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THINK ABOUT YOUTH!

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Contents

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.
The future of every individual and the humankind in general depends on the child, its development, and the creation of self and the world around it. This knowledge and belief create the personality of each individual and its functioning, relating to the family, environment, itself and the world in general.
The aim of the journal, through the dissemination of research conclusions and experiences is to help educate people who are responsible for the development of each child through adulthood and the functioning of the world. A special problem is the ethical principles in working with children, which, although very clearly are defined by numerous conventions and laws, often cause numerous dilemmas and attitudes and are not incorporated in the life of the child. The aim of the journal is not only education and exchange of experience, but also stimulating the existing experiences and influencing the development of ethical attitudes, all to prevent mental problems in children and young people.

Prof. Dubravka Kocijan Hercigonja,
MD-PhD

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, PhD - editor

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Significant factors in the treatment process of children and adolescents

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Summary

The success of treatment outcomes, especially in children and adolescents, depends on a number of factors; from the etiology of the disease itself, the influence of the environment, the approach to understanding the needs of the child in relation to the stage of development and mental functioning. In this process, apart from the disease process itself, the relationship between parents and health care staff, the way of establishing a relationship, ie communication, plays an important role. In working with sick children, especially those who were involved in many forms of medical interventions due to the type of disease, we gained insight into the dissatisfaction of children, parents and health professionals regarding organizational and professional needs, which reflects on the treatment process and requires additional education and help.

Key words: *sick child, communication, sick child - health worker relationship*

Sažetak

Reakcije i ponašanja djece i adolescenata pod utjecajem su brojnih faktora, a posebice ranijih iskustava, odnosa u obitelji i okruženju, kao i same faze razvoja. Isto najviše dolazi do izražaja u posebnim, za dijete drugačijim, situacijama, kao što je npr. bolest. Rani odnosi roditelj-dijete bitan su preduvjet za razvijanje osjećaja sigurnosti i utječu na djetetovu percepciju svijeta i sebe u tom svijetu; točnije dijete stvara sliku o sebi, svojim vrijednostima, odnosima i samopouzdanju, što bitno utječe na funkcioniranje i odnose kasnije u životu. Isto posebice dolazi do izražaja u novim situacijama, uključujući bolest te sve promjene vezane uz bolesna stanja. Često se postavlja pitanje kako neko dijete ili adolescent prihvaća nove situacije, uključujući separacije, promjene načina življenja, dok neka druga djeca to ne mogu. Bitni čimbenici koji utječu na proces stvaranja odnosa su nasljeđe, biološke promjene i karakteristike, psihološko funkcioniranje koje je povezano s ranim odnosima i slikom koju je dijete stvorilo o sebi i svom okruženju. Ako se radi o bolesnom djetetu, tada je neophodno dobro poznavanje djetetovih psiholoških potreba, kao i poznavanje karakteristika faza razvoja te odnosa s okolinom jer samo kroz poznavanje navedenog moći ćemo razumijeti reakcije bolesnog djeteta, koje bitno utječu na tijek i ishod bolesti. Zdravstveni djelatnici u tom procesu imaju bitnu ulogu.

Ključne riječi: *bolesno dijete, komunikacija, odnos bolesno dijete - zdravstveni radnik*

Introduction

The reactions and behaviours of children and adolescents are influenced by a number of factors, especially previous experiences, family and environmental relationships, as well as the developmental stages themselves. The same is mostly expressed in special, different for the child, situations, such as illness.

Early parent-child relationships are an essential prerequisite for developing a sense of security and affect a child's perception of the world and of themselves in that world; more precisely, the child creates an image of himself, his values, relationships and self-confidence, which significantly affects the functioning and relationships later in life. The same is especially evident in new situations, including illness and all changes related to illness. The question is often asked how a one child or adolescent accepts new situations, including separations, lifestyle changes, while some other children cannot. Important factors influencing the relationship formation process are heredity, biological changes and characteristics, the psychological functioning associated with early relationships, and the image the child has created of himself and his environment.

If it is a sick child, then it is necessary to have a good knowledge of the child's psychological needs, as well as knowledge of the characteristics of developmental stages and relationships with the environment because only through knowledge can we understand the reactions of a sick child, which significantly affect the course and outcome. Healthcare professionals play an important role in this process.

The child, especially at the earliest age, needs a close relationship with the mother, i.e. another close person that he perceives as inseparable from himself, and he experiences separation from the mother at that earliest stage as a loss of himself. Today, knowing the importance of attachment and all the consequences, we also understand the many developmental transformations from childhood to the end of adolescence. A child with insecure attachment, as well as a child who has undergone changes in relationships and functioning, will develop numerous deviations in the way of functioning, and if it is a sick child, then the same will have negative reflections on the course of treatment. The disease changes parent-child relationships in different ways; from separation as a result of hospitalization or rehabilitation process to changes in parental relationships that the child often does not understand, especially if the same applies to changes in previous behaviours, lifestyles, denials, isolations, or feelings of stigmatization. All of the above has a significant impact, both on the psychological development of the child and on the treatment process itself.

The important question is how to help a sick child. In order to be able to help the child as health professionals, it is necessary to know the child's needs that are related to the developmental stages and the influences and relationships in which the child grew up. How to help a child overcome the fears arising from separation, learn to deal with numerous procedures during treatment that he does not understand, and often the present fear of death? In this new situation, the family can very often, by their actions, which are the result of their fears and insufficient knowledge of the outcome of the disease, make it difficult for the child to accept the changes brought about by the disease. Very often, parents feel insufficiently informed about the course of the disease, which leads them to a state of helplessness, sometimes guilt, which is reflected in the relationship with the sick child.

Healthcare professionals are faced with a number of problems that arise not only from the disease itself, but also from the relationship with the sick child and his parents. There are often many organizational problems, such as lack of time, insufficient knowledge of how to approach the child, as well as many other factors that significantly affect the relationship with the sick child and his family, and often reflect on the outcome of the disease.

The purpose of the research

Based on the above, we wanted to determine through our pilot research which are the needs of a sick child, and which of parents and health professionals.

We are encouraged by the experience of working in children's and adolescent psychiatric clinics, where one of the reasons for coming are certain mental problems related to treatment of a chronic disease, most often according to our experience in the form of anxiety, depression, fears, resistance to previous forms of functioning and denying positive outcomes. One example is a 10-year-old girl suffering from leukemia, and she was brought to the clinic for lethargy, sleep problems, writing off previous interests because "nothing makes sense". During the interview, it was reported that she was treated with a group of peers in one pediatric ward, and they all had the same diagnosis. Upon discharge, they had joint check-ups to which, as the girl stated, some members would not come because they had died in the meantime. She verbalized the fear of who would not be on the next check, whether it was her or someone else. No one talked to them about it, and the feeling of writing off the future, desires, and plans became more and more intense.

Furthermore, we have the example of a 14-year-old girl who was severely injured in an accident with numerous burns and organ damage, which required surgical procedures. Numerous problems in the muscular system indicated appropriate physical therapy. Although she was involved in the help of a psychiatrist during her stay in the ward, she found it very difficult to endure rest, pain, numerous tests and procedures, and she responded to everything with tears and resistance. The physiotherapist did not establish a relationship with the child, but reacted violently to her resistance, refusing to perform physical therapy, even though it was indicated. The nurses found it very difficult to cope with the girl's resistance to any changes and procedures and avoided communicating with the girl as much as possible, except for the most necessary procedures, which resulted in psychological changes in the girl in the form of reluctance, refusal to communicate and any more active therapy. Given the serious threat to her health, and on the advice of a psychiatrist, the parents moved the girl to another institution where the staff treated her with a lot of understanding and encouragement, which changed her way of functioning. She accepted therapeutic procedures, became more active and after a several-month stay in the hospital was discharged in a significantly improved condition.

Methodology

Based on the above experience, a questionnaire (attached) was compiled for health professionals in the final grades of medical schools, a questionnaire for health professionals who are employed, as well as a questionnaire for hospitalized, sick children and their parents.

The study was conducted at the Medical College in Pakrac under the leadership of _____, in Tuzla under the leadership of _____ and in Zadar under the leadership of _____. 169 high school medical students were included (Tuzla 30, Pakrac 49, Zadar 90). An important question was how much information they received during schooling to work with hospitalized, seriously ill children. The range of grades was from 1 to 5. Students from Tuzla answered with an average grade of 2.57, from Pakrac 3.43, and from Zadar 3.87. A special problem was their insufficient knowledge in working with children under three years of age, oncology patients, children with mental problems, as well as with children where long-term hospitalization is required. When assessing the negative and positive sides of the profession, most students emphasized helping and saving lives, while the negative sides were stress due to excessive responsibility, poor working conditions, encounters with death and insufficient knowledge of emotional problems and needs of newborns. Most respondents estimate that they know a lot (13.3%) and well (34.4%) about emotional development, and through that about the needs of children.

When enumerating the needs of health care workers, the sample consisted of 30 health care workers. A large number of respondents (Tuzla - 76.6%, Pakrac - 75.51%, Zadar - 54.4%) expressed the need for better knowledge of the needs of children, especially seriously ill children with a fatal outcome, which teachers did not talk to them. The majority of employees, 90% of them, expressed the need for continuous education, especially in working with cancer patients, working with children with mental health problems, as well as with children where long-term hospitalization is required. Only 10% of employees think that they do not need it.

In relation to the examined children, the analysis was performed on 19 hospitalized children and their parents in Zadar and 11 children who came to seek help in the polyclinic, ie a total of 30 children. All the children answered that the most difficult thing for them was separation from their parents, taking blood and waiting for the findings. 6 out of 30 of them answered that they did not need to change anything, while the others listed the need for more attention, games, conversations by nurses. In relation to parents, out of 30, only four felt satisfied with the information and communication received, while the rest needed more communication, patience, being informed in an appropriate and understandable way, optimism and encouragement.

These data, although deficient given the inability to include more children, still indicate the need for a more comprehensive approach to hospitalized and chronically ill children and parents, but also assistance to health professionals in their work, which, in our opinion, necessitates more extensive testing on a larger sample.

It is important to emphasize the need for a good knowledge of children's needs arising from the stage of development of the child and adolescent, the characteristics of family and social relationships and specific influences and changes associated with the current situation, in this case the disease. Changes related to the disease relate to the process of the disease itself and to its reflection on the changed way of life that this process brings. All these factors are important for the form of communication, both with the sick child and his environment. It is important to provide the child with a sense of security through understanding his problems and accordingly apply optimal approaches, without the health professionals themselves developing symptoms of burnout, and parents through appropriate help develop optimal approaches for the child and for themselves that lead to improvement or healing.

Furthermore, each age and each condition has its own specifics and that successful communication includes not only communication skills that are modified according to the psychological needs of the child, but also continuous assistance to health professionals in acquiring new knowledge and help in gaining knowledge about the specifics of addictive approaches. of age, the child's problems and his family's reactions. In doing so, it is important to preserve your stability and the quality of your work.

In conclusion, we emphasize the importance of this in the process of treating children, helping families, but also preserving the stability of employees and we consider it important to expand the study to a sufficiently large cause to be able to draw appropriate conclusions regarding approaches and organization.

Attachments:

SURVEY FOR HOSPITALIZED CHILDREN:

1. How long are you at the hospital?
2. What do you find the hardest?
3. What do you need?
4. Has anyone explained to you why you are here?

SURVEY FOR PARENTS:

1. Are you satisfied with the amount of information received about the hospitalization of your child by the medical staff?
2. What knowledge and skills do you need to make the course of your child's stay in the hospital easier?
3. What knowledge and skills do you need to make it easier for your child to stay in the hospital?
4. Which support system did you use during hospitalization?
5. What did you need from the medical staff?

SURVEY FOR HEALTHCARE STAFF:

1. Do you think you have enough knowledge to work with hospitalized children?
2. Do you think you have enough information and knowledge to work with?

a. Long-term hospitalization	1	2	3	4	5
b. Oncology patients	1	2	3	4	5
c. Psychological difficulties	1	2	3	4	5
d. Physical injuries	1	2	3	4	5

3. How competent do you feel to work with sick / hospitalized children?

1	2	3	4	5

4. Do you think that you need additional education on this topic and which ones?
5. State what are the positive and what are the negative sides of your profession.

SURVEY FOR STUDENTS:

1. Do you think that during your schooling you received enough information to work with hospitalized children?
2. Do you think you have gotten enough information and knowledge to work with:

a. Long-term hospitalization	1	2	3	4	5
b. Oncology patients	1	2	3	4	5
c. Psychological difficulties	1	2	3	4	5
d. Physical injuries	1	2	3	4	5

3. How competent do you feel to work with sick / hospitalized children?

1 2 3 4 5

4. Do you think that changes are needed in the education system on this topic and which ones?
5. List what are the positive and what are the negative sides of your profession for you.

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Alienated Parents' Experiences - Other Side Perspective

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Umjesto zahvale roditeljima koji su nesebično podijelili svoja intimna i bolna iskustva, citat jednog od njih koji nas je posebno nadahnuo: „Dijete je svrha, svrha života, a ne cilj koji treba postići".
Pišući o vama, pišemo za djecu.

Instead of thanking the parents who selflessly shared their intimate and painful experiences, a quote from one of them that especially inspired us: "A child is a purpose, a purpose in life, not a goal to be achieved".
Writing about you, we write for children.

Summary

Alienated / targeted parents are a relatively neglected population in scientific and practical terms, although it is estimated that more than 10% of parents experience or have experienced this form of domestic violence. Few studies to date have shown serious consequences for their mental health of with the perception of insufficient system support. The aim of this paper is to deeply explore the experiences and emotions of alienated / targeted parents before, during and after separation / divorce, stressing their cooperation with institutions and their needs in Croatia, given that no such research has been conducted in the region yet. Based on in-depth interviews with 17 alienated / targeted parents, this paper provides an overview of their experiences: (a) the influences of primary families; (b) unclear circumstances of the termination of the romantic relationship; (c) false accusations of violence; (d) the path to helplessness; (e) reflection on other aspects of life; and (f) needs by the system.

Key words: *parental alienation, alienated parents, targeted parents*

Sažetak

Otuđeni/otuđivani roditelji relativno su zapostavljena populacija u znanstvenom i praktičnom smislu, iako se procjenjuje da više od 10% roditelja doživljava ili je doživio ovaj oblik partnerskog nasilja. Dosadašnja malobrojna istraživanja govore o ozbiljnim posljedicama po mentalno zdravlje otuđenih/otuđivanih roditelja uz percepciju nedostatne podrške sustava. Cilj ovog rada je dubinski istražiti iskustva, doživljaje i emocije otuđenih roditelja prije, za vrijeme i nakon razdvajanja/razvoda s posebnim osvrtom na suradnju s institucijama sustava i njihove potrebe u Hrvatskoj, s obzirom na to da u regiji dosad nije provedeno istraživanje koje bi se bavilo specifično ovom populacijom. Na temelju dubinskih intervjua sa 17 otuđenih/otuđivanih roditelja, ovaj rad donosi pregled njihovih iskustava: (a) utjecaji primarnih obitelji; (b) nejasne okolnosti prekida partnerskog odnosa; (c) lažne optužbe; (d) put do bespomoćnosti; (e) odraz na ostale aspekte života i (f) potrebe od strane sustava.

Ključne riječi: *otuđenje, otuđeni roditelji, otuđivani roditelji*

Introduction

The concept of parental alienation has been around since the middle of the last century, under different names and with different theoretical conceptualizations (Woodall and Woodall, 2019), but to date many scholars and practitioners understand the dynamics of parental alienation in different ways (Buljan Flander and Roje Đapić, 2020). Still, there is a consensus about the fact that some children unjustifiably reject one parent while at the same time idealising the other parent (e.g. Baker and Ben-Ami, 2011; Bernet et al., 2010; Gardner, 2002), which contemporary literature places in the domain of motional abuse of children by parents who interfere and disrupt the child's relationship with others parents (von Boch-Galhau, 2018).

The American stream (Parental Alienation Study Group, PASG) in its explanation of parental alienation currently advocates a factor model, according to which parental alienation is determined if he following factors are present: (1) the child refuses a relationship with one parent, (2) previously there was an adequate attachment relationship between the child and the rejected parent, (3) the rejected parent did not abuse or neglect the child, (4) the other parent uses alienating strategies (e.g. obstructs the child's and other parent's contacts, negatively describes the other parent to the child), (5) there are noticeable signs of alienation in the child (e.g., campaign to denigrate a rejected parent, presenting false cenarios) (e.g. Baker, 2020; Johnston and Sullivan, 2020).

The European stream (European Association of Parental Alienation Practitioners, EAPAP) explains parental alienation through a psychodynamic perspective, perceiving the rejection of one parent as a consequence of the child's pathological fusion with the other parent, resulting in induced defensive splitting in the child's intrapsychic world, which is then projected onto the primary objects (parents) and to the external observer this manifests as the idealization of one versus the demonization of the other parent (Woodall et al., 2020).

Both currents have emphasised the importance of the lack of ambivalence in a child, which in recent years has been shown through the validated instrument "The parental acceptance–rejection questionnaire"(e.g. Bernet et al., 2018). The results clearly indicate reduced ambivalence towards parents of alienated children, compared to children from traditional families, children of divorced parents in general, and children who have been abused/neglected (Bernet et al., 2018). Parental alienation today, therefore, in the broadest sense can be recognized as splitting in a child manifested through a lack of ambivalence towards parents. Splitting represents a cognitive distortion, a pattern of perception and thinking (Beck, Davies and Freeman, 2015), so there is a high risk in the future that the child "splits", roughly separates events, people, situations, self-image in black and white terms (APA, 2010).

The prevalence of parental alienation is difficult to assess by analysing existing data due to different definitions and terminology, the fact that some parents are alienated and do not recognize it, as ell as the fact that some parents are not alienated but feel that way (Harman, Leder-Elder and Biringen, 2016). By extrapolation based on the results of a study with 610 parents in North America, Harman et al. (2016) estimate that 13.4% of parents have experienced that the other parent alienates and/or has alienated their children, which is a worryingly high prevalence. Guided by the best interests f the child and placing the child in the focus of interest, which is desirable in practical work, unfortunately alienated parents as a group are often neglected in both scientific and practical terms. Harman, Kruk and Hines (2018) warn of this problem and state that alienation is basically an nrecognized form of violence, not only against children, but also a form of partner violence against the alienated parent and his primary family.

Alienated parents, especially mothers who are traditionally perceived as primary caregivers, are often affected bythe stigma that they have certainly in some way contributed to such strong rejection by their own children (Finzi-Dottan, Goldblatt, & Cohen-Masica, 2011). The idea that alienation is exclusively a product of high-conflict divorce can also cast an apparent responsibility on alienated parents (Roje Đapić and Buljan Flander, 2020), although the fact is that alienation can also occur in whole families (Baker, 2006), and the act of divorce is often the cause of manifestation of one parent's alienating behaviours (Woodall and Woodall, 2017).

Some researches explore the experiences of alienated parents, their intrapsychic and relational problems, and difficulties with the system, but those are few in numbers. Poustie, Matthewson, and
Balmer (2018) published arguably the most comprehensive research on the subject, based on 126 interviews with alienated parents. They found that the most difficult things for them were: feelings of distance from their own children, emotional and financial exhaustion, feelings of impaired psychological well-being and concern for the well-being of their children. The experience of oneself as a victim of domestic violence was often present, with a lack of understanding by experts. Lee-Maturana et al. (2019) conclude, based on a review of nine smaller studies in this area, that alienated parents are predominantly dissatisfied with the justice and health care system, burdened with feelings of despair, frustration and isolation, but also have some resilience, i.e. are not inclined to give up. Scharp et al. (2020) find that alienated parents cope with stress through the mechanisms of distraction and negation. However, due to prolonged helplessness in the alienation process, especially if court proceedings are lengthy and ineffective, according to Evenson and Simone (2005), alienated parents may develop depressive disorder and complex posttraumatic stress. In addition to mental health, Kruk (2010) finds consequences to other aspects of life, such as growing social isolation, more frequent job losses, inability to establish and/or maintain new relationships in life, all mediated by shame, stigma, helplessness and hopelessness.

The aim of this paper is to deeply explore the experiences and emotions of alienated parents before, during and after separation/divorce with special reference to cooperation with institutions and their needs in Croatia, given that no research has been conducted in our region as of yet which would deal specifically with this population.

Methodology

Participants

The participants are parents whose children are alienated or in the process of alienation alienated and targeted parents, according to Roje Đapić, Buljan Flander and Galić, 2020). They were recruited from the authors' institution and through an association cooperating with the authors' institution, in order to ensure that indeed they are alienated/targeted parents, recognized as such by experts, and not parents who independently (or unprofessionally) declare themselves alienated/targeted. The sample includes only those parents, whose children (with the same partner) are alienated/in the process of alienation (all children if they have more). There was a total of 17 participants (12 men/fathers, 5 women/mothers), ranging in age from 36 to 54 years (M=47.78). This appropriate sample was selected for the purpose of collecting "information-rich" statements, with depth replacing representativeness (Patton, 2002; Creswell, 2007). Twelve participants have tertiary or higher education; seven of them have secondary education. Ten of them have one child, four have two children, and three have three children with a partner who is alienating or has alienated the child/children. Descriptive data on alienating parents are not presented because they were obtained partially and indirectly, potentially diminishing their accuracy. Fifteen of them were previously married, and two of them were in a relationship, i.e. extramarital union with a partner who is alienating the child/children. For the participants who were married, in 11 cases the divorce process was judicially terminated, and for four it was not at the time of the interview. Marriages/extramarital unions lasted from 8 months to 16 years (M=11.4 years). The time elapsed from separation/initiation of divorce to interview ranged from 13 months to eight years (M=4.6 years), except for one case, in which the separation occurred during the mother's pregnancy. The age of the participants' children at the time of the interview ranged from two to 17 years (M=9.3 years).

Method

In-depth interviews were conducted from 2018 to 2020. At the very beginning of the interview, the participants were thanked for their participation and were given the following instructions: "Although you are in the role of a parent, we are interested in your personal experiences. Please answer the questions as extensively as possible and pay special attention to your own experiences and emotions in each answer."

The interviews were semi-structured with the following main areas: (1) general data; (2) family relationships before separation/divorce; (3) divorce/separation; (4) family relationships after divorce/separation; (5) experience with system institutions; (6) needs within the system. At the very end, the participants were given the opportunity to add something they considered relevant. The interviewers did not use the term "alienation" with the participants at any time in order not to affect their answers.

Except in theme of general data (age, gender, number/age/gender of children, etc.), the participants were asked questions openly and broadly, for example: "Describe family relationships before separation/divorce". Asking sub-questions as needed was planned, but given that the participants answered the questions very extensively and comprehensively without difficulty, sub-questions were generally not needed. The most frequently asked sub-questions were: "How was it for you? / How did you feel? /What was that experience for you like? "

The interviews lasted from 40 to 90 minutes (M=63 minutes), depending on the extensiveness of the answers. All interviews were conducted by one of the authors of this paper, a master of psychology with psychotherapeutic education, according to a jointly established protocol, who in no way participated in the processing, treatment or expertise of the family before, during or after this research.

Analysis

The conducted interviews were subsequently transcribed. The approach to analysis was inductive in accordance with the phenomenological paradigm (Moustakas, 1994), in order to understand the experiences of the participants. Interpretative Phenomenological Content Analysis (IPA) was used. The two authors of this paper read all the transcripts several times independently, with the process of summarising the answers (identification of topics) and first with an independent, then joint initial interpretations of the results, after which the answers were categorised according to the main topics. Independent identification of topics contributed to intercoder reliability (Schwandt, 2001). The topics were grouped into clusters (e.g. experience of psychological well-being, suggestions for improving practice), with constant parallel checking of the validity of the topics and clusters in the original answers of the participants. The transcripts were then coded according to topics and clusters in the computer program Atlas.ti. The credibility of the analysis was ensured by the independent work of two authors according to the same principles (Lincoln and Guba, 1990), whose disagreements were discussed and resolved with the mediation of the third author.

Results

The presentation of the results is organized according to the final clusters and topics: (a) the influence of primary families; (b) unclear circumstances of the termination of partnership; (c) false accusations; (d) the road to helplessness; (e) reflection on other aspects of life; and (f) needs from the system.

a) The influence of primary families

The importance of the parents and possible other members of the extended family (e.g. sister, brother) is very clearly noticed in the experiences of the participants, both on the part of the alienating and on the part of the alienated/targeted parent.

Significant involvement of extended family members of alienating parents in the relationship/marriage is emphasised, sometimes before the birth of children and before separation/divorce, with participants feeling that extended family members (usually the other parent's mother) tried to control relationships and excessively interfere with the partner and parental relationship.

"Her mother was constantly present, even though we did not live in her apartment but in a rented one. We couldn't talk for a minute without her getting involved. She had her key, she would just come over (…) and if I said something, I would get a "lecture" that she helps us and that I'm ungrateful, comments about my mom not being here, that I might be jealous because of that."

"He and his mother… I don't know, as if they wanted to have a child, and I was their auxiliary uterus. I know it sounds crazy, but it really was that way. We lived with his parents, the dad didn't interfere much, but Branko /changed name of ex-husband/ and his mom planned our marriage and life, they planned my pregnancy as if I was not right next to them during that conversation."

Relationships with the primary family of the alienating parent showed to be significant for the alienation process itself, when in some cases the alienating parent passively let the alienation process to his/her family members and they successfully "did the job".

"Her mother told her, for example, that I wanted to kill her before she was even born, and then you hear a 4.5-year-old child repeat it (…) the wife said nothing, she didn't speak against me, but she didn't stop her mother either, who was doing a nice job for her."

"She would just keep quiet because she is under his roof, she can't go against her father, but her father can go against me as much as he wants."

"We would have agreed somehow, but then his parents would come and then all of that would go down the drain (…) His mother is a better mother than me, his father is the smartest man in the world."

Two participants spontaneously offered the hypothesis of a transgenerational transmission of trauma in the primary family of the alienating parent that would underlie the alienation.

"One thing that is very interesting to me, her mother, the kid's grandmother, is also divorced and I don't know that man at all (…) and her father, the grandmother's, is a hated character in the family, he is never mentioned (…) Their fathers are bad just because they are men".

"A lot of them killed themselves in that family, I don't know the details, but I also know that her mother tried to kill herself (…) With all this now, as if they are trying to kill me, you know, erase me (…) as if someone has to die".

Regarding their primary family, some participants had the impression that they hadn't received enough support.

"And my family, nothing, they didn't even want to hear about the divorce, let alone to help me. I was completely broken, in a lot of ways, even financially. They didn't help me. According to them, I should have still been married (…) If it wasn't for some friends, I don't know how I would have survived."

Many participants were further affected by the fact that their primary family was also affected by alienation, by the inability to establish contact and relationships with the child, which burdened them emotionally.

"And my mother hasn't seen the kid in ten years. I barely saw her myself, always supervised, in her house, with her mom or sister. My mother didn't have access for ten years (…) How many tears has she shed for her granddaughter (…) and me, how do I comfort her".

b) Unclear circumstances of the termination of partnership

More than half of the participants don't have a clear cause, reason or context for the termination of the partnership, while the rest state distancing (3), excessive differences (2), adultery on their part (1) and adultery on the part of the partner (2).

Four participants describe the projective tendencies of the ex-partner, which caused them confusion, guilt and re-examination of reality.

"*We had each other's passwords for everything, so even if I wanted to cheat on him, I wouldn't do it through Facebook. But he imagined that I have lovers because of some friends on Facebook (…) Nothing was clear to me, he started to talk about how I didn't like him, accusations saying why don't leave if I'm better off with others (…) There was no way to justify myself, and I started wondering if I did something so terrible by having friends, by looking at those profiles, awful."*

"After she gave birth, I don't know if it was postpartum depression or if something else 'broke,' we couldn't talk anymore, she was very angry at everything (…) So one night the baby girl couldn't sleep at all, she cried, she (mother) was very tired and nervous, I saw that she transferred that nervousness to the child, you couldn't tell which was worse any more (…) I asked her to go to sleep, that I put the child to sleep, and instead of being glad to be able to rest, glad that I quickly calmed the child, I mean, I didn';t blame her or say anything bad (…) You see, I'm still justifying putting the child to sleep. Basically, she went crazy, saying that I think she is a bad mother, that I insult her (…)".

c) False accusations

Eleven participants were particularly burdened by the false allegations of violence, while all participants had at least some allegations of bad behaviour towards child and/or ex-partner that they believe were deliberately fabricated or over exaggerated by the alienating parents. In some cases, the allegations (which were later dismissed as unfounded) contributed significantly to the alienation, especially with the passage of time ranging from a few months to more than a year until they were resolved within the system.

"You know, when you're being investigated for sexually abusing your children, you don't get to see them for 13 months, and six months after that, you see them twice a week for an hour under supervision in a supermarket playroom. So, it's enough for her to get the idea and report it and you don't have your children for a year and a half (…) And not to mention what you go through, how you feel during this investigation (…) In the end, all charges were dropped, but no one can bring back the time that was lost."

"I almost became labelled as a domestic abuser (…) She cut herself on the arm with a knife, there, and so shallowly, she called the police, saying that I wanted to kill her, that I attacked her with a knife (…) Although it was all made up and nothing happened, you have to go through it all (…) and then she's afraid to hand over the kid to me because I allegedly tried to kill her, she can't go to mediation with me because I tried to kill her with a knife (…) we can't go to the Child and Youth Protection Centre together because I cut her with a knife (…) and everything drags on, and the policewoman immediately saw that it wasn't deep and that she made it herself, I still have pictures."

"It was cold in the car while we drove her to kindergarten together (…), she says: "Dad, it's cold", I say that the car also needs some time to warm up, mom then turns around and says to the child: "Dad intentionally wants you to be cold" (…) later accuses me of it as neglect".

d) The road to helplessness

Although all participants still strive to have a relationship with their children, all of them are dominated by the emotion of (learned) helplessness through the various stages of the interview.

Some participants describe helplessness with this expression exactly, some name it differently, but further analysis shows that it refers to helplessness, while some express themselves in metaphors.

"Pathetic, miserable and helpless, that's how I've felt a hundred times so far and I'll probably feel that way again."

"A certain indifference entered me (…) So after ten years, more, 12 years, I tried everything, I did everything, I spent my health, not to mention money (…) It's torture for both me and the child, these encounters don't make any sense when she still turns her head when she sees me and 'sits through' that hour under supervision. Whatever I try to do any more, I have already lost her."

"It feels like someone throwing you in a pool with your hands and feet bound and saying: "Swim! Compete!' You can't even surface, you can't breathe, let alone swim in a race."

Helplessness occurs predominantly due to systematic explicit rejection by the child and long-term inability to solve problems within the system.

"He cries, screams, tears away, he won't come with me (…) I thought of all the advice and that maybe I should ignore it, set boundaries, somehow calm him down, but after I don't know how many times, I couldn't do it anymore, I would sit with him and cry. "

"Then everyone in the Centre changes after two years, so we start from the beginning, getting to know each other, a new measure, school for parents, mediation, counselling, then one court procedure, a third procedure, two more are separate that I know of so far. And all that time, whatever I do or don't do, for the little one it's the same. I can't speed it up."

All participants describe a sense of frustration when asked about experiences with the institutions, which seem to be mostly slow, sluggish, with insufficient understanding of the issue and determination to solve the problem.

"*Believe me, I would like her to really understand what she is doing and to decide that she won't do it anymore, but she won't do it without pressure, she just won't (…) For three years I haven't seen the child properly until we came to the expertise, until then the child was afraid of me, she wouldn't go against the child's will (…) When the experts pressured her, all of a sudden she everything is possible, we go for ice cream. With her, nothing happens without pressure, someone should have pressured her a long time ago."*

"If he sees that he can ignore the verdict, the measure, the advice and everything, if he sees that they believe he is protecting the children from me, even though no one still explains to me what they should be protected from, then of course he will continue to ignore."

"Someone needs to have the courage to make a decision, but everyone just 'passes the hot potato' around."

Some participants state that they encountered prejudice from people employed in the system, as if they themselves were responsible for rejection, and unprofessional advice that they experienced as minimizing the seriousness of the situation.

"They tell me that I'm nervous, that I'm hostile (…) I am, yes, I'm both and a lot more, because for me it's not the first but a hundred and first time having this conversation on the same topic, and I still don't see my child, regardless of the fact that I saw this particular lady for the first time, I don';t know her name anymore (…) and then she asks me if I am like that in front of the child, as if saying the child rejects you because you are like that".

"Now the two of them sit together, a social worker and a psychologist, and they tell me to find a new wife, to redirect my energy, something like that (…) At first, I didn't think I understood, then I am thinking – what kind of advice is that, then again, I think maybe I really do need to redirect energy, then I ask myself – are they insane."

e) Reflection on other aspects of life

All participants, without being directly asked, describe that the experience of their children being alienated from them has left consequences on other aspects of their lives, of which emotional and financial exhaustion prevail; mental health disorders and relationship difficulties are also present.

"I'm tired, that describes me best (…) I haven't been at sea, in the snow, I haven't been anywhere in years, everything went to the lawyers, and I haven't even asked for the property part yet because I'm afraid he will then retaliate even harder through the girls (children)".

"I'm afraid, I'm still afraid today, that if the adult daughter (who was also previously alienated, but is united with her mother) doesn't answer her cell phone because, for example, she was on the toilet and didn't hear the call, I'm immediately afraid it's over, that I don't have her anymore."

"I can't sleep; it's a disaster, I just think, what I could have done, what I should have done."

"It is a special kind of sorrow that overwhelms the whole being. You have a living child, and yet you don't have a child. You can't mourn him, you can't be with him."

"I don't think I could ever have a child again. I didn';t tell her (current partner), but I'll have to tell her. I couldn't go through any of this again. "

"You know how interested I am in getting into new relationships? I'm not interested. And who would be interested in getting into a relationship with me? I deal with the courts 24/7, and when I don't, I'm like a wreck of a man."

f) Needs from the system

Participants expect that system's staff is educated, sensitised, fast and firm in resolving cases of alienation from the very beginning of the process and that they take responsibility. Some of the participants emphasise the need to be heard and treated with respect.

"Unfortunately, I came to the right experts late, but I saw that there are some and that is why I would tell everyone that, following the example of real experts, they need a lot of knowledge and determination, without calculating and switching whose job it is, 'this does not concern me' attitude".

"I've read a lot and learned about this topic, it's sad when I have to explain to people whose job it is that a five-year-old won't just say that his dad wanted to kill him before he was even born if someone didn't manipulate the child (…) We need you to know that, we need things to go fast before such big problems occur because then it is much harder to mend the damage (…) It should not be allowed for someone to manipulate for months and months because for example a child is sick, then a business meeting came up, then it was something third, and then the child was already heavily alienated by the time it came to an appointment."

"Apart from these concrete things, I needed this today, for someone to smile at me, you know, to look at me as a human being, to see that someone understands that it's hard for me, even though the child is the most important, to be able to tell a story."

Discussion

This paper explores the experience, insight and emotions of alienated parents before, during and after separation/divorce with special reference to cooperation with system institutions and their needs in Croatia. The discussion will be organized in the same way as the results, given the final clusters and topics.

a) The influence of primary families

The importance and influence of primary families in the process of alienation in Croatian participants are more prominent than in current theories and findings of foreign research. Woodall and Woodall (2019), explaining the dynamics of alienation, talk about the transgenerational transmission of trauma in the primary family of the alienating parent, which was spontaneously described by two participants in this study. However the importances of the primary family of alienated/targeted parents, as well as the complicity of the primary family of the alienating parents have not been recognized in previous research. The reason for this can be found in the traditional nature of our society, which implies a greater attachment of adults to their primary families (e.g. Miralao, 1997; Smart, 2000), which in the context of alienation may be more important than in American and British society from which theories and research in this area predominantly arise.

It has been observed that the primary family of alienating parents (or at least some of its members) is in some cases actively involved in the parental partnership even before the separation/divorce, with participants feeling that extended family members (usually the other parent's mother) sought to control relations and excessively encroach on their relationship. This speaks of the symbiotic family dynamics of alienating parents, which should be further and more deeply explored, but indicates the psychodynamic basis of the process of alienation, in accordance with current European theories (Woodall et al., 2020).

Leaving alienation to one's primary family by the alienating parent represents an alienation strategy not covered by earlier categorizations (e.g., Warshak, 2003; Baker and Fine, 2008; Woodall and Woodall, 2017). This has a strong implication for checking and using the factor model of alienation in science and practice because as one of the necessary factors to define alienation it prescribes is that alienation strategies are observed in the alienating parent (e.g. Baker, 2020; Johnston and Sullivan, 2020). According to the literal interpretation of this factor, it seems that it is necessary for the parent to apply alienating strategies, and from this research it is evident that it can be done by someone else, such as the child's grandmother. Alternatively, passively leaving alienation to another person can also be considered an alienating strategy, along with other passive methods.

Regarding the primary families of alienated/targeted parents, it is important to point out that according to the participants, they were also emotionally affected by the alienation, i.e. the inability to establish and maintain a relationship with the child/children. Alienating the child from the family of the other parent has been recognized as a sign of alienation (Gardner, 2002), but there is not enough research that would address the experiences of extended family members of the alienated child. It is evident from this research that their emotional burden additionally burdens alienated/targeted parents, and the necessary scientific and practical attention could be paid to them as well. In addition to the interest and care for the child, members of the primary family prove to be important for the support of the alienated/targeted parent, more precisely, some participants point out as a particularly difficult experience the lack of such support. Disabling the parental role is emotional violence even outside the context of alienation (e.g. Summers, 2006; Mechanic, Weaver, & Resick, 2008), so alienated/targeted parents can be viewed as victims of emotional abuse by a former partner. Social support for victims of violence is crucial for adjustment and recovery (e.g. Rivero, 2012; Žukauskienė et al., 2019), so it is not surprising to find that the lack of primary family support has been particularly difficult for some participants and which they also emphasize as one of the salient experiences in the process of alienation.

b) Unclear circumstances of the termination of partnership

Less than half of the participants state the usual reasons (cause) for separation or divorce such as estrangement, excessive differences or adultery (Hawkins, Willoughby and Doherty, 2012), and with the rest there is no clear cause, reason or context for the termination of the partnership. At the same time, the projective tendencies of the former partner are noticed in four of them, which caused them confusion, guilt and testing the reality. Although for the purposes of this research the mental health of alienating parents has not been analysed and cannot be concluded, based on counter-transference reactions of participants, a hypothesis of latent or manifest psychopathology and/or elements of psychopathology can be made, as well as the use of immature defence mechanisms, predominantly projection (e.g. Ogden, 1979; Sandler, 2018).

According to the literature, alienating parents usually contain elements of narcissistic, borderline and paranoid personality disorder, delusional disorders and delusions (Woodall and Woodall, 2017). Gordon, Stoffey, and Bottinelli (2008) analysed the MMPI-II personality profiles of alienating parents and concluded that they have a clinically significantly higher level of use of primitive defence mechanisms compared to other parents in divorce, and Siegel and Langford (1998) warn of their marked defensiveness in the personality inventory, by which they express primitive defences and/or resistance to interventions. Mental health and defence mechanisms of alienating parents should be further examined with respect to prominent hypotheses and findings.

c) False accusations

False allegations of child abuse have been identified as a method of alienation according to existing classifications (e.g. Warshak, 2003; Baker and Fine, 2008; Woodall and Woodall, 2017). Karen and Nick Woodall (2017) describe the dual alienating power of false accusations of child abuse – on the one hand they are an alienating strategy in themselves (convincing a child that the other parent has harmed him), and on the other, they are often a way to prolong court proceedings and prevent to the other parent and child maintaining the relationship, which corresponds to the experiences of the participants in this research. In addition to the allegations of abuse themselves, exaggerating the other parent's failure to diminish their authority and/or parental competencies has also been recognized as a classic alienation strategy (Warshak, 2003). Baker and Fine (2008) describe the same behaviours as creating an impression of danger for the child from the other parent.

What earlier research and theories do not recognize are the false accusations of the other parent for violence directed at him or her and not the child. Specifically, if an alienating parent falsely accuses the other parent of violence against him or herself rather than directly against the child, especially in a sluggish administrative system, it can also serve as an alienation strategy. This can reinforce alienation directly (giving the child details of the allegations) and indirectly with the passage of time, at the same pace as false accusations of violence against the child (Woodall and Woodall, 2017).

A special problem in practice is the setting the distinction between true and false accusations of violence (either against a child or against an ex-partner), and within the category of false accusations, the distinction between intentionally false accusations, which represent child abuse and system manipulation, and unfounded accusations resulting from authentic care (Tromce and Bala, 2005; Veraa, 2009). There is a danger that experts, depending on the area of specialization, will tend to believe each accusation or hold each accusation unfounded and act accordingly for months or years until the process is officially completed, and any bias prevents prudent judgment and genuine protection of children as well as adults (Guarnera, Murrie and Boccaccini, 2017). Therefore, especially in cases of separated parents, it is very important to ensure a prompt response of the system and, with intersectoral cooperation, to complete the investigation and possible trial as soon as possible.

d) The road to helplessness

Helplessness is one of the most difficult emotions that people can face (Arambašić, 2007). Although all participants in this study continue to make some effort to maintain or establish a relationship with their children, they have a strong sense of helplessness.can reinforce alienation directly (giving the child details of the allegations) and indirectly with the passage of time, at the same pace as false accusations of violence against the child (Woodall and Woodall, 2017). Through their own life stories, they lead the authors through a process of falling into a sense of helplessness, which mostly involves a lot of invested energy and experienced frustration in relation to their children and the system, rejection and embarrassment, and eventually leads to learned helplessness through the passage of time. The phenomenon of learned helplessness was first named by Seligman and Maier (1967) and described as a learned acceptance of discomfort without attempting to control an event or escape from it. Learned helplessness results in cognitive, motivational, and emotional deficits after people are systematically met with the expectation of being helpless in uncontrollable circumstances.

Given that alienated parents are denied the opportunity to fulfil their parental role over a long period of time and given that they perceive the institutions of the system predominantly slow, and professionals as people who lack understanding and determination, learned helplessness is an expected emotion or condition. The study by Lee-Maturane et al. (2019) brings similar findings – they find "frustration and despair" in alienated parents, and at the same time persistence in some aspects of the struggle for a relationship with their children.

Learned helplessness can serve as an overture to a number of psychological difficulties, such as depression (Dušanić, 2007), which research also finds in alienated parents (e.g. Evenson and Simone, 2005; Kruk, 2010). It would be worthwhile to further investigate the dynamics of the development of psychological difficulties in alienated parents and the possible mediating effect of feelings of (learned) helplessness in their aetiology.

e) Reflection on other aspects of life

Alienation affects various aspects of the life of alienated/targeted parents, from which psychological difficulties can be singled out (e.g. sleep problems, chronic feelings of exhaustion, pronounced fear), financial problems and relationship problems (e.g. resistance to a romantic relationship or having another child). These findings, although somewhat different in content, are consistent with the findings of Kruk (2010), who finds more frequent job loss, the inability to establish and maintain new relationships in life in alienated parents.

No further research has been done on this topic, and it would be worth checking in more detail which areas of the life of alienated/targeted parents can alienation affect and in what way. However, the currently listed perceived effects of alienation on the broader picture of life of alienated/targeted parents can be related to the consequences suffered by victims of other forms of violence by their partners. These are consequences on physical and mental health, distorted self-image, difficulties at work, social and family relationships (e.g. Mignon, Larson and Holems, 2002; Tjaden, 2000; Campbell, 2002; Lysova, Dim and Dutton, 2019), which corresponds to the experiences of alienated/targeted parents, in accordance with the definition of alienation as a type of domestic violence (Harman, Kruk and Hines, 2018).

f) Needs from the system

Participants need an adequate and professionally responsible response from people employed in the system in terms of sensibility, knowledge, speed and determination. They also emphasize the importance of a humane approach that includes authentic interest and respect. These needs were presented by the participants mainly as opposed to what they have experienced, which is especially important feedback for experts from all sectors involved in these cases.

Conclusion

The aim of this paper was to deeply explore the experiences and emotions of alienated parents before, during and after separation/divorce with special reference to cooperation with system institutions and their needs in Croatia, given that no research has been conducted in our region so far which would deal specifically with this population, and foreign research is rare and much more often focused on alienated children than parents.

Some of the findings are consistent with previous theories and research, including feelings of helplessness, impaired mental health, problems in various aspects of the lives of alienated/targeted parents and the importance of support they receive or don't receive from loved ones and from the system, from which the perspective of isolating this vulnerable group as victims of domestic violence arises, in accordance with which they deserve further research and professional attention. Some of the findings are partly new in this area, such as the identification of the use of false accusations by alienating parents as an alienation strategy, not only for violence against children or exaggeration of the other parent's failure, but also for violence against themselves, which along with the slowness and sluggishness of the system can greatly contribute to alienation. It is extremely important to differentiate real victims of domestic violence in order for them to receive adequate help (the children as well) from a manipulation of the system, which is not possible without the prompt reaction of the judicial system.

Countertransference reactions of confusion, guilt and testing the reality by alienated/targeted parents in partner relationships with alienating parents shed additional light on theses on the elements of personality pathology and the use of immature defence mechanisms of alienating parents.

A very important topic of this paper is the influence of primary families because, although some theories speak of family dynamics and transmission of transgenerational traumas in the primary families of alienating parents, their impact on direct alienation (while the parent passively leaves the child abuse to them) has not been described. The population of the extended family of the alienated/targeted parent has not been investigated at all so far, and the findings of this research show that it is also affected by alienation and that it has an important impact on the life of the alienated/targeted parent.

The findings of this paper open up many opportunities for further research, for example possible additional strategies of alienation in our society in relation to the ones described so far, dynamics of primary families of both parents in alienation, underlying psychopathology and defence mechanisms of alienating parents, obviously complex dynamics of mental health problems and other aspects of life of alienated/targeted parents through the prism of helplessness, extended family of the alienated/targeted parent, challenges and opportunities to improve the quality and efficiency of system reactions, for which the results and considerations from this research can serve as a starting point and the source of hypotheses.

The scientific contribution of this paper is reflected in the depth and width of collected data on the experiences of scientifically very neglected, but numerous and vulnerable population of parents who have experience with parental alienation, based on which a better insight into their experience of the alienation process is obtained, through which the original theoretical theses from the domain of alienation are described, but also into the broader psychological sciences. The practical contribution of this paper is predominantly for professionals working with this population of parents and families, in illuminating the experience of "the other side", clearly presenting authentic experiences and the need to improve daily work.

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Life in quarantine as a possible cause of psychological identity crisis in development

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Summary

The subject of the exposition is the impact and consequences of crises in the environment on the child's psyche. The topic of this article is the growth and psychosocial development of children in a pandemic with COVID 19, which includes, among other things, life in quarantine.

The introductory part of the article contains data on the modern understandings of disease and health. According to the World Health Organisation, the premise of its action is to achieve the highest possible degree of absence of the disease, with the necessary treatment, that is, the emphasis is placed on prevention. In this part of the article, the World Health Organisation predicts that in the twenty-first century, mental disorders, primarily depression, will break out in a high place in the overall disease prevention. This is more of a reason for the professional public to pay attention to the influence of unfavourable external living conditions on the human psyche.

The presence of the COVID 19 virus in the general population is further elaborated, with emphasis on the specifics of the subpopulation of children. Particular emphasis is placed on the fact that it is about, a previously unknown, strain of a virus from a certain known group of viruses, as well as its undetermined origin in the living environment of the population. Another difficulty from the same is the open question of how to suppress its effect which is a new challenge for scientists. A noteworthy problem is that there is no scientific experience gained so far on this problem for this strain of virus because it is new.

The next part of the article lists the specifics of the child's psyche that increase sensitivity to life in crises, with emphasis on structural changes in children's ego under the influence of unfavourable living conditions caused by the crisis in society, and the evolution of this transformation is currently largely unknown to experts. The answer may be given by future scientific research. In the same context, different features of the clinical picture are elaborated, as well as the available possibilities of diagnosis and prognosis of such a mental state.

The article provides recommendations for strengthening the possibility of recognising this new mental disorder, such as:

- assessment of the client's ability to adapt to changes in life habits that are inevitable in quarantine.
- assessment of the effectiveness of the use of defence mechanisms in an individual client, as a measure of a person's ability to defend themselves from stressful actions from their immediate environment.
- notice the existence of a latent mental disorder that poses a risk for the development of manifest disease.
- assess the potential of the family and its response to the crisis as a (dis)functional unit, that is to assess whether the living conditions of the child in question are sufficient for the young psyche to resist the changed living conditions brought by quarantine.

The article concludes by stating that at this moment it is not yet possible to make a decisive professional elaboration of these premises and the distinction between the immediate reaction to insufficient life activities caused by quarantined life and the occurrence of permanent mental disorder. This will be possible only after a certain amount of time has passed, as is the case in the development of post-traumatic stress disorder which is a consequence of the action of nosological factors, but to which life in quarantine does not belong.

The conclusion is followed by a special appendix in which the conditions of children with special needs and children of divorced parents in quarantined living conditions are elaborated.

Key words: *COVID 19 virus, child's psyche, children with special needs.*

Sažetak

Predmet izlaganja su utjecaj i posljedice kriznih stanja u okruženju na dječiju psihu Tema članka je rast i psihosocijalni razvoj djece u uvjetima pandemije s COVID 19, što podrazumijeva između ostalog i život u karanteni.

Uvodni dio članka sadrži podatke o suvremenom shvaćanju bolesti i zdravlja. Prema stavu Svjetske zdravstvene organizicije premisa njezinog djelovanja je postignuće što višeg stupnja odsustva bolesti, uz neophodno liječenje, to jest naglasak se stavlja na prevenciju. U ovom dijelu članku navode i predviđanja Svjetske zdravstvene organizacije da će u dvadestprvom stoljeću duševni poremećaji i to prvenstveno depresije izbiti na visoko mjesto u ukupnoj prevalenciji bolesti. To je razlog više, da stručna javnost posveti pozornost utjecaju nepovoljnih vanjskih životnih uvjeta na psihu čovjeka.

Dalje se elaborira prisustvo virusa COVID 19 u općoj populaciji s naglaskom na specifičnosti subpopulacije djece. Posebno se podvlači činjenica da se radi o do sada nepoznatom soju virusa iz određene poznate grupe virusa, kao i nepoznaica njegova porijekla u životnom okruženju stanovništva. Također teškoću iz istog predstavlja i otvoreno pitanje kako suzbiti njegovo djelovanje što je novi izazov za znanstvenike. Posebna teškoća jeste što o tom problemu nema do sad stečenog znanstvenog iskustva za taj soj virusa, jer je nov.

U slijedećem dijelu članka navode se specifičnosti dječije psihe koje povećavaju osjetljivost na život u kriznim situacijama, s naglaskom na strukturne promjene dječijeg ega pod utjecajem nepovoljnih životnih uvjeta koje prozrokuje krizno stanje u društvu.

To podrazumijeva nastanak jedne vrste psihičke krize, koja može preći u traumu, a evolucija te preobrazbe je za sada uglavnom nepoznata stručnjacima. Odgovor mogu dati buduća znanstvena istraživanja. U istom kontekstu se elaboriraju različite osobenosti kliničke slike, te dostupne mogućnosti dijagnoze i prognoze takvog psihičkog stanja.

U članku se navode preporuke za jačanje mogućnosti prepoznavanja tog novog psihičkog poremećaja kao što su:
- procjena sposobnosti klijenta da se prilagodi promjenama životnih navika koje su u karanteni neminovne.
- procjena učinkovitosti korišćenja mehanizama obrane kod pojedinog klijenta, kao mjere sposobnosti ličnosti da se brani od stresnog djelovanja iz svog neposrednog okruženja.

- uočiti postojanje latentnog psihičkog poremećaja koji predstavlja rizik za razvoj manifestnog oboljenja.
- uraditi procjenu potencijala obitelji i njezinog odgovora na krizu kao (dis)funkcionalne jedinice, to jest procijeniti da li su životni uvjeti dotičnog djeteta dostatni za odolijevanje mlade psihe na promijenjene životne prilike koje je sa sobom donijela karantena.

Članak se zaključuje konstatacijom da ovom momentu još nije moguća decidna stručna elaboracija navedenih premisa i distinkcija između neposredne reakcije na nedostatne životne aktivnosti koje prouzrokuje život u karanteni i nastanka trajnog psihičkog poremećaja,.To će biti moguće tek nakon stanovitog vremenskog odmaka, kao što je slučaj u nastanku postraumatskog stresnog poremećaja koji je posljedica djelovanja nozoloških faktora,ali u koje život u karanteni ne spada.

Nakon zaključka slijedi poseban dodatak u kojem se elaboriraju stanja djece s posebnim potrebama i djece razvedenih roditelja u uvjetima života u karanteni.

Ključne riječi: *COVID 19, dječja psiha, djeca s posebnim potrebama.*

Introduction

In the spring of 2020, the world found itself in unprecedented living conditions due to an infectious disease. Following the presence of infectious diseases and their spread in the form of epidemics and pandemics throughout history, it is evident that today science has largely solved most of the infectious diseases that have affected all of humanity through the past.

By remedying many infectious diseases that have plagued the population in the past, the problem has not been completely solved because even today, there are diseases that raise several questions for experts. The situation is further worsened by the fact that completely new and previously unknown diseases are constantly appearing and affecting the entire population. The current COVID 19 pandemic has put the world in front of new trials and unknowns in terms of recognition and treatment. This is an unexpected challenge for scientists because the modern age with high scientific knowledge has brought the world various benefits in terms of preserving the health of the population. In the last decades of the last century, the goal of health care for the population on a global scale has changed. Thus, today we are not talking about the fight against disease, but the current premise is to preserve health. This is the fundamental motto on which the World Health Organisation operates.

The rise in living standards brings, among other things, well-being from illness, which in essence is not as simple a process as it may seem at first glance. All this directly reflects on the quality of life of the individual and thus on the entire social community. Yet, despite all the technological and scientific advances, even today, humanity is struggling with different kinds of medical problems that are different from those that man has struggled with over the centuries. As already mentioned, science has managed to solve the problem of most infectious diseases, but with the development of industrialisation and lifestyle changes as a result of technological progress, their place was soon taken by new diseases and, due to frequency, took the first place. Also, on the other hand, there is an increase in the number of chronic patients, which is a direct consequence of increasing life expectancy. Thus today, the general concern for the preservation of health is considerably different from in former times.

In solving it, among other things, experiences from the past are also used, and time and the course of things show that some of these old methods are very applicable and useful even today. In particular, this topic refers to quarantine as the oldest form of defence against the spread of infectious diseases, which with the advent of COVID 19, has been re-actualised as a form of prevention against the spread of this currently widespread infectious disease.

When theses are presented for discussion on a certain professional-scientific issue, one of the basic premises is to find out what are the previous experiences of experts in the fight against COVID 19. The answer to that will have to wait.

Although this current virus belongs to the group of coronaviruses, about which there is some knowledge and experience, they are not fully applicable due to the fact that its decisive symptomatology has not yet been determined. It is also not possible to consult professional literature since it is practically non-existent at this moment. Currently, ID specialists from all over the world exchange their clinical observations on the course and appearance of the disease on a daily basis, searching for a solution. Their experiences in different parts of the world are that the same disease is full of new symptoms every day.

Following the topic of this presentation, the question arises where is the individual in all this?

The individual person is seen in this context in all its dimensions, including compliance with the environment in which she or he lives. This environment changes with the circumstances, and it is necessary to emphasise that a very important component of the living environment are the psychological determinants according to which the individual lives.

All of this points to the conclusion that it is no longer enough to understand the cause of a particular disease, but the fact that the disease is the result of a combination of negative factors in the human environment. Stress weakens the immune system and the body becomes more susceptible to disease.

What happens to an individual and his family in quarantine conditions: in situations of a limited range of motion and a drastic reduction in direct contact between people? To this should be added situations where children, in particular, are completely excluded from the former normal contacts with peers at school and outside.

It is indisputable that this is an interaction of several factors:
- Overall changed lifestyle,
- Changes in life habits,
- For children, termination of regular schooling and transition to new educational opportunities,
- Lack of movement and physical activity in general.
- Almost complete reduction of direct interpersonal contacts, only indirect communication with the wider community remains, and direct communication exists functioning mainly within members of the same household or to some extent in the working environment of the individual. In addition, there is a relative abundance of virtual communication via the Internet, the media. Yet this type of communication, in addition to all the advantages it provides to the daily life of an individual in modern living conditions, also has its negative sides.

Poor social life is fertile ground for the development of psychological disorders and disruption of balance for all categories of the population. In this respect, it seems that, in the first place, the key cause is the situation of all-day and all-night stay of the whole family together, because many parents stay to work at home. In many families, the new situation at first may be perceived as even a positive change because the family spends more time together. However, this can prove counterproductive for many families if such a situation persists.

Factors that can destabilize a harmonious balance, both of the individual and the whole family during quarantine, could be labelled as stressors:

- *Family dysfunction,*
- *The presence of fear of suffering from acute illness, which is the cause of life in quarantine,*
- *Uncertainty and possibly fatal outcomes of the current disease.*

Health education makes people more sensitive, more able to recognize the disease, but primarily, it favours the development of their ability to protect themselves from disease. Although the ubiquitous stress produced by the above factors generates a general feeling of fear, this does not mean that all individuals will react in the same way to a new situation. Most will be able to adapt to a greater or lesser extent to the new conditions of everyday life. But not everyone.

In this case, the decisive question is: what are the psychological dangers caused by the action of the Coronavirus, officially COVID 19, in the spring of 2020?

As far as the field of mental health is concerned, what is available to experts are comparisons with crises in general in which the population may fall, but a definite answer to the question posed at this time cannot be given. The attitude of the professional public regarding the psychological consequences of life in quarantine is in the phase of predictions and assumptions, which is understandable because only time and the scientific research that will follow will be able to give a satisfactory answer. What can be expected? Will experiences from previous epidemics or pandemics help? What does life in quarantine bring on the psychological level? What will be the clinical picture in people of developmental age? How to help those who need help and how to recognise that moment? So this range of issues could go wide, as there are many unknowns.

The first thought in elaborating the question of the impact of quarantine on the psychic sphere, among experts, but also among non-experts, evokes an association with war and an attempt to compare it with the circumstances of war. Unfortunately, the generation of parents of today's children in the Balkans has a lot of experience in this. Although COVID 19, as well as war, directly endanger human life, it still seems that such a comparison is not possible, and it will be difficult to get answers to current questions.

The reason is that this time the direct cause - the enemy - is not physically visible and recognisable. Today we have only the consequence of the behaviour of that enemy — disease.

The basic instrument for recognising a psychological problem in general, and thus for the one that arose as a result of living in quarantine, is a psychological-psychiatric interview. Well-conceived anamnesis questions are the starting point. However, when it comes to people in the developmental age, a specific problem opens up right at the beginning: since a person develops, they do not have a constant in the line of longitudinal development and are, figuratively speaking, different every day.

This is a very significant specificity of the developmental age and especially delicate in the diagnosis of a mental disorder, and also in a situation where scientific research is being conducted because there is no sample constant. Once the symptom is known, it is necessary to distinguish its origin: is it a reaction to the new way of life in quarantine, is it that a healthy person fails to adapt to that situation so far and results in a symptom, or is it a transformation of symptoms of previously mentally ill individuals.

What clinical picture of the psychological reaction is expected? It will be very diverse, all depending on the age of the child or young person, but also according to the individual structure of their psychological profile. Of course, it is not possible to list the various symptoms that a psychologist will encounter in practice. However, it is worth noting the possibility of psychosomatic disorder, which is easily missed in everyday work, as a significant consequence of stress. There is also a possibility of a completely new phenomenon in the child's, and especially in the adolescent's, behaviour: addiction to the Internet, games or even gambling.

The specifics of developmental disabilities are reflected in the child's psyche in three ways:

a) Living in frustrating circumstances inevitably affects the quality of mental health because the child's psyche does not have a sufficiently developed internal defence against the influence of disturbing factors.

b) The growth and development of a young person under extraordinary circumstances have the character of a universally negative experience that can ultimately be traumatic.

c) The childish ego under such conditions of development suffers a thorough restructuring.

There is no doubt that the quarantine situation meets all of the above possibilities, even though in these conditions the basic necessities of life are generally not impaired, that is, the assumption is that there is enough food and sleep.

Therefore, if such living conditions do not last too long, they do not have to leave lasting consequences, but it depends on the personality structure sui generis and its previous ability to adapt to changes in living conditions. In any case, the quality of the emotional climate in the family is crucial as a stimulus for the child's development.

At this point, it is estimated that the main danger that life in quarantine can pose, both for children and adults, is that this situation can be a trigger for the already existing latent readiness of the individual to react in a psychopathological manner. In other words, quarantine can cause a clinically recognisable occurrence of a mental disorder, which in the former normal living conditions might not have occurred.

The emergence of a mental disorder, according to the theory of psychodynamic psychology, is based on a certain fixation, an unresolved problem within the psyche in one of the earlier developmental stages. In such a case, it is a lack of the child's psychic potential to cope with frustrating influences from the external environment. That is why it is of fundamental importance for the one who makes the diagnosis to have an impeccable knowledge of the peculiarities of each of the developmental stages that a child's personality goes through in order to reach psychological maturity.

One of the basic features of a mental disorder in developmental age is not always simple and reliable in its recognisability, which has great diagnostic value. Therefore, one of the basic questions in the interview is to find out whether the child during his life in quarantine has noticed any change in behaviour in terms of daily habits, feeding, sleeping, communication.

Furthermore, it is necessary to observe the child's behaviour in relation to the behaviour of their peers. The diagnostic procedure in child and adolescent psychopathology requires a certain time lag in the observation of behaviour while taking into account all the elements of somatopsychic development of the child or the combination of etiological factors. Once a child is diagnosed, it is never final. The diagnosis made requires continuous monitoring with the need to supplement at all times.

The following should be kept in mind:

- *Assessing the quality of a child's psychological potential is a process of determining whether a condition meets age norms, that is, whether there is an appropriate level of development of mental and cognitive functions, including emotional intelligence.*
- *Observing the child's behaviour in his immediate environment. In quarantine, of course, these are only close family members.*
- *Observe the personality of the parents and their upbringing attitude.*

Diagnosis and prognosis should be viewed in their unique association with the action of etiopathogenetic factors. In practice, the prognosis is more important for parents than diagnosis, which in itself indicates how important the attitude of parents will be for the course and success of treatment. It is understood that the situation with a psychopathological disorder that has arisen in response to adverse environmental conditions has a more favourable prognosis, compared to the sui generis disorder. Having in mind all the complexity and mutual connection of etiological factors that lead to mental disorder, it is clear that it is sometimes difficult to give a diagnosis, and thus a certain prognosis of further emotional and cognitive development.

Interview with a child / adolescent

It has already been stated that the basic diagnostic instrument in child psychiatry is a psychological-psychiatric interview. This is also true for crisis triage according to psychopathological elements in the clinical picture. The purpose of the interview is to determine whether there are deviations in the presented content in relation to the situation before the quarantine. In doing so, in addition to longitudinal observation of the obtained content through the stages of development, also determine whether the listed symptoms exceed the limits that indicate a crisis state. Direct questions to the child/adolescent can help:

- *Whether suicidal thoughts occur*
- *Whether they experienced any kind of domestic violence during quarantine*
- *How they assess the attitude of their family members towards the situation everyone is in now*
- *What is the attitude towards work habits, that is, school teaching according to the online method*
- *Whether and to what extent they lack socialising with peers and group life in general*

It is necessary to mention something else that is well known to all who work with children, as it is not always easy to get certain information from a young client. The difficulty is that in practice it is not possible to conduct a standardised interview, especially when it comes to very young children. There is only as much verbal content material as the young client willingly offers. Any further insistence usually ends with the child's deeper withdrawal. Some younger children will again answer the question clearly and directly, but also often the answer will be silent or will offer some interpretation of the question asked. Similarly, it can be found in adolescents, but they will usually give a meaningful answer after an interval of short silence.

These are situations that require the therapist more or less individual professional skills to obtain data. In other words, sometimes an older child tries to confuse the therapist with a game of silence or an incoherent response and thus dominate the therapeutic situation. However, the ability to manipulate symptoms in children and young people is not particularly likely, but such situations can shed light on significant etiological signs in the clinical picture for a skilled and experienced therapist.

Play and drawing in young children are understood as the equivalent of an interview and there is nothing special to add. Certainly, what was not obtained in the interview with the client, can be obtained from the heteroanamnesis:

- *Anamnesis on the quality of the child';s life so far*
- *Whether there were any difficulties in the educational process*
- *Whether there is a positive heredity for mental disorders*
- *Whether the child has suffered from psychological difficulties before and whether professional help has been requested as a result*
- *Assess the parent's attitude towards the child's current problem*

In all of the above, it is necessary to look at the emotional state in the family, regardless of the fact that it is clear to every mental health professional what an irreplaceable role the family has for the child's life. It goes without saying that dysfunctional families are most affected by extraordinary life circumstances. As with the action of any unfavourable factor, so under the conditions of quarantine life, its most vulnerable member, which is the most commonly the child, will react first and most painfully. So, both in the conditions of living in quarantine and the possible recognition of signs that the family is suffering, for the expert the focus is on assessing the dynamics of family functionality.

If, based on all the above in terms of the manner and content of the interview, the therapist concludes that the client's condition goes beyond the crisis or suspects the development of a deeper psychopathological disorder, a consultation with a child psychiatrist is indicated. At the same time, the therapist should not be burdened with the question of whether it is necessary to include drug therapy in a given case because that falls within the domain of the psychiatrist's responsibility.

In such a situation, the psychotherapist should very carefully and cautiously inform the parents, but also the adolescent, of the need to go to a psychiatrist.

Instead of a conclusion at this point, it is possible to state only a couple of expert statements, which can be understood as certain recommendations. It is too early to predict how effective they will be because the virus is still among the population and epidemiologists cannot predict what will happen in the foreseeable future of a few months and perhaps in the long run.

For mental health professionals it would be desirable to pay your attention and focus on:

- *Assessment of the client's ability to adapt to changes in life habitats that are inevitable in quarantine. If a young person was successfully socialised before quarantine, the better chances of surviving in quarantine without serious consequences for further psychological development.*
- *The importance of recognising the use of defence mechanisms in the individual client, as a measure of a person's ability to defend himself from stressful actions from his immediate environment.*
- *Any latent mental disorder poses a risk for the development of a manifested disease.*

Colloquially, some experts in the field of mental health mention the term civil post-traumatic mental disorder, which could develop after a period of seemingly good mental health after living in quarantine. However, the verification of this new nosological entity should be left to time and not rush to equate the d velopment of psychological trauma with life in quarantine. Every psychological trauma and reaction to it has its latent period, during which the child's inner psychic potentials have the task of coping with the traumatic experience on the basis of which a manifest mental disorder will or will not result. Whether the life of a child in quarantine, without direct association with peers, with monitoring of school classes online, with the already mentioned situations within the family, will be a truly traumatic experience for a child and result in a new type of psychological trauma, is not yet known. For now, we can not say anything definite. It is to be assumed that there will be negative consequences, but in what clinical form and to what extent, only time will show, but also new scientific research in this area.

At this moment, it is not yet possible to professionally elaborate on these premises and the parallels between life in quarantine, the immediate reaction to stress and the possible occurrence of a permanent mental disorder. This will be possible only after a certain time lag, as is the case with the onset of post-traumatic stress disorder resulting from the action of nosological factors to which life in quarantine does not belong.

It is necessary to mention the assessment of the family's potential and its response to the crisis as a (dys)functional unit, for example, to assess whether the living conditions of the child in question are sufficient for the young psyche to resist the change in living conditions brought by quarantine. However, since this is certainly an integral part of the daily work of psychologists, pedagogues, social workers, teachers and other profiles dealing with children, further elaboration on this issue at this point does not seem necessary.

Children with special needs and life in quarantine

As much as it seemed to the parents of healthy children that quarantine brings a number of unpredictable situations in dealing with children. However, when it comes to children with special needs, the situation becomes much more complicated. It should be immediately pointed out that this is the domain of work of special pedagogues, occasionally psychiatrists - especially when the application of drug therapy is needed, but there is also a side where the need to involve a psychologist is shown.

An obvious problem for all children, in general, is the extreme limitation of their ability to move when they are in quarantine conditions. We can only imagine what this means for children with special needs, where motor skills are one of the most important ways of expression. It is neither possible to adequately explain to these children the new situation in their lives and the lives of their families, nor is it possible to do a substitute activity. This is a great challenge for the parents of these children in terms of education, especially since there is no possibility of direct social engagement such as staying in institutions and occupational therapy. Therefore, parents of these children should be put in the focus of professional help here and try to show them ways to spend time with their children.

The attitude of the parents of these children towards their upbringing is caring, but sometimes overly caring, which is quite understandable. However, there are also those who transfer their parental responsibilities to institutions. This is very important for a psychologist to recognise, who finds himself in a situation to advise those parents. These are situations where it may be necessary to consult a psychiatrist.

It is important to also mention children of divorced parents, where regular visits to a parent with whom they do not live are often absent during quarantine, and all depend on the goodwill or refusal of the parent with whom the child lives to maintain or disintegrate contact with the other parent. However, the issue of the consequences of parental divorce on the child's psyche is in itself a particularly delicate area in the psychological sense: extensive, diverse and unpredictable, so within the topic of this presentation, it would be necessary to approach it from a special angle and with special attention, for which the framework of this paper is insufficient.

Experienced experts of all profiles, who deal with children's health problems, will certainly not miss this area and their special attention to these children will not be missed.

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Growing-Up in a Family or Alternative Care

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Summary

Growing-up consists of complex processes of growth, development and maturing. A child can`t grow- up alone; a child needs its family to feel loved, safe and accepted. Parents create a family and they are the ones that create emotional climate – the most important factor in healthy development. Parenthood is the most complex mission life can offer us. Most parents achieve that «mission» with love and success, unconditionally and constantly, «learning» parenthood lessons day by day.

Some parents fail in doing it. Emotional climate created in insufficient parenthood is not a safe environment for children and adolescents to grow-up in. In such families the climate is filled with conflicts, and developmental processes follow «wrong paths», slow down or are stopped. Clinical practice in child and adolescent psychiatry demonstrates a spectrum of psychological/ mental difficulties in children that grew up in such families.

Some disfunctional parents can learn to be better parents, often with help of experts in the field. Some parents accept «parenthood lessons» with difficulties.

In such situations, institutional interventions, that have to evaluate parental competencies and decide on alternative models of care, are complex and demanding tasks that seek high level of expertness in all members included in the process. Isolating a child from its primary family is not an easy decision. It is even harder to yield that decision in the right moment and not harm developmental processes in child/adolescent that are already «undermined».

Key words: *children and adolescents, developmental processes, parenthood, alternative care*

Sažetak

Odrastanje obuhvaća složene procese cjelokupnog rasta, razvoja i sazrijevanja. Dijete ne može odrastati samo. Ono treba svoju obitelj u kojoj se osjeća voljeno, sigurno i prihvaćeno. Obitelj stvaraju roditelji i oni kreiraju emocionalnu klimu - najvažniji čimbenik zdravog razvoja. Roditeljstvo je najsloženija zadaća koju nam život nudi. Većina roditelja tu „zadaću" uspješno, bezrezervno, postojano i s ljubavi ostvaruje, "učeći lekcije roditeljstva u hodu".

Neki roditelji u tome ne uspijevaju. Emocionalna klima koju kreira insufijentno roditeljstvo nije siguran prostor u kojemu djeca i adolescenti mogu zdravo odrastati. U tim obiteljima se stvara ozračje bremenito konfliktima, u kojemu razvojni procesi djece kreću „krivim putem", usporavaju se ili zaustavljaju. Klinička praksa dječje i adolescentne psihijatrije pokazuje čitav spektar psihičkih/psiholoških poteškoća djece iz ovakvih obitelji.

Neki disfunkcionalni roditelji uspijevaju naučiti biti bolji roditelji, najčešće uz pomoć stručnjaka. Neke roditelje je teško naučiti roditeljstvu.

U tim situacijama intervencija institucija, koja treba procijeniti roditeljske kompetencije, te donijeti odluku o alternativnim oblicima skrbi složen je i zahtjevan zadatak koji traži visoku razinu stručnosti svih sudionika u tom procesu. Izdvajanje djeteta iz primarne obitelji nije nimalo laka odluka. Još je teže tu odluku donijeti u pravo vrijeme i ne naškoditi već ionako „uzdrmanim" razvojnim procesima djece/adolescenata.

Ključne riječi: *djeca i adolescenti, razvojni procesi, roditeljstvo, alternativna skrb*

Introduction

Growing up includes complex processes of overall growth, development and maturation from the birth of a child to the attainment of maturity status. (Blos, 1962) A child cannot grow up alone. It needs a family in which it feels loved, safe and accepted. The family is created by the parents, and they create the emotional climate in which the child grows up. Families differ in many ways - primarily by personality traits of the parents, upbringing styles, systems of moral values and norms of behavior. (Tadic, 1981)

Parenthood

To be a parent is a desire that belongs to the dialectic of narcissistic conflicts. The parent, in the parental role, identifies with his own parents, acts on its own way, and is able to feel how he/she creates and how much fulfillment he/she gains from this creation. (Nikolic, 1988) Parenting is the most complex task that life offers us, a role in which we give ourselves unreservedly, constantly and with sincere love, a role that we all "learn on the go". (Graovac, 2010)

Most parents respect their children, accept their parental role responsibly, respect the importance of both parents for the child's development, and do not set up competitively. Most parents worry if they are "good enough" in parenting, because parenting is not just a positive or a negative experience, it changes following the developmental cycles of the family and the developmental processes of the child. Parenting is accompanied by ups and downs and crises. (Pernar, 2010)

It is very important that professional help is available for parents who need guidance and support in fulfilling their parental role. The quality of parental care depends on the personality traits of the parents, interpersonal relationship of the parents, the harmonization of their parenting styles, as well as the experiences of the parents during their own growing up.

Parents' expectations focused on their children, as well as on their own parental role, represent significant factors in shaping and realization of the parenthood.

The theory of social learning points to basic features of parenting - respect for the child's developmental readiness, the predominance of reward and gratification over punishment and frustration, showing love and respect, clear and consistent rules, open communication and age-appropriate level of freedom given to the child in decision making. (Hay et al., 2010, Berneir, 2010)

Healthy parenting necessarily involves parental authority and the emotional availability of parents. It gives a lot of love and warmth, but also control. The described parenting style is unquestionably appropriate for the child's early development, because it sets boundaries that are important in upbringing. Healthy parenting encourages development of the child's characteristics (curiosity, self-confidence, independence and good school success), democratic authority, communication skills with the child, encouraging the child with respect for his/ her individual characteristics, not insisting on the right of the adult to which the child must adapt. Children raised in conditions of the described parenting style will develop feelings of trust, honesty, respect and mature responsibility. (Vasta, 1997) For proper development, the most important thing is the emotional climate in the family environment in which the child grows up. (Nikolic, 1988)

Some parents fail to be good parents. In the spectrum of immature behaviors of parents, role "swapping", developmental interferences, child neglect, violence against children or in front of children are often observed. Denial of emotional availability of parents is a feature of dysfunctional families and presents a risk for developmental processes of the child. The emotional climate created by insufficient parenting is not a safe space in which children can grow up healthy. In these families, an atmosphere of conflict is created, which results in children's developmental processes going "wrong", slowing down or stopping. The clinical practice of child and adolescent psychiatry shows a broad spectrum of psychological / mental difficulties of children raised in such families.

Some dysfunctional parents manage to learn to be better parents, most often with the help of professionals. Sometimes it is very difficult to teach some parents on parenting.

Attachment

The emotional climate in the family is very important for the proper development of good and secure attachment - one of the fundamental characteristics of a healthy personality. Describing the importance of attachment, Bowlby (1982) states: "For mental health, it is believed that it is essential that a young child feels a warm, intimate and lasting relationship with his/ her mother (or permanent surrogate mother) in which they both experience joy and satisfaction." (Bowlby, 1982)

Attachment is a natural bond between a child and his/ her mother, a specific type of communication that enables development of a close emotional relationship, where they influence each other, adapt to each other and pave the way for the development of attachment. Experiences of interaction with the mother are grouped together and create a system of representations that shapes the child's behavior. Attachment is important for emotional regulation.

Young children are not able to regulate emotions on their own, the mother is the child's regulator of affects. (Pernar, 2008) Safely attached children have a sense of security, trust in others, positive expectations, sensitivity to inner states, empathy. Attachment disorders result in disorganization of behavioral patterns and impairment of capacity for self-regulation of stress and affect. (Vlastelica, 2014) Insecurely attached children show a spectrum of behavioral pathology - from avoidance or ignore, through angry rejection mixed with seeking of intimacy and contact, to confused, aimless and disorganized behavior.

Assessment of parental competencies

Assessing parental competencies and deciding on alternative forms of care is a complex and demanding task that requires a high level of expertise of all participants in the process. Separating a child from the primary family is not an easy decision. It is even more difficult to make this decision at the right time, considering possible consequences on previous and further developmental processes of children and adolescents.

The examples that follow below illustrate the complexity of assessment of parental competencies, as well as the possible consequences on children's development in situations when decisions are made too quickly or too slowly.

> *Vignette 1 - an example of the effects of too slow institutional interventions: Assessment of parental competencies of a single father of two boys (8 and 4 years old) one year after children were temporarily placed in the institution.*

Parents are characterized by a chaotic model of family life in the primary and secondary family, impulsiveness, unplanned parenthood. The mother left her partner and children, according to the father she never took care of children, he took care of everything and "everything was fine" until they started going to school. The first report of the social care center, which states the opposite, dates from the time when the younger child was 2.5 years old. From the moment the older boy started going to school, there were a number of reports from the school professional staff that point to marked difficulties in adjusting to and engaging in the minimum tasks that were required.

During the first semester of first grade, school reports indicate serious problems of the boy who "is unable to sit for long, disturbs other students in the classroom, rolls on the floor of the classroom and school hallways, stabs them with pencils, pushes, beats, disrupts order, destroys other students' belongings, steals, shouts, uses inappropriate vocabulary, does not listen to the content of the school hours, does not take notebooks or books out of the school bag even though his teacher demands he does so, runs away from the classroom, and lately even refuses to go home ... "

The Social care center initiates the process of assessing parental care.

Significant family dysfunction is observed during parenting assessment. Both parents had a difficult upbringing, achieved poor school success, dropped out of school early, were employed occasionally for shorter periods of time, and therefore did not provide for the necessary socio-economic conditions for the family. Their partnership is superficial, burdened with contradictions, role swapping, shaped by the pathology of similar, immature partners. The psychological/ mental profile of the father has characteristics of personality disorder, with limited possibilities of treatment and correction of behavior due to the ego syntony of his pathology.

Both children show behaviors that belong to the pathology of Attachment Disorder - disorganized, confused, aimless and aggressive behavior. Children are at a high risk, and developmental processes could not "wait" for possible parental corrections that could take several years.

The psychological development of children with attachment disorder in the described example shows that pathology in children already exists, and in the future we can expect progression in the direction of psychopathological disorders during childhood, adolescence and adulthood - from behavioral disorders/ personality disorders to psychotic disorders.

> *Vignette 2 - an example of the effects of too rapid institutional interventions: Assessment of parental competencies in a complete family with three children (15, 14 and 12 years of age).*

The Social care center, based on the school's notice, is initiating procedure with a suggestion of separation of the oldest daughter for one year, because she, for the second time, repeated the same class.

The medical documentation recorded daughter's health problems in the last two years, three surgical procedures, one surgical procedure in preparation, psychosomatic symptoms and difficulties, frequent medical examinations and follow-up. Until then, the child had been successful in fulfilling school obligations and manifested adequate behavior.

After occurrence of health problems, she often misses school. The school notes difficulties in cooperation of school staff with parents. The family doctor's report does not indicate elements of child neglect.

Family milieu analysis indicates specific family dynamics. In addition to the health problem of the oldest daughter, one son is a child with special needs, and the youngest son is hypersensitive, prone to psychosomatic reactions.

The daughter was, with justification, absent from school after surgical procedure, and when she returned to school, she felt that others do not believe her and that they do not want to help her, she felt cheated. The new retraumatization is intensified with the change of school.

In their parenting style, parents are protective of all their children, which is certainly partly due to the increased involvement of parents towards the child with special needs. Namely, their experiences of seemingly "banal" situations that have realistically progressed into serious and life-threatening health situations in the case of their middle child, have justifiably made them more cautious. School professional staff "trivialized" psychosomatic disorders and exert "pressure" in order to help, which leads to the opposite effect - a drop in school achievement and repetition of class on two occasions.

School failure, observed isolated from specific family circumstances, may seem as a result of insufficient parenting, but parenting analysis, in this case, shows otherwise.

Parents nurture a specific way of dealing with stress – the father practices exercise and "suffering", and the mother is sensitive, subdepressed, easily cries. Family style contains the message that difficulties should be dealt with "n a quiet and patient way" protecting each other. The father, while protecting both mother and children, takes on the heavier part of parenting. Family dynamics and patterns of coping with difficulties in which suffering dominates form a fertile ground for psychosomatic reactions in response to stressful situations.

But in the family, there is closeness, attachment and sharing of life's difficulties that need to be respected. Families need help – support for the parents and help children to better cope with stressful situations. Analysis of family relationships and family dynamics shows no signs of child neglect. In conclusion - there is no basis for separating the child.

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Too rapid interventions by the institutions in this example bring new stressors for parents, lead to destabilization of parents and parenthood, which leads to new traumatization of all family members, including parents and all children. In other words, there is a retraumatization of the whole family, which results in increased anxiety, increased depression of all family members, which forms fertile ground for an increase in psychosomatic reactions as a way of coping with stressful situations in children. Separating a daughter for a year is a "threat" to the family, which leads to a "thickening" of the family, which, observing the expected developmental processes (the daughter is in early adolescence) leads to regression. The developmental tasks of adolescence would, in the case of separation of the child from the family, have to be "on hold", with subsequent difficulties in terms of identity development, which would result in "delayed adolescence".

Conclusion

Parental emotional health is key to healthy parenting. "If a child has healthy parents, he/she will learn healthy principles: that love means protection, care, loyalty, sacrifice. If he/ she has emotionally unhealthy parents, the child will unconsciously incorporate a clear lesson of their problematic relationship: that love suffocates, that anger instills fear, that addiction is humiliating, or one of a million other harmful variations" (Lewis, 2009)

Healthy parenting creates a healthy emotional climate in the family in which the path of attachment development is paved and flows along developmental lines towards strengthening security, developing independence, ownership of inner experiences, and understanding oneself and others. Dysfunctional parenting paves the way for risky development of children and adolescents.

The process of assessing parental competencies is a complex and demanding task that requires a high level of expertise of all participants in the process. Therefore, expert assessment of attachment in the parenting assessment process is extremely significant and useful. Separating a child from the primary family is not an easy decision. It is even more difficult to make this decision at the right time and not to harm the already "shaken" developmental processes of children / adolescents.

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PROFESSIONAL ARTICLE

PSYCHOTHERAPY IN ACHIEVING HEALTH AND WELL-BEING FOR CHILDREN AND YOUNG PEOPLE
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Parents and Adolescents

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Summary

When a child reaches the developmental stage of adolescence, a new dynamic emerges in the family between parents and adolescents. The developmental tasks of adolescence bring new and different relationships to which both parties need to adapt.

During the process of growing up and separation from parents, in an adolescent's life new significant others appear. These new object relations and new connections create a very slippery field between the adolescent and his or her parents. The generational gap among parents and adolescent is inevitable.

However, adolescence does not happen only to adolescents, it also affects parents in a different, specific way. Developmental tasks and developmental processes in adolescence require high capacities for adjustment from both, the adolescents, and their parents. Along with the adolescent growing up, his parents are experiencing changes.
Parents of the adolescent, just like a mother for a little baby, must be present so that their adolescent could separate from them and develop, grow up.

Key words: *adolescence, family, developmental tasks, adjustment*

Sažetak

Kada dijete dostigne razvojnu fazu adolescencije u obitelji se pojavljuje nova dinamika između roditelja i adolescenata. Razvojne zadaće adolescencije donose nove i drugačije odnose na koje se obje strane trebaju prilagoditi.

U procesima odrastanja i odvajanja od roditelja na obzoru adolescenata pojavljuju se novi značajni drugi. Ove nove objektne relacije i novi odnosi stvaraju vrlo skliski teren za sukobe na relaciji adolescent - roditelji. Generacijski jaz između roditelja i adolescenata gotovo je neizbježan.

Međutim, adolescencija se ne događa samo adolescentima, ona se na specifičan način događa i njihovim roditeljima. Razvojne zadaće i razvojni procesi u adolescenciji traže i od adolescenata i od njihovih roditelja kapacitete za prilagodbu. Usporedo sa adolescentom koji odrasta, i njegovi roditelji doživljavaju promjene.

Roditelji adolescenta, kao majka malom djetetu, moraju biti tu da bi se adolescent od njih mogao odvojiti i odrasti.

Ključne riječi: *adolescencija, obitelj, razvojne zadaće, prilagodba*

Introduction

Adolescence is a developmental period by which the process of growing up is finalized. When children reach the stage of adolescence a specific phase of the family life cycle begins, which sets new tasks and goals for both the adolescent and the parents of the adolescent.

Families differ in many ways. Primarily through the personality traits of the parents, educational styles, system of moral values and norms of behavior. In a healthy family system, parental couple makes up one subsystem and the children another. In families, there are different ways and different levels of communication between members. All of those factors mentioned above interact with each other and affect all family members. In the developmental period of adolescence, earlier relationships are now questioned and shaped in a different unique way. Adolescence is a developmental phase in which further development achievements are built on earlier ones, but, as psychoanalysts state, it is also a time for a “second chance” or correction of unresolved conflicts of earlier developmental stages. During adolescence, developmental corrections are possible due to the significant potential for neuroplasticity of the brain, which decreases after the end of adolescence.

Normal and pathological in adolescence

Due to the range of diversity of adolescent behavior, and differences in cultural and social norms of behavior, it is very difficult to determine what is normal and what is pathological in adolescence.

Whether or not the environment will accept some adolescent behaviors depends more on environmental standards than on the adolescents themselves. Environmental standards include value systems, cultural and moral norms, but also the threshold of sensibility for adolescent behaviors. Often, adults have more capacity and justification for children's misdeeds, while they are very critical of adolescent behaviors. It seems that adults can more easily retain the memory of the "child within" than the "adolescent within".

The seemingly comfortable and adapted behavior of an adolescent does not necessarily directly mean good mental health; it can also be an expression of passive obedience to the demands of the environment. Passivity, resignation and uncriticism are not traits that lead to the development of a healthy, responsible and socially mature person.

Parents

Being a parent is a desire that belongs to the dialectic of narcissistic conflicts. Becoming a parent means identifying with your own parents and being able to act in your own way. Being a parent to an adolescent is a different position of parenting compared to the earlier developmental stages of a child. During adolescence, a lot happens for the first time - to both adolescents and their parents.

From an adolescent's perspective, his parents look like two middle-aged people, who happen to be his parents, who are much worse than the parents of his friends and the only thing they know is to invent stupid rules and complain. The gap between parent and adolescent stems from the parents' experience that "the child is two years younger than his or her real age" and the adolescent's experience that he or she is "two years older than his or her real age". This gap is difficult to overcome due to the adolescent's constant oscillation between mature and childish behavior, which recognizes the adolescent's dilemma – TO GROW UP or NOT TO GROW UP.

In principle, parents find it difficult to bear the adolescence of their children because everything in adolescence takes place rapidly. Adolescent behavior sometimes seems consistent with inner feelings, but very often it is completely opposite and defensive. Adolescents often feel that their parents do not understand them, and parents feel as if everything they say and do is in vain. In conversations, "both sides" have the experience of talking via "deaf phones".

Boundaries in adolescence

A generation gap is inevitable, especially in preadolescence and early adolescence. During these periods of growing up, parents have the most problems with their adolescents. Parents have the experience as if everything they have taught their children until then has disappeared without a trace, and the feeling of helplessness that some parents talk about is particularly difficult. In adolescence, all family functions are called into question, especially boundaries. The adolescent needs the boundaries set by his parents so that he can "break them down". This need to push boundaries is one of the specific urges in adolescence and that is why the adolescent needs them. It is the parents who set them up, not the adolescents.

The boundaries should be "neither too firm yet clear, nor too soft yet recognizable". Although it is the parents who set the boundaries and the adolescent the one who needs to break them down, parents are expected to allow the adolescent to experiment within and outside the boundaries of the family system. If there is no limit, the adolescent rushes into new experiences, has a feeling of great freedom, but at the same time deep down he thinks that his parents do not care, that he is not important to them. In these circumstances, the adolescent easily enters into conflicts with his environment by checking unconsciously whether the parents will notice it.

In conditions of too tight and rigid boundaries, where adolescent attempts to separate are sanctioned or punished in harsh ways, it is difficult for the adolescent to attach to peer groups. These adolescents remain lonely, without friends and either remain "attached" to their parents or join any group of peers who want to accept them into their ranks. The importance of adolescent groups, both constructive and destructive, is very great.

Parents can hold boundaries in an appropriate way if their partnership is stable. In a healthy family system, the strongest emotional connection is between parents, despite the fact that, by the definition of the family, its basic function is to raise children. Only in families with a quality parental relationship (marital or extramarital), a clear division of roles, clear boundaries, and a clear attitude toward authority can we expect a proper upbringing and a successful completion of an adolescent's search for identity.

Parental behavior

Parents who show excessive attention or excessive concern do not help their adolescent grow up. Furthermore, if parents constantly criticize the adolescent or try to fight his "battles" at school instead, they only increase the gap and misunderstanding between friends or family. Too violent environmental reactions to an "adolescent's internal and external storms" can significantly reduce his or her own defenses and ability to cope with tension. Crises can become more frequent leaving an adolescent with a sense of destructive insecurity and distrust of those closest to him.

It is not easy for parents to understand and accept that their, until yesterday a small child, now needs some other people with whom he wants to hang out, when until recently he spent most of his extracurricular time at home or near the house. The parent also needs time to get used to the new situation in which the child "now shares with others".

During the developmental period of adolescence, both parents and adolescents experience their depressive states. Parental grief and parental fears are processes those parents need to overcome, respecting growing up as well as rules and boundaries as a necessity. A child who grows up should be allowed to grow up, to find his own path, and it is not good to "tie" him too much or "let him go" too quickly. As contradictory as it may seem at first glance, the adolescent does not "leave" his parents without grief. Depressive states in this phase of "untying" are completely normal and common occurrences of growing up. These depressive states are part of the developmental process that allows the adolescent to accomplish developmental tasks and achieve their independence. Just as in early childhood it is necessary for the mother of a small child to be with the child in order for the child to leave her, so in adolescence the parents need to be there for the adolescent to be able to separate from them.

Dysfunctional families

A small number of adolescents fail to solve the developmental tasks of adolescence, partly due to hereditary potential, partly due to unresolved tasks of earlier stages of development that precede adolescence, due to parental psychopathology or due to some of the many aspects of family dysfunction.

Families that are dysfunctional nurture specific systems and beliefs that we call “family myths”, and are expressed indirectly or not at all but are implied. They depict the personality traits of parents, their parenting styles, systems of moral values, and norms of behavior. “Family myths” affect the daily functioning of the family, and their impact is particularly strong in times of crisis in the family, such as the family with adolescence, when the developmental processes of adolescence require change and adjustment from the family as a whole.

An adolescent in a family that functions according to the rules of the family myth “absolute togetherness” has no possibility of separation from parents. In such families there is no privacy of members, no secrets or personal property. All family members function according to the rule “everything is ours and everything is shared”, including space, time, things, interests, and impulses...

In families where the rule “everything is in the family” applies, the adolescent is given a message that outside the family one should not look for pleasure, emotional connections or anything else, because everything outside the house is dangerous and hostile. Adolescents from such families perceive the world as a dangerous place where it is best not to even go, but to stay in the family. There are no ideal families, although some families think they are.

In “ideal families, any dissent or opposition qualifies as hatred or a threat to leave. An adolescent from the “ideal family” must choose between the right to a different view of the world from his parents and the parent themselves, and he can easily lose his own identity.

“Democratic families” sound very attractive to adolescents, but the family as a peer society, in which there are no boundaries between family subgroups, where often mothers and daughters exchange clothes and makeup or fathers and sons go out together looking for fun is not a family that offers what children and adolescents need for healthy development.

The use of authority is a necessary feature of the parent subsystem. Parenting always requires the use of. Parental authority should be inversely proportional to the age of the child, as the child gets older, more mature and more responsible the need for the parental authority diminishes. The weak parental subsystem, due to its own insecurity and inefficiency, easily falls into the opposite of constant checking and ordering, and thus leads to the denial of individuation, separation from parents and growing up.

Emotional climate in the family

For proper development, the emotional climate in the family environment in which the child or adolescent lives and grows is of paramount importance.

If the emotional climate in the family is disturbed by constant conflicts, the adolescent's search for his own identity will be difficult. An adolescent who is preoccupied or involved in parental conflict, who lives in difficult social conditions or in a family with a seriously ill member or is seriously ill himself has no space to grow up on his own and is forced to become very serious.

Nature does not tolerate skipping and it is very likely that these people will later enter the phase of "second adolescence".

Therapeutic interventions in adolescence

Therapeutic interventions in adolescence are needed when developmental processes take an undesirable course. In addition to therapeutic interventions involving the adolescent, it is important to assess the extent of parent-centered therapeutic interventions required. Therapeutic interventions involving the whole family aim to establish clear boundaries between subsystems in the family (parents - children), strengthen the subsystem of the parent pair, improve communication within the family, help adolescent separation and individuation and create stability consistent with the developmental stage of the adolescent family.

In other words, the goal of therapeutic intervention in psychotherapeutic work with adolescents should be focused on both adolescents and their parents. The laws of physiological development are always a good indicator of the direction of psychotherapeutic intervention.

Dysfunctional families

A small number of adolescents fail to solve the developmental tasks of adolescence, partly due to hereditary potential, partly due to unresolved tasks of earlier stages of development that precede adolescence, due to parental psychopathology or due to some of the many aspects of family dysfunction.

Conclusion

Parenting is the most complex task that life offers us, a role in which we give ourselves unreservedly, constantly and above all with sincere love to our children, but a role that we all "learn as we go along". The temptation of parenthood lasts as long as it does, and it is certainly most complex in adolescence, because it happens to parents as well, not just their adolescents.

The therapeutic alliance built by the adolescent, parents, and psychotherapist, represents a jointly created space in which positive shifts in the treatment of adolescents and directing developmental processes towards healthier options are possible.

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Childhood Trauma and Developmental Processes

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Summary

The importance of childhood trauma on development processes are described in numerous studies. Traumatic childhood experiences have a profound impact on many different areas of child/adolescent functioning - on an emotional, behavioral, physical, cognitive, and thought level.

Clinical entities associated with the traumatic experience in children and adolescents are common in psychiatric practice. Frequent manifestations of these experiences are described as PTSD, but also as depression, as anxiety, or somatization, as behavior disorders or dissociative reactions. In clinical work with children and adolescents, it is necessary to emphasize the importance of understanding traumatic experiences through the dimensions of developmental processes.

This article illustrates the complexity of the clinical presentation of adolescents with a traumatic experience during childhood.

Key words: *child, adolescent, development processes, trauma, psychopathology*

Sažetak

Traume doživljene tijekom djetinjstva i utjecaj trauma na razvojne procese opisani su u brojnim studijama. Traumatska iskustva tijekom djetinjstva imaju intezivan tjecaj na mnoga različita područja funkcioniranja djeteta/adolescenata - na emocionalnoj, bihevioralnoj, fizičkoj, kognitivnoj i misaonoj razini.

Klinički entiteti povezani s traumatskim iskustvom u djece i adolescenata česti su u psihijatrijskoj praksi. Manifestacije ovih iskustava opisuju se kao PTSP, ali i kao depresija, anksioznost ili somatizacija, kao poremećaji ponašanja ili disocijativne reakcije. U kliničkom radu s djecom i adolescentima potrebno je naglasiti važnost razumijevanja traumatskih iskustava kroz dimenzije razvojnih procesa.

Ovaj članak ilustrira složenost kliničkih slika adolescenata s traumatskim iskustvom tijekom djetinjstva.

Ključne riječi: *dijete, adolescent, razvojni procesi, trauma, psihopatologija*

Introduction

The importance of childhood trauma on developmental processes are described in numerous studies. Traumatic childhood experiences have a profound impact on many different areas of child/adolescent functioning - on an emotional, behavioral, physical, cognitive, and thought level. Children and adolescents can experience traumatic situation in family, school, and society, as well as participants in natural disasters, war, terrorism, epidemics and other forms of violence and tragedies.

Clinical practice of child and adolescent psychiatry many times shows that most of childhood trauma begins at home.

Childhood trauma

Isolated but intense traumatic events tend to produce conditioned behavioral and biological responses in children and adolescents, most commonly with the manifestation of a spectrum of PTSD diagnoses. Recurrent traumas have a strong adverse effect on the development of the mind and the brain. Chronic trauma has a pervasive effect on neurobiological development of the child and adolescent.

In conditions of healthy development, child learns to regulate his own behavior by anticipating his caregiver's responses to him. These interactions allow him to create "internal work models," through the internalization of the affective and cognitive characteristics of their primary relationships. As early experiences are gained in the context of the developing brain, neural development and social interaction are inseparably linked. According to Tucker (Tucker, 1992) "For the human brain, the most important information for successful development is conveyed by the social rather than the physical environment. The child's brain must begin participating effectively in the process of social information transmission that offers entry into the culture. "

Early patterns of attachment shape the quality of information processing throughout the life span. Secure infants learn how to trust - what they feel and how they understand the world, that allows them to rely both on their emotions and thoughts to react to any given situation. Their experiences of feelings understood provides them that they can make good things happen, but if they do not know how to deal with difficult situations, they can find people who can help them. Safe children learn words to describe their emotions, learn to communicate and express their feelings. They can describe their physiological states (e.g., when they are hungry or thirsty) as well as emotional states (e.g., when they are sad or happy). Their parents can recognize how their children are feeling and help them when they are in trouble to regain a sense of security and control. Secure attachment relieves suffering caused by trauma.

When trauma occurs in supportive families, the child's reaction is likely to resemble that of a parent. In conditions where the trauma is massive or when the caregivers themselves are the source of the traumatization, children cannot modulate their arousal. This causes a breakdown in their ability to process, integrate and categorize what is happening.

At the core of traumatic stress is a breakdown in the ability to regulate internal states. If the traumatization persists, children dissociate - relevant sensations, affects, and cognitions cannot be connected (separated into sensory fragments) and, as a result, these children cannot understand what is happening or devise and take appropriate action plans.

When caregivers are emotionally absent, inconsistent, frustrating, violent, intrusive, or neglectful, children are liable to become intolerably distressed and unlikely to develop a sense that the external environment can provide relief. Thus, children with insecure attachment patterns have trouble relying on others to help them, while unable to regulate their emotional states by themselves. As a result, they experience excessive anxiety, anger, and longings to be taken care of. These feelings may become extreme and lead to dissociative states or self-defeating aggression. Spaced out and hyperarousal children learn to ignore either what they feel (their emotions), or what they perceive (their cognitions).

When children are unable to achieve a sense of control and stability, they become helpless.

If they are unable to understand what is happening and cannot do anything to change it, they switch from a (stressful) stimulus to a (fight / flight / freeze) response without the ability to learn from experience. In situations after that, when they are exposed to reminders of a traumatic experience
(images, sounds, smells, physiological states, situations, etc.) they tend to behave as if they have been traumatized again – a catastrophic sensations. Many of the problems of traumatized children can be understood as the child's effort to minimize an objective threat in order to regulate emotional stress. Often the environment does not understand the nature of the child's / adolescent's behavior, it could be described as oppositional, rebellious, unmotivated, or antisocial behavior.

Clinical practice

The reactions of the child / adolescent after the traumatic experience serve to change the senses associated with the trauma. Over time, tolerance grows for the experienced traumatic experience that is accepted as a part of life, which does not mean that the traumatic experience was unnoticed. Child / adolescent reactions are normal reactions to abnormal occasions, a set of feelings of thought, and actions aimed at mitigating the effects of the traumatic experience. During further development, psychopathological manifestations may occur that may not directly indicate the traumatic experience.

Clinical entities associated with the traumatic experience in children and adolescents are common in psychiatric practice. Manifestations of these experiences are described as PTSD, but also as depression, as anxiety, or somatization, often as behavior disorders or dissociative reactions. The diagnosis of PTSD is not developmentally sensitive and does not adequately describe the impact of exposure to childhood trauma on the developing child. Currently clinicians have no other diagnostic entity that describes the pervasive impact of trauma on child development. These children are given a range of "comorbid" diagnoses, as if they occurred independently from the PTSD symptoms, none of which do justice to the spectrum of problems of traumatized children, and none of which provide guidelines on what is needed for effective prevention and intervention. Underneath depressive and anxiety states, somatization, behavioral disorders, or dissociative reactions in clinical practice, we often find traumatic experiences.

The examples that follow below illustrate the complexity of the clinical presentation of adolescents with a traumatic experience during childhood.

Vignette 1: ANNA, 17 years
admitted to hospital with a diagnosis of depression

Symptoms at admission were reduced and unstable mood, anger, aggression against things, self-harm behavior. She has been living with her mother for the last 3 years, before she lived with her father and mother in low. Parent divorced when she was 4 years old. Mother's observations about Anna state self-harm from 14 years, last month worse than before, lack of communication, alone, without friends, worried her.

Anna's mother was treated because of depression. Actually she is unstable, confused, try to be supportive, but helpless.

Parents did not notice the traumatic effects of divorce and mother's depression on their child until she became depressed and began to self-harm.

Vignette 2: TINA, 14 years
admitted to hospital with a diagnosis of acute psychosis

Symptoms at admission were suicidal ideation, reduced and unstable mood, anger, aggression against things, screaming without control, problems in school and with pears...

For the last year she has been living with her mother younger brother and father in low, before she lived with her father and grandmother without contacts with mother. Parent divorced when she was 7 years old. Tina describes emotional abuse by her father and grandmother.

Tina's mother was treated because of depression after divorce, actually is stable, supportive, engaged, in stable partner relation. Tina has good relations with father in low.

Tina was discharged from the hospital with diagnoses Adjustment disorder, Short psychotic episode, Psoriasis, Reumatoid artritis. Motivated to continue treatment in the day hospital, which included individual and group psychotherapy and medication.

Vignette 3: MAIA, 13 years
admitted to hospital with a diagnosis of Anorexia nervosa

Symptoms at admission were reduced diet, low body weight, preoccupation with physical appearance, reduced and unstable mood, anger, suicidal ideation, aggression, peer problems.

Maia lives with her father, older brother, and father's parents. Her mother died when she was 7 years old. Her father is often absent due to obligations at work and a new partnership. Maia is not close with brother, he is "in his world". Lack of communication in family. All family members have their own way of dealing with loss. Interactions in family are reduced, focused on facts, without presenting or talking about emotions, non-stable, non-supportive atmosphere.

All patients are adolescents whose developmental processes are ongoing and are shaken by the experience of trauma that was not recognized. They show different ways of dealing with trauma, different levels, and qualities of relationships with family members. There are significant differences in the ability or inability of mothers / fathers to recognize the suffering of a child. Clinicians recognized different diagnoses when assessing hospitalization.

During the diagnostic process, traumatic experiences were found and presented in different ways in the clinical presentation.

Conclusion

Clinical entities associated with the traumatic experience in children and adolescents could be described as PTSD, but also as depression, dissociative reactions understood as acute psychoses, eating disorders or other diagnosis.

Trauma affects the processes of growth and development. Traumatic experiences affect children's expectations of the world, the security of living with others, and a sense of personal integrity. Trauma changes the inner images of the child's world, shapes the understanding of oneself and others, leads to expectations or expectations in relation to the future, affects present and future experiences and behavior.

In clinical work with children and adolescents, it is necessary to emphasize the importance of understanding traumatic experiences through the dimensions of developmental processes.

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Psychotherapeutic Treatment of The Boy with School Phobia

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Summary

In this case study I am going to represent my work with a boy aged 13, who is, at the first place, included into a psychotherapeutic treatment because of his school phobia. However, in the background of this school phobia, there were separation anxiety, early trauma experiences and the issue of attachment. This writing presents the importance of differential diagnostics when psychotherapeutic treatment with children and adolescents are in focus, as well the fact that in work with children and adolescents, we must be aware of the fact that the development of symptomatology lies in different samples and that is very important to look broader picture in treatment and not to bring conclusions too fast. Psychotherapeutic treatment was held in a continuous manner, 18 months, through 50 meetings. I used the principles of integrative psychotherapy. When choosing methods of my work and choice of interventions, I used theory and approaches od different psychotherapeutic directions, and the psychotherapeutic work with this boy was based on awareness, reparation, and integration of alienated parts of self, strengthening Ego and routing to present day and identity, as well as strengthening of his self-awareness in interaction with other persons. In this essay, the importance of bringing changes in the most important boy's environments: family and school, together with providing psychotherapeutic help to the boy, is emphasized too.

Key words: *school phobia, early trauma, attachment*

Sažetak

U ovoj studiji slučaja prikazaću rad sa dječakom u dobi od 13 godina koji se uključuje u psihoterapijski tretman prvobitno zbog školske fobije. Međutim, u pozadini školske fobije stajala su separacijska anksioznost, rana traumatska iskustva, te pitanje prvrženost. Rad pokazuje važnost i značaj diferencijalne dijagnostike kada je u pitanju psihoterapijski tretman sa djecom i adolescentima, te da u radu sa djecom i adolescentima moramo biti svjesni da razvoj simptomatologije leži u različitim uzorcima i da je u tretmanu važno gledati širu sliku i zaključke ne donositi prebrzo. Psihoterapijski tretman se odvijao kontinuirano, 18 mjeseci, kroz 50 susreta. U radu sam koristila principe integrativne psihoterapije. Pri odabiru pristupa u radu i izboru intervencija koristila sam se teorijom i pristupima različitih psihoterapijskih pravaca, a psihoterapijski rad sa dječakom se bazirao na osvještavanju, reparaciji i integraciji otuđenih dijelova selfa, jačanju Ega i usmjeravanju na sadašnjost i identitet, te jačanju svijesti o sebi u interakcijama sa drugim osobama. Također, u radu je istaknuta važnost unošenja promjena u dječakovim najvažnijim okruženjima, porodici i školi, paralelno sa pružanjem individualne psihoterapijske pomoći dječaku.

Ključne riječi: *školska fobija, rana trauma, privrženost*

Introduction

The school phobia arise as strong unreal fear of school that can become panic. The cause of development of the school phobia, according to psychodynamic learning, are difficulties in personality's organization, disorganized relation parents – child some social and cultural factors. School itself, as a phobia object, comes into this relation later (Tadić,2003). Children that suffer from this school phobia have certain features of the personality as it follows: enhanced insecurity, addiction, timidity, tendency to depressive and phobic answers, enhanced vulnerability, egocentrism and tendency to set-backs and projection. (Tadić.2003) For some of the authors phobia represents revival and repetition of tremble of the separation from the parents, and it is not school phobia- they suggest to call it like that. A child has no certainty into his/her parent's feelings and has a fear of abandoning. The mother of this boy had strong ambiguous feelings towards the boy from this case study. She had bad childhood and traumatic loss of her parents while she was an adolescent. She, herself, had a fear of separation and since the beginning, from the boy's birth she delivered her concerns and her fears. She is very much dominant in relation to the boy's father who gives impression of a passive and uncertain person. Tadić (2003) claims that a child, who grows in a family like this, feels overprotected and responds with animosity against addiction and fear from its own aggression.

To these answers, mother offers aggression and feeling of guilt, as well as new overprotection and compliance. Apart from this theory of the arise of the school phobia, I observed this boy's symptoms through Bowlby's theory of attachment. The attachment has a key role in a child's development, child's perception of relationship to others, because a child learns to be compassionate, learns social norms and controls behaviors which are not socially acceptable. This theory is important in development of one's idea of oneself, because a child through the relation with tutor strengthens perception of her/himself as lovable, worthy and competent. A child satisfies need for security, kinship, comfort and predictability through attachment (Bam and Morisson, 2011 according to Klarin, 2006). Based on parents' ability to perceive child's needs and respond to them, a child builds a picture about itself as a being who is (not) worth loving, caring and as a result it delivers conclusions about situations when a child has needs- if parents will respond or not. Since infantry period, inner model creates, which in the first place serves for interpretation and communication to parents, and later for development of relations to other people. In contact with this boy I recognized features of anxious – avoiding and ambivalent – antagonizing attachment.

Diagnostics and process of the treatment

The boy is 13 and he is in the second term of the seventh grade. He is an excellent student. The symptoms, which caused him to start with therapy, are strong fear from school that goes to panic, which then results in him being unable to attend school. At home, he is very fond of his school obligations. The boy feels fear on other places (home, street…) too, especially in the moments when he stays alone. He does not have developed relationships with other children of his age. He spends his time with his Granny gladly (his father's mother) who together with his mother takes care of him from his birth.

He sees himself as an old man, and he emphasizes that he does not have common features with other children of his age.

From hetero-anamnesis data I see that he was born from the first regular, planned and wanted pregnancy in natural way, on time. Immediately after his birth it is diagnosed that the boy was born with one kidney.

The other kidney had hydronephrosis (widened kidney channel) and it was surgically treated in his first month of life - two times. In his first year of life, because of his kidney problems, he had constant medical tests. A couple of times he was hospitalized, every time accompanied by his mother. Because of this health problem the boy has regular six month visits to doctors up to present day. Beside these kidney problems, in the first months of his life, deformities with both of his feet are diagnosed, and this needs constant doctors' supervision and interventions. During his first year of life, the boy constantly wears plasters and langetas which changed on monthly basis. His parents informed me that the wearing and changing these plasters vas very painful, and it constrained the boy from movement. Because of these feet problems, a boy did not crawl as toddlers do, and he started walking when he was 15 months old. The sphincter control was established when he was three. His parents told me that they did not force the boy to stop wearing diapers because of the kidney problems, and the boy himself wanted to stop using them when he was three. He pronounced his first words when he was two.

The first separation happened when he was one year old, when his mother turned back to her job after her maternity leave. His father's mother takes over and starts taking care of him. In the meantime, when the boy was three, he got a sister. His mother emphasizes that he took his sister's coming very well, and that he took part in taking care of his sister. He was not "hard" for upbringing. He did not like to play. Usually he took part in activities of the adults surrounding him. When he, in the age of five, started attending kindergarten, problems with adaptation to other children started appearing and it goes on in primary school. He was a victim of the bullying several times and that is the reason why he changed school.

His mother, at an early age lost both parents in a very traumatic way. Often, she feels depressive, especially after the boy's birth and dealing with his health problems. She is highly educated, employed and very committed to her job. His father is a craftsman. She is dominant person regarding to him. A few months before any of the boy's symptoms occurred, his mother started with psychotherapeutic treatment. (KBT approach is used- cognitive-behavioral therapy). The change needed by the treatment is turning back the roles that belong to her. In the first place, the roles of the mother and of the housewife, because she let the granny taking care of the kids and house chores. The boy is attached to Granny. Because all of that his mother limited his dwelling at Granny's to a period of one hour a day. These changes in family dynamics take places a month before this fear of school appearance. After that, mother stops her individual therapy.

Keeping in mind the health problems and staying in hospital during the boy's first year of life (these are early traumatic experiences) as well the stress that parents undergone during this period, traumatic losses that the mother had in her adolescence, negative experience of preschool and school environment, phenomenology of the boy's person organization and development of the symptoms, I observe through the theory as following: psychodynamic explanation of the school phobia origination, Bowlby's theory of attachment, Bronfenbrenner's theory of ecological system. The boy came to therapy with symptoms of school phobia. However, in the background of this phobia, there stood separation anxiety, early traumatic experiences and the issue of attachment. I made the treatment plan as following:

1. *To direct the boy to psychological testing*
2. *To work on the symptoms reduction, as soon as possible to strengthen the boy in attending school classes on a regular basis*
3. *To realize cooperation with school*
4. *After normalizing the process of the boy's attending the school, to work on the deeper processes which are connected to separation and attachment*
5. *To include parents into advisory and/or psychotherapeutic work in order to change family's dynamics and parents' attitude toward the boy*

After psychological clinical assessment were finished, it is concluded that "the case is about the boy that intellectually functions in rank more than average. It is hypersensitive, as well as rigid boy and in whose clinical picture separation anxiety dominates, and potential for development of obsessive- compulsive symptom is perceived. The boy is reserved in expressing his real emotions, thoughts and experiences, and that can be seen through a dialogue with him, in test results and through the high score on the control scale (his need to leave a positive impression about one self). It is necessary to work on reduction of the boy's multiple anxious symptomatology, strengthening of his self confidence and learning how to express his emotions and wishes without constraints through continuous therapeutic work."

The first contact and therapy are easy established, and that is a result of the boy's positive transfer as well as mine positive countertransference in relation with him. In the first part of the therapy I use formulations according KBT approach due to decreasing of feeling of fear and establishing possibility for him to go back to school as soon as possible and attend it regularly. The goal is achieved very soon, after a couple of meetings. After the fear from school had decreased, in the middle part of therapy, the space, for working on deeper processes related to reparation of attachment and separation, creates. I am aware that he is at chronological age when the process of leaving of parents idealization should take place and the beginning of the psychological separation from them, but because of fixation to earlier developmental phases and uncertain attachment, this process can not begin.

In the middle part of the treatment I use the principles Ziegler's treatment of the reconstruction of the attachment (safety, protection, accepting, belonging, trust, relations, picture of one self) I start the treatment and go on with the focus on establishing and maintaining therapeutic connection, as well as corrective emotional experience. It is of great importance for me that my message is "I can see you and I accept you as you are and I like you the way you are."

During our common meetings with the boy and his parents I perceive ambivalence of their experience of the boy. I consider these meetings very important, because it is present when I subtly confront to his parents, especially to the mother, when they express negative attitudes toward the boy. In the boy's presence, I always have consistent attitude toward the boy.

Strengthening of the social competencies and strengthening of his positive picture of himself are important parts of the treatment. Following the boy's rhythm, slowly the themes of bullying are opening. In the beginning, while opening these themes, dissociation from the feelings related to these painful experiences can be spotted. He retells the experiences as if they did not happen to him, and if emotions are shown, they are not harmonized with content they bear. He uses humor as a defense from painful memories. Space for reparation opens in places where suspense or time out in development had happened. On these places, slowly and carefully, by working through traumatic experiences of peer violence, we come to suppressed feelings, in the first place anger and helplessness, which he integrates. It is hard for him to accept and claim his own anger. This spot of working on anger is a spot of time out in therapy, because I work on similar processes myself in my therapy. After the permission to anger which he needed from me, he targeted it to his parents, especially to his mother, so the process comes opposite to idealization and to starting point of the separation from his parents.

In psychotherapy of children and adolescents, working with parents is very important, especially if a child is younger, because it is totally dependent of its parents. Parents are entitled to quit treatment at any time. Because of that, it is very important for me, to make kind of deal with parents that follows: disappearance of symptoms of the school phobia is not the end of the therapy. During treatment I meet parents every time. In the first part of the therapy with the boy, I have a short conversation with them, sometimes in the boy's presence, sometimes in private with them only. In advanced phase of the therapy I tend to meet them rarely. Both parents come to every meeting. While meeting them, mother is a leading figure in a relation to a father. The father supports everything that mother says, by nodding and only sometimes he delivers some of his experiences with the boy which only support her story. The mother always speaks in a half- quiet controlled manner of voice behind which I always feel suppressed aggressions. No matter what is the topic of the dialogue I start with, she always turns back to expressing boy's negative sides. All the time she repeats what "needs to be improved" and "what is not good" about the boy.

In my work with the parents I use consultations and psycho- education in order to understand psychodynamics of beginning of the symptoms and how they are important in overcoming of difficulties in the boy's functioning, as well for them to become aware of their unreal negative picture that they have about their boy and negative expectation that they have from him. I have meetings with them, both alone and in the boy's presence due to perceiving dynamics of their relationships, but also to demonstrate by myself how to be in the contact with the boy. The most challenging part of the therapeutic process was working with parents, because of the strong double countertransference which I felt towards boy's mother.

I consider the cooperation with the school as a very important of the treatment of this boy. In Bronfenbrenner's theory of ecological school systems, together with parents, represents part of microsystem, the "circle" that is closest to a child. Bronfenbrenner considers that a child and the environment (where a child develops and grows) permanently affect to each other. These influences are bilateral or transactional – between a child and the environment there is a reciprocal relation and mutual conditioning. Environmental conditions affect development of a certain child's characteristics but these influences depend on the nature and characteristics of a child itself, and partly they are shaped by themselves (FMK, 2011).

The boy was not included into individual treatment at school. However, in cooperation with school psychologist, teachers get instructions how to behave with the boy. Within the school, the boy got included into the program of development of social skills and it means him taking part in workshops together with the group of students from the school. As therapy went by, I myself became acquainted with his talents, capacities and interests. In cooperation with school psychologist, the boy was included into activities according to his interests. The success in these activities and excellent results he achieved as well as the changes that he undergone on the personal plan, open up possibilities of contact to his age-mates. Although he was an excellent student always, from the beginning of the therapy up to a present day, he really shines with his school achievements. He does not put a lot of efforts into studying, but natural intellect, doing school tasks in time, regular studying, strengthened stimulation, creating of highly positive attitude towards school, improvement of his relationship to his age-mates and teachers, as well as release from inner tension which resulted in resolving of inner conflicts as a result of the therapeutic process. They all give unbelievable results. Of course, it does not happen overnight. Together with the psychotherapy process, changes happen slowly. I see all these positive changes, which happen in the school environment, as a confirmation of Bronfenbrenner's theory of ecological system about mutual effect of parts of this system.

From the very beginning of the boy's encounter with preschool facility and primary school, his characteristics conditioned unfavorable answer of the environment which was unfavorable, too) changes that psychotherapy results on his personality plan (when we speak about his functioning and positive change of his picture of himself).as well as the changes that happen in new school environment, reverse mutual activities of the boy and school environment(teachers, peers),so the school becomes supportive environment. So, in a certain way, these factors take over the role of therapeutic and corrective elements when the boy finishes his treatment.

As the final part of the treatment, I consider his wish to finish the process. After 18 months of regular psychotherapy all of the symptoms vanished. The boy should start the ninth grade. He misses his friends and teachers. His view of himself and other people is changed. He does not attend extracurricular activities that he does not like and he obtained that over his parents. He is excellent in school. Also, his need to finish psychotherapy I see like confrontation to parents as well as mine authority. I consider to support him in that and that is an excellent intervention, especially because I know that significant changes are made in his environment, family, school. His family and school can be sufficient support on the way of healthy development.

Conclusion

The conclusion to this case study would be that it is important to keep the same principle: integrative approach, differential diagnostics and parallel to individual therapeutic treatment with a child, to organize work with parents and school, as well as regular individual psychotherapy of the therapist and supervision. In work with children and adolescence we must be aware that the development of symptomatology lies in different samples and that in treatment it is important to look broader picture and not to jump to conclusions too fast.

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