SOCIJALNA PSIHIJATRIJA – ČASOPIS HRVATSKOGA PSIHIJATRIJSKOG DRUŠTVA

SOCIJALNA PSIHIJATRIJA – THE JOURNAL OF THE CROATIAN PSYCHIATRIC SOCIETY

Izdavač/Publisher
Medicinska naklada

Adresa Uredničkog odbora/Address of the Editorial Board
SOCIJALNA PSIHIJATRIJA
Klinika za psihijatriju, Klinički bolnički centar Zagreb, Kišpatićeva 12, 10000 Zagreb, Hrvatska
Department of psychiatry, University Hospital Centre Zagreb, Kišpatićeva 12, 10000 Zagreb, Croatia

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Medicinska naklada d.o.o., Zagreb

Časopis je utemeljen 1973. u Klinici za psihijatriju Kliničkog bolničkog centra Zagreb i Medicinskog fakulteta Sveučilišta u Zagrebu, gdje je i sjedište Uredničkog odbora.
The journal was established in 1973. in Zagreb, in the Clinic for Psychiatry, University Hospital Centre Zagreb, School of Medicine, Zagreb and the Editorial board headquarters are situated there as well.

Indeksiran je u bazama: SCOPUS, PsychINFO, Excerpta Medica (EMBASE), Index Copernicus, Google Scholar, EBSCO, HRČAK, CiteFactor
Socijalna psihijatrija is indexed in SCOPUS, PsychINFO, Excerpta Medica (EMBASE), Index Copernicus, Google Scholar, EBSCO, HRČAK, CiteFactor

Izlazi četiri puta godišnje.

Godišnja pretplata za ustanove iznosi **300,00 kn**; za pojedince **150,00 kn**. Cijena pojedinačnog broja **50 kn** (u cijenu su uključeni poštanski troškovi).
IBAN: HR2223600001101226715, Medicinska naklada, Cankarova 13, 10000 Zagreb, Hrvatska (za časopis Socijalna psihijatrija).

The Journal is published four times a year. Orders can be made through our office-address above.
The annual subscription for foreign subscriber is: for institutions **40 €**, for individuals **20 €**, and per issue **10 €** (the prizes include postage).
Payment by check at our foreign currency account:
Zagrebačka banka d.d., Paromlinska 2, 10000 Zagreb, Croatia
IBAN: HR2223600001101226715, **SWIFT:** ZABAHR2X (for Socijalna psihijatrija).

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Socijalna psihijatrija

UDC 616.89
SPSIDE 47 (4) 431-532 (2019)
ISSN 2459-6140

VOL. 47 – 2019
BROJ/NUMBER 4
ZAGREB, prosinac/December 2019.

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Cilj rada bio je ispitati samostigmatizirajuće stavove ispitanika iz skupine oboljelih od duševnih bolesti i utvrditi njihov stupanj samopoštovanja i samoefikasnosti u usporedbi s ispitanicima iz kontrolne skupine ispitanika iz opće populacije. U istraživanju je sudjelovalo 176 ispitanika podijeljenih u dvije skupine. Ispitivanu skupinu (74 ispitanika) činili su pacijenti hospitalizirani u Klinici za psihijatriju KBC-a Rijeka, a kontrolna skupina (102 ispitanika) izabrana je iz uzorka opće populacije. Svi ispitanici su popunili sljedeće upitnike: Rosenbergovu ljestvicu samopoštovanja i Ljestvicu opće samoefikasnosti, dok su pacijenti popunili i Upitnik o procjeni samostigmatizacije, konstruiran samo za potrebe ovog istraživanja. Oboljeli od duševnih bolesti iskazali su statistički značajno nižu razinu samopoštovanja i samoefikasnosti u odnosu na opću populaciju. Dobiveni rezultati pokazali su statistički značajnu, negativnu korelaciju između stupnja samopoštovanja i samoefikasnosti u odnosu na percipiranu samostigmatizaciju. Znači, ispitanici s nižim rezultatima na samopoštovanju i samoefikasnosti imaju izraženije samostigmatizirajuće stavove. Takvi stavovi su refleksija društvenih stereotipa prema osobama s mentalnim bolestima te njihovog prihvaćanja i primjene od duševnih bolesnika, što su preduvjeti nastanka samostigme. Samostigmatizacija ima dalekosežne posljedice na kvalitetu života, životnu funkcionalnost te socijalne i društvene interakcije pogođenih pojedinaca.

***/** The aim of this paper was to examine the self-stigmatizing attitudes of the examinees from the group of mentally ill patients and determine their level of self-esteem and self-efficacy while comparing their results with those of examinees from the control group from the general population. 176 participants were included in this research and divided into two groups. The first group (74 subjects) consisted of patients hospitalized at the Psychiatric Department of the Clinical Hospital Centre Rijeka and the second, control group (102 subjects) was selected from a sample of the general population. The respondents were given a questionnaire that consisted of the Rosenberg Self-Esteem Scale and the General Self-Efficacy Scale, while psychiatric patients were also given the questionnaire for assessing self-stigmatization which was designed for the purpose of this research. The first group (psychiatric patients) has statistically significantly lower levels of self-esteem and self-efficacy than the examinees from the general population. Our results show statistically significant negative correlation between the degree of self-esteem and self-efficacy in relation to perceived self-stigmatization. Those participants with lower levels of self-esteem and self-efficacy have more self-stigmatizing attitudes. These attitudes reflect the stereotypes about people with mental illness present in society and subsequently the acceptance and application of those stereotypes by the psychiatric patients, which are the preconditions for self-stigma. Self-stigmatization has far-reaching consequences on the quality of life, life functionality, and the social interaction of affected individuals.*

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KLJUČNE RIJEČI / *KEY WORDS*:
Oboljeli od duševnih bolesti / *Mentally Ill Patients*
Samoefikasnost / *Self-efficacy*
Samopoštovanje / *Self-esteem*
Samostigmatizacija / *Self-stigmatization*
Stigma / *Stigma*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2019.433

UVOD

Prema Rječniku hrvatskoga jezika, pojam *stigma* (grč. στίγμα) označava neko nepoželjno obilježje ili žig, odnosno u prenesenom značenju to je „trajna sramota koja prati čovjeka u životu“ (1), ili „znak sramote i beščašća“ (2). Termin *stigma* ima nekoliko različitih značenja, a sva su označena negativnim predznakom, odnosno označava nekog tko se izdvaja od ostalih, nekog tko izlazi iz okvira „normalnog“. Važno je razumjeti povijesni kontekst ovog pojma kako bi se što bolje razumjelo njegovo današnje značenje. Stigma je danas povezana s predrasudama, a u kontekstu kakvom je danas poznajemo, prvi put je spominje francuski sociolog Émile Durkheim (3), dok prvu definiciju nudi kanadsko-američki sociolog Erving Goffman (4).

Suvremeni koncept stigmatizacijskog modela ponudili su 2001. godine američki sociolozi Bruce G. Link i Jo C. Phelan koji smatraju da je za pojavu stigme potrebno 6 osnovnih komponenti: etiketiranje (*labelling*), stereotipiziranje, separacija, gubitak (društvenog) statusa, diskriminacija i zavisnost stigme o moći (5). Iako stigma ostavlja značajne posljedice na stigmatiziranog pojedinca, protiv stigme postoje načini suzbijanja i smanjenja njezinog utjecaja, a to se odvija na nekoliko razina (6): intrapersonalnoj, interpersonalnoj, instituci-

INTRODUCTION

According to the Dictionary of the Croatian Language, the term *stigma* (Greek στίγμα) denotes an undesirable attribute or mark or, figuratively speaking, it is “a permanent disgrace accompanying a person in his/her entire life” (1) or “a mark of disgrace and dishonour” (2). The term *stigma* has several different meanings, all of which are associated with negative connotations, i.e. it indicates someone that stands out from the rest, someone falling outside the scope of the “normal”. It is important to understand the historical context of this term in order to better comprehend its contemporary meaning. Nowadays, stigma is closely related to prejudices, and in the context in which we understand it today it was first mentioned by the French sociologist Émile Durkheim (3), while its first definition was provided by the Canadian American sociologist Erving Goffman (4).

The first contemporary concept of the stigmatization model was provided by American sociologists Bruce G. Link and Jo C. Phelan, who believe that six basic components are required for stigma to emerge: labelling, construction of stereotypes, separation, deprivation of (social) status, discrimination, and dependence of stigma on power (5). Although stigma results in considerable consequences for the stigmatized person, there are ways to suppress it and re-

onalnoj/organizacijskoj, društvenoj te političkoj/strukturalnoj.

(Samo)stigmatizacija duševnih bolesnika

Stigma duševnih bolesnika vjerojatno postoji oduvijek – u povijesnim tekstovima mogu se pronaći živopisni opisi različitih oblika abnormalnog ponašanja i neprilika s kojima su se suočavali mentalno oboljeli tijekom povijesti (7). Takve ljude oduvijek se obilježavalo i upozoravalo na njihove (negativne) osobine.

Stigmatizacija osoba koje boluju od duševnih bolesti definira se kao negativno obilježavanje, marginaliziranje i izbjegavanje osoba upravo zato što imaju psihičku bolest (8). Stigma osoba s duševnim problemima danas je vrlo raširena i duboko ukorijenjena u društvu. Osim što direktno utječe na njihov život, stigmatizirane osobe zbog toga neće potražiti odgovarajuću pomoć (9) ili će odustati tijekom liječenja (10). Tijekom života suočavaju se s dvostrukim problemom: s jedne strane moraju se nositi sa svojom bolešću i simptomima koje utječu na kvalitetu njihova života, partnerske odnose i svakodnevnom funkcioniranje (11). S druge strane postoji nerazumijevanje društva prema njihovim problemima, diskriminira ih se i postoje predrasudni stavovi. Društvena diskriminacija iskazuje se na četiri načina: nepružanje pomoći, izbjegavanje, prisilno liječenje i segregirane institucije (12). Velik broj oboljelih pati od posljedica stigme čak i više nego od posljedica psihičke bolesti. Kako bi izbjegli sram i izolaciju mnogi oboljeli prikrivaju bolest i mogu odustati od liječenja što ih stavlja u poziciju ugrožavanja svojega zdravlja i manjih šansi za oporavak (13).

Rüsch i suradnici (11) identificirali su tri skupine osobina na temelju kojih društvo percipira (i posljedično stigmatizira) duševne bolesnike: strah i isključenje (osobe s teškim psihičkim poremećajima su opasne i treba ih se bojati - is-

duce its impact on the stigmatized individual, which takes place on several levels (6): intrapersonal, interpersonal, institutional/organizational, social, and political/structural.

(Self-)stigma of the people with mental illness

The stigma of people with mental illness has probably always existed - historical texts contain picturesque descriptions of various forms of abnormal behaviour and distress faced by the people with mental illness in history (7). Such people have always been labelled and admonished for their negative characteristics.

The stigmatization of people with mental illness is defined as negative labelling, marginalization, and avoidance of people precisely because such people suffer from mental illness (8). The stigma of people with mental health problems is nowadays quite widespread and profoundly entrenched in society. Apart from a direct influence on their lives, a stigmatized person would not seek adequate help (9) or they would give up during their treatment (10). In their lives, they are faced with a twofold problem: on the one hand, they have to cope with their illness and the symptoms influencing the quality of their lives, relationships, and everyday functioning (11). On the other hand, in society there is a lack of understanding for their problems, they are discriminated, and there are prejudicial attitudes. Social discrimination materializes in four forms: not providing help, avoidance, compelling treatment, and segregated institutions (12). A great number of affected people suffer from the consequences of stigmatization even more severely than from the consequences of mental illness. In order to avoid shame and isolation, many people conceal their illness and may abandon their treatment, thus potentially endangering their health and reducing the prospects for their recovery (13).

Rüsch et al. (11) identified three groups of characteristics on the basis of which society perceives

ključuju se iz društva i smještaju u institucije); sposobnost odlučivanja (duševni bolesnici su neodgovorni te nisu sposobni donositi odluke sami za sebe); te benevolentnost (duševni bolesnici se ponašaju kao djeca te drugi trebaju brinuti za njih). Također, na temelju dosadašnjih istraživanja (14-17), duševne bolesnike se stigmatizira u pet osnovnih atributa, odnosno etiketa: opasni, nesposobni, slabići, lijeni te neizlječivi.

Samostigmatizacija (naziva se još i autostigmatizacija, internalizirana stigma ili *selfstigma*) je proces tijekom kojeg osoba koja boluje od duševnih bolesti internalizira negativne stavove o mentalnim bolestima i poistovjećuje se s njima (18). Istraživanja pokazuju da samostigma ostavlja štetne posljedice na živote duševnih bolesnika (19) te smanjuje šanse za oporavak (16). Iako je smanjenje samopoštovanja i samoefikasnost jedna od češćih posljedica samostigme, ono se ne javlja kod svih – kod nekih može djelovati energizirajuće i osnaživ ački, dok drugi ostaju relativno ravnodušni (20,21).

Da bi se doživjela samostigma osoba prije svega mora biti svjesna postojećih stereotipa (primjerice, osobe s duševnim bolestima su same krive za svoje stanje) te se s takvim stavovima moraju slagati (22). Međutim, osim ova dva preduvjeta, bitna je primjena navedenih stereotipa prema sebi („*Bolujem od duševne bolesti te sam sam kriv za to*“) (21). Pojedini autori stoga ističu hijerarhijsku komponentu samostigme s obzirom da osoba koja boluje do neke duševne bolesti mora biti svjesna postojanja negativnih stavova prije nego se složi s njima i počne ih internalizirati (5,22).

Samostigma se temelji na tri osnovne, međusobno povezane, kategorije koje su ishodište za bilo koju vrstu stigme, a to su predrasude, stereotipi i diskriminacija. Međutim, razlika je u percepciji. Primjerice, kod socijalne stigme o duševnim bolesnicima, društvo ima negativna vjerovanja, odnosno stereotipe o njima (mišlje-

(and consequently stigmatizes) mentally ill people: fear and exclusion (people with severe psychological disorders are dangerous and should be feared - these are excluded from society and should be institutionalized); decision-making abilities (mentally ill people are irresponsible and not capable of making decisions for themselves); and benevolence (mentally ill people behave like children and others should care for them). Also, on the basis of previous studies (14-17), mentally ill people are stigmatized through the usage of five basic attributes or labels: dangerous, incapable, weak, lazy, and incurable.

Self-stigmatization (also called auto-stigmatization, internalized stigma, or *self-stigma*) is a process where a person suffering from a mental illness internalizes negative attitudes towards mental illnesses and identifies with them (18). Studies show that self-stigma has adverse effects on the life of mentally ill people (19) and reduces the chances for recovery (16). Although impairment of self-esteem and self-efficacy is one of the most common consequences of self-stigma, it does not always occur - for some people, it may have energizing and strengthening effects while others remain relatively indifferent (20,21).

First of all, in order to experience self-stigma, a person should be aware of existing stereotypes (for example, people with mental illnesses are to be blamed for their condition) and should agree with this view (22). However, along with these two prerequisites, it is essential that they apply such stereotypes to themselves (“*I suffer from a mental illness and I and only I am to be blamed for that*”) (21). Some authors therefore emphasize the hierarchical component of self-stigma considering that a person suffering from some mental illness must be aware of the existence of negative attitudes before they accept these and start to internalize them (5,22).

Self-stigma is founded on three basic interrelated categories, which are the origins for any type of stigma: prejudices, stereotypes, and discrimination. However, the difference lies in percep-

nje da su opasni, nesposobni i slično), dok sami duševni bolesnici imaju manjkavo vjerovanje u sebe. Društvene predrasude o duševnim bolesnicima temelje se na negativnim vjerovanjima iz čega proizlazi, primjerice, strah prema njima. S druge strane, ako se duševni bolesnici slažu s takvim stavovima, u njima to izaziva negativne emocionalne reakcije što dovodi do pada samopoštovanja i samoefikasnosti. U konačnici to dovodi do javne diskriminacije, odnosno kod stigmatizirane skupine izaziva podržavajući ponašajni odgovor.

Prema teorijskom modelu samostigme (21) za nastanak je potrebna grupna identifikacija i legitimitet. Da bi samostigma bila moguća, potrebna je svjesnost o stigmi (engl. *stigma awareness*) te slaganje sa stereotipima (engl. *stereotype agreement*) koje nastaje kada stigmatizirani pojedinac podržava uobičajene društvene stereotipe (primjerice, osobe s duševnim bolestima su slabići). Proces samostigmatizacije nastavlja se stereotipnim samopridruživanjem (engl. *stereotype self-concurrence*) kada pojedinac primjenjuje kulturološki internalizirana vjerovanja o sebi (primjerice, ja sam slabić jer bolujem od duševne bolesti). Sve to u konačnici dovodi do smanjenja razine samopoštovanja i samoefikasnosti zbog poistovjećivanja s negativnim vjerovanjima i stavovima.

tion. For example, regarding the social stigma of mentally ill people, society holds negative beliefs, i.e. stereotypes about them (the belief that they are dangerous, incapable, and similar beliefs), while mentally ill people's faith in themselves is flawed. Social prejudices against mentally ill people are based on negative beliefs resulting, for example, in fear of them. On the other hand, if mentally ill people agree with such attitudes, this provokes negative emotional reactions in them, which leads to lowered self-esteem and self-efficacy. Eventually, this leads to public discrimination or causes sustaining or supporting behavioural response in a stigmatized group.

According to the theoretical model of self-stigma (21), group identification and legitimacy is required for the occurrence of self-stigma. To make self-stigma possible, stigma awareness and stereotype agreement are necessary, and they occur when a stigmatized individual supports common social stereotypes (for example, people with mental illnesses are weak). The process of stigmatization continues with stereotype self-concurrence when a person applies culturally internalized beliefs regarding them (for example, I am weak because I suffer from a mental illness). Eventually, all of this leads to low levels of self-esteem and self-efficacy due to identification with negative beliefs and attitudes.

CILJ RADA

Cilj ovog istraživanja je ispitati samostigmatizirajuće stavove ispitanika iz skupine oboljelih od duševnih bolesti i utvrditi njihov stupanj samopoštovanja i samoefikasnosti te usporediti njihove rezultate s ispitanicima iz kontrolne skupine ispitanika iz opće populacije. Specifični ciljevi su utvrditi utječe li niži stupanj samopoštovanja i samoefikasnosti na izraženije samostigmatizirajuće stavove te istražiti utjecaj sociodemografskih obilježja na samopoštovanje i samoefikasnost te percepciju samostigme.

RESEARCH AIM

The objective of this study is to explore the self-stigmatizing attitudes of examinees in a group of mentally ill people, determine the level of their self-esteem and self-efficacy, and compare their results with the results of examinees in a general population control group. The specific objectives are to establish whether lower levels of self-esteem and self-efficacy influence more prominent self-stigmatizing attitudes and to explore the influence of sociodemographic characteristics on self-esteem and self-efficacy and the perception of self-stigma.

METODE

U istraživanju je sudjelovalo 176 ispitanika (N=176) podijeljenih u dvije skupine: skupina oboljelih od duševnih bolesti (N=74) te kontrolna skupina ispitanika iz opće populacije (N=102). Prvu skupinu činili su pacijenti hospitalizirani na Klinici za psihijatriju Kliničkog bolničkog centra Rijeka. Oni su izabrani metodom prigodnog ili raspoloživog uzorka koji je zbog specifičnosti populacije koju se istražuje u tom trenutku bio najpogodniji. U istraživanje su bili uključeni punoljetni bolesnici, bez obzira na vrstu psihijatrijske dijagnoze zbog koje su hospitalizirani, a koji su u takvom psiho-fizičkom stanju da su sposobni dati adekvatne podatke. Isključeni su dementni, delirantni i akutno psihotični bolesnici kao i oni bolesnici koji su somatski kompromitirani tako da je njihovo stanje utjecalo na sposobnost davanja valjanih podataka. Drugu skupinu ispitanika činile su punoljetne osobe iz opće populacije koje su izabrane metodom uzorka lančane reakcije ili tzv. grude snijega.

Instrumenti korišteni u istraživanju su sljedeći upitnici:

- Upitnik o sociodemografskim obilježima ispitanika
- Rosenbergova ljestvica samopoštovanja (*Rosenberg self-esteem scale*) (23) koju čini deset tvrdnji od kojih je pet pozitivnih i pet negativnih, a veći rezultat upućuje na višu razinu samopoštovanja
- Upitnik o procjeni samostigmatizacije koji je konstruiran za potrebe ovog istraživanja. Čini ga 20 tvrdnji čiji se odgovori vrednuju prema Likertovoj ljestvici od 5 stupnjeva (od "u potpunosti se ne slažem" do „u potpunosti se slažem"). Veći broj bodova označava veći stupanj slaganja sa samostigmatizirajućim tvrdnjama. Cronbach Alpha iznosi 0.9117, što ukazuje na visoku pouzdanost, te
- Ljestvica opće samoefikasnosti (*General Self-Efficacy Scale*) (24) koja mjeri opći i stabi-

METHODS

The study included 176 examinees (N=176) divided into two groups: a group of mentally ill people (N=74) and a control group of examinees from the general population (N=102). The first group consisted of patients hospitalized in the Psychiatry Clinic of the Rijeka Clinical Hospital Centre. They were selected by a convenient sample which, due to the specific property of the population being examined, was the most appropriate at the time. The study included adult patients, regardless of the type of their psychiatric diagnosis for hospitalization, if their psychological and physical conditions enabled them to provide adequate data. The study excluded demented, delirious, and acutely psychotic patients, as well as those somatically compromised, whose condition influenced their ability to provide valid data. The other group of examinees consisted of adult people from the general population selected by using chain referral sampling or so-called snowball sampling.

The instruments used in this research were the following questionnaires:

- a questionnaire on the sociodemographic characteristics of examinees;
- the Rosenberg self-esteem scale (23) consisting of ten-item statements, of which five were positive and five were negative, with higher results indicating a higher level of self-esteem;
- a questionnaire on self-stigmatization assessment constructed for the requirements of this study. It consists of 20 statements, with answers rated according to the Likert 5-item scale (from "agree completely" to "disagree completely"). A higher score means a higher degree of agreement with self-stigmatization statements. Cronbach's alpha is 0.9117, which indicates a high reliability; and
- the General Self-Efficacy Scale (24), which measures the general and stable feeling of

lan osjećaj osobne efikasnosti u suočavanju s različitim stresnim situacijama. Veći broj bodova ukazuje na viši stupanj samoefikasnosti.

Statistička obrada podataka provedena je uz pomoć statističkog programa Statistica 12.0 (StatSoft Inc., Tulsa, SAD), a podatci su prikazani u tablicama i grafički. Kako bi se utvrdila normalnost proveden je D'Agostino-Pearsonov test normalnosti koji pokazuje da rezultati Rosenbergove ljestvice samopoštovanja (p=0,0010) i Ljestvice opće samoefikasnosti (p=0,0051) ne zadovoljavaju pretpostavku normalnosti te na njihovu analizu primjenjujemo neparametrijske metode. Upitnik o procjeni samostigmatizacije zadovoljava pretpostavku normalnosti (p=0,4325) te se pri njegovoj analizi koristimo parametrijskim metodama. Kod uspoređivanja parametra centralne tendencije dviju skupina koristi se Mann-Whitneyev test u neparametrijskom slučaju, a t-test u parametrijskom slučaju. Kod korelacijske analize koristi se Pearsonova mjera korelacije.

REZULTATI

U istraživanju je sudjelovalo sveukupno 176 ispitanika, od toga 74 iz ispitivane skupine duševnih bolesnika (42,04 %) te 102 iz kontrolne skupine iz opće populacije (57,95 %). U obje skupine sudjelovalo je više ispitanika ženskog nego muškog (62,5 %) spola. Svi sociodemografski podatci navedeni su u tablici 1.

Prema analizi prosječnih odgovora ispitanika na postavljene tvrdnje iz upitnika o procjeni samostigmatizacije, najviše ih se slaže s tvrdnjama da izbjegavaju mjesta gdje se okuplja puno ljudi, da ne govori ljudima o svojoj bolesti, da ih je strah da ih osobe iz okoline manje poštuju zbog njihove bolesti, da okolina smatra da su duševni bolesnici sami krivi za svoju bolest te da su razočarani u sebe zbog svoje bolesti.

personal efficacy in confronting various stressful situations. A higher score indicates a higher level of self-efficacy.

Statistical processing was performed using the statistical package Statistica 12.0 (StatSoft Inc., Tulsa, USA), and data are presented in tables and charts. In order to establish the normality, the D'Agostino-Pearson test was performed and showed that the results of the Rosenberg self-esteem scale (p=0.0010) and general self-efficacy scale (p=0.0051) do not comply with the normality assumption and that non-parametric methods are applied to the respective analysis. The questionnaire on the evaluation of self-stigmatization complies with the normality assumption (p=0.4325) so that parametric methods are used for the respective analysis. The Mann-Whitney and the t-test were used to compare the central tendency parameter of the two groups for non-parametric and parametric cases respectively. The Pearson correlation measure was used for the correlation analysis.

RESULTS

The study included a total of 176 examinees, of which 74 were in the group of mental patients (42.04%) and 102 in the general population control group (57.95%). Both groups included more females than males (62.5%). All sociodemographic data are shown in Table 1.

According to the analysis of the examinees' mean answers to the statements made in the questionnaire about self-stigmatization evaluation, most of them agree with the statements that they avoid places where there are many people, that they do not talk with other people about their illness, that they fear being less respected by people from their environment due to their illness, that their environment believes that mentally ill people themselves are to be blamed for their illness, and that they are disappointed in themselves because of their illness.

TABLICA 1. Sociodemografski podatci ispitanika
TABLE 1. Sociodemographic data of examinees

	Duševni bolesnici / Mental patients		Opća populacija / General population		Ukupno / Total	
	N	*%*	*N*	*%*	*N*	*%*
Dob / Age						
18-29 godina / 18-29 years	3	*4,05*	27	*26,47*	30	*17,04*
30-45 godina / 30-45 years	24	*32,43*	33	*32,35*	57	*32,38*
46-59 godina / 46-59 years	35	*47,29*	33	*32,35*	68	*38,63*
60-75 godina / 60-75 years	10	*13,51*	8	*7,84*	18	*10,22*
više od 76 godina / older than 76 years	1	*1,35*	0	*0*	1	*0,56*
bez odgovora / answer N/A	1	*1,35*	1	*0,98*	2	*1,13*
Spol / Gender						
muški / male	25	*33,78*	33	*32,35*	58	*32,95*
ženski / female	46	*62,16*	64	*62,74*	110	*62,50*
bez odgovora / answer N/A	3	*4,05*	5	*4,90*	8	*4,54*
Obrazovanje / Education						
osnovna škola / primary school	6	*8,10*	3	*2,94*	9	*5,11*
srednja škola / secondary	56	*75,67*	51	*50,0*	107	*60,79*
viša škola / high school	2	*2,70*	17	*16,66*	19	*10,79*
fakultet / university	8	*10,81*	27	*24,47*	35	*19,88*
bez odgovora / answer N/A	2	*2,70*	4	*3,92*	6	*3,40*
Veličina naselja / Community size						
> 100.000 stanov. / > 100.000 inhabitants	22	*29,72*	7	*6,86*	29	*16,47*
30.000-100.000 stanov. / 30.000-100.000 inhabitants	4	*5,40*	54	*52,94*	58	*32,95*
5.000-30.000 stanov. / 5.000-30.000 inhabitants	14	*18,91*	15	*14,70*	29	*16,47*
< 5.000 stanov. / < 5.000 inhabitants	29	*39,18*	14	*13,72*	43	*24,43*
bez odgovora / answer N/A	5	*6,75*	12	*11,76*	17	*9,65*

Najmanje se slažu s tvrdnjama da bi duševne bolesnike trebalo izolirati od ostatka društva, da ih okolina smatra opasnima, da se ne osjećaju ugodno u društvu osoba koje nisu duševno bolesne, da osobe s duševnim bolestima ne bi trebale raditi te da smatraju da osobe s duševnim smetnjama manje doprinose društvu. U grafikonu 1. prikazani su prosječni odgovori (*mean*) ispitanika na tvrdnje iz upitnika o procjeni samostigmatizacije.

Statističkom analizom utvrđeno je kako ne postoji statistički značajna razlika između ispitanika muškog i ženskog spola po ispitivanim skupinama u razini samopouzdanja i samoefikasnosti.

Testovi korelacije pokazali su kako postoji statistički značajna ($P<0,0001$) i jaka pozitivna korelacija (0,6462) između stupnja samopouzdanja i stupnja samoefikasnoti u skupini oboljelih od duševnih bolesti, dakle duševni bolesnici višeg stupnja samopouzdanja imat će viši

They agree the least with the statements that mental patients should be isolated from the rest of the society, that their environment considers them dangerous, that they do not feel comfortable in the company of people who are not mentally ill, that mentally ill people should not have jobs, and that mentally disturbed people contribute less to society. Table 1 presents the examinees' mean answers to the statements made in the questionnaire about the evaluation of self-stigmatization.

Statistical analysis established that there was no statistically significant difference between male and female examinees with regard to self-esteem and the level of self-efficacy.

The correlation tests showed that there is statistically significant ($P<0.0001$) and strong positive correlation (0.6462) between the degree of self-esteem and the degree of self-efficacy in the group of mentally ill people, so mentally ill people showing a higher degree of self-esteem

GRAFIKON 1. Prosječni odgovori (*mean*) ispitanika na tvrdnje iz upitnika o procjeni samostigmatizacije
CHART 1. The examinees' mean answers to statements in the questionnaire about self-stigmatization evaluation

stupanj samoefikasnosti. U skupini ispitanika iz opće populacije također postoji statistički značajna (p<0,0001) i jaka pozitivna korelacija (0,6606) između stupnja samopouzdanja i stupnja samoefikasnosti, dakle ispitanici višeg stupnja samopouzdanja imat će viši stupanj samoefikasnosti.

Usporedbom rezultata o stupnju samopoštovanja između skupine duševnih bolesnika i skupine iz opće populacije iznalazi se statistički jako značajna razlika (p<0,0001). Statistički značajna razlika (p<0,0001) dobiva se i usporedbom rezultata o stupnju samoefikasnosti između skupine duševnih bolesnika i skupine iz opće populacije. Rezultati Mann-Whitneyevog testa

have a higher degree of self-efficacy as well. In the general population group, there is also statistically significant (p<0.0001) and strong positive correlation (0.6606) between the degree of self-esteem and the degree of self-efficacy, so examinees showing a higher degree of self-esteem have a higher degree of self-efficacy as well.

The comparison of results regarding the degree of self-esteem between the group of mentally ill people and the general population group showed a statistically very significant difference (p<0.0001). A statistically significant difference (p<0.0001) is seen in the comparison of results regarding the degree of self-efficacy in the group of mentally ill people and the gener-

prikazani su kutijastim dijagramom (*box and whisker plot*) u grafikonima 2. i 3.

Rezultati ispitivanja Pearsonovog koeficijenta korelacije pokazuju da postoji statistički značajna (P<0,0001), negativna korelacija (-0,6865) između stupnja samopoštovanja i stupnja samostigmatizacije duševnih bolesnika, odnosno da oni ispitanici koji iskazuju viši stupanj samopoštovanja, imaju niže samostigmatizirajuće stavove. Također, rezultati pokazuju da postoji statistički značajna (P<0,0001), negativna korelacija (-0,4885) između stupnja samoefikasnosti i stupnja samostigmatizacije duševnih bolesnika, odnosno da oni ispitanici koji imaju izraženije samostigmatizirajuće stavove, iskazuju niži stupanj samoefikasnosti. Dobiveni rezultati grafički su prikazani u grafikonima 4. i 5.

RASPRAVA

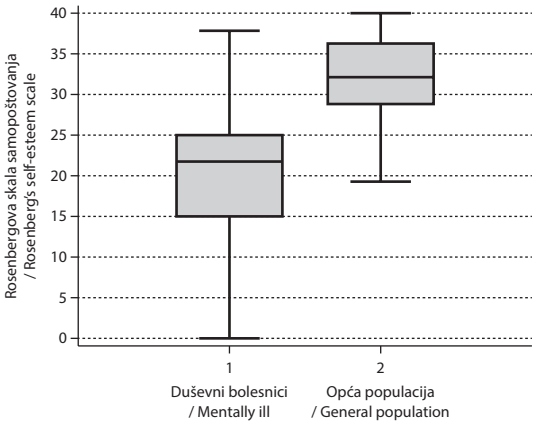
Utjecaj samopoštovanja i samoefikasnosti na samostigmatizaciju već je ranije istraživan u stručnoj literaturi te su rezultati ovog rada u skladu s dosad objavljenima. Održavanje odre-

al population group as well. The results of the Mann-Whitney test are shown by means of and whisker plot in Chart 2 and Chart 3.

Examination of results of the Pearson correlation coefficient shows that there is statistically significant (P<0.0001) negative correlation (-0.6865) between the degree of self-esteem and the degree of self-stigmatization in mentally ill people, i.e. examinees showing a higher degree of self-esteem have less pronounced self-stigmatizing attitudes. Also, results show that there is statistically significant (P<0.0001) negative correlation (-0.4885) between the degree of self-efficacy and the degree of self-stigmatization in mentally ill people, i.e. examinees showing more prominent self-stigmatizing attitudes show a lower degree of self-efficacy. The obtained results are shown in Chart 4 and Chart 5.

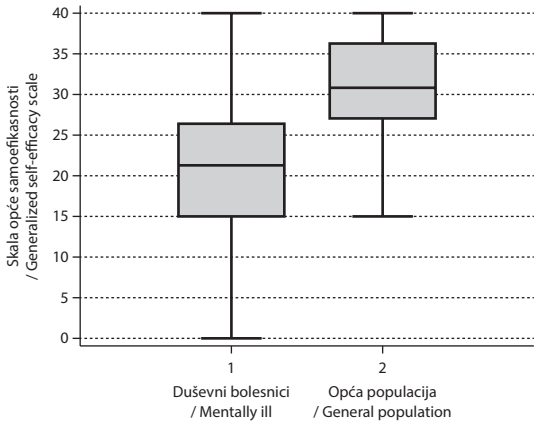
DISCUSSION

The influence of self-esteem and self-efficacy on self-stigmatization has been previously explored in literature and the results of this study comply with the published results. Maintain-



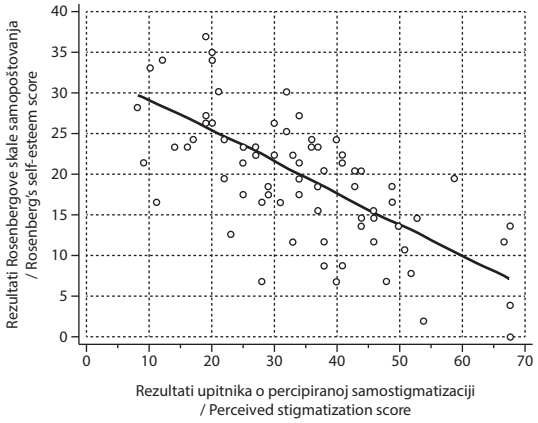
GRAFIKON 2. Usporedba rezultata Rosenbergove ljestvice samopoštovanja između ispitanika iz skupine duševnih bolesnika (*n=73*) i skupine iz opće populacije (*n=102*) pokazuje niži stupanj samopoštovanja duševnih bolesnika

CHART 2. Comparison of the Rosenberg self-esteem scale between the group of mentally ill people (*n=73*) and the general population group (*n=102*) shows a lower degree of self-esteem in mentally ill people

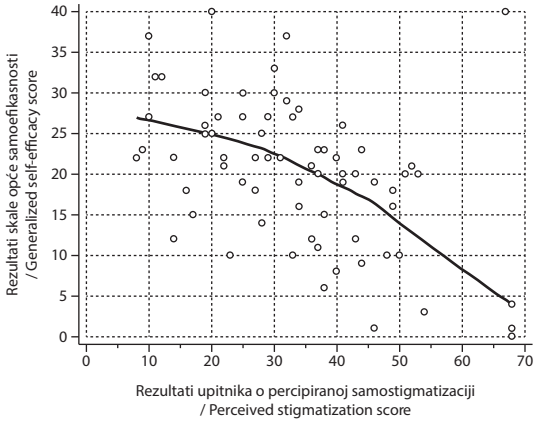


GRAFIKON 3. Usporedba rezultata Ljestvice opće samoefikasnosti između ispitanika iz skupine duševnih bolesnika (*n=72*) i skupine iz opće populacije (*n=102*) pokazuje niži stupanj samoefikasnosti duševnih bolesnika

CHART 3. Comparison of the General Self-Efficacy Scale results between the group of mentally ill people (*n=72*) and the general population group (*n=102*) shows a lower degree of self-efficacy in mentally ill people



GRAFIKON 4. Dijagram rasipanja pokazuje negativnu korelaciju između stupnja samopoštovanja i samostigmatizacije
CHART 4. Scatter plot shows negative correlation between the degree of self-esteem and self-stigmatization.



GRAFIKON 5. Dijagram rasipanja pokazuje negativnu korelaciju između stupnja samoefikasnosti i samostigmatizacije
CHART 5. Scatter plot shows negative correlation between the degree of self-efficacy and stigmatization.

đene razine samopoštovanja važno je za svakog pojedinca, a njegova važnost posebno se ističe kod oboljelih od duševnih bolesti jer predstavlja jedan od preduvjeta za uspješan oporavak (25). Očekivana je razlika u stupnju samopoštovanja između oboljelih od duševnih bolesti i opće populacije, no iznenađuje prilično velika razlika u dobivenim rezultatima. Prosječni rezultat u skupini ispitanika duševnih bolesnika ukazuje na nizak stupanj samopoštovanja što izaziva poteškoće u svakodnevnom funkcioniranju jer takve osobe neuspjehe pripisuju sebi i smatraju da vlastite sposobnosti ne mogu promijeniti trudom zbog toga što pri suočavanju s teškoćama mogu imati osjećaj gubitka kontrole, što im pojačava osjećaj inferiornosti i smanjenog samopoštovanja. I kad dožive uspjeh, ovakve osobe ga pripisuju sreći ili nekom drugom vanjskom čimbeniku (26). Neki autori smatraju da smanjenje samostigmatizirajućih stavova kod duševnih bolesnika može povećati razinu samopoštovanja (16).

Posljedica smanjenog samopoštovanja i samoefikasnosti dovodi do tzv. „zašto uopće pokušati" efekta (*Why Try Effect*) (27) gdje samostigmatizirajući stavovi počinju imati utjecaj na životne ciljeve (22), odnosno samostigma postaje prepreka njihovom ostvarivanju. Naime, smanjeno samopoštovanje dovodi do osjećaja

ing a certain level of self-esteem is important for every individual, particularly in mentally ill people because it represents one of the prerequisites for a successful recovery (25). The difference in the degree of self-esteem between mentally ill people and the general population is to be expected, but what is surprising is the rather large difference in the results obtained. The average result in the group of people with mental illness indicates a low degree of self-esteem, which causes difficulties in everyday functioning since such people impute the failures to themselves and believe that no efforts can change their capabilities and therefore may feel out of control, which intensifies feelings of inferiority and compromised self-esteem. Even when they are successful, such people attribute this to luck or some other external factor (26). Some authors believe that a decrease of self-stigmatizing factors in mentally ill people may increase their level of self-esteem (16).

The consequences of reduced self-esteem and self-efficacy result in the so-called Why Try Effect (27), where self-stigmatizing attitudes begin to influence life goals (22), i.e. self-stigma becomes a hindrance in their realization. Reduced self-esteem leads to feelings of inferiority and the abandonment of certain objectives, for example employment or independent living

manje vrijednosti i odustajanja od određenih ciljeva, primjerice zapošljavanja ili samostalnog života (28). Takvi pojedinci često razmišljaju: „zašto pokušati pronaći posao kad ga neću niti moći obavljati“ ili „zašto da pokušam živjeti samostalno kad nisam sposoban za to“ (27). Posebnu ulogu u ovakvom razmišljanju ima niska samoefikasnost koje je prisutna kod duševnih bolesnika koji su sudjelovali u ovom istraživanju. Niska samoefikasnost povezana je s neuspjehom s kojim se susreću duševni bolesnici prigodom traženja posla ili rješavanja stambenog pitanja (22,29,30).

Iako su rezultati pokazali značajnu povezanost između niskog samopoštovanja i samostigmatizacije, određen broj ispitanika iz skupine duševnih bolesnika iskazao je visoku razinu samopoštovanja. Naime, osim činjenice da to mogu biti osobe koje prirođeno imaju snažno razvijeno samopoštovanje, treba uzeti u obzir da na razinu samopoštovanja utječu brojni drugi faktori poput osobne financijske situacije i društvenog položaja, specifične psihijatrijske dijagnoze i pripadajućih simptoma, pa čak i mogućnost pristupa zdravstvenoj skrbi i zadovoljstvo liječenjem (31). Međutim, podatci iz literature pokazuju kako, paradoksalno, stigma može imati osnažujući učinak, ili pak nema gotovo nikakvog učinka na pojedinca (20,21,32).

Iako se većina duševnih bolesnika uključenih u istraživanje nije složilo ili je zauzelo neutralan stav na postavljene tvrdnje o samostigmatizaciji, značajan broj ispitanika iskazao je slaganje s navodima iz upitnika o procjeni samostigmatizacije, koji u nekim česticama iznosi i više od 50 %: *„izbjegavam mjesta gdje se okuplja puno ljudi“* (51,43 %); *„strah me je da me osobe iz okoline manje poštuju zbog moje bolesti“* (51,39 %) i *„razočaran sam u sebe zbog svoje bolesti“* (50,68 %). Tvrdnje sličnog sadržaja i u drugim istraživanjima o samostigmatizaciji pokazale su se najizraženijima (33). Radi se o tipičnim samostigmatizirajućim stavovima iz kojih se najlakše može iščitati utjecaj osnovne

(28). Such individuals often have the following thoughts: “Why try finding a job when I could not even do it properly?” or “Why try living on my own when I am not capable of ?” (27). Low self-efficacy, which is present in mentally ill people who participated in this study, plays a special role. Low self-efficacy is connected to failure faced by mentally ill people when seeking employment or housing (22,29,30).

Although the results revealed a significant correlation between low self-esteem and self-stigmatization, a certain number of examinees from the group of mentally ill people demonstrated high levels of self-esteem. Apart from the fact that these may be people with innately highly developed self-esteem, it should be considered that many other factors influence the level of self-esteem, such as the financial situation and the social position, specific psychiatric diagnoses and respective symptoms, and even the availability of healthcare and satisfaction with medical treatment (31). However, data shows that, paradoxically, stigma may have a strengthening effect or almost no effect on an individual (20,21,32).

Although most of the mentally ill people included in the research disagreed or were neutral about the questionnaire statement on self-stigmatization, a considerable number of examinees disagreed with the questionnaire statement on evaluation of self-stigmatization, which in some items exceeds 50%: *“I avoid places where there are many people”* (51.43%); *“I am afraid that people in my environment respect me less due to my illness”* (51.39%); and *“I am disappointed in myself because of my illness”* (50.68%). Similar statements in other studies on self-stigmatization showed as most prominent (33). This is about typical self-stigmatizing attitudes, where it is easy to observe the influence of the basic mental illness, for which they are labelled, on their everyday functioning, and the importance that such attitudes have for social behaviour.

duševne bolesti zbog koje su etiketirani na njihovo svakodnevno funkcioniranje te značenje koje imaju na društveno-socijalno ponašanje.

Ohrabruje podatak da neke stigmatizirajuće stavove u našem istraživanju ispitanici snažno odbacuju, poput navoda da bi duševne bolesnike trebalo izolirati od ostatka društva s čime se ne slaže čak 91,67 % ispitanika te tvrdnje da okolina duševne bolesnike smatra opasnim s kojom se nije složilo 71,83 % ispitanika.

Dobiveni rezultati našeg istraživanja uklapaju se u teorijski model samostigmatizacije (21) koji pretpostavlja da je osoba prije svega svjesna stereotipa koji se odnose na određenu skupinu (primjerice, osobe s duševnim bolestima su same krive za to) te se moraju slagati s njima. Međutim, navedena dva kriterija nisu dovoljna za razvoj samostigme, već je za njezin nastanak bitna aktivna primjena stigmatizirajućih stereotipa u odnosu na sebe (primjerice, sam sam kriv za svoju bolest) (22).

Začarani krug koji čini niska razina samopoštovanja i samoefikasnosti te izražena samostigmatizacija izazov su samim bolesnicima, ali i njihovim obiteljima te profesionalcima koji provode liječenje i pružaju im potporu. Rezultati istraživanja pokazuju da je nužno uložiti dodatne napore u senzibiliziranju javnosti o utjecaju predrasuda, diskriminacije, stereotipizacije i stigme na živote stigmatiziranih te aktivno uključiti zakonodavnu razinu u razvoj strategija za smanjenjem stigme duševnih bolesnika, ali u konačnici i svih drugih skupina. Na individualnoj razini potrebno je poticati sve pogođene samostigmom na jačanje njihovog psihosocijalnog kapaciteta te provoditi s njima programe osnaživanja. Također, trebalo bi razmisliti o uvođenju nekog od već postojećih programa borbe protiv samostigmatizacije u hrvatski javnozdravstveni sustav te na svim razinama zdravstvene skrbi za psihičke bolesnike.

Ovo istraživanje ima nekoliko ograničenja. Uzorak ispitanika s duševnim smetnjama je

It is encouraging that the examinees strongly reject some stigmatizing attitudes in our study, such as the statement that mentally ill people should be isolated from the rest of society, which was rejected by as much as 91.67% of the examinees, while 71.83% of examinees disagree with the statement that the people around them consider mentally ill people dangerous.

The results obtained in our study comply with the theoretical model of self-stigma (21), which assumes that a person is, before all, aware of stereotypes referring to an entire group (for example, mentally ill people themselves are to be blamed) and should agree with such stereotypes. However, these two criteria are not sufficient for the development of self-stigma. Active implementation of stigmatizing stereotypes related to the self is essential for stigma to occur (for example, you yourself are to be blamed for your illness) (22).

A vicious circle consisting of low self-esteem and self-efficacy and prominent self-stigmatization represents a challenge not only for mentally ill people themselves, but also for their families and professionals providing medical care and support. The results of this study indicate that further efforts are necessary to raise public awareness about the influence of prejudices, discrimination, stereotypes, and stigma on the life of the stigmatized, and an active engagement on the legislative level is necessary for the development of strategies for the reduction of stigmatization of mentally ill people, and eventually of all other groups as well. At the individual level, it is necessary to encourage all those affected by self-stigmatization to strengthen their psychosocial capacity and conduct strengthening programs. Furthermore, introducing some of the already existing programs against self-stigmatization should be considered at all levels of medical care for psychiatric patients.

This study has several limitations. Sample of the people with mental disorders were conve-

prigodan s obzirom da su u istraživanje bili uključeni oni pacijenti koji su tijekom navedenog razdoblja bili na liječenju u Klinici za psihijatriju KBC-a Rijeka. Iz navedenog proizlaze još dva ograničenja: zbog jednostavnosti pristupa i ograničenog vremena nismo bili u mogućnosti uključiti duševne bolesnike koji funkcioniraju u svakodnevnim životnim aktivnostima, odnosno ne liječe se u okviru psihijatrijske bolničke skrbi. Uz to, u istraživanju su bili uključeni samo pacijenti jedne psihijatrijske klinike kojoj uglavnom gravitiraju osobe s prebivalištem u jednom dijelu Hrvatske (Istra, Primorje, Gorski kotar i Lika). Ograničavajući faktor je i relativno malen uzorak ispitanika. Također, u istraživanju su bili uključeni duševni bolesnici bez obzira na njihovu osnovnu psihijatrijsku dijagnozu. S obzirom da je ovim istraživanjem utvrđena povezanost i utjecaj samopoštovanja i samoefikasnosti na samostigmatizaciju, u narednim bi studijama trebalo istražiti utjecaj nekih drugih psihosocijalnih elemenata, poput kvalitete života, samoće, socijalne izoliranosti i nade. Također, trebalo bi ispitati razinu samostigmatizacije prema skupinama psihijatrijskih poremećaja, primjerice na skupini ispitanika s anksioznim poremećajima, poremećajima osobnosti, bolestima ovisnosti ili onima koji boluju od shizofrenije i srodnih poremećaja.

ZAKLJUČAK

Značajan dio ispitanika iskazuje samostigmatizirajuće stavove te su oni povezani sa smanjenim razinama samopoštovanja i samoefikasnosti. Ovim je istraživanjem još jednom potvrđena prisutnost samostigmatizirajućih stavova, odnosno da je samostigma karakteristično obilježje duševnih bolesnika. Ovakvi stavovi refleksija su prisutnih društvenih stereotipa prema osobama s mentalnim bolestima te njihovog prihvaćanja i primjene od strane duševnih bolesnika, što su preduvjeti nastanka samostigme. Radi se o kompleksnoj vezi različi-

nient considering that the study included patients that were undergoing treatment at the Psychiatry Clinic of the Clinical Hospital Centre Rijeka. This results in two more limitations: due to the simplicity of approach and limited time we were not able to include mentally ill people who function in everyday activities, i.e. people who are not undergoing treatment within the scope of psychiatric medical care. The study only included patients from one psychiatric clinic, where people with a permanent residence in only one part of Croatia (Istra, Primorje, Gorski kotar, or Lika) gravitate. Another limiting factor is a relatively small sample as well. Also, the research included mentally ill people regardless of their basic psychiatric diagnosis. Considering that this study established a connection with and influence of self-esteem and self-efficacy on self-stigmatization, future studies should explore the influence of some other psychosocial elements, such as quality of life, loneliness, social isolation, and hope. Also, the level of self-stigma should be explored in respect to groups of people with psychological disorders, for example in a group of examinees suffering from anxiety disorders, personality disorders, addiction, schizophrenia, or similar disorders.

CONCLUSION

A considerable segment of examinees express self-stigmatizing attitudes and these are connected to reduced levels of self-esteem and self-efficacy. This study once again confirmed the presence of self-stigmatizing attitudes, i.e. that self-stigma is a distinctive characteristic in mentally ill people. Such attitudes reflect the existing social stereotypes in respect to the mentally ill people and the acceptance and implementation of these stereotypes by mentally ill people, which are prerequisites for the occurrence of self-stigma. This is related to a complex connection of various internal

tih vanjskih i unutarnjih faktora koji u konačnici imaju dalekosežne posljedice na liječenje i tijek bolesti pojedinca, kvalitetu njihova života, životnu funkcionalnost te na njihove socijalne i društvene interakcije.

Uloga zdravstvenih djelatnika koji su završili edukaciju iz promocije i zaštite mentalnog zdravlja jest da budu upoznati s posljedicama samostigmatizacije te da prepoznaju pojavu takvih stavova kod oboljelih od duševnih bolesti i budu sposobni pružiti im podršku i pomoć. Također, važna je preventivna uloga ovog profila zdravstvenih djelatnika koji u direktnom kontaktu s bolesnicima mogu raditi na povećanju samopoštovanja i samoefikasnosti.

and external factors that eventually result in far-reaching consequences for the treatment and course of an individual's illness, the quality of their life, life functionality, and their social interactions.

The role of healthcare professionals who completed their education in health promotion and health is to be familiar with the consequences of self-stigmatization, recognize the occurrence of such attitudes in mentally ill people, and be capable of providing them with support and help. Also, prevention is important for healthcare professionals who can work on increasing self-esteem and self-efficacy in a direct contact with mentally ill people.

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Mjerenje zadovoljstva životom jednom česticom / *Single-Item Life Satisfaction Measurement*

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Generalno zadovoljstvo životom često je mjereno jednom česticom, no psihometrijske karakteristike takvog načina mjerenja rijetko su provjeravane. Glavni cilj ovog istraživanja je provjera pouzdanosti i valjanosti mjerenja zadovoljstva životom jednom česticom uspoređujući mjerenje jednom česticom s Ljestvicom zadovoljstva životom (SWLS). Istraživanje je provedeno na tri nezavisna prigodna uzorka studenata i odraslih. Pouzdanost mjerenja zadovoljstva životom jednom česticom procijenjena je dvjema metodama procjene (korištenjem formule za korekciju zbog atenuacije i korištenjem faktorske analize). Obje metode ukazuju zadovoljavajuću pouzdanost jedne čestice u sva tri nezavisna uzorka. Mjerenje zadovoljstva životom jednom česticom pokazalo je odgovarajuću kriterijsku valjanost. Kako bismo provjerili konstruktnu valjanost koristili smo povezanost između dviju mjera zadovoljstva životom i mjera općeg psihičkog distresa (CORE-10, CORE-OM i DASS-21). Rezultati ukazuju na zadovoljavajuću konstruktnu valjanost mjere zadovoljstva životom jednom česticom, odnosno ukazuju da je ta mjera snažnije povezana s mjerama općeg psihičkog distresa.

/ General life satisfaction is often measured by a single item, but psychometric characteristics of this form of measurement are rarely verified. The main goal of this research is the verification of reliability and validity of single-item life satisfaction measurement by comparing single-item measurement with the Satisfaction with Life Scale (SWLS). The research was conducted on three independent convenience samples of students and adults. The reliability of single-item life satisfaction measurement was evaluated using two evaluation methods (using the correction for attenuation formula and factor analysis). Both methods indicate satisfactory reliability of a single item in all three independent samples. Single-item life satisfaction measurement showed appropriate criterion validity. In order to verify construct validity, the correlation between two life satisfaction measurements and general psychological distress measurements (CORE-10, CORE-OM, and DASS-21) was utilized. The results indicate satisfactory construct validity of single-item life satisfaction measurement, which implies that this measurement is more strongly associated with measurements of general psychological distress.

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KLJUČNE RIJEČI / *KEY WORDS*:
Zadovoljstvo životom / *Life Satisfaction*
Mjere s jednom česticom / *Single-Item Measurement*
Pouzdanost / *Reliability*
Valjanost / *Validity*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2019.449

UVOD

Pojam subjektivne dobrobiti podrazumijeva afektivne i kognitivne procjene koje neka osoba donosi o kvaliteti svog života (1). Tako ona uključuje doživljavanje ugodnih emocija, nisku razinu neugodnih raspoloženja i visok stupanj zadovoljstva životom (2). Zadovoljstvo životom kao kognitivna komponenta subjektivne dobrobiti evaluacijski je proces kojim osoba ocjenjuje kvalitetu svog života prema vlastitom jedinstvenom setu kriterija (3). Čine ga dva aspekta: globalni osjećaj zadovoljstva životom i zadovoljstvo pojedinim područjima života (3). Globalni osjećaj zadovoljstva životom podrazumijeva širu, kognitivno utemeljenu evaluaciju pojedinca o kvaliteti života u cjelini, a zadovoljstvo pojedinim područjima života predstavlja evaluaciju specifičnih aspekata života (3). Upravo zbog različitih standarda usporedbe između pojedinaca prigodom procjene zadovoljstva životom važno je ispitati globalnu procjenu nečijeg života, a ne samo zadovoljstvo pojedinim aspektima života (3). Osoba može biti zadovoljna u većini područja svog života, ali zbog nezadovoljstva u samo jednom području ipak sveukupno biti nezadovoljna. Globalna procjena zadovoljstva životom povezanija je s područjima koja su pojedincu važnija, nego s onima manje važnima (4). Zadovoljstvo životom tako je mjera kognitivne procjene kvalitete ukupnih životnih okolnosti u kojima pojedinac živi (5).

Istraživanja sustavno pokazuju važnost konstrukta zadovoljstva životom, jer je snažno i konzistentno povezan s pozitivnim životnim ishodima poput zdravlja, prihoda i bolje radne učinkovitosti (1,6-8). Zadovoljstvo životom jedan je od nekoliko aspekata mentalnog zdravlja. Mjere zadovoljstva životom osjetljive su na cijeli spektar funkcioniranja te su istovremeno i indikator psihopatologije i dobrobiti. Zadovoljstvo životom tako je pozitivno povezano s općim zdravljem, optimizmom, samoučinkovitošću i samopoštovanjem (9-13), a negativno

INTRODUCTION

Subjective wellbeing implies a person's affective and cognitive estimates regarding their quality of life (1). This includes the experience of positive emotions, a low level of unpleasant moods, and a high level of life satisfaction (2). Life satisfaction as a cognitive component of subjective wellbeing is an evaluation process through which a person evaluates the quality of their life according to their unique set of criteria (3). It is constituted of two aspects: the overall feeling of life satisfaction and satisfaction with individual areas of life (3). The overall feeling of life satisfaction implies an individual's wider, cognitive-based evaluation regarding overall quality of life, while satisfaction with individual areas of life represents evaluation of specific aspects of life (3). A person can be satisfied with the majority of their areas of life, but dissatisfaction with only one area can lead to overall dissatisfaction. Overall life satisfaction evaluation is more connected with areas which are more important for an individual than with those which are less important (4). Life satisfaction is therefore the measurement of cognitive quality evaluation of overall life circumstances of an individual's life (5).

Studies consistently show the importance of the life satisfaction construct because it is strongly and consistently correlated with positive life outcomes such as health, income, and improved work efficiency (1,6-8). Life satisfaction is one of several aspects of mental health. Life satisfaction measurements are sensitive to an entire range of functioning and are simultaneously an indicator of psychopathology and wellbeing. Life satisfaction is positively associated with overall health, optimism, self-efficacy, and self-respect (9-13), and negatively with depression, anxiety, and general psychological distress (14) and negative affect (15).

Experts have consistently supported the inclusion of measurements of life satisfaction in

s depresivnošću, anksioznošću i općim psihološkim distresom (14) te negativnim afektom (15).

Stručnjaci se uporno zalažu za uključivanje mjere zadovoljstva životom u strategije javnih politika. Tako Francuska od 2010. g., a Velika Britanija od 2011. g. sustavno mjere stupanj zadovoljstva životom svojih građana koristeći rezultate kao smjernice za različite strateške odluke. Vlada SAD-a provodi projekt *Healthy People 2020* čiji je cilj promocija kvalitete života, a u kojem je jedna od mjera i zadovoljstvo životom (1). Podatci o zadovoljstvu životom koriste se u svrhu mjerenja kvalitete života, praćenja socijalnog napretka, evaluacije politika i identificiranja uvjeta dobrog života (16).

Zbog svog iznimnog značenja mjera zadovoljstva životom uključena je i u sveobuhvatna socijalna istraživanja. Primjer takvih mjera su panel studije poput *Germany Socio-Economic Panel* (GSOEP), *British Household Panel Study, Swiss Household Panel i Australian Household, Income and Labour Dynamics* (HILDA) te međunarodna istraživanja političkih, socijalnih, ekonomskih i kulturoloških determinanti kvalitete života poput *Gallup World Poll, World Values Survey* te *European Social Survey*. Ovakva istraživanja provode se kako bi se utvrdili različiti aspekti funkcioniranja pojedinca u društvu te stoga moraju biti provedena na velikim reprezentativnim uzorcima, a uključuju brojna pitanja. Radi toga je primarni cilj zadržati pažnju sudionika kako bi odgovorio na sva pitanja, čemu idu u prilog kratke, ali pouzdane i valjane mjere. Zadovoljstvo životom se često mjeri samo s jednom česticom koja u pravilu glasi "*Koliko ste zadovoljni svojim životom kao cjelinom*", a odgovara se na ljestvici čiji se broj stupnjeva razlikuje od istraživanja do istraživanja (1). Ovakav način mjerenja je u skladu s Teorijom homeostaze subjektivne kvalitete života autora Roberta A. Cumminsa (17). Uočivši da ljudi uglavnom opisuju svoje zadovoljstvo životom koristeći se pozitivnim

public policy strategies. Since 2010 in France and 2011 in Great Britain, the citizens' level of life satisfaction has been consistently measured and the results used as guidelines for various strategic decisions. The USA government is implementing a project called *Healthy People 2020*, the goal of which is the promotion of life quality and the measurements of which include life satisfaction (1). Data on life satisfaction are used for the purposes of measuring life quality, monitoring social progress, policy evaluation, and the identification of conditions for a good life (16).

Due to its extraordinary importance, life satisfaction measurement has been included in comprehensive social studies. Examples of such measures include panel studies such as *Germany Socio-Economic Panel* (GSOEP), *British Household Panel Study, Swiss Household Panel*, *Australian Household, Income and Labour Dynamics* (HILDA), and international studies of political, social, economic, and cultural determinants of quality of life, such as *Gallup World Poll, World Values Survey* and *European Social Survey*. Such studies are conducted in order to determine various aspects of an individual's functioning in society and therefore must be conducted on large representative samples, and include numerous questions. Due to this, the primary goal is to retain the participants' attention so that they answer all questions, which is why brief but reliable and valid measurements are an advantage. Life satisfaction is often measured using a single item, which is usually "*How satisfied are you with your life overall?*" and is answered on a scale whose number of components varies from study to study (1). This form of measurement is in accordance with the theory of subjective wellbeing homeostasis by Robert A. Cummins (17). Noticing that people usually describe their satisfaction with life using the positive part of the scale ranging from dissatisfaction to satisfaction, Cummins (17,18) posits a hypothesis

dijelom ljestvice raspona od nezadovoljstva do zadovoljstva, Cummins (17,18) postavlja hipotezu o održavanju kvalitete života u ravnoteži, tj. hipotezu o postojanju mehanizma za održavanje doživljaja subjektivne kvalitete života na određenoj razini, na višim pozitivnim vrijednostima (između 60-80 % ljestvičnog maksimuma). Rezultati istraživanja pokazuju da značajne promjene u životnim uvjetima dovode do privremene promjene u razini kvalitete života, ali da tijekom vremena dolazi do povratka razine kvalitete života na onu karakterističnu za pojedinca, dok samo ekstremni unutrašnji ili vanjski čimbenici dovode do trajnog, značajnog smanjenja samoprocjene kvalitete života (19).

Instrumenti koji mjere zadovoljstvo životom pojavljuju se u tri formata: 1. mjerenje zadovoljstva životom jednom česticom (npr. 17,18,20), 2. mjerenje zadovoljstva životom ljestvicom općeg zadovoljstva (npr. 21,22) i 3. mjerenje zadovoljstva životom po specifičnim životnim domenama (npr. 23,24). U posljednje se vrijeme sve češće koriste izrazito kratke i globalne mjere, posebice u istraživanjima koja koriste *on-line* metodu prikupljanja podataka.

Nekoliko je praktičnih i teorijskih prednosti kratkih mjera. Kratke mjere smanjuju troškove istraživanja i njegovu dužinu (25), razumljive su sudionicima istraživanja i reprezentiraju globalan način na koji ljudi razmišljaju (26). Teorijska prednost mjera jednom česticom veže se uz jasniju standardizaciju mjere nekog konstrukta. Uporaba istih standardiziranih, besplatnih za upotrebu i lako implementiranih mjera može olakšati prikupljanje usporedivih rezultata u različitim istraživanjima (26), te biti poticaj za evaluaciju ishoda u kliničkoj praksi (27).

Unatoč navedenim razlozima za korištenje mjera s jednom česticom, postoji preferencija korištenja mjera s više čestica zbog pretpostavljenih boljih psihometrijskih svojstava dužih ljestvica (28), koje označava viši stupanj pouz-

on the maintenance of quality of life in balance, i.e. a hypothesis on the existence of a mechanism for maintaining the experience of subjective wellbeing on a certain level, on higher positive values (between 60 and 80% of the scale maximum). Study results show that significant changes in living conditions lead to a temporary change in the level of quality of life, but that over time the level of quality of life returns to that characteristic for an individual, while only extreme internal or external factors lead to a permanent, significant reduction in self-evaluation of quality of life (19).

Instruments for quality of life measurement appear in three formats: 1. single-item life satisfaction measurement (e.g. 17,18,20), 2. life satisfaction measurement using the general satisfaction with life scale (e.g. 21,22), and 3. life satisfaction measurement according to specific domains (e.g. 23,24). Recently, very short, general measurements have increasingly been used, especially in studies using the on-line method of data collection.

Short measurements have several practical and theoretical advantages. Short measurements reduce study expenses and its length (25), are understandable for study participants, and represent the general way people think (26). The theoretical advantage of single-item measurement is linked with a clearer standardization of the measurement of a certain construct. Using the same standardized, free to use, and easy to implement measurements can facilitate the collection of comparable results in various studies (26) and serve as incentive for the evaluation of outcomes in clinical practice (27).

Despite the abovementioned reasons for using single-item measurements, there is a preference for using multi-item measurements due to assumed improved psychometric characteristics of longer scales (28), which are marked by a greater level of reliability and validity due to increased variability of results and greater range of measurement (29-32).

danosti i valjanosti zbog povećane varijabilnosti rezultata i veće širine mjerenja (29-32).

Kao potencijalni problem primjene mjera jednom česticom često se navodi poteškoća u dokazivanju njezinih psihometrijskih karakteristika. Smatra se kako mjere jednom česticom imaju nisku pouzdanost zbog osjetljivosti na djelovanje nesistematskih varijabilnih faktora te povezano s tim i nisku razinu valjanosti. Glavna kritika primjene mjera jednom česticom je nemogućnost procjene pouzdanosti tipa unutarnje konzistencije. Zbog toga se procjene pouzdanosti mjera jednom česticom određuju alternativnim metodama (npr. 33). Čak i uz relativno visoku pouzdanost, valjanost može biti niska ili barem slabija nego kod ljestvica s više čestica. Ljestvice s više čestica mogu zahvatiti različite značajke konstrukta, što rezultira valjanijom mjerom. Glavna zabrinutost u vezi mjera jednom česticom je da su one vrlo uske i možda neće biti moguće uhvatiti širinu konstrukta. Iako je zadovoljstvo životom relativno uski konstrukt, koji se može zahvatiti jednim pitanjem, potrebne su izravne usporedbe valjanosti mjera s jednom i više čestica.

Mjere s više čestica, međutim, imaju neka ograničenja radi kojih se u istraživačkom i kliničkom radu možemo odlučiti za primjenu samo jedne čestice. Prigodom ispunjavanja monotonih ljestvica s dugim trajanjem sudionici mogu osjetiti dosadu, iritaciju, zamor, gnjavažu, frustraciju ili ljutnju (34,35). To može rezultirati smanjenom kognitivnom participacijom (36) koja povećava nemarno i nasumično odgovaranje, koje narušava pouzdanost i valjanost rezultata (37,38). Čak i niska razina nepažljivog i nasumičnog odgovaranja može značajno utjecati na valjanost korelacijskih istraživanja (39,40). Niska stopa odgovaranja može dovesti i do pristranog uzorka (41) što utječe na mogućnost generalizacije rezultata (42). Mjere jednom česticom mogu imati veću pojavnu valjanost zbog percepcije čestice kao direktne mjere konstrukta (43). Mjere jednom česticom mogu

One commonly cited potential problem of applying single-item measurements is the difficulty of proving its psychometric characteristics. It is believed that single-item measurements have a low reliability due to their sensitivity to non-systematic variable factors and therefore have a low level of validity. The main criticism of the application of single-item measurements is related to the impossibility of assessing the type of internal consistency reliability. Therefore, assessments of the reliability of single-item measurements are determined using alternative methods (e.g. 33). Even with relatively high reliability, validity can be low or at least lower than in multi-item scales. Multi-item scales can encompass various construct characteristics, which results in a more valid measurement. The main concern regarding single-item measurements is that they are very narrow and may not be capable of encompassing the construct range. Although life satisfaction is a relatively narrow construct, which can be encompassed with only one question, there is a need for direct comparison of validity of single-item and multi-item measurements.

However, multi-item measurements have certain limitations which can lead to the application of only one item in research and clinical work. While filling in monotonous scales that take a long time, participants may experience boredom, irritation, fatigue, annoyance, frustration, or anger (34,35). This may result in reduced cognitive participation (36) which increases careless and random answering, which then lowers reliability and validity of results (37,38). Even a low level of inattentive and random answering may significantly affect the validity of correlational studies (39,40). A low rate of answers may also lead to a biased sample (41), which affects the possibility of generalizing the results (42). Single-item measurements may have greater face validity due to the perception of the item as a direct measurement of construct (43). Single-item measurements may be stimulating for use in clinical practice be-

biti poticajne za uporabu u kliničkoj praksi jer omogućuju trijažu onih pacijenata kojima je potrebna detaljnija provjera, te evaluaciju i praćenje ishoda liječenja (27,44).

Druga psihometrijska prednost korištenja mjera jednom česticom odnosi se na problem varijance zajedničke metode. Ako su podatci prikupljeni na isti način može doći do međusobne povezanosti koja se više temelji na vrsti podataka nego na stvarnim vezama između varijabli (45). U odnosu na mjere s više čestica mjere s jednom česticom mogu pružiti točniju procjenu nekog globalnog, složenijeg koncepta. Tako, primjerice, istraživanja provedena s psihijatrijskim (27) i onkološkim (44) pacijentima pokazuju kako se na temelju globalnih mjera mogu razlikovati sudionici kojima je potrebna pomoć zbog depresivnih smetnji, stresa, umora i snižene kvalitete života. Prigodom mjerenja nekog globalnog konstrukta mjerom koju čini jedna čestica odgovor sudionika može reflektirati samo one facete koje su njemu osobno važne, dok su kod mjera s više čestica sve facete jednako vrednovane. Mjera jednom česticom prikladna je za one konstrukte koji imaju jednoznačno značenje kod sudionika, koji se mogu lako i podjednako zamisliti te za one konstrukte čiji su atributi konkretni (32). Također, globalna mjera konstrukta može biti korisna istraživačima kada je riječ o konstruktima koji su relativno veliki što otežava stvaranje čestica koje obuhvaćaju sve njegove atribute. Dodatna prednost korištenja mjera jednom česticom je jasnoća u prenošenju rezultata laicima jer se uporišnim točkama čestice mogu dodijeliti lako razumljiva značenja. Istraživanja su pokazala kako jedna čestica može pružiti smisleniju informaciju kad je riječ o konstruktima koji su jednoznačni i jasni sudionicima (46).

Dosadašnja istraživanja pouzdanosti i valjanosti mjerenja zadovoljstva životom jednom česticom daju obećavajuće rezultate. Istraživanja kriterijske valjanosti, koja označava stupanj u

cause they enable triage of patients who require more detailed examination and evaluation and monitoring of treatment outcomes (27,44).

The second psychometric advantage of using single-item measurements is related to the problem of common-method variance. If the data was collected in the same way, this may lead to interconnectedness based more on the type of data than on actual connections between variables (45). In comparison with multi-item measurements, single-item measurements may offer a more precise evaluation of a global, more complex concept. For example, studies conducted on psychiatric (27) and oncological (44) patients show that global measurements may indicate which participants need help due to depression, stress, fatigue, and reduced quality of life. While measuring a certain global construct using single-item measurement, the participants' replies may reflect only those facets that are important to them personally, while in the case of multi-item measurements all facets are equally evaluated. Single-item measurement is appropriate for constructs which participants perceive as having a single meaning, which can be easily and equally imagined, and those whose attributes are concrete (32). Also, global measurement of construct may be valuable for researchers when constructs are relatively large, which complicates the creation of items that encompass all of their attributes. An added advantage of using single-item measurement is the clarity in conveying the results to laypeople because easily understandable meaning can be attributed to the item's reference points. Studies have shown that a single item can offer more meaningful information in the case constructs that are unequivocal and clear to the participants (46).

Existing studies of reliability and validity of single-item life satisfaction measurements provide promising results. Studies on criterion validity, which indicates to what degree the results measured using a certain questionnaire

kojemu su rezultati mjereni određenim upitnikom povezani kriterijem koji je zlatni standard, daju podršku kriterijskoj valjanosti mjerenja zadovoljstva životom jednom česticom (1,47-49). Također, istraživanja konstruktne valjanosti, koja se definira kao stupanj u kojemu su rezultati mjereni određenim upitnikom povezani s drugim mjerama na način koji je konzistentan s teorijski određenim hipotezama, idu u prilog mjerenja zadovoljstva životom jednom česticom. Usporedbom Ljestvicom zadovoljstva životom (21) dobivena je slična povezanost sa sociodemografskim varijablama i različitim mjerama zdravlja, ličnosti i dobrobiti (1,49). Također je dobivena slična povezanost između dviju mjera zadovoljstva životom sa školskim uspjehom te različitim indikatorima mentalnog zdravlja i dobrobiti (48).

Dosadašnja istraživanja pouzdanosti i valjanosti mjerenja zadovoljstva životom su malobrojna unatoč čestom korištenju jedne čestice kao mjere zadovoljstva životom. Upravo zbog široke primjene mjera jednom česticom kao i sve brojnijih istraživanja, pogotovo *online* metodom koja nam donosi budućnost, u kojima mjerne ljestvice trebaju biti kratke, a isto tako i pouzdane i valjane u reprezentiranju konstrukta koji mjere, važno je prikupljati informacije o metrijskim karakteristikama mjera zadovoljstva životom jednom česticom. Zbog važnosti populacijskih procjena kvalitete života važno je provjeriti psihometrijska svojstva takvih mjera u različitim kulturama. Do sada nije bilo istraživanja valjanosti i pouzdanosti mjerenja zadovoljstva životom jednom česticom na uzorcima građana Hrvatske te je ovaj rad tako prvo takvo istraživanje.

Cilj ovog istraživanja bio je utvrditi psihometrijska svojstva, odnosno odrediti stupanj pouzdanosti, te kriterijsku i konstruktnu valjanost mjere zadovoljstva životom jednom česticom. Konkretno, procijenili smo valjanost kriterija mjere zadovoljstva životom s jednom česticom uspoređujući ih dobro utvrđenom

are related to the criterion which is the gold standard, provide support for criterion validity of single-item life satisfaction measurement (1,47-49). Also, studies of construct validity, which indicates to what degree the results measured using a certain questionnaire are related to other measurements in a way that is consistent with theoretically defined hypotheses, go in favour of single-item life satisfaction measurement. A comparison with the Satisfaction with Life Scale (21) provided a similar correlation with sociodemographic variables and various measurements of health, personality, and wellbeing (1,49). A similar correlation between two life satisfaction measurements and school achievement and various indicators of mental health and wellbeing was also discovered (48).

Existing studies of reliability and validity of life satisfaction measurements are few in number despite the fact that a single item is commonly used in life satisfaction measurement. Due to the wide application of single-item measurement, as well as the increasing number of studies, especially those using the on-line method, in which the measurement scales need to be short but also reliable and valid in representing the measured construct, it is important to collect information on metric characteristics of single-item life satisfaction measurements. Due to the importance of the evaluation of the population's quality of life, it is important to examine the psychometric characteristics of such measurements in various cultures. There have been no previous studies of the validity and reliability of single-item life satisfaction measurement on a sample of Croatian citizens, which makes this paper the first such study.

The goal of this study was to determine the psychometric characteristics, i.e. identify the degree of reliability and the criterion and construct validity of single-item life satisfaction measurement. More specifically, we evaluated the validity of single-item life satisfaction measurements by comparing them using a well-established

mjerom zadovoljstva životom s više čestica – Ljestvica zadovoljstva životom (21). Konstruktnu valjanost smo utvrdili usporedbom povezanosti između dviju mjera zadovoljstva životom i teorijski relevantnog konstrukta psihičkog distresa. Važno je istaknuti da smo istraživanja proveli na tri neovisna uzorka punoljetnih osoba.

multi-item life satisfaction measurement – the Satisfaction with Life Scale (21). Construct validity was determined using a comparison of correlation between two life satisfaction measurements and the theoretically relevant construct of psychological distress. It is important to emphasize that the studies were conducted on three independent samples of adults.

METODA

Sudionici

Istraživanje je provedeno na tri neovisna, prigodna uzorka, jednom uzorku studenata, a druga dva odraslih zaposlenih osoba. U istraživanju je sudjelovalo N_S=687 studenata (od toga 74,5 % studentica) u dobi od 18 do 26 godina (M_S = 21,5, SD_S = 1,90). U prvom uzorku odraslih sudjelovalo je N_{O1}=174 (77 % žena) zaposlenih u dobi između 22 i 62 godine (M_{O1} = 35,7, SD_{O1} = 8,25), a u drugom N_{O2}=221 sudionik (95 % žena) u dobi od 20 do 72 godine (M_{O2} = 41,3, SD_{O2} = 12,49). Neke analize provedene su na studentskom i ukupnom odraslom uzorku (N_O=395).

Mjerni instrumenti

U sva tri uzorka primijenjene su dvije identične mjere procjene zadovoljstva životom, te je uz njih, u svakom uzorku primijenjena različita mjera psihičkog distresa.

Ljestvica zadovoljstva životom (engl. *Satisfaction with Life Scale*, SWLS)(21) je globalna procjena zadovoljstva životom te je najčešće korištena mjera zadovoljstva životom. Sastoji se od pet tvrdnji za koje sudionici procjenjuju svoj stupanj slaganja. U izvornoj verziji riječ je o ljestvici Likertovog tipa sa sedam uporišnih točaka i ta je originalna verzija korištena u dva odrasla uzorka. U studentskom uzorku korištena je modificirana verzija s petostupanjskom ljestvicom, što je sukladno istraživanjima

METHOD

Participants

The study was conducted on three independent convenience samples, one consisting of students and the remaining two of employed adults. N_S=687 students participated in the study (74.5% of whom were female) aged between 18 and 26 (M_S = 21.5, SD_S = 1.90). In the first sample of adults, N_{O1}=174 (77% women) were employed adults aged between 22 and 62 (M_{O1} = 35.7, SD_{O1} = 8.25), while in the second there were N_{O2}=221 participants (95% women) aged between 20 and 72 (M_{O2} = 41.3, SD_{O2} = 12.49). Some analyses were conducted on both the student and total adult samples (N_O=395).

Measurement instruments

In all three samples two identical life satisfaction assessment measurements were applied, and in each sample another different measurement of psychological distress was also applied.

The Satisfaction with Life Scale (SWLS) (21) is a global assessment of life satisfaction and is the most commonly used life satisfaction measurement. It consists of five items, with participants assessing to what extent they agree with each of them. The original version contained a Likert scale with seven reference points, and this original version was used in two adult samples. A modified version with a five-point scale was used in the student sample, which is in accordance with studies that have shown

koja su pokazala kako je verzija s pet stupnjeva usporediva s onom od sedam stupnjeva (50) te da su psihometrijske karakteristike obiju vrsta ljestvica gotovo identične (51). Ukupan rezultat izračunava se zbrajanjem rezultata na svim tvrdnjama (raspon od 5 do 25) i označava stupanj zadovoljstva životom pri čemu veći rezultat predstavlja veće zadovoljstvo. Pouzdanost tipa unutarnje konzistencije mjerena Cronbach alfa koeficijentom u ovom istraživanju na studentskom uzorku iznosi α_S = 0,78 (petostupanjska ljestvica), a na dva odrasla uzorka koji su procjene davali na sedam stupnjeva koeficijenti pouzdanosti su redom α_{O1} = 0,87; α_{O2} = 0,90.

Zadovoljstvo životom izmjereno je i česticom „*Koliko ste sveukupno zadovoljni svojim životom*?" ljestvicom za procjenu od 0 (u potpunosti nezadovoljan/a) do 10 (u potpunosti zadovoljan/a).

Psihički distres

U prvom odraslom uzorku psihički distres procijenjen je CORE-OM upitnikom (engl. *Clinical Outcome in Routine Evaluation – Outcome Measures*)(52,53) koji je konstruiran kao panteorijska i pandijagnostička mjera opće psihološke uznemirenosti, a sadrži 34 čestice. Zadatak sudionika je procijeniti koliko često se osjećao na opisani način tijekom proteklog tjedna (0-nikada, 1-vrlo rijetko, 2-ponekad, 3-često, 4-gotovo uvijek). Čestice se odnose na četiri dimenzije - subjektivna dobrobit, problemi/simptomi, svakodnevno funkcioniranje i rizik. U ovom istraživanju koristili smo ukupni rezultat kao mjeru općeg psihičkog distresa, te se teorijski raspon kreće od 0 do 136. Koeficijent pouzdanosti tipa unutarnje konzistencije je visok i iznosi α = 0,95.

U studentskom uzorku koristili smo skraćenu verziju CORE-OM upitnika – CORE-10 (engl. *Clinical Outcome in Routine Evaluation – 10*)(54). Sadrži deset čestica koje obuhvaćaju iskustvo anksioznih i depresivnih simptoma, traumu,

that the version with five points is comparable with the one with seven points (50) and that the psychometric characteristics of both scale types are almost identical (51). The total score is obtained by adding the results of all items (randing from 5 to 25) and indicates the degree of life satisfaction, with a higher score representing greater satisfaction. The reliability of the type of internal consistency measured by Cronbach's alpha coefficient on the student sample of this study was α_S = 0.78 (five-point scale), while in the case of the two adult samples with assessments given for seven points the coefficients of reliability were α_{O1} = 0.87 and α_{O2} = 0.90 respectively.

Life satisfaction was also measured using the item "*How satisfied are you with your life overall?*" with the assessment scale ranging from 0 (completely dissatisfied) to 10 (completely satisfied).

Psychological distress

In the first adult sample, psychological distress was assessed using the CORE-OM questionnaire (*Clinical Outcome in Routine Evaluation – Outcome Measures*) (52,53) which was constructed as a pantheoretical and pandiagnostic measurement of general psychological distress consisting of 34 items. The participants' task was to assess how often they felt a certain way over the preceding week (0-never, 1-very rarely, 2-sometimes, 3-often, 4-almost always). The items were related to four dimensions – subjective wellbeing, problems/symptoms, everyday functioning, and risk. In this study the total result was used as a measurement of general psychological distress, with the theoretical range from 0 to 136. The reliability coefficient of the type of internal consistency was high at α = 0.95.

A shortened version of the COME-OM questionnaire was used in the student sample – the CORE-10 (*Clinical Outcome in Routine Evaluation - 10*) (54). It contains ten items encompassing the experience of symptoms of anxiety

tjelesne probleme, funkcioniranje (generalno, intimni i socijalni odnosi) te rizik za sebe. Sudionici daju svoje procjene na ljestvici od 0 - nikada do 4 - gotovo uvijek. Ukupan rezultat je zbroj procjena za svaku tvrdnju, a viši rezultat upućuje na višu razinu općeg psihičkog distresa (raspon od 0 do 40). Pouzdanost ljestvice je zadovoljavajuća i iznosi α = 0,82.

U drugom uzorku odraslih koristili smo Ljestvicu depresivnosti, anksioznosti i stresa (DASS-21, engl. *Depression, Anxiety and Stress Scale-21*) (55) koja mjeri učestalost i intenzitet neugodnih emocionalnih stanja depresivnosti, anksioznosti i stresa u razdoblju od proteklih sedam dana. Sastoji se od tri podljestvice: depresivnosti (DASS-21D), anksioznosti (DASS-21A) i stresa (DASS-21S). Svaka podljestvica sastoji se od 7 čestica, a zadatak sudionika je označiti koliko se svaka tvrdnja odnosila na njega u proteklih tjedan dana na ljestvici Likertovog tipa sa četiri stupnja (0 - uopće se nije odnosilo na mene, do 3 - gotovo u potpunosti ili većinu vremena se odnosilo na mene). Rezultat za svaku podljestvicu kreće se u rasponu od 0 do 21 i računa se tako da se zbroje rezultati dobiveni na 7 čestica koje čine podljestvicu. Ukupni rezultat se dobiva zbrajanjem rezultata na svim podljestvicama, a teorijski raspon je od 0 do 63. Pouzdanost cijele ljestvice na našem uzorku iznosi α = 0,95.

Osim navedenog, primijenjen je i upitnik demografskih podataka kojim su prikupljeni podatci o dobi, spolu, obrazovanju te mjestu/gradu življenja.

REZULTATI

Prema vrijednostima Kolmogorov-Smirnovljevog testa distribucije Ljestvice zadovoljstva životom (na studentskom uzorku), čestice koja samostalno predstavlja mjeru zadovoljstva životom te CORE-10 i CORE-OM upitnika statistički značajno odstupaju od normalne (tablica 1). Kolmogorov-Smirnovljev test je zbog

and depression, trauma, physical problems, functioning (general, intimate, and social relations), and risk to oneself. The participants provide their assessments on a scale from 0 – never to 4 – almost always. The total result is gained by adding the assessment for each item, with a higher result indicating a higher level of general psychological distress (ranging from 0 to 40). The scale reliability is satisfactory at α = 0.82.

In the second adult sample the DASS-21 scale (*Depression, Anxiety and Stress Scale-21*) (55) was used, which measure the frequency and intensity of unpleasant emotional states of depression, anxiety, and stress within the preceding seven days. It consists of three sub-scales: depression (DASS-21D), anxiety (DASS-21A), and stress (DASS-21S). Each sub-scale consists of seven items, and the participants' task is to indicate to what extent each claim was true for them over the preceding week on a Likert type scale with four points (from 0 – not true for me to 3 – almost completely or most of the time true for me). The result for each sub-scale ranges from 0 to 21 and is gained by adding together the results gained on the seven items that make up the sub-scale. The total result is gained by adding together the results of all sub-scales, with the theoretical range from 0 to 63. The reliability of the entire scale on our sample was α = 0.95.

Furthermore, a questionnaire on demographic data was also used to collect data on age, gender, education, and place of residence.

RESULTS

According to the values of the Kolmogorov-Smirnov distribution test of the Satisfaction with Life Scale (on the student sample), the items that independently represent the measurement of life satisfaction and the CORE-10 and CORE-OM questionnaires statistically significantly deviate from the norm (table 1). Due to its sensitivity to sample size, the Kolmogorov-Smirnov test is occasionally a

svoje osjetljivosti na veličinu uzorka ponekad prestrog pokazatelj normalnosti distribucije te može biti značajan čak i kad se rezultati neznatno razlikuju od normalne distribucije (56). Zbog navedenog, najbolje je zaključiti je li distribucija normalna na temelju asimetričnosti i spljoštenosti distribucija. Uvidom u indekse asimetričnosti i spljoštenosti sve distribucije se mogu smatrati normalnima i prihvatljivima za daljnje korištenje parametrijskih postupaka, jer se prema Klineovim parametrima normalnosti distribucije indeksi asimetričnosti nalaze se u rasponu od ± 3, a indeksi spljoštenosti u rasponu od ± 10 (57).

Deskriptivna statistika

Rezultati pokazuju da se prosječna vrijednost procjene zadovoljstva životom na obje mjere kreće u gornjoj polovici ljestvičnog raspona. Na ljestvicama psihičkog distresa sudionici postižu u prosjeku niske vrijednosti (tablica 1).

Pouzdanost

Za procjenu pouzdanosti Ljestvice zadovoljstva životom korišteni su koeficijenti pouzdanosti tipa unutarnje konzistencije. Za procjenu pouzdanosti mjerenja zadovoljstva životom jednom česticom važno je koristiti formulu za korekciju zbog atenuacije (58). Dobivene pouzdanosti

too strict indicator of normal distribution and may be significant even when the results differ insignificantly from normal distribution (56). For this reason, it is best to conclude whether distribution is normal on the basis of kurtosis and skewness of distribution. Insight into indices of asymmetricity and flattening shows that all distribution can be considered normal and acceptable for further use of parameter procedures, since according to Kline's parameters of distribution normality indices of skewness are within the range of ± 3, while the indices of kurtosis is in the range of ± 10 (57).

Descriptive statistics

Results show that the average value of life satisfaction assessment of both measurements is within the upper half of the scale range. On scales of psychological distress participants achieve lower values on average (table 1).

Reliability

Internal consistency reliability coefficients were employed for the evaluation of the Satisfaction with Life Scale. It is important to use the formula for attenuation correction (58) for reliability evaluation of single-item life satisfaction measurement. The reliability coefficients of the Satisfaction with Life Scale are α_S

TABLICA 1. Deskriptivna statistika i rezultati Kolmogorov-Smirnovljevog testa za korištene mjerne instrumente, Ljestvicu zadovoljstva životom (SWLS), česticu koja samostalno predstavlja mjeru zadovoljstva životom, CORE-10, CORE-OM i DASS-21
TABLE 1. Descriptive statistics and results of the Kolmogorov-Smirnov test for employed measurement instruments, Satisfaction with Life Scale (SWLS), the item that independently represents life satisfaction measurement, CORE-10, CORE-OM, and DASS-21

Mjera / Measurement	Uzorak / Sample	N	M	SD	Teorijski raspon / Theoretical range	K-S z	Spljoštenost / Kurtosis	Asimetričnost / Skewness
SWLS	Studenti / Students	725	18.7	3.25	0 – 25	2.871**	-0.605	0.546
	Odrasli$_1$ / Adults$_1$	169	21.8	5.80	0 – 35	0.798	-0.041	-0.371
	Odrasli$_2$ / Adults$_2$	221	23.3	6.53	0 – 35	1.256	-0.501	-0.138
ZŽ jedna čestica / LS single item	Studenti / Students	702	7.9	1.43	0 – 10	5.163**	-1.125	-2.311
	Odrasli$_1$ / Adults$_1$	174	6.9	1.83	0 – 10	2.236**	-0.439	-0.077
	Odrasli$_2$ / Adults$_2$	221	7.5	2.05	0 – 10	2.463**	-0.532	-0.545
CORE-10	Studenti / Students	715	12.3	5.92	0 – 40	1.910**	0.566	0.426
CORE-OM	Odrasli$_1$ / Adults$_1$	172	35.1	18.80	0 – 136	1.929**	1.226	1.297
DASS-21	Odrasli$_2$ / Adults$_2$	219	25.5	22.58	0 – 63	0.931	0.584	-0.217

Legenda: **p<0.01 / Key: **p<0.01

Ljestvice zadovoljstva životom su redom α_S = 0,78 (petostupanjska ljestvica), α_{O1} = 0,87; α_{O2} = 0,90 (sedmostupanjske ljestvice).

Pouzdanost mjere zadovoljstva životom jednom česticom određena korištenjem formule za korekciju zbog atenuacije (58) na studentskom uzorku iznosi 0,64, a na odraslom 0,74 te predstavlja minimalnu razinu pouzdanosti.

Drugi način procjene pouzdanosti mjere s jednom česticom je faktorska analiza. Provedena je eksploracijska faktorska analiza u koju su uključene čestice Ljestvice zadovoljstva životom zajedno s česticom koja samostalno predstavlja mjeru zadovoljstva životom. Prije provedbe faktorske analize testirani su njezini preduvjeti. Kaiser-Meyer-Olkinov test prikladnosti uzorka, koji pokazuje proporciju varijance koja je objašnjena latentnim faktorima, bio je zadovoljavajuće visok (KMO_S = 0,84; KMO_O = 0,90)(59). Dodatno, Bartlettov test, koji provjerava postoji li statistički značajna razlika između korelacijske matrice i matrice identiteta u kojoj su korelacije između varijabli jednake nuli, pokazao se statistički značajnim (χ^2_S = 1560,98, df = 15, p < 0,01; χ^2_S = 1269,11 df = 15, p < 0,01). Navedeni rezultati opravdavaju provođenje faktorske analize na ovim uzorcima i pripadnim podatcima. Faktorske analize provedene su metodom analize glavnih komponenata. Na oba uzorka ekstrahiran je jedan faktor, prema Kaiser-Guttmanovom kriteriju, koji objašnjava 55 % varijance u uzorku studenata i 65 % varijance na uzorku odraslih te je dobivena veličina komunaliteta čestice koja je samostalna mjera zadovoljstva životom 0,70 (studentski uzorak) i 0,77 (odrasli uzorak) i ona je procjena pouzdanosti te čestice (tablica 2).

Valjanost

Za provjeru kriterijske valjanosti mjerenja zadovoljstva životom jednom česticom korišten je stupanj povezanosti između navedene čestice i Ljestvice zadovoljstva životom.

= 0.78 (five-point scale), α_{O1} = 0.87, and α_{O2} = 0.90 (seven-point scale) respectively.

The reliability coefficient of single-item life satisfaction measurement determined using the correction for attenuation formula (58) was 0.64 for the student sample and 0.74 for the adult sample, and represents the minimal level of reliability.

Factor analysis is the other type of reliability evaluation for single-item measurement. Exploratory factor analysis was conducted and included the items from the Satisfaction with Life Scale together with the item that independently represents life satisfaction measurement. Before factor analysis was conducted, its preconditions were tested. The Kaiser-Meyer Olkin test for sampling adequacy, which shows the proportion of variance explained by latent factors, showed adequately high values (KMO_S = 0.84; KMO_O = 0.90) (59). Furthermore, Bartlett's test, which is used to establish whether there is a statistically significant difference between the correlation and the identity matrix, in which the correlations between variables are zero, was shown to be statistically significant (χ^2_S = 1560.98, df = 15, p < 0.01; χ^2_S = 1269.11 df = 15, p < 0.01). These results justify conducting factor analysis on these samples and the associated data. Factor analyses were conducted using the method of principal component analysis. One factor was extracted on both samples using the Guttman-Kaiser criterion, which accounts for 55% of variance in the student sample and 65% of variance on the adult sample, thus providing item communality value, which represents an independent life satisfaction measurement. Its score was 0.70 (student sample) and 0.77 (adult sample), and it represents the reliability of that item (table 2).

Validity

The degree of correlation between single-item life satisfaction measurement and the Satisfaction with Life Scale was used to evaluate the criterion validity of single-item life satisfaction measurement.

TABLICA 2. Dobivene vrijednosti komunaliteta za čestice Ljestvice zadovoljstva životom (SWLS) i česticu koja samostalno predstavlja mjeru zadovoljstva životom
TABLE 2. Obtained communality values for the items of the Satisfaction with Life Scale (SWLS) and the item that independently represents life satisfaction measurement

		Komunalitet (studentski uzorak) / Communality (student sample)	Komunalitet (uzorak odraslih) / Communality (adult sample)
SWLS	Moj je život vrlo blizu onome što smatram idealnim. / My life is very close to what I consider ideal.	0.592	0.774
	Moji životni uvjeti su izvrsni. / My living conditions are excellent.	0.537	0.663
	Zadovoljan/a sam svojim životom. / I am satisfied with my life.	0.701	0.787
	Do sada sam ostvario/a važne stvari koje želim u životu. / So far, I have achieved important things I want in life.	0.402	0.533
	Kad bih živio/la ispočetka, ne bih gotovo ništa promijenio/a. / If I lived my life again, I would not change almost anything.	0.394	0.711
Jedna čestica / Single item	Koliko ste sveukupno zadovoljni svojim životom? / How satisfied are you with your life overall?	0.700	0.767

Korelacije između rezultata na Ljestvici zadovoljstva životom i mjere zadovoljstva životom jednom česticom, izračunate Pearsonovim koeficijentom korelacije na svakom uzorku posebno, su redom r_S = 0,70 (p < 0,01); r_{O1} = 0,82 (p <0,01) i r_{O2} = 0,80 (p < 0,01).

Provjera konstruktne valjanosti mjerenja zadovoljstva životom jednom česticom provedena je usporedbom povezanosti zadovoljstva životom mjerenog jednom česticom i Ljestvicom zadovoljstva životom mjerama psihičkog distresa. Kako smo u svakom uzorku koristili drugu mjeru psihološke uznemirenosti, detaljni rezultati prikazani su u tablici 3. Kako bi se provjerilo postoji li statistički značajna razlika između korelacija dviju mjera zadovoljstva životom s rezultatima na CORE-10, CORE-OM i DASS-21 upitnicima korištena je revidirana verzija Steiger Z koeficijenta (Z_H)(60). Kao što je prikazano u tablici 3, dobivena je statistički značajna razlika između dviju mjera zadovoljstva životom u njihovoj povezanosti s rezultatom na CORE-10 i CORE-OM upitniku. Snažniju povezanost s oba upitnika ostvaruje mjera zadovoljstva životom jednom česticom. Iako je isti trend prisutan i kod korelacije s DASS-21 upitnikom, ta razlika nije dosegla razinu značajnosti.

Correlations between the results on the Satisfaction with Life Scale and single-item life satisfaction measurement, obtained using Person's correlation coefficient on each sample independently, were r_S = 0.70 (p < 0.01), r_{O1} = 0.82 (p <0.01), and r_{O2} = 0.80 (p < 0.01) respectively.

The evaluation of construct validity of single-item life satisfaction measurement was conducted by comparing the correlation of single-item life satisfaction measurement and the Satisfaction with Life Scale using measurements of psychological distress. Since a different measurement of psychological distress was used in each sample, detailed results are shown in table 3. In order to establish whether there is statistically significant difference between the correlation of two life satisfaction measurements with the results of CORE-10, COME-OM, and DASS-21 questionnaires, a revised version of the Steiger Z coefficient (Z_H) (60) was used. As shown in table 3, a statistically significant difference between two life satisfaction measurements was obtained regarding their correlation with the results of CORE-10 and CORE-OM questionnaires. Single-item life satisfaction measurement showed a stronger correlation with both questionnaires. Although the same trend is present in the correlation with the DASS-21 questionnaire, this difference did not reach the level of coincidence.

TABLICA 3. Povezanost mjera zadovoljstva životom i rezultata na upitnicima psihičkog distresa
TABLICA 3. The correlation between life satisfaction measurements and the results obtained from questionnaires about psychological distress

	SZŽ / LS	Jedna čestica / Single item	Z_H
CORE-10	- 0.496**	- 0.526**	1.25*
CORE-OM	-0.375**	-0.477**	2.40**
DASS-21	-0.268**	-0.289**	0.52

Legenda: ** p < 0.01, * p < 0.05 / Key: ** p < 0.01, * p < 0.05

RASPRAVA

Cilj ovog rada bio je provjera valjanosti i pouzdanosti mjerenja zadovoljstva životom jednom česticom. Prije provjere metrijskih karakteristika uspoređene su vrijednosti deskriptivne statistike obiju mjera zadovoljstva životom.

Radi usporedbe s rezultatima dobivenim u drugim istraživanjima, dobivene aritmetičke sredine na obje mjere su pretvorene u postotak ljestvičnog maksimuma (%SM). Razina zadovoljstva životom mjerena Ljestvicom zadovoljstva životom iznosi 74,8 % SM na studentskom uzorku, te 62,3 % SM odnosno 66,6 % SM na odraslim uzorcima. Kada se zadovoljstvo životom mjerilo jednom česticom tada ono iznosi redom 78,8 % SM; 69,8 % SM te 74,7 % SM. Dobiveni rezultati ukazuju kako su sudionici u prosjeku zadovoljni svojim životom jer se dobiveni rezultati nalaze iznad ljestvične točke neutralnosti. Dobivene vrijednosti u skladu su s dosadašnjim istraživanjima provedenim na općoj populaciji. Prosječne vrijednosti zadovoljstva životom mjerene Ljestvicom zadovoljstva životom i jednom česticom nalaze se unutar teorijski očekivanog normativnog raspona od 60 % do 80 % ljestvičnog maksimuma koji nalazimo u zdravoj općoj populaciji (17,18). Također, dobivene razine zadovoljstva životom sukladne su s rezultatima istraživanja na uzorku hrvatskih studenata (61). Dobivene vrijednosti u skladu su i s Teorijom homeostaze subjektivne kvalitete živote spomenute u uvodu ovoga rada prema kojoj je vrijednost zadovoljstva životom koja se nalazi u pozitivnom dijelu ljestvice rezultat

DISCUSSION

The aim of this paper was to evaluate the validity and reliability of single-item life satisfaction measurement. Before evaluating metric characteristics, descriptive statistics values of both life satisfaction measurements were compared.

For the purposes of comparison with results obtained in other studies, the obtained arithmetic means of both measurements were translated into percentages of the scale maximum (%SM). The level of life satisfaction measured using the Satisfaction with Life Scale is 74.8% SM for the student sample and 62.3% SM and 66.6% SM for the adult samples. Single-item life satisfaction measurements showed 78.8% SM, 69.8% SM, and 74.7% SM respectively. The obtained results indicate that the participants were, on average, satisfied with their life because the obtained results are greater than the scale neutral point. The obtained values are in accordance with previous studies conducted on the general population. The average values of life satisfaction obtained using the Satisfaction with Life Scale and single-item life satisfaction are within the theoretically expected normative range of 60-80% of the scale maximum found in the healthy general population (17,18). Furthermore, the obtained values of life satisfaction are also in accordance with the results of studies conducted on a sample of Croatian students (61). The obtained values are in accordance with the theory of subjective quality of life homeostasis mentioned in the introduction, according to which the value of life satisfaction found in the positive part of

djelovanja homeostatskog mehanizma koji je analogan mehanizmu održavanja krvnog tlaka ili tjelesne temperature koje se u normalnim okolnostima zadržavaju na optimalnoj razini za funkcioniranje organizma (19). Teorija pretpostavlja da je generalno pozitivni pogled na život neophodan za normalno funkcioniranje pojedinca, da se djelovanje homeostatskog mehanizma događa jer ljudi imaju koristi od pozitivnog pogleda na vlastiti život te da su se mehanizmi održavanja životnog zadovoljstva unutar normativnih vrijednosti koje su optimalne za preživljavanja razvili tijekom evolucije (19).

Provjera pouzdanosti mjerenja zadovoljstva životom jednom česticom u ovom je istraživanju provedena na dva načina. Prvi način procjene pouzdanosti učinjen je korištenjem formule za korekciju zbog atenuacije temeljem koje je određena minimalna razina pouzdanosti koja iznosi 0,64 na studentskom i 0,74 na odraslom uzorku. Drugi način procjene pouzdanosti učinjen je korištenjem faktorske analize temeljem koje je dobivena pouzdanost veličine 0,70 (studentski uzorak) i 0,77 (odrasli uzorak). Dobivene vrijednosti u ovom istraživanju ukazuju na zadovoljavajuću razinu pouzdanosti mjerenja zadovoljstva života jednom česticom [s obzirom na kriterije pouzdanosti postavljene od Nunnally i Bernstein (62)]. U istraživanju provedenom na longitudinalnim podatcima u četiri inozemne panel studije dobivene su procjene pouzdanosti u rasponu od 0,68 do 0,74 (63), a u istraživanju provedenom na uzorku studenata u kojemu je pouzdanost procijenjena korištenjem formule za korekciju zbog atenuacije dobivena vrijednost pouzdanosti je 0,68 (49). Dobivene pouzdanosti u našem istraživanju čak su i nešto više od do sada dobivenih u drugim istraživanjima.

Provjera kriterijske valjanosti mjerenja zadovoljstva životom jednom česticom učinjena je korištenjem stupnja povezanosti s Ljestvicom zadovoljstva životom. Dobivene su visoke po-

the scale is the result of the homeostatic mechanism, which is analogous to the mechanism of maintaining blood pressure or body temperature, which are kept at the optimal level for the functioning of the organism in normal circumstances (19). The theory posits that a generally positive life outlook is necessary for an individual's normal functioning, that the homeostatic mechanism operates because people benefit from a positive outlook on their own life, and that the mechanisms of maintaining life satisfaction within normative values which are optimal for survival developed during evolution (19).

Reliability evaluation of single-item life satisfaction measurement was conducted in two ways as part of this study. The first type of reliability evaluation was conducted using the formula for attenuation correlation, on the basis of which a minimal reliability level was determined, 0.64 for the student sample and 0.74 for the adult sample. The second tape of reliability evaluation was conducted using factor analysis, on the basis of which the reliability values were 0.70 (student sample) and 0.77 (adult sample). The values obtained as part of this study indicate a satisfactory reliability level of single-item life satisfaction measurement (with respect to reliability criteria posited by Nunnually and Bernstein [62]). A study conducted on longitudinal data of four foreign panel studies the obtained reliability evaluation values ranged from 0.68 to 0.74 (63), and in a study conducted on a sample of students in which reliability was evaluated using the formula for attenuation correction the obtained reliability value was 0.68 (49). The reliability values obtained in our study are even somewhat higher than values obtained in previous studies.

The evaluation of criterion validity of single-item life satisfaction measurement was conducted using the degree of correlation with the Satisfaction with Life Scale. The re-

zitivne i statistički značajne povezanosti između mjerenja zadovoljstva životom jednom česticom i rezultata na SWLS ljestvici na sva tri uzorka r_S = 0,70 (p < 001); r_{O1} = 0,82 (p < 0,01) i r_{O2} = 0,80 (p < 0,01). Veličina povezanosti u skladu je s onima dobivenim u prijašnjim istraživanjima, u kojima se povezanosti kreću od 0,57 do 0,80 (1,47-49). Ovi nalazi pokazuju da mjerenje zadovoljstva životom jednom česticom ima primjerenu kriterijsku valjanost.

Provjera konstruktne valjanosti mjerenja zadovoljstva životom jednom česticom učinjena je usporedbom povezanosti zadovoljstva životom mjerenog jednom česticom i rezultata na SWLS ljestvici s mjerama općeg psihičkog distresa. Dobivene su umjerene povezanosti između obih načina mjerenja kvalitete životom i mjera psihičkog distresa (tablica 3). Provjerom postojanja razlike između dviju mjera zadovoljstva životom u njihovoj povezanosti s korištenim mjerama distresa dobivena je statistička značajna razlika za mjeru CORE (na studentskom i prvom odraslom uzorku) na način da je snažniju povezanost s mjerama opće psihološke uznemirenosti ostvarila mjera zadovoljstva životom jednom česticom. Za mjeru DASS-21 razlika u povezanosti dviju mjera zadovoljstva životom s tom mjerom nije značajna, iako je uočen isti trend snažnije povezanosti za mjeru s jednom česticom. Dobiveni rezultati su u skladu s dosadašnjim istraživanjima. U istraživanju koje su proveli Arrindell i sur. (14) zadovoljstvo životom negativno je povezano s depresivnošću (r = –0,55), anksioznošću (r = –0,54) i općim psihološkim distresom (r = –0.55). Istraživanje koje su proveli Larsen i sur. (15) ukazalo je na negativnu povezanost zadovoljstva životom i negativnog afekta (r = –0.31). Rezultati istraživanja koji su proveli Cheung i Lucas (1) pokazali su negativnu povezanost između zadovoljstva životom i neuroticizma (r = -0,29), i pozitivnu povezanost između zadovoljstva

sults showed high positive and statistically significant correlations between single-item life measurement and the results of the SWLS scale on all three samples: r_S = 0.70 (p < 001), r_{O1} = 0.82 (p < 0.01), and r_{O2} = 0.80 (p < 0.01). The correlation size is in accordance with the values obtained in previous studies, in which the correlation values range from 0.57 to 0.80 (1,47-49). These results show that single-item life satisfaction measurement has appropriate criterion validity.

The evaluation of construct validity of single-item life satisfaction measurement was conducted by comparing the correlation of single-item life satisfaction measurement and the results of the SWLS scale with measurement of general psychological distress. The obtained values showed moderate correlation between both types of life satisfaction measurement and the measurement of psychological distress (table 3). The evaluation of difference between the two types of life satisfaction measurement regarding their correlation with the employed measurements of distress provided a statistically significant difference for the CORE measurement (on the student and first adult samples), with single-item life satisfaction measurement showing stronger correlation with measurements of general psychological distress. In the case of DASS-21 measurement, the difference in the correlation of the two measurements of life satisfaction with this measurement was not significant, although the same stronger correlation with single-item measurement was identified. The obtained results are in accordance with existing studies. In a study by Arrindell et al. (14) life satisfaction is negatively correlated with depression (r = -0.55), anxiety (r = -0.54), and general psychological distress (r = -0.55). A study by Larsen et al. (15) showed negative correlation between life satisfaction and negative affect (r = -0.31). The results of a study by Cheung and Lucas (1) showed negative correlation between life satisfaction and neu-

životom i mjere mentalnog zdravlja na dva različita uzorka (r = 0,36; r = - 0,41), pri čemu su povezanosti sukladne ako se zadovoljstvo mjeri s jednom česticom ili sa SWLS. U našem smo istraživanju dobili snažnije povezanosti kada se koristi mjera s jednom česticom što govori u prilog pretpostavci da je takva globalna mjera bolji pokazatelj aktualnog stanja. Drugim riječima, kada osoba procjenjuje zadovoljstvo životom na jednoj čestici, ta je procjena komprimirani pokazatelj subjektivne dobrobiti. U situacijama u kojima postoji neki negativni vanjski ili unutrašnji čimbenik, a postojeći mehanizmi nisu dostatni da ublaže i/ili kompenziraju njegovo djelovanje, dolazi do sloma homeostaze i smanjenja subjektivne dobrobiti. Takvi ekstremni čimbenici narušavaju homeostazu te dolazi do pada postotka ljestvičnog maksimuma ispod 60 (19). Stanje trajnog smanjenog zadovoljstva životom negativno je povezano s mentalnim zdravljem i svakodnevnim funkcioniranjem (64).

Ograničenja i smjernice za buduća istraživanja

Ovo istraživanje ima nekoliko ograničenja koje valja spomenuti. Glavni nedostatak odnosi se na uzorke na kojemu je provedeno. Riječ je o prigodnim uzorcima. Uzorak koji je prigodno odabran podložan je brojnim nedostatcima i ograničenjima u donošenju zaključaka, a rezultati dobiveni na takvom uzorku ne mogu se primijeniti na opću populaciju (65). Obilježava ga homogenost sudionika po dobi i obrazovanju kao i samoselekcija koja dodatno povećava vjerojatnost njihove međusobne sličnosti. Na smanjenu mogućnost generalizacije dobivenih rezultata ukazuje i mali udio muških sudionika. Bilo bi dobro buduća istraživanja pouzdanosti i valjanosti mjerenja zadovoljstva životom jednom česticom provesti na reprezentativnom uzorku. Provjera pouzdanosti u ovom istraživanju bila je ograničena transverzalnim nacrtom istraži-

roticism (r = -0.29), and positive correlation between life satisfaction mental health measurement on two different samples (r = 0.36; r = -0.41), with the correlations being compatible if satisfaction is measured using a single item or SWLS. Our study showed stronger correlations for single-item measurement, which is in favour of the assumption that such general measurements are a better indication of the current condition. In other words, when an individual evaluates life satisfaction on the basis of a single item, this evaluation is a compressed indicator of subjective wellbeing. In situations where there is a negative external or internal factor, and the existing mechanisms are inadequate to mitigate and/or compensate for its action, there is a breakdown of homeostasis and a reduction of subjective wellbeing. Such extreme factors impair homeostasis and lead to a reduction of the scale maximum percentage below 60 (19). Permanent reduction in life satisfaction is negatively correlated with mental health and daily functioning (64).

Limitations and guidelines for future research

This study has several limitations that should be mentioned. The main drawback is related to the samples. These are convenience samples. The sample that was conveniently selected is susceptible to numerous drawbacks and limitations in drawing conclusions, and the results obtained on such a sample cannot be applied to the general population (65). It is marked by homogeneity of participants according to age and education, as well as self-selection, which further increases the probability of their mutual similarity. A small number of male participants also indicates a reduced possibility of generalization of obtained results. Future studies of reliability and validity of single-item life satisfaction measurement should be conducted on a representative sample. In this study, the reliability evaluation was limited by the trans-

vanja. Prikupljanje podataka u jednoj vremenskoj točki onemogućilo je provjeru test-retest pouzdanosti koju bi bilo poželjno provjeriti u budućim istraživanjima. Također, ovakav nacrt istraživanja utjecao je i na mogućnost provjere određenih aspekata valjanosti, tj. onemogućio je provjeru prediktivne valjanosti mjerenja zadovoljstva životom jednom česticom koju bi također bilo poželjno ispitati u budućim istraživanjima.

Unatoč ovim ograničenjima, ovo je istraživanje polučilo važne rezultate. Prije svega, potvrdilo je dosadašnje inozemne nalaze koji su govorili o opravdanosti korištenja mjere jednom česticom za procjenu kvalitete života. Radi se o pouzdanoj i valjanoj procjeni, koja je jednostavna i razumljiva, te stoga primjenjiva kako u kliničkoj praksi, tako i u istraživanjima. Jednostavnije rečeno, ljudi mogu jednim brojem izraziti koliko su zadovoljni svojim životom, a ta procjena reflektira stanje psihološkog homeostatskog mehanizma. Ako se procjena kreće ispod 60 % ljestvičnog maksimuma, valja pretpostaviti da je došlo do teškoća u uspostavi psihološke ravnoteže, što može biti posljedica nekog akutnog događanja, ali i kroničnih psihičkih smetnji. Stoga je pitanje „*Koliko ste zadovoljni svojim životom kao cjelinom*“ dobro uključiti u rutinsku kliničku procjenu, jer će omogućiti trijažu osoba s aktualno ugroženim mentalnim zdravljem. Dodatno, rezultati ovog istraživanja potvrđuju nalaze dosadašnjih istraživanja oko mogućnosti korištenja ljestvice SWLS s dvije ljestvice procjene – one s pet i one sa sedam stupnjeva. Naši rezultati pokazuju da se na oba način dobivaju sukladni rezultati (50,51).

Mjera zadovoljstva životom jednom česticom trebala bi biti dio protokola u istraživanjima u području psihijatrije, kliničke psihologije i srodnih disciplina, što bi omogućilo vrlo ekonomičnu i razumljivu usporedbu različitih dijagnostičkih skupina, terapijskih ishoda, životnih uvjeta i ostalih važnih čimbenika.

versal outline of the study. Data collection at a single point in time precluded the evaluation of test-retest reliability, which should be evaluated in future studies. Furthermore, this study outline also affected the possibility of evaluating certain validity aspects, i.e. precluded the evaluation of predictive validity of single-item life satisfaction measurement, which should also be assessed in future studies.

Despite these limitations, this study showed important results. Firstly, it confirmed existing foreign results which showed that using single-item life satisfaction measurement was justified. This is a reliable and valid assessment which is simple and understandable, and therefore applicable in both clinical practice and research. To put it simply, people can use a single number to express how satisfied they are with their life, and this assessment reflects the state of the psychological homeostatic mechanism. If the assessment is below 60% of the scale maximum, it should be assumed that there were difficulties in achieving psychological balance, which can be a consequence of an acute event or chronic psychological disturbances. Therefore, the question "*How satisfied are you with your life overall?*" should be included in routine clinical evaluation because it can enable the triage of people with endangered mental health. Moreover, the results of this study confirm the findings of existing studies concerning the possibility of using the SWLS with two assessment scales – one with five and one with seven points. Our results show that both types achieve compatible results (50,51).

Single-item life satisfaction measurement should be part of the protocol in studies from the field of psychiatry, clinical psychology, and related disciplines, which would enable a very economical and understandable comparison of different diagnostic groups, therapeutic outcomes, living conditions, and other important factors.

ZAKLJUČAK

Rezultati ovog istraživanja pokazuju da je korištenje jedne čestice za procjenu zadovoljstva životom psihometrijski opravdano. Dobivene su zadovoljavajuće razine pouzdanosti, te je potvrđena kriterijska i konstruktna valjanost takvog načina mjerenja kvalitete života. S obzirom na sve izraženiji trend korištenja kratkih, a psihometrijski zadovoljavajućih upitnika, koji bi bili prihvatljivi i za sudionike, ali i za istraživače, ovi rezultati upućuju na mogućnost korištenja jedne čestice za globalnu procjenu kvalitete života u istraživačkoj, ali i u kliničkoj praksi.

CONCLUSION

The results of this study show that using a single item for life satisfaction assessment is psychometrically justified. Satisfactory levels of reliability were obtained and both criterion and construct validity of this type of quality of life measurement were confirmed. With regard to the increasingly common use of brief, psychometrically satisfactory questionnaires which are acceptable to both participants and the researchers, these results indicate the possibility of using a single item for general assessment of quality of life in both research and clinical practice.

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Alzheimerova bolest kroz prizmu ljudskih prava / *Alzheimer's Disease and Human Rights*

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Ostvarivanje ljudskih prava u starosti znači prije svega skrb za kvalitetu života osoba oboljelih od Alzheimerove bolesti i sprječavanje diskriminacije na osnovi starosti i bolesti. U ovome radu analiziramo najkvalitetnije instrumente zaštite ljudskih prava oboljelih od Alzheimerove bolesti, a koji se temelje na načelima autonomije, samoodređenja i najboljeg interesa oboljele osobe. Takvi se zahtjevi najbolje mogu ostvariti u sustavima koji predviđaju više različitih modaliteta zaštite oboljelih od Alzheimerove bolesti. Pravni status skrbnika i odlučivanje o pravima, interesima i potrebama osoba oboljelih od Alzheimerove bolesti uz podršku, informirani pristanak oboljele osobe na medicinski tretman i/ili istraživanje o samoj bolesti kao i mogućnost sklapanja anticipirane naredbe instrumenti su zaštite njihovih ljudskih prava. Život osoba treće dobi reguliran je zakonskim mjerama i politikama koje nisu posebno okrenute njihovim potrebama, te u svojoj suštini krše temeljna ljudska prava, osobito kada je riječ o osobama oboljelima od Alzheimerove bolesti. Palijativna skrb jedna je od tih mjera koje treba smatrati temeljnim ljudskim pravom oboljelih od Alzheimerove bolesti.

/ The management of human rights in old age primarily refers to providing care related to the quality of life of people suffering from Alzheimer's disease and preventing discrimination on the basis of age and illness. This paper analyses the best instruments for the protection of human rights of those suffering from Alzheimer's disease based on the principles of autonomy, self-determination, and the patient's best interests. Such requirements can best be met in systems providing several various forms of protection for people suffering from Alzheimer's disease. The legal status of caregivers and making decisions regarding the rights, interests, and needs of people suffering from Alzheimer's disease with the support, informed consent of the patient to medical treatment, and/or research of the disease itself, as well as the option of anticipated disposition, are all instruments for the protection of their human rights. The life of the elderly is regulated by legal measures and policies which are not directly focused on their needs and inherently violate basic human rights, especially in the case of people suffering from Alzheimer's disease. Palliative care is one of the measures which should be considered a basic human right of people suffering from Alzheimer's disease.

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KLJUČNE RIJEČI / *KEY WORDS*:
Alzheimerova bolest / *Alzheimer's Disease*
Ljudska prava / *Human Rights*
Poslovna sposobnost / *Legal Capacity*
Informirani pristanak / *Informed Consent*
Palijativna skrb / *Palliative Care*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2019.470

UVOD

Alzheimerova bolest kao najučestaliji oblik demencije je javnozdravstveni problem o čemu svjedoče statistike koje ukazuju da broj oboljelih u svijetu iznosi 50 milijuna, te se procjenjuje da se svake godine javlja 10 milijuna novih slučajeva (1). Alzheimerova bolest (AB) je progresivno stanje koje uvelike utječe na starije ljude pogađajući njihovo pamćenje, jezik, sposobnost komuniciranja, raspoloženje i osobnost (2). Osoba nije u mogućnosti adekvatno komunicirati sa svojom okolinom, a često se pojavljuju poremećaji u ponašanju, psihički simptomi u obliku poteškoća u kontroli emocija, halucinacije, psihomotorički nemir, agresivna stanja, dezorganizirano ponašanje i dr. (3). Uzevši u obzir činjenicu da prosječna životna dob stanovništva kontinuirano raste, a da je natalitet u većini zemalja sve niži, sasvim je realno zaključiti da su demencija i Alzheimerova bolest jedan od najozbiljnijih problema današnjice (4). Prepoznati važnost zaštite ljudskih prava osoba oboljelih od Alzheimerove bolesti nije samo pitanje socijalne osjetljivosti, već i izravan odnos prema vlastitoj budućnosti. Bitan element kojim se može vrednovati stupanj demokracije jedne zajednice upravo se sastoji u svijesti o potrebi zaštite drugih (5). Zbog toga prvo analiziramo zaštitu osoba oboljelih od Alzheimerove bolesti u međunarodnoj razini uzimajući u obzir socijalni i medicinski kontekst Konvencije o pravima osoba s invaliditetom. U tom dijelu poglavlja posebna se pozornost obraća potpori i sustavu odlučivanja koji se najčešće odvija između liječnika i pacijenta i/ili osobe koja pruža skrb i njeguje oboljelu osobu. U tom kontekstu istaknuli smo i međunarodnopravnu zaštitu oboljelih Konvencijom o ukidanju svih oblika diskriminacije nad ženama koja je ključna zbog demencije koja je značajno više prisutna kod žena, što je posljedica njihovog nešto duljeg prosječnog životnog vijeka (6,7). Nadalje, za donošenje odluka koje imaju zakonom određene posljedice tzv. pravne implikacije, potrebno

INTRODUCTION

Alzheimer's disease as the most common form of dementia is a public health problem, as illustrated by statistical data according to which the number of patients in the world is 50 million, with estimates of 10 million new cases per year (1). Alzheimer's disease (AD) is a progressive state which significantly impacts the elderly by affecting their memory, language, ability to communicate, mood, and personality (2). The person is not able to adequately communicate with their surroundings and there are often behavioural disturbances, psychological symptoms in the form of difficulty with controlling emotions, hallucinations, psychomotor distress, aggression, disorganized behaviour, etc. (3). Taking into account the fact that the average age of the population is continually rising while the birth rates of most countries are falling, it is entirely realistic to conclude that dementia and Alzheimer's disease are some of the most serious problems today (4). Identifying the importance of human rights of people suffering from Alzheimer's disease is not just an issue of social sensitivity but also directly tied to our future. An important element that can be used to evaluate the level of democracy in a community is the awareness of the necessity of protecting others (5). Therefore, we first analyse the protection of people suffering from Alzheimer's disease on the international level, taking into account the social and medical contexts of the Convention on the Rights of People with Disabilities. In that part of the paper special attention is given to the support and system of decision-making which most commonly takes place between the physician and the patient and/or the caregiver of the patient. In this context, we have also emphasized the protection of patients under international law according to the Convention on the Elimination of All Forms of Discrimination against Women, which is of key importance because dementia affects women significantly more due to their somewhat longer average life span (6,7). Furthermore, adopting decisions which have legally determined consequences, so-called legal implications, requires the

je ispunjavati »minimalne uvjete odgovarajuće sposobnosti« za sklapanje određenih ugovora i sl. (8), stoga je prije pokretanja postupka za lišavanje poslovne sposobnosti oboljele osobe potrebno razmotriti pitanje rješava li skrbništvo probleme koje ima osoba oboljela od Alzheimerove bolesti, a zbog kojih se skrbništvo namjerava pokrenuti ili je moguće primijeniti alternativni oblik zaštite odlučivanjem uz podršku bez oduzimanja poslovne sposobnosti. Poslovna sposobnost je temeljno ljudsko pravo, a posebno pravo oboljele osobe od Alzheimerove bolesti. Zbog toga prizmu ljudskih prava oboljelih od Alzheimerove bolesti analiziramo u članku 12. Konvencije o pravima osobama s invaliditetom tako da dajemo komparativni prikaz kao prilog promišljanju promjena hrvatskog zakonodavstva (*de lege data)* i zakonodavstva drugih država članica (*de lege ferenda*) Europske unije, a sve sa svrhom promicanja veće zaštite ljudskih prava osoba oboljelih od Alzheimerove bolesti i priznavanja statusa invaliditeta. Slijedom navedenog, poslovna sposobnost, institut informiranog pristanka i palijativna skrb, temeljni su mehanizmi zaštite ljudskih prava oboljelih od Alzheimerove bolesti kojima ćemo u ovom radu obratiti posebnu pozornost (5).

ZAŠTITA OBOLJELIH OD ALZHEIMEROVE BOLESTI U OKVIRU MEĐUNARODNOG PRAVA

Osobe oboljele od Alzheimerove bolesti nisu sposobne donositi informirane odluke i brinuti se o sebi pa je dužnost svake države omogućiti maksimalnu i potpunu zaštitu njihova dostojanstva. U tom području na međunarodnoj razini veliku ulogu ima Konvencija o osobama s invaliditetom zajedno s Fakultativnim protokolom i Konvencija o ukidanju svih oblika diskriminacije nad ženama (5,9). Konvencija o osobama s invaliditetom zajedno

fulfilment of "minimal conditions of appropriate capability" for the conclusion of certain contracts, etc. (8). Therefore, before commencing the process of legal capacity deprivation of a patient, it is important to consider the question of whether guardianship solves the problems of a person suffering from Alzheimer's disease which are the cause of initiating guardianship or whether it is possible to apply an alternative form of protection through support-based decision-making without legal capacity deprivation. Legal capacity is a basic human right, especially in the case of a person suffering from Alzheimer's disease. Therefore, the issue of human rights of people suffering from Alzheimer's disease is analysed in article 12 of the Convention on the Rights of People with Disabilities, so we provide a comparative presentation as a contribution to considering alterations of the Croatian legislation (*de lege data*) and legislations of other European Union member states (*de lege ferenda*) with the purpose of promoting better protection of human rights of people suffering from Alzheimer's disease and granting them disability status. Consequently, legal capacity, informed consent, and palliative care are all basic mechanisms for the protection of human rights of people suffering from Alzheimer's disease, who are the subject of special attention in this paper (5).

PROTECTION OF PEOPLE SUFFERING FROM ALZHEIMER'S DISEASE IN THE FRAMEWORK OF INTERNATIONAL LAW

People suffering from Alzheimer's disease are not capable of making informed decisions and taking care of themselves, so the duty of every state is to provide maximum and complete protection of their dignity. In this respect, on the international level, the Convention on the Rights of People with Disabilities together with the Optional Protocol and the Convention on the Elimination of All Forms of Discrimination against Women play an important role (5,9). The Convention on

s Fakultativnim protokolom koja je donesena od Ujedinjenih naroda 2006. godine, a sve sa ciljem unaprjeđenja i zaštite prava osoba s invaliditetom. Konvencija o pravima osoba s invaliditetom je globalni dokument koji, osim što je obvezujući za države stranke, predviđa i sustav kontrole i sankcija, a poštivanje prava u pojedinim državama prati putem izvješća koje se podnosi Odboru za prava osoba s invaliditetom (10). Konvencija u odredbi članka 1. stavka 2. određuje osobe s invaliditetom (*engl. persons with disabilities*) kao osobe koje imaju »dugotrajna tjelesna, mentalna, intelektualna ili osjetilna oštećenja, koja u međudjelovanju s različitim preprekama mogu sprječavati njihovo puno i učinkovito sudjelovanje u društvu na ravnopravnoj osnovi s drugima«. Iako je Konvencija o pravima osoba s invaliditetom prvi međunarodni ugovor koji izrijekom priznaje temeljna ljudska prava osobama s invaliditetom i pojašnjava koje obveze imaju države s obzirom na postojeća prava, ta se prava u praksi učestalo uskraćuju (11). Ako uzmemo u obzir da termin invaliditet odgovara pojmu tjelesne poteškoće, radi pravilnog shvaćanja značenja kategorija osoba na koje se Konvencija odnosi prijevod bi trebao glasiti drugačije. Iako sam naziv Konvencije o pravima osoba s invaliditetom ne implicira da se odnosi na osobe s duševnim smetnjama, autorice predlažu da bi prijevod naziva trebao glasiti »Konvencija o pravima osoba s invaliditetom, osoba s mentalnim poteškoćama i osoba s duševnim smetnjama« kako bi bilo jasnije što je predmet regulative, odnosno znanstvene rasprave. Jedno od osnovnih obilježja Konvencije o pravima osoba s invaliditetom je medicinski i socijalni model. U svojim odredbama medicinski model pokazuje osobu s invaliditetom kao »pacijenta« kojemu je potrebna odgovarajuća skrb i pomoć. Socijalni model pokazuje utjecaj određenih društvenih stavova, kao što su predrasude i nemogućnost aktivnog uključivanja u različite oblike društvenog života odnosno socijalni model se temelji na sljedećim pretpostavkama (12):

the Rights of People with Disabilities together with the Optional Protocol, signed by the United Nations in 2006, has the goal of improving and protecting the rights of people with disabilities. The Convention on the Rights of People with Disabilities is a global document which is binding for member states and includes a system of control and sanction, while the respect for rights in individual countries is monitored using a report filed to the Council for Persons with Disabilities (10). In article 1, paragraph 2, the Convention defines persons with disabilities as persons who have "long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others." Although the Convention on the Rights of People with Disabilities is the first international agreement which expressly grants basic human rights to people with disabilities and explains the obligations of member countries regarding existing rights, these rights are often withheld in practice (11). If we take into consideration that the term disability refers to physical difficulty, for the purpose of accurately understanding the meaning of the categories of people to whom the Convention applies, the translation should be different. Although the name of the Convention on the Rights of People with Disabilities does not imply that it refers to people with mental difficulties, the authors suggest that the name should be the "Convention on the Rights of People with Disabilities, People with Mental Difficulties, and People with Mental Disturbances" with the purpose of clarifying the subject of the regulation and scientific discussion. The basic characteristics of the Convention on the Rights of People with Disabilities include the medical and social models. In its definitions, the medical model identifies a person with disabilities as a "patient" who requires appropriate care and aid. The social model displays the influence of certain social attitudes such as prejudices and the inability to actively participate in various forms of social life. In other words, the social model is based on the following assumptions (12):

- Stanje nije krivnja pojedinca
- Fokus je na vještinama i mogućnostima koje osoba ima, a ne na onome što nema
- Pojedinac može biti u potpunosti shvaćen kroz svoju povijest, interese itd.
- Utjecaj se prepoznaje u okolini koja je podržavajuća
- Ključna vrijednost je potvrđena odgovarajućom komunikacijom
- Mogućnosti se trebaju poduzeti za rehabilitaciju i ponovno osposobljavanje
- Odgovornost da se dopre do osoba s AB leži kod osoba koje (još) nemaju AB.

Upravo je zbog toga važno isticanje i promicanje prava osoba s invaliditetom jer određene odredbe priznaju osobama s invaliditetom jednaka prava koja se u mnogobrojnim međunarodnim ugovorima jamče svim osobama. Želimo istaknuti da je u ovom pogledu Konvencija za osobe s invaliditetom promjenu paradigme za osobe s duševnim smetnjama koje su lišene poslovne sposobnosti (13).

Sa stajališta ljudskih prava, preporučuje se da se osobe koje imaju intelektualne i psihosocijalne poteškoće ne stavljaju pod skrbništvo, nego da im se omogući odgovarajuća zaštita i podrška pri donošenju vlastitih odluka. Institut skrbništva je oblik zaštite maloljetnih osoba bez roditeljske skrbi i punoljetnih osoba koje nisu sposobne brinuti se o sebi kao i osoba koje nisu u mogućnosti štititi svoja prava i interese. Skrbništvo je u okviru djelokruga poslova centara za socijalnu skrb koji donose rješenja o imenovanju skrbnika koji brine o pravima i interesima štićenika (14). Stoga, kada govorimo o Konvenciji o pravima osoba s invaliditetom, članak 12. ne spominje odlučivanje uz podršku, ali ukazuje na obvezu država potpisnica da pruže podršku osobama s invaliditetom kada im je potrebna za ostvarenje poslovne sposobnosti. Važno je spomenuti da donošenje odluka sadrži dvije premise temeljene na članku 12. Prva pravna premisa je da svi imaju pravo na

- The condition is not the individual's fault
- The focus is on the skills and abilities the person has, and not the ones they do not have
- The individual can be entirely understood through their history, interests, etc.
- Influence is identified in a supportive environment
- The key value is confirmed using appropriate communication
- Steps should be taken to ensure rehabilitation and reconditioning
- People who do not (yet) have AD have the responsibility to reach people with AD

This is why it is important to emphasize and promote the rights of people with disabilities, since certain provisions grant people with disabilities equal rights which are guaranteed to all people in numerous international agreements. We wish to point out that in this respect the Convention on the Rights of People with Disabilities requires a paradigm shift for people with mental disturbances who have been deprived of legal capacity (13).

From the position of human rights, it is recommended that people with intellectual and psychosocial difficulties not be put under guardianship but granted appropriate protection and support in making their own decisions. Guardianship is a form of protection intended for underage people without parental care and adults who are unable to care for themselves, as well as people who are unable to protect their rights and interests. Guardianship is within the scope of centres for social welfare, which render decisions regarding naming guardians who care for the rights and interests of people under their guardianship (14). Therefore, when discussing the Convention on the Rights of People with Disabilities, article 12 does not mention support-based decision-making, but does indicate the obligation of signatory countries to provide support for people with disabilities when they require it to achieve legal capacity. It should be pointed out that making decisions contains two premises based on article

donošenje vlastitih odluka, tzv. samostalno odlučivanje, a druga pravna premisa je da države moraju osigurati adekvatnu pomoć osobama s invaliditetom, ako im je ona potrebna kako bi im bilo omogućeno ostvarivanje poslovne sposobnosti, a pod time se misli odlučivanje uz podršku (15). Nadalje, Odbor Ujedinjenih naroda za prava osoba s invaliditetom navodi da članak 12. stavak 3. sukladno kojem su države dužne poduzeti odgovarajuće mjere kako bi osobama s invaliditetom osigurale pristup potpori koja bi im za ostvarivanje pravne sposobnosti mogla biti potrebna, treba tumačiti kao zahtjev da države članice poduzmu mjere kojima će princip »odlučivanja umjesto drugoga« (engl. *substitute decision-making*) zamijeniti »odlučivanjem uz potporu« (engl. *supported decision-making*). Stoga, iz tumačenja odredbe članka 12. stavka 4., prema kojem su države dužne osigurati sve zaštitne mjere, proizlazi da nije u potpunosti isključena mogućnost potpunog lišavanja poslovne sposobnosti ako je riječ o teškim oblicima invaliditeta (11).

S gledišta ljudskih prava oboljelih od Alzheimerove bolesti, potporu oboljeloj osobi može, na primjer, pružiti netko od članova obitelji, njegovatelj, skrbnik, a potpora se može pružati povremeno ili stalno. Pružena potpora treba doprinijeti razumijevanju mogućnosti izbora ili pojašnjavanju o nekim etičkim pitanjima o kojima treba donijeti odluku u vrijeme kada osoba ne može više samostalno odlučivati. Osobe koje donose odluke o osobama koje boluju od demencije ne trebaju nužno imati stručno znanje o etičkim teorijama. U određenim situacijama oni trebaju biti svjesni etičkih pitanja s kojima se suočavaju te sposobni promišljati ih da bi utvrdili što je ispravno ili pogrešno (8). Zato Konvencija o pravima osoba s invaliditetom sukladno članku 12. stavak 5. predviđa da će države stranke poduzeti odgovarajuće i djelotvorne mjere kako bi se osigurala jednaka prava osoba s invaliditetom da posjeduju i naslijeđuju imovinu, kontroliraju vlastite financijske poslo-

12. The first legal premise is that everyone has the right to make their own decisions, i.e. independent decision-making, while the other legal premise is that countries must ensure adequate aid for people with disabilities if they require it in order to achieve legal capacity, which refers to support-based decision-making (15). Furthermore, the United Nations Council for Persons with Disabilities states that article 12, paragraph 3, according to which countries are obligated to take appropriate measures in order to ensure support for people with disabilities which they may need in order to achieve legal capacity, should be interpreted as a request for member countries to take measures to replace the principle of "substitute decision-making" with "support-based decision-making". Therefore, according to the interpretation of the provision of article 12, paragraph 4, according to which countries are obligated to ensure all measures of protection, it follows that the possibility of complete deprivation of legal capacity is not entirely excluded in cases of severe forms of disability (11).

From the viewpoint of human rights of people suffering from Alzheimer's disease, support for the patient can be provided, for instance, by one of their family members, a caregiver, or a guardian, and support can be given occasionally or permanently. Support should be in the service of understanding the possibility of choice or clarifying certain ethical issues which should be decided upon when the person is no longer able to make independent decisions. People who make decisions about those suffering from dementia do not necessarily need to have expert knowledge about ethical theory. In certain situations, they need to be aware of ethical issues they encounter and be able to consider them in order to ascertain what is right and wrong (8). This is why the Convention on the Rights of People with Disabilities, in accordance with article 12, paragraph 5, stipulates that member countries will take appropriate and effective measures to ensure equal rights for people with disabilities, including the right to own and inherit property, control their finances, have equal access to

ve, imaju jednak pristup bankovnim kreditima, hipotekama i drugim oblicima financiranja. Ta odredba osigurava i da osobe s invaliditetom ne budu bez vlastite volje lišene svojeg vlasništva. Iskustva i smjernice u tom pogledu daje i Ured visokog povjerenika Ujedinjenih naroda za ljudska prava koji navodi da osobe koje pomažu pojedincu mogu pomoći da prenese svoje namjere drugim osobama ili da shvati koje su mu alternative na raspolaganju (16).

Uzimajući u obzir da je Alzheimerova bolest podjednaka među spolovima, dok je prevalencija značajno više prisutna kod žena (6) što je posljedica njihovog nešto duljeg prosječnog životnog vijeka, u nastavku teksta istaknuli bismo ulogu Konvencije o ukidanju svih oblika diskriminacije nad ženama koja je usvojena na skupštini Ujedinjenih naroda 18. prosinca 1979., a stupila je na snagu 3. rujna 1981. Konvencija o ukidanju svih oblika diskriminacije nad ženama u članku 11. navodi da žene imaju pravo na socijalnu zaštitu, osobito u slučaju odlaska u mirovinu, nezaposlenosti, bolesti, invalidnosti, starosti i druge nesposobnosti za rad te pravo na plaćeni dopust, što je ključno iz aspekta žena oboljelih od Alzheimerove bolesti. Organizacija za istraživanje demencije *Alzheimer's Research UK* u izvještaju pod naslovom »Žene i demencija: Marginalizirana većina« navodi da je trenutno više od 500,000 žena u Velikoj Britaniji pogođeno demencijom. U izvještaju se navodi da u Velikoj Britaniji od demencije boluje preko 850.000 osoba. Procjenjuje se prema tim podatcima da je to u prosjeku 61 % žena u odnosu na 39 % muškaraca. Također se navodi da žene u šezdesetim godinama imaju dvostruko veći rizik dobiti Alzheimerovu bolest nego rak dojke i druge srčane bolesti. Uzimajući u obzir da je upravo dob jedan od glavnih faktora rizika, demencija je bolest koja pogađa osobe iznad 55 godina, više od bilo koje druge velike i opasne bolesti kao što su rak, moždani udar, bolesti srca i dijabetesa. Ovu činjenicu ističemo kako bismo naveli da se dobna granica za Alzheimerovu bolest spustila

their bank loans, mortgages, and other forms of financing. This provision also ensures that people with disabilities cannot be deprived of their property against their will. In this respect, experiences and guidelines are also provided by the United Nations Office of the High Representative, which states that people who aid individuals may help them communicate their intentions to others or understand which alternatives are at their disposal (16).

Keeping in mind that Alzheimer's disease is equally represented in both sexes, with the significantly higher prevalence in women (6), which is a consequence of their somewhat longer life span, we wish to emphasize the role of the Convention on the Elimination of All Forms of Discrimination against Women, adopted at the United Nations assembly of December 18, 1979 and entered into force on September 3, 1981. In article 11 of the Convention on the Elimination of All Forms of Discrimination against Women, it is stated that women have the right to social protection, especially in case of retirement, unemployment, illness, disability, old age, and other reasons for incapacity for work, as well as paid leave, which is crucial from the perspective of women suffering from Alzheimer's disease. In a report entitled "Women and dementia: the marginalized majority", *Alzheimer's Research UK*, an organization for the research of dementia, states that currently more than 500.000 women are affected by dementia in Great Britain. The report states that there are over 850.000 people suffering from dementia in Great Britain. According to this data, it is estimated that 61% of sufferers are women and 39% men. It is also stated that women in their sixties have twice the risk of developing Alzheimer's disease than breast cancer or cardiac diseases. Taking into consideration that age is one of the main risk factors, dementia is a disease that affects people over 55 years of age, more than any other dangerous illness such as cancer, stroke, heart diseases, and diabetes. Therefore, it can be observed that the age limit for Alzheimer's disease has lowered and that women provide care to people suffering from

te da žene više nego dvostruko češće preuzimaju ulogu njegovateljice osoba oboljelih od Alzheimerove bolesti koja se na poslijetku pokazuje izrazito stresnom, kako stoji u izvještaju (17).

TEMELJNI MEHANIZMI ZAŠTITE LJUDSKIH PRAVA OBOLJELIH OD ALZHEIMEROVE BOLESTI

Poslovna sposobnost - ljudsko pravo oboljelih od Alzheimerove bolesti

Poslovna sposobnost temeljno je ljudsko pravo oboljelih od Alzheimerove bolesti. Naime, kada govorimo o lišavanju poslovne sposobnosti oboljelih od Alzheimerove bolesti, tada ono predstavlja ograničenje prava osobe da samostalno odlučuje o svom životu. O toj prizmi ljudskih prava oboljelih od Alzheimerove bolesti navodi i članak 12. stavak 2. Konvencije o pravima osoba s invaliditetom koji određuje da države stranke trebaju prihvatiti da osobe s invaliditetom imaju pravnu i poslovnu sposobnost na jednakoj osnovi kao i druge osobe u svim aspektima života. Stoga odluku o oduzimanju poslovne sposobnosti treba donositi s krajnjim oprezom i potrebno je prije konačne odluke procjenjivati sposobnost za odlučivanje. Postojanje simptoma bolesti ili dijagnoza nisu dovoljni da bi se nekoga lišilo poslovne sposobnosti. Prije pokretanja postupka za lišavanje poslovne sposobnosti potrebno je razmotriti pitanje rješava li skrbništvo specifične probleme koje ima osoba oboljela od Alzheimerove bolesti, a zbog kojih se skrbništvo namjerava pokrenuti zbog poteškoća u socijalnom funkcioniranju ili su nužne promjene u drugim oblicima rješavanja problema oboljelih od Alzheimerove bolesti kao što je institut odlučivanja uz podršku bez oduzimanja poslovne sposobnosti (5).

Lišenje poslovne sposobnosti u hrvatskom obiteljskopravnom uređenju uvedeno je u Obitelj-

Alzheimer's disease twice as often, which is ultimately shown to be extremely stressful, as stated in the report (17).

BASIC MECHANISMS OF HUMAN RIGHTS PROTECTION FOR PEOPLE SUFFERING FROM ALZHEIMER'S DISEASE

Legal capacity – a human right of people suffering from Alzheimer's disease

Legal capacity is a basic human right of people suffering from Alzheimer's disease. When we speak of legal capacity deprivation of people suffering from Alzheimer's disease, we are referring to the limitation of a person's rights to independently make decisions about their life. Article 12, paragraph 2 of the Convention on the Rights of People with Disabilities also discusses the issue of human rights of people suffering from Alzheimer's disease, stating that member countries must accept that people with disabilities have legal capacity on the same grounds as other people in all aspects of life. Therefore, the decision regarding the deprivation of legal capacity should be made very carefully, and before making the final decision an evaluation of decision-making should be conducted. The presence of symptoms of a disease or a diagnosis are not sufficient to deprive someone of legal capacity. Before initiating proceedings for legal capacity deprivation, it is necessary to consider the question of whether guardianship solves specific problems of a person suffering from Alzheimer's disease which are the cause of initiating guardianship due to difficulties in social functioning or whether there is a need for change in other forms of solving problems of people suffering from Alzheimer's disease such as support-based decision-making without legal capacity deprivation (5).

In Croatian family law, legal capacity deprivation was introduced in the Family law from 1998, which mentions several approaches in determin-

ski zakon iz 1998. koji spominje više pristupa u određivanju razloga za lišenje poslovne sposobnosti i kao uzroke nabraja mentalno oštećenje ili psihičku bolest, ovisnost o opojnim sredstvima, senilnost, demenciju i druge uzroke. Obiteljski zakon iz 2003. propisuje kako će sud u izvanparničnom postupku punoljetnu osobu djelomice ili potpuno lišiti poslovne sposobnosti ako se ona zbog duševnih smetnji ili drugih uzroka nije sposobna brinuti o osobnim potrebama, pravima i interesima ili ako ugrožava prava i interese drugih osoba (18). Novim Obiteljskim zakonom bitno se mijenja institut skrbništva jer udovoljava Konvenciji za zaštitu osoba s invaliditetom. Prema članku 233. Obiteljskog zakona zaštitu osoba s invaliditetom potrebno je osigurati drugim sredstvima i mjerama predviđenima posebnim propisima prije nego što se donese odluka o lišenju poslovne sposobnosti i skrbničkoj zaštiti. U provođenju skrbničke zaštite potrebno je težiti što je moguće manjim ograničenjima prava osobe pod skrbništvom. U postupanju s osobom pod skrbništvom koja je lišena poslovne sposobnosti moraju se uzeti u obzir osobnost, sadašnji ili ranije izraženi stavovi osobe, kao i zaštita njezina dostojanstva i dobrobiti. Potrebno je poticati samostalno donošenje odluka od osobe lišene poslovne sposobnosti te joj pružati podršku u donošenju odluka, kao i u sudjelovanju u životu zajednice. Skrbnik je dužan prihvatiti želje i osobne stavove štićenika, osim ako je to u suprotnosti s njegovom dobrobiti. Prema Obiteljskom zakonu iz 2015. osobe s duševnim smetnjama općinski sudovi više ne mogu potpuno lišiti poslovne sposobnosti, već moraju točno utvrditi u kojim segmentima života bolesna osoba nije sposobna štititi svoje interese, a u kojim segmentima ima i dalje pravo odlučivanja. Kod instituta djelomičnog lišenja poslovne sposobnosti predlaže se sudskom odlukom odrediti u kojim segmentima je osoba lišena poslovne sposobnosti. Uveden je i institut anticipirane naredbe u kojem osoba sama može odrediti skrbnika (19). Dijagnosticiranje bolesti u ranom stadiju važno je ne samo zbog medicinskih razloga,

ing reasons for legal capacity deprivation and its list of reasons includes mental damage or mental illness, addiction to opiates, senility, dementia, and other reasons. According to the Family law from 2003, in a non-contentious civil proceeding the court will partially or completely deprive an adult person of legal capacity if due to mental disturbances they are unable to take care of their personal needs, rights, and interests or if they endanger the rights and interests of other persons (18). The new Family law significantly alters guardianship because it complies with the Convention on the Rights of People with Disabilities. According to article 233 of Family law, protection of people with disabilities needs to be ensured by other means and measures provided by special provisions before any decisions regarding legal capacity deprivation and guardianship are made. It is necessary to strive for minimal limitations of rights of a person who is under the protection of guardianship. In the treatment of a person under guardianship who has been deprived of legal capacity, it is necessary to take into consideration personality, their current or previously expressed attitudes, as well as the protection of their dignity and wellbeing. It is necessary to encourage the person deprived of legal capacity to make independent decisions and provide support for making decisions as well as participating in community life. The guardian is obligated to accept the wishes and personal attitudes of the person under guardianship, unless it endangers their wellbeing. According to the Family law from 2015, people with mental disturbances can no longer be deprived of legal capacity by municipal courts. Instead, they must accurately ascertain in which areas of life the person is incapable of protecting their interests, and in which areas they still have the right to make decisions. When it comes to partial legal capacity deprivation, it is suggested that the court of law decides in which areas the person is deprived of legal capacity. Anticipated disposition has also been instituted, allowing a person to choose their guardian (19). Diagnosing a disease in an early stage is important not only for medical reasons,

nego i zbog rješavanja pravnih pitanja kada su osobe još uvijek u stanju samostalno donositi odluke o sebi. Institut anticipiranih naredbi omogućuje osobama unaprijed odlučiti o pojedinim aspektima života. Anticipirana naredba koja se primjenjuje na temelju hrvatskog zakonodavstva veliki je pomak u zaštiti ljudskih prava osoba oboljelih od Alzheimerove bolesti jer se na taj način ostvaruju načela autonomije i samoodređenja. Općenito anticipirana naredba odnosi se na odluke o medicinskim postupcima, a sadržajno se može proširiti i na neka imovinska pitanja čime se značajno proširuje opseg zaštite prava i dostojanstva bolesne osobe. Istaknimo da pri tome pravni učinci nastupaju još za vrijeme života sastavljača, za razliku od oporuke koja se definira kao posljednja volja kojom ostavitelj raspolaže svojom imovinom u slučaju smrti (5).

Procjenjuje se da oko milijun odraslih osoba u Europi, uglavnom osoba s intelektualnim poteškoćama i/ili psihičkim poteškoćama podliježe nekom obliku zakonskog zastupanja, bilo djelomičnog ili potpunog. Njihovi zakonski zastupnici su članovi obitelji ili predstavnici države, primjerice, ravnatelji ustanova, drugi zaposlenici u području socijalne skrbi. Oni koji podliježu punom zakonskom zastupanju gube gotovo sva građanska prava i potreban im je zakonski zastupnik kako bi donosio odluke koje imaju pravni učinak u većini područja njihova života (20). Štrkalj Ivezić (21) navodi da se stručnjaci iz područja prava i bioetike slažu da sposobnost za odlučivanje uključuje četiri aspekta koja treba uzeti u obzir kod svake procjene mentalne razine prije nego što se osobu liši poslovne sposobnosti. Četiri aspekta podrazumijevaju: razumijevanje informacija važnih za donošenje odluke, sposobnost procjene, odnosno primjena informacija na vlastitoj situaciji, sposobnost korištenja tih informacija u procesu donošenja odluke i sposobnost komuniciranja jasne odluke, odnosno konzistentnog izbora (21). Klinički intervjui i specifični upitnici služe kao instrumenti za procjenu sposobnosti i bez obzira koji instrument

but also for solving legal issues when a person is still able to independently make decisions about themselves. Anticipated disposition enables a person to decide on individual aspects of life in advance. Anticipated disposition applied on the basis of Croatian legislation is a great improvement in the protection of human rights of people suffering from Alzheimer's disease because it ensures the principles of autonomy and self-determination. Generally speaking, anticipated disposition refers to decisions regarding medical procedures, and may be expanded to certain property issues, which significantly expands the scope of protection of rights and dignity of a sick person. Also, we should point out that legal effects come into power during the life of the author, unlike in the case of a will, which is defined as the last will which enables the deceased to manage their property in case of death (5).

It is estimated that approximately one million adult people in Europe, most of whom have intellectual difficulties and/or mental difficulties, are subject to some form of legal representation, whether partial or complete. Their legal representatives are family members or state representatives, for instance institution managers and other employees in the field of social welfare. Those who are subject to full legal representation lose almost all civil rights and require a legal representative who makes decisions that have a legal effect in most areas of their life (20). Štrkalj Ivezić (21) claims that legal and bioethics experts agree that the decision-making ability includes four aspects that need to be considered in any evaluation of mental capacity before a person is deprived of legal capacity. The four aspects include: understanding information important for making decisions, the ability to assess, i.e. apply information to one's own situation, the ability to use this information in the decision-making process, and the ability to communicate a clear decision, i.e. consistent choice (21). Clinical interviews and specific questionnaires serve as instruments for the assessment of ability, and regardless of which instrument is used, it is important to

je primijenjen od navedenih, važno je utvrditi činjenice. Sposobnost za odluke može biti selektivna, što znači da osoba može donijeti neke odluke, a druge ne može. Dakle, osobi nedostaje sposobnost za većinu odluka što je slučaj kod osoba oboljelih od Alzheimerove bolesti. Kod Alzheimerove bolesti gubitak mentalne sposobnosti može varirati, stoga treba procjenjivati razinu mentalne sposobnosti osobe da donese odluku na vrijeme. U skladu s time treba razmotriti mogućnost odgode procjene do trenutka kada će osoba ponovno steći sposobnost (21). U skladu s time, kratko ispitivanje mentalnog statusa tzv. MMSE služi da se kod starijih osoba provede kratka mjera procjene mentalnog stanja, a uključuje bolesnike s demencijom i Alzheimerovom bolesti kao i druge bolesnike s kognitivnim oštećenjima. MMSE kliničko testiranje jedno je od najviše korištenih kratkih instrumenata za probir na kognitivna oštećenja i praćenje bolesnikova stanja tijekom vremena (22).

Suvremena pravna praksa

Glede primjera pozitivne prakse istaknuli bismo činjenicu da u mnogim zakonodavstvima odustaju od postupka lišenja poslovne sposobnosti, a zaštita ljudskih prava osoba s duševnim smetnjama pruža se različitim, alternativnim oblicima skrbi. Slično i Zakon o ubrojivosti koji je donesen 2005. godine, stupio na snagu 2007. godine, a vrijedi za područje Engleske i Welsa. Zakon o ubrojivosti namijenjen je osobama koje nemaju sposobnost donošenja odluka za sebe zbog, na primjer, poteškoća u učenju, problema mentalnog zdravlja ili stanja poput demencije. Zakon o ubrojivosti obuhvaća važne odluke koje se odnose na pojedinca i njegovu imovinu, financijske poslove, pitanje zdravstva i socijalne skrbi. Također se odnosi na svakodnevne odluke, kao što su pitanja osobne njege, odijevanja ili prehrane. To može pomoći u podršci njegovateljima da donose odluke za budućnost osoba koje boluju od demencije. Svako donošenje odluke u ime osobe za koju se

ascertain the facts. The decision-making ability can be selective, meaning that a person may be able to make only certain decisions. Therefore, such a person lacks the ability to make most decisions, which is the case with people suffering from Alzheimer's disease. In Alzheimer's disease, the loss of mental ability can vary, which is why a person's mental ability for timely decision-making should be evaluated. Accordingly, the possibility of delaying evaluation until the moment when the person regains their ability should be considered (21). According to this, the mini-mental state examination or MMSE is used in the elderly to conduct a short evaluation of the mental state, and includes patients with dementia and Alzheimer's disease, as well as other patients with cognitive damage. MMSE clinical testing is one of the most commonly used short instruments for testing for cognitive impairment and following a patient's state over a certain period (22).

Contemporary legal practice

Regarding examples of good practice, we would like to point out the fact that many legislations are abandoning the process of legal capacity deprivation, and the protection of human rights of people with mental disturbances is ensured using various alternative forms of caregiving. The same is true of the Accountability law, which was introduced in 2005 and came into power in 2007 and is valid in England and Wales. The Accountability law was intended for persons who are unable to make decisions for themselves due to, for instance, learning difficulties, mental health problems, or conditions such as dementia. The Accountability law encompasses important decisions related to the individual and their property, finances, healthcare, and social welfare. It also relates to daily decisions, such as the issues of personal care, dressing, or nutrition. This can provide support for caregivers in making decisions for the future of people who suffer from dementia. Whenever one makes decisions for a person who is considered to be lacking mental abilities,

smatra da joj nedostaje mentalne sposobnosti mora se učiniti u njezinom najboljem interesu. Treba uzeti u obzir i mogućnost odgode odluke dok osoba stekne dovoljno mentalne sposobnosti da donese odluku samostalno. Također treba uključivati osobu kojoj nedostaje mentalne sposobnosti da sudjeluje u odluci što je više moguće, saznati stavove te osobe, uzeti u obzir mišljenja drugih, kao što su njegovatelji i ljudi zainteresirani za dobrobit te osobe (23). Za utvrđivanje sposobnosti za donošenje odluka kao i postojanje pretpostavki za odlučivanje o pojedinom poslu provode se različite vrste testova sposobnosti. Postoje tzv. pravni testovi koji se odnose na oporuku, darivanje, sudjelovanje u sudskom postupku, sudjelovanje u ugovoru i sklapanje braka (24).

Pomoć odraslim osobama bez primjene lišenja poslovne sposobnosti doživjelo je njemačko zakonodavstvo, a riječ je o uvođenju instituta *Betreuung*. Jedno od osnovnih obilježja instituta pomoći odrasloj osobi je ta da se imenovanjem pomoćnika odrasloj osobi, ne gubi poslovna sposobnost. Na taj način potiče se veća zaštita ljudskih prava starijih osoba u smislu poticanja na samostalno donošenje odluka sa ciljem socijalizacije i integracije u društvo (25). Sustav pomoći odraslim osobama koji se temelji na pomoći i brizi reguliran je paragrafima od 1896. do 1908. (26). Nadalje, Paragraf 1896. BGB određuje pretpostavke za imenovanje pomoćnika odrasloj osobi. Pomoćnik se imenuje osobi koja zbog svoje psihičke bolesti ili tjelesnih, umnih i duševnih smetnji nije u stanju potpuno ili djelomično obavljati poslove, a poseban skrbnički sud je tijelo nadležno za imenovanje opunomoćenika na zahtjev odrasle osobe ili po službenoj dužnosti. Paragraf 1987. BGB određuje da više osoba može biti imenovano pomoćnikom odrasloj osobi, na primjer, fizička osoba koja je podobna za obavljanje pravnih poslova u okviru ovlasti koje odredi sud, skrbnik iz udruge samo uz suglasnost udruge i skrbnik iz nadležnih državnih tijela također uz odobrenje. Također je u paragrafu

this must be performed in their best interests. The possibility of delaying a decision until the person gains enough mental ability to make the decision independently must also be taken into account. One should encourage a person lacking mental capacities to participate in decision-making as much as possible, learn about their attitudes, and take into consideration the opinions of others, such as caregivers and people interested in the person's wellbeing (23). Various kinds of ability tests are conducted to establish the ability to make decisions as well as the existence of requirements for making decisions regarding a certain type of occupation. There are so-called legal tests related to writing wills, giving gifts, participating in court proceedings, negotiating contracts, and entering into marriage (24).

German legislation already contains the principle of providing aid to adults without legal capacity deprivation in the form of *Betreuung*. One of the basic characteristics of providing help to an adult is that they do not lose legal capacity by being assigned an assistant. Greater protection of human rights of older persons is thus encouraged by stimulating independent decision-making with the goal of socialization and integration into society (25). The system of providing aid for adult persons based on aid and care is regulated by paragraphs 1896 to 1908 (26). Furthermore, paragraph 1896 BGB determines the preconditions for assigning an assistant to an adult person. The assistant is assigned to a person who, due to psychological illness or physical or mental problems, is not able to partially or completely perform occupations, and a special custodial court is a body responsible for appointing fiduciaries at the request of an adult person or according to official duty. Paragraph 1987 BGB determines that several people can be appointed as assistants for an adult person. For instance, a natural person eligible for performing legal duties within the powers determined by a court of law, a caregiver from an association, but only with the agreement of the association, and a caregiver from competent authorities, also with permission. Paragraph 1899 BGB also states that a court of law can ap-

1899. BGB sadržano da sud može imenovati više opunomoćenika ali i da mora specificirati poslove između njih. Pitanja koja se tiču osobnih stanja i u kojima postoji mogućnost kršenja ljudskih prava odrasloj osobi sadržana su u paragrafu 1904. BGB, a tiču se poduzimanja određenih liječničkih postupaka kao što su pregledi, liječenje i liječnički zahvati. Dok paragraf 1906. BGB sadrži uvjete o smještaju u psihijatrijske ili druge ustanove gdje je takav smještaj moguće ishoditi samo uz odluku skrbničkog suda, a iznimno bez odluke ako postoji opasnost od nastajanja štete za život ili zdravlje osobe. Odobrenje pomoćnika za smještaj u psihijatrijsku ustanovu može biti zamijenjeno i odobrenjem od opunomoćenika, ali se traži u pisanom obliku sastavljena punomoć koja se izrijekom odnosi na postupke smještaja u ustanove. Glede raspolaganja imovinom paragraf 1908. BGB određuje samo uz odluku suda, a dužnosti pomoćnika prestaju ako više nije prikladan za obavljanje dužnosti, ako sam zatraži razrješenje ili ako odrasla osoba zatraži njegovo razrješenje (26*)*.

Nadalje, Austrijski pravni sustav također poznaje primjenu konvencijskog prava sustavom odlučivanja uz podršku na dva načina, izjave o raspolaganju pacijenata (*Patientenverfügungen*) i anticipirane punomoći (*Vorsorgevollmacht*). Za razliku od njemačkog pravnog okvira ovaj model traži dodatne pretpostavke da bi izjave odrasle osobe bile pravno obvezujuće. Na primjer, za izjavu o raspolaganju pacijenata (*Patientenverfügungen*) traži se pisana forma ovjerena od javnog bilježnika, odvjetnika ili pravobranitelja za zaštitu prava pacijenata. Osoba mora biti svjesna posljedica takve izjave koja mora biti vlastoručno potpisana s naznačenim datumom kad je sačinjena zato što ta vrsta anticipirane naredbe ima vremenski ograničeni učinak na rok od pet godina. Dodatna pretpostavka koja se traži da izjava bude pravno obvezujuća je potrebna konzultacija s liječnikom o sadržaju i njezinim posljedicama na primjenu medicinskog tretmana, a na liječniku je odgo-

point several fiduciaries but must specify their individual responsibilities. The questions regarding personal states, which may involve a breach of human rights of an adult person, are contained in paragraph 1904 BGB and are concerned with certain medical procedures such as examinations, treatments, and medical operations. Paragraph 1906 BGB contains the conditions for placing a person in psychiatric or other institutions which may be done only with the permission of the court of caregiving, and without this permission only in exceptional situations if the person's life or health are in danger. An assistant's permission for placement in a psychiatric institution can be replaced with a fiduciary's permission, but a written authorisation directly related to the procedures of accommodation in institutions must be provided. Regarding property management, paragraph 1908 BGB determines that it can be done only with the permission of a court of law, while an assistant's duties end if they are no longer eligible for their performance, if they request to be dismissed, or if the adult person requests their dismissal (26).

Furthermore, the Austrian legal system also recognized the application of convention law through support-based decision-making in two ways: a living will (*Patientenverfügungen*) and anticipated disposition (*Vorsorgevollmacht*). Unlike the German legal framework, this model requires additional conditions for the adult person's statements to be legally binding. For example, a statement regarding a living will (*Patientenverfügungen*) requires a written form certified by a public notary, lawyer, or ombudsman for the protection of the patient's rights. The person must be aware of the consequences of this statement and it must be hand-signed and contain the date of its composition because this type of anticipated disposition is effective during a time limit of five years. An additional precondition which must be fulfilled for the statement to be legally binding is a necessary consultation with a physician regarding its content and consequences for the application of medical treatment, and it is the physician's responsibility to assess the mental

vornost da procijeni mentalnu sposobnost osobe koja takvu izjavu sastavlja (27). Anticipirana punomoć (*Vorsorgevollmacht*) i odluke koje se tiču zdravlja starijih osoba uređene su Općim građanskim zakonikom kojima se određuje osoba od povjerenja, koja radi u ime i za račun opunomoćitelja (28).

Dobre primjere sustava odlučivanja uz podršku poznaje i Švedska kroz osobne pravobranitelje i osobnu asistenciju koju treba izdvojiti od pomoći u kući ili usluge skrbi u kući. Osobni pravobranitelj (engl. *personligt ombud*) razvijen je u Švedskoj nakon psihijatrijske reforme 1995. godine i pruža potporu u donošenju odluka korisnicima psihijatrijskih usluga (29). Osobnog pravobranitelja po zahtjevu pojedinca financiraju općine ili ih mogu angažirati udruge. Ta vrsta podrške uspješna je u pomaganju onima do kojih je najteže doprijeti i koji su prije toga bili bez ikakve podrške. Budući da ne postoji birokratska procedura za dobivanje osobnog pravobranitelja, dovoljan je samo ispunjen zahtjev kako bi se ostvarilo pravo na osobnog pravobranitelja. Pravobranitelj nema fiksno radno vrijeme, već prilagodljivo, što znači da je u svakom trenutku dostupan pojedincu. Također pomaže pojedincu u različitim pitanjima, kao što je odluka o stambenom smještaju ili zanimanju. Osobni pravobranitelj time prepoznaje potrebu za skrb o pojedincu i osigurava da primi svu nužnu pomoć (30). Naime, prva bitna karakteristika pravobranitelja je da su oslobođeni odgovornosti glede medicinskog liječenja osobe o kojoj skrbe i ne donose odluke o medicinskim tretmanima. Svake godine oko 6 do 7000 tisuća osoba primi pomoć od 300 osobnih pravobranitelja raspoređenih na više od 100 organiziranih aktivnosti. U prosjeku na godinu imaju 15 do 20 korisnika godišnje. Što se tiče troškova plaće, jedan dio plaće osobnog pravobranitelja pokriva Vlada, a drugi dio kao i troškove prostorije, prijevoza i sl. pokrivaju općine iz svojih proračuna. U samo 10 % troškova rada pravobranitelja uključene su

ability of a person composing such a statement (27). Anticipated disposition (*Vorsorgevollmacht*) and decisions related to the health of the elderly are regulated by General civil law, which appoints a person of trust who acts in the name of the trustor (28).

Good examples of the system of support-based decision-making can also be found in Sweden's personal ombudsmen and personal assistance, which should be differentiated from aid in the home or caregiving in the home. The position of a personal ombudsman (*personligt ombud*) developed in Sweden following the psychiatric reform of 1995 and provides support in decision-making to users of psychiatric services (29). At the behest of an individual, the personal ombudsman is paid by a municipality or an association. This type of support is successful in providing help to those who are most difficult to reach and who did not previously receive any support. Since there is no bureaucratic procedure for being assigned a personal ombudsman, a filled-out request is enough to exercise the right to a personal ombudsman. Instead of fixed work hours, an ombudsman has adjustable work hours, which means that they are available at any time. They also provide help regarding various issues such as decisions about residence or employment. Therefore, a personal ombudsman recognizes the need to provide care to an individual and ensures that they receive all necessary aid (30). The first important characteristic of an ombudsman is that they do not have any responsibilities regarding medical treatment of the person they are providing care to and do not make any decisions regarding medical treatment. Every year, approximately between six and seven thousand people receive help from 300 personal ombudsmen who are deployed on more than one hundred organized activities. On average, they have 15 to 20 users per year. One part of the personal ombudsman's salary is covered by the government and the other half, including expenses related to accommodation, transport, etc., is covered by the municipalities' budget. Only 10% of the expenses related to the work of a personal ombudsman is covered by

županije. Druga karakteristika pravobranitelja je da rade u timovima zbog stresa i razmjene iskustava. Većina pravobranitelja kroz svoje prijašnje poslove ima dobro razvijene vještine i profesionalno iskustvo u radu s ljudima, poznavanju psihijatrijskog djelovanja te na području zdravstvene djelatnosti. Dodatna znanja i vještine stječu edukacijom o socijalnim i upravnim pravima kako bi zaštitili ljudska prava svojih korisnika (31). Glede osobne asistencije, svaki korisnik ima pravnog punomoćnika, tj. osobnog zastupnika koji podržava korisnika, na primjer, u podnošenju zahtjeva za uslugu osobnog asistenta i odabir pružatelja usluge, odabiru jamca usluge kao i osiguravanju da se osobna asistencija pruža tako da se poštuje osoba s invaliditetom, uključujući priznavanje njezinog osobnog integriteta i nadzor usluge kako bi se osiguralo ispunjavanje standarda dogovorenih s osobom s invaliditetom (32).

Informirani pristanak - ljudsko pravo oboljelih od Alzheimerove bolesti

Informirani pristanak (engl. *informed consent)* svoje povijesno uporište nalazi u sudskim nirnberškim procesima 1947. godine na temelju kojeg je stvoren Nirnberški kodeks koji u prvoj točki govori o »dobrovoljnom pristanku kao apsolutno bitnom« (33). Povijesni razvoj informiranog pristanka prati slijed i drugih sudskih procesa kao što su Salgo vs. Leland Stanford Jr. (34) i Natanson vs. Kline (35). Međutim, Američka znanstvenica i etičarka Ruth Faden koja je među prvima utemeljila pojam informiranog pristanka bolesnika: »obaviješteni je pristanak jednostavno rečeno izjava bolesnika ili ispitanika nekog znanstvenog istraživanja koja liječnika ili medicinskog istraživača opunomoćuje da provede određene mjere, terapiju ili da uključi ispitanika u istraživački protokol«, navodi da se pojam informiranog pristanka temelji na dvije premise. Prva je da bolesnik ima pravo na sve informacije kako bi mogao donijeti informira-

counties. The second characteristic of an ombudsman is that they work in teams due to stress and sharing of experiences. Most ombudsmen have well-developed skills and professional experience in working with people, knowledge of psychiatric work, and the field of medical work. They gain additional knowledge and skills regarding social and administrative rights in order to protect their users' human rights (31). Concerning personal assistance, each user has a legal representative, i.e. a personal representative who supports the user, for example in applying for the services of a personal assistant and selecting the service provider and service guarantor, as well as ensuring that personal assistance is provided in a way that respects the person with disabilities, including ensuring respect for their personal integrity and supervising service in order to ensure that standards agreed upon with the person with disabilities are met.

Informed consent – a human right of people suffering from Alzheimer's disease

Informed consent has its historical basis in the court proceedings in Nuremberg in 1947, on the basis of which the Nuremberg Code was created, the first point of which states that "informed consent is absolutely essential" (33). The historical development of informed consent follows the development of other court proceedings such as Salgo vs. Leland Stanford Jr. (34) and Natanson vs. Kline (35). However, American scientist and ethicist Ruth Faden, who was one of the first to lay the groundwork for the term of informed consent of patients states that "informed consent is, simply put, the statement of a patient or participant of a certain scientific research which authorises a physician or medical researcher to implements certain measures or therapy, or include the participant in a research protocol", also claiming that informed consent is based on two premises. According to the first, the patient has the right to all information in order to make an informed decision about recommended medical

nu odluku o preporučenom medicinskom tretmanu i druga je da bolesnik ima pravo prihvatiti ili odbiti prijedlog ili preporuku liječnika. Na primjer, ima pravo odbiti i predloženi medicinski zahvat (5). Slijedom toga, informirani pristanak je nastao iz načela autonomije prema kojem svaki bolesnik donosi važne odluke o svom životu u skladu s vlastitim ciljevima i vrijednostima. Ako bolesna osoba, na primjer osoba koja boluje od Alzheimerove bolesti, nije sposobna za davanje informiranog pristanka, umjesto nje odlučit će njezin zakonski zastupnik ili skrbnik, ovisno o pravnom sustavu uz odobrenje nadležnih upravnih tijela ili sudova. Odluke skrbničkih tijela koje se tiču zdravlja, ali i drugih odluka koje su u interesu oboljele osobe od Alzheimerove bolesti, mogu se zamijeniti i anticipiranim naredbama koje su korak dalje od navedenih načela u području zaštite ljudskih prava osoba oboljelih od Alzheimerove bolesti (5).

Ljudsko pravo oboljelih od Alzheimerove bolesti institutom informiranog pristanka na nacionalnoj razini detaljno je reguliran Zakonom o zaštiti prava pacijenata i Zakonom o zaštiti osoba s duševnim smetnjama. Ustavne odredbe koje jamče zaštitu ljudskih prava osoba oboljelih od Alzheimerove bolesti jesu pravo na nepovredivost ljudske slobode i osobnosti te pravo na vlastito nesmetano tjelesno-biološko postojanje. Proso obrazlaže da to pravo daje svakoj osobi potpunu pravnu vlast glede objekta prava i ističe da su to pravo na život, tijelo, kao i duševno ili tjelesno zdravlje uz poštivanje granica određenim tuđim pravima (36). Upravo zato odredba članka 23. Ustava Republike Hrvatske nalaže da nitko ne smije biti podvrgnut bilo kakvom obliku zlostavljanja ili bez svoje privole podvrgnut liječničkim ili znanstvenim pokusima (37). Sukladno tome, Turković zaključuje da se pravo na informirani pristanak bolesnika, odnosno pravo na odbijanje medicinskog tretmana, u prvom redu temelji na članku 35. Ustava, koji nalaže da se

treatment, while the second is that the patient has the right to accept or reject a physician's suggestion or recommendation. For instance, they have the right to reject a suggested medical procedure (5). Therefore, informed consent developed from the principle of autonomy, according to which each patient makes important decisions about their life in accordance with their own goals and values. If a sick person, for example a person suffering from Alzheimer's disease, is incapable of giving informed consent, the decision will be made for them by their legal representative or caregiver, depending on the legal system and with the approval of competent administrative organs or courts of law. The decisions of custodial bodies related to health and other decisions which are in the interest of a person suffering from Alzheimer's disease may be replaced by anticipated dispositions, which are one step away from the abovementioned principles in the area of the protection of human rights of people suffering from Alzheimer's disease (5).

The human rights of people suffering from Alzheimer's disease are regulated on the national level through informed consent by the Law on the protection of rights of patients and the Law on the protection of persons with mental disorders. The constitutional provisions ensuring the protection of human rights of people suffering from Alzheimer's disease are the right to the inviolability of human freedom and personality and the right to physical and biological existence. Proso explains that this right gives each individual full legal power with regard to the object of law and points out that the right to life and the body, as well as psychological and physical health, are determined by the rights of others (36). Therefore, the provision of article 23 of the Constitution of the Republic of Croatia states that no one can be the target of any form of maltreatment or subjected to medical or scientific tests without consent (37). According to this, Turković concludes that the right of patients to informed consent, i.e. the right to refuse medical treatment, is primarily based on article 35 of the Constitution, which states that every person and citizen is guaranteed

svakom čovjeku i građaninu jamči poštivanje i pravna zaštita njegovog osobnog i obiteljskog života, dostojanstva, ugleda i časti. U primjeni tog prava relevantne su i druge odredbe Ustava člankom 40. kojima se jamči sloboda vjeroispovijesti (38). Na primjer, treba uzeti u obzir može li se osoba oboljela od Alzheimerove bolesti podvrgnuti istraživanju navedene bolesti ako joj, na primjer, vjera to ne dopušta.

Hrvatska je na području zdravstvene zaštite istaknula svoju odlučnost u zaštiti ljudskih prava bolesnika Zakonom o zaštiti prava pacijenata koji je donijela 2004., gdje su po prvi puta u sustavu zdravstvene zaštite na jednom mjestu sva prava pacijenata (39). U odnosu na prijašnje zakone o zaštiti prava pacijenata, trenutni Zakon o zaštiti prava pacijenata (40) unaprijedio je zaštitu ljudskih prava osoba oboljelih od Alzheimerove bolesti na način da se vodi etičkim načelima kojima se jamči poštivanje ljudskog bića, kao što su očuvanje fizičkog i mentalnog integriteta te zaštita osobnosti. Svakom bolesniku jamči se jednako pravo na kvalitetnu zdravstvenu zaštitu. Temeljne vrijednosti koje se promiču Zakonom o zaštiti prava pacijenata iz 2008. vrlo su bliske filozofiji palijativne skrbi. Ovdje možemo istaknuti članak 4. Zakona o zaštiti prava pacijenata koji navodi kako se »načelo humanosti zaštite prava bolesnika ostvaruje i osiguravanjem prava na fizički i mentalni integritet bolesnika«. Slijedom toga zaštita ljudskih prava osoba oboljelih od Alzheimerove bolesti podrazumijeva pravo na suodlučivanje prema članku 6. Zakona o zaštiti prava pacijenata koje obuhvaća pravo pacijenta na obaviještenost i pravo na prihvaćanje ili odbijanje pojedinog dijagnostičkog, odnosno terapijskog postupka (33,41). Temeljem članka 8. Zakona o zaštiti prava pacijenata, pacijent ima pravo dobiti obavijesti na način koji mu je razumljiv s obzirom na dob, obrazovanje i mentalne sposobnosti. Kada je priroda bolesti pacijenta takva da može ugroziti zdravlje drugih ljudi, pacijent s punom poslovnom sposob-

the respect and legal protection of their personal and family life, dignity, reputation, and honour. In the enforcement of this right, there are other provisions of article 40 of the Constitution which ensure freedom of religious belief (38). For instance, it should be taken into consideration if a person suffering from Alzheimer's disease can be subjected to the study of this disease if, for example, their religion does not allow that. In the field of healthcare, Croatia has emphasized its determination regarding the protection of human rights of patients through the Law on the protection of the rights of patients, which was introduced in 2004 and collected all the rights of patients for the first time in the system of healthcare (39). In comparison with previous laws on the protection of the rights of patients, the current Law on the protection of the rights of patients (40) has improved the protection of human rights of people suffering from Alzheimer's disease by following ethical principles which ensure the respect for the human being as well as the preservation of physical and mental integrity and the protection of personality. Every patient is guaranteed the same right to quality healthcare. The basic values promoted by the Law on the protection of the rights of patients from 2008 are very close to the principles of palliative care. Here we can point out article 4 of the Law on the protection of the rights of patients, which states that the "principle of humaneness of the protection of the rights of patients is also achieved by ensuring the rights to physical and mental integrity of patients". Therefore, the protection of human rights of people suffering from Alzheimer's disease includes the right to co-decision according to article 6 of the Law on the protection of the rights of patients, which encompasses the right of patients to information and the right to accept or refuse a particular diagnostic or therapeutic procedure (33,41). On the basis of article 8 of the Law on the protection of the rights of patients, the patient has the right to receive information in the form that is understandable to them with respect to their age, education, and mental capacities. When the nature of the illness is such that it

nošću ne može se odreći prava na obaviještenost o svom zdravstvenom stanju. Pacijent ili skrbnik oboljele osobe od Alzheimerove bolesti može tražiti drugo stručno mišljenje i ima pravo biti obaviješten o svim poduzetim radnjama u slučajevima kad pristanak oboljelog nije uvjet započinjanja terapije. Oboljela osoba ili njezin skrbnik na potpisanom obrascu suglasnosti prihvaćaju ili odbijaju preporučeni medicinski postupak. Iznimno, ako je riječ o neodgodivom medicinskom zahvatu, on se može učiniti i bez potpisanog pristanka, ali samo dok ta opasnost traje. Bitno je napomenuti da skrbnik može suglasnost u bilo koje vrijeme povući potpisivanjem izjave o odbijanju pojedinoga dijagnostičkog, odnosno terapijskog postupka. Zbog toga se skrbniku trebaju dati sve one informacije koje bi se dale samom bolesniku zato što skrbnici trebaju rukovoditi prethodno izraženim željama bolesnika. Zakon o zdravstvenoj zaštiti propustio je to propisati, a to je obveza koja proizlazi iz članka 9. Bioetičke konvencije koja navodi da će se uzeti u obzir ranije izražene želje pacijenta glede medicinskog zahvata, ako u vrijeme zahvata nije u stanju izraziti svoje želje (38).

U Republici Hrvatskoj prvi Zakon o zaštiti osoba s duševnim smetnjama donesen je 1997. i najznačajniji je pravni mehanizam zaštite ljudskih prava osoba s duševnim smetnjama zato što je spriječio pravnu prazninu u reagiranju prema neubrojivim osobama i omogućio njihovo izdvajanje iz kaznenopravne regulative (42). Naime, u mnogim segmentima Zakon o zaštiti osoba s duševnim smetnjama ugrožavao je ljudska prava i slobode psihijatrijskih bolesnika pa se predloženim izmjenama nastojalo ublažiti spomenuti raskorak između zakonskih rješenja i prakse postupanja prema osobama s duševnim smetnjama. Zbog svega navedenog osobe s duševnim smetnjama našle su se u središtu pozornosti i ta problematika postala je predmet mnogobrojnih kongresa i rasprava, znanstvenih i stručnih članaka (43). Zakonom

can endanger the health of other people, a patient with full legal capacity cannot waive the right to be informed about their health. The patient suffering from Alzheimer's disease or their guardian can ask for another expert opinion and has the right to be informed about all the actions that have been taken in cases when patient consent is not a condition for initiating therapy. The patient or their guardian sign a form declaring whether they accept or refuse the recommended medical procedure. Only in the case of medical procedures that cannot be postponed can the procedure be conducted without signed consent, but only while there is danger for the patient. It is important to point out that the guardian can retract the consent at any moment by signing a statement about refusing a certain diagnostic or therapeutic procedure. This is why guardians need to be provided with all the information that should be provided for the patient, since the guardian has to act according to the patient's previously expressed wishes. The Law on healthcare failed to proscribe this, but it is a duty that proceeds from article 9 of the Convention on bioethics, which states that all of the patient's previously expressed wishes regarding medical procedures must be taken into consideration if the patient was unable to express their wishes at the time of the procedure (38). In the Republic of Croatia, the first Law on the protection of persons with psychological disorders was introduced in 1997 and is the most significant legal mechanism for the protection of human rights of people with psychological disorders because it corrected the legal gap in the reaction towards people with psychological disturbances and enabled their exclusion from criminal law regulations (42). In many of its segments the Law on the protection of persons with psychological disorders endangered the human rights and freedoms of psychiatric patients, and the suggested changes were aimed at mitigating the abovementioned gap between legal solutions and the practice of treating people with psychological disorders. Due to all this, persons with psychological disturbances found themselves in the centre of attention, and this problem became the

o zaštiti osoba s duševnim smetnjama iz 2014. unaprijeđen je položaj ljudskih prava osoba s duševnim smetnjama. Odredba informiranog pristanka definirana je sukladno članku 3. stavka 13. Zakona o zaštiti osoba s duševnim smetnjama. Prema navedenom članku informirani pristanak definira se kao slobodno dana suglasnost osobe s duševnim smetnjama za primjenu određenoga medicinskog postupka, koja se zasniva na odgovarajućem poznavanju svrhe, prirode, posljedica, koristi i rizika toga medicinskog postupka i drugih mogućnosti liječenja. Osoba s duševnim smetnjama sposobna je za davanje pristanka ako može razumjeti informaciju koja je važna za davanje pristanka, upamtiti tu informaciju i koristiti ju u postupku davanja pristanka. Nadalje, člankom 16. stavak 1. i člankom 17. stavak 3. istaknuta je pojačana zaštita osoba s duševnim smetnjama uvjetovanjem primjene posebnih medicinskih postupaka i sudjelovanjem u biomedicinskim istraživanjima samo uz pisani pristanak osobe. Zakon o duševnim smetnjama znatno je izmijenjen u odnosu na prethodna zakonska rješenja i u pogledu usmenog i pisanog pristanka na smještaj u psihijatrijsku ustanovu. Umjesto dosadašnjeg usmenog pristanka sada mora biti pisani pristanak, sukladno članku 12. Zakona o duševnim smetnjama, koji je sastavni dio medicinske dokumentacije i osoba s duševnim smetnjama može ga povući u bilo kojem trenutku (44).

Između implementacije novih rješenja učinjene su promjene u pogledu zamjenskog pristanka zakonskog zastupnika. Osobe koje nisu u mogućnosti izraziti svoju volju i dati pristanak za smještaj u psihijatrijsku ustanovu mogu biti smještene pristankom skrbnika ili osobe od povjerenja, što se smatra dobrovoljnim smještajem. Ta odredba ujedno proizlazi iz Konvencije o zaštiti osoba s invaliditetom koja zahtijeva »individualni pristup svakoj osobi s duševnim smetnjama te uzimanje u obzir stupnja očuvanosti njezinih sposobnosti, a sve kako

subject of numerous congresses and discussions and scientific and expert articles (43). The Law on the protection of persons with psychological disorders from 2014 improved the position of human rights of persons with psychological disorders. The provision of informed consent was defined in accordance with article 3, paragraph 13 of the Law on the protection of persons with psychological disorders. According to this article, informed consent is defined as a freely given consent of a person with a psychological disorder for the purposes of a certain medical procedure, which is based on appropriate knowledge of the purpose, nature, consequences, benefits, and risk of the medical procedure and other treatment options. A person with psychological disturbances is capable of giving consent if they can understand the information important for giving consent, remember the information, and use it in the process of giving consent. Furthermore, article 16, paragraph 1 and article 17, paragraph 3 emphasize the increased protection of people with psychological disorders by necessitating the application of special medical procedures and enabling participation in biomedical research only with signed consent. The Law on psychological disorders has been significantly altered in relation to previous legislative solutions and with respect to oral and written consent to being placed in a psychiatric institution. Instead of the previous oral consent, written consent is now required according to article 12 of the Law on psychological disorders, which is an integral part of medical documentation and a person with psychological disorders can retract it at any moment (44).

Between the implementations of new solutions, changes regarding the legal representative's proxy consent have been introduced. Persons who are not able to express their wish and give consent for placement in a psychiatric institution can be placed there with the consent of a guardian or a person of trust, which is then considered voluntary placement. This provision proceeds from the Convention on the Protection of Persons with Disabilities, which demands "an individual approach to any person with psychological distur-

bi se spriječilo da njihovo zastupanje preuzmu skrbnici koji često zlorabe svoj položaj« (43). Slijedom toga članak 12. Zakona o zaštiti osoba s duševnim smetnjama propisuje da se prije davanja pristanka mora utvrditi sposobnost osobe s duševnim smetnjama za davanje pristanka. Također bitno je istaknuti da su izmjene i nova rješenja u hrvatskom zakonodavstvu rezultat usklađivanja s konvencijskim pravom i praksom Europskoga suda. Novina kojom je poboljšan status osoba s duševnim smetnjama, a ujedno time i status osoba oboljelih od Alzheimerove bolesti, propisana je Zakonom o zaštiti osoba s duševnim smetnjama iz 2014. Tim zakonom omogućuje se uporaba anticipirane naredbe za slučaj buduće nesposobnosti očitovanja volje (44).

Palijativna skrb - ljudsko pravo oboljelih od Alzheimerove bolesti

Svjetska zdravstvena organizacija palijativnu medicinu definira kao »skrb koja poboljšava kvalitetu života životno ugroženih bolesnika i njihovih obitelji, prevencijom, identifikacijom i ublažavanjem patnje, boli i drugih tjelesnih, psihosocijalnih i duševnih poteškoća« (45). Ustavne odredbe koje jamče pravo na palijativnu skrb osobama oboljelim od Alzheimerove bolesti navodi se u članku 59. Ustava gdje se svakom jamči pravo na zdravstvenu zaštitu (37). Iako »bolest i starost nisu sinonimi«, starije su osobe često zbog svoje dobi vitalno ugrožene (46). Zato se u članku 16. Zakona o zdravstvenoj zaštiti navodi da mjerama zdravstvene zaštite pripadaju i posebne mjere zdravstvene zaštite koje su namijenjene stanovništvu starijem od 65 godina, dok članak 25. navodi da zdravstvena zaštita na primarnoj razini obuhvaća i patronažne posjete, zdravstvenu njegu i liječenje u kući. Ovdje posebno ističemo palijativnu skrb kao temeljno ljudsko pravo osoba oboljelih od Alzheimerove bolesti, a propisana je člankom 17. stavak 8. Zakona o zdravstvenoj zaštiti kao jedna od mjera zdravstvene zaštite za nebances and consideration of the level of preservation of their abilities with the purpose of preventing their representation being taken over by guardians who often abuse their position" (43). Consequently, article 12 of the Law on the protection of persons with psychological disorders states that before giving consent, the ability of the person with a psychological disorder for giving consent must first be established. It is also important to emphasize that the changes and new solutions in Croatian legislature are the result of alignment with conventional law and practice of the European Court. One novelty, which improved the status of people with psychological disorders and thus that of people suffering from Alzheimer's disease, was proscribed by the Law on the protection of persons with psychological disorders from 2014. This law enables the use of anticipated disposition in case the patient is incapable of expressing their wishes in the future (44).

Palliative care – a human right of people suffering from Alzheimer's disease

The World Health Organization defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual" (45). Constitutional provisions ensuring the right to palliative care for people suffering from Alzheimer's disease are found in article 59 of the Constitution, which states that every person is ensured the right to healthcare (37). Although "illness and old age are not synonymous", the life of the elderly is often endangered due to their age (46). Consequently, article 16 of the Law on healthcare states that healthcare measures include special healthcare measures intended for the protection of people above the age of 65, while article 25 states that, on the primary level, healthcare

izlječivo bolesne, odnosno umiruće osobe (47). Mimica navodi da se tijekom palijativne skrbi osoba oboljelih od Alzheimerove bolesti liječnici i njegovatelji svakodnevno susreću s određenim simptomima kao što su problemi s hranjenjem, nepokretnost, neurološki problemi, bolovi i infekcije zbog čega je potrebna hospitalizacija i terminalna njega (48). Sukladno tomu, člankom 26. Zakona o zdravstvenoj zaštiti propisano je da zdravstvena zaštita na primarnoj razini obuhvaća palijativnu skrb i pruža se djelatnošću palijativne skrbi. Zakon o zdravstvenoj zaštiti predviđa primjenu obveznog preventivnog minimuma za starije te je predviđeno osnivanje ustanova za palijativnu skrb (47).

Što se tiče razvoja palijativne skrbi o osobama s demencijom, u Hrvatskoj strategiji borbe protiv Alzheimerove bolesti i drugih demencija – prijedlog nacrta uz nadopune (50) navodi se da 30 % do 40 % bolesnika koji trebaju palijativnu skrb u Republici Hrvatskoj boluje od neurodegenerativnih bolesti i Alzheimerove bolesti. U tu svrhu zahtijeva se da se palijativni timovi i obitelji educiraju u skladu s potrebama oboljelih od Alzheimerove bolesti. Zagovara se regionalni razvoj palijativne skrbi o osobama s demencijom u Republici Hrvatskoj. Naime, treba istaknuti činjenicu da je demencija smrtonosna bolest. Ta činjenica koju su skloni previdjeti mnogi liječnici, a posebice članovi obitelji oboljelih, zahtijeva da se od trenutka postavljanja dijagnoze počne planirati palijativna skrb o osobi oboljeloj od Alzheimerove bolesti. Takvim pristupom oboljelom od Alzheimerove bolesti podiže se kvaliteta preostaloga života i podrška u procesu prihvaćanja bolesti, kao i olakšavanja bolnih simptoma te žalovanja obitelji koja ujedno takvim pristupom dolazi u središte interesa. Specifičnosti palijativne skrbi o osobama oboljelima od Alzheimerove bolesti su prije svega edukacija članova obitelji o tijeku bolesti, psihoedukacija o psihijatrijskim simptomima koji prate bolest, kao i o potrebi za palijativnom skrbi. Zbog toga je važan institut informiranog pristanka oboljele osobe, npr., kao što je pri-

encompasses house visits from visiting nurses and healthcare and treatment in the home. Here we wish to point out palliative care as a basic human right of people suffering from Alzheimer's disease, and article 17, paragraph 8 of the Law on healthcare defines it as one of the healthcare measures intended for the incurably sick and dying persons (47). Mimica claims that in palliative care of people suffering from Alzheimer's disease, physicians and caregivers encounter symptoms such as feeding problems, immobility, neurological problems, pains, and infections, all of which require hospitalization and terminal care (48). Accordingly, article 26 of the Law on healthcare states that on the primary level healthcare includes palliative care and is administered as part of palliative care. The Law on healthcare provides for the application of mandatory preventive minimum for the elderly and the establishment of institutions for palliative care (47).

Regarding the development of palliative care for people with dementia and the Croatian strategy for the fight against Alzheimer's disease and other forms of dementia, the preliminary draft with supplements (50) states that 30 to 40% of patients requiring palliative care in Croatia suffer from neurodegenerative diseases and Alzheimer's disease. Therefore, it is required that palliative teams and families be educated in accordance with the needs of those suffering from Alzheimer's disease. A regional development of palliative care for people with dementia in Croatia is advocated. It should be stressed that dementia is a deadly disease. This fact, overlooked by many physicians and especially patients' family members, means that a plan for palliative care for a person suffering from Alzheimer's should be made from the moment when the diagnosis is made. This approach to a person suffering from Alzheimer's disease raises the quality of their remaining life and provides support in accepting the disease, as well as alleviating painful symptoms and the bereavement of family members, who are therefore simultaneously put in the centre of interest. The specifics of palliative care for people suffering from Alzheimer's disease are

stanak na bolničko liječenje, u situacijama kada te osobe nisu u stanju same donositi odluke i štititi vlastita prava i interese (3,5).

Prema podatcima Međunarodnog udruženja za Alzheimerovu bolest (ADI – *Alzheimer's Disease International*) i Europskog udruženja za Alzheimerovu bolest (*Alzheimer Europe*) za 2012., procjenjuje se da je u Republici Hrvatskoj od demencije bolovalo 80 864 osoba, što znači 1,89 % našeg stanovništva. Broj osoba koje su se brinule o oboljelima od Alzheimerove bolesti jest 202 164 i uglavnom su to članovi obitelji. Prema tim se podatcima procjenjuje da je to u prosjeku 2,5 osobe po bolesniku. Slijedom toga, ukupna procjena broja osoba na koje je djelovala demencija iznosi 282 948 osoba, odnosno 6,63 % hrvatskog stanovništva. Svjetska zdravstvena organizacija proglasila je 2012. Alzheimerovu bolest svjetskim javnozdravstvenim prioritetom i predložila svim svojim članicama, uključujući i Hrvatsku, da izrade akcijske planove ili nacionalne strategije za borbu protiv Alzheimerove bolesti. Navodi se da će Alzheimerova bolest »u skoroj budućnosti postati sve veća i veća prijetnja čovječanstvu« (50). Zbog toga možemo zaključiti da ukupan broj bolničkih kreveta koje smo prikazali u tablici nije dovoljan u odnosu na broj koji navodi Nacionalni program razvoja palijativne skrbi u Republici Hrvatskoj 2017.-2020. (51). U Nacionalnom programu donesenom u svibnju 2017. godine posebno se ističe dugotrajna ovisnost o tuđoj pomoći zato što povećanje broja oboljelih naglašava potrebu za budućim planiranjem smještajnih kapaciteta za bolesnike sa uznapredovalim demencijama kako u institucijama zdravstvene tako i socijalne zaštite u Republici Hrvatskoj. Područje palijativne skrbi za osobe oboljele od demencije detaljno je razrađeno aktivnošću Akcijskog plana utvrđivanja potreba i osiguranje smještajnih kapaciteta za bolesnike s uznapredovalim demencijama. Zato ovdje otvaramo pitanje jesu li osobama oboljelih od Alzheimerove bolesti i kojima je namijenjena palijativna skrb narušena temeljna ljudska pra-

primarily the education of family members on the course of the disease, psychoeducation on psychological symptoms that come with the disease, as well as the need for palliative care. This is why the patient's informed consent is important, for instance consent for hospital treatment, in situations when the person is unable to make decisions independently or protect their rights and interests (3,5).

According to the data of Alzheimer's Disease International (ADI) and Alzheimer Europe for 2012, it is estimated that 80.864 people suffered from Alzheimer's disease in Croatia, which represents 1.89% of the population. The number of people who provided care for people suffering from Alzheimer's disease is 202.164, and mostly included family members. Consequently, it is estimated that the number of people affected by dementia is 282.948, or 6.63% of the Croatian population. In 2012, the World Health Organization declared Alzheimer's disease a public health priority of the world and suggested that its members, including Croatia, develop action plans or national strategies for the fight against Alzheimer's disease. It is stated that Alzheimer's disease will "become an increasingly great threat to humanity in the near future" (50). Consequently, we can conclude that the total number of hospital beds shown in the table is insufficient in relation to the number stated by the National development program for palliative care in the Republic of Croatia 2017-2020 (51). The National program from May 2017 emphasizes a long-lasting dependence on other people's aid because the increase in the number of patients stresses the need for future planning of accommodation capacities for patients with progressed dementia in institutions for healthcare and social security in Croatia. The field of palliative care for people suffering from dementia was elaborated in detail by the Action plan for identifying needs and ensuring accommodation capacities for patients with progressed dementia. Consequently, we pose the question of whether human rights of people suffering from Alzheimer's disease who need palliative care are being violated if we consider the fact that Croatia

va, ako istaknemo činjenicu da Republika Hrvatska još uvijek nije osigurala dovoljan broj smještajnih kapaciteta za bolesnike s uznapredovalim demencijama.

ZAKLJUČNA RAZMATRANJA

Konvencijsko pravo koje ističe kontekst shvaćanja zaštite ljudskih prava oboljelih od Alzheimerove bolesti pokazuje nam da lista ljudskih prava zahtijeva da se starije osobe i osobe oboljele od Alzheimerove bolesti promatraju kao subjekt, a ne kao objekt prava. Konvencija o pravima osoba s invaliditetom nam u tom pogledu pokazuje koliko je važna autonomija pri donošenju odluka, socijalnog uključenja u društveni život i koliko je važno osobama oboljelim od Alzheimerove bolesti priznati status osobe s invaliditetom, a istovremeno omogućiti odlučivanje uz podršku. Na taj način ostvaruju se njihova ljudska prava koja se temelje na načelima autonomije, samoodređenja i najboljeg interesa odrasle osobe. Uzimajući u obzir kako će kombinacija dužeg života i starenja u narednim desetljećima uvećati broj oboljelih od Alzheimerove bolesti i demencije kao bolesti 21. stoljeća (52) možemo zaključiti da Konvencija o pravima osoba s invaliditetom zahtijeva reviziju hrvatskog zakonodavstva o poslovnoj sposobnosti. Na način da se umjesto zakonskog zastupanja donese zakonodavstvo koje će omogućiti oboljelima podršku u donošenju odluka, a u skladu s člankom 12. U tom kontekstu, skrbnička zaštita oboljelih od Alzheimerove bolesti nam pokazuje da komparativni propisi prepoznaju sve više oblika zaštite osoba oboljelih od Alzheimerove bolesti, što znači i više mogućnosti pri izboru instituta podrške u odlučivanju koja otvara prostor individualizaciji i prilagodbi potrebama svake oboljele osobe.

Informirani pristanak, kao pravo bolesnika na odbijanje ili prihvat medicinskog tretmana jedno je od najznačajnijih pitanja u području ljudskih prava oboljelih od Alzheimerove bole-

has still not ensured sufficient accommodation capacity for patients with progressed forms of dementia.

CONCLUDING REMARKS

The conventional right that stresses the context of understanding the protection of human rights of people suffering from Alzheimer's disease shows that the list of human rights demands that the elderly and people suffering from Alzheimer's disease be considered as the subject and not the object of law. The Convention on the Rights of People with Disabilities shows the importance of autonomy in making decisions, the involvement in social life, and how important it is to grant people suffering from Alzheimer's disease the status of a person with disabilities, while simultaneously giving them the option of support-based decision-making. This approach respects their human rights, which are based on the principles of autonomy, self-determination, and best interests of an adult person. Considering that in the coming decades the combination of a longer life span and ageing is expected to increase the number of patients suffering from Alzheimer's disease and dementia as illnesses of the 21st century (52), we can conclude that the Convention on the Rights of People with Disabilities demands a revision of Croatian legislature regarding legal capacity. Instead of legal representation, a new legislation should provide patients with support-based decision-making according to article 12. In this context, guardianship of people suffering from Alzheimer's disease shows that comparative provisions identify an increasing number of forms of protection for people suffering from Alzheimer's disease, which means more possibilities when choosing support-based decision-making which opens room for individualization and adjustment to the needs of each patient. Informed consent as the patient's right to refuse or accept medical treatment is one of the most significant issues in the field of human rights of people suffering

sti. Uzimajući u obzir da se još uvijek ne zna točan uzrok Alzheimerove bolesti, ali i da postoje određeni čimbenici koji doprinose pojavi bolesti (53) možemo zaključiti da osoba koja primjećuje prve simptome Alzheimerove bolesti, davanjem informiranog pristanka na prihvaćanje određenog tretmana ili istraživanja o samoj bolesti može pomoći u otkrivanju lijeka za Alzheimerovu bolest. Također zaključujemo da se donošenje odluka i sudjelovanje u donošenju odluka institutom informiranog pristanka smatra ljudskim pravom osobe oboljele od Alzheimerove bolesti jer se time ostvaruje njezina autonomija volje i samoodređenja (5). Budući da institut informiranog pristanka osim autonomije štiti i dostojanstvo bolesnika, provođenje medicinskoga tretmana bez pristanka bolesnika, odnosno unatoč protivljenju bolesnika može biti u suprotnosti s nekim odredbama međunarodnih konvencija za zaštitu ljudskih prava. Hrvatska je pak na području zdravstvene zaštite istaknula svoju odlučnost u zaštiti ljudskih prava oboljelih od Alzheimerove bolesti u nacionalnom zakonodavstvu tako da se vodi etičkim načelima kojima se jamči poštivanje ljudskog bića, kao što su očuvanje fizičkog i mentalnog integriteta te zaštita osobnosti. Svako potporno i palijativno liječenje bolesnika u terminalnom stadiju bolesti zahtijeva multidisciplinaran pristup koji će uključivati kvalitetnu pravnu zaštitu prema kojoj svaki bolesnik donosi važne odluke o svom životu u skladu s vlastitim ciljevima i vrijednostima (54). U tom kontekstu zakonodavna reforma u tom području bi trebala ići u pravcu izmjene Zakona o zaštiti prava pacijenata i Pravilnika o obrascu suglasnosti te obrascu izjave o odbijanju pojedinog dijagnostičkog, odnosno terapijskog postupka koji propisuje isti sadržaj obrasca suglasnosti kojom se prihvaća pojedini preporučeni dijagnostički, odnosno terapijski postupak te sadržaj obrasca izjave o odbijanju pojedinog preporučenog dijagnostičkog, odnosno terapijskog postupka u zdravstvenim ustanovama, trgovačkim društvima koja obavljaju zdravstvenu djelatnost te kod

from Alzheimer's disease. Considering that the exact cause of Alzheimer's disease is still unknown and that there are certain factors which contribute to disease onset (53), we can conclude that the person who notices the first symptoms of Alzheimer's disease may help in discovering a cure for Alzheimer's disease by consenting to a certain treatment or research on the disease. Furthermore, we conclude that making decisions and participating in decision-making through informed consent is considered a human right of a person suffering from Alzheimer's disease because this respects their autonomy and self-determination (5). Since informed consent protects not only the patient's autonomy but also their dignity, conducting a medical procedure without the patient's consent or despite their refusal may be in violation of certain provisions of international conventions on the protection of human rights. In the field of healthcare, Croatia has stressed its determination in the protection of human rights of people suffering from Alzheimer's disease within national legislature by following ethical principles that ensure the respect of the human being, such as the maintenance of physical and mental integrity, and the protection of personality. Providing supportive and palliative care for patients in the terminal stage of the disease demands a multidisciplinary approach which includes quality legal protection, according to which each patient makes important decisions about their life in accordance with their own goals and values (54). In the context of legislature, a reform of this field should move towards altering the Law on the protection of the rights of patients and the Regulation on the consent form and the form for declaring refusal of a diagnostic or therapeutic procedure, which defines the content of the consent form which declares the acceptance of a recommended diagnostic or therapeutic procedure, and the content of the form for declaring refusal of a recommended diagnostic or therapeutic procedure in medical institutions, companies that provide medical treatment, and in private medical workers (55) with regard to palliative care as a

privatnih zdravstvenih radnika (55) u pogledu palijativne skrbi kao imperativu temeljnog ljudskog prava oboljelih od Alzheimerove bolesti. Posebno uzimajući u obzir da je načelom samoodređenja napušteno načelo paternalizma i da Hrvatska svojim pravnim i zdravstvenim sustavom mora udovoljiti članku 9. Konvencije o zaštiti ljudskih prava i dostojanstva ljudskog bića u pogledu primjene biologije i medicine: Konvencija o ljudskim pravima i biomedicini (56), koja propisuje da se uzimaju u obzir ranije izražene želje pacijenta, ako u vrijeme zahvata nije u stanju izraziti svoje želje. U tom kontekstu, epidemiologija Alzheimerove bolesti zahtijeva novi pristup i organizaciju modela palijativne skrbi, napuštanje predrasuda i borbu protiv diskriminacije, a sve u cilju zaštite ljudskih prava oboljelih od Alzheimerove bolesti.

basic human right of people suffering from Alzheimer's disease. Considering that the principle of self-determination abandoned the principle of paternalism and that the Croatian legal and health systems must meet the requirements of article 9 of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: the Convention for human rights and biomedicine (56), which states that the patient's previously expressed wishes must be taken into account if they are unable to express their wishes at the time of the procedure. In this context, the epidemiology of Alzheimer's disease demands a new approach and organization of the palliative care model, the abandonment of prejudices, and a fight against discrimination with the aim of protecting human rights of people suffering from Alzheimer's disease.

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Dinamika srama u psihoterapiji osoba ovisnih o alkoholu

/ Dynamics of Shame in Psychotherapy of Alcoholics

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Cilj ovog članka je naglasiti psihodinamsku ulogu srama u alkoholizmu te njegovu važnost u procesu psihoterapijskog liječenja osoba s dijagnosticiranim sindromom ovisnosti o alkoholu. Velika većina osoba ovisnih o alkoholu emocionalno je nezrela, a sram je snažno utjecao na izgradnju njihovih ličnosti. Sram je odredio razvoj njihovih identiteta te je potaknuo nastanak duboko ukorijenjenih emocija nepovjerenja, krivnje, inferiornosti i izolacije. Grupna psihoterapija prva je linija psihoterapijskog liječenja alkoholizma. No, njezin pozitivan ishod ograničen je činjenicom da se, upravo zbog sustava scenarija zasnovanog na sramu te često popratne anksioznosti i emocionalne labilnosti, osobe ovisne o alkoholu nerado pridružuju grupi, a ako joj se i pridruže, najčešće je to kratkoročno. U ovom članku razmatramo stilove grupnih psihoterapija koji bi mogli imati pozitivniji ishod u liječenju osoba ovisnih o alkoholu. Analiza objavljene literature ukazala je na nedostatak integrativnog psihoterapijskog pristupa liječenju.

/ The aim of this article is to highlight the psychodynamic role of shame in alcoholism and its importance in the psychotherapeutic treatment of alcoholics. Alcoholics are often emotionally immature and have a shame-based personality. Shame has strongly influenced the development of their identity and led to deeply ingrained feelings of mistrust, guilt, inferiority, and isolation. Group psychotherapy is the first line of psychotherapeutic treatment of alcoholism, but its successfulness is limited by the fact that alcoholics find joining and staying in a group quite difficult due to a shame-based script system and accompanying anxiety and emotional lability. We discuss the styles of psychotherapeutic groups that may be more effective with alcoholics. A review of published literature indicated the lack of integrative psychotherapeutic treatment.

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KLJUČNE RIJEČI / *KEY WORDS*:
Alkoholizam / *Alcoholism*
Ovisničko ponašanje / *Addictive Behavior*
Sram / Shame
Grupna psihoterapija / *Group Psychotherapy*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2019.497

UVOD

Alkoholizam, kao treći najčešći zdravstveni poremećaj uz kardiovaskularne i maligne bolesti, važan je socio-medicinski problem u mnogim državama (1). Stopa alkoholizma povećava se jednako kao i stopa nasilja i smrti povezanih s alkoholizmom. Godine 2015. u Hrvatskoj su od ukupnog broja hospitaliziranih psihijatrijskih pacijenata 18,2 % bile osobe ovisne o alkoholu, ne računajući pacijente na odjelima interne medicine, traumatološkim odjelima ili u općim bolnicama koji su liječeni od sekundarnih bolesti koje se mogu razviti kao posljedica zlouporabe alkohola (2). Jedno novije istraživanje provedeno u Hrvatskoj otkrilo je da je 6% odraslih muškaraca ovisno o alkoholu te da ih 15 % umjereno konzumira alkohol (3).

DEFINICIJA ALKOHOLIZMA

Alkoholizam je složeni socijalni i medicinski fenomen čije liječenje zahtijeva kombinaciju individualnog-kliničkog i socijalnog-psihijatrijskog-psihoterapijskog pristupa. Brojni pristupi koji se koriste u liječenju alkoholizma, poglavito genetički, biološki, kemijski, patofiziološki te socio-kulturni, razvojni i psihodinamski, odražavaju problematiku kompleksnosti shvaćanja alkoholizma. Samim time čini se da je interdisciplinarni i integrativni pristup jedini mogući pristup koji će omogućiti dublje razumijevanje fenomena alkoholizma budući da mnoga nastojanja da se razvije jedinstvena teorija alkoholizma ili da se identificiraju tipovi „pre-alkoholnih" ličnosti nisu iznjedrila željene rezultate (4).

Predložene su mnoge definicije alkoholizma, neke od njih biološki ili psihološki orijentirane, a jedan manji broj ih se temeljio na sociološkim razmatranjima. Skupina stručnjaka pri Svjetskoj zdravstvenoj organizaciji (WHO) (5) predložila je definiciju koja je snažno utjecala na razvoj alkohologije.

INTRODUCTION

Alcoholism, as the third most frequent disorder after cardiovascular and malignant diseases, represents a significant socio-medical problem in many countries (1). The number of alcoholics is increasing, and so are alcohol-related violence and deaths. In 2015 in Croatia, 18.2% of psychiatric inpatients were alcoholics, not including the patients treated at departments of internal medicine, traumatology, or in general practice for disorders secondary to alcohol abuse (2). A recent study in Croatia showed that 6% of the adult male population is alcoholic and 15% are moderate alcohol consumers (3).

DEFINITION OF ALCOHOLISM

Alcoholism is a complex social and medical phenomenon, and the treatment for alcoholism requires a combined individual-clinical and social-psychiatric-psychotherapeutic approach. The complexity of understanding the problem of alcoholism is reflected in the number of approaches used, from genetic, biological, chemical, and pathophysiological to socio-cultural, developmental, and psychodynamic. Thus, it seems that the only possible approach to understanding the phenomenon of alcoholism is an interdisciplinary and integrative approach, as many attempts to develop a single theory of alcoholism or identify types of "pre-alcoholic" personality have failed (4).

Many definitions of alcoholism have been proposed, some biologically-oriented, some psychologically-oriented, and some socially-oriented. A group of experts from the World Health Organization (5) suggested a definition that has greatly influenced the development of alcohology.

Alcohol-related disorders in the 10th International Classification of Diseases (ICD) are

Prema 10. Međunarodnoj klasifikaciji bolesti (*10th International Classification of Diseases - ICD*) poremećaji povezani s alkoholizmom klasificirani su na sljedeći način: štetna uporaba, sindrom ovisnosti, stanje apstinencije, stanje apstinencije s delirijem, psihotični poremećaji, psihotični poremećaji uključujući alkoholnu halucinozu, alkoholnu ljubomoru, alkoholnu paranoju, amnestički sindrom i rezidualni psihotični poremećaj (6). Dijagnostički i statistički priručnik za duševne poremećaje (*The Diagnostic and Statistical Manual, version V - DSM-V*), zlouporabu i ovisnost o alkoholu spaja u jedan poremećaj koji naziva ovisnošću i srodnim poremećajima uz blagu, umjerenu ili izraženu kliničku sliku (7).

ETIOLOGIJA ALKOHOLIZMA

Alkoholizam je iznimno kompleksan odraz niza karakteristika osobe i značajki socijalnog okruženja u kojemu osoba živi (8). Uzroci alkoholizma mogu se podijeliti u tri glavne skupine: a) biološke teorije koje uključuju nasljednu i genetičku teoriju (9), neurobiološku teoriju (10) i neurobihevioralnu teoriju (11); b) psihološke teorije (12); i c) socio-kulturne teorije: uključujući teoriju sustava (13,14), teoriju socijalnog učenja (15), antropološke teorije (16,17) i gospodarske teorije (18).

ZNAČAJKE LIČNOSTI OSOBA OVISNIH O ALKOHOLU

U prošlosti je bilo mnogo pokušaja klasifikacije osoba ovisnih o alkoholu na temelju njihovih bioloških, sociooloških i psiholoških karakteristika. Najnovija ih literatura opisuje prema karakteristikama njihove ličnosti, navikama povezanima s konzumiranjem alkohola, psihopatologiji i psihičkim značajkama (19-21).

Pregledni članak koji analizira objavljena psihoterapijska istraživanja (22) navodi neurotičnost, slabost ega, ovisnost i promjene ličnosti

as follows: harmful use, syndrome of dependency, condition of abstinence, condition of abstinence with delirium, psychotic disorders including alcoholic hallucination, alcoholic jealousy, alcoholic paranoia, amnestic syndrome, and residual psychotic disturbances (6). The Diagnostic and Statistical Manual, version V (DSM-V), combines alcohol abuse and alcohol dependence into a single disorder called alcohol use disorder with mild, moderate, or severe clinical presentation (7).

ETIOLOGY OF ALCOHOLISM

Alcoholism is a very complex reflection of the mixed characteristics of a person and their social surroundings (8). The causes of alcoholism can be divided into three main groups including a) biological theories that encompass hereditary or genetic theories (9), neurobiological theory (10), and neurobehavioral theory (11); b) psychological theories (12); and c) socio-cultural theories encompassing the theory of systems (13,14), the theory of social learning (15), anthropological theories (16,17), and economic theories (18).

PERSONALITY CHARACTERISTICS OF ALCOHOLICS

In the past, there have been numerous attempts to classify alcoholics into groups according to their biological, sociological, and psychological characteristics. The most recent literature describes alcoholics according to their personality characteristics, drinking habits, psychopathology, and psychological characteristics (19-21).

A review article of published psychotherapy research (22) listed neuroticism, a weak ego, addiction, and personality changes as the main psychodynamic personality characteristics of an alcoholic. There is ample evidence of a weak

kao glavne psihodinamske karakteristike ličnosti osoba ovisnih o alkoholu. Brojni su dokazi koji potvrđuju prisutnost slabog ega kod osoba ovisnih o alkoholu, njihove psihopatološke crte ličnosti, antisocijalno ponašanje, hostilnost kao posljedicu nemogućnosti kontrole poriva, impulzivnost, nisku toleranciju frustracija, teškoće u uspostavljanju odgovarajućih odnosa, probleme sa seksualnim identitetom te negativne predodžbe o sebi (engl. *self-images*) (12, 23-27).

Većina psihoanalitičara smatra da se uzrok alkoholizma krije u brojnim specifičnim neuspjesima u emocionalnom razvoju osobe te u obiteljskom okruženju. Što se trauma ranije dogodila u razvojnom procesu, ili što je ranije u životu zaustavljen razvoj, što je ranije došlo do ekspresije nezrelijeg ponašanja, slabijeg ego-identiteta i ličnosti, nezrelijih mehanizama obrane, to je problem zlouporabe alkohola ozbiljniji i slabija je prognoza ishoda liječenja (4,26,28-33).

Prema Hartmanu (34) i Austrianu (35), sposobnost ega da neutralizira agresiju odraz je snage i zrelosti ega, što je važno za uspostavljanje stabilnih objektnih odnosa. Eriksonova teorija (36,37) opisuje slijed faza razvoja ega tijekom života. Ta psihosocijalna teorija razvoja i Hartmanova adaptacija (34) pružaju nam konceptualno objašnjenje psihičkog razvoja osobe tijekom života, u svakoj fazi njezina psihosocijalnog razvoja. Osobu ovisnu o alkoholu Erickson opisuje kao osobu s negativnim ego-identitetom koji umanjuje i dokida sposobnosti te osobe. Razvojni je model adekvatan budući da je razvoj identiteta odrasle osobe interaktivan proces između djeteta, obitelji i šireg društva (36). Sram kod odrasle osobe snažno je povezan s našim odnosom prema objektnom svijetu (38,39). Sram je jedna od najsnažnijih ljudskih emocija, koja nastaje kao rezultat negativne procjene cijelog selfa ili nekog aspekta selfa. Sram se javlja kao posljedica neprihvaćanja ili odbacivanja određenog dijela samoga sebe, odnosno dijela selfa kojega osoba ne može prihvatiti i integrirati u cjelovitu sliku sebe i osoba ne

ego in alcoholics, their psychopathological traits, antisocial behaviour, hostility as a sign of poor control of drives, impulsivity, low tolerance to frustrations, difficulties in establishing adequate relationships, problems with sexual identity, and a negative self-image (12,23-27).

Most psychoanalysts believe that the cause of alcoholism lies in numerous specific failures in the individual emotional development and family circumstances. The earlier in the developmental process the trauma happened, or the earlier the arrested development, the more immature the behaviour, the weaker the ego identity and personality, the more immature the defence mechanisms, the more serious is the drinking problem and the poorer is the prognosis (4,26,28-33).

According to Hartman (34) and Austrian (35), the capacity of the ego to neutralize aggression is the measure of the ego strength and maturity and is important in establishing stable object relationships.

Erikson's theory (36,37) describes the sequence of phases in ego development over a lifetime. This psychosocial theory of development and Hartman's adaptation (34) offer a conceptual explanation of the psychological development of an individual during life, in each phase of a person's psychosocial development. Erickson describes an alcoholic as an individual with a negative ego-identity that lessens and destroys their abilities.

A developmental model is appropriate since adult identity development is an interactive process between a child, its family, and the wider society (36). In the adult, shame has a great deal to do with our links to the object world (38,39). Shame is one of the strongest human emotions, resulting from the negative evaluation of the whole *self* or some aspect of the *self*. Shame occurs as a result of non-acceptance or rejection of a particular part of *the self*, or a part of the *self* which a person cannot

želi da taj dio nje uopće postoji. Javlja se u situacijama kada osoba uvidi i prepozna da je počinila neku povredu ili prekršila standard koji smatra važnim (40), što dovodi do intenzivnog preplavljujućeg osjećaja potpune nemoći, bezvrijednosti, beznačajnosti, želje da se osoba povuče u sebe, da nestane, „propadne u zemlju". Spada u moralne emocije i važan je za razvoj društva, kulturnih i društvenih normi te sprječava njihovo kršenje. Ovaj sram se naziva adaptacijskim sramom i možemo reći da je dobar, jer ima zaštitnu ulogu osiguravajući ponašanje u skladu s društvenim i kulturnim normama te je socijalno poželjan i konstruktivan, a može biti različitog intenziteta, za razliku od patološkog srama, koji se naziva prikriveni sram (engl. *hidden shame)*, koji se nalazi u podlozi raznih kliničkih patoloških fenomena kao što su destruktivna i agresivna ponašanja, suicidalnost, ovisnosti, alkoholizam, poremećaji uzimanja hrane, patološki narcizam, itd. (41,42).

Sve dosad, psihoterapijska istraživanja usmjerena na osobe ovisne o alkoholu uglavnom nisu bila usmjerena na pitanje srama, posebice ne na njegove različite manifestacije u ponašanju. Budući da je sram najčešći popratni osjećaj koji se javlja uz neuspjeh te u sebi nosi implikaciju prijetnje od odbačenosti, on ima posebice važnu ulogu u liječenju osoba ovisnih o alkoholu.

UTJECAJ SRAMA NA RAZVOJ IDENTITETA

Identifikacija je temeljni ljudski proces koji započinje unutar obitelji. Dijete se počinje formirati ugledavši se na jednog ili oba roditelja. Mi se identificiramo s našim roditeljima, starijom braćom i sestrama te bakama i djedovima. U mnogim obiteljima, osjećaji srama, straha i poniženosti prevalentni su elementi roditeljske klime koji snažno utječu na razvoj identiteta djeteta predškolskog uzrasta. Identifikacija zasnovana na ljubavi, strahu ili sramu razvija se na temelju roditeljskog modela skrbi za dijete (43).

accept and integrate into the whole *self-image*, and the person does not want that part of it to exist at all. It occurs in situations when a person realizes and recognizes that he/she committed a breach or violated the standard that is considered important (40), which causes an intense, overwhelming feeling of complete helplessness, worthlessness, and insignificance, a desires to withdraw into oneself, to disappear. It belongs to moral emotions and is important for the development of the society and the cultural and social norms, and prevents their violation. This shame is called adaptive shame and we can say that it is good because it has a protective role since it provides behaviour in accordance with social and cultural norms and is socially desirable and constructive, but may be of different intensity, in the contrast to pathological shame, also called hidden shame, which underlies various pathological phenomena such as destructive or aggressive behaviour, suicidality, addiction, alcoholism, eating disorders, pathological narcissism, etc. (41,42).

So far, psychotherapy research in alcoholics has mostly bypassed shame, especially its different manifestations in behavior. As shame accompanies failure and carries an implicit threat of abandonment, it is especially important in the therapy of alcoholics.

EFFECT OF SHAME ON THE DEVELOPMENT OF IDENTITY

Identification is a basic human process and begins within the family. A child begins modeling himself after one or both parents. We identify with our parents and older siblings and grandparents. In many families, shame, fear, and humiliation shape the parental climate and powerfully influence the development of the identity of a pre-school child. Love-based, fear-based, or shame-based identification develops according to the pattern of parental care (43).

Potreba za identifikacijom nešto je što nikad ne prerastemo, iako ona tijekom života može postati snažnije diferencirana. Taj primarni proces identifikacije s roditeljima postupno se prenosi i na neposredno okruženje, odnosno svijet nama važnih osoba. Proces identifikacije s osobama istog spola također se nastavlja, ali broj osoba s kojima se poistovjećujemo povećava se i uključuje učitelje, kulturu, mentore, profesionalnu identifikaciju itd.

Internalizacija je iznimno važna karika koja identifikaciju pretvara u identitet. Postoje tri glavna aspekta internalizacije. Prvi je internalizacija određenih emocija, vjerovanja ili stavova. Drugi je internalizacija načina kako se naši bližnji ophode prema nama – što je temelj našeg odnosa prema sebi. Treći je internalizacija identifikacije s negativnim porukama kao što su one zasnovane na strahu i/ili sramu nasuprot onih pozitivnih zasnovanih na ljubavi i poštovanju (44).

Mnogi se autori slažu da postoje tri motivacijska sustava – emocije, nagoni i potrebe – koji su snažno povezani s razvojnim procesom i sramom.

Postoje različita teorijska objašnjenja motivacijskih sustava. Silvan Tomkins vjeruje da je emocionalni sustav jedan važan motivacijski sustav (43,45). On opisuje devet temeljnih urođenih afekata koji su podložni ograničavajućem utjecaju srama (koje naziva *afektima zasnovanima na sramu* - engl. *affect-shame binds*). Za razvoj takvih afekata zasnovanih na sramu presudno je važno kako su roditelji i značajne druge osobe (druge osobe koje su važne u životu) reagirale na ekspresiju pojedinog afekta. Ako je poslije svake ekspresije nekog afekta dijete posramljeno, onda svaku njegovu sljedeću ekspresiju tog afekta kontrolira sram.

Drugi iznimno važan motivacijski sustav je sustav nagona. U psihoanalitičkoj teoriji, nagon je konceptualiziran pomoću seksualnosti (46,47). Sustav nagona povezuje se sa sramom, posebice seksualnost kao jedan od najvažnijih psiho-

We never outgrow the need to identify, although this need may become more differentiated during life. The first process of identification with parental figures gradually expands to the immediate world – the significant others. Identification with the same sex also continues, but the number of identification figures increases – teachers, culture, mentors, professional identification, etc.

Internalization is a very important link by which identification leads to identity. There are three main aspects of internalization. The first one is internalization of specific affects, beliefs, or attitudes. The second one is the internalization of the ways in which we are treated by significant others – this is the basis of our relationship with ourselves. The third aspect of internalization is identification images that can be negative, i.e. terror- and/or shame-based, or positive, i.e. love- and respect-based (44).

Many authors agree that there are three motivational systems – affects, drives, and needs – which are strongly connected with the developmental process and associated with shame.

There are different theoretical explanations of motivational systems. Silvan Tomkins thinks that one important motivational system is the affect system (43,45). He has described nine basic affects that are innate and can be bound and subjected to the limiting influence of shame (so-called affect-shame binds). For the development of such affect-shame binds, the way the parents and significant others respond to the expression of a particular affect is crucial. If each affect is followed by shaming, then the expression of the affect is controlled by shame.

Another very important motivational system is the drive system. In psychoanalytic theory, the drive has been conceptualized by sexuality (46,47). The drive system is associated with shame, especially sexuality as one of the most significant psychologically based drives, which

loški temeljenih nagona koji je duboko povezan s našom samosvjesnošću i seksualnim životom tijekom adolescencije i odrasloga života, a dio je i našeg unutarnjeg osjećaja adekvatnosti kao muškarca ili žene. On ima iznimno važnu ulogu u ljudskim odnosima.

Treći iznimno važan konceptualni motivacijski sustav, koji je središnji kada govorimo o ljudskoj motivaciji, identitetu i razvoju čovjeka, sustav je potreba (48-51). On se također može povezati sa sramom i sram ga može kontrolirati. Organizacija sustava potreba izrazito je kompleksna. Postoje brojne potrebe (52), kao što su potreba za odnosom, potreba za dodirom, potreba za prihvaćanjem, potreba za identifikacijom, potreba za diferencijacijom, potreba za hranom i potreba za afirmacijom.

Prema Kaufmanu, prethodno opisana tri motivacijska sustava arene su unutar kojih se sram može generirati i u konačnici može početi kontrolirati sve što se izravno poveže s njime (52). Razvoj afekata podložnih ograničavajućem utjecaju srama, nagona podložnih ograničavajućem utjecaju srama te potreba podložnih ograničavajućem utjecaju srama (engl. *affect-shame, drive-shame, and need-shame binds*) tri su važna čimbenika internalizacije. Tri glavna procesa internalizacije – način na koji doživljavamo sebe, načini kako se prema nama ophode značajne druge osobe (druge osobe koje su nam važne u životu), kakav unutarnji odnos gajimo sami prema sebi te naše poistovjećivanje s negativnim predodžbama vezanim za self – temelj su razvoja identiteta.

Dokaze povezanosti srama i identiteta pronalazimo u jeziku i predodžbama (53,54). Iskustva srama povezana sa *selfom* pomoću jezika možemo tumačiti kao presudno važna iskustva, npr. nešto ne valja sa mnom kao s osobom. Potraga za identitetom je glavni razvojni konflikt i podrazumijeva dva procesa u opoziciji - diferencijaciju i identifikaciju.

Koncept *selfa,* kao i mnogi drugi psihoanalitički termini su različito definirani, što i reflektira

is very deeply connected with our self-consciousness and sexual life in adolescence and adulthood, and is a part of our inner sense of adequacy as men and women. It plays a very important role in human relationships.

The third very important conceptual motivational system, which is central to human motivation, identity, and human growth, is the need system (48-51). It can become bound to and controlled by shame. The need system has a very complex organization. There are many specific needs (52), such as the need for relationships, the need for touching, the need for holding, the need for identification, the need for differentiation, the need to nurture, and the need for affirmation.

According to Kaufman, the three motivational systems described above are the arenas in which shame can be generated and eventually control whatever has become directly associated with shame (52). The development of affect-shame, drive-shame, and need-shame binds are three important contributors to internalization. The three main processes of internalization – our sense of who we are, the actual ways in which we are treated by significant others (an inner relationship with ourselves), and identifications with internal images – form the basis for identity development.

The link between shame and identity is evidenced in language and imagery (53,54). Through language, we can interpret shameful experiences about the self as essentially meaningful, i.e. something is wrong with me as a person. The search for identity is the main developmental struggle and includes seemingly opposing processes, such as differentiation and identification.

The concept of the *self,* like many other psychoanalytic terms, is differently defined, reflecting generally the diversity of current psychoanalytic theories (55). *Self psychology* emphasises a person's experience of being in

općenito različitost aktualnih psihoanalitičkih teorija (55). *Self psihologija* naglašava iskustvo osobe da bude u odnosu s drugim osobama kao i tijekom procesa terapije (56,57). Prema Kohutu razvoj kohezivnog *selfa* ovisi o emocionalnoj dostupnosti i odgovoru značajnih odraslih osoba kod djeteta i njihovom empatijskom odgovoru da osoba postigne zdravi razvoj *selfa* procesom zrcaljenja, idealizacijom, povezivanjem i optimalnom frustracijom. On smatra da je razvoj psihopatologije povezan s neuspjehom tih razvojnih procesa. Razvoj zdravog *selfa* se događa u tri osovine: grandioznost, idealizacija i povezivanje. Grandioznost omogućava stabilan osjećaj samopoštovanja, razvoj ambicije i svrhe i potreban je stabilan *self-objekt* koji će zrcaliti potvrdu kvaliteta i postignuća djeteta. Idealizacija omogućava postavljanje i održavanje stabilnih ciljeva i ideala povezivanjem sa *self-objektom* kako bi se razvili kapaciteti da se bude autentičan u izražavanju osjećaja u intimnim odnosima s drugim osobama. Kohezivni *self* se razvija ako su majka i značajne druge osobe dovoljno dobri, jer tada *self-objekti* postaju sve manje značajni i kohezivni *self* preuzima dominantnu ulogu. Osoba može razviti zdrave odnose s drugim ljudima pri čemu se ne traži od drugih osoba ili supstituta da popunjavaju *self-objektne funkcije*, jer je osoba razvila vlastitu kohezivnu *self* strukturu procesom transmutirajuće internalizacije (56). Prema psihodinamskim teorijama korijeni srama sežu u najranije djetinjstvo, odnosno dojenačku dob. U dojenačkoj dobi dijete ne razlikuje sebe i majku, njegov doživljaj je simbiotski i ono je u svojim očima stopljeno s majkom. Zbog problema u ranom dijadnom odnosu s prvim značajnim objektom, najčešće majkom, dijete ne nailazi na adekvatni empatijski odgovor, počinje se osjećati loše i bezvrijedno, jer nije uspjelo zadobiti očekivanu ljubav, pažnju i razumijevanje. Ako se takva iskustva ponavljaju, kod djeteta se generira nesiguran, nekohezivan i nedostatan osjećaj *selfa,* koji je osjetljiv na pojačani osjećaj srama (58,59). Ovakva iskustva Kohut naziva neuspjehom zrcaljenja *self-objek-*

a relationship with others as well as during the process of therapy (56,57). According to Kohut, development of *a cohesive self* depends on the emotional availability and response of significant adults in a child's life and their emphatic response for a person to achieve healthy *self-development* through a process of mirroring, idealization, connection, and optimal frustration. Kohut believes that the development of psychopathology is related to the failure of these developmental processes. The development of a healthy *self* occurs on three axes: grandiosity, idealization, and connection. Grandiosity allows a stable sense of *self-esteem*, the development of ambition and purpose, and a stable *self-object* is required to reflect the confirmation of the quality and achievement of the child. Idealization enables the installation and maintenance of stable goals and ideals through a connection with the *self-object* in other to develop the capacity to be authentic in expressing feelings in intimate relationships with other people. A *cohesive self* develops if the mother and significant others are good enough, because then *self-objects* become less significant and the *cohesive self* takes over the dominant role. A person can develop healthy relationships with other people without requiring other persons or substitutes to fill in *self-object functions* because the person has developed his or her own cohesive *self-structure* through the process of transmuting internalization (56). According to psychodynamic theories, the roots of shame go back to early childhood or infancy. The infant child does not distinguish between himself/herself and his/her mother, his/her experience is symbiotic and in its eyes blended with its mother. Due to problems in the early dyadic relationship with the first significant object, usually the mother, the child does not find an adequate emphatic response and begins to feel bad and worthless because it failed to receive the love, attention, and understanding it expected. If such experiences are repeated

ta. Između 12. i 18. mjeseca života dijete počinje razlikovati sebe i majku i tijekom druge godine života se pojačava iskustvo srama, osobito ako je doživljaj samoga sebe prožet negativnim iskustvima tijekom natjecanja i uspoređivanja s drugima. Dijete počinje osjećati izolaciju, odvojenost i umjesto da se razvija osjećaj autonomije i neovisnosti razvija se inferiornost tijekom uspoređivanja i natjecanja s drugima. Da bi se izbjegla anksioznost zbog osjećaja odvojenosti i izolacije traži se podrška od idealiziranog roditelja, svemoćnog roditelja, najčešće oca. Tijekom četvrte godine života dolazi do postupnog oblikovanja idealnog *selfa*, koji nastaje od internaliziranih vrijednosti i očekivanja postavljenih primarno od značajnih odgajatelja (roditelja), ali i šireg socijalnog okruženja. U ovom razvojnom razdoblju dijete uspoređuje sliku svoga idealnog *selfa* s aktualnim *selfom*. Ego ideal je mjerilo prema kojem se ego procjenjuje i ako se ne uspijeva zadovoljiti postavljeni ideal, javlja se smanjeno samopouzdanje, osjećaj neuspjeha i sram. Osjećaj srama se učvršćuje i razvija se identitet zasnovan na sramu u pozadini kojega je patološki sram, a najveća prijetnja je strah od odbacivanja i napuštanja (40).

U svojoj pionirskoj studiji identiteta Erickson je sram smjestio u drugu od osam faza kriza indetiteta koje obilježavaju naše živote (60). Prema njegovoj teoriji, druga faza (koja se odnosi na razdoblje između prve i treće godine života) razdoblje je treninga toalete čiji je ishod autonomija nasuprot srama i sumnje. Djeca se u toj fazi pokušavaju razviti u autonomna bića, a ako strah i sumnja dominiraju autonomijom, moguće je da se javi kompulzivna sumnja, ali i krutost opsesivne ličnosti. Povrh toga postoje i druge psihopatologije povezane s krutim pristupom u učenju kontroliranja sfinktera u analnoj fazi razvoja djeteta te s intenzivnim i prekomjernim posramljivanjem (alkoholizam, delinkventno ponašanje, paranoidne ličnosti, impulzivni poremećaji itd.). Svaka sljedeća kriza, barem djelomično, podrazumijeva preoblikovanje srama (61).

in the child, an insecure, non-cohesive, and insufficient sense of *self* is generated, which is then sensitive to an increased sense of shame (58,59). Kohut has called such experiences a failure of *self-object* mirroring. At the age of between 12 and 18 months, a child begins to distinguish between itself and its mother, and in the second year of its life increases the experience of shame, especially if the experience it is overwhelmed with is a negative experience when it competes and compares itself with others. To avoid anxiety due to feelings of separation and isolation, the support of the idealized or omnipotent parent, who is most often the father, is required. During the fourth year of life there is a gradual formation of the *ideal self*, which results from internalized values and expectations created primarily by significant caretakers (parents) but also by the wider social environment. In this developmental period the child compares the image of his/her *ideal self* with his/her *current self*. The ego ideal is a benchmark against which the ego is assessed, and if one fails to satisfy the ideal, diminished *self-confidence* and a sense of failure and shame appear. The sense of shame solidifies and an identity based on shame develops in the background, which represents pathological shame with the greatest threat being the fear of rejection and abandonment (40).

In his pioneering study of identity, Erickson placed shame at the second of eight stages of identity crisis that span our life cycle (60). According to his theory, the second stage (approximately between the first and the third year of life) is the period of toilet training, and the outcome of this stage is autonomy versus shame and doubt. At this stage, children attempt to develop into autonomous beings and if shame and doubt dominate over autonomy, compulsive doubting as well as inflexibility of the obsessive personality may occur. In addition, there are other psychopathologies related

Sram je najvažnija emocija za razvoj nepovjerenja, krivnje, osjećaja inferiornosti i izoliranosti itd. Tijekom razvoja i druge se emocije mogu povezati sa sramom no, unatoč tomu, sram je središnji afekt (emocija) koji oblikuje osjećaj identiteta.

Znanstvenici i teoretičari poslije Ericksona produbili su teoriju srama s psihoanalitičke točke gledišta. Neki su od njih proučavali međusobne odnose između krivnje, srama, identifikacije i superega (62), a drugi su glavni naglasak svojih istraživanja stavili na sram. Broucek razmatra sram u odnosu na narcističke poremećaje (63), a Nathanson (64) sintetizira istraživanja o percepciji djeteta, psihoanalitičku teoriju i Tomkinsovu teoriju afekata (65-67).

To potvrđuje da je sram doista zauzeo središnje mjesto, ali nijedna teorija – psihoanalitička teorija, teorija objektnih odnosa, interpersonalna i kognitivno-bihevioralna teorija – ne uspijeva u potpunosti objasniti ulogu srama u normalnom ili psihopatološkom razvoju i identitetu. U današnje vrijeme najvažnija i najutjecajnija teorija koja se bavi pitanjem srama je teorija afekata Silvana Tomkinsa. Tomkinsova teorija scenarija (engl. *script theory*) scenu definira kao „osnovni element u životu koji živimo" (53). Scene srama organiziraju se oko *selfa* u klastere: afekata, nagona i interpersonalnih potreba. Razvoj višestrukih afekata podložnih ograničavajućem utjecaju srama (engl. *multiple affect-shame binds*) duboko utječe na razvoj *selfa*.

Glavne scene srama prvo prolaze fazu magnifikacije putem predodžbi i nadalje transformaciju putem jezika. Prema Tomkinsovoj teoriji scenarija (engl. *script theory*) ti su procesi pokretači razvoja različitih tipova patoloških poremećaja *selfa*, a jednako tako igraju i središnju ulogu u psihoterapiji. Prisutnost srama povećava vjerojatnost međusobne povezanosti scena, a četiri glavne kategorije scena srama – kategorija afekata podložnih ograničavajućem utjecaju srama, kategorija nagona podložnih ograničavajućem utjecaju srama, kategorija interpersonalnih potreba podložnih ograni-

to overly rigorous toilet training and excessive shaming (alcoholism, delinquent behaviour, paranoid personalities, impulsive disorders, etc.). Each subsequent crisis involves, at least in part, a reworking of shame (61).

Shame is the most critical affect in the development of mistrust, guilt, inferiority, isolation, etc. Other affects can merge with shame during development, but the central affect for the sense of identity is indeed shame.

Researchers and theorists after Erickson deepened the theory of shame from the psychoanalytic perspective. Some of them have explored the connections between guilt, shame, identification, and the superego (62), and others continue the inquiry into shame. Broucek examines shame in relation to narcissistic disorders (63), and Nathanson (64) synthesizes the research from infant observation, psychoanalytic theory, and Tomkins' affect theory (65-67).

Shame has therefore been moved to the central place, but none of the theories – psychoanalytical, object-relation, interpersonal, or cognitive-behavioural – can fully explain the role of shame in normal or psychopathological development and identity. Today, the most important and most powerful theory in the examination of shame is the affect theory by Silvan Tomkins. Tomkins' script theory defines the scene "as the basic element in life as it is lived" (53). Scenes of shame become organized around clusters of the self: affect, drive, and interpersonal need. The development of specific multiple affect-shame binds significantly shape the evolving self.

The governing scenes of shame first undergo magnification by imagery and further transformation by language. According to Tomkins' theory, these processes are central to the development of various pathological distortions of the self and equally to psychotherapy. The presence of shame increases the

čavajućem utjecaju srama i kategorija osjećaja vlastite svrhe podložnog ograničavajućem utjecaju srama (engl. *affect-shame, drive-shame, interpersonal need-shame, and purpose-shame scenes*) – nastavljaju upravljati razvojem ličnosti. Magnifikacija scena kontinuirani je proces, a taj niz međusobno povezanih scena ili zbivanja povezanih sa sramom grade jezgru srama unutar *selfa*. Prema Kaufmanovoj konceptualizaciji srama, te se jezgre kristaliziraju u profil srama (61). Upotreba profila srama iznimno je korisna u kliničkoj i psihoterapijskoj praksi. Osjećaj srama ima specifične obrambene scenarije, ukorijenjene u sramu i organizirane oko srama. Postoji mnogo različitih obrambenih scenarija srama organiziranih oko srama, kao što su gnjev, prezir, perfekcionizam, borba za moć, prebacivanje krivnje, povlačenje u sebe, humor, poricanje itd. Oni obuhvaćaju jasna pravila povezana s djelovanjem i kognicijom, a njihova je uloga da predvide i kontroliraju scene srama.

Ego je središte ličnosti koje osjeća i razmišlja, predviđa i prosuđuje, ima volju i usmjerava. U terminima ego psihologije (69) *self* je definiran kao niz reprezentacija *selfa* u egu. Identitet je svjesno iskustvo tog *selfa*, pomoću aktivnog, živog odnosa koji *self* njeguje sa *selfom* (61). Iako su vanjski odnosi vidljiviji, unutarnji odnosi s internaliziranim roditeljima i značajnim drugim osobama u životu nisu ništa manje vitalni jer su dio sigurnosti i integriteta osobe.

Obrambeni scenariji predviđaju i kontroliraju buduće, vanjske scene srama. Oni podrazumijevaju nastojanje da se izbjegne ili pobjegne od osjećaja srama, no scenariji identiteta podložnog ograničavajućem utjecaju srama neizbježno opetovano kreiraju sram.

Kad govorimo o krajnjem ishodu razvoja, ako je glavni identitet izgrađen na osjećaju srama, onda govorimo o identitetu zasnovanom na sramu (engl. *shame based identity*) te o sindromu zasnovanom na sramu (engl. *shame based syndrome*). Internalizacija i daljnja magnifikacija srama kreira identitet koji permanentno održava i širi sram.

likelihood of interconnection between the scenes and the four general classes of shame scenes – affect shame, drive shame, interpersonal need shame, and purpose shame – continue to govern personality development. The magnification of scenes is an ongoing process, and these coalescing scenes of shame create the shame nuclei within the self. According to Kaufman's conceptualization of shame, these nuclei crystallize in a shame profile (61). Using the shame profile is very useful in clinical and psychotherapeutic practice. The affect of shame has specific defending scripts which are rooted in and become organized around shame. There are many different defending scripts organized around shame, such as rage, contempt, striving for perfection, striving for power, transfer of blame, internal withdrawal, humour, denial, etc. They comprise distinctive rules for action and cognition, and their function is to predict and control scenes of shame.

The ego is the centre of personality that feels and thinks, anticipates, and judges, has will and directs. In terms of ego psychology (69), the *self* is defined as a series of representations of the *self* in the ego. Identity is the conscious experience of that self through an active, lively relationship that nurtures the *self* with the *self* (61). External relationships with others are more visible, but internal relationships with internalized parents and significant others are not less vital because they are a part of a person´s security and integrity.

Defending scripts predict and control future, externally based scenes of shame. It means avoiding and escaping shame, but identity scripts based on shame inevitably reproduce shame.

In regard to the final outcome in the development, when the main identity is based on shame, we speak about shame-based identity and shame-based syndrome. Internalization and further magnification of shame create

Konačno, sram i krivnja, a isto tako i rezultati istraživanja trebali bi se interpretirati u okviru teorijske konceptualizacije tih dviju emocija (70).

ALKOHOLIZAM – SINDROM ZASNOVAN NA SRAMU

Alkoholizam je sindrom zasnovan na sramu baš kao i drugi sindromi ovisnosti. Stvarni ili imaginarni objekt potencijalno ima moć da u nama probudi kompulzivnu žudnju za njime. Treba razlikovati objekt bilo koje ovisnosti i proces kojim dolazi do razvoja ovisnosti i kojim se ovisnosti održava (52). Nadalje, odnos također može biti još jedan oblik ovisnosti. Ovisnost o kockanju ili poslu odražava ovisničke procese. U suštini, ovisnički je proces kompulzivan, repetitivan i snažno se opire promjeni. Prema Kohutu *self-objekt* je vanjski objekt, osoba ili aktivnost koja može postati dio *selfa* (71,72). U psihopatološkim poremećajima, kada osoba ima razvojni deficit ili oštećeni *self,* koristi *self-objekt* da se umiri, utješi ili uskladi. Alkohol se može smatrati takvim *self-objektom* (73), što ga osoba kompulzivno uzima da se umanji anksioznost i da se „zacijele“ *self* oštećenja i ujedno umanji osjećaj srama i izolacije, jer osoba ovisna o alkoholu nema internaliziranu funkciju samoumirivanja i nije u stanju samostalno umiriti psihičku tenziju tako da se funkcija postiže izvana konzumiranjem alkohola. Nakon epizoda pijenja javlja se ponovno osjećaj srama (uz krivnju) i da bi ga se eliminiralo osoba ovisna o alkoholu kompulzivno repetira spiralu srama ponovno posežući za alkoholom koji je *self-objekt* bez kojega osoba ne može funkcionirati. Krystal (1974) (74) smatra da je ovisnost pokušaj samopomoći koji je neuspješan jer se *fragmentirani self* pokušava popraviti na način da ovisna osoba traži stalnu vanjsku gratifikaciju, jer je iznutra prazna. Vanjska gratifikcija, koja se postiže uzimanjem alkohola, stvara lažni osjećaj neovisnosti i autonomije. *Self-medi-*

an identity that permanently maintains and spreads shame.

Finally, shame and guilt, as well as research findings, should be interpreted within the theoretical conceptualization of these two emotions (70).

ALCOHOLISM – A SHAME-BASED SYNDROME

Alcoholism, as well as other addictive disorders, is a shame-based syndrome. A real or imagined object potentially has the power to be compulsively desired. The object of any addiction must be distinguished from the process by which an addiction develops and continues to maintain itself (52). Furthermore, a relationship can also represent a form of addiction. Addiction to gambling or work reflects addictive process. Essentially, the addictive process is compulsive, repetitive, and highly resistant to change.

According to Kohut, the *self-object* is an external object, person, or activity that can become a part of the *self* (71,72). In psychopathological disorders, when a person has a developmental deficit or impaired *self*, he or she use the *self-object* to calm down, comport, or reconcile himself/herself. Alcohol can be considered a *self-object* (73) which a person compulsively takes to reduce anxiety and “heal” *self-damage*, and at the same time reduce feelings of shame and isolation because the person addicted to alcohol does not internalize the function of *self-soothing* and is unable to calm psychic tension on his/her own, so that function is achieved externally by consuming alcohol. After episodes of drinking, a feeling of shame (with guilt) reappears, and in order to eliminate it, the person addicted to alcohol compulsively repeats the spiral of shame, once again reaching for alcohol, which is a *self-object* without which a person cannot function.

kacijska hipoteza navodi da je ovisnost deficit *selfa* i afekta uzrokovan strukturalnim oštećenjima i alkohol je sredstvo *self* regulacije (75) budući da *self* ima poriv da se samonadopuni (76). Konačno važno je razumjeti da su alkoholičarevi odgajatelji bili neempatični, nekonzisistentni i toksični prema njemu u ranom djetinjstvu, što je prouzročilo oštećenje *selfa* (77).

Da bismo razumjeli ovisnički proces, iznimno je važno osvijestiti dubok, često obeshrabrujući osjećaj bespomoćnosti u odnosu na samu ovisnost, što posljedično potiče razvoj sekundarnog srama zbog same ovisnosti. Osoba se osjeća poniženo u svakoj situaciji kad osjeti da ju ovisnost kontrolira ili kad ne uspije nadjačati ovisnički poriv ili kad nema moć nad njime (52,61). Osoba koja se osjeća kao da ju je vlastita ovisnost porazila počinje mrziti samu sebe ili osjeća prezir prema vlastitoj nemoći, nedostatku odlučnosti i unutarnje snage. Samim time ovisnički proces opetovano odigrava scenarij koji budi osjećaj intenzivnog srama i samorazočaranja, a sram se povezuje s drugim negativnim emocijama.

Ovisnosti su ukorijenjene u internaliziranim scenarijima srama (engl. *shame based scripts*). Osoba opetovano žudi za objektom, a ta žudnja opetovano posljedično budi osjećaj razočaranja (52,61,68). Alkohol se doživljava poput sredstva koje ubija osjećaj srama, dok je superego alkoholičara topiv u alkoholu, odnosno alkohol otapa krivnju (64).

Ovisnost je djelomično nadomjestak za nezadovoljene interpersonalne potrebe, koje su posljedica oštećenih ili poremećenih interpersonalnih potreba koje kontrolira sram. Alkohol („boca“) nadomjestak je za međuljudski odnos. Isto tako, ovisnost o sedativu koji stišava intenzivne negativne emocije je taj nadomjestak. Zbog poremećenih međuljudskih odnosa tijekom razvoja, vitalne potrebe povezuju se sa sramom i sram ih kontrolira, što posljedično dovodi do osjećaja preplavljenosti negativnim emocijama. U tom procesu primarna funkcija

Krystal (1974) (74) suggests that addiction is an attempt of *self-help* that is unsuccessful because the *fragmented self* is trying to repair itself in such a way that a dependent person requires permanent external gratification because they are empty inside. External gratification which is achieved by drinking alcohol creates a false sense of independence and autonomy. The *self-medication* hypothesis states that dependence is a deficit of *self* and affect caused by structural damage, and alcohol is a means of *self-regulation* (75) because the *self* has a drive to complete itself (76). Finally, it is important to understand that an alcoholics' caretakers were non-empathic, inconsistent, and toxic to them in early childhood, causing their *self-damage* (77).

Central to the understanding of the addictive process is a profound, often discouraging sense of powerlessness over the addiction itself, engendering secondary shame about the addiction itself. A person feels humiliated whenever they feel controlled by addiction or fail to break it or regain power over it (52,61). People defeated by their addiction start to hate themselves or are disgusted with their own helplessness, lack of resolve, and inner strength. Therefore, the addictive process repeatedly re-enacts a scene that creates intense shame and self-disappointment, and the shame is associated with other negative affects.

Addictions are rooted in internalized scenes of shame. The objects are repeatedly longed for, which repeatedly leads to disappointment (52,61,68). Alcohol seems to act as a shame-killer, and in alcoholics the superego is soluble in alcohol, i.e. alcohol takes away the guilt (64).

Addiction partly functions as a replacement for shame-bound interpersonal needs resulting from failed or disturbed relationships that are controlled by shame. Alcohol ("the bottle") is a replacement for human relationship. Likewise, dependence on a sedative for intense

ovisnosti je da omogući bijeg od intenzivnih ili nepodnošljivih negativnih emocija. Osjećaj može uključivati samo sram, sram stopljen s drugim negativnim emocijama ili bilo koju drugu negativnu emociju. Tomkins (43) je rekao da ovisnost sedira intenzivne negativne emocije, ali budući da i sama ovisnost budi emociju srama, ona je istodobno i pokretač opetovanih ciklusa – repetitivnog odigravanja scenarija koji ponovno bude osjećaj srama i nadalje ga intenziviraju. Presudno važni propusti i neuspjesi u ljudskom okruženju rezultiraju snažnim osjećajem srama koji sputava ekspresiju vitalnih potreba. Prema Tomkinsu, presudno važan element za razumijevanje prirode ovisnosti je progresija ovih sedirajućih scenarija (engl. *sedative scripts*) u „pre-ovisničke" scenarije (*engl. pre-addictive scripts*) te u konačnici u ovisničke scenarije (engl. *addictive scripts*).

SRAM I AGRESIJA

Problem povezanosti srama s ljutnjom i bijesom ostaje nerazjašnjen. Tomkins (65,66, 78) iznosi pretpostavku da se urođeni afekt ljutnje aktivira kad je intenzitet podražaja na razini višoj od optimalne tijekom presudno važnog razdoblja. On također primjećuje da se naučena ljutnja (kombinacija ekspresije urođene i naučene ljutnje) koristi s ciljem promjene interpersonalnog polja. Kaufman (52) vjeruje da je ljutnja izazvana sramom svjesni konstrukt „scene" u kojoj osoba nastoji upotrijebiti ekspresiju ljutnje s ciljem promjene posramljujuće interakcije.

O sramu se često govori kao o osjećaju koji kao da izaziva agresiju i fenomen objektnog narcizma (64,79).

Freudov izvorni koncept libida podrazumijevao je i afekt i nagon, ali bez jasne distinkcije. Libido je s vremenom potisnuo koncept nagona, ali koncept afekta je ostao nejasan (80). I dalje se smatralo da urođeni modeli „instinktivnih

negative emotions is that substitute. Due to the disturbance in human relationships during development, vital needs become bound by shame, which leads to overwhelming negative affect and the function of addiction is primarily to escape from intense or overwhelming negative affect. The affect may include shame alone, shame conjoined with other negative affects, or any negative affect. Tomkins (40) has said that addiction sedates intense negative affect, but addiction also reproduces shame, thereby reactivating the cycle, repeatedly re-enacting the scene that recreates and intensifies shame. Critical failures in the human environment have resulted in deep shame surrounding these vital needs. According to Tomkins, central to the understanding of the nature of addiction is the progression from sedative scripts to pre-addictive scripts to addictive scripts.

SHAME AND AGGRESSION

The problem of association of shame with anger and rage remains unsolved. Tomkins (65,66,78) suggests that the innate affect of anger is activated when the stimulus density remains at a higher than optimal level for a critical period. He also notes that learned anger (the combination of innate anger and the learned display of anger) is used to alter the interpersonal field. Kaufman (52) believes that shame-anger represents a conscious script of "scene" in which a person attempts to use the display of anger to alter the shaming interaction.

Shame is often talked about as if it causes aggression and the phenomenon of object-narcissism (64,79).

Freud's original concept of libido subsumed both the affect and drive without distinguishing either. Libido subsequently gave way to the drive concept, but affect remained obscured

nagona“ - seksualnosti i agresije - determiniraju ličnost i psihopatologiju. Sullivan (49,81,82) i Fairbarn (51) navode da je potraga za zadovoljavajućim, sigurnim odnosom važnija od gratifikacije nagona i samim time došlo je do razvoja interpersonalne teorije i teorije objektnih odnosa (83).

Tomkins kaže da je afekt primaran, a ne odnosi ili nagoni. On afekt promatra kao primarni, urođeni biološki motivacijski mehanizam. Iskustva srama povezana s drugim afektima, psihološkim nagonima ili interpersonalnim potrebama postaju važan pokretač internalizacije (80). Agresija je pritom tek produženje afekta (emocije) koja se provodi u djelo, a krivnja zbog agresije ne proizlazi iz nagona, ona je derivat emocije (80).

Prema Tomkinsovoj teoriji bijes je negativni afekt povezan s ljutnjom. Bijes je jedna od onih spontanijih, prirodnijih reakcija za koje je zamijećeno da često slijede poslije srama. Bez obzira na to je li bijes potisnut ili se otvorenije izražava, njegova glavna svrha je obrana, a sekundarno on osjećaj srama može transferirati na drugu osobu (52). Iako se i hostilnost ili ogorčenost također mogu javiti kao mehanizmi obrane *selfa* od potencijalnih novih iskustava srama, one gube svoju poveznicu s izvorom i prerastaju u generaliziranu reakciju usmjerenu gotovo na svakoga tko bi se mogao naći u blizini. Bijes je mehanizam samozaštite te istodobno obrambeni mehanizam od snažno izraženog osjećaja srama (52).

Obrambene strategije, kao što su prezir, okrivljavanje, bijes i perfekcionizam primarno se razvijaju kao sredstva koja omogućavaju lakše sučeljavanje s vanjskim izvorima srama.

Kruti obrambeni mehanizmi vode prema narušenim odnosima s drugim ljudima što nadalje osobu izlaže novom obliku pritiska. Sram je moguće promijeniti isključivo izgradnjom novih interpersonalnih odnosa te reparacijom štete nanesene tijekom razvojnih faza.

(80). Personality and psychopathology were still conceived as determined by the innate patterning of “instinctual drives” – sexuality and aggression. Sullivan (49,81,82) and Fairbarn (51) argued that the pursuit of a satisfying, secure relationship mattered more than the gratification of drives and thus the interpersonal theory and the object-relation theory were born (83).

Tomkins says that affect, and not relationships or drives, is of primary importance. He looks at affect as a primary innate biological motivating mechanism. Experiencing shame in connection with other affects, psychological drives, or interpersonal needs becomes a significant contributing source of internalization (80). Aggression is nothing more than the extension of affect into action, and guilt over aggression is not a drive derivate. It is an affect derivate (80).

According to Tomkins’ theory, rage is a negative affect connected with anger. Rage is one of those more spontaneous, naturally occurring reactions which often follows shame. Whether held inside or expressed more openly, rage serves the purpose of defence and may also transfer shame to another person (52). Although hostility or bitterness arise to protect the self against further experiences of shame, they become disconnected from its originating source and become a generalized reaction directed towards almost anyone who may approach. Rage protects oneself and defends against excessive shame (52).

Defending strategies, such as contempt, blame, rage, or perfectionism are acquired primarily in an attempt to cope with externally-based sources of shame.

Rigid defence mechanisms lead to disturbed relationships with other people, which imposes new pressure on a person. Only through the restoration of interpersonal relationships and correction of developmental damage may shame be changed.

SRAM I ANKSIOZNOST

Sram je oblik ekspresije anksioznosti, koju definiramo kao prijetnju osjećaju vlastite vrijednosti i samopoštovanju. Sullivan (84) kaže da se „iskustvo kompleksnih derivacija anksioznosti, kao što su krivnja, sram, poniženje izazvano ismijavanjem i izrugivanjem itd., ubrzava, a zajedno s tim neugodnim iskustvom ubrzava se i razvoj vještine provođenja različitih oblika sigurnosnih mjera – interpersonalnih aktivnosti koje omogućavaju bijeg od anksioznosti ili maksimalno ublažavanje tog osjećaja. U tom kontekstu sram se također prezentira kao jedan od više različitih načina ekspresije anksioznosti." Sullivan (49) je taj problem razmotrio na sljedeći način: „Anksioznost ne samo da se javlja sama od sebe, nego i kao posljedica doživljaja nekih kompleksnih emocija (kao što su nelagoda, sram, poniženje, krivnja ili razočaranje) u koje je anksioznost integrirana tijekom najranijih procesa učenja."

Nathanson (64) ne izjednačava sram i anksioznost jer su različite manifestacije anksioznosti često teško zamjetne, teško ih je identificirati ili shvatiti u smislu njihova podrijetla i svrhe. Zbog nepreciznosti jezika unutarnje iskustvo srama obično se pogrešno identificira kao anksioznost, pa čak kao paranoidne misli.

Psihoterapeuti u svojoj svakodnevnoj praksi često svjedoče povezanosti agresije i anksioznosti, a novija istraživanja posvećena biološkim temeljima anksioznosti pokazuju da su privrženiji muškarci često istodobno i više anksiozni (85).

SHAME AND ANXIETY

Shame is one of the expressions of anxiety defined as a threat to one's sense of personal worth and self-esteem.

Sullivan (84) says that "the experience of complex derivatives of anxiety, such as guilt, shame, humiliation by ridicule, etc., grows apace; and along with all this unpleasant experience, there goes the acquiring of more and more skill at various kinds of security operations – interpersonal activities for escaping from or minimizing anxiety". In this context, shame is presented as one of the various expressions of anxiety. Sullivan (49) addressed this problem as follows: "Anxiety appears not only as awareness of itself but also in the experience of some complex emotions (such as embarrassment, shame, humiliation, guilt, chagrin) into which it has been elaborated by specific early training." Nathanson (64) does not equate shame with anxiety because the various manifestations of anxiety are often not easy to observe, identify, or understand in terms of origins and purposes. Due to the imprecision of language, the inner experience of shame is typically misidentified as anxiety or even as paranoid thoughts.

In their everyday practice, psychotherapists often witness a connection between aggression and anxiety, and recent studies of the biological basis of anxiety suggest that the more attaching males are also more anxious (85).

RAZVOJNA PITANJA U PROGRAMU PSIHOTERAPIJSKOG LIJEČENJA OSOBA OVISNIH O ALKOHOLU

Liječenje osoba ovisnih o alkoholu je specifično u usporedbi s drugim kategorijama psihopatoloških smetnji i ono zahtijeva specifičan psihoterapijski pristup. Specifičnosti alkoholizma prepoznate su u ranoj fazi razvoja psihodi-

DEVELOPMENTAL QUESTIONS IN THE PSYCHOTHERAPEUTIC TREATMENT OF ALCOHOLICS

The treatment of alcoholics is specific in comparison with other categories of psychopathological disturbances and requires a specific psychotherapeutic approach. The specificities of alcoholism were recognized in the early development of the psychodynamic

namskog pristupa alkoholizmu, koji se smatrao sličnim *acting-out* poremećajima (delinkvenciji), ranim poremećajima ega, narcističkim poremećajima i graničnim poremećajima ličnosti (86). Posljedično, modifikacije uvedene u program liječenja alkoholizma bile su nadahnute tehnikama koje su se koristile u radu s djecom (87), delinkventima (88) te pacijentima koji su patili od ozbiljnijih poremećaja. Neki psihoterapeuti provode veći broj intervjua tijekom liječenja s ciljem uspostavljanja „institucionalnog podešavanja" (engl. *institutional setting*) koje zamjenjuje majčinsku skrb (ili skrb neke druge osobe) koja je vjerojatno bila nedostupna tijekom djetinjstva osobe ovisne o alkoholu. Ističe se gratifikacijski pristup terapijskog tima kao i postupno usmjeravanje na frustracije koje je „pacijent spreman prihvatiti". Različiti oblici liječenja alkoholizma uključuju individualne i grupne metode, metode averzije te hipnozu. Psihoterapijsko liječenje osoba ovisnih o alkoholu usmjereno je na ublažavanje osjećaja krivnje i srama te na jačanje ego-identiteta. Spoznaje o alkoholizmu kao sindromu zasnovanom na sramu (52,61,68) važne su u psihoterapijskom pristupu alkoholičarima s obzirom na to da alkoholičari teško prihvaćaju liječenje.

Često zbog svjesnih i nesvjesnih kontratransfernih reakcija te „sumnje" povezane s predviđanjem uspješnosti ishoda liječenja osobe ovisne o alkoholu, psihoterapeut oklijeva prigodom donošenja odluke vezane za pitanje treba li se uključiti u proces liječenja osobe ovisne o alkoholu. Na dubljoj razini to je najvjerojatnije posljedica skrivenih nesvjesnih poriva koji su povezani s još uvijek prisutnim „moraliziranjem i spekuliranjem o tome je li alkoholizam bolest ili nije?" Takvi su stavovi naglašeniji kad su u pitanju osobe ovisne o alkoholu sklone nasilnom ponašanju. Osim toga, gratifikaciju kao dio terapije i psihopatologije često narušavaju recidivi.

Psihoterapijski pristup ovom problemu može ponuditi mogućnost za jasnije definiran i raznolikiji program liječenja. U rješavanju ovog kompleksnog problema ponekad je potrebno

approach to alcoholism, which was considered similar to acting-out disorders (delinquency), disturbances of early ego states, narcissistic disturbances, and borderline disorders (86). Consequently, modifications introduced in the treatment of alcoholism were inspired by techniques used in children (87), delinquents (88), and patients with more serious disturbances. Some psychotherapists perform more interviews during therapy to ensure that there is an "institutional setting" as a replacement for maternal care (or her substitute) that was probably missing during the alcoholic's childhood. Gratification attitude of the therapeutic team is also emphasized, as well as a successive introduction of frustrations that "the patient is able to accept". Different types of alcoholism treatment include individual and group methods, aversion methods, and hypnosis. Psychotherapeutic treatment of alcoholics is aimed at diminishing the feeling of guilt and shame and strengthening the ego function of identity. Findings related to alcoholism as a shame-based syndrome (52,61,68) are important for the psychotherapeutic approach to alcoholics since it is hard for alcoholics to admit they have a problem and accept treatment.

Often, conscious and unconscious countertransference reactions and "doubt" regarding the successfulness of alcoholism treatment make psychotherapists reluctant to become involved in alcoholism treatment. On a deeper level, it is probably the case of hidden unconscious drives that are covered by still existent "moralizing attitudes and speculations related to the question of whether alcoholism is a disease or not?" These attitudes are more pronounced in relation to aggressive alcoholics. Moreover, gratification in therapy and psychopathology is often disturbed by relapses.

The psychotherapeutic approach to this problem can offer an opportunity for a clearer and more versatile therapeutic treatment. To solve

primijeniti sveobuhvatniji pristup koji u obzir uzima i socijalnu komponentu (89). No, cilj i mjera terapije koju provodi psihoterapeut u liječenju osobe ovisne o alkoholu ne bi se trebali isključivo svoditi na potpunu apstinenciju, nego bi terapeut trebao biti usmjeren na evaluaciju napredovanja pacijenta tijekom primjene programa liječenja i njegove sve snažnije izražene sposobnosti prilagodbe i sazrijevanja.

Činjenica je da saznanja vezana za razvoj i psihološke aspekte ličnosti osobe koja je ovisna o alkoholu (stupanj razvoja ega, karakteristike identiteta, psihološke značajke *selfa*, obrambeni mehanizmi itd.) mogu omogućiti pružanje adekvatnijeg programa liječenja. Ekspresija agresije, depresije ili srama – važna je za evaluaciju razvojnog stadija osobe ovisne o alkoholu te za primjenu psihoterapijske metode kao i općenito psihosocijalne metode.

LIJEČENJE ALKOHOLIZMA

Iako neki kliničari i grupe zagovaraju koncept kontrolirane konzumacije alkohola, većina kliničara, kao i većina dobro kontroliranih studija ukazuje u prilog potpune apstinencije od alkohola kao o najvažnijem elementu uspješne strategije liječenja alkoholizma (90).

U liječenju alkoholizma moguće je koristiti različite metode uključujući psihofarmakoterapiju, psihoterapiju, bihevioralnu terapiju, socioterapiju, radnu terapiju, obiteljsku terapiju te klubove za liječenje osoba ovisnih o alkoholu. Povrh toga, različite institucije koriste različite metode liječenja, ovisno o brojnosti osoblja, njihovoj stručnosti i obrazovanju kao i o drugim čimbenicima.

Općenito, na liječenje se svojevoljno prijavljuje vrlo mali broj osoba ovisnih o alkoholu. Oni su uglavnom prisiljeni na taj korak budući da su izloženi pritisku obitelji, ili imaju zdravstvenih problema ili ih na to prisiljavaju neke druge socijalne komplikacije. Pacijenti koji se dragovoljno

such a complex problem, one sometimes needs to use a wider approach that takes into account a pronounced social component (89). However, for a psychotherapist, the aim and measure of the treatment of an alcoholic should not be total alcohol abstinence but an assessment of the patient's progress during the course of therapy and their increased adaptability and maturity.

It is a fact that the knowledge of developmental and other psychological aspects of an alcoholic's personality (the state of ego development, identity characteristics, self-psychological traits, defence mechanisms, etc.) may help in providing more adequate treatment. The expression of aggression, depression, or shame – manifest or latent – is important in the assessment of the developmental stage of an alcoholic or in the application of the psychotherapeutic and total psychosocial method.

TREATMENT OF ALCOHOLISM

While some clinicians and groups advocate the concept of controlled drinking, most clinicians and the majority of well-controlled studies indicate that complete abstinence from alcohol is the centrepiece of successful treatment strategy for alcohol abuse (90).

Different methods may be used in the treatment of alcoholism, including psychopharmacotherapy, psychotherapy, behavioural therapy, sociotherapy, occupational therapy, family therapy, and clubs for the treatment of alcoholics. In addition, different institutions use different methods of treatment, which depend on the number, expertise, and education of staff and other factors.

In general, few alcoholics come for treatment voluntarily. They mostly do it under pressure of family members, health problems, or social complications. Patients who voluntarily com-

prijavljuju na liječenje imaju i najbolje prognoze liječenja jer su oni uglavnom priznali i prihvatili svoj problem ovisnosti o alkoholu te traže pomoć.

PSIHOTERAPIJA ZA OSOBE OVISNE O ALKOHOLU

Psihoterapijski postupci neizostavan su dio programa liječenja alkoholizma. Sve su metode iskušane, od individualnih do grupnih terapija pa sve do najpovršnijih terapija i psihoanalize, a u novije vrijeme i obiteljskih terapija (91).

Kad je psihoterapeut usredotočen na razloge zašto osoba pije, psihoterapija je uspješnija nego kad je fokus usmjeren na nejasna pitanja psihodinamike (90). Posebice je važno usredotočiti se na situacije kad osoba pije; motivacijski sustav kao pokretač zlouporabe alkohola; očekivanja koja osoba ima vezano za konzumiranje alkohola te alternativne načine rješavanja problematičnih situacija.

Za uspješnost programa liječenja prvi je kontakt iznimno važan i upravo tada terapeut mora biti aktivan i suportivan. Povrh toga, terapeut bi alkohol trebao razmatrati kao psihološki obrambeni mehanizam, ali istodobno mora biti usmjeren i na emocionalne i intelektualne namjere između pacijenta i terapeuta u početnoj fazi liječenja.

Iako i dalje ne postoji uniforman psihoterapijski pristup koji se propisuje (92), neka načela psihoterapije u radu s osobama ovisnim o alkoholu mogu se sažeti na sljedeći način:

1. Apstinencija mora biti potpuna i doživotna.
2. Potrebno je razriješiti snažno poricanje pacijenta i to po mogućnosti što ranije u programu liječenja.
3. Klasične psihoanalitičke tehnike rijetko su uspješne zbog intenziteta transfernog odnosa te su se modificirani psihoanalitički orijentirani programi u kojima terapeut preuzima aktivniju ulogu i samim time

mit to treatment have the best prognosis because they have already admitted that they are alcoholics and need help.

PSYCHOTHERAPY OF ALCOHOLICS

Psychotherapy procedures are always used in the treatment of alcoholism. All methods have been attempted, from individual and group therapy to most superficial therapy to psychoanalysis to, lately, family therapy (91).

When a psychotherapist focuses on the reasons why a person drinks, psychotherapy is more successful than when the focus in on vague psychodynamic issues (90). It is especially important to focus on situations in which a person drinks, the motivating process behind drinking, expectations from drinking, and alternative ways of coping with such situations.

The first contact, during which the therapist has to be active and supportive, is very important for successful treatment. The therapist must also deal with alcohol as a psychological defence and with emotional and intellectual intentions between the patient and the therapist at the beginning of therapy.

Although there is little uniformity in the type of psychotherapy prescribed (92), some principles of psychotherapy for alcoholics may be summarized as follows:

1. Abstinence must be total and lifelong.
2. The massive use of denial by the patient must be dealt with, preferably at the earliest occasion.
3. Classical psychoanalytic techniques are rarely successful because of the intensity of the transference relationship while modified psychoanalytic-oriented programs in which the therapist takes a more active role and thereby reduces the transference relationship proved more effective (93).

umanjuje transferni odnos pokazali učinkovitijima (93).

4. Grupna terapija je prioritet kod mnogih osoba ovisnih o alkoholu jer će one u takvim okolnostima biti u stanju lakše prihvatiti svoju ovisnost te će, identificirajući se s grupom ili novim članom, bez oklijevanja i srama prionuti rješavanju problema svoje ovisnosti.
5. Obiteljska terapija pomaže u procesu restrukturiranja patoloških odnosa unutar obitelji osobe ovisne o alkoholu.

Literatura rijetko spominje istraživanja povezana s primjenom psihoterapije u liječenju osoba ovisnih o alkoholu, ali je dostupan veći broj istraživanja koja nastoje objasniti uzrok alkoholizma s psihološkog i psihodinamskog teorijskog aspekta. To što slučajevi koji su razmotreni unutar objavljenih istraživanja ne zadovoljavaju dijagnostičke kriterije za ovisnost o alkoholu prema kriterijima MKB-10 i DSM 5 ujedno je i glavni nedostatak tih istraživanja.

Većina osoba ovisnih o alkoholu dragovoljno prihvaća prvu fazu liječenja jer je ona usmjerena na ublažavanje simptoma sustezanja. U toj fazi zbog nedostatka uvida, osoba ovisna o alkoholu lakše će prihvatiti svoje fizičko, nego psihičko stanje. Upravo je zato u tom trenutku važno uspostaviti pozitivan raport, radni savez i suradnju s pacijentom u kojem ga tretiramo kao partnera i suradnika u liječenju u kojem on aktivno surađuje, te ojačati njegovu motivaciju za nastavak liječenja.

Kod nekih osoba ovisnih o alkoholu ne postoje „dokazi" o bolesti jer su im simptomi sustezanja prilično blagi.

Osobe ovisne o alkoholu koje ne prihvaćaju liječenje, posebice one koje manifestiraju nasilno ponašanje, često su neodgovorne i nisu u stanju kontrolirati zlouporabu alkohola i svoje ponašanje prema okolini. Taj mehanizam odbijanja bolnice (terapeuta) kao „negativnog objekta" (94,95) kod određenih pacijenata može trajati godinama.

4. Group therapy is a priority for many alcoholics because they can gratify their dependency needs through identification with a group or with a new member that they start to take care of without hesitation and shame.
5. Family therapy helps in restructuring pathological relationships within a family of alcoholics.

In literature, studies related to the psychotherapy of alcoholics are scarce, while there are a larger number of studies attempting to explain the causes of alcoholism from psychological and theoretical psychodynamic aspects. The flaw in the existing studies is that the presented cases do not satisfy the ICD-10 or DSM-V diagnostic criteria for alcoholism.

Most alcoholics voluntarily agree to the first phase of the treatment because it is focused on relieving withdrawal symptoms. In this phase, alcoholics are more likely to accept their physical condition than their psychological condition due to the lack of insight. This is why it is important to use this phase to establish a positive transfer and raise motivation for further anti-alcoholic treatment.

That is why it is at this point important to establish a positive report, working alliance, and cooperation with the patient, whereby we treat the patient as a partner and associate in a treatment in which they actively cooperate and strengthen his/her motivation to continue the treatment.

In some alcoholics, the proof of "illness" is not present because their withdrawal symptoms are quite mild.

Alcoholics that do not accept the treatment, especially in situations when they manifest aggressive behaviour, are often irresponsible and cannot control their drinking and behaviour toward their environment. This mechanism of dismissing the hospital (or the therapist) as a "bad object" (94,95) can last for years in certain patients.

Liječenje osobe ovisne o alkoholu nije uvjetovano isključivo potrebom da se ublaže simptomi sustezanja, a da se pritom zanemaruje važnost stjecanja uvida u kompleksnost liječenja. Rezultati najnovijeg istraživanja pokazuju da su nasilni alkoholičari vrlo često imali puno slabiji ego od alkoholičara koji nisu bili skloni agresiji, te da su bili depresivniji i skloniji suicidalnim nakanama te da su istodobno iskazivali nižu razinu psihosocijalnog funkcioniranja (96). Potrebno je više istraživanja koja će se usmjeriti na otkrivanje većeg broja odgovora vezanih za glavne točke zastoja u razvoju koji bi nam bili korisni u psihoterapiji povezanoj s liječenjem osoba ovisnih o alkoholu.

GRUPNA PSIHOTERAPIJA OSOBA OVISNIH O ALKOHOLU

Psihoterapija osoba ovisnih o alkoholu treba pružiti reparativan odnos koji u osobi stvara osjećaj sigurnosti koji iscjeljuje sram putem novih iskustava identifikacije. Bitan čimbenik u iscjeljivanju srama je empatija dobronamjerne druge osobe koja razumije i prihvaća osobu ovisnu o alkoholu, kako bi mogla eventualno sama sebe razumjeti i prihvatiti. Identifikacija je sredstvo za održavanje bliskih odnosa s drugom osobom (97) i kamen je temeljac normalnog sazrijevanja, a želja za identifikacijom snažna je snaga tijekom života. Odgovarajuća identifikacija s terapeutom može biti presudan aspekt u psihoterapiji za pacijente koji su se pogrešno identificirali ili nisu bili u stanju uspostaviti konstruktivne identifikacije u ključnim točkama svog emocionalnog razvoja (97).

Iznad svega, psihoterapija je odnos, a ne tehnika ili strategija. Reparativan odnos je odnos koji popravlja razvojne deficite.

Prigodom razmatranja terapijskog modaliteta javlja se temeljna potreba za individualnim odnosom koji će razriješiti osjećaj srama koji se razvio rano u životu te deprivaciju u najranijim

The treatment of an addicted alcoholic is not focused solely on the need to alleviate withdrawal symptoms and simultaneously ignore the importance of the insight into the complexity of treatment of such persons. The findings of the most recent studies show that aggressive alcoholics most probably have a weaker ego-strength than non-aggressive alcoholics, that they have a stronger inclination to depression and suicidal ideation, and that they have poorer psychosocial functioning (96). Further research is required to provide more answers about the main developmental "stuck points", which may be useful in the psychotherapy of alcoholics.

GROUP PSYCHOTHERAPY OF PERSONS DEPENDENT ON ALCOHOL

Psychotherapy of persons dependent on alcohol should provide a reparative relationship that creates a sense of security and heals shame through new experiences of identification. An important factor in the process of healing shame is the empathy of another benevolent person who understands and accepts the alcohol addict, so that they can understand and accept themselves. Identification is a means of maintaining a close relationship with another person (97) and is a cornerstone of normal maturation, and the desire for identification is a powerful force throughout life. Appropriate identification with the therapist may be a crucial aspect of the psychotherapy of patients who have been mis-identified or were unable to establish constructive identification at crucial points of their emotional development (97).

Above all, psychotherapy is a relationship, not a technique or strategy. A reparative relationship is a relationship that repairs developmental deficits.

odnosima. Terapija može biti poput iznimno snažnog naknadnog roditeljevanja (engl. *reparenting*) s ciljem da se izgradi siguran, samoafirmirajući identitet svjestan vlastite vrijednosti, kompetentan *self* koji je sve više sposoban živjeti autonomno (80).

Suportivne grupe i psihoterapijske grupe rješavaju nezaobilazan sekundarni sram koji se javlja kao reakcija na sam sindrom. Kaufman kombinira individualnu i grupnu psihoterapiju u liječenju ovisničkih sindroma (61).

Grupna je psihoterapija važna zbog fenomena socijalizacije, kondenzacije i povratnog odgovora (engl. *mirroring*), koji su moćni elementi grupnog procesa. Grupna je psihoterapija jedna od metoda koja se može odabrati za liječenje alkoholičara (98) budući da se zbog slabosti ega, alkoholičari osjećaju sigurno jedino kad su u grupi. Čini se da osobe ovisne o alkoholu svoju ovisnost o alkoholu miješaju s ovisnošću o grupi. Grupna psihoterapija osoba ovisnih o alkoholu može se provoditi i s hospitaliziranim i s ambulantnim pacijentima. Dostupne su različite opcije vezane za metodu rada i grupni proces, a odabir ovisi o stupnju ovisnosti pacijenta i njegovim bihevioralnim problemima, kao što su agresija ili depresija.

ZAŠTO JE TAKO TEŠKO PRIDRUŽITI SE GRUPI ILI OSTATI U NJOJ?

Pridruživanje grupi i ostanak u njoj prilično je zahtjevan proces za osobe ovisne o alkoholu jer imaju sustav scenarija temeljen na sramu i jer su anksiozni i emocionalno labilni.

Ako je *self* erodirao i na temelju nekih čimbenika koje smo razmatrali u prethodnom poglavlju nije dostatan, osobi će možda biti teško ostvariti interpersonalni kontakt unutar grupe. Sram nastaje u odnosu (99). On je zaštitni mehanizam kako bi se izbjegla ranjivost izazvana gubitkom povezanosti u odnosu.

When considering the question of therapeutic modality, there is a fundamental need for an individual relationship to repair early shame and relationship deprivation. Therapy can provide significant reparenting that is aimed at building a secure, self-affirming identity, a competent self able to live with increasing autonomy (80).

Support groups and treatment groups resolve inevitable secondary shame about the syndrome itself. Kaufman combines individual and group therapy in the treatment of addictive syndromes (61).

Group psychotherapy is important because of the phenomena of socialization, condensation, and mirroring, which are powerful parts of the group process. Group psychotherapy is one of methods of choice in the treatment of alcoholics (98) because the ego deficiency in alcoholics makes them feel safe only when they are in a group. It seems alcoholics mix their alcohol dependency with that of group. Group psychotherapy of alcoholics may be performed on outpatient and inpatient basis. Different options may be available regarding the method of work and group process, the choice of which depends on the severity of the patient's dependence and behavioural problems, such as aggression or depression.

WHY IS JOINING AND STAYING IN A GROUP SO DIFFICULT?

Joining and remaining in a group is quite difficult for alcoholics because they have a shame-based script system and are very anxious and emotionally disturbed.

If the self is eroded and insufficient according to certain factors discussed above, it can be difficult for a person to make an interpersonal contact in a group. Shame arises in a relationship (99). It is a protective mechanism whose function is to avoid the vulnerability at the cost

Posramljeni pojedinci nesvjesno priželjkuju da druga osoba preuzme odgovornost za iscjeljenje rupture (100), a posramljene će osobe također najvjerojatnije biti sklone koristiti strategije ne bi li se obranile od ranjivosti i kontakta u grupi.

To je još evidentnije među osobama ovisnim o alkoholu jer je intenzitet srama koji osjećaju puno snažniji, ali je i često prikriven agresijom i izraženom anksioznošću (4,22,27,37,96). Samim time bi se u grupnoj psihoterapiji osoba ovisnih o alkoholu trebala primjenjivati „kultura predstavljanja", a važan dio svake sesije trebao bi biti posvećen uvodnom predstavljanju ili „kratkom razgovoru" između članova. Izvjesno je da takav pristup u grupi pojačava osjećaj sigurnosti i podrške te istodobno smanjuje osjećaj srama.

GRUPNA PSIHOTERAPIJA KOJA BI MOGLA BITI UČINKOVITIJA KOD OSOBA KOJE SE LIJEČE OD ALKOHOLIZMA

Kriterij učinkovitoga grupnoga rada uključuje geografsku i kulturološku dostupnost sudionicima te strukturu i sadržaj koje sudionici percipiraju kao zanimljive i korisne. No, ne postoji jedan oblik grupne psihoterapije prikladan za sve. Program grupe mora slijediti psiho-edukacijsku smjernicu te udovoljavati potrebama najvećeg dijela grupe. Osobama s relativno nenarušenim osjećajem *selfa,* koje su istodobno psihološki sofisticirane i suportivno-ekspresivne, otvorena će grupa predstavljati učinkovit pristup. Ego alkoholičara je slab, oni su ranjivi, a njihov koncept *selfa* izrazito je fragmentiran i stoga bi se naglasak trebao staviti na autonomiju (4,27,96). Dijalog u grupi ima moć dodatno narušiti koncept *selfa* fragmentiranog pojedinca koji otvorenost doživljava kao prijetnju svojoj ranjivosti, a ne kao prigodu za razvoj.

of loss of contact in a relationship. Shamed individuals unconsciously wish for the other to take responsibility for repairing the rupture (100), and shamed persons in a group are likely to use strategies to defend against vulnerability and contact.

This is even more evident among alcoholics because their level of shame is higher and often disguised by aggression and strong anxiety (4,22,27,37,96). Therefore, in a group psychotherapy of alcoholics, a "culture of introduction" should be fostered and a substantial part of each session should be dedicated to long introductions or "check-ins" with brief dialogues between members. Such an approach will probably increase the feeling of safety and support within the group and diminish the feeling of shame in this relationship.

TYPE OF PSYCHOTHERAPY GROUP THAT MAY BE MORE EFFECTIVE WITH ALCOHOLICS

Criteria for an effective group include geographic and cultural accessibility for the participants and a structure and content that is perceived to be interesting and beneficial.

However, there is no single format or type of psychotherapy group appropriate for everybody. A group program should follow a more psycho-educational format and meet the needs of the largest part of the group. For persons with a reasonably intact sense of self who are psychologically rather sophisticated, the supportive-expressive, open group approach is effective. Alcoholics have a weak ego, they are vulnerable, and their self-concept is very fragmented, so the emphasis should be on autonomy (4,27,96). A dialogue in the group can worsen the self-concept of fragmented individuals who see openness as a threat to their vulnerability rather than an opportunity for growth.

S obzirom na različite razine psihosocijalne zrelosti alkoholičara, različitu jakost ega i različitu razinu srama (4,22,27,37,96), program bi trebao uključivati tri faze: uvodnu fazu te prvu fazu i drugu fazu grupne psihoterapije.

Uvodna faza

Ova je faza usmjerena na simptome sustezanja te psihofizički oporavak. Individualni kontakt, podrška i didaktički pristup iznimno su važni.

Prva faza grupne psihoterapije

Prva faza grupne psihoterapije strukturirana je na način da pruža maksimalnu sigurnost, prihvaćanje i minimalni rizik od psihičke izloženosti. Na ovoj razini grupa je psiho-edukativna i vremenski ograničena uz mogućnost nastavka u otvorenoj grupi bez vodstva.

Značajke prve faze grupne psihoterapije su sljedeće:

a) Ne spominje se podrška ili savjetovanje kako bi se na minimum smanjila mogućnost implikacije terapijskog umanjivanja ili neuspjeha, a naglasak je na edukaciji i pozitivnom ishodu.

b) Naglasak je na psiho-edukativnom, usmjerenom i tematskom radu. Didaktička uvodna faza preduvjet je za ulazak u ovu grupu, odnosno faza koja se pohađa prije ulaska u ovu grupu.

c) Grupa ne bi trebala brojiti više od 14 do 16 članova kako bi, s jedne strane, bio moguć izravan kontakt članova, kao i kontakt s terapeutom, a s druge strane, kako bi se osobe mogle suočiti s određenim zahtjevima a da se pritom ne osjećaju previše izloženo.

d) Grupa je zatvorena i traje najmanje 8 sesija po 90 minuta svaka.

e) Na kraju programa, svim se članovima pruža mogućnost da nastave sa svojim radom u drugoj fazi grupne terapije.

Since alcoholics have different levels of psychosocial maturity, different ego strengths and different levels of shame (4,22,27,37,96), a program should include three levels: the introductory phase, first-level, and second-level group psychotherapy.

Introductory phase

This phase deals with withdrawal symptoms and psychophysical recovery. Individual contact, support, and didactic approach are very important.

First-level group psychotherapy

First-level group psychotherapy is structured in order to provide maximum safety, holding, and minimum risk of psychological exposure. At this level, the group is psycho-educational and limited in time, with a possibility of continuance in an open non-directive group.

A first-level group psychotherapy meets the following characteristics:

a) No mention is made of support or counselling for minimaze therapeutic implication of diminishment or failure, and an emphasis is on education and positive outcome.

b) The emphasis is psycho-educational, directive, and thematic. Prior to entering this group, there is a didactic introductory phase.

c) The group should not have more than 14-16 members to allow, on the one hand, for a more direct contact among the group members and with the therapist, and on the other, for persons to confront potential demands without feeling too exposed.

d) The group is closed and lasts for 8 sessions of 90 minutes each.

e) At the end of the program, all members are offered the option of continuing with their work in the second-level group.

Druga faza grupne psihoterapije

Rad ove grupe trebao bi trajati jednu godinu, a sudjelovanje u njoj je na dragovoljnoj bazi. Članovi grupe trebaju završiti prethodne faze. U ovoj grupi fokus je na interpersonalnoj razmjeni između članova te na dubljim razinama svjesnosti i procesa. Cilj je razviti otvorenost te povećati kapacitet za smanjenje tenzija i konflikata, produbljenje shvaćanja vlastitog *selfa* i prihvaćanje sebe putem procesa istraživanja obrambenih mehanizama u odnosu prema drugim članovima grupe. Članovi se potiču s drugima podijeliti svoje osjećaje srama i anksioznosti, razviti toleranciju i promijeniti svoje autoagresivne modele (intoksikacija) ili agresivne modele ponašanja (verbalne i/ili fizičke) prema drugima u konstruktivnije obrambene mehanizme, jer je agresija iznimno važan dio kliničke slike alkoholizma i procesa grupne psihoterapije.

ZAKLJUČAK

Analizom objavljenih psihoterapijskih istraživanja zaključeno je da u liječenju osoba ovisnih o alkoholu nedostaje integrativni psihoterapijski pristup alkoholizmu, posebice na području liječenja psihoterapijom. Samim time bi predložena metodologija mogla pružiti rješenja za unaprjeđenje liječenja psihoterapijom osoba koje se liječe od alkoholizma.

Iako su dosad zanemarivani te minimizirani, ego-identitet i sram su sada postali središnji elementi. Moramo razumjeti alijenirajući učinak srama i rasvijetliti njegov utjecaj na razvoj kako ličnosti tako i psihopatologije alkoholizma.

Za psihoterapeuta verbalizacija, kao oblik ponašanja i mišljenja, otkriva ne samo dinamiku strukture ega i superega, nego i dinamiku terapijskih procesa.

Sram bi mogao biti značajan čimbenik kada govorimo o teškoćama u odnosima, kao što je

Second-level group psychotherapy

Group psychotherapy should last for one year and the participation is voluntary. The group members should have finished the previous phases. In this group, the focus is on interpersonal exchange between members, on deeper levels of consciousness and process. The goal is the development of openness and increase in the capacity for relieving tension and conflicts, understanding oneself, and accepting oneself through the exploration of defences in relation to other members of the group. Members will be encouraged to share their anxiety and shame, develop their tolerance, and change their autoaggressive (intoxications) or aggressive behaviour (verbal or/and physical) towards others into more constructive defence mechanisms because aggression is a very important part of the clinical picture of alcoholism and the group psychotherapy process.

CONCLUSION

A review of existing psychotherapeutic studies indicates that an integrative psychotherapeutic approach to alcoholism is lacking, especially in psychotherapeutic treatment. Therefore, the methodology suggested in this paper could provide solutions for the improvement of psychotherapeutic treatment of persons with alcoholism.

Although previously neglected and minimized, ego identity and shame have moved to the centre stage. We must understand the alienating affect of shame and illuminate its impact on the development of both personality and psychopathology of alcoholism.

To a psychotherapist, verbalization as a form of behaviour and thinking reveals not only the dynamics of the ego and the superego-structure but also the dynamics present in the therapeutic process.

Shame may be a significant element in most relationship difficulties, such as alcohol abuse

zlouporaba alkohola (101). Svaka osoba ovisna o alkoholu čija se ovisnost temelji na sramu iskazivat će drukčiji klaster modela ponašanja, fantazija, intrapsihičkih funkcija te mehanizama samoobrane. Drugim riječima, u terapijskom odnosu, terapeut otkriva jedinstvenu psihodinamiku svakog pojedinog pacijenta. Osim toga potrebna su istraživanja u kojima je važno razumjeti neke opće premise specifičnih psihopatologija.

(101). Each shame-based alcoholic will present a different cluster of behaviours, fantasies, intrapsychic functions, and self-protective defences. In other words, in a therapeutic relationship, the therapist discovers each patient's unique psychodynamics. In addition, there is a requirement for studies with an emphasis on the importance of understanding some general premises of specific psychopathologies.

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Vjerovanja terapeuta o terapiji izlaganjem
/ Therapeuts' Beliefs about Exposure Therapy

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Brojna istraživanja potvrđuju učinkovitost tehnike izlaganja zbog čega se ta tehnika smatra prvim izborom u tretmanu većine anksioznih poremećaja. Unatoč tome u praksi se tehnika nedovoljno primjenjuje. Osim nesklonosti klijenata da se izlažu neugodi, tome pridonose i negativni stavovi terapeuta prema primjeni ove tehnike. Cilj je istraživanja ispitati stavove terapeuta prema terapiji izlaganjem, te razlike u vjerovanjima s obzirom na tip i razinu psihoterapijske edukacije, kao i na iskustvo u primjeni ove terapije. U istraživanju je sudjelovalo 226 terapeuta različitih psihoterapijskih usmjerenja i razina edukacije. Ispitanici su ispunili kratki *online* upitnik koji je sadržavao Ljestvicu vjerovanja terapeuta o izlaganju. Rezultati pokazuju da terapeuti bihevioralno-kognitivnog usmjerenja i oni koji u svom radu primjenjuju tehniku izlaganja imaju pozitivniji stav prema njezinoj primjeni u odnosu na terapeute drugih psihoterapijskih usmjerenja i one koji je u svom radu ne koriste. Među bihevioralno-kognitivnim terapeutima, akreditirani terapeuti, supervizori i supervizanti imaju pozitivniji stav od terapeuta na nižim stupnjevima edukacije. Može se zaključiti da znanje i pozitivna vjerovanja o terapiji izlaganjem potiču primjenu ove tehnike, a pozitivna iskustva u primjeni povratno podržavaju i jačaju pozitivna vjerovanja o njoj. Preporuča se da se u okviru edukacije iz bihevioralno-kognitivne terapije radi na prepoznavanju i mijenjanju potencijalnih disfunkcionalnih vjerovanja o terapiji izlaganjem.

/ Numerous studies have confirmed the efficacy of exposure therapy, which is why this approach is considered the primary option in the treatment of most anxiety disorders. Despite this fact, in practice this approach is not used enough. Apart from the reluctance of clients to expose themselves to discomfort, therapists' negative attitudes to exposure therapy also contribute to this. The aim of this study is to examine therapists' attitudes toward exposure therapy and differences in beliefs according to type and level of psychotherapeutic education as well as experience with using this type of therapy. 226 therapists of various psychotherapeutic orientations and education levels participated in the study. The participants filled in a short online questionnaire which contained the Therapist Beliefs about Exposure Scale. The results show that behavioural-cognitive therapists and those who apply exposure therapy in their work have a more positive attitude toward its use in comparison with therapists of other psychotherapeutic orientations and those who do not use exposure therapy in their work. Among behavioural-cognitive therapists, accredited therapists, supervisors, and supervisees have a more positive attitude than therapists with lower levels of education. It may be concluded that knowledge and positive beliefs about exposure therapy encourage the application of this technique, while positive experiences of its application support and strengthen positive beliefs about it. It is suggested that within the training in behavioural cognitive therapy more effort should be invested into recognizing and altering potential dysfunctional beliefs about exposure therapy.

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KLJUČNE RIJEČI / *KEY WORDS*:
Terapija izlaganjem / *Exposure therapy*
Vjerovanja terapeuta / *Therapists' beliefs*
Kognitivna bihevioralna terapija / *Cognitive-behavioral therapy*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2019.525

UVOD

Bihevioralno-kognitivni tretmani koji uključuju izlaganje smatraju se najučinkovitijim psihoterapijskim pristupom u tretmanu anksioznih poremećaja, što je potvrđeno većim brojem meta-analiza (1–3). Brojna istraživanja potvrđuju da je terapija izlaganjem metoda izbora za tretman paničnog poremećaja s agorafobijom (4), specifične fobije (5), socijalne fobije (6), posttraumatskog stresnog poremećaja (7), opsesivno-kompulzivnog poremećaja (8) i anksioznosti u vezi sa zdravljem (9). Izlaganje zastrašujućem podražaju empirijski je dokazan princip za promjenu patološke anksioznosti (10,11) pa većina učinkovitih tretmana anksioznih poremećaja, kao i poremećaja vezanih uz stres uključuje neku vrstu izlaganja. Bihevioralno-kognitivni tretmani s naglaskom na izlaganju pokazuju se učinkovitima i u smanjenju komorbidnih stanja poput depresije (12).

Nekoliko je objašnjenja za terapijske promjene koje nastaju kao rezultat izlaganja. Model habituacije (13) navodi kako tijekom izlaganja dolazi do smanjenja straha zbog navikavanja na zastrašujući podražaj. Prema kognitivnom modelu izlaganje omogućuje promjenu disfunkcionalnih vjerovanja u vezi odgovornosti, razine prijetnje, potrebe za kontrolom i sigurnosti (14). Model emocionalnog procesuiranja (10) pretpostavlja da je smanjenje straha posljedica

INTRODUCTION

Behavioural-cognitive treatments which include exposure are considered the most effective psychotherapeutic approach in the treatment of anxiety disorders, which numerous meta-analyses have confirmed (1-3). Numerous studies have confirmed that exposure therapy is used for the treatment of panic disorder with agoraphobia (4), specific phobia (5), social phobia (6), post-traumatic stress disorder (7), obsessive-compulsive disorder (8), and health-related anxiety (9). Exposure to a frightening stimulus is an empirically proven method of altering pathological anxiety (10,11), which is why most effective treatments of anxiety disorders, as well as stress-related disorders, include some form of exposure. Behavioural-cognitive treatments with an emphasis on exposure have also shown to be effective in the case of comorbid conditions such as depression (12).

There are several explanations for therapeutic changes that occur as a result of exposure. According to the habituation model (13), during exposure there is a reduction of fear due to habituation to a frightening stimulus. According to the cognitive model, exposure allows for a change in dysfunctional beliefs regarding responsibility, threat levels, the need for control, and safety (14). According to the model of emotional processing (10), the reduction of fear is a

integracije korektivnih informacija u sadašnje pamćenje do kojeg dolazi tijekom izlaganja. Model suočavanja ističe značenje smanjenja i zamjene anksioznih misli adaptivnijim načinima razmišljanja. Povećanje percipirane samoefikasnosti za toleriranje zastrašujućih podražaja i reakcije straha dovodi do smanjene percepcije prijetnje što posljedično smanjuje anksioznost (15). Model inhibitornog učenja smatra da tijekom terapije izlaganjem ne dolazi do brisanja ranije uvjetovane reakcije straha, već je ona nadjačana sekundarnim inhibitornim učenjem (16). Istraživanja podržavaju ovaj model i potvrđuju da je aktivnost amigdale inhibirana kortikalnim utjecajima (17). Neispunjavanjem negativnih očekivanja o strahu razvija se tolerancija emocija straha, gađenja i nesigurnosti.

Bolji učinci izlaganja postižu se ako se pri tome od pojedinca traži da odustane od korištenja različitih sigurnosnih ponašanja, tj. ponašanja koja dovode do trenutnih olakšanja, ali dugoročno imaju glavnu ulogu u održavanju anksioznosti. Ipak, pokazuje se da plansko korištenje nekih sigurnosnih ponašanja u početku tretmana fobija i OKP-a te njihovo postupno smanjivanje tijekom tretmana ne ometa napredak u terapiji (18). Ponekad se čak pacijente potiče na suprotna ponašanja koja potiču anksioznost, čime se učinak izlaganja pojačava (npr. socijalnog fobičara potiče se da namjerno skreće pažnju na sebe, upada drugima u razgovor i sl.).

Terapija izlaganjem podrazumijeva povremeno izlaženje iz uobičajenih okvira provođenja terapijskog susreta. Ponekad je potrebno s klijentom otići u stvarne životne situacije (npr. u autobus ili tramvaj, u trgovački centar i sl.), a ponekad je potrebno u seansu uključiti podražaje koji izazivaju anksioznost (npr. donijeti pauka ili iglu, dovesti psa i sl.). Budući da je ponekad teško organizirati takve situacije (npr. kod straha od letenja), sve se češće koristi virtualno izlaganje koje pokazuje podjednaku učinkovitost (19).

consequence of the integration of corrective information in the current memory, which occurs during exposure. The coping model emphasises the significance of reduction and replacement of anxious thoughts with more adaptive thinking patterns. An increase in perceived self-efficacy in tolerating frightening stimuli and fearful reactions leads to decreased threat perception, which consequently reduces anxiety (15). According to the inhibitory learning model, during exposure therapy an earlier conditioned fearful reaction is not erased but overpowered by secondary inhibitory learning (16). Existing studies support this model and confirm that the activity of the amygdala is inhibited by cortical influences (17). A lack of fulfilment of negative expectations related to fear promotes tolerance of fear, disgust, and uncertainty.

Exposure has better effects if an individual is asked to stop using various safety behaviours, i.e. behaviours which lead to temporary relief but in the long term play an important role in maintaining anxiety. However, it has been shown that using certain safety behaviours at the beginning of treatment for phobias and OCD, followed by their gradual reduction during treatment, does not inhibit progress of the therapy (18). Patients are sometimes even encouraged to use behaviours which stimulate anxiety in order to increase the effect of exposure (e.g. a person with social phobia is encouraged to intentionally direct attention to themselves, interrupt other people's conversations, etc.).

Exposure therapy implies occasional departures from the conventional framework of conducting therapy. Sometimes it is necessary to take the patient into real life situations (e.g. take them to a bus or tram, a shopping centre, etc.) and at other times it is necessary to include stimuli which induce anxiety (e. g. bring a spider, a needle, a dog, etc.) in the therapy session. Since it is sometimes difficult to organize such situations (e.g. in case of fear of flying), virtual exposure is increasingly used and shows equal effectiveness (19).

Terapija izlaganjem pokazuje se učinkovitom i u tretmanu djece predškolske dobi, pri čemu se izlaganje provodi uz pomoć roditelja (20). Premda priručnici za tretman anksioznosti kod djece (npr. *Coping Cat* (21)) sadrže različite druge komponente (npr. kognitivno restrukturiranje, relaksacija), značajnija poboljšanja primjećuju se tek nakon uvođenja izlaganja (22).

Klinička iskustva upućuju na relativno visok postotak anksioznih pacijenata koji ne reagiraju na dobiveni tretman (34-36 %), kao i velik broj odustajanja od tretmana (16-20 %). Velik broj nereagiranja na tretman i povrata simptoma je u skladu s nedovoljnom dostupnosti učinkovitih tretmana u kliničkoj praksi, što se posebno odnosi na tretmane zasnovane na izlaganju. Usprkos povećanju korištenja usluga mentalnog zdravlja, uporaba psihoterapijskih tretmana je u posljednja dva desetljeća opala, dok se uporaba psihofarmaka povećala (23). U usporedbi s drugim terapijskim intervencijama, upravo je izlaganje među najmanje korištenim tehnikama među kliničarima (24).

Stavovi kliničara značajni su za prihvaćanje i učenje novih tehnika, kao i za njihovu primjenu u svakodnevnoj kliničkoj praksi (25). Čak i iskusni i vješti kliničari mogu izbjegavati preporučene intervencije zbog negativnih stavova i vjerovanja, ili pak etičkih dilema.

Istraživanja pokazuju da kliničari u prosjeku imaju umjereno negativna vjerovanja o terapiji izlaganjem, a čak i oni koji sami navode da je koriste nerijetko imaju o njoj negativna vjerovanja (26). Nužno izazivanje neugode kod pacijenata kroz terapiju izlaganjem kako bi se došlo do klinički značajnih promjena, može biti u kontradikciji s moralnim normama kliničara, primjerice da ne smiju štetiti pacijentu te da moraju ublažiti njegovu neugodu (27,28). Osim toga, terapeuti se boje da bi izlaganje moglo naštetiti klijentu i dovesti do kognitivne dekompenzacije (29), pojačanja simptoma (30) ili tjelesne štete (31). Neki terapeuti smatraju da je namjerno poticanje anksioznosti

Exposure therapy has also shown to be effective in the treatment of pre-school children, which is conducted with the help of parents (20). Although manuals for the treatment of anxiety in children (e.g. *Coping Cat* (21)) contain various other components (e.g. cognitive restructuring, relaxation), significant improvement is noticed only after introducing exposure (22). Clinical experience indicated a relatively high percentage of anxious patients who do not react to treatment (34-36%), as well as high treatment dropout rates (16-20%). The high percentage of patients who do not react to treatment and whose symptoms return is in accordance with inadequate accessibility of effective treatments in clinical practice, particularly in the case of treatments based on exposure. Despite the increase in the use of mental health services, the use of psychotherapeutic treatments has decreased in the past two decades, while the use of psychopharmaceuticals has increased (23). In comparison with other therapeutic interventions, exposure is among the least used techniques among clinicians (24).

The attitudes of clinicians are significant for the acceptance and learning of new techniques, as well as their application in everyday clinical practice (25). Even experienced and skilful clinicians sometimes avoid recommended interventions due to negative attitudes and beliefs or ethical dilemmas. Studies have shown that, on average, clinicians have moderately negative beliefs about exposure therapy, and even those who claim they use it often have negative beliefs about it (26). Necessary induction of anxiety in patients through exposure therapy with the aim of achieving clinically significant changes can be in contradiction with the moral norms of clinicians, for example those that proscribe that they must never cause harm to the patient and must decrease their discomfort (27,28). Moreover, therapists fear that exposure could harm the client and lead to cognitive decompensation (29), increase of symptoms (30), or bodily harm (31). Some therapists believe that intentional provocation of anxiety during exposure therapy

tijekom terapije izlaganjem u osnovi neetično (28), averzivno i neprihvatljivo za pacijente (32) te da povećava odustajanje od tretmana (33). S druge strane, istraživanja ne nalaze razlike u odustajanju od terapije izlaganjem od odustajanja od drugih bihevioralno-kognitivnih tretmana (34). Dio terapeuta brine o tome da bi izlaganje moglo i njima samima naštetiti vikarijskom traumatizacijom (32) ili sudskim tužbama pacijenata. Kao dodatni izvori subjektivnih prepreka u primjeni terapije izlaganjem navodi se i nelagoda ili anksiozna osjetljivost terapeuta tijekom izlaganja (35).

Negativna vjerovanja kliničara prepreka su u kompetentnoj primjeni terapije izlaganjem (27,32), usprkos tome što istraživanja potvrđuju da je ona učinkovita, sigurna, izdržljiva i nosi minimalne rizike kad se ispravno primjenjuje. Negativna očekivanja potiču terapeute koji se odluče na njezinu primjenu na pretjerani i nepotrebni oprez, kao što je izbor zadataka koji izazivaju manju anksioznost, prerano prekidanje izlaganja, toleriranje čestog korištenja sigurnosnih ponašanja i strategija za smanjenje anksioznosti, te izbjegavanje izlaganja klijenata najjače zastrašujućoj situaciji (26), što značajno smanjuje učinkovitost tretmana. Premda pacijenti izvještavaju o ekstremno rijetkim negativnim posljedicama interoceptivnog izlaganja (36), terapeuti nerijetko pretpostavljaju da produženo i intenzivno interoceptivno izlaganje paničnih pacijenata dovodi do dekompenzacije, gubitka svijesti, pojačanja simptoma i konačno odustajanja od tretmana zbog čega su skloni oprezu u primjeni ove tehnike i često koriste ograničeno interoceptivno izlaganje, uz korištenje kontroliranog disanja kao sigurnosnog ponašanja.

Prisutnost komorbidnog depresivnog poremećaja također se često smatra preprekom za uspješnu primjenu terapije izlaganjem (37). Premda se prisutnost komorbidnog psihotičnog poremećaja ranije smatrala glavnim kriterijem isključivanja za primjenu terapijskih

is inherently unethical (28), aversive and unacceptable for the patient (32), and that it increases treatment dropout (33). On the other hand, studies have found no differences in treatment dropout between exposure therapy and other behavioural-cognitive treatments (34). Some therapists believe that exposure could harm themselves through vicarious traumatisation (32) or the patients' legal actions. Additional sources of subjective obstacles for the use of exposure therapy include discomfort or anxiety sensibility of the therapist during exposure (35).

Clinicians' negative beliefs are an obstacle in competent application of exposure therapy (27,32) despite the fact that studies have shown that it is effective, safe, durable, and carries minimum risk when used correctly. Negative expectations encourage excessive and unnecessary caution in therapists who decide to use it, which means they choose a less anxiety provoking items for the exposure task, avoid exposing clients to the most frightening situations, tolerate frequent use of safety behaviours and strategies for anxiety reduction, and prematurely interrupt the exposure (26), which significantly reduces the effectiveness of treatment. Although patients report on extremely rare negative consequences of interoceptive exposure (36), therapists often assume that prolonged and intense interoceptive exposure of panick patients leads to decompensation, loss of consciousness, increase of symptoms, and finally treatment dropout, which is why they are likely to exercise caution in the application of this technique and often use limited interoceptive exposure with the use of controlled breathing as a safety behaviour.

The presence of a comorbid depressive disorder is often considered an obstacle for a successful application of exposure therapy (37). Although the presence of a comorbid psychotic disorder was earlier considered the main criterium of exclusion for the application of therapeutic interventions based on exposure, recent studies

intervencija zasnovanih na izlaganju, novije studije izvještavaju o učinkovitosti primjene izlaganja u tretmanu anksioznosti i kod pacijenata s psihozom (37).

Budući da negativna vjerovanja obeshrabruju terapeute u korištenju tehnike izlaganjem, pacijenti nerijetko ostaju zakinuti za učinkovit i brz tretman. Istražujući upotrebu terapije izlaganjem među terapeutima u Njemačkoj Böhm i sur. (38) došli su do zapanjujućih rezultata. Premda su gotovi svi terapeuti zahtijevali od osiguravajućeg društva pokriće za korištenje izlaganja u radu s pacijentima s opsesivno-kompulzivnim poremećajem, preko 80 % pacijenata je izvijestilo da tijekom tretmana nije korišten niti jedan oblik izlaganja. Isto tako, unatoč dokazima da učinkoviti tretmani za post-traumatski poremećaj uključuju produženo izlaganje, istraživanja ukazuju da samo 6-13 % veterana koji traže pomoć zbog PTSP-a dobivaju empirijski dokazane tretmane (39), najčešće zbog strahova terapeuta i pacijenata o mogućnosti toleriranja terapije izlaganjem. Kvalitativnom analizom intervjua s veteranima koji su sudjelovali u osam seansi izlaganja autori su utvrdili da, usprkos početnom pogoršanju simptoma, većina veterana navodi da je to bilo pozitivno i korisno iskustvo. Premda su neki htjeli ranije prekinuti tretman, većina navodi da je izlaganje značajno doprinijelo poboljšanju. Becker i sur. (29) nalaze da 83 % privatnih terapeuta nikad ne koristi izlaganje u imaginaciji, premda je to ključna komponenta produženog izlaganja u tretmanu osoba s PTSP-om. Zanimljivo je da, premda kliničari koji rade s pacijentima oboljelim od PTSP-a vjeruju da je terapija izlaganjem učinkovitija od suportivne psihoterapije, istovremeno izvještavaju da više vremena primjenjuju suportivnu psihoterapiju ili psihoedukaciju (40).

Najčešći razlozi za nedovoljno korištenje terapije izlaganjem u radu s djecom su produženo trajanje seanse, nedostatak treninga terapeuta, te zabrinutost u vezi reakcije roditelja (41).

report on the effectiveness of using exposure in the treatment of anxiety even in psychotic patients (37).

Since negative beliefs discourage therapists from using exposure therapy, patients are often deprived of effective and quick treatment. In their research of the use of exposure therapy among therapists in Germany, Böhm et al. (38) have found astonishing results. Although almost all therapists required an insurance cover from an insurance agency for the use of exposure in their work with patients with obsessive-compulsive disorder, over 80% of patients reported that not a single form of exposure was used during treatment. Also, despite evidence that effective treatment for post-traumatic stress disorder include prolonged exposure, studies have shown that only 6-13% of veterans seeking help for PTSD receive empirically proven treatments (39), most often due to the fears of therapists and patients regarding the possibility of tolerating exposure therapy. Qualitative analysis of interviews with veterans who participated in eight exposure sessions showed that, despite initial worsening of symptoms, most veterans claimed that it was a positive and useful experience. Although some of them wanted to stop the treatment prematurely, most claimed that exposure significantly contributed to their improvement. Becker et al. (29) found that 83% of private therapists never use exposure in imagination, even though this is a key component of prolonged exposure in the treatment of people with PTSD. It is interesting that clinicians who work with patients with PTSD believe that exposure therapy is more effective than supportive therapy, but also report that they spend more time on the use of supportive therapy or psychoeducation (40).

The most common reasons for insufficient use of exposure therapy with children are prolonged session duration, lack of therapist training, and concerns related to parent reac-

Primjena terapije izlaganjem u radu s djecom podrazumijeva poštivanje posebnih etičkih principa (42) s obzirom na osjetljivost populacije, činjenicu da se ne javljaju samostalno na tretman, kao i mogućnost da ne razumiju racionalu tretmana. Osim toga, primjena terapije izlaganja u radu s djecom u pravilu podrazumijeva rad s cijelom obitelji, a ponajprije roditeljima.

Negativna vjerovanja o terapiji izlaganjem mogu biti posebno izražena kod terapeuta početnika te interferirati s izvođenjem uspješnog tretmana. Tako su Farrell i sur. (43) utvrdili da su terapeuti početnici s negativnim vjerovanjima kreirali manje ambiciozne hijerarhije za izlaganje, birali zadatke koji potiču manju anksioznost, te na različite načine nastojali umanjiti anksioznost klijenata tijekom izlaganja što je sve moglo nepovoljno utjecati na terapijske ishode. Osim toga, negativna su vjerovanja bila povezana s izraženijom anksioznosti i kod samih terapeuta, kako za vrijeme pripreme, tako i tijekom samog izlaganja.

Cilj je ovog istraživanja ispitati vjerovanja terapeuta različitih terapijskih usmjerenja i različite razine terapijske edukacije o terapiji izlaganjem. Pretpostavlja se da će terapeuti s više iskustva u primjeni terapije izlaganjem i oni s više znanja imati o njoj pozitivnija vjerovanja.

tion (41). Use of exposure therapy the work with children assumes a respect for special ethical principles (42) with regard to population sensitivity, the fact that they do not come to treatment on their own, as well as the possibility that they do not understand the reasons for treatment. Moreover, the use of exposure therapy with children usually involves work with the entire family, primarily the parents.

Negative beliefs about exposure therapy can be especially pronounced in novice therapists and may interfere with conducting successful treatment. Farrell et al. (43) have found that beginner therapists with negative beliefs created less ambitious exposure hierarchies, selected tasks which provoke less anxiety, and attempted to decrease client anxiety in various ways during exposure, all of which had a negative effect on the results of therapy. Furthermore, negative beliefs were connected with more pronounced anxiety in the therapists themselves, both during preparation and exposure itself.

The aim of this study is to examine beliefs about exposure therapy about therapists from various therapeutic orientations and of different level of education. It is assumed that therapists with more experience with the use of exposure therapy and those with more knowledge about it will have more positive beliefs.

METODA

Sudionici

U istraživanju je sudjelovalo 226 stručnjaka (86,6 % žena) u dobi od 24 do 60 godina (M=35,24; SD=8.32) koji se bave psihoterapijskim radom ili su uključeni u edukaciju u okviru jedne od psihoterapijskih škola. Od toga ih 49,8 % ima manje od 3 godine staža u radu s klijentima. Uzorak čine dominantno psiholozi (78,5 %), nakon čega slijede psihijatri i specijalizanti psihijatrije (13,4 %), a preostalih 8 %

METHOD

Participants

The study included 226 experts (86.6% women) aged from 24 to 60 (M=35.24; SD=8.32) engaged in psychotherapeutic work or involved in education within the framework of one of the psychotherapeutic schools. 49.8% of the participants had less than three years of experience in working with clients. The sample consisted mostly of psychologists (78.5%), followed by psychiatrists and psychiatry specialist trainees

su liječnici drugih specijalnosti. U svom terapijskom radu 86.9 % ispitanika koristi bihevioralno-kognitivnu terapiju, dok su drugi psihoterapijski pravci manje zastupljeni (geštalt terapija 3,2 %, kibernetika 2,7 %, transakcijska analiza 1,8 %, EMDR 1,4 %, a svi ostali manje od 1 % ispitanika), zbog čega su grupirani u zajedničku kategoriju „ostalih pravaca". Nešto više od polovine ispitanika (njih 52,9 %) navodi da u svom terapijskom radu primjenjuje terapiju izlaganjem. U ukupnom uzorku (61,1 %) sudionika uključeno je u niže stupnjeve psihoterapijske edukacije, 27,4 % pohađa završni stupanj edukacije, dok su ostali (11,5 %) akreditirani terapeuti i edukatori/supervizori.

Mjerni instrument

Primijenjena je *Ljestvica vjerovanja terapeuta o izlaganju - SVTI* (*Therapist beliefs about exposure scale – TBES* (26)) koja je za potrebe ovog istraživanja prevedena na hrvatski jezik. U izradi prijevoda sudjelovala su 3 psihoterapeuta. Deacon i sur. konstruirali su ovu ljestvicu s ciljem procjene terapeutovih ograda u primjeni terapije izlaganjem, kao što je očekivanje da terapija izlaganjem može biti štetna za pacijenta, da je pacijent neće moći tolerirati, odnosno da je postupak neetičan (26). Ljestvica se sastoji od 21 čestice, a za svaku od njih ispitanici procjenjuju stupanj slaganja na ljestvici od 0 (uopće se ne slažem) do 4 (u potpunosti se slažem). Ukupni rezultat dobiva se zbrajanjem rezultata na pojedinim česticama pri čemu veći rezultat upućuje na negativnija vjerovanja terapeuta. Na ispitanom uzorku utvrđen je visok koeficijent unutrašnje pouzdanosti (*Cronbach Alpha*) koji iznosi .91.

Postupak

Istraživanje je uglavnom provedeno putem interneta, a ispunjavanje *online* upitnika trajalo je oko 10 minuta. Poziv za sudjelovanje u istraživanju objavljen je na internetskim stranicama

(13.4%), with the remaining 8% being physicians of other specialties. 86.9% of participants said they used behavioural-cognitive therapy in their work, while other psychotherapeutic schools were less represented (gestalt therapy 3.2%, cybernetics 2.7%, transaction analysis 1.8%, EMDR 1.4%, with the remaining ones being represented by less than 1% of the participants), due to which they were grouped under a common category of "other schools". A little over a half of the participants (52.9%) stated that they used exposure therapy in their work. In the total sample, 61.1% of participants was included in lower levels of psychotherapeutic education, with 27.4% attending the final level of education and the remaining 11.5% being accredited therapists and educators/supervisors.

Measurement tools

The Therapist beliefs about exposure scale (TBES) (26) was used and was translated into Croatian for the purposes of this research. Three psychotherapists worked on the translation. Deacon et al. constructed the scale with the aim of assessing therapist reservations regarding the use of exposure therapy, such as the expectation that exposure therapy can be harmful to the patients, that the patient will not be able to tolerate it, or that the procedure was unethical (26). The scale consists of 21 items, for each of which the participants estimate to what degree they agree with them, from 0 (Completely disagree) to 4 (Completely agree). The total score is obtained by summing up the results from all items, with a higher score indicating negative therapists' beliefs. The tested sample showed a high internal consistency (Cronbach alpha .91).

Procedure

The research was mainly conducted via the internet, and filling in the online questionnaire took approximately 10 minutes. The invitation

pojedinih psihoterapijskih škola te je proslijeđen putem e-pošte terapeutima i polaznicima različitih psihoterapijskih edukacija. Manji dio sudionika ispunio je papirnatu verziju upitnika. Provjereno je i potvrđeno je da nema značajnih razlika u rezultatima ispitanika s obzirom na način ispunjavanja upitnika.

REZULTATI

Prosječni relativni rezultat na Ljestvici vjerovanja terapeuta o terapiji izlaganjem na ukupnom uzorku iznosi 1,49, pri čemu se raspon rezultata kreće od ,14 do 3,62. Kako bi se utvrdilo postoje li razlike u vjerovanjima o terapiji izlaganjem između terapeuta različitih psihoterapijskih usmjerenja (bihevioralno-kognitivnog i drugih psihoterapijskih pravaca), te ovisno o tome primjenjuju li tehniku izlaganja u svojem radu ili ne, izračunati su t-testovi za nezavisne uzorke. Utvrđen je značajan efekt terapijskog usmjerenja. Bihevioralno-kognitivni terapeuti imaju pozitivniji stav prema terapiji izlaganjem od terapeuta drugih usmjerenja. Utvrđen je i snažan efekt primjene tehnike. Terapeuti koji u svojem radu primjenjuju terapiju izlaganjem imaju značajno pozitivniji stav prema njoj u odnosu na one koji je ne primjenjuju (tablica 1).

Kako bi se provjerio učinak razine psihoterapijske edukacije na stavove prema terapiji izlaganjem provedena je jednosmjerna analiza varijance (ANOVA). S obzirom da se istraživanju odazvao vrlo mali broj terapeuta drugih tera-

to participate in the research was published on the internet sites of psychotherapeutic schools and forwarded to therapists and trainees of various psychotherapeutic educations via e-mail. A smaller section of participants filled in a printed version of the questionnaire. It was tested and confirmed that there were no significant differences in the results regarding the form of the questionnaire.

RESULTS

The mean relative results on the Therapist beliefs about exposure scale of the total sample was 1.49, with the results ranging from .14 to 3.62. In order to establish whether there were differences in beliefs about exposure therapy between therapists of various psychotherapeutic schools (behavioural-cognitive and other psychotherapeutic schools) and depending on whether or not they use exposure therapy in their work, t-tests for independent samples were calculated. It was shown that the effect of therapeutic schools was significant. Behavioural-cognitive therapists have a more positive attitude to exposure therapy than therapists of other schools. Furthermore, a significant effect of the use of this technique was also found. Therapists who use exposure therapy in their work have a significantly more positive attitude toward it than those who do not use it (table 1).

In order to assess the effect of the level of psychotherapeutic education on the attitudes toward exposure therapy, a one-way analysis

TABLICA 1. Vjerovanja terapeuta o terapiji izlaganjem ovisno o psihoterapijskom usmjerenju i primjeni tehnike
TABLE 1. Therapist beliefs about exposure therapy depending on the psychotherapeutic school and use of the technique

		N	M	SD	raspon / range	t	Cohen d
Psihoterapijsko usmjerenje / Psychotherapeutic school	bihevioralno-kognitivno / behavioural-cognitive	186	1.43	.66	.14 – 3.14	3.43**	0.70
	druga usmjerenja / other schools	28	1.89	.62	.33 – 3.62		
Primjena tehnike izlaganjem / Use of exposure therapy	da / yes	113	1.19	.56	.14 – 2.67	7.70***	1.06
	ne / no	103	1.81	.61	.33 – 3.62		

** p < .01*** p < .001 / ** p < .01*** p < .001

TABLICA 2. Razlike u vjerovanjima bihevioralno-kognitivnih terapeuta o terapiji izlaganjem s obzirom na razinu edukacije
TABLE 2. Difference in the beliefs of behavioural-cognitive therapists about exposure therapy regarding to the level of education

	1 - niži stupnjevi edukacije (N=118) / 1 – lower levels of education (N=118)		2 - završni stupanj edukacije (N=54) / 2 – final level of education (N=54)		3 - akreditirani terapeuti (N=14) / 3 – accredited therapists (N=14)		ANOVA		
	M	SD	M	SD	M	SD	$F_{(2, 183)}$	η^2	Post-hoc (LSD)
SVTI	1.69	.64	1.06	.42	.74	.29	34.53***	.27	1>2,3

SVTI – rezultat na Ljestvici vjerovanja terapeuta o terapiji izlaganjem*** p < .001 / SVTI – score on the Therapist Beliefs about Exposure Scale*** p < .001

pijskih usmjerenja, analiza je provedena samo na uzorku bihevioralno-kognitivnih terapeuta koji su podijeljeni u tri skupine: 1. akreditirani terapeuti i supervizori, 2. terapeuti na završnom stupnju edukacije (supervizanti) i 3. terapeuti uključeni u niže stupnjeve edukacije. Rezultati upućuju na statistički značajnu razliku između pojedinih skupina. *Post-hoc* analizom (LSD test) utvrđeno je da terapeuti uključeni u niže stupnjeve edukacije imaju izraženija negativna vjerovanja od terapeuta u završnom stupnju edukacije i akreditiranih terapeuta.

RASPRAVA

Psihološki tretmani zasnovani na izlaganju sustavno pokazuju superiornu učinkovitost u usporedbi s drugim terapijskim intervencijama, što izlaganje čini ključnom komponentom bihevioralno-kognitivnih tretmana anksioznosti (11,44). Unatoč empirijskim dokazima o njezinoj efikasnosti, često se navode podaci o podzastupljenosti terapije izlaganjem u kliničkoj praksi. Osim nesklonosti samih pacijenata koji u pravilu izbjegavaju neugodne situacije, tome uvelike pridonose i negativni stavovi i predviđanja terapeuta. Ovim se istraživanjem željelo ispitati kakva vjerovanja o terapiji izlaganjem imaju hrvatski terapeuti različitih psihoterapijskih usmjerenja, te različitih iskustava i razine edukacije. Suprotno očekivanjima temeljenima na rezultatima drugih istraživanja ovdje dobiveni rezultati upućuju da ispitani terapeuti u pro-

of variance (ANOVA) was conducted. Since a very small number of therapists of other therapeutic schools responded to the research, the analysis was conducted only on the sample of behavioural-cognitive therapists divided into three groups: 1. accredited therapists and supervisors, 2. therapists attending the final level of education (supervisees), and 3. therapists involved in lower levels of education. The results indicate a statistically significant difference between individual groups. A post-hoc analysis (LSD test) showed that therapists involved in lower levels of education had more pronounced negative beliefs than therapists in the final level of education and accredited therapists.

DISCUSSION

Psychological treatments based on exposure continually show superior effectiveness in comparison with other therapeutic interventions, which makes exposure a key component of behavioural-cognitive treatments for anxiety (11,44). Despite empirical evidence of its effectiveness, data about underrepresentation of exposure therapy in clinical practice are often cited. Apart from the reluctance of the patients themselves, who usually avoid unpleasant situations, therapists' negative attitudes and predictions significantly contribute to this. The aim of this research was to examine the attitudes about exposure therapy among Croatian therapists of various psychotherapeutic schools and with different experience and levels of education. Despite expectations based on the results

sjeku nemaju izražen negativan stav prema terapiji izlaganjem (prosječna procjena 1,49 na ljestvici od 0 do 4). Moguće je da su se pozivu na sudjelovanje u ispitivanju odazvali oni terapeuti koji imaju pozitivniji stav prema ovoj terapiji, dok su se oni s izraženijim negativnim stavom i odbili izjašnjavati o njoj. Sličan prosječni rezultat dobivaju i autori ljestvice na većem uzorku psihoterapeuta različitih usmjerenja (26). Sadržajnom analizom odgovora uočava se da su terapeuti najviše zabrinuti o pacijentovom podnošenju neugode koju izlaganje izaziva (prosječna procjena na toj čestici iznosi 2.59). Osim toga smatraju da je tijekom izlaganja neophodno koristiti neku strategiju za smanjenje napetosti kao što su relaksacija ili kontrolirano disanje (prosječna procjena na toj čestici iznosi 3.22). Ovi su rezultati u skladu s iskustvima tijekom edukacije prema kojima su neiskusni terapeuti, vjerojatno zbog svojih negativnih vjerovanja, skloni poticanju i podržavanju pacijenata u korištenju različitih sigurnosnih ponašanja (u prvom redu relaksacijskih postupaka), kao i preranom prekidanju izlaganja.

Rezultati pokazuju da bihevioralno-kognitivni terapeuti imaju u prosjeku značajno pozitivnija vjerovanja o terapiji izlaganjem od terapeuta drugih psihoterapijskih usmjerenja. Utvrđeno je da samo 23,1 % bihevioralno-kognitivnih terapeuta ima donekle negativna vjerovanja (prosječna procjena po čestici veća od 2), pri čemu su svi na početnom stupnju edukacije, dok je među drugim terapeutima takvih desetak posto više (32,1 %). Ohrabrujuće je što terapeuti drugih usmjerenja nemaju u prosjeku izražena negativna vjerovanja prema terapiji izlaganjem (prosječna procjena od 1,89 na ljestvici od 0 do 4), što upućuje da nemaju izražene sumnje u učinkovitost terapije izlaganjem ili strahove u vezi mogućih negativnih posljedica njezine primjene pa se može pretpostaviti da će bolje prepoznati kada je terapija izlaganjem korisna za određenog pacijenta.

of other studies, the obtained results show that the therapists who participated in this study do not have, on average, a pronounced negative attitude to exposure therapy (with an average score of 1.49 on a scale from 0 to 4). It is possible that therapists with more positive attitudes to this type of therapy responded to the invitation to participate in this research, while those with more negative attitudes refused to express their opinions about it. A similar mean result was obtained by the authors of the scale on a larger sample of psychotherapists of various schools (26). Content analysis of answers shows that therapists were mostly concerned about the patient's experience of discomfort produced by exposure (with the average score for this item being 2.59). Also, they believe that it is necessary to use strategies for the reduction of tension during exposure, such as relaxation or controlled breathing (with the average score for this item being 3.22). These results are in accordance with experiences during education, according to which inexperienced therapists, probably due to their negative beliefs, are more prone to encourage and support the patient in using various safety behaviours (primarily relaxation techniques), as well as premature interruption of exposure.

The results show that behavioural-cognitive therapists have, on average, significantly more positive beliefs about exposure therapy than therapists from other psychotherapeutic schools. It was found that only 23.1% of behavioural-cognitive therapists have somewhat negative beliefs (average score per item greater than 2), all of whom were on the beginning level of education. Among therapists there are ten percent more of them with somewhat negative beliefs (32.1%). It is encouraging that therapists of other schools do not have, on average, pronounced negative beliefs about exposure therapy (average score of 1.89 on a scale from 0 to 4), which indicates that they do not have pronounced doubts in the effectiveness of exposure therapy or fears about possible negative

Premda je u ispitanom uzorku gotovo polovica mlađih terapeuta s iskustvom kraćim od 3 godine i utvrđena je značajna negativna povezanost izraženosti negativnih vjerovanja s radnim iskustvom terapeuta (r=.30), posebno nas je zanimalo postoji li razlika u vjerovanjima između onih terapeuta koji u svojoj kliničkoj praksi primjenjuju terapiju izlaganjem i onih koji ju ne primjenjuju. Dobiveni rezultati upućuju na značajan efekt iskustva u primjeni terapije izlaganjem na stavove prema njoj. Terapeuti koji je koriste u svojem radu imaju o njoj i značajno pozitivnija vjerovanja od onih koji je ne koriste. Moguće je da su pozitivna iskustva u primjeni izlaganja umanjila početne strahove i nesigurnost terapeuta, što je u skladu s nalazima Eftekharija i suradnika (45) da iskustva uspjeha potkrepljuju namjeru za daljnje korištenje ove tehnike. Značajan efekt pozitivnog iskustva u primjeni nalaze i Hundt i suradnici (39) koji su utvrdili da bihevioralno-kognitivni terapeuti mlađe dobi i s manje iskustva, ali koji češće provode tretman pacijenata s PTSP-jem češće biraju empirijski dokazane tretmane kao što je terapija izlaganjem. Autori zaključuju da bolje poznavanje protokola i veće povjerenje terapeuta u vlastite kompetencije povećava njegovu spremnost da preporuči i primijeni terapiju izlaganjem.

Analiza učinaka razine edukacije na vjerovanja o terapiji izlaganjem samo u skupini bihevioralno-kognitivnih terapeuta pokazuje da supervizanti i akreditirani terapeuti imaju pozitivnija vjerovanja od onih na nižim razinama edukacije. Pri tome svi akreditirani terapeuti koriste terapiju izlaganjem, gotovo svi supervizanti (92,7 %), ali samo 37,5 % onih koji su na nižem stupnju edukacije. Ovi su podatci ohrabrujući s obzirom na brojne nalaze o rijetkom korištenju izlaganja čak i među bihevioralno-kognitivnim terapeutima (46). Premda se navodi da je to najčešće zanemarena terapijska strategija u rutinskoj kliničkoj praksi (47), čini se da je

consequences of its application, which means that it is possible to assume that they will be able to recognize situations when exposure therapy is beneficial for the patient.

Although younger therapists with less than three years of experience make up almost half of the sample of participants and although a significantly negative correlation between pronounced negative beliefs and therapist work experience was found (r=.30), it was of particular interest to discover whether there was any difference in beliefs between therapists who use exposure therapy in their clinical practice and those who do not. The obtained results indicate a significant effect of experience with using exposure therapy on attitudes toward it. Therapists who use it in their work also have significantly more positive beliefs about it than those who do not use it. It is possible that positive experiences with using exposure reduced initial therapist fears and insecurities, which is in accordance with the findings of Eftekhari et al. (45), who found that experiences of success encourage further use of this technique. A significant effect of positive experience of application was also found by Hundt et al. (39), who ascertained that behavioural-cognitive therapists who are younger and have less experience but frequently treat patients with PTSD are more likely to choose empirically proven treatments such as exposure therapy. The authors conclude that greater knowledge of protocol and more confidence in the therapist's own competences increase their readiness to recommend and use exposure therapy.

Analysis of the effect of the education level on the beliefs about exposure therapy in the group of only behavioural-cognitive therapists shows that supervisees and accredited therapists have more positive beliefs than those on lower levels of education. All of the accredited therapists use exposure therapy, as do almost all supervisees (92.7%), but only 37.5% of those on lower levels of education. This data is encouraging with regard to numerous findings about infrequent use

većina ispitanih educiranih terapeuta koristi, premda ne raspolažemo podatcima na temelju kojih možemo tvrditi da to čine redovito kada za to postoji indikacija.

Dobiveni rezultati o značajnom učinku znanja o terapiji izlaganjem u skladu su s očekivanjima i mogu se objasniti u okviru kognitivnog modela. Terapeuti koji imaju više znanja o učinkovitosti i o načinu primjene terapije izlaganjem imaju pozitivnija vjerovanja o njoj. Oni predviđaju da može biti korisna za pacijente s anksioznim problemima, što će ih vjerojatnije ohrabriti za njezino korištenje, a nova pozitivna iskustva u primjeni dodatno će ojačati pozitivna vjerovanja i očekivanja, te potkrijepiti daljnju primjenu.

Suprotno njima, terapeuti s nedovoljno znanja i iskustva imaju negativnija predviđanja o mogućim posljedicama, zbog čega su manje skloni korištenju terapije izlaganjem u radu s pacijentima. Izbjegavanjem njezine primjene nisu potaknuti na učenje o samoj tehnici i ne dovode se u prigodu za stjecanje pozitivnih iskustava. Time se dodatno podržavaju negativna vjerovanja te se onemogućuje njihova eventualna promjena. U prilog tome idu i rezultati Whiteside i sur. (48) koji su istraživali primjenu terapije izlaganjem i drugih terapijskih tehnika u radu s anksioznom djecom. Autori nalaze da je terapija izlaganjem bila rijetko korištena u kliničkom radu terapeuta, iako ih je većina izjavila da su BKT orijentacije i da koriste BKT tehnike u svom radu. Ipak, utvrđeno je da terapeuti s više terapijske edukacije i oni s pozitivnijim stavovima češće koriste izlaganje, što upućuje na potrebu za dodatnom edukacijom, kao i korekcijom nefunkcionalnih vjerovanja terapeuta.

Nekoliko je istraživanja pokazalo korisnost specifične edukacije o primjeni terapije izlaganjem. Farrell i sur. (49) nalaze da „pojačani" trening koji uključuje promjenu stavova temeljenu na socijalno-kognitivnoj teoriji daje bolje

of exposure, even among behavioural-cognitive therapists (46). Although it is said to be the most frequently neglected therapeutic strategy in routine clinical practice (47), it seems that it is used by most educated therapists who participated in the research, although we do not have data that would allow us to claim that they do so regularly when there is indication for it.

The obtained results regarding the significant effect of knowledge about exposure therapy are in accordance with expectations and can be explained in the framework of the cognitive model. Therapists who have more knowledge about the effectiveness and use of exposure therapy have more positive beliefs about it. They assume that it can be useful for patients with anxiety issues, which probably encourages them to use it, while new positive experiences of its application additionally strengthen their positive beliefs and expectations and support its further use.

On the other hand, therapists with insufficient knowledge and experience have more negative predictions about possible consequences, which is why they are less likely to use exposure therapy in their work with patients. By avoiding its use, they are not encouraged to learn about the technique itself and do not put themselves in situations in which they can obtain positive experiences. This further supports negative beliefs and prevents the possibility for their change. This is supported by the results found by Whiteside et al. (48), who investigared the use of exposure therapy and other therapeutic techniques in the work with anxious children. The authors found the therapists rarely used exposure therapy in their clinical work, although most of them declared themselves as behavioural-cognitive therapists. However, it was found that therapists with more education in therapy and those with more positive attitudes use exposure more frequently, which indicates the need for additional education, as well as correction of non-functional therapist beliefs.

rezultate od standardnog treninga u bihevioralno-kognitivnoj terapiji. Terapeuti koji su bili uključeni u pojačani trening su nakon njega bili značajno manje zabrinuti zbog izlaganja i više su ga koristili u radu s pacijentima.

Primjena intenzivnog interaktivnog treninga s ciljem usvajanja adekvatnih vjerovanja i namjera kliničara za primjenu terapije izlaganjem pokazuje pozitivne učinke na percepciju značenja primjene ove tehnike za pomaganje pacijentima u prevladavanju simptoma, na procjenu korisnosti za pacijente te na procjenu samoefikasnosti u primjeni tehnike (50). Sudjelovanje u navedenom treningu smanjilo je zabrinutost terapeuta da bi izlaganje moglo izazvati neugodu kod pacijenta, kao i predviđanja mogućih negativnih ishoda.

Premda nema jasnih smjernica za specifičan trening terapeuta sa ciljem povećanja korištenja terapije izlaganjem, Farrell i sur. (43) predlažu da se u procesu promjene negativnih stavova koriste tehnike temeljene na nalazima istraživanja iz područja socijalne i kognitivne psihologije, a u prvom redu spoznaje iz dvoprocesnog modela u zaključivanju, potreba za spoznajom i afektom te inokulacija stava. Harned i sur. (35) smatraju da bi dodavanje motivacijskih strategija moglo značajno povećati učinkovitost uobičajenih treninga za prevladavanje subjektivnih prepreka terapeuta.

Provedeno istraživanje ima i određena ograničenja. Ponajprije, provedeno je na prigodnom uzorku terapeuta u kojem dominiraju oni bihevioralno-kognitivne orijentacije, dok su terapeuti ostalih psihoterapijskih usmjerenja zastupljeni u znatno manjoj mjeri zbog slabijeg odaziva na sudjelovanje u istraživanju, što svakako otežava generalizaciju rezultata. Nadalje, u ispitivanje nisu uključene mjere nekih crta ličnosti terapeuta za koje se pretpostavlja da bi mogle biti povezane s primjenom terapije izlaganjem. Primjerice, Meyer i sur. (51) nalaze da vjerojatnost izbjegavanja korištenja

Several studies have shown the advantages of education about the use of exposure therapy. Farrell et al. (49) found that enhanced training which includes a change of attitudes based on social-cognitive theory provides better results than standard training for behavioural-cognitive therapy. Therapists who were involved in enhanced training were significantly less concerned about exposure afterwards and used it more often in their work with patients.

The use of intensive interactive training with the aim of adopting adequate beliefs and intentions for the application of exposure therapy shows positive effects on the perception of the significance of using this technique for helping patients overcome symptoms, the assessment of its usefulness for patients, and the assessment of self-efficacy in the application of the technique (50). Participation in this training reduced the therapists' concerns that exposure could provoke discomfort in the patient, as well as predictions of possible negative outcomes.

Although there are no clear guidelines for specific therapist training with the aim of increasing the use of exposure therapy, Farrell et al. (43) suggest that techniques based on findings of studies from the field of social and cognitive psychology should be used in the process of altering negative attitudes, primarily the findings from a dual processing in reasoning, the need for cognition, and attitude inoculation. Harned et al. (35) believe that adding motivational strategies could significantly increase the effectiveness of usual training methods for overcoming therapists' subjective obstacles.

This research also had certain limitations. First of all, it was conducted on a convenience sample of therapists dominated by those of behavioural-cognitive orientation, while therapists of other psychotherapeutic schools were much less represented due to a poor response to research participation, which certainly makes result generalization difficult. Furthermore, the research did not include measurements of certain

terapije izlaganjem ovisi o nekim kakteristikama pacijenta i terapeuta. Utvrdili su da terapiju izlaganjem češće izbjegavaju terapeuti s jače izraženom anksioznom osjetljivosti i oni s negativnim vjerovanjima o primjeni te terapije. Veća je vjerojatnost da terapiju izlaganjem neće koristiti s pacijentima koji su emocionalno osjetljiviji, koji sami pokazuju nespremnost za sudjelovanje u izlaganju te oni koji imaju komorbidne psihotične smetnje. Buduća bi se istraživanja mogla usmjeriti na ispitivanje nekih karakteristika terapeuta (npr. anksioznost kao crta ličnosti, anksiozna osjetljivost i sl.) što bi moglo pomoći u izboru kandidata za uključivanje u specifične psihoterapijske edukacije, kao i u izradu edukativnih programa.

Unatoč navedenim nedostatcima dobiveni su rezultati u skladu s očekivanjima i s nalazima ostalih autora te imaju korisne praktične implikacije. Značajan učinak razine edukacije i iskustva u primjeni na vjerovanja o terapiji izlaganjem upućuje na potrebu bolje informiranosti svih terapeuta o značaju i učinkovitosti ove terapije. Više autora ističe kako je edukacija terapeuta za kompetentnu primjenu terapije izlaganjem zdravstveni prioritet (52,53), jer bi se na taj način povećala dostupnost efikasnog tretmana pacijentima s anksioznim poremećajima. Negativni stavovi i nedostatak znanja terapeuta smatraju se primarnom preprekom za širu primjenu terapije izlaganjem (54). Poseban je problem što su takva negativna vjerovanja dosta stabilna i opstaju unatoč tome što nisu potkrijepljena nalazima istraživanja (55), te unatoč tome da čak i sami pacijenti često preferiraju ovaj oblik tretmana.

Američko psihologijsko udruženje ističe tri bitna izvora za donošenje odluke o izboru tretmana u kliničkoj praksi zasnovanoj na dokazima („*evidence-based practice*“), a to su poznavanje tretmana koji su dokazano učinkoviti, stručnost kliničara za njihovu primjenu, te prefe-

personality traits of therapists which could be correlated with the use of exposure therapy. For example, Meyer et al. (51) found that the probability of avoiding exposure therapy depends on certain characteristics of the patient and the therapist. They established that exposure therapy was more frequently avoided by therapists with more pronounced anxiety sensitivity and those with negative beliefs about the application of exposure therapy. It is more likely that they will not use exposure therapy with those patients who are emotionally more sensitive, those who show reluctance towards participating in exposure, and those who have comorbid psychotic disturbances. Future studies could focus on exploring certain therapist characteristics (e.g. anxiety as a personality trait, anxiety sensitivity, etc.), which could help in selection of candidates for specific psychotherapy training, as well as the creation of education programs. Despite these shortcomings, the obtained results were in accordance with expectations and the findings of other authors, and have useful practical implications. A significant effect of the level of education and experience with the use of exposure therapy on the beliefs about it indicate the need for greater awareness of all therapists about the significance and effectiveness of this form of therapy. Several authors point out that therapist education for competent application of exposure therapy is a health priority (52,53) because it could increase the availability of effective treatment for patients with anxiety disorders. Negative attitudes and lack of therapist knowledge are considered to be the primary obstacles in a wider use of exposure therapy (54). It is especially problematic that such negative beliefs are fairly stable and persist despite not being supported by research findings (55) and despite the fact that patients themselves often prefer this type of treatment.

The American Psychological Association emphasises three important sources for decision-making in the choice of treatment in evidence-based practice knowledge of evidence-based treatment with evidence of effectiveness, therapist

rencije i vrijednosti klijenata (56,57). Zbog toga je u okviru edukacije iz bihevioralno-kognitivne terapije nužno provjeravati i ispravljati moguća iskrivljena vjerovanja o primjeni terapije izlaganjem koja mogu biti prepreka u odluci o njezinom korištenju, u motiviranju pacijenata na aktivnu suradnju, kao i u njezinoj pravilnoj primjeni. Koliko nam je poznato, navedena ljestvica prvi je puta primijenjena s terapeutima u Hrvatskoj, te je pokazala visoku pouzdanost. Nadamo se da će biti dobro polazište za provjeru eventualnih pogrešnih vjerovanja terapeuta čije korigiranje može dugoročno dovesti do povećanja upotrebe ove učinkovite terapije.

expertise in its application, and client preferences and values (56,57). Therefore, as part of education in behavioural-cognitive therapy, it is important to evaluate and correct possible distorted beliefs about the application of exposure therapy which could be an obstacle to its implementation and competent delivery, as well as to motivating patients for active participation. According to our knowledge, this scale was used for the first time with therapists in Croatia and has shown a high level of reliability. We hope that it will serve as a good basis for the evaluation of misguided therapist beliefs, the correction of which may in the long term lead to the increase in the use of this effective therapy.

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1. konferencija Europskog udruženja za kliničku psihologiju i psihološke tretmane (EACLIPT)

/ The First Conference of the European Association of Clinical Psychology and Psychological Treatment – EACLIPT

„Nema zdravlja bez psihičkog zdravlja: europska klinička psihologija preuzima odgovornost"
/ "There is no health without mental health: European clinical psychology takes responsibility"
Dresden, Njemačka, 31. listopad – 2. studeni 2019.
/ Dresden, Germany, 31 October – 2 November, 2019

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2019.543

U Amsterdamu 2017. godine, na Europskom kongresu psihologije, osnovano je Europsko udruženje za kliničku psihologiju i psihološke tretmane (*The European Association of Clinical Psychology and Psychological Treatment* – EACLIPT). Klinički psiholozi iz različitih dijelova Europe osjetili su potrebu udruživanja i promicanja kliničke psihologije kao primjene znanstvene discipline. Jedan od poticaja je svakako bio rastući broj psihičkih smetnji u svim dobnim skupinama, koji se događa posljednjih desetljeća. Klinička psihologija je razvila čitav niz teorijskih modela, dijagnostičkih instrumenata i tretmanskih pristupa psihičkim smetnjama. EACLIPT je osnovan 2017. godine u okviru Europske federacije društava psihologa (*European Federation of Psychologists' Associations* – EFPA) s ciljem poticanja istraživanja, obrazovanja i širenja znanstveno evaluiranih nalaza o:

- dijagnostici i klasifikaciji psihičkih poremećaja
- biopsihosocijalnim mehanizmima zdravlja i bolesti
- psihološkim tretmanima i psihoterapijama
- prevenciji i rehabilitaciji psihičkog zdravlja
- primjeni psiholoških tretmana koji su znanstveno utemeljeni.

In Amsterdam in 2017, at the European Congress of Psychology, the *European Association of Clinical Psychology and Psychological Treatment* (EACLIPT) was founded. Clinical psychologists from various parts of Europe felt the need to unite and promote clinical psychology as an applied scientific discipline. One incentive was certainly the growing number of psychological disorders in all age groups over the previous several decades. Clinical psychology has developed a range of theoretical models, diagnostic instruments, and types of treatment for psychological disorders. EACLIPT was founded in 2017 within the framework of the *European Federation of Psychologists' Associations* (EFPA) to encourage research, education, and dissemination of scientifically evaluated findings on:

- diagnostics and classification of psychological disorders
- biopsychosocial mechanisms of health and illness
- psychological treatments and psychotherapies
- prevention and rehabilitation of psychological health
- application of scientifically based psychological treatments

EACLIPT je u svoje dvije godine postojanja ostvario nekoliko važnih ciljeva. Članstvo se približava broju 1000, članovi su iz svih europskih zemalja, ali i onih izvan Europe. Učlanjenje je još uvijek besplatno. Osnovana je mreža nacionalnih predstavnika čiji je osnovni zadatak širenje informacija o EACLIPT-u i međusobna koordinacija različitih stručnih i strukovnih pitanja. Autorica ovog teksta je nacionalna predstavnica Hrvatske. Jedan od prvih uspješno obavljenih zadataka bila je izrada kompetencija kliničkih psihologa, koje se objavljene u proljeće 2019. godine i mogu se pronaći na poveznici: https://cpe.psychopen.eu/article/35551/.

Osim toga, u siječnju 2019. pokrenut je časopis *Clinical Psychologyin Europe: The Official Journal of the European Association of Clinical Psychology and Psychological Treatment*. Časopis nudi otvoren pristup, izlazi kvartalno, a važno je znati da su prijava, obrada i objavljivanje članaka potpuno besplatni. Više informacija se može naći na: https://CPE.PsychOpen.eu. Cilj koji je uredništvo postavilo je učiniti ga vodećim europskim časopisom iz kliničke psihologije, a kvaliteta do sada objavljenih članaka, te entuzijazam urednika stvaraju sve uvjete da se ovaj cilj vrlo brzo i ostvari.

U Dresdenu je od 31. listopada do 2. studenog 2019. godine održana 1. EACLIPT konferencija. Tema konferencije *„Nema zdravlja bez psihičkog zdravlja – europska klinička psihologija preuzima odgovornost"* oslikala je potrebu premještanja psihičkog zdravlja u društveni fokus. Na konferenciji je sudjelovalo više od 500 kliničkih psihologa i ostalih stručnjaka za psihičko zdravlje iz preko 30 zemalja. Konferenciju su obilježila zanimljiva predavanja eminentnih pozvanih predavača: Claudi Bockting i Susan Bögels (Sveučilište u Amsterdamu), David Clark (Sveučilište u Oxfordu), Stefan Hofmann (Sveučilište u Bostonu) i Maria Karekla (Ciparsko sveučilište), koja su potaknula rasprave o etiološkim i tretmanskim modelima za različite psihičke smetnje u cjeloživotnoj perspektivi. Tema koja

In its two years of existence, EACLIPT has achieved several important goals. There are near one thousand members from all European countries, as well as from countries outside Europe. Membership is still free. A network of national representatives whose main task is disseminating information on EACLIPT and mutual coordination regarding various issues related to the profession has been formed. The author of this text is the national representative for Croatia. One of the first successfully completed tasks was the creation of competences of clinical psychologists, published in the spring of 2019 and available at the following link: https://cpe.psychopen.eu/article/35551/. Also, in January 2019, the *Clinical Psychology in Europe: The Official Journal of the European Association of Clinical Psychology and Psychological Treatment* was launched. The journal is open access, published quarterly, and it is important to emphasize that submission, processing, and publication of articles are entirely free of charge. More information is available at: https://CPE.PsychOpen.eu. The editorial board want to make it the leading European journal on clinical psychology, and the quality of published articles and the enthusiasm of the editor provide all the preconditions for the achievement of this goal.

From October 31st to November 2nd 2019, the first EACLIPT conference was held in Dresden. The topic of the conference, *"There is no health without mental health: European clinical psychology takes responsibility"*, showed the need for bringing mental health into the focus of society. Over 500 clinical psychologists and other experts for mental health from over 30 countries participated in the conference. The conference was marked by interesting presentations held by eminent invited lecturers, Claudi Bockting and Susan Bögels (University of Amsterdam), David Clark (Oxford University), Stefan Hofmann (Boston University), and Maria Karekla (University of Cyprus), which inspired

se posebno isticala, a vjerujemo da će biti sve više u središtu stručne pozornosti, jest primjena digitalnih tehnologija u tretmanu psihičkih poremećaja.

Na konferenciji u Dresdenu je dogovoreno da će se od 2021. godine konferencije održavati jednom godišnje.

EACLIPT je mlado i dinamično udruženje koje okuplja vrhunske znanstvenike i stručnjake koji se bave psihičkim zdravljem. Nastavi li se razvijati ovom dinamikom nesumnjivo će postati jedno od utjecajnih udruženja u vibrantnom području kliničke psihologije. Stoga je vrijedno biti članom ovog udruženja, u koje se mogu učlaniti psiholozi, ali i drugi srodni stručnjaci, prije svega psihijatri.

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discussions on etiological and treatment models for various psychological disorders from a lifelong perspective. One topic which was especially highlighted, and one which should receive increasing attention from experts, was the application of digital technologies in the treatment of psychological disorders.

At the conference in Dresden, it was decided that from 2021 conferences would be held once per year.

EACLIPT is a young, dynamic association which gathers top scientists and experts who work in the field of mental health. If it continues to develop at this rate, it will undoubtedly become one of the most influential associations in the vibrant field of clinical psychology. Therefore, it is valuable being a member of this association, one which can be joined not only by psychologists but also related experts, primarily psychiatrists.

Prof. Nataša Jokić-Begić, PhD
National representative for Croatia at EACLIPT
Department of Psychology, Faculty of Humanities and Social Sciences, Zagreb, Croatia

Kongresi u 2020. godini
/ Congresses in 2020

12th World Congress on Alzheimer's Disease & Dementia
Bangkok, 23. – 24. siječnja 2020.

22nd Congress of the European Society for Sexual Medicine
Prag, 23. – 25. siječnja 2020.

7th International Conference on Depression, Anxiety and Stress Management
Barcelona, 24. – 25. siječnja 2020.

American Psychoanalytic Association National Meeting
New York, 11. – 16. veljače 2020.

13. tjedan psihologije u Hrvatskoj
17. – 23. veljače 2020.

57th American College of Psychiatrists Annual Meeting
Fort Lauderdale, 19. – 23. veljače 2020.

2nd European Autism Congress
Budimpešta, 28. – 29. veljače 2020.

9th European Conference on Clinical Neuroimaging
Pariz, 2. – 3. ožujka 2020.

33rd Annual General Meeting of British NeuroPsychiatry Association
London, 5. – 6. ožujka 2020.

ECNP Workshop for Early Career Scientists in Europe
Nica, 5. – 8. ožujka 2020.

ECNP New Frontiers in Digital Health Meeting
Nica, 8. – 10. ožujka 2020.

8th International Conference on Mental Health and Human Resilience
Rim, 9. – 10. ožujka 2020.

31st Annual Meeting American Neuropsychiatric Association
Philadelphia, 18. – 21. ožujka 2020.

3rd International Congress on Evidence Based Mental Health: From Research to Clinical Practice
Ioannina, 18. – 22. ožujka 2020.

40th Annual Anxiety and Depression Conference
San Antonio, 19. – 22. ožujka 2020.

ECNP School of Child and Adolescent Neuropsychopharmacology
Venecija, 22. – 27. ožujka 2020.

16. hrvatski psihijatrijski dani
Opatija, 23. – 25. ožujka 2020.

7th International Conference of Non-Invasive Brain Stimulation
Baden-Baden, 24. – 26. ožujka 2020.

14th International Conference on Psychotherapy and Counseling
Pariz, 26. – 27. ožujka 2020.

28th European Congress of Psychiatry
Madrid, 28. – 31. ožujka 2020.

22nd International Neuroscience Winter Conference
Sölden, 29. ožujka – 2. travnja 2020.

Congress of the Schizophrenia International Research Society
Firenca, 4. – 8. travnja 2020.

6. hrvatsko-ruski psihijatrijski kongres
Opatija, 16. – 18. travnja 2020.

3rd International Conference on Addiction & Psychiatry
Amsterdam, 23. – 24. travnja 2020.

3rd International Conference on Psychiatry and Psychological Disorders
Berlin, 23. – 24. travnja 2020.

64th American Academy of Psychoanalysis and Dynamic Psychiatry Annual Meeting
Philadelphia, 23. – 25. travnja 2020.

173rd Annual Meeting of the American Psychiatric Association
Philadelphia, 25. – 29. travnja 2020.

2nd World Depression Congress
Istanbul, 27. – 28. travnja 2020.

13rd Organization for the Study of Sex Differences Annual Meeting
Marina del Rey, 4. – 7. svibnja 2020.

IX. hrvatski kongres o psihofarmakoterapiji
Zagreb, 12. – 15. svibnja 2020.

29th Danubian Psychiatric Symposium: Psychiatry, Medicine and Society
Zagreb, 13. – 15. svibnja 2020.

27th International Symposium on Controversies in Psychiatry
Barcelona, 14. – 16. svibnja 2020.

27th Annual International „Stress and Behavior“ Neuroscience and Biopsychiatry Conference
St. Petersburg, 16. – 19. svibnja 2020.

35th International Conference on Psychiatry and Mental Health
Osaka, 18. – 19. svibnja 2020.

Dubrovnik Summer School of Psychotraumatology
Dubrovnik, 25. – 28. svibnja 2020.

XXII. dani psihologije
Zadar, 28. – 30. svibnja 2020.

60th International Neuropsychiatric Congress
Pula, 28. – 31. svibnja 2020.

Current Psychiatry, American Academy of Clinical Psychiatrists
Washington, 5. – 6. lipnja 2020.

International Conference of Eating Disorders
Sydney, 11. – 13. lipnja 2020.

10th International Congress of Cognitive Psychotherapy
Rim, 18. – 21. lipnja 2020.

22nd Annual Conference of the International Society for Bipolar Disorders
Chicago, 18. – 21. lipnja 2020.

109th American Psychoanalytic Association Annual Meeting
Chicago, 19. – 21. lipnja 2020.

CINP World Congress
Taipei, 25. – 28. lipnja 2020.

ECNP School of Neuropsychopharmacology
Oxford, 28. lipnja – 2. srpnja 2020.

The Royal College of Psychiatrists International Congress
Edinburgh, 29. lipnja – 2. srpnja 2020.

International Conference on CBT for Children and Adolescents
Zagreb, 9. – 11. srpnja 2020.

41st STAR Conference
Haifa, 13. – 16. srpnja 2020.

32nd International Congress of Psychology
Prag, 19. – 24. srpnja 2020.

128th Annual Convention of the American Psychological Association
Washington, 6. – 9. kolovoza 2020.

50th Annual Congress of the European Association for Behavioural and Cognitive Therapies
Atena, 2. – 5. rujna 2020.

2nd International Conference on Trauma & Mental Health
Jeruzalem, 6. – 8. rujna 2020.

33rd ECNP Congress
Beč, 12. – 15. rujna 2020.

12th International Conference on Early Intervention in Mental Health
Rio de Janeiro, 20. – 23. rujna 2020.

Hrvatski kongres o Alzheimerovoj bolesti
Supetar, 14. – 17. listopada 2020.

20th WPA World Congress of Psychiatry
Bangkok, 14. – 17. listopada 2020.

2nd Global Conference on Addiction Medicine, Behavioral Health and Psychiatry
Orlando, 22. – 24. listopada 2020.

Neuroscience Annual Meeting
Washington, 24. – 28. listopada 2020.

28. godišnja konferencija hrvatskih psihologa
Šibenik, 11. – 14. studenog 2020.

36th International Society for Traumatic Stress Studies Annual Meeting
Atlanta, 5. – 7. studenog 2020.

PREDMETNO I AUTORSKO KAZALO ZA VOLUMEN 47/2019.

PREDMETNO KAZALO

AUTORSKO KAZALO

Upute autorima

O časopisu

Socijalna psihijatrija je recenzirani časopis koji je namijenjen objavljivanju radova iz područja socijalne psihijatrije, ali i iz kliničke psihijatrije i psihologije, biologijske psihijatrije, psihoterapije, forenzičke psihijatrije, ratne psihijatrije, alkohologije i drugih ovisnosti, zaštite mentalnog zdravlja osoba s intelektualnim teškoćama i razvojnim poremećajima, epidemiologije, deontologije, organizacije psihijatrijske službe. Praktički nema područja psihijatrije iz kojeg do sada nije objavljen pregledni ili stručni rad.

Svi radovi trebaju biti pisani na hrvatskom i engleskom jeziku.

Svi zaprimljeni radovi prolaze kroz isti proces recenzije pod uvjetom da zadovoljavaju i prate kriterije opisane u Uputama za autore i ne izlaze iz okvira rada časopisa.

Uredništvo ne preuzima odgovornost za gledišta u radu - to ostaje isključivom odgovornošću autora.

Časopis objavljuje sljedeće vrste članaka: uvodnike, izvorne znanstvene, stručne i pregledne radove, prikaze bolesnika, lijekova i metoda, kratka priopćenja, osvrte, novosti, prikaze knjiga, pisma uredništvu i druge priloge iz područja socijalne psihijatrije i srodnih struka.

Iznimno Uredništvo časopisa može prihvatiti i drugu vrstu rada (prigodni rad, rad iz povijesti struke i sl.), ako ga ocijeni korisnim za čitateljstvo.

Tijekom cijelog redakcijskog postupka, *Socijalna psihijatrija* slijedi sve smjernice Odbora za etiku objavljivanja (*Committee of publication ethics* – COPE), detaljnjije na: https://publicationethics.org/files/Code%20of%20Conduct_2.pdf, kao i preporuke ponašanja, izvještavanja, uređivanja i objavljivanja znanstvenih radova u časopisima medicinske tematike kojeje objavio Međunarodni odbor urednika medicinskih časopisa (*International Committee of Medical Journal Editors* – ICMJE), detaljnije na: http://www.icmje.org/journals-following-the-icmje-recommendations/.

Urednici časopisa *Socijalna psihijatrija* također su obvezni osigurati integritet i promicati inovativne izvore podataka temeljenih na dokazima, kako bi održali kvalitetu i osigurali utjecaj objavljenih radova u časopisu, a sukladno načelima iznesenim u Sarajevskoj deklaraciji o integritetu i vidljivosti (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5209927/).

Uredništvo

Svaki rad zaprimljen u Uredništvu časopisa *Socijalna psihijatrija* pregledava glavni urednik. Ako rad ne zadovoljava kriterije opisane u Uputama za autore, glavni urednik časopisa rad vraća autoru. Radovi koji zadovoljavaju uvjete bit će upućeni na recenziju.

Recenzija

Radovi koji su pisani prema Uputama za autore, šalju se na recenziju.

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Instructions to authors

Aim & Scope

Socijalna psihijatrija is a peer-reviewed journal intended for publication of manuscripts from the fields of social psychiatry, clinical psychiatry and psychology, biopsychology, psychotherapy, forensic psychiatry, war psychiatry, alcoholism and other addictions, mental health protection among persons with intellectual and developing disabilities, epidemiology, deontology and psychiatric service organisations.

All manuscripts must be written in the Croatian and English language.

All manuscripts undergo the same review process if they follow the scope of the Journal and fulfil the conditions according to the Author guidelines.

The Editorial board will not take the responsibility for the viewpoint of the Author's manuscript – it remains the exclusive responsibility of an Author.

Socijalna psihijatrija publishes the following types of articles: editorials, original scientific papers, professional papers, review's, case reports, reports on drugs and methods of treatment, short announcements, annotations, news, book review's, letters to the editor, and other papers in the field of social psychiatry.

Exceptionally, the Editorial board can accept other kinds of paper (social psychiatry event paper, social psychiatry history-related paper, etc.).

During the whole peer-reviewed process, the *Socijalna psihijatrija* journal follows the Committee of publication ethics (COPE) guidelines (https://publicationethics.org/files/Code%20of%20Conduct_2.pdf) as well as the "Recommendations for the conduct, reporting editing, and publication of scholarly work in medical journals" set by the International Committee of Medical Journal Editors (ICMJE - http://www.icmje.org/journals-following-the-icmje-recommendations/).

Editors at the *Socijalna psihijatrija* journal pay close attention to the integrity and visibility of scholarly publications as stated in Sarajevo Declaration (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5209927/).

Editorial board

Each received manuscript is evaluated by the Editor-in-Chief. The manuscripts that do not meet the main criteria listed in the Author guidelines are returned to the Author. Manuscripts that are qualified are processed further.

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Manuscripts that meet the scope of the Journal and are prepared according to the Author guidelines are sent to peer-review.

Socijalna psihijatrija advises its reviewers to adhere to the Journal's Guidelines for peer-reviewers available on the Journal webpage.

Etički kodeks

Podrazumijeva se da su svi autori radova suglasni o publikaciji i da nijedan dio rada nije prije publikacije u *Socijalnoj psihijatriji* već bio objavljen u drugom časopisu te da nije u postupku objavljivanja u drugom časopisu.

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Časopis *Socijalna psihijatrija* je časopis otvorenog pristupa i njegov je sadržaj dostupan besplatno na mrežnim stranicama časopisa.

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Rad i svi prilozi dostavljaju se isključivo u elektroničkom obliku. Preporučena duljina teksta iznosi do 20 kartica (1 kartica sadrži 1800 znakova s razmacima). Tekstove treba pisati u Wordu, fontom postavljenim za stil Normal, bez isticanja unutar teksta, osim riječi koje trebaju biti u boldu ili italiku. Naslove treba pisati istim fontom kao osnovni tekst (stil Normal), u poseban redak, a hijerarhiju naslova može se označiti brojevima (npr. 1., 1.1., 1.1.1. itd.).

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Naslovna stranica rada sadrži: naslov i skraćeni naslov rada, puna imena i prezimena svih autora, naziv ustanova u kojima rade. Sažetak treba sadržavati do 200 riječi. U sažetku treba navesti temu i svrhu rada, metodologiju, glavne rezultate i kratak zaključak. Uz sažetak treba navesti 3 do 5 ključnih riječi koje su bitne za brzu identifikacijsku klasifikaciju sadržaja rada.

Znanstveni i stručni radovi sadrže ove dijelove: sažetak, uvod, cilj rada, metode, rezultati, rasprava i zaključci.

Uvod je kratak i jasan prikaz problema; u njemu se kratko spominju radovi onih autora koji su u izravnoj vezi s istraživanjem što ga rad prikazuje.

Ethical code

All the submissions are accepted with the understanding that they have not been and will not be published elsewhere in any substantially format.

The Editorial board, with the agreement of the Author and Publisher, can republish previously published manuscripts.

The manuscript published in *Socijalna psihijatrija* can be published elsewhere without the permission of the Author, Editorial board and Publisher, with the note that it has already been published in *Socijalna psihijatrija*.

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Open-access

Socijalna psihijatrija is an open-access journal, and all its content is free and available at the Journal’s webpage.

Article processing charges

The translation or language editing of the manuscript from Croatian to English (and *vice versa*) is funded by authors.

Manuscript preparation

Manuscripts, figures and tables should be submitted in electronic form. Normally, manuscripts should be no longer than 20 standard pages (one standard page is 1800 keystrokes – characters with spaces). Texts should be written in Microsoft Word, in a continuous font and style: the one set under the Normal style, with no additional font effects used other than words that should be in bold or italic. Tittles should be written in the same font as the rest of the text (Normal style) in a separate row, and title hierarchy should be shown using numbers (e.g. 1., 1.1., 1.1.1., etc.).

There should be a title, name and surname, address, town, state and e-mail indicated for the corresponding author.

The title page should contain: the full and shortened title of the article, full names and full surnames of all authors of the article, and the institution they work for. All the authors should also provide an ORCHID ID (please check the following website: https://orcid.org/register). The article should have a summary not exceeding 200 words. The summary should briefly describe the topic and aim, the methods, main results,

Cilj je kratak opis što se namjerava istraživati, tj. što je svrha istraživanja.

Metode se prikazuju tako da se čitatelju omogući ponavljanje opisanog istraživanja. Metode poznate iz literature ne opisuju se, već se navode izvorni literaturni podatci. Ako se navode lijekovi, rabe se njihova generička imena (u zagradi se može navesti njihovo tvorničko ime).

Rasprava sadrži tumačenje dobivenih rezultata i njihovu usporedbu s rezultatima drugih istraživača i postojećim spoznajama na tom području.U raspravi treba objasniti važnost dobivenih rezultata i njihova ograničenja, uključujući i implikacije vezane uz buduća istraživanja, ali uz izbjegavanje izjava i zaključaka koji nisu potpuno potvrđeni dobivenim rezultatima.

Zaključci trebaju odgovarati postavljenom cilju istraživanja i temeljiti se na vlastitim rezultatima.

Tablice treba smjestiti unutar Word-dokumenta na kraju teksta, a označiti mjesto njihovog pojavljivanja u tekstu. Ako se tablica daje u formatu slike (tj. nije izrađena u Wordu), za nju vrijede upute kao za slike. Svaka tablica treba imati redni broj i naslov.

Slike treba priložiti kao posebni dokument u .tiff ili .jpg (.jpeg) formatu, minimalne rezolucije 300 dpi. Uz redni broj svaka slika treba imati legendu. Reprodukciju slika i tablica iz drugih izvora treba popratiti dopuštenjem njihova autora i izdavača.

Rad može sadržavati i zahvalu na kraju teksta.

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Arapskim brojkama upisuju se podatci koje se može pronaći u samom izvorniku ili u nekoj bibliografskoj bazi podataka i to sljedećim redom: godina, volumen ili svezak, sveščić ili broj (engleski *issue* ili *number* – no.), dio (engleski *part*), dodatak (engleski *supplement* ili *suppl.*),

and conclusion. The summary should be followed by 3 to 5 key words for easy identification and classification of the content of the article.

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The Introduction section is a short and clear overview; it briefly mention Authors involved with the research of the paper.

The Aim section briefly describes the goals and intentions of the research, i.e. the point of the research.

The Methods section should be presented in such way as to allow the reader to replicate them without further explanation. Methods known from the literature need not be described but should simply be referred to by their generic names (trade names should be given in parentheses).

The Discussion section includes the results and their comparison with the results of other researchers and well known scientific knowledge in that area. It should also explain the significance of the results and their limitations, including implications regarding future studies, statements and conclusions that are not verified by the results should be avoided.

The Conclusions section should correspond to the aim of the study and be based on its results.

Tables should be placed at the end of the text in the Word document and with an indication where they are to appear in the published article. If the table is submitted as an image (i.e. is not constructed in Microsoft Word), the same instructions as for images apply.

Images should be submitted separately in .tiff or .jpg (.jpeg) format, with a minimum resolution of 300 dpi. Every image should have a number and caption. Reproduction of images and tables from other sources should be accompanied by a full reference and authorization by their Authors and Publisher.

The manuscript may have an acknowledgement at the end of the text.

References should be written with Arabic numerals in parentheses.

References

Socijalna psihijatrija applies the Vancouver referencing style according to the International Committee (ICMJE) standards. ICMJE recommends citation of the complete manuscripts, i.e. publicly accessible manuscripts, meaning that summaries, announces, etc. should be avoid.

Repeated citing of a manuscript should be marked by the same number as when it is mentioned for the first time.

Quotation marks should be used when citing another text. This mode of citation should only be used when the information cannot be properly reformulated or summarized (e.g. when referring to a definition).

Secondary citations refer to cases when Authors quote a passage from an inaccessible work to using a different text than the one where the quote originated. This kind of quotation should be avoided as much as possible i.e. always try to find the original scientific manuscript. In cases when it is not possible, the manuscript should cite the work that was used and not the work in which the information was primarily published.

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In case the manuscript has six or fewer Authors, all of them should be listed. Should the manuscript have more than six Authors, the first six should be listed and the rest of them marked with the abbreviation *et al.* or i sur. First list the surname and then the initials of the first name(s). Multiple initials for the same person should be written without spaces.

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Titles and subtitles are copied from the original and separated by a colon. Only the first word of the title and name are written in capital letters.

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Kingdon DG, Aschroft K, Bhandari B, Gleeson S, Warikoo N, Symons M et al. Schizophrenia and borderline personality disorder: similarities and differences in the experience of auditory hallucinations, paranoia and childhood trauma. J Nerv Ment Dis 2010; 10(6): 399-403.

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Book issue is indicated by the ordinary number and the abbreviation “Ed”. In case the book has more than one volume, use the abbreviation “Vol”.

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Mimica N. Delirij. U: Begić D, Jukić V, Medved V. (ur.). Psihijatrija. Zagreb: Medicinska naklada, 2015, pages: 84-86.

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