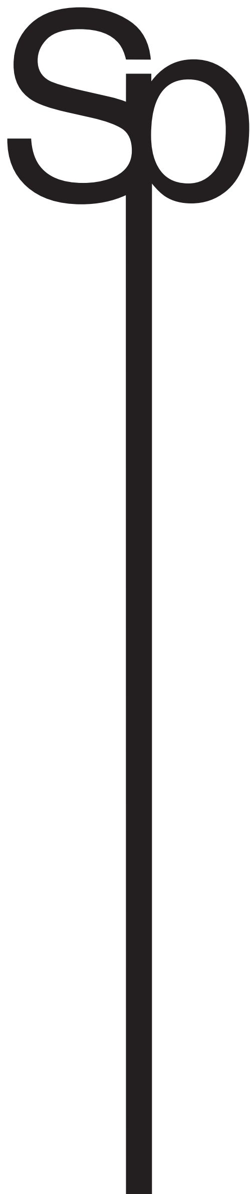

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Rizični i zaštitni čimbenici psihološke dobrobiti kod žena koje su proživjele iskustvo spontanog pobačaja

/ Risk and Protective Factors of Psychological Well-Being in Women Who Experienced Miscarriage

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Majčinstvo je jedna od ključnih uloga u životu većine žena, no nažalost, oko 20 % svih trudnoća završi spontanim pobačajem. Osnovni cilj ovog rada bio je istražiti doprinose rizičnih (ponovljeni pobačaji, vrijeme proteklo od spontanog pobačaja, procjena negativnog utjecaja spontanog pobačaja na svakodnevni život, procjena uznemirenosti nakon spontanog pobačaja) i zaštitnih čimbenika (različite strategije suočavanja, socijalna podrška partnera i okoline, te kvaliteta bračne komunikacije) simptomima depresivnosti, anksioznosti i stresa, te općem zadovoljstvu životom. U istraživanju su sudjelovale 152 sudionice koje su proživjele iskustvo spontanog pobačaja (prije 24. tjedna trudnoće). Sudionice su u prosjeku imale 33 godine (SD = 6,73), dok je vrijeme proteklo od posljednjeg spontanog pobačaja iznosilo 3,39 godine (SD = 4,77) s rasponom od tjedan dana do 28 godina. Korišteni su mjerni instrumenti koji obuhvaćaju suočavanje sa stresom, socijalnu podršku, kvalitetu bračne komunikacije, zadovoljstvo životom, depresivnost, anksioznost i stres. Nalazi pokazuju da je viša gestacijska dob fetusa u trenutku gubitka trudnoće negativno povezana sa zadovoljstvom životom, a što je duže razdoblje od spontanog pobačaja, prisutno je manje simptoma depresivnosti, anksioznosti i stresa, uz veće zadovoljstvo životom. Također, negativan utjecaj spontanog pobačaja na svakodnevni život povezan je s lošijom psihološkom dobrobiti. Regresijskim analizama utvrđeno je da je korištenje izbjegavajućih strategija suočavanja značajan prediktor psihološke dobrobiti (pozitivan prediktor anksioznosti, stresa i depresivnosti, odnosno negativan zadovoljstva životom). Kvaliteta bračne komunikacije negativan je prediktor depresivnosti, anksioznosti i stresa, odnosno pozitivan prediktor zadovoljstva životom. Dodatno, niže razine stresa uz veće zadovoljstvo životom imaju sudionice koje percipiraju više socijalne podrške od okoline. Subjektivna procjena zdravstvenog stanja pokazala se značajnim prediktorom mjera psihološke dobrobiti. Istraživanje, između ostalog, ukazuje da je psihološka dobrobit žena koje su doživjele spontani pobačaj najugroženija neposredno nakon samog događaja iz čega proizlazi potreba za ciljanim intervencijama.

/ Motherhood is one of the key roles in the lives of most women, however, approximately 20% of all pregnancies unfortunately end in miscarriage. The main aim of this paper was to explore the contributions of risk (recurrent miscarriages, time passed since a miscarriage, assessment of the negative impact of miscarriage on everyday life, assessment of distress experienced after miscarriage) and protective factors (various coping strategies, social support received from the partner and the environment, and the quality of marital communication) to the symptoms of depression, anxiety and stress, as well as to life satisfaction in general. A total of 152 participants who have experienced miscarriage (before the 24th week of pregnancy) took part in the study. The average age of the participants was 33 years (SD = 6.73), while the time passed since the last miscarriage was 3.39 years (SD = 4.77) with a range from one week to 28 years. The measuring instruments used included coping with stress, social support, quality of marital communication, life satisfaction, depression, anxiety and stress. The findings indicate that higher gestational age of the fetus at the time of pregnancy loss is negatively associated with life satisfaction, and the more time passes since the miscarriage the fewer are the symptoms of depression, anxiety and stress, with increasing life satisfaction. Furthermore, the negative impact of miscarriage on everyday life is associated

with poorer psychological well-being. It was determined through regression analyses that the use of avoidance coping strategies is a significant predictor of psychological well-being (a positive predictor of anxiety, stress and depression, i.e. negative predictor of life satisfaction). Marital communication quality is a negative predictor of depression, anxiety and stress, i.e. positive predictor of life satisfaction. In addition, lower stress levels, along with higher life satisfaction, were observed in participants who perceived more social support from their environment. The subjective health status assessment proved to be a significant predictor of psychological well-being measures. Among other things, this study indicates that the psychological well-being of women who experienced a miscarriage is most at risk immediately after the event, thus creating the need for targeted interventions.

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UVOD

Spontani pobačaj opisuje se kao neželjeni gubitak trudnoće prije 20. tjedna trudnoće ili gubitak ploda tjelesne mase manje od 500 grama (1). Istraživanja pokazuju da otprilike 20 % svih trudnoća završi spontanim pobačajem unutar prvih 22 tjedna, što čini rani gubitak trudnoće najčešćom opstetričkom komplikacijom (2). Podatci o prevalenciji spontanih pobačaja ukazuju da stopa spontanih pobačaja raste s godinama pri čemu je oko 27 % kod žena u dobi između 25 i 29 godina, dok doseže oko 40 % kod žena u dobi od 40 godina, te do 75 % kod žena od 45 godina ili starijih. Rizični čimbenici uključuju dob, pušenje, konzumaciju droga i alkohola te lošu kontrolu kroničnih poremećaja kao što su dijabetes i hipertenzija (3,4). Ovom događaju mogu doprinijeti različiti uzroci uključujući virusne infekcije, kromosomske poremećaje i probleme s luteinskim razdobljem. Često ostaje nejasnim pravi uzrok spontanog pobačaja, što dodatno otežava situaciju mnogim ženama (5). Naime,

INTRODUCTION

Miscarriage is described as an unwanted loss of pregnancy before the 20th week of gestation or the loss of a fetus weighing less than 500 g (1). Studies have shown that approximately 20% of pregnancies end in miscarriage within the first 22 weeks, which makes early pregnancy loss the most common obstetric complication (2). Data on the prevalence of miscarriages indicate that the miscarriage rate increases with age, amounting to approx. 27% among women between 25 and 29 years of age, reaching approx. 40% among 40-year-old women and up to 75% among women 45 years old or older. Risk factors include age, smoking, drugs and alcohol consumption, and poor control of chronic disorders such as diabetes and hypertension (3,4). Other factors can also contribute to these events, including viral infections, chromosomal abnormalities and problems with the luteal phase. The real cause of a miscarriage often remains unclear, which makes the situation even more difficult for many women (5). More precisely, in such circumstances the parents

u tim okolnostima roditelji sami konstruiraju ideje o uzroku, pri čemu prema nekim podatcima više od polovice osjeća osobnu krivnju (6). Nadalje, bez jasnog uzroka, žene često ne mogu postići osjećaj zatvaranja ili razumijevanja svog gubitka, što može produljiti emocionalnu bol i tugu te povećati razine anksioznosti i nesigurnosti u pogledu budućih trudnoća (7). Spontani pobačaj može biti izuzetno stresno iskustvo kako za ženu tako i za njezinog partnera (8-10). Reakcije žena variraju i uključuju osjećaje olakšanja, praznine, usamljenosti i krivnje. Međutim, tugovanje i osjećaj krivnje mogu trajati i godinama nakon spontanog pobačaja. Gubitak trudnoće može imati dugoročne negativne posljedice uključujući povećan rizik za samoubojstvo kod žena koje su ga doživjele (10-12).

Mentalno zdravlje majki nakon spontanog pobačaja

Istraživanja ukazuju na vezu između iskustva spontanog pobačaja i povećane anksioznosti, depresivnosti te visokih razina psihološke uznemirenosti (13). Zanimljivo je da i do 6 mjeseci nakon pobačaja mnoge žene i dalje pate od povišenih razina anksioznosti, te su pod povećanim rizikom za razvoj opsesivno kompulzivnog poremećaja i posttraumatskog stresnog poremećaja (14,15). Nadalje, žene često doživljavaju intenzivniju tugu i veći broj simptoma depresivnosti nakon pobačaja u usporedbi sa svojim partnerima (16). Dodatno, anksioznost i depresivnost mogu egzistirati čak i nakon rođenja drugog zdravog djeteta (17). Žene koje su proživjele gubitak trudnoće često izvještavaju o nižem zadovoljstvu životom u usporedbi s onima koje nisu imale spontani pobačaj (18).

Stresni životni događaji i važnost socijalne podrške

Prema transakcijskoj teoriji stresa i suočavanja (19) stres se definira kao izloženost podražajima koji se procjenjuju kao štetni, prijeteći ili

construct their own ideas about the cause, and according to some data, more than half of them feel personal guilt (6). Furthermore, without a clear cause, women often cannot achieve a sense of closure or understanding with regard to their loss, which can prolong emotional pain and sadness, and can increase the levels of anxiety and uncertainty when it comes to future pregnancies (7). Miscarriage can be an extremely stressful experience both for the woman and her partner (8-10). Women's reactions vary and include feelings of relief, emptiness, loneliness and guilt. Feelings of grief and guilt, however, can last for a long time, even years after the miscarriage. Pregnancy loss can have long-term negative consequences, including an increased risk of suicide in women who have experienced it (10-12).

Mental health of mothers after a miscarriage

Studies indicate that there is a strong link between the experience of miscarriage and increased anxiety, depression and high levels of psychological distress (13). Interestingly, even up to six months after the miscarriage, many women still suffer from increased anxiety levels, and are at a higher risk of developing obsessive compulsive disorder and posttraumatic stress disorder (14, 15). Furthermore, women often experience more intense grief and more symptoms of depression after a miscarriage compared to their partners (16). Anxiety and depression can also exist even after giving birth to a second, healthy child (17). Women who have experienced pregnancy loss often report lower life satisfaction compared to those who have not experienced a miscarriage (18).

Stressful life events and the importance of social support

According to the Transactional Theory of Stress and Coping (19), stress is defined as exposure to stimuli that are appraised as harmful, threatening or challenging, and which exceed an indi-

izazovni, a koji nadilaze sposobnost pojedinca da se s njima suoči. Prema literaturi (20) šest je karakteristika koje su zajedničke svim stresnim događajima i koje negativno utječu na život pojedinca. Valentnost se odnosi na poželjnost ili nepoželjnost stresnog događaja, pri čemu je nepoželjnost spontanog pobačaja povezana s povišenim razinama uznemirenosti i teškoćama u prihvaćanju gubitka. Suprotno tome, žene koje nisu željele trudnoću često doživljavaju samo fizičku, a ne i emocionalnu traumu (često osjećaju olakšanje) (21). Kontrolabilnost stresnog događaja odnosi se na percepciju pojedinca da je svojim postupcima izazvao stresnu situaciju, pri čemu žene sklone samookrivljavanju često izvještavaju o povišenim razinama anksioznosti i depresivnosti (22). Nepredvidljivost također pridonosi povišenim razinama psihološke uznemirenosti. Od ostalih značajnih karakteristika ističu se magnituda (razina negativne promjene u svakodnevnim aktivnostima), centralnost (prijetnja za postizanje ciljeva) te potencijalni fizički umor (20,23).

U kontekstu suočavanja s gubitkom djeteta istraživanja pokazuju da žene koje nemaju djecu često izvještavaju o više simptoma depresivnosti i anksioznosti (10,24). Što se tiče stilova suočavanja, dva su glavna pristupa: suočavanje usmjereno na problem i suočavanje usmjereno na emocije. Suočavanje usmjereno na problem uključuje aktivnosti koje mijenjaju ili uklanjaju stresore, dok se suočavanje usmjereno na emocije odnosi na smanjivanje emocionalne napetosti i negativnih emocija (19). Emocionalno suočavanje može imati pozitivan utjecaj na psihološke ishode nakon traumatskog iskustva (25) dok izbjegavajuće suočavanje, koje uključuje odustajanje, poricanje i samookrivljavanje, može biti rizičan faktor za razvoj depresivnosti (25,26). Navedeno potvrđuju i nalazi istraživanja provedenog u Hrvatskoj, koje je pokazalo da su žene koje su češće koristile izbjegavajuće suočavanje nakon rođenja djeteta češće doživljavale simptome PTSP-a (25). Nadalje, viša dob i niže obrazovanje pokazali su

vidual's capacity to cope with them. According to literature (20), there are six characteristics common to all stressful events, which have a negative impact on an individual's life. Valence refers to the desirability or undesirability of a stressful event, whereby the undesirability of a miscarriage is associated with increased levels of distress and difficulty accepting loss. In contrast, women who did not want the pregnancy often experience only the physical, and not the emotional trauma (they often feel relief) (21). The controllability of a stressful event refers to the individual's perception of having caused the stressful situation with their own actions, whereby women prone to blaming themselves often report increased levels of anxiety and depression (22). Unpredictability also contributes to increased levels of psychological distress. Among other significant characteristics, the most prominent ones include magnitude (level of negative changes to everyday activities), centrality (threat to achieving goals) and potential physical fatigue (20, 23).

In the context of coping with the loss of a child, studies have shown that women who do not have children often experience more symptoms of depression and anxiety (10, 24). In terms of coping styles, there are two main approaches: problem-focused coping and emotion-focused coping. Problem-focused coping includes activities that alter or remove stressors, while emotion-focused coping refers to reducing emotional tension and negative emotions (19). Emotion-focused coping can have a positive impact on the psychological outcomes after a traumatic experience (25), while avoidance coping, which includes giving up, denial and self-blame, can be a risk factor for developing depression (25, 26). The abovementioned has also been confirmed by a study conducted in Croatia, which has shown that women who used avoidance coping strategies more frequently after childbirth also experienced symptoms of PTSD more often (25). Furthermore, older age and lower education levels have proved to be significant predictors of mental health difficulties in this group of women (8, 27).

se značajnim prediktorima teškoća mentalnog zdravlja kod ove skupine žena (8,27).

Dosadašnja istraživanja ističu da socijalna podrška partnera igra ključnu ulogu u procesu oporavka nakon spontanog pobačaja. Partnerova podrška nije samo važna za emocionalno zacjeljivanje, već i za smanjenje negativnih emocionalnih doživljaja (24). Istraživanja dodatno naglašavaju važnost odnosa s partnerom nakon spontanog pobačaja pri čemu su interpersonalna i seksualna udaljenost povezane s višim razinama anksioznosti, depresivnosti i zbunjenosti (28). Uz navedeno, dijeljenje tuge s drugima također se ističe kao snažan prediktor procesa zacjeljivanja (29). Prethodno navedena istraživanja podupiru dokaze o kratkoročnim i dugoročnim posljedicama gubitka trudnoće na psihološko funkcioniranje žena i kvalitetu bračnih odnosa (30,31), no osjećaj gubitka nakon spontanog pobačaja često ostaje neprepoznat kako od zdravstvenih radnika tako i od prijatelja i obitelji (13).

CILJ ISTRAŽIVANJA

Ovo istraživanje ima za cilj istražiti čimbenike koji su povezani s psihološkom dobrobiti kod žena koje su doživjele iskustvo spontanog pobačaja. Fokus će biti na identificiranju rizičnih i zaštitnih čimbenika koji pridonose simptomima anksioznosti, depresivnosti i stresa, kao i općem zadovoljstvu životom. Analizirani su čimbenici povezani s pojedincem (kao što su dob, broj djece, materijalni i zdravstveni status, stupanj obrazovanja) i karakteristikama samog događaja (broj spontanih pobačaja, gestacijska dob fetusa u trenutku gubitka trudnoće, planiranost trudnoće, razina uznemirenosti zbog pobačaja, proteklo vrijeme od pobačaja, predvidljivost spontanog pobačaja i magnituda - procjena negativnog utjecaja spontanog pobačaja na svakodnevni život), strategije suočavanja, percepcija podrške partnera i podrške okoline te kvaliteta bračne komunikacije.

The studies conducted so far emphasize that social support from partners plays a key role in the recovery process after a miscarriage. Partner's support is important not only for emotional healing, but also for reducing negative emotional experiences (24). Studies additionally emphasize the importance of partner relationships after experiencing a miscarriage, whereby interpersonal and sexual distance are associated with higher levels of anxiety, depression and confusion (28). In addition to the above, sharing grief with others also stands out as a significant predictor of the healing process (29).

The abovementioned studies support the evidence relating to the short-term and long-term consequences of pregnancy loss when it comes to the psychological functioning of women and the quality of marital relations (30, 31), but the sense of loss after a miscarriage often remains unrecognized both by the healthcare professionals and by the friends and families (13).

AIM

The aim of this study is to explore the factors associated with the psychological well-being of women who have experienced miscarriage. The focus will be on identifying the risk and protective factors contributing to the symptoms of anxiety, depression and stress, as well as overall life satisfaction. We analyzed the factors associated with individuals (such as age, number of children, material and health status, education level) and the characteristics of the event itself (the number of miscarriages, gestational age of the fetus at the time of pregnancy loss, planned pregnancy, level of distress caused by the miscarriage, time passed since the miscarriage, predictability of miscarriage and magnitude – assessment of the negative impact of miscarriage on everyday life), as well as coping strategies, perception of support received from the partner and from the environment, and marital communication quality.

Older age, higher number of miscarriages and higher gestational age of the fetus at the time

Očekuje se da će viša dob, veći broj spontanih pobačaja, veća gestacijska dob fetusa u trenutku gubitka trudnoće biti povezani s višom razinom anksioznosti, depresivnosti i stresa, odnosno nižom razinom zadovoljstva. Očekuje se i da će planiranost trudnoće, procjena uznemirenosti i magnitude stresnog događaja biti povezani s višom razinom anksioznosti, depresivnosti i stresa, odnosno nižom razinom zadovoljstva životom. Osim toga očekuje se da će veći broj djece, bolje materijalne prilike, viši stupanj obrazovanja biti povezani s nižim razinama anksioznosti, depresivnosti i stresa, odnosno višim zadovoljstvom životom. Vrijeme proteklo od spontanog pobačaja i predvidljivost bit će u negativnoj korelaciji sa simptomima depresivnosti, anksioznosti i stresa, odnosno u pozitivnoj sa zadovoljstvom životom. Češće korištenje emocionalnog i problemskog suočavanja, veća socijalna podrška partnera i okoline te veća kvaliteta bračne komunikacije bit će povezani s nižim razinama anksioznosti, depresivnosti i stresa, odnosno višim zadovoljstvom životom. Suprotan obrazac povezanosti očekuje se za izbjegavajuće suočavanje. Konačno, očekuje se da će sociodemografske karakteristike pojedinca (dob, broj djece, materijalni i zdravstveni status), karakteristike spontanog pobačaja, strategije suočavanja, socijalna podrška partnera i okoline te kvaliteta bračne komunikacije biti značajni prediktori mjera psihološke dobrobiti.

METODA

Sudionici

Ukupno su u istraživanju sudjelovale 152 sudionice koje su proživjele iskustvo spontanog pobačaja. Prosječna dob sudionica bila je 32,97 godina (SD = 6,73). Prosječno vrijeme koje je proteklo od posljednjeg spontanog pobačaja iznosi 3,39 godina (SD = 4,77) s rasponom od tjedan dana do 28 godina. Prosječan broj spontanih pobačaja koje su doživjele sudionice

of pregnancy loss are all expected to be associated with higher levels of anxiety, depression and stress, that is, lower satisfaction levels. It is also expected that the planning of pregnancy, and an assessment of distress and magnitude of the stressful event will be associated with higher levels of anxiety, depression and stress, that is, lower life satisfaction levels. Moreover, it is expected that having more children, better material circumstances and a higher level of education will be associated with lower levels of anxiety, depression and stress, that is, higher life satisfaction. Time passed since the miscarriage and its predictability will be negatively associated with the symptoms of depression, anxiety and stress, that is, positively associated with life satisfaction. More frequent use of emotion-focused and problem-focused coping strategies, better social support from the partners and the environment, and a better quality of marital communication will be associated with lower levels of anxiety, depression and stress, that is, higher life satisfaction. A reverse association pattern is expected in terms of avoidance coping. Finally, the sociodemographic characteristics of individuals (age, number of children, material and health status), characteristics of the miscarriage, coping strategies, social support from the partner and the environment, and marital communication quality are expected to be significant predictors of psychological well-being measures.

METHOD

Participants

A total of 152 participants who have experienced miscarriage took part in the study. The average age of the participants was 32.97 years (SD = 6.73). The average time passed since the last miscarriage was 3.39 years (SD = 4.77) with a range from one week to 28 years. The average number of miscarriages experienced by the participants amounted to 1.33 (SD = 0.63), whereby the maximum number recorded was four. The majority of the participants (84.87%) suffered the loss

iznosi 1,33 (SD = 0,63) pri čemu je maksimalni zabilježeni broj bio četiri. Većina sudionica (84,87 %) doživjela je gubitak u rasponu od 5. do 12. tjedna trudnoće. Oko 45 % sudionica nema djece, dok ostalih 55 % ima djecu. Sudionice su uglavnom zadovoljne svojim partnerskim odnosima (M = 5,77, SD = 1,19) te navode da pružaju visoke razine podrške svojim partnerima (M = 4,34, SD = 0,62). Oko 75 % sudionica je planiralo trudnoću, a 94,74 % je izjavilo da je trudnoća bila željena. Više od 21 % pobačaja bilo je uzrokovano kromosomskim poremećajem. Najveći postotak sudionica (40 %) nikada nije saznao uzrok gubitka trudnoće, dok 25,74 % sudionica navodi ostale uzroke uključujući trombofiliju, fizički napor i bakterijsku infekciju. Dodatni zabilježeni uzroci uključuju višeplodnu trudnoću (3,3 %), anomaliju maternice (2,63 %), preeklampsiju (0,66 %).

Mjerni instrumenti

Upitnik sociodemografskih podataka sadržavao je pitanja o subjektivnoj procjeni zdravstvenog stanja (1 - jako loše, 5 - odlično), obrazovanju (NSS, SSS, VŠS, VSS), obiteljskim materijalnim prilikama (ispodprosječne, prosječne, iznadprosječne)[1], radnom i partnerskom statusu. Osim upitnika za prikupljanje sociodemografskih podataka za potrebe ovog istraživanja konstruiran je upitnik koji se odnosio na karakteristike spontanog pobačaja. Konkretno, obuhvaćeni su podatci o planiranosti i željenosti trudnoće, gestacijskoj dobi fetusa u trenutku gubitka trudnoće, ukupnom broju spontanih pobačaja te vremenu proteklom od spontanog pobačaja. Sudionice su odgovarale i na pitanja koja su se odnosila na uznemirenost, predvidljivost i magnitudu (negativan utjecaj koji je spontani pobačaj imao na njihov svakodnevni život). Pritom je teorijski raspon na svim varijablama vezanim uz karakteristike spontanog pobačaja bio od 1 do 5.

[1] ispodprosječne materijalne prilike u daljnjoj su analizi pridružene prosječnim materijalnim prilikama

between the 5th and 12th week of pregnancy. Approximately 45% of the participants did not have children, while the other 55% had children. The participants were mainly satisfied with their partner relationships (M = 5.77, SD = 1.19) and claimed to provide high levels of support to their partners (M = 4.34, SD = 0.62). Around 75% of the participants planned their pregnancies, and 94.74% stated that they wanted the pregnancy. More than 21% of the miscarriages was caused by chromosomal abnormalities. The highest percentage of participants (40%) never found out the cause of pregnancy loss, while 25.74% of them stated other causes such as thrombophilia, physical strain and bacterial infections. Other recorded causes included multiple pregnancy (3.3%), uterine abnormalities (2.63%), and preeclampsia (0.66%).

Measuring instruments

The sociodemographic data questionnaire contained questions relating to the subjective health status assessment (1 – poor, 5 – excellent), education (low-skilled, secondary education, higher vocational education, university degree), family material circumstances (below average, average, above average)[1], and work and partner relationship status. In addition to the sociodemographic data questionnaire, a questionnaire referring to the characteristics of the miscarriage was constructed for the purposes of this study. More precisely, data on whether the pregnancy was planned and wanted was collected, including the data on the gestational age of the fetus at the time of pregnancy loss, the total number of miscarriages and time passed since the miscarriage. The participants also answered questions relating to distress, predictability and magnitude (negative impact that the miscarriage had on their lives). At the same time, the theoretical range on all variables relating to the characteristics of the miscarriage was from 1 to 5.

[1] Below-average material circumstances were joined with the average material circumstances in further analysis

Upitnik suočavanja sa stresom (COPE; 32) sastoji se od 14 podljestvica (svaka podljestvica ima po dvije čestice), a koje se grupiraju u tri glavne strategije suočavanja: suočavanje s problemima, suočavanje s emocijama i izbjegavanje. Suočavanje s problemima uključuje aktivno rješavanje problema, izražavanje osjećaja, planiranje te traženje podrške. S druge strane, suočavanje s emocijama obuhvaća humor, konzumiranje sredstava ovisnosti, pozitivno razmišljanje i prihvaćanje. Strategije izbjegavanja uključuju odustajanje, odvraćanje pažnje, poricanje, religiozne strategije i samookrivljavanje. Sudionici su na ljestvici procjene od 1 do 4 (1 - gotovo nikada; 4 - gotovo uvijek) odgovarali koliko su često pojedinu strategiju koristili tijekom proteklog tjedna. Koeficijenti pouzdanosti za podljestvice u ovom istraživanju iznosili su: emocionalno suočavanje (α = 0,51), izbjegavajuće suočavanje (α = 0,66) i problemsko suočavanje(α = 0,85).

Ljestvicom instrumentalne i emocionalne socijalne podrške (33) u ovom istraživanju mjerila se socijalna podrška partnera (5 čestica), te emocionalna i instrumentalna podrška okoline (14 čestica). Teorijski raspon rezultata za podršku partnera može biti od 1 do 5, dok je za podršku okoline od 1 do 3. Koeficijenti pouzdanosti za pojedine podljestvice iznosili su: socijalna podrška partnera (α = 0,95) te emocionalna i instrumentalna podrška okoline (α = 0,86).

Ljestvica zadovoljstva brakom (34) sastoji se od šest tvrdnji koje opisuju opću ocjenu zadovoljstva odnosom s partnerom. Sudionici izražavaju svoje (ne)slaganje s tvrdnjama na ljestvici procjene od 7 stupnjeva pri čemu (-3) označava "potpuno netočno", a (+3) "potpuno točno". Ukupni rezultat na ljestvici je prosječna vrijednost procjena za sve tvrdnje, a teorijski raspon rezultata može biti od 1 do 7 pri čemu veći rezultat ukazuje na veće zadovoljstvo odnosom. U ovom istraživanju koeficijent α iznosi 0,86.

The stress-coping questionnaire (COPE - Coping Orientation to Problems Experienced Inventory; 32) consists of 14 subscales (each subscale has two items), which are grouped into three main coping strategies: problem-focused coping, emotion-focused coping and avoidance. Problem-focused coping includes active problem solving, expressing feelings, planning and seeking support. On the other hand, emotion-focused coping includes humor, consumption of addictive substances, positive thinking and acceptance. Avoidance coping strategies include giving up, distraction, denial, religious strategies and self-blame. On the assessment scale ranging from 1 to 4 (1 – almost never; 4 – almost always), the participants indicated how often they had used each strategy in the previous week. Reliability coefficients for the subscales in this study amounted to the following: emotion-focused coping (α = 0.51), avoidance coping (α = 0.66) and problem-focused coping (α = 0.85).

The Instrumental and Emotional Social Support Scale (33) was used in this study in order to measure the social support received from partners (five items), and the emotional and instrumental support from the environment (14 items). The theoretical range of results for partner support could be from 1 to 5, while for social support it was from 1 to 3. The reliability coefficients for individual subscales were the following: social support from the partner (α = 0.95), and emotional and instrumental support from the environment (α = 0.86).

The Marital Satisfaction Scale (34) consists of six statements describing the general satisfaction when it comes to the relationship with one's partner. The participants expressed their (dis) agreement with the statements on a 7-point assessment scale, ranging from (-3) "completely inaccurate" to (+3) "completely accurate". The total result on the scale is the average value of assessments for all statements, and the theoretical range of the results could span from 1 to 7, whereby a higher result indicated higher satisfaction with the relationship. The coefficient α in this study amounted to 0.86.

Ljestvica kvalitete bračne komunikacije (35) ima deset tvrdnji koje opisuju opću evaluaciju komunikacije s partnerom. Sudionici izražavaju svoje (ne)slaganje s tvrdnjama na ljestvici od 7 stupnjeva, gdje (-3) označava "potpuno netočno", a (+3) "potpuno točno". Ukupan rezultat formira se kao prosjek procjena za sve tvrdnje, a teorijski raspon može biti od 1 do 7. U ovom istraživanju, koeficijent pouzdanosti α iznosio je 0,94.

Ljestvica depresivnosti, anksioznosti i stresa - DASS (36) se sastoji od 42 čestice podijeljene u tri podljestvice, od kojih svaka ima 14 čestica. Depresivnost se odnosi na simptome poput apatije i beznadnosti, anksioznost na pobuđenost autonomnog sustava te situacijsku anksioznost, dok se stres odnosi na nestrpljenje, kroničnu pobuđenost i uznemirenost. Sudionici su davali odgovore na ljestvici procjene od četiri stupnja (0 – uopće se ne odnosi na mene, 3 – potpuno se odnosi na mene) pri čemu veći broj označava veću izraženost simptoma. U ovom istraživanju koeficijenti pouzdanosti su sljedeći: depresivnost (α = 0,96), anksioznost (α = 0,92), stres (α = 0,95).

Ljestvica zadovoljstva životom (37) sastoji se od 5 čestica koje mjere globalne kognitivne procjene zadovoljstva životom. Sudionici procjenjuju stupanj slaganja sa svakom tvrdnjom koristeći ljestvicu od 7 stupnjeva (1 – uopće se ne slažem, 7 – u potpunosti se slažem). Ukupan rezultat određuje se zbrajanjem svih procjena pri čemu viši rezultat upućuje na veće zadovoljstvo životom. U ovom istraživanju koeficijent pouzdanosti α iznosi 0,86.

Statističke analize

Kako bi se odgovorilo na postavljene ciljeve analizirani su osnovni deskriptivni čimbenici, izračunate interkorelacije između pojedinih skupina varijabli te su provedene hijerarhijske regresijske analize gdje su kriteriji bili pojedine mjere psihološke dobrobiti (depresivnost, anksioznost, stres i zadovoljstvo životom).

The Marital Communication Quality Scale (35) consists of ten statements describing a general evaluation of communication with one's partner. The participants expressed their (dis)agreement with the statements on a 7-point scale, ranging from (-3) "completely inaccurate" to (+3) "completely accurate". The total result is formed as the average value of assessments for all statements, and the theoretical range could span from 1 to 7. The reliability coefficient α in this study amounted to 0.94.

The Depression, Anxiety and Stress Scale – DASS (36) consists of 42 items divided into three subscales, each consisting of 14 items. Depression refers to symptoms such as apathy and hopelessness, anxiety due to autonomic system activation and situational anxiety, while stress refers to impatience, chronic arousal and agitation. The participants provided answers on a 4-point assessment scale (0 – does not refer to me at all, 3 – refers to me completely), whereby a higher score indicated a greater severity of symptoms. The reliability coefficients in this study were the following: depression (α = 0.96), anxiety (α = 0.92), stress (α = 0.95).

The Satisfaction with Life Scale (37) consists of five items measuring the global cognitive assessments of satisfaction with life. The participants indicated their level of agreement with each statement using a 7-point scale (1 – I strongly disagree, 7 – I completely agree). The total result was determined as the sum of all assessments, whereby a higher score indicated higher satisfaction with life. The reliability coefficient α in this study amounted to 0.86.

Statistical analyses

In order to provide an answer to the set goals, the main descriptive factors were analyzed, the intercorrelations between individual groups of variables were calculated, and hierarchical regression analyses were conducted in which particular measures of psychological well-being (depression, anxiety, stress and life satisfaction) served as the criteria.

Postupak istraživanja

Istraživanje je dobilo odobrenje Etičkog povjerenstva Odjela za psihologiju na Sveučilištu u Zadru. Ispitivanje je provedeno *online* putem različitih *Facebook* grupa; uključujući grupe poput Centra za reproduktivno mentalno zdravlje, Mame na Fejsu, Mame iz različitih gradova te grupe posvećene trudnicama i majkama. Sudjelovanje u istraživanju bilo je dobrovoljno, uz zajamčenu anonimnost sudionica, a na početnoj stranici istraživanja bile su jasno istaknute svrha i ciljevi istraživanja. Sudionicama je naglašeno da imaju pravo odustati u bilo kojem trenutku. Također, ponuđena im je mogućnost kontakta s Centrom za reproduktivno mentalno zdravlje za stručnu pomoć, ako im istraživanje izazove neugodne emocionalne reakcije.

Study procedure

The study was approved by the Ethics Committee of the Department of Psychology at the University of Zadar. The study was conducted online, via various Facebook groups; including groups such as *Centar za reproduktivno mentalno zdravlje* (Centre for Reproductive Mental Health), *Mame na Fejsu* (Moms on Facebook), *Mame iz različitih gradova* (Moms from Different Cities) and groups dedicated to pregnant women and mothers. Participation in the study was voluntary, with guaranteed anonymity of the participants, and the purpose and aims of the study were clearly stated on the study home page. It was emphasized to the participants that they had the right to withdraw from participation in the study at any time. Furthermore, they were offered the possibility to contact the Centre for Reproductive Mental Health in order to receive professional help if this study caused any unpleasant emotional reactions.

REZULTATI

Ispitivanje razina depresivnosti, anksioznosti, stresa i zadovoljstva životom

Osnovni deskriptivni čimbenici prikazani su u tablici 1.

Analize distribucija rezultata (tablica 1) pokazuju da su asimetričnost i kurtičnost unutar prihvatljivih granica normalne raspodjele, što omogućuje korištenje parametrijskih postupaka (38). Prosječni rezultati na Ljestvici zadovoljstva životom ukazuju na općenito visoku razinu zadovoljstva, dok su rezultati na podljestvicama depresivnosti, anksioznosti i stresa pokazali generalno prosječne razine simptoma. Većina sudionica doživljava normalne razine simptoma, no približno 12 % doživljava teške, a više od 17 % izrazito teške simptome anksioznosti. Oko 8 % sudionica izvještava o ozbiljnim ili izrazito ozbiljnim simptomima depresivnosti, dok preko 17 % doživljava teške, a oko 9 % izrazito teške simptome stresa.

RESULTS

Assessment of depression, anxiety, stress and life satisfaction levels

The main descriptive factors are presented in Table 1.

The result distribution analyses (Table 1) indicate that skewness and kurtosis are within the acceptable limits of normal distribution, which enables the use of parametric procedures (38). The average results obtained on the Satisfaction with Life Scale indicate a generally high level of satisfaction, while the results obtained in the depression, anxiety and stress subscales showed generally average symptom levels. The majority of the participants experienced normal symptom levels, however, approximately 12% of them experienced severe symptoms, and 17% experienced extremely severe symptoms of anxiety. Around 8% of the participants reported experiencing severe or extremely severe symptoms of depression, while over 17% experienced severe, and around 9% experienced extremely severe symptoms of stress.

TABLICA 1. Deskriptivni čimbenici i pokazatelji normalnosti distribucije za korištene varijable (N=152)
TABLE 1. Descriptive factors and indicators of normality of distribution for the variables used (N=152)

	M	SD	Min	Maks / Max	Asimetričnost / Skewness	Kurtičnost / Kurtosis	K-S
Dob / Age	32,97	6,73	21	50	0,50	-0,36	0,10
Zdravstveno stanje / Health status	3,99	0,79	2	5	-0,39	-0,38	0,25**
Gestacijska dob / Gestational age	9,96	4,31	2	24	1,51	2,32	0,18**
Proteklo vrijeme / Time passed	176,16	248,15	1	1456	2,26	6,11	0,25**
Uznemirenost / Distress	4,78	0,51	3	5	-2,35	4,68	0,49**
Predvidljivost / Predictability	1,97	1,20	1	5	0,97	-0,18	0,29**
Magnituda / Magnitude	3,97	0,99	1	5	-0,64	-0,32	0,23**
Problemsko suočavanje / Problem-focused coping	28,61	6,27	14	40	-0,18	-0,73	0,09
Emocionalno suočavanje / Emotion- focused coping	17,40	2,84	12	24	0,03	-0,67	0,08
Izbjegavajuće suočavanje / Avoidance coping	20,98	4,72	12	34	0,26	-0,25	0,07
Socijalna PP / Social PS	4,17	1,03	1	5	-1,28	0,83	0,21**
Podrška okoline / Environment support	2,02	0,44	1	3	0,41	-0,19	0,09
KBK / QMC	5,44	1,39	1,2	7	-1,05	0,45	0,15**
Depresivnost / Depression	9,56	10,21	0	40	1,12	0,49	0,18**
Anksioznost / Anxiety	10,11	9,29	0	42	1,09	0,62	0,17**
Stres / Stress	16,95	11,16	0	42	0,36	-0,92	0,11*
Zadovoljstvo životom / Life satisfaction	23,75	5,91	9	35	-0,25	-0,48	0,10

Legenda: Proteklo vrijeme - vrijeme prošlo od posljednjeg spontanog pobačaja (u tjednima), Socijalna PP – socijalna podrška partnera, KBK – kvaliteta bračne komunikacije, K-S - Kolmogorov-Smirnov test; * - p <0,05; ** - p <0,01
/ Legend: Time passed – time passed since the last miscarriage (in weeks), Social PS – social partner support, QMC – quality of marital communication, K-S - Kolmogorov-Smirnov test; * - p <0.05; ** - p <0.01

U okviru prvog problema istraživanja analizirane su interkorelacije između pojedinih varijabli koje su uključene u daljnje analize, te je vidljivo da je riječ uglavnom o niskim međusobnim korelacijama (tablica 2). Vidljivo je da je viša dob povezana s nižim razinama depresivnosti i stresa. Sudionice s višim materijalnim prilikama i boljim zdravstvenim stanjem izvještavaju o boljoj psihološkoj dobrobiti (veće zadovoljstvo životom i niže razine depresivnosti, anksioznosti i stresa). Žene koje imaju djecu izvještavaju o nižim razinama depresivnosti, anksioznosti i stresa te većem zadovoljstvu životom.

Kada je riječ o karakteristikama spontanog pobačaja, analize su pokazale da što je više vremena proteklo od spontanog pobačaja, to su sudionice izvještavale o boljoj psihološkoj dobrobiti (odnosno nižim razinama depresivnosti, anksioznosti i stresa te većem zadovoljstvu životom). Međutim, veća gestacijska dob fetusa u trenutku gubitka trudnoće povezana je s nižim zadovoljstvom životom. Žene koje su planirale trudnoću izvještavaju o većem zadovoljstvu životom. Viša procjena uznemirenosti zbog spontanog pobačaja pozitivan je

As part of the first research problem, the intercorrelations between individual variables which were included in further analyses were investigated, and it was evident that these were mainly low mutual correlations (Table 2). It can be observed that older age is associated with lower levels of depression and stress. Participants with better material circumstances and better health reported better psychological well-being (higher satisfaction with life and lower levels of depression, anxiety and stress). Women who have children reported lower levels of depression, anxiety and stress, and higher satisfaction with life.

In terms of the characteristics of the miscarriage, analyses have shown that the more time had passed since the miscarriage, the better was the psychological well-being reported by the participants (i.e. lower levels of depression, anxiety and stress, and higher satisfaction with life). However, higher gestational age of the fetus at the time of pregnancy loss was associated with lower satisfaction with life. Women who planned their pregnancies reported higher satisfaction with life. Higher assessments in terms of distress due to the miscarriage are positively correlated with depression, anxiety and stress

korelat simptoma depresivnosti, anksioznosti i stresa, odnosno negativan korelat zadovoljstva životom. Sudionice koje percipiraju više socijalne podrške partnera imaju manje simptoma depresivnosti i stresa, te su zadovoljnije životom. Sudionice koje imaju kvalitetniju komunikaciju s partnerom te veću podršku okoline pokazuju manje simptoma depresivnosti, anksioznosti i stresa te su zadovoljnije životom. S druge strane, sudionice koje češće koriste izbjegavajuće suočavanje manje su zadovoljne životom te imaju više simptoma depresivnosti, anksioznosti i stresa, dok sudionice koje koriste emocionalno suočavanje pokazuju manje simptoma depresivnosti i veće zadovoljstvo životom. Varijable razina obrazovanja, broj pobačaja, predvidljivost spontanog pobačaja i problemsko suočavanje nisu pokazale povezanost ni s jednom kriterijskom varijablom te zbog preglednosti nisu prikazane u tablici 2.

Regresijske analize

Provedene su četiri hijerarhijske regresijske analize pri čemu su kriteriji bili pojedini indikatori psihološke dobrobiti odnosno anksioznost, depresivnost, stres i zadovoljstvo životom. U prvom i drugom koraku uvedene su sociodemografske karakteristike i karakteristike spontanog pobačaja koje su se pokazale povezanima s pojedinim kriterijskim varijablama. U trećem su koraku uvedene strategije suočavanja, a u četvrtom socijalna podrška partneru i okoline te kvaliteta bračne komunikacije.

Rezultati hijerarhijske regresijske analize za kriterij depresivnosti prikazani su u tablici 3. Dobiveni rezultati impliciraju da sudionice koje svoje zdravstveno stanje procjenjuju boljim te sudionice koje izvještavaju o manjem negativnom utjecaju spontanog pobačaja (na njihov svakodnevni život) imaju manje simptoma depresivnosti. Kvalitetnija bračna komunikacija povezana je s manje simptoma depresivnosti.

symptoms, i.e. a negatively correlated with life satisfaction. The participants who received more social support from their partners experienced fewer symptoms of depression and stress, and were more satisfied with their lives. The participants who had better communication with their partners and higher support from their environment displayed fewer symptoms of depression, anxiety and stress, and were more satisfied with their lives. On the other hand, the participants who used avoidance coping strategies more frequently were less satisfied with their lives and experienced more symptoms of depression, anxiety and stress, while those participants who used emotion-focused coping displayed fewer symptoms of depression and higher life satisfaction. No association was observed between the education level, number of miscarriages, predictability of miscarriage and problem-focused coping variables and any of the criterion variables, therefore, for reasons of clarity, they were not presented in Table 2.

Regression analyses

Four hierarchical regression analyses were conducted in which the individual psychological well-being indicators, i.e. anxiety, depression, stress and life satisfaction, served as the criteria. Sociodemographic characteristics and characteristics regarding the miscarriage which proved to be associated with individual criterion variables were introduced in the first and second steps. Coping strategies were introduced in the third step, while social partner support and support from the environment, as well as marital communication quality, were introduced in the fourth step. The results of hierarchical regression analysis for the depression criterion are presented in Table 3. The obtained results imply that the participants who assessed their own health better and those who reported experiencing fewer negative effects of the miscarriage (on their everyday lives) had fewer symptoms of depression. Better marital communication was associated with fewer depression symptoms. In

TABLICA 2. Korelacije između pojedinih varijabli korištenih u ovom istraživanju (N=152)
TABLE 2. Correlations between individual variables used in this study (N=152)

	1 Dob / Age	2 MP / MC	3 ZS / HS	4 BD / WC	5 PV / TP	6 GD / GA	7 P	8 U / D	9 M	10 IS / AC	11 ES / EC	12 PP / PS	13 PO / ES	14 KBK / QMC	15 D	16 A	17 S	18 ZŽ / LS
1	-	-0,16*	0,00	0 ,49**	0 ,59**	0,01	0,12	-0,07	-0,01	-,001	0,08	-0,13	0,09	-0,14	-0,17*	-0,13	-0,17*	0,06
2		-	0,06	-0,20*	-0,13	0,04	0,14	0,15	0,07	-0,15	-0,03	0,20*	0,04	0,18*	-0,05	-0,08	-0,07	0,23**
3			-	-0,02	-0,07	-0,13	0,17*	-0,08	-0,12	-0,16*	0,24**	0,25**	0,28**	0,27**	-0,33**	-0,32**	-0,39**	0,34**
4				-	0,44**	-0,04	-0,06	0,01	-0,16	-0,07	0,03	-0,22**	0,01	-0,19*	-0,21**	-0,09	-0,18*	,17*
5					-	0,02	-0,08	-0,06	-0,12	-0,07	0,05	-0,04	0,07	-0,04	-0,21**	-0,17*	-0,21**	0,16*
6						-	0,12	0,17*	0,16*	0,17*	-0,09	0,03	0,17*	-,011	0,11	0,09	0,08	-0,17*
7							-	0,14	0,09	-0,14	0,06	0,29**	0,08	0,21*	-0,06	-0,13	-0,04	0,16*
8								-	0,43**	0,09	-0,23**	0,10	-0,08	0,06	0,19*	0,13	0,14	0,02
9									-	0,33**	-0,19*	-0,18*	-0,17*	-0,14	0,40**	0,26**	0,32**	-0,22**
10										-	-0,14	-0,23**	-0,14	-0,28**	0,49**	0,43**	0,49**	-0,38**
11											-	0,13	0,12	0,11	-0,23**	-0,09	-0,16	0,18*
12												-	0,22**	0,81**	-0,27**	-0,15	-0,23**	0,42**
13													-	0,13	-0,23**	-0,19*	-0,29**	0,27**
14														-	-0,35**	-0,31**	-0,36**	0,48**
15															-	0,76**	0,79**	-0,59**
16																-	0,83**	-0,45**
17																	-	-0,54**
18																		-

Legenda: MP - materijalne prilike (prosječne/iznadprosječne), ZS - subjektivna procjena zdravstvenog stanja, BD - ima/nema djecu, PV - vrijeme proteklo od posljednjeg spontanog pobačaja (u tjednima), GD - gestacijska dob, P - planiranost, U - procjena uznemirenosti, M - magnituda; procjena negativnog utjecaja događaja na svakodnevni život, IS - izbjegavajuće suočavanje, ES - emocionalno suočavanje, PP - socijalna podrška partneru, PO - podrška okoline, KBK - kvaliteta bračne komunikacije, D - depresivnost, A - anksioznost, S -stres, ZŽ - zadovoljstvo životom, * - p<0,05, ** - p<0,01
/ Legend: MC – material circumstances (average/above average), HS – subjective health status assessments, WC - with/without children, TP – time passed since the last miscarriage (in weeks), GA – gestational age, P - planned, D – distress assessment, M - magnitude; assessment of negative impact of the event on everyday life, AC – avoidance coping, EC – emotion-focused coping, PS – social partner support, ES – environment support, QMC – quality of marital communication, D - depression, A - anxiety, S - stress, LS – life satisfaction, * - p<0.05, ** - p<0.01

Nasuprot tome, sudionice koje izvještavaju o češćem korištenju izbjegavajućih strategija suočavanja imaju više simptoma depresivnosti. Konačni model objašnjava oko 37 % varijance depresivnosti.

Druga analiza provedena je za kriterij simptoma anksioznosti (tablica 4). Postupak uvođenja varijabli u analizu bio je identičan kao u prethodnoj analizi. Konačni model objašnjava 28 % varijance kriterija. Rezultati pokazuju da sudionice s boljim zdravstvenim stanjem, duljim vremenom od spontanog pobačaja te boljom kvalitetom komunikacije s partnerom doživljavaju manje simptoma anksioznosti. S druge strane, izbjegavajuće suočavanje pozitivno je povezano sa simptomima anksioznosti

contrast, the participants who reported using avoidance coping strategies more frequently experienced more depression symptoms. The final model explains around 37% of the depression variance.

The second analysis was conducted for the anxiety symptoms criterion (Table 4). The procedure for introducing the variables into the analysis was identical to the previous analysis. The final model explains 28% of the criterion variance. The results showed that the participants with better health, longer time period since the miscarriage and better communication with their partner experienced fewer symptoms of anxiety. On the other hand, there was a positive association between avoidance coping strategies and symptoms of

TABLICA 3. Rezultati hijerarhijske analize za kriterij depresivnosti (N=152)
TABLE 3. Hierarchical analysis results for the depression criterion (N=152)

	korak / step	korak / step	korak / step	korak / step
	β	β	β	β
Dob / Age	-0,07	-0,04	-0,04	-0,05
ZS / HS	-0,30**	-0,27**	-0,22**	-0,16*
Djeca / Children	-0,17*	-0,09	-0,09	-0,13
Proteklo vrijeme / Time passed		-0,12	-0,11	-0,09
Uznemirenost / Distress		0,02	0,03	0,05
Magnituda / Magnitude		0,30**	0,21**	0,17**
IS / AC			0,33**	0,28**
ES / EC			-0,06	-0,06
SPP / SPS				0,03
Podrška okoline / Environment support				-0,06
KBK / QMC				-0,23*
R2	0,15	0,27	0,38	0,42
R2kor / R2cor	0,13	0,24	0,34	0,37
F(df)	8,40**	8,80**	9,66**	8,55**
	(3,15)	(6,15)	(9,14)	(12,14)
ΔR2		0,12	0,11	0,04

Legenda: ZS - procjena zdravstvenog stanja, Djeca – nema/ima djecu, Proteklo vrijeme - vrijeme proteklo od posljednjeg spontanog pobačaja (u tjednima), Uznemirenost - procjena uznemirenosti uzrokovane spontanim pobačajem, Magnituda - procjena negativnog utjecaja događaja na svakodnevni život, KBK - kvaliteta bračne (partnerske) komunikacije, IS - izbjegavajuće suočavanje, ES - emocionalno suočavanje, SPP- socijalna podrška partnera, β - vrijednost standardiziranog regresijskog koeficijenta, R2 - ukupan doprinos prediktora objašnjenoj varijanci, R2kor - korigirani koeficijent multiple determinacije, F - vrijednost F-omjera, df - stupnjevi slobode, ΔR2 - promjena u postotku objašnjene varijance prediktora, * - p<0,05, ** - p<0,01
/ Legend: HS – health status assessment, Children – with/without children, Time passed - time passed since the last miscarriage (in weeks), Distress – assessment of distress caused by the miscarriage, Magnitude - assessment of negative impact of the event on everyday life, QMC – quality of marital (partner) communication, AC - avoidance coping, EC - emotion-focused coping, SPS - social partner support, β - standardized regression coefficient value, R2 – total predictor contribution to explained variance, R2cor - corrected multiple determination coefficient, F – F-ratio value, df – degrees of freedom, ΔR2 - change in the percentage of explained predictor variance, * - p<0.05, ** - p<0.01

TABLICA 4. Rezultati hijerarhijske analize za kriterij anksioznosti (N=152)
TABLE 4. Hierarchical analysis results for the anxiety criterion (N=152)

	korak / step	korak / step	korak / step	korak / step
	β	β	β	β
ZS / HS	-0,29**	-0,28**	-0,25**	-0,21**
Proteklo vrijeme / Time passed		-0,15*	-0,14*	-0,14*
Magnituda / Magnitude		0,19**	0,12	0,12
IS / AC			0,32**	0 ,29**
ES / EC			0,05	0,05
SPP / SPS				0 ,23
Podrška okoline / Environment support				-0,07
KBK / QMC				-0,30**
R	0,09	0,17	0,27	0,32
R2kor / R2cor	0,09	0,15	0,24	0,28
F(df)	15,55*	9,93**	9,02**	7,44**
	(1,15)	(3,15)	(6,15)	(9,14)
ΔR2		0,08	0,10	0,05

Legenda: ZS - procjena zdravstvenog stanja, Proteklo vrijeme - vrijeme proteklo od posljednjeg spontanog pobačaja (u tjednima), Magnituda - procjena negativnog utjecaja događaja na svakodnevni život, IS - izbjegavajuće suočavanje, ES - emocionalno suočavanje, SPP – socijalna podrška partnera, KBK - kvaliteta bračne komunikacijeβ - vrijednost standardiziranog regresijskog koeficijenta, R2 - ukupan doprinos prediktora objašnjenoj varijanci, R2kor - korigirani koeficijent multiple determinacije, F - vrijednost F-omjera, df - stupnjevi slobode, ΔR2 - promjena u postotku objašnjene varijance prediktora, * - p<0,05, ** - p<0,01
/ Legend: HS – health status assessment, Time passed - time passed since the last miscarriage (in weeks), Magnitude - assessment of negative impact of the event on everyday life, AC - avoidance coping, EC - emotion-focused coping, SPS- social partner support, QMC - quality of marital communication, β - standardized regression coefficient value, R2 – total predictor contribution to explained variance, R2cor - corrected multiple determination coefficient, F – F-ratio value, df – degrees of freedom, ΔR2 - change in the percentage of explained predictor variance, * - p<0.05, ** - p<0.01

(pri čemu socijalna podrška partnera pokazuje supresorski efekt budući da nije u korelaciji s navedenim kriterijem).

Treća analiza usmjerena je na simptome stresa no uvedeni su različiti sociodemografski čim-

anxiety (whereby social support from the partner had a suppressor effect since it had no correlation with the abovementioned criterion).

The focus of the third analysis was on the symptoms of stress, however different sociodemo-

benici i čimbenici povezani s karakteristikama spontanog pobačaja, ovisno o prethodno utvrđenim korelacijama između prediktorskih i kriterijske varijable stresa (tablica 5). Postavljeni model objašnjava oko 41 % varijance kriterija. Rezultati pokazuju da manje simptoma stresa doživljavaju sudionice koje imaju kvalitetniju bračnu komunikaciju i veću podršku okoline te sudionice boljeg zdravstvenog stanja. Suprotno, više simptoma stresa doživljavaju sudionice koje koriste izbjegavajuće strategije suočavanja.

Što se tiče zadovoljstva životom, postavljeni model objašnjava 38 % varijance kriterija. Pritom, značajni doprinos ostvaruju podrška okoline i kvaliteta bračne komunikacije. Veće zadovoljstvo životom imaju sudionice boljeg materijalnog i zdravstvenog stanja, kao i one koje imaju djecu, veću podršku okoline i kvalitetniju bračnu komunikaciju. S druge strane, one koje koriste izbjegavajuće suočavanje manje su zadovoljne životom. Rezultati hijerarhijske regresijske analize za kriterij zadovoljstva životom prikazani su u tablici 6.

graphic factors and factors associated with the characteristics of the miscarriages were introduced, depending on the previously determined correlations between predictor variables and the stress criterion variable (Table 5). The set model explains around 41% of the criterion variance. The results indicate that those participants who had better marital communication and more support from the environment, as well as those with better health, experienced fewer stress symptoms. In contrast, the participants who used avoidant coping strategies experienced more stress symptoms.

As regards satisfaction with life, the set model explains 38% of the criterion variance. In that respect, support from the environment and the quality of marital communication had a significant contribution. Participants with a better material and health status were more satisfied with their lives, as well as those that have children, better support from their environment and better marital communication. On the other hand, those who used avoidance coping strategies were less satisfied with life. The results of hierarchical regression analysis for the life satisfaction criterion are presented in Table 6.

TABLICA 5. Rezultati hijerarhijske analize za kriterij stresa (N=152)
TABLE 5. Hierarchical analysis results for the stress criterion (N=152)

	korak / step	korak / step	korak / step	korak / step
	β	β	β	β
Dob / Age	-0,09	-0,04	-0,06	-0,07
Zdravstveno stanje / Health status	-0,36**	-0,34**	-0,30**	-0,23**
Broj djece / Number of children	-0,14	-0,07	-0,05	-0,09
Proteklo vrijeme / Time passed		-0,15	-0,12	-0,10
Magnituda / Magnitude		0,23**	0,12	0,10
IS / AC			0,35**	0,30**
ES / EC			-0,01	-0,01
SPP / SPS				0,12
Podrška okoline / Environment support				-0,13*
KBK / QMC				-0,29**
R2	0,18	0,26	0,39	0,45
R2kor / R2cor	0,16	0,23	0,35	0,41
F(df)	10,85** (3,15)	10,20** (5,15)	11,28** (8,14)	10,41** (11,14)
ΔR2		0,08	0,13	0,06

Legenda: ZS - procjena zdravstvenog stanja, Proteklo vrijeme - vrijeme proteklo od posljednjeg spontanog pobačaja (u tjednima), Magnituda - procjena negativnog utjecaja događaja na svakodnevni život, IS - izbjegavajuće suočavanje, ES - emocionalno suočavanje, SPP – socijalna podrška partnera, KBK - kvaliteta bračne komunikacijeβ - vrijednost standardiziranog regresijskog koeficijenta, R2 - ukupan doprinos prediktora objašnjenoj varijanci, R2kor - korigirani koeficijent multiple determinacije, F - vrijednost F-omjera, df - stupnjevi slobode, ΔR2 - promjena u postotku objašnjene varijance prediktora, * - p<0,05, ** - p<0,01
/ Legend: HS – health status assessment, Time passed - time passed since the last miscarriage (in weeks), Magnitude - assessment of negative impact of the event on everyday life, AC - avoidance coping, EC - emotion-focused coping, SPS- social partner support, QMC - quality of marital communication, β - standardized regression coefficient value, R2 – total predictor contribution to explained variance, R2cor - corrected multiple determination coefficient, F – F-ratio value, df – degrees of freedom, ΔR2 - change in the percentage of explained predictor variance, * - p<0.05, ** - p<0.01

TABLICA 6. Rezultati hijerarhijske analize za kriterij zadovoljstva životom (N=152)
TABLE 6. Hierarchical analysis results for the life satisfaction criterion (N=152)

	korak / step	korak / step	korak / step	korak / step
	β	β	β	β
Materijalne prilike / Material circumstances	0,24**	0,24**	0,21**	0,18**
ZS / HS	0,30**	0,26**	0,23**	0,14*
Djeca / Children	0,21**	0,13	0,13	0,21**
Proteklo vrijeme / Time passed		0 ,14	0,13	0,09
Gestacijska dob / Gestational age		-0,13	-0,10	-0,11
Planiranost / Planned		0,12	0,08	0,04
Magnituda / Magnitude		-0,15*	-0,08	-0,02
IS / AC			-0,21**	-0,14*
ES / EC			0,05	0,05
SPP / SPS				,09
Podrška okoline / Environment support				,13*
KBK / QMC				,27**
R	0,19	0,26	0,31	0,44
R2kor / R2cor	0,18	0,23	0,26	0,38
F(df)	11,83**	7,38**	6,29**	8,22**
	(3,15)	(7,14)	(10,14)	(13,14)
ΔR2		0,07	0,05	0,13

Legenda: Materijalne prilike (prosječne/iznadprosječne), ZS - procjena zdravstvenog stanja, , Djeca - nema/ima
/ Legend: Material circumstances (average/above average), HS – health status assessment, Children - with/without

RASPRAVA

Osnovni cilj istraživanja bio je istražiti povezanost različitih rizičnih i zaštitnih čimbenika sa simptomima anksioznosti, depresivnosti i stresa kod žena koje su imale iskustvo spontanog pobačaja. U prvom dijelu istraživanja analizirane su povezanosti između osobnih karakteristika sudionica, specifičnih aspekata spontanog pobačaja te njihovih rezultata na mjerama anksioznosti, depresivnosti, stresa i zadovoljstva životom.

Rezultati su pokazali da je viša dob povezana s manje simptoma depresivnosti i stresa, dok su bolje materijalne prilike povezane s većim zadovoljstvom životom. Sudionice koje procjenjuju svoje zdravstveno stanje boljim imaju manje simptoma depresivnosti, anksioznosti i stresa, što ukazuje da dobro zdravstveno stanje može djelovati kao zaštitni čimbenik za mentalno zdravlje nakon spontanog pobačaja (39). Što se tiče broja djece, rezultati ukazuju da majke koje imaju djecu doživljavaju manje simptoma depresivnosti te su zadovoljnije životom. Ovi rezultati podržavaju prethodna istraživanja koja su istaknula važnost navedenih zaštitnih

DISCUSSION

The main aim of the study was to explore the connection between the various risk and protective factors and the symptoms of anxiety, depression and stress in women who have experienced miscarriage. In the first part of the study, we analyzed the connections between the personal characteristics of the participants, the specific aspects of the miscarriages and their results in relation to the measures of anxiety, depression, stress and life satisfaction.

The results showed that older age was associated with fewer symptoms of depression and stress, while better material circumstances were associated with higher life satisfaction. The participants who assessed they were in better health experienced fewer symptoms of depression, anxiety and stress, which indicates that good health could act as a protective factor for mental health after a miscarriage (39).

As regards the number of children, the results indicate that mothers with children experienced fewer symptoms of depression and more satisfaction with life. These results support the findings of previous studies which highlighted the

faktora (10,23,40,41). Rezultati provedenog istraživanja pokazuju da su sudionice zadovoljnije životom te pokazuju manje simptoma depresivnosti, anksioznosti i stresa što je više vremena prošlo od spontanog pobačaja. Dobiveni rezultati potkrepljuju polazište teorija hedonističkog kruga i zadane vrijednosti (42,43). Teorija hedonističkog kruga pretpostavlja da će se zadovoljstvo životom tijekom procesa prilagodbe (unatoč jakom utjecaju velikih životnih događaja) vratiti na osnovnu razinu specifičnu za pojedinca (42). Također, ovi rezultati podržavaju i postavke teorije zadane vrijednosti koja implicira da se ljudi mogu prilagoditi gotovo svim životnim događajima pri čemu se vremenom smanjuje intenzitet emocionalnih reakcija (43). Pri interpretaciji ovih rezultata važno je napomenuti da je nešto više od 40 % žena u ovom istraživanju doživjelo spontani pobačaj prije više od godinu dana. Iako simptomi anksioznosti i depresivnosti mogu trajati duže (44), rezultati istraživanja (28) pokazuju da se ti simptomi često povlače unutar godine dana ili ranije. Također je bitno naglasiti da većinu uzorka čine žene koje su zadovoljne partnerskim odnosom te kvalitetom bračne komunikacije. Naime, prethodna istraživanja pokazuju da zadovoljstvo partnerskim odnosom olakšava proces tugovanja te se povezuje s posttraumatskim rastom kod žena (45).

Gestacijska dob fetusa pri kojoj je došlo do gubitka trudnoće negativno je povezana sa zadovoljstvom životom, drugim riječima, što je žena duže bila trudna kad se pobačaj dogodio, zadovoljstvo životom je manje. Ovi nalazi u skladu su s pretpostavkama o razvoju privrženosti između majke i njena djeteta pri čemu će reakcije na gubitak biti izraženije kod onih žena kod kojih je emocionalna veza duže stvarana (46). Drugim riječima, prekid emocionalne veze s nerođenim djetetom može imati negativne implikacije na procjene zadovoljstva životom nakon gubitka trudnoće. Dodatno, one sudionice koje procjenjuju da ih je spontani pobačaj više uzne-

importance of the abovementioned protective factors (10, 23, 40, 41). The results of the conducted study indicate that the participants were more satisfied with their lives and displayed fewer symptoms of depression, anxiety and stress after more time had passed since the miscarriage. The obtained results support the views of the hedonic treadmill and the default value theories (42, 43). The hedonic treadmill theory suggests that during the adaptation process (despite the strong influence of major life events) an individual's satisfaction with life will return to a baseline level specific for the individual (42). Furthermore, these results also support the assumptions of the default value theory which implies that people can adapt to almost any situation in life, whereby the intensity of emotional reactions decreases with time (43). When interpreting these results, it is important to mention that a little over 40% of the women participating in this study experienced the miscarriage more than a year before the study. Although the symptoms of anxiety and depression could last longer (44), the results of this study (28) indicate that these symptoms often resolve within one year or earlier. It should also be noted that the majority of the sample consisted of women who were satisfied with the relationship with their partner and the quality of marital communication. Namely, previous studies indicated that satisfaction with one's partner relationship facilitates the grieving process and is associated with posttraumatic growth in women (45).

The gestational age of the fetus at the time of pregnancy loss was negatively associated with life satisfaction, in other words, the longer a woman was pregnant at the time of miscarriage, the lower was her life satisfaction. These findings are consistent with the assumptions on the development of attachment between a mother and her child, whereby the reactions to the loss will be more pronounced in women whose emotional connection was being created for a longer time (46). In other words, the termination of emotional connection with one's unborn child can have negative implications for the assessments of life

mirio izvještavaju o više simptoma depresivnosti te sukladno tome veća magnituda stresnog događaja pozitivan je korelat simptoma anksioznosti, depresivnosti i stresa te negativan zadovoljstva životom. Ovi nalazi upućuju da je riječ o kumulativnom djelovanju stresnih životnih događaja (20,47).

Kada je riječ o strategijama suočavanja, rezultati istraživanja su pokazali da sudionice koje češće koriste izbjegavajuće strategije suočavanja pokazuju više simptoma anksioznosti, depresivnosti i stresa te su manje zadovoljne životom. Ovi rezultati podupiru neke prethodne nalaze (23,41) koji impliciraju da je učestalije korištenje strategija kao što su odustajanje, poricanje i samookrivljavanje povezano s lošijom psihološkom prilagodbom. Emocionalno suočavanje u negativnom je odnosu sa simptomima depresivnosti, a u pozitivnom sa zadovoljstvom životom što upućuje da emocionalno suočavanje može imati korisne učinke nakon spontanog pobačaja poboljšavajući psihološke ishode i kvalitetu života (25,26). S druge strane, problemsko suočavanje nije bilo povezano ni s jednom ispitivanom varijablom, što podupire prethodna istraživanja koja ukazuju da u situacijama s malo kontrole, poput zdravstvenih problema, emocionalno suočavanje prevladava (25). Rezultati istraživanja pokazuju da je veća socijalna podrška partnera i okoline povezana s nižim razinama depresivnosti i stresa te većim zadovoljstvom životom. Dodatno, podrška okoline negativno je povezana sa simptomima anksioznosti. U skladu s očekivanjem, kvaliteta bračne komunikacije negativno je povezana sa simptomima iz sve tri skupine (depresivnost, anksioznost i stres), no dobivena je pozitivna povezanost sa zadovoljstvom životom. Ovi nalazi podupiru postavke modela socijalno kognitivne obrade kao i teorije razgovorom potaknute ponovne procjene (48,49). Prema modelu socijalno-kognitivne obrade (49), razgovaranje je jedan od ključnih čimbenika koji olakšava oporavak nakon traumatskog događaja pri

satisfaction after pregnancy loss. In addition, the participants who estimated that they were more disturbed by the miscarriage reported experiencing more depression symptoms, so accordingly, a higher magnitude of a stressful event was positively correlated with the symptoms of anxiety, depression and stress, and negatively correlated with life satisfaction. These findings point to a cumulative effect of stressful life events (20, 47).

In terms of coping strategies, study results have shown that the participants who used avoidance coping strategies more frequently displayed more symptoms of anxiety, depression and stress, and were less satisfied with life. These results support some previous findings (23, 41) which imply that a more frequent use of strategies such as giving up, denial and self-blame is associated with poorer psychological adjustment. Emotion-focused coping is negatively associated with the symptoms of depression, but is positively associated with life satisfaction, indicating that emotion-focused coping can have beneficial effects after a miscarriage by improving the psychological outcomes and the quality of life (25, 26). On the other hand, problem-focused coping was not associated with any of the examined variables, thus supporting the findings of previous studies which indicated that in situations with little control, such as health problems, emotional-focused coping prevails (25). Study results have shown that higher social support from the partner and the environment is associated with lower levels of depression and stress, and higher life satisfaction. Additionally, support from the environment is negatively associated with anxiety symptoms. In line with the expected results, the quality of marital communication is negatively associated with the symptoms relating to all three groups (depression, anxiety and stress), however, a positive association was observed in terms of life satisfaction. These findings support the assumptions of the social cognitive processing model, as well as conversation-based reassessment theory (48, 49). According to the social cognitive processing model (49), conversation is one of the key factors that facilitates recovery after a traumatic event,

čemu socijalna podrška smanjuje stres djelujući na kognitivnu obradu informacija. Drugim riječima, socijalna podrška pomaže u konsolidaciji trenutnih informacija, pruža novu perspektivu o događaju te povećava osjećaj kontrole nad emocionalnim reakcijama. Sukladno tome, inhibiranje razgovora o doživljenoj traumi smanjuje sposobnost obrade tih iskustava. Dodatno, prema teoriji razgovorom potaknute ponovne procjene (45,48) podržavajući razgovor omogućava pojedincu artikulaciju, elaboraciju i razjašnjavanje relevantnih misli i osjećaja. Istraživanja dodatno pokazuju da je dijeljenje tuge s drugima jedan od najsnažnijih prediktora njenog razrješenja (50) pri čemu najviše razine depresivnosti u razdoblju od 6 mjeseci nakon spontanog pobačaja imaju žene (51) čiji partneri nisu željeli razgovarati o pobačaju.

Doprinos pojedinih rizičnih i zaštitnih čimbenika u objašnjenju psihološke dobrobiti kod žena koje su doživjele spontani pobačaj

Regresijskim analizama, u konačnom modelu, objašnjeno je 37 % varijance depresivnosti, 28 % varijance anksioznosti te 41 % varijance stresa. Rezultati pokazuju da se dobro zdravstveno stanje pokazalo pozitivnim prediktorom psihološke dobrobiti (konkretnije bolje zdravstveno stanje u negativnoj je vezi s razinama anksioznosti, depresivnosti i stresa, odnosno u pozitivnoj vezi sa zadovoljstvom životom). Pritom je bitno istaknuti da je spontani pobačaj gubitak te da faze tugovanja između ostalog uključuju i fazu depresivnosti (40). Osim što se očituju emocionalnim simptomima, depresivnost, anksioznost i stres mogu se manifestirati i fizičkim simptomima kao što su umor, nedostatak energije, promjene u apetitu i spavanju, mišićna napetost, glavobolje, povišen krvni tlak, ubrzano disanje i poremećaji spavanja. Nalazi pokazuju da sudionice koje imaju djecu imaju manje simptoma depresivnosti što

in which case social support reduces stress by affecting the cognitive processing of information. In other words, social support helps consolidate the current information, provides a new perspective with regard to the event and increases the sense of control over one's emotional reactions. Accordingly, inhibiting conversations about the experienced trauma reduces the ability to process these experiences. Furthermore, according to the conversation-based reassessment theory (45, 48) supportive conversation enables the individual to articulate, elaborate and clarify the relevant thoughts and emotions. Studies have additionally shown that sharing one's grief with others represents one of the strongest predictors of its resolution (50), whereby the highest levels of depression in the period of six months after the miscarriage are experienced by women (51) whose partners did not want to talk about the miscarriage.

Contribution of individual risk and protective factors to the explanation of psychological well-being in women who experienced a miscarriage

A total of 37% of the depression variance, 28% of the anxiety variance and 41% of the stress variance were explained through the final model of regression analyses. The results indicate that good health proved to be a positive predictor of psychological well-being (more precisely, better health is negatively associated with the levels of anxiety, depression and stress, i.e. it is positively associated with life satisfaction). At the same time, it is important to emphasize that miscarriage represents a loss and the stages of grief, among other things, also include a depression phase (40). In addition to being manifested through emotional symptoms, depression, anxiety and stress can also be manifested through physical symptoms such as fatigue, lack of energy, changes in appetite and sleep patterns, muscle tension, headaches, increased blood pressure, rapid breathing and sleep disorders. The findings

ponovno ukazuje na važnost majčinstva za žene pri čemu one koje nisu još uvijek ispunile tu ulogu spontanom pobačaju pripisuju veće značenje (18). Procjena negativnog utjecaja spontanog pobačaja na svakodnevni život (magnituda) kod žena pozitivan je prediktor depresivnosti i ovaj je nalaz u skladu s nalazima prethodnih istraživanja (20). Vrijeme proteklo od spontanog pobačaja negativan je prediktor anksioznosti i ovi rezultati podupiru nalaze prethodnih studija (46,52) pri čemu vremenom žene (koje su doživjele spontani pobačaj) osjećaju sve manje simptoma kao što su poteškoće s disanjem, drhtanje ruku, pojačano znojenje i teškoće s opuštanjem. Broj spontanih pobačaja u ovom istraživanju nije se pokazao značajnim korelatom psihološke dobrobiti, iako neka prethodna istraživanja ukazuju da su žene s ponavljajućim spontanim pobačajem pod povećanim rizikom za razvoj teškoća mentalnog zdravlja (53).

U skladu s pretpostavkama, izbjegavajuće suočavanje pokazalo je samostalni doprinos u objašnjenju varijance svih mjera psihološke dobrobiti. Premda se radi o neophodnoj strategiji neposredno nakon traumatskog događaja dugoročno korištenje ovih strategija suočavanja ometa procesuiranje traume i rješavanje problema čime pridonosi lošijem mentalnom zdravlju (25). Kvaliteta bračne komunikacije pokazala se negativnim prediktorom depresivnosti, anksioznosti i stresa što ukazuje na važnost održavanja bliskosti s partnerom nakon spontanog pobačaja (23,29,54). Dodatno, podrška okoline značajan je i negativan prediktor stresa što potvrđuje teze o zaštitnoj ulozi socijalne podrške od negativnih utjecaja stresa (24).

Kada je riječ o zadovoljstvu životom, konačnim regresijskom modelom objašnjeno je 38 % varijance zadovoljstva životom pri čemu su se kao značajni pozitivni prediktori izdvojili sljedeći prediktori: materijalne prilike, zdravstveno stanje, imanje djece, podrška okoline, kvaliteta

indicate that the participants who have children had fewer symptoms of depression, thus once again acknowledging the importance of motherhood for women, whereby those women who still have not fulfilled that role attribute a greater meaning to the experience of miscarriage (18). An assessment of the negative effects of miscarriage on women's everyday life (magnitude) is a positive predictor of depression and these findings are consistent with the findings of previous studies (20). Time passed since the miscarriage is a negative predictor of anxiety and these results support the findings of previous studies (46, 52) in which it was observed that, as time passes, women (who have experienced a miscarriage) feel fewer symptoms such as difficulty breathing, hand tremors, increased perspiration and difficulty relaxing. The number of miscarriages did not prove to be a significant correlate for psychological well-being in this study, although some previous studies indicate that women with recurring miscarriages are at an increased risk of developing mental health difficulties (53).

In accordance with the assumptions, it was observed that avoidance coping independently contributed to the explanation of variance of all psychological well-being measures. Although it is a necessary strategy immediately after experiencing a traumatic event, long-term use of these coping strategies disturbs the processing of the trauma and problem resolution, thus contributing to poorer mental health (25). It was observed that the quality of marital communication is a negative predictor of depression, anxiety and stress, indicating the importance of maintaining closeness with one's partner after experiencing a miscarriage (23, 29, 54). Furthermore, social support is a significant negative predictor of stress, which confirms the assumptions about the protective role of social support against the negative impacts of stress (24).

In terms of life satisfaction, the final regression model explains 38% of the life satisfaction variance, whereby the following predictors are emphasized as significant positive predictors: material circumstances, health status, having children,

bračne komunikacije (tablica 6). Izbjegavajuće suočavanje pokazalo se negativnim prediktorom zadovoljstva životom što je su skladu s drugim istraživanjima koji također ukazuju na negativne posljedice korištenja izbjegavajućeg stila suočavanja (25,55). Suprotno, bolje zdravstveno stanje pokazalo se pozitivnim prediktorom zadovoljstva životom što je u skladu s prethodnim istraživanjima, koja pokazuju da je opće zadovoljstvo životom povezano s općim zadovoljstvom zdravljem (56) te da je osobna procjena zdravlja jedan od ključnih faktora subjektivne dobrobiti i kvalitete života (57). Bračna komunikacija i podrška okoline pokazale su se pozitivnim prediktorima zadovoljstva životom što je u skladu s ranijim istraživanjima o pozitivnim učincima socijalne podrške (50,51,54). Dobiveni nalazi su u skladu s prethodnim istraživanjima i impliciraju na važnost osobnih procjena zdravlja, te na zaštitnu ulogu socijalne podrške kao i o mogućim negativnim posljedicama korištenja izbjegavajućih strategija suočavanja.

Završna razmatranja

Rezultati provedenog istraživanja pružaju vrijedne spoznaje o čimbenicima koji pridonose simptomima depresivnosti, anksioznosti i stresa kod žena koje su doživjele spontani pobačaj i jedno je od rijetkih istraživanja ove tematike na hrvatskom uzorku. Rezultati ovog istraživanja, između ostalog, ukazuju na važnost socijalne podrške (partnera i okoline) te podržavajuće komunikacije s partnerom nakon gubitka trudnoće. Iako su provedenim istraživanjem utvrđeni neki značajni doprinosi, potrebno je istaknuti i njegove nedostatke. Prije svega budući da je riječ o korelacijskom nacrtu nije moguće utvrditi uzročno-posljedičnu vezu između ispitivanih varijabli. Također, istraživanje je provedeno korištenjem *online* upitnika koji se temeljio na samoiskazu. Važno je istaknuti da je uzorak sudionica dosta heterogen što se tiče vremena proteklog od spontanog pobačaja.

social support, quality of marital communication (Table 6). Avoidance coping strategies have proved to be a negative predictor of life satisfaction, which corresponds to other studies which also point to the negative consequences of the avoidance coping style (25, 55). In contrast, better health has proved to be a positive predictor of life satisfaction, which corresponds to the previously conducted studies the results of which have showed that general life satisfaction is associated with general satisfaction with one's health (56) and that the subjective health status assessment is one of the key factors for subjective well-being and quality of life (57). Marital communication and social support have proved to be positive predictors of life satisfaction, which is consistent with earlier studies on the positive effects of social support (50, 51, 54). The obtained results are in line with the previous studies and imply the importance of subjective health assessments, as well as the protective role of social support and the possible negative effects of using avoidance coping strategies.

Final observations

The results of the conducted study have provided valuable insights into the factors contributing to the symptoms of depression, anxiety and stress in women who have experienced a miscarriage, and is one of the rare studies on this topic conducted on a Croatian sample. Among other things, the results of this study indicate the importance of social support (from the partner and the environment) and supportive communication with the partner after pregnancy loss. Although some significant contributions were observed in the conducted study, its shortcomings should also be pointed out. Above all, since this is a correlation design, it is not possible to establish a causal link between the variables examined. Furthermore, the study was conducted by means of an online questionnaire based on self-reporting. It should be emphasized that the sample of participants was quite heterogeneous in terms of the time passed since the miscarriage.

Osim važnih praktičnih implikacija, rezultate je nužno interpretirati i u sklopu bioetičkih razmatranja i to u prvom redu uzimajući u obzir emocionalni i psihološki utjecaj na pojedince i parove pri čemu je nužno pružanje podrške svima onima koji doživljavaju pobačaj uvažavajući tugu i traumu koje mogu nastati (što su između ostalog pokazali i rezultati provedenog istraživanja). I dalje je upitno prepoznaje li naše društvo gubitak koji se doživljava kroz pobačaj te bi iz bioetičke perspektive bilo jako bitno potaknuti rasprave o tome kako zdravstveni djelatnici, obitelji i zajednice mogu pružiti podršku parovima (ističući važnost priznavanja gubitka i pružanje podrške u procesu žalovanja). Dodatno, kada dođe do spontanog pobačaja nužno je razmotriti i etičke implikacije medicinskih intervencija (kiretaža, medikamentna terapija, praćenje i čekanje) kao i s time povezane kulturne i religijske perspektive (razumijevanje i uvažavanje različitih reakcija tugovanja i pružanja podrške nakon spontanog pobačaja) pri čemu se ističu pravo na autonomiju žene nad vlastitim tijelom, razmatranje spontanog pobačaja kao prirodne pojave ili medicinskog problema (koji zahtijeva intervenciju) te pitanje moralnog statusa fetusa u kontekstu emocionalne povezanosti s fetusom i tugovanjem nakon gubitka trudnoće (58,59).

Ključne praktične implikacije provedenog istraživanja povezane su sa psihoedukacijom o važnosti pružanja podrške neposredno nakon spontanog pobačaja, njegovim najčešćim posljedicama te rizičnim faktorima koji pridonose pojavi teškoća nakon ovakvog događaja. Zdravstveni djelatnici trebali bi njegovati empatičan pristup te objasniti pacijentici rizike i ograničenja pojedinih intervencija kod spontanih pobačaja te po potrebi pružiti i osigurati psihološku podršku (60). Rezultati ovog istraživanja jasno pokazuju da je važno i promicanje preventivnih aktivnosti prema zaštiti fizičkog zdravlja jer je subjektivna procjena

Besides the important practical implications, the results must be interpreted within the bioethical considerations as well, primarily taking into account the emotional and psychological impact on individuals and couples, whereby it is necessary to provide support to all those experiencing miscarriage by taking into consideration the grief and trauma that may occur (which, among other things, was presented in the results of the conducted study as well). It is still questionable whether our society recognizes the loss experienced through miscarriage and, from a bioethical perspective, it would be of outmost importance to encourage discussion on how healthcare professionals, families and communities can provide support to couples (by emphasizing the importance of recognizing their loss and supporting them in their grieving process). Additionally, in case of a miscarriage, it is also essential to consider the ethical implications of medical interventions (curettage, medication therapy, monitoring and waiting), as well as the associated cultural and religious perspectives (understanding and acknowledging the different reactions in grief and providing support after a miscarriage), whereby emphasis should be placed on a woman's right to bodily autonomy, consideration of the miscarriage as a natural phenomenon or a medical issue (requiring intervention), and the issue of the moral status of the fetus within the context of emotional connection with the fetus and grieving after pregnancy loss (58, 59). The key practical implications of the conducted study are associated with psychoeducation on the importance of providing support immediately after a miscarriage, its most common consequences and the risk factors contributing to the occurrence of difficulties after such an event. Healthcare professionals should foster an empathetic approach and explain to the patient the risks and limitations of each intervention in the event of a miscarriage, and they should also provide and ensure psychological support if necessary (60). The results of this study clearly show that promoting preventive activities towards the protection of physical health is also important, because women's sub-

fizičkog zdravlja žena značajni prediktor mjera psihološke dobrobiti. Kako bi se prekinula društvena šutnja nakon spontanog pobačaja, buduća istraživanja trebala bi se usmjeriti na proučavanje reakcija tugovanja kod žena i muškaraca i to kako bi vremenom spontani pobačaj bio prepoznat kao psihološki, a ne samo kao medicinski događaj (9). Naime, rezultati ovog istraživanja pokazuju da približno 30 % sudionica doživljava ozbiljne i/ili izrazito ozbiljne simptome anksioznosti, dok oko 25 % sudionica izvještava o ozbiljnim i/ili izrazito ozbiljnim simptomima depresivnosti i stresa nakon spontanog pobačaja što ukazuje na važnost ciljanih intervencija.

jective physical health assessment is a significant predictor of psychological well-being measures. In order to put an end to the social silence following a miscarriage, future studies should focus on examining the grieving reactions among women and men, so that with time miscarriage could be recognized as a psychological, and not only medical event (9). Namely, the results of this study have shown that approximately 30% of the participants experienced serious and/or extremely serious symptoms of anxiety, while approximately 25% of the participants experienced serious and/or extremely serious symptoms of depression and stress after a miscarriage, thus emphasizing the importance of targeted interventions.

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Demografske značajke medicinskih sestara i profesionalno sagorijevanje: *burnout* u domovima za starije osobe u Hrvatskoj i Sloveniji

/ Demographic Characteristics of Nurses and Professional Burnout: Burnout in Nursing Homes in Croatia and Slovenia

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Ispitan je sindrom profesionalnog sagorijevanja među medicinskim sestrama/tehničarima i njegovateljicama/njegovateljima u domovima za starije osobe u Hrvatskoj i Sloveniji. Ukupno je sudjelovalo 436 ispitanika (240 iz Hrvatske i 196 iz Slovenije). Istraživanje je uključivalo analizu demografskih podataka poput dobi, bračnog statusa, obrazovanja i radnog staža te njihovog odnosa sa sindromom profesionalnog sagorijevanja. Za ispitivanje razine profesionalnog sagorijevanja primijenjen je validirani upitnik *The Oldenburg Burnout Inventory* (OLBI). Rezultati su pokazali visoku razinu sindroma profesionalnog sagorijevanja u objema državama s gotovo polovicom ispitanika u kategoriji visokog intenziteta. Demografske varijable nisu iskazale jasan značajan učinak na varijablu profesionalnog sagorijevanja. Analize nisu pokazale značajne razlike između Hrvatske i Slovenije u pogledu izraženosti intenziteta sindroma sagorijevanja. Istaknuta je važnost problema sindroma profesionalnog sagorijevanja među zdravstvenim radnicima u domovima za starije osobe te potreba za daljnjim istraživanjem kako bi se bolje razumjeli faktori koji doprinose tom fenomenu kao i potreba za većim uzorkom ispitanika pojedinih potkategorija istraživanih varijabli.

/ This study examined the syndrome of professional burnout among nurses/technicians and caregivers in nursing homes in Croatia and Slovenia. A total of 436 respondents participated in the study (240 from Croatia and 196 from Slovenia). The study included an analysis of demographic data such as age, marital status, education and length of service, as well as the respondents' attitude towards the professional burnout syndrome. A validated questionnaire, The Oldenburg Burnout Inventory (OLBI), was used to assess the level of professional burnout. The results showed high levels of professional burnout syndrome in both countries, with almost half of the respondents being in the high-intensity category. Additionally, demographic variables did not have a clear significant impact on the professional burnout variable. Analyses did not show significant differences between Croatia and Slovenia in terms of burnout syndrome intensity. The importance of the professional burnout syndrome problem among healthcare workers in nursing homes was highlighted, as well as the need for further research in order to better understand the factors contributing to this phenomenon, and the need to include a larger sample of respondents within specific subcategories of the researched variables.

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UVOD

Sestrinska profesija smatra se jednom od težih profesija na globalnoj razini i karakterizirana je velikim opterećenjem, brzim tempom i intenzitetom rada (1) pa se stoga sestrinstvo smatra rizičnom profesijom za nastanak profesionalnog sagorijevanja (2). Pojam sagorijevanje (engl. *burnout*) sedamdesetih je godina prošloga stoljeća u New Yorku prvi put u kliničkom smislu upotrijebio psiholog Herbert J. Freudenberger (3), kada se bavio ovisnicima o psihoaktivnim supstancijama koje se u to vrijeme nazivalo „burnouts". Taj naziv označavao je osobu koja nije bila zainteresirana ni za što osim za drogu i postizanje njenog psihostimulativnog efekta što je za posljedicu kod osobe dovodilo do propadanja motivacije te radnih i životnih sposobnosti (4). Freudenberger je u članku izdanom 1974. godine opisao gubitak volje, snage, energije te iscrpljenost među liječnicima koji su pružali podršku ovisnicima. Tada je prvi put upotrijebljen izraz „burnout" koji je ostao utemeljen te se kao takav zadržao do današnjeg dana (5).

Nekoliko godina kasnije profesorica socijalne psihologije Christine Maslach, koja se smatra jednom od vodećih istraživača na području profesionalnog sagorijevanja (4), zajedno sa suradnicima definira profesionalno sagorijevanje kao sindrom emocionalne iscrpljenosti, depersonalizacije i smanjenog osobnog postignuća u pojedinaca koji imaju kontaktnu odnosno

INTRODUCTION

The nursing profession is globally considered to be one of the more challenging professions, characterized by heavy workloads, fast pace and work intensity (1), therefore nursing is viewed as a profession with a high risk of developing professional burnout (2). The term "burnout" was first used in a clinical sense by psychologist Herbert J. Freudenberger (3) in New York in the 1970s while he was working with individuals addicted to psychoactive substances, who were at that time called "burnouts". The term denoted an individual who was not interested in anything except drugs and achieving their psycho-stimulating effect, which resulted in declining motivation, work and life skills (4). In an article published in 1974, Freudenberger described the loss of will, strength and energy, as well as exhaustion, among doctors who provided support to addicts. This was when he first used the term "burnout", which has remained a well-established term to this day (5).

A few years later, Christine Maslach, social psychology professor who is considered as one of the leading researchers in the field of professional burnout (4), together with her colleagues defined professional burnout as a syndrome of emotional exhaustion, depersonalization and reduced personal achievement in individuals who are engaged in a contact or helping profession and are working with people (6). Burnout is a long-term response to chronic emotional and interpersonal stressors at work, and is defined through three dimensions: exhaustion, feelings of cynicism,

pomagačku profesiju u radu s ljudima (6). Sagorijevanje je dugotrajni odgovor na kronične emocionalne i međuljudske stresore na poslu, a definira se u tri dimenzije: iscrpljenost, osjećaj cinizma i profesionalna neučinkovitost (7). Kasnije je ovaj sindrom prerastao specifičan radni kontekst pomagačkih profesija i smatra se da su stresu izloženi radnici na svim poslovima (8). Svjetska zdravstvena organizacija (SZO) definira sagorijevanje sindromom, a konceptualiziran je kao rezultat kroničnog stresa na radnom mjestu koji nije uspješno kontroliran. Karakteriziraju ga tri dimenzije: osjećaj gubitka energije ili iscrpljenost, povećana mentalna udaljenost od posla, osjećaj negativizma ili cinizma u vezi s poslom te smanjena profesionalna učinkovitost. Prema Svjetskoj zdravstvenoj organizaciji uzrok nastanka sagorijevanja je dugotrajna izloženost stresu u radu i posljedica je neriješenog stresa (9), dok teorija koju zastupa Maslach opisuje sagorijevanje kao stanje koje se javlja kao rezultat dugotrajne neusklađenosti između osobe i najmanje jedne od sljedećih šest dimenzija posla:

1. Opterećenje - oporavak se osobe ne može postići zbog pretjeranih zahtjeva;
2. Kontrola - zaposlenici nemaju dovoljnu kontrolu nad resursima potrebnima za rad;
3. Nagrada - izostanak adekvatne nagrade (financijske, društvene i intrinzične) za obavljeni posao;
4. Suradništvo - zaposlenici ne percipiraju osjećaj povezanosti sa svojim kolegama i menadžerima, što dovodi do frustracije;
5. Nepravednost - nejednakost radnog opterećenja i plaća;
6. Vrijednosti - zaposlenici na poslu djeluju protiv vlastitih uvjerenja i težnji (10).

Jedna od podjela čimbenika rizika za nastanak sagorijevanja dijeli se u tri kategorije:

1. Intrapersonalni čimbenici gdje je fokus na nedostatku ravnoteže između očekivanja njegovatelja i stvarnosti;

and professional ineffectiveness (7). This syndrome later outgrew the specific work context of helping professions and it is considered that workers in all professions are exposed to stress (8). The World Health Organization (WHO) defines burnout as a syndrome, conceptualized as the result of chronic workplace stress that is not successfully managed. It is characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, feelings of negativism or cynicism relating to one's job, and reduced professional efficacy. According to the World Health Organization, the cause of burnout is long-term exposure to stress at the workplace and it represents a consequence of unresolved stress (9), while the theory advocated by Maslach describes burnout as a condition that occurs as the result of a long-term mismatch between an individual and at least one of the following six job dimensions:

1. Workload – an individual is unable to recover due to excessive demands;
2. Control – employees do not have sufficient control over the resources needed for work;
3. Reward – lack of adequate reward (financial, social and intrinsic) for the work performed;
4. Community – employees do not feel a sense of connection with their colleagues and managers, which leads to frustration;
5. Fairness - inequality in terms of workload and wages;
6. Values - employees act against their own beliefs and aspirations at work (10).

One of the divisions of risk factors for the occurrence of burnout includes three categories:

1. Intrapersonal factors where focus is on the lack of balance between caregiver's expectations and reality;
2. Interpersonal factors where the relationship between caregiver and client/patient is emphasized;
3. Organizational factors based on the mismatch between workers and work organization (11).

2. Interpersonalni čimbenici gdje se naglašava odnos između njegovatelja i klijenta/pacijenta;
3. Organizacijski čimbenici temeljeni na neusklađenosti između radnika i organizacije posla (11).

Sagorijevanje potiču stresori kao što su pretjerani i ometajući zahtjevi zbog vrlo zahtjevnih pacijenata, nedostatka dobrog odnosa i angažman samog pacijenta kao i nedostatak poštovanja, brojni administrativni poslovi te sam sadržaj rada (12).

Simptomi sagorijevanja se mogu svrstati u četiri ključne dimenzije:

1. iscrpljenost (ozbiljan gubitak energije koji rezultira osjećajem fizičke i mentalne iscrpljenosti);
2. mentalna udaljenost (nevoljkost ili odbojnost prema poslu, ravnodušnost i cinizam);
3. kognitivno oštećenje (problemi s pamćenjem, poremećaji pažnje i koncentracije te loša kognitivna izvedba);
4. emocionalno oštećenje (intenzivne emocionalne reakcije poput ljutnje ili tuge i osjećaj preplavljenosti vlastitim emocijama).

Sekundarni atipični simptomi karakteriziraju se kao depresivno raspoloženje, psihološki distres i psihosomatske tegobe (13). Različiti simptomi vezani uz tjelesne i psihičke probleme kao što su glavobolja, prehlada, nesanica, anksioznost te poremećaji povezani s koncentracijom i pamćenjem (14) rezultiraju čestim izostancima s posla kao i sveprisutnim napuštanjem postojećeg radnog mjesta (15).

Fizička, psihička i emocionalna iscrpljenost su ozbiljan problem s kojim se mnoge medicinske sestre suočavaju zbog dugotrajnog stresa na radnom mjestu, a karakteriziraju ih kronični umor, problemi sa spavanjem, pažnjom, fizički problemi poput boli u prsima, lupanja srca, vrtoglavice, gastrointestinalni simptomi, gubitak apetita, depresija i ljutnja (16).

Burnout is triggered by stressors such as excessive and disruptive demands due to very demanding patients, lack of a good relationship and engagement of the patients themselves, as well as lack of respect, numerous administrative tasks and the content of the work itself (12).

The symptoms of burnout can be classified into four key dimensions:

1. Exhaustion (serious loss of energy resulting in a feeling of physical and mental exhaustion);
2. Mental distance (reluctance or aversion to work, indifference and cynicism);
3. Cognitive impairment (memory problems, attention and concentration disorders, and poor cognitive performance);
4. Emotional impairment (intense emotional reactions such as anger or sadness, or feeling overwhelmed by one's own emotions).

Secondary atypical symptoms are characterized by depressed mood, psychological distress and psychosomatic complaints (13). Various symptoms related to physical and psychological issues such as headaches, colds, insomnia, anxiety and disorders associated with concentration and memory (14) result in frequent absences from work, as well as in general abandonment of the current workplace (15).

Physical, mental and emotional exhaustion are a serious problem present among many nurses due to long-term stress at the workplace, and are characterized by chronic fatigue, difficulty sleeping or paying attention, physical issues such as chest pain, palpitations, dizziness, gastrointestinal symptoms, loss of appetite, depression and anger (16).

Due to impaired mental and physical health of nurses, the consequences of burnout could be manifested in the quality of health care, which could affect the conditions of patients and their recovery (14).

The World Health Organization officially recognized burnout as an occupational phenomenon in 2019, and it was then included in the 11th re-

Zbog narušenog mentalnog i tjelesnog zdravlja medicinskih sestara, posljedice sagorijevanja se mogu očitovati u kvaliteti zdravstvene njege, što može utjecati na stanje pacijenata i njihov oporavak (14).

Svjetska zdravstvena organizacija je 2019. godine službeno priznala sagorijevanje kao profesionalni fenomen i uvrstila ga u 11. reviziju Međunarodne klasifikacije bolesti (MKB-11) (17).

Za mjerenje sagorijevanja najčešće se koristi *Maslach Burnout Inventory* (MBI), validirani upitnik (18), koji su po prvi puta operacionalizirali 1980-ih Maslach i suradnici te se smatra standardnim alatom za istraživanje u ovom području. Upitnik je posebno dizajniran za procjenu trodimenzionalnog iskustva sagorijevanja: emocionalne iscrpljenosti, depersonalizacije i manjka osobnog postignuća (19) za razliku od Oldenburškog upitnika (OLBI) koji je primijenjen u ovom istraživanju te procjenjuje dvije dimenzije: iscrpljenost i otuđenost (20). Općenito, u kasnijim radovima je doživljaj smanjenog postignuća izostavljen iz primarnih dimenzija sagorijevanja te se smatra njihovom posljedicom. S druge strane, iscrpljenost i depersonalizacija ili psihološka distanciranost od vlastitog posla su ključne dimenzije ovog sindroma (6) i važne su za diferencijalnu dijagnostiku gdje se ponajprije želi razlikovati sagorijevanje od kroničnog umora ili uz rad vezane depresivnosti (21).

Prije samo dvadesetak godina nije se pridavalo toliko pozornosti fenomenu sagorijevanja kao danas, međutim, koncept ima dugu tradiciju i istražuje se desetljećima (12). Istraživanja u ovom području rastu, kao i interes stručnjaka usmjerenih na mentalno zdravlje vezano uz rad što se najbolje može potkrijepiti trendom koji je vidljiv u broju objavljenih radova.

Povezano sa sociodemografskim karakteristikama brojne su studije pokazale da dob može biti jedan od čimbenika povezanih s profesionalnim sagorijevanjem.

vision of the International Classification of Diseases (ICD-11) (17).

The Maslach Burnout Inventory (MBI), a validated questionnaire (18) which was first operationalized in the 1980s by Maslach et al. and which is considered a standard research tool in this field, is used for the purpose of measuring burnout. The questionnaire was specially designed to assess the three-dimensional experience of burnout: emotional exhaustion, depersonalization and reduced personal accomplishment (19), as opposed to the Oldenburg Burnout Inventory (OLBI) which was applied in this study and which assesses two dimensions: exhaustion and disengagement (20). In general, the feeling of reduced accomplishment was omitted from the primary dimensions of burnout in the later works, and is considered to be its consequence. On the other hand, exhaustion and depersonalization or psychological distancing from one's work are key dimensions of this syndrome (6), and are important for differential diagnostics where the primary goal is to distinguish burnout from chronic fatigue or work-related depression (21).

Only twenty years ago, the burnout phenomenon did not receive as much attention as it receives today, however, the concept has a long tradition and has been researched for decades (12). Research in this field is growing, as is the interest of experts focused on work-related mental health, which can be best supported by the trend that is observable in the number of works published.

In relation to sociodemographic characteristics, numerous studies have shown that age can be one of the factors associated with professional burnout.

It was noted that burnout mainly affects nurses under the age of 35 (22, 23), and emphasis was placed on the need to take into account the fact that young nurses represent the largest percentage of medical staff working in nursing homes (24, 25). Among women, burnout is most often present between the ages of 20 and 35, and after the age of 55 (26). Younger nurses who are at the start of their careers may experience more stress

Napominje se da sagorijevanje uglavnom pogađa medicinske sestre mlađe od 35 godina (22, 23) te se naglašava da treba uzeti u obzir kako su upravo mlade medicinske sestre najveći postotak medicinskog osoblja prisutnog u domovima (24,25). Kod žena je najviše sagorijevanje prisutno u dobi od 20 do 35 godina i nakon 55. godine (26). Mlađe medicinske sestre, koje su na početku svoje karijere, mogu biti pod većim stresom zbog prilagodbe na zahtjevno radno okruženje, visoki tempo rada uz češći noćni rad i nedostatak iskustva u suočavanju s teškim situacijama (27). Starije medicinske sestre mogu biti izložene sagorijevanju zbog dugogodišnjeg rada, akumuliranog stresa i nedostatka promocija ili napredovanja u karijeri (28), dok neki autori tvrde da dob nije značajno povezana sa sagorijevanjem (29-31).

Kod istraživanja bračnog statusa, pojedina istraživanja ukazuju da je razina sagorijevanja kod udanih medicinskih sestara niža nego kod neudanih, odnosno da je kod samaca viša nego kod oženjenih. Mnoga istraživanja pokazuju da medicinske sestre i tehničari koji žive sami ili imaju problema u partnerskim odnosima mogu biti izloženiji emocionalnom iscrpljivanju i većem riziku za nastanak profesionalnog sagorijevanja (32), dok se kod nekih istraživanja nije pronašla značajnu povezanost između varijabli sagorijevanja i bračnog statusa (33), jer se smatra da na parove pozitivno utječe siguran i podržavajući način života koji im pruža obiteljsko okruženje (34), odnosno dostupnost socijalne podrške.

Što se tiče variable obrazovanja, istraživanja pokazuju da su više razine sagorijevanja povezane s medicinskim sestrama niže razine obrazovanja, jer se u svom radu mogu suočiti sa složenim medicinskim zadatcima i donošenjem odluka što može rezultirati većim stresom i osjećajem nesigurnosti u vlastite sposobnosti (35,36). Zdravstveni radnici mogu biti skloniji ozbiljnom sagorijevanju ako nisu u mogućnosti unaprijediti svoje obrazovanje ili ako su to učinili, a njihov je posao ostao isti (35). Manja je

because they are adapting to a demanding working environment and a high working pace with more frequent night work, and they lack experience in dealing with difficult situations (27). Older nurses may be exposed to burnout due to their long-term work, accumulated stress and lack of promotions or career advancement (28), while some authors claim that there is no significant correlation between age and burnout (29-31).

When it comes to researching marital status, some studies have shown that the level of burnout among married nurses is lower than among unmarried nurses, i.e. that it is higher among single individuals than among those who are married. Many studies have shown that nurses and technicians who live alone or have problems in their partner relationships may be more exposed to emotional exhaustion and are at a higher risk of professional burnout (32), while some studies did not find a significant correlation between burnout variables and marital status (33) because it is considered that couples are positively influenced by a safe and supportive lifestyle provided by the family environment (34), i.e. the availability of social support.

As regards the education variable, studies have shown that higher levels of burnout are associated with nurses with lower levels of education, because they may face complex medical tasks and decision-making situations in their work, which can result in higher stress levels and a sense of insecurity in their own abilities (35, 36). Healthcare workers may be more prone to severe burnout if they are unable to further their education or if they have done so, but their job has remained the same (35). Nurses with a master's degree are less likely to report severe burnout than nurses with a high school education (37), because a higher academic degree in nursing is associated with lower odds of developing professional burnout due to greater expertise and confidence in performing their duties (38). The connection between education levels and burnout can also be observed in other professions, and it is related to job complexity, difficulty of tasks performed and autonomy in one's work (39).

vjerojatnost da će visoko sagorijevanje prijaviti medicinske sestre s magisterijem za razliku od sestara na razini srednjoškolskog obrazovanja (37), jer je viši akademski stupanj u sestrinstvu povezan s manjim izgledima za profesionalno sagorijevanje zbog veće stručnosti i samopouzdanja u obavljanju svojih dužnosti (38). Veza između razine obrazovanja i sagorijevanja prisutna je i u drugim profesijama, a povezana je uz složenost poslova, izazovnost zadataka te autonomiju u radu (39).

Radni staž odnosi se na ukupno razdoblje provedeno na radnom mjestu uključujući sve prethodne radne pozicije te je često povezan sa sagorijevanjem medicinskih sestara. One mlađe od 27 godina s radnim stažem manjim od četiri godine pokazuju visoke razine sagorijevanja (40). Što osoblje duže radi, njihova razina zadovoljstva i postignuća u vezi s poslom je niža, jer dugogodišnjim radnim iskustvom može biti izloženo većem riziku od sagorijevanja zbog akumuliranog stresa, emocionalnog iscrpljivanja i fizičkog napora koji dolazi s dugotrajnim radom u zahtjevnom okruženju zdravstvene skrbi (41). Zato se u cilju smanjenja sagorijevanja te zbog vlastite dobrobiti mora osvijestiti i temeljito razumjeti fenomen profesionalnog sagorijevanja, kako samih medicinskih sestara, tako i uprave zdravstvenih i socijalnih ustanova (42).

Uspoređujući dobivene podatke raznih istraživanja te povezanosti sociodemografskih značajki s profesionalnim sagorijevanjem, zaključci autora su različiti i često se ne podudaraju.

CILJ ISTRAŽIVANJA

Cilj istraživanja je opisati pojavnost i izraženost profesionalnog sagorijevanja kod medicinskih sestara/tehničara i njegovateljica/njegovatelja zaposlenih u hrvatskim i slovenskim domovima za starije osobe, usporediti ih te utvrditi odnos dobi, spola, bračnog statusa, obrazovanja i radnog staža s profesionalnim sagorijevanjem.

Length of service refers to the total period spent at a workplace, including all previous positions, and is often associated with burnout among nurses. Nurses under 27 years of age with less than four years of work experience display high levels of burnout (40). The longer the staff work, the lower are their levels of job satisfaction and achievement, because long-term work experience may expose them to a greater risk of burnout due to accumulated stress, emotional exhaustion and physical strain that come with long-term work in the demanding healthcare environment (41). It is, therefore, important to bring awareness to and thoroughly understand the phenomenon of professional burnout both among the nurses themselves and among the management of health and social care institutions, in order to reduce burnout and ensure the individuals' own well-being (42).

When comparing the data obtained from various studies and the connection of sociodemographic features with professional burnout, the conclusions of authors differ and often do not coincide.

AIM

The aim of the study is to describe the incidence and severity of professional burnout among the nurses/technicians and caregivers employed in Croatian and Slovenian nursing homes, to compare them and to determine how age, gender, marital status, education and length of service are associated with professional burnout.

METHODOLOGY

Participants

A total of 436 participants took part in the study. Requests were sent via e-mail to the addresses of nursing homes in Croatia and Slovenia. Directors, head nurses/technicians and health care managers received the requests in which they were informed about the method of conducting

METODOLOGIJA

Sudionici

U istraživanju je sudjelovalo 436 sudionika. Zamolbe su poslane putem elektroničke pošte na adrese domova za starije i nemoćne osobe u Hrvatskoj i Sloveniji. Ravnatelji, glavne medicinske sestre / tehničari te voditelji zdravstvene njege zaprimili su zamolbe u kojima im je objašnjeno na koji će se način provoditi istraživanje. Rukovoditelji su imali zadaću proslijediti upitnike te potaknuti medicinske sestre / tehničare na ispunjavanje.

Podatci kažu da je u Hrvatskoj sudjelovalo 240 sudionika zaposlenih u domovima za starije osobe [Ž=221 (92 %); M=14 (6 %); neodgovoreno = 4 (2 %)] te 196 sudionika u Sloveniji [Ž= 181 (92 %); M=15 (8 %)].

Zbog izrazite razlike u broju muških i ženskih sudionika u hrvatskom i slovenskom uzorku, statističke analize vezane uz spol nisu provođene te ovaj cilj istraživanja nije ispunjen.

Radni staž bio je sličan u obje države. Kod sudionika u hrvatskim domovima za starije osobe iznosio je od tri mjeseca do 42 godine, dok je medijan iznosio 18 godina. Kod sudionika u slovenskim domovima bio je od tri mjeseca do 43 godine, dok je medijan bio 15 godina.

Bračni status kod hrvatskog uzorka: 133 sudionika bilo je u *braku* (55 %), 51 (21 %) bio je u *vezi; samaca* je bilo 26 (10 %), *rastavljenih* 22

the study. The managers' task was to forward the questionnaires and encourage the nurses/technicians to complete them.

The data show that the Croatian sample included a total of 240 participants working in nursing homes [F=221 (92%); M=14 (6%); not completed = 4 (2%)], while the Slovenian sample included 196 participants [F= 181 (92%); M=15 (8%)].

Due to a significant difference in the number of male and female participants both in the Croatian and Slovenian samples, statistical analyses relating to gender were not conducted and this research goal was not fulfilled.

The length of service was similar in both countries. For participants in Croatian nursing homes, it ranged from three months to 42 years, while the median was 18 years. For participants in Slovenian nursing homes, it ranged from three months to 43 years, while the median was 15 years.

As regards the marital status in the Croatian sample, 133 participants were *married* (55%), 51 (21%) were in *a relationship;* 26 (10%) were *single*, 22 (9%) were *divorced* and eight (3%) were *widowed*. In the Slovenian sample, 86 participants were *married* (44% of the sample), while a total of 76 (39%) were in *a relationship*. A total of 21 (10%) participants were *single;* nine were *divorced* (4%), and four (2%) were *widowed*.

The Croatian and Slovenian samples mostly differ in the percentages of the participants involved in relationships, which amounted to 39% in the Cro-

TABLICA 1. Frekvencije i postotci sudionika u istraživanju iz Hrvatske (N=240) i Slovenije (N=196) prema potkategorijama varijabli dobi i obrazovanja
TABLE 1. Frequencies and percentages of study participants from Croatia (N=240) and Slovenia (N=196) according to the subcategories of age and education variables

	Dob f (%) kategorije u godinama / Age f (%) categories according to age					Obrazovanje f (%) / Education f (%)				
	18-24	25-33	34-44	45-54	55- 65	Njegovatelji / Caregivers	SSS / High School	Bacc. med. techn.	Mag. med. techn.	Ostalo / Other
Hrvatska / Croatia	31	40	56	69	44	76	99	35	12	18
	13%	17%	23%	29%	18%	32%	41%	15%	5%	7,5%
Slovenija / Slovenia	16	53	49	53	25	29	77	74	5	11
	8%	23%	25%	23%	13%	15%	39%	38%	2%	6%

(9 %) i *udovaca/ica* osam (3 %). Kod slovenskog uzorka 86 sudionika je u *braku* (44 %) uzorka, dok je u *vezi* ukupno 76 (39 %). U skupini *samaca* je 21 (10 %); *rastavljenih* je devet (4 %) te *udovaca/ica* četiri (2 %).

Hrvatski i slovenski uzorak se u najvećem dijelu razlikuju s obzirom na sudionike u vezi gdje ih u hrvatskom uzorku ima 39 %, dok ih je u slovenskom 21 %. U uzorak su bile uključene medicinske sestre/tehničari svih razina obrazovanja te njegovateljice/njegovatelji. Hrvatski i slovenski uzorak ispitanika s obzirom na udio pojedinih razina obrazovanja razlikuju se kod njegovateljica gdje u hrvatskim domovima one čine 32 % uzorka, dok je u slovenskim domovima taj udio svega 15 %. Bacc. med. techn. u hrvatskim domovima čine 15 %, a u slovenskim 38 % uzorka, dok je udio mag. med. techn. u hrvatskom uzorku 5 %, a u slovenskom svega 2 %.

Instrumenti

The Oldenburg Burnout Inventory (OLBI) – upitnik sagorijevanja koji je validiran na hrvatskom uzorku od 3010 nastavnika (43), preuzet je od autora Demerouti i Bakker (44) te preveden na hrvatski jezik metodom dvostrukog prijevoda. Upitnik mjeri ukupni intenzitet, kao i dvije dimenzije profesionalnog sagorijevanja, iscrpljenost i otuđenost. Sastoji se od ukupno 16 tvrdnji s kojima se ispitanik mogao složiti ili ne složiti te odabrati na Likertovoj 4-stupanjskoj ljestvici odgovor, odnosno broj za koji smatra da odgovara njegovom stanju:

1 = Uopće se ne slažem; 2 = Ne slažem se; 3 = Slažem se; 4 = Potpuno se slažem.

Ukupni rezultat na upitniku može se formirati kao zbroj odgovora na čestice i tada je ukupni raspon od 16 do 64 ili kao prosječan rezultat po čestici pa je ukupan rezultat moguć u rasponu od 1 do 4, gdje se u oba slučaja mora napraviti prethodno obrnuto bodovanje pozitivnih formuliranih čestica. Viši ukupni rezultat podrazumijeva viši stupanj sagorijevanja na poslu. U

atian sample, and 21% in the Slovenian sample. Nurses/technicians of all levels of education, as well as caregivers, were included in the sample. The Croatian and Slovenian samples of respondents when it came to the share of different levels of education differed among caregivers, i.e. in Croatian nursing homes they made up 32% of the sample, while in Slovenian nursing homes that share was only 15%. The share of bacc. med. techn. in Croatian nursing homes was 15%, and in Slovenian nursing homes they made up 38% of the sample, while the share of mag. med. techn. in the Croatian sample was 5%, while in the Slovenian sample it was only 2%.

Instruments

The Oldenburg Burnout Inventory (OLBI) – burnout questionnaire validated on a Croatian sample of 3010 teachers (43), was taken from the authors Demerouti and Bakker (44) and translated into Croatian using the double translation method. The questionnaire measures the total intensity, as well as the two dimensions of professional burnout, exhaustion and disengagement. It consists of a total of 16 items with which the respondent could agree or disagree, and could then select an answer on the provided 4-point Likert scale, i.e. they could select the number that they believe corresponds to their condition:

1 = Strongly disagree; 2 = Disagree; 3 = Agree; 4 = Strongly agree.

The total score on the questionnaire can be formed as the sum of the answers provided for the items and then the total range spans from 16 to 64, or as an average score per item, in which case the total score is achievable in the range from 1 to 4. In both cases a previous reverse scoring of the positively formulated items shall be performed. A higher overall score implies a higher degree of burnout at work. In this study, we used the total score of the average per item. The scores can also be presented through the categories of professional burnout levels. Since there are no generally accepted threshold values for categories

ovom istraživanju koristili smo ukupan rezultat prosjeka po čestici. Rezultate je moguće prikazati i preko kategorija razine profesionalnog sagorijevanja. Budući da u literaturi nema opće prihvaćenih graničnih vrijednosti za kategorije niti kliničkih validacija, koristili smo uz upute o bodovanju navedenih graničnih vrijednosti za kategorije razina profesionalnog sagorijevanja:

low = nisko (≤ 1,62), *medium* = srednje (1,63 do 2,67) i *high* = visoko (≥ 2,68) prema Delgadillo i sur. (45).

Indeks pouzdanosti upitnika OLBI) izražen *Cronbach Alpha*-om u hrvatskom uzorku iznosio je 0,87, a u slovenskom 0,85.

Anketni upitnik sastavili su autori za opsežnije istraživanje i sadrži pitanja o sociodemografskim značajkama. Iz tog su upitnika za potrebe ovog rada preuzete četiri značajke: dob, bračni status, obrazovanje i radni staž medicinskih sestara/ tehničara. Varijable radnih uvjeta i drugih okolinskih faktora nismo uzeli u ovo istraživanje jer su nas zanimale samo demografske varijable.

Postupak

Za prikupljanje podataka koristila se *online* metoda anketiranja putem anketnog upitnika *Google Forms*, a podatci su se prikupljali na prigodnom uzorku medicinskih sestara/tehničara svih razina obrazovanja te njegovateljica. U Hrvatskoj je ispitivanje provedeno u deset, a u Sloveniji u devet gradova u kojima su medicinske sestre pristale na ispunjavanje upitnika. Za dozvolu istraživanja u Hrvatskoj se kontaktirao Gradski ured za socijalnu zaštitu, zdravstvo, branitelje i osobe s invaliditetom Grada Zagreba koji je dao dozvolu za istraživanje u 10 državnih domova na području Grada Zagreba, a isti je princip primijenjen za Zadarsku i Istarsku županiju.

Dozvolu za istraživanje u slovenskim domovima odobravali su ravnatelji ustanova. Oni su

or clinical validations in the literature, along with the scoring instructions, we used the following specified threshold values for professional burnout level categories:

low (≤ 1.62), medium (1.63 to 2.67) or high (≥ 2.68), according to Delgadillo et al. (45).

The reliability index of the OLBI questionnaire, expressed by Cronbach's Alpha coefficient, amounted to 0.87 in the Croatian sample, and 0.85 in the Slovenian sample.

The survey questionnaire was compiled by the authors for the purpose of conducting a more extensive study and it contains questions about the sociodemographic characteristics. Four characteristics were taken from this questionnaire for the purposes of this paper: age, marital status, education and length of service of nurses/technicians. We did not consider the variables of working conditions and other environmental factors in this study because we were only interested in exploring the demographic variables.

Procedure

The online method of surveying by means of a Google Forms survey questionnaire was used for data collection, and the data were collected from a convenience sample of nurses/technicians of all levels of education and caregivers. The survey was conducted in ten cities in Croatia and nine cities in Slovenia, where nurses agreed to fill out the questionnaire. In order to obtain the research permits in Croatia, we contacted the City of Zagreb – City Office for Social Protection, Health, War Veterans and People with Disabilities which issued the permit for research in 10 state nursing homes in the area of the City of Zagreb, and the same principle was applied in the Zadar and Istria Counties.

The research permits in Slovenian nursing homes were approved by the directors of the institutions. They forwarded the request to the head nurses/technicians and health care managers who were asked to further communicate the information and encourage their colleagues to fill

zamolbu prosljeđivali glavnim medicinskim sestrama/tehničarima te voditeljima zdravstvene njege koji su bili zamoljeni za daljnji prijenos informacija i animiranje radnih kolegica i kolega na ispunjavanje upitnika. Ispitanicima se uz zamolbu i objašnjenje o istraživanju navela poveznica na koju mogu pristupiti svojim mobitelom ili računalom putem nekih trenutnih aplikacija *Viber, Messenger, WhatsApp* i sl. Upitnik se ispunjavao dobrovoljno i anonimno, a samo ispunjavanje i slanje istom ispitivaču imalo je isto značenje kao i informirani pristanak za sudjelovanje u istraživanju.

REZULTATI

Rezultati su prvo prikazani prema ukupnom rezultatu na upitniku profesionalnog sagorijevanja – OLBI (prosjek po čestici), kao i prema mjeri kategorija prema intenzitetu profesionalnog sagorijevanja za Hrvatsku i Sloveniju i njihova statistička usporedba te onda i analiza za obje skupine sudionika prema istraživanim demografskim varijablama.

a) Ukupni rezultat na upitniku profesionalnog sagorijevanja (prosjek po čestici)

Budući da su zadovoljene sve pretpostavke za provedbu parametrijskog testa s ciljem utvrđivanja razlike između prosječnog rezultata ispitanika iz Hrvatske i Slovenije, proveden je t-test rezultati kojega pokazuju da se prosječni rezultati na upitniku OLBI između ispitanika iz Hrvatske i onih iz

out the questionnaire. Along with the request and explanation concerning the research, the respondents were given a link that they could access on their mobile phones or computers via an application currently in use, such as Viber, Messenger, WhatsApp, etc. They filled out the questionnaire anonymously and on a voluntary basis, and the action of filling out the questionnaire and sending it back to the researcher also served as an informed consent to participate in the study.

RESULTS

The results were first presented according to the total score on the professional burnout questionnaire - OLBI (average per item), as well as by the measure of categories according to the intensity of professional burnout both for Croatia and Slovenia, their statistical comparison, and then through an analysis concerning both groups of participants according to the researched demographic variables.

a) Total score on the professional burnout questionnaire (average per item)

Since all the prerequisites for the implementation of the parametric test with the aim of determining the difference between the average score of the respondents from Croatia and Slovenia were met, a *t-test* was conducted the results of which showed that there was no significant statistical difference in the average scores on the OLBI questionnaire between the respondents from Croatia and those from Slovenia $t(434) = .97$, $p = .331$.

TABLICA 2. Deskriptivna statistika ukupnog rezultata na upitniku OLBI za sudionike u istraživanju iz Hrvatske (N=240) i Sloveniје (N=196)
TABLE 2. Descriptive statistics of the total score achieved on the OLBI questionnaire for study participants from Croatia (N=240) and Slovenia (N=196)

	M	SD	CI (95 %) donja granica / CI (95%) lower limit	CI (95 %) gornja granica / CI (95%) upper limit	C	Min	Max	Skewness	Kurtosis	Shapiro-Wilk p
OLBI ukupni rezultat HR / OLBI total score CRO	2.57	.47	2.51	2.64	2.56	1.31	3.88	0.04	-0.03	.165
OLBI ukupni rezultat SLO / OLBI total score SLO	2.59	.44	2.52	2.65	2.56	1.19	3.81	-0.025	0.59	.229

Slovenije statistički značajno ne razlikuju t(434) = .97, p = .331.

Iz tablice se vidi da se distribucije ukupnog rezultata na upitniku OLBI kod sudionika iz Hrvatske i Slovenije ne razlikuju statistički značajno od normalne (prema testu Shapiro-Wilk). Većina rezultata u hrvatskom dijelu (oko 70 %) uzorka nalazi se u rasponu prosječnog rezultata po čestici na OLBI-u od 2,1 do 3,04, dok se kod slovenskog uzorka nalazi u rasponu od 2,15 do 3,03.

b) Rezultati ispitanika na upitniku OLBI izraženi u kategorijama razine profesionalnog sagorijevanja

S ciljem utvrđivanja postojanja statistički značajnih razlika između frekvencija hrvatskih i slovenskih medicinskih sestara unutar pojedinih kategorija razina profesionalnog sagorijevanja proveden je hi-kvadrat test koji je pokazao da statističke razlike ne postoje (hi-kvadrat 2, N = 436 = 0.35, *p* = .839.

c) Rezultati prema demografskim značajkama

Dob

U istraživanju su se uspoređivali rezultati hrvatskog dijela uzorka na upitniku OLBI između pet dobnih skupina: 18-24 (N=31), 25-33

As can be seen in the table, the distributions of the total score on the OLBI questionnaire among participants from Croatia and Slovenia did not significantly statistically differ from normal (according to the Shapiro-Wilk test). Most of the results in the Croatian part (approx. 70%) of the sample were in the range of the average score per item on the OLBI questionnaire, from 2.1 to 3.04, while in the Slovenian sample they were in the range from 2.15 to 3.03.

b) Respondents' scores on the OLBI questionnaire expressed in professional burnout level categories

With the aim of determining the existence of statistically significant differences between the frequencies of Croatian and Slovenian nurses within individual categories of professional burnout levels, a Chi-square test was conducted which showed that there were no statistical differences (Chi-square 2, N = 436 = 0.35, *p* = .839).

c) Scores according to demographic characteristics

Age

The scores in the Croatian part of the sample on the OLBI questionnaire were compared among five age groups in the study: 18-24 (N=31), 25-33 (N=40), 34-44 (N=56), 45-54 (N=69) and 55-65 (N=44). According to the one-way ANOVA

TABLICA 3. Deskriptivna statistika rezultata sudionika u istraživanju prema kategorijama razine profesionalnog sagorijevanja na upitniku OLBI u hrvatskim i slovenskim domovima za starije osobe
TABLE 3. Descriptive statistics of the scores of the study participants according to the professional burnout level categories on the OLBI questionnaire in Croatian and Slovenian nursing homes

Mjesto rada / Place of work		Niska / Low	Srednja / Medium	Visoka / High	Ukupno / Total
Hrvatska / Croatia	Opažene frekvencije / Observed frequencies	5	124	111	240
	Postotak unutar skupine / Percentage within group	2%	52%	46%	100%
Slovenija / Slovenia	Opažene frekvencije / Observed frequencies	3	98	95	196
	Postotak unutar skupine / Percentage within group	1.5%	50%	48.5%	100%

TABLICA 4. Deskriptivna statistika rezultata sudionika iz Hrvatske i Slovenije na upitniku OLBI prema demografskim varijablama i njihovim potkategorijama te rezultati ANOVA-e između potkategorija unutar pojedinih varijabli
TABLE 4. Descriptive statistics of the scores of participants from Croatia and Slovenia on the OLBI questionnaire according to demographic variables and their subcategories, as well as ANOVA results between subcategories within individual variables

	Hrvatska / Croatia					Slovenija / Slovenia				
	N	M	SD	Schapiro Wilk *p*	ANOVA	N	M	SD	Schapiro Wilk *p*	ANOVA
Dob / Age 18-24	31	2.64	.47	.230	*F*=1.537 (df)=4 *p*=.192	16	2.45	.53	.630	*F* = 2.789 (df)=4 *p* =.028
Dob / Age 25-33*	40	2.53	.50	.763		53	2.46	.43	.123	
Dob / Age 34-44*	56	2.53	2.65	.141		49	2.71	.50	.825	
Dob / Age 45-54	69	2.50	.50	.390		53	2.63	.38	.631	
Dob / Age 55-65	44	2.72	.40	.570		25	2.65	.27	.251	
Bračni status - samci / Marital status - single	26	2.62	.54	.813	*F*=2.273 (df)=3 *p*=.081	21	2.44	.35	.342	*F*=1.199 (df)=3 *p*=.311
Bračni status - u braku / Marital status-married	133	2.64	2.72	.404		86	2.60	.39	.522	
Bračni status - u vezi / Marital status - in a relationship	51	2.51	.47	.212		76	2.60	.51	.907	
Bračni status - rastavljeni/udovci / Marital status - divorced/widowed	30	2.41	.41	.519		13	2.71	.40	.281	
Obrazovanje - njegovatelji / Education - caregivers	76	2.62	.54	.698	*F*=.390 (df)=2 *p*=.677	29	2.53	.37	.702	*F*=2.403 (df)=2 *p*=.093
Obrazovanje - SSS / Education – high school	99	2.55	.45	.156		77	2.55	.41	.327	
Obrazovanje - bacc./mag. / Education - bacc./mag.	47	2.57	.45	.155		79	2.68	.44	.556	
Radni staž / Length of service	240	18	11.5	<.001		196	17.58	12.44	<.001	

*Statistički značajna razlika između tih dviju dobnih skupina kod slovenskih sudionika
/ *statistically significant difference between these two age groups among Slovenian participants

(N=40), 34-44 (N=56), 45-54 (N=69) i 55-65 (N=44). Jednosmjerni ANOVA test pokazao je da nema razlika u intenzitetu profesionalnog sagorijevanja između različitih dobnih skupina *F* (4)=1.537, *p*=.192. I u slovenskom uzorku uspoređivali su se rezultati na upitniku OLBI između pet dobnih skupina: 18-24 (N=16), 25-33 (N=53), 34-44 (N=49), 45-54 (N=53) i 55-65 (N=25). Jednosmjerni ANOVA test pokazao je da se dobne skupine razlikuju prema rezultatu na upitniku profesionalnog sagorijevanja *F* (4) = 2,789, *p* =.028, dok je kvadrirana eta = 0,05, što prema Cohenovoj konvenciji (46) upućuje na malu veličinu učinka i znači praktično nebitnu razliku između dobnih skupina. Istovremeno se ta statistička razlika prema Bonferroni *post hoc* testu temelji samo na razlici između dviju dobnih skupina, "25-33" i "34-44" i to u

test, there were no differences in the intensity of professional burnout between different age groups *F* (4)=1.537, *p* =.192. The scores on the OLBI questionnaire in the Slovenian sample were compared among five age groups as well: 18-24 (N=16), 25-33 (N=53), 34-44 (N=49), 45-54 (N= 53) and 55-65 (N=25). According to the one-way ANOVA test, the age groups differed according to the score on the professional burnout questionnaire *F* (4) = 2.789, *p* =.028, while the eta squared was = 0.05, which according to Cohen's convention (46) indicates a small effect size and represents a practically insignificant difference between age groups. At the same time, this statistical difference according to the Bonferroni *post hoc* test is based only on the difference between two age groups, "25-33" and "34-44", in the direction of higher scores on the OLBI questionnaire of the "25-33" age group, while no

smjeru većih rezultata na upitniku OLBI dobne skupine "25-33", dok između ostalih dobnih skupina značajne razlike nisu utvrđene.

Bračni status

a) S ciljem usporedbe rezultata ispitanika različitog bračnog statusa na upitniku OLBI, usporedili smo pet kategorija bračnog statusa kod *hrvatskog dijela uzorka*: *samce* (N=26), *u braku* (N=133), *u vezi* (N=51), *rastavljene* (N=22) i *udovice/udovci* (N=8). U cilju uravnoteženja broja ispitanika prema potkategorijama i mogućnosti komparacije sa slovenskim uzorkom spojene su kategorije *"rastavljenih"* i *"udovaca"* u jednu kategoriju koju smo onda koristili u analizi. Jednosmjerni ANOVA test pokazao je da nema značajnih razlika između ispitanika različitog bračnog statusa s obzirom na profesionalno sagorijevanje F(3) = 2,273, *p* =.081

b) U *slovenskom uzorku* sudionika s ciljem utvrđivanja odnosa varijable bračnog statusa i varijable profesionalnog sagorijevanja usporedilo se pet kategorija: *samci* (N=21), *u braku* (N=86), *u vezi* (N=76), *rastavljeni* (N=9) i *udovice/udovci* (N=4). Kao i kod hrvatskog uzorka, u cilju uravnoteženja broja sudionika prema potkategorijama, spojene su kategorije "rastavljenih" i "udovaca" u jednu kategoriju koju smo onda koristili u analizi. Rezultati jednosmjernog ANOVA testa pokazali su da nema razlika između rezultata sudionika različitog bračnog statusa na upitniku OLBI kod slovenskog uzorka F(3) = 1,199, *p* =.311.

Obrazovanje

a) S ciljem utvrđivanja odnosa varijable obrazovanja i varijable profesionalnog sagorijevanja u *hrvatskom dijelu uzorka* počeli smo s usporedbom pet kategorija različitog stupnja obrazovanja: njegovatelji (N=76), me-

significant differences were found among other age groups.

Marital status

a) In order to compare the scores of respondents of different marital status on the OLBI questionnaire, we compared five categories of marital status in *the Croatian part of the sample*: *single* (N=26), *married* (N=133), *in a relationship* (N=51), *divorced* (N=22) and *widowed* (N=8). In order to balance the number of respondents per subcategory and to allow comparisons with the Slovenian sample, the categories *of "divorced"* and *"widowed"* were combined into one category which was then used in the analysis. The results of the one-way ANOVA test showed that there were no significant differences between respondents of different marital status when it comes to professional burnout F(3) = 2.273, *p* =.081

b) In *the Slovenian sample* of participants, with the aim of determining the correlation between the marital status variable and the professional burnout variable, five categories were compared: *single* (N=21), *married* (N=86), *in a relationship* (N=76), *divorced* (N=9) and *widowed* (N=4). As with the Croatian sample, in order to balance the number of participants per subcategory, the categories "divorced" and "widowed" were combined into one category which was then used in the analysis. The results of the one-way ANOVA test showed that there were no differences between the results of participants of different marital status on the OLBI questionnaire in the Slovenian sample F(3) = 1.199, *p* =.311.

Education

a) In order to determine the relationship between the variable of education and the variable of professional burnout in *the Croatian part of the sample*, we started with a comparison of the five categories of different education levels: caregivers (N=76), nurses/technicians with a high school level of educa-

dicinske sestre/tehničari na srednjoškolskoj razini obrazovanja (N=99), bacc. med. techn. (N=35), mag. med. techn. (N=12) i ostali (N=18). S ciljem uravnoteženja broja sudionika prema pojedinim kategorijama spojili smo kategorije bacc. i mag. med. techn. u jednu, uklonili kategoriju „ostali“ koji se nisu izjasnili o svom stupnju obrazovanja te u konačnici u obradi rezultata radili s tri kategorije (njegovatelji, medicinske sestre/tehničari na srednjoškolskoj razini obrazovanja te bacc. med. techn./ mag. med. techn). Rezultati jednosmjernog ANOVA testa pokazali su da se ispitanici različitog stupnja obrazovanja u hrvatskom dijelu uzorka statistički značajno ne razlikuju s obzirom na intenzitet profesionalnog sagorijevanja F(2) = .390, *p* = .677.

b) S ciljem utvrđivanja odnosa varijable obrazovanja i varijable profesionalnog sagorijevanja, *u slovenskom se uzorku* također usporedilo pet kategorija različitog stupnja obrazovanja: njegovatelji (N=29), medicinske sestre/tehničari na srednjoškolskoj razini obrazovanja (N=77), bacc. med. techn. (N=74), mag. med. techn. (N=5) i ostali (N=11) prema istom principu spajanja kategorija bacc. i mag. med. techn. i bez kategorije „ostali“ kao i kod hrvatskog uzorka. Rezultati jednosmjernog ANOVA testa su kao i u hrvatskom uzorku pokazali da se sudionici različitog stupnja obrazovanja statistički značajno ne razlikuju s obzirom na intenzitet profesionalnog sagorijevanja F(2) = 2,403 , *p* = .093.

Radni staž

a) S ciljem utvrđivanja povezanosti između varijable radnog staža i varijable profesionalnog sagorijevanja, a budući da distribucija varijable radnog staža u *hrvatskom uzorku* značajno odstupa od normalne (Shapiro-Wilk, tablica 5), koristio se neparametrijski Spearmanov test povezanosti.

tion (N=99), bacc. med. techn. (N=35), mag. med. techn. (N=12) and others (N=18). In order to balance the number of participants per individual category, we combined the bacc. and mag. med. techn. categories into one category, removed the category “others” who did not declare their level of education, and we ultimately observed three categories when processing the results (caregivers, nurses/technicians with a high school level of education, and bacc. med. techn./mag. med. techn.). The results of the one-way ANOVA test showed that there was no statistically significant difference among the respondents of different education levels in the Croatian part of the sample when it comes to the intensity of professional burnout F(2) = .390, *p* = .677.

b) In order to determine the relationship between the variable of education and the variable of professional burnout, the five categories of different education levels were compared *in the Slovenian sample* as well: caregivers (N=29), nurses/technicians with a high school level of education (N=77), bacc. med. techn. (N=74), mag. med. techn. (N=5) and others (N=11), following the same principle of combining the bacc. and mag. med. techn. categories and removing the “others” category, as in the case of the Croatian sample. As in the Croatian sample, the one-way ANOVA test results showed that there was no statistically significant difference among participants of different education levels when it comes to the intensity of professional burnout F(2) = 2.403, *p* = .093.

Length of service

a) In order to determine the connection between the length of service variable and the professional burnout variable, and since the distribution of the length of service variable in *the Croatian sample* significantly deviated from normal (Shapiro-Wilk, see Table 5), the non-parametric Spearman correlation test was used. It was determined that in the Croatian part of the sample there was no sta-

Utvrđeno je da u hrvatskom dijelu uzorka varijable radnog staža i profesionalnog sagorijevanja nisu statistički značajno povezane - *rho* (238) = 0.03, *p* = .671.

b) Za razliku od većine ostalih varijabli, distribucija varijable radnog staža i u *slovenskom uzorku* značajno odstupa od normalne (Shapiro-Wilk, tablica 4). Rezultati su pokazali da iako postoji statistički značajna povezanost između radnog staža i rezultata na upitniku OLBI, *rho* (194) =.17, *p* = .021, ta je povezanost prema veličini koeficijenta nikakva ili neznatna uz koeficijent determinacije od 0,03 (dakle, samo 3 % zajedničke varijance obih varijabli), dok je i veličina učinka prema Cohenovoj konvenciji mala (*rho* manji od 0,2).

RASPRAVA

Sestrinska profesija mora se suočiti sa značajnim izazovima kako bi smanjila prevalenciju sagorijevanja, jednog od sindroma koji najviše utječe na zdravlje medicinskih sestara i ima ozbiljne posljedice, kako za pacijente, tako i ustanove u kojima rade (47). Analizirajući rezultate na upitniku OLBI prema korištenim kriterijima u kategorijama razine profesionalnog sagorijevanja, uočljivo je da gotovo 50 % sudionika u hrvatskom uzorku pripada kategoriji visoke razine profesionalnog sagorijevanja. Vrlo slični rezultati dobiveni su i u slovenskom dijelu uzorka. Statistički značajnih razlika između sudionika iz Hrvatske i onih iz Slovenije s obzirom na intenzitet profesionalnog sagorijevanja kao i prema pripadnosti pojedinim kategorijama razine profesionalnog sagorijevanja nema.

Promatrajući varijablu dobi, između različitih dobnih skupina, u ovom istraživanju u hrvatskom dijelu uzorka značajne razlike nisu utvrđene, dok je u slovenskom uzorku nađena statistički značajna razlika, ali male veličine učinka i to samo između dviju dobnih skupina. Re-

tistically significant correlation between the length of service variable and professional burnout variable - *rho* (238) = 0.03, *p* = .671.

b) As opposed to the majority of other variables, the distribution of the length of service variable significantly deviated from normal in the *Slovenian sample* as well (Shapiro-Wilk, see Table 4). The results showed that although there was a significant statistical correlation between the length of service and scores on the OLBI questionnaire, *rho* (194) =.17, *p* = .021, according to the size of the coefficient, this correlation was nil or insignificant, with a coefficient of determination amounting to 0.03 (therefore, only 3% of the common variance of both variables), while the effect size according to Cohen's convention was small (*rho* lower than 0.2).

DISCUSSION

The nursing profession must face significant challenges in order to reduce the prevalence of burnout, one of the syndromes with the greatest effects on the health of nurses, which has serious consequences both for the patients and for the institutions where they work (47). Upon analyzing the results of the OLBI questionnaire according to the used criteria in the categories of professional burnout levels, it is noticeable that almost 50% of the participants in the Croatian sample were placed in the high level of professional burnout category. Very similar results were obtained in the Slovenian part of the sample as well. There were no statistically significant differences between the participants from Croatia and those from Slovenia with regard to the intensity of professional burnout, as well as in terms of belonging to certain categories of professional burnout levels.

In observing the age variable, no significant differences were found in the Croatian part of the sample in this study, while a statistically significant difference was found in the Slovenian sample, however with a small effect size and only between two age groups. The results of other authors are not uniform either. According to some

zultati ostalih autora također nisu ujednačeni. Prema nekim istraživanjima dob medicinskih sestara nije povezana s profesionalnim sagorijevanjem (48), druga potvrđuju da su starije medicinske sestre više izložene profesionalnom sagorijevanju (35,49-52), dok neki autori navode da su profesionalnom sagorijevanju izloženije mlađe medicinske sestre (53).

Vezano uz bračni status, medicinske sestre u hrvatskim i slovenskim domovima različitog bračnog statusa, bez obzira jesu li u braku, u vezi, samci ili udovice, ne razlikuju se statistički značajno prema razini profesionalnog sagorijevanja (33,49). Analizirajući istraživanja ostalih autora i ovdje su mišljenja podijeljena. Biti samac ili u braku nije povezano sa sagorijevanjem (54), dok neki navode da je veća prevalencija sagorijevanja među samcima (55,56) i to kod mlađih, muških, neoženjenih medicinskih tehničara. Niža razina sagorijevanja je kod oženjenih, ali bez djece (57), dok neka istraživanja navode da je brak varijabla bitna za nastanak sagorijevanja (53).

Uspoređujući rezultate medicinskih sestara/tehničara različitog stupnja obrazovanja počevši od njegovateljica, medicinskih sestara/tehničara na razini srednjoškolskog obrazovanja, bacc. i mag. med. techn. u objema državama, rezultati pokazuju da se oni statistički značajno ne razlikuju. Ovakve nalaze moguće je možda tumačiti i djelovanjem treće varijable (vrsta posla), koja je prikrila pravi odnos varijable obrazovanja i profesionalnog sagorijevanja.

Naime, nerijetko se događa da se medicinske sestre uz rad obrazuju, ali i nakon što steknu viši stupanj obrazovanja, nastavljaju raditi na istom radnom mjestu. Dakle, bez obzira na stupanj obrazovanja, dio sestara radi isti posao i izložene su istim zahtjevima i stresorima. Drugo objašnjenje bilo bi nedovoljna snaga testa zbog čega je i realno postojeće razlike u izraženosti profesionalnog sagorijevanja između potkategorija obrazovanja teško detektirati.

studies, there is no association between the age of nurses and professional burnout (48), other studies confirm that older nurses are more exposed to professional burnout (35, 49-52), while some authors observe that younger nurses experience more exposure to professional burnout (53).

In terms of marital status, there is no significant statistical difference according to the level of professional burnout among the nurses of different marital status who are working in Croatian and Slovenian nursing homes, regardless of whether they are married, in a relationship, single or widowed (33, 49). After analyzing the studies conducted by other authors, it was observed that opinions are divided in this matter as well. On the one hand, there was no association between single or married status and burnout (54), while some authors reported that the prevalence of burnout was higher among single individuals (55, 56), specifically among younger, male, unmarried medical technicians. A lower level of burnout was found in individuals who are married, but without children (57), while some studies indicated that marriage represents an important variable for the occurrence of burnout (53).

Upon comparing the results among nurses/technicians with different levels of education, starting from caregivers, nurses/technicians with a high school education level, bacc. and mag. med. techn. in both countries, the results show that there is no statistically significant difference. Such findings could perhaps be interpreted through the action of a third variable (type of job), which could have obscured the true connection between the education variable and professional burnout.

More precisely, it often happens that nurses undergo additional education while working, but even after obtaining a higher level of education, they continue to work at the same workplace. Therefore, regardless of the level of education, some nurses still perform the same job and are exposed to the same demands and stressors. Another explanation could be seen in an insufficient power of the test, which is why it is difficult to detect real existing differences in the expression

Istraživanja pokazuju da između razine sagorijevanja i sociodemografskih karakteristika kao što je razina obrazovanja, nema značajne povezanosti (33,49,50). Neki autori navode da je viši obrazovni status povezan s višim stupnjem sagorijevanja (58), dok pojedini imaju upravo suprotne zaključke i smatraju da mag. med. techn. na menadžerskim pozicijama imaju nizak stupanj sagorijevanja (59).

Uspoređujući dobivene rezultate vezane uz radni staž ne možemo izvesti jednoznačni zaključak budući da u hrvatskom uzorku nije utvrđena statistički značajna povezanost varijable radnog staža i profesionalnog sagorijevanja, dok je u slovenskom uzorku ta povezanost pozitivna i statistički značajna, ali gledajući i druge statističke parametre osim *p*, ta povezanost bi se mogla promatrati i kao neznačajna, no na budućim je istraživanjima da utvrde pravu prirodu tog odnosa.

Istraživanja autora su oprečna i kod ove varijable. Dužina radnog staža nema učinak na profesionalno sagorijevanje (49), dok se prema nekim istraživanjima medicinske sestre od šeste godine rada često suočavaju s fizičkim i psihičkim problemima povezanima s radnim pritiskom ili preopterećenjem, signalizirajući početak emocionalne iscrpljenosti i sagorijevanja (50). Osobe koje imaju malo radnog iskustva imaju veliku predispoziciju za nastanak profesionalnog sagorijevanja (55,60).

ZAKLJUČAK

Na našem uzorku sudionika, korištenom metodologijom i instrumentarijem, nismo uspjeli utvrditi značajne razlike unutar demografskih varijabli s obzirom na profesionalno sagorijevanje medicinskih sestara/tehničara u domovima za starije u Hrvatskoj i Sloveniji.

Iako je naše istraživanje provedeno na prigodnim, dostupnim uzorcima zaposlenih u Hrvatskoj i Sloveniji, ono pokazuje da je profesional-

of professional burnout between the subcategories of education.

Studies have shown that there is no significant correlation between the level of burnout and sociodemographic characteristics such as the level of education (33, 49, 50). Some authors state that a higher educational status is associated with a higher degree of burnout (58), while some have reached the exact opposite conclusions and believe that individuals with mag. med. techn. education in managerial positions experience a low degree of burnout (59).

Comparing the results obtained with regard to the length of service, we could not draw an unequivocal conclusion since no statistically significant correlation was observed between the length of service and professional burnout variables in the Croatian sample, while in the Slovenian sample this connection was positive and statistically significant. However, looking at other statistical parameters besides *p*, this correlation could also be viewed as insignificant, but it is up to future studies to determine the true nature of this relationship.

The studies conducted by different authors are conflicting in terms of this variable as well. On the one hand, the length of service had no effect on professional burnout (49), while according to some studies, nurses from the sixth year of work onward often face physical and psychological problems related to work pressure or overload, thus signaling the beginning of emotional exhaustion and burnout (50). Individuals with little work experience have a high predisposition for the occurrence of professional burnout (55, 60).

CONCLUSION

In our sample of participants, with the methodology and instrumentation used, we were unable to determine significant differences within the demographic variables in terms of professional burnout among nurses/technicians in nursing homes in Croatia and Slovenia.

no sagorijevanje ili engl. *burnout* prisutno među medicinskim sestrama/tehničarima i njegovateljicama/njegovateljima koje rade u domovima za starije osobe. Istraživanje je pokazalo da se oko 50 % sudionika nalazi u kategoriji visoke razine profesionalnog sagorijevanja. Nisu utvrđene značajne razlike između hrvatskog i slovenskog uzorka s obzirom na korištene mjere profesionalnog sagorijevanja. Također, između ispitivanih potkategorija demografskih varijabli (dobi, bračnog statusa i obrazovanja) nisu se pokazale značajne razlike među sudionicima s obzirom na intenzitet profesionalnog sagorijevanja. Za varijablu radnog staža temeljem statističkih pokazatelja iz ovog istraživanja ne možemo jasno reći da je povezana s varijablom profesionalnog sagorijevanja, ali niti odlučno osporiti tu povezanost.

Ograničenja ovog istraživanja u prvom redu proizlaze iz prigodnog uzorka te nedovoljnog broja sudionika u pojedinim demografskim kategorijama. Razlike u broju sudionika u pojedinim kategorijama utjecale su i na valjanost rezultata i snagu testova. To je mogući razlog zbog kojeg nismo utvrdili neke razlike koje smo očekivali. Dakle, uglavnom negativni nalazi dobiveni u ovom istraživanju mogu biti posljedica upravo ovih metodoloških ograničenja koja proizlaze iz malog i homogenog uzorka. Također, nismo uključili varijable koje bi opisale mehanizme koje stoje u podlozi povezanosti sociodemografskih varijabli i profesionalnog sagorijevanja. Buduća istraživanja trebala bi uključiti medijacijske varijable poput konflikta uloga, socijalne podrške ili dostupnih resursa na poslu kako bi objasnili povezanost između sociodemografskih značajki zaposlenih i razine sagorijevanja na poslu.

Kao smjernicu za buduća istraživanja izdvojili bismo potrebu za prikupljanjem podataka na reprezentativnim uzorcima zdravstvenih radnika u domovima za starije te uključivanje individualnih i organizacijskih prediktora sagorijevanja na poslu.

Although our study was conducted on available convenience samples of employees in Croatia and Slovenia, its results have shown that professional burnout is indeed present among the nurses/technicians and caregivers working in nursing homes. The study has shown that approximately 50% of the participants could be placed in the high level professional burnout category. No significant differences were found between the Croatian and Slovenian samples with regard to the professional burnout measures used. Furthermore, in the examined subcategories of demographic variables (age, marital status and education), no significant differences were observed among the participants when it comes to the intensity of professional burnout. For the length of service variable, based on the statistical indicators from this study, we cannot clearly state that it is associated with the professional burnout variable, but we cannot decisively dispute this connection either.

The limitations of this study primarily stem from the convenience sample and the insufficient number of participants in certain demographic categories. Differences in the number of participants in some cases affected the validity of the results and the strength of the tests. This could be a possible reason due to which we did not find some differences that we expected. Therefore, the mostly negative findings obtained in this study may well be the result of these methodological limitations resulting from a small and homogeneous sample. Moreover, we did not include variables that would describe the mechanisms underlying the association between sociodemographic variables and professional burnout. Future studies should include mediating variables such as role conflict, social support or resources available at work in order to explain the association between the sociodemographic characteristics of employees and the level of burnout at work.

As a guideline for future studies, we would like to single out the need for data collection on representative samples of healthcare workers in nursing homes and the inclusion of individual and organizational predictors of burnout at work.

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Empatija prema poremećaju uporabe alkohola i psihodinamsko razumijevanje: narativni pregled

/ Empathy Towards Alcohol Use Disorder and Psychodynamic Understanding: A Narrative Review

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Iako je poremećaj uporabe alkohola (PUA) ozbiljan i složen mentalni poremećaj, još uvijek nailazi na brojne sumnje, nesporazume, nedostatak podrške te nedostatak empatije od okoline i zdravstvene struke jer većina ljudi smatra da je osoba sama uzrokovala bolest. Svrha ovog narativnog pregleda literature je odgovoriti na istraživačko pitanje o empatiji prema PUA i psihodinamskom razumijevanju pacijenata s PUA koristeći se literaturom objavljenom u bazama podataka (*Web of Science, PubMed* i *Google Scholar*) u posljednjih 60 godina. Prikazuje se suvremeno psihodinamsko razumijevanje PUA temeljem ego i *self*-psihologije razvoja osoba s tim poremećajem kao i psihodinamsko objašnjenje za nedostatak empatije zdravstvenih djelatnika i društva, unatoč prihvaćenom medicinskom modelu razumijevanja ovisnosti. Suvremeno psihoanalitičko razumijevanje PUA povezano je s patnjom što je suprotno od traženja zadovoljstva (posebno prema mišljenju neuroznanstvenika) i ranijih psihodinamskih formulacija (traženje zadovoljstva ili motivi za samodestrukciju), jer je traženje olakšanja koje pruža alkohol uglavnom posljedica nesposobnosti osobe koja pati od ovisnosti u reguliranju njezinih emocija (anksioznost, depresija), samopoštovanja, interpersonalnih odnosa i ponašanja, posebno vlastite brige o sebi. S kliničke perspektive važno je razumijevanje konstrukta empatije prema pacijentima s PUA i PUA s psihodinamskog aspekta kako bi se razumjela psihološka pozadina ovisničkog ponašanja i povećala empatija u liječenju ovisničkih poremećaja kombinacijom psihoterapijskih, bihevioralno-socioterapijskih i farmakoterapijskih pristupa.

/ Although alcohol use disorder (AUD) is a serious and complex mental disorder, it is still surrounded by numerous doubts, misunderstandings, lack of support and lack of empathy from the environment and the health profession, because most people consider that the individual caused it on their own. The purpose of this narrative literature review is to answer the research question regarding empathy towards AUD and the psychodynamic understanding of patients with AUD by using the database literature (Web of Science, PubMed, and Google Scholar) published in the last 60 years. The contemporary psychodynamic understanding of AUD based on the ego and self-psychology of development of the individuals with this disorder is presented, as well as a psychodynamic explanation for the lack of empathy provided by healthcare professionals and the society, despite it being an accepted medical model of understanding addiction. Contemporary psychoanalytic understanding of AUD is linked to suffering, which is opposite from pleasure seeking (especially according to neuroscientists) and the earlier psychodynamic formulations (pleasure seeking or motives for self-destruction), because seeking relief from alcohol is mainly a consequence of the addicted individual's inability to regulate their emotions (anxiety, depression), self-esteem, interpersonal relationships and behavior, especially their self-care. From a clinical perspective, it is important to understand the construct of empathy towards patients with AUD, as well as AUD from a psychodynamic aspect, in order to understand the psychological background of addictive behavior and increase empathy in the treatment of addictive disorders by combining psychotherapeutic, behavioral-sociotherapeutic and pharmacotherapeutic approaches.

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UVOD

Iako su uporaba psihoaktivnih tvari i posljedični nastanak ovisnosti jedan od glavnih problema u svijetu, prepoznavanje ovisnosti i preventivni i terapijski programi su još uvijek nedovoljno učinkoviti (1). Sve je više dokaza koji pokazuju da uporaba i legalnih (alkohol, duhan, kofein) i ilegalnih psihoaktivnih tvari (androgeni anabolički steroidi, amfetamini, benzodiazepini, kanabis, kokain, heroin/opijati, halucinogeni, inhalatori, khat i propisane/zlouporabljene psihoaktivne tvari) ozbiljno povećava morbiditet (zdravstvene posljedice) i smrtnost te da se učinkovito liječenje može postići integriranim programima zdravstvene skrbi (2). Dvije najtoksičnije tvari od svih psihoaktivnih tvari su alkohol i duhan. Farmakološki tretmani za poremećaj uporabe alkohola (PUA) su učinkoviti, posebno u kombinaciji s drugim bihevioralnim ili psihosocijalnim intervencijama (3). Disulfiram (4, 5), naltrekson (6-9), akamprosat (7, 8, 10) i nalmefen (11) su odobreni farmakološki tretmani za PUA. Osim toga, lijekovi za druge zdravstvene indikacije mogu se propisati "off-label" (topiramat, gabapentin, baklofen), a potencijalno se istražuju i novi lijekovi (vareniklin). Jedan od najvećih problema farmakološkog tretmana osoba s PUA je nesuradljivost (engl. *non compliance*) (3). Bihevioralni pristupi su najčešće korištene kliničke metode za liječenje osoba s PUA, uključujući motivacijski intervju, kogni-

INTRODUCTION

Although the use of psychoactive substances and the resulting addiction represent some of the main problems globally, the recognition of addiction, as well as the preventive and therapeutic programs, remain insufficiently effective (1). Accumulating evidence suggests that the use of both legal (alcohol, tobacco, caffeine) and illegal psychoactive substances (androgenic anabolic steroids, amphetamines, benzodiazepines, cannabis, cocaine, heroin/opiates, hallucinogens, inhalants, khat, and prescribed/abused psychoactive substances) significantly increases morbidity (health consequences) and mortality, as well as that effective treatment is achievable through integrated health care programs (2). Out of all of the psychoactive substances, the two most toxic ones are alcohol and tobacco. Pharmacological treatments for alcohol use disorder (AUD) are effective, especially in combination with other behavioral or psychosocial interventions (3). Disulfiram (4, 5), naltrexone (6-9), acamprosate (7, 8, 10), and nalmefene (11) are pharmacological treatments approved for AUD. In addition, medications for other health indications can be prescribed "off-label" (topiramate, gabapentin, baclofen), and further potentially useful medications are being researched as well (varenicline). One of the biggest problems in the pharmacological treatment of individuals with AUD is noncompliance (3). Behavioral approaches are clinical methods most widely used for treating individuals with AUD, including

tivno-bihevioralnu terapiju, upravljanje kriznim situacijama, terapiju za parove, obiteljsku terapiju, terapiju usmjerenu na traumu, terapiju umrežavanjem, terapijsku zajednicu, pristup osnaživanja u zajednici kroz grupe samopomoći, klubove za liječenje ovisnosti od alkohola, usredotočenu svjesnost (engl. *mindfulness*), psihodinamsku psihoterapiju, grupnu terapiju i fizičku aktivnost (12). U posljednjih nekoliko godina, bihevioralne intervencije i pristupi sve se više razvijaju i evaluirani su u istraživanjima te su postupno usvojeni u različite vrste i programe liječenja. Dva ključna pitanja u procjeni utjecaja ovih pristupa su: zadržavaju li ti pristupi ljude u liječenju i pomažu li pacijentima smanjiti/eliminirati njihovu pretjeranu konzumaciju psihoaktivnih tvari i alkohola (12).

Istraživanja ishoda liječenja pacijenata s PUA uglavnom su usmjerena na karakteristike pacijenata, modalitete liječenja (simptome sustezanja, terapijsku zajednicu, savjetovanje), mjesto liječenja (bolnica ili ambulantno) i profesionalnu pozadinu terapeuta (specijalist ili obiteljski liječnik) (13). Zajednički čimbenici poput empatije terapeuta igraju važnu ulogu u liječenju ovisničkih ponašanja (14). Empatija je ključna u terapijskom odnosu kako bi se taj odnos poboljšao i kako bi se bolje razumjelo unutarnji svijet pacijenta (15). Iako je terapijski odnos poznat kao važan čimbenik u ishodima liječenja, područje zlouporabe psihoaktivnih tvari, uključujući PUA, sporo prihvaća istraživanja u ovom području (13). U psihoterapijskoj praksi već je dugo poznato da terapijski čimbenici imaju značajnu ulogu u terapijskom ishodu. Tri terapijska čimbenika smatraju se nužnima za terapijsku promjenu: iskrenost, bezuvjetno pozitivno poštovanje i empatija (16). Nadalje, istraživanja u području empatije imaju različite rezultate zbog razlika u metodologiji istraživanja. Empatija se općenito kao vještina može trenirati i pozitivno utječe na ishode u terapiji (17, 18). Empatija omogućava pacijentu prepoznavanje nesvjesnih emocija i mijenjanje

motivational interviewing, cognitive behavioral therapy, contingency management, couples' therapy, family therapy, trauma-informed therapy, network therapy, therapeutic community, self-help group community empowerment approach, alcohol addiction treatment clubs, mindfulness, psychodynamic psychotherapy, group therapy, and physical activity (12). In recent years, behavioral interventions and approaches have been increasingly developed and evaluated in research trials, and have been gradually integrated into various treatment types and programs. The two key guiding principles in assessing the impact of these approaches are the following: whether these approaches retain people in treatment and whether they help the patients to reduce/eliminate their excessive use of psychoactive substances and alcohol (12).

Studies on the outcomes of the treatment of patients with AUD predominantly focus on patient characteristics, treatment modalities (withdrawal symptoms, therapeutic community, counseling), place of treatment (hospital or outpatient), and professional background of the therapists (specialist or family doctor) (13). Common factors such as therapist empathy play an important role in the treatment of addictive behaviors (14). Empathy is a crucial element in the therapeutic relationship when it comes to improving this relationship and ensuring a better understanding of the patient's inner world (15). Although it is well-known that the therapeutic relationship plays an important role for treatment outcomes, the field of psychoactive substance abuse, including AUD, has been slow to embrace research in this area (13). It has long been known in psychotherapy practice that therapeutic factors have a significant role in the therapeutic outcome. The following three therapeutic factors are considered necessary for therapeutic change: honesty, unconditional positive regard and empathy (16). Furthermore, studies in the field of empathy have yielded different results due to the differences in their research methodologies. Generally, empathy as a skill can be trained and has a positive impact on therapy outcomes (17, 18). Empathy allows the patient to recognize the un-

njegovog/njezinog *self*-koncepta, što također omogućuje i promjenu u ponašanju (19).

Konzumacija alkohola ukorijenjena je u kulturi i tradiciji (20). Ponašanje u odnosu na konzumaciju alkohola kulturološki je regulirano i propisano te se ponašanje osoba koje piju alkohol prepoznaje kao „uporaba" i „zlouporaba". Konzumacija alkohola ima ulogu u društvenoj kategorizaciji jer kulturni konteksti i tradicije utječu na percepciju ponašanja u vezi s pijenjem i prosuđivanje prema osobama koje piju alkohol (20).

Ranije gledište je bilo da kultura utječe na uporabu alkohola, a kasnije se smatralo da neke kulturne grupe imaju kognitivne sheme i strukture međuljudskih odnosa koje dopuštaju uporabu alkohola bez značajnog gubitka kontrole, dok druge kulturne grupe imaju probleme povezane s alkoholom jer njihove različite psihološke i odnosne strukture potiču gubitak kontrole nad uporabom alkohola. Čini se da su u zapadnim modernim društvima stresori kroz utjecaj okoliša promiču sve veću konzumaciju alkohola kao jedan od načina suočavanja sa stresorima (21).

Na prevalenciju konzumacije alkohola uz pojedinačne čimbenike stresa utječu kulturni i regionalni obrasci konzumacije alkohola, društveni uzori, zakonski zahtjevi i zabrane. Kulturološki čimbenici utječu na početak uporabe alkohola, okolišni i društveni čimbenici su važni u prijelazu na opasnu konzumaciju, dok su neurobiološki i drugi čimbenici rizika izraženiji u prijelazu na PUA (22).

Postoje tri prototipska obrasca uporabe alkohola ili psihoaktivnih tvari: medicinska, uobičajena redovita i povremena uporaba. U suvremenim društvima prisutan je i četvrti obrazac uporabe koji karakterizira ovisnička uporaba ili ovisnost često o velikim dozama alkohola ili drugih psihoaktivnih tvari, pa se ovisnost obično definira kao individualni neuspjeh, a ne kao društveni obrazac. Stoga se kao objašnjenje koristi konceptualizacija obrasca opetovane teške

conscious emotions and change their self-concept, which also enables a change in behavior (19).

Alcohol consumption is rooted in culture and tradition (20). Behavior in relation to alcohol consumption is culturally regulated and prescribed, while the behavior of individuals who drink alcohol is recognized as "use" and "abuse". Alcohol consumption plays a role in social categorization because cultural contexts and traditions influence the perception of drinking behavior and judgments towards individuals who drink alcohol (20).

An earlier view was that culture influences alcohol use, and later it was considered that some cultural groups have cognitive schemas and interpersonal relationship structures that allow alcohol use without a significant loss of control, while other cultural groups have alcohol-related problems because their different psychological and relational structures encourage the loss of control over alcohol use. It seems that in the modern Western societies, through the influence of the environment, stressors promote an increasing consumption of alcohol as one of the ways of coping with the stressors (21).

In addition to individual stress factors, the prevalence of alcohol consumption is also influenced by cultural and regional patterns of alcohol consumption, social role models, legal requirements and prohibitions. Cultural factors influence the beginning of alcohol use, environmental and social factors are important in the transition to hazardous consumption, while neurobiological and other risk factors are more pronounced in the transition to AUD (22).

There are three prototypical patterns of alcohol or psychoactive substance use: medical, habitual/regular, and occasional use. A fourth pattern of use is also present in the modern societies, characterized by addictive use or dependence, often on large doses of alcohol or other psychoactive substances, therefore addiction is usually defined as an individual failure, rather than a social pattern. For this reason, the conceptualization of the pattern of repeated severe addictive alcohol consumption is used as an explanation, and the problems for the individual and the environment

ovisničke konzumacije alkohola, a zanemaruju se problemi za osobu i okolinu koji proizlaze iz tog obrasca. Koncept se usredotočuje na obrazac uporabe, a ne na nemogućnost kontrole ili suzdržavanja od uporabe unatoč štetnim posljedicama (22).

U suvremenim društvima postoji značajna ujednačenost u društvenom rješavanju problematičnih situacija i osoba, uključujući i probleme s alkoholom i psihoaktivnim supstancama. U većini društava postoje bolnice i druge zdravstvene službe (medicinski djelatnici), sudovi i policija (suci i policajci), ustanove socijalne skrbi (socijalni radnici) te crkve i druge vjerske ustanove (svećenstvo), od kojih svatko rješava dio problema vezanih uz alkohol ili psihoaktivne tvari (23). Svaka od tih struka, odnosno institucija različito gleda na zlouporabu alkohola. Medicinska struka smatra da je zlouporaba alkohola bolest.

U objašnjenju problema povezanih s alkoholom postoje različite teorije: neurobiološke, socio-kulturološke i psihološke. Iako je medicinski model prihvaćen u problemima vezanim uz alkohol, još uvijek postoji nedovoljno prihvaćanje ovog koncepta na razini zdravstvene struke, kao i šire kulturne zajednice. Stoga smo u postojećoj literaturi pretražili relevantne podatke o empatiji i razumijevanju pojma alkoholne bolesti s naglaskom na psihodinamsko objašnjenje. Interakcija između pacijenta s ovisnošću i zdravstvenih djelatnika od velike je važnosti u svakodnevnoj kliničkoj praksi.

Prvi cilj ovog članka je narativni pregled empatije prema osobama s PUA iz psihodinamske perspektive koristeći se literaturom objavljenom u posljednjih 60 godina. Željeli smo saznati postoje li dokazi koji upućuju na postojanje ovog područja u literaturi. Istraživačka pitanja o empatiji prema pacijentima s PUA su: koji su dokazi o empatiji prema pacijentima s PUA i koji su dokazi o razumijevanju neempatičnog stava prema pacijentima s PUA iz psihodinamske perspektive. Kako bismo bolje razumjeli ova pitanja, pretražili smo noviju literaturu ve-

arising from this pattern are ignored. The concept focuses on the pattern of use rather than on the inability to control or refrain from use despite adverse consequences (22).

There is significant uniformity in the social handling of problematic situations and individuals in the modern societies, including problems with alcohol and psychoactive substances. In most societies, there are hospitals and other health services (medical professionals), courts and police (judges and police officers), social welfare institutions (social workers), churches and other religious institutions (clergy), and each of them solves part of the problems relating to alcohol or psychoactive substances (23). Each of these professions or institutions views alcohol abuse differently. The medical profession considers alcohol abuse to be a disease.

Different theories exist when it comes to explaining alcohol-related problems: neurobiological, socio-cultural and psychological. Although the medical model is accepted in relation to alcohol-related problems, there is still insufficient acceptance of this concept at the health profession level, as well as at the wider cultural community level. We have, therefore, searched the existing literature for relevant data regarding empathy towards and understanding of the concept of alcoholic disease, with an emphasis on psychodynamic explanation. The interaction between a patient with addiction and healthcare professionals is of great importance in everyday clinical practice.

The first aim of this article was to provide a narrative review of empathy towards individuals with AUD from a psychodynamic perspective, by using the literature published in the last 60 years. We wanted to find out whether there was any evidence that pointed to the existence of this field in literature. The research questions about empathy towards AUD patients were the following: what evidence exists with regard to empathy towards AUD patients and what evidence exists with regard to the understanding of non-empathic attitudes towards AUD patients from a psychodynamic perspective. In order to better understand these questions, we searched the more recent literature

zanu uz psihodinamsko razumijevanje ovisnosti o alkoholu. Stoga je drugi cilj bio istražiti koji su dokazi o aspektima funkcije ega, *self*-regulacije i srama kod pacijenata s PUA. Treći cilj je utvrditi koji su dokazi o posljedicama nekoherentnog razvoja *selfa*, i konačno, što je važno u liječenju pacijenata s PUA.

METODOLOGIJA

Da bismo odgovorili na prvi cilj narativnog pregleda usredotočili smo se na pretraživanje baza podataka (*Web of Science, PubMed* i *Google Scholar*) u području ovisnosti, posebno obraćajući pažnju na psihodinamsko proučavanje empatije prema osobama s PUA koristeći sljedeće ključne riječi prema naslovu medicinskih područja (engl. *Medical Subject Headings* (MeSH)): "poremećaj uporabe alkohola", "alkoholizam", "ovisnost o alkoholu", "empatija" i "psihodinamsko razumijevanje". Pretraživanje je provedeno u tri koraka. Prvo, relevantan članak odabran je evaluacijom naslova. U drugom koraku pročitani su sažetci relevantnih članaka. Treći korak uključivao je u cijelosti čitanje članaka odabranih u prethodnim koracima. Dodatno smo uključili članke koji se odnose na aspekte funkcije ega, *self*-regulacije, srama i nekoherentnog razvoja *selfa* kod pacijenata s PUA kako bismo odgovorili na ostala istraživačka pitanja iz psihodinamske perspektive.

Nakon isključenja članaka prema kriterijima uključivanja i isključivanja, četiri recenzenta postigla su suglasnost o uključivanju 53 istraživanja u ovaj pregledni rad. Uključena su samo istraživanja koja su svi autori nedvosmisleno smatrali prikladnima za pregled.

IDENTIFIKACIJA ČLANAKA

Kriteriji uključivanja bili su sljedeći: članci objavljeni od 1. siječnja 1980. do 2. travnja 2024.; evaluacija empatije kod pacijenata s PUA

relating to the psychodynamic understanding of alcohol addiction. The second aim, therefore, was to investigate what evidence exists when it comes to the aspects of ego function, self-regulation and shame in patients with AUD. The third aim was to determine what evidence exists when it comes to the consequences of incoherent development of the self, and finally, what is important in the treatment of patients with AUD.

METHODOLOGY

In order to provide an answer for the first aim of the narrative review, we focused on searching the database literature (Web of Science, PubMed and Google Scholar) in the field of addiction, paying special attention to the psychodynamic study of empathy towards patients with AUD using the following Medical Subject Headings (MeSH) terms as keywords: "alcohol use disorder", "alcoholism", "alcohol addiction", "empathy" and "psychodynamic understanding". The search was performed in three steps. First, a relevant article was selected by evaluating the titles. In the second step, abstracts of relevant articles were read. The third step involved reading the complete text of the articles selected in the previous steps. We additionally included articles referring to the aspects of ego function, self-regulation, shame and incoherent development of the self in AUD patients in order to answer the remaining research questions from a psychodynamic perspective.

The four reviewers reached a consensus on including a total of 53 studies in this review article after having excluded articles according to the inclusion and exclusion criteria. Only those studies that all reviewers unequivocally considered suitable for the review were included.

ARTICLE IDENTIFICATION

The inclusion criteria were the following: articles published from January 1, 1980 until April 2, 2024; evaluation of empathy in AUD patients and

i psihodinamsko razumijevanje PUA, originalni članci s presječnim dizajnom i istraživanja objavljena na engleskom jeziku. Primijenjeni su sljedeći kriteriji isključivanja: članci na jezicima koji nisu engleski, članci s prikazima slučajeva, pregledi i meta-analize, kvalitativna istraživanja, pisma urednicima, sažetci kongresa, kratki izvještaji, stručna mišljenja i sl.

REZULTATI I RASPRAVA

Empatija prema pacijentima s PUA: pregled literature

Istraživanja u području psihoterapije i savjetovanja pokazala su pozitivnu povezanost između empatije terapeuta, topline i iskrenosti s poboljšanim ishodom liječenja (24-26). Karakteristike terapeuta koje su se pokazale povezanima s ishodom liječenja ovisnosti o psihoaktivnim tvarima su razvijanje snažnog terapijskog saveza, empatija, iskrenost i poštovanje (27-29). Istraživanja su pokazala da su karakteristike terapeuta koje ocjenjuje pacijent pouzdaniji prediktori ishoda nego kad ih ocjenjuje terapeut (30,31). Utvrđeno je da je ishod liječenja PUA tri mjeseca od završetka liječenja značajno povezan sa stupnjem percepcije stručnosti terapeuta i empatijom (13). Jedno istraživanje je pokazalo da je stav osoblja prema muškim pacijentima oboljelim od PUA bio više konfrontirajući i kritičniji u usporedbi s empatičnijim i podržavajućim stavom prema pacijenticama koje su oboljele od PUA, što je povezano sa stereotipima koje terapeuti imaju o interpersonalnom ponašanju muških i ženskih pacijenata s PUA (32). Među 589 slučajno odabranih stručnjaka, oni koji su prihvatili koncept PUA kao bolesti vjerovali su u pozitivnu prognozu i imali pozitivne stavove prema pacijentima s PUA, dok su ih oni s negativnim stavovima prema pacijentima s PUA stigmatizirali i smatrali da su osobe ovisne o alkoholu same odgovorne za svoje probleme (33). Važnost empatije terapeuta pokazana je istra-

psychodynamic understanding of AUD, original articles with cross-sectional design and studies published in the English language. The following exclusion criteria were applied: articles in languages other than English, case report articles, reviews and meta-analyses, qualitative studies, letters to the editor, congress abstracts, brief reports, expert opinions, etc.

RESULTS AND DISCUSSION

Empathy towards patients with AUD: a literature review

Studies in the field of psychotherapy and counseling have shown a positive correlation between a therapist's empathy, warmth and honesty, and an improved treatment outcome (24-26). The characteristics of therapists that were found to be associated with psychoactive substance abuse treatment outcomes include developing a strong therapeutic alliance, empathy, honesty and respect (27-29). Studies have shown that therapist characteristics rated by a patient are more reliable predictors of outcomes than those provided by therapists (30, 31). It was observed that the outcome of AUD treatment three months after treatment completion was significantly associated with the degree of perceived therapist expertise and empathy (13). One study found that the attitude of staff members towards male AUD patients was more confronting and critical as opposed to a more empathic and supportive attitude towards female AUD patients, which is connected with the stereotypes held by therapists when it comes to the interpersonal behavior of male and female AUD patients (32). Among the 589 randomly chosen professionals, those who accepted the concept of AUD as a disease believed in a positive prognosis and had positive attitudes toward AUD patients, while those with negative attitudes toward AUD patients stigmatized them and considered that alcohol dependent individuals are responsible for their own issues (33). The importance of therapist empathy was observed in studies investigating the

živanjem odnosa između empatije terapeuta i ishoda liječenja PUA. To je bilo veliko, multicentrično, randomizirano kontrolirano istraživanje koje je pokazalo da razvoj vještina i empatija terapeuta neovisno doprinose ukupnoj koristi dobivenoj iz kombinirane bihevioralne intervencije (14). Poznavanje stavova stručnjaka osnova je za razvoj vještina u tretmanu PUA (34). Bolji ishodi liječenja za pacijente s PUA povezani su s empatijom i pozitivnim stavovima terapeuta prema njima (35,36). Istraživanja ukazuju na povezanost između stavova i empatije, gdje promjena stava dolazi iz znanja i iskustva (37,38). Zato se empatija kao vještina snažno ističe i poučava u različitim programima liječenja PUA, uključujući programe za studente medicine i sestrinstva (39-41). Osim toga, danas se koriste različite tehnologije za poboljšanje empatije prema stigmatiziranim skupinama, poput pacijenata s PUA, kao što su inženjerska rješenja iz obrade govora i jezika (42), video modeliranje (43) i virtualna stvarnost (44). Simulacija s pojedincem koji je obolio od PUA poboljšava elemente empatije poput empatične brige i usklađenog afekta (45). Nadalje, medicinske sestre koje rade u području mentalnog zdravlja pokazale su povećanu empatiju prema konzumentima s dvostrukom dijagnozom, a razina empatije varira ovisno o dobi, kliničkom okruženju, radnom sektoru i radnom iskustvu medicinske sestre (46). Stručnjaci s većom empatijom češće su provodili sustavno testiranje na rizičnu konzumaciju alkohola (47).

Razumijevanje ovisnosti o alkoholu iz psihodinamske perspektive

Psihodinamska psihoterapija dugo se koristi za razumijevanje konzumacije alkohola za modifikaciju i regulaciju raspoloženja ljudi. Za razumijevanje ovisnosti o alkoholu i drugih ovisnosti iz suvremene psihodinamske perspektive fokus je na ego/*self*-psihologiji, teoriji objektnih odnosa i teoriji privrženosti (48).

connection between therapist empathy and AUD treatment outcomes. This was a large, multicenter, randomized controlled trial which showed that skill building and therapist empathy independently contribute to the overall benefit derived from the combined behavioral intervention (14). Knowing professionals' attitudes is the basis for the development of skills when it comes to AUD treatment (34). Better treatment outcomes for AUD patients are associated with empathy and positive therapist attitudes towards them (35, 36). Conducted studies point to a link between attitudes and empathy, whereby attitude change stems from knowledge and experience (37, 38). Empathy as a skill is, therefore, strongly emphasized and taught in various AUD treatment programs, including programs intended for medical and nursing students (39-41). Moreover, various technologies are used nowadays in order to improve empathy towards stigmatized groups such as AUD patients, including engineering solutions in terms of speech and language processing (42), video modeling (43) and virtual reality (44). Simulation practice with an individual suffering from AUD improves elements of empathy such as empathic concern and shared affect (45). Furthermore, nurses working in the field of mental health showed increased empathy towards consumers with dual diagnosis, and empathy levels varied based on the nurses' age, clinical setting, work sector and work experience (46). Professionals with greater empathy conducted systematic screening for risky alcohol consumption more frequently (47).

Understanding alcohol addiction from a psychodynamic perspective

Psychodynamic psychotherapy has long been used to understand the consumption of alcohol for the purpose of modifying and regulating people's moods. In order to understand alcohol addiction and other addictions from a modern-day psychodynamic perspective, focus has been placed on ego/self-psychology, object relations theory and attachment theory (48).

a) Aspekti funkcije ega kod pacijenata s PUA

Postoji mnogo dokaza o slabom egu kod osoba ovisnih o alkoholu, što se manifestira slabom kontrolom emocija, kontrolom impulsa, impulzivnosti, niskom tolerancijom na frustraciju, poteškoćama u uspostavljanju prikladnih odnosa, problemima sa seksualnim identitetom i negativnom slikom o sebi (49-51). Kako bi se osoba s alkoholnom ovisnošću uspješno liječila važno je poboljšati njihovu snagu ega (52,53). Snaga ega definirana je kao sposobnost da osoba ima pozitivan stav prema sebi i svojim sposobnostima, samopoštovanje, emocionalnu fleksibilnost, sposobnost uspostavljanja zrelih odnosa i socijalnih interakcija (54,55). Niža snaga ega kod osoba ovisnih o alkoholu značajan je pokazatelj njihove loše suradnje u liječenju (55,56), a njihov negativni identitet ega smanjuje i uništava stav prema vlastitim sposobnostima (57).

b) Ovisnost kao poremećaj samoregulacije (engl. *self-regulation*)

Rane psihodinamske formulacije pokazuju da su ovisnički poremećaji, uključujući PUA, utemeljeni na traženju zadovoljstva ili samouništenju. Isto pokazuju i neuroznanstveni nalazi u objašnjenju uzroka ovisničkog ponašanja. Amigdala je mala struktura slična bademu smještena duboko u anteroinferiornom području temporalnog režnja mozga. To je zapravo heterogeno područje mozga sastavljeno od trinaest jezgri i kortikalnih područja i njihovih podjedinica (58), povezano s frontalnim korteksom, hipokampusom, septalnim jezgrama i medijalnom dorzolateralnom jezgrom talamusa. Brojna istraživanja povezuju amigdalu s obradom motivacijskog značenja podražaja i posredovanjem te kontrolom osnovnih emocija poput ljubavi, straha, ljutnje, anksioznosti i općenito negativnih afektivnih stanja (59-62). Amigdala je djelomično kontrolirana dopaminskim sustavom (63), koji je bitan dio moždanog sustava nagrade i generira osjećaj zadovoljstva

a) Aspects of ego function in patients with AUD

There is a lot of evidence about the weak ego of individuals addicted to alcohol, which is manifested in a weak control of emotions, impulse control, impulsivity, low frustration tolerance, difficulties in establishing appropriate relationships, problems with sexual identity, and a negative self-image (49-51). In order to successfully treat an individual suffering from alcohol addiction, it is important to improve their ego strength (52, 53). Ego strength is defined as the ability of an individual to have a positive attitude towards themselves and their own abilities, self-esteem, emotional flexibility, the ability to establish mature relationships and social interactions (54, 55). Lower ego strength in people addicted to alcohol is a significant indicator of their poor cooperation during treatment (55, 56), and their negative ego identity reduces and destroys their attitude toward own abilities (57).

b) Addiction as a self-regulation disorder

Early psychodynamic formulations suggested that addictive disorders, including AUD, are rooted in pleasure-seeking or self-destruction. The same was suggested in the neuroscientific findings when explaining the causes of addictive behavior. The amygdala is a small almond-like structure located deep in the anteroinferior region of the temporal lobe. It is, in fact, a heterogeneous area of the brain consisting of thirteen nuclei and cortical regions and their subunits (58), which is connected to the prefrontal cortex, hippocampus, septal nuclei, and the medial dorsal nucleus of the thalamus. Numerous studies link the amygdala with the processing of the motivational meaning of stimuli and with the mediation and control of basic emotions such as love, fear, anger, anxiety, and generally negative affective states (59-62). The amygdala is partially controlled by the dopaminergic system (63), which is an essential part of the brain's reward system, and generates a sense of pleasure in response to alcohol (64). According to current knowledge, all addictive substances activate dopaminergic neurons whose bodies are located in the ventral teg-

kao odgovor na alkohol (64). Prema trenutnim saznanjima sve ovisničke tvari aktiviraju dopaminske neurone čija su tijela smještena u ventralnom tegmentalnom području mozga (65). Projekcije dopaminergičkih neurona putuju do jezgre akumbensa, prefrontalnog korteksa i amigdala (66). Mezolimbički put, odnosno dopaminergički put od ventralno tegmentalnog područja do jezgre akumbensa, utvrđen je kao središnji dio mozga koji upozorava pojedinca na mogućnost nagrade kao odgovor na njegovu akciju (mehanizam pojačanja) (67). Ovo otkriće predstavilo je mehanizam kojim etanol može potaknuti aktivnost u mezolimbičko-dopaminergičkom sustavu koji predviđa nagradu.

Može se reći da razumijevanje ovisnosti iz neuroznanstvene i suvremene psihodinamske perspektive nije proturječno. Iako neuroznanstvenici govore o traženju zadovoljstva uzimanjem sredstva ovisnosti, a suvremeni psihodinamski pristup o patnji koja leži iza ovisnosti (48), može se reći da je to traženje zadovoljstva zapravo obrana od duboke patnje.

U razdoblju 1960-ih i 1970-ih suvremeni psihodinamski pristupi opisivali su ovisnost kao perspektivu strukture ega, *selfa*, emocija i objektnih odnosa, ističući kako su razvojni poremećaji u doživljavanju i obradi emocija, posebno srama, osjećaja *selfa* i samopoštovanja, ključni za međuljudske odnose i ponašanje koji su glavni čimbenici za razvoj i održavanje ovisnosti (48). Suvremena psihodinamska formulacija smatra da su ovisnički procesi ukorijenjeni u patnji, jer pacijent s PUA ne može regulirati svoje emocije, samopoštovanje, ponašanje, posebno brigu o sebi (68). Tijekom razvojnih faza (od djetinjstva do odrasle dobi), važni su utjecaji okoline na sposobnost samoregulacije oko roditeljstva, sigurnosti, traumatičnih iskustava i odnosa s vršnjacima (69,70). Ovo je važno imati na umu tijekom tretmana da bi tretmani bili učinkoviti jer kod pacijenata s PUA razvojni poremećaji u najranijim fazama odrastanja imaju velik utjecaj, a na njih ne postoje sjećanja ili simboličke reprezentacije.

mental area (VTA) of the brain (65). Projections of dopaminergic neurons travel to the nucleus accumbens (NAc), the prefrontal cortex (PFC), and the amygdala (66). The mesolimbic pathway, i.e. the dopaminergic pathway from the VTA to the NAc, has been determined as the central part of the brain system which alerts the individual of the possibility of reward in response to their action (reinforcement mechanism) (67). This discovery has introduced a mechanism by which ethanol could induce activity in the mesolimbic-dopaminergic system that predicts reward.

It could be said that understanding addiction from neuroscientific and modern psychodynamic perspectives is not contradictory. Although neuroscientists talk about seeking pleasure by taking an addictive substance and the modern psychodynamic approach refers to the suffering that lies behind addiction (48), it could be said that this pleasure-seeking is actually a defense against deep suffering.

In the 1960s-1970s period, the contemporary psychodynamic approaches described addiction through the perspective of the structure of the ego, the self, emotions, and object relations, emphasizing how developmental impairments in experiencing and processing emotions, especially shame, the sense of self and self-esteem, were essential to interpersonal relationships and behavior, which are crucial factors for the development and maintenance of addiction (48). The modern psychodynamic formulation describes the addictive processes as being rooted in suffering because an AUD patient cannot regulate their emotions, self-esteem, behavior, and especially self-care (68). During the developmental stages (from childhood to adulthood), environmental influences that affect the ability to self-regulate around parenting, security, traumatic experiences and relationships with peers are important (69, 70). It is important to keep this in mind during treatments in order to make the treatments effective, because in AUD patients, developmental impairments in the earliest stages of development have a great impact, but there are no memories or symbolic representations of them.

c) Ovisnost kao sindrom temeljen na sramu

Ovisnički poremećaji su sindrom temeljen na sramu u kojem stvarni ili zamišljeni objekt potencijalno ima moć da ga se prisilno (kompulzivno) želi (71). Pregled objavljene literature pokazao je da osobe s PUA često imaju emocionalno nezreli karakter te da je njihova osobnost temeljena na sramu. Sram snažno utječe na razvoj njihovog identiteta i dovodi do duboko ukorijenjenih osjećaja nepovjerenja, krivnje, inferiornosti i izolacije (72). U literaturi koja se odnosi na ovisnost i PUA nedostaju radovi o sramu koji se specifično odnose na razvojne procese, iako je poznato da je ovisničko ponašanje temeljeno na sramu jer se većina istraživanja odnosi na kognitivne, bihevioralne i biološke pristupe (49). Sram je jedna od najjačih ljudskih emocija, što je rezultat negativne evaluacije cjelokupnog sebe ili nekog aspekta sebe. Pojavljuje se kada osoba ne može prihvatiti sebe ili neki dio sebe što uzrokuje intenzivan i preplavljujući osjećaj bespomoćnosti, bezvrijednosti, nevažnosti i želje za nestajanjem (73). Kao i krivnja, sram pripada moralnim emocijama koje su važne za razvoj društvenih i kulturnih normi te sprječavanje njihovog kršenja. Ovaj tip srama naziva se prilagodljivim (adaptivnim) sramom. On je u osnovi dobar, za razliku od patološkog srama (tzv. skriveni sram) koji je u pozadini psihopatoloških poremećaja i fenomena (agresivno ponašanje, suicidalnost, ovisničko ponašanje uključujući PUA, poremećaji prehrane, patološki narcizam, itd.) (74). Ovisnički proces je prisilan (kompulzivan), ponavljajući i iznimno otporan na promjene. U psihopatološkim poremećajima osoba zbog razvojnog deficita i oštećenog *selfa* (75) koristi vanjske objekte kao *self*-objekte kako bi se smirila. Budući da osobe sklone alkoholu nisu internalizirale kapacitet za samoumirivanje, one alkohol mogu smatrati *self*-objektom koji smanjuje anksioznost, „liječi“ razvojne poremećaje i smanjuje osjećaje srama i izolacije (76). Sram i krivnja ponovno se pojavljuju na-

c) Addiction as a shame-based syndrome

Addictive disorders are a shame-based syndrome in which a real or imagined object potentially has the power to be compulsively desired (71). The review of published literature indicated that individuals with AUD often have emotionally immature characters and a shame-based personality. Shame has a strong influence on the development of their identity and leads to deeply rooted feelings of mistrust, guilt, inferiority, and isolation (72). In the literature that addresses addiction and AUD, there is a lack of publications on shame that specifically refer to developmental processes, even though addictive behavior is known to be based on shame because most studies refer to cognitive, behavioral and biological approaches (49). Shame is one of the strongest human emotions, resulting from a negative evaluation of the whole self or some aspect of the self. It emerges when an individual cannot accept themselves or a part of themselves, which causes an intense and overwhelming feeling of helplessness, worthlessness, insignificance and desire to disappear (73). Similar to guilt, shame is part of the moral emotions which are important for the development of social and cultural norms, and the prevention of their violation. This type of shame is called adaptive shame. It is basically good, as opposed to pathological shame (i.e. hidden shame) which underlies psychopathological disorders and phenomena (aggressive behavior, suicidality, addictive behaviors including AUD, eating disorders, pathological narcissism, etc.) (74). The addiction process is compulsive, repetitive and highly resistant to change. Due to a developmental deficit and a damaged self (75), in psychopathological disorders an individual uses external objects as self-objects in order to calm down. Since individuals prone to alcohol consumption have not internalized the capacity to self-soothe, they can consider alcohol as a self-object that reduces anxiety, “cures” developmental impairments, and reduces feelings of shame and isolation (76). Shame and guilt re-emerge after episodes of

kon epizoda pijenja, koje se prisilno (kompulzivno) ponavljaju i osoba više ne može funkcionirati bez alkohola, oslanjajući se na alkohol kao na samopomoć, stvarajući lažni osjećaj neovisnosti i autonomije (77). Hipoteza o samoliječenju tvrdi da je ovisnost rezultat razvojnih deficita u kojima je alkohol sredstvo samoregulacije (78) jer su skrbnici (roditelji) ovisnika bili neempatični, nekonzistentni i toksični u ranim fazama njihovog razvoja, uzrokujući njihovu *self*-oštećenost (79). Osoba ima dubok osjećaj nemoći jer ne može kontrolirati ovisnost, javlja se sekundarni sram te se osjeća poniženo jer je kontrolirana ovisnošću (71,80). Čini se da alkohol ubija sram jer je super-ego osobe ovisne o alkoholu topljiv u alkoholu i alkohol uklanja krivnju (80). Može se reći da im alkohol ("boca") zamjenjuje ljudski odnos. Važne ljudske potrebe postaju vezane uz sram zbog poremećaja u ljudskim odnosima tijekom razvoja koji uzrokuju preplavljenost negativnim afektom pa je funkcija ovisnosti bijeg od preplavljujućih negativnih afekata. Stoga se tvrdi da ovisnost ublažava sram, ali ga i ponovno reproducira, što aktivira krug i spiralu srama tijekom ponavljajućih obrazaca (81).

Posljedice nekohenzivnog razvoja *selfa*

U ovisnosti, kao posljedica nekohenzivnog razvoja *selfa* (75), prisutno je sljedeće: a) poremećene emocije, b) poremećeni odnosi sa samim sobom i drugima, te c) poremećena briga o sebi (48).

a) Poremećaj u doživljavanju emocija

Današnje psihodinamsko razumijevanje smatra da pacijenti s ovisnosti o alkoholu pate zbog svojih emocija. Osjećaju se prazno i nesposobno koristiti se vlastitim emocijama kako bi usmjerili svoje reakcije i ponašanje (51,69,82). Osoba sklona ovisnosti doživljava ekstremnu patnju jer su njezini osjećaji zaista intenzivni, neizdržljivi, preplavljujući i razarajući. Stoga se naglašavaju nedostatci u obrani od osjećaja i impulsa pa osoba, zbog nedostataka u psihološ-

drinking, which are compulsively repeated, and the individual can no longer function without alcohol, relying on alcohol as self-help and creating a false sense of independence and autonomy (77). The self-medication hypothesis considers addiction to be the result of developmental deficits in which alcohol is a means of self-regulation (78) because the addict's caregivers (parents) were unempathetic, inconsistent and toxic in the early stages of their development, thus causing their self-damage (79). The individual experiences a deep sense of powerlessness because they cannot control the addiction, secondary shame occurs and they feel humiliated because they are controlled by the addiction (71, 80). It seems that alcohol kills shame because the superego of an individual addicted to alcohol is soluble in alcohol and alcohol removes guilt (80). It could be said that alcohol ("the bottle") is a substitute for a human relationship. Vital human needs become tied up in shame due to disruptions in human relationships during development which cause an overflow of negative affects. The function of addiction is, therefore, to escape from the overwhelming negative affects. It is, thus, considered that addiction alleviates shame, but also reproduces it again, in this way activating the cycle and spiral of shame through repetitive patterns (81).

The consequences of non-cohesive development of the self

The following is present as a consequence of non-cohesive development of the self when it comes to addiction (75): a) disordered emotions, b) disordered relations with self and others, and c) disordered self-care (48).

a) Disordered emotions

According to the current psychodynamic understanding, AUD patients suffer due to their emotions. They feel empty and unable to use their own emotions to guide their reactions and behavior (51, 69, 82). An individual prone to addiction experiences extreme suffering because their feel-

koj strukturi i slabog ega, konzumira ovisničku tvar kako bi lakše prevladala neizdržive osjećaje, posebno ljutnju i agresiju (49,83-85). Drugim riječima, konzumiranje alkohola ili drugih psihoaktivnih tvari olakšava inače neizdržive osjećaje i afekte ili ih čini podnošljivijima i manje zbunjujućima.

b) Poremećaj u odnosu sa *selfom* i drugima

Oslanjajući se na spoznaje iz *self* psihologije (76,86), nedavna istraživanja ističu unutarnja stanja samoneugodnosti (engl. *self-discomfort*) kod osoba s PUA. Unutarnja kohezija je nedovoljna, a postoje povremeni i/ili kronični osjećaji bespomoćnosti, fragmentacije, osiromašenosti, srama i niskog osjećaja vlastite vrijednosti. Kao posljedica toga osjećaji ljutnje, opijenosti ili bahatosti prikrivaju osnovni osjećaj praznine i nedostatnosti (49,72,87).

To je važno u liječenju ovisnosti, jer se na taj način prepoznaje problem nedostatka samopouzdanja i bolnog nedostatka samopoštovanja kako bi se izbjegao narcistički slom (74,75). Samo-liječenje alkoholom pomaže prisilno (kompulzivno) smanjiti emocionalnu bol uzrokovanu deficitima u samom sebi i identitetu (engl. *self and identity deficits)*. Budući da osobe ovisne o alkoholu imaju poteškoće u podnošenju bolnih emocija i stresa, kao i poteškoće u interakcijama s drugim ljudima, alkohol pruža privremeno olakšanje bolnih intrapsihičkih i interpersonalnih poteškoća. Alkohol pomaže ljudima da se povežu s drugima zbog oštećenog osjećaja sebe (engl. *damaged sense of self*), niskog samopoštovanja (engl. *self-esteem*) i problematičnih međuljudskih odnosa (51).

c) Poremećena briga o sebi

Kapacitet za brigu o sebi (engl. *self-care*) kod ovisnih osoba nedovoljno je razvijen ili manjkav, što se odnosi na funkcije brige o sebi (engl. *self-care*) koje osiguravaju sigurnost, dobrobit i mogućnost preživljavanja (68,87). Osobe sklo-

ings are very intense, unbearable, overwhelming and devastating. Therefore, deficiencies in their defense against feelings and urges are emphasized, and the individual, due to deficiencies in the psychological structure and their weak ego, consumes an addictive substance in order to overcome unbearable feelings, especially anger and aggression, more easily (49, 83-85). In other words, taking alcohol or other psychoactive substances relieves otherwise unbearable feelings and affects, or makes them more tolerable and less confusing.

b) Disordered relations with self and others

Relying on the insights of self-psychology (76, 86), recent findings highlight the internal states of self-discomfort in individuals with AUD. Internal cohesion is insufficient and they experience occasional and/or chronic feelings of helplessness, fragmentation, impoverishment, shame, and a low sense of self-worth. As a consequence, feelings of anger, intoxication or arrogance mask the basic feeling of emptiness and inadequacy (49, 72, 87).

This is important in addiction treatment, because in this way the problem of lack of self-confidence and a painful lack of self-esteem are recognized in order to avoid a narcissistic breakdown (74, 75). Self-medication with alcohol helps to compulsively reduce the emotional pain caused by self and identity deficits. Since individuals addicted to alcohol have difficulties in tolerating painful emotions and stress, as well as difficulties in interactions with other people, alcohol creates a temporary relief from painful intrapsychic and interpersonal difficulties. Alcohol helps individuals connect with others because of a damaged sense of self, low self-esteem, and problematic interpersonal relationships (51).

c) Disordered self-care

The self-care capacity in addicted individuals is underdeveloped or deficient, which refers to self-care functions that ensure safety, well-be-

nije ovisnosti imaju oštećenja vezana uz potencijalno opasne i stvarno opasne situacije te ne prepoznaju uzročno-posljedičnu vezu prije rizika. Anksioznost, strah i briga su kod njih manjkavi u vezi situacija koje im mogu naškoditi. Nedostaje im anticipativna krivnja i sram te im zbog toga nedostaju sposobnosti za brigu o sebi (engl. *self-care*).

Razumijevanje nepostojanja empatije prema pacijentima s PUA iz psihodinamske perspektive

Pojam "poremećaj brige o sebi" (engl. "*disordered self-care*") ukazuje na važnost terapijskog saveza kao ključnog elementa u promicanju promjene i opisuje ključne elemente tog saveza kao ljubaznost, podršku, empatiju, poštovanje, strpljenje i upute. Ovisnički poremećaji ukorijenjeni su u patnji - ne u potrazi za zadovoljstvom ili samouništenjem, kako su to sugerirali raniji psihodinamski obrasci. Patnja je uglavnom posljedica nesposobnosti ovisne osobe da regulira svoje emocije, samopoštovanje (engl. *self-esteem*), odnose i ponašanje, posebno svoju brigu o sebi (engl. *self-care*). Suvremeno psihoanalitičko razumijevanje ovisničkih poremećaja povezano je s patnjom u suprotnosti s potragom za zadovoljstvom (posebno neuroznanstvenika), jer traženje olakšanja u alkoholu obično proizvodi više patnje nego olakšanja. S obzirom na teškoće s kojima se suočavaju ovisne osobe u regulaciji emocija, osjećaja sebe/samopoštovanja (engl. *self-esteem*), odnosa i brige o sebi (engl. *self-care*), suvremeni psihoterapeut mora biti interaktivniji (balansirajući razgovor i slušanje) i uključiti stavove ljubaznosti, podrške, empatije, poštovanja, strpljenja i uputa u cilju izgradnje i održavanja snažnog terapijskog saveza (48,49,72). Ovi elementi ključni su kako bi se prevladali i suočili s problemima nedostupnih ili intenzivnih emocija, srama, narušenog samopoštovanja (engl. *self-esteem*)/odnosa i loše brige o sebi (engl. *self-care*).

ing and the possibility of survival (68, 87). Individuals prone to addiction have impairments associated with potentially and actually dangerous situations and do not recognize the causal link before the risk. Their anxiety, fear and worry are deficient when it comes to situations that could harm them. They lack anticipatory guilt and shame, and therefore lack self-care abilities.

Understanding the lack of empathy towards AUD patients from a psychodynamic perspective

The concept of "disordered self-care" indicates the importance of therapeutic alliance as a key element in promoting change, and describes the key elements of this alliance as kindness, support, empathy, respect, patience and instruction. Addictive disorders are rooted in suffering – not in seeking pleasure or self-destruction, as suggested by earlier psychodynamic formulations. The suffering is mainly a consequence of the addicted individual's inability to regulate their emotions, self-esteem, relationships, and behavior, especially their self-care. Contemporary psychoanalytic understanding of addictive disorders is linked with suffering as opposed to pleasure seeking (especially among neuroscientists), because looking for relief in alcohol usually produces more suffering than relief. Considering the difficulties which addicted individuals face in terms of regulating their emotions, sense of self/self-esteem, relationships and self-care, a contemporary psychotherapist needs to be more interactive (by balancing between talking and listening) and needs to incorporate attitudes of kindness, support, empathy, respect, patience and instruction for the purpose of building and maintaining a strong therapeutic alliance (48, 49, 72). These elements are essential in order to overcome and face the problems caused by inaccessible or intense emotions, shame, broken self-esteem/relationships, and poor self-care.

Što je bitno u liječenju osoba ovisnih o alkoholu?

Iako postoje dokazi da je empatija povezana s pozitivnim ishodima PUA, moralni model ovisnosti i neriješena pitanja kontratransfera mogu otežati empatično razumijevanje stručnjaka za pacijente koji boluju od PUA (88). Moralni model razumijevanja ovisnosti pretpostavlja da ovisnost nastaje iz prirođenih karakterističnih nedostataka i moralnih slabosti (89,90). Ova je percepcija povezana s negativnim i kritičkim stavovima prema takvim pacijentima što rezultira nedostatkom empatije (91,92). Stručnjaci s takvim stavovima vjeruju da je osoba s ovisnošću o alkoholu isključivo odgovorna za svoje stanje. Nadalje, stručnjaci koji podržavaju model prema kojem je ovisnost o alkoholu bolest, a koji je Svjetska zdravstvena organizacija uvela 1952. godine (93,94), istovremeno mogu imati moralistička uvjerenja (17,95,96). Neriješeni kontratransferni problemi kod stručnjaka još su jedna značajna prepreka empatiji prema pacijentima s PUA. To se najvjerojatnije događa jer je gotovo svakoga pojedinca, direktno ili indirektno, na neki način dotaknuo život (97).

Tijekom liječenja osoba ovisnih o alkoholu važno je imati na umu dinamiku razvoja ovisnosti i ranjivost samih osoba, koja se temelji na sramu, slabom egu i poremećenom *selfu*, poremećenim emocijama, poremećenim odnosom sa sobom i drugima te poremećenom brigom o sebi (engl. *self-care*) (48,49,51,72,75). Suvremeni psihoterapijski tretmani koriste interaktivne, podržavajuće i empatične stavove i tehnike koje pomažu pacijentima i terapeutima da se usredotoče na ranjivosti i disfunkcije koje održavaju patnju i bol ovisnika. Stari psihoanalitički pristupi temeljeni na pasivnosti, terapijskom distanciranju i interpretativnim metodama mogli bi pojačati zbunjenost, sram i otuđenje, koji su inače ključni problemi u dinamici ovisnosti. U suvremenom psihoterapijskom pristupu pacijentu s ovisnošću naglasak

What is important in the treatment of individuals addicted to alcohol?

Although evidence exists that empathy is associated with positive outcomes in the treatment of AUD, the moral model of addiction and unresolved countertransference issues may hinder the empathic understanding of professionals towards patients with AUD (88). The moral model of understanding addiction assumes that addiction arises from inherent character flaws and moral weaknesses (89, 90). This perception is associated with negative and critical attitudes towards such patients, resulting in a lack of empathy (91, 92). Professionals with these attitudes believe that an individual suffering from alcohol addiction is solely responsible for their own condition. Furthermore, professionals who support the model according to which alcohol addiction is a disease, which was introduced by the World Health Organization in 1952 (93, 94), may at the same time have moralistic beliefs (17, 95, 96). Unresolved countertransference issues in professionals represent another significant obstacle when it comes to empathy towards AUD patients. This most likely occurs because almost every individual has, either directly or indirectly, been in some way affected by life's difficulties (97).

During the treatment of individuals addicted to alcohol, it is important to take into account the dynamics of addiction development and the vulnerability of the individuals themselves, which is based on shame, weak ego and disturbed self with disturbed emotions, disturbed relation with self and others, and disturbed self-care (48, 49, 51, 72, 75). Contemporary psychotherapy treatments use interactive, supportive and empathic attitudes and techniques that help patients and therapists focus on the vulnerabilities and dysfunctions that perpetuate the addicts' suffering and pain. The old psychoanalytical methods based on passivity, therapeutic detachment and interpretive methods could intensify confusion, shame and alienation, which otherwise represent central problems in the dynamics of addiction. In

je na interaktivnosti, odnosno na uravnoteženom razgovoru i slušanju. Važni terapijski elementi su podrška, empatija, ljubaznost, poštovanje, strpljenje i poučavanje o izgradnji i održavanju snažnog terapijskog saveza. Mentalizacija je jedan od osnovnih aspekata psihoterapijskog rada, što je izuzetno važno za pacijente s ovisnošću (98). Važno je uporno se usredotočavati na pacijente kako bi se dosegli i verbalizirali njihovi osjećaji te kako bi se održavali. Uloga psihodinamskog razumijevanja vrlo je važna u kontekstu dobrog terapijskog saveza, a nedostatak mentalizacijske sposobnosti implicira poremećenu percepciju psihofarmakoterapije, socioterapije i drugih terapijskih pristupa (74). Empatični način funkcioniranja potiče prenošenje *self*-objekta, koje olakšavaju procese internalizacije koji mogu dovesti do smanjenja potrebe pacijenta s PUA za čvrstom negacijom bolesti (99). To je važno za promicanje javnog i globalnog mentalnog zdravlja, gdje su ključna tri međusobno povezana koncepta empatija, koherentnost i otpornost. Pokazano je da prakticiranje ljubavi, ljubaznosti i empatije prema sebi i drugima doprinosi izgradnji samopouzdanja (engl. *self-confidence*) i samokoherentnosti (engl. *self-coherence*), pomaže u stvaranju zdravih i zrelijih odnosa, povećava individualnu i zajedničku otpornost, promiče ljudska prava, fizičko i mentalno zdravlje.

SNAGE I OGRANIČENJA

Ovaj narativni pregled literature sintetizira znanje o empatiji prema pacijentima s PUA, kao i psihodinamsko razumijevanje osoba ovisnih o alkoholu. Pruža se brz i detaljan pregled o aspektima funkcije ega, *self*-regulaciji, sramu i *self*-razvoju kod pacijenata s PUA, neempatičnom stavu prema pacijentima s PUA u terapijskom odnosu. U ovom smo se pregledu usredotočili na psihodinamsko razumijevanje pacijenata s PUA i konstrukta empatije jer smo

the modern psychotherapeutic approach to patients with addiction, emphasis is placed on interactivity, i.e. on balanced conversation and listening. Important therapeutic elements include support, empathy, kindness, respect, patience and teaching about building and maintaining a strong therapeutic alliance. Mentalization is one of the fundamental aspects of psychotherapy work, which is extremely important for patients with addiction (98). It is important to persistently focus on patients in order to reach and verbalize their feelings, and to maintain them. The role of psychodynamic understanding is very important in the context of a good therapeutic alliance, and a lack of mentalizing capacity implies a disturbed perception of psychopharmacotherapy, sociotherapy and other therapeutic approaches (74). The empathic method of functioning promotes self-object transferences, which facilitate the internalization processes that may lead to a reduction of the AUD patient's need to rigidly maintain their denial of the illness (99). This is important for the purpose of promoting public and global mental health, where three key interrelated concepts include empathy, coherence and resilience. It has been shown that practicing love, kindness and empathy towards oneself and others contributes to building self-confidence and self-coherence, helps create healthy and more mature relationships, increases individual and community resilience, promotes human rights, as well as physical and mental health.

STRENGTHS AND LIMITATIONS

This narrative literature review synthesizes the knowledge on empathy towards AUD patients, as well as the psychodynamic understanding of alcohol dependent individuals. It provides a quick and detailed overview of the aspects of ego function, self-regulation, shame and self-development in patients with AUD, the non-empathic attitude towards patients with AUD in the therapeutic relationship. In this review, we focused on the psychodynamic understanding of patients with AUD and

željeli ukazati na važnost interakcije između pacijenata s ovisnostima i njihovih pružatelja zdravstvenih usluga što je svakodnevni izazov za one koji liječe takve pacijente. Zbog obilja teorijskih i empirijskih spoznaja o pacijentima s PUA i poremećajima ovisnosti, nismo mogli detaljnije uključiti kulturološke i neurobiološke čimbenike u etiologiju i liječenje ovisnosti. Svjesni smo uobičajenih ograničenja narativnog naspram sustavnog pregleda literature kao potencijalno pristranog izvora i odabira literature, kvalitativne analize umjesto kvantitativne sinteze, a time i manje zaključaka utemeljenih na dokazima.

ZAKLJUČCI

Uz kulturološko i neurobiološko razumijevanje i pristupe liječenju PUA, iz kliničke perspektive važno je razumjeti psihodinamsko sile koje su u osnovi ovisničkog ponašanja, kao i osjećajna stanja pacijenata s ovisnostima, jer je to ključno za razvoj terapijskog odnosa koji može pružiti kontekst za uspješno liječenje (68). Postojeći podatci u odnosu na empatiju prema pacijentima s PUA i drugim ovisničkim ponašanjima pokazali su da je psihodinamska perspektiva jedna od najmoćnijih paradigmi za usmjeravanje kliničara u liječenju ranjivosti koje dovode i održavaju ovisničko ponašanje. Empatija, ljubaznost, podrška, strpljenje, klima uzajamnog poštovanja i poučavanja nužni su i sukladni psihodinamskom pristupu u liječenju pacijenata koji boluju od bolesti ovisnosti (68) jer takav pristup ublažava patnju i bol povezanu s ovisnošću. Povećanje znanja i svijesti da je PUA temeljen na patnji, a ne na zadovoljstvu, moglo bi povećati empatiju stručnjaka i okoline u podršci liječenju ovih pojedinaca. Suvremeni psihodinamski pogled pruža razumijevanje, empatiju, nadu i nudi učinkovitije načine za prevladavanje samouništavajućih (engl. *self-defeating*) tragičnih uzroka i posljedica ovisnosti. U svakodnevnoj

the construct of empathy, because we wanted to highlight the importance of interaction between patients with addictions and their health care providers, which is a daily challenge for those who treat such patients. Due to the abundance of theoretical and empirical knowledge on patients with AUD and addition disorders, we could not include in more detail the cultural and neurobiological factors into the etiology and treatment of addiction. We are aware of the usual limitations of the narrative versus systematic literature review as a potentially biased source and literature selection, qualitative analysis instead of quantitative synthesis, and thus fewer evidence-based conclusions.

CONCLUSIONS

In addition to the cultural and neurobiological understanding and approaches to the treatment of AUD, from a clinical perspective it is important to understand the psychodynamic forces that underlie addictive behavior, as well as the emotional states of patients with addictions, because this is crucial for developing a therapeutic relationship that can provide a context for successful treatment (68). The existing data relating to empathy for patients with AUD and other addictive behaviors have shown that the psychodynamic perspective is one of the most powerful paradigms for guiding clinicians in the treatment of vulnerabilities that lead to and maintain addictive behaviors. Empathy, kindness, support, patience, a climate of mutual respect and teaching, are all necessary and consistent with the psychodynamic approach in the treatment of patients suffering from addiction (68), because such an approach alleviates the suffering and pain associated with addiction. Increasing the level of knowledge and awareness that AUD is based on suffering, and not pleasure, could help increase the empathy of professionals and of the environment when it comes to supporting the treatment of these individuals. The contemporary psychodynamic perspective provides understanding, empathy, hope, and offers more effective methods to overcome the self-defeating tragic causes and consequences of addic-

kliničkoj praksi kombinacija bihevioralnih, psihosocijalnih, farmakoterapijskih i psihoterapijskih pristupa pokazala se najučinkovitijom. U budućnosti će od velike važnosti biti istraživanja o ishodima kombiniranih tretmana (psihoterapijskih, farmakoterapijskih i socioterapijskih).

tion. In daily clinical practice, a combination of behavioral, psychosocial, pharmacotherapeutic and psychotherapeutic approaches has proved to be the most effective. In the future, studies addressing the outcomes of combined treatments (psychotherapeutic, pharmacotherapeutic and sociotherapeutic) will be of great importance.

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Neke perspektive primjene tjelesno orijentiranih terapija i terapije pokretom i plesom u liječenju traume

/ *Some Perspectives on the Use of Body-Oriented Psychotherapies and Dance/Movement Therapy in Trauma Treatment*

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U današnje su vrijeme događaji i ponašanja koja se mogu doživjeti kao traumatična postali sve učestaliji. Zbog značajnih posljedica koje traumatska iskustva mogu izazvati, potrebno je uložiti posebne napore u prevenciju ili smanjenju simptoma povezanih s traumom. Takvi pristupi trebaju se usredotočiti na psihološki i fizički oporavak uključujući različite tehnike za uklanjanje stvarnih i simboličkih ozljeda zarobljenih u tijelu. Naime, tijekom traume tijelo je često žrtva, ali i nositelj bolnog iskustva. Zbog toga se ono kasnije može doživjeti kao podsjetnik na traumu, uzrok boli, ozljede, straha i bespomoćnosti. Stoga je logično da tijelo treba biti dio terapijskog procesa. Budući da se tjelesno orijentirane psihoterapije i terapija pokretom i plesom fokusiraju na tjelesne senzacije, svjesnost o tijelu i tjelesnu memoriju, ove vrste terapija mogu biti osobito korisne u liječenju traume. Brojne studije su potvrdile da ove vrste intervencija mogu imati različite pozitivne učinke na fiziološko i psihosocijalno funkcioniranje, posebno u smanjenju anksioznosti, straha, srama i uznemirujućih sjećanja, kao i u poticanju jedinstva duha i tijela, brige o sebi, emocionalnog izražavanja te osjećaja sigurnosti, slobode i nade. Potrebna su daljnja istraživanja usmjerena na razmatranje dobrobiti i prikladnih načina uključivanja tjelesnog iskustva tijekom terapijskog procesa. Na taj bi se način ostvarile pretpostavke prema kojima bi se tijelo, umjesto kao izvor i podsjetnik bolnog iskustva, moglo doživjeti kao izvor ozdravljenja u okviru holističkog pristupa u terapiji traume.

/ *The events and behaviors that could be perceived as traumatic have nowadays become more and more frequent. Due to the significant consequences that traumatic experiences can cause, special efforts should be made to prevent or reduce the symptoms associated with trauma. Such approaches should focus on psychological and physical recovery, including various techniques to eliminate the real and symbolic injuries trapped in the body. Namely, in the course of trauma, the body is often the victim, but also the bearer of a painful experience. For this reason, it can later be perceived as a reminder of the trauma, the cause of pain, injury, fear and helplessness. It is, therefore, logical that the body should be part of the therapeutic process. Since body-oriented psychotherapies and dance/movement therapy focus on bodily sensations, body awareness and body memory, these types of therapies can be particularly helpful in the treatment of trauma. Numerous studies have confirmed that these types of interventions can have various positive effects on physiological and psychosocial functioning, particularly in reducing anxiety, fear, shame and disturbing memories, as well as in promoting mind-body unity, self-care, emotional expression and feelings of safety, freedom, and hope. Further research should be conducted to explore the benefits and appropriate ways of incorporating bodily experiences into the therapeutic process. In this way, assumptions that the body could be perceived as a source of healing, rather than a source and reminder of a painful experience, could be realized as part of a holistic approach in the treatment of trauma.*

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KLJUČNE RIJEČI / *KEY WORDS:*
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Terapija pokretom i plesom / *Dance movement therapy*
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Terapija / *Treatment*

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UVOD

Traumatska iskustva uključuju stanja izazvana bolnim i zastrašujućim podražajima, praćena emocijama poput straha, uznemirenosti, panike, bespomoćnosti, srama i sl., te su obilježena naglim sužavanjem svijesti na sadašnji trenutak i tjelesnom ukočenošću. Mogu biti potaknuta različitim neželjenim, prijetećim i/ili opasnim podražajima i neizbježni su dio našeg postojanja, od prenatalnog razdoblja do trenutka umiranja. Štoviše, tijekom života doživljavamo različite traumatske događaje koji mogu dovesti do narušavanja psihofizičke homeostaze. Nažalost, danas je sve više događaja koji se mogu doživjeti kao traumatični, poput emocionalnog, fizičkog i/ili seksualnog zlostavljanja, zanemarivanja, loše obiteljske dinamike, mobinga, vršnjačkog nasilja, siromaštva, kroničnih bolesti, bolnih medicinskih tretmana, svjedočenja činovima nasilja, nesreća, prirodnih katastrofa, izbjeglištva, življenja u ratnim zonama, terorizma, gubitka voljene osobe (1,2). Prema Strategijskoj inicijativi za traumu i pravdu (SAMHSA's *Trauma and Justice Strategic Initiative*) trauma je rezultat jednog ili niza događaja koje osoba doživljava kao fizički i emocionalno štetne ili prijeteće, te zbog toga imaju trajan negativan utjecaj na funkcioniranje osobe kao i na njeno fizičko, socijalno, emocionalno ili mentalno blagostanje.

INTRODUCTION

Traumatic experiences include conditions induced by painful and frightening stimuli, accompanied by emotions such as fear, agitation, panic, helplessness, shame, etc., and characterized by a sudden narrowing of awareness to the present moment and physical rigidity. They can be triggered by various unwanted, threatening and/or dangerous stimuli, and are an unavoidable part of our existence that begins in the prenatal period and ends at the moment of dying. Moreover, we experience various traumatic events throughout our lives that can lead to a disruption of psychophysical homeostasis. Unfortunately, there is an increasing number of events these days that could be experienced as traumatic, such as emotional, physical, and/or sexual abuse, neglect, poor family dynamics, mobbing, bullying, poverty, chronic illnesses, painful medical treatments, witnessing acts of violence, accidents, natural disasters, refugee situations, living in war zones, terrorism, loss of loved ones, etc. (1, 2). According to SAMHSA's Trauma and Justice Strategic Initiative, trauma is the result of one or a series of events that an individual perceives as physically or emotionally harmful or threatening, and that have a lasting negative impact on their functioning and their physical, social, emotional or mental well-being (3).

Such circumstances can lead to post-traumatic stress disorder (PTSD), which is defined as a

Takve okolnosti mogu dovesti do posttraumatskog stresnog poremećaja (PTSP), koji se definira kao kronični i onesposobljavajući poremećaj karakteriziran simptomima poput ponovnog proživljavanja negativnog iskustva, izbjegavanja, emocionalne otupljenosti ili preuzbuđenosti (4). Ovaj poremećaj može biti praćen suicidalnim mislima, neprilagođenim ponašanjem te komorbidnim psihijatrijskim poremećajima kao što su anksioznost, depresija, panika, opsesivno-kompulzivni poremećaj, ovisnost i sl. Ponekad je PTSP popraćen zdravstvenim problemima, kroničnom boli, problemima u međuljudskim odnosima, poremećajima spavanja ili hranjenja, te različitim psihosomatskim poremećajima (5). Iz tih razloga posebnu pažnju treba obratiti prevenciji i liječenju simptoma povezanih s traumom. Na primjer, Protokol za poboljšanje liječenja (*The Treatment Improvement Protocol,* TIP) je složeni model koji ima za cilj ublažiti rizike ili simptome uzrokovane traumatskim iskustvom (6). To je holistički model intervencije koji kombinira strategije informiranosti o traumi i specifične strategije usmjerene na traumu, a terapiju definira kao oblik izgradnje otpornosti, razvoja sigurnosti i stjecanja vještina suočavanja s posljedicama traume. Ovaj i drugi slični pristupi koji se usredotočuju na pojedince koji pate od traumatskih iskustava temelji se na ideji promicanja otpornosti kao sposobnosti osobe da se pozitivno prilagodi stresu ili neugodnim iskustvima (7). U tom smislu Kumarov CR8 model otpornosti (*Kumar's CR8 model of resilience*) opisuje osam strategija otpornosti: povezanost, radoznalost, komunikaciju, kontrolu, promjenu, prihvaćanje, jasnoću fokusa, povjerenje, povezanost i kreativnost (8). Razumijevanje i primjena ovih strategija treba biti uključena u različite terapijske pristupe i važna su tema za znanstveno istraživanje i praktičnu primjenu. Osim toga, sve se više istraživanja usredotočuje na razumijevanje interakcije između traumatskih događaja i njihovih posljedica. Razmatrani su različiti aspekti, poput psihofizičkih reakcija na traumu,

chronic and debilitating disorder characterized by symptoms such as re-experiencing, avoidance, emotional blunting or hyperarousal (4). This disorder can be accompanied by suicidal thoughts, maladaptive behavior and comorbid psychiatric disorders such as anxiety, depression, panic, obsessive-compulsive disorder, addiction, etc. PTSD is sometimes accompanied by medical conditions, chronic pain, problems in interpersonal relationships, sleep or eating disorders, or various psychosomatic disorders (5). For these reasons, special attention should be paid to the prevention and treatment of trauma-related symptoms. The Treatment Improvement Protocol (TIP), for example, is a complex model that aims at alleviating the risks or symptoms caused by a traumatic experience (6). It is a holistic intervention model that combines trauma-informed and trauma-specific strategies, and defines treatment as a form of building resilience, developing safety and acquiring coping skills to deal with the consequences of trauma. This and other similar approaches that focus on individuals suffering from traumatic experiences are based on the idea of promoting resilience as an individual's ability to positively adapt to stress or adversity (7). In this sense, Kumar's CR8 model of resilience describes eight resilience strategies: connectedness, curiosity, communication, control, change, acceptance, clarity of focus, trust, connectedness and creativity (8). The understanding and application of these strategies should be incorporated into various therapeutic approaches, and they represent an important topic for both scientific research and practical application. In addition, an increasing amount of studies is focusing on understanding the interaction between traumatic events and their consequences. Various aspects have been considered, such as the psychophysical reactions to trauma, the mechanism of anchoring trauma in the body, as well as the process of activation, remembering and processing of the traumatic experience (9, 10). It can be concluded from study results and statements of traumatized persons that the body, as the most prominent indirect victim, should be the central link in trauma treat-

mehanizam „učahurenja“ traume u tijelu te proces aktivacije, prisjećanja i obrade traumatskog iskustva (9,10). Iz rezultata istraživanja i izjava traumatiziranih osoba može se zaključiti da tijelo, kao najistaknutija neizravna žrtva, treba biti središnja karika u liječenju traume. Ne samo u smislu da se tijelo zaliječi, već i da reapsorbira bolne ureze koji su ukorijenjeni u tjelesnom sjećanju. Tijelo proces samoizlječenja ponekad provodi nesvjesno, kao što je pokazalo istraživanje Galit, Dita i Rachel (11), koji su, proučavajući tjelesne pokrete osoba tijekom prepričavanja traumatskih sjećanja, identificirali tri glavne kategorije pokreta koji prate verbalizaciju traumatskog događaja: ilustrativni, regulirajući i utješni pokreti. Druga istraživanja potvrđuju da pozitivne promjene u interoceptivnim i proprioceptivnim senzacijama povezanima s traumatskim iskustvom mogu zadovoljavajuće utjecati na trajanje i kvalitetu osjećaja povezanih s traumom (12). Ovo „progovaranje“ tijela iznimno je važno jer, kako primjećuje Etherington (10), trauma stvara kaos, a kaos može uzrokovati gubitak govora, nijemost i tišinu. Ali tada tijelo pronalazi drugi način da govori za nas, i nakon toga naš duh preživljava i nadilazi naše fizičko tijelo. Zbog toga je rad s tjelesnim iskustvom postao ključan u holističkom konceptu terapije traume, što je posebno prepoznato u području tjelesno orijentiranih psihoterapija i terapije pokretom i plesom. Njihov je cilj, osim uvođenja tijela kao značajnog medija u terapijski proces, i poticanje sudjelovanja traumatiziranih osoba u ugodnim, utješnim i smirujućim aktivnostima koje mogu omogućiti da se um odmakne od neželjenih misli, osjećaja i impulsa.

TJELESNO ORIJENTIRANE PSIHOTERAPIJE

Budući da je trauma pohranjena na somatskoj i senzomotornoj razini, verbalno-kognitivni i narativni pristupi ponekad mogu biti nedovoljni za obradu traumatskog iskustva. Uključiva-

ment. This is not only in the sense to heal the body, but also to reabsorb the painful incisions that are anchored in the body's memory. The body sometimes carries out the self-healing process unconsciously, as shown in the study conducted by Galit, Dita and Rachel (11) who, in studying body movements of individuals while they were recounting traumatic memories, identified three main categories of body movements that accompany the verbal recounting of a traumatic event: illustrative, regulating and consoling movements. Other studies confirmed that positive changes in interoceptive and proprioceptive sensations related to a traumatic experience can have a positive impact on the duration and quality of feelings associated with the trauma (12). This "speaking" of the body is extremely important because, as Etherington (10) notes, trauma creates chaos, and chaos can cause speechlessness, muteness and silence. The body, however, then finds another way to speak for us, and after that our spirit survives and transcends our physical body. For this reason, working with bodily experience has become essential in the holistic concept of trauma treatment, which is especially recognized in the field of body-oriented psychotherapies and dance/movement therapy. Their aim is not only to introduce the body as an important medium in the therapeutic process, but also to encourage the participation of traumatized individuals in pleasurable, comforting and calming activities that can allow the mind to move away from unwanted thoughts, feelings and impulses.

BODY-ORIENTED PSYCHOTHERAPIES

Since trauma is stored at the somatic and sensorimotor levels, verbal-cognitive and narrative approaches can sometimes be insufficient to process a traumatic experience. By involving the body in the therapy, we facilitate the processing of locked body memory, the restoration of vitality and the recovery of the nervous system that has been dysregulated by trauma. In these cases, verbalization

njem tijela u terapiju olakšavamo procesuiranje zaključane tjelesne memorije, vraćanje vitalnosti i oporavak živčanog sustava koji je disguliran traumom. U tim slučajevima verbalizacija nije isključena već upravo može potaknuti i/ili moderirati terapijski proces i komunikaciju između klijenta i terapeuta. Osim toga potiče klijenta da, kada je spreman, pronađe riječi za opisivanje svojih iskustava. Kao dio dinamičkog neverbalnog i verbalnog dijaloga između terapeuta i klijenta, stvara se prijelaz iz bolnog i neugodnog prema onom ugodnom i boljem. Na fizičkoj razini to se može manifestirati kao prijelaz iz napetosti, ukočenosti i krutosti u fluentnost, lakoću i opuštenost (13). Davanje pažnje tjelesnim senzacijama i osjećajima povezanima s traumatskim iskustvom je iscjeljujući te vodi prema promjeni i novoj perspektivi. U suvremenim psihoterapijskim pristupima tijelo je mnogo više od „spremnika" za potisnute osjećaje. Tijelo je nositelj sjećanja, znanja i "unutarnje mudrosti" što može služiti kao vodič za terapijske ciljeve. U takvoj terapijskoj međuigri fizička i kinestetička empatija je ključna, posebno s klijentima koji su imali negativna i bolna iskustva s drugim ljudima. Naime, osjećaj povjerenja u druge ljude treba ponovno izgraditi, a terapeut predstavlja osobu s kojom klijent uči stvarati odnos povjerenja i harmonije (14).

Na temelju razumijevanja važnosti tijela i jedinstva duha i tijela, tjelesno orijentirane psihoterapije definirane su kao zajednički pojam za sve psihoterapije koje eksplicitno koriste tjelesne tehnike za poticanje dijaloga između klijenata i psihoterapeuta o onome što se doživljava i percipira. U različitim pravcima, u okviru tjelesno orijentiranih psihoterapija, tijelo se smatra sredstvom komunikacije i istraživanja (15). Prema Geuteru (16) njihovi pristupi obuhvaćaju psihološke i somatske procese u terapiji uključivanjem različitih tehnika povezanih s tijelom i dimenzijama tjelesnog iskustva kao što su poticanje svjesnosti o tijelu, regulacija disanja, uzemljenje, eksperimentiranje s posturom tijela i mišićnom napetosti, proučava-

is not excluded, but can stimulate and/or moderate the therapeutic process and communication between the client and the therapist. It also encourages the client to find the words to describe their experiences when they are ready. As part of the dynamic non-verbal and verbal dialogue between the therapist and the client, a transition is created from a painful and uncomfortable state towards a pleasant and better one. On a physical level, this can be manifested as a transition from tension, stiffness and rigidity to fluency, lightness, and relaxation (13). Paying attention to the bodily sensations and feelings associated with the traumatic experience provides healing, and leads to change and a new perspective. In contemporary psychotherapy approaches, the body is much more than just a "repository" for repressed feelings. The body is a carrier of memories, knowledge and "inner wisdom", which can serve as a guide for therapeutic goals. In such a therapeutic interplay, physical and kinesthetic empathy is crucial, especially with clients who have had negative and painful experiences with other people. Indeed, a sense of trust in others needs to be rebuilt, and the therapist then represents a person with whom the client learns to create a relationship of trust and harmony (14).

Based on understanding the importance of the body and the body-mind unity, body-oriented psychotherapies have been conceptualized as a common term for all psychotherapies that explicitly use body techniques to encourage dialogue between clients and psychotherapists about what is experienced and perceived. In different courses, within body-oriented psychotherapies, the body is seen as a means of communication and exploration (15). According to Geuter (16), their approaches encompass both psychological and somatic processes in therapy by incorporating various body-related techniques and bodily experience dimensions, such as encouraging body awareness, breath regulation, grounding, experimenting with the body posture and muscle tension, studying different ways of bodily communication, etc. Movement and motion can also be useful because, as emphasized in dance/

nje različitih načina tjelesne komunikacije i dr. Pokret i kretanje također mogu biti korisni jer, kako se naglašava u terapiji pokretom i plesom, fizički pokreti odražavaju emocionalno stanje ali isto tako promjene u obrascima kretanja dovode do promjena u psihosocijalnom iskustvu (17). Tijekom terapijskog procesa mogu biti promatrane i korištene i neke druge dimenzije tjelesnog iskustva kao što su: geste, držanje tijela, izrazi lica, fizičke (neurovegetativne) senzacije, mišićni tonus, kontakt očima, odnos s članovima grupe, korištenje prostora, osobni profil kretanja. Učinkovitost korištenja tjelesno orijentiranih psihoterapija leži u pokušaju da se promiče samoregulacija na način koji pomaže klijentima da ostvare bolji kontakt sa samim sobom kako bi bolje upravljali svojim životima i odnosima s drugim ljudima. Polazna točka za to je dodir s tjelesnim iskustvima, i kao takav pristup je posebno prikladan za osobe s traumatskim iskustvima (16).

Različita istraživanja pokazala su da osobe s PTSP-om često imaju temeljnu disregulaciju u modulaciji uzbuđenja, što može biti povezano s problemima u razini svjesnosti o tijelu, samosvijesti i regulaciji afekta (18,19). Studije u području neurobiologije ukazuju da evolucijski stariji dio CNS-a, koji ima važnu ulogu u obradi prekomjernog stresa nije učinkovito dosegnut kognitivnim i verbalnim intervencijama, jer one uglavnom podražavaju prefrontalni korteks. Stoga bi pristup *bottom-up,* koji se usredotočuje na tijelo i tjelesne senzacije, mogao biti prikladniji za regulaciju uzbuđenja i afekta kod PTSP-a (18,20). U tom kontekstu mogu biti korisne tjelesno-orijentirane psihoterapije, jer se temelje na tjelesnoj aktivnosti, tjelesnosti i tjelesnom iskustvu kao središnjim temama i glavnom fokusu intervencije (4,16).

Meta-analiza provedena s ciljem evaluacije koristi intervencija usmjerenih na tijelo i pokret kod odraslih osoba s PTSP-om pokazala je da one ublažavaju simptome PTSP-a s umjerenim do velikim učinkom. Na temelju dobivenih re-

movement therapy, physical movements reflect the emotional state, however changes in movement patterns lead to changes in the psychosocial experience as well (17). Several other dimensions of the bodily experience can also be observed and utilized during the therapeutic process, such as gestures, body posture, facial expressions, physical (neurovegetative) sensations, muscle tone, eye contact, relationship with group members, use of space, personal movement profile. The effectiveness of using body-oriented psychotherapies lies in the effort to promote self-regulation in such manner that helps clients get more in touch with themselves in order to better manage their lives and their relationships with others. The starting point for this is contact with bodily experiences, and as such, the approach is especially suitable for individuals with traumatic experiences (16).

Various study findings have shown that individuals with PTSD often suffer from a fundamental dysregulation of arousal modulation, which can be associated with problems in body awareness, self-awareness and affect regulation levels (18, 19). Studies in the field of neurobiology suggest that the evolutionarily older part of the central nervous system, which plays an important role in processing excessive stress, is not effectively reached by cognitive and verbal interventions, because these mainly stimulate the prefrontal cortex. Therefore, a bottom-up approach that focuses on the body and bodily sensations might be more suitable for the regulation of arousal and affect in PTSD (18, 20). In this context, body-oriented psychotherapies may be beneficial because they are also based on physical activity, corporeality and bodily experience as the central topics and core focus of the intervention (4, 16).

A meta-analysis conducted with the aim of evaluating the benefits of body- and movement-oriented interventions (BMOIs) in adults with PTSD found that they alleviate PTSD symptoms with a moderate to large effect. Based on the obtained results, the authors concluded that the inclusion of BMOIs in established treatments could improve the overall treatment outcomes and prevent premature therapy droputs. According to the

zultata autori su zaključili da njihovo uključivanje u uobičajene tretmane može poboljšati ukupnu uspješnost tretmana i spriječiti prerano odustajanje od terapije. Prema autorima provedenog istraživanja mehanizmi djelovanja koji doprinose njihovoj učinkovitosti odnose se privikavanje na tjelesne senzacije potkrijepljeno iskustvom usmjeravanja pažnje na tijelo uz osjećaj pripadnosti i prihvaćanja vlastitog tijela. Njihove prednosti također se mogu objasniti činjenicom da nemaju neželjene nuspojave, a mogu dodatno poboljšati fizičko zdravlje i ublažiti simptome poput boli i umora (4).

Tjelesno orijentirane psihoterapije obuhvaćaju širok raspon pristupa i tehnika. Neke od njih se temelje na *mindfulness* pristupu u okviru kojih se potiče doživljavanje tijela sa stavom prihvaćanja i neosuđivanja. To se postiže preusmjeravanjem fokusa s neugodnih misli i sjećanja prema trenutnim tjelesnim senzacijama korištenjem tehnike kao što su skeniranja tijela ili vježbe disanja (21). Na taj se način, osim regulacije autonomnog živčanog sustava, potiče opuštanje te smanjuju stres, ruminaciju i uznemirenost (22). Nadalje, Classen i sur. (23) su naveli da je senzomotorna psihoterapija provedena u grupi sudionika s kroničnom anksioznošću zbog složene traume utjecala na značajno poboljšanje tjelesne svjesnosti i sposobnost samosmirivanja, te na smanjenje simptoma anksioznosti. Jedna od tjelesno orijentiranih psihoterapija koja se koristi kod traumatiziranih osoba je *Somatic Experiencing®* (SE) usmjerena na obnavljanje funkcionalnosti dinamičkog sustava koji se sastoji od supkortikalnog, autonomnog, limbičkog, motoričkog sustava i pobuđenosti, a koji može biti značajno disreguliran u uvjetima traume i kroničnog stresa (24). Ovaj pristup ima za cilj upućivanje pažnje klijenta na interoceptivne, proprioceptivne i kinestetičke osjete, kao i na instinktivne, tjelesno zaštitne odgovore povezane s akutnim reakcijama na stres u formi borbe, bijega i zamrzavanja. Rezultati kliničke primjene SE pokazuju da ova terapija može biti nadopuna kognitivnim ili ne-

authors of the conducted study, the mechanisms of action that contribute to the effectiveness of using BMOIs include habituation to bodily sensations complemented by the experience of peaceful embodiment, with a sense of belonging and improved body acceptance. Their benefits can also be explained by the fact that they have no undesirable side effects, and can also improve physical health and alleviate symptoms such as pain and fatigue (4).

Body-oriented psychotherapies encompass a wide range of approaches and techniques. Some of them are based on the mindfulness approach, which encourages perceiving the body with an accepting and non-judgmental attitude. This can be achieved by shifting the focus of attention from unpleasant thoughts and memories to actual bodily sensations, by using techniques such as the body scan or breathwork (21). In this way, in addition to regulating the autonomic nervous system, relaxation is promoted and stress, rumination and agitation are reduced (22). Furthermore, Classen at al. (23) found that sensorimotor psychotherapy conducted in a group of participants with chronic anxiety due to complex trauma significantly improved their level of body awareness, the ability to self-soothe, and reduced their anxiety symptoms. One of the body-oriented psychotherapies used with traumatized individuals is Somatic Experiencing® (SE) aimed at restoring the functionality of the core response network (CRN), complex dynamic system consisting of the subcortical, autonomic, limbic, motor and arousal systems, which may be severely dysregulated in conditions of traumatic experiences and chronic stress (24). The aim of this approach is to focus the clients' attention to the interoceptive, proprioceptive and kinesthetic senses, as well as instinctive, bodily protective responses connected with acute reactions to stress such as, fight, flight and freeze. The results of the clinical application of SE show that this therapy can serve as a supplement to cognitive or some other somatic approaches (25). Furthermore, approaches may be mentioned that include touch-based interventions aimed at

kim drugim somatskim pristupima (25). Nadalje, mogu se spomenuti pristupi koji uključuju intervencije temeljene na dodiru s ciljem oslobađanja fizičke napetosti i emocionalnog stresa pohranjenog u tijelu (21). Neke su studije pokazale da terapijski dodir može biti dobro sredstvo za iscjeljivanje traume, ali pod uvjetom da se s posebnom pažnjom poštuju etička pitanja, tjelesne granice i pristanak klijenta (26). Ponekad se samo-dodir može uvesti kao gesta prihvaćanja i zaštite vlastitog tijela i kao siguran prijelaz u procesu oslobađanja od straha od dodira druge osobe. Primjer terapije koja kombinira dodir i verbalnu ekspresiju je *Mindful Body Awareness* (MBA). S ciljem procjene procesa na kojima se temelji MBA, Price i suradnici (27) su koristili upitnik *The Helpfulness Aspects of Therapy* i rezultati su analizirani fenomenološki, metodom intervjua. Na temelju ove analize pojavile su se četiri teme povezane s ukupnom dobrobiti: a) interoceptivna svjesnost, b) osjećaj osobnog djelovanja, c) odnos s terapeutom koji je omogućio povjerenje i kreiranje terapijskog procesa, i d) transformativno iskustvo. Autori su također zaključili da je korištenje dodira u razvoju interocepcije osobito značajno i da je MBA učinkovit pristup u razvoju interocepcije i „uzemljenosti" u vlastitom tijelu.

Prethodna istraživanja i nalazi kliničke prakse pokazuju da tjelesno orijentirane terapije mogu biti učinkoviti alati za rješavanje traumatskih iskustava. Temelje se na ideji da tijelo može imati važnu ulogu u oblikovanju naših života i da poštivanje jedinstva tijela i uma može stvoriti uvjete da se od bolnih sjećanja odmaknemo prema novim iskustvima.

TERAPIJA POKRETOM I PLESOM

Terapija pokretom i plesom (TPP) područje je ekspresivnih art-terapija koje se temelje na istraživanju tjelesnih senzacija, svjesnosti tijela i psihosocijalnih odgovora korištenjem različitih kvaliteta pokreta, oblika tijela, posture,

releasing physical tension and emotional stress stored in the body (21). Some studies indicated that therapeutic touch can be a good therapeutic tool to heal trauma, but under the condition that special attention is paid to respecting the ethical issues, physical boundaries and the client's consent (26). Self-touch may sometimes be introduced as a gesture of acceptance and protection of one's own body, and as a safe transition in the process of getting rid of the fear of being touched by another person. An example of a therapy that combines manual (touch-based) and verbal expression is Mindful Body Awareness (MBA) therapy. With the aim of evaluating the processes underlying MBA, Price at al. (27) used the Helpfulness Aspects of Therapy questionnaire and the results were analyzed phenomenologically, using the interview method. Based on this analysis, four topics related to the overall well-being emerged: a) interoceptive awareness, b) sense of personal agency, c) relationship with the therapist that facilitated trust and conceptual framing of the therapeutic process, and d) transformative experience. The authors also concluded that the use of touch in the development of interoception is of particular importance, and that MBA is an effective approach in the development of interoception and "grounding" in one's own body.

Previous studies and clinical practice findings suggest that body-oriented psychotherapies can be effective tools for addressing traumatic experiences. They are based on the idea that the body can play an important role in shaping our lives and that respecting the body-mind unity can create the conditions for us to move away from painful memories towards new experiences.

DANCE/MOVEMENT THERAPY

Dance/movement therapy (DMT) is part of expressive art-therapies based on the exploration of bodily sensations, body awareness and psychosocial responses through the use of different movement qualities, body shapes, posture, space and

prostora i kreativnosti (17). Može se spomenuti nekoliko teorijskih polazišta koje podržavaju korištenje TPP u terapiji traume. Jedan od njih je koncept somatologije koji pretpostavlja da prva razina ljudskog postojanja ima uporište na tjelesnom i senzomotornom planu (28). Korištenje TPP-a kod osoba s traumatičnim iskustvima također je podržano teorijom privrženosti, budući da trauma može dovesti do problema u osjećaju privrženosti, ne samo prema drugim ljudima već i prema sebi. Tako različite tehnike u ovom pristupu, poput zrcaljenja, refleksije, uzemljenja, usklađivanja s vlastitim tijelom, simbolizacija tijelom i dr., pomažu klijentima da otkriju svoje tijelo kao izvor zadovoljstva, da prihvate svoje tijelo i da ga povežu s drugim ljudima (29). U tom kontekstu Dieterich-Hartwell (30) predlaže tri koraka intervencije u svom TPP modelu oporavka: sigurnost, regulacija preuzbuđenosti i pozornost na interocepciju. Posljednji korak je posebno važan jer su nedostatak interocepcije i fizička nepovezanost često prisutni kod osoba koje su preživjele traumu. Prema nekim autorima to može dovesti do nedostatka cjelovitog tjelesnog doživljaja, te posljedično do raznih mentalnih poremećaja (31).

Značajna vrijednost TPP-a je u tome što prihvaća kreativnost i maštu, dopuštajući odmicanje od stvarnosti i proigravanje s novim perspektivama. To je također fleksibilan, permisivan i neinvazivan pristup usmjeren na osobu, koji se može koristiti s različitim vrstama trauma i u različitim terapijskim uvjetima. Primjerice, Ambra (32) je anketirala TPP terapeute koji rade sa žrtvama incesta i dobila podatke da ova vrsta intervencije pomaže u područjima asertivnosti, slike tijela, seksualnosti, granica, sigurnosti, povjerenja i srama. Neki su autori pokušali utvrditi kako TPP može utjecati na mentalno zdravlje osoba koje su preživjele nasilje. Na primjer, Özümerzifon i dr. (33) navode su da su se žene, koje su proživjele intimno partnersko nasilje i koje su sudjelovale u virtualnim TPP radionicama osjećale bolje te da se u njih smanjila pojavnost neugodnih emocija i

creativity (17). Several theoretical backgrounds can be mentioned that support the use of DMT in the field of trauma treatment. One of these is the concept of somatology, which assumes that the first level of human existence has a foothold in the body and sensory-motor plane (28). The use of DMT in dealing with individuals with traumatic experiences is also supported by attachment theory, as trauma can lead to disruption of attachment, not only to other people, but also to oneself. Therefore, various techniques in this approach, such as mirroring, reflection, grounding, body attunement, body-symbolization, etc. help clients to discover their bodies as a source of pleasure, to accept their bodies and connect them with other people (29). In that context, Dieterich-Hartwell (30) proposes three intervention steps in her DMT recovery model: safety, regulation of hyperarousal, and attention to interoception. The last step is especially important because a lack of interoception and physical disconnection are often present in trauma survivors. According to some authors, this can lead to a lack of complete bodily experience and, consequently, to various mental disorders (31).

A significant value of DMT is that it embraces creativity and imagination, allowing one to step away from reality and play with new perspectives. It is also a flexible, permissive, non-invasive and person-centered approach that can be used with various types of traumas and in different therapeutic contexts. For example, Ambra (32) surveyed DMT therapists working with incest victims and obtained data that this type of intervention helps in the areas of assertiveness, body image, sexuality, boundaries, safety, trust and shame. Some authors have tried to determine how DMT can affect the mental health of survivors of violence. For example, Özümerzifon et al. (33) reported that female survivors of intimate partner violence who participated in the virtual DMT workshops felt better, and their unpleasant emotions and tension were reduced. They also reported that they had found new ways to express themselves, that they were more in tune with their bodies and that they learned

napetosti. Izvijestile su također da su pronašle nove načine da se izraze, da su više usklađene sa svojim tijelom i da su naučile nove navike brige o sebi. U kontekstu obiteljskog nasilja Devereaux (34) je opisala kako je TPP prikladna metoda za tretiranje negativnih simptoma zlostavljanja i kako je "re-koreografiranje" obiteljske dinamike i odnosa koji su bili poremećeni obiteljskim nasiljem značajno pomoglo obiteljima da nauče nove načine samoregulacije.

Pierce (35) je predložila svojevrsni TPP model kod odraslih s disocijativnim simptomima povezanima s traumom, koji se sastoji od tri faze: sigurnost i stabilizacija, integracija traumatskog sjećanja i razvoj relacijskog identiteta. U svojem je pristupu koristila različite tehnike TPP-a kao što su kinestetičko zrcaljenje, usklađivanje tijela s drugim tijelom, samosvijest, interaktivnu regulaciju, simboličko izražavanje te interakcijski pokret kao intervencije koje su imale pozitivan učinak na podržavanje *bottom-up* integracije i rješavanje psihoemocionalnih poteškoća. Slično, Koch i Harvey (36) uveli su *Baum-circle*, oblik slobodne improvizacije u kojoj članovi grupe slijede određenu osobu u pokretu. Rezultat je pokazao da su inducirane slobodne asocijacije, u skupini traumatiziranih disocijativnih pacijenata u okviru grupnog procesa, omogućile izražavanje tjelesno memoriranih pozitivnih i negativnih sadržaja. Osim toga, Tomaszewski i sur. (37) su na temelju sustavnog pregleda literature zaključili da TPP može doprinijeti poboljšanju u području percepcije tjelesnih senzacija, psiholoških procesa, međuljudskih odnosa, senzomotorne percepcije i motoričkih vještina. Također su istaknuli da učinkovitost terapijskog programa ovisi o korištenim tehnikama, stabilnosti intervencije te vještinama i educiranosti terapeuta.

Terapija pokretom i plesom isto tako može biti prikladan pristup za odrasle osobe koje su preživjele torturu. Na primjer, Gray (38) je uočila da individualne seanse TPP-a mogu vratiti osjećaj cjelovitosti i poboljšati interakciju i

new habits of self-care. In the context of domestic violence, Devereaux (34) described that DMT is an appropriate method for treating negative symptoms of abuse and that "re-choreographing" the family dynamics and relationships that had been disrupted by domestic violence remarkably helped families to learn new ways of self-regulation.

A kind of DMT model in adults with dissociative symptoms related to trauma was proposed by Pierce (35), and it consists of three phases: safety and stabilization, integration of the traumatic memory, and development of the relational self. In her approach, she used various DMT techniques such as kinesthetic mirroring, body-to-body attunement, self-awareness, interactive regulation, symbolic expression, and interactional movement as interventions which had a positive impact on supporting the bottom-up integration and resolution of psychoemotional distress. Similarly, Koch and Harvey (36) introduced the "Baum-circle", a form of free improvisation in which group members follow a mover. The result showed that induced free associations in a group of traumatized dissociative patients facilitated the expression of both positive and negative body memory contents within the group process. In addition, based on their systematic literature review, Tomaszewski at al. (37) concluded that DMT can bring improvements in the perception of bodily sensations, psychological processes and interpersonal skills, as well as sensory-motor perceptions and motor skills. They also pointed out that the effectiveness of the therapy program depends on the methods used, the stability of the intervention, as well as the skills and training of the therapist.

Dance/movement therapy may also be an appropriate approach for adult survivors of torture. For example, Gray (38) observed that individual DMT sessions can restore a sense of wholeness, and improve interaction and skills to create quality relationships. Similarly, Harris (39) conducted DMT programs with adolescent survivors of torture during war and organized violence. The goal of the program was the following: (1) to

vještine stvaranja kvalitetnih odnosa. Slično je Harris (39) provodio programe TPP-a s adolescentima koji su preživjeli torturu tijekom rata i organiziranog nasilja. Cilj programa bio je: (1) desomatizirati pamćenje, (2) promicati iskustva svjesnosti, (3) olakšati usvajanje iskustva za kontrolirano smanjenje tjeskobe i agresije i (4) potaknuti radost kreativnosti koja sudionicima omogućuje da simboliziraju njihove traumatične gubitke i nade za budućnost. Rezultati su ukazali na poboljšanje grupne kohezije, a sudionici su također izvijestili o kontinuiranom smanjenju simptoma anksioznosti, depresije, nametljivih slika iz prošlosti, povećane uzbuđenosti i agresije. Prema Kochu i Weidinger-von der Recke (40) TPP se pokazao korisnim u rješavanju različitih traumatskih sadržaja u osoba koje su doživjele silovanje, mučenje i ratno iskustvo. U tom smislu isti autori navode da je kombinirana primjena verbalne psihoterapije i TPP-a (grupna ili individualna), kakva se provodi u centru za liječenje REFUGIO u Münchenu, pokazala uspješne rezultate i može se koristiti na umirujući i klinički odobren način. Nadalje, TPP je posebno prikladan za ljude koji su neverbalni ili koji imaju poteškoća u verbaliziranju svojih osjećaja. Collis (41) je opisala projekt usmjeren na istraživanje potencijala TPP-a u osoba s intelektualnim i razvojnim poteškoćama pogođenih traumom. Podteme koje su proizašle iz primjene kreativnog pokreta uključivale su autonomiju, težinu kao kvalitetu dinamike pokreta, svjesnost i brigu o sebi. Rezultati su također pokazali da razigrana upotreba TPP tehnika može biti polazište za susretanje s osobnim iskustvom i za ublažavanje negativnog utjecaja traume. Primjena TPP-a isto je tako razmatrana kod starijih osoba, posebice onih koji su pretrpjeli neurotraumu, a neka su istraživanja potvrdila da bi mogla pozitivno utjecati na njihove motoričke, psihičke i kognitivne funkcije (42).

Neke tehnike TPP-a također su korisne za djecu koja još nemaju dovoljno razvijen rječnik da bi opisala svoja iskustva i osjećaje. Tako, na primjer, Lee i sur. (43) su dobili rezultate prema ko-

de-somatize memory, (2) to promote mindfulness experiences, (3) to facilitate the adoption of experiences for controlled reduction of anxiety and aggression, and (4) to stimulate the joy of creativity that allows participants to symbolize their traumatic losses and hopes for the future. The results indicated an improvement in group cohesion, and participants also reported a continued reduction in the symptoms of anxiety, depression, intrusive memory, increased arousal, and aggression. According to Koch and Weidinger-von der Recke (40), DMT has proved to be helpful in addressing various trauma content in individuals who have experienced rape, torture and war. In this sense, the same authors state that the combined use of verbal psychotherapy and DMT (group or individual therapy), as carried out at the REFUGIO treatment center in Munich, has yielded successful results and can be used in a facilitative and clinically approved manner. Furthermore, DMT is especially appropriate for individuals who are non-verbal or who have difficulties in verbalizing their feelings. Collis (41) described a project aimed at exploring the potential of DMT in working with individuals with intellectual and developmental disabilities affected by trauma. Sub-themes that emerged from the application of creative movement tasks included autonomy, weight as quality of movement dynamics, awareness and self-care. The results also showed that the playful use of DMT techniques can serve as a starting point for interacting with personal experiences and for relieving the negative impacts of trauma. The use of DMT is also being considered in older people, particularly those who have suffered neurotrauma, and some studies have confirmed that it could have a positive impact on their motor, psychological and cognitive function (42).

Some DMT techniques are also useful for working with children who still lack the vocabulary to describe their experiences and feelings. For example, Lee et al. (43) found that DMT together with play and games was an appropriate approach for children who were at high risk of developing PTSD after the Taiwan earthquake.

jima je TPP zajedno s korištenjem igre prikladan pristup za djecu koja su bila pod visokim rizikom od PTSP-a nakon potresa u Tajvanu. Kreativni ples i pokret im je pomogao da se izraze tijelom i da obrade osjećaje uznemirenosti i tjeskobe. Za djecu koja su doživjela seksualno zlostavljanje Ho (44) je utvrdila da mogu biti prikladni za TPP program koji se fokusira na osjećaje sigurnosti, granice, te koncepte mjesta i prostora. U tom slučaju mogu učinkovito podržati istraživanje unutarnjeg ritma, osobnih granica i osjećaja sigurnosti, slobode i nade u bolju budućnost. Colace (45) ističe da su govor tijela i neverbalna komunikacija ključni pristupi pacijentima s razvojnom traumom. Na temelju promatranja odnosa dojenčeta i skrbnika u relaciji s korištenjem zajedničkih ritmova, usklađenosti, disanja i regulacije afekta, autorica je zaključila kako trajni nedostatak usklađenosti od strane primarnog skrbnika može imati traumatične učinke na djecu. Primjena TPP-a kod djece temelji se na određenim specifičnostima koje trebaju uzeti u obzir manju sposobnost suočavanja s traumom, ranjivost ove populacije i stupanj psihofizičkog razvoja. Na primjer, Devereaux i Harrison (46) proveli su *neurodevelopmentally-informed dance movement therapy* u djece s kompleksnom traumom. Zaključili su da bi intervencije trebale slijediti stupanj neurološkog razvoja svakog pojedinog djeteta te da se metafore i simboli mogu koristiti za regulaciju tjelesnih sjećanja.

Iako se TPP preporučuje u terapiji traume, neki klijenti na početku terapijskog programa odbacuju rad na tijelu, jer su njihova tijela povezana s boli i povredom. U takvom slučaju, mogu biti korisni drugi umjetnički mediji i/ili komplementarne terapije u cilju uvođenja klijenata u svijet mašte i neograničenog samoizražavanja. Na primjer, vođena imaginacija, psihofizička relaksacija, meditacija, poezija ili neki drugi književni tekst, vizualni mediji, glazba i sl. mogu poslužiti kao "most" koji olakšava uranjanje u svijet samo-istraživanja. Na taj se način vlastito tijelo može polako i postupno prihvatiti kao instrument samospoznaje i obrade vlastitih

Creative dance and movement helped them express themselves by using their bodies and process the feelings of distress and anxiety. For children who have experienced sexual abuse, Ho (44) found that a DMT program focusing on feelings of safety, boundaries and concepts of place and space could be appropriate. In that case, they could effectively support exploration of their inner rhythm, personal boundaries and feelings of safety, freedom and hope for a better future. Colace (45) emphasized that body language and nonverbal communication are crucial approaches when dealing with patients with developmental trauma. Based on their observations of the infant-caregiver relationship in correlation with using shared rhythms, attunement, breathing and affect regulation, the author pointed out that a persistent lack of attunement by the primary caregiver could have traumatic effects on the children. The use of DMT in children is based on certain specificities that should take into account the lower ability to cope with trauma, the vulnerability of this population and the stage of their psychophysical development. For example, Devereaux and Harrison (46) carried out the neurodevelopmentally-informed dance/movement therapy in children with complex trauma. They concluded that interventions should follow the degree of neurological development of each individual child, and that metaphors and symbols could be used to regulate body memories.

Although DMT is recommended in trauma treatment, some clients reject bodywork at the beginning of the therapy program because their bodies are associated with pain and hurt. In such cases, other forms of artistic media and/or complementary therapies may be useful in order to introduce the clients to the world of imagination and unrestricted self-expression. For example, guided imagery, psychophysical relaxation, meditation, poetry or some other literary text, visual media, music, etc. can be used as a "bridge" that facilitates immersion into the world of self-exploration. In this way, one's own body can slowly and gradually be accepted as an instrument

misli i osjećaja. Donošenje odluke o tome kada i koju TPP tehniku koristiti u okviru terapijske seanse je dodatni zahtjev, ali i pozitivan izazov za terapeuta. U svakom slučaju treba poštovati potrebe i sklonosti klijenta dok se pažljivo gradi pozitivan transfer i terapijski savez.

I na kraju, pojedini su autori ukazali na važnost brige o sebi kod terapeuta koji rade s osobama s traumatskim iskustvima. Naime, neka istraživanja pokazuju da indirektna trauma doživljena tijekom terapijskog odnosa može imati negativan utjecaj na psihofizičko zdravlje terapeuta. njegove međuljudske odnose, kao i na postizanje pozitivnog transfera i učinkovitost terapije (47). Učinak indirektne traume može biti posebno intenzivan za TPP terapeute koji dodatno proživljavaju traumatsko iskustvo klijenta u vlastitom tijelu koristeći se utjelovljenjem, usklađivanjem vlastitog tijela s tijelom klijenta i kinestetičkom empatijom. Stoga bi briga o sebi i ljubaznost prema sebi trebala biti obvezna za terapeute iz područja TPP-a, ali i za ostale tjelesno orijentirane psihoterapeuta, a može uključivati različite strategije upravljanja stresom kao i savjetovanje, superviziju ili psihološku pomoć, kada je to potrebno (48,49).

ZAKLJUČAK

Traumatska iskustva su prožimajući dio ljudskog postojanja, a manifestiraju se u okviru različitih fizičkih, emocionalnih i psihosocijalnih simptoma koji često dovode do mentalnih poremećaja poput PTSP-a. Ta iskustva izazvana su širokim rasponom uzroka, od fizičkog i emocionalnog zlostavljanja do prirodnih katastrofa, izbjeglištva i rata. S obzirom na složenost i incidenciju traume, prevencija i liječenje simptoma povezanih s traumom je izuzetno važna. U tom kontekstu, kao posebno učinkovite pokazale su se tjelesno orijentirane psihoterapije koje uključuju tijelo tijekom procesuiranja i oslobađanja od traumatskih sjećanja. Ovi pristupi uključuju tehnike poticanja osjetilne percepcije, somat-

for self-awareness and for processing one's own thoughts and feelings. Deciding when and which DMT technique needs to be used in the therapy session is an additional requirement, but also a positive challenge for the DMT therapist. In any case, the client's needs and preferences should be respected while carefully building a positive transference and therapeutic alliance.

Finally, some authors emphasized the importance of self-care in therapists working with individuals with traumatic experiences. Namely, some studies suggest that indirect trauma experienced in the course of a therapeutic relationship can have a negative impact on the therapist's psychophysical health and interpersonal relationships, as well as on achieving a positive transference and effectiveness of therapy (47). The effect of indirect trauma can be particularly intense for DMT therapists who additionally relive the client's traumatic experience through their own bodies by using embodiment, attunement of their own body with their client's body, and kinesthetic empathy. Therefore, self-care and self-kindness should be mandatory for DMT therapists, but also for other body-oriented psychotherapists, and may include various stress management strategies, as well as counseling, supervision or psychological help when necessary (48, 49).

CONCLUSION

Traumatic experiences are a pervasive part of human existence, manifesting in various physical, emotional and psychosocial symptoms that often lead to mental disorders such as PTSD. These experiences emerge due to a wide range of causes, from physical and emotional abuse to natural disasters, refugeeness and war. Given the complexity and prevalence of trauma, prevention and treatment of trauma-related symptoms are crucial. Body-oriented psychotherapies that work with the body in order to process and release traumatic memories have proved to be particularly effective in this context. These approaches include techniques of sensory perception stimulation,

skog iskustva i terapijskog dodira u cilju reguliranja autonomnog živčanog sustava i emocionalnih stanja povezanih s traumom. Tjelesno orijentirane psihoterapije omogućuju pacijentima da se povežu sa svojim tijelima, razviju svijest o tjelesnim senzacijama i promiču samoregulaciju dinamičnim dijalogom između terapeuta i klijenta. Također, primjena TPP-a koja koristi tijelo i pokret kao medij za istraživanje i izražavanje fizičkih i emocionalnih stanja, može biti od posebne važnosti. TPP pomaže osobama koje su preživjele traumu vratiti osjećaj sigurnosti, regulirati pretjerano uzbuđenje i doživjeti tijelo kao izvor ugode i ozdravljenja. Korištenjem kreativnosti i mašte TPP može poboljšati mentalno zdravlje, socijalne vještine i potaknuti razmatranje novih perspektiva kod osoba koje su preživjele različita traumatska iskustva. Rezultati istraživanja i klinička praksa potvrđuju da tjelesno orijentirane terapije, uključujući TPP, mogu značajno pridonijeti oporavku osoba s traumatičnim iskustvima. Naime, ovi pristupi omogućuju pacijentima da obrade traumatska sjećanja u svojim tijelima, razviju nove strategije suočavanja i promiču osobni rast i otpornost. Također, potrebna su daljnja istraživanja kako bi se tijelo promoviralo kao vrijedna tema u okviru holističkog pristupa u terapiji traume.

somatic experience and therapeutic touch, which help to regulate the autonomic nervous system and the emotional states associated with trauma. Body-oriented psychotherapies enable patients to connect with their bodies, develop an awareness of bodily sensations and promote self-regulation through a dynamic dialog between the therapist and the client. In addition, the use of DMT, which uses the body and movements as a medium for exploring and expressing physical and emotional states, can also be of particular importance. DMT helps trauma survivors to restore a sense of safety, regulate hyperarousal, and experience their body as a source of pleasure and healing. By using creativity and imagination, DMT can improve mental health and social skills, and can induce consideration of new perspectives in survivors of various traumatic experiences. Research results and clinical practice have confirmed that body-oriented psychotherapies, including DMT, can significantly contribute to the recovery of individuals with traumatic experiences. Namely, these approaches enable the patients to process traumatic memories through their bodies, develop new coping strategies and promote personal growth and resilience. Further research is also necessary in order to promote the body as a valuable topic in terms of the holistic approach in trauma treatment.

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Upute autorima

O časopisu

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

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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).

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