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Samoozljeđivanje i suicidalnost srednjoškolaca prije i tijekom pandemije COVID-19

/ Self-Injury and Suicidality Among High-School Students Prior to and During the COVID-19 Pandemic

Ines Rezo Bagarić, Nika Sušac, Linda Rajhvajn Bulat

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Ciljevi istraživanja bili su usporediti pojavnost samoozljeđivanja i suicidalnih misli na uzorku srednjoškolaca Grada Zagreba 2016. i 2021. godine te istražiti prediktore samoozljeđivanja i suicidalnih misli kod srednjoškolaca. U istraživanju su sudjelovali učenici 1. razreda zagrebačkih srednjih škola, pri čemu je 2016. godine sudjelovalo 269, a 2021. godine 353 učenika. U oba uzorka najzastupljeniji su bili učenici koji pohađaju gimnazije, prosječne dobi 15 godina, s podjednako djevojaka i mladića. Ukupno gledajući, rezultati ukazuju na dvostruko veću pojavnost samoozljeđivanja kod zagrebačkih srednjoškolaca u usporedbi 2016. (17,0 %) i 2021. godine (29,1 %). Kod suicidalnih misli nisu nađene značajne razlike, iako je udio sudionika koji su iskazali da su barem jednom razmišljali o suicidu bio visok (2016. 27,7 %, a 2021. 24,8 %). Međutim, djevojke iskazuju otprilike dvostruko više samoozljeđivanja (2021. 38,2 %) i suicidalnih misli (34,2 %) od mladića (2021. 19,9 % samoozljeđivanja i 15,8 % suicidalnih misli). Mladi koji procjenjuju da njihove obitelji imaju manje novaca od drugih iskazuju najviše samoozljeđivanja i suicidalnih misli. Rezultati hijerarhijskih regresijskih analiza ukazuju da odabrani skupovi prediktora objašnjavaju izrazito visoke postotke varijance i samoozljeđivanja (43,6 %) i suicidalnih misli (41,9 %). Značajni čimbenici za obje vrste autoagresivnih pokazatelja su manje izražavanja topline od roditelja i više odbijanja te nekonstruktivni načini suočavanja sa stresom, kao i lošije samopoimanje u određenom aspektu.

/ *The objectives of the study were to compare the occurrence of self-injury and suicidal ideations on a sample of high-school students in the City of Zagreb in 2016 and 2021, and to examine the predictors of self-injury and suicidal ideations among high-school students. The participants of the study were 1st grade students from high schools in Zagreb, with 269 students participating in 2016, and 353 in 2021. The most represented group in both samples were the students attending gymnasium, aged 15 on average, with a roughly equal share of boys and girls. The results point to a twofold increase in the occurrence of self-injury among Zagreb high-school students when comparing 2016 (17.0%) and 2021 (29.1%). No significant differences were found in suicidal ideations, although the proportion of participants who reported thinking about committing suicide on at least one occasion was high (27.7% in 2016 and 24.8% in 2021). Adolescent girls reported roughly two times more self-injury (38.2% in 2021) and suicidal ideations (34.2%) than adolescent boys (19.9% self-injury and 15.8% suicidal ideations in 2021). Most self-injuries and suicidal thoughts were reported by young people who estimated that their families had less money than others. The results of hierarchical regression analyses showed that selected sets of predictors accounted for markedly high variance percentages of both self-injuries (43.6%) and suicidal ideations (41.9%). Significant factors for both types of self-aggressive behaviours include lower expression of parental warmth and more parental rejection, as well as non-constructive ways of coping with stress and more negative self-concept in a certain aspect.*

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UVOD

Adolescencija je razvojno razdoblje u kojem se povećava razina internaliziranih problema poput depresivnosti i anksioznosti, kao i rizik za pojavu autoagresivnih ponašanja poput samoozljeđivanja i suicidalnosti (1,2). Pri tome je u posljednjih 30 godina prisutan značajan porast internaliziranih problema adolescenata (3), a istraživanja nalaze slične trendove za samoozljeđivanje i suicidalne misli. U međunarodnoj literaturi o samoozljeđivanju istraživači uglavnom koriste dva slična, ali ipak različita pojma – namjerno samoozljeđivanje (engl. *Deliberate self-harm*, DSH) i nesuicidalno samoozljeđivanje (engl. *Non-suicidal self-injury*, NSSI). Namjerno samoozljeđivanje označava termin za nanošenje boli ili ozljeda samom sebi, sa suicidalnom namjerom ili bez nje te se uglavnom javlja u europskim i australskim istraživanjima. Istraživanja iz Sjeverne Amerike obično koriste termin nesuicidalnog samoozljeđivanja koji je izravno i namjerno nanošenje boli ili ozljeda samom sebi, koje se ne provodi s namjerom počinjenja suicida ni iz kulturalnih ili religijskih običaja (4). Životna prevalencija kod adolescenata iznosi 8 – 47 %, a češće se pojavljuje kod djevojaka (5). U ovom radu pregled literature uključuje i istraživanja namjernog samoozljeđivanja (DSH) i nesuicidalnog samoozljeđivanja (NSSI) u onim terminima koje su koristili autori pojedinih istraživanja. U odjeljcima Metoda i Rezultati bit će naznačeni specifični termini

INTRODUCTION

Adolescence is a developmental period during which the level of internalising problems, such as depression and anxiety, increases along with the risk for the occurrence of self-aggressive behaviours, such as self-injury and suicidality (1, 2). At the same time, a significant increase in internalising problems among adolescents has been noted (3) over the last 30 years and studies observe similar trends in self-injury and suicidal ideations. In the literature on self-injury/self-harm researchers mostly use two similar, yet different terms - deliberate self-harm (DSH) and non-suicidal self-injury (NSSI). DSH is used as a term for self-injurious behaviours with and without suicidal intent, mostly in European and Australian research. Research from North America usually uses the term NSSI - direct and deliberate self-infliction of pain or self-harm, which is not performed with a purpose of committing suicide nor due to cultural or religious customs (4). Lifetime prevalence in adolescents is 8–47%, and it is more common in girls (5). In this paper, the literature review includes research both on DSH and NSSI, using the terms used by the authors of the studies. In the sections dedicated to the methods and results, we will indicate the specific terms used for the the purposes of this study. Suicidality refers to a heterogeneous group of behaviours including suicidal ideations, plans, suicide attempts and a committed suicide (6). In Croa-

korišteni u ovom istraživanju. Suicidalnost se pak odnosi na heterogenu skupinu ponašanja koja uključuje suicidalne misli, planove, pokušaje te učinjeni suicid (6). U Hrvatskoj, kao i u drugim zemljama svijeta, suicid je u 2020. godini bio drugi vodeći uzrok smrti adolescenata u dobi 15 – 19 godina, nakon prometnih nesreća (7,8). Podatci Ministarstva unutarnjih poslova pokazuju da je u 2019. godini bilo 26 pokušaja te šest izvršenih samoubojstava kod djece i mladih, u 2020. godini 52 pokušaja i 10 izvršenih samoubojstava, a u 2021. godini 63 pokušaja te sedam izvršenih samoubojstava djece i mladih (9-11).

Odnos samoozljeđivanja, suicidalnih misli i suicidalnosti je višeznačan. Iako samoozljeđivanje samo po sebi ne uključuje nužno suicidalnu namjeru nego ima cilj smanjenja psihološke boli i patnje, istraživanja pokazuju da su i namjerno samoozljeđivanje i nesuicidalno samoozljeđivanje snažni prediktori suicidalnih misli (1,12). Suicidalne misli su pasivne misli o želji za smrću ili aktivne misli o suicidu koje nisu popraćene pripremnim ponašanjem (13). Devet od 10 adolescenata koji su pokušali suicid ujedno izvještavaju o samoozljeđivanju (14), a 70 % adolescenata koji se samoozljeđuju imali su pokušaj suicida (15). Ipak, oko 70 % ljudi koji imaju suicidalne misli ne pokušaju učiniti suicid, no suicidalne misli su značajan rizik za pokušaj suicida (16), što upućuje na važnost praćenja i reagiranja na samoozljeđivanje i suicidalne misli kod mladih.

Primjetan je zabrinjavajući porast samoozljeđivanja i suicidalnih misli u prethodnom desetljeću. Tako se broj pedijatrijskih hospitalizacija zbog samoozljeđivanja i suicidalnih misli u američkim bolnicima udvostručio u razdoblju 2015. – 2018. godine (16), dok su hitni prijami zbog samoozljeđivanja adolescenata u Kanadi povećani za 135 % u razdoblju 2009. – 2017. godine (17). Navedena istraživanja pronašla su češća povećanja samoozljeđivanja i suicidalnih misli za djevojke nego za mladiće.

tia, as in other countries around the world, in 2020 suicide was the second leading cause of death in adolescents aged 15 to 19, after traffic accidents (7, 8). According to data from the Ministry of Interior, among children and young people there were 26 attempted and 6 committed suicides in 2019, 52 attempted and 10 committed suicides in 2020, and 63 attempted and 7 committed suicides in 2021 (9, 10, 11).

The relation between NSSI, DSH, suicidal ideations and suicidality is multifaceted. Although NSSI by itself does not include suicidal intent, but is rather aimed at alleviating psychological pain and suffering, studies show that NSSI is a strong predictor of suicidal ideations (1), as is DSH (12). Suicidal ideations represent passive thoughts about wanting to be dead or active thoughts about suicide, which are not accompanied by preparatory behaviour (13). Nine out of ten adolescents who have attempted suicide also report NSSI (14), and 70% of adolescents who engage in NSSI have attempted to commit suicide (15). Although about 70% of people with suicidal ideations do not attempt to commit suicide, suicidal ideations represent a significant risk for attempted suicide (16), which points to the importance of monitoring and reacting to self-injury and suicidal ideations in youth.

In the past decade, a worrying increase in self-injury and suicidal ideations has been observed. the number of paediatric hospitalisations due to NSSI and suicidal ideations doubled in US hospitals during the period 2008-2015 (16), while emergency visits by adolescents for NSSI in Canada increased by 135% in the period 2009-2017 (17). These studies have identified higher effects of the increase in NSSI and suicidal ideations among adolescent girls than boys.

Following the increase in the occurrence of self-injury and suicidal ideations, researchers were interested in examining the effects of the COVID-19 pandemic on the occurrence

S obzirom na povećanje pojavnosti samoozljeđivanja i suicidalnih misli istraživače je zanimalo kako se pandemija COVID-19 odrazila na pojavnost autoagresivnih ponašanja. Naime, pandemija COVID-19 koja je u lipnju 2022. godine uzrokovala 6,3 milijuna smrtnih slučajeva i preko 530 milijuna slučajeva zaraze odrazila se na sve aspekte života mladih ljudi. Različita istraživanja pokazala su kako je mladima narušenije mentalno zdravlje u kontekstu pandemije nego starijima, poglavito zbog različitih društvenih ograničenja koja su morala nastupiti zbog pandemije (npr. 18,19). To se objašnjava teorijom socioemocionalne selekcije (20) koja smatra da su mladi motivirani ponašanjima i aktivnostima koje se odnose na „pripremu za budućnost", tijekom pandemije uglavnom ograničena, dok su stariji motivirani doživljavanjem pozitivnih iskustava, koja su tijekom epidemije i dalje bila moguća. Dodatno, prema Modelu integracije snaga i ranjivosti (21) stariji odrasli manje reagiraju na dnevne stresore, doživljavaju manje neugodnih emocija i pokazuju bolje ishode mentalnog zdravlja (20,22), što objašnjava razlike u ishodima mentalnog zdravlja i tijekom pandemije.

Istraživanje Steeg i sur. (23) bavilo se usporedbom pojavnosti namjernog samoozljeđivanja prije i tijekom pandemije na području Velike Britanije za sve dobne skupine. Od lipnja 2020. do srpnja 2021. godine adolescenti u dobi 10 – 17 godina češće su registrirani u primarnoj zdravstvenoj zaštiti zbog samoozljeđivanja, nego što je to bilo u istom razdoblju godinu dana ranije (23), dok druge dobne skupine nisu pokazale povećanje stope samoozljeđivanja. Drugo istraživanje, provedeno u 10 zemalja (Engleska, Škotska, Irska, Austrija, Italija, Mađarska, Srbija, Turska, Oman i Ujedinjeni Arapski Emirati), provjeravalo je razlike u hitnim psihijatrijskim prijamima zbog namjernog samoozljeđivanja djece i adolescenata tijekom karantene zbog pandemije COVID-19 u ožujku i travnju 2020., u odnosu na isto razdoblje 2019. godine (24). Iako je u karantenskom razdoblju broj hitnih

of self-aggressive behaviours. The COVID-19 pandemic, which in June 2022 registered 6.3 million deaths and over 530 million infection cases, has affected all aspects of young people's lives. Various studies have shown that during the pandemic young people experienced more mental health problems than older people, especially because of various social restrictions that needed to be introduced (e.g. 18, 19). These findings can be explained by the socioemotional selectivity theory (20), which states that young people are motivated by behaviours and activities related to "the preparation for the future", which have largely been restricted during the pandemic, whereas older people are motivated by positive experiences, which were still possible during the pandemic. Furthermore, according to the Strength and Vulnerability Integration Model (21), older adults show less reactivity to daily stressors, experience fewer negative emotions, and show better mental health outcomes (20, 22), which also explains the differences in the mental health outcomes during the pandemic.

A study conducted by Steeg et al. (23) focused on the comparison of the occurrence of self-harm before and during the pandemic among all age groups in the UK. From June 2020 to July 2021, adolescents aged 10 to 17 years were more frequently admitted in primary healthcare due to self-harm compared with the same period in the previous year (23), while no increase in the rates of self-harm was observed in other age groups. Another study implemented in 10 countries (England, Scotland, Ireland, Austria, Italy, Hungary, Serbia, Turkey, Oman and United Arab Emirates) examined the changes in emergency psychiatric admissions for self-harm of children and adolescents during the COVID-19 lockdown in March and April of 2020 compared with the same period in 2019 (24). Although emergency psychiatric admissions decreased during the lockdown, an increase in self-harm was recorded, from 50% in 2019 to 57% in 2020 (24). An Australian

psihijatrijskih prijama opao, svejedno je zabilježen porast samoozljeđivanja, s 50 % u 2019. na 57 % u 2020. godini (24). Australsko istraživanje je pratilo promjene u pojavnosti samoozljeđivanja i suicidalnih misli u hitnim prijamima na godišnjoj razini prije pandemije (2015. – veljača 2020.) te tijekom pandemije (ožujak 2020. – lipanj 2021.). Rezultati su pokazali rast ovih ponašanja od 8,4 % godišnje prije pandemije, dok se od pandemije postotak povećao na 19,2 % rasta godišnje, poglavito zbog porasta kod djevojaka u dobi 13 – 17 godina (čak 47,1 % godišnje od pandemije), dok kod mladića nije bilo značajnog porasta (25). Brausch i sur. (26) usporedili su dva uzorka američkih adolescenata – prije i nakon početka pandemije po različitim parametrima mentalnog zdravlja i zaključili da su mladi u pandemijskom uzorku iskazali više simptoma internaliziranih problema i suicidalnih misli od mladih prije pandemije. Kod kanadskih adolescenata (27) također je primjetan porast u stopama samoozljeđivanja i suicidalnih misli u pandemiji, a posebno su rizični bili mladi koji pokazuju teškoću u rodnom identitetu, nisu živjeli s oba roditelja, pokazuju druge probleme mentalnog zdravlja ili češću uporabu marihuane.

Prediktori samoozljeđivanja i suicidalnih misli

Prema Integriranom teorijskom modelu nesuicidalnog samoozljeđivanja (28), postoji niz čimbenika rizika i ranjivosti koji dovode do samoozljeđivanja kod mladih. Distalni čimbenici rizika odnose se na genetsku predispoziciju za visoku emocionalnu i kognitivnu reaktivnost, zlostavljanje i zanemarivanje u djetinjstvu te obiteljsko neprijateljstvo i kritiziranje. Distalni čimbenici rizika predviđaju intrapersonalne i interpersonalne čimbenike ranjivosti. Intrapersonalni čimbenici ranjivosti su snažne neugodne emocije i kognicije te niska tolerancija stresa. Interpersonalni čimbenici ranjivosti su nerazvijene komunikacijske vještine i nerazvijene vještine rješavanja problema u socijalnim odnosima.

study examined the changes in the annual occurrence of self-harm and suicidal ideations in emergency departments before the pandemic (2015 – February 2020) and during the pandemic (March 2020 – June 2021). The results showed an increase in these behaviours of 8.4% per year before the pandemic, while in the period since the COVID-19 pandemic the growth increased to 19.2% per year, primarily due to increased presentations of girls aged 13 to 17 (as much as 47.1% per year since COVID-19), whereas no significant increase was observed in adolescent boys (25). Brausch et al. (26) compared two samples of American adolescents, before and after the emergence of the pandemic, on various parameters of mental health and concluded that young people in the pandemic sample showed more symptoms of internalizing problems and suicidal ideation than young people before the pandemic. In Canadian adolescents (27), there was also a noticeable increase in the rates of self-injury and suicidal ideation during the pandemic. Mainly at risk were young people who showed difficulty with gender identity issues, did not live with both parents, showed other mental health problems or more frequent use of marijuana.

Predictors of Self-injury and Suicidal Ideations

According to the Integrated Theoretical Model of NSSI (28), there are a number of risks and vulnerability factors leading to NSSI in young people. Distal risk factors refer to the genetic predisposition for high emotional and cognitive reactivity, childhood abuse and maltreatment, and familial hostility and criticism. Distal risk factors forecast intrapersonal and interpersonal vulnerability factors. Intrapersonal vulnerability factors are highly aversive emotions and cognitions and poor stress tolerance. Interpersonal vulnerability factors are poor communication skills and poor social problem-solving skills. Together, these vulnerability factors

Zajednički, ovi čimbenici ranjivosti predviđaju emocionalne reakcije zbog stresnih događaja koji izazivaju preveliku ili premalu pobuđenost kod mlade osobe ili pak zbog stresnih događaja koji su preveliki socijalni zahtjevi na mladu osobu. U interakciji odgovora na stres sa specifičnim čimbenicima ranjivosti na koncu dolazi do samoozljeđivanja u funkciji regulacije afektivnog iskustva ili regulacije socijalnih situacija. Pojedini čimbenici iz opisanog teorijskog modela nesuicidalnog samoozljeđivanja (28) potvrđeni su u različitim istraživanjima. Primjerice, višestruko je potvrđeno kako su distalni čimbenici nepovoljnih životnih događaja poput zlostavljanja i zanemarivanja rizični faktori za pojavu i veću učestalost nesuicidalnog samoozljeđivanja kod mladih (29,30). Među intrapersonalnim čimbenicima u istraživanjima se posebno ističe povezanost nesuicidalnog samoozljeđivanja i loše slike o sebi (31), dok je u interpersonalnim čimbenicima važan nedostatak strategija nošenja sa stresom, što se kontinuirano pokazuje kao prediktor nesuicidalnog samoozljeđivanja (31). Dodatno, kao rizični čimbenici u istraživanjima i namjernog i nesuicidalnog samoozljeđivanja pokazali su se ženski rod, starija dob adolescenata, niži materijalni status obitelji, anksiozna privrženost, narušeno mentalno zdravlje, nedostatak socijalne podrške (npr. 32, 33).

Prediktori suicidalnih misli slični su spomenutim prediktorima samoozljeđivanja. Prema Joinerovoj Interpersonalnoj teoriji suicidalnog ponašanja (34) možemo općenito podijeliti prediktore suicidalnosti na one koji dovode do kapaciteta za počinjenje suicida te prediktore koji jačaju želju za počinjenjem suicida. Prediktori vezani uz kapacitet za počinjenje odnose se na iskustva različitih nepovoljnih životnih događaja, poput nesreća, gubitaka i zlostavljanja, kao i iskustva samoozljeđivanja koja dovode do habituacije na bol i smanjenja straha od smrti kod pojedinaca. To je u skladu s nalazima istraživanja o kumulativnim nepovoljnim životnim događajima kao prediktorima suicidalnih misli (35), posebice

predict emotional reactions due to stressful events that trigger over- or under-arousal of a young person, or due to stressful events that present unmanageable social demands for a young person. The interaction between the stress response and the specific vulnerability factors finally leads to NSSI, which functions as a means of regulating affective experience or a social situation. Certain factors from the described theoretical model of NSSI (28) have been confirmed by different studies. For example, a number of studies have confirmed that distal factors of adverse life experiences, such as abuse and maltreatment, represent risk factors for the occurrence and higher frequency of NSSI among young people (29, 30). Among intrapersonal factors, studies especially highlight the connection between NSSI and poor self-image (31), while among interpersonal factors they point to a lack of strategies for coping with stress as an important deficiency, which repeatedly emerges as a predictor of NSSI (31). Additionally, studies have shown that risk factors for DSH and NSSI include female gender, older adolescent age, lower family economic status, anxious attachment, mental health problems, and a lack of social support (e.g. 32, 33).

Predictors of suicidal ideations are similar to the above-mentioned predictors of self-injury. According to Joiner's Interpersonal theory of suicidal behaviour (34), predictors of suicidality can generally be divided into those that lead to the capacity to commit suicide and the predictors that strengthen the suicidal desire. The predictors related to the capacity to commit suicide refer to experiencing various negative life events, such as accidents, losses and abuse, as well as experiences of NSSI, which lead to pain habituation and reduced fear of death in individuals. This is in line with the findings of the studies focusing on cumulative adverse life experiences as predictors of suicidal ideations (35), particularly various forms of abuse (36), and the above-mentioned relationship between

raznih oblika zlostavljanja (36), kao i o već spomenutoj vezi samoozljeđivanja i suicidalnih misli (1). Prediktori vezani uz želju za počinjenjem suicida odnose se na čimbenike narušene slike o sebi i izolacije. Narušena slika o sebi povezana je s doživljajem mlade osobe da je na teret obitelji i drugima u okolini te suicid vidi kao olakšavanje svojim bližnjima. Izolacija je povezana s doživljajima nedovoljnog pripadanja i otuđenja zbog kojih se mlada osoba ne osjeća kao integralni dio obitelji, kruga prijatelja ili drugih, njoj vrijednih, grupa. Ponovno, navedeni čimbenici se mogu pronaći u nizu istraživanja, u različitim oblicima istraživanih varijabli, poput narušenog mentalnog zdravlja i sniženog samopoštovanja (37), nedostatka strategija konstruktivnog suočavanja sa stresom (38), više roditeljske kontrole, a manje roditeljske topline i razumijevanja (39), socijalne izolacije i nedostatka prijatelja, kao i generalnog nedostatka socijalne podrške (40).

Samoozljeđivanje sa suicidalnom namjerom i suicidalnom misli ili bez njih snažni su prediktori počinjenja suicida (15) te ih je potrebno dodatno istražiti. Uz to, unatoč prisutnosti problema samoozljeđivanja i suicidalnosti, u Hrvatskoj su i dalje o tome provedena malobrojna istraživanja, uglavnom na kliničkim uzorcima (33,41-43). Stoga su ciljevi ovoga istraživanja bili:

1. Usporediti pojavnost samoozljeđivanja i suicidalnih misli na uzorku srednjoškolaca Grada Zagreba 2016. i 2021. godine;
2. Istražiti pojavnost i prediktore samoozljeđivanja i suicidalnih misli kod srednjoškolaca.

METODA

Sudionici

U istraživanju su sudjelovali učenici 1. razreda zagrebačkih srednjih škola pri čemu je 2016. godine sudjelovalo 269 učenika, a 2021. godine

NSSI and suicidal ideations (1). The predictors related to the suicidal desire refer to the factors of impaired self-image and isolation. Impaired self-image is connected to a young person's experience of being a burden to their family and other people in their environment, which is why suicide is viewed as a relief for these people. Isolation is related to the experiences of alienation and insufficient sense of belonging, due to which a young person does not feel as an integral part of the family, a circle of friends or other groups that are important to them. Once again, these factors can be found in a number of studies and in various forms of analysed variables, such as mental health problems and lower self-esteem (37), a lack of strategies to cope with stress in a constructive manner (38), higher levels of parental control, with less parental warmth and understanding (39), social isolation and a lack of friends, as well as a general lack of social support (40).

NSSI, DSH and suicidal ideations are strong predictors for committing suicide (15) and therefore require further studies. In addition, despite the presence of the problems of NSSI and suicidality, few studies on these issues have to date been implemented in Croatia, mainly on clinical samples (33,41-43). Therefore, the objectives of this study were: (1) to compare the occurrence of self-injury behaviours and suicidal ideations on a sample of high-school students in the City of Zagreb in 2016 and 2021 and (2) to study the occurrence and predictors of self-injury behaviours and suicidal ideations in high-school students.

METHOD

Participants

The participants of the study were 1st grade students from high schools in Zagreb, with 269 students participating in 2016, and 353 in 2021. The most represented group in both sam-

353 učenika. U oba uzorka najzastupljeniji su bili učenici koji pohađaju gimnazije (tablica 1.) te je prosječna dob bila 15 godina (tablica 2.).

U tablici 3. prikazana je raspodjela sudionika prema rodu, pri čemu je 2021. godine raspodjela bila ravnomjerna, dok su u uzorku iz 2016. bile zastupljenije učenice. Većina sudionika dolazi iz cjelovitih obitelji, pri čemu je udio onih koji imaju razvedene roditelje u oba uzorka oko 16 % (tablica 4.). Većina sudionika procjenjuje da dolaze iz obitelji prosječnog materijalnog statusa (tablica 5.).

ples were the students attending gymnasium (Table 1) and the average age of participants was 15 (Table 2).

Table 3 shows the distribution of participants by gender, which was equal in 2021, while female students prevailed in the 2016 sample. The majority of participants came from intact families, with the proportion of students whose parents were divorced being about 16% in both samples (Table 4). The majority of participants estimated that their families were of average economic status (Table 5).

TABLICA 1. Raspodjela sudionika prema vrsti srednjoškolskog programa koji pohađaju
TABLE 1. Distribution of participants according to the type of high school programme

	2016. godina		2021. godina	
	Frekvencija / Frequency	Postotak / %	Frekvencija / Frequency	Postotak / %
Trogodišnja strukovna škola / Three-year vocational school	56	21,0	127	36,2
Četverogodišnja strukovna škola / Four-year vocational school	76	28,5	71	20,2
Gimnazija / Gymnasium	135	50,6	153	43,6

TABLICA 2. Dob sudionika
TABLE 2. Participants' age

	Min	Max	M	SD
2016. godina	14	17	15,16	0,468
2021. godina	14	16	14,78	0,468

TABLICA 3. Raspodjela sudionika prema rodu
TABLE 3. Participants' gender

	2016. godina		2021. godina	
	Frekvencija / Frequency	Postotak / %	Frekvencija / Frequency	Postotak / %
Ženski / Female	170	63,2	162	45,9
Muški / Male	99	36,8	191	54,1

TABLICA 4. Raspodjela sudionika prema bračnom statusu roditelja
TABLE 4. Distribution of participants according to parents' marital status

	2016. godina		2021. godina	
	Frekvencija / Frequency	Postotak / %	Frekvencija / Frequency	Postotak / %
U zajedničkom braku ili izvanbračnoj zajednici / Marriage or cohabitation	209	78,0	288	82,5
Razvedeni / Divorced	42	15,7	55	15,8
Udovac/udovica / Widowed	12	4,5	2	0,6
Ostalo / Other	5	1,9	4	1,1

TABLICA 5. Raspodjela sudionika prema procjeni materijalnog statusa obitelji
TABLE 5. Distribution of participants according to the assessment of the family economic status

	2016. godina		2021. godina	
	Frekvencija / Frequency	Postotak / %	Frekvencija / Frequency	Postotak / %
Manje od drugih obitelji / Less than other families	32	12,1	25	7,4
Kao i druge obitelji / Like other families	173	65,3	220	64,7
Više od drugih obitelji / More than other families	60	22,6	95	27,9

Instrumentarij

Sociodemografska obilježja

U oba istraživanja prikupljeni su podatci o spolu, dobi, vrsti srednjoškolskog programa koji učenik pohađa i bračnom statusu roditelja. Sudionici su također procjenjivali financijske mogućnosti svoje obitelji u usporedbi s drugim obiteljima. Na svim navedenim pitanjima sudionici su odabirali neki od unaprijed ponuđenih odgovora osim na pitanju o dobi koje je bilo otvoreno. Ispitan je i niz drugih sociodemografskih obilježja sudionika, no ona neće biti korištena u analizama u sklopu ovog rada.

Samoozljeđivanje i suicidalne misli

U istraživanju 2016. godine korišten je Upitnik samoiskaza rizičnog i delinkventnog ponašanja SRDP-2015 (44) u sklopu kojeg su ispitana i autoagresivna ponašanja. Od sudionika se tražilo da navedu koliko su se često u posljednjih godinu dana ponašali na određene načine, a bili su im ponuđeni odgovori na ljestvici: 0 – niti jednom, 1 – jednom ili dvaput, 2 – nekoliko puta godišnje, 3 – jednom mjesečno, 4 – nekoliko puta mjesečno i 5 – nekoliko puta tjedno. Nesuicidalno samoozljeđivanje je ispitano korištenjem čestice „*Namjerno se povrijedio/la (npr. rezao/la se, čupao/la, palio/la, udarao/la, grebao/la do krvi), a da si nisi htio/htjela oduzeti život*“, a suicidalne misli česticom „*Razmišljao/la o tome da počiniš samoubojstvo*“.

Kriterijske varijable su 2021. godine ispitane korištenjem Inventara preuzimanja rizika i

Instruments

Socio-demographic characteristics

The data on gender, age, type of high school programme the student attended and their parents' marital status were collected in both surveys. The participants also assessed the family economic status in relation to other families. For all these questions, participants selected their response from a predefined set of options, except for the question about the respondent's age, which was open-ended. A number of other participants' socio-demographic characteristics were also examined, but these features will not be used in this paper's analyses.

Self-injury and suicidal ideations

In 2016, the Self-Reported Delinquency and Risk Behaviours Questionnaire (SRDP-2015) was used (44), which included the assessment of self-aggressive behaviours. The participants were asked to state how often in the past year they behaved in certain ways, and they provided their responses on the following scale: 0 – Not even once, 1 – Once or twice, 2 – Several times a year, 3 – Once a month, 4 – Several times a month, and 5 – Several times a week. NSSI was tested through the item *"Have you deliberately hurt yourself (e.g. cut your skin, pulled, burned, hit or scratched parts of your body) without the intention of taking your life?*", and suicidal ideations were tested through the item *"Have you thought about committing suicide?"*.

The Risk-Taking and Self-Harm Inventory for Adolescents (45) examined the criterion vari-

samoranjavanja adolescenata (*The Risk-Taking and Self-Harm Inventory for Adolescents*; 45) pri čemu je ukupno korišteno odabranih 13 čestica. Za ispitivanje namjernog samoozljeđivanja sa suicidalnom namjerom ili bez nje korišteno je 11 čestica (na primjer „*Jesi li se ikada namjerno porezao/la?*"), a za suicidalne misli čestica „*Jesi li ikada ozbiljno razmišljao/la da počiniš samoubojstvo?*". Sudionici su odgovore davali na ljestvici: 0 – nikada, 1 – jednom, 2 – više od jednom i 3 – mnogo puta. Ukupan rezultat za samoozljeđivanje dobiven je kao prosjek svih 11 odgovora pri čemu viši rezultat ukazuje na veću učestalost samoozljeđivanja. Nakon ispunjavanja upitnika sudionici su odgovarali na dva dodatna pitanja o samoozljeđivanju, jesu li se ikada namjerno ozlijedili te ako jesu, koje su sve dijelove tijela namjerno ozljeđivali, pri čemu su im na tom pitanju bili ponuđeni odgovori.

Roditeljstvo

Karakteristike roditeljstva ispitane su Upitnikom socijalnog konteksta roditeljstva (*Parents as Social Context Questionnaire*, PASCQ, 46) u sklopu kojeg su sudionici procjenjivali ponašanja svojih roditelja prema njima, i to posebno za majku, a posebno za oca. Ukupno se upitnik sastoji od 24 čestice za svakog roditelja, koje su podijeljene u 6 podljestvica (po 4 čestice za svaku podljestvicu): toplina, odbijanje, struktura, kaos, potpora autonomiji i prisila. Sudionicima su ponuđeni odgovori na ljestvici: 1 – uopće se ne slažem, 2 – većinom se ne slažem, 3 – većinom se slažem i 4 – u potpunosti se slažem. U sklopu ovog rada izračunati su ukupni rezultati za oba roditelja zajedno na svakoj od podljestvica kao prosjeci svih pripadajućih čestica, a viši rezultati na pojedinoj podljestvici ukazuju na njenu veću izraženost u roditeljskom ponašanju iz perspektive sudionika.

Samopoimanje

Samopoimanje sudionika ispitano je korištenjem Marshovog upitnika samoopisivanja II (*Self-Description Questionnaire II*, SDQ II;

ables in 2021, with a total of 13 selected items being used. To assess self-injury behaviour, 11 items were used (e.g. *"Have you ever intentionally cut your skin?*"), and the item *"Have you ever seriously thought about killing yourself?"* was used to assess suicidal ideations. The participants provided their responses on the following scale: 0 – Never, 1 – Once, 2 – More than once, and 3 – Many times. The total score for DSH was calculated as the average of all 11 responses, and the higher score indicates the higher frequency of DSH. After completing the questionnaire, the participants provided answers to two additional questions on DSH: whether they had ever deliberately injured themselves, and if they had, which body parts they had deliberately injured (with answer options provided for that question).

Parenthood

The characteristics of parenting style were examined by means of the Parents as Social Context Questionnaire (PASCQ, 46), whereby the participants assessed their parents' behaviours, separately for mothers and fathers. The questionnaire comprises a total of 24 items for each parent, divided into the following 6 subscales (with 4 items per subscale): Warmth, Rejection, Structure, Chaos, Autonomy Support and Coercion. The participants provided their responses using the following scale: 1 – Completely disagree, 2 – Mostly disagree, 3 – Mostly agree, and 4 – Completely agree. For the purposes of this paper, total results for both parents together were calculated for each subscale as average scores of all corresponding items, with higher results on individual subscale indicating its higher presence in parental behaviour, as seen from the participants' perspective.

Self-concept

Participants' self-concept was assessed by means of the Marsh's Self-Description Questionnaire II – SDQ II (47), with only four fol-

47) pri čemu su u ovom istraživanju korištene samo četiri podljestvice koje se odnose na tjelesni izgled (8 čestica), samopoštovanje (10 čestica), odnos s vršnjacima istog (10 čestica) i s vršnjacima suprotnog spola (8 čestica). Primjer čestice za samopoštovanje je „*Većinu toga što radim, uradim dobro*“. Ponuđena ljestvica za davanje odgovora bila je: 1 – netočno, uopće me ne opisuje, 2 – uglavnom netočno, 3 – više netočno nego točno, 4 – više točno nego netočno, 5 – uglavnom točno, 6 – točno, u potpunosti me opisuje. Ukupni rezultati za sve četiri podljestvice izračunati su kao prosjek odgovora na pripadajućim česticama pri čemu su pojedine čestice prethodno obrnuto kodirane na način da viši rezultat ukazuje na pozitivnije samopoimanje.

Suočavanje sa stresom

Za ispitivanje suočavanja sa stresom korišten je Njemački upitnik suočavanja za djecu i adolescente (*German Coping Questionnaire for Children and Adolescents* SVF-KJ; 48) koji se sastoji od 36 čestica podijeljenih u 9 podljestvica (po 4 čestice za svaku podljestvicu): umanjivanje, distrakcija/rekreacija, kontrola, pozitivne samoupute, traženje socijalne podrške, pasivno izbjegavanje, ruminacija, ravnodušnost, agresija. Primjer tvrdnje je „*Radim plan kako riješiti problem*“. Od sudionika se traži da označe koliko često čine pojedine radnje kada se nalaze u nekoj stresnoj situaciji ili se suočavaju s nekim problemom na ljestvici: 0 – nikada, 1 – rijetko, 2 – ponekad, 3 – često i 4 – gotovo uvijek. U ovom radu su podljestvice grupirane u nekonstruktivne (izbjegavanje, ruminacija, rezignacija, agresija) i konstruktivne načine suočavanja sa stresom (umanjivanje, distrakcija/rekreacija, kontrola, pozitivne samoupute, traženje socijalne podrške) te su dva ukupna rezultata dobivena kao prosjek odgovora na svim pripadajućim česticama pri čemu viši rezultat ukazuje na češće korištenje nekonstruktivnih, odnosno konstruktivnih načina suočavanja.

lowing subscales being used in this study: physical appearance (8 items), general self-esteem (10 items), same-sex relationships (10 items) and opposite-sex relationships (8 items). A sample item for general self-esteem is "*Most of the things I do, I do well*". The response scale was provided and included the following options: 1 – False, does not describe me at all, 2 – Mostly false, 3 – More false than true, 4 – More true than false, 5 – Mostly true and 6 – True, fully applies to me. The total scores for all four subscales were calculated as the average response for corresponding items, with certain items being previously reversely coded, so that the higher score indicated a more positive self-concept.

Coping with stress

The German Coping Questionnaire for Children and Adolescents, SVF-KJ (48) was used to test coping with stress. The test consists of 36 items divided into 9 subscales (with 4 items per each subscale): minimisation, distraction/recreation, situation control, positive self-instructions, social support, passive avoidance, rumination, resignation, and aggression. A sample item was "*I make a plan how to fix the problem*". Participants were asked to rate how often they performed certain actions when they were faced with a problem or a stressful situation, by using the following scale: 0 – Never, 1 – Rarely, 2 – Sometimes, 3 – Often, and 4 – Almost always. In this paper, these subscales were divided into non-constructive (avoidance, rumination, resignation, aggression) and constructive ways of coping with stress (minimisation, distraction/recreation, situation control, positive self-instructions, seeking social support). Thus, two total scores were obtained as the average responses to all corresponding items, with the higher result indicating a more frequent usage of non-constructive, i.e., constructive ways of coping.

Postupak

Podatci prikupljeni 2016. godine dio su većeg longitudinalnog projekta (IP-2014-09-8546 Ekonomske teškoće obitelji, psihosocijalni problem i obrazovni ishodi adolescenata u vrijeme ekonomske krize – FEHAP) koji je financirala Hrvatska zaklada za znanost. Podatci su prikupljani u tri vremenske točke, a u ovom radu korišteni su oni iz prve točke, kada su sudionici pohađali 1. razred srednje škole te su izdvojeni podatci samo iz zagrebačkih srednjih škola, dok je cijelo istraživanje provođeno u šest županija središnje Hrvatske. Prikupljanje podataka se provodilo grupno u razredima tijekom proljeća 2016. godine i trajalo je dva školska sata. Prije prikupljanja podataka roditelji učenika bili su upoznati s istraživanjem na roditeljskim sastancima i u pisanom obliku.

U jesen 2021. godine podatci su prikupljeni u sklopu pilot istraživanja za veći projekt (IP-2020-02-5967 Međugeneracijski prijenos rizika za mentalno zdravlje adolescenata – INTRAD) koji također financira Hrvatska zaklada za znanost. Podatci su prikupljeni grupno u učionicama sudionika tijekom jednog školskog sata, a roditelji su prethodno bili informirani o istraživanju pisanim putem. U oba istraživanja posebna je pažnja obraćena tome da cijeli postupak prikupljanja, obrade podataka i izvještavanja o njima bude proveden u skladu s Etičkim kodeksom istraživanja s djecom (49) te se posebno vodilo računa o dobrovoljnosti sudjelovanja, anonimnosti sudionika i povjerljivosti prikupljenih podataka. Također su oba istraživanja prije provedbe odobrili Ministarstvo znanosti i obrazovanja i Etičko povjerenstvo Pravnog fakulteta u Zagrebu.

Obrada podataka

Pri usporedbi rezultata iz 2016. i 2021. odgovori na pripadajućim česticama su dihotomizirani kako bi se mogao usporediti udio mladih koji

Procedure

In 2016, the data were collected as part of a larger longitudinal project (IP-2014-09-8546 Family Economic Hardship, Psychosocial Problems and Educational Outcomes of Adolescents in the Time of Economic Crisis – FEHAP) funded by the Croatian Science Foundation. The data were collected at three time points, but in this paper only the data from the first point are used, when the participants attended 1st grade of high school. Furthermore, only the data related to Zagreb high schools were used, while the whole study was implemented in six counties of Central Croatia. Group data collection was conducted in classes during two school hours in the spring of 2016. Prior to data collection, parents were informed about the study during the parents' meetings and in writing.

In autumn 2021, the data were collected as part of a pilot study conducted for a larger project (IP-2020-02-5967 Intergenerational Risk Transmission for Adolescent Mental Health – INTRAD), also funded by the Croatian Science Foundation. The data were collected in groups, in participants' classrooms during one school hour, with parents being previously informed about the study in writing. In both studies, special attention was paid to ensuring that data collection, processing and reporting procedures were fully in line with the Code of Ethics for Research Involving Children (49). The aspects of voluntary participation, participant anonymity and confidentiality of collected data were particularly taken into account. Prior to their implementation, the Ministry of Science and Education and the Ethical Review Board of the Faculty of Law in Zagreb approved both studies.

Data processing

When the results from 2016 and 2021 were compared, the responses on corresponding items were dichotomised to enable a comparison between the proportion of young people

navode da su barem jednom i onih koji navode da se uopće nisu ponašali na ispitivane načine. Kada se radilo o samoozljeđivanju, iz podataka iz 2021. korištena je čestica samoprocjene jesu li se barem jednom namjerno ozlijedili, a ne ukupni rezultat na ljestvici, kako bi se osigurala što veća usporedivost s rezultatima iz 2016. Za navedene usporedbe korišten je hi-kvadrat test.

Kako bi se ispitali prediktori samoozljeđivanja i suicidalnih misli korišteni su podatci prikupljeni 2021. godine te su provedene hijerarhijske regresijske analize. Pritom je kod samoozljeđivanja kao kriterij korišten ukupni rezultat na ljestvici.

REZULTATI

Dobiveni rezultati ukazuju na porast određenih problema kod zagrebačkih srednjoškolaca. Naime, 2016. godine 17,0 % učenika navelo je da su se barem jednom samoozljeđivali bez suicidalne namjere, dok je 2021. godine taj udio iznosio čak 29,1 %, odnosno postotak u drugom istraživanju bio je gotovo dvostruko veći (χ^2 = 11,501, p < ,001). Kada se sagledaju ljestvični podatci iz 2021. godine, prosječan odgovor sudionika je da se nikada nisu samoozljeđivali (M = 0,41; SD = 0,585), što je u skladu s postotkom učenika koji navode da su se barem jednom ponašali na taj način. U 2021. godini dodatno je ispitano i na kojim su se dijelovima tijela samoozljeđivali te se pokazalo da se u najvećem broju radi o rukama, dlanovima, prstima i noktima (tablica 6.). Kod suicidalnih misli nisu nađene značajne razlike između dva istraživanja (χ^2 = ,584, p > ,05), no u oba je udio sudionika koji su iskazali da su barem jednom

who reported certain behaviours on at least one occasion, and those who reported that they had never behaved in the manners being assessed. Regarding DSH in 2021, the item on whether the participants had ever deliberately hurt themselves was used instead of the overall score on the scale in order to ensure maximum comparability with the 2016 data. Chi-square test was used to perform the comparisons.

The data collected in 2021 were used to test the predictors of self-injury and suicidal ideations, with hierarchical regression analyses being performed. In doing so, the total score on the scale was used as the criterion for self-injury.

RESULTS

The results obtained point to an increase in certain problems in high school students in Zagreb. Namely, 17.0% of students reported having injured themselves without suicidal intent on at least one occasion in 2016, while in 2021 this share was as high as 29.1%, i.e., the percentage almost doubled in the second study (χ^2 = 11,501, p < .001). When the scale data for 2021 are observed, the average participants' response is that they never engaged in hurting themselves (M = 0.41; SD = 0.585), which is in line with the percentage of students who reported that they had behaved in this manner on at least one occasion. The 2021 study additionally tested which parts of the body had been affected by self-harm, and the results revealed that these were largely arms, hands, fingers and nails (Table 6). No significant differences were found regarding suicidal ideations between the two studies (χ^2 = .584, p > .05), but in both iterations the proportion of participants who reported having con-

TABLICA 6. Raširenost samoozljeđivanja pojedinih dijelova tijela
TABLE 6. Prevalence of self-injury of specific body parts

Torzo/trup, trbuh, stražnjica ili bokovi / Torso, stomach, buttocks or hips	Glava / Head	Lice / Face	Vrat / Neck	Ruke, dlanovi, prsti, nokti / Hands, arms, fingers, nails	Noge, stopala, nožni prsti / Legs, feet, toes
27,0%	23,6%	10,1%	12,4%	84,3%	38,2%

razmišljali o suicidu bio visok (2016. 27,7 %, a 2021. 24,8 %).

Daljnje analize su pokazale da značajno više samoozljeđivanja iskazuju djevojke nego mladići, i to otprilike dvostruko više, a ista je situacija i kod suicidalnih misli (tablica 7.). Takav se trend nalazi i u rezultatima iz 2016. godine i u podatcima prikupljenima 2021. godine. Što se materijalnog statusa tiče, u tablici 8 prikazane su razlike u postotcima mladih koji su iskazali da se samoozljeđuju i imaju suicidalne misli ovisno o tome kako mladi procjenjuju materijalni status svojih obitelji (imaju manje novaca od drugih obitelji, jednako kao druge obitelji ili više od drugih obitelji). Mladi koji procjenjuju da njihove obitelji imaju manje novaca od drugih iskazuju najviše samoozljeđivanja i suicidalnih misli (tablica 8.).

Kako bi se ispitao doprinos pojedinih prediktorskih varijabli u objašnjavanju samoozljeđivanja i suicidalnih misli izračunate su hijerarhijske regresijske analize u kojima su kao prediktori redom uvođene sociodemografske varijable, varijable roditeljstva, različiti aspekti samopoimanja i strategije suočavanja sa stresom. Prethodno su izračunate korelacije izmesidered suicide on at least one occasion was high (27.7% in 2016 and 24.8% in 2021).

Further analyses showed that adolescent girls report significantly more self-injury than adolescent boys, specifically twice as much, and the same applies to suicidal ideations (Table 7). Such a trend is found in the data from 2016 and the data collected in 2021. In relation to the economic status, Table 8 shows the differences in the percentages of young people who reported that they self-injure and have suicidal ideations depending on how young people assess the financial status of their families (they have less money than other families, the same as other families or more than other families). Young people who assessed that their families had less money than others reported most self-injury and suicidal thoughts among all groups (Table 8).

To test the contribution of individual predictor variables in explaining self-injury and suicidal ideations, hierarchical regression analyses were performed, in which the following predictors were introduced: socio-demographic variables, variables of parenthood, different aspects of self-concept and strategies for coping with stress. Correlations between all tested variables

TABLICA 7. Rodne razlike u samoozljeđivanju i suicidalnim mislima
TABLE 7. Gender differences in self-injury and suicidal ideation

		Djevojke / Adolescent girls	Mladići / Adolescent boys	χ^2
Samoozljeđivanje / Self-injury	2016. godina	21,3%	9,5%	6,017**
	2021. godina	38,2%	19,9%	12,770***
Suicidalne misli / Suicidal ideation	2016. godina	33,9%	16,7%	9,099**
	2021. godina	34,2%	15,8%	14,030***

**p<,01; ***p<,001

TABLICA 8. Razlike u postotcima samoozljeđivanja i suicidalnih misli između mladih iz obitelji različitog materijalnog statusa
TABLE 8. Differences in self-injury and suicidal ideation between adolescents from families of different economic status

		Manje od drugih obitelji / Less than other families	Kao i druge obitelji / Like other families	Više od drugih obitelji / More than other families	χ^2
Samoozljeđivanje / Self-injury	2016. godina	38,7%	12,4%	18,3%	12,982**
	2021. godina	52,4%	25,5%	32,2%	7,084*
Suicidalne misli / Suicidal ideation	2016. godina	48,4%	24,9%	25,0%	7,528*
	2021. godina	66,7%	20,9%	24,7%	20,977***

*p<,05; **p<,01; ***p<,001

đu svih ispitivanih varijabli koje su prikazane u tablici 9. Pritom je kao indikator bračnog statusa korištena dihotomizirana varijabla gdje su roditelji koji su u braku ili izvanbračnoj zajednici kategorizirani u jednu, a svi ostali u drugu skupinu. Korelacijska analiza pokazala je da određene sociodemografske varijable nisu bile značajno povezane s kriterijskima te one nisu uvrštene u daljnje analize, odnosno za kriterij samoozljeđivanja korišten je samo rod sudionika, a za suicidalne misli i procjena materijalnog statusa obitelji.

Kada je kao kriterijska varijabla korišteno samoozljeđivanje (tablica 10.), ženski rod pokazao se značajnim prediktorom u prvom koraku analize kojim je objašnjeno 7,6 % varijance kriterija. Uvođenjem varijabli roditeljstva objašnjeno je dodatnih 26,4 % varijance samoozljeđivanja te su se kao značajni prediktori

had previously been calculated, as shown in Table 9. In this process a dichotomous variable was used, whereby parents who are married or cohabitating were listed in one group, and all others parents in the other. The correlation analysis showed that certain socio-demographic variables were not significantly related to criterion variables, which is why they were excluded from further analyses, i.e., only the participants' gender was used for the criterion of self-injury, with the assessment of family's economic status also included for the criterion of suicidal ideations.

When self-injury was used as a criterion variable (Table 10), female gender proved to be a significant predictor in the first step of the analysis, which accounted for 7.6% of the criterion variance. The introduction of parenthood variables accounted for the additional 26.4% of the self-injury variance, with lower parental warmth

TABLICA 9. Korelacije pretpostavljenih prediktorskih i kriterijskih varijabli
TABLE 9. Correlations between predictors and criterion variables

	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.
Samoozljeđivanje / Self-injury	,757**	-,256**	,047	,022	-,041	-,432**	,486**	-,311**	,367**	-,436**	,302**	-,505**	-,369**	-,348**	-,191**	-,171**	,485**
Suicidalne misli / Suicidal ideations	-	-,232**	,051	,026	-,113*	-,388**	,407**	-,389**	,315**	-,410**	,251**	-,526**	-,446**	-,355**	-,226**	-,191**	,503**
Rod / Gender		-	-,514**	,073	-,012	,012	-,052	,126*	-,048	,039	,083	,248**	,159**	,204**	,209**	-,047	-,460**
Vrsta srednjoškolskog programa / Type of high school programme			-	-,053	,164**	,088	-,106	-,138*	,004	,048	-,072	-,089	-,009	,018	-,179**	,176**	,452**
Bračni status roditelja / Parents' marital status				-	-,086	,036	-,074	,003	-,036	,065	-,056	-,041	-,055	-,029	-,040	-,045	-,050
Materijalni status / Family economic status					-	-,018	,014	,022	,007	,040	,038	,135*	,188**	,134*	,092	,065	,010
Toplina / Warmth						-	-,438**	,516**	-,393**	,655**	-,355**	,362**	,221**	,343**	,202**	,227**	-,180**
Odbijanje / Rejection							-	-,323**	,647**	-,509**	,603**	-,387**	-,241**	-,338**	-,108	-,129*	,288**
Struktura / Structure								-	-,257**	,607**	-,190**	,330**	,256**	,273**	,280**	,220**	-,244**
Kaos / Chaos									-	-,459**	,697**	-,331**	-,154*	-,223**	-,090	-,047	,387**
Potpora autonomiji / Autonomy support										-	-,443**	,402**	,253**	,286**	,153*	,274**	-,196**
Prisila / Coercion											-	-,260**	-,147*	-,137*	-,018	-,164**	,240**
Samopoštovanje / General self-esteem												-	,700**	,643**	,536**	,336**	-,517**
Samopoimanje tjelesnog izgleda / Physical appearance													-	,525**	,553**	,255**	-,369**
Odnosi s vršnjacima istog spola / Same-sex relationships														-	,543**	,209**	-,316**
Odnosi s vršnjacima suprotnog spola / Opposite-sex relationships															-	,167**	-,320**
Konstruktivno suočavanje / Constructive coping																-	,111*
Nekonstruktivno suočavanje / Non-constructive coping																	-

*p<,05; **p<,01

TABLICA 10. Rezultati hijerarhijske regresijske analize za samoozljeđivanje kao kriterij
TABLE 10. Results of hierarchical regression analysis for self-harm as a criterion

Model	Prediktori / Predictors	b	SE	β
1	**Rod / Gender**	**-,329**	**,072**	**-,283****
R^2_{corr} = 0,08; ΔF = 21,11**; F = 21,11**; %V = 7,6; Δ%V = 7,6				
2	**Rod / Gender**	**-,309**	**,062**	**-,266****
	Toplina / Warmth	**-,324**	**,091**	**-,272****
	Odbijanje / Rejection	**,259**	**,070**	**,279****
	Struktura / Structure	,032	,068	,032
	Kaos / Chaos	-,006	,072	-,007
	Potpora autonomiji / Autonomy support	-,104	,087	-,100
	Prisila/ Coercion	,002	,069	,002
R^2_{corr} = 0,34; ΔF = 17,12**; F = 18,90**; %V = 34,0; Δ%V = 26,4				
3	**Rod / Gender**	**-,253**	**,061**	**-,218****
	Toplina / Warmth	**-,295**	**,088**	**-,247****
	Odbijanje / Rejection	**,211**	**,068**	**,227****
	Struktura / Structure	,052	,066	,052
	Kaos / Chaos	-,016	,069	-,018
	Potpora autonomiji / Autonomy support	-,061	,083	-,058
	Prisila / Coercion	-,008	,066	-,009
	Samopoštovanje / General self-esteem	**-,164**	**,053**	**-,250****
	Samopoimanje tjelesnog izgleda / Physical appearance	-,060	,041	-,108
	Odnosi s vršnjacima istog spola / Same-sex relationships	-,011	,048	-,016
	Odnosi s vršnjacima suprotnog spola / Opposite-sex relationships	,067	,035	,119
R^2_{corr} = 0,40; ΔF = 7,12**; F = 15,86**; %V = 40,2; Δ%V = 6,2%				
4	**Rod / Gender**	**-,148**	**,065**	**-,128***
	Toplina / Warmth	**-,299**	**,086**	**-,251****
	Odbijanje / Rejection	**,226**	**,066**	**,243****
	Struktura / Structure	,081	,064	,081
	Kaos / Chaos	-,078	,070	-,086
	Potpora autonomiji / Autonomy support	-,093	,082	-,089
	Prisila / Coercion	-,027	,065	-,031
	Samopoštovanje / General self-esteem	-,093	,056	-,142
	Samopoimanje tjelesnog izgleda / Physical appearance	-,052	,040	-,094
	Odnosi s vršnjacima istog spola / Same-sex relationships	-,017	,047	-,024
	Odnosi s vršnjacima suprotnog spola / Opposite-sex relationships	**,070**	**,034**	**,125***
	Konstruktivno suočavanje / Constructive coping	-,044	,052	-,047
	Nekonstruktivno suočavanje / Non-constructive coping	**,173**	**,044**	**,271****
R^2_{corr} = 0,44; ΔF = 7,87**; F = 15,42**; %V = 43,6; Δ%V = 3,4				

*p<,05; **p<,01

istaknuli niža toplina i veće odbijanje od roditelja. U trećem koraku uvedene su prediktorske varijable samopoimanja čime je objašnjeno još 6,2 % varijance. Samopoštovanje je ovdje bilo jedini poseban značajan prediktor pri čemu niže samopoštovanje predviđa veću učestalost samoozljeđivanja. Posljednjim korakom objašnjeno je dodatnih 3,4 % varijance kriterija te se pokazalo da češće korištenje nekonstruktivnih obrazaca nošenja sa stresom kod sudionika predviđa češće samoozljeđivanje. U tom posljednjem koraku analize samopoštovanje više nije bilo značajan prediktor, što je vjerojatno posljedica medijacijskih efekata. Također se u tom koraku samopoimanje odnosa s vršnjacima suprotnog spola pokazalo kao dodatan značajan prediktor, gdje je moguće da se radilo o posljedici visokih interkorelacija različitih aspekata samopoimanja. Ukupno je analizom objašnjeno 43,6 % varijance samoozljeđivanja.

U tablici 11. prikazani su rezultati hijerarhijske regresijske analize za suicidalne misli kao kriterijsku varijablu. Sociodemografske varijable objasnile su 4,7 % kriterija, pri čemu je ženski rod i ovdje bio značajan samostalni prediktor. Roditeljske varijable objašnjavaju 22,9 % suicidalnih misli, a osim niske topline i visokog odbijanja koji su bili značajni i u prethodnoj analizi, pokazalo se da je manja struktura u roditeljstvu također prediktor suicidalnih misli. Uloga roda i roditeljskih varijabli ostala je značajna i nakon uvođenja varijabli samopoimanja, čime je objašnjeno još 10,0 % varijance kriterija. Lošije samopoimanje tjelesnog izgleda istaknulo se kao jedini značajan prediktor suicidalnih misli u ovom bloku varijabli te je zadržalo svoju značajnost i u posljednjem koraku analize. Ponovno je strategijama suočavanja sa stresom objašnjen značajan postotak varijance kriterija (4,3 %) te su se nekonstruktivni obrasci istaknuli kao zaseban prediktor. U posljednjem koraku analize rod i struktura u roditeljstvu izgubili su značajnost kao prediktori suicidalnih misli, što se vjerojatno može

and higher parental rejection emerging as significant predictors. In the third step, predictor variables of self-concept were introduced, which accounted for the further 6.2% of the variance. Self-esteem proved to be the only significant individual predictor, with lower self-esteem predicting a higher frequency of self-injury. The last step accounted for the additional 3.4% of the criterion variance and showed that more frequent usage of non-constructive stress-coping strategies predicts more frequent self-injury among participants. In this final step of the analysis, self-esteem was no longer a significant predictor, which is probably a consequence of mediating effects. In addition, the opposite-sex peer relations emerged as an additional significant predictor in this step, which may have been caused by high inter-correlations of different aspects of self-concept. The analysis accounted for a total of 43.6% of the self-injury variance.

Table 11 shows the results of the hierarchical regression analysis for suicidal ideations as a criterion variable. Socio-demographic variables accounted for 4.7% of criteria, with female gender re-emerging as a significant individual predictor. Parenthood variables accounted for 22.9% of suicidal ideations. In addition to low parental warmth and high parental rejection, which had proven to be significant in prior analysis, it was shown that less structure in parenting was also a predictor of suicidal thoughts. The roles of gender and parental variables remained significant even after self-concept variables had been introduced, which accounted for the further 10.0% of the criterion variance. More negative self-concept of physical appearance emerged as the only significant predictor of suicidal ideations in this block of variables, and its significance was preserved in the final step of the analysis. The stress-coping strategies once again accounted for a significant percentage of the criterion variance (4.3%) and non-constructive strategies emerged as a separate predictor. In the last step of the analysis the variables of gender and structure in parenting

TABLICA 11. Rezultati hijerarhijske regresijske analize za suicidalne misli kao kriterij
TABLE 11. Results of hierarchical regression analysis for suicidal ideations as a criterion

Model	Prediktori / Predictors	b	SE	β
1	**Rod / Gender**	**-,420**	**,116**	**-,232****
	Materijalni status obitelji / Family economic status	-,082	,104	-,050
R^2_{corr} = 0,05; ΔF = 6,81**; F = 6,81**; %V = 4,7; Δ%V = 4,7				
2	**Rod / Gender**	**-,385**	**,104**	**-,212****
	Materijalni status obitelji / Family economic status	-,091	,091	-,056
	Toplina / Warmth	**-,329**	**,150**	**-,178***
	Odbijanje / Rejection	**,293**	**,115**	**,200****
	Struktura / Structure	**-,308**	**,112**	**-,198****
	Kaos / Chaos	,010	,119	,007
	Potpora autonomiji / Autonomy support	-,030	,145	-,018
	Prisila / Coercion	,067	,114	,049
R^2_{corr} = 0,28; ΔF = 13,22**; F = 12,15**; %V = 27,6; Δ%V = 22,9				
3	**Rod / Gender**	**-,315**	**,101**	**-,174****
	Materijalni status obitelji / Family economic status	-,002	,086	-,001
	Toplina / Warmth	**-,310**	**,143**	**-,168***
	Odbijanje / Rejection	**,224**	**,110**	**,153***
	Struktura / Structure	**-,255**	**,106**	**-,164***
	Kaos / Chaos	,026	,111	,018
	Potpora autonomiji / Autonomy support	,015	,136	,009
	Prisila / Coercion	,027	,107	,020
	Samopoštovanje / General self-esteem	-,103	,085	-,102
	Samopoimanje tjelesnog izgleda / Physical appearance	**-,291**	**,068**	**-,336****
	Odnosi s vršnjacima istog spola / Same-sex relationships	,023	,079	,022
	Odnosi s vršnjacima suprotnog spola / Opposite-sex relationships	,103	,058	,118
R^2_{corr} = 0,38; ΔF = 10,09**; F = 12,77**; %V = 37,6; Δ%V = 10,0%				
4	Rod / Gender	-,142	,106	-,079
	Materijalni status obitelji / Family economic status	-,028	,083	-,017
	Toplina / Warmth	**-,320**	**,138**	**-,173***
	Odbijanje / Rejection	**,252**	**,106**	**,172***
	Struktura / Structure	-,200	,103	-,129
	Kaos / Chaos	-,075	,112	-,053
	Potpora autonomiji / Autonomy support	-,024	,133	-,015
	Prisila / Coercion	-,006	,104	-,005
	Samopoštovanje / General self-esteem	,023	,088	,023
	Samopoimanje tjelesnog izgleda / Physical appearance	**-,265**	**,066**	**-,307****
	Odnosi s vršnjacima istog spola / Same-sex relationships	,011	,076	,010
	Odnosi s vršnjacima suprotnog spola / Opposite-sex relationships	,105	,056	,119
	Konstruktivno suočavanje / Constructive coping	-,112	,085	-,077
	Nekonstruktivno suočavanje / Non-constructive coping	**,301**	**,071**	**,301****
R^2_{corr} = 0,42; ΔF = 9,10**; F = 13,04**; %V = 41,9; Δ%V = 4,3				

*p<,05; **p<,01

pripisati medijacijskim efektima. Odabranim prediktorima objašnjeno je ukupno 41,9 % varijance suicidalnih misli.

RASPRAVA

Prvi cilj ovog rada bio je usporediti pojavnost samoozljeđivanja i suicidalnih misli na uzorku srednjoškolaca Grada Zagreba u petogodišnjem razdoblju. Rezultati ukazuju na značajan porast samoozljeđivanja kod mladih, koje se gotovo udvostručilo (29,1 % 2021. godine u odnosu na 17 % 2016. godine). Iako se pojavnost suicidalnih misli nije povećala (27,7 % 2016. i 24,8 % 2021.), ovaj veliki skok autoagresivnog ponašanja ukazuje na značajne poteškoće mentalnog zdravlja mladih u (post)pandemijskom razdoblju. Kao što je u uvodu naglašeno, samoozljeđivanje sa suicidalnom namjerom ili bez nje nerijetko dovodi do samih pokušaja suicida (15,34,50) te je time alarm za trenutne i buduće probleme u ponašanju i doživljavanju adolescenata i zahtijeva ranu intervenciju sa svrhom smanjivanja rizika od suicida (51). Kako se adolescenti samoozljeđuju najčešće na području ruku (to se događa kod preko 80 % mladih iz našeg uzorka koji se samoozljeđuju), moguća je vjerojatnost ranog uočavanja problema od (brižnih) odraslih, ali i od bliskih prijatelja. U tu je svrhu o ovoj temi potrebna edukacija školskih djelatnika, ali i otvaranje tabuiziranih tema kao što su samoozljeđivanje i suicidalnost i s učenicima i roditeljima.

Kako u ovom, tako se i u drugim istraživanjima pokazalo kako se pandemija COVID-19 negativno odrazila na mentalno zdravlje, pogotovo mladih (23,24). Robillard i sur. (52) navode kako jedan od povoda samoozljeđivanju je nemogućnost regulacije emocija, naročito u situacijama koje su izvan naše kontrole i koje ne možemo riješiti. Autori navode da je pandemija upravo jedna od takvih situacija i time objašnjavaju porast samoozljeđivanja u doba pandemije, koje dodatno eskalira kod mladih koji su

lost their significance as predictors of suicidal thoughts, which is likely to be attributed to mediating effects. Selected predictors accounted for a total of 41.9% variance of suicidal ideations.

DISCUSSION

The first objective of this paper was to compare the prevalence of self-injury behaviour and suicidal ideations on a sample of high-school students in the City of Zagreb over a five-year period. The results indicate a significant, almost two-fold increase in self-injury among young people (29.1% in 2021 compared with 17% in 2016). Although the occurrence of suicidal ideation did not increase in the same period (27.7% in 2016 and 24.8% in 2021), such a surge in self-aggressive behaviours points to significant mental health problems in young people in the (post)pandemic period. As pointed out in the Introduction, NSSI and DSH frequently lead to suicide attempts (15,34,50), and therefore represent an alarm for the current and future problems in adolescents' behaviour and experiences requiring early interventions aimed at reducing suicide risk (51). Since adolescents most frequently self-injure their hands and arms (which was the case for over 80% of young people in our sample who engage in self-injury behaviour), the likelihood of an early detection of the problem by (caring) adults or close friends is possible. Therefore, training school staff about this issue is necessary, along with opening up taboo topics such as self-injury and suicidality for discussion with students and parents.

In the context of the pandemic, its negative impact on mental health, particularly among youth, was confirmed by a number of studies (23, 24). Robillard and et al. (52) state that one of the reasons for self-injury is the inability to regulate emotions, especially in situations beyond our control and that we cannot solve. The authors state that the pandemic is precisely one of those situations and thus explain the in-

distanciraniji od svojih vršnjaka. Stoga je neizmjerno važno u budućnosti pri odlučivanju o epidemiološkim mjerama voditi računa kako će se one odraziti na mentalno zdravlje građana, jer je ono neizostavni dio zdravlja uopće (53). Jedan od pomaka u tom smjeru bilo bi uključivanje stručnjaka mentalnog zdravlja (psihologa, psihijatara, socijalnih radnika...) u stožere koji odlučuju o zdravstvenim i socijalnim politikama u kriznim situacijama, a što tijekom pandemije COVID-19 u Hrvatskoj nije bio slučaj. Mjere izolacije i *online* nastave pridonijele su otežanom zadovoljavanju razvojnih potreba u adolescenciji, a djecu koja odrastaju u obiteljima koje su u riziku stavila su u još nesigurnije i resursima oskudnije okruženje te time i u veći rizik od pojave poteškoća mentalnog zdravlja (23,54).

U literaturi se dosljedno pokazuje kako su djevojke u većem riziku i za samoozljeđivanje i za suicidalne misli od mladića (39,55), a isto je potvrđeno i u ovom istraživanju. Izrazito je važno istaknuti kako, iako kod oba roda vidimo značajan porast samoozljeđivanja, gotovo dvostruki broj djevojaka (u odnosu na mladiće) i u prvom i u drugom valu istraživanja izvješćuje o oba istraživana problema u spektru suicidalnosti. Ovakav nalaz u kojem su djevojke pod značajno većim rizikom od suicidalnosti ukazuje na to da bi se u budućim istraživanjima trebalo provoditi odvojene analize za mladiće i djevojke, istražiti specifične prediktore samoozljeđivanja i suicidalnih misli djevojaka odnosno mladića, dok je u praktičnom radu potrebno što prije usmjeriti se na zaštitu mentalnog zdravlja djevojaka i jačati zaštitne čimbenike koji doprinose očuvanju i promicanju njihovog mentalnog zdravlja.

Što se tiče socioekonomskih obilježja, veći udio samoozljeđivanja i suicidalnih misli vidljiv je kod mladih lošijeg materijalnog statusa. Odrastanje u siromaštvu (ili riziku od siromaštva) za sobom povlači niz nepovoljnih životnih okolnosti (npr. učestali nepovoljni

crease in self-injury during the pandemic, which further escalates among young people who are more distant from their peers. It is vitally important that any future decisions on epidemiological measures consider the impact that these measures have on citizens' mental health, which is an integral part of the overall health (53). A positive step in that direction would be to ensure that mental health professionals (e.g., psychologists, psychiatrists, social workers, etc.) are included in the bodies responsible for making decisions on health and social policies in crisis situations (such as the Civil Protection Headquarters in Croatia), which was not the case in Croatia during the COVID-19 pandemic. The measures of social isolation and online learning contributed to difficulties in meeting developmental needs during adolescence. Children growing up in at-risk families were restricted to less safe and deprived environments, which increased their risk of mental health problems (23,54).

The literature consistently shows that girls are at higher risk of both NSSI and suicidal ideations than boys (39, 55), and this was confirmed in this study as well. It is essential to point out that, although we see a significant increase in self-injury in both genders, almost twice as many adolescent girls (when compared to adolescent boys) reported experiencing both of the studied problems from the spectrum of suicidality in both the first and the second wave of the study. This finding, in which girls are at a significantly higher risk of suicidality, indicates that in future research, separate analyses should be conducted for boys and girls, whereas specific predictors of self-injury and suicidal thoughts of girls and boys should be investigated. At the same time, in practical work, it is necessary to focus on protecting girls' mental health as soon as possible and to strengthen the protective factors contributing to preserving and promoting their mental health. With respect to socio-economic characteristics, a higher share of self-injury and suicidal ideations was noted among young people of lower financial status. Growing

životni događaji, izraženi stres, nedovoljno resursa za optimalni psihosocijalni razvoj adolescenata, nedostupnost, niže obrazovanje i/ili nedovoljna uključenost roditelja u probleme odrastanja djece, stigmatizacija u školskom okruženju...), koje mogu prethoditi ili dodatno održavati poteškoće mentalnog zdravlja mladih.

Kako je drugi cilj ovog rada bio istražiti prediktore samoozljeđivanja i suicidalnih misli kod srednjoškolaca uz već navedene sociodemografske čimbenike provjeren je doprinos i nekih osobnih i roditeljskih čimbenika u objašnjavanju navedenih konstrukata. Rezultati hijerarhijskih regresijskih analiza ukazuju da odabrani skupovi prediktora objašnjavaju izrazito visoke postotke varijance i samoozljeđivanja (43,6 %) i suicidalnih misli (41,9 %). Pritom je manje izražavanja topline od roditelja i više odbijanja povezano s obje vrste autoagresivnih pokazatelja, dok je izostanak strukture i vođenja od roditelja povezan s većom suicidalnošću mladih. Prema Joinerovoj Interpersonalnoj teoriji suicidalnog ponašanja (34) osjećaj nepripadanja nikome je jedan od glavnih elemenata koji vode ka pokušaju i/ili počinjenju suicida, a opetovano odbijanje od strane roditelja i izostanak pokazivanja roditeljske topline, ljubavi i prihvaćanja u osjetljivom adolescentskom razdoblju mogu izrazito narušiti pojedinčevu sliku o sebi i podržati vjerovanje da je neželjen/a ili da nigdje ne pripada. S druge strane, kako navodi Pećnik (56), struktura i vođenje već od najranije dobi jedan su od četiri stupa roditeljstva koja su u najboljem interesu djeteta i odgovaraju na djetetove potrebe za sigurnošću, predvidivošću i kompetentnošću. Kod adolescenata usmjeravanje mlade osobe, postavljanje jasnih granica prihvatljivog i neprihvatljivog ponašanja, objašnjavanje određenih pravila (ponašanja) te podržavanje u suočavanju s problemima može doprinijeti uspješnijem suočavanju s problemima te smanjenim „tunelskim“ načinom raz-

up in poverty (or at risk of poverty) implies a series of adverse living conditions (e.g. more frequent negative life events, high stress, inadequate resources for adolescents' psychosocial development, lower parental education level, their lack of availability and/or their insufficient involvement in their children's growing-up problems, stigmatisation in school environment, etc.), which may precede or further sustain mental health problems in young people.

Having in mind that the second objective of this paper was to study the predictors of self-injury behaviour and suicidal ideations in high-school students, in addition to the above socio-demographic factors, the contribution of certain personal and parental factors in explaining these constructs was also examined. The results of hierarchical regression analyses indicated that the selected sets of predictors accounted for markedly high variance percentages of both self-injuries (43.6%) and suicidal ideations (41.9%). Lower expression of parental warmth and more frequent parental rejections were related to both types of self-aggressive indicators, while a lack of structure and parental guidance was tied to higher suicidality among young people. According to Joiner's interpersonal theory of suicidal behaviour (34), the feeling of not belonging to anyone is one of the key elements leading to an attempt or an act of suicide, and repeated parental rejection and a lack of expressing parental warmth, love and acceptance during the sensitive adolescent period may seriously undermine a person's self-image and support the belief that they are unwanted and do not belong anywhere. On the other hand, as noted by Pećnik (56), from the earliest age, structure and guidance constitute one of the four pillars of parenting, which are in the best interest of the child and respond to the child's needs for security, predictability and competence. For adolescents, guiding a young person, setting clear limits of acceptable and unacceptable behaviours, explaining certain rules (of behaviour), and providing support in

mišljanja, tipičnom za pojedince sklone počinjenju suicida (57, 58).

Što se tiče samopoimanja adolescenata, percepcija vlastitog tjelesnog izgleda pokazala se značajnom u predviđanju suicidalnih misli. Usmjerenost na vlastiti tjelesni izgled znatno je veća u razdoblju adolescencije u odnosu na raniji period života (59, 60) i zadovoljstvo izgledom uvelike određuje i generalnu sliku o sebi i psihosocijalno funkcioniranje uopće (61). Povezanost (ne)zadovoljstva tjelesnim izgledom, samopoštovanja i mentalnog zdravlja posebno je značajna kod djevojaka (60,62) koje su, kako je i ranije prikazano, ranjivije za samoozljeđivanje i suicidalne misli. Također, nisko samopoštovanje se pokazalo značajnim u predviđanju samoozljeđivanja adolescenata, što je u skladu s Nockovim Integriranim teorijskim modelom samoozljeđivanja (28) prema kojem intrapersonalni faktori ranjivosti, među kojima su i snažne averzivne kognicije i emocije usmjerene prema sebi, predviđaju neadekvatne ili neprilagođene odgovore osobe na stres, što vodi samoozljeđivanju.

Konačno, posljednji skup prediktorskih varijabli odnosio se na načine suočavanja sa stresom, koji su također objasnili značajan postotak varijance obih kriterija (3,4 % i 4,3 %). U ovom istraživanju u grubo smo, iz ranije navedenih statističkih razloga, podijelili načine suočavanja na konstruktivne i nekonstruktivne i upravo su se potonji pokazali značajnima u predviđanju samoozljeđivanja i suicidalnih misli. Nekonstruktivni načini suočavanja uključivali su izbjegavanje, ruminaciju, rezignaciju i agresiju. Iz ranijih istraživanja već je dobro poznato da su ruminacije česte kod suicidalnih mladih i onih koji se samoozljeđuju (63-65), a što se tiče agresivnosti, istraživanja pokazuju da su mladi koji iskazuju eksternalizirane probleme u ponašanju češće u riziku od samoozljeđivanja i suicida od onih mladih koji nemaju te probleme (66,67). Nadalje, strategije izbjegavanja suočavanja u koje se ubraja

facing challenges may contribute to better coping and reduced "tunnel vision", which is a way of thinking typical for individuals prone to committing suicide (57, 58).

With respect to adolescents' self-concept, the perception of one's own physical appearance proved to be significant in predicting suicidal ideations. The focus on one's physical appearance is considerably higher in the period of adolescence than in pre-adolescent life (59, 60) and satisfaction with one's physical appearance has a large influence on the general self-image as well as the overall psychosocial functioning (61). The relation between (dis)satisfaction with physical appearance, self-esteem and mental health is particularly significant in girls (60,62) who are, as previously shown, more vulnerable to self-injury and suicidal thoughts. In addition, low self-esteem proved to be significant for predicting self-injuring among adolescents, which is in line with Nock's integrated theoretical model of NSSI (28), whereby intrapersonal vulnerability factors, including high self-directed aversive cognitions and emotions, predispose a person to inadequate or maladapted responses to stress, which, in turn, lead to self-injury.

The last set of predictor variables was related to ways of coping with stress, which also explained a significant percentage of variance of both criteria (3.4% and 4.3%). For statistical reasons outlined above, in this paper we divided the stress coping strategies into constructive and non-constructive, with the latter emerging as significant for predicting both self-injuries and suicidal thoughts. Non-constructive stress-coping strategies included avoidance, rumination, resignation and aggression. It is well-known from earlier studies that ruminations are common among suicidal youth and those who engage in self-injury (63, 64, 65), and with regard to aggression, studies show that young people with externalising behaviour problems are at a higher risk of NSSI and suicide than young people without such problems (66, 67). Further-

i rezignacija kao odustajanje od suočavanja, može voditi izolaciji i otuđenju koji povećavaju vjerojatnost suicidalnosti kod mladih te su i ranija istraživanja pokazala kako je ono povezano s internaliziranim i eksternaliziranim problemima kod mladih (68). Iako ovi nalazi imaju jasne praktične implikacije i ukazuju na to koji načini suočavanja sa stresom nisu korisni i mogu dovesti do problema mentalnog zdravlja, važno je mladima osvijestiti kojim obrascima ponašanja zamijeniti te nekonstruktivne, odnosno podučiti ih konstruktivnim načinima suočavanja sa stresom, kao što je rješavanje problema, osvještavanje i traženje socijalne podrške, ne samo od vršnjaka, već i od odraslih, primjenjivanje kognitivnih samouputa i sl. Takve tehnike pridonose jačanju otpornosti mladih i razvoju samosvijesti, u čemu su dobri, a u čemu nisu te kako se suočiti s teškim situacijama koje ih zasigurno čekaju u životu. Pri takvom osnaživanju mladih važno je da su odrasli koji su s njima u kontaktu topli, brižni, strukturirajući, reflektivni na njihove potrebe te usmjeravajući, budući da se pokazalo da su upravo ta obilježja roditeljstva zaštitni čimbenik u prevenciji mentalnog zdravlja.

Na kraju, iako je ovo istraživanje dalo vrijedne nalaze, pogotovo s obzirom na to da je tema suicidalnosti u općoj populaciji adolescenata kod nas izrazito rijetko znanstveno istraživana, važno je upozoriti i na neke nedostatke njegove provedbe. Kao prvo, kako je istraživanje provedeno 2021. godine zapravo je probno istraživanje inače većeg znanstvenog projekta, korišten je relativno mali prigodni uzorak, što onemogućava generaliziranje rezultata na populaciju učenika prvih razreda zagrebačkih srednjih škola, već usporedbom podataka iz dva vala istraživanja možemo vidjeti tek trend u promjenama poteškoća mentalnog zdravlja mladih. Dodatni nedostatak u ovoj prigodnosti je to što su u uzorku podzastupljene strukovne škole koje pohađaju većinom učenice, a

more, avoidant coping strategies, which include resignation and giving up, can lead to isolation and alienation, which, in turn, increase the likelihood of suicidality among youth. As earlier studies have shown, such behaviour is related to internalising and externalising problems among youth (68). Although these findings have clear practical implications and indicate which stress coping strategies are not useful and can lead to mental health problems, it is important to raise young people's awareness of behavioural patterns which should replace these non-constructive behaviours, i.e. teach them the constructive stress coping strategies, such as problem-solving and seeking social support, not only from their peers, but also from adults, applying cognitive self-instructions, etc. These techniques help build resilience and develop self-awareness about things young people are good at and things they are not so good at, and show them how to cope with difficult situations they may well encounter in their lifetime. In such youth empowerment activities, it is important that adults interacting with young people are warm, caring and reflective of their needs, and that they provide structure and guidance, since it has been proven that these characteristics of parenthood are a protective factor in mental health prevention.

Finally, although this study provided valuable findings, especially given the fact that the topic of suicidality in the general population of adolescents is very rarely scientifically studied, it is important to address some of the limitations of its implementation. First of all, since the study implemented in 2021 was actually a pilot study of a larger scientific project, a relatively small convenience sample was used, which prevents the generalisation of results to the population of 1st grade students from highs schools in Zagreb. Instead, the comparison of the data obtained in the two studies allows us to simply observe a trend in the changes of mental health problems in youth. An additional limitation of the convenience sample used is that vocational schools attended large-

koje su nam se u ranijim istraživanjima pokazale najrizičnijima u ovom spektru problema (no, da su bile zastupljenije, već sada istaknute promjene u suicidalnosti i samoranjavanju mladih bi vjerojatno bile još nepovoljnije). Također, iako se u literaturi (naročito američkoj) jasno razdvaja nesuicidalno samoozljeđivanje (*nonsuicidal self-injury – NSSI*) od namjernog samoozljeđivanja (*deliberate self-harm – DSH*), mjerni instrument korišten u ovom istraživanju nije ispitivao namjeru počinjenja suicida pri samoranjavanju. Konačno, usporedba između rezultata iz dvaju istraživanja prezentirana u ovom radu nije direktno usporediva kako nije riječ ni o longitudinalnim podatcima ni o istoj metodologiji istraživanja, već su samo uspoređeni podatci o prevalenciji samoranjavanja i suicidalnih misli. Buduća istraživanja usmjerena većem razumijevanju poteškoća mentalnog zdravlja mladih općenito, a suicidalnosti i samoranjavanja u adolescenciji pogotovo, izrazito su potrebna. Naravno, poželjno je da se pritom koriste veliki uzorci na općoj populaciji, ne samo kliničkoj koja je češće zastupljena, te da se mladi prate već od predadolescentnog razdoblja, prije nego se problemi najčešće pojavljuju. Pritom se pokazalo također izrazito važnim voditi računa o rodnim razlikama i specifičnostima poteškoća mentalnog zdravlja djevojaka u odnosu na mladiće.

ly by female students were underrepresented in the sample, and earlier studies had shown that these students are at the highest risk for these problems (had these students been better represented, the observed changes in suicidality and NSSI among youth would likely have been even more unfavourable). Furthermore, although in literature (particularly American) non-suicidal self-injury (NSSI) is distinguished from deliberate self-harm (DSH), the measuring instrument used in this study in 2021 sample did not examine suicidal intent in the act of inflicting self-harm. Finally, a comparison of the results from the two studies presented in this paper was not directly comparable, given that these were neither longitudinal data, nor was the research methodology the same: instead, simply the data on the prevalence of self-injury behaviour and suicidal thoughts were compared. Future research focused on enhancing the understanding of mental health problems in young people in general, and particularly of suicidality and self-injury in adolescence, is highly needed. Naturally, such studies should aim to use large samples of general population, rather than only clinical population, which is more frequently represented, and young people should be monitored from pre-adolescent age, when the problems most frequently emerge. At the same time, it was also important to consider gender differences and the specifics of girls' mental health difficulties compared to boys.

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Socijalno-ekonomski status i mentalno zdravlje u Crnoj Gori: socio-geneza duševnih poremećaja u jednom tranzicijskom društvu

/ Socioeconomic Status and Mental Health in Montenegro: Socio-genesis of Mental Disorders in a Transitional Society

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Socijalnim modelom u psihijatriji prepoznata je socijalno-genetska osovina etiologije duševnih poremećaja. Istraživanja na Zapadu uglavnom pokazuju da poremećaji iz psihotične i depresivne kategorije zahvaćaju pripadnike nižih socijalno-ekonomskih stratuma. Da bi se opisao socio-ekonomski status psihijatrijskih pacijenata u crnogorskom društvu, kao tranzicijskom, te da bi se ukazalo na socijalno-etiološku osovinu geneze duševnih poremećaja u navedenom društvenom kontekstu, pristupljeno je istraživanju s kvazieksperimentalnim dizajnom. Kontrolni dio uzorka čine sudionici u istraživanju kod kojih nije dijagnosticiran duševni poremećaj, dok se eksperimentalni dio uzorka sasoji od pojedinaca kod kojih je dijagnosticiran psihotični ili depresivni poremećaj. Rezultati istraživanja ukazuju na tijesnu prepletenost socijalne i psihijatrijske problematike u crnogorskom društvu: psihijatrijski pacijenti dolaze iz porodica slabijeg socijalno-ekonomskog statusa, a i sami su opterećeni nizom socio-ekonomskih problema poput onih stambene prirode. Uvažavajući teorijske i praktične spoznaje socijalnog modela u psihijatriji, a s obzirom na rezultate istraživanja, na incidenciju i prevalenciju duševnih poremećaja u jednom tranzicijskom društvu moglo bi se utjecati intervencijama u području socijalne politike.

/ In psychiatry, the social model recognises the socio-genetic axis of the etiology of mental disorders. Research conducted in the western countries generally indicates that disorders within the range of psychotic and depressive categories affect members of the lower socioeconomic strata. For the needs of this paper, a quasi-experimental research was conducted in order to describe the socioeconomic status of psychiatric patients in Montenegrin society, which can be categorised as transitional, and to underline the socio-etiological axis of the genesis of mental disorders in the aforementioned social context. The control sample consisted of research participants who have not been diagnosed with a mental disorder, whereas the experimental sample consisted of individuals who have been diagnosed with a psychotic or depressive disorder. The results of the study indicate the intertwined nature of social and psychiatric issues within Montenegrin society: psychiatric patients were from families of a lower socioeconomic status, and burdened with a number of socioeconomic issues, such as those of a residential character. Taking into consideration both theoretical and practical knowledge brought about by the social model in psychiatry together with the results of our study, it is our conclusion that the incidence and prevalence of mental disorders in a transitional society could be influenced by interventions in the field of social policy.

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UVOD

U psihijatriji je aktualan bio-psiho-socijalni model tumačenja geneze duševnih poremećaja (1) koji poremećaj sagledava kao rezultantu međusobnog djelovanja čovjekove biološke/konstitucionalne osovine, psiholoških faktora, te okolinskih/socijalnih utjecaja. Tek poslijeratnom „socijalnom revolucijom" (2) u području pomažućih profesija otvoren je prostor za ispitivanje društvenih, interpersonalnih i okolinskih faktora u etiologiji duševnih poremećaja. Jedan od je socijalnih faktora koji je, u istraživanjima na Zapadu, dovođen u vezu s postojanjem duševnog poremećaja socijalno-ekonomski status pojedinca i porodice. U skladu sa socijalnom paradigmom u psihijatriji (3), ovaj faktor je tretiran kao jedan od socio-genetskih vektora duševnih poremećaja.

Autori koji su radili na meta-analizi dvadeset istraživanja povedenih između 1950. i 1980. godine u Sjevernoj Americi i Europi (4) utvrđuju da su stope duševnih poremećaja oko 2,5 puta veće u najnižim socijalno-ekonomskim slojevima u usporedbi s višim. Novija studija (5) pokazuje da su „uobičajeni duševni poremećaji" poput depresije i anskioznih poremećaja distribuirani tako da prate ekonomske indikatore pojedinca, porodice i zajednice, odnosno da su siromašniji i socijalno isključeni slojevi

INTRODUCTION

Psychiatry is currently dominated by the bio-psycho-social model of interpretation of the genesis of mental disorders (1), which treats the disorder as a result of a combination of a person's biological/constitutional axis, psychological factors, and environmental/social influences. Social, interpersonal and environmental factors have started to be examined in the context of aetiology of mental disorders only after the postwar "social revolution" (2) in the field of helping professions. The research conducted in the western countries found that the socioeconomic status of the individual and the family is one of the social factors linked to the emergence of mental disorders. In line with the social paradigm in psychiatry (3), this factor was treated as one of the socio-genetic vectors of mental disorders.

The authors of a meta-analysis (4) of twenty studies conducted between 1950 and 1980 in North America and Europe stated that the rates of mental disorders were about 2.5 times higher in the lowest socioeconomic strata than in the higher ones. A recent study (5) showed that "common mental disorders", such as depression and anxiety disorders, are distributed in a way that they follow the economic indicators associated with the individual, the family and the community, i.e. that the poor and so-

stanovništva pod većim rizikom kada je u pitanju pojava poremećaja iz ove grupe. Srodna studija (6) dovodi u vezu postojanje financijskog duga kod pojedinca s duševnim poremećajem: što više financijskih obaveza pojedinci imaju, to su veće mogućnosti da se kod njih razvije duševni poremećaj.

Kada su u pitanju poremećaji raspoloženja, Marić (7) ističe da se ovi poremećaji često javljaju „i kod viših socio-ekonomskih grupa, za razliku od shizofrenije, koja se javlja kod siromašnih porodica." Ipak, na istom mjestu, autor dodaje i da ima istraživanja koja „s razlogom" ukazuju da su depresije veoma česte i kod nižih socijalno-ekonomskih kategorija „usled nemogućnosti realizacije kvalitetnih modela življenja sa posledičnim razočarenjima". Novija studija koja je osnovana na pregledu relevantne literature (8) pokazuje da su poremećaji raspoloženja (kao i poremećaji povezani s anksioznošću) 2,5 puta češći kod mladih koji su slabijeg socijalno-ekonomskog statusa, nego kod njihovih vršnjaka koji dolaze iz dobrostojećih porodica. Munjiza (9) pak navodi da relevantnim istraživanjem nije pronađena statistički značajna razlika ni kod teže depresivne epizode ni kod distimije u odnosu na obrazovni status, kao jedan od indikatora socijalno-ekonomskog statusa. Miech i Shanahan su u novijoj studiji (10) identificirali da se simptomi depresije ponašaju različito u funkciji vremena u odnosu na stupanj obrazovanja ispitanika: što je stupanj obrazovanja pojedinca viši, to simptomi depresije postaju blaži tijekom dužeg razdoblja. Drugim istraživanjem (11) je identificirano da postoji snažna negativna korelacija između stupnja obrazovanja i „uobičajenih duševnih poremećaja", dok istim istraživanjem nije identificirana direktna veza između prihoda i ovih poremećaja. Dodajući dizajnu istraživanja varijablu spola, Brown i Harris (12) su pokazali da je stopa depresija kod žena iz radničke klase gotovo četiri puta veća nego kod žena iz srednje klase. U studiji (13) koja razmatra

cially excluded groups in the population were at a greater risk of occurrence of disorders. A related study (6) linked the existence of financial debt with mental disorders: the more financial obligations an individual has, the greater the chances of developing a mental disorder.

In terms of mood disorders, Marić (7) pointed out that these disorders also often occurred "in higher socioeconomic groups, unlike schizophrenia, which normally occurs in poor families." However, the author added that there were studies that "justifiably" indicated that depression was also common among lower socioeconomic categories "due to the impossibility of achieving quality models of living, with consequent disappointment". A more recent study, based on a review of the relevant literature (8), showed that mood disorders (as well as anxiety-related disorders) were 2.5 times more common among young people from a lower socioeconomic background than among their peers from well-off families. On the other hand, Munjiza (9) stated that the relevant research did not find a statistically significant difference neither in severe depressive episodes nor in dysthymia in relation to educational status, as one of the indicators of socioeconomic status. In a recent study (10), Miech and Shanahan found that depressive symptoms behave differently over time in relation to the level of education of the subjects: the higher the level of education of the individual, the milder the symptoms of depression over a longer time interval. Another study (11) found that there was a strong negative correlation between the level of education and "common mental disorders", while the same study did not identify a direct link between income and these disorders. Adding the gender variable to the research design, Brown and Harris (12) found that the rate of depression among working-class women was nearly four times that of middle-class women. A study (13) that considered several socioeconomically conceptualised predictor models for depressive symptomatology in married couples,

više socijalno-ekonomski konceptualiziranih prediktorskih modela za depresivnu simptomatologiju kod bračnih parova, identificirano je da porast vrijednosti indikatora putem kojih je operacionaliziran konstrukt „ekonomske poteškoće“ utječe na povećanje izražavanja depresivne simptomatologije kod oba supruga. Navodeći nalaze Bebbingtona iz 1981. godine, Munjiza (14) utvrđuje tendenciju prema većoj stopi prevalencije depresije kod radničke klase nego kod ostalih klasa. Ovdje se, u skladu sa socijalističkim društvenim uređenjem, o radničkoj klasi govori kao o zajednici ljudi koji imaju nižu ili srednju stručnu spremu, dok se termin „više klase“ koristi da bi se imenovali pojedinci s visokim obrazovanjem. Možemo zaključiti da je, iako rezultati istraživanja na Zapadu nisu do kraja konzistentni, generalno utvrđena negativna korelacija između pojedinih indikatora socijalno-ekonomskog statusa pojedinca i poremećaja raspoloženja kao i uobičajenih duševnih poremećaja.

Rezultati poznatijih istraživanja koja dovode u vezu psihotične poremećaje (naročito shizofreniju) i socijalno-ekonomski status, a na koje se osvrće Kecmanović (15), favorizirajući tezu da postoji koncentracija osoba oboljelih od shizofrenije, kao i onih koji pate od ostalih vrsta psihoza, u nižim socijalnim strukturama. Munjiza konstatira (16) da „ni incidencija ni prevalencija shizofrenije nisu haotično distribuirani u socijalnim klasama“, da se „stalno nailazi na više slučajeva u nižim klasama nego što se to može očekivati slučajem“ te da se povećanje stope ovog poremećaja u najnižim socijalnim klasama može smatrati „čvrsto ustanovljenim“. Analizirajući rezultate obimnijih istraživanja distribucije duševnih poremećaja prema zanimanjima, to jest rezultate istraživanja međuodnosa psihoze, ekonomske sigurnosti i socijalnog prestiža, Clark (17) zaključuje da je, za mentalno zdravlje, prestiž važniji od ekonomske sigurosti i materijalnih prinadležnosti koje osigurava obavljanje određenog za-

found that an increase in the value of indicators used to operationalize the concept of “economic difficulties” led to an increase in the manifestation of depressive symptomatology in both spouses. Citing the findings of Bebbington from 1981, Munjiza (14) found a tendency towards a higher prevalence of depression among the working class than among other classes. In line with the socialist system of government, working class was defined as a community of people with lower or secondary education, while the term “upper class” was used to designate individuals with higher education. Although the results of research conducted in the western countries are not completely consistent, we can conclude that a negative correlation has generally been established between certain indicators of an individual’s socioeconomic status and mood disorders, as well as common mental disorders.

Results of a well established study linking psychotic disorders (especially schizophrenia) with socioeconomic status, to which Kecmanović refers (15), favoured the thesis that in lower social structures there was a concentration of people suffering from schizophrenia, as well as those suffering from other types of psychosis. Munjiza stated (16) that “neither the incidence nor the prevalence of schizophrenia is chaotically distributed in social classes”, that “more cases are constantly encountered in lower classes than can be expected by chance” and that the increase in the rate of this disorder in the lowest social classes could be considered “firmly established”. Analysing the results of more extensive research on the distribution of mental disorders according to occupations, i.e. the relationship between psychosis, economic security and social prestige, Clark (17) concluded that, for mental health, prestige was more important than economic security and material belongings ensuring the performance of a certain occupation. Research (18) conducted by Pasamanick, Roberts, Lemkau and Krueger in Boston, on a representative sample consisting of non-hospitalised individuals, sup-

nimanja. Istraživanje (18) koje su Pasamanick, Roberts, Lemkau i Krueger provodili u Bostonu i to na reprezentativnom uzorku koji su sačinjavali nehospitalizirani pojedinci, išlo je u prilog tezi o koncentraciji psihotičnih poremećaja među nižim socijalno-ekonomskim slojevima. Ovo istraživanje je pokazalo da broj psihotičnih poremećaja, u cjelini, opada sa porastom indikatora socijalno-ekonomskog statusa, osim za najniži socijalni sloj. Jaco je, istražujući (19) odnos između incidencije svih oblika psihotičnih poremećaja i socijalnog statusa stanovnika Teksasa, utvrdio korelaciju zakrivljenog oblika (poput slova „U“). Ovim istraživanjem je, naime, identificiran visok stepen incidencije psihotičnih pormećaja među pripadnicima najnižeg i najvišeg socijalno-ekonomskog sloja, dok pripadnici srednjih slojeva pokazuju relativno nizak stupanj obolijevanja od psihotičnih poremećaja.

Operacionalizirajući, za potrebe istraživanja, konstrukt „socijalno-ekonomski status“ ističemo da je ovaj koncept, kako kažu Oakes i Rossi (20), latentna varijabla koja se ne može neposredno opažati i mjeriti. Da bismo konstrukt socijalno-ekonomskog statusa učinili manifestnim i eksplicitnim, pošli smo operacionalizacijom ovog konstrukta koju su predložili Galobadares i saradnici (21). Ova grupa autora, polazeći od Veberovih sociooloških koncetapa, ističe da je društvo hijerarhijski stratificirano duž mnogih dimenzija, što rezultira postojanjem različitih društvenih grupa čiji članovi dijele zajedničku poziciju na tržištu rada. Posljedično, pojedinci koji su članovi ovih grupa dijele slične „životne šanse“ koje su u vezi sa društvenim statusom i pozicijom na tržištu rada. Za potrebe istraživanja, a polazeći od navedenih koncepata, definirali smo sljedeće indikatore socijalno-ekonomskog statusa: 1) kvalitet stambene jedinice, 2) da li je ispitanik u podstanarskom statusu, 3) materijalni status primarne porodice, 4) prosječna mjesečna primanja-premorbidno, 5) zanimanje prema EseC

ported the thesis about the concentration of psychotic disorders among the lower socioeconomic strata. This research showed that the number of psychotic disorders, as a whole, decreased with an increase in indicators of socioeconomic status, except for the lowest social classes. Investigating (19) the relationship between the incidence of all forms of psychotic disorders and the social status of Texas residents, Jaco (19) found a curved correlation (in the form of the letter “U”). This research identified a high incidence of psychotic disorders among members of the lowest and highest socioeconomic strata, while members of the middle strata showed a relatively low incidence of psychotic disorders.

By operationalizing the construct of “socioeconomic status” for the purpose of this study, we underline that this concept, as Oakes and Rossi (20) argued, is a latent variable that cannot be directly observed and measured. In order to make the construct of socioeconomic status manifest and explicit, we used the operationalization of the construct proposed by Galobadares et al. (21). Starting from Weber’s sociological concepts, this group of authors argues that society is hierarchically stratified along many dimensions, which results in the existence of different social groups whose members share a common position in the labour market. Consequently, individuals who are members of these groups share similar “life chances” in relation to their social status and position in the labour market. For the purpose of the study and starting from the aforementioned concepts, we defined the following indicators of social and economic status: 1) quality of housing, 2) whether the respondent is a tenant, 3) financial status of the primary family, 4) average monthly income - pre-morbidity, 5) occupation according to the EseC classification of pre-morbidity, 6) level of education, 7) monthly household income, 8) monthly income per household member, 9) whether the respondent has been a beneficiary of social welfare.

klasifikaciji-premorbidno, 6) stupanj obrazovanja, 7) mjesečna primanja domaćinstva, 8) mjesečna primanja po članu domaćinstva, 9) je li ikada bio korisnik socijalnog osiguranja.

S obzirom da istraživanje provodimo u specifičnim društvenim okolnostima smatramo da se ova studija može tretirati i kao dopuna istraživanjima čiji su rezultati ranije prezentirani. Drugim riječima: naša studija testira pretpostavku da se socijalna i psihijatrijska problematika prepliću, ne samo u visoko razvijenim zemljama Zapada, nego i u jednom tranzicijskom društvu kakvo je crnogorsko. Ova kontekstualna razlika daje posebno značenje našem istraživanju čineći ga dodatno aktualnim, a njegove rezultate potencijalno aplikativnim. U nastojanju da opišemo specifičnosti društveno-političkog konteksta u kojem istražujemo, podsjetit ćemo da je tranzicija definirana kao „suvremeno prijelazno razdoblje koje od nekadašnjeg real-socijalizma vodi društvu izgrađene demokracije i tržišne privrede“ te da se u relevantnim bibliografskim jedinicama navodi da „sadržinu tranzicije čine: strukturno-institucijske reforme, makroekonomska stabilizacija, ekonomska liberalizacija, prestrukturiranje poduzeća i tranzicija tržišnoj privredi“ (22). Na istom mjestu u literaturi se kaže „da se zemlje koje su u privredi krenule ovim putem nazivaju zemljama u tranziciji.“ Imajući to u vidu naglasit ćemo da je čitav tranzicijski proces, u ovdje postavljenim društvenim okvirima, imao posebno turbulentan tok (ratovi u okruženju, izloženost sankcijama, ekspanzija siromaštva itd.). Zalazeći u teren mentalnog zdravlja historičari čak navode (dakako metaforički) da je početkom devedesetih godina XX. vijeka, koje su obilježene početkom tranzicije ali i ratovima u okruženju, crnogorsko društvo držano u stanju „permanentne ratne psihoze“ (23), dok autori iz područja socijalne politike, slično, govore o ovom razdoblju razvoja crnogorskog društva kao o razdoblju „tranzicijskog šoka“ (24). Pod teretom navedenih promjena tranzicija u Crna Gori

Given that we were conducting our study in very specific social circumstances, we believed that it could be treated as supplementary to the research presented earlier. In other words, our study tested the assumption that social and psychiatric issues were intertwined not only in highly developed western countries, but also in transitional societies such as Montenegrin society. This contextual difference is of particular significance for our research, making it even more current and its results potentially applicable. In an effort to describe the specifics of the socio-political context of this study, we note that transition is hereby defined as “the modern transition period that transforms a society from former real-socialism into democracy and a market economy” and that relevant literature states that “the content of the transition consists of the following: structural-institutional reforms, macroeconomic stabilisation, economic liberalisation, restructuring of companies and transition to a market economy” (22). Simultaneously, relevant literature states that “countries that have taken this path of economic development are referred to as countries in transition.” Bearing the above in mind, we underline that the entire process of transition, as defined in the social framework set in this paper, had a particularly turbulent course (wars in the region, exposure to sanctions, expansion of poverty, etc.). When approaching the field of mental health, historians metaphorically state that in the early 1990s, which were marked by the beginning of the transition and wars in the region, Montenegrin society was kept in a state of “permanent war psychosis” (23). Similarly, authors from the field of social policy speak of this period of development of Montenegrin society as the period of “transitional shock” (24). Weighed by the aforementioned changes, in Montenegro, the transition was marked by an overall social crisis giving birth to numerous social problems and deviations (25) that have resulted in a series of stressogenic factors, which are not prevalent in orderly western societies where the aforementioned studies were con-

noj Gori je obilježena sveukupnom društvenom krizom, koja je porodila brojne socijalne probleme i društvene devijacije (25), što je rezultiralo brojnim stresogenim faktorima, kakvi nisu djelatni u uređenim zapadnim društvima, u kojima su provođene ranije spomenute studije. Prisutnost ovih faktora, koji na pojedinca, grupu i zajednicu djeluju iz socio-političke makro-sfere pruža distinktivnost i aktualnost našem istraživanju.

Najopćenitiji cilj ovog rada je detektiranje utjecaja socio-ekonomskih faktora na nastanak duševnih poremećaja u crnogorskom društvu kao tranzicijskom, a u komparaciji s rezultatima analognih studija na Zapadu. Cilj je, također, utvrditi poveznicu između socio-ekonomskih faktora mentalnog zdravlja i hereditarnog opterećenja duševnim poremećajima u porodici. Drugim riječima, namjeravamo pokazati je li se (i ako jest, na koji način) socio-ekonomski status psihijatrijskih pacijenata u crnogorskom društvu razlikuje od ekvivalentnog statusa mentalno zdravog dijela populacije. Ukazivanje na isprepletenost socijalne i psihijatrijske problematike bi i u analiziranim društvenim okvirima ukazalo na značenje prevencije duševnih poremećaja iz vizure socijalne politike i socijalnog rada, onako kako je to slučaj na Zapadu. Značenje socijalne tematike u tumačenju kompleksne etiologije duševnih poremećaja na Zapadu je već toliko prepoznato da se u pojedinim bibliografskim jedinicama, socijalni radnik naziva i „psihijatrom za siromašne“ (26).

U tripartitnoj podjeli istraživanja na deskriptivna, eksploracijska i eksplanacijska, naše istraživanje se može okarakterizirati kao eksploracijsko, dok je ono, metodološki, nomotetičko. Odnosno, cilj je, na makro-planu (i jezikom velikih brojeva) identificirati i „izoštriti“ korelaciju između varijabli „socio-ekonomski status“ i „postojanje duševnog poremećaja“, sve u opisanom tranzicicijskom kontekstu i bez ulaženja u detalje koji bi na razini ličnosti tumačili mehanizme kojima socio-etiološki

ducted. The presence of these factors affecting the individual, group and the community from the socio-political macro-sphere provides our study with distinctiveness and relevance.

The most general objective of this paper was to detect the impact of socioeconomic factors on the emergence of mental disorders in Montenegrin society, as a transitional type of society, and to compare that impact with the results of similar studies conducted in the western countries. The aim was also to establish a relationship between socioeconomic factors of mental health and hereditary burden of mental disorders in the family. In other words, our intention was to find whether (and if so, in what way) the socioeconomic status of psychiatric patients in Montenegrin society differed from the equivalent status of the mentally healthy part of the population. An overview of the intertwined nature of social and psychiatric issues in the given social framework should also indicate the importance of prevention of mental disorders from the point of view of social policy and social welfare, as is the case in the western countries. The significance of social topics in the interpretation of the complex aetiology of mental disorders in the West has already been recognised to such a degree that, according to some sources in literature, the social worker has also been called a “psychiatrist for the poor” (26).

In terms of the tripartite division of research into descriptive, exploratory and explanatory, our study can be characterised as exploratory, and methodologically nomothetic. In other words, on a macro level (and using the language of large numbers), the goal was to identify and “fine-tune” the correlation between the variables of “socioeconomic status” and “existence of a mental disorder” in the context of transition, and without going into too many details that would, at the level of personality, interpret the mechanisms by which socioetiological factors acted as causes of mental disorders. Therefore, our study was set in a unique socio-political

faktori djeluju kao uzročnici duševnih poremećaja. Ovim straživanjem, dakle, u unikatnom društveno-političkom kontekstu, testiramo na Zapadu već identificiranu korelaciju između socio-ekonomskog statusa i duševnog poremećaja. Ako se pokaže da rezultati našeg istraživanja prate ranije prikazane nalaze, dobio bi se još jedan pouzdani indikator o sprezi socio-ekonomskog statusa i duševnih poremećaja i otvorile bi se perspektive u prevenciji duševnih poremećaja iz vizure socijalne politike u tranzicijskom društvu. Ako se pokaže da rezultati naše studije odudaraju od ranije prezentiranih, koji su identificirani u razvijenim državama Zapada, moglo bi se pristupiti idiografskim (psihodinamskim ili ekološko-sistemskim) studijama, koje bi oslikale prirodu korelacije navedenih varijabli u crnogorskom društvu i dale odgovor na pitanje zašto se veza između socio-ekonomskog statusa i duševnog poremećaja „ponaša" drugačije u jednom tranzicijskom društvu nego u razvijenim društvima Zapada. Ovim istraživanjem, dakle, kao nomotetičkim i eksplorativnim, otvaramo put za potencijalnu idiografsku i eksplanacijsku studiju.

METODA

Uzorak

Istraživanje ima kvazieksperimentalni dizajn, pri čemu uzorak (N=341) sačinjavaju dvije grupe: klinička/eksperimentalna (N1=126) kod čijih je pripadnika identificiran duševni poremećaj i zdrava/kontrolna (N2=215) koja je reprezent opće populacije Crne Gore. Prema obliku dijagnosticiranog poremećaja klinički dio uzorka čine 85 ispitanika kod kojih je prisutan neki oblik *psihotičnog* poremećaja (što, procentualno, iznosi 67 % ovog dijela uzorka) i 41 ispitanik čija je primarna nozološka kategorija *depresivni* poremećaj raspoloženja, bilo da su prisutne psihotične promjene ili nisu (radi se o 33 % kliničkog uzorka). Za potrebe istraživa-

context and used to test the correlation between the socioeconomic status and the mental disorder already identified in the western countries. If the results of our study followed the previously presented findings, one more reliable indicator of the relationship between socioeconomic status and mental disorders would be obtained, which would in turn open up perspectives for the prevention of mental disorders from the point of view of social policies in a transitional society. On the other hand, if the results of our study deviated from those previously presented in relation to developed western countries, it would be possible to develop further idiographic (psychodynamic or ecological-systemic) studies, which would depict the nature of the correlation of the said variables in Montenegrin society and provide an answer to the question of why the relationship between the socioeconomic status and the mental disorder "acted" differently in a transitional society than in developed western societies. Therefore, with this nomothetic and exploratory study we pave the way for a potential idiographic and explanatory study.

METHOD

Sample

The study had a quasi-experimental design, whereby the sample (N=341) consisted of two groups: clinical/experimental (N1=126), whose members have been diagnosed with a mental disorder, and healthy/control (N2=215), representing the general population of Montenegro. In terms of the type of the diagnosed disorder, the clinical sample consisted of 85 subjects who suffered from some form of *psychotic* disorder (67 per cent of the clinical sample) and 41 subjects who fell under the primary nosological category of a *depressive* mood disorder, regardless of the presence of psychotic changes (33 per cent of the clinical sample). For the purpose of this study, the presence (or absence)

nja, a na temelju psihijatrijske anamneze i iskaza sudionika u istraživanju, evidentirana je prisutnost (ili odsutnost) *hereditarnog opterećenja* u odnosu na duševni poremećaj. S obzirom na cilj istraživanja pri formiranju kontrolne grupe vođeno je računa da ona, po socijalno-demografskim varijablama koje mogu biti značajne za dalje analize, oslikava populaciju Crne Gore.

Instrumentarij i postupak istraživanja

Na temelju prikazane operacionalizacije konstrukta „socijalno-ekonomski status", pristupljeno je postupku prikupljanja podataka. Istraživački postupak je imao oblik usmene ankete pri čemu je od svakog sudionika u istraživanju traženo da ponudi odgovore na devet ranije navedenih indikatora putem kojih je operacionaliziran navedeni konstrukt. Istraživački postupak je obavljen od travnja do kolovoza 2017. godine za eksperimentalnu grupu, odnosno tijekom rujna 2017. godine za kontrolnu grupu. Podatci za eksperimentalni dio uzorka su većim dijelom prikupljani u okviru Psihijatrijske klinike Kliničkog centra Crne Gore (Podgorica) i to kako s onim sudionicima u istraživanju koji su liječeni ambulantno, tako i s onima koji su liječeni u stacionaru. Manji dio eksperimentalnog uzorka bili su sudionici u istraživanju koji se liječe u Zdravstvenoj ustanovi Specijalna bolnica za psihijatriju „Dobrota" (Kotor). Prikupljanje podataka za kontrolnu grupu je obavljano na terenu, u gradovima triju crnogorskih regija (sjeverna, središnja i južna). Svi participanti su dali suglasnost za sudjelovanje u istraživanju i potpisali informirani pristanak.

REZULTATI

Empirijska građa je obrađena pomoću statističkog programa SPSS. Od statističkih operacija rađeni su hi-kvadrat računi za kategorijalne

of a hereditary burden in relation to the mental disorder was recorded on the basis of the psychiatric anamnesis and the testimony of research participants. Taking into consideration study objectives, during the formation of the control group, we ascertained that it reflected the whole population of Montenegro in terms of socio-demographic variables that might be significant for further analysis.

Instruments and procedure

The process of data collection was conducted on the basis of the previously presented model of operationalization of the "socioeconomic status" construct. The study procedure took the form of an oral survey, in which each participant was asked to offer answers to nine previously mentioned indicators according to which the said construct was operationalized. The study was conducted in the period from April to August 2017 for the experimental group, and in September 2017 for the control group. Data collection for the experimental sample was for the most part conducted at the Psychiatric Department of the Clinical Centre of Montenegro (Podgorica), both with the participants who were treated on an outpatient basis, and those treated in an inpatient setting. A small group within the experimental sample was comprised of patients who were being treated at the "Dobrota" Health Institution Special Hospital for Psychiatry (Kotor). Data collection for the control group was performed on the ground, in municipalities belonging to the three Montenegrin regions (northern, central and southern). All participants gave their consent to participate in the study and signed an informed consent form.

RESULTS

Empirical material was processed using the SPSS statistical programme. In terms of statistical operations, chi-square tests were per-

varijable, ovisno o odgovoru sudionika u istraživanju. Plan obrade i prikaza rezultata dat je u tablici 1.

U tablici 2 su prikazani rezultati hi-hvadrat testa za svaku od devet varijabli putem koje je operacionaliziran konstrukt „socio-ekonomski status." Dat je prikaz za svaki od tri slučaja koja su navedena u tablici 1, za prvu situaciju: bez kontrole hereditarnog opterećenja sudionika u istraživanju.

Rezultati prikazani u tablici 2 mahom ukazuju na specifičan socio-ekonomski status pojedinaca iz kontrolne grupe. Na temelju uvida u krostabulacije promptno zaključujemo da su, u odnosu na većinu indikatora i za veći broj testiranih slučajeva, psihijatrijski pacijenti slabijeg socijalno- ekonomskog stanja od mentalno zdravog dijela crnogorske populacije.

Da bi se smanjio utjecaj herediteta na zaključke o socijalno-etiološkoj osovini analiziranih poremećaja, pristupljeno je statističkom postupku sličnom onom čiji su rezultati upravo prezentirani, ali tek nakon što su iz uzorka odstranjeni oni ispitanici kod kojih je zabilježen pozitivan nalaz na hereditet. U nastavku su date vrijednosti za ponovljene hi-kvadrat testove, u situaciji u kojoj je kontrolirano hereditarno opterećenje ispitanika. Da se ne bismo ponavljali, prikazat ćemo samo one varijable za koje je, makar u jednom od tri moguća slučaja, dobijen rezultat koji se razlikuje od odnosnog rezultata dobijenog u situaciji 1. Rezultati hi-kvadrat testa za situaciju 2 dati su u tablici 3.

formed for categorical variables, depending on the responses provided by research participants. Data processing plan and overview of results are provided in Table 1.

Table 2 shows the results of the chi-square test for each of the nine variables according to which the "socioeconomic status" construct has been operationalized. It contains an overview for each of the three cases listed in Table 1 for the first situation, i.e. without hereditary burden control in relation to the research participants.

The results shown in Table 2 mostly indicate the specific socioeconomic status of individuals from the control group. The analysis of the crosstabulation shows that in relation to most indicators, and for a larger number of tested cases, psychiatric patients were of lower socioeconomic status than the mentally healthy part of the Montenegrin population.

In order to reduce the influence of heredity on the conclusions about the socio-etiological axis of the analysed disorders, a statistical procedure similar to the one just presented was undertaken, but only after removing respondents who tested positive for heredity from the sample. The values for repeated chi-square tests are given below for a situation where the hereditary burden of the subjects was controlled. In order to avoid repetition, we show only the variables for which the obtained result differed from the corresponding result obtained in situation 1 in at least one of the three possible cases. Table 3 presents the results of the chi-square test for situation 2.

TABLICA 1. Plan obrade podataka i prikaza rezultata istraživanja
TABLE 1. Data processing plan and presentation of research results

	Situacija 1: bez kontrole herediteta / Situation 1: No heredity control	**Situacija 2: uz kontrolu herediteta / Situation 2: Heredity control**
Slučaj 1 / Case 1	Klinički/zdravi uzorak / Clinical/healthy sample	Klinički/zdravi uzorak / Clinical/healthy sample
Slučaj 2 / Case 2	Pojedinci s psihozom/zdravi uzorak / Individuals suffering from psychosis/healthy sample	Pojedinci s psihozom/zdravi uzorak / Individuals suffering from psychosis/healthy sample
Slučaj 3 / Case 3	Pojedinci s depresijom/zdravi uzorak / Individuals suffering from depression/healthy sample	Pojedinci s depresijom/zdravi uzorak / Individuals suffering from depression/healthy sample

TABLICA 2. Socijalno-ekonomski status-krostabulacije, situacija 1
TABLE 2. Socioeconomic status and crosstabulation in situation 1

	Slučaj / Case	Varijabla / Variable	Nivo značajnosti / Significance
V 1	Slučaj 1 / Case 1	Kvaliteta stambene jedinice / Quality of the housing unit	Chi=14,127 (df=4) p<0,01
	Slučaj 2 / Case 2	Kvaliteta stambene jedinice / Quality of the housing unit	Chi=11,210 (df=4) p<0,05
	Slučaj 3 / Case 3	Kvaliteta stambene jedinice / Quality of the housing unit	Chi=12,204 (df=4) p<0,05
V 2	Slučaj 1 / Case 1	Da li je podstanar / Are they a tenant	Chi=3,795 (df=2) p>0,1
	Slučaj 2 / Case 2	Da li je podstanar / Are they a tenant	Chi=6,807 (df=2) p<0,05
	Slučaj 3 / Case 3	Da li je podstanar / Are they a tenant	Chi=0,585 (df=1) p>0,1
V 3	Slučaj 1 / Case 1	Materijalni status primarne porodice / Material status of the primary family	Chi=10,060 (df=4) p<0,05
	Slučaj 2 / Case 2	Materijalni status primarne porodice / Material status of the primary family	Chi=6,581 (df=4) p>0,1
	Slučaj 3 / Case 3	Materijalni status primarne porodice / Material status of the primary family	Chi=12,080 (df=4) p<0,05
V 4	Slučaj 1 / Case 1	Prosječna mjesečna primanja – premorbidno / Average monthly income - pre-morbidity	Chi=58,596 (df=9) p<0,01
	Slučaj 2 / Case 2	Prosječna mjesečna primanja – premorbidno / Average monthly income - pre-morbidity	Chi=66,452 (df=9) p<0,01
	Slučaj 3 / Case 3	Prosječna mjesečna primanja – premorbidno / Average monthly income - pre-morbidity	Chi=18,221 (df=9) p<0,05
V 5	Slučaj 1 / Case 1	Posao prema ESeC - premorbidno / Job according to ESeC – pre-morbidity	Chi=46,444 (df=10) p<0,001
	Silučaj 2 / Case 2	Posao prema ESeC - premorbidno / Job according to ESeC – pre-morbidity	Chi=46,473 (df=10) p<0,001
	Slučaj 3 / Case 3	Posao prema ESeC - premorbidno / Job according to ESeC – pre-morbidity	Chi=23,670 (df=10) p<0,01
V 6	Slučaj 1 / Case 1	Stupanj obrazovanja / Level of education	Chi=26,889 (df=3) p<0,001
	Slučaj 2 / Case 2	Stupanj obrazovanja / Level of education	Chi=28,907 (df=3) p<0,001
	Slučaj 3 / Case 3	Stupanj obrazovanja / Level of education	Chi=5,735 (df=3) p>0,1
V 7	Slučaj 1 / Case 1	Mjesečna primanja domaćinstva / Household monthly income	Chi=39,816 (df=10) p<0,01
	Slučaj 2 / Case 2	Mjesečna primanja domaćinstva / Household monthly income	Chi=39,425 (df=10) p<0,01
	Slučaj 3 / Case 3	Mjesečna primanja domaćinstva / Household monthly income	Chi=17,794 (df=10) p<0,1
V 8	Slučaj 1 / Case 1	Mjesečna primanja po članu domaćinstva / Monthly income per member of household	Chi=30,432 (df=6) p<0,001
	Slučaj 2 / Case 2	Mjesečna primanja po članu domaćinstva / Monthly income per member of household	Chi=38,150 (df=6) p<0,001
	Slučaj 3 / Case 3	Mjesečna primanja po članu domaćinstva / Monthly income per member of household	Chi=9,763 (df=6) p>0,1
V 9	Slučaj 1 / Case 1	Da li je bio kornisnik soc. osiguranja / Were they beneficiaries of social welfare	Chi=36,847 (df=1) p<0,01
	Slučaj 2 / Case 2	Da li je bio kornisnik soc. osiguranja / Were they beneficiaries of social welfare	Chi=45,647 (df=1) p<0,01
	Slučaj 3 / Case 3	Da li je bio kornisnik soc. osiguranja / Were they beneficiaries of social welfare	Chi=9,899 (df=1) p<0,05

TABLICA 3. Socijalno-ekonomski status-krostabulacije, situacija 2
TABLE 3. Socioeconomic status and crosstabulation in situation 2

V 1	Slučaj 1 / Case 1	Kvaliteta stambene jedinice / Quality of the housing unit	Chi=5,602 (df=4) p>0,1
	Slučaj 2 / Case 2	Kvaliteta stambene jedinice / Quality of the housing unit	Chi=11,210 (df=1) p<0,05
	Slučaj 3 / Case 3	Kvaliteta stambene jedinice / Quality of the housing unit	Chi=12,204 (df=4) p<0,05
V 3	Slučaj 1 / Case 1	Materijalni status primarne porodice / Material status of the primary family	Chi=7,627 (df=4) p>0,1
	Slučaj 2 / Case 2	Materijalni status primarne porodice / Material status of the primary family	Chi=6,851 (df=4) p>0,1
	Slučaj 3 / Case 3	Materijalni status primarne porodice / Material status of the primary family	Chi=12,080 (df=4) p<0,05

Rezultati prikazani u tablici 3 pokazuju da u situaciji 2 ne postoji razlika između eksperimentalne i kontrolne grupe što se tiče kvaliteta stambene jedinice, dok je takva razlika identificirana u situaciji 1. Također, u situaciji kontroliranog herediteta nije identificirana značajna razlika između eksperimentalne i kontrolne grupe u odnosu na materijalni status primarne porodice, dok je takva razlika prepoznata u situaciji 1.

The results shown in Table 3 confirm that in situation 2 there was no difference between the experimental and control groups in terms of quality of housing, whereas such a difference was identified in situation 1. Additionally, in the situation of controlled heredity, no significant difference was identified between the experimental and control groups in relation to the material status of the primary family, whereas such a difference was noted in situation 1.

RASPRAVA

Rezultati dobijeni na V1 (tablica 2) ukazuju da pojedince s duševnim poremećajima treba tražiti među onim društvenim slojevima koji žive u oskudnim stambenim uvjetima. Ovaj nalaz, osim u općenitom smislu (slučaj 1), vrijedi kako za pojedince sa psihotičnim (slučaj 2), tako i za one s depresivnim poremećajem (slučaj 3). Uvidom u krostabulacije zaključujemo da u sva tri analizirana slučaja za V1 matrica povezanosti varijabli ima sličnu distribuciju: u srednjim kategorijama („stan donekle uvjetovan“ i „stan uvjetovan“) razlike između opserviranih i idealnih frekvencija su minimalne, ali postaju izrazite kako se krećemo prema ekstremima. Tako je među ispitanicima iz eksperimentalne grupe znatno više onih koji žive u „vrlo neuvjetovanom“ stanu nego što bi bilo očekivano u idealnom slučaju, dok je u istom dijelu uzorka, analogno, znatno manje onih koji žive u luksuznim uvjetima nego što bi bilo očekivano pod pretpostavkom da varijable o kojima je riječ nisu povezane. Situacija je, za ekstremne vrijednosti u V1, upravo suprotna sa zdravim dijelom uzorka. Što se tiče vlasništva nad stambenom jedinicom (V2) jedini slučaj u kojem je dobijen statistički značajan podatak je onaj drugi. Uvidom u krostabulacije zaključujemo da je među pojedincima kod kojih je dijagnosticiran neki oblik psihotičnog poremećaja više podstanara ili onih koji žive kod rodbine u stanu koji ne plaćaju, nego što bi to

DISCUSSION

The results obtained for V1 (Table 2) suggest that individuals with mental disorders may be found among members of lower social strata and living in poor housing conditions. Except in the general sense (case 1), this finding applies to both individuals with psychotic disorder (case 2) and those with depressive disorder (case 3). By analysing the crosstabulations, we found that in all the three cases analysed for V1, the matrix of relationships between variables had a similar distribution, i.e., in the middle categories ("housing is somewhat adequate" and "housing is adequate"), the differences between observed and ideal frequencies were minimal, but they became more pronounced as we moved to the extremes. Thus, among the respondents from the experimental group, there were significantly more people living in "very inadequate" housing than would be expected in the ideal case, while in the same sample, analogously, there were significantly fewer people than expected living in luxurious conditions, assuming that the variables in question were not related. For the extreme values in V1, the situation is exactly the opposite with the healthy part of the sample. With regards to ownership of housing (V2), the only case in which statistically significant data was obtained was the second one. The analysis of the crosstabulations showed that among individuals who suffered from some type of a psychotic disorder, there were more tenants or

bilo za očekivati u idealnom slučaju. Analogno, u ovom dijelu uzorka se nalazi manje pojedinaca koji su sami vlasnici stambene jedinice u kojoj žive, nego što bi bilo očekivano. Postojanje poremećaja iz psihotičnog spektra se u Crnoj Gori očigledno isprepliće s komplikacijama u stambenoj problematici, što je, kako će se pokazati, tek segment preklapanja narušenog mentalnog zdravlja i loše socijalno-ekonomske pozicije pojedinca i porodice. Ovaj nalaz, iako može biti značajan za neke aspekte socijalne politike, te za aktivnosti u oblasti tercijarne prevencije duševnih poremećaja (odnosno-za komunalnu psihijatriju i socijalni rad), u dizajnu našeg istraživanja nema eksplanacijsko nego tek deskriptivno značenje. Naime, polazeći od toga da je vlasništvo nad stambenom jedinicom relativno dugotrajna kategorija, pri prikupljanju podataka nismo bilježili odgovore o stambenim uvjetima premorbidno i retrospektivno, već smo se fokusirali na aktualno stanje.

Vrijednosti u varijabli „materijalni status primarne porodice“ (V3), kao promjenjivoj koja, osim deskriptivnog, u kontekstu našeg istraživanja može imati i izvjesno prediktorsko značenje, povezane su s postojanjem duševnog poremećaja openito, kao i s postojanjem depresivnog poremećaja. U prvom slučaju priroda ove veze je vrlo interesantna. Naime, na osnovi uvida u krostabulacije možemo zaključiti da identificirana povezanost nije linearna: u svim kategorijama koje su predviđene kao odgovori u V3, broj i procenat pojedinaca s poremećajima su veći nego što bi to bilo očekivano u idealnom slučaju, osim u srednjoj kategoriji-„prosječno imovinsko stanje.“ Drugim riječima, proporcija ispitanika koji imaju duševni poremećaj, a koji dolaze iz porodica prosječnog imovinskog stanja je znatno manja nego što bi to bio slučaj da dvije analizirane varijable nisu povezane. Istovremeno, proporcija ovih ispitanika u situacijama koje se grupiraju oko ekstrema (siromašne/veoma siromašne i

those who lived with relatives in an apartment they did not pay for, than would be expected in the ideal case. Analogously, fewer individuals in this sample were owners of a housing unit than would be expected. The existence of disorders on the psychotic spectrum in Montenegro is obviously interlinked with complications around housing issues, which, as this study shows, is only a segment of overlapping between impaired mental health and poor socioeconomic position of individuals and families. Although it may be important for certain aspects of social policy and activities in the tertiary prevention of mental disorders (i.e. communal psychiatry and social work), this finding does not have explanatory, but rather descriptive significance in the design of our study. Given that the ownership of a housing unit is a relatively long-term category, we have not recorded answers about housing conditions pre-morbidity and retrospectively while collecting data. Instead, we focused on the current situation.

The values in the variable of “material status of the primary family” (V3), which in the context of our study may have had some predictive significance, were linked to the existence of mental disorders in general, and depressive disorders. In the first case, the nature of this relationship is very interesting. Namely, the analysis of crosstabulation indicated that the identified relationship was not linear: in all the categories provided as answers in V3, the number and percentage of individuals with disorders were higher than ideally expected, except for the middle category indicating the average material status. In other words, the proportion of respondents with mental disorders who came from families of average means was significantly lower than would have been the case if the two analysed variables were not related. Simultaneously, when grouped around extremes (poor/very poor and well-off/very well-off families) the proportion of these respondents was higher than it would have been the case if there was no relationship between the

dobrostojeće/veoma dobrostojeće porodice) je veća nego što bi to bio slučaj u situaciji da ne postoji veza između varijabli. Očigledno, duševni poremećaji u crnogorskom društvu imaju tendenciju da se grupiraju u porodicama koje su u odnosu na materijalno stanje bliže krajnjim vrijednostima. Na ovom mjestu ćemo, tragajući u socijalno-političkom stratumu za etiološkim faktorima duševnih poremećaja te poštujući neka osobna zapažanja do kojih smo došli tijekom postupka prikupljanja podataka, kao i činjenicu da se čak 61,3 % naših ispitanika nalazi u razdoblju od 31 do 60 godina, pokušati dati značenje upravo navedenim nalazima. Na osnovi do sada rečenog može se pretpostaviti da su, u smislu mentalnog zdravlja, „žrtve tranzicije" zapravo pojedinci koji su odrasli u dobrostojećim i siromašnim porodicama, dok je nekadašnja srednja klasa, u odnosu na psihološki kriterij, paradoksno, najbolje podnijela tranziciju. Ono što ostaje kao moguće tumačenje jest da su transgeneracijski siromašni pojedinci, u situaciji u kojoj su dodatno pogođeni socijalno-ekonomskom deprivacijom, očekivano počeli pokazivati znakove psihološkog malreagiranja. Istovremeno, pozivajući se na aksiološku osovinu koja je bila karakteristična za razdoblje SFRJ, tumačenje za drugi ekstrem (ispitanici iz boljestojećih primarnih porodica) bi bilo da je među pojedincima koji su, tijekom razdoblja komunizma, pripadali višim društvenim slojevima, došlo do naglog gomilanja socijalno-ekonomskih problema, kao i do rasta dirkemovske socijalne anomije u situaciji kraha ranije etabliranih vrijednosti s kojima je ovaj dio populacije bio sistemski srastao, i konačno-do manifestiranja psihičkih problema. Drugo moguće tumačenje bi se kretalo u pravcu analize da su pojedinci koji dolaze iz bogatijih porodica imali slabije razvijeme mehanizme suočavanja s tranzicijskim stresom, te da su pojedinci koji dolaze iz najsiromašnijih porodica, očekivano, bili najviše pogođeni tranzicijom kao socio-ekonomskim procesom, dok je srednja klasa imala izgrađene mehanizvariables. Therefore, it is clear that mental disorders in Montenegrin society tend to be grouped in families that are, in relation to their financial situation, closer to the extreme values. In our search for etiological factors of mental disorders in the socio-political stratum and taking into account some personal observations that we made during the data collection process, as well as the fact that as many as 61.3 per cent of our respondents were in the category of 31 to 60 years of age, here we will try to attribute meaning to the aforementioned findings. Based on the discussion so far, it can be assumed that in terms of mental health "victims of transition" are actually those individuals who grew up in wealthy or poor families, while, in relation to the psychological criterion, the former middle class, paradoxically, coped with the transition in the best way possible. A possible explanation for this is that trans-generationally poverty-striken individuals found in the situation of additional pressure of socioeconomic deprivation started to show signs of poor psychological reaction, as it was expected. At the same time, if we take into account the axiological basis that characterised the period of SFRY, the explanation for the other extreme (respondents from well-off primary families) could be that individuals who had belonged to higher social strata during communism quickly accumulated a whole range of socioeconomic problems and were faced with the growth of Durkheim's social anomie due to the collapse of previously established values with which this part of the population was systematically fused, which then manifested as mental problems. Another possible interpretation could be that individuals coming from wealthier families had less developed coping mechanisms for transition-related stress, and that individuals coming from the poorest families were, as expected, most affected by the transition as a socioeconomic process, while the middle class had built-in mechanisms that enabled it to overcome transitional adversities without manifesting psychological problems. At the lev-

me koji su joj omogućili da tranzicijske nedaće prebrodi bez manifestiranja psihičkih problema. Na razini analize individualnih poremećaja koji su predmet našeg rada, za varijablu V3 nije nađena značajna povezanost sa psihotičnim poremećajem, dok je takva povezanost identificirana kada su u pitanju depresije. Na osnovi uvida u krostabulacije zaključit ćemo da i u ovom slučaju priroda veze između varijabli prati onaj oblik koji je opisan u slučaju 1, te da depresija pokazuje tendenciju grupiranja kod pojedinaca koji su odrasli u siromašnijim i bogatijim porodicama, dok je stopa ovog poremećaja među pojedincima koji su odrasli u porodicama prosječnog materijalnog stanja niža nego što bi to bio slučaj kada ove dvije varijable ne bi bile povezane.

Varijable „prosječna mjesečna primanja," „posao/zanimanje ispitanika", te „stupanj obrazovanja" su posebno važne kada je u pitanju socijalno-ekonomska pozicija samog pojedinca te smo ih u tablici 2 prikazali jednu za drugom. Operacionalizirajući koncept životnih šansi u nekoliko socijalno-ekonomskih varijabli od kojih su najvažnije obrazovanje, prihod i zanimanje, ustanovit ćemo da na ovom mjestu zapravo analiziramo jezgru socijalno-ekonomskog statusa ispitanika u skladu sa selektiranom operacionalizacijom ovog koncepta. Krostabulacije u analiziranim situacijama za sve tri varijable zapravo direktno potvrđuju ono što je implicitna hipoteza našeg istraživanja, tj. da je socijalno-ekonomski status duševno oboljelih u crnogorskom društvu u premorbidnoj fazi života nepovoljniji nego što je socijalno-ekonomski status prosječnog žitelja Crne Gore. Jedina iznimka je slučaj 3 za V6, gdje nije identificirana statistički signifikantna povezanost između depresivnih stanja i stupnja obrazovanja.

Uvažavajući stav pojedinih istraživača (27), koji tvrde da je stupanj obrazovanja glavna komponenta konstrukta „socijalno-ekonomski status", posebno ćemo se osvrnuti na rezultate

el of analysis of individual disorders that are the subject of this paper, for variable V3, no significant relationship was found with psychotic disorders, while such a relationship was identified for depression. The analysis of crosstabulation indicated that the nature of the relationship between variables in this case followed the form described in case 1, and that depression tended to prevail in individuals who grew up in poorer or wealthier families, while the rate of this disorder in individuals who grew up in families of average material status was lower than would be the case if the two variables were not correlated.

The variables of "average monthly income", "job / occupation of the respondents", and "level of education" presented consecutively in Table 2 proved especially important in relation to the socioeconomic position of the individual. While operationalizing Weber's concept of life chances according to several socioeconomic variables, the most important of which are education, income and occupation, we have established that we actually had to analyse the core of the respondents' socioeconomic status in line with the selected form of operationalization of this concept. Crosstabulations in the analysed situations for all three variables directly confirmed the implicit hypothesis of our research, i.e., the socioeconomic status of the mentally ill in Montenegrin society in the pre-morbidity phase of life is less favourable than the socioeconomic status of the average Montenegrin citizen. The only exception was the case 3 for V6, where no statistically significant association between depressive states and the level of education was identified.

Taking into account the position of some researchers (27) who claim that the level of education is the main component of the construct of "socioeconomic status", we paid particular attention to the results identified in relation to the variable V6. The variables of "level of education of the respondents" and "mental health/disorder" were significantly statistically related in

te koji su identificirani u odnosu na varijablu V6. Varijable „stupanj obrazovanja ispitanika“ i „mentalno zdravlje/poremećaj“ su statistički značajno povezane u prvom i drugom slučaju, dok u trećem nisu. Rezultati koje očitavamo u krostabulacijama za one slučajeve u kojima je identificirana povezanost između analiziranih varijabli nedvosmisleno ukazuju da je priroda ove veze takva da su niži stupnjevi obrazovanja povezani s postojanjem duševnog poremećaja, odnosno da su poremećaji rjeđi kod pojedinaca višeg obrazovnog statusa. Usporedbom između frekvencija dobijenih za slučaj 1, očitavamo da je očekivana frekvencija pojedinaca u kategoriji „osnovna škola i niže“ za klinički dio uzorka 16,6, dok je opservirana vrijednost čak 28. Analogne brojke za zdravi dio uzorka su obrnute: 27,4 (idealno) i 16 (identificirano). Također, u kliničkom dijelu uzorka je znatno manje ispitanika u kategoriji „visoka škola i više“ (14) nego što je očekivano (26,9), dok je u zdravom dijelu uzorka i za ovu kategoriju situacija invertirana. Ovakav oblik povezanosti stupnja obrazovanja i postojanja poremećaja može se pratiti i za slučaj 2. Tako, u krostabulacijama čitamo da očekivana vrijednost u kategoriji „osnovna škola i niže“ za poduzorak osoba kod kojih je dijagnosticirana psihoza iznosi 10,7, dok je opservirana vrijednost čak 21. Analogne brojke za zdravi dio uzorka su, s druge strane, 26,3 (očekivano) i 16 (opservirano). Slučaj 3 je specifičan, budući da je ovo jedini od svih devet slučajeva koji se, uže, odnose na socijalno-ekonomski status ispitanika, u kojem nije identificiran značajan odnos između postojanja poremećaja i konkretnog indikatora socijalno-ekonomskog stanja. Naime, postojanje depresivnog poremećaja, prema prikazanim rezultatima hi-kvadrata, nije u vezi sa stupnjem obrazovanja ispitanika. Ovaj nalaz, ipak, ostaje razumljiv s aspekta razvoja i kliničke slike dvaju duševnih poremećaja koji su ovdje u fokusu. Kako, naime, među psihotične poremećaje spada i shizofreni, koji često počinje u ranim dvadesetim godinama,

the first and second case, while in the third this was not the case. The results found in the crosstabulations of the cases in which a relationship between the analysed variables was identified unequivocally suggest that the nature of this relationship is such that lower levels of education may be linked with mental disorders, i.e., mental disorders occurred less frequently in persons who have completed higher education. When comparing the frequencies obtained for the case 1, it can be observed that the expected frequency of individuals in the category of “primary school and below” for the clinical sample was 16.6, whereas the observed value was as high as 28. The analogous figures for the healthy part of the sample point to a reverse trend: 27.4 (ideal) and 16 (identified). Additionally, in the clinical sample, there were significantly fewer respondents in the category of “high school and higher” (14) than expected (26.9), while in the healthy part of the sample, the situation was inverted for this category. This form of correlation between the level of education and the existence of disorders may be examined for the case 2. Thus, the crosstabulations indicate that the expected value in the category of “primary school and lower” for the subsample of individuals diagnosed with psychosis was 10.7 whereas the observed value was 21. On the other hand, the analogous figures for the healthy part of the sample were 26.3 (expected) and 16 (observed). The case 3 is specific, as this was the only one among the nine cases under scrutiny relating to the socioeconomic status of respondents in which no significant relationship was identified between the existence of the disorder and a specific indicator of socioeconomic status. According to the presented results of chi-square tests, the existence of a depressive disorder was not related to the level of education. This finding remains unsurprising from the developmental aspect and the clinical picture of the two mental disorders that are in the focus of this paper. Having in mind that schizophrenia, the onset of which is often recorded in the early twenties, falls under the category of a psychotic

za očekivati je da i sam tok poremećaja, između ostalog, onemogućava dio pojedinaca koji pate od psihoze da steknu visoko obrazovanje. Također, u sklopu pojedinih psihotičnih poremećaja dolazi do ozbiljnije kognitivne deterioracije što, očekivano, remeti motivaciju za školovanjem, te narušava spoznajne kapacitete pojedinca. Sve ovo se u manjoj mjeri odnosi na poremećaje čija je primarna simptomatologija depresivna.

Tri posljednje varijable prikazane u tablici 2 (V7, V8, V9) mogu se interpretirati i kao dopuna rezultatima koje smo dobili pri analizi varijabli V4 , V5 i V6, i to kao suplement koja nam omogućuje da analizu proširimo na domaćinstvo u kojem ispitanik živi. U svim slučajevima (osim situacije 3 za V8) u tablici 2 očitavamo značajnu povezanost između tri razmatrana indikatora socijalno-ekonomske pozicije domaćinstva i postojanja duševnih poremećaja. Na temelju uvida u krostabulacije utvrdit ćemo da opći smjer povezanosti između razmatranih indikatora socijalno-ekonomskog statusa pojedinca i domaćinstva, s jedne strane, i postojanja, kao i vrste duševnog poremećaja, s druge strane, ostaje isti kao onaj koji smo istakli u komentarima za V4, V5 i V6: psihijatrijski pacijenti u crnogorskom društvu žive u domaćinstvima koja su slabijeg socijalno-ekonomskog statusa u odnosu na mentalno zdravi dio populacije ove države.

Posebno ćemo se osvrnuti na nalaze povezane s varijablom 9, jer oslikavaju isprepletenost socijalne i psihijatrijske problematike u jednom tranzicijskom društvu. Povezanost između korišćenja socijalne pomoći i vrijednosti koje u našem istraživanju može imati varijabla duševnog poremećaja/mentalnog zdravlja je identificirana kao statistički značajna za sva tri slučaja. Na osnovi uvida u krostabulacije utvrđujemo da su pojedinci koji su premorbidno bili korisnici socijalne pomoći, češći u sve tri kategorije dizajna istraživanja koje podrazumijevaju postojanje duševnog

disorder, it can be expected that the course of the disorder may prevent some individuals suffering from psychosis from obtaining higher education. Additionally, certain psychotic disorders lead to more serious forms of cognitive deterioration, which, consequently, often has a negative impact on the motivation for education and impairs an individual's cognitive capacities. All of the above to a lesser degree applies to disorders with primary depressive symptomatology.

The last three variables presented in Table 2 (V7, V8, V9) may be interpreted as supplementary to the results obtained in the analysis of variables V4, V5 and V6, in the sense that they allowed us to extend the analysis to the respondents' households. Table 2 indicates that in all cases (except in the situation 3 for V8) there was a significant correlation between the three indicators of the socioeconomic position of a household and the existence of mental disorders. Based on the crosstabulations, we found that the general direction of the correlation between the indicators of the socioeconomic status of individuals and households, on the one hand, and the existence and type of mental disorder on the other, remained the same as the one pointed to in our comments relating to V4, V5 and V6, i.e., psychiatric patients in Montenegrin society live in households of a lower socioeconomic status compared to the mentally healthy part of the population of the country.

We would like to specifically address the findings relating to the variable 9, as they reflect the intertwined nature of social and psychiatric issues in a transitional society. The correlation between the use of social welfare and the values that in our study may be attributed to variable of mental disorder/mental health was identified as statistically significant for all three cases. The analysis of the crosstabulation indicated that individuals who were beneficiaries of social welfare in the pre-morbidity phase featured more frequently in all three categories of the study design implying the existence of

poremećaja (situacije 1, 2, 3) nego što bi to bio slučaj da ove dvije varijable nisu povezane. Ovaj nalaz, zapravo, podvlači činjenicu da je u crnogorskom društvu, siromaštvo kao sistemski društveni problem isprepleteno sa psihopatološkim stanjima, na razini individualnog psihološkog problema. Problematizirajući osnovne epistemološke i teorijske postavke pomažućih profesija mogli bismo, stoga, argumentirati da u jednom društvu duševni poremećaj nije do kraja osobni, individualni problem, već se dijelom radi o psihološkom obliku manifestiranja dubljeg, strukturnog i društvenog problema. Na to nas, uostalom, upućuju sve analize kojima smo za potrebe ovog rada pristupili.

Što se tiče ponovljenog postupka, odnosno hi-kvadrat testova u situaciji kontroliranog herediteta, posebno je interesantno da je rezultat za V2 dao drugačije rezultate (samo) u slučaju 1. Naime, u situaciji kontroliranog herediteta opservirane vrijednosti za zdravi i klinički dio uzorka u odnosu na vrijednosti varijable „kvaliteta stambene jedinice“ su u skladu s vrijednostima koje su očekivane pod pretpostavkom da varijable o kojima je riječ nisu povezane. Za slučajeve 2 i 3, pak, hi-kvadrat i dalje daje statistički značajnu razliku, kao što je to identificirano i u prvoj situaciji. Za V3 se rezultati, u situaciji 2, u odnosu na rezultate iz situacije 1, također razlikuju samo u prvom slučaju. Dok je u prvoj situaciji identificirana povezanost između analiziranih varijabli, u situaciji kontroliranog herediteta takva povezanost nije nađena. Smatramo da je donekle značajan opći zaključak povodom predstavljenih nalaza. Naime, razlike između situacije 1 i situacije 2, o kojima govorimo, su takve da, ako se dizajnom eliminira (odnosno-kontrolira) hereditetarni faktor, broj identificiranih statistički značajnih veza između varijabli opada. Vjerojatno je da hereditet kao etiološki faktor poremećaja iz latentne osovine pojačava matricu povezanosti između socijalnih varijabli koje su prikazane u

a mental disorder (the situations 1, 2, and 3) than it would be the case if these two variables were not correlated. In fact, this finding underscores the fact that poverty, as a systemic social problem in Montenegrin society, is intertwined with psychopathological conditions at the level of an individual psychological problem. While analysing the basic epistemological and theoretical postulates of helping professions, we could argue that mental disorders are not a completely personal or an individual problem, but, in part, a psychological form of manifestation of a deeper, structural and social problem. After all, all the analyses undertaken for the purposes of this paper point to that conclusion.

With regards to the repeated procedure, i.e., chi-square tests in the situations of controlled heredity, it is particularly interesting to note that the results for V2 (only) were different only in the case 1. In the situation of controlled heredity, the observed values for the healthy and clinical samples in relation to the values of the variable of “quality of housing” were in line with the values expected under the assumption that the variables in question were not correlated. For the cases 2 and 3, on the other hand, the chi-square still pointed to a statistically significant difference, as identified in the first situation. For V3, the results for the situation 2 were different that the results for the situation 1 only in the first case. Whilst in the first situation the correlation between the analysed variables was identified, in the situation of controlled heredity such a relationship was not found. We are of opinion that the general conclusion regarding the presented findings is somewhat significant. The differences between the situation 1 and the situation 2 are such that if the design eliminated (i.e. controlled) the hereditary factor, the number of identified statistically significant correlations between variables would decrease. It is probable that heredity, as an etiological factor of mental disorders from the latent axis, reinforces the matrix of correlations between

tablici 3 (V1, V3) i duševnih poremećaja. Sve navedeno nas upućuje na zaključak da hereditarno opterećenje i slabiji socio-ekonomski status, svakako uz druge varijable koje nisu bile prepoznate dizajnom ovog istraživanja, združeno generiraju duševne poremećaje, u analiziranom društvenom okviru. Ove analize pokazuju da je i u društvenim okolnostima u kojima je rađeno naše istraživanje djelatna bio-psiho-socijalna matrica etiologije duševnih poremećaja, koja je spomenuta na početku rada i danas je standard antropologije pomažućih profesija.

Povezujući rezultate našeg istraživanja s onim što je rečeno u uvodnom dijelu rada ukazat ćemo na činjenicu da je u skladu s bio-psiho-socijalnim određenjem čovjeka u psihijatriji (ali i u pomažućim strukama uopće) i našim istraživanjem pokazano da je duševni poremećaj rezultat genetske/hereditarne osnove i okolinskih/socijalnih utjecaja. Na tragu istraživanja iz razdoblja „socijalne revolucije" u pomažućim strukama potvrdili smo da socio-ekonomska problematika ostaje povezana s postojanjem duševnih poremećaja, pri čemu postojanje hereditarnog opterećenja, kao latentna, pozadinska varijabla „katalizira" vezu između socio-ekonomskih faktora i mentalnog zdravlja. U jednadžbi koja rezultira duševnim poremećajem značajnu ulogu svakako imaju i individualno psihološki/psihodinamski faktori koji, međutim, dizajnom naše studije nisu uzeti u razmatranje.

ZAKLJUČCI

Rezultati ove studije s obzirom na kontekst u kojem je istraživanje rađeno dopuna su istraživanjima slične tematike na Zapadu. Istraživanjem je potvrđeno da su socijalna i psihijatrijska problematika u tijesnoj vezi i u jednom tranzicijskom društvu. Doprinos istraživanja, a u vezi sa postavljenim ciljevima, može se sumirati putem dvaju nalaza: prvog, koji kaže

the social variables shown in Table 3 (V1, V3) and mental disorders. All of the above leads us to the conclusion that hereditary burden and lower socioeconomic status, along with other variables that were not taken in the consideration in the design of this study, jointly contribute to development of mental disorders in the analysed social framework. These analyses show that even in the social circumstances in which our research was carried out, the bio-psycho-social matrix of the aetiology of mental disorders, mentioned at the beginning of the paper, is present, and that it represents the standard of in the anthropology of helping professions.

By linking the results of our research with what was noted in the introductory part of this paper, we would like to underline the fact that in line with both the bio-psycho-social definition of human being in psychiatry (and helping professions in general) and our research mental disorders result from genetic/ hereditary basis and environmental/social influences. In line with research from the period of the "social revolution" in the helping professions, we have confirmed that socioeconomic issues remain linked to the existence of mental disorders, whereby the existence of hereditary burden, as a latent background variable, "catalyses" the correlation between socioeconomic factors and mental health. Individual psychological/ psychodynamic factors certainly play a significant role in the equation resulting in a mental disorder. However, they were not taken into consideration in the design of our research.

CONCLUSIONS

Given the context in which this study was conducted, the results complement research on similar topics conducted in the western countries. Our study confirmed that social and psychiatric issues are also closely linked in a transitional society. In relation to the defined objectives, the contribution of the study may

da je socijalno-ekonomski status psihijatrijskih pacijenata u crnogorskom društvu u aktualnom trenutku slabiji od socijalno-ekonomskog statusa pripadnika generalne populacije i drugi, koji smatra da je socijalno-ekonomski status duševno oboljelih, u navedenom društvenom kontekstu, bio slabiji i premorbidno, odnosno retrospektivno. Oba nalaza ukazuju na potrebu da se unaprijedi status društveno i psihološki vulnerabilnih grupa, iz vizure socijalne politike i socijalnog rada. U tom bi smislu trebalo problemu mentalnog zdravlja prići ne samo idiografski i na razini pojedinca, već i na razini društvenih stratuma, kao što su socio-ekonomski raslojene klase, a iz vizure javnih politika. S obzirom na rezultate istraživanja možemo tvrditi da bi ove politike trebalo tako definirati da djeluju egalitaristički, odnosno da smanjuju socio-ekonomske nejednakosti u jednom tranzicijskom društvu. Posljedično, reducirala bi se prevalencija duševnih poremećaja kod velikog dijela populacije, odnosno kod onih pojedinaca koji pripadaju nižim socio-ekonomskim stratumima, a za koje je istraživanjem pokazano da su posebno vulnerabilni kada je u pitanju mentalno zdravlje. S obzirom da je ovo istraživanje sociološko i nomotetsko, ostaje potreba da se jednim komplementarnim istraživanjem, dubinsko-psihološkog i idiografskog karaktera odgovori na pitanje: kako se društveni vektori prelamaju kroz ličnost pojedinca, čineći ga ranjivim na deklanširanje duševnog poremećaja.

be summarized in the following two findings: 1) the socioeconomic status of psychiatric patients in Montenegrin society is currently weaker than the socioeconomic status of the general population and 2) the socioeconomic status of mentally ill, in the above mentioned social context was weaker even in the pre-morbid phase, i.e. retrospectively. Both findings point to the need to improve the status of socially and psychologically vulnerable groups in the domain of social policy and welfare. Therefore, the problem of mental health should be approached not only at the idiographic and individual level, but also at the level of social strata, such as socioeconomically stratified classes, and from the point of view of public policies. Considering the results of the study, we can argue that these policies should be defined in a way to result in an egalitarian effect, i.e. to reduce socioeconomic inequalities in a transitional society. Consequently, the prevalence of mental disorders in a significant part of the population would be reduced, particularly among those individuals who belong to lower socioeconomic strata, and for whom research has shown to be particularly vulnerable when it comes to mental health. Having in mind that this study applied sociological and nomothetic approach, complementary idiographic and in-depth psychological research is needed to answer the question of how social vectors are refracted in the personality of an individual, making them vulnerable to the triggering of mental disorders.

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Starije žrtve obiteljskog nasilja u Hrvatskoj: presječno istraživanje jednog savjetovališta

/ Elderly Victims of Domestic Violence in Croatia: A Cross-sectional Study of a Single Counseling Center

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Hrvatska je europska zemlja s jednom od najviših stopa obiteljskog nasilja a bez nacionalne strategije zlostavljanja starijih osoba. Cilj ovog istraživanja je odrediti razlike između žrtava obiteljskog nasilja starijih od 60 godina i žrtava mlađih od 60 godina. Od ukupno 3164 odrasle osobe koje su zatražile pomoć u Savjetovalištu za žrtve nasilja u obitelji u Zagrebu, 200 su bile starije od 60 godina. Istraživanje je uključilo izravne strukturirane intervjue s ciljem prikupljanja sociodemografskih podataka, podataka o vrsti nasilja, počiniteljima nasilja, prijavama nasilja nadležnim institucijama te vrsti intervencija. Primijenjen je Pearsonov koeficijent korelacije i z-test s Bonferronijevom korekcijom za utvrđivanje razlika između žrtava obiteljskog nasilja starijih od 60 godina i žrtava mlađih od 60 godina s obzirom na sociodemografska obilježja, vrstu nasilja i intervencije. Snaga povezanosti kategorijskih varijabli određena je Cramerovim V. Binarna logistička regresija utvrdila je neovisne doprinose sociodemografskih obilježja, obilježja obiteljskog nasilja i s njime povezanih intervencija za predviđanje vrste nasilja kojemu su bile izložene žrtve obiteljskog nasilja starije od 60 godina. Starije su žrtve češće imale niži stupanj obrazovanja, bile su udovci/udovice, umirovljenici, a počinitelji nasilja bila su njihova djeca, braća i sestre i drugi članovi obitelji, tijekom dužeg razdoblja, a najčešće vrste zlostavljanja bili su ekonomsko zlostavljanje ili kombinacija fizičkog i ekonomskog nasilja u usporedbi s mlađim žrtvama obiteljskog nasilja. Starije žrtve rjeđe prijavljuju obiteljsko nasilje nadležnim institucijama zbog njihove ekonomske ovisnosti ili ovisnosti povezane s čimbenicima zdravlja o članovima obitelji koji su često i počinitelji. Posljedično, prevencija i intervencija stručnih i nadležnih institucija su ograničene.

/ Croatia is one of the European countries with the highest prevalence of domestic violence (DV) and without a national policy on elder abuse. The aim of the study was to determine the differences between elderly victims (EV) of DV aged 60+ in comparison with younger DV victims (aged <60). A total out of 3164 adults who visited the Counseling Center for DV in Zagreb, 200 of them were aged 60+. Structured face-to-face interviews to collect socio-demographic data, types of abuse, perpetrators and reporting of abuse, and types of interventions were applied. To identify differences between the elderly (60+) and younger (<60) DV victims regarding the socio-demographic characteristics, characteristics of abuse, and related interventions Pearson's $\chi 2$ test and z-test with the Bonferroni's correction were applied. Strength of association between categorical variables was determined by Cramer's V. Binary logistic regression determined independent contributions of socio-demographic characteristics, characteristics of DV, and related interventions in predicting types of abuse experienced by elder DV victims (60+). EV were more likely lower educated, widowed, retired, abused by their children, siblings, and other family members, experienced longer DV, financial and a combination of physical and financial abuse compared to younger DV victims. EV rarely report DV to the authorities due to financial or health-related dependency on family members who are often the perpetrators. Consequently, prevention and intervention by competent authorities are limited.

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UVOD

Prema *Home Office* „Obiteljsko je nasilje svaki incident kontrole, uznemiravanja, prisile ili prijetnje, nasilja ili zlostavljanja (psihičkog, fizičkog, seksualnog, ekonomskog ili emocionalnog) usmjeren na osobe starije od 16 godina koje su ili su bile intimni partneri ili su u obiteljskom srodstvu, bez obzira na spol ili rod“ (1). Budući da ne postoji međunarodno priznata ili jedinstvena definicija obiteljskog nasilja, ova je najsveobuhvatnija od postojećih. Obiteljsko je nasilje problem koji muči sva društva ili društvene slojeve, bez obzira na dob, spol, obrazovanje, socioekonomski status ili vjersku pripadnost (2). Nadalje, obiteljsko nasilje ima najvišu stopu ponavljajuće viktimizacije i kod muškaraca i kod žena žrtava obiteljskog nasilja (3). Zlostavljanje i nasilni obrasci ponašanja prema starijim osobama definiraju se kao „jedan ili ponavljajući čin, ili izostanak odgovarajućeg postupanja, u bilo kojem odnosu koji podrazumijeva postojanje međusobnog povjerenja, koji nanosi štetu starijoj osobi ili ju uznemirava” (4). Brojne su definicije povezane s nasiljem nad starijim osobama. Prema centrima za kontrolu i sprječavanje bolesti (CDC) (5) zlostavljanje starijih osoba uključuje fizičko zlostavljanje (kad se povreda dogodi kao rezultat udarca rukom ili nogom, guranja, šamaranja, namjernog izazivanja opeklina i drugih obrazaca nasilnog ponašanja), seksualno zlostavljanje (uključuje prisilu starije osobe da

INTRODUCTION

According to the Home Office: “Domestic violence (DV) is any incident of controlling, coercive or threatening behavior, violence or abuse (psychological, physical, sexual, financial or emotional) between those aged 16+ who are or have been intimate partners or family members, regardless of gender or sexuality” (1). As there is no internationally accepted or unique definition of DV, this is the most comprehensive one. DV plagues all societies or social stratifications, regardless of age, gender, educational and socioeconomic status, or religion (2). Furthermore, DV has the highest rate of recurrent victimization for male and female victims (3). Elder maltreatment, or elder abuse, is broadly defined as “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person” (4). There are numerous definitions relating to elder abuse. According to the Centers for Disease Control and Prevention (CDC) (5), elder abuse includes physical abuse (when an injury occurs as a result of hitting, kicking, pushing, slapping, burning, or another show of force), sexual abuse (involves forcing an older person to take part in a sexual act when he/she does not or cannot consent), psychological or emotional abuse (behaviors that harm an old-

sudjeluje u seksualnom činu protiv svoje volje ili bez njezina pristanka), psihičko ili emocionalno zlostavljanje (nasilni obrasci ponašanja koji izravno slabe osjećaj vlastite vrijednosti i samopoštovanja žrtve; primjeri uključuju korištenje pogrdnih imena, zastrašivanje, posramljivanje, uništavanje imovine te onemogućavanje starije osobe da viđa prijatelje i obitelj) te ekonomsko zlostavljanje (protuzakonito korištenje novca, nekretnina i druge imovine starije osobe).

Specifična područja za koja i dalje ne postoje podatci su intervencije usmjerene na zanemarene starije osobe, senzibilizaciju javnosti, starije osobe izložene zlostavljanju, stručnjake odgovorne za prevenciju zlostavljanja, nasilne skrbnike koji su članovi obitelji i druge skrbnike (6). Premda je zlostavljanje starijih osoba problem prisutan kod jedne od šest osoba starijih od 60 godina (7), čini se da je riječ o zanemarenom javno zdravstvenom problemu diljem svijeta. Također, iako su stručnjaci pri zdravstvenim i socijalnim institucijama kao i zakonodavne agencije veću pozornost obratile ovom problemu tijekom proteklih 30 godina (8,9), a CDC(10) i Svjetska zdravstvena organizacija (SZO) ovaj problem postavile kao prioritet (11). I dalje nam nedostaju podatci o prirodi i posljedicama obiteljskog nasilja i zlostavljanja starijih osoba u usporedbi s drugim dobnim skupinama (12). Pregledni rad i meta-analiza provedena u 28 država, od visokorazvijenih do nerazvijenih, nije utvrdila značajne razlike u rasprostranjenosti zlostavljanja starijih osoba između muškaraca i žena (7).

Hrvatska je europska država s visokom stopom obiteljskog nasilja (13). Od 2004. do 2006. godine, prema Europskom izvješću o prevenciji nasilja nad starijim osobama, u Hrvatskoj je stopa slučajeva sa smrtnim ishodom na 100 000 ljudi starijih od 60 godina bila 1,4 (što ju je smjestilo na 25. mjesto od 44 države koje su dio Europskog ureda SZO). Zlostavljanje starijih osoba također je važan problem jer Hrvatska nema nacionalnu strategiju vezanu za ovo područje (14).

er person's self-worth or well-being; examples include name-calling, scaring, embarrassing, destroying property, or not letting the elder see friends and family), and financial abuse (illegal misuse of older person's money, property, or assets).

Specific areas that still lack evidence are interventions that target elder neglect, public awareness, older adults who experience maltreatment, professionals responsible for abuse prevention, abusive family caregivers, and caregivers (6). Although elder abuse affects one in six adults aged 60+ (7), it seems to be a comparably neglected public health issue worldwide. Even though health and social service professionals and law enforcement agencies have paid greater attention to this problem over the past 30 years (8, 9), and the CDC (10) and the World Health Organization (WHO) have made it a priority (11), we still lack data about the nature and consequences of DV and abuse of elderly persons in comparison to other age groups (12). A systematic review and meta-analysis that included 28 countries, ranging from high-income to low-income ones, found no significant difference in elder abuse prevalence between women and men (7).

Croatia is among the European countries with the high prevalence of DV (13). Between 2004 and 2006, according to the European report on prevention of elder abuse, homicide rates per 100,000 people aged 60+ were 1.4 in Croatia (placing it 25th among 44 countries in the WHO European Region). Elder abuse is also a significant problem because Croatia does not have a national strategy on elder abuse (14).

Systematic research of DV perpetrated against the elders in Croatia was first initiated approximately ten years ago, after several years of activities aimed at sensitizing the professionals and raising public awareness about the problem (15,16). One study found that 61.1%

Sustavno istraživanje obiteljskog nasilja počinjenog nad starijima u Hrvatskoj prvi je put pokrenuto prije približno deset godina, nekoliko godina nakon provođenja aktivnosti usmjerenih na senzibilizaciju struke i javnosti o ovom problemu (15,16). Jedno je istraživanje pokazalo da je 61,1 % od 303 ljudi u dobi od 65 do 97 godina doživjelo najmanje jednu vrstu obiteljskog nasilja u barem jednoj situaciji (17). Drugo je istraživanje pokazalo kako je 24,1 % starijih žrtava bilo psihički zlostavljano, 6,4 % ekonomski, 4,4 % fizički i 2,1 % seksualno zlostavljano. Počinitelji su često bili bračni partneri, pa sinovi, kćeri i bračne partnerice (18). Drugo istraživanje je također pokazalo povezanost između učestalosti zloporabe alkohola i nasilnih incidenata, posebice kako su starije osobe koje konzumiraju alkohol također sklone počiniti nasilja (19).

Prema Europskom regionalnom uredu SZO zlostavljanje starijih osoba raširenо je u svim zemljama obuhvaćenim tim uredom SZO (14). Stoga je svrha ove studije bila istražiti situaciju u Hrvatskoj kako bi se dobio uvid i potom rezultati iskoristili za utjecaj na kreatore politika i kreiranje specifičnih programa intervencije i tretmana za starije osobe.

Cilj ovog istraživanja bio je utvrditi sociodemografska obilježja starijih žrtava obiteljskog nasilja (osobe u dobi iznad 60 godina), vrste i trajanje zlostavljanja, počinitelje zlostavljanja, prijavu zlostavljanja, vrste savjetovanja u usporedbi s mlađim žrtvama obiteljskog nasilja u dobi ispod 60 godina posebno s obzirom na starije žrtve obiteljskog nasilja.

METODE

Uzorak istraživanja

Od ukupno 3296 osoba koje su došle u Savjetovalište za žrtve obiteljskog nasilja u Zagrebu od 1. siječnja 2013. godine do 20. lipnja 2017. godine, 132 je bilo isključeno iz istraživanja, jer su bili maloljetni ili su odbili sudjelovati u

of 303 people aged 65-97 experienced at least one form of family violence on at least one occasion (17). In a subsequent study, 24.1% of elder victims reported psychological abuse, 6.4% financial exploitation, 4.4% physical abuse, and 2.1% sexual abuse. The abusers were often husbands, followed by sons, daughters, and wives (18). The study also established a correlation between alcohol consumption frequency and exposure to violence, specifically that older persons who consume alcohol incline to commit violent acts (19).

According to the European WHO Regional Office, elder maltreatment is pervasive in all WHO European Region countries (14). Thus, the purpose of this study was to explore the situation in Croatia to gain insight and, subsequently, to use the results in order to influence the policymakers and to create specific intervention and treatment programs for the elderly.

This study aimed to determine the socio-demographic characteristics of elderly DV victims aged 60+, types and duration of abuse, perpetrators of abuse, reporting of abuse, types of counseling compared to younger DV victims aged <60, with a specific focus on the elderly victims of DV.

METHODS

Study sample

Of the total of 3296 individuals who visited the Counseling Center for Domestic Violence Victims in Zagreb between January 1, 2013, and June 20, 2017, 132 were excluded from the study because they were underage or refused to participate in the study. Among the 3164 adult victims of DV (mean age 40.7±11.5 years) who visited the Counseling Center during the study period and had complete data available, 1548 were aged 18-39 years, 1416 were aged

istraživanju. Od 3164 odraslih žrtava obiteljskog nasilja (prosječna dob 40,7±11,5 godina) koji su došli u Savjetovalište tijekom navedenog razdoblja i za koje postoje potpuni podatci, 1548 su imali 18-39 godina, 1416 ih je bilo u dobi 40-59 i 200 starijih od 60 godina. U zapadnim se društvima starija životna dob poklapa s dobi odlaska u mirovinu sa 60 ili 65 godina (20). Sedamstodevedeset i četiri ispitanika bili su muškarci, a 2370 žene. Mlađa je skupina uključivala 749 (25,3 %) muškaraca i 2215 žena (74,7 %) mlađih od 60 godina (prosječna dob 39,05±9,69 godina; raspon od 18 do 59 godina). Prosječna dob mlađih ženskih i mlađih muških žrtava obiteljskog nasilja bila je ista 38,79±9,2 godina (raspon od 18 do 59 godina) za žene, i 39,83±9,25 godina (raspon od 18 do 59 godina) za muškarce.

Ciljana skupina ovog istraživanja sastojala se od 200 muškaraca i žena starijih od 60 godina, odnosno starijih žrtava obiteljskog nasilja (prosječna dob 65±5,2 godina; raspon od 60 do 82 godine). U toj skupini su 155 (77,5 %) ispitanika bile žene, a 45 (22,5 %) muškarci. Nije bilo razlike između muških i ženskih ispitanika u odnosu na dob. Prosječna dob starijih ženskih žrtava obiteljskog nasilja bila je 65,82±5,23 godina (raspon od 60 do 82 godina), a starijih muških žrtava obiteljskog nasilja 65,29±5,15 godina (raspon od 60 do 79 godina).

Izvor podataka

Analizirali smo podatke dobivene od žrtava zlostavljanja koje su osobno dolazile u Savjetovalište za žrtve obiteljskog nasilja u Zagrebu tijekom navedenog razdoblja trajanja istraživanja. Od svog osnivanja 2005. godine Savjetovalište pruža profesionalnu pomoć žrtvama obiteljskog nasilja u području psihološkog, socijalnog i pravnog savjetovanja. Svi stručnjaci u Savjetovalištu imaju dugogodišnje iskustvo u radu sa žrtvama obiteljskog nasilja. Digitalna baza podataka u upotrebi je od 2011. godine, a sve stručne osobe koje rade u Savjetovalištu

40-59 years, and 200 were aged 60+. In Western societies, the onset of older age coincides with the retirement age at 60 or 65 (20). 794 subjects were men, and 2370 were women. The younger group included 749 men (25.3%) and 2215 women (74.7%) aged <60 (mean age 39.05 ±9.69 years; a range from 18 to 59). The average age of both younger female and younger male DV victims was the same 38.79±9.82 years (a range from 18 to 59) for female victims, and 39.83 ±9.25 years (a range from 18 to 59) for male victims.

The study's interest group consisted of 200 men and women aged 60+, i.e., elderly DV victims (mean age 65±5.2 years; a range from 60 to 82). In the subject group, 155 (77.5%) were female, and 45 (22.5%) were male. There was no difference between male and female subjects regarding their age. The average age of elderly female DV victims was 65.82 ± 5.23 years (a range from 60 to 82), and elderly male victims were 65.29±5.15 years (a range from 60 to 79).

Data source

We analyzed the data on abused victims who had personally visited the Counseling Center for Domestic Violence Victims in Zagreb during the study period. Since its establishment in 2005, the Center provides professional help to DV victims in psychological, social, and legal counseling. All professionals at the Center have years-long experience in working with DV victims. A digital database has been in use since 2011, and all professionals at the Center received training in data collection and electronic system data entry. DV victims aged 18+ usually contacted the Center either by visiting the Center, making a telephone call, or by sending an e-mail. Counseling is free-of-charge, voluntary, and anonymous. Victims' names are not included in the database to protect their confidentiality and security.

obučene su za prikupljanje podataka i njihov sustavni elektronski unos. Žrtve obiteljskog nasilja starije od 18 godina najčešće su zatražile pomoć u Savjetovalištu osobno ga posjetivši, uputivši telefonski poziv ili putem elektronske pošte. Savjetovanje se ne naplaćuje, dragovoljno je i anonimno. Imena žrtava nisu unesena u bazu podataka s ciljem zaštite povjerljivosti i njihove sigurnosti. Svi su ispitanici svojim potpisom dali pristanak za prikupljanje podataka.

Prikupljanje podataka

Rutinski postrupak vezan za žrtve obiteljskog nasilja u Savjetovalištu uključuje strukturirani izravni intervju s osobom kako bi žrtva imala dovoljno vremena da opiše svoja traumatska iskustva povezana s obiteljskim nasiljem. Istraživači su sudionicima ponudili mogućnost sudjelovanja u istraživanju tek nakon što su žrtve primile profesionalnu pomoć, a uvjet za sudjelovanje u istraživanju bio je da su osobno došle u Savjetovalište. Istraživači su koristili strukturirani pristup usklađen s *Home Office* definicijom obiteljskog nasilja (1) s ciljem prikupljanja podataka za istraživanje kao i dizajn mjernih instrumenata proizišao iz temeljitog proučavanja literature o obiteljskom nasilju.

Strukturirani intervju je sadržavao sljedeće: (a) sociodemografske podatke (spol, dob, stupanj obrazovanja, bračni i radni status); (b) podatke o obiteljskom nasilju (počinitelj: bračni partner, bivši partner, izvanbračni partner, roditelj, dijete, brat ili sestra, drugi član obitelji; trajanje obiteljskog nasilja; i vrstu obiteljskog nasilja: jedan oblik (fizičko, psihičko, ekonomsko, seksualno) ili više oblika zlostavljanja; (c) nadležna institucija kojoj je prijavljeno obiteljsko nasilje (centri za socijalnu skrb, policija, prekršajni ili kazneni sud); (d) vrsta savjetovanja (psihološko, socijalno ili pravno savjetovanje i podrška, ili njihova kombinacija).

Istraživači su osigurali odgovarajuće procedure postupanja i zaštitu sudionika uključenih u istraživanje. Također, identitet sudionika je povjerljiv i zaštićen. Sudionici su informirani o svrsi ovog

Each subject signed a written consent for data collection.

Data collection

The routine procedure with DV victims at the Center includes a structured face-to-face interview to allow the victims the time needed for describing their traumatic experiences related to DV. The researchers asked the subjects to participate in the study only after having received professional assistance, and the research requirement was that the subjects visited the Centre personally. The researchers used a structured approach harmonized with the Home Office definition of DV (1) to collect data for the study and the study instrument design based on a literature review on the DV.

A structured approach provided the following data: (a) socio-demographic data (gender, age, education level, marital and occupational status); (b) DV-related data (the perpetrator: spouse, ex-partner, cohabiting partner, parent, child, sibling, other family members; duration; and types of DV: single-type abuse - physical, psychological, financial, sexual or multiple-type abuse); (c) an institution to which DV was reported (social welfare centers, police, misdemeanor or criminal courts); and (d) types of counseling (psychological, social, or legal counseling and support, or a combination of these).

The researchers secured proper implementation procedures and the safety of the persons involved in this study. Also, the identity of subjects has to remain confidential and protected. The subjects received information about the purpose of this voluntary study that excluded financial or any other compensation. The subjects confirmed their willingness to participate in the study by signing a written, coded informed consent that granted their anonymity and the right to withdraw from the study without any further explanation

dragovoljnog istraživanja bez zajamčene financijske ili druge nagrade. Također su potvrdili svoju spremnost za sudjelovanje u istraživanju vlastoručnim potpisom šifriranog informiranog pristanka u pisanom obliku kojim im je zajamčena anonimnost kao i pravo da odustanu od istraživanja bez dodatnih objašnjenja ili bilo kakvog utjecaja na pruženu pomoć - savjetovanje. Uz navedeno savjetovano im je da za daljnja objašnjenja kontaktiraju istraživače koji provode istraživanje, odnosno stručnjake u Savjetovalištu. Dosljednost postupka prikupljanja podataka koji su provodili istraživači bila je 0,98 %.

Provedbu istraživanja odobrili su Etičko povjerenstvo Sveučilišnog odjela za forenzične znanosti Sveučilišta u Splitu (Prot. br. 2181-227-05-12-19-0001) kao i Etičko povjerenstvo Doma za djecu i odrasle – žrtve obiteljskog nasilja „Duga-Zagreb“ (Savjetovalište je dio Doma „Duga-Zagreb“; Prot. br. 01-19/10-7-4). Dizajn istraživanja je omogućio ispravno postupanje i zaštitu sudionika sukladno važećim etičkim standardima (20-24).

Statistička analiza

Istraživači su ispitali *post-hoc* razlike u proporcijama s neparametrijskim Pearsonovim hi-kvadrat testom i z-testom s Bonferronijevom korekcijom s ciljem određivanja razlika između starijih iznad 60 godina i mlađih ispod 60 godina žrtava obiteljskog nasilja u odnosu na sociodemografska obilježja, obilježja zlostavljanja i s njime povezanih intervencija. Istraživači su također proveli Phi za 2x2 ili Cramerov V za veće kontingencijske tablice s ciljem definiranja snage povezanosti između kategorijskih varijabli.

Binarnom logističkom regresijom utvrđeni su neovisni doprinosi sociodemografskih obilježja (spol, obrazovanje, zaposlenje i bračni status), obilježja obiteljskog nasilja (počinitelj obiteljskog nasilja, trajanje obiteljskog nasilja i prijavljivanje nasilja nadležnim institucijama) i povezanih intervencija (vrste savjetovanja) u predviđanju vrsta zlostavljanja (jedna vrsta ili

and any impact on the provided help-seeking assistance. In addition, they were advised to contact the research conductors, e.g., professionals at the Centre, for further explanations. The data collection procedure consistency implemented by the researchers was at 0.98%.

The Ethics Committee approved the study of the University of Split, Department of Forensic Sciences (Registration no. 2181-227-05-12-19-0001), and the Ethics Committee of the Home for Children and Adult Victims of Domestic Violence “Duga–Zagreb” (the Center is one of the facilities of “Duga-Zagreb”; Registration no. 01-19/10-7-4). The study design ensured the correct performance of the procedures and the study subjects’ safety according to the current ethical standards (20-24).

Statistical analysis

The researchers tested post-hoc differences between proportions with a non-parametric Pearson chi-square test and z-test with Bonferroni’s correction to determine differences between the elderly (60+) and younger (<60) DV victims regarding the socio-demographic characteristics, characteristics of abuse, and related interventions. The researchers also conducted Phi for 2x2 or Cramer’s V for larger contingency tables to determine the strength of the association between categorical variables.

Binary logistic regression determined independent contributions of socio-demographic characteristics (gender, education, employment, and marital status), characteristics of DV (DV perpetrator, duration of DV, and reporting DV to the authorities), and related interventions (types of counseling) in predicting types of abuse (single-type vs. multiple-type) experienced by elder DV victims (60+).

All statistical analyses were performed in a free statistics environment R, the 3.3.2 version (25, 26).

kombinacija više vrsta nasilja) koje su doživjele žrtve obiteljskog nasilja u dobi iznad 60 godina.

Sve su statističke analize provedene u besplatnom statističkom okruženju R, verzija 3.3.2 (25, 26).

REZULTATI

Sociodemografska obilježja starijih u usporedbi s mlađim žrtvama obiteljskog nasilja

Rezultati istraživanja nisu ukazali na razlike između starijih i mlađih žrtava obiteljskog nasilja s obzirom na spol (p=0,382) (tablica 1). Kada je riječ o obrazovnom statusu, značajno više starijih žrtava obiteljskog nasilja imalo je završenu osnovnu školu (41 % *vs*. 9 %; p<0,001), dok je u skupini mlađih žrtava više žrtava obiteljskog nasilja imalo završenu srednju školu (59 % *vs*. 47 %), višu školu (7 % *vs*. 4 %) ili visoko obrazovanje (21 % *vs* 9%; p<0,001).

Dobivene su razlike između dviju dobnih skupina vezane uz njihov bračni status (p<0,001). Rezultati su pokazali da su starije žrtve obiteljskog nasilja rjeđe bile u postupku razvoda braka u odnosu na mlađu skupinu žrtava (4 % *vs*. 15 %; p<0,001) koje su češće živjele u izvanbračnim zajednicama (14 % *vs*. 4 %; p<0,001) ili su bile razvedene (18 % *vs*. 10 %; p=0,003).

Značajno veći broj mlađih žrtava obiteljskog nasilja bili samci su (9 % *vs*. 3 %; p<0,001) i znatno su rjeđe bili udovci u usporedbi sa skupinom starijih žrtava obiteljskog nasilja (2 % *vs*. 36 %; p<0,001). Kada je riječ o onima u braku, rezultati nisu pokazali razlike između skupina mlađih i starijih žrtava obiteljskog nasilja (p >0,05). Također, rezultati povezani s radnim statusom pokazali su da su mlađe žrtve obiteljskog nasilja češće bile zaposlene (68 % *vs*. 14 %; p<0,001) ili nezaposlene (26 % *vs*. 8 %; p<0,001), dok je značajno veći broj starijih žrtava obiteljskog nasilja bio u mirovini (78 % *vs*. 7 %; p<0,001).

RESULTS

Socio-demographic characteristics of elderly DV victims compared to younger DV victims

The study results did not reveal any difference between the elderly and the younger DV victims regarding the gender (p=.382) (Table 1). Concerning the education level, significantly more elderly DV victims had an elementary level of education (41% vs. 9%; p<.001), whereas in the younger group, more DV victims had high school education (59% vs. 47%), college (7% vs. 4%), or a university degree (21% vs. 9%; p<.001).

The two age groups were different concerning the marital status distribution (p<.001). The results showed that elderly DV victims were less often undergoing a divorce compared to younger DV victims (4% vs. 15%; p<.001) who were more often either living in cohabitation (14% vs. 4%; p<.001), or were divorced (18% vs. 10%; p=.003).

A significantly higher number of younger DV victims was single (9% vs. 3%; p<.001) and were significantly less likely to be widowed compared to the elderly DV victims (2% vs. 36%; p<.001). However, where the married status is concerned, the results did not establish any differences between the younger and the elderly DV victims (p > .05). Also, the findings related to the employment status showed that younger DV victims were more often employed (68% vs. 14%; p<.001) or unemployed (26% vs. 8%; p<.001) while a significantly higher number of elderly DV victims was retired (78% vs. 7%; p<.001).

DV types and duration

The study results showed no difference between the two age groups regarding the type of experienced DV, including physical, psycho-

TABLICA 1. Sociodemografska obilježja žrtava obiteljskog nasilja u odnosu na dob (*N* = 3164)
TABLE 1. Socio-demographic characteristics of victims of DV related to age (*N* = 3164)

Žrtve obiteljskog nasilja / Victims of DV								
Obilježja / Characteristics	**< 60 godina (*n* = 2964) / aged < 60 years (*n* = 2964)**		**≥ 60 godina (*n* = 200) / aged ≥ 60 years (*n* = 200)**		**χ^2**	***df***	***p***	***Cramer's V/ φ***
Spol; *f* (%) / Gender; *f* (%)					0,77	1	0,382	0,016[a]
Muškarci / Men	749	(25,3)	45	(22,5)				
Žena / Women	2215	(74,7)	155	(77,5)				
Obrazovanje; *f* (%) / Education; *f* (%)					182,52*	3	<0,001	0,245
Osnovna škola / Elementary	268	(9,1)	81	(40,5)				
Srednja škola / High school	1758	(59,4)	94	(47,0)				
Viša škola / College	199	(6,7)	7	(3,5)				
Fakultet / University	623	(21,1)	18	(9,0)				
Bračni status; *f* (%) / Marital status; *f* (%)					512,22*	5	<0,001	0,406
U braku / Married	1239	(42,7)	91	(45,5)				
Brakorazvodna parnica u tijeku / Divorcing	421	(14,5)	7	(3,5)				
Izvanbračna zajednica / Cohabitation	407	(14,0)	7	(3,5)				
Razveden / Divorced	511	(17,6)	19	(9,5)				
Samac / Single	259	(8,9)	5	(2,5)				
Udovac / Widowed	67	(2,3)	71	(35,5)				
Radni status; *f* (%) / Employment status; *f* (%)					964,57*	2	<0,001	0,567
Zaposlen / Employed	1898	(67,8)	27	(13,6)				
Nezaposlen / Unemployed	722	(25,8)	16	(8,0)				
U mirovini / Retired	181	(6,5)	156	(78,4)				

Napomena: a - φ; * p<0.001.
/ Note: a - φ; * p< .001.

Vrste i trajanje obiteljskog nasilja

Rezultati istraživanja nisu pokazali nikakve razlike između dviju dobnih skupina vezano za vrstu nasilja uključujući fizičko, psihičko ili seksualno zlostavljanje (p>0,05; p=0,65; p=0,38). Ekonomsko zlostavljanje bilo je češće prisutno u skupini starijih žrtava (10 % *vs*. 4 %; p=0,040). Analiza različitih kombinacija obiteljskog nasilja pokazala je tek neznatne razlike u kombinaciji fizičkog i ekonomskog nasilja, koje su češće doživljavale starije žrtve obiteljskog nasilja (2 % *vs*. 0%; p=0,013) (tablica 2).

logical, or sexual abuse (p>.05; p=.65; p=.38). Financial abuse was more frequent in the elderly group (10% vs. 4%; p=.040). The analysis of various DV combinations revealed only a significant difference for a combination of physical and financial abuse, which was more often experienced by the elderly DV victims (2% vs. 0%; p=.013) (Table 2).

Regarding the DV duration, the study results showed no difference between the two age groups concerning the first occurrence of DV (p=.160), but DV duration of up to 6 months

TABLICA 2. Vrste doživljenog zlostavljanja (*N* = 3164)
TABLE 2. Types of DV experienced by victims (*N* = 3164)

Žrtve obiteljskog nasilja / Victims of DV						
Vrsta zlostavljanja / Type of abuse	**< 60 godina (*n* = 2964) / aged < 60 years (*n* = 2964)**	**≥ 60 godina (*n* = 200) / aged ≥ 60 years (*n* = 200)**	**χ^2**	***df***	***p***	***Cramer's V***
Vrsta zlostavljanja; *f* (%) / Type of abuse; *f* (%)			19,97*	11	0,046	0,080
Jedan oblik zlostavljanja / Single-type abuse						
Fizičko / Physical	322 (11,0)	13 (6,6)				
Psihičko / Psychological	730 (24,8)	52 (26,3)				
Ekonomsko / Financial	187 (6,4)	20 (10,1)				
Seksualno / Sexual	35 (1,2)	1 (0,5)				
Više oblika zlostavljanja / Multiple-type abuse						
PSP	531 (18,1)	27 (13,6)				
PSF	594 (20,2)	49 (24,7)				
PSS	63 (2,1)	3 (1,5)				
PHF	33 (1,1)	1 (0,5)				
PHS	10 (0,3)	3 (1,5)				
PSPF	267 (9,1)	20 (10,1)				
PSPS	126 (4,3)	7 (3,5)				
PSFS	42 (1,4)	2 (1,0)				

Napomena: *p<0,05; **p<0,001; *Kratice:* PSP = kombinacija psihičkog i fizičkog zlostavljanja; PSF = kombinacija psihičkog i ekonomskog zlostavljanja; PSS = kombinacija psihičkog i seksualnog zlostavljanja; PHF = kombinacija fizičkog i ekonomskog zlostavljanja; PHS = kombinacija fizičkog i seksualnog zlostavljanja; PSPF = kombinacija fizičkog, psihičkog i ekonomskog zlostavljanja; PSPS = kombinacija psihičkog, fizičkog i seksualnog zlostavljanja; PSFS = kombinacija psihičkog, ekonomskog i seksualnog zlostavljanja
/ Note: * p< .05; ** p< .001; *Abbreviations:* PSP = a combination of psychological and physical abuse; PSF = a combination of psychological and financial abuse; PSS = a combination of psychological and sexual abuse; PHF = a combination of physical and financial abuse; PHS = a combination of physical and sexual abuse; PSPF = a combination of psychological, physical, and financial abuse; PSPS = a combination of psychological, physical, and sexual abuse; PSFS = a combination of psychological, financial, and sexual abuse

Kada je riječ o trajanju obiteljskog nasilja, rezultati istraživanja nisu pokazali razliku između dviju dobnih skupina vezano za jedan incident obiteljskog nasilja (p=0,160), dok je trajanje obiteljskog nasilja do 6 mjeseci bilo češće u mlađoj dobnoj skupini (17 % *vs*. 9 %; p=0,002) te su stariji sudionici puno češće bili izloženi obiteljskom nasilju koje je trajalo dulje od dvije godine (46 % *vs*. 29 %; p<0,001) (tablica 3).

Počinitelji obiteljskog nasilja

Bračni partner (55 % *vs*. 34 %), bivši partner (10 % *vs*. 4 %), ili izvanbračni partner (12 % *vs*. 4 %) značajno su češće bili počinitelji u mlađoj dobnoj skupini u usporedbi sa skupinom starijih žrtava obiteljskog nasilja (p<0,001; p=0,002; p<0,001).

was more frequent in the younger group (17% vs. 9%; p=.002), whereas the elderly subjects experienced DV longer than two years more frequently (46% vs. 29%; p<.001) (Table 3).

Perpetrators of DV

A spouse (55% vs. 34%), a former partner (10% vs. 4%), or a cohabitating partner (12% vs. 4%) were significantly more often DV perpetrators in the younger group compared to the elderly DV victims group (p<.001; p=.002; p<.001). At the same time, a higher and statistically significant rate of perpetrators of DV against elderly victims were children (41% vs. 4%; p<.001). Furthermore,

TABLICA 3. Obilježja doživljenog obiteljskog nasilja kod starijih i mladih žrtava i povezane intervencije (N = 3164)
TABLE 3. Characteristics of DV experienced by elderly and younger victims and related interventions (N = 3164)

Žrtve obiteljskog nasilja / Victims of DV						
Obilježja zlostavljanja / Characteristics of abuse	**< 60 godina (*n* = 2964) / aged < 60 years (*n* = 2964)**	**≥ 60 godina (*n* = 200) / aged ≥ 60 years (*n* = 200)**	**χ^2**	***df***	***p***	***Cramer's V/ φ***
Počinitelj; *f* (%) / Perpetrator; *f* (%)			432,91**	6	<0,001	0,370
Bračni partner / Spouse	1616 (54,5)	68 (34,0)				
Bivši partner / Ex-partner	294 (9,9)	7 (3,5)				
Izvanbračni partner / Cohabiting partner	356 (12,0)	8 (4,0)				
Roditelj / Parent	268 (9,0)	2 (1,0)				
Dijete / Child	126 (4,3)	81 (40,5)				
Brat/sestra / Sibling	46 (1,6)	7 (3,5)				
Drugi član obitelji / Other family member	258 (8,7)	27 (13,5)				
Trajanje zlostavljanja; *f* (%) / Duration of DV; *f* (%)			29,74**	4	<0,001	0,097
Jednom / First occurrence	156 (5,3)	6 (3,0)				
< 6 mjeseci / < 6 months	499 (16,8)	17 (8,5)				
6-12 mjeseci / 6-12 months	594 (20,0)	33 (16,5)				
> 1 godina< 2 godina / > 1 year < 2 years	869 (29,3)	53 (26,5)				
Više od 2 godine / more than 2 years	846 (28,5)	91 (45,5)				
Prijava centru za socijalnu skrb; *f* (%) / Reported to social welfare center; *f* (%)			12,92**	1	<0,001	0,064[a]
Ne / No	1706 (57,6)	141 (70,5)				
Da / Yes	1258 (42,4)	59 (29,5)				
Prijava policiji; *f* (%) / Reported to the police; *f* (%)			1,54	1	0,215	0,022[a]
Ne / No	2086 (70,4)	149 (74,5)				
Da / Yes	878 (29,6)	51 (25,5)				
Prekršajna prijava; *f* (%) / Misdemeanor complaint; *f* (%)			6,27*	1	0,012	0,045[a]
Ne / No	2576 (86,9)	186 (93,0)				
Da / Yes	388 (13,1)	14 (7,0)				
Kaznena prijava; *f* (%) / Criminal charges; *f* (%)			3,25	1	0,071	0,032[a]
Ne / No	2783 (93,9)	194 (97,0)				
Da / Yes	181 (6,1)	6 (3,0)				
Vrsta savjetovanja; *f* (%) / Type of counseling; *f* (%)			2,23	3	0,525	0,027
Psihološko / Psychological	156 (5,3)	12 (6,0)				
Socijalno / Social	49 (1,7)	6 (3,0)				
Pravno / Legal	121 (4,1)	8 (4,0)				
Kombinirano / Combined	2638 (89,0)	174 (87,0)				

Napomena: a - φ; * p<0,05; ** p<0,001.
/ Note: a - φ; * p< .05; ** p< .001.

Istodobno, češće i statistički značajno djeca su bila počinitelji obiteljskog nasilja nad starijim žrtvama (41 % *vs*. 4 %; $p<0{,}001$). Nadalje, roditelji su znatno češće bili počinitelji obiteljskog nasilja u mlađoj dobnoj skupini (9 % *vs*. 1 %; $p<0{,}001$), dok su braća i sestre (4 % *vs*. 2 %; $p=0{,}040$) i drugi članovi obitelji (14 % *vs*. 9 %; $p=0{,}020$) bili znatno češće počinitelji obiteljskog nasilja u starijoj dobnoj skupini (tablica 3).

Prijavljivanje obiteljskog nasilja i vrste intervencije

Rezultati istraživanja povezani s prijavama obiteljskog nasilja nadležnim institucijama pokazali su da su mlađi sudionici značajno češće prijavljivali obiteljsko nasilje centrima za socijalnu skrb (42 % *vs*. 30 %) ili prekršajno (13 % *vs*. 7 %) u usporedbi sa starijim sudionicima ($p<0{,}001$; $p=0{,}012$). Rezultati nisu ukazali ni na kakve razlike između dviju skupina kad je riječ o učestalosti prijava obiteljskog nasilja policiji ili kaznenih prijava ($p=0{,}215$; $p=0{,}071$) ili učestalosti i vrsti savjetovanja ($p=0{,}525$) (tablica 3).

Binarna logistička regresija

Korištena je binarna logistička regresija s metodom unosa kako bismo odredili vjerojatnost da će starija žrtva obiteljskog nasilja iznad 60 godina biti izložena jednoj vrsti zlostavljanja ili kombiniranom zlostavljanju na temelju sociodemografskih obilježja žrtve (spol, obrazovanje te radni i bračni status), obilježja zlostavljanja (počinitelj i trajanje obiteljskog nasilja te prijava nasilja nadležnim institucijama) i provedenim intervencijama (vrsta savjetovanja). Model logističke regresije bio je statistički značajan ($\chi2(13)=27{,}27$, $p=0{,}011$) i objasnio je 18,9 % (Nagelkerke $R2$) odstupanja za vrstu obiteljskog nasilja nad starijih osobama (tablica 4).

Tablica 4. prikazuje vjerojatnost da starije žrtve doživljavaju jednu vrstu ili kombinirano zlostavljanje. Waldov test je pokazao da su jedina dva statistički značajna pokazatelja u predviđa-

parents were more often DV perpetrators in the younger group (9% vs. 1%; $p<.001$), while siblings (4% vs. 2%; $p=.040$) and other family members (14% vs. 9%; $p=.020$) were more often DV perpetrators in the elderly group (Table 3).

Reporting of DV and types of intervention

The study results related to the DV reporting to the authorities showed that the younger subjects reported DV to a social welfare center (42% vs. 30%) or filed misdemeanor charges (13% vs. 7%) significantly more frequently compared to the elderly subjects ($p<.001$; $p=.012$). The results did not reveal any difference between the two groups in the frequency of DV reporting to the police or filing criminal charges ($p=.215$; $p=.071$) or in the frequency and type of counseling ($p=.525$) (Table 3).

Binary logistic regression

The researchers used the binary logistic regression with method enter to determine the probability for elderly DV victims (60+ years old) to experience single-type or multiple-type abuse based on victims' socio-demographic characteristics (gender, education, employment, and marital status), characteristics of DV (DV perpetrator, duration of DV, and reporting DV to the authorities), and experienced interventions (types of counseling). The logistic regression model was statistically significant ($\chi2(13)=27.27$, $p=.011$) and explained 18.9% (Nagelkerke $R2$) of the variance for the type of DV against elderly victims (Table 4).

Table 4 illustrates the probability of elderly victims experiencing single or multiple DV types. The Wald test showed that only two predictors were statistically significant in predicting the

TABLICA 4. Binarna logistička regresija: predviđanje vrste obiteljskog nasilja nad starijim osobama temeljem seta prediktora (*N* = 200)
TABLE 4. Binary logistic regression: Predicting the type of DV against elderly victims on the basis of a set of predictors (*N* = 200)

				95% CI for odd sratio		
Prediktori* / Predictors*	***B***	***Wald***	***p***	***Lower***	***Exp(B)***	***Upper***
Spol / Gender	0,001	0,000	0,999	0,445	1,001	2,251
Obrazovni status / Education level	0,484	0,671	0,413	0,510	1,622	5,161
Radni status / Employment status	-1,523	6,237*	0,013	0,066	0,218	0,721
Bračni status / Marital status						
u braku / married	-	0,213	0,899	-	-	-
razveden / divorced	0,022	0,002	0,963	0,411	1,022	2,541
udovac / widowed	-0,220	0,133	0,715	0,246	0,802	2,618
Počinitelj zlostavljanja / DV perpetrator						
partner / partner	-	0,350	0,839	-	-	-
dijete / child	0,004	0,000	0,995	0,326	1,004	3,088
drugi član obitelji / other family member	0,240	0,232	0,630	0,479	1,271	3,378
Trajanje zlostavljanja / DV duration	0,239	2,143	0,143	0,922	1,270	1,749
Prijava centru za socijalnu skrb / Reported to social welfare center	0,900	4,847*	0,028	1,104	2,459	5,478
Prijava policiji / Reported to the police	0,245	0,287	0,592	0,521	1,278	3,137
Prekršajna prijava / Misdemeanor complaint	1,186	1,772	0,183	0,571	3,275	18,791
Kaznena prijava / Criminal charge	0,704	0,288	0,591	0,155	2,021	26,371
Vrsta savjetovanja / Type of counseling	-0,138	0,072	0,789	0,317	0,871	2,395

Napomena: CI: confidence interval.; * p<0,05. *Varijable su kodirane*: Vrsta zlostavljanja (0 = jedan oblik; 1 = više oblika); spol (0 = muškarac; 1 = žena); obrazovni status (0 = niži; 1 = visoki); bračni status (0 = zaposlenost; 1 = nezaposlenost); bračni status (0 = u braku ili izvanbračnoj zajednici; referentne grupe za usporedbu; 1 = razvod braka u tijeku ili razveden; 2 = udovac); Počinitelj zlostavljanja (0 = partner; referentne grupe za usporedbu; 1 = dijete; 2 = brat/sestraili drugu član obitelji); trajanje zlostavljanja (što je viši broj duže je vrijeme zlostavljanja); prijava centru za socijalnu skrb (0 = ne; 1 = da); prijava policiji (0 = ne; 1 = da); prekršajna prijava (0 = ne; 1 = da); kaznena prijava (0 = ne; 1 = da); vrsta savjetovanja (0 = jedan oblik; 1 = kombinirano).
-2 Log likelihood= 217,91, Cox &SnellR^2 = 0,141, NagelkerkeR^2=0,189.
/ Note: DV – domestic violence; CI: confidence interval.; * p< .05. *Variables are coded*: DV type (0 = single; 1 = multiple); gender (0 = male; 1 = female); education level (0 = low; 1 = high); employment status (0 = employed; 1 = unemployed); marital status (0 = married or cohabitating; reference group for comparison; 1 = divorced or divorcing; 2 = widowed); DV perpetrator (0 = partner; reference group for comparison; 1 = child; 2 = siblings or other family members); DV duration (the higher the number, the longer the DV); social welfare center complaint (0 = no; 1 = yes); police complaint (0 = no; 1 = yes); misdemeanor charge (0 = no; 1 = yes); criminal charge (0 = no; 1 = yes); type of counseling (0 = single; 1 = combined).
-2 Log likelihood = 217.91, Cox & Snell R^2 = .141, NagelkerkeR^2= .189.

nju tipa obiteljskog nasilja: radni status i prijava centru za socijalnu skrb (p=0,013; p=0,028). Zaposlene žrtve obiteljskog nasilja imale su 4,5 puta veću vjerojatnost da će doživjeti kombinaciju vrsta obiteljskog nasilja u usporedbi s umirovljenim žrtvama obiteljskog nasilja. One žrtve koje su prijavile obiteljsko nasilje centru za socijalnu skrb imale su 2,5 puta veću vjerojatnost da će doživjeti kombinaciju vrsta obiteljskog nasilja od žrtava koje to nisu prijavile.

Moguće je u određenoj mjeri predvidjeti vjerojatnost da će starije žrtve doživjeti jednu ili više vrsta nasilja u obitelji, a na temelju navedenog skupa prediktora, uglavnom vezanih uz radni status i prijave centru za socijalnu skrb.

DV type: employment status and complaint filed to a social welfare center (p=.013; p=.028). The employed DV victims had a 4.5-fold probability of experiencing multiple-type abuse compared to the retired DV victims. Those who filed a complaint to a social welfare center had a 2.5-fold probability of experiencing multiple-type abuse compared to those who did not file such a complaint.

It is possible to predict the probability of elderly victims experiencing single or multiple types of DV to a certain extent and based on the mentioned set of predictors, mostly concerning the employment status and complaints filed to a social welfare center.

RASPRAVA

U istraživanju nisu dobivene razlike između žrtava obiteljskog nasilja starijih iznad 60 godina i mlađih ispod 60 godina žrtava u odnosu na spol. Obje skupine su uključile približno 25 % muških sudionika, što je u skladu s podatcima iz Sjedinjenih Američkih Država koji pokazuju da je 76 % žena i 24 % muškaraca doživjelo obiteljsko nasilje (27).

Naši rezultati za starije žrtve obiteljskog nasilja su u skladu sa samo-prijavljenim podatcima o obiteljskom nasilju u Hrvatskoj (18) i sa slovenskim istraživanjem provedenim na pacijentima primarne zdravstvene zaštite (28). No, razlikuju se od podataka dobivenih iz istraživanja provedenih u Kanadi, Albaniji, Kolumbiji i Brazilu (29), Australiji (30) i Izraelu (31), koja pokazuju da je ženski spol ključno obilježje žrtava obiteljskog nasilja u starijoj životnoj dobi. Premda su istraživači općenito prepoznali ženski spol kao rizični čimbenik za starije žrtve obiteljskog nasilja (32,33), potrebna su nova istraživanja kako bismo stekli dublje razumijevanje tog fenomena, posebice u vezi raznih čimbenika poput kulturne pozadine, rodnih uloga i društvenih odnosa. Većina istraživanja o obiteljskom nasilju isključivo su se fokusirala na ženski spol (34-37). Međutim, podatci dobiveni iz istraživanja usmjerenih na muške žrtve obiteljskog nasilja dovoljno su uvjerljivi da se zajamči i rodna perspektiva pri analiziranju obiteljskog nasilja u starijoj populaciji (38). Nadalje, rezultati vezani za skupinu mlađih žrtava obiteljskog nasilja snažno podržavaju mogućnost da je obiteljsko nasilje nasilan čin i protiv muškaraca i žena. Oni tako potvrđuju paradigmu vezanu za obiteljsko nasilje koja nije rodno uvjetovana (37,39,40).

Druga istraživanja su pokazala kako su starije žrtve obiteljskog nasilja uglavnom bile manje obrazovane te da nisu imale dostatne financijske resurse. Većina su bili udovci/udovice i oslanjali su se na obitelji, za razliku od skupine mlađih žrtava obiteljskog nasilja (31,41). Rezultati našeg istraživanja su u skladu s tim podatcima: većina

DISCUSSION

In study sample there was no any gender differences between the elderly (60+) and the younger DV victims (<60). As both the study groups included approximately 25% of men, this is in line with the USA data showing that 76% of women and 24% of men have experienced DV violence (27).

Our finding related to the elderly DV victims is in line with self-reported data on DV in Croatia (18) and a Slovenian study on primary care patients (28). However, it differs from the data obtained from Canada, Albania, Colombia, and Brazil (29), Australia (30), and Israel (31), which show that female gender is an essential determinant for experiencing elder abuse. Although the researchers have generally recognized the female gender as a risk factor for elder abuse (32, 33), more research is needed to understand this phenomenon, specifically relating to various factors like cultural backgrounds, gender roles, and social relations. Most DV studies focused on female gender exclusively (34-37). However, the evidence derived from the research focusing on male DV victims is strong enough to warrant gender perspective in analyzing DV in the elderly population (38). Furthermore, results obtained from the younger DV victims group strongly suggest that DV concerned violent offenses against both women and men. They also confirmed the non-gender-specific paradigm concerning DV (37,39,40).

Other studies found that elderly DV victims mostly had lower education levels and did not have sufficient financial resources. Most of them were widowed and relied on their families, unlike the younger DV victims group (31,41). The study results are in line with these findings: most elderly DV victims in our subject group were retired (78.4%) and, thus, were exposed to a higher risk of DV. Retired persons are generally socially vulnerable and

starijih žrtava obiteljskog nasilja u našem uzorku ispitanika bile su umirovljene (78,4 %) i, samim time, izložene većem riziku za obiteljsko nasilje. Umirovljene osobe su općenito društveno ranjivija skupina i osiromašena te često izložena značajnom riziku za različite oblike zlostavljanja unutar obitelji i drugih sustava skrbi. Drugim riječima, ekonomska autonomija mogla bi spriječiti dio obiteljskog nasilja. Glavna obilježja današnjeg stanja Hrvatske su visoka stopa nezaposlenosti, niske mirovine, reforme sustava socijalne skrbi te privatizacija zdravstvenog i stambenog sustava.

Kada je riječ o počiniteljima obiteljskog nasilja, muž, bivši partner ili izvanbračni partner te roditelji bili su puno češće počinitelji u mlađoj skupini žrtava obiteljskog nasilja. Istodobno, veća je vjerojatnost da su djeca, braća i sestre te drugi članovi obitelji bili počinitelji obiteljskog nasilja u starijoj skupini.

Naši rezultati nisu potvrdili rezultate ranijih istraživanja provedenih u visoko razvijenim državama (42) kad je riječ o nasilju nad intimnim partnerom u starijoj populaciji. Nedostaju istraživanja provedena u srednje razvijenim i nerazvijenim državama (7). Neka su istraživanja pokazala da su intimni partneri najčešće počinitelji obiteljskog nasilja (43,44). S druge strane, nekoliko je istraživanja pokazalo da su zlostavljači bili djeca (45) i drugi članovi obitelji (46). Hrvatsko istraživanje provedeno 2009. godine koje je uključilo 303 starija muškarca i žene pokazalo je da su intimni partneri i drugi članovi obitelji bili počinitelji obiteljskog nasilja u jednakom broju slučajeva (18). U našem uzorku ispitanika većina starijih sudionika su bile udovice/udovci. Kod njih su najčešće počinitelji bili djeca (40,5 % slučajeva) ili drugi članovi obitelji (13,5 % slučajeva), dok je u skupini mlađih žrtava obiteljskog nasilja bila veća vjerojatnost da su počinitelji bili supružnici te bivši ili izvanbračni partner. Drugim riječima, u 76,4 % slučajeva mlađi su ispitanici prijavili nasilno ponašanje intimnog partnera, a u skupini starijih žrtava 41,5 %.

Kako je dugotrajno obiteljsko nasilje bilo češće u starijoj skupini u usporedbi s mlađom skupi-

impoverished and often at significant risk of different forms of abuse within their own families and other systems of care. In other words, financial autonomy could prevent some form of DV. As a country, the main characteristics of Croatia concern unemployment, low pensions, reforms of the social welfare system, and privatization of the health care system and housing.

Regarding the DV perpetrator, a spouse, former partner or a cohabitating partner, and parents were significantly more often perpetrators in the younger group than in the elderly group of DV victims. At the same time, children, siblings, and other family members were more likely to be DV perpetrators in the elderly group.

Our results did not confirm previous findings for high-income countries (42) relating to intimate partner violence (IPV) in the elderly population. However, studies from low-income and middle-income countries are mostly missing (7). Some studies found that intimate partners were most likely to perpetrate DV (43,44). On the other hand, a few studies found that children (45) and other family members (46) were the abusers. A Croatian study conducted in 2009, including 303 older men and women, found that intimate partners and other family members were DV perpetrators in an equal number of cases (18). In our sample, a majority of elderly subjects were widows. Also, in these cases, it was most likely that the perpetrators were children (40.5% of the cases) or other family members (13.5% of the cases), whereas, in the younger DV victims group, the DV perpetrator was more likely to be the spouse, ex-partner, or the cohabiting partner. In other words, in 76.4% of the cases, younger subjects reported IPV, and in 41.5% of the cases, elderly subjects reported IPV.

As long-term DV was more frequent in the elderly DV victims group than among younger subjects, this implies a higher vulnerability of

nom žrtava obiteljskog nasilja, to ukazuje na veću ranjivost starijih osoba na obiteljsko nasilje s obzirom na njihovu ovisnost (ekonomsku ili onu povezanu sa zdravljem) o skrbnicima. No, s obzirom da je visoka stopa obiteljskog nasilja među starijim osobama i dalje često neotkrivena, to ograničava daljnje preporuke i podršku (12). Više od 50 % žrtava obiteljskog nasilja uključenih u istraživanje, neovisno o njihovoj dobi, doživjelo je kombinirano zlostavljanje, i to najčešće kombinaciju psihičkog i ekonomskog zlostavljanja. Učestalost jedne vrste zlostavljanja dobivene u ovom istraživanju u skladu je s podatcima dobivenim u ranijim istraživanjima (7,12,18,29,46) provedenim na starijim žrtvama obiteljskog nasilja koje češće doživljavaju ekonomsko zlostavljanje ili kombinaciju fizičkog i ekonomskog zlostavljanja u odnosu na skupinu mlađih sudionika.

Kada se radi o prijavljivanju obiteljskog nasilja nadležnim institucijama, mlađi su sudionici bili značajno skloniji prijaviti obiteljsko nasilje centru za socijalnu skrb (42 % *vs*. 30 %) ili prekršajno 13 % *vs*. 7 %) od starijih žrtava obiteljskog nasilja. Nadalje, starije žrtve obiteljskog nasilja u našem istraživanju rjeđe su prijavljivale zlostavljanje institucijama, poput centara za socijalnu skrb ili institucijama izvršne vlasti, uključujući sudove. Nasilje nad starijim osobama je ozbiljan globalni zdravstveni problem koji negativno utječe na kvalitetu života, dobrobit i mortalitet žrtava. Podatci o intervencijama usmjerenima na prevenciju zlostavljanja starijih osoba su ograničeni (6). Gotovo tri četvrtine starijih žrtava obiteljskog nasilja nisu prijavili doživljeno zlostavljanje ni jednoj nadležnoj instituciji. Ta spoznaja naglašava važnost savjetovališta za žrtve obiteljskog nasilja da zatraže pomoć kao i mjesta koja se bave preventivnim i interventnim aktivnostima.

Schiamberg i Gans (47) opisuju model koji međusobno povezuje čimbenike i fokus smješta na roditelja i dijete u različitim okruženjima od mikrosustava (odnosi) do makrosustava (sociokulturološko) i odražava međugeneracijsku dinamiku. Postojeći pokazatelji podupiru multifaktorsku etiologiju zlostavljanja starijih

elderly subjects to DV due to their dependency (financial or health-related) on caregivers. However, as a high DV rate among older adults remains undetected, which limits further referral and support (12). More than 50% of DV victims included in the study, irrespective of their age, experienced a multiple-type abuse, most commonly the combination of psychological and financial abuse. The frequency of single-types of abuse identified in the study is in line with the one reported by other authors (7,12,18,29,46), with elderly DV victims experiencing financial abuse and a combination of physical and financial abuse more often compared to younger subjects.

Regarding DV reporting to the authorities, younger subjects were significantly more inclined to report DV to a social welfare center (42% vs. 30%) or file misdemeanor charges (13% vs. 7%) than elderly DV victims. Furthermore, our study's elderly DV victims were less likely to report abuse to the authorities, such as social welfare centers or law enforcement, including courts. Elder maltreatment is a global health problem and a severe health issue that negatively reflects the quality of life, well-being, and victims' mortality. The evidence related to interventions aimed at preventing elder abuse is limited (6). Almost three-quarters of elderly DV victims did not report the experienced abuse to any competent institution. This finding emphasizes the importance of counseling centers for abuse victims to seek help and find professionals performing abuse prevention and intervention activities.

Schiamberg and Gans (47) described a model that synthesizes inter-relating factors and focuses on the aging parent and the child in various environments, ranging from the micro-system (relationship) to the macro-system (sociocultural) and reflecting intergenerational dynamics. The current evidence supports the multifactorial etiology of elder abuse involving

osoba uključujući čimbenike rizika povezane sa zlostavljanom starijom osobom, počiniteljem, tipom odnosa i okruženjem (48).

Dosad, javno-zdravstvene institucije kao i one koje pružaju socijalnu zaštitu nisu stavljale fokus na zlostavljanje starijih osoba na način na koji to čine s drugim oblicima zlostavljanja (7). Ako stopa starijih žrtava zlostavljanja ostane ista, broj žrtava ubrzano će rasti zbog problema starenja populacije (49). Samim time presudno je važno razviti i evaluirati intervencije s ciljem smanjenja stope zlostavljanja starijih osoba i njegovih posljedica.

Premda su neka istraživanja pokazala rodne razlike povezane s vrstom zlostavljanja starijih osoba (29, 43) naši rezultati ne potvrđuju te rezultate, što je u skladu s meta-analizom provedenom 2017. godine (7) i prethodnim istraživanjima provedenima u Hrvatskoj (18). Među starijim žrtvama obiteljskog nasilja kod zaposlenih je osoba bila prisutna 4,5 puta veća vjerojatnost da će doživjeti kombinaciju različitih vrsta zlostavljanja u odnosu na umirovljene žrtve. Žrtve koje prijave zlostavljanje centrima za socijalnu skrb imale su 2,5 veću vjerojatnost da će biti žrtve kombinacije različitih vrsta zlostavljanja od osoba koje nisu prijavile zlostavljanje centru za socijalnu skrb. Ovi rezultati upućuju na to da će starije žrtve nasilja u obitelji vjerojatnije prijaviti zlostavljanje ako je nasilje višestrukog tipa i ako se smatra ozbiljnijim.

Ograničenja našeg istraživanja su svojstvena dizajnu presječnih istraživanja što isključuje mogućnost kauzalnog interpretiranja. Također, potencijalna pogreška u prisjećanju i pristranost informacija bili su mogući zbog podataka koje su davali sami ispitanici. Drugo, istraživanje se fokusiralo na fizičko, psihičko, ekonomsko i seksualno zlostavljanje starijih osoba i nije obuhvatilo druge podtipove (poput zanemarivanja i zdravstvenog zlostavljanja) zlostavljanja starijih osoba. Treće, relativno mali uzorak ispitanika ograničio je broj varijabli za analizu i dublje razumijevanje društvenih okolnosti zlostavljanja starijih osoba. Nadalje, autori nisu mogli procijeniti legitimnost samoprijavljenih

risk factors related to the abused older person, perpetrator, relationship, and the environment (48).

So far, public health, and social institutions have failed to address the problem of elder abuse in the way they are addressing other forms of violence (7). If the proportion of elder abuse victims remains the same, the number of victims will rapidly increase due to the aging population (49). Therefore, it is crucial to develop and evaluate the interventions to reduce elder abuse and its consequences.

Although some studies found gender differences concerning the type of elder abuse (29, 43), our results did not confirm this finding, which is in line with a meta-analysis performed in 2017 (7) and a previous study carried out in Croatia (18). Among the elderly DV victims, the employed victims had a 4.5-fold probability of experiencing multiple-type abuse than the retired victims. Those reporting the abuse to social welfare centers had a 2.5-fold probability of being victims of multiple-type abuse than those who did not report the abuse to a social welfare center. These results imply that elderly DV victims are more likely to report abuse if DV is multiple-type and perceived as more serious.

The limitations of our study are inherent to the cross-sectional study design, which precludes causal interpretation. Also, a potential recall and information bias were possible due to participant-reported data. Second, the study focused on physical, psychological, financial, and sexual elder abuse and excluded other subtypes (such as neglect and medical abuse) of elder abuse. Third, a relatively small sample size limited the number of variables for analysis and a deeper understanding of the social circumstances of elder abuse. Furthermore, the authors could not assess the legitimacy of self-reported information in this study. Clinical data are never representative of the whole population of help-seekers.

informacija u ovom istraživanju. Klinički podatci nikad nisu reprezentativni za cijelu populaciju osoba koje traže pomoć. No, naši rezultati pružaju profil starijih žrtava obiteljskog nasilja i zlostavljanja te razlike u odnosu na mlađe žrtve u Hrvatskoj, odnosno u Zagrebu.

Prednost našeg istraživanja je ta da su istraživači koristili izravan pristup prikupljanja podataka – intervjuima vođenima izravno sa starijim žrtvama. Mnogi stručnjaci na ovom području (7,50,51) tvrde da je to najučinkovitiji način. Nadalje, ranija istraživanja predlažu odabir žrtava koje su zatražile pomoć na izravniji način (ne putem telefona ili preko oglasa na internetu) (52).

Istraživanje je pokazalo da je obiteljsko nasilje presudno važno pitanje u starijoj populaciji te da spol nije determinanta za zlostavljanje starijih osoba. Nadalje, rezultati su pokazali rasprostranjenost psihičkog zlostavljanja kada se radi o nasilju nad starijim osobama. Kombinacija psihičkog i ekonomskog zlostavljanja bila je drugi najzastupljeniji tip zlostavljanja nakon čega je slijedilo ekonomsko zlostavljanje te kombinacija fizičkog, psihičkog i ekonomskog zlostavljanja. Više od polovice žrtava obiteljskog nasilja u našem istraživanju doživjelo je dugotrajno kombinirano zlostavljanje. Starija je populacija iznimno ranjiva na obiteljsko nasilje jer ga žrtve rijetko prijavljuju, posebice ako su umirovljene i posljedično više ovisne o počiniteljima, uglavnom djeci ili drugim članovima obitelji.

Zlostavljanje starijih osoba je zanemareno područje i istraživači tek počinju razotkrivati njegovu učestalost i prirodu, a druga je područja još potrebno definirati (11). Iako stječemo sve više znanja o praktičnim pristupima prevenciji zlostavljanja starijih osoba (10) i dalje je potrebno stjecati dublje razumijevanje zlostavljanja starijih osoba te kako ga spriječiti, posebice u zemljama u razvoju (11). Općenito, višesektorna i interdisciplinarna suradnja mogu umanjiti ovaj problem, uključujući sektor socijalne skrbi, sektor obrazovanja kao i zdravstveni sektor (11) i samim time potrebna su daljnja istraživanja da bismo povećali njihovu učinkovitost.

However, our results provide a profile of elderly DV victims and elder abuse and differences compared to younger victims in Croatia, i.e., in Zagreb.

Our study's strength is that the researchers used a direct approach to collect data, i.e., through face-to-face interviews with elderly victims. Many experts in the field (7, 50, 51) claim that it is the most effective method. Furthermore, earlier studies suggested recruiting help-seekers who may have sought help in a more direct way (not over the phone or through advertisements on the Internet) (52).

The study results showed that DV is a vital issue in the elderly population and that gender does not play a determinant role in elder abuse. Furthermore, the results revealed a prevalence of psychological abuse in elder abuse. A combination of psychological and financial abuse was the second most prevalent type of abuse, followed by a single-type financial abuse and a combination of psychological, physical, and financial abuse. More than a half of DV victims included in our study experienced long-term, multiple-type abuse. The elderly are highly vulnerable to DV because they rarely report DV, especially if they are retired and consequently more dependent on the perpetrators, mostly their children or other family members.

Elderly abuse is a neglected area, and the researchers are only beginning to disclose its scope and nature, while other areas still have to be delineated (11). Although we are gaining more knowledge and insight into practical approaches to elder abuse prevention (10), there is still a lot to be learned about elder abuse and the ways to prevent it, particularly in developing countries (11). Generally, multiple sectors and interdisciplinary collaboration can reduce elder abuse, including the social welfare, education, and the healthcare sectors (11); therefore, we need further research to make it as efficient as possible.

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Holistički biopsihosocijalni pristup u postizanju oporavka osoba s dijagnozom psihoze

/ Holistic Biopsychosocial Approach in the Recovery of Persons Diagnosed with Psychosis

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Ističe se da postoji veliki broj osoba oboljelih od poremećaja s psihozom koje ne reagiraju zadovoljavajuće na liječenje antipsihoticima te da je potrebno razmotriti utjecaj psihosocijalnih stresora, a time i primjenu psihosocijalnih postupaka prema individualnom planu liječenja. Ovaj pristup nije zadovoljavajuće prisutan u psihijatrijskoj praksi što za posljedicu može imati veliki broj pacijenata koji se proglašavaju terapijski rezistentnim a da se ne primijene i procijene učinkovitosti psihosocijalnih postupaka i psihoterapije. Upravo zbog toga putem prikaza izrade biopsihosocijalne formulacije i individualnog plana liječenja pacijentice s dvije epizode psihoze željeli smo upozoriti da je potrebno pacijentu pristupiti sveobuhvatno. To znači na način sagledavanja utjecaja biopsihosocijalnih čimbenika na rizik pojave psihoze i adekvatno primijeniti biopsihosocijalne i psihoterapijske postupke. Cilj nam je pacijentima omogućili optimalno liječenje koje će dovesti do oporavka i smanjiti rizik za ponovnu pojavu psihoze. Bez biopsihosocijalnog pristupa mnogi će se naći u riziku da ostanu bez nade u oporavak, da budu proglašeni terapijski rezistentnima, loše prognoze kod kojih se više ne očekuje poboljšanje. U izradi plana liječenja koristili smo Kormilo oporavka koje se pokazalo korisnim alatom u izradi individualnog plana liječenja i evaluaciji postignutih rezultata za primjenu u psihijatrijskoj praksi.

/ *Although it has been pointed out that there is a large number of persons diagnosed with psychotic disorder who do not respond satisfactorily to treatment with antipsychotics, and that it is necessary to consider the influence of psychosocial stressors, and thus the application of psychosocial interventions according to an individual treatment plan, this approach is not satisfactorily implemented in psychiatric practice. This could result in a large number of patients who are declared therapeutically resistant without being offered psychosocial interventions and psychotherapy. For this reason, through the presentation of the creation of a biopsychosocial formulation and an individual treatment plan for a patient with two episodes of psychosis, we wanted to emphasize that it is necessary to approach the patient comprehensively by looking at the influence of biopsychosocial factors on the risk of psychosis and to adequately apply biopsychosocial and psychotherapy interventions in order to provide patients with optimal treatment that would enable recovery and reduce the risk of relapse of psychosis. Without a biopsychosocial approach, many will find themselves at risk of being left without hope of recovery and of being declared therapeutically resistant with a poor prognosis where improvement is no longer expected. In creating the treatment plan, we used the Helm of Recovery scheme, which proved to be a useful tool in creating an individual treatment plan and evaluating the results achieved for use in psychiatric practice.*

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UVOD

Oporavak je danas prihvaćen kao internacionalni standard organizacije skrbi za mentalno zdravlje i očekivani ishod liječenja Zbog toga je potrebno napraviti otklon od isključivog fokusa na simptome i dominantnog pristupa liječenju putem lijekova prema individualnom holističkom pristupu orijentiranom prema ciljevima oporavka koje određuje sam pacijent (1). Istraživanja upućuju da 30 do 40 % pacijenata s dijagnozom shizofrenije nema povoljni odgovor na lijekove (2,3) pa bi u ovoj skupini bolesnika uzroke neučinkovitost lijekova trebalo tražiti u psihosocijalnim stresorima (3,4) i rješavanju teškoća psihosocijalnim postupcima. Povećana otpornost prema stresu povezana je s oporavkom i smanjenjem samostigmatizacije (5), a i povećana efikasnost povezana je s niskom razinom samostigmatizacije (6). Snižena otpornost prema stresu povezana je s većim rizikom za psihozu, dok je povećanje razine otpornosti prema stresu povezana s manje izraženim simptomima**,** boljim funkcioniranjem i uspješnijim suočavanjem sa stresom (7,8). Iako se brojni psihosocijalni postupci kao što su dobar odnos terapeut – pacijent, trening socijalnih vještina, zapošljavanje uz podršku, rad s obitelji i drugi povezuju s poboljšanjem ishoda liječenja (9), još uvijek su zanemareni u svakodnevnoj psihijatrijskoj praksi. Zanemarivanjem utjecaja biopsihosocijalnih čimbenika i primjene psihosocijalnih postupaka mnogi oboljeli od shizofrenije i sličnih poremećaja ostaju bez nade, odustaju od liječenja i bivaju proglašeni „kroničnim“ slučajevima kod kojih se ne očekuje oporavak što također ima za posljedicu nerazvijanje usluga u zajednici koji ovi ljudi trebaju za oporavak. Stoga napore treba usmjeriti na podučavanje kompetencija psihijatara za biopsihosocijalni pristup (10–12), kako bismo pomogli velikom broju osoba koje bez ovog pristupa ostaju zarobljeni u ulozi bolesnika, odustaju od životnih ciljeva i postaju isključeni iz zajednice.

INTRODUCTION

Today, recovery is accepted as an international standard for the organization of mental health care and the expected outcome of treatment. It is thus necessary to stop focusing on symptoms exclusively and change the dominant approach to treatment with drugs by applying a holistic approach oriented towards recovery goals determined by individual patients (1). Research suggests that 30% to 40% of patients diagnosed with schizophrenia do not respond favorably to medication (2,3). Therefore, in this group of patients, the causes of drug ineffectiveness should be sought in psychosocial stressors (3,4) and the solution should be the use of psychosocial interventions. Increased resilience to stress is associated with recovery and reduced self-stigmatization (5), as well as increased treatment efficacy with a low level of self-stigmatization (6). Reduced resilience to stress is associated with a higher risk for psychosis, while increased levels of resilience to stress are associated with less pronounced symptoms, better functioning and more successful coping with stress (7,8). Although numerous psychosocial interventions, such as a good therapist-patient relationship, training in social skills, supported employment, family interventions, etc. are associated with improved treatment outcomes (9), they are still neglected in everyday psychiatric practice. By neglecting the influence of biopsychosocial factors and the application of psychosocial interventions, many patients with schizophrenia and related disorders remain hopeless, give up on treatment and are often declared “chronic” cases where recovery is not expected, and in many cases this also leads to underdeveloped community services that these individuals need in order to recover. Efforts should therefore be directed at organizing training for psychiatrists in biopsychosocial approach (10–12) so to help a large number of people who otherwise remain trapped in their role as patients, give up their life goals and become excluded from the community.

CILJ RADA

Putem prikaza izrade biopsihosocijalne formulacije i individualnog plana liječenja želimo potaknuti primjenu holističkog biopsihosocijalnog pristupa u liječenju osoba s psihozom kako bismo prevenirali nepovoljnu prognozu i potaknuli oporavak. Želimo upozoriti na brojne pacijente koji će se bez biopsihosocijalnog pristupa naći u riziku da ostanu bez nade u oporavak, da budu proglašeni terapijski rezistentnim pacijentima loše prognoze kod kojih se više ne očekuje poboljšanje.

METODE

U ovom radu opisat ćemo proces izrade biopsihosocijalne formulacije i individualnog plana liječenja na primjeru jedne pacijentice kako bi putem prikaza oglednog primjera potaknuli druge psihijatre da rutinski primjenjuju sveobuhvatni biopsihosocijalni pristup i individualni plan liječenja u svojoj praksi. Za izradu biopsihosocijalne formulacije i individualnog plana liječenja koristili smo se smjernicama psihijatrijskih društava (13) i Kormilom oporavka (14).

PRIKAZ PACIJENTICE

Kratka povijest bolesti

Marija traži pomoć zbog pojave sličnih simptoma psihoze koji su u prvoj epizodi bolesti prije dvije godine dijagnosticirani kao akutni prolazni poremećaj sličan shizofreniji (F23.2). Stanje je procijenjeno remisijom nakon višemjesečnog liječenja primjenom antipsihotika i suportivne psihoterapije u okviru koje je postigla uvid u bolest, naučila prepoznati simptome psihoze, oslobodila se straha od ponovne epizode psihoze te počela planirati pronalaženje posla. Prva epizoda nastala je u okolnostima preseljenja u drugu državu s partnerom koji joj je bio značaj-

AIMS

By developing a biopsychosocial formulation and an individual treatment plan, we aimed to encourage the application of a holistic biopsychosocial approach in the treatment of individuals with psychosis in order to prevent an unfavorable prognosis and to promote recovery. Our aim was to emphasize the fact that there are numerous patients who would end up exposed to the risk of being left without any hope of recovery, declared therapeutically resistant patients with a poor prognosis, and no longer expected to improve without the use of the biopsychosocial approach.

METHODS

In this paper, we will describe the process of developing a biopsychosocial formulation and an individual treatment plan using the example of one patient in order to encourage other psychiatrists to routinely apply a comprehensive biopsychosocial approach and an individual treatment plan in their practice. We used the guidelines of psychiatric societies (13) and the Helm of Recovery scheme (14) to create the biopsychosocial formulation and the individual treatment plan.

CASE REPORT

Brief anamnesis and medical history

Marija requested psychiatric assistance due to the appearance of symptoms of psychosis, similar to those in her first episode of psychosis two years before, when she was diagnosed with an acute transient disorder similar to schizophrenia (F23.2). Remission was achieved after several months of treatment with antipsychotics and supportive psychotherapy, during which she gained insight into the disease, learned to recognize the symptoms of psychosis, overcame the fear of a repeated episode of psychosis, and started planning to find a job. The first episode

na emocionalna podrške, međutim zbog posla joj često nije bio dostupan, što je često bilo povezano s porastom anksioznosti.

Druga epizoda psihoze koju ovdje opisujemo odvija se u sličnim okolnostima kao prva, nakon što se u želji za osamostaljenjem preselila u drugi grad i odvojila od roditelja. Ovoj epizodi je prethodio i prekid za nju značajne emocionalne veze kao i nezadovoljstvo na radnom mjestu, teškoće u komunikaciji sa suradnicima na poslu i prema nadređenoj osobi i teškoće uklapanja u sredinu u kojoj nije mogla uspostaviti odnose s drugim ljudima i osjećala se osamljeno.

Simptomi su bili slični onima u prvoj epizodi: imala je slušne halucinacije, čula je glasove koji su komentirali njeno ponašanje (omalovažavali su njeno ponašanje i donesene odluke, od najmanjih sitnica, npr. što je pojela za doručak do odluka vezanih uz posao), doživljavala je da je ljudi čudno gledaju i da joj smjeraju nešto loše napraviti. Imala je osjećaj da je cijeli njen život namješten i kontroliran, kao da nije realan, bila je sniženog raspoloženja, bezvoljna, odustala je od većine aktivnosti koje je voljela kao što je to bio odlazak u teretanu i kukičanje, dala je otkaz na poslu i javila se svojoj psihijatrici. Predloženo joj je liječenje u dnevnoj bolnici što je prihvatila. Simptomi psihoze, u koje je imala uvid, su se povukli nakon mjesec dana. Međutim, i dalje je bilo prisutno depresivno raspoloženje i ozbiljne teškoće u funkcioniranju. U odnosu na stanje nakon prve epizode kada je bila puna optimizma u ishod liječenja, sada je situacija drugačija, sumnja u svoj oporavak („ne vjerujem u oporavak, ali možda se dogodi neki pomak“), razmišlja ima li uopće ovaj život smisla, a premda nema suicidalnih misli, verbalizira doživljaj manje vrijednosti: („smatram se manje vrijednom jer imam mišljenje da se ne mogu družiti s bilo kim, nego s psihičkim bolesnicama kao što sam ja“); („ponekad se pitam vrijedi li imati takav nikakav život kao

occurred while she was moving to another country with her partner who provided significant emotional support, but was often unavailable due to work, which was often associated with an increase in the patient's anxiety level.

Here, we describe the second episode of psychosis that took place in similar circumstances as the first, after the patient moved to another city and separated from her parents because of her desire for independence. This episode was also preceded by the break-up of an important emotional relationship, as well as dissatisfaction at the workplace, difficulties in communicating with her colleagues at work and with her superior, and difficulties with fitting in an environment where she could not establish relationships with other people and therefore felt lonely.

The symptoms were similar to those of the first episode: she had auditory hallucinations, heard voices commenting on her behavior (belittling her behavior and decisions, from the smallest details, e.g. what she ate for breakfast to work-related decisions) and had thoughts about people looking at her strangely or intending to do something bad to her. She felt like her whole life was rigged and controlled, like it was surreal. Her symptoms included depressive mood and avolition, she gave up most of the activities she loved, such as going to the gym and crocheting, and she quit her job and reported to her psychiatrist. She was offered treatment in a day hospital, which she accepted. The symptoms of psychosis, which she had insight into, disappeared after a month. However, depressed mood and severe difficulties in functioning persisted. Compared to the situation after the first episode, when she had been full of optimism about the outcome of the treatment, the situation was now different, and she doubted her recovery ("I do not believe in recovery, but maybe some progress will happen"). She thought about whether her life had any meaning at all, and although she did not have suicidal thoughts, she verbalized the experience of lesser value: "I consider myself less valuable because I have the opinion that I cannot associate with anyone, except with people with mental health disorders like me";

moj“. Navodi da je inače i prije prve epizode bolesti imala sniženo samopouzdanje, međutim da se to sve više pogoršalo kada je dobila dijagnozu, a osobito sada u drugoj epizodi, jer je vjerovala da se neće ponoviti ako redovito uzima lijekove.

Funkcioniranje

Funkcioniranje se uvijek opisuje odvojeno od simptoma bolesti jer daje podatke o težini bolesti i specifičnim teškoćama pacijenta koji su moguće razvojno uvjetovani ako su bili prisutni prije pojave mentalnog poremećaja. Teškoće u funkcioniranju stoga nisu samo posljedica bolesti, ali su rizik za ponovnu pojavu epizode (9). Marija se u ovoj epizodi ponaša drugačije, postaje regresivna, ne koristi više svoje sposobnosti, odluke prepušta majci, a u aktivnostima svakodnevnog života sudjeluje tek uz njen poticaj. Ovisna je o podršci bliskih osoba i očekuje apsolutnu podršku. Zapustila je brigu o sebi tako npr. brine o svojoj higijeni, ali ne brine više o svom vanjskom izgledu, slabo se kreće, dobila je na tjelesnoj težini. S obzirom na prethodna negativna iskustva i prekide radnih odnosa zbog prezahtjevnih uvjeta rada u ne baš prijateljskoj radnoj okolini, ne usudi se više tražiti posao te iako povremeno pregledava oglase, ne javlja se na natječaje. Navodi da se posve isključila iz života zajednice, više ne odlazi u teretanu niti ima neki hobi. U stresnim situacijama zna reagirati impulzivno, ne promisliti detaljnije o odlukama koje donosi. U nedostatku podrške, osjeća se tjeskobno, nesigurno, loše i burno reagira na kritiku, izrazito koristi kao mehanizam obrane projekciju, a ovisno o razini stresa, moguće su i paranoidne interpretacije, ali i izbjegavajuća ponašanja te povlačenje do potpune izolacije. Nikad nije manifestirala agresivno ponašanje prema drugoj osobi. Potporu roditelja doživljava kao veliku podršku, međutim također i kao prepreku za svoju želju da se od njih odvoji iz straha da će se

“sometimes I wonder if it is worth having a life like mine”. She stated that she had low self-confidence even before the first episode of the disease, but that it had gotten worse when she received her diagnosis, and especially now in the second episode, because she had believed that it would not happen again if she took medication regularly.

Functioning

Functioning is always described separately from the symptoms of the disease because it provides information about the severity of the disease and specific difficulties of the patient, which may be developmentally determined if they were present before the appearance of the mental disorder. Difficulties in functioning, therefore, are not only a consequence of the disease, but represent a risk for a recurrence of the episode (9). In this episode, Marija behaved differently, became regressive, no longer used her abilities, left decisions to her mother, and participated in everyday activities only with her mother’s encouragement. She was dependent on the support of people close to her and expected absolute support. She neglected taking care of herself. For example, she took care of her hygiene, but she no longer cared about her appearance, reduced her physical activity and gained weight. Considering previous negative experiences and interruptions of working relationships due to overly-demanding working conditions in a not very friendly working environment, she did not dare to look for another job anymore, and although she occasionally looked at advertisements, she did not apply for jobs. She stated that she had completely cut herself off from community life, no longer went to the gym nor had any hobbies. In stressful situations, she sometimes reacted impulsively, without carefully considering the consequences of the decisions she made. In the absence of support, she felt anxious, insecure, reacted poorly and impulsively to criticism and used projection as a defense mechanism. Depending on the level of stress, paranoid interpretations are possible, as well as evasive behavior and withdrawal to complete isolation. She never manifested aggressive behavior towards another person. She per-

ponovno pojaviti psihoza. Navodi teškoće u stvaranju odnosa s ljudima, ne zna kako bi im prišla, a nije baš ni puno povjerljiva prema ljudima. Trenutno komunicira isključivo s roditeljima.

Razvojna anamneza

Kako bismo utvrdili utjecaj ranog razvoja kao i događaja tijekom cijelog životnog ciklusa na način na koji se ponaša, misli i osjeća, kako reagira na povredu regulacije samopoštovanja, kako se nosi s tjeskobom, kakvo je samopoštovanje i samopouzdanje i odnosi povjerenja prema drugima, ovaj put smo više pozornosti obratili razvojnoj anamnezi. Saznali smo da je u ranom razvoju, pa i sada u odrasloj dobi, odnos majke prema njoj pretjerano brižan, teško je podnosila fizičku odvojenost od majke kada bi osjećala tjeskobu. Misli da je bila favorizirano dijete u odnosu na svoju sestru, posebno zato što je sestra bila ljubomorna na nju. Sa sestrom nije imala blizak odnos. U osnovnoj i srednjoj školi bila je povučena, imala je osjećaj da se ne uklapa najbolje među vršnjake, uvijek je bila vezana za majku, kasnije i za jednog prijatelja koji joj je postao dečko. Odlazak u drugi grad zbog školovanja joj je bio težak zbog odvajanja od roditelja, ali stanje je bilo podnošljivo zbog prijatelja koji joj je bio podrška. U odrasloj dobi nije uspostavljala veze s vršnjacima, uglavnom je bila vezana za odnos s dečkom. Prema ljudima nije povjerljiva, ima dojam da nisu dobronamjerni. Pri ponovnim separacijama od roditelja nastupila je izrazita tjeskoba i pojava psihoze.

Dobrog je tjelesnog zdravlja, nešto je dobila na težini zbog nekretanja, od lijekova uzima jedino psihofarmake. U obitelji sestra je imala problema s depresijom, no nitko nije imao problema s psihozom. Nikada ranije, kao ni sada, nije imala suicidalne misli i namjere, niti je manifestirala agresivno ponašanje prema drugima.

ceived the support of her parents as great, but also as an obstacle to her desire to separate from them, in fear that psychosis would reappear. She stated that she had difficulties in forming relationships with people, did not know how to approach them, and was not very trusting of people. She currently communicates only with her parents.

Developmental anamnesis

In this case, we focused more attention on the developmental anamnesis in order to determine the impact of early development as well as of events during the patient's entire life on the way the patient behaves, thinks and feels, how she reacts to a violation of self-esteem regulation, how she deals with anxiety, and to evaluate her self-esteem, self-confidence and trust in relationships with others. We learned that in her early development, and even now in adulthood, her mother's attitude towards her was excessively caring, and the patient could hardly bear physical separation from her mother when she felt anxious. She thought she was the favored child compared to her sister, especially because her sister was jealous of her. She did not have a close relationship with her sister. In primary and secondary school, she was withdrawn and had the feeling that she did not fit in well with her peers, being always attached to her mother, and later to a friend who became her romantic partner. Moving to another city for education was difficult for her because of the separation from her parents, but the situation was bearable because of a friend who supported her. In adulthood, she did not establish relationships with her peers and was mostly tied to the relationship with her partner. She was not trusting towards people and had the impression that they were not benevolent. During the repeated separations from her parents, she was very anxious and subsequently developed psychosis. She was in good physical health, but she gained some weight due to reduced physical activity. Her only medication has been her psychopharmacotherapy. In her family, her sister had problems with depression, but no one had problems with psychosis. She never had suicidal thoughts and intentions before, nor has she ever shown aggressive behavior towards others.

Biopsihosocijalna formulacija s psihodinamskom formulacijom

Marija u dobi od 26 godina, nezaposlena administratorica s dvije psihotične epizode primljena je u dnevnu bolnicu zbog niza teškoća nakon prestanka simptoma akutne faze u drugoj epizodi bolesti kao što su: sniženo raspoloženje, gubitak nade u oporavak, gubitak smisla života, nisko samopouzdanje sa samo-stigmatizacijom te ozbiljnim teškoćama funkcioniranja koje uključuju teškoće brige o sebi, u donošenju odluka i socijalnu izolaciju. Druga epizoda bolesti nastala je u okolnostima kumulativnog stresa odvajanja od obitelji i prekida emocionalno značajne veze kod osobe osjetljive na separaciju i okolnostima stresa na radnom mjestu kod osobe s teškoćama u komunikaciji i pretjerano opreznoj u kontaktu s drugim ljudima. Vulnerabilnost temeljnog doživljaja sebe kao manje vrijednog i slabosti ega putem teškoća upravljanja tjeskobom i korištenja nezrelijih obrana i mehanizama sučeljavanja u situacijama povezane su s teškoćama iz simbiotske faze. Ozbiljne teškoće u upravljanju visokim razinama anksioznosti koje se javljaju u situacijama separacije postaju prijetnja raspadu kohezije temeljnog doživljaja sebe i psihološki su rizik za pojavu psihotičnih simptoma kao nefunkcionalnog mehanizma obrane od raspada temeljnog doživljaja sebe i objektnog svijeta pod cijenu testiranja stvarnosti. U situacijama stresa često burno reagira, koristi nezrele obrane, projekciju, idealizaciju drugih, devaluaciju sebe, regresiju, motoričko neverbalno izražavanje unutrašnje napetosti (*acting out*) i projektivnu identifikaciju s pojavom ideja odnosa. Druge ljude s kojima je u bliskom odnosu na nesvjesnoj razini doživljava kao dijelove temeljnog doživljaja sebe bez kojih ne može funkcionirati jer su joj potrebni za umirenje tjeskobe, što je očigledno u njenim teškoćama separacije od značajnih objekata, roditelja i dečka koji služe kao umirujući objekti. Negativnog je doživljaja vlastitog iden-

Biopsychosocial and psychodynamic formulation

Marija, aged 26, an unemployed administrator with two psychotic episodes, was admitted to a day hospital due to a series of difficulties after the remission of the acute phase symptoms of her second episode of the disease. Her current symptoms include depressive mood, loss of hope of recovery, loss of meaning in life, low self-esteem with self-stigmatization and serious difficulties in functioning, e.g. difficulties in self-care, decision-making and social isolation. The second episode of the disease happened in circumstances of cumulative stress due to separation from the family and the break-up of an emotionally significant relationship in a person sensitive to separation. Also, she experienced stress at the workplace, which was significant for a person with communication difficulties and overly cautious in contact with other people. The vulnerability of the fundamental experience of oneself as less valuable and the weakness of the ego through difficulties in managing anxiety and using more immature defenses and coping mechanisms in situations are associated with difficulties from the symbiotic phase. Serious difficulties in managing high levels of anxiety that occur in situations of separation become a threat to the disintegration of the cohesion of the self and represent a psychological risk for the appearance of psychotic symptoms as a dysfunctional defense mechanism against the disintegration of the self and the object world at the cost of reality testing. In stressful situations, she often reacted impulsively, used immature defense mechanisms, projection, idealization of others, self-devaluation, regression, acting out and projective identification with the appearance of delusions of reference. She perceived other people with whom she was in a close relationship on an unconscious level as parts of the self, without which she could not function because she needed them to calm her anxiety, which is evident in her difficulties in separation from significant objects, her parents and her partner, who served as calming objects. She had a negative experience of her own identity, especially after being diag-

titeta, osobito nakon postavljanja dijagnoze mentalnog poremećaja, ne vidi mogućnost kako bi se mogla vratiti među vršnjake, naći i zadržati posao, teško joj je zamisliti odvajanje od roditelja jer misli da bi to rezultiralo novom epizodom bolesti. Na razini *ego* funkcioniranja teže procjenjuje svoje sposobnosti, ambivalentna je u određivanju ciljeva, međutim uspijeva jedno vrijeme funkcionirati na radnom mjestu dok se ne pojave neke stresne okolnosti, stoga pokazuje dobre resurse koji bi se mogli ojačati putem različitih psihosocijalnih postupaka. Ima uvid u svoje teškoće komunikacije s drugim ljudima, ali vjeruje da bi se uz pomoć to moglo promijeniti. Postoji biološka predispozicija za depresiju, dobro reagira na lijekove koji uspješno otklanjanju pozitivne simptome, dok je za druge teškoće potrebno koristiti psihosocijalne postupke. Postoji opasnost da se problemi ove osobe dijagnosticiraju kao negativni simptomi bolesti, ako se ne bi razmotrili na holistički način i kada joj ne bi bili dostupni psihosocijalni postupci koji joj mogu pomoći da se oporavi.

Individualni plan liječenja

Biopsihosocijalna formulacija, a osobito psihodinamska formulacija su nam pomogle da razumijemo da bi za prevenciju pojave ponovne epizode bilo važno raditi na ciljevima koji osnažuju *ego* i temeljni doživljaj sebe kao što su bolja kontrola i upravljanje tjeskobom, korištenje zrelijih mehanizama obrane, poboljšanje mentalizacije, povećanje vještina za samostalni život i rad, povećanje samopoštovanja i samopouzdanja i prevencija samostigmatizacije koja dodatno smanjuje već od ranije narušeno samopouzdanje. Također, bilo bi korisno povećati kapacitet pacijentice za odvajanje od emocionalno značajnih objekata u smislu postizanja konstantnosti objekta fokusiranim treningom socijalnih vještina usmjerenim na povećavanje samopouzdanja, treningom asertivnosti i komunikacijskih vještina, treningom upravljanja

nosed with a mental disorder. She did not see the possibility of being able to return to her peers and to find and keep a job. Also, it was difficult for her to imagine being separated from her parents because she thought that this would result in a new episode of illness. At the level of ego functioning, she had difficulties with assessing her abilities and was ambivalent in setting goals. However, she managed to function at a workplace for a while, until some stressful circumstances manifested, thus demonstrating the presence of good resources that could be strengthened through various psychosocial interventions. She had insight into her difficulties in communicating with other people, but she believed that this could change with help. There was a biological predisposition to depression, and she responded well to drugs that successfully treated positive symptoms, while for other difficulties it was necessary to use psychosocial interventions. There was a danger that her problems would be diagnosed as negative symptoms of the disease, if they were not considered holistically and when psychosocial interventions would not be available to help her to recover.

Individual treatment plan

The biopsychosocial formulation, and especially the psychodynamic formulation, helped us to understand that, and in order to prevent the occurrence of a new episode, it was important to work on goals that would strengthen the ego and the self, such as better control and management of anxiety, use of more mature defense mechanisms, improvement of mentalization, increase of skills for independent living and work, increase of self-esteem and self-confidence and prevention of self-stigmatization, which further reduce the already damaged self-confidence. Also, it was useful to increase the patient's capacity for separation from emotionally significant objects in terms of achieving object constancy through focused social skills training aimed at increasing self-confidence, assertiveness and communication skills training, anxiety management training and work on stigmatization. It was also useful to work with the family, especially the mother, in terms of encour-

tjeskobom i rada na stigmatizaciji. Koristan bi bio i rad s obitelji, osobito s majkom, u smislu poticanja postupnog odvajanja kako bi se smanjili psihološki rizici za nastanak ponovne epizode. Kod ove pacijentice bila bi indicirana suportivna psihodinamska psihoterapija i/ili empatičan pristup terapeuta koji putem svoje umirujuće terapijske funkcije potiče internalizaciju kapaciteta za bolje ovladavanje tjeskobom. Pacijentica ima uvid u simptome bolesti, dobro reagira i prihvaća liječenje lijekovima, ali uzimanje antipsihotika nije dovoljna zaštita u situacijama brojnih psiholoških rizika, stoga bi u planu liječenja trebalo planirati smanjenje psiholoških rizika.

Kako biopsihosocijalnu formulaciju objasniti pacijentici

Uspostavljanje terapijskog saveza je zajednički dogovor između pacijenta i psihijatra. Stoga je važno biopsihosocijalnu formulaciju iznijeti pacijentici na jednostavan način uz obrazloženje čimbenika rizika i mogućnosti njihovog otklanjanja kao i predlaganjem mogućih dostupnih metoda liječenja. S obzirom na demoralizaciju nakon druge epizode bolesti, ovoj je pacijentici važno pojasniti da put oporavka nikada nije pravocrtan i da se od mogućih pogoršanja može puno naučiti za daljnju prevenciju. Na primjer, kako je razvoj njene druge epizode pokazao povezanost sa stresorima s kojima se teško nosi, poboljšanje otpornosti prema stresu moglo bi biti značajno u prevenciji ponovne epizode.

Kormilo oporavka u izradi individualnog plana liječenja

Planovi liječenja u akutnoj fazi i fazi stabilizacije se razlikuju. Nakon izlaska iz akutne faze prestankom psihotičnih simptoma koristili smo shemu kormila kako bi Mariji protumačili što sve utječe na mentalno zdravlje i oporavak i kako bi zajedno dogovorili plan liječenja. Pitali smo ju što bi za nju značio oporavak, a dobili

aging a gradual separation in order to reduce the psychological risks of a relapse. Supportive psychodynamic psychotherapy and/or an empathetic approach of a therapist who, through its calming therapeutic function, encourages the internalization of capacities for better anxiety management would be indicated in this patient. The patient had insight into the symptoms of the disease, responded well and accepted drug treatment; however, taking antipsychotics was not sufficient protection in situations of numerous psychological risks, and therefore the reduction of psychological risks should be included in the treatment plan.

How to explain biopsychosocial formulation to the patient

The establishment of a therapeutic alliance represents a mutual agreement between the patient and the psychiatrist, and it is therefore important to present the biopsychosocial formulation to the patient in a simple way by at the same time explaining the risk factors and the possibility of their elimination, as well as by proposing the available treatment methods for recovery. Considering the demoralization after the second episode of the disease, it was important to explain to the patient that the road to recovery is never a straight line and that much can be learned from setbacks regarding further prevention. For example, as the development of the patient's second episode showed an association with stressors that were difficult to cope with, improving resilience to stress could be significant in preventing a new episode.

The Helm of Recovery scheme in the development of an individual treatment plan

Treatment plans in the acute phase and in the stabilization phase were different. After coming out of the acute phase and the remission of psychotic symptoms, we used the Helm of Recovery scheme to explain to Marija what affected mental health and recovery, and to agree on a treatment plan together. We asked her what recovery would mean for her, and we got the answer that she

odgovor da želi spriječiti ponovnu epizodu bolesti i da se želi ponovno zaposliti.

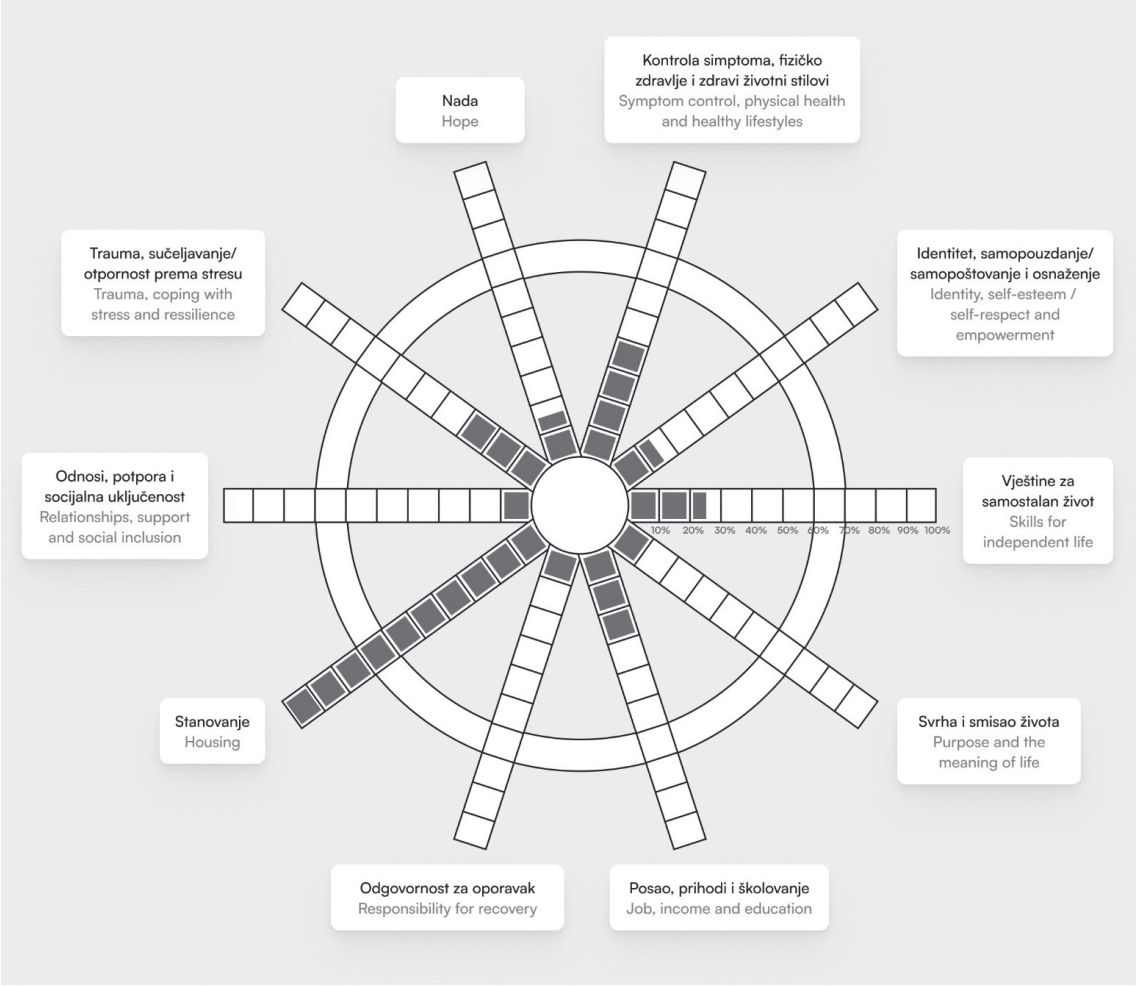
U prvoj točki procjene dobili smo sljedeće stanje i ciljeve prikazano na slici 1 (sl. 1):

Nada: pacijentica vjeruje da se teško može oporaviti, međutim ostavlja tračak nade da bi se to ipak moglo dogoditi. Ostavlja dojam da će se to dogoditi nekako spontano, gotovo „slučajno", bez uvažavanja vlastitih kapaciteta i snaga. Bez nade nema oporavka ni sudjelovanja pacijenta u procesu oporavka, stoga je obnavljanje nade bio naš prioritet. Ukazali smo na njene kapacitete da se oporavi kao i da iz iskustva druge epizode može puno toga naučiti, jer oporavak nije pravocrtna linija. Također smo joj putem video prikaza ukazali na iskustva drugih osoba s psihozom koji su se oporavili i nakon višekratnih

wanted to prevent a new episode of the disease and that she wanted to get a job again.

At the first assessment point, we obtained the following state and goals shown in Figure 1 (Figure 1):

Hope: Although the patient believed that it was difficult to achieve recovery, she retained a glimmer of hope that this could still happen. She gave the impression that it would somehow happen spontaneously, almost "accidentally", without considering her own capacities and strengths. Without hope there is no recovery, and the patient cannot participate in the recovery process, so restoring hope was our priority. We pointed out her capacities to recover, as well as that she could learn a lot from the experience of the second episode because recovery is not a straight line. Through video presentations, we



SLIKA 1. Kormilo oporavka – početna procjena.
FIGURE 1. The Recovery Helm – baseline assessment.

epizoda i hospitalizacija (https://www.youtube.com/watch?v=AUjDXHOXFm8). Predložen joj je razgovor sa skupinom oporavljenih vršnjaka i uključivanje u *online* podršku vršnjaka.

Svrha, smisao života i motivacija za promjenu: Marija smatra da je njezin život upropašten i da je upitno ima li smisla išta poduzimati i planirati kada je bolesna. Odmah smo intervenirali i podsjetili ju da je prije ove epizode njen smisao života bio pronalaženje posla, uživanje u nekim hobijima, ali i u druženju s manjom grupom poznanika i prijatelja te da joj tijekom liječenja možemo pomoći da bolje razradi ciljeve (kratkoročni, dugoročni).

Odgovornost za oporavak: Marija aktualno ne vidi svoju aktivnost za postizanje oporavka jer sumnja da je to moguće, pa je svu odgovornost delegirala na svoju majku. Istakli smo da vjerujemo da ona može obnoviti svoje snage i preuzeti upravljanje svojim životom kao što je to ranije činila, sada osnažena nekim novim vještinama koje je stekla tijekom liječenja pa očekujemo da će biti uspješnija.

Kontrola simptoma, tjelesnog zdravlja i zdravi stilovi života: rekla nam je da joj lijekovi dobro pomažu kada se pojave simptomi psihoze, međutim ne pomažu joj da poveća samopouzdanje, odvoji se od roditelja i da se bolje nosi sa stresom. Predložili smo joj trening vještina za povećanje samopouzdanja i stres menadžment za bolje nošenje sa stresnim situacijama. Istaknuli smo da bi njen raniji interes za kreativan rad također mogao pomoći pa smo predložili da možda proširi svoje interese i pokuša s kreativnim aktivnostima kao što je slikanje u našoj radionici radne terapije. Također smo sugerirali da bi bilo dobro obnoviti njen interes za zdravi stil života tj., za zdravu prehranu i fizičku aktivnost.

Identitet, samopouzdanje, samopoštovanje i osnaživanje: Marija nam je rekla da je njeno povjerenje u sebe i svoje vrijednosti poljuljano, da dijagnoza psihoze za nju znači sram i strah da će je ljudi izbjegavati**.** Objasnili smo joj da se to

also showed her the experiences of other people with psychosis who recovered even after multiple episodes and hospitalizations (https://www.youtube.com/watch?v=AUjDXHOXFm8). She was offered a conversation with a group of peer workers and involvement in online peer support.

Purpose, meaning of life and motivation to change: Marija believed that her life was ruined and that it was doubtful whether it made sense to do or plan anything when she was sick. We immediately intervened and reminded her that before this episode, her meaning in life was finding a job, enjoying some hobbies, but also socializing with a small group of acquaintances and friends, and that during treatment we could help her to better develop her goals (short-term and long-term).

Responsibility for recovery: At the time, Marija was not aware of her ability to achieve recovery because she doubted that it was possible, so she delegated all responsibility to her mother. We pointed out that we believed she could regain her strengths and take control of her life as she did before, now empowered with some new skills she had acquired during treatment, so we expected her to be more successful.

Symptom control, physical health and healthy lifestyle: She told us that the medication helped her when symptoms of psychosis appeared, but that they did not help her increase her self-confidence to separate from her parents and to better cope with stress. We suggested training skills to increase self-confidence and stress management to better deal with stressful situations. We pointed out that her earlier interest in creative work might also help, so we suggested that she should perhaps broaden her interests and try creative activities such as painting in our occupational therapy workshop. We also suggested that it would be good to renew her interest in a healthy lifestyle, namely in healthy nutrition and physical activity.

Identity, self-esteem, self-respect, empowerment: Marija told us that her confidence in herself and her values was shaken, and that the diagnosis of psychosis meant shame and fear that people would avoid her. We explained to her that this happened to many people who were diagnosed with a mental

pojavljuje kod mnogih koji imaju neku od dijagnoza mentalnog poremećaja, ali ne kod svih i da je važno usvojiti stavove da osoba nije manje vrijedna zato što ima dijagnozu, dapače, da može biti ponosna da se unatroč dosta teškoća dobro nosila sa životnim izazovima, osim kada se nađe u situaciji stresa. Predložili smo da se priključi grupi u kojoj se prorađuju postupci sprječavanja samostigmatizacije, kao i da pogleda prezentaciju vezanu za prevenciju samostigmatizacije (https://www.youtube.com/watch?v=z33gT_jC-n0). Ovdje nam je cilj pomoći Mariji u izgradnji pozitivnog identiteta putem obnove samopouzdanja i vještina koje potiču samopouzdanje, otkloniti samostigmatizaciju te putem kontinuirane individualne suportivne psihodinamske psihoterapije stabilizirati temeljni doživljaj sebe i ojačati *ego*.

Odnosi, podrška i socijalno uključivanje: Marija procjenjuje da je posve izolirana, međutim svjesna je da izolacija loše utječe na mentalno zdravlje, željela bi se uključiti u društvo, ali ne zna kako. Ponudili smo joj pomoć u izradi plana uključivanja u društvo uz pomoć volontera ili vršnjačkog pomagača (*peer worker*) kako bi joj pomogli da se uključi u hobije i aktivnosti koje želi. Predložili smo joj mogućnost individualnog rada s obitelji kako bi joj pomogli da se odvoji na zdrav način, što je za sada otklonila, jer se još uvijek boji da bi odvajanje opet dovelo do psihoze. Majka je uključena u grupnu terapiju roditelja koja je više orijentirana na edukaciju o bolesti, a manje na trening komunikacije pa treba razmotriti mogućnost uključivanja majke u grupu koja radi i na promjeni komunikacije.

Vještine za samostalni život: Marija procjenjuje da su njene vještine za samostalni život niske jer se nije uspjela osamostaliti, tj. odvojiti od roditelja, što ne može opstati na poslu jer su joj radni zadatci teški, loše komunicira s ljudima i loše se nosi s bilo koji stresom. Ipak, priznaje da neke aktivnosti može obaviti sama, iako je sklona prepustiti ih drugima. Rekli smo joj da

disorder, but not to all, and that it was important to adopt the attitude that a person was not less valuable because of a diagnosis. On the contrary, she could be proud that she had coped well despite many difficulties with life's challenges, except when she found herself in a stressful situation. We suggested joining a group where self-stigmatization prevention interventions are addressed, as well as to watch a presentation related to self-stigmatization prevention (https://www.youtube.com/watch?v=z33gT_jC-n0). Here, our goal was to help Marija build a positive identity through the restoration of self-confidence and skills that promote self-confidence, remove self-stigmatization, as well as through continuous individual supportive psychodynamic psychotherapy, stabilizing the basic experience of the self and strengthening the ego.

Relationships, support and social inclusion: Marija estimated that she was completely isolated, however, she was aware that isolation has a bad effect on mental health and that she would like to join the community, but she did not know how. We offered her help in creating a social inclusion plan with the help of a volunteer or a peer worker to help her get involved in the hobbies and activities she wanted. We suggested to her the possibility of individual work with the family to help her separate in a healthy way, which she has ruled out for the time being, because she was still afraid that the separation would lead to another psychosis. The mother was included in the group therapy for the parents, which was more oriented towards psychoeducation and less towards communication training, so the possibility of including the mother in the group, which also worked on changing communication, should be considered.

Skills for independent life: Marija estimated that her skills for independent life were low because she did not manage to become independent, i.e. separate from her parents, which meant that she could not survive at work because her work tasks were difficult, she did not communicate well and did not cope well with any kind of stress. However, she admitted that she was capable of doing some activities by herself, although she tended to leave them to others. We told her that she had a lot of strengths and that her skills could

ona ima puno snaga i da bi se njene vještine mogle povećati putem učenja različitih vještina koje bi nakon toga trebala primjenjivati u praksi. Preporučili smo joj učenje sljedećih vještina: vještine rješavanja problema, konflikta, vještine komunikacije, vještine postupanja s ljutnjom i vještine nošenja sa stresom. U tome joj može pomoći radni terapeut, socijalni pedagog, vršnjak ili koordinator liječenja (*case manager*), ako će biti potrebno.

Posao, financije, obrazovanje: Marija je izjavila da se želi zaposliti, ali da ima dojam da bira teške poslove koji nisu za nju. Nezadovoljna je aktualnom pozicijom i nezaposlenošću, kao i mogućnostima zaposlenja koje se nude u njenoj okolini, a s obzirom na njenu edukaciju. Razmišlja o različitim tečajevima koje bi mogla upisati i tako pronaći neko prikladnije radno mjesto. Teško joj je odabrati novu edukaciju zbog straha da će pogriješiti. Financijski je ovisna o roditeljima, što joj dodatno pojačava nezadovoljstvo. Unatoč svemu, motivirana je za promjenu kao i za pronalazak posla. Predložili smo da joj naš radni terapeut ili socijalni pedagog mogu pomoći u razradi ciljeva i donošenju odluke što zaista želi upisati.

Stanovanje: Trenutno je zadovoljna sa stanovanjem kod roditelja i za sada ne misli na preseljenje.

Utjecaj traume/ stresa i otpornost na stres: Uz ranije opisane stresne situacije (npr. na poslu), navodi da je dijagnoza mentalnog poremećaja za nju stres. Mišljenja je da se generalno slabo nosi sa stresnim situacijama. Preporučili smo individualnu proradu razgovora o reakciji na dijagnozu, kao i antistigma modul u grupi.

Tijek procesa liječenja ili kako se ciljevi ostvaruju

Prva značajna promjena (a koja je ujedno bila poticaj i za ostale) je vraćanje nade u mogući oporavak. Mariji su pomogli sadržaji vezani uz prikaze oporavljenih pacijenata, ali i aktivnije

be increased by learning different skills that she should then put into practice. We recommended her to learn the following skills: problem solving skills, conflict skills, communication skills, anger management skills and stress management skills. An occupational therapist, social pedagogue, peer worker or case manager could help her in this, if necessary.

Job, income, education: Marija stated that she wanted to get a job, but she had the impression that she had been choosing difficult jobs that were not for her. She was unsatisfied with her current position and unemployment, as well as with the employment opportunities offered in her area, given her education. She was thinking about different courses she could enroll in and thus find a more suitable job. It was difficult for her to choose a new education for fear of making a mistake. She was financially dependent on her parents, which further increased her dissatisfaction. Despite everything, she was motivated to change as well as to find a job. We suggested that our occupational therapist or social pedagogue could help her develop her goals and decide what she really wanted to enroll in.

Housing: She was currently happy with living with her parents and was not thinking of moving for the time being.

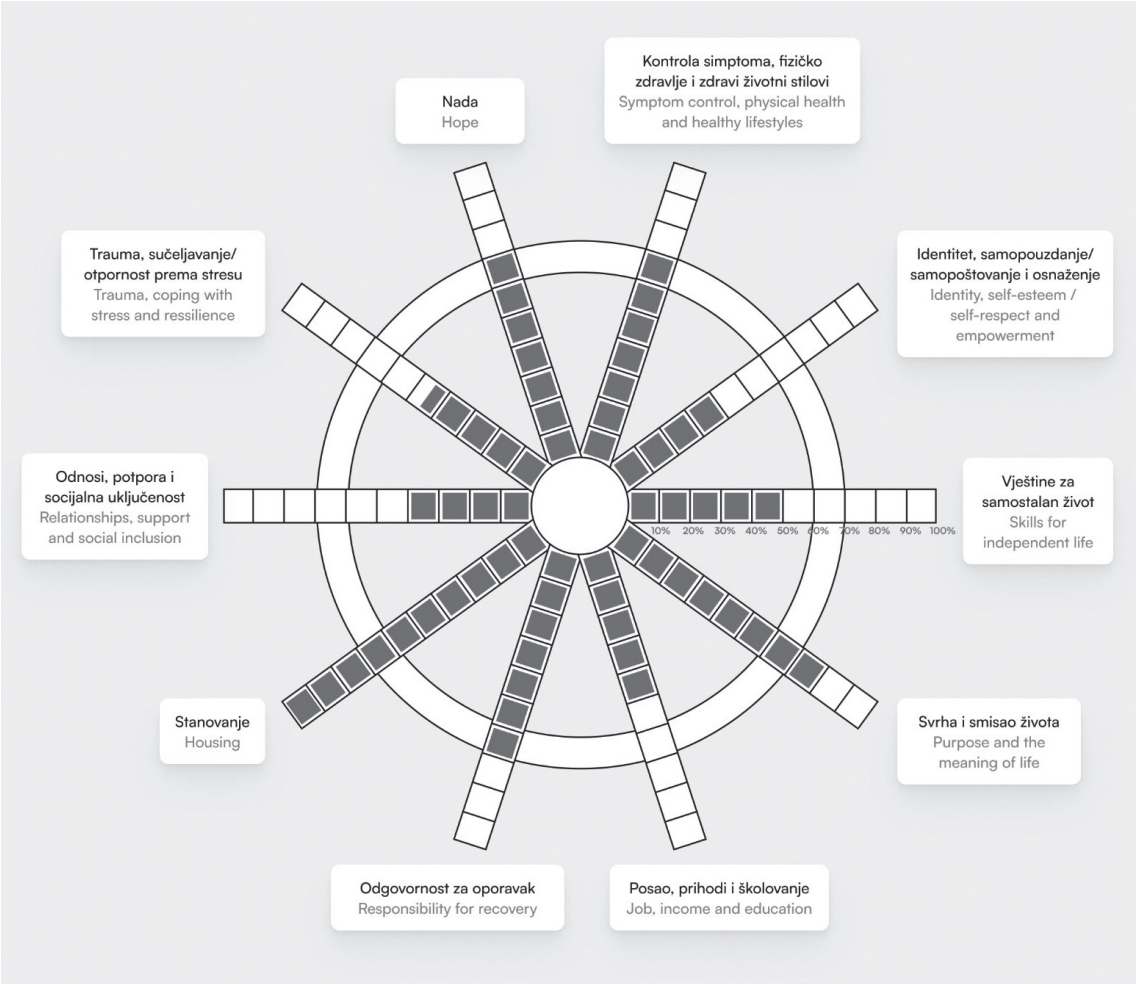
Trauma, coping with stress and resilience: In addition to the previously described stressful situations (e.g. at work), the patient stated that the diagnosis of a mental disorder was stress-inducing for her. She thought that she generally coped poorly with stressful situations. We recommended individual processing of the conversation about the reaction to the diagnosis, as well as the antistigma module in the group.

The course of the treatment process or how the goals were achieved

The first significant change (which was also an incentive for the others) was the restoration of hope of a possible recovery. Content related to the presentations of recovered patients, more active involvement in groups at the day hospital and learn-

uključivanje u grupe u dnevnoj bolnici i saznavanje informacija o teškoćama s kojima se nose drugi i kako ih nastoje prevladati. Dodatno se radilo i na edukaciji o bolesti, ne samo u smislu prepoznavanja simptoma, već i na individualnim putevima oporavka. Objašnjeno je da lijekovi nisu jedina metoda liječenja te da se i unatoč njima, a bez „krivnje" pacijenta, epizoda psihoze može ponoviti što ne treba doživjeti kao katastrofu nego kao iskustvo iz kojeg se može nešto novo naučiti. Rekli smo joj i da se poboljšanjem boljeg nošenja sa stresom i tjeskobom, kao i boljim komunikacijskim vještinama, taj rizik može smanjiti. Na ovaj se način, vraćanjem nade, ali i poticanjem dodatnih vještina i osvještavanjem postojećih, dogodio i pomak u preuzimanju odgovornosti za vlastiti oporavak, nalaženju svrhe i smisla u životu te okretanju ne samo na kontrolu pozitivnih simptoma, već i na fizičku aktivnost i okretanju zdravijim stilovima života. Iako se i dalje kontinuirano radi na osnaživanju i stvaranju pozitivnijeg identiteta, samopouzdanje je i dalje nisko. Ovo se posebno odnosi na ostvarivanje novih socijalnih kontakata, iako otvorenije pristupa drugim članovima grupe i više komunicira s kontaktima koje ima posredno putem obitelji. Trenutno usvaja nove vještine naučene u treningu socijalnih vještina, bolje komunicira s roditeljima i uspije iznijeti vlastito mišljenje bez konfliktnih situacija i *acting outa*, iako i dalje nije motivirana za opciju obiteljske psihoterapije. Samostalnija je u donošenju odluka, počela je s hobijima, sama istražuje opcije volontiranja i suzila je izbor mogućnosti za edukaciju koja bi joj pomogla u pronalaženju posla. Stava je da se bolje može nositi sa stresom, iako je i dalje sklona izbjegavati zahtjevnije situacije. Dogovoren je otpust iz dnevne bolnice i nastavak liječenja ambulantno s istim planom nastavka psihosocijalnih postupaka i suportivne psihodinamske psihoterapije. Stanje kod otpusta iz dnevne bolnice procijenjeno je na kormilu (sl. 2). Kako bismo pratili stanje oporavka i po

ing information about the difficulties that others were dealing with and how they tried to overcome them helped her with this. Additionally, we were working on psychoeducation, not only in terms of recognizing symptoms, but also on individual recovery paths. It was explained that medications were not the only method of treatment and that despite them, and without the "fault" of the patient, an episode of psychosis could happen again, which should not be experienced as a disaster but as an experience from which something new could be learned. We also told the patient that by improving coping with stress and anxiety, as well as by obtaining better communication skills, that risk could be significantly reduced. In this way, by restoring hope, but also by encouraging additional skills and raising awareness of the existing ones, a shift occurred in taking responsibility for her own recovery, finding purpose and meaning in life, and turning not only to controlling positive symptoms, but also to physical activity and a healthier lifestyle. Although continuous efforts were being made to strengthen and create a more positive identity, her self-confidence was still low. This especially applied to forming new social contacts, although the patient approached other members of the group more openly and communicated more with the contacts she had indirectly through the family. She is currently adopting new skills learned in social skills training, communicating better with her parents and managing to express her own opinion without conflict situations and acting out, although she is still not motivated to attend family psychotherapy. The patient has become more independent in her decision-making, has started hobbies, is researching volunteering options on her own, and has narrowed down the options for education that would help her find a job. Her attitude is that she can handle stress better, although she still tends to avoid more demanding situations. Discharge from the day hospital and continuation of outpatient treatment with the same plan of continuation of psychosocial interventions and supportive psychodynamic psychotherapy was agreed upon. The patient's condition at discharge from the day hospital was assessed at formation of the Helm of Recovery scheme (Figure 2). In order to monitor the state



SLIKA 2. Kormilo oporavka – procjena nakon završetka programa.
FIGURE 2. The Recovery Helm – final assessment.

potrebi revidirali plan liječenja, u planu je ponovna procjena nakon 3 mjeseca.

RASPRAVA

Biopsihosocijalni pristup razumijevanju nastanka mentalnih poremećaja, individualni plan liječenja i poticanje oporavka je standard postupanja u psihijatriji (10,11). U izradi plana liječenja psihijatru su korisni alati koji mu pomažu da izradi kvalitetan plan liječenja. Stoga smo željeli testirati upotrebljivost kormila kao alata za izradu individualnog plana liječenja i evaluacije plana liječenja.

Kormilo oporavka se pokazalo korisnim alatom u izradi individualnog plana liječenja kako su to

of recovery and, if necessary, revise the treatment plan, we planned to re-evaluate after 3 months.

DISCUSSION

The biopsychosocial approach to understanding the origin of mental disorders, an individual treatment plan and encouraging recovery is the standard of practice in psychiatry (10,11). In creating a treatment plan, psychiatrists need useful tools that help to create a high-quality treatment plan, and we therefore wanted to test the usability of the Helm of Recovery scheme as a tool for creating an individual treatment plan and its evaluation.

The Helm of Recovery scheme has proven to be a useful tool in creating an individualized treatment plan as suggested by its authors (14). Restoring

sugerirali njegovi autori (14). Obnavljanje nade, smisla života i poticanje odgovornosti pokazalo se ključnim za poticanje procesa oporavka ove pacijentice, kao što se također navodi u istraživanjima drugih autora (15). Iz rada s ovom pacijenticom želimo naglasiti da je gubitak nade u oporavak povezan s demoralizacijom i odustajanjem od oporavka što se očituje u pojavi depresivnih simptoma i niskog samopoštovanja, stoga je važno ne zamijeniti ove simptome s negativnim simptomima shizofrenije uz zanemarivanje primjene psihosocijalnih postupaka. Prva intervencija kod osoba koje su izgubile nadu u oporavak mora biti obnavljanje nade što se kod ove pacijentice pokazalo učinkovitom intervencijom. Kormilo oporavka nam je također pomoglo da identificiramo da su otpornost na stres, teškoće u odnosima i socijalne vještine ključne za oporavak ove pacijentice i prevenciju recidiva bolesti što je bio jedan od njenih glavnih ciljeva. Od velike koristi u radu s ovom pacijenticom su nam bili psihodinamski koncepti i psihodinamska formulacija (PF) kojima posvećujemo veliki dio ove rasprave. U izradi plana liječenja za ovu pacijenticu potvrdili smo iskustva drugih autora o koristi PF za razumijevanje psihološke dimenzije teškoća koje su povezane s načinom na koji se osoba ponaša, osjeća i misli kod svih osoba neovisno o dijagnozi (16,17), pa tako i u izradi plana liječenja za osobe s psihozom (18–20). PF također pomaže predvidjeti kako bi se osoba mogla ponašati u budućnosti i kako bi mogla reagirati na neželjene događaje i metode liječenja (16). U radu s ovom pacijenticom PF nam je bila korisna u određivanju ciljeva liječenja, prevenciji ponovne epizode bolesti i u evaluaciji postignutog. PF nam je pomogla da razumijemo da su glavni ciljevi za prevenciju recidiva kod ove pacijentice u jačanju ega i stabilizaciji temeljnog doživljaja sebe planiranjem postupaka koji jačaju *ego* i temeljni doživljaj sebe kao što su trening vještina, povećanje otpornosti na stres i suportivna psihodinamska psihoterapija u kojoj empatijska funkcija terapeuta ima važan utjecaj na stabilizaciju psihološke strukture.

hope, meaning of life and encouraging responsibility proved to be crucial for encouraging the recovery process of our patient, as was also reported by other authors (15). From our work with this patient, we would like to emphasize that the loss of hope for recovery was associated with demoralization and giving up on recovery, which manifested in the appearance of depressive symptoms and low self-esteem. Therefore, it is important not to confuse these symptoms with negative symptoms of schizophrenia while neglecting the application of psychosocial interventions. The first intervention for individuals who have lost hope of recovery must be the restoration of hope, which proved to be an effective intervention for this patient. The Helm of Recovery scheme also helped us identify that resilience to stress, relationship difficulties, and social skills were key to our patient's recovery and relapse prevention, which was one of her main goals. Psychodynamic concepts and psychodynamic formulation (PF), to which we devoted a large part of this discussion, were very useful in working with the patient. In creating a treatment plan for the patient, we confirmed the experiences of other authors about the usefulness of PF for better understanding of the psychological dimension of difficulties that are related to the way a person behaves, feels and thinks in all people, regardless of diagnosis (16,17), and also in creating a treatment plan for people with psychosis (18–20). PF also helps predict how a person might behave in the future and how they might react to adverse events and treatment methods (16). During our work with the patient, PF was useful in determining treatment goals, preventing a recurrence of the disease and in evaluating the achievements. PF helped us understand that the main goals for relapse prevention in the patient were to strengthen the ego and to stabilize the core experience of the self through planning interventions that strengthen the ego and core experience of the self, such as training in skills, increasing resilience to stress and supportive psychodynamic psychotherapy, where the therapist's empathic function had an important influence on the stabilization of the psychological structure.

PF za osobe s psihozom također pomaže u pronalaženju povezanosti između simptoma psihoze i pacijentovog iskustva, primjeni psihoterapijskog pristupa u razgovoru o reakciji na dijagnozu koji smanjuje rizik za razvoj samostigmatizacije i depresije (21,22). Ovi koncepti su nam bili korisni u povezivanju slušnih halucinacija s njenim doživljajem sebe kao manje vrijedne osobe, što smo i objasnili pacijentici čime smo pomogli da iskustvo psihoze bude na neki način manje zastrašujuće. Također smo s pacijenticom razgovarali o njenom doživljaju srama i manje vrijednosti vezano za dijagnozu u cilju smanjenja samostigmatizacije koja je postala prepreka njenom sudjelovanju u oporavku.

U skladu s iskustvima drugih autora da osobe s dijagnozom psihoze imaju teškoća iz simbiotske faze (23–25), kao i u razvoju sigurne privrženosti koja je povezana sa sposobnosti mentalizacije (26,27), opservirali smo ove teškoće u radu s našom pacijenticom. Glavni psihološki problem ove pacijentice koji je rizik za psihozu je pretjerana ovisnost o vanjskim objektima koja je vjerojatno povezana s njenim iskustvom pretjerano gratificirajuće simbioze zbog čega nije došlo do razvoja optimalne frustracije neophodne u razvoju kapaciteta za toleranciju tjeskobe, tj. sposobnosti za samo-umirenje koje više ne ovisi isključivo o prisutnosti vanjskih objekata da obavljaju tu funkciju. Dvije epizode psihoze nastale su u okolnostima odvajanja od majke koja još uvijek ima funkciju self objekta koji je nužan za psihološko umirenje u situacijama stresa. Kako majčinska umirujuća funkcija nije internalizirana, potrebno je fizičko prisustvo majke ili drugih ljudi koji obavljaju funkciju selfobjekta, primjerice dečka pacijentice. U trenutcima separacije kod osoba s ovim teškoćama dolazi do panične anksioznosti koja prijeti dezorganizaciji doživljaja temeljnog doživljaja sebe i u tim okolnostima psihoza je nezreli mehanizam obrane (28,29). Ovo nam je pomoglo da razumijemo da je u

In individuals with psychosis, PF also helps find the connection between the symptoms of psychosis and the patient's experience, applying a psychotherapeutic approach in talking about the reaction to the diagnosis that reduces the risk for the development of self-stigmatization and depression (21,22). These concepts were useful to us in connecting the auditory hallucinations with the patient's experience of herself as a less valuable person, which we explained to the patient, thus helping make the experience of psychosis less frightening. We also talked with the patient about her experience of shame and lowered self-esteem related to the diagnosis in order to reduce the self-stigmatization that became an obstacle to her participation in recovery.

Based on experiences of other authors, individuals diagnosed with psychosis experienced difficulties in the symbiotic phase (23–25) and in the development of secure attachment, which is linked to the ability for mentalization (26,27), and we observed these difficulties while working with our patient. The main psychological problem of this patient, which represents a risk for psychosis, was an excessive dependence on external objects, probably related to her experience of excessively gratifying symbiosis leading to a lack of development of the optimal level of frustration necessary for the development of the capacity for anxiety tolerance, i.e. the capacity for self-soothing, which does not depend solely on the presence of external objects to perform this function. The two episodes of psychosis developed in the circumstances when the patient was separated from the mother who still had the function of a self-object, necessary for psychological comfort in stressful situations. Since the mother's calming function was not internalized, the physical presence of the mother or other people who performed the function of the self-object, for example the patient's romantic partner, was necessary. In moments of separation, individuals with these difficulties experience panic anxiety, which threatens to disorganize the self, and in such circumstances, psychosis represents an immature defense mechanism (28,29). This helped

terapijskom odnosu važno ostvariti odnos povjerenja koji bi u daljnjem tijeku mogao biti osnova za korektivno emocionalno iskustvo koje će pomoći u izgradnji boljeg upravljanja s tjeskobom i smanjenja ovisnosti do vanjskih objekata. U daljnjem smo se tijeku rada odlučili za primjenu suportivne psihodinamske psihoterapije uz mogućnost obiteljske terapije s ciljem olakšavanja separacije, što za sada nije cilj pacijentice.

ZAKLJUČAK

Ciljevi liječenja osoba sa psihozom nakon akutne faze uključuju smanjenje rizika za ponovnu pojavu epizode psihoze. Potrebno je primijeniti holistički pristup u procjeni rizika koji uključuje procjenu biološke, socijalne i psihološke vulnerabilnosti kao i primjene biopsihosocijalnih postupaka koji smanjuju vulnerabilnost, a time i rizik za pojavu psihoze. Biološki rizik kod ove pacijentice dobro je kontroliran antipsihoticima. Međutim, u izlaganju stresnim okolnostima, antipsihotici nisu dovoljna zaštita te je potrebno primijeniti psihosocijalne postupke kako bi se poboljšale vještine u komunikaciji i nošenju sa stresom, kao i suportivnu psihodinamsku psihoterapiju s ciljem jačanja ega, osobito korištenja zrelijih mehanizama obrane i boljeg upravljanja s tjeskobom i stabilizacije temeljnog doživljaja sebe. Kormilo oporavka se pokazalo kao koristan alat u procjeni potreba i odabiru postupaka za postizanje oporavka kao i u evaluaciji napretka. U izradi plana oporavka ove pacijentice osobito je bila korisna psihodinamska formulacija čime se potvrdilo njeno značnje u izradi plana liječenja neovisno o planiranju psihoterapije. Ovaj primjer pokazuje da biopsihosocijalni pristup treba primijeniti u radu s pacijentima bez obzira na dijagnozu, što može potaknuti psihijatre da ga implementiraju u svakodnevnu psihijatrijsku praksu, kako bi poboljšali i pratili ishode liječenja pacijenata.

us understand that it was important to establish a relationship of trust in the therapeutic relationship, which could serve as the basis for a corrective emotional experience that would help build a better capacity for management of anxiety and, subsequently, reduce dependence on external objects. In the further course of work we decided to apply supportive psychodynamic psychotherapy with the possibility of family therapy, aiming to facilitate separation, which was not the patient's goal at the time.

CONCLUSION

Treatment goals for people with psychosis after an acute phase include reducing the risk of psychotic episode recurrence. It is necessary to apply a holistic approach to risk assessment, including the assessment of biological, social and psychological vulnerability, as well as the application of biopsychosocial interventions that reduce vulnerability, and thus the risk of psychosis. The biological risk in our patient was well controlled with antipsychotics. However, in exposure to stressful circumstances, antipsychotics are not sufficient protection and it is necessary to apply psychosocial interventions to improve skills in communication and dealing with stress, as well as supportive psychodynamic psychotherapy with the aim of strengthening the ego, especially the use of more mature defense mechanisms and better management of anxiety and stabilization of the self. The Helm of Recovery scheme has proven to be a useful tool in assessing needs and selecting interventions to achieve recovery as well as to evaluate progress. Psychodynamic formulation was particularly useful in the development of the patient's recovery plan, which confirmed its importance in the development of a treatment plan independently from psychotherapy planning. This example showed that a biopsychosocial approach should be applied in working with patients regardless of diagnosis, which may encourage psychiatrists to apply it in daily psychiatric practice to improve and to monitor the patient treatment outcomes.

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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.

Peer-review

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.

Uredništvo može objaviti neki već prije tiskani tekst uz dogovor s autorima i izdavačima.

Rad objavljen u *Socijalnoj psihijatriji* smije se objaviti drugdje bez dopuštenja autora, uredništva i izdavača, uz navod da je već objavljen u *Socijalnoj psihijatriji*.

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Sukob interesa

Časopis *Socijalna psihijatrija* potiče i podržava sve autore i recenzente da prijave potencijalne sukobe interesa kako bi se osigurala transparentnost prigodom pripreme i recenzije radova. Prema ICMJE-u: „Sukob interesa postoji ako autorove (ili institucija u kojoj je autor zaposlen) financijske (zaposlenje, u posjedu dionica, plaćeni honorar), akademske, intelektualne ili osobne veze neprimjereno utječu na njegove odluke“ (detaljnije objašnjenje dostupno je na mrežnim stranicama ICMJE-a: http://www.icmje.org/conflicts-of-interest/).

Otvoreni pristup

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

Naplata troškova prijevoda radova

Autor snosi troškove prijevoda na engleski ili hrvatski jezik, odnosno lektoriranja rada.

Oprema rukopisa

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.).

Autoru koji je zadužen za dopisivanje treba navesti titulu, ime i prezime, adresu, grad, državu i adresu e-pošte. Također je potrebno navesti i ORCHID identifikatore svih autora (više na https://orcid.org/register).

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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Conflict of interest

Socijalna psihijatrija encourages all Authors and Reviewers to report any potential conflicts of interest to ensure complete transparency regarding the preparation and reviewing of the manuscript. According to the International Committee of Medical Journal Editors (ICMJE): “Conflict of interest exists when an author (or the author’s institution) has financial (employment, consultancies, stock ownership, honoraria and paid expert testimony) or personal relationship, academic competition or intellectual passion that inappropriately influences his actions.” (available at: http://www.icmje.org/conflicts-of-interest/).

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.

U tekstu se literaturni podatak navodi arapskim brojem u zagradi.

Literatura

Časopis *Socijalna psihijatrija* usvojila je Vancouverski stil citiranja literature, prema standardima ICMJE koji preporučuju citiranje djela objavljena u cijelosti, odnosno ona koja su javno dostupna, što ujedno znači da treba izbjegavati navođenje sažetaka, usmenih priopćenja i sl.

Ponovno citiranje nekog rada treba označiti istim brojem pod kojim je prvi put spomenut.

Prigodom doslovnog navođenja izvatka iz drugog teksta koriste se navodnici. Ovaj način citiranja treba koristiti samo u slučajevima kada se informacija ne može kvalitetno preformulirati ili sažeti (npr. kod navođenja definicija).

Sekundarno citiranje odnosi se na slučaj kada autor koristi navod iz djela kojemu nema pristup, već je do navoda došao posredstvom drugog rada u kojem je izvorni rad citiran. Ovaj način citiranja treba izbjegavati gdje god je to moguće, odnosno uvijek treba pokušati pronaći izvorno djelo. Ako to nije moguće, u popisu literature se navodi rad koji je zaista korišten, a ne rad u kojem je informacija primarno objavljena.

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Ako djelo ima šest autora, navode se svi autori. Ako djelo ima više od šest autora, navodi ih se prvih šest, a ostali se označavaju kraticom *et al.* ili *i sur.* Prvo se navodi prezime, a potom inicijali imena. Više inicijala imena iste osobe piše se bez razmaka.

2. Naslov i podnaslov rada

Prepisuju se iz izvornika i međusobno odvajaju dvotočkom. Samo prva riječ naslova i vlastita imena (osobna, zemljopisna i dr.) pišu se velikim početnim slovom.

3. Naslov časopisa

Naslovi časopisa skraćuju se sukladno sustavu koji koristi MEDLINE (popis kratica dostupan je na adresi: http://www.ncbi.nlm.nih.gov/nlmcatalog/journals). Naslov časopisa se ne skraćuje ako se on ne nalazi na prethodno navedenom popisu kratica.

4. Numerički podatci o časopisu

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.

Original scientific and professional papers should be arranged into sections as follows: summary, introduction, aim, methods, results, discussion and conclusion.

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.

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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.

1. Authors

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.

2. Title and subtitle

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.

3. Journal title

Journal titles are shortened according to the MEDLINE system (a list of abbreviations is available at: http://www.ncbi.nlm.nih.gov/nlmcatalog/journals). The title of the journal is not shortened if fit is not found in the abovementioned shortcut list.

stranice (engleski *pages*). Broj sveščića upisuje se u okruglu zagradu, a obvezno ga je upisati ako paginacija (numeracija) svakog sveščića počinje od 1. Ako ne možete prepoznati broj/sveščić časopisa (primjerice, kad su sveščići uvezani), taj se podatak može izostaviti. Stranice rada se upisuju od prve do zadnje.

Primjer:

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5. Izdanje knjige

Navodi se rednim brojem i kraticom izd. Rednom broju sveska knjige (ako je djelo u više svezaka) prethodi oznaka sv.

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Primjer:

Millon T. Brief History of Psychopathology. In: Blaney PH, Millon T (eds.) Oxford Textbook of Psychopathology. New York: Oxford University Press, 2009.

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Navode se samo ako se citira dio knjige, uz oznaku str. (engleski *pages*).

Primjer:

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

11. URL/Web adresa

Obavezno se navodi za mrežne izvore.

12. Datum korištenja/pristupa

Obavezno se navodi za mrežne izvore.

13. DOI

Ako postoji, obavezno se navodi za mrežne izvore.

Primjer:

Cook A, Spinazzola J, Ford J, Lanktree C, Blaustein M, Cloitre M, DeRosa R, Hubbard R, Kagen R, Liautaud J, Mallah K, Olafson E,van der Kolk B. Complex trauma in children and adolescents. Psych Ann 2005; 35(5): 390-398. Preuzeto 14. listopada 2017. shttps://doi.org/10.3928/00485713-20050501-05.

4. Numerical journal data

The data that can be found in the original or in any of the bibliographic database should be written in Arabic numerals, in the following order: year, volume, issue, part, supplement, pages. Issue number is entered in parentheses and it is required to enter it starting from 1. In case the issue of the Journal cannot be recognized (e.g. when the issues are bonded), that data may be omitted. The page numbers are written from first to last.

E. g.

Kingdon DG, Aschroft K, Bhandari B, Gleeson S,Warikoo N, Symons Metal. 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.

5. Book issue

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”.

6. City of issue

Insert only the first city from the original work. For every additional city, use the abbreviation etc.

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8. Year of issue

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E.g.

Kring AM, Johnson SL, Davison GC, Neale JM. Abnormal Psychology. New York: Wiley, 2013.

9. Book chapter

Book chapter should list the authors and title followed by book data. Use the abbreviation “In” before the Editor’s name:

E. g.

Millon T. Brief History of Psychopathology. In: Blaney PH, Millon T (eds.) Oxford Textbook of Psychopathology. New York: Oxford University Press, 2009.

10. Book page

Book pages are marked with “pages” only if a part of the book is being quoted:

E. g.

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

11. Web address

Required for online resources.

12. Date of use

Required for online resources.

13. DOI

If available, it is mandatory to cite online resources.

E. g.

Cook A, Spinazzola J, Ford J, Lanktree C, Blaustein M, Cloitre M, et al. Complex trauma in children and adolescents. Psych Ann 2005; 35(5): 390-398. Accesed 14. October 2017. https://doi.org/10.3928/00485713-20050501-05.