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Disruption of parent – child relationship and emotional and behavioural disorders. A case study

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Zakłócenie relacji rodzic – dziecko oraz zaburzenia emocjonalne i behawioralne. Studium przypadku

Badanie dotyczy niepokoju i agresji u dzieci z zaburzeniami emocjonalnymi i behawioralnymi oraz pozbawionych opieki rodzicielskiej. Przedstawiono studium przypadku dziecka uczestniczącego w interwencji. Dziecko należy do grupy (N = 40) wychowanej poza rodziną i podlegającej czterem strategiom interakcji: głos normalny i język pozytywny, wysoki ton i pozytywny język, normalny ton i negatywny język oraz wysoki ton i negatywny język. Nadzór prowadzono w celu gromadzenia danych przez niezależnego obserwatora na standardowej liście kontrolnej. Wyniki wskazują na silną zależność między lękiem a agresją, a użycie języka negatywnego o wysokim tonie wzmacnia agresywne wrażenia u dzieci z zaburzeniami emocjonalnymi i behawioralnymi. W pracy zarysowano związek między pozbawieniem opieki rodzicielskiej a zaburzeniami emocjonalnymi i behawioralnymi. Zakłócona relacja dziecko – rodzic jest predyktorem możliwych trudności w rozwoju i adaptacji dziecka.

Słowa kluczowe: zaburzenia emocjonalne; zaburzenia zachowania; agresja; lęk; dzieci pozbawione opieki rodzicielskiej

1. Introduction

Child psychopathology studies are focused on family system, complex relationships in families and reciprocal information between different family subsystems. It is necessary to research the disturbed families, which affects both individual family members and their children (Linares, 2006). The family reactions and behavior dealing with typical and atypical problems plays an important role in the adaptation of children. Stress leads to change, growth and reorganization of families (Mash & Wolfe, 2010). Children have the amazing ability to adapt to changing inquiries, which is essential for their development. However, they need a secure environment to adapt successfully or their development can be disturbed. All children have to deal with varying levels of stress, and these experiences can play a strengthening role in their psyche if this do not exceed their ability to cope with stress (Masten, 2007).

Although the child establishes successful strategies adapting to anger and aggression manifestations of family members, overdosing with negative experiences and challenging adaptive abilities of child can cause excessive frustration which often manifests itself with symptoms of fear, anxiety, problems with peers or school, and emotional or conduct disorders (El-Sheikh et al., 2008). Stressful events in the family affect each child in a different and unique way, but certain situations cause more intense stress reactions and consequences. Child abuse is among the most unfavorable and destructive forms of stress, but dysfunctions in the family, such as parental alienation and disruption of the parent-child relationship, also create serious outcomes for the emergence of emotional and behavioral problems (Mash & Wolfe, 2010).

2. Material studied

2.1. Attachment theory and child development

The formation of reliable attachment is the foundation of child development and interpersonal competencies. Attachment theory is founded by psychiatrist John Bowlby as a result of his focused experimental and research work on parent-child separation affecting an overall personal and behavioral development of the individual. J. Bowlby developed a psychological, evolutionary, and ethological theory that provided a descriptive and explanatory framework for understanding the interpersonal relationships of human beings. His followers believe that the child needs a secure relationship with a significant adult, and disturbance of child-parental relationship affects normal social and emotional development of the child. Parent-child attachment and the home ethos play

a crucial role in regulating emotions in early stage of development. Emotion regulation refers to the ability of modulating or control the emotion and impulses intensity and expression in an adaptive way (Maughan & Cicchetti, 2002). Children are more likely to exhibit emotional and behavioral problems as a result of their negatively distorted views of themselves and others when a lack of supportive and secure family environment is established (Feiring & Cleland, 2007). The abnormal development studies are based on extensive research of the child-parental relationship, and attachment plays a key role in emotional health of adolescents and attachment theory integrates evolutionary biology aspects with existing psychodynamic concepts of early childhood experiences (Bowlby, 1988). Attachment refers to the process of establishing and maintaining an emotional connection of the child with parents or other significant adults, and the ability to create and maintain an emotional connection with others is considered as a key feature of mental health (Matanova, 2003).

2.2. Emotional and behavioural disorders

Emotional and conduct disorders according to the International Classification of Diseases (ICD-10) differentiates the main referred disorders in childhood and adolescence under heading V "Mental and behavioural disorders", in subheadings from F-90 to F-98 (International Classification of Diseases, 2003; Popova, 2018). The clinical point of view in behavioural disorders connects them with the presence of emotional disorders, which makes them interrelated in etiologically and symptomatically concern (Matanova, 2003).

Emotional disorders in childhood are characterized by changes in mental states such as anxiety, depression, experiencing a strong negative emotion, symptomatically expressed by somatic manifestations of the child expecting future danger or unhappiness. The definition captures two main characteristics of anxiety – a strong negative emotion and fear (Barlow, 2002; Mash & Wolfe, 2010). Updated eleventh version of the ICD is planned to be introduced in most countries in the world by 2022 and presents a radical change in the diagnostic basis and classification of emotional disorders. ICD-11 completely eliminates the "Behavioural and emotional disorders with onset usually occurring in childhood and adolescence" category and its individual subheadings are classified in other groupings with which they share symptoms according to the latest research findings emphasizing the continuity of emotional and conduct manifestations in different age stages (Gaebel et al., 2017; Reed et al., 2019, World Health Organization, 2018).

Emotional disorders are distrubuted between the cathegories "Anxiety and fear-related disorders" (06), "Mood disorders" (06) and the new rubric "Disorders specifically associated with stress" (06) with different variations, according

to age – children, adolescents and adults. Anxiety and fear-related disorders describes excessive fear, anxiety and related behavioural disturbances, with symptoms that are severe enough to result in significant distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Mood disorders refer to depression and depressive episodes, and Disorders specifically associated with stress are directly related to exposure to a stressful or traumatic events to emphasize that these disorders share the necessary etiologic requirement, as well as to distinguish included disorders from the various other mental disorders that arise as a reaction to stressors. ICD-10 reactive attachment disorder of childhood and disinhibited attachment disorder of childhood are reclassified to this grouping owing to the lifespan approach of the ICD-11 and in recognition of the specific attachment-related stressors inherent to these disorders (Reed et al., 2019).

Behavioural disorders are categorized in "Disruptive behavior or dissocial disorders" (06) replacing the ICD-10 Behavioral Disorders (F91), and are characterized by recurrent and persistent behavioural problems such as defiant, disobedient, provocative, disruptive or dissocial behaviours, persistently violating the basic rights of others or major age-appropriate societal norms, rules, or laws (World Health Organization, 2018). Children and young people with behavioral problems demonstrate a variety of destructive and disruptive actions, ranging from opposition and oppositional behavior, such as whining, swearing, and irritability, to more serious forms of antisocial behavior such as vandalism, theft, assault (Mash & Wolfe, 2010). The new classification reflects to a greater extent the full range of behavioral disorders and phenomenology observed in the two conditions included in this heading: "Oppositional and defiant disorder" (6C90) and "Conduct-dissocial disorder" (6C91). Various studies have outlined that destructive behavior and conduct disorders are often associated with problematic psychosocial environments and psychosocial risk factors, such as peer rejection, deviant community influences, parental mental health problems, and family dysfunctions. Limited prosocial emotions can be assigned to both disruptive behaviour and dissocial disorders sections as a main indicator to identify them (Reed et al., 2019; World Health Organization, 2018).

3. Problem statement and area description

It has been found that children with emotional and behavioural disorders, raised outside the family environment and without parents demonstrate the greatest manifestations of aggression and anxiety traced in an author's study of the influence of language on the aggression and anxiety (Zlatkova-Doncheva, 2019). The aim of the present study is to trace the behavioural manifestations

of aggression and anxiety among children with emotional and behavioral disorders who have a broken relationship with their parents. Due to their specifics, personal features and behavioral characteristics they are placed in more vulnerable position than their peers and justify the need of different approach to compensate the negative impact on their overall development. The hereby proposed scope is an instance from Bulgaria and it includes at-risk children grown outside of their families living in residential care centers. General hypothesis underlines that anxiety is a possible preposition of behavioural disorders and it is connected with lack of parental care. Second hypothesis proposes that negative language with a strong tone increases the aggression and anxiety of children with emotional and behavioral disorders.

The question of the present research is: What is the impact of language to anxiety and aggression of children deprived of parental care and would anxiety transform into conduct and behavioural problems in case of disturbed relationship child-parent?

4. Methodology

The study is aimed to research an individual case of a child raised without parents in a residential care centre who has “Other mixed disorders of conduct and emotions”, (F 92.8) according to ICD 10. The choice of the case is motivated by the lack of parental attachment and the presence of both emotional and behavioral disorders, examining the manifestations of aggression and anxiety. The child is one of the participants in a previous experiment with 40 children raised without parents in a residential care centre. The study traces the language influence on levels of aggression and anxiety of children experienced four different interaction strategies applied by four volunteers: normal voice and positive language; high tone and positive language; normal tone and negative language, and high tone and negative language. Surveillance has been conducted for data collection accomplished by independent observer subjecting reactions of the child from case study (as well as the other 39 participants) as a result of the four strategies. Anxiety has been indicated using indicators based on A. M. Prihojan’s anxiety concepts of defining anxiety in the context of self-assessment and interpersonal anxiety (Prihojan, 2000; Zlatkova-Doncheva, 2017). The criteria are measured in the following 10 indicators: diffidence, dependence, dissatisfaction, reliance, insecurity (for self-assessment anxiety); inadequacy, inactivity, non-communication, inability to seek help, and lack of empathy (for interpersonal anxiety). Aggression has been identified using Buss-Durky's classification of aggression, and a subject of observation (dependent variables) are five of the eight indicators of aggression: physical aggression (fighting); verbal aggression

(rude language and offend others); aggressive irritability (gets irritated and looses quickly temper); hostility (sabotages other children) and indirect aggression (unfounded gets angry to others).

Dependent variables were defined according to possibility to measure certain behavior reactions indicating anxiety and aggression. The measurement item analysis registers high internal consistency in general, positive correlation and high reliability (r_{sb}= 0.685, alpha of Crohn = α = α = .734). The items' difficulties are within acceptable limits and the scale has a high reliability value with an average inter-correlation of 0.368.

The results of the researched case study of the child are compared with the previously measured and analyzed results of the 40 children by the same methodology with the same indicators and criteria. Use of the tone (power of the voice) is preliminary measured and all linguistic signs (positive and negative words) are used with a normal tone (has a volume of 60 dB) and with a high tone – 75dB (decibels).

Result proceedings from the experienced four strategies compare means between all the participants of the residential centers and a new intervention group (*N* = 11) with the highest degree of aggressive behavior based on a comparison of averages between participants from all centres and child from the case study is one of those eleven children with the highest aggression values measured. Repetitive measures in a normal environment (their daily life) have been re-examined for the new intervention group to check whether the registered aggressive behaviors are affected by the impact intervention strategies or are a result of the child's overall personality characteristics. The same aggression and anxiety indicators are verified in an assessment scale replenished by six specialists and care givers who normally look after children (educators, assistant educators, social worker). All indicators were measured by the same observed behavior reactions showing expression of aggression and anxiety variables that have been experienced within the surveillance with language strategies. In addition, the specialists evaluate other general behavioral manifestations of the eleven most aggressive children, including the presented case study.

5. Results

5.1. Description of case study

A 15-year-old boy. The child is raised in a single-parent family, the mother has left the family and has abandoned him since birth (unknown) and the father was looking after the child. The father went to prison and the grandmother took the responsibility to look after the child. At the age of 8 the child is placed in a Home for children deprived of parental care after a request from grandmother,

who is unable to take care. At the age of 11, the child is reintegrated back into the family environment with his grandmother, often ran away from school, „wandered", committed some hooligan and anti-social actions. In 2017 at the age of 13 he was placed in a residential care center for for children deprived of parental care in Veliko Tarnovo, Bulgaria. The child maintains episodic contacts with his grandmother and aunts, and is a student in 5th grade at a local school. Since he was placed in residential care changes 4 schools because of aggressive behavior, non-compliance with rules and discipline, unbearable behavior, disrespect of authorities, refusal to study, running away from class. He repeated 6th grade twice and currently being a student in 6th grade (he was not able to pass next grades because of very low academic results). He has occasional contacts with the family with a short-term positive effect on behaviour.

5.2. Basic characteristics of the child

The child has "Other mixed disorders of conduct and emotions", (F 92.8) according to ICD 10 and applies cognitive functioning within the norm. Active attention is impaired and needs breaks to focus attention and complete tasks at once. The semantic-logical memory reports better possibilities in comparison with the mechanical one, as both are within the average norm – 63% success rate. Some thinking difficulties have been identified, and he manages to perform analysis, synthesis and generalization with additional support. The IQ is 80 according to Wechsler which is a low result within the norm. Difficulties in socio-communicative and emotional development have been identified as well as problems with emotions regulation. The child follows his own desires and has difficulties to obey rules. He is guided by the principles of "pleasure", clearly states his needs and expects immediately satisfying of his needs. When needs are not satisfied, he falls into crises in which he cries and screams for a long time. Psychological research shows dependence on smoking (desire to smoke every 10-15 minutes), manifestations of often destructive behavior, which is expressed in physical and verbal violence against other children at school and in the residential centre. He shows behavioral disorders, aggression towards children and staff in the residential care centre in case of non-satisfaction of his desires. He refuses to study, does not prepare and often leaves classes. There are registered anti-social actions that are expressed in hooliganism and vandalism, beatings of other children and theft.

5.3. Results about aggression and anxiety

The distribution of the assessment results for aggression, self-assessment and interpersonal anxiety scales is normal, with a predominant negative excess

E < 0 and is slightly asymmetric right drawn. The child from case study registers some of the highest values for aggression, as well as for anxiety compared to the intervention group (N=40). Mean values for physical aggression of the case study (M = 3.50; SD = 0.54) and the intervention group (M = 2.10, SD = 0.84), demonstrates that the child exhibits destructive behavior to an extremely large extent. An identical trend is found in the other indicators of aggression, registering a higher level of aggressive behavior (Table 1) and all mean values are above 3.00 compared to the intervention group.

Table 1

*Mean values of **aggression** for intervention group and case study*

Intervention group N = 40			Case study		
	Mean	SD		Mean	SD
Physical agression	2.10	0.84	Physical agression	3.50	0.54
Verbal agression	2.95	0.83	Verbal agression	3.83	0.40
Aggressive irritability	3.08	0.72	Aggressive irritability	3.83	0.40
Hostility	2.65	0.93	Hostility	3.83	0.40
Indirect agression	2.83	0.72	Indirect agression	3.33	0.51

It is registered that verbal aggression, *aggressive irritability* and *hostility* show extremely high values demonstrating that destructive behavior of the child is externalized (fight, insults, harassment) to others. Self-assessment and interpersonal anxiety indicators (Table 2) also report higher values comparison to intervention group, and only *reliance* indicator register slightly lower mean values of the child (M = 3.00, SD = 0.63) compared to the whole intervention group (M = 3.06, SD = 0.53).

Table 2

*Mean values of **anxiety** for intervention group and case study*

Self-assessment anxiety Intervention group			Self-assessment anxiety Case study		
	Mean	SD		Mean	SD
Diffidence	3.19	0.45	Diffidence	3.50	0.54
Dependence	3.06	0.53	Dependence	3.00	0.63
Dissatisfaction	2.85	0.54	Dissatisfaction	2.83	0.75
Reliance	2.83	0.43	Reliance	3.50	0.83
Insecurity	2.68	0.60	Insecurity	3.16	0.75
Interpersonal anxiety Intervention group			Interpersonal anxiety Case study		
	Mean	SD		Mean	SD
Inadequacy	3.19	0.45	Inadequacy	3.66	0.51
Inactivity	3.06	0.53	Inactivity	3.83	0.40
Non-communication	2.85	0.54	Non-communication	3.33	0.81
Inability to seek help	2.83	0.43	Inability to seek help	3.50	0.54
Lack of empathy	2.68	0.60	Lack of empathy	3.66	0.51

Examined child from the case study registered higher values of all the rest anxiety indicators with predominant interpersonal than self-assessment anxiety, and low levels of empathy are identified. It could be assumed that destructive manifestations cause difficulties in interpersonal relationships and are preceded by high personal anxiety. Oppositional behavior is supposed by the age of the child (15 years teenager) but aggressive manifestations intensity and the strong anxiety symptoms give indications for emotional origin of the disorder, and the behavioral disorder is rather concomitant.

Correlation analysis of individual results is conducted by Kendall-Tau rank coefficient (tau-b $r\tau$ of Kendall), taking into account the small number of the assessment respondents (6) defining abnormal distribution and requires nonparametric statistical methods. Data analysis (Table 2) suggests low correlation between *aggression* and *anxiety* despite the highest mean values of aggression indicators: *physical aggression* correlates only with *non-communication* ($r\tau = .90$; $p < .05$), *verbal aggression* with *dependence* ($r\tau = .74$; $p < .05$) and *inactivity* ($r\tau = 1.00$; $p < .05$); *aggressive irritability* with *dependence* ($r\tau = .74$; $p < .05$); *indirect aggression* with *insecurity* ($r\tau = .85$; $p < .05$), and *irritability* with *dependence* ($r\tau = .74$; $p < .05$) and with *aggressive irritability* ($r\tau = 1.00$; $p < .05$). Self-esteem anxiety indicators register higher correlation, such as *dependence* with *dissatisfaction* ($r\tau = .80$; $p < .05$) and with *insecurity* ($r\tau = .80$; $p < .05$); *dissatisfaction* with *reliance* ($r\tau = .80$; $p < .05$). No good correlation has been identified between the self-esteem and interpersonal anxiety, and only *dependence* demonstrates good correlation with *inactivity* ($r\tau = .74$; $p < .05$), and *diffidence* with *inability to seek help* ($r\tau = 1.00$; $p < .05$).

Presented data suggests that anxiety as a core derivative of emotional-behavioral symptoms, is the foundation of provocative and destructive behavior. Strong internal insecurity is expressed in dependence of external stimuli and need of affirmation and evaluation of others due to trauma or negatively saturated emotional experiences, and could be a preposition for behavioral disorders. The case study largely demonstrates the relation of insecurity and dissatisfaction as a result of unfavorable life factors and violence, assuming that anxiety is directly dependent on aggressive behavior in different situations. Anxiety determines the way in which the individual interacts with other people and adapts to surrounding world, which is directly related to lifeskills and adaptive skills development – communication, independence, self esteem, adequate reactions, assessment of situations, emotional resilience and confidence (Prihojan, 2000; Zlatkova-Doncheva, 2018).

5.4. Other behavior manifestations

Assessment of specialists outline that the child from case study intensively violates established rules in the residential care centre, and is strongly influenced

by mates with identical behavioural problems and from marginalized community. Academic skills of the researched case are significantly low despite his normal cognitive functioning (Table 3). The influence of external authorities outside family environment is related to the teenage crisis and the strong dependence on friends is a normal phenomenon. The problems in current case derive from antisocial behavior of the child strongly associated with external authorities from the community. An in-depth analysis of results identifies that strong insecurity of the child and dependence of external stimuli arouses him searching for people with identical behavioral that will confirm his personality and allow him to connect emotionally without feeling anxious. It can be assumed that inability of the child to find an inner incentive to assert his identity in front of others is the reason for this phenomenon, and it is determined by his weak skills to build a trusting relationship due to unreliable attachment and lack of basic trust. From attachment theory point of view concomitant factors as mother abandoning as well as disturbed child-parent relations, indicates previously possible reactive attachment disorder which subsequently transforms into anxiety and behavioral disorder. Relation between anxiety disorders and attachment disorders has been confirmed in other studies (Mash & Wolfe, 2010) and may assume that in current case study emotional disorders are leading and behaviour disorder is rather subsequent.

Table 3

Mean values of other behavior manifestations

	Mean	Std.Dev.		Mean	Std.Dev.
Violates rules in residential car centre and	3,83	0,40	Is influenced by friends outside residential care centre	3,50	0,54
Has antisocial behavior and ha: been condamned for crime actions	4,00	0,00	Friends outside the residential care centre have stronger authority than teachers	2,83	0,98
Has low academic achievements at school	4,00	0,00	Friends outside residential care centre have negative influence or childs behaviour	3,50	0,54
Often runs away from school	3,16	0,98	Friends outside residential care centre are from marginalized corr munity	3,83	0,40

5.5. Language strategies influence on aggression and anxiety of studied case

Dynamics and impact of the four intervention strategies used: positive and negative language with high and normal tone outline that child demonstrates very different results from whole intervention group and negative language with a high tone has higher impact on aggression and anxiety of the child case study while negative language with normal tone has higher influence on

the aggression and anxiety of whole intervention group. Results confirm the hypothesis that negative language with high tone most provokes destructive behaviour of children with emotional and behavioral disorders, and mean values of aggression for intervention group is M = 2.35; SD = 1.56, and the child from case study has highest degree for all aggression variables (5.00 – including verbal aggression, physical aggression, indirect aggression, as well as irritability and hostility).

Negative language with high tone provokes all indicators of both self-assessment and interpersonal anxiety, with a total score of 5.00 for both scales (Table 4). Moreover, although the results for aggression variables of intervention group when positive language with a high tone is used are very low (M = 0.28; SD = 0.72), in similar situation the case study demonstrates highest rate for aggressive irritability.

Table 4

Mean values of 4 strategies for aggression and anxiety for intervention group and case study

Aggression Intervention group			Aggression Case study	
	Mean	SD		Value
Positive language Normal tone	0.37	0.92	Positive language Normal tone	0
Positive language High tone	0.27	0.71	Positive language High tone	1
Negative language Normal tone	2.47	1.32	Negative language Normal tone	3
Negative language High tone	2.35	1.56	Negative language High tone	5
Self-assessment anxiety Intervention group			**Self-assessment anxiety Case study**	
	Mean	SD		Value
Positive language Normal tone	0.37	0.93	Positive language Normal tone	0
Positive language High tone	0.27	0.72	Positive language High tone	3
Negative language Normal tone	2 48	1 32	Negative language Normal tone	4
Negative language High tone	2 35	1 56	Negative language High tone	5
Interpersonal anxiety Intervention group			**Interpersonal anxiety Case study**	
	Mean	SD		Value
Positive language Normal tone	0.37	0.93	Positive language Normal tone	0
Positive language High tone	0.27	0.72	Positive language High tone	1
Negative language Normal tone	2.48	1.32	Negative language Normal tone	2
Negative language High tone	2.35	1.56	Negative language High tone	5

An identical tendency is observed for anxiety: positive language with high tone provokes his inadequate reactions (need of attention), as well as diffidence, dependence, and dissatisfaction which repeated results from specialist's assessment scale for his anxiety. Negative language with a normal tone can also provoke his diffidence, dependence, dissatisfaction, and reliance. These results confirm the assumption of leading anxiety disorder, but also reaffirm the hypothesis of

the influence of paralinguistic sign (tone) to behaviour of children with emotional and conduct disorders.

6. Discussion

Relation between increased tone and destructive behavior is also confirmed from other studies outlined that children with anxiety, depressive and behavioral disorders react in an inadequate and distorted" way to external stimuli and situations, interpreting them in more negative way than they actually are (Muris et al., 2003; Albano et al., 2003; Alfano et al, 2002). The use of language from these situations should be clarified in more details, and children with emotional disorders experience strong difficulties in understanding language messages (Friend, 2000), and current study outlines impact of specific language elements – lexical signs (semantic meaning) and paralinguistic sign “tone”.

Results confirm the hypothesis that using words with negative meaning in combination with high tone (shouting) are completely non effective and even could increase destructive behavior, which is important for both parents and professionals working with children with emotional and behavioral disorders. Results outline that negative language with high tone most provokes destructive manifestations in children with emotional and behavioral problems, which can be explained with their inability to interpret adequate situations and signals from external sources, including language messages. Experienced language strategies would affect child relationship with others – negative language would determine anxiety in communication combined with low empathy enhance aggressive behavior.

Lack of empathy is an expression of insecurity and inferiority expressed through aggression towards others. Demonstrated lack of empathy predicts difficulties in inhibiting emotions and impulses according to social requirements and is a preposition for future destructive manifestations and behavioral disorders, especially when child is exposed to negative language and raised tone. At the same time, lack of empathy poses a particularly serious threat of antisocial behavior, so developing empathy within children is a possible protective factor for behaviour disorders prevention.

In addition, current study outlines a tendency for the strong relation between anxiety and aggressive manifestations. Dependence on external stimuli leads to insecurity and dissatisfaction which are transformed into inadequate reactions to others, communication problems, lack of initiative and empathy and finally erupting into destructive and asocial behaviors. Aggression is an expression of an inner anxiety of the child when adapting to other people and causes inferiority which can grow into a protective mechanisms leading to suffering and increasing cruelty to others in order to increase the inner significance

of child personality. High levels of aggression are provoked by desperate need of affirmation and fear of negative feedback or rejection. Situations are interpreted with more negative meaning than they are as the child has difficulties to manage negative experiences and tries to establish identity through destructive behaviour as a protective mechanism to hide his vulnerability.

7. Conclusion

Case study analysis confirms that anxiety, as a basic symptom of emotional disorders is the foundation of destructive behaviour. Traumas and adverse life events including family disturbances can provoke appearance of emotional and behavioral disorders. An in-depth analysis of the results identify that insecurity induces child to commit with peers with identical behaviour reaffirming his personality and allowing him to connect emotionally without feeling anxious. It is assumed that the reason for this phenomenon is the inability of the child to find an internal incentive for affirmation and self identification which is determined by his weak skills to build trust, due to unreliable attachment as a result of lack of parental care and disturbed child-parental connection.

Current study outlines the relation between deprivation of parental care and emotional and behavioral disorders, and disturbed child-parent relationship is a predictor for possible difficulties in child development and adaptation. Similar problem could occur in families with parental alienation or broken relationship with only one of the parents. Stressful events and dysfunctions in the family, such as disruption of the parent-child relationship create serious preconditions for the emergence of emotional and behavioural issues as far as broken attachment and lack of trust between the child and the parent can lead to increased anxiety, aggression, decreased confidence and difficulties in the child's adaptive abilities and interpersonal relationships.

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