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Department of psychiatry, University Hospital Centre Zagreb, Kišpatićeva 12, 10000 Zagreb, Croatia

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Kontakt/Contact
socijalna.psihijatrija@kbc-zagreb.hr
http://www.kbc-zagreb.hr/soc.psi

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SADRŽAJ / *CONTENTS*

Obilježja klubova liječenih alkoholičara u Hrvatskoj

/ *Characteristics of the Clubs of Alcoholics in Treatment in Croatia*

Ana Opačić[1], Tereza Oreb[1], Katarina Radat[2]

[1] Sveučilište u Zagrebu, Pravni fakultet, Studijski centar socijalnog rada, orcid org/00000002-3486-0696, [2] Društvo za socijalnu podršku, orcid.org/0000-0003-0580-9792, Zagreb, Hrvatska

/[1] University of Zagreb, Faculty of Law, Department for Social Work, orcid.org/0000-0002-3486-0696, [2]Society for Social Support, orcid org/0000-0003-0580-9792, Zagreb, Croatia

Klubovi liječenih alkoholičara (KLA) važni su dionici u cjelovitom tretmanu alkoholizma u Hrvatskoj. Cilj rada je prikazati organizacijska obilježja, obilježja stručnog rada te potrebe KLA koje iskazuju stručni djelatnici i članovi predsjedništva. Istraživanje je provedeno anketnim upitnikom s članovima predsjedništva u 84 KLA, te sa 80 stručnih djelatnika. U svrhu provedbe istraživanja izrađen je odvojeni instrumentarij za predstavnike KLA i stručne djelatnike, a podatci su prikupljeni metodom poštanske ankete i licem u lice. Rezultati ukazuju da KLA u prosjeku djeluju 20 godina, imaju 23 člana, a 11 % članstva čine žene apstinentice te 28 % članovi obitelji. Nešto je manji broj članova u zagrebačkim KLA. KLA su podijeljeni s obzirom na upotrebu disulfirama. Preko 80 % KLA uključeno je u izvanklupske aktivnosti, a njihovi predstavnici procjenjuju da im je potrebna organizacijska i financijska podrška, posebice u KLA izvan Zagreba. Što se tiče stručnjaka, većina ih je dodatno educirana za rad u KLA (74 %), no i dalje procjenjuju potrebu za ulaganjem u stručni razvoj, posebice mlađi stručnjaci. Stručni rad obilježavaju raznovrsne tehnike rada, širok raspon pomažućih pristupa i raznovrsnost tema koje se obrađuju na sastancima. Stručnjaci visoko procjenjuju odnose prema članovima, iskazuju visoke procjene svoje kompetentnosti, procjenjuju da rad u KLA pridonosi njihovom osobnom razvoju te imaju niži doživljaj profesionalnog stresa. Zaključno su navedene preporuke za unaprjeđenje rada KLA u Hrvatskoj.

/ Clubs of alcoholics in treatment (CATs) are important stakeholders in the alcoholism treatment in Croatia. The aim of this paper was to present organisation characteristics, professional work characteristics and assessed needs from the position of presidency members and professional workers. The survey was conducted with representatives of 84 CATs and 80 professionals. Separate research instruments were developed for presidency members and therapists. Questionnaires were collected by post and face-to-face. Results indicate that, on average, CATs work for 20 years, have 23 members, with women making up 11% and family members making up 28% of members. There are fewer members in CATs in Zagreb. CATs are divided concerning the use of disulfiram. Over 80% of CATs are involved in out-group activities. Representatives estimate the need for organizational and financial support, especially those outside Zagreb. Regarding professionals' perspective, most of them are additionally educated (74%), but still assess the need for further professional development, especially younger experts. Professional work is characterised by diverse techniques, a wide range of supporting approaches and diverse topics processed at CAT's meetings. Experts assess relationships towards members with high rates, show high estimates of their competence, assess that work in the CATs contributes to their personal development and have a lower assessment of professional stress. In conclusion, recommendations are proposed based on research findings.

ADRESA ZA DOPISIVANJE / *CORRESPONDENCE*:
Doc. dr. sc. Ana Opačić
Pravni fakultet Sveučilišta u Zagrebu
Studijski centar socijalnog rada
Nazorova 51
10 000 Zagreb, Hrvatska
Tel: 01 4895 801
E-pošta: ana.opacic@pravo.hr,
orcid.org/0000-0002-3486-0696

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UVOD

Djelovanje klubova liječenih alkoholičara (dalje u tekstu KLA) zauzima važno mjesto u tretmanu i resocijalizaciji osoba s problemom alkoholizma i članova njihovih obitelji. Klubovi liječenih alkoholičara su oblik terapijskih zajednica kojima je cilj nastavak liječenja, održavanje apstinencije, ali i cjelovita rehabilitacija i resocijalizacija osobe s problemom ovisnosti i članova njihove obitelji (1). Od KLA kao grupe samopomoći očekuje se pomoć članovima u uspostavljanju i održavanju apstinencije od alkohola, stvaranje preduvjeta za uključivanje obitelji, poboljšanje komunikacije s članovima obitelji, uspostavljanje boljih odnosa u radnom i najužem okruženju te povećanje zadovoljstva samim sobom.

Postojanje KLA u zajednici doprinosi razvijanju mreže socijalnih usluga u području resocijalizacije liječenih ovisnika o alkoholu. KLA kao dio lokalne zajednice služe olakšavanju promjene ponašanja pojedinca i uključenih obitelji, ali i unaprjeđenju zdravlja i suzbijanju alkoholom izazvanih poremećaja među širim stanovništvom (2). Danas na području cijele Hrvatske djeluje oko 180 KLA (3). S ciljem međusobnog povezivanja KLA formirani su savezi na lokalnoj, regionalnoj i nacionalnoj razini (4).

Za funkcioniranje KLA važne su osobe na upravljačkim funkcijama. Najčešće su to osobe

INTRODUCTION

The activity of the clubs of alcoholics in treatment (further CAT) have an important role in the treatment and resocialization of people with alcohol addiction and their family members. CATs are therapeutic communities whose aim is the continuation of treatment, maintaining abstinence, holistic rehabilitation and resocialization of person with addiction and their family members (1). CAT as a self-help group is expected to support members in their abstinence, create the preconditions for involving the family, improve the communication of the abstainer with family members, establish better relations at the workplace and the immediate environment and increase self-confidence. The existence of community-based CATs has contributed to the network of social services in the area of resocialization of people with alcohol addiction. The CAT as a part of local community serves to alleviate the behavioural change of an individual and involved family members, but also to the promotion of health and the suppression of alcohol-induced disorders among the wider population (2). Nowadays around 180 CATs operate in Croatia (3). With the aim of interconnecting the CATs, communities or alliances have been formed on the local, regional and national levels (4).

Important roles for managing CAT are presidency members (usually people in treatment), professional workers and paraprofessionals.

na liječenju, stručni djelatnici i paraprofesionalci.

Rad KLA temelji se na formalno pravnim postavkama djelovanja organizacija civilnog društva sukladno Zakonu o udrugama (5) (NN 74/14, čl.13.) te u organizacijskoj strukturi imaju upravljačka tijela predsjednika, dopredsjednika, tajnika, blagajnika i druga tijela sukladno zakonskim i statutarnim obvezama.

Za pružanje stručne pomoći u KLA angažirani su stručni djelatnici te paraprofesionalci (6). Stručni djelatnici najčešće su socijalni radnici, liječnici, medicinski tehničari, kao i druge pomažuće profesije (7). Oni osiguravaju vođenje KLA kao grupe za podršku koristeći načela savjetovanja. Uz njih, snažni zagovornici postizanja tretmanskih ciljeva su osobe koje su prošle liječenje i članovi njihovih obitelji s prethodnim uspješnim suočavanjem s alkoholizmom.

Promatramo li KLA kao organizacije civilnog društva, tada uočavamo manjak istraživanja s ovom temom, kako u domaćoj, tako i u inozemnom literaturi. Istraživanja usmjerena općenito na organizacije civilnog društva gotovo uopće ne obuhvaćaju u svome uzorku KLA s obzirom na njihovu specifičnost i suženo područje djelovanja. U okviru istraživanja vezanog uz razvijanje socijalnih usluga u zajednici, KLA su prepoznati kao organizacije koje lokalne zajednice financijski podržavaju te koje doprinose rješavanju problema ovisnosti (8). Slijedom navedenog, jedan od ciljeva ovog rada biti će upoznavanje funkcioniranja KLA u Hrvatskoj.

Uloga stručnog djelatnika u KLA

U cjelovitom tretmanu alkoholizma visoko se vrednuje multidisciplinaran pristup (9). I dok o učincima grupe imamo saznanja (10,11), o stručnim djelatnicima u grupama podrške za osobe ovisne o alkoholu imamo nešto manje spoznaja.

The CATs activity is based on the formal legal grounds in accordance with the law on civil society organizations (5) (Official Gazette 74/14, Art. 13). In its organizational structure, a CAT has the governing bodies of the president, vice-president, secretary and treasurer.

Professional workers and paraprofessionals are engaged in providing professional support (6). Professional staff are mostly social workers, doctors, medical technicians as well as other professions of assistants (7). They run CAT as a support group using the principles of counselling. Paraprofessionals are usually volunteers that are strong promotors of therapeutic aims after having strong personal experience with alcohol addiction and being successful in treatment.

If we look at the CAT as a civil society organization, then we notice a lack of studies on this topic, both in domestic and foreign literature. The studies focused on civil society organizations in general almost never include CATs in their sample, given their specificity and narrow scope of action. Within the research related to the development of social services in the community, the CAT is recognized as an organization that is financially supported by local communities and which contributes to solving addiction-related issues (8). Following this, one of the aims of this paper is to become familiar with how CATs in Croatia function.

Role of a professional worker in the CAT

In the overall treatment of alcoholism, a multidisciplinary approach is highly valued (9). Although we have the knowledge of the effects of the group (10,11), there are fewer findings on professionals in support groups for persons with alcohol addiction.

Mosey (12) emphasizes the importance of respecting the client's personality, perceiving his individuality and empathy as some of the

Mosey (12) ističe važnost poštivanja osobnosti klijenta, percipiranje njegove individualnosti i empatiju kao neke od glavnih elemenata učinkovitog odnosa između klijenta i terapeuta. U savjetovališnom pristupu prihvaćanje i poštovanje klijenta ključna su stavka (13). Građenjem pomažućeg odnosa stručnjak može pomoći klijentu posvetiti se promjeni vlastitim ritmom (14). Jedna od poteškoća koju se može očekivati u odnosu osobe ovisne o alkoholu i stručnjaka jest osjećaj tjeskobe ili nelagode (15). Iz tog je razloga važno da je stručnjak usmjeren na snage, a ne na teškoće ili probleme korisnika, jer je to ono što osobu motivira na promjenu (16). Rezultati tretmana bolji su kad osoba shvaća da je ona sama odgovorna za promjenu (17).

Stručni djelatnik u KLA ubrzava proces oporavka i pozitivnih obiteljskih promjena. Pritom otklanja otpore i brine da ozračje u KLA bude dovoljno poticajno (18). McLachlanovo (19) istraživanje pokazalo je da bi osoba ovisna o alkoholu osjećala da ima koristi od tretmana za nju je najvažnije da terapeuta percipira kao socijalno kompetentnog od samog početka grupne terapije. U programu SHARP (*The Share-Help Alcohol Recovery Program*) alkoholizam se promatra u kontekstu društvenog sustava, pa se i grupni tretman promatra kao važan dio oporavka (20). Da bi se postigla resocijalizacija osobe ovisne o alkoholu potrebno je mijenjati stil života i na taj način repozicionirati se unutar društva. Zadatak je stručnog djelatnika u KLA pomoći članovima u organiziranju aktivnosti u svakodnevnom životu, donošenju odluka bitnih za kvalitetno funkcioniranje i stvaranju novih odnosa (6).

Karakteristike stručnog djelatnika u KLA

Savjetodavni programi dat će slabe rezultate uspješnosti, ako su stručnjaci nedovoljno educirani (17). Nedostatak educiranosti savje-

main elements of an effective relationship between a client and a therapist. In counselling, accepting and respecting the client is crucial (13). Through the construction of a helpful relationship, a professional can help the clients to devote themselves to change at their own pace (14). One of the difficulties that can be expected in the relationship between a person with addiction and a professional is a sense of anxiety or discomfort (15). For this reason, it is important that the professional focuses on the client's strengths rather than his or her difficulties or problems because that is what motivates the person to change (16). The results of the treatment are better when a person realizes that he/she is responsible for the change (17).

The CATs' professionals accelerate the recovery process and positive family changes. Thereby they remove the resistances and take care that the atmosphere in the CAT is sufficiently stimulating (18). McLachlan's (19) research has shown that people with alcohol addiction will benefit from the treatment if they perceive the therapist as socially competent from the very beginning of group therapy. Within SHARP (The Share-Help Alcohol Recovery Program), alcoholism is observed in the context of the social system, so group treatment has been seen as an important part of recovery (20). In order to achieve the resocialization of a person with alcohol addiction, it is necessary to change their lifestyle and thus reposition them within society. The task of the CAT's professional is to assist members in organizing activities in everyday life, making decisions essential for good functioning and creating new relationships (6).

Characteristics of an expert in the CAT

Counselling programs will give poor performance results if professionals are insufficiently educated (17). The lack of educated countovatelja na području alkoholizma globalni je problem (21) te stoga posebnu pozornost treba obratiti jačanju kompetencija stručnih voditelja. Hudolin (22) kao poželjne karakteristike stručnog djelatnika u KLA navodi posvećivanje puno pozornosti redovitom doškolovanju, aktivnost u znanstvenom istraživanju, motivaciju i razriješenost vlastitih problema u vezi s pijenjem. U Italiji je edukaciju za rad s osobama ovisnima o alkoholu *Territorial Alcoholism Training* organizirala KLA, a njome se u suradnji s profesionalcima, javnim organizacijama i institucijama razvijaju vještine na volonterskoj osnovi, što pomaže razvoju teritorijskih programa diljem Italije (23). Sličnu edukaciju za stručne djelatnike KLA redovito organizira Hrvatski savez KLA liječenih alkoholičara (24), koja može rezultirati pozitivnijim stavovima prema osobama koje boluju od alkoholizma (25).

Za stručne djelatnike nije dovoljno samo stjecanje teorijskog znanja o problemima vezanima za alkohol (26), već bi stručni djelatnici trebali biti adekvatno osposobljeni i u području komunikacijskih vještina, rehabilitacije i prevencije (23). Većina stručnih djelatnika koji rade u KLA (63,4 %) dodatno su educirani (psihoterapijski pravci, edukacija o alkoholizmu ili poslijediplomski studiji) (3). U području dodatnih edukacija značajni su i neki manje konvencionalni pristupi poput art-terapije kao psihoterapijskog pravca koji stimulira senzorni sustav, smanjuje razinu stresa, opušta i poboljšava komunikaciju osoba ovisnih o alkoholu (27).

Za ukupnu konzistentnost i autentičnost stručnih djelatnika u KLA važno je da odnos stručnog djelatnika prema alkoholu bude jasan i utemeljen na osobnoj opredijeljenosti (22). Na rad stručnog djelatnika mogu utjecati i njegovi osobni stavovi prema zlopotrebi alkohola, posebice nedostatno razumijevanje medicinskog modela bolesti ovisnosti, stav da se osobama s takvim problemom ne može pomoći ili da ovakve usluge leže izvan njihove odgovornosti, te

sellors in the field of alcoholism is a global problem (21), so special attention should be paid to strengthening competencies of professional therapists. Hudolin (22) recognises the following desirable characteristic of a CAT's professional: dedicating a lot of attention to constant specialization, activity in scientific research, motivation, and the resolution of their own drinking-related problems. In Italy, Territorial Alcoholism Training is organized by CATs, and through it, in cooperation with professionals, public organizations and institutions, skills are developed on a voluntary basis, which helps to develop territorial programs across Italy (23). Similar training for CATs' professionals is regularly organized by the Croatian association of clubs of alcoholics in treatment (24), which may result in more positive attitudes towards persons with alcohol dependency (25).

For professionals it is not enough to acquire theoretical knowledge of alcohol-related issues (26), but to also be adequately trained in communication skills, rehabilitation and prevention (23). Most CATs' professionals (63,4%) are further educated (psychotherapy, alcoholism-oriented education or postgraduate studies) (3). In the field of additional education, there are significant non-conventional approaches such as art therapy, the psychotherapeutic approach that stimulates the sensory system, reduces stress levels, relaxes and improves the communication of people with alcohol dependency (27).

For the overall consistency and authenticity of the CATs' professionals, it is important that their relationship with alcohol is clear and based on personal orientation (22). The personal attitudes towards alcohol abuse may also affect a professional's work, especially the lack of understanding of the medical model of addiction, the attitude that people with this problem cannot be helped or that such services lie beyond their responsibility and pessimism pesimizam u vezi rada s korisnicima koji zlopotrebljavaju alkohol (28). Pristup alkoholizmu donekle se razlikuje s obzirom na temeljnu profesiju. Tako, primjerice, za razliku od nezdravstvenih radnika koji rade u ovom području (socijalni radnici i stručnjaci) koji više prihvaćaju hipotezu alkoholizma kao samoliječenja, zdravstveni radnici (psihijatri) preferiraju pogled na alkoholizam kao bolest (29).

Osim stručnih djelatnika ponekad u KLA djeluju i paraprofesionalni radnici, odnosno osobe koje su se same izravno ili posredno u obitelji susrele s problemom alkoholizma, a koje su prošle potrebnu edukaciju za rad u KLA i razriješile osobne poteškoće u vezi pijenja (22). Ovakvi članovi imaju osobno iskustvo alkoholizma i oporavka, dok profesionalni djelatnici umjesto osobnog iskustva alkoholizma imaju obrazovanje koje im omogućuje objektivno sagledavanje problema primjenom znanstvenog znanja (30). Istraživanje Flora i Raftopoulosa (31) pokazuje da AA grupe u Grčkoj općenito imaju negativan stav prema stručnim djelatnicima s obzirom da im je najvažnije dijeljenje osobnih iskustva, a ne teorijsko znanje. Tako su terapeuti koji su manje isticali vlastito profesionalno postignuće, a više radili na postizanju i održavanju apstinencije postizali bolje rezultate u radu s osobama ovisnima o alkoholu (32). Budući da su osobe koje se liječe od ovisnosti o alkoholu često stigmatizirane (33), iznimno je važno da stručni djelatnik pokaže poštovanje, bezuvjetno prihvaćanje i pozitivan stav prema svakom novom članu od kojeg se očekuje da bude aktivan i predan radu od samog početka pohađanja sastanaka KLA (34).

Važno je napomenuti da u istraživačkoj praksi dominiraju istraživanja o pristupu samopomoći u modelu anonimnih alkoholičara, dok izostaju istraživanja o klubovima liječenih alkoholičara kao rjeđem modelu prakse. Primjer takvih studija su dvije talijanske studije (35,36) koje se obje bave obilježjima članstva i doprinosom članstva apstinenciji, dok izostaje istraživanje

in dealing with clients who abuse alcohol (28). Approach to alcoholism is somewhat different considering the basic profession. For example, unlike non-health workers in this area (social workers and counsellors) who prefer the hypothesis of dealing with alcoholism as self-treatment, healthcare workers (psychiatrists) prefer to view alcoholism as a disease (29).

In addition to professionals, paraprofessionals or persons who are directly or indirectly faced with alcoholism in the family can sometimes also work in CATs. They have usually undergone the necessary education for working in the CATs and solved their personal drinking problems (22). Such members have a personal experience of alcoholism and recovery, while professionals, instead of having personal experience of alcoholism, have an education that enables them to objectively comprehend problems by applying scientific knowledge (30). The study by Flora and Raftopoulos (31) shows that AA groups in Greece generally have a negative attitude towards professionals, since they value the sharing of personal experiences more than theoretical knowledge. Thus, the therapists who emphasized their own professional achievement less and worked harder to achieve and maintain abstinence showed better results in working with people with alcohol addiction (32). Since people who are being treated for alcohol addiction are often stigmatized (33), it is extremely important for a professional to show respect, unconditional acceptance and positive attitude toward each new member, from whom it is expected to be active and committed from the very beginning of the attendance at CAT meetings (34).

It is important to mention that in research practice there is a significant number of studies covering the Alcoholics Anonymous model, while studies on clubs of alcoholics in treatment are less frequent, since this model of samih obilježja rada. Stoga ćemo se ovim istraživanjem usmjeriti na obilježja stručnog rada (korišteni pristupi i tehnike) te potrebe koje prepoznaju stručni djelatnici.

CILJ ISTRAŽIVANJA

S obzirom na važnost djelovanja KLA u Hrvatskoj te nedostatak empirijskih spoznaja o njihovom funkcioniranju, cilj rada bio je utvrditi organizacijska obilježja KLA, obilježja stručnog rada te potrebe KLA koje prepoznaju članovi predsjedništva i stručni djelatnici.

METODA ISTRAŽIVANJA

Istraživanje je provedeno u sklopu istraživačkog projekta „*Uloga i značaj pojedinih dimenzija u radu Klubova liječenih alkoholičara kao organizacija civilnog društva u Republici Hrvatskoj*“ uz prethodnu suglasnost Hrvatskog saveza klubova liječenih alkoholičara. Istraživanje je provedeno anketnim ispitivanjem kombinacijom kontakta licem u lice i poštanskom anketom tijekom čitave 2014. godine. Anketari su bili studenti socijalnog rada i autori istraživanja. Istraživanje je provedeno poštujući etičke standarde dobrovoljnosti i anonimnosti, a svim klubovima dostavljena je brošura s preliminarnim rezultatima istraživanja kako bi se sudionici o njima informirali.

Upitnici su poslani svim KLA u Hrvatskoj, a u konačnici je upitnik ispunilo 84 predstavnika KLA kao članova predsjedništva (iz svakog KLA po jedan predstavnik) te 80 stručnih djelatnika iz različitih dijelova Hrvatske od ukupno 180 KLA. Nisu prethodno utvrđeni kriteriji isključivanja sudionika, no postoji i mogući rizik da su u uzorak uključeni oni predstavnici koji su pozitivnije orijentirani prema temi istraživanja.

U obradi podataka korištena je deskriptivna statistika i korelacija te testovi razlika t-test,

practice is also less common. As examples of studies on CAT we may use two Italian studies (35,36), both covering membership characteristics and effects on abstinence, but not the functioning of CAT. Thus, we will here focus on the characteristics of professional work (techniques and approaches) and needs recognised by professionals.

AIM OF THE RESEARCH

Given the importance of the CATs’ work in Croatia and the lack of empirical insights into their functioning, the aim of this paper was to identify organisation characteristics of the CATs’ characteristics of professional work and the needs of the CATs recognised by members of the presidency and professional workers.

METHODS

The research was conducted within the project “*The role and significance of clubs of alcoholics in treatment as civil society organizations in the Republic of Croatia*” with the prior consent of the Croatian association of Clubs of alcoholics in treatment. The survey was conducted using a combination of *face to face* contact and indirect postal contact during 2014. The field researchers were social work students and the authors of this paper. Research was conducted in compliance with ethical standards of informed consent and anonymity, and a short brochure with preliminary results was sent to every CAT in Croatia.

Questionnaires were sent to every CAT in Croatia. Finally, we collected 84 questionnaires from the CATs’ presidency (one questionnaire per CAT) out of possible 180 and 80 from therapists from different parts of Croatia. There weren’t any criteria of participants’ exclusion so there is a risk that representatives with a

ANOVA, hi-kvadrat, dok je faktorska analiza korištena za sažimanje upitnika koji propituju određene aspekte rada stručnih djelatnika. Normalnost distribucije na kontinuiranim varijablama provjeravana je Kolmogorov-Smirnovim testom (KS-z). U radu je korišten kriterij značajnosti od 5 % rizika. Podatci su analizirani u programskom paketu SPSS 22.0.

Sudionici

U istraživanju je sudjelovalo 84 članova predsjedništva iz 84 različita KLA, od čega ih je 67,1 % izvan Zagreba te 32,9 % u Zagrebu. U udjelu KLA izvan Zagreba, 15 ili 20,5 % ih se nalazi u jednoj od primorskih županija, dok ih je 34 ili 46,6 % u kontinentalnim županijama.

Među članovima predsjedništva bilo je 69 % muškaraca te 26,19 % žena (udio žena je viši nego što je uobičajeno u članstvu), prosječne dobi od 51,8 godina (SD = 16,903, MIN=31, MAKS= 78). Što se tiče funkcija u KLA među ispitanicima je najviše sudjelovalo predsjednika (53 ili 65,43 %). Ispitanici su na svojoj funkciji u prosjeku 5,27 godina (SD= 4,967, MIN= 2 mjeseca, MAKS = 24 godine).

U istraživanju je sudjelovalo 80 stručnih djelatnika iz različitih dijelova Hrvatske, i to 33,3 % iz zagrebačkih KLA i 66,7 % iz KLA izvan Zagreba (45,8 % iz kontinentalnih i 20,8 % iz primorskih županija). S obzirom na profesiju, sudjelovalo je 27,8 % (N= 22) viših medicinskih tehničara, 38 % (N= 30) socijalnih radnika, 19 % liječnika različitih profila (N=15) i 12 stručnjaka ostalih pomažućih profesija, poput psihologije, socijalne pedagogije i drugih (15,2 %). Stručnjaci u prosjeku rade 13,79 godina u KLA (SD= 12,28), iako 50 % ispitanih radi do 8 godina u KLA, ali zbog ispitanika s duljim stažem (najviše do 42 godine), prosječna duljina rada je nešto viša od vrijednosti medijana. Većina stručnjaka radi u jednom KLA (49 ili 65,3 %), dok preostali rade u 2, 3 ili najviše 4 KLA.

generally more positive attitude towards this research topic prevail in the sample.

Data analysis was based on descriptive statistics, correlations, t-test, ANOVA and Chi-square to test the differences and factor analysis. The normality of the distribution was tested using the Kolmogorov-Smirnov test (KS-z). We used a significance criterion of 5%. Data were analysed using the software SPSS 22.0.

Participants

Out of 84 CATs' representatives, 67% are outside Zagreb, and 33% are from Zagreb. Out of those outside Zagreb, 15 representatives, or 20.5%, are in one of the coastal counties, while 34, or 46.6%, are in continental Croatia. The representatives that filled in the questionnaire were mostly men (69%), while 26.19% were women, with the average age being 51.8 years (SD = 16.903, MIN=31, MAX= 78). These representatives were mostly presidents (N= 53, 65.43%) and the representatives have, on average, been employed in this position for 5.27 years (SD= 4.967, MIN= 2 months, MAX = 24 years).

80 therapists from different parts of Croatia participated in the survey: 33.3% from Zagreb CATs and 66.7% from CATs outside Zagreb (45.8% from continental and 20.8% from coastal counties). With regard to the profession, 27.8% (N = 22) are medical technicians, 38% (N = 30) social workers, 19% doctors (N = 15) and 12 experts from other professions such as psychology, social pedagogy and others (15.2%). On average, the therapists have worked in the CAT for 13.79 years (SD = 12.28), although 50% of them have worked for 8 years, but because of those with longer careers (up to 42 years), the average length of career is somewhat higher than the median value. Most therapists work in one CAT (49 or 65.3%), while the rest work in 2, 3 or 4 CATs.

Instrumentarij

Za potrebe ovog istraživanja izrađen je instrumentarij koji je pokrivao različite aspekte djelovanja KLA i stručnog rada.

Upitnik za članove predsjedništva pokrio je pitanja o sljedećim aspektima mjerenim s po jednom varijablom: dugotrajnost rada KLA, broj i struktura članstva, duljina grupnih sastanaka, korištenje disulfirama, organiziranje izvanklupskih aktivnosti, koje oblike podrške pružaju određene institucije, kakva je percepcija odnosa šire okoline prema radu KLA. Uz ove, dodana je ljestvica procjene potreba za budući rad KLA. Sudionici su na ljestvici od 1 do 4 procjenjivali sedam potreba: potrebe za financijskim sredstvima, boljim prostorom, novim članstvom, boljim statusom u okolini te potrebe za boljim odnosima među članovima, među članovima i stručnjakom te s ostalim KLA.

Upitnik za stručne djelatnike sastojao se od općih socio-demografskih varijabli: stručna sprema, duljina rada u KLA, broj KLA u kojima stručnjak radi, završene dodatne edukacije; te sljedećih varijabli koje se odnose na obilježja rada:

- procijenjene potrebe za unaprjeđenjem rada. Upitnik je sadržavao šest različitih potreba s procjenama na ljestvici od 1 do 4 (potrebe za supervizijom, dodatnim edukacijama, timski rad, veći honorar, bolji prostorni uvjeti, manje članova)
- potrebe za dodatnim edukacijama u osam područja vezanim za alkoholizam i psihosocijalni rad (procjene na ljestvici od 1 do 4)
- učestalost korištenja pojedinih tehnika u radu. Ukupni rezultat izračunat je kao prosječna vrijednost sedam tvrdnji na ljestvici od 1 do 5
- zastupljenost određenih tema u grupnom radu. Ukupni rezultat izračunat je kao prosječna vrijednost 14 tvrdnji na ljestvici od 1 do 5

Research instruments

For the purpose of this research, separate questionnaires were developed in order to cover various aspects of the CAT's functioning and professional work.

The questionnaire for the presidency members covered the following aspects, each measured with one variable: duration of the CAT's work, number and membership structure, length of group meetings, use of disulfiram, organizing community-based activities, types of support provided by certain institutions and perception of the relation between CAT and wider environment. In addition to this, there was a scale of perceived needs for future work. These seven needs (rated on a scale 1-4) were: finances, better facilities, new members, better status in the community, better group relations, better relations among the members and with the therapist, and better relations with other CATs.

The questionnaire for professional workers consisted of general socio-demographic variables: the basic profession, how long they have worked in the CAT, the number of CATs where the therapist works and additional education; and complex variables regarding some characteristics of their work:

- estimated needs for the improvement of the workplace containing six different needs (estimated on a scale 1-4). These included: the need for supervision, additional education, teamwork, bigger salaries, better facilities and fewer members.
- the need for additional education in eight areas connected with alcoholism and psychosocial work.
- the frequency of using certain techniques in the job. The total score was calculated as the average value of seven statements on a scale of 1-5.
- the representation of different topics at the group meetings. The total score was calcu-

- učestalost korištenja pomažućih terapijskih postupaka koju smo mjerili kao prosječan rezultat od 14 različitih postupaka u radu (ljestvica u intervalu od 1 do 5), a koeficijent Cronbachov alfa je visokih 0,934
- procjena odnosa prema članovima s ljestvicom sa 19 tvrdnji (interval stupnja slaganja od 1 do 5), s visokom koeficijentom pouzdanosti Cronbachov alfa od 0,907. Ukupni rezultat na ljestvici izračunan je kao prosječna vrijednost odgovora na svim česticama
- doživljaj rada u KLA koji ima 10 čestica, sa stupnjevima slaganja od 1 do 5. Primjeri tvrdnji su: *˝Rad u KLA me ispunjava˝; ˝Rad u KLA mi je postao monoton˝; ˝Mislim da se radom u KLA unapređujem profesionalno˝; ˝Kroz rad u KLA sam spoznao neke stvari o sebi˝; ˝U KLA susrećem situacije koje me osobno opterećuju˝*.

REZULTATI

Obilježja klubova liječenih alkoholičara: perspektiva članova predsjedništva

Rezultati pokazuju da su KLA uglavnom dugotrajne organizacije koje u prosjeku djeluju preko 20 godina (N= 82; M= 21,44; SD = 13,89, MIN= 2, MAKS= 47 godina, KS-z = 1,065). Do 10 godina ih djeluje 30,5 %, 20,7 % KLA djeluje od 11 do 20 godina, 19,5 % od 21 do 30 godina, a čak 29,3 % i preko 31 godinu.

Struktura članstva vrlo je različita. Prosječan broj članova je čak 23 člana (M= 23,1, SD= 17,504)**,** no on uključuje i članove obitelji (tablica 1). Ipak, KLA možemo naći u rasponu od manjih do velikih terapijskih zajednica. Tako je 13 % KLA s do 10 članova, dok u čak 21,7 % KLA ima između 21 i 30 članova, a u 16,9 % i više od 30 članova.

Utvrđena je statistički značajna razlika u brojnosti članova s obzirom na to jesu li KLA u Za-

lated as the average value of 14 statements on a scale of 1-5.

- the frequency of the use of therapeutic techniques measured as the average result of 14 different procedures in the work (scale in the range of 1 to 5), with high Cronbach's alpha coefficient of 0.934.
- the assessment of relations toward members with 19 items (scale 1-5), with high Cronbach's alpha coefficient of 0.907. The total score was calculated as the average value on all items.
- the experience of their work in CAT with 10 items on a scale of 1 to 5. Some examples of the items are: *Work in the CAT fills me up; Work in the CAT became monotonous; I think that I'm developing professionally through my work in CAT*; *Through this work I've realised some things about myself*; *I encounter situations in the CAT that burden me personally*.

RESULTS

Characteristics of CATs: presidency members' perspectives

The results show that CATs are mostly long-term organizations with an average work time of over 20 years (N= 82; M = 21.44, SD = 13.89, MIN = 2, MAX = 47 years, KS-z = 1.065). 30.5% work up to 10 years, 20.7% from 11 to 20 years, 19.5% from 21 to 30 years, and 29.3% work for over 31 years.

Membership structure is very different. The average number of members is 23 (M = 23.1, SD = 17.504), including family members (Table 1). However, CATs can be found in ranges from small to large therapeutic communities. In 13% of CATs there are up to 10 members, while in 21.7% there are between 21 and 30 members, and 16.9% of CATs have more than 30 members.

TABLICA 1. Broj i struktura članova KLA
TABLE 1. Number and structure of the membership

Broj članova / Number of members		N	M ± SD	KS-z test	MIN	MAKS / MAX
Ukupno svi klubovi / total		83	23,1 ± 17,504	1,819*	2	100
Klubovi u Zagrebu / CATs in Zagreb	t= 2,452*, df= 61,52	24	18,25 ± 5,95	0,926	9	34
Klubovi izvan Zagreba / CATs outside Zagreb		49	26,20 ± 21,06	1,285	2	100
Muški apstinenti / Male abstinent		82	13,59 ± 10,95	2,072	1	70
Ženski apstinenti / Female abstinent		83	2,55 ± 2,674	2,010**	0	15
Samci apstinenti / Abstinent without family support		82	4,85 ± 9,457	2,766**	0	70
Članovi obitelji u pratnji / Supporting family members		80	8,14 ± 8,431	1,663*	5	57
Broj članova kao podrška ženama / Supporters for female abstinent		77	0,9 ± 1,382	2,633**	0	8

** značajnost na razini 0,001; * značajnost na razini 0,05 / ** significance at the level 0,001; * significance at the level 0,05

grebu ili izvan Zagreba. Naime, KLA u Zagrebu u prosjeku imaju nešto manje članova, dok KLA izvan Zagreba imaju u prosjeku nešto više od 26 članova.

Muški apstinenti čine 61 % članstva, žene apstinentice su zastupljene u članstvu s oko 11 %, samci bez pratnje obitelji čine 20 % članstva, a članovi obitelji čine 28 % članstva. Svega 32 % žena dobiva podršku od bliske osobe u obliku dolazaka u KLA. U 14 KLA ili 17 % nema uopće žena apstinentica, dok čak 22,22 % KLA (N = 19) ima preko 20 % žena apstinentica u svom članstvu. Što se tiče podrške ženama apstinenticama, u čak 49 % KLA (N = 31), žene nemaju nikakvu podršku (ni s jednom ženom ne dolazi bliska osoba na sastanke), ali ohrabrujuće je da u 22 KLA (34,9 %) čak 50 % žena ima podršku bliske osobe.

U prosjeku grupni sastanci traju 90 minuta što se smatra optimalnim vremenom za grupni rad (N = 82, M = 2,87, SD = 0,766, KS-z = 2,352**). Ipak, 31,7 % KLA ima sastanke u trajanju do jednog sata (N = 26), 42 KLA ili 51,2 % 90 minuta, dok 14 KLA (17 %) ima sastanke trajanja 120 minuta. Dulji sastanci nalaze se češće u KLA s više članova (r = 0,273, p = 0,013).

Što se tiče nekih drugih obilježja tipičnih za rad KLA situacija nije posve usklađena, posebice oko pijenja disulfirama. Tako se u 47 ili 56,8 % KLA disulfiram pije, dok to nije slučaj

CATs in and outside Zagreb statistically significantly differ in number of their members. On average, CATs in Zagreb have fewer members, while CATs outside Zagreb have more members on average.

Male abstinents make up 61% of all members, while female women abstinents make up approximately 11%, members without support make up 20% of membership and family members account for 28% of membership. Only 32% of women receive support from those close to them in the form of arrivals at the CAT. In 14 CATs, or 17%, there are no women abstinents, while 22.22% of CATs (N = 19) have over 20% abstinent women in their membership. In approximately 49% of CATs (N = 31), women come with no support, but it is encouraging that in 22 CATs (34.9%), 50% of women have close family support.

On average, CAT's meetings last for 90 minutes which is considered to be the optimal time frame for group work (N= 82, M= 2.87, SD= 0.766, KS-z= 2.352**). However, 31.7% of CATs have meetings for up to an hour (N = 26), 42 CATs or 51.2% for 90 minutes, while 14 CATs (17%) have sessions lasting 120 minutes. Longer meetings are more common in CATs with more members (r = 0.273, p = 0.013).

As for some other characteristics typical of CAT work, the situation is not entirely unified, especially when it comes to drinking disulfiram. In 47 u 43,2 % ili 34 KLA. Iako se hi–kvadrat testom razlika nije pokazala statistički značajnom ($hi^2 = 3,493$, df= 1, p= 0,052), konzumacija disulfirama je nešto uobičajenija praksa u zagrebačkim KLA (u 75 % se disulfiram koristi), dok u KLA izvan Zagreba, gotovo je izjednačen broj KLA u kojima se koristi disulfiram (52,08 %) u odnosu na one u kojima se ne koristi (47,9 %).

Nadalje, 13 KLA (17,3 %) radi i na dan blagdana, dok preostali na blagdan ne održavaju sastanke.

Većina KLA (N = 71 ili 84,3 %) organizira izvanklupske aktivnosti ili u njima sudjeluje. Kada govorimo o izvanklupskim aktivnostima, najčešće se odvija međusobno posjećivanje članova (i to u 75 % KLA), potom se organiziraju izleti (62 % KLA), tribine i skupovi (53,57 % KLA) te sudjelovanja na večeri poezije (44 % KLA). Različite izvanklupske aktivnosti se u najvećem broju KLA organiziraju dva puta godišnje (32,14 % KLA).

Kako bi financirali svoje aktivnosti, KLA imaju više izvora. Većina KLA ima članarinu (73,8 %), u različitim iznosima od 5 do 50 kuna mjesečno. Međutim, najznačajniji izvor sredstava su jedinice lokalne samouprave (63 %), odnosno Grad Zagreb ili županije (27,38 %). Oko 20 % KLA ima podršku određenih ministarstava ili poduzeća.

KLA u prosjeku imaju podršku od oko 4 organizacije u svom okruženju (N= 80; M= 3,6, SD= 1,804; KS-z= 1,612*).

Ukupno gledajući, u velikom broju KLA (N= 58 ili 76,3 %) šira okolina pruža neformalnu podršku. U 5 KLA se prepoznaje da je odnos okoline ili negativan ili da nije upoznata okolina s radom (6,5 %), dok kod 13 ili 17,1 % KLA šira okolina ne pokazuje interes za radom KLA.

Neki KLA nameću se kao lideri u svojoj zajednici te su poznati i po osnivanju novih KLA. Takvih je 25 % u našem uzorku koji su osnovali novi KLA, dok ih 75 % nema takvo iskustvo. Najčešće se radi o osnivanju jednog KLA.

or 56.8% of CATs members use disulfiram, while this is not the case in 43.2%, or 34 CATs. Although differences are not statistically significant ($\chi^2 = 3.493$, df = 1, p = 0.052), consumption of disulfiram is a somewhat more common practice in Zagreb (in 75% of CATs disulfiram is used), while in CATs outside Zagreb there is an equal number of CATs using disulfiram (52.08%) compared to those in which it is not used (47.9%).

Furthermore, 13 CATs (17.3%) work during feast days, while the rest do not hold meetings.

Most CATs (N= 71 or 84.3%) organize or engage in community-based or out-group activities. In most cases, this means visiting members in their private home (in 75% of CATs), organizing trips (in 62% of CATs), forums and round tables (53.57% of CATs) and participating in poetry nights (44% CATs). Different out-group activities are most commonly organized twice a year (in 32.14% of CATs).

CATs have multiple sources to finance their activities. Most of them charge a fee (73.8%) ranging from 5 to 50 HRK per month. The most significant sources are cities and municipalities (for 63% of CATs) and counties/the City of Zagreb (27.38% of CATs). Approximately 20% of CATs receive support from ministries or the private sector.

On average, CATs can count on 4 supporting organizations within their surrounding (N= 80; M= 3.6, SD= 1.804; KS-z= 1.612*). Informal support from the community is recognised in the majority of CATs (N= 58 or 76.3%). Only 5 CATs recognise a negative attitude stemming from the community, while in 13 CATs (17.1%) representatives claim that their community does not show interest in their work or the CAT.

Some CATs are considered to be leaders in their community and are known for developing new CATs. This is the case for 25% of CATs in our sample, which helped in developing at least one new CATs, while 75% of CATs didn't participate in developing new CATs.

Predstavnici KLA iskazivali su potrebe kako bi se unaprijedio rad. Navedenih sedam potreba podijelili smo u dva faktora temeljem faktorske analize s uključenom Varimax rotacijom. Prvi faktor (λ = 2,418, objašnjava 34,54 % varijance) čine potrebe za unaprjeđenjem podrške iz okoline te uključuje potrebe za financijskim sredstvima, boljim prostorom, novim članstvom i boljim statusom u okolini. Drugi faktor (λ = 1,525, objašnjava 21,79 % varijance) čine potrebe za boljim funkcioniranjem grupne dinamike, a sastoji se od potrebe za boljim odnosima među članovima, među članovima i stručnjakom te s ostalim KLA.

Iz tablice 2. možemo vidjeti kako najveća potreba postoji za unaprjeđenjem vanjske ili organizacijske podrške KLA. Ta je potreba posebno izraženija u KLA izvan Zagreba u odnosu na KLA u Zagrebu koji takve potrebe nešto manje ističu.

Obilježja stručnog rada i perspektiva stručnih djelatnika

Rad u KLA iziskuje dodatno usavršavanje te tako 74,7 % stručnjaka (N= 56) osim temeljenog obrazovanja ima završene i dodatne edu-

The CATs' representatives assessed the needs that could help them to improve their work. Seven needs were divided into two factors in a factor analysis with Varimax rotation. The first factor (λ= 2.418, explains 34.54% of variance) is a need for enhanced community support including finances, better facilities, new members and a better status in the community. The second factor (λ= 1.525, explains 21.79% of variance) includes the needs for better group functioning, specifically better group relations, better relations between the members and the therapist, and better relations with other CATs. In Table 2 we can notice that there is a need to enhance community or organizational support. This is mostly recognised for CATs outside Zagreb when compared to CATs in Zagreb.

Characteristics of professional work and therapists' perspectives

Work in the CAT requires additional education and 74.7% of therapists in the sample (N= 56) have some kind of additional education, mostly family therapy (N= 20), reality psychotherapy

TABLICA 2. Potrebe KLA koje doprinose kvalitetnijem funkcioniranju (MIN-1; MAKS-4)
TABLE 2. CAT's needs that would contribute to better functioning (MIN-1; MAX-4)

Prepoznate potrebe KLA liječenih alkoholičara / Recognised needs within CATs		N	KS-z test	M	SD
Faktor 1. Unaprjeđenje organizacijske podrške KLA / Factor 1. Improving organizational support		**79**	**1,220**	**3,06**	**0,545**
KLA u Zagrebu / CATs in Zagreb	t= 2,02*, df= 67	24	0,792	2,94	0,46
KLA izvan Zagreba / CATs outside Zagreb		45	1,160	3,21	0,57
Povećati iznos novčanih sredstava / Increased finances		79	3,353**	3,56	0,675
Promijeniti prostor / Better – new facilities		76	2,672**	1,91	1,11
Privući nove članove / Attract new members		78	3,109**	3,41	0,78
Poboljšati status u okolini / Improve the status in the wider surrounding		78	3,064**	3,36	0,868
Faktor 2. Unaprjeđenje grupne dinamike / Factor 2. Improving group dynamics		**79**	**0,921**	**2,74**	**0,824**
KLA u Zagrebu / CATs in Zagreb	t= -1,514, df= 67	**24**	**0,575**	**3,01**	**0,726**
KLA izvan Zagreba / CATs outside Zagreb		**45**	0,851	**2,7**	**0,879**
Unaprijediti odnose između članova / Improve relations among members		77	1,875*	2,74	0,992
Unaprijediti odnose sa stručnjakom / Improve relations between members and therapists		78	2,020**	2,36	1,116
Zainteresirati članove za komunikaciju s drugim KLA / Increase members' interest for communication with other CATs.		78	2,477**	3,12	0,868

** značajnost na razini 0,001; ** značajnost na razini 0,05 / ** significance at the level 0,001; * significance at the level 0,05

kacije, uglavnom obiteljsku terapiju (N= 20), realitetnu psihoterapiju (N= 13), edukaciju iz područja alkoholizma (N= 20) te ostale psihoterapijske pravce ili poslijediplomski studij.

Stručni djelatnici su se reflektirali na mogućnosti koje bi im pomogle u unaprjeđenju rada. Procijenjene potrebe za unaprjeđenjem rada su faktorskom analizom s uključenom Varimax rotacijom podijeljene u faktor 1: podrška profesionalnom razvoju (λ= 1,89, objašnjava 31,59 % varijance), te faktor 2: organizacijske pretpostavke (λ= 1,76, objašnjava 29,32 % varijance).

Iz tablice 3. može se uočiti da je stručnjacima u odnosu na organizacijske pretpostavke potrebnije uložiti u profesionalni razvoj superviziju, edukaciju i timski rad.

Potreba za ulaganjem u profesionalni razvoj posebno je izraženija kod stručnih djelatnika s kraćim stažom rada u KLA (r= -0,43, p= 0,000). Ista potreba je naglašenija kod socijalnih radnika u odnosu na stručnjake koji imaju završeno sestrinstvo ili liječnike različitih profila.

(N= 13), education in the field of alcoholism (N= 20) or other psychotherapy approach or postgraduate study.

The therapists reflected on possibilities that would help them to improve their work. These were divided by factor analysis with Varimax rotation into factor 1: professional development support (λ = 1.89, explains 31.59% of variance) and factor 2: organizational assumptions (λ = 1.76, explains 29.32% variance). Table 3 shows that professional workers have more need for investment in their professional development through supervision, education and team work, than for better organisation prerequisites.

The need for investing in professional development is particularly pronounced in professional staff with less experience (r = -0.43, p = 0.000). The same need is emphasized in social workers compared to nurses or doctors of different profiles.

Given that the need for education was particularly emphasized, therapists looked at what

TABLICA 3. Potrebe stručnih djelatnika za unaprjeđenjem rada (MIN-1; MAKS-4)
TABLE 3. Therapists' needs that would contribute to better work (MIN-1; MAX-4)

Mogućnosti koje bi unaprijedile rad / Possibilities that could improve work in CAT		N	KS-z test	M	SD
Faktor 1: Podrška profesionalnom razvoju / Factor 1: Supporting professional development		**78**	**1,673***	**2,94**	**0,62**
Socijalni radnici / Social workers	F= 3,19, df= 2, p= 0,048	30	1,264	3,04	0,49
Stručnjaci sestrinstva / Medicine nurse		21	1,2	3,0	0,43
Liječnici / Doctors		15	0,446	2,62	0,74
Kontinuirana supervizija / Continuing supervision		77	3,123**	2,86	0,738
Dodatna edukacija iz područja psihoterapije i savjetovanja / Additional education in psychotherapy and counselling		78	2,233**	2,95	0,924
Timski rad (suradnja s pojedinim stručnjacima drugih profesija) / Team work (cooperation with different professionals)		78	2,657**	3,01	0,747
Faktor 2: Organizacijske pretpostavke / Factor 2: Organisation prerequisites		**78**	**1,076**	**2,17**	**0,79**
Socijalni radnici / Social workers	F= 1,798; df= 2	30	0,715	2,27	0,764
Stručnjaci sestrinstva / Medicine nurse		21	0,782	2,34	0,81
Liječnici / Doctors		14	1,1	1,85	0,888
Veći honorar / Raised salaries		75	2,168**	2, 33	1,105
Bolji prostorni uvjeti / Better facilities		78	1,883*	2,15	1,094
Manji broj članova / Fewer members		77	2,371**	1,78	0,82

** značajnost na razini 0,001; ** značajnost na razini 0,05 / ** significance at the level 0,001; * significance at the level 0,05

S obzirom da se potreba za edukacijama posebno istaknula, stručnjaci su se osvrnuli na to koji bi im tip edukacije bio potreban. Faktorskom analizom smo edukacije podijelili na teme uže u području alkoholizma (λ = 3,06, objašnjava 38,28 % varijance), a drugi faktor su teme u području pružanja psihosocijalne podrške (λ = 2,68, objašnjava 33,51 % varijance). Iako postoji potreba za različitim edukacijama, nešto su izraženije potrebe za edukacijama u pružanju psihosocijalne podrške, posebice u radu s obiteljima. Otvara se i potreba za edukacijama u području kombinacije alkoholizma i drugih ovisnosti (tablica 4). Obje skupine edukacija potrebnije su stručnjacima s kraćim stažom rada u KLA, dakle osjećaju više potrebe za znanjima u užem području alkoholizma (r= -0,25, p= 0,003), ali i u pružanju cjelovite psihosocijalne podrške (r= -0,29, p= 0,01).

type of education they needed, which is divided into two groups by factor analysis. The first consists of topics related to alcoholism as a disease (λ = 3.06, explains 38.28% of variance), while the second factor is topics in field of psychosocial support (λ = 2.68, explains 33.51% of variance). Although there is a need for different types of education, there is a growing need for training in providing psychosocial support, especially in working with families. There is also a need for education in the field of alcoholism and other addictions (Table 4). Both types of education are more expressed by experts with less work experience, which is why they feel more need for knowledge regarding alcoholism (r = -0.25, p = 0.003) but also in providing full psychosocial support (r =- 0.29, p = 0.01).

Regarding therapist's professional background, social workers expressed more need for educa-

TABLICA 4. Potrebe stručnih djelatnika za dodatnim edukacijama (MIN-1; MAKS-4).
TABLE 4. Therapists' needs for additional education (MIN-1; MAX-4).

Potreba za edukacijama / Need for education		N	KS-z test	M	SD
Faktor 1. Teme uže vezane za područje alkoholizma / Factor 1. Topics connected with alcoholism		**78**	**1,261**	**2,63**	**0,74**
Socijalni radnici / Social workers	F= 5,81, df= 2, p= 0,005	30	0,828	2,85	0,703
Stručnjaci sestrinstva / Medical nurses		21	0,973	2,77	0,62
Liječnici / Doctors		14	0,539	2,13	0,934
Komorbiditet alkoholizma i drugih psihičkih bolesti / Comorbidity of alcoholism and other psychic diseases		76	2,421**	2,64	0,95
Specifične skupine pogođene alkoholizmom (mladi, žene, samci) / Alcoholism among specific groups (young people, women, people in single households)		77	2,420**	2,68	0,91
Kombinacija alkoholizma i drugih ovisnosti / Combination of alcoholism and other addictions		78	2,392**	2,72	0,852
Tjelesno zdravlje liječenih alkoholičara / Physical health of people with an alcohol problem		78	2,030**	2,49	0,85
Faktor 2. Teme psihosocijalne podrške / Factor 2. Topics connected with psychosocial support		**78**	**1,338**	**2,71**	**0,75**
Socijalni radnici / Social workers	F= 1,737; df= 2	30	0,751	2,69	0,787
Stručnjaci sestrinstva / Medicine nurse		21	1,075	2,96	0,52
Liječnici / Doctors		14	0,817	2,52	0,835
Obiteljski odnosi / Family relations		77	2,781**	2,81	0,86
Komunikacijske vještine / Communications skills		77	1,800*	2,62	1,00
Zakonska regulativa u pojedinim područjima (socijalna prava, obiteljsko pravo, kazneno pravo i sl.) / Legislation in certain domains: social welfare, family law, criminal law		77	2,429**	2,70	0,92
Grupni rad / Group work		77	2,384**	2,68	0,94

** značajnost na razini 0,001; ** značajnost na razini 0,05 / ** significance at the level 0,001; * significance at the level 0,05

Što se tiče profila stručnjaka, socijalni radnici u nešto su većoj mjeri iskazali potrebu za edukacijama u užem području alkoholizma u odnosu na stručnjake iz područja sestrinstva ili liječnike različitih specijalizacija.

U svom radu stručnjaci koriste raznovrsne tehnike (tablica 5). Najčešće se sastanci temelje na poticanju grupnih diskusija, iznošenju svjedočanstava članova i stručnjaci se bave formalnim obvezama KLA. Nešto rjeđe stručnjaci se koriste kreativnim tehnikama, a po potrebi primjenjuju individualni pristup.

Slično prethodnom, stručnjaci u radu koriste širok dijapazon različitih tema (tablica 6), a najčešće su to teme koje se tiču održavanja apstinencije, partnerskih odnosa i načina suočavanja sa svakodnevnim problemima. Najrjeđe se stručnjaci dotiču teme duhovnosti, ekonomskog statusa i razvoja alkoholizma u prošlosti.

Očekivano, stručnjaci koji imaju neke dodatne edukacije, obrađuju širi raspon različitih tema u odnosu na one koji nemaju dodatnu edukaciju.

Na razini cijelog uzorka prosječno su ispitanici kvalitetu odnosa s članovima procijenili s visokih 4,26 (N= 79; KS-z = 1,157; SD= 0,42). Posebice je visoko slaganje ispitanika s tvrdnjom *Pokazujem prijateljsko raspoloženje prema*

tion in the field of alcoholism in comparison with nurses and doctors.

Therapists use different techniques in their work (Table 5). Most frequently, meetings are based on encouraging group discussion, presenting personal testimonies and dealing with the CAT's formal commitments. Therapists rarely use creative techniques and, where appropriate, apply individual approach.

As in the previous case, therapists also use a wide range of different topics for group meetings (Table 6) and most often these topics are related to maintaining abstinence, partner relationships and ways of dealing with everyday problems. Therapists rarely discuss topics of spirituality, economic status and alcoholism development in the past.

As expected, therapists with additional education use a broader range of different topics in relation to those without additional education.

On the whole sample level, respondents rated the quality of relationship with members with a high average rate of 4.26 (N= 79; KS-z = 1.157; SD = 0.42). They particularly agree with the statements *I show a friendly mood towards the members* (M = 4.54, SD = 0.53) and *I'm actively listening to each member* (M = 4.66, SD =

TABLICA 5. Učestalost korištenja različitih tehnika u radu (MIN:1, MAKS: 5)
TABLE 5. Frequency of using different techniques in group work (MIN:1, MAX: 5)

Tehnike rada / Working techniques	N	KS-z test	M	SD
Prethodno pripremanje za sastanak / Prior preparation for the meeting	80	1,633*	3,59	1,08
Kreativne tehnike / Creative techniques	78	2,463**	3,05	0,91
Aktivno sudjelujem u formalnim obvezama KLA (pisanje projekta, pisanje izvještaja, vođenje zapisnika) / Active involvement in formal obligations (writing projects, writing reports, writing group minutes)	78	1,786*	3,69	1,23
Individualni rad s nekim članom / Individual work with a member	80	2,066**	3,44	1,00
Iznošenje osobnih iskustava dugogodišnjih apstinenata ('svjedočanstva' članova iz matičnog ili drugih KLA) / Sharing personal testimonies of members with long-term abstinence from domestic or other CAT	79	1,688*	3,7	0,99
Predavanje o pojedinoj temi / Giving a lecture on a certain topic	80	1,848*	3,75	1,05
Vođenje grupne diskusije / Facilitating group discussion	80	3,006**	4,43	0,73
Ukupna raznovrsnost primijenjenih tehnika u radu / Overall diversity of different techniques	**80**	**0,878**	**3,67**	**0,53**

** značajnost na razini 0,001; ** značajnost na razini 0,05 / ** significance at the level 0,001; * significance at the level 0,05

TABLICA 6. Učestalost obrađivanja različitih tema na sastancima (MIN:1, MAKS:5)
TABLE 6. Frequency of working on different topics at group meetings (MIN:1, MAX:5)

Teme na sastancima / Topics at group meetings		N	KS-z test	M	SD
Održavanje apstinencije / Maintaining abstinence		79	2,668**	**4,39**	0,74
Partnerski odnosi / Intimate partner relationships		78	2,522**	**4,31**	0,74
Način suočavanja sa svakodnevnim problemima / Coping with everyday problems		79	2,220**	**4,27**	0,76
Slika o sebi, samopouzdanje i samopoštovanje / Self-image, self-esteem, self-confidence		79	2,278**	4,19	0,86
Emocije članova / Dealing with emotions		80	1,994**	4,13	0,77
Roditeljstvo / Parenthood		79	2,131**	3,99	0,9
Kvalitetno provođenje slobodnog vremena / Quality leisure time		79	2,182**	3,89	0,92
Prijateljski odnosi / Friendships		80	1,918**	3,78	0,87
Funkcioniranje na radnom mjestu / Work-place functioning		78	2,143**	3,65	0,88
Tjelesno zdravlje / Physical health		79	1,881*	3,65	0,97
Mentalno zdravlje / Mental health		79	2,117**	3,63	0,96
Razvoj alkoholizma / Alcoholism development		77	1,946**	3,58	0,91
Duhovnost / Spirituality		79	2,364**	2,77	0,95
Ekonomski status / Economic status		79	2,366**	3,08	0,94
Ukupna raznovrsnost tema / Overall diversity of topics		80	0,539	3,81	0,56
Stručnjaci s dodatnim edukacijama / Experts with additional education	t= 1,998, df= 73, p= 0,049	56	0,455	3,88	0,5
Stručnjaci bez dodatnih edukacija / Experts without additional education		19	0,809	3,59	0,63

** značajnost na razini 0,001; ** značajnost na razini 0,05 / ** significance at the level 0,001; * significance at the level 0,05

članovima (M= 4,54, SD= 0,53) i *Aktivno slušam svakog člana* (M= 4,66, SD= 0,62). Nešto niže slaganje ispitanika je s tvrdnjom *Uspijevam sa svakim članom doći do istog viđenja njegova alkoholizma* (M= 3,53, SD= 0,75) i *Sa svakim članom ostvarujem slaganje oko toga kako može unaprijediti svoj život* (M= 3,61, SD= 0,77).

Zanimljivo je da su u ovom pitanju utvrđene i određene statistički značajne razlike temeljem regionalnog položaja KLA (F= 3,654, df= 2, p= 0,031). Tako stručnjaci koji rade u primorskim KLA imaju najviše procjene odnosa prema članovima (M= 4,51, SD= 0,34) u odnosu na stručnjake u kontinentalnim KLA (M= 4,17, SD= 0,44), odnosno u zagrebačkim KLA (M= 4,28, SD= 0,36).

Sukladno prethodnim odgovorima, stručni djelatnici u radu koriste širok raspon terapijskih pomažućih postupaka (N= 78; KS-z= 1,009; M= 4,33; SD= 0,54). Stručnjaci najčešće koriste učenje kvalitetne komunikacije među članovima (M=

0.62). To a lesser extent they agree with the statements *I manage to share with the member the same view of his alcoholism* (M = 3.53, SD = 0.75) and *I manage to establish an agreement with each member regarding how they can improve their life* (M = 3.61, SD = 0.77).

It is interesting that we found some statistically significant differences based on regional position of the CAT (F= 3.654, df= 2, p= 0.031). Therapists in coastal CATs have the highest assessment of their relation towards members (M= 4.51, SD= 0.34) compared to those in continental counties (M= 4.17, SD= 0.44) or in CATs in Zagreb (M= 4.28, SD= 0.36).

As in previous responses, therapists use a wide range of therapeutic procedures (N= 78; KS-z= 1.009; M = 4.33, SD = 0.54). Most often they enhance the learning of quality communication among members (M = 4.62, SD = 0.59), developing motivation for change (M = 4.52, 4,62, SD= 0,59), razvijanje motivacije za promjenom (M= 4,52, SD= 0,72) i jačanje pouzdanja u mogućnost promjene (M= 4,49, SD= 0,72). Nešto se rjeđe stručnjaci služe postupcima uviđanja sličnosti među članovima (M= 4,04, SD= 0,76), poticanjem članova da utječu na svoje okruženje (M= 4,09, SD= 0,83) i učenjem članova kako funkcioniraju drugi oko njih (M= 4,12, SD= 0,81).

Posljednji ispitani konstrukt bio je doživljaj stručnjaka o radu u KLA gdje smo faktorskom analizom s uključenom Varimax rotacijom dobili tri faktora. Prvi faktor je doživljaj kompetentnosti za rad u KLA (uključuje tvrdnje: *Rad u KLA me ispunjava. Rad u KLA mi je postao monoton. Tijekom rada u KLA imam priliku biti kreativan. Osjećam da ne znam dovoljno za rad u KLA.*). Ovaj faktor ima karakteristični korijen 2,26 i objašnjava 22,61 % varijance. Drugi faktor je profesionalni i osobni razvoj radom u KLA**,** ima karakteristični korijen 2,1 i objašnjava 21,02 % varijance. Drugi faktor uključuje tvrdnje: *Mislim da se radom u KLA unapređujem profesionalno. Kroz rad u KLA sam spoznao neke stvari o sebi. Radom u KLA sam bolje upoznao kako drugi ljudi funkcioniraju.* Treći faktor se odnosi na profesionalni stres radom u KLA**,** ima karakterističan korijen 1,87 te objašnjava 18,68 % varijance. Ovaj faktor uključuje tvrdnje *Rad u KLA me frustrira. U KLA susrećem situacije koje me osobno opterećuju. Vremenom mi rad u KLA postaje sve stresniji*

Svoje kompetencije stručnjaci procjenjuju prosječno sa 4,2 (N= 80; KS-z= 1,05; SD= 0,65), slažu se da rad u KLA doprinosi njihovom osobnom i profesionalnom razvoju (N= 80; KS-z= 1,122; M= 4,14, SD= 0,7) te imaju nizak doživljaj profesionalnog stresa (N= 80; KS-z= 1,116; M= 1,89, SD= 0,67). Određene statistički značajne razlike pronađene su jedino s obzirom na profesiju (F= 4,02, df= 2, p= 0,023). Tako nešto veću razinu profesionalnog stresa doživljavaju liječnici (M= 2,11, SD= 0,64) i stručnjaci iz područja sestrinstva (M= 2,04, SD= 0,65) u odnosu na socijalne radnike (M= 1,62, SD= 0,64) koji imaju najmanji doživljaj stresa.

SD = 0.72) and strengthening confidence in the possibility of change (M = 4.49, SD = 0.72). The method of finding similarity between members is a bit less common (M = 4.04, SD = 0.76), as well as encouraging members to influence their environment (M = 4.09, SD = 0.83) and teaching members how other people function (M = 4.12, SD = 0.81).

Finally, we wanted to see how therapists feel about their work in CAT. This is divided into 3 factors by factor analysis with the Varimax rotation. The first factor (λ = 2.26, explains 22.61% of variance) is the sense of competence including items: *Work in the CAT fulfils me; Work in the CAT became monotonous; While working in the CAT I have a chance to be creative; I feel I don't have enough knowledge to work in a CAT.* The second factor (λ = 2.1, explains 21.02% of variance) refers to the contribution of a CAT to a therapist's personal development. It includes items: *I think that I'm developing professionally through my work in CAT*; *Through this work I've realised some things about myself*; *By working at the CAT, I got better acquainted with how other people function.* The third factor relates to professional stress (λ = 1.87, explains 18.68% of variance). This factor includes items: *Work in the CAT frustrates me*; *I encounter situations in the CAT that personally burden me; Over time, work at the CAT is becoming more and more stressful*.

All three factors show a high degree of satisfaction among the respondents. Their competence is, on average, estimated at 4.2 (N= 80; KS-z= 1.05; SD = 0.65), they agree that work in the CAT contributes to their personal and professional development (N= 80; KS-z= 1.122; M = 4.14, SD = 0.7) and have a low experience of professional stress (M = 1.89, SD = 0.67). Certain statistically significant differences were found only with regard to the profession (F = 4.02, df = 2, p = 0.023). A slightly higher level of professional stress is experienced by doctors (M = 2.11, SD = 0.64) and nurses (M = 2.04, SD = 0.65) when compared to social workers (M = 1.62, SD = 0.64).

RASPRAVA

Rezultati istraživanja pokazuju da su KLA organizacije s dugom tradicijom djelovanja u prosjeku preko 20 godina. U prosjeku imaju 23 člana, ali postoje značajne razlike u brojnosti članova (posebice su veći KLA izvan Zagreba u gradovima koji nemaju tako razgranatu mrežu klubova). Žene sudjeluju u članstvu s oko 10 %, a članovi obitelji sa 28 %.

Sastanci klubova uglavnom traju preporučenih 90 minuta. Većina KLA organizira izvanklupske aktivnosti koje su snažan poticaj ukupne promjene i stabilne apstinencije članova (37). Najveće neusklađenosti vide se o korištenju disulfirama gdje su KLA podijeljeni.

Što se tiče vanjske podrške, jedinice lokalne i regionalne samouprave dominantan su izvor financiranja rada, a nešto se rjeđe koriste nacionalni ili privatni izvori. To je potvrđeno i u istraživanju o organizacijama civilnog društva gdje su KLA one organizacije koje dominantno podržava lokalna razina (8). Općenito gledajući, situacija s podrškom iz okruženja je zadovoljavajuća, KLA su umreženi u prosjeku s barem 4 organizacije i većina (76 %) prepoznaje neformalnu podršku šire okoline. Važno je istaknuti da četvrtina klubova ima iskustvo osnivanja novog KLA, čime se promiču kao lideri u ovom području. Razmišljajući o tome što bi moglo unaprijediti rad KLA predstavnici stavljaju veći naglasak na daljnje unaprjeđenje organizacijske podrške u odnosu na unaprjeđenje grupne dinamike.

Što se tiče stručnjaka, većina ih je dodatno educirana za potrebe vođenja KLA (75 %). No, suprotno mišljenju članova predsjedništva, procjenjuju većima potrebe za ulaganjem u profesionalni razvoj, a manje potrebe za organizacijskom podrškom. Unutar potrebe za profesionalnim razvojem posebno je apostrofirana potreba za supervizijom imajući u vidu neposredan rad s osobama koje uz alkoholizam imaju iskustvo gubitaka, trauma i kompleksnih

DISCUSSION

The research results show that CATs are organizations with a long tradition, on average of over 20 years. There are 23 members on average, but there are significant differences in the number of members (CATs outside of Zagreb are usually bigger). Women participate in the membership with about 10%, and family members make up 28% of the total number.

The clubs' meetings generally last 90 minutes. Most CATs organize out-group activities that are a powerful stimulus for total change and stable membership abstinence (37). The greatest disparities are seen in the usage of disulfiram and the CATs are divided regarding this matter.

As far as external support is concerned, the local and regional governments are the dominant sources of funding, while national or private sources are rarely used. This is also confirmed in the research on civil society organizations where the CATs are organizations that are predominantly supported on the local level (8). In general, the situation with support from the surrounding is satisfactory, CATs are networked with four organizations on average and most (76%) recognize informal support of the wider environment. It is important to note that a quarter of clubs have experience of establishing a new CAT, and these can be seen as leaders in this area. Considering what could improve their work, the representatives place greater emphasis on further improvement of organizational support in relation to improving group dynamics.

As far as experts are concerned, most of them are additionally educated for work in a CAT (75%). But, contrary to the opinion of the presidency members, they put more emphasis on the need for investment in professional development and less on the need for organizational support. Within the need for professional development, supervision is particularly emphaživotnih problema (38). Ovaj nalaz je posebno važan znajući da je percepcija stručnjaka kao kompetentnog značajna za motivaciju članova (19), odnosno izravno je povezana s učincima programa (17).

Potrebu za jačanjem kompetencija više naglašavaju stručnjaci s kraćim stažom u KLA te socijalni radnici. Socijalni radnici u odnosu na liječnike i medicinske sestre više naglašavaju potrebe za specifičnijim edukacijama u području alkoholizma kao bolesti ovisnosti. Ovako iskazana potreba može se povezati s rezultatima prethodnih istraživanja u kojima je utvrđeno da su zdravstveni stručnjaci skloniji alkoholizam promatrati kao bolest, dok drugi stručnjaci više prihvaćaju hipotezu alkoholizma kao samoliječenja (29) ili možemo reći u našim okvirima prizmom rada na sebi.

Stručni rad karakterizira raznovrsnost tehnika u radu, širok raspon pomažućih postupaka, kao i raznovrsnost tema. Visoko su procijenjeni odnosi s korisnicima. Ovo je posebice važno jer je u ranijem istraživanju utvrđeno da raznovrsnost doprinosi osobnoj promjeni članova obitelji (11), dok je za promjenu članova s problemom ovisnosti osim raznovrsnih tema, značajan i odnos stručnjaka (10).

Stručnjaci ukupno gledajući visoko procjenjuju svoje kompetencije za rad s članovima, prepoznaju da KLA doprinosi kako osobnom, tako i profesionalnom razvoju te imaju nizak doživljaj profesionalnog stresa. Ovdje je posebno važno istaknuti da stručnjaci prepoznaju kako je njihova uloga povezana s osobnim razvojem, a osobna je komponenta ključna da bi stručnjak bio autentičan i konzistentan (22,28).

Kao neke od ograničenja istraživanja možemo navesti izostanak slučajnog uzorka te je moguće da je spremnost na sudjelovanje doprinjeo višim procjenama što se ogleda u činjenici da nije zadovoljen kriterij normalnosti distribucije na mnogim varijablama. Također, postojala su dva modaliteta prikupljanja podataka (licem

sised, given that many people with addiction problems have experienced loss, trauma and complex life problems (38). This finding is particularly important because the perception of experts as being competent is a significant factor in motivating members (19) and is directly related to the effects of the program (17).

The need for strengthening competencies is emphasized by the professionals with less work experience and by social workers. In comparison with doctors and nurses, social workers emphasize the need for more specific education in the field of alcoholism as an addiction disease. This need can be linked to the results of existing studies, according to which health professionals are more inclined to consider alcoholism a disease, while other experts are more likely to accept the hypothesis of dealing with alcoholism as self-treatment (29) or, in other words, that a person "has to work on himself or herself".

Professional work is characterized by a variety of techniques, a wide range of supporting procedures, as well as a variety of topics. Relationships with members are rated highly. This is especially important because earlier research has found that the diversity of topics and approaches contributes to the positive personal change of family members (11), while both diversity of topics and professional relationship are important predictors for the change of members with addiction problem (10).

Experts evaluate their competences for working with members highly, recognize that the CAT contributes both to personal and professional development and have a low experience of professional stress. Here it is particularly important to note that they recognize how their role is related to personal development, and the personal component is crucial for an expert to be authentic and consistent (22,28).

As some of the limitations of the study we can point out the absence of a random sample, and it is possible that readiness to participate conu lice i poštanski) te bi bilo potrebno osigurati jedan dosljedno provedeni način, preferirano kontakt licem u lice.

Ono što smatramo jakim stranama istraživanja jest postojanje dvaju izvora informacija koji upotpunjava dobivene zaključke. Također, u istraživanju je bilo zastupljeno oko polovice svih KLA u Hrvatskoj te smatramo da dobiveni rezultati ukazuju na moguće trendove reprezentativne za situaciju u KLA na nacionalnoj razini.

Posebice smatramo korisnim izradu specifičnog instrumenta za obje skupine sudionika koji se može u budućnosti unaprjeđivati i kontinuirano koristiti.

ZAKLJUČAK

KLA kao organizacije civilnog društva s dugogodišnjom tradicijom u zajednici zauzimaju posebno mjesto u pružanju specifičnih socijalnih usluga u zajednici s ciljem očuvanja apstinencije i psihosocijalne rehabilitacije osoba s problemom ovisnosti. Ovim istraživanjem nastojali smo upoznati organizacijska obilježja, obilježja stručnog rada i potrebe KLA iz uloge stručnih djelatnika i članova predsjedništva.

Rezultati ukazuju da KLA imaju dvojaki karakter grupe za podršku i organizacije civilnog društva te se podjednako u većini KLA njeguje kako unutarnja grupna dinamika i pružanje cjelovite podrške, tako i kvalitetan odnos s okruženjem.

Da bi djelovanje KLA bilo još kvalitetnije, ovim istraživanjem možemo konstatirati da postoji potreba za sljedećim:

- Ujednačiti rad s obzirom na brojnost članova, te propitati korištenje disulfirama s obzirom na podijeljenost KLA oko ove prakse
- Potaknuti i promovirati pozitivnu praksu KLA i prema drugim organizacijama, kao

tributed to higher estimates, which is reflected in the fact that the criterion of normality distribution on many variables was not met.

There were also two modalities of data collection (face to face and postal) and it would be necessary to provide a consistent approach, preferably face to face contact.

One aspect which we consider a strong side of the study is the existence of two sources of information that contribute to the obtained conclusions. Also, around half of all CATs in Croatia were represented in the survey, and we believe that the obtained results point to possible representative trends for the situation on the national level.

In particular, we believe that it would be useful to create a specific instrument for both groups of participants, which could be further improved and used in the future.

CONCLUSION

The CATs as a civil society organization with a longstanding community tradition have a special place in providing social service in the community by preserving abstinence and providing psychosocial rehabilitation of people with addiction problems. Through this study, we tried to get acquainted with the organizational characteristics, the characteristics of professional work and the needs of the CATs from the viewpoint of professional staff and members of the presidency.

The results indicate that the CATs have a dual character of support groups and civil society organizations, and in the majority of CATs both internal group dynamics and providing full support are nurtured, as well as a solid relationship with the surrounding community.

In order for the CATs to function even better, we can conclude that there is a need to:

- standardize work with regard to the number of members, and to discuss the use of

što su izvanklupske aktivnosti i osnivanje novih KLA
- Osigurati kontinuirano i održivo financiranje koristeći širi izvor sredstava financiranja
- Ulagati u profesionalni razvoj stručnjaka, posebice onih koji tek ulaze u sustav osiguravanjem kontinuirane edukacije i supervizija. Supervizija je snažan mehanizam za povezivanje osobnog i profesionalnog što se prethodno pokazalo važnim za kvalitetan rad
- Promovirati interdisciplinaran holistički pristup stručnjaka koji koriste raznovrsne tehnike, teme i terapijske postupke u radu kao primjer dobre prakse i u drugim područjima.

Zaključno, smatramo da je potrebno u budućnosti nastaviti daljnja istraživanja kako bi se doprinijelo razumijevanju ne samo obilježja, nego i učinaka djelovanja KLA kao grupa podrške i terapijskih zajednica.

disulfiram since practise varies to a great extent
- encourage and promote positive practice of the CATs, such as out-group activities and the establishment of new CATs
- ensure ongoing and sustainable funding using a wider source of funding
- invest in professional development of experts, especially those who are just entering the system by providing continuous education and supervision. Supervision is a powerful mechanism for reflecting personal and professional that has previously proved to be important for work.
- promote the holistic interdisciplinary approach that uses various techniques, themes and therapeutic procedures as an example of good practice towards other areas.

In conclusion, we believe that it is necessary to continue researching this topic in order to contribute to the understanding of not only the features but also the effects of the activities of the CAT as a support group and of the therapeutic communities.

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Simptomi anksioznosti i depresivnosti te stavovi spram pravednosti u svijetu u uzorku slijepih i gluhih osoba Osječko-baranjske županije

/ *Symptoms of Anxiety, Depression and Attitudes Toward Justice in the World in a Sample of Deaf and Blind Persons in Osijek Baranja Region*

Đorđe Pojatić[1], Dunja Degmečić[1,2]

[1]Sveučilište Josipa Jurja Strossmayera u Osijeku, Medicinski fakultet, Klinički bolnički centar Osijek, Klinika za psihijatriju, Osijek, Hrvatska

/ *[1]Josip Juraj Strossmayer University in Osijek, Faculty of Medicine, [2]University Hospital Centre Osijek, Department of Psychiatry, Osijek, Croatia*

Cilj istraživanja bio je odrediti razine simptoma depresivnosti, anksioznosti u slijepih i gluhih ispitanika, njihove stavove o pravdi u svijetu, usporediti navedene razine između dviju skupina i kontrolne skupine te usporediti socio-demografska obilježja triju ispitivanih skupina. Studija je provedena kao presječno istraživanje. U studiju je uključeno 49 slijepih, 46 gluhih i 38 ispitanika iz kontrolne skupine. Za procjenu simptoma depresije i anksioznosti korišteni su Bekovi upitnici za procjenu depresivnosti i anksioznosti. Stavovi o pravednosti u svijetu procijenjeni su Ljestvicom općih stavova o pravdi u svijetu (Dalbert, Schmidt, Montada). U anketiranju gluhih ispitanika sudjelovao je prevoditelj hrvatskoga znakovnog jezika, a slijepim ispitanicima upitnici su pročitani. Gluhe osobe statistički su značajno depresivnije i anksioznije u odnosu na kontrolnu skupinu ispitanika ($p<0,001$, $p<0,001$). Gluhe osobe nisu pokazale izraženije stavove o pravdi u svijetu u odnosu na ispitanike kontrolne skupine. Slijepe osobe imaju statistički značajno izraženije stavove o pravdi u svijetu ($p<0,001$) te značajno više razine anksioznih simptoma u odnosu na kontrolnu skupinu ($p=0,035$). Rezultati studije otkrivaju značajno više razine anksioznosti i depresivnosti gluhih i slijepih ispitanika, prikazuju negativnu korelaciju između izraženih stavova o pravdi u svijetu i razina anksioznosti u gluhih ispitanika. Rezultati prikazuju izraženije stavove o pravdi u svijetu u slijepih u odnosu na gluhe ispitanike i kontrolnu skupinu.

/ *The aim of this study was to determine the level of anxiety and depression of deaf and blind people and their attitudes towards justice in the world. The aim was also to compare these levels between two groups and the control group and determine the sociodemographic characteristics of the three groups. The study was designed as a cross sectional study. The study included 46 deaf, 49 blind and 38 participants in the control group. Anxiety and depression levels were measured using the Beck Anxiety and Depression Inventory. Attitudes towards justice were measured using the General Belief in a Just World Scale. The group of deaf people was interviewed by a researcher using the Croatian Sign Language. A group of blind people was interviewed by the researcher. Deaf people had a significantly higher Beck Anxiety score ($p<0,001$) and Beck Depression score ($p<0,001$) compared to the control group. Deaf patients did not have a significantly higher General Belief score compared to the control group. Blind patients had a significantly higher General Belief score compared to the control group ($p<0,001$) and a significantly higher Beck Anxiety score ($p=0,035$) compared to the control group. The results of this study revealed significantly higher levels of depression and anxiety among deaf and blind patients, they showed a negative correlation between positive attitudes toward a just world and anxiety among deaf patients. They did show higher levels in attitudes of blind people towards a just world compared to deaf and control groups.*

ADRESA ZA DOPISIVANJE / *CORRESPONDENCE:*
Izv. prof. prim. dr. sc. Dunja Degmečić, dr. med.
Medicinski fakultet Osijek
Sveučilište Josipa Jurja Strossmayera
J. Huttlera 4
31 000 Osijek, Hrvatska
E-pošta: ddegmecic@gmail.com

KLJUČNE RIJEČI / *KEY WORDS*:
Depresija / *Depression*
Anksioznost / *Anxiety*
Pravedan svijet / *Just world*
Sljepoća / *Blindness*
Gluhoća / *Deafness*

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UVOD

Gluhoća se definira kao oštećenje sluha veće od 91 decibela na jednom uhu, koje je urođeno ili stečeno (1). Neovisno o dobi gubitka sluha, gluhe osobe pokazuju značajno višu pojavnost depresivnih i tjeskobnih simptoma u odnosu na osobe bez oštećenja sluha (2,3). Visoke razine stresa u gluhih osoba prema dosadašnjim istraživanjima proizlaze iz osamljenosti i nedostatka socijalnih kontakata (2). Isključenost iz socijalnih kontakata u gluhih osoba često dovodi i do pojave somatskih simptoma i socijalne disfunkcije čak i ako se radi o gluhoći nastaloj u mlađoj dobi, studentskoj populaciji (3). Navedeno su rizični čimbenici koji dovode do toga da gluhe osobe u odnosu na opću populaciju bez oštećenja sluha češće počine suicid, a osobito rizični faktori pri tomu su muški spol, starija životna dob te prisutnost više somatskih i psihijatrijskih komorbiditeta (4). Prevladavanje simptoma depresije i anksioznosti, prema rezultatima dosadašnjih studija, značajno ovisi o razini socijalne podrške okoline, prihvaćanju invaliditeta te odgovarajućem obrascu ponašanja prema ograničenjima koja proizlaze iz invaliditeta. Gluhe osobe s razrađenim strategijama pozitivnog mišljenja, rješavanja ograničenja proizašlih iz nagluhosti ostvaruju značajno višu kvalitetu života u odnosu na osobe s izbjegavajućim ponašanjima (5). Do sada je objavljeno nekoliko studija koje su utvrdile povoljan utjecaj

INTRODUCTION

Deafness is defined as a hearing impairment greater than 91 decibels in one ear, which can be either congenital or acquired (1). Regardless of the age when the hearing loss occurred, deaf people show significantly higher incidence of symptoms of depression and anxiety in comparison with people without any hearing impairment (2,3). According to research, high levels of stress in deaf people arise from loneliness and lack of social contact (2). Being excluded from social interactions often leads to the development of somatic symptoms and social dysfunction among deaf people, even if the hearing impairment occurred at a younger age, during student years (3). The aforementioned are risk factors which lead to deaf people committing suicide at a higher rate than the general population, while additional risk factors include the male sex, older age and additional somatic and psychiatric comorbidities (4). According to existing studies, the predominance of symptoms of depression and anxiety is significantly dependent on the level of social support from the person's surroundings, acceptance of disability and on following an adequate behavioural pattern in accordance with the limitations brought on by the disability. Deaf people with developed strategies of positive affirmation and dealing with limitations stemming from hearing impairment have a significantly higher quality of life compared to people with avoidance behaviour patterns (5). So far, strategija suočavanja sa stresom na kvalitetu života i psihičko zdravlje gluhih ispitanika, no i dalje nedovoljno utvrđene ostaju strategije koje vode gluhe osobe prevladavanju stresa i psihičkom zdravlju (1).

Poseban problem u istraživanju pojavnosti simptoma psihijatrijskih bolesti i strategija za suočavanje s ograničenjima svakodnevnog života u populaciji gluhih osoba je činjenica da osobe koje su prelingvalno gluhe nisu u mogućnosti govoriti i pisati te se stoga služe znakovnim jezikom. Osobe sa stečenim gubitkom sluha, premda se također mogu koristiti znakovnim jezikom, obično su u mogućnosti čitati te ih je moguće ispitati standardnim upitnicima za procjenu psihijatrijskih simptoma. Primjena upitnika prevedenih na znakovni jezik čak je i u takvih ispitanika uspješna u mjerenju simptoma psihijatrijskih bolesti, no ostaje upitna racionalnost primjene upitnika standardiziranih na znakovni jezik, budući da je pisanim upitnicima također moguće adekvatno procijeniti depresivne i druge simptome (6).

Sličnu depresivnu reakciju, ograničenja svakodnevnog života i potrebu za psihičkom prilagodbom gore navedenom pokazuju osobe s potpunim ili djelomičnim gubitkom vida. Sljepoća se definira kao gubitak vida od 95 % na boljem oku uz maksimalno moguću korekciju. Kongenitalni gubitak vida u adolescenata povezan je s visokim razinama anksioznosti, a prema nekim saznanjima i s depresivnosti (7). Gubitak vida je stresan događaj, budući da čovjek najveći dio informacija prikuplja vidom te je nerijetko prihvaćanje gubitka vida povezano s depresivnom reakcijom (8). Depresivni simptomi posebice su izraženi kod starijih osoba s gubitkom vida budući da starija životna dob nosi sa sobom veći rizik i sklonost depresiji i drugim mentalnim bolestima (9). Prema dosadašnjim saznanjima depresivni su simptomi jače izraženi u osoba koje imaju druge somatske bolesti, kojima nedostaje socijalna podrška ili, s druge strane, imaju po-

several studies have been published that show a positive influence of stress management strategies on the quality of life and mental health of deaf participants. However, strategies helping deaf people overcome stress and leading them to mental well-being are still underdeveloped (1).

When investigating the symptoms of psychiatric illnesses and strategies for facing daily life limitations in the population of deaf people, the fact that people with prelingual deafness are not able to speak or write, and therefore use sign language, presents a special problem. People with an acquired hearing impairment, although also able to use sign language, are usually able to read, which allows the use of standard written questionnaires in assessing their psychiatric symptoms. The use of questionnaires translated to sign language is successful in assessing psychiatric symptoms even in those patients. However, the use of questionnaires standardized for sign language remains questionable since written questionnaires also provide the possibility of adequately assessing the symptoms of depression, as well as other symptoms (6).

Similarities in depressive reactions, daily life limitations and the need for mental adaptation to the aforementioned limitations are also seen in people with complete or partial loss of vision. Blindness is defined as vision loss of over 95% on the healthier eye with the best possible correction. In adolescents, congenital vision loss is associated with high levels of anxiety and, according to some findings, depression (7). Loss of vision is a stressful event because a person acquires most of their sensory information through sight, which is why acceptance of vision loss is often related to a depressive reaction (8). Symptoms of depression are especially dominant among the elderly with vision loss since old age brings a higher risk from and a tendency toward developing depression and other mental illnesses (9). According to existing findings, symptoms of depression are more intense in people suffering from other somatic teškoće u komunikaciji s vlastitom socijalnom okolinom (8). Značajnu ulogu u prilagodbi na gubitak vida u svim dobnim skupinama imaju rano prihvaćanje gubitka vida te zdravi psihološki mehanizmi prilagodbe na navedeni gubitak (10). Dosadašnja su istraživanja utvrdila značajnu prednost ispitanika sa zrelim mehanizmima obrane od stresa u prilagodbi na iznenadan ili postupan gubitak vida. Povoljan učinak na psihičko zdravlje takvih ispitanika proizlazi u potpunom prihvaćanju gubitka, kanaliziranju stresa zrelim mehanizmima obrana od stresa poput humora i sublimacije te izraženih pozitivnih očekivanja od vlastite budućnosti (5). S obzirom na dosadašnje spoznaje da pozitivna percepcija budućnosti i podrške od socijalne okoline može djelovati na psihičko zdravlje skupina gluhih i slijepih ljudi ostaje nužno utvrditi je li i u kojoj mjeri stav osobe o općoj pravdi u društvu povezan s boljim psihičkim zdravljem. Naime, prema teoriji generalnog vjerovanja u pravdu u svijetu („*Beliefs In A Just World*" *Theory*), ljudi koji vjeruju da je njihova okolina pravedno mjesto vjeruju da se dobro dobrim vraća, odnosno da svaki čovjek dobije ono što zaslužuje. Vjerovanje u pravednost u svijetu zapravo je mehanizam suočavanja sa stresom budući da pomaže racionalizaciji stresnih događaja i nošenju sa stresom svakodnevnog života (11). Ljudi s izraženijim stavovima o pravdi u svijetu kognitivno ocjenjuju događaje manje stresnim te se osjećaju sigurnijima od neželjenih događaja. Prema nekim istraživanjima izraženiji stavovi o pravdi u svijetu povezani su s boljim autonomnim odgovorom kardiovaskularnog sustava, slabijim tjelesnim manifestacijama stresa i većom učinkovitošću pri izvođenju mentalnih i fizičkih zadataka (12). Izraženi stavovi o pravednom svijetu preveniraju i nastanak težih psihijatrijskih bolesti poput depresije i anksioznog poremećaja (13). Zanimljiva je i činjenica da mehanizmi suočavanja sa stresom, poput teorije o pravdi u svijetu, djeluju zaštitno i kod pacijenata s teš-

illnesses and those missing social support or, on the other hand, having difficulties with communication within their social circle (8). Early acceptance of vision loss and healthy psychological adaptation mechanisms are key in adapting to vision loss in all age groups (10). Research has shown that participants with mature coping mechanisms are at a significant advantage when dealing with adapting to a sudden or gradual loss of vision. In those participants, favourable impact on mental health stems from complete acceptance of vision loss, channelling stress through mature coping mechanisms such as humour and sublimation, as well as expressing positive expectations about their future (5). Considering the knowledge that positive perception of the future and support from one's social circle can have an effect on mental health of blind and deaf people, it remains to be seen whether or not, and to what extent, a person's views on justice in society in general is associated with a healthier mental state.

According to the "Beliefs in a Just World" theory, people who believe that their surroundings are a just place also believe that if you do good, good comes back to you and that every person gets what they deserve. Belief in a just world actually represents a coping mechanism since it helps rationalize stressful events and deal with stress in daily life (11). People with stronger beliefs in justice in the world cognitively perceive events as less stressful and feel safer from unwanted events. According to some studies, a stronger belief in a just world is linked to a better autonomous response of the cardiovascular system, less dominant somatic manifestations of stress and higher efficacy when performing mental and physical tasks (12). Stronger belief in a just world prevents the development of more severe psychiatric illnesses such as depression and anxiety disorders (13). Interestingly, coping mechanisms, such as the Just World Theory, have a protective effect on patients with severe mental illnesses and also decrease the intensity of paranoid thoughts in patients with schizophrenia kim psihijatrijskim bolestima, odnosno smanjuju i razinu paranoidnih ideja u oboljelih od shizofrenije (14). Međutim, ostaje nejasno jesu li izraženi stavovi o pravednosti u svijetu djelotvoran čimbenik u smanjenju depresivnih simptoma i anksioznosti u populacijama gluhih i slijepih osoba kao specifičnim populacijama izoliranim od socijalnih kontakata i specifičnih podražaja vanjske okoline te ima li povezanosti s drugim obilježjima tih dviju skupina poput materijalnog stanja i dobi nastanka senzornog oštećenja.

CILJEVI ISTRAŽIVANJA

Osobe s oštećenjem sluha i vida posebno su ranjive populacije čija socijalna prilagodba, funkcioniranje u sklopu aktivnosti svakodnevnog života te mentalno zdravlje jako ovisi o podneblju u kojemu žive, tj. o osviještenosti društva o njihovim specifičnim potrebama i njihovum ispunjavanju. Pojavnost simptoma mentalnih bolesti u populacijama gluhih i slijepih osoba, kao i mehanizmi suočavanja sa stresom, do sada nisu istraživani u RH, stoga je osnovni cilj ove studije mjerenje tih simptoma s nekoliko specifičnih ciljeva:

1. Opis sociodemografskih obilježja uzorka slijepih, gluhih i ispitanika kontrolne skupine s prebivalištem u Osječko-baranjskoj županiji, njihovih mjesečnih primanja po ukućaninu.
2. Utvrđivanje razine depresivnih, anksioznih simptoma te izraženosti stavova o pravednosti u svijetu u populacijama slijepih i gluhih osoba.
3. Usporedba razine depresivnih, anksioznih simptoma te izraženosti stavova o pravednosti u svijetu populacija slijepih i gluhih osoba s kontrolnom skupinom slične dobi i spola.
4. Utvrđivanje povezanosti izraženih stavova o pravednom svijetu s mjesečnim prima-

(14). However, it remains to be seen whether or not strong views on a just world act efficiently in decreasing the symptoms of depression and anxiety among deaf and blind people, since these are specific populations isolated from social contact and specific stimuli from their surroundings. It is also unclear if there is a connection between such views and other characteristics of these two populations, such as financial status and the age of sensory impairment onset.

RESEARCH GOALS

Persons with hearing or vision impairment are an especially vulnerable population and their adaptation to society, functioning within the context of daily life activities and mental health are highly dependent on the area where they live – on whether the society around them is aware of their specific needs and of fulfilling them. The incidence of mental illnesses in the population of deaf and blind people, as well as their coping mechanisms, have not yet been studied in Croatia. Therefore, the main goal of this study is to examine the aforementioned through several specific objectives:

1. Analysis of the sociodemographic characteristics of the sample of blind and deaf participants and a control group with residence in the Osijek-Baranja county, and their monthly household per capita income;
2. Determining the level of symptoms of depression and anxiety as well as determining the belief in a just world in the groups of blind and deaf participants;
3. Comparison of the level of symptoms of depression and anxiety, as well as comparison of the levels of belief in a just world between the groups of blind and deaf participants and the control group involving participants of the same age and sex;
4. Determining the connection between the expressed views about a just world with

njima po ukućanima slijepih i gluhih ispitanika.

5. Utvrđivanje povezanosti izraženih stavova o pravednom svijetu i dobi gubitka vida u slijepih ispitanika.
6. Utvrđivanje povezanosti izraženih stavova o pravednom svijetu i razina anksioznih i depresivnih simptoma u usporednim skupinama.

METODE I ISPITANICI

Istraživanje je provedeno kao presječna studija. Sudionici su istraživanja gluhe i slijepe osobe, članovi Udruge gluhih i nagluhih Osječko-baranjske županije te članovi Udruge slijepih Osječko-baranjske županije. Kontrolna skupina oblikovana je od osoba bez postojećeg vidnog ili slušnog oštećenja. U istraživanju je sudjelovalo 49 slijepih, 46 gluhih i 38 ispitanika iz kontrolne skupine. Sudionici su istraživanja gluhe osobe obaju spolova s oštećenjem sluha na jednom uhu u razini višoj od 91 decibela, koje je nastalo rođenjem ili je stečeno, a prisutno je u trajanju od najmanje 5 godina. Najznačajniji kriteriji za uključivanje u istraživanje jest duljina trajanja oštećenja sluha kako bi se sa što većom sigurnošću ispitali simptomi psihijatrijskih bolesti u osoba koje su ovim oštećenjem pogođene dulje vrijeme jer su takvi simptomi jako izraženi gubitkom sluha koji nastupa akutno. Slijepe su osobe one koje imaju 95 % oštećenja vida na boljem oku uz najbolju moguću korekciju, koje su slijepe od rođenja ili je gubitak vida nastao tijekom života, a traje dulje od pet godina. Iznenadan nastup gubitka vida također može stvoriti akutne psihološke posljedice te je u svrhu istraživanja odabran uzorak kod kojeg je mogućnost akutnih psihijatrijskih zbivanja isključena. Kontrolna skupina oblikovana je od osoba obaju spolova, sličnog raspona godina, bez prisutnog oštećenja sluha

monthly per capita household income within the groups of blind and deaf participants.

5. Determining the connection between the expressed views about a just world and the age of vision impairment onset in blind participants;
6. Determining the connection between the expressed views about a just world and the levels of symptoms of depression and anxiety within the groups.

PARTICIPANTS AND METHODS

This research was designed as a cross-sectional study. The participants in the study were deaf and blind people, members of the Association of Deaf and Hearing-impaired Persons of the Osijek-Baranja County and the Association of Blind Persons of the Osijek-Baranja County. The control group consisted of people without an existing impairment of sight or hearing. 49 blind and 46 deaf people were included in the study, while the control group consisted of 38 participants. The participants in the study were deaf people of both sexes, with hearing impairment in one ear greater than 91 decibels, either congenital or acquired, lasting for at least five years. The most significant criteria for inclusion in the study was the duration of hearing impairment, so that symptoms of mental illnesses could be examined with a high degree of certainty in participants who have had hearing impairment for a longer period of time, since such symptoms are very prominent when hearing impairment occurs acutely. Blindness is defined as a 95% impairment of vision on the healthier eye with the best possible correction, congenital or acquired, lasting longer than five years. Sudden vision loss can also cause acute psychological damage which is why, for the purposes of this study, participants with a confirmed absence of acute psychiatric symptoms were used to create the research group. The control group contained participants of both sexes, in a similar age range, without any i vida te uz odsutnost drugih psihijatrijskih bolesti ili ozbiljnije somatske bolesti, a izabrana je nasumičnim telefonskim pozivima uz uvjet da udovoljavaju navedenim kriterijima i pristaju na sudjelovanje u istraživanju. U oblikovanju uzorka kontrolne skupine posebno je značajno podudaranje svih triju skupina u odnosu na spol i dob budući da male spolne i dobne razlike mogu dovesti do značajno drukčijih rezultata ljestvica vjerovanja u pravedan svijet i upitnika za procjenu depresivnosti i anksioznosti. Populacija starijih i mlađih ispitanika obično ima bolje rezultate na ljestvici vjerovanja u pravedan svijet u odnosu na osobe srednje dobi, dok je kod ženskog spola taj rezultat na spomenutoj ljestvici niži. Rezultati upitnika za procjenu anksioznosti i depresije također su viši kod ženskoga spola i u starijih bolesnika. Zbog malog broja slijepih i gluhih ispitanika u Osječko-baranjskoj županiji u istraživanje su uključeni svi koji ispunjavaju navedene uvjete o razini i trajanju oštećenja, a daljnje postupke nasumičnog izbora između tih ispitanika nismo bili u mogućnosti provesti. Istraživanje je provođeno dva mjeseca, od veljače do travnja 2015. godine.

Pomoću sociodemografskog upitnika prikupljeni su podatci o spolu, razini obrazovanja, bračnom statusu i razdoblju gubitka osjeta u gluhih i slijepih osoba te o spolu, razini obrazovanja i bračnome statusu kontrolne skupine ispitanika. Prikupljeni su i podatci o dobi nastanka senzornog oštećenja, mjesečnim primanjima po ukućaninu obitelji te rezultati upitnika za procjenu anksioznosti, depresivnosti i generalnih uvjerenja o pravdi u svijetu. Za određivanje razina simptoma depresije i anksioznosti korištene su samoocjenske ljestvice prevedene na hrvatski jezik „Beckov upitnik za procjenu depresije i ankioznosti“ dobre pouzdanosti i valjanosti od kojih se svaka sastoji od 21 pitanja s dva ili tri ponuđena odgovora (15). Korište-

hearing or vision impairment and without any psychiatric illness or severe somatic disease. The participants for the control group were selected randomly through telephone calls, the only conditions being meeting the inclusion criteria and accepting to participate in the study. When forming the control group, it was of specific importance to create samples in which participants' age and sex were as similar as possible to the other two groups, because even small differences in age and sex can lead to significantly different results on the just world belief scale and in the questionnaire for examining symptoms of depression and anxiety. Older and younger participants usually have better results on the just world belief scale in comparison with participants in the middle age group, while female participants tend to score lower on the aforementioned scale. Female participants and older participants also tend to score higher on the questionnaire for examining symptoms of depression and anxiety. Since there is only a small number of deaf and blind persons in the Osijek-Baranja county, everyone meeting the inclusion criteria in terms of intensity and duration of sensory impairment was included in the study, which is also why further steps of random selection among those included were not possible. The study was conducted over the course of two months, from February to April 2015.

A sociodemographic questionnaire was used to acquire data on sex, level of education, marital status and the duration of sensory impairment in the groups of blind and deaf participants, as well as the data on sex, level of education and marital status in the control group. Data was also acquired on the age of sensory impairment onset, monthly per capita household income, as well as the results of the questionnaire for examining symptoms of depression and anxiety and general just world beliefs. To determine the symptoms of depression and anxiety, the Beck Depression Inventory and Beck Anxiety Inventory, reliable self-scoring scale questionnaires, were translated into Croatian and given to parna je inačica „Beckova upitnika za procjena depresivnosti I“ (16). Za određivanje razine stavova o pravdi u svijetu korišten je upitnik „Općih stavova o pravdi u svijetu“ (Dalbert, Montada, Schmidt), koji se sastoji od šest ponuđenih tvrdnji koje se odnose na osobna uvjerenja ispitanika (17). Skupina gluhih ispitanika koji se koriste znakovnim jezikom intervjuirana je uz pomoć posebno obučenog prevoditelja hrvatskoga znakovnog jezika, angažiranoga zbog poteškoća u razumijevanju složenijih izraza u upitnicima te gramatičkih razlika hrvatskoga znakovnog jezika i književnoga hrvatskog jezika koje su dovodile do značajnih razlika u razumijevanju pitanja. Skupina slijepih ispitanika također je ispitana u suradnji s volonterima Udruge slijepih osoba Osječko-baranjske županije te su njima tvrdnje samoocjenskih upitnika pročitane. U oba slučaja pomagači u intervjuiranju ispitanika bile su osobe od njihovog povjerenja te je osigurana privatnost njihovih iskaza.

Kategorijski podatci predstavljeni su apsolutnim i relativnim frekvencijama. Numerički podatci u slučaju raspodjela koje slijede normalnu distribuciju opisani su aritmetičkom sredinom i standardnom devijacijom, a u ostalim slučajevima medijanom i granicama interkvartilnog raspona. Normalnost raspodjele numeričkih varijabli testirana je Kolmogorov-Smirnovljevim testom. Razlike normalno raspodijeljenih numeričkih varijabli između dviju nezavisnih skupina testirane su Studentovim t-testom, a u slučaju odstupanja od normalnosti Mann-Whitneyevim U- testom. Povezanost normalno raspodijeljenih varijabli ocijenjena je Pearsonovim koeficijentom korelacije r, a u slučaju odstupanja od normalne raspodjele Spearmanovim koeficijentom korelacije ρ (ro). Sve P vrijednosti dvostrane su. Razina značajnosti postavljena je na $\alpha = 0,05$. Za statističku analizu korišten je paket SPSS for Windows 8 (inačica 20, SPSS inc., Chicago, IL,USA).

ticipants, each consisting of 21 questions with two or three answer choices (15). We used “Beck Depression Inventory I” (16). To determine the views on world justice, the questionnaire “General Belief in a Just World Scale” by Dalbert, Montada and Schmidt was used, consisting of six choice statements about the participant’s personal beliefs (17). The group of deaf participants using sign language was interviewed by a specially trained translator of the Croatian sign language, who was brought on due to difficulties in understanding more complex terminology in the questionnaires and also because of grammar differences between the Croatian sign language and the Croatian literary language, which led to significant differences in understanding the questions. The group of blind participants took part in the study with the help of volunteers from the Association of Blind Persons of the Osijek-Baranja County and the questionnaire items were read to them. In both cases, people assisting in interviewing the participants were trustworthy individuals and the participants’ privacy regarding the answers they provided was ensured.

Categorical data were descriptively described as absolute and relative frequencies. Numerical data were described as mean and standard deviations in cases of normal data distribution, while in cases showing dispersed data distribution, data were described as medians and interquartile ranges. Numerical data distribution normality was tested using the Kolmogorov-Smirnov test. Tests used for differences between numerical variables were the student t-test, for normal distribution, and Mann-Whitney U-test if data distribution was dispersed. The correlation between normally distributed variables was determined using the Pearson correlation coefficient r, while the Spearman correlation coefficient ρ (rho) was used in cases of dispersed data distribution. All P values were two-sided. Statistical significance was at $\alpha = 0.05$. SPSS for Windows 8 (version 20, SPSS Inc., Chicago, IL, USA) was used for statistical data analysis.

REZULTATI

Istraživanjem je obuhvaćeno 133 ispitanika, od kojih je 49 slijepih, 46 gluhih i 38 ispitanika kontrolne skupine. Srednja dob slijepih ispitanika bila je 45 godina s interkvantilnim raspršenjem od 29 do 70 godina od čega je 23 (46,93 %) muškog, a 26 ispitanika (53,07 %) ženskog spola. Srednja je dob gluhih ispitanika 43 godine s interkvantilnim raspršenjem od 31 do 72 godine od čega je 23 ispitanika (50 %) muškog, a 23 ispitanika (50 %) ženskog spola. Ispitanici kontrolne skupine srednje su dobi od 46 godina s interkvantilnim raspršenjem od 30 do 70 godina, 19 (50 %) su žene, dok je 19 ispitanika (50 %) muškog spola (tablica 1).

Najviše ispitanika živi u bračnoj zajednici, 76 (57,1 %), od kojih značajnije ispitanici kontrolne skupine (Fisherov egzaktni test, p = 0,005).

Prema mjesečnim primanjima po ukućaninu tri skupine ispitanika se međusobno razlikuju (H=54,071, p < 0,001, Kruskal Wallisov H-test), odnosno slijepi ispitanici (p<0,001) i ispitanici kontrolne skupine (p<0,001) imaju značajno viša primanja u odnosu na gluhe ispitanike, dok između slijepih ispitanika i kontrolne skupine nema značajne razlike (p=0,980) (tablica 2).

RESULTS

133 participants were included in the study. 49 of them were blind, 46 were deaf, while 38 formed the control group. The median age of blind participants was 45, with the interquartile range being between 29 and 70 years of age. 23 (46.93 %) of them were men and 26 (53.07 %) were women. The median age of deaf participants was 43, with the interquartile range being 31 to 72 years of age. 23 (50 %) were men and 23 (50 %) were women. The median age of the control group participants was 46, with the interquartile range being 30 to 70 years of age. 19 (50 %) participants in the control group were women and 19 (50 %) were men (Table 1).

Most participants were married, 76 (57.1 %) of them, more significantly so in the control group (Fisher's exact test, p = 0.005).

Based on monthly per capita household income, there were differences between the three groups of participants (H = 54.071, p < 0.001, Kruskal-Wallis H test). Blind participants (p < 0.001) and those in the control group (p < 0.001) had a significantly higher income than deaf participants. On the other hand, there were no significant differences between blind participants and the control group (p = 0.980) (Table 2). The sever-

TABLICA 1. Sociodemografske karakteristike gluhih, slijepih i ispitanika kontrolne skupine
TABLE 1. Sociodemographic characteristics of blind and. deaf participants and the control group

	Gluhi ispitanici / deaf participants (n, %)	Slijepi ispitanici / blind participants (n, %)	Kontrolna skupina / control group (n,%)	Ukupno / total (n,%)
Muškarci / men	24 (52,2)	22 (44,9)	15 (39,5)	61 (45,86)
Žene / women	22 (47,8)	27 (55,1)	23 (60,5)	72 (54,1)
Ukupno / total	46 (100)	49 (100)	38 (100)	133 (100)
Oženjen/udana / married	22 (47,8)	24 (49)	30 (78,9)	76(57,1)
Slobodan/udovac / widower	24 (52,2)	25 (51)	8 (21,1)	57(42,9)
Ukupno / total	46 (100)	49 (100)	38 (100)	133 (100)
Osnovno obrazovanje / elementary school	7 (15,2)	15 (30,6)	1 (2,6)	23 (17,3)
Srednja škola / high school	37 (80,4)	25 (51,0)	25 (65,8)	87 (65,4)
Fakultet / college	2 (4,3)	9 (18,4)	12 (31,6)	23 (17,3)
Ukupno / total	46 (100)	49 (100)	38 (100)	133(100)

broj ispitanika, postotak / number of participants/percentage

TABLICA 2. Mjesečna primanja po skupini ispitanika
TABLE 2. Monthly per capita household income

Skupine ispitanika / groups of participant	Gluhi ispitanici / deaf participants	Slijepi ispitanici / blind participants	Kontrolna skupina / control group	p*
Medijan / median (25 %-75 %)	1.100(837-1.418)	2.133(1.750-3.050)	2.500 (1.950-3.083)	<0.001

*Kruskal Wallisov H-test / *Kruskal Wallis H test

Razine simptoma depresivnosti, anksioznosti i stavova o pravdi u svijetu izmjerene su u skupinama gluhih, slijepih i ispitanika kontrolne skupine. Navedeni rezultati uspoređeni su između skupina.

Gluhi, slijepi i ispitanici iz kontrolne skupine međusobno se razlikuju prema rezultatima koje postižu na Beckovoj ljestvici depresivnosti (H=17,142, p<0,001, Kruskal Wallisov H-test) pa gluhi ispitanici postižu više razine depresivnosti u odnosu slijepe ispitanike (p=0,041) te još izraženije u odnosu na kontrolnu skupinu (p<0,001), dok nema statistički značajne razlike između slijepih ispitanika i kontrolne skupine (tablica 3).

Depresivni simptomi gluhih ispitanika povezani su s njihovim nižim mjesečnim primanjima (Pearsonov koeficijent korelacije R = 0,392, p = 0,07).

Sve tri skupine ispitanika se međusobno značajno razlikuju s obzirom na rezultate koje postižu na Beckovoj ljestvici anksioznosti (H=24,321, p<0,001, Kruskal Wallis H test) pa su tako gluhi ispitanici postigli najviše razine anksioznosti koje su značajno više u odnosu na skupinu slijepih ispitanika (p=0,18), još izraže-

ity of symptoms of depression and anxiety, as well as the levels of expressed views about a just world were measured in the group of blind participants, deaf participants and the participants in the control group. Analysis of the collected data and comparison between the groups was performed.

Deaf participants, blind participants and participants in the control group had different scores on the Beck Anxiety Inventory (H = 17.142, p < 0.001, Kruskal-Wallis H test). Deaf participants had higher levels of depression in comparison with blind participants (p = 0.041), and even more so in comparison with the participants in the control group (p < 0.001). On the other hand, there were no statistically significant differences between blind participants and the control group (Table 3).

Symptoms of depression in deaf participants showed a correlation with their lower monthly income (Pearson correlation coefficient R = 0.392, p = 0.07).

All three groups of participants had significantly different scores on the Beck Anxiety Inventory (H = 24.321, p < 0.001, Kruskal-Wallis H test). Deaf participants had the highest levels of anxiety, which were significantly higher in com-

TABLICA 3. Srednje vrijednosti Beckove ljestvice depresivnosti između skupina
TABLE 3. Beck Depression Inventory score among groups of participants

Beckova ljestvica depresivnosti / Beck Depression Score	Broj ispitanika / number of participants	Medijan / median (25%-75%)	p*	p* (između skupina) / (between groups)
Slijepi ispitanici / blind participants Kontrolna skupina / control group	49 38	8 (4-17) 3,5 (1-9)	<0,001	0,152
Kontrolna skupina / control group Gluhi ispitanici / deaf participants	38 46	3,5 (1-9) 10 (6-17)		<0,001
Gluhi ispitanici / deaf participants Slijepi ispitanici / blind participants	46 49	10 (6-17) 8 (4-17)		0,041

*Kruskal Wallisov H-test / *Kruskal Wallis H test nije u odnosu na kontrolnu skupinu (p<0,001), a slijepi ispitanici dostižu značajno više razine anksioznosti u odnosu na kontrolnu skupinu (p=0,035) (tablica 4).

Skupine ispitanika se međusobno razlikuju prema izraženosti generalnih stavova o pravdi u svijetu (H=18,796, p<0,001, Kruskal Wallisov H-test) te prema rezultatima slijepi ispitanici pokazuju izraženije stavove o pravdi u svijetu u odnosu na gluhe ispitanike (p<0,001) i ispitanike kontrolne skupine (p<0,001), dok između gluhih ispitanika i kontrolne skupine nema značajnih razlika (p=0,852) (tablica 5).

Generalni stavovi o pravdi u svijetu gluhih ispitanika manje su izraženi što su mjesečna primanja po ispitaniku niža (Spearmanov koeficijent korelacije ρ = -0,588, p = 0,01), dok su generalni stavovi o pravednosti u svijetu slijepih ispitanika također manje izraženi što su mjesečna primanja slijepih ispitanika niža (Pearsonov koeficijent korelacije R = -0,429, p = 0,01). Značajno izraženije generalne stavove o pravdi imaju ispitanici koji su izgubili vid nakon treće godine života (Mann-Whitneyev U-test, p = 0,029) (tablica 6).

parison with blind participants (p = 0.18) and even more so in comparison with the control group (p < 0.001). Blind participants had a significantly higher level of anxiety in comparison with the control group (p = 0.035) (Table 4).

There were differences between the groups of participants regarding expressed beliefs in a just world (H = 18.796, p < 0.001, Kruskal-Wallis H test). According to the results, blind participants had stronger beliefs in a just world in comparison with deaf participants (p < 0.001) and participants in the control group (p < 0.001). On the other hand, there were no significant differences between deaf participants and the control group (p = 0.852) (Table 5).

General belief in a just world was less strong the lower the monthly income per participant (Spearman correlation coefficient ρ = -0.588, p = 0.01), while general belief in a just world among the blind participants was also less strong the lower their monthly income (Pearson correlation coefficient R = -0.429, p = 0.01). Participants who lost their vision after the age of three had significantly stronger belief in a just world (Mann-Whitney U-test, p = 0.029) (Table 6).

TABLICA 4. Srednje vrijednosti anksioznosti prema Beckovoj ljestvici između skupina
TABLE 4. Beck Anxiety Inventory score among groups of participants

Beckova ljestvica anksioznosti / Beck Anxiety Score	Broj ispitanika / number of participants	Medijan / median (25 % - 75 %)	p*	p* (između skupina) / (between groups)
Slijepi ispitanici / blind participants Kontrolna skupina / control group	49 38	11 (3-29) 4 (1-12)	<0,001	0,035
Kontrolna skupina / control group Gluhi ispitanici / deaf participants	38 46	4 (1-12) 19 (13-26)		<0,001
Gluhi ispitanici / deaf participants Slijepi ispitanici / blind participants	46 49	19 (13-26) 11 (3-29)		0,018

*Kruskal Wallisov H-test / *Kruskal Wallis H test

TABLICA 5. Razlike u generalnim stavovima o pravdi u svijetu između skupina
TABLE 5. General beliefs in a just world among groups

Generalni stavovi o pravdi u svijetu / general beliefs in a just world	Broj ispitanika / number of participants	Medijan / median (25 %-75 %)	p*	p* (između skupina) / (between groups)
Slijepi ispitanici / blind participants Kontrolna skupina / control group	49 38	27 (20-29) 22 (18,75-25,00)	<0,001	<0,001
Kontrolna skupina / control group Gluhi ispitanici / deaf participants	38 46	22 (18,75-25,00) 22 (20-14)		0,852
Gluhi ispitanici / deaf participants Slijepi ispitanici / blind participants	46 49	22 (20-24) 27 (20-29)		<0,001

*Kruskal Wallisov H-test / *Kruskal Wallis H test

TABLICA 6. Generalni stavovi o pravdi u svijetu s obzirom na dob nastanka oštećenja vida
TABLE 6. General beliefs in a just world depending on age of vision impairment

Dob gubitka vida / age of vision impairment	Medijan / median (25 % – 75 %)	P*
Rođenjem ili prije 3. godine života / by birth of before the age of three (N = 26)	26,50 (23,75 –29,00)	
Nakon 3. godine / after the age of three (N = 13)	29 (27 – 32)	0,029

*Mann-Whitneyev U-test / *Mann-Whitney U test

Što su generalni stavovi o pravdi u svijetu izraženiji, to je razina anksioznosti u skupini gluhih niža (Spearmanov koeficijent korelacije ρ = -0,353, p = 0,015), dok u drugim skupinama nema statistički značajne povezanosti izraženosti generalnih stavova o pravdi u svijetu sa simptomima anksioznosti i depresivnosti.

Among the deaf participants, the stronger belief in a just world, the lower their level of anxiety was (Spearman correlation coefficient ρ = -0.353, p = 0.015). Among the participants in the other two groups, there were no statistically significant correlations between the expressed beliefs in a just world and symptoms of anxiety and depression.

RASPRAVA

U ovom istraživanju utvrđivala su se sociodemografska obilježja i uspoređivale razine anksioznosti, depresivnosti i generalnih vjerovanja u pravedan svijet u populacijama slijepih, gluhih i ispitanika bez senzornih oštećenja s mjestom boravka u Osječko-baranjskoj županiji.

Oba promatrana uzorka ispitanika značajno su rjeđe u bračnoj zajednici u odnosu na ispitanike kontrolne skupine bez senzornog oštećenja (p = 0,005). Oštećenje vida i sluha i do sada su u velikim populacijskim studijama označeni kao faktori koji otežavaju sklapanje bračne zajednice i češće dovode do samačkog života (18). Međutim, poznata je i činjenica da je samački način života rizični čimbenik za nastanak senzornih oštećenja, odnosno češći i brži gubitak vida i sluha u uvjetima samostalnog života (18,19). Senzorno oštećenje u navedene dvije populacije stvara začarani krug, budući da znatno smanjuje izglede za osnivanje bračne zajednice, a kasniji izostanak supružnika dovodi do nemogućnosti pravovremenog prepoznavanja daljeg propadanja vida i sluha. Izostanak partnera je osim toga jedan od najvažnijih čimbenika za kasniji razvoj depresivnog poremećaja (20).

DISCUSSION

This study analysed the sociodemographic characteristics and compared the levels of anxiety, depression and general beliefs in a just world in a population of blind participants, deaf participants and participants with no sensory impairment residing in the Osijek-Baranja county.

In both researched groups, there was a significantly smaller number of married participants in comparison with those in the control group with no sensory impairment (p = 0.005). Large population studies have shown vision and hearing impairment to be the factors that make getting married more difficult and more often lead to a solitary life (18). However, it is also known that solitary life represents a risk factor for the development of sensory impairment, i.e. it can increase the prevalence and progression rate of vision and hearing impairment when a person leads a solitary life (18,19). In these two populations, sensory impairment leads to a vicious circle. Sensory impairment significantly reduces the chances of getting married and subsequently the absence of a spouse prevents further progression of vision and hearing loss from being recognised in a timely manner. Moreover, the absence of a partner is one of

Obitelji gluhih ispitanika u usporedbi s obiteljima slijepih ispitanika i ispitanicima kontrolne skupine imaju značajno niže prihode po članu obitelji (p < 0,001) što je direktan pokazatelj lošijeg materijalnog statusa gluhih osoba u ispitivanim uzorcima. U dosadašnjim istraživanjima slijepih i gluhih osoba obje skupine su češće lošijeg socioekonomskog položaja, budući da su češće nezaposleni, nisu u bračnoj zajednici i postižu niže razine obrazovanja (21,22). Rezultati ovog istraživanja svrstavaju gluhe ispitanike u posebnu, nižu socijalnu kategoriju što se može objasniti izostankom adekvatne financijske skrbi, koju je društvo u Republici Hrvatskoj ipak osiguralo slijepim osobama (23).

Slijepi ispitanici postižu značajno više razine anksioznosti (p = 0,035), no ne i depresivnosti (p = 0,152) u odnosu na kontrolnu skupinu ispitanika. Visoke razine anksioznosti, no ne i depresivnosti na samoocjenskim upitnicima uglavnom su u skladu s rezultatima drugih studija te oslikavaju stanje psihičkog zdravlja uzorka slijepih ispitanika pri čemu je korištena do sada često rabljena metodologija presječnog istraživanja (8 ,16).

Razine generalnih stavova o pravdi u svijetu značajno su više u slijepih ispitanika u odnosu na gluhe ispitanike (p<0,001) i kontrolnu skupinu ispitanika (p < 0,001). Visoke razine anksioznosti u skupini slijepih ispitanika su iznenađenje s obzirom na izražene stavove o pravdi u svijetu, jer visoka razina anksioznosti nije očekivana kada su zaštitni mehanizmi ličnosti izraženi (24). Skupina slijepih ispitanika se time ističe u tri ispitivane skupine jer ima značajno izraženiji mehanizam nošenja sa stresom ili izražene stavove o očekivanoj pravednosti što možda proizlazi i iz smanjenog uvida u realitet posljedično senzornom oštećenju vida (25). Jednostavnije, moglo bi se reći da su stavovi o pravednosti u svijetu, koji je objektivno nepravedan visoko izraženi zbog manje socijalnih interakcija pa time slijepi ispitanici postižu slabiji uvid u stanje

the most important factors in the development of depression later in life (20).

The families of deaf participants have a significantly lower per capita household income (p < 0.001) than those of the blind and control group participants, which is a direct indicator of the poorer financial status of deaf participants in the sample. Previous research has shown that blind and deaf individuals find themselves in the low socioeconomic class more often because they are more often unemployed, unmarried and have a lower level of education (21,22). According to the results of this study, deaf participants fall under a special, lower social category, which can be explained by a lack of adequate financial support, which is, however, provided for blind persons by the state (23).

When compared to participants in the control group, blind participants had significantly higher levels of anxiety (p = 0.035), but not depression (p = 0.152). Higher levels of anxiety, but not depression, seen in the self-grading questionnaires reflect the results of other studies and show the mental health state of blind participants, whereby the often-used cross-sectional study design was also used here (8,16).

General beliefs in a just world were significantly stronger in blind participants when compared to deaf participants (p < 0.001) and participants in the control group (p < 0.001). High levels of anxiety in the group of blind participants came as a surprise considering their expressed beliefs in a just world, because a high level of anxiety is usually not expected in persons with strong defence mechanisms (24). This makes the group of blind participants special among the three analysed groups because blind participants have significantly stronger stress coping strategies or strong beliefs in a just world, which may also result from a lack of insight into the reality due to visual impairment (25). In simpler terms, it can be said that beliefs in a just world, which is objectively unjust, are strong due to a lack of social interactions, which is why blind participants svakodnevnog života (26). Ostaje nužno dalje proučavanje strategija prevladavanja stresa u slijepih ispitanika jer takve spoznaje mogu služiti u psihoterapijskim procesima pri psihološkoj adaptaciji na gubitak vida i mogu značajno pridonijeti očuvanju psihičkog zdravlja slijepih ispitanika (25).

Vrlo zanimljivu spoznaju predstavlja rezultat značajno izraženijih generalnih stavova o pravdi u svijetu u slijepih ispitanika koji su vid izgubili nakon treće godine u odnosu na ispitanike koji su ga izgubili prije tog razdoblja (p = 0,029). Pretpostavljamo da je rani gubitak vida, poput drugih traumatskih događaja posebno snažna trauma ako se dogodi u razdoblju intenzivnog razvoja djetetove ličnosti te osim fizičkog oštećenja oštećuje i prilagodbene kapacitete ličnosti što vjerovanje u pravdu u svijetu zapravo i jest, no i o toj temi do sada nema objavljenih istraživanja (27,28). Potrebno je provesti dodatna istraživanja na većem broju ispitanika, kako bi se utvrdilo je li to uistinu tako.

Razine depresivnosti i anksioznosti koje postižu gluhi ispitanici značajno su više u odnosu na ispitanike kontrolne skupine (p < 0,001), ali i slijepe ispitanike (p=0,018, p=0,041). Značajno više razine depresivnosti i anksioznost gluhih osoba u odnosu na kontrolnu skupinu ispitanika s prebivalištem u Osječko-baranjskoj županiji konzistentne su s dosadašnjim istraživanjima i potvrđuju poguban utjecaj prirođenog ili stečenog gubitka sluha na mentalno zdravlje gluhih ispitanika (1,2). Rizici za mentalno zdravlje gluhih osoba su ponajprije smanjena mogućnost interakcija sa članovima obitelji i prijateljima, sudjelovanja u obrazovnom sustavu i zapošljavanja (2). Jasno je da gluhi ispitanici postižu značajno niže razine mentalnog zdravlja u usporedbi sa slijepim ispitanicima, što se djelomično može objasniti i većim učinkom gubitka socijalnih interakcija u odnosu na slijepe osobe i to zbog jezične barijere jer jako mali broj ljudi, pa i članova

lack insight into the state of everyday life (26). It is important to study these strategies used to overcome stress in the blind population further because they can be used in psychotherapeutic processes for adapting to loss of vision and also significantly contribute to the preservation of blind participants' psychological health (25).

A very interesting piece of information acquired from the data analysis was that blind participants who lost their sight after the age of three had significantly stronger general beliefs in a just world than those who lost their sight earlier in life (p = 0.029). Our assumption is that early loss of vision, just like every other traumatic event, represents an especially severe trauma if it occurs during the period of a child's intensive personality development, so it inflicts not only physical damage, but also damage to adaptive abilities – and belief in a just world is exactly that. However, there is no published research on this topic (27,28). It is necessary to conduct further research on a larger number of participants to determine whether this is true or not.

Levels of depression and anxiety among the deaf participants were significantly higher in comparison with participants in the control group (p < 0.001) and blind participants (p = 0.018, p = 0.041). Significantly higher levels of depression and anxiety among deaf participants compared to the control group participants residing in the Osijek-Baranja county are consistent with previous research and this data confirms the unfavourable effect of congenital or acquired hearing loss on the deaf participants' mental health (1,2). Reduced ability to interact with family and friends, participation in the education system and employment represent the primary mental health risks among deaf persons (2). It is clear that deaf participants have significantly lower levels of mental health in comparison with blind participants, which can be explained in part by the fact that the absence of social interactions has a more powerful effect on deaf than on blind persons. This is a consequence of a language barrier obitelji gluhih ispitanika, koristi znakovni jezik. U dosadašnjim studijama je upravo to glavni faktor koji dovodi do izolacije gluhih i gluhonijemih osoba i pojave simptoma depresije i anksioznosti (1). Iz navedenih razloga na ispitivanom uzorku gluhih osoba anketiranje je provedeno uz asistenciju prevoditelja znakovnog jezika što se u dosadašnjim studijama pokazalo opravdanim i korisnim za razumijevanje sadržaja upitnika za procjenu simptoma psihijatrijskih bolesti (29). Nije dokazana razlika u stavovima o pravdi u svijetu kod gluhih ispitanika u odnosu na kontrolnu skupinu ($p = 0,852$) te početna pretpostavka o niskim kapacitetima suočavanja sa stresom u obliku generalnih vjerovanja u pravdu u svijetu nije dokazana što vodi zaključku da taj oblik kognitivnog prilagodbenog mehanizma na stres nije znatno narušen oštećenjem sluha ispitanika (30). Saznanje da gluhi i slijepi ispitanici pokazuju značajne razlike u izraženosti generalnih vjerovanja u pravdu u svijetu ($p < 0,001$) je novo saznanje koje do sada nije istraživano, a u okviru ispitivanog uzorka može biti objašnjeno samo razlikom u tipu senzornog oštećenja budući da su sve ostale karakteristike uzoraka međusobno slične. Iz navedenog se može zaključiti da gluhi i slijepi ispitanici koriste različite strategije suočavanja sa stresom s obzirom na to da su im i senzorna oštećenja drugačija te da se u sklopu ograničenja u aktivnostima svakodnevnog života na druge načine suočavaju sa stresom (15,28).

Nova spoznaja je i činjenica da su izraženiji stavovi o pravdi u svijetu predstavljaju zaštitni čimbenik za psihičko zdravlje gluhih osoba pa je tako razina anksioznosti, no ne i depresivnosti, u gluhih ispitanika niža što su stavovi o pravdi u svijetu izraženiji ($p = 0,015$) što je slično rezultatima istraživanja na osobama bez oštećenja sluha, a spoznaja može biti korisna u kreiranju psihoterapijske podrške gluhim pacijentima u prevladavanju anksiozne simptomatologije (2).

that occurs due to the fact that very few people, including deaf persons' family members, use sign language. Previous studies have shown that this is the main factor that leads to the isolation of deaf and speech-impaired persons and the occurrence of the symptoms of depression and anxiety (1). Because of the aforementioned reasons, the examination of deaf participants was conducted with the assistance of a sign language interpreter. Previous studies have shown that this is a valid and useful approach to understanding the contents of the questionnaire for psychiatric disorder symptom assessment (29). There was no difference in beliefs in a just world between the group of deaf participants and the control group ($p = 0.852$), so the starting hypothesis on the inability to cope with stress in the context of general beliefs in a just world was not proven. This leads us to conclude that this type of cognitive stress coping mechanism is not significantly affected by the participants' hearing impairment (30). Discovery that deaf and blind persons are significantly different in terms of expressed beliefs in a just world ($p < 0.001$) represents a new piece of information that has not previously been studied. In terms of the analysed sample, this can be explained only by the difference in the type of sensory impairment, considering that all other characteristics of the sample are similar. Based on that, it can be concluded that blind and deaf participants use different stress coping strategies, considering that they have different types of sensory impairments and different ways of facing stress due to limitations in their everyday lives (15, 28).

The fact that stronger beliefs in a just world are a protective factor for mental health of deaf participants is also a new piece of information, with levels of symptoms of anxiety, but not depression, being lower when beliefs in a just world are stronger ($p = 0.015$), which is similar to the results of research on the participants with no hearing impairment. This information can be helpful in creating psychotherapeutic support for deaf patients in overcoming symptoms of anxiety (2).

ZAKLJUČCI

Razine anksioznosti značajno su više u uzorku gluhih ispitanika u odnosu na uzorak slijepih ispitanika i kontrolnu skupinu te između uzorka slijepih ispitanika i kontrolne skupine.

Razine depresivnosti značajno su više samo u uzorku gluhih ispitanika u usporedbi s kontrolnom skupinom ispitanika.

Slijepi ispitanici postižu izraženije stavove o generalnoj pravdi u svijetu o odnosu na skupinu gluhih i kontrolnu skupinu ispitanika no zaštitni učinak izraženih stavova o pravdi u svijetu na smanjenje simptoma anksioznosti dokazan je samo u uzorku gluhih ispitanika.

CONCLUSIONS

Levels of anxiety are significantly higher among deaf participants in comparison with blind participants and the control group, as well as among blind participants in comparison with the control group.

Levels of depression are significantly higher only among deaf participants in comparison with the control group.

Blind participants have stronger beliefs in a just world in comparison with deaf participants and the control group, but the protective effect of expressed views about a just world on alleviating symptoms of anxiety was proven only in deaf participants.

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Hitna stanja kod demencije i psihičkih poremećaja u starijoj životnoj dobi

Dementia and Psychiatric Emergencies in the Elderly Population

Miroslav Herceg[1,2], Mirna Sisek-Šprem[2], Krešimir Puljić[2], Dora Herceg[1]

[1] Sveučilište u Zagrebu, Medicinski fakultet, [2]Klinika za psihijatriju Vrapče, Zagreb, Hrvatska /

/ [1]*University of Zagreb, Faculty of Medicine,* [2]*University Department of Psychiatry Vrapče, Zagreb, Croatia*

S obzirom na kontinuirano povećanje broja starijih osoba u ukupnoj populaciji u Hrvatskoj, za očekivati je da će se broj starijih osoba s akutnim psihičkim smetnjama koje zahtijevaju hitno zbrinjavanje sve više povećavati. Najčešći psihički poremećaji kod starijih osoba su: depresivni poremećaji, kognitivni poremećaji, demencija, poremećaji vezani uz uzimanje alkohola, poremećaji vezani uz druga zdravstvena stanja i lijekovima izazvani poremećaji. Gerijatrijski bolesnici bi u pravilu prvo trebali biti pregledani od strane stručnjaka somatske medicine (internista, neurologa, kirurga) prije nego što se upućuju u hitnu psihijatrijsku službu, kako bi se ustanovilo da su primarne smetnje iz psihijatrijske domene. Izražena depresija, suicidalnost, agitacija, sklonosti lutanju i ostalim rizičnim ponašanjima kod kuće, izražena anksioznost i smanjena sposobnost brige o sebi, glavni su razlozi hospitalizacije kod ovih bolesnika.

/ Related to the fact of the continuous increase in the number of elderly people in the total population of Croatia, it can be expected that the number of elderly people with acute psychiatric disorders that require emergency care will increase. The most common psychiatric disorders found in the elderly are depressive disorders, cognitive disorders, dementia, alcohol-related disorders, disorders related to other health conditions and drug-induced disorders. Geriatric patients should, generally speaking, first be reviewed by a psychosomatic medical specialist (internist, neurologist, surgeon) before they are sent to psychiatric emergency services in order to establish that the primary complaint is connected with the psychiatric domain. Pronounced depression, suicidality, agitation, wandering tendencies and other home-based risk behaviours, with anxiousness and reduced self-care ability, are the main reasons for hospitalization.

ADRESA ZA DOPISIVANJE /
CORRESPONDENCE:
Doc. dr. sc. Miroslav Herceg, dr. med.
Klinika za psihijatriju Vrapče
Bolnička c. 32
10 000 Zagreb, Hrvatska
E-pošta: miroslav.herceg@bolnica-vrapce.hr

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UVOD I DEFINICIJE

S obzirom na kontinuirano povećanje broja starijih osoba u ukupnoj populaciji u Hrvatskoj, za očekivati je da će se broj starijih osoba s akutnim psihičkim smetnjama koje zahtijevaju hitno zbrinjavanje sve više povećavati (1). Najčešći psihički poremećaji kod starijih osoba su: depresivni poremećaji, kognitivni poremećaji, demencija, poremećaji vezani uz uzimanje alkohola, poremećaji vezani uz druga zdravstvena stanja i lijekovima izazvani poremećaji (2-4). Predisponirajući čimbenici rizika za obolijevanje od psihičkih poremećaja u starijoj dobi uključuju: visoki komorbiditet, smanjenje kognitivnih sposobnosti, smanjenje u socijalnim interakcijama, smanjenja autonomije, financijska opterećenja, gubitak članova obitelji i prijatelja, gubitak posla (umirovljenje) (5). Razlozi posjećivanja hitne psihijatrijske službe kod ove populacije bolesnika mogu biti: nagla pojava halucinacija, sumanutosti ili paranoje, inkoherentno i dezorganizirano mišljenje, suicidalne ideje ili namjere, gubitak motivacije, antisocijalno ponašanje. Demencija i problemi u ponašanju, poremećaji spavanja, psihoze, agitirana stanja, deliriji uzrokovani drugim zdravstvenim stanjem ili lijekovima su također česti uzrok traženja psihijatrijske pomoći (6,7).

Pamćenje je proces pohranjivanja i reproduciranja ili vraćanja naučenih i pohranjenih informacija u svjesno. Pamćenje se može podijeliti na kratkoročno i dugoročno.

Amnezija je djelomičan ili totalni gubitak sposobnosti prisjećanja informacija ili iskustava iz prošlosti uz inače održano intelektualno funkcioniranje. Amnezija se može podijeliti na anterogradnu (sposobnost usvajanja novih informacija) i retrogradnu (sposobnost prisjećanja već naučenih informacija) (8,9).

Paramnezije su lažna sjećanja uzrokovana smetnjama prisjećanja. Konfabulacije spadaju u paramnezije. To su netočna i pogrešna (izmišljena) sjećanja koja bolesnik iznosi u namjeri

INTRODUCTION AND DEFINITIONS

Related to the fact of the continuous increase in the number of elderly people in Croatia, it is expected that the number of elderly people with acute psychiatric disorders requiring urgent care will increase (1). The most common psychological disorder in the elderly are depressive disorders, cognitive disorders, dementia, alcohol-related disorders, disorders related to other health conditions and drug-induced psychiatric disorders (2-4). Predisposing risk factors for psychiatric disorders in the elderly include high comorbidity, decline in cognitive abilities, decline in social interactions, decreased autonomy, financial burdens, loss of family and friends and occupational loss (retirement) (5). Reasons for employing psychiatric emergency service in this patient population may be a sudden appearance of hallucinations, delusions or paranoia, incoherent and disorganized thinking, suicidal ideation or intentions, lack of motivation and antisocial behaviour. Dementia and behavioural problems, sleep disturbances, psychosis, agitated conditions, deliriums caused by other health conditions or medications are also a common cause of searching for psychiatric help (6,7).

Memory is the process of storing and reproducing and/or restoring the learned and stored information consciously. Memory can be split into short-term and long-term memory.

Amnesia is a partial or total loss of ability to recall information or experiences from the past with maintained intellectual functioning. Amnesia can be divided into anterograde (the ability to receive new information) and retrograde (the ability to recall the already learned information) (8,9).

Paramnesia is false memories caused by a disorder of memory. Confabulation is a part of paramnesia, which is incorrect and wrong (fantastical) memories that the patient uses in order to da prikrije „rupe" u sjećanju. Konfabulacije se mogu naći kod bolesnika s amnezijom, s oštećenjem frontalnog režnja mozga ili bolesnika s nekim od poremećaja ličnosti.

Delirij, amnestički poremećaj i demencija svrstavaju se u kognitivne poremećaje kojima su zajedničke karakteristike oštećenja u sjećanju, gubitak sposobnosti govora i pažnje. Svaki gubitak pamćenja sam po sebi nije demencija (10,11).

Amnestički poremećaj je karakteriziran gubitkom sjećanja koji uzrokuje značajni dizabilitet u funkcioniranju uz intaktne izvršne funkcije i senzorij. Lijekovi koji se najčešće povezuju s amnezijom su benzodiazepini kao i antikonvulzivi, metotreksat i otrovi (živa, olovo i otapala). Alkoholom uzrokovani perzistirajući amnestički poremećaj kod kroničnog konzumiranja alkohola uzrokovan je nedostatkom vitamina (tiamina), a naziva se Korsakovljev sindrom. Sljedeći uzrok privremenog gubitka pamćenja vezanog uz alkohol su takozvani „*blackouts*" (zatamnjenja sjećanja) (3).

Demencija je karakterizirana teškim kognitivnim oštećenjima, ponajprije progresivnim gubitkom pamćenja i ostalih izvršnih sposobnosti kao što su apstraktno mišljenje, inteligencija, učenje, sposobnost govora, orijentacija, percepcija, koncentracija, pažnja, sposobnost uvida i socijalne vještine bez oštećenja svijesti (12,13).

KLINIČKA SLIKA

Bolesnici s demencijom rijetko se sami javljaju u hitnu psihijatrijsku službu. Uglavnom ih dovode članovi obitelji zbog poremećaja u njihovom ponašanju, kao što su lutanja, neprimjereno seksualno ili osobno ponašanje, potencijalno opasno ponašanje (ostavljanje upaljene pećnice) ili psihičkih poremećaja kao što su psihoza, depresija, paranoja, agitacija, promjene raspoloženja, smetnje spavanja i apetita (6). Obično se to događa u noćnim satima i u dane

conceal the "holes" in their memory. Confabulation can be found in patients with amnesia, with damage of the frontal lobe of the brain or in some patients with personality disorders.

Delirium, amnestic disorders and dementia are classified into cognitive disorders with common characteristics of impairment in memory, loss of speech skills and attention. Each loss of memory alone does not represent dementia (10,11).

Amnestic disorder is characterized by a loss of memory which causes significant function disability with the intact executive function and sensory. Drugs that are most commonly associated with amnesia are benzodiazepines as well as anticonvulsants, methotrexate and poisons (mercury, lead and solvents). Alcohol-induced persistent amnesic disorder with chronic alcoholism caused by a lack of vitamins (thiamine), is called Korsakoff syndrome. Causes of temporary memory loss that are also associated with alcohol are so-called "blackouts" (3).

Dementia is characterized by severe cognitive impairments, primarily by progressive loss of memory and other executive abilities such as abstract thinking, intelligence, learning, speech ability, orientation, perception, concentration, attention, insight and social skills with intact consciousness (12,13).

CLINICAL PRESENTATIONS

Patients with dementia rarely come to a psychiatric emergency service by themselves. They are most commonly taken there by their families because of behavioural disorders such as wandering, inappropriate sexual or personal behaviour, potentially dangerous behaviour (leaving the oven switched on) or psychiatric disorders such as psychosis, depression, paranoia, agitation, mood swings, disturbance of sleep and appetite (6). This usually happens at night and at weekends when the family vikenda kada obitelj provodi najviše vremena s bolesnikom i ima uvid u njegovo ponašanje, a u domovima za starije u to vrijeme (tijekom noći i vikendima) bude smanjena služba te se oni teško mogu brinuti o takvim bolesnicima. Početak psihijatrijskih simptoma kod ovih bolesnika kao što su anksioznost, promjene raspoloženja, kognitivne smetnje i psihotični simptomi mogu se povezati s nekim rizičnim čimbenicima kao što su nedavni smrtni slučajevi, preseljenja, separacije, nedavne promjene u medikamentnoj terapiji, različite somatske bolesti, od uroinfekcija do za život opasnih bolesti (karcinoma). Rani bihevioralni simptomi demencije uključuju dezinhibirano ponašanje i apatiju, koji mogu progredirati do agitacije. Nemir i agresivno ponašanje mogu biti posljedica deluzija koje su kod ovih bolesnika prisutne u 30-50 % slučajeva. Najteži dio kliničke slike za obitelj i okolinu su progesivne promjene bolesnikove osobnosti: socijalno povlačenje, introverzija, hostilnost, paranoja i iritabilnost. Mnogi bolesnici imaju i halucinatorna doživljavanja (osobito vidna) i sumanutosti, što su najčešći razlozi dolaska u hitnu službu. Stariji bolesnici s depresijom mogu imati probleme s pamćenjem koji bi u kliničara mogli pobuditi sumnju na demenciju. Ovo stanje se naziva pseudodemencija ili depresijom uzrokovana kognitivna disfunkcija. Ovi bolesnici imaju intaktnu orijentaciju, pažnju i koncentraciju i fluktuirajuće smetnje pamćenja. Obitelj svjedoči naglom nastanku promjena, a bolesnik je svjestan problema s gubitkom pamćenja (uglavnom kratkotrajnog pamćenja) i zabrinut je zbog toga (14).

Stanja konfuzije i dezorijentacije su stanja kod kojih je oštećena orijentacija u vremenu, prostoru ili drugim osobama, a rijetko i prema samome sebi. Iako je konfuzija obilježje organskih poremećaja, može se vidjeti i u nekim psihijatrijskim poremećajima kao što su shizofrenija, delirij, demencija, amnestički poremećaj i drugi poremećaji. Jedan od najčešćih uzroka akutno-konfuznog stanja u hitnoj psihijatrijskoj am-

spends more time with the patient and has insight into his or her behaviour, and during such periods (at night and at the weekend) in nursing homes staff numbers are reduced, and they can hardly take care of such patients. The beginning of psychiatric symptoms in these patients such as anxiety, mood swings, cognitive impairment and psychotic symptoms can be associated with some risk factors such as recent deaths, relocation, separation, recent changes in medication therapy, various somatic diseases, urinary infection or even life-threatening diseases (cancer). Early behavioural symptoms of dementia include disinhibited behaviour and apathy, which can progress to agitation. Fear and aggressive behaviour can be the result of delusions that are present in these patients in 30-50% of cases. For the family and the patient's environment, the hardest part of the clinical picture are progressive changes of the patient's personality: social retreat, introversion, hostility, paranoia and irritability. Many patients also have hallucinatory perceptions (especially visual ones) and delusions, which are the most common causes of seeking the assistance of emergency services. Older patients with depression may have memory problems that could cause the clinician to suspect there is presence of dementia. This condition is called pseudodementia or depression caused by cognitive dysfunction. These patients have intact orientation, attention and concentration and fluctuating memory impairment. The family witnesses the sudden emergence of changes, and the patient is aware of memory loss problems (mostly short-term memory) and is concerned about it (14).

The states of confusion and disorientation are states with impairment in the orientation in time, space or regarding other persons, and rarely regarding themselves. Although confusion is a feature of organic disorders, it can be seen in some psychiatric disorders such as schizophrenia, delirium, dementia, amnesia and other disorders. One of the most common bulanti je delirij. Delirij je akutni, reverzibilni psihoorganski sindrom karakteriziran smanjenom mogućnosti reagiranja na vanjske podražaje i poremećajem svijesti, poremećajem senzoričkih sposobnosti, poremećajem spavanja i psihomotoričke aktivnosti, dezorijentacijom i poremećajem pamćenja. Delirij obično nastaje u kratkom razdoblju i ograničenog je trajanja te ima nekakvu organsku podlogu. Prodromalni znakovi i simptomi koji mogu prethoditi stanju delirija mogu biti: anksioznost, nemir, pospanost ili insomnija i tranzitorna halucinatorna doživljavanja. Delirij se pojavljuje kod više od 15 % svih hospitaliziranih bolesnika u općoj bolnici s većim udjelom (20-30 %) kod starijih osoba, osobito onih s već postojećim kognitivnim oštećenjima. Bolesnici s demencijom su visoko predisponirani za razvoj delirija. Delirij je ozbiljno i za život opasno stanje na koje uvijek moramo sumnjati kad kod bolesnika uočimo fluktuirajuće promjene u orijentaciji i konfuziji (15). Mogu se pojaviti vizualne, olfaktorne ili taktilne halucinacije, kao i razne sumanutosti. Bolesnici mogu pokazivati promjene raspoloženja od apatije do bijesa i razdražljivosti, koje ponekad vode i u agresivno ponašanje. Skrbnici se često mogu žaliti na poremećen ciklus spavanja i budnosti s vidnim pogoršanjem simptoma u večernjim satima, što je poznato kao tzv. sindrom zalazećeg sunca (engl. *sundowning syndrome)*. Kod opservacije ovakvih bolesnika treba imati na umu da se psihički status kod njih može mijenjati iz sata u sat, tako da i uredan i lucidan psihički status prigodom pregleda može biti u kontradikciji s izjavama članova obitelji ili bolničkog osoblja, a što nas dodatno upućuje na sumnju da se radi o deliriju.

KLINIČKA PROCJENA

Diferencijalna dijagnostika mogla bi se pojednostavniti i na sljedeći način: ako simptomi i imaju fluktuirajući tijek, treba misliti na delirij; ako postoje psihotični simptomi sa zaravnje-

causes of the acutely confused state in psychiatric emergency service is delirium. Delirium is an acute, reversible psycho-organic syndrome characterized by reduced response to external stimuli and consciousness disorders, sensory abnormalities, sleep disturbances and psychomotor activity, disorientation and memory disorders. Delirium usually occurs in a short period of time and is of limited duration and has some organic basis. Prodromal signs and symptoms that may precede the state of delirium may be: anxiety, restlessness, drowsiness or insomnia and transitory hallucinatory perception. Delirium occurs in more than 15% of all hospitalized patients in the general hospital with a higher proportion (20-30%) in elderly, especially those with already existing cognitive impairment. Dementia patients are highly predisposed to the development of delirium. Delirium is a serious life-threatening condition that we must always suspect when we notice fluctuating changes in orientation and confusion in patients (15). Visual, olfactory or tactile hallucinations, as well as various delusions may occur. Patients may show mood swings from apathy to anger and irritability, which sometimes lead to aggressive behaviour. Caregivers often complain about a disturbed cycle of sleep and wakefulness with a worsening of symptoms in the evening, known as the so-called sundowning syndrome. When observing such patients, one should have in mind that their psychological status may vary from hour to hour, so that a normal and lucid psychological status during the examination may be in contradiction with the statements of family members or hospital staff, which further leads to suspicions of delirium.

CLINICAL EVALUATION

Differential diagnosis could be simplified in the following way: if the symptoms have a fluctuating course, delirium should be taken into consideration, and if there are psychotic symptoms nim efektom, tada treba misliti na psihotične poremećaje kao što je shizofrenija; ako postoji opći kognitivni deficit s amnezijom, treba misliti na demenciju; ako postoje simptomi promjene raspoloženja, treba misliti na afektivne poremećaje.

Svakako treba izbjegavati bilo kakve lijekove prije postavljanja definitivne dijagnoze i otkrivanja uzroka konfuznosti i dezorijentiranosti u podlozi.

Akutna agitacija i psihotična stanja povezana s demencijom su hitna stanja u psihijatriji zbog rizika od samoozljeđivanja ili ozljeđivanja drugih, zbog agresivnog ponašanja ili odbijanja uzimanja lijekova, odbijanja liječenja, zbog općeg zdravstvenog stanja, zapuštene higijene, dehidracije (neuzimanja hrane i tekućine). Kod više od 50 % bolesnika s demencijom prezentiraju se psihotični simptomi poput paranoidnih sumanutosti ili halucinacija te oko 90 % pokazuje agitaciju tijekom trajanja bolesti. Ova dva klastera simptoma kod ovih bolesnika obično se pojavljuju istovremeno, naročito kada se razvija paranoja i strah prema skrbnicima. U ranim i srednjim stadijima demencije postoji visoki udio depresije koja može biti povezana i s visokim rizikom od suicidalnosti. Odbijanje hrane, tekućine, lijekova te ostalih neophodnih pretraga zbog demencije može kod bolesnika dovesti do ozbiljnog gubitka tjelesne težine sve do kaheksije. Tri najčešća lijeka koji mogu pojačati apetit su mirtazapin, olanzapin i megestrol acetat. Kod dementnih bolesnika s depresijom odbijanje hrane i pića može predstavljati indirektno suicidalno ponašanje. Bolesnicima s delirijem, agitacijom i suicidalnošću potreban je intenzivan 24-satni nadzor i intenzivna psihijatrijska skrb. Moramo imati na umu da dementni i delirantni bolesnici u jedinici intenzivne skrbi s konstantnom sestrinskom njegom, mogu vrlo brzo iščupati intravenske infuzije, nazogastrične sonde, urinarne katetere i drugo. U ovakvim akutnim situacijama psihijatar bi trebao pokušati komunicirati s dementnim

with a flattened effect, then one should think of psychotic disorders such as schizophrenia. If there is a general cognitive deficit with amnesia, one should think of dementia. If there are moody symptoms, one should think of affective disorders.

Certainly, any medications should be avoided before establishing a definitive diagnosis and detecting the cause of confusion and disorientation in the background.

Acute agitation and psychotic states associated with dementia are urgent state in psychiatry because of the risk of self-injury or injury to others due to aggressive behaviour or refusal of medication, refusal of treatment due to the general health status, neglected hygiene, dehydration (food and fluid unavailability). In more than 50% of patients with dementia there are psychotic symptoms such as paranoid delirium or hallucinations, and about 90% show agitation during the course of the disease. These two clusters of symptoms in these patients usually occur at the same time, especially when paranoia and fear of caregivers are developed. In the early and middle stages of dementia there is a high proportion of depression that may be associated with a high risk of suicidality. Rejection of food, fluids, drugs, and other necessary medical exams because of dementia can lead to serious weight loss, even to cachexia. The three most common drugs that can stimulate the appetite are mirtazapine, olanzapine and megestrol acetate. Refusal of food and beverages in patients with dementia suffering from depression may represent indirectly suicidal behaviour. Patients with delirium, agitation and suicidal activity need intensive 24-hour supervision and intensive psychiatric care. We must bear in mind that dementia and delirium patients in the intensive care unit with constant nursing care can rapidly rip out the intravenous infusion, nasogastric probe, urinary catheter and the like. In such acute situations, a psychiatrist should try to communicate with bolesnikom na njegovoj razini ohrabrivajući pacijenta i pokušati ga orijentirati u prostoru, vremenu i prema drugim osobama (16,17).

Kod razgovora s ovakvim bolesnicima ne bi trebalo inzistirati na prisjećanju nekih događaja i naglašavati njihov gubitak pamćenja, nego ih treba ohrabrivati i pružiti im potporu. Također, treba vidjeti je li nas bolesnici dobro čuju i vide, nose li naočale i radi li im slušni aparat. S njima treba razgovarati polagano, koristiti jednostavne rečenice, izbjegavati kompleksna pitanja. Može se dogoditi i da se više puta tijekom razgovora treba ponovno predstavljati. Od velikog bi značenja tijekom razgovora s bolesnikom bilo imati u ordinaciji i njihove članove obitelji ili skrbnike. Probleme s pamćenjem treba uvijek razmatrati ozbiljno, a ne ih minimalizirati ili opravdavati kao normalnom pojavom u starijoj životnoj dobi ili ih odmah proglasiti simptomom depresije. U zadnje vrijeme identificiran je i prijelazni stadij između kognitivnih promjena vezanih uz normalno starenje i Alzheimerove bolesti, nazvan blagi kognitivni poremećaj. Blagi kognitivni poremećaj može se vidjeti u bolesnika s gubitkom pamćenja koji je izražen u većoj mjeri nego što bi bilo očekivano s obzirom na godine, a još ne zadovoljava kriterije za Alzheimerovu demenciju. Probir i longitudinalno praćenje kod ovih bolesnika su vrlo važni, jer se iz ove subpopulacije bolesnika regrutiraju oni s mogućom Alzheimerovom demencijom. Blagi kognitivni poremećaj smatra se visokim rizikom za razvoj Alzheimerove demencije.

Uzimanje podataka (heteroanamneze) od obitelji, prijatelja, zdravstvenog osoblja iz domova za starije i udomiteljskih obitelji je od velike važnosti kako bismo imali uvid u osnovno funkcioniranje i ponašanje bolesnika i usporedili ga sa sadašnjim (aktualnim) ponašanjem. Važne su nam detaljne informacije o prijašnjim psihijatrijskim liječenjima, somatskim, kirurškim i drugim liječenjima, naročito ozljedama. Također treba obratiti pozornost na eventualno

a demented patient at his level by encouraging the patient and trying to orient him in space, time and in relation with other people (16,17).

When talking to such patients, one should not insist on recalling some events and emphasizing their memory loss but should instead be encouraging and supportive. Also, we need to check if the patients hear and see us properly, whether they are wearing glasses and hearing aids. Talk to them slowly, use simple sentences, and avoid complex issues. You may also have to introduce yourself several times during the conversation. It would be of great significance to have their family members or caregivers in the clinic during the conversation with the patient. Memory problems should always be considered seriously, not minimized or justified as a normal occurrence in the elderly or immediately declare them the symptom of depression. Recently, a transitional stage has been identified between cognitive changes associated with normal aging and Alzheimer's disease, termed as mild cognitive disorder. Mild cognitive disorder can be observed in patients with memory loss which is expressed to a greater extent than is anticipated with respect to the patient age, and does not yet meet the criteria for Alzheimer's dementia. Probes and longitudinal monitoring in these patients are very important because patients in this subpopulation are recruited with those with possible Alzheimer's dementia. Mild cognitive disorder is considered a high risk for developing of Alzheimer's dementia.

Taking information from family, friends, health care staff from nursing homes and foster families is of great importance in order to have an insight into the basic functioning and behaviour of patients and to compare them with the current (actual) presentation. Important information on previous psychiatric treatments, somatic, surgical and other treatments, especially injuries, is important. Attention should also be paid to the neglect or abuse of the elderly. It is very important to exclude other causes and risk factors of zanemarivanje ili zlostavljanje osoba starije životne dobi. Vrlo je važno isključiti druge uzroke i rizične faktore amnezije kao što su: anamneza traume glave, epileptički napadi, infekcije, tumori i slično. Važno je isključiti delirij i depresivni poremećaj i druge reverzibilne uzroke dementnih stanja prije nego što se zaključi da bolesnik ima demenciju. Kod bolesnika treba napraviti kompletan psihički status i MMSE (*Mini-Mental State Examination*). Uz standardne laboratorijske pretrage trebalo bi odrediti saturaciju kisika, vitamin B_{12}, folate, hormone štitnjače i VDRL (10,18,19). U daljnjoj obradi, koja nije u sferi hitne psihijatrijske ambulante, bilo bi preporučljivo učiniti rendgen toraksa, EEG, apolipoprotein E (Apo E), genotipizaciju, CT, PET-CT (10,20,21). Heteroanamnestički podatci su od velike važnosti kao i uvid u propisanu farmakološku terapiju koju bolesnik uzima i podatci o samoj adherenciji za navedenu terapiju. Moguće nuspojave vezane uz međusobne interakcije lijekova kod ovih bolesnika su vrlo česte. Kod ovih bolesnika se u pravilu često susreće i polifarmacija. Neke skupine lijekova također mogu izazvati promjene psihičkog statusa kod ovih bolesnika kao što su opijatski analgetici, kortikosteroidi, psihostimulansi, antihistaminici i antikolinergici. Stariji bolesnici s delirijem i depresijom mogu izgledati dementno i kada to nisu. Treba paziti kada se ova dva stanja pojave istovremeno - najvažnija klinička značajka je klinički tijek. Delirij nastaje naglo i ima fluktuirajući tijek simptoma, dok demencija ima postupni početak i statični ili progresivni tijek. Najčešće susrećemo delirij koji je superponiran na demenciju. Bez obzira na dob bolesnika, uvijek treba misliti na uzimanje alkohola i drugih sredstava ovisnosti (10,22).

POSTUPCI I INTERVENCIJE

Gerijatrijski bolesnici bi u pravilu prvo trebali biti pregledani od stručnjaka somatske medicine (internista, neurologa, kirurga) prije nego

amnesia, such as: history of head trauma, epileptic attacks, infections, tumours and the like. It is important to exclude delirium and depressive disorder and other reversible causes of dementia before it is concluded that the patient has dementia. Patients should make a complete mental status examination and MMSE (mini-mental status exam). Along with standard laboratory tests, oxygen saturation, vitamin B12, folate, thyroid hormones and VDRL should be determined (10,18,19). In further treatment, which is not in the sphere of psychiatric emergency services, it would be advisable to do X-rays, EEG, apolipoprotein E (Apo E), Genotyping, CT, PET-CT (10,20,21). Data from heteroanamnesis are of great importance, as well as insight into the prescribed pharmacological therapy that the patient is taking and the adherence to the therapy. Possible side effects of drug interaction in these patients are very common. Polypharmacy usually occurs in these patients as a rule. Some drug groups may also cause changes in the mental status in these patients such as opiate analgesics, corticosteroids, psychostimulants, antihistamines and anticholinergics. Older patients with delirium and depression may look demented even when they are not. Care should be taken when these two conditions appear simultaneously; the most important clinical feature is the clinical course. Delirium develops rapidly and has a fluctuating course of symptoms, while dementia has a gradual start and a static or progressive course. The most commonly encountered delirium is the one superimposed on dementia. Regardless of the age of the patient, one should always exercise caution regarding taking alcohol and other addictive drugs (10,22).

PROCEDURES AND INTERVENTIONS

Geriatric patients should first be screened by psychosomatic medicine specialists (internists, neurologists, surgeons) before referring to psyšto se upućuju u hitnu psihijatrijsku službu, kako bi se ustanovilo da su primarne smetnje iz psihijatrijske domene. Ako je bolesnik somatski nestabilan, trebao bi biti zadržan u jedinici somatske medicine, a psihijatra bi trebalo uključiti konzultativno. Kada bolesnik jednom postane somatski stabilan, može se premjestiti na psihijatrijski odjel, ako je to klinički indicirano (6,23).

U planu postupanja glavna je dilema treba li ove bolesnike zaprimiti na psihijatrijski ili somatski odjel. Kod bolesnika s izraženom depresijom, suicidalnošću, agitacijom, sklonostima lutanju i ostalom rizičnom ponašanju kod kuće, izraženom anksioznošću i smanjenom sposobnošću brige o sebi, to su glavni razlozi hospitalizacije. Starije osobe imaju osobit rizik od suicida, pogotovo muške osobe koje su razvedene ili udovci (24,25). Starije osobe imaju veću prevalenciju depresije, imaju više somatskih bolesti, više su socijalno izolirani, imaju više kognitivnih smetnji i problema sa spavanjem. Kod starijih osoba zabilježen je manji broj pokušaja suicida, ali veći broj izvršenih suicida jer biraju smrtonosnije metode (26,27).

Kod bolesnika sa smetnjom pamćenja općenito ključno je otkriti uzrok takvog stanja i onda tretirati to stanje u pozadini. Ako je oštećenje pamćenja jako izraženo, a bolesnik nema obiteljsku i socijalnu potporu, indicirano je hospitalno psihijatrijsko liječenje (po mogućnosti na psihogerijatrijskom odjelu) do stabilizacije psihičkog stanja i mogućnosti adekvatnog vanbolničkog zbrinjavanja. Bolesnici s izraženom jakom anksioznošću, suicidalnošću, depresijom, deluzijama i halucinacijama, mogućim samoozljeđivajućim ponašanjem (lutanje) moraju se odmah hospitalizirati (1,28).

Kod prijama ovih bolesnika u psihijatrijsku bolnicu, svakako bi ih trebalo smjestiti na psihogerijatrijski odjel. Ne bi bilo zgodno osamdeset petogodišnjeg, starijeg, agitiranog i dementnog bolesnika staviti na odjel i u sobu s devetnaestogodišnjim maničnim bolesnikom. Boravak u

chiatric emergency services to find out whether the primary complaint is psychiatric. If the patient is somatically unstable, he should remain in the somatic medicine unit, and a psychiatrist should be consulted. Once the patient becomes somatically stable, he can be referred to a psychiatric unit if clinically indicated (6,23).

In the treatment plan, the main dilemma is whether these patients should be admitted to a psychiatric or somatic department. In patients with pronounced depression, suicidality, agitation, wandering tendencies and other home-based risk behaviour, along with anxiousness and reduced self-care ability, these are the main reasons for hospitalization. Elderly persons have a particular risk of suicide, especially men who are divorced or widowed (24,25). Elderly people have a greater prevalence of depression, have more somatic illnesses, are more socially isolated, have more cognitive impairment and sleep problems. Smaller number of suicide attempts have been reported in elderly people, but a greater number of suicides have been committed because they chose more lethal methods (26,27).

In patients with memory impairment, it is crucial to find out the cause of such a condition and then treat that condition in the background. If the impairment of memory is very pronounced, and in the case of a lack of family and social support, hospital psychiatric treatment (preferably in the psycho-geriatric department) is indicated to stabilize the mental state and the possibility of adequate outpatient care. Patients with severe anxiety, suicidal ideation, depression, delusions and hallucinations, possible self-neglecting behaviour (wandering) must be hospitalized immediately (1,28).

When these patients are admitted to a psychiatric hospital, they should be placed in a psycho-geriatric department, and it would not be convenient for an eighty-five-year-old, agitated and demented patient to be placed in the same department and room with a nineteen-year-old bolnici (trajanje hospitalizacije) je obično duže kod ovih bolesnika u usporedbi s mlađim bolesnicima. Nažalost, iako neke ustanove imaju specifične programe za dementne bolesnike, ova subpopulacija bolesnika često nije sposobna sudjelovati u takvim programima. Očekivani ciljevi hospitalnog psihijatrijskog liječenja su uvođenje ili korekcija terapije, stabilizacija ponašanja, psihoedukacija obitelji i smještaj bolesnika u primjerenije ustanove, ako je to potrebno (29,30).

Hospitalizacija bolesnika s demencijom je potencijalno stresno iskustvo za pacijenta i obitelj. Rizik od komplikacija tijekom boravka u bolnici je prilično visok, i preporuka je izbjeći nepotrebne hospitalizacije za osobe s demencijom. Komplikacije tijekom bolničkog liječenja osoba s demencijom su učestale, a najčešće se pojavljuju upala pluća, otežano gutanje, uroinfekcije, padovi (npr. prijelomi kuka), sepse, slabija pokretljivost (funkcionalnost). Posebno su važni suradnja između stručnog osoblja i njegovatelja, kao i planiranje zbrinjavanja osoba s demencijom nakon bolničkog liječenja (1,31,32).

Kod agitiranih stanja kod ovih bolesnika primjenjuju se niske doze visokopotentnih tipičnih ili atipičnih antipsihotika. U pravilu bi trebalo izbjegavati niskopotentne antipsihotike kao što su promazin, klorpromazin, levomepromazin i kombinacije lijekova općenito koliko je god to moguće (33-35). Glavno pravilo kod primjene ovih lijekova u bolesnika s demencijom je općenito „*start low and go slow*“, dakle započeti s malom dozom i postupno povisivati dozu. Kod akutno psihotičnih i agitiranih bolesnika najčešće se primjenjuju sljedeći antipsihotici: haloperidol 0,25-2 mg, risperidon 0,5-2 mg, olanzapin 2,5-5 mg, flufenazin 0,5-5 mg, kvetiapin 25 mg. Najčešće se primjenjuje haloperidol, jer ima manje antikolinergičko djelovanje, manje aktivnih metabolita i smanjenju mogućnost izazivanja hipotenzije. Nadalje, njegove su prednosti što se može pri-

manic patient. The length of stay in hospital (length of hospitalization) is usually longer with these patients in comparison to younger patients. Unfortunately, although some institutions have specific programs for dementia patients, this subpopulation of patients are often unable to participate in such programs. The expected goals of hospital psychiatric treatment include the introduction or correction of therapy, behavioural stabilization, family psychoeducation and patient accommodation in a more appropriate institution if necessary (29,30).

The hospitalization of patients with dementia is a potentially stressful experience for the patient and family. The risk of complications during hospital stay is quite high, and the recommendation is to avoid unnecessary hospitalization for people with dementia. Complications during hospitalization in people with dementia are frequent, and most commonly take the form of pneumonia, difficulty in swallowing, urinary-infection, falls (for example hip fractures), sepsis, poor mobility (functionalities). Of particular importance is the cooperation between professional staff and caregivers, as well as planning for the treatment of people with dementia after hospitalization (1,31,32).

In case of agitated conditions in these patients, low doses of high-potent, typical or atypical antipsychotics are used. As a rule, low-potency antipsychotics such as promazine, chlorpromazine, levomepromazine and combinations of drugs should be avoided as much as possible (33-35). The main rule in the use of these drugs in patients with dementia is generally “start low and go slow”, therefore start with a low dose and gradually increase the dose. In the case of acute psychotic and agitated patients, the following antipsychotics are most commonly used: haloperidol 0.25-2 mg, risperidone 0.5-2 mg, olanzapine 2.5-5 mg, fluphenazine 0.5-5 mg, quetiapine 25 mg. Haloperidol is most commonly used because it has less anticholinergic mijeniti peroralno u obliku tableta ili tekućine (kapi) te parenteralno, intramuskularno ili čak intravenski. Iako antipsihotici nove generacije imaju prednosti u pogledu nuspojava pred antipsihoticima prve generacije, potreban je oprez kod primjene novih atipičnih antipsihotika zbog povećanog rizika od cerebrovaskularnih nuspojava. Ako su antipsihotici u nekoliko doza neučinkoviti ili su kontraindicirani, ili je stanje uzrokovano sustezanjem od alkohola ili lijekova, preporuča se terapija diazepamom 5-10 mg ili lorazepamom 0,5-2,5 mg (36,37). Ako je bolesnik i dalje izrazito psihomotorno agitiran te može postati opasan za sebe i okolinu, treba razmotriti primjenu fizičkog sputavanja. Treba biti posebno oprezan s primjenom benzodiazepina, naročito dugodjelujućih kao što je diazepam, jer može izazvati akumulaciju i uzrokovati ozbiljne nuspojave kao što su: poremećaj koordinacije, konfuzija, prejaka sedacija, padovi ili čak dezinhibicija. Uvijek kada imamo neobjašnjivo stanje sedacije, smetnje hodanja, padove ili kognitivne smetnje, treba isključiti uzimanje benzodiazepina. Isto tako, nagli prekid uzimanja benzodiazepina kod ovih bolesnika može izazvati simptome sustezanja, uključujući delirantna i psihotična stanja te epileptičke napade (38-42).

Psihoedukacija članova obitelji je vrlo važna te ju treba započeti već u prijamnoj ambulanti. Briga za dementnog bolesnika može postati teret za svakoga, posebno za starijeg supružnika koji i sam ima tjelesnih i kognitivnih smetnji. Ako to kliničar uoči, potrebno je razmotriti uključivanje takvog bolesnika u drugu zdravstvenu ili socijalnu ustanovu s intenzivnijim nadzorom i skrbi o bolesnicima (43-46). Indikacija za hospitalizaciju ponekad je i iscrpljenost osoba koje o bolesniku skrbe odnosno neformalnih njegovatelja koje su također nerijetko starije životne dobi (supružnici) ili su zaposlene (djeca). Ponekad se u bolnicu zaprimaju osobe s demencijom koje žive same, a više ne mogu samostalno funkcionirati, te im

activity, less active metabolites and reduced hypotension. Furthermore, its advantage is that it can be administered orally in the form of tablets or liquids and parenterally, intramuscularly or even intravenously. Although the new generation of antipsychotics has less side effects in comparison with the first generation of antipsychotics, caution is required when using new atypical antipsychotics due to increased risk of cerebrovascular side effects. If antipsychotics in several doses are ineffective or are contraindicated, or if the condition is caused by alcohol or drug withdrawal, diazepam 5-10 mg or lorazepam 0.5-2.5 mg (36,37) is recommended. If the patient is still psychologically disturbed and can become dangerous to themselves and the environment, the use of physical restraint should be considered. Special care should be taken with the use of benzodiazepines, particularly long-acting like diazepam, as it may cause accumulation and cause serious side effects such as: coordination disorder, confusion, excessive sedation or even disinhibition. Whenever there is an unexplainable sedation condition, walking disturbances, falls or cognitive impairment, the use of benzodiazepines should be excluded. Likewise, an abrupt withdrawal of benzodiazepines in these patients may cause the symptoms of diarrhoea, including delirium and psychotic states and epileptic attacks (38-42).

Psycho-education of family members is very important and should start in the emergency department. Care for a demented patient can become a burden to everyone, especially for an older spouse who has self-cognitive and cognitive disabilities. If the clinician is aware of this, it is necessary to consider including such a patient in another health or social institution with more intensive supervision and patient care (43-46). The indication of hospitalization is sometimes the exhaustion of persons who are taking care of the patient and/or informal care givers who are also often older (spouses) or are employed (children). Sometimes peose uz pomoć Centra za socijalnu skrb započinje organizirati smještaj u odgovarajuću ustanovu ili udomiteljsku obitelj (1,47-51).

ZAKLJUČAK

Svakom pacijentu s akutnim psihičkim smetnjama, bez obzira na dob, treba pristupiti temeljito i razborito kako bi se mogle donijeti ispravne odluke o daljnjim medicinskim postupcima, postavljanju dijagnoze i liječenju. S obzirom na već opisani široki spektar psihijatrijskih poremećaja koji se mogu pojaviti kod osoba starije životne dobi, osim samog pregleda pacijenta i anamnestičkih podataka, od velike važnosti su i heteroanamnestički podatci (podatci članova obitelji, osoba koje žive s pacijentom u istom kućanstvu, osoba koje su na razne druge načine uključene u pacijentov svakodnevni život). Jako bitno je isključiti postojanje somatskih poremećaja koji bi mogli biti uzrokom psihičkih simptoma kod takvih osoba, pa se naglasak stavlja na timski rad psihijatara i drugih specijalista (internista, neurologa, liječnika obiteljske medicine…), kako bi se što brže i bezbolnije, a sve na dobrobit pacijenta, došlo do postavljanja ispravne dijagnoze, i samim time započelo što ranije liječenjem. Izražena depresija, suicidalnost, agitacija, sklonosti lutanju i ostalim rizičnim ponašanjima kod kuće, izražena anksioznost i smanjena sposobnost brige o sebi, glavni su razlozi hospitalizacije ovih bolesnika.

ple with dementia who live alone and can no longer function independently are accepted to the hospital, and with the help of the Centres for Social Welfare they begin to arrange accommodation in the appropriate institution or foster family (1,47-51).

CONCLUSION

Any patient with acute mental disorder, regardless the age of the patient, should be approached thoroughly and reasonably so that the correct decisions on further medical procedures, diagnosis and treatment could be made. Given the broad spectrum of psychiatric disorders that may occur in elderly persons, apart from the examination and the medical history of the patient, heteroanamnestic data (data from family members, persons living with the patient in the same household, persons that are in many different ways involved in the patient's daily life) is also of great importance. It is very important to exclude the existence of somatic disorders that may be the cause of psychological symptoms in such persons, so emphasis is placed on the teamwork of psychiatrists and other colleagues (internists, neurologists, family medicine physicians, etc.), so that an accurate diagnosis and treatment is made as fast and as painlessly as possible for the benefit of the patient's wellbeing. Pronounced depression, suicidal ideation, agitation, a tendency to wander and other high-risk behaviours at home, anxiousness and reduced ability to care for oneself are the main reasons for hospitalization in these patients.

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Somatizacija kao obrana od narcističke povrede

Somatization as a Defence from Narcissistic Injury

Zrnka Kovačić Petrović[1], Tina Peraica[2,3], Dragica Kozarić-Kovačić[3]

[1] Medicinski fakultet Sveučilišta u Zagrebu i Klinika za psihijatriju Vrapče Zagreb, [2] Klinička bolnica Dubrava, Klinika za psihijatriju, Referentni centar Ministarstva zdravstva za poremećaje uzrokovane stresom, Zagreb, [3]Sveučilišni odjel za forenzične znanosti Sveučilišta u Splitu, Split, Hrvatska

/ [1]*University of Zagreb, Faculty of Medicine and University Psychiatric Hospital Vrapče, Zagreb,* [2]*University Hospital Dubrava, Department of Psychiatry, Referral Center for Stress-related Disorders of the Ministry of Health, Zagreb and* [3]*University of Split, Department for Forensic Sciences, Split, Croatia*

Somatizacijski poremećaj je poremećaj u kojem se psihički problemi i emocionalni konflikti izražavaju tjelesnim simptomima, a somatizacija je psihološki mehanizam u kojem se psihički problemi i emocionalni konflikti manifestiraju tjelesnim simptomima za koje se ne nalazi organska podloga. Može se javiti kao zasebni ili komorbidni poremećaj, osobito s poremećajima raspoloženja, anksioznim poremećajima, poremećajima ličnosti (najčešće histrionski poremećaj ličnosti i opsesivno-kompulzivni poremećaj ličnosti). Ovakve osobe primarno se javljaju u ambulante opće medicine ili tjelesne ambulante i tek kasnije i na psihijatrijska liječenja. Liječenje osoba s tzv. somatoformnim poremećajima je kompleksno, vrlo dugo i zahtjevno te je potrebna cijela lepeza psihijatrijskih vještina, često bez pozitivnih rezultata.

U ovom radu prikazana je pacijentica kod koje je traumatska i konfliktna situacija na poslu doživljena kao narcistička povreda koja je dovela do razvoja dramatične kliničke slike u oblku somatizacija i somatizacijskog poremećaja kod osobe s histronskim poremećajem ličnosti. Nemogućnost suočavanja s povredom selfa kod histrionskog poremećaja ličnosti može dovesti do somatizacije kao načinom rješavanja problema. Prigodom liječenja je važno identificirati točan uzrok, tj. okidač (engl. *trigger*) koji je doveo do nastanka poremećaja te suočiti pacijenta s psihološkom i emocionalnom etiologijom tegoba, što uvelike doprinosi boljem terapijskom ishodu. Važnost pravovremenog prepoznavanja somatizacija je između ostaloga nužna i zbog izbjegavanja nepotrebnih tjelesnih dijagnostičkih postupaka, kao i zbog socijalne i radne disfunkcionalnosti takvih osoba.

/ Somatization disorder is characterized by a tendency of a person to communicate psychological distress and emotional conflicts through physical symptoms, while somatization is a psychological mechanism manifesting psychological distress and emotional conflicts as physical symptoms that lack an organic basis. It can develop as a single disorder or a mental disorder comorbid with other disorders, especially co-occurring with mood disorders, anxiety disorders, and personality disorders (most commonly, histrionic and obsessive-compulsive personality disorders). In most cases, people suffering from such disorders seek help from general practitioners or at healthcare facilities specialized for physical disorders. It is only after this that they seek psychiatric assistance.

The treatment of people suffering from so-called somatoform disorders is complex, time-consuming and demanding and it requires a broad spectrum of psychiatric skills. However, it rarely yields positive outcomes.

This research paper focuses on a case study of a patient with histrionic behaviour who experienced a conflict situation at work as a narcissistic injury. The narcissistic injury triggered the development of a dramatic clinical picture in the form of somatization and, consequently, the development of the somatization disorder.

The inability of a person with a histrionic personality disorder to confront an injury of self can trigger somatization as a defence mechanism. The treatment requires careful identification of the root cause, the so-called trigger that initiated the development of the disorder, and the confrontation of a patient with the psychological and emotional etiology of his/her symptoms. Such an approach has a profound impact on a more positive outcome of the therapy. However, timely detection of somatization is important, among other things, to avoid unnecessary physical diagnostic procedures and to enable the normal performance of social and occupational roles of a patient.

ADRESA ZA DOPISIVANJE / *CORRESPONDENCE:*
Zrnka Kovačić Petrović, dr. med.
Medicinski fakultet Sveučilišta u Zagrebu
Šalata 3b
10 000 Zagreb, Hrvatska
Tel: +385 98 230 969
E-pošta: zrnka.kovacic@gmail.com

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UVOD

Somatizacija je psihološki mehanizam u kojem se psihički problemi i emocionalni konflikti izražavaju tjelesnim simptomima i manifestira se cijelim nizom polimorfnih tegoba za koje se ne nalazi organska podloga. Somatizacija je tendencija osobe da komunicira psihološki distres somatskim simptomima i traži za njih medicinsku pomoć, pa se somatoformni poremećaji tipično prvo vide u nepsihijatrijskom okruženju (liječnici opće medicine i razni specijalisti tjelesne medicine) (1). Konverzivni poremećaj je specifični oblik somatizacije u kojem su prisutni funkcionalni neurološki simptomi i ako se manifestiraju kao dio multisustavnog somatoformnog sindroma primarna dijagnoza je somatizacijski poremećaj (2).

Povijest somatizacija povezana je s povijesti histerije za koju se smatralo da ekskluzivno zahvaća žene, a njezino poimanje se je počelo mijenjati nakon 1950. godine (3).

Somatoformni poremećaji bili su klasificirani u DSM-IV klasifikaciji (4), kao i u MKB-10 klasifikaciji (5), a u DSM-5 klasifikaciji ova skupina poremećaja je postala poremećaj sa somatskim simptomima (6), dok se poremećaji s organski neobjašnjenim simptomima dijagnosticiraju kao konverzivni poremećaj (poremećaj s funkcionalnim neurološkim simptomima) i više nema somatizacijskog poremećaja. U MKB-10

INTRODUCTION

Somatization is a psychological mechanism of expressing somatic distress and symptoms and attributing them to a wide spectrum of polymorphic health conditions that lack an organic basis. Furthermore, somatization is a tendency of a person to experience and communicate somatic distress and to seek medical assistance to alleviate it. Consequently, somatoform disorders are usually first observed at non-psychiatric medical facilities (by general practitioners and various medical professionals specialized in physical illnesses) (1). Conversion disorder is a specific form of somatization commonly characterized by functional neurological symptoms. If symptoms manifest as a part of the multisystem somatoform syndrome, somatization disorder is the primary diagnosis (2).

The history of somatization is related to the history of hysteria, which was considered to be a female disease exclusively until the 1950s (3).

The Diagnostic and Statistical Manual of Mental Disorders – IV (DSM-IV) classification (4), as well as the International Statistical Classification of Diseases and Related Health Problems – 10 (ICD-10) (5), included somatoform disorder. However, the Diagnostic and Statistical Manual of Mental Disorders – V (DSM-V) classification classifies somatoform disorder as a disorder characterized by somatic symptoms (6). Furthermore, this classification classifies disorders with symptoms lacking an organic basis as a conversion disorder (a disorder characterized by functional neurological symptoms) and omits somatization disorder. The klasifikaciji konverzivni poremećaj je svrstan u skupinu disocijativnih poremećaja.

Konverzivni poremećaj ima obično iznenadni početak, kratkog je trajanja za razliku od somatoformnih poremećaja koji imaju kroničan tijek. Glavno obilježje konverzivnog poremećaja je prisutnost simptoma ili deficita voljne, motoričke ili osjetilne funkcije koji upućuju na neku neurološku bolest ili neki drugi poremećaj (pareze, paralize, kontrakture, hiperkinezije u obliku tremora glave, ekstremiteta i cijeloga tijela, različiti tikovi kao i poremećaji govora kao mucanje, afazija i mutizam). Uzrokovan je psihološkim čimbenicima jer je zamijećeno da pojavi ili pogoršanju simptoma ili deficita prethodi konflikt ili drugi stresor. Somatizacijski poremećaj je jaki psihijatrijski poremećaj koji se odlikuje mnogim recidivirajućim značajnim tjelesnim tegobama, a simptomi mogu uključivati jedan ili više tjelesnih sustava ili funkcija, kao što su kardiopulmonalni, gastrointestinalni, genitourinarni, muskuloskeletalni, neurološki simptomi uz umor i bol (7).

Kod somatizacijskog poremećaja prisutan je komorbiditet s drugim psihijatrijskim poremećajima, osobito s poremećajima raspoloženja, anksioznim poremećajima, poremećajima ličnosti (najčešće histrionski poremećaj ličnosti i opsesivno-kompulzivni poremećaj ličnosti) (8).

Etiologija somatizacijskog poremećaja je vrlo raznolika jer postoje i različite kliničke manifestacije što i ukazuje na multifaktorsku etiologiju. Predisponirajući čimbenici mogu biti: genetski, psihodinamski, neuropsihološko-neurofiziološko-psihofiziološki, crte ličnosti (neuroticizam, aleksitimija, negativni afektivitet, introspektivnost, itd.), razvojno učenje i sociokulturni (9). Dominantni etiološki čimbenici mogu kod jednog pacijenta biti predominirajući, a kod drugog minorni.

U psihodinamskim teorijama klasično psihoanalitičko razumijevanje konverzivnog pore-

ICD-10 classification placed the conversion disorder in the group of dissociative disorders.

Commonly, conversion disorder has a sudden onset and is of a shorter duration, while so-called somatoform disorders are chronic in nature. The main characteristic of conversion disorder is a presence of symptoms or a lack of voluntary motor or sensory control, usually indicative of a neurological illness or disorder (e.g. paralysis, contracture, hyperkinesis including various forms of tremor affecting the head, extremities and the whole body, various forms of tics, as well as speech disorders, namely stuttering, aphasia and mutism). Psychological factors are identified as underlying factors since it has been observed that a conflict or other psychological stressor usually precedes the onset or the deterioration of symptoms. Somatization disorder is a serious psychiatric condition characterized by numerous significant recurring physical symptoms affecting any part or system of the body or several organ systems or functions. The symptoms can be cardiopulmonary, gastrointestinal, genitourinary, musculoskeletal or neurological and are usually accompanied by fatigue and pain (7).

Somatization disorder is often comorbid with other psychiatric disorders, especially mood disorders, anxiety disorders, or personality disorders (most commonly histrionic and obsessive-compulsive personality disorders) (8).

The etiology of the somatization disorder accounts for a wide diversity and broad spectrum of clinical manifestations suggesting its multifactorial etiology. Predisposing factors include genetic, psychodynamic, neuropsychological-neurophysiological-psychophysiological, and personality traits (e.g. neuroticism, alexithymia, negative affectivity, introspection, etc.), developmental-learning and sociocultural factors (9). While dominant etiological factors can be prevalent in one patient, they can be minor in another patient.

In the psychodynamic approach, traditional psychoanalysis explains the conversion disorder as a symbolic representation of subconscious conflicts (violent and sexual in nature). In the contemporary Western world, somatic symptoms explained mećaja je simbolička reprezentacija nesvjesnih konflikata (agresivnih ili seksualnih). U suvremenom zapadnom svijetu somatski simptomi koji su jednostavna simbolička reprezentacija intrapsihičkih konflikata su iznimno rijetki te se danas mnogi nesvjesni konflikti iz prošlosti smatraju posttraumatskim (10). Somatizacija se prema psihodinamskim objašnjenjima gleda kao oblik simboličke komunikacije, obrambeni mehanizam i razrješenje konflikta. To je proces putem kojega tijelo prevodi mentalni stres u fizičku ekspresiju koja ima simboličku vrijednost. Proces somatizacije također predstavlja primitivni obrambeni mehanizam, poput poricanja i represije, protiv nepoželjnih želja i nakana. Kao sredstvo razrješenja konflikta, osoba koja somatizira baca krivnju na svoje tijelo zbog „grešaka" ili se fokusira na simptome da izbjegne nepodnošljivu situaciju. Teorije koje su povezane s razvojnim učenjem govore o tome kako dijete rano nauči da biti bolestan ili žaliti se na simptome može biti nagrađeno pažnjom i simpatijom, ili opet da takvo ponašanje dovodi do izbjegavanja konflikta i odgovornosti, tako da se somatizacija razvije kao stil sučeljavanja. Istraživanja su pokazala da djeca koja su izložena tjelesnim bolestima i bolnom ponašanju kod članova obitelji imaju povećani rizik za razvoj somatizacije (10,11). Precipitirajući čimbenici uključuju životne događaje i situacije (teški gubitci, tjelesne bolesti ili ozljede, prekidi odnosa, itd.) (11).

Tretman osoba koje spadaju u skupinu tzv. somatoformnih poremećaja je kompleksan, vrlo dug i zahtjevan te je potrebna cijela lepeza psihijatrijskih vještina, često bez pozitivnih rezultata.

Cilj prikaza je pokazati kako je traumatska i konfliktna situacija na poslu, doživljena kao narcistička povreda, dovela do razvoja dramatične kliničke slike u obliku somatizacija kod pacijentice s histrionskim poremećajem ličnosti.

as a simple symbolic representation of intrapsychic conflicts are extremely rare. Similarly, many subconscious conflicts from the past are observed as posttraumatic (10). Psychodynamic explanations of somatization assume that somatization is a mode of symbolic communication, defence mechanism and conflict management. It is a way the body transforms mental stress into a physical manifestation with a symbolic value. Furthermore, somatization is a primitive defence mechanism against unwanted desires and intentions, similar to denial and repression. As a means of resolving conflicts, a somatising person experiences their body as a "defect or mistake" or focuses on physical symptoms in order to avoid an unbearably stressful situation. Theories relating to developmental learning observe that children may learn that illness or symptoms are likely to be rewarded by attention and sympathy or, similarly, that this can be a mechanism of avoiding conflicts and responsibilities. Consequently, somatization becomes a style of conflict management and attention seeking. Studies suggest that children exposed to physical illness and pain behaviour of other family members are at higher risk of developing somatization (10,11). Precipitating factors include life events and situations (e.g. painful losses, physical illness and injuries, separations, relationship breakups, etc.) (11).

The treatment of persons suffering from so-called somatoform disorders is complex, time-consuming and arduous and demands a broad spectrum of psychiatric skills. However, it rarely yields positive results.

The objective of the case study: To demonstrate that a conflicting situation at work, experienced as a narcissistic injury, can trigger a dramatic clinical picture in the form of somatization in a female patient with a histrionic personality disorder.

CASE STUDY

A patient in her 50s is admitted to a psychiatric ward due to extremely severe anxiety and psychomotor agitation following a number of medical examinations and diagnostic screenings that failed to detect any physical disorder or illness.

PRIKAZ BOLESNICE

Bolesnica u dobi od 50 godina primljena je na odjel zbog visokog stupnja anksioznosti te izrazitog psihomotornog nemira nakon opsežnih i opetovanih tjelesnih pregleda i pretraga kojima nije nađen tjelesni poremećaj ili bolest. Kod prijama zapomaže, hvata se za glavu, sjeda na pod tijekom intervjua te na dramatičan i teatralan način iznosi niz somatizacija koje hipertrofira i na koje je fiksirana. Žali se da je "boli i peče mozak", posebno oko lijevog uha, navodi "užasnu" fotofobiju, strašno joj se povraća, ima neizdrživu bol i kočenje u vratu koji se spuštaju niz kralješnicu i ne spava tjednima.

Intervju je vođen tijekom nekoliko dana nakon što je sedirana anksioliticima. Pacijentica je rastavljena, majka odraslog sina s kojim živi, radi u struci kao upravna pravnica, paralelno studira politologiju na kojoj je apsolventica. Svoju primarnu obitelj opisuje korektnom, no odnosi su oduvijek bili "hladni", otac je počinio suicid. Za sebe kaže da je oduvijek bila perfekcionist. Navodi da su se bolovi prvi puta počeli javljati nakon "akustičke traume" na radnom mjestu kada joj je nadređeni svom snagom zalupio slušalicu nakon verbalnog konflikta putem telefona. Do tada je imala „odličan" odnos s nadređenim, opisuje ga „idealnim", smatrala je da ju cijeni i poštuje i ona se je trudila biti što bolja na svom poslu, a tome je i težila u svom životu. Nije mogla ni pomisliti da bi nadređeni reagirao na taj način. Nadređeni joj je izgovorio da nije sposobna razumjeti ni najjednostavniji ugovor, koji je sačinila prema njegovim uputama. Ona se uvijek trudila sve napraviti što je više moguće dobro, jer smatra da jedino tako dobro funkcionira. Kada mu je pokušala reći da je ugovor napravila kako je on tražio, nadređeni je počeo na nju vikati, „doslovno urlati i svom snagom je zalupio telefonsku slušalicu". Napravila je jaki trzaj glavom, tresak slušalice joj je "odjeknuo kao eksplozija u glavi" te je osjetila jaku bol u lijevom uhu, nestabilnost i

Prior to admittance, she calls for help, grabs her head, sits on the floor during the interview and reports a number of somatizations on which she is fixated, and she exaggerates dramatically and theatrically. She complains about "a burning and aching sensation in her brain", especially in the area of the left ear, she talks about an "unbearable" photophobia, she feels nauseous, feels like vomiting, describes an excruciating pain and stiffness in the neck area radiating down the spine and also talks about sleeping problems that have bothered her for weeks.

The medical interview takes place over the course of several days following sedation with anxiolytic drugs. The patient is a divorced mother of a grown-up son with whom she shares her household. She works as a paralegal and simultaneously she is a graduate student at the Faculty of Political Sciences. She describes the family she grew up in as fairly normal, but "reserved and emotionally cold." Her father committed suicide. She says that she has always been a perfectionist. She states that the first time she felt pain was after the "acoustic trauma" she experienced at work when her boss abruptly hung up the phone following a verbal conflict over the phone. She claims that until then she had an "excellent" relationship with her boss. She describes him as the "ideal boss." She sincerely believed that he had felt nothing but respect for her and she was doing her best to provide excellent performance at work. Similarly, she has been a perfectionist in other aspects of her life. It never occurred to her that her boss could react in such a way. He told her that she could not understand even the simplest contracts, e.g. the one she drafted following his instructions. She was devoted to excellence at work since she was convinced that this was the only way for her to function. However, when she tried to explain that she had strictly followed his instructions, he started shouting at her, "literally, he shouted his head off and then hung up the phone." At that moment she moved her head in an awkward way, and the echo of the slammed phone reverberated in her head "like a detonation." Immediately, she felt severe pain in her left ear, as well as unsteadiness. She staggered while walking. The pain in her ear intensified with time and on several occasions, over the course of 2 years following the traumatic zanošenje u hodu. S vremenom se intenzitet bolova u uhu pojačavao te je višekratno obrađivana od neurologa, otorinolaringologa, oftalmologa (obilna medicinska dokumentacija) u razdoblju od dvije godine. Često je posjećivala hitne medicinske prijame. Nakon niza pregleda otorinolaringolog je utvrdio “akustičku traumu” te je započeto liječenje klonazepamom. Međutim, unatoč terapiji tegobe su se intenzivirale i proširile na bolove u želucu, kralješnici, itd. Socijalno i radno funkcioniranje pacijentice bilo je izrazito oštećeno i bila je na višemjesečnom bolovanju.

Na početku liječenja nije uopće bila suradljiva i zbog izrazite anksioznosti liječenje je započeto anksioliticima i antidepresivom uz suportivni pristup. Ne prihvaća emocionalnu i psihološku etiologiju svojih smetnji. Zabrinuta je za tjelesno zdravlje te inzistira na nizu tjelesnih pretraga. Fiksirana je na pažnju vlastite sestre, zahtijeva njezin dolazak navodeći minorne razloge.

Smatra da nema mentalnih tegoba te da su uzrok sniženom raspoloženju i nesanici jedino bolovi. Ne priznaje događaj na poslu kao glavni uzrok svojih tegoba, a neprihvatljive osjećaje “premješta” na razne dijelove tijela za što nalazi niz racionalnih objašnjenja. Psihijatrijsko liječenje doživljava kao osobni poraz.

Odrastala je u obitelji koja je bila emocionalno hladna, osobito majka koja je bila distancirana, često joj je prigovarala ako ne bi postizala uspjehe u školi ili općenito u nekim drugim aktivnostima. Znala ju je i fizički kažnjavati uz verbalna omalovažavanja. Starija sestra je bila favorizirana jer je bila bolja učenica od nje i činilo se da joj sve polazi za rukom. Često ju je majka uspoređivala sa sestrom, koja je bila usmjerena na postizanje uspjeha. Čini joj se da je s ocem imala bolji odnos, on je bio seduktivan, nju je favorizirao i čini joj se da je to dodatno frustriralo majku. Majka je bila hladna i prema ocu, a on je bio usmjeren na svoju karijeru. Nakon što je doživio otkaz na poslu nakon

experience, a neurologist, an otorhinolaryngologist and an ophthalmologist (she provides well-documented medical records) examined her. She sought urgent medical assistance at emergency facilities on many occasions. After a number of medical examinations, the otorhinolaryngologist diagnosed her with an “acoustic trauma” and prescribed her clonazepam. However, despite therapy, her condition deteriorated and now she had symptoms in the stomach, the spine, etc. Her performance of social and occupational roles was seriously compromised, and she had been prescribed a several-month sickness leave.

The patient’s lack of cooperativeness marks the beginning of the treatment. Furthermore, due to heightened anxiety, the treatment includes anxiolytics and antidepressants along with a supportive approach. She refuses to accept the emotional and psychological etiology of her condition. She is worried about her physical health and she demands a thorough physical check-up. She seeks her sister’s attention intensely and keeps finding trivial reasons to ask her to visit her.

Moreover, she denies any possibility of psychological distress or emotional disturbance claiming that the physical pain she feels is the sole cause of her low mood and insomnia. She does not recognize her experience at work as the main trigger of all her problems. In addition, she unconsciously “converts” unacceptable feelings she feels into physical sensations in various parts of her body and offers a number of rational explanations for them. She experiences the psychiatric treatment to which she is subjected as a personal failure.

She was brought up in an emotionally cold family. Her mother was especially emotionally detached. On top of that, she criticised her when her school performance was not up to the expectations or generally when she was not successful in other activities. Sometimes she even punished her physically. She also had a habit of belittling her verbally. Her older sister was her mother’s favourite because she was a better student and generally seemed more of an achiever in a number of ways. Her mother habitually compared her to her sister, a success-oriented person. She feels she had a better relationship with her seductive father and that uspješne karijere, u njezinoj dobi od 7 godina je počinio samoubojstvo. To ju je izuzetno pogodilo i nakon toga smatra da više nije mogla vjerovati muškarcima. Obitelj je imala oskudnu komunikaciju izvan vlastitog obiteljskog sustava, držali su se kao da vrijede više od ostalih. To je majka često znala isticati, a nakon očeve smrti komunikacija se još više prorijedila. Nije ostvarivala emocionalne veze sa suprotnim spolom zbog toga što smatra da im se ne može vjerovati. Udala se na drugoj godini fakulteta, nakon što je ostala trudna s kolegom s godine. Veza je započela na jednom tulumu i završila njenom trudnoćom, koju je teško prihvatila, kao i brak, koji je trajao svega nekoliko mjeseci. Prekinula je studij politologije, htjela je biti novinarka. Prebacila se na studij upravnog prava, koji je uspješno završila i zaposlila se. Studij politologije je nastavila nakon što je sin odrastao.

Otvoreno izražava hostilnost prema muškarcima, govori da su oni osobe kojima se ne može vjerovati, ali unatoč toga ostvaruje odnos na odjelu s jednim pacijentom. Sa sinom ima izrazito hladan odnos. Tijekom hospitalizacije on ju ne posjećuje dok ona istovremeno traži maksimalni angažman od sestre.

Postavljene su dijagnoze somatizacijskog poremećaja komorbidnog s histroničkim poremećajem ličnosti.

Terapijski ciljevi su bili ograničeni i usmjereni na razvoj mogućnosti introspekcije, stjecanje uvida o utjecaju histrionskog ponašanja na okolinu, učenje toleriranja negativnih emocija, postavljanje jasnih granica u odnosima i redukciju ovisničkog ponašanja. Psihoterapijsko liječenje bilo je moguće započeti tek nakon redukcije početne anksioznosti, histrionskog načina reagiranja i somatizacija. Bolesnica postupno i samo djelomično stječe uvid u psihološku etiologiju svojih smetnji u smislu psihološke nadgradnje. Prihvaća konfliktnu situaciju sa šefom kao jedan od mogućih uzroka za nastanak njezinih tegoba. Nakon otpusta nije došla na do-

she was his favourite. She also feels that this was an additional source of her mother's frustrations. Her mother's relationship with her father, a career-oriented man, was also emotionally cold and detached. Despite her father's successful career, his work contract was terminated abruptly, and he committed suicide when she was seven. This was a devastating experience for her that made her lose trust in men. From then on, she believed she could not trust them. Since a sense of superiority had prevailed in her family, they had not nurtured many relationships outside their family. Her mother had a tendency to emphasize this illusory superiority and after her father's death, communication outside the family became even rarer. She did not engage in emotional relationships with the opposite sex because she firmly believed that men could not be trusted. She married when she was a sophomore, after becoming pregnant by a fellow student. Their relationship started at a party and ended with her pregnancy. She struggled to come to terms with her pregnancy, as well as her short marriage that ended after several months. She dropped out of the Faculty of Political Sciences. She wanted to become a journalist. She enrolled in the Public Administration College from which she graduated successfully and found a job immediately after. When her son grew up, she returned to the University and finished her studies.

She does not hesitate to show her hostility towards men openly, to say they cannot be trusted. However, she starts a relationship with a patient in the same ward. Her relationship with her son is emotionally cold. He does not come to the hospital to visit her. At the same time, while at the hospital, she demands a maximum involvement from her sister in her treatment.

She is diagnosed with a somatization disorder comorbid with a histrionic personality disorder.

The treatment goals are limited to and focused on the development of her introspection potential, as well as on raising awareness about the histrionic behaviour's impact on the environment. In addition, the goal is to learn skills to tolerate negative emotions, to learn to create healthy boundaries in relationships and to reduce addictive behaviours. The psychiatric treatment starts after reducing the govorenu kontrolu, tek je naknadno došla na jedan (ujedno i posljednji) kontrolni pregled.

RASPRAVA

Unatoč histrionskoj strukturi ličnosti, koja se na razvojnom kontinuumu kod pacijentice nalazila u području granične organizacije ličnosti, funkcionirala je na relativno zdravoj razini sve do doživljene narcističke povrede, nakon koje je razvila somatizacije i disfunkcionalnost (10). Histrionska obilježja njezine ličnosti su se očitavala u sklonosti teatralnosti, dramatizaciji, preuveličanom izražavanju osjećaja, površnoj i labilnoj afektivnosti, traženju pažnje, neadekvatnoj zavodljivosti, egocentričnosti, priželjkivanju priznanja, lakoj povredljivosti i samougađanju uz manipulativno ponašanje prema okolini.

Osobe s histrionskom organizacijom ličnosti imaju teškoće u self-percepciji sebe i drugih (doživljavanje sebe i drugih na stabilan, integriran, kompleksan i ispravan način), interpersonalnim odnosima (uspostavljanju stabilnih emocionalnih veza i odnosa), afektivnoj regulaciji, testiranju realiteta te imaju krhku ego i superego integraciju uz korištenje nezrelih obrambenih mehanizama osobito u stresnim situacijama (12). Takve osobe su preokupirane temama spola, seksualnosti i moći te nesvjesno na sebe gledaju kao na slabe, manjkave, obezvrijeđene, a osobama suprotnog spola zavide i vide ih kao moćne i prijeteće (13).

Dosta je istraživanja posvećeno histrionskom poremećaju ličnosti u kojem su obrasci ponašanja relativno dobro poznati i definirani. Etiologija samog poremećaja ostaje do kraja nerazjašnjena, a terapijske mogućnosti su ograničene (14).

Postoji nekoliko teorija o razvoju histrionskih crta ličnosti: neurokemijske (hiperaktivnost autonomnog živčanog sustava kao uzrok afektivne nestabilnosti), biosocijalne (naučeno

level of anxiety, histrionic behaviour responses and somatizations. The patient gradually and only partially gains insight into the psychological etiology of her condition where the constitution of the psychological superstructure is concerned. She recognizes the conflict with her boss as a possible underlying cause of her condition. After being discharged from the hospital, she does not show up for her scheduled follow-up. Subsequently, she shows up for a control visit that was also her last visit.

DISCUSSION

Notwithstanding the histrionic personality structure that was in the category of borderline personality organization along the developmental continuum, the patient functioned relatively well until the conflict with her boss, which she experienced as a narcissistic injury. Only then did she start somatising and her performance of expected occupational and social roles was compromised (10). The traits of her histrionic personality were visible in her tendency to be theatrical, to dramatize, to overplay emotions, to display shallow and labile affect, to seek attention, to act seductively in inappropriate situations, to be self-centred, and to seek gratification, as well as in her vulnerability, her self-indulgence and her inclination to be manipulative.

Persons with a histrionic personality organization frequently struggle with the accuracy of their self-perception and their perception of other people (namely, their perception of themselves and other people in a stable, integrated, complex, and accurate way), with interpersonal relationships (keeping stable emotional relationships) and also with affect regulation and reality testing. Furthermore, the integration of their egos and superegos is fragile and they are inclined to use immature defence mechanisms, especially in stressful situations (12). Such persons are preoccupied with topics of gender, sexuality and power and unconsciously perceive themselves as weak, defective, worthless. At the same time, they envy persons of the opposite sex and perceive them as powerful and dangerous (13).

Although a number of studies identify and elaborate on behavioural patterns of histrionic per-ponašanje – ispunjenje želja manipulativnim ponašanjem), sociokulturne (češće kod naroda koji teže izravnom iskazivanju emocija) i psihodinamsko-razvojne teorije (14). Prema psihodinamskim objašnjenjima glavni etiološki čimbenici su: "odsutnost majke" - hladnoća i osuda u odnosu, zavodljiva očinska figura, visoka razina stresa tijekom odrastanja, nepovoljna seksualna klima – izrazito stimulirajuća ili pak ozračje koje uči potiskivati seksualnost, izmjena uloga – poticaj da dijete preuzme roditeljsku ulogu i socijalna izolacija – traženje gratifikacija unutar obitelji (15,16). Osobe sa značajnim histrionskim crtama često imaju prisutan strah od iskazivanja pravih emocija od kojih se brane nezrelim obrambenim mehanizmima: potiskivanjem, poricanjem, disocijacijom, premještanjem i racionalizacijom (17). S psihodinamskog aspekta kod pacijentice nalazimo opisane karakteristike u njezinoj razvojnoj anamnezi koje se odnose na obilježja histrionskog poremećaja ličnosti. Svoje istinske osjećaje je potiskivala, imala je nesvjesnu želju za dobrom majkom, koja bi se konfrontirala s očevom seduktivnošću. Kod takvih osoba, kao i pod pacijentice, prema Johnsonu (15) na libidinoznoj strani često postoji nesvjesno rivalstvo, strah od osvete, žudnja za novim ocem, novim muškarcem koji će preuzeti brigu o njoj i spasiti je. Na anti-libidinoznoj strani otac je često doživljen kao zavodnik i oskvrnitelj, razvratan i pokvaren. Postoji ogromna nesvjesna hostilnost prema muškarcima zbog osjećaja eksploatiranosti. Ovaj osjećaj hostilnosti i mržnje je u osnovi zdrav i proizlazi iz libidinoznog selfa, dok je na anti-libidinoznoj strani selfa doživljen kao tajni odnos što rezultira u histeričnim osjećajima da je učinjeno nešto loše, odnosno osoba se doživljava zavodnicom. Iako, bolesnica govori o muškarcima kao osobama kojima se ne može vjerovati, prema kojima izražava verbalnu agresiju, traži gratifikaciju u odnosima s muškarcima o kojima razvija neku vrstu ovisničkog odnosa. Njezini odnosi su površni jer kontakt nije siguran. Odnos sa šefom je bio

sonality disorder, the etiology of the disorder still remains unexplained, and therapeutic approaches limited (14).

There are several theories relating to the development of the histrionic personality traits: the neurochemical theory (the hyperactivity of the autonomous nervous system as a cause of affective instability), the biosocial theory (learned behaviour – manipulation as a model of getting what they want), the sociocultural theory (more common among cultures that value uninhibited display of emotions) and the psychodynamic developmental theory (14). According to the psychodynamic explanation, the main etiological factors are: the "absent mother" – emotionally cold and judgemental mother; a seductive father figure; a high level of perceived stress in formative years; an unsupportive sexual climate in the family of origin (especially stimulating or, in contrast, an environment teaching a repressive approach towards sexuality); encouragement of a child to take on a parenting role; and social isolation – seeking gratification within the family (15,16). Persons with strongly pronounced histrionic personality traits are commonly reluctant to express their true emotions and are inclined to use immature defence mechanisms (namely repression, denial, dissociation, displacement and rationalization) to block them (17). From the psychodynamic point of view, the above-mentioned traits of the histrionic personality were identified in the developmental history of the patient, notably her tendency to repress her true feelings, her subconscious yearning for a "good" mother that would stand in the way of her father's seductiveness. According to Johnson (15), unconscious rivalry, fear of revenge, yearning for a new father, a new man that will take on responsibility for her and save her are common traits on the libidinal side of persons with histrionic personality disorder and this was also true for the patient. On the antilibidinal side, such persons/patients often experience their fathers as seducers and sacrilegists, as well as corrupt and perverse persons. Additionally, since these patients feel they have been victims of abuse, there is an unconscious heightened sense of hostility in them directed towards men. In its core, this feeling of hostility and hatred is healthy. It infantilan i po ovisničkom modelu s transfernom relacijom idealizirane očinske figure. Njezin seksualni život je konfliktuozan, a odnos s muškarcima je manipulativan.

Narcistička povreda događa se kada osoba s narcističkim obilježjima doživi da je njezin „pravi self" otkriven, što je prijetnja samopoštovanju i vrijednosti osobe s narcističkom strukturom (18-20). Traumatsko iskustvo u komunikaciji sa šefom pacijentica je doživjela kao narcističku povredu. Njezina nemogućnost suočavanja s narcističkom povredom selfa, s obzirom na njezinu primarnu strukturu ličnosti karakteriziranu histrionskim poremećajem, dovela je do somatizacija kao načina rješavanja problema.

Osobe koje imaju izražena narcistička obilježja u svojoj strukturi ličnosti, pokušavaju održati idealiziranu sliku o sebi kao nepobjedivoj osobi i perfekcionistu te takvu sliku nastoje projicirati prema drugim osobama. Njezina se idealna slika o sebi „raspala" nakon reakcije nadređenoga što je dovelo do gubitka sigurnosti, jer je izgubila kohezivnost slike o sebi, koja se temeljila na njezinom krhkom samopoštovanju i osjećaju nesigurnosti, od kojega se branila potrebom za divljenjem i nedostatkom empatije za druge zbog infantilnog osjećaja vlastite važnosti. Njezin odnos s majkom je bio traumatičan (hladna, emocionalno odsutna i kritizirajuća majka, koja ju je fizički kažnjavala i verbalno omalovažavala), dok ju je otac kojega je doživljavala bliskim zbog njegove seduktivnosti, i kojem se divila razočarao počinivši samoubojstvo. Narcističke obrane (svjesno poricanje, projekcija, nesvjesna represija, distorzija) koje uključuju preuveličavanje ili umanjivanje, racionalizaciju, ovisničko ponašanje i traženje pomoći od osoba koje će podržati njihov iskrivljeni pogled na svijet, rascjep (engl. *splitting*), gdje se ljudi i situacije vide kao dobri ili loši, odnosno u crno bijelim pojmovima) razvijaju se kako bi se sačuvali idealizirani aspekti selfa i porekla ograničenja koja u poza-

arises from the libidinal-self. However, at the same time, the antilibidinal-self feels that it is engaged in a "forbidden" relationship. This triggers hysterical feelings, feelings driven by a sense that something unacceptable has been done. In other words, this person experiences him/herself as a seducer. While the patient talks about men as persons that are not to be trusted and displays aggression verbally, she seeks gratification in her relationships with men and even develops a form of addictive behaviour. Her relationships with men are superficial because she feels vulnerable. Her relationship with her boss was infantile. She created paternal transference by turning her superior into an idealized father-figure. Her sexual life was marked by conflict and her approach to men manipulative.

A narcissistic injury happens when a narcissistic person feels that their "true self" has been disclosed. Such a disclosure represents a direct threat that has the potential to undermine narcissistic self-respect and self-worth (18-20). The patient experienced the traumatic telephone conversation with her superior as a narcissistic injury. Since the histrionic personality behaviour was a trait of the patient's primary personality structure, her inability to accept and resolve the narcissistic injury triggered somatization as a mode of managing the problem.

Persons with pronounced narcissistic characteristics in their personality organization struggle to preserve their idealized indestructible and perfect self-representations and they have a tendency to project them onto other people. Her ideal self-representation became fragmented when her superior reacted in such an abrupt way that she lost cohesiveness of her self-representation, which was built on low self-esteem and fragile sense of security from which she defended herself by seeking attention and admiration and by failing to show compassion because of a prevalent infantile sense of self-importance. Her relationship with her mother was traumatic (her mother was emotionally cold and detached, overly critical and did not refrain from punishing her physically and abusing her verbally) while her seductive father, with whom she was close, betrayed her when he committed suicide. Narcissistic defence mechanisms dini imaju često svjesne ili nesvjesne osjećaje srama i krivnje (18,21).

Konflikt sa šefom je bio dodatno traumatizirajuće iskustvo za nju s obzirom da ga je idealizirala, kao i oca. Njezina vrijednost reakcijom šefa je bila dovedena u pitanje, osjetila se bezvrijednom, s obzirom na njeno krhko samopoštovanje, koje je ranjivo i na najmanju dozu kriticizma. Njezina se fragilna idealizirana slika o sebi kao perfektnoj osobi fragmentirala, odnosno raspala u komadiće i od emocionalne boli izazvane narcističkom povredom se obranila somatizacijama (9-11) koje su dovele do somatizacijskog poremećaja. Prema psihodinamskim objašnjenjima tjelesni simptomi su odraz mentalnog stresa i imaju simboličku vrijednost. Kod pacijentice od tjelesnih simptoma najizraženija je bila „akustička trauma" (oglušila je nakon šefova omalovažavanja čime na simboličan način više ne čuje ono što ne može prihvatiti). Somatizacijama se je obranila od neprihvatljivih self-objektnih reprezentacija i ujedno „razriješila" nesvjesni konflikt povezan s rascjepom na dobre i loše self-objektne reprezentacije (18). Dodatno je mogući izvor njezine velike anksioznosti prigodom prijama bilo okretanje agresije prema sebi u obliku autodestrukcije zbog identifikacije s ocem koji je doživio profesionalni neuspjeh nakon kojega je počinio samoubojstvo. Njezina velika narcistička investicija bila je u profesionalni self, i u tom segmentu svojega identiteta je najbolje funkcionirala, koji je destruiran reakcijom šefa i njezinim mogućim doživljajem da ne valja ni u ovome segmentu svojega identiteta u kojega se najviše investirala.

Somatski simptomi su psihološka obrana protiv mentalne nestabilnosti i kao drugi mehanizmi obrane, somatizacija smanjuje intrapsihički distres (22). Ovo se još naziva i primarna dobit (2) koja služi da održi psihološki ekvilibrij, ali se pri tome iskrivljuje i narušava realnost. Pažnja se usmjerava na simptome koji se prezentiraju i stvarni problem, odnosno izvor mental-

(e.g. conscious denial, projections, unconscious repression, distortion), including exaggeration or undermining, rationalization, addictive behaviour and an inclination to seek help from people that will, most likely, support her distorted views, splitting (polarization of people and situations into good-bad, black-white) develop as a defence system to protect idealized aspects of self and to deny limitations often related to conscious or unconscious feelings of shame and guilt (18,21).

The conflict with her superior was especially traumatizing since she idealized him in the same way she idealized her father. Not only did her boss' reaction jeopardize her sense of self-worth, but since her fragile, vulnerable, and sensitive self-esteem was as insubstantial as a house of cards, she now felt worthless. Her fragile idealized self-representation, an image of a perfect person, became fragmented, it broke into pieces, and somatizations became the first line of defence against emotional distress inflicted by the narcissistic injury (9-11). Consequently, she developed the somatization disorder. According to the psychodynamic explanation, physical symptoms are symbolic manifestations of mental distress. In our case study, the "acoustic trauma" ("hearing loss as a consequence of her boss' reaction" symbolically represents her inability to hear things she cannot accept) was the most prevalent physical symptom. Her somatizations became defence mechanisms against unacceptable self-object representations and also a way for her to "resolve" the subconscious conflict relating to splitting the self-object representations into good and bad (18). In addition, it is possible that her self-destruction (possibly a result of identification with her father whose suicide was a consequence of his inability to accept his professional failure) triggered heightened anxiety at the moment of hospitalization. Her professional-self was her major narcissistic investment and a segment of her identity that functioned the best. However, her boss' reaction may have made her realize that she was "no good" even in the segment of her identity that was her major narcissistic investment and that she felt most confident about.

Somatic symptoms represent psychological defence mechanisms against mental instability. Simne nestabilnosti je blokiran i ne bude stvarno doživljen ili je doživljen samo djelomično (21). Pacijentica nije mogla prihvatiti psihološku odnosno emocionalnu podlogu svojih tegoba te je tijekom dvije godine odlazila na brojne tjelesne pretrage. Na aktualnu hospitalizaciju je došla na nagovor sestre nakon brojnih negativnih tjelesnih nalaza.

Jednom kada se simptom ili simptomi pojave mogu se svjesno koristiti da se postignu optimalne interpersonalne koristi i to se naziva sekundarnom dobiti (2). U somatizaciji je osnova psihički poremećaj, koji je prijetnja mentalnoj stabilnosti i prijetnja mentalnom integritetu, i koji dovodi do anksioznosti koja između ostaloga mobilizira somatizaciju kao obrambeni mehanizam (17,23). Ovaj proces je nesvjestan, a somatske obrane dovode do neorganskih tjelesnih (somatskih) simptoma i konvertiraju psihičku, odnosno emocionalnu bol u tjelesnu. Takve osobe „koriste“ svoje somatske simptome u interpersonalnim postignućima da dobe najviše što mogu od svojih smetnji i to predstavlja sekundarnu psihološku dobit (pacijentica je zadobila sestrinu pažnju, koja ju je u protekle dvije godine stalno obilazila i pomagala u organizaciji pretraga, ali i svakodnevnog života). Ovakvi pacijenti se osjećaju i vjeruju da su bolesni i nisu svjesni svojeg bazičnog psihičkog poremećaja ili traumatskog psihološkog iskustva, odnosno motivacije koja pobuđuje simptome. Oni isto tako nisu svjesni da su njihovi simptomi lažni (1) i najčešće reflektiraju pacijentovo shvaćanje koncepta bolesti tako da često puta opisi simptoma budu bizarni i atipični (bolesnicu “boli i peče mozak”, posebno oko lijevog uha, navodi “užasnu” fotofobiju, strašno joj se povraća, ima neizdrživu bol koja se spušta niz kralješnicu, kočenje u vratu, ne spava tjednima, itd.).

Postavljeni terapijski ciljevi kod pacijentice tijekom hospitalizacije su bili vrlo ograničeni zbog visoke razine njezine anksioznosti, koja je bila preplavljujuća.

ilar to other defence mechanisms, somatization reduces intrapsychic distress (22). This phenomenon is also called a primary gain (2) that serves as an agent sustaining the psychological equilibrium. However, this equilibrium comes at a price – a distorted reality. Attention becomes focused on the reported symptoms and, consequently, the actual problem or the source of mental instability and distress is blocked, and the person is unable to experience the stressful event, or they experiences it only partially (21). Since the patient could not accept the psychological (emotional) cause of her physical illness, she subjected herself to a number of medical examinations over the course of 2 years. However, medical examinations and screenings failed to establish a connection between her symptoms and an organ impairment, so her sister insisted on psychiatric help and her insistence made the patient agree to be hospitalized.

The moment a symptom or symptoms appear, they can be consciously used for optimal interpersonal gain, also known as a secondary gain (2). Intrapsychic distress is the root cause of somatization. It is a psychological condition that represents a threat to the mental stability and integrity of a person. It triggers anxiety that, among other things, unconsciously mobilizes somatization as a defence mechanism (17,23). Furthermore, somatic defence mechanisms trigger physical (somatic) symptoms and convert psychological (emotional) pain into physical illness. People diagnosed with somatization disorder have a tendency to “use” their somatic symptoms for their interpersonal gain in order to attain as much as possible from their physical illness. This represents a secondary gain (the patient attracted her sister's attention; over the course of 2 years her sister visited her regularly, helped her organize medical examinations and also assisted her in her everyday life). Such patients do not feel physically well, and they honestly believe they are sick. Simultaneously, they are not aware of their primary psychological condition, the traumatic psychological experience or, in other words, they are not aware of the underlying psychological motivators of the physical symptoms. Similarly, they are not aware that their symptoms are false (1) and that they, most commonly, reflect the patient's understanding of the concept of illness. Consequently, descriptions

Neliječeni pacijenti često postanu ogorčeni, ljuti, nepovjerljivi, "zakazuju" u svakodnevnim aktivnostima. Prigodom liječenja je važno identificirati točan uzrok, tj. okidač (engl *trigger*) koji je doveo do nastanka poremećaja i važno je suočiti pacijenta s psihološkom i emocionalnom etiologijom tegoba. Postoje različite terapijske mogućnosti, iako često s vrlo ograničenim rezultatima. Vrlo često je potrebna psihofarmakološka terapija s obzirom na visoki stupanj anksioznosti, ali i komorbidnih anksioznih i depresivnih poremećaja (pacijentica je dobivala anksiolitik i antidepresiv) (1,8). Što se tiče psihoterapijskog liječenja ono može biti: etiološko s psihodinamskim (17) i integrativno-psihoterapijskim pristupom (24), koji su usmjereni na rješavanje emocionalnih konflikata u podlozi somatizacije ili simptomatsko, najčešće kognitivno-bihevioralni pristup (25), koji je usmjeren na identificiranje negativnih misli, rad na impulzivnom ponašanju, učenje vještina rješavanja problema. Dodatne terapijske mogućnosti su uključene u grupni psihoterapijski rad (26,27).

Teškoće u verbaliziranju emocija, razlikovanju između tjelesnih senzacija i različitih emotivnih stanja, zbunjenost i frustracija kada se pokušava razgovarati o emocionalnom doživljavanju zbog aleksitimičnih karakteristika (28,29) čine komunikaciju s ovim pacijentima otežanom i napornom. Odsustvo simboličkog razmišljanja i siromaštvo fantazija izraženi su do te mjere da kod terapeuta kontratransferno uzrokuju osjećaj praznine i dosade.

S obzirom na česte somatizacije ove osobe nerijetko prolaze niz nepotrebnih medicinskih pretraga uzrokujući frustraciju liječnika i medicinskog osoblja. U većini slučajeva psihoanalitički orijentirana psihoterapija ne dovodi do poboljšanja tako da se kod ovih pacijenata mogu, pored suportivne psihoterapije, kombinirano koristiti različiti terapijski postupci poput kognitivno-bihevioralnih postupaka, metoda primijenjene psihofiziologije (engl.

of symptoms are often bizarre and atypical (e.g. the patient's "brain burns and aches", especially in the area of the left ear, she also describes "unbearable" photophobia, she feels like vomiting, an excruciating pain is spreading down her spine, her neck is stiff, she does not sleep for weeks, etc.).

In the case of the patient, identified therapeutic goals during hospitalization were limited due to prevalent heightened anxiety.

It is common for untreated patients to feel bitter, angry, distrustful and not be capable of running everyday errands. Where treatment is concerned, it is important to identify the accurate cause – the trigger that caused the problem in the first place. Furthermore, it is of greatest importance for patients to be confronted with the psychological and emotional etiology of their problems. A number of therapeutic approaches are available, but the results attained are often limited. Most commonly, therapeutic approaches include psychopharmacological therapy to decrease heightened anxiety, but also to treat comorbid anxiety and depressive disorders (the patient was prescribed anxiolytics and antidepressants) (1,8). Where psychotherapeutic treatment is concerned, there are various approaches: etiological combined with psychodynamic (17) and integrative-psychotherapeutic approach (24), aimed at solving underlying emotional conflicts that trigger somatizations. Another possibility is a symptomatic cognitive-behavioural approach (25) aimed at identifying negative thoughts, modifying impulsive behavioural patterns, learning problem-solving skills. Additionally, a group-work approach is also recommended (26,27).

The alexithymic traits (28,29) of somatising patients, namely difficulty in articulating and identifying feelings and distinguishing between feelings and the bodily sensations, as well as confusion and frustration that arise in conversations focused on their emotional experience make communication with patients difficult and demanding. A lack of symbolic reasoning and restricted imagination are so pronounced that, countertransferentially, the therapist may begin to feel emptiness and boredom.

As a consequence of frequent somatizations, somatising patients commonly subject themselves *biofeedback*), autogenog treninga, farmakološkog tretmana, uključujući i modificirane oblike psihodinamske psihoterapije. Grupna terapija može biti dobra alternativa ili dodatak individualnoj psihoterapiji. U tretmanu primarne aleksitimije, ali i osoba s aleksitimičnim karakteristikama, koje se javljaju i kod somatoformnih poremećaja, prisutna je nesposobnost prepoznavanja i izražavanja emocija, stoga se mogu primijeniti razni oblici suportivne psihoterapije dok se za sekundarnu aleksitimiju može koristiti modificirana psihodinamska psihoterapija (28,30).

U zaključku se može reći da je pravovremeno prepoznavanje somatizacija, kao psihološke obrane od emocionalnog distresa, nužno zbog izbjegavanja nepotrebnih dijagnostičkih postupaka i preveniranja socijalne, radne i drugih oblika disfunkcionalnosti takvih osoba, a ujedno i ublažavanja njihovih patnji.

to a number of unnecessary medical examinations. This can trigger frustration in physicians and medical personnel. In most cases, psychoanalytically oriented psychotherapy does not yield positive results. This is why medical professionals combine supportive psychotherapy with various therapeutic approaches, namely, the cognitive-behavioural approach, applied psychophysiology (e.g. *biofeedback*), autogenic training, pharmacologic treatment, and modified forms of psychodynamic therapy. In this particular segment, group therapy represents an acceptable alternative or addition to individual psychotherapy. Since difficulties in identifying and describing feelings often mark the treatment of the primary alexithymia, as well as the treatment of persons with alexithymic personality traits that are also common in the so-called somatoform disorders, it is advisable for medical professionals to use various modes of supportive psychotherapy. Modified psychodynamic psychotherapy (28,30) is recommended for the treatment of secondary alexithymia.

In conclusion we can say that timely identification of somatization as a defence mechanism against intrapsychic distress is necessary to avoid unnecessary diagnostic procedures and to prevent compromised performance of the patient's social and occupational roles and to alleviate their suffering in the process.

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Školska fobija – kad strah drži djecu daleko od škole, uz prikaz slučaja i terapijskog tretmana

/ *School Phobia - When Fear Keeps Children Away From School*

Ljubica Paradžik[1], Iva Zečević[1], Ana Kordić[1], Vlatka Boričević Maršanić[1,2], Nela Ercegović[1], Ljiljana Karapetrić Bolfan[1], Davorka Šarić[1]

[1]Psihijatrijska bolnica za djecu i mladež, Zagreb, [2] Sveučilište Josipa Jurja Strossmayera u Osijeku, Medicinski fakultet, Osijek, Hrvatska

/ [1]*Psychiatric Hospital for Children and Adolescents, Zagreb,* [2]*Josip Juraj Strossmayer University of Osijek Medical School, Osijek, Croatia*

Školska fobija nije posebna dijagnoza, već klinički entitet koji uključuje anksioznost i izbjegavajuće ponašanje povezano s odlaskom ili boravkom u školi, koje se može javiti bilo kada tijekom školovanja. Najčešće se radi o separacijskoj ili socijalnoj anksioznosti, mada odbijanje pohađanja škole može biti povezano i s drugim emocionalnim poremećajima u djece i adolescenata kao što su generalizirani anksiozni poremećaj, panični poremećaj ili depresija. Osim što remeti funkcioniranje obitelji, školska fobija ima i ozbiljne posljedice na školski uspjeh i socijalne odnose školarca te može biti vrlo težak poremećaj u djetinjstvu. U diferencijalnoj dijagnostici važno je školsku fobiju razlikovati od poremećaja ponašanja s namjernim izostajanjem iz škole te antisocijalnim ponašanjima (krađa, laganje i dr.) i tendencijom zabavi. Važno je započeti tretman što ranije kako dijete ne bi zaostajalo sa školskim gradivom, gubilo vezu s vršnjacima, dobivalo pažnju roditelja ostajanjem kod kuće. U liječenju je potreban multidisciplinaran pristup koji uključuje suradnju psihijatra i/ili psihologa, roditelja, stručnih djelatnika škole, liječnika obiteljske ili školske medicine i prema potrebi centra za socijalnu skrb ako se radi o dugotrajnom izostanku iz škole ili problemima u funkcioniranju obitelji. Liječenje školske fobije zahtijeva primjenu različitih terapijskih postupaka u okviru multimodalnog pristupa: psihoedukacijom roditelja, individualnu psihoterapiju (analitičku ili kognitivno-bihevioralnu), grupnu terapiju i obiteljsku psihoterapiju ovisno o težini poremećaja i uzrocima njegovog nastanka. U težim slučajevima koji ne reagiraju na psihoterapijsko liječenje primjenjuju se i lijekovi iz skupine antidepresiva i anksiolitika.

U radu su prikazane suvremene spoznaje školske fobije te liječenje kognitivno bihevioralnim terapijom uz prikaz jednog kliničkog slučaja.

/ School phobia is not a separate diagnosis, but a clinical entity that includes anxiety and avoidance behaviour related to either going to or staying in school, which may appear at any time during education. In most cases it is a manifestation of separation or social anxiety, although refusal to attend school may also be related to other emotional disorders in children and adolescents, such as generalized anxiety disorder, panic disorder or depression. Besides disrupting the normal functioning of a family, school phobia has serious negative consequences on a child's education and social relations, and as such may be a very complicated childhood disorder. In differential diagnosis it is important to differentiate school phobia from truancy, antisocial behaviour (stealing, lying, etc.) and engaging in fun activities. Early treatment is important in order to minimize the child's falling behind in school, losing contact with other children and getting extra attention from parents by staying at home. Treatment requires a multidisciplinary approach that includes the cooperation of a psychiatrist and/or psychologist, parents, school staff, a physician and social services in case of long-term absence from school or dysfunctional family surroundings. A multimodal treatment approach combining various techniques is required: the psychoeducation of parents, individual psychotherapy (psychoanalytic or cognitive-behavioural), group therapy and family psychotherapy depending on the severity and causes of the disorder. In severe cases that do not respond to psychotherapy, antidepressant and anxiolytic medications can be prescribed. This paper presents recent findings on school phobia and treatment with cognitive-behavioural therapy, and one clinical case.

ADRESA ZA DOPISIVANJE / *ADDRESS FOR CORRESPONDENCE:*
Prim. Ljubica Paradžik, dr. med.
Psihijatrijska bolnica za djecu i mlade
Ulica I. Kukuljevića 11
10 000 Zagreb, Hrvatska
E-pošta: ljubica.paradzik@djecja-psihijatrija.hr

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UVOD

Školska fobija je iracionalni strah ili anksioznost povezana s odlaskom u školu ili boravkom u školi na nastavi (1). Karakteristično je da dijete izbjegava odlazak u školu povremeno ili stalno, ne želi krenuti u školu, krene pa se vrati ili ne može izdržati do kraja nastave. Dijete se može izrazito uznemiriti i na samu pomisao odlaska u školu te ostaje kod kuće s roditeljima u vrijeme kada treba biti u školi.

Nepohađanje škole zbog straha odnosno emocionalnih razloga za razliku od delinkvencije prvi puta je opisao Broadwin 1932. godine (2), a naziv školska fobija su prvi put upotrijebili Johnson i sur. 1941. godine (3) opisujući strah od škole uzrokovan anksioznošću djeteta zbog separacije od majke.

Školska fobija nije posebna dijagnoza u klasifikacijama psihičkih poremećaja (4), već je dio kliničke slike najčešće emocionalnih (internaliziranih) poremećaja u djece i adolescenata kao što su anksiozni poremećaji i depresija. Odbijanje odlaska ili boravka u školi nastaje najčešće zbog anksioznosti vezane uz separaciju od roditelja ili bliskih osoba, ili averzivnih situacija u školi vezanih uz socijalne situacije kao što su interakcije s vršnjacima/učiteljima i profesorima; ili ispitne situacije. Školska fobija može nastati i zbog pozitivnog pokrepljenja neodlaska u školu načinima kao što su gledanje televizije, igranje videoigara ili pažnja roditelja koju dijete dobiva dok nije u školi. Djeca

INTRODUCTION

School phobia is an irrational fear or anxiety associated with going to school or staying in the classroom (1). It is typical for a child to avoid going to school, whether periodically or permanently, it does not want to go to school, goes to school, but then returns home, or cannot stay in the classroom until the end of the class. A child can be extremely upset even thinking about going to school and stays at home with its parents during school time.

School non-attendance caused by fear or emotional reasons, and not by delinquency, was first described by Broadwin in 1932 (2), and the name "school phobia" was first used by Johnson et al. in 1941 (3), describing fear of school caused by child anxiety due to the separation from the mother.

School phobia is not a separate diagnosis in psychological disorders classifications (4) but it is a part of the clinical features of the most common emotional (internalized) disorders in children and adolescents, such as anxiety disorders and depression. The rejection of going to or staying in school is most commonly caused by anxiety related to separation from parents or close people, or aversive social situations such as peer/teacher interactions or exam situations. School phobia can also arise by positive reinforcement of school non-attendance such as watching television, playing video games or parents' attention when a child is not in school. Children do not ne iskazuju antisocijalna ponašanja (krađa, laganje i dr.) po čemu se školska fobija razlikuje od poremećaja ponašanja. Školsku fobiju potrebno je razlikovati i od izostanaka iz škole zbog tjelesne bolesti, obiteljskih ili socijalnih razloga (putovanje, financijski problemi, zanemarivanje, bježanje zbog zlostavljanja i dr.) (5, 6).

Većina školske djece povremeno želi ostati kod kuće. Razlika od ove normalne razvojne tendencije i ozbiljne školske fobije je u trajanju izostanka iz škole. O školskoj fobiji se govori ako dijete izostaje iz škole zbog emocionalnih razloga duže od dva tjedna. Akutna školska fobija podrazumijeva izostanak iz škole do godine dana i češće se javlja u mlađe djece nakon značajnijih promjena u obiteljskoj sredini (1). Kronična školska fobija odnosi se na nepohađanje škole duže od godine dana, češće se javlja u adolescenata i zahtjevnija je za liječenje (1).

Osim što remeti funkcioniranje obitelji, školska fobija ima niz kratkoročnih i dugoročnih posljedica. Kratkoročne posljedice su slabiji školski uspjeh i poteškoće u socijalnim odnosima školarca. Dugoročne posljedice mogu biti školski neuspjeh, ranije napuštanje školovanja, nezaposlenost, poteškoće socijalnog funkcioniranja, problemi u interpersonalnim odnosima i braku te povećani rizik od psihijatrijskih bolesti u odrasloj dobi. Zbog svega navedenog školska fobija može biti vrlo težak poremećaj u djetinjstvu, kojem treba ozbiljno pristupiti (7).

EPIDEMIOLOGIJA ŠKOLSKE FOBIJE

Kako školska fobija nije zasebna dijagnoza u klasifikacijama psihičkih poremećaja, a time i kriteriji ovog kliničkog entiteta nisu precizno definirani, u istraživanjima je teško odrediti prevalenciju. Prema nekim istraživanjima čak

express antisocial behaviour (theft, lying, etc.), and, therefore, school phobia differs from behavioural disorders. School phobia also needs to be distinguished from school absence due to physical illness, family or social reasons (travel, financial problems, neglect, abduction, etc.) (5,6).

Most children occasionally want to stay at home. The difference between this normal developmental tendency and serious school phobia is in the duration of school absence. We may speak of school phobia if a child is absent from school because of emotional reasons for more than two weeks. Acute school phobia implies absence from school for up to one year and more often occurs in younger children after significant changes in the family environment. Chronic school phobia refers to school non-attendance for more than a year, and it is more frequent among adolescents and more difficult to treat (1).

Apart from disturbing the way a family functions, school phobia has a number of other short-term and long-term consequences. Short-term consequences can be poorer results at school and difficulties in school and family social relationships. Long-term consequences include school failure, early abandonment of schooling, unemployment, difficulties in social functioning, problems in interpersonal relationships and marriage and increased risk of psychiatric disorders in adulthood (e.g. agoraphobia, anxiety, depression, alcoholism and antisocial behaviour). Unpleasant feelings related to school and aversion to learning and achievement represent the risk of early school dropout (23,24). Because of this, school phobia can be a very difficult childhood disorder that needs a serious approach (7).

SCHOOL PHOBIA EPIDEMIOLOGY

Since school phobia is not a separate diagnosis in psychological disorders classifications, and therefore the criteria of this clinical entity are not precisely defined, it is difficult to determine

28 % djece iskazuje neki oblik izbjegavanja škole u nekom trenutku u životu (1, 8). U svom najblažem obliku školska fobija pogađa između 5 i 10 % djece, a u najtežem obliku pogađa 1 % djece (9).

Školska fobija javlja se podjednako kod dječaka i djevojčica, djece svih razina intelektualnih sposobnosti i socio-ekonomskog statusa (SES) (7). Može se javiti kod svih dobnih skupina, iako nešto češće u dobi od 5-7 godina, i potom 11-14 godine (10).

Međutim, neke demografske karakteristike mogu biti vezane uz određene podtipove školske fobije. Tako su djeca iz obitelji nižeg SES češće anksiozna i u strahu od interakcija s vršnjacima i nastavnicima, dok su djeca iz obitelji višeg SES više u strahu od ispitnih situacija i evaluacije vezano uz ocjenjivanje. Školska fobija zbog separacijske anksioznosti češća je kod djevojčica dok je školska fobija koja se javlja zbog specifične fobije češća u dječaka (11).

Školska fobija se može javiti u maloj školi, osnovnoj školi ili srednjoj školi, a zabilježeno je i javljanje na fakultetu (12). Adolescenti koji razviju školsku fobiju često imaju neke od simptoma i u mlađoj dobi (13). Rano prepoznavanje školske fobije važno je za uspješan tretman (14).

ETIOLOGIJA ŠKOLSKE FOBIJE

Uzroci školske fobije su heterogeni, kao što je i klinička prezentacija. Školska fobija je multifaktorski uvjetovana i rezultat je interakcije genetske predispozicije i nepovoljnih okolnosti u obiteljskoj, školskoj i socijalnoj sredini koje mogu biti u funkciji predisponirajućih, precipitirajućih ili faktora održavanja (15). Teorije učenja naglašavaju značajnu ulogu socijalnog potkrepljenja i modeliranja u nastanku školske fobije (11).

the prevalence in research. According to some studies, 28% of children report some sort of school avoidance at some point in their lives (1,8). In its simplest form, school phobia affects between 5 and 10% of children, and in the most severe form it affects 1% of children (9).

School phobia occurs equally often in boys and girls, in children of all intellectual ability levels and socio-economic status (SES) (7). It may occur at all ages, though somewhat more often at the ages of 5-7, and 11-14 (10).

However, some demographic characteristics may be related to certain subtypes of school phobia. Thus, children coming from families of lower socio-economic status are more often anxious and scared of interactions with peers and teachers, while children coming from families of higher socio-economic status express more fear during exam situations and evaluations related to appraisal. School phobia caused by separation anxiety is more common in girls, while school phobia caused by specific phobia is more common in boys (11).

School phobia can occur in preschool, elementary school, high school and in college (12). Adolescents who develop school phobia often have some of the symptoms at the younger age (13). Early recognition of school phobia is important for successful treatment (14).

SCHOOL PHOBIA ETIOLOGY

The causes of school phobia are heterogeneous, and so is the clinical presentation. School phobia is multifactorially conditioned and is a result of the interaction between genetic predisposition and adverse family circumstances or the environment, and school or social environment that might have the function of predisposing, precipitating or sustaining factors (15). Theories of learning emphasize the important role of social support and modelling in the appearance of school phobia (11).

Modeli nastanka. Četiri su modela pružila moguća objašnjenja za nastanak školske fobije: psihoanalitički, bihevioralni, kognitivni i neurobiološki model.

Prema psihoanalitičkom modelu za nastanak školske fobije odgovoran je odnos između majke i djeteta. Anksiozna majka svojim ponašanjem uzrokuje preveliku ovisnost djeteta o njoj, pri čemu se kod djeteta javlja separacijski strah, a kod njih oboje osjećaj hostilnosti prema onom drugom. Posljedično, dijete razvija potisnutu anksioznost, koja se kasnije manifestira u vidu školske (16).

Prema bihevioralnom modelu uzrok školske fobije je naučena poveznica između škole i neugodnih iskustava. Djeca se uče strahu uparivanjem opasnog objekta ili situacije (npr. socijalna odbačenost od strane vršnjaka) s neutralnim (škola), nakon čega slijedi izbjegavanje objekta (škola) koji prije nije izazivao strah, a sada ga izaziva. Izbjegavanje škole zbog neugodnih iskustava rezultira negativnim potkrepljenjem, jer smanjuje anksioznost i donosi olakšanje, ali jača strah, od škole.

Prema kognitivnom modelu u osnovi nastanka školske fobije su kognitivne distorzije, tj. iskrivljena uvjerenja djece vezana, u ovom kontekstu, uz školu. Ta uvjerenja mogu proizlaziti iz raznih izvora, npr. iz situacije u kojoj je dijete doživjelo neuspjeh (negativna ocjena iz testa), visokih očekivanja roditelja (ako ne uspiju opravdati previsoka očekivanja svojih roditelja), niskog samopouzdanja (mišljenja da nisu dovoljno dobri da bi se družili sa svojim vršnjacima) i sl. Dijete u tim situacijama može nastaviti razmišljati o sebi na distorzirani način: „što ako me danas prozove da ispravim, nisam dovoljno naučio, nisam spreman… nikad ovo neću naučiti… glup sam"; „roditelji će se ljutiti na mene ako ne dobijem pet… mislit će da sam lijen, a ja im neću moći objasniti… neće me voljeti kao prije"; „čak i da sad odem do njih (kolega iz razreda) i počnem razgovor s nekom svojom temom to će im sigurno biti glupo…

Models of origin. Four models provide possible explanations for the appearance of school phobia: Psychoanalytic, Behavioural, Cognitive and Neurobiological.

According to the Psychoanalytic model, the relationship between a mother and a child is responsible for school phobia appearance. An anxious mother, causes the child's dependence on her through her behaviour, by evoking the fear of separation in a child, so they both start to feel hostility towards each other. Consequently, a child develops suppressed anxiety, which is later manifested as school phobia (16).

According to the Behavioural model, the cause of school phobia is a learned link between school and unpleasant experiences. Children learn it by combining a dangerous object or situation (e.g. social disapproval by peers) with neutral stimulus (school), followed by avoiding an object (school) that earlier did not provoke fear and now is causing it. Avoiding school due to unpleasant experiences is the result of negative reinforcement, because it reduces anxiety and brings relief, but consequently causes even greater fear of school.

According to the cognitive model, the underlying phenomenon of school phobia is cognitive distortion, i.e. children's distorted beliefs related to school. These beliefs can usually arise from various sources, for example from a situation where a child experienced failure (a bad test score (F)), its parents' high expectations (if it cannot justify its parents' high expectations), low self-esteem (the child's opinion that it is not good enough to socialize with its peers), etc. In these situations, a child may continue to think about itself in a distorted way: "What if the teacher says that I'll need to correct that bad grade today, I haven't studied enough, I'm not ready; I will never learn this; I'm stupid; My parents will be angry with me if I don't get an A; They will think I'm lazy, and I won't be able to explain this to them; They will not love me like they used to; Even if I meet them (classispast ću budala i smijat će mi se… baš sam čudak" i sl. Kognitivnim distorzijama zajedničko je da ih karakterizira precjenjivanje mogućnosti javljanja i veličine opasnosti te podcjenjivanje osobne sposobnosti suočavanja.

Neurobiološki čimbenici se odnose na genetsku predispoziciju za razvoj anksioznih poremećaja i disregulaciju u neurotransmiterskim sustavima noradrenalina, serotonina i dopamina, te promjene u aktivnosti moždanih regija odgovornih za odgovor organizma na opasnost i stres kao što su amigdala i hipokampus (17).

Uzroci poremećaja. Djeca koja razviju školsku fobiju su vulnerabilnija, nesigurna, ovisna, sklona depresivnom i anksioznom reagiranju u stresnim situacijama. Uzroci njena nastanka, kao što je već spomenuto, su razoliki, a mogu proizlaziti iz osobina djeteta (separacijska i socijalna anksioznost) ili njegove okoline (obiteljska, školska i sl.)

Separacijska anksioznost podrazumijeva primarni strah od odvajanja od roditelja pri čemu je dijete simbiotski vezano uz roditelja. Djetetovo izbjegavanje ili odbojnost prema školi proizlazi iz problema u odnosu s majkom u kojem majka nesvjesno prenosi na dijete vlastitu anksioznost zbog separacije te nehotice potiče djetetovo ovisničko i izbjegavajuće ponašanje (17). Dijete tako ne stječe potreban osjećaj sigurnosti, koji mu omogućava da funkcionira i kad roditelj nije u blizini. Roditelji su hiperprotektivni i djeca u takvim obiteljima slabije razvijaju socijalne vještine.

Socijalna anksioznost karakterizirana je strahom od neuspjeha, bilo u obliku straha djeteta da neće zadovoljiti očekivanja drugih (roditelja, nastavnika) ili da neće ispuniti vlastita visoka očekivanja. Roditelji mogu biti skloni primjeni represivnih odgojnih postupaka (prijetnje, fizičko kažnjavanje).

Obiteljska okolina može biti značajan izvor stresa za dijete koji može rezultirati odbijanjem odlaska u školu. Promjena škole zbog preseljenja

mates) and start to talk about something I like, it will surely be stupid; I'll make a fool of myself and they'll laugh at me; I'm such a weirdo." Cognitive distortions are commonly characterized by overestimating the likelihood of occurrence and magnitude of danger, together with underestimating personal coping skills.

Neurobiological factors refer to genetic predispositions causing the development of anxiety disorders, the development and dysregulation of norepinephrine, serotonin and dopamine, changing the activity in brain regions of amygdala and hippocampus, which are responsible for the body's response to danger and stress (17).

Causes of the disorder. Children who develop school phobia are more vulnerable, insecure, dependent and prone to depressive and anxiety responses in stressful situations. The causes of its appearance, as mentioned above, are distinct and may arise from the characteristics of a child (separation and social anxiety) or its environment (family, school, etc.)

Separation anxiety implies the primary fear of separation from parents, whereby a child is symbiotic with its parents. A child's avoidance or aversion to school arises from the mother's problem, in which she unconsciously transfers her own separation anxiety onto her child and inadvertently encourages the child's addictive and avoiding behaviour (17). In that way, a child doesn't acquire a necessary sense of security, which allows it to function even when the parent is not nearby. Because such parents are hyper-protective, their children are less likely to develop social skills.

Social anxiety is characterized by the fear of failure, either in the fear of a child's failure to meet the expectations of others (parents, teachers) or failure to meet their own high expectations. Parents may be prone to use repressive educational practices (threats, physical punishment).

Family environment can be a significant source of stress for a child that can result in school može biti vrlo teška za djecu, naročito ako dijete nije očekivalo ili željelo promjenu. Stresne situacije u obitelji (kao što su bolest, nesreće i smrt) mogu također dovesti do naglog odbijanja pohađanja škole, koji se može razviti i u kroničnu školsku fobiju, naročito ako se neodlazak u školu potkrepljuje od članova obitelji. Psihopatologija roditelja i maritalni konflikti mogu biti uzrokom školske fobije jer uzrokuju stres kod djeteta i negativno se odražavaju na roditeljstvo te roditelji nisu u mogućnosti ili ne žele pronaći rješenja za problem nepohađanja škole svojeg djeteta. U ovakvim slučajevima u tretman je potrebno uključiti dijete, ali i roditelje, odnosno cijelu obitelj (7).

Školska sredina može također biti stresogeni čimbenik za dijete na različite načine. Ispitne situacije bilo pismene ili usmene, domaće zadaće, pritisak vršnjaka, zlostavljanje vršnjaka, javni nastup situacije su koje mogu kod djeteta dovesti do povišene razine anksioznosti ili straha koji može rezultirati odbijanjem odlaska u školu (7).

KLINIČKA SLIKA ŠKOLSKE FOBIJE

Razvoj školske fobije. Okidač (*trigger*) za javljanje školske fobije mogu biti različite situacije vezane za obitelj ili školu (18). Dijete razvija simptome anksioznosti koji se mogu manifestirati kao trbobolja, mučnina, vrtoglavica, temperatura (19). Zbog tih tjelesnih simptoma roditelj dopušta djetetu da ostane kod kuće. Ostanak kod kuće dovodi do smanjenja anksioznosti čime se negativno potkrepljuje neodlazak u školu i omogućuje razvoj školske fobije. Ako dijete i dobiva pažnju roditelja pojačanom brigom za tjelesno zdravlje, oslobađanje od školskih obveza kod kuće, ugađanje djetetu posebnom prehranom, igrom, neodlazak u školu pozitivno se potkrepljuje što doprinosi održavanju poremećaja.

Školska fobija može se manifestirati prikriveno ili otvoreno. Mlađa se djeca najčešće žale na somatske simptome (vrtoglavica, ošamućenost,

refusal. Changing school due to relocation can be very difficult for a child, especially if the child did not expect or want that change. Stressful family situations (such as illness, accidents and death) may also lead to a sudden rejection of school attendance, which can also turn into chronic school phobia, especially if school avoidance is being reinforced by family members. Parental psychopathology and marital conflicts may induce school phobia because they stress the child, which reflects negatively on parenting itself. In that way, parents are unable or unwilling to find solutions to the problem of school non-attendance. In such cases, treatments should involve both the child and its parents, or even the whole family (7).

School environment may also be a stressful factor for a child in different ways. Exam situations, either written or oral, homework, peer pressure, peer abuse, public appearance; these are all situations that can lead to an increased level of anxiety or fear that may result in school refusal (7).

CLINICAL PICTURE OF SCHOOL PHOBIA

Development of school phobia. Triggers for reported school phobia could be various situations related to family or school (18). A child develops symptoms of anxiety which can be manifested as stomach ache, nausea, dizziness or fever (19). Because of these physical symptoms, parents allow their child to stay at home. Staying at home leads to anxiety reduction, which is a negative reinforcement for school non-attendance, and contributes to the development of school phobia. If a child receives its parents' attention through increased physical care, liberation from school responsibilities, adjusting to its special diet or playing, school non-attendance is in that case positively reinforced, and contributes to maintaining a disorder.

glavobolja, tremor, palpitacije, pritisak u prsima, bol u abdomenu, mučnina, povraćanje, proljev, bol u leđima i zglobovima) (20). Simptomi se obično javljaju ponedjeljkom ujutro prije polaska u školu pa roditelji mogu misliti da je dijete bolesno i da ne može pohađati školu. Katkad se intenzivni somatski simptomi anksioznosti javljaju tijekom boravka u školi zbog čega se dijete vraća kući ranije. Mlađa djeca mogu također odbijati odlazak u školu uz izljeve plača, ljutnje ili bijesa. Starija djeca prije polaska u školu mogu navoditi uplašenost, tjeskobu, bespomoćnost (20). Anksiozna reakcija može ponekad poprimiti intenzitet panične atake. Neka djeca se trude otići u školu pri čemu su simptomi intenzivniji što su bliže školi, dok druga djeca odbijaju i pokušati otići u školu. Ako dijete ostaje kod kuće, simptomi nestaju, ali se vraćaju ponovno sljedeće jutro prije škole. Karakteristično je i da simptomi izostaju tijekom vikenda i praznika.

Školska fobija može se javiti iznenada nakon praznika, promjene škole, sukoba s vršnjacima ili nastavnicima, izbivanja iz škole zbog bolesti (21). Nekad se školska fobija javlja nakon najavljenog cijepljenja ili sistematskog pregleda. Što duže dijete izostaje iz škole, povratak u školu je teži.

Djeca sa školskom fobijom mogu imati istovremeno i simptome nekih drugih psihičkih poremećaja pri čemu su kod mlađe djece češći komorbidni anksiozni poremećaji kao što su generalizirani anksiozni poremećaj ili specifična fobija, a kod adolescenata panični poremećaj i depresija.

Kratkoročne posljedice školske fobije uključuju slabiji školski uspjeh, poteškoće u obiteljskim odnosima i probleme u odnosima s vršnjacima. Dugoročne posljedice školske fobije su školski neuspjeh, napuštanje školovanja, nezaposlenost, poteškoće socijalnog funkcioniranja, problemi u interpersonalnim odnosima i braku, te povećani rizik psihijatrijskih bolesti u odrasloj dobi (npr. agorafobija, anksioznost, depresija, alkoholizam i antisocijalna ponašanja) (22).

School phobia can be manifested or latent. Younger children tend to complain about somatic symptoms (dizziness, numbness, headache, tremor, palpitations, chest tightness, abdominal pain, nausea, vomiting, diarrhoea, back and joint pain) (20). Symptoms usually occur on Monday morning before going to school, and then parents think that a child is ill and not able to go to school. Occasionally, intensive somatic symptoms of anxiety occur in school, so a child returns home earlier. Younger children may also refuse to go to school, experiencing outbursts of crying, anger or rage. Older children may feel fear, anxiety or helplessness before going to school (20). Anxiety reactions may sometimes be as intense as panic attacks. Some children struggle with going to school, and as soon as they come close to the school building, symptoms become more intense. Other children refuse to even try going to school. If a child stays at home, the symptoms disappear, but they return again the next morning before school. It is also common for the symptoms to be missing on weekends and holidays.

School phobia can occur suddenly after holidays, school changes, conflicts with peers or teachers or due to school outbreaks of illnesses (21). Sometimes school phobia occurs after the announcement of vaccination or physical examination. The longer a child is absent from school, the harder it is for him or her to return to it.

Children suffering from school phobia may also have symptoms of some other psychic disorders at the same time, whereby younger children more commonly experience comorbid anxiety disorders such as generalized anxiety disorder or a specific phobia, while panic disorder and depression are more common in adolescent patients.

It is important to distinguish a child who is unjustifiably absent from school from a child with

Neugodni osjećaji vezani za školu te averzija prema učenju i postignuću rizik su i za rani prekid školovanja (23,24).

Važno je razlikovati dijete koje neopravdano izostaje iz škole (markira) od djeteta sa školskom fobijom. Dijete koje markira izostaje iz škole bez znanja i dopuštenja roditelja, boravi izvan kuće, najčešće s vršnjacima sličnog ponašanja provodeći vrijeme u zabavi, nezainteresirano je za školske sadržaje i učenje, te često iskazuje i antisocijalna ponašanja (krađe, laganje, i dr.). Kod neopravdanog izostajanja iz škole (markiranja) često se radi o poremećaju ponašanja.

Nepohađanje škole može biti i simptom depresije ili psihotičnog poremećaja što treba imati na umu prigodom postavljanja dijagnoze školske fobije i razmotriti u diferencijalnoj dijagnostici.

LIJEČENJE ŠKOLSKE FOBIJE

U liječenju je potreban multidisciplinaran pristup koji uključuje suradnju psihijatra i/ili psihologa, roditelja, stručnih djelatnika škole, liječnika obiteljske ili školske medicine i prema potrebi Centra za socijalnu skrb ako se radi o dugotrajnom izostanku iz škole ili problemima u funkcioniranju obitelji. Liječenje započinje savjetovanjem i psihoedukacijom roditelja o poremećaju, a može obuhvaćati individualnu psihoterapiju (psihoanalitičku ili kognitivno-bihevioralnu), grupnu terapiju i obiteljsku psihoterapiju, ovisno o težini poremećaja i uzrocima njegovog nastanka. Koristi se niz tretmana, odnosno primjenjuju se različiti terapijski postupci.

Rad na tome da se dijete ponovno vrati na nastavu cilj je u mnogim terapijskim pristupima: bihevioralnom, kognitivno-bihevioralnom, psihodinamskom i obiteljskom (5). U težim slučajevima koji ne reagiraju na psihoterapijsko liječenje, primjenjuju se i lijekovi iz skupine antidepresiva i anksiolitika. Uspješnom se pokazala primjena antidepresiva iz skupine selektivnih inhibitora

school phobia. A child who is missing from school without the knowledge and consent of a parent resides outside the home, most often with peers with similar behaviour, spends time at parties, shows no interest in school content and learning, and often expresses antisocial behaviour (theft, lying, etc.). Skipping classes can be found in behavioural disorders.

School absence can also be a symptom of depression or psychotic disorder, which should be kept in mind when establishing a school phobia or differential diagnosis.

TREATMENT OF SCHOOL PHOBIA

During treatment, and in case of long-term school absenteeism or problems with the functioning of the family, it's important to include a multidisciplinary approach. It involves a psychiatrist and/or a psychologist, parents, school staff, family or school physicians and, if necessary, the Social Welfare Centre. The treatment begins with counselling and the parents' psychoeducation about the disorder and may include individual psychotherapy (psychoanalytic or cognitive-behavioural), group therapy and family psychotherapy, depending on the severity and causes of the disorder. A variety of treatments are used, i.e. different therapeutic procedures.

The goal of many therapeutic approaches such as behavioural, cognitive-behavioural, psychodynamic and family therapy is to return a child to school (5). In severe cases, if a child does not respond to psychotherapeutic treatment, it is common to use drugs such as antidepressants and anxiolytics. The use of antidepressants in the group of selective serotonin reuptake inhibitors (SIPPSs) (fluvoxamine, sertraline, fluoxetine, escitalopram) has been shown to be successful, regardless of the presence of depression. SIPPS therapy should last 4-6 months after the improvement ponovne pohrane serotonina (SIPPS) (fluvoksamin, sertralin, fluoksetin, escitalopram) neovisno o prisutnosti depresije. Terapija SIPPS treba trajati 4-6 mjeseci nakon poboljšanja primarnih simptoma, a potom se postupno smanjuje doza do ukidanja. Anksiolitici se kod djece s jakom anksioznošću primjenjuju kratkotrajno prije odlaska na spavanje ili prije odlaska u školu.

Primarni cilj liječenja školske fobije je smanjiti anksioznost oko odlaska i boravka u školi (5). Važno je započeti tretman što ranije kako dijete ne bi zaostajalo sa školskim gradivom, gubilo vezu s vršnjacima i dobivalo pažnju roditelja ostajanjem kod kuće. Što duže dijete izostaje iz škole, anksioznost oko povratka u školu raste i povratak je teži. Roditelji ponekad nastoje problem riješiti promjenom škole što intenzivira anksiozne smetnje kod djeteta (21). Dok je dijete kod kuće važno je održati kontinuitet sa školom te iako ne pohađa nastavu inzistirati da redovito piše školske zadaće te kontaktira nastavnike i učenike iz razreda, kako bi se spriječilo zaostajanje u školskom gradivu i intenziviranje anksioznosti. Potrebna je suradnja roditelja i stručnjaka u čijem je tretmanu dijete zbog emocionalnih poteškoća sa školom kako bi se učitelje senzibiliziralo za emocionalne tegobe djeteta, omogućio postupni povratak i pozitivno ozračje (povjerenje, sigurnost) pri povratku djeteta u školu.

Liječenje školske fobije obično traje od nekoliko tjedana do nekoliko mjeseci. Prema podatcima istraživanja 70 % djece ponovno krene u školu nakon jednogodišnjeg tretmana (25).

Tretman školske fobije najčešće se provodi ambulantno ili u okviru dnevno bolničkog liječenja. U vrlo rijetkim slučajevima se dijete zbog školske fobije hospitalizira. Naročito je korisno ako je tijekom psihijatrijskog liječenja dijete uključeno u školu u bolnici kako bi se postupno izlagalo nastavi i školskim aktivnostima i omogućila desenzitizacija na školu. Takav tretman provodi se u okviru kognitivno-bihevioralne terapije (KBT) koja će, uz prikaz slučaja, biti pojašnjena u nastavku rada.

of primary symptoms, and then the dose should gradually be reduced to *termination*. Anxiolytics are used in children with severe anxiety shortly before going to bed or before going to school.

The primary goal of the treatment of school phobia is to reduce anxiety caused by going to and staying in school (5). It is important to start treatment as early as possible, so that a child does not lag behind the school curriculum, lose contact with peers, and get the parents' attention by staying at home. The longer a child stays out of school, the harder the school comeback is because anxiety levels rise.

Parents sometimes try to solve the problem by changing schools, which intensifies the anxiety disorder in the child (21). While the child is at home, it is important to maintain school obligations, and even though the child does not attend classes, one should insisted on it doing homework and contacting classroom teachers as well as classmates daily in order to prevent school backlash and anxiety intensification. During treatment, collaboration of parents and experts is needed in order to sensitize teachers to the child's emotional problems, and to set a positive atmosphere (trust, safety) to help ease the return to school.

Treatment of school phobia typically takes several weeks to several months. According to research data, 70% of children return to school after one year of treatment (25). Treatment of school phobia usually involves outpatient care or day care hospitalization. It is very rare that a child is hospitalized due to school phobia. It is particularly useful if a child is included in hospital school during psychiatric treatment, where it can be gradually exposed to school activities and to enable desensitization to school. Such treatment is carried out within cognitive-behavioural therapy (CBT), which will be explained in the follow-up, as well as a *clinical case*.

KOGNITIVNO-BIHEVIORALNA TERAPIJA ŠKOLSKE FOBIJE

Kognitivno bihevioralna terapija (KBT) često je terapija izbora za liječenje školske fobije (10), jer joj je u cilju prepoznati i modificirati neprimjerene i maladaptivne misli, osjećaje i ponašanja. Takvi tretmani su, u kliničkoj praksi, često korišteni za tretiranje odbijanja škole temeljeno na anksioznosti, budući da nude konkretne upute djeci kako se nositi sa situacijama koje u njima izazivaju anksioznost, upute za konfrontaciju situacija straha te modifikaciju maladaptivnih misli (26). Kognitivno-bihevioralna terapija (KBT) uključuje psihoedukaciju, trening socijalnih vještina, kognitivnu restrukturaciju, relaksaciju te metodu postupnog izlaganja, što se pokazalo vrlo važnim u prevladavanju školske fobije (27). Kognitivno-bihevioralna terapija (KBT) je, za razliku od ostalih pristupa, jedina terapijska tehnika koja nudi dovoljnu empirijsku potporu (28). Rezultati meta-analize istraživanja tretmana školske fobije upućuju na učinkovitost kognitivno-bihevioralne terapije (KBT) osobito u pogledu ponovnog povratka djeteta na nastavu (14). Last i sur. (1998.) su u istraživanju na 105 djece pokazali učinkovitost KBT kod školske fobije (26). Djeca su bila randomizirana u skupinu za KBT ili u skupinu za edukativno-suportivnu terapiju (EST). KBT pristup bazirao se na postupnom izlaganju školi s ciljem povratka djeteta u školu. EST se sastojala od podučavanja djece i podrške djeci. Djecu se ohrabrivalo da govore o svojim strahovima, učilo ih se da razlikuju strahove, anksioznost i fobiju. Na kraju tretmana, 95 % djece u KBT skupini se vratilo u školu, a 45 % u skupini EST. Edukativno-suportivna terapija (EST) pokazala se sličnom kognitivno-bihevioralnoj terapiji (KBT) te također učinkovitom, no nije davala direktne, specifične upute o tome što bi dijete trebalo raditi za prevladavanje straha te se nije izlagalo školi, odnosno nije dobivalo pozitivna potkrepljenja za odlazak u školu.

COGNITIVE-BEHAVIORAL THERAPY OF SCHOOL PHOBIA

Cognitive-behavioural therapy (CBT) is often the therapy of choice for the treatment of school phobia (10) because it is intended to identify and modify inappropriate and maladaptive thoughts, feelings and behaviours. In clinical practice, such treatments are often used to address anxiety-based school rejection, as they offer specific guidance to children to deal with anxiety situations, directions to confront fear situations and modification of maladaptive thoughts (26). Cognitive-behavioural therapy (CBT) involves psychoeducation, social skills training, cognitive restructuring, relaxation and the method of gradual exposure, which has proven to be very important in overcoming school phobia (27). Cognitive-behavioural therapy (CBT) is, unlike other approaches, the only therapeutic technique that provides sufficient empirical support (28). The meta-analysis results show the importance of cognitive-behavioural therapy (CBT), particularly for returning a child to school (14). Last et al. (1998) showed the effectiveness of CBT regarding school phobia in a study of 105 children (26). The children were randomly divided into a CBT group and an Educational-supportive therapy group (EST). The CBT approach was based on gradual school presentation, with the aim of returning a child to school. The EST consisted of teaching and supporting children. Children were encouraged to talk about their fears, and taught to distinguish fears, anxiety and phobia. At the end of the treatment, 95% of children included in CBT returned to school, and in the EST group 45% of them returned to school. EST has shown to be similar to cognitive-behavioural therapy (CBT) and also effective, but has failed to provide direct, specific instructions on what a child should be doing to overcome fear, did not exhibit school or did not receive positive reinforcement while going to school.

Kognitivno-bihevioralna terapija (KBT) je vrlo strukturirana terapija u kojoj se djecu postupno izlaže školskim situacijama. Premda se često koristi uz farmakoterapiju, prednost je ta da KBT prevenira povrat simptoma, jer se djecu uči kako se nositi s problemima, što dovodi do dužeg trajanja postignutih učinaka. Djecu se ohrabruje da se suočavaju sa strahovima i podučava ih se kako da mijenjaju negativne misli koje su u osnovi fobije i izbjegavajućeg ponašanja. U kognitivnoj terapiji i roditeljima se pomaže osvijestiti njihova disfunkcijska vjerovanja vezana za djecu i zamijeniti ih adaptivnijim vjerovanjima (19).

Ono što se pokazalo učinkovitim faktorima za uspješan tretman su uključenost roditelja, odnosno dobra suradnja s njima, ako su u pitanju mlađa djeca (do adolescencije), te nepostojanje komorbiditeta (29). Uz to, za dobar ishod je posebno korisna tehnika izlaganja, posebice ako postoji prolongirana školska odsutnost. Studije su pokazale da je upravo izlaganje najbolji tretman jer se na taj način najbolje umanjuje strah (30).

Bihevioralne intervencije ponajprije se osnivaju na postupcima izlaganja (10). Najčešće se radi postupak sistematske desenzitizacije koji se osniva na postupnom izlaganju zastrašujućim situacijama vezanim za školu uz uvježbavanje tehnike relaksacije, rješavanja problema i socijalnih vještina (10). Na primjer, sistematska desenzitizacija postupnog izlaganja za dijete može početi gledanjem slike škole (što kod djeteta nije zastrašujuće), nakon čega slijedi šetnja ili vožnja do škole (što je za dijete minimalno zastrašujuće), a nakon toga se dijete izlaže igranjem na školskom igralištu (što mu je umjereno zastrašujuće). Kada dijete savlada jedan stupanj izlaganja, odnosno kada ta situacija kod djeteta više ne izaziva visoku anksioznost, prelazi se na novi stupanj. U ovom slučaju to za dijete može biti ulazak u zgradu škole (jako zastrašujuće), a pohađanje nastave bio bi najviši stupanj neugode (izrazito

Cognitive-behavioural therapy (CBT) is a highly structured therapy in which children are gradually exposed to school situations. Although often used with pharmacotherapy, CBT prevents the recovery of symptoms as children learn how to cope with problems, which results in longer effect duration. Children are encouraged to face fears and taught how to change negative thoughts, which are the foundation of phobia and avoidance behaviour. In cognitive therapy, parents can also recognize and evaluate their dysfunctional beliefs related to their children in order to replace them with more adaptive beliefs (19).

Parental involvement, a good relationship with parents, younger children and adolescents, as well as a lack of comorbidity have been identified as effective and important factors for a treatment to be successful (29). Additionally, exposure techniques are particularly useful, especially if there is a prolonged school absence. Studies have shown that exposure is the best treatment for reducing fear (30).

Behavioural interventions are primarily based on exposure procedures (10). Systematic desensitization is the most commonly used process, which is based on gradual exposure to frightening school-related situations through practicing relaxation, problem-solving and social skills training (10). For example, systematic desensitization through gradual exposure can begin with a child looking at a picture of school (which is not frightening for a child), followed by a walk or a ride to school (which is minimally frightening for a child), and eventually exposing a child to playing on the school playground (which is moderately frightening) . When a child reaches one stage of exposure, or when that situation fails to cause a high level of anxiety, the child proceeds to the next level. In this case, it can be the child's entry into the school building (very frightening), and school attendance would be the highest degree of discomfort (extremely frightening), which is also one of the goals of therapy - that in this situation the level of anxiety can be tolerated.

zastrašujuće), što je ujedno i cilj terapije - da u toj situaciji razina anksioznosti za dijete bude podnošljiva.

King i Bernstein (2001.) su našli kako oko polovina djece koja izbjegavaju školu postižu slab školski uspjeh (11). Jedno istraživanje provedeno u razdoblju od 15 do 20 godina pratilo je 35-ero djece, koja su u dobi između 7 i 12 godina bila u tretmanu zbog školske fobije. Nađeno je da su u odrasloj dobi oni dvostruko češće trebali psihijatrijsku skrb u usporedbi s kontrolnom skupinom psihički zdravih ispitanika (25). Slična istraživanja (31) upućuju na onesposobljujuće dugoročne posljedice neliječene školske fobije u obliku problema sa zapošljavanjem i rizika od psihijatrijskih poremećaja. Zbog toga bi školska fobija trebala biti prepoznata kao značajan problem i privući pažnju svih koji su uključeni u školovanje djece.

PRIKAZ BOLESNICE

Djevojčica u dobi 13 godina, pohađa šesti razred osnovne škole, upućena je na psihijatrijski pregled od pedijatra zbog niza somatskih tegoba (mučnine, pritisak u prsnom košu, te bolovi u koljenima i rukama). Opsežnom pedijatrijskom obradom nije nađen uzrok somatskim tegobama. Tijekom intervjua doznaje se da je djevojčica odrasla u hiperprotektivnoj obitelji, majka je visokoanksiozna, ali nije nikad bila uključena u psihijatrijski tretman, otac brižan i pasivan. Rani psihomotorni razvoj djevojčice bio je uredan. Djevojčica nije pohađala predškolsku ustanovu, a u maloj je školi pokazivala separacijske smetnje (plakanje, mučnina, tražila je prisutnost majke, teško se odvajala od nje). Polaskom u školu ponovo je iskazivala separacijske teškoće (plač, mučnine, trbuhobolju, zabrinutost za roditelje). Tijekom osnovne škole bila je odlična učenica, sklona perfekcionizmu, dobro prihvaćena od vršnjaka. Početkom šestog razreda djevojčica je izostala iz škole dva tjedna (listopad) zbog urinar-

King and Bernstein (2001) have found that about half of the children who avoid school achieve poor school success (11). One study on school phobia, conducted over a period of 15 to 20 years, followed 35 children whose age was between 7 and 12. It was found that they were twice as likely to need psychiatric care at an adult age than a control group of mentally healthy subjects (25). Similar studies (31) refer to the disabling long-term consequences of untreated school phobia in terms of unemployment and the risk of psychiatric disorders. For this reason, school phobia should be recognized as a significant problem and attract the attention of all who are involved in child education.

CASE REPORT

A girl at the age of 13, who is attending the sixth grade of elementary school, has been advised to undergo psychiatric examination by a pediatrician for a series of somatic problems (nausea, chest tension, pain in knees and hands). Extensive pediatric treatment did not find the cause of somatic problems. During the interview, it was found out that the girl has been growing up in a hyper-protective family, her mother is highly anxious, but has never been involved in psychiatric treatment, and her father is caring and passive. Early psychomotor development was without any severe deviations. The girl didn't attend kindergarten, and in preschool she showed separation issues (crying, nausea, always demanding the mother's presence, it was hard for her to be separated from her mother). When she started going to school, she expressed separation issues (weeping, nausea, tiredness, concern for her parents). During elementary school, she was an excellent student, prone to perfectionism, well-received by peers. At the beginning of the sixth grade, the girl was absent from school for two weeks (October) for urinary infection, after which she manifested frequent somatic complaints along with occasional absence from school. Since December, she has complained nog infekta nakon čega manifestira učestale somatske pritužbe uz povremeno izostajanje iz škole. Od prosinca se žali na intenziviranje tjelesne tegobe te prestaje pohađati školu. Tjelesne pritužbe (mučnina, težina u prsnom košu, slabost, bolovi u zglobovima) izražene su ujutro prije polaska u školu, a povlačile bi se ako je ostajala kod kuće i ne bi se pojavljivale do sljedećeg dana, odnosno vremena polaska u školu. Učinjena je opsežna somatska obrada tijekom prosinca i siječnja, te se djevojčica javlja na prvi psihijatrijski pregled u veljači. Do dolaska psihijatru djevojčica nije pohađala školu tri mjeseca.

Nakon multidisciplinske obrade (psihijatar, psiholog, logoped, neuropedijatar, EEG) kod djevojčice je utvrđeno da se radi o školskoj fobiji u osnovi koje je separacijski anksiozni poremećaj.

Na početku psihoterapijskog liječenja s djevojčicom i roditeljima definirani su sljedeći problemi: visoka anksioznost i somatizacije ujutro prije polaska u školu, potpuni prestanak učenja, nepohađanje škole. Postavljeni su sljedeći terapijski ciljevi: reducirati anksioznost vezano uz školu, uspostaviti izvršavanje obaveza vezano za školu, postupni povratak u školu. Djevojčica se vratila u školu tri mjeseca nakon uključivanja u psihijatrijski tretman, odnosno nakon 4,5 mjeseca (od potpunog prestanka pohađanja škole), tj. 5 tjedana prije završetka školske godine, te je vrlo dobrim uspjehom završila školsku godinu.

S djevojčicom je napravljena kognitivna konceptualizacija tijekom koje se primjenjuje kognitivna terapija, koja uključuje rad na automatskim mislima te posredujućim i bazičnim vjerovanjima (slika 1).

Bihevioralne tehnike koje su korištene s djevojčicom bile su ove: edukacija o osjećajima, prepoznavanje anksioznosti i tehnike relaksacije (abdominalno disanje), samoopažanje (dnevnik aktivnosti i osjećaja), planiranje ak-

about the intensification of her physical symptoms, due to which she stopped attending school. Physical complaints (nausea, chest pain, weakness, joint pain) were most prominent in the morning, before going to school, would recede if she stayed at home, and wouldn't appear until the next day or school time. Extensive somatic treatment was performed during December and January, and the girl was examined by a psychiatrist for the first time in February. Prior to visiting the psychiatrist, she had not attended school for three months.

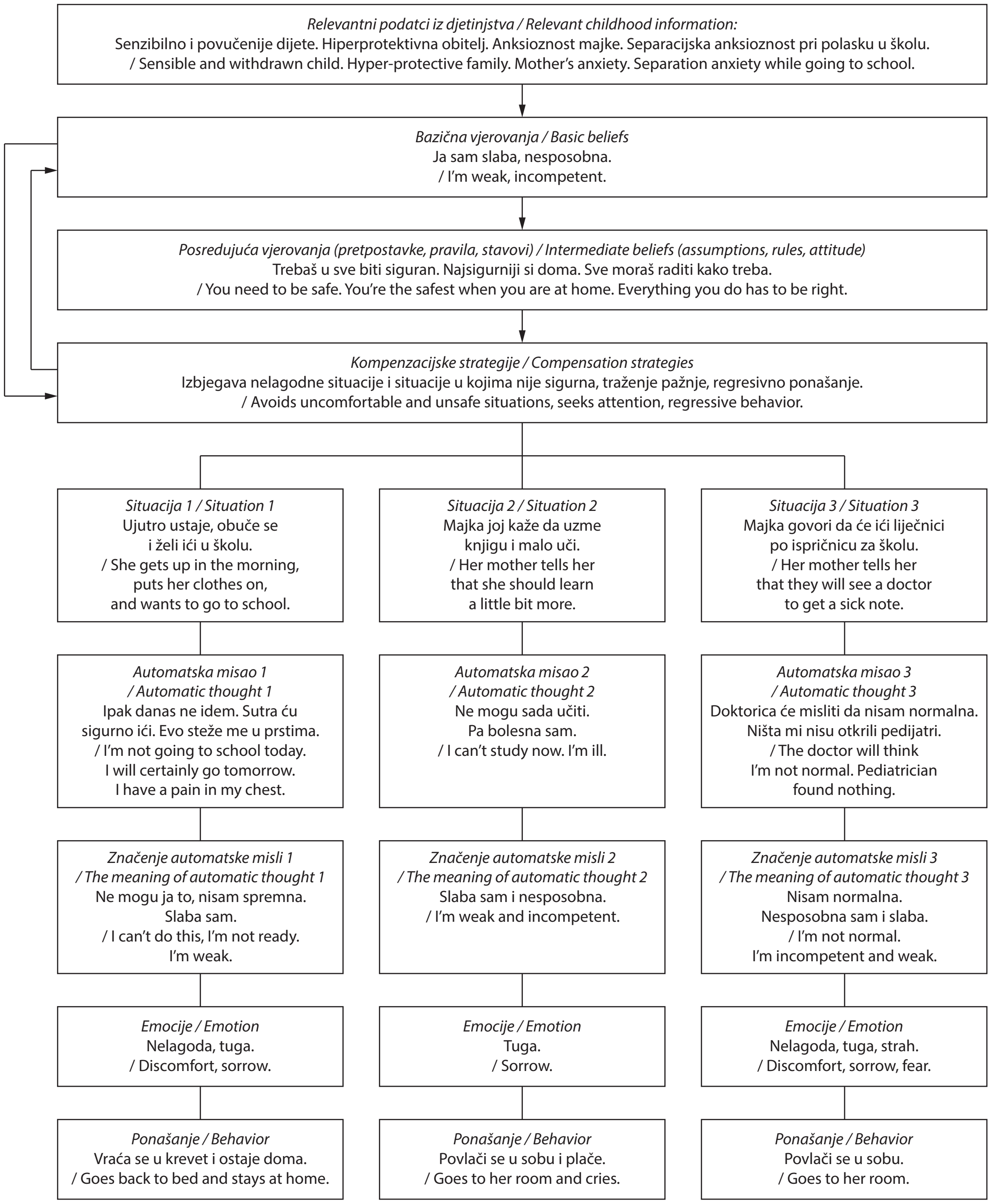
After multidisciplinary examination (psychiatrist, psychologist, speech therapist, neuro-pediatrician, EEG), it was concluded that this girl was suffering from school phobia, which originated from separation anxiety disorder.

At the beginning of psychotherapeutic treatment, which included the girl and her parents, the following problems were defined: high anxiety and somatization in the morning before going to school, complete cessation of learning, failure to attend school. The following therapeutic goals have been set: reducing school-related anxiety, establishing school-related obligations and gradual return to school. The girl returned to school three months after being enrolled in psychiatric treatment, i.e. after 4.5 months (since complete cessation of school attendance), i.e. 5 weeks before the end of the school year, and she was very successful at completing the school year (finished with the grade B).

Cognitive-behavioural therapy, which included working on automatic thoughts and intermediate and basic beliefs, was applied through cognitive conceptualization (Figure 1).

The behavioural techniques used in the treatment were: education regarding emotions and feelings, recognizing anxiety and teaching relaxation techniques (diaphragmatic breathing), self-report (diary of activities and emotions/feelings), activity planning and graduate tasks (school tasks), self-conditioning and parents' conditioning for completing tasks (self-praistivnosti i stupnjeviti zadatci (školske obveze), samopotkrepljivanje i potkrepljivanje od roditelja za izvršene zadatke (samopohvale, izlet u Zagreb, odjeća), sistemska desenzitizacija, tj. postupno izlaganje školi (hijerarhija situacija i izlaganje: šetnje u blizinu škole, prošetati se po školskom dvorištu, ući u školu, biti malo u predvorju škole uz ugodnu aktivnost, odlazak

ing, a trip to Zagreb, buying new clothes), systematic desensitization (gradual exposure to school: hierarchy of situations and exposure - walking by the school, walking in the school backyard, entering the school, being in the school hallway doing a satisfying activity, going to school during the opposite shift, conversation with a school teacher or school pedagogue



SLIKA 1. Prikaz kognitivne konceptualizcije djevojčice sa školskom fobijom

FIGURE 1. Cognitive conceptualization of a girl with school phobia

u školu u suprotnoj smjeni, razgovor s razrednicom, školskim pedagogom i dogovor o planu rada i ispitivanja, polaganje prvog ispita iz najlakšeg predmeta, pisanje testova i provjera znanja jednom tjedno), ugodne aktivnosti (izlasci i izlaganje s roditeljima nevezano uz školu uz praćenje uživanja i zadovoljstva, druženje s prijateljicom), trening socijalnih vještina (gledanje u oči, davanje komentara i komplimenata drugima).

Od kognitivnih tehnika u radu s djevojčicom korištene su: psihoedukacije o anksioznosti, normaliziranje teškoća, distrakcija (brojanje, gledanje izvan učionice što se zbiva), modifikacija negativnih automatskih misli i nalaženje alternativnih, realističnijih i funkcionalnijih misli (negativna misao „Svi će vidjeti da se bojim, da sam jadna" promijenjena u „Ako sam došla u školu to znači da nisam toliko slaba. Jadna bih bila da sam ostala doma. Uvijek sam bila dobra učenica to znači da ja puno toga mogu. Ako i primijete da sam preplašena svi nastavnici su rekli da će mi pomoći."), modeliranje i igranje uloga, pozitivne samoizjave („Ja mogu odgovarati. Mogu doći u školu. Učila sam, želim pokazati da se trudim, a i želim se riješiti toga gradiva.").

Rad s roditeljima uključivao je sljedeće tehnike: psihoedukacija o anksioznosti i školskoj fobiji, o kognitivno bihevioralnom modelu anksioznosti i KBT, pomaganje djevojčici u provođenju bihevioralnih i kognitivnih tehnika te inkorporaciji u svakodnevni život, uz pomoć roditelja kao koterapeuta. Zajedno s djevojčicom roditelji su provodili stupnjevite zadatke vezane uz školske obveze (redovito pisanje zadaća, kontakti s razrednicom i stručnim timom škole), plan aktivnosti tijekom dana - strukturiranje dana, pozitivno potkrepljenje (pohvala, pažnja, nagrade) za izvršene zadatke, postupno izlaganje zastrašujućim situacijama i prekid sigurnosnih ponašanja (izbjegavanje škole i negativno potkrepljenje). S roditeljima se provodila i kognitivna restrukturacija njihovih automatskih

and making an agreement of the work plan and oral exams, taking the easiest exam first, taking exams once a week in the beginning), satisfying activities (going out with friends and tracking the enjoyment or satisfaction unrelated to school), social skills training (maintaining eye contact when talking to someone, making comments and giving compliments to others).

The cognitive techniques used in the treatment were: psychoeducation about anxiety, normalization of difficulties, distraction (counting, looking outside of the classroom at whatever is happening outside), modification of negative automatic thoughts and finding alternative, more realistic and functional thoughts (negative thought: "Everyone will see that I'm afraid, I'm so miserable" changed to "If I come to school, it'll mean I'm not as weak as I thought", "I'd have been miserable if I'd stayed at home", "I have always been a good student, so I can do a lot of things", "If they notice I'm frightened, all of the teachers will help me"); modelling and role-playing, positive self-expression ("I can do it" (in test situations), "I can go to school," "I've studied", "I want to show my effort because I've been studying", and "I want to pass that exam and get rid of it").

Working with parents included the following techniques: psychoeducation on anxiety and school phobia, the cognitive behavioural anxiety model and CBT in general, helping the girl to conduct and incorporate behavioural and cognitive techniques in everyday life, with her parents being co-therapists. The parents have, together with the child, carried out gradual tasks related to school duties (writing assignments regularly, keeping in contact with the school teacher and the school's professional team), performed the activity plan during the day - structuring the day, providing positive reinforcement (praise, attention, awards) for accomplished tasks, progressive exposure to frightening situations and the removal of security behaviours (school avoidance and negative reinforcement). The parents were also involved in cognitive restructuring of their automatic negativnih misli („Pa kako ćeš ti to sve naučiti, past ćeš razred...") kako bi usvojili realističnije i funkcionalnije kognitivne obrasce („Polako ćeš se pripremati, imati ćeš pomoć, do sada si bila odlična učenica, uz trud i pomoć ćeš uspjeti to svladati").

KBT je provođena jednom/tjedan u trajanju od četiri i pol mjeseca. Uz KBT, suradnju s roditeljima i školom djevojčica je naučila prepoznati svoju anksioznost i smanjiti je na razinu uz koju je mogla funkcionirati. Izvršavala je redovito kod kuće obaveze vezano uz školu, uz postupno odgovaranje u školi. Vratila se u školu nakon 4,5 mjeseca. Razred je završila vrlo dobrim uspjehom.

ZAKLJUČAK

Školska fobija nije posebna dijagnoza u klasifikacijama psihičkih poremećaja, već klinički entitet koji uključuje anksioznost i izbjegavajuće ponašanje vezano uz odlazak u školu, koje se može javiti bilo kada tijekom školovanja. Najčešće se radi o separacijskoj ili socijalnoj anksioznosti, mada odbijanje odlaska u školu može biti povezano i s drugim emocionalnim poremećajimae u djece i adolescenata kao što su generalizirani anksiozni poremećaj, panični poremećaj ili depresija. Dijete zaostaje u savladavanju gradiva i gubi kontakt s vršnjacima. To djeluje frustrirajuće na dijete i rezultira daljnjim povlačenjem od školskih aktivnosti. Stoga su rano postavljanje dijagnoze i rana intervencija od ključne važnosti za liječenje školske fobije. Škola može pomoći u ranoj detekciji ovog poremećaja suradnjom i informiranjem roditelja o izostancima, školskom medicinom i drugim stručnjacima upućivanjem djeteta na procjenu psihofizičkog stanja, određivanjem primjerenog oblika školovanja u skladu sa sposobnostima djeteta te tijekom tretmana uvažavanjem terapijskih planova i preporuka omogućiti djetetu da lakše prevlada školsku fobiju. S obzirom na to da se školska fobija

negative thoughts ("How will you manage to learn it all?", "You will fail this class") in order to adapt more realistic and functional cognitive patterns ("You are going to be ready", "You were an excellent student", "You will manage to master it with help and effort").

CBT was performed once a week for four and a half months. With CBT and cooperation with her parents and school, the girl learned to recognize her anxiety and reduce it to the level of normal functioning. She had regular school-related duties at home, with gradual oral exams in school. She returned to school after 4.5 months. She successfully completed the class with a very good success (grade B).

CONCLUSION

School phobia is not a separate diagnosis in psychological disorders classifications, but a clinical entity that involves anxiety and avoidance associated with school attendance, which can occur at any time during schooling. Most often it is related to separation or social anxiety, although school refusal may be related to other emotional disorders in children and adolescents such as generalized anxiety disorder, panic disorder or depression. A child fails in completing school activities and might lose all contacts with peers. This can be frustrating for a child and may result in a further withdrawal from school activities. Therefore, early diagnosis and early intervention are of crucial importance for the treatment of school phobia. The school can help in early recognition of school phobia by cooperating and informing parents about skipping school, informing the school doctor and other experts, sending a child to undergo an assessment of the complete psychophysical condition and adjusting the form of education program based on the child's abilities. During treatment, it is important to accept therapeutic plans and recommendations in order to enable a child to overcome school phobia easily. Given that uspješno liječi postupnim izlaganjem zastrašujućim situacijama vezanim uz školu, važno je izbjegavati školovanje kod kuće zbog školske fobije i omogućiti postupan povratak djeteta na nastavu.

school phobia is treated successfully through gradual exposure to frightening school-related situations, it is important to avoid home-based schooling due to school phobia and to ensure that the child returns to school gradually.

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Upute autorima

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