ISSN 2637-2487 (online)
ISSN 2637-2517 (print)

THINK ABOUT YOUTH!

No.01. - December 2018

Psychotherapy In Achieving Health And Well-being for Children And Young People

Interdisciplinary Journal of Psychotherapy

Psychotherapy in Achieving Health and Well-being for Children and Young People

Interdisciplinary Journal of Psychotherapy

Poublisher:
BHIDAPA - Bosnian-Herzegovinian Association for Integrative Child and Adolescent Psychotherapy Emerika Bluma 9; 71000 Sarajevo; Bosnia and Herzegovina; www.bhidapa.ba; journal.psychotherapy.ba

DTP: City Group

Number: 1.

Year: 2018.

Interdisciplinary Journal of Psychotherapy
Psychotherapy in Achieving Health and Well-being for Children and Young People

ISSN: 2637-2487 (Online) http://journal.psychotherapy.ba/
ISSN: 2637-2517 (Print)

Contents

ORIGINAL RESEARCH ARTICLE

Mindfulness – focused awareness: application in children at a psychiatric ward 5

Doc. dr. sc. Vlatka Boričević Maršanić
Ana Kordić, mag.psych.
Mia Flander, mag.psych.

REVIEW ARTICLE

Single-parent families: Category at increased risk of poverty 17

Romana Galić, univ.spec.act.soc.
Darija Zubić, Master of Psychology

PROFESSIONAL ARTICLE

Transforming modern revolution in human science into guidelines for effective parenting (Innovative ways of influencing, and connecting with, teenagers) 29

Albert Mrgole PhD., psychotherapist

Participation of children with Asperger syndrome in group psychodrama therapy 43

Tatjana Krstić, Assistant Professor
Marina Obrenović, Teaching Assistant
Maja Pisarić, Clinical Psychologist
Tatjana Barišić, Clinical Psychologist

CASE STUDY

Overview of trauma treatment in the framework of integrative child psychotherapy 51

Belma Žiga, Psychologist

A child of a terminally ill parent - adjustment and grief 61

Mia Roje, mag.psych.
Prof. Gordana Buljan Flander, PhD
Vlatka Boričević Maršanić, MD-PhD
Ina Larsen Matić, senior student of Split University Medical School

Case study of a therapeutic work with a child after loss 71

MSc Đana Lončarica, Psychologist
Gestalt Psychotherapist, Family Systematic Psychotherapist,
Children and Adolescent Integrative Psychotherapist

A twenty-year-old adolescent victim of incest 79

Azra Arnautović, Primarius MD MSc, Paediatrician,
Group Analyst, Integrative psychotherapist for children and adolescents

Dear readers,

With great pleasure, the Bosnian-Herzegovinian Integrative Child and Adolescent Psychotherapy Association - BHIDAPA presents the Interdisciplinary Journal of Psychotherapy: ***Psychotherapy in Achieving Health and Well-being for Children and Young People***. The journal aims to present, through original scientific, review, expert articles and case studies, multidisciplinary approaches to the recognition and understanding of the mental health problems of children and young people, and optimal prevention, therapeutic and rehabilitative activities that promote the Healthy development of the child. We hope that the articles of contemporary scientific and professional methods and approaches to children and young people in the areas of children's and adolescent psychotherapy, health, social protection, education and juvenile justice will be a source of search for unique standards of health protection and the well-being of every child.

With respect,
Mirela Badurina, editor

NUMBER: 1.; DECEMBER, 2018.; RECIEVED: SEP 11, 2018.; ACCEPTED: SEP 11, 2018.; 5-15

Mindfulness – focused awareness: application in children at a psychiatric ward

Doc. dr. sc. Vlatka Boričević Maršanić
Psychiatric Hospital for Children and Adolescents, Zagreb, Croatia
11 Ivan Kukuljević street, Zagreb, Croatia
E-mail: vlatka.boricevic.marsanic@djecja-psihijatrija.hr

Ana Kordić, mag.psych.
Psychiatric Hospital for Children and Adolescents, Zagreb, Croatia
11 Ivan Kukuljević street, Zagreb, Croatia
E-mail: ana.kordic@djecja-psihijatrija.hr

Mia Flander, mag.psych.
SUVAG Polyclinic, Zagreb, Croatia
10 Ljudevit Posavski street, 10000, Zagreb
mflander@suvag.hr

Summary

Mindfulness (focused awareness) pertains to a state of mind in which attention is focused to one's own experiences (physical sensations, thoughts, emotions) or enviroment (sounds, smells) in the present moment with an accepting and nonjudgmental attitude. Although mindfulness had been present in the tradition of religions of both the East and West for more than 2500 years, mindfulness based therapy (MBT) was brought into modern medical practice in the late 1970s. Studies have shown that mindfulness has positive effects in children on symptoms of depression, anxiety, attention-deficit/hyperactivity disorder, impulsivity, eating disorders, addicition.

Mindfulness has been incorporated in the comprehensive therapy program at the closed psychiatric ward (ages 7 to 14) since 2015 of the Psychiatric Hospital for Children and Adolescents, Zagreb, Croatia. It is applied in group sessions with children with various mental health disorders combined with other cognitive behavioral therapy (CBT) techniques ev-

ery work day in the duration of approx. 20 minutes. Mindfulness techniques include sensory exercises (smell, taste), breathing exercises, body examination, guided imagination, movement exercises, standing yoga, listening meditation. When applying mindfulness in children it is necessary to shorten the duration of the exercises, as well as adjust them by incorporating elements of play. Mindfulness exercises are gladly accepted by the children and have lead to a reduction in internalised and externalised problems.

***Key words**: mindfulness, children's psychiatric ward, children's mental health disorders*

Sažetak

Mindfulness (usredotočena svjesnost) odnosi se na stanje svijesti s pažnjom usmjerenom prema vlastitim iskustvima (tjelesne senzacije, misli, osjećaji) ili okolini (zvukovi, mirisi) u sadašnjem trenutku sa stavom prihvaćanja i neprosuđivanja. Iako je mindfulness prisutan u tradiciji religija Istoka i Zapada već više od 2500 godina, terapije bazirane na usredotočenoj svjesnosti (eng. mindfulness based therapy – MBT) uvedene su u suvremenu medicinsku primjenu tek krajem 1970-tih godina. Istraživanja potvrđuju da mindfulness ima pozitivne učinke u djece na simptome depresije, anksioznosti, poremećaja pažnje i koncentracije te hiperaktivnosti, impulzivnosti, poremećaji hranjenja, ovisnosti.

Mindfulness je uključen u sveobuhvatni terapijski program na zatvorenom psihijatrijskom odjelu Psihijatrijske bolnice za djecu (dob 7 do 14 godina) od 2015. godine. Primjenjuje se u grupnom radu kod djece s različitim poremećajima mentalnog zdravlja kombiniran s drugim tehnikama kognitivno-bihevioralne terapije (KBT) svakog radnog dana u trajanju oko 20 min. Mindfulness tehnike uključuju senzorne vježbe (miris, okus), vježbe disanja, pregled tijela, vođenu imaginaciju, vježbe kretanje, stojeća joga, meditacije slušanja. Kod primjene mindfulnessa u djece potrebno je skratiti vrijeme trajanja vježbi te ih prilagoditi djece unoseći elemente igre. Mindfulness vježbe rado su prihvaćene od strane djece te rezultiraju smanjenjem internaliziranih i eksternaliziranih problema.

***Ključne riječi:** mindfulness, dječji psihijatrijski odjel, poremećaji mentalnog zdravlja djece*

Introduction

The term ***mindfulness*** pertains to a state of mind in which attention is focused to one's own experiences (physical sensations, thoughts, emotions) or enviroment (sounds, smells) in the present moment with a nonjudgmental attitude (1, 2). The key point in mindfulness is to apply focused attention aimed at the present moment in which every thought, emotion or physical sensation that appears in the consciousness is noticed and accepted without judgement just as they are (1).

Interventions and mindfulness based therapy (MBT) was brought into modern medical practice in the late 1970s (2, 3). Mindfulness-based techniques are a part of the so-called third wave of CBT psychotherapeutic approaches (4). MBT draws its roots from meditative techniques that have been present in the tradition of religions of both the East and the West for more than 2500 years. Contemporary adjustments to traditional Buddhist meditation techniques open the way for application and acceptance of mindfulness in different cultures and surroundings (1). What makes mindfulness and meditation similar is that attention is directed, and what separates them is that the goal of mindfulness is not to clear the mind, but to accept everything noted in the focus of attention with a nonjudgmental attitude.

Although mindfulness is still approached with distrust in medicine, there is more and more evidence that MBT-s are effective in mental disorders such as depression, anxious disorders, eating disorders, addiction in adults (5-11) as well as children and adolescents (12-17), and that they lead to improvements in depressive symptoms, anxiety, stress and quality of life in patients with malignant and cardiovascular diseases, chronic pain and chronic somatic diseases (6, 18-22). These effects have been confirned in comparison with different control interventions (waiting list or usual treatment). Since mindfulness reduces stress in adults and children, it can be useful in prevention as well, because learning how to handle frustrative situations with focused awareness helps in dealing with stress in life, both currently and in the future (1).

Mindfulness based therapies

Mindfulness based therapies include various techniques and interventions, ranging from siting meditation and breathing exercises to movement meditation and application of mindfulness in everyday life and activities, such as eating, walking and showering with focused awareness. Mindfulness training is most often performed through groups in structured programs, usually lasting for 8 sessions, after which it is possible to continue application of the excercises in groups or individually.

Kabat-Zinn (1) developed a structured program for stress reduction based on mindfulness (Mindfulness-based stress reduction - MBSR) in the late 1970s, as a supplement

to basic medical treatment, in which mindfulness-based exercises constitute a primary therapeutic tool. Mindfulness exercises in the MBSR program include body examination, siting meditation, Hatha yoga, walking meditation and mindfulness in everyday life, e.g. eating. MBSR has spread rapidly and is offered today by numerous hospitals, clinics, schools, prisons and various other institutions worldwide (1).

Segal, Williams and Teasdale (23) integrated MBSR with cognitive-behavioral techniques for depression in the 1990s and developed a cognitive therapy based on mindfulness (Mindfulness Based Cognitive Therapy – MBCT) for treating depression. Applying mindfulness exercises in persons suffering from depression disrupts the automatic ruminative pattern of negative thoughts that increases the probability of a depression relapse (24). The effectiveness of MBCT preventing a depression relapse in persons that have had three or more depressive episodes is equal to that of antidepressant maintenance therapy, and MBCT has been included in therapeutic guidelines for depression relapse prevention (25).

The effectiveness of MBT has been confirmed, besides depression (acute episode and relapse prevention), also for anxious disorders, bipolar disorder, eating disorders and addiction as well (26-29), while some disorders such as schizophrenia and social anxiety react better to standard therapeutic procedures (30).

Effect of mindfulness on the organism and brain

Mindfulness has positive effects on cognitive, emotional and physical functioning (31-35), which has been confirmed in numerous studies. Cognitive effects can be seen in increased attention span, cognitive flexibility, creativity and rumination reduction (31). Mindfulness decreases emotional reactivity, improves emotional regulation, empathy, satisfaction and increases resilience to stressful situations (31).

Neurophysiological effects of mindfulness include normalisation of blood pressure, heart rate and respiratory rate, as well as oxygen consumption (35), neuroendocrine status (reduced activity of hypothalamic–pituitary–thyroid axis and cortisone levels), sympathetic and parasympathetic nervous system, inflammation (lowered level of proinflammatory cytokines) which regulate different metabolic functions and organ systems (digestive, immune and cardiovascular system) (34, 35). The reduction in stress levels after mindfulness results in hightened productivity and effectiveness of persons.

Studies have shown that regular application of mindfulness leads to significant functional and structural changes in the brain as well. Mindfulness allows for psychological and behavioral answers that are more flexible to internal and external stimuli, which is a result of hightened activity and thickness of the cortex in the frontal regions of the brain, which are responsible for self-regulation, and lowered activity of the amigdala, with better control of strong emotions (33). A higher degree of emotional stability and lower

reactivity is also the result of higher activity of the anterior cingulate cortex, attached to the prefrontal cortex (33). Mindfulness meditation increases alfa and theta waves in EEG-s, which results in improvements in cognitive processes (36) and endorphin, serotonin and dopamine releases, positively affecting mood (35).

Mindfulness: mechanism of action

The effectiveness of mindfulness in improving mental disorders includes several mechanisms of action: cognitive change, improved self-control and self-regulation, exposure to uncomfortable and painful experiences which leads to a decrease in emotional reactivity (31-33).

Cognitive change or metacognitive awareness pertains to the development of a "remote" or "decentered" perspective in which persons perceive their thoughts and emotions as "mental events" rather than facts (1). Our mind is occupied with thoughts about the past or the future – the things we have done or should be doing – which are connected to feelings of depression and anxiety. The basic assumption in mindfulness is that by living in the present moment without judgement and with openness and acceptance, a broader perspective is possible; thoughts are observed as cognitive events that come and go rather as the absolute truth, emotions are observed as the current experience rather than something we have to fight against, physical sensations are observed as the body's answer to emotions. Thus, the relationship towards the symptoms is altered, rather than the symptoms themselves (1).

Mindfulness creates "space" between perception and answer. A person becomes able to answer to stressful situations reflectively and based on their own choice, not by reflex or reactively. Emotional reactiviy is reduced as well ass automatic non-useful behavioral patterns with avoidance strategies that only increase the intensity or frequency of unwanted uncomfortable internal experiences (37). These maladaptive strategies contribute to the prsistance of many, if not all, emotional disorders (2). Moreover, deep and steady breathing, included in mindfulness meditation, decreases symptoms of discomfort in the body by balancing the activity of the sympathetic and parasympathetic systems (1).

Application of mindfulness in children and adolescents

When applying mindfulness in kids and adolescents it is neccesary to consider developmental characteristics and cognitive abilities (38). Mindfulness exercises that are used in adults should be adapted for children, meaning shortening of the duration, usage of simplified language and introducing elements of play, activity, movement and fun. Application of mindfulness in children includes the involvment of their parent/guardian

in order for them to familiarize themselves with the basic principles of the exercises, as well as to follow along with their children during the exercises. The sequence of the exercises is also adapted to children: first, exercises of attention towards the external surroundings are performed, followed by body experiences and lastly mind exercises and meditation for older children. Mindfulness exercises used in children and adolescents can vary, and most often include exercises for senses, movements, body examination, listening, breathing, and various exercises of meditation for older children and adolescents (12, 38).

Although there have been considerably less studies on the application and effects of mindfulness in children and adolescents than in adults, there is evidence for positive effects of different interventions and therapies based on mindfulness applied in schools, nonclinical and clinical populations on physiological, socioemotional and behavioral functioning of children and adolescents (12-17, 39-45). MBT-s are acceptable and kindly accepted by children, and there is no data on negative influence and unwanted reactions. As in new scientific fields, previous studies on mindfulness in chilredn and adolescents have numerous methodological limitations, such as a small number of participants, lack of control groups and/or randomisation of participants and standardised measuring instruments, the use of self-report questionnaires and bias due to inclusion of volunteers instead of chosen participants, all of which contributes to the conclusion that the results of the studies and their conclusions may be considered as preliminary.

Studies have shown that mindfulness exercises can increase the ability of children to face stress by improving cognitive flexibility, self-regulation, mood and overall socioemotional development (38). Kabat-Zinn (1) emphasizes that mindfulness, because of looking at thoughts and emotions without judgement and not reacting impulsively, enables the acceptance of stressful events as challenges instead of as threats, thus increasing the ability of children and teens to face current and future life challenges.

It has been found in clinical populations of children and adolescents that mindfulness has a beneficial impact on reduction of anxiety, depression, somatic symptoms, symptoms of post-traumatic stress disorder, attention deficit, distractibility, behavioral issues, agressiveness, impulsiveness, peer abuse, expulsion from school as well as an improvement in cognitive inhibition, selfconfidence, social skills (12-17, 39-45). A family mindfulness program for children on the autism spectrum has proven to be effective in reducing social communication problems, as well as marking an improvement of emotional and behavioral functioning of children and improvement of the functioning of parents and their parenting process (46).

Studies on the effectiveness of mindfulness in children and adolescents at risk of cardiovascular diseases and obesity have shown better results for mindfulness in comparison to standard educational and therapeutic programs (47, 48).

Application of mindfulness at the Inpatient unit of the Psychiatric Hospital for Children and Adolescents

The Inpatient Unit of the Psychiatric Hospital for Children and Adolescents is the only closed psychiatric ward for children and adolescents up to age of 18 years in the Republic of Croatia. The capacity of the unit is 37 beds (25 acute and 12 chronic). The most severe cases (suicide attempts, psychotic reactions, auto and heteroagressive states as a part of different diagnostic criteria) in child and adolescent psychiatry in Croatia are treated at this ward. In diagnosing and treatment multidisciplinary (childrens' and adolescents' psychiatrist, clinical psychologist, social worker, work therapist, EEG, neuropediatrician, medical nurses) and multimodal approach is being followed (individual and group psychotherapy by psychiatrist and psychologist, family therapy, sociotherapy, occupational therapy).

Mindfulness has been applied at the Inpatient Unit of the Psychiatric Hospital for Children and Adolescents since 2015 in a group of elementary school-aged children (7 to 14 years old) as part of a multimodal therapeutic program individualised according to the needs of the child and his/her family. It is an open transdiagnostic group varied in the age of children and duration of hospitalization. The inclusion criteria are the positive opinion of the treating psychiatrist and parents/guardians consent. The group usually has 4-6 children. Mindfulness exercises are performed every work day in the duration of 20 to 30 minutes, depending on the number of children, their mental state at the moment and the conditions on the ward at the moment. For the children who have joined for the first time, a brief explaination of mindfulness is given, as well as the aim of the mindfulness exercises. The children participate in the mindfulness exercises one or more times, depending on the duration of their treatment, and exclusively during their stay at the ward. The exclusion criteria include poor reality testing, intolerance for group sessions and processes, severe cognitive impairment, intoxication, acute states of anxiety and depression, suicidal risk, manic episodes, weak motivation, oppositionality and antisocial features.

At the beginning the exercises of attention towards the external surroundings are practised (taste – chocolate, lemon; smell – flower, orange, spices; touch – various textures, ice; sight – one object, room, clothing diary; listening – bell, different musical rythms), followed by body experiences (movement – "train", "Indians", "dance"; breathing. my arms are a magnet, cold and warm breath, breathing with our stomach; body examination – Spaghetti test, fall snowflakes fall; everyday activities – teeth brushing, walking) and finally exercises for the mind and meditation for older children (thoughts – "River of thought", "Empty slate", "Thoughts as a vanishing cloud", "Glitter powder bottle", "Conveyor belt of worry"; emotions – "Weather forcast of emotions").

After participating in mindfulness exercises, the children report on feeling of relaxation, improved mood. The staff has noticed a decrease in "acting out" reactions and agressive behavior, as well as an improvement in cooperation by the children who attended the exercises. The goal is to teach the children mindfulness exercises so they can continue applying them after their hospital treatment.

Mindfulness is increasingly used in clinical conditions and psychiatric institutions for children and adolescents (49-51). Application of mindfulness in psychiatric wards requires realistic understanding of the possibilities and challenges: patients with a more severe symptomatology and comorbidity, acute phase of illness, side-effects of medicament therapy, changes in group participants, current possibilites at the ward. Mindfulness exercises should, thus, be adapted to the population of patients and conditions at the ward. The choice of patients is important to avoid the disruptions of group sessions. Studies on the effectiveness of mindfulness on the population of patients at the psychiatric wards are still in early stages, but report on positive results (49-51).

Conclusion

Interventions and therapies based on the mindfulness principle represent rational, relatively fast, pleasant and nonstigmatising preventative and therapeutic procedures for internalised (emotional) and externalised (behavioral) problems that can be applied in different populations of children and adolescents (schools, health institutions, social care institutions).

Further research is needed to overcome the methodological limitations of previous studies, so that mindfulness may become an evidence-based intervention.

References:

1. Kabat-Zinn J. Mindfulness-based interventions in context: Past, present, and future. Clin Psychol Sci Prac 2003; 10: 144–156.
2. Bishop M, Lau S, Shapiro L i sur. Mindfulness: A proposed operational definition. Clin Psychol Sci Prac 2004; 11: 230–241.
3. Baer RA. Mindfulness training as a clinical intervention: a conceptual and empirical review. Clin Psychol Sci Prac 2003; 10(2): 125-143.
4. O'Brien K, Larson C, Murrell A. Third wave behavior therapies for children and adolescents: Progress, challenges, and future directions. In Greco LA, Hayes SC (Eds.). Acceptance and mindfulness treatments for children and adolescents (pp. 15–35). Oakland, CA: New Harbinger, 2008.
5. Goyal M, Singh S, Sibinga EM i sur. Meditation Programs for Psychological Stress and Well-being: A Systematic Review and Meta-analysis. JAMA Intern Med 2014.
6. Gotink RA, Chu P, Busschbach JJV, Benson H, Fricchione GL, Hunink MGM. Standardised Mindfulness-Based Interventions in Healthcare: An Overview of Systematic Reviews and Meta-Analyses of RCTs. PLoS One 2015; 10(4): e0124344.
7. Galante J. Effects of mindfulness-based cognitive therapy on mental disorders: a systematic review and meta-analysis of randomised controlled trials. J Res Nurs 2012; 0(0): 1–23.
8. Chiesa A, Serretti A. Mindfulness based cognitive therapy for psychiatric disorders: A systematic review and meta-analysis. Psychiatry Res 2011; 187: 441–453.
9. Piet J, Hougaard E. The effect of mindfulness-based cognitive therapy for prevention of relapse in recurrent major depressive disorder: A systematic review and meta-analysis. Clin Psychol Rev 2011; 31: 1032–1040.
10. Chen KW, Berger CC, Manheimer E i sur. Meditative Therapies for Reducing Anxiety: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. Depress Anxiety 2012; 29: 545–562.
11. Strauss C, Cavanagh K, Oliver A, Pettman D. Mindfulness-based interventions for people diagnosed with a current episode of an anxiety or depressive disorder: a meta-analysis of randomised controlled trials. PLoS One 2014; 9: e96110.
12. Black DS, Milam J, Sussman S. Sitting-meditation interventions among youth: are view of treatment efficacy. Pediatrics 2009; 124: e532–e541.
13. Burke CA. Mindfulness-based approaches with children and adolescents: a preliminary review of current research in an emergent field. J Child Fam Stud 2009; 19: 133–144.
14. Bögels S, Hoogstad B, van Dun L, de Schutter S, Restifo K. Mindfulness training for adolescents with externalizing disorders and their parents. Behav Cogn Psychother 2008; 36: 193–209.
15. Biegel GM, Brown KW, Shapiro SL, Schubert CA. Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: a randomized clinical trial. J Consult Clin Psych 2009; 77: 855–66.
16. Van der Oord S, Bögels SM, Peijnenburg D The effectiveness of mindfulness training for children with ADHD and mindful parenting for their parents. J Child Fam Stud 2012; 21: 139–147.
17. Weijer-Bergsma E, Formsma AR, Bruin EI, Bögels SM. The effectiveness of mindfulness training on behavioral problems and attentional functioning in adolescents with ADHD. J Child Fam Stud 2012; 5, 775–787.
18. Piet J, Wurtzen H, Zachariae R. The effect of mindfulness-based therapy on symptoms of anxiety and depression in adult cancer patients and survivors: A systematic review and meta-analysis. J Consult Clin Psych 2012; 80: 1007–1020.

19. Veehof MM, Oskam MJ, Schreurs KMG, Bohlmeijer ET. Acceptance-based interventions for the treatment of chronic pain: A systematic review and meta-analysis. Pain 2011; 152: 533–542.
20. Abbott RA, Whear R, Rodgers LR i sur. Effectiveness of mindfulness- based stress reduction and mindfulness based cognitive therapy in vascular disease: A systematic review and meta-analysis of randomised controlled trials. J Psychosom Res 2014; 76: 341–351.
21. Kozasa EH, Tanaka LH, Monson C i sur. The effects of meditation-based interventions on the treatment of fibromyalgia. Curr Pain Headache Rep 2012; 16: 383–387.
22. Bohlmeijer E, Prenger R, Taal E, Cuijpers P. The effects of mindfulness-based stress reduction therapy on mental health of adults with a chronic medical disease: A meta-analysis. J Psychosom Res 2010; 68: 539–544.
23. Segal ZV, Williams JMG, Teasdale JD. Mindfulness-based cognitive therapy for depression: a new approach for preventing relapse. New York, NY: Guilford Press, 2002.
24. Kuyken W, Byford S, Taylor RS, i sur. Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. J Consult Clin Psych 2008; 76(6): 966-978.
25. National Institute of Health and Care Excellence [NICE] Depression: the treatment and management of depression in adults (update). London: Author, 2009.
26. Williams J, Alatiq Y, Crance C, et al. Mindfulness-based cognitive therapy (MBCT) in bipolar disorder: preliminary evaluation of immediate effects on between-episode functioning. J Affect Disord 2008; 107(2): 275-279.
27. Katterman SN, Kleinman BM, Hood MM, Nackers LM, Corsica JA. Mindfulness meditation as an intervention for binge eating, emotional eating, and weight loss: a systematic review. Eat Behav 2014; 15(2): 197-204.
28. Hofmann SG, Sawyer AT, Witt AA, Oh D The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. J Consult Clin Psych 2010; 78, 169-183.
29. Grow JC, Collins SE, Harrop EN, Marlatt GA. Enactment of home practice following mindfulness-based relapse prevention and its association with substance-use outcomes. Addict Behav 2015; 40: 16-20.
30. Davis L, Kurzban S. Mindfulness-based treatment for people with severe mental illness: A literature review. Am J Psychiatr Rehabil 2012; 15: 202–232.
31. Shapiro S, Carlson L, Astin J, Freedman B. Mechanisms of mindfulness. J Clin Psychol 2006; 62(3): 373–386.
32. Hölzel BK, Lazar SW, Gard T, Schuman-Olivier Z, Vago DR, Ott U. How does mindfulness meditation work? Proposing mechanisms of action from a conceptual and neural perspective. Perspect Psychol Sci 2011; 6: 537–559.
33. Tang YY, Posner MI. Theory and method in mindfulness neuroscience. Soc Cogn Affect Neurosci 2013; 8: 118–120.
34. Grossman P, Niemann L, Schmidt S, Walach H. Mindfulness-based stress reduction and health benefits: a meta-analysis. J Psychosom Res 2004; 57(1): 35–43.
35. Chiesa A, Serretti A. A systematic review of neurobiological and clinical features of mindfulness meditations. Psychol Med 2010; 40: 1239–1252.
36. Ahani A, Wahbeh H, Nezamfar H, Miller M, Erdogmus D, Oken B. Quantitative change of EEG and respiration signals during mindfulness meditation. J Neuroeng Rehabil 2014; 11: 87.
37. Desrosiersa A, Vineb V, Klemanskib DH, Nolen-Hoeksema S. Mindfulness and Emotion Regulation in Depression and Anxiety: Common and Distinct Mechanisms of Action. Depress Anxiety. 2013; 30(7): 654–661.

38. Semple R, Lee J, Miller L. Mindfulness-based cognitive therapy for children. In R. A. Baer (Ed.) Mindfulness-based treatment approaches: Clinician`s guide to evidence base and applications. Burlington, MA: Academic Press, 2006.
39. Abrams H. Towards an understanding of mindful practices with children and adolescents in residential treatment. Resid Treat Children Youth 2007; 24(1/2): 93–109.
40. Beauchemin J, Hutchins TL, Patterson F. Mindfulness meditation may lessen anxiety, promote social skills, and improve academic performance among adolescents with learning disabilities. Complement Health Pract Rev 2008; 13(1): 34–45.
41. Semple R, Lee J, Rosa D, Miller L. A randomized trial of mindfulness based cognitive therapy for children: Promoting mindful attention to enhance social emotional resiliency in children. J Child Fam Stud 2010; 19(2): 218–229.
42. Singh N, Wahler R, Adkins A, & Myers R. Soles of the feet: A mindfulness-based self-control intervention for aggression by an individual with mild mental retardation and mental illness. Res Dev Disab 2003; 24(3): 158–169.
43. Saltzman A, Goldin P. Mindfulness-based stress reduction for school-age children. In Greco LA, Hayes SC (Eds.). Acceptance and mindfulness treatments for children and adolescents. Oakland, CA: New Harbinger, 2008.
44. Lee CSC, Ma MT, Ho HY, Tsang KK, Zheng YY, Wu ZY. The Effectiveness of Mindfulness-Based Intervention in Attention on Individuals with ADHD: A Systematic Review. Hong Kong J Occup Ther. 2017 Dec;30(1):33-41
45. Siebelink NM, Bögels SM, Boerboom LM, de Waal N, Buitelaar JK, Speckens AE, Greven CU. Mindfulness for children with ADHD and Mindful Parenting (MindChamp): Protocol of a randomised controlled trial comparing a family Mindfulness-Based Intervention as an add-on to care-as-usual with care-as-usual only. BMC Psychiatry. 2018 Jul 25;18(1):237.
46. Ridderinkhof A, de Bruin EI, Blom R, Bögels SM. Mindfulness-Based Program for Children with Autism Spectrum Disorder and Their Parents: Direct and Long-Term Improvements. Mindfulness (N Y). 2018;9(3):773-791.
47. Gregoski MJ, Barnes VA, Tingen MS, Harshfield GA, Treiber FA. Breathing awareness meditation and LifeSkills Training programs influence upon ambulatory blood pressure and sodium excretion among African American adolescents. J Adolesc Health 2011; 48(1): 59-64.
48. Kumar S, Croghan IT, Biggs BK, Croghan K, Prissel R, Fuehrer D, Donelan-Dunlap B, Sood A. Family-Based Mindful Eating Intervention in Adolescents with Obesity: A Pilot Randomized Clinical Trial. Children (Basel). 2018 Jul 6;5(7).
49. Sams DP, Handley ED, Alpert-Gillis LJ. Mindfulness-based group therapy: Impact on psychiatrically hospitalized adolescents. Clin Child Psychol Psychiatry. 2018 May 1:1359104518775144.
50. Didonna F, Bhattacherjee S. Mindfulness-based training in residential settings: rationale, advantages and obstacles. Advances in psychiatric treatment (2014), vol. 20, 422–430.
51. Sams DP, Garrison D, Bartlett J. Innovative Strength-Based Care in Child and Adolescent Inpatient Psychiatry. J Child Adolesc Psychiatr Nurs. 2016 Aug;29(3):110-7.

REVIEW ARTICLE

PSYCHOTHERAPY IN ACHIEVING HEALTH AND WELL-BEING FOR CHILDREN AND YOUNG PEOPLE
NUMBER: 1.; DECEMBER, 2018.; RECIEVED: OCT 3, 2018.; ACCEPTED: OCT 3, 2018.; 17-27

Single-parent families: Category at increased risk of poverty

Romana Galić, univ.spec.act.soc.

Darija Zubić, Master of Psychology

Summary

There are very few scientific researches on family structure, especially on single-parent families, and they do not follow the rapid changes within the family structure. Therefore, we can draw conclusions on problems and difficulties in single-parent families based on a small number of researches conducted. Society is expected to provide families with the greatest protection and support possible, regardless of the type of family, so that they can fully fulfill their tasks and responsibilities within the community (Maleš, 1999). However, the society's response to the needs of families, and especially of single-parent families, is not quick, strong or effective enough. Apart from the phrase "single-parent family", other phrases were once used in professional literature as synonyms, such as: "abandoned" or "incomplete family", "deficient family", "broken family", "truncated" or "fractional family". However, due to their stigmatization and negative connotations, such phrases have since been abandoned. Today, phrases with a narrower meaning are used, for instance "single parent", "one parent", "parent without a spouse" and "parent living alone" (Piorkovska-Petrović, 1990). According to the Social Welfare Act (OG 157/13, 152/14, 99/15, 52/16, 16/17 and 130/17), a single parent is a parent who takes care of their child and supports them on their own, and a single-parent family is a family made up of a child or children and one parent. According to the postmodern paradigm, language use is of great importance (Ajduković, 2008), and according to Rabateg-Šarić, Pećnik and Josipović (2003), the term "single-parent family" is the most appropriate one, as it is value-neutral and points to what single parents have in common, which is the fact that one parent raises a child alone.

***Key words**: family, single-parent families, the phenomenon of child poverty*

Sažetak

Znanstvenih istraživanja o obiteljskoj strukturi, posebno o jednoroditeljskim obiteljima, je vrlo malo i ne prate brze promjene unutar obiteljske strukture. Stoga, o problemima i teškoćama u jednoroditeljskim obiteljima možemo zaključivati na temelju malog broja provedenih istraživanja. Od društva se očekuje da obitelji, neovisno o kojem se tipu obitelji radi, pruži najveću zaštitu i potporu kako bi ona mogla u potpunosti ispuniti svoje zadaće i odgovornosti unutar određene zajednice (Maleš, 1999). No, društvo na potrebe, posebno jednoroditeljskih obitelji ne odgovara dovoljno brzo, snažno i djelotvorno. Nekada su se, u stručnoj literaturi uz izraz jednoroditeljska obitelj, kao sinonim koristili različiti izrazi kao što su: napuštena ili nekompletna obitelj, deficijentna obitelj, razorena obitelj, krnja ili nepotpuna obitelj. No, radi stigmatizacije i negativog prizvuka danas su takvi nazivi napušteni. Koriste se neki izrazi koji su po svom značenju uži, npr. samohrani roditelj, roditelj samac, jedan roditelj, roditelj bez bračnog partnera, roditelj koji živi sam (Piorkovska – Petrović, 1990). Prema Zakonu o socijalnoj skrbi (NN 157/13, 152/14, 99/15, 52/16, 16/17 i 130/17) samohrani roditelj je roditelj koji sam skrbi za svoje dijete i uzdržava ga, a jednoroditeljska obitelj je obitelj koju čine dijete, odnosno djeca i jedan roditelj. Prema postmodernističkoj paradigmi velika je važnost uporabe jezika (Ajduković, 2008), a prema Raboteg-Šarić, Pećnik i Josipović (2003), termin "jednoroditeljske obitelji" je najprikladniji, jer je vrijednosno neutralan i jer ističe ono što je zajedničko samohranim roditeljima, a to jest činjenica da jedan roditelj sam odgaja dijete.

***Ključne riječi**: obitelj, jednoroditeljska obitelj, fenomen siromaštva djece*

Introduction

Family is the pillar of every society and is as such the focus of attention of scientists from different scientific disciplines. Although they differ in terms of determining the basic characteristics of family, most scientists agree that biological and social reproduction of life represent the basic functions of family. Family has always been the primary community whose task has been to provide optimal conditions for the growth and the development of a child (Maleš, 1999).

Family is a community made up of spouses or cohabiting partners, children and other relatives living together, earning a living, obtaining profit in some other way and spending it together (Social Welfare Act OG 157/13, 152/14, 99/15, 52/16, 16/17 and 130/17).

Constant transformations of society lead to a transformation of family which gradually changes itself and its roles, as well as adjusts to social requirements and needs. During the development of society, family has quite successfully resisted various challenges put before it (economic, political, cultural, etc.). Each of said challenges represented a new test of family adaptability as the structure, value and functions of family were continuously put to the test (Ljubetić, 2006). Some of said changes in the family structure include: a decrease in the number of marriages entered into, an increase in the number of divorces, a decline in fertility rates, a decline in fertility in marital unions, an increase in age when one enters into the first marriage, a greater propensity of couples to cohabit, an increase in the number of children born out of wedlock, an increase in the number of employed women (mothers), new marriages after divorce (Raboteg-Šarić, Pećnik and Josipović, 2003), and families in which children grow up with one biological parent and a stepmother or a stepfather (Ljubetić, 2006).

There are very few scientific researches on family structure, especially on single-parent families, and they do not follow the rapid changes within the family structure. Therefore, we can draw conclusions on problems and difficulties in single-parent families based on a small number of researches conducted. Society is expected to provide families with the greatest protection and support possible, regardless of the type of family, so that they can fully fulfill their tasks and responsibilities within the community (Maleš, 1999). However, the society's response to the needs of families, and especially of single-parent families, is not quick, strong or effective enough. Apart from the phrase "single-parent family", other phrases were once used in professional literature as synonyms, such as: "abandoned" or "incomplete family", "deficient family", "broken family", "truncated" or "fractional family". However, due to their stigmatization and negative connotations, such phrases have since been abandoned. Today, phrases with a narrower meaning are used, for instance "single parent", "one parent", "parent without a spouse" and "parent living alone" (Piorkovska-Petrović, 1990). According to the Social Welfare Act (OG 157/13, 152/14, 99/15, 52/16, 16/17 and 130/17), a single parent is a parent who takes care of their child and supports them on their own, and a single-parent family is a family

made up of a child or children and one parent. According to the postmodern paradigm, language use is of great importance (Ajduković, 2008), and according to Rabateg-Šarić, Pećnik and Josipović (2003), the term "single-parent family" is the most appropriate one, as it is value-neutral and points to what single parents have in common, which is the fact that one parent raises a child alone.

One of the biggest challenges faced by single-parent families are problems of economic nature. Studies show that single-parent families are at increased risk of poverty, as well as clearly point to numerous harmful factors of life in poverty, both for parents and for the development of a child.

There is no universal or single definition of poverty. According to the Scottish Poverty-InformationUnit (BBC, 2005, Bejaković, 2005), people are poor whenever they do not have enough resources for their material needs, and whenever their conditions exclude them from active participation in activities considered commonplace within the society. Poverty is manifested in a variety of ways, including a lack of income and resources necessary to ensure sustainable existence, as well as hunger and malnutrition, poor health, unavailability or limited access to education and other basic services, an increase in mortality, including mortality from illness, homelessness, inadequate housing conditions, unstable environment, social discrimination and isolation (Strategy for Combating Poverty and Social Exclusion in the Republic of Croatia 2014-2020).

Method

This review paper also contains commented data on the rates of single-parent families and poverty for Croatia and the European Union. The results are based on the data collected during the census (2011) by the Croatian Bureau of Statistics, as well as on Eurostat research data (2015) and the results obtained during previous researches on the topic in question.

Results and discussion

Single-parent families

The European Union

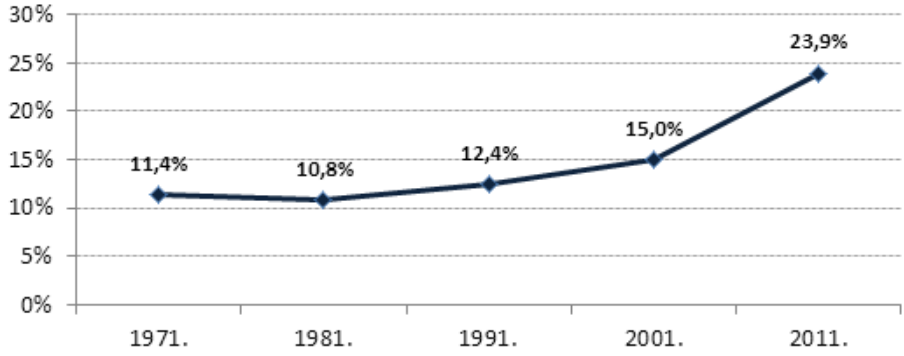
The nuptiality rate in the European Union dropped from 7.9 to 4.2 per 1,000 inhabitants from 1964 to 2014, while the divorce rate increased from 0.8 to 1.9 in the same period.

Eurostat data (2015) show that 40% European Union children are born out of wedlock, while the share of single-parent families amounts to 16% (Eurostat, 2011).

Out of the total number of families in the European Union, 13.4% are mothers with children, while 2.6% are fathers with children. The highest number of single-parent families in the total number of families with children was found in Latvia (40%), followed by Estonia (30.73%) and Lithuania (30.21%). The lowest number of single-parent families was found in Cyprus (12.77%), Greece (14.53%) and the Netherlands (17.74%).

Republic of Croatia

Over the last three decades, the total number of families in the Republic of Croatia showed a significant decrease in the share of married couples with children, as well as an increase in the number of single-parent families. The share of single-parent families (according to Croatian censi) is shown in Graph 1.



Graph 1 Share of single-parent families throughout the years

It is apparent that, according to population censuses in Croatia, the proportion of single-parent families was 11.4% in 1971, 10.8% in 1981, 12.4% in 1991, and 15% in 2001 (Puljiz and Zrinščak 2002). According to the census data for 2011 from the Central Bureau of Statistics, the proportion of single-parent families amounted to as much as 23.9% of all families.

There are five times more single mothers than fathers in single-parent families, i.e. 19.6% of all Croatian families are mothers with children, and 3.8% are fathers with children. Furthermore, there is an increasing number of children born out of wedlock. Although data for the Republic of Croatia are not as high as in some other countries in Western Europe (about 30%), an increasing trend is evident. Namely, the number of children born out of wedlock in Croatia ranged from 5-7% from 1960 to 1999 (Akrap and Živić, 2001), while in 2003 it was 10.1% (CROSAT, 2005), and in 2014 it was already 17.3% (Statistical Yearbook of the Republic of Croatia, 2015).

The Risk of Poverty in the EU

According to the Central Bureau of Statistics (2015), the average rate of the risk of poverty for the European Union in 2014 was 17.2%, and Croatia was ranked eighth according to height of this rate, in the group of countries with an above-average risk of poverty (19.4 %). The highest rate of the risk of poverty in 2014 was found in Romania (25.4%), followed by Spain (22.2%), and Greece (22.1%). The rate of the risk of poverty in Croatia is 19.4 percent. The lowest rates of poverty risk were recorded in the Czech Republic (9.7%), the Netherlands (11.6%), and Denmark (11.9%).

According to age and sex, the poverty rate is highest in people aged 65 and older (23.1%), and it is higher in women than in men. According to a research done by Carlson and Concoran, (2001), single mothers with children are five times more likely to live in poverty than children with married parents.

The Impact of Poverty on Children in Single-Parent Families

Along with the phenomenon of the feminization of poverty, we are also increasingly faced with the infantilization of poverty, i.e. the increase in the number of poor children. According to Šućur (2001), the reason for the increase in the number of poor women and children is most often found in the increase of single-parent families. The risk of poverty for single-parent families is above average, and the rates of infant poverty in single-parent families are four times higher than those in two-parent families.

The phenomenon of child poverty is extremely total, and the consequences of experiencing life in poverty may have more far-reaching and greater consequences on children than on adults. Child poverty is not just the state of the present, but it is also a danger of growing up in, and being doomed to, poverty. Also, according to the findings of Dobrotić, Pećnik, and Baraen (2015), children growing up in single-parent families are faced with a greater risk of lower educational outcomes and of leaving the education system early than children growing up in two-parent families.

The responsibility and duty of each community is to take care of and to care for the most vulnerable groups of society. The society directs special care towards the well-being of children. In 2013, the Croatian UNICEF Office initiated and facilitated the implementation of a comprehensive survey on poverty and well-being of pre-school children in our country, and the authors of the research are Prof. Zoran Šućur, PhD, Mirjana Kletečki Radović, PhD, Olja Družić Ljubotina, assistant professor, and Zdenko Babić, associate professor. In addition to the data on the spread of the risk of poverty among pre-school children in Croatia, the living conditions of pre-school children in the most unfavorable financial situations were also analyzed in detail; namely those of the children from families who receive social assistance. According to the results of this research in 2012, 20.5% of pre-school children lived below the relative poverty threshold, more than 15% of poor pre-school children lived in urban areas in single-parent families, while the propor-

tion of this group of children in rural areas was 3 times smaller. Furthermore, the results showed that 65% of children in poor families lived in villages, that 68% of families with pre-school children who receive social assistance lacked money for food, that 62% of pre-school children from poor families lived in the country, and that 39% of them in the city do not attend kindergarten because the parents cannot afford it; that almost 1/4 of poor preschool children live in households where no one is employed, and that nearly 1/3 of children with developmental difficulties in families who receive social assistance have difficulty accessing rehabilitation services. This data is clearly visible in Table 1.

Table 1. Some of the results of the research on the poverty and well-being of pre-school children (Šućur, Kletečki Radović, Družić Ljubotina, and Babić, 2013)

	%
Preschool children below the poverty threshold	20.5
Children in urban areas in single-parent families	15
Children from poor families in the country	65
Poor children from households where no one is employed	25
Roma children who lack in most things necessary for child development	50

According to the aforementioned UNICEF research, pre-school children living in poverty are highly materially and socially deprived in all areas required for optimum development (Šućur et al., 2015). Health services and other expert services in the community are often unavailable to poor families in rural areas outside city centers. Low-income families cannot afford adequate food, shelter, and other material goods that aid a child's healthy cognitive and social development (Hanson, McLanahan and Thomson 1997, Hill et al. 2001; all cited in Carlson and Concoran, 2001).

The economic status of neighborhoods and schools that give bad examples and create social situations of alcoholism, drugs, and aggressive behavior affect the development of the child (Obradović and Obradović, 2006). Moreover, poverty and economic stress may lead to inadequate upbringing, which bears negative consequences for child development and adjustment (Conger et al., 1994, Dodge, Petit, and Bates 1994, cited in Carlson and Corcoran, 2001).

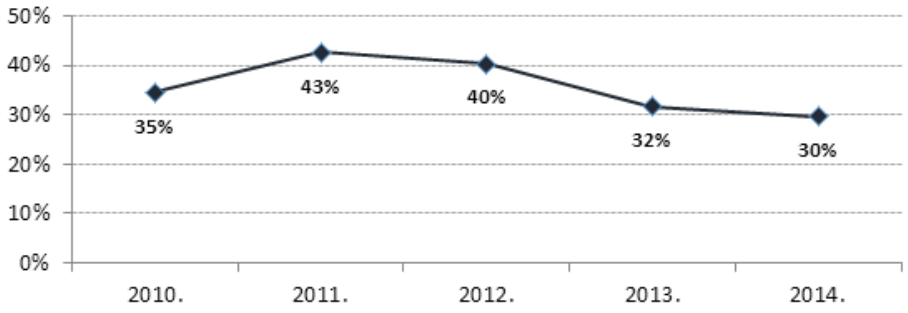
Financial Status and the Risk of Poverty in Single-Parent Families

When discussing the financial status, although material difficulties proved to be a mediator in the relationship between single parenting and psychological well-being, and the quality of life of the parents, it is important to note that the very structure of single-parent families further contributes to the likelihood of the development of material hardships. Single-parent families face more risks such as poverty, discrimination in employment, economic deprivation, and low income, but also poor accessibility and information, social network shortcomings, and inadequate social support. Thus, the relationship between single-parenthood and these factors is complex and multidimen-

sional. At the same time, financial status is an important determinant of the well-being and quality of life. The aforementioned unfavorable social circumstances pose a threat to the needs of members of single-parent families and may lead to unfavorable consequences on the personal, family, and community level. This suggests that single-parent families, along with balancing their professional and family lives, low levels of education, and insufficient social security coverage (Bonoli, 2005) represent a group of new social risks (Ajduković, 2008).

As previously mentioned, one of the increased risks in single-parent families is the risk of poverty. According to the Scottish PovertyInformationUnit (Bejaković, 2005), people are poor if they do not have enough resources for their material needs and are excluded from active participation in activities that are commonplace in society. Poverty is thus manifested in a variety of ways, including a lack of income and resources necessary to ensure sustainable existence, as well as hunger and malnutrition, poor health, unavailability or limited access to education and other basic services, an increase in mortality, including mortality from illness, homelessness, inadequate housing conditions, unstable environment, social discrimination and isolation (Strategy for Combating Poverty and Social Exclusion in the Republic of Croatia 2014-2020, 2014).

A Eurostat survey has shown that single parents in Europe have, on average, a 23% lower standard of living compared to all families with children, i.e. a 27% lower standard in relation to the entire population (Raboteg-Šarić, Pećnik and Josipović, 2003). The results of the Central Bureau of Statistics (2015) show that single-parent families have a significantly higher poverty rate than full families, and that it ranged from 34.6% to 29.6% between 2010 and 2014. According to a research done by Carlson and Concoran (2001), single mothers with children are five times more likely to live in poverty than children with married parents. Rates of the risk of poverty from 2010 to 2014 in single-parent families in the Republic of Croatia, according to the Central Bureau of Statistics (2017), are shown in graph 2.



Graph 2. Rates of the risk of poverty from 2010 to 2014 in single-parent families in the Republic of Croatia, according to the Central Bureau of Statistics (2017).

The results show that the single-parent poverty risk rate reached its peak in 2011 (a high 43%) and gradually decreased thereafter, to 30% in 2014.

Economic status is an important mediator of influence on family structure and child development; the family structure/economic status correlation and poor income have been proven to have adverse effects on children, as reflected in poor academic achievement, behavioral problems, and worse health (Duncan and BrooksGunn 1997, as cited in Carlson and Concoran, 2001).

Additionally, economic status has emerged as an important factor in parent well-being in single-parent families, manifesting through psychological problems (such as anxiety and depression), physical health, and quality of life in general, which impacts the overall family functioning.

According to a meta-analysis of 67 studies (Amato, 2001; Čudina-Obradović and Obradović, 2006), if the single parent is the mother, adverse effects of poorer economic status in the family manifest through: lower sociability, lower child self-esteem, an increased number of emotional issues, a higher level of unacceptable behavior, and poor academic achievement of children.

Social support as a solution

Positive effects of social support in almost every aspect of life have been the subject of long-standing research. One of the early definitions presents social support as a means secured through interaction with others and as a buffer against stress (Cohen, Wills, 1985, as cited in Karačić, 2012). A large number of studies indicate that people with a well-developed social support network are of better physical health than those with fewer social relations (Karačić, 2012).

Social support contributes to well-being both directly and indirectly, acting as a factor of protection from acute and chronic stress (Pećnik and Raboteg-Šarić, 2004). The reduction of stress and its adverse effects occurs in two ways: people with high levels of social support can assess a stressful situation as being less threatening than people with lower levels of social support, because they know that there are other people who are willing to help; social support improves the person's ability to cope with a stressor because of access to providers of various forms of emotional, practical, or material assistance (Pećnik and Raboteg-Šarić, 2004).

Economic pressures, business demands, household demands, and informal social support are reflected in the quality of parental behavior in single-parent and two-parent families (Leinonen et al., 2003, as cited in Pećnik and Raboteg-Šarić, 2004). It is therefore not surprising that a series of studies show that social support is an important factor or protection against adverse effects of stress on parenting itself (Pećnik, 2003, as cited in Pećnik and Raboteg-Šarić, 2004).

In the context of single-parent families, social support may manifest through emotional support (e.g. after divorce and the accompanying stress), but also through entirely practical support at the level of society. Such support may manifest through:

- Accessible high-quality services for children and families that enable family and work reconciliation;
- Early childhood institutions as an investment in children that will result in improved educational, social, and employment outcomes
- Customized and flexible forms of work for single parents
- An improved support/alimony system
- Targeted family benefits through the social protection system (e.g. upgrading of single-parent family benefits, universal child allowance, housing allowance, etc.)
- Employment assistance, single-mother homes, financial aid, sick child care, parent-child workshops, etc.

Earlier research (Cairney et al., 2003; Cohen and Dekel, 2000) has confirmed that this form of social support in particular may play a significant role in the relationship between family structure and psychological well-being and/or the quality of life of parents of single-parent families.

References:

1. Ajduković, M. (2008). Socijalni problemi, socijalni rizici i suvremeni socijalni rad, Revija za socijalnu politiku, 15 (3), 395-414.
2. Amato, P.R. (2001). Children of divorce in the 1990s: an update of the Amato and Keith (1991) meta-analysis. Journal of Family Psychology, 15 (3), 355-370.
3. Bejaković, P. (2005). Siromaštvo, Financijska teorija i praksa, 29(1), 133-136.
4. Bonoli, G. (2005). The politics of the new social policies. Policy & Politics, 431-449.
5. Cairney J., Boyle M., Offord D.R., Racine Y. (2003). Stress, social support and depression in single and married mothers. Soc Psychiatry Psychiatr Epidemiol 38, 442–449.
6. Carlson, M. J. & Corcoran, M. E. (2001). Family structure and children's behavioral and cognitive outcomes. Journal of Marriage and Family, 63(3), 779-792.
7. Cohen, O., Dekel, R. (2000). Sense of coherence, ways of coping and well being of married and divorced mothers. Contemporary Family Therapy.
8. Čudina-Obradović, M. & Obradović, J. (2006). Psihologija braka i obitelji. Zagreb: Golden marketing – Tehnička knjiga.
9. Dobrotić, I., Pećnik, N., Baran, J. (2015). Potrebe roditelja i pružanje usluga roditeljima koji podižu djecu u otežanim okolnostima, RODA - Parents in Action Association
10. European Statistical System, Eurostat 2011. [Retrieved January 5, 2016, from: https://ec.europa.eu/CensusHub2/query.do?step=downloadResult#]
11. Eurostat (2015). Donosi li 21. stoljeće promjene? [Retrieved February 4, 2019, from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Marriages_and_births_in_Croatia/hr]
12. Grozdanić, S. (2000). Jednoroditeljske obitelji prema uzrocima njihova nastanka. Zagreb University Faculty of Law, Social Work Study Center, Review, UDK 173.5/.6. Hetherington, 1972.
13. Karačić, S. (2012). Socijalna podrška kod adolescenata s tjelesnim oštećenjem. JAHR, 3, 5.
14. Ljubetić, M. (2006). Obitelj u povijesnom i suvremenom kontekstu . [Retrieved January 5, 2016, from http://www.ffst.unist.hr/images/50013806/Ljubetic_022006.pdf]
15. Maleš, D. (1999). Uloga majke i oca u odgoju djeteta In: Čikeš, J. (ed.) Obitelj u suvremenom društvu. Zagreb: National Institute for the Protection of Motherhood and Youth.
16. Obradović i Obradović, 2006
17. Pećnik, N., Raboteg-Šarić, Z. (2005). Neformalna i formalna podrška jednoroditeljskim i dvoroditeljskim obiteljima. Rev. soc. polit., Year 12, No. 1, Pages 1-21, Zagreb.
18. Piórkowska-Petrović, K. (1990).: Dete u nepotpunoj porodici, Beograd: Prosveta
19. Indicators of Poverty and Social Exclusion, Croatian Bureau of Statistics, 2017.
20. Puljiz V., Zrinščak, S. (2002).: Hrvatska obiteljska politika u europskom kontekstu, Revija za socijalnu politiku 9(2), 117-137.
21. Raboteg-Šarić, Z., Pećnik, N. & Josipović, V. (2003). Jednoroditeljske obitelji: osobni doživljaj i stavovi okoline. Zagreb: National Institute for the Protection of Family, Motherhood and Youth.
22. Statistički ljetopis Republike Hrvatske 2015. (2015)., Croatian Bureau of Statistics [Retrieved January 5, 2016, from http://www.dzs.hr/Hrv/Publication/stat_year.htm]
23. Šućur, Z. (2001). Siromaštvo: teorije, koncepti i pokazatelji, Revija za socijalnu politiku 8(3), 341-345.
24. Šućur, Z., Kletečki Radović, M., Družić Ljubotina, O. & Babić, Z. (2015). Siromaštvo i dobrobit predškolske djece u Republici Hrvatskoj. Zagreb: UNICEF Croatia.

NUMBER: 1.; DECEMBER, 2018.; RECIEVED: SEP 15, 2018.; ACCEPTED: SEP 15, 2018.; 29-41

Transforming modern revolution in human science into guidelines for effective parenting

(Innovative ways of influencing, and connecting with, teenagers)

Albert Mrgole
PhD., psychotherapist in private practice and author, Vezal Institute
Kamnik, Slovenia, +386 41 737 321, albert.mrgole@vezal.si

Summary

Since a revolutionary shift in the sciences of human behavior from the focus on cognition and intellectual functioning to understanding emotional functioning, both from intrapersonal as well as from interpersonal perspective, that influence is also reflected in psychotherapeutic work with children and adolescents. Following that approaches, we[1] *have developed a way to shift perspective from child/adolescence – cognitive and behavior – symptom-focused to systemic and emotionally-focused impacts of relationships. In that perspective, work with parental influence on child and adolescence development is seen in a new framework. As we put parental influence in the central perspective, the main dilemma in our work was how to effectively bring all new scientific knowledge into the context of domestic everyday life. One part of our answer is in shifting the style of narrative from scientific and professional language to pragmatic discourse. The second part is related to focusing on the preventive influence of parental emotional responsiveness in the period of development when the most significant behavior changes are recognized, the beginning of teenage years.*

We prepared our contribution through a decade of educational work and training of skills with parents, which we summarized in our book Connect with Your Teenager: A Guide to Everyday Parenting. In that perspective, we developed a unique style of presenting the

1 I must mention the important influence and share of my wife, co-therapist and coauthor Leonida Mrgole, who invented numerous creative and effective solutions in our parenting role as well as in therapeutic work and parenting training courses. We are a coherent team in our live presentations and appearances.

messages through stories in typical everyday situations, where parents can identify with, and recognize, the most influential moments.

The book works as a self-help and self-reflective guide with some therapeutic inputs, as well as a pragmatical and supportive tool. As only an emotional self-experience creates a permanent change, we designed the content so that parents can come in touch with their own transgenerational parental patterns and become aware of it, and consequently, they can manage it differently. On another level, they receive help to regulate their spontaneous emotional responses, in which parents lose the attachment influence through connection and bonding. As a very effective way of demonstrating what is going on in the behavioral and cognitive part, we identified typical repetitive cycles and named them parental dances with underlying important emotional dynamics. Through live stories, we demonstrated pragmatical responses, in which parents can grasp key moments with their children to keep and repair safe connection and influence.

***Key words**: Parenting, teenagers, parental influence, emotional regulation, parenting power, parental dances, systemic and emotionally-focused understanding*

Povzetek

Odkar se je na področju znanosti o človekovem vedenju zgodil revolucionalrni premik od kognitivnega in intelektualnega k razumevanju čustvenega delovanja, tako v notranje-osebnem kot v med-osebnem, se ta vpliv odraža tudi v psihoterapevtskem delu z otroki in adolescenti. V sledenju novih pristopov, sva[2] razvila način za premik perspective od fokusa na simptome otrok/ adolescentov k sistemskim in čustveno usmerjenim vplivom medsebojnih odnosov. V tej perspektivi je videti delo z vplivom staršev na razvoj otrok in adolescentov v novih okvirjih. Ko sva postavila starševski vpliv v središče, je bila glavna dilema najinega dela, kako učinkovito prenesti vsa znanstvena spoznanja v kontekst vsakdanjega domačega življenja. En del najinega odgovora je v premiku narativnega stila od znanstvenega in strokovnega k pragmatičnemu diskurzu. Drugi del pa je povezan z osredotočenostjo na preventivni vpliv čustvene odzivnosti staršev v razvojnem obdobju, ko opazimo največ vedenjskih sprememb, na začetku najstništva.

Svoj prispevek sva ustvarila skozi desetletje v edukativnem delu in usposabljanju veščin pri starših, kar sva povzela v svoji knjigi ***Connect with your Teenager: A Guide to Everyday Parenting.*** *Na ta način sva razvila edinstven način predstavitve sporočil prek zgodb iz tipičnih vsakdanjih situacij, s katerimi se starši lahko identificirajo in v njih prepoznajo najbolj vplivne momente.*

2 Omeniti moram pomemben prispevek in vpliv moje žene Leonide Mrgole, koterapevtke in sovtorice, ki je v najini starševski vlogi iznašla veliko ustvarjalnih in učinkovitih rešitev, prav tako pa tudi pri terapevtskem delu in na treningih za starše. V zasebnem in strokovnem življenju delujeva kot usklajen tim.

Knjiga učinkuje hkrati kot vodnik za samopomoč z nekaterimi terapevtskimi vložki in kot praktično in podporno orodje. Ker samo čustvena izkušnja na sebi ustvarja spremembo na daljši čas, sva ustvarila vsebino na način, da lahko starši pridejo v stik s svojimi lastnimi transgeneracijskimi vzorci in se jih zavedajo, posledično pa jih lahko spremenijo. Na drugi ravni pa jim pomagava, da lahko uravnavajo spontane čustvene odzive, v katerih starši izgubljajo vpliv navezanosti prek stika in povezanosti. Kot zelo učinkovit način, da staršem predstaviva, kaj se dogaja na kognitivni in vedenjski strani, sva orisala ponavljajoče se zaplete, ki sva jih poimenovala vzgojni (starševski) plesi, v katerih pod površino poteka pomembna čustvena dinamika. Prek življenjskih zgodb sva pokazala praktične odzive, v katerih starši lahko ujamejo ključne trenutke v odnosu z otroki, da ohranijo in popravijo varno povezanost in svoj vpliv.

Ključne besede: *Starševstvo, najstniki, starševski vpliv, čustvena regulacija, starševska moč, vzgojni plesi, sistemsko in v čustva usmerjeno razumevanje*

The background of the approach

In the last 20 years, we have been witnessing a revolutionary change in the understanding of emotions. Through discoveries in neurobiology, social psychology, mindfulness practices and new approaches in work with emotions in psychotherapy, namely with Sue Johnson's contribution in Emotionally Focused Therapy, the new knowledge has been persistently spreading to all other fields of human sciences. The focus is significantly shifted from previous rational, cognitive and intellectual to new understanding of the emotional part of human functioning. That is a paradigmatic shift influencing the whole field of social sciences. The Bowlby's attachment theory is reconceptualized. In the field of work with children and adolescents, we are dealing with new perspectives on safe responsiveness of parents and influences on emotional regulation of children through parenting (Porges, 1997; Meins, 1997; Meins et al., 1998, 2002; Slade, 2005; 2006; Schore, 2016).

We live in a time rich in knowledge development with science repetitively proving that the concept of the safe responsiveness of parents is the foundation for shaping the child's most important life experiences (Allen & Fonagy, 2006; Cooper, Redfern, 2016; Hughes, Baylin, 2012; Schofield, Beek, 2005; Siegel, 2001; 2007; 2011; 2013). Attachment, which is the most important basis for parental influence on children, also shapes within this concept. Safe responsiveness enables parents and other important people to participate in the shaping of interpersonal integration, which then facilitates the shaping of the meaningfulness of all events that take place within such interaction (Bowlby, 1969, 1973, 1988).

Remaining in safe connection with the parents is the child's fundamental need. Without it, the child's independence won't be successful. Research shows that the experience of safe attachment is directly related to healthy development in many areas: emotional flexibility, social functioning and cognitive abilities (Mikulincer & Shaver, 2007). Safe attachment builds resilience when tackling distress during development. On the other hand, research confirms that children who are not safely attached show emotional rigidity, problems in social relationships with others, poor concentration, problems understanding mental event in others, greater risk when managing social situations (Siegel, 2001; 2013; Schofield, Beek, 2005). Unsuitable experiences with attachment lead to greater vulnerability of children. The most unfavorable among experiences with attachment when safety is at risk is disorganized/disoriented, confused attachment which contributes to the shaping of behavior of growing children and requires clinical treatment (schizoid episodes, psychopathological results, violent behavior).

With speedy development of new knowledge on parental influence, some new questions are to be answered. Who is the most important subject of psychotherapeutic work in the case of symptomatic child or adolescent? Who has the most important role in child or adolescent development changes? In our work, we focused on the issue how to transfer all knowledge to parents who are in direct contact with their children. How can we improve and change everyday interactions, and the mentality of everyday domestic life?

At this point, we faced a dilemma in what language and in what style we can reach the language of parents and their way of understanding. We decided to speak in the pragmatial language of domestic stories with a simple comentary. So we wrote a manual for everyday use instead of a professional book. During literature review, we found out that most parental guides still focus on the cognitive and behavioural dimension of the understanding of interpersonal realtionships (Steinbeck, 2002; 2013) and most parents are not aware of emotional dimensions that accompany what they know on the behavioural and cognitive level. In our psychotherapeutic work, we got very pragmatical questions from parents, who wanted to know how to respond in very specific situations to respect the principles of a healthy and safe respose, for years. By elaborating, we found out that significant ruptures occure by the beginning of puberty, when children become teens. What are key momentums?

In everyday life of parents and adolescents, situations occur, in which parents lose their influence, their parental power and connection, and on the other hand, children consequently loe their purpose, which leads to lack of motivation and life engagement.

Out of transgenerational influences, parents persist in certain behaviors. Changes in parenting styles and mentality of parenting create new conditions, in which old patterns are no longer effective.

Many parents are lost in that changes, they lose their authority and the child's reactions worry them.

Advice and parental practices from the past do not work anymore. Parents do not have any ideas how to keep their authority, connection, how to follow modern parental paradigms and how to manoeuvre between so many parenting ideologies.

On the basis of our own experience with four children as well as our therapeutic work, we have researched for years the influence of a lost connection and how some unwanted forms of behavior develop, from difficult behavior, emotional problems, loss of motivation, school drop-out, self-harm, depression, deviant behavior and others.

The most difficult task for parents of teens[3] is how to establish a safe emotional connection and bonding with their kids in everyday life. Not what, but how! As they try to find an appropriate solution, it seems that they are somehow lost between their dysfunctional patterns and new ideologies of parenting.

All that is mentioned above is the reason that we, my wife Leonida Mrgole and me, wrote a parenting manual Connect with Your Teenager, which first became a bestseller in Slovenian language and then we had it translated into English. In the book, we demonstrate, through more than 200 stories and examples, how to create an effective parental

3 We use the term 'teen' to describe young people at that age and keep the context of interpersonality. There are also concepts of puberty and adolescence, which have a more biological and sociological connotation. (Siegel, 2013; Mrgole & Mrgole, 2017).

response, how to regulate the influence of own transgenerational patterns, in which parents can solve their unfinished stories from the past, to typical complications with teens, when the connection is lost and consequently children miss the support needed for a healthy development. It is a systemic regulative that potentially creates pathological forms in adolescents' mental health.

We need to find updated answers on already known questions. Is parenting art or science? What influence do parents have on the safe development of a child, especially in adolescence? What are preventive patterns that can provide safe development in adolescents? Can we prevent conflicts between parents and adolescents that become a daily routine, and normally guide the relationship towards wounds, distance and broken intimate bonds and lead to problems in adolescents' mental health? Who is responsible for deadly habits in our relationships?

In our book, we illustrate a lot of useful and functioning solutions and tips with regard to parental initiative for connecting and reconnecting with teenagers (Mrgole & Mrgole, 2017).

Parental influence, i.e. how parents imprint the child's experience with the emotional quality of their responses, is one of the most important statements and orientations in our therapeutic work. It means that parents' changes in a relationship, particularly in emotional, reflective and empathic responsiveness, can make a big difference in influencing adolescents' behavior and mental state.

Parental responses are mostly driven by intensive emotions. They act spontaneously and out of awareness. But we can create responsiveness where parents can influence, in a preventive way, and where they can maintain the teens' motivation for cooperation. In the first chapter of our book, we discuss some of topics that can help parents with the awareness of their spontaneous reactions. There are many mindfulness-based approaches to influence the change in the parental mindset, the awareness of our own patterns, the awareness of a safe base, the function of a safe launching pad, a child as the owner of his/her own experiences and achievements, parents as a safe haven (Porges, 1997; Siegel, 2013; Mrgole & Mrgole, 2017).

As adolescents are very provocative and conflictive in their own struggles during their development and in everyday relationships with other important people, they can provoke parents' responses, where parents lose parental influence, parental power[4], connection and safe belonging (Pollak, Pedulla & Siegel 2014), where they misunderstand the mentalization and emotional regulation (Fonagy et al., 2002). On the other hand, when teens lose connection, it is manifested in their health, psychological, behavioral and mental issues.

4 Here we will just outline the topic. We discuss the terms in more detail in our book *Connect with your Teenager* (2017).

We describe the mutual influence between parents and teens with the metaphor of a systemic dance (Johnson, 2004; 2008; 2013; Dallos, Draper, 2015; Butler, 2015). In this dance, dancers are in a mutual relationship, the actions and emotions of one of them influence the response of the other one. And the actions and emotions of the other one will in turn influence the actions of the first one. Like we can dance in integration, connection and harmony, we can also ruin our bond by using harmful and destructive habits and responses. It is important for parents to bear their influence in mind and to step out of deadly dances. We identified some typical dances that effectively help parents and us in our therapeutic work as the first step in understanding the rational, raising the awareness and moving to effective changes in relationships. These dances are briefly described below.

Typical disconnecting parental dances[5]

It is important to mention that parents, on the rational level, are aware of the described interaction and of the fact they are caught into repetitive their patterns. But they lack the understanding of the emotional dimension of the whole process. In that sense, the dance metaphor helps them to perceive, to understand and to make a step towards the change needed.

Parents are drawn to the discussed dances since they are in interaction with their young children. They can be their established mutual behaviors which run along tracks known in advance—which they don't even realize. We usually deal with issues and our internal thoughts (for example: why won't he listen to me, why do we always have to argue, when will he begin studying, how can I make her tidy up her room, must our Sunday lunch really be spoiled every time)—but don't see the pattern or the big picture of the relationship in which we actively participate.

Let's take a look at parental dances[6] through typical behaviors repeated by both sides. A dance begins in a mild form, and gradually progresses towards harsher and rougher ones.

5 The statement comes from our modern Slovenian (Central European) temporal and cultural context. It would be interesting to examine how common those parental behaviors can be identified in other contemporary cultural contexts.

6 The metaphor "parental dances" is used to describe the circular influence pattern that develops when parents and children interact. The similar metaphor was already used by Salvador Minuchin as "family dances," and also by Susan Johnson as "dances in partnership." In our next Slovenian book, we focus on the outline of parental dances, which are systematically arranged on the basis of parenting examples from childhood to adulthood, and shown as a search for connection and solutions in the form of safe attachment.

The sense and the motivation for it lies under the surface in emotional dynamics, where the effect is in shifting the power and influence from the parents to teens.

Dance No.1: ***"I'm afraid of the child"***

On the surface parents are afraid of their children or of conflicts.

On the other side, under the surface, teens have a growing sense of power, they disregard boundaries and rules, they disregard the authority and they seem convinced that no one can touch them.

Dance No.2: ***Inconsistency and indecisiveness***

On the rational part we can see plenty of words from parents without clear focus and true intention. Children perceive them as inconsistent and indecisive.

Such behavior of parents enables children to evade their duties (some children achieve it with blackmail; when younger children, for example, don't want to go to bed, they provoke behaviors when their parents give in, for example they throw up, get a fever, have cramps in their stomach...). But teens just do it their own way.

Dance No.3: ***"Please do what I tell you"***

Nice parents who ask and plead nicely, beg, and repeat their pleading.

What happens in the child's felt experience? Disregard, of course. The child doesn't hear and doesn't do what we ask him to do.

Dance No.4: ***Arguing (one of the most popular dances among parents)***

Parents believe that they can convince their children with words, they explain and justify.

On the other hand, children rebel using the same weapon: by arguing. The dance looks like this: the more the parents argue, the more the child argues (in the end, children always win, while parents feel powerless and despaired).

Dance No.5: ***Pursuing***

Parents try to use pursuing to get to the truth, to information about their teen, they ransack the teen's room, browse their mobiles, enter the teen's room uninvited...

Such behavior leads to evasion, concealment and secrets in teens.

Dance No.5: ***Intrusiveness, control***

Parents who are intrusive usually don't even realize it. Intrusive behaviors are behaviors which don't allow teens to have their autonomy and independence, in which they need space to explore, test, acquire their own experience. Intrusiveness is expressed as: "When will you start studying? Have you made a study plan for your next exam? How

many equations will you do today? How many calories have you eaten? Look at the way your shoes are tied. Are you wearing skateboard pads?"

Teens who perceive their parents as intrusive will rebel to, withdraw from, hide from such parents. If the parents' intrusiveness is related to close control, teens tend to develop hidden rebellion, sabotage and other physical symptoms which usually really worry us.

Dance No.6: ***Prohibiting***

We may know this dance from when we were growing up.

If our parents (or other adults) prohibited us something, we developed rebellious behavior. In teens, prohibition leads to an even greater desire to achieve the prohibited.

Dance No.7: ***Using deadly habits***

When parents are aware of their parental powerlessness and ineffectiveness, they switch from a friendly to a less friendly mode. This results in behaviors whose common denominator is that they destroy connections (according to Glasser[7] the most known are: criticizing, blaming, complaining, nagging, humiliating, comparing, threatening, bribing, punishing). They are the most common part of parents' everyday spontaneous responses in relationships with their teens.

And what happens when parents or other important adults (especially teachers) use such behaviors? Withdrawal from the connection, attitude of rejection, perhaps even unplugging from the relationship. In a word: disconnection.

Dance No.8: ***Power struggle***

This is an area of emotionally more intensive activity from the very beginning.

When parents face their teens with the idea of using power, along the lines of: now you'll see, I'll show you, we declare war on the teen. Teens usually translate the use of power into an invitation to power struggle, which they misunderstand as a fight to the end, meaning that they'll show us that they won't relent in their power. The more parents (and other adults) try to manipulate or control teens' behavior by using power, the more teens will rebel using even more power, also above all boundaries.

Dance No.9: ***Ignoring***

When parents run out of power, they usually give up. That's when we hear that they don't care about the child anymore. It is even more worrying when parents show their children with their behavior that they don't care about them anymore by ignoring them, excluding them from the relationship and attachment.

7 Glasser, 2002, 2010a, 2010b.

This results in great distress and anxiety in teens which they usually don't show because of their pride. Instead, they develop behaviors with which they hide their vulnerability.

Dance No.10: ***Chaos***

When parents' behaviors are chaotic, meaning that life one day is one way and completely different the next day, or when one set of rules is used one time and no rules the next, or when for example the father is sober one time and drunk the next, or when the mother is psychically stable one time and completely off balance the next, children don't get safe responses and develop a chaotic experience. In such cases, children don't have the fundamental sense of security, and in the future, they spread chaotic patterns in those areas where they themselves endured a chaotic experience.

Dance No.11: ***Abuse***

This dance is the most horrible of all, and we must not let it happen. When adults abuse children, children get stuck at the level of development when the abuse took place. For children, abuse represents a trauma, preventing them from developing healthily and undermining their fundamental sense of security.

Conclusion

Delineating parental dances is the first step to help parents to make changes so that their emotionally drived responsiveness to teenagers' needs and their provocative behavior becomes healthier and safer. They need more help to change the deeply-rooted spontaneous cultural and transgenerational patterns of parenting, where, in effect, adolescents miss emotional response (Schore, 2016; Tronick, 2007) and attachment support, which are essential for their healthy development in contemporary circumstances (Arnett Jensen & Chen, 2013).

References:

1. Allen, J., & Fonagy, P. (2006). Eds., Handbook of mentalization-based treatment. Hoboken, New York: Wiley.
2. Arnett Jensen, L., & Chen, X. (2013). Adolescent Development in a Diverse and Changing World: Introduction. Journal of Research on Adolescence, 23(2), 197–200.
3. Bowlby, J. (1969). Attachment and loss, Vol. 1: Attachment. New York: Basic Books.
4. Bowlby, J. (1973). Attachment and loss, Vol. 2: Separation Anxiety and Anger. New York: Basic Books.
5. Bowlby, J. (1988). A secure base: Parent-child attachment and healthy human development. New York: Basic Books.
6. Bowlby, J. (2005). The Making and Breaking of Affectional Bonds. New York: Routledge.
7. Butler, E. A. (2015). Interpersonal affect dynamics: It takes two (and time) to tango. Emotion Review, 7, 336–341.
8. Cooper, A.; Redfern, S. (2016). Reflective Parenting: A guide to understanding what's going on in your child's mind. London: Routledge.
9. Dallos, R. (2004). Attachment narrative therapy: integrating ideas from narrative and attachment theory in systemic family therapy with eating disorders. Journal of Family Therapy, 26, 40–65.
10. Dallos, R. (2007). Attachment Narrative Therapy: Integrating attachment, systemic and narrative therapies. Maidenhead: Open University Press/McGraw Hill.
11. Dallos, R., & Draper, R. (2015). An Introduction to Family Therapy: Systems theory and practice (4th ed.). Maidenhead: Open University Press.
12. Davidson, Richard J. & Begley Sharon. (2012). The Emotional Life of Your Brain. New York: Hudson Street Press.
13. Fonagy, P., Gergely, G., Jurist, E.L., & Target, M. (2002). Affect regulation, mentalization and the development of the self. New York: Other Press.
14. Glasser, W. (2002). Unhappy Teenagers: A Way for Parents and Teachers to Reach Them. New York: Harper Collins Publishers Inc.
15. Glasser, W. (2010a). Choice Theory: A New Psychology of Personal Freedom. Harper Collins e-books.
16. Glasser, W. (2010b). Choice Theory in the Classroom. Harper Collins e-books.
17. Goleman, D. (2006). Social Intelligence: The New Science of Human Relationships. New York: Bantam Books.
18. Greenberg, L. S. , (2002). Emotions in paretning. In: Emotion-focused therapy: Coaching clients to work through their feelings. , (pp. 279-299). Washington, DC, US: American Psychological Association.
19. Hughes, D. A., Baylin, J. (2012). Brain - based Parenting. The neuroscience of caregiving for healthy attachment. New York, London: W.W. Norton & CJohnson, S. (2004). The Practice of Emotionally Focused Marital Therapy. Creating Connection. New York: Brunner/Mazel.
20. Johnson, S. (2008). Hold me tight: Seven conversations for a lifetime of love. New York: Little, Brown and Company.
21. Johnson, S. (2013). Love Sense: The Revolutionary New Science of Romantic Relationships. New York: Little, Brown and Company.
22. Johnson, S. M., & Whiffen, E. V. (ed.) (2006). Attachment Processes in Couple and Family Therapy. New York, London: Guilford.

23. Jones, E. (2000). Family Systems Therapy. Developments in the Milan-systemic therapies, New York: John Wiley & Sons.
24. Meins, E. (1997). Security of attachment and the social development of cognition. Hove, UK: Psychology Press.
25. Meins, E., Fernyhough, C., Russell, J., Clark-Carter, D. (1998). Security of Attachment as a Predictor of Symbolic and Mentalising Abilities: A Longitudinal Study. Social development, 7, 1 - 24.
26. Meins, E., Fernyhough, C., Wainwright, R., Das Gupta, M., Fradley, E., & Tuckey, M. (2002). Maternal mind-mindedness and attachment security as predictors of theory of mind understanding. Child Development, 73, 1715-1726.
27. Mikulincer M.; Shaver P.R. (2007). Attachment in Adulthood. Structure, Dynamics, and Change. New York: Guilford Press.
28. Mrgole, A. & Mrgole, L. (2017). Connect With Your Teenager: A Guide to Everyday Parenting. Kamnik, Slovenia: Vezal Institute.
29. Parker, S., Nelson, B., Epel, E., & Siegel, D. (2015). The science of presence: A central mediator of the interpersonal benefits of mindfulness. In K. W. Brown, J. D. Creswell & R. M. Ryan (Eds.). Handbook of Mindfulness: Theory, Research, and Practice, (pp. 225–244). New York, NY: The Guilford Press.
30. Pollak, S. M., Pedulla, T., & Siegel, R. D. (2014). Sitting together: Essential skills for mindfulness-based psychotherapy. New York, NY: Guilford Press.
31. Porges, S.W. (1997). Emotion: an evolutionary by-product of the neural regulation of the autonomic nervous system. Annals of the New York Academy of Sciences, 807, 62-77.
32. Schofield, G.; Beek, M. (2005), Providing a secure base: Parenting children in long-term foster family care, Attachment & Human Development, 7(1): 3 – 25.
33. Schore, A. H. (2016). Affect Regulation and the Origin of the Self. London: Routledge.
34. Siegel, J. D. (2001). Toward an interpersonal neurobiology of the developing mind: attachment relationships, 'mindsight,' and neural integration. Infant Mental Health Journal, Vol. 22 (1–2), 67–94.
35. Siegel, J. D. (2007). The mindful brain: Reflection and attunement in the cultivation of well-being. New York, NY: Norton & Company.
36. Siegel, J. D. (2011). Mindsight, The new science of personal transformation. New York: Bantam Books.
37. Siegel, J. D. (2013). Brainstorm: The Power and Purpose of the Teenage Brain. New York: Jeremy P. Tarcher/ Penguin.
38. Siegel, D., & Solomon, M. (2003). Healing Trauma: Attachment, Mind, Body and Brain, New York: W.W. Norton & Company Inc.
39. Siegel, J. D., & Hartzell, M. (2004). Parenting from the inside out. New York: Penguin.
40. Siegel, D. J., & Bryson, T. P. (2011). The whole-brain child: 12 revolutionary strategies to nurture your child's developing mind. New York, NY: Bantam Books.
41. Slade, A. (2005). Parental reflective functioning: An introduction. Attachment and Human development, 7(3), 269-281.
42. Slade, A. (2006). Reflective Parenting Programs: Theory and Development. Psychoanalytic Inquiry 26, 640-657.
43. Steinberg, L., & Silk, J. S. (2002). Parenting adolescents. In M. H. Bornstein (Ed.), Handbook of parenting: Children and parenting (2nd ed., Vol. 1, pp. 103–133). Mahwah, NJ: Lawrence Erlbaum Associates.

44. Steinberg, L. (2013), Adolescence (10th ed), Boston: McGraw Hill.
45. Tronick, E. Z. (2007). The neurobehavioral and social-emotional development of infants and children. New York: WW Norton.

PROFESSIONAL ARTICLE

PSYCHOTHERAPY IN ACHIEVING HEALTH AND WELL-BEING FOR CHILDREN AND YOUNG PEOPLE
NUMBER: 1.; DECEMBER, 2018.; RECIEVED: SEP 12, 2018.; ACCEPTED: SEP 12, 2018.; 43-50

Participation of children with Asperger syndrome in group psychodrama therapy

Tatjana Krstić
Assistant Professor, Faculty of Medicine, Department of Psychology
Novi Sad, Serbia, +381 64 1838830, tatjana.krstic@mf.uns.ac.rs

Marina Obrenović
Teaching Assistant, Faculty of Philosophy, Department of Psychology
Novi Sad, Serbia, +381 64 1781524, marina.oros@ff.uns.ac.rs

Maja Pisarić
Clinical Psychologist, Institute for Child and Youth Health Care of Vojvodina
Novi Sad, Serbia, +381 63 8936514, maja.pisaric@izzzdiovns.rs

Tatjana Barišić
Clinical Psychologist, Institute for Child and Youth Health Care of Vojvodina
Novi Sad, Serbia, +381 63 8025250, tatjana.barisic@izzzdiovns.rs

Summary

Among developmental disorders there is hardly a more controversial diagnosis than Asperger syndrome (AS). It was first considered as a separate entity in the 1994 Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), while the most recent edition of the Manual (DSM-5) from 2013 treats both autism and AS jointly under the title of Autistic Spectrum Disorder. Another standpoint views AS not as a disorder, but as a specific cognitive style. All controversy surrounding the diagnosis aside, along with the extremely prolonged time period needed for determining that a child's specific problems in functioning are AS related, the clinical practice points to a need for support to be provided to these children and their parents.

The difficulties of children with AS are most pronounced in the domain of social functioning. Children fail to establish a satisfactory interaction with their peers, although they are

aware of other people and show interest in them. They often do not understand rules of socially acceptable behavior and lack empathy. Emotions are expressed in unusual ways, lacking subtlety and refinement.

Experience in conducting psychotherapy with children with AS in our region is still rather limited. Considering that children's psychodrama should support social development, as well as free expression of emotions by means of stage improvisation in contact with peers, we deemed it useful in supporting children whose primary difficulties lie in the domain of socio-emotional functioning.

Our aim is to demonstrate the possibilities and challenges of organizing psychodrama groups which would include children with AS, as well as the benefits of such therapeutic approach. We present the inclusion of two children with characteristics of AS. The key conflict area for both children was social functioning (peer rejection). The parents were highly motivated for their children's participation in psychodrama (children were previously involved in individual psychotherapy) and interviews were conducted with them before and after each group cycle. The girl, aged 10 years, participated in two psychodrama groups (each consisted of 10 sessions) and the boy, aged 11, took part in one psychodrama group, which included 10 sessions.

Even in a safe environment offered by the "as if" approach typical for a children's psychodrama group, specific challenges were observed in children with AS which pertained to their difficulties in different domains of functioning and behavior. Significant insights into everyday functioning of children with AS were made possible by their inclusion in psychodrama. This allowed the therapists to work with their parents on creating support for various activities of everyday life. Children's psychodrama groups can offer valuable support to children whose difficulties lie mainly in social and emotional domains.

Key words: *children's psychodrama, group therapy, Asperger syndrome*

Sažetak

Kada su u pitanju razvojni poremećaji, retko koja dijagnoza budi više kontroverze od Aspergerovog sindroma (AS). U Dijagnostičkom i statističkom priručniku mentalnih poremećaja iz 1994. godine (DSM-IV) je prvi put izdvojen kao poseban dijagnostički entitet, a u najnovijem priručniku (DSM-5) iz 2013. godine su autizam i AS objedinjeni pod nazivom Poremećaji autističnog spektra. Postoji i stanovište da u pitanju nije poremećaj, već samo drugačiji kognitivni stil. Bez obzira na kontroverze oko samog dijagnostičkog određenja, kao i veoma produženog vremena prepoznavanja o kakvim specifičnim poteškoćama u detetovom funkcionisanju se radi, klinička praksa ukazuje na potrebu za podrškom ovoj deci i njihovim roditeljima.

Poteškoće kod dece sa AS su najizraženije u sferi socijalnog funkcionisanja. Deca ne uspevaju da ostvare zadovoljavajuću interakciju sa vršnjacima, ali su svesna drugih ljudi i pokazuju interesovanje za njih. Često ne razumeju pravila socijalno prihvatljivog ponašanja i

ispoljavaju nedostatak empatije. Izražavanje emocija može biti neobično ili im nedostaje suptilnosti i preciznosti u ispoljavanju emocija.

Psihoterapijska iskustva u radu sa decom sa AS su u našoj sredini još uvek prilično skromna. S obzirom da bi dečija psihodrama trebalo da podrži kako socijalni rast tako i slobodno izražavanje emocija putem scenske improvizacije u kontaktu sa više dece približnog uzrasta, smatrali smo da može biti značajan vid podrške deci koja pokazuju primarne teškoće u oblasti socio-emocionalnog funcionisanja.

Cilj našeg rada jeste da prikažemo mogućnosti, načine i izazove u radu dečije psihodramske grupe u koju se uključe deca sa AS, kao i benefite od tog psihoterapijskog pristupa. U radu će biti prikazano uključivanje dvoje dece sa pokazateljima AS. Ključna konfliktna područja kod oba deteta su se odnosila na poteškoće u socijalnom funkcionisanju (odbačenost od strane vršnjaka). Roditelji su ispoljili visoku motivaciju za učešće dece u psihodrami (deca prethodno bila uključena na individualnu psihoterapiju) i sa njima su obavljeni individualni razgovori pre i nakon završetka psihodramskh susreta. Devojčica, stara 10 godina je učestvovala u dve psihodramske grupe (svaka sa po 10 susreta), a dečak uzrasta 11 godina je učestvovao u jednoj psihodramskoj grupi, odnosno 10 susreta.

Čak i u bezbednom okruženju koje nudi "kao da" pristup, primaran za dečju psihodramsku grupu, uočeni su određeni izazovi za decu sa AS, koji će biti diskutovani. Značajni uvidi u funkcionisanje dece dobijeni tokom učestvovanja u grupi omogućili su terapuetima da sa roditeljima kreiraju i podršku usmerenu na svakodnevne životne aktivnosti. Dečja psihodramska grupa može da ima blagotvoran potencijal za psihoterapijski rad i podršku deci sa poteškoćama u socijalizaciji, razumevanju i izražavanju emocija.

***Ključne riječi**: dječja psihodrama, grupna terapija, Aspergerov sindrom*

Introduction

Asperger's syndrome (AS) has recently come into focus of thorough scientific research (Attwood, 2010). It was defined for the first time as a separate diagnostic category in 1994. in Diagnostic and statistical manual of mental disorders (DSM-IV) (American Psychiatric Association, 1994). In the most recent edition of the Manual (DSM-5) autism and AS were united under the wider diagnostic label of Autism spectrum disorder (American Psychiatric Association, 2013). There is no consensus regarding the cause of autism and similar traits, but there is evidence that emphasize the importance of genetic factors (Colvert et al., 2015). Another standpoint considers AS a specific cognitive style, rather than a separate disorder. The Central coherence theory states that individuals with AS have very low central coherency and are therefore extremely detail-focused and lack focus on the wider global picture or context (Shah & Frith, 2006). Some authors view AS as a part of a social-communication disability continuum, in-between autism and normalcy. Children with AS are described as lacking "cognitive empathy" or "theory of mind" – they have difficulties in imagining and understanding other people's thoughts and emotional states (Baron-Cohen, Wheelwright, Skinner, Martin, & Clubley, 2001; Rueda, Fernandez-Berrocal, Baron-Cohen, 2015). Difficulty with theory of mind leads to difficulties in the domain of social functioning. These problems usually become more visible when children start school and fail to establish successful interaction with peers. It is important to emphasize that these children are aware of their peers and show interest in interaction. They lack social skills and do not understand the rules of socially acceptable behavior, and hence may appear rude or bad-mannered. Their emotional expression may be unusual and lack subtlety and refinement (Attwood, 2010). Probably, the lack of deviations in intellectual development may be the most significant factor to the problem of identifying the children with AS. Although neuropsychological tests indicate that there might be a specific profile of intellectual functioning in children with AS, global intelligence in these children is usually average or above average (Noterdaeme, Wriedt, & Höhne, 2010). Regardless of dilemmas with the diagnostic category and delayed recognition of the specific difficulties in children's functioning, clinical practice highlights the need for providing support for these children and their parents.

Children's psychodrama and children with AS

Children's psychodrama is a group psychotherapeutic method in which children guided by two therapists create stories that provide basis for free play. During the making of the story children become involved in the creative process. These stories are always acted out in the "as if" world, fantasy world. Children are provided with a safe setting suitable for experiences that may be inaccessible in everyday life. They are encouraged to express their inner psychological states and learn how to change their everyday behavior-

al patterns. The main goal in therapy is not to express or discuss problematic behaviors, but to promote spontaneity and activate free creativity (Krüger, 2002). Symbolic play is of central importance in children's psychodrama because it allows manifestations of specific characteristics of child's creativity (Aichinger & Holl, 2017).

In our country experiences with psychotherapeutic work with children with AS are still rather limited. Children's psychodrama aims to support social development and free emotional expression through role-play within small peer group. Therefore we consider this particular psychotherapeutic method a potentially significant form of support for children with difficulties in the domain of social-emotional functioning. Regardless of the predominant symptoms, group psychotherapy is in general method of choice for children for whom the group is a better environment for expression of oneself and of one's problem than the individual setting and one-on-one relationship with the therapist (Aichinger & Holl, 2017). Although our integrative approach to children's psychodrama differs from classical Moreno's psychodrama, some previous studies report beneficial outcomes using classical psychodrama with adolescents and young adults with AS (Munir, Scholwinski & Lasser, 2006; Takahara, 2002).

The challenge of children's psychodrama with children with AS lies in the fact that they do not play projectively. Even when the play appears to be projective, these children do not project themselves nor their experiences. Their behavior may be misleading, but their explanation of the pretend play is based on rational facts and does not include true immersion in the projective play. However, these children may enjoy and benefit from group work, if they like the activities and if they are not expected to act more socially competent than they actually are (Jacobsen, 2003).

In the following, we will present case presentations of two children of similar age who both manifest some traits of AS. Both of these children were in individual psychotherapy previous to inclusion in children's psychodrama groups. Parents of both children showed high levels of motivation for child's participation in group therapy. We conducted interviews and consultation sessions with parents before the beginning and after the ending of group cycles. The boy (child A), aged 11, participated in one group that included 10 sessions. The girl (child B), aged 10, participated in two different groups, successively, each including 10 sessions. She participated in the first group along with the boy A. The main conflict domain in both children were difficulties in social functioning. They both failed to get involved in topics shared by their peers and experienced frequent peer rejection. They were both highly involved in their own interests (computer games and drawing). Their parents stated that in social situations their child tends to "say something inappropriate to the situation". Both children reacted impulsively when facing even the mild frustration in home environment. The boy A complained and reported deep dissatisfaction regarding peer rejection, usually through depressive elaborations. The girl B, however, did not manifest suffering because of peer rejection, even though parents described several situations that could be considered bullying, in which B did not react or did not know how to cope.

First children's psychodrama group

This group included two girls and three boys. During the first session all children seemed mildly inhibited, except for B, who initiated conversation with every group member and acted exaggeratedly theatrical. In the beginning it seemed that this kind of behavior was perceived as interesting and spontaneous by other children. However, shortly it began to bother other children, especially when she did not respect other's psychological space and touched or hugged them (for example, she touched some interesting elements of their clothes). She repeatedly chose the same role in each session. She also manifested difficulties in getting out of the role. She frequently spoke out of line, but when her turn to speak she would "block" or say something inappropriate or unusual, provoking laughter in other children. As the group dynamic progressed, other children started excluding her from play. She also stared to isolate herself, creating her own play through improvisation and it seemed she enjoyed these activities.

From the beginning, the boy A manifested strong desire to fit in and to participate in group activities. He engaged in all activities, from warm-up to enacting. He contributed with topics of school, grades, achievement. Other boys liked that he showed great knowledge of particular areas of his interests (for example, about space). He was very pleased when others accepted his suggestions and proposals. Regardless of the notion of his acceptance by the other members of the group, he mostly avoided eye contact with other children and both therapists. He put great effort to rationally play the role, but failed to relax and be spontaneous. As the group progressed, he began talking about his emotional states, laughed more and acted more spontaneous, but still very inhibited. He frequently stated that he enjoys coming to our sessions. His parents confirmed and noted that psychodrama group is the only activity he likes to attend.

Second children's psychodrama group

This group, apart from B, included two more girls and three boys. Similarly to the first group, B was very open in the beginning, introduced herself and posed various questions initiating interaction with others. She did not seem bothered that this group included different children than the previous. She did not mention the previous group. She repeatedly chose the same role and imposed topics within her area of interest – drawing animals. She frequently isolated herself and it did not seem as she enjoyed the activities with other children. Sometimes she acted eccentrically and laughed loudly, which was met with disapproval by other children. Albeit she was not openly rejected by others, children did not show interest in interaction with her and did not chose to engage in play with her. It seemed she was not aware of this and she did not put effort in joining in play. At the end of each session she told us she enjoyed herself and "could hardly wait for the next one", but it seemed this was just the repetition of other children's words.

Conclusion

Recognition of the difficulties in children with AS is often challenging and untimely, mostly because of the wrong interpretation of child's behavior, by both parents and professionals. For this reason, opportunities for appropriate and prompt support for these children are often missed (Krstić, Slavković, Knežević, & Milankov, 2016).

Inclusion of children with AS traits in our children's psychodrama groups showed they may benefit from this kind of therapy, mostly through social participation with peers, but also through feelings of satisfaction and security provided by therapeutic setting. We were able to notice differences between children, confirming their uniqueness and different challenges and capacities in everyday functioning. Experience of other therapists point out the tendency of these children to isolate themselves and spend time apart from others (Jacobsen, 2003). The girl from our groups did not refuse cooperation with other group members, but this interaction was scarce. Parents of both children provided feedback that their child showed interest and enjoyed coming to our sessions. Children's expression of their satisfaction is considered improvement. The greatest progress in their functioning is the fact that they engaged in interaction with their peers. For both parents of children with AS and professionals who work with them, it is important to understand and accept that these children have different needs and different interests, but need a supportive environment just like every other child.

References:

1. Aichinger, A., & Holl, W. (2017). Group Therapy with Children: Psychodrama with Children. Wiesbaden: Springer.
2. American Psychiatric Association (1994). Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). Washington DC: APA.
3. American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Washington DC: APA.
4. Attwood, T. (2010). Aspergerov sindrom: Vodič za roditelje i stručnjake. Jastrebarsko: Naklada Slap.
5. Baron-Cohen, S., Wheelwright, S., Skinner, R., Martin, J., & Clubley, E. (2001). The autism-spectrum quotient (AQ): Evidence from Asperger Syndrome/high-functioning autism, males and females, scientist and mathematicians. Journal of Autism and Developmental Disabilities, 31(1), 5-17.
6. Colvert, E., Tick, B., McEwen, F., Stewart, C., Curran, S. R., Woodhouse, E., Gillan, N., Hallett, V., Lietz, S., Garnett, T., Ronald, A., Plomin, R., Rijsdijk, F., Happe, F., & Bolton, P. (2015). Heritability of autism spectrum disorder in a UK population-based twin sample. JAMA Psychiatry, 72(5), 415-423.
7. Jacobsen, P. (2003). Asperger Syndrome and Psychotherapy: Understanding Asperger Perspective. London and New York: Jessica Kingsley Publishers.
8. Krstić, T., Slavković, S., Knežević, J., & Milankov, V. (2016). Challenges for early recognition of children with Asperger syndrome. Early Intervention in Special Education and Rehabilitation: Thematic Collection of International Importance, 241-254.
9. Krüger, R. T. (2002). Wie wirkt Psychodrama? Zeitschrift für Psychodrama und Soziometrie, 2, 273-317.
10. Munir, S., Scholwinski, E., & Lasser, J. (2006). The use of psychodrama techniques for students with Asperger‘s disorder. Journal of School Counseling, 4(2), n2.
11. Noterdaeme, M., Wriedt, E., & Höhne, C. (2010). Asperger`s syndrome and high-functioning autism: Language, motor and cognitive profiles. European child & adolescent psychiatry, 19(6), 475-481.
12. Rueda, P., Fernandez-Berrocal, P., & Baron-Cohen, S. (2015). Dissociation between cognitive and affective empathy in youth with Asperger syndrome. European Journal of Developmental Psychology, 12(1), 85-98.
13. Shah, A., & Frith, U. (2006). Why do autistic individuals show superior performance on the block design task? Journal of Child Psychology and Psychiatry, 34, 1351-1364.
14. Takahara, A. (2002). Psychodrama in children and adults with high-functioning pervasive developmental disorders. Bulletin of Faculty of Education, Nagasaki University, 63, 59-70.

NUMBER: 1.; DECEMBER, 2018.; RECIEVED: OCT 1, 2018.; ACCEPTED: OCT 1, 2018.; 51-59

Overview of trauma treatment in the framework of integrative child psychotherapy

Belma Žiga
Psychologist, CBT Therapist, Child and Adolescent Integrative Psychotherapist
Foundation for Support to Victims of War "Wings of Hope", Sarajevo
061 510 968
ziga.belma@gmail.com

Summary

Childhood trauma undermines the feeling of safety and takes a heavy toll on the formation of self-image and the perception of the surrounding world.

This case study describes psychotherapeutic work with a nine-year old girl, who experienced traumatic event caused by her father. Following the critical event, the father was hospitalised. Upon completion of his clinical treatment, he became withdrawn, which changed the family dynamics. During the course of the critical event, the girl experienced overwhelming fear. Early on in the course of the treatment, she complained of being irritable, feeling anxious about most of her school activities and having nightmares.

Psychotherapeutic treatment extended over a period of one year and was divided into three stages. The initial phase focused on the establishment of the therapeutic alliance and development of the sense of safety. During the central stage of the treatment, the focus was on creating the trauma narrative and processing the experience. Final stage of the treatment focused on building patient's personal resources and improvement of her overall functionality.

This paper illustrates the integration of trauma-focused Cognitive-Behavioural Therapy (CBT) with elements of play therapy and use of drawing, used in this case to facilitate processing of the trauma.

***Key words**: traumatic event, childhood trauma, trauma treatment*

Sažetak

Doživljena traumatska iskustva u djetinjstvu narušavaju osjećaj sigurnosti i utiču na oblikovanje slike o sebi i svijeta oko sebe.

Ova studija slučaja opisuje psihoterapijski rad s djevojčicom (9) koja je doživjela traumatski događaj koji je izazvao njen otac. Otac, nakon kritičnog događaja, biva hospitaliziran a nakon toga se povlači u sebe i od tada se mijenja obiteljska dinamika. U toku kritičnog događaja, djevojčica je doživjela intenzivan strah. Na početku tretmana djevojčica se žali na pojačanu razdražljivost, anksioznost vezanu za većinu školskih aktivnosti i noćne more.

Psihoterapijski tretman je trajao godinu dana i odvijao se u tri faze. Početni cilj je bio izgradnja terapijskog odnosa i razvijanje osjećaja sigurnosti. U središnjem dijelu tretmana radilo se na kreiranju traumatskog narativa i preradi traume. Završna faza je rezultirala jačanjem resursa i poboljšanjem funkcionalnosti.

U radu je prikazana integracija kognitivno biheviоralne terapije fokusirane na traumu sa elementima terapije igrom i korištenjem crteža tokom prerade traume.

***Ključne riječi**: traumatski događaj, trauma u djetinjstvu, tretman traume*

Introduction

Many children experience significant stressors during childhood. These events may vary in intensity, quality and the impact they have on a particular child. The range of potentially traumatic childhood events encompasses sexual or physical abuse, exposure to domestic violence, traumatic loss of a close person, war and experience of exile, serious traffic accidents, fire and medical trauma. (Cohen, Mannarino & Deblinger, 2012).

According to the fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2013), to be able to diagnose Posttraumatic Stress Disorder, it is required that a child over six year of age experienced a life-threatening situation, serious injury or sexual violence (Criterion A). The second requirement, (Criterion B) is the presence of intrusive symptoms resulting from the traumatic experience, such as recurring flashbacks or dreams (in children, the content of dreams does not necessarily need to suggest recognisable traumatic experience), dissociative responses which cause the person to feel as if traumatic event was recurring, intense psychological distress related to trauma reminders and significant response to those reminders. In addition to symptoms specified above, other symptoms (Criterion C) include notable avoidance of disturbing memories as well as avoidance of external reminders of trauma. The fourth diagnostic requirement (Criterion D) includes negative change in mood or cognition such as the emergence of negative notions of self, others or the surrounding world and distorted notions of the cause or the consequence of the event that gives rise to the feeling of guilt. Negative notions are often combined with negative feelings of fear, anger and guilt and/or loss of interest in important activities. Finally, significant changes in emotional response and reactivity are commonly manifested in temper tantrums, self-destructive behaviour, hyperactivity and attention deficit issues.

The research shows that the high percentage of persons exposed to childhood trauma develop maladaptive emotional and behavioural responses that impede their psychosocial development and adjustment (Cohen, Mannarino & Deblinger, 2012). As noted by Profaca and Arambašić (2009), the impact of childhood trauma could be wide ranging and could impede academic achievement and cognitive development, causing a range of psychological issues.

Trauma represents an act of violence against the life philosophy or the worldview that made the world, as previously seen in the eyes of the person experiencing trauma, feel like a safe place. As a result, posttraumatic symptoms occur as the result of undermined or destroyed worldview (Subotić, 1996). In persons who experienced trauma, part of the brain that evolved to “scan” for threats, remains overactive and becomes stimulated upon exposure to the smallest signs of threat, regardless of whether the threat is real or misinterpreted, which often triggers acute reaction to stress, followed by very unpleasant emotions and overwhelming physical reactions (Van der Kolk, 2014).

In children who experienced trauma, problems occur in functioning of the hormonal system, specifically the hypothalamus area, which plays critical role in stressful situations. Autonomous nervous system becomes stimulated, which causes increased hyperactivity and irritability, often manifested in social and school situations (Harris, Putnam and Fairbank, 2006).

Pynoos, Steinberg and Goenjian (1996) note several areas of child development strongly affected by exposure to trauma, specifically: focus/cognition/learning, self-image, perception of self-efficacy, autonomous nervous system activation, specific concerns, impulse control, moral development, awareness/perception of continuity, representation of self and others, biological development, interpersonal and family relations and development of competencies.

Psychopathological phenomena, resulting from traumatic experience may occur in each of these areas. Therefore, traumatic experience may impede or otherwise adversely affect critical developmental areas. Arambašić (2005) explains this process by pointing to the interaction between traumatic events and loss experienced in everyday life, noting that despite differences between the two, they still share much in common. Differences include intrusive thoughts, anxiety and avoidance, all of which are distinct features of trauma. Similarities are much more common. They occur in the form of ***disorganisation or disruption*** of the previously established routine. ***Attachment*** is yet another common area. Arambašić notes that ***both events cause the sense of vulnerability.*** Other similarities include ***destruction or loss of self and feeling of helplessness and loss of control.***

Purpose of the Paper

The purpose of this paper is to showcase the specific nature of the treatment of Posttraumatic Stress Disorder of a nine-year old girl resulting from a single traumatic event, within the framework of integrative child and adolescent psychotherapy.

Anamnesis

Mother of the nine-year old girl came to see a psychologist and asked for help because the girl had repeatedly complained of anxiety, nightmares, irritability and overwhelming feeling of fear prior to being examined in school orally or in writing. The girl was third and youngest child in the family. The family lived together, in their own house.

A year prior to commencement of the treatment, the girl, together with older sister, mother and father, experienced a traffic accident. The accident caused by the father, occurred as the result of a psychotic episode. At the moment of the accident, the father believed that he and his family were pursued by dangerous individuals in another ve-

hicle, and that he had to get away from them. Immediately after the accident, the father was forcefully committed to psychiatric hospital. Immediately before being committed, as he was driving, he suddenly changed direction, drove at high speed, changed lanes, drove on the sidewalk, went to a location away from the planned destination, broke the metal chain, smashed into the metal door and drove the car into the underground garage. Other than some bruising and minor injuries, none of the persons in the car sustained any serious injuries. Similarly as with other traumatic experiences, this one too was complex in nature, tied to different stressful situations involving the girl and shaped by her great concern for her father and her mother. In addition to traumatic experience, father's subsequent withdrawal, feeling of guilt which was the only thing clearly verbalised and inability to make contact, all represented the loss for the girl. The girl too experienced guilt, resulting from her conclusion that she was responsible for father's withdrawal, because "she was the only one who experienced problems after the accident". Adjustment to new family situation was impeded because the girl was all alone in her grief – the subject of grief was not openly discussed within the family and the mother's resources were solely dedicated to providing care to the father.

Based on the information received from the mother, the teacher and the girl, the girl was irritable and high-strung, experiencing strong hand tremors, nightmares, high level of anxiety in the school environment and difficulties maintaining focus. These problems had adverse effect on her academic achievement.

Therapy and Discussion

Feeling of vulnerability is central issue resulting from traumatic event. Our autonomous nervous system, which regulates breathing and blood flow, functions without our control, maintaining balance between energy supply and demand of different systems. When the body requires higher level of energy due to a perceived threat, the brain prepares the body, putting the sympathetic nervous system in motion by triggering the fight-or-flight response, taking the energy away from the non-essential systems such as digestion, speech or long-term memory. Once the threat is no longer present, parasympathetic system restores normal bodily functions. In stress-free times, these two systems operate in balance. During traumatic experience, the balance is disrupted, and we either become highly alerted or we "freeze". To restore balance between these systems, trauma needs to be processed through relaxation, breathing exercises, physical activity, guided meditation or play. The purpose of relaxation is to enable the child to gain control over situations in which trauma reminders emerge. At the outset of the therapy, it was agreed that the goal would be for the girl to learn to relax by mastering relaxation and safe place techniques. The girl was highly anxious, very alert and highly emotionally responsive. She reported that the relaxation techniques had a calming effect on her. In addition to that, these techniques were highly valuable therapeutically. We focused our attention to

learning to breathe and to relax and we drew an image of the safe place. Relaxation techniques turned into a kind of a ritual and part of our each appointment was dedicated to breathing and physical activity. Along with the development of our therapeutic alliance and the sense of safety, part of our work focused on the ability to recognise different emotions. We acknowledged the fact that we should be familiar with the whole range of emotions to be able to better express ourselves. Upon commencement of the treatment, the mother was provided with training on the subject of responses to traumatic experience. This effort primarily focused on allowing "negative" emotions resulting from traumatic event to be expressed and acknowledging traumatic experience as such.

In the central phase of the treatment, we focused our efforts on the trauma narrative, often relying on drawings, sandbox games and guided meditation to adapt the therapy to the age of the girl.

At the moment of trauma, hippocampus, which deals with memory and spatial mapping and thalamus, which integrates the two, shut down. This causes persons who experienced trauma to recall traumatic experience in fragments. This also explains why persons with Posttraumatic Stress Disorder may experience extreme responses to specific sensory stimuli. Certain scent, image or sound may trigger traumatic memories. Traumatic memory is formed and stored in different way compared to explicit memory. That means that traumatic event is not remembered as a finished, linear storyline about something that happened at some point. Instead, it is activated by sensory stimuli which cause emotional states experienced during the traumatic event to emerge. It is as if there is no past – the feeling of vulnerability is real in the present moment. The approach to trauma processing needs to take into account the way in which traumatic memory is stored. When working with children, communication needs to be driven by play. To children, play comes as naturally as breathing and it represents the language they know and understand. Play is not only important catalyst of child development – it also has valuable therapeutic potential. Child's verbal abilities are often insufficient to allow for adequate self-expression, but play makes it possible. Having in mind the fact that trauma is stored in a non-verbal manner, different modes of play and drawing can help process trauma using different senses. Guided play, guided conversation, open and active approach are all necessary for the child to acknowledge and integrate traumatic events (feelings and experiences). Children are unable to initiate discussion on things that have overwhelming effect on them, things they hide from themselves or the things they cannot articulate.

The main aim of integrative psychotherapy is to harness the relationship between the therapist and the patient, the ability to establish full contact in the present moment – as a step toward establishing healthier relationship with others while also developing a stronger sense of self-satisfaction (Erskine, 2015). For the girl, the place of therapy was perceived as safe place to speak of her feelings and her experience, without the risk of further exacerbating her mother's anxiety or making her father even sadder due to

his feelings of guilt. The girl was protective of her parents, but found the place where her sense of safety was restored. She told the story of her trauma several times. She managed to tell it without crying or great distress. She drew how she felt and illustrated the worst moment of the accident. Her trauma narrative emerged in different ways, with new details added each time the story was told. We wrote a letter to children who shared similar experience. The most important principle of trauma-focused CBT is to ensure gradual exposure to traumatic experience. For that reason, the discussion on the subject of traumatic experience recurred in almost every session. It is also important to repeatedly present traumatic experience in different ways adding to the narrative the details of the experience, such as the scents or sounds. These techniques are designed to enable the therapist to prevent maladaptive avoidance of trauma triggers (Cohen, Mannarino & Deblinger, 2012).

When traumatic experience cannot be expressed verbally, it remains captured at a symbolic level. To reach it, it needs to be externalised in a symbolic form, through an image or a drawing. Given the fact that children experience drawing as a sensory exercise, they have the ability to recall memories of the traumatic experience by drawing "what happened". Drawing initiates the process of healing and the actual drawing gives us an accurate symbolic representation of the traumatic experience. Drawing also makes it easier for the child to verbalise and organise traumatic narrative in a meaningful way, while helping reduce reactivity due to exposure. Drawing also shows us what happened to the child. Adults often deprive children of information, leaving them in the state of confusion. There was no discussion in the girl's home about the accident. After the first shock subsided, although they were all shaken, they never discussed what happened. In this case, we had what is often referred to as "the double wall of silence", where adults protect the children by keeping quiet, while the children also protect the adults and no one is talking about what's on their mind. Through support and training, the family was allowed to discuss the accident and the way it made them feel. One of the interventions in the central phase of the therapy focused on the feeling of guilt. The girl developed the feeling of guilt, because the trauma was never discussed and she believed that she was the only one who experienced fear and therefore concluded that father's grief was her fault. Through therapy, the girl learned to better understand the event and its impact on all members of the family, which encouraged her to approach the father more freely and initiate contact.

During the final phase, the emphasis was put on her right to have a happy childhood and her acceptance of the fact that her father was different than before. Despite that, life must go on and the girl is now capable of successfully overcoming developmental challenges that come her way.

Conclusion

Childhood traumatic experience is real and it has real consequences to the overall functioning of the child. Depending on the age when the critical event occurred and parental reaction to it, the consequences may vary and may be observed in family, school and social interactions.

Children experience trauma as an implicit experience which encompasses a range of sensory perceptions resulting from visual, auditory, palpatory, olfactory and gustatory stimuli. Given physical symptoms and undermined sense of safety, the first priority was to establish safety and ensure physical relaxation. In later phases, emphasis was put on the creation of trauma narrative, taking into account gradual exposure to traumatic experience through the use of different senses.

Child integrative psychotherapy, combined with trauma-focused CBT, requires more work to be done with family members while the interventions during the course of the treatment are tailored to child's age. It is a supportive and flexible method of work with children rooted in the relationship with the therapist, which recognises and responds to the child's age, both at the moment traumatic event occurred and at the moment the therapy commenced. Particular strength of this approach is reflected in the use of play as an important form of communication for children. Techniques used include the use of therapeutic dolls, sandbox, clay, movement and role play. Processing of the traumatic experience is initiated and encouraged through the use of drawing. In addition to drawing, efforts were made to create trauma narrative which included all senses and resolve the feeling of guilt, which often goes hand in hand with the traumatic experience.

References:

1. American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th ed). Washington DC: APA.
2. Arambašić, L. (2005). Gubitak, tugovanje, podrška. Jastrebarsko: Naklada Slap.
3. Cohen, J. A., Mannarino, A. P., & Deblinger, E. (Eds.). (2012). Trauma-focused CBT for children and adolescents: Treatment applications. New York, NY, US: Guilford Press.
4. Erskine, R.G. (2015). Relational Patterns, Therapeutic Presence: Concepts and Practice of Integrative Psychotherapy. London: Karnac.
5. Harris, W.W., Putnam, F.W., Fairbank, J.A. (2006). Mobilizing trauma resources for children, U: A.F. Lieberman, R. DeMartino (ur.), Intervention for children exposed to violence. Johnson and Johnson Pediatric Institute, 311-339. L.L.C., www.JJPI.com.
6. Profaca, B. i Arambašić, L. (2009). Traumatski događaji i trauma kod djece i mladih. Klinička psihologija, 2 (1-2), 53-73.
7. Pynoos, R.S., Steinberg, A.M., Goenjian, A. (1996). Traumatic stress in childhood and adolescence – Recent developments and current controversies, U: B.A. van der Kolk, A.C. McFarlane, L. Weisaeth (ur.), Traumatic stress – The effects of overwhelming experience on mind, body and society, 331-358. New York: The Guilford Press.
8. Subotić, Z. (1996). Tretman traume. U: J.Pregrad (ur) Stres, trauma, oporavak, udžbenik programa “Osnove psihosocijalne traume i oporavka”; Društvo za psihološku pomoć, Zagreb
9. Van der Kolk, B. A. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. New York, NY, US: Viking.

NUMBER: 1.; DECEMBER, 2018.; RECIEVED: SEP 7, 2018.; ACCEPTED: SEP 7, 2018.; 61-70

A child of a terminally ill parent - adjustment and grief

Mia Roje, mag.psych.
Poliklinika za zaštitu djece i mladih Grada Zagreba [Child and Youth protection Centre of Zagreb], Zagreb, Croatia, 00385977693266, mia.roje@poliklinika-djeca.hr

Prof. **Gordana Buljan Flander**, PhD, psychologist and psychotherapist
Poliklinika za zaštitu djece i mladih Grada Zagreba [Child and Youth protection Centre of Zagreb], Zagreb, Croatia, 0038598453114, gordana.flander@poliklinika-djeca.hr

Vlatka Boričević Maršanić, MD-PhD., specialist of psychiatry, subspecialist in child and adolescent psychiatry,
Psihijatrijska bolnica za djecu i mladež [Psychiatric Hospital for Children and Youth], Zagreb, Hrvatska, 00385014862500, vlatka.boricevic.marsanic@djecja-psihijatrija.hr

Ina Larsen Matić, senior student of Split University Medical School,
Croatia

Summary

This paper presents a treatment of a girl (age 9) whose parents voluntarily turn to a psychologist after the father of the girl was diagnosed with terminal cancer with life expectancy of six to twelve months. The girl reported no appreciable diseases. She is the only child in the family, has high intellectual capacity and never reported any socio-emotional difficulties. The case study gives an overview of the counselling work with the mother and psychological support to the child through several stages: (1) coping with the illness; (2) bodily and mood changes of the father; (3) side-effects of the father's treatment; (4) severe health deterioration of the father; (5) father's approaching death; (6) father's death; (7) grief and adjustment. The girl and the mother reacted to all aforementioned stages in very different ways, thus the interventions were also focused on invoking mother's emphatic understanding of the girl and preserving their relationship. The girl went through three stages of grief: (1) perceived loss of the father through the deterioration of his psychophysical condition; (2) perceived loss of the mother, who is all too busy looking after the father;

(3) the death of the father, which makes the subject relevant for a deeper understanding of the emotional processes of a child in such a complex traumatic situation. An integrative therapeutic approach was used as method.

***Key words**: grief, adjustment, parental death, parental terminal disease*

Sažetak

U ovom radu prikazan je tretmanski rad s djevojčicom (dobi 9 godina) čiji se roditelji samoinicijativno javljaju psihologu nakon što je ocu postavljena dijagnoza terminalne faze karcinoma s perspektivom životnog vijeka od šest do dvanaest mjeseci. Djevojčica je urednog razvoja, jedino dijete u cjelovitoj obitelji, visokih intelektualnih kapaciteta i bez ranijih socio-emocionalnih teškoća. Prikaz slučaja uključuje prikaz savjetodavnog rada s majkom i psihološke podrške djetetu kroz nekoliko etapa: (1) suočavanje s bolešću; (2) očeve promjene tjelesnog i emocionalnog tipa; (3) nuspojave liječenja; (4) značajna pogoršanja zdravstvenog stanja oca; (5) približavanje smrti oca; (6) smrt oca; (7) tugovanje i prilagodba. Djevojčica i majka značajno drugačije oživljavaju sve opisane faze te se intervencije usmjeravaju i na majčino empatijsko razumijevanje djevojčice te očuvanje njihovog odnosa. Djevojčica prolazi kroz tri ciklusa tugovanja: (1) percipirani gubitak oca kroz pogoršanje njegovog psihofizičkog stanja; (2) percipirani gubitak majke zbog stalne okupiranosti skrbi o ocu; (3) smrt oca, što temu čini značajnom za dublje razumijevanje emocionalnih procesa djeteta u ovako kompleksnoj traumatskoj situaciji. Korišten je integrativni terapijski pristup kao metoda rada.

Ključne riječi: *tugovanje, prilagodba, smrt roditelja, terminalna bolest roditelja*

Introduction

We all lose someone or something at some point in our lives, i.e., we all suffer a loss (Profaca, 2010). "The grief work is an intrapsychic process that occurs after the subject loses the object to whom it is attached and in which it learns to completely let it go" (Laplanche and Pontalis, 1992, p. 411). The aim or the outcome of mourning is not to forget the deceased person, but to accept the fact that the person is no longer (Arambašić, 2005), which is the process. According to Profaca (2010), loss and mourning are not exclusively related to the death of a person. One can lose many things and feel grief for it. Arambašić (2005) argues that one can lose material things, but there are also some more abstract losses such as the loss of self-esteem, the loss of perceived identity, etc.

For person who suffered a loss, any loss is difficult and it is not for others to assess his or her grief. In other words, it does not matter who or what we lost but what was our attachment to the lost object like. Many authors suggest that there are two exceptions to this rule, namely the death of a child and the death of parents in childhood, both of which are universally difficult losses. Following the parental loss, children have to take responsibility and assignments in their immediate family that once belonged to their parents, and the feelings of helplessness and fear for the future are especially strong (Lake, 2000, according to Abramušić, 2005).

The grieving theories are many, however, the best known is the theory of grief by Kubler-Ross and Kessler (2005) from 70s of the last century, which has been empirically and clinically corroborated many times since. According to this theory, the grieving occurs in stages, as follows: (1) denial i.e., shock; (2) anger and rage; (3) sadness, depression (4) experimenting the new reality and (5) integration of loss.

The mother turned to the health institution specialised in analysing, treating and supporting children with traumatic experiences and their families. She asked for an emergency appointment, explaining that her husband, who is the father to their 9 year old child, has been diagnosed with a terminal stage malignant cancer with metastases spread to multiple organs. The appointment was schedule in ten working days.

Problem description

The mother came to the first appointment alone, since the girl was on vacation with members of her extended family at the time. She was in the stage of shock and denial, explaining that she still does not believe that the diagnosis is true. At this point, the girl only knows that the father is ill but she does not know the details and the father has not spoken to her about it. She explained that the father had hard time accepting the diagnosis, that he is depressed and in pains, having hard time getting up and performing basic daily tasks. As the mother explained, she has "spared" the girl the trouble by

distracting her in different ways. The girl did not ask questions about the father's condition. Although, it was the first time that they separated for this long, the girl parted from her parents without much trouble and went to the coast with the extended family, and the mother promised to visit her soon. The mother turned to a child psychologist for counselling about how to approach the girl and inform her about the situation.

History

The girl is nine years old and she just graduated from the third grade of primary school. She is an "A" student, and according to her mother, she likes school and learning. She is the only child in the family, living with the mother and the father. The parents are employed. The father retired few months earlier but he still occasionally works. Both of them are educated, holding university qualifications. The mother is in her middle-age and the father is older. The pregnancy, delivery and early development went properly. The girl began to walk and talk, and control bowel and bladder muscles at an appropriate age. She attended a pre-school education and has properly adjusted. She has not suffered any serious illnesses in the childhood nor has she had traumatic experiences or losses in the closer family. She attends several extra-curricular activities and is a very sociable person. She has the best girlfriend whom she hangs around every day. The family relations are normal, and the girl is particularly attached to the father whom she spends most time with. The extended family lives in another town in Croatia, where the girl was born, but the parent moved when the girl was very young, so she has memories of the life in this environment only. She enjoys visiting members of the extended family and spending time with them. The mother described her as a warm, dear and sensible child of many interests and hobbies.

Psychological analysis results

Few days following the initial interview with the mother, after the girl returned from vacation, the psychological analysis was made. In communication with the therapist the girl warm and open but she refused to talk about the father and his illness, despite therapist's insistence. She approached the tests with pleasure, having no difficulties in understanding and following the instruction. According to the therapist's finding, the girl has "cognitive capacity high above the average, regular visual-motor and visual-spatial perception and integration, a proper development of personality with a mild separation anxiety symptomatology, and she is currently in a high stress situation due to severe illness of the parent, going through the adjustment period". Parent counselling (with the mother only, since the father could not leave home) and intensive support to the girl were indicated. The mother is willing to join the counselling sessions on parenting, but

not ready to undergo a separate treatment/support for herself with another expert. The distance from the family and friends is a risk factor, since the mother and the girl have no natural helpers in the immediate surrounding. The psychologist appointments are taking place approximately every 10 days.

The further work is conceived as a phased-approach to work with the mother and the girl individually in accordance with objective change in the father's condition, taking into account the observations on three distinct stages of the girl's grief. (1) perceived loss of the father through the deterioration of his psychophysical condition; (2) perceived loss of the mother, who is all too busy looking after the father; (3) the death of the father.

1. Coping with the illness

The mother has need to broadly explain the health condition of the girl's father. Few sessions later, the initial shock was replaced by anger (followed by expected course of reactions), which she channelled into "the fight against the disease" to which she invests a considerable amount of energy. On cognitive level she demonstrates no denial, on the contrary, she is very well informed about the diagnosis and the life expectancy (6 to 12 months), all available therapies, side-effects, symptoms, etc. On emotional level, however, she does not accept the reality and feels that she "can win the battle".

Since according to the mother's account, the father does not demonstrate the capacity to talk to the girl about the disease, the mother was advised to talk to her about it in the father's presence. She told her once again that the father was sick and it was rather bad, but that he will be treated and that they will do whatever it takes to help him, but it is possible that over time it will get worse or better, and that they are not sure if he will be better and able to recover from this illness. She also stressed that this was different from when we get a fever, sore throat or earache (which the girl experienced). In the end, the mother asked her if she had any questions, and since she had none, the mother invited her to turn to her whenever she felt the need to ask or talk to her about it.

In the first session following the analysis, the girl spontaneously spoke about the father's illness, retelling the discussion she had with the mother. She felt that the mother and the father are very concerned, but she claimed not to have been too concerned, since she believed that the father will get better, though she has heard that he might not. She refused to play or engage in creative and projective techniques, and wanted to talk about the diseases in general. She finds it difficult to talk about it with the mother and the father, since they are concerned.

2. Father's bodily and mood changes/side-effects of the father's treatment

About a month later, the father started experiencing pain on a daily basis, and his depressive mood became more obvious. He was almost completely incapable of carrying

out the basic functions such as maintaining personal hygiene. The mother was still focused on "fighting", denying grief and claiming that she "could not afford it". She claimed not to have talked about her husband's illness with anyone else other than the child's psychologist, and she is very committed to her work. The mother explained that the girl is happy to help caring for the father, and sometimes she feels that the girl is caring for her too, which she perceives as the girl's expression of love and attachment. The mother was advised about how to bring the girl back to the role of a child. She also explained to the girl that the worsening of the father's condition was sometimes a reaction to the treatment, and sometimes the result of his illness, and that they were not sure if he will recover. Once again, she invited the girl to ask questions or talk about it, but she refused. Manifestly, the mother follows all the instructions, but her emotional status is not aligned with it, and the girl assumes more responsibilities of caring. She described how she shaved her dad and tried to cheer up her mum.

The girl feels that she has already lost the father because she can no longer remember what he was like before. Afraid that she might forget "the old Dad", she gladly recounts some of their joint memories from before the illness. She claims that all this is not so hard for her as much as it is for her Mum, and she often asks herself if that is all right. She often needs emotion normalisation. The most difficult thing about this situation is that she misses her Dad driving her around, coming to her school plays, taking her to the swimming pool. She is questioning if the father will ever recover enough to be able to do all those things again. She reacts positively to the replies such as: *"I believe that you would like that and I hope he will, but there is a great chance of that not happening"*, and repeats such lines and wants to hear them over and over again. She says that when with the therapist, she "solves jigsaw puzzles in her head". She prefers discussions on a general level, e.g., what happens to people when they cannot recover from an illness. Having touched upon the subject of death, she brought a child book on death to the next session and wanted to talk about death. During the discussion, she does not relate the topic to her father. After the initial frustration and sadness (she says she mostly cries in bed, but when prompted, she is willing to engage emotionally) about her dad not being "as he once was", she creates a life in which her father is not involved anymore and she speaks openly about it, e.g., *"Uncle XY drives me.."*, *"I will go to the poor with "XY"*. In her spare time she still cares for him and the mother, but the intensity of this need is dropping. Despite her objection, during each session a game - "goofing around", as she calls it - is introduced to stimulate joy and role of the child, with clear messages that it is all right to play and be joyful.

The mother occasionally feels angry when the girl is in the role of the child. She tries to understand her and at one level she is glad - as she says - that the girl is coping with her father's illness better than she does, but that makes her feel more lonely in her grieving. She repeatedly refused professional support for herself, but she started talking to some adults in her surroundings.

3. Sever deterioration of the father's health condition

The father now spends most time in a hospital in another city, where his parents live. The mother and the girl pay visits to him every weeken or almost every weekend. The mother on several occasions witnessed - and the girl only once - the acute worsening of the father's condition that threatened his life. The girl has been through a crisis intervention.

The mother is overwhelmed with grief, feelings of helplessness and hopelessness. It becomes almost impossible for her to talk about her husband without being overwhelmed with intense emotions. As much as she tries to support the girl, during their conversations she often "breaks down and the child ends up comforting her". She is still preoccupied with medical condition of her husband and the ways to help him, but she gradually integrates the fact that he will die.

The girl does not like visiting the father, saying that she can barely recognise him and that she finds the scenes from hospital very difficult and traumatic. She feels that things are completely out of control and that everything is unpredictable, which is why she feels taken with fear. She prefers to telephone him or pay very short visits. Following the counselling, the mother shows understanding for such behaviour but the girl feels that no one really understands her. The most difficult aspect of the current situation for the girl is the loss of the mother, who – as ***she says*** - "will never laugh again". The mother is very caring, providing the girl with everything material she needs, hugging her and kissing every day. Yet, the girl misses some of their joint activities and discussions that are not related to the father. The girl discussed the possible death of her father with the therapist, but she could not discuss this subject with her mother, except for one time when they were together with the therapist. The mother was overwhelmed, and the girl found this experience very uncomfortable. The session has been recast with the girl. Few months earlier, the mother and the girl have booked a weekend trip to another country. The mother considered cancelling the trip due to a strong sense of guilt for not spending every moment she had with her husband. But, since the trip was of key importance for the girl and since the father, in a period of lucidity, said that they should go, the mother took the girl to the trip. The trip becalmed the girl, for she understood that "Mum was still there".

4. The father's approaching death

Approximately two weeks before the death of the father, it became clear that he would die within a month, of which the doctors warned the family. The mother wanted to be with him all the time, while for the girl it was important to finish the school year. It was agreed that the girl would go with her mother on a weekend and return to the best friends, whose parents are familiar with the situation. The girl sensed that this might be the last time to see the father. In the session with the therapist she wrote a letter to the

father, which she decided to leave in the therapist's office instead of giving it to either mother or father. Based on a clinical impression, the father was not ready to say good bye or openly discuss the illness with the girl, so the girl in this way symbolically said good bye to him. The letter says: ***"Dear Dad, thank you for everything. You were the best dad in the world and please forgive me for the times when I was a little bit naughty. I love you"***. In the discussion about the letter, she explained that she wrote in the past tense (you were the best Dad) because she was addressing "the old Dad" who was, due to constant recollection and discussions, more strongly etched into her memory than the father from the period of illness. The mother received telephone support twice a week, and the girl attended psychological sessions also twice a week, at her own discretion or as per psychologist assessment. Since the Polyclinic was in the same street where she lived, the girl was coming to the sessions by herself. Following a short account of the current situation, I mostly played with the girl. The girl often stressed that it feels nice to be "allowed to laugh" She had hard time leaving the therapist. An envelope was made for her to write or draw the things she wanted to say to the therapist until the next time they meet.

5. Father's death

The mother called to say that the father has passed. She was provided support. As for the girl, it was suggested that the mother pick her up from home, but prior to that, to call the landlords and ask them to take the girl's mobile phone from her before someone calls to express condolence. However, the mother's psychophysical condition was not fit for travel, so the girl was collected by the members of extended family. She has not asked any questions, although she later explained that she knew what happened. It took a lot of encouragement and practice to help the mother convey the message about the father's death to the girl. Namely, she wanted to convey it using unclear phrases such as "Daddy has left" or "Daddy is no longer with us". She was afraid of hurting the girl "more than needed". She even suggested that the girl should stay in Zagreb and not go to the funeral. As for the funeral, it was agreed that she should ask the girl if she wanted to go and that someone should explain to her what happens there. Also, it was suggested that the girl should go with someone she knows but who is not the close family member who can look after her, and if need be, leave the funeral with the girl. Ultimately, the girl went for a funeral mass, but not to the funeral itself.

In the next session (two weeks following the father's death), the mother and the girl spontaneously entered the therpaist's office together. The mother burst into tears, while the girl was silent, watching the mother with interest. She subsequently said that she is not as sad as her Mum, although she too was very sad. After this, they were received separately. The mother felt relieved over the girl's reaction, but she also demonstrated lack of understanding. The girl kept asking whether her reactions were normal, and whether she should be more sad. Few sessions later she admitted that she felt a relief,

which was very important to normalise for both the girl and the mother who, in addition to her husband also lost the "purpose" i.e., "the battle". The mother quickly returned to work, but she also agreed to receive professional psychiatric support of the Polyclinic, which is provided as part of the parental counselling, mostly because she had hard time falling asleep.

The girl understood mother's question about whether she wanted to go to the funeral as an instruction not to go, which bothered her and which is why she was angry with her. She was also angry with her mother for crying a lot, especially when they go to the cemetery. She was interested in all the details about the funeral, which she thoroughly discussed and drawn with her therapist. After two sessions dedicated to the funeral she said: *"we have now buried these funerals too"*.

6. Grieving and adjustment

The mother and the girl are now grieving the death of the husband/father, but they are in different stages of grief, and it has been five months since the father's death. The mother is predominantly sad (stage 3), while for the girl it took about three months to start mourning the father, as she was in the stage of emotional shock (stage 1). As her mother become more empowered and supportive of the child, the girl began to feel and express her sorrow, thus entering into the stage of experimenting (stage 4) and progressing toward integration. In sessions with the therapist, the relevance of play is emphasised, as well as development of interests and problems appropriate to her age and restoring normal life. When prompted, she brought photos of her father, making a favourite album, and she gladly talks about their shared anecdotes. She is capable of getting sad and cheerful when talking about the father. Her process today appears to be a normal grieving process, without any signs of trauma.

With the assistance of the therapist, the mother hired "a nanny" whose task is to spend 2 hours a day with the girl - while the mother is at work - playing, taking her out, which the girl accepted very well.

Conclusion

The child and the mother went no only through different stages of grieving at different times but they also went through a different experience of reality. While the mother "fought" for the life of the father, the girl was grieving the loss of the father (as she knew him and loved him) and after that, the loss of the mother who was emotionally no longer there for her. The mother began her grieving process only when the father died, but at the time, the girl felt lonely and detached from the mother's current emotions. The girl's third grieving was significantly different from the mother's "first", which created an additional gap between them due to different object of the loss (partner v. father) and development age of the child.

In this complex situation it is of crucial importance for a therapist not to assume (who, when and what they mourn), but rather to carefully investigate and provide the support needed at a given time. Also, it is a challenge not to lose sight of the ultimate goal, which is not only to support the girl in grieving her father's loss, but also to provide support to both the mother and the girl as a community to establish a new balance in their family life. Finally, an active engagement and overcoming some of the usual constrains (for example, assistance in seeking a person who would spend time with the child) were in this case positive for the patients - with no adverse effects on the therapeutic relationship, and for the therapist, thanks to the supervision and primarily because of the lack of natural helpers in the mother's and girl's life.

References:

1. Kübler-Ross, E., & Kessler, D. (2005). On grief and grieving: Finding the meaning of grief through the five stages of loss. Simon and Schuster.
2. Laplanche, J., Pontalis, J. B., Zdjelar, R., & Buden, B. (1992). Rječnik psihoanalize. August Cesarec.
3. Arambašić, L. (2005). Gubitak, tugovanje, podrška. Naklada Slap.
4. Profaca, B. (2010). Kako pomoći tugujućem djetetu. Poliklinika za zaštitu djece grada Zagreba.

NUMBER: 1.; DECEMBER, 2018.; RECIEVED: SEP 8, 2018.; ACCEPTED: SEP 8, 2018.; 71-77

Case study of a therapeutic work with a child after loss

MSc Đana Lončarica, Psychologist
Gestalt Psychotherapist,
Family Systematic Psychotherapist,
Children and Adolescent Integrative Psychotherapist,
Agency for Psychotherapy, Counselling and Education KONTAKT- HOMINI, Sarajevo, Bosnia and Herzegovina
Mobile phone: +387 61 181-342; e-mail: loncaricam@yahoo.com

Summary

This case study is on the work with a thirteen-year old boy, brought into psychotherapy by his mother after a traumatic loss of the father. It aims to show the process of grieving, an unopen topic of loss in the family, cooperation with parents and inclusion in the psychotherapeutic process, to allow herself, but also the child, to express grief as a consequence of a great loss. The work with a grieving child brings us into contact with our own grieving and grieving processes, so it is essential to be aware of the counter-transfer reactions. The case study shows an integrative approach to work with children, loss and the specificity of working with children.

***Key words**: loss, grieving process, expressing emotions in children*

Sažetak

U studiji slučaja bit će prikazan rad sa trinaestogodišnjim dječakom kojeg na psihoterapiju dovodi majka nakon traumatskog gubitka njegovog oca. Rad će prikazati proces žalovanja kroz koji dječak prolazi i značaj teme gubitka koja se nije otvarala u porodici. Također rad prikazuje važnost saradnje s roditeljima i mogućnost uključivanja u psihoterapijski proces, kako bi i sebi, ali i djeci mogli dati "dozvolu" da izraze tugu koja je posljedica velikog gubitka. Rad s djetetom koji žaluje dovodi nas u kontakt i sa vlastitom tugom, ali i sa vlastitim procesima žalovanja, tako da su kontratransferne reakcije veoma značajne i kojih je važno, biti svjestan u radu. Studija slučaja prikazat će integrativni pristup rada s djecom kada je u pitanju gubitak,ali i specifičnosti rada s djecom.

***Ključne riječi**: gubitak, proces žalovanja, izražavanje emocija kod djece*

Introduction

It is a fact that children and adolescents do not behave the same way in the grieving process as adults, which brings most people to conclusion that they do not experience it as "deeply" as adults or that their grieving lasts shorter. Not only that, but there is also a conviction that children do not go into grieving process at all.

It is important to know that children process information differently than adults and that at a given moment they can "digest" only a small amount of data. However, at the same time, it does not mean that losses do not cause suffering in them and that the grieving process is not hard for them (Vulić-Prtorić, 2003) .Different way of data processing, in comparison to adults, is conditioned by still underdeveloped thought processes and linguistic abilities, which are also in the developmental phase, and it cannot be changed before its due time. There is a conviction among experts today that children, just like the adults, go through a grieving process, but that its characteristics are set by the level of the child's cognitive, emotional and social development (Janković, 2004) but we must not forget about the large influence of the environmental factors bare.

Aim of the work

The aim of this work is to show therapeutic work with children with a delayed grieving process after a traumatic loss, but also to show integrative approach in working with children and adolescents.

Case study (anamnesis)

Boy N. is the first and only child in the family. Birth and development passed all in order and had the usual flow. The conversation with the mother and the boy reveals that spouses functioned well together and the boy's mother had a great support in his father. The father was very involved in the boy's life and upbringing, he organised family free time, which they spent on picknicks, at the sport event, in play with the boy, etc. The mother says that she relied completely on her husband, who had a special energy and was a great initiator and support to his family and friends. The boy started going to school at the age of six and he was an excellent student. After his father got sick, he started withdrawing and getting lower grades in school, unlike before. Several times the class-teacher informed the mother on conflicts with two of his class peers. In contact with the mother and the boy, the boy talks about two friends who do not have parents. Even though she speaks of support by her mother, brothers and sisters after the husband's death, the boy's mother does not share her sadness with them because she is convinced, they do not understand her.

Sessions with the mother and the boy indicated grieving after a traumatic loss of the father, through which process they did not go through after the death. We could say that the grieving was delayed in a sense that the loss was not talked about not were emotions recognised or identified.

As if the phase of denial, characteristic for grieving and loss, has never been moved away from. Symptoms of depression can be seen in the mother, for what a psychiatric evaluation and a complete psychological examination should be done. After the first session, it was recommended that the boy's mother starts with personal individual psychotherapy with a colleague of mine. Mother talks about his problems and disputes with peers, with occasional aggressive behaviour, and long periods of time boy spends playing games leading to weaker academic performance.

Therapeutic work and discussion

The goal of the therapeutic work is for the boy to go through the grieving process, recognise and identify emotions, share experience of loss in a safe, protected context. Of course, aims are establishing better social relations in school, regular school attendance and functional behaviour, as mother particularly expressed to be the important goals. At the beginning of the psychotherapy, the psychotherapist estimated and recognised that one significant goal is to help the boy understand his emotions, go through the process of grieving and integrate it in his life and experience.

After establishing a relation of trust between the psychotherapist and the boy, in the following sessions topics of death and loss of the father were open. It is familiar that after the age of ten, the notion of death becomes more abstract for children and they can better understand long-term consequences of loss. At this age, children think more about justice and injustice, faith and parapsychological phenomena.

At the beginning, the child spoke of death with reserve, pointing out that he did not mention the death of his father mostly because of family members for whom it was very difficult.

He says it was truly difficult for everyone so he and mom avoided mentioning it. There is a strong need to keep the event at distance and gradually let it in. Due to inability to tolerate strong reactions, the child can spend a long period of time avoiding thoughts of death and behave in a usual way. Anxiety reaction is usual for a child his age. Guilt is common, as is identification with the deceased person, different regressive behaviours, outbreaks of aggression, and depressive symptoms. The boy began isolating himself from peers, daydreaming and became incapable of sharing emotions with adults and peers. It seems that the ability to deny or supress through various methods increases with the age.

Projective technics were used in further psychotherapeutic work with the boy and he started to express his emotions through modelling clay and drawing. Noticeably he expresses and recognises emotions and verbalises them. Besides grief and anger he feels due to loss, increasingly perceptible is the feeling of shame from the class peers, with whom he does not speak of his loss. The occurring shame, often happens in the adolescence in which the boy is now. The feelings of shame and embarrassment are most often associated with fear of rejection by peers.

The key change in therapy occurs through boy's understanding that tension and grief in him are not expressed and that unexpressed emotions create additional fear and confusion resulting in aggressiveness towards the others. In psychotherapeutic work, it can be seen that playing games represent an escape from reality for the boy, but also a contact with the father, who installed those games for him and played them with him. The boy starts to talk about the father, which he did not do before, remember their picknicks and travels; he starts to talk about him with the psychotherapists and father's friends and the mother who is starting to understand that the boy needs to talk about him and that it will not additionally harm him.

Mother joins that psychotherapeutic session for the last twenty minutes when they openly talk about their emotions. Since they have not yet adopted social rules of conduct, after the loss, children can become very aggressive, breaking things, hitting people around them etc.

Due to its unacceptability, the mentioned reactions are usually condemned rather than attributed to the true meaning, i.e. seen as reactions to loss (Arambašić, 2005).

Precisely that was could be seen in the boy. Due to aggressive behaviour, many peers avoid him and his behaviour was considered as insolence by peers and teachers. This further lead to his withdrawal and closure. What can also be noticed is that schools are also unprepared for the loss of children's parents and the boy was not provided proper support and understanding. It alone tells of how reactions to loss, in terms of denial, silence, and a collective deflection, are not characteristic only for individuals, families, but also educational institutions that should also play a significant role in the grieving process.

When it comes to grieving the death of a parent, the most influential factor is the functioning of the surviving parent; the worst it is, the process of child's grieving is harder and longer. It is, of course, not related to temporary dysfunction occurring immediately after the loss, but on a long-term dysfunction and adjustment problem of the surviving parent (Whitfield, 2007).

As for the techniques applied in the next phase of psychotherapeutic work, those are "box of memories" and "farewell letter". Various things can be placed in the box of memories that remind the grieving child of the deceased. These may be photos, letters, or items that a child received from a person who is no longer present. By using this technique, the loss can become more real because they relate the dead person to specific items.

Another technique often used in working with children who survived the loss of a close person, is a farewell letter written to the deceased person. In this way, the child writes what they would like to say to that person but for which they do not have chance any more. What is important for the application of these, and all other, techniques is to respect the readiness of the child and not to rush them in that process.

After applying these techniques and the talk about the loss, the boy started to talk more openly about the death of the father and changes that occurred afterwards. In this phase of psychotherapy, the mother stopped bringing the boy to sessions. It seemed that she was not ready to open the topics of the loss and grieving that the boy started opening not only in sessions, but also in his family context. For those reasons, it was not possible to enter the final phase of the psychotherapy.

The end of the therapy may include fear, arousal, or a mixture of all emotions. It is important to always look back on the what they have gone through together, difficulties and successes, the realised and unrealised changes (Erskin,2015).

This is how the optimal end of psychotherapy looks like but often it is not possible to reach it in psychotherapy. It is especially emphasised in work with children because their parents decide for them, who sometimes out of the best intent do the biggest mistake, and slow down or interfere with the therapeutic course. For that reason, in working with children and adolescents it is the most important to have parents as associates and involve them in the therapeutic process (Dalos, 2012).

Counter-transfer feelings in the work with this client were from gentleness, care, joint grieving with him for his father, to sincere respect, belief in the boy's strengths and potential every child has. That place seems to be very significant, a place of a true faith and hope the boy will go through the grieving process.

Among the laity there is belief that the process of child's grieving always ends successfully, i.e. that children and adolescents do not have severe and long-term consequences of the suffered loss.

However, in some research a quite firm connection is established between depression in adult age and characteristics of the grieving process in childhood (Dyregrov,2001) it was shown that, for example that depressive disorders are more frequent in people that loss parents in childhood, than when the death happens to an adult. That connection is explained by difficulties in the grieving process or by the child having the so-called complicated or difficult grieving, usually due to insufficient and inappropriate support of the adults.

What is extremely important to point out in children's grieving is the responsibility to show such support is on the adults and they cannot free themselves of it. the job of the adults is to continuously start a conversation on the deceased person, on how the child feels about it, but also to accept rejection at the same time. That does not mean that

children and adolescents do not need adults but that they do not feel the need for the contact with them at that moment. Task of the adults is to constantly send a clear message to children and adolescents who have suffered a loss that they are available but also ready to respect their decision that they will use that "availability". It is not an easy task, but it can be successfully done and if they face difficulties, it is their duty to find another adult to help them in it. adults find helplessness especially difficult because they cannot remove the child's pain and suffering and it is hard to see them in such state.

Since losses and grieving are universal phenomena, it is not possible to be in contact with grieving person and that even professionals cannot avoid feeling feel like them, to some extent. In such situation the biggest (and sometimes the only) award to the professionals is when they see that someone is feeling better thanks to their support. However, there are people who only poorly recover from the loss, or it seems that they have not recovered at all. Even people who work with others in the grieving process can be severely reminded of their own losses they did not get over but for which they thought they had "forgotten" a long time ago. Even they then need support from the people in their environment and/or professionals, even when they are professionals themselves.

Conclusion

The first writings on children's and adolescents' grieving are found in the works of Sigmund Freud and John Bowlby. Sigmund Freud belied that grieving has an important psychological function because it enables the child to separate from the dead person. This process has always been painful and represent an inner fight because there is an intensive desire for the lost close person and, on the other hand, they should face the fact that the person is gone. In psychotherapeutic work with the boy, intertwined and recognised were the desire and the need to accept the loss of father. What was especially important was involvement of the parent to their own psychotherapy so that the parent would accept own sadness and loss. The boy had a chance to express his emotions in a safe environment, in a way acceptable to him. Despite its importance, especially when the topic of loss is in question, the final phase of the psychotherapy was not reached. This work reminds us once more how important parents are in working with children, and their support, and how significant they are as collaborators. Changes and process the children go through in the psychotherapeutic context, are necessary to be supported and recognised by the parents, which often does not happen, and what represent an additional challenge for psychotherapists. As far as the wider social context is concerned, it can be said that in today's society there is no awareness of the need to recover but also of the need for support in that recovery. In other words, support in grieving happens within institutionalised denial, in time when rituals are given much less significance than before but education on losses and grieving is lacking on all levels.

References:

1. Arambašić, L. (2005). Gubitak, tugovanje, podrška. Jastrebarsko: Naklada Slap.
2. Dalos, R. (2012). Sistemska porodična psihoterapija. Novi Sad: Psihopolis.
3. Dyregrov A. (2001). Tugovanje u djece. Zagreb: Educa.
4. Erskin, M. (2015). Integrativna psihoterapija na djelu. Novi Sad: Psihopolis.
5. Janković, J. (2004). Pristupanje obitelji. Zagreb: Alinea.
6. Vulić-Prtorić, A. (2003). Depresivnost u djece i adolescenata. Jastrebarsko: Naklada Slap.
7. Whitfield,C. (2007). Tješiti. Zagreb: Nacionalna biblioteka.

NUMBER: 1.; DECEMBER, 2018.; RECIEVED: SEP 11 , 2018.; ACCEPTED: SEP 11 , 2018.; 79-87

A twenty-year-old adolescent victim of incest

Azra Arnautović
Primarius MD MSc, Paediatrician,
Group Analyst, Integrative psychotherapist for children and adolescents
"Empatija" Association for mental health support, psychotherapy and education, Tuzla
Maršala Tita 42, Tuzla, Bosna i Hercegovina
Mobile phone: +387 61 735 110
e-mail:azra.ai@bih.net.ba

Summary

Author describes in this work the course of the psychotherapeutic treatment of a twenty-year-old adolescent who, at the age of 12, became a sexual abuse victim by her father. As she was growing up, she was exposed to other forms of violence and developed an insecure attachment. She became insecure, obedient, isolated, ashamed, with an enormous fear of her father. Trauma-focused cognitive-behaviouristic therapy (TFCBT) was implemented with an eclectic approach (genogram, drawing, associative cards, guided fantasies) and psychoeducation. For seven months, weekly one-hour long sessions took place. Client interrupted treatment due to changed life circumstances. Besides difficulties in psychotherapeutic work with young victims of incest, topics here are also contextual factors and consequences for the psychotherapeutic treatment.

***Key words**: incest, child abuse*

Sažetak

Autorica u radu opisuje tok psihoterapijskog tretmana dvadesetogodišnje adolescentkinje koja je u uzrastu od 12 godina počela bivati, žrtva seksualnog zlostavljanja od strane oca. Tokom odrastanja bila je izložena i drugim oblicima nasilja. Odrastajući u nasilju razvija nesigurni atachment. Postala je nesigurna, poslušna, izolovana, postiđena, sa ogromnim osjećajem straha od oca. U psihoterapijskom tretmanu primjenjena je Kognitivno biheviroalna terapija usmjerena na traumu (TFCBT), uz eklektički pristup (genogram, crtež, asocijativne karte, vođene fantazije), te psihoedukaciju. Psihoterapijski tretman se odvijao jedan put sedmično, sat vremena, u periodu od sedam mjeseci. Prekinut je željom klijen-

tice zbog životnih okolnosti u kojima se našla. Osim poteškoća u psihoterapijskom radu s mladima žrtvama incesta, tematizirani su kontekstualni faktori i posljedice za psihoterapijski tretman.

***Ključne riječi**: incest, zlostavljanje djece*

Introduction

Generally – violence is a tool for those in power to show or reinforce their control over those that lack it. almost every relationship with disrupted power balance has a potential for violence to be manifested – by a more powerful person towards the less powerful one. In the USA, one to four girls and one to six boys are abused (Mitchell, 2010). European data shows that one of five children are sexually abused (Council of Europe, 2010). Bosnia and Herzegovina has no official record on abuse. In our society, and wider, the topic of incest is still a taboo, although media increasingly exposes such cases. Not reporting it right after the first act of abuse, but after a significant time passes, makes it worse. Reasons are numerous: usually the child or a close family member are not believed it has been done; family moral norms, in the psychological sense, rule out a possibility it can happen within the family; shame if others find it out; sometimes, due to family dynamics, the child is unaware of what is happening to them, especially if there is no aggressiveness or intimidation. Depending on the age, consequences occurring are more complicated and lasting for a person who experienced abuse.

Meeting and the first session with the client

The first contact with the client was in the Centre for therapy and rehabilitation. It is a center dealing with psychotherapeutic treatment for victims of war, domestic violence and sexual abuse. Case-dependent, treatment in the Centre is conducted on outpatient basis or in the stationary. The intake team decides on it in agreement with the client or her family.

Client was brought by the police in the Centre after she reported abuse and, according to the protocol for such cases, medical examinations (including a gynecological examination) was conducted at the Clinical Centre. She stated she could not take the pressure and abuse she was exposed to anymore. The decision to report it, replaced fear and shame she felt, regardless of the consequences it could bare, with which her father threatened.

Upon intake: a beautiful twenty-year-old girl, middle height, undernourished.

She seemed sad, depressed and confused. She often sighed. She told her story quietly, intermittently crying, exhausted, with her head down, without looking at the social worker taking her statement.

Those were only bits and parts of what she would later tell in the psychotherapeutic sessions. She worried about her mother and younger brother. Experience she had did not provide her with trust in people or in what she was told: that she was safe now, that her father does not know she reported him and that he will be arrested. She comes from a family in which violence (all forms except for sexual abuse) was performed on daily

basis by her father - on her mother and brother, too. The stationary was recommended to ensure isolation and security from the perpetrator and provide conditions to start the treatment. First, the doctor estimated her to be: aware, afebrile, eupnoeic, oriented in time and space, towards herself and others, answering questions adequately, affects follow mimics, depressive, scared, confused and not suicidal. Without visible outer wounds. The intake team consists of the medical doctor, nurse and social worker. To make her feel secure, she was provided a crisis intervention. After three days, she left the Centre self-initiatively. She returned home to her mother and brother, worried the father would harm them because he still was not in jail.

Phases of the therapeutic work

Treatment required a complex, multidisciplinary approach. For this case, a small team was formed: psychotherapist, doctor, social worker and lawyer. Each team member has set tasks from their domain. Plan is made individually. Increasingly used in sexually abused children treatment, trauma-focused cognitive-behavioristic treatment was implemented. Treatment is conducted in phases, so to gradually expose to the traumatic context decrease anxiety, reduce and overcome symptoms of avoiding, creating capacities of incorporating experiences, which would open possibility to work on distorted cognitions and reach a modelling of adaptive confrontation (Bilić V. et all, 2012). ***The first phase*** is a preparation for the next phase where trauma should be worked through. Techniques and interventions are used, appropriate to the age and type of traumatic experience. In the ***first*** phase, therapist and psychotherapy represent supporting figures and a safe place where clients can remember their painful childhood memories and explore to them (Corey, 2004). In ***the working through phase*** the aim is a gradual confrontation with traumatic experiences until there is no emotional agitation or avoidance. Gradualness is very important. According to (Cohen and Mannarino, 1997) it takes one third of the entire treatment duration. A change of cognitive distortions is implemented; the intensity of “triggers” and negative emotions are reduced; the sense of control over memories is developed or increased; new coping strategies are learnt; they learn again to understand traumatic event and consequences of trauma through psychoeducation. All of that is needed to “design” trauma integration, positive self-image development and an optimistic vision of the future. It is not an easy job and it requires time, patience and understanding. In working with children, it is necessary to take care of the traumatic event hierarchy development. Each step needs to be sufficiently difficult to challenge anxiety, but simple enough for a child to believe that they can overcome it. After they successfully confront that step, it continues towards a scarier memory, and ending with the scariest one. In the ***first*** phase, traumatic memories are several times reconsidered so that the child would be become sufficiently confident to confront them without fear. It is important to reduce the feeling of anxiety over time (Cohen and Mannarino, 1997).

To enter the phase of exposure to trauma, the quality of family relationships and social resources, existing beliefs and values and the child's life circumstances stressfulness are important (Bilić V, et al, 2012). However, TFCBT is not a therapy of choice in cases of an explicit resistance, compromised intellectual abilities, and especially suicidal tendencies, severe depression and changed, dangerous behaviour for the environment and the individual. The feeling of anger and difficulty to express are a part of the sexually abused children symptomatology. (Bilić V, et al, 2012). ***Psychoeducation*** teaches them what traumatic event is, the usual reactions of children and parents, the symptoms and possible related disturbances, and information on every step of the treatment. Correction of misleading beliefs about sexuality and information on healthy sexuality in cases of sexual abuse and compulsory consent of parents (in juvenile children) are important in psychoeducation in the field of sexual education.

In sexually abused children boundaries are breached, fluid. Sexual abuse does not respect boundaries (Buljan Flander G, Kocijan Hercigonja D, 2003).

For the beginning of the work with the client, key moments were to build relationship, trust and empathy and insight into resources - increasing the existing and building the new. Her self was not built, she did not have a self-image, and those parts that were present, were a negative image without self-confidence, validation, without seeing anything positive she had. Her attachment is insecure. Also, she had other consequences of a sexually abused person in a form of a posttraumatic stress disorder (PTSD) (insomnia, lack of concentration, flashbacks, constant anticipation of danger, lack of appetite) depression, anxiety, consequences in the field of sexuality, physical consequences such as frequent stomach-aches, interpersonal relationships, social functioning, with present cognitive distortions and symptoms of a dissociation and avoidance.

In the first phase it has been worked on the preparation for phase when she should enter the trauma. During the first sessions, genogram showed the existing relations in the family and that the client had a supportive person, her grandmother, that loved and supported her a lot. Grandmother did not live with them but the client had a phone contact with her and occasionally visits. Several techniques for identification and differentiation of emotions were used: character drawings, associative cards. Working on emotions is important for recognising relationships between negative emotions and reminders of trauma, adopting skills that enable talking about emotions with others but also for emotional management. Guided fantasies that were sometimes projective, in a sense of enlightening some resources she would later use while facing stressful situations, or trauma triggers. She has built her "safe place" and used it when she felt lack of energy, fear of the father, after having nightmares she could not cope with. For the purpose of learning coping skills with daily stressors, dealing with traumatic event(s) during therapy and reducing intensity of symptoms related to trauma, in this phase breathing skills and progressive muscle relaxation were learnt.

The client occasionally brought in dreams that had a content of nightmares of the survived. Those topics cannot be neglected and simultaneously deepened because conditions for a deeper working through the trauma were not yet created. Interventions were very careful with psychoeducation on trauma, recognition and definition of emotions. During the work in the first ten to twelve sessions (approximately three months) there were some current events that required counselling and crisis intervention. The client, her mother and brother, were exposed to verbal attacks by the family and her father. The role of her mother, who "woke up" in a support and care for the client, was important. Now, for the first time, her mother provides a selfless support. She was also in the psychotherapy with another psychotherapist. The relationship between the mother and the daughter was disturbed. The client was extremely angry at her mother for not protecting her when needed.

Parallel work with the both of them resulted in the client showing compassion and understanding for the mother's situation. Finally, she had a mother as a support to carry on. It was a significant point in the work because it is vital to involve parent(s)/guardians for several reasons: reducing problems in behaviour and depressive symptoms in the child (Deblinger et al., 1996); parent's emotional reaction to trauma is the strongest predictor of the treatment result (along with the type of treatment) (Cohen and Mannarino, 1996). Parent's support is significantly related to reducing the symptoms in children (Cohen and Mannarino, 1997). Empathy and support she received made her braver. Working on restructuring of negative cognitions she had was important. She confirmed what she thought about herself and how she saw the world around her. The aim was to develop, or at least try to, suitable attributions and cognitions about the event, and avoid consequences related to distorted interpretation of the traumatic event and self-image. It was a difficult work. Usually it was self-blaming ("everything is my fault, why did I not report it before, maybe I should not have reported it now, etc."), then exaggeration of danger ("what if he goes out and from the prison find someone to kill us") -she had a great fear of father as she remember previously experienced violence. One of cognitive distortions was from the domain of the changed perception of the environment: she occasionally mentioned that "Everybody knew what was happening and they did not get involved" and states "They knew father did many other bad things to others, as well."

During the psychotherapeutic work, client's memories of sexual abuse in early childhood were not reached. It is possible that there was no incest at that time, or that trauma is buried deeply, which happens in painful experiences in order to "survive". There is also the abuser-manipulator who intermittently loves and threatens, convinces the child in lies and craziness, so the child-victim is not quite sure what really happened (Courtois, 1988).

In the working through phase, the client resisted or avoided to talk about anything related to the abuse. At that time her father was released and tried from the freedom. Encountering her father again, even in the presence of the police, triggered her fears

and images of the experienced. The client described that encounter on four pages. She wrote she could stand his gaze. She felt safe because the mother and the police were there. That night she did not slept well. She noticed she had a lower level of anxiety, more awareness of being protected. These client insights are important for the continuation of working through the trauma. We continued on making a description of the traumatic event. The aim it to expose and process. Interventions depended on the reactions the client showed. The client came weekly to sessions, which positively affected reducing anxiety in sessions. Regularity and continuity of sessions are important because long periods between sessions increase fear intensity. Positive effects of previous psychotherapeutic work are obvious: though present, level of anxiety is lower, there is less feeling of guilt and more self-efficiency. That was an important insight. Slowly she began to feel proud for reporting abuse. She found a temporary job in a store. Living together with mother and brother gave her sense of belonging and security while father was in jail. Occasionally she seemed satisfied. What could be felt in each session, was the presence of insecurity and fear of the court trial verdict but also great expectations that the justice will be served. Punishment meant justice and justice provided freedom and possibility of life in a better future. Punishment is something her father earned, and in her fantasy "suffered" for what he had done. She completely denied possibility that it may be inadequate or he might be freed. Denial was her usual defence mechanism. These moments in session were another confirmation of the state of the self and the need for a long-term work of the self: the question of identity, possible borderline personality disorder, body-image distortion, atypical depression. A psychological evaluation was necessary.

Suddenly she got into the end phase because the court decision was inadequate. Due to new circumstances the previous phase was not completed. When she heard the verdict was not even a minimal sentence, the client went into an emotional crisis. She was lost. She went back into the state of a total fear, helplessness, lack of trust towards the world and the environment she lives in. That changed the psychotherapeutic course: partially set back, unfinished and in crisis. Due to severe counter-transfer reactions the psychotherapist became aware of, it was impossible to find adequate "tool" to repair the new situation. The client has, after several crisis intervention sessions, self-initiatively interrupted the treatment. She got married suddenly and thoughtlessly as a way of protection from the father. She did not respond to the proposed continuation of therapy.

Conclusion

Though still a taboo, sexual abuse of children is not a new topic. The case describes the complexity of growing up in a violent environment, exposure to violence and its permanent consequence. Often recovery depends on the influence of context in which the child is growing up.

Psychotherapists working with child sexual abuse are at risk of severe counter-transfer reactions and possible unconsciously occurring roles in the client but also the therapist (Gruden, 1992). Supervision of the professionals is an essential for the work in this field.

References:

1. Anonimus. Američka Psihijatrijska Udruga, (2014): Dijagnostički i statistički priručnik za duševne poremećaje. DSM-5.Zagreb, Naklada Slap. 718-719.
2. Ajduković M, Pavleković G, (2000); Nasilje nad ženom u obitelji. Zagreb. Društvo za psihološku pomoć.
3. Bilić V, Buljan Flnder G, Hrpka H, (2012). Nasilje nad djecom i među djecom. Zagreb. Naklada Slap.
4. Berliner L, Elliott D.M.(2002): Sexual Abuse of Children. U: Myers,J.E.B, Berliner L, BriereJ, Hendrix C.T., Jenny C, RedT.A, The APSAC Haendboock on Child Maltreatment. Thousand Oaks, CA:Saga Publications.
5. Bojanin S, Popović Deušević S, (2012): Psihijatrija razvojnog doba. Institut za mentalno zdravlje 2012. Beograd.
6. Buljan FlanderG, Kocijan-Hercigonja D, (2003): Zlostavljanje i zanemarivanje djece. Zagreb. Nakladnik Marko M usluge d.o.o.
7. Butollo W, Kruesmann M, Hagl M,(2000): Život nakon traume. O psihoterapijskom postupanju sa užasom. Zenica. Dom štampe.
8. Corey G, (2004):Teorija i praksa psihološkog savjetovanja i psihoterapije. Jastrebarsko. Naklada Slap.
9. Council of Europe (2010). One in Five. The Council of Europe Campaign to stop sexual violence against children. http;//www.coe.int/t/dg3/children/1in%/default_en.asp17.01.2010.
10. Gruden V, (1992): Psihoterapija. Zagreb: Medicinska naklada.
11. Gregurek R, Ladika I,(1995): Transferni i kontratransferni problemi u liječenju bolesnika transplantacijom koštane srži. Liječ Vjesn 117: 2- 8.
12. George M, (1996): Listening and hearing: Child sex abuse. Nursing Standard, (10)22-23.
13. Kozarić-Kovačić D, (2008): Integrativna psihoterapija. Psychiatria Danubina, 20, 3; 352-364.
14. Harville H, (2003): Kako dobiti ljubav koju zelite. Zagreb. Mozaik knjiga.
15. Jackson Sh, Newall E, Backett-Milburn K, (2015): Children's narratives of sexual abuse. Child and Family SocialWork 2015, 20, pp 322–332 (lični slobodan prevod)
16. Milosavljević M, (1999): Seksualno zlostavljanje djece. Sarajevo. Forum demokratske alternative.
17. Mitchell,M.W.(2010)Child sexual abuse: A school leadership issue.The Clearing House: A Journal of Educational Strategies, Issues and ideas, 83(39,101-104.
18. Pereda N, Guilera G, Forns M. & Gomez-Benito J, (2009): The prevalence of child sexual abuse in community and student samples: a meta-analysis. Clinical Psychology Review, 29, 328–338 (lični slobodan prevod)
19. Racker H, (1968): Classical and present techniques in psycho - analysis. u: Racker H, (ur.) Transference and Countertransference, New York: Press, Inc, str. 23-70.
20. Radinov T,(2013): Gestalt terapija. Zagreb. Naklada Slap.
21. Ramirez C, Pinzon-Rondon A. & Botero J, (2011): Contextual predictive factors of child sexual abuse:the role of parent-child interaction. Child Abuse & Neglect, 35, 1022–1031 (lični slobodan prevod).
22. Schafer R, (1983):The analytic attitude. New York: Basic Books.
23. Sanderson C, (2005): Zavođenje djetata. Zagreb. VBZ.
24. Winnicott D.W, (1976): Dijete, obitelj i vanjski svijet. Zagreb. Naprijed.


THINK ABOUT
YOUTH!