



CRISIS SITUATIONS AMONG CHILDREN/ADOLESCENTS WITH EMOTIONAL AND BEHAVIOURAL DISORDERS IN EDUCATION

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Abstract/Izveček Employees in education, especially in residential treatment centres, face crisis situations as a result of emotional and behavioural problems/disorders of children and adolescents. They most often face various types of violence, self-aggression, use of illicit substances and abuse. Cases of children and adolescents with mental health problems are frequent. Crisis interventions differ with the complexity of the situation, and regardless of the approach, an appropriate relationship is crucial to any solution. The purpose of this article is to present and elaborate the most common crisis situations and some successful interventions in such cases.

Krizne situacije otrok/mladostnikov s čustvenimi in vedenjskimi motnjami v vzgoji in izobraževanju Zaposleni v vzgoji in izobraževanju, zlasti v vzgojnih zavodih se srečujejo s kriznimi situacijami, ki so posledica čustvenih in vedenjskih težav/motenj otrok/mladostnikov.. Najpogosteje se spopadajo z različnimi vrstami nasilja, avtoagresijo, uporabo prepovedanih substanc ter zlorabami. Pogosti so tudi primeri otrok/mladostnikov, ki jim lahko pripisujemo težave v duševnem zdravju. Krizne intervencije se razlikujejo od zahtevnosti situacije, ne glede na pristop pa je za vsa kakršno reševanje ključnega pomena odnos. Namen prispevka je prikazati in elaborirati najpogostejše krizne situacije ter nekatere uspešne intervencije za tovrstne primere.

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Introduction

Residential treatment centres are intended for educational, social, emotional and thus, comprehensive compensation for and correction of what children did not receive in their earlier development, and which represents deviations from the expected (Krajncan, 2003). It is an extremely sensitive field of work where both emotional and rational categories meet. The result means frequent crisis situations faced by educators in residential treatment centres. The crisis situation or the process in which a crisis forms must be understood as a psychological burden that significantly deviates from the normal state. The state of mental stress is perceived as difficult to accept and often leads to emotional destabilization. We also speak of a crisis when “changed situations require solutions that cannot be managed with previously available or obvious options for solving problems” (Droos, 2001). As a result, the burdens of children/adolescents that they carry often escalate. In addition, educators in residential treatment centres often encounter children/adolescents who mostly have mental health problems. The scale of the problem is of great concern, especially owing to the difficulty of accessing outpatient psychiatric services. Moreover, inappropriate treatment may strengthen or trigger mental disorders even more, which can represent failure during the stay in the residential treatment centre; thus, it is necessary to determine what types of treatment models are used in the institution's practice when working with individual disorders (Zalokar, 2013). In crisis situations, professionals or educators must be able to intervene and deal with such situations effectively. Given all the above, the following text will review the most common crisis situations faced by educators in residential treatment centres and, as a result, review the concept of crisis intervention. In connection with the above, we will explore the techniques that can be used in certain crisis situations. Techniques mainly mean the tools that can be used if a child/adolescent poses a danger to him/herself or others. We know various intervention methods that can be used in crisis situations. From the general model of approach in crisis interventions, we focused on individual approaches, which according to information from practitioners and statements in the literature are used with the most common and most difficult cases, that is from various forms of self-aggression (suicide attempts, self-injury), physical and psychological violence, the use of illicit substances and subsequent conditions, to abuse and mental health problems. Through comparative analysis of various studies, we will explore the following issues: What types of crises exist? How can we help children/adolescents in difficult situations?

How can we learn crisis intervention? And finally, how to help the educator in such situations, how to empower him/her to act appropriately? Upon raising such questions, we shall try to summarize insights into the treatment of children/adolescents in psychosocial crises and explain the crisis intervention measures.

Method

The article includes an analysis of definitions and existing research related to the issue of crisis intervention at home and abroad. We used the descriptive and comparative method, with the help of which we reflected on and evaluated the existing literature and transferred it to the field of crisis situations and crisis intervention.

Results and discussion

Children/adolescents in residential treatment centres often face crisis situations. In addition to the circumstances at home and emotional and/or behavioural problems/disorders, these are also caused by the new circumstances in which they must find and prove themselves. Kobolt (2011) says that emotional and behavioural disorders manifest as passive/withdrawn behaviour or as aggressive/impulsive behaviour. Since Kobolt uses the term problems, she adds that these must occur over a long period of time or be the result of severe losses which occur suddenly or of pressures which are usually not permanent. She also defines these children as children with dissocial behaviour that is intense, repetitive, and permanent. In addition, problems manifest themselves as problems in social integration, which is mostly unsuccessful. Skalar (2003, p. 9) cites them as “children whose behaviour endangers themselves, their life and health, their personal and social integrity, and children whose behaviour is threatening to the social environment because it is directed against the rules, worth and values, and against applicable moral norms and laws”. To better understand how to react in children/adolescents’ crisis situations, we first focused on what a crisis or crisis situation is.

A crisis is a loss of mental balance which a person feels when dealing with events and living conditions with which he or she is currently unable to cope, owing to the nature and extent of his or her skills gained from previous experience and proven tools for achieving important life goals or for coping with their life situation (Cullberg, 1978, Sonneck 2000).

“A crisis emerges at the moment when an individual’s usual problem-management mechanisms are not appropriate or are insufficient and the person cannot solve the problem which is very important to him/her. At that moment the person becomes confused, does not take appropriate action and the crisis is not resolved, but it deepens” (Tekavčič-Grad, 1994, p. 1). Droos (2001) describes a crisis situation or the process in which a crisis is formed as a psychological burden that significantly deviates from the normal state. The state of mental stress is perceived as difficult to accept and often leads to emotional destabilization. We also talk about a crisis when “a changed situation requires solutions that cannot be managed with the presently available or obvious possibilities for solving problems.” The crisis is thus expressed differently depending on the individual, while all the definitions have in common that if an individual, at a given moment cannot solve the stressful situation with normal life mechanisms or experiences, the situation escalates. Based on the reviewed literature (Krajnčan, 2003, Marovič, 2018, Skalar 2003, Kobolt, 2011, Zalokar, 2013, Šoln Vrbinc, Jakič Brezočnik, Švalj, 2016, Myschker, 2009), we classified the most common escalations or crisis situations faced by professionals in residential treatment centres into:

- externally-directed aggression and violence,
- self-aggression,
- use of prohibited substances,
- abuse and
- mental disorders or mental health problems.

Crisis situations

Aggression is a behavioural trait that manifests primarily in violent, domineering acts against others. It is any form of behaviour intended to harm or injure another living being who wishes to avoid such behaviour. The author also states that aggression is learnt (Pačnik, 1998). Mrevlje (1995) adds that aggression is not accidental, but targeted and intentional. Brekoviwitz (1993) distinguishes between the following forms of aggression:

- verbal aggression (insults, remarks, jokes, etc.),
- indirect aggression (intrigue),
- aggression directed outwards (towards others),
- self-directed aggression (suicide, alcoholism, self-loathing, etc.),

- instrumental aggression (serves to achieve a goal, aggression is merely the means),
- - hostile aggression (injuring or killing someone),
- active aggression (actively doing something to the detriment of another),
- passive aggression (by not doing something the person causes harm to another),
- consciously controlled (planning a robbery), and
- impulsive aggression (impulsive violent reaction to a stimulus).

Externally-directed aggression and violence are the type of aggression directed outwards, typical of which are impulsive reactions, characterized by anger attacks and rage, which can lead to a state of reduced conscious thinking. This type of aggression can be directed at other people or at objects. In the case of aggression against other people, it is a matter of physical or verbal attacks, while in the case of aggression directed at objects, it is mainly the destruction of material goods, throwing objects, etc. (Hrastar, Bužan, Mrže, Hitejc, 1988). From the sociological psychological aspect, aggression can be defined as a social problem in the interaction between two individuals or groups and depends on the individual's characteristics and the situation or circumstances where the behaviour takes place. Aggression is behaviour done with the intent to cause harm or pain to a living being that seeks to avoid such an act (Krahé, 2013).

In addition to aggressive outbreaks, which mostly occur among peers or in relation to educators, residential treatment centres also face self-aggression, which is more difficult to identify.

Self-aggression is behaviour that forces an individual into relationships in which they feel depreciated and/or experience rejection or loss (Tomori, 1988). A self-aggressive act is an individual's message to society, from which we can discern despair, rebellion, contempt, and other feelings (Šajn, 1995 in Matiš, 2018). Self-aggressive behaviour is most clearly and recognizably shown through coefficients of suicide and suicide attempts, which nowadays represent a global problem (Mrevlje, 1995, p. 6). Self-aggression may actualize in the physical realm, where pain predominates, and aggression is directed at individual parts of the body, occurring as self-harm or suicide, as well as in the psychological field, where the emphasis is on suffering (Milosavljevič, Milenkovič, 1988).

Miličinski (1989) divides different forms of self-aggression more specifically into:

- Indirect self-destructive behaviour (abandoning treatment for serious illnesses, gambling, risky sports, psychosomatic diseases, prostitution, driving under the

- influence, excessively risky self-sacrificing behaviour, and abuse of alcohol or illegal drugs) (Mrevlje, 1995).
- Suicidal thinking (personal suicidal thoughts, thinking about what one could do to him/herself and how (Gaber, 2011).
- Suicidal tendencies (acts against oneself, although it is a behaviour that is not direct and has not yet resulted in a suicidal act. Alcohol abuse is often an example of such tendencies (Mrevlje, 1995).
- Parasuicidal pause (the escape of an individual from an unbearable condition. Such intentions seem like a suicide attempt, but the individual does not perceive it as such (e.g., self-poisoning with medicinal substances) (Gaber, 2011).
- Suicide threats (the individual informs the surroundings of his/her self-aggressive intentions, but has not done anything yet (Mrevlje, 1995).
- Intentional self-harm (the individual intentionally injures parts of the body in a way that is not socially acceptable, but has no suicidal intent (Thanks, 2012).
- Parasuicidal gesture (self-poisoning with drugs) (Mrevlje, 1995).
- Attempted suicide (self-harm, ingestion of large amounts of chemicals, self-poisoning, which the affected individual began and performed with the intention to harm as well as to draw attention (Mrevlje, 1995).

There is a thin line between self-aggression and mental health problems. Therefore, it is difficult to find a dividing line to distinguish one from the other. Professional staff in residential treatment centres perceive that many children/adolescents show various signs and symptoms of mental disorders or illness. Upon examination by specialists (psychiatrists or clinical psychologists), many find that they need regular treatment for mental disorders that have been detected, or it is revealed that mental disorders had existed for a long time previously and had not been identified and treated. In some cases, hospitalization is urgently needed (Zalokar, 2013). In a 2012 survey, Zalokar (2013) found that 41.95% of children and adolescents enrolled in residential treatment centres have mental health problems. The study identified a wide range of disorders, from behavioural and emotional disorders to bipolar disorder, anxiety, depression, ADHD, hyperkinetic disorders, and obsessive-compulsive disorders.

We decided to list some disorders so as to provide insight into the varied spectrum of disorders or problems faced by educators in residential treatment centres and thus to highlight the issue of mixed disorders. In addition, we sought point out the

problem of employee qualifications for dealing with children/adolescents with mental health problems.

Only Residential and Counselling Centre Planina has the authority to accept children/adolescents with mild to moderate mental problems/disorders (VIZ Planina, 2020), while other residential treatment centres have no authorisation and are therefore not competent in these cases. Nevertheless, children/adolescents with defined problems/disorders are placed all over Slovenia.

Marovič (2018) also points this out, noting that most problems arise from a misalignment between the child/adolescent's disorder and the limited, socio-pedagogical approach of a residential treatment centre, which then finds itself unable to cope with such a child/adolescent. She adds that:

Problems mainly arise when we find that the child/adolescent has exceeded the scope of the residential treatment centre which with its socio-pedagogical approaches - due to a combination of various factors (individual's non-cooperation; various forms of aggression, violence against oneself and/or others; consumption of illicit substances; the institutional environment is more threatening than his/her home environment, etc.) - can no longer help him/her (Marovič, 2018, p. 136).

When children/adolescents are being placed in a residential treatment centre, they experience distress because this is an extremely invasive measure that withdraws an individual from his/her own environment and places him/her in a new environment among unknown people. This would cause stress even in people without problems or disorders. Dežman (2015) says that in such cases, adolescents are particularly likely to resort to drugs or alcohol more quickly, since these offer a kind of withdrawal from their new situation, and especially emphasizes that those who increase their drug use upon coming to the institution and thus get closer to becoming addicted are dangerous. Dežman (2018) adds that there is no data on adolescents starting to use illicit substances consequent to their arrival at a residential treatment centre, while Mashowuer (2015, in Antoničič, 2019) states the opposite, namely that many young people start using directly on arrival at a residential treatment centre.

In addition to the crisis situations we have already mentioned, we also focused on abuse, which must not be overlooked, and which resonates in residential treatment centres, although this topic often remains undiscussed.

By the term abuse we mainly indicate sexual abuse (other types of abuse were included in the chapter on violence) which may occur to a child/adolescent during the time of his/her placement in a residential treatment centre, regardless of whether it is committed by peers, a family member or someone else during the course of placement.

Bašič (1997, p. 142) defines sexual abuse of a child/adolescent as “participation of dependent children and minors in sexual activities with an adult or a person older or bigger than them, in which the child or adolescent is abused as a sexual object for satisfying the sexual needs or desires of a person older than him/her and in which he/she does not have the opportunity to choose whether to consent to sexual activity or not, due to unequal powers in the relationship between him/her and another person.” N. Končnik Goršič (1995, p. 174) says that “we speak of sexual abuse when an adult, to satisfy his or her own sexual needs, exploits a child who is neither emotionally nor rationally mature enough to understand and oppose the act.” Frei (1996, in Cerkovnik Hvala, M. 2008) states that sexual abuse is when an adult intentionally uses a child to sexually arouse him/herself and/or to satisfy his/her own sexual desire. It often happens that the child/adolescent trusts or even depends on this adult. In addition, the adult is always in a stronger position in relation to the child. Thus, it is difficult for a child to freely decide on the actions required of him/her by the adult. He/she also cannot consciously participate in the said acts. When the child/adolescent agrees to participate under these conditions, it is impossible to overlook the damage this represents for the child's further development.

Moreover, Repič (2006) emphasizes that, in addition to the above, any involuntary contact with an older person can be classified as sexual abuse. When sexual abuse occurs, it is necessary to be aware that in such situations, the child needs safety the most. In addition to safety, it is necessary to provide him/her with shelter, a sense of acceptance and respect for his needs (Zaviršek and Lamovec, 1994). Zaviršek and Lamovec (2004) adds that the first step is most important; this refers to the moment when a third person becomes aware of the abuse. This person must believe the finding and be ready to help the child, express empathy for the child's pain and begin taking steps to prevent any further abuse.

Professionals employed in a residential treatment centre are expected to acquire competences with which they would be able to work in the environment specified during their studies.

However, we are aware that it is difficult to be prepared for the institutional environment and that competence is acquired through experience. Therefore, we tried to answer the question of what crisis interventions really are and which should be used in certain crisis situations to prevent or mitigate individual damage.

Crisis interventions

The help following a crisis or distress is called crisis intervention, intervention in crisis, or help or aid in distress (Tekavčić-Grad, 1994). The basic goal of crisis intervention should be the return of the individual to (at least) the level of daily functioning that was characteristic of the individual before the crisis (Ucman, 2018). “Crisis intervention is an independent method of counselling, therapy and treatment [...]” (Stein 2009, p. 151). It must be adapted to the individual and his/her specific situation. (Collins, Collins, 2005). The professional must assess the impact of the crisis on the behaviour, cognition, development and ecosystem of the child/adolescent. Once the professional establishes this kind of understanding of the user in crisis, he/she can decide which short-term or long-term approach he/she will take. Since the well-being of the child and the prevention of his or her vulnerability come first and are the most important, workers in residential treatment centres usually have very limited time to react. Regardless of the time options given to them, the goals of an individual intervention are certainly the following (Collins, Collins, 2005):

- to ensure the safety of the child/adolescent,
- to restore current emotional balance (if possible, of course),
- to manage the crisis in the short term and connect the client with appropriate resources.

In addition, Stein (2009) sets out some general principles of crisis intervention, which are as follows:

- quick start,
- ancillary activity,
- flexibility of methods,
- focus on the current situation/event,
- integration of and into the environment,
- relief and cooperation.

In a crisis situation, the professional should act in the following six steps. Collins and Collins (2005) state that it is necessary to approach the child or adolescent in a supportive and empathetic manner, by intervening in a way that creates safety, stabilizes the situation and prevents aggravation and, if possible, meets the individual's present needs. In addition, explore and evaluate the scale of crisis responses, explore alternatives and develop different options.

At the same time, help the child/adolescent activate his/her personal and social capital and, if necessary, connect with the environment. In the 6th and final step, anticipate further developments and possible actions.

We have listed some basic assumptions that apply to general and broader crisis interventions. However, we also focused on the specific ones, which differ according to the type of crisis situation. We emphasize that the choice of method or crisis intervention depends on the child/adolescent we work with and one of the essential competences is certainly the empathy of the professional worker, with which he/she establishes an important relationship, which is essential for any further work in the residential treatment centre.

Additionally, we believe that the trust established between the educator and the child/adolescent is of key importance. Only in this case can we test further methods, which without trust, would be unlikely to produce results.

As has been established above, the educators in residential treatment centres often face the consequences of adolescent drug abuse. Professionals (Krajncan and Šoln Vrbinc, 2015, Zalokar, 2013, Dežman, 2005, Dežman, 2008, etc.) are critical of the topic of drugs in residential treatment centres, as they all point out professional incompetence among staff and residential treatment centres as the very impetus for such cases. Thus, everyone cites as a "measure" only the prevention of use and raising awareness of young people about the harmful effects of drugs, therefore working on prevention, but there is no sign of any crisis intervention to be deployed in case of use, if we exclude communal treatment. Dežman (2008) even cites ways for residential treatment centres to deal with users of psychoactive substances who oppose treatment. Such a user should continue to live in the residential treatment centre, but does not receive appropriate treatment, since residential treatment centres do not have programs for users, which they do not accept at the declarative level.

Additionally, an adolescent who is addicted to drugs and refuses treatment can be transferred to a home or, as a juvenile, be returned to his or her home environment. At this point, we wondered whether the strategies mentioned could even be called "strategies". We believe that they are oriented towards repression and fail to offer the individual enough help in the area where he/she would obviously need it. Although residential treatment centres are not responsible for working with young people addicted to drugs, it is necessary that they find a range of strategies and offer help within their capabilities.

Nevertheless, we emphasize that the educator has too much responsibility, having to seek ways to constructively help the individual on his/her own.

Regarding aggressive behaviour and violence, which can also occur as a result of drug abuse, Mlinarič (2000) emphasizes that educators must provide children who show aggressive behaviour with positive experiences among peers, an environment in which the individual will not feel threatened. They should try to enable a sense of acceptance in the group and discover activities in which the child or adolescent can assert him/herself. In addition, they should offer the individual an open conversation about his/her reactions and offer various options for resolving conflicts. However, it is also necessary to allow the individual to experience responsibility for his/her actions.

In cases of self-aggression and related self-harm behaviour, an interdisciplinary approach, anticipating cooperation of the residential treatment centres, social services, health services and the young person's family, is crucial for successful treatment of children/adolescents with such problems. All the agents should regularly inform each other about the child's/adolescent's condition, especially when new episodes appear, and the level of suicide risk changes (Kvas Kučič, Krajnik and Konec Juričič, 2012; Self-harm in over 8s: long-term management, 2011). For problems of self-aggression, we focused on techniques which the educators can teach the children/adolescents prone to self-harm, thus preventing greater harm, but still offering some satisfaction to the individuals. Galonar Vodopivec (2006, p. 293) presents techniques that are useful at the very moment when an individual feels consumed by the need for self-harm. These can also be called minimization techniques or alternative ways of coping with distress. These techniques replace invasive methods of self-harm with methods that are less harmful:

- relaxation techniques
- physical activity,
- slow, calming activities.

In addition, it is necessary to reduce the individual's risk factors that we have the power to influence, and surely to strengthen the protective factors and improve the quality of life of the child/adolescent with these problems. It is also recommended to record a journal of triggers (Self-harm in over 8s: long-term management, 2011). As an aid, distraction methods (one of the minimization techniques) are also mentioned, which distract the person from damaging their skin. Distractions without serious consequences include the following: drawing on the skin with a red marker, snapping the rubber band on the wrist, sticking patches on the places which the person wants to injure, temporary tattoos or applying henna and removing the applied, squeezing (red coloured) ice cubes, rubbing the ice cubes on the parts of the body which the person wants to injure, applying food colouring diluted with warm water to the body, chewing leather, using make-up to draw injuries on the hand, creating an artificial layer of skin by applying skin colour plasticine, which can serve as a basis for careful cuts that do not reach the skin (artificial blood can be used for additional effect), hot shower and rough peeling, drawing on old scars, biting chilli peppers, rubbing the skin with a toothbrush, holding a bottle filled with hot water, etc. (Distractions that can help..., 2007, p. 1)

However, when self-injurious behaviour occurs, Mlinarič (2000 in Matiš, 2018) states that medical care or even hospitalization is required in the event of serious injuries. In addition, it is necessary to seek the help of appropriate professionals (psychiatrist, psychologist), while identifying the causes of such actions and trying to eliminate them.

We believe that educators in residential treatment centres who face this type of problem should be well-aware of and educated on how to act in situations where self-harm occurs. They should know when an emergency call is necessary and how to act before the emergency medical help arrives. In such cases, educators should not be left on their own to learn and educate themselves on this topic, as education on this topic should be mandatory and funded by the employers. In addition, they should have clear instructions on how to proceed in such cases, as well as be legally protected if such situations do occur and they do the best that is in their power.

It should be emphasized that appropriate professionals should be available to the population mentioned at all times or somewhere in their vicinity, to offer help as soon as possible. They know from practice that this is, unfortunately, not the case. The waiting periods for paediatric psychiatrists are long, and most residential treatment centres operate in such a way that several children visit a paediatric psychiatrist at once, and not during individual escalations, if we exclude cases involving hospitalization.

As already mentioned, the boundaries between mental health, mental health problems and mental health disorders in this issue blur quickly. Recently, there more and more children/adolescents have been placed in residential treatment centres while suffering from these problems/disorders.

Although children/adolescents with such problems are placed in residential treatment centres throughout Slovenia, only Residential and Counselling Centre Planina has the authority to accept such cases. However, in the given situation, a professional cannot rely on jurisdiction and is forced to do something for this population and try to achieve improvements and results. The STEPPS Program has also proven to be a successful method for working with children/adolescents with mental health problems/disorders. The STEPPS program incorporates the principles of systemic therapy (Liebman, Minuchin, Baker, 1974), according to which maladaptive behaviours are maintained by an individual's systems made up of family members, friends, the school environment, health care staff, and others. When changing inappropriate behaviours, it is therefore necessary to also change the response of the systems to these behaviours. For this purpose, important others from different systems are included in the reinforcement groups, which encourage and reward the newly learned behavioural patterns (integrated systemic and cognitive-behavioural component) (Black et al., 2004). However, when we talk about insensitive, apathetic traits, research results testify to the effectiveness of functional family therapy. Comprehensive and individualized treatment at a mental health centre resulted in a reduction in behavioural disorders and lower re-arrest rates. Caldwell et al. (61) reported that adolescents with severe problems/disorders showed improvement in a safe facility for serious offenders, by using the intensive treatment program which utilized reward-oriented approaches, was focused on the adolescent's personal interests and taught empathy skills.

More specifically, the reports show that adolescent offenders receiving intensive treatment were less prone to relapse during the 2-year follow-up period, compared to offenders treated under the standard treatment program at the same correctional facility (Zalokar, 2013).

Nevertheless, we must remain aware that this therapy can only be performed by those who are qualified for it and again, to call on to greater opportunities for additional education of employees.

Abuse may also lead to mental health problems. How do we deal with such cases? It is difficult for children to talk about abuse, especially sexual abuse, which is often a taboo topic. Our response to the child's story or revelation is extremely important. In particular, the reaction we offer to the child telling the story determines whether he/she will continue with the story or not. It is emphasized that the child should not be questioned but left to talk freely. It does not matter whether we obtain all the details from the first narrative, since it is necessary that we respond clearly, with focus and let the child tell us as much as he/she can in a given situation

In addition, it is recommended that we keep repeating to the child that we believe him/her and will protect him, praise him/her for telling his/her story, empower him/her that he or she is not guilty for what happened, and emphasize that we will try to do everything in our power to ensure that such events never happen again. A sexually abused child loses the sense of safety that is absolutely necessary for his/her development, so it is necessary to help re-establish that feeling. How can we try to achieve this? We can mainly experiment with pre-determined rituals, and with a certain routine, ensure that the child knows what to expect. For example, we can always use the same ritual before going to bed, having dinner together, or reading a fairy tale. It is necessary to consistently adhere to agreements and not to promise something that cannot be fulfilled, and in doing so, make it clear to the child we are at his/her disposal when he/she wants or needs it. It is necessary to offer additional attention, while not being too intrusive. Moreover, we should not pretend that the event did not occur, minimize it, or remain silent about it, as this can only further traumatize the child (Society for Nonviolent Communication, 2016). In view of this, it is necessary to record all the observations in connection with the said event as accurately as possible, since the data collected may be extremely important for further consideration. In making notes, it is necessary to record the facts exactly as stated by the child and not by one's own interpretation or generalization.

Since we must follow the principle of ensuring the safety and well-being of the child, the perceived abuse must immediately be reported to the competent institutions (regardless of whether the abuse occurred within the residential treatment centre, or a suspicion of abuse in the home environment was detected). Anyone who suspects abuse is obliged to report such a suspicion. Thus, the competent social work centre or the police (working group for non-violence in nursing, Slovene: *Delovna skupina za nenasilje v zdravstveni negi*) must be notified within 24 hours.

Upon performing all official duties in connection with the report and upon ensuring the basic safety of the child, the real hard work begins, concerning the “healing of wounds” and the empowerment of the child.

Despite the specifics of sexual abuse, the same psychotherapeutic techniques are used to treat such abuse as for other psychological traumas. In the aftermath of sexual abuse, psychotherapy is thus usually used in three stages. The first phase ensures safety, which includes creating a safe environment, including the feeling of being accepted by the environment with the people who are important for the child. In doing so, it is necessary to identify the problem of which the child should try to be aware.

The second phase deals with remembering and mourning, which is done through reconstruction of the story, mourning the trauma, and processing traumatic feelings. In the third phase, the emphasis is on integration into normal life in terms of building relationships and creating the future (Kristberg, 1995; Uranjek, 2001; in Rojšek, 2002). Regardless of the methods used to deal with the traumatic consequences of sexual abuse, we would like to highlight that the key to any success is the relationship, which represents the foundation for further treatment of the individual.

Conclusion

Residential treatment centres accept children and adolescents with emotional and behavioural problems/disorders; the parents of these children may feel educationally helpless or may have a home environment that is so threatening that the child/adolescent is placed in a residential treatment centre. Children/adolescents from the age of 6 until the age of 17 are placed in residential treatment centres. Those centres, which are intended for minors, accept adolescents between the ages of 14-18, with the possibility to extend their stay until the age of 21 (Skalar, 1995; in Šoln Vrbinc, Jakič Brezočnik, Švalj, 2016).

In the institutions, where all the threads of life exist in one place, the child/adolescent often encounters crisis situations, which are made even more demanding because of their pre-existing emotional and behavioural problems/disorders.

A crisis, which can be understood as a moment in which an individual's established mechanisms fail and the person cannot solve the problem as he or she would like (Tekavčič-Grad, 1994), is experienced daily by children/adolescents placed in residential treatment centres. Everyone experiences crisis differently, and while some may experience a situation as an everyday event, others experience the same situation as very stressful. Therefore, it is the educator's duty to assess with empathy whether or when an individual experiences a situation as a crisis, even in cases when it is not expressed alarmingly. According to professionals (Krajncan, 2003, Marovič, 2018, Skalar 2003, Kobolt, 2011, Zalokar, 2013, Šoln Vrbinc, Jakič Brezočnik, Švalj, 2016, Myschker, 2009), the most common crisis situations that require intervention are the following: externally-directed aggression and violence, self-aggression, use of illicit substances, abuse and mental disorders or mental health problems. The intensity of escalation is reflected differently. In identifying a correct reaction in these situations, we believe that the key is to establish a solid, high-quality relationship, which is also emphasized by Krajncan and Bajželj (2008), and forms the starting point for any quality work with individuals, not only in residential treatment centres but also in general. However, when a crisis situation occurs, our reaction depends on the type of situation itself. Crisis intervention should have a basic goal: to pursue the individual's return at least to the level of normal life (Ucman, 2008). We emphasize that in pursuing this goal, it is first necessary to ensure the safety of the individual and other participants. The type of intervention depends on the individual and the situation, while regardless of the situation, we try to adhere to the six basic principles mentioned by Stein (2009): that it is necessary to intervene quickly, offer an ancillary activity, choose flexible methods, focus on the current situation, get involved in the environment and offer relief and cooperation at the same time. Speedy intervention also depends on a call for emergency medical assistance or to the police, especially in cases where the child's/adolescent's life is endangered, and time plays a key role. When a crisis situation involving violence occurs, such as outwardly directed aggression, which is most often expressed in anger attacks and rage and can be directed at people or objects (Hrastar, Bužan, Mrže, Hitejc, 1988), it is first necessary to prevent the attack and protect oneself, the perpetrator and the others involved.

The offenses must also be reported to the competent authorities. In doing so, it is useful to prepare and provide a sufficiently safe and stimulating living environment for those children/adolescents who are more prone to violent outbursts. As a positive thing, Mlinarič (2000) also points out good experience with peers and taking responsibility for one's own actions. This range of combined factors should encourage more effective intervention in the event of violent outbursts and, in addition, reduce the number of violent situations. We are aware that it is difficult to eradicate violence in residential treatment centres, but we can do a lot to reduce such situations and to resolve them when such escalations occur.

In crisis situations related to self-aggressive behaviour, which is most often expressed in the physical field, where aggression is directed at parts of the body, such as self-harm or suicide (Milosavljevič, Milenkovič, 1988), crisis intervention is crucial, since young lives may be at risk. Thus, in the case of self-harm or suicide attempts, we use minimization techniques that alternatively allow coping with distress and prevent more invasive attempts at self-harm.

Among these, Galonar Vodopivec (2006) classifies relaxation techniques, physical activities and slow activities which enable calming. In addition, distraction methods (Distractions that can help..., 2007) are highlighted, which prevent self-harm intentions or suicide attempts, whereby the individual is distracted by some other technique, for example a hot shower, snapping rubber bands instead of cutting him/herself, rough peeling, massaging with ice cubes, drawing on the skin, etc.

The goal of such methods is to prevent the serious damage that could be caused by self-harm. However, when physical injuries have already occurred, in the worst cases, medical care, emergency medical care, hospitalization are required, along with the identification and elimination of the causes of such actions. Here, it is important to know the child/adolescent well. Only then will we be able to determine whether self-injurious behaviour is merely a cry for help or attention seeking that does not signify a serious tendency towards self-harm, or whether self-injurious behaviour can be threatening. Nevertheless, we emphasize that any act of self-harm or suicide attempt must be taken extremely seriously, since a critical outcome can occur quickly.

In dealing with self-aggression, we quickly step into the field of mental health or mental health problems/disorders. In recent years, the latter have been common among the population placed in residential treatment centres. Zalokar (2013) cites a whole range of mental health problems.

In the survey performed in 2012, she found that as many as 41.95% of children/adolescents living in residential treatment centres needed special care because of these problems. Although only Residential and Counselling Centre Planina has the authority to care for children/adolescents with mental health problems, other residential treatment centres in Slovenia are also dealing with such individuals. The STEPPS Program is cited as a successful method for working with this population. The program contains elements of systems theory, in which unapproved behaviours are maintained by the systems in the individual's environment (family members, friends, school, etc.); therefore, in changing inappropriate behaviours, it is necessary to first change the systems' responses to these behaviours (Black et al., 2004). This means that it is necessary to work with the entire environment surrounding the individual with mental health problems and to change the negative responses of such systems into positive ones in order to achieve results. In addition to the STEPPS program, functional family therapy is also mentioned as very effective. It offers successful results, especially when working with children/adolescents with insensitive, apathetic traits.

In addition to these methods, it would be necessary to emphasize the need for good interdepartmental cooperation (especially cooperation between paediatric psychiatry and residential treatment centres), which means that different professions have to help each other and act for the benefit of the child/adolescent.

In everyday life, children and especially adolescents, encounter alcohol and illicit substances. From simple experimentation, which is most common during adolescence, however, they can quickly advance to addiction problems.

Thus, the institutional environment must also be concerned with the consumption of alcohol and illicit substances. There, consumption may increase as a consequence of stress, and lead to addiction. Unfortunately, there are no guidelines for how educators should act when a minor is under the influence of illicit substances. One possibility mentioned by Dežman (2008) involves the exclusion of the child/adolescent from the residential treatment centre, especially in cases when the child/adolescent refuses to attend treatment. Considering that measure, we critically state that help for individuals in such cases must not be denied, but it is necessary to establish cooperation with institutions working in the field of illicit substances. In addition, educators need to be educated in this area to be aware of the type of drug currently on the market, as well as its effects.

In addition, they need to be taught how to intervene appropriately when a child/adolescent is under the influence of illicit substances. At the same time, we emphasize once more the importance of trust between the individual and the educator. Only in this way can we do the most in this area and offer help most effectively.

Among the frequent crisis situations, we also mentioned abuse, where we focused primarily on sexual abuse. We speak of sexual abuse when an adult uses a child who is not mature enough to understand the act and oppose it, to satisfy the adult's own sexual needs (Končnik Goršič, 1995). In many places, sexual abuse is still a taboo subject and is often not talked about. Nevertheless, such situations occur even behind the walls of residential treatment centres. When such a crisis situation occurs, the event must be reported immediately. Reporting is also required in case of suspicion of abuse, within 24 hours, to the competent social work centre or the police. Upon the report, the real hard work with the child/adolescent begins, since the child/adolescent needs to be empowered again. The Association for Nonviolent Communication (2006) emphasizes the importance of response when an individual confides in us.

In cases like this, it is necessary to offer support, give them time, not ask too many questions, and give them a sense of safety. In addition, we should not promise them anything we will not be able to deliver but let them know that we will be here for them when most needed. Thus, in such situations the educator should be a confidant, supporter and protector of the child/adolescent. He/she should strengthen their relationship and try to boost optimism in the individual, while also trying to work well with the individual's support network and competent institutions which can offer help.

The added value of the article is a systematic theoretical overview of the most common crisis situations, which in addition to the escalations mentioned, offers professionals the possibility of interventions or approaches to be used in a given situation, while also presenting the starting point for the formulation of guidelines in crisis situations in residential treatment centres. We believe that in future, guidelines for dealing with crisis situations will become imperative. Thus, regardless of the wide range of crises that we face in residential treatment centres, they would offer some security for educators and management, or at least some sort of instruction on how to act when individual escalations occur.

At the same time, the guidelines would also offer professionals protection before the law, enabling the educator to act in accordance with the regulations (assuming that such regulations or guidelines existed). We strongly believe this would alleviate the additional burden that educators face in the view of threats from parents who want to bring in lawyers, claiming that educators have not acted properly in certain situations, which are unfortunately on the rise. We are certainly aware of the difficulty of the situation, as well as the specifics of working with such a population. It is also clear to us that there is no recipe for education; what works for one individual may not be a success for another. Nevertheless, we consider that basic guidelines for the most common crisis situations can and must be established, thus providing educators with partial relief and safety, as well as competence in performing their work. In addition, we call for better interdepartmental cooperation, which would also mean greater success in times of crisis situations.

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