

# Age-developmental stage and severity of trauma related symptoms, anxiety and depressive symptoms in participants who lost their fathers during the war in Croatia

---

Dijanić Plašč, Ivana; Poljarević, Sanja; Lončar, Mladen; Henigsberg, Neven

Source / Izvornik: Collegium Antropologicum, 2011, 35, 139 - 44

Journal article, Published version

Rad u časopisu, Objavljena verzija rada (izdavačev PDF)

Permanent link / Trajna poveznica: <https://um.nsk.hr/um:nbn:hr:105:277024>

Rights / Prava: [In copyright](#) / [Zaštićeno autorskim pravom.](#)

Download date / Datum preuzimanja: **2024-05-19**



Repository / Repozitorij:

[Dr Med - University of Zagreb School of Medicine  
Digital Repository](#)



# Age-Developmental Stage and Severity of Trauma Related Symptoms, Anxiety and Depressive Symptoms in Participants who Lost their Fathers during the War in Croatia

Ivana Dijanić Plašć<sup>1</sup>, Sanja Poljarević<sup>2</sup>, Mladen Lončar<sup>3</sup> and Neven Henigsberg<sup>3</sup>

<sup>1</sup> »Duga – Zagreb« Home for Adult and Child Victims of Family Violence, Zagreb, Croatia

<sup>2</sup> Private Neuropsychiatric Practices, Pula, Croatia

<sup>3</sup> University of Zagreb, Croatian Institute for Brain Research, Zagreb, Croatia

## ABSTRACT

*Children of different ages will experience a traumatic event in a different ways. The most important in the generalization of research findings is recognizing that children of different ages think differently, act differently and have different emotional functioning. Experiences that are extremely traumatic to an adult may be perceived by a young child as something that is not so frightening. The fear that the child feels will more frequently be a reflection of that of the adult rather than generated by the child's own perception of the event. So, the individual experience of the trauma is age dependent. Our study focused on children who lost their fathers in conditions of war. The aim was to explore the association between age-developmental stages and the severity of trauma related symptoms, anxiety and depressive symptoms in participants who lost their fathers during the war. The study included 103 people who lost their fathers during the war in Croatia, who came to the physical and psychiatric examination organized by the Ministry of Family, War Veterans and Intergenerational Solidarity. The sample was consisted of the participants who were children, or not born yet, at the time when they lost their fathers during the war in Croatia. At the time of interview, the participants were aged between 15 and 35 years old. Data was collected using a structured clinical interview which also included socio-demographic data. Data about former and current psychiatric symptoms were collected using the following instruments: Clinician- Administered PTSD Scale (CAPS), Hamilton anxiety scale (HAMA), Hamilton depression scale (HAMD). Results showed that there was significant correlation between age and results on used scales. The participants who lost their fathers at a very young age or even before they were born showed less trauma symptoms ( $r=0.249$ ;  $p<0.05$ ) less anxiety ( $r=0.374$ ;  $p<0.01$ ) and depressive ( $r=0.384$ ;  $p<0.01$ ) symptoms than participants who lost their fathers at an older age. The study confirmed that the individual experience of the trauma of losing a father in war circumstances is associated with age.*

**Key words:** trauma, children, trauma related symptoms, anxiety, depression

## Introduction

Separation and loss increase the chances of various difficulties in a child's psychological development<sup>1,2</sup>, and these occur often during the war. For example, 56% of the children exposed to war in Croatia feel that they need some type of psychological help<sup>3,4</sup>. Children who lost a parent have a significantly larger frequency of post-traumatic stress disorder (PTSD) than children who did not lose a parent<sup>5</sup>. Researchers have determined a high level

of co-morbidity between PTSD and depression among children exposed to war traumas and who have lost one or both parents<sup>6</sup>. As such, we found a very high frequency of PTSD in the group of children who live with one parent. It is possible that these children continued to live in vulnerable families whose members suffered as a result of the loss of a family member and the grieving process was ongoing. The surviving parent and other

family members can also have post-traumatic stress disorder and depression as a result of living in war circumstances and are therefore not able to create a protective atmosphere for the child's development. It is known that the children of depressed parents are faced with a higher risk of psychopathology and other difficulties<sup>5,7</sup>. In addition, continuously difficult socio-economic situations and the loss of stability and togetherness in emotional relationships in these families further exacerbate the problem, especially in refugee families who cannot return to the life they had before the war without the family member they lost<sup>5,6</sup>. The positive relationship between the child and parent, who plays an important protective role and encourages the child's positive development, is broken<sup>5,8</sup>. As a result the loss of one or both parents in early childhood can have serious long-term negative effects on psychological health. It seems that the traumatic event in itself is not the only thing responsible for long-term negative effects, but that the chronic tension surrounding such a traumatic experience also plays a role<sup>5,9–11</sup>. Even though children's physical injuries can be similar to those of adults, their psychological reactions to trauma can be very different because of their quickly changing stages of development, their limited ability to deal with the problem and lack of ability to seek services<sup>12,13</sup>. The manifestation of symptoms linked to trauma is different with children than with adults and likely to change over time<sup>12,14</sup>. The general assessment is that children who have been exposed to war stressors have an 10 to 90% increased rate of frequency of post-traumatic symptoms which are manifested with anxiety disorders such as PTSD and other psychiatric disorders including depression, violent behaviour and somatic symptoms<sup>3,15–18</sup>. Such wide range is mostly depended on some other circumstances (exact age-developmental stage, supportive parenthood or nearest ones, coping strategies, nature of the trauma, etc.) that could influenced on the type and severity of post-traumatic symptoms. However, of all the stressors imposed on civilians who suddenly find themselves in the middle of a war, perhaps the most difficult is the loss of loved ones<sup>19,20</sup>. Children are not only innocent victims of war but are also saddened because of the loss of those close to them. Despite the abundance of literature on the psychological effects of the scars of the death of a parent, there is little research on grieving in children and its long-term effects. Contemporary literature suggests that the psychological health of a child who has experienced the death of a parent is firstly dependent on the support of the wider family and on the child's relationship with the surviving parent<sup>21</sup>. Research has shown that those who successfully went through the grieving process over time recovered from the psychological stress caused by the death of their father. The importance of family and social support, common ideology, religion and a feeling of togetherness can increase resiliency and act as a mechanism for dealing with problems<sup>3</sup>. Gudas described that the circumstances surrounding a death can prevent children and adolescents from grieving the loss, therefore increasing the risk of long-term consequences<sup>17,22</sup>. The data suggest that the symptoms of post-trau-

matic stress disorder in children do not decrease over time. This is in accordance with the work of Rozensky and associates which indicates that exposure to serious violence correlated with permanent symptoms<sup>23</sup> and the work of Desivily and associates which suggests that adolescents who are the victims of terrorism show symptoms of post-traumatic stress disorder even 17 years later<sup>17,24</sup>. Numerous researches have confirmed that older children are more vulnerable to psychological effects of trauma than younger children<sup>25,26</sup>. However, despite exposure to a whole spectrum of heinous acts, some children can adapt with minimal symptoms. Some of the protective factors have been discovered: the child's ability to recognise and avoid danger, their ability to use adults to take care of them, their ability to control their anxiety, the child's ability to dedicate himself to a goal<sup>27</sup>. Among other factors are the degree of social and family cohesion and support system as well as common values and beliefs. Biological factors and temperament modulate the reaction to stress but little is known about their specific values<sup>3</sup>. Age can give some idea regarding how children will react to exposure to violence but by itself gives only a partial picture<sup>28</sup>. War and violence affect children in different ways depending on their age and stage of development<sup>29</sup>.

The aim of this study was to explore the association between age-developmental stages and the severity of trauma related symptoms, anxiety and depressive symptoms in participants who lost their fathers during the war. We also tested whether there existed differences between genders based on the severity of trauma related symptoms, anxiety and depressive symptoms.

## Subjects and Methods

The data were gathered for a convenience sample of 103 participants who came to the physical and psychiatric examination at the Clinic for Tumours in Zagreb. The examinations were organized by Ministry of family, war veterans and intergenerational solidarity. Survey included participants between 15 and 35 years old who lost their fathers during the war in Croatia while they were children. All participants gave their written informed consent. Data were collected using a structured clinical interview which also included socio-demographic data: the age of the participant, educational status, marital status, employment status, parenthood status, number of children and their age, income, previous treatment, type of treatment, psychiatric heredity and addictions. The participants were also interviewed about their total household income and on the number of dependents in their household. Data about previous and current psychiatric symptoms were collected using the following instruments: Clinician-Administered PTSD Scale (CAPS)<sup>30</sup>, Hamilton anxiety scale (HAMA)<sup>31</sup>, Hamilton depression scale (HAMD)<sup>32</sup>.

## Statistics

Several statistical analyses were performed. Standard statistical methods were used to calculate means and standard deviations ( $X \pm SD$ ). In correlation analysis Pearson coefficient correlation ( $r$ ) was used. The statistical significance of group differences was tested by t-test. Significance was set at  $p < 0.05$ . Analysis was performed using SPSS, version 16<sup>33</sup>.

## Results

Socio-demographic characteristics of the participants are shown in Table 1. The study results showed that correlation between the child's age at the time of loss and the total CAPS results, is statistically significant ( $r = 0.361$ ;  $p < 0.01$ ) (Table 2). This correlation showed that

**TABLE 1**  
SOCIO-DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS  
( $N = 103$ )

Characteristic	Participants				
	No. (%)				
Sex					
Men				36	(35.0)
Women				67	(65.0)
Education					
Primary school				18	(17.5)
Secondary school				64	(62.1)
College / University education				21	(20.4)
Employment status					
Employed				43	(41.7)
Unemployed				6	(5.8)
Student / Pupil				54	(52.4)
Marital status					
Married				22	(21.4)
Unmarried				75	(72.8)
Divorced				2	(1.9)
Unmarried but live together				4	(3.9)
Age	N	M	SD	Min.	Max.
Total	103	23.42	5.14	5	35
Female	67	23.28	4.98	15	35
Male	36	23.67	5.48	15	35

children who lost their fathers at a younger age had a lower total CAPS result which indicates that they had a lower degree of demonstrating symptoms linked to the traumatic event they experienced. Similarly, children who lost their father at an older age had a higher total CAPS result indicating that they had a higher degree of symptoms linked to the traumatic experience. Also, the results of our research show that there is a statistically significant relationship between the age of children when they lost their fathers ( $r = 0.325$ ;  $p < 0.01$ ) and the degree of severity of symptoms of mortification and total avoidance (Table 2). The results obtained indicate that children who lost their fathers at a younger age demonstrate fewer symptoms of mortification and avoidance than children who lost their fathers at an older age. Additionally, we didn't find a statistically significant correlation between the age of children when they lost their fathers and demonstration of symptoms of permanent stimulation of the vegetative system ( $r = 0.160$ ;  $p > 0.05$ ), with children who lost their fathers at a younger age (Table 2). A statistically significant correlation wasn't confirmed between the age of children when they lost their fathers and the degree of demonstrating significant difficulties and damaged functionality ( $r = 0.148$ ;  $p > 0.05$ ). The results did not show a statistically significant correlation between the age of participants at the time of loss and the degree of symptoms of reliving the trauma ( $r = 0.070$ ;  $p > 0.05$ ). By testing the relationship between the age of participants and the time of loss and the level of anxiety and depression, the results obtained show that there is a statistically significant correlation between age and degree of anxiety ( $r = 0.374$ ;  $p < 0.01$ ) because the results showed that participants who lost their fathers at a younger age demonstrated a lower degree of anxiety (Table 3). The same results were obtained for the correlation between age and degree of depression ( $r = 0.386$ ;  $p < 0.01$ ) since the participants who lost their fathers at a younger age demonstrated a lower degree of depression (Table 3). Testing the differences based on the gender of the partic-

**TABLE 3**  
PEARSON'S COEFFICIENT OF CORRELATION BETWEEN THE AGE AT WHICH THE CHILD LOST HIS FATHER AND THE TOTAL RESULTS ON THE HAMILTON ANXIETY SCALE AND HAMILTON DEPRESSIVE SCALE

	Total HAMA results	Total HAMD results
Age	.374**	.386**

\*\* $p < 0.01$

**TABLE 2**  
PEARSON'S COEFFICIENT OF CORRELATION BETWEEN THE AGE AT WHICH CHILDREN LOST THEIR FATHERS AND SUB-SCALES AND TOTAL RESULTS ON THE CAPS

	B criteria total symptoms of repeatedly reliving	C criteria total avoidance and symptoms of mortification	D criteria total symptoms of permanent stimulation of the vegetative system	F criteria total significant disorders and damaged functionality	Total number of CAPS points
Age	.070	.325**	.160	.148	.249*

\* $p < 0.05$ , \*\* $p < 0.01$

**TABLE 4**  
DIFFERENCES ACCORDING TO GENDER ON CAPS (T-TEST ANALYSIS)

	Gender	N	M	SD	t	p
B criteria total symptoms of repeatedly reliving	female	67	8.07	2.84	-1.159	.249
	male	36	8.81	3.40		
C criteria total avoidance and symptoms of mortification	female	67	10.42	3.29	-.340	.734
	male	36	10.67	3.95		
D criteria total symptoms of permanent stimulation of the vegetative system	female	67	10.75	2.34	.536	.593
	male	36	10.47	2.69		
F criteria total significant disorders and damaged functionality	female	67	5.87	2.01	.074	.941
	male	36	5.83	2.29		
Total CAPS points	female	67	29.13	6.34	-.553	.581
	male	36	29.94	8.30		
Total HAMD results	female	67	12.04	5.16	.341	.734
	male	36	11.67	5.71		
Total HAMA results	female	67	12.34	5.19	-.040	.968
	male	36	12.39	6.07		

ipant showed that there were no statistically significant differences in any of the sub-scales on the CAPS survey or in the total results (Table 4). Furthermore, there were no statistically significant differences on the scales of depression and anxiety (Table 4).

## Discussion and Conclusion

One of the more important aspects of clinical work with traumatised children is the realisation that children of different ages think differently, act differently and react emotionally in a different way<sup>34</sup>. Children of different ages will experience a traumatic event in a different ways. Experiences that are traumatic for adults do not necessarily have to be so for children. On the other hand experiences that are extremely traumatic for a small child do not have to be experienced as something terrifying by adults. The research has shown that a three or four year old child will experience separation from his parents and family as a deeply traumatic event<sup>34</sup>. The trauma of this event can be easily seen when the behaviour and functioning of these children is observed over time. Our study confirmed that the individual experience of the trauma of losing the father in war circumstances is associated with age. Results showed that there was significant correlation between age and results on used scales. The participants who lost their fathers at a very young age or even before they were born showed less trauma symptoms, less anxiety and depressive symptoms than participants who lost their fathers at an older age. The results obtained are in accordance with the research that studied children in Croatia during the time of war. Vizek-Vidović and associates compared younger children (grades 2–5) to an older group (grade 6–8) in Croatia and found that older children demonstrated more depressive and anxious reactions<sup>35</sup>. Studies on children who lost their parents during times of peace show different levels

of harmful effects on their psychological health. In their study on 38 children between the ages of 5 and 12, Weller, Weller, Fristad and Bowes discovered that 37% of them satisfied the diagnostic criteria for a great depressive disorder and 61% of them had suicidal intentions during the three months following their parent's death<sup>36</sup>. Elizur and Kaffman followed 25 children between the ages of 2 and 12 over 3.5 years following the death of their father in war and found that over half of them showed great dependence on others, episodes of rage and fear and 40% demonstrated pathological grieving (i.e. symptoms of such gravity that they impaired children in their daily life and functioning in the family, school and among friends)<sup>37,38</sup>. They discovered that the severity of the reaction to grief depended on the quality of the relationship with their father before his death, on the ability of mothers to share grief with the child and on the availability of a wider family. There are numerous factors that prevented children who lost their father in war from successfully going through the grieving process and in this way successfully recovering from the psychological stress caused by the loss. Above all this is the link of a child's psychological reaction to trauma to the reactions of a parent<sup>26,39,40</sup>, namely their mother. Bryce, Walker Ghorayeb and Kanj noted that the psychological reactions of Lebanese children (between 5 and 7 years of age) were best predicted by the level of symptoms of depression in the mother<sup>41</sup>. The existence of psychopathology before the tragedy, a history of exposure to traumatic experiences, participative estimate of stress factors and efficacy of the style of adaptation affect the risk of long-term trauma<sup>42</sup>. In the long-term, a series of maladaptive, emotional, cognitive and behavioural problems are observed in these children, who having their roots in the first adaptive reactions to the traumatic event<sup>34</sup>. Temporary disappearance and re-emergence of the clinical problems during development is common in traumatized children; symptoms and psychological difficulties become dormant,



change or even disappear completely during certain stages of development<sup>34</sup>. The child's functioning can then seem age-appropriate. However, this does not mean that the child should not be monitored permanently because it is very often the case that a group of symptoms appears again when a new phase of development begins<sup>34</sup>, that is later in adulthood.

Gender can also be an important factor in the natural course of symptoms linked to trauma among children traumatized by war. Our study did not show statistically significant differences according to gender on any of the scales, the reason for which may lie in an unequal number of male and female participants. This also brings up the issue of whether it is possible that a mother figure has an effect on the absence of differences between genders during the traumatic experience of losing a father in circumstances of war. This assumption is based on the fact that gender roles are learning, so some behaviour and reactions can manifest itself through learned patterns of the parental model. When discussing traumatic war experiences studies have confirmed the existence of differences between the genders in PTSD symptoms, anxiety and depression. It has also been confirmed that female adolescents have a higher level of PTSD symptoms<sup>6</sup> and greater fears linked to war than male adolescents<sup>17,43–46</sup>. The same was confirmed among Israeli girls and young children after the Gulf War, but the symptoms weakened significantly over time, which could be explained with some other circumstances (exact age-developmental stage, supportive parenthood or nearest ones, coping strategies, nature of the trauma, etc.) that

could influenced on the type and severity of post-traumatic symptoms<sup>17,47,48</sup>. The results of studies which included children from Bosnia showed that boys and girls exposed to war trauma who remained in the war zone can have a different natural course of symptoms caused by trauma<sup>17,49,50</sup>. It is believed that girls are at a higher risk after exposure to war trauma as compared to boys because of the different mechanism they have for dealing with problems<sup>51,52</sup> and difficulties they have in adapting to repetitive trauma<sup>17,53</sup>. This can also be interpreted by the fact that girls are usually raised to openly express their fears, difficulties and other emotions while boys are usually discouraged from such open expression of emotions and it is therefore more likely that they will hide, deny or suppress difficult feelings and emotions<sup>28,54</sup>. The main limitation of this study is a lack of medical documentation on data related to the family history of psychiatric illnesses as well as information about life history of our participants from the time they lost their fathers in the war circumstances. We suspect that there could be some other life events and surroundings that could make an impact on participant's mental health. Therefore it is important to emphasize that our findings cannot be generally applied to all Croatian persons who lost their fathers in the war circumstances. In conclusion, the study confirmed the association between age-developmental stage in the time of losing father in war circumstances and severity of trauma symptoms 17 years after. Therefore, there is the need for permanently monitor a person's clinical status regardless of the momentary status of treatment.

## REFERENCES

- DE ZULUETA CF, *Int Rev Psychiatry*, 19 (2007) 221. — 2. MURTHY RS, LAKSHMINARAYANA R, *World Psychiatry*, 5 (2006) 25. — 3. SHAW JA, *Clin Child Fam Psychol Rev*, 6 (2003) 4. — 4. BARATH A, *Croat Med J*, 43 (2002) 213. — 5. HASANOVIĆ M, SINANOVIĆ O, SELIMBAŠIĆ Z, PAJEVIĆ I, AVDIBEGOVIĆ E, *Croat Med J*, 47 (2006) 85. — 6. AJDUKOVIĆ M, *Adolescence*, 33 (1998) 209. — 7. BEARDSLEE WR, GLADSTONE TR, WRIGHT EJ, COOPER AB, *Pediatrics*, 112 (2003) 119. — 8. GRIBBLE PA, COWEN EL, WYMAN PA, WORK WC, WANNON M, RAOOF A, *J Child Psychol Psychiatry*, 34 (1993) 507. — 9. HASANOVIĆ M, SINANOVIĆ O, PAVLOVIĆ S, *Croat Med J*, 46 (2005) 105. — 10. WOLFF PH, TESFAI B, EGASSO H, ARADOM T, *J Child Psychol Psychiatry*, 36 (1995) 633. — 11. ATWINE B, CANTOR-GRAAE E, BAJUNIRWE F, *Soc Sci Med*, 61 (2005) 555. — 12. STEIN BD, COMER W, KELLEHER GK, *Soc Psychiatry Psychiatr Epidemiol*, 34 (1999) 464. — 13. MAGWAZA AS, KILLIAN BJ, PETERSEN I, PILLAY Y, *Child Abuse Negl*, 17 (1993) 795. — 14. TERR LC, *Too scared to cry* (Harper & Row, New York, 1990). — 15. ALLWOOD MA, BELL-DOLAN D, HUSAIN SA, *J Am Acad Child Adolesc Psychiatry*, 41 (2002) 450. — 16. GOLDSTEIN RD, WAMPLER NS, WISE PH, *Pediatrics*, 100 (1997) 873. — 17. HADI FA, LLABRE MM, *J Trauma Stress*, 11 (1998) 45. — 18. THABET A, VOSTANIS P, *J Child Psychol Psychiatry*, 40 (1999) 385. — 19. RUTTER M, *J Child Psychol Psychiatry*, 22 (1981) 323. — 20. KAFFMAN M, ELIZUR E, *Int J Fam Ther*, 6 (1984) 259. — 21. BREIER A, KESLOE JR, KIRWIN PD, BELLER SA, WOLLKOWITZ OM, PICKAR D, *Arch Gen Psychiatry*, 45 (1988) 987. — 22. GUDAS LJ, *Concepts of death and loss in childhood and adolescence: A developmental perspective*. In: SAYLOR CF (Ed) *Children and disasters* (Plenum Press, New York, 1993). — 23. ROZENSKY RH, SLOAN IH, SCHWARZ ED, KOWALSKI JM, *Psychological response of children to shootings and hostage situations*. In: SAYLOR CF (Ed) *Children and disasters* (Plenum Press, New York, 1993). — 24. DESIVILYA HS, GAL R, AYALON O, *J Trauma Stress*, 9 (1996) 881. — 25. BLOCH DA, SILBER E, PERRY SE, *Am J Psychiatry*, 113 (1956) 416. — 26. GREEN BL, KOROL M, GRACE MC, VARY MG, LEONARD AC, GLESEER GC, SMITSON-COHEN S, *J Am Acad Child Adolesc Psychiatry*, 30 (1991) 945. — 27. LUSTIG SL, KIA-KEATING M, GRANT-KNIGHT W, GELTMAN WG, ELLIS H, KEANE T, KINZIE JD, SAXE G, *White paper: Child and adolescent refugee mental health* (Boston Medical Center, Boston, 2002). — 28. BERMAN H, *Public Health Nurs*, 18 (2001) 243. — 29. GARBARINO J, KOSTELNY K, *What do we need to know to understand children in war and community violence*. In: APFEL R, SIMON B (Ed) *Minefields in their hearts, the mental health of children in war and community violence* (University Press, London, 1996). — 30. BLAKE DD, WEATHERS FW, NAGY LM, KALOUEPEK DG, GUSMAN FD, CHARNEY DS, KEANE TM, *J Trauma Stress*, 8 (1995) 75. — 31. HAMILTON M, *Br J Med Psychol*, 32 (1959) 50. — 32. HAMILTON M, *J Neurol Neurosurg Psychiatry*, 23 (1960) 56. — 33. *Statistical Package for the Social Sciences*, version 16.0 (SPSS Inc, Chicago). — 34. BRUCE DP, *APSAC Advis*, 6 (1993) 1. — 35. VIZEK-VIDOVIĆ V, KUTEROVAC-JAGODIĆ G, ARAMBASIC L, *Scand J Psychol*, 41 (2000) 297. — 36. WELLER RA, WELLER EB, FRISTAD MA, BOWES JM, *Am J Psychiatry*, 148 (1991) 1536. — 37. ELIZUR E, KAFFMAN M, *J Am Acad Child Adolesc Psychiatry*, 21 (1982) 474. — 38. ELIZUR E, KAFFMAN M, *Am J Orthopsychiatry*, 53 (1983) 668. — 39. SHAW JA, *Psychiatr Q*, 71 (2000) 227. — 40. SMITH P, PERLIN A, YULE W, RABE-HESKETH S, *J Child Psychol Psychiatry*, 42 (2001) 395. — 41. BRYCE J, WALKER N, GHORAYEB F, KANJ M, *Soc Sci Med*, 28 (1989) 685. — 42. PINE DS, COHEN JA, *Biol Psychiatry*, 51 (2002) 519. — 43. ABDELKHALEK AM, *Psychol Rep*, 81 (1997) 247. — 44. HUSAIN S, NAIR J, HOLCOMB W, REID J, VARGAS V, NAIR S, *Am J Psychiatry*, 155 (1998) 1718. — 45. MASCOUD MS, ABER JL, *Child Dev*, 67 (1996) 70. — 46. AWADH A, VANCE B, EL-BEHLAWI V, PUMARIEGA A, *J Child Fam Stud*, 7 (1998) 493. — 47. KLINGMAN A, *Prof Psychol Res Pract*, 23 (1992) 521. — 48. SCHWARZWALD J, WEISENBERG M, ZAHAVA S, WAYSMAN M, *J Abnorm Psychol*, 102 (1994) 404. — 49. STICHICK BETANCOURT T, KHAN KT, *Int Rev Psychiatry*, 20 (2008)

317. — 50. KUTEROVAC — JAGODIĆ G, J Clin Psychol, 59 (2003) 9. — 51. ELBEDOUR S, BENSEL RT, BASTIEN D, Child Abuse Negl, 17 (1993) 805. — 52. SCHWARZWALD J, WEISENBERG M, ZAHAVA S, WAYS-MAN M, J Abnorm Psychol, 102 (1993) 404. — 53. ZIV A, KRUGLANSKI

AW, SHULMAN S, J Pers Soc Psychol, 30 (1974) 24. — 54. GILLIGAN C, In different voice (Harvard University Press, Cambridge, 1982).

#### *I. Dijanić Plašć*

»Duga – Zagreb« Home for Adult and Child Victims of Family Violence, p.p. 133, 10000 Zagreb, Croatia  
e-mail: ivana.dijanic@zg.t-com.hr

### **RAZVOJNA DOB I TEŽINA SIMPTOMA POVEZANIH S TRAUMOM I SIMPTOMIMA ANKSIOZNOSTI I DEPRESIJE KOD ISPITANIK A KOJI SU IZGUBILI OČEVE TIJEKOM RATA U HRVATSKOJ**

#### **S A Ž E T A K**

Djeca različite dobi doživljavaju traumatski događaj na različite načine. Prilikom generalizacije rezultata istraživanja najvažnije je razumjeti da djeca različite dobi različito razmišljaju, različito se ponašaju i različito emocionalno funkcioniraju. Iskustva koja su iznimno traumatična za odrasle, malo dijete može shvatiti kao nešto što nije tako zastrašujuće. Također, strah koje dijete osjeća će češće biti odraz straha koji osjećaju odrasli nego što će ga stvoriti djetetov vlastiti doživljaj događaja. Dosadašnja istraživanja su potvrdila da je individualno doživljavanje traume ovisno o dobi. Naše istraživanje usmjereno je na osobe koje su izgubile očeve kao djeca u ratnim uvjetima. Cilj je bio istražiti povezanost između dobi u kojoj su osobe ostale bez oca i težine simptoma vezanih uz traumu, simptoma anksioznosti i simptoma depresije kod ispitanika koji su izgubili očeve za vrijeme rata. Istraživanje je obuhvatilo 103 ispitanika koji su izgubili očeve tijekom rata u Hrvatskoj, a koji su došli na tjelesne i psihijatrijske preglede organizirane od Ministarstva obitelji, branitelja i međugeneracijske solidarnosti. Uzorak su sačinjavali sudionici koji su u ratnim okolnostima ostali bez oca u razvojnem životnom periodu od najranije do adolescentne dobi. Podaci su prikupljeni pomoću strukturiranog kliničkog intervjua koji je uključivao i socio-demografske podatke. Podaci o bivšim i sadašnjim psihijatrijskim simptomima su prikupljeni pomoću sljedećih instrumenata: Klinička skala za posttraumatski stresni poremećaj (CAPS), Hamiltonova skala za procjenu anksioznosti (HAMA), Hamiltonova skala za procjenu depresivnosti (HAMD). Rezultati su pokazali da postoji značajna korelacija između dobi i rezultata na korištenim skalama. Sudionici koji su izgubili očeve u vrlo mladoj dobi ili čak prije nego su rođeni pokazali su manje simptoma traume ( $r=0,249$ ,  $p<0,05$ ), manje simptoma anksioznosti ( $r=0,374$ ,  $p<0,01$ ) i depresije ( $r=0,384$ ,  $p<0,01$ ) od sudionika koji su izgubili očeve u starijoj dobi. Istraživanje je potvrdilo da je individualno iskustvo traume zbog gubitka oca u ratnim okolnostima povezano s dobi.