Socijalna psihijatrija

UDC 616.89
SPSIDE 46 (2) 227-338 (2018)
ISSN 2459-6140

VOL. 46 – 2018
BROJ/NUMBER 3
ZAGREB, rujan/September 2018.

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Razlike u samoprocjeni samopoštovanja, socijalne i emocionalne usamljenosti s obzirom na sociodemografske karakteristike starijih osoba

/ Differences in Self-Assessment of Social and Emotional Loneliness and Self-Esteem with Regard to Sociodemographic Characteristics of the Elderly

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Uvod: Usamljenost se karakterizira kao neugodna, bolna, anksiozna čežnja za drugom osobom ili osobama, koja nastaje kada se osoba osjeća odbačenom, otuđenom ili neshvaćenom od drugih te joj nedostaje društvo za socijalne aktivnosti i emocionalnu intimnost. Svrha istraživanja je usporediti razlike u samoprocjeni socijalne i emocionalne usamljenosti te samopoštovanja s obzirom na mjesto stanovanja sudionika (dom umirovljenika ili vlastita kuća), sociodemografske karakteristike sudionika (spol, dob, bračno stanje, razina obrazovanja) i zdravstveno stanje. **Sudionici i metode**: Za prikupljanje primarnih podataka odabran je prigodan uzorak slučajnim odabirom od 379 sudionika na području Varaždinske i Međimurske županije pri čemu je u istraživanju sudjelovalo 178 sudionika koji žive u kućama i 201 sudionik iz domova umirovljenika. Kao instrumenti istraživanja korišteni su ovi upitnici: Rosenbergova ljestvica samopoštovanja, Ljestvica socijalne i emocionalne usamljenosti te polustrukturirani upitnik sociodemografskih podataka konstruiran za potrebe ovog istraživanja. **Rezultati**: Rezultati su pokazali da su sudionici u domu umirovljenika koji imaju nižu razinu obrazovanja i lošije zdravstveno stanje ujedno iskazali nižu razinu samopoštovanja, a neudati/neoženjeni sudionici su iskazali veću razinu usamljenosti u ljubavi i usamljenosti u obitelji. Kod sudionika u kućama rezultati su pokazali kako su sudionici stariji od 85 godina svoje samopoštovanje procijenili najnižim te su iskazali najveću socijalnu usamljenost i usamljenost u ljubavi. **Zaključak:** S obzirom da je usamljenost složen konstrukt, potrebno je provoditi daljnja, kontinuirana istraživanja iz drugih perspektiva kako bi se mogli razviti modeli prevencije te povećala kvaliteta života osoba starije životne dobi.

*/ **Background:** Loneliness is characterised as an unpleasant, painful, anxious longing for another person or persons, occurring when one is feeling rejected, alienated or not understood by others and misses the company of others for social activities and emotional intimacy. The purpose of this study was to compare the level of perceived social and emotional loneliness in two groups of elderly people, one in institutions/retirement homes and the other in their homes/households, and determine to which extent loneliness was linked with self-esteem and sociodemographic variables of the examinees.*

***Subjects and Methods:** In order to gather primary data, a random sample of 379 participants from Varazdin and Medimurje County was selected, with 178 participants living in their homes and 201 institutionalized in retirement homes. The following questionnaires were used as the research instruments: Rosenberg's Self-Esteem Scale, Emotional and Social Loneliness Scale, Self-Care Scale, and a semi-standardized questionnaire of sociodemographic data that was designed for the needs of this study.*

***Results:** The results showed that the participants who live in retirement homes and have a lower level of education and worrisome health conditions also have a lower level of self-esteem, while the unmarried participants showed a higher*

level of loneliness in love and family. The results of those living in their home showed that the participants older than 85 estimate their self-esteem the lowest and had the highest level of social loneliness and loneliness in love.

Conclusion: *Given that loneliness is a complex notion, it is necessary to conduct further research from different perspectives in order to develop prevention models, and thus prevent the consequences of loneliness, with the aim of achieving increased quality of life for the elderly.*

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KLJUČNE RIJEČI / KEYWORDS:
Samopoštovanje / *Self-esteem*
Usamljenost / *Loneliness*
Starije osobe / *The elderly*
Domovi umirovljenika / *Retirement homes*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2018.229

UVOD

Porastom životnog vijeka briga i skrb za osobe starije životne dobi su međunarodni izazov i javnozdravstveni imperativ pa je stoga potrebno promicati zdravo, aktivno starenje i dobrobit starijih osoba (1). Usamljenost je značajan stresor i poznat uzrok mnogih kroničnih zdravstvenih problema u različitim populacijama te „uzrokuje pad funkcionalnosti i porast smrtnosti u velikim uzorcima starijih osoba iz više različitih kultura“ (2-5). Tako razlikujemo socijalnu usamljenost koja se odnosi na neuključenost u socijalnu mrežu, zatim emocionalnu usamljenost koja se javlja prigodom odsustva bliskog odnosa te usamljenost koja proizlazi iz nezadovoljstva obiteljskim i romantičnim odnosima (6). Većina ljudi koji se osjećaju usamljeno pokušavaju se riješiti samoće prije nego što ona postane ekstremna i to najčešće ostvarivanjem novih društvenih veza (7). Naime, starije osobe suočavaju se s brojnim izazovima kako bi ostale društveno aktivne, ali nedavna istraživanja (8-12) pokazuju veliku raznolikost u dobnim promjenama

INTRODUCTION

The increased life expectancy and care for the elderly represent an international challenge and a public health imperative, so it is necessary to promote healthy, active aging and the well-being of older people (1). Loneliness is a significant stressor and is known to cause many chronic health problems in different populations; it also “causes functional decline and increase in mortality in large samples of older people from multiple cultures” (2-5). Therefore, we distinguish social loneliness, which refers to exclusion from social networks, emotional loneliness, which occurs during the absence of a close relationship, and loneliness which derives from a dissatisfied family and romantic relations (6). Most people who feel lonely try to get rid of loneliness before it becomes extreme, most commonly through new social relations (7). In fact, older people are faced with a number of challenges so as to stay socially active, but recent research (8-12) shows diversity in age changes and social life satisfaction. Social relations and social

i zadovoljstva socijalnim životom. Društveni odnosi i socijalna integracija ključni su za emocionalno ispunjenje i razvoj tijekom života, pri čemu izvor zadovoljstva i socijalne podrške starijima čine društvo i emocionalna potpora njihove djece, rođaka i prijatelja s kojima starije osobe uživaju u zajedničkom provođenju vremena znajući da uz sebe imaju dobro poznate osobe kojima se mogu obratiti za pomoć ako se za to ukaže potreba (13,14). Promjena boravišta uzrokuje neugodnosti u bilo kojoj dobi, ali je posebno teška u starosti pri čemu je za stariju osobu promjena mjesta boravišta često praćena socijalnom izolacijom, problemima u prilagodbi i osjećajem da se nekomu nameće ili da joj se netko nameće (15,16). Općenito se pretpostavlja da bi većina starijih ljudi što je duže moguće željela ostati kod svoje kuće, no zbog produženog životnog vijeka i opadanja funkcionalne sposobnosti sve veći broj starijih osoba živi u domovima (17-19). Zbog toga je prigodom smještaja u ustanovu potreban ponajprije dobrovoljni pristanak starije osobe (20). Temeljem navedenog poštivanje autonomije kod starijih osoba u domovima umirovljenika je poseban izazov, jer mnoge starije osobe doživljavaju stvaran i stalan gubitak neovisnosti i autonomije s obzirom da institucionalni zahtjevi otežavaju potpuni individualni pristup (21). Nadalje, starije osobe koje žive u domovima često bivaju stereotipizirane kao nemoćne i nesamostalne, odnosno ako je osoba smještena u dom za starije i nemoćne „ona je automatski gledana kroz prizmu nedostataka/slabosti, a ne očuvanih sposobnosti, a identitet te iste osobe se gubi, jer je klasificirana na temelju zajedničkih obilježja grupe u kojoj se nalazi“ (22) što se svakako može odraziti na gubitak samopoštovanja. Osobe s niskim samopoštovanjem imaju malo povjerenja u sebe i ne osjećaju se ugodno u društvenim interakcijama (23). Također, niska razina samopoštovanja doprinosi povećanoj razini usamljenosti i obrnuto, odnosno visoka razina usamljenosti doprinosi niskom samopoštovanje (23).

integration are key to emotional fulfilment and development throughout life, whereby the source of satisfaction and social support for the elderly are the company and emotional support of their children, relatives and friends with whom they enjoy spending time with, knowing that they have people close to them who they can turn for help if they need it (13,14). Changing residences causes discomfort at any age, but is particularly difficult in the old age, whereby changing the place of residence is often followed by social isolation, problems of adaptation and the feeling of intruding or being intruded on by someone (15,16). It is generally assumed that most elderly would prefer to stay in their home as long as possible, but due to a prolonged life spam and declined functional ability, a growing number of elderly people live in retirement homes (17-19). For this reason, voluntary consent of the elderly person is needed for accommodation in the institution (20). Based on the above, respecting the autonomy of elderly people in retirement homes represents a special challenge, as many elderly people experience a real and permanent loss of independence and autonomy since institutional requirements make it difficult for a completely individual approach (21). Furthermore, elderly people living in homes are often stereotyped as helpless and dependent, i.e. if a person is placed in a home for the elderly and infirm, one is automatically looked through the prism of disadvantages / weaknesses and not preserved abilities, and the identity of that person is lost because it is classified based on the common features of the group in which it finds itself, which can certainly result in the loss of self-esteem (22). People with low self-esteem have little confidence in themselves and do not feel comfortable in social interactions (23). Additionally, a lower level of self-esteem contributes to a higher level of loneliness and vice versa: a high level of loneliness contributes to low self-esteem (23).

CILJ ISTRAŽIVANJA, ISTRAŽIVAČKI PROBLEMI I HIPOTEZE

Vodeći se dosadašnjim istraživanjima koja su pokazala kako je promjena boravišta u starijoj životnoj posebno teška te nepovoljno utječe na socijalni i emocionalni život starijih osoba (15,16,21,22), cilj ovog istraživanja je utvrditi razlike u samoprocjeni socijalne i emocionalne usamljenosti te samopoštovanja s obzirom na mjesto stanovanja starijih osoba (dom za starije osobe ili vlastita kuća), sociodemografske karakteristike (spol, dob, obrazovanje, bračno stanje) i zdravstveno stanje starijih osoba.

Prvo istraživačko pitanje koje smo postavili jest postoji li razlika između starijih osoba koje žive u domu umirovljenika i starijih osoba koje žive u kućama u samoprocjeni samopoštovanja, socijalne usamljenosti i emocionalne usamljenosti (usamljenosti u ljubavi i usamljenosti u obitelji). S obzirom na rezultate ranijih istraživanja (15-18,23), pretpostavljamo da će sudionici u ovom istraživanju koji žive u domovima umirovljenika iskazati nižu razinu samopoštovanja a veću razinu usamljenosti u sve tri dimenzije usamljenosti (socijalna usamljenost, usamljenost u ljubavi i usamljenost u obitelji).

Drugo istraživačko pitanje koje smo postavili jest postoji li razlika u samoprocjeni samopoštovanja te socijalne i emocionalne usamljenosti s obzirom na spol (muški i ženski), dob (65-74, 75-84 i stariji od 85 godina), bračno stanje (neudana/neoženjen,udovac/ica, razveden/a, u braku), razinu obrazovanja (osnovna škola, srednja škola i viša i/ili visoka škola) te zdravstveno stanje sudionika (izvrsno i dobro ili zabrinjavajuće). S obzirom na rezultate ranijih istraživanja (6,22,36-38) pretpostavljamo da će žene u obje skupine sudionika iskazati niže samopoštovanje a veću socijalnu i emocionalnu usamljenost. Što se tiče dobi, pretpostavljamo da će porastom dobi sudionici u objema skupinama procjenjivati niže samopoštovanje a veću socijalnu i emocionalnu usamljenost. Također

STUDY OBJECTIVE, RESEARCH PROBLEMS AND HYPOTHESES

Guided by previous research that showed that change of residence in elderly age is particularly difficult and adversely affects the social and emotional lives of the elderly (15,16,21,22), the aim of this study was to determine the differences in self-assessed social and emotional loneliness and self-esteem with respect to the place of residence of the elderly (retirement homes or their own home), sociodemographic characteristics (sex, age, education, marital status) and their health.

The first research question we asked as whether there was a difference between older people living in retirement homes and older people living in their own homes in self-assessment of self-esteem, social loneliness and emotional loneliness (loneliness in love and loneliness in family). Given the results of previous studies (15-18,23), we assumed that participants in this study living in retirement homes will show a lower level of self-esteem and a higher level of loneliness in all three dimensions of loneliness (social loneliness, loneliness in love and loneliness in family).

Another research question we asked was whether there was a difference in self-assessment of self-esteem and social and emotional loneliness with regard to gender (male and female), age (65-74, 75-84 and older than 85), marital status (unmarried, widowed, divorced, married), level of education (elementary school, high school and higher education and / or university) and health of the participants (excellent and good or worrisome). Given the results of earlier studies (6,22,36,37,38), we assumed that women in both groups will show lower self-esteem and greater social and emotional loneliness. As far as age was concerned, its increase lowers the assessment of self-esteem and brings greater social and emotional loneliness. Participants

pretpostavljamo da će sudionici u objema skupinama koji su neudani/neoženjeni ili udovci/ice, nižeg obrazovanja te zabrinjavajućeg zdravstvenog stanja iskazati niže samopoštovanje i veću razinu socijalne i emocionalne usamljenosti.

in both groups who were unmarried or widowed, with lower education and worrisome health conditions, were also expected to show lower self-esteem and a higher level of social and emotional loneliness.

METODOLOGIJA

Sudionici

Za prikupljanje primarnih podataka odabran je prigodni uzorak od 379 sudionika na području Varaždinske i Međimurske županije. Taj dio uzorka sastojao se od sudionika koji žive u domovima umirovljenika (šest domova) i sudionika koji žive u kućama (tablica 1). Prosječna dob sudionika koji žive u domovima za starije iznosila je 80,64 godine (SD=6,48), a za sudionike koji žive u kućama 71,41 godinu (SD=5,77). U objema skupinama najveći je broj sudionika ženskog spola pri čemu je u domu umirovljenika sudjelovalo 70,6 % žena, 28,9 % muškaraca (0,5 % nije popunilo taj dio u upitniku), a od sudionika koji žive u kućama sudjelovalo je 68,0 % žena te 32,0 % muškaraca. Što se tiče bračnog stanja, gotovo podjednak broj sudionika koji žive u kućama su udovci/udovice (44,4 %) te u braku (43,8 %), dok je kod sudionika u domovima umirovljenika više udovaca/udovica (69,7 %), a u braku je svega 10,0 % sudionika. U domovima

METHODOLOGY

Participants

In order to gather primary data, a suitable sample of 379 participants from Varazdin and Medimurje County was selected. Part of the sample consisted of participants living in retirement homes (6 retirement homes) and part were participants living in their own homes (**Table 1**). The average age of participants living in retirement homes was 80.64 (Standard Deviation (SD) =6.48) years, while those in their homes were aged 71.41 years (SD=5.77). In both groups, the number of female participants was higher, with 70.6% of women living in retirement homes and 28.9% of men in retirement homes (0.5% did not fill out that part in the questionnaire), while 68.0% of the participants living in their home were women and 32.0% were men. As for marital status, almost the same number of participants living in their houses were widowed (44.4%) and married (43.8%),

TABLE 1. Participants with regard to place of residence and list of participating retirement homes

		Frequency	Percentage
Place of residence	Retirement homes	201	53.0%
	House/household	178	47.0%
	Total	379	100.0%
Retirement homes	Caritas' home "Sv. Ivan Krstitelj"	27	13.4%
	Home for the elderly and infirm persons "Novinšča"	42	20.9%
	Home for the elderly and infirm persons Varaždin	64	31.8%
	Home for the elderly and infirm persons Sv. Ana	29	14.4%
	Home for the Elderly and Infirm People "Novi Život"	25	12.4%
	Home for the Elderly and Infirm People "Matija"	14	7.0%
	Total	201	100.0%

umirovljenika je 12,4% sudionika razvedeno, a neudano/neoženjeno 8 % sudionika, dok je od sudionika u kućama 5,6 % razvedeno, a neudano/neoženjeno 6,2 %. Od sudionika u kućama, 41,0 % ima završenu osnovnu školu, 44,4 % ima završenu srednju školu, a 14,6 % ima završenu višu i/ili visoku školu. U domovima umirovljenika 50, 2 % sudionika ima završenu osnovnu školu, 35,8 % završenu srednju školu, a 11,0% ima završenu višu i/ili visoku školu.

Iz tablice 1 vidimo kako 47,0 % sudionika živi u kućama, a 53,0 % u domovima umirovljenika. Tako je u Caritasovom domu „Sv. Ivan Krstitelj" sudjelovalo 13,4 % sudionika, u domu „Novinščak" 20,9 %, u domu „Varaždin" 31,8 %, u domu „Sv. Ane" 14,4 %, u domu „Novi Život" 12,4 % te u domu „Matija" 7,0 % sudionika.

Postupak

U istraživanje nisu bili uključeni sudionici s težim psihofizičkim bolestima (poput demencija, shizofrenije, PTSP-a, uznapredovalih stadija malignih bolesti, CVI s posljedicom afazije i potpune nepokretnosti i slično), odnosno u istraživanju su mogli sudjelovati samo oni sudionici koji su sposobni sami se brinuti za sebe tijekom obavljanja svakodnevnih zadataka (hranjenje, hodanje, presvlačenje, kupanje). Istraživanje se provodilo u razdoblju od početka mjeseca siječnja do konca mjeseca travnja 2017. godine. Sudionicima je naglašeno da je sudjelovanje u istraživanju anonimno i dobrovoljno te da će u prosjeku trajati oko trideset minuta i da u svakom trenutku mogu prekinuti sudjelovanje ako za tim osjete potrebu. Kod sudionika koji žive u svojim kućama odabran je prigodni uzorak do kojeg smo došli putem Udruge umirovljenika. Ispitivači su sudionike posjetili u njihovim kućama pri čemu su ih ispitivači upoznali sa svrhom istraživanja te im je ponuđen anketni upitnik samo ako su izrazili želju da sudjeluju u istraživanju. Za sudionike koji su smješteni u domovima za starije ispitivanje su proveli socijalni radnici i radni terapeuti i to u sobama

while there were widowed participants among those living in retirement homes (69.7%) compared with married ones (10.0%). 12.4% of the participants who lived in retirement homes were divorced and 8.0% unmarried, while among those living in their homes 5.6% were divorced and 6.2% unmarried. Among the participants living in their houses, 41.0% completed elementary school, 44.4% completed high school and 14.6% had a higher and / or university education. In retirement homes 50.2% of participants completed elementary school, 35.8% completed high school and 11.0% had a higher and / or university education.

Procedure

The study excluded participants with severe psychophysical illnesses (such as dementia, schizophrenia, PTSD, advanced stage of malignancy, CVI with aphasia and complete immobilization), i.e. it included only those who were able take care of themselves while doing everyday tasks (feeding, walking, changing, bathing). The study was conducted from the beginning of January to the end of April, 2017. Participants were told that participation in the study was anonymous and voluntary and would last approximately 30 minutes, and that they could back out at any time if they wanted. A suitable sample was taken among the participants who live in their homes, which was acquired through the Pensioners' Association. The participants were questioned in their homes, were acquainted with the purpose of the study and offered the questionnaire only if they wanted to participate. Participants living in retirement homes were questioned by social workers and work therapists in their rooms. They were also informed about the purpose and manner of completing the questionnaire and guaranteed anonymity, and were told they could back out at any time. Since the first participants (in

umirovljenika. Ispitivači su na jednak način kao i sudionike u kućama informirali o svrsi i načinu popunjavanja upitnika, zajamčenoj anonimnosti te su im naglasili da u bilo kojem trenutku mogu odustati od sudjelovanja. Budući da se već kod prvih sudionika (jedne i druge skupine) pokazalo da imaju poteškoća prigodom samostalnog popunjavanja upitnika nakon dane upute (teško im je bilo pisati u upitnik, slabi vid, brzo su se zamarali) kako ne bi bilo razlike u dobivanju informacija od sudionika do sudionika, čitavo istraživanje je provedeno usmenim putem, odnosno ispitivači su čitali pitanja i bilježili odgovore. Međutim, oni sudionici koji su iskazali želju da sami ispune upitnik, ispitivači su im to i omogućili. U prosjeku je anketiranje trajalo trideset minuta po sudioniku.

Instrumenti

Sociodemografski podatci i zdravstveno stanje

Za potrebe ovog istraživanja autori su izradili strukturirani upitnik koji je sadržavao sociodemografske podatake koji su uključivali: dob (65-74 godina, 75-84 godina, iznad 85 godina), spol (muški i ženski), razina obrazovanja (osnovna škola, srednja škola, viša škola, visoka škola), bračno stanje (neudana/neoženjen, razveden/a, udovac/ica, u braku), mjesto stanovanja (dom umirovljenika ili vlastita kuća). Također, upitnik je sadržavao tvrdnje koje se odnose na općenito zdravstveno stanje sudionika: izvrsno (nemam zdravstvenih poteškoća), dobro (imam samo lakše povremene poteškoće), zabrinjavajuće (imam neku težu bolest).

Osim sociodemografskih podataka anketnim su upitnikom prikupljeni, iako nisu prikazani u ovome radu, sljedeći podatci: vrsta kućanstva (samačko ili više članova), materijalno stanje (visina mjesečnog dohotka), veličina stambenog prostora, mjesto stanovanja (grad ili selo) sposobnost samozbrinjavanja (fizička skrb, psihološka skrb, emocionalna skrb i duhovna skrb).

both groups) showed difficulty in completing the questionnaire after being given instructions (they found it difficult to write in the questionnaire, they had vision problems, they were tired and so on), and in order to avoid differences in obtained information from the examinees, the whole examination was conducted verbally, i.e. the examiner read questions and recorded the answers. However, those examinees who expressed the desire to fill out the questionnaire themselves were able to do so.

Instruments

Sociodemographic data and health condition

For the purpose of this study, the authors produced a structured questionnaire containing sociodemographic data that included: Age (65-74 years, 75-84 years, over 85 years), gender (male and female), level of education (elementary school, high school, higher education, university), marital status (single, divorced, widow, married), place of residence (home / institution or own house). Additionally, the questionnaire contained statements regarding the overall health condition of the examinee: excellent ("I do not have health problems"), good ("I have only occasional difficulties") and worrisome ("I have a serious illness"). In addition to sociodemographic data, a survey questionnaire, although not shown in this paper, collected the following data: household type (single or multiple), financial status (monthly income), housing size, place of residence (city or village), self-maintenance ability (physical care, psychological care, emotional care and spiritual care).

Rosenberg's Self-Esteem Scale

Rosenberg's Self-Esteem Scale (Rosenberg Self-Esteem Scale – RSE, 1965) (24) is a scale that contains 10 items corresponding to a 5-de-

Rosenbergova ljestvica samopoštovanja

Rosenbergova ljestvica samopoštovanja (Rosenberg Self-Esteem Scale – RSE, 1965) (24) je ljestvica koja sadrži 10 čestica na koje se odgovara na ljestvici Likertovog tipa s 5 stupnjeva od 1 do 5 (1 - u potpunosti netočno, 2 - uglavnom netočno, 3 - ni točno ni netočno, 4 - uglavnom točno, 5 - u potpunosti točno). Ukupni se rezultat formira kao linearna kombinacija procjena na svakoj od čestica. S obzirom da veći rezultat na ljestvici ukazuje na veće samopoštovanje, negativne tvrdnje je bilo potrebno dekodirati u pozitivne. Na uzorku ovog istraživanja izračunali smo Cronbachov koeficijent alfa koji iznosi 0,86, što ukazuje na visoku pouzdanost.

Ljestvica socijalne i emocionalne usamljenosti

Ljestvica socijalne i emocionalne usamljenosti (SELSA-S ljestvica) (25) koju smo koristili u ovome radu sastoji se od tri podljestvice kojima se zasebno ispituju usamljenost u domenama prijateljskih odnosa (podljestvica socijalne usamljenosti, 13 čestica), odnosa s obitelji (podljestvica usamljenosti u obitelji, 11 čestica) i ljubavnih veza (podljestvica usamljenosti u ljubavi, 12 čestica). Dakle svekupno je 36 tvrdnji na koje se odgovara na ljestvici Likertovog tipa sa 7 stupnjeva od 1 do 7 (1-uopće se ne slažem, 2-uglavnom se ne slažem, 3-donekle se ne slažem, 4-niti se slažem, niti se ne slažem, 5-donekle se slažem, 6-uglavnom se slažem, 7-potpuno se slažem). Sve podljestvice sadrže i pozitivno i negativno formulirane tvrdnje pri čemu veći rezultat ukazuje na veću usamljenost pozitivne tvrdnje smo dekodirali u negativne. Na uzorku ovog istraživanja izračunali smo Cronbachov koeficijent alfa. Tako pouzdanost za socijalnu usamljenost iznosi 0,94, za usamljenost u ljubavi 0,86, a za usamljenost u obitelji 0,91.

Statistička analiza

Prije analize podataka prema postavljenim problemima istraživanja, provjerena je normalnost distribucije Kolmogorov-Smirnoffovim testom i

gree Likert-type scale from 1 to 5 (1 – totally inaccurate, 2 – mostly inaccurate, 3 – nor accurate or inaccurate, 4 – mostly correct, 5 – completely correct). The overall result is calculated as a linear combination of estimates on each of the items. Given that higher scores on the scale indicate greater self-esteem, the negative statements had to be decoded as positives. On the sample in this study, we calculated Cronbach's alpha coefficient, which was 0.86 and indicated a high reliability.

Scale of social and emotional loneliness

The scale of social and emotional loneliness (SELSA-S Scale) (25) was used in this work and consists of three sub-scales that examine loneliness in the domains of friendly relationships (sub-scales of social loneliness, 13 items), family relationships (sub-scale of loneliness, in family, 11 items) and love relationships (subscale of loneliness in love, 12 items). There were thus 36 statements that corresponded to the Likert-type scale with 7 degrees from 1 to 7 (1 – I completely disagree, 2 – I mostly disagree, 3 – I partly disagree, 4 – I neither agree nor disagree, 5 – I partly agree, 6 – I mostly agree, 7 – I completely agree). All sub-scales contained both positively and negatively formulated statements, with the larger result indicating greater loneliness, so we had to decode positive statements into negative ones. In the sample of this study, we computed the Cronbach alpha coefficient. For social loneliness it was 0.94, 0.86for loneliness in love and 0.91 for loneliness in the family.

Statistical analysis

Prior to analysing the data according to the set research problems, the distribution of the normality was verified by the Kolmogorov-Smirnoff test and the Shapiro-Wilk test. Considering the deviation of the observed variables from the normal (Gauss) distribu-

Shapiro-Wilkovim testom. S obzirom da se ustvrdilo odstupanje promatranih varijabli od normalne (Gaussove) distribucije testiranje je provedeno pomoću neparametrijskih inačica testova odnosno Kruskal Wallisovim testom, Mann-Whitneyevim U testom, Wilcoxon W testom. Kako bi se uočila povezanost između promatranih varijabli i kategorija izračunat je Spearmanov koeficijent korelacije, a za utvrđivanje značajnosti svih testova, prigodom testiranja, postavljena je na 5 %, što je razina pouzdanosti od 95 %. U svrhu statističke analize upotrijebili smo statistički program SPSS (inačica 21.0, SPSS Inc., Chicago, IL, SAD).

REZULTATI

Iz tablice 2 vidimo značajnu razliku kod samopoštovanja s obzirom na mjesto stanovanja sudionika (p<0,05), pri čemu je manja prosječna vrijednost rangova za sudionike u domovima umirovljenika (177,83) u odnosu na sudionike u kućama (200,50), što ukazuje da su odgovori na ljestvici samopoštovanja značajno veći za sudionike u kućama. Iz tablice 2 također vidimo značajnu razliku kod usamljenosti u ljubation, the testing was performed using nonparametric variants of the test or Kruskal Wallis test, Mann-Whitney's In Test and Wilcoxon W test. The significance for all tests was set at 5%, which is the 95% confidence level. For the purpose of statistical analysis we used the SPSS statistical program (version 21.0, SPSS Inc., Chicago, IL, USA).

RESULTS

Table 2 shows significant difference in self-esteem with regard to the place of residence of the participants (p<0.05), with lower average values for the participants in retirement homes (177.83) compared with the participants living in their home (200.50), which suggests that the responses on the scale of self-esteem were significantly higher for participants living in their homes.

Table 2 also shows a significant difference in loneliness with regard to the place of residence of the participants (p<0.05), with the average value being higher for the participants living in retirement homes (202.15) than in those

TABLE 2. The values of overall results of the participants living in retirement homes and their houses with regard to self-esteem, social loneliness, loneliness in love and family

	Participants	N	Arithmetical mean rankings	p*
Self-esteem	D	199	177.83	**.043**
	K	177	200.50	
	Total	376		
Social loneliness	D	197	191.0	.328
	K	175	180.71	
	Total	372		
Loneliness in love	D	191	202.15	**.000**
	K	171	158.43	
	Total	362		
Loneliness in family	D	192	193.15	.083
	K	175	173.97	
	Total	367		

Legend: D-participants in institutions (retirement homes), K- participants in their homes
*Mann-Whitney U test, Wilcoxon W test

vi s obzirom na mjesto stanovanja sudionika (p<0,05), pri čemu je prosječna vrijednost rangova veća za sudionike u domovima umirovljenika (202,15) u odnosu na sudionike u kućama (158,43), što ukazuje da su odgovori na podljestvici usamljenosti u ljubavi značajno veći za sudionike u domovima umirovljenika.

Iz tablice 3 vidimo značajnu razliku kod sudionika koji žive u kućama kod usamljenosti u ljubavi s obzirom na spol (p<0,05), pri čemu je prosječna vrijednost rangova veća za ženske sudionike (92,73), u odnosu na muške (71,42), što ukazuje da su odgovori ženskih sudionika na podljestvici usamljenosti u ljubavi značajno veći od muških sudionika. Međutim, kod usamljenosti u ljubavi uočena je značajna razlika kod sudionika koji žive u domovima umirovljenika s obzirom na spol (p<0,05) pri čemu je prosječna vrijednost rangova veća za muške (111,60) u odnosu na ženske sudionike (90,13), što ukazuje da su odgovori muških sudionika na podljestvici usamljenosti u obitelji značajno veći od odgovora ženskih sudionika.

Iz tablice 4 vidimo značajnu razliku kod samopoštovanja s obzirom na dob sudionika koji

living in their homes (158.43), suggesting that responses to loneliness in love were significantly higher for participants in retirement homes.

Table 3 shows a significant difference between the participants living in their homes when it comes to loneliness in love in terms of gender (p<0.05), with the average value higher for female participants (92.73) compared with male (71.42), indicating that responses in women to loneliness in love were significantly higher than those of male participants. However, for loneliness in love there was a significant difference in the number of the participants living in retirement homes in terms of gender (p<0.05), with the average values higher for male participants (111.60) compared with female participants (90.13), indicating that male responses to loneliness in family were significantly higher than female ones.

Table 4 shows a significant difference in self-esteem with respect to the age of the participants living in their homes (p<0.05), with the average value (94.32) being the highest for the participants in the age group 65-74 and the lowest (10.50) in the age group over 85 years.

TABLE 3. Values of the results on self-esteem, social loneliness, loneliness in love and loneliness in family with regard to gender (in both groups of participants)

	Gender	N		Arithmetical rankings		p*	
		D	K	D	K	D	K
Self-esteem	Male	58	57	108.44	91.37	.157	.671
	Female	140	120	95.80	87.88		
	Total	198	177				
Social loneliness	Male	58	56	107.36	86.47	.183	.784
	Female	193	119	95.51	88.72		
	Total	197	175				
Loneliness in love	Male	56	54	93.99	71.42	.746	**.009**
	Female	135	117	96.83	92.73		
	Total	191	171				
Loneliness in family	Male	57	56	111.60	84.44	**.014**	.521
	Female	135	119	90.13	89.68		
	Total	192	175				

Legend: D - participants in institutions (retirement homes), K - participants in their homes
* Mann-Whitney U test, Wilcoxon W test.

TABLE 4. Values of the results on self-esteem, social loneliness, loneliness in love and loneliness in family with regard to age (in both groups of participants)

	Age (in years)	N		Arithmetical mean rankings		p*	
		D	K	D	K	D	K
Self-esteem	65-74	29	125	105.62	94.32	.269	**.002**
	75-84	112	47	100.97	79.66		
	85 and more	54	4	87.74	10.50		
	Total	195	176				
Social loneliness	65-74	29	123	103.53	82.09	.523	**.017**
	75-84	111	47	94.00	96.83		
	85 and more	55	4	103.16	144.25		
	Total	195	174				
Loneliness in love	65-74	28	119	114.09	78.40	**.042**	**.002**
	75-84	111	47	87.27	97.98		
	85 and more	50	4	101.48	150.13		
	Total	189	170				
Loneliness in family	65-74	28	124	104.70	80.34	.417	**.004**
	75-84	108	46	95.86	102.34		
	85 and more	53	4	88.12	140.63		
	Total	189	174				

Legend: D - participants in institutions (retirement homes), K - participants in their homes
* Kruskal Wallis test

žive u kućama (p<0,05) pri čemu je prosječna vrijednost rangova (94,32) najveća za sudionike u dobnoj skupini 65-74 godina, a najniža prosječna vrijednost rangova (10,50) je u dobnoj skupini starijih od 85 godina.

Kod socijalne usamljenosti s obzirom na dob uočena je značajna razlika kod sudionika koji žive u kućama (p<0,05), pri čemu je prosječna vrijednost rangova (144,25) najveća za ispitanike u dobnoj skupini starijih od 85 godina, a najniža prosječna vrijednost rangova (82,09) je u dobnoj skupini 65-74 godina.

Kod usamljenosti u ljubavi s obzirom na dob uočena je značajna razlika u obje skupine sudionika (p<0,05) pri čemu je najveća prosječna vrijednost rangova (114,09) za sudionike koji žive u domovima umirovljenika u dobnoj skupini 65-74 godina, a najniža prosječna vrijednost rangova (87,27) je u dobnoj skupini 75-84 godina. Kod sudionika koji žive u kućama najveća prosječna vrijednost rangova (150,13) je u

Regarding social loneliness with respect to age, a significant difference was observed among the participants living in their homes (p<0.05), with the average value (144.25) being the highest for the participants over the age of 85 and the lowest (82.09) in the age group of 65-74 years.

Regarding loneliness in love with respect to age, a significant difference was observed in both groups of participants (p<0.05), with the highest average value (114.09) in the participants living in retirement homes in the age group 65-74 and the lowest average value (87.27) in the age group of 75-84 years. The participants living in their homes rank the highest (150.13) in the age group of 85 and the lowest average value of 78.40 was observed in the age group of 65-74 years.

For loneliness in family with respect to age, a significant difference was observed among the participants living in their homes (p<0.05),

dobnoj skupini starijih od 85 godina, a najniža prosječna vrijednost rangova (78,40) je u dobnoj skupini 65-74 godina.

Kod usamljenosti u obitelji s obzirom na dob uočena je značajna razlika kod sudionika koji žive u kućama (p<0,05), pri čemu je najveća prosječna vrijednost rangova (140,63) za sudionike starije od 85 godina, a najniža (80,34) je u dobnoj skupini 65-74 godina.

Iz tablice 5 vidimo značajnu razliku kod usamljenosti u ljubavi s obzirom na bračno stanje u obje skupine sudionika (p<0,05), pri čemu kod sudionika u kućama koji su udovci/ice najveća je prosječna vrijednost rangova (120,83), a najniža prosječna vrijednost rangova je kod sudionika u kućama koji su u braku (45,57).

with the highest value (140.63) in the participants older than 85 and the lowest (80.34) in the age group of 65-74 years.

Table 5 shows a significant difference in loneliness in love in terms of marital status in both groups of participants (p<0.05), where the highest average value (120.83) was observed among the participants who were widowed and living in their homes, and the lowest average value among married participants and participants living in their homes (45.57). The highest average value (127.07) was found among the participants who were unmarried and living in retirement homes, while the lowest average value was in married participants living in retirement homes (50.39). For loneliness in fami-

TABLE 5. Values of the results on self-esteem, social loneliness, loneliness in love and loneliness in family with regard to marital status (in both groups of participants)

	Marital status	N		Arithmetical rankings		p*	
		D	K	D	K	D	K
Self-esteem	Single	16	11	92.66	85.09	.228	.198
	Widow	138	79	96.35	81.65		
	Divorced	25	10	121.16	79.05		
	Married	20	77	104.63	98.40		
	Total	199	177				
Social loneliness	Single	16	11	121.28	111.77	.095	.116
	Widow	136	78	98.99	93.91		
	Divorced	25	10	77.82	76.10		
	Married	20	76	107.70	80.06		
	Total	197	175				
Loneliness in love	Single	15	10	127.07	116.90	**.000**	**.000**
	Widow	132	76	103.77	120.83		
	Divorced	25	9	71.02	99.00		
	Married	19	76	50.39	45.57		
	Total	191	171				
Loneliness in family	Single	15	11	137.43	120.55	**.031**	**.000**
	Widow	134	78	92.96	102.16		
	Divorced	23	9	93.35	100.83		
	Married	20	77	93.18	97.51		
	Total	192	175				

Legend: D - participants in institutions (retirement homes), K - participants in their homes
* Kruskal Wallis Test

Kod sudionika u domovima umirovljenika koji su neudani/neoženjeni najveća je prosječna vrijednost rangova (127,07), a najniža sudionika u domovima umirovljenika koji su u braku (50,39).

Kod usamljenosti u obitelji s obzirom na bračno stanje u obje skupine sudionika uočena je značajna razlika (p<0,05) pri čemu je za sudionike u kućama koji su neudani/neoženjeni najveća prosječna vrijednost rangova (120,55), a kod sudionika u kućama koji su u braku je najniža (97,51). Kod sudionika u domovima umirovljenika najveća je prosječna vrijednost rangova neudanih/neoženjenih sudionika (137,43), a najniža je kod sudionika u domovima umirovljenika koji su u braku (93,18).

Iz tablice 6 vidimo značajnu razliku kod samopoštovanja s obzirom na obrazovanje sudionily with respect to marital status there was a significant difference (p<0.05) in both groups of participants, where the participants who were unmarried and living in their homes showed the highest average value (120.55), and the participants who were married and living in their homes showed the lowest average value rating (97.51). The highest average value was found among the participants who were unmarried and living in retirement homes (137.43), and the lowest average value was found among the participants who were married and living in their homes (93.18).

Table 6 shows a significant difference in self-esteem with regard to education (p<0.05) among both group of the participants. The participants living in their homes who have a

TABLE 6. Values of the results on self-esteem, social loneliness, loneliness in love and loneliness in family with regard to education (in both groups of participants)

	Level of education	N		Arithmetical mean rankings		p*	
		D	K	D	K	D	K
Self-esteem	Elementary school	100	72	89.04	77.18	**.010**	**.036**
	Secondary school	71	79	98.42	95.89		
	Higher education and/ or University	22	26	128.59	100.79		
	Total	193	177				
Social loneliness	Elementary school	99	71	96.83	92.10	.465	.374
	Secondary school	70	78	99.04	88.32		
	Higher education and/ or University	22	26	82.59	75.85		
	Total	191	175				
Loneliness in love	Elementary school	99	70	93.87	95.41	.324	.068
	Secondary school	65	76	98.11	82.39		
	Higher education and/ or University	22	25	78.23	70.62		
	Total	186	171				
Loneliness in family	Elementary school	99	72	91.67	94.87	.825	.212
	Secondary school	65	77	96.84	80.57		
	Higher education and/ or University	22	26	91.89	90.98		
	Total	186	175				

Legend: D - participants in institutions (retirement homes), K -participants in their homes
* Kruskal Wallis test

ka koji žive u kućama (p<0,05) i sudionika koji žive u domovima umirovljenika. Kod sudionika u kućama koji imaju završenu višu i/ili visoku školu najveća je prosječna vrijednost rangova (100,79), a kod sudionika u kućama koji imaju završenu osnovnu školu je najniža (77,18). Kod sudionika domovima umirovljenika koji imaju završenu višu i/ili visoku školu najveća je prosječna vrijednost rangova (128,59), a kod sudionika u domovima umirovljenika je najniža (89,04).

Iz tablice 7 vidimo značajnu razlika kod samopoštovanja s obzirom na zdravstveno stanje u obje skupine sudionika (p<0,05) pri čemu je najveća prosječna vrijednost rangova (94,69), kod sudionika u kućama koji su svoje zdravstveno stanje procijenili kao izvrsno i dobro, a kod sudionika u kućama koji su svoje zdravstveno stanje procijenili kao zabrinjavajuće je najniža (59,98). U domovima umirovljenika najveća je prosječna vrijednost rangova (110,05) kod sudionika koji su svoje zdravstveno stanje procijenili kao izvrsno i dobro, a kod sudionika koji

higher / university education had the highest average value (100.79), and the participants living in their homes who only completed elementary school had the lowest average value (77.18). The participants living in retirement homes who competed higher / university education had the highest average value rating (128.59), while the lowest average value was found among the participants living in retirement homes who only completed elementary school (89.04).

Table 7 shows a significant difference in self-esteem with respect to the health status of both groups of the participants (p<0.05), with the highest average value (94.69) being found among participants living in their houses who assessed their health status as excellent and good, and the lowest average value of rating (59.98) found among participants living in their homes who assessed their health as the most worrisome. In the retirement homes, the highest average value (110.05) was among the participants who assessed their health as ex-

TABLE 7. Values of the results on self-esteem, social loneliness, loneliness in love and loneliness in family with regard to health status (in both groups of participants)

	Health condition	N		Arithmetical mean rankings		p*	
		D	K	D	K	D	K
Self-esteem	Excellent and good	128	148	110.05	94.69	**.000**	**.001**
	Worrisome	70	29	80.20	59.98		
	Total	198	177				
Social loneliness	Excellent and good	127	145	93.24	84.82	.056	.117
	Worrisome	70	29	109.45	100.88		
	Total	197	174				
Loneliness in love	Excellent and good	122	143	92.47	85.27	.240	.890
	Worrisome	69	27	102.24	86.70		
	Total	191	170				
Loneliness in family	Excellent and good	123	147	95.01	84.02	.619	**.032**
	Worrisome	69	27	99.16	106.44		
	Total	192	174				

Legend: D-participants in institutions (retirement homes), K-participants in their homes * Mann-Whitney U test, Wilcoxon W test

su svoje zdravstveno stanje procijenili kao zabrinjavajuće je najniža (80,20).

Kod usamljenosti u obitelji uočena je značajna razlika kod sudionika koji su u kućama ($p<0,05$), pri čemu je veća prosječna vrijednost rangova (106,44) kod sudionika koji su svoje zdravstveno stanje procijenili kao zabrinjavajuće a niža prosječna vrijednost rangova (84,02) je kod sudionika koji su svoje zdravstveno stanje procijenili kao izvrsno i dobro.

Na tablici 8 prikazani su koeficijenti korelacije za sudionike smještene u kućama. Iz prikazane tablice može se uočiti kako je najveća pozitivna razina korelacije zabilježena za usamljenost u obitelji i usamljenost u ljubavi ($r=0,537$, $p<0,01$), dok je najveća negativna korelacija zabilježena između socijalne usamljenosti i samopoštovanja ($r=-0,521$, $p<0,01$), te između usamljenosti u obitelji i samopoštovanja ($r=-0,499$, $p<0,01$).

Na tablici 9 prikazani su koeficijenti korelacije za sudionike smještene u domovima umirovljenika. Iz prikazane tablice može se uočiti

cellent and good, and those who assessed their health as worrisome had a low average value (80.20). With loneliness in family, there was a significant difference among the participants living in their homes ($p<0.05$), with the higher average value (106.44) being among the participants who assessed their health status as worrisome and lower average value (84.02) among the participants who assessed their health as excellent and good.

Table 8 shows correlation coefficients for participants living in their homes. The highest positive level of correlation was recorded for loneliness in family and loneliness in love ($r = 0.537$, $p<0.01$), while the highest negative correlation was recorded between social loneliness and self-esteem ($r = -0.521$, $p<0.01$) and between loneliness in family and self-esteem ($r = -0.499$, $p<0.01$).

Table 9 shows the correlation coefficients for the participants in retirement homes. The highest positive correlation level was recorded for loneliness in family and social loneliness (r

TABLE 8. Values of Spearman's correlation coefficient between self-esteem, social loneliness, loneliness in love and loneliness in family among the participants living in their homes

		1.	2.	3.	4.
Self-esteem	r	-			
Social loneliness	r	-.521**	-		
Loneliness in love	r	-.324**	.266**	-	
Loneliness in family	r	-.499**	.358**	.537**	-

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

TABLE 9. Values of Spearman's correlation coefficient between self-esteem, social loneliness, loneliness in love and loneliness in family among the participants living in retirement homes

		1.	2.	3.	4.
Self-esteem	r	-			
Social loneliness	r	-.483**	-		
Loneliness in love	r	-.203**	.365**	-	
Loneliness in family	r	-.321**	.517**	.334**	-

** Correlation is significant at the 0.01 level (2-tailed).
* Correlation is significant at the 0.05 level (2-tailed).

kako je najveća pozitivna razina korelacije zabilježena za usamljenost u obitelji i socijalnu usamljenost (r=0,517, p<0,01), dok je najveća negativna korelacija zabilježena između socijalne usamljenosti i samopoštovanja (r=-0,483, p<0,01).

RASPRAVA

Analizom skupnih razlika između sudionika koji žive u domovima umirovljenika i sudionika koji žive u kućama dobiven je jednim dijelom postojeći trend razlike pri čemu se pokazalo kako su sudionici koji žive u domovima procijenili veću razinu usamljenosti u ljubavi. Međutim, iznenađujuće je da između obih skupina sudionika nije bilo statistički značajne razlike u socijalnoj usamljenosti i usamljenosti u obitelji, što nam otvara nova pitanja povezana s kvalitetom života starijih osoba u vlastitoj kući i i njihovoj društvenoj sredini. S obzirom da domski smještaj izdvaja staru osobu iz njene fizičke i socijalne sredine te ju tako izlaže pojačanom stresu i nezadovoljstvu (15), rezultati našeg istraživanja pokazali kako su sudionici u domovima umirovljenika svoje samopoštovanje procijenili nižim u odnosu na sudionike u kućama. Kako bi se očuvala samostalnost i autonomija starije osobe te rasteretili institucionalni oblici skrbi potrebno je promicati boravak i skrb starijih osoba u vlastitome domu što je dulje moguće. „Obiteljski i društveni odnosi temeljni su elementi kvalitete života starijih osoba, pri čemu su visoke razine usamljenosti upravo povezane sa smještajem u domu“ (26). Tako je poštivanje autonomije kod starijih osoba u domovima umirovljenika poseban izazov, jer mnoge starije osobe doživljavaju stvaran i stalan gubitak neovisnosti i autonomije s obzirom da institucionalni zahtjevi otežavaju potpuni individualni pristup (27). Goffman (27) spominje „kontaminaciju osobnosti“ te ju opisuje kao otuđenje osobnih stvari dola-

= 0.517, p<0.01), while the highest negative correlation was between social loneliness and self-esteem (r = -0.483, p<0.01).

DISCUSSION

The aim of this study was to determine the differences in self-assessed social and emotional loneliness and self-esteem with regard to the place of residence (retirement homes or their own homes), sociodemographic characteristics (gender, age, education, marital status) and health status of elderly people.

By analysing collective differences between the participants living in retirement homes and participants living in their own homes, an existing trend of difference was identified, showing that those living in retirement homes reported a greater level of loneliness in love. However, it is surprising that there was no statistically significant difference between the two groups of participants in social loneliness and loneliness in family, which raises new questions about the quality of life of the elderly living in their homes and their social environment.

Given that retirement home accommodation displaces older persons from their physical and social environment and exposes them to increased stress and dissatisfaction (15), the results in our study have shown that participants in retirement homes rated their self-esteem lower than those living in their home. In order to preserve the independence and autonomy of the elderly and relieve the institutional forms of care, it is necessary to promote care for the elderly and enable them to stay in their own home as long as possible. “Family and social relations are the fundamental elements of the quality of life of older people, with high levels of loneliness being associated with living in a retirement home” (26). Respecting the autonomy of elderly people in retirement homes is a special challenge, as many elderly people

skom u instituciju, pregled cijelog tijela koji je neugodan i ponekad ponižavajući kao i ulazak osoblja u bilo koje vrijeme u sobu korisnika u domovima što svakako može utjecati na opadanje samopoštovanja.

Analizom samoprocjene usamljenosti prema spolu, dobiveni su rezultati pokazali kako su žene koje žive u kućama iskazale veću razinu usamljenosti u ljubavi. Rezultati sličnih istraživanja (6,22,28) pokazali kako su žene usamljenije u intimnim i prijateljskim odnosima (emocionalna usamljenost), a muškarci u socijalnim odnosima u grupi (socijalna usamljenost).

Ako ćemo pogledati rezultate ovog istraživanja prema dobnim skupinama sudionika u kućama, možemo vidjeti kako su sudionici u najstarijoj dobnoj skupini (iznad 85 godina) procjenili nižu razinu samopoštovanja. Također, rezultati našeg istraživanja pokazali su kako obrazovaniji sudionici u objema skupinama (sudionici u domovima umirovljenika i u kućama) procjenjuju svoje samopoštovanje značajno većim u odnosu na sudionike s nižim obrazovanjem.

Razmatranjem rezultata korelacijske analize uočava se negativna korelacija u obje skupine sudionika i to kod socijalne usamljenosti u odnosu na samopoštovanje. Utjecaj starenja na stvaranje pojma o sebi predmet je mnogih istraživanja, ali valjani zaključci o odnosu samopoštovanja i dalje nisu doneseni (29). Međutim „postupno opadanje samopoštovanja u djetinjstvu slijedi daljnje opadanje u adolescenciji da bi se samopoštovanje postupno povećavalo i došlo do vrhunca u odrasloj dobi i završilo oštrim padom u staroj dobi s početkom u 70-im godinama života“ (6,30). Nadalje, pogledom na zdravstveno stanje sudionika iz rezultata našeg istraživanja možemo vidjeti kako su sudionici u domovima umirovljenika i sudionici u kućama koji su svoje zdravstveno stanje procijenili kao izvrsno i dobro ujedno iskazali i veću razinu samopoštovanja.

experience a real and permanent loss of independence and autonomy since institutional requirements make it difficult for a complete individual approach (27). Goffman (24) mentions “personality contamination” and describes it as alienation of personal things by coming to the institution, including a whole body cheque up that is uncomfortable and sometimes humiliating as well as staff entering at any time into the room of the home user, which can certainly affect the decline in self-esteem.

The analysis of self-assessment of loneliness by gender showed that women living in their homes demonstrated a greater level of loneliness in love. The results of similar studies (6,22,28) showed that women are lonelier in intimate and friendly relationships (emotional loneliness) and men in social relationships in a group (social loneliness).

If we look at the results of this survey by age groups of those living in their homes, we can see that participants in the oldest age group (over 85) estimated a lower level of self-esteem. Also, the results of our study show that more educated participants in both groups (participants in retirement homes and their own homes) estimate their self-esteem significantly higher than those with a lower education.

Considering the results of the correlation analysis, there was a negative correlation in both groups of participants in case of social loneliness in relation to self-esteem. The influence of aging on the perception of oneself is the subject of many studies, but valid conclusions on self-esteem have not yet been made (29). However, “the gradual decline in self-esteem in childhood follows a further decay in adolescence, a gradual increase and reaching its peak in adulthood, and then ends with a sudden fall by the age of 70” (6,30). Furthermore, if we look at the health status of the participants, we can see that the participants in retirement homes and those living in their homes who assessed their health as excel-

Analizom razlika u procjeni usamljenosti s obzirom na dobne skupine provedenog istraživanja možemo vidjeti kako su najveću razinu usamljenosti procijenili sudionici u domovima umirovljenika u dobnoj skupini od 65. do 74. godine i to na području usamljenosti u ljubavi. Dobiveni rezultati su dijelom i očekivani s obzirom da navedeni sudionici spadaju u skupinu „mlađi-stariji" koja se susreće s promjenom životnih obveza nastalih procesom umirovljenja. Ako pogledamo bračno stanje sudionika možemo vidjeti kako su sudionici u domovima umirovljenika koji su neudati/neoženjeni iskazali veću razinu *usamljenosti u ljubavi* i *usamljenosti u obitelji*, međutim udovci/ice koji žive u kućama iskazali su veću razinu *usamljenosti u ljubavi*. Također, dobivene rezultate možemo potkrijepiti činjenicom da su novi brakovi starijih udovaca i udovica sretniji i uspješniji od onih ponovno sklopljenih u mlađoj dobi, a kao razlog tome navodi se „veća sloboda starijih od obveza prema djeci i poslu" (33) pa su svjesniji potrebe za ljubavlju. Što se tiče dobnih skupina, sudionici stariji od 85 godina koji žive u kućama iskazali su veću socijalnu usamljenost i usamljenost u ljubavi, a usamljenost u obitelji iskazali su ispitanici u dobnoj skupini od 65. do 74. godine. S obzirom da starija životna dob može biti izazov u promjeni uloga kao što su postajanje bake i djeda, odlazak u mirovinu, smrtni slučajevi bliskih osoba te potencijalno smanjenje društvenih mreža (34) može ugroziti odnosno spriječiti stvaranje novih prijateljstava i održavanje postojećih odnosa (35). Umirovljenje formalno oslobađa pojedinca od radnih obveza i ostavlja mu na raspolaganju znatno više slobodnog vremena koje može ispuniti na različite načine (31). Umirovljenici koji imaju kvalitetniji kontakt sa svojom socijalnom mrežom (djeca, unuci, srodnici, prijatelji) aktivniji su i zadovoljniji tim odnosima, uključeniji su u život zajednice (npr. kino, kazalište, organizirani sadržaji) i samim time zadovoljniji su položajem u društvu, provođenjem slobodnog

lent and good also expressed a higher level of self-esteem.

By analysing the difference in assessment of loneliness with regard to the age groups, we can see that the highest level of loneliness was evaluated by participants in retirement homes and in the age group 65-74, in the area of loneliness in love. The results obtained are partially expected as these participants fall into the "younger – older" group, which is faced with changes in their life obligations due to their retirement. If we look at the marital status of the participants, we can see that unmarried participants living in retirement homes showed a greater level of loneliness in love and loneliness in family, but the widowers/widows who live in their homes showed a greater level of loneliness in love. Furthermore, the results obtained can be supported by the fact that the new marriages of older widows/widowers are happier and more successful than those at a younger age, which is explained by being liberated from the obligation towards children and work (33) and, therefore, aware of the need for love. As for the age groups, the participants older than 85 living in their own homes showed greater social loneliness and loneliness in love, and loneliness in family was expressed by the participants in the age group 65-74. Given that the older age can be a challenge in changing roles such as becoming grandparents, retirement, deaths of close relatives and potential reduction of social networks (34), it can also endanger or prevent creating new friendships and maintaining existing relationships (35).

Retirement formally liberates an individual from work obligations and leaves him/her much more spare time to use in various ways (31). Pensioners who have better contact with their social network (children, grandchildren, relatives, friends) are more active and satisfied with these relationships, more involved in community (e.g. cinema, theatre, organized events) and are, therefore, more satisfied with their position in society, leisure time, past life,

vremena, dosadašnjim životom te usporedbom svoga života sa životima prijatelja (32). Nadalje, zaštitni čimbenik koji je dosljedno potvrđen u istraživanjima je prisutnost partnera, odnosno osobe s partnerom doživljavaju manje socijalne i emocionalne usamljenosti od osoba koje nisu u partnerskoj vezi (6). Bračni status povezan je sa smanjenim mortalitetom, tj. povezan je s produženim životnim vijekom do čak deset godina (36). Također, utvrđeno je da su oženjeni i oni u trajnoj izvanbračnoj vezi manje usamljeni od samaca, razvedenih i udovaca (37). Kad se analiziraju uzorci starijih osoba kod kojih je zamijećen porast usamljenosti vidi se da je taj porast veći među udovcima/udovicama i osobama lošijeg zdravstvenog stanja nego među oženjenima/udanima i dobrog zdravstvenog stanja (22). Naime, kada je riječ o smrti supružnika, za drugog supružnika financijska, domaćinska i emocionalna odgovornost se i više nego udvostručuje, pri čemu su ljutnja, depresija, beznađe, usamljenost i osjećaj socijalne izolacije najvažniji osjećaji supružnika koji je izgubio izvor emocionalne podrške (28). Smrt bračnog partnera na članove socijalne mreže udovca djeluje centripetalno, odnosno okupljaju se prijatelji i rođaci te pružaju emocionalnu i instrumentalnu podršku, a rastava braka na socijalnu mrežu djeluje centrifugalno, prijatelji i rođaci se povlače i ponekad se trajno udaljuju i prekidaju vezu, posebice sa ženama (38) „Smrt supružnika može biti posebno teška u slučaju jasne podjele tradicionalnih spolnih uloga u vezi kada je jedan partner nepripremljen na preuzimanje zadataka koji su nužni da bi se održavalo domaćinstvo. Tako je udovištvo za većinu starijih osoba daleko više od emocionalnog gubitka žene ili muža, ono obično znači duboku promjenu življenja koja nije slobodno izabrana ni željena, oduzimanje svakodnevne aktivnosti interakcija, gubitak budućnosti koju su zajedno planirali, blizinu završetka života, a često i gubitak identiteta i životnog smisla“ (28).

and also when comparing their lives with the lives of their friends (32). Furthermore, the protective factor that was consistently confirmed in studies is the presence of a partner, i.e. a person with a partner experiences less social and emotional loneliness than single people (6). Marital status is associated with reduced mortality, i.e. it is associated with an extended lifespan of up to ten years (36). It has also been confirmed that married people and those in a lasting extramarital relationship are less lonely than single, divorced and widowed people (37). When analysing the patterns of elderly people with a higher level of loneliness, it has been found that this increase is higher among widows / widowers and people with a poorer health status than among married people and those a good health status (22). When it comes to the spouse's death, the financial, household and emotional responsibility of the other spouse is more than doubled, with anger, depression, hopelessness, loneliness and social isolation being the main feelings of a spouse who lost the source of emotional support (28). The death of a spouse acts centripetally on the members of the social network of widows/widowers, that is, they gather friends and relatives and provide emotional and instrumental support, while divorce acts centrifugally: friends and relatives draw back and sometimes permanently alienate themselves and end any relationship, especially women.

"Spousal death can be particularly difficult in the case of a clear division of traditional sex roles when one partner is unprepared to take on the tasks that are necessary to maintain the household. Thus, widowhood for most of the elderly is far more than the emotional loss of a wife or husband, it usually means a profound change of life that is not freely chosen or desired, taking away everyday interaction activities, loss of the future planned together, closeness to death, and often loss of identity and life meaning" (28).

Ograničenja istraživanja

Naposlijetku, potrebno je naznačiti ograničenja provedenog istraživanja, ponajprije ograničenja uzorka i odabranog nacrta istraživanja. Uzorak se sastojao od dvije različite i relativno male skupine sudionika što može negativno utjecati na reprezentativnost uzorka i smanjiti mogućnost generalizacije rezultata. Tako veličina uzorka i činjenica da se istraživanje provelo u danom trenutku a ne tijekom dužeg razdoblja, ograničuje valjanost procjena i onemogućuje dinamičku analizu, odnosno provedeno istraživanje dalo je samo uvid u trenutačno stanje sudionika te je na taj način onemogućeno mjerenje trajnosti (dinamike) usamljenosti. Također sudionici koji su u domu i sudionici u kućama kako se razlikuju u uzorku ovog istraživanja tako se razlikuju i u populaciji po pitanju dobi, spola, zdravstvenog stanja, obrazovanja i bračnog stanja. Nadalje, podatke koji su interpretirani osim autora ovog rada prikupljali su i socijalni radnici i radni terapeuti (za sudionike u domovima umirovljenika) te se taj dio prikupljanja podataka odvijao izvan kontrole autora ovog istraživanja. S obzirom da se istraživanje temeljilo na samoiskazima odnosno samoprocjeni starijih osoba te zbog njihovog brzog zamaranja pri samostalnom rješavanju upitnika, anketiranje je provedeno usmenim putem, pa postoji mogućnost da su sudionici davali socijalno poželjne odgovore.

Kao sljedeći ograničavajući čimbenik je sama dobna podjela koju smo koristili u istraživanju pri čemu je dob sudionika kao jedna vrlo važna varijabla prikupljena prema dobnim rasponima umjesto precizno zbog čega je dobivena nejednakost u veličinama podskupina. Tako srednja dob (75-85 godina) obuhvaća čak deset godina što je ogroman raspon u starijoj dobi i može značiti velike razlike u funkcionalnoj sposobnosti. Sljedeći značajan nedostatak je kros-sekcijski nacrt istraživanja pri čemu su zaključci ovog istraživanja isključivo korelacijske prirode te kao takvi ne predstavljaju uzročno-posljedične odnose među varijablama.

Study limitations

Finally, it is necessary to point out the limitations of the study, primarily sample limitations and the selected design of the study. The sample consisted of two different and relatively small groups of participants, which could adversely affect the representativeness of the sample and reduce the validity of generalizing the results. Furthermore, the size of the sample and the fact that the study was carried out at a single point rather than a longer period of time limits the validity of the estimates and prevents dynamic analysis, i.e., the conducted study only provided insight into the present state of the participants and thus does not measure the actual persistence of loneliness. Additionally, participants in retirement homes and in their own homes also differed in age, gender, health, education and marital status. Furthermore, the data interpreted were not only collected by the author of this work but also by social workers and work therapists (for participants in retirement homes) and this part of data gathering was carried without any control of the author of this study. Since the study was based on self-assessment of elderly persons and because of their rapid fatigue in solving the questionnaire, the interview was conducted verbally and there was a possibility that the participants provided socially desirable answers.

The next limiting factor was the age distribution we used in the research, where the age of the participants as a very important variable was collected by age range and not precisely, which consequently resulted in inequality in subgroup sizes. Thus, middle age (75-85) covers up to ten years, which is a huge range at an older age and can mean major differences in functional ability. The final significant disadvantage is the cross-sectional design of the research, where the conclusions of this study are exclusively correlative in nature and as such do not represent causative-consequential relationships among the variables.

ZAKLJUČAK

Usamljenost je značajan javnozdravstveni problem s kojim se susreću osobe starije životne dobi. Provedeno istraživanje dalo nam je uvid u različitosti ali i sličnosti u samoprocjeni usamljenosti i samopoštovanja između sudionika u domovima umirovljenika i sudionika u kućama. Tako su rezultati pokazali kako su sudionici u domu umirovljenika koji imaju nižu razinu obrazovanja i lošije zdravstveno stanje ujedno iskazali nižu razinu samopoštovanja, a neudati/neoženjeni sudionici su iskazali veću razinu usamljenosti u ljubavi i usamljenosti u obitelji. Kod sudionika u kućama rezultati su pokazali kako su sudionici stariji od 85 godina svoje samopoštovanje procijenili najnižim te su iskazali najveću socijalnu usamljenost i usamljenost u ljubavi.

Iako ovo istraživanje ima dosta ograničenja i nedostataka, ovakva i slična istraživanja su potrebna kako bi se mogli razviti modeli prevencije usamljenosti te time spriječiti njezine posljedice s ciljem povećanja kvalitete života osoba starije životne dobi.

Kako bi se nadopunile spoznaje iz ovog istraživanja bilo bi korisno za buduća istraživanja procijeniti povezanost funkcionalne sposobnosti i samozbrinjavanja (*self-care*) sa usamljenosti te utjecaj usamljenosti na negativno zdravstveno ponašanje poput konzumacije alkohola, pušenja, smanjene fizičke aktivnosti ili pak učestalijih korištenja zdravstvenih usluga. Svakako bilo bi korisno provesti i kvalitativno istraživanje putem polustrukturiranih intervjua kako bi se dobio širi uvid u problematiku usamljenosti kod starijih osoba.

CONCLUSION

Loneliness is a major public health problem which older people face. The present study has provided insight into differences and similarities in self-assessment of loneliness and self-esteem among participants in retirement homes and participants living in their own homes. The results showed that the participants living in retirement homes who had a lower level of education and poor health also showed a lower level of self-esteem, and unmarried participants demonstrated a higher level of loneliness in love and loneliness in family. For the participants living in their own homes, the results showed that participants over the age of 85 rated their self-esteem the lowest and expressed the highest social loneliness and loneliness in love.

Although this study has a many of limitations and disadvantages, further studies are needed in order to develop models of loneliness prevention and thus prevent its effects, with the aim of increasing the quality of life of older persons.

In order to complement the findings from this study, it would be useful for future studies to assess the correlation between functional ability and self-care with loneliness and the impact of loneliness on negative health behaviour such as alcohol consumption, smoking, reduced physical activity or more frequent use of health services. It would certainly be useful to conduct qualitative research through semi-structured interviews to gain a wider insight into loneliness issues among the elderly.

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„Ne idi, molim te“ – kognitivno-bihevioralni tretman djeteta sa separacijskim anksioznim poremećajem

/ “Don’t leave, please” – cognitive behavioural treatment of a child with separation anxiety disorder

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Separacijski anksiozni poremećaj (SAP) ili anksiozni poremećaj zbog separacije u djetinjstvu dijagnosticira se kada strah od odvajanja od osoba za koje je dijete vezano (roditelj ili druge osobe – figure privrženosti) čini žarište anksioznosti. Ubraja se u najučestalije anksiozne poremećaje u djece mlađe od 12 godina s tipičnim početkom u dobi 8-12 godina. Povezan je s izbjegavajućim ponašanjem što može dovesti do poteškoća na emocionalnom i socijalnom planu, a u težim slučajevima rezultirati narušenim školskim funkcioniranjem te reduciranim sveopćim funkcioniranjem djeteta. Prikazujemo slučaj dječaka u dobi od 10,5 godina, koji je nakon multidisciplinske timske obrade kojom je utvrđeno postojanje značajnih teškoća iz anksioznog kruga s dominantnim separacijskim poteškoćama, uključen u kognitivno-bihevioralni tretman. Cilj ovog rada je prikazati važnost multidisciplinskog pristupa dijagnostici i liječenju, suvremene spoznaje kognitivno-bihevioralnog pristupa i tretmana te doprinos uključenosti roditelja kao koterapeuta u implementaciji tehnika radi boljeg ishoda cjelokupnog tretmana.

/ Separation anxiety disorder (SAD), or anxiety disorder due to separation in childhood, is diagnosed when the fear of separation from an attachment figure is the focus of anxiety. The level of separation anxiety has to be inappropriate for the age of the child and accompanied by impaired functioning. SAD is the most common anxiety disorder among children under the age of 12, with a typical onset at the age of 8-12 years. A common feature of separation anxiety disorder is avoidance behaviour, and if left untreated can lead to strong emotional distress or affect social life of a child, family and educational functioning. In this paper, we describe a boy aged 10 years and 5 months (4th grade of elementary school), who was referred for multidisciplinary team assessment, was diagnosed with anxiety disorder (with dominant separation anxiety problems) and was later included in cognitive-behavioural therapy. This article presents recent findings on cognitive-behavioural approach and treatment and discusses the importance of a multidisciplinary approach in assessment and treatment of SAD as well as the parents’ participation in CBT implementation to improve treatment outcome.

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KLJUČNE RIJEČI / *KEY WORDS*:
Anksiozni poremećaji / *Anxiety Disorders*
Separacijski anksiozni poremećaj, / *Separation Anxiety Disorder*
Djeca, / *Children*
Kognitivno–bihevioralna terapija / *Cognitive Behavioural Therapy*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2018.251

UVOD

Separacijski anksiozni poremećaj (SAP) (ili anksiozni poremećaj zbog separacije u djetinjstvu) najučestaliji je anksiozni poremećaj u djece mlađe od 12 godina te obično počinje u dobi između osme i dvanaeste godine (1). Osnovno obilježje ovog poremećaja je razvojno neprimjerena razina anksioznosti koja se odnosi na odvajanje od osoba za koje je dijete vezano (roditelj ili druge osobe – figure privrženosti), a manifestacije su (2): nerealne, preokupirajuće brige o povredi osobe za koju je dijete vezano te strah da se neće vratiti; nerealne, preokupirajuće brige da će neki neugodan događaj dovesti do odvajanja od osobe za koju je najviše vezano; trajno odbijanje ili protivljenje odlasku na spavanje bez blizine osobe za koju je dijete najviše vezano; trajni, za tu dob neodgovarajući strah da bude samo ili bez osobe za koju je najviše vezano kod kuće tijekom dana, prekomjerna, ponavljajuća uznemirenost u situacijama očekivanja, za vrijeme ili odmah nakon separacije od bliske osobe (2) i drugi. U situacijama izloženosti separaciji od doma ili figure privrženosti djeca doživljavaju značajan distres te pokušavaju izbjeći separaciju, a izbjegavajuće ponašanje uključuje plač, tantrume ili odbijanje sudjelovanja u aktivnostima koje zahtijevaju separaciju (na primjer odlazak na spavanje, izlete i sl.). Prema Dijagnostičkom i statističkom priručniku (DSM-V) za duševne poremećaje Američkog psihijatrijskog udruženja (3) za dijagnozu SAP-a moraju biti zadovoljena barem tri kriterija, smetnje moraju trajati barem četiri tjedna i značajno ometati svakodnevno socijalno, akademsko ili obiteljsko funkcioniranje. Početak poremećaja je najčešće prije osamnaeste godine, a vrlo rijetko se dijagnosticira prije šeste godine života budući da je ovaj tip anksioznosti česta pojava u djece u dobi od sedmog mjeseca do šeste godine života (3).

Prema istraživanju Bacow i sur. (4) prosječna dob početka smetnji je 8,59 godina. Procjena životne prevalencije SAP-a u općoj populaciji

INTRODUCTION

Separation anxiety disorder (SAP) (or childhood separation anxiety disorder) is the most common anxiety disorder in children under the age of 12 and usually develops at the age of 8 to 12 (1). The main feature of this disorder is a developmentally inappropriate level of anxiety concerning separation from attachment figures (parents or other persons), and its manifestations are the following (2): an unrealistic, preoccupying concern about hurting an attachment figure and the fear of never seeing that figure again; unrealistic, preoccupying concern about an unpleasant event leading to the separation from a major attachment figure; permanent refusal or reluctance to go to sleep without being near a major attachment figure; permanent, age-inappropriate fear of being home alone or without a major attachment figure during the day; excessive, recurrent agitation while waiting for an attachment figure or immediately after the separation from an attachment figure (2) and others. When exposed to separation from home or attachment figures, children experience significant distress and try to prevent the separation from happening by means of crying, throwing a tantrum or refusing activities that require separation (for instance, going to bed, field trips, etc.). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) of the American Psychiatric Association (3), in order to diagnose SAP, at least three of the criteria must be fulfilled, the disturbances must be present for at least four weeks and must cause significant impairment of everyday social, academic or family functioning. The disorder usually occurs before the age of 18 and is very seldom diagnosed before the age of 6, since this type of anxiety is common in children between 7 months and 6 years of age (3).

According to a study conducted by Bacow and associates (4), the average age of onset of disturbances is 8.59. The prevalence of SAP in the

je 4,1 % (5), učestaliji je kod djevojčica (6,8 %), nego kod dječaka (3,2 %), a prema istraživanju Foley i sur. (6) 50 – 70 % djece s dijagnozom SAP-a dolazi iz obitelji nižeg socioekonomskog statusa. U kliničkom uzorku djece i mladih SAP je najučestaliji od svih anksioznih poremećaja (49 %).

Nastanak i održavanje SAP-a uključuju interakciju bioloških, kognitivnih, okolinskih i bihevioralnih faktora, kao i karakteristike temperamenta djeteta. Nasljednost SAP-a je procijenjena na 73 % u općem uzorku šestogodišnjih blizanaca, uz veću stopu zastupljenosti kod djevojčica (7). Također, disregulacija neurotransmiterskih sustava noradrenalina, serotonina i dopamina te promjene u strukturama kao što su amigdala i hipokampus imaju značajnu ulogu u razvoju SAP-a (8). „Bihevioralno inhibirani temperament" u kojem dijete pokazuje znakove pretjerane anksioznosti kad je izloženo novim, nepoznatim situacijama povezan je s nastankom SAP-a.

Istraživanja ukazuju kako je SAP najviše od svih anksioznih poremećaja oblikovan okolinskim faktorima (7). Roditeljska ponašanja kao što su niska razina topline (9) te pretjerano zaštićivanje i intruzivnost u obliku pretjerane uključenosti u djetetove svakodnevne aktivnosti (kupanje, hranjenje, navike spavanja, oblačenje, donošenje odluka) kojima se obeshrabruje razvoj autonomije djeteta (10) povezana su s nastankom i održavanjem SAP-a. Roditelji često podržavaju sigurnosna (ponašanja koja služe za trenutno smanjenje anksioznosti i straha kad osoba osjeća intenzivnu prijetnju ili tjeskobu ili procjenjuje da je ugrožena i u opasnosti) i izbjegavajuća ponašanja djeteta (neučinkovite strategije suočavanja koje uključuju izbjegavanje situacija/ljudi i sl. – sve ono što provocira tjeskobu i/ili strah, a što sveukupno može ojačati već postojeće simptome u djece) (11).

Istraživanja iz razvojne psihologije ukazuju da su različiti oblici nesigurne privrženosti (izbjegavajuća, ambivalentna i dezorganizirana pri-

general population is estimated to be 4.1% (5), and is more common in girls (6.8%) than in boys (3.2%). According to a study by Foley and associates (6), 50-70% of children diagnosed with SAP come from families of lower socio-economic status. SAP is the most recurrent anxiety disorder in the clinical sample of children and youth (49%).

Onset and persistence of SAP entail the interaction of biological, cognitive, environmental and behavioural factors, as well as the child's temperament features. SAP heritability was estimated at 73% in a general sample of six-year-old twins, with a higher incidence rate with girls (7). Furthermore, the dysfunction of the norepinephrine, serotonin and dopamine neurotransmitter system, as well as the changes in structures such as amygdala and hippocampus, significantly contribute to the development of SAP (8). A child with a "behaviourally inhibited temperament", which is associated with the onset of SAP, demonstrates signs of excessive anxiety when exposed to new, unfamiliar situations.

Studies suggest that SAP is an anxiety disorder modelled by environmental factors, more so than any other anxiety disorder (7). Parental behaviour such as low levels of emotional warmth (9), overprotection and intrusiveness, demonstrated as over-engagement in the child's everyday activities (bathing, feeding, sleeping habits, dressing, decision making) which discourages the development of the child's autonomy, (10) are associated with the onset and persistence of SAP. Parents often support the child's safety behaviour (behaviour used to reduce anxiety and fear when the person feels intensely threatened or anxious or believes to be threatened and in danger) and the child's avoidant behaviour (non-efficient coping strategies that entail situation/people avoidance, etc. – everything that provokes anxiety and/or fear, which may result in an increase of the child's already existent symptoms) (11).

vrženost) djece čimbenik rizika za razvoj anksioznih poremećaja (12). Djeca su u riziku razvoja SAP-a ako je jednom od roditelja dijagnosticiran psihički poremećaj (13). Djeca roditelja s anksioznim poremećajem imaju čak pet puta veći rizik za razvoj anksioznog poremećaja, a potvrđena je i povezanost paničnog poremećaja kod roditelja s razvojem SAP-a kod djece (14). Rana trauma ili separacije od primarnog skrbnika djeteta (izloženost zlostavljanju, dugotrajna hospitalizacija, traumatizirajući događaji, rođenje brata/sestre) imaju snažan utjecaj na razvoj SAP-a, školske fobije te smetnje iz depresivnog kruga.

SAP se često razvije nakon vanjskog stresogenog događaja. Uobičajeni precipitirajući čimbenici su: gubitak bliske osobe (iz obitelji ili kućnog ljubimca), oboljenje djeteta ili bliske osobe, promjene škole, razvod roditelja, promjene mjesta prebivališta, hospitalizacije ili određene katastrofe koje su uključivale odvojenost od osoba kojima je dijete privrženo. Kod adolescenata nastanak SAP-a može biti povezan s odlaskom na fakultet, napuštanjem roditeljskog doma, kao i s prihvaćanjem uloge roditelja.

U kliničkoj slici SAP-a u mlađe djece pri separaciji ili anticipaciji separacije pri odlasku u vrtić ili školu česte su somatske pritužbe (trbuhobolje, glavobolje, mučnine, povraćanje). U djece i adolescenata s recidivirajućim bolovima u trbuhu, kod 79 % bio je dijagnosticiran anksiozni poremećaj od čega je 43 % djece imalo separacijski anksiozni poremećaj, 31 % generalizirani anksiozni poremećaj te 21 % socijalnu fobiju (15). Somatizacije se javljaju dominantno tijekom tjedna te su odsutne u dane vikenda i školskih praznika (16). Anksioznost pri pokušaju separacije može progredirati do paničnih ataka (lupanje srca, mučnina, skraćenje daha, vrtoglavica).

Simptomi separacijske anksioznosti manifestiraju se različito, ovisno o dobi djece: manja djeca (5-8 godina) uglavnom izražavaju zabrinutost vezanu za nerealno ozljeđivanje osoba

Developmental psychology studies suggest that different forms of insecure attachment in children (avoidant, ambivalent and disorganized) represent a risk factor for developing anxiety disorders (12). Children risk developing SAP if one of their parents has been diagnosed with a psychotic disorder (13). Children of parents with anxiety disorders have a fivefold increased risk of developing an anxiety disorder. Furthermore, the link between parents with panic disorders and children developing SAP has been confirmed (14). An early trauma or separation from the child's primary guardian (exposure to abuse, long period of hospitalisation, traumatic events and birth of a sibling) can significantly contribute to developing SAP, school phobias and depressive disorders.

SAP often develops after an external stressogenic event. Common precipitating factors are: loss of a loved one (relative or a pet), disease of a child or a loved one, change of school, parents' divorce, change of residence, hospitalisation or a disastrous event that involved the child's separation from his/her attachment figures. SAP onset in adolescents may be associated with starting university, leaving their parental home, as well as accepting their parental role.

The clinical manifestation of SAP in younger children during separation or the anticipation of separation on their way to kindergarten or school are often of the somatic type (stomach aches, headaches, nausea, vomiting). 79% of children and adolescents with recurring stomach aches were diagnosed with an anxiety disorder, 43% of whom were diagnosed with separation anxiety disorder, 31% with a generalised anxiety disorder and 21% with a social phobia (15). Somatic manifestations occur predominantly on workdays and not on weekends and school holidays (16). Anxiety while trying to separate may progress to panic attacks (palpitations, nausea, shortness of breath, vertigo).

Separation anxiety symptoms have different manifestations depending on the child's age:

kojima je dijete privrženo te odbijanje odlaska u školu; djeca u dobi 9-12 godina često pokazuju snažnu uznemirenost u situacijama separacije, dok se kod adolescenata (13-16 godina) najčešće uočava odbijanje odlaska u školu i tjelesne komplikacije. Noćne more sa separacijskim sadržajima uglavnom su prisutne kod djece mlađe dobi dok su rijetke kod djece u dobi 9 - 16 godina (17). U većini istraživanja se pokazalo kako separacijska anksioznost u djetinjstvu prerasta tijekom adolescencije u socijalnu fobiju te agorafobiju ili panični poremećaj.

Kad su odvojena od osobe za koju su privržena, djeca sa SAP-om mogu manifestirati razne patološke reakcije: socijalno povlačenje, tugu, teškoće koncentracije, difuzne fobije (životinje, mrak, provalnici, strah od aviona i letenja). Neka djeca izvijestila su o neobičnim perceptivnim iskustvima kad su sama, posebice u mraku (obrisi sjena ili osoba u mraku, oči u mraku koje ih gledaju, zastrašujuća stvorenja koja ih pokušavaju dograbiti) (3). Kad su jako uznemirena, pri anticipaciji ili pokušaju separacije, djeca mogu pokazivati izrazitu agitiranost, ali i opozicionalno ponašanje (tantrume bijesa, agresivnost, vrištanje, prijetnje) (18).

Djeca sa SAP-om često su preokupirana brigom kako će, na primjer, biti oteta, izgubiti se ili biti napuštena te da će oni sami ili osobe uz koje su vezani oboljeti od neke bolesti. Prateća izbjegavajuća ponašanja protežu se na kontinuumu ovisno o težini poremećaja: kod blažih oblika SAP-a uključuju nastojanja da su roditelji lako dostupni kada je dijete separirano od njih (npr. da ih može telefonski kontaktirati), umjereni stupanj uključuje odbijanja spavanja kod prijatelja (jer to uključuje višesatno odvajanje od roditelja). Djeca s težim oblicima SAP-a odbijaju odlaske u školu ili spavanje u vlastitoj sobi (dolaze roditeljima ili braći/sestrama noću u krevet, žele stalno biti uz svoje roditelje). Mnoga djeca, posebice manja, često slijede roditelje te odbijaju separaciju i u okviru svoga doma dok starija djeca odbijaju odlazak od kuće i sudjelo-

young children (ages 5-8) usually express their concern about unrealistic injuries of their attachment figures and refuse to go to school; children ages 9-12 often demonstrate agitation in separation situations, while adolescents (ages 13-16) usually refuse going to school and suffer from physical complications. Nightmares of separation usually occur in children of a young age and are very rare with children ages 9-16 (17). Most studies show that childhood separation anxiety evolves into social phobia, agoraphobia or panic disorder during adolescence.

When separated from their attachment figure, children with SAP may demonstrate different pathological reactions: social withdrawal, sadness, difficulty concentrating, diffuse phobias (animals, dark, burglars, fear of air planes and flying). Some children reported having unusual perceptual experiences when alone, especially in the dark (outlines of shadows or people in the dark, eyes looking at them from the dark, frightening creatures that are trying to grab them) (3). When very upset, while anticipating the separation or when trying to separate, the children may demonstrate exceptional aggressiveness but also oppositional behaviour (temper tantrums, aggressiveness, screaming and threats) (18).

Children with SAP are often worried that they will, for example, get kidnapped, lost or abandoned and that they themselves or their attachment figures will be diagnosed with a disease. There is a wide range of accompanying avoidant behaviour which depends on the disorder severity: milder forms of SAP involve the child's desire to be able to easily access parents during separation (for example, by phone), while the moderate form of SAP involves refusing sleepovers (because that would imply being separated from parent for hours). Children with more severe forms of SAP refuse going to school or sleeping in their rooms (they come to their parents' or siblings' beds at

vanje u vršnjačkim aktivnostima bez prisutnosti roditelja (17).

Djeca s ovim poremećajem pokazuju poteškoće funkcioniranja u različitim područjima: izbjegavaju i/ili prestaju pohađati sportske ili grupne aktivnosti s vršnjacima (rođendane, zabave, druženja). Akademski uspjeh može biti narušen zbog odbijanja odlazaka u školu (veliki broj izostanaka, pad školske godine, školovanje kod kuće, čak i napuštanje školovanja u ekstremnim slučajevima). Prema Kearneyju (16) 75 % djece sa SAP-om pokazuje neki oblik odbijanja odlazaka u školu. Odbijanje pohađanja škole utvrđeno je kod 75 % djece sa SAP-om, a SAP je dijagnosticiran kod 80 % djece koja su odbijala odlazak u školu (5).

Anksiozni poremećaji se često javljaju udruženi s ostalim psihijatrijskim poremećajima (19), naročito kod djevojčica. Tako je u 79 % djece sa SAP-om utvrđen barem još jedan, a u 54 % dva ili više komorbidnih psihijatrijskih poremećaja (20). Uz SAP se često javlja specifična fobija i generalizirani anksiozni poremećaj. Povezanost anksioznosti i depresije je utvrđena mnogobrojnim istraživanjima te tako jedna trećina djece sa SAP-om razvije depresivni poremećaj (18).

U dijagnostici SAP-a važan je multidisciplinski pristup što uključuje pregled dječjeg i adolescentnog psihijatra, psihologijsku obradu, pregled logopeda i neuropedijatra te EEG radi diferencijalne dijagnostike i procjene komorbidnih stanja. Uz klinički intervju u okviru kojeg je potrebno prikupiti podatke o razvoju djeteta, funkcioniranju i psihosocijalnoj situaciji obitelji od različitih izvora (roditelji, članovi obitelji, odgajatelji, stručni suradnici škole/vrtića, učitelje, liječnik primarne zdravstvene zaštite ili školske medicine), potrebna je i opservacija djeteta. Također je važno napraviti funkcionalnu analizu djetetova ponašanja (FAP) kojom se utvrđuje disfunkcionalno ponašanje, odnosno što prethodi određenom ponašanju, koje oblike ponašanja dijete pokazuje, prati se učestalost,

night and want to be near their parents all the time). Many children, especially young ones, often follow their parents around the house and refuse separation even within the house, while older children refuse to leave the house and participate in peer activities without their parents present (17).

Children with this disorder demonstrate difficulties functioning in different areas: they avoid and/or stop attending sports or group activities with their peers (birthday parties, celebrations, gatherings). School attendance refusal may impair the child's academic performance (increased absence, failing a grade, home-schooling, in extreme cases, even leaving school). According to Kearney (16), 75% of children with SAP demonstrate a certain form of school attendance refusal. School attendance refusal was found in 75% of children with SAP, and SAP was diagnosed in 80% of children refusing school attendance (5).

Anxiety disorders frequently co-occur with other anxiety disorders (19), especially in girls. At least one comorbid psychiatric disorder was diagnosed in 79% of children with SAP, and two or more comorbid psychiatric disorders in 54% of them (20). Specific phobia and generalised anxiety disorder frequently co-occur with SAP. Many studies have confirmed the link between anxiety and depression: one third of children with SAP develop a depressive disorder (18).

When diagnosing SAP, it is relevant to have a multidisciplinary approach, which involves an examination by a child and adolescent psychiatrist, psychological evaluation, examination by a speech-language pathologist and neuropaediatrician and an EEG as a part of differential diagnostics and assessment of comorbidities. Alongside a clinical interview which requires gathering data concerning the child's development as well as the functioning and psycho-social situation of the family from different sources (parents, family members, educators, school and kindergarten expert associates, teachers,

trajanje, intenzitet ponašanja i posljedice koje slijede nakon ponašanja.

FAP ima za cilj identificirati što dijete određenim ponašanjem dobije ili izbjegava te kako se određeno ponašanje održava i što ga potiče te koje socijalno značenje ima. U FAP-u, uz pomoć roditelja, nastoji se ispitati precipitante (događaje koji neposredno prethode ili mogu služiti kao okidač), predisponirajuće čimbenike (čimbenici koji čine osobu podložnom ili ranjivom za razvoj određenog poremećaja), kontekst i modulirajuće varijable (varijable koje utječu na intenzitet i frekvenciju smetnji), podržavajuće okolnosti te izbjegavajuća ponašanja djeteta. Mogu se koristiti i različiti upitnici i ljestvice za procjenu anksioznosti, ostale psihopatologije i funkcioniranja djeteta koje ispunjavaju starije dijete, roditelji ili odgajatelj/učitelj.

U diferencijalnoj dijagnostici iznimno je važno razlikovati razvojno primjerenu i prekomjernu razinu separacijske anksioznosti. Normalna razvojno primjerena separacijska anksioznost doseže vrhunac između devetog i trinaestog mjeseca života djeteta te se smanjuje nakon druge godine uz tendenciju povećanja autonomije djeteta do treće godine života. Simptomi separacijske anksioznosti opet se povećavaju od četvrte do pete godine te posebice u razdoblju polaska u školu (21).

Granice kliničke značajnosti separacijske anksioznosti mogu biti kulturološki uvjetovane jer različite kulture imaju različita očekivanja glede autonomije djeteta, potrebne razine nadzora odrasle osobe te navika spavanja (22).

Liječenje separacijskog anksioznog poremećaja zahtijeva primjenu različitih terapijskih postupaka te multimodalan pristup u planiranju i provođenju tretmana. Većina dostupnih podataka o učinkovitosti tretmana SAP-a referira se na nefarmakološke terapijske tehnike liječenja, i to psihoedukaciju, bihevioralni tretman te kognitivno-bihevioralnu terapiju (KBT) (20). Međutim, kod težih kliničkih slika SAP-a lijekovi

primary care physician or school physician), child observation is also necessary. Furthermore, it is important to conduct a functional analysis of the child's behaviour (FAP), which will detect dysfunctional behaviour, i.e. what precedes certain behaviour and what forms of behaviour the child demonstrates, examine the frequency, duration, and intensity of the behaviour, as well as the consequences that derive from it.

The aim of FAP is to identify the child's gains from certain behaviour or what the child wishes to avoid by behaving in a certain manner, as well as how that particular behaviour persists, what it is that incites it, and what its social connotations are. FAP, with the help of the child's parents, tries to examine the precipitating factors (events that immediately precede or may trigger the behaviour) and predisposing factors (factors that make the person susceptible or inclined to develop a certain disorder), context and modulating variables (variables that influence the intensity and frequency of disturbances), supporting environment, and child's avoidant behaviour. Different questionnaires and rating scales for anxiety, other psychopathologies and child functioning filled out by an older child, parent or educator/teacher may be used.

In differential diagnostics, it is of utmost importance to distinguish between developmentally appropriate and excessive levels of separation anxiety. Normal, developmentally appropriate separation anxiety peaks when the child is aged between 9 and 13 months and decreases after the age of 2, and the child's autonomy tends to increase by the age of 3. Separation anxiety symptoms increase again in the age of 4 to 5, especially in the period before starting school (21).

The clinical relevance of the separation anxiety level may be culturally determined because different cultures have different expectations concerning the child's autonomy, level of necessary adult supervision and sleeping habits (22).

prvog izbora su antidepresivi iz skupine selektivnih inhibitora ponovne pohrane serotonina (SIPPS). Multimodalna studija (CAMS) ukazala je na kratkotrajnu učinkovitost monoterapije KBT-om i monoterapije sertalinom u liječenju SAP-a, dok je kombinacija sertalina i KBT-a davala dugoročnije učinke (23). Međutim, za sada regulatorne agencije za lijekove nisu odobrile ni jedan SIPPS za liječenje SAP-a.

Cilj ovog rada je prikazati važnost multidisciplinarnog pristupa dijagnostici i liječenju SAP-a, suvremene spoznaje kognitivno–bihevioralnog pristupa i tretmana te uključenosti roditelja kao koterapeuta u implementaciji tehnika radi boljeg ishoda cjelokupnog tretmana.

KOGNITIVNO–BIHEVIORALNI TRETMAN SEPARACIJSKOG ANKSIOZNOG POREMEĆAJA

Temeljem snažne empirijske podloge već preko 20 godina se u liječenju anksioznih poremećaja djece u dobi od 7 godina i više primjenjuje kognitivno-bihevioralni tretman (24). U terapiju mogu biti uključeni i roditelji, a osnovne komponente uključuju: psihoedukaciju o anksioznosti, vještine upravljanja somatskom anksioznošću, kognitivno restrukturiranje, metode izlaganja i plan prevencije povrata simptoma. Psihoedukacija pruža razvojno primjerene informacije o anksioznosti, o stimulatorima straha te uključuje pojašnjavanje koncepta povezanosti misli, osjećaja i ponašanja. Također, roditeljima kao koterapeutima u procesu liječenja važno je razjasniti pozitivno i negativno potkrepljenje koje održava poremećaj, ulogu sigurnosnih ponašanja u održavanju poremećaja te osnovne postavke KBT-a.

Tehnika upravljanja somatskim simptomima usmjerena je na autonomno uzbuđenje, a uključuje podučavanje djeteta kako prepoznati simptome anksioznosti i tjelesne reakcije na anksioznost, a somatski simptomi anksioznosti mogu

Treatment of separation anxiety disorder requires the application of different therapy procedures and a multimodal approach to planning and conducting treatments. Most of the available SAP treatment efficacy data refers to non-pharmacological therapy treatment techniques, in particular psychoeducation, behavioural treatment and cognitive-behavioural treatment (CBT) (20). However, in case of a more severe clinical manifestation of SAP, selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed antidepressants. The Child/Adolescent Anxiety Multimodal Study (CAMS) revealed a short-term efficacy of CBT monotherapy and sertaline monotherapy in treating SAP, whereas the combination of CBT monotherapy and sertaline monotherapy ensured a long-term effect (23). However, medicines regulatory agencies have not yet approved a single SSRI for treating SAP.

The aim of this article is to explain the relevance of a multidisciplinary approach to SAP diagnostics and treatment, contemporary advancements of the cognitive-behavioural approach and treatment and including parents as co-therapists during technique implementation in order to obtain better outcomes of the whole treatment.

COGNITIVE-BEHAVIOURAL TREATMENT FOR SEPARATION ANXIETY DISORDER

Due to strong empirical grounds, cognitive-behavioural treatment has been used for treating anxiety disorders in children of the age of 7 and above for over 20 years (24). This therapy may involve parents and its main components entail: psychoeducation in the area of anxiety, somatic anxiety management skills, cognitive restructuring, exposure therapy methods and relapse prevention plan. Psychoeducation provides developmentally appropriate information on anxiety, fear stimulation and involves ex-

se umanjiti tehnikama relaksacije (progresivna mišićna relaksacija, abdominalno disanje).

Kognitivno restrukturiranje treba biti razvojno primjereno i usmjereno na prepoznavanje maladaptivnih misli i poučavanje novim, realističnijim mislima, usmjerenih k rješavanju problema, a kognitivne intervencije su usmjerene na modifikaciju maladaptivnih misli i kognitivnih distorzija te usvajanje novih adaptivnijih misli.

Bihevioralnim intervencijama oblikuju se nova, željena ponašanja i uče se nove vještine upravljanja starim, anksioznim obrascima ponašanja. Tehnike izlaganja uključuju postupno, sistematično izlaganje situacijama straha. Prevencija povrata simptoma se usredotočuje na konsolidiranje i generaliziranje naučenog u tretman i tijekom vremena (25).

Meta-analiza primjene KBT-a kod anksioznih poremećaja djece i mladih pokazala je uspješnost u individualnom i grupnom terapijskom okviru (26). U istraživanju Walters i sur. (27) ispitivana je učinkovitost grupnog KBT tretmana u 80 djece u dobi 4 - 8 godina s dijagnozama SAP-a, socijalne fobije te generaliziranog anksioznog poremećaja. Uspoređivana je učinkovitost terapije orijentirane samo na roditelje te kombinacije tretmana „dijete + roditelj". Moduli s djecom uključivali su psihoedukaciju o anksioznosti, relaksacijski trening, *problem-solving* tehnike, razvijanje socijalnih vještina, kognitivno restrukturiranje te samoupute. Modul za roditelje uključivao je psihoedukaciju, strategije nošenja s anksioznošću, savjetovanje o odnosu s djetetom, vještine komunikacije te rješavanja problema uz smjernice za potkrepljivanje ponašanja koje je dijete naučilo na modulima. Kriterijima za anksiozni poremećaj u odnosu na 60 % djece u skupini koja je imala samo tretman za roditelje više nije udovoljavalo 75 % djece koja su prošla kombinirani KBT tretman za djecu i roditelje. Moduli za roditelje mogu biti korisni, posebice za manju djecu koja su nedostupna kognitivnim intervencijama u okviru KBT-a. Tako se za djecu predškolske dobi učinkovitim

plaining the concept of thoughts, feelings and behaviour interconnectedness. Furthermore, it is important to explain to parents, who act as co-therapists, the positive and negative reinforcement which preserves the disorder, the role of safety behaviour in disorder persistence and basic principles of CBT.

The somatic anxiety management technique focuses on autonomic arousal and involves teaching the child to recognise anxiety symptoms and physical reactions to anxiety. The somatic anxiety symptoms may be alleviated by relaxation techniques (progressive muscle relaxation, abdominal breathing).

Cognitive restructuring should be developmentally appropriate and directed towards recognising maladaptive thoughts and learning how to engage in new, more realistic and solution-oriented thoughts. Cognitive interventions are directed towards modifying maladaptive thoughts and cognitive distortions and adopting new, more adaptive thoughts.

Behavioural interventions shape new, desired behaviours and teach new skills for managing old anxiety behaviour patterns. Exposure therapy techniques involve gradual, systematic exposure to fear-inducing situations. The relapse prevention plan focuses on consolidating and generalising the knowledge gained through treatment and over time (25).

Meta-analysis of CBT application in cases of anxiety disorders in children and youth has proven the success of CBT in both individual and group therapy (26). The study conducted by Walters and associates (27) examined the efficacy of group CBT treatment with 80 children aged 4-8 who were diagnosed with SAP, social phobia and generalised anxiety disorder. The study compared the efficacy of parent-focused therapy and combined "child + parent" treatment. The children modules involved psychoeducation in the area of anxiety, relaxation training, problem-solving techniques, social skills development, cognitive restructuring

pokazao program CALM (*Coaching Approach Behavior and Leading by Modeling* – Oblikovanje ponašanja kroz vođenje i modeliranje) (28), a to je oblik tretmana „dijete + roditelj". Program se primjenjuje za djecu u dobi 3-7 godina, usmjeren je prema roditeljima, odnosno uči roditelje vještine učinkovitog potkrepljivanja ciljanih pomaka u ponašanju djeteta, odnosno vježbanje i primjenu tih vještina u samoj seansi interakciji roditelj - dijete, a kasnije i primjenom u svakodnevnom životu djeteta (24).

Eisen i sur. (11) su razvili desetotjedni program za djecu sa SAP-om koji uključuje roditeljsku implementaciju KBT strategija kod kuće (psihoedukacija, relaksacija, kognitivne intervencije, postupno izlaganje, prevencija povrata simptoma). Ove intervencije pokazale su se vrlo učinkovitima te nakon primjene čak petero od šestero djece nije više zadovoljavalo kriterije za SAP.

Ako postoji izbjegavanje pohađanja nastave, potrebna je suradnja terapeuta sa školom. Neke od korisnih strategija kod nepohađanja nastave su: održavanje suradnje i redovitih sastanaka s roditeljima, rješavanje eventualnih poteškoća u školi koje mogu biti povezane s izbjegavanjem škole (strah od određenog učitelja, sukobi s vršnjacima), izrada postupnog plana povratka djeteta u školu, dopuštenje roditelju da inicijalno prati dijete u školu te po potrebi bude uz dijete (postupno izlaganje), dopuštenje inicijalno kraćeg boravka djeteta u školi te postupno produljivanje vremena boravka, utvrđivanje „sigurnog mjesta" kamo će dijete moći otići, ako ga preplavi anksioznost (npr. soba psihologa, pedagoga...), ohrabrivanje interakcije u malim grupama, potkrepljivanje pozitivnih rezultata djeteta te nagrađivanje nastojanja i zalaganja djeteta, a ne samo krajnjeg rezultata (29).

Uključenost roditelja u tretman anksioznog poremećaja djeteta je od velike važnosti zbog implementacije terapijskih tehnika kod kuće i generalizacije rezultata. Također, roditelji često nisu svjesni činjenice da potkrepljuju anksio-

and self-instruction techniques. The parents module involved psychoeducation, anxiety coping strategies, counselling on the relationship with the children, communication and problem-solving skills with guidance for reinforcing behaviour the children acquired through their module. 75% of children who underwent combined CBT treatment for children and parents no longer met the anxiety disorder criteria, in comparison with 60% of children in the group whose parents underwent the parent-focused therapy. Parent modules may be useful, especially for younger children who cannot participate in cognitive interventions of CBT. For example, along those lines, the program Coaching Approach behaviour and Leading by Modelling (CALM) (28), a form of "child + parent" treatment, proved to be efficient for pre-school children. The program is used for children of ages 3-7 and is parent-focused, i.e. it teaches parents the skill of efficiently reinforcing improvements in their child's behaviour, and in particular coaches the use of these skills during in-session parent-child interactions and later in the child's everyday life (24).

Eisen and associates (11) devised a ten-week program for children with SAP that requires parents to implement CBT strategies at home (psychoeducation, relaxation, cognitive interventions, gradual exposure, relapse prevention plan). These interventions have proven to be very efficient, and after their application as many as 5 out of 6 children no longer met the SAP criteria.

If school attendance avoidance exists, the therapist needs to cooperate with the school. Some useful strategies for tackling school attendance refusal are the following: cooperating with the parents and meeting them on a regular basis; eliminating potential issues in school that might be connected to school avoidance (fear of a certain teacher, peer conflicts); devising a gradual school re-entry plan; allowing the parent to initially accompany the child to

zna ponašanja svoje djece i time održavaju trajanje poremećaja (30).

PRIKAZ SLUČAJA

Dječak u dobi 10,5 godina, učenik četvrtog razreda osnovne škole, živi s roditeljima, jedinac, upućen je na psihijatrijski pregled zbog intenzivnog straha ostati sam kod kuće, biti odvojen od roditelja uz zabrinutost za njihovo zdravlje te promjene u navikama spavanja (dolazi roditeljima u krevet gotovo svaku noć) u trajanju od šest mjeseci. Pojavi smetnji prethodio je događaj kada je majka otišla do obližnje trgovine dok je dječak spavao. Kad se probudio, zvao je majku na mobitel, no ona se nije javljala jer je mobitel ostavila kod kuće. U iščekivanju i nakon dolaska majke dječak je postao izrazito uznemiren, uz grčevit plač. Od tada je sklon prekomjernoj brizi za zdravlje roditelja te učestalo propituje: „Je li sve u redu?“, „Hoće li mama i tata biti dobro?“ Ne može ostati sam kod kuće bez bliske osobe (roditelj, baka ili djed). Ako kraće vrijeme ostaje sam kod kuće, kada majka ode na posao, a otac još nije došao s posla, mora biti u stalnoj telefonskoj vezi s majkom. Boji se spavati sam u svojoj sobi, noću dolazi roditeljima u krevet. Smetnje su izraženije tijekom tjedna, a manje intenzivne vikendom. Dječak ne odbija odlaske u školu te je svladavanje gradiva uredno. Ranije je dječak bio dobro socijaliziran i vršnjaci su ga dobro prihvaćali. Unatrag šest mjeseci ne ide na vanškolske aktivnosti, što uključuje sportske aktivnosti i strani jezik, a slobodno vrijeme provodi kod kuće te uz kompjuter, izbjegava kontakte s vršnjacima, fiksiran je na roditelje.

Rani psihomotorni razvoj dječaka bio je uredan. Nije teže bolovao, somatski je zdrav te nije ranije psihologijski ni psihijatrijski liječen. Pri polasku u vrtić ispoljavao je poteškoće adaptacije uz plačljivost i teže odvajanje od majke. Spavao je s roditeljima u sobi do šeste godine života. Nakon polaska u školu, na izletima na more sa sportskom grupom svakodnevno je više puta

school and, if necessary, staying with the child (gradual exposure); initially allowing a shorter school stay for the child and gradually increasing the school stay period; finding a “safe place” the child may visit if overwhelmed with anxiety (for example, the school counsellor or psychologist’s office); encouraging small group interaction; reinforcing the child’s positive results and rewarding the child’s effort and engagement, not just the final results (29).

The parents’ inclusion in the child’s anxiety disorder treatment is very important in order to enable the implementation of therapy techniques at home and generalise the results. Furthermore, parents are often not aware of the fact that they reinforce their children’s anxious behaviour and help the disorder persist (30).

CASE STUDY

A boy, 10.5 years old, in the fourth grade of elementary school, living with his parents and an only child, was referred for a psychiatric examination due to intense fear of staying home alone and being separated from his parents, concerns for his parents’ health and changes in sleeping habits (coming to his parents’ bed almost every night) in a period of 6 months. The disturbances started after one particular event: the child’s mother went to a nearby store while the child was asleep. When he woke up, he tried reaching his mother on her cell phone, but she did not answer as she had left her cell phone at home. While waiting for his mother to return, he became extremely agitated and started crying frantically, which continued even after his mother returned home. Ever since, the boy was prone to excessive concern for his parents’ health and often asked: “Is everything all right?”, “Will mum and dad be all right?” He could not stay home alone without a person close to him (parents, grandparents). If he had to stay home alone for a shorter period of time, when his mother went to work and his father

nazivao roditelje. Tijekom ljetovanja s bakom na moru zahtijevao je da spava s njom u sobi.

Majka dječaka je tijekom studija liječena zbog anksioznosti i paničnih ataka te je ponovno nakon poroda bila uključena u psihijatrijski tretman do šeste godine dječaka. U odgoju je hiperprotektivna, visoke razine kontrole, pomaže dječaku u učenju. Roditelji opisuju dječaka kao senzibilnog, a u odgoju su permisivni. Različito percipiraju dječakove teškoće: otac smatra da dječak „privlači pažnju" dok majka zauzima zaštitnički stav. Oboje navode teškoće u vlastitom funkcioniranju zbog smetnji djeteta.

Multidisciplinska obrada dječaka (EEG i pregled neurologa, psihijatra i obrada psihologa i logopeda) pokazala je da se radi o dječaku iznadprosječnih intelektualnih sposobnosti sa simptomima separacijske anksioznosti te izrazitije narušenim obiteljskim i socijalnim funkcioniranjem.

Slika 1. prikazuje dijagram kognitivne konceptualizacije za dječaka s ključnim bazičnim i posredujućim vjerovanjima i glavnim strategijama suočavanja.

Tijek tretmana

Na početku psihoterapijskog liječenja s dječakom i roditeljima definirani su sljedeći terapijski ciljevi: naučiti opustiti se i umiriti (usvojiti tehnike relaksacije), povećati samostalnost dječaka (da ostaje sam kod kuće i spava u svojoj sobi), uključivati u aktivnosti s vršnjacima.

Tretman je započet psihoedukacijom roditelja i djeteta, a u nastavku su primijenjene bihevioralne i kognitivne tehnike. Roditeljima i dječaku su prikazani KBT model anksioznosti, povezanost misli, osjećaja, ponašanja, pozitivno i negativno potkrepljenje koje održava poremećaj, uloga sigurnosnog ponašanja te osnovne postavke KBT-a.

Dječak je podučen *tehnikama relaksacije* (abdominalno disanje i progresivna mišićna re-

had not yet returned, he had to be on the phone with his mother the whole time. He was afraid of sleeping alone in his room and would come to his parents' bed at night. The disturbances were more present on workdays, and less present on weekends. The child did not refuse going to school and his academic performance did not change. The boy used to be well-socialised and accepted among peers. Six months ago, he stopped attending his extra-curricular activities, including sports activities and foreign language classes, and was spending his time at home in front of the computer, avoiding contact with peers, fixated on his parents.

The boy's early psychomotor development was normal. He suffered no severe illness, had no somatic symptoms, nor had he undergone psychological or psychiatric treatment. When starting kindergarten, he had troubles adapting and wold cry and have difficulties separating from his mother. He slept in the room with his parents until the age of 6. After starting elementary school, during field trips to the sea side with his sports team, he would call his parents several times a day. He spent summer holidays at the seaside with his grandmother and would ask to sleep in the room with her.

The child's mother was treated for anxiety and panic attacks during her university studies and underwent psychiatric treatment again after giving birth, until the boy was 6. She is an overprotective parent, exercises a high level of control and helps the child study. The parents describe the child as sensitive and their parenting as permissive. They perceive the child's difficulties differently: the father believes that the child "wants to attract attention", whereas the mother has a protective attitude. Both of them confirm having difficulties functioning due to their child's disturbances.

Multidisciplinary examination of the child (EEG and neurologist and psychiatrist examination, psychological and speech-language pathologist evaluation) showed that the child is of above

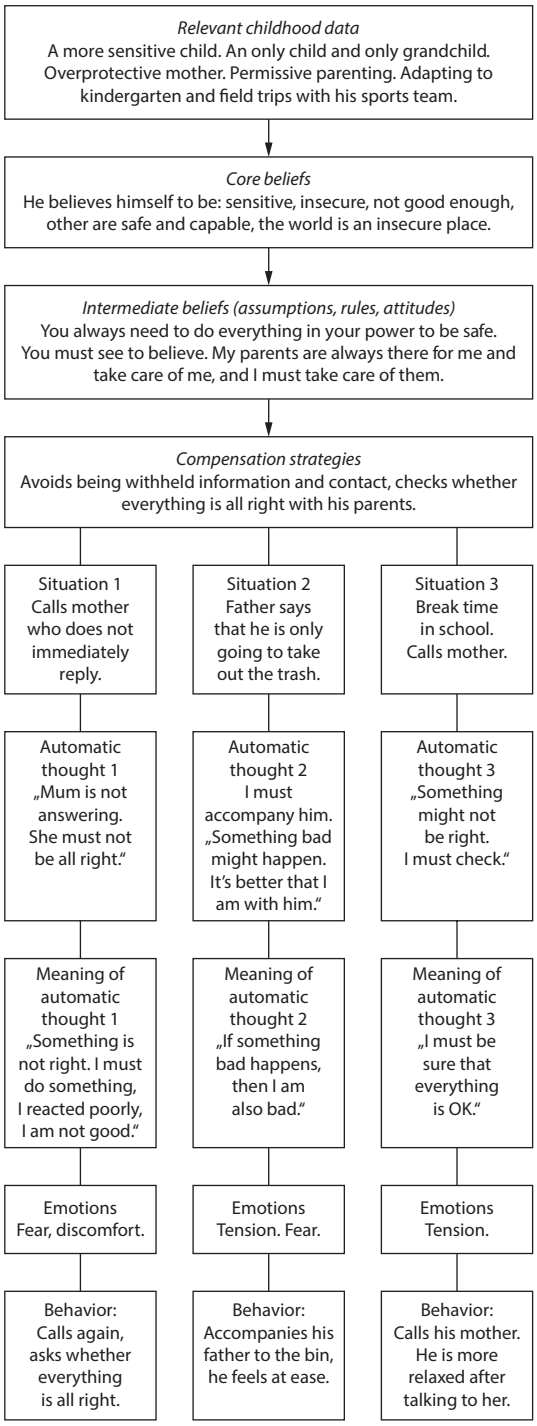

FIGURE 1. Overview of the child's cognitive conceptualisation.

laksacija prilagođena djeci). Navedene tehnike dječak je prihvatio, marljivo vježbao te naučio prepoznati razliku između napetog i opuštenog fizičkog stanja. Usporedno je provedena *edukacija o osjećajima* kako bi lakše prepoznao prve znakove pobuđenosti i primijenio tehnike relaksacije prije eskalacije anksioznosti.

average intelligence and that he demonstrates symptoms of separation anxiety and substantially impaired family and social functioning.

Figure 1 shows a diagram of the child's cognitive conceptualisation with key core and intermediate beliefs and main coping strategies.

The treatment process

The following therapy goals were set with the child and parents at the beginning of the psychotherapy treatment: learn how to relax and calm down (adopt relaxation techniques), increase the child's independence (staying at home alone and sleeping in his room) and inclusion of peer activities.

The treatment began with the psychoeducation of the parents and the child, and behavioural and cognitive techniques were applied later on. The parents and child were presented the CBT anxiety model; thoughts, feelings and behaviour interconnectedness; positive and negative reinforcement which reflect the disorder; role of safety behaviour; and basic principles of CBT.

The boy was shown relaxation techniques (abdominal breathing and progressive muscle relaxation adapted for use with children). The child accepted the aforementioned techniques, practised them diligently, and learned how to recognise the difference between a tense and relaxed physical state. At the same time, the child participated in an *education on feelings* in order to become able to easily recognise the first signs of anxiety and apply relaxation techniques before the anxiety escalated.

The *gradual exposure* technique was used in order to develop the child's independence in terms of staying home alone and sleeping in his own bed. At the beginning, relaxation techniques, distraction and self-calming sentences were used during exposure; but in later stages, the child would expose himself to uncomfortable situations without distractions (for example, it was agreed that the child, when his mother was

Tehnika *postupnog izlaganja* korištena je kako bi se razvila samostalnost dječaka u ostajanju kod kuće i u spavanju u vlastitom krevetu. U početku su pri izlaganju korištene tehnike relaksacije, distrakcija i samoumirujuće rečenice, a u kasnijim fazama izlagao se neugodnim situacijama bez distrakcije (npr. kad je majka odlazila na posao, dogovoreno je da dječak gleda crtane filmove na TV-u i koristi umirujući samogovor: „Još ću malo izdržati, sve je u redu." Kad je otac odlazio baciti smeće, dječak je najprije gledao oca kroz prozor, zatim ostajao u sobi uz jedan telefonski poziv i konačno ostajao sam u sobi uz umirujući samogovor). Postupno je smanjivao sigurnosna ponašanja (pozivi majci i povremeno ocu) i sve dulja razdoblja ostajao sam kod kuće. Za svaki pozitivan pomak dječak je nagrađivan pohvalama roditelja i terapeuta te je koristio i pozitivne samoizjave (samopohvale) s ciljem potkrepljenja željenih obrazaca ponašanja.

Kod buđenja noću dogovoreno je da roditelji u početku dođu u sobu dječaka i pomognu mu da se umiri pomoću tehnika relaksacije i potom vrate u svoju sobu. Potom su, sukladno dogovoru s terapeutom i uz pristanak dječaka, na pozive dječaka i nakon buđenja dječaka tijekom noći, roditelji ostajali u svojoj sobi i odgovarali umirujućom rečenicom: „Tu smo, sve je u redu." Dječak je pritom koristio umirujuće rečenice, distrakciju, relaksaciju, imaginaciju ugodnih prizora kako bi se umirio i ostao u svom krevetu bez odlaženja u krevet roditeljima. Dječak je konačno spavao sam u sobi, uz otvorena vrata i lagano noćno svjetlo. Tijekom postupnog izlaganja dječak je vodio dnevnik spavanja te je za samostalno spavanje u svom krevetu korištena tehnika žetoniranja uz podupiruće potkrepljivače prema dječakovom izboru. Tehnika žetoniranja ili „ekonomija žetona" je sustav potkrepljivanja temeljen na upotrebi žetona koji mogu biti zvjezdice, kvačice, sličice, a sami žetoni se zarađuju izvođenjem poželjnih ponašanja i zatim se mogu

at work, would watch cartoons on the TV and use a self-calming speech: "I will hold on for a little bit longer, everything is all right". When his father would go to take out the trash, the child would, at first, watch his father through the window, then stay in the room while talking with him on the phone and, finally, stay in the room using a self-calming speech). The child gradually reduced his safety behaviour (phone calls to mother and occasionally father) and extended the periods of staying home alone. Each positive improvement of the child was praised by his parents and therapist, and he used positive self-statements (self-praise) in order to reinforce the desired behaviour patterns.

When it comes to waking up at night, it was agreed that the parents would initially come to the child's room and help him calm down using relaxation techniques and then return to their room. Later on, as agreed with the therapist and with the child's consent, when the child would wake up and call his parents to come to his room, the parents would stay in their room and answer with the following calming sentence: "We are here, everything is all right". The child would then use calming sentences, distraction and relaxation and imagine pleasant scenes in order to calm down and stay in his bed without going to his parents' bed. Finally, the child began sleeping alone in his room, with the door open and a discrete night light. During his gradual exposure, the child kept a sleep diary and used the token economy technique with supporting reinforcers of his choice for sleeping alone in his bed. The token technique or the "token economy" is a reinforcement system based on the use of tokens (stars, clips, cards), and one can earn a token by engaging in desired behaviour, which can then be exchanged for a range of other reinforcers such as activities, etc. The rules for applying the token technique is to specify the desired behaviour for which tokens may be obtained and define the number of tokens given for exhibiting one of the defined desired behaviours.

zamijeniti nizom drugih potkrepljivača kao što su aktivnosti, itd. Pravila za primjenu žetoniranja su specificirati ciljna ponašanja za koja se mogu dobiti žetoni te definirati broj žetona koje je moguće dobiti za izvođenje pojedinog ciljnog ponašanja.

Uz navedeno su korištene i pohvale roditelja i terapeuta, kao i samopohvale, za svaki napredak.

Od kognitivnih intervencija provodila se *kognitivna restrukturacija* koja je započeta identifikacijom negativnih automatskih misli (NAM) i prepoznavanjem kognitivnih distorzija (katastrofiziranje, emocionalno zaključivanje). Dječak je za domaću zadaću vodio dnevnik misli, osjećaja, ponašanja. Raspravljene su prednosti briga (dobije blizinu roditelja) te nedostatci (gubitak vremena, napetost, ljutnja roditelja), kao i sklonost precjenjivanju opasnosti, podcjenjivanje svojih snaga te je stavljen naglasak na normalizaciju stanja. Potom se radilo na modifikaciji NAM-a i nalaženju alternativnih, funkcionalnijih misli (npr. negativna misao „Mama se ne javlja, sigurno joj se nešto dogodilo" zamijenjena je adaptivnijom „Znam da je na poslu i da je dobro. Vjerojatno sada ne može pričati. Zvat ću ju kasnije kako smo se dogovorili."). Dječak je usvojio novo „pravilo" kojeg bi se prisjetio u situacijama kad bi prepoznao svoje NAM, a glasilo je: „Misli nisu činjenice. To što ja mislim da bi moglo biti nešto loše, ne znači da će se dogoditi."

Poticano je i druženje izvan obitelji, u početku s najboljim prijateljem, potom druženje s većom skupinom djece (3-4 dječaka). Broj i vrijeme druženja postupno je povećavano uz redukciju sigurnosnih ponašanja (pozivi roditeljima).

Evaluacija, problemi i zapreke te rezultati tretmana

Tretman koji je provodio certificirani KBT terapeut trajao je pet mjeseci, ukupno je provedeno 13 seansi s čestoćom susreta u prosjeku

In addition to the above, praise from the parents and therapists as well as self-praise were used for any type of progress.

Concerning the cognitive interventions, *cognitive restructuring* was implemented, which started by identifying negative automatic thoughts and recognising cognitive distortions (catastrophisation, emotional conclusion). The child was given the task of keeping a diary of his thoughts, feelings and behaviour. The advantages of worrying (being close to his parents) and disadvantages of worrying (loss of time, tension, parents' anger) were discussed, as well as the proneness to overstate danger and understate his own strength; emphasis was placed on the normalisation of the condition. This was followed by work on negative automatic thoughts modification and finding alternative, more functional thoughts (for example, the negative thought: "Mum is not answering, something must have happened to her" was replaced by a more adaptive one: "I know she is at work and that she is all right. She probably cannot talk now. I will call her later, as agreed."). The child adopted a new "rule" that he would recall in situations when he would recognise his negative automatic thoughts: "Thoughts are not facts. If I believe that something bad might happen, it does not mean that it will necessarily happen".

Socialising outside the family was encouraged: at first with his best friend, then with a larger group of children (3-4 boys). The frequency and duration of these encounters increased with the reduction of safety behaviour (calls to parents).

Evaluation, problems, obstacles and the results of the treatment

The treatment conducted by a certified CBT therapist lasted for 5 months and comprised a total of 13 sessions, on average 1 session in every 10 days. The obstacles in working with the client consisted in the initial difficulties in establishing cooperation with the child's par-

jednom u deset dana. Poteškoće u radu s klijentom odnosile su se na početnu nešto teže uspostavljenu suradnju s roditeljima, vezanu uz stavove oca kako dječak svojim ponašanjem samo privlači pozornost zbog čega je povremeno gubio strpljenje i pokazivao iritabilnost dok je majka u tim situacijama bila pojačano zaštitničkog stava i time pozitivno (pažnja) i negativno (izbjegavanje neugodnih situacija) potkrepljivala probleme djeteta. Stoga je opetovano provođena psihoedukacija roditelja o KBT modelu anksioznosti i važnosti usklađenosti u odgoju i dosljednosti.

Dječak je dobro napredovao uz pomoć roditelja te uz potkrepljivanja i naglasak na njegovoj snazi i prednosti. Naučio je samoopažanje i prepoznavanje vlastite anksioznosti i brige. Usvojio je tehnike relaksacije te je naučio osvijestiti i preuzeti kontrolu nad svojim fiziološkim reakcijama i mišićnom tenzijom u stresnim situacijama. Također, naučio je identificirati i modificirati NAM, odnosno naći adaptivniji odgovor na negativne projekcije budućnosti. Sigurnosna ponašanja (telefonski pozivi majci i ocu) u potpunosti su prekinuta. Spavanje dječaka u vlastitom krevetu regulirano je već nakon mjesec dana tretmana, a roditelji iskazuju zadovoljstvo jer mogu otići van iz stana te ponovno spavaju zajedno. S obzirom na značajan postignuti napredak, seanse su prorijeđene na jednom u mjesecu. S ciljem smanjenja mogućnosti povrata simptoma stavljen je naglasak na *problem solving* tehniku.

RASPRAVA

Povezanost i privrženost djeteta i odrasle osobe ima vrlo važnu ulogu u psihičkom razvoju svakog pojedinca, no određene poteškoće i poremećaj samog odnosa mogu biti izrazito onesposobljavajući za samu osobu (u ovom slučaju dijete koje će pokazivati teškoće funkcioniranja na raznim životnim poljima), ali i utjecati na sveopće funkcioniranje cjelokupne obitelji.

ents, due to the father's attitude that the child was merely attracting attention, which led to occasional lack of patience and signs of irritability, whereas the mother would show an increasingly protective attitude in those situations and thus positively (attention) and negatively (avoiding unpleasant situations) reinforced the child's issues. Therefore, the psychoeducation of the parents concerning the CBT anxiety level and the importance of harmonised parenting approaches and consistency was repeated.

The child made good progress with the help of his parents and reinforcement, as well as through stressing his strengths and advantages. He learned how to be self-reflective and how to recognise his own anxiety and concerns. He adopted relaxation techniques and learned how to become aware of his physiological reactions and muscle tension in stressful situations and control them. Furthermore, he learned how to identify and modify negative automatic thoughts, i.e. to find a more adaptive response to negative predictions. His safety behaviour (phone calls to the mother and father) has been completely eliminated. Sleeping in his own bed was regulated already after a month of treatment, and the parents were very satisfied that they could leave the apartment and sleep together again. Considering the significant progress made, the sessions now take place once a month. In order to decrease the possibility of relapse, the problem solving technique is being employed.

DISCUSSION

The connection and attachment between a child and adult play a significant role in the psychological development of every individual. However, certain difficulties and relationship disorders can prove exceptionally disabling for the person (in this case, the child that will demonstrate difficulties functioning in different areas) but can also affect the overall functioning of the whole family. Due to the developmental specifics of

Zbog razvojnih specifičnosti djeteta tijekom terapije bilo je važno prilagoditi primijenjene kognitivno-bihevioralne tehnike (npr. progresivna mišićna relaksacija s elementima igre, afektivna edukacija uz biblioterapiju i terapijske lopte, kao i kognitivna restrukturacija za koju su korištene priče, crtani misaoni oblačići ili strip uz pomoć terapeuta), te ih unijeti u svakodnevni život djeteta uz pomoć roditelja. Stavljen je naglasak na nužnost istodobnog terapijskog rada i s djetetom i s roditeljima, korištenja roditelja kao koterapeuta budući da neka roditeljska ponašanja mogu podržavati sigurnosna i izbjegavajuća ponašanja djeteta te da anksioznost roditelja može egzacerbirati djetetovu anksioznost te time dovesti do začaranog kruga. Također, otežavajući faktor u terapijskom radu s dječakom bio je i pozitivan psihijatrijski hereditet kod majke dječaka. Psihopatologija majke s hiperprotektivnim odgojem doprinosila je razvoju i održavanju poremećaja kod dječaka, stoga je bilo važno, a u cilju što boljeg ishoda tretmana, uzeti u obzir što više faktora te pomno isplanirati seanse i način terapijskog rada.

ZAKLJUČAK

Separacijski anksiozni poremećaj čest je u kliničkoj praksi u dječjoj psihijatriji. Stresni životni događaji u predisponiranih pojedinaca u okviru specifične obiteljske dinamike dovode do razvoja poremećaja. Prikazani slučaj potvrđuje nužnost uključivanja roditelja u tretman mlađeg djeteta sa SAP-om te učinkovitost KBT-a kao terapije prvog izbora i kod djece sa značajnije oštećenim obiteljskim i socijalnim funkcioniranjem, što je i u skladu s rezultatima istraživanja (26).

the child, it was important to adapt the behavioural and cognitive techniques applied (for example, combine progressive muscle relaxation with ludic elements, affective education with bibliotherapy and therapy balls, and cognitive restructuring which used stories, thought bubbles or comics with the therapist's assistance) during the treatment and implement them in the child's everyday life with the help of his parents. Emphasis was placed on the necessity of simultaneous therapy work with both the child and parents, using parents as co-therapists, since some parental behaviour may support the child's safety and avoidant behaviour, and the parents' anxiety may exacerbate the child's anxiety, thus creating a vicious circle. Furthermore, an aggravating factor in the child's therapy was his mother's positive history of psychiatric disorders. The mother's psychopathology combined with overprotective parenting contributed to the onset and persistence of the child's disorder. Therefore, in order to achieve the optimal result of the treatment, it was important to take into account as many factors as possible and to carefully plan the sessions and the mode of therapy.

CONCLUSION

Separation anxiety disorder is common both in clinical practice and child psychiatry. Stressful life events in the lives of predisposed individuals within a specific family dynamic lead to the development of the disorder. The present case confirms the necessity of the parents' inclusion in the treatment of a younger child with SAP as well as the efficacy of CBT as the first choice of treatment, even with children with substantially impaired family and social functioning, which also agrees with the study results (26).

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Značenje simptoma shizofrenog bolesnika tijekom trajanja grupne psihoterapije i nakon njenog završetka

/ Meaning of symptoms in a schizophrenic patient during and after long-term psychodynamic group psychotherapy

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Značajan doprinos psihoanalitičkih teorijskih koncepata i znanja u liječenju shizofrenih bolesnika je u razumijevanju značenja simptoma u kontekstu individualnih životnih događaja. Iako se shizofreni bolesnici međusobno značajno razlikuju, njihovi se simptomi najčešće mogu razumjeti kao obrana od nepodnošljivih iskustava. Svjesna i nesvjesna značenja iskustava derivat su unutarnjeg svijeta individuuma, koji isto tako biva formiran od životnih iskustava, najviše onih iz ranog djetinjstva kada se počinje razvijati osjećaj selfa i identiteta.

Mogućnost razumijevanja simptoma i ponašanja shizofrenih bolesnika koju daje primjena psihodinamskih teorija i znanja kao i participacija u psihoterapijskom procesu pružaju kliničarima platformu za cjeloviti uvid u psihodinamiku i funkcioniranje ličnosti pacijenta oboljelog od shizofrenije, a time i adekvatno planiranje terapijskih intervencija i procesa liječenja u cjelini. Rad sadrži prikaz dugogodišnjeg grupnog procesa s kroničnim shizofrenim bolesnicima te razvoj razumijevanja psihotičnih simptoma jednog od članova grupe.

/ Understanding the meaning of symptoms in the context of individual life events would be a significant contribution to psychoanalytic theoretical concepts and knowledge in treating schizophrenic patients. Although schizophrenic patients differ significantly, their symptoms can usually be understood as a defence from unbearable experiences. Conscious and unconscious meanings of experience are a derivative of the inner world of the individual, which is also formed of life experiences; most of them come from the early childhood when the feeling of self and identity begins to develop. The ability to understand the symptoms and behaviour of schizophrenic patients by applying psychodynamic theories and knowledge as well as participation in the psychotherapeutic process provides clinicians with a platform for a complete insight into psychodynamics and functioning of a person suffering from schizophrenia and also contributes to adequate planning of therapeutic interventions and treatment process as a whole. This paper presents a long-term group process with chronic schizophrenic patients and the development of understanding of the psychotic symptoms in one member.

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KLJUČNE RIJEČI / KEY WORDS:
Psihodinamska grupna psihoterapija / *Psychodynamic Group Psychotherapy*
Shizofrenija / *Schizophrenia*
Značenje simptoma / *Meaning of Symptoms*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2018.269

UVOD

Značajan doprinos psihoanalitičkih teorijskih koncepata i znanja u liječenju shizofrenih bolesnika je u razumijevanju značenja simptoma u kontekstu individualnih životnih događaja (1). Psihoanalitički koncepti mogu učiniti razumljivim manifestacije bolesti kao što su halucinacije i sumanutosti kao i specifična, često bizarna ponašanja, i time olakšati uspostavljanje terapijske alijanse te provođenje cjelovitog plana liječenja. Iako se shizofreni bolesnici međusobno značajno razlikuju, njihovi simptomi se najčešće mogu razumjeti kao obrana od nepodnošljivih iskustava (2). Takva iskustva uključuju kronični užas (*terror*) (3-5), prijetnju anihilacijom ili nedostatkom humanog kontakta (6), a zajednička im je psihotična obrana koja štiti oboljelog tako da mijenja iskustvo realnosti. To znači da je subjektivni životni stres jedan od bitnih elemenata u nastanku shizofrenije, a težina stresnih događaja je determinirana svjesnim i nesvjesnim značenjima proživljenih iskustava te kvalitetom socijalnog suporta (1).

Svjesna i nesvjesna značenja iskustava su derivat unutarnjeg svijeta individuuma, koji isto tako biva formiran od životnih iskustava, najviše onih iz ranog djetinjstva kad se počinje razvijati osjećaj selfa i identiteta. Osobna značenja iskustava determiniraju način na koji individuum percipira sebe i druge, doživljava anksioznosti i emocije, te razvija obrane i kapacitete nošenja sa stresom (1,7).

Poznato je da psihotični bolesnici imaju velike teškoće na planu interpersonalnih odnosa koji ograničavaju njihov kapacitet za komunikaciju, intimnost i participaciju u socijalnom matriksu (8). Od svih psihotičnih bolesnika kronični shizofreni bolesnici su najoštećeniji te često imaju vrlo malo odnosa izvan najuže obitelji i često žive emocionalno udaljeni, izolirani, uz izbjegavanje socijalnih kontakata. Lucas (9) naglašava da kronični psihotični bolesnici trebaju

INTRODUCTION

A significant contribution of psychoanalytic theoretical concepts and knowledge in treating schizophrenic patients is understanding the meaning of symptoms in the context of individual life events (1). Psychoanalytic concepts can make sense of manifestations of illness such as hallucinations and delusions as well as specific, often bizarre behaviours, thus facilitating the establishment of a therapeutic alliance and the implementation of a comprehensive treatment plan. Although schizophrenic patients differ significantly from each other, their symptoms are most commonly understood as a defence from unbearable experiences (2). Such experiences include chronic terror (3,4,5), the threat of annihilation or the lack of human contact (6), which share a psychotic defence that protects the patient by changing the experience of reality. This means that subjective life stress is one of the most important elements in the development of schizophrenia, and the severity of stress events is determined by the conscious and unconscious meanings of lived experience and the quality of social support (1).

Conscious and unconscious meanings of experience are a derivative of the individual inner world, which is also formed of life experiences, most of them from early childhood when the feeling of self and identity begins to develop. The personal meanings of experiences determine the way an individual perceives himself and others, experiences anxiety and emotions, and develops defence and stress-carrying capacities (1, 7).

It is known that psychotic patients have great difficulties in interpersonal relationships, which limits their capacity for communication, intimacy and participation in the social matrix (8). Of all psychotic patients, chronic schizophrenic patients are most affected and often have very few relationships outside the immediate family, often leading an emotionally distant and isolated life, avoiding social contacts. Lucas (9) emphasizes that, first of all, chronic

prije svega suportivnu okolinu „da za njih misli i o njima brine“.

Grupna psihoanalitička psihoterapija pruža mogućnost socijalizacije odnosno poboljšanja kvalitete interpersonalnih odnosa psihotičnih bolesnika (10,11). Grupni terapijski okvir kao demokratska situacija omogućuje članovima kontakt s osobama sa sličnim tegobama, i komunikaciju te učenje iz interpersonalnih odnosa koje uzajamno uspostavljaju u sigurnoj i zaštićujućoj sredini. Sličnosti s ostalim članovima grupe smanjuju doživljaj usamljenosti i stigmatizacije (12). ''Vertikalni transfer'' prema terapeutu slabijeg je intenziteta nego u individualnoj terapiji i lakše se izbjegava duboka regresija, a ''horizontalni transferi'' su raspršeni između članova grupe tako da je emocionalni naboj u grupi slabiji i time podnošljiviji psihotičnim pacijentima te lakše dostupan terapijskoj intervenciji (14,15). Susret s vlastitim bolesnim dijelom i psihopatologijom ostalih članova izgrađuje kritičniji odnos prema poremećaju i adekvatniji uvid u njihove probleme. Radom u grupi postiže se i bolje testiranje realiteta, budući da je lakše razlikovati objektivnu i subjektivnu realnost u doživljaju drugih članova (12-14).

CILJ RADA I HIPOTEZA

Cilj rada je prikaz postupnog stjecanja uvida u značenje psihotičnih simptoma i ponašanja kroničnog shizofrenog bolesnika u dugotrajnoj psihodinamskoj grupnoj psihoterapiji, reakcija članova grupe kao i reperkusije grupne dinamike na funkcioniranje pacijenta u realitetu.

Hipoteza je da će u dugotrajnoj psihodinamskoj grupnoj psihoterapiji pacijenti razviti uvid u svoju bolest te razumijevanje značenja svojih psihotičnih simptoma što će im pomoći pri boljoj adaptaciji na socijalnu sredinu uz poboljšanje kvalitete bliskih interpersonalnih odnosa.

psychotic patients need a supportive environment “to think and care for them”.

Group psychoanalytic psychotherapy provides the possibility of socialization or improvement of the quality of interpersonal relationships of psychotic patients (10,11). The group therapeutic framework as a democratic situation enables members to contact people with similar disorders, and communication as well as learning from interpersonal relationships that are reciprocally established in a safe and protected environment. Similarities with other members of the group reduce the experience of loneliness and stigmatization (12). “Vertical transference” towards the therapist is weaker in intensity than in individual therapy and it is easier to avoid deep regression, while “horizontal transferences” are dispersed among group members so that the emotional charge in the group is weaker and more tolerable *to psychotic patients and more readily accessible to therapeutic intervention (14,15*). A confrontation with their own illness and the psychopathology of other members engenders a more critical attitude towards the disorder and a more adequate insight into their problems. Group work means a better testing of reality since it is easier to differentiate between objective and subjective reality in the experience of other members (12-14).

OBJECTIVE AND HYPOTHESIS

The aim of this paper was to provide a gradual overview of the psychotic symptoms and behaviour of chronic schizophrenic patients in long-term psychodynamic group psychotherapy, reactions of group members and repercussions of group dynamics for patient functioning in reality.

The hypothesis is that during long-term psychodynamic group psychotherapy patients will gain insight into their illness and understand the meaning of their psychotic symptoms, which will help them to better adapt to the social environment while improving the quality of close interpersonal relationships.

OPIS SLUČAJA I GRUPNI PROCES

Opis slučaja – anamneza

Pacijent Ranko u vrijeme opisanih događanja imao je 57 godina. Rođen je u jednom dalmatinskom gradu, u obitelji pomorca kao stariji sin. U okviru školskih obveza iznadprosječno uspješan, ali introvertiran, socijalno izoliran, s malo prijatelja zbog čega je od rane dobi nesretan. Od djetinjstva se interesira za šah.

Psihičke smetnje se prvi put manifestiraju nakon završetka srednje škole kad se ne uspijeva upisati na fakultet u rodnom gradu (sam izričito želi studirati u Zagrebu), pa ga otac šalje na rad rođacima u inozemstvo. Nakon nekoliko mjeseci razvija opsesivnu simptomatiku pa se vraća u domovinu, a otac mu odobrava studij izvan rodnog grada. Upisuje jedan od tehničkih fakulteta, živi u studentskom domu gdje manifestira teškoće u komunikaciji i socijalnoj adaptaciji. Na četvrtoj godini studija umire mu otac, što Ranko teško doživljava. Počinje se psihoterapijski liječiti u tadašnjem Centru za mentalno zdravlje, a nakon manifestacije floridne psihoze na četvrtoj godini studija s paranoidno-halucinatornom simptomatikom biva hospitaliziran. U individualnu psihoterapiju ga uzima poznati psihijatar koji se bavi ovim poremećajima, ali prima i psihofarmake i EST. Iznimno motiviran za studij, uči za ispite na odjelu tijekom liječenja. Uz terapiju uspješno završava studij s visokim prosjekom. Šahovske probleme počinje konstruirati na drugoj godini studija, objavljuje ih i aktivan je u klubu problemista. Nakon studija zaposlio se u struci kao inženjer i u istoj tvrtki radi 30 godina do invalidske mirovine.

U dobi od 32 godine se upoznao, a kasnije i oženio, s intelektualno inferiornom ženom i uskoro dobio kćer. Ženini roditelji su aktivno pomagali mladi par i unuku do svoje smrti desetak godina kasnije i do tada je brak funkcionirao. To je razdoblje od 13 godina stabilne faze

CASE DESCRIPTION AND GROUP PROCESS

Case description – anamnesis

Patient Ranko was 57 years old at the time of the described events. He was born in a Dalmatian town, as an older son in a seaman's family. Regarding academic obligations he was above-averagely successful, but was introverted, socially isolated and with few friends, which is why he had been unhappy since an early age. He had been interested in chess since childhood.

His mental disturbances manifested for the first time after he graduated from high school and failed to enrol in his hometown college (he explicitly wanted to study in Zagreb), and his father sent him abroad to work with relatives. After several months he developed obsessive symptoms and returned to his homeland. His father approved of his studies outside the hometown. He enrolled in one of the technical faculties in Zagreb and lived in a student home, where he manifested difficulties in communication and social adaptation. His father died during the fourth year of his studies, which Ranko found difficult to endure.

He started with psychotherapeutic treatment as an outpatient at the Mental Health Center, and when paranoid-hallucinatory symptomatology of florid psychosis manifested during the fourth year of study, he was hospitalized. He was treated with individual psychotherapy by a well-known psychiatrist who worked with such disorders and he also took medication and EST. He was exceptionally motivated to study, and studied for exams in hospital wards during his treatment. While being treated, he successfully completed the course with high-level grades. In the second year of study he started developing chess puzzles which were published. He was also active in the chess club. After graduation he worked as an engineer in the same company for 30 years until his disability retirement.

At 32 years he met and later married a less educated woman and soon had a daughter. His wife's

bolesti, bez hospitalizacija, ali uz individualnu psihoterapiju i psihofarmake.

Nakon smrti ženinih roditelja počinje kriza u braku, dijete počinje manifestirati psihičke smetnje i socijalna služba kćerku dodjeljuje Rankovoj majci i bratu na odgoj (u drugom gradu), a on se rastaje od žene nakon četiri godine. Godine 1990. hospitaliziran je zbog egzacerbacije bolesti i tada započinje grupnu psihoterapiju u kojoj participira devet godina.

U kontinuitetu se pacijent bavi sastavljanjem šahovskih problema, kojih je do 1995. godine sastavio 360. U svjetskim časopisima je objavio pedesetak problema, sudjelovao je u radu kluba, te sudio na natjecanjima i dobio status majstora.

Nakon rastave, od 1995. godine živi sam. Tijekom sudjelovanja u grupnom procesu postaje evidentno i psihopatološko značenje bavljenja problemskim šahom.

Grupa

Radi se o grupi od osam shizofrenih pacijenata vođenoj koterapijski prema principima grupne analize, s modificiranom tehnikom primjerenom psihotičnim pacijentima. Grupa je počela radom 1990. godine, a vodila su je dva grupna analitičara u izvanbolničkim uvjetima, jedanput tjedno, u trajanju od jedan sat. Svi članovi grupe bili su shizofreni pacijenti, višekratno hospitalno liječeni, s višegodišnjim trajanjem bolesti, koji su uključeni u grupnu psihoterapiju u fazi remisije. Svi su bili u redovnom ambulantnom psihijatrijskom tretmanu uz uzimanje odgovarajućih psihofarmaka.

Pet članova grupe sudjelovalo je u kontinuitetu svih devet godina, a tri člana su se uključila kasnije, jedan u petoj te dva člana u šestoj godini trajanja grupe.

Boris, profesor filozofije, liječi se od studentskih dana. U 35. godini života, nakon četvrte hospitalizacije uključen je u grupu. Živi s roparents were actively helping the young couple and granddaughter until they passed away ten years later, and the marriage functioned until they died. This was a period of 13 years of stable course of disease, without hospitalization, but with individual psychotherapy and medication.

After the death of his wife's parents the crisis in their marriage started, as the child began to manifest mental distress and social service assigned the daughter to Ranko's mother and brother for upbringing and education (in another city). Four years later, he divorced his wife. In 1990 he was admitted to the hospital due to disease exacerbation and started with group psychotherapy in which he participated for nine years.

The patient was continuously engaged in developing chess puzzles and developed 360 of them until 1995. He published fifty puzzles in international journals, he participated in the activity of the club, was the referee at the competition and obtained the status of a master. He has been living alone since the divorce in 1995. During the participation in the group process, the psychopathological significance of dealing with chess puzzles became evident.

The group

The group consisted of eight schizophrenic patients cotherapeutically guided by the principles of group analysis, with a modified technique appropriate for psychotic patients. The group began working in 1990 and was led by two group analysts on an outpatient basis, once a week, for one hour. All members of the group were schizophrenic patients, repeatedly hospitalized, had the disease for years, and were included in group psychotherapy in the remission phase. All of them were in regular outpatient psychiatric treatment with the use of appropriate medication.

Five members of the group participated in continuity for all nine years, three members joined the group later, one in the fifth and two members in the sixth year of the group's existence.

diteljima, nikad nije radio zbog kontinuirano prisutnih slušnih halucinacije te povremenih ideja odnosa refrakternih na psihofarmake. U grupi aktivan, konstruktivan, često propituje uvriježene stavove i stereotipe, „grupni filozof".

Davor, mladi pravnik, uključen je u ovu grupu nakon kraćeg, neuspješnog sudjelovanja u grupi više funkcionalne razine gdje je ometen kognitivnim teškoćama i produktivnim simptomima teško sudjelovao te prestao dolaziti. U sadašnjoj grupi redovit, sve obilnijih verbalizacija i interakcija, boljeg funkcioniranja, tijekom grupe uspijeva položiti pravosudni ispit i zaposliti se.

Nenad dolazi u grupu nakon višegodišnjeg liječenja simpleks forme shizofrenije uz simptomatski alkoholizam. U prve dvije godine izrazito šutljiv, autističan, da bi postupno postao aktivniji, topliji i boljih interakcija. U grupi uspostavlja stabilniju remisiju i apstinenciju od alkohola.

Nela je u dobi od trideset četiri godine i tri hospitalizacije uključena u grupu, stomatolog, ali nikad nije radila u struci. U adolescentnoj dobi izgubila je oba roditelja, odrasla uz stariju sestru s kojim ima ambivalentan simbiotski odnos. U grupi vrijedan, aktivan i analitičan član, dobrih interakcija.

Andrija, dolazi u petoj godini rada grupe, nakon svoje pete hospitalizacije, sklon prekidima liječenja, neuzimanju lijekova, u grupi ima ulogu „zločestog djeteta", ali i ulogu člana koji otvoreno izražava otpor autoritetima općenito, kao i otpor terapeutima. Dobro prihvaćen, na kraju rada grupe bolje funkcionira u realitetu.

Renata, uključena u grupu nakon druge hospitalizacije, ukupno je participirala u grupi zadnje tri godine njenog trajanja. Najmanje regresivna članica, najboljeg socijalnog funkcioniranja izvan grupe, udata, majka dvoje djece, aktivan član, dobrog testiranja realiteta, u

Boris, a professor of philosophy, has been in psychiatric treatment from his student days. At the age of 35, after the fourth hospitalization, he was included in the group. He lived with his parents, never worked because of the constantly present auditory hallucinations and the occasional ideas of reference refractory to psychopharmacological treatment. He was very active in the group, constructive, often challenging conventional attitudes and stereotypes and nicknamed the "group philosopher".

Davor, a young lawyer, was included in this group after a shorter, unsuccessful participation in a group of higher functional level, where, hindered by cognitive disabilities and positive symptoms, he had difficulties participating and stopped joining the group. In the current group he attended regularly, more often verbalized and interacted, functioned better, and during the group therapy he passed the bar exam and found employment.

Nenad joined the group after years of treatment for the simplex form of schizophrenia with symptomatic alcoholism. In the first two years, he was extremely silent, autistic and only gradually become more active, warmer, with better interaction. The group established a more stable remission and alcohol abstinence.

Nela joined the group at the age of thirty-four and after three hospitalizations; she was a dentist but had no work experience. In adolescence, she lost both her parents and grew up with an older sister with whom she had an ambivalent symbiotic relationship. In the group she was a valuable, active and analytic member, with good interactions.

Andrija joined the group in the fifth year of the group's work, after his fifth hospitalization; he was prone to discontinuation of therapy, not adhering to drug treatment and had the role of a "malicious child" but also the role of a member who expresses opposition to the authorities in general as well as resistance to therapists. He

grupi zauzima majčinsku ulogu, savjetuje, konfrontira, sklona konkretnijim oblicima pomoći (telefonira izvan grupe kad netko nije dobro, poziva na kavu i sl.). U grupi stječe uvid u svoju pretjeranu potrebu da brine o svima i sve kontrolira, uspostavlja stabilnu, dugotrajnu remisiju.

Ivo, najmlađi član, uključen nakon prve epizode bolesti, sa značajnim hereditetom (sestra i brat boluju od teškog oblika shizofrenije), participira u grupi devet godina. Socijalno i materijalno ugrožen, bez podrške obitelji (sam se uzdržava na studiju strojarstva u Zagrebu), inače, rodom iz Bosne, predmet je pažnje i skrbi grupe na emocionalnoj pa i konkretnoj razini, ima ulogu „djeteta grupe" koje tijekom godina napreduje, završava studij, a isto tako ostvaruje dobru remisiju.

Ranko je najstariji član grupe, unatoč dugotrajnoj shizofreniji ostvario je obitelj kao i uspješno profesionalno funkcioniranje. Prošao mnoge tretmane, terapeute i bolnice, predstavlja pravu „povijest psihijatrije" i često je u službi savjetnika te identifikacijskog modela za mlađe članove.

Grupa je prošla dugi proces uspostavljanja kohezije, prevladavanja psihotičnih modela komunikacije (autističnih monologa) preko dijeljenja iskustava hospitalizacija, psihotičnih simptoma, lijekova i nuspojava, stigme duševne bolesti, da bi u petoj godini počela obrađivati i razumijevati značenje simptoma bolesti.

U prikazima grupnog procesa vezanima za cilj ovog rada sudjelovali su sljedeći članovi grupe: Ranko, Boris, Davor, Nela, Nenad, Renata.

Iz protokola

192. seansa, 1995. godina

Davor: Razmišljao sam o prošloj grupi. Razgovarali smo o paranormalnim pojavama. Mislim da je to interesantno i da možemo na taj način objasniti svoju bolest.

was well-accepted, and, at the end of the group work, functioned better in reality.

Renata joined the group after her second hospitalization and has participated in the group for the last three years. She was the least regressive member with the best social function outside the group, married, a mother of two children, and an active member with good reality testing; she took a maternal role in the group, advised, confronted, was prone to more concrete forms of help (phone calls outside the group when someone is not well, invites for a cup of coffee and similar). In the group she gained insight into her overwhelming need to care for everyone and control everything, establishing a stable, long-lasting remission.

Ivo, the youngest member, joined after the first episodes of illness with significant heredity (sister and brother suffered from severe forms of schizophrenia) and participated for nine years. Socially and materially endangered, without family support (supporting himself during the study of mechanical engineering in Zagreb). He was born in Bosnia and became the subject of care and attention of the group on both the emotional and concrete level, assuming the role of "group child" that progressed over the years; he finished his studies and also had a good remission.

Ranko was the oldest member of the group. Despite his long-lasting schizophrenia, he started a family and succeeded in professional life. He went through many treatments, therapists and hospitals and represents the right "history of psychiatry"; he often provided counselling and was the identification model for younger members.

The group has gone through the long process of establishing cohesion, overcoming the psychotic models of communication (autistic monologues), sharing experiences of hospitalization, psychotic symptoms, drugs and side effects and mental stigma, so as to begin to deal with and understand the symptoms of the disease in the fifth year.

Ranko: To je nešto što se događa svima nama psihičkim bolesnicima.

Nenad: Da, tu se pojavljuju neke stvari koje se ne mogu uvijek objasniti.

Davor: Tu se pojavljuju neke stvari koje se normalnim ljudima ne mogu dogoditi. *Osjećaj paranoje*.

Nenad: Da, to je istina.

Nela: Ja ne znam zašto mi o tome razgovaramo.

Ranko: Ja sam se problemima posvetio od malih nogu. Kad to meni puno znači. Ja sam preko šaha prognozirao atentat, zbog toga sam došao u jedno pogoršanje situacije, jer sam imao zle slutnje i ogromnu krivicu za ono što se zbilo. To je nekakva megalomanija, omnipotencija, da ja mogu utjecati na sve događaje, a s druge strane ja to nikad nisam želio upotrijebiti, da bih ja nekome učinio zlo, točno sam htio da bude manje žrtava, i kad bi problem stremio prema katastrofi, ja sam u zadnji čas skrenuo misli. Kao da ću parapsihološki utjecati na događaje i stvarno se tako kasnije i dogodilo.

Nenad: Pred jedno osam godina bila je neka emisija u kojoj je rečeno da si zamislite što bi željeli da se dogodi. Ja sam si tako u nekom euforičnom raspoloženju slušao muziku, i pomislio da dođe do potresa u Panami, da se razdvoje dvije Amerike. Nakon šest sati dogodio se taj potres.

Davor: Ozbiljno?

Ranko: Netko te vodio. Zašto si došao na ideju u Panami, a zašto ne u Gvatemali. Da ovakve stvari pričaš nekom drugom mislio bi da si lud.

Nenad: Ja se tada još nisam liječio.

Ranko: Onda to koincidiranje izaziva paranoičnu reakciju, osjećaj da si jako moćan. Baš sam Igoru govorio kako sam razmišljao o nekim svojim problemima i tu je večer bilo izvlačenje lota, i onda su došli ti brojevi koji su bili povezani bilo preko leksikona, bilo preko mojih problema.

In the presentation of the group processes related to the objective of this study, the following members of the group participated: Ranko, Boris, Davor, Nela, Nenad, Renata.

From the protocol

192nd session, 1995

Davor: I was thinking about the last group. We talked about paranormal phenomena. I think it is interesting and that we can explain our disease in that way.

Ranko: This is something that happens to all of us who are mentally ill.

Nenad: Yes, there are some things that cannot always be explained.

Davor: There are some things that do not happen to ordinary people. The feeling of paranoia.

Nenad: Yes, that's true.

Nela: I do not know why we talk about it.

Ranko: I have dedicated myself to puzzles since childhood. This means a lot to me. Through chess I predicted an assassination, which is what led to a deterioration of the situation, because I had a bad feeling about it and huge guilt for what happened. It is a kind of megalomania, omnipotence, that I can influence all the events, on the other hand I never used it, that I would do something wrong, I wanted there to be fewer victims, and when the puzzle would head towards a disaster, I would divert my thoughts at the last moment. As if I was going to influence the events parapsychologically and it really happened that way later.

Nenad: Eight years ago, there was a broadcast in which you were told to imagine what you would like to happen. I'd been listening to music in some euphoric mood, and I thought about an earthquake in Panama, which would separate the two Americas. Six hours later the earthquake occurred.

Davor: Seriously?

Boris: Nisi me uvjerio.

Ranko: Nisam jer si krajnji skeptičar.

Terapeut 1 (T1): Ranko je svojim problemima povezan sa cijelim svijetom i to mu daje osjećaj moći.

Terapeut 2 (T2): Nela je rekla da te probleme povezuje sa svojim unutrašnjim i vanjskim svijetom.

Ranko: Da, u fazi apstinencije od šaha ja sam izgubljen.

Davor: Možda ste tako rješavali emocionalni problem.

Ranko: To je bio pokušaj neke sublimacije, ali samo pokušaj. U početku moj slagateljski rad nije bio uspješan, a kad je postao uspješan koincidirao je s mojim pogoršanjem. Ja sam u početku bio racionalan. Ja sam bio svjestan da su moja inteligencija i racionalno mišljenje oštećeni već u početnoj fazi moje bolesti. Onda sam se trudio maksimalno disciplinirati i učiti u smislu neke mentalne higijene, da bi se novo znanje moglo asimilirati s razumijevanjem.

T1: Izgleda da je nešto zapelo u emocijama.

Ranko: Ja sam emocionalno strahovito bio prikraćen jer sam znao da neću imati uspjeha. U mojem emocionalnom životu ja sam se oženio i dobio kćer, samo se to ostvarilo. Moj je mozak bio tako strukturiran da ja nisam bio spreman za nikakvu uzajamnu torturu (zajednički život) nego za samostalnu strukturu. Naravno da mi je trebala ljubav, toplina i seks, ali sam se ja toga dobrovoljno odrekao i priuštio si druga zadovoljstva preko šaha. To me je nekad izluđivalo.

Boris: Čovjek može naći interes i zadovoljstvo u sebi.

Ranko: Sve što je paranormalno ne znači da ne postoji i da se s time ne može funkcionirati. To mi ostavlja neki prostor za sebe i izlaz, uvijek izlaz...

Ranko: Somebody guided you. Why did you come up with an idea for Panama, and why not in Guatemala? If you talked to someone else, he would think you are crazy.

Nenad: I was not in treatment at that time.

Ranko: Then this coincidence leads to a paranoid reaction, a feeling that you are very powerful. I was just telling Boris that I was thinking about some of my problems and that night was the lotto numbers were drawn, and then there came those numbers that were connected either through the lexicon or my puzzles.

Boris: I'm not convinced.

Ranko: That's because you're the ultimate sceptic.

Therapist 1 (T1): Ranko is connected with the problems of the whole world and that gives him a sense of power.

Therapist 2 (T2): Nela has said that that she relates these problems with her inner and outer world.

Ranko: Yes, in the phase of abstinence from chess I'm lost.

Davor: Perhaps you were solving an emotional problem in this way.

Ranko: It was an attempt of some kind of sublimation, but only an attempt. Initially, my work was not successful, and when it became successful it coincided with deterioration. I was initially rational. I was aware that my intelligence and rational thinking had been already damaged in the initial phase of my illness. Then I had to discipline myself to the maximum and learn in a sense some mental hygiene, so that the new knowledge could be assimilated with understanding.

T1: It seems as if something got stuck in terms of emotions.

Ranko: I was emotionally terribly crippled because I knew I would not be successful. In my

Davor: S tim treba biti oprezan.

Nenad: Ti tome previše posvećuješ pažnje. Ispada da ti je to najvažnija stvar u životu.

Ranko: To mi je važno, iako se grupa s tim ne slaže.

Nela: Znate li još koga tko tako rješava šahovske probleme?

Ranko: Ne, nikoga. Dapače, kad sam pokušao na takav način razgovarati s njima u klubu bili su jako neprijateljski raspoloženi prema meni.

Nela: Rekli ste da se iza takvih problema osjećate lošije i onda dolazite na kontrolu. Ne mislite da vas šahovski problemi dovode u lošu fazu bolesti?

Ranko: Jednim dijelom.

Nela: Ako ste usamljeni možemo se sastati u Maksimiru…

Ranko: Nisam rekao kakav je bio epilog tog problema. Poslije je izbio rat, 15.11. je razarač gađao Split. Granata je točno pogodila tu kuću u kojoj je bio uzorak tih pločica.…

T2: Nela vam je dala prijedlog…

Ranko: Pitanje je da li ću ja to prihvatiti, odbaciti ili razmotriti…

256. seansa, 1997. godina.

U grupu se vratio Andrija poslije hospitalizacije i pokušaja suicida. Ranko objavljuje da se osjeća loše, da je eksperimentirao s terapijom i da je dobio neurovegetativne simptome za što krivi lijekove. Renata mu kaže da neurovegetativna distonija nije od lijekova nego zbog nezadovoljstva unutarnjim i vanjskim svijetom.

Ranko: Napravio sam jedan pokus što spada u zonu sumraka. Sastavio sam jedan problem s elektroničkim uređajem, isti dan su se sudarila dva aviona, Tupoljev i Boing. To je jedno opterećenje, jedno s drugim u koliziji.

Renata: Rješenje je baciti šah i probleme, i izaći iz zone sumraka.

emotional life I got married and got a daughter, only that was realized. My brain was so structured that I was not ready for any reciprocal torture (shared life), but for an independent structure. Of course I needed love, warmth and sex, but I voluntarily gave up on it and through chess I enjoyed other pleasures. It drove me crazy sometimes.

Boris: A man can find interest and pleasure within himself.

Ranko: Everything that is paranormal does not mean it does not exist and that one cannot function with it. It leaves room for myself and a way out, always a way out…

Davor: You have to be careful with this.

Nenad: You pay too much attention to that. It ends up being the most important thing in your life.

Ranko: That matters to me, although the group does not agree with it.

Nela: Do you know anyone else who solves chess puzzles in such a way?

Ranko: No, no one. In fact, when I tried to talk to them in such a manner, they were very hostile toward me.

Nela: You said that after such problems you feel worse and then come to a check-up. Don't you think chess puzzles bring trigger a bad stage of illness?

Ranko: Only partly.

Nela: If you are lonely we can meet in Maksimir…

Ranko: I did not say what the epilogue of that problem was. The war broke out later, November 15 the destroyer fired at Split. The grenade struck the exact house in which a pattern of those tiles was.…

T2: Nela made a suggestion…

Ranko: The question is whether I will accept this, dismiss or consider…

U dvije prikazane seanse u razmaku od dvije godine (5. i 7. godina terapije) Ranko opširno iznosi svoje preokupacije problemskim šahom, koji osim realne afirmacije (niz objavljenih problema u svjetskim časopisima, član FIDE) ima i psihotično značenje te zadovoljava omnipotentne i grandiozne potrebe. Tijekom svih sedam godina uz kontinuirano bavljenje šahom na svoj način, pacijent je u remisiji, socijalno funkcionira, radi. U grupnom kontekstu Rankovi šahovski problemi omogućavaju grupi bavljenje psihotičnim dijelovima ličnosti, iako grupa u cijelosti konfrontira Ranka s omnipotentnim i grandioznim aspektima njegovih sadržaja i traži od njega da se okrene realitetu i realnim odnosima.

Grupa dogovorno završava u proljeće 1999. godine. Zadnje dvije godine sadržaj diskusija se premješta na aktualne probleme s Rankovom kćeri, koja se psihoterapijski liječi. U stalnom je konfliktu s bakom i stricem, u kojem Ranko često telefonski posreduje, kao i u njenom dogovorenom dolasku u Zagreb na studij. Ranko se u tom razdoblju uglavnom odriče bavljenja šahovskim problemima i preokupiran je realitetom. Jednoj od svojih grupnih koterapeuta nastavlja dolaziti na kontrolne preglede (T1), a drugoj (T2) na individualnu psihoterapiju s idejom da nauči bolje komunicirati s kćeri. S dolaskom kćeri nastupaju novi problemi. Ona odbacuje njegove pokušaje preuzimanja očinske uloge. Zahtjevna je, osobito na materijalnom planu, konfliktna, nesigurna, odbacuje njegove pokušaje da joj se približi i daje podršku, osim kad je i sama u regresivnom stanju. Tada komuniciraju na stari način iz ranog djetinjstva: igraju se s medvjedićima, u toj igri on igra razne uloge koje ona čas prihvaća čas odbacuje. Majka i brat se upliću u odnos s kćeri, brat rivalizira u očinskoj ulozi, te odnos s kćeri postaje sve konfliktniji. Ranko postupno razvija brojne somatizacije, jača njegova anksioznost te počinje svakodnevno tražiti pomoć različitih medicinskih službi (HMP, raznih specijalista, dežurnih

256th session, 1997

Andrija returned to the group after hospitalization and attempted suicide. Ranko said he feelt bad, experimented with therapy, and got neurovegetative symptoms because of the wrong medication. Renata told him that neurovegetative dystonia is not because of drugs but because of dissatisfaction with the inner and outer world.

Ranko: I did one experiment that best fits the twilight zone. I developed a problem with an electronic device, and the same day two planes collided, Tupoljev and Boeing. It's a burden, one is in collision with the other.

Renata: The solution is to throw away chess and puzzles and get out of the twilight zone.

In the two presented sessions in two years (5th and 7th year of therapy), Ranko extensively outlined his preoccupation with chess puzzles, which besides real affirmation (a series of chess puzzle publications in world journals, FIDA member) also had a psychotic meaning and satisfied his omnipotence and grandiose needs. During all seven years and continuous dealing with chess in his own way, the patient was in remission, socially functioning, working. In a group context, Ranko's chess puzzles enabled the group to engage in psychotic aspects of personality, although the group completely confronted Ranko with the omnipotent and grandiose aspects of his content and asked him to turn to reality and real relationships.

The group concluded in the spring of 1999. In the last two years, the content of the discussion shifted to the current problems with Ranko's daughter, who was treated psychotherapeutically. She was in constant conflict with her grandmother and uncle in which Ranko often intervened by phone calls, as well as in her scheduled arrival to Zagreb to study. In that period, Ranko mostly relinquished chess puzzles and was concerned with reality. He continued to come to check-ups to one of his group co-therapists (T1)

psihijatara u bolnici). Počinju se razvijati smetnje pamćenja, postaje sve konfuzniji, kognitivno dezorganiziran, gubi stvari, zaboravlja terapijske termine, redovito uzimanje lijekova i sl. Brat počinje razmišljati o oduzimanju poslovne sposobnosti i postavljanju skrbnika. Opisano stanje traje oko godinu i pol; na kraju prestaje uzimati lijekove. U psihičkom pogoršanju Ranko sam dolazi u bolnicu i biva hospitaliziran prvo na zatvorenom odjelu, a potom na otvorenom odjelu sa psihoterapijskim programom, koji vodi njegov terapeut (T1). Za vrijeme boravka u bolnici pacijent relativno brzo prestaje biti zaboravljiv i u bolničkim okvirima funkcionira potpuno neupadno (pohađa program u cjelini i na vrijeme, kontaktira s ostalim pacijentima, odlazi na vikende i sl.). Ponovno se počinje baviti šahovskim problemima i odlazi u klub. Po otpustu dobro funkcionira, bez značajnijih kognitivnih smetnji, a u fazama anksioznosti sada konzultira terapeute telefonom, a izvan radnog vremena terapeute medicinske sestre s odjela koje su psihoterapijski educirane i upoznate s njegovom cjelokupnom situacijom i kliničkom slikom te mu pružaju suport i kontejnersku funkciju. Odnos s kćeri se sada ustalio, Ranko se pomirio s razinom njihove komunikacije (igre s medvjedićima), uz njeno promjenjivo raspoloženje.

RASPRAVA

Iako formulacije o shizofrenoj psihopatologiji reflektiraju naoko bezbroj različitih kliničkih slika koje ovi pacijenti prezentiraju, postoji nekoliko činjenica koje prihvaća svaki psihodinamski obrazovani kliničar. I vrlo neobična ponašanja i doživljavanja shizofrenih pacijenata mogu se razumjeti kao izraz specifičnih psihičkih procesa, odnosno mehanizama obrane kao što su npr.: projekcija, poricanje disocijacija i sl. Sa strukturnog gledišta shizofreni pacijent ima slabo definirane granice između unutarnjeg i vanjskog svijeta koji vode oštećenjima testira-

and to the other (T2) for individual psychotherapy with the idea of learning how to better communicate with his daughter. New problems arose with the daughter's arrival. She rejected his attempts to take over his fatherly role. She was demanding, especially in a material sense, conflicting, uncertain and rejected his attempts to approach her and provide support except when in regressive state. Then they communicate in the way they used to when she was a child: they play with teddy bears in which he plays various roles that she accepts at one moment and at the other dismisses. The mother and brother meddled with their relationship; the brother was a rival for the role of the father, and the relationship with his daughter became increasingly conflicting. Ranko gradually developed numerous somatizations, his anxiety intensified and he started to seek help from various medical services on a daily basis (emergency service, various specialists, attending psychiatrists in the hospital). Memory disorder begin to develop, and he was becoming more confused, cognitively disorganized, losing things, forgetting his scheduled therapies and administering of medication regularly, etc. The brother began to consider limiting his business ability and setting up a guardian system. The described condition lasted for about a year and a half, and eventually he ceased to take medication. Amid psychotic decompensation, Ranko came to the hospital and was hospitalized first in a closed ward and then in an open ward with a psychotherapy program led by his therapist (T1). During the hospital stay, the patient relatively quickly stopped being forgetful and in hospital conditions he functioned completely normally (he visited the program in general and in time, had contacts with other patients, left during weekends, etc.). He started to work with chess puzzles again and attended to the club. Upon discharge he was functioning well without any significant cognitive impairments, was consulting the therapist by phone in phases of anxiety and outside therapy sessions he consulted nurses within departments who are psy-

nja realiteta praćenih poremećajima mišljenja. Konačno, objektni odnosi su poremećeni, a ti poremećaji oslikavaju i poremećenu konstrukciju self-reprezentacije (15).

Neki psihoanalitičari (16-18) pretpostavili su da kod svih emocionalno poremećenih individuuma postoji psihotična jezgra. Psihotična jezgra može se sagledati kao primitivna strukturna konstelacija koja je ishod psihičkih trauma koje je dijete iskusilo u specifičnom matriksu (dijadi) majka-dijete (15) gdje se prema Winnicottu (19) poremećaj manifestirao, i u funkciji „objektne majke" koja regulira instinktne potrebe, kao i „okolinske (*environmental*) majke" čija je uloga pružanje podržavajuće okoline uz zadovoljavanje potrebe ega. Emocionalni razvoj dalje se odvija na poremećen način rezultirajući strukturnim defektima, nedostatkom konsolidacije ego granica, psihopatološki konstruiranim reprezentacijama selfa, razvojnim fiksacijama, kompenzatornim obranama i adaptacijama, s mogućim sumanutim distorzijama vanjskog svijeta. Shizofreni pacijenti zbog nedostatka stratifikacije strukturne hijerarhije nemaju dovoljnu integraciju, strukturu i perceptivnost za stvaranje normalnih ljudskih odnosa. Umjesto da se direktno odnose s vanjskim objektima prema svojim mogućnostima, oni se povlače iz poznate realnosti i konstruiraju drugu realnost koja je samo njihova. Ono što se čini objektnim odnosima u shizofrenom svijetu nisu stvarne interakcije između dviju osoba temeljene na izmjeni osjećaja. Iako se čini da se shizofreni pacijenti odnose prema objektima, oni u stvari uspostavljaju odnos prema različitim dijelovima selfa (1,2,15). Bion (16) naglašava da kad imamo pred sobom pacijenta u psihotičnom stanju treba misliti o njegova dva dijela ličnosti: psihotičnom i nepsihotičnom, a ne o cjelovitoj osobi. Cilj psihotičnog dijela ličnosti je olakšavanje emocionalne boli projekcijom. Psihotični dio napada sve dijelove uma (*mind*) koji imaju veze s doživljajem emocionalne svje-

chotherapeutically trained and acquainted with his overall situation and clinical presentation and provide support and container function. The relationship with his daughter was now stable, and Ranko reconciled with the level of their communication (playing with teddy bears) and with her changing mood.

DISCUSSION

Although the formulations of schizophrenic psychopathology reflect the seemingly countless different clinical images presented by these patients, there are several facts accepted by every psychodynamically trained clinician. Both very strange behaviours and experiences of schizophrenic patients can be understood as an expression of specific psychic processes, i.e. defence mechanisms such as projection, denial, dissociation, etc. From a structural point of view, a schizophrenic patient has poorly defined boundaries between the internal and external worlds that lead to reality-testing damages followed by thinking disorders. Finally, object relations are disturbed, and these disorders also depict a disrupted self-representation structure (15).

Some psychoanalysts (16-18) have assumed that there is a psychotic core in all emotionally disturbed individuals. The psychotic core can be viewed as a primitive structural constellation that represents the result of psychic trauma that the child experienced in the specific mother-child matrix (dyad) (15) where, according to Winnicott (19), the disorder manifested, and in the function of the "object mother" that regulates instinctive needs as well as the "environmental mother", whose role is to provide a supportive environment meeting the needs of the ego. Emotional development unfolds in a disturbed manner, resulting in structural defects, lack of consolidation of ego boundaries, psychopathological constructed representation of the self, developmental fixations, compensatory defences and adaptations, with possible delusional distortions

snosti (*awareness*) i o unutarnjoj i o vanjskoj realnosti.

U pokušaju da izbjegne neizbježnu bol u odnosu prema odvojenim objektima, psihotični self poduzima napad na svaki mentalni proces koji može zaprijetiti da donese svjesnost o ljudskoj potrebi i potencijalnoj zdravoj ovisnosti (16,17,20).

Ranka je privukao šah od najranijeg djetinjstva i tada mu je ispunjavao usamljenost i prazninu. Nakon manifestacije bolesti u situaciji separacije odlaskom na studij, i boravkom u stranom gradu, usamljenom u novoj sredini, šahovski problemi počinju služiti kao nadomjestak za realne objektne odnose, te zadovoljavaju emocionalne potrebe za afirmacijom i omnipotencijom. Nakon smrti oca na zadnjoj godini fakulteta i nemogućnosti prolaska kroz proces žalovanja u pravom smislu riječi, bavljenje šahovskim problemima se intenzivira i involvira na magijski način cijelu obitelj u svjetske događaje, osobito nakon što ostvaruje svoj vlastiti brak i dobiva dijete. Usprkos višegodišnjem dobrom socijalnom funkcioniranju, bez egzacerbacije bolesti, psihotični grandiozni dio je uvijek aktivan. Uz to se veže realna afirmacija jer je na tom planu izuzetno uspješan.

U grupnom procesu pacijent obilno iznosi psihotične sadržaje vezane uz šah, intenzivnije nakon prvih godina rada grupe kada to budi veliku radoznalost i interes ostalih članova, da bi ga postupno članovi grupe ponovljeno konfrontirali s realitetom i značenjem šaha za njegovu bolest. Prije završetka grupe Ranko gotovo u cijelosti prestaje s konstruiranjem problema okrećući se realitetu odnosa s kćeri. Frustriran i odbačen u tom odnosu ulazi u regresiju, somatizira, traži pomoć na sve strane, frustracija se nastavlja, te pacijent konačno razvija sliku suspektne pseudodemencije (21). Kognitivne smetnje se mogu razumjeti kao napad na kognitivni aparat prema Bionu (16), i svjesnost o bolnim osjećajima povezanih s ovisnošću o objektu te ima značenje poziva u

of outside world. Schizophrenic patients lacking the stratification of structural hierarchy do not have sufficient integration, structure and perceptiveness to create normal human relations. Instead of directly relating to external objects according to their capabilities, they are withdrawing from the known reality and construct another reality that is only theirs. What seem to be object relations in the schizophrenic world are not the real interaction between two people based on the exchange of feelings. Although it seems that schizophrenic patients are related to the objects, they actually establish relationship to various parts of the self (1,2,15).

Bion (16) points out that when we have a patient in a psychotic state before us we should consider them as having two personalities – psychotic and nonpsychotic – not as about wholesome person. The goal of the psychotic part of personality is to alleviate emotional pain by projection. The psychotic part attacks all components of the mind that are connected with experience of emotional awareness and inner and outer reality.

In an attempt to avoid the inevitable pain in relation to the separate objects, the psychotic self takes offense at every mental process that can threaten to bring awareness of human need and potential healthy addiction (16,17,20).

Ranko was attracted by chess from early childhood, and then it filled the loneliness and emptiness. After the manifestation of the disease in the separation situation due to leaving to study and staying in a strange town, lonely in the new environment, chess puzzles began to serve as a substitute for real object relationships and satisfy the emotional need for affirmation and omnipotence. After the death of his father in the final year of study and his inability to go through the process of mourning in the real sense, dealing with chess puzzles intensified and involved, in a magical way, the whole family into global events, especially after achieving his own marriage and getting a child. Despite the many years of good social functioning without

pomoć, izraz je bespomoćnosti i regresije. Mnestičke smetnje se povlače nakon hospitalizacije na odjelu sa psihodinamskim psihoterapijskim programom koji, i nakon otpusta, sa svojim educiranim osobljem pruža mogućnost zrcaljenja (22) i kontejnersku funkciju, zajedno s nastavkom psihoterapijskog odnosa sa psihoterapeutima. Bolesnik se ponovo vraća sastavljanju šahovskih problema koji služe istoj funkciji kao i ranije te na taj način uspostavlja svoju homeostazu. Danas Ranko ima 71 godinu. U remisiji je, redovitom psihijatrijskom tretmanu, od spomenute hospitalizacije nije bio u bolnici. Živi s kćeri, i dalje sastavlja šahovske probleme, povremeno ih objavljuje. Psihotični dio je i dalje aktivan, ali uz uvid da „ne smije pretjerati, jer postaje previše paranoičan", kako sam kaže.

ZAKLJUČAK

Mogućnost razumijevanja simptoma i ponašanja shizofrenih pacijenata koju pruža primjena psihodinamskih teorija i znanja kao i participacija u dugotrajnom psihoterapijskom procesu pruža kliničarima platformu za cjeloviti uvid u psihodinamiku i funkcioniranje ličnosti pacijenta oboljelog od shizofrenije, a time i adekvatno planiranje terapijskih intervencija i procesa liječenja u cjelini.

the exacerbation of the disease, the psychotic grandiose part was always active. In addition to this, there was a real affirmation because he was exceptionally successful in this respect.

In the group process, the patient brought out a lot of psychotic content connected with chess, more intensively after the first years of the group's work when this aroused great curiosity and interest of the other members, in order for them to gradually confront him with the reality and meaning of the chess for his illness. At the end of the group work, Ranko almost completely stopped constructing chess puzzles, turning to the reality of his relationship with daughter. Frustrated and rejected in this relationship he entered regression, somatised, sought help everywhere, was continuously frustrated, and finally developed a suspected pseudodementia (21). According to Bion (16), cognitive impairments can be understood as an attack on the cognitive apparatus and awareness of painful feelings related to dependence to the object, and is a cry for help, the expression of helplessness and regression. Today, Ranko is 71. He is in remission, regular psychiatric treatment, he has not been in hospital since the abovementioned hospitalization. He lives with his daughter, still compiles chess puzzles and occasionally publishes them. The psychotic part is still active, but with the insight that he "should not overdo it, because he becomes too paranoid" as he says himself.

CONCLUSION

The ability to understand the symptoms and behaviour of the schizophrenic patients provided by the application of psychodynamic theories and knowledge as well as participation in the long-term psychotherapeutic process provides clinicians with a platform for a complete insight into psychodynamics and functioning of a person with a schizophrenic illness, and thus adequate planning of therapeutic interventions and the treatment process as a whole.

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Teorijski koncepti narcističnog poremećaja ličnosti. Prikaz narcističnog poremećaja u grupnoj analizi

/ Theoretical Concepts of Narcissistic Personality Disorder. Overview of Narcissistic Disorder in Group Analysis

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Narcizam se u novije vrijeme sve češće razmatra u psihijatrijskoj literaturi, prije svega jer se nalazimo u dobu kada je izrazito raširen te se često se vidi kod osoba na vodećim funkcijama tako da za neke postaje model poželjnog ponašanja. Patologija narcizma se počinje intenzivnije proučavati početkom 20. stoljeća te kulminira radovima Kohuta i Kernberga. Prema mnogim istraživanjima prevalencija narcističkog poremećaja ličnosti u općoj populaciji iznosi 1 % što je veliki broj, no s druge strane dijagnoza narcističnog poremećaja u kliničkoj praksi rijetko se postavlja. Dijagnoza je iznimno složena, te je teško povući granicu između normalnog i patološkog narcizma, a dodatne komplikacije izaziva nedovoljan naglasak u stručnoj literaturi na dva tipa ovog poremećaja: vulnerabilni i grandiozni. Liječenje poremećaja iznimno je dugotrajno i zahtjevno prije svega zbog izostanka uvida pacijenta kao i zbog njegove usmjerenosti na međuljudske odnose. Terapijski izbor kojim bi se moglo pomoći ovim osobama da osvijeste svoje stanje te ga kontroliraju kako bi im se omogućilo stvaranje zdravih međuljudskih odnosa je psihoterapija, što individualna, što grupna. U ovom je radu naglašen grupni rad koji bi narcističnim pacijentima empatijom koja se stvara u grupama i kohezijom koja je esencijalna za integraciju narcističnog pacijenta pomoglo izgraditi manjkave intrapersonalne strukture, a dinamikom grupnog rada i povratnom vezom (*feedback*) pokazati kako svojim ponašanjem utječe na druge.

/ Narcissism has been discussed in the literature with increasing frequency, primarily because we are living in an age when it is widespread and is often seen in people holding leadership positions, so that for some it has become a model of desirable behaviour. Pathological narcissism began to be more intensively studied in the early 20th century, which culminated in the works of Kohut and Kernberg. According to many studies, the prevalence of narcissistic personality disorders in the general population is 1%, which is a large number, but on the other hand its diagnosis in clinical practice is rarely described. Diagnosis is extremely complex, and it is difficult to distinguish the boundary between normal and pathological narcissism, while additional complications result in insufficient emphasis in the professional literature on the two types of this disorder: vulnerable and grandiose. Treatment of the disorder is extremely long-lasting and demanding, primarily because of the patient's lack of insight and its focus on interpersonal relationships. Psychotherapy, either individual or in a group, is emphasized as a therapeutic choice that could help patients revitalize their condition, control it and enable them to create healthy interpersonal relationships. In this paper, we discuss the group work, that could help narcissistic patients to build upon a lack of intrapersonal structures through group empathy and cohesion that is essential for the integration of a narcissistic patient through the dynamics of group work and based on feedback about how their behaviour affects others.

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KLJUČNE RIJEČI / KEY WORDS:
Dijagnoza / *Diagnose*
Grupni rad / *Group Work*
Narcizam / *Narcissism*
Narcistični poremećaj ličnosti / *Narcissistic Personality Disorder*
Liječenje / *Treatment*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2018.285

UVOD

Narcističnim poremećajem ličnosti (NPL) se nazivaju načini odnošenja s drugima, u kojima su istinski i zreli odnosi s drugima oštećeni ili ne postoje, što znači da ne postoji opažanje i reakcija na drugu osobu (objekt) kao odvojenu od samog sebe (od vlastitog selfa) te razumijevanje i uvažavanje da ta druga osoba može imati vlastite potrebe, želje, misli i reakcije koje su drugačije od objektovih.

Prema mnogim istraživanjima prevalencija narcističkog poremećaja ličnosti u općoj populaciji kreće se oko 1 % što je veliki broj, no s druge strane njegova dijagnoza u kliničkoj praksi rijetko se postavlja. U svojoj knjizi *„The Culture of Narcissism"*, C.Lasch (1) navodi da je društvo postalo preokupirano sobom i narcistično. Danas su mnoga istraživanja pokazala da je narcistična samoapsorpcija zaista u porastu (2,3).

Osnovna obilježja narcistične osobnosti su pervazivna grandioznost, potreba za divljenjem i manjak empatije koji se javljaju u ranoj mladenačkoj dobi i perzistiraju u različitim kontekstima tijekom života (4).

U klasifikaciji DSM 5 narcistični poremećaj ličnosti šifriran je pod brojem 301.81 a u MKB 10 kao F 60.81 (4,5)

Dijagnostički kriteriji NPL-a (4) definiraju taj poremećaj osobnosti kao obrazac koji je

INTRODUCTION

Narcissistic ways of relating with others are those in which the true and mature relationships with others are damaged or do not exist. This means there is no perception and reaction to another person (object) as separate from oneself (from own self) and the understanding and appreciation that this other person may have their own needs, desires, thoughts and reactions that are different from the subject's.

According to many studies, the prevalence of narcissistic personality disorders in the general population is 1%, which is a large number, but on the other hand it is seldom diagnosed in clinical practice. In his book "The Culture of Narcissism", C. Lasch (1) states that society has become narcissistic and preoccupied with itself. Now, many studies have shown that narcissistic self-absorption is indeed increasing (2,3).

The basic features of narcissistic personality are pervasive grandeur, the need for admiration, and the lack of empathy occurring in early youth and persistent in different contexts throughout life (4).

In DSM 5, narcissistic personality disorder is under code number 301.81 and under F 60.81 in ICD-10 (4,5).

The NPD diagnostic criteria (4) define this personality disorder as a form that is constantly present, characterized by grandeur (fantasies

stalno prisutan, a odlikuje se grandioznošću (u fantazijama i ponašanju), potrebom za neprestanim divljenjem i nedostatkom empatije. Počinje u ranoj odrasloj dobi i prisutan je u raznim kontekstima. Za postavljanje dijagnoze mora biti zadovoljeno barem 5 od sljedećih 9 kriterija:

1. grandiozni osjećaj vlastite važnosti,
2. zaokupljenost fantazijama o neograničenu uspjehu, moći, ljepoti ili inteligenciji,
3. uvjerenje da je on ili ona posebna i jedinstvena, da ga razumiju samo slični njemu te da se treba povezivati samo s ljudima na visokim položajima,
4. potreba za pretjeranim divljenjem,
5. polaganje prava, očekivanje posebnog tretmana i poslušnosti od drugih,
6. sklonost iskorištavanju drugih u međuljudskim odnosima radi postizanja vlastitih ciljeva,
7. nedostatak empatije prema drugima, njihovim željama, osjećajima i potrebama,
8. intenzivna zavist prema drugima ili uvjerenje da drugi zavide njemu,
9. arogantnost i bahatost u ponašanju i stavovima.

Iz gore navedenih kriterija je evidentno da DSM-5 pažnju usmjerava na grandiozni tip narcizma, zanemarujući vulnerabilni koji je često vidljiv u kliničkoj praksi.

TEORIJSKI KONCEPTI FREUDA, KOHUTA I KERNBERGA

Freud razlikuje primarni i sekundarni narcizam. Primarni narcizam označuje libidnu investiciju ega odnosno selfa, stanje koje postoji prije nego što libido bude investiran u drugu osobu ili osobe. Sekundarni narcizam nastaje iz povlačenja katekse s objekta ponovno na self i pojavljuje se u odrasloj dobi (6). Prema Freudu sekundarni narcizam je stanje

and behaviours), the need for constant admiration and lack of empathy. It begins in early adulthood and is present in various contexts. For the diagnosis to be established, at least five of the following nine criteria must be satisfied:

1. Grand feeling of self-importance.
2. Fascination with fantasies about unlimited success, power, beauty or intelligence.
3. Belief that he or she are special and unique, that they can only understood by those similar to them and that they should be connected only to people in high positions.
4. Need for excessive admiration.
5. Claiming rights, expectation of special treatment and obedience from others.
6. Tendency to exploit others in interpersonal relationships to achieve their own goals.
7. Lack of empathy towards others, their wishes, feelings and needs.
8. Intense envy towards others or belief that others envy them.
9. Arrogance and haughtiness in behaviour and attitudes.

From the aforementioned criteria, it is evident that DSM-5 focuses on the grand type of narcissism, neglecting the vulnerable type that is often seen in clinical practice.

THEORETICAL CONCEPTS OF FREUD, KOHUT AND KERNBERG

Freud distinguishes between primary and secondary narcissism. Primary narcissism signifies a libidinous investment of the ego or self, a condition that exists before the libido is invested in another person or persons. Secondary narcissism is caused by the withdrawal of cathexis from the subject back to the self and appears in adulthood (6). According to Freud, secondary narcissism is a condition when people are occupied with themselves, and others serve as means to satisfy their needs.

kada su ljudi okupirani sobom, a drugi im služe kao sredstva za zadovoljenje njihovih potreba.

Sekundarni narcizam, kao libidna investicija selfa nastala povlačenjem libida investiranog u objekte na vlastiti self, za Freuda je primarno obrambeni manevar kojim se osoba štiti od anksioznosti i drugih bolnih afekata povezanih s objektima. Međutim, dobro mišljenje o sebi i visoko samopoštovanje može postojati kao stvarni osjećaj, bez obrambene namjere, što Freud nije uzimao u obzir. Stoga se prema toj postavci teško može razlikovati obrambeni od stvarnog osjećaja samopoštovanja. S druge strane, Kohut je smatrao da se narcizam ne treba promatrati kao nešto loše što vidimo kod nezrelih osoba, već da je narcizam preduvjet za uspješan život koji uključuje objektne odnose, a pojavu sekundarnog narcizma treba shvaćati kao ostatak normalnog procesa sazrijevanja (7).

Osnova Kohutove self psihologije i njegove teorije narcizma je koncept selfa. Self je identitet, tj. integrirano poimanje sebe kao jedinstvenog pojedinca koji doživljava, osjeća, misli, procjenjuje i djeluje sam ili u interakciji s drugim uz koherentan osjećaj vremena i vlastite prošlosti. Prema njemu self je srž osobnosti (8). Self-psihologijski model gleda na osobu kao na onu koja traži određenu vrstu odgovora od drugih u svojoj okolini da bi razvila i zadržala osjećaj samopoštovanja i blagostanja. Razvoj kohezivnog selfa postupan je i događa se tijekom ranog djetinjstva kao rezultat kontinuiranog roditeljskog zrcaljenja, ogledanja i empatiziranja (razumijevanja i odobravanja) djetetovih normalnih tendencija za idealizacijom i grandioznošću. Kohut je liječeći narcistične pacijente zamijetio da umjesto neurotskih simptoma oni imaju pritužbe na razočaravajuće socijalne i emotivne odnose uz preosjetljivost na omalovažavanje od drugih. Njegova teorija proizašla je iz kliničkog opažanja da takvi klijenti stvaraju jedan od

Secondary narcissism, as libidinous investment of the self created by withdrawing the libido invested into objects onto your own self, is for Freud primarily a defensive manoeuvre which protects a person from anxiety and other painful affects associated with objects. However, a good sense of self and high self-esteem can exist as a real feeling without defensive intent, which Freud did not consider. Therefore, according to this thesis, it is difficult to distinguish the defensive from the real sense of self-esteem. On the other hand, Kohut believed that narcissism should not be seen as a bad thing that we see in immature persons but rather that narcissism is a prerequisite for a successful life involving object relationships and the emergence of secondary narcissism should be perceived as the remainder of the normal maturing process (7).

The basis of Kohut's self-psychology and his theory of narcissism is the concept of self. The self is the identity, i.e. an integrated concept of self as a unique individual who experiences, feels, thinks, evaluates and acts alone or interacts with others with a coherent sense of time and of one's own past. According to him, self is the core of personality (8). The self-psychological model looks at a person as the one who searches for a certain type of response from others in their environment to develop and maintain a sense of self-esteem and well-being. The development of the cohesive self is progressive and occurs during early childhood as a result of continuous parental reflection, mirroring and empathizing (understanding and approval) of the child's normal tendencies for idealization and grandeur. During treatment of narcissistic patients, Kohut noticed that instead of neurotic symptoms they had complaints about disappointing social and emotional relationships with hypersensitivity to belittling by others. His theory stems from the clinical observation that such clients create one of two types of transfers, mirroring or idealizing (9). Mirrored transfer is that in which the lack of or incorrect response to the child's need

dvije vrste transfera zrcaleći ili idealizirajući (9). Zrcalni je transfer onaj u kojem je ponovno oživljeno nedovoljno ili krivo odgovaranje na dječje potrebe za prihvaćanjem i potvrđivanjem preko „zrcaljenja". Kohut je gledao na taj oblik transfera kao na oživljavanje situacije iz djetinjstva gdje se dijete isticalo kako bi dobilo majčinu pozornost, a koja mu je omogućila da se osjeća potvrđenim i vrijednim. Idealizirani transfer je onaj u kojem su ponovno oživljene potrebe za spajanjem s izvorom „idealizirane" snage i smirenja.

Kohutova self psihologija razlikuje se od ego psihologije po tome što umjesto konflikata kod njega centralno mjesto promatranja zauzimaju defekti i deficiti. Defektne strukture se smatraju odgovornima za defektno funkcioniranje i naglasak je na dječjim potrebama, a ne na potisnutim nagonima. Stoga se izgradnja psihičke strukture i popravljanje defekata selfa smatra važnijim od razrješenja konflikta.

Prema Kohutu, narcizam je komponenta psihe svakog čovjeka. Svi se rađamo s narcizmom, ali tijekom našeg razvoja on se mijenja i sazrijeva zajedno s nama pretvarajući se iz infantilnog narcizma u zdravi narcizam odrasle osobe (10,11). Ako se ovaj proces poremeti, nastaje narcistički poremećaj ličnosti. Naglašavao je da su ove osobe razvojno zastale na razini u kojoj trebaju specifičan odgovor od druge osobe u svom okruženju kako bi zadržali kohezivan self. Kada takav odgovor izostane (roditeljsko zakazivanje) dolazi do fragmentacije selfa pogotovo u stresnim situacijama, kada self izgubi kohezivnost te se javlja nesigurnost i gubitak samopoštovanja.

Narcistični self je prema Kernbergu integriran, iako patološki (12). Kernberg smatra da se ne radi o poremećaju u prijelazu infantilnog u zdravi narcizam, nego isključivo o patološkoj strukturi nastaloj u fazi razvoja ličnosti. Naime, pacijenti s narcističkim poremećajem identificiraju se sa svojom idealiziranom slikom kako bi

for acceptance and confirmation by "mirroring" is resurrected. Kohut looked at this form of transfer as a revival of the childhood situation where the child tried to stand out in order to gain maternal attention, which enabled it to feel confident and valuable. Idealized transfer is one where the need for merging with the source of "idealized" strength and calm is revived.

Kohut's self-psychology is different from ego psychology in the fact that, instead of conflict, the central place is occupied by observing defects and deficits. Defective structures are considered responsible for defective functioning, and emphasis is placed on the child's needs rather than on suppressed instincts. Therefore, building a psychological structure and repairing defects of the self is considered more important than conflict resolution.

According to Kohut, narcissism is a component of every person's psyche. We are all born with narcissism, but during our development it changes and matures together with us, turning from infantile narcissism to a healthy adult narcissism (10,11). If this process is disrupted, it results in a narcissistic personality disorder. He emphasized that the development of these people has stalled at a level where they needed a specific response from another person in their environment to maintain a cohesive self. When such a response is absent (parental failure), fragmentation of the self occurs, especially in stressful situations: the self loses cohesion and insecurity and loss of self-esteem arise.

According to Kernberg, the narcissistic self is integrated, although pathologically (12). Kernberg believes that this is not a disorder in the transition from infantile to healthy narcissism, but is exclusively a pathological structure created in the developmental phase of personality. Specifically, patients with narcissistic disorders identify themselves with their idealized picture to deny dependence on external objects (people) as well as their internal images. At the same time, they deny unacceptable images of themselves

porekli ovisnost o vanjskom objektu (ljudima) kao i njihovim unutrašnjim slikama. U isto vrijeme poriču neprihvatljive slike sebe projicirajući ih na druge (13). Patološki grandiozni self objašnjava relativno dobro ego funkcioniranje u prisutnosti primitivnih mehanizama obrane koji su tipični za pacijente s graničnim poremećajem ličnosti (rascjep, projektivna identifikacija, omnipotencija, devaluacija, idealizacija, negiranje) (14).

Kernberg je narcizam vidio kao rezultat patološke organizacije selfa (doživljaj sebe), idealnog selfa (idealizirane verzije sebe) i idealnog objekta (idealizirane slike druge osobe, najčešće majke) (12,15). Ove se tri psihičke strukture sjedinjuju u grandiozni self (15). Kernbergov grandiozni self isključivo je patološki element koji ima obrambenu funkciju, pogotovo protiv investiranja u druge i ovisnosti o drugima. Ta karakteristika se može manifestirati kao pseudo-samodostatnost gdje pacijenti poriču potrebu za drugima dok u isto vrijeme pokušavaju zadiviti druge i izmamiti odobrenje. U Kernbergovom grandioznom selfu koegzistiraju osjećaji inferiornosti i grandioznosti.

Agresija koja je česta kod NPL-a je čini se sekundarni fenomen prema Kohutu (tj. narcistični bijes koji se javlja kada izostanu zrcaljenje i idealizirane gratifikacije). Kernberg je agresiju vidio kao primarni faktor. Jedna od manifestacija narcistične agresije je kronična zavist koja tjera pacijenta da uništi dobro u drugome. Često se uspoređuju s drugima te se muče osjećajem inferiornosti i čežnje za onim što drugi ima. Međutim, treba napomenuti da etiologija i patogeneza NPL-a, ne mora uvijek upasti u model ili Kohuta ili Kernberga. Nasuprot pacijentima s NPL-om koji su tijekom razvoja osjetili roditeljsko empatijsko zakazivanje, kod nekih pacijenata je došlo do odgoja u kojem su roditelji poticali grandioznost djeteta modelom ekscesivnog zrcaljenja. Takvi roditelji su obasipali svoje

by projecting them to others (13). The pathologically grandiose self explains a relatively good ego function in the presence of primitive defence mechanisms that are typical for patients with borderline personality disorder (fragmentation, projective identification, omnipotence, devaluation, idealization, denial) (14).

Kernberg views narcissism as a result of a pathological self-organization (self-experience), an ideal self (idealized versions of self) and an ideal object (idealized image of another person, mostly mothers) (12,15). These three psychological structures are united in the great self (15). Kernberg's great self is a pathological element that has a defensive function, especially against investing in others and dependence on others. This feature can be manifested as pseudo-self-sufficiency where patients deny the need for others while at the same time trying to fascinate others and elicit approval. In Kernberg's grandiose self, there are coexisting feelings of inferiority and grandeur.

Aggression that is common in NPD is a secondary phenomenon according to Kohut (i.e. narcissistic anger that occurs when there is no mirroring and idealized gratification). Kernberg saw aggression as a primary factor. One of the manifestations of narcissistic aggression is the chronic envy that causes the patient to destroy the good in the other. They often compared themselves with others and are tormented by the sense of inferiority and longing for what others have.

However, it should be noted that the aetiology and pathogenesis of NPD does not always have to adhere to the model of Kohut or Kernberg. In contrast to patients with NPD who felt parental empathy during development, some patients had experienced an upbringing in which the parents encouraged the child's grandeur through the model of excessive mirroring. Such parents showered their child with excessive approval and admiration, which is why it felt very special and gifted. When these children grow up, they often do not get the response from others they had received from their parents (16).

dijete pretjeranim odobravanjem i divljenjem zbog čega su se ona osjećala zaista posebna i nadarena. Kada ta djeca odrastu ne dobivaju često odgovor od drugih kakav su dobivali od roditelja (16).

KRIVNJA, SRAM I NARCISTIČNI BIJES

Krivnja je bolan osjećaj žaljenja i odnosi se na ono što je učinjeno. Kod krivnje objekt negativne percepcije nije self, nego specifično ponašanje. Krivnja nastaje kao posljedica kritične procjene superega. Ako su moralne norme manje ili više realistično postavljene, što upućuje na zrelost i strukturiranost superega, a odstupanja od tih normi nisu prevelika, osjećaj krivnje je neugodan, ali još uvijek podnošljiv i nije proganjajući i preplavljujući (17,18).

Intenzivan i široko zastupljen osjećaj krivnje u kliničkoj slici i životu bolesnika upućuje na poremećaj superega (19,20). Na neurotskoj razini strukturacije nalazimo elemente poremećaja superega, ali uglavnom ne nalazimo poremećaj selfa. Poremećaj selfa nalazimo u regresivnijih bolesnika u kojih se nalazi i poremećaj superega.

Sram, zavist i bijes su narcistički afekti (21). Sram se pojavljuje kad osoba doživljava da je objekt neempatijskog promatranja i procjenjivanja, da je u središtu pažnje i procjene socijalne okoline koja nije dobronamjerna ni empatijska, nego je kritična i emocionalno hladna. Međutim, taj doživljaj može biti projekcija vrlo kritičnog samoprocjenjivanja, odnosno kritičnog superega kad bolesnik nesvjesno sam sebi sudi oštrije i procjenjuje se negativnije nego ga procjenjuju drugi (22). Doživljaj selfa normalno nije u fokusu pažnje i percepcije, nego je u pozadini. Uobičajeno je pažnja usmjerena prema van, te se percipira realnost, na primjer, tuđe i vlastito ponašanje, a ne percipira se self.

GUILT, SHAME AND NARCISSISTIC ANGER

Guilt is a painful feeling of regret for actions performed in the past. In guilt, the object of negative perception is not the self, but specific behaviour. Guilt is the result of a critical appraisal of the superego. If moral standards are more or less realistically set, indicating the maturity and structure of the superego, and deviations from these norms are not too large, the feeling of guilt is uncomfortable but still tolerable and is not haunting and overwhelming (17,18).

Intense and wide-spread feeling of guilt in the clinical picture and the patient's life points to a disorder of the superego (19,20). At the neurotic level of structuring, we find elements of superego disorders but mostly do not find a disorder of the self. We find the disorder of the self in more regressive patients with the disorder of the superego present as well.

Shame, envy and anger are narcissistic affects (21). Shame occurs when a person experiences being an object of non-empirical observation and assessment, in the centre of attention and assessment of a social environment that is not good or empathic but is critical and emotionally cold. However, this experience can be a projection of a very critical self-assessment, i.e. a critical superego due to which patients unconsciously judge themselves more strictly and evaluate themselves more negatively than others evaluate them (22). Self-experience is normally not in the focus of attention and perception, but in the background. Attention is usually outwardly oriented, and reality is what is perceived, such as others and their own behaviour, and not the self.

Shame is usually more painful than guilt. It is followed by the experience of shrinking, feelings of worthlessness and helplessness. Blame is followed by the experience of tension, remorse and regret.

Sram je obično bolniji od krivnje. Prate ga doživljaj smanjivanja, osjećaja bezvrijednosti i bespomoćnosti. Krivnju prati je doživljaj napetosti, kajanja i žaljenja.

Od tih dvaju osjećaja sram je razvojno stariji. Krivnju povezujemo s edipskom, a sram s preedipskom razinom psihičkog funkcioniranja. Strukturni preduvjet za krivnju jest superego. On je nasljednik edipskog kompleksa što razvojno odgovara otprilike trećoj godini života. Razvojni preduvjet za sram jest pojavljivanje selfa što sram razvojno locira u drugu godinu života (16).

Sposobnost osjećaja srama i krivnje može se smatrati zdravom i važnom u održavanju socijalne povezanosti. Naime, krivnja u svojim pozitivnim aspektima vodi do korekcije neprihvatljiva ponašanja, a sram do jačanja osobnih granica i čuvanja privatnosti.

Sram kao narcističan afekt ima važnu ulogu u nizu kompleksnih afektivnih stanja povezanih s narcizmom kao što su bijes, zavist, očaj, beznađe, prijezir, taština, umišljenost, ambicija, ponos, bezobzirnost, osveta (17).

Krhko samopoštovanje i samopouzdanje narcističnih pacijenata predisponira ih za povredu i na najmanju kritiku. Potreba za osvetom, za ispravljanjem krivoga te duboko utemeljena prisila za slijeđenjem svoga osvetoljubivog cilja, neke su od najvažnijih karakteristika fenomena narcističnog bijesa. Narcistično vulnerabilne osobe odgovaraju na aktualnu ili anticipiranu narcističnu povredu sramom i povlačenjem ili narcističnim bijesom (23).

Za vrijeme ispoljavanja narcističnog bijesa dolazi do potpunog zanemarivanja razumskih ograničenja i bezgranične želje za zadovoljštinom i osvetom zbog nanesene povrede. Narcistično pretjerano osjetljivi koji često već beznačajna protivljenja i neusklađenost sa svojim očekivanjima osjećaju kao snažnu narcističnu povredu, ne mogu mirovati dok ne unište nejasno doživljenog napadača koji se usudio su-

Of these two feelings, shame is developmentally older. We associate guilt with the Oedipus complex, and shame with the pre-oedipal level of psychic functioning. The structural prerequisite for guilt is the superego. It is the successor of the Oedipus complex, which develops in approximately the third year of life. The developmental prerequisite for shame is the emergence of the self that is developmentally located in the second year of life (16).

The ability to feel shame and guilt can be considered healthy and important in maintaining social cohesion. Namely, guilt in its positive aspects leads to corrections of unacceptable behaviour and shame to the strengthening of personal boundaries and protecting privacy.

Shame as a narcissistic affect plays an important role in a series of complex affective states associated with narcissism such as anger, envy, despair, hopelessness, contempt, vanity, ambition, pride, wantonness, revenge (17).

The significant self-esteem and self-confidence of narcissistic patients predisposes them to injury even from the slightest criticism. The need for revenge, for correcting the wrong and deep-rooted compulsion to follow their vindictive goal, are some of the most important features of the narcissistic anger phenomenon. Narcissistic vervable people respond to current or anticipated narcissistic injury by shame and withdrawal or narcissistic rage (23).

During the manifestation of narcissistic anger comes a complete neglect of rational limitations and boundless desire for satisfaction and revenge for the injury caused. To overly sensitive narcissistic personalities, insignificant opposition and inconsistency with their expectations often feel like a powerful narcissistic injury, and they cannot rest until they have destroyed a vaguely experienced attacker who has dared to contradict them, disagree with them or overshadow them (24).

protstaviti, ne složiti se s njim ili ih zasjeniti (24).

MOGUĆNOSTI TRETMANA

Pacijenti s NPL-om koji dolaze na terapiju često se žale na kvalitetu svojih intimnih veza, bilo ljubavnih bili socijalnih koje su obično površne i kratkotrajne. Često se opisuju usamljenima, bez ikakvih suportivnih veza uz osjećaj nevoljenosti. Njihove poteškoće u interpersonalnim odnosima često su posljedica njihove potrebe za divljenjem, iskorištavanjem drugih i manjkom poštovanja i osjećaja za druge. Ako tijekom terapije postignu određeni stupanj empatije, mogu parcijalno zamijeniti zavist i početi prihvaćati druge kao zasebne osobe s vlastitim potrebama. Ako do toga dođe, postoji mogućnost da postanu sposobni izbjeći završetak života u ogorčenju i izolaciji. Cilj liječenja je smanjiti dominaciju lažnog selfa te jačanje pravog selfa narcističnih pacijenata. Zadatak je razviti sposobnost samoopservacije grandioznih fantazija koji u konačnici vodi njihovom odbacivanju. Uz adekvatnu konfrontaciju i interpretaciiju kod pacijenta bi trebalo doći do odricanja od idealizirane slike selfa. Odricanjem idealizirane-lažne slike selfa javlja se žalovanje, jer je pacijent sagradio čitav život na lažnoj slici. Tek odbacivanjem lažnog selfa moguće je susresti se s realnošću i integrirati ju. Prihvaćanjem autentičnog selfa vremenom nestaje osjećaj praznine, srama i neadekvatnosti.

I Kohut i Kernberg (25,26) su vjerovali da je psihoanaliza terapija izbora za većinu pacijenata s NPL-om. Za Kohuta je empatizacija terapeuta osnova u terapiji NPL-a. Terapeut mora empatizirati s pacijentovim pokušajem da reaktivira roditeljsko zakazivanje u odnosima te omogućiti stvaranje zrcalnog, idealizirajućeg i blizanačkog transfera.

Kohut se fokusira u terapiji na empatijskom opserviranju, razvoju i proradi triju tipova trans-

TREATMENT POSSIBILITIES

Patients with NPD who come to therapy often complain about the quality of their intimate relationships, whether love relationships or social ones, which are usually superficial and short-lived. They often describe themselves as lonely, without any supportive relationships and with a feeling of being unloved. Their difficulties in interpersonal relationships often result from their need for admiration, exploitation of others and having less respect and feelings for others. If a certain degree of empathy is achieved through therapy, they can partially replace envy and begin accepting others as separate individuals with their own needs. If this happens, there is a possibility for them to become capable of avoiding living out their life in bitterness and isolation. The goal of the treatment is to reduce the domination of the false self and strengthen the true self of narcissistic patients. The task is to develop the ability of self-preservation of grand fantasies that ultimately leads to their rejection. With adequate confrontation and interpretation in the patient, there should be a rejection of the idealized self-image. Rejecting the idealized false image of self results in an appearance of anxiety because the patient has built their entire life on a fake image. It is possible to encounter reality and integrate it only by rejecting the false self. By accepting the authentic self, the feelings of emptiness, shame and inadequacy disappear with time.

Kohut and Kernberg (25,26) believed that psychoanalysis was the therapy of choice for most patients with NPD. For Kohut, empathizing by a therapist is the basis for NPD therapy. The therapist must empathize with the patient's attempt to reactivate parenting failure in relationships and enable the creation of mirror, idealizing and twin transfer.

Kohut focuses on empathic observation, development and analysis of three types of transfer: mirroring, idealizing and so-called alter ego transfer.

fera: ogledajući, idealizirajući i tzv. alterego transfer.

Kernberg temelji terapiju na konfrontaciji i interpretaciji patološkog grandioznog selfa i negativnog transfera pokazujući pacijentu njegov utjecaj na druge. Ipak primjena konfrontacije u terapiji mora ići uz maksimalni oprez, da ih bolesnik ne doživi kao napad na sebe, jer će tada samo još više pojačati svoje obrane. Što se tiče terapije unutar terapijskog saveza također bi trebalo proraditi bolesnikovu ekstremnu senzitivnost na greške u empatiji.

Ipak, neki pacijenti neće tolerirati ništa drugo nego empatični pristup po Kohutovom modelu. Bilo kakvo odstupanje od ovog modela, dovelo bi do pacijentovog povlačenja i doživljaja nesporazuma, te potrebe za prekidom terapije. U drugim slučajevima pacijent bi mogao dobro prihvatiti interpretaciju zavisti i natjecateljskog raspoloženja te stoga bolje odgovoriti na Kernbergov pristup. Mnogi pacijenti ipak imaju koristi od kombinirane terapije.

Kod pacijenata koji funkcioniraju na krajnje graničnoj razini, sa slabim egom i nedostatkom kontrole impulsa, Kernberg smatra da suportivna psihoterapija daje bolje rezultate nego ekspresivna ili analiza.

Neki autori preporučuju i navode kako bi kombinirana individualna i grupna psihoterapija mogla imati koristi za narcistične pacijente. Naime, u grupi narcistični pacijenti se konfrontiraju sa činjenicom da i drugi imaju potrebe te da ne mogu očekivati da će biti cijelo vrijeme u centru pažnje. Također, narcistični pacijenti mogu imati koristi od *feedback*-a - odgovora drugih zbog utjecaja i načina na koji njihove crte osobnosti utječu na druge. Ipak, ne preporuča se u grupi imati više od jednog narcističnog pacijenta istovremeno zbog pacijentovih potreba i zahtjeva koji mogu preplaviti i nadjačati potrebe drugih članova grupe (27). Foulkes je naglašavao zrcaljenje i *feedback* kao

Kernberg bases therapy on the confrontation and interpretation of the pathological grandiose self and negative transfer, showing the patient their influence on others. However, the use of confrontation in therapy has to be performed with the utmost caution, so that the patient does not experience it as an attack on themselves, since then they will only increase his defence. As far as therapy within a therapeutic alliance is concerned, the patient's extreme sensitivity to empathy should also be developed.

Still, some patients will not tolerate anything but an empathetic approach to the Kohut model. Any deviation from this model would lead to the withdrawal of the patient and the experience of misunderstanding and the need for interruption of therapy. In other cases, the patient could accept the interpretation of envy and competitive mood well and therefore respond better to Kernberg's approach. However, many patients benefit from combined therapy.

In patients who work at the ultimate border level, with decreased ego and lack of impulse control, Kernberg suggests that supportive psychotherapy gives better results than expressive therapy or analysis.

Some authors recommend and suggest that combined individual and group psychotherapy could benefit narcissistic patients. Namely, in a group narcissistic patients are confronted with the fact that others have needs too and cannot expect to be in the centre of attention all the time. Also, narcissistic patients may benefit from feedback-responses from others due to the influence and the way their personality traits affect others. However, it is not recommended to have more than one narcissistic patient in the group at the same time because of this patient's needs and requirements that can overwhelm and overcome the needs of other group members (27). Foulkes emphasized mirroring and feedback as an important phenomenon in a group when patients meet themselves through the effect they leave on others and the image that others shape about them.

važne fenomene u grupi kada pacijent upoznaje sebe putem učinka koji ostavlja na druge i slike koju drugi oblikuju o njima.

Terapija narcizma jednim se dijelom temelji na procesu žalovanja za narcističnom grandioznosti, uz razvoj zrelije slike o sebi i drugima. Ovaj kapacitet za žalovanje i tolerancija iskustva depresije uključujući krivnju i žaljenje, obično upućuju na bolju prognozu u terapiji patološkog narcizma (28).

U grupnom radu s narcističnim pacijentima često možemo zamijetiti tzv. otpor narcističnog bolesnika koji se prije svega očituje u potrebi da se u grupi djeluje suprotno od raspoloženja koje se u njoj uspostavlja i tako dolazi u središte pažnje (29). Narcistična osoba ima veliku potrebu zavesti grupu kao i druge članove grupe koristiti kao slušače za prezentaciju svojih referenci kako bi dobila divljenje i poštovanje koje im je bazično nisko. Stoga se narcistični pacijenti često u grupi prezentiraju kao monopolisti ispunjavajući i kraće šutnje pričom o sebi te koristeći svaku prigodu da se nadovežu na razgovor koji se vodi pričom o sebi. Monopolisti često ne doživljavaju druge članove grupe kao ravnopravne niti imaju potrebu za povratnom spregom u komunikaciji. Poznato je da član-monopolist ne može u osnovi ni čuti ni prihvatiti interpretaciju koju dobije u grupi te ga je u tim situacijama potrebno izravno i jasno konfrontirati. Osim toga postoji i posve oprečni način funkcioniranja u grupi kada osoba sve loše mazohistički pripisuje sebi, te pati zbog doživljaja sebe kao ništavne i manje vrijedne od drugih članova. Tim načinom također dolazi u središte pažnje grupe, te se grupa bavi problemom takve osobe, hrabreći ju i empatizirajući s njom. Na taj način narcistična osoba dobiva potkrepljenje i potvrdu za kojom bazično žudi. Bolesnici iz prvog spomenutog tipa svjesno smatraju da mnogo vrijede, dok iz drugoga svjesno smatraju da manje vrijede. Ipak u oba slučaja tzv. grandiozni self vlada osobom. Što se tiče obrana

Narcissism therapy is partially based on a process of mourning for narcissistic grandeur, with the development of a more mature image of themselves and others. This capacity for grief and tolerance of experiences of depression, including guilt and regret, usually indicates a better prognosis for the treatment of pathological narcissism (28).

In group work with narcissistic patients, we can often observe the so-called resistance of a narcissistic patient, which manifests itself primarily in the need to act contrary to the mood of the group and thus come to the centre of attention (29). A narcissistic person has a great need to entice a group as well as use other members of the group as listeners to present their references in order to gain admiration and respect that is initially low. Therefore, narcissistic patients often appear in the group as monopolists, filling in shorter silence with stories about themselves and using every opportunity to make the ongoing conversation a story about themselves. Monopolists often do not experience other members of the group as equal or have the need to show restraint in communication. It is well known that a member-monopolist cannot even basically hear or accept the interpretation they receive in the group and needs to be confronted with it directly and clearly in those situations. Additionally, there is a completely contradictory way of narcissistic functioning in a group when the patient masochistically attributes all bad things to themselves and suffers because they experience themselves as worthless and less valuable than other members. In this way, they also become the centre of the group's attention, and the group deals with the problems of this person, encouraging them and empathizing with them. In this way, the narcissistic person receives the corroboration and confirmation that they crave. Patients of the first mentioned type consciously consider themselves to be of great value, while patients of the second type

koje vidimo kod takvih pacijenata najčešća je racionalizacija kojom se brane od nerazvijenog emocionalnog života i nemogućnosti empatiziranja. Pokazuju i projektivnu identifikaciju kojom svoje osjećaje ubacuju u druge članove grupe, a često i u voditelja s čime se grupa dugo bori, pogotovo slabiji članovi. Narcistični pacijenti posebno su skloni izazivati agresiju u drugima protivljenjem, podsmjesima i sl. kao da govori vi ste predamnom nemoćni kao što sam ja nemoćan pred vašim konstruktivnim razgovorima.

Osim monopoliziranja grupe, agresije koju izazivaju u drugima, često se nameću i kao paralelni voditelji zauzimajući tako prostor voditelja pogotovo u situacijama kad im je raspoloženje povišeno. Preuzimajući ulogu liječnikovog asistenta često rade opservacije tuđih problema negirajući svoje (27).

U grupnoj analizi posebna se pažnja narcističnih pacijenata usmjerava prema tzv. zrcaljenju (*mirroring*) Prema Pinesu (30) u grupnoj analizi postoje dvije vrste zrcaljenja. Jedna ide konfrontacijom koja je destruktivna, koja budi rane negativne oblike dijadnog odnosa. Drugi oblik je više pregovarački, istražujući između nekoliko osoba koje dijele isti psihološki prostor, te koje izražavaju različita stajališta o istom iskustvu. Ovaj posljednji oblik zrcaljenja može imati pozitivne učinke na narcističnog pacijenta u grupi.

Narcistični pacijenti u grupama skloni su razvijanju tzv. malignog zrcaljenja. Maligno zrcaljenje možemo vidjeti kada osobine koje ne volimo kod sebe vidimo u drugoj osobi u grupi, tj. kada se zrcale negativni dijelovi selfa. Takvi pacijenti nisu skloni uvidu. To je posebna situacija u grupnom procesu gdje terapeut mora brzo reagirati kako bi prevenirao utjecaj na terapijsko djelovanje zbog jakih destruktivnih snaga (30). Inače Zinkin je u svojim radovima naglašavao i korist koju mogu narcistični (i drugi) pacijenti imati i od neempatijskog zrcaljenja u grupi.

consciously believe they are worth less; in both cases, the so-called grandiose self governs the person. As for the defence we see in such patients, the most common is rationalization that defies the underdeveloped emotional life and the inability to empathize. They also show projective identification and project their feelings onto other members of the group, and often the leader with which the group is struggling for a long time, especially the weaker members. Narcissistic patients are particularly inclined to provoke aggression in others with opposition, ridicule and so on, as if to tell them they are helpless before they just like they are helpless before your constructive conversations.

In addition to monopolizing the group, with the aggression they cause in others they often impose themselves as parallel leaders, thus taking the role of a leader, particularly in situations where the mood is aggravated. By taking over the role of physician's assistant they often make observations on the problems of others and deny their own problems (27).

In group analysis, narcissistic patients direct special attention towards so-called "mirroring". According to Pines (30), there are two types of mirroring in the group analysis. One is going through a confrontation that is destructive and awakens the worst negative forms of a dyadic relationship. The other is more negotiating and exploratory, taking place among several people sharing the same psychological space and expressing different views on the same experience. This latter form of mirroring can have positive effects on a narcissistic patient in the group.

Narcissistic patients in the group are inclined to develop so-called malignant mirroring. Malignant mirroring is when traits we do not like in ourselves are seen in another person in the group, i.e. when the negative parts of the self are mirrored. Such patients are not prone to insight. This is a special situation in the group process where the therapist must react quickly to prevent the influence on therapeutic action

Grupu terapiju narcistični bolesnici teže podnose od individualne terapije gdje je sva pažnja usmjerena na njih. U grupi moraju dijeliti s grupom vrijeme, voditelja, iskustva što im teško pada. Najteže im ipak pada izloženost kritici ili neslaganju drugih članova grupe. Ovi pacijenti u grupi rijetko pitaju, budu zainteresirani za probleme drugih, pomažu ili potiču druge, tako da njihova emocionalna hladnoća posebno dolazi do izražaja u grupnom radu. Najveći izazov u terapiji su pacijenti kojima se psihopatološke reakcije približavaju graničnoj osobnosti, te s antisocijalnim problemima.

Problem u terapiji NPL-a javlja se i zbog stalnih pokušaja obezvrjeđivanja terapijskog procesa i pritužbi na terapeuta u kojeg projicira osobine lošeg objekta. Takvo ponašanje može izazvati neadekvatne kontratransferne reakcije terapeuta i kritiziranje pacijenta što kod pacijenta može pojačati doživljaj srama i krivnje. Umjesto toga kod psihoterapije NPL-a, terapeut mora imati visok kapacitet za kontejniranje bez kritiziranja.

Tijekom procesa liječenja može se povremeno opservirati hipomano raspoloženje što je povezano s razdobljima grandioznosti. S druge strane, njihova ranjivost na kritiku, perzistentni osjećaji srama i poniženja te nisko samopoštovanje mogu biti povezani sa socijalnim povlačenjem i depresivnim raspoloženjem.

Što se tiče farmakoterapijskog liječenja poremećaja ličnosti, konkretnog psihofarmaka nema kao niti algoritama, a kliničari se snalaze liječeći pacijente simptomatski.

U istraživanju koje je tri godine pratilo pacijente s NPL-om u terapiji pokazalo se smanjenje narcističnih simptoma u području interpersonalnih odnosa i obrazaca reaktivnosti kao i grandioznog doživljaja sebe (16,32,33). Od devet simptoma navedenih u DSM-u za šest se pokazala visoka razina promjenjivosti:

due to severe destructive forces (30). However, Zinkin also regularly emphasized the benefits that narcissistic (and other) patients may have from the non-empathy mirroring in the group.

Narcissistic patients tolerate group therapy with more difficulty than individual therapy where all the attention is directed to them. In the group they must share the time, the leader and the experience, which is very difficult for them. However, what is most difficult for them is exposure to criticism or disagreement with other group members. These patients in the group rarely ask about or are interested in the problems of others or help and encourage them, so their emotional coldness is particularly manifested in group work. The biggest challenge in therapy are patients with psychopathological reactions approaching borderline personality disorder and those with antisocial problems.

The problem with NPD therapy is due to ongoing attempts to undermine the therapeutic process and complaints about the therapist to which the traits of the bad object are projected. Such behavior can cause inadequate contra-transfer responses by the therapist and criticizing of the patient, which can enhance the experience of shame and guilt in the patient. Instead, in NPD psychotherapy, the therapist must have a high containment capacity without criticism.

A hypomanic mood may occasionally be observed during the treatment process, which is associated with periods of grandeur. On the other hand, their vulnerability to criticism, persistent feelings of shame and humiliation and low self-esteem can be associated with social withdrawal and depressive mood.

As far as pharmacotherapy in personality disorders is concerned, there are no psychopharmaceuticals or algorithms and the clinicians treat the patients symptomatically.

A three-year study of patients with NPD in therapy showed a reduction in narcissistic symptoms in the area of interpersonal relation-

- grandiozne fantazije
- posebnost
- traženje posebnih prava
- arogantno ponašanje
- iskorištavanje
- nedostatak empatije.

Tri simptoma NPL-a pokazala su se stabilnima, a to su:

- zavist
- potreba za divljenjem
- prenaglašavanje svojih talenata i postignuća.

PRIKAZ PACIJENTA U OKVIRU GRUPNE ANALIZE

Pacijent Marko u dobi je od 49 godina, zaposlen, visoko pozicioniran na radnom mjestu, oženjen, otac dvaju odraslih sinova, situiran. Od obiteljskog herediteta za psihičke bolesti navodi da je otac prekomjerno konzumira alkohol duže vrijeme. U ranom odrastanju opisuje iskustva nerazumijevanja, neuvažavanja, sputanosti i emocionalne depriviranosti od strane roditelja. Majka je bila pasivna u odgoju, a otac grub. Unazad više godina liječen je psihijatrijski zbog smetnji uzrokovanih sudjelovanjem u ratu, poremećaja ličnosti i štetne uporabe alkohola. Poremećaj ličnosti u medicinskoj dokumentaciji šifriran je pri svakoj hospitalizaciji kao F 60.8. Također je u više navrata hospitalno liječen zbog ovisničkog ponašanja kod poremećaja u strukturi ličnosti. Navodi da je prijame u bolnicu u alkoholiziranom stanju većinom svjesno isplanirao tako što je namjerno konzumirao veće količine alkohola kako bi „došao u bolnicu i odmorio se“. Od supruge se ipak dobiju posve suprotni heteroanamnestički podatci o razlozima i načinima na koje je pacijent bio hospitaliziran. Prema supruzi sklon je izvrtanju događaja i manipulaciji. Tijekom hospitalizaships and patterns of reactivity as well as of the grand experience of self (16,32,33). Of the nine symptoms listed in the DSM there was a high level of variability for six of them:

- grandiose fantasies,
- uniqueness,
- seeking special rights,
- arrogant behaviour,
- exploitation,
- lack of empathy.

Three symptoms of NPD were shown to be stable:

- envy,
- the need for admiration,
- excessive emphasizing of one's own talents and achievements.

OVERVIEW OF NARCISSISTIC DISORDER IN GROUP ANALYSIS

Marko was a 49-year-old patient, employed, highly positioned at work, married, father of two grown sons and well-situated. To questions ranging from family heredity to mental illness, he states that his father has been consuming excessive amounts of alcohol for a long time. As for early childhood, he describes experiences of misunderstanding, disregard, inhibition and emotional deprivation by his parents. The mother was passive in the upbringing, and his father was strict. For the past several years he had been treated psychiatrically for disturbances caused by his participation in the war, personality disorders and harmful use of alcohol. The personality disorder in medical records is coded at each hospitalization as F 60.8. He has also been hospitalized several times because of addictive behaviour as part of the disorders in the structure of his personality.

The patient stated that most of his admissions to the hospital in an alcoholic state were consciously planned by intentionally consuming larger amounts of alcohol to "come to the

cija na odjelu, razvidno iz dekursusa, uvijek je bio neupadan i suradljiv. Hospitalizacije je mahom napuštao na vlastiti zahtjev. Potpuno je nekritičan spram pretjerane konzumacije alkohola uz sklonost racionalizaciji i negiranju. U medicinskoj dokumentaciji evidentirani su i povremeni konflikti u obitelji, a u jednom je navratu imao mjeru obveznog psihijatrijskog liječenja zbog nasilja u obitelji.

Prema zadnjem psihologijskom testiranju pacijent je visoko iznadprosječnog intelektualnog funkcioniranja. Bilježilo se nisko temeljno samopoštovanje i samopouzdanje te generalizirana nepovjerljivost. Osnovni obrazac prilagodbe umnogome je podređen „krpanju" narcističnih lezija uz sustavno zapostavljanje potreba za bliskošću. Kompulzivno je fokusiran na formalni aspekt socijalne i profesionalne afirmacije što mu donosi narcističnu gratifikaciju. Frustracije racionalizira, negira i/ili projicira. Sklon je omnipotentnom postavljanju, zazire od „jadanja i pokazivanja slabosti". Kada se silom prilika susretne sa vlastitom nemoći (ograničenja) reagira tjeskobom, depresivnim otklonom, sramom, samoizolacijom i pasivizacijom.

Tijekom dolaska u aktualnu terapiju grupne analize bio je na bolovanju. Bolovanje je uslijedilo posljedično kumulativnim frustracijama u okviru teškoća prilagodbe nezadovoljavajućem i frustrirajućem poslovnom okruženju gdje se osjeća zakinut, omalovažen i podcijenjen. Neadekvatna je i obiteljska situacija u smislu manjka emocionalne uzajamnosti sa suprugom i djecom. Nedostatak bliskih emocionalnih odnosa racionalizira. U terapiji o tome priča s pasivnom ljutnjom kao da očekuje da bliskost od članova obitelji bude usmjerena prema njemu, ali ne i u suprotnom smjeru. Blažu depresivnu dekompenzaciju prati pasivna agresivnost, infantilna ljutnja, ogorčenost i doživljaj prikraćenosti. Alkohol konzumira radi „otupljenja" afekta, čemu pribjegava u situacijama pojačanog stresa kada prijeti otkazivanje osnovnih obrambenih mehanizama. Površno je svjestan

hospital and rest". However, his wife gave completely opposite heteroanamnestic information on the reasons and the ways in which the patient was hospitalized. According to his wife, he was inclined to distort and manipulate events. During hospitalization at the department, apparent from the decorsus, he was always unobtrusive and cooperative. He mostly left hospitalizations at his own request. He was completely uncritical about the excessive consumption of alcohol, with a tendency to rationalize and negate. In medical records, occasional family conflicts were also recorded, and at one time there was a measure of compulsory psychiatric treatment due to family violence.

According to the most recent psychological test, the patient had high above-average intellectual functioning. Low self-esteem and self-confidence as well as generalized mistrust were noted as well. The basic pattern of adaptation was greatly subordinated to the "patching up" of narcissistic lesions with a systematic neglect of the need for closeness. It was compulsively focused on the formal aspect of social and professional affirmation that brings narcissistic gratification. Frustrations were rationalized, denied and/or projected. He was inclined to take an omnipotent attitude and shied away from "misery and weakness". When he was forced to confront his own impotence (constraints), he responded with anxiety, depression, shame, self-isolation and passivation.

The patient was on sick leave upon arrival to the current therapy group. The sick leave had been initiated by cumulative frustrations from the difficulties in adjustment to an unsatisfactory and frustrating business environment where he felt deprived, belittled and underrated. The family situation was also inadequate in the sense of a lack of emotional reciprocity with his wife and children. He rationalized the lack of close emotional relationships. In therapy, he talked about this with passive anger, as if expecting the attentions of family members to

vlastitih neadekvatnih obrazaca prilagodbe, ali jasniji uvid priječi rigidnost i narcistična vulnerabilnost, odnosno teškoće prihvaćanja konfrontacije.

Kod pacijenta su naznačene uz dominantno narcistična obilježja ličnosti, disocijalna i pasivno-agresivna obilježja.

Pacijent je u grupnoj terapiji zadnjih šest seansi te ćemo prikazati njegov rad u grupi u to vrijeme koji, iako kratak, obiluje narcističnom psihopatologijom i sukladnim obrascima ponašanja u grupi.

Tijekom Markove prve seanse nakon kraćeg otpora grupe novom članu u smislu ignoriranja njegovog dolaska, Marko se predstavlja i počinje opisivati svoj život kronološkim redom. Iznosi niz činjenica, reference svog uspjeha i postignuća na raznim poljima života bez afektivne popraćenosti. Svi članovi osim jednog, Filipa, s također narcističnim crtama, gledaju u pod, a Filip pozorno prati sve što Marko govori. Filipova zainteresiranost vjerojatno dodatno Marka motivira da nastavi detaljno izlaganje. Svoj život Marko gotovo idealizira. S obzirom na Markovu sklonost idealiziranju, gotovo hvaljenju svog života bez problema, pitam ga koji su razlozi što se odlučio na grupnu terapiju. Facijalnom ekspresijom pokazuje začuđenost zbog prekidanja dužeg izlaganja, te daje do znanja da mu se ne sviđa pitanje. Navodi da je njegov problem alkohol, ali da alkohol zapravo nije problem, jer on to drži pod kontrolom i da se on napije kad želi doći u bolnicu i maknuti se od svega. Uzimanje alkohola racionalizira. Kratko se dotakne razloga nedavne intoksikacije alkoholom i sudskog spora zbog povrede prava iz radnog odnosa. Član grupe Ivan upita ga zašto je na sudu, ali konkretan odgovor Marko izbjegava, mijenja temu i opisuje svoje radno mjesto i uvjete. Nikome nije jasan razlog sudskog spora pa nastavljaju s nizom potpitanja na koja im ne daje konkretne odgovore zbog čega na kraju odustaju. Na svaki upit člana grupe Marko ne

focus on him, but not vice versa. Milder depressive decompensation was accompanied by passive aggressiveness, infantile anger, bitterness and experience of deprivation. He consumed alcohol in order to "blunt" the affect in situations of increased stress when threatened with cancellation of basic defence mechanisms. He was superficially aware of his own inadequate patterns of adaptation, but clearer insight was prevented by rigidity and narcissistic vulnerability, i.e. difficulties in accepting confrontation.

The patient was characterized by the dominant features of narcissistic personality and dissociative and passive-aggressive features.

The patient has in group therapy for the last six sessions as of this writing, and we will present his work in the group at that time, which, though brief, was abundant with narcissistic psychopathology and consistent patterns of behaviour in the group.

During Marko's first session, after the group's short resistance to the new member in the sense of ignoring his arrival, Marko presented himself and began to describe his life in chronological order. He stated a number of facts and references to his success and achievement in various fields of life without affective accompaniment. All members except one, Philip, who had narcissistic traits, looked at the floor, while Philip was closely following everything that Marko said. Filip's interest likely further motivated Marko to continue the detailed presentation. Marko almost idealized his own life. Considering Marko's tendency to idealize, almost praising his life and presenting it without any problems, I asked what his reasons for choosing group therapy were. His facial expression showed his astonishment with the interruption of his long exposition, and he made it known that he did not like the question. He argued that his problem was alcohol, but that alcohol was not really a problem because he kept it under control and only got drunk when he wanted to go to the hospital to get away from it all. He rationalized his drink-

reagira najbolje u smislu ili da ignorira pitanje ili člana koji postavlja pitanje pogleda ispod oka. U svojim odgovorima ističe svoje uspjehe na poslu. Nakon što je iznio niz uspjeha na radnom mjestu počinje pričati o nezadovoljstvu bračnim odnosima. Kao razlog nezadovoljstva i konflikata navodi sklonost supruge pretjeranom iskazivanju osjećaja, pretjeranoj privrženosti i predbacivanju da nema emocionalnog odgovora s njegove strane. Opisujući suprugu, dobije se dojam da njezino ponašanje prikazuje kao pretjerano privrženo, da je puna ljubavi prema njemu, gotovo kao da ga „obožava". Dalje racionalizira svoje ponašanje u smislu manjka emocionalnog odgovora s njegove strane navodeći da „muški to ne rade". Grupa obeshrabrena izostankom adekvatnih odgovora,više ne postavlja potpitanja, a Marko nastavlja dominirati gotovo cijelom seansom. Zatim nastavlja o nezadovoljavajućim odnosima s djecom prikazujući ih kao neuspješne u usporedbi sa sobom, pogotovo što se tiče školskog uspjeha. Opisuje što im je sve omogućio, te kako su nezahvalni. Jedno od djece mu je prigovorilo da ne mora doktorirati da bi znao živjeti. U isto vrijeme pokušava tu situaciju prikazati kao da mu djeca prigovaraju i predbacuju, ali s isticanjem vlastita uspjeha. Dobijem dojam da se silno trudi da grupi pokaže kako je uspješan, kako je doktorirao, stekao znanstvenu titulu docenta, radi kao vještak, zarađuje mnogo novca i sl. Upitam ga što misli zašto mu je sin to rekao, a on odgovori, jer ga je htio uvrijediti. Opisuje također slab odnos sa starijim sinom, te kako ga nikad ne zove na telefon. Komunikacija s djecom većinom se odvija posredno preko supruge. Član grupe ga pita zašto on ne potencira češće druženje sa sinom koji se odselio, na što kaže da se valjda sin treba njemu javiti i on to potencirati. Nakon nekoliko rečenica i to ponašanje opravda, govori kako nemaju vremena, puno rade, sin ima svoj život i svoje prijatelje. Pri kraju grupe Filip navodi da se vidi u njemu, iako se ostatak grupe sa time ne slaže.

ing. He briefly touched upon the reasons for his recent alcohol intoxication and a court dispute for breach of employment rights. Ivan, a group member, asked him why he was in court, but Marko avoided giving a specific answer, changed the subject and described his workplace and conditions. No one was clear on the cause of the court dispute, and they continued with a series of questions that did not receive clear answers, after which they ultimately gave up. Marko did not respond properly to any question posed by a member of the group, and would respond in a way that missed the sense of the question, simply ignored the question or would keep surreptitiously glancing at the member that had posed the question. In his answers, he pointed out his success at work. Having put forth a series of workplace successes, he began to talk about his dissatisfaction with his marital relationships. He claimed his wife's tendency to exaggerate feelings, excessive attachment and reproach for no emotional response from his side was the cause of his dissatisfaction and the conflict. When he described his wife, one got the impression that he presented her behaviour as overly affectionate, full of love for him, almost as if she "worships" him. He further rationalizes his behaviour in the sense of a lack of emotional response from his side by saying "men don't do it". The group, discouraged by the lack of adequate responses, no longer asked question, and Marko continued to dominate almost during the entire session. He continued by talking about his unsatisfactory relationships with his children, presenting them as unsuccessful in comparison with himself, especially as far as school success was concerned. He described everything he has made possible for them and how ungrateful they were. One of the children complained to him that he did not have to have a doctorate to know how to live. At the same time, he tried to present this situation as if his children complain and are reproachful, but with an emphasis on their own success. I got the impression that he was making great efforts to show how successful he was, as he had received a

Tijekom druge seanse Markova narcistična patologija dolazi do izražaja kada ga u njegovom izlaganju prekine jedan od članova grupe sa željom da iznese svoje iskustvo. Na ubacivanje u riječ Marko vrlo burno reagira, bijesan je, te prigovara dotičnom članu grupe. Filip koji je u prethodnoj grupi smatrao da ima dosta sličnosti s Markom i koji je u prethodnim seansama prorađivao dijelove svoje patologije, konfrontira Marka s njegovim bijesom. Objašnjava kako je i on prije znao burno reagirati kada ga netko prekine, jer je smatrao da ga time vrijeđa i omalovažava. Marko ne pristaje na ponuđenu Filipovu interpretaciju te racionalizira svoj istup. Brzo se nakon toga povlači i šuti do kraja grupe.

Tijekom treće seanse se uključuje u grupni rad odmah na početku grupe i obraća samo voditelju ignorirajući druge članove grupe. Doima se veseo. Govori kako je popravio odnos sa sinom, opisuje bolje odnose sa suprugom zadnjih nekoliko dana, iznosi niz pojedinosti. Navodim da mi se čini kao da traži potvrdu od voditelja i grupe (koja ga je kritizirala zbog odnosa s djecom) da je nešto dobro napravio s čime se djelomično slaže. Šuti do kraja grupe, ali ju aktivno prati.

Tijekom četvrte grupe Marko iznosi konflikt s obitelji oko jednog važnog događaja te kako smatra da bez njegove pomoći oni to neće moći organizirati. Racionalizira svoje pasivno agresivno ponašanje u tom slučaju i neadekvatan obrazac ponašanja. Zbog neslaganja oko detalja organizacije potpuno se isključio i prekinuo suradnju s obitelji oko tog događaja. Ponovno ga s ponašanjem konfrontira Filip koji mu opisuje kako je i on znao slično reagirati.

U petoj seansi grupu započinje Marko i priča o relativnosti života, kako se on sa svime pomirio, kako je sve tako kako je i ne može se promijeniti. Jedna članica grupe, Marija, kaže da se ljudi odluče na grupnu terapiju kad smatraju da ipak mogu nešto promijeniti i da i on sigurno ima nešto za promijeniti. Ne daje konkretan

doctorate, gained the scientific title of a docent, worked as an expert, earned a lot of money and so on. I asked him why he thinks that his son told him that, and he replied it was because he wanted to offend him. He also described a poor relationship with his older son, and how he never calls him on the phone. Communication with children mostly took place indirectly through his wife. A member of the group asked him why he did not encourage more frequent socializing with the son that had moved away, to which he answered that the son should contact him, emphasizing it was the son's duty. Only a few sentences later he also justified this behaviour in his sons, saying how they do not have the time, they work a lot, the son has his own life and his friends. At the end of the group session, Philip claimed that he can see himself in Marko, although the rest of the group does not agree with that.

During the second session, Marko's narcissistic pathology was evident when he was interrupted in his speech by one of the group members with the desire to share their own experiences. Marko reacted very violently to the interruption; he was angry and complained about that member of the group. Philip, who in the previous group session believed that he had a lot of similarity with Marko and who had been analysing parts of his pathology in previous sessions, confronted Marko on his anger. He explained how he had also previously been known to react violently when someone interrupted him because he thought he was insulting and belittling him. Marko did not agree with the interpretation of offered by Philip and rationalized his action. Quickly thereafter he withdrew and was silent until the end of the group session.

During the third session, he joined in group work immediately at the beginning of the group and addressed himself only to the leader, ignoring the other members of the group. He seemed cheerful. He said he had improved his relationship with his son, described an improved relationship with his wife in the last couple of

odgovor, zatim kaže kako ni ne zna zašto je tu, jer je njemu u životu, kad promisli, baš super, situiran je, ima super posao, zdrav je, ima obitelj, aludirajući kako je u boljem položaju od drugih članova grupe. To izaziva bijes u ostatku grupe, te ga konfrontiraju kako im se čini da i nije tako. Na njihove pokušaje konfrontacije sve odbacuje s podsmjehom.

Tijekom šeste grupne seanse na kojoj je Marko, vodi se tema što je važnije nasljeđe ili okolina. Grupa oscilira između dvije teze te zaključuje kako je važnija okolina. Tijekom njihovog konstruktivnog razgovora Marko se nekoliko puta ubacuje iznoseći svoje neslaganje s bilo kakvim zaključkom. U jednoj situaciji čak je i sam sebi kontradiktoran, ali dominira izražaj njegova neslaganja i proturječja što posebno smeta jednoj članici grupe koja ga konfrontira na što se Marko ovlaš nasmije.

Tijekom samo šest seansi kojima je do sada pacijent prisustvovao može se iščitati obilje narcistične psihopatologije koja je navedena u prije opisanom tekstu. Smatra se da bi pacijent od grupne terapije u perspektivi mogao imati koristi u empatičnoj konfrontaciji, dozvoljavanju razvoja idealizirajućeg i zrcalećeg transfera, te povratnom odgovoru od grupe na osjećaje koje u njima izaziva njegovo ponašanje.

RASPRAVA I ZAKLJUČAK

Zdravi međuljudski odnosi su karakterizirani empatijom i usmjerenošću na osjećaje drugih, interesom za ideje drugih i tolerancijom ambivalencije u dugotrajnim emocionalnim vezama bez odustajanja te mogućnošću spoznavanja doprinosa svake strane nekog sukoba. Osobe s narcističnim poremećajem ličnosti s druge strane pristupaju ljudima kao objektima zadovoljenja vlastitih potreba koje odbacuju nakon njihovog zadovoljenja bez brige o osjećajima drugih. Ljudi se ne vide kao osobe sa zasebnim postojanjem i vlastitim potrebama. Narcistične

days and gave a series of details. I stated that it seemed to me that he was looking for confirmation from the leader and the group (who had criticized him for his relationship with his children) that he was doing something well, with which he partially agreed. He was silent until the end of the group, but actively followed the discussion.

During the fourth session, Marko reported a family conflict around an important event and thought that without his help they would not be able to organize the event. He rationalized his passive-aggressive behaviour and his inadequate pattern of behaviour. Because of the disagreement around the details of organization, he completely cut himself off and ended collaboration on the event with the family. Again, Philip confronted him and described to him that he used to react in a similar fashion.

In the fifth session, the group began with Marko talking about the relativity of life and that he has accepted that everything is the way it is and that it cannot be changed. One member of the group, Marija, said that people opt for group therapy when they feel that they can change something and that he certainly has something to change. He did not give a specific answer, only saying he did not even know why he was there because when he thought about it, everything in his life was going great, he was well-situated, had a great job, was healthy and had a family, also implying he was in a better position than other group members. This provoked rage in the rest of the group and they confronted him by saying that to them it did seem like that. He dismissed their attempts to confront him with ridicule.

During Marco's sixth group session, the theme of the session was whether heredity or the environment is more important. The group oscillated between the two theses and concluded that the environment is more important. During their constructive conversation, Marko joined in on several occasions by expressing his disagreement with any conclusion. In one situation he was even self-contradicting, but his

osobe mogu biti stvarno talentirane, međutim, njihovi talenti, koji imaju izvorište u pravom selfu, iskorištavaju se u službi lažnog selfa. Emocionalni teret očekivanja i zahtjeva okoline koji su internalizirani postali su preveliki. Kao prilagodba velikim i nerealnim očekivanjima razvili su hipertrofirani lažni self, a njihov je autentični self progresivno izgubio pristup svjesnom egu, te je ostao zarobljen u nesvjesnom, gdje je njegov razvoj zaustavljen.

Mnoge vrlo uspješne osobe imaju naznačene narcistične crte ličnosti prije svega jer narcizam dovodi do velikih ambicija koje pokušavaju, a često i uspijevaju ostvariti. Za njih neostvarenje ambicije vodi poniženju koje grčevito pokušavaju izbjeći, stoga neuspjeh nije opcija. Međutim ako te crte nisu nefleksibilne, tvrdokorne i trajne u svim situacijama uzrokujući funkcionalne teškoće ili subjektivni distres, ne označuju se kao narcistični poremećaj ličnosti. Cilj liječenja je smanjiti dominaciju lažnog selfa te jačanje pravog selfa narcističnih pacijenata. Zadatak je razviti sposobnost samoopservacije grandioznih fantazija koji u konačnici vodi njihovom odbacivanju. Uz adekvatnu konfrontaciju i interpretaciiju kod pacijenta bi trebalo doći do odricanja od idealizirane slike selfa. Neki autori preporučuju i navode kako bi kombinirana individualna i grupna psihoterapija mogla imati koristi za narcistične pacijente. Naime, u grupi narcistični pacijenti se konfrontiraju s činjenicom da drugi imaju potrebe također te da ne mogu očekivati da će biti u centru pažnje cijelo vrijeme. Također, narcistični pacijenti mogu imati koristi od *feedback*-a - odgovora drugih zbog utjecaja i načina na koji njihove crte osobnosti utječu na druge. Ipak, ne preporuča se u grupi imati više od jednog narcističnog pacijenta istovremeno zbog pacijentovih potreba i zahtjeva koje mogu preplaviti i nadjačati potrebe drugih članova grupe (26). Grupnu terapiju narcistični bolesnici teže podnose od individualne terapije gdje je sva pažnja usmjerena na njih. U grupi moraju dijeliti

contributions were dominated by the expression of his disagreement and contradiction, which specifically affected one of the members of the group that confronted him, to which Marko only laughed.

During the six sessions in which the patient had been present, one can observe an abundance of narcissistic psychopathology that is described above. It is believed that the patient could benefit from group therapy in the future through empathic confrontation, allowing the development of an idealizing and reflective transfer and a response from the group to the feelings that his behaviour causes in them.

DISCUSSION AND CONCLUSION

Healthy interpersonal relationships are characterized by empathy and focus on the feelings of others, interest in their ideas, tolerance of ambivalence in long-lasting emotional relationships without giving up and the ability to recognize the contributions of each side of a conflict. People with narcissistic personality disorder, on the other hand, approach people as objects for meeting their own needs that they reject after satisfying those needs without worrying about the feelings of others. People are not seen as individuals with a separate existence and their own needs. Narcissists can be very talented; however, their talents, having the true self as the source, are exploited in the service of the false self. The emotional burden of expectations and requirements of the environment that has become internalized has become too great. As an adaptation to great and unrealistic expectations, they developed a hypertrophied false self, and their authentic self progressively lost access to the conscious ego and remained imprisoned in the unconscious, where its development was stopped.

Many very successful individuals have marked narcissistic personality traits first and foremost because narcissism leads to great ambitions that they try and often succeed in realizing.

vrijeme, voditelja, iskustva što im teško pada. Najteže im ipak pada izloženost kritici ili neslaganju drugih članova grupe.

Istraživanje koje je tri godine pratilo pacijente s NPL-om u terapiji pokazalo je smanjenje narcističnih simptoma u području interpersonalnih odnosa i obrazaca reaktivnosti kao i grandioznog doživljaja sebe (15,31,32). Tri simptoma NPL-a pokazala su se stabilnima, a to su zavist, potreba za divljenjem i prenaglašavanje svojih talenata i postignuća.

For them, unrealized ambitions lead to humiliation that they frantically trying to avoid, so failure is not an option. However, if these traits are not inflexible, stubborn and persistent in all situations causing functional difficulties or subjective distress, they are not classified as narcissistic personality disorder. The goal of the treatment is to reduce the domination of the false self and strengthen the true self of narcissistic patients. The task is to develop the ability of self-preservation of grand fantasies that ultimately leads to their rejection. With adequate confrontation and interpretation in the patient, there should be a renunciation of the idealized self-image. Some authors recommend and suggest that combined individual and group psychotherapy could benefit narcissistic patients. Namely, in a group narcissistic patients are confronted with the fact that others have needs as well and that they cannot expect to be in the centre of attention all the time. Furthermore, narcissistic patients may benefit from feedback-responses from others due to the influence and the way their personality traits affect others. However, it is not recommended to have more than one narcissistic patient in a group at the same time because the patient's needs and requirements can overwhelm and overcome the needs of other group members (26). Narcissistic patients tolerate group therapy with more difficulty than individual therapy where all the attention is directed at them. In the group they must share the time, the leader and the experience, which is very difficult for them. However, what is most difficult for them is exposure to criticism or disagreement with other group members.

The three-year follow-up of patients with NPD in therapy showed a reduction in narcissistic symptoms in the area of interpersonal relationships and patterns of reactivity as well as of the grandiose experience of the self (15,31,32). The three symptoms of NPD were found to be stable: envy, the need to be admired and overemphasizing of their talents and achievements.

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Stigmatizacija duševnih bolesnika od srednjoškolaca*

*/ Stigmatisation toward the mentally ill in high school students**

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*Preuređeni dio istraživanja diplomskog rada Diplomskog sveučilišnog studija sestrinstvo – promicanje i zaštita mentalnog zdravlja

**Adapted from a part of the graduation thesis at University Graduate Programme of Nursing – Promotion of Mental Health Care*

Cilj ovog istraživanja bio je ispitati stavove srednjoškolaca prema shizofreniji, depresiji i posttraumatskom stresnom poremećaju te koliko na formiranje njihovih stavova utječe formalno obrazovanje, spol, religijska pripadnost, obrazovanje i bračni status roditelja. U istraživanju je sudjelovalo 156 učenika završnih razreda iz tri srednje škole na području Primorsko-goranske županije: 57 učenika za zanimanje medicinska sestra/medicinski tehničar opće njege Medicinske škole u Rijeci, 41 učenik Salezijanske klasične gimnazije u Rijeci i 58 učenika Pomorske škole u Bakru. Korišten je upitnik koji se sastoji od demografskog upitnika i upitnika ljestvice stavova prema duševnim bolesnicima. Rezultati su pokazali da postoji statistički značajna razlika u stavovima srednjoškolaca prema psihijatrijskim bolesnicima s obzirom na srednju školu koju pohađaju, u korist učenika medicinske škole koji imaju pozitivnije stavove od ostalih, te je i statistički značajna razlika u stavovima prema pojedinim psihijatrijskim bolestima, tako da najviše negativnih stavova srednjoškolci imaju prema shizofreniji, a najmanje prema depresiji. Ne postoji razlika u stavovima srednjoškolaca s obzirom na vjersku pripadnost i bračni status roditelja. Razlika u stavovima s obzirom na obrazovanje roditelja statistički je značajna samo u stavu prema shizofreniji, gdje su rezultati pokazali negativnije stavove srednjoškolaca čije su majke visoko obrazovane. Razlike u stavovima prema spolu ispitanika nije bilo moguće sa sigurnošću utvrditi s obzirom da su većina ispitanika ženskog spola učenice za zanimanje medicinska sestra i nije ih objektivno uspoređivati s učenicima muškog spola koji su većinom učenici pomorske škole. Usporedba podataka dobivenih od gimnazijalaca kojih je podjednako prema spolu**,** nije pokazala razlike između stavova po spolu. Prema rezultatima istraživanja možemo zaključiti da na formiranje stavova srednjoškolaca prema psihijatrijskim bolesnicima uvelike utječe formalno obrazovanje, odnosno stečeno znanje o psihijatrijskim bolestima, što je dokazano u istraživanju na ispitanicima srednjoškolcima medicinske škole koji su pokazali najmanju stigmatizaciju psihijatrijskih bolesnika, vjerojatno zbog stručnog znanja koje su stekli tijekom obrazovanja. Na osnovi te činjenice možemo zaključiti da u budućnosti treba više raditi na edukaciji o psihijatrijskim bolestima i mentalnom zdravlju, i tek onda možemo očekivati manju stigmatizaciju psihijatrijskih bolesnika u društvu.

***/** The aim of this study was to examine the attitudes of high school students toward schizophrenia, depression and posttraumatic stress disorder and explore how formal education, gender and religious affiliation affected those attitudes together with the education and marital status of their parents. A total of 156 fourth-grade students from three secondary schools in the Primorje-Gorski Kotar County participated in the study: 57 medical nursing students from the Medical High School in Rijeka, 41 students from the Salesian Classical High School in Rijeka and 58 students from the Maritime High School in Bakar. A demographic questionnaire and a questionnaire on attitudes toward patients with mental illnesses were used. The results have shown that there was a statistically significant difference in the attitudes of high school students toward psychiatric patients based on the secondary school they attended, showing that students from the Medical school had more positive attitudes toward the mentally ill than others, and there was also a statistically significant difference regarding the attitudes toward specific psychiatric illnesses. High school students had the most negative attitudes toward schizophrenia and the least negative toward depression. There was no difference in the attitudes of high school students with regard to their religious affiliation and marital status of parents. The differences in attitudes based on the parents'*

levels of education were statistically significant only regarding the attitudes toward schizophrenia – the results showed that high school students whose mothers were highly educated had more negative attitudes. High school differences in attitudes based on the gender of the participants could not be established since the majority of participants from the Medical High School were female nursing students, while male students were the majority at the Maritime High School. Comparison of data obtained from high school students by gender did not reveal differences in attitudes based on gender. In order to explore the difference in attitudes based on gender, it would be necessary to extend the study to a much larger number of respondents and exclude students from medical schools. Based on the results of this study, it can be concluded that the attitudes of high school students toward psychiatric patients were greatly influenced by formal education, i.e. acquired knowledge on psychiatric illnesses, since high school students from the Medical high school showed the smallest extent of stigmatization toward psychiatric patients, most likely due to the expertise and knowledge obtained through their education. Therefore, we can conclude that in the future more effort should be put into education on psychiatric disorders and mental health in general, and only then could we expect less stigmatization toward psychiatric patients in our society.

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KLJUČNE RIJEČI / *KEY WORDS*:
Stigmatizacija / *Stigmatization*
Shizofrenija / *Schizophrenia*
Depresija / Depression
PTSP / *Posttraumatic Stress Disorder*
Srednjoškolci / *High school students*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2018.307

UVOD

U svim poznatim civilizacijama ljudi su vjerovali kako su na neki način duševne bolesti i nasilje povezani. U kasnom srednjem vijeku, pod utjecajem kršćanske crkve, natprirodne teorije mentalnih poremećaja ponovno su dominirale Europom. Praznovjerje, astrologija i alkemija prevladavali su u djelovanju i razmišljanju. Počevši od 13. stoljeća, mentalne bolesnike, posebno žene, počeli su progoniti kao opsjednute vještice. Lov na vještice i čarobnjaštvo nisu popustili sve do 17. i 18. stoljeća, nakon što je više od 100.000 opsjednutih i navodnih vještica spaljeno na lomači (1,2).

Koliko god danas ljudi žele vjerovati da su se izdigli od prije opisanih postupaka ili da je sadašnjost uvijek najnaprednije vrijeme, na ljudsko se razmišljanje i danas dalje uglavnom odražavaju iste ili slične teorije o duševnim bolestima kao one u proteklim tisućljetnim razdobljima,

INTRODUCTION

Throughout history and in all known civilizations, people often believed in the connection of mental illness and violence. In the late Middle Ages, the supernatural theory of mental disorders dominated in Europe under the influence of the Christian church. Superstition, astrology and alchemy prevailed both in action and thought. At the beginning of the 13th century, mentally ill, especially women, were persecuted as posessed witches. Hunting witches and witchcraft did not diminish until the 17th and 18th centuries, and in that period more than 100,000 alleged witches had been burnt at the stake (1,2).

As much as people today want to believe that they have moved past the mind-set described above or that the current period is always the most advanced, human thinking today still largely reflects in the same or similar theories of mental illnesses as those in past millennia, which is also noted in some modern studies (3,4).

što se spominje i nekim suvremenim istraživanjima (3,4).

U današnje vrijeme znatnog napretka znanosti i saznanja u razumijevanju bioloških odnosa u mentalnim bolestima ipak, čini se, ne napredujemo dovoljno u boljem socijalnom prihvaćanju osoba s duševnim bolestima. Stavovi okoline prema mentalnim bolesnicima i psihijatrijskom liječenju uglavnom su i danas nepovoljni (5,6).

Mentalni bolesnici skloni su prikriti svoju bolest, a eventualno otkriti detalje o svojim teškoćama i liječenju samo osobama kojima vjeruju. Osim toga, zbog negativnog stava okoline sebe smatraju manje vrijednima. Ove odlike samostigmatizacije uvelike pogoršavaju psihosocijalne i mentalno higijenske uvjete oboljelih, otežavaju ishod liječenja i njihovu socijalnu i medicinsku rehabilitaciju (7).

U psihijatrijsku terminologiju izraz stigma uveo je kanadski sociolog Erving Goffman koji istražuje reakcije osoba koje ponašanjem ili izgledom odstupaju od društveno prihvaćenih standarda. Stigma se odnosi na sramotu koju takve osobe mogu osjetiti, pa zbog straha od diskreditiranja okoline, a u obranu svog identiteta, prikrivaju svoje nedostatke (8).

Brojna istraživanja ukazuju na uglavnom negativne društvene reakcije prema osobama s mentalnim bolestima. Ispitanici smatraju da su mentalno bolesni manje predvidljivi i da nemaju dobre ishode u liječenju za razliku od onih s tjelesnim bolestima. Ta uvjerenja povezana su s odbijanjem društva i podrazumijevaju neke, ali ne sve, učinke stigme na mentalno oboljele osobe. Stigmatizirane osobe s duševnim bolestima često trpe zbog odbacivanja iz okoline i diskriminacije u svim životnim situacijama. Stigma mentalne bolesti ima pogubne učinke na živote osoba s ozbiljnim mentalnim bolestima, osobito oboljelih od shizofrenije. Poguban učinak takvog stava nerijetko dovodi do začaranog kruga u kojem sami „nosioci stigme“ prihvaćaju diskriminatorski i pokroviteljski (paternalistič-

Today, in a period of considerable advances in science, knowledge and understanding of the biological base of mental illness, it seems that we have not progressed sufficiently toward better social acceptance of persons with mental health disorders. Even today, attitudes toward patients with mental health problems and in psychiatric treatment, are still mostly unfavourable (5,6).

Patients suffering from mental disorders are sometimes inclined to conceal their illness, eventually disclosing details of their difficulties and treatment only to people they trust. In addition, because of the perceived negative attitudes in their social environment, they feel less valuable. These characteristics of self-stigmatization worsen the psychosocial and mental hygiene conditions of the patients, complicating the treatment outcome and the patients' social and medical rehabilitation (7).

In psychiatric terminology, the term *stigma* was introduced by Canadian sociologist Erving Goffman. Goffman explored the reactions of people who deviated from socially accepted standards by their behaviour or appearance. Stigma refers to the shame that such people may feel, the fear of being discredited by others and hiding their perceived imperfections in order to defend their own identity (8).

Numerous studies point to mostly negative social reactions to people with mental illnesses. Respondents believe that the mentally ill are less predictable and that they do not have good outcomes in treatment, as opposed to those with physical illnesses. These beliefs are associated with social rejection and comprise some of, but not all, effects of stigma on mentally ill persons. Stigmatized persons with mental illnesses often suffer from rejection from their environment and discrimination in everyday situations. The stigma of mental illness has detrimental effects on the lives of people suffering from severe mental illnesses, particularly schizophrenia. The ruinous effects of stigmatizing attitudes often lead to the vicious circle in which the "stigma bear-

ki) stav okoline. Sve to rezultira povlačenjem bolesnika iz javnog života, skrivanjem bolesti, osjećajem srama i najgore od svega, nerijetko izbjegavanjem liječenja (9-11).

Tijekom proteklog razdoblja u znanosti je provedeno mnogo istraživanja kako bi se utvrdio učinkoviti način i strategija borbe protiv stigmatizirajućih stavova i diskriminirajućeg ponašanja društva (12). Posebno su važna znanstvena istraživanja i saznanja o utjecaju formalnog obrazovanja, okoline, obitelji, konfesijske opredjeljenosti, spola i drugih čimbenika na formiranje stavova o mentalnim bolestima (13-16). Postoje i istraživanja o stigmatizaciji duševnih bolesnika od strane studenata (17,18), kao i o od srednjoškolaca, ali su znatno rjeđa (19,20).

CILJ ISTRAŽIVANJA

Cilj ovog istraživanja bio je ispitati kakvi su stavovi srednjoškolaca prema oboljelima od psihijatrijskih bolesti i koliko na stigmatizaciju duševnih bolesnika utječe formalno obrazovanje, spol, religijska pripadnost, obrazovanje i bračni status roditelja.

Odabrane su tri psihičke bolesti i/ili stanja. Kao najozbiljnija, kronična i invalidizirajuća duševna bolest koju karakterizira posebni tip poremećaja mišljenja, afekta i ponašanja odabrana je shizofrenija, dok je zbog činjenice da je danas najučestalija od svih psihičkih bolesti odabrana depresija i depresivnost. Trijadu upotpunjuje posttraumatski stresni poremećaj, koji je posljedica događaja koji su ugroza nečijeg života ili tijela, a koji je u našem društvu prisutan u većem broju kao posljedica Domovinskog rata.

ISPITANICI I METODE

U istraživanju je sudjelovalo 156 učenika završnih razreda iz tri srednje škole na području Primorsko-goranske županije: 57 učenika za

ers" themselves accept the discriminatory and patronizing attitudes of society. As a result, patients withdraw from their social environment, concealing the disease, feeling ashamed, and worst of all, often avoiding treatment (9-11).

Hitherto, a significant amount of scientific research has been carried out to discover an effective strategy to combat stigmatizing attitudes and discriminatory behaviours in society (12). Formal education, social environment, family, confession, gender and some other factors are of particular importance in the formation of attitudes about mental illnesses (13-16). There are also studies on stigmatization of mental patients by university students (17,18) and by high school students, but they are few (19,20).

RESEARCH GOAL

The aim of this study was to examine the attitudes of high school students toward psychiatric illnesses and how much the stigmatization of patients with mental health disorders was affected by the students' formal education, gender and religious affiliation, and the educational and marital status of their parents.

Three mental illnesses and / or conditions were selected. Schizophrenia was selected as the most serious, chronic and disabling mental illness, characterized by a particular type of disorder of thought, affect and behaviour; depression was selected due to the fact that it is the most frequent of all psychiatric disorders today. The triad was completed with posttraumatic stress disorder, the disorder that has been diagnosed often in our society after the psycho-traumatisation during the Homeland War.

PARTICIPANTS AND METHOD

156 final grade students from three high schools in the Primorsko-goranska County participated in the survey: 57 medical nursing stu-

zanimanje medicinska sestra/medicinski tehničar opće njege Medicinske škole u Rijeci, 41 učenik Salezijanske klasične gimnazije u Rijeci i 58 učenika Pomorske škole u Bakru. Istraživanju su pristupili svi učenici koji su toga dana bili na nastavi.

Korišten je upitnik koji se sastoji od demografskog upitnika i upitnika ljestvice stavova prema duševnim bolesnicima (21).

Ispitivanje je provedeno u terminima redovne nastave tijekom ožujka i travnja 2017. godine. Ispitivanje je bilo dragovoljno i anonimno, te su ispitanici upoznati sa svrhom istraživanja. Prilikom istraživanja poštivali su se etički i bioetički principi, te je osigurana privatnost i zaštita tajnosti podataka.

Prikupljeni podatci statistički su analizirani i prikazani kao apsolutne i postotne vrijednosti, te kao aritmetička sredina ± standardna devijacija. Za analizu statistički značajnih razlika varijabli izraženih u nominalnoj mjernoj ljestvici korišten je hi-kvadrat test. Za testiranje razlika na kontinuiranim varijablama korištena je jednosmjerna analiza varijance i t-test za zavisne uzorke. Statistička značajnost određena je na $p<0,05$. Podatci su analizirani putem statističkog programa SPSS 16 (*Statistical Package for the Social Sciences, version 16.0., SPSS Inc, Chicago IL*).

dents from the Medical High School in Rijeka, 41 students from the Salesian Classical High School Rijeka and 58 students from the Maritime School in Bakar. The study was attended by all students who were in the classroom on the given day.

The questionnaire that was administered had two parts: a socio-demographic questionnaire and a questionnaire on attitudes toward patients with mental health disorders (21).

The study was carried out during regular teaching hours in March and April 2017. Participation in the study was voluntary and anonymous, and the interviewees were informed of the purpose of the study. During the study, ethical and bioethical principles were respected and privacy of data ensured.

The collected data were statistically analysed and presented as absolute and percentage values and as arithmetic middle ± standard deviation. A hi-squared test was used for the analysis of statistically significant differences in the variables expressed in the nominal measure scale. One-way variance analysis and t-test for were used for dependent samples. Statistical significance was set at $p<0.05$. The data were analysed with SPSS 16 (Statistical Package for the Social Sciences, version 16.0, SPSS Inc., Chicago IL).

REZULTATI

Demografski podatci

Podatci koji su prikupljani demografskim obrascem odnose se na školu koju pohađaju, dob, spol i vjersku pripadnost ispitanika, te na bračno stanje i stupanj obrazovanja njihovih roditelja.

Dob i spol

Prosječna dob svih ispitanika je 19,2 godine (SD=0,677); 74 (47,4 %) učenika je muškog, a 82 (52,6 %) ženskog spola. Prosječna dob i

RESULTS

Demographic data

Data that were collected through the demographic form consisted of information on the school the participants attended, their age, gender and religious affiliation s, and the marital status and level of education of their parents.

Age and gender

The average age of all participants was 19.2 years (SD = 0.677), and 74 (47.4%) of them were boys and 82 (52.6%) were girls.

učestalost spola prema školama prikazani su u tablici 1.

Prema podatcima prikazanima u tablici 1 vidljivo je da se učenici statistički značajno razlikuju u dobi (F=69,495, p<0,01) i prema spolu (χ2=59,928, p<0,01) s obzirom na školu koju pohađaju. Učenici iz Medicinske škole značajno su stariji u odnosu na učenike iz Salezijanske gimnazije i učenike Pomorske škole. Učenici Medicinske škole uglavnom su djevojke, dok su učenici Pomorske škole uglavnom mladići.

Vjerska pripadnost

Na pitanje o religijskoj pripadnosti većina učenika, tj. 131 (84 %) se izjasnilo da pripada kršćanskoj vjeroispovijesti. Četvero učenika izjasnili su se kao pripadnici pravoslavne vjeroispovijesti (2,6 %), troje islamske vjeroispovijesti (1,9 %), a trinaestero učenika se izjašnjavaju kao ateisti (8,3 %). Petero (3,2 %) učenika je na pitanje vjerske pripadnosti zaokružilo odgovor „ostalo". Ni jedan učenik nije se izjasnio kao pripadnik budizma ili judaizma. Učestalost vjerske pripadnosti prema školama prikazana je u tablici 2. pri čemu su učenici koji su odgovorili da su pravoslavne vjeroispovijesti pripojeni ispitanicima koji su se izjasnili kao pripadnici kršćanske vjeroispovijesti.

Učenici se ne razlikuju u vjerskoj pripadnosti s obzirom na školu koju pohađaju (χ2=10,225, p>0,05). Naime, u sve tri ispitivane škole većina ispitanika se izjašnjava da su kršćanske vjeroispovijesti.

According to the data presented in **Table 1**, students statistically significantly differed in age (F = 69.495, p <0.01) and gender (χ2 = 59.928, p<0.01) considering the school they were attending. Students from the Medical High School were considerably older than students from the Salesian Classical High School and students of the Maritime High School. Medical school students were mostly girls, while Maritime School students were mostly young men.

Religious affiliation

When asked about their religious affiliation, most students, 131 (84%) of them, stated that they were Catholics. Four students declared themselves as members of the Orthodox Church (2.6%), three of them were members of Islam (1.9%) and thirteen students declared themselves atheists (8.3%). Five (3.2%) of the students chose "other" regarding religious affiliation. No student declared themselves as a member of Buddhism or Judaism. The frequency of religious affiliation in schools is shown in **Table 2**, where Orthodox students were grouped with Catholics under the term "Christian".

Students did not differ in their religious affiliation depending on the school they attended (χ2 = 10.225, p>0.05). In all of the three schools, most students declared themselves as members of the Christian faith.

TABLE 1. Average age and frequency of gender of participants

	Medical High School N=57	Salesian High School N=41	Maritime High School N=58	*Oneway ANOVA*	
	M (SD)	M (SD)	M (SD)	F	p
AGE	19.8 (0.411)	18.8 (0.435)	18.9 (0.595)	69.495	.001
	N (%)	N (%)	N (%)	*Hi-square test*	
GENDER				χ^2	p
Girls	46 (80.7)	27 (65.9)	9 (15.5)	52.928	.001
Boys	11 (19.3)	14 (34.1)	49 (84.5)		

TABLE 2. Review of different religious affiliation of participants in schools

	Medical High School N=57	Salesian High School N=41	Maritime High School N=58	*Hi-square test*	
	N (%)	N (%)	N (%)	χ^2	p
Christian	50 (87.7%)	38 (92.7%)	47 (81.0%)	10.225	.116
Muslim	1 (1.8%)	2 (4.9%)	0		
Atheist	5 (8.8%)	1 (2.4%)	7 (12.1%)		
Other	1 (1.8%)	0	4 (6.9%)		

Obrazovanje roditelja

Prema podatcima prikazanima u tablici 3. vidljivo je da se majke (χ2=52,095) i očevi (χ2=29,252) statistički značajno razlikuju u stupnju obrazovanja s obzirom na školu koju im pohađa dijete. Premda nam hi-kvadrat ne dozvoljava određivanje između kojih skupina postoji statistički značajna razlika, pregledom učestalosti možemo zaključiti da su majke i očevi djece koja pohađaju Gimnaziju češće fakultetski obrazovani, u odnosu na majke i očeve djece koja pohađaju Medicinsku i Pomorsku školu.

Bračni status roditelja

Većina roditelja u ukupnom uzorku ispitanih učenika je u bračnoj zajednici (n=120, 76,9 %). Dvoje učenika imaju roditelje koji žive u izvanbračnoj zajednici (1,3 %). Razvedene roditelje ima 25 učenika (16 %). Sa samohranim ocem živi troje (1,9 %) učenika, a sa samohra-

Parents' education

As shown in **Table 3**, mothers (χ2 = 52,095) and fathers (χ2 = 29,252) significantly differed in the level of education depending on the school their child was attending. Although the hi-squares did not allow determination between the groups, we could conclude through frequency analysis that mothers and fathers of the children attending the Salesian Classical High School were more often college educated than mothers and fathers of children attending the Medical and Maritime High School.

Marital status of parents

Most parents in the total sample of the examined students were married (n = 120, 76.9%). Two students had parents living in extramarital cohabitation (1.3%). 25 students had divorced parents (16%). Only three (1.9%) students were living with a single father, and six (3.8%) with the single mother. The marital status of

TABLE 3. Educational level of mothers and fathers of participants in different schools

	MOTHER			FATHER		
	Medical High School N=57	Salesian High School N=41	Maritime High School N=58	Medical High School N=57	Salesian High School N=41	Maritime High School N=58
	N (%)	N (%)	N (%)	N (%)	N (%)	N (%)
Elementary school	7(12.3)	0	3 (5.2)	0	0	3 (1.9)
High school	43 (75.4)	16 (39.0)	36 (62.1)	47 (82.5)	15 (37.5)	38 (65.5)
College	3 (5.3)	0	10 (17.2)	4 (7.0)	7 (17.5)	8 (13.8)
University and higher	4 (7.0)	25 (61.0)	9 (15.5)	6 (10.5)	18 (45.0)	9 (15.5)
Hi-square test		χ2=52.095 p=.001			χ2=29.252 p=.001	

nom majkom šest učenika (3,8 %). Bračni status roditelja prema školama koje pohađaju ispitanici prikazan je u tablicama 4. i 5., pri čemu su roditelji u izvanbračnoj zajednici svrstani u kategoriju u braku, a odabiri samohrana majka i samohrani otac su svrstani u zajedničku kategoriju samohranih roditelja.

Učenici se ne razlikuju prema bračnom statusu roditelja s obzirom na školu koju pohađaju ($\chi2$=8,336, p>0,05). Većina roditelja učenika iz sve tri škole je u braku (tablica 4.).

STAVOVI PREMA PSIHIJATRIJSKIM BOLESNICIMA

Stavovi prema psihijatrijskim bolesnicima i vrsti bolesti s obzirom na školu koju učenici pohađaju

Kako bismo odgovorili na prvi cilj istraživanja ispitali smo razlikuju li se srednjoškolci u stavovima prema psihijatrijskim bolesnicima s obzirom na škole koje pohađaju. Prosječne vrijednosti stavova prema osobama oboljelima od depresije, shizofrenije i PTSP-a kod učenika različitih škola prikazane su u tablici 5.

parents in the three schools is shown in **Table 4** and in **Figure 5**, where parents in cohabitation were classified as married and both single mothers and single fathers were classified in a common category of single parents.

The students did not differ based on their parents' marital status between the three schools ($\chi2$ = 8.336, p>0.05). Most of the students' parents from all three schools were married (**Table 4**).

ATTITUDES TOWARD PSYCHIATRIC PATIENTS

Attitudes toward psychiatric patients and type of mental health disorders based on the school attended by the student

In order to satisfy the first research objective, we examined whether high school students differed in their attitudes toward psychiatric patients based on the schools they were attending. The average values of high school students' attitudes toward persons suffering from depression, schizophrenia and PTSD are shown in **Table 5**.

TABLE 4. Marital status of parents in different schools

	Medical High School N=57	Salesian High School N=41	Maritime High School N=58	Hi-square test
	N (%)	N (%)	N (%)	$\chi2$=8.336 p=.080
Married	45 (78.9)	36 (87.8)	41 (70.7)	
Divorced	7 (12.3)	3 (7.3)	15 (25.9)	
Single parent	5 (8.8)	2 (4.9)	2 (3.4)	

TABLE 5. Average scores and differences in attitudes toward depression, schizophrenia and PTSD in schools

	Medical High School N=57	Salesian High School N=41	Maritime High School N=58	*Oneway ANOVA*	
	M(SD)	M(SD)	M(SD)	F	p
Depression	33.9 (6.58)	38.0 (5.37)	40.1 (6.34)	14.602	.001
Schizophrenia	38.4 (5.36)	41.6 (5.02)	43.2 (5.46)	11.663	.001
PTSD	34.8 (6.17)	38.8 (4.93)	40.8 (5.57)	16.858	.001

Učenici se statistički značajno razlikuju u stavovima prema oboljelima od depresije (F=14,602, p<0,01), shizofrenije (F=11,663, p<0,01) i PTSP-a (F=16,858, p<0,01). Tukey *post-hoc* testom dobiveno je da učenici Medicinske škole imaju statistički značajno pozitivnije stavove prema oboljelima od depresije, shizofrenije i od PTSP-a u odnosu na učenike koji pohađaju Gimnaziju i učenike koji pohađaju Pomorsku školu. Učenici iz Gimnazije i učenici Pomorske škole ne razlikuju se u svojim stavovima prema oboljelima od depresije, shizofrenije i PTSP-a.

U ukupnom uzorku dobiveno je da učenici postižu najniži rezultat na podljestvici depresije (M=37,3, SD=6,72), zatim na podljestvici PTSP (M=38,1, SD=6,19), a najveći na podljestvici shizofrenije (M=41,0, SD=5,67), tj. učenici imaju najpozitivniji stav prema oboljelima od depresije, zatim slijedi stav prema oboljelima od PTSP-a, a najnegativniji stav iskazuju prema oboljelima od shizofrenije. Kako bismo ispitali jesu li razlike u prosječnom intenzitetu stava spram oboljelih od depresije, shizofrenije i PTSP-a na razini statističke značajnosti primijenjen je niz zavisnih t-testova. Razlike u intenzitetu stavova s obzirom na različite bolesti provjerene za su za svaku školu posebno, te za ukupan uzorak. S obzirom da razlike u intenzitetu stavova unutar škola imaju isti smjer (odnosno razlike u stavovima između bolesti jednake su za sve tri škole) u tablici 6. prikazani su rezultati koji se odnose na ukupan uzorak.

Prema podatcima prikazanima u tablici 6. vidljivo je da je prosječna vrijednost stava prema

Students differed significantly in their attitudes toward depression (F = 14.602, p<0.01), schizophrenia (F = 11.663, p<0.01) and PTSD (F = 16.858, p<0.01). Tukey's post-hoc test showed that the students from the Medical High School had significantly more positive attitudes toward depression, schizophrenia and PTSD than students attending the Salesian Classical High School and students attending the Maritime High School. Salesian High School students and Maritime High School students did not differ in their attitudes toward people suffering from depression, schizophrenia or PTSD.

In the overall sample, a lower score was recorded on the depression subscale (M = 37.3, SD = 6.72) then on the PTSD subscale (M = 38.1, SD = 6.19), and the highest score was noted on the schizophrenia subscale (M = 41.0, SD = 5.67), which means that students had the most positive attitudes toward depressed patients, followed by patient with PTSD s, and the most negative attitudes were expressed toward patients with schizophrenia. In order to examine whether the differences in the displayed attitudes toward depression, schizophrenia and PTSD were at the level of statistical significance, a number of dependent t-tests were applied. Differences in the intensity of attitudes were checked for each school separately and for the total sample. Given that differences in the attitudes toward psychiatric disorders within schools had the same direction, the results shown in **Table 6** represent the total sample.

According to data presented in **Table 6**, we can see that the average score in attitudes toward pa-

TABLE 6. Display of differences in the attitudes toward depression, schizophrenia and PTSD in the total number of participants

	Total number of participants N=156			
	M(SD)		t	p
Depression	37.3 (6.72)	**Depression-Schizophrenia**	-8.109	.001
Schizophrenia	38.1 (6.19)	**Depression-PTSD**	-1.703	.090
PTSD	41.0 (5.67)	**Schizophrenia -PTSD**	6.730	.001

oboljelima od shizofrenije statistički značajno negativnija u odnosu na prosječne vrijednosti stavova prema oboljelima od depresije i PTSP-a. Prosječne vrijednosti stavova prema oboljelima od depresije i oboljelima od PTSP-a se ne razlikuju.

Stavovi prema psihijatrijskim bolesnicima i vrsti bolesti s obzirom na spol ispitanika

Ispitano je također postoji li statistički značajna razlika u stavovima prema oboljelima od depresije, shizofrenije i PTSP-a s obzirom na spol ispitanika. Prosječne vrijednosti stavova za muške i ženske ispitanike te značajnost razlike prikazane su u tablici 7.

Učenici se statistički značajno razlikuju u stavovima prema oboljelima od depresije, shizofrenije i PTSP-a s obzirom na spol. Djevojke imaju statistički značajno pozitivnije stavove prema oboljelima od sve tri bolesti u odnosu na mladiće. Međutim, s obzirom da većina djevojaka pohađa medicinsku školu, a većina mladića pomorsku srednju školu postoji mogućnost da su dobivene razlike u spolu odraz specifičnosti srednje škole koju ispitanici pohađaju (od ranije je utvrđeno da učenici srednje medicinske imaju pozitivnije stavove).

Kako bismo provjerili jesu li razlike u spolu odraz vrste škole koje ispitanici pohađaju, ispitali smo postoje li razlike između djevojaka i mladića koji pohađaju Gimnaziju s obzirom da je to jedini uzorak u kojem je spol donekle podjednako zastupljen i dozvoljava statističku

tients with schizophrenia was statistically lower compared with the average scores in attitudes toward patients with depression and PTSD. The average values of attitudes toward patients with depression and patients with PTSD did not differ.

Attitudes toward psychiatric patients and mental health disorders according to the gender of participants

We analysed whether there were statistically significant differences in attitudes toward depression, schizophrenia and PTSD in relation to the gender of participants. The average scores of attitudes in male and female participants and the significance of differences are shown in **Table 7**.

Students differed significantly in attitudes toward depression, schizophrenia and PTSD according to their gender. Girls had statistically more positive attitudes toward patients suffering from all three disorders than boys. However, since most girls attended the Medical High School and most boys the Maritime High School, there was a possibility that gender differences in attitudes depended on the high school attended by the participants (since it had been shown earlier that Medical High School students had more positive attitudes).

In order to check if gender differences were the a reflection of the school, we examined whether there were differences between girls and boys attending the Salesian High School since it was the only sample in which both genders were somewhat equally represented and allowed

TABLE 7. Average scores and differences in attitudes toward depression, schizophrenia and PTSD according to the gender of participants in the whole sample

	Boys N=74	Girls N=82		
	M (SD)	M (SD)	t	p
Depression	38.8 (6.89)	35.9 (6.28)	2.784	.006
Schizophrenia	42.5 (5.48)	39.7 (5.53)	3.176	.002
PTSD	40.1 (5.93)	36.2 (5.84)	4.187	.000

usporedbu. T-testom za nezavisne uzorke nije dobivena značajna uloga spola u prosječnim stavovima kod učenika koji pohađaju Gimnaziju (tablica 8.).

Stavovi prema psihijatrijskim bolesnicima i vrsti bolesti s obzirom na religijsku pripadnost

Jedan od ciljeva istraživanja bio je ispitati razlikuju li se učenici u stavovima prema psihijatrijskim bolesnicima s obzirom na religijsku pripadnost. Od ponuđenih kategorija većina učenika se izjasnila kao pripadnici kršćanstva (86,6 %), 13 kao ateisti (8,3 %), troje (1,9 %) islamske vjeroispovijesti, pet je odgovorilo ostalo, dok niti jedan učenik nije bio budist ili židov. S obzirom da u pojedinim kategorijama broj učenika ne prelazi 5, usporedba u stavovima spram psihijatrijskih bolesnika moguća je samo između onih učenika koji su se izjasnili za kršćanstvo i učenika koji se izjašnjavaju kao ateisti.

Prosječne vrijednosti te razlike u stavovima između učenika koji su kršćani i onih koji su ateisti prikazane su u tablici 9.

statistical comparison. T-test for independent samples did not show significant gender role differences in attitudes of students attending Salesian Classical High School (**Table 8**).

Attitudes toward psychiatric patients and mental health disorders according to religious affiliation

One of the aims of the study was to examine whether students differed in attitudes toward psychiatric patients in regard to the students' religious affiliation. Most students declared themselves Catholic (86.6%), 13 of them declared themselves atheists (8.3%), only three (1.9%) were Muslim and five of them answered "other"; no students were Buddhist or Jewish. Since the number of students in some categories did not exceed 5, a comparison of attitudes toward psychiatric patients was only possible between those students who declared themselves Catholics and atheists.

The average scores of attitudes and of difference between the students who were Catholics and those who were atheists are shown in **Table 9**.

TABLE 8. Average scores and differences in attitudes toward patients with depression, schizophrenia and PTSD according to gender among students of the Salesian Classical High School

	Boys N=14	Girls N=27	*T-test*	
	M (SD)	M (SD)	t	p
Depression	38.9 (5.12)	37.6 (5.53)	.773	.444
Schizophrenia	42.7 (3.15)	41.0 (5.73)	1.015	.316
PTSD	40.2 (5.68)	38.2 (4.47)	1.191	.241

TABLE 9. Average scores and differences in attitudes toward depression, schizophrenia and PTSD in Catholics and atheists

	Catholics N=135	Atheists N=13	*T-test*	
	M (SD)	M (SD)	t	p
Depression	37.7 (6.4)	35.3 (9.78)	1.208	.332
Schizophrenia	41.2 (5.40)	40.1 (7.94)	.710	.272
PTSD	38.1 (6.02)	37.8 (7.19)	.202	.955

Premda učenici koji se izjašnjavaju kao ateisti u prosjeku imaju pozitivnije stavove spram psihijatrijskih bolesnika u odnosu na učenike koji se izjašnjavaju kao kršćani, između njih nema razlika.

Stavovi prema psihijatrijskim bolesnicima i vrsti bolesti s obzirom na bračni status roditelja

Kako bi se ispitalo razliku učenika u stavovima prema psihijatrijskim bolesnicima s obzirom na bračni status roditelja, ta kategorija je dihotomizirana. Naime, za potrebe usporedbe napravljene su dvije kategorije bračnog statusa: živi s oba roditelja (oženjeni i izvanbračna zajednica) i živi samo s jednim roditeljem (razvedeni, samohrani otac i samohrana majka).

Učenici se ne razlikuju u prosječnim stavovima prema psihijatrijskim bolesnicima s obzirom na to žive li s oba ili samo s jednim roditeljem (tablica 10.).

Stavovi prema psihijatrijskim bolesnicima i vrsti bolesti s obzirom na obrazovanje roditelja

Kako bi se ispitalo razliku u stavovima s obzirom na stupanj obrazovanja majke i oca, kategorija obrazovanja je dihotomizirana na način da osnovna škola i srednja škola čine jednu kategoriju obrazovanja, a viša škola i visoka škola drugu kategoriju obrazovanja. Prosječne vrijed-

Although on average atheist students had more positive attitudes toward psychiatric patients compared with students who profess themselves Catholics, **there were no statistically significant differences between them**.

Attitudes toward psychiatric patients and mental health disorders based on parents' marital status

In order to examine the difference between the students' attitudes toward psychiatric patients with regard to their parents' marital status, this category was split into two categories of marital status: students living with both parents (married and cohabitating) and students living with only one parent (divorced, single father or single mother).

Students did not differ in average attitudes toward psychiatric patients whether they lived with both or only with a single parent (**Table 10**).

Attitudes toward psychiatric patients and mental health disorders due to parents' level of education

In order to examine the difference in attitudes according to the educational levels of the parents, the education levels of the parents were split into two categories, the first being elementary and secondary school and the second college and university education. Average scores of attitudes toward depression, schizophrenia

TABLE 10. Average scores and differences in attitudes toward depression, schizophrenia and PTSD based on the marital status of the parents of the participants

	Both parents N=122	Single Parent N=34	*T-test*	
	M (SD)	M (SD)	t	p
Depression	37.5 (6.74)	36.6 (6.69)	.680	.497
Schizophrenia	41.1 (5.69)	40.9 (5.68)	.166	.868
PTSD	38.2 (6.3)	37.6 (5.87)	.467	.641

nosti stavova prema depresiji, shizofreniji i PTSP-u s obzirom na stupanj obrazovanja majke prikazane su u tablici 11.

Učenici se ne razlikuju u svojim stavovima prema psihijatrijskim bolesnicima s obzirom na obrazovni status majke u odnosu na depresiju i PTSP, dok je kod shizofrenije dobivena statistički značajna razlika. Učenici čije majke imaju viši obrazovni status imaju negativnije stavove prema oboljelima od shizofrenije (tablica 11.).

Prosječne vrijednosti stavova prema oboljelima od depresije, shizofrenije i PTSP-a s obzirom na stupanj obrazovanja oca ispitanika (tablica 12.).

Učenici se ne razlikuju u svojim stavovima prema psihijatrijskim bolesnicima sobzirom na obrazovni status oca u odnosu na oboljele od depresije, shizofrenije i PTSP-a (tablica 12.).

and PTSD according to the mother's degree of education are shown in **Table 11**.

Students did not differ in their attitudes toward psychiatric patients based on their mother's level of education in relation to depression and PTSD, but there was a statistically significant difference for schizophrenia. Students whose mothers had higher levels of education demonstrated more negative attitudes toward patients with schizophrenia (**Table 11**).

The average scores of attitudes toward depression, schizophrenia and PTSD according to the degree of education of the father of the respondent are shown in **Table 12**.

Students did not differ in their attitudes toward psychiatric patients suffering from depression, schizophrenia or PTSD based on the father's level of education (**Table 12**).

TABLE 11. Average scores and differences in attitudes toward depression, schizophrenia and PTSD according to the mother's level of education

	Elementary & Highschool N=105	College & University N=51	*T-test*	
	M (SD)	M (SD)	t	p
Depression	36.9 (6.98)	38.0 (6.13)	-.956	.341
Schizophrenia	40.1 (5.42)	43.0 (5.68)	-3.183	.002
PTSD	37.6 (6.61)	38.9 (5.19)	-1.244	.215

TABLE 12. Average scores and differences in attitudes toward depression, schizophrenia and PTSD according to the father's level of education

	Elementary & Highschool N=103	College &University N=52	*T-test*	
	M (SD)	M (SD)	t	p
Depression	37.1 (6.36)	37.6 (7.48)	-.417	.677
Schizophrenia	40.5 (6.13)	41.9 (4.59)	-1.452	.149
PTSD	37.4 (6.38)	39.3 (5.74)	-1.727	.086

RASPRAVA

U istraživanju koje je obuhvatilo 154 učenika završnih razreda triju srednjih škola na području Primorsko–goranske županije statistički je

DISCUSSION

In a survey involving 154 students of the final grades in three high schools in the area of Primorsko-Goranska County, a statistically signif-

značajna razlika u prosječnoj dobi učenika, i to za godinu dana u korist učenika za zanimanje medicinska sestra/medicinski tehničar opće njege (medicinska sestra) Medicinske škole u Rijeci u odnosu na učenike Pomorske škole Bakar i Salezijanske gimnazije. Razlog za godinu dana razlike u dobi učenika je taj što se učenici za zanimanje medicinska sestra školuju pet godina.

Prema spolu postoji velika razlika u broju djevojaka i mladića koji se obrazuju u ovim školama. Ipak, razlika je najveća u Pomorskoj školi gdje se učenici obrazuju većinom za tradicionalno „muška" zanimanja dok je u medicinskoj školi u zanimanju medicinska sestra ta razlika nešto manja. U posljednjih 30-tak godina broj mladića koji se obrazuju za to „tradicionalno žensko" zanimanje je u značajnom porastu.

Pretpostavka da će razlika u stavovima srednjoškolaca prema psihijatrijskim bolesnicima biti statistički značajna s obzirom na različitost srednjih škola koje pohađaju je točna. Učenici iz Gimnazije i učenici Pomorske škole ne razlikuju se u svojim stavovima prema oboljelima od depresije, shizofrenije i PTSP-a. Učenici Medicinske škole imaju statistički značajno pozitivnije stavove prema oboljelima od depresije, shizofrenije i od PTSP-a u odnosu na učenike koji pohađaju Gimnaziju i učenike koji pohađaju Pomorsku školu. To može biti tako jer učenici za zanimanje medicinska sestra tijekom svog formalnog obrazovanja u četvrtom razredu imaju predmet Zdravstvena njega - zaštita mentalnog zdravlja u obimu od 37 sati teorije i 37 sati vježbi, a u petom razredu predmet Zdravstvena njega psihijatrijskih bolesnika u obimu od 34 sati teorije i 102 sata vježbi. Tijekom nastave učenici vježbe odrađuju na Klinici za psihijatriju KBC-a Rijeka te su u kontaktu s psihijatrijskim bolesnicima, djelatnicima i obiteljima bolesnika. Teoriju da dobra edukacija utječe na smanjivanje stigme potkrepljuju finski autori (16) istraživanjem iz 2016. godine,

icant difference in average age was observed among medical nursing students from the Medical High School in Rijeka compared with the students of the Bakar Maritime High School and the Salesian High School. The explanation for this can be found in the longer duration of schooling for medical nurses in the Medical High School (5 years of educational curriculum – one year more than the other two schools).

Substantial gender differences were noted regarding the number of girls and boys who were being educated in the schools. Male predominance was characteristic of the maritime school where the students are traditionally educated for "male" professions, while this gender traditionalism was decreasing in the nursing school. In the last 30 years, the number of male students who have being educated for this "traditionally female" occupation has increased significantly.

The hypothesis that there will be a statistically significant difference in the attitudes of high school students toward psychiatric patients depending on the high schools they were attending proved to be correct. Salesian High School students and Maritime High School students did not differ in their attitudes toward people suffering from depression, schizophrenia or PTSD. Students of the Medical High School had significantly more positive attitudes toward depression, schizophrenia and PTSD than the students attending Salesian High School and students attending the Maritime High School. This may be because nursing students had substantial teaching hours on mental health care during their formal education in the 4th grade, consisting of 37 hours of theory and 37 hours of practicals, and in the 5th grade they receive education on psychiatric health care of psychiatric patients comprising 34 hours of theory and 102 hours of practicals. During these courses, students take their practicals at the Department of Psychiatry in Rijeka Clinical Hospital Center and are in contact with mental health workers, psychiatric patients and their families. The notion that good education

koji su predložili pojačanu edukaciju o mentalnom zdravlju formalnim obrazovanjem medicinskih sestara iz područja mentalnog zdravlja u kurikulumu zdravstvenog odgoja u osnovnim i srednjim školama.

Pretpostavka da će razlika u stavovima srednjoškolaca prema oboljelima od shizofrenije biti statistički značajna u odnosu na oboljele od depresije i posttraumatskog stresnog poremećaja također je potvrđena. Unatoč značajnoj razlici u stavovima između škola, najizraženiji negativni stavovi srednjoškolaca su prema oboljelima od shizofrenije, potom od posttraumatskog stresnog poremećaja, te najmanje negativni prema oboljelima od depresije. Ovi rezultati su u skladu s rezultatima istraživanja koje su proveli britanski istražitelji 2014. godine (22) i koje je pokazalo da su stavovi društva prema osobama sa shizofrenijom daleko više stigmatizirajući nego prema osobama s anksioznošću i depresijom. Shizofrenija je u društvu prepoznata kao najteža psihijatrijska bolest, s najvećom stigmatizacijom i diskriminacijom, što potvrđuje i istraživanje hrvatskih autora (23), koji su proveli istraživanje o stigmatizaciji pacijenata oboljelih od shizofrenije i koje je pokazalo da nema razlike između opće populacije, te zdravstvenih djelatnika i budućih zdravstvenih djelatnika, iako su medicinske sestre zaposlene na psihijatrijskim odjelima pokazale veći stupanj prihvaćanja takvih pacijenata i veće razumijevanje prema samoj bolesti. Nažalost, shizofrene osobe i same sebe u velikom stupnju stigmatiziraju, kako pokazuju rezultati istraživanja hrvatskih autora (24).

Pretpostavku da razlika u stavovima srednjoškolaca prema psihijatrijskim bolesnicima nije statistički značajna s obzirom na spol nije moguće potvrditi ovim istraživanjem. Kako su većina ispitanika ženskog spola učenice za zanimanje medicinska sestra nije ih objektivno uspoređivati s učenicima muškog spola koji su većinom učenici pomorske škole. Iako su

affects the reduction of stigma was supported by Finnish authors (16) in a study from 2016, who suggested that enhanced mental health education through formal nursing education also be added to the curriculum of health education in primary schools and high schools.

The hypothesis that the difference in high school students' attitudes toward schizophrenia patients will be statistically significant compared with attitudes to those suffering from depression and posttraumatic stress disorder was also confirmed. Despite a significant difference in attitudes between schools, the most pronounced negative attitudes were toward patients with schizophrenia, followed by patients with posttraumatic stress disorder, and the least negative attitudes were shown toward patients with depresssion. These results are consistent with the results of the study conducted by British investigators (22) in 2014, which showed that the attitudes of society toward people with schizophrenia are far more stigmatizing than attitudes toward persons with anxiety disorders or depression. Schizophrenia has been recognized in society as the most severe psychiatric illness with the greatest stigma and discrimination, as confirmed in a study by Croatian authors (23) who examined the stigmatization of schizophrenic patients. The study found no significant difference in attitudes between the general population and healthcare workers, although nurses employed in psychiatric department showed a greater degree of acceptance of patients with schizophrenia and greater understanding of the disease itself. Unfortunately, the patients suffering from schizophrenia self-stigmatize to a great degree, as demonstrated in a study by Croatian authors (24).

The hypothesis that the difference in the attitudes of high school students toward psychiatric patients will not be statistically significant in terms of gender could not be confirmed in this study. Since most female participants were nursing school students, we could not objective-

neka istraživanja opće populacije pokazala da muškarci imaju izraženije negativne stavove od žena (25). U nekim istraživanjima stavova javnosti o osobama s mentalnim poremećajima, dokazano je da nema statističke značajnosti među spolovima (20). Usporedba podataka dobivenih od gimnazijalaca kojih je u podjednakom broju prema spolu, nije pokazala razlike između stavova po spolu. Da bi se istražila razlika u stavovima među spolovima potrebno je proširiti istraživanje na mnogo veći broj ispitanika, te iz njega izuzeti učenike medicinskih škola.

Potvrđena je pretpostavka da razlika u stavovima srednjoškolaca prema psihijatrijskim bolesnicima neće biti statistički značajna s obzirom na religijsku pripadnost. Premda učenici koji se izjašnjavaju kao ateisti u prosjeku imaju pozitivnije stavove spram psihijatrijskih bolesnika u odnosu na učenike koji se izjašnjavaju kao kršćani, ne postoje među njima razlike. Jean Decety s Univerziteta u Chicagu i njegovi suradnici (26) proveli su 2015. godine istraživanje u 6 zemalja što je dokazalo da su djeca odrasla u obitelji ateista značajno više empatična i altruistična. Kako se tek 8,3 % (13 učenika) ispitanika u ovom istraživanju izjasnilo kao ateist, ovi rezultati se ne mogu uzeti kao pouzdani, te bi bilo vrijedno istražiti hipotezu na većem uzorku.

Potvrđena je pretpostavka da razlika u stavovima srednjoškolaca prema psihijatrijskim bolesnicima neće biti statistički značajna s obzirom na bračni status roditelja. Učenici se ne razlikuju u prosječnim stavovima prema psihijatrijskim bolesnicima s obzirom na to žive li s oba ili samo s jednim roditeljem. Kako na stavove srednjoškolaca osim roditelja utječu društvo i mediji, često puta i negativno, o čemu se navodi i u radu hrvatskog autora (27), razumljivo je da razlika stavova srednjoškolaca prema psihijatrijskim bolesnicima nije značajna s obzirom na bračni status roditelja. Moguće je da bi se daleko drugačiji rezultati dobili da je istraživaly compare them with male students who were predominantly maritime school students. Although some surveys of the general population have shown that men have more pronounced negative attitudes toward the mentally ill than women (25), others have found no statistically significant difference among the genders (20). **Comparison of data on differences in attitudes according to gender obtained from Salesian High School students did not show differences in attitudes by gender**. In order to explore the difference in attitudes due to gender, it would be necessary to extend the study to a much larger sample and probably exclude students from medical high school.

The hypothesis that the difference in attitudes of high school students toward psychiatric patients will not be statistically significant based on the religious affiliation of the students was confirmed. Although atheist students on average had more positive attitudes toward psychiatric patients compared with students who professed to be Christian, there were no statistically significant differences between them. Jean Decety from the University of Chicago and his associates (26) conducted a survey in 6 countries in 2015, which demonstrated that children in families of atheists were significantly more empathetic and altruistic. As only 8.3% of the participants in the current study (13 students) declared themselves atheists, these results cannot be taken as reliable, and it would be worthwhile to investigate this topic on a larger sample.

The hypothesis that the difference in the attitudes of high school students toward psychiatric patients will not be statistically significant depending on the marital status of the parents was also confirmed. Students did not differ in average attitudes toward psychiatric patients whether they lived with both or only with one parent. As the attitudes of high school students, apart from parents, are unfortunately also being negatively affected by the society and the media, which was also discussed in a study

nje provedeno među učenicima nižih razreda osnovnih škola kada je utjecaj roditelja na djecu daleko veći nego kod srednjoškolaca završnih razreda. Ipak, tada bi trebalo prvo ispitati stavove roditelja i utvrditi razlikuju li se stavovi roditelja u braku od stavova samohranih roditelja, pa tek potom ispitati stavove učenika, te ih povezati.

Pretpostavka da će razlika u stavovima srednjoškolaca prema psihijatrijskim bolesnicima biti statistički značajna s obzirom na obrazovanje roditelja je manjim dijelom potvrđena. S obzirom na obrazovni status očeva učenici se ne razlikuju u svojim stavovima prema psihijatrijskim bolesnicima u odnosu na depresiju, shizofreniju i PTSP. Učenici se ne razlikuju u svojim stavovima prema psihijatrijskim bolesnicima s obzirom na obrazovni status majke u odnosu na depresiju i PTSP, dok je kod shizofrenije dobivena statistički značajna razlika. Učenici čije majke imaju viši obrazovni status (24,4 %) imaju negativnije stavove prema oboljelima od shizofrenije, suprotno očekivanjima da će djeca roditelja s višim stupnjem obrazovanja imati manje izražene negativne stavove prema shizofrenim bolesnicima, jer bi znanje trebalo smanjiti predrasude. Vjerojatno za to postoji više razloga, a jedan od mogućih je da te obitelji imaju shizofrene bolesnike, pa postoji jaka samostigmatizacija shizofrenih bolesnika i njihovih obitelji (4,24).

ZAKLJUČAK

Iz svega navedenog moguće je zaključiti kako postoji značajna stigmatizacija psihijatrijskih bolesnika među učenicima određenih završnih razreda srednjih škola Primorsko-goranske županije. Značajno više su stigmatizirani shizofreni bolesnici nego depresivni i PTSP. Najmanje stigmatiziraju duševne bolesnike učenici medicinske škole koji se obrazuju za zanimanja medicinska sestra/tehničar što je u skladu s postavkom kako na stavove utječe

by Croatian author (27), it was understandable that the difference in attitudes of high school stands toward psychiatric patients was not significantly different based on the marital status of their parents. It is possible that far different results would have been obtained if the survey was conducted among primary school students, as the influence of parents on children is more significant at that age. In such a study, the parents' attitudes should be examined first, taking into consideration the attitudes of both married and single parents and then comparing their attitudes with the attitudes of students.

The hypothesis that the difference in attitudes of high school students toward psychiatric patients will be statistically significantly different depending on their parents' education was confirmed to a certain extent. Based on the educational status of their fathers, students did not differ in their attitudes toward psychiatric patients regarding depression, schizophrenia or PTSD. Students did not differ in their attitudes toward psychiatric patients based on their mother's educational status regarding depression and PTSD, but attitudes toward schizophrenia were significantly different. Students whose mothers had higher educational status (24.4%) had more negative attitudes toward patients suffering from schizophrenia – contrary to expectation that children of parents with higher education would have less pronounced negative attitudes toward schizophrenia, as knowledge should reduce prejudice. There are probably several reasons for these results: some members of the family may have suffered from schizophrenia and, as can be seen from the papers mentioned above, there is a strong trend of self-stigmatization in patients with schizophrenia and their families. The Japanese have therefore have changed the name of schizophrenia to "disorder of integration" for the purpose of stigmatization reduction, which has led to a significant reduction of the stigma in society, healthcare workers, families and the patients themselves (4,24).

znanje. Zato je potrebna znatno veća edukacija mladih koji se nalaze na pragu zrelosti i započimanja odraslog načina života. Dužnost je zajednice da im omogući život bez predrasuda za dobrobit sviju.

CONCLUSION

Based on the results described above, we can conclude that there is significant stigmatization of psychiatric patients among final year high school students of Primorsko-goranska County. Patients with schizophrenia were significantly more stigmatized than depressed patients and patients with PTSD. Patients with mental health disorders were least stigmatized by medical high school students who were educated in nursing programs, which is consistent with the notion that knowledge affects the attitudes towards mental illness. It is therefore necessary to significantly improve the education of young people who are at the threshold of maturity and have just started to form their adult lifestyle. It is the duty of the community to enable them to live without prejudice for the benefit of all.

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Miroslav Goreta

Prilozi za univerzalnu teoriju i praksu prisilnog psihijatrijskog tretmana

/ Contributions to universal theory and practice of involuntary psychyatric treatment

Početkom ove, 2018. godine, Medicinska naklada i Klinika za psihijatriju Vrapče objavile su knjigu prim. dr. sc. Miroslava Gorete **Prilozi za univerzalnu teoriju i praksu prisilnog psihijatrijskog tretmana.** Ovo je deveta Goretina samostalna knjiga (uz 13 onih u kojima je suurednik i koautor) koja potvrđuje znanu činjenicu da „Goreta još ima što reći". Radi se o knjizi od oko stotinjak stranica što naizgled djeluje da se radi o maloj knjizi, no po sadržaju, njegovoj obradi i pristupu temi, radi se o velikoj knjizi.

Knjiga sadrži 24 poglavlja i dva dodatka. Pojedina poglavlja obrađuju teme kao što su internacionalni i nacionalni dokumenti koji se odnose na regulaciju prisilnog psihijatrijskog tretmana, psihijatrijskog tretmana s informiranim pristankom *lege artis*, tretmana s pristankom koji ne ispunjava kriterije informiranog pristanka, tretmana bez pristanka i bez prisile te zamjenskog pristanka na psihijatrijski tretman. Nadalje, opisuje se procjena opasnosti pacijenta koji otklanja dobrovoljni tretman te prisilni tretman u izvaninstitucijskim, psihijatrijskim, ne-psihijatrijskim ili samo parcijalno psihijatrijskim institucijama, zatim prisilna hospitalizacija bez prisilnog tretmana i provođenje psihijatrijskog tretmana osoba koje mu se ne protive, iako nemaju očuvane kapacite-

At the beginning of the year 2018, Medicinska naklada and the University psychiatric hospital Vrapče published a book by prim. dr. sc. Miroslav Goreta **"Prilozi za univerzalnu teoriju i praksu prisilnog psihijatrijskog tretmana"** (**Contributions to the universal theory and practice of involuntary psychiatric treatment**). This is the author's ninth independent book (along with 13 other co-authors and co-editors), confirming the well-known fact that "Goreta still has something to say".

It is a book of about a hundred pages, which makes it seem a small book, but its content, analysis and approach to the topic make it a large book.

The book is composed of 24 chapters and two appendixes. Each chapter analyses topics such as international and national documents which are related to the regulation of involuntary psychiatric treatment, psychiatric treatment with *lege artis* informed consent, treatment with consent that does not meet the criteria for informed consent, treatment without consent that is not forced and informed consent by proxy. It further describes the evaluation of dangerousness of patients who decline voluntary treatment, as well as involuntary treatment outside of institutions, within psychiatric institutions and non-psychiatric and partially psychiatric institutions; it looks at in-

te za davanje informiranog pristanka. Slijede središnje teme ove knjige u poglavljima naslovljenim: *Apsolutno ukidanje psihijatrijskog tretmana osoba koje nisu dale informirani pristanak, Ukidanje svih oblika prisilnog forenzičko-psihijatrijskog tretmana i Ukidanje kazneno-pravne forenzičke psihijatrije* te poglavlja o aproksimativnim procjenama koristi i štete uvjetovane ukidanjem svih oblika prisilnog psihijatrijskog tretmana. Nakon upozorenja na problem indikacijske nesigurnosti pri preporučivanju bilo kojeg oblika psihijatrijskog tretmana, indikacijskog minimuma za parcijalno zadržavanje prisilnog psihijatrijskog tretmana i eliminacije svih nemedicinskih čimbenika pri indiciranju i provedbi prisilnog psihijatrijskog tretmana, piše o utvrđivanju moguće odgovornosti za sve oblike neopravdanog prisilnog psihijatrijskog tretmana, a sve promatra u kontekstu načela razmjernosti kao ključnog kriterija za procjenu opravdanosti prisilnog psihijatrijskog tretmana. Slijedi kritički pogled prema budućnosti, odnosno razmatranje očekivanja u odnosu na daljnju primjenu ili potpuno ukidanje prisilnog psihijatrijskog tretmana. Na kraju su dva dodatka: *Smjernice o članku 14. Konvencije o pravima osoba s invaliditetom: Pravo na slobodu i sigurnost osoba s invaliditetom, Odbor za prava osoba s invaliditetom, usvojene tijekom 1.4· sjednice Odbora održane u rujnu 2015. godine i Pravilnik o vrstama i načinu primjene mjera prisile prema osobi s težim duševnim smetnjama koji je 2014. godine donio ministar zdravstva RH („Narodne novine", 76/2014*), dva aktualna dokumenta koji kao antipodi ilustriraju teorijsku (prvi prilog) i praktičnu (drugi prilog) dimenziju o kojoj je riječ u knjizi.

Poznavateljima problematike primjene prisilnih mjera u svakodnevnoj psihijatrijskoj praksi, knjiga je lako čitljiva, jasna, prožeta dovoljnim brojem argumenata za svaku tvrdnju koju iznosi. Goreta naglašava da UN-ova Konvencija o pravima osoba s invaliditetom, a posebno Smjernice o čl. 14. *Konvencije o pravima osoba s*

voluntary hospitalizations without the use of involuntary treatment and the treatment of those who do not protest against treatment although they do not have the capacity to give informed consent. Following this are the central themes of this book addressed in chapters headed: "Apsolutno ukidanje psihijatrijskog tretmana osoba koje nisu dale informirani pristanak", "Ukidanje svih oblika prisilnog forenzičko-psihijatrijskog tretmana" and "Ukidanje kazneno-pravne forenzičke psihijatrije" ("The absolute abolition of psychiatric treatment of persons who have not given informed consent", "Abolition of all forms of involuntary forensic-psychiatric treatment" and "The abolition of penal-judicial forensic psychiatry"), and chapters evaluating the benefits and damage that could arise from abolition of all forms of involuntary psychiatric treatment. After warning of the problem posed by indication uncertainty when recommending any form of psychiatric treatment, the indication minimum for partial involuntary psychiatric treatment and elimination of all non-medical factors when indicating and implementing involuntary psychiatric treatment, the author also discusses the possible liability for all forms of unjustified involuntary psychiatric treatment; all of this is examined in the context of the proportionality principle as the key criteria for assessing the justification of involuntary psychiatric treatment. This is followed by a critical look into the future, a consideration of the expectations for further implementation or the complete abolishment of involuntary psychiatric treatment. Two appendixes are at the end of the book:

(Guidelines for article 14. Convention on the rights of persons with disabilities: liberty and security of person, Committee for the rights of persons with disabilities, adopted during the 1.4 Committee meeting held in September of the year 2015 and the Regulations for the types and ways to implement involuntary measures towards persons with serious mental illnesses, which was passed by the minister of health of the Republic of Croatia "Narodne novine", 76/2014); the-

invaliditetom Odbora za prava osoba s invaliditetom, usvojene u rujnu 2015. godine inzistira na apsolutnom ukidanju psihijatrijskog tretmana osoba koje nisu dale informirani pristanak. Iz toga izvlači zaključke, a sve na osnovi svog iznimno bogatog psihijatrijskog iskustva i teorijskog znanja, kojima upozorava da „to neće ići". Naime **apsolutnom** zabranom primjene bilo kakvih mjera prisile nad osobama s duševnim smetnjama koje su osobe s invaliditetom, ne bi se samo ukinula višestoljetna praksa, nego i paradigma pristupa duševnom bolesniku čija psihopatologija determinira ne samo potencijalno opasno ponašanje, nego narušava i mogućnost izražavanja slobodne volje, a što je simptom bolesti.

Za ovu knjigu bi se moglo reći da je to „mala velika knjiga". Mala je po obimu, no velika po sadržaju, a još veća po načinu kako autor pristupa problemu prisilnog psihijatrijskog tretmana. Goreta je, naime, u hrvatskoj psihijatrijskoj javnosti poznat kao jedan od „najliberalnijih" hrvatskih psihijatara. Pa, onda, kada on problematizira neku zakonsku odredbu, a sada i konvenciju UN, koja, ne samo na prvi pogled, nego i svojim duhom i intencijom, nastoji štititi osobe s duševnim smetnjama, u ovom slučaju još uz to i one koje su osobe s invaliditetom zbog mentalnih problema, onda „tu ima nešto". Velika je ovo knjiga, a velik je i njezin autor, što teškoj temi pristupa izrazito oprezno. Taj oprez na trenutak bi čitatelja mogao dovesti u zabludu – da autor podržava ono što kritizira, no radi se o tome da on ne odbacuje problematične postavke Konvencije i Odbora u totalu - nego sve ono što je teorijski i praktično prihvatljivo, a Goreta zna što je to, i, s obzirom na svoj habitus, na to ima pravo, dograđuje, opravdava i preporuča za primjenu u praksi. Zato svakom onom koji se ne slaže s njegovim stavovima, koji ih kritizira i odbacuje, prije nego to učini preporučujem da se raspita na osnovi čega ih je Goreta zasnovao, zašto ih zagovara! (Međutim, veći je problem s onima

se two documents, like antipodes, illustrate the theoretical (first appendix) and practical (second appendix) dimension which the book discusses.

For those who have an understanding of the problems of implementing involuntary measures in everyday psychiatric practise, the book is easily readable, clear and imbued with enough arguments for every claim it makes. Goreta emphasizes that the UN Convention on the rights of persons with disabilities, especially the guidelines for article 14, Convention on the rights of persons with disabilities, Committee for the rights of persons with disabilities, adopted in September 2015, insists on the absolute abolishment of psychiatric treatment of persons who do not give informed consent. Based on his very rich psychiatric experience and theoretical knowledge, he warns in his conclusions that this is "not going to work". Absolute prohibition of any and all involuntary psychiatric measures towards persons with mental disorders, who are also persons with disabilities, would not only put a ban on many centuries worth of practice but also on the paradigm approach to persons with mental illness, who's psychopathology determines not only their potentially dangerous behaviour but also disrupts their ability to express free will, this being a symptom of their disease.

This book can be described as being a "big little book". Small in size but large in content and even greater in the way the author approaches the problem of involuntary psychiatric treatment. Goreta is known in the Croatian psychiatric public as being one of the "most liberal" psychiatrists. With this in mind, when he presents as problematic a legal regulation and now a UN Convention, which not only at first glance but its essence and intention attempts to protect persons with psychiatric disorders, in this case those who are also persons with disabilities due to their mental disorder, there "must be something there".

This is a big book, and so is its author, who approaches a very serious and difficult topic with extreme caution. His caution may at times mislead the reader into thinking that the author

koji se prema ovome, pa i svemu, odnose ignorantski jer im je tako lakše!).

Ova knjiga je namijenjena svima onima koji se u svom poslu susreću s osobama s duševnim smetnjama koji su osobe s invaliditetom – liječnicima, psihijatrima, socijalnim radnicima, socijalnim pedagozima, psiholozima, medicinskim sestrama, pravnicima i svima drugima koji se zalažu za unaprjeđenje prava osoba s duševnim smetnjama. Knjiga će svakako naići na dobar prijam i odjek u javnosti. No, za očekivati je da bi se prema njoj mogli zauzeti suprotni stavovi – velika većina psihijatara i drugih psihijatrijskih djelatnika knjigu će dočekati kao „melem na ranu" („konačno je netko rekao ono što i mi mislimo"!), no nekritični zagovornici ljudskih prava, a takvih nije malo, mogli bi je dočekati „na nož".

U svakom slučaju, smatram da je ova knjiga vrijedan doprinos psihijatrijsko pravnoj misli o pravima osoba s duševnim smetnjama. Ona, opisujući postojeća rješenja prisilnog tretmana i svake druge prisile prema osobama s duševnim smetnjama, upozorava na realne opasnosti kojima bi te osobe bile izložene u slučaju apsolutne zabrane primjene bilo kakvih mjera prisile.

Predviđajući da će ova „mala velika knjiga" postati paradigmatično štivo hrvatske forenzičke psihijatrije i psihijatrijskog prava, te zaštite i unaprjeđenja prava osoba s duševnim smetnjama, sa zadovoljstvom je preporučujem stručnoj javnosti.

Vlado Jukić

supports what he is criticizing; he does not in fact discard the problematic postulates of the convention and committee completely – but rather supports everything that is theoretically and practically acceptable: Goreta knows what that is, and, given his habitus, has the right to do so, upgrading, justifying, and recommending for use in practice. So for all those who do not agree with his opinions, who criticize and discard, I recommend that before doing so, they first examine what Goreta has built his opinions on and why he advocates them! (The bigger problem being those people who approach this and all other things with ignorance, because it's the easier way!)

This book is intended for all those who come into contact with persons with mental disorders who are also persons with disabilities – doctors, psychiatrists, social workers, social pedagogues, psychologists, nurses, lawyers and all those who are advocates in the advancement of the rights of persons with psychiatric disorders.

The book will surely be well-accepted by the public. It is to be expected that the book will be met with opposing views – the majority of psychiatrists and other mental health workers will welcome the book as something that soothes the wound (finally someone has said what we are thinking), but those who uncritically promote human rights will greet the book with knife in hand.

In any case, I think this book is a worthy contribution to the psychiatric legal thought on the rights of persons with psychiatric disorders. In describing the existing position of involuntary treatment and all other coercive methods used on persons with psychiatric disorders, it warns of the very real danger these people face if absolute prohibition of involuntary methods is put into effect.

Foreseeing that this "big little book" will become a paradigm text in Croatian forensic psychiatry, psychiatric law and in the protection and advancement of the rights of persons with psychiatric disorders, I am very happy to recommend the book to the professional public.

Vlado Jukić

Vlado Jukić

Psihijatrijske teme za nepsihijatre (i psihijatre)

Psychiatric Themes for Non-psychiatrists (and Psychiatrists)

Krajem ljeta ove, 2018. godine, u nakladi je Klinike za psihijatriju Vrapče, Medicinske naklade i Hrvatskog psihijatrijskog društva objavljena knjiga prof. Vlade Jukića „*Psihijatrijske teme za nepsihijatre (i psihijatre)*“. Radi se o lijepo uređenoj i oku privlačnoj knjizi od petstotinjak stranica velikog A4 formata.

Jukić je sakupio i u ovoj knjizi objavio 63 svoja već prije objavljena članka pisana u razdoblju od 1991. do 2017. godine. Knjiga je podijeljena na osam dijelova. U svakom od ovih dijelova je više (od četiri do 14) članaka koji su posvećeni određenoj tematici. Jedino su u Sedmom dijelu članci različite tematike. Osmi dio je posvećen, kako Jukić navodi, „lakšim“ psihijatrijskim temama.

U prvom je dijelu šest psihijatrijskih tema; u drugom su četiri članka posvećena bolnici Vrapče, a u trećem dijelu, onom posvećenom forenzičko psihijatrijskim i pravno psihijatrijskim problemima, 14 je članaka. U četvrtom dijelu devet je članaka koji govore o raznim etičko-psihijatrijskim problemima, a u petom, posvećenom temama psihijatrije u Domovinskom ratu, šest je članaka. Pet članaka posvećenih raznim (socijalno psihijatrijskim) aspektima posttraumatskog stresnog poremećaja sačinjavaju šesti dio knjige. U sedmom dijelu 12 je članaka različite tematike (o suicidu, du-

At the end of the summer of 2018, a book entitled “*Psihijatrijske teme za nepsihijatre (i psihijatre)*” by Vlado Jukić was published by the University Psychiatric Hospital Vrapče, *Medicinska naklada* and the *Croatian Psychiatric Association*. It is a five hundred page book in A4 format, put together nicely and pleasing to the eye.

In this book, Jukić gathered together 63 of his previously published articles, written between the years 1991 and 2007. The book is separated into eight parts. Each part contains articles (from four to fourteen) dedicated to a certain topic. The seventh part is the only one that contains articles on multiple topics. The eighth part is dedicated to, as Jukić calls them, “light” psychiatric themes.

The first part contains six psychiatric subjects; the second is composed of four articles dedicated to the “Vrapče” hospital and the third part is devoted to forensic psychiatric and legal psychiatric problems discussed in 14 articles. In the fourth part there are nine articles dealing with various ethical psychiatric problems, whereas the fifth deals with psychiatric topics related to the Croatian War of Independence. Five articles, dedicated to different (social psychiatric) aspects of post-traumatic stress disorder, comprise the sixth part of the book. The seventh part addresses various topics: suicide,

hovnosti, strahu i povjerenju, nasilju, problemima komunikacije s duševnim bolesnicima, trendovima i konceptima u psihijatriji, poremećajima ličnosti, značenju tjelesne aktivnosti u liječenju psihijatrijskih bolesnika, ekonomiji u psihijatriji, pravima osoba s duševnim smetnjama te o značenju prijevoda Jaspersove Opće psihopatologije na hrvatski jezik i značenju te knjige u hrvatskoj psihijatrijskoj i intelektualnoj javnosti).

Ovi, iako „tehnički", podatci upućuju na širinu Jukićevih psihijatrijskih ili bolje rečeno društveno psihijatrijskih interesa. No njegovi se interesi, a to je dobro poznato u psihijatrijskim krugovima, ne iscrpljuju na ovdje obrađivanim temama. Spomenimo samo da je preko 50 njegovih radova (među kojima nisu radovi sakupljeni u ovoj knjizi) citirano u najznačajnijim bazama podataka. Praktički je teško naći psihijatrijsko područje koje ne bi bilo zastupljeno u Jukićevim radovima. Ako se tome dodaju knjige koje je objavio i uredio te ako se zna koliko je stručnih skupova o raznim psihijatrijskim temama priredio, onda tek možemo imati uvid u širinu njegovih interesa i područja u kojima je dao značajan doprinos.

Jukić, čini se, piše s lakoćom. Njegovi tekstovi su, unatoč nešto većem broju asocijacija, sabijenim u umetnute rečenicama i zagrade, čitljivi i jasni. U njima se, uz stručnu i znanstvenu odmjerenost, povremeno nazire emocionalni angažman. To je posebno vidljivo u člancima o Bolnici „Vrapče", psihijatriji u Domovinskom ratu, položaju i pravima psihijatrijskih bolesnika... No, uvijek je vidljiva njegova težnja da bude precizan i jasan. I u tome uspijeva. Posebno uspijeva artikulirati one probleme kojih se drugi psihijatri, zbog raznoraznih razloga, klone. Njegovo mišljenje i njegovi stavovi u stručnim se krugovima prihvaćaju s uvažavanjem, a već godinama u gotovo svakoj kriznoj psihijatrijskoj situaciji u Hrvatskoj očekuje se njegova reakcija i angažman. To potvrđuje i niz ovdje priređenih članaka. On se nije libio

spirituality, fear and trust, violence, problems in communication with mentally ill patients, trends and concepts in psychiatry, personality disorders, the importance of physical activity in treatment of mentally ill patients, economics in psychiatry, the rights of persons with mental disorders, the significance of the translation of Jasper's general psychopathology into the Croatian language and the importance this book has for Croatian psychiatry and the intellectual public.

This information, although "technical", provides insight into Jukić's broad psychiatric or rather social psychiatric interests. As is well known in psychiatric circles, his interests are not exhausted by the themes elaborated in the book. It is worth mentioning that over 50 of his works (not collected in this book) are cited in the most significant databases. It is difficult to find a topic in psychiatry that is not represented in Jukić's works. If we also consider the books he has published and edited as well as the many professional meetings and conferences he has organized, we begin to grasp the broad spectrum of his interests and the areas in which he has made a significant contribution.

Jukić, it seems, writes with ease. Despite the numerous digressions compressed in brackets and inserted sentences, his texts are easy to read and clear. Although he always writes with professional and scientific restraint, an emotional involvement is sometimes felt. This is especially clear in the articles about the "Vrapče" hospital, psychiatry in the war, the status and rights of psychiatric patients... his aspiration to be precise and clear is always evident, and this he achieves. He is especially successful in articulating the problems that other psychiatrists, for various reasons, avoid. His opinions and viewpoints are accepted and respected in professional circles, and for years his reaction and involvement has been expected in all crisis situations pertaining to psychiatry. This is confirmed by many of the articles presented here.

otvarati najintrigantnije teme hrvatske psihijatrijske stvarnosti kao što su pitanja položaja psihijatrije i psihijatrijskog bolesnika u medicini i društvu, pitanja odnosa prema „osjetljivim“ kategorijama bolesnika (npr. oboljelima od PTSP-a), pitanja odnosa medija i nevladnih udruga prema psihijatrijskim djelatnicima i bolesnicima, pitanja međusobnih odnosa među psihijatrima, pitanja odnosa psihijatrije i drugih grana medicine i druga.

Zbog toga je, a ne zato što je dugogodišnji ravnatelj naše najveće psihijatrijske ustanove, Bolnice „Vrapče“ (koju je, usput budi rečeno, doveo do statusa klinike), i što je predsjednik Hrvatskog psihijatrijskog društva, profesor Jukić zauzeo jedno od vodećih mjesta u hrvatskoj psihijatriji. Tomu su doprinijeli njegovi česti nastupi u medijima i na javnim tribinama. Promovira psihijatriju kao struku i znanost nastojeći je, bez stigme, približiti onima kojima bi ona mogla biti potrebna. To čini s velikim umijećem. Zato je prepoznat i prihvaćen i u javnosti.

Ova knjiga sve to potvrđuje i dopunjava. Jukić njome stručnoj i intelektualnoj javnosti još jednom nudi promišljanje o raznim psihijatrijskim temama koje imaju društvenu konotaciju i koje mogu biti interesantne ne samo onima koje i inače interesiraju ove teme, nego onima koji će knjigu, kao znatiželjnici i ljubitelji knjige, prelistati. Naići će, naime, na zanimljive i lako čitljive tekstove od kojih neki imaju i polemički karakter.

I na kraju, s uvjerenjem da će ova knjiga naići na dobar prijam, kako kod stručnjaka - psihijatara, liječnika, psihologa, socijalnih pedagoga, socijalnih radnika, medicinskih sestara, tako i kod onih koje psihijatrija interesira samo kao literatura, ili kao struka u koju, možda zbog vlastitih potreba, žele zaviriti sa strane, ne dvojim da će ona zauzeti važno mjestu u hrvatskoj psihijatrijskoj publicistici. Držim da će postati orijentir i pomoćna literatura svima onima koji obavljaju važne funkcije u hrvatskoj psihijatriji,

He did not hesitate to broach the most intriguing themes current in Croatian psychiatry, such as the status of psychiatry and psychiatric patients in medicine and society, attitudes towards “sensitive” categories of patients (e.g. those with PTSD), the media and non-profit organizations and their relation to psychiatric workers and patients, the relationship between psychiatrists and between psychiatry and other fields of medicine.

It is for these reasons, and not because he is the long-time director of the biggest psychiatric institution, the “Vrapče” hospital (which he, incidentally, led to the title of university hospital), nor because he is the president of the Croatian Psychiatric Association, that professor Jukić has taken one of the leading roles in Croatian psychiatry. His appearances in the media and public assemblies have contributed to this. He promotes psychiatry both as a profession and scientifically, endeavouring to bring it closer, without stigma, to those that may need it. He does this with great skill. This is why he is recognized and accepted by the public.

This book confirms and complements all of this. Once again Jukić offers the professional and intellectual population a chance to contemplate various psychiatric topics that have a social connotation and may be of interest not just to those who are routinely interested in such topics but also those curious book lovers who will leaf through it. They will come across interesting and readable texts, some of which are of a polemic character.

Finally, with the assurance that this book will be well received among professionals – psychiatrists, physicians, psychologists, social pedagogues, social workers, nurses – and among those that are interested in psychiatry as a work of literature or as a profession which, for their own needs, they may want to take a glance at, there is no doubt that it will occupy an important place in Croatian psychiatric non-fiction prose. I feel it will become a landmark and a helpful

pa i u zdravstvu. Time će postati polazišna osnova i alat u daljnjem promišljanju i izgradnji hrvatske psihijatrije. A u onoj daljnjoj budućnosti, ostat će orijentir i svjedok vremena u kome je nastala. Svjedočit će o stanju hrvatske psihijatrije tijekom i nakon Domovinskog rata, odnosno krajem 20. i početkom 21. stoljeća.

Iako se naslovom knjige sugerira da je ona u prvom redu namijenjena nepsihijatrima, dakle onima koji nisu profesionalno vezani uz psihijatrijske bolesnike, ona je ipak u prvom redu namijenjena djelatnicima u psihijattriji i svima onima koji se u svom radu susreću s psihijatrijskim bolesnicima. Onima koje se zanimaju za psihijatrijske teme, a nisu profesionalno vezani uz psihijatriju i psihijatrijske bolesnike, knjiga će poslužiti kao izvor informacija o društveno psihijatrijskim temama koje su inače razbacane po raznim časopisima i knjigama. Sada će ih naći u jednoj knjizi.

Zato čitateljima sa zadovoljstvom preporučujem knjigu *„Psihijatrijske teme za nepsihijatre (i psihijatre)“* prof. Vlade Jukića. Uvjerena sam da će, listajući i čitajući ovu knjigu, biti dodatno inspirirani i potaknuti na daljnji rad na razvoju i unaprjeđenju naše psihijatrije, a na dobro psihijatrijskih bolesnika.

Petrana Brečić

piece of literature to all those performing important functions in Croatian psychiatry and health care. Hence it will become a starting point and tool for further deliberation and development of Croatian psychiatry. In the distant future, it will remain a landmark and witness to the time in which it was created. It will be witness to the state of Croatian psychiatry during and after the war, at the end of the 20th century and beginning of the 21st century.

Although the title suggests that it is intended primarily for non-psychiatrists, in other words, those who are not professionally linked to psychiatric patients, it is in fact primarily aimed at psychiatric workers and all those who are in contact with psychiatric patients through their work. For those interested in psychiatric themes who are not professionally linked to psychiatry and psychiatric patients, the book will serve as a source of information about social psychiatric topics which are normally scattered throughout various books and journals. Now they can be found in a single book.

I can therefore recommend to readers, with much satisfaction, the book *“Psihijatrijske teme za nepsihijatre (i psihijatre)*” by prof. Vlade Jukić. I am convinced that in flipping through and reading this book, they will be additionally inspired and encouraged to promote and further the development of our psychiatry for the good of psychiatric patients.

Petrana Brečić

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

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Instructions to authors

Aim & Scope

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

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

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

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

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

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

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

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

Editorial board

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