experiences, also according to the latest studies in neurobiology, determine, especially in childhood, at the level of the various encephalic areas, stable structural changes, so that solid traces of these negative experiences remain in these brain areas.

Normality and pathology

It is difficult to define what is normal in a child. So difficult that the oddities, in the field of child neuropsychiatry, are numerous. In the meantime, whether or not one observes psychological problems in a child depends very much on the sensitivity and discernment abilities of the observer. Some have considerable difficulty in noticing elements that are definitely pathological; others, on the contrary, judge behaviour that is very close to the norm, if not perfectly normal, as needing special attention. As a consequence of this, children are judged *normal or disturbed* according to the sensitivity, attention and psychological characteristics of the adults who observe them and relate to them.

For example, paediatricians are often assailed by parents' anxieties when they notice unusual behaviour in their children: sleep disturbances, frequent crying, refusal of food, hysterical attitudes, hypochondriac complaints, fears, regressive phases, obsessive attitudes, tics, etc. However, many of these symptoms fortunately

disappear without a trace with the passage of time. On the contrary, some parents do not notice anything strange in their child until he or she enters school and it is only after the teachers report that they become aware of their child's problems. Moreover, it is well known that mothers and teachers agree on the evaluation of certain symptoms, such as tics, stuttering, lying, stealing, hyperactive behaviour, but they do not agree at all on the evaluation of more profound and serious symptoms such as closure, sadness, shyness, isolation.

Another oddity, due to the different interpretation of the child's signs of distress, is evident in the work of school teams. If there is no team in the school, there are few subjects defined as pathological. If, on the other hand, the team is active in the school, the children with problems become many. We have personally verified this situation. When we were called to a school, the request almost always concerned one or two problematic cases but, after a few days of our stay, we were inundated with reports of pupils who, according to the teachers, presented such disorders that our intervention was necessary. We used to say, jokingly, that our presence in the classrooms stimulated the production of disabled children!

The reasons for these 'oddities' are well known.

For Freud, there is no difference between the healthy person and the person with neurosis. Both present the same types of conflicts, use the same types of defences, go through the same stages of maturation in their childhood (De Ajuriaguerra, Marcelli, 1986, p. 48). And just as with adults, all normal children, as Melania Klein says, have unresolved unconscious problems and use the same defence systems as pathological children, so the presence of one or more symptoms is not a sure indication of pathology. For these reasons, almost all symptoms present in a disturbed child can, at least for some time and with less severity, also occur in a perfectly normal child.

Children are, by definition, *evolving beings*. This means that each child presents, at various stages of development, various changes and moments of crisis. Therefore, during the course of his or her life there may be symptoms and disorders that disappear at a later stage or are replaced by others.

Another reason has to do with environment and people. Some children are unhappy and inhibited at home, but not at school, while others are obedient and easy to control at home, but rebellious and difficult to handle in the classroom. Ultimately, depending on the environment in which the child is placed and the people with whom he or she relates, behaviours and symptoms may or may not occur that may worry us.

Finally, we know how both family members and teachers are easily alarmed when children show attitudes of excessive vivacity, resourcefulness and reactivity, rather than when they are quiet, withdrawn and apathetic. This different way of manifesting distress and discomfort may explain, at least in part, the higher number of males who are reported as having psychological problems.

How then to distinguish a problem child from a normal one?

This distinction can only be made with certain parameters in mind:

1. *The quantity and variety of symptoms.* Normal children have few symptoms that signal discomfort, disturbed children have many and varied ones.

2. *The quality of the symptoms presented.* Some symptoms are very frequent, while others are rarer. Thus, the presence of several rare symptoms suggests a pathology in the child.

3. *The age of the child.* There are some ages at which certain behaviours, for instance babbling, fears, enuresis or enco-

presis, are frequent, while at other ages they are rarely evident. The presence, therefore, of behaviour that is not usual for the age, may suggest a pathology.

4. *The intensity of symptoms.* The intensity of symptoms is also important in distinguishing pathology from normality. This applies to almost all symptoms: anxiety, fear, restlessness, instability, aggression, and so on. If, for example, a child asks to sleep in his parents' bed but easily desists, the concern for possible psychological problems of the child will be modest, but if he absolutely must sleep in his parents' bed, because away from them he falls prey to terror and nightmares, this eventuality takes on greater weight in the overall diagnosis of a child with psychological disorders.

5. *The duration of a symptom.* Returning to the previous example, if a small child only asks sometimes to sleep in his parents' bed, for example when he has the flu or other organic ailments, because he feels safer and calmer with them, we will not have to worry much; if, on the other hand, this problem is prolonged over the years, this particular symptom will take on greater value.

6. *The examination of the child's developmental lines.* If, albeit with various fluctuations, the examination of the child's development shows a progressive and harmonious evolution of the various areas, one can reasonably assume that the child's life is proceeding normally. If, on the other hand, in one or more areas, there is a slowdown, a blockage or worse a stable regression in development, this data will allow us to think that something important is disturbing the child's psyche. Ultimately we must add to the previous elements what De Ajuriaguerra and Marcelli (1986,

p. 47) call an *economic evaluation.* This evaluation allows us to understand whether the symptoms presented by the child manage to contain the conflictual anguish, allowing the child's maturative movement, or prove ineffective in curbing the anguish that continually presents itself, which arouses new symptomatic behaviour and hinders maturative movement. This applies to intelligence, to language, to learning, but also to autonomy, to communication and socialisation skills, as well as to all other areas.

Neurosis and defence mechanisms

Psychodynamic theories provide a more precise and complete explanation of neurotic disorders in children and adults. According to these theories, neurotic symptoms represent attempts by means of which the ego tries to resolve anxiety, which results from conflicts between various psychic activities. In particular, the ego tries to resolve the drives of the id that clash with those of the superego. All of this within the ideal model of the ego and the external contingent conditions.

The libidinal or aggressive drives of the id try to push the ego towards a certain type of behaviour that satisfies these drives. In turn, however, many of these libidinal or aggressive drives are censored by the superego as being at odds with ethical, social, cultural or family norms. This entails a continuous effort on the part of the ego to satisfy the pressing demands of the id, in such a way, however, that they do not conflict with the super-ego's moral demands, with the ego's ideals and with contingent conditions. Otherwise anguished feelings of guilt would ensue. When the normal psychological means the ego has at its disposal fail to resolve the anxiety arising between these different demands, neurotic symptoms appear. These are the last means the ego has to overcome anxiety. Freud recalls in an essay on obsessive neurosis that in every neurosis we find hidden behind the symptoms, the same

instincts. Phobias, obsessions, somatisations, anxiety crises and hysterical manifestations therefore have a common basis, they are a means of avoiding growing anguish.

In children, it is preferred to speak of neurotic traits, rather than neurosis, because in childhood the personality is evolving and in formation. Therefore the defences used by the child are not yet mature and neurotic symptoms, although frequent, are not structured and stable, like those of adults, so they are considered 'normal' if they occur occasionally and mildly.

For psychoanalysis, the ego utilises various types of psychological defences, partly unconscious, partly coercive, put in place to reduce or suppress any disturbance that might endanger its integrity and internal equilibrium. Some of these *defences are egosyntonic*, in that they are consistent with the needs of the Ego, others are *egodystonic or pathogenic,* in that the egoic function of examining reality is interrupted, leaving room for the reuse of archaic ways of thinking, perceiving and relating to reality (Galimberti, 2006, pp. 604-607).

Alongside the defence mechanisms discovered by Freud, other scholars, over time, have added others.

Thus, the defence mechanisms used by the ego during childhood and adolescence are numerous *(Kaplan, Sadock, 1993, p. 199).*

Denial

This is a common form of defence in children. It consists of falsifying facts, impulses, reality data or aspects of the self or the perceptual world in order to maintain psychic well-being. This defence system is mainly used to avoid recognising painful experiences. For example, if the child has lost his father, he may say: 'My daddy is not dead at all. He will be back in a few days'. And so, in the case of parental separation he will be able to say with certainty: 'My parents have not separated, daddy comes home at

night and then leaves early in the morning to go to work, and that is why I do not see him'. The massive use of this defence mechanism produces negative consequences, as the real problems are neither addressed nor solved.

Regression

This is also a frequent defence mechanism. When the child is involved in circumstances that trigger more anxiety in him than he can cope with, he abandons the behaviour patterns appropriate to his age and regresses to a type of behaviour that, in the past, fulfilled him. He then momentarily abandons certain more evolved behaviours and uses more infantile ones, reverting to a phase prior to his current development. For example, he may start behaving capriciously, as a small child would, he may talk like a baby, reject solid food for liquid food, and so on. In other cases he may regress to the anal phase and begin to wet and dirty himself again, or to the oral phase, and ask to be fed and rocked like a baby. In either case, his dependence on his mother and other protective figures is accentuated. Regression is almost never total, but concerns one or more aspects of the child's psychic life.

When this type of defence occurs, the way the parents behave is crucial. If father and mother, understanding the signals coming from the child, make every effort to relieve the pressure on him and give him what he needs at that difficult juncture, the regression may rapidly diminish, then disappear altogether, and the child will resume more mature behaviour appropriate to his chronological age. It may happen, however, that the parents are insensitive even to such obvious signs of distress or are too busy or tormented by their own problems to be able to behave and react in the most appropriate way. In such cases, the symptoms of regression may not only persist, but also become more pronounced; thus, the child may suffer a partial halt in its development, accompanied by a contraction of its personality.

Distortion

This defence reshapes external reality to satisfy internal needs *(*Kaplan Sadok, 1993, p.199).

Primitive idealisation

Through this mechanism, external objects that are seen as either 'all good' or 'all bad' are unrealistically endowed with great powers (Kaplan Sadok, 1993, p.199).

Projection or displacement

Unacceptable feelings and impulses towards a person, when these create conflict, are shifted to another person, an animal or a 'substitute' object, which takes on the role of a manifest, or apparent, object and is in close symbolic relation to the real object or mental representation that causes the activation of this defence. This defence mechanism often intervenes in phobias, whereby the unacceptable feeling is shifted onto the 'phobogenic' object.

Projective identification

Through this defence, unwanted aspects of the self are deposited within another person, so that the projecting subject feels at one with the object of projection *(*Kaplan Sadok, 1993, p.199).

The split

The same object or person is divided, split into two: one good and one bad, in such a way as to be able to direct onto the split parts the opposite feelings that this object or this person inspires: for example: hatred towards the bad part of the mother, love towards the good part; desire for acceptance towards the good part, desire for death and destruction towards the bad part. This is a primitive defence mechanism, typical of the first months of life, which in the adult can present itself in various forms of psychosis.

Implementation

It is the attempt to avoid confronting one's own unconscious conflicts, seeking solutions on the plane of reality, in order to solve with actions an inner conflict that one does not want to acknowledge (Galimberti, 2006, pp. 604-607).

The blockade

"An inhibition, usually temporary, especially of affect, but sometimes also of thought and impulses" (Kaplan Sadok, 1993, p.199).

Hypochondria

"It is the transformation of reproach towards others into self-reproach and a lament of suffering, somatic illness and neurasthenia (Kaplan Sadok, 1993, p.199)".

Identification

"Identification with the beloved object can serve as a defence against the distress and suffering that accompany separation or loss of the object, whether real or threatened" (Kaplan Sadok p.1993).

Introjection

This indicates the defensive process by which the subject phantasmatically 'introjects' (partial or total) objects and their qualities into his or her own interior. The notion of introjection was adopted by Freud in opposition to that of projection. Through introjection the ego attempts to incorporate external values and norms into its own structures so as not to experience them as oppressive and foreign. It is an essential mechanism in infantile development, as it allows the child to assimilate significant figures, such as parents, and to retain them internally, so as to 'resort' to their qualities even in their absence.

Passive-aggressive behaviour

"Aggression towards an object expressed indirectly and ineffectively through passivity, masochism and hostility towards oneself" (Kaplan Sadok, 1993, p.200).

The schizoid fantasy

Tendency to use fantasy and indulge in autistic withdrawal, with the aim of resolving a conflict and obtaining gratification (Kaplan Sadok, 1993, p.200).

Somatisation

Defensive conversion of psychic derivatives into somatic symptoms, tendency to react with somatic manifestations (Kaplan Sadok, 1993, p. 200).

Revolt against oneself

An unacceptable impulse towards others is turned towards oneself (Kaplan Sadok, 1993, p.200).

The false ego

When a child is unable to master situations that are too difficult, complex or frequent, he may try to control reality by playing a part or wearing a mask that makes him well accepted, especially by adults, to whom he will appear as a good, obedient, calm, cooperative, cheerful child, etc. This mask or act allows him to relate better to others and to prove both to others and to himself. This mask or act allows him to relate better to others and to prove both to others and to himself that he is equal to the situation. Unfortunately, this way of solving problems involves a considerable expenditure of psychic energy and can, in time, prove counterproductive, because the reality he hides behind is too different from appearances (Oliverio Ferraris, 2005, p. 103).

Apathy and sleepy detachment

Other mechanisms for decreasing anxiety are described by Sullivan (1962, p. 74). When the child is involved in circumstances that trigger more anxiety in him than he can cope with, one of the psychological mechanisms he can use to diminish the suffering caused by anxiety is *apathy* by which all the tensions caused by the needs are appreciably attenuated but not eliminated.

This defence is implemented when the unmet needs are very important and serious. When the child is older, *sleepy detachment* also reduces severe and prolonged distress. This type of detachment is very similar to apathy and is caused by unavoidable and prolonged distress.

Selective inattention

Another method of defence used by the child, especially when desiring impossible things, is *selective inattention*. Using this defence, the child treats desired objects and things as if they did not exist (Sullivan, 1962, p. 197).

Stereotypes and repetitive activities

Stereotypes and all *repetitive activities* can also, in our opinion, be considered as instruments of defence against anxiety. These allow us to focus our attention on something or some activity that is pleasant and relaxing, so as to ward off anxieties and gloomy or fearful thoughts. When the stereotypies are of the motor type, to this distraction effect is also added an effect of discharging anxiety and tension, through a repetitive, very simple, easy and banal physical activity.

Activism

A series of commitments, often excessive and convulsive, in a variety of activities are common in adults: mental, physical, relational, sentimental, sexual, implemented rapidly, without appropriate pauses and without excessive reflection. These convulsive and excessive engagements, both motor and intellectual, are rightly judged by outside observers as neurotic engagements. Insofar as they have the purpose, sometimes unconscious but often perfectly conscious and declared, of attempting to diminish anxiety, pain and inner sadness by engaging in multiple activities with grit and frenzy.

Similarly, the child, through the convulsive motor activity exercised in the home, playground or school environment, tries to push away or give vent to the thoughts, anxieties and fears that distress and grip him. In this way he obtains an improvement, even if, at times, only momentary, of his suffering.

Focusing on specific sectors and tasks

In some particularly disturbed children, such as those suffering from Asperger's syndrome, we find the child's particular attention and therefore ability in certain specific fields, for example, in science, mathematics, computer science. This focusing of attention on a specific field, to the exclusion of all else, could be one of the many defence modalities that the ego implements to ward off anxiety, fears, and all the disturbing emotions in that, by considerably delimiting the sphere of one's interests, the child avoids frustrations due to the inability to manage difficult family and friendship relationships well.

12 - The signs of suffering

From what we have said, it is possible to deduce that some of the symptoms presented by children represent modes of *immediate reaction* to the negative event or events in which they are involved, other types of symptoms signal the *consequences of the damage caused to the psyche* by these negative events, and others must be considered as the child's ego's implementation of particular *defences*. For Stefana and Gamba (2013, p. 356) 'It is worth remembering that symptomatology, like coins, has two sides: it expresses the difficulties, but also the best possible adaptation for that person in an attempt to defend himself from anguish and pain'.

In any case, symptoms are merely signals or, if you like, messages sent by an ego in difficulty or clearly suffering, so that 'for psychoanalysis, the symptom is an index of a subjective discomfort, which cannot be read without taking into account the child's experience and the family and social context in which it is inserted and manifests itself' (Mazzoni, 2013, p. 71).

Only if we can understand what is going on in the child's psyche and the environment in which he or she lives, can we understand what suffering he or she is experiencing, what difficulties and conflicts are gripping his or her soul, and what we can do to alleviate his or her anxieties.

The symptoms presented by children have some peculiar characteristics that distinguish them from those of adults:

- much more than those of the adult *have a reactive character*. They can therefore appear suddenly when the reality of life becomes distressing for the child, just as they can disappear with a simple change in environmental conditions;

- *have no general meaning*. Their meaning is personal and specific to each child. For example, the symptom 'refusal to go to school' can manifest many different realities: that

the child is not well prepared and, therefore, fears making a bad impression by going to school; that he has a lack of sleep so that it is painful for him to get up in the morning; that he is afraid to leave a familiar place for a stranger; that he does not want to leave his home because he fears that something bad might happen to his parents; that if he leaves his home and is ill, he will not be able to get the help he needs. And again, the same symptom: refusal to go to school may signal his fear of being laughed at or persecuted by his classmates for some reason; his poor and difficult relationship with one or more teachers, and so on;

- *The child's psychological and behavioural phenomenology changes with age.* Certain manifestations are normal at a certain age and pathological at others:

- *The same maladaptive situations may manifest themselves at different stages of development with entirely different symptomatic expressions.* For instance, the reaction to frustration may manifest itself in early childhood with systematic opposition or with affective regression; in preschool and school age it may manifest itself with pavor crises or with onychophagy. Similarly, autoerotic behaviours to compensate for frustrations may be expressed in early childhood through thumb sucking or with rhythmic pendular movements of the head and trunk, while in school age they may become evident through genital masturbation;

- *sex-related differences are numerous.* Rebellious behaviour is markedly more common in boys, whereas expressed fears and depressive stages are more frequent in girls. Moreover, both have external manifestations of aggres-

sion around the age of two or three, but in girls, this behaviour lasts for a short time, whereas in boys it continues until the first years of primary school. Moreover, boys continue to express their aggressive feelings outwardly and through their bodies, whereas girls tend to internalise these feelings or express them through language and behaviour.

Categorical and dimensional approach

For all these reasons, developmental psychiatry presents the characteristics of a pre-eminent *asystematicity.* The nosographically well delimited forms are not only the least frequent, but are also highly questionable, while there are numerous forms that cannot be exactly defined nosographically. Therefore, *the categorical approach* (Militerni, 2004, p. 95), used, for example, by the various DSMs, is not always possible and useful, as it allows patients with similar clinical or etiopathogenetic features to be grouped into types or categories.

The reasons are numerous. Meanwhile, as Sogos et al. (2009, p. 81) say:

"In the field of psychic and behavioural disorders, it is rarely possible to establish categories that are completely homogeneous, mutually exclusive and have precise defining characteristics and no limiting case. Psychopathological categories are generally prototypical, in the sense that each member shares with the prototype a greater or lesser number of characteristics present with varying degrees of intensity. The boundaries of these categories therefore appear, by their very nature, blurred and in some cases overlap. The belonging of a case to a diagnostic class does not therefore preclude its belonging to other classes. However, in any typological classification it must be possible to demarcate the categories in relation to one another. If the defining characteristics

of the groupings are continuously defined, it is necessary to arbitrarily establish boundaries between the categories. It is therefore possible to find oneself in the situation where two individuals, who fall at adjacent but opposite points of an arbitrary boundary, are diagnosed differently.

Stefana and Gamba (2013, p. 357) add:

"This is because the criteria of categorical systems, in and of themselves, essentially represent abstractions dictated by organisational requirements, guaranteeing the reproducibility and reliability of the diagnosis, but not its construct validity".

Sogos et al. (2009, pp. 82-83) add further criticism of the categorical approach:

"The first criticism stems from the concern - in some cases well-founded - that the diagnosis takes on the value of a self-fulfilling prophecy. In other words, it is feared that the diagnostic label induces in the people with whom the individual enters into relationship a series of prejudices and expectations that suggest to the labelled person a behaviour congruent with them'.

Therefore, psychiatric labels risk obscuring important individual differences resulting in social stigmatisation of the patient.

"The second criticism, on the other hand, expresses the fear that the inclusion of a disorder in a psychopathological category may lead to a standardisation of the therapeutic work and to omitting fundamental variables, such as the patient's life history and his particular cognitive organisation".

The practitioner may, moreover, be influenced in choosing symptoms for a diagnostic hypothesis by his or her personal prejudices, schemata or expectations through selective attention that will filter the complex of information provided by the patient's accounts and behaviour.

And they conclude:

"Properly, therefore, diagnosis and classification should be used to describe disorders and areas of deficit and to facilitate

therapeutic work, and not to qualify people or justify social control or labelling".

If one wants, at any cost, to include in a very precise syndrome the child's suffering, which is expressed through a wide and varied constellation of signs, which on the other hand often change over time, one runs the risk of obtaining a series of different diagnoses and, above all, one runs the risk of carrying out partial interventions that do not address the child's real problems, but only some manifestations of these problems. The diagnostic label absolutely fails to represent the child in his or her complexity and originality, as nothing tells us about his or her history, the current reality in which he or she lives, nor does it enlighten us on the possible evolution of the disorder.

An example of multiple diagnosis

The case of Marco that we present is an example of multiple diagnosis.

Marco came to our observation when he was eight years old. But already at fifteen months he had been examined by a child neuropsychiatrist who had diagnosed ***language difficulties*** *and therefore recommended that he be placed in a nursery school, so that the little one would have more linguistic stimuli by attending this institution. When he was four years old, he was examined by an otorhinolaryngologist who, noting a* ***deviation of the nasal septum and slight hearing loss,*** *recommended the removal of his tonsils and adenoids.* ***This*** *was carried out immediately afterwards. The doctor also recommended speech therapy, which the child underwent for two years. Visited later by another child neuropsychiatrist, he diagnosed* ***hyperactivity disorder*** *for which psychomotricity was recommended. Visited, finally, at a children's neuropsychiatry department , a diagnosis of* ***dyslexia*** *was made, for which specific pedagogical activities for this disorder were recommended.*

In this excursus of visits and diagnoses, we think that the essence of the child's problems concerning his relational life was probably not taken into account. In this case, his relational life with his mother. This woman, since she had been practically absent from the child's life, since she worked from morning to night, had entrusted the little one to the care of babysitters and grandparents, so that for years she was only able to highlight and report to the specialists she consulted the problem of the delay in language development and certainly not the affective deficiency the child was suffering. But even afterwards, as his attention was focused on the symptoms rather than on his child's suffering, the resulting diagnoses changed over time. When the child came to our observation, the problems the mother reported had become even different: she complained that the child presented hostile, aggressive, disobedient and defiant attitudes towards her. Even towards strangers, when upset, he showed little control of his emotions with impetuous and poorly controlled behaviour, considerable anxiety and distractibility.

Therefore, the relationship with the mother had become increasingly conflictual as, over the years, the child had often felt very neglected.

A difficult case of categorical diagnosis

It would be very difficult to place the problems presented by Maria, aged 5, into a well-defined category. The child lived in a family in which a father described as a quiet, intelligent, extrovert, cheerful, sociable, ambitious and somewhat conceited man, who had a poor relationship with his daughter because of his work commitments, was contrasted by a mother who was affectionate, altruistic, but very anxious, extremely sensitive, sometimes depressed, who had suffered panic attacks, with fainting spells and

heart palpitations, sudden and unmotivated fears, for which she underwent psychological and pharmacological therapies.

These parents had also been living in a state of perpetual conflict as a couple for eight years due to their difficult relationship with their families of origin.

The parents had requested a visit from their daughter as she had already had a bad time in kindergarten and had been categorically refusing to go to school for a few weeks. She also appeared very touchy, with sudden and unmotivated crying fits. She urinated frequently throughout the day and had numerous phobias, especially of insects, along with many other fears: that her parents might die, that they might abandon her, that she herself might die even from minor injuries or illnesses. Sometimes the child would scold and reproach her mother, complaining that she lived in a 'dirty family'. When she saw her parents bickering, she would lock herself in another room and tell them, shouting, to stop attacking each other. She also wanted to sleep in her parents' bed and had great difficulty leaving her home. She complained of being alone, put the dummy in her mouth, both when she cried and when she went to bed. She also complained of throbbing in her arms and various parts of her body, of pain in her feet, legs and knees. She was also described by her mother as 'mischievous' about sexual matters.

A categorical diagnosis in this, as in many other cases, would not only be exceedingly difficult, but would be absolutely useless in order to understand the child's real problems, so as to deal with them effectively. Such a diagnosis could, for example, focus on fears (school phobia, insects, parental death, fear of death, fear of being abandoned); or regressive symptoms (putting a dummy in her mouth); or psychosomatic problems (throbbing in the arms and various parts of the body, pains in the feet, legs and knees); sleep disorders (needing to sleep in the parents' bed); or, finally,

aggressive behaviour (blaming the mother for making her live in a dirty household).

A categorical diagnosis was useless, especially when it was possible to hear directly from the child's voice her problems, through the stories she told, such as the beautiful but also very painful ones we report.

A flower, a diamond, a heart and a lot of stink

"Once upon a time there was a family. They had a beautiful house and they had a daughter. One fine day the daughter looked at a blue flower and said, 'I want to take it'. She took it and after a few days the little girl grew big. And the flower became big too and inside the flower was a diamond and inside the diamond was the little heart of the little girl that was growing. The little girl was happy because she had a diamond in the house.

Her mother did not notice and threw away the flower with the diamond and the heart inside. The daughter looked for the diamond but couldn't find it and so she became smaller and smaller and became a newborn and the mother said, "How can it be that she became a newborn?" This new-born child spoke and asked her mother for the diamond and the mother said it was in the rubbish. She (the baby) *picked it up and it was all dirty. Afterwards they cleaned it, but it smelled like fish. And the child came back big, but it still stank'.*

One is amazed at how a child of just five years old could describe her history and current problems so well.

The interpretation of this first story is not at all difficult.

Maria finds herself living in a wealthy family (*they had a beautiful house*). Everything seems to be going well. The child is of normal intelligence, in fact very lively, has good self-esteem, and wants to grow up quickly *(The daughter one fine day looked at a blue flower and said: 'I want to take it'. She took it and after a few days the child grew big. And the flower also became big and*

inside the flower was a diamond and inside the diamond was the little heart of the little girl that was growing). But there is a big 'but'. The mother, without realising the evil she was doing, put the little girl in a very uncomfortable situation; the little girl probably referred to the considerable conflicts with her father (*her mother did not realise this and threw away the flower with the diamond and the heart inside).* The consequence was, unfortunately, the child's regression in some areas of development (*The daughter looked for the diamond but could not find it, so she became smaller and smaller, and became an infant).* The mother, realising that something serious and important had happened to her daughter, tried to understand why (*and the mother said: "How can it be that she became a baby?").*

Maria, at this point, makes her mother explicitly understand her considerable discomfort *(This newborn child spoke and asked her mother for the diamond and the mother said it was in the rubbish).* The mother, finally aware that she has made mistakes, tries to address and solve the little girl's problems by accepting a course of action to help her resolve her conflicts and takes her daughter to a neuropsychiatric centre so that she can be given the help she needs to solve her problems. Fortunately, some of the parents' and daughter's most serious problems are resolved *(She* (the child) *took it back and it was all dirty. They cleaned it afterwards, but it smelled like fish. And the child grew back)*.

However, the child realises that, despite the efforts of her parents and carers, not all her problems have been eliminated. Something of the traumas she had suffered while witnessing her parents' constant fighting for years remained in her heart *(And the little girl grew up again, but, despite this, she remained smelly).*

Mary's second story, which we report, highlights more clearly her most pressing and serious problem: the conflict between her parents.

Litigious princes

"Once upon a time there was a beautiful princess who had a fiancé with whom she went for walks in a flowery meadow. One day they decided to marry and had a son named David. But they quarrelled and wanted to break up.

Davide's mother had already given birth and was very worried because she did not know what to say to her son when he grew up. The parents broke up.

When David grew up he asked: "Don't I have a daddy?" And his mother said, "I'll explain it to you when you get older!" And then later she told him: "We broke up because of (our) *families". The child had run away from the family and was looking for his daddy and the mother went to look for him. Afterwards* (the mother) *found dad and son walking and said: "But what are you doing here!" And she scolded daddy. The mother was in despair. Afterwards they all made up and lived happily ever after*."

In this tale Mary once again highlights how in her family there were all the prerequisites for a happy marriage: beauty, wealth, love, an idyllic environment, the birth of a child *(Once upon a time there was a beautiful princess who had a fiancé with whom she went for a walk in a flowery meadow. One day they decided to get married and had a son named David).* Unfortunately, however, these assumptions were not enough (*But they quarrelled and wanted to break up).* At this point, the child's greatest fear is evident: the fear that the separation of her parents would result in the loss of her relationship with her dad *(Afterwards she found dad and son walking and said: "But what are you doing here!" And she scolded daddy).*

As can be deduced from these accounts, the symptoms presented by the child tell us little or nothing about the causes of her problems, nor do they make us understand her suffering. These problems, and the suffering that follows from them, become evident when she is given the opportunity to freely express her

dreams, desires, emotions, and thoughts, through the use of free drawing and the telling of a few stories that are also freely constructed. Ultimately, we believe that it is from their words, drawings and stories that we can truly understand the inner world of children and certainly not from their symptoms.

The dimensional approach

This is why we find *the dimensional approach* much more useful, as it allows us to comprehensively describe the child in his complexity, peculiarities together with his personal and family history. Per Militerni (2004, p. 97):

"In a dimensional system, reference is made to defined dimensions, understood as characteristics that are arranged along a continuum with varying degrees of expressiveness. In this perspective, an emotional state (e.g. anxiety) or a behaviour (e.g. repetitiveness) or a certain way of relating (e.g. sociability), can be considered as dimensions and must therefore be evaluated, not as elements that allow assignment to a category, but in themselves, based on a quantification of attributes'.

Ultimately, a dimension is assigned according to the frequency and severity of the symptom. To put it simply, in the dimensional approach, symptoms only serve us to understand how deep and intense the child's suffering is at that stage of his or her development, as well as allowing us to know, following therapeutic interventions, whether this suffering is diminishing or not.

The child's emotions and feelings

Emotions and feelings are always present in children as in adults. Even very young children feel intense desires, possess emotions, feelings and fantasies. The process of cognition has not yet begun but desires and preferences, fears and anger, feelings of love and hate, are already present (Isaacs, 1995, p. 31). Children's emotions are numerous but are not always clearly recognisable,

especially by those parents and adults who find it difficult to experience their relationship with them with empathy.

Infantile emotions often come to the fore in a disproportionate and excessive manner because, in early childhood, situations have an all-or-nothing character. Thus, from euphoria one can pass to anguish and vice versa; and from the latter, quite quickly, one can return to a situation of normality. Although childhood emotions seem fleeting and superficial, all medical-pedagogical experience proves that they can also be very profound (Osterrieth, 1965, p. 96).

Very often parents see non-existent emotions and feelings in the child and this is due to the changing moods of children. Because after a trauma, a frustration, such as a heavy reprimand or severe punishment, they see the child smiling and active again, they imagine and delude themselves that the child is much stronger than he really is. But as Bettelheim (1987 p. 405) says,

"*...the moods of a child are much more changeable than those of most of us adults; but this does not mean that his emotions are any less deep than those of adults, and that they do not continue to act in him, even if he seems to have forgotten them at the moment. The pain, however, will soon return to assail him, and then the child will be even more distressed, at the idea of having momentarily betrayed his innermost feelings'.*

Crying

Crying is defined as "expressive behaviour characterised by tear secretion, modification of breathing and participation of the whole body that expresses, like laughter, an emotional reaction aimed at releasing tension" (Galimberti, 2006, p. 72).

Crying in adults

We adults cry when we are affected by intense physical or moral pain or discomfort, or by a strong emotion. We cry when

we want to communicate our intimate suffering to our loved ones, so that they can better understand us, listen to us and console us. We also weep to vent and free our souls from excessive tensions and worries, because we know that after shedding many tears, we feel better, we free ourselves, we are more serene. But, strangely, we adults also cry when what we see or hear greatly stimulates our laughter.

Women cry considerably more than men. So much so that in the premenstrual period, the slightest thing is enough to trigger intense crying fits in them. Of course, one can also cry by faking it, as actors do, without being affected by any real emotion. In this case, crying can be a tool to bend the soul of others to our needs, desires or even whims.

Baby crying

No adult cries as much as an infant, who, by the way, can cry without tears, given the immaturity of the lacrimal duct.

The newborn baby's ease of crying is due to various reasons:

1. A first reason can be found in the fact that his nervous system is still immature. This immaturity leads him to have a difficult and precarious emotional balance that very easily triggers crying.

2. A second reason is the infant's inability to communicate his or her needs, except by a very simple means, such as crying, which is capable of stimulating in the parent and in the adults close to him or her, care for him or her.

3. A third reason is suggested by psychoanalysts who judge the crying of the newborn baby as a consequence of the loss of their primitive state of bliss within the mother's womb.

4. A fourth reason may be found in the fact that for the newborn child, both the world outside him and the inner world are realities yet to be discovered and known, before being controlled and managed. He finds himself like a lost adult in a foreign country, without money, without any point of reference, but also without knowing the language and customs of the place.

The purposes of weeping

A young child's means of communication are rudimentary and primitive, so crying is the first and most important form of communication with the world and is intended to draw the attention of parents or carers to him or her, so that they can offer him or her what he or she needs: food, cleanliness, presence or affectionate closeness. It should be noted in this respect that children in Western countries cry more than those where the young are more often in close contact with their mothers. It is also known that babies of anxious mothers cry considerably more than those who are lucky enough to be in the arms of a calm and serene mother.

With crying, the child communicates:

- *Crying is used to express its demands to meet its needs.* The child communicates its discomforts, its pains, its suffering, both physical and psychological: I am cold, I am hot, I am hungry, I am thirsty, my tummy hurts, my skin is irritated, I am nervous, I am tense, I am tired. And so on. If the infant could put his needs into words, they would be of this tenor: 'Please, Mummy, cover me more: I am cold'. Or conversely: 'What are you waiting for to take this blessed blanket off me, it's too heavy and it's suffocating me'. "Give me something to eat, my tummy is empty and muttering". "Is it possible that you didn't notice that the nappy is dirty and my delicate skin

is getting irritated?" "Maybe I swallowed too much milk and too fast, my abdomen hurts. I'm waiting for a good massage from you and I'm sure it will pass." "I'm tired, what a day! Everyone wanting to kiss me! Everyone talking excitedly to my face! I really want to have a nice, healthy sleep, to relax a little; please hurry up with all the tasks necessary to put me to bed. I can't take it anymore!" In this sense, *crying protects the baby* from hunger, thirst, colds, excessive heat, physical and psychological discomfort as well as stressful situations. For these reasons, crying is the most appropriate and adequate tool for satisfying its needs and for the removal of unpleasant circumstances. Among other things, when the mother lavishes her baby with cuddles and tenderness, even if she does not succeed in removing the cause of her crying, she achieves the aim of diminishing her child's distress (Sullivan, 1962. P. 70);

- *Through crying, especially in the evening, he gives vent to the tension accumulated during waking*. Since crying produces a stress-relieving hormone that makes one feel better, his cries are like a valve that allows the child to vent excessive inner tension;

- *When the child is older, he may also cry to satisfy a momentary whim*: having a toy that is not his, getting a forbidden food, being allowed to spend more time in front of the TV, and so on. Parents, depending on their personality and parenting style: permissive, authoritative, authoritarian, behave differently. *Permissive or anxious parents* are usually too careful to see in every cry a need to be satisfied; *authoritarian parents*, on the contrary, will judge most of the child's cries as tantrums

to be ignored. Only parents who *are mature, authoritative, balanced and serene* will know how to respond to the child's requests in an appropriate manner, implementing the most suitable and opportune behaviour;

- *crying can be an expression of his psychological suffering.* The most frequent psychological suffering of the very young child is fear. The child may become frightened for many reasons: because of too much attention from a person unknown to him, because of sudden noises, because he is frightened by someone who has raised his voice, because his little brother, sometimes unintentionally, has hurt him. Other times he is frightened because of a fall or because he has lost his balance. In many cases, although he has not suffered any physical trauma, he cries because of the fear he has experienced, because of the alarmed faces he sees around him or simply because he is hungry for physical closeness and cuddles;

- *With crying, the child can express his anger and rage.* When the environment around him, despite all his efforts and attempts at communication, does not understand or satisfy his needs; when the family environment is too tense, anxious or conflictual and, therefore, not suitable to satisfy his primary need for serenity and peace. Similarly, the child expresses his anger and rage through crying when he feels abandoned or neglected, due to frequent or too prolonged maternal or paternal absences.

- *the child may cry because of physical suffering.* For example, when he has hurt himself while playing, running or in his clumsy attempts to discover and conquer

the world around him. Crying caused by intense physical pain is easy to understand as it is a desperate, inconsolable cry that may last for a long time (even hours), and causes the child to sweat and have a red face. The baby's physical discomfort may also be due to air bubbles in the tummy (*infant colic),* which present themselves with sudden crying, contraction of the legs on the abdomen, flatulence. In these cases, even when the mother picks him up, the baby does not calm down easily.

Crying does not always succeed in consoling. When this happens, the child's anguish is accentuated along with that of the parents, and since if he manages to fall asleep it is only out of exhaustion, when he wakes up he starts crying again, because sleep has failed to soothe him.

The first encounters between parents and baby, outside of the womb, frequently in our historical period risk becoming the first clashes. The reason is simple: on the one hand, we have a small human being who still has an immature nervous system that makes him easy to emotions, both positive and negative. A human being who does not know the world in which he finds himself and who, therefore, does not know how to relate to it: he does not know whom and what to trust, whom and what to fear. A small human being easy to smile, but also to despair. Easy to joy but also to sadness. Easy to optimism but also to the blackest pessimism. It is not difficult to observe all this in an infant who, at a given moment, is playing or sleeping blissfully in his mother's arms, while, a moment later, he is screaming at the top of his lungs, distressed and frightened by something that has occurred in his body, but also only in his mind.

Alongside the psychological fragility of the newborn child, we have a mother, a woman, nowadays increasingly psychologically delicate, but also lacking those contributions, those knowledge, those apprenticeships, and therefore, ultimately, those skills,

in relating to a small child, and even more so to a newborn child. A woman who finds it difficult to focus all her attention on the little one, as sometimes her efforts and mind are reserved more for social, sentimental and work activities, than for the search for the best relationship with her child.

And so, despite the fact that both the mother and the infant need to get to know each other, despite the fact that both need to discover each other, to talk to each other, to confront each other, despite the fact that both need to find useful mutual understandings and agreements, their relationship can be disturbed, distant, and often even conflictual.

It should also be borne in mind that the child carries within him, alongside his limited knowledge of the world around him, his hereditary characteristics. Characteristics that may or may not facilitate this encounter, this dialogue and this understanding. In turn, the mother carries within herself, alongside her genetic heritage, a baggage of both positive and negative experiences, experiences that have been deposited in her being, over many years of relations with the environment in which she lived and with which she still interacts. The mother may carry in her ego the dreams, hopes, loves, joy and optimism towards motherhood and life in general, but she may on the other hand carry, as a result of her difficult experiences, as a consequence of her encounters and clashes that have marked her during the years of her life, anxieties, phobias, fears, inner conflicts, depression and sadness,

When she relates with her child, she ultimately has within her a heavy load of experiences: positive and negative. The positive experiences, had with one's parents, with one's family, with one's friends, will give this woman-mother an extra edge, in knowing how to listen and in knowing how to understand the messages present in crying and then in knowing how to manage the needs of her little one. On the contrary, negative experiences in childhood,

adolescence and adult life, since they may have left anxiety, bitterness, anger, rage and easy reactivity in her soul, risk making it difficult for her to listen, understand and manage her child as a whole. Ultimately, while for mothers whom life has enriched with positive contributions, the baby's crying will simply be a communication tool, valuable for understanding and then satisfying the needs of the child, for others, crying may become an instrument of suffering and torture capable of leading, mother and child, to conflict. Moreover, since adult weeping very often has the meaning of intense physical and psychic suffering, these mothers will tend to see themselves as mothers incapable of giving joy and serenity to their little one, so they will tend to blame themselves for not understanding, not knowing how to respond adequately to their child's needs, not knowing how to accept his calls, not knowing how to evaluate them correctly. Or, on the contrary, they will be ready to judge him as a little tyrant, busy from morning to night making them suffer and despair with his unstoppable crying.

Interventions

- In the meantime, it is important to try to live the relationship with the child as calmly as possible. This approach will help us to understand better, so that we can intervene effectively. Anxiety is never a good counsellor! However, without getting overwhelmed by anxiety, it is not good to ignore the baby's crying. It is always useful to listen to it and intervene promptly, as every type of communication needs immediate and attentive listening and an appropriate response. Otherwise, crying with the meaning of request can easily become crying of anger and rage;

- In order to decode the needs of the baby, we must use not only reason, but also instinct and experience. For example, reason can tell us whether it is feeding time, bath time or nap time. Experience can tell us what the most frequent reasons for crying are: tiredness, a desire to sleep, irritation in the private parts and so on. Every mother's instinct can help us find the most appropriate remedy on that occasion: breastfeeding, cuddling, hugging, rocking, playing with him, relaxing him with a good massage or bath, and so on:

- When we realise that crying is just an outburst of inner tension, it is good to let the child free itself of this accumulated tension in its soul by cuddling it and cradling it in our arms, but also by reassuring it with our smile and a caressing tone of voice. Let us remember that even older children deserve and need cuddles, reassurance and kisses. These manifestations of love, like a balm over wounds, help to heal the small traumas suffered during the day, so that they can more easily resume the path of maturity and growth.

Older, experienced mothers know many useful tricks, especially for younger children:

- it is good to know that up to six months the best positions for sleeping the baby are on its side or on its stomach;

- if the baby is still in the cradle, he will fall asleep more easily if we place some small pillows or rolled-up blankets next to him so that he feels as contained as in the womb;

- for many children a small handkerchief or napkin placed on their face helps them to relax;

- ❖ sucking: the dummy, the bottle, the mother's breast, also stops crying. This small gratification helps them regain their momentarily lost calm and psychic balance;

- ❖ rocking and singing a lullaby have always been used to soothe and calm babies and there is no reason to abandon this ancient and effective custom. All babies love to be rocked, as this reminds them of the mother's womb. And it is for this reason that many babies immediately fall asleep in passing cars, waking up as soon as the car stops;

- ❖ Let us not reproach the child if it cries, as if it were a wicked and evil child whose greatest amusement consists in making us despair with its cries. He has no reason to harm us, for to harm his mother is to harm himself. Each of us, big or small, needs to be accepted, even when we manifest a negative emotion, such as suffering. We cannot only accept the child's signals of joy and well-being, while rejecting those of pain and anguish;

- ❖ if we think that the crying is due to colic, to alleviate his discomfort and to try to calm him down, let us give him as much tranquillity as possible, as the baby may have reacted with the crying, not so much because of the pain felt as because of the fear of these new and different sensations in his body. Let us then place him in a secluded place, with little light and few noises, and massage his tummy with slow, circular and rhythmic movements, which have the power not only to relax his abdomen, but also his tense and frightened soul. If necessary, we can also use a warm infusion to relax;

- ❖ All mothers know that bathing in lukewarm water before bedtime is very useful, as the warm, liquid element reminds the baby of the mother's womb. And this brings him relaxation and pleasure, helping him to sleep;

- ❖ Every child has its own position and favourite place to rest. Some like to lie on their stomach when awake, others in the opposite position: on their stomach. If they are then made to assume this position, on their mother's lap, they rest more easily. But as we said above, it is never convenient to keep them on their stomachs when they are sleeping;

- ❖ With regard to noise, too, every child has its own preferences. Some children like to stay in an environment where there is not the slightest noise, others fall asleep more easily if they are lulled to sleep by a gentle sound, others still fall asleep if they are in contact with the soothing voices of adults, especially the voices of parents or older siblings, so they like to fall asleep in the same room, where the adults are, or in a room not far away;

- ❖ As for the crying tantrum, while the diagnosis made by the parents is certainly correct, one should certainly not give in to the blackmail of crying. This does not mean, however, that the child does not still deserve to be cuddled and soothed.

In conclusion, let us remember that we must not be afraid to spoil young children. If they are welcomed, loved, listened to, cuddled and well looked after, they will be strong, mature and independent children in the future. If, on the other hand, they are

not cared for, listened to and loved, they will be more fragile, nervous and irritable and will give their parents much more trouble in the future.

Anger and rage

It is not difficult to get an idea of anger and rage because all of us adults have, many times, directly experienced these emotions or noticed them in the eyes, body and behaviour of others. Anger and rage are emotional, intense, primal, universal reactions present in all higher animals. From a deep and lasting frustration that affects us and that we judge unacceptable, a reaction of intense dissatisfaction arises, which provokes this type of reaction, which manifests itself in sudden and overwhelming ways.

When anger grows within us, we feel discomfort and tension gradually increasing, until we have the possibility of unloading it on the person who provoked it or on other absolutely innocent people, animals or things who are forced, in spite of themselves, to suffer our mistreatment and insults. Only then, when we respond by attacking the person we perceive as the source of threat or when we can unload our aggression on others, does the tension diminish and we regain a state of momentary and partial well-being.

With regard to the *distinction between anger and rage*, the former is an emotion, while rage is the behaviour resulting from this emotion. Ultimately, one feels anger, but one acts in an angry manner.

Anger and rage are therefore protection mechanisms that signal to us that something is wrong in our relationship with others. They make us aware that someone is hurting us, that our rights have been violated, that our needs and desires have not been met. These reactions stimulate us to stand up for ourselves and give us the motivation to do so, so that we can reassert ourselves and our just and sacrosanct rights and needs.

Since these physiological emotions trigger the survival instinct, which mobilises all the physical energies necessary to defend oneself, threaten and strike at those one perceives as enemies or adversaries, the body is placed in a position of defence and offence, so that it is ready and tense to snap and trigger a fight to eliminate or render harmless those one perceives as a source of irritation, pain, or worse danger. During the whole time of the emotional reaction, the glands that lead to the production of adrenalin and noradrenalin hormones are stimulated. These hormones, in turn, cause an increase in blood pressure and heart rate. In this way, the heart and lungs provide the entire body with the necessary energy propellant to cope with the extraordinary and sudden demand.

The outward manifestations are striking: the face, sometimes red, other times clearly purple, is distraught with the typical expression of anger. The bloodshot eyes communicate to those in front of us as enemy, blame and repression, and let them know that we are ready to attack. The mouth, teeth, and hands, clenched by the stiffening of normal muscle tension, are ready to attack in order to frighten, bite, or hit the person(s) one considers a threatening opponent. But if this is not possible, the same hormones prepare the muscles of the lower limbs for a hasty escape. Unfortunately, however, in this particular condition, the mind, blinded by hatred and the need to do harm, aims only at choosing the best strategy of offence or defence, neglecting the consequences of the aggressive acts that are about to be performed. As a result, the effectiveness of reason is greatly diminished. For this reason, purely human and rational communication skills are reduced to a minimum, so that the negative characteristics of the other person are often overestimated, while, at the same time, the positive ones are underestimated. Moreover, in the heat of anger, the mind focuses on the triggers and erases everything else. We become 'blinded by rage' in a destructive but, at times, also self-destructive

spiral. Blinded, we become unable to explain our reasons clearly. Our words, in the grip of anger, are made up of screaming, bellowing and grunting, as of an enraged animal, while destructive thoughts of revenge prevail.

The very young child manifests his anger with shouting and kicking, with attempts to hit and bite, with stubborn refusal to eat or with uncontrolled expulsion of faeces. Older ones can already express their feelings better with more moderate words and gestures. It should be borne in mind that, fortunately, the anger and rage of children, although more intense than that of adults, is also more fleeting.

In the child's anger there is, as in that of adults, a blind irrationality, such that they even desire the elimination and destruction of the obstacle to the exhaustion of the child's desire, even if it is a person who should be fundamental and much loved for them at that moment.

The case we present is an example of this:

Nine-year-old Fabio was born to a woman who had always experienced very complicated and difficult emotional situations. His mother had first married a man by whom she had a daughter. When she separated from her husband, she had cohabited for two years with Lorenzo's father, from whom she had separated when the child was only two years old. Immediately afterwards she had started a relationship with a married man. This relationship had lasted several years. When the woman decided to leave her lover, he started to persecute her, threatening her in various ways. The man's behaviour prompted the woman to decide to move with her son to another region of Italy, thus removing the danger posed by her ex-lover from her. With this decision, however, the son felt he was forced to stay away from his father, his grandparents, his companions and the house and home town where he had lived until then.

The child, very resentful of this situation, in his search for a minimum of inner well-being, felt the need to defend himself and punish those who had done and were doing him harm. As we can see from his story, this need for defence and punishment in his fantasy had taken on dramatic aspects.

The Knight, the Dragon and the Witch

"Once upon a time there was a knight who rode his horse very far. One day he came to a point and there he saw a dragon. Slowly approaching the beast, the dragon woke up and rode away. But the knight with his horse chased him and killed him. He killed it because his commander, his king, told him to kill the dragon because it was a threat to the country.

When he killed the dragon, he took it to the country and placed it before the king. However, the knight did not know that the king was a witch who put a curse on the knight and turned him into a frog. The frog went to the house of a princess. This girl was the daughter of a king from another country. When he arrived at the princess's house, she said to him: "But who are you?" The frog replied, "I am the knight but the witch put a curse on me. The princess understood the problem and so she kissed him, and the knight returned to normal.

The knight and the princess ran with the guards to the witch and imprisoned her in the dungeon. From that day on, the witch was in the dungeon, so the knight and the king's daughter lived happily ever after'.

If we interpret Fabio's story in the light of his family and personal history, we understand that he feels an overriding need to eliminate the evil being that threatens his and his family's safety (*Once upon a time there was a knight who rode his horse far away. One day he came to a point and there he saw a dragon. Slowly approaching the beast, the dragon woke up and rode away. But the knight with his horse chased it and killed it).*

He obeys the dictates of his commander and king, which in this case is his mother who is being persecuted by a 'bad' man *(she killed him because his commander, his king, told him to kill the dragon because it was a threat to the country).* However, he knows that his problems are not only outside his family, but live next door to him: the biggest problem is his mother, who with her incongruous behaviour has systematically made and continues to make him anxious and in great difficulty. (*When he killed the dragon, he took it to the country and put it before the king. However, the knight did not know that the king was a witch who put a curse on the knight and turned him into a frog).* At this point, the solution can only come from outside his family. The solution can only come from a girl, a good princess, the daughter of a real king and not a witch (*The frog went to the house of a princess. This girl was the daughter of another king from another country. When he arrived at the princess's house, she said to him: "But who are you?" But the frog replied: "I am the knight but the witch has put a curse on me. The princess understood the problem and so she kissed him, and the knight returned to normal).* And it is by allying himself with this girl that he can get his mother, the cause of most of his problems, locked up in the dungeon, so that she can no longer harm him (*The knight and the princess ran together with the guards to the witch and imprisoned her in the dungeon*. *From that day on, the witch was in the dungeon, so the knight and the king's daughter lived happily ever after).*

There are various types of anger:

What we have described is the most severe and striking form of anger. There are, fortunately, milder forms in which this emotion only manifests itself with mild irritability, annoyance or impatience.

When anger manifests itself immediately after an unpleasant or punitive event in an explosive manner, it is called *uninhibited*

anger. If, on the other hand, it builds up over time and expresses itself later with outbursts of anger, it is called *implosive or inhibited anger.*
The latter type of anger is characteristic of those children who, being very careful about formal compliance or for fear of punishment and adult reactions, manage to keep their anger at bay or mask it, under the influence of educational inhibition, so as not to compromise their image in the eyes of their parents or other educators. However, the reflections of this violent emotion do not disappear, but accumulate over time, until the children are able to contain them. When the tension has reached its peak, they explode in agitated and decomposed anger, lose control of their words and actions, and overreact. In these cases, by rebound effect, the more the anger is repressed, the more easily it is manifested as a sudden outburst.

This can happen at any time, but it is more likely to happen during adolescence. At this stage of growth, the child discovers himself to be strong and decisive, so that he no longer fears physical punishment. At this age, anger can manifest itself in all its intensity, leaving parents shocked and puzzled by the presence of such a violent emotion in a child who, until then, had been judged as calm and polite.

In self-punishing rage, the destructive force of anger spills over and is directed towards oneself. Its destructive charge becomes self-punishing and self-defeating. In such cases, the child blames himself, blames himself, hurts himself and runs the risk of permanently losing his self-esteem because he cannot find, or prefers not to find, a target on which to direct his discontent. The repressed anger, turning against him, leads him to tear out his hair, bite his nails, and bang his head against the walls. At the same time, depressive symptoms increase and feelings of inferiority are fuelled.

When the mind can no longer handle these conflicts, the body can suffer, and *psychosomatic illnesses* such as headaches, gastroenteritis, and vomiting can occur. In the meantime, immune defences decrease and, consequently, the onset of viral and bacterial diseases is facilitated.

Another path of anger and rage is that of *impotence*. In these cases, the child appears apathetic, loses body tone, becomes flabby, tired, complains of headaches, lack of appetite and fatigue. In these cases, anger hides behind moaning, whining and discouragement.

Anger can also be expressed or masked. Disguised forms of *anger* are psychological attacks such as backbiting, slander, irony, insinuations, and disparaging criticism of the object believed to be the cause of the frustration, with the aim of casting it in a bad light, belittling its qualities or trying to blame it.

Ultimately, however, all types of anger can be of great harm to oneself and others: uninhibited anger can lead to the breakdown of friendship and family relationships. Self-punishing or impotent forms of anger can be harmful to the very health of the child who experiences them. Moreover, when the object of the anger is a person whom the child should love or who has done him good, he may feel guilty for letting himself be carried away by this intense, aggressive emotion.

Resentment

Anger does not last. It can disappear as quickly as it appears. But if it turns into tenacious and deep resentment and rancour, it can last for many years. Resentment is thus a feeling of deep aversion and resentment towards a person, an environment or a situation, mostly hidden in the soul and not openly manifested, which lasts over time. One feels resentment especially towards well-known people, to whom one is bound by ties of affection or kinship, and who are therefore relevant in one's life. In resentment

there is *rumination*, i.e. the continuous brooding, day after day, over the episode that made us suffer, and often also over the ways in which we can make amends. In such cases, the suffering for the wrong suffered is continually self-feeding.

The displacement of anger

In many situations, the child, unable or unable to react adequately to anger, ends up venting his or her anger not on the real object that provoked it, e.g. his or her mother, father or one of the family members, whom he or she does not have the courage or does not want to confront, but on a less fearsome or more easily reachable target, who acts as a scapegoat *(anger displacement).* The scapegoat can from time to time be one's own younger brother or sister, the weak and fragile classmate, the disabled person, the child 'different' because of language or skin colour. Even innocent objects and animals can suffer the consequences. Parents often complain that the child destroys pencils, toys, tears up books, disrupts his room, chases and tries to crush the innocent kitten, without realising that these behaviours arise from his difficulty in directly expressing his anger at the people who make him or have made him suffer.

The dissociation of anger

Another form of reaction to anger is the *dissociation* described by Freud. In these cases, a hidden but conscious part of the personality denies that the aggressive, painful, loss event really happened, while, at the same time, another part of the personality will continue to believe that it really did happen.

What is certain is that the precipitous enactment of defensive processes - repression or dissociation, resulting in fixation - begins much more easily in childhood than in adulthood. Therein lies the explanation of why and how experiences of loss in early

childhood lead to incomplete personality development and a predisposition to psychic disorders (Bowlby, 1982, p. 60).

Anger, therefore, is a secondary feeling, but is always derived from a primary feeling. Animals often attack because they are suffering, attacked, disturbed, tormented. They attack to drive an intruder out of their territory or to defend their offspring. In human beings, the primary feeling may concern one or more of our fears due to incongruous behaviour on the part of those around us: fear of not being loved, of being pushed away, abandoned, of being left alone, of being scolded, punished, belittled or unjustly denigrated.

Anger worsens when we attribute to the other person the will to hurt, when we have the feeling that the person who makes us feel bad is committing an abuse, a lack of consideration. There are children who react very easily even to trivial motives, while others, on the other hand, who are more serene, balanced and more capable of rationality and emotional control, accept and endure even very intense stimuli. It is especially the touchy ones who often feel hurt and upset for sometimes trivial reasons, to which they react with bitterness, ruminating resentment and revenge. These children always find in the words and gestures of others something that affects them unjustly.

Every child has a particular type of anger that distinguishes his or her personality type and every child has a different way of manifesting it. Therefore, anger and rage have considerable *subjective characteristics, as it* is not so much the stimulus that triggered them that matters as the brain that processed them. Anger, if it manifests itself exceptionally and for serious reasons, has a positive function in itself, as it serves to protect us from the abuse of others. If, on the other hand, it manifests itself frequently or excessively, it is seriously detrimental to the individual, to others and to society; it should, therefore, be a wake-up call for parents,

who should be able to understand the truer and deeper causes of this outburst.

Anger in the various stages of a child's life

In the first months of life, anger and aggression occur when the usual sequences are not respected or the usual gratifications do not appear at the right time. In the child, fear and a feeling of threat to one's own survival are often behind the anger. For Bowlby (1982, p. 55) anger, although we do not always realise it, is an immediate, common and constant reaction to loss, and is an integral part of grief reactions. The human baby, like other baby animals, feels lost and distressed when it loses contact with its family group, as this loss can be fatal to its safety, its well-being, its very survival. He therefore reacts by quickly trying to find the lost people and, when he finds them, he discourages them from similar behaviour in the future by means of harsh reprimands (Bowlby, 1982, p. 56).

And again the same author:

"The hypothesis I put forward, therefore, is that in the young child the experience of separation from the maternal figure is particularly apt to arouse psychic processes of crucial importance for psychopathology, just as inflammation and the consequent scar tissue phenomena are for pathophysiology. This does not mean that a mutilated personality must necessarily result, but rather that, as in the case of rheumatic fevers, all too often the formation of consequent scar tissue can lead to more or less severe dysfunction" (Bowlby, 1982, p. 60). "It seems that a person stricken by loss fights with fate with all his emotional being, desperately trying to reverse the course of time and recover those happy days that were suddenly taken away from him. Far from facing reality, trying to adapt to it, a person affected by loss engages in a struggle with the past' (Bowlby, 1982, p. 98).

In the two- to three-year-old *child*, anger may be due to being held back, thwarted, frustrated, in his expectations.

At school age, fits of anger are often due to the difficulties the child may have in relating well with peers and teachers. Also at this age, the child easily recognises family disagreements, but being unable to remedy them he gets angry, sometimes at one parent, sometimes at the other, because they make him anxious and difficult. He often also turns his anger towards himself, because he somehow holds himself responsible for their disagreements or because he is unable to remedy them.

In adolescence, fits of anger and rage are directed towards parents by whom he does not feel understood in his needs for autonomy and freedom, but also towards classmates by whom he does not feel respected and towards friends when he feels betrayed.

The causes of fits of rage may therefore be due to something that happened at the time or shortly before, or they may find their origin in a more or less distant period of time. In many cases, the early frustrations that the child suffered are important. These frustrations may be of various kinds: a temporary abandonment by one or both parents, a particularly tense family climate, a mother or father with psychological problems who are unable to respond adequately to the child's needs, and so on.

Reactivity to a stimulus is never equal. A child when calm and content can react well to intense negative stimuli. Conversely, at certain times and under certain conditions, he may react badly to even a minimal stimulus. For example, he is more likely to react badly when he is tired and stressed from a day in which his primary physiological needs have not been met: sleep, food, play, free movement, attention, cuddles and environmental serenity.

At other times, fits of rage may arise in a child who has become particularly irritable due to a steady stream of unsuitable

behaviour over time, even if these attitudes, when examined individually, do not appear particularly intense and serious: too much favouritism to his detriment, too much criticism and negative comparisons, too many reprimands and punishments, too many mild clashes within the family, excessive demands in terms of quantity or quality, excessive manifestations of anxiety on the part of parents or relatives, etc.

Crises due to a state of physical fragility and weakness that turns into a state of psychic fragility and weakness, such as when the child is or has just emerged from a state of organic illness, for which he or she has had to undergo therapies and interventions in an outpatient setting, or worse, in an inpatient setting, should not be underestimated.

Affective spasms

A particular mode of expression of anger are affective spasms. Rosine Debray describes them as follows :

"In a situation of frustration, which causes anger, the baby suddenly starts to sob, breathing becomes increasingly rapid and, after a last gasp accompanied by stridor without respiratory response, the chest freezes in forced inhalation and the baby goes into apnoea. Cyanosis appears, the child loses consciousness, falls like a rag doll, sometimes there is a turning of the eyes. The attack may lead to a convulsive seizure, often of the tonic type with possible clonic tremors, with or without loss of urine' (Debray and Belot, 2009, p. 57).

The duration of the respiratory pause ranges from a few seconds to about a minute. The pale form, which is rarer, is caused by pain, shock, emotion or fear. The child, after a cry, sometimes barely audible, becomes very pale and falls into syncope. The most severe forms of affective spasms can be mistaken for convulsive seizures, as the child systematically presents a convulsive seizure immediately after a trauma.

The causes of anger

As far as the causes of anger are concerned, we must be able to distinguish:

1. The reaction to something unjust that was done to the child.
2. The need and the pleasure of creating around oneself a moment of confusion and destructiveness.
3. Pretentious behaviour.

1. The reaction to something unjust that was done to the child.

It is not difficult that something unfair has been done to the child by the parents, siblings, some classmate or the teachers. In such cases, have the courage to tell the child: "You are right, we as parents behaved badly". "I as a mother, as a father was wrong, I scolded you unfairly". "The teacher was too hard on you". "Your brother or your partner should not have treated you this way". Having this courage, we said, makes anger disappear as if by magic. These words have the power to communicate unquestionable truths and realities to the child: everyone can make mistakes. Children can make mistakes, but so can adults. The important thing, when this happens, is to admit one's mistakes, apologise, and strive to avoid the same thing happening in the future. These words, or words like them, have the power to make the child feel the love and esteem we have for them and the care we feel for their feelings and emotions.

2. The need and the pleasure of creating around oneself a moment of confusion and destructiveness.

The impulse to convulsively de-clutter objects or toys, as well as the need for destructiveness, is very strong in children who suffer and have suffered a lot. In these, especially boys, the desire

and need to unload aggression, anxiety and inner tension on something or someone is present. But, increasingly in males, a certain degree of destructive impulse is also present in normal subjects (Isaacs, 1995, p. 69). When the need arises to express one's inner energy aggressively, it is important to ensure that the child has a great deal of freedom and opportunity to do so, without hurting himself or others and without incurring reprimands and punishments. This is possible by using free play, or by means of equally free and spontaneous motor activities in the open air.

3. Pretentious behaviour.

Some crises can certainly be pretextual. These are pseudo-crises aimed at obtaining something that is forbidden: excessive use of TV or video games, food, toys and objects that parents do not see fit to allow or are unable to buy at the time. In such cases, crises should certainly be ignored, but never underestimated. They should be ignored because responding to a crisis born of a whim, by satisfying the whim itself, risks triggering a vicious circle, whereby the child 'gets a crisis' every time it wants to obtain something forbidden. However, they should not be underestimated, since often these outbursts of discomfort arise from incongruous parental behaviour.

In other words, the child is often desperate to obtain an expensive and useless toy, but behind this request hides his discomfort and suffering, due to much more important real shortcomings: the need for clear rules and straightforward behaviour; lack of dialogue or attention from parents or relatives; occasional or limited opportunities to play freely and for a reasonable time with peers on a daily basis; the presence of unsuitable behaviour by parents towards him or their relationship; and so on.

Possible interventions

We have observed in numerous cases of children with this symptomatology which behaviour can be unhelpful or even tend to worsen these manifestations and which can be more helpful and productive.

It does not appear useful to us:

- *scold more and more or punish the child more and more severely.* In short, despotism at any cost does not work. In such cases, even if the desired effect is achieved at the time, more anger and more rage remains, is nurtured and accentuated within the child's soul;

- *ignoring the reasons for anger and rage.* The lack of understanding accentuates the feeling of loneliness and sadness in the child and increases his or her reactivity towards parents, other adults or peers;

- *not to reflect on what is going on in the child's soul.* In such cases it is like closing one's eyes to reality, hoping that it does not exist, or even worse, hoping that there is only a bad and rebellious child to be tamed with a whip and halter, like a wild horse;

- *respond with anger and rage to the child's anger.* In such cases, a duel is initiated that will certainly do neither the parents nor the child any good, since either the latter will be forced to internalise his or her emotions, with consequent self-accusations, self-punishment, somatisation, etc., or the angry behaviour will increase, whether towards the parents or towards brothers, sisters or other, completely innocent children;

- *In our opinion, the so-called 'physical restraint' put in place by parents or educators to prevent the child from hurting himself or herself is also of little use*. Since the

child is already imprisoned and upset by his emotions, he perceives others and the world around him in an even more negative and repressive manner.

It seems useful to us instead:

- *being able to remain calm, making* an effort to understand what may have been the cause of the onset of this emotion in your child;

- *reflect his emotions and accept them.* "I understand that you are angry because you had to leave your favourite game to go out with dad and mum. But it was too late and we couldn't wait any longer."

- *Communicate to the child* the reasons that led us to reprimand or punish him/her. Instead of saying: 'I am angry with you...', it is better to say: 'I was afraid of what might happen to you in that situation and that is why I had to scold or punish you';

- *try to calm him down with an affectionate and serene attitude*, while at the same time working to solve the underlying problems from which his anger and rage may have arisen;

- *distract and divert his attention,* on a pleasant or neutral activity or game;

- *contain the child in an affective sense,* trying to make him understand our efforts to understand the reasons for his anger, while, at the same time, we strive to show him the best ways to avoid it, better manage it or control it;

- *set clear rules.* Children accept rules if they are clear, straightforward and not constantly changed. For example, for a child who continually asks for money or toys, it is indispensable to put precise indications, taking into account one's own economic possibilities and the need to teach the child the prudent use of money: 'You will have your weekly pocket money of tot euros which you can spend as you wish. Only for your birthday, name day and end of school will you get a nice toy':

- *try to prevent seizures* by, for example, giving the child a few minutes' notice to stop what he is doing, thus avoiding forcing him to abruptly stop the activity he has started;

- *intervene decisively,* making it clear that you are not prepared to be blackmailed by such incongruous behaviour, when the crises occur in public places: church, restaurant, shop, with the aim of more easily obtaining something forbidden or not appropriate at the time;

- *Get the child used to expressing his or her discomfort and suffering* through continuous listening, so as to clarify your or another's behaviour;

- *teach them to give appropriate and non-destructive responses,* without being subjugated by others, but also without getting into fits of rage.

Anxiety

We spoke in a previous chapter about the anxiety of adults. Children's anxiety, at least apparently, is very different.

Meanwhile, the child can hardly communicate his anxiety in a direct way. He will say that he is sick, that he does not want to go out or go to school. He will complain about the pain in his tummy, he will vomit, cry, throw tantrums, but he will never tell you that he feels anxiety. This inner emotion we will have to understand from his eyes and his tense gaze. We will have to perceive this painful emotion from his behaviour: from his hugs to his mother or father from whom he cannot tear himself away when he has to go to school or to another place without his parents. We will have to interpret her by observing the convulsive way in which she draws. We will have to perceive her from her stories and fantasies, in which sad and anguished themes often prevail. De Ajuriaguerra and Marcelli (1986, p. 277) describe the infant's anxiety as follows:

"*...it is sufficient to recall the lost face, the large, wide-open eyes, the shrill, incessant cries of anguish, the generalised hypertonia with frequent agitation of the lower limbs of the eleven-twelve-month-old infant, when admitted for a trivial intercurrent reason, ...".*

As far as his behaviour is concerned, the anxious child is often irritable, grumpy, has difficulty falling asleep, but also has difficulty carrying out daily tasks; he appears distracted, his concentration is erratic, he bites his nails *(onychophagia),* his body can sometimes be shaken by tics, he has difficulty breathing deeply, so he complains of a lump in his throat, he needs constant reassurance. Only from these and other bodily or behavioural manifestations will we be able to tell when and how much he is affected by this emotion.

The causes of anxiety

According to the constitutionalist conception, anxiety would be the result of a genetic-based predisposition that would lead to neuropsychic modes of functioning in which hyperemotionality,

neuro-muscular hyperexcitability, lability of the neuro-vegetative balance, asthenia, tremors, etc. prevail (Militerni, 2004, p. 372).

According to behavioural theory, just as Pavlovian experimental neuroses through repeated frustrations lead to states of restlessness, hyperexcitability, anorexia and insomnia in animals, so too in humans repeated stresses, frustrations and traumas lead to anxiety disorders. "Subsequent elaborations of behavioural theory have proposed that anxious symptoms are to be interpreted as maladaptive learned patterns of behaviour". (Militerni, 2004, p. 372). *According to psychoanalytic theory,* anxiety is part of neurosis and is therefore the consequence of a conflict between the needs of the id and those of the superego.

In our opinion, many of the symptoms we notice in children have anxiety as their main component, which is like the substratum of much of psycho-affective pathology. Anxiety is mixed with fears and phobias; it represents the other side of the coin in cases of childhood depression; it is hidden by apparent indifference; it is present on a massive scale in autism; it abnormally stimulates motility in hyperactive children; it greatly disturbs the functionality of internal organs, translating, in children who tend to somatise it, into *somatic symptoms* such as stomach pains, headaches, nausea, vomiting, palpitations, dizziness.

The various types of anxiety

Separation anxiety

When a child is forced to move away from his parents, family members, his most cherished objects, his home, without having the psychological maturity to do so, his suffering manifests itself in a type of *anxiety* that we call *separation anxiety*. Behind separation anxiety there is always a child who suffers because of his insecurity or his fears. For this very insecure child, the father, another family member, but even more so the mother, are important sources of security. Just as they are sources of security, but on

a much lesser level, his home, his room, his toys. These people and these objects represent a possible lifeline for the child; they are instruments capable, at least in part, of calming, reassuring, chasing away fears, banishing nightmares, relieving the restlessness that grips him. This is why his unease is accentuated when he is forced to move away from objects, places, but above all from the people who give him this feeling of tranquillity and security.

When it is time to sleep, a really difficult time for these children, if the anxiety and fears are not excessive, he will be content to stay in the room where at least one of the parents is present, but if the anxiety is greater, he will ask for his mother to stay near him, holding his hand, until he is able to fall asleep. If the anxiety is even more severe, he will ask for his mother to sleep with him all night long in his cot. When his fears and tension are even more intense, it will not be enough for him to stay in his parents' room, nor will it be enough for him to sleep in their bed: he will ask to be held by his mother or at least touch a part of her dress or body, especially her hair.

Separation anxiety also manifests itself when the child is forced to go far away from his parents, for reasons that might be very pleasant for other children: a trip, a reward trip, an overnight stay with the scouts, a party with his companions. In such cases, even if he is in the company of friends or people he knows well, he is assailed by fears and intense feelings of homesickness, so when his parents are away, he will do anything to keep in touch with them via the telephone. Sometimes he fears that something bad might happen to them: that they might fall ill, die or disappear and, therefore, leave him alone and abandoned. In other cases he may be afraid that catastrophic events will strike his family or himself: that he may get lost and never find his parents, that he may be sick and have no help from his mum and dad, and so on.

Generalised anxiety disorder

In generalised anxiety disorder, the object of anxiety is not linked to a specific element, as is the case with fears and phobias, nor to a specific situation, as is the case with separation anxiety . These children are afraid of everything, so they show anxiety and worry for various reasons: when they are left alone, when they have to have new experiences, when they are asked to perform a task and so on. They worry about the quality of performance, e.g. grades in school tests, just as they worry about possible catastrophic events: earthquakes, wars, storms. These worries cause them motor restlessness, easy fatigability, difficulty in concentrating, irritability, muscle tension, sleep disturbances, mimic tension and neurovegetative manifestations. These children suffering from generalised anxiety, for Militerni (2004, p. 376), also tend to be overly conformist and perfectionist, with feelings of dissatisfaction with performance.

Somatised anxiety

In children, the body is the most common route for the expression of anxiety. This can manifest itself with a series of symptoms that, at first, may suggest a problem of an organic nature: tension or pain in the stomach and intestines, vomiting, diarrhoea, but also migraine, joint pains that occur at specific times and moments, dizziness, allergic manifestations and so on. Symptoms that appear to be organic, but which become evident in certain particular emotional situations: when mum and dad move away from the child, when he has to go to school or to another place, little or no loved by him. Symptoms that disappear completely when the child has the opportunity to stay with his parents or to stay away from certain places and particular stressful situations.

Possible interventions

The child's anxious manifestations are likely to exacerbate the parents' and family members' anxiety. In turn, this will tend to accentuate the child's anxiety.

For this reason, the first task of the parents and operators is to try to understand, through a careful examination of the child's life, what may have caused the anxiety, so as to eliminate possible anxiety situations that are still active. Subsequently, the parents' and operators' task will be to find out which attitudes are most suitable, capable of reducing the child's anxiety.

Many times, helped by the therapist, it is necessary for parents to make courageous and strong decisions: such as temporarily removing the child from school, drastically reducing the time spent studying, watching TV, playing video games, making an effort to change their anxious behaviour, their incorrect educational style, or, when necessary, increasing their dialoguing and playful presence. One can also intervene by giving the child more security and confidence in what they do or say. It has proved very useful in our experience to stimulate the child to create stories as a comment on his or her drawings. In such cases, one should not comment on these stories except positively. Parents' tales and fairy tales, in which the protagonists of the story experience difficulties that they manage to overcome, so that there is always a happy ending, have proved useful to all peoples and times. It would also be important to have the child perform relaxation exercises using Autogenic Training.

Trichotillomania and onychophagy

In *trichotillomania,* the child feels an irresistible urge to roll, touch, caress or, in the most severe cases, pull out his own hair or that of his mother when she stays close to him. When the hair is pulled out, these children may give themselves patches of alopecia. This behaviour causes stress to the whole family, who cannot bear to see their child pulling out his hair and causing himself

baldness. "This behaviour may appear in situations of anxiety, frustration or lack of affection: separation from parents, the death of one of them, the birth of a baby brother, placement in an institution..." (De Ajuriaguerra, Marcelli, 1986, p. 92). In these cases it is useless to scold the child: it is not with scolding that anxiety decreases. It is much better to behave with him in a closer and more affectionate manner and, if necessary, to engage him in small manual tasks or suggest that he unload his anxiety on some soft object, to hold and squeeze in his hands.

In onychophagia, on the other hand, the child feels the need to suck his fingers, to bite his nails or the skin around the nail. This behaviour is very frequent in anxious, overly lively, active and authoritarian children who need to contain their tension and nervousness (De Ajuriaguerra, Marcelli, 1986, p. 92). Onychophagy can be interpreted as a persistence of the infantile autoerotic need to suck: first the dummy and then the finger. Sometimes it is a transitory behaviour lasting a few days or a few months. However, it can become an ingrained behaviour and persist into adulthood. Since it is judged by adults: parents, relatives, teachers, as a 'vice' and a reprehensible behaviour, also from a hygienic point of view, the child itself, if sensitive to the judgement of others, tries to avoid it in every way, but often with poor results; hence, even if secretly, it continues to bite its nails.

Numerous interventions were proposed to dissuade the child and also the boy from this behaviour. Since it has been seen that threats, reprimands and chastisements are of no use, attempts have been made to act by means of repulsive techniques such as bandaging the fingers or putting a bitter substance on them. Or, on the contrary, attempts have been made to make little girls and girls proud of their nails by putting on nail varnish and taking perfect care of them. However, this, like all symptoms that signal discomfort or a clear psychic disturbance, requires interventions that must first of all concern the child's living environment, in order to

make it as serene as possible, while the child is followed and treated through individual psychotherapy.

Fears and phobias

Infantile fears are much more frequent and numerous than those present in adults, since the child, when it is born, goes from a safe and secure intrauterine situation to a reality perceived as 'risky', in which everything is new and unknown to it. He does not yet know who and what he can trust and what may be a source of danger to him. Since the child is in a projective and animistic mental disposition, danger can arise from everything and not only from every person.

Fears are much more numerous in childhood because, at this age, the human being is more emotional, has fewer defences than adults, has a physiological lack of reality judgement and considerable difficulty in distinguishing fears that come from the outside world from those that arise in his inner world. In other words, he has difficulty distinguishing *true, objective fears from false, subjective ones.* For the child, this distinction does not exist, and what is internal can be projected outwards and vice versa.

Fears are present in almost all children who, for various reasons, suffer from some psycho-affective problem, whether mild or severe. That is why we often find fears in hyperactive children as in inhibited ones, in aggressive children as in depressed ones. On a massive scale we find fears in autism and other pervasive developmental disorders. Ultimately, the life of every child who, for whatever reason, has suffered a lot or still suffers, is often accompanied by fears. And even if these are not directly manifest, they are often present and peep out from his behaviour, which we often judge as puerile and foolish.

All fears are felt more when the child is alone, they are better experienced and counteracted when he is in the company of his parents or some family member. It is the physical presence of the parents, and especially the physical presence of the mother, that is best able to drive away the child's fears. It is for this reason that when he is assailed by fears during the night, he takes refuge in his parents' cot and stays cuddled up to his mother.

Physiological and pathological fears

Just as with anxiety and other signs of distress in children, in order to assess whether *a fear is physiological or pathological*, certain distinguishing features must be taken into account:

1. *First of all, the age of the child.* Is this type of fear typical for the age of the child or not?

If a child of one to three years of age does not want to detach himself from his mother's hand or from a known person to go into the arms of a stranger, this is certainly not a pathological fear, since, for a child of this age, such behaviour is healthy and natural. Inherent in this period of his development is mistrust of strangers, because he fears that they might harm him, while trust is only placed in perfectly known persons, with whom he has established a particularly intense and stable emotional bond. But if this happens at an older age: four to five years, one can realistically deduce that there is something troubling that child's soul.

In the same way, if he refuses or is afraid to go to nursery school or before the age of three to four in kindergarten, and therefore recalcitrates, cries, and complains of all possible and imaginable ailments, in order to stay at home, he is not an insecure and fearful child, nor is he a capricious child; he reacts naturally and spontaneously to a situation that, for his age, is unnatural. It is a different matter if the same behaviour occurs in a five- to six-year-old child. At this age we can rationally think that there is

some problem in the child or in the school environment where he should be placed, towards which there is a stubborn rejection.

2. *The characteristics of phobias*. To understand whether a fear is a symptom of a psychic pathology or not, we must ask ourselves whether the phobic objects are typical of a certain developmental phase or not. We know, for example, that from zero to three years of age, the fear of abandonment is present, but it diminishes and then gradually disappears after this age. If this fear occurs at five to six years of age or at a later age, we can reasonably suspect that it is a pathological fear.

3. *Number and frequency*. Two other elements to be considered in order to judge whether the child's fears are physiological or pathological are the number and frequency of their fears. We must ask ourselves: are the fears of the child in question few or many? Do they occur rarely and only in certain circumstances, or are they so frequent that they limit the child's free activity and thus prevent him from a normal social life? For example, is the child only afraid of the dark, or alongside this are there also fears of water, insects, being away from parents, etc.? And does this fear of the dark only occur occasionally, e.g. when he is physically ill, or almost every night?

4. *The intensity.* How intense are these fears? Are they so compelling that they limit his autonomy, his living space, his possibility of socialisation in relation to his age, or does the child manage to live with these fears quite well?

5. *The association with other signs of distress.* Another important element that helps us discern pathological fears from physiological ones is the association or not with

other symptoms. If alongside the fears there are other manifestations of inner suffering, such as sleep disturbances, psychomotor instability, tics, excessive jealousies, behavioural disorders or worse, there are other manifestations that indicate regression in the child, the attention should be considerably greater than if only those types of symptoms are present.

There are various reasons why the child is frequently unable to describe or only communicate his fears verbally and openly:

- being small he lacks the necessary verbal terms;
- is ashamed of his fears and fears being laughed at;
- fears create such anxiety in him that his ability to express them verbally is paralysed;
- sometimes fears are not well defined.

Nevertheless, it is not difficult to understand them from the behaviour of the little one, who, when confronted with people, objects or particular situations, stiffens, cries, runs away or takes refuge in the safety of his home or, even better, in the arms of mum and dad.

However, Marco and Luisa manage to describe their fears very well.

Marco's fears

Seven-year-old Marco expresses it this way:

"My fears are many: fear of the dark when I am alone, fear of insects, and fear when I am in serious trouble. I used to have other fears, but they have now passed and they were the shadows when my parents were fighting. The shadows I see resemble thieves who exchange weapons and attack me. Sometimes I also see some kind of shadows hiding behind the curtain'.

Luisa's fears

Eleven-year-old Luisa describes her fears as follows:

"I am afraid that my parents will abandon me or die, as well as my grandmother and sister. I get very agitated and cannot calm down and at that moment I am afraid of everything. I am afraid that I won't be able to get through this. I have bad feelings: I feel as if I am in a labyrinth from which I can no longer get out, then this labyrinth becomes covered and there I suffocate to death. Then I feel like something black is falling on me. I am afraid because I see bad things. I am afraid that my sister does not love me, as well as my parents and grandparents. I feel alone and I am afraid of everything. I am afraid of what I see, of everything around me. I see ugly things inside me that I cannot erase: of dead people who want to kill me, who take me. Then I enter a black hole in which I see bad things. I see dead people I don't know, in bad conditions I can't draw. I am afraid and if I close my eyes it is the same. All this I can't get out of my mind'.

The causes of fears

According to the constitutionalist conception, there would be genetic causes as there is a higher concordance of the disorder in homozygotic twins and a higher incidence among ascendants and collaterals (Militerni, 2004, p. 383).

Neurochemical investigations revealed serotonergic dysfunction.

Neuroimaging suggests dysfunction of striatal-thalamo-cortical circuits.

For psychoanalysis, fears arise when sexual or aggressive thoughts are present and are censored. These thoughts threaten to emerge from the unconscious, so that a series of defence mechanisms are activated that result in the displacement of anxiety, from the feared drive, to an external object or situation that has some symbolic connection with it.

From an environmental point of view, fear is very similar to anxiety, to the point that we can consider them two sides of the same coin, as these two emotions have in common unpleasantness and the resulting behaviour, which, most of the time, is disorganised and tending to escape, i.e. to move away from what is feared.

Both anxiety and fear are two emotions that children manifest quite frequently, although it is always rather difficult for us adults to differentiate and interpret the emotion they manifest in an 'adult' way. It is easy for us to understand the fear our child may feel when faced with a snake wriggling near him or a dog barking at him. On the other hand, when our child has to go to school, where he finds teachers and classmates he knows very well, or when he has to stay at his grandparents' or alone in his cot while we stay in the next room, we cannot understand the causes of his fear, so we are left wondering: "But what is it that frightens him so much? And again: "But why does my child fear what others do not fear?"

In reality, fears can certainly be *linked to a specific trauma*, due to the phobic element, e.g. fear of dogs and cats can certainly be caused by a dog or by a cat that attacked or harmed the child. Likewise, fear of the dark may have been caused by the fright experienced by the child when he tripped and fell in a dark room. Often, however, there is no connection between the fear and the specific trauma, as, frequently, pathological fears are merely the *result of the child's inner suffering.* Suffering due to an unsuitable upbringing or an environment that is particularly disturbed, stressful or that presents or has presented little attention and consideration for the child's emotional-emotional needs. Fears can also arise as a *parental and* family *contagion*: it is not uncommon to find parents with the same or similar fears as their children.

Unfortunately, in our current society, the suffering that a child is made to endure is considerable, because, strangely enough, the capacity to correctly assess what he can and must endure for

his normal, healthy growth and what it is not right, nor correct to make him endure, is considerably greater in simpler, more primitive societies than in more evolved societies like ours. It is as if the cultural elements underlying these capacities, cultural elements that are normally passed on from one generation to the next and accepted and made their own by the latter, have undergone, in modern Western societies, as it were, a halt or considerable deformation. This is due to various causes, among which are individualism; subjectivism; relativism; the conflict between spouses; the excessive work and social commitments required of parents and especially mothers; the greed for money and power that encourages many mass-media managers to take no account of the possible, indeed probable, damage caused to children by television programmes and video games in which frightening, anxious and terrifying elements are lavished with full force, or in any case elements that are not suitable for the serene development of minors.

Ultimately, today, despite the enormous spread of the culture of childhood, we understand and care much less and much worse about the needs of the child than we did a few decades ago.

In addition, the total sexual and sentimental freedom granted to young people also allows procreation by persons unsuitable for parenthood, so that many fears are transmitted from parents to children, either by imitation, whereby fearful and anxious parents transmit their fears and anxieties to their children, or because of a particularly stressful and anxious environment that is little or not at all conducive to healthy development (De Negri et al., 1970, p. 135).

Age-related fears

Physiological fears are very frequent *around the age of two to three years* because, for them to appear, it is necessary for the

feeling of individuality to have emerged in the child. The frequency of fears increases until the age of three and decreases thereafter as reality becomes more precise and adualism diminishes. This type of fear varies according to age:

Between the ages of two and four, fear of wriggling *animals* such as snakes and other reptiles is common. *In the pre-school* age of three to five, the fear of darkness, night, monsters and thieves prevails. The fear of the doctor and of uniforms in general is also of this age. Particularly too many visits, too many examinations, too many therapies carried out by unknown persons, in equally anonymous and smelly environments, do not fit in well with the heightened sensitivity of the little ones.

In school age, which ranges from six to ten years, fear of animals is often present**.** Especially of large animals, such as big dogs, horses, oxen.

Regarding the size of animals, the smaller one is, the more one is afraid of large animals: wolves, dogs, strangers, ghosts, ogres, etc. The bigger one is, the more one is afraid of small animals, e.g. mice, cockroaches or annoying insects.

Main fears

The specific fears that invade a child's soul can be numerous. We will describe just a few of them.

❖ ***Fear of abandonment***

One of the first *fears* is that of the child *being abandoned by* its parents. This fear, physiologically, concerns the age range from zero to three years. But if the child is anxious and insecure, it can also extend to a much higher age than is physiological.

The fear of being abandoned, of losing and not finding their parents, is an emotion common to the young of many animals.

Chicks only feel safe if the hen with her protective shadow watches over them. Kittens that are only a few weeks old, even if they are swaggering, never stray too far from their mother's scent and warmth. The reason is simple: if the mother is far away there is a risk that they will no longer be cared for and fed. If the mother is far away there is the danger of being mauled and devoured by some other animal in search of small, defenceless prey.

Since the human infant remains dependent on parents and adults for a much longer time than the young of other animals, he feels the need for many years to have not only a mother, but a pair of parents and, if possible, also a host of family members and relatives at his side. This need is due to the complexity of the human being. For the human puppy, every familiar person is precious because of the help and support they can offer him at some time in life. Behind the fear of abandonment there is, therefore, a clearly biological motivation, concerning the child's well-being and its own possibility of healthy and balanced growth. Alongside this motivation we also find psychological implications, since between the human mother and her child there is a very intimate and special bond and relationship. The mother is for the child not only a source of physical well-being and security, but also a source of psychological well-being and security.

If the mother comes first, in the sphere of people who can give security, then comes the father and, next, the other family members: especially grandparents and uncles. All these people are for the child a source of love and trust and, therefore, security. They are the adults capable of reassuring with their gaze, words and gestures. They are the adults capable of banishing physical and moral pain with just a kiss. They alone love immensely.

❖ ***Fear of the stranger***

Similar to this is the *fear of the stranger*, which arises physiologically at around six to eighteen months. At this age, the child recognises its mother and father well, so it easily identifies who is

not its own father and mother. The child therefore at this age, when it encounters a stranger, looks at it with terror, turns around and then dives trembling into the arms of its mother or father, demanding protection. Hers is, therefore, *the fear of what it is not.* If it is a familiar face then it is something good, reassuring, trustworthy and safe. If it is not a familiar and friendly face, then it is someone or something that can be a source of fear. To this imaginary danger the child may react with anguish, uncontrolled anger, flight, but also with self- and hetero-aggressive behaviour.

❖ ***Fears of emotional punishment***

The child knows that his life and well-being depend exclusively on his parents. One of his greatest fears is that of not being loved by them. Not being loved means the risk of being removed, abandoned and left to his own devices. Unfortunately, this risk is often threatened by family members in order to force the child to obey: "If you don't leave your game and come immediately to get dressed, mummy will go away and leave you". "If you continue being a brat, I will put you in boarding school". "If you don't learn to pee in the potty, Mummy won't love you any more". These fears are also fuelled by television programmes in which news events concerning children are presented in all their crudeness, every day, on all television channels, for several months, without any concern whatsoever for the harm being done to minors.

❖ **Fear of bogeymen**

Again with the aim of repressing the child's behaviour that is deemed unsuitable, to push him towards greater autonomy or to obtain the required obedience, parents bring out other fears, such as those of 'bogeymen'. These are mysterious entities that parents can use to intimidate or punish the child: the bogeyman, the man with the sack, the doctor, the babau.

❖ ***Fear of the dark***

One of the most frequent fears is the fear of the dark. Because of this fear, many children are afraid to go from one room to another if it is not well lit, or, when they are asleep, they want there to always be a light on in their room to chase away the black shadows of the night.

This, too, has a biological imprint: in the light, young animals can see everything around them and if there is danger they can flee, whereas in the dark it is easier to be attacked by some nocturnal predator. Therefore, in the dark of night, behind every corner, every door, every curtain, every window, an element of risk and danger may lurk in the eyes and heart of the child. In the dark, thieves and murderers move about. With the favour of darkness, the foulest deeds are carried out. But, above all, with darkness, terrifying illusions are easy, whereby shadows can take on the guise of devils, witches, ogres, evil wizards and dragons, just as they can transform themselves into the bogeyman of which Mummy and Daddy speak.

The night is also a time of separation from the warmth, the embrace, the smell, the gaze of the parents. In the night, one is entrusted, with sleep, to a fantastic world, unknown, always different and not directly manageable by the child: a world, therefore, by its very nature dangerous and treacherous.

Fear of the dark is more acute and frequent in our present time, since when the child wakes up during the night, he does not find, as he did in the small tents or poor houses of the past, his parents or at least some of his many brothers and sisters. Often he finds only inert puppets beside him, incapable of welcome and comfort, while mum and dad are in a place that is far away for him: in another room! Therefore he cannot rely on his mother's or father's smell or their warm, soft and cosy bodies for security. Moreover, unfortunately, his falling asleep is nowadays more and more often preceded not by the tender fairy tales told by his father or mother, while they hold him tightly in their embrace, but by the

crude and often violent and cold images from TV or from wars and fighting monsters in video games that he has just left. Monsters "that can yes be destroyed with a cannon or laser gun" but "that can also suddenly hit you, without you expecting it and devour you in one bite!"

❖ ***Fear of loud noises***

Another very frequent *fear* is that of *loud noises*: thunder, bombs, sudden shouts, fireworks. This fear is also easily understood on a biological level. A quiet environment is perceived by all animals, and also by the baby of man, as peaceful and tranquil, whereas a noisy environment, which usually manifests itself when another animal pounces on the cubs to tear them apart, is perceived as full of danger and threats.

❖ ***Anxiety and social phobia***

The shy child experiences *social anxiety* when he has to face or talk to other people: he manifests his discomfort through *avoidance*. This is why, for example, the shy child asks mum and dad to ask at the newsstand if his favourite magazine has arrived. Similarly, he trembles when he has to expose himself in public, as in end-of-year plays. In such cases it is not difficult for him to put his feet up and refuse to come out from behind the curtain of the theatre, even though he knows his part very well. Social anxiety impairs crucial areas of the individual's functioning and can have serious repercussions on self-esteem and sense of self-efficacy, with the risk of developing secondary depression. Unlike adults, the child with social anxiety, even if he understands the origin of his anxiety, does not recognise that his fear is excessive and unreasonable. This may diminish with time, so that the child, as he becomes more confident, is likely to be able to cope with the same embarrassing situations without any problems.

The same is not true when *social phobia* is present. In these cases, there is an intense and persistent fear that others may humiliate us or have a negative judgement of us. And because this phobia concerning social or performance situations that may cause embarrassment is pronounced, irrational and persistent, the more the parents push the child to engage in anxiety-provoking behaviour, the more this difficulty is accentuated.

Social fear translates into excessive shyness in front of unfamiliar people, by refusing to participate in group games, but also by refusing to go to places, such as school, where it is necessary to relate to and confront adults and peers who may misjudge the child (Militerni, 2004, p. 377). Between social anxiety and phobia, as with all symptoms of distress, there are no clear separations but there is a *continuum* of severity. Says De Acutis (2009, p. 609):

"One observes the existence of a link between the two conditions that would allow one to delineate a continuum between normality and pathology in the area of social anxiety, which underlies the fear of being judged negatively by others with respect to both one's qualities and one's performance, within specific social contexts".

- ***Fear of deformed faces***

This fear arises when a deformed face, compared to the usual human face shape, appears before the child. Father Christmas's thick, unkempt beard or the clown's huge nose and mouth can cause fear. Similarly, the face of an old man or woman with a very droopy appearance can create fear. Again, the fear arises from a different reality than the usual one to which the child was accustomed. The face of the mother and father is young and beautiful, whereas anything that looks deformed looks ugly and creates fear.

- ***Fear of water***

Generally speaking, children love water and are at ease in the liquid world, whether of the sea or of their own tub. Therefore,

this type of fear can easily arise from frustrating experiences: for example, because of some sea wave that has submerged the child for a moment or because of some careless and careless behaviour on the part of the mother at bath time. For this reason, precisely because the child instinctively loves water, if there are no valid triggering reasons, such as those we have just described, this type of fear reveals considerable tension and anxiety in the child's soul, due to deeper problems.

- **Fear of death**

A frequent fear is that something seriously harmful will happen to himself, his parents or people close to him and much loved: such as being injured, traumatised or, worse, that there is a possibility that these people may die. The child, because of his dependence on others, constantly finds himself in a situation of helplessness and fragility for many years. This can explain this kind of fear, which, even if it is not always expressed verbally, can manifest itself in various ways and with various requests: not to be left alone at bedtime, not to go to school, not to go without one's parents to parties, and so on. In these and similar cases, the child fears that in his absence his parents might die or get very hurt, or that the same misfortune might happen to him if deprived of the care and immediate intervention of mum and dad.

A radio report to conquer fear

Francesco, the son of parents with excellent social standing, who had lived in a difficult environment due to his father's obsessive traits and his mother's anxiety, presented numerous fears when he came to our observation that prevented him from a normal social life.

Of these, certainly the most serious were those that referred to his parents: he was afraid to leave them and therefore refused to go to school, as this could mean not seeing them again and being abandoned. At the same time, however, in his drawings and

the stories he constructed, there was a desire to get away from them and their psychologically oppressive and anxious behaviour, even travelling to foreign countries and cities. In the course of therapy, these fears gradually changed until they took on disconcerting protective aspects, probably due to guilt feelings, towards father and mother. For example, when the father went to work, he was forced, during the entire journey, to talk to his son with the mobile phone inserted in the helmet of the motorbike, to reassure him that he was all right and that he had not met with an accident. The father, during the journey between home and work, was forced to carry out like a radio commentary on everything that was happening along the road: where he was, what was happening around him at the time, and how he was feeling. But even when he was in the office, he had to keep in touch with his son for quite a while, meticulously recounting every activity he undertook. It was only when the child regained his composure, through the modification of his living environment combined with individual psychotherapy, that he was able to be content with a simple goodbye, when his father left home and when, safe and sound, he arrived at the office.

Interventions

- In order to understand whether it is a physiological or pathological fear, but also to ascertain whether what the child manifests is only fear or is, instead, a true phobia, the opinion of a neuropsychiatrist is often necessary. He will look for possible environmental causes of such symptoms and will also assess whether there are other symptoms that can better clarify the overall picture.

- It is very helpful to listen to how the child feels and the reasons he gives for his fears. It is equally important to allow him to express his needs and emotions through

drawing, stories and through free self-directed play. In this way he will be able to free himself from these fears, translating them into images, stories, games and behaviour.

- ❖ While we are engaged in seeking out and then eliminating, or at least reducing, any attitudes and behaviour that might be the cause of his uneasiness and fears, we should absolutely avoid treating his fears with condescension, or worse, mocking him for how he feels. These incongruous behaviours would only accentuate the child's distrust in others, while at the same time they could cause a further decrease in his self-esteem. As Bettelheim (1987, p. 97) says: "The parent who does not accept our fears is outside and therefore cannot console us, the one who accepts them is close to us".

- ❖ Since, as we have said, symptoms are the child's way of manifesting his suffering or defending himself from it, it is good to respect the child's fears and avoid forcing him to abruptly face a situation he fears, also because fear has a large component of irrationality. It is much better to wait until the child has acquired greater serenity before gradually confronting the feared situations.

- ❖ Since one of the causes of fears *is parental or family contagion*, it is important for parents to limit their anxieties and apprehensions as much as possible, both for their child's educational activities and for minor medical or family problems, so that they do not infect and involve the child with their own adult fears. It is therefore good not to be influenced by the frequent and numerous alarms that come from the media. Alarms that

encourage parents to make frequent recommendations to the child in order to avoid improbable dangers. The risk is that the excessive protection put in place for him will make him believe that nature, the world, others, everything around him, can be a source of danger *(image of the world deformed in a negative sense).*

Hate for hearts and kisses

Luigi, aged 10, was born into a normally structured family. The father was described by his wife as a very apprehensive man, but affectionate and present in the family and in bringing up the children when work allowed. He was therefore able to relate well with Luigi. The mother, on the other hand, described herself as an impulsive, nervous, anxious woman with a changeable mood, very much conditioned by events. She was aware that she transmitted anxiety to her children and husband, but could not control this emotion. Moreover, in her educational behaviour, she saw herself as an unmaternal 'woman soldier', scarcely sweet and affectionate towards her two children. She sometimes presented aggressive outbursts towards objects or towards Luigi and his sister, to whom she blamed the negative problems in the family context.

By getting married, the woman had focused much of her interests and goals on her husband and the relationship: 'I thought the couple was the most important thing in marriage', so she felt the commitment to the children was too heavy and difficult. For this reason, she described her relationship with her husband as 'good', while her relationship with Luigi had become increasingly conflictual over time.

Luigi's problems had started very early. Placed in the kindergarten when he was only two years old, he cried during the first days, but then, at least apparently, he seemed to have got used to the new and different environment. In the kindergarten, although the child tried to relate to other peers, he could not fully integrate, as he tended to talk about things that interested and

pleased him and not those that others might like or be interested in. The difficulties in socialisation and integration had worsened during primary school. During this period, the child tended to alienate and isolate himself from the class group, from which, moreover, he was laughed at. At the age of seven Luigi was also included in a pre and after-school service, while during the summer, he was made to attend the Grest organised by the same service. Following this attendance, his parents noticed a marked deterioration in his behaviour: increased reactivity and aggressiveness and the use of swear words towards both peers and adults. His socialisation skills were very poor: he could only play with one companion. For a year, his parents enrolled him in five-a-side football, but even in this environment problems arose, as the other children, seeing that he could not play well, did not pass him the ball.

Needless to say, his self-esteem, also due to these negative experiences in relationships with peers and adults, was very low.

Along with integration, socialisation and behavioural problems, Luigi suffered from various and numerous fears and phobias from an early age: of being alone at home, of going from one room to another, of the dark and of illness. Since the boy had started to manifest the latter phobia, when he got wet he felt the need to dry himself immediately with a hair dryer. Also being afraid of infections and microbes, he refused to be kissed by anyone and if someone kissed him by force or inadvertently, he would immediately wipe his face to avoid any contamination. Manifesting also a phobia of dirt, with the intention of cleaning himself, he would often turn on the water tap, wet his finger and run it over all the parts of his body that he considered dirty. Perhaps because of this same fear of becoming infected, he refused to take off his jacket when he was at school.

He also had a particular hatred for designs depicting hearts or kisses. He therefore absolutely did not want his mother, his little

sister or other people in the family to wear any clothing in which these two images were depicted. Even when he watched TV, he would immediately change channel if he saw such images. Strangely enough, however, he loved films and documentaries in which snakes, dinosaurs, sharks and piranhas were present. Of all these animals he not only had no fear but was actually very attracted. Alongside these, the child manifested numerous behavioural disorders: because he felt misunderstood by everyone, he behaved disobediently, nervously, irritably, grumpily and aggressively. He swore at everyone and in particular at his younger sister, whom he insulted heavily and with whom he often quarrelled. In games and behaviour she did not accept any parental advice. His mood was almost always marked by sadness and anger. His mother bitterly reported that 'Luigi never laughs, never shows contentment or enthusiasm for the toys he receives. He always appears dissatisfied with everything. He tends to walk around his room grumbling and talking to himself'. As far as activities and interests were concerned, Luigi tended to focus his attention for a remarkably long time and obsessively on certain topics: for example, dinosaurs or footballers. During the period in which his attention was focused on dinosaurs he walked and moved around the house like them, while collecting books, pictures and objects that reproduced them. When his passion had shifted to football he was constantly talking about football and wanted to watch all the matches. His attention and concentration on assigned tasks was also very poor, so that even if he sometimes accepted some of his parents' requests, he could never complete them.

If we examine this case, we have a better understanding of how childhood psychological disorders can arise, evolve and manifest themselves.

1. In the meantime, it should be pointed out that this child's suffering manifests itself not with one but with a multipli-

city of symptoms: fears, phobias, compulsions, severe difficulties in integration and socialisation, anger, sadness, behavioural disorders, poor attention and concentration skills, repetitive behaviour, etc.

2. Moreover, if we review Luigi's story we understand well what happens when the relationship with an important, indeed essential, figure such as the mother does not proceed properly. Since this woman did not have the necessary skills to deal with her maternal role, she was driven to look outside the family in various childcare services for the help she needed to manage her son. Although she did not have any work commitments outside the family, she felt the need to use the crèche, pre-school and after-school services and, in the holidays, the Grest.

3. The support received from these services had not only failed to address or diminish the child's problems but had almost certainly contributed to exacerbating them, as it had contributed to digging a deeper furrow in the mother-child relationship.

4. It is also interesting to note what happens in relations with the family and the social environment when psycho-affective development does not proceed properly. With regard to his relationship with his parents and, above all, with his mother, when the child was unable to get the necessary care and attention from them, the first psychic disturbances had manifested themselves. These, in turn, had made his relations with his parents even more difficult, with the consequences of his increased discomfort, but also with a greater predisposition on their part to try to remove the child from the home environment, for an increasingly longer period of time, with a consequent worsening of Luigi's

psychic condition, but also of the parent-child relationship and bond. His hatred of the images of hearts and kisses makes this serious crisis in the relationship very clear. He felt that there was a feeling of love between his parents from which he was excluded!

5. With regard to his relationship with his peers, Luigi tried to relate to them in the nursery school, but was unable to do so correctly, as his lack of inner serenity prevented him from modelling himself adequately with the other children, and he was expelled from them. This, in all likelihood, had contributed to accentuating his suffering, sense of exclusion, anger and rage, while diminishing his self-esteem even more. This difficult psychological condition, in turn, forced him to isolate himself even more from others and to engage in aggressive behaviour towards everyone: both peers and adults.

The rejection of the school

This disorder manifests itself in the more or less explicit refusal to go to school.

The intensity and severity of the opposition to this institution are very varied. They range from mild discomfort, when the child is forced to leave home to go to school, manifested with phrases such as: 'What a nuisance school is! "I'm tired today: I don't want to go to school", to outright phobia. In this case, the signs of the child's considerable distress are obvious and characteristic: in the morning, the child tends to get up late, moves slowly in every activity he is forced to perform. He gets dressed, washes and has breakfast, trying in every way to postpone leaving his home and family. Sometimes he clearly manifests his refusal. Explicit reasons, when requested, are of the type: 'school is bad', 'teachers are bad', 'classmates push me, they beat me'. In other cases, the child

simply underlines his refusal with 'I don't want to, I don't like it'. When parents are not softened up and insist that they still go to school every day, the child may manifest psychosomatic symptoms: such as abdominal pain, nausea, vomiting, physical weakness, trembling, diffuse sweating, dizziness, headaches or, worse, may have anxiety attacks that may even panic. If parents then insist on not taking their child's fears into account, regressive symptoms may occur, such as enuresis, encopresis, the search for liquid food, the need to return to sleeping in mum and dad's bed. In addition, other concomitant fears may occur or worsen, such as that of one's own and/or one's parents' death or that the family will break up with the separation of mum and dad, and so on. Sometimes hysterical conversion symptoms are evident: deafness, widespread paralysis. As well as tics may be present.

All these symptoms, however, disappear, or regress considerably, when parents agree to leave their child at home.

These manifestations are more frequent in pre-school, as this institution represents the child's first real detachment from his parents and home, at an age when not all children are psychologically mature enough to face the world outside their family.

In these cases, the typical scene is that of a mother who, having decided that the child must go to school, encourages and prepares him psychologically: she buys him a nice backpack in which to put his favourite toy, a good snack, some colouring books, and accompanies him, saying that they are going to a place where he can meet many nice children, with whom he can play and have fun. The child, who usually acquiesces joyfully, gets into the car and then, holding tightly onto the hand of his mother, walks through the corridors and enters the classroom intended for him. Everything seems to be going well as long as the mother's hand is clasped to his or as long as she is there with him. When, after entrusting him to the teacher. she greets him with a loud kiss and a 'see you soon' and disappears through the door, the child, at first

astonished at what is happening, and then frightened, begins to cry and calls her running after her. If the mother retraces her steps, he clings to her, looks at her tense and trembling, and afterwards, for quite a while, he does not detach himself from her, as he fears that the painful experience of which he was the victim a moment before may be repeated. If the mother, agreeing to the teachers' pressure, goes away, to return after a few hours, the child, after crying for a while, stops, and, sulking, begins to play with the other children, or, tense and frightened, remains in a corner or by the classroom door, waiting in vain for the woman. When she reappears after a few hours, he looks at her reproachfully, but is happy to be able to return to his home. Unfortunately, from then on, the child will look at his mother and her words with suspicion, since the boundless trust he had in her, as the person who chooses only good and beautiful things for him, will have been, at least in part, shattered!

It can also happen that after an apparent disappearance of the symptoms, they recur with the same intensity each time the child is forced to confront a new school environment. This was the case with eleven-year-old Dario.

Dario was brought to our attention because he very adamantly refused to attend secondary school. As he was a very capable and intelligent boy, he had no problem learning the curriculum subjects. His rejection of school was only motivated with the words: 'School is bad. I don't like school, I don't want to go". The parents were in despair as the boy had presented the same refusal both in kindergarten and primary school but, after a few months of continuous insistence and violent tantrums, he 'adapted'. This time, however, by displaying aggressive and violent attitudes, he absolutely would not agree to their demands. When we advised the parents to accept their son's fear and make him study, at least for some time, at home, the child was delighted, so much so that he was himself phoning his classmates to get his homework, which

he did systematically and with great joy at home. It was he himself who asked to go to school, but only once a month, together with his mother, and only for the time necessary to be questioned by the teachers, and then return home.

This phobia is more frequent in males and it has been seen that the higher the age at which it occurs, the more serious the psychological problems of the child. Therefore, if the fear of going to school can only be a sign of immaturity in the three- to four-year-old child, it can be a sign of significant psychological distress if it appears or continues after the age of six.

Unfortunately, when this fear occurs in the compulsory school period, it takes on greater social significance in the eyes of parents than when it occurs in kindergarten. In these cases, parents can hardly accept the decision to let their child leave the school environment, even if only for a short time.

Causes:

Biological causes:

A lability of certain endocrine and neurotransmitter systems, noradrenergic (Militerni, 2004, p. 374).

Psychological and environmental causes

To understand this type of rejection, we must necessarily consider that entering school forces the child to deal with environments, people and situations that are significantly different and much more complex than those present in a normal family. It is very difficult to deal with these new environments, people and situations, especially if there is not the necessary intellectual or psycho-affective maturity. The premises of the school are very different from the rooms of his home, which the little one knows very

well because they have been mute spectators of so many of his moments of play. The people are different: caretakers, teachers and classmates, compared to those with whom he was used to dealing and with whom he had already established an important emotional bond. Moreover, the school environment is much larger than in his family: not a few small rooms but large, long corridors with numerous classrooms. Moreover, the school environment is hardly willing to display the particularly protective, affectionate and accepting behaviour towards him that is present in a normal family context. This environment requires attention and well-defined performances: one has to listen to what is explained, one has to draw, write, read, learn and then report what has been studied, and so on. This is an environment that judges every performance. It is an environment that requires considerable self-control from the child: one does not leave the classroom and go to the bathroom when one wants to; one does not get up from the desk without the teacher's permission; one does not play when one has to study; one does not talk to other classmates when the lesson is in progress, and so on.

It is natural, therefore, that many children, even perfectly normal ones, experience some fear and a certain difficulty in adapting during the first days or even the first weeks of attending school. This reality, by its very nature difficult, can become distressing when the child, for various reasons, already presents or suffers from immaturity, retardation, disability, psychological difficulties.

The possible causes of school rejection are numerous:

- *separation anxiety*. Since the reassuring presence of his parents, family members and/or his usual living environment is still indispensable for a child who is too young or mentally ill, there is an intense fear of separation from his mother and family environment to face unknown people and environments;

- *psycho-affective immaturity*. For the still immature child, inclusion in the school environment may mean being forced to grow up so as to lose intimacy with the mother (Bettelheim 1987);

- *previous traumatic experiences*. Sometimes the refusal to go to school stems from traumatic experiences previously had in the school context or in relations with a group of irritating, aggressive, violent peers, even outside the school environment. The negative experience may also have occurred with non-familiar adults, who had excessively oppressive, anxious, authoritarian or repressive behaviour towards the child. In these cases, in the child's eyes, outside the family context, both minors and adults take on markedly negative characteristics;

- *presence of hostile desires*. The child may be afraid that his or her unconscious hostile desires for parents or other family members may come true, so that they may be injured or die, during his or her absence;

- *jealousy towards the younger sibling*. For a child suffering from intense jealousy, it can be very distressing to leave younger siblings at home with their parents;

- *fear of not being rescued.* Many children are afraid of illness and/or death. This fear is greatly mitigated by the presence of their parents who, in their eyes, are the only ones who can rescue them and save them in the event of a major illness;

- *learning difficulties*. Teachers often assume in the eyes of pupils the role of severe judges of their actions. Therefore, the child who presents excessive difficulties in

school activities, which he/she perceives as very demanding and stressful, may feel a considerable fear of their negative judgements. This will lead him or her to try to avoid all contact with teachers, staying away from school;

- *judgements on his conduct.* Another fear may arise from the judgments that teachers may make about his behaviour. Especially if this is characterised by uncontrollable instability and restlessness. In such cases, the imperious need to keep away from teachers and other school authorities in order to avoid reprimands and punishments seems obvious;

- *difficulties in integration, socialisation and communication.* When a child presents such problems, school becomes intolerable at as he is forced to suffer marginalisation and ridicule by peers, who easily notice his problems and limitations.

Interventions

Since, as we have just said, the causes that can upset the child, preventing his confidence from maturing sufficiently so as to face the new and difficult reality of school, can be many and various, while waiting to understand and resolve them, all measures aimed at chastising and/or reproaching the child for his behaviour are certainly counterproductive. It is a good idea, therefore, to accept his suffering as real (Bettelheim 1987), and not to underestimate his fears, nor systematically mistake them for tantrums or signs of laziness.

It is important to try to understand the reasons for his fear by analysing his living environment, not only at school but also, and above all, in his family. It is not always easy to succeed in this task, as the child tends to give the explanations that he thinks are

most accepted by adults and not the deepest and truest ones. Parents and teachers, on the other hand, tend to adopt the motivations that best suit their wishes and needs, rather than admitting the real motivations. Despite this, it is necessary to try to understand the real reasons for rejection, so as to take decisive action to remove the possible causes. One can then discover, for example, a child's psycho-affective immaturity with still excessive dependence on parental figures. A mother who is overprotective or intrusive towards her dependent child, or an absence or poor physical or moral presence of the father figure, may be evident in his family environment. Stressful or difficult situations may be present, such as a bereavement in the family, a divorce or separation of parents, abrupt changes of environment, the inadequacy of reference figures, recent hospitalisation, etc.

While, however, efforts are made to discover and treat the reasons for the child's discomfort, it is often necessary to remove him or her, even momentarily, from school for a few days or weeks. This interruption is often perceived as smoke and mirrors, both by the parents and by the teachers following the child. On the parents' side, in the case of both being busy with work, the greatest resistance is often due to management difficulties: "Where can we leave the child and who can look after him during the many hours of our absence?" On the part of both: teachers and parents, the fear of the child's lack of or poor school performance due to his or her absence is also very intense. Added to this is the fear "that he will get used to not attending school and staying at home", so that, at a later stage, it might be difficult for him to return to the classroom.

Unfortunately, both parents and teachers do not use the same yardstick for fear of school that they constantly use for their personal phobias. It is easy, for example, for these same adults to have fears: of the lift, of the aeroplane, of insects, because of which they do not get on lifts and prefer to walk several flights of

stairs, they do not set foot on aeroplanes but book coach or train journeys, they do not go to the countryside to stay well clear of insects. However, they find it unacceptable for a child to be afraid to go to school! We think that this, like other phobias, should be given the utmost respect by parents and educators, as the fundamental objective always remains the psychological well-being of the child; therefore, a momentary removal of the child should be accepted with serenity. We have observed how in many cases, momentary interruption of school activities gives the child a concrete sense of solidarity and understanding on the part of his parents, teachers and adults in general. It is like saying to the child: 'We know that you are ill and we understand your suffering, which we share, so we have no intention of sacrificing your well-being to your school obligation'. This message of affection and love reassures and reassures more than any other discourse and prevents the child's psychological condition from deteriorating further.

On the other hand, our personal experience has always confirmed to us that the child who is of an appropriate age to be able to easily move away from the family (three to four years old), who has the necessary serenity to be able to do so, and who finds a normally accepting and welcoming classroom environment, prefers to be at school with his peers rather than at home, without peers and with only the company of the TV and one of his parents or grandparents.

At a later stage, after the appropriate measures have been taken to improve the child's psychological well-being, the phase of re-entry into the school environment can begin: re-entry to be carried out very gradually. At first, the presence at school may be only a few minutes, even in the company of the mother, father or some other family member who can best give the child serenity and security, and then gradually increase the time spent in the classroom, while the presence of family members in the school environment may decrease.

Teachers are well advised to respect the pupil's problems by putting him at ease, including by engaging him in enjoyable activities, especially during the first few days back in class, so that the schooling process takes place in a gradual, serene, pleasant and rewarding manner.

The loss of security

For Militerni (2004, p. 97) "Security refers to that feeling of emotional stability resulting from the maturation of certain "internal" certainties, which allow the child to face new situations and cope with unusual situations". One of the child's greatest anxieties is the loss of security. The anguish he feels in such cases is well known.

The events that can lead to insecurity are numerous. Let us give a few examples. One morning, as the little one is getting out of bed, his mother introduces him to the new nanny, who, in a sweet and welcoming manner, makes every effort to befriend him. Fortunately, after a few days, this young woman fully succeeds in winning his trust and affection. Unfortunately, after a few months, as the little one's parents have found another girl more willing or cheaper, the nanny approaches him with tears in her eyes to say goodbye, as she will have to leave. At the same time she reassures him that she will visit him often and that they will always remain good friends. Of course this does not happen! This promise is just a pitiful lie. After the first occasional contacts the young woman, having found another job and other interests, no longer telephones, while visits become increasingly rare.

Let us now take another example among many possible ones: the mother accompanies the child to the kindergarten and leaves him, reassuring him, amidst a thousand kisses and warm tears, that she will come very soon to pick him up again: 'Just the time to buy you a little present and then I will be back to you and we will go home'. Of course, being a pitiful lie, this does not happen. The

mother does buy the child a present, but her absence, which has lasted too long for her to be able to bear it comfortably, causes the child to fear that she has lost her forever, a fear that is confused with anger at the deception. And of no use is the little gift to erase these feelings! If these or similar events are repeated several times, it will be easy for mistrust to creep into the child's soul. Distrust not only towards the mother figure, but also towards all adults and towards life in general. Alongside mistrust, insecurity will strongly emerge.

For this reason, the sense of loss of security can be *acute* or *chronic*. In both cases, the child experiences, along with fear, pain, suffering and anger. Of course, the consequences will be more severe when the loss of security is chronic, rather than when the traumatic event is rare and resolves itself in a short time.

The reasons that can lead to the loss of security are many. Let us recall just a few of the most important ones:

- Since the child's primary source of security is his or her mother and parents to whom, especially when he or she is young, there is a special attachment, a mother or father with little or occasional presence leads to a sense of insecurity;

- the same feeling is present when the child, although not mature enough to cope with a separation from his or her parents, is forcibly removed from his or her home and family to be placed in environments not familiar to him or her, in the company of unknown people. Even in this case he may experience anxiety or worse, *abandonment anxiety*;

- Economic difficulties can also be a source of insecurity, either because the child feels anxiety and concern in his or her surroundings about this difficult and worrying life situation, or because he or she feels belittled and 'different' in comparison with others;

- ❖ with regard to the presence of a disability, this only leads to a sense of insecurity when the family, the school and the social environment that the child attends fail to cope well with his or her limitations and difficulties;

- ❖ reasons for insecurity the child feels when he finds himself involved in situations of family disharmony (De Negri et al., 1970, pp. 116-117). In these cases, since every child needs to feel protected, supported and loved by his family members, a source of security is the feeling that his parents are united and their bond is stable and solid. When, on the other hand, there are continuous, traumatic contrasts between the parents, the child feels the fear and the concrete risk of the break-up of the family bond and the possible loss of one or both parents;

- ❖ Finally, it should not be forgotten that reasons for insecurity may arise from excessively authoritarian, limiting and frustrating parental behaviour or, conversely, from excessively permissive behaviour.

Conduct disorders

The term conduct disorder describes a range of inappropriate behaviour in which the fundamental rights of others or the norms and rules of social life are violated (DSM - IV-TR). Children with conduct disorders are easily recognised because they are the despair of their parents, teachers and all educators in general. They are called 'difficult children' or 'terrible children', to avoid using the designation 'bad children', which would imply judgement and moral condemnation. How, on the other hand, to name children who are quarrelsome, who lose control easily, who have aggressive, vindictive, resentful attitudes, who tell lies, who use foul language? How should we judge irritating children, who seem to take

pleasure in breaking the rules, whether at home, at school or outside school? Children who dream and sometimes run away, who play hooky from school? How do we assess seemingly insensitive children for harming others, while they are ready to challenge and accuse peers and adults? Children who seem to have no feelings of guilt or shame about their deplorable conduct? Children who, in order to avoid severe punishment, seem to pretend to repent and feel guilt, only to continue to commit the same acts and engage in the same behaviour?

On the other hand, punishments, even the harshest, such as expulsion from school or slaps from the mother, or worse, belting from the father, following their shenanigans, seem to have no positive effect. Their behaviour does not change, except slightly and for a short time, after which they continue to assault, continue to play truant, continue to steal and continue to swear.

In summary, children with conduct disorders may present:

- ❖ lack of concern for the feelings of others;
- ❖ disobedient, irritating, defiant and accusatory attitudes;
- ❖ little respect and empathy for the needs and wants of others and their objects;
- ❖ feelings of bitterness towards those who have harmed them;
- ❖ aggressive and sometimes cruel attitudes towards people and animals;
- ❖ joy and enjoyment in destroying, spite or harming others: physical harm with violence and, sometimes, gratuitous injuries or injuries caused by totally irrelevant acts, but also moral harm, since in adolescence these youngsters can drag others, 'the good guys', into deplorable acts and conduct: such as excessive drinking, smoking, partying;

- ❖ lack of sensitivity to authoritarian and punitive educational attitudes;

- ❖ frequent presence of foul language.

Older children with conduct disorders play truant the most, which is also why they have lower cognitive skills; they are the most likely to run away from home and sometimes spend the night away from home; they may engage in various delinquent acts: theft, mugging, extortion, bullying and bullying of peers, sexual violence, defacing walls, damaging monuments, fraud, theft, etc.

Because of their behaviour, these minors solicit attitudes of rejection, non-acceptance and isolation both from adults, such as parents and teachers, and sometimes even from peers, when their disturbing and aggressive behaviour is directed towards them.

The severity of these symptoms can vary widely, so that *conduct disorder* can be classified as *mild, medium or severe,* depending on the number, type and intensity with which the child's disturbing behaviour occurs. The number of children diagnosed with conduct disorder appears to have increased markedly in recent decades.

The causes

Neurobiological causes

A genetic predisposition is hypothesised as at least one of the parents often has a similar disorder and psychopathological disorders such as alcohol dependency, mood disorders and schizophrenia are present among the ascendants and collaterals (Militerni, 2004, p. 325).

Environmental causes

These causes assume pre-eminent significance (Militerni, 2004, p.325). If one delves into the intimate lives of these minors, one realises that, even unintentionally, harm has been done to them or is still being done to them.

Sometimes it turns out that they have been physically harmed, but most often psychological harm has been done to them: "rejection and abandonment by parents, [...] contradictory norms of upbringing with strict discipline, physical and sexual abuse, lack of supervision, early placement in institutions, frequent changes of caregivers, [...] rejection by peers, exposure to neighbourhood violence" (DSM - IV- TR). Also for Bowlby (1982, p.48), these disorders arise when the child is subjected to excessive pressure. As a result, he has to massively use his defensive manoeuvres to cope with anxiety. Such pressures can arise from organic disease, physical impediment, poor intellectual gifts and many other environmental circumstances: rejection and open hostility from parents, illegitimacy, loss of maternal care. For Wolff (1970, p. 164), sometimes a parent of these children, often the mother, has an ambivalent attitude: on the one hand she reproaches her child for his behaviour, on the other hand, without being aware of it, she encourages him. There is therefore inconsistency or unconscious permissiveness in these mothers. Some condone delinquent behaviour for years before acting on their son unexpectedly, and often only do so when his behaviour has drawn public attention to the family.

Other causes may lie in underground tension or open parental conflict. These children are often the battleground or weapons used in conflicts between spouses, when they are unable to keep their children away from their conflictual behaviour.

Other parents fail to adequately develop their children's super-ego in the field of discipline (Wolff, 1970, p. 164).

Ultimately, the suffering endured by these children results in their low tolerance of frustrations, hyperreactivity and inner anger, which stimulates them to such behaviour. This almost always triggers a vicious circle: the more they exhibit irritating, aggressive and destructive behaviour, the more others punish them, manifesting attitudes of rejection, moral condemnation, isolation, non-

acceptance and exclusion. These attitudes, in turn, accentuate their frustration and anger, resulting in an increase in conduct disorders.

Psychomotor instability

One of the most frequent reasons for consultation in the field of child neuropsychiatry is psychomotor instability. Children with this disorder have considerable difficulty in sitting still for prolonged periods of time. They are therefore described as children with 'quicksilver on them'. These children are often unable to maintain the motor behaviour that is required of them, even for a very short time *(motor impersistence);* they nervously walk up and down the room; if they are forced to sit they constantly move the chair but also the desk, which sways and shakes following their unconscious movements. Despite the fact that in the home and school environment they are unable to stop, except for brief moments, when the children themselves have the opportunity to move, play and run freely over large spaces, strangely, they move almost normally.

This should not appear unusual, if one thinks that the anxiety of these children is greatly accentuated when they are confined in an environment that is stressful for them, such as a normal school classroom in which discipline and self-control are rightly required. In these environments, these children, because they continually disrupt lessons, never staying in their seats but wandering between desks, touching everything and bothering everyone, are continually reprimanded and punished by teachers. In addition, because they often interrupt other pupils in their tasks, bumping into them, pushing them and taking their objects and work tools, they are removed by their own classmates.

In games, due to their considerable impatience, since they perceive the time that separates them from the realisation of their desires as excessive and frustrating, they find it very difficult to

respect turns, so they try to bypass the other children, creating confusion and angry reactions, resulting in marginalisation. The teachers, 'devastated' by their behaviour, but aware that they possess good intelligence, state that: "they could do a lot if only they were more attentive". Ultimately, their school performance is often poor, but certainly not because of any particular intellectual deficits.

From what we have said, it is easy to deduce that relationships with peers, but also with teachers and parents, are particularly tense, difficult and often conflictual. It is easy for attention disorders and instability to be associated with behavioural disorders, with aggression, outbursts of anger, oppositional attitudes, a tendency to lie, insult or commit acts of vandalism, when they are forced to sit still in their desks or when they are frequently reprimanded and punished. Sometimes they manage to be leaders of their more rambunctious classmates. If aggression prevails, however, they are rejected by peers and adults alike.

"Most of the contributions in the literature have analysed the relational problems of children with ADHD, highlighting how the presence of a deficit in executive functions of inhibitory control - at the basis of the oppositional components (Pfiffner et al., 2005) - frequently triggers a vicious circle in the relationship with other individuals" (Bacchini et al. 2011, p. 621).

In the family, these children run, jump, and climb frantically over sofas and other furniture, while they are in constant turmoil. They turn the house upside down, leaving everything in disarray, for which they are constantly scolded and punished, while the people around them are constantly on edge and are ready to block their every initiative, imagining it harmful to furniture and furnishings. And it is these constant restraints, these repeated reminders and reprimands to get calmer and more appropriate behaviour from them that irritate these children and stimulate aggression and

outbursts of anger in them. Also because, having little tolerance for frustration, they easily lose self-control.

If their self-control is low, their self-esteem is also low, as they suffer endless negative judgements and reproaches, so much so that they are also referred to as 'unbearable children'.

In youth, this instability is compounded by risky attitudes and behaviour, such as the use of cigarettes, drugs and alcohol, as well as self-harming and anti-social behaviour: young people are arrested twice as often as others; young people are convicted of serious crimes, five times as often as others; and they serve nine times as many prison sentences as other young people.

Their troubles continue into adulthood. At this age they are often dismissed, they are forced to change jobs frequently and, if married, their family and couple relationships are difficult and conflictual.

Unstable fakes

It is necessary, however, to clearly distinguish unstable children from those who are not unstable at all.

1. *Lively children are not unstable.* Liveliness is a physiological condition of childhood, related to temperamental differences and gender. Boys move more than girls and some children are genetically more lively than others. But, as Oliverio Ferraris (2005, p. 56) puts it: *'the problem is that being lively, in urban living conditions, poses problems that once did not exist or existed to a much lesser extent. Children and young people could let off steam in wild outdoor and group games and were not forced to lead sedentary lives, alternating between school desks and the home television set'.* Unfortunately, in today's family and urban environment, there is little opportunity to express normal childhood vitality without incurring constant reprimands and punishments!

2. *Children with mental retardation are not unstable*. They only appear as restless in the eyes of teachers and parents because they are mentally younger than their chronological age and, therefore, still have the vivacity of all young children. Moreover, these children often become impatient when they are forced to remain in a classroom that is not suitable and appropriate for their linguistic and cultural development, so they are forced to engage in activities that are not appropriate for their mental age. These schoolchildren with mental retardation would not behave as 'unstable' if only they could have the space and time appropriate to their mental age, as well as tools and teaching methods that are appropriate to their intellectual and cognitive development.

3. *They are not unstable children forced to sit for hours on end in their desks,* without the possibility of enjoying a long and healthy recreation in the open air. Recreation that could allow them to discharge the psychic and motor tension that has accumulated in the confined environment of the classroom, also due to the continuous focus on teaching activities. Their behaviour should not be defined as unstable but as *impatient*: rightly impatient towards a non-physiological school practice that, unfortunately, is becoming increasingly common in our classrooms.

4. *They are only* ill-behaved, in the literal sense, those children whose restless behaviour is continually reinforced by incongruous or over-permissive attitudes on the part of their parents and sometimes even teachers.

5. *They are not unstable, finally, those children who are victims of teaching that is so boring and pedantic* that it encourages them to run away as their only chance of salvation, lest they die of tedium!

Attention disorders

In children suffering from motor instability, we also frequently find attention disorder.

Attention is a very complex concept, so we will try to simplify it as much as possible. Galimberti (2006, p. 219) defines it as 'the capacity to select stimuli and to put into action the mechanisms that store information in short- and long-term memory stores'. Attention involves various capacities.

Meanwhile, successful attention requires responding only to the relevant aspects of a task or situation, ignoring the non-essential ones *(selective attention)* (Silieri et al., 1998, p. 8). This ability to focus only on certain stimuli considered important, leaving out the others, depends on the characteristics of the stimuli, the subject's internal needs, expectations and past experiences (Galimberti, 2006, p. 220). Depending on the combination of these elements, different levels of attention occur among different individuals. Since this capacity allows for the selection of certain stimuli while neglecting others, it is closely linked to learning: "I learn what I am interested in learning and nothing else" (Galimberti, 2006, p. 221).

In the concept of attention we also find the ability to keep it on one stimulus and not to disperse it (*sustained attention)*, but also the ability to divide it simultaneously over different stimuli when necessary (*attentional capacity*). In order to then be able to fix the information in memory, *concentration* is indispensable.

While attention reveals a state of receptivity that allows perception and acquisition of information, concentration is selective and directs attention towards specific information, thus allowing

the information to be fixed (Oliverio Ferraris, 2005, p. 70). It is evident that the more the child concentrates on a piece of information, the greater the trace that this piece of information will leave in his or her memory and the better the learning will be. To do all this certainly requires great efforts of will, but also considerable inner serenity.

Attention disorders can be temporary such as *inattention, distractibility,* or structural such as *aprosexia* (Galimberti, 2006, p. 221).

Inattention is a temporary reduction in attention due to physical or mental fatigue.

Distraction is an interruption of attention due to the action of other stimuli unrelated to this activity.

Distractibility, unlike distraction, which is temporary, is a subject's natural propensity to be distracted. Distractibility is normal in children, but can be a symptom of maladjustment if prolonged and when associated with other disorders.

Aproxyxia is the structural inability to maintain attention: because ideation is rarefied; concentrated on a few themes, as in depressive states; because it is overabundant, as in manic states; due to an excess of emotions or affective charges that interfere in the thought processes, or due to the presence of fixed ideas, as in phobic-obsessive states, which impose themselves in a forced way on consciousness, reducing the possibility of attention' (Galimberti, 2006, p. 221).

Self-control skills

In both psychomotor instability and attention disorders, *self-control skills* are severely lacking. According to Galimberti (2006, p. 252): 'Self-control is the ability to dominate, select, coordinate, or inhibit one's affects, desires, or drives, so that one's conduct

does not jeopardise the attainment of one or more goals considered highly desirable for oneself. It requires a deferral of immediate pleasures and gratifications'.

Unfortunately, this is not always possible, even if the goal to be achieved is also desirable and attractive. It is not always possible when the anxiety, inner tension, aggressiveness, destructiveness and fears present in the child's soul exceed his or her capacity for self-control, so that, although he or she wants in every way to be calm, good and good, so as to please his or her parents and educators, he or she cannot control the drive of emotions that are too intense for his or her possibilities. Nor, on the other hand, is this feasible when the child's image of his parents, educators, but also of the world around him, is considerably negative. In such cases, pleasing one's parents, educators and the world, means even more submitting to someone or something that he thinks has harmed him and that he fears will continue to harm him in the future.

When the child exercises maximum self-control*, there is inhibition and coercion*. When, on the other hand, he exercises very little self-control, *extreme impulsiveness* occurs. The latter is defined as the disposition to behave hastily and violently, so as to respond quickly and without adequate reflection to a stimulus. This acting in an immediate manner and without adequate reflection results in considerable difficulty in foreseeing the consequences of one's actions.

There are various types of impulsiveness:

- *motor impulsiveness*, which is expressed through poorly controlled motor activities;
- *cognitive impulsivity*, when there is a lack of concentration on the task and a tendency to make decisions too quickly;
- *unplanned impulsiveness*, when there is a poor assessment of the consequences of one's acts or words, and, therefore, lacks proper planning.

The causes

Organic causes

In psychomotor instability, a minimal brain dysfunction or hypofunctionality of the dopaminergic system has been hypothesised.

Environmental causes

The environmental causes are psychological distress, which manifests itself in children, especially boys, through the body and through excessive motor activity.

Careful examination of the living environment of these minors reveals the presence of emotionally difficult environmental situations to deal with and manage. According to most studies carried out in this regard, the most frequent cases of psychomotor instability and lack of self-control have been identified in subjects who have had critical, intolerant and devaluing parents. In such environments, we often find family disagreements, separated or divorced parents, or parents who, while remaining under the same roof, frequently attack each other without being able to have a serene and constructive dialogue. In the living environment of these children we find experiences of institutionalisation or traumatic or prolonged hospitalisation. We observe the presence of chaotic family lives, with exaggerated work rhythms. We note frustrations and traumas suffered by the children due to psychological problems present in their parents, resulting in frustrating educational attitudes that are inadequate to their needs. At other times, these are children who have been forced to leave the warm and safe family nest early, to be placed in institutions such as crèches or baby parks, in which they have found themselves uncomfortable due to the presence of unfamiliar adults and minors, with whom they have not established any important and solid emotional ties.

However, there are also more specific causes that can lead to this type of symptom:

- *the excessive use of electronic tools* such as TV, video games, I Pods, IPad. These tools limit free and spontaneous play in the open air, dialogue with peers and adults, exercise, contact with nature. They also prevent moments of inner silence and reflection. These are all fundamental experiences for a healthy and serene human growth;

- *inadequate school environment*. Unfortunately, school often contributes heavily to these symptoms. Too many hours of lessons, too little time devoted to motor activities and recreation accentuate anxiety and tension, resulting in disturbing behaviour, which is followed by reprimands and punishments that accentuate the child's malaise;

- *excessive time spent on educational activities at home.* When the child uses a large part of his or her extracurricular time to carry out additional school-type activities, the right balance between intellectual commitments and physical activities, the latter being made up of play and movement, is altered. These activities are equally indispensable for the physical and psychological well-being of children;

- *the relationship with over-stressed parents, teachers and educators.* Very often the child is forced to relate to adults worn out by work commitments, hectic city life, and unrewarding family and marital relationships. These adults resent normal childish vivacity, especially that of males, so that scolding and unjustified punishment of normally lively children is easy. This is unfortunately followed by a worsening of the child's

psychological state, with the emergence of real psychomotor instability;

- *the presence of accentuated congenital vivacity*. When this is poorly tolerated and not well managed by the child's living environment, it triggers inadequate responses, consisting of constant reprimands, restraints and punishments, resulting in a pathological type of instability;

- *the non-acceptance of different gender-specific needs*. The non-acceptance of gender-specific needs in the school environment forces teachers to have an identical educational and training programme. This significantly penalises little boys who, by their nature, would need more motor activities and free play, carried out in the open air, than little girls;

- *the poverty of the family and friendship network*. A lacking, frayed, sometimes absent family network prevents children from those daily exchanges and games, both with other children and with adults, that are precious for psychological well-being;

- *the organisation of life in city neighbourhoods*. A city life organised predominantly around work and economic activities, which clearly neglects children's needs for play and movement as well as their relational and affective needs, is not indifferent.

Interventions

- In the meantime, it is good to drastically reduce the use of electronic devices and, at the same time, it is important to

encourage free and spontaneous play in the open air, dialogue with peers and adults, and contact with nature. Reducing the time spent on electronic devices can allow for valuable activities such as reading, as well as the possibility of enjoying the pleasure of inner silence and reflection.

- Set and delimit the time to be allocated to schoolwork. Time that should not exceed two to three hours per day. Furthermore, the hours dedicated to this activity should always be alternated with moments of leisure and free play.

- The use of psychostimulants to treat instability, as is frequently done in the United States, may modify this symptom momentarily in a positive direction, but does not resolve it. The results obtained are rather discouraging in the long run. In children treated with such psychotropic drugs, there was no evidence of better social integration or attainment of higher levels of schooling than in controls.

- It is important to give these minors the opportunity to play in large spaces, because in these their exuberance is greatly diminished.

- Since these children become considerably calmer if all their initiatives are not continually blocked, through reprimands or repeated threats, you have to be able to make them feel that their exuberant needs are understood and accepted and that you are willing to play with them, helping them to discover, manipulate and use objects and the world around them in the best possible way. Very useful in this respect is the technique of *Free Self-Directed Play*.

- Educational activities in the school environment must necessarily take this reality into account; they must therefore

be very short, varied, gradual and interesting. These activities must also be interspersed with moments of free play.

- Suggestions to parents to improve erroneous educational attitudes, so as to offer the child the right physical as well as psychological space, but also to reduce excessive parental control, possible emotional deficiencies and insufficient attention given to the child's needs, are fundamental.

- When combined with other interventions*, the behavioural approach,* in which the child is rewarded when he or she achieves certain goals: for example, when he or she demonstrates more attention and less hyperactivity, can certainly be useful.

- *In the systemic approach*, these children are seen as scapegoats for family conflicts or anxieties, for which family therapy is adopted;

- *Couples therapy* is useful when a state of conflict in the parents is present.

- *Psychomotor exercises, music therapy, relaxation therapies and analytical psychotherapy* are also used in this type of problem.

- In the school environment, a number of strategies are recommended to maintain attention, such as directly and frequently involving the children presenting these problems by trying to connect to the personal experience of these pupils, grasping and valuing their specific interests. Teachers are also advised to modulate the tone of voice so as to attract their attention more strongly, as well as to reward these individuals a great deal. Alternative learning

tools such as *cross multiple-choice cards, research and planned learning* are also useful.

Disobedience

The disobedient child has little adherence to the other's requests, has difficulty involving him/herself in shared activities, has little respect for rules, has oppositional behaviour, to which correspond, if parents and educators want to force the child to do as requested, fits of rage (Militerni, 2004, p. 105).

This behaviour, whereby the child refuses to submit to demands given by parents or another authority, is considered by psychoanalysis to be characteristic of the anal phase of psychic development (second to third year). At this stage, the child needs to differentiate his or her ego from that of the mother and the caregivers, so as to have his or her own autonomy and, consequently, greater control over himself or herself and the outside world. At this age, therefore, this type of behaviour should not be assessed as pathological, neither by parents nor by other educators. Instead, this symptom should only be worthy of attention if it is detected abnormally at a higher age.

We find disobedient behaviour in many children with various other signs of distress: children with fears, hyperactivity, irritability; children with attention disorders or oppositional defiant disorder. The peak of disobedience is, we believe, in children with pervasive developmental disorder. These seem not even to hear the requests made by others, so they continue imperturbably in the activity or game undertaken and when forced to stop, they respond with irritation and aggression. In these children, if the pathology is very severe, this symptom is better accepted by educators and parents, as the obvious handicap justifies it; if, on the other hand, it is present in children with high-functioning autistic disorder, the lively intelligence, together with the remarkable abilities in remembering, calculating and spontaneously carrying out complex

activities, provokes in parents and teachers, clearly negative judgements, as well as expressions of annoyance with threats and punishments, since they are judged as very capricious and insubordinate children to be brought into line by means of punishments, rather than as little beings upset by serious psychological problems.

Interventions

1. Isaacs (1995, p. 89) advises, meanwhile, to divide the demands made on the child into three categories:

- *things for which we demand absolute obedience.* In this case, if our request is wise and useful, it is good to act firmly, even if gently and affectionately. It is important, however, that these requests are not numerous and frequent as, if they were, we would constrain the child excessively, considerably limiting his or her possibilities of judgement and choice, so we risk nurturing in the child either excessively weak and inhibited behaviour or, on the contrary, aggressive, oppositional, destructive and rebellious attitudes.

- *Things in which we have hopes and preferences we suggest directly or indirectly but do not impose.* In this case it is good to make it clear to the child what, in our opinion, are the best choices, but we avoid imposing them on the child.

- *Things in which we leave the child free to choose.* In this case we joyfully accept his choices without burdening him with the fact that we would have done otherwise.

2. When making requests, it is useful to remember that the child has a different view of time than we do. That is why

we try not to suddenly get in the way of the activities in which he is engaged. When we need to ask him for something, let him know in good time so that can complete what he has already started. If parents want to do everything in a hurry, they will end up with a child who will not cooperate.

3. After making sure that what we ask is right, we use an attitude in our requests in which firmness is combined with gentleness, affection and trust, so that he feels our esteem, our respect but also the trust we have in him. Trust that what we have asked he will do. If we remain calm, affectionate and trusting, it is much easier for the child to obey our requests; if, on the other hand, there is already the preconception within us that he will behave disobediently, he will feel our lack of trust in him, but also our anger and rage ready to manifest itself, so that he will interpret what we ask of him as a violent, unjust imposition. It is therefore certainly counterproductive to shout. When parents shout, children only obey because they are frightened, but this frightening upsets them, so in the future they will tend to live even more in their own world and see their parents as bad enemies, and will therefore obey less and less.

4. Let us also bear in mind that in a relationship with a child it is good not to consider every momentary refusal as absolute disobedience. Sometimes his "no" only means that he has not yet finished what he started, so that after he has finished his game or put his thoughts and emotions in order, his "no" may well turn into "yes".

5. If the child manifests an open attitude of defiance, anger and starts throwing tantrums, it is not helpful to scold him. It is much better to wait for him to calm down and then

make our request again, always very calmly and affectionately. The important thing is to make sure he does not achieve anything with his tantrums (Isaacs, 1995, pp. 92-93).

6. To distinguish what is capricious from what is not, we must necessarily listen to the child's inner experiences. If the child is psychologically disturbed and therefore anxious, tense, tired and nervous, he will certainly not be able to respond promptly to our requests. Our task, in these cases, is not to impose our discipline and make him obey us at any cost, but to make him more serene, so that he can have the possibility and the ability to be obedient, without making a considerable effort on himself. If, in these cases, as often happens, we make violent impositions, we risk accentuating his discomfort and, therefore, we risk worsening his entire affective-relational life, including his disobedient behaviour. We have said that the maximum of disobedience is found in the child with autistic disorder but it is no coincidence that in these children we find the maximum of psychological disorders.

The aggressive manifestations of the child

Aggression is always present in human beings and takes the most varied forms according to age. It is present in infants, as in adolescents or adults, although the ways and means by which it is manifested and expressed vary.

Already in the *first months of life*, especially when the habitual sequences are not respected or the usual gratifications do not appear at the right time, the infant, when irritated or dissatisfied, shows its aggression by biting the mother's nipple, clenching its fists, regurgitating or refusing food.

In the *two to four year old child,* anger and aggression manifest themselves when he is restrained, thwarted, frustrated, in his expectations in an excessive way (Osterrieth, 1965, p. 62). At this age, when the mother, in order to clean or because she is tired of seeing him running around the house, isolates him for a few moments in his playpen or in his cot, he, like an angry prisoner, manifests his indignation by slamming toys on the playpen or cot. Other children, in their desire and pursuit of harm, attach themselves, tearing at their mother's or sister's hair. However, with affective-relational maturation there is a gradual decrease in the use of aggression or its prevalent use in symbolic play. As Spok (1957, p. 423) puts it:

"A normal child learns to control himself little by little as he grows up, through manifestations of his own nature and good relations with his parents. At the age of one to two, when he is angry with another child, he is capable of biting his arm without a moment's hesitation. But by the age of three or four he has already learnt that violent aggression is a bad thing, but he likes to pretend to kill by shooting a hypothetical Indian'.

For Bollea (1985, p. 267), the development of the aggressive drive goes through three stages:

a) *At an early stage*, the child does not realise the harm that his or her hostile acts can do to another person.

b) *In the second stage*, the child perceives that the other receives harm because of his activity, but he does not care and, if anything, is happy to have exercised power;

c) *In a third phase*, the child identifies with what the other feels, perceives that the other feels pain like him and anticipates the mother's negative judgement of his aggressive activity.

In early and later childhood, motor aggression prevails, whereby, during school time, children storm the person from whom they have received frustration with their fists. Often, however, they also attack younger and weaker children: such as little brothers, little sisters or schoolmates who are more fragile and less aggressive. *Towards the end of childhood*, verbal aggression is added to physical aggression.

However, overall, as affective-relational maturation proceeds, all aggressive manifestations, both verbal and physical, tend to diminish as the child is increasingly capable of greater emotional and rational control.

The various types of aggression

Physiological, pathological and apparent aggressiveness

Just as the most peaceful and helpful adult can become aggressive if provoked, so too the most contented and happy child can have his moments of anger and defiance and his urge to destroy and hurt (Isaacs, 1995, p. 75). There is therefore also in the child a physiological aggressiveness, used to defend his body, his life, his rights, his needs, and there is a *pathological aggressiveness*.

In children, aggression is pathological:

- when for his age he should have a good awareness of any suffering inflicted on others;
- when he attacks persons or things that have not caused him any harm, nor threatened his physical and/or moral integrity, nor attempted to take possession of his property;
- when the reaction to the negative behaviour of others is excessive and disproportionate;
- when it tends to interpret as aggressive behaviour and attitudes that are not aggressive;

There is also *an apparent aggressiveness* that manifests itself, for example, when children use small animals, especially insects, worms, snails but, in some cases, also larger animals, such as chicks, cats and dogs, to play, but also to satisfy their curiosity and desire for possession. For example, when small children pull the wings off flies, crush worms, dismember butterflies, torment kittens or puppies, pulling their tails, rolling them around, carrying them from one part of the house or garden to another, as if they were made of fluff, it is by no means certain that these are manifestations of aggression or cruelty. They may just be behaviour for the purpose of play, knowledge, understanding or possession. Apparent aggression is also that of siblings who fight when they have nothing to do at home, or that of boys who fight, wrestle and chase each other at school break to play and to prove their strength, virility and dexterity, but also to vent repressed energy. Even in these cases 'appearances can be deceptive', so it is much better to avoid intervening, punishing but also worrying excessively.

Aggressive manifestations

The child may manifest aggression through *motor activities*: biting, hitting, slapping, kicking and punching, spitting at people, animals or objects.

If the child has the possibility of language, aggression may be expressed verbally, including through the *use of words and phrases* that may offend, insult or hurt those in front of him/her. In some cases, on the contrary, the child achieves the same purpose *by ignoring*, sometimes for hours and days, the person or persons he or she wants to hurt.

Naturally, the greater the aggression, the more frequent are the conflict situations both with adults: family and teachers, and with peers. Integration and socialisation processes are therefore greatly impaired and limited.

Other manifestations of aggression are related to *oppositional and negativistic behaviour*. Children who use this type of behaviour persist in systematically and categorically refusing any request made to them, even if, at times, they are proposals that should be pleasant and congenial to them. With such behaviour, the child manages to slow down or boycott the demands and needs of those whom he or she wants to hurt at that moment.

If the aggressive child is placed at school, his behaviour often creates havoc in the class group and sometimes also in the other school environments. The school becomes a place of threats, insults, aggression, damage and provocation for him. His impulsive and violent attitudes lead him to react angrily and angrily when confronted with even the slightest opposition, as well as to beat his classmates and adults and break his own and other people's objects. Sometimes, and today this happens more and more frequently, these children manage to involve their parents in their dysfunctional behaviour, who are urged to act against teachers or their classmates, thus undermining and destroying the alliance that should always exist between the school and the family, as well as between the various families of the pupils.

Gender differences

As far as gender differences are concerned, girls' and boys' quarrels are handled very differently. While the former mainly use words, moral blackmail and behaviour of emotional rejection and dialogue to hit others, the boys' aggression is expressed in a direct manner, so they tend to defend themselves and attack each other physically rather than verbally. While boys attack their mates mainly with fists, slaps and kicks, girls prefer to use bad language and innuendo to hit their opponents and, above all, their 'adversaries'. Moreover, in the use of swearing, males clearly prevail over females. This behaviour leads parents and teachers to punish boys more harshly than girls.

These gender differences were more present in the past, when different education between the two genders was prevalent. In this period, both due to the very similar type of upbringing between males and females, and the constant frequency of one sex with the other, these differences have diminished somewhat. It has been noted that in mixed classes, which are clearly prevalent in Italy, the use of swearing, explicit threats, but also hand-wringing by girls has increased considerably, compared to when classes were divided by gender.

The causes

The causes of aggressive manifestations can be manifold.

1. *Aggressiveness as a need for growth.*
2. *Aggressiveness as a sign of suffering caused by a deep inner conflict.*
3. *Aggressiveness as a search for dialogue.*
4. *Aggressiveness as defence of one's rights.*
5. *Aggressiveness as the need to defend oneself against the behaviour of others that is deemed harmful.*
6. *Aggressiveness as a need to defend loved ones.*
7. *Aggressiveness as jealousy.*
8. *Aggressiveness as competition.*
9. *Aggressiveness as emulation.*
10. *Aggressiveness as a desire for possession.*
11. *Aggressiveness as an expression of guilt.*

12. *Aggressiveness as a consequence of an unsuitable educational style.*

13. *Aggression as readiness and defence of one parent against the other.*

1. Aggressiveness as a need for growth

The child needs to grow and affirm its ego, its will, its desires, its autonomy. It is through self-assertion that the child's ego is distinguished from the ego of its parents and from that of other adults or peers. The ability to say 'no' becomes a tool and a means of maturation for the development of his or her identity and personality. Asserting oneself as an individual different and separate from others is, therefore, quite normal during the growth phase. The parent or educator must necessarily take into account the child's needs during this particular period: the need to discover and seek out new objects and different materials; the need to have new experiences; the need to try out objects and living beings, but also the need to test oneself. These needs cannot be satisfied by the usual toys, of which our homes are overflowing: all made of the same material, all built by adults for specific games. Educators should accept and make their own these needs, helping the children in their discoveries and research, joyfully collaborating with them, without hindering them with continuous 'no's', which mostly arise from prejudices and unjustified anxieties. In these cases, the most frequent phrases heard are: "This is dangerous: don't touch it"; "This is not suitable for you"; "This is dirty"; and so on.

Because of this, the child feels blocked in all his initiative, creativity, freedom of movement and discovery of the world and reality around him. This being blocked and limited creates frustration and anxiety for him, from which aggressive behaviour can arise.

When parents and educators notice that the child's expressions of aggression arise from his desire for discovery and the need to acquire greater autonomy, they have a duty to teach him the best ways to assert his needs and individuality, without using behaviour that worsens the relationship with him.

On the other hand, the child must also gradually accept that there are games and activities that he can do and others that he cannot do. He has to accept that there are objects that mum and dad can allow him to use in his own way and if necessary even break, just as there are objects, considerably dangerous or expensive, that parents have a duty to deny him the use of. But even in this case, the child needs to feel that dad and mum are pleased with his need to discover new objects and new games and that they participate with pleasure in his adventures.

The child needs to know that his parents have great respect for his needs, so that if they say "no" to a toy, they are ready to offer him other toys in exchange; or they are ready to assist him in using the toy of his choice, in the best and safest way. He also needs to feel that those close to him are willing to make arrangements; that the needs of the one do not conflict with, but may well marry the needs of the other; and, finally, that if the rules and prohibitions are few and fair, they can be accepted.

The contrasts from which aggression can arise as a need for growth and autonomy, are more frequent when the child is entrusted predominantly or especially to the mother or other female figures. These, by their nature, tend to limit and over-protect children, rather than stimulating them to make the best use of new and different tools and materials. This overprotective and limiting attitude is accentuated when the child is cared for by persons who, either because of their psychological problems, or because of their age or role, tend to easily see non-existent dangers and impending misfortunes in the child's every behaviour.

2. *Aggressiveness as a sign of suffering caused by deep inner conflicts*

From the earliest months of life, the child has a dual attitude towards the world, and therefore towards his mother, father and other family members: on the one hand, there is love, when they understand, accept, console and defend him, showing respect, affection, esteem, consideration and attention towards him; on the other hand, he may feel resentment, anger and even hatred, when his mother, father or other family members do not understand or do not fully satisfy his deepest and most essential needs. This may occur, for example, when they do not gratify his behaviour, when excessive rigour rather than love and respect prevails in his upbringing. Resentment, anger and hatred, the child may also manifest when forced to live in a frequently conflictual climate: in an environment in which tension prevails rather than serenity, discord rather than concord, impatience rather than acceptance, disaffection rather than mutual esteem.

According to Bollea (1985, p. 267): 'Aggression can give rise to negative and later destructive behaviour only and essentially as a reaction to an external or internal conflict, a conflict that, depending on the developmental period in which it arose, fixes, in part, the mode of aggression proper to that period for subsequent periods.

These children are often referred to as *'touchy children'* because, being very sensitive to the judgement and behaviour of others, they are very easily offended and angry. When everything is going well for us, when our soul is peaceful and content, we easily accept the frustrations that life inevitably brings. This is not the case when our soul is troubled and suffering shakes our heart. In such cases, even the slightest frustration becomes unbearable, so we reject it vigorously, as it upsets the already precarious balance of our psyche. Susceptible children easily become bad-tempered, tend to be very critical of others, do not accept jokes, and

easily withdraw into themselves. Since they are very sensitive to tone of voice, attitudes, expressions, their social relationships are difficult.

In all circumstances, in which the child's living environment is not in keeping with his or her needs, the aggression manifested signals not only inner suffering, but also the need for revenge for the suffering endured, which is momentarily alleviated through aggressive behaviour.

Destroying, for example, at school, what is dear to other children, tearing up their notebooks, breaking their pencils, hurling erasers at them, offers momentary relief to the inner anguish of these children. We said momentarily, because this type of manifestation triggers a vicious circle of reprimands, notes in the register, expulsion from class and school, punishments, expressions of dislike by teachers and classmates. All this, in turn, only increases the child's suffering and, consequently, further aggressive and/or destructive behaviour is fuelled.

In these cases it is necessary to break this unproductive circle: eliminating everything that makes the child feel bad and establishing a new and different relationship with him. A relationship that allows him to express and manifest, through dialogue or play, his pain, disappointments, intimate suffering, guilt, aggressive and destructive thoughts. In these cases, it is ultimately necessary to establish a relationship that allows him to trust others, life and the world.

Finally, since among the factors of the behavioural disorders the psycho-environmental factors predominate, and among them the 'psychology of the relatives, or rather, in some cases, the psychopathology, not only of the parental figures but of the entire family unit and its degree of interaction in the surrounding environment' (Mastrangelo 1975 p. 249), psychological help to these parental figures through appropriate psychotherapy is often indispensable.

3. Aggressiveness as a search for dialogue

Behind some of the belligerent and warlike behaviour of children, there is often a desire for attention and listening. The child, in these cases, misbehaves to communicate those needs that have been neglected or not taken into proper consideration. These are messages such as: 'I am tired, I need to get away from others and be taken to my room and my cot to rest'. Or: 'I need cuddles from mummy and daddy, who have been busy all evening listening to others and neglecting me'. Or: 'I miss playing with Mummy and Daddy, who are too busy working. I miss being able to listen to their fairy tales and talk to them, rather than always being in front of the TV'.

In all these cases, what is there to advise parents but to listen to and meet the needs of their children?

4. Aggressiveness as defence of one's rights

Man, like all animals, possesses the instinct to protect what is his, what is dear to him, or what is indispensable to his physical and mental health.

Attacking those who threaten us, those who take something important from us or disregard our feelings and needs, is an instinctive behaviour that is fundamental to the survival of the individual and the species. This type of *physiological aggression* ceases when the threat is absent or diminished.

For example, the aggression of the older sibling towards the younger one when the latter, taking advantage of the parents' protection of him, steals toys from him and runs away or worse, throws them away and breaks them out of spite.

There are other rights that the child seeks to defend. For example, the right to face life and the encounter with adults and unknown peers, with the right gradualness: "You took me to kindergarten without taking into account my fears and my suffering:

now it is my turn to make you suffer". The right to live in a peaceful environment: 'I cannot stand your shouting, your bickering, your screaming, your mutual accusations'. The right to have adult and responsible parents: "I don't accept that my mother brings her boyfriends into the house, forcing me to respect and welcome them as if they were family members or even as if they were new fathers, while to me they are just obnoxious people who appear for a while, only to disappear, suddenly, for no apparent reason, leaving me increasingly alone and confused".

In these situations, it is necessary to be able to listen to the child's reasons, before deciding to think that, in any case, those who show aggression are always wrong and therefore deserve reprimands and punishments.

This does not mean that one must accept every aggressive attitude, but that it is the duty of adults to understand whether, and for how long, the child has been deprived of some of his rights. A right that he now claims by means that are certainly striking, but understandable, given his age. Fortunately, when we listen and make an effort to understand his motivations, so as to offer him or give him back what was unjustly taken away or denied to him, very often these negative attitudes disappear as if by magic.

5. Aggressiveness as the need to defend oneself against the behaviour of others, deemed harmful

When children are placed in school communities and in social or sports groups in which peer relationships are characterised by prevaricatory and violent attitudes, it is easy for minors to feel compelled to use the same negative ways as other peers, in order to defend themselves or self-protect. These behaviours can also be carried out by serene and responsible children who come from families in which violence in relationships between people is excluded. When teachers and educators generally become aware of this, punishments and repressive individual or group attitudes are

of no use. In such cases, one has to start thinking about why this climate of violence has been created, and what the best educational programmes can be for the whole group concerned with the problem. It is always worthwhile to achieve the goals of a healthy and peaceful coexistence, even if a considerable amount of time and energy must be committed to achieve this.

6. Aggressiveness as a need to defend loved ones

Children often find themselves in the need to defend people who are dear or important to them, such as mothers and fathers, their brothers, sisters, friends, from those who try to besmirch their name or dignity. Unfortunately, in conflicts between children, insults towards each other's parents are frequent: 'Your mother is...' "Your father is ..." "You are the son of ...", to which the child feels compelled to respond with other insults, threats or manhandling behaviour. Less obvious and explicit is the child's defence when it is a family member who insults and speaks ill of another family member: mother against father, grandmother against son-in-law and vice versa. In these cases there is usually no immediate belligerent response against the offender or accuser. More often a strong resentment arises, which is, however, kept concealed. Resentment that will only manifest itself on other occasions, provoked, at times, even by trivial and futile motives, in the form of pseudo-hatred or explicit irritating behaviour. Even in this case, before reacting to the child's aggressiveness with such violence, it is good to try to understand what is troubling the child's soul and to correct one's own or others' behaviour.

7. Aggressiveness as jealousy

Jealousy, and thus rivalry, can be evident both towards other children and adults. One can be jealous of a new-born baby brother or of a particularly well-liked baby brother by one or both

parents. One fears that the little brother will usurp one's predominant role. One can be jealous of one's classmates because they are better or more popular with teachers. One can also be jealous of one or both parents when, as is increasingly the case today, after separation or divorce, Dad and Mum start other 'stories' with new 'friends and girlfriends', 'boyfriends or girlfriends', 'husbands or wives'.

Pathological jealousy frequently affects insecure children: insecure of their own qualities, insecure of their parents' love and presence, insecure of the goodness of others, but also of the world around them. In these cases, the goal must be to restore the child's self-esteem and rebuild trust in their parents and others.

8. Aggressiveness as competition

We know that contention and confrontation in the family, at school or in sport tends to bring out considerable violent attitudes. Frequently, unfortunately, competition is artfully provoked, in the family by parents, at school by teachers, in sport by coaches. To be the best of classmates, to get the highest mark, to be the best in school, to win and humiliate opponents in sports competitions, are seen by adults as the best way to stimulate children's abilities to the maximum. In order to get the maximum drive and motivation from the children, so as to achieve the set goals, adults do not spare the use of distinctly aggressive language. This childish attitude on the part of educators takes no account of the fact that a child's abilities and maturity are not measured in grades or sports victories! On the other hand, we do not think it is appropriate to add new aggressive stimuli to those already abundantly present in television programmes, films and video games!

9. Aggressiveness as emulation

The child learns and then imitates the attitudes and behaviour that he sees in his living environment. It is therefore not difficult

for him to reproduce the violent behaviour he observes around him. In these cases, aggression arises from modelling himself on the behavioural style of those closest to him or of the person with whom he identifies. This is why adults have a duty to constantly set a good example in controlling their impetuosity.

The same happens in adolescents who are included in the 'pack', who, conditioned by the rules present in the group, have considerable difficulty controlling their violent behaviour and attitudes. In these cases, the individual feels relieved and deprived of responsibility for personal decisions, since he or she feels the duty to accept the decisions made by the leaders or the majority of peers. For these reasons, the juvenile does not act aggressively out of frustration or to discharge excessive anxiety, but to adhere to a group logic, which sees violence as necessary and consistent with the needs of the group itself.

Emulation is, unfortunately, not limited to seeing the behaviour of other adults or peers in his or her real life, but can also involve the attitudes observed on TV, in films and video games. Often, without parents, who are too busy or absent, being able to act as a filter, minors are in contact with representations in which aggressiveness and arbitrariness are the masters. In many TV programmes for many years, models of heroes without fear but also without mercy and without any willingness to listen and understand others have prevailed. The adult to be imitated is quick, strong, self-confident, but very often also remarkably violent and lacking any feeling of pity towards 'enemies'. To the spectacles of TV and films are added video games, where destroying the other, with all the weapons at one's disposal, is almost always the basic rule of the game, so that in the long run attacking and destroying become 'normal' attitudes, pleasant and fun in the lives of minors. This kind of violence reduces inhibitions and certainly does not educate to the need to seek and find alternative solutions to problems and conflicts between human beings.

As can easily be understood, the negative influence of these communication tools is all the greater the younger the child is, since, given their immaturity, they do not have the possibility of critically processing the messages they receive, just as they are unable to correctly discriminate the differences between real life and fantasy. Suggestibility is also significantly greater in children, adolescents and young people with psycho-affective problems, which make them more fragile and suggestible.

The prevention of this type of violence should certainly be implemented in schools and in the family but, the greatest responsibility lies with society. It is the state that has the regulatory means to prevent the violence represented from entering the homes, rooms and souls of minors, but also of adults, at all hours of the day and night.

10. Aggressiveness as a desire for possession

The motive of possession originates from the impelling childish desire to exercise power and to demand for oneself a position of greater control over others, or to exclusively possess an object or a role.

The child who snatches the ball from his weaker, defenceless little brother tends to exert power over him, because he feels bigger and stronger. In the same way, however, a small child, through weeping, wailing and shrieking, makes his mother, in order to indulge him, take away the desired object that belongs to his older brother to give it to him. Also in this case, albeit indirectly, the younger child uses, through his mother, a power over his older brother.

Controlling and educating this desire for power is possible, not only by words, but also by the example of adults.

11. Guilt aggression

When the child feels a strong sense of guilt and shame, he tends to attack not only those who generated this feeling, but also those who innocently stand in his way at that moment. When parents but also teachers or other adults induce feelings of guilt in the child with words or behaviour, the child feels the guilt as a wound, which needs vindictive and aggressive behaviour to be healed in some way.

12. Aggressiveness as a consequence of an unsuitable educational style

There are educational styles in which the values of welcome, brotherhood, love, acceptance and gift are transmitted to children, but there are unfortunately also educational styles in which disvalues are transmitted: such as violence, bullying, arrogance and exploitation of others for one's own ends. In these cases, the erroneous principle of responding 'an eye for an eye and a tooth for a tooth' to what is suffered is constantly emphasised. There are also educational styles in which parents constantly and frequently use psychological, moral or physical punishment. These erroneous educational styles urge the acceptance and use of force and violence on many, too many occasions in one's life. If these are the reasons for the aggressiveness of the child in question, a radical change in the parental education style is called for, including through long and constant family training.

Arguments between children

Arguing expresses, through words and gestures, discomfort with another. Often the quarrel is not preceded by any reflection but is immediately triggered by an interpersonal conflict: "He should not have said those words to me". "She should not have made that gesture towards me". "He should not have taken my things away from me". And so on.

Children quarrel mainly over the possession of a toy or over a different way of playing. These disagreements allow them to learn to accept the limits that others, life and the world impose on their needs and will.

Arguments between children are significantly different from those between adults. Meanwhile, they are much more frequent. There are children capable of 'bickering' ten times a day and 'making up' just as many times. And after making up, children are ready to play together again 'as friends as before and more than before'. For Berberi (2013, p. 60), children 'go off on a wild goose chase. But the biggest difference between adult and child quarrels is after the fight: when the acute phase is over, children have a very rapid emotional decantation, negative emotions are immediately extinguished, leaving no aftermath'.

Adults, on the other hand, quarrel more seldom, as they are better able to control themselves and have diplomatic attitudes in their relationships, but with difficulty they are able to forgive and thus make peace. This is because adults' emotions are much more stable, durable and interfere with the relationship. Therefore, in adults resentment and anger can persist for decades (Barberi, 2013, p. 62).

Moreover, children, unlike adults, have a remarkable and innate ability to solve their problems quickly and on their own and do not need the intervention of outsiders at all, as the latter only risk complicating their relationship. Adults, when they do intervene, do so for reasons of justice, to keep the situation under control, out of fear that the children will hurt themselves, to protect and defend the youngest and most fragile child. These interventions are almost always counterproductive because, if not well implemented, they exacerbate the problem. This is why it is necessary for adults to be very cautious and to know when and how to intervene, leaving it up to the children, as far as possible, to resolve their conflicts. When adult action is necessary, since they

sense the presence of a real and imminent danger, it is good that their intervention is carried out in a serene, controlled and calm manner, without ever adding aggression to more aggression, through beatings or punishments, without looking for the culprit and without imposing solutions. Agreements between children come about more easily if they are managed by themselves, since the child when faced with the others' resistance is forced to find an alternative (Barberi, 2013, p. 66). However, adults will later undertake to teach their furious children the best and most tested ways not to fight: learning to respect turns, accepting compromises, deciding on rules before starting the game, accepting the eventual victory of the opponent in a sporting spirit, and so on. Rules that children will be eager to apply to settle their disputes.

Sometimes children, as well as adults, provoke the quarrel in order to have the opportunity to express and manifest frustration, tension and repressed aggression through this behaviour, due to the stress accumulated in the relationship with the living environment.

It should be kept in mind that children's quarrels may only be apparent. Many times what looks like a fight is not a fight at all. It is easy for their fighting, especially when it happens between boys, to be just a way to activate and compare some of their abilities: such as strength, agility, intelligence, dexterity and cunning.

Bad language

Foul language is made up of insults, swearing, epithets, use of expressions referring to human excrement (*scatology)*. The use of foul language is present in conduct disorders, but this symptom, like many other signs of the child's distress, does not have an unambiguous meaning.

The use of swear words can be due to multiple reasons:

- ❖ sometimes it is just a way of surprising and embarrassing the interlocutor;

- In classrooms, swearing can be a way of attracting the attention of other children so that they laugh or are scandalised;
- at other times, children say curse words to make themselves feel grown up; this happens especially when they realise that adults use them constantly in their living environment;
- Not to be underestimated is the use that a child can make of it as a means of defence, towards peers who torment him with offensive and denigrating gestures or words;
- swearing can also be the price to pay for being accepted in a peer group;
- In some cases, swearing is just a way of easing psychic tension.

The problem of foul language does not usually arise in the family environment since, if the parents do not use it at all and if the child has been strictly forbidden to use this type of expression, it is difficult for the child, at least in their presence, to contravene this rule. If, on the other hand, the parents do use this kind of language, they are not so shocked by their child's expressions.

In the school environment, to limit or eliminate this use, teachers should avoid reactions of astonishment, scandal or anger, as students feel a sense of power if the teacher displays such emotions. At the same time, however, in order to avoid imitation and adaptation by other pupils, it is also necessary to nip such use in the bud by means of behavioural techniques such as response reward, response cost, and aversive consequences. Any reprimands and punishments must naturally be adapted to the child's social level, psycho-affective development and social reality.

Lies

Lies are defined as the concealment or false reproduction of facts in order to seek advantageous situations and to avoid difficult situations so as not to cause harm to oneself or others. Children's lies, however, do not always have these characteristics, as the alteration of reality, rather than to gain an advantage, may be carried out solely for the pleasure of fantastic reproduction (Barberi, 2013, Vol. 2, p. 529).

For De Ajuriaguerra and Marcelli (1986, p. 162) there are various types of lies.

1. *Utilitarian lies* serve the child to gain an advantage or to avoid annoyance and punishment. In such cases it is good to detect the lie in order to avoid favouring others in the future, but, on the other hand, it is right to avoid dramatising them, so as not to undermine the child's self-esteem.

2. *Compensatory* lies are lies that serve the child to give others and himself a better image . The child may tell his peers that he is the son of a very rich, very important person, that he lives in a big villa, that he spends his holidays in some tropical paradise, whereas the reality is much more modest. These kinds of lies, which may be normal up to the age of six since they are part of children's narcissistic fantasies, if they persist, have, from a psychopathological point of view, a greater value than utilitarian lies, so it is worth investigating the reasons that may have led the child to use them.

3. *Mythomania.* The height of confabulatory reverie is in mythomania, a condition in which narcissistic support is built on nothing (De Ajuriaguerra, Marcelli, 1986, p. 163).

Sometimes, however, as we can read in this account by a little girl, the lies are provoked by parents who pay little attention to the needs of their children.

A lying child

Once upon a time there was a basket that had been lost and was found by a girl who took it home. The mother doesn't want it and tells her: 'Take it and take it outside'. She brings it back, but because she is smart she takes it back with her and tells mum that she had taken it outside. The mother had doubts that she had not brought it and when the child goes to school she checks and finds the basket. When the child returns home she finds Mummy angry and asks her: "Mummy why are you angry?" And Mummy replies: "Because you lied to me and now you are going to detention".

Mum threw the basket away, but the child did not give up and took the basket back and hid it in the ground and told mum that she had thrown it away and mum believed her and made up with the child.

The interpretation of the story is quite simple. The child finds something important to her, in this case *a basket,* but it could be anything else the child cares about. It could be a friendship, a feeling, a loving emotion, perfectly normal and physiological, but the parent, for no good reason, not only reprimands the child but forces her to deprive herself of what is very dear to her (*The mother does not want it and tells her "Take it and take it outside")*. The child, seeing her mother's unjust request, begins a path of lies and deception *(She takes him (it) back (*outside), *but because she is clever she takes him back and tells her mother that she had taken him outside).* This educational path, made up of unmotivated fights and prevarication on the part of the parent, proves to be absolutely useless and counterproductive, both for the daughter and for the mother *(The mother had the doubt that she had not brought him and when the child goes to school she checks and finds the*

basket). The erroneous educational path continues through punishment and spite (*When the child returns home she finds her mother angry and asks her "Mummy why are you angry?" And Mummy replies "Because you lied to me and now you are going to be punished").*

In the conclusion of this story it seems that the victory belongs to the child *(but the child does not give up and takes back the basket and hides it under the ground and tells her mother that she threw it away and the mother believed her and made peace with the child)*; in reality both contenders come out the losers: the mother as educator who has lost, through her behaviour, the esteem and trust of her daughter and the latter who has learnt to have a false and lying behaviour with others and with the world.

Thefts

One should not speak of theft before the age of six, or in any case before the child has acquired the concept of ownership: 'This thing is mine, this, on the other hand, is Giulio's', but also before that the child has internalised the moral concept: 'This action of mine is good'; 'This behaviour of mine is bad'.

The places of theft change with age. Young children steal at home, when they are older they steal in places the child usually frequents and only later in supermarkets (Ajuriaguerra and Marcelli, 1986, p. 163).

This behaviour is more frequent in males than in females.

The child may steal the objects that most interest him/her at that moment, or he/she may appropriate things that have no value for him/her. From a psychopathological point of view, this distinction is important, as the child may have the 'need' to steal things he does not have and would like to have, or the child may have the need to satisfy an imperious inner need to take from others

what does not belong to him, just for the pleasure of taking something from others or just for the pleasure of possessing something, even though he does not need it and it will never be used by him.

This symptom, too, can therefore have various meanings:

- "I want to have what others have".
- "If mum and dad buy what they want at that time, it is only fair that I also take their money to have the things I like.
- "The others are bad to me, it is only fair that I take away their things to punish them".
- "I like to see the angry faces that other people have when they discover that they are missing items".
- "I take the money or objects of my mother or father who neglect me, to get something material from them, even if I can't have what I would like to have: their attention".
- "It's nice to feel like you can do something bad to other people's beards and not get caught".

For Bettelheim (1987 p. 153): 'Perhaps there is no thing that upsets parents more than theft. And more upsetting than the act itself is that our child may grow up to be a dishonest person. So our reactions are proportionate more to anxiety about the future than to the actual misdeed'. But this is not always the case. For some parents, on the contrary, their child's dexterity is a boast, so that even if they reprimand the child, in their hearts they are proud of his or her abilities.

In this case too, intervention can only arise from knowledge of the child's inner experiences. In any case, it is a good idea not to neglect this symptom, as the child may see these behaviours as something to be proud of and therefore repeat them, with disastrous consequences for his or her future life.

Interventions in behavioural disorders

In behaviour disorders, practitioners and parents often ask themselves whether and how to intervene: whether to punish or console; whether to have an indifferent or permissive attitude.

As we mentioned when discussing the various symptoms, each of them can have several reasons. It is important to find out which is the correct one. If the conduct disorder stems from the child's psycho-affective problems, it is absolutely useless to base our intervention on punishments, reprimands or chastisements. These measures would only worsen the child's inner experiences, which are already considerably disturbed. A child with many psychological problems is unlikely to behave in an exemplary manner plare! To achieve improvements in behaviour, it is necessary to ensure that the child acquires greater serenity and confidence in others and in himself. Efforts must therefore be made to improve the child's self-confidence, but also his trust in his parents, or at least in some adult from whom he can introject a positive image.

If, on the other hand, we feel that this child has lacked effective guidance, the presence of an authoritative but also affectionate adult could achieve good results in a short time. When children lack an adult who gives them precise rules, they feel as if abandoned to themselves. Therefore, manifestations of hostility, bullying and aggression must be dealt with and contained by the adult, albeit without repressive attitudes. External control calms the child and gives him the opportunity to learn to control his hostility and to adapt his desires to the reality around him. In this way, he will feel better protected from his own impulses and the anxiety and guilt that such impulses entail. However, these interventions require the utmost respect. Children should neither be humiliated nor ridiculed. Moreover, if clear and precise rules are established, the need for punishment is reduced to a minimum. When a prohibition is not observed, it is good to express regret in

a sincere manner and to disapprove not of the child but of the action he has performed. If it is then explained to the child what his incorrect behaviour entails or may entail and what the correct behaviour would have been, it is easier for him to learn to behave better.

There is another condition about which little is said, and that is the one in which the same child presents several behavioural disorders with one person, e.g. the father, but not with another, e.g. the mother or grandmother. Similarly, a conduct disorder may manifest itself in one environment, e.g. at school, but not at home or vice versa. In these cases, it is clear that the therapeutic effort will necessarily have to be directed primarily at these persons or this environment, rather than at the child.

Punishments

We know that it is illusory to think we can do without punishments; but when parents are authoritative and their educational line is clear, precise and firm, this should rarely occur. Where this is not the case, where we notice that misbehaviour is too frequent, we must necessarily ask ourselves whether the educational style used is correct.

Punishments, if they are not to be inappropriate, must be fair, balanced and limited in time and must fit into a serene and linear educational design.

Punishments can be inappropriate for various reasons:

- when the child, due to his or her age or intellectual or affective maturity, is not yet aware of the lack made;
- when they are unable to control their actions effectively. For example, due to the presence of psychological issues;
- when the child had no intention of transgressing, so that the highlighted failure was caused by an occasional event;

- when the parents had not established a clear and precise rule. Punishments often arise because the child does not know exactly what his or her rights and duties are;

- when the punishment stems from an outburst of bad temper or a moment of anger, from unmotivated fears or anxieties, or from parental or educator fatigue;

- when the limits and prohibitions imposed on the child are excessive.

Physical punishments should be avoided because, through this type of punishment, an immediate docility and submissiveness on the part of the child is achieved, accompanied by an instantaneous interruption of the inappropriate behaviour, but the most important objective of maintaining the appropriate behaviour over time, even in the absence of the parents, is not achieved.

Says Bonino (2012, p. 34):

"... it is good to remember that physical punishments are completely useless for regaining authority and teaching children to behave positively. They are of no use in achieving compliance with the rules of coexistence and are actually counterproductive. Physical punishment, first of all, teaches children that problems are solved by aggression, i.e. by the law of the strongest. In this way they do not learn to solve difficult situations, and above all they do not learn to deal with conflicts in a constructive way, with less primitive solutions that are capable of really smoothing out problems of coexistence: children cannot learn not to hit if they are beaten'.

Moreover, physical punishment is often the result of exasperation, irritation, or fatigue, and is therefore the result of an impulsive reaction, so that no learning occurs.

Self-harm

In self-injury, the child, in moments of crisis when he is particularly anxious, nervous, angry, depressed, but at other times also for no apparent reason, hurts himself in various ways: he bangs his head on the wall, punches and slaps himself, scratches his arms and legs, etc. It is not, therefore, someone or something that hurts him, but he inflicts suffering, pain, and sometimes even mutilation on himself. The reactions of those who witness these behaviours are the most varied: some scold the child to make him stop, others embrace him and try to console him, others flail about and shout in discomfort, and still others try to block his hands and body by all means.

The causes

There can be many reasons for this behaviour:

- ❖ desire for punishment to silence guilt;
- ❖ response to a severe frustration suffered;
- ❖ signal to the environment. As in 'I am there. I have needs. Listen to me!"(De Ajuriaguerra, Marcelli, 1986, p.187);
- ❖ self-stimulation in a context of isolation (De Ajuriaguerra, Marcelli, 1986 p.187);
- ❖ way of coping with internal conflicts made up of oppressive and unbearable thoughts and emotions through self-provoked physical pain;
- ❖ way to focus one's attention on reality and not on fantastic ideas. Also because it has been experimentally verified that the more patients suffer from tension or dissociative feelings, such as a sense of unreality, the less pain they experience;

- need to express their anger towards others. In this way, the child avoids attacking the person(s) around him or her that he or she cares about;
- masochistic pleasure in experiencing intense painful sensations;
- alteration of the differentiation between self and non-self;
- defective perception and integration of painful stimuli (De Ajuriaguerra, Marcelli, 1986, p. 490-492);
- Some authors associate self-injury with suicide attempts, assuming that these are self-destructive behaviours and an attack on one's own body.

There is no doubt that often this self-aggression is usually accompanied by a state of considerable inner suffering, associated with anger. These manifestations are frequent in children deprived of maternal care, in subjects with autistic disorder or institutionalised subjects, but also in all children in whom suffering and anger do not find more suitable means or instruments to manifest themselves than the dramatic ones described above. We have clear proof of this in the fact that when this state of considerable discomfort or suffering diminishes, these behaviours disappear as if by magic.

Giovanni's raids

The case of Giovanni is significant. This adolescent boy, admitted to a psychiatric hospital for spastic paresis of the lower limbs and serious behavioural disorders was, both during the day and at night, constantly restrained, as he was severely self-destructive: he would punch himself in the face and put his fingers in his mouth to the point of lacerating his cheeks so that rivulets of blood gushed out. This symptomatology seemed resistant to any

therapy with psychotropic drugs but also to attempts at communication which, when possible, given the serious situation in the ward, we tried to implement. Since, stimulated by Prof. Basaglia's ideas, we had managed to open up the ward to the outside world so that the patients were invited to go out not only into the hospital garden, but also outside its walls, Giovanni was the only patient who remained confined inside his dormitory and, moreover, contained in his bed. One day, all attempts having failed, we thought of trying to put him outside the ward too, albeit sitting and tied in a wheelchair. Since the first two or three days he would scream angrily and struggle trying to turn the chair upside down, so that he would hurt himself when he fell, we thought of putting a sturdy mentally retarded patient next to him, who was very sociable, helpful and cheerful, to prevent this from happening.

An unexpected friendship had sprung up between the two. The patient with mental retardation, despite not being able to speak, fed Giovanni at lunch and dinner time, allowed him to smoke by handing him a cigarette, and let him back into the ward when he needed to attend to his physiological needs. Seeing Giovanni more cheerful and smiling, whereas before he was perpetually sad and angry, we tried to let his arm free. Not only did the boy no longer hit himself, but he was happy to be able to smoke and eat without any outside help. This encouraged us to let his other arm and legs free as well. The self-harm had disappeared, not only that, but he, taking advantage of his friend's remarkable strength, using his rickety wheelchair, had found a way to have fun, making raids all over the hospital, laughing and joking with everyone he met, including some nuns who frowned upon his running up and down the hospital's narrow streets, combined with the many jeers he handed out left and right to the people he met.

Fabrizio's signs of distress

Fabrizio, aged five, was another case in which, along with many other symptoms related to the suffering he experienced, there was aggression towards both others and himself.

The child was the son of a separated couple. The father was described by the mother as introverted, selfish, uncaring and gentle towards his wife and child. The latter, on the other hand, described herself as an expansive, somewhat aggressive but sensitive woman.

Already a few months into the marriage there had been problems in the marital relationship, which had resulted in separation. Giuseppe had, therefore, lived in a family in which parental relations had always been conflictual.

The manifestations of his suffering had been multiple over the years: initially he presented stuttering, a tendency towards isolation, easy crying, and morbid attachment to his mother and maternal grandmother. Later, however, aggression towards his parents, relatives and other children had clearly manifested itself, while emotional detachment towards his father increased. After the parents' separation, the prevailing symptoms were an accentuation of isolation, nocturnal enuresis, sadness, hatred towards the house in which he lived, fear of loneliness, the need to sleep systematically in his parents' bed, even at his mother's request and need, and finally the presence of hetero- and self-aggression,

As can be clearly observed in the two cases we have presented, self- and hetero-aggression is never highlighted as an isolated symptom, but is almost always linked to a constellation of signs that highlight considerable suffering on the part of the child or adolescent. Suffering that may have originated at an early age, but still continues to accompany the child as a sad legacy.

Obsessive and compulsive disorders

That children, along with the pleasure of de-cluttering, also have an instinctive need for order at certain times of the day is

well known. One of the components that provides them with security is that events in and around their family take place according to a well-established routine and ritual. For example, at breakfast, some children want to drink milk from the cup they are fond of; during lunch, they always want to sit in the same chair; if they are used to watching cartoons while eating, they insist that things do not change. Bedtime rituals are also well known. Rituals made up of routine activities: going to the bathroom, brushing teeth, giving daddy a goodnight kiss, putting the pillow away, telling a story or reading a fairy tale and then, for girls, a teddy bear or favourite doll in their arms and for boys, a cartoon hero's sword placed beside the bed, ready to be drawn against imaginary enemies. These and other rituals tend to disappear, generally, around the age of seven to eight, (De Ajuriaguerra, Marcelli, 1986, p. 285) after which time most children accept some changes in their daily routine.

Only when this type of manifestation is very coactive and is associated with other signs of the child's distress are we in the presence of *obsessive symptoms.* These are characterised by persistent and recurrent ideas, thoughts, impulses or mental images, which the will is unable to eliminate from the field of consciousness. Ideas, thoughts and impulses, which constitute a source of disturbance and discomfort for the child. These ideas and impulses may also have aggressive or destructive components, of which the child is ashamed or blames himself.

Obsessions and/or compulsions interfere, sometimes severely, with the child's daily activities: study, social life, hygiene, play, etc. They make many moments of the child's day difficult, as not only do they leave him no respite and no room to devote himself to anything else, but they also cause him a great deal of tiredness and exhaustion.

Children suffering from obsessive symptoms perceive these thoughts as something *intrusive* and, therefore, independent of the

normal flow of their thoughts, but also as something *annoying*, both in terms of their content and the frequency with which they occur and cause them discomfort. But while the adult perceives these thoughts as *meaningless*, *irrational and exaggerated*, or in any case *not justified* by the reality in which he lives and moves, so he is aware of their morbid character, even though he cannot help but suffer them, the child does not always have the clear awareness that obsessions and compulsions are something unreasonable that involves him.

Compulsions

Alongside obsessions, the child also suffers *from compulsions or obsessive rituals*. These consist of mental actions and behaviours that are carried out as a response to the obsessions and represent an attempt at a solution; as, even if temporarily, these rituals are followed by a sense of relief from the discomfort caused by the obsessions.

Rituals can be of various kinds: some children need to repeat a prayer a certain number of times to avert death or illness for themselves or another family member. Others, who are afraid that certain objects or clothing they touch may contaminate them, have the need to continuously wash their hands, clothes or other personal items. Then there are children who feel the urge to hurt some family member or to perform some very risky action: for example, crossing the street while cars are speeding by; so, in order to avoid this, they feel the need to walk on the pavement touching all the poles they come across in their path. Still other children may have a fear of being exposed to danger, or feel responsible and guilty for such danger and, therefore, feel the need to count certain particular objects they encounter, for example, all white cars, or to repeat certain words in order to prevent catastrophic events.

As we have seen, the types of obsessions and compulsive rituals can be very varied and numerous, can change over time (Militerni, 2004, p. 384), and can present themselves in a *more or less severe form.* In the latter case, they cause the child considerable frustration and suffering, not least because the various rituals they are forced to perform have repercussions on their family and social life and school performance. For this reason, depression and anxiety, which often appear in these cases, while on the one hand can be the cause of the symptoms, on the other can be their consequence.

The causes

Genetic investigations have shown a high concordance of the disorder in homozygotic twins and a higher incidence among ascendants and collaterals (Militerni, 2004, p 383).

Neurochemical investigations revealed serotonergic dysfunction.

Neuroimaging suggests a dysfunction of striatal-thalamo-cortical circuits.

Environmental causes. Obsessive-compulsive symptoms often occur in conjunction with certain stressful events such as the start of school, the separation of parents, and changes of home. It is also evident how certain psychopathological characteristics of the parents, with consequent improper educational behaviour, can contribute to the genesis of the disorder. Alongside these children, we can also find very anxious parents or parents with similar problems, who implement excessively severe, empowering and blaming educational behaviour towards their children . According to the psychoanalytic interpretation, these symptoms are more or less desperate attempts at restraining drives experienced as dangerous and destructive, in such a way as to maintain an identical and invariable environment and to ensure this immobility.

Love and hate

Salvatore, aged eleven, was the son of separated parents, whose relationship had deteriorated after the birth of the child. The parents started him to attend pre-school when he was two years and eight months old, but although the child cried every time he was brought to school, not accepting to leave his home and his parents, they did not give up on their intention as the child 'had to get used to it'. The nursery school teachers noticed that the child showed good intelligence but appeared grumpy and withdrawn, with difficulties in socialising and integrating with peers.

The little boy's symptoms became more pronounced when mental disorders became evident in his mother. He had become more aggressive with his parents and grandparents, while presenting fear of others, of the outside world: he feared that something bad might happen to himself or his parents. He also presented phobia of insects, diseases and germs. And because he feared being infected, he washed his hands many times a day and blew continuously to remove microbes from his mouth. For the same reason, he did not want to be touched and did not accept kisses from anyone. His problems were not limited to phobias and obsessive-compulsive symptoms, he reacted by verbally and physically attacking his mother when reprimanded, as he said he could not accept submitting to her commands. He appeared disobedient, nervous, irritable and displayed provocative, hostile, negativistic, easily losing control and vindictive attitudes in the home environment. If his mother asked him for something or said or made a gesture that bothered him, he would 'scream like crazy'. The emotions he manifested most frequently were, therefore, anger and aggression.

Serious problems in socialisation were also evident: he did not want to leave home and it was not until the end of the fourth grade that he was able to make friends with two children. Very jealous of his belongings, he gave nothing and gave nothing to anyone. He also refused to taste food that was not on his limited

menu. His interests were very narrow: he talked, read, collected and was only interested in dinosaurs. On the other hand, he was so busy studying that he did not play any sports for fear of not being able to study enough. While he was aggressive towards his classmates, towards his teachers he was particularly polite and very respectful. Despite his provocative and aggressive behaviour towards his mother, he was very jealous of her, so much so that he told his father: 'Mummy is mine, you have to leave'.

When asking the child what could be the reason for his problems, he emphasised above all the separation of his parents.

Examination of this case shows how environmental components were relevant in the emergence and maintenance of the child's psychological disorders: the presence in the mother of major psychological problems, conflict in the parents that later led to their separation, and lack of attention to the child's signs of distress manifested by both parents.

In addition to obsessive compulsive problems, many other symptoms of distress are evident in Salvatore: severe problems with socialisation, an angry and aggressive attitude towards his mother and father, and severely limited interests.

We think it is evident how the conflict between the parents and the subsequent separation caused Salvatore an inner conflict that was difficult to overcome, which manifested itself in attitudes of hatred but also jealousy towards the mother and rejection of the father. Between the two parents, the child seemed to have chosen the mother, since she was the person from whom he could receive care, but at the same time there was in him the awareness that the woman had also participated and was participating in his malaise.

Jealousy and rivalry

Present in the feeling of jealousy is the fear of losing the other or something of the other: his presence, his love, the material, affective or spiritual contributions that the other can bestow.

The child is jealous when the baby brother is born or when the father kisses the mother. The mother is jealous when her son dares to give more kisses to grandma or the nanny than to her. The girl is jealous when her best friend at school wrongs her by sitting with another girl. The young man is jealous when the girl of his dreams pays attention to another man. The employee is also jealous when the office manager puts another employee next to him in his room to help him and not him.

Since all people, at least once in their lives, have felt the pangs of jealousy and since it is present in all ages and in both sexes, this feeling is not in itself a sign of pathology.

On the contrary, since in all relationships there is always the feeling of belonging and the fear of losing something that we feel is ours, jealousy is considered not only a physiological but also an indispensable feeling, as it sets in motion the instinct of defence, which tends to protect us and safeguard us from the loss of something important or fundamental to our life and our physical or psychological well-being.

Pathological jealousy

If, however, this feeling is very strong and involving and is also accompanied by other problems in the child, especially if it is combined with regressive-type manifestations, we can undoubtedly catalogue it as an important sign of the child's inner suffering, which must be dealt with in the right way. The manifestations that should alert us above all concern a series of unusual behaviours.

When it is the older sibling who is jealous of the new baby brother, seen as the one who steals his mother's love and interest, the older child, despite his age, tends to behave more childishly

than he did previously: such as going back to sleeping in his parents' bed; wanting to eat the same food as his younger brother or suck milk from the bottle or even from his mother's breast; losing control of his sphincters that he had already acquired; going back to crawling or crawling on all fours. In these cases, aggressive behaviour towards the newcomer is also evident in both words and attitudes: "Mummy, why don't we give him to Auntie Anna, who has no children, the little brother?" Or worse: "Why don't we send him back to the hospital where you got him?" Sometimes the jealous child fears that the coming of the little brother is related to his 'bad' behaviour (Isaacs, 1995, p. 79). "Is it true, Mummy, that if I am good, you send little brother away?"

In these cases, if we investigate the reality of the child before the birth of the baby brother, we find, almost always, already present and active, some psychological problems which, even if not manifested in an obvious way, as regressive behaviour is, already disturb the normal relational life of the child.

The counter-evidence of what we have said can be found in the examination of many children who experience a good relationship with their parents. These, having lived in a serene environment, full of love, attention and dialogue, do not manifest any feelings of jealousy towards the newcomer. On the contrary, the presence of a little brother or sister awakens, matures and activates, maternal and paternal feelings, imbued with joy, tenderness, protection and love.

Therefore, when jealousy manifests itself in a resounding way, the birth of the little brother is just 'the last straw', it is just that one more problematic event that grafts itself overbearingly onto the psyche of an already fragile and affectively deficient child. It is very difficult to be forced to share something with others when one is very poor! How equally difficult it is to harmonise such an important event in one's inner life, when one's ego is already struggling in a fragile and unstable equilibrium. It is

necessary, then, to enrich the jealous child with tenderness, care and attention, rather than attacking him with reproaches and guilt-ridden phrases, because, as Osterrieth (1965, p. 120) says

"It must not be forgotten that the child is all the more likely to feel rejected and to fear being deprived of love, the more he has hostile feelings towards the newcomer who makes his parents' joy and happiness: in a certain sense he is therefore doubly guilty. As a result, he should be doubly loved and cared for, which is precisely what parents, grandparents, uncles and aunts do not do, in the classic situation in which they all swoon over the perfection of the newborn and pay no attention whatsoever to the unfortunate elder brother, who suddenly finds himself relegated to second place and who will attribute all this to his own wickedness or bad feelings'.

In Antonio we find many elements of what we have said above.

Antonio's jealousy

Antonio, who had been brought to our observation at the age of five, was almost four years old when his little brother was born, so his mother was very surprised at the various regressive symptoms and behaviours the child displayed at that time. The child had returned to crawling, put everything in his mouth like a small child and sometimes wanted to be fed. In his mother's absence he would try to attack his little brother. In addition, when the woman was breastfeeding the baby, he would go into another room and 'throw everything up in the air', thus expressing his anger. If he was nervous, and wanted to do something that was forbidden to him, he would throw everything in his hand at the walls but also at people. He would only calm down in front of the TV, which he wanted on for three to four hours a day.

If we examine the intra-family dynamics, we realise that Antonio's problems were already present before the birth of his little

brother. The father, a quiet and good man, had little time to devote to his children. His mother, more authoritative and aggressive than her husband and very attentive and fussy, had already established a conflictual relationship with Antonio when he was still very young, due to his excessive need for order and cleanliness and his demand to be promptly obeyed by his son. Needs and demands that clashed with the disorder caused at home by little Antonio and his disobedient behaviour.

The relationship between mother and son had then deteriorated during the expectation of the baby brother. During this time, scolding, punishment and even slapping had become much more frequent, as the child had become more nervous, biting his nails, more aggressive towards his mother, more irritable and whiny.

How to behave

Before a new pregnancy, one should make sure that one's relationship with one's children is good and satisfactory. Once this premise is acquired, all those recommendations that are usually made to expectant mothers are certainly useful:

- Have the older sibling(s) of the unborn child participate in the new event with affection, joy and tenderness from the very beginning of the pregnancy, so that the children, as in the parental couple, have plenty of time to metabolise the event;

- minimise the distance of the children from their mother during hospitalisation for childbirth;

- getting older siblings to participate in the care of the newborn through small tasks;

- after pregnancy, continue to give attention to the eldest children, so that the joy of birth and readiness to welcome the newcomer expands in their hearts;

- ❖ avoid constant prohibitions or worse reproaches and threats: "Don't touch him!"; "Watch out, you're hurting him!" "You are a brute, if you wake him up and make him cry I will beat you!"

- ❖ It is also useful, after some time, to put the little brothers and sisters together in the same room, so that an alliance and communion is born between them;

- ❖ if the mother is very busy with the newborn child, the father, grandparents or uncles should be more active towards the other children, offering them an even warmer, affectionate, joyful, close and dialoguing presence, in such a way as to make up for the mother's momentary, lesser availability.

Sleep disorders

This chapter gives us a good understanding of how difficult it is, in the field of child neuropsychiatry, to distinguish between normality and pathology. "My five-year-old daughter has difficulty going to bed. She often calls me after telling her the story and wants me to stay with her until she falls asleep. Is this request of hers normal or pathological?" "My son sometimes wakes up screaming and crying. What does that mean?" "In the room where my children sleep there is always gnashing of teeth. Why do they do this? " "My twelve-year-old daughter doesn't fall asleep unless she has a doll next to her that has become filthy over the years. Should I leave it with her or at least force her to replace it with a new one?"

In order to be able to answer these questions correctly, certain data could certainly be helpful: such as the age of the child, the duration and intensity of the disorder, the frequency with which this symptom manifests itself and, above all, the presence or absence of other concomitant symptoms that make the child's life

miserable. However, it would still be very difficult to distinguish which sleep disorder should be judged pathological and which physiological, without first having examined the child's entire affective-relational life in order to grasp all the movements of his or her soul, in relation to internal reality and the external environment.

We are well aware of the importance that sleep has on the physical and psychic health of all animals and, in particular, humans. All research, even the most recent, confirms the need in all ages of man, but especially in childhood, for many hours of rest and sleep, especially during the night. Sleep is a physiological phenomenon that is fundamental to life. When one sleeps, there is an interruption of the sensory and motor relationships that bind the organism to the external environment. This momentary interruption allows both body and mind, the indispensable, necessary rest. Not only that, but during sleep the mnestic traces given by daytime experience are selected, integrated, connected and programmed so that they can be put to good use later on. Good sleep 'refreshes' in the sense that it makes one feel good and drives away anxiety and sad thoughts. A good night's sleep improves immune defences, memorising abilities and helps to have healthier and more peaceful social relationships. Therefore, sleep in children is important for their physical and psychological health, as well as for memorisation and learning.

The duration of sleep is longer in infants, while it gradually decreases as they grow up and becomes much shorter in old age. But even at this age, a good night's sleep is essential. It has been found that older people who get enough sleep have better skills in memorising and managing interpersonal relationships.

Since every child is different, some of them sleep through the night, even as infants, so that even their parents can sleep peacefully; while there are others that make mum and dad despair for years. In any case, there are always many parents who, at one time

or another, have had to face, during the years of their child's growth, some problem with falling asleep or some sleep disorder. These problems occur physiologically much more intensely in the child's first year of life, and then gradually diminish.

Although the benefits that sleep brings are numerous, there are many difficulties that children have in accepting to let go in the arms of Morpheus. These difficulties are only understandable if one grasps what the child's particular condition is at these times.

Falling asleep means leaving parents, objects and known places, to enter an unknown world in which, through dreams, all kinds of events can occur: some beautiful, such as dreaming of flying or of being able to achieve things impossible in real life; some ugly, such as dreaming of falling and hurting oneself; and some terrifying, as described by a child we followed: "Like when the bogeyman seems to envelop you with his cloak, or like when the bad robots advance with their powerful disintegrators, but you can do nothing to counter them and you can't even run away, because your legs don't obey you".

During the waking hours, mum and dad are always ready to face and solve their child's problems, while during the night, he feels alone, since he cannot take with him the people who could defend him or who give him, by their mere presence, a feeling of security. The child feels alone in facing the fear of the dark and of thieves; alone in facing the terrifying illusions that the darkness around him can create in the corners of his room; alone in facing nightmares; alone against the 'bogeyman'.

The frequency and number of alterations or difficulties in children's falling asleep is the best demonstration of the fragility of this area (De Ajuriaguerra, Marcelli, 1986, p. 73).

1. Irregularity of sleep-wake rhythm.
2. Difficulty falling asleep.
3. Anxious or distressing dreams.

4. Pavor nocturnus (night terror).
5. Night terrors.
6. Acute hallucinatory syndrome.
7. Sleep paralysis.
8. Sleepwalking.
9. Bruxism.
10. Excessive sleepiness *(hypersomnia).*

1. Irregularity of sleep-wake rhythm

One speaks of irregularity in the sleep-wake rhythm when the child, at certain times, sleeps little overall: because he or she falls asleep late; because he or she wakes up early; because he or she has nocturnal awakenings. These children do not fall asleep at the required times and in the required manner; they do not accept to stay in their own bed, nor do they accept to sleep in their own room. When they first wake up at night, they often go to their parents' bed and refuse to return to their own bed.

2. Difficulty falling asleep

With regard *to the difficulties in falling asleep*, De Ajuriaguerra and Marcelli (1986, p.75) describe this disorder as follows: "The child resists going to bed, establishes increasingly long and complex rituals, requires a counterphobic comfort (light, transitional object, thumb), needs a story told by one of his parents..." These difficulties can go as far as *bedtime phobia,* in which the little one "is panicked when he feels he is about to fall asleep, wants his hand held, wants to fall asleep between his parents".

Severe early insomnia *may be present in the first year of life.* This type of insomnia can occur in both its *agitated* and *calm forms. In the agitated form*, the child cries, screams, agitates to the point of exhaustion, then starts crying and screaming again. Sometimes this insomnia is accompanied by rhythmic movements and violent rocking or self-aggressive behaviour. *In the calm form*, on the other hand, '...the child remains in his bed, wide-eyed, silent both day and night. He seems to ask for nothing, and to expect nothing' (De Ajuriaguerra, Marcelli, 1986, p.76).

3. Anxious and distressing dreams

During sleep, the child may suffer from dreams that cause him anxiety or, even worse, distress. For this reason, while he sleeps he groans, cries, calls for help, because of the 'bad dreams' he has. Even in these cases, it is natural for him to seek tranquillity, acceptance and security in his parents' bed.

4. *Pavor nocturnus (night terror)*

The little one may also be a victim of *night terrors* whereby, during REM sleep, he appears agitated and presents neurovegetative phenomena (sweating). The things that terrorise him are not just bad dreams but sudden terrifying sensations that accompany fleeting mental images. Because of such sensations, the child wakes up distressed, his eyes wide open towards some imaginary object, 'screaming in his bed, his eyes aghast, his face terrified. He is confused, disoriented, does not recognise who is around him, not even his mother; he seems inaccessible to any reasoning' (De Ajuriaguerra, Marcelli, 1986, p. 77). While on awakening he remembers nothing. On these occasions it is best not to wake or touch the child. Mum and dad can possibly stay close to him and in a calm, quiet voice try to reassure him. Fortunately, night terrors are rare and affect children between the ages of four and seven.

5. Nightmares

While asleep, the child falls prey to nightmares, wakes up suddenly, makes some movements, moans full of terror at what he saw in his sleep, but manages to express his anguish by recalling the dream that troubled him. Nightmares, unlike night terrors, are frequent and occur in children between 8 and 10 years of age. In this case, unlike in *pavor nocturnus,* the child needs to be reassured by his parents and, through cuddling, accompanied to fall back to sleep.

6. Acute hallucinatory syndrome

It affects both boys and girls between the ages of two and thirteen. It is a rare syndrome (one case in 56,000). The onset is always acute and manifests itself during night sleep with a sudden vision of terrifying, voracious, filthy, repulsive little animals, swarming all over the place *(microdermozoopsies),* as a result of which the child manifests an abrupt awakening with great psychomotor agitation, with trembling, hypersudorisation, pallor, tachycardia, and profound anguish. These episodes are followed by periods of prolonged insomnia, as the child does everything possible not to fall asleep, to prevent these hallucinations from recurring.

7. Sleep paralysis

Some children, waking up suddenly from a nightmare, for a few seconds or a few minutes, find that they cannot move or cannot call out loud to their parents. They can only groan and move their eyes.

8. Sleepwalking

In somnambulism, the child engages in complex psychomotor behaviours: such as getting out of bed, walking, opening and

closing doors, etc. In these cases, the child manages, at least partially, to perceive external reality but is not interested in what surrounds him. He appears as if immersed in his own thoughts, so he behaves like an automaton with limited movements and an uncertain gait, while his gaze is fixed. After a period of walking that can vary greatly (from five to thirty minutes) the child returns to his bed or allows himself to be led there meekly. The next day he will not remember anything that happened. In the mild form of somnambulism, the child tries to get up but remains seated on his bed.

These behaviours take place while the child continues to sleep, to the extent that on waking up he/she does not remember anything that he/she did during the sleepwalking period. Again, no attempt should be made to wake the child. Sleepwalking crises reach their peak during adolescence, declining around the age of seventeen to eighteen.

Anxiety and inner conflicts have also been blamed for these symptoms. In somniloquy, on the other hand, *the child* speaks during sleep, but remembers nothing of what he or she said.

9. Bruxism

Children suffering from this motor automatism grind their teeth during sleep.

The causes of sleep disorders

The causes of sleep disorders can be very varied:

Organic causes. Numerous medical conditions, especially affecting the respiratory tract and gastro enteric system, can cause sleep disorders.

Environmental causes. These can be very trivial, such as an excessive rigidity of mealtimes, an abundant or unsuitable diet, poor soundproofing; habits that do not suit the child's needs, such as going to bed at different times.

Sleep can be disturbed by more important causes:

- when there is a difficult relationship between the child and its caregivers due to parental educational difficulties (De Ajuriaguerra, Marcelli, 1986, p. 74);

- when caregivers suffer from psychological disorders, whereby they communicate their anxieties and fears to the child and have difficulty understanding and meeting the child's needs;

- when the child is involved in stressful or frustrating situations;

- when there is excessive anxiety on the part of the parents with regard to the child's sleep;

- when the child is prey to conflict dynamics and emotional disorders related to the growth process, resulting in pervasive developmental disorders, depression, anxious attachment, separation anxiety, motor and/or mental hyperactivity, etc.

Interventions

Without wishing to give recipes, which are generally of little use as each child is an individual case, we feel it is only right to suggest at least a few useful expedients:

1. Children like things to unfold according to certain schedules, rules and rhythms. It is therefore a good idea to give them a precise time, after which invariably the parents will begin to perform, in a cheerful and affectionate manner, all the bedtime rituals: brushing teeth, going to the bathroom, putting on pyjamas, kissing them goodnight, etc. Exceptions can certainly be made to the timetable, as long as they are truly exceptions and, therefore, rare.

2. When the child has fears and needs more accompaniment to sleep, it is certainly helpful to be there to reassure him or her with our presence. However, it is equally important to ensure that the child spends the whole day in a peaceful and joyful manner. Because 'a good day prepares for a good night'.

3. To ensure that the transition from wakefulness to sleep is the least traumatic, the telling of a fairy tale or the reading of a chapter from a book is important. Today, unfortunately, the number of children who fall asleep with their parents' fairy tales is significantly decreasing (Oliverio Ferraris, 2005, p. 107). The habit of listening to a fairy tale is important, since fairy tales, in addition to promoting sleep, make the imagination run wild, develop auditory memory, imagination and intelligence, improve the child's linguistic abilities, and allow greater emotional closeness and better dialogue with parents. This moment of intimacy helps the child overcome his fears and resolve some of his psychological problems, since the serenity of the parents, their love, their solid and secure presence, are transmitted to the child's soul, calming him down, while at the same time offering him greater security. The story can be an opportunity to learn, in addition to numerous new words and literary expressions, some basic knowledge: how to use courage by combining it with prudence, how to combine cunning with generosity, how to reconcile fantasy with reality. Repeating the same story can also be useful in helping the child to discover new expressions and idioms, new synonyms, new aspects and details of the story he or she has been told and which have escaped him or her.

4. The bedtime should be compatible with children's need for an adequate number of hours of sleep. If children do not

get enough sleep, not only will their capacity for memorising, attention and comprehension be diminished, but there is a serious risk of an overall deterioration in their psychic and relational life, as anxiety, fears, nervousness, irritability and moments of sadness are more likely to arise. These are symptoms that can negatively affect their relationships with peers, parents and adults in general. On the other hand, parents, after a day spent on various domestic, educational or work commitments, have the need and the right to have a few hours to get together as a couple.

5. We absolutely avoid leaving the TV, computer, video games, tablets and mobile phones in the child's room, as these instruments bring a considerable amount of exciting, anxious and often even frightening stimuli to the child's soul. Stimuli that in quantity and quality are the opposite of those necessary to favour sleep, such as tranquillity, serenity, relaxation, sweetness, feeling protected. This habit of leaving various electronic devices in children's rooms is, unfortunately, becoming more and more widespread, as the increased well-being allows many of these objects to be distributed throughout the house. Parents are often happy that their children also use various electronic devices in the evening and at night: 'That way they stay quiet in their bed'. Things are unfortunately not like that. The damage that the child suffers on the quantity and quality of sleep, but also on many other aspects of his or her mental and intellectual life, is such that this type of behaviour is strongly discouraged.

6. Unlike TV and video games, which should be avoided, one can safely leave the child with his transitional object, whatever it may be: the doll, the soft toy, the fluorescent Madonna, the sword that defends him from 'monsters', and

so on, as these objects help him to acquire greater peace of mind and security. When these objects, due to time and continuous use, have become old and degraded, it is a good idea not to exchange them for new and shiny ones, since the bond that is established between the child and its *transitional object*, to which the child attributes considerable affective values, is so unique that it is difficult to replace it.

7. It is good for the child to get used to having a place of its own to sleep: its own cot or cot, to be placed first next to its parents' bed and then in a room next to theirs. In the event, however, that the child, for whatever reason: illness, momentary discomfort, fears, nightmares, sleep apnoea, etc., should need the reassuring and protective intervention of his parents, it is useful to try to reassure him by staying next to his cot for a few moments. If this does not suffice, the child can be placed in the cot, so that he feels safer and more secure, except to return him to his own bed once the crisis has ceased and he has fallen asleep again. Another exception to the use of the cot is when the whole family wants to be close together to laugh and play, such as during the mornings of feast days, when one is free of commitments and can laze around together.

8. If the child requires them, it is undoubtedly useful to put everything he or she may need during the night: a handkerchief, a light, a glass with water, a potty for peeing, a toy, a book to read, and so on.

We have spoken of the importance of sleep for the serene and harmonious development of the child. However, even in this one must not overdo it. Some parents and relatives, in order to be free to do their chores or in any case not to have to take care of the

child for some time, do everything they can to make the child sleep even when he or she has no need or desire to do so. This is not at all helpful as it risks making the child regress and prevents all those motor, language and social experiences, which only when awake he could carry out.

Depressive symptoms

Depressive symptoms in childhood are much more frequent than they are highlighted and diagnosed. The reasons why educators (parents, relatives, teachers) find it difficult to recognise them and thus deal with them appropriately, are due to the fact that the child is rarely able to express his or her feelings and emotions verbally. Moreover, in minors, depression takes on very different characteristics from those present in adults. Characteristics that conceal and mask it behind attitudes and behaviour that are only outwardly joyful and lively.

Depression of the newborn

Lack of maternal care, depending on its severity and duration, is responsible for various psychopathological situations. If the deficiency lasts more than a month, the picture known as *anaclitic depression,* so well described by Spitz, begins.

The infant, prey to this type of depression, initially cries intensely, then his crying becomes plaintive, more monotonous and less modulated and finally turns into a cry. The child appears prostrate. He lies in bed for long hours, on a low stomach, with little reaction to stimuli. His gaze is dull and dejected. The facial expression becomes rigid, sad and anxious. The apparent indifference to his surroundings is evident, as is the withdrawal, isolation and refusal of contact. At the moment of awakening, the child's classic manifestations towards his mother are missing: his joyful warbling, lullabies, playing with his hands or rattles. Also noticeable is the absence of exploratory curiosity. There is, on the

other hand, frequent self-stimulation: with rocking in the genupeptal position, solitary rhythms, especially during the day but also at night or in the falling asleep phase. These stimulations can go as far as self-aggressive behaviour. Psychomotor acquisitions, such as the onset of sitting and walking, are delayed and there is also a delay in sphincter control. Often these children do not begin to ambulate until around twenty months of age. Language and communication development are usually profoundly disturbed and delayed. There is also weight loss and a decrease in the immune system, which makes it easier to fall ill.

If the mother's absence lasts beyond the third month, this condition can lead to irreversible mental retardation, sometimes even to severe general organic conditions (*marasmus*) and delayed skeletal development.

Depression in the child between three and five years old

The child's depression at this age presents some symptoms similar to those of the young child: isolation or withdrawal, self-stimulation, crying that lasts a long time with or without an apparent reason , prolonged chronic and compulsive masturbatory behaviour, but there is also agitation and psychomotor instability, while affectivity is inconstant. Thus, if at certain times there is intense affective seeking in the child, at other times there is relational rejection, with manifestations of anger and violence when he is thwarted in his desires.

The mood tends to oscillate between euphoric agitation and silent crying. Self- and/or hetero-aggressive behaviour is also present, sleep difficulties with frequent nocturnal awakenings, nightmares and daytime sleepiness, to which are added intermittent enuresis and encopresis, appetite alterations, with food refusal or, on the contrary, bulimia. Finally, there is extreme sensitivity to further separations, with intense relational demands. Since the

need for a dual relationship still persists, inclusion in the nursery school becomes difficult and can be a source of further trauma.

Depression in children aged 5-6 years to 12-13 years

At this age, the child possesses more elaborate means of defence. Therefore, signs of moral distress, bewilderment and despondency emerge from words, facial expressions, looks and tone of voice. For these reasons, depressive symptoms are quite eloquent. Boredom, closure, a sense of incapacity, difficulty in receiving and accepting help from others, a tendency to self-punishness, poor facial expressiveness are evident. Expressiveness is also reduced, so that the child appears as 'switched off', stiffened, has little gestures, moves as if in slow motion, tires easily and gives up activities that he used to enjoy so much. Imagination and attention are scarce.

In addition, the depressed child has difficulty concentrating, presents continuous phobic-obsessive controls, has excessive and overflowing affectivity and may present provocative and self punitive behaviour. Anxiety states with distress and recurring thoughts, sleep disturbances with nocturnal awakenings, with or without nightmares, are present. In other cases, on the contrary, the child seems to take refuge in sleep, and thus sleeps excessively. Some eating disorders may also be present: the child eats occasionally, sometimes refusing food, at other times greedily taking it.

Depression at this developmental stage also manifests itself in excessive sensitivity, loss of interests, behaviour of self-loathing and self-evaluation, feelings of helplessness, guilt, shame, and negative comments about oneself and one's actions. These comments can be expressed directly in sentences such as: "I can't, I can't do it, I don't know". "I'm tired, I don't feel like doing anything". "I only make mistakes". "I am bad, nobody loves me". Alongside these symptoms there may be signs of protest, anger, impulsivity and aggression, repeated theft, lying, mythomaniac

behaviour, easy fatigability, maladjustment between the child and his environment. In particular, maladjustment towards peers, running away and finally school failure, due to instability of attention and difficulties in concentration. Depressed individuals are also more at risk of suicide and conduct problems (Wright, Strawderman et al., 1996, p. 181).

The younger the child, the more the symptomatology is enriched with psychosomatic symptoms: anorexia, sleep disturbance, diarrhoeal episodes, dermatological affections *(eczema, alopecia),* respiratory affections *(asthma).*

Not all of the above symptoms are always present, so there may be a depression with a prevalence of somatised symptoms, a depression with prevalent school difficulties, but also a depression in which conduct disorders or other symptom groups are prevalent.

As for adults, it seems that depression is more frequent in girls than in boys.

The causes

Genetic causes. Studies on monozygotic twins have shown concordance values of 65%, whereas in dizygotic twins these values are around 15% (Militerni, 2004, p. 394).

Biological causes. Reduced increment of growth hormone after stimulus (growth hormone or GH) and dysfunction of the serotonergic system are reported. Ultimately there should be a hypothalamic-pituitary dysfunction of the noradrenergic and serotonergic regulatory systems. (Militerni, 2004, p. 395).

Environmental causes. Spitz also called *h ospidalism* the anaclitic depression of the new-born child, because it frequently occurs in brephotrophs (De Negri et al., 1970, p. 127-128). This makes us think that depression is closely linked to environmental situations in which the care of the infant is not sufficient to establish and maintain a solid and stable emotional bond. Moreover, de-

pression is more frequent when there are serious affective deficiencies on the part of family members, educational chaos, and changes in maternal image.

For Bowlby (1982, p. 73), the loss of a loved one, in popular wisdom and experience, has always been associated with depression and extreme gestures. Even in the animal world, puppies look for other animals within their family to protect and care for them. The emotional bond that is created between the child and the beloved family member is defended against intruders with aggression, but also with punishment of the family member who should have protected, assisted and cared for it and did not. The defence of this bond is also present, by the way, in human lovers. Maintaining a bond is like loving someone, losing the bond is like suffering for someone. And if the threat of loss leads to anguish, real emotional loss causes suffering and anger.

Symptoms of childhood depression are also present when the *affective deficiencies are partial.* For example, when the child does not receive sufficient care for a long time, due to severe maternal depression or other psychopathological problems; when short but repeated absences are present; or when there are marked distortions in the mother-child relationship.

Depression is three times more frequent when parents have suffered from the same disorder. Depression is more likely to occur when there is parental or child illness with hospitalisation, when there is a dysfunctional family system, when there is the loss of a parent or loved one through divorce or death, when there are family crises, when the family is forced to emigrate, but also when parents have little time to devote to their children.

In this account of Maria, aged twelve, whose mother was incapable of affectively providing for her children and was therefore forced to place them in various institutions, one can well understand the feeling of emotional deprivation experienced by her and all children who find themselves in the same situation as her.

The balloons that flew in the sky

Once upon a time there was a lady who was buying balloons and they flew. The lady's name was Francesca, like her mother, and she had 11 children and they were not happy because there were only three balloons. So the mother went to buy more. In the end all the children died because the mother was old and so were the children. The balloons flew into the sky together with a letter that said 'Mummy I love you'.

Mary's interpretation of the story clearly makes us think of a mother who tries hard to give her children the affection they desire and are entitled to. However, she fails to give them all as much as she should (*Once upon a time there was a lady who was buying some balloons that flew. The lady's name was Francesca, like her mother, and she had eleven children and they were not happy because there were only three balloons).* Despite the mother's efforts, her affective contributions were inadequate, so much so that the children died *(So the mother went to buy more. In the end all the children died because the mother was old and so were the children).* In spite of this, the children continue to love their mother because they know that she had done her best for them (*The balloons flew into the sky together with a letter that said 'mummy loves you').*

Suicide attempts

Suicide attempts are rare in children under the age of ten, but frequent in adolescents. Deshaies cited by De Ajuriaguerra (1993, p. 497) distinguishes four forms of child suicide:

Emotional-impulsive suicide: this occurs when the child's emotionality is very high, so it can result in acts without control or restraint.

Passionate suicide: in these cases the act of suicide is driven by passion, for example, jealousy towards a brother or sister, but also towards a partner or towards a parent.

The imaginative form: in this form of suicide, the child carries out this external act, reproducing it for an inner purpose.

Simulated suicide: this type of suicide is carried out in order to achieve a specific goal on the part of the child, e.g. to ensure that the father does not abandon the family.

The causes

"Most authors agree that the suicidal child develops in an inadequate psychosocial environment" (De Ajuriaguerra, 1993 p. 495).

Child suicides are often linked in the press to school-related causes: for example, getting bad marks at school or being expelled from the institution for disciplinary reasons. In these cases, the child is driven to suicide not only by the disesteem caused by bad grades or punishments, but also by the possible punitive consequences that he imagines his parents or other family members may bring upon him. The mass media, however, neglect to add that many family causes are also frequent in child suicide: lack of affection, the presence of conflicting or separated parents, the presence of mothers unwilling to accept the maternal role, the lack of a father figure with an absent or very detached father towards his children, so that there is no authoritative figure in the family (De Ajuriaguerra, 1993, p. 495). Therefore, before the act of suicide, depressive symptoms are often present with: malaise, sadness, anger, low self-confidence in oneself and in others, fears in facing new and difficult situations. Therefore, in many cases the act of suicide is an escape from a situation deemed unbearable.

I tics

These kinds of symptoms are very obvious. The child suddenly, repeatedly, without being able to stop them for a long time, makes sudden, abrupt and imperious movements. Galimberti (2006, p. 604-605) describes the tic as follows: 'Rapid, repetitive,

coordinated and stereotyped movement, repeated in mimicry and gestures, which occurs in relation to the subject's tension without being able to be prevented by the will. This is because the execution of these movements is preceded by an imperious need, for which attempts at repression cause discomfort. Tics disappear in sleep, when the subject is very relaxed or in certain moments of distraction (De Ajuriaguerra, 1993, p. 258).

In *simple tics*, movements may involve only a few muscle groups and, therefore, only a small part of the body, such as blinking, rolling one's eyes, coughing, opening one's mouth, shrugging, closing one's fist.

In *complex tics*, movements may involve a large number of muscles, so the subject jumps, touches something, smells, shakes his head, etc.

Tics can affect all the muscles of the body. If, for example, the muscles of the eyes, neck, throat or fingers are affected, their contraction causes blinking, grimacing of the face, movements of the neck, hands, coughing, throat scraping, snorting, sniffing, grunting. If the muscles of the lower limbs are affected, movements such as stamping the feet, jumping and so on may occur.

These movements are like caricatures of voluntary movements and therefore, like all caricatures and also because they are often repeated, they have the effect of stimulating hilarity in the people present who observe them. Above all, they provoke laughter from peers who, unable to control their aggressive instincts, often react by making fun of the child suffering from this disorder.

Parents also experience these kinds of symptoms poorly when they are present in their children, as they notice that the tics increase when the child is more tense or when he or she is in an inactive attitude, e.g. in front of the TV, while they decrease or are absent when the child is relaxed. This leads them to believe that,

through willpower, it is always possible to control these movements, so they disapprove and scold their child in the vain hope that he or she will decide to stop performing 'these absurd and ridiculous movements'.

We have said that it is a vain hope, since the child realises that it would be much better for him not to perform them, but he also knows that if he tries to delay them, through the use of his will, he will be forced to suffer increasing and increasingly heavy anxiety. Anxiety that will only diminish, at least momentarily, when he has given free rein to these movements.

Two types of tics are distinguished according to their duration: *transient tics and chronic tics*.

Transient tics are transient and disappear spontaneously after a short time.

Chronic tics persist into adulthood.

Often tics, especially if chronic and therefore long-lasting, cause the sufferer feelings of shame and frustration, social withdrawal, intense shyness, depressed mood, difficulties in socialising with the peer group, also due to the latter's mocking attitudes. All of this, in turn, accentuates the child's discomfort, which can lead to an aggravation of the ticular manifestations.

Many parents, fortunately, resign themselves knowing, also from common experience, that transient tics are the most frequent and that there is a good chance they will disappear as the child acquires more serenity.

The causes

Biological causes. Involvement of the dopaminergic system is suspected (Militerni, 2004, p. 388).

Environmental causes. For De Ajuriaguerra and Marcelli (1986, p. 90) tics are a means by which the child manifests and discharges, at least momentarily, his anxiety, psychic tension and

conflicts. Also for Galimberti (2006, p. 605) 'When the affection does not depend on organic lesions, it is of psychogenic origin'.

For Rouart (in De Ajuriaguerra, 1993, p. 260), there are two types of tics. *A first type* is present in well-adjusted children with good school skills but anxious and childish. In these cases the tics represent the child's best way of venting emotional distress and tension. *The second type* is instead present in children who are unstable, turbulent, inattentive at school, extroverted. In these cases: 'the tic is a paroxysmal manifestation of a maladjustment to the environment, to which is associated behaviour made up of turbulence and a constrictive attitude, aggression and fear'. Ultimately, in this second type, tics would be the motor expression and a way of discharging conflicts and psychic tension, in subjects with excessive hetero- and self-aggressiveness.

Interventions

As one can well understand from what we have said, it is perfectly useless, indeed counterproductive, to scold or reproach the child because of his tics. These behaviours would make him feel not only negatively but also not accepted by his parents and educators, which would risk creating new anxiety in him that, in turn, would be expressed by accentuating the tics. It is therefore a good idea to avoid scolding him or pointing out his movements. It is better to pretend nothing has happened and to try and find the best strategies to make him more serene: less scolding, more emotional closeness, less schoolwork, less TV and video games, more free play in the open air, more sport, more dialogue, more environmental serenity. If it is the child himself who brings up the subject of tics, one can try to reassure him that it is nothing serious and that there is a good chance that these movements will soon disappear.

It is certainly useful to keep a diary in which to note down all the behaviour that accentuates the child's anxiety and uneasiness and that which, on the other hand, has the capacity to reassure him

and make him feel more at ease. This will help adults understand the child's inner world and modify the environment in which the child lives in a positive direction, making it as serene and peaceful as possible. To do this, it is essential to avoid conflict or conflict with the spouse, other family members or other children, while at the same time it is good to reward the child frequently for what he does, what he says, his abilities, his good character and the help he offers in the home.

If the parents or carers of the child suffer from anxiety or depression, they will have to commit themselves to treating these disorders, either through psychotherapy or the use of appropriate medication. In this way, these parents will be able to relate in a calmer, safer and more serene manner, both towards the child suffering from tics and towards other family members.

Should the symptoms persist, relaxation therapy such as Autogenic Training can certainly be helpful. If the tics are associated with other major psychological problems, it is certainly advisable to have the child undergo good individual psychotherapy.

Eating disorders in children

Lack of appetite

Children's suffering often manifests itself on the level of nutrition since this, like sexuality, is closely connected to affectivity and the first mother-child relationships that occur precisely through the acts connected with nutrition. The mother who feeds the child gives the latter not only organic well-being but also relational well-being. Even when the child is older, since feeding is a social act in which communicative, relational, affective and emotional elements converge, the pleasure of feeding is closely linked to the relations that the child has with its parents and with the environment that surrounds it.

To understand a child's lack of appetite, one only has to think of us adults. Rarely does an adult's diet remain constant over time: periods of increased appetite or even gluttony alternate with days or periods when we have little or no desire to eat. The variability in nutrition is considerable, and can be linked to a variety of physiological causes, such as seasonal variations, or to pathological causes, both organic and psychic. We eat less during illness, but also during periods of convalescence. We have little appetite or refuse food when anxiety grips our stomach, when sadness and depression assails us, but also when we are very irritated or upset. In turn, however, it is also a common experience of how anxiety, dissatisfaction and melancholy can lead us to overeat, in an effort to seek gratification to make up for the joys that are denied us at the time.

Problems of lack of appetite in children may be due to changes in diet, during the transition from liquid to solid food, from sweet to salty food. Periods of inappetence are present when there is less growth that physiologically requires less caloric intake; when the child suffers from physical ailments such as intestinal disorders, influenza and exanthematous diseases that frequently affect minors, or due to times of increased stress, anxiety and irritability. Sometimes food choices are associated with affective states, whereby a food becomes 'hateful' for several years, just because the child's psyche links traumatic or stressful events to that food.

Therefore, days or periods of inappetence are part of the child's normal life and therefore should not cause any concern. During these periods, it is sufficient to wait calmly for the baby's condition to recover. But since food is seen, above all by mothers, as the fundamental element of their children's lives and also as the very essence of their own caring abilities, the refusal of food, even if limited or occasional, easily creates in anxious, insecure or excessively fussy women, a sense of inadequacy that stimulates

them to insist on offering food, even if the child for whatever reason refuses to take it. This insistence that the child eat becomes like a fight between the child and the mother. And it is a fight that harms one and the other. It harms the child insofar as the latter feels suffocated by the mother's anxiety and loses the pleasure of food, it stresses and depresses the mother, insofar as the latter perceives the child as a source of problems, rather than pleasures and gratifications, so that the more intense the conflicts between mother and child during the meal, the greater the food refusal behaviour will be (Ammanniti, 2009, p.28). Unfortunately, these conflicts risk breaking or altering that basic mother-child bond that is indispensable for healthy and harmonious growth.

Interventions

To improve the child's relationship with food, it is enough to consider that nature has linked intense pleasures to acts that are fundamental for survival: such as the act of sexuality and eating. The parents' task is only to maintain in the child the pleasure of eating, avoiding incongruous behaviour such as associating negative emotions with these acts. It is therefore good to create a pleasant and tension-free atmosphere during mealtimes (Oliverio Ferraris, 2005, p. 140), avoiding excessively heated, depressing or unpleasant topics of discussion. Above all, it is important to avoid constant reprimands: 'Sit properly. "Don't touch the food with your hands". "Eat faster." And so on. Let us try to live and let people live this moment with joy, stimulating dialogue and family communion, so that it is an occasion for meeting and not for confrontation, a time for dialogue and not for grumbling. To create moments of pleasant dialogue and family communion and not isolation, the television and other electronic devices should be banned during meals. If the child is small, we can possibly entertain him or her by telling fairy tales, even made up on the spot.

It would be good not to expect the youngest to eat in a polite and impeccable manner (Oliverio Ferraris, 2005, p. 141). If necessary, let us feed the little one, but, at the same time, let him eat, if he wants, with his own spoon or even with his hands, to satisfy the pleasure of feeding himself and to improve his autonomy at the same time. If parents are overly attentive to the quality and quantity of food that the child takes in, they give him the negative message that eating is a duty and not a pleasure to offer oneself. Let us therefore strive to live and let our children experience eating as a pleasant moment to be enjoyed together. Knowing that the greater our anxiety, the more we aggravate the eventual eating disorder. It is not a bad thing then to remember that no child has ever died who had the possibility of eating properly!

Since man is an omnivorous animal, he is potentially open to all foods. To help the child vary his diet, it is necessary for him to choose them spontaneously. To do this, while we offer foods that the child likes, we also put small portions of other foods on the table that he can enjoy on his own if he wants to. Mothers' experience teaches mothers that children are more likely to accept new foods if they see other children eating them, and that a positive experience with one food increases the likelihood that another proposed food will be liked.

Since colour, smell and appearance count for a lot in food, qualities that can influence taste perception positively or negatively, let us strive to ensure that food also looks and smells good.

We do not rush the child when feeding, but let him chew slowly and enjoy each food. If the child is old enough to do so, it is certainly useful to invite him or her to participate in the choice and preparation of food, so that he or she becomes the protagonist of his or her diet and not a passive subject of it.

As far as quantity is concerned, let us not create unnecessary problems. Let us simply put a small portion of food on his plate or, at any rate, a smaller quantity than he would eat, so that he

himself asks for more. Whenever and if possible, let the child himself serve himself directly from the serving dish (Oliverio Ferraris, 2005, p. 141).

In the event that the child does not eat everything that has been prepared by us, we do not show any sign of disappointment, nor do we insist that he or she finish the food on the plate. Instead, we remove the dish from the table with a satisfied smile and move on to the next course. If this is not forthcoming, we interrupt the meal.

From what we have said, it can be deduced that there is no point in giving rewards if the child eats and punishments if it does not, since food should be a pleasure in itself. If the child's appetite decreases for a while, let us not become agitated and point out our concern, but wait calmly for this period of inappetence to pass.

If the child has real problems with food, it is best to avoid talking about this with relatives and friends but, if necessary, to turn to a specialist with confidence.

Anorexia

As far as *actual anorexia* is concerned, however, the focus must necessarily be different and much greater.

First of all, it is fair to point out that anorexia in the infant and the child, although having the same name, is considerably different from that of the adolescent or the young girl. That of the child usually presents itself in much less severe forms and has the possibility of changing quite easily and rapidly, if the environment in which he or she lives changes in positive terms.

Although it can appear at any time in the baby's life, anorexia occurs most frequently around the fifth to eighth month, often coinciding with weaning (*second trimester anorexia*) (De Ajuriaguerra, Marcelli, 1986, p. 114). In this phase the child has difficulty accepting, not only the different types of food that are offered to him, but also the different ways in which they are taken. It

is not indifferent to take food from the warm, soft, mother's breast, rather than from a cold feeding bottle or worse from a teaspoon. The sensations change, but so do the emotions felt by the baby, who is forced to accept a first partial detachment from his mother. A detachment that, even if very limited, can be difficult for him.

Between the child who does not eat, and therefore does not gain weight, and the parents, a vicious circle is often set in motion: by not eating properly, the child becomes thinner but also physically more fragile, and thus more easily falls ill. This prompts the parents to have the child examined by doctors who propose various drug therapies. The parents' anxiety, combined with the new visits and therapies, accentuates the child's discomfort, who refuses to feed himself even more.

Problems in accepting the food offered may occur at an older age, when the mother, by including new foods in the diet, proposes tastes and smells to which the child is not accustomed. Tastes and smells that more traditionalist infants have difficulty accepting and which they judge to be disgusting *(elective aversions),* while, on the contrary, they show a considerable desire for certain specific foods *(food selectivity).* Generally, the disgusting foods are those based on vegetables and pulses, while those that are highly desired are crisps, snacks, sweets and all foods rich in chocolate and fat. Elective aversions are sometimes associated with episodes of anorexia.

In other cases, the child has no problems, neither with the quantity nor with the quality of food, but is only disconcerted by the different modes of feeding: no longer in his mother's arms but in a high chair, no longer feeding as needed but at set times, no longer calmly and unhurriedly but stimulated to hurry because of the parents' commitments. When the child is then able to walk, other types of conflicts in the area of feeding are likely to start between the child and the mother or carer. For example, the parents would like the child to sit at the table or in its seat, while the

child, in the grip of an irrepressible need for movement, likes to walk around the house and continue to play while feeding. Parents would like him not to soil himself or at least not dirty the whole room where he eats, and instead the child, by messing, soils not only himself but the whole house. Furthermore, when the child, even if small, is placed frequently and for a long time in front of the TV, he does not accept to feed himself unless he is watching his favourite cartoons *(inappropriate habits).*

Overfeeding

Overeating easily leads to obesity, which, in turn, can trigger numerous medical, social and relational problems: respiratory and cardiovascular diseases, orthopaedic problems, tumours, as well as the need to accept the psychological suffering inflicted on children referred to as 'fat'. Clinically, a child is considered obese if he or she is at least 20 per cent overweight compared to the norm for his or her age and height (De Ajuriaguerra, Marcelli, 1986, p. 116).

Obesity today has become a social problem as the percentage of children suffering from excessive weight, in populations that can afford an abundance of food, increases every year. In just twenty years, the number of obese children in the western world has tripled, and the rate at which they are getting fat is also increasing.

One of the causes of obesity is the significant decrease in physical activity; another important reason is the atavistic complex we carry with us, due to the fact that for hundreds of thousands of years we have had to fight against starving our children. We therefore have great difficulty in limiting our children's food desires, even when these desires are excessive. The binomial fat = good health, is difficult to banish and continues to linger in the minds of parents, especially mothers.

Interventions

To avoid overeating and the resulting obesity, it is good:

- ❖ prepare foods that the child likes but with limited calories;
- ❖ avoid cooking excessive amounts of food, so that the child, having finished his or her ration, cannot ask for more;
- ❖ To promote satiety, an excellent expedient is to prepare salads, fruit salads, cooked vegetables and plenty of fruit, without overdoing the seasonings;
- ❖ keep in the fridge, in small quantities, only a few selected foods and therefore avoid, in the diet of the whole family and not only for the child, fatty foods, excessive condiments, snacks;
- ❖ practice and have their children practice physical activities;
- ❖ avoid having your child eat in front of the TV or while using other electronic devices.

Bulimia

The classic image of the bulimic child is that of a chubby kid who sneaks up to the refrigerator at night and tries to empty it, stuffing his mouth and devouring everything he can get his hands on, before being discovered by his parents. Bulimic children indiscriminately pack high-calorie foods into one gargantuan meal: such as jam, chocolate, cold pasta left at lunchtime, fatty cheeses and so on. Inherent in the concept of bulimia is the imperious need to binge on anything edible, without even being able to taste what one is swallowing.

Potomania

In potomania, there is an overwhelming need to drink large quantities of water or sugary liquids: fruit juices, orangeade, etc.

The pica

Children displaying this symptom tend to swallow inedible substances and objects: nails, coins, paper, earth, sand, etc. However, one can only speak of a child suffering from *pica* when the child is well past the age of discovering the characteristics of objects through the mouth.

Coprophagy

If the young child between the ages of two and four has no problems playing with his or her faeces, a disgust for this material should arise at a higher age. This does not come about in the child with *coprophagia*, who continues to play with his faeces, even after this age. The same may occur in the child with psychotic regression.

The causes

Organic causes

Eating disorders can be caused by medical conditions such as the presence of endocrinopathies, metabolic diseases, gastrointestinal pathologies, oral-glossopharyngeal motor disorders, etc.

Environmental causes

The environmental causes are complex and numerous.

When eating disorders of a certain severity are present in a child, we frequently find a conflictual and tense family climate. Sometimes the clashes occur precisely at mealtimes. In some children, the bad relationship with food may be caused by the need to demonstrate a minimum of independence from overly oppressive parents, who attach too much importance to food and the need for the child to obey their demands. In such cases he/she must eat; if

he/she does not eat, it makes the parents feel bad, as it delegitimises their authority and, at the same time, increases maternal and/or paternal anxiety.

In other cases, it is the parents' haste that prevents the child from enjoying food. The haste and impatience due to various commitments and work becomes, with regard to the child, a compulsion to eat everything and quickly, without the possibility of a calm dialogue and without enjoying anything. With the easy consequence of having, because of this, nausea, vomiting and other intestinal discomforts that emphasise, in the child's soul in a negative way, both the act of eating and the food itself.

Interventions

Since this type of problem is linked to psychic disorders of a certain importance, it is not enough to focus only on the symptoms related to nutrition; it is often necessary to address the overall well-being of the child and the family in which the child lives. It is therefore necessary:

- improve erroneous educational attitudes, because they are too oppressive, anxious, frustrating, irritating, while at the same time offering the child the right physical and psychological space;

- daily encourage free and spontaneous play in the open air, in the company of some peers with whom a relationship of dialogue and friendship has been established;

- limit, if excessive, the time spent studying, alternating it with moments of leisure, to be implemented away from electronic devices;

- in the presence of conflict in the family environment, it is essential to initiate serious couple or family therapy;

- carry out activities with the child to help him or her regain good serenity and psychological balance, through psychomotor exercises, music therapy, relaxation therapy, psychotherapy.

Alterations in sphincter control

For De Ajuriaguerra and Marcelli (1986, p. 124) 'the acquisition of sphincter control occurs as a result of the pleasure felt first for expulsion, then for retention, then for the coupled retention-expulsion: the new mastery over one's own body provides the child with a happiness reinforced by maternal satisfaction'.

These physiological functions can alter the mother-child relationship, so that there may be a mother who takes pleasure in cleaning the child and takes advantage of those moments to have a moment of greater dialogue and intimacy with the child, while, on the other hand, there may be a mother who gets upset, gets nervous or feels disgust at being forced to perform these tasks. In this case, it is evident that the woman sends a negative message to the child about the child's body, which translates into a negative message about the child itself.

In addition, the mother, even without meaning to, makes judgements on her child's behaviour in this regard: for example, her child is good when he takes his daily 'poo-poo' first in his nappy and then in the potty, while he is bad when he does not, when he does it too often or when he does it at the least opportune time or place, forcing his mother to engage in unpleasant and laborious operations. On the other hand, the child also makes judgements about the mother on these occasions. For him, a mother is good when she welcomes his excrement and is quick and good at cleaning, while she is bad when she gets angry or nervous too much or too easily, for reasons related to her physiological functions and hygiene.

Enuresis

Enuresis is defined as the active, complete and uncontrolled emission of urine after the period of physiological maturity has passed. While for authors such as Ajuriaguerra and Marcelli (1986, p. 124) this maturity is acquired between three and four years of age, for other authors the limit of the physiological acquisition of sphincter control should be within five to six years.

A distinction *is made between primary enuresis* when this control is not gained at a physiological age and *secondary enuresis* when this control, which had already been gained, is lost at a later stage. With regard to frequency, *enuresis* can be *daily, weekly or occasional*. While, as regards the time of day in which the uncontrolled expulsion of urine occurs, it can be *diurnal, nocturnal or mixed. Nocturnal enuresis* is more frequent in males while *diurnal enuresis* is more frequent in females. This disorder usually diminishes considerably after puberty.

Enuresis may lead to a decrease in self-esteem, may force the child to avoid sleeping outside the home, with consequent impairment of his relational and social life, and may trigger a bad relationship between the child and the mother, who may feel forced to work much harder because of this problem. In such cases, anger, rage and resentment may rise in the woman's soul towards her 'pissy' child. The latter, in turn, affected by these negative feelings, is likely to experience this problem with anxiety, fear, feelings of guilt and indignity which, in turn, may lead not only to a persistence of enuresis, but also to other manifestations of suffering and inner discomfort. It is therefore a good idea to strive to resolve this disorder quickly and radically, to prevent the child and his family from continuing frustration.

The causes

Organic causes

Genetic factors and various organic causes have been blamed: such as anatomical and functional abnormalities of the bladder; dysfunctions of the genito-urinary tract; urinary tract infections; but also sleep disorders, whereby the urge to urinate fails to interrupt the child's excessively deep sleep. Nocturnal enuresis is also associated with deficient nocturnal production of the antidiuretic hormone (ADH- antidiuretic hormone) by the hypothalamus. This hormone reduces diuresis during the night. Therefore, replacement therapy with desmopressin is recommended in these cases.

Environmental causes

If organic and hereditary components can contribute to the onset of enuresis, we believe that psychological factors of environmental origin are the most frequent and important. In fact, enuresis from neurological damage does not usually exceed 30% of cases, while enuresis from psychological pathogenesis reaches 70%.

Inner well-being or discomfort greatly influences sphincter control of both faeces and urine, so much so that in animals and humans fear and other intense emotions, not only negative but also positive, can alter this control. Hence the expression 'shitting oneself with fear' but also 'laughing with laughter'.

Also for De Ajuriaguerra and Marcelli (1986, p. 126): "The psychological factors remain the most evident. Suffice it to recall the frequent correspondence between the appearance and disappearance of enuresis and that of an episode that marks the child's life: family separation, the birth of a little brother or sister, entry into school, emotions of any kind...".

The environmental reasons that can lead to enuresis can be, as with the other signs of suffering, numerous: family conflicts, socio-economic deficiencies, institutionalisation, hospitalisation, parents with phobic-obsessive characteristics, excessively authoritarian and repressive attitudes on the part of family members or

adults, change of home, excessively authoritarian educational approach, and so on. The child suffering from enuresis is described as being phlegmatic, shy, anxious, insecure, therefore enuresis due to environmental reasons can be considered as a manifestation of anxiety with a neurovegetative effect on bladder functions, or as an expression of hostility towards a mother who is not attentive to her child's needs.

Interventions

- In the meantime, it is good to approach this problem with tranquillity, serenity and confidence.
- Avoid scolding or blaming the child for this involuntary disorder. The frustration that would result, in addition to the risk of causing psychological problems, could make the enuresis persist over time. These children, on the contrary, need more gratification and emotional reassurance.
- Have the child eat dinner very early in the evening or in any case a few hours before going to bed, so that, while awake, a large part of the water drunk during dinner is eliminated with urine.
- Avoid, especially in the evening, feeding your child salty or water-rich foods.
- Place a small light next to the child's bed and his potty, so that when he wakes up, he can urinate easily without having to go to the toilet.
- Use alarm devices, which allow the child to wake up as soon as he starts wetting the bed. In this way he will get

used to contracting the bladder sphincter every time the alarm sounds.

- ❖ It is also a good idea for parents to take turns making the child urinate in the potty, at least two to three times during the night, at times when he or she usually wets himself or herself.

- ❖ Mark on a chart the nights and times when the child had enuresis.

- ❖ In order to strengthen the bladder musculature and to accustom the child to exercising more control over reflexes, one can encourage the child to hold his or her pee for some time during the day, in waking moments, with a voluntary action.

- ❖ To further motivate the child, you can reward him with a small present every night that he does not wet the bed.

Frequent daytime urination syndrome

In some children there is an urgent, imperative and incoercible urge to urinate during the day, with very short intervals ranging from five to twenty minutes. "Although the concomitance of some organic triggering factor, possibly of a viral nature, cannot be ruled out, frequent daytime urination, unaccompanied by nocturia, seems to suggest a behavioural aetiology" (Walker, Rickwood, 1989, p. 48). The causes of this symptom are most often to be found in a situation of stress, depression and anxiety in the child.

Encopresis

It is defecation in the underwear or nappy even when the child is over two to three years old.

Also for this disorder, *a* distinction *is made between a primary encopresis,* when the child has not yet achieved good control of the anal sphincter. And *a secondary encopresis*, when, after a more or less long period of stool control, the child returns to soiling.

During defecation, some children seem not to notice what is happening and continue to play quietly, others isolate themselves in a corner and then voluntarily defecate outside the potty or the toilet, others still run to the toilet but do not make it in time.

In turn, however, these various behaviours may be found in the same child on different occasions, so it is not always clear how voluntary this disorder is or is not. Encopresis is often associated with enuresis (Militerni, 2004, p. 338).

Causes

Organic causes

A 'trivial' cause can be found in children who suffer from constipation or who have fissures or other anal lesions. In these cases, a vicious circle is often set in motion: the child, due to constipation, experiences considerable pain during defecation, so he or she tries to hold back the faeces as much as possible; this increases the consistency of the faeces and, therefore, the child's pain during defecation is accentuated. The pain experienced, in turn, increases the child's repulsion towards this physiological function.

Environmental causes

According to Militerni (2004, p. 337): "Very often the disorder is the expression of a serious disharmony in the child's relations with his parents". The same author states that in these cases "...it is frequent to find conflictual family dynamics and inadequate affective-educational styles" (Militerni, 2004, p. 337). This symptom is often present in autistic children, psychotic regressions and other severe psychic disorders. In these cases, the child

may present a defiant attitude, whereby he or she exhibits dirty laundry, showing insensitivity to observations and reprimands.

As one can well understand, parents almost always tolerate this type of disorder very badly and adopt repressive and blaming attitudes that accentuate the difficulties in their relationship with their child and consequently also the symptoms.

Interventions

When encopresis is due to painful defecation, interventions will be aimed at avoiding constipation and treating the anal area. When, on the other hand, encopresis is only an indication of a broader and more important psychological disturbance, such as an altered parent-child relationship, it will necessarily be necessary to intervene by means of psychotherapy aimed at both the family and the child.

Self-esteem and self-efficacy

Self-esteem is one of the most important aspects of the individual's intrapsychic world.

For Militerni (2004, p. 100): "Self-esteem can be defined as the evaluation of qualities that the individual perceives as his own. Each individual makes qualitative judgements about himself and his own qualities: aesthetic, moral, social, intellectual, motor etc. "Unlike self-esteem, which rather concerns a general value judgement about oneself, *self-efficacy* consists in the conviction of being able to achieve a specific goal, carrying out all the steps to reach the goal". (Bonino, 2006, p. 26).

Self-esteem reflects not only the objective view of our personal, family and social reality, but above all, it reflects how others judge and evaluate us. Having low self-esteem means having negative feelings about one's own qualities, abilities or competences.

When a child is excessively reprimanded for his or her limitations in learning, for his or her outward appearance, or for the

way he or she behaves, he or she will necessarily find it difficult to see himself or herself in the right perspective, so it is easy for the dislike to lead to anxiety, insecurity, closedness, shyness and sadness, which can go as far as severe depression.

When low self-esteem is present, even if it arises from a particular defect of the child, it tends to spread to all aspects of his life. If, for example, a child is teased because of a physical defect, there is a risk that the suffering he feels because of his classmates' behaviour will disrupt his inner world, so that he may think that he is not good enough even in learning. This will lead him to face study and questions without the necessary inner serenity and with little confidence in himself and his qualities, with negative consequences also on his school performance. In other cases, on the contrary, the frustrations suffered may stimulate in the child the need to defend his or her ego from the devaluation operated by the external environment, resulting in unstable, aggressive, irritating, choleric and explosive behaviour.

The causes of disaffection

Both self-esteem and self-efficacy are developed primarily through positive personal experiences. The reasons that can lead to disesteem may not only arise from external judgement, but also stem from an excessively harsh way in which the child judges himself, inn reference to others. It may happen, for example, that a child judges himself as incapable because, despite all his efforts, he does poorly at school, and this despite the fact that the responsibility for his poor performance can be blamed on some incompetent teacher or on his parents who were not attentive and helpful in providing him with the necessary help and support in the home environment or a suitable climate for studying and learning. On the other hand, in turn, self-esteem conditions learning, so that a vicious circle can be triggered: low self-esteem leads to difficulties in learning, and these, in turn, further diminish confidence in

oneself and one's own qualities. We often find low self-esteem in children with physical or mental disabilities if the handling of the disability is not properly addressed.

Low self-esteem can occur when praise and commendation are scarce, while reminders and reprimands are frequent. Low self-esteem can also occur when the child is in a broken or conflict-ridden family, in which the parents have childish, immature and responsible behaviour. In this case, the negative judgement on the parents reflects on the child itself, as part of the same family community. This occurs not only because the child may feel that he or she is, at least in part, responsible for the conflict or separation, but also because of the negative image the parents give of each other.

How to be a proud son when the mother is judged by the father, but also by the father's family, to be "a crazy, hysterical, no-good woman who broke up a family to run off with the first hottie she could find" while the father is seen by the other side as "an overbearing, irresponsible man incapable of providing for his family?"

In Marco, a thirteen-year-old boy, we could only detect low self-esteem from his stories, while his parents only noticed in him and reported his fears, writing difficulties, anxieties and nervousness as problems.

An ugly child who wanted to learn to drive

"Once upon a time there was Luigi. Today was the day to get his driving licence. In the driving school everyone laughed at him because he had a moustache and yellow teeth. When he got into the car, the teacher was frightened by his ugliness. Luigi was surprised by the teacher's reaction and pressed the accelerator. The teacher told him that he was wrong. Every thing he did he scolded him. He was very confused and then, in the end, he did not get his licence and his friends made fun of him. He tried again to drive

the car well and succeeded, but he did not realise that a car was coming at him, hit him and he died".

In this first story, carried out in his therapeutic journey, the child describes, as best one could, what triggers dislike, what keeps it alive and the consequences it causes. In the meantime, he immediately points out how simple diversity can become physical ugliness in the eyes of others and how this very often provokes hilarity and ridicule (*In the driving school everyone laughed at him because he had a moustache and yellow teeth).* The hilarity and derision, in turn, provoke in the unfortunate person a state of frustration that translates into psychological malaise, resulting in incapacity in the activities undertaken (*Luigi was surprised by the teacher's reaction and pressed the accelerator).* Inability, in turn, fuels other frustrations: in this case, failing the driving tests. These frustrations are followed by further mockery by his peers for failing (in the *end he did not get his driving licence and his friends made fun of him).* It should be noted how the negative reactions of those around, even if adult and with an educational role, often only accentuate the problems of the child, who is the victim of these problems (*The teacher told him that he was wrong. Every thing he did she reprimanded him).*

Marco, in his account, then emphasises how the consequence of the disaffection causes a serious inner discomfort in him: confusion, which, in turn, only worsens the performance (*He was very confused).* The resulting pessimism and mental state prevent the child's positive reaction from succeeding (*He tried again to drive the car well and succeeded, but did not realise that a car was coming at him, the car hit him and he died).*

These last, tragic words, with which Marco ends the story, highlight very well the state of mind of children suffering from disesteem. Being run over and dying are not only the baleful consequence of inner discomfort and consequent confusion, they can

also, unfortunately, represent the deepest desire of every child who finds himself in this serious situation of malaise!

Victim of the goddess of ugliness

"Once upon a time there was a man called Claudio. All the girls liked him. One day, in the sky, the goddess of ugliness saw him and made him ugly, with eyes of different colours. When the girls saw him they fainted from such ugliness. He, discovering the spell, ascended into the sky and asked the goddess the reason for the spell, and she replied that no one could be more beautiful than she was, but that what counted was inner beauty and not outer beauty'.

In this second story, Marco manifests his low self-esteem by focusing it, once again, on physical beauty. In this case it is the envy of others that causes his problems. The child tries to understand why he might be involved in this kind of situation and blames it no longer on himself but on someone outside of him (*One day, the goddess of ugliness saw him in the sky and made him ugly, with eyes of different colours)*. The consequences of this can only be disastrous (*When the girls saw him they fainted from such ugliness)!* However, since his problems come from outside, he can try to solve them *(He discovered the spell and went up to the sky and asked the goddess the reason for the spell and she answered that no one could be more beautiful than her).* At the end of the tale, the child tries to accept himself as he is, putting into the mouth of the jealous goddess herself the words he will have said so many times to try to diminish his low self-esteem (*that what counted was inner beauty and not outer beauty).*

The different tree

"Once upon a time there was a seed, the farmer started to water the seed and, after a while, a beautiful fir tree was born, which was different from the others: with yellow leaves in the

shape of a forest tree. The other pine trees saw him as different and made fun of him, and he respected deva that he was different because he was better and asked to be left alone. The poor tree thought about what the other pines were saying and doubted whether it was a real pine tree. Searching, he discovered that he had been planted there by mistake. Nevertheless, he was happy because he realised that he was special.

Marco's improvement is very evident in this third tale, in which he manages to have a good acceptance of himself and his particular characteristics, so that he can compare himself with other peers and react appropriately to their mockery *(The other pines saw him as different and made fun of him and he replied that he was different because he was better and asked to be left alone).* And it is always in this tale that the child manages to detach himself from the need to conform to the group by exalting his peculiarities. In fact, at the end of the story, Marco manages to judge his diversity not as a limitation or a handicap but as a value *(However he was happy because he realised he was special).*

Interventions

Self-esteem is a valuable asset that must be cultivated and protected. It is the task of parents, family members, teachers and adults in general to nurture it in children's souls and then nurture it so that it grows and develops properly.

- In order to achieve this, since self-esteem arises first and foremost from a good relationship with adults, it is good to listen to the child attentively when he tells of his feats, discoveries or small 'inventions'. This will make him feel proud of himself and his abilities. Furthermore, it is important to respond promptly to his needs, as caring and consistent responses will make him feel loved and, therefore, self-confident.

- Moreover, it is fundamental that the adults who are important to him: parents and teachers, perceive the child in a positive way, so that when they find themselves talking about him within the family, with strangers or with friends, they will highlight his merits and not his defects. Similarly, when these adults converse with the child, while praising and highlighting all the positive behaviours he or she carries out and all the qualities he or she possesses, they will try to leave out any deficiencies or shortcomings.

- If the child presents attitudes and behaviour that are definitely criticisable or negative, it is necessary to analyse all the attitudes from the environment that tend to make them worse and those, on the other hand, that tend to improve them. In this way, all negative judgements that tend to worsen his or her self-esteem will be drastically reduced, while those words and behaviours that tend to improve it will be reinforced

- It is also important to make the most of all the child's particular abilities, giving him tasks in which he can bring out his particular talents and abilities. Similarly, to avoid possible frustration, he should be given tasks appropriate to his intellectual and cognitive possibilities, so that he can always accomplish them, quickly and well. Expectations of him will necessarily have to be reasonable, without trying to ask too much of him by pushing him beyond his limits and, above all, without making unnecessary comparisons with his siblings or other peers.

- It is good to help the child with low self-esteem, in the achievement of some of his goals, whatever they may

be: school, sporting, artistic, technical, etc., without ever taking his place, so that he can be proud of everything he has achieved. This can be done by helping him in the development of some of his passions, which can be painting, drawing, music, writing, etc.

- The teachers, for their part, will try to establish a special and individual, though not privileged, channel of communication with the child who has low self-esteem. This special attention will make him or her feel wanted and thus stronger and more secure. In group work, they will allow the child whose self-esteem they want to improve to play the role that is most congenial to them and that is also important for the success of the work.

Communication disorders

For communication to take place, correctly, several elements are required.

1. *Interest.* Interest is the first of these elements. If the other can give something to the child, can help him, support him, assist him in something, his interest in communicating will be very high. On the contrary, if through his experience the child has found that others do not listen to him, are not close to him, do not support and help him, his interest in communicating will be very low. It is evident that the child's interest in communicating with his mother and father is considerable, since they are the people who, more than any other, can give him the things that are fundamental to him: food, security, warmth, affection, acceptance.

2. *The pleasure in communicating*. If dialogue with the other is pleasant, gratifying, attractive, tempting, the child will make many efforts to dialogue frequently and in the best possible way. On the contrary, if he is afraid of the other,

if he perceives the other as an enemy, if he does not trust him, if he is afraid of the world, if communication brings him suffering, if his needs are not listened to, he will lack an important stimulus to communicate.

3. *Adequate psychic conditions.* Certainly very deficient intellectual capacities diminish the possibility of structuring one's ideas and thinking adequately; certainly neurological or sensory disorders can make verbal language difficult if not impossible, but communication, even if in a simple and poor manner, can still take place. The most important deficit, capable of preventing the possibility of dialogical communion with the other, the normal and correct processing of thought, its translation into words comprehensible, by means of language, even to subjects of high intellectual capacity, concerns the subject's emotional and affective disorders. Excessive arousal, considerable anxiety, coercive fear, inhibiting depression, considerably reduce the subject's ability to communicate, since, the subject's mind, greatly altered, prevents the organisation and processing of thought and makes normal exposition of content impossible. If thought is greatly disturbed, or worse disrupted and unstructured, language and communication, in general, will also suffer considerably. For all these reasons, the quality and quantity of communication in adults and minors is by no means constant but varies continuously according to the person's psychic condition, and this, in turn, is influenced by the environment in which the subject lives. Therefore, psychological malaise is capable of blocking or deconstructing communication and language in both adults and children to the point of dissociation and autism. Alterations in the communication system and social interaction are present in a more or less evident, more or less severe, more or less conspicuous

manner in almost all psychic disorders: they are not lacking in children with attention deficit and hyperactivity, in anxiety disorders, in very shy and closed children or children with low self-esteem, in conduct disorders, in depressed children. They are present when the child suffers from fears and phobias, but, above all, they are more evident in children with selective mutism, stuttering and Autistic Disorder. There is, therefore, a continuum between a relational situation in which communication is easy, fluid, immediate, which greatly facilitates dialogue, understanding and communion with the other, and the opposite condition: in which the subject's communicative and relational abilities are minimal and/or very disturbed.

Total muteness acquired

This type of mutism occurs towards all people and can appear after a psychological shock. Fortunately, just as suddenly as it appears, it can also disappear just as quickly and suddenly. Usually, acquired total mutism is followed by a period in which the subject speaks in a whisper or presents a stutter.

Stable selective mutism

In selective mutism, the child can only speak and communicate in certain environments and with certain people, but cannot do the same in other environments and with other people. For example, he can speak in his home, but not outside it. He can talk to family members, but not to strangers; to classmates, but not to the teacher; to all but one teacher. Although the fact of talking in the home but not outside the home gives the idea of a physical space, in reality these are always psychological spaces, which the child has succeeded or not yet succeeded in conquering.

To understand selective mutism, we must graphically imagine the achievement of social communication as concentric

circles. In the first, the innermost one, there is the figure of the mother and father. If the child manages to relate well with these basic figures, he will acquire the necessary strength and confidence to open up to his grandparents, and then progressively to his brothers and sisters. Later he will try to relate well with other family members; then it will be the turn of a few companions with whom a good relationship has been established for some time, and only at the end of a process of maturation will he be able to relate also with strangers. Every bond of trust that he manages to establish well is an achievement, but it is also a solid basis for going further, for conquering the next social and communicative level. The more anxious, shy, psychologically disturbed the child is, the more he remains anchored to lower levels of development, which prevent him from conquering new communicative and social environments. Since, in the long run, this limitation is perceived by the child as a deficiency in relation to others, there is the risk of an accentuation of his discomfort and inner difficulties. This is why selective mutism can last for several years.

Interventions

When these communication difficulties are present, it is essential to create a serene and joyful environment around the child, so that he feels at ease both in the family and at school. At the same time, it is a good idea to avoid pressurising the child in order to push him or, worse, force him to communicate, as this violence will only worsen his already bad relationship with reality outside him. Since it is rare for communication to disappear completely, it is important that parents and educators accept without reservation the tools, methods and times that the child is able to use.

Within the class, it is a good idea for him initially to enter into a relationship with a single peer of his choice with whom there is an affinity of character and with whom he can establish, or has

already established, some communication and understanding, even non-verbal.

Stuttering

This is an impairment that affects the orderly and effective display of ideas and feelings through words. It is present in approximately 1 per cent of children, mainly boys (three to four boys to one girl) (De Ajuriaguerra, Marcelli, 1986, p. 247).

There are two distinct types of stuttering that often co-exist in the same subject: *the tonic type and the clonic type*. In *tonic type stuttering*, the subject has difficulty emitting a sound, while in *clonic type stuttering* there is interrupted and explosive repetition of the same syllable.

In stuttering, various other symptoms may be present as corollaries, such as facial twitching, tics or the presence of variable, more or less stereotyped gestures, along with other emotional manifestations, such as facial flushing, a painful feeling of discomfort, sweating hands.

A child's stammering is considered physiological up to the age of three to five years, since, at this age, the elocution difficulty may not be related to any emotional problem, but may arise from the need of the child, who is learning language, to find appropriate syllables and words to express his or her thoughts.

Causes

Possible organic causes

Both a possible genetic predisposition and a delay in language acquisition are indicated as organic causes.

Possible psychological causes

According to Militerni (2004, p. 365): "The psychogenetic orientation tends to emphasise a finding, which is also very frequent, represented by a close link between stuttering and emotional conditions, particularly evident in certain relational situations".

In fact, this symptom, has a variable trend: it increases with increasing emotionality, decreases a lot when the child is calm and attenuates when the language is automated (singing, playing, repetition of pieces from memory). In some cases there are remissions that may last even several months, alternating with phases of flare-ups (Militerni, 2004, p. 366).

The highest incidence of stuttering occurs between the ages of six and ten; precisely with the child's insertion into the school environment. Insertion that requires a considerable psychological commitment. (Militerni, 2004, p. 366).

According to De Ajuriaguerra and Marcelli (1986, p. 107) this symptom is most frequently found in subjects with introversion, anxiety, passivity, submissiveness, aggression and impulsiveness.

The psycho-physiological approach makes stuttering the result of a conflict "in which anxiety provokes the block that by negative feedback later releases speech and it is from this that the fragmentary and repetitive aspect of language manifests itself (Sheehan, in De Ajuriaguerra, Marcelli, 1986, p. 107)". Psychoanalysis, on the other hand, places stuttering between conversion hysteria and obsessive neurosis.

Interventions

The treatment of this disorder relies heavily on orthophonic re-education, relaxation techniques, the possibility of expressing latent aggression in play, psychodrama, but also individual psychotherapy.

Socialisation disorders

As for social interaction, that is, the ability to enter into a relationship with the other, this requires adequate inner experiences. The other must not create discomfort or fear in me, on the contrary,

I must perceive him as a friend, close, available, attentive and accepting. This will push me to open up to him. This will stimulate me to seek confrontation and dialogue with him. If this does not happen, if the other is perceived as distant and cold, if the other is perceived as the bearer of anxieties, fears, insecurities and frustrations, social interaction will be deficient or will not take place at all.

The child only acquires the ability to socialise with strangers if he has experienced a serene and satisfying relationship with family figures. It is only the goodness of this relationship and the serenity of the living environment in which he or she has lived that will enable him or her to open his or her mind, interest and constructive attention also to strangers. Social interaction skills can be excellent, good, normal, modest or poor and, therefore, pathological. We will have, at one extreme, children who socialise easily with everyone, while at the other extreme we will find children with severe forms of autism, who do not communicate or have severe difficulties in communicating. The children closest to the norm are those who open up to others, when and only if they are certain they can trust them. Then there are the children who interact, but with constant confrontation, spite and aggression. Then there are those who manage to interact, fully and constructively, only with a companion who has personality characteristics very close to or complementary to their own. Then there are children who are only able to interact with an adult: usually their mother, father, aunt or grandparent. More severely disturbed children will also have difficulty communicating with their mother or father.

Difficulties in socialising can manifest themselves with inhibition or disinhibition,

Forms with inhibition

In these forms, the mimicry is not very lively, the posture is excessively stable, the child does not adhere to the instructions, or, if he does, he does so passively; he does not take the initiative in the exchange; he limits himself to answering the questions put to him; the language is coarse and poor on the narrative level (Militerni, 2004, p. 108). We find these forms of socialisation difficulties in the shy, inhibited child, in social phobia, in anxiety and mood disorders, in selective mutism, in oppositional defiant disorder, when low self-esteem is present due to inadequacy or malformations or disabilities and, of course, in pervasive developmental disorders.

Shapes with disinhibition

In these forms there are high levels of motor activity. The child also over-familiarises with strangers, appears particularly curious, but distractible. He answers questions put to him by enriching the answers with sentences that do not fit the context. He asks continuous questions without being interested in the answers. Even in this form, if the quantity of socialisation is good, the same cannot be said for the quality of the relationship, as the normal flow of interpersonal exchanges is compromised. This form with disinhibition is mainly present in manic mood disorders, conduct disorders and attention deficit hyperactivity disorder.

Difficulties during play

It is well known that play has various purposes and is a central element in a child's life. Through this basic growth tool, the small human being develops all human potential: intelligence, emotionality, sociability, affectivity, motor skills, sensorial skills, etc.

Since play is indispensable for him to explore and get to know the material, emotional, relational and social world around him, it is through play that he learns to know, communicate and

socialise with others. By controlling and modulating his emotions and impulses, the child gradually becomes independent from his parents and adults, strengthens his will, discovers the need for rules and the ways in which he can use them to best effect, and comes into contact with himself and the world of nature.

Play is also an excellent tool for understanding the dynamics concerning the child's inner world (Militerni, 2004, p. 78). Through play we understand: the quantity and quality of his needs; his imaginative capacities; his more or less normal or accentuated needs for order, method, cleanliness; his inner harmony or disharmony; his psychomotor skills; his tolerance or intolerance to frustrations; his greater or lesser need to communicate with others, and so on. Through play, his disinhibition or inhibition; his inner serenity or his state of tension and excitement; his state of well-being and joy or his state of sadness and apathy; his greater or lesser reactivity; his tendencies towards aggression and destructiveness are made evident. Ultimately, the variety, richness and quality of the child's games allow us to observe his inner world and to know the greater or lesser seriousness of his possible psycho-affective problems.

When we observe a child playing, if his activities are rich and varied, if he plays constructive games, and if he is able to play both alone and with adults and his peers, we can be fairly reassured that his inner world is not very disturbed.

On the contrary, they are signs of an altered inner reality:

- when the little one, during its first year of life, does not participate in the simple games proposed by its mother and when, older, it fails to play, or plays very little, with its parents or with other adults, with whom it has established an affective and trusting bond;

- when around the age of three to four, he is also unable to accept the games and rules proposed by others, so

that solitary games prevail in the day over those played in twos or in groups;

- ❖ The opposite situation, in which the child can only play group games, but is unable and unwilling to play, even for a short time, alone, is also a negative sign;

- ❖ when the child does not use or misuses age-appropriate toys or uses only a few toys and in a repetitive manner;

- ❖ when aggressive, destructive or regressive activities and fantasies clearly and consistently prevail in solitary, two-person or group play;

- ❖ when the game or games are too unstable, changeable and chaotic;

The most severe impairment is found in children with autistic disorder, whose games are very poor, repetitive, abnormal. Games of imagination, simulation and social imitation are often lacking in these children. They especially like lonely games tary, as they often refuse to participate in those proposed by others and do not respect any rules. It has been noted, however, that these same children happily accept free self-managed play, as they feel perfectly free in this mode.

Finally, it should not be underestimated that therapies using play are among the most effective and widespread.

Repetitive behaviour and stereotypies

Repetitive behaviour and resistance to change are not in themselves characteristic conducts of a pathology, as they are present in both adults and normal children, especially when they are under particular stress. In these cases, the repetition of movement,

such as turning a pen, a sheet of paper, a small toy between the fingers, has the effect of releasing inner tension, relaxing and improving, at the same time, concentration on the task to which the subject is currently engaged.

However, the need for repetitive behaviour is greatly accentuated when the child is suffering internally or when he is stressed, frustrated or worse traumatised. In these cases, in order to feel calm, he needs objects and the world outside him to change little or nothing. Therefore, we find these attitudes to a remarkable extent especially in children with obsessive traits or autistic syndromes. These children cannot stand objects being placed even in a slightly disordered way and like events around them to always unfold in the same way and using the same objects. They therefore easily go into crisis if adults change even slightly the occupations, places and events that accompany them during the day.

Galimberti (2006, p. 359) expresses himself in this regard as follows: 'This thesis, as well as by Malinowski, who sees in the ritual repetition and codified an effective tool for reducing anxiety, is also supported by Van Gennep A., who assigns to the ritual the task of protecting the individual in the phases of transition from adolescence to adulthood, from celibacy to marriage, from life to death, and the like. Along the same lines is the interpretation of De Martino E., for whom ritual helps to overcome and endure the difficulties one encounters on a daily basis, as it provides reassuring models of behaviour, guaranteed by tradition'.

Stereotypies

Stereotypy refers to the repetition of an unchanged and constant sequence of a behaviour.

Stereotypies may involve motor activity (*motor stereotypies*), communication, both written and verbal *(communication stereotypies)*, *games (game stereotypies), drawing (drawing stereotypies)* and so on.

When the child presents *motor stereotypies*, he or she moves certain parts of the body in a rhythmic way for a long time: the hands, trunk, face or head. When the stereotypies affect the hands they are like cakes, moved on a surface, waved in the air or in front of the eyes, rubbed or clapped on top of each other. If they affect the trunk, it may undergo rocking movements backwards and forwards or from side to side.

When the child shows stereotypies in communication, he or she emits the same shrieks or a continuous sound with the same tone or asks the same questions over and over again, even though he or she knows the answers very well. Other children with this type of symptoms write long lists of words, phrases and names.

If interest stereotypies are present, children become absorbed in one or more types of interests that are narrow and abnormal either in intensity or focus and appear subservient to useless habits or specific rituals. For example, they always demand to see the same film or cartoon or they only want to talk about a certain topic: dinosaurs, witches, films by a certain actor.

Stereotypes in behaviour are often characterised by demands that are always the same. For example, to press the lift button, to wet their hands, to turn the light on and off.

As far as *stereotypies in toys are concerned*, once a toy is chosen, it is used by the child in the same way again and again, for far, far too long. For example, the child continually makes the same toy car move back and forth, in the same place, or continuously spins its wheels with his finger. Other children move a piece of cardboard in front of their eyes or spin a spinning top.

Stereotypies in drawing are also very evident. Children suffering from them tend to always draw the same element that, for some reason, is predominant in their minds at that moment, without making any criticism for anomalies in the drawing. Therefore, these children may always represent the same subject in their drawings, for example: a remarkable series of poles, a small house

with an absurd number of windows and doors, a sky with several suns or moons, a sea dotted with a considerable number of buoys and so on.

Stereotyped behaviour can vary over time in its characteristics, intensity and frequency, depending on environmental changes and the child's experiences at any given time.

The causes

Various stereotyped movements are present in animals when they are kept under conditions of discomfort and excessive stress. These behaviours do not occur or cease, when they are given the opportunity to lead a normal social and relational life and are offered sufficient living space. In human beings, we find stereotyped behaviour when the psyche is subjected to a considerable and enduring state of tension and malaise. These behaviours are present in autistic children, in those from orphanages and orphanages, in some mentally retarded people, in some deafness or blindness sufferers, whenever these disabled people are poorly managed by their families or institutions, so that they are subjected to considerable emotional deficiencies, combined with excessive frustration and stress.

In these children we can find all the types of stereotyped behaviour we have described above (Militerni, 2004, p. 255). Also in these children, as in animals, these types of symptoms are greatly attenuated or disappear completely when their anxiety and suffering diminish. That is why it is absolutely useless and counterproductive to strive to limit or try to extinguish these signs of suffering, through reprimands or worse through the use of punishments. Far better is to strive to offer the child a more serene, joyful and dialoguing environment.

Cognitive function disorders

A disturbance in cognitive functions is defined as a child's inability to perform at school: reading, writing, calculating, corresponding to his or her age and class.

The causes

This inability can have many causes: some may relate to the child, but others can certainly be attributed to the child's school and/or family environment.

Genetic and organic causes

Since learning capacities require biological and functional structures capable of performing the required activities, the child may have difficulties in one or more school performances because his or her intellectual capacities are deficient or not mature to a greater or lesser degree, in one or more functions due to particular genetic predispositions or due to one or more illnesses that the subject has undergone during his or her intra- and extra-uterine life, illnesses that have caused anatomical or functional alterations in the brain.

Environmental causes

Presence of affective-relational problems.

Cognitive functions are not isolated from the affective-relational context. The key to intelligence and mental development lies in early relationships and emotional experiences with the mother and the child's caregiver. All learning, scholastic and otherwise, is greatly facilitated when there is a good inner serenity, which allows the child to live in harmony with himself and with

others, while anxiety, depression and fears greatly disturb the capacity for attention and concentration. These capacities are indispensable in all learning, as they determine a greater and more stable memorisation, better performance in the processes of analysis and auditory synthesis, easier capacities in conceptualisation, better utilisation and exposition of what has been read or learnt. A good inner serenity allows the child a more stable and valid relationship with the teachers, a more lively interest in the various topics proposed for learning, greater resistance to frustration and an easier ability to move from one topic to another. Learning does not take place or takes place abnormally when the child is in the grip of tension, anxiety, fears, conflicts, or when sadness and melancholy deprive the child of the desire and the will to learn. Evidence of this is the sudden and conspicuous drop in school performance when something important upsets the child's soul: the presence of conflict or separation between parents in their family, a radical change in their living environment, such as the bereavement of some family member important to the child, a move, the birth of a sibling, fostering by persons with psychological disorders. The same teachers and parents later notice a recovery in cognitive abilities when the problems that afflicted the child have been happily resolved or the child has found better compensatory ways.

Cognitive function disorders can be caused by all those distressing situations that lead to anxiety, mood disorders, feelings of inadequacy, low self-esteem, pervasive developmental disorder, attention deficit hyperactivity disorder, etc. (Militerni, 2004, p. 108). A meta-analysis (Kavale and Forness, 1996) shows that children with learning disabilities have less ability to interact, communicate, empathise and play than their peers" (Donfrancesco, 1996, p. 76).

According to De Ajuriaguerra and Marcelli (1986, p. 135): 'Clinical experience shows how artificial it is to separate the so-

called affective state from cognitive functions, given that disturbances in one sphere end up, as a matter of course, affecting the other: thus some serious affective alterations are always accompanied, in the long run, by cognitive alterations. Similarly, it is exceptional that mental deficiency is not complicated by some affective difficulty, which is all the more serious the deeper the deficiency'.

This does not mean, however, that every psycho-affective disorder has a negative influence on learning and that every child with mental retardation will also have psycho-affective problems, but that there are frequent, possible influences between the two.

According to Morin (2001, p. 19): 'There is a close relationship between intelligence and affectivity: the faculty of reasoning can be reduced, if not destroyed, by a deficit of emotion; the weakening of emotional capacity can also be the cause of irrational behaviour and, in some ways, emotional capacity is indispensable to the implementation of rational behaviour'.

For Greenspan and Benderly (1988, p. 3): 'We have discovered that the highest capacities of the human mind, such as intelligence, morality, and sense of self, have unexpected common origins'.

And again Greenspan himself, analysing the early stages of the mind's development adds: "...it has been seen that each stage requires a series of fundamental and specific experiences and subtle emotional exchanges. Hence, it is not the intellect that dominates passion and feeling but the reverse'.

Lack of an individualised programme

Often, when a normal variability in cognitive abilities results in an IQ that is well below average, the operators (teachers, parents and neuropsychiatrists) do not always have the willingness or the foresight to offer these children, who are at the lower end

of the normal range, an individualised programme. In these situations, they are expected to perform in the same way as their peers with a significantly higher IQ. And since this is not possible, they are forced for years to tackle tasks that are not suited to their logical and cognitive development, with consequences on both the educational and psychological and relational levels.

Lack of suitable tools

Although the world of school publishing is very rich, it is not uncommon to find children lacking the appropriate tools for *learning*. As can be the lack of books, cards and other aids appropriate to their cultural and scholastic level.

Deficiencies in teaching

The child may fail to learn because of uncaring, unskilled or teachers who use methodologies that are not appropriate for his or her age or development. Many times these shortcomings relate to his or her family members. When there is a lack of willing, able and attentive parents or family members to follow their child through the course of his or her school life, the consequences are often just as dramatic. As Donfrancesco (1996, pp.441-442) says: "The person must be able to count on the cooperation of a supportive environment that facilitates, or at least does not hinder, progress towards the desired goals".

Lack of interest and motivation

Another cause must be found in the lack of interest or motivation for one or more school subjects. Each of us, adult or child, has particular predispositions and 'loves', just as we have particular dislikes towards one or more school subjects.

Scarce availability of time and psychic energy

The presence in the child's life of other, more pressing or involving commitments, resulting in a lack of time and energy available for study, should not be underestimated. For example, excessive extracurricular commitments: sports, music, dance or an inordinate use of electronic devices such as TV, computers, mobile phones, etc. Moreover, even today, it is not uncommon to find children unable to follow a normal school course because they are engaged in occupations that are indispensable to support other family members or to care for sick or incapacitated parents, siblings and grandparents.

Disorders of sexuality

The child recognises its gender very early: around the age of two to three. Already at the age of four to five, his sexual curiosity is evident. At this age, both boys and girls ask questions and show curiosity about the genitals and their functions, but they also have exhibitionist and voyeuristic attitudes towards not only other children but especially adults. Masturbatory behaviour also starts at a very early age (two to three years). Throughout childhood, sexual play within the same sex or with the opposite sex is not uncommon, but also play in which the child dresses up in the clothes of the opposite sex *(transvestism).* For these reasons, as for many other signs of distress, it is difficult to distinguish in the field of child sexuality what is normal from what is not. In many cases we are not allowed to diagnose specific sexual pathologies, since many apparently abnormal manifestations, present in childhood, disappear in adulthood. Attention should only be paid to sexual behaviour that is markedly abnormal in relation to age.

Abnormal sexual manifestations are present in psychotic children in whom, without any restraint, there may be sexual interests towards the father, mother or other adults, but also uncontrollable masturbatory and exhibitionistic behaviour This is be-

cause the severe inner suffering that pervades these children prevents and alters the adequate control of all drives, including sexual drives.

Both prevention and therapy of psychological problems related to the child's living environment require the input of numerous actors.

Parents' contributions

Since the child, when it is born, is not able to create and manage the external environment, so that it is suitable for its needs, this management must necessarily be provided by adults and especially by its parents. It is the adults who must work to ensure that the child is welcomed and can live in a home that is welcoming, albeit simple and clean. A home where he can satisfy his needs for food, hygiene, cleanliness, but also his needs for affectivity, social relations and play, needs that are indispensable to the development of every human being. It is the adults, who, with their discernment, with their will, with their commitment, will have to ensure that the child, when it comes into the world, can find parents who are sufficiently suited to the task of education and training.

Meanwhile, the child needs to find, when it is born, a good mother with whom to relate. A mother capable of entering into intimate contact with him. A mother who possesses affection in her manners, serenity in her soul, willingness and gentleness in her care; as well as good communication skills, so that she can easily establish an effective dialogue with her child. However, alongside a mother, a child that is born also needs a father who possesses good paternal qualities: a father who is serene, calm, responsible, secure and authoritative. A father who is attentive to the needs of the family. A father who is willing to commit his skills to following, protecting, caring for and guiding his little

ones. Since a child needs to live with essentially serene and balanced parents, although perfect normality is not essential, it is nevertheless important that they possess a good psychological balance. Therefore, the future parent should not fall prey to neurosis, psychosis or character and behavioural disorders. He or she should not be the bearer of excessive anxiety; he or she should not be easy prey to depression; just as he or she should not possess a rigid, obsessive, aloof, irritating, stressful, belligerent, quarrelsome or, worse, violent personality.

It should not, in the end, present major disturbances in relationships and communication. On the contrary, the future parent should know how to listen easily, to understand the peculiar characteristics of each child, so as to respond and meet their needs in an individualised manner. A future parent should be capable of softness, closeness, acceptance, warmth and availability, so as to give the children, according to their age and development, a sufficient amount of his or her time and energy. A future parent should possess good moral and spiritual qualities, along with qualities of faithfulness, seriousness, capacity for care and sacrifice, as well as good skills and availability for work and social commitments. A future parent should also be capable and committed to building an affectionate, stable, responsible, serene, dialoguing couple life, so as to be able to establish a serene, joyful and welcoming climate in the home environment.

It follows from this that the choice of partner should be particularly conscious, careful and targeted. Therefore, this choice cannot and should not be left solely to the feelings and emotions of the moment.

The contributions of society

As far as caring for minors is concerned, this is a dutiful commitment that should be fully assumed especially by parents and family members, but not only by them. The whole of society should feel the importance of caring for children and take upon itself this fundamental task. If only because it is convenient for it. If society, the whole of society gives generously of its commitment to man's cubs, it will, after a few years, have good, healthy citizens, who will be able to make their contribution to its development with skill, commitment, attention and willingness. If this does not happen, if society or a part of it, out of petty calculations or to protect and ensure ever greater economic profits for the exploiters of human resources, fails to do so, the fruits of this incompetence will be disturbed or sick people who, in milder cases, will find it difficult to make an active contribution to the community through their work, while, in more serious cases, they will weigh economically for many decades, sometimes for the rest of their lives, on both their families and the community.

1. The care needed by the child

- *There is material care.* These are aimed at protecting and, if necessary, curing the child from disease, infection and physical trauma so that it develops in a healthy, robust and strong manner. This care is attentive to sufficient and proper nutrition, cleanliness of the body and the environment where the child lives, is activated in the event of illness, and is committed to preventing risks and dangers.
- *There is affective-relational care.* These aim to develop, and then maintain, good psychic health in the child, so that each child succeeds in developing a harmonious, serene, sociable, affectionate and lively personality.

- *There is educational care.* These aim to develop all the human qualities of the child: intelligence, culture, sociality, mobility, autonomy, language, morality, spirituality, etc.

- *There is social and political care.* Parents, but also family members and society as a whole, should be active in accompanying and guiding the child in getting to know and integrating with the vast social and political world. They can do this by using a series of interventions aimed at connecting children to the reality outside the family, not only with regard to the peer group, friendships and love affairs but, above all, with regard to engagement with life, social and political activities in the city and nation. They can do this not only through cultural interventions, but also, and above all, by stimulating in the child the development of will, courage, determination, loyalty and self-denial towards others.

- *Last but not least, there is spiritual and moral care.* This kind of care helps the child to discover in its own heart and in the world, the ethical and moral values of its actions, but also the divine presence underlying these values.

All care should have equal value in the life of the child and thus of society. When in the various historical periods some, wrongly considered more important, are favoured over others, one does a disservice to children and future generations of adults. It is undoubtedly a serious shortcoming to commit oneself to the development of a large and strong child, if one does not commit oneself at the same time to ensuring that he or she is also psychologically healthy and mature. There is no point in bringing up a child with great intellectual, cul tural and professional skills if we do not at the same time commit ourselves to developing his moral and ethical qualities. There is a risk that these high capacities will

not only fail to serve the human community, but be used for the purpose of exploiting and harming the poorest and most defenceless.

It should also be borne in mind that all cares have a close connection with each other. Material cares often have affective implications. Just as affective, relational and spiritual cares have material implications. A mother who breastfeeds her little baby nourishes her body, but at the same time creates and develops a bond of mutual love and dialogue, by which she nourishes her child's soul with affection, security and joy. Similarly, when a mother bathes her baby, she cleans her body, while at the same time providing her little one with pleasant and beneficial sensations of warmth, tenderness and comfort. Sensations and emotions that will make him stronger and more self-confident. Similarly, when a child exercises in a sport, not only his muscles are activated, but also his will and self-control. On these occasions, an improvement in his psychological, but also social well-being is evident, as he learns to respect the rules and his peers. It should also not be forgotten that the more serenely a child grows up, the better his immune system will be able to respond to the attacks of various germs and thus the more likely he is to grow up healthy and strong.

We also know that there is a very close relationship between caring activities and the person or persons who carry them out. Precisely because caring activities have multiple functions, the child links them closely to certain persons: there are activities that he wants to be carried out only by the mother, just as there are activities that he wants to be carried out only by the father or grandparents. He therefore suffers when it is not this person who is activated. We could give many examples. If in the first two to three months the child appears indifferent to the breastfeeder, later on he clearly shows joy and interest when it is the mother who does this and, on the other hand, shows disappointment when the

milk is given to him by another person. Moreover, when he is older, he will verbalise all this: he will ask for the bottle to be given by the mother and only by the mother, while he will accept that other types of food are given by the father or grandparents. Even some children, when they have to eat milk soup in the morning, want their mother to prepare it and not their grandmother or worse, another stranger; just as they ask for a certain person to dress them or clean them. These behaviours, which are often judged as vices or whims, actually respond to precise psychological needs.

This search for a specific emotional bond also persists in the first classes of primary school. When in these classes, through misfortune, the regular teacher falls ill or is forced to absent herself, the substitute teacher, at least initially, is not given the same affectionate and tender treatment: 'Because that's not our teacher', the pupils confidently assert. This behaviour is not a sign of malice towards the substitute teacher, it is just an expression of the need that children have for a bond of affection to remain stable over time. The same happens in many animals that only accept certain care from their owner and not from others.

From what we have said, we deduce that it is not indifferent for the child the bond that is established between the food, objects and care activities offered to him and the person or persons who offer them. For the parents, too, the bond of attachment to their child will change and may break down when it is other arms that cradle their child, when it is other people's words that console him, when it is other hands that dry his tears, other eyes that respond to his smile, other hearts that converse with him. In such cases, something important is in danger of being altered or may be permanently broken.

These basic psychological realities do not seem to be taken into account by the business world when it tries in every way to

expand the market for objects, tools and services, offered to women and mothers, glamorising them as help and support for women and families.

2. Creation of a suitable family environment for minors

In addition to the parents and relatives of a child, the whole of society must necessarily contribute to the creation of an environment suitable for the harmonious and serene development of a child.

Its task should be to help the formation of healthy families that are also capable of carrying out their assigned tasks to the full. One speaks in these cases of *functional families.* Every family leaves indelible marks in the souls of its members, both positive and negative, so that it is the family that is the primary and irreplaceable place for those relationships of trust, reciprocity and gift, which are essential to form, nurture and protect the development of man's puppies, who will be the new citizens of tomorrow.

It is within the family that future human generations are born, and it is the family that provides, through the labour of its members, the necessary resources for life together: food, clothing, housing, health care and other biological and material needs. It is the family that provides for the psychological and educational needs of the offspring, developing the personality of the individual members. It is only in this basic institution that we find those prerequisites of responsibility, stability, continuity and gradualness of the educational processes, capable of raising men and women with a solid and secure identity and personality. Men and women who are not only intelligent and capable, but also serene, mature and responsible persons. Only in families will future generations be able to find that bond of love between two beings of different sexes, that affection, attention and care, capable of developing all the potential of the human being, in a climate of serenity, openness

to life, trust and security. Moreover, it is above all the family that takes special care of children, the elderly, the sick and the disabled.

It is always in this institution that children carry out the best apprenticeship in the service of others, and thus in the service of the community. It is therefore the family that lays the foundations of education for social roles, with the acceptance of responsibilities towards the wider world outside it. Education for social roles that will be expanded and completed, at a later stage, through the work of the school and other educational agencies. It is in the bosom of the family that, in the various peoples, the deepest and truest religiosity is cultivated and expressed, since it is only in this institution that moral, religious, ethical teachings and the fundamental values of the human race are transmitted from adults to the new generations, without frills or grand external manifestations, but in the most intimate, profound and true manner. Again, it is through the family that the fundamental knowledge and basic culture of mankind are passed on to the new generations. It is within the family walls that the development of the sexual and personal identity that is in its potential state in our genes takes place. Finally, it is above all the family that supports its members in the adversities and tensions associated with the inevitable transitional phases of life, in stressful events, in cases of disability, illness, old age, or in the presence of bereavement or loss.

From what we have said, it is imperative that institutions take charge of the formation and protection of families and their members, enacting laws and measures that help structure an effective understanding between the sexes, so that mutual trust and not mistrust and suspicion is nurtured and developed between men and women, union and not disunity is realised, love and not hatred grows . It is the State's duty to enact laws that protect the integrity, stability and solidity of every marriage union. Laws that facilitate the emergence of an efficient family network, that prevent the

mass media from penetrating the family fabric and eventually weakening and disintegrating it.

3. Promotion of suitable work activities for minors and their families

The work commitment of the parents, but also of other family members caring for the child, can have a significant bearing on both the onset of mental illness and the possibility of curing it.

Extra-family work

In recent decades, scholars and the media have considerably highlighted and well described what fundamental functions *extra-family work* has.

This type of activity enables the autonomy of individuals and couples from their families of origin, ensuring their survival and social well-being, through the purchase of goods and services essential for food, hygiene, health, culture, social exchange and recreational activities. Extra-family work, while contributing to the progress of humanity, enables people to spark their imagination, unleash their creativity, allowing their dreams, plans, desires and aspirations to come true.

Intra-family work

In recent decades, unfortunately, there has not been as much attention paid to work within the family and the home *(intra-family work*). This kind of commitment to the world of affection and relationships is increasingly undervalued; indeed, it is now so discredited and debased in the eyes of public opinion, that it is judged as second-rate work and thus distinctly ancillary. So that *housewives*, not by choice, but forced into this condition due to the lack of extra-family work, are almost ashamed of their condition, since they consider their commitment within the home and family not only unrewarding, but also useless, empty, sterile, dull and

humiliating. Not only that, but also the state and civil society see it as a serious problem that needs to be addressed and overcome as soon as possible. This happened for various reasons: the struggle for so-called 'women's liberation'; industries' need for cheap labour; unbridled consumerism and so on.

In reality, however, on closer inspection, one could hardly find a job or a commitment as important and fundamental to the life and well-being of individuals and society.

Intra-family commitment:

- is essential to the construction of the individual's ego, as it allows the distinction of self from other and, subsequently, enables the development of all the human potentialities inscribed in the genes. These could not be activated without the intervention of other human beings linked to the child by stable and intense affective-relational bonds;

- the formation of each human being's personality; his or her communication and expressive abilities; the possibility or otherwise of controlling drives, emotions and feelings; the acquisition of a correct sexual identity; the growth of autonomy, strength, courage, determination, security; motor skills, the individual's dynamism, resourcefulness and determination;

- The acquisition of a sense of honour, duty and loyalty to others, respect for rules and social norms, and the construction and enhancement of the family and affective network, a network in which both the child and the adult can find help, support and acceptance at every stage of

their lives, all stem from intra-family commitment.

Some of these tasks are predominantly, though not exclusively, maternal, others are predominantly paternal; many of these tasks are the prerogative of both parents, but there is no doubt that this type of work and commitment is fundamental and irreplaceable for the entire human community. The quantity and quality of an adult human being's characteristics are closely linked to the characteristics of the family environment in which he or she lived. Therefore, if this environment is suitable and favourable, the child's development will be serene, harmonious, rich, complete; if, on the other hand, this environment is inadequate, the development will be monotonous, deficient, disturbed or clearly pathological.

One can safely say even more: intra-family work is a prerequisite for extra-family work. Without intra-family work, in its absence or when it is not performed properly, work outside the family and social welfare is also compromised. This is because the presence within society of human beings with deficient, disturbed or clearly pathological capacities and qualities, if on the one hand prevents any stable and productive work input, on the other hand requires considerable resources for diagnosis, treatment and care.

For these reasons, for a good and healthy social life, the presence of extra-family work activities must necessarily be balanced by the presence of adequate and appropriate intra-family commitments.

To achieve this goal, it is indispensable to consider extra-family work as a source for satisfying essential needs and certainly not those induced by consumerism. In this way we could avoid making it an idol placed at the centre of our lives, to which we sacrifice everything: personal life, couple life, family life, upbringing and childcare. An idol capable of absorbing a good part of

our physical and psychic energies, on which we pour almost all our expectations.

As for the State, on the other hand, there is a need for a policy that values and promotes intra-family commitment, just as there is a need for laws and regulations that provide stable and concrete support for every person, be they man or woman, who chooses to commit themselves to work in the world of affection and family relations.

Environmental therapy

need for early intervention on the child's signs of distress should be taken for granted, as most patients undergoing psychiatric treatment report mental disorders already present in childhood or adolescence (Caviglia, Zarrella, 2011, p. 401). Furthermore, "recent longitudinal studies have shown the likelihood that a disorder diagnosed in childhood may increase the risk of psychiatric illness in adulthood by a factor of three" (Caviglia, Zarrella, 2011, p. 402). Intervening early, therefore, is certainly very useful because, as Sogos et al. (2009, p. 470):

"We know that early intervention with respect to overt illness activates resources, in the child and the environment, capable of modifying the course of the psychological disorder. Focusing efforts on understanding vulnerable developmental moments and their relationship to stressful life events favours a mental health model aimed at prevention rather than mere treatment'.

Since the inception of child neuropsychiatry, it has seemed obvious to practitioners to take into account not only the child, but also his or her family, embedded in the social environment, as the bearers of needs are not only the children but also their families and the child's living environment. However, in recent years, due to an increasingly organicistic view of child problems, this methodology is often neglected. Many minors, after the first diagnostic examinations, are entrusted for years to rehabilitation centres,

to which they are often transported by minibuses that 'pick them up' from their homes and schools, without a systematic and constant intervention in the child's living environment being planned and implemented.

We believe it is important, instead, to undertake together with parents, teachers, sports coaches and other educators, who are in contact for whatever reason with the child, a real journey in common. A journey to try to gradually change the child's living environment in a positive direction, in order to change their inner experiences for the better.

To do this, it is necessary to establish a broad, continuous, valid and in-depth relationship with all educators, made up of reciprocal listening, understanding, esteem, trust, balance and availability. This is not only in order to better understand the minor's reality, but also to develop the most mature and valid attitudes and behaviour in the persons closest to them.

In the meantime, it is good for parents to be aware of their child's limitations but also of their child's reality, with its current problems but also with its abilities and potential, while at the same time it is important for them to be made aware of the educational or rehabilitative path they intend to take. In addition, it is useful to realistically, but also with healthy optimism, envisage the child's present and possible future scenarios if the most appropriate interventions are implemented.

The main objectives of environmental therapy are numerous:

- the first is to continue investigating the relationships that the child has established both within and outside the family, so as to highlight any affective and educational shortcomings, so as to understand which erroneous dynamics it is possible and good to intervene on;

- At the same time, an attempt will be made to provide parents with a new yardstick and new tools for understanding

that will enable them to feel part of the therapeutic project. A therapeutic project that includes, very often, a greater awareness of their child's disorders and the reasons that may have forced him or her to manifest certain behaviours and attitudes, in order to better accept their child and the expressions of his or her psychic suffering. It is indispensable, for example, that family members better understand the meaning of their child's anxieties and fears, tantrums, provocations and disturbing behaviour, but also of any attitudes of closure;

- ❖ at the same time, in order to improve the child's relationship with his or her family, and between the family and the social environment as a whole, efforts will be made to establish a greater and more stable understanding and trust not only between the parents and the child, but also between one spouse and the other, between the parents and other family members, and between the parents and the child's close caregivers;

- ❖ efforts will also be made to help parents gain more confidence in their own abilities and better educational skills;

- ❖ if psychological disorders are present in parents and family members, these should be addressed through appropriate psychological and/or pharmacological therapies.

We know that this is not easy, as some parents and family members are not always willing to work together. Some of them, for example, are willing to take their child to the therapist so that he can heal him and make him well, but they are not willing to use even a small part of their time to collaborate on this. Moreover, the needs of family members are often very different from those

felt by specialists. For example, some parents want the therapists to modify their child's behaviour that they find disturbing, but they are not at all willing to modify their own behaviour that might have provoked it. These parents also feel a lot of aggression and resentment towards their son and would like the therapist to endorse their negative judgement of him, so as to avoid any possible sense of guilt.

Caring for parent-child dialogue

One of the first interventions should be aimed at helping parents to establish an effective dialogue with their children. The human being is formed through communication and interaction. The human being is built and enriched through communication and interaction. We therefore believe that the human being when disturbed by psychological problems, especially if he or she is in the developmental stage, can and must be healed through effective communication and interaction.

When one listens to children with psycho-affective disorders and their families, one gets the distinct feeling that a disturbed communication has been established between the children and those close to them, made up of mutual suspicions and accusations, rather than mutual understanding. Adults are quick to reproach and point out the many nefariousnesses of minors. Nefariousnesses that may relate to school: 'He does not study' - 'He studies too little' - 'He studies too slowly' - 'He is always distracted'. Or they may relate to their children's behaviour: 'He plays with his siblings in a violent way and hurts them' - 'He does not respect his shifts' - 'He does not obey' - 'He is deaf to every warning' - 'He responds to us parents in a rude way', etc.

Even minors, as can be seen from their spontaneous accounts, make accusations against adults: 'My parents do not understand me and scold and punish me for everything. "They are always nervous". "I don't understand them".

Ultimately, very often, when a psycho-affective disorder is present, the dialogue between adults and minors is as if broken or even interrupted, while, at other times, it appears significantly altered and disturbed by strong negative emotions.

To make communication more effective and functional, it is necessary to use certain tricks.

1. Avoid haste.

We only converse well when we are not urged on by impatience, haste or eagerness for things to be done, words to be said or phrases we would like to hear from the other. If we do not have enough time, being together becomes a race to do and act, rather than to live, with serenity, tranquillity and fullness, words, gestures, feelings and emotions. This is true in the relationship with all children, but it is even more true for children with psychological problems. These, many times, do not possess the capacity to open readily to our questions, if they are made in a hasty and convulsive manner, without taking into account their needs of the moment.

The greatest difficulties in opening up readily to dialogue are present in almost all psychic disorders, but are greater when suffering manifests itself in the form of shyness, closure, sadness, inhibition. In these cases, to favour dialogue it is indispensable to create around and beside the child, a serene, calm, patient and welcoming environment, in which words and questions are few, while willingness to listen is great.

2. Avoiding the role of pedantic teachers

Parents and teachers are the educators par excellence, but a good educator should not stand, like certain pedantic teachers, always with a red-blue pencil in hand, ready to point out, in a punctilious manner, every imperfection and every error of the pupil. Judging and reprimanding frequently or in excessive tones, com-

promises openness, prevents the child from externalizing the deepest contents of his or her soul, exasperates and forces closure, defence, aggression, or to say, lying, what the other expects to hear.

It must also be borne in mind that when a child is disturbed by anxiety, tension, fears, sadness, he becomes much more sensitive and reactive to every observation and every reminder, and therefore tends to react very badly to every observation. His soul, already torn apart, reacts in these cases as it can and as it knows how. Therefore, while at first the parents and teachers notice that the most disturbing symptoms appear to have improved, so much so that for a few days, after reprimands and exemplary punishments, the child behaves better, later, after a short time, his acts return the same as before, if not worse than before.

This is because children, all children, by their nature would like to be good and good-hearted, so as to make their parents and other educators happy, while also making themselves happy. Children live on the love and esteem of dad and mum and adults. The joy of these is also their joy. When a child with psychological problems behaves badly, it is certainly not a sign of naughtiness or brattiness. He interacts in this way because he cannot do better or differently. The problems, conflicts and anxieties in his soul prevent him from doing so. He is prevented from doing so by the anger and rage by which his mind is ravaged; it is for this reason that, at least initially, the child, using himself to the utmost and forcing himself on, tries by all means to be as his parents and other educators would like him to be, but then, overwhelmed by his problems and suffering, his disturbing behaviour tends to recur. Often in the parent-child relationship, a vicious circle is established in which, to an unsettling, harsh and frustrating attitude on the part of the parent, the child reacts with a state of suffering and discomfort that leads him to be more irritating, aggressive, disobedient, unhelpful, and uncaring of others and his duties. This condition encourages the parent to scold and punish him more. This worsens

the child's inner experiences and deteriorates even more the relationship both with the adult and with all the other people with whom the child deals, for example, brothers and sisters.

It is then necessary to break this vicious circle and establish a virtuous one in which the protagonist can only be the parent, who must succeed in replacing reprimands with praise and punishments with rewards.

3. Avoid frequent and excessively severe punishment

Punishments, if frequent or too severe, risk breaking the dialogue with the child, who may feel humiliated and unloved. Moreover, the son, after having served his misdeeds, thinks that he is ready to do some more. Among other things, the child realises that it is not difficult to avoid being discovered and punished with some ruse (Bettelheim 1987 p. 149), and learns to establish a relationship of lies and falsehoods with adults.

4. Don't shout

Very often, people shout when they are afraid of not being able to keep a situation under control and hope that by raising their voices and scaring the children, they will come to their senses and be obeyed promptly. This is true in the short term and on individual incidents but, in the long run, as the 'screaming mothers and teachers' themselves note, their children 'grow deaf and no longer listen', so they are forced to raise their voices louder and louder and increase the number and severity of punishments inflicted on the disobedient. The reason for this behaviour on the part of children is simple. They love to obey people towards whom they feel esteem and respect. They love to obey people who make them feel good, while they tend to disobey people who make them feel bad or make them uncomfortable.

5. ***Active listening***.

Listening means sensing the movements of the child's soul and harmonising with them. Every parent needs to feel what the child thinks of him, what he feels, wants and seeks from him and expects from him. Children, despite the many requests they make, often only desire tenderness, warmth, presence and affection. *Active listening* means trying to appreciate every attempt at communication, so as to empathically understand what is behind the words, comments, trivial questions, but also what is behind the behaviour. During active listening one tries to go beyond the literal meaning of words and gestures, so as to understand the deeper and truer causes. For these reasons, one should reflect more on the needs of the other person than on their words.

Silences are also important in this type of listening. Often, when we are able to put ourselves on the same wavelength as a child, when our heart is close to his, the simple listening is already an effective help and therapy, because it allows the child to find in our soul, that comfort, that support, that understanding and love that he seeks.

Active listening is important in any communication that wants to be effective, but it is even more so when we relate to a child with psychological problems. These children rarely express their sadness and anxiety verbally; they rarely state that they are troubled or upset by fears and anxieties, nor do they easily communicate the reasons for their feelings and emotions. It is therefore necessary for parents and educators in general to be able to go beyond their words, beyond their apparently incomprehensible and sometimes unacceptable or disturbing behaviour, in order to understand them fully, so as to be able to alleviate their hidden suffering.

6. We offer the child an accepting and encouraging attitude.

This means that we must be able to make the child understand that we are willing to listen to, if not to share, all his opinions and ideas, even if they differ from our own, because every human being, even if small and in training, can be the bearer of correct ideas and opinions. It is from acceptance that positive confrontation is born and develops. When this acceptance is lacking, so that we would like our child to be as we dreamed and wished him to be, or to have the same characteristics as when he was younger or when he did not have the psychological problems he now has, dialogue becomes difficult, disturbed and unproductive.

On the other hand, you cannot force a child to open up and confide his or her truest and deepest feelings, emotions and thoughts, if you do not put him or her in a position to feel free to say everything he or she feels, knowing that he or she will not cause great pain or harm.

7. Have as a perspective the encounter and not the confrontation with the child.

Dialogue and communication are not about deciding, using words, ideas and subtle arguments or, worse, using force and violence, who is better, stronger, more determined, more resilient. Dialogue and communication do not ultimately serve to declare a winner in a confrontation, but should be aimed at facilitating encounter and understanding. Even if this is not always possible, even if this understanding cannot always be found, there should be, however, on the part of us adults, at all times, this desire and this kind of inner tension.

8. Dialogue must take individual needs and requirements into account.

The needs of one child are different from those of another. The needs of a child at a given time in its life are different from those of the same child at a different stage of its development. No

two children are the same, with the same tastes, the same inner reality, the same desires, just as the same needs do not exist in a human being at different times and periods of his life. Moreover, the needs of a child with psychological problems are much more intense and are, at times, unclear, linear and coherent, compared to those of a normal child and this is perhaps why it is more difficult to understand and accept them.

9. We try to satisfy his deepest and truest needs.

We often find children with psycho-affective disorders crying for hours on end, shouting and screaming at the top of their lungs, stomping their feet, insulting, threatening and attacking, in order to have one more toy, a more complete and powerful mobile phone, a forbidden sweet, an extra 15 minutes of TV or video game. However, the moment we have satisfied all these needs, they return to shouting and stomping, they return to threatening and attacking. Usually the comment that is made to these behaviours is that "...children today are never satisfied with what they are given". However, if we manage to go beyond appearances and look at the truest and deepest needs, we discover that it is not the latest mobile phone that they really want, it is not the forbidden snack they are looking for, it is not an extra 15 minutes of TV that they really want. We discover, in short, that their truest and deepest desires are others: they would like, for example, for the family to spend more time together; they would like there to be more loving gestures between their parents and in their family and less aggressive behaviour and words; they would ask for more presence from their mothers and fathers who are often absent or too busy; they would like to be able to play freely in green spaces; they would ask for more physical and psychological space in which to move or even more cuddles and more intimate dialogue. Ultimately, we discover that so-called 'tantrums' hide important

and real needs, which children are not always able to express clearly.

10. Let us strive to communicate positive feelings through dialogue

Many times, the anxiety and sadness that pervade us, the difficulties of life, the ugliness that surrounds us, the unhappy encounters, lead us to view the world, life, and others with discouragement and excessive pessimism. We also feel the same pessimism and discouragement towards our mentally ill child: 'That's just the way he is' - 'He is badly made' - 'There is nothing we can do' - 'He cannot change' - 'Everything we do is useless'. These phrases or thoughts, while on the one hand limiting and castrating our potential, at the same time discourage and dishearten an already tried child. For these reasons, his discomfort is accentuated and aggravated. Let us instead try, as far as possible, to offer them a healthy optimism, made of hope and trust in the world, in others but, above all, in themselves.

11. ***We always insert a rich, tender and warm emotional charge and participation into the dialogue.***

Words and encouragement towards children with psycho-affective disorders, if they are full of love and tender, warm participation, can help them to be more serene and with less tension and fear. It is this greater inner serenity that can contribute to their maturation and personality development, with positive consequences on behaviour. We can achieve this by saying the right word at the right time, by giving our support, our comfort and above all by valuing them. Each of us needs someone to highlight our qualities and abilities and not our limitations and flaws. This makes us feel good, gives us security, strength, courage, makes us face life better and with more grit. Dislike on the part of the other, especially if it comes from a parent, seen as the most important

human being in his or her life, pushes children to closure, sadness, abandonment, discouragement and renunciation. Or, on the contrary, to increased irritability, grumpiness, if not outright aggression.

12. We participate in the child's experiences.

Our task is also to participate in his feelings, in his experiences, in the emotions of the moment, so that his needs become our needs, his suffering becomes our suffering, his desires become our desires. In this way, we will implement a full participation and sharing of thoughts, feelings and emotions that will strengthen our mutual bond, illuminate his life with joy, warm his heart, and offer him certainty and hope.

13. We communicate what is useful to them.

It is not always possible to communicate everything. While parent-child dialogue is fundamental in an educational process, it is also true that children cannot always be involved in everything. There are some things that are the preserve of adults and must remain in the adult domain. Children should not be involved in topics that they are unable to understand, nor should they be made accomplices in situations that might frighten them, make them anxious or create inner conflicts. Think, for instance, of the sentimental and sexual adventures that separated parents or single mothers tend to communicate to their children. We are thinking of quarrels and disputes with relatives or neighbours, in which parents are often involved, but we are also referring to anxieties and fears, of which adults may be victims. These, if communicated to children, risk provoking in them a constant feeling of imminent danger: 'Don't do this because it is dangerous' - 'Don't do this because you could die or your parents could die'.

Instead, we try to communicate what can be useful to them, what can improve their serenity and inner well-being. Let us keep

to ourselves anything that might accentuate their upset, their anxieties, their fears. And finally, let us protect them from anything that might put them in conflict with themselves or with the people they would and should love and respect.

14. The dialogue should be calm, gentle and delicate.

Let us try to have a calm and peaceful dialogue. "Our task is to create the conditions in which the voice of reason can be heard and followed. If we become agitated and anxious, we will not be able to make that feeble voice speak, and if our child fears our disappointment and punishment, he will not be in a position to listen to it' (Bettelheim 1987, p. 150).

It seems superfluous to remind us to avoid rough manners, harsh words that humiliate, offend, alienate and frighten. Television and other mass media are increasingly accustoming us to the use of 'heavy' and offensive words, used by aggressive and overbearing 'heroes'. This kind of language is never useful or appropriate, not least because the child risks making it his own. He will therefore tend to use it first with his peers and siblings and later, when he is older, when he is no longer afraid of adults, there is a real risk that he will use it against his parents, other family members, as well as teachers and other educators. Kindness, gentleness and acceptance in manners and words always pay off, as they provide sympathy, human warmth and comfort to the people around us. These, in the end, will reward us with just as much kindness and gentleness.

School and children with psycho-affective disorders

The presence in schools of children with psychological problems has become increasingly frequent, both because of the laws on school integration and because of the real increase in psychological disorders in developmental age. This integration is by no means simple, so if it is not well managed, it not only does not

solve the problems of the child with psychological problems, but risks aggravating them.

In order to understand and know how to deal with such problems, it is essential to consider all the components involved: the school as an institution, the teachers, the 'normal' pupils and their families, the child with psychological problems, his parents and family members.

The School

This institution has many and various needs that must be met, or it will be ineffective. There are didactic, educational, managerial and other needs. For this reason, a child with psychological problems can entail considerable difficulties but, as many pilot experiences have shown, the integration of these children can become a splendid challenge to be faced and overcome. Therefore, if this integration is well managed, the results for the problem child, but also for the school as a whole, can be considerable.

Teachers

As far as teachers are concernedthey are often squeezed by multiple demands and needs that come from various realities: they have to be accountable in some way to the school officials, the various laws and regulations, the school teams, the parents of the child with problems, as well as the parents of the other children. Teachers, above all, then have to be accountable to their own conscience and sense of responsibility. In addition, teachers, today more and more often, are forced to endure threats, more or less explicit, of legal proceedings that may come from both the parents of the problem child and the parents of the normal children in the class. Threats may also include being exposed to the media pillory. This pillory, which, being always in search of an audience, is ready to be activated immediately and easily, whenever, in the

school environment, problems arise that may affect minors, especially those with disabilities. Such accusations and threats risk diminishing the serenity of teachers' work and make their work and the serene management of these children even more difficult. It is evident that it is particularly difficult to balance all these sometimes conflicting needs, especially when there is more than one child with problems in the same class.
Then there is the difficult collaboration between curricular teachers and support teachers. The former tend to criticise, without sometimes having an exact understanding of the problem, the support teachers' poor management of the disturbed child. Bad management that, according to them, causes discomfort in the class. Support teachers, on the other hand, are likely to defend themselves by saying that curricular teachers focus all their attention on normal pupils, neglecting or not working effectively for children with psycho-affective disorders.

Parents and 'normal' pupils

We should not be scandalised by the fact that normal pupils, sensing the diversity of pupils with mental disorders, treat them differently from their peers who are free of such problems. Man is by nature very sensitive to all diversities, as these can represent a risk and a danger to be escaped or resisted. These two behaviours: exclusion of the different or aggression towards the different, are inherent in the human species. The task of parents and educators, however, should be to correct and model these instinctive behaviours, to adapt them to the values of welcome, brotherhood and love towards those most in need of help. Unfortunately, this type of education and training is not always implemented. On the contrary, sometimes adults, not controlling these instinctive repulsive impulses themselves, give their children a helping hand, as they have an irrational fear that the child who is different may somehow 'infect' their 'little ones'!

The parents of the child with problems

As far as parents of pupils with psychological problems are concerned, it is common for them to accuse the school and the teachers, both class and support teachers, of not paying enough attention to their children. Often the accusations are of the following kind: 'The teachers neglect my son and push him aside. "They scold him constantly and excessively". "They don't know how to understand him, they don't know how to handle him". "In one year he has learned almost nothing". But since the parents and relatives of these children are aware of the problems that their child can give to the class where he or she is placed, their attitude and behaviour is mixed, both towards their child with problems and towards the teachers and school authorities. At some times and on some occasions they appear helpful and cooperative, at other times and on other occasions, they openly manifest their irritation, resentment, if not explicit aggression.

To understand these different attitudes, it is necessary to understand the inner experiences of these parents: they know that their child creates problems in the classroom or even at school, since every day in their home and on many other occasions, they have come up against these problems that they are unable, despite all their efforts, to solve. On the other hand, precisely because they are aware of their difficulties and limitations, they hope that better trained, qualified and more experienced people will be able to deal with their children's problems better. They therefore trust in the school as the institution that, more than any other, is made up of people specialised in educational issues.

With regard to the parents of normal children, the most frequent accusation by these parents concerns the lack of respect and acceptance of their children: 'The other children mock him'. Or: 'The other classmates don't want him near them, they don't even talk to him, they ignore him completely and the parents of these classmates do not intervene in their children at all'.

Children with psycho-affective problems

Finally, if we reflect on children with psychological problems, they do not always have the ability to integrate well into the school environment. And this is for various reasons:

- because of their poor attention span, it is difficult for them to concentrate and listen to teachers' explanations. This makes them distracted and, this distraction, in turn, leads to disruption and discomfort in the classroom, as well as constant reprimands towards them by teachers;

- Being close to other children does not automatically imply an improvement in the integration and socialisation abilities of children with psycho-affective disorders. This closeness can, in many cases, even be counterproductive, as the other children, noticing their different way of relating, interacting, behaving, moving, paying attention, may react by marginalising them from the group or by verbally and physically attacking them. In some cases, even, these 'different' children are subjected to real bullying. It is evident that in all these situations the image these children have of others, of the world and of themselves worsens considerably;

- Their easy irritability can lead to considerable frustration when they are not well received by peers or are forced to endure reprimands, reminders or punishments from teachers;

- Some children with mental disorders, because they tend to close in on themselves, alienating themselves from the world around them, it is as if they do not listen to what is going on in the classroom, and

this prevents them from the attunement that is indispensable for learning and socialisation;

- ❖ Moreover, since these particular pupils are often wracked by fears, conflicts, anxiety and restlessness, their interest in curricular subjects may be minimal;

- ❖ Finally, since some children with mental disorders, especially those suffering from psychomotor instability, easily tire of maintaining the same position and move about constantly, they attract the ire of teachers because of the disruption they bring to the classroom.

Possible interventions

Since the integration of children with psycho-affective disorders is particularly complex, it certainly cannot be delegated to the support teacher alone. Alongside this figure, which is certainly basic, many other professionals and many other people must lend their commitment, their contribution and their collaboration: the personnel of the child neuropsychiatry services present in the area, curricular teachers, school directors, parents, social and voluntary services present in the neighbourhood, and so on. It is from all these figures that a global project can and must be born, tailor-made for the child and his or her living environment. Therefore, in order to achieve this objective, it is indispensable that a relationship of mutual help and collaboration be established between all the operators.

In this overall project, all the best means and ways to achieve the set goals will have to be indicated from time to time. Furthermore, since the most suitable strategies for children with psycho-affective problems may be very different from those used with normal children, in many cases it will be necessary to do away with the usual goals and strategies usually found in classrooms.

Let us give a few examples.

Today, there are more and more *children with generalised developmental disorder* in schools. These children almost constantly live a severely disturbed inner reality of anxieties, phobias and conflicts, with considerable distrust and rejection of others and the world in general. These particular pupils, who have considerable difficulty integrating with their peers and adults, as they are closed in their own anxious world, when the behaviour of others does not perfectly match their needs and desires, they perceive those as enemies, ready to carry out further violence against them. Therefore, a normal classroom environment in which the teacher explains the lesson, interrogates, asks everyone to do their homework in the exercise book and tests on the blackboard, is remarkably traumatic for them, as well as absolutely incomprehensible and useless. It is therefore necessary for the school, with regard to them, to substantially change the objectives: not the learning of the contents of the curricular subjects, but their greater inner serenity and greater trust in themselves and in others; not the classroom that frightens them because it is too noisy and with an excess of stimuli, but a quiet and peaceful room, in which these children can play freely, relating only with a remarkably helpful teacher with special empathic qualities; not the usual textbooks, which are absolutely useless for their needs, which are always different and unexpected, but many toys and natural materials, from which these children can choose from time to time the objects that are most congenial to them to use in the games that they consider, at that moment, most appropriate and close to their needs and interests. It will also be necessary to change the roles: not a teacher who guides the child in the activity that he or she considers most useful for him or her, but a teacher who joyfully and willingly participates in the activity or game chosen at a given moment (*free self-managed play*). It is therefore evident that the role of this teacher will have to be totally different from that used with normal

children: not a person who teaches something to a child who does not know, but a friendly person who is able to show him great respect, availability and considerable understanding for the serious problems he suffers from. A friendly person who is able to focus on the quality, goodness and depth of the relationship and not on the teaching activities. A friendly person who commits his affection and presence in order to give serenity where there is anxiety, certainty where there is insecurity, trust where there is mistrust, hope where there is disappointment (Tribulato, 2013, p. 163).

Another example might concern *particularly shy and introverted children.* Since, albeit less dramatically than children with generalised developmental disorder, the view these children have of the world and of others is imbued with fear, fears and insecurities, teachers will necessarily have to take into account the fragility of these children's souls. Therefore, as long as these negative emotions are present in their souls, teachers will have to avoid encouraging the child to integrate with the entire peer group, but will try to foster a good relationship between the two of them. This relationship, to be established with a companion or companion with whom these children will be able to build a good understanding, will provide them with a secure base from which to gradually achieve good emotional-relational growth. This is because only a two-way relationship that is intense, full and rich in dialogue and mutual understanding can give shy and introverted children the chance to open up to a broader and richer, but also much more complex integration.

As far as children *with behaviour disorders are concerned*, since for these minors the characteristics of the teachers and the ways in which they relate to them are very important, it is necessary for them to be looked after by teachers who know how to combine authoritative attitudes with a great willingness to listen empathetically. For this reason, if the child has been placed in a

class in which with most of the teachers and pupils he has established very conflictual and unproductive relationships for him and for his peers, one should have the courage and determination to move him to another class, with other teachers and other peers, so as to start from scratch more serene and useful relationships for his social and relational growth. As far as the relationship between school staff and parents is concerned, it is important to avoid overwhelming the latter with the problems that their child's pathology causes to the class and the school: "Mario today has been particularly disobedient, aggressive, uncooperative, psychologically absent and indifferent to teaching activities and explanations. "Mario is always unprepared and his folder is very messy. Today, in class, he was so disruptive that he prevented me from teaching", and so on. These complaints on the part of teachers, since they cannot be well handled by the parents of the child with problems, will inevitably lead to a greater devaluing and punitive attitude on the part of the latter towards their child, with a consequent worsening of his psychological condition and, consequently, of his disturbing behaviour. On the other hand, it is easy for the phrases we have quoted, or similar phrases, to bring out, in the parents of these children, attitudes of aggression and revenge towards the teachers and those in charge of the school, with the impossibility of establishing a real and fruitful understanding and collaboration. For these reasons, it would be good for teachers and the school as a whole to be able to address the problems of pupils with behavioural disorders by valuing and emphasising to their family members the good qualities and abilities of their children, rather than their limitations and shortcomings. Only at a later stage, when a good understanding has been established between the school and the family, will it be possible to very tactfully suggest to the parents the best strategies with which they can help their child acquire greater serenity and balance, also indicating the

most effective ways and the best specialists capable of following and helping them.
In order to make this positive image credible in one's own eyes and in the eyes of parents and the pupil himself, however, it is essential to be able to have an attitude of confidence, both in one's own ability to achieve the results one has set out to achieve, and in the possibilities inherent in each child of being able to relate well to peers and others, at a time when his or her soul has acquired greater serenity and joy.
Parents, in turn, must understand and value the willingness, ability and desire on the part of the school and the teachers to work for the good of their child. Consequently, it is important for them to highlight these abilities and willingness in the eyes of their child, so as to help establish a good bond of trust and affection between him and his teachers.

Therapy through play

Play has often been used in child psychotherapy, since the child, up to a certain age, does not have the linguistic abilities to communicate its deepest and truest thoughts and emotions. During play, the child directly and unproblematically manifests its interests and needs, its anxieties and fears.

Games can be *led* by parents, teachers or other adults. This type of play has the advantage of 'teaching' the child what he does not know, what he cannot do. The limitation of this type of activity lies in thinking of the child as the one who does not know, who has to learn or has to be guided by us adults to do something that we think is useful to him.

Free games are those that are usually played with peers. In this type of games, the participants agree on which activity to perform, the rules to follow, the tools or toys to be used and any roles to be played by everyone during the game. For example: "Let's play Indians. You play the redskin, Marco and I will be the soldiers who capture the Indian after a furious fight. These sticks are the rifles and swords and these are the arrows. You are then freed by Antonio and Luca, who are your Indian friends, and you run away; we will try to get you back'.

In this type of game, the child has more opportunities to develop his social skills. For while at times he will be the one to lead the game, at other times, in order to participate, he will be forced to accept the rules that others have dictated to the group, or at any rate he will have to learn to mediate with others on how he is to participate and his role. This type of game is ideal for children with normal psychic development. It is not, however, suitable for children with significant psycho-affective disorders, as they do not possess the necessary willingness, pliability, acceptance and patience to conduct it effectively. It is difficult for not only children with autistic disorder to relate well to the peer group, but also children who are easily irritable, those with considerable psychomotor instability, aggressive, grumpy children, but also those who are very shy, closed, introverted and suspicious.

The free self-managed game

In all these cases, the type of approach we have studied, which we have called *Free Self-Directed Play*, is much more useful. In this mode of play, it is only the child interested in therapy who chooses which game or activity to play. The adult or therapist, like a friend who is particularly helpful and attentive to the child's needs, has only the task of helping, encouraging and supporting the child in his or her activities and instances of the moment. The

adult will have the role of an affectionate and patient playmate who does not criticise or question what he or she is doing, unless his or her activity involves a real and imminent danger to his or her safety or that of other people. Ultimately, in the technique of *'Self-Directed Free Play'* it is he, the highly disturbed child, who is the real leader, while the adult or therapist assumes the role of gregarious (Tribulato, 2013, p. 102-103).

This type of therapy starts from the assumption that it is difficult, if not impossible, for the adult, even a very well-prepared, attentive and sensitive one, to know what is useful to the child and what can make him feel good, at a given moment, because the knowledge he has of the intimate life of a child at a given juncture, is very scarce, incomplete and fragmentary. Moreover, his vision as an adult, his information, but also the personal needs of the moment, collaborate to distort his judgement on the intimate life of these children, preventing him from seeing beyond his own rational knowledge. Added to this is the fact that the emotions present in the psyche of these minors are so far removed from the reality experienced by adults on a daily basis, are so intense, changeable and often also so confused and contradictory that they are difficult, if not impossible, for adults to understand.

This type of play achieves the goal of better inner serenity and greater trust in others, in the world and in oneself, since the child is shielded from any possible external intrusion. Intrusion that, in these children, could lead to the accentuation or stabilisation of their inner anxiety and thus their malaise. This is because the more serious the problems of children with psycho-affective disorders, the greater their sensitivity to frustrations. Therefore, any initiative by adults or therapists, even the most praiseworthy, which, however, was not desired and requested by them at the time, can be judged as an intrusion and violence by the outside world. Allowing the child full autonomy and freedom, in the choice of the

activity or game to be performed, finally makes him feel free, active and autonomous. Ultimately, in *Free Self-Directed Play* it is the child who helps himself with the support of the adult and not the other way around. To avoid, therefore, worsening this inner world of theirs and the difficult relationship they have with other human beings, the therapist will only collaborate with the child's activities and games, even if these may seem repetitive, useless and silly.

Expressive activities

All expressive activities - clay, plasticine, drawing, painting, music, storytelling, drama - are beneficial to the child's psychological well-being, since the child, when given the opportunity to express himself freely, also has the chance to reveal to himself, before others, his inner world, made up of thoughts, feelings, emotions and, at the same time, has the opportunity to process his deep-seated emotions, while commenting and fantasising on the work he has done.

Symbolic expression essentially has the function of highlighting, by means of imaginative production, one's conflicts and problems, while, at the same time, providing the possibility of getting rid of them. In this sense, all expressive activities are also therapeutic, as they gradually succeed in modifying the behaviour of those who implement them, first in fiction and then in reality.

Drawing and free storytelling

In this technique, the child is asked to draw a picture, using only a pencil, a sheet of paper and a set of colours. The child is asked to draw what he wants and it is added that, if he wants, he can colour the drawing. It is then left up to him to choose the subject to be drawn and, if he wishes to colour it, it is left up to him to choose the colours. When the child has completed the drawing, ask him or her what subject is represented and what story he or

she would like to build from what he or she has drawn. The child can be helped to better clarify and develop the content of what he has drawn, by means of a few questions, but without ever intervening in the content. To expand the story and bring out the most interesting content, one can ask, for example: "What happened one day?".

This technique, which is generally well accepted between the ages of five and ten, allows a gentle and respectful approach to the child's inner world, so as to know directly what his needs, desires, emotions and fears are, while, at the same time, it allows the child to free himself from the disturbances and conflicts that shake his soul, communicating them to a friendly person. A friendly and trustworthy person not only because her intention is to help him, but also because she shows him her affection by listening to him, without asking for anything, without demanding anything.

Therefore, precisely in order to fully respect the wishes and wishes of the child, in the event that the child does not wish to make any drawings or does not wish to tell a story, this choice is calmly accepted.

Music therapy

"Music is everywhere. Without music, our life would be like a world without colours. From birth we react with micro-movements in response to rhythms, cadences, the harmonic succession of sounds. Music is outside and inside us. It passes through the body and does not leave us indifferent. Our organism is made to receive it, respond to it and understand it (Oliverio Ferraris, 2008)'.

Music is born with man: when a child starts walking, if he hears music, he moves his body to the rhythm of it. The pleasure of listening, but also of making music, with the strangest and most unusual objects, is innate in man. So much so that there are numerous musical instruments invented and then used by human beings, throughout the ages and among many peoples.

Music is an excellent communication tool, capable of strengthening the bonds on which human societies are based; it facilitates interaction between the sexes; it positively influences the mood; it has the power to relax or stimulate; it provides excitement and excitement. Therefore, musical activities have always been used in many moments of human life. Music is essential when one wants to create joy, excitement and complicity in moments of love encounters, such as during courtship and marriage. Similarly, it is essential in religious rituals or to aid dialogue and communion with God. Music is used to celebrate important events, such as name days, birthdays, weddings, and the harvesting of the fruits of the earth. Similarly, all peoples use songs and music in funeral ceremonies to console their souls. Music is performed in war to instil courage in one's soldiers and to frighten opponents, but also to celebrate peace.

On the other hand, all mothers, from every era and every people, have used and use singing and music, by means of lullabies, to soothe their baby's crying and to help it fall asleep . Similarly, all mothers in every culture and age have used and use songs and nursery rhymes for their babies, to make them laugh or facilitate learning.

Making music improves intellectual abilities. Bonfranceschi (2013, p. 21) writes: 'Results showed that early musicians, in addition to being more proficient in psychomotor coordination exercises, also had a greater amount of white matter in the corpus callosum region, an area that allows the two hemispheres - including motor areas - to collaborate, connecting them through nerve fibres'.

Almost all children, therefore, have an interest in music. It is not just today, therefore, that music is used as a therapeutic medium: to relax or stimulate; to develop creativity or to allow a better dialogue with the body; to help release sadness and tension but also to give joy, strength, determination; to encourage meditation

and introspection but also to allow better socialisation and integration with the peer group.

The purposes of music therapy can, therefore, be aimed at:

- ❖ awaken sensitivity;
- ❖ refine sensory perceptions (Wagner, 2010, p. 26);
- ❖ improve intellectual abilities;
- ❖ improve movement skills and coordination (Wagner, 2010, p. 28);
- ❖ make physical activity more fun and therefore more acceptable;
- ❖ develop gesture skills;
- ❖ teaching the child to hear and listen actively and consciously;
- ❖ externalising experiences that are difficult to translate into verbal language (Galimberti, 2006, p. 169);
- ❖ escape from the grim and gloomy thoughts of everyday life;
- ❖ stimulate imagination and creativity;
- ❖ develop team spirit;
- ❖ develop a sense of order and discipline;
- ❖ reduce psychic tension (Galimberti, 2006, p. 169);
- ❖ lowering the heart rate, slowing breathing, relieving pain, etc.

Techniques vary according to the child's needs, taking into account their age and the needs of the moment. In music therapy, depending on the particular needs of the child, a *collective or individual technique* can be used.

The collective technique is applied when the child is able to follow the rhythm of the group. *Individual techniques* are used when the child is too young or has severe mental disorders and is therefore unable to follow the rhythm of the group and integrate with it. In this case, the fact that the child is alone with the educator gives him/her peace of mind and security, as he/she feels immune to criticism from peers.

In music therapy there are basically two methods.

1. *The active method.* This consists of active participation of the subject through movement, eurythmy, rhythmics, dance, singing, singing games, roundabouts or the practice of an instrument. Among the active methods*, rhythmics* is the best known system. In rhythmics, which is usually accompanied by the piano, music and movement are combined and their therapeutic effects complement each other and are combined. In many cases, the child is allowed to improvise movements under the influence of the music without suggesting anything. In other cases, images can be suggested, which the child has to perform through his body or through musical notes. *In eurythmy*, another of the active methods, music provides the rhythms that stimulate the will, calm the emotions, regulate movement, and bring order, clarity and determination. Whether one or the other method is used depends on the type of disorder to be addressed, but also on the instrument to be used and the piece of music to be performed. *Singing* has a threefold function: *diagnostic,* in that it enables the child's character and temperament to be discovered through the different nuances of his or her voice timbre; *educational and therapeutic*, in

that the way in which children are made to sing can help them overcome their anxieties and can be decisive in shaping their character. In *mimed singing,* the acts and situations of the characters are evoked by gestures, mimicry or dance. This type of singing allows the children's personality to emerge, while satisfying their desire for action. Mimed singing also facilitates the development of children's powers of observation, creativity and initiative. Finally, *roundabouts and sung games* develop the imagination, teach respect for rules and assigned roles, and encourage coordination between mental images and gestures.

2. *The passive method*, on the other hand, uses only the audition of music. In this case, the most suitable pieces of music are chosen, depending on the aims to be achieved: to relax, to calm, to give vigour and courage, to excite, to instil joy, etc.

The tools

Depending on the instruments used, different effects can occur.

Percussion instruments, such as the drum, bass drum, triangle, accommodate the child's aggressiveness and excitability well, so they are indicated when irritability, aggressiveness and psychomotor instability are present.

The use of stringed instruments, such as the lyre, violin, cello and harp, because of their very sweet and harmonic sound, are used to improve the subject's breathing and emotional state.

The free, folkloric dance is particularly suitable for sad and melancholic subjects, as it infuses joy and cheerfulness.

Psychodrama

For many children with neurotic traits or psycho-affective disorders in the broadest sense, all dramatisation techniques are effective in releasing, and sometimes resolving, the issues that plague their inner world.

Analytical psychodrama is a psychotherapeutic technique introduced in the 1920s by J. L. Moreno (in Arieti, 1970, p. 1673) and has the advantage of addressing and involving several subjects simultaneously. The participants are the protagonist, or subject; the director, or main therapist; the auxiliary ego and the group. The protagonist presents a private or group problem; the auxiliary egos help him bring his personal and collective drama to life and correct it. Everyone, in turn, proposes a theme and roles are distributed. The composition of the group makes it possible to form a family. For Moreno, unrewarding or clearly frustrating experiences, experienced in the past, do not disappear, but remain at an unconscious level in the children's souls, pressing, with their anxiety-laden charge, on their ego. In psychodrama, such experiences can be released more easily, as they are relived in an unreal, play-like atmosphere. To perform psychodrama, only a plot is written from the suggestions of the children, especially the disturbed ones, and a play is performed by improvising the lines.

Roles can and must change, in such a way that different experiences take place. Therefore, the same child may also choose to perform contrasting and opposing roles, just as contrasting and opposing are often the feelings that stir in one's heart. Only later is the rationalisation of what was experienced in the scene implemented, trying to give a reason for the actions and words.

Psychodrama ultimately serves to:

- freely communicate one's inner experiences;
- uncover feelings and then control them;
- release aggression, anger and inner conflicts.

Psychomotricity

Psychomotricity studies and educates psychic activity through body movements (Galimberti, vol. 3, p. 248). It is an important tool in psycho-affective disorders as, through listening to one's own body moving in space, releasing, contracting, pulsing and living in the surrounding world, in relation to others and objects, the child also expresses and discovers the emotions that involve him or her. This therapy invests the whole personality because, especially in childhood, motor phenomena are closely linked to psychic phenomena. Control over the body also becomes control over inner tensions. Conversely, the release of muscular tensions also helps the release of inner tensions, anxieties, fears and aggression. In this way, psychomotricity improves the relationship with oneself, objects and the people around us. This type of therapy acts on both the psychic and motor level, thus enabling better space-time organisation and a more lively and richer gestural expression. It fosters sociability, speech, mimicry and, by acting on emotionality, helps to develop better self-mastery, greater personal security and improved affective inhibition.

Psychomotor re-education offers good results on numerous psycho-affective symptoms: psychomotor instability, hyperemotionality, autism, enuresis, tics, but also on speech disorders such as stuttering. In inhibited, withdrawn, clumsy subjects, disinhibiting exercises such as dancing, singing, sports, games are used. In unstable, anxious, restless, nervous subjects, with difficulties in attention and concentration, attention exercises, relaxation exercises, and sensual exercises are mainly used. In less severe subjects group exercises can be implemented, in more severe ones individual treatment is preferred.

Therapies with animals

Human beings have always been in contact with animals: small or large. Children first come into contact with small animals:

butterflies, snails, caterpillars, ants, ladybirds, and then with larger animals such as birds, dogs, rabbits, lambs, goats, horses. Therefore, the benefits that their presence offers to the psycho-affective development of children have been known since antiquity: companionship, play, communication, comfort. These benefits are due to the patience of many companion animals, and their willingness to accept not only the caresses of small humans, but also their more rough and improvised bodily contacts.

Pet therapy or animal-assisted therapy is not simply playing with one or more animals: it is, instead, an activity te rapeutic in the true sense of the word, aimed at improving the physical and psychic condition of patients through the company of an animal. The aim of this therapy is to create a social-affective-relational relationship between the child and the animal, similar to that which might arise between two human beings who have the possibility of building a friendship and mutual understanding. However, it must always be considered as a supportive therapy to other therapeutic interventions and, therefore, cannot replace them.

Pet Therapy can improve the quality of life of children with affective-relational problems, since the animal, a being capable of relations, affection and communication, is able to create in the child positive and relaxing emotions of companionship and play, since, by its nature, it has the ability to establish very simple and essential relations with human beings. The animal, unlike its peers, but also some more irritating adults, does not ask questions that may embarrass the child, does not scold it, does not judge it, does not tease it, does not marginalise it. He unconditionally accepts and bonds with those in front of him, whatever their pathology or psychological problem. It therefore facilitates the child's affective growth, strengthens his or her emotionally appropriate behaviour, helps him or her to develop a positive self-image, at the same time reducing his or her anxiety and helping to improve his or her

mood. As a result, the child becomes more able to cope with stressful situations, traumas and frustrations.

The animals most frequently used in pet therapy are cats, dogs, horses, donkeys, birds, dolphins, fish, rabbits, turtles and chicks.

Each animal is associated with a certain type of disorder.

The dog, due to its liveliness and affection, is useful for more apathetic, closed, sad or depressed children. Observing *the fish in the aquarium*, moving slowly and silently in their liquid world, helps reduce anxiety and thus greatly relaxes. *Birds*, because they are small and soft, stimulate tenderness and love even in aggressive subjects, while *the horse, a* symbol of strength, elegance and virility, facilitates social relationships, increases self-esteem and self-confidence, and is therefore more useful to shy and complex subjects. *The dolphin*, given its natural desire to play and communicate with humans, is indicated for children suffering from learning, affectivity, relationship, behaviour, muscle coordination and language disorders. This cetacean helps improve self-confidence and stimulates children's motor and communication skills. *Dolphin therapy* is also useful because the animal element combines and adds to the pleasantness of the liquid element, which is certainly capable of reducing stress and tension, bringing the child back to a condition of primitive happiness.

All animals, then, given their needs for care, cleaning, feeding and nurturing, stimulate caring for another living being and bring gratification, while helping the subject out of his or her problems.

Like all therapies, this one, if not well evaluated, has its risks.

A first risk to be avoided is not to improve, but to worsen the child's living environment.

I remember Mario, an autistic child whose father, in search of 'something' to solve his son's problems, had unexpectedly taken a dog into his home, as he had read about the 'miracles' of animal-

assisted therapy. This dad had not taken into account the fact that taking in an animal entails duties and tasks. Duties and tasks that were impossible to fulfil not only by Mario, because he was excessively disturbed, but also by his parents, who perceived these tasks as too burdensome. Therefore dad and mum's behaviour, due to the stress resulting from these new commitments, to which the dog's presence forced them, worsened considerably; but also the child, due to his numerous and intense phobias, was unable to accept the cumbersome presence of the animal. Ultimately, the son's problems worsened considerably.

Therefore, before deciding whether or not to take an animal into the home, it is a good idea to assess both the child's degree of acceptance and one's readiness to take in another living being, which requires a great deal of attention and care. Ultimately the animal can be useful, if this presence within the family is able to improve the whole family climate.

Another risk of this therapy is to think that an animal can replace the interpersonal relationship with human beings: this is impossible. An animal cannot replace an absent parent, nor is it able to provide the attention, care and emotional warmth that only human beings can and should give. Therefore, when a child has affective-relational problems of a certain importance, it is first of all necessary to be able to treat the difficulties and limitations of the people living next to him, rather than simplistically 'entrusting' the child to one or more animals, imagining that they can make up for the deficiencies of humans: be they parents, relatives or teachers.

Family therapy

The term 'family therapy' refers to all intervention models which, although they follow different theories, practices and techniques, aim to treat - in the double sense of 'curing' and 'caring' - families rather than individuals, working on their emotional and cognitive interactions (Shazer, 1991). Family therapy thus stems

from the need to intervene, within the social context and in particular within dysfunctional families, both to search for the causes and to treat the psychological disorders, meeting during therapy not only the 'designated' patient but also the family context within which he or she is placed (Andolfi, 2009). The aim is to modify the relational dynamics between the various family members in order to improve the functioning of the family as a whole and bring well-being to the individual. In particular, the often hidden ways in which the balance of the whole family is based are analysed, in order to help the various members to identify them and become aware and in control of them. Family therapy differs from individual therapy by viewing the family as a 'system', composed of various interacting parts. The system is greater than the sum of its parts, so a change in any one part may be able to change all parts of the system. Ultimately, a change in one member of the group can affect all the other members.

From this point of view, it does not mean a direct intervention to a single individual, but the whole family unit, with its specific interpersonal dynamics, is taken care of.

Whereas in the past, family theories gave more emphasis to the spatial dimension as the main parameter of observation, while the temporal dimension was only taken into account in the present portion, in the *trigenerational perspective* the relational observation is no longer limited to the basic nuclear family but includes at least three generations. This perspective is based on the idea that individual histories are highly intertwined with those of previous generations and that the individual cannot be understood apart from a historical and intergenerational observation of his or her family relationships. Each family system is thought to have its own cultural identity that defines its ideo-affective values, role expectations and ways of dealing with certain significant events. This identity is transmitted from generation to generation, through

myths, loyalties, family mandates and scripts. In this way, the present of each family member is conditioned. Through trigenerational observation, an attempt is made to reconstruct the intergenerational web of relationships, in order to understand the implicit links between current behaviour and experiences and unmet needs of the past.

This leads to a new conceptualisation of family time, in which the present is understood as the nodal point linking past experiences and future prospects in a temporal succession. Family history is no longer understood as the succession of years, but as the interweaving of evolutionary lines of an ancient past, united with the myths handed down by the older generations and those of a future that lives in the hopes and latent projects of the elderly towards the new generations (Andolfi, 1988).

The individual, in this perspective, is embedded in the process of his temporal evolution, and his behaviour is assigned a value in the light of previous and subsequent events. The individual's behaviour then becomes comprehensible only in the light of the context and organisation of the system of relations in which he is embedded. Behaviour takes on meaning in relation to the situation, i.e. the circumstances that may influence a person's behaviour at a given time.

The symptom acquires a new meaning; it is no longer the manifestation of an individual malaise, but is the expression of a malaise that is connected to a dysfunctional organisation of the system as a whole. Understanding it requires broadening the observation, extending the investigation from the person who is the bearer to his or her significant relationships. The symptom is also the result of a multigenerational process, postulating the existence of transgenerational forces capable of exerting an influence on current relationships (Bowen, 1979).

Behavioural therapy

This type of therapy "addresses observable behaviour, without taking into account the underlying motivations or associated experiences" (Militerni, 2004, p. 136). For this type of therapy, all behaviour is acquired through learning and conditioning processes, whereby both 'normal' and deviant behaviour are learnt. The therapy is inspired by the principles of conditioning and aims to modify the child's behaviour in a positive sense, favouring desirable behaviour and inhibiting maladaptive behaviour.

Behavioural therapy uses various techniques.

Systematic desensitisation

This technique is mainly used for the treatment of fears and phobias. Initially, the child is taught exercises through which he or she can relax and regain the well-being lost due to fears or other anxious events. Afterwards, a hierarchical order of the stimuli capable of triggering the phobic reaction is established: from the phobic condition that causes mild anxiety to the most severe one.

The subject is then invited to imagine the stimuli capable of triggering the phobic reaction, starting with the mildest ones and then tackling the more severe ones, counteracting them each time by means of the relaxation exercises already learnt.

Combined exposure

The subject is brought into contact with a stimulus or situation that causes him/her discomfort, gradually and for an increasing length of time, but is helped through preventive interventions that aim to reduce his/her anxiety.

Response prevention

This technique consists in blocking, for a longer time than the patient is normally able to procrastinate the response, the symptomatic behaviour that the subject normally engages in following exposure to a situation of which he is afraid.

Operating behaviour

"Operant behaviour is based on the principle that behaviour is strongly influenced by the consequences it produces" (Militerni, 2004, p. 138).

Since the subject's behaviour is a consequence of the responses that follow his or her behaviour, it is evident that if the subject has a positive response, he or she will tend to maintain that behaviour; conversely, if he or she has a negative response. Various types of reinforcement are used to motivate the child to implement and repeat a certain positive behaviour.

Positive reinforcement is the pleasant or positive reward given to the child when he/she performs socially appropriate behaviour. For example, the child is rewarded with tokens that he or she can use to buy or obtain pleasant objects or experiences, whenever he or she performs appropriate activities: if he or she was attentive and did not become excessively distracted during lessons, if he or she did not get up from the desk for a certain amount of time, if he or she did not swear for a certain amount of time, and so on. Positive reinforcements are also praise, desired objects, games, pleasurable activities, food, in short, anything that can please the child.

Negative reinforcement consists of causing an aversive stimulus to cease when a given behaviour is implemented.

Punishment: is represented by the aversive stimulus that is given to the child when he or she engages in negative behaviour. For example, the *response cost is* used*:* the child is given a certain number of tokens that can be spent to buy objects he likes. These tokens will be taken away from him, one by one, if he engages in inappropriate behaviour.

Through the teaching of social skills, an attempt is also made to encourage desired behaviour through observation and imitation.

The treatment initially involves identifying the behaviour(s) to be increased or decreased and their frequency, then identifying

the environmental factors that extinguish or reinforce these behaviours, and finally selecting and activating the types of reinforcers that can influence the behaviour (Militerni, 2004, p. 139).

Cognitive-behavioural therapy

In cognitive-behavioural therapy, a lot of data is collected by means of interviews and observation of the parents and child, also using rating scales and tests. Before employing specific therapeutic techniques, an attempt is made to bring the parents and the child to conceptualise the problem from a cognitive-behavioural perspective as thoughts, attitudes, beliefs, are important factors in understanding a certain type of behaviour (Militerni, 2004, p. 1140). "The fundamental objective for cognitive therapy is represented by the definition of the reciprocal relationships between cognitive processes, emotional processes and explicit behaviour" (Militerni, 2004, p.140).

For example, as far as parents are concerned, it proved useful to produce in them an understanding of some fundamental assumptions:

(a) it is what they think about the child and its behaviour that determines their emotional reactions;

b) some of their emotional reactions negatively influence the child's behaviour;

c) their ideas and emotions can be replaced with others more likely to help the child.

As far as the child is concerned, it is useful to make him/her aware that there are other ways of feeling and behaving in problematic situations that affect him/her. An attempt will therefore be made to explore with the child the negative consequences of his disturbed behaviour and the positive consequences to which other, more appropriate alternative behaviours can lead.

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