Disability and mental health in the developmental age: intervention models and the client/service relationship in two centers of specialization in Belgrade. Pilot study

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Introduction

This study is the result of scientific collaboration between the "*La Sapienza*" Faculty of Psychology 1 of Rome and the Faculty of Special Education and Rehabilitation of University of Belgrade. The agreement between the two institutions includes a comparative study of intervention models on disability and mental disturbances in the developmental age. Majority of the pilot study was conducted at the *Institut za Mentalno Zdravlje* (IMZ, Institute of Mental Health) of Belgrade, while research samples were also provided by the *Institut za Eksperimentalnu Fonetiku i Patologiju Govora* (IEFPG, Institute of Experimental Phonetics and Pathology of Language).

Serbia provides a free public socio-health service for its citizens. It is organized in three levels: basic services, hospitals, and highly specialized centers. The two institutes involved in our study are both highly specialized centers.

The Institute of Mental Health (IMZ) is a national public health service that receives referrals also outside of Belgrade. The institution offers services to both adults and patients in the developmental age, and it is divided in many departments.

The Institute of Experimental Phonetics and Pathology of Language (IEFPG) operates in collaboration with the national health department and offers free services for language and hearing disabilities.

Personnel in both institutions are highly qualified and selected based on their *curriculum vitae*.

Our research, exploratory in aim as well as its methodology of data collection, was conducted in three phases: field observation, interview with key figures, construction and administration of questionnaires. These were conducted by one of the authors, who collected data for three months at the IMZ in Belgrade while being sponsored by the "*La Sapienza*" University.

The goal of the first phase of observation, which lasted approximately three weeks, was to collect information regarding the institute's methods. These data were then used in the second and third phases of the study, in conduction of interviews with key figures and conceptualization and administration of the questionnaires, respectively.

Five interviews were conducted: three of which involved the personnel (a psychologist, a psychiatrist and a special educator), the other two involving mothers of two patients. We decided to interview the mothers of the patients instead of the patients themselves because the questions were inappropriate for the patients whose age ranged from 12 years old and below. In fact, it involves subjects who are not responsible for their treatment choice, nor are they the ones who request for treatment. Certainly, they are in the condition to report discomfort, but in any case, the parents are those who request for intervention (by their own initiative or upon the school/pediatrician's suggestion, rarely upon request of their disabled child). It is always the parents who decide upon the treatment and, possibly, choose to discontinue it. We believe that interviewing the young recipients of this service could have a

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high informational value. For instance, in order to understand whether they perceive the benefits of the treatment or whether they complain about its costs in terms of time and emotional constraints. Nevertheless, this information is not central to the goal of this research, and it is also why we were convinced of the need to focus on the relationship between the service providers and those who chose to utilize them—the parents. The reason for which two mothers were interviewed and not, for instance, a mother and a father, resides in the fact that during the first phase of observation on the field, the presence of the mothers in the institute was significantly higher than that of the fathers' (with a ratio of 10/1). During the following questionnaire administrations, however, we tried to achieve a certain number of fathers (19 of which participated).

The semi-structured interviews were created in order to explore some aspects already decided upon during the beginning of the research. These principally involve: the intervention model proposed by the two institutes and the presence or absence of a phase of demand analysis (cfr Carli, 1987); the types of treatment most used and the characteristics of its clients and their families; who referred the patients to the service; the diagnostic process; the criteria for deciding the type of intervention; the type of information provided by the service; and the type of demand which the clients requested of the service.

The intervention models of the two institutes

The following data emerged from interviews and field observation:

The clients in the developing age, in which we are interested in this research, consulted the Institute of Mental Health (IMZ) for problems of varying nature. These, according to criteria created by the same institution, range from mild learning difficulties to pervasive developmental disorders. The institute is subdivided into different departments based on the gravity and type of disorder. Several activities are conducted as outpatient, day hospital, as well as in-patient (for graver conditions as well as clients that come outside of Belgrade). Personnel include psychiatrists, psychologists, special educators, and nurses.

The clinical intervention model was based on a medical perspective that places the problem of the clients within a traditional and individual pathologic and psychopathologic picture (using instruments such as the DSM, neuropsychological tests, performance evaluation tests, cognitive tests, etc.) The evaluation of symptoms, therefore, is not focused on a single concept that assigns meaning to the said symptoms within a series of interactions between the patient, his/her family, and the context in which he/she belongs. As a result, there has been no analysis of intervention demand, neither was the client involved in the creation of the project (i.e. explanation of the criteria of efficacy and shared definition of the objectives of the intervention between the professionals and the clients). The treatment follows traditional criteria of individual psychopathology/rehabilitation, and can be pharmacological and/or consist of individual rehabilitation activities (i.e. psychomotor, cognitive), group activities, and psychotherapy. The psychiatrists have the ultimate responsibility regarding the treatment, including the pharmacological aspect. The special educators are responsible for specific aspects within the realm of rehabilitation. The psychologists carry out diagnostic tasks and stay in contact with the families, to whom they provide support and instructions in the phase of intervention. This is also where the families are advised to follow certain behaviors considered useful for the improvement of the patient. The diagnosis made by the psychologist is based on individual interviews as well as including the families, and in test administration.

Majority of the personnel of the Institute of Experimental Phonetics and Pathology of Language (IEFPG) are special educators as well as some psychologists. The psychologist offers family support. They also provide differential diagnoses that rule out disturbances considered to require psychiatric treatment. In such cases, the patients are referred to other institutions such as the Institute of Mental Health (IMZ). Such problems, in which the psychopathologic component is considered prevalent, are not treated at the IEFPG. Problems related to language and hearing disabilities, which are treated by the IEFPG, are not treated from a psychological perspective, except for the aspect regarding family support.

The concept of disability adopted by the institution is therefore of the individual-functional type, and not bio-psychosocial. The intervention is of the rehabilitative type.

Definition of the dimensions investigated by the questionnaire

This first phase allowed us to identify some aspects to explore through two questionnaires, one addressed to professionals of the two institutes, and the other addressed to the parents of the patients. The goal was to understand in what way a clinical imposition could affect the level of agreement between the two sides in the relationship, professionals and parents, concerning several aspects related to the intervention.

1. Attitude of the two groups (professionals and parents) regarding the four criteria of definition of intervention efficacy.
2. The attitude of the parents and of the professionals towards psycho-pharmacological therapy.
3. Expectations of the professionals and the parents regarding the outcome of the interventions.
4. Evaluation by the parents and the professionals of the outcomes of the interventions.
5. Satisfaction and reciprocal agreement in the relationship of collaboration/support between the professionals and the parents.

Dimension 1 analyzes the attitudes of the two groups, parents and professionals, towards four criteria of intervention efficacy: reduction of symptoms, increase of the social competence of the patient, increase of the individual well-being of the patient, increase of the well-being of the whole family. We were interested in understanding whether, in the presence of an intervention model that is strongly prescribed and does not anticipate a phase of shared definition and explanation of objectives together with the family, there was some agreement regarding the criteria of intervention efficacy.

Dimension 2 analyzes the attitude of the professionals and parents regarding psycho-pharmacologic therapy. Such attitude could be more positive when attention from both is directed towards symptom control and its effect on relationships.

Dimensions 3 and 4 respectively analyze the expectations regarding the outcome of the interventions, followed by its evaluation. These are measured by items that request the subject to express his opinion in terms of: a) If directed to parents, expectations at the beginning of the treatment regarding their child and evaluation of the outcome of the said treatment at the moment of questionnaire administration; b) If directed to professionals, general expectations at the beginning of the treatment regarding the patients and general evaluation of treatment outcomes. The subjects were requested to describe: reduction of symptoms, increase in the patient's social competence, increase in the personal well-being of the patient, and increase in the well-being of the family. Moreover, in this case, we wanted to understand what kind of agreement the professionals had with the parents in the absence of a phase of common definition and explanation of the objectives, and in particular, whether the two groups had similar levels of expectations, followed by the same evaluations of the outcomes. We also wanted to see whether both groups' initial expectations were satisfied or not.

Dimension 5 analyzes how the two groups, in describing the relationship with their counterpart (i.e. parents towards professionals and the services; professionals towards parents), expressed satisfaction and agreement. The parents are requested to describe how the professionals handled their need to be taken cared of and the latter's availability in the relationship. The professionals were requested to describe the collaboration and approval of the parents regarding the proposed intervention, as well as how accessible and supportive the parents perceived them to be.

The terms “satisfaction” and “agreement” do not necessarily define a useful relationship more than a relationship without conflict, wherein a counterpart corresponds to the other’s expectations, and roles occur within the client/service relationship. This dimension does not evaluate the real efficiency of the relationship between components of the service and its use in terms of differentiated participation, but in terms of the conception and the creation of the intervention, especially the perception of the two groups to have had a harmonious and unanimous relationship.

The connotation of this dimension comes from the preliminary phase of observation. After which it seemed plausible to define the service/client relationship in terms of relationship aimed at the creation of an agreement in which the technician is responsible for the evaluation focused on the patient and for the strategy of intervention, and in which the parents expect such evaluation and are satisfied by its accuracy.

Negotiation of the intervention

The observational analysis had already led us to conclude that the two institutions did not base their interventions on demand analysis, and that there has been no phase of shared construction of the intervention objectives. In the questionnaire for professionals, we included control items regarding these aspects: namely, in case of disagreement with the family, whether the professionals were willing to consider strategy change according to the needs and opinions of the parents. Furthermore, the parents were asked some questions regarding whether they agreed with the diagnosis made by the service and whether they agreed with the proposed intervention.

Description of the questionnaires

The questionnaire for the professionals was composed of 50 items in which some item groups were formulated to explore the dimensions previously enumerated. These were expressed with both positive and negative propositions, to which the subjects had to respond using a 5-point Lickert scale which provided a maximum agreement and no agreement on each of the affirmations contained in the questionnaire. A reduced form has been administered to the nurses, this time without questions regarding diagnostic choices and treatment strategies (except regarding the use of psycho-pharmaceutical drugs).

As already stated, some items were formulated in sentences with positive connotations with respect to the dimension (e.g. dimension 2, “The administration of psycho-pharmaceutical drugs is indispensable to the treatment of patients with psychic disturbances”), and others in sentences with negative connotations (e.g. “The psycho-pharmaceutical drugs inhibit the patient’s freedom of expression”). All questionnaires were codified reversing the points of the negative items in order to make them coherent with the positive polarization of the dimensions enumerated previously, and in order to analyze them statistically.

The parents involved in the research belonged to three client categories: parents of patients in treatment from the time of the study (Parent T); parents whose child has been in treatment with WITHIN the institution, and during the time of study were present for follow-up (Parent F-u); parents whose children were, at the time of the study, under assessment by the institution, and awaiting decision on the type of treatment to be used (Parent V). For some dimensions, Parent V cannot be codified and therefore, questionnaires provided for them excluded some items.

The questionnaire for the Parents T and F-u were composed of 52 items, while the questionnaire for Parent V was composed of 45 items, using a 5-point Lickert scale, expressed in both negative and positive sentences. The questionnaire items were identical or perfectly comparable to the items of the professional’s questionnaire, and the dimensions explored were the same. For some of these dimensions, a different number of items has been used with respect to the version proposed for the professionals.

Subjects

Thirty-six professionals voluntarily joined the study and constituted 90% of the professionals actually employed by the two institutions for the intervention in the developmental age (table 1):

Table 1: group of professionals by professional type and their respective institutions (IMZ and IEFPG)

institution	Psychologists	Psychiatrists	Special educators	Nurses	Tot
IMZ	4	4	8	8	24
IEFPG	0	0	12	0	12
Tot	4	4	20	8	36

The composition of the professional group reported in Table 1 reflects the organogram of the two institutions involved, including only the personnel in healthcare and not the administrative and other services. All professionals who were present in health care services during the administration procedure were called upon to answer the questionnaire.

The parents called to answer the questionnaire totaled a number of 82 and were distributed as (table 2):

Table 2: group of parents by gender, institution and type of treatment

Institution	Actual Treatment			Follow Up			Assessment			Tot		
	M	F	Tot	M	F	Tot	M	F	Tot	M	F	tot
IMZ	3	28	31	3	4	7	7	18	25	13	50	63
IEFPG	6	13	19	0	0	0	0	0	0	6	13	19
Tot	9	41	50	3	4	7	7	18	25	19	63	82

The administration of the questionnaires to the parents took approximately 20 days for both institutions. All involved parents received the questionnaire with the request to give it back within seven days from the date of reception. Eighty-two parents comprised 82 percent of the total of 100 questionnaires distributed.

The problems that the parents reported as motivation for seeking the institutes' services principally included: anxiety, aggressive behavior, somatic disturbances such as enuresis and headache, difficulties in attention and concentration, language and hearing problems, and tics.

Seventy parents provided information regarding the source of referral (table 3):

Tabella 3 - invianti	
Friends, acquaintances, relatives	23 (33%)
Autonomously	12 (17%)
Primary physician or specialist	9 (13%)
School	8 (11%)
Social and health services	8 (11%)
Speech therapist	6 (9%)
Psychologists	4 (6%)
	Tot 70 (100%)

Results

The dimensions explored by the two different questionnaires related to the two groups, despite being conceptually identical (or comparable) were, in some cases, composed of a different number of items. Evidently, the raw numbers obtained per every dimension, derived from the sum of the points attributed to single items, did not fall within the median range for the two samples in question.

Therefore, two adjustments have been made, one related to the readability of the data in the succeeding tables; the other related to the analysis of data.
Regarding the readability of the data in the tables, we used the median value per item per dimension (the total of each dimension was divided by the number of the item that it was made of). For the analyzability of the data, proportional points have been used, each one related to the maximal margin of the range, corrected according to the formula $2\sqrt{\text{arcsen } x}$ (cfr Ercolani, Areni, & Mannetti, 1990 for the analysis of the variance with proportional points).

Comparison of the subjects from the two different institutes.
Another preliminary phase of data analysis was that of comparing the groups of parents and of professionals coming from IMZ with those coming from the IEFPG, to control if the responses of these two groups were significantly different. We conducted two ANOVAs, one for every group (parents and professionals), with an independent factor (institution of origin) and a repeated factor (the dimensions of the questionnaire). The results demonstrated that the institution of origin did not have an effect on the response of the parents ($F = 1.04$, $p = .40$), and the same was true for the professionals ($F = 2.15$, $p = .061$).

Control of the variable “gender”
Although we have not hypothesized an effect on the variable “gender” on the dimensions of the questionnaire, nonetheless, we decided to control, on a single group of parents, whether responses differed according to whether the treatment was carried out with mothers or fathers.
The results of the variable analysis showed that the gender did not affect the dimensions ($F = .1234$, $p < .29$)
Therefore, the variable “gender” was not considered in the analysis.

Control of the “type of profession” variable
It was not statistically possible to control such variable because, when distributed, the number of subjects per group became scarce.

Dimension 1 – Criteria of intervention efficacy
Analyses were on: a) the level of agreement between parents and professionals on the four criteria of efficacy; b) the difference, in the preferences of the subjects, among the four criteria of efficacy.
The results showed (table 4) that the two groups did not significantly differ in their attitudes towards the four criteria of efficacy proposed ($F = 0{,}122$ $p = .73$), while there has been a significant difference only for the factor “criteria” ($F = 20{,}9$ $p < .0001$).

Table 4 –Comparison between parents and professionals on the four criteria of intervention efficacy
Repeated Measures Analysis of Variance - Sigma-restricted parameterization
Effective hypothesis decomposition

	SS	D.o.F.	MS	F	p
Group	0,041	1	0,041	0,122	0,727103
Criteria	7,809	3	2,603	20,912	0,000000
Criteria*Group	0,409	3	0,136	1,094	0,351755

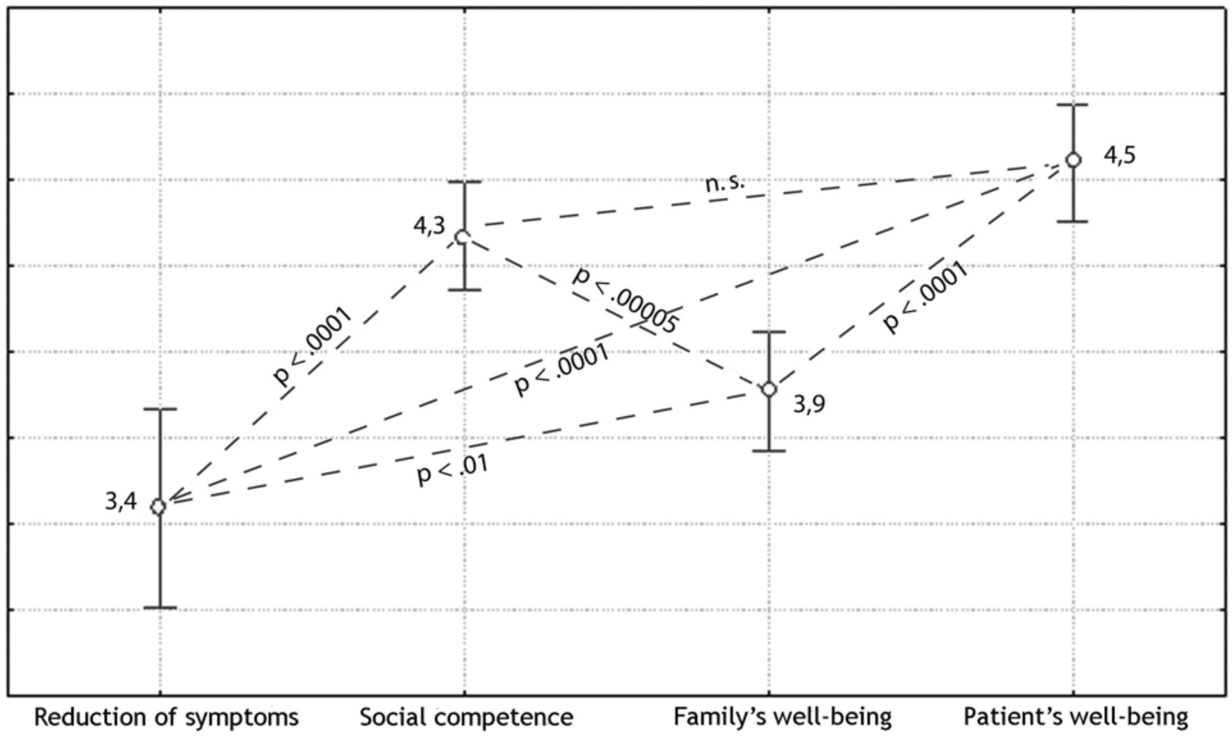
mean and st. dev.

	Decrease in symptoms		Social competence		Well-being of the family		Well-being of the patient	
	$\overline{X}$	D.S.	$\overline{X}$	D.S.	$\overline{X}$	D.S.	$\overline{X}$	D.S.
Parents	3,31	1,54	4,36	0,73	3,9	0,97	4,49	0,8
Professionals	3,59	1,4	4,26	0,63	3,9	0,72	4,43	0,62
Parents + Professionals	3,45	1,47	4,31	0,68	3,9	0,84	4,46	0,71

A post-hoc analysis (graph 1) in which the professionals and parents were considered as one group showed that the increase in personal well-being of the patient and of his/her social competence were criteria that both groups considered to be the most important in the definition of intervention efficacy. The increase in the well-being of the whole family received a lower point in the first two, and higher than the criterion “reduction of patient symptoms,” which received the lowest point among the criteria.

Graph 1

Duncan Post Hoc tests - Comparison between criteria of efficacy - Group: parents and professionals



Dimension 2 – Position towards the use of psycho-pharmaceutical therapy

In this comparison, the parents showed a positive attitude towards the use of psycho-pharmaceutical products, more so than that of the professionals, who were next to uncertain (F = 6,701 p = .01). Among the professionals, the nurses were the group that most favored the use of pharmacological products. However, the scarce number of subjects that emerged from the distribution in professional groups did not allow us to arrive at a statistical conclusion.

Table 5 –Comparison of parents and professionals on their attitudes towards the use of psycho-pharmaceutical drugs – mean and st. dev.

	$\overline{X}$	D.S.
Parents	3,7	0,61
Professionals	3,2	0,66

Dimensions 3 and 4 – Expectations regarding treatment results and evaluation of the treatment results

This analysis responds to the questions: a) comparing the initial expectations of the parents regarding the outcome of the intervention conducted on their child with the evaluation they gave on the said intervention and, whether there was a difference between the two, b) comparing the professionals’ general expectations regarding the outcome of their interventions with the evaluation they provided towards the end, and whether a difference exists, c) whether the two groups (parents and professionals) responded similarly to some questions?

Table 6 – Comparison between parents and professionals regarding expectations and evaluation towards treatment results – mean and st. dev.

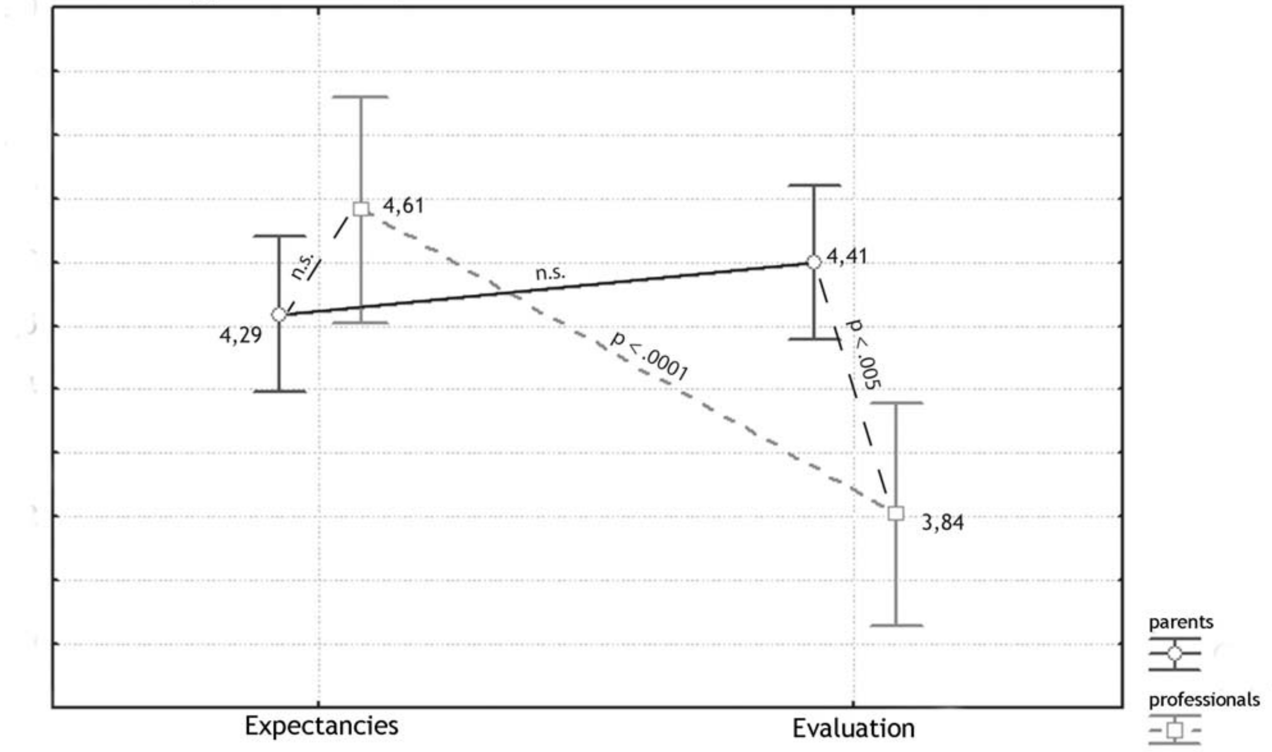
	Expectations towards treatment results		Evaluation of treatment results	
	$\overline{X}$	D.S.	$\overline{X}$	D.S.
Parents	4,29	0,77	4,41	0,71
Professionals	4,61	0,47	3,84	0,67

Graph 2 shows that there was a significant difference between the initial expectations and the evaluation of the treatment outcome only in the professional group. Parents and professionals had similar positive expectations (4,3 for parents and 4,6 for professionals, no effect of the variable “group”); while the parents claimed that their evaluation of the treatment was on the same level as their expectations (4,4 vs 4,3, p n.s.). The professionals, on the other hand, had significantly lower scores on their evaluation of treatment with respect to their initial expectations (3,8 vs 4,6, p < .0001).

GRAPH 2 - Comparison between parents and professionals on intervention expectancies and evaluation of the treatment outcome

Repeated measure Analysis of variance - Current effect: F(1,80) = 18,694, p = ,00004

Effective Hhypothesis decomposition



Dimension 5 – Comparison between parents and professionals regarding satisfaction and agreement in the reciprocal relationship

Table 7 – Comparison between parents and professionals regarding satisfaction and agreement in the reciprocal relationship
Repeated Measures Analysis of Variance - Sigma-restricted parameterization Effective hypothesis decomposition

	SS	D.o.F.	MS	F	p
Group	1,0622	1	1,0622	35,47	0,000000
	$\overline{X}$	D.S.			
Parents	4,14	0,49			
Professionals	3.47	0,41			

Table 7 shows a difference between parents and professionals in this dimension (F = 35,47, p <.0001). Parents perceived the relationship with the professionals and the service as a source of satisfaction and agreement to a larger extent than that perceived by the professionals. A control performed on the specific items of this dimension allowed us to affirm that this is an opinion widely spread among professionals. Or rather, some professionals gave a negative evaluation of the relationship with parent-clients in at least one of the items related to the dimension of reciprocal satisfaction-agreement (majority of the professionals gave high scores on at least one of the items that specifically studied the perception of being under pressure by the parents).
In particular, for the professionals, the dubious satisfaction in the relationship is due to the fact that they think parents expect more from them. The professional's attribution of expectation to the parents did not correspond to the statements of the parents regarding services obtained in terms of satisfaction.

Negotiation of the demand for intervention

In addition to dimensions previously mentioned as well as to complete the analysis carried out during the field observation, we included some questions within the questionnaire regarding the process of negotiating the demand for intervention. The results showed that 64% of professionals stated that the parents' opinions do not have to be considered if they happen to disagree with the former. Eighty-two percent declared that, however, parents always have to be involved in the intervention planning. Another useful element to be highlighted is the high level of perception that the personnel of the two institutes are competent: almost 80% of the subjects stated that their institute is the most competent in treating that type of disturbance.

Regarding the parents, 75% declared satisfaction with the diagnosis, and the same percentage stated that they completely understood the proposed interventions of the professionals, that these are adequate, and that the explanation provided regarding the nature of the problems of their children was useful in helping them understand their children's behavior. Furthermore, only 30% of them declared the desire for a treatment that also addresses possible family problems.

Discussion

As the first qualitative result of our study, derived from field observation and analysis of some interviews, we found that, coherently with a strong medical model, there has been no initial demand analysis in both institutions. Neither has there been a phase of negotiation which allowed the shared construction and explanation of the intervention objectives with the clients. This model, therefore, implies that intervention demand analysis on the part of the family is not an essential information for the evaluation of the problem and on which to base the intervention. Moreover, the etiopathogenesis of the problems is not under discussion and already considered defined *a priori* and valid. Therefore, it makes no sense to include it as part of the goals of negotiation. The prestige of the two institutions and the qualified professionals in their employ justify this type of attitude.

The goal of our study was to therefore understand how the professionals and clients behave in terms of agreement and satisfaction with respect to various aspects of the intervention process. Certainly, agreement and satisfaction alone do not measure the quality of intervention. What they do measure is the presence or lack of a collusive settlement characterized by a mutual agreement that the institution does carry out a highly qualified but unobjectionable treatment, and that clients have faith in the goodness of what they are receiving despite their lack of control in the process.
To summarize the data derived from the questionnaires we administered:

1. Professionals and clients consider the criteria of intervention efficacy in a similar manner.
2. The parents evaluate the treatment efficacy as corresponding to their initial expectations, which were high, and claim satisfaction. On the other hand, the professionals were significantly less satisfied by the treatment outcome with respect to their initial expectations. Furthermore, the professionals' evaluation of the treatment outcome was significantly less positive than that of the parents'. Finally, the parents expressed a moderate approval regarding psycho-pharmacological products, which the professionals were uncertain about.
3. The professionals attributed to the client/service relationship a significantly lower satisfaction-reciprocal agreement than the parents, who were, on the other hand, satisfied.

The picture that emerged seemed to be that the clients were satisfied while the professionals were preoccupied. Such preoccupation is what led us to reflect and to try to interpret the data from this pilot study.
The element that made us think of a dead end regarding the relationship between the service and the clients or a failure in the collusive settlement that we described earlier, was the general satisfaction that the parents showed regarding the intervention and the relationship with the service, to which the professionals corresponded with a significantly lower satisfaction rate.

The problematic aspect of the satisfaction of the parents could consist of a certain lack of criticism regarding the many questions we proposed, and this could lead to the consideration of the satisfaction as perceived on a superficial and general level, not necessarily based on judgment of specific elements. It could also be that these parents were satisfied by simply having found a highly qualified structure that could help them deal with their problems with their children. This constant and unarticulated expression of satisfaction could indicate an attachment to the service and fear of being abandoned by it, therefore functioning only to maintain these ties with the institution. In this line of reasoning, if we want to interpret the parents' choice of criteria of intervention efficacy (the same ones chosen by the professionals), we can observe that those that received the highest points appear to be the least pretentious, or rather, the personal well-being of their children and the possibility that he increase his social competence. On the other hand, the well-being of the family does not seem to be an aim to be prioritized by the parents. Although the well-being of the family could be legitimately desirable in a problematic context in which the relationships are affected (psychopathological disturbances, psychological disabilities, sensorial impairment), parents do not consider themselves as possible beneficiaries of interventions. Symptom decrease is the criterion which receives the lowest scores, probably due to the fact that most of these young patients have disturbances whose symptoms can only be partially reduced (e.g. children with congenital disabilities). Therefore, these parents seem reasonable and appropriate in their requests and general satisfaction, including the use of pharamacotherapy, regarding which the professionals appear uncertain.

Such an acritical satisfaction could lead to difficulties for professionals to find points of reference that guide the efficacy of their actions. Therefore, it is possible that the preoccupation of the professionals, that in some ways contrasts with our cited high opinion regarding their competence, could be the price that they pay for satisfying the parents' expectations in this bond: the professional carries in him/herself the uncertainty, the self-criticism and the pressure of parents which turns to unconditioned satisfaction. This fantasy of "taking care" cannot be made explicit or disconfirmed by offering a professional relationship in which each side accepts the due responsibility. At this point, we want to cite a document written in 2006 by the Serbian Commission on Mental Health about the stress conditions of the personnel of the mental health institute called "Apathy and the Burn Out Syndrome." The document referred to this problem as widespread across the whole Serbian territory, therefore reinforcing our hypothesis regarding the burn out syndrome which manifests as a dysfunctional aspect of the organizations that employ "helping professionals"—people strictly tied to the characteristics of the relationship with the client, especially to its predatory emotional component.

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