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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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Psychotherapeutic treatment of children and adolescents in creative relational family therapy[1]

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Summary

Relational Family Therapy understands the family as a system in which family members are interconnected and influence one another. Children's behaviour is understood as a response to systemic needs, therefore it is important for children to be included in the therapy to ensure systemic changes. For adults and older children, support in the form of a talk in psychotherapy can alleviate hardship; however, such support is not sufficient for younger children, or in those children who are growing up in violence, or experience abuse or painful separation from their parents. These children often block their feelings and have little knowledge of how to express them. Whatever bad things happen to them, they feel responsible and blame themselves. Since they do not yet know how to cognitively distinguish what is and what is not true about themselves, they can have false beliefs about themselves. Children who suppress their emotions do not feel good and have problems getting in touch with others, which can be reflected in behavioural, emotional and unexplained health problems. In order to get in touch with others and express their blocked emotions, they must first feel their body and be aware of their feelings, for which they need

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psychotherapeutic support. The therapist helps them express their emotions that are not accessible solely through verbal communication. In order to do this, the therapist uses creativity and includes various therapeutic techniques and strategies that are experiential, suitable for the child's development stage, and child friendly: projection photography, drawing, sandplay, puppets, family genograms, and clay. In the article we will present clinical practice and various creative ways that bring new experiences in the therapeutic process and enable children to change their ways of thinking, feeling and behaviour, and enable parents to understand and connect with children. The workshop will be experiential. Participants will be able to integrate theory into practice and try different creative techniques themselves. Acquired practical knowledge and personal experience can help psychotherapeutic treatment of children and adolescents and their families.

***Key words**: children, adolescents, Relational Family Therapy, creativity, experiential techniques.*

Introduction

Relational Family Therapy (Gostečnik, 2004) is an innovative psycho-organic model based on three basic levels of experience, i.e. systemic, interpersonal and intrapsychic; and these three levels are based on five relational mechanisms: projection-introjection identification, compulsive repetition, the core affect, the affective psychic construct and the regulation of the affect (Gostečnik, 2015). This model understands the family as a system in which family members are interconnected and interacting with one another, which allows the therapist to understand family dynamics, the interaction of relationships and communication patterns. When the family is in distress, it is extremely important that all family members participate in the therapy in order to ensure systemic change (Becvar & Becvar, 1982; Broderick, 1990; Ruble, 1999). The involvement of children in the therapy process is crucial because children often act as a barometer of the family system and its (non)functioning (Wolfe & Collins-Wolfe, 1983), while changes are lesser and slower when children do not participate in therapy (Keith & Whitaker, 1981). Children, however, differ in their level of understanding their world and the ability to successfully navigate in the adult world (Gelman & Bloom, 2000; Pereira & Smith-Adcock, 2011). Children under the age of eleven do not yet have a fully developed abstract thinking ability, which is a prerequisite for meaningful verbal expression and understanding of complex issues and emotions (Bratton, Ray, Rhine & Jones, 2005; Piaget, 1951). Even children with highly developed verbal abilities cannot adequately express their experiences, concerns, fears and internal struggles (Landreth, 2012). Children living in dysfunctional families, in which, for example, they experience violence, alcoholism, have experienced abuse, or are experiencing the painful divorce of their parents, block the feelings associated with traumatic events and have little knowledge of how to express them (Oaklander, 2006). Research in neurobiological development and psychological trauma (Morrison & Homeyer, 2008; Perry & Szalavitz, 2007) shows how play stimulates neural structures in the brain. Traumatized children re-experience traumatic events, as trauma often remains stuck in the nonverbal parts of the brain. Playing out the event with movement helps to awaken the memory from nonverbal parts of the brain to the frontal lobe (Morrison & Homeyer, 2008; van der Kolk, 1994). The most critical result of trauma is the loss of control, which has far-reaching consequences. The child is overwhelmed by stress, and if parents are the source of stress, the child cannot regulate and process the arousal in their autonomic nervous system, which destroys the ability to integrate what has happened. Sensations, affects, and thinking are dispersed into sensory fragments and are not connected (van der Kolk, 1987, 2005). Children tend to blame themselves for whatever bad has happened to them. Not being able to cognitively distinguish between what is true about themselves and what is not, they can form false beliefs about themselves. Children who thus repress emotions do not feel good and have issues in establishing contact with others, which can be reflected in behavioural, emotional or unexplained health problems. But in order to be able to get in touch with

others and express their blocked emotions, they need to feel their body and be aware of their feelings. To be able to do this, they need support (Oaklander, 2006). Support in the form of a talk in therapy can alleviate the distress of adults and older children, but it is not enough to provide therapeutic support for the youngest family members (Gil & Sobol, 2005). Symbolic play allows the child to control one part of her/his behaviour so that s/he can feel stronger (van der Kolk, 1987). The author (van der Kolk, 2005) also emphasizes the need of intervention, which includes movement and pleasant experience. A predominantly speaking approach thus does not capture the child's primary way of communication and expression, such as experiential play; therefore, in the treatment of families with children, child-friendly approaches appropriate to their developmental stage should be applied.

Relational Family Therapy with the elements of play

Many family therapists have thus expanded their clinical practice and introduced various techniques and strategies into family therapy that benefit children (Wehrman & Field, 2013). From the very beginning, play is the most natural way of communication for children (Oaklander, 1979) and enables the involvement of younger children in therapy (Gil, 1994). Eliana Gil (1994), a pioneer in the field of family therapy combined with play, claims that play in family therapy can connect individuals to one another in carrying out a simple and pleasant task that releases defence mechanisms and enables communication at a deeper level in which imagination, metaphors, and symbols can be expressed. Play between parents and children is one of the concrete ways in which families express and release natural creativity. They can play at any time, experiencing mutual positive emotions. Interactive play can create attachment or at least motivate family members to participate in positive common experiences. It stimulates a creative family atmosphere and helps them adapt in conflict situations (Harvey, 2003). When playing, children express their thoughts and feelings, solve problems, relieve tension and discover alternative ways at both verbal and non-verbal levels. When they are involved in family therapy through play, often the defence is reduced and the depth of interaction becomes much more visible (Gil, 1994). They can express their hidden thoughts and emotions, which they would not be able to do in mere conversation. Play helps them bridge the gap between their experience and understanding, thus providing a means for insight, learning, solving and dealing with problems (Bratton, Ray, Rhine & Jones, 2005). From the point of view of involuntary clients, playing attracts children and adolescents into a working alliance. In a safe environment in which they do not feel threatened, children and adolescents are more willing to participate in the therapeutic process (Schaefer, 2003). Before using various playing techniques, however, it is first necessary to establish a safe therapeutic relationship which is the basis of change.

Therapeutic relationship

Therapeutic relationship is placed in the very centre of Relational Family Therapy, enabling the change of fundamental relational structures (Gostečnik, 2004). Thus, before using any specific methods, the relationship between a therapist and a child based on empathy should first be built (Hopkins, 2000). The empathic attitude of the therapist enables an experience of a relationship that is different from previous relationships (Simonič, 2010). It replaces missing parental functions in the relationship with the therapist. The emphasis is on experiencing therapy, rather than on interpretation (Gostečnik, 2013; Winnicott, 1987). The first therapist's task is therefore to enable the child to experience security (Oaklander, 2007), while providing a safe foundation for the child and the parent, with the ultimate goal of helping the parent provide such foundation for the child (Shi, 2003). Additionally, playing is the most natural way of building relationships and a means by which the development of cooperation can be encouraged (Landreth, 2012). As a person of temporary attachment, the therapist creates an environment in which parents can freely explore new approaches to parenting. Consequently, the child can freely explore the new emotional area and experience a new parent-child relationship. In general, the therapist must understand the dynamics of the parent-child relationship and the model of constructive interaction with the child, show that s/he can effectively provide safe foundations, offer effective approaches to parenting, and provide comfort. Within the framework of safe foundations, the therapist gradually encourages the parent and the child to explore a new relationship, with the goal of changing the model of child's internal functioning (Shi, 2003). The therapist achieves this with an empathic relationship in the therapeutic process with interventions at the systemic, interpersonal and intrapsychic levels (Gostečnik, 2004).

Therapeutic process

A family in which a child has emotional, behavioural or unexplained medical problems (without a physical cause) can be included in the therapeutic process. These problems are: children behave inappropriately, they cannot get rid of feelings of anxiety, phobias, and nightmares; they suffer from self-harming and eating disorders, have problems at school and in social contacts, suffer from the feelings of inferiority, bad self-esteem, loneliness, experience distress due to parental divorce, relocation to an extended family, have experienced a traumatic event, violence or abuse, are experiencing hardship associated with placement in a foster or adoptive family, or their parents have problems with setting boundaries, disagreements about upbringing, feel helpless, confused, incompetent, etc. (Jerebic, 2015).

At the beginning of the process, the therapist explains the structure that provides security. The therapist also explains that the therapy is carried out in various ways, and at the

same time makes room for parents to talk about their expectations about the therapeutic process. When the parents 'make' the child an identified patient (Gostečnik, 2004), the therapist, in the presence of the child, explains that the child does not feel good about whatever causes the child's unwanted behaviour, while at the same time relieving the child of the feelings of guilt and telling them that the meetings are intended for them to feel good. The therapist also shows parents and children the room that is adapted for children and where there are various play materials. Children are excited, and at the end of the therapy session their answer to the therapist's question if they want to return is usually affirmative (Jerebic, 2015). The therapist's intervention is to liberate identified patient of scapegoating (Gostečnik, 2017) and the main task is consistent regulation of feelings and difficult affects that occur in therapy (Gostečnik, 2013).

Creativity in Relational Family Therapy

Specific, structured techniques used by the author of the present article in the therapeutic process are based on the principles of Relational Family Therapy and in addition to play, they also allow projection. They enable communication, experiencing and expressing feelings. They include drawing, clay, imagination, storytelling, photographs, cards, puppets, sandplay, directed family genograms and various games (Jerebic, 2015). When a child builds his world in a sandbox, makes a drawing, tells a story, he experiences himself. Whatever the child does, it is a projection of something within him. For example, when he tells a story, its contents mirror the child's experiences, needs, desires, and feelings (Oaklander, 2006). Since each emotion has its own physical component, the therapeutic process helps children to become more aware of their body and its reactions, which allows regulation and, consequently, gaining control over their behaviour. Together with the child, the therapist can then access the most important internal messages through the body (Gostečnik, 2013; Schore, 2003; Siegel, 1999, 2010). Some techniques are guiding (such as storytelling and the use of puppets), others are more spontaneous and non-structured (such as fantasy play roles and free play). All techniques include parents, children and the therapist (Gil, 2014), but they can choose the ones that they prefer.

Conclusion

By means of a range of play or expressive therapy techniques and approaches, the therapist can elicit the full participation of family members, in order to uncover, address and resolve problems or underlying patterns of family dysfunction. The involvement of children in the process of Relational Family Therapy proved to be a successful method in terms of changes in the family system (Jerebic, 2015). By means of a child-friendly approach parents can get to know and feel what their children feel and experience and how they experience others. Relational Family Therapy also recognizes that parental traumas often get transferred to their children (Gostečnik, 2017). The child's behaviour is thus placed in a different context, where there is room for understanding the feelings of children and adolescents, which are also regulated in therapy. In a safe therapeutic relationship, various techniques help children express their feelings, while at the same time they awaken parents' emotional memories of their own childhood. Parental affect regulation improves their own response, which enables affect regulation in the child and consequently leads to different behaviour. This is due to different and newly created communication that, in a safe and playful therapeutic relationship, enables the child-parent connection. From this we can conclude that the inclusion of children in therapy together with (non-abusive) parents helps children process distress, which gives them the feeling of security, so that also later in life, they will be able to trust, develop well, better understand themselves and their responses as adults and thus live more quality life.

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A place for psychotherapy counseling in the development of emotional intelligence

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Summary

Emotional intelligence comprises a set of emotional skills that allow one to correctly select feelings and unconscious mechanisms in interacting with others, and contributes to the development of self-confidence, improved understanding of relationships with the environment, and the regulation of emotions for the purpose of emotional and intellectual development. Since the relationship is essential for the development of emotional intelligence, already in the earliest stages of life, family and parental relationships are a major factor in developing it. As parents transfer their embedded beliefs, cultural characteristics and early relationships to the parent-child relationship, psychotherapy counseling is a method of choice by which parents, recognizing and changing their beliefs and actions, stimulate positive emotional development in their children.

***Key words**: emotional intelligence, psychotherapy counseling, emotional development of children*

Sažetak

Emocionalna inteligencija obuhvaća skup emocionalnih vještina koje omogućuju da se na ispravan način odaberu osjećaji i nesvjesni mehanizmi u interakciji s drugim osobama, a doprinosi razvoju samopouzdanja, poboljšanju razumijevanja odnosa s okruženjem te regulaciju emocija s ciljem emocionalnog i intelektualnog razvoja. Kako je odnos bitan za razvoj emocionalne inteligencije, već u najranijem životnom periodu obitelj i roditeljski odnosi glavni su čimbenik u razvoju iste. Kako na odnos roditelj-dijete roditelji prenose svoja ugrađena vjerovanja, kulturalne karakteristike i svoje rane odnose, psihoterapijsko savjetovanje je metoda izbora kojom roditelji, prepoznajući i mijenjajući svoja vjerovanja i postupke, stimuliraju pozitivan emocionalni razvoj kod svoje djece.

***Ključne riječi**: emocionalna inteligencija, psihoterapijsko savjetovanje, emocionalni razvoj djece*

Introduction

The very name emotional intelligence was first mentioned in Arlie Hochschild's work in 1983 (1) and in the title of Wayne Payne's doctoral thesis in 1986 (2), and the first book on emotional intelligence was written by Daniel Goleman in 1996 (3). By many definitions, it denotes a set of emotional skills that allow one to correctly select the feelings and unconscious mechanisms in interaction with others, which contributes to improving the development of each person's understanding and relationships. Thus, it involves the ability to accurately perceive, evaluate, express emotions, understand and cognize emotions and regulate them with the aim of emotional and intellectual development.

Development, specifics and approach

An important factor in the development of emotional intelligence are early relationships within the family, as the primary goal during development is to develop beliefs about oneself and their capacities through parental relationships, which depend on the parent's developmental experiences, cultural characteristics and beliefs. In order for parents to have a positive effect on the child, it is necessary to involve them in psychotherapy counseling in order to identify their own unconscious resistance, to develop a relationship with the child through basic listening, encouraging, seeking help, and respecting the needs of others without neglecting their own needs. Areas that encompass emotional intelligence are: self awareness, which includes our own emotions, control over emotions, how we manage emotional reactions regardless of the type and intensity of stress; motivation, which includes ways to make it easier to reach our goal and our level of perseverance, empathy towards recognizing others' emotions and responding to others' emotions, and finally, how we relate to others, which includes understanding others' emotions and helping to create relationships and resolve conflicts. The question we often ask is whether certain emotions will help us achieve our goal. Very often we meet with persons who have adequate cognitive and emotional functioning, but in their daily life function from a position of subordination, both professionally, emotionally and socially. The question that arises from this is what influences our attitudes, beliefs and behavior, who were our identification models, what messages we received in our earliest relationships, which formed our beliefs and influenced the creation of a self-image (4, 5, 6).

The family is our first school for learning emotions. Parental relationships and child-parent relationships are the basis for creating a picture of ourselves that we later transmit into all other relationships. According to numerous studies, early relationships depend on parental developmental experiences, cultural characteristics, and beliefs that parents developed during their earliest development in relation to significant persons in their environment (4, 5, 6). There is also a wealth of research that discusses the link

between performance in life, both cognitively and emotionally. The importance of the child-parent relationship from birth to earlier is emphasized. Basic skills that help secure development are the skills of listening, appreciation, seeking recognition and praise, but also helping and giving praise, and the same is possible only through alignment with the essentials, parents, and then educators and teachers.

It is important to emphasize that emotions are present at every moment of our lives in every activity and affect our thoughts, actions, relationships, and especially beliefs about ourselves. The model we get in the family through early relationships with parents and important people is an identification model that is responsible for developing our attitudes and the picture we have of ourselves, and which model we transmit later in life into all other relationships. It is imperative that parents receive through psychotherapy counseling an understanding of the importance of their behaviors, value systems and ways of functioning. In order for parents to realize the same, it is important for them to recognize their developmental patterns that they convey in relationships with their children, as well as to recognize the importance of emotions in their own functioning.

Conclusion

It is important for parents to understand through psychotherapy counseling the importance of listening skills, encouraging them to seek help, and appreciating others' opinions through developing empathy, all through balancing relationships with important people in the environment, while respecting boundaries. It is important through psychotherapy counseling to learn how to deal with anger and that we can express it positively, deal with fear, and whether fear can be a positive motivation and finally, deal with sadness, learn how to show it and how to continue to believe it.

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The use of modern technology in psychological treatment

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Summary

In this paper, we present the treatment of a girl (10) who is in therapy because of low self-esteem and problems in the school environment due to difficulties in exercising rights to an individualized approach regarding her reading and writing difficulties. Her mother and the girl claim that the teacher shows no understanding for the girl's difficulties and their relationship is not improving. The girl shows signs of disharmonious development; despite her language difficulties, she shows above-average non-verbal intelligence, emotional immaturity and anxiety. She lives in an intact family with a sister (without difficulties). After a multidisciplinary assessment and two months of psychological treatment (once a week), communicating with her school's professional service, the teacher publicly reads her essay in front of the whole class as an example of how not to write essays. Immediately after that, and one month before the end of the school year, the girl refuses to write any essays or written exams, which makes finishing the fourth grade much more difficult. Considering it was necessary to urgently encourage the girl to write, so that she would successfully finish the school year, in addition to crisis intervention, a smart board was also used. With guidance and support from the psychologist, the girl started writing on the smart board in one session; she was also in continual treatment and the school was also contacted.

***Key words**: writing and reading difficulties, fear of writing, modern technologies in therapy*

Sažetak

U ovom radu prikazan je tretmanski rad s djevojčicom (10) koja je u tretmanu psihologa zbog niskog samopoštovanja i problema u školskom okruženju, uslijed otežanog ostvarivanja prava na individualizirani pristup zbog teškoća čitanja i pisanja. Prema navodima majke i djevojčice učiteljica ne pokazuje razumijevanje za teškoće djevojčice te se ne uspijeva unaprijediti njihov odnos. Djevojčica je disharmoničnog razvoja; unatoč jezičnim teškoćama, neverbalno iznadprosječno inteligentna, emocionalno nezrelija, anksiozna. Odrasta u cjelovitoj obitelji uz stariju sestru koja nema teškoća. Nakon multidisciplinarne obrade i dva mjeseca psihologijskog tretmana (jednom tjedno) uz komunikaciju sa stručnom službom škole, djevojčica doživljava da učiteljica javno čita njen sastavak kao primjer kako se sastavak ne treba pisati pred cijelim razredom. Neposredno nakon toga djevojčica mjesec dana prije kraja školske godine odbija pisati sastavke i bilo kakve pisane provjere, zbog čega je značajno otežano završavanje četvrtog razreda. S obzirom na ta da je bilo potrebno djevojčicu što hitnije osnažiti na pisanje, kako bi uspješno završila školsku godinu, uz kriznu intervenciju korištena je i pametna ploča. Na pametnoj ploči djevojčica je uz vodstvo i podršku psihologa počela pisati kroz jedan susret, a osiguran je nastavak tretmana i nadalje kontaktirana škola.

***Ključne riječi**: teškoće pisanja i čitanja, strah od pisanja, moderne tehnologije u terapiji*

Introduction

We are presenting the diagnostic and therapeutic course of work of the psychologist with an eleven-year-old girl. Her mother comes to the Child and Youth Protection Centre, a health institution specialised for diagnosing, treatment and support to children with traumatic experience and their families, asking for an appointment with the psychologist because she has figured that the girl is in need of emotional support in the context of her school.

Description of Problem

The girl comes to our Institution escorted by her mother who describes difficulties in the relationship of her daughter with her teacher who does not accept the girl's tempo of work, i.e. her right to an individualised approach. Documentation and talking with her mother inform us that the girl was previously examined in a psychiatric hospital, and that, apart from speech therapy, an individualised approach was also recommended. Despite previous recommendations by professionals, her mother says that the girl's teacher does not show understanding for an individualised approach to which the girl is entitled (additional time for solving tasks, teacher's support, shorter periods of work and breaks when necessary, and similar). Her mother also describes her daughter's exposure to bullying by other school girls, in person and via the Internet, and says that she believes it significantly diminishes the girl's self-esteem and academic success, and that she is often sad because nobody wants to be friends with her at school. After mother's intervention and an intervention, in collaboration with the girl's school, her situation at school improves and teasing by her peers is reduced. However, her mother feels helpless regarding the relationship and behaviour of her teacher towards the girl.

History

The girl is attending the fourth grade of elementary school and she is an A student. Her extracurricular activities include dancing and the girl says that it is fun and relaxing. She also likes to draw, play with her mum, socialise with her friends, and generally enjoys using the mobile phone, PC and tablet. Her mother describes her as warm, empathetic, readily helping others, and as a person for whom justice is important, but also as not very independent regarding school obligations. The girl lives in her intact primary family which is functional. In her social contacts she is prone to socialising with children younger than herself and to playing games more appropriate for pre-school children

Psychological assessment

The girl is emotionally warm and open, expresses closeness with the psychologist at the first session. During the interview when describing behaviours she has experienced from her peers and the teacher, regressive behaviours and a significant level of anxiety are present. She says she is often sad, she does not want to go to school and she is often scared. During the initial interview, the girl shows diminished self-esteem ("I am fun and like to play, but there is also another side of me"). She explains her 'another side' as an inability to control her anger. She also says "I am worthless", "I cannot do anything well", "I am simply not good".

We find out that only her mum can calm the girl down regarding her thoughts and feelings of control. She does not perceive her own resources for behavioural and emotional control, even when encouraged. She describes her relationships with others "I *pretend* when I come somewhere. I do my best to make them love me. But then, even when I am at my best, I know they will not accept me, just like at school."

At the initiative of the psychologist, a psychiatrist and a speech therapist are also included in the multidisciplinary examination. Psychologist used Raven's colored matrix (CPM), Bender gestalt test (BG-II), Beck's youth inventory (BYI-II), Incomplete sentences (TNR), and the drawing test. Psychological analysis revealed that she was a girl of normal cognitive development with high levels of anger, signs of depression and anxiety of separation and social type. The girl was assessed as emotionally immature, which is why she relies on adult guidance. Going to school because of her previous experience of peer violence is a stressful experience for her. The multidisciplinary examination finds that the girl is emotionally a little immature, with normal cognitive development, reading difficulties and signs of depression, and separation as well as social anxiety. We recommend a maximum level of understanding and support in the school environment to continue her education in her class with individualised procedures included. Furthermore, we recommend that the girl be included in speech therapy and psychological treatment, and that her parents be included in counselling. We send her school recommendations about the necessary procedures for adequate support appropriate for her difficulties.

Course of treatment

Following our team recommendations, once a week for one of hour the girl comes for psychological treatment. Most of the meetings at the beginning of the psychologist talked alone with her mother and then alone with the girl, and only in few occasions the girl and her mother at the meeting were together. We were primarily work on developing the relationship with the girl, her self-image and processing the emotions she has been+- experiencing. In emotionally demanding situations, the girl still lisps, while the

psychologist ignores it and does not talk about it with the girl. Only a few sessions later, lisping is reduced, and almost disappears towards the end of the school year.

During one of her visits to the Centre, the girl also visits the Brave Phone. Coordinators draw the phone close to the girl, explain what the Brave Phone has been doing, which children call and why they do it. She is very much impressed by the visit and after a few days she calls and shares her current problems with the volunteers. After that she describes the volunteer as a very nice and compassionate person, and that she felt she was very important to the volunteer, who gave her super ideas so she has been feeling empowered after the telephone call.

After the multidisciplinary assessment and more than a month of psychological treatment conducted once a week, the girl experiences that the teacher publicly, in front of the class, reads her written task as a good example of how not to write. Immediately after that, a month before the end of the school year, the girl refuses to do written tasks of any type, which makes her finishing the fourth grade much more difficult.

Psychological crisis intervention is conducted in order to restore her feeling of safety, normalise her experienced reactions, establish her emotional equilibrium, increase self-efficacy in coping with current difficulties at school, and finally start the process of recovery aiming at emotional difficulties prevention and an integration of that traumatic experience (Arambašić, 2002). The girl describes what happened the day when her teacher showed and read her essay in front of her class as an example of how not to write. To facilitate her description of the event, we use drawing (Patterson, 2011). Her thoughts are analysed in detail, including those at the moment of the event, and those after the event, and she says: "I only wanted it to stop, I could not say anything", adding "I was only thinking that now everybody knows I was the worst", which deeply shook, scared and disconcerted her (Lamb et al, 2007). During the intervention, the psychologist assessed traumatic signs in the girl (Buljan Flander, 2016; Cook & Newman, 2014; DSM-5, 2014; Profaca, 2016; Profaca & Arambašić, 2009). Regarding the interventions, the girl is explained that her teacher's behaviour was inadequate and that it was a threatening and inappropriate behaviour which was going to be reported to the institutions in charge (Buljan Flander, Profaca, 2010; Bilić, Buljan Flander & Hrpka, 2012; Buljan Flander & Kocijan-Hercigonja; 2003).

Since it happened only a month before the end of the school year, and the girl refuses to do any written tasks or tests, and it is necessary to urgently motivate her to do it. The girl describes that the school "has taken over her life and forbidden her to be a child." Within the crisis intervention, we use a smart board. The girl has already stated and talked about her love for TV, spending time on the Internet and her mobile phone because it is fun and because of the content offered by these media that corresponds to her age appropriate interests (Livinstone et al., 2011; Livingstone et al., 2017; Huda et al., 2017).

There are a number of recent studies that indicate greater success therapy using modern technologies, not only as an additional tool but also as a specially developed application (Kobak, Mundt and Kennard, 2015, Grist et al., 2019) because of the closeness of this form of communication to children and young people. Regarding Croatian data from the 2019 national survey (Zagreb Child and Youth Protection Center, 2019) almost all adolescents have access to internet from their home (99.5%), 95.1% from their mobile phone, and 77.9% from their school. Every third adolescent uses social network from 3 to 5 hours a day, and every fifth adolescent for more than 5 hours a day. Considering that an earlier survey (The Brave Phone and The Child Protection Center of Zagreb, 2013) found that 47% of children and young people spend 1-2 hours a day on Facebook, 34% less than half an hour, and 19% spend 3 or more hours, it is obvious that there is a trend of increasing time spent on the Internet, and this is supported by research in the world. The above data support the fact that the channels of modern technology to children are closer than ever, and there are their way of communication.

Accordingly, the use of a smart board was one of the psychological interventions in the course of treatment. The psychologist motivates her to write on the smart board by first optionally drawing and exploring colours and functions of the board. The psychologist suggests that the girls could draw her essay as she imagined it, so the girl draws, as she calls it "Monster Grue". She describes her drawing as "A big monster who wishes evil things for children and deliberately wants them to be bad. It visits children while they are asleep, and most often when they are at school. It constantly reminds children that they are the worst in writing essays and that they can never succeed. Monster Grue tells children that they will never successfully do any written tasks always telling other children that these were the worst."

After drawing and describing done by the girl, the psychologist asks her what could chase the monster away and asks her to draw it on the other part of the board. The girl denies the idea that it could vanish, and after that, encouraged by the psychologist, she draws: herself, her mum, the psychologist, the Brave Phone icon, a written commendation of herself and nice socialising with others. The psychologist asks her to briefly describe the previously mentioned visit to the Brave Phone. The girl is not very inclined to do it, but the psychologist writes these questions in one corner of the board: ***"Who? What? Where? When? How? Why?"*** for the girl to give short answers, which she does. After a few consecutive encouragements and support, the girl manages to write a short essay about her visit to the Brave Phone. She is very proud and happy to have easily overpowered ***Grue.***

During treatment, her mother describes the girl's learning and doing homework at home as a very exhausting experience, since they spend whole days trying to learn and write, while the girl often cries and refuses to write, expresses doubts about her own abilities and her mother comforts her. Looking into the girl's daily schedule, the psychologist gets an impression that the girl does not have free time and that she usually, spends

her whole days, from the moment she arrives from school till late evenings, doing her homework. A few days after that, mother claims that the has girl started fulfilling her school writing obligations with ease, which is the reason why she also has started perceiving herself as more efficient. Her mother is counselled about support and guidance, schedules for learning and playing, which she consistently follows till the end of that school year. The psychologist, the girl and her mother plan daily schedules together so that the rhythm of fulfilling school obligations and playing and socialising are balanced and all three of them sign a 'contract'. The 'contract' having been signed, the girl's impression is that now her school will permit her to 'live her childhood life'.

Ten days prior to the end of that school year, the girl is notably anxious due to time pressure and the amount of school obligations. The psychologist has empowered the girl. Talking to the psychologist, the girl mentions again that she does not play enough and that she liked the smart board. Now she would like to play so that they record something. The psychologist suggests they could video-tape some content, but first they need to write the script for that. The girl writes the script about animals almost on her own, after which they video-tape that. Having reviewed the recording, the girl is satisfied with the script, and especially with the fact that she has written it independently. She concludes that everything is easier through play and fun.

The girl successfully fulfils all school obligations, does her writing tasks and tests accomplishing A grade. She attributes a large portion of the merit to herself which especially satisfies her. She still comes for a psychological follow-up once in three weeks.

Conclusion

As professionals, we are often focused on the risks of modern technologies and media. We represent the interest of children by providing education and prevention, as well as assessments and treatment within the scope of our expertise, working mostly with parents and children having experienced unpleasant episodes via modern technologies. We are often forgetting that modern technologies and media, both for us and the children and apart from bringing risks, open various opportunities we can utilise, only if we want. Consistent with all recent studies, and clinical practice insights, children are fully exposed to media and they use them in various ways and for different purposes, like getting information, acquiring education, having fun, realising social contacts and developing social network, thus meeting many of their needs. If we, as professionals, need to approach children and their world via their channels freely offered by children, then modern technologies are a world of opportunities for therapeutic work.

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Work with Nina whose parents are in higly conflictual divorce

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Summary

This case study describes psychotherapy work with a seven-year-old girl Nina whose parents are in high-conflict divorce. Within a month since beginning of our psychotherapy work behavioural changes occured in Nina's behaviour: crying, sudden mood changes, separation and sleeping problems. The first part of psychotherapy was about creating secure and confidental relation with the girl but also with her parents through counseling and psychoeducation. The main goal was to strengthen and conncet inner image of the mother and father in the girl thus integrating split parts of personality. The focus of work with the parents was to raise awareness of their responsibility and obligation as parents, that is to protect the child from suffering by creating safe, stable and predictable environment. Psychotherapy work lasted for five monts, discountinously and it is terminated due to parents' non-cooperation.

***Key words**: high-conflict divorce, psychoeducation*

Sažetak

U ovoj studiji slučaja opisan je psihoterapijski rad sa sedmogodišnjom djevojčicom Ninom čiji su roditelji u visokokonfliktnom razvodu. Unatrag mjesec dana od početka našeg psihoterapijskog rada kod Nine su nastupile promjene u ponašanju: plačljivost, nagle promjene raspoloženja, problemi sa separacijom i sa spavanjem. Prvi dio terapije odnosio se na stvaranje odnosa sigurnosti i povjerenja s djevojčicom, ali i s njenim roditeljima kroz savjetovanje i psihoedukaciju. Glavni cilj bio je osnažiti i povezati unutarnju sliku majke i sliku oca kod djevojčice te na taj način integrirati rascijepljene dijelove ličnosti. Fokus rada s roditeljima bio je osvijestiti odgovornost i obvezu njih kao roditelja, a to je da zaštite dijete od patnje stvarajući sigurnu, stabilnu i predvidljivu okolinu. Psihoterapijski rad trajao je pet mjeseci, diskontinuirano, a prekinut je zbog nesuradnje roditelja.

***Ključne riječi**: visokokonfliktni razvod,psihoedukacija*

Introduction

A divorce is stressful event for a whole family system and especially for children. A divorce lasts for a long period, starting since parents are still married and then follows divorce process and adjustment that can last for many years after the divorce. The adjustment of a child depends on how parents have coped with the divorce and to what extent they have adjusted to a new situation. About one-third of divorces are characterized by high conflicts but after divorce process the level of conflict in majority declines, while in the smaller parts it continues even three to five years after the divorce (McIntosch, 2003; according to Bilić, Buljan Flander, Hrpka, 2012). The impact of the divorce on a child is minimal if both parents are available to a child and if they also cooperate in education after the divorce regardless their mutual feelings (Buljan Flander et al., 2018). The best interest for a child when it comes to divorce of parents is to grow up with both parents who cooperate and make mutual decision about child because it is his/her need and right (Buljan Flander et al., 2018). Constant conflicts between parents, non-cooperation, mutual accusations and child alienation make divorce traumatic for a child and cause significant consequences for his/her mental health. Alienation of a child represents the ultimate form of manipulation with a child and it is considered as emotional abuse of a child (Gardner, 1998, according to Warshak, 2008).

This case study describes psychotherapy work with a seven-year-old girl Nina. Nina is a girl whose parents are divorced since she was four-year-old, but after the divorce they fail to cooperate and raise her together.

Psychotherapy treatment lasted for five months. It was discontinuous and took place in a private practice. Meetings with the mother of the girl were performed with the same frequency as with the girl, once in a week, except in the time when the girl was with the father because then she did not attend therapy sessions. Two meetings were realized with the girl's father. At the end, psychotherapy treatment was terminated due to non-cooperation of parents.

The theoretical directions that were support to understand the case are developmental theories, psychosexual development theory (Freud, 1900, according to Corey, 2004), psychosocial development theory (Erikson, 1963, according to Corey, 2004) and attachment theory (Bowlby, 1982, according Buljan Flander i sur., 2018). Since the girl is born and raised in dysfunctional family the question is whether all her body and emotional needs are satisfied to establish relationship of trust, image of world as safe place and secure attachment style.

History and development of the problem

The girl is born from a neat pregnancy and delivery. An early psychomotor development proceeded neatly. However, the girl is born and raised in non-stable environment, in dysfunctional family, parental relations have been disturbed since the mother's pregnancy. When the girl was three-year-old the divorce process began and ended one year after. After the divorce, parents cannot agree about mutual decisions about the girl, they do not respect Court decisions, mutual accusations are often and Centre for social work is constantly involved in the case. The girl attended kindergarten where she started to show signs of separation anxiety. She was enrolled in the primary school on time. The first class she finished successfully. Within a month she started to show changes in her behaviour, she became more crying, she often changes moods, sleeps less, separation difficulties have intensified as well as more frequent abdominal pain. Due to mentioned difficulties mother has sought psychotherapy help for the girl. After the first meeting with the mother and taking detailed history, the first meeting with the girl was arranged and it is planned to initiate meeting with the father. Nina's inhibition, lack of initiative, separation anxiety and non-secure attachment in relation with the mother could be noticed at the first meeting with Nina.

Psychotherapy treatment

At the beginning of our psychotherapy work, psycho diagnostic is made for better insight in the girl's physical state. Thinking differentially diagnostically, based on the girl's observations, by insights in psychological test, projective techniques and interview with the parents and guided by DSM-V (2013), it can be concluded that clinical picture indicates the symptoms of child depression that resulted from growing up within a disturbed family dynamics and constant conflicts of parents before, during and after the divorce.

Integrative therapy is relationship therapy, so in the beginning I have indulged in staying with Nina while we slowly have built relationship of trust through conversations, play therapy and creative techniques that the girl usually loves. The girl needed safety, stability, predictability, peace of mind, a place where she would be able to show her feelings, thoughts and needs without worrying about hurting or losing someone. This is precisely what is set as one of the goals of therapy with the girl since it is known that high-conflict relations between parents impair the child's sense of security and trust.

What I have learned from the girl in the first part of the therapy is that she longed for family unity and that she is still in the phase when she hopes that parents will reconcile. The moment when she said that for the first time was one of the key moments in establishing our relationship. Since the parents have not yet separated parent from the partnership

role, the girl has not yet accepted the parental divorce as final and she hopes situation will change. Working on the case I often asked for supervision. Dynamics that belongs to family parents brought with them in the therapy and I could exactly experience what it was like to be between the conflicts what is exactly where the girl Nina was. In relation with the parents, I have occasionally felt insecure, afraid, angry and helpless.

Since high-conflict divorces and manipulations with the child could cause splitting as defence mechanism that can be predisposition for severe mental disorders in the future, I have set the following as the second aim of the therapy: strengthen and connect inner image of the mother and father at the girl and thus integrate split part of personalities that is preparation of base for challenging developmental phase that follows. I have worked on this aim, inter alia, through questions and conversations about what the girl likes to do with mother and what with the father, what she recognizes in herself that is similar to mother and what to father, what father does well and what mother does etc.

In the central part of the therapy we have dealt a lot with emotions, relaxation exercises, children with problems are known to switch off and block their bodies, and by proper breathing and relaxation exercises we help them to feel and listen their body and thus come in contact with their emotions that are hardly recognizable and verbalized in this age (Oaklander, 1978).

The focus of the work with parents was through psychoeducation to raise awarness of their responsibility and obligation as parents and that is to protect child against suffering by creating secure, stable and predictable environment through communication without quarrels, cooperation and mutual decision making about the child, regardless their mutual feelings. In this case it was difficult to create this due to complex dynamics of relations between the parents that is the cause of emotional difficulties in the girl. The parents repeatedly cancelled the agreed joint appointments, continued with mutual accussations and non-cooperation. Psychotherapy was terminated due to their non-cooperation, but secure and open relationship with the girl is made and the Center for social work is notified about the risk this child faces with.

Conclusion

The relation of trust and safety is created in the work with the girl following continuous work on building inner bridge that connects inner image of the mother and father. For her I have represented factor of integration of split parts of herself, making base for the following developmental phase. Regarding work with the parents there was no significant progress. Regardless the psycho education of what their conflicts and non-cooperation do to the child and the further risks for the child's mental health, they reacted poorly and continued their behaviour. This case is a good example how important is in the therapy with a child to get involved his/her parents for cooperation because

otherwise the question is how "powerful" a therapist is? Furthermore, it is important to emphasize that psychotherapy work with children requires multidisciplinary and intersectional cooperation that is necessary to act in the best interest of the child.

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"Invisible child" – Integrative psychotherapeutic treatment of a child with anxiety disorder

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Summary

In this case study I am going to present the work with an eight-year old girl, a second grader of a primary school, who has been coming to the therapy for five months.

In the initial part of the therapy it was being worked on the establishment of the relationships between the therapist and the client, in the central part it was about the overall improvement of an image of oneself, reduction of anxiety, strengthening and expressing of one's own emotions and their verbalisation, psychoeducation of parents and school. In the final part of the therapy, the accent is on the strengthening of parents' competences and gradual exposing of the girl to the fears and planning of the therapy ending.

The objective of this paper is to present the importance of recognising the early traumatic events at children, which may be triggers later for anxiety disorders and contributions to the involvement of parents and school as a co-therapist for having a better outcome of the entire treatment.

***Key words**: anxiety disorders, expressing emotions at children, psychoeducation*

Sažetak

U ovoj studiji slučaja prikazat ću rad s osmogodišnjom djevojčicom učenicom drugog razreda osnovne škole, koja dolazi na terapiju pet mjeseci.

U početnom dijelu terapije radilo se na uspostavljanju odnosa između terapeuta i klijenta, u središnjem dijelu radilo se o sveukupnom poboljšanju slike o sebi, smanjenju anksioznosti, osnaživanju i iskazivanju vlastitih emocija te verbalizaciji istih, psihoedukaciji roditelja i škole. U završnom dijelu terapije akcenat je na jačanju roditeljskih kompetencija, te postepenom izlaganju strahovima djevojčice i planiranju kraja terapije.

Cilj ovog rada je prikazati važnost prepoznavanja ranih traumatskih događaja kod djece, koji kasnije mogu biti okidači anksioznih poremećaja i doprinosa uključenosti roditelja i škole kao koterapeuta, radi boljeg ishoda cjelokupnog tretmana.

***Ključne riječi**: anksiozni poremećaji, izražavanje emocija kod djece, psihoedukacija*

Introduction

Anxiety (sinking feeling, dread, fear, panic, uneasiness, concern) is an experience in the development of the personality, experienced by every person during their development. It is important for preserving the organism integrity. A certain degree of anxiety is desirable because of the motivation of a person for more productive behaviour. It is important to learn how to control it (Begić 2014).

Fears and different forms of anxiety make the integral part of the development of every child. An estimation is that more than 90% of children in the age 2 - 14 has at least one specific fear, and most of them has several fears. Fears and anxiety, either they are normal part of the development, or they are a response to the specific threatening situation, represent an adaptive response because they warn the child to take precautionary measures and to get prepared for numerous challenges which they will have to deal with (Paulton, Trainor, Stanton, McGee, Davies and Silva, 1997). Anxiety is a condition, characterised by feeling of internal disorder and fear that something horrible will happen. A person often feels like they are going to lose control over themselves. That person is not aware of their tension and where it comes from, they are not aware of that unpleasant condition, and anxious reaction is the attempt of the body to get rid of tension. When the anxiety becomes long-lasting and intensive and when it starts to disturb normal social and psychic functioning - then it is about a disorder (Lebedina – Manzoni, 2007); resp. when the fear and anxiety substantially affect the functioning of the child, disturb the normal psychosocial development and lead to the difficulties in school, social and family environment – then it is talked about the anxiety disorder (Boričević-Maršanić, 2013). As the most of other psychological phenomena, the fear and anxiety are interwoven a lot in the childhood and it is difficult to differ them (Poulton et al., 1997, according to Vulić- Prtolić, 2002). Because of the afore-mentioned, the fears and anxieties are most often researched on a parallel level.

The most often changes in behaviour that are connected to the anxiety are the outbursts of rage, cry, confused behaviour, but shyness or insecurity are also possible to take place in social context (Vulić – Prtolić, 2006). When it is spoken about the risk factors for development of anxiety disorders, we find general and specific factors in literature that are related to certain anxiety disorder. Many variables are considered as risk factors at anxiety disorders (Beesdo et al. 2009). Experiences in childhood have a great role, most of epidemiologic studies find a connection between the damaging experiences in childhood (f.e. loss of parents, divorce, child abuse and negligence) with the phenomenon of mental disorders (Beesdo et al. 2009).

Family history and dynamics – researches prove that anxiety disorders appear more frequently between close relatives. Researchers point out that the children may learn fears and phobia by looking at and imitating their parents (Beesdo et al. 2009). Researches from developmental psychology show that the different forms of insecure de-

votion (avoiding, ambivalent and disorganised devotion) of children are the risk factor for the development of anxiety disorders (Sroufle LA, 2005).

Objective of this paper

The objective of this paper is to present the importance of recognising the early traumatic events at children, which may be triggers later for anxiety disorders and contributions to the involvement of parents and school as the co-therapist for having a better outcome of the entire treatment, but also to present an integrative approach in working with children and adolescents.

Presentation of the case

At the period of our first meeting, the girl was the second-grader of the primary school, who was eight years old at that time. She lives in a four-member family with her parents and older brother. Her parents had occasional difficulties in their partner relationship during the pregnancy period when the mother was expecting this girl, and also later on when the girl was at the age of four. Mum states that her pregnancy was taking a normal course, but that she occasionally felt a loss of vitality, weakness in the first months of her pregnancy, she had often morning sicknesses and she vomited a lot. Overdue pregnancy, baby delivery by C-section. Parents also state that the pregnancy with the girl has not been planned. In the infancy she was calm, she slept a lot, and based on the mother's statements her early development was in accordance with the expectations for that age. At the age of three and a half, she underwent the tonsillectomy surgery, she cried a lot during her stay in a hospital and she cried a lot also after the medical treatment, she slept badly. The reason for her coming to the therapy is having the difficulties in learning – poor concentration, fear from public expression, somatic symptoms (pain in abdomen…) – psychosomatization, physical tension and internal uneasiness – animation; recently, the fears also appeared which are shown by the girl especially when it comes to the visiting a dentist or driving in an elevator. The girl had been attending the day nursery for two years before she went to school, she did not communicate to children and nursery-school teachers, it was suspected of a selective mutism disorder.

After the birth of the girl and problems, which were experienced by the parents, the family dynamics was changing, partner relationship is full of lack of trust, as stated by her mother, they are more oriented onto parents' responsibility and obligations which they have about their children, especially in relation to the girl.

During the conversation with parents, I ask also for their permit to get in touch with the school and to talk to the teacher and nursery-school teacher, who works in the

extended day programme as to get the whole picture about the girl, her behaviour in school and academic achievements.

Course of the treatment and diagnostics

Already at the very beginning, an insight can be received into family dynamics, relationships of parents and insecure attachment. An initial diagnostic picture, which can be seen at the girl based on the symptoms, as described by the parents, which can be also seen both in the family and in the development anamnesis (refuse to talk in the nursery – refuse to talk in specific situations with a retained ability to speak in other circumstances, f.e. she talks at home, resp. in situations in which she feels pleasant and secure; specific phobia – dentist, public expressions, driving in an elevator as well as other symptoms that were appearing – fright, uneasiness, tension, pain in abdomen and other somatic symptoms, exaggerated concern about her parents, tension in muscles) started manifesting significantly in her pre-school period; and some of the symptoms are present even today in her everyday life, their recognising according to the classification of disorders may indicate some of the anxiety disorders. The anxiety disorders are diagnosed when they are the subjectively experienced feelings of anxiety that meet the criteria of classification of mental illnesses and disorders (DSM - ***Diagnostic and Statistical Manual of Mental Disorders*** - 5 and ICD - ***International Classification of Diseases*** - 10). The very course of the therapy was going in several phases according to the objectives of the therapeutic work, which were the following: establish the relation of trust and security, discover the cause/background of fears and anxiety and help the girl through the treatment to integrate causes in a healthy and functional way, psychoeducation of parents and school.

The hypotheses in relation to the set objectives are the following: authentic and correct experience of ***a therapist – client*** opens the space of resilience – secure organismic self-regulation; parents behaviour, experience in childhood and traumatic events, which may be triggers for development of anxiety disorder, psychoeducation of parents, school environment may reduce symptoms, prevent further deterioration, keep healthy development and have strong implications to the prognosis and treatment.

In the beginning of the psychotherapeutic treatment, we have also agreed the plan of having a meeting once a week, which includes the work with the girl and psychoeducation of parents. I have also offered and referred parents to my colleague for family/partner or marriage counselling and individual therapy. I believe that fears and anxiety, shown by the girl in everyday life, have their background in traumatic experience of being abandoned by her father and his leaving their family home, which has resulted in impossibility and inability to express emotions, which additionally strengthen the anxiety symptoms and they are manifested as anxiety disorders. It can be also seen through

the anamnesis that the first symptoms of anxiety disorders at the girl are manifested through the prism of selective mutism – anxiety disorder, and previously the traumatic event took place related to her father's leaving their family home. It is important for me to have a broad picture through this therapeutic experience and observe the parallel processes that appear, as well as the symptoms and their manifestation through everyday life of the girl.

Our first meetings were very quiet, she communicated but only with encouragement through my questions. I was making her acquainted with toys and what I like; sometimes it seemed to me that I talked to myself, she was quiet until I discovered the magic of her great love for board games. We used our first several meetings for getting to know each other and creating the feeling of safety, better contact with the girl. I had a feeling that she was checking my patience and ability to stay with her. Using the play therapy, we started to know each other increasingly better, and the girl started to talk more about herself, things that she liked and her family. Due to the girl's tension that I felt at our first meetings, she showed the anxiety also by her body, she had a bent body posture, her shoulders were bent forward and hands were squeezed and interwoven. I had a feeling that she felt very tight in her own body and that she felt great unpleasantness. In addition to the board games, which became our everyday ritual and her great joy because somebody spends some time playing with her, which she confirmed to me several times, I was thinking that it was necessary to work out something that would reduce tension also for her body. I had a feeling that the body requested larger energy, relaxedness and growth. I decide to continue with the board games because it was the only thing that she wanted to do with me at our first meetings, and in addition to the afore-mentioned I choose a relaxation technique and a safe place technique. I believed that the relaxation techniques would be useful for her to calm down her body, tension and anxiety, which was physically visible. I knew that the relaxation represented a condition of psychic and physical relaxedness, in which we bring body to the condition and feeling of being calmed down and pleasantness. Since then our meetings included also the breathing techniques, sometimes we did it in silence, and occasionally with a quiet and relaxing music.

After several sessions, get-acquainted meetings, eliminating tension, introducing and relaxing, and perhaps first of all and the most important one - creating trust and staying in contact, the girl starts to share her emotions. She believes me and feels safe. I come back to the question that has bothered me for a long time, and I could not answer it to myself. What is it that I cannot see, and the girl tries to tell me?

She brings me to my answer at the end of one of our meetings, when we were already before the very end, packing the board games, she looked at me and said: "You know, nobody has ever tried this hard with me like you do". Exactly at that moment, the exchange of trust took place between me and the girl, which represents at the same time also the key moment in our therapeutic work. For the first time the girl admits me that

she is finally seen now, that nobody saw her for the past seven years until now, i.e. she was a completely invisible child.

After showing her needs and emotions in front of her mother, the girl has been significantly opened in a therapeutic relation. We have continued to use projective techniques, when the girl continues to express her emotions with drawing and modelling clay. We talk about things which make her happy, what makes her sad, when she feels fear, how it looks like when she is sad, she increasingly talks, draws, writes, works out the games through which she is going to talk to me and open the topic of emotions and feelings. We have worked a lot also on completing the sentences, which were related to the attitude towards her mother, father, family as a whole, obligations, identification, male/female friends – other children, reactions to frustration, feeling of pleasantness and unpleasantness. She gives me a lot of information here about her attitudes and feelings, I can say also about her needs. The most important were the answers that she gave me about her father.

Through the play therapy – a game with masks, she supported herself and made herself stronger to express her needs, tension and defencelessness that she felt, and to show her emotions in the right way, and not through the confuse and closing towards herself that was manifested as anxiety. She spoke frankly about the emotions, and so did her mum, too; they supported each other. I realised how much the girl had the need to show and to express her emotions to her mother, which she had kept for a long time.

Through the work with the client I constantly relied on and supported myself with the theory, especially on a comprehensive theory of personality development, which includes also a potential crisis in every developmental task, resp. indicates the possibility for inadequate overcoming of the developmental task. If we have not overcome the previous tasks, we will have troubles to deal with the following life tasks. Based on the concept of this theory an integrated and functional person should overcome one's life cycles successfully enough, with the aim of having the feeling that one's own life is complete. Erik Erikson, a renowned psychoanalyst, gave his systematisation of a human development and he assumed that every degree of the development brought the potential crisis with itself, resp. a danger to have the developmental tasks completed inadequately. Erikson spoke about several principles that are necessarily brought by the development, as well as about the development phases through which every being would have to go.

Occasionally, I invite parents for conversation, in the beginning we agreed to have regular meetings as I work with the girl and that they would start with an individual therapy and a partner counselling. I talked to the parents about the development periods of every child, devotion, development of fears at children, anxiety, needs, self-respect, parents' relationships and how they affect the children.

In this final part, it is important for me to make together with the parents and the girl a plan for gradual exposing and to strengthen parents' competences through psychoedu-

cation. I plan also to take a look with the parents and the girl to the passed joint pathway which we stepped through, to look at all challenges, difficulties and successes that we have made on this no-return travel. It is very important for me that the girl does not experience the ending of the therapy as leaving because it was one of her fears in the first place. I want to have the positive ending, especially for the girl. A good ending may be celebrated as a concert, entertainment, recognition and joy for one good ending, well done homework, with the view to everything that we have done and with the view to the future. I want to have the ending of the therapy as the agreed ending between me as the therapist, the parents and the girl; resp. when we jointly agree that the therapy shall end – to leave and plan enough space for processing the feelings, arisen by the very notion of the therapy ending, but definitely to leave the possibility for coming back to the therapy in case of some changed circumstances, when and if additional help might be needed again.

Conclusion

The family of the girl has changed a lot after the very appearance at the therapy. The change is not only visible in relation to the girl, but it is also reflected in the first place through the relationship of the parents and the dynamics of the whole family. I have to point out that after their initial inaccessibility, they have opened the contents of their relationships and accepted the help that has been offered to them. It can be seen that they have the will and that they want things to be improved and to function in the best possible way.

The girl has achieved large breakthroughs in the therapeutic process, the anxiety has been reduced, pain in abdomen is increasingly rare, she has become more liberate in expressing and showing her emotions and feelings, her concern about her parents is still present but to the far less extent, she speaks more frankly about her fears. One thing that I do not know and that I cannot be sure about how the things will proceed is the partner relationships between her parents, insecurity and severity that the girl has carried. There is her need to keep them, but I know that the therapeutic process at children is clearer to me now and that through the correct experience, which the girl has received during this therapeutic process, the organism opens the pathway for itself towards health and growth. I believe in her capacities.

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Cognitive-bihevioral therapy disorder treatment

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Summary

Opposing and defiance disorder is characterized by conspicuous defiance, disobedience, and destructive behavior that does not involve delinquent practice or extreme forms of aggressive or dissociative behavior. Children who exhibit behavioral problems within the context of this disorder often have difficulties communicating with their environment (primarily with family), difficulties in adequately expressing emotions, and avoiding everyday tasks and responsibilities. The aim of this paper is to present a cognitive-behavioral approach to disorders such as opposing and defiance.

This study portrays a case of a ten years old client who has, for a longer period of time, before inclusion in the treatment, displayed behavior which manifested through failure to respect the rules and agreements set in the family, disobedience, for departures from home, constant and repetitive lying, and occasional attacks of rage and anger. Also, since starting school, she had difficulty in mastering the school material, hence during the therapeutic treatment we were also working on this problem.

***Keywords**: opposing defiance disorder, difficulty in mastering the school material, cognitive-behavioral therapy*

Sažetak

Poremećaj u vidu protivljenja i prkosa karakteriše upadljivo prkošenje, neposlušnost i destruktivno ponašanje koje ne uključuje delikventske postupke niti ekstremne oblike agresivnog ili disocijalnog ponašanja. Djeca koja ispoljavaju probleme ponašanja iz okvira ovog poremećaja često imaju poteškoće u komunikaciji sa okolinom (primarno sa porodicom), poteškoća u adekvatnom ispoljavanju emocija, te izbjegavanje svakodnevnih

zadataka i obaveza. Cilj ovog rada jeste prikaz kognitivno-bihevioralnog pristupa kod poremećaja u vidu protivljenja i prkosa.

U ovoj studiji prikazan je slučaj desetogodišnje klijentice koja je prije uključenja u tretman duži vremenski period ispoljavala ponašanje koje se manifestovalo kroz nepoštivanje pravila i dogovora koje ima u porodici, neposlušnosti, odlazaka od kuće, ponavljanog laganja, te povremenih napada bijesa i ljutnje. Također, od polaska u školu imala je poteškoća u savladavanju školskog gradiva, pa smo tokom terapijskog tretmana radili i na ovom problemu.

***Ključne riječi**: poremećaj u vidu protivljenja i prkosa, poteškoće u savladavanju školskog gradiva, kognitivno-bihevioralna terapija*

Introduction

Behavioral disorders are the most frequently diagnosed disorders in mental healh institucions for chlidren and adolescents (Pejović Milovanović, Popović Deušić, Aleksić. 2002.). Opposing and defiance disorder belongs to the group of behavioral disorders and usually appears with younger children, primarily characterized by visible defiance, disobedience and disturbed behavior that doesn't involves deliquent practices or even more extreme forms of aggressive or antisocial behavior (International Classification od Diseases, ICD-10)). Its basic characteristic is the existence of permanently negative, defiant, provocative and destructive behavior that is outside the normal behavioral framework for children of the same age and socio-cultural background (Popović Deušić,1999). Cognitive-behavioral therapy for children is a popular form of psychotherapy used for a range of mental health problems in children and youth (Stallard, 2010.). There is a generally accepted view that cognitive psychotherapy is used to treat children and youth with behavioral disorders. (Pejović, Milovančević, Popović Deušić, Aleksić, 2002.). Cognitive-behavioral strategies with children and adolescents use enactive, performance-based procedures as well as cognitive interventions to produce changes in thinking, feeling and behavior. (Kendall, 1991b, Kendall 1993.). Cognitive-behavioral therapy integrate cognitive, behavioral, affective, social and contextual strategies for a change (Kendal 1993.).

Cognitive-behavioral therapy may be contraindicated in cases where it exhibits problems in the field of language or cognitive development. However, when entering treatment, we rarely know in advance what difficulties we will encounter, and the client has just been diagnosed (during a psychodiagnostic assessment) with problems in cognitive ability. In this case, cognitive-behavioral interventions were applied in accordance with the needs and capabilities of the child in order to treat them as successfully as possible. Also, one of the goals of this paper is to present the importance of involving parents in therapeutic treatment. When engaging parents (caregivers) in therapy, the primary focus of intervention remains on solving the child's problems, while parental involvement is based on the application of skills in the child's daily functioning, support for maintaning positive behaviors and performing tasks.

Case study

Client A.M. (2006) is accompanied by her mother, following instructions of the family doctor. Attends ffifth grade of elementary school. She lives with her mother, stepfather, brother and half-sister. Second child in order of birth. Until five years ago, she lived with her father, mother and older brother. The mother states that she decided to leave the marriage because of disturbed family relashionships and excessive alcohol consumption by her husband. Shortly afterwards, the mother established a new marriage with her current husband, and the girl lived with her brother and grandparents (the mother's

parents) during this period. In 2012., the mother gave birth to her younger sister. According to her mother, A.M. rarely sees her father, who is currently abroad (Croatia).

The impression is that during the stay with the grandparents the girl had no special restictions, primarly by the grandfather. If the mother gives her punishment, the girl seeks approval from her granparents. During the conversation with the mother and the girl, one gets the impression that the girl does not have a permanent family environment, unique house rules, obligations and responsibilities to be respected.

She started school on time and regularly completed the first four grades. She does her school work with the help of her family, but has trouble learning the curriculum and managing the school. She does her school work partially independent, while it is necessary to further encourage, motivate and supervise homework. She understnds the things taught at school, „does not cause problems", but is not actively involved in class.

History of current problem development

In the last few years, she has been manifesting behavior that is manifested in disregard of the rules and agreements in the family. Client spent time outside and she leaves her house for couple of hours, not telling her parents.

She repeatedly lies, is disobedient, occasionally has attacks of anger and rage accompanied by crying and noise. After the parents, most often the mother, notice that she was lying, there is a conflict, altercation and punishment. In previous years, the mother used to give punishments and the girl sougt permission from grandparents.

Since starting school, there are problems in mastering school curriculum. She often avoids doing her homework. Primarily there are problems with the acquisition of mathematics curriculum. In other classes, she does not interfere with teachers, but also does not show interest througt class activity, collaborating or writing down what is required of her. She seems uninterested in particpating in class and learning school materials.

Emotional problems

She is often angry, resentful, easly angry with others, emotionally tense. She most often cites situations where she is angry or furious. There is low tolerance for frustration, and even the slightest ban leads to „hysteria", emotional arousal, anger and „sulk".

Cognitive problems

During the psychodiagnostic assessment (interview, observation, CBCL, REVISK, Pmcol, LB-R, My family, KDO) prior to joining psychoterapy treatment, it was noted that general mental abilities were below average, manifestly whitin the below-average values, and there are aggrivating circumstances that would impair the adoption of she school curriculum and tasks if it comes to cognitive ability.

Problems in maintainig concentration and tencity of attention. Often unable to follow while someone is speaking, she interupts the conversation and has no patience to listen. During the work, expresses problems in determining the clear flow of thoughts that occurr at certain moments.

Behavioral problems

Client defies the demands of adults. Does not follow agreements with adults, punishments or rules. There is impulsive reaction and a low threshold of tolerance for frustration. These problems occur primarly whitin family. No more extreme forms of aggression or dissociative behavior have been noticeable or mentioned. At school, she obeys the rules of conduct but does not complete tasks. She reacts instanly, not thinking about the consequences in the future, nor is she interested in anticipating the consequences of her actions in advance. She repeatedly demands fulfillment of her desires and needs, but has no adopted habits and a sense of responsibility towards fulfilling obligations with the family.

Treatment plan

Problems	Goals	Interventions
Emotional dysregulation - problems in recognizing and naming emotions	Teach a girl to recognize what she is doing and how she is feeling Impulsive behavior reduction Reduction of anxiety	Psychoeducation Relaxation techniques Problem solving Coping Cards
Problems in adopting school curriculum	Structure of activities related to school curriculum	Activity logging Learning training Parent training
Non-compliance / avoidance	Reduction of lying Engaging in everyday tasks at home	Activity logging Social skills training Parent training

Treatment flow

The treatment was conducted during nine meetings. During each encounter, the girl was treated individually, while the mother was involved depending on the topic, or involved as needed and / or familiar with the homework/task. During the first session, the girl was left alone with a psychologist. A plan was agreed with the girl in advance and

she agreed to have her mother wait in front of the office. After the session is over, she will invite her mother to come in. We agreed the goals of the treatment together, and I explained what it was important for her to improve in order to feel better.

In order to gain insight into her emotions and behavior, a psychoeducation about emotions was done at one of the next two meetings. During work, the girl was tasked with naming the emotions in the pictures, showing on the body where she felt a particular emotion, describing the situation she was feeling, and what she thought in those moments.

The hardest part was talking about the thoughts that came to her mind during an event that evoked a certain emotion. For her, it was difficult to focus on the topic of conversation. She would often interrupt the conversation and try to start a conversation about another event that preceded it. It was necessary to return to the needed topic by asking again the previous question.

Anger is an emotion she could relate to through a detailed description of physical manifestations, and by listing several situations in which she feels it. With the aim of reducing anger, we worked to find a way to solve the problem or what to do when "I can't control my anger". Together we designed the face cards we made in the form of a "frog." Her task was to count whenever she felt anger, tension or rage to the number that came to her mind, then choose a color, and then how many color letters she selected open the "frog" so many times, and discover possible actions that would contribute to reducing the negative emotions. She brought her "frog" home so she could exercise daily.

Over the next two sessions, we worked on promotion and developing self-control through social skills training (Stephan and Marciante, 2007). During the training I noticed that she understood the matter without any problems and she completed all the tasks successfully. After training, she wrote down five essential sentences that should help her in her daily routine. She was given homework, which we discussed at our next session. During the social skills training, but also during the assessment, an increased level of anxiety is shown by the girl through impatience.

At the next session, we focused on reducing anxiety, and she first received proper breathing training, and later practiced proper and deep breathing. After that, we did progressive muscle relaxation (Stephan and Marciante, 2007). The girl was given the task of practicing deep breathing every morning and before going to bed, with written instructions.

During the seventh session an activity plan was agreed. On the said plan it was necessary to record whether she had fulfilled them within seven days. The mother was involved in the development of the activity plan and was tasked with monitoring whether the girl was adhering to the plan. The plan outlines daily activities (morning activities, school preparation, school attendance), homework, learning, breathing / relaxation exercises, etc., and is broken down by hour and day of the week. After an

agreed activity plan, we did some reading exercises. She took one of the picture books home and was given the task of reading it and drawing the picture she wanted from the picture book.

On the last session with the girl we evaluated the work to the date. She was given an incentive to continue executing and implementing what she had learned so far. By the time of the evaluation meeting, she had received two picture books to read, I reminded her to continue to do breathing exercises daily, to use coping cards ("frog"), to tell her mother daily what she had to do for homework and to devote herself to it. In agreement with the mother, activity tables were provided to record whether the girl was adhering to the task.

Therapeutic relationship

The therapeutic relationship was good. During the therapy sessions, the girl sought to be actively involved and cooperative in the work. All tasks are tailored to her needs and capabilities in order to prevent "loss of concentration" or disinterest ". The mother showed a strong willingness to commit to treatment and we had a very good cooperation. She took an active part in the discussions and sought suggestions that she received in everyday life. She assisted the girl in completing the tasks by reminding, encouraging and motivating her to do the same until the next meeting.

Problems / obstacles

The primary problem in the worki with the girl is that due to problems in cognitive functioning, the cognitive concept could not be significantly incorporated into therapy. All the tasks had to be written down so she could be reminded at home, otherwise she would forget. Because of these problems, it was also important to involve the mother in therapeutic treatment in order to monitor the completion of the tasks the girl receives at home. There was a concern that the mother would not be actively involved in the treatment, but she showed tremendous cooperation and interest during her work.

Results of treatment

Identified problems included emotional dysregulation - problems in naming and recognizing emotions, problems in adopting school materials, and non-compliance with rules / avoidance. After the completion of the treatment, which was conducted through nine sessions, there was a reduction of impulsive behavior and lying, reduction of anxiety, a structured approach to mastering the school material, and the client was involved in daily obligations.

She did not leave the house without informing the householders. After leaving the house, she must report to one of the adults and return home at the agreed time. She helps with certain household chores (cleaning the dishes, going shopping, cleaning her room, etc.) on a daily basis. The girl goes to school every day and regularly announces the tasks and responsibilities that she has. She practices reading and writing every day and strives to do her homework. In the previous semester, she had a good success and had no negative grades. She regularly goes to treatment with a defectologist and works on improving reading and writing techniques and mastering mathematics.

Conclusion

The achieved goals and results of the work indicate the effectiveness of cognitive–behavioral therapy in the treatment of disorders in the form of opposition and defiance.

Although some psychotherapists do not recommend cognitive-behavioral treatment for children with certain difficulties in cognitive functioning, a major improvement can be achieved by adapting treatment to the child, through creative action, by following the child's needs, and moving away from the pre-recommended structure to guide the treatment. It is important to emphasize that during the therapeutic treatment, communication of family members improved and the client received significant support from the family, which ultimately contributed to the successful completion of the treatment.

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