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SADRŽAJ / *CONTENTS*

Inovativni konceptualni model sociokulturnih sastavnica kvalitete života starijih osoba

/ *Innovative Conceptual Model of Socio-Cultural Components of Quality of Life in Elderly Persons*

Damir Poljak[1], Marija Ovsenik[1], Špiro Janović[2], Jurica Veronek[2], Maja Bajs Janović[3]

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Ciljevi: Glavni cilj istraživanja je istražiti utjecaj sociokulturnih čimbenika na kvalitetu života starijih osoba u Republici Hrvatskoj. Teorijski cilj istraživanja odnosi se na oblikovanje teorijskog konstrukta utjecaja sociokulturnih čimbenika na kvalitetu života starijih osoba te metodom modeliranja oblikovati model sociokulturnih čimbenika kvalitete života starijih osoba u Republici Hrvatskoj. *Pozadina*: Problem istraživanja je identifikacija sociokulturnih sastavnica kvalitete života starijih osoba u Republici Hrvatskoj. Osnovna svrha istraživanja je identificirati sastavnice modela sociokulturnih dimenzija koje utječu na kvalitetu života osoba starije životne dobi u Republici Hrvatskoj. *Dizajn*: U istraživanju je primijenjena kvantitativna istraživačka paradigma. Za postizanje teorijskih ciljeva istraživanja korištene su opće znanstvene metode. Podatci su prikupljeni upitnicima. *Metode:* Teorijski ciljevi istraživanja ispunjeni su pregledom novije znanstvene literature. U svrhu ovog istraživanja kao mjerni instrumenti primijenjeni su WHOQOL-BREF upitnik i Hofstedeov upitnik. *Rezultati*: Na temelju obrađenih podataka istraživanja napravljeni su konceptualni multivarijatni regresijski modeli zadovoljavajuće domene kvalitete života osoba starije životne dobi. Načinjeni multivarijatni regresijski modeli predikcije pojedinih domena kvalitete života u kojima prediktorske varijable u multivarijatnom okružju definiraju utjecaj na te domene. Način odabira prediktorskih varijabli uključivao je postavljene ciljeve (dobnu, spolnu, regionalnu, bračnu komponentu te sve domene Hofstedeovog upitnika). *Zaključak*: U konceptualnom modelu shematski je prikazano da sociokulturne sastavnice kvalitete života ovise o društvenoj nejednakosti, životnim usmjerenjima, kontroli neizvjesnosti, djelovanju pojedinca individualizmom ili kolektivizmom, te odnosom prema muškarcu i ženi. Sve to zajedno određuje nacionalnu kulturu i predstavlja sociokulturni kapital određenog društva. Postoje razlike prema spolu koje su određene kontrolom neizvjesnosti, tjelesnim i psihičkim zdravljem, socijalnim odnosimsa, osobnim stavovima i religioznosti, te okolinom u kojoj osoba živi. *Važnost za kliničku praksu*: Socijalna gerontologija je mlada znanstvena disciplina i istraživanja na njenom području nalaze svoju primjenu u modernom društvu implementacijom rezultata istraživanja u socijalno i političko okruženje inovativnim modelima u skrbi za starije osobe.

/ Objectives: The main objective of the study was to investigate the influence of socio-cultural factors on the quality of life in elderly persons in Croatia. The theoretical objective of the study was to form a theoretical construct of the influence of socio-cultural factors on the quality of life of the elderly and to create a model of the socio-cultural factors of the quality of life of the elderly in Croatia using the modelling method. Background: The study problem was to identify the socio-cultural components of the quality of life in elderly persons in Croatia. The main purpose of the study was to identify the components of the model of socio-cultural dimensions that have an impact on the quality of life in elderly persons in Croatia. Design: The quantitative research paradigm was applied to the study. To achieve the theoretical objectives of the study, general scientific methods were used. Data were collected through questionnaires. Methods: The theoretical objectives of the study were reached by reviewing recent scientific literature. For the purpose of this study, the WHOQOL-

BREF and the Hofstede questionnaires were used as measuring instruments. Findings: The conceptual multivariate regression models of a satisfactory domain of quality of life in elderly persons were created based on processed study data. The multivariate regression models for the prediction of certain domains of quality of life in which predictor variables in a multivariate environment define the impact on these domains were created. The method of selecting predictor variables included the set objectives (age, gender, regional, and marital components and all dimensions of the Hofstede questionnaire). Conclusion: The conceptual model presents a schematic overview of the socio-cultural components of the quality of life that depend on social inequality, life orientations, uncertainty control, acts by individuals through individualism or collectivism, and the attitude towards men and women. All this combined determines a national culture and represents the socio-cultural capital of a certain society. There are differences by gender that were determined by uncertainty control, physical and mental health, social relations, personal attitudes and religiosity, and the environment in which a person lives. Importance for clinical practice: Social gerontology is a young scientific discipline and research in this field finds its application in modern society by implementing research results on the social and political environment with innovative models of care for elderly persons.

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UVOD

Starenje je multidimenzionalni fenomen koji je potrebno istraživati na temelju karakteristika stanovništva (1). Suvremena istraživanja nastoje otkriti razloge zbog kojih je starost postala socijalni problem te društvene uvjete u kojima je došlo do pojave problema. Zahvaljujući porastu životnog standarda i unaprijeđenju sustava zdravstvene i socijalne zaštite svjedoči se činjenici da se životni vijek produljio i predviđa se da će se do 2060. godine srednja dob stanovništva Europske unije zadržati na 47,6 godina, što je u usporedbi s prošlim stoljećem 15 godina više. Istraživanja starenja i obolijevanja tradicionalno se usredotočuju i na društveno–medicinske aspekte bolesti i individualnu patologiju starijih. Društvene promjene u procesu starenja podrazumijevaju promjene u odnosu društva i pojedinca, a očituju se u promjenama društve-

INTRODUCTION

Aging is a multidimensional phenomenon that needs to be investigated based on the characteristics of the population (1). Contemporary research seeks to reveal the reasons why old age has become a social problem together with the social conditions in which the problem occurred. Thanks to the increase in the standard of living and the improvement of the health care and social protection systems, life expectancy has increased. It is predicted that by 2060, the average age of the population of the European Union will remain at 47.6 years, which is 15 years more compared to the last century. Research into aging and disease traditionally focuses on the socio-medical aspects of disease and the individual pathology of the elderly. Social changes in the aging process imply changes in the relationship between society and the individual, and are manifested in

nih aktivnosti, interakciji i ulozi starijih osoba. Sve više je starijih osoba koje su aktivne i produktivne, te starost doživljavaju kao priliku za nove mogućnosti (2). Sociokulturne promjene i sam proces starenja stanovništva u Hrvatskoj započeo je početkom šezdesetih godina prošlog stoljeća, a na njega su utjecali smanjenje nataliteta, produljenje života stanovništva, iseljavanje mladih iz ruralnih sredina u urbane, iseljavanje u inozemstvo i ratni gubitci (3). Utjecaj društvenih, političkih i ekonomskih uvjeta na temelju kojih se mjeri perspektiva životnog puta kompleksan je pristup istraživanju kvalitete života zbog povijesnog konteksta koji utječe na okolinu (4). O problemima kvalitete života osoba starije životne dobi u Republici Hrvatskoj iz perspektive sociokulturnih čimbenika rađena su brojna istraživanja u pojedinim regijama. Tako, na primjer, istraživanjem osjećaja usamljenosti i kvalitete života provedenim u Osječko–baranjskoj županiji nisu pronađene razlike u kvaliteti života i osjećaju usamljenosti, a u longitudinalnom istraživanju o kvaliteti života u proučavanom razdoblju od 2003. i 2008. godine u Bjelovarsko–bilogorskoj županiji dobiveni rezultati ukazuju na pad subjektivne kvalitete života. Općenito gledajući, unatoč regionalno različitim podatcima u regijama Hrvatske 2003. i 2008. godine dobiveni rezultati ukazuju na pad subjektivnog zadovoljstva kvalitetom života (5).

Istraživači otkrivaju da faktori koji utječu na kvalitetu života starijih osoba ovise o različitim sociokulturnim kontekstima i društvenim normama. Različiti povijesni, politički i kulturni utjecaji u primorskoj i u kontinentalnoj Hrvatskoj jedan su od razloga za provođenje ovog istraživanja u Republici Hrvatskoj.

changes in social activities, interaction and the role of the elderly. There are more and more older people who are active and productive, seeing old age as an opportunity for new possibilities (2). Socio-cultural changes and the process of aging of the population in Croatia began in the early 1960s, and it was influenced by the decrease in the birth rate, increase in life expectancy, emigration of young people from rural to urban areas, emigration abroad and war casualties (3). The influence of social, political and economic conditions on the basis of which the perspective of the life course is measured is a complex approach to researching the quality of life due to the historical context that affects the environment (4). Numerous studies on the quality-of-life problems in elderly persons in the Republic of Croatia from the perspective of socio-cultural factors have been conducted in a number of regions. Thus, for example, the study on the feeling of loneliness and quality of life conducted in Osijek-Baranja County found no differences in quality of life and feeling of loneliness, whereas the longitudinal study on quality of life conducted in Bjelovar-Bilogora County in the period 2003-2008 obtained results indicating a decline in the subjective quality of life. Generally speaking, despite the fact that the data vary across Croatian regions, the results obtained in 2003 and 2008 indicate a decline in subjective satisfaction with quality of life (5).

Researchers found that the factors affecting the quality of life in elderly persons depend on various socio-cultural contexts and social norms. Different historical, political and cultural influences in coastal and continental Croatia are one of the reasons for conducting this study in the Republic of Croatia.

METODE

Dizajn istraživanja

U svrhu ovog istraživanja kao mjerni instrumenti primijenjeni su:

METHODS

Study design

For the purpose of this study, the following measuring instruments were used:

1. WHOQOL – BREF upitnik za mjerenje kvalitete života
2. Hofstedeov upitnik kulture.

Teorijski ciljevi istraživanja prikazani su pregledom novije znanstvene literature. Pretraživanjem novije znanstvene literature dobio se uvid u postojeća istraživanja iz područja sociokulturnih čimbenika i kvalitete života. Dosadašnji pregled literature pokazuje da i dalje postoji neistraženi segment povezanosti između sociokulturnih čimbenika i kvalitete života te ga je stoga potrebno istražiti u Republici Hrvatskoj. Drugi set empirijskih ciljeva ostvaren je pomoću statističkih metoda. Navedeno istraživanje djelomično je dio doktorske disertacije prvog autora.

Sudionici i uvjeti

U istraživanje je uključeno 630 ispitanika iz cijele Hrvatske. U istraživanju je primijenjeno dvofazno uzorkovanje: najprije stratificirano, a potom namjensko. Ispitano je 330 ispitanika iz kontinentalne i 300 ispitanika iz primorske Hrvatske. Iz svake županije uključeno je 30 ispitanika, svi stariji od 60 godina i svi aktivni umirovljenici u udrugama umirovljenika. Obuhvaćen je približno jednak broj ispitanika muškog i ženskog spola. Na naslovnoj stranici svakog upitnika napisan je naziv županije iz koje je ispitanik. Istraživanje se provodilo tijekom kolovoza 2021. godine.

Prikupljanje podataka

Ispitanici su bili usmeno (na sastanku udruge umirovljenika) zamoljeni da sudjeluju u istraživanju i njihovo je sudjelovanje u istraživanju bilo anonimno. Anketiranje ispitanika proveli su volonteri Saveza umirovljenika. Prije anketiranja provedena je edukacija anketara o načinima prikupljanja podataka. Shodno navedenom, anketari su objašnjavali ispitanicima upitnik, te ga kasnije samostalno ispunjavali.

1. The WHOQOL – BREF questionnaire for measuring quality of life
2. The Hofstede Culture in the Workplace Questionnaire.

The theoretical objectives of the study are presented by reviewing recent scientific literature. By searching recent scientific literature, an insight into existing research in the field of socio-cultural factors and quality of life was obtained. A review of the recent literature indicates an unexplored segment of the connection between socio-cultural factors and quality of life, which should therefore be investigated in Croatia. The second set of empirical objectives was achieved by using statistical methods. Some parts of the aforementioned study are part of the first author's doctoral dissertation.

Participants and conditions

The study comprised 630 respondents from all over Croatia. A two-phase sampling was applied: a stratified sampling in the first stage, and a purposive sampling in the second. Three hundred and thirty respondents from continental and three hundred respondents from coastal Croatia were surveyed. Thirty respondents from each county were included, all older than sixty and active in retired persons' associations. An approximately equal number of male and female respondents was included. The name of the county where a respondent lived was written on the title page of each questionnaire. The study was conducted in August 2021.

Data collection

Respondents were asked verbally (at a meeting of a retired persons' association) to participate in the study and their participation was anonymous. The respondents were surveyed by volunteers of the Retired Persons' Federation. Before the survey, the interviewers were trained on the methods of data collection. Accordingly, the interviewers explained the questionnaire to the respondents, and filled it out independently.

Analiza podataka

Bez obzira što su se koristili standardizirani upitnici, izračunate su metrijske karakteristike pojedinih domena. Faktorska analiza je korištena samo kako bi se potvrdilo da pojedine čestice odgovaraju definiranim domenama te da je unutarnja konzistencija pojedinih domena odgovarajuća.

U svrhu istraživanja provedena je deskriptivna statistička analiza. Dodatna analiza konzistencije upitnika provedena je pomoću Cronbach alfa koeficijenta, Spermanovim rho korelacijskim koeficijentom, Mann–Whitneyevim U test, $\chi 2$ testom te Kolmogorov–Smirnovljevim testom.

Data analysis

Regardless of the fact that standardized questionnaires were used, metric characteristics of individual domains were calculated. Factor analysis was used only to confirm that individual variables corresponded to the defined domains and that the internal consistency of individual domains was appropriate.

For the purpose of the study, a descriptive statistical analysis was performed. An additional analysis of the consistency of the questionnaire was performed using the Cronbach alpha coefficient, Spearman's rho correlation coefficient, Mann–Whitney U test, $\chi 2$ test, and Kolmogorov–Smirnov test.

REZULTATI

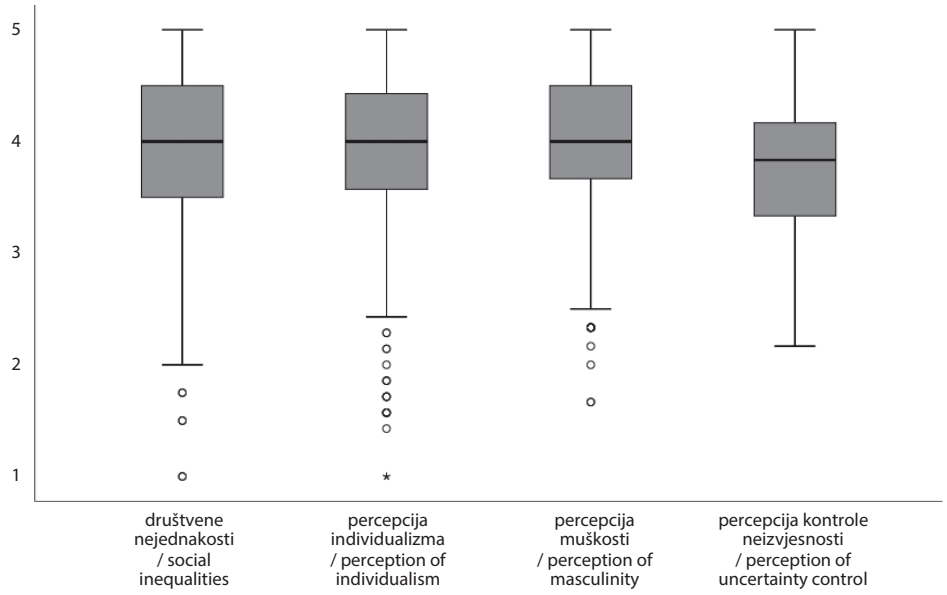
Sociodemografske karakteristike ispitanika uključenih u studiju (ukupni N=630) prikazane su u tablici 2. Žena je bilo nešto više u odnosu na muškarce: 54,0 % naprama 46,0 %, a nešto više od polovice ispitanika je imalo srednju stručnu spremu (53,0 %). U braku je ili živi s partnerom 447 (71,0 %) ispitanika, a 210 (33,3 %) ih živi u primorskim županijama Republike Hrvatske. Prosječna vrijednost (SD) dobi svih ispitanika uključenih u studiju bila je 69,3 ± 6,14 godine. Svega devet ispitanika (1,4 %) trebalo je pomoć pri ispunjavanju upitnika.

Prikaz ukupnih vrijednosti pojedinih domena Hofstedeovog modificiranog upitnika na cjelokupnom uzorku (ukupni N=630) pokazuje prosječne vrijednosti pojedinih domena Hofstedeovog modificiranog upitnika na cjelokupnom uzorku (kada se ukupne vrijednosti podijele s brojem čestica u domeni). Ako se pojedine domene promatraju međusobno, onda je najmanja standardizirana vrijednost u domeni percepcije kontrole neizvjesnosti, dok ostale 3 domene imaju podjednake vrijednosti (medijan 4,0). (grafikon 1).

FINDINGS

The socio-demographic characteristics of the study subjects (total N=630) are presented in Table 2. The study comprised slightly more women than men (54.0% versus 46.0%) and slightly more than half of the respondents had a secondary vocational education (53.0%). 447 (71.0%) respondents were married or lived with a partner, and 210 (33.3%) of them lived in the coastal counties of the Republic of Croatia. The average age (AA) of all respondents included in the study was 69.3 ± 6.14 years. Only 9 respondents (1.4%) needed help to fill out the questionnaire.

The presentation of total values for individual domains of Hofstede's modified questionnaire on the entire sample (total N=630) demonstrates the average values for individual domains of Hofstede's modified questionnaire on the entire sample (when the total values are divided by the number of variables in each domain). If individual domains are observed together, the smallest standardized value was found in the domain of perception of uncertainty control, whereas the other three domains had equal values (median 4.0). (Chart 1).

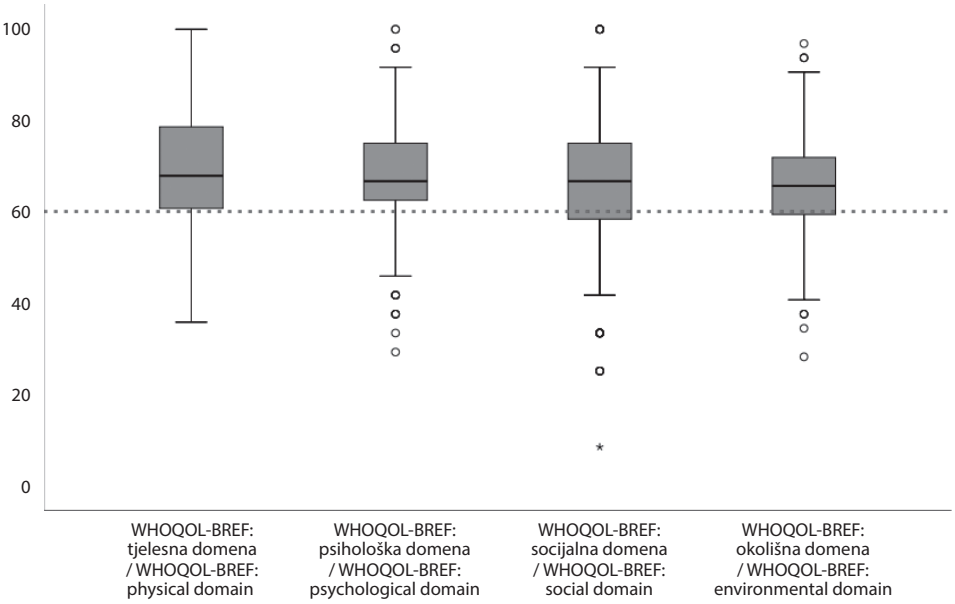


GRAFIKON 1. Prikaz prosječnih vrijednosti pojedinih domena Hofstedeovog modificiranog upitnika na cjelokupnom uzorku kada se ukupne vrijednosti podijele s brojem čestica u domeni (ukupni N=630)

CHART 1. Presentation of the average values for each of the domains of Hofstede's modified questionnaire on the entire sample if the total values are divided by the number of variables per domain (total N=630)

U grafikonu 2 prikazana je razina zadovoljavajuće kvalitete života tjelesne, psihološke, socijalne i okolišne domene čije su vrijednosti iznad 60, te raspodjela u odnosu na tu referentnu vrijednost.

Chart 2 shows the level of a satisfactory quality of life in physical, psychological, social and environmental domains with the values above 60, and the distribution in relation to that reference value.



GRAFIKON 2. Prikaz pojedinih domena WHOQOL–BREF upitnika u odnosu na referentnu vrijednost zadovoljavajuće kvalitete života (vrijednost >60)

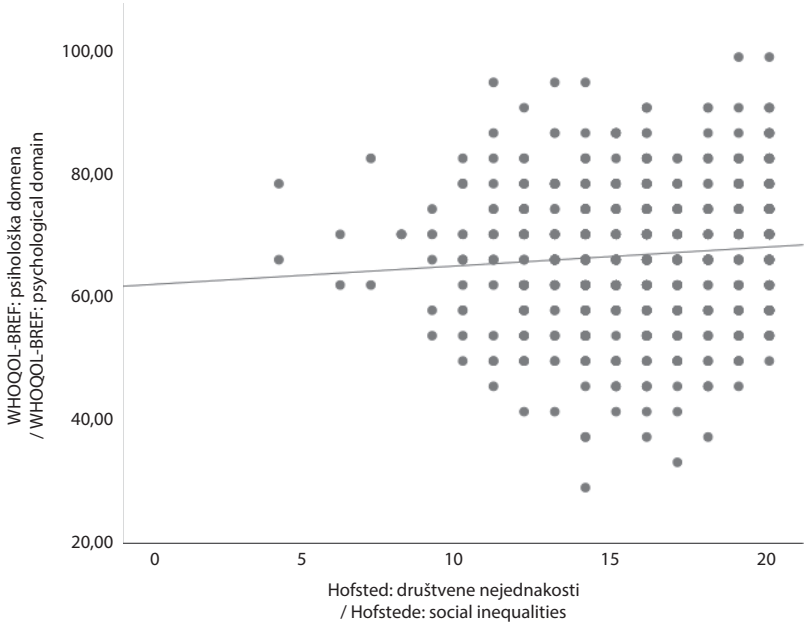
CHART 2. Presentation of each of the domains of the WHOQOL-BREF questionnaire in relation to the reference value of a satisfactory quality of life (value >60)

Kod ispitivanja WHOQOL–BREF tjelesne domene 78,57 % ispitanika ima zadovoljavajuću vrijednost WHOQOL–BREF tjelesne domene, dok je kod 21,43 % ispitanika WHOQOL–BREF tjelesne domene nezadovoljavajuća. Ispitivanjem WHOQOL–BREF psihološke domene 75,08 % ispitanika ima zadovoljavajuću vrijednost WHOQOL–BREF psihološke domene, dok je kod 24,92 % ispitanika WHOQOL–BREF psihološka domena nezadovoljavajuća. Ispitivanjem WHOQOL–BREF socijalne domene 59,21 % ispitanika ima zadovoljavajuću vrijednost WHOQOL–BREF socijalne domene, dok je kod 40,79 % ispitanika WHOQOL–BREF socijalna domena nezadovoljavajuća. Ispitivanjem WHOQOL–BREF okolišne domene 66,83 % ispitanika ima zadovoljavajuću vrijednost WHOQOL–BREF okolišne domene, dok je kod 33,17 % ispitanika WHOQOL–BREF okolišna domena nezadovoljavajuća.

U grafikonu 3 razvidno je da postoji pozitivna korelacija između psihološke domene kvalitete života te domene percepcija društvene nejednakosti.

For the WHOQOL-BREF physical domain, 78.57% of respondents had a satisfactory value of the WHOQOL-BREF physical domain while 21.43% of respondents had an unsatisfactory value. For the WHOQOL-BREF psychological domain, 75.08% of the respondents had a satisfactory value in the WHOQOL-BREF psychological domain, while 24.92% of the respondents had an unsatisfactory value. For the WHOQOL-BREF social domain, 59.21% of the respondents had a satisfactory value of the WHOQOL-BREF social domain, while 40.79% of the respondents had an unsatisfactory value. For the WHOQOL-BREF environmental domain, 66.83% of respondents had a satisfactory value in the WHOQOL-BREF environmental domain, while 33.17% of respondents had an unsatisfactory value.

Chart 3 indicates a positive correlation between the psychological domain of quality of life and the domain of perception of social inequality.

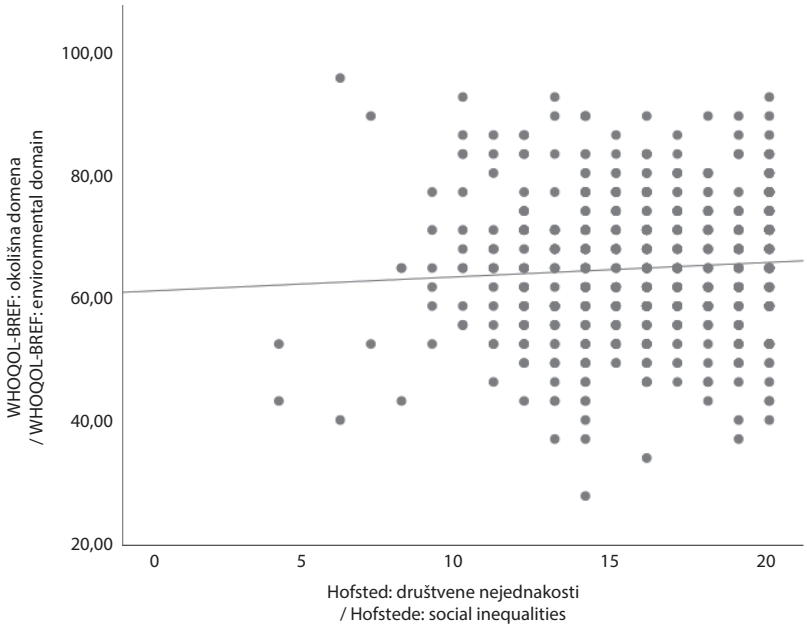


GRAFIKON 3. Povezanost WHOQOL–BREF psihološke domena kvalitete života u odnosu na percepciju društvene nejednakosti

CHART 3. Correlation between the WHOQOL–BREF psychological domain of quality of life and the perception of social inequality

Analizom grafikona 4 uočava se da postoji pozitivna korelacija između okolišne domene kvalitete života te domene percepcija društvene nejednakosti.

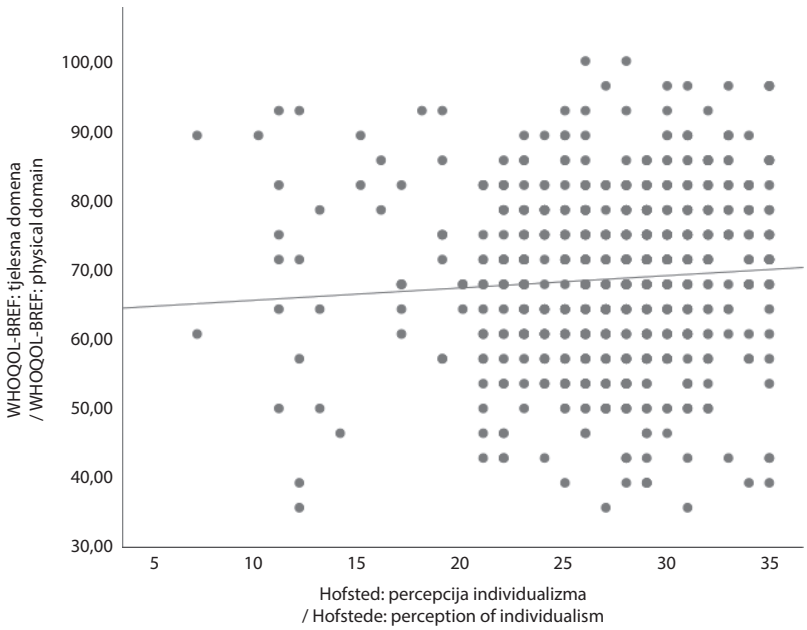
The analysis of Chart 4 indicates a positive correlation between the environmental domain of quality of life and the domain of perception of social inequality.



GRAFIKON 4. Povezanost WHOQOL–BREF okolišne domene kvalitete života u odnosu na percepciju društvene nejednakosti
CHART 4. Correlation between the WHOQOL–BREF environmental domain of quality of life and the perception of social inequality

Da postoji značajna pozitivna korelacija između tjelesne domene kvalitete života te domene percepcija individualizma vidljivo je u rezultatima prikazanim u grafikonu 5.

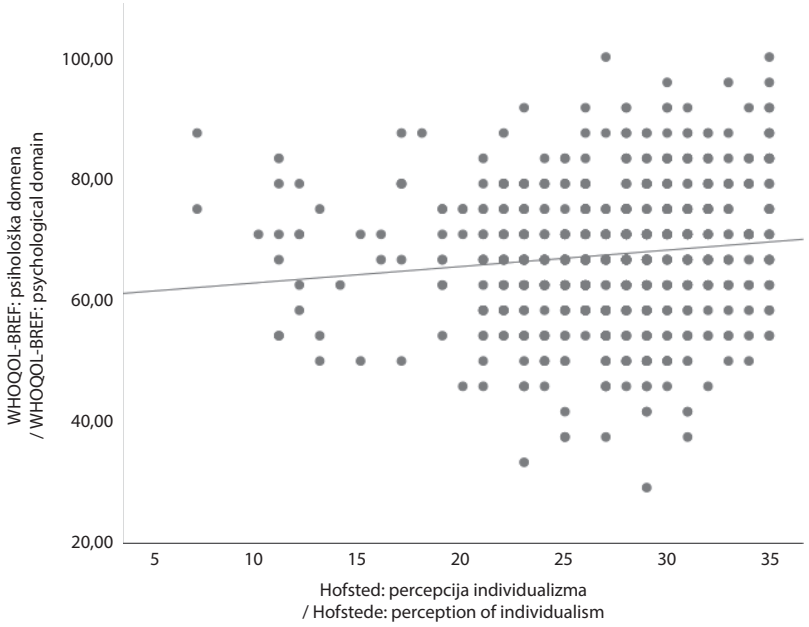
The results shown in Chart 5 indicate a significant positive correlation between the physical domain of quality of life and the domain of perception of individualism.



GRAFIKON 5. Povezanost WHOQOL–BREF tjelesne domene kvalitete života u odnosu na percepciju individualizma
CHART 5. Correlation between the WHOQOL–BREF physical domain of quality of life and the perception of individualism

U grafikonu 6 prikazano je da postoji značajna pozitivna korelacija između psihološke domene kvalitete života te domene percepcija individualizma.

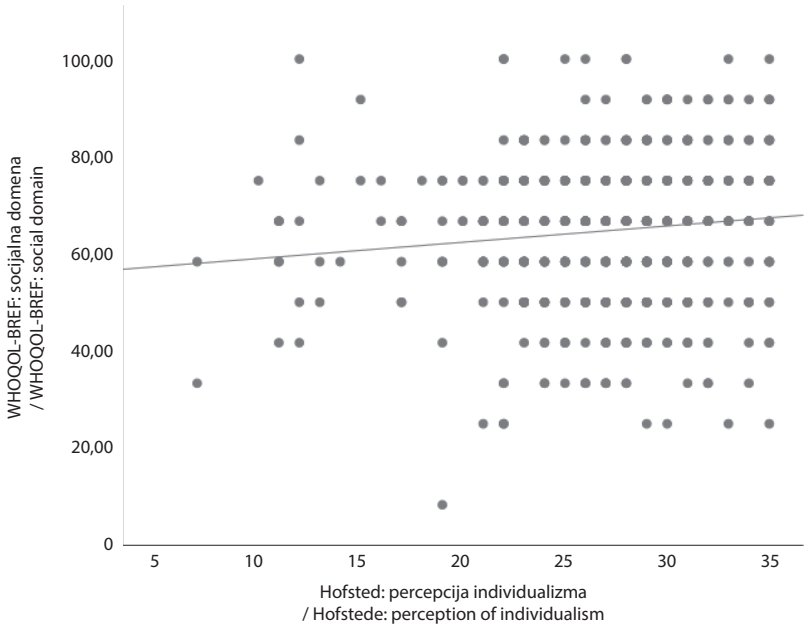
Chart 6 indicates a significant positive correlation between the psychological domain of quality of life and the domain of perception of individualism.



GRAFIKON 6. Povezanost WHOQOL–BREF psihološke domene kvalitete života u odnosu na percepciju individualizma
CHART 6. Correlation between the WHOQOL–BREF psychological domain of quality of life and the perception of individualism

U grafikonu 7 vidljiva je pozitivna korelacija između socijalne domene kvalitete života te domene percepcija individualizma.

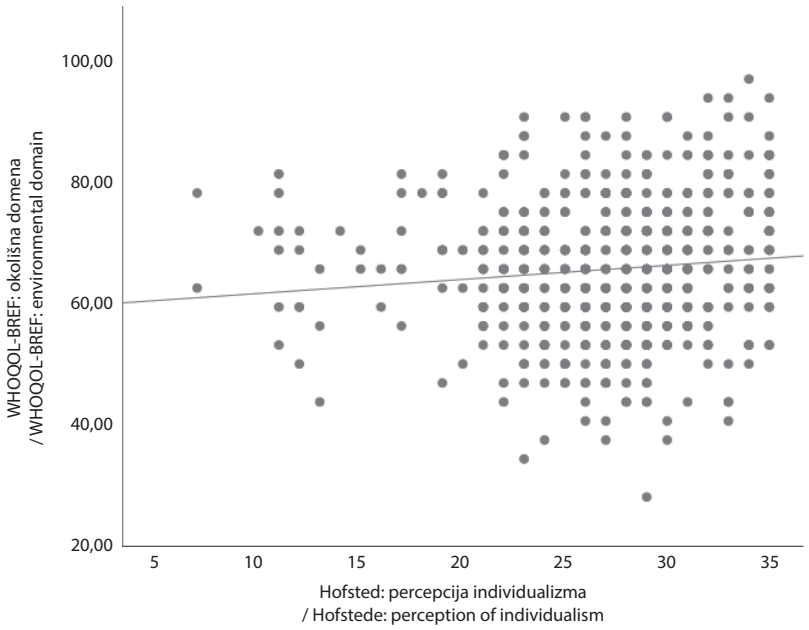
Chart 7 shows a positive correlation between the social domain of quality of life and the domain of perception of individualism.



GRAFIKON 7. Povezanost WHOQOL–BREF socijalne domene kvalitete života u odnosu na percepciju individualizma
CHART 7. Correlation between the WHOQOL–BREF social domain of quality of life and the perception of individualism

U grafikonu 8 vidljiva je pozitivna korelacija između okolišne domene kvalitete života te domene percepcija individualizma.

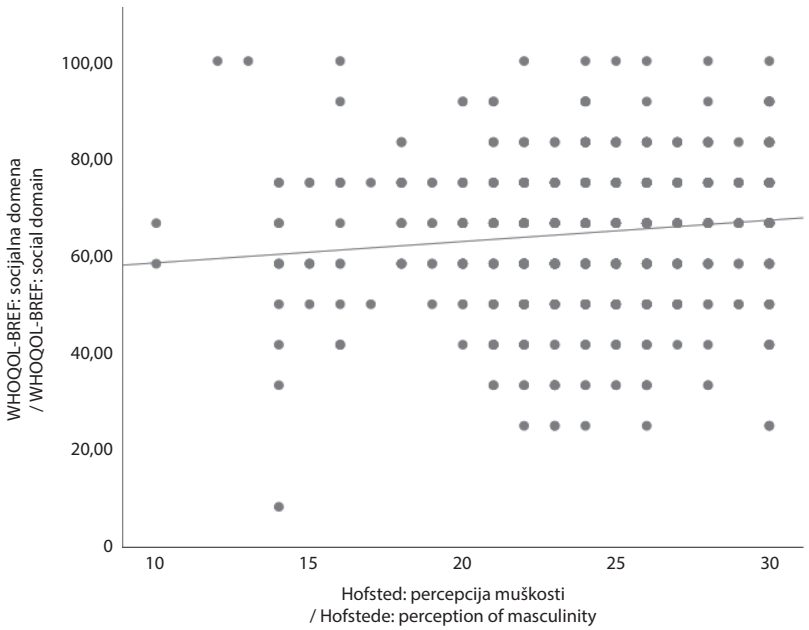
Chart 8 shows a positive correlation between the environmental domain of quality of life and the domain of perception of individualism.



GRAFIKON 8. Povezanost WHOQOL–BREF okolišne domene kvalitete života u odnosu na percepciju individualizma
CHART 8. Correlation between the WHOQOL–BREF environmental domain of quality of life and the perception of individualism

U grafikonu 9 razvidno je da postoji značajna pozitivna korelacija socijalne domene kvalitete života te domene percepcija muškosti.

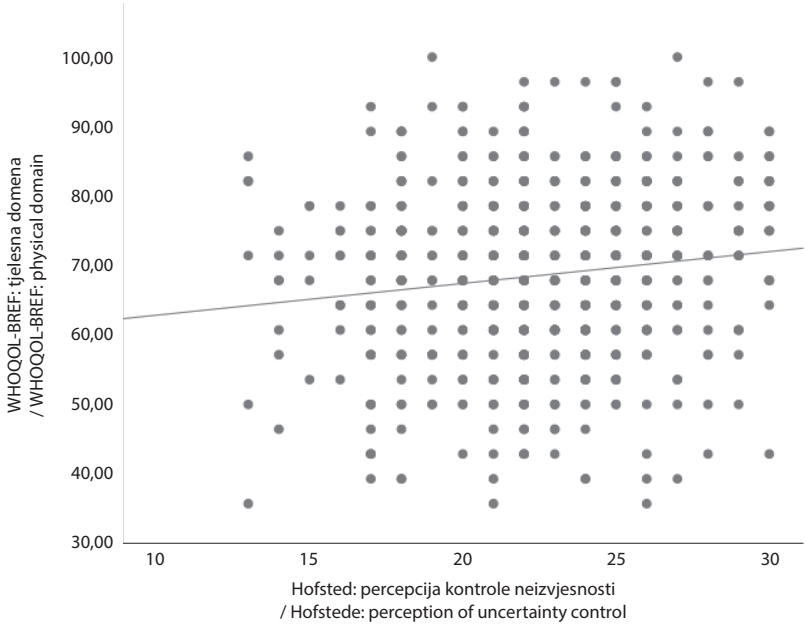
Chart 9 indicates a significant positive correlation between the social domain of quality of life and the domain of perception of masculinity.



GRAFIKON 9. Povezanost WHOQOL–BREF socijalne domene kvalitete života u odnosu na percepciju muškosti
CHART 9. Correlation between the WHOQOL–BREF social domain of quality of life and the perception of masculinity

U grafikonu 10 razvidno je da postoji značajna pozitivna korelacija tjelesne domene kvalitete života te domene kontrole neizvjesnosti.

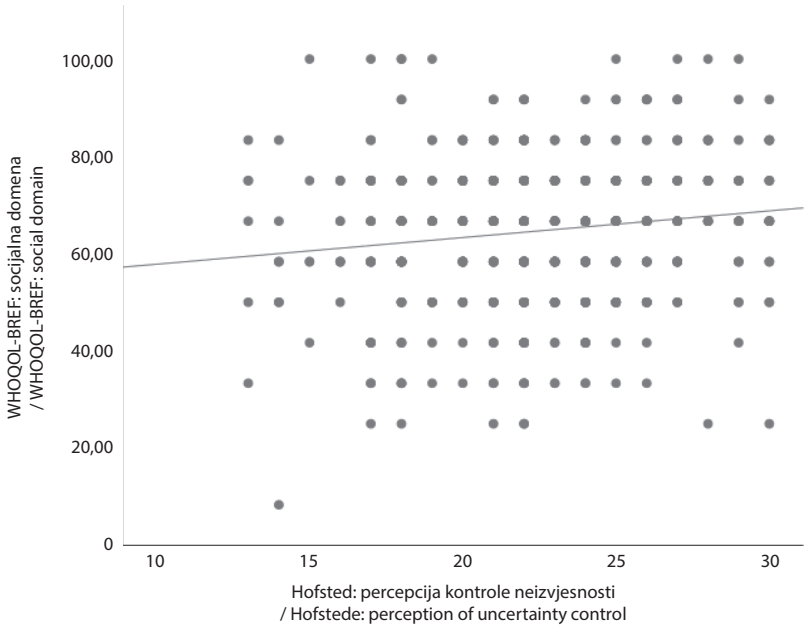
Chart 10 shows a significant positive correlation between the physical domain of quality of life and the domain of uncertainty control.



GRAFIKON 10. Povezanost WHOQOL–BREF tjelesne domene kvalitete života u odnosu na percepciju kontrole neizvjesnosti
CHART 10. Correlation between the WHOQOL–BREF physical domain of quality of life and the perception of uncertainty control

U grafikonu 11 razvidno je da postoji značajna pozitivna korelacija socijalne domene kvalitete života te domene kontrole neizvjesnosti.

Chart 11 indicates a significant positive correlation between the social domain of quality of life and the domain of uncertainty control.



GRAFIKON 11. Povezanost WHOQOL–BREF socijalne domene kvalitete života u odnosu na percepciju kontrole neizvjesnosti
CHART 11. Correlation between the WHOQOL–BREF social domain of quality of life and the perception of uncertainty control

Konceptualni regresijski model predikcije odgovarajuće tjelesne domene kvalitete života prikazan je u tablici 1. Od svih prediktorskih varijabli kao značajna varijabla se izdvaja domena *percepcije kontrole neizvjesnosti* koja za jedinično povećanje skora povećava vjerojatnost pripadnosti skupini sa zadovoljavajućom kvalitetom života tjelesne domene za 1,07 puta (95 % CI 1,01–1,14; P=0,027), odnosno 7 %, a kontrolirano na utjecaj svih ostalih varijabli u ovom multivarijatnom modelu.

Konceptualni multivarijatni regresijski model predikcije zadovoljavajuće psihološke domene kvalitete života prikazan je u tablici 2. Od svih varijabli jedino se dob izdvaja kao značajni prediktor zadovoljavajuće psihološke domene kvalitete života i to s OR=0,96 (95 % CI 0,93–0,99; P=0,012) što znači da mlađi ispitanici imaju bolju psihološku kvalitetu života.

Percepcija kontrole neizvjesnosti je jedini značajni prediktor predikcije zadovoljavajuće razine socijalne domene kvalitete života s OR=1,06 (95 % CI 1,01–1,11; P=0,029), kontrolirano na utjecaj ostalih varijabli u regresijskom modelu.

The conceptual regression model for the prediction of the corresponding physical domain of quality of life is presented in Table 1. Of all the predictor variables, the domain of *perception of uncertainty control* stands out as a significant one whose one unit increase in the value increases the probability of belonging to the group with a satisfactory quality of life in the physical domain by 1.07 times (95% CI 1.01–1,14; P=0.027) or 7%, controlled for the influence of all other variables in this multivariate model.

The conceptual multivariate regression model for predicting a satisfactory psychological domain of quality of life is presented in Table 2. Of all the variables, age is the only one that stands out as a significant predictor of a satisfactory psychological domain of quality of life, with OR=0.96 (95% CI 0.93–0.99; P=0.012), leading to a conclusion that younger respondents had a better psychological quality of life.

The perception of uncertainty control is the only significant predictor of a satisfactory level of the social domain of quality of life with OR=1.06 (95% CI 1.01–1.11; P=0.029), controlled for the influence of other variables in the regression model.

TABLICA 1. Konceptualni multivarijatni regresijski model predikcije zadovoljavajuće tjelesne domene kvalitete života: binarna logistička regresija
TABLE 1. Conceptual multivariate regression model of predicting a satisfactory physical domain of quality of life: binary logistic regression

	B	S.E.	df	OR	95% CI		P
					Donji / Lower	Gornji / Top	
Hofsted: Društvene nejednakosti / Hofstede: Social inequalities	0,03	0,03	1	1,03	0,96	1,10	0,419
Hofsted: Percepcija individualizma / Hofstede: Perception of individualism	–0,01	0,02	1	0,99	0,95	1,04	0,731
Hofsted: Percepcija muškosti / Hofstede: Perception of masculinity	0,01	0,03	1	1,01	0,95	1,08	0,679
Hofsted: Percepcija kontrole neizvjesnosti / Hofstede: Perception of uncertainty control	0,07	0,03	1	**1,07**	**1,01**	**1,14**	**0,027**
Ženski spol vs. muški spol / Female vs. male	0,12	0,20	1	1,13	0,76	1,66	0,549
U braku vs. žive sami / Married vs. single	–0,19	0,22	1	0,83	0,53	1,28	0,389
Kontinentalna vs. Primorska regija / Continental vs. coastal region	–0,10	0,21	1	0,90	0,59	1,37	0,626
Dob (godine) / Age (years)	–0,02	0,02	1	0,98	0,95	1,01	0,197

TABLICA 2. Konceptualni multivarijatni regresijski model predikcije zadovoljavajuće psihološke domene kvalitete života: binarna logistička regresija
TABLE 2. A conceptual multivariate regression model of predicting satisfactory psychological domains of quality of life: binary logistic regression

	B	S.E.	df	OR	95% CI		P
					Donji / Lower	Gornji / Top	
Hofsted: Društvene nejednakosti / Hofstede: Social inequalities	–0,02	0,03	1	0,98	0,92	1,05	0,618
Hofsted: Percepcija individualizma / Hofstede: Perception of individualism	0,03	0,02	1	1,03	0,98	1,07	0,228
Hofsted: Percepcija muškosti / Hofstede: Perception of masculinity	0,03	0,03	1	1,03	0,97	1,09	0,321
Hofsted: Percepcija kontrole neizvjesnosti / Hofstede: Perception of uncertainty control	–0,02	0,03	1	0,98	0,93	1,04	0,526
Ženski spol vs. muški spol / Female vs. male	–0,31	0,19	1	0,73	0,50	1,06	0,098
U braku vs. žive sami / Married vs. single	–0,20	0,21	1	0,82	0,54	1,24	0,342
Kontinentalna vs. Primorska regija / Continental vs. coastal region	–0,08	0,20	1	0,93	0,62	1,38	0,710
Dob (godine) / Age (years)	–0,04	0,02	1	0,96	0,93	0,99	**0,012**

TABLICA 3. Konceptualni multivarijatni regresijski model predikcije zadovoljavajuće socijalne domene kvalitete života: binarna logistička regresija
TABLE 3. Conceptual multivariate regression model of predicting a satisfactory social domain of quality of life: binary logistic regression

	B	S.E.	df	OR	95% CI		P
					Donji / Lower	Gornji / Top	
Hofsted: Društvene nejednakosti / Hofstede: Social inequalities	0,02	0,03	1	1,02	0,97	1,08	0,457
Hofsted: Percepcija individualizma / Hofstede: Perception of individualism	0,01	0,02	1	1,01	0,97	1,05	0,753
Hofsted: Percepcija muškosti / Hofstede: Perception of masculinity	0,04	0,03	1	1,04	0,99	1,10	0,119
Hofsted: Percepcija kontrole neizvjesnosti / Hofstede: Perception of uncertainty control	0,06	0,03	1	1,06	1,01	1,11	**0,029**
Ženski spol vs. muški spol / Female vs. male	–0,17	0,17	1	0,85	0,61	1,18	0,321
U braku vs. žive sami / Married vs. single	0,10	0,18	1	1,10	0,77	1,58	0,585
Kontinentalna vs. Primorska regija / Continental vs. Coastal region	0,29	0,18	1	1,33	0,94	1,88	0,107
Dob (godine) / Age (years)	0,00	0,01	1	1,00	0,97	1,03	0,891

Percepcija društvenih nejednakosti je jedini značajni prediktor predikcije zadovoljavajuće razine okolišne domene kvalitete života s OR=1,06 (95 % CI 1,01–1,12; P=0,046), kontrolirano na utjecaj ostalih varijabli u regresijskom modelu.

The perception of social inequalities is the only significant predictor of the prediction of satisfactory level of the environmental domain of quality of life with OR=1.06 (95% CI 1.01–1.12; P=0.046), controlled for the influence of other variables in the regression model.

TABLICA 4. Konceptualni multivarijatni regresijski model predikcije zadovoljavajuće okolišne domene kvalitete života: binarna logistička regresija
TABLE 4. Conceptual multivariate regression model of predicting a satisfactory environmental domain of quality of life: binary logistic regression

	B	S.E.	df	OR	95% CI		P
					Donji / Lower	Gornji / Top	
Hofsted: Društvene nejednakosti / Hofstede: Social inequalities	0,06	0,03	1	*1,06*	1,01	1,12	**0,046**
Hofsted: Percepcija individualizma / Hofstede: Perception of individualism	0,02	0,02	1	1,02	0,98	1,06	0,303
Hofsted: Percepcija muškosti / Hofstede: Perception of masculinity	–0,03	0,03	1	0,97	0,92	1,03	0,336
Hofsted: Percepcija kontrole neizvjesnosti / Hofstede: Perception of uncertainty control	0,00	0,03	1	1,00	0,95	1,05	0,944
Ženski spol vs. muški spol / Female vs. male	–0,01	0,17	1	0,99	0,71	1,39	0,965
U braku vs. žive sami / Married vs. single	–0,10	0,19	1	0,91	0,62	1,32	0,605
Kontinentalna vs. Primorska regija / Continental vs. coastal region	0,20	0,18	1	1,22	0,85	1,75	0,274
Dob (godine) / Age (years)	0,01	0,01	1	1,01	0,98	1,04	0,609

RASPRAVA

Analiza ispitivanog uzorka s obzirom na sociodemografske pokazatelje

U istraživanje je bilo uključeno 630 ispitanika iz cijele Hrvatske, po 30 ispitanika iz dvadeset županija i grada Zagreba. Prema regionalnoj pripadnosti 240 (38,1 %) ispitanika dolazi iz panonske Hrvatske, 210 (33,3 %) iz primorske Hrvatske, 150 (23,8 %) iz sjeverne Hrvatske 150 (23,8 %) ispitanika. Razvrstano prema regijama iz kontinentalne Hrvatske dolazi 420 (66,7 %) ispitanika, dok iz primorske Hrvatske dolazi 210 (33,3 %) ispitanika. Svi ispitanici stariji su od 60 godina i aktivni su članovi udruga umirovljenika u svojim sredinama. Aritmetička sredina životne dobi ispitanika iznosi 69,3 ± 6,14. Najveći broj ispitanika ima srednju razinu obrazovanja (334 – 53 %), slijede ispitanici s višom razinom obrazovanja (164 – 26 %), te s visokom razinom obrazovanja (68 - 10,8 %) i osnovno školskom razinom (61 - 10,2 %).

DISCUSSION

Analysis of the examined sample in respect of socio-demographic indicators

630 respondents from all over Croatia were included in the study, i.e., 30 respondents from each of the twenty Croatian counties and the city of Zagreb. According to regional affiliation, 240 respondents (38.1%) came from Pannonian Croatia, 210 (33.3%) from coastal Croatia, and 150 (23.8%) from northern Croatia. Sorted by region, 420 (66.7%) respondents came from continental Croatia and 210 (33.3%) from coastal Croatia. All respondents were older than sixty years and active members of retired persons' associations in their communities. The arithmetic mean of the respondents' age was 69.3 ± 6.14. The largest number of respondents had a medium level of education (334 - 53%), followed by respondents with a higher level of education (164 - 26%), high level of education (68 - 10.8%) and elementary school level of education (61 - 10.2%).

Analiza rezultata dobivenih Hofstedeovim modificiranim upitnikom na cjelokupnom uzorku ispitanika

U rezultatima povedenog istraživanja prikazani su rezultati svih domena Hofstedeovog modificiranog upitnika koji uključuje društvenu nejednakosti, percepciju individualizma, percepciju muškosti te percepciju kontrole neizvjesnosti. U svim domenama dobiven je zadovoljavajući koeficijent unutarnje konzistencije Cronbachov α koji je bio u rasponu od 0,676 u domeni društvene nejednakosti do 0,716 u domeni percepcija individualizma, dok je za cjelokupni upitnik Cronbachov α koeficijent iznosio 0,725. Ako se pojedine domene razmatraju međusobno, najmanja je standardizirana vrijednost u domeni percepcije kontrole neizvjesnosti, dok ostale 3 domene imaju podjednake vrijednosti.

Analiza rezultata dobivenih odgovora iz WHOQOL–BREF upitnika

U ispitivanju WHOQOL–BREF tjelesne domene 78,57 % ispitanika ima zadovoljavajuću vrijednost WHOQOL–BREF tjelesne domene, dok je kod 21,43 % ispitanika WHOQOL–BREF tjelesne domene nezadovoljavajuća. Kod WHOQOL–BREF psihološke domene 75,08 % ispitanika ima zadovoljavajuću vrijednost WHOQOL–BREF psihološke domene, dok je kod 24,92 % ispitanika WHOQOL–BREF psihološka domena nezadovoljavajuća. Prema WHOQOL–BREF socijalnoj domeni 75 % ispitanika ima zadovoljavajuću vrijednost, dok je WHOQOL–BREF okolišna vrijednost 71,88 % ispitanika izrazilo zadovoljavajuću vrijednost.

Opis rezultata WHOQOL–BREF

Ako se usporede dobiveni rezultati istraživanja s rezultatima tjelesne domene u istraživanju s rezultatima istraživanja iz 2005. godine, ari-

Analysis of the results obtained by Hofstede's modified questionnaire on the entire sample of respondents

The results of the study show the results for all domains of Hofstede's modified questionnaire, including social inequality, perception of individualism, perception of masculinity and perception of uncertainty control. In all domains, a satisfactory internal consistency (Cronbach's α) coefficient was obtained, ranging from 0.676 in the domain of social inequality to 0.716 in the domain of perceptions of individualism. The internal consistency (Cronbach's α) coefficient for the entire questionnaire was 0.725. If individual domains are analysed together, the smallest standardized value was found in the domain of perception of uncertainty control, whereas the other three domains had equal values.

Analysis of the results obtained from the WHOQOL-BREF questionnaire

In the WHOQOL-BREF physical domain, 78.57% of respondents had a satisfactory value of the WHOQOL-BREF physical domain, while 21.43% of respondents had an unsatisfactory value of the WHOQOL-BREF physical domain. In the WHOQOL-BREF psychological domain, 75.08% of respondents had a satisfactory value of the WHOQOL-BREF psychological domain, while 24.92% of the respondents had an unsatisfactory WHOQOL-BREF psychological domain. In the WHOQOL-BREF social domain, 75% of the respondents had a satisfactory value, whereas in the WHOQOL-BREF environmental domain, 71.88% of the respondents had a satisfactory value.

Description of WHOQOL–BREF results

If the results of this study are compared with the results for the physical domain obtained in the study from 2005, the arithmetic mean of the

tmetička sredina domene tjelesnog zdravlja u provedenom istraživanju iznosi 68,63, dok je u usporednom istraživanju 66,35, što nije statistički značajna razlika. Ako se usporede dobiveni rezultati istraživanja s rezultatima psihološke domene aritmetička sredina domene psihičkog zdravlja iznosi 67,50, dok je u usporednom istraživanju 60,98. Dobiveni rezultati pokazuju veće zadovoljstvo psihičkim zdravljem. Kod usporedbe dobivenih rezultata ovog istraživanja s rezultatima socijalne domene aritmetička sredina domene socijalnih odnosa iznosi 64,75, dok je u usporednom istraživanju 63,99, što je statistički sličan rezultat zadovoljstva socijalnim odnosima.

U SAD–u je povedeno nacionalno longitudinalno istraživanje o socijalnoj izolaciji starijih osoba s ciljem identifikacije podgrupa starijih osoba s rizikom socijalne izolacije i procjenom prevalencije socijalne izoliranosti među starijim osobama koje žive u zajednici. Analizom rezultata utvrđeno je da 24 % osoba starijih od 65 godina živi u socijalnoj izolaciji, a 4 % ih je opisano ozbiljno društveno izoliranima. Multivarijabilnom logičkom regresijom prikazano je da u tu skupinu najviše pripadaju neoženjeni muškarci, niske razine obrazovanja i niskih financijskih prihoda. Kada se usporede dobiveni rezultati provedenog istraživanja s rezultatima okolišne, aritmetička sredina domene zadovoljstva okolinom u provedenom istraživanju iznosi 65,59, dok je u usporednom istraživanju 64,86, što je statistički sličan rezultat zadovoljstva okolinom. Kao razina zadovoljavajuće ili odgovarajuće kvalitete života uzeta je razina pojedinih domena iznad 60, te nije bilo značajnih razlike između pojedinih domena kvalitete života, odnosno svi ispitanici su imali podjednako dobru kvalitetu života u tjelesnoj, psihičkoj, socijalnoj i okolišnoj domeni (6).

Provedeno istraživanje iz 2018. godine o zadovoljstvu kvalitetom života pomoću WHOQOL–BREF upitnika na temelju dobivenih rezultata definira da postoji statistički značajna razlika u

physical health domain in our study was 68.63 and 66.35 in the comparative study, which was not a statistically significant difference. If the results of the our study are compared with the results of the psychological domain, the arithmetic mean of the mental health domain in our study was 67.50 and 60.98 in the comparative study. The obtained results indicate a greater level of satisfaction with psychological health. When comparing the results of our study with the results obtained for the social domain, the arithmetic mean of the social domain was 64.75 in our study and 63.99 in the comparative study, which represents a statistically similar result for the satisfaction with social relations.

In the USA, a national longitudinal study on social isolation of elderly persons was conducted with the aim of identifying subgroups of elderly persons at risk of social isolation and assessing the prevalence of social isolation among elderly persons living in a community environment. The analysis of the results demonstrated that 24% of persons over the age of 65 lived in social isolation, and 4% of them were described as severely socially isolated. Multivariable logistic regression showed that unmarried men with low level of education and low financial income mostly belonged to this group. When the results of the conducted study were compared with the results for the environmental domain, the arithmetic mean for the environmental satisfaction domain in our study was 65.59, and 64.86 in the comparative study, which was a statistically similar result for environmental satisfaction. The score above 60 for each individual domain was taken as a satisfactory or adequate quality of life level with no significant differences between individual domains of quality of life, i.e., all respondents had an equally good quality of life in the physical, psychological, social and environmental domains (6).

Based on the results obtained in the study conducted in 2018 on satisfaction with quality of life using the WHOQOL-BREF questionnaire demonstrated a statistically significant differ-

ocjeni tjelesne domene kvalitete života mlađih ispitanika u odnosu na starije, no da ne postoji statistički značajna razlika u domeni tjelesnog zdravlja među različitim kategorijama ispitanika starijih od 60 godina (7).

Tijekom 2019. godine provedeno je istraživanje na uzorku od 100 ispitanika o povezanosti tjelesne aktivnosti i kvalitete života osoba u dobi dobi od 70 do 90 godina. Ukupni indeks kvalitete života iznosio je 57 %. Nije utvrđena statistički značajna razlika u odnosu na spol, dob, životni standard, uspješnost, zdravlje, bliske odnose, pripadnost zajednici te sigurnost u ukupnoj kvaliteti života. Prema teoriji homeostaze, ako kvaliteta života padne ispod 60 %, dolazi do narušavanja psihofizičkog funkcioniranja pojedinca. Autori navode da je razlog nižeg indeksa kvalitete života činjenica da je svaki peti stanovnik u zemlji nezadovoljan životnim standardom (8).

Godine 2018. provedeno je istraživanje na uzorku od 235 ispitanika iz Dalmacije, svi stariji od 60 godina o percepciji starih osoba u Hrvatskoj o uspješnom starenju. Gotovo 88 % ispitanika definira tri čimbenika koja su najvažnija u subjektivnoj procjeni starijih osoba, a to su dobro zdravlje, samozadovoljstvo i sposobnost pojedinca da se brine o samom sebi. Za psihičku dobrobit pojedinca navedeni su unutar kategorija kao najvažnije ljubav, podrška obitelji i djeca (9).

I u ostalim istraživanjima u Istri (10) i u SAD–u dobiveni su slični rezultati (11).

Konceptualni multivarijatni regresijski modeli

Konceptualni regresijski model predikcije odgovarajuće tjelesne domene kvalitete života koji je prikazan u tablici 1. ukazuje da se od svih prediktorskih varijabli kao značajna varijabla izdvaja domena *percepcije kontrole neizvjesnosti* koja za jedinično povećanje skora povećava vjerojatnost pripadnosti skupini sa zadovoljavaju-

ence in the assessment of the physical domain of quality of life of younger respondents when compared to the elderly. However, no statistically significant difference was found in the physical health domain among different categories of respondents older than 60 years (7).

In 2019, a study was conducted on a sample of 100 respondents on the connection between physical activity and quality of life of people aged 70 to 90 years. The overall quality of life index was 57%. No statistically significant difference was found in relation to gender, age, standard of living, performance, health, close relationships, belonging to a community and safety in the overall quality of life. According to the homeostasis theory, if the quality of life falls below 60%, the psychophysical functions become impaired. The authors state that the reason for the lower quality of life index was the fact that every fifth resident of the country expressed dissatisfaction with the standard of living (8).

In 2018, a survey was conducted on the perception of successful aging of elderly persons in Croatia on a sample of 235 respondents from Dalmatia, all older than 60 years. Almost 88% of the respondents defined the three factors that are most relevant for a subjective assessment of elderly persons, i.e., good health, self-satisfaction and an individual's ability to take care of him or herself. The most important categories for mental well-being of an individual were love, family support and children (9).

Similar results were obtained in other studies conducted in Istria (10) and in the USA (11).

Conceptual multivariate regression models

The conceptual regression model for the prediction of an adequate physical domain of quality of life shown in Table 1 indicates that of all the predictor variables, the domain *of uncertainty control perception* stands out as a significant variable. This variable per unit increase in the score

ćom kvalitetom života tjelesne domene za 1,07 puta (95 % CI 1,01–1,14; P=0,027), odnosno 7 %, a kontrolirano na utjecaj svih ostalih varijabli u ovom multivarijatnom modelu.

Konceptualni multivarijatni regresijski model predikcije zadovoljavajuće psihološke domene kvalitete prikazuje da se od svih varijabli jedino dob izdvaja kao značajni prediktor zadovoljavajuće psihološke domene kvalitete života i to s OR=0,96 (95 % CI 0,93–0,99; P=0,012) što znači da mlađi ispitanici imaju bolju psihološku kvalitetu života.

Percepcija kontrole neizvjesnosti je jedini značajni prediktor predikcije zadovoljavajuće razine socijalne domene kvalitete života s OR=1,06 (95 % CI 1,01–1,11; P=0,029), kontrolirano na utjecaj ostalih varijabli u regresijskom modelu.

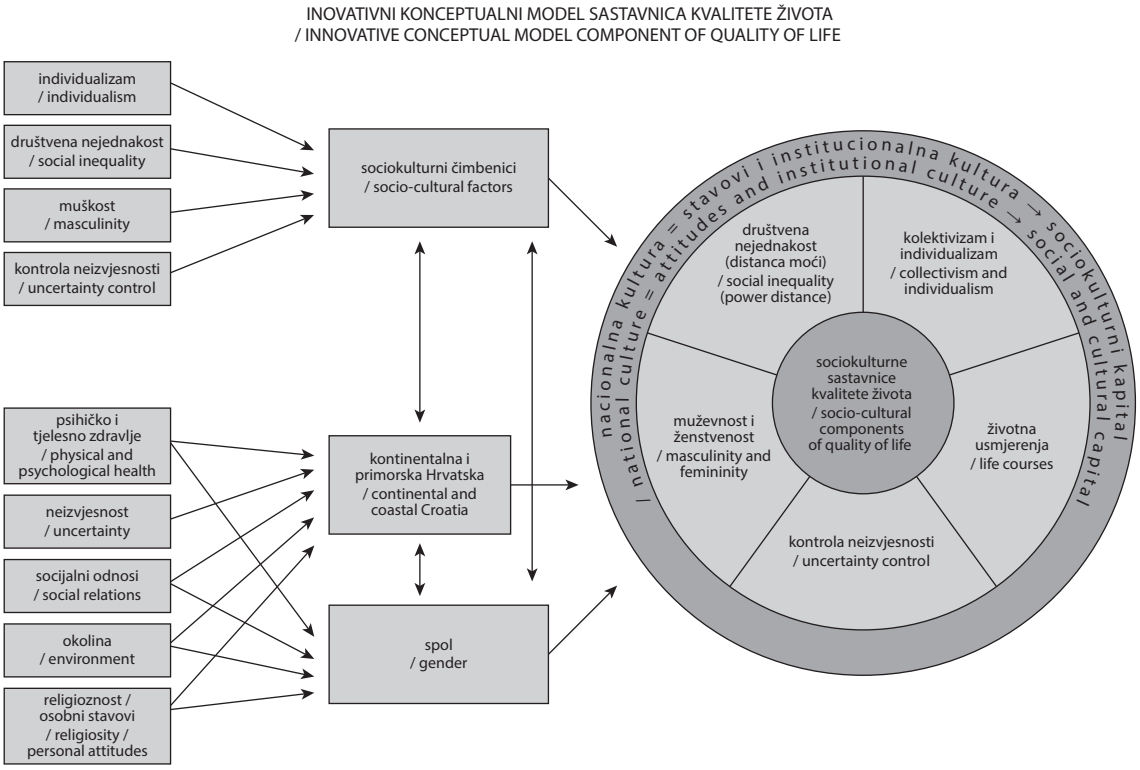
Percepcija društvenih nejednakosti je jedini značajni prediktor predikcije zadovoljavajuće razine okolišne domene kvalitete života s OR=1,06 (95 % CI 1,01–1,12; P=0,046), kon-

advances the probability of belonging to a group with a satisfactory quality of life in the physical domain by 1.07 times (95% CI 1.01–1.14; P=0.027), or 7%, and controlled for the influence of all other variables in this multivariate model.

The conceptual multivariate regression model for predicting a satisfactory psychological domain of quality of life showed that, of all variables, only age stood out as a significant predictor of a satisfactory psychological domain of quality of life, with OR=0.96 (95% CI 0.93–0.99; P=0.012), implying that younger respondents had a better psychological quality of life.

The perception of uncertainty control was the only significant predictor of a satisfactory level of the social domain of quality of life with OR=1.06 (95% CI 1.01–1.11; P=0.029), controlled for the influence of other variables in the regression model.

The perception of social inequalities was the only significant predictor of a satisfactory level of the environmental domain of qual-



SLIKA 1. Inovativni konceptualni model sociokulturnih sastavnica kvalitete života
FIGURE 1. Innovative conceptual model of socio-cultural components of quality of life

trolirano na utjecaj ostalih varijabli u regresijskom modelu.

Na temelju dobivenih rezultata istraživanja napravljen je Inovativni konceptualni model sociokulturnih sastavnica kvalitete života (slika 1).

ZAKLJUČAK

Otkrivanje i razumijevanje socijalnih i kulturnih sastavnica kvalitete života iznimno je važno za podizanje kvalitete života starijih osoba. Sagledavanje povijesnih, kulturnih i političkih odrednica društvenog i političkog života u Hrvatskoj temelj je razumijevanja postojeće problematike. Za rješavanje problema potrebna je izgradnja socijalnih mreža i socijalne podrške, razumijevanje promjena u obiteljskoj strukturi, prepoznavanje zdravstvenih čimbenika fizičkog, mentalnog i duhovnog zdravlja pojedinca, te utjecaja socio–ekonomskih i sociokulturnih faktora.

U konceptualnom modelu shematski je prikazano da sociokulturne sastavnice kvalitete života ovise o društvenoj nejednakosti, životnim usmjerenjima, kontroli neizvjesnosti, djelovanju pojedinca individualizmom ili kolektivizmom, te odnosom prema muškarcu i ženi. Sve to zajedno određuje nacionalnu kulturu i sociokulturni je kapital društva. Na sve to utječu sociokulturni čimbenici, bilo da se radi o kontinentalnoj ili primorskoj Hrvatskoj. Postoje razlike prema spolu koje su određene kontrolom neizvjesnosti, tjelesnim i psihičkim zdravljem, socijelnim odnosima, osobnim stavovima i religioznosti, te okolinom u kojoj osoba živi.

U Hrvatskoj nije do sada provedeno dovoljno istraživanja koja bi omogućila kvalitetne regionalne usporedbe. Zbog toga preporučamo da se ovoj problematici na nacionalnoj razini obrati veća pozornost, da se provode longitudinalna istraživanja koja bi tijekom vremena identificirala promjene i omogućila istraživanja i rezultate na kontinuiranoj osnovi.

ity of life with OR=1.06 (95% CI 1.01–1.12; P=0.046), controlled for the influence of other variables in the regression model.

Based on the obtained study results, an innovative conceptual model of socio-cultural components of the quality of life was created (Figure 1).

CONCLUSION

Discovering and understanding the social and cultural components of the quality of life is extremely important for raising the quality of life in elderly persons. The analysis of the historical, cultural and political determinants of social and political life in Croatia forms the basis for understanding the existing problems. To solve the problem, it is necessary to build social networks and social support, understand the changes in the family structure, recognize the health factors of the physical, mental and spiritual health of an individual, as well as the influence of socio-economic and socio-cultural factors.

The conceptual model presents a schematic overview of the socio-cultural components of the quality of life that depend on social inequality, life orientations, uncertainty control, acts by individuals through individualism or collectivism, and the attitude towards men and women. All this combined determines a national culture and represents the socio-cultural capital of a society. All of this is also influenced by socio-cultural factors, whether we are looking at continental or coastal regions of Croatia. There are gender differences that are determined by uncertainty control, physical and psychological health, social relationships, personal attitudes and religiosity, and the environment in which a person lives.

So far, not enough research has been carried out in Croatia to enable quality and reliable comparisons. For this reason, we recommend that more attention be paid to this issue at the national level and that longitudinal research be conducted to identify changes over time and enable research and results on a continuous basis.

LITERATURA / *REFERENCES*

1. Sanderson W, Scherbov S. New Approaches to the Conceptualization and Measurement of Age and Aging. J Aging Health 2016; 28(7): 1159-77.
2. Štifanić M. Društveni aspekti starenja i obolijevanja. Diacovensia 2018;26(3):505-27. Preuzeto s: https://doi.org/10.31823/d.26.3.8
3. Nejašmić I, Toskić A. Starenje stanovništva u Hrvatskoj–sadašnje stanje i perspektive. Hrvatski geografski glasnik 2013; 75(1): 89-110. https://doi.org/10.21861/HGG.2013.75.01.05
4. Bara M, Podgorelec S. Društvene teorije umirovljenja i produktivnog starenja. Etnološka tribina 2015; 45(38): 58-71. https://doi.org/10.15378/1848-9540.2015.38.02
5. Vuletić G, Stapić M. Kvaliteta života i doživljaj usamljenosti kod osoba starije životne dobi. Klinička psihologija 2013; 6(1-2): 45-61. Preuzeto s https://hrcak.srce.hr/167454
6. Martinis T. Percepcija kvalitete života u funkciji dobi. 2005. Preuzeto s: http://darhiv.ffzg.unizg.hr/id/eprint/337/1/Tina-Martinis.pdf
7. Brumnić V, Sukić L L, Jelica S.Utjecaj dobi na kvalitetu života gerijatrijske populacije // Zbornik prispevkov Celostna obravnava pacienta. Novo mesto: Univerza v Novem mestu, 2018, 76-82.
8. Pjevač N, Benjak T, Pjevač N. Povezanost tjelesne aktivnosti i kvalitete života starijih osoba. J Applied Health Sciences 2019; 5(2): 163-9. Preuzeto s: https://doi.org/10.24141/1/5/2/2
9. Tucak Junaković I, Nekić M. Percepcija uspješnog starenja u starijih osoba. Acta ladertina 2016; 13(2): 171-87. Preuzeto s: https://hrcak.srce.hr/190147
10. Ambrosi-Randić N, Plavšić M, Strenja E. Uspješno starenje. Pula: Društvo psihologa Istre etc., 2008.
11. Phelan AE, Anderson LA, LaCroix AZ, Larson EB. Older adults' views of „successful aging" – how do they compare with researchers' definitions? J Am Geriatr Soc 2004; 52(2): 211-16. Preuzeto s: https://doi.org/10.1111/j.1532–5415.2004.52056.x

Mentalno zdravlje osoba oboljelih of Alzheimerove bolesti

/ Mental Health of Persons with Alzheimer's Disease

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Cilj ovog rada je prikazati mentalno zdravlje osoba oboljelih od Alzheimerove bolesti opisivanjem neuropsihijatrijskih simptoma koji se javljaju tijekom bolesti te putem sustavnog prikaza istraživanja prevalencije navedenih simptoma. Neuropsihijatrijski simptomi Alzheimerove bolesti su simptomi koji uključuju promjene ličnosti, poremećaje raspoloženja, motoričkih aktivnosti i brojne druge promjene koje osim samog oboljelog mogu opaziti i osobe u okolini bolesnika (liječnici, njegovatelji i dr.). Također, simptomi negativno utječu ne samo na oboljele, već i na osobe oko njih (obitelj, njegovatelji, sustav skrbi za oboljele, te cjelokupno društvo).

Rad prikazuje Alzheimerovu bolest općenito i njezine neuropsihijatrijske simptome njihovim definiranjem, opisom, načinom tretmana, mjerenjem i grupiranjem. U radu je prikazana i prevalencija neuropsihijatrijskih simptoma, te su nalazi dobiveni sustavnom analizom dostupnih istraživanja uspoređeni s nalazima ranijih istraživanja. Tako su najčešći bili simptomi apatije, depresije i iritabilnosti, a najrjeđi simptomi euforije i halucinacije, što je bilo u skladu s nalazima ranijih istraživanja (uz manja odstupanja, koja su također prikazana u radu). S obzirom na očekivani porast starijih osoba u društvu te samim tim i oboljelih od raznih vrsta demencije (od kojih je Alzheimerova bolest najčešća), očekivano je da će rasti interes kako za samu bolest, tako i za njezine simptome.

/ This paper aims to describe the mental health of patients with Alzheimer's disease, considering the neuropsychiatric symptoms appearing over the course of the illness and a systematic review of research studies on the prevalence of the symptoms. The neuropsychiatric symptoms of Alzheimer's disease involve altered personality traits, mood and motor disorders, and numerous other signs apparent not only to patients but also to other people (physicians, caregivers, etc.). Namely, besides the patients, the symptoms equally affect their environment (family, caregivers, system of care for people with the disease, and the entire society).

This paper presents Alzheimer's disease in general and its neuropsychiatric symptoms, through their definition, description, treatment interventions, measurement, and classification. The paper also discusses the prevalence of neuropsychiatric symptoms, contrasting the findings from the systematic review with the results of previous research studies. Accordingly, the symptoms of apathy, depression, and irritability tend to prevail, while euphoria and hallucinations seem the least prevalent, which is consistent with the research findings from previous studies (with minor deviations, also presented in the paper). Given the projected increase of the elderly population and, accordingly, more people suffering from different types of dementia (most often Alzheimer's disease), the interest in the disease and its symptoms is expected to further increase in the future.

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KLJUČNE RIJEČI / *KEY WORDS*:
Alzheimerova bolest */ Alzheimer's Disease*
Demencija */ Dementia*
Neuropsihijatrijski simptomi */ Neuropsychiatric Symptoms*
Ponašajni i psihološki simptomi demencije */ Behavioural and Psychological Symptoms of Dementia*
Prevalencija */ Prevalence*

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UVOD

Jedan od najznačajnijih svjetskih demografskih trendova je starenje stanovništa. Starost je pak razdoblje u kojem se mogu javiti brojne bolesti, a jedna od najtežih je demencija. Iako postoje različiti uzroci demencije, jedan od najčešćih je Alzheimerova bolest (1,2). Možemo ju definirati kao neizlječivo, progresivno propadanje moždanih stanica, koje kod oboljelih u konačnici rezultira gubitkom mentalnih, psihičkih i fizičkih funkcija (3). U Hrvatskoj je prema podatcima Hrvatskog zavoda za javno zdravstvo 2017. broj oboljelih od demencije bio 86 000, a broj hospitaliziranih osoba s Alzheimerovom bolešću narastao je sa 225 2012. godine, na 612 2016. godine (4). Također, očekuje se da će do 2050. godine doći do udvostručenja broja osoba koje žive s demencijom, na 14 298 671 u EU i 18 846 286 u široj europskoj regiji, te da će se navedeno povećanje negativno odraziti na socijalne i zdravstvene sustave (5). Povećanje se očekuje i na globalnoj razini, gdje se, također do 2050. godine, očekuje 152 milijuna oboljelih od demencije. Stoga ni ne čudi da je Svjetska zdravstvena organizacija prepoznala demenciju kao javnozdravstveni prioritet (2).

Alzheimerova bolest je bolest mozga za koju je karakteristična progresivnost, a očituje se propadanjem kognitivnih funkcija. Prvi puta ju je opisao dr. Alois Alzheimer 1906. godine kao bolest okarakteriziranu znatnim gubitkom pamćenja i mikroskopskim promjenama na

INTRODUCTION

The ageing of population has profoundly marked global demographics. Many diseases afflict elderly people, notably dementia, among other severe conditions. Although there are various causes of dementia, it is commonly induced by Alzheimer's disease (1,2). The latter is defined as a chronic, progressive degeneration of brain cells, eventually entailing a decline of mental, psychological, and physical functions in patients (3). According to the Croatian Public Health Care Institute, 86.000 people had dementia in Croatia in 2017, while the number of people hospitalised with Alzheimer's disease increased from 225 in 2012 to 612 in 2016 (4). Moreover, the number of persons with dementia is expected to double by 2050, reaching 14,298,671 in the EU and 18,846,286 in the wider European area, and having profound implications for the social welfare and health care systems (5). The corresponding increase would equally affect the global population, with an estimated 152 million people with dementia by 2050. Consequently, the World Health Organisation listed dementia among the leading public health priorities (2).

Alzheimer's disease is a progressive brain disease, manifesting itself in degenerating cognitive functions. Dr Alois Alzheimer first described the disease in 1906, characterised by profound memory loss and microscopic brain changes. Although the degree of impairment

mozgu. Sam stupanj propadanja je individualan, no propadanje je nezaustavljivo, utječe na pamćenje, mišljenje i ponašanje oboljelih te u konačnici dovodi do smrti. U većini slučajeva simptomi se javljaju kasnije u životu (nakon 65. godine), postupni su (6,7), no ponekad bolest može nastupiti i naglo, kada su prisutni »okidači« poput emocionalnog šoka, značajnih promjena u okolini, komorbiditeta (postojanja neke druge teške bolesti), kirurških zahvata, i sl. (3). Jedan od prvih simptoma i znakova bolesti je gubitak kratkotrajnog pamćenja, a u konačnici simptomi postaju toliko ozbiljni da negativno utječu ili čak potpuno onemogućavaju obavljanje svakodnevnih aktivnosti (6, 7). Progresija bolesti i njezinih simptoma može se podijeliti u ranu, srednju i kasnu fazu (7), tj. Alzheimerova bolest može biti blaga, umjerena i teška (8). Prosječno osobe s dijagnozom žive četiri do osam godina. Za bolest trenutno nema lijeka, već je liječenje usmjereno na usporavanje propadanja funkcija i poboljšanje kvalitete života oboljelih (6).

Jedan od simptoma Alzheimerove bolesti su i neuropsihijatrijski simptomi (kratica NPS). To su simptomi koji se javljaju tijekom prirodnog toka razvitka bolesti (9, 10) no mogu se javiti i prije samih kognitivnih promjena (9, 11, 12) i promjena u svakodnevnom funkcioniranju osobe (12). Oni podrazumijevaju promjene ličnosti te poremećaje raspoloženja, motoričkih aktivnosti, misli, emocija i percepije, a osim samog subjektivnog iskustva oboljelog mogu ih opaziti i druge osobe (njegovatelji, liječnici i sl.) (10). Mogu varirati ovisno o jačini same bolesti (13) te imaju tendenciju pogoršanja u njezinom tijeku (14). Osim naziva neuropsihijatrijski simptomi (NPS) koristi se još i naziv ponašajni i psihološki simptomi demencije (*behavioral and psychological symptoms od dementia* - BPSD) (15,16). NPS su vrlo česti (javljaju se u 80-90 % oboljelih) (10,17,18), prisutni su u svim stadijima bolesti (14) te su relativno trajni (19), a negativno utječu na kvalitetu života oboljelih,

is individual, it is nonetheless irreversible, affecting memory, cognition, and behaviour, and ultimately leading to death. Typically, the symptoms appear at an elderly age (after the age of 65) and gradually (6,7). However, a sudden onset of Alzheimer's disease has also been observed, triggered by emotional distress, abrupt changes in the environment, comorbidity (co-occurrence of two or more diseases), surgery, etc. (3). Short-term memory loss is one of the first symptoms and signs of the disease, ultimately aggravating to the point of disrupting or impairing daily functioning (6,7). Alzheimer's disease and its symptoms evolve from early to middle, and late stages (7), with mild, moderate, and severe manifestations (8). Life expectancy for persons diagnosed with Alzheimer's disease is four to eight years. The disease has been incurable to date; therefore, treatment is directed at delaying functional decline and improving the quality of life for patients (6).

Neuropsychiatric symptoms (NPS) are typical of Alzheimer's disease. They occur over the natural progression of the illness (9,10). However, they may also precede cognitive changes (9,11,12) and disturbances in daily functioning (12). The symptoms involve altered personality traits and mood disorders, impaired motor activity, cognition, emotional experience, and perception, observed from the subjective standpoint of the patient and equally by other people (caregivers, physicians, etc.) (10). The symptoms vary depending on the severity of the condition (13) and tend to aggravate with the progression of the disease (14). Besides neuropsychiatric symptoms (NPS), the term "behavioural and psychological symptoms of dementia" (BPSD) is equally used (15,16). NPS are quite prevalent (in 80-90% of patients) (10,17,18) at all stages of the disease (14) and generally chronic (19), affecting the quality of life for patients, their caregivers/family (10,11, 16-18, 20), and the entire range of care services

njihovih njegovatelja/obitelji (10,11,16-18,20) te općenito na cijeli sustav skrbi za oboljele (10). Tako kod oboljelih NPS ubrzavaju fizičke disfunkcije i kognitivan pad (12), dok kod njegovatelja/obitelji dovode između ostalog do javljanja depresije (21), povećanja stresa (10,21,22), financijskih poteškoća, zdravstvenih problema, socijalne izolacije (21), sukoba u obitelji (23). Na razini sustava skrbi za oboljele koriste se veći novčani resursi za brigu za oboljele (10, 24), dolazi do ranije institucionalizacije oboljelih (17,18,25), te su NPS općenito jedan od glavnih razloga za institucionalizaciju oboljelih (26,27).

NPS su povezani i s češćim fizičkim ograničavanjem oboljelih koji ih iskazuju, kao i s češćim korištenjem psihotropnih lijekova (28). Za NPS je karakteristično da su po svojoj pojavnosti heterogeni (10,29,30) te zbog toga i nepredvidivi (10,30). Utječu na emocionalno stanje oboljelog, i to posredno, putem utjecaja na sadržaj misli, na motoričke funkcije, te na način na koji osoba percipira svijet oko sebe. Klinička slika je vrlo različita od osobe do osobe te ovisi o vrsti demencije. Pojedini simptomi mogu nalikovati (npr. apatija i depresija) zbog čega je i njihov tretman otežan (10).

Tijek javljanja i razvijanja neuropsihijatrijskih simptoma prati tijek razvoja same Alzheimerove bolesti te su oni najučestaliji u umjerenoj i uznapredovaloj fazi bolesti (31). Na samom početku, u blagoj fazi bolesti, javljaju se uznemirenost, depresija, anksioznost i sl. Umjerenu fazu bolesti karakterizira javljanje agresije i izraženije uznemirenosti (31), te se počinju javljati deluzije, halucinacije (32, 31), dezinhibicija i paranoja (31). Također, često dolazi do pogoršanja postojećih simptoma, poput anksioznosti i depresije, i to zbog sve težeg općenitog funkcioniranja oboljelih i otežane interakcije sa svojom okolinom i drugim osobama. Osim toga, neki simptomi koji su se ranije javili se u uznapredovalim fazama bolesti mijenjaju, pa se kao pojavni oblik primjerice

(10). The NPS equally accelerate physical dysfunctions and cognitive decline for patients (12), entailing depression for caregivers/family (21), higher caregiver burden (10, 21,22), financial difficulties, medical conditions, social isolation (21), family conflicts (23), etc. At the system level, the cost of care services increases (10, 24). Notably, the condition leads to earlier placement in institutional care (17,18,25), largely driven by the NPS (26,27).

The symptoms are equally linked to greater use of physical restraints for patients and higher prescription of psychotropic medication (28). Heterogeneous manifestation is typical for NPS (10,29,30), making them unpredictable (10,30). Indirectly, the NPS affect the patient's emotional state, thought content, motor functions, and the perception of reality. Clinical manifestations vary significantly for each person and depend on the type of dementia in question. Some symptoms may seem alike (e.g. apathy and depression), which further complicates the treatment (10).

The onset and development of neuropsychiatric symptoms follow the course of development of Alzheimer's disease itself, and they are most common in the moderate and advanced stages of the disease (31). At the very beginning, in the mild stage of the disease, agitation, depression, anxiety, etc., appear. The moderate stage of the disease is characterized by the appearance of aggression and more pronounced agitation (31), delusions, hallucinations (31,32), disinhibition and paranoia (31). Also, the existing symptoms, such as anxiety and depression, often become worse due to the increasingly difficult general functioning of the patient and difficult interaction with their environment and others. In addition, some of the symptoms that occur at the earlier stage change in the advanced stages of the disease. Therefore, symptoms such as pacing, sleep disorders, etc., may occur as a manifestation of e.g. agitation. In the final and most severe

uznemirenosti mogu javiti koračanje, poremećaji spavanja, itd. U posljednjoj, teškoj fazi Alzheimerove bolesti, teško je i odrediti pojavnost neuropsihijatrijskih simptoma s obzirom da osobe u ovoj fazi potpuno gube mogućnost komunikacije, te je njihovo fizičko zdravlje i funkcioniranje izrazito narušeno (javljaju se učestale infekcije, otežano gutanje, gubitak težine ...) (31).

Biologijska podloga neuropsihijatrijskih simptoma tumači se povezanošću s promjenama koje nastaju u moždanim strukturama i neurotransmiterima. Tako primjerice mogu nastati kortikalne promjene povezane s neurodegeneracijom, promjene u bijeloj tvari u bazalnim ganglijima, frontalnom i parijetookcipitalnom režnju te povišenje supkortikalne koncentracije noradrenalina, kao i sniženje koncentracije serotonina (33).

Usmjerivši se na moždane strukture i njihovu povezanost sa specifičnom simptomatologijom primijećeno je kako osobe oboljele od Alzheimerove bolesti koje razviju i psihozu imaju veće oštećenje i gubitak kortikalnih sinapsi od oboljelih od Alzheimerove bolesti bez psihoze. Također, prisutnost psihoze kod oboljelih povezana je i s naglašenim smanjenjem dotoka krvi, metabolizma glukoze i volumena sive tvari u neokorteksu, no to nužno ne znači i da navedene osobe nemaju patološke promjene u hipokampusu i entorinalnom korteksu, kao i oštećenje kratkotrajnog pamćenja. Ono što zapravo razlikuje oboljele od Alzheimerove bolesti s psihozom i bez psihoze je područje oštećenja – kod oboljelih sa psihozom ono se nalazi u neokortikalnim područjima, i to posebno u frontalnim kortikalnim područjima (uključujući dorzolateralni prefrontalni korteks). U neokortikalnim područjima primijećeno je i povećano nakupljanje patoloških tau proteina povezanih s mikrotubulima - MAPT (fosfo MAPT i fibrilarni MAPT) pri čemu je važno naglasiti da nije bilo moguće odrediti je li primjećeno povećanje povezano s ubrzanjem patoloških

stage of Alzheimer's disease, it is difficult to determine the occurrence of neuropsychiatric symptoms, because at this stage patients lose their ability to communicate completely, and their physical health and functioning is severely impaired (they suffer from frequent infections, difficulty swallowing, weight loss, ...) (31).

The biological background of neuropsychiatric symptoms is explained by the association with changes occurring in brain structures and neurotransmitters. Thus, for example, cortical changes associated with neurodegeneration, changes in white matter in the basal ganglia, frontal and parietal-occipital lobes, and increased subcortical norepinephrine levels, as well as decreased serotonin levels, may occur (33).

Focusing on brain structures and their association with specific symptomatology, it was observed that patients with Alzheimer's disease who develop psychosis also have greater damage and loss of cortical synapses than people with Alzheimer's disease without psychosis. Also, the presence of psychosis in patients is associated with a marked decrease in blood flow, glucose metabolism and grey matter volume in the neocortex, but this does not necessarily mean that these patients do not have pathological changes in the hippocampus and entorhinal cortex and short-term memory impairment. What actually distinguishes Alzheimer's patients with and without psychosis is the area of damage, i.e., in patients with psychosis it is located in neocortical areas, especially in the frontal cortical areas (including the dorsolateral prefrontal cortex). In neocortical areas, an increased accumulation of pathological tau proteins associated with microtubules - MAPT (phosphoMAPT and fibrillar MAPT) was observed, and it is important to emphasize that it was not possible to determine whether the observed increase was associated with acceleration of pathological

procesa ili je ono uzročno povezano sa samim nastupom psihoze (34).

Iako serotonergički sistem (jedan od najistraživanijih dijelova središnjeg živčanog sustava) utječe ne samo na regulaciju molekula za koje je poznato da uzrokuju Alzheimerovu bolest, poput hiperfosfoliziranog tau i Aß, već i na kogniciju (tj. njezinu modulaciju), sama interakcija između kognitivnog deficita i serotonergičkog sistema nije potpuno istražena, te zapravo nedostaje potpuno razumijevanje mehanizama koji su u podlozi neuropsihijatrijskih simptoma i kognitivnog deficita koji se javljaju uz Alzheimerovu bolest (35).

Osim biologijskog rizika za razvijanje psihoze u Alzheimerovoj bolesti rizik je djelomično i genetski uvjetovan, što su prikazala i istraživanja obiteljskog „nakupljanja" psihoze kod Alzheimerove bolesti, iako nije pronađena određena genetska varijanta za koju bi se nedvojbeno moglo smatrati da pridonosi povećanju rizika od razvitka psihoze kod oboljelih od Alzheimerove bolesti. Također, važno je naglasiti da genetske varijante koje povećavaju rizik za razvoj same Alzheimerove bolesti nisu povezane sa psihozom. Stoga se kao najvjerojatnijim smatra model u kojem je genima za Alzheimerovu bolest potaknuto napredovanje patologije neovisno modificirano genetskim varijantama za razvijanje Alzheimerove bolesti s psihozom (34).

Usmjerivši se pak na delirij, često njegovom javljanju prethodi stvaranje citokina kao sastavnog dijela upalnog odgovora nastalog kao reakcija na traume i upalne procese. Navedeno je potvrđeno i kliničkim iskustvom prema kojem kada se kod osoba s demencijom jave upalne bolesti, primjerice mokraćnog ili dišnog sustava, kod osoba se razvije delirantno stanje (33).

Prema vodećim hipotezama smatra se da uzrok delirija zapravo leži u javljanju dopaminergičke hiperaktivnosti i to kao posljedice kolinergičkog deficita, što se može i potvrditi činjenicom

processes or causally related to the onset of psychosis (34).

Although the serotonergic system (one of the most studied parts of the central nervous system) affects not only the regulation of molecules known to cause Alzheimer's disease, such as hyperphosphorylated tau and Aß, but also cognition (its modulation), the interaction between cognitive deficit and the serotonergic system has not been fully investigated, and, in fact, there is a lack of full understanding of the mechanisms underlying the neuropsychiatric symptoms and cognitive deficits that occur with Alzheimer's disease (35).

Apart from the biological determinants, the risk of developing psychosis in Alzheimer's disease is partly genetically determined, as shown by the research on familial "accumulation" of psychosis in Alzheimer's disease, although no specific genetic variant has been found that could undoubtedly increase the risk of developing psychosis in Alzheimer's patients. Also, it is important to emphasize that genetic variants that increase the risk of developing Alzheimer's disease itself are not associated with psychosis. Therefore, a model in which genes for Alzheimer's disease stimulate the progression of pathology independently modified by genetic variants to develop Alzheimer's disease with psychosis is considered most likely (34).

Focusing on delirium, it is often preceded by cytokine production as an integral part of the inflammatory response in response to trauma and inflammatory processes. It has been confirmed by clinical experience that when patients with dementia develop inflammatory diseases such as urinary or respiratory diseases, they also develop a delirium (33).

According to leading hypotheses, it is believed that the cause of delirium lies in the occurrence of dopaminergic hyperactivity, as a consequence of cholinergic deficiency, which can

da se smatra da upravo korištenje dopaminergičkih lijekova poput bupropinona prethodi javljanju delirija (33).

Upravo zbog prepoznate važnosti i utjecaja neuropsihijatrijskih simptoma, kako na život oboljelih, tako i na one oko njih, odlučili smo se u našem radu i usmjeriti na navedeno područje, tj. na neuropsihijatrijske simptome i njihovu raširenost, koju ćemo u glavnom dijelu rada prikazati sustavnim pregledom postojećih istraživanja te iz navedenog izvesti zaključke.

SUBSINDROMI

Dosadašnja istraživanja su pokazala da se simptomi ne javljaju jedan po jedan, tj. izolirano, već u grupama, zbog čega postoji mogućnost grupiranja simptoma u tzv. klastere, tj. sindrome (18,23). Tako su različiti autori grupirali simptome u različiti broj grupa. Primjerice Aalten i sur. (36) klasificirali su tri subsindroma - psihoza (halucinacije i deluzije), rapoloženje/apatija (apatija, poremećaji spavanja, poremećaji apetita/hranjenja, depresija) i hiperaktivnost (euforija, iritabilnost, motoričko ponašanje koje odstupa od normalnoga, uznemirenost i dezinhibicija), dok anksioznost nije pripadala ni u jedan sindrom, već je bila simptom »za sebe«. Tri klastera simptoma prepoznali su i Kim, Ok Noh i Kim (23) nakon provedene faktorske analize simptoma. Klastere su nazvali psihoza (anksioznost, halucinacije, depresija/disforija, elacija/euforija i deluzije), hiperaktivnost (uznemirenost/agresija, iritabilnost, dezinhibicija) i simptomi fizičkog ponašanja (poremećaji spavanja, apatija/indiferentnost, poremećaji apetita/hranjenja, te motoričko ponašanje koje odstupa od normalnog). S druge strane, Mirakhur i sur. (37) su identificirali četiri subsindroma: fizičko ponašanje (apatija, poremećaji spavanja, poremećaji hranjenja/apetita, motoričko ponašanje koje odstupa od normalnoga), psihoza (halucinacije i deluzije), afekt (uznemirenost/agresija, iritabilnost/labilnost,

be confirmed by the fact that the use of dopaminergic drugs, such as bupropinone, precedes delirium (33).

Given the acknowledged importance and impact of neuropsychiatric symptoms on patients' lives and their environment, the central part of this paper examines the neuropsychiatric symptoms and their prevalence based on a systematic review of relevant research studies, and followed by a set of conclusions.

SUBSYNDROMES

The examined research studies demonstrated that symptoms did not appear in isolation, emerging individually, but rather in association, which allowed their classification in clusters or syndromes (18,23). Accordingly, different authors classified the symptoms in various numbers of clusters. For example, Aalten et al. (36) classified three subsyndromes - psychosis (hallucinations and delusions), mood disorders/apathy (apathy, sleeping disorders, appetite/eating disorders, depression), and hyperactivity (euphoria, irritability, aberrant motor behaviour, agitation, and disinhibition). However, anxiety was seen as a distinct symptom that could not be referred to any of the other syndromes. Kim, Ok Noh & Kim (23) also identified three clusters of symptoms based on factor analysis. The clusters were classified as psychosis (anxiety, hallucinations, depression/dysphoria, elation/euphoria, and delusions), hyperactivity (agitation/aggression, irritability, disinhibition), and physical behaviour symptoms (sleeping disorders, apathy/indifference, appetite/eating disorders, aberrant motor behaviour). On the other hand, Mirakhur et al. (37) distinguished four subsyndromes: physical behaviour (apathy, sleeping disorders, eating/appetite disorders, aberrant motor behaviour), psychosis (hallucinations and delusions), affect (agitation/aggression, irri-

depresija/disforija i anksioznost) i hipomanija (euforija/elacija i dezinhibicija,). Četiri subsindroma prepoznali su i Kang i sur. (18), koji su simptome grupirali u grupe afekt (anksioznost, depresija/disforija), hiperaktivnost (dezinhibicija, iritabilnost/labilnost, uznemirenost/agresija), apatija/vegetativni simptomi (poremećaji apetita, apatija/indiferentnost, poremećaji spavanja), te psihoza (halucinacije i deluzije).

Spalletta i sur. (30) su pak u svojem istraživanju definirali čak pet sindroma: afektivni (depresija i anksioznost), psihomotorni (iritabilnost, motoričko ponašanje koje odstupa od normalnog, uznemirenost), manični (dezinhibicija i euforija), psihotični (halucinacije i deluzije), te konačno apatični (apatija).

Navedeno grupiranje smatra se važnim jer je prepoznat potencijal za postojanje zajedničkog neurobiološkog uzroka simptoma koji su grupirani zajedno zbog čega bi njihovo identificiranje bilo važno i korisno za odabir najboljeg tretmana za određenu grupu simptoma (11,18,28). Moguće je i da simptomi koji su grupirani u isti sindrom imaju i iste druge rizične i uzročne faktore nastanka, kao i da su određeni načini terapije učinkovitiji kada su usmjereni na cjelokupni sindrom, a ne samo na pojedinačne simptome (16). Razlike u grupiranju (tj. odabiru koji simptom pripada u koji sindrom) između autora mogu se pripisati razlikama između populacija u istraživanjima, te između mjesta na kojima su podatci ispitanika regrutirani/prikupljeni podatci (npr. osobe u domovima za starije, gerontološkim centrima, bolnicama i sl.) (17), kao i razlikama u broju uključenih ispitanika, načinima mjerenja i općenito dizajnu istraživanja (36).

MJERENJE

NPS se mjere putem nekoliko instrumenata, no najpoznatiji i najčešće korišten je Neuropsihijatrijski inventar (*Neuropsychiatric Inventory*

tability/affective lability, depression/dysphoria, and anxiety), and hypomania (euphoria/elation and disinhibition). Kang et al. (18) equally described four subsyndromes, notably affect (anxiety, depression/dysphoria), hyperactivity (disinhibition, irritability/affective lability, agitation/aggression), apathy/vegetative symptoms (appetite disorders, apathy/indifference, sleeping disorders), and psychosis (hallucinations and delusions).

Finally, in their research study, Spalletta et al. (30) defined five syndromes: affective (depression and anxiety), psychomotor (irritability, aberrant motor behaviour, agitation), manic (disinhibition and euphoria), psychotic (hallucinations and delusions), and apathetic syndrome (apathy).

These classifications have been acclaimed for their potential to identify common neurobiological causes of symptoms grouped in clusters, which could facilitate prescribing the best treatment for a specific cluster (11,18,28). Furthermore, symptoms classified under the same syndrome might also share similar risk factors and causes of their manifestation. Moreover, recommended treatment could also prove more effective when directed at the entire syndrome, rather than individual symptoms (16). Variations in classification (assigning symptoms to syndromes) between the authors might have ensued from the differences among research populations, including the settings where participants were recruited/data was collected (e.g. persons in nursing homes, gerontological centres, hospitals, etc.) (17), as well as the differences in participant number, methods of measurement, and the overall research design (36).

MEASUREMENT

While several instruments can measure NPS, the neuropsychiatric inventory (NPI) is generally the most popular and widely used

- NPI (18,36). To je instrument s prvotno 10, a sada 12 čestica, kojim se mjeri težina i frekvencija/učestalost neuropsihijatrijskih simptoma kod osoba oboljelih od demencije (36). Simptomi koji se mjere su: halucinacije, deluzije, uznemirenost/agresija, anksioznost, depresija/disforija, apatija, iritabilnost, dezinhibicija, euforija, motoričko ponašanja koje odstupa od normalnoga, poremećaji spavanja, te poremećaji hranjenja/apetita (36-39). Posljednja dva simptoma (poremećaji spavanja, te poremećaji hranjenja/apetita) su naknadno dodani prvotnoj verziji od 10 čestica (36). Svaka čestica mjeri ozbiljnost/težinu simptoma na ljestvici 1-3, te frekvenciju/učestalost na ljestvici 1-4. Rezultat za pojedini simptom se dobiva množenjem frekvencije/učestalosti i ozbiljnosti/težine simptoma (36-39), a može iznositi od 1 do 12 (37-39). Ukupan rezultat se pak dobiva zbrajanjem rezultata za svaki pojedini simptom (36-39), te može iznositi od 0 do 144 (37,39). Osim samih neuropsihijatrijskih simptoma, NPI mjeri i količinu stresa kod njegovatelja povezanu sa svakim neuropsihijatrijskim simptomom (36).

Zbog prirode same bolesti često je nemoguće od samog oboljelog dobiti odgovarajuće informacije za opisivanje neuropsihijatrijskih simptoma koje ima. Stoga se osim direktnog razgovora s oboljelim, u svrhu dijagnosticiranja i opisivanja simptoma, potrebne informacije dobivaju od njegovatelja oboljelog i članova obitelji. Važno je pri dijagnosticiranju uzeti u obzir i same osobe, kao i njegovatelja/članove obitelji jer ta dva gledišta ne moraju biti usuglašena (10). Točnije, njegovatelj može drugačije ocijeniti simptome i njihovu težinu/učestalost javljanja od same osobe. No, i sama osoba zbog prirode svoje bolesti može neadekvatno prepoznati i opisati svoje simptome. Upravo zbog navedenog smatramo kako je važno da su oba gledišta uključena u proces opisivanja simptoma i tijeka bolesti.

instrument (18,36). It is an instrument initially comprising ten, and currently twelve items, measuring the weight and frequency of neuropsychiatric symptoms in persons with dementia (36). These symptoms involve hallucinations, delusions, agitation/aggression, anxiety, depression/dysphoria, apathy, irritability, disinhibition, euphoria, aberrant motor behaviour, sleeping disorders, and eating/appetite disorders (36-39). The latter (sleeping and eating/appetite disorders) have subsequently been added to the initial version of ten items (36). Each item measures the severity of symptoms on a scale of 1-3 and their frequency on a scale of 1-4. The score for each symptom is calculated by multiplying the frequency and the severity of symptoms (36-39), ranging from 1-12 (37-39). The total score is then calculated by adding up the scores for individual symptoms (36-39); it can range from 0-144 (37,39). Besides neuropsychiatric symptoms, NPI equally measures caregiver burden for each neuropsychiatric symptom (36).

Considering the nature of the disease, it is often impossible to obtain an adequate description of neuropsychiatric symptoms from patients. For this reason, besides a direct conversation with patients, relevant information is also requested in interviews with caregivers or family members who can help identify and describe the symptoms. When diagnosing the disease, both patients and their caregivers/family members should be consulted as their views were not always reconciled (10). In fact, caregivers might assess the symptoms and their severity/frequency differently than the patient. Given the character of the disease, patients might also identify and describe their symptoms inadequately. For this reason, exploring both views is pivotal to describing the symptoms and the progression of the disease appropriately.

TRETMAN

Dva su osnovna pristupa u liječenju NPS-a - farmakološki (korištenje lijekova poput antidepresiva, antipsihotika, benzodiazepina i drugih) i ne-farmakološki (poput terapije svjetlom, muzikoterapije, aromaterapije, masaža, zatim vježbanje, grupne aktivnosti, itd.) (10). Iako je u velikom broju slučajeva primijenjen farmakološki tretman, danas je njihovo korištenje potrebno dobro razmotriti. Neki od razloga su što oboljeli mogu imati komorbidne bolesti zbog kojih mogu koristiti druge lijekove pa su moguće interakcije (10). Učinkovitost lijekova nije jednaka za sve simptome. Tako je primjerice za uznemirenost upitna učinkovitost lijekova, što je u kombinaciji s činjenicom da lijekovi vrlo često imaju i nuspojave, dovelo do usmjeravanja na ne-farmakološki odgovor na problem (40). Zbog navedenog preporuke su da se kao prvi odgovor na NPS koristi nefarmakološki tretman, a ako se lijekovi moraju koristiti da se tijekom što kraćeg razdoblja koristi najmanje štetan lijek. Osim toga je važno biti svjestan kako ne postoji tretman koji će odgovarati svima i biti primjeren u svakoj situaciji (14).

Specifičnosti farmakoterapijskih principa u liječenju neuropsihijatrijskih simptoma

Ublažavanje neuropsihijatrijskih simptoma (poput npr. anksioznosti) važno je za oboljele kako zbog lakšeg zbrinjavanja u instituciju, olakšanja općenite skrbi za osobu, ali i zbog same osobe, kako bi se održalo i poboljšalo njezino opće stanje. Tako se za anksioznost koriste lijekovi s anksiolitičkim djelovanjem, i to u niskoj dozi (zbog potencijalnog negativnog utjecaja na kognitivne funkcije, ali i sedativnog djelovanja), poput primjerice klonazepama, sulprida, alprazolama, antidepresiva koji pripadaju skupini inhibitora povratne pohrane serotonina i brojnih drugih (33).

Kod farmakoterapijskog odgovora na psihotične simptome koriste se antipsihotici poput

TREATMENT

There are two common treatment interventions for NPS - the pharmacological (using medication such as antidepressants, antipsychotics, benzodiazepine, and others) and the non-pharmacological treatment (such as light therapy, music therapy, aromatherapy, massage, exercise, group activities, etc.) (10). Although pharmacological treatment is quite habitual, careful consideration is advised nowadays. For some patients, reasons may involve comorbidity and possible interactions of the drugs prescribed (10). Moreover, medication is often not equally effective in treating every symptom. For example, the efficacy of medication for treating agitation is rather arguable, notably against the common side effects of different drugs. Accordingly, the attention has been shifting onto non-pharmacological responses (40). Moreover, the non-pharmacological approach has been indicated as the first-line treatment of NPS. However, if medication is required, it has been recommended to prescribe the least harmful medication for the shortest time possible. That said, it is also noteworthy that no treatment is equally effective for all patients, nor appropriate in every case (14).

Specifics of pharmacotherapeutic principles in the treatment of neuropsychiatric symptoms

Alleviation of neuropsychiatric symptoms (such as anxiety) is important for patients to facilitate care in the institution, facilitate general care for the person, but also for the person him or herself, in order to maintain and improve their general condition. Thus, low doses of anxiolytic drugs are used for anxiety (due to a potential negative impact on cognitive functions, but also sedative effects), such as clonazepam, sulpride, alprazolam, antidepressants belonging to the group of serotonin reuptake inhibitors and many others (33).

klozapina, risperidona, olanzapina i sl. koji uzrokuju manje ekstrapiramidalnih simptoma od primjerice haloperidola i promazina, te također nemaju tako jako antikolinergičko djelovanje poput njih. No, ono što antipsihotici nose sa sobom i zbog čega ih je potrebno koristiti u prvom redu nakon neuspješnog korištenja nefarmakoloških načina tretmana ili ako je prisutan znatan rizik od ozljeđivanja drugih osoba ili od samoozljeđivanja, kao i njihovu upotrebu potrebno ograničiti na što kraće vrijeme (3 – 6 mjeseci) i na što manju dozu, je povećanje smrtnosti kod oboljelih od demencije koji ih koriste. Stoga primjerice za risperidon početna doza iznosi 0,5 do 1 mg, za olanzapin 2,5 mg, klozapin 12,5 mg, a za haloperidol 0,5 mg (33).

Depresija kod oboljelih liječi se korištenjem antidepresiva prilagođenih kliničkoj slici starijih osoba, sa posebnim naglaskom na postizanje ravnoteže serotonina (33). Tako se primjerice od inhibitora ponovne pohrane serotonina i noradrenalina koriste mirtazapin (7,5 do 30 mg navečer), duloksetin (40 do 60 mg/dan) i venlafaksin (37,5 do 200 mg/dan), zatim selektivni inhibitori ponovne pohrane serotonina poput citaloprama (do 20 mg/dan), sertalina (12,5 do 50 mg/dan), fluoksetina (5 do 20 mg/dan), te fluvoksamina (50 do 100 mg/dan). Osim navedenih, koriste se i ostali antidepresivi, poput bupropiona (75 do 150 mg, 2 x/dan) i tianeptina (12,5 mg, 2 x/dan) (33).

Za poremećaje spavanja/dnevnog ritma koriste se hipnotici, primjerice fluzepam, nitrazepam, zolpidem i sl., a samo iznimno i antipsihotici (33).

Antipsihotici (dopaminski antagonisti) se također koriste i za liječenje delirija te je, kao što je ranije navedeno, potreban poseban oprez pri njihovom korištenju kod osoba s demencijom (33). Preporučene doze su primjerice 2,5 do 5 mg/dan za olanzapin, 0,5 do 1 mg/dan za risperidon, te 25 do 50 mg/dan za kvetiapin (41).

In the pharmacotherapeutic response to psychotic symptoms, antipsychotics such as clozapine, risperidone, olanzapine, etc. are used, which cause fewer extrapyramidal symptoms than, for example, haloperidol and promazine, and also have less strong anticholinergic effects. However, antipsychotics should be used primarily after unsuccessful use of non-pharmacological treatments or if there is a significant risk of injury to others or self-harm, and their use should be limited to the shortest possible time (3 - 6 months) and at the lowest possible dose, as they increase mortality in people with dementia. For example, for risperidone the starting dose is 0.5 to 1 mg, for olanzapine 2.5 mg, clozapine 12.5 mg, and for haloperidol 0.5 mg (33).

Depression in patients is treated using antidepressants adapted to the clinical picture of the elderly, with special emphasis on achieving serotonin balance (33). For example, mirtazapine (7.5 to 30 mg in the evening), duloxetine (40 to 60 mg/day) and venlafaxine (37.5 to 200 mg/day) are used as serotonin and norepinephrine reuptake inhibitors, as well as selective serotonin reuptake inhibitors such as citalopram (up to 20 mg/day), sertalin (12.5 to 50 mg/day), fluoxetine (5 to 20 mg/day), and fluvoxamine (50 to 100 mg/day). In addition to the above, other antidepressants are used, such as bupropion (75 to 150 mg, twice daily) and tianeptine (12.5 mg, twice daily) (33).

Hypnotics such as fluzepam, nitrazepam, zolpidem, etc. are used for sleep/circadian rhythm disorders;, antipsychotics are used only exceptionally (33).

Antipsychotics (dopamine antagonists) are also used to treat delirium, and, as noted earlier, special caution is required when using them in patients with dementia (33). The recommended doses are, 2.5 to 5 mg/day for olanzapine, 0.5 to 1 mg/day for risperidone, and 25 to 50 mg/day for quetiapine (41).

PREVALENCIJA NEUROPSIHIJATRIJSKIH SIMPTOMA

Više od 80 % oboljelih tijekom bolesti razvije barem jedan NPS (42). Gauthier i sur. (14) smatraju da je ta prevalencija još i veća te da 80-97 % oboljelih od Alzheimerove bolesti u tijeku bolesti ima barem jedan NPS.

U nastavku rada analizirano je 10 radova koji su istraživali prevalenciju NPS-a, mjerenih putem NPI upitnika.

Tablica 1. prikazuje prevalenciju 12 NPS-a mjerenih putem NPI upitnika. Za svaki rad prikazana je prevalencija svakog simptoma (podebljanim slovima su označena tri najčešća simptoma, a ukošenim tri najrjeđa simptoma).

Tablica 2. prikazuje simptome od najčešćeg (na 1. mjestu) do najrjeđeg (na 12. mjestu).

PREVALENCE OF NEUROPSYCHIATRIC SYMPTOMS

Over 80% of patients report at least one NPS over the course of the disease (42). Gauthier et al. (14) found the prevalence even higher, with 80-97% of patients with Alzheimer's disease developing at least one NPS over the course of the disease.

Below we present ten papers on the prevalence of NPS measured by the NPI questionnaire.

Table 1. shows the prevalence of twelve NPS measured by the NPI questionnaire. For every reviewed paper, the prevalence is indicated per symptom (the three most prevalent symptoms are marked in **bold** and the three least prevalent symptoms in *italics*).

Table 2. further presents the symptoms from the most prevalent (presented first) to the least prevalent (the twelfth).

TABLICA 1. Sumiranje rezultata istraživanja
TABLE 1. Summary of research results

NPI (% prevalencije) / NPI (% of prevalence)	**Broj rada i autori / No. of research study and authors**									
Simptomi / Symptoms	1. Sannemann et al. (49)	2. Aalten et al. (36)	3. Musa et al. (50)	4. Aalten et al. (16)	5. Mirakhur et al. (37)	6. Bergh et al. (39)	7. Kang et al. (18)	8. Karttunen et al. (51)	9. Wetzels et al. (19)	10. Mulders et al. (44)
Deluzije / Delusions	*5*	34,7	*18,9*	19,4	49,5	44,9	22,9	22,5	*21,4*	*7,1*
Halucinacije / Hallucinations	*5*	*13,1*	*9,4*	*9,1*	*27,8*	*17,7*	*10,7*	15,4	*10,3*	*5,8*
Uznemirenost / Agitation	**35**	28,6	32,1	31,1	62,8	**51**	31,5	29,6	**53,8**	**38,2**
Depresija / Depression	33	**57,3**	**56,6**	**36,7**	54,3	45,8	**53,1**	**37,1**	26,5	16,9
Anksioznost / Anxiety	27	39,2	**50,9**	**37,0**	50,2	35,4	**43,1**	25,8	37,6	16
Euforija / Euphoria	*10*	*7*	*9,4*	*4,9*	*16,6*	*18,7*	*6*	*5,8*	*13,7*	*10,2*
Apatija / Apathy	**34**	**59,3**	**58,5**	**55,2**	**76**	44,8	**47,8**	**47,9**	**53**	**55,6**
Dezinhibicija / Disinhibition	16	*12,6*	24,5	*9,5*	*29,5*	**50**	*22,8*	*14,6*	27,4	22,7
Iritabilnost / Irritability	**36**	**39,7**	45,3	32,1	63	**63,5**	41,3	**34,2**	**58,1**	**37,3**
Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	18	34,7	28,3	27,5	**64,5**	45,8	26,2	18,8	50,4	33,3
Poremećaji spavanja / Sleeping disorders	*14*	18,1	24,5	19,5	53,8	*32,3*	27,2	*13,9*	23,1	11,6
Poremećaji hranjenja/ apetita / Eating/appetite disorders	23	24,6	35,8	21,8	**63,7**	*32,3*	34,1	25,8	36.8	20,9

TABLICA 2. Rang lista simptoma
TABLE 2. Ranking list of symptoms

Broj rada u tablici radova / Number of study in the table of research studies		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
Autori / Authors		Sannemann et al. (49)	Aalten et al. (36)	Musa et al. (50)	Aalten et al. (16)	Mirakhur et al. (37)	Bergh et al. (39)	Kang et al. (18)	Karttunen et al. (51)	Wetzels et al. (19)	Mulders et al. (44)
Redosljed simptoma od najprevalentnijeg do najmanje prevalentnog / Order of symptoms from the most to the least prevalent	1.	Iritabilnost / Irritability	Apatija / Apathy	Apatija / Apathy	Apatija / Apathy	Apatija / Apathy	Iritabilnost / Irritability	Depresija / Depression	Apatija / Apathy	Iritabilnost / Irritability	Apatija / Apathy
	2.	Uznemirenost / Agitation	Depresija / Depression	Depresija / Depression	Anksioznost / Anxiety	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Uznemirenost / Agitation	Apatija / Apathy	Depresija / Depression	Uznemirenost / Agitation	Uznemirenost / Agitation
	3.	Apatija / Apathy	Iritabilnost / Irritability	Anksioznost / Anxiety	Depresija / Depression	Poremećaji hranjenja / Eating disorders	Dezinhibicija / Disinhibition	Anksioznost / Anxiety	Iritabilnost / Irritability	Apatija / Apathy	Iritabilnost / Irritability
	4.	Depresija / Depression	Anksioznost / Anxiety	Iritabilnost / Irritability	Iritabilnost / Irritability	Iritabilnost / Irritability	Depresija / Depression	Iritabilnost / Irritability	Uznemirenost / Agitation	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour
	5.	Anksioznost / Anxiety	Deluzije / Delusions	Poremećaji hranjenja / Eating disorders	Uznemirenost / Agitation	Uznemirenost / Agitation	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Poremećaji hranjenja / Eating disorders	Anksioznost / Anxiety	Poremećaji hranjenja / Eating disorders	Dezinhibicija / Disinhibition
	6.	Poremećaji hranjenja / Eating disorders	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Uznemirenost / Agitation	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Depresija / Depression	Deluzije / Delusions	Uznemirenost / Agitation	Poremećaji hranjenja / Eating disorders	Anksioznost / Anxiety	Poremećaji hranjenja / Eating disorders
	7.	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Uznemirenost / Agitation	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Poremećaji hranjenja / Eating disorders	Poremećaji spavanja / Sleeping disorders	Apatija / Apathy	Poremećaji spavanja / Sleeping disorders	Deluzije / Delusions	Dezinhibicija / Disinhibition	Depresija / Depression
	8.	Dezinhibicija / Disinhibition	Poremećaji hranjenja / Eating disorders	Dezinhibicija / Disinhibition	Poremećaji spavanja / Sleeping disorders	Anksioznost / Anxiety	Anksioznost / Anxiety	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Motoričko ponašanje koje odstupa od normalnog / Aberrant motor behaviour	Depresija / Depression	Anksioznost / Anxiety
	9.	Poremećaji spavanja / Sleeping disorders	Poremećaji spavanja / Sleeping disorders	Poremećaji spavanja / Sleeping disorders	Deluzije / Delusions	Deluzije / Delusions	Poremećaji spavanja / Sleeping disorders	Deluzije / Delusions	Halucinacije / Hallucinations	Poremećaji spavanja / Sleeping disorders	Poremećaji spavanja / Sleeping disorders
	10.	Euforija / Euphoria	Halucinacije / Hallucinations	Deluzije / Delusions	Dezinhibicija / Disinhibition	Dezinhibicija / Disinhibition	Poremećaji hranjenja / Eating disorders	Dezinhibicija / Disinhibition	Dezinhibicija / Disinhibition	Deluzije / Delusions	Euforija / Euphoria
	11.	Deluzije / Delusions	Dezinhibicija / Disinhibition	Halucinacije / Hallucinations	Halucinacije / Hallucinations	Halucinacije / Hallucinations	Euforija / Euphoria	Halucinacije / Hallucinations	Poremećaji spavanja / Sleeping disorders	Euforija / Euphoria	Deluzije / Delusions
	12.	Halucinacije / Hallucinations	Euforija / Euphoria	Euforija / Euphoria	Euforija / Euphoria	Euforija / Euphoria	Halucinacije / Hallucinations	Euforija / Euphoria	Euforija / Euphoria	Halucinacije / Hallucinations	Halucinacije / Hallucinations

Sistematizirajući radove o prevalenciji možemo zaključiti:

1. Svim radovima je zajedničko da je prevalencija euforije među najmanjima u svakom pojedinačnom radu. U 6 od 10 radova euforija je bila na zadnjem mjestu, a u preostalim radovima bila je na 10. i 11. mjestu.
2. Većini radova je zajednička činjenica da su depresija, apatija i iritabilnost među najčešćim NPS u svakom pojedinačnom radu. Tako je primjerice apatija u 9 od 10 radova jedan od najčešćih simptoma, dok je depresija u 6 od 10 radova među najčešćima kao i iritabilnost također u 6 od 10 radova. Poremećaji spavanja su većinom imali nisku prevalenciju (raspon od 11,6 do 27,2 %) te su nakon sortiranja simptoma po prevalenciji, većinom bili u donjoj polovici rang ljestvice. Također, u većini radova su halucinacije imale nisku prevalenciju (5-27,8 %) te su većinom bile na samom dnu »rang ljestvice« simptoma (11. ili 12. mjesto u većini radova).
3. Odstupajući nalaz je prevalencija poremećaja spavanja i poremećaja hranjenja/apetita u jednom od istraživanja. Naime, kod drugih radova ovi simptomi su prema prevalenciji uvijek u donjoj polovici simptoma (maksimalno do 27,2 % za poremećaje spavanja i 36,8 % za poremećaje hranjenja i apetita), dok je u radu Mirakhur i sur. (37) njihova prevalencija viša (53,8 % za poremećaje spavanja i 63,7 % za poremećaje hranjenja/apetita). Štoviše, u navedenom radu poremećaji hranjenja/apetita imaju 3. najvišu prevalenciju, a poremećaji spavanja su po prevalenciji 7. (od 12), dok su u drugim radovima poremećaji hranjenja/apetita na 5., 6., 7., 8. i 10. mjestu, a poremećaji spavanja su većinom na 9. mjestu. U radu Kang i sur. (18) poremećaji spavanja su također na 7. mjestu, ali je njihova prevalencija značajno manja [27,2 % naspram 53,8 % u radu Mirakhur i sur. (37)], zbog čega i dalje ovaj podatak smatramo odstupajućim.

The main findings from the studies on the prevalence point to the following conclusions:

1. The lowest prevalence of euphoria is a consistent finding in all studies. Namely, in 6 out of 10 papers, the euphoria was ranked last, and in the remaining studies, it was ranked tenth or eleventh.
2. Another consistent finding in most studies concerned the highest prevalence of depression, apathy, and irritability among the NPS. For example, apathy was mentioned among the most prevalent symptoms in 9 out of 10 studies, while depression and irritability appeared highly prevalent in 6 out of 10 studies. Conversely, sleeping disorders had a low prevalence (ranging from 11.6 - 27.2%), and were generally placed at the bottom end. Likewise, hallucinations had a rather low prevalence. According to most studies (5 - 27.8%), the symptom was placed at the very bottom (ranked eleventh or twelfth by most studies).
3. In one of the research studies, there was a discrepancy concerning the prevalence of sleeping and eating/appetite disorders. Namely, in all other studies, these symptoms consistently assumed the bottom half of the ranking by prevalence (up to 27.2% for sleeping disorders and 36.8% for eating/appetite disorders). Notwithstanding, Mirakhur et al. (37) found their prevalence higher (53.8% for sleeping disorders and 63.7% for eating/appetite disorders). In fact, in that study, eating/appetite disorders had the third-highest prevalence, while the prevalence of sleeping disorders was ranked seventh (out of 12). On the contrary, other authors ranked eating/appetite disorders fifth, sixth, seventh, eighth or tenth, while sleeping disorders were commonly ranked nineth. According to Kang et al. (18), sleeping disorders were equally ranked seventh, with a considerably lower prevalence (27.2% against

Odstupajući nalaz je i u prevalenciji motoričkog ponašanja koje odstupa od normalnog - u radu Mirakhur i sur. (37) prevalencija je od 64,5 %, te se time nalazi na 2. mjestu najčešćih simptoma u tom radu, dok se u drugim radovima prevalencija kretala u rasponu od 18 do 50,4 % (4.-8. mjesto prema prevalenciji u svakom od relevantnih radova). Ovakve odstupajuće nalaze objašnjavamo činjenicom da ispitanicima u istraživanju nije potvrđena dijagnoza isključivo Alzheimerove bolesti, zbog čega postoji mogućnost da je došlo do »kontaminacije« uzorka putem ispitanika s potencijalnom dijagnozom druge vrste demencije (frontotemporalna, itd.), koja podrazumijeva i drugačiju kliničku sliku, pa samim time i javljanje/tijek NPS-a (37).

Odstupajući nalaz je i niska prevalencija apatije u radu Bergh i sur. (39). Kao što smo ranije naveli, u svim drugim radovima je prevalencija apatije bila među najvišima u svakom od radova (nalazila se na 1. mjestu u 7 radova te na drugom mjestu u preostala 2 rada). No, u radu Bergh i sur. (39) apatija se nalazi na 7. mjestu, s prevalencijom od 44,8 %. U istom radu odstupajuća je i prevalencija dezinhibicije, koja je s 50 % na 3. mjestu, dok se u drugim radovima prevalencija kretala u rasponu od 9,5 do 29,5 % (što znači da je dezinhibicija većinom bila na 10. mjestu). Kao potencijalno objašnjenje za ovakav odstupajući nalaz jest činjenica da je ovo istraživanje provedeno na osobama koje žive u domu za starije osobe, te da se simptomi drugačije manifestiraju kod njih u odnosu na osobe koje žive kod kuće. Također, domovi za starije koji su sudjelovali u istraživanju bili su jedni od boljih po educiranosti svojih djelatnika o demenciji zbog čega autori smatraju da je došlo do redukcije nekih simptoma (39). Moguće je i da je došlo do utjecaja drugih faktora, poput težine demencije, stresa kod njegovatelja (39,43), upotrebe različitih lijekova

53.8% in Mirakhur et al. (37)), confirming the discrepancy of that particular finding.

Discrepancies also concerned aberrant motor behaviour.. According to Mirakhur et al. (37), its prevalence was 64.5% (making it the second most prevalent symptom in that study). However, in other studies, its prevalence ranged from 18 - 50.4% (ranked fourth to eighth by prevalence in all studies). The circumstances in which research participants had not been explicitly diagnosed with Alzheimer's disease might have accounted for the discrepancies. Namely, participants with other types of dementia (frontotemporal, etc.) might have "contaminated" the research sample, having different clinical manifestations, including different onset/progression of the NPS (37). A low prevalence of apathy in Bergh et al. (39) equally represented a discrepancy. As discussed above, the prevalence of apathy was quite high according to all other authors (ranked first in 7 papers and second in the remaining 2 papers). However, in Bergh et al. (39), apathy was ranked seventh, with a prevalence of 44.8%. In that study, the prevalence of disinhibition (50%, ranked third) also represented a discrepancy against 9.5 - 29.5% in other studies (generally ranking the prevalence of disinhibition tenth). In this respect, a research sample involving nursing home residents might have accounted for the discrepancy, given the potentially different symptom manifestations in that case, compared to persons living in family homes. Furthermore, nursing homes that participated in the research study were particularly effective in training their staff on dementia, which might have mitigated some symptoms, according to the authors (39). Other factors also might have interfered, such as the severity of dementia, caregiver burden (43, 39), prescription of different medications and treatment (39)

i tretmana (39) i sl., koji i inače mogu utjecati na pojavnost i tijek simptoma (39).

U radovima Wetzels i sur. (19) i Mulders i sur. (44) depresija je imala nisku prevalenciju (26,5 % i 16,9 %) te se nalazila na 7. i na 8. mjestu prevalencije simptoma. Navedeno je odstupajući nalaz, jer je u većini drugih istraživanja depresija bila u gornjoj polovici ljestvice, tj. na 1., 2., ili 3. mjestu (57,1 %, 56,6 %, 53,1 % i sl.). Ovakav nalaz objašnjavamo na različite načine. Tako je primjerice u radu Mulders i sur. (44) prosječna dob ispitanika bila značajno niža od ostalih radova (60,1 godinu) zbog čega postoji mogućnost da se takvo ranije javljanje Alzheimerove bolesti zbog svoje drugačije kliničke slike (pa posljedično i simptoma) odrazilo i na prevalenciju NPS-a. No, u istraživanju Wetzels i sur. (19) prosječna dob bila je 81,7, stoga ne možemo sa sigurnošću tvrditi da je uzrok ovakvog odstupajućeg nalaza dob. Još jedan od potencijalnih razloga za odstupajući nalaz vidimo u činjenici da je u oba istraživanja korištena posebna verzija NPI upitnika, a to je bio NPI-NH (*Nursing home*). Ova verzija upitnika je namijenjena korištenju u domovima za starije, a primjenjuju ju sami profesionalni njegovatelji (19). Stoga smatramo da postoji mogućnost da, iako navedeni upitnik mjeri 12 istih simptoma kao i »običan« NPI upitnik, zbog činjenice da ga primjenjuju sami njegovatelji (a ne ispitivač posebno treniran u tu svrhu), možda može dovesti do razlika u pojavnosti, pa samim tim i prevalenciji simptoma. Posebno je to relevantno ako uzmemo u obzir da Gauthier i sur. (14) navode da njegovatelji i općenito osoblje domova za starije često nisu »opremljeni« za odgovarajuće opisivanje simptoma osobe. Konačno, oba istraživanja su jedina od prikazanih provedena u Nizozemskoj i u domovima za starije. Naime, iako je još nekoliko radova provedeno u Nizozemskoj, ispitanici su bili korisnici izvaninstitucionalnog oblika skr-

etc., impacting the incidence and the evolution of symptoms (39).

In Wetzels et al. (19) and Mulders et al. (44), depression also had a low prevalence (26.5% and 16.9%), ranked seventh and eighth. That equally represented a discrepancy, as most other research studies highly ranked the prevalence of depression, that is, first, second or third (57.1%, 56.6%, 53.1%, etc.). That finding may be looked at from several different angles. For example, in Mulders et al. (44), the average participant age was considerably lower (60.1 years) than in other studies, which might have reflected on the prevalence of the NPS given the different clinical manifestations (and consequently, symptoms) in early-onset Alzheimer's disease. On the other hand, in Wetzels et al. (19), the average participant age was 81.7, which prevented attributing the discrepancy entirely to age. Another possible explanation for the discrepancy was a tailored version of the NPI questionnaire used in both studies, namely the NPI-NH (Nursing home). That version was intended for administration by professional caregivers at nursing homes (19). Consequently, although that version of the questionnaire measured the same twelve symptoms as the standard NPI questionnaire, the administration by caregivers (instead of survey administrators trained for the purpose) might have been responsible for variations in incidence, and accordingly, in the prevalence of symptoms. That appeared particularly relevant considering the findings of Gauthier et al. (14) on an insufficient capacity of caregivers, and nursing home staff in general, to describe the symptoms adequately. Finally, both research studies were the only ones in this review conducted in the Netherlands and in nursing homes. Namely, although several other research studies also took place in the Netherlands, their participants in-

bi. Smatramo kako postoji mogućnost da je navedeni odstupajući nalaz zapravo rezultat postojanja neke specifičnosti kulturnog okruženja ispitanika. Tako primjerice Gauthier i sur. (14) navode da postoje razlike u prevalenciji NPS s obzirom na kulturne razlike i to kako one oblikuju ljudska ponašanja (tj. njihovo iskazivanje i vrednovanje).

4. Kumulativan zaključak svih radova je da su apatija, depresija i iritabilnost među najprevalentnijim NPS-a Alzheimerove bolesti. Navedeno je i u skladu s ranijim spoznajama koje navode da su apatija (14,42,45,46) i depresija (14,42,47) među NPS koji se najčešće javljaju. Cerejeira, Lagarto i Mukaetova-Ladinska (10) pak navode da su najprevalentniji simptomi apatija, depresija, iritabilnost, anksioznost i uznemirenost. U nekim radovima simptomi anksioznosti i uznemirenosti bili su na 2. i 3. mjestu prema prevalenciji, što bi ih i svrstalo u jedne od najprevalentnijih simptoma, no u drugima su bile na 7. i 8. mjestu. Stoga možemo reći kako se prevalencija navedenih simptoma zajedno s prevalencijom simptoma motoričkog ponašanja koje odstupa od normalnog, te poremećaja hranjenja/apetita kretala po cijelom rasponu zastupljenosti. Tako su osim anksioznosti i uznemirenosti, u nekim radovima i motoričko ponašanje koje odstupa od normalnog, kao i poremećaji hranjenja/apetita bili visoko zastupljeni (na 2. i 3. mjestu), dok su na drugima pak bili nisko zastupljeni (8. i 10. mjesto). S druge pak strane, euforija i halucinacije su u analiziranim radovima bili najmanje prevalentni NPS. Navedeno je i u skladu s navodima Cerejeira, Lagarto i Mukaetova-Ladinska (10) koji navode da su najrjeđi NPS euforija, halucinacije i dezinhibicija. Dezinhibiciju nakon naše analize radova, zbog odstupajućeg nalaza, ne možemo svrstati u najrjeđe simptome (u nekim radovima je bila na 3. i 5. mjestu po zastupljenosti), no možemo reći da je većinom bila među najmanje prevalen-

volved service users of non-institutional care. Therefore, we might also attribute the discrepancy to the particularities of the cultural environment of different respondents. In this respect, Gauthier et al. (14) indicated variations in the prevalence of NPS given the cultural differences and their impact on human behaviour (that is, their expression and assessment).

4. The overall conclusion, based on all reviewed studies, is that apathy, depression, and irritability represent the most prevalent NPS in Alzheimer's disease. This conclusion corresponds to earlier findings indicating apathy (42, 14, 45, 46) and depression (14,42,47) as the most common NPS. Furthermore, Cerejeira, Lagarto & Mukaetova-Ladinska (10) found that apathy, depression, irritability, anxiety, and agitation were most prevalent. Some authors also highly ranked the symptoms of anxiety and agitation (second or third by prevalence), while others ranked them seventh or eighth. Those symptoms, including aberrant motor behaviour and eating/appetite disorders, spread over the entire range of prevalence. Besides anxiety and agitation, some authors also considered aberrant motor behaviour and eating/appetite disorders highly prevalent (ranked second or third), while others found them much less prevalent (ranked eighth or tenth). On the other hand, euphoria and hallucinations appeared least prevalent in the reviewed studies. Cerejeira, Lagarto & Mukaetova-Ladinska (10) corroborated that finding, indicating euphoria, hallucinations, and disinhibition among the least common NPS. Nevertheless, based on our literature review, disinhibition could not be considered a rare symptom due to the existing discrepancies (some studies ranked it third or fifth most prevalent). Notwithstanding, based on the reviewed studies, disinhibition could still be considered among the least prevalent

tnim simptomima u prikazanim radovima (većinom se nalazila na 8., 10. i 11. mjestu). Slično je i sa simptomima poremećaja spavanja i deluzija, koji su se nalazili većinom u donjoj polovici tablice (9., 10. i 11. mjesto).

symptoms (generally ranked eighth, tenth or eleventh least prevalent). Likewise, the symptoms such as sleeping disorders and delusions were also generally at the bottom of the ranking (nineth, tenth or eleventh).

Osvrt na metodologiju

U tablici 3. prikazali smo najvažnije dijelove metodologije svakog od analiziranih radova te ćemo se u nastavku i osvrnuti na njih.

Methodology review

Table 3. presents the relevant aspects of methodology for each of the reviewed studies, further discussed below.

TABLICA 3. Metodologija
TABLE 3. Methodology

	Broj rada i autori / No. of research study and authors				
	1. Sannemann et al. (49)	**2. Aalten et al. (36)**	**3. Musa et al. (50)**	**4. Aalten et al. (16)**	**5. Mirakhur et al. (37)**
Veličina uzorka (broj sudionika istraživanja) / Sample size (number of research participants)	687	199	53	2345	435
Populacija istraživanja / Research population	Oboljeli od demencije stariji od 60.g, sudionici DELCODE istraživanja, od čega je 242 bilo u dijagnostičkoj grupi za subjektivni kognitivni pad (*Subjective cognitive decline – SCD*), 115 sa blagim kognitivnim oštećenjem, 77 sa Alzheimerovom bolešću, 209 zdravih "kontrola" i 44 rođaka u 1. stupnju osoba oboljelih od Alzheimerove bolesti. Ispitanici su bili govornici njemačkog jezika, koji nisu imali trenutnu značajnu depresivnu epizodu niti trenutne ili prijašnje značajne psihijatrijske poremećaje., te su imali partnera u istraživanju, koji su služili kao pružatelji informacija o sudioniku. Većina partnera su bili supružnici (53,1%), zatim djeca (20,4%), i prijatelji (11,6%) ispitanika. / Persons with dementia older than 60, participants of DELCODE research, 242 of whom were in the diagnostic group for subjective cognitive decline (SCD), 115 with mild cognitive impairment, 77 with Alzheimer's disease, 209 healthy persons in the "control group", and 44 first-degree relatives of persons with Alzheimer's disease. Participants were German language speakers, having no current significant depressive episode, nor current or prior significant psychiatric disorders, and having research counterparts who assisted with providing information on participants. Most counterparts were spouses (53.1%), followed by children (20.4%), and friends (11.6%) of participants.	Oboljeli od demencije pod DSM-IV kriterijima, korisnici ambulantnih usluga mentalne skrbi, uključeni u Maastricht istraživanje ponašanja u demenciji, imali su njegovatelja s kojim su barem jednom tjedno bili u kontaktu, te nisu živjeli u domovima za starije. Većinom su bili ženskog spola (n=114), te je većina ispitanika (n=146) imala dijagnozu Alzheimerove bolesti. / Persons with dementia according to DSM-IV criteria, outpatients of clinical mental health care services, included in the Maastricht research on behaviour in dementia, in contact with a caregiver at least once a week, and not living in nursing homes. Mostly female (n=114), and mostly participants (n=146) diagnosed with Alzheimer's disease.	Oboljeli od Alzheimerove bolesti, stariji od 65. godina, govornici španjolskog jezika sa barem 4. godine obrazovanja, koji nisu imali značajne senzoričke poteškoće, povijest moždanih udara te značajne psihijatrijske poremećaje. / Persons with Alzheimer's disease, older than 65, Spanish language speakers with at least four years of education, with no significant sensory impairment, history of strokes or significant psychiatric disorders.	Oboljeli od Alzheimerove bolesti, 31,6% (n=745) bilo je muškog spola, a ostalih 68,4% (n=1609) je bilo ženskog spola. / Persons with Alzheimer's disease, 31.6% (n=745) male and 68.4% (n=1609) female.	Oboljeli od demencije koji su koristili usluge klinika za pamćenje 66% ženskog spola, prosječnog trajanja demencije 5,7 ± 3,5 godina. / Persons with dementia using memory clinic services, 66% female, with an average history of dementia of 5.7 ± 3.5 years.
Prosječna dob sudionika / Average participant age	70,4	76,43	73,8	76,9	78
Tip istraživanja / Type of research	Kvantitativno istraživanje / Quantitative research	Kvantitativno istraživanje / Quantitative research	Kvantitativno istraživanje / Quantitative research	Kvantitativno istraživanje / Quantitative research	Kvantitativno istraživanje / Quantitative research
Mjerni instrument / Research instrument	NPI-Q	NPI	NPI	NPI	NPI
Način prikupljanja podataka / Data collection method	Upitnik / Questionnaire	Upitnik / Questionnaire	Upitnik / Questionnaire	Uvidom u podatke koje je svaki od centara prikupio temeljem NPI upitnika i poslao u centar za koordiniranje / Insight into the data collected by centres via the NPI questionnaire and sent to the coordination centre	Upitnik ispunjavan putem intervjua sa njegovateljem / Questionnaire completed in interviews with caregivers

TABLICA 3. Metodologija *(nastavak)*
TABLE 3. Methodology *(continued)*

	Broj rada i autori / No. of research study and authors				
	6. Bergh et al. (39)	**7. Kang et al. (18)**	**8. Karttunen et al. (51)**	**9. Wetzels et al. (19)**	**10. Mulders et al. (44)**
Veličina uzorka (broj sudionika istraživanja) / Sample size (number of research participants)	169	778	240	290	225
Populacija istraživanja / Research population	Oboljeli od demencije koji su korisnici domova za starije osobe. (62%) ženskog spola. / Persons with dementia and residents of nursing homes. (62%) female.	Oboljeli od Alzheimerove bolesti koji su bili pacijenti iz Kliničkog istraživačkog centra za demenciju u Južnoj Koreji, od čega 237 (30,5%) muškaraca i 541 (69,5%) žena. / Persons with Alzheimer's disease and patients of the Clinical Research Centre for Dementia of South Korea, of whom 237 (30.5%) men and 541 (69.5%) women.	Oboljeli od vrlo blagog i blagog oblika Alzheimerove bolesti, koji su živjeli u Finskoj i sudjelovali u kontroliranoj rehabilitacijskoj studiji ALSOVA, te su imali njegovatelja iz obitelji s kojim su svakodnevno bili u kontaktu. 53, 1% bilo je ženskog spola. / Persons with a very mild and mild form of Alzheimer's disease, living in Finland and participating in controlled rehabilitation study ALSOVA, in daily contact with a caregiver in their family. 53.1% were female.	Oboljeli od demencije iz Nizozemske, korisnici usluga 14 posebnih jedinica za demenciju u 9 domova za starije, koji nisu imali po život opasnu bolest u vrijeme uključivanja, te su bili smješteni u dom za starije barem u zadnja 4 tjedna. Većinom ženskoga spola (71,7%). 35% njih je imalo Alzheimerovu bolest, dok je ostatak imao većinom nespecificiranu demenciju (52,1%), što se smatralo indikacijom za prisutnost više moždanih poremećaja u isto vrijeme. Ostatak ispitanika je imao veaskularnu demenciju (11,1%), te kombinaciju vaskularne demencije i Alzheimerove bolesti (1,7%). / Persons with dementia from the Netherlands, service users of 14 special units for dementia in 9 nursing homes, with no life-threatening conditions at the time of entering the research, placed in nursing homes at least in the previous 4 weeks. Mostly female (71.7%). 35% had Alzheimer's disease, while others had unspecified dementia (52.1%), as an indication of co-occurrence of several brain disorders. The remaining participants had vascular dementia (11.1%) and a combination of vascular dementia and Alzheimer's disease (1.7%).	Oboljeli od demencije kojima je dijagnoza postavljena postavljena po DSM-IV i to ranije u životu (prije 65. godine), smješteni u 8 domova za starije u Nizozemskoj (u trajanju od barem četiri tjedna). U samom trenutku uključivanja u istraživanje su uključeni i pacijenti stariji od 65.g. Najviše ispitanika bolovalo je od Alzheimerove bolesti, n=72, 32%. Ostatak je imao vaskularnu demenciju (n=29, 12,9%), frontotemporalnu demenciju (n=36, 16%), demenciju povezanu s alkoholom (n=40, 17,8%), te demenciju s drugim uzrocima (n=48, 21,3%). / Persons with dementia diagnosed according to DSM-IV at a younger age (before the age of 65), residents of 8 nursing homes in the Netherlands (for at least four weeks). Patients over 65 years of age were involved in the research in its beginning. Most participants had Alzheimer's disease, n=72, 32%. Others had vascular dementia (n=29, 12.9%), frontotemporal dementia (n=36, 16%), dementia induced by alcohol abuse (n=40, 17.8%), and dementia having other causes (n=48, 21.3%).
Prosječna dob sudionika / Average participant age	84,9	73,2	75,1	81.7	60.1
Tip istraživanja / Type of research	Longitudinalno kvantitativno istraživanje / Longitudinal quantitative research	Kvantitativno istraživanje / Quantitative research	Kvantitativno istraživanje / Quantitative research	Longitudinalno kvantitativno istraživanje / Longitudinal quantitative research	Kvantitativno istraživanje / Quantitative research
Mjerni instrument / Research instrument	NPI	NPI	NPI	NPI	NPI
Način prikupljanja podataka / Data collection method	Strukturirani intervju sa njegovateljima ispitanika / Structured interview with caregivers of participants	Intervju sa njegovateljima ispitanika / Interview with caregivers of participants	Intervju s njegovateljima i upitnici koje su ispunjavali sami pacijenti / Interview with caregivers and questionnaires completed by patients independently	Strukturirani intervju sa njegovateljima ispitanika / Structured interview with caregivers of participants	Intervju sa njegovateljima ispitanika / Interview with caregivers of participants

Sva istraživanja analizirana u prethodnom dijelu rada bila su po svom metodološkom pristupu kvantitativna, dok su neka od njih još uz to bila i longitudinalna. Navedeno smo i očekivali s obzirom da smo bili usmjereni na istraživanja prevalencije. Ipak, smatramo kako bi sljedeći korak mogao biti i kvalitativno istražiti područje, tj. temu mentalnog zdravlja oboljelih od Alzheimerove bolesti, čime bi se stekao uvid u same probleme, njihov »opis«, kao i u razmišljanja i stavove samih oboljelih

In terms of methodology, all reviewed research studies were quantitative, and some were longitudinal as well. That approach corresponded to our expectation and focus on studies researching prevalence. However, future research should also examine the mental health of patients with Alzheimer's disease from a qualitative perspective. That would allow further insight into specific issues, their "description", and patient views and attitudes concerning the challenges they faced. The re-

o njihovim problemima. Prevalencijska istraživanja su nam zapravo dala uvid samo u brojčanu sliku problema, točnije koji postotak osoba ima određeni simptom, za što smatramo da je samo vrh »sante leda«. Naime, svaki od mjerenih simptoma zapravo ima svoju pojavnost u životu oboljelih, on utječe na njih na određeni način, te se one s njim moraju naučiti individualno nositi, što sve smatramo ključnim uzeti u obzir pri pronalaženju odgovarajućih odgovora na probleme mentalnog zdravlja osoba oboljelih od Alzheimerove bolesti.

Smatramo i kako su istraživanja bila po svojoj metodologiji međusobno neujednačena. Tako je trajanje longitudinalnih istraživanja bilo različito (24 mjeseca, 16 mjeseci, ….), kao i uzorkovanje (posebno broj sudionika i njihova dob), što je, po našem mišljenju, otežalo uspoređivanje rezultata istraživanja. Naime, broj sudionika kretao se od 53 do 2 345 ispitanika, što smatramo problematičnim jer je kod manjeg broja uključenih teže rezultate uopćiti na cjelokupnu populaciju, te rastu šanse da takav rezultat bude pristran. Mišljenja smo da je navedeno posebno važno kada su istraživanja kvantitativna, jer, laički rečeno, 30 % uzorka od 53 ispitanika nije jednako 30 % uzorka od 2 345 ispitanika zbog čega smatramo da će tada i dobivena prevalencija biti teško usporediva. Osim samog broja sudionika uzorkovanje se razlikovalo i po dobi ispitanika, koja je iznosila 60,1 do 84,9 godina, što je prilično značajan raspon. Posebno je navedeno problematično ako znamo da je Alzheimerova bolest degenerativna bolest, što znači kako možemo pretpostaviti da je što je osoba starija, njeno oštećenje veće. Stoga smatramo da uspoređivanje rezultata različitih dobnih skupina može biti upitno, što su potvrdili i Gumus i sur. (25) koji su u svom istraživanju razlika u prevalenciji i težini NPS između mlađih (oni kojima je bolest dijagnosticirana prije 65. godine) i starijih oboljelih prikazali kako je tijek bolesti, pa samim time i njezinih simptoma, između ovih dviju skupina različit.

search on prevalence provided an insight into the quantitative side of the issue, notably the share of patients with certain symptoms, seen as merely the “tip of the iceberg”. Namely, each measured symptom affected patients’ lives, had a certain impact, and thus required adopting individual coping mechanisms. Such impacts deserved careful consideration to help identify and address mental health issues of patients with Alzheimer’s disease properly.

The analysed studies used in this review have relied on different research methodologies. For example, the duration of longitudinal research studies varied (24 months, 16 months…), as well as the sample (notably participant number and age), complicating the comparison of research results. The participant number ranged from 53 to 2,345 respondents, which prevented generalising the results to the entire population and increased the risk of research bias for small sample sizes. In our view, the sample size is particularly relevant in quantitative research. In simple terms, 30% of the sample comprising 53 participants was difficult to correlate with 30% of the sample involving 2,345 participants. Accordingly, variations in the sample size lowered the comparability of research results on prevalence. Besides the sample size, participant age also widely varied across the samples, ranging from 60.1 to 84.9 years. The age difference is a specific issue in the light of the degenerative nature of Alzheimer’s disease, assuming progressive impairment with age. Comparing research results for different age groups thus appeared arguable, as discussed by Gumus et al. (25). These authors researched differences in the prevalence and severity of the NPS among younger patients (diagnosed before the age of 65) and older persons, notably concerning the progression and symptoms of the disease for the two age groups.

Data collection methods also differed. Namely, the reviewed studies applied two versions of the NPI questionnaire that, despite measuring the

Neujednačen je bio i način prikupljanja podataka. Tako su u istraživanjima korištene različite verzije istog upitnika, NPI, koje, iako mjere istih 12 neuropsihijatrijskih simptoma, ipak imaju određene različitosti (jedna od verzija namijenjena direktnom ispunjavanju od osoblja u domovima za starije, dok drugu ispunjavaju posebno obučeni ispitivači putem strukturiranog intervjua s ispitanicima). Mišljenja smo kako navedeno može biti problematično iz razloga što su ispitivači posebno obučeni upravo u svrhu provedbe intervjua/ispunjavanja upitnika, dok osoblje doma za starije, unatoč svojoj stručnosti za rad s oboljelima to nije zbog čega može doći do neujednačenosti pri ispunjavanju (primjerice neko pitanje je krivo shvaćeno, preskočeno i sl.). Također, ponekad je upitnik ispunjavala sama osoba, a ponekad je to činio ispitivač na temelju intervjua. Smatramo da navedeno može biti problematično, jer sama osoba najčešće ne poznaje potencijalne stručne izraze u upitniku, može biti zbunjena oblikom pitanja i značenjem određenih riječi/izraza, zbog čega može krivo shvatiti pitanje i sl. Problematično je i što se radi o populaciji starijih osoba koje uz to što boluju od demencije, imaju i probleme mentalnog zdravlja zbog čega im samostalno ispunjavanje upitnika može biti otežano. Stoga smatramo kako bi bilo bolje kada bi upitnik ispunjavala posebno za to obučena osoba temeljem intervjua s ispitanikom. U toj situaciji ispitivač bi bila osoba koja je detaljno upoznata sa samim instrumentom zbog čega može ispitaniku pomoći pri njegovom ispunjavanju prilagodbom pitanja njegovom stupnju razumijevanja i stanju, otkloniti potencijalne nedoumice i sl., čime bi se osigurala i ujednačenost ispunjavanja.

U nekim od radova mjesto provedbe istraživanja nije navedeno. Mišljenja smo da je mjesto provedbe potrebno navesti, jer okolina u kojoj se oboljeli nalaze utječe kako na njih same, tako i na njihove simptome. Primjerice, osobe koje su smještene u institucijama (psihijatrijske bol-

same twelve neuropsychiatric symptoms, had certain differences. Notably, one version was designed for administration by nursing home staff, while the other was intended for trained survey administrators conducting structured interviews with respondents. That might have generated inconsistencies: while the administrators were specifically trained to conduct interviews/complete the questionnaire, the nursing home staff, despite their medical expertise, were not trained in survey methods. Under the circumstances, the inconsistencies in survey administration could have resulted in, for example, misunderstanding or skipping questions, etc.

Furthermore, respondents also occasionally completed the survey independently, and other times, survey administrators filled in the questionnaires based on the interviews. That might have entailed further methodological inconsistencies possibly due to potential unfamiliarity with the terminology used in the questionnaire, confusion over the formulation of questions or the meaning of certain words/expressions, which might have caused respondents to misunderstand questions, etc. A specific challenge also concerned the elderly population struggling not only with dementia but also mental health issues, which might have affected their ability to complete the survey independently. Therefore, survey administration by trained professionals seemed preferable, based on the interviews with participants. In any circumstance, administrators had to be well familiar with the instrument to assist respondents with their answers, adjust the questions to participants' cognitive abilities and conditions, i.e. remove possible confusion and thus ensure standardised survey conditions.

Furthermore, some studies did not specify the research setting. In our view, an indication of setting appeared quite relevant given its impact on patients and their symptoms. For example, symptoms (and their severity) could differ for patients in institutional care (psychi-

nice, domovi za starije, itd.) mogu imati drugačije simptome (i njihov intenzitet) u odnosu na one koji žive kod kuće. Također, osobe koje žive u obitelji zasigurno imaju drugačija iskustva u odnosu na one koje žive same, te se navedeno, po našem mišljenju, može odraziti i na psihičke simptome osoba, te posljedično i na njihovu prevalenciju. Kulturni kontekst također može imati utjecaj na pojavnost simptoma. Tako primjerice u određenim kulturnim krugovima postoji stigma povezana s problemima mentalnog zdravlja zbog čega će osobe iz tih krugova oklijevati pri odgovaranju na pitanja vezana uz njih ili će možda davati neistinite odgovore kako bi probleme smanjili ili potpuno prikrili. Na važnost kulturalnog konteksta i njegov odnos s prevalencijom NPS-a osvrnuli su se i Gauthier i sur. (14) koji su primijetili da su kulturne razlike (i način na koje one oblikuju iskazivanje i vrednovanje ljudskih ponašanja) povezane s razlikama u prevalenciji NPS-a.

Konačno, jedan od problema koji smo identificirali bila je sposobnost oboljelih za davanje pristanka. Mišljenja smo da tu sposobnost ne bi trebalo podrazumijevati. Tako smo se pri analizi istraživanja zapitali s obzirom na populaciju koja je istraživana, koliko su oboljeli stvarno i razumjeli na što pristaju, tj. što njihov pristanak podrazumijeva. Osim navedenog, zapitali smo se i koliko je etički da u slučajevima kada su intervjuirani njegovatelji osoba, oni otkrivaju »intimu« oboljelih, koji ovisno o stupnju svoje bolesti, toga moguće nisu uopće svjesni. Također, u određenom broju pristanak za sudjelovanje u istraživanju davali su zakonski zastupnici osobe, za što smatramo da također može biti problematično. Naime, mi zapravo ne znamo mišljenje same osobe, tj. bi li ona pristala na sudjelovanje u istraživanju, kao i bi li dozvolilča korištenje svojih medicinskih podataka za istraživanje. Davanje informiranog pristanka je jedno od ljudskih prava svake osobe, a pitanje informiranog pristanka i mogućnosti njegovog davanja kod oboljelih od Alzheimerove bolesti već je spomenuto u literatric hospitals, nursing homes, etc.) and those living in their homes. Moreover, persons living with their families were bound to have different experiences from those living alone, which, in our opinion, determined the psychological symptoms and, accordingly, their prevalence. The cultural context also influenced the symptom incidence. Furthermore, some cultural environments might have perpetuated the stigma associated with mental health issues, which could have caused the respondents to hesitate before answering personal questions or to provide false claims in an attempt to understate or hide their condition. Gauthier et al. (14) discussed the impact of the cultural context and its relationship with the prevalence of NPS, observing that the cultural differences (and the ways these shaped the expression and assessment of human behaviour) correlated with the variations in the prevalence of the NPS.

Finally, one of the encountered issues concerned the ability of persons with the disease to provide consent. We found that this ability should not be assumed. Upon our review, we wondered, given the research population in question, to what extent had the persons with the disease been aware of giving consent, or what their consent presumed. Furthermore, we wondered whether it was ethical for caregivers, in cases when they had been interviewed, to reveal the "intimate" matters of patients, who, depending on the stage of the disease, might have been entirely unaware of the circumstances. Moreover, in some cases, legal guardians gave consent on behalf of participants, which could also be considered controversial as participants' intent was not evident; that is, whether they were indeed willing to participate and give consent to access their medical records for research purposes. The opportunity to provide informed consent was a human right belonging to every person. Literature discussed the issue of providing opportunities for an informed consent to patients with Alzheimer's disease, suggesting a variety of solutions. One option is

turi, te su ponuđena različita rješenja. Jedno od tih rješenja je i tzv. anticipirana naredba. Ona bi u ovom slučaju mogla sadržavati pitanje davanja pristanka za medicinske postupke ili za sudjelovanje u istraživanjima i sl. Konkretno, to znači da bi oboljeli mogli u ranijoj fazi bolesti, dok su funkcije još očuvane, odrediti kako žele da se postupa u budućnosti (1, 48).

ZAKLJUČAK

Alzheimerova bolest, kao najčešći uzrok demencije, problem je koji znatno pogađa države te se očekuje kako će navedeni negativan utjecaj u budućnosti sve više rasti, kako će rasti i broj oboljelih. Posebno je alarmantna i činjenica da bolest ne pogađa samo pojedinca, već i osobe oko njega, odnosno negativno se odražava na sve razine društva. Unatoč najčešće blagom početku bolesti (uz iznimku »okidača« koji ju mogu ubrzati), progresija bolesti (i posljedično propadanje funkcija osobe) su konstantni. Kako za bolest još uvijek nemamo lijek, očekuje se značajno narušena kvaliteta života osobe (i njezinih najbližih) do njezine smrti. Sami simptomi bolesti su različiti od osobe do osobe te ovise o fazi bolesti.

Tijekom bolesti javljaju se i NPS, koji su vrlo česti (u 80-90 % oboljelih), a uključuju poremećaje raspoloženja, misli, emocija, motorike i sl. Utječu na oboljele (ubrzavaju napredovanje postojećih disfunkcija), članove obitelji (izolacija, sukobi, financijske poteškoće), te na sustav skrbi za oboljele (dovode do ranije institucionalizacije, zahtijevaju veće novčane i ljudske resurse za brigu o oboljelima).

Njihov intenzitet povezan je sa samom bolešću, stoga možemo reći da variraju ovisno i o stupnju bolesti. Klinička slika je vrlo različita i individualna, kao i manifestiranje simptoma, zbog čega je i razgraničavanje između njih ponekad otežano. Stoga ni ne čudi činjenica da se simptomi vrlo često ne javljaju izolirano, već u grupama, koje se razlikuju od istraživanja do istraživanja

the so-called advance directive. It could include giving consent to medical interventions or participation in research, etc. In practice, it would allow people at an earlier stage of the disease, while all functions were still retained, to decide on different procedures for the future (1, 48).

CONCLUSION

As the most common cause of dementia, Alzheimer's disease has considerably affected countries across the globe. Moreover, its negative effects are expected to increase in the future, including the number of people with the disease. It is distressing that the disease does not affect only the patient, but equally close people, and other segments of society. Despite a typically mild onset (except for the "triggers" that may accelerate the course of the disease), its progression (and the impairment of functions) is continuous. To date, the condition has been incurable; a decreasing quality of life is thus predicted for persons with the disease (and close people) for the remainder of their lives. The symptoms vary from one person to another, depending on the stage of the disease.

The NPS occur quite frequently over the course of the disease (in 80-90% of cases), including disturbed mood, cognition, emotions, motor functions, etc. They affect patients (by accelerating the progression of the existing dysfunctions), family members (entailing isolation, conflicts, financial difficulties), and the system of care for persons with the disease (leading to earlier institutional placement, requiring greater financial and human resources for care services).

The severity of NPS correlates with the stage of the disease. Clinical manifestations are quite diverse and individual, like the symptoms, making them difficult to delineate. It is, therefore, unsurprising that the symptoms typically do not appear in isolation, but rather in clusters, with various compositions in different research studies (from three to four or

(od tri do četiri ili pet grupa subsindroma). Razlog grupiranja je odabir najboljeg tretmana za određenu grupu simptoma jer se predmnijeva da simptomi iz iste grupe imaju i iste uzročne faktore. Tretman može biti farmakološki i nefarmakološki. Farmakološki tretman podrazumijeva korištenje različitih vrsta lijekova, dok je nefarmakološki tretman usmjeren na različite vrste terapija i aktivnosti, poput terapije svjetlom, grupne terapije, vježbanja i sl. Iako je farmakološki tretman raširen, zbog rizika kao npr. interakcija s drugim lijekovima ili nuspojava te zbog njegove upitne učinkovitosti, preporučeno je prvo na simptome pokušati odgovoriti nefarmakološkim putem, a tek potom korištenjem najmanje štetnog lijeka u što kraćem trajanju.

S obzirom da se simptomi javljaju na različitim područjima, bilo je potrebno ujednačiti način njihovog mjerenja. Nekoliko je instrumenata za mjerenje NPS-a, a najčešće korišten je Neuropsihijatrijski inventar (*Neuropsychiatric Inventory* - NPI).

Prevalencija navedenih simptoma varira od istraživanja do istraživanja. Općenito je visoka (čak i viša od 90 %). Najčešćima se smatraju simptomi apatije, depresije, iritabilnosti, anksioznosti i uznemirenosti, dok se najrjeđima smatraju euforija, halucinacije i dezinhibicija. Navedeno je i u skladu s našom provedenom sustavnom analizom istraživanja. Primijetili smo neujednačenost prema metodologiji u odnosu na broj sudionika, trajanje istraživanja, dob ispitanika, kao i prema tome tko je ispunjavao upitnik. Problematičnim smo identificirali i pitanje davanja pristanka oboljelog za uključivanje u istraživanje, što je moglo utjecati na etičnost istraživanja.

Unatoč navedenom, smatramo da je naša sustavna analiza istraživanja bila valjana i korisna, na što ukazuje i činjenica da se dobiveni rezultati analize, uz manja odstupanja, poklapaju s rezultatima ranijih istraživanja. Također, smatramo kako smo ovim radom prikazali i ukazali na neupitnu važnost NPS-a te se nada-

five groups of subsyndromes). Classifying the symptoms facilitates recommending the most suitable treatment for a specific group of symptoms, assuming that the symptoms from the same cluster share their causes. Treatment is pharmacological or non-pharmacological. The pharmacological approach presumes prescribing medication, whereas the non-pharmacological treatment proposes various therapies and activities, such as light therapy, group therapy, exercise, etc. Although pharmacological treatment is widely applied, due to its risks, such as interactions with other medications, side effects, and arguable efficacy, the non-pharmacological treatment is preferred, and, only secondly, the prescription of the least harmful medication for the shortest time possible.

While symptoms may pertain to different domains, their measurement requires a standardised approach. Several instruments can measure NPS, with the Neuropsychiatric Inventory (NPI) having the broadest application.

Although the symptom prevalence varies in different studies, overall it is quite high (even above 90%). Apathy, depression, irritability, anxiety, and agitation are the most prevalent symptoms, while euphoria, hallucinations, and disinhibition represent the least prevalent ones. That finding has also ensued from our systematic review of research studies. The observed methodological inconsistencies concerned sample size, research duration, participant age, and the person administering the questionnaire. Further issues included giving consent by or on behalf of people with the disease, with implications for the research ethics.

Notwithstanding, the present systematic review is seen as valid and useful, substantiated by the concordance between its findings and the research results from previous studies, notwithstanding minor deviations. This paper has also discussed and underscored an irrefutable impact of the NPS, intending to encourage further research in the field. Besides the

mo da smo doprinijeli budućim istraživanjima ovog područja. Mišljenja smo da će se analiza osim u očitom, kvantitativnom smjeru trebati kretati i u kvalitativnom smjeru. Kvantitativna istraživanja prikazuju samo brojčani dio slike NPS-a. Nedostaje kvalitativan opis simptoma, načina kako se javljaju i utječu na oboljele i njihovu okolinu. Tek »sklapanjem« navedenih dvaju aspekata ovog problema moći ćemo ga u potpunosti pojmiti te se kvalitetnije usmjeriti na pronalaženje odgovarajućeg odgovora.

quantitative approach, future research ought to consider the qualitative perspective. Namely, quantitative research could only indicate the figures concerning the NPS. However, a qualitative description of the symptoms is missing, notably the ways the symptoms manifest and affect persons with the disease and their environment. Combining both aspects would allow us to understand the condition better and streamline our efforts to address the related issues more effectively.

LITERATURA / *REFERENCES*

1. Dološić S. Ljudska prava oboljelih od Alzheimerove bolesti: završni specijalistički rad. Osijek: Sveučilište Josipa Jurja Strossmayera u Osijeku, Pravni fakultet Osijek, 2016.
2. Abate G, Memo M, Uberti D. Impact of COVID-19 on Alzheimer's disease risk: viewpoint for research action. Healthcare 2020; 8(3): 286. Preuzeto 13. srpnja 2021. s https://doi.org/10.3390/healthcare8030286
3. Puljak A, Perko G, Mihok D, Radašević, H, Tomek–Roksandić S. Alzheimerova bolest kao gerontološki javnozdravstveni problem. Medicus 2005; 14(2): 229-35.
4. Hrvatski zavod za javno zdravstvo. Alzheimerova bolest. Preuzeto 16. studenog 2021. s https://www.hzjz.hr/aktualnosti/alzheimerova-bolest/
5. Alzheimer Europe. Dementia as a European priority: a policy overview. Preuzeto 31. prosinca 2020. s: https://issuu.com/alzheimer-europe/docs/dementia_as_a_european_priority
6. ALZ. What is Alzheimer's Disease? Preuzeto 13. srpnja 2021. s: https://www.alz.org/alzheimers-dementia/what-is-alzheimers
7. MSD Hrvatska. Alzheimerova bolest. Preuzeto 15. srpnja 2021. s: http://www.msd-prirucnici.placebo.hr/msd-prirucnik/neurologija/delirij-i-demencija/alzheimerova-bolest
8. ALZ. Stages of Alzheimer's. Preuzeto 13 srpnja 2021. s: https://www.alz.org/alzheimers-dementia/stages
9. Fernández M, Gobartt AL, Balaña M, COOPERA Study Group. Behavioural symptoms in patients with Alzheimer's disease and their association with cognitive impairment. BMC Neurol 2010; 10: 87. Preuzeto 15. srpnja 2021. s https://doi.org/10.1186/1471-2377-10-87
10. Cerejeira J, Lagarto L, Mukaetova-Ladinska EB. Behavioral and psychological symptoms of dementia. Front Psychol 2012; 3: 73. Preuzeto 15. srpnja 2021. s https://doi.org/10.3389/fneur.2012.00073
11. Lyketsos CG, Carrillo MC, Ryan JM, Khachaturian AS, Trzepacz P, Amatniek J *et al*. Neuropsychiatric symptoms in Alzheimer's disease. Alzheimers Dement 2011; 7: 532-9.
12. Apostolova LG, Cummings JL. Neuropsychiatric manifestations in mild cognitive impairment: a systematic review of the literature. Dement Geriatr Cogn Disord 2008; 25(2): 115-26.
13. Artaso Irigoyen B, Goñi Sarriés A, Gómez Martínez AR. Síntomas neuropsiquiátricos en el síndrome demencial. Rev Neurol 2004; 38(6): 506-10. Preuzeto 23. studenog 2021. s https://doi.org/10.33588/rn.3806.2003437
14. Gauthier S, Cummings J, Ballard C, Brodaty H, Grossberg G, Robert P *et al*. Management of behavioral problems in Alzheimer's disease. Int Psychogeriatr 2010; 22(3): 346-72.
15. Finkel SI, Costa e Silva J, Cohen G, Miller S, Sartorius N. Behavioral and psychological signs and symptoms of dementia: a consensus statement on current knowledge and implications for research and treatment. Int Psychogeriatr 1996; 8(3): 497-500.
16. Aalten P, Verhey FRJ, Boziki M, Bullock R, Byrne EJ, Camus V *et al*. Neuropsychiatric syndromes in dementia: results from the European Alzheimer disease consortium: Part I. Dement Geriatr Cogn Disord 2007; 24(6): 457-63.
17. Garre-Olmo J, López-Pousa S, Vilalta-Franch J, de Gracia Blanco M, Vilarrasa AB. Grouping and trajectories of the neuropsychiatric symptoms in patients with Alzheimer's disease, part I: symptom clusters. J Alzheimers Dis 2010; 22(4): 1157-67.
18. Kang HS., Ahn IS, Kim JH, Kim DK. Neuropsychiatric symptoms in korean patients with Alzheimer's disease: exploratory factor analysis and confirmatory factor analysis of the Neuropsychiatric inventory. Dement Geriatr Cogn Disord 2010; 29(1): 82-7.
19. Wetzels RB, Zuidema SU, de Jonghe JFM, Verhey FRJ, Koopmans RTCM. Course of neuropsychiatric symptoms in residents with dementia in nursing homes over 2-year period. Am J Geriatr Psychiatry 2010; 18(12): 1054-65.
20. Rabins PV, Lyketsos CG, Steele CD. Practical dementia care. New York: Oxford University Press, 2006.
21. Brodaty H, Donkin M. Family caregivers of people with dementia. Dialogues Clin Neurosci 2009; 11(2): 217-28.

22. Song JA, Park JW, Kim H. Impact of behavioral and psychological symptoms of dementia on caregiver burden in nursing homes. J Korean Gerontol Nurs 2013; 15(1): 62-74.
23. Kim B, Ok Noh G, Kim K. Behavioural and psychological symptoms of dementia in patients with Alzheimer's disease and family caregiver burden: a path analysis. BMC Geriatr 2021; 21(1): 160. Preuzeto 13. srpnja 2021. s https://doi.org/10.1186/s12877-021-02109-w
24. García-Alberca JM, Lara JP, Garrido V, Gris E, González-Herero V, Lara A. Neuropsychiatric symptoms in patients with Alzheimer's disease: the role of caregiver burden and coping strategies. Am J Alzheimers Dis Other Demen 2014; 29(4): 354-361. Preuzeto 15. srpnja 2021. s https://doi.org/10.1177/1533317513518649
25. Gumus M, Multani N, Mack ML, Tartaglia MC. Alzheimer's Disease Neuroimaging Initiative. Progression of neuropsychiatric symptoms in young-onset versus late-onset Alzheimer's disease. Geroscience 2021; 43(1): 213-23.
26. Liken MA. Caregivers in crisis: moving a relative with Alzheimer's to assisted living. Clin Nurs Res 2001; 10(1): 52-68.
27. Gaugler JE, Yu F, Krichbaum K, Wyman JF. Predictors of nursing home admission for persons with dementia. Med Care 2009; 47(2): 191-8.
28. Frisoni GB, Rozzini L, Gozzetti A, Binetti G, Zanetti O, Bianchetti A *et al*. Behavioral syndromes in Alzheimer's disease: description and correlates. Dement Geriatr Cogn Disord 1999; 10(2): 130-8.
29. Shaji S, Bose S, Kuriakose S. Behavioral and psychological symptoms of dementia: a study of symptomatology. Indian J Psychiatry 2009; 51(1): 38-41.
30. Spalletta G, Musicco M, Padovani A, Rozzini L, Perri R, Fadda L *et al*. Neuropsychiatric symptoms and syndromes in a large cohort of newly diagnosed, untreated patients with Alzheimer disease. Am J Geriatr Psychiatry 2010; 18(11): 1026-35.
31. Klepac N. Nove spoznaje o Alzheimerovoj bolesti. U: Klepac N, Borovečki F (ur.) Alzheimerova bolest u kliničkoj praksi. Zagreb: Medicinski fakultet, 2018.
32. Borovečki F. Rana dijagnoza Alzheimerove bolesti. Medicus 2019; 28(1): 23-26.
33. Mimica N, Kušan Jukić M. Demencija i psihički poremećaji. Medicus 2017; 26(2): 215-222.
34. Murray PS, Kumar S, DeMichele-Sweet MA, Sweet RA. Psychosis in Alzheimer's disease. Biol Psychiatry 2014; 75(7): 542-552.
35. Chakraborty S, Lennon JC, Malkaram SA, Zeng Y, Fisher DW, Dong H. Serotonergic system, cognition, and BPSD in Alzheimer's disease. Neurosci Lett 2019; 704: 36-44.
36. Aalten P, de Vugt ME, Lousberg R, Korten E, Jaspers N., Senden B *et al*. Behavioral problems in dementia: a factor analysis of the neuropsychiatric inventory. Dement Geriatr Cogn Disord 2003; 15(2): 99-105.
37. Mirakhur A, Craig D, Hart DJ, McLlroy SP, Passmore AP. Behavioural and psychological syndromes in Alzheimer's disease. Int J Geriatr Psychiatry 2004; 19(11): 1035-9.
38. Prado-Jean A, Couratier P, Druet-Cabanac M, Nubukpo P, Bernard-Bourzeix L, Thomas P *et al*. Specific psychological and behavioral symptoms of depression in patients with dementia. Int J Geriatr Psychiatry 2010; 25(10): 1065-72.
39. Bergh S, Engedal K, Røen I, Selbæk G. The course of neuropsychiatric symptoms in patients with dementia in Norwegian nursing homes. Int Psychogeriatr 2011; 23(8): 1231-9.
40. Cohen-Mansfield J, Marx MS, Dakheel-Ali M, Regier NG, Thein K, Freedman L. Can agitated behavior of nursing home residents with dementia be prevented with the use of standardized stimuli?. J Am Geriatr Soc 2010; 58(8): 1459-64.
41. Lucijanić D, Kušan Jukić M, Mimica N. Delirij superponiran na demenciju – klinička slika i preporuke za liječenje. Soc Psihijat 2016; 44(2): 130-9.
42. Lyketsos CG, Lopez O, Jones B, Fitzpatrick AL, Breitner J, DeKosky S. Prevalence of neuropsychiatric symptoms in dementia and mild cognitive impairment: results from the cardiovascular health study. JAMA 2002; 288(12): 1475-83.
43. Rozzini L, Cornali C, Chilovi BV, Ghianda D, Padovani A, Trabucchi M. Predictors of institutionalization in demented patients discharged from a rehabilitation unit. J Am Med Dir Assoc 2006; 7(6): 345-9.
44. Mulders AJMJ, Fick IWF, Bor H, Verhey FRJ, Zuidema SU, Koopmans RTCM. Prevalence and correlates of neuropsychiatric symptoms in nursing home patients with young-onset dementia: The BEYOnD Study. J Am Med Dir Assoc 2016; 17(6): 495-500.
45. Mulin E, Leone E, Dujardin K, Delliaux M, Leentjens A, Nobili F *et al*. Diagnostic criteria for apathy in clinical practice. Int J Geriatr Psychiatry 2011; 26(2): 158-65.
46. Simonetti A, Pais C, Jones M, Cipriani MC, Janiri D, Monti L *et al*. Neuropsychiatric symptoms in elderly with dementia during COVID-19 pandemic: definition, treatment, and future directions. Front Psychiatry 2020; 11: 579842. Preuzeto 19. srpnja 2021. s https://doi.org/10.3389/fpsyt.2020.579842
47. Starkstein SE, Jorge R, Mizrahi R, Robinson RG. The construct of minor and major depression in Alzheimer's disease. Am J Psychiatry 2005; 162(11): 2086-93.
48. Dološić S, Milić Babić M, Rusac S. Alzheimerova bolest kroz prizmu ljudskih prava. Soc Psihijat 2019; 47(4): 470-96.
49. Sannemann L, Schild AK, Altenstein S, Bartels C, Brosseron F, Buerger K *et al*. Neuropsychiatric symptoms in at-risk groups for AD dementia and their association with worry and AD biomarkers – results from the DELCODE study. Alzheimers Res Ther 2020; 12: 131. Preuzeto 19. srpnja 2021. s https://doi.org/10.1186/s13195-020-00701-7
50. Musa G, Henríquez F, Muñoz-Neira C, Delgado C, Lillo P, Slachevsky A. Utility of the Neuropsychiatric Inventory Questionnaire (NPI-Q) in the assessment of a sample of patients with Alzheimer's disease in Chile. Dement Neuropsychol 2017; 11(2): 129-36.
51. Karttunen K, Karppi P, Hiltunen A, Vanhanen M, Välimäki T, Martikainen J *et al*. Neuropsychiatric symptoms and quality of life in patients with very mild and mild Alzheimer's disease. Int J Geriatr Psychiatry 2011; 26(5): 473-82.

Trebamo li se otuđiti od otuđenja?

/ Should we Alienate Ourselves from "Parental Alienation"?

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U znanstvenim i stručnim psihologijskim, psihijatrijskim i pravnim krugovima diljem svijeta vodi se rasprava o uporabi koncepta roditeljskog otuđenja. U Hrvatskoj znanstvenoj i stručnoj literaturi prevladavaju tekstovi u kojima se „otuđenje" promatra kao na znanosti utemeljen konstrukt. Ono što nedostaje su tekstovi koji propitkuju znanstvenu utemeljenost „otuđenja" i problematiziraju moguće posljedice upotrebe takvog, u ovom trenutku još uvijek, nedovoljno jasno definiranog i operacionaliziranog koncepta, na dobrobit naših korisnika. U ovom radu iznesene su poteškoće s ovim konceptom i stavljene u kontekst prakse temeljene na dokazima te su prikazane potencijalne štetne posljedice upotrebe „otuđenja" u radu sa ženama žrtvama nasilja i korištenja „otuđenja" kao još jedne strategije prisile i kontrole nad žrtvama.

/ In recent years, there have been discussions within the scientific and professional communities in the fields of psychology, psychiatry and law about the application of the concept of parental alienation. The Croatian scientific and professional literature is dominated by texts in which "parental alienation" is seen as a science-based construct. What is missing are texts that question the scientific soundness of "parental alienation" and examine the possible consequences of using the concept that has still neither been sufficiently defined nor operationalized in the best interest of our patients. This paper presents a number of difficulties related to this concept in the context of evidence-based practice and describes potentially adverse consequences of using "parental alienation" in working with women victims of violence and the application of "parental alienation" as yet another strategy of coercion and control over victims.

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Obiteljsko nasilje / *Family Violence*

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Koliko je znanost živa i promjenjiva najbolje smo mogli pratiti u posljednje dvije pandemijske godine tijekom kojih su novi nalazi dolazili gotovo svakodnevno i tijekom kojih je bilo vidljivo kako su se medicinske i epidemiološke preporuke mijenjale u skladu s tim spoznajama. Inače, promjene u psihologiji i psihijatriji nisu tako brze i događaju se sporije, iako fundus znanstvenih spoznaja svakodnevno raste. Tako smo tijekom povijesti mogli pratiti kako neki entiteti temeljem znanstvenih spoznaja prestaju biti dijagnostičke kategorije (npr. homoseksualnost) te kako se neki novi uvode (npr. poremećaj prejedanja). Radne skupine za novi DSM-5 osnovane su još 2000. godine s ciljem generiranja sumarnih pregleda znanstvenih spoznaja relevantnih za pojedine dijagnoze, otkrivanja gdje još postoje nedoumice i nedovoljno dokaza, s ciljem da se upravo u tim područjima znanstveni interes potakne u budućnosti i donesu konačne odluke o uvrštavanju u novo, peto izdanje DSM-a (1).

Na primjeru ovisnosti možemo pojasniti kako nije nevažno koja se terminologija koristi i koliko su važne znanstvene spoznaje prije nego nešto bude prihvaćeno kao dijagnostička kategorija. Nakon što je kumulirano dovoljno dokaza da postoje znatne kliničke, fenomenološke, genetske, neurobiološke i ostale sličnosti između ovisnosti o psihoaktivnim tvarima i ovisnosti o kockanju donesena je odluka da se te dvije dijagnoze stave u istu kategoriju u DSM-5. Time Patološko kockanje postaje Poremećaj kockanja, ali ono što je značajnije - prestaje se dijagnosticirati kao poremećaj kontrole impulsa i počinje se dijagnosticirati kao ovisnost (2).

Ta promjena ima značajne implikacije na tretman i konceptualizaciju poremećaja. Upravo zbog potencijalnih posljedica koje, ne samo dijagnosticiranje, već i samo imenovanje nekih koncepata ima na korisnike naših usluga, iznimno je važno tome pristupati oprezno i utemeljeno na znanstvenim spoznajama. Na primjer, u DSM-III koristio se termin transseksualnost

We were best able to track how vibrant and changing science is in the last two pandemic years, during which new findings were coming almost on daily basis and during which it was evident that medical and epidemiological recommendations were changing in line with the findings. Otherwise, changes in psychology and psychiatry are not taking place so rapidly and usually occur at a slower pace, although scientific knowledge is expanding almost every day. Throughout history, we have been able to track how certain concepts, based on scientific knowledge, cease to be diagnostic categories (e.g. homosexuality) and how some new ones are being introduced (e.g. binge eating disorder). Working groups for the adoption of the new DSM-5 were established back in 2000 with the aim of generating summary reviews of scientific findings relevant to individual diagnoses, discovering the areas where there are still doubts and insufficient evidence with the aim of stimulating future scientific interest in these areas and making final decisions on the inclusion in the new, fifth edition of the DSM (1).

On the example of addiction, we can explain that it is not irrelevant what terminology is used and how important scientific knowledge is before accepting something as a diagnostic category. After collecting sufficient evidence about significant clinical, phenomenological, genetic, neurobiological and other similarities between substance use disorder and gambling disorder, a decision was reached to include the two diagnoses in the same category in the DSM-5. Consequently, the diagnosis of Pathological Gambling (PG) was replaced with Gambling Disorder (GD), and, even more significantly, it is no longer to be diagnosed as an impulse control disorder but rather as an addiction (2).

This change implies significant implications for the treatment and conceptualization of disorders. Precisely because of the potential consequences that not only diagnosis, but also the mere definition of certain concepts have on our patients, it is extremely important to approach this topic with caution and based on scientific findings. For example, the third edition of the DSM used the term “transsexualism” as a disorder classified

i bio je u kategoriji poremećaja koji se pojavljuju u djetinjstvu i adolescenciji. U DSM-IV taj je termin zamijenjen terminom Poremećaja rodnog identiteta i premješten u seksualne poremećaje. Promjena u DSM-5 je ta da je uvedena Rodna disforija i da fokus više nije na identitetu osobe, već na uznemirenosti koju *trans* osobe mogu osjećati kad njihov biološki spol nije usklađen s njihovim rodnim identitetom. Ove su promjene pratile promjene u istraživanjima i kliničkoj praksi, ali i društvene promjene i uvelike su utjecale na to da se o transrodnosti više ne govori kao o poremećaju koji osobe imaju samim time što su transrodne, već se fokus usmjerio na to da neki od njih mogu zbog toga osjećati uznemirenost.

Aktualno, slična rasprava se vodi o konceptu „otuđenja“[1]. Prema definiciji „*Otuđenje od roditelja je psihičko stanje u kojem se dijete – najčešće ono kojem su roditelji uključeni u visoko konfliktan razvod – snažno udruži s jednim roditeljem (preferiranim roditeljem) i odbija odnose s drugim roditeljem (otuđeni roditelj) bez opravdanog/legitimnog opravdanja. Najčešći uzrok „otuđenja“ je indoktrinacija preferiranog roditelja da ne voli ili da se boji otuđenog roditelja.*“ (3). Gardner, koji je prvi uveo ovaj termin u literaturu je „otuđenje“ opisao kroz osam ponašanja: ocrnjivanje jednog roditelja (kampanja ocrnjivanja), fenomen djeteta „nezavisnog mislitelja“ (odnosno negiranje utjecaja preferiranog roditelja), apsurdni razlozi i racionalizacije za odbacivanje roditelja, nedostatak ambivalencije prema roditeljima, nedostatak krivnje zbog ponašanja prema odbačenom roditelju, slaganje s jednim roditeljem pri roditeljskim sukobima i prezentiranje posuđenog scenarija (4).

U Hrvatskoj se posljednjih godinu dana u medijima i na društvenim mrežama raspravlja o pojmu i upotrebi koncepta „otuđenja“ djeteta.

[1] Termin „otuđenje“ koristit će se kao prijevod termina engl. *parental allienation*. Termin je stavljen u navodne znakove „“ kako bi se naglasilo da se radi o konceptu, a ne znanstveno potvrđenom konstruktu.

under “Disorders usually first evident in infancy, childhood, and adolescence”. With the release of the DSM–IV, the term was replaced with the term “gender identity disorder in adults and adolescence” and placed in the category of sexual disorders. The new DSM-5 introduces gender dysphoria, switching the focus from the person’s identity to psychological distress that a transgender individual may experience when there is incongruence between one’s sex assigned at birth and one’s gender identity. These changes went hand-in-hand with changes in research and clinical practice, as well as social changes, and have greatly influenced to fact that being transgender is no longer referred to as a disorder that individuals have only because they are transgender. Instead, the focus is now on the psychological distress that some might feel due to that.

At the moment, a similar debate is going on about the concept of “parental alienation”[1]. According to the definition, “*Parental alienation is a mental state in which a child – usually one whose parents are involved in a highly conflicted divorce – allies strongly with one parent (the favoured parent) and rejects a relationship with the other parent (the alienated parent) without a justified/legitimate reason. In most cases, “parental alienation” results from the psychological manipulation of the favoured parent who does not love or is afraid of the alienated parent.*” (3). Richard Gardner was the first to introduce the term into the literature. He described parental alienation by eight symptoms: denigration of one parent (denigration campaign), the “independent-thinker” phenomenon (i.e., the child denies the influence of the favoured parent), absurd reasons and rationalizations for rejecting, lack of ambivalence towards the parents, absence of guilt over behaving towards the alienated parent, support of one parent in the parental conflict and presence of borrowed scenarios (4).

In the last year, there has been much discussion in Croatian news and social media about the term

[1] The term “parental alienation” is put in inverted commas to emphasize that it is a concept rather than a scientifically validated construct.

Pri tome nismo jedinstveni, slična se rasprava vodi ili se vodila u mnogim zemljama i dovela je u nekima od njih i do uvođenja zakonskih odredbi (npr. u Španjolskoj je u travnju 2021. donesen novi Zakon o zaštiti djece u kojem je jedna od velikih promjena uklanjanje upotrebe Sindroma roditeljskog otuđenja) (5). Nažalost, trenutno kod nas nedostaje literatura koja iznosi suvremene znanstvene spoznaje o konceptu „otuđenja".

Nekoliko je osnovnih pitanja koja se postavljaju, a na koja prema našem mišljenju još uvijek nije odgovoreno na adekvatan način. To su:

1. Što protivnici „otuđenja" imaju protiv „otuđenja"?
2. Radi li se o pseudoznanosti ili ne?
3. Radi li se o stavljanju interesa žena žrtava nasilja ispred interesa njihove djece?
4. Kamo i kako dalje?

Prvo je važno potpuno razjasniti da protivnici koncepta „otuđenja" ne negiraju postojanja ponašanja koja su vidljiva u kliničkoj praksi – djeca koja iskazuju otpor ili odbijaju druženja s jednim roditeljem, roditelji koji ocrnjuju jedni druge pred djecom, interferiraju sa susretima i koriste druge strategije kako bi narušili odnos između djeteta i drugog roditelja, te da takva ponašanja mogu imati štetne posljedice za dijete. Jednako tako ne negiraju ni potrebu da se ta ponašanja prepoznaju, procjenjuju i da se s roditeljima i djecom radi na poboljšanju odnosa (u slučajevima kad nema sumnje na nasilje). Međutim, kad ono što opažamo nazivamo nekim terminom, a posebno terminom koji pretendira postati dijagnoza, onda se više ne radi samo o opisu ponašanja, već i pretpostavljanim mehanizmima kako do tog ponašanja dolazi te pretpostavci da se ono jasno identificira i razlikuje od sličnih koncepata.

I tu nastaje problem! Jer, u posljednjih 36 godina, od kad je Gardner (6) uveo termin otuđenja u psihologijsku literaturu, nije akumulirano dovoljno znanstvenih dokaza da možemo reći

and the use of the concept of "parental alienation" In this, we are not unique, as similar discussions have been taking place in many other countries, in some resulting with the adoption of legal provisions (e.g. a new Child Protection Act was adopted in Spain in April 2021, according to which one of the major novelties is the elimination of "Parental Alienation Syndrome") (5). Unfortunately, in Croatia, there is a lack of literature that would present contemporary scientific findings about the concept of "parental alienation".

There are several basic questions that are being raised, and, in our opinion, they have not been adequately answered so far. These are:

1. What do opponents of "parental alienation" have against "parental alienation"?
2. Is it pseudoscience or not?
3. Is it about putting the interests of women victims of violence before the interests of their children?
4. In which direction and how to proceed?

First of all, it is important to fully clarify that opponents of the concept of "parental alienation" do not deny the existence of certain behaviours that are visible in clinical practice, e.g., children showing resistance or refusing to spend time with one parent, parents denigrating each other in front of children, interfering when contact takes placer or using other strategies to disrupt the relationship between the child and the other parent, nor the fact that such behaviours can have detrimental consequences for the child. To the same extent, they do not disregard the need to recognise and assess such behaviours and to work with parents and children to improve their relationship (in cases where there is no suspicion of violence). However, when we use a term for something under observation, and especially if that term might become a diagnosis, it is not a matter of the description of a particular behaviour, but of the assumed mechanisms leading to that behaviour and the assumption that it has to be clearly identified and distinguished from similar concepts.

And this is where the problem arises! In the last thirty-six years, since Gardner (6) introduced the

da upravo ta ponašanja stoje iza tog pojma, da upravo ti mehanizmi objašnjavaju to ponašanje te ne znamo koja su ponašanja specifična upravo za „otuđenje“. Dakle, protivnici „otuđenja“ protivnici su korištenja tog pojma kao dijagnostičkog, znanstvenog i psihološkog konstrukta u kliničkim procjenama ili vještačenjima te protiv donošenja odluka temeljem korištenja tog pojma (7). Sam Bernet, jedan od najvažnijih zagovornika „otuđenja“ (8), kaže da nije bitno koji se termin koristi dok se god slažemo da govorimo o istoj stvari. No, ne govorimo o istoj stvari. Jer, kad govori o „otuđenju“, Bernet i ostali zagovornici tog koncepta govore, ne samo o ponašanjima djeteta, već, polazeći iz psihoanalitičke perspektive, podrazumijevaju i cijeli niz mehanizama, ponašanja i motivacije koja se nalazi u podlozi ponašanja „otuđujućeg“ roditelja, a koja za cilj imaju odvajanje djeteta i drugog roditelja (9). Prema njima termin „otuđenja“ odnosi se na skup pretpostavki koje okrivljuju roditelja s kojim dijete ostaje vezano i taj skup pretpostavki nije dovoljno utemeljen na znanstvenim spoznajama, niti njima potkrijepljen (10).

Postavljanje dijagnoze i imenovanje nekog psihičkog stanja ima svoje jasne koristi. Između ostalog osigurava pravi tretman, olakšava komunikaciju među stručnjacima i omogućava da osoba ima temeljem toga neke beneficije. Ali jednako tako znamo da to sa sobom nosi i neke negativne posljedice – nekad je teško, zbog sličnosti u simptomima postaviti točnu dijagnozu, a ako se postavi kriva dijagnoza onda to može imati značajne i štetne posljedice za osobu. Neke dijagnoze sa sobom nose i značajnu stigmu i diskriminaciju, naročito kad se neprimjereno koriste. To može dovesti do nepoštenog odnosa prema toj osobi, uskraćivanja usluga ili prilika i ostalih negativnih reakcija od drugih osoba (11). Cijeli proces postavljanja dijagnoze ili imenovanja nekog psihičkog stanja je vrlo osjetljiv i može imati dalekosežne posljedice za sve uključene osobe. Zbog toga

term into the psychology literature, insufficient scientific evidence has been accumulated to be able to claim that these behaviours fully define the concept and that these mechanisms explain this type of behaviour. In other words, we lack knowledge about what behaviours are specific to “parental alienation”. Thus, opponents of “parental alienation” refuse to use the term as a diagnostic, scientific and psychological concept in clinical assessments and expert opinions and stand against making decisions based on the use of the term (7). Bernet himself, as one of the most prominent proponents of “parental alienation” (8), said that it did not matter which term was used as long as we agreed to talk about the same thing. However, we are not talking about the same thing. When Bernet talks about “parental alienation”, he and other proponents of the concept do not talk only about the child’s behaviour. Starting from a psychoanalytic perspective, they also imply a whole range of mechanisms, behaviours and motivations underlying the behaviour of the “alienating” parent, the aim of which is to separate the child from the other parent (9). According to them, the term “parental alienation” refers to a set of assumptions blaming the parent with whom the child remains attached and this set of assumptions has not been sufficiently founded in scientific knowledge nor substantiated by scientific evidence(10).

Establishing a diagnosis and naming a mental state have clear benefits. Among other things, in that way the right treatment can be provided and effective communication between professionals facilitated while the patient can get certain benefits. On the other hand, this can also result in some negative consequences, i.e., it is sometimes difficult to make an accurate diagnosis because of similar symptoms and if a misdiagnosis is made, it can have significant and harmful consequences for the patient. Some diagnoses can also carry a lot of stigma and discrimination, especially if they are used inappropriately. In turn, this can lead to unfair treatment of the patient, denial of services or opportunities, or various other negative reactions from others (11). The whole pro-

kritičari „otuđenja“ zagovaraju da treba ostati na razini deskriptivnih termina, ograđujući se od zaključaka koje ne možemo nedvojbeno dokazati. A dosadašnja literatura pokazuje da se „otuđenje“, kako ga definiraju zagovornici, ne može nedvojbeno dokazati.

ZNANSTVENA UTEMELJENOST „OTUĐENJA“

Kako bismo odgovorili na pitanje radi li se u slučaju teorije „otuđenja“ djeteta o pseudoznanosti ili ne, važno je staviti stvari u malo širi kontekst prakse temeljene na dokazima i jaza između teorije i prakse (engl. *science-practictionar gap*). Gotovo sve pomagačke znanstvene discipline suočene su s problemom dualnosti – s jedne strane nalaze se znanstvenici koji svoj rad temelje na znanstvenim dokazima, a s druge praktičari koji se na njih oslanjaju vrlo malo ili nikako (12). U prvoj su kategoriji znanstvenici koji provode znanstvena istraživanja i kojima znanost služi i kao zaštita od vlastitih pristranosti u zaključivanju. Stručnjaci/praktičari u ovoj kategoriji aktivno prate znanstvene spoznaje i implementiraju ih u svoju praksu (dijagnostiku i tretman). U drugoj su grupi praktičari koji su nakon svojih temeljnih studija zanemarili proučavanje znanstvenih istraživanja, praćenje najnovijih spoznaja i temeljem toga prilagodbu prakse. Razlozi toga su mnogobrojni i dio ih se odnosi i na zatvorenost znanstvene zajednice, njihovu čestu nerazumljivost u komunikaciji i udaljenost u istraživačkim temama od onog što praktičare zanima i/ili mori u svakodnevnoj praksi. Stoga se ti stručnjaci u svojoj praksi oslanjaju na svoje kliničko iskustvo, ono što su naučili od autoriteta tijekom studija ili kasnijih edukacija, ili na vlastitu intuiciju. Zbog svega navedenog nisu bez razloga sve češće u literaturi iznošene tvrdnje da su znanstveni temelji kliničke psihologije i srodnih struka na sve klimavijim nogama i da je jaz između znanstvenika i praktičara

cess of making a diagnosis or naming a mental state is very sensitive and can have far-reaching consequences for everyone involved. For this reason, the critics of “parental alienation” advocate that it should remain at the level of a descriptive term, disassociated from conclusions that cannot be conclusively proven. The available literature shows that “parental alienation” cannot be conclusively proven as defined by its proponents.

SCIENTIFIC FOUNDATION OF “PARENTAL ALIENATION”

In order to establish whether the theory of “parental alienation” falls in the domain of pseudoscience or not, it is important to put things in a broader context of evidence-based practice and the science-practitioner gap. Almost all ancillary scientific disciplines are faced with the problem of duality. On the one hand, there are scientists who base their work on scientific evidence, and on the other, there are practitioners who rely on them very little or not at all (12). Scientists conducting scientific research for whom science also serves as a protection against their own biases in reasoning belong to the first category. Professionals/practitioners belonging to this category actively monitor scientific knowledge and implement it in their practice (diagnostics and treatment). Practitioners who tend to neglect the scientific research, fail to follow the latest findings and adapt their practice after having completed their basic education belong to the second category. The reasons for this are numerous and partly related to the fact that the scientific community is rather closed, often incomprehensive in communication and distanced in research topics from what practitioners are interested in or striving to resolve in everyday practice. In their practice, they have to rely on their own clinical experience, what they learned during their studies or subsequent training, or on intuition. Because of the above mentioned, it is not without reason that the literature nowadays claims more frequently that the scientific foundations of clinical psychology and relat-

sve veći. U prilog tome idu i istraživanja koja pokazuju da je većina stručnjaka mentalnog zdravlja skeptična prema praksi temeljenoj na dokazima (13) te da pri odabiru intervencija odluku više temelje na svom kliničkom iskustvu, intuiciji ili teorijskoj orijentaciji nego na rezultatima istraživanja (14,15). Znanost ponekad kasni za aktualnim problemima iz prakse, a mnoga istraživanja ne daju jednoznačne rezultate i jasne smjernice za praksu. Osim toga, broj znanstvenih časopisa i objavljenih istraživanja je u geometrijskom porastu i nije jednostavno pratiti sve relevantne znanstvene spoznaje, a praktičari za to često nemaju ni vremena u svom svakodnevnom radu. S druge strane, znanstvenici rjeđe izlažu na stručnim konferencijama kako bi približili znanstvene nalaze praktičarima. Teret odgovornosti za ovakav jaz je dakle na obje strane i važno je raditi na tome da se on smanji. Jer nažalost, posljedice ove dualnosti u najvećoj mjeri osjećaju korisnici naših usluga.

Kao što smo gore naveli, neki stručnjaci mentalnog zdravlja koriste nepodržane, neprovjerene i na druge načine problematične tretmane i dijagnostičke metode. Nažalost, istraživanja ukazuju da su neki praktičari presamouvjereni u svojim procjenama i predikcijama, da imaju mnogo pristranosti u zaključivanju i konceptualizaciji klijentovih problema i da često koriste tehnike koje su znanstveno upitne ili kontroverzne (12). Neki nažalost, vrlo samouvjereno koriste dijagnoze čija se utemeljenost i valjanost tek treba potvrditi, kao što je to slučaj kad je u pitanju „otuđenje“ djeteta (16). Problem s upitnim dijagnozama je posebno naglašen u sudskim procesima gdje se temeljem njih donose dalekosežne posljedice za sve uključene (17). Pri tome je važno biti potpuno otvorena uma na činjenicu da je znanost živa, da se svakodnevno objavljuju nove spoznaje i da će nešto što je trenutno upitne znanstvene valjanosti možda biti potvrđeno u budućim istraživanjima. No, teret dokaza je na onima koji zagovaed professions are on increasingly shaky legs and that the gap between scientists and practitioners has been widening. This is supported by research showing that most mental health professionals are sceptical of evidence-based practices (13) and that when choosing interventions, they base their decisions more on their clinical experience, intuition or theoretical orientation than on the results of research (14:15). Science sometimes legs behind current problems in practice and many studies do not provide unambiguous results and clear guidelines for practice. In addition to that, the number of scientific journals and published research is on a geometric rise. It is not easy to follow all relevant scientific findings and practitioners often do not even have enough time to do it in their day-to-day work. On the other hand, scientists present their findings at professional conferences less frequently to bring scientific findings closer to practitioners. The burden of responsibility for this gap, therefore, lies on both sides and it is important to exert effort to reduce it. Unfortunately, the consequences of this duality are largely felt by those who use our services.

It follows that certain mental health professionals use unsupported, unchecked and in other ways problematic treatments and diagnostic methods. Unfortunately, research suggests that some practitioners are overconfident in their assessments and predictions, exert a lot of bias when reaching conclusions and conceptualizing patient problems, and often use techniques that are scientifically questionable or controversial (12). Sadly, some of them very confidently use diagnoses the foundation and validity of which have yet to be confirmed. This is the case with “parental alienation” (16). The problem with questionable diagnoses is particularly evident in court proceedings as they have far-reaching consequences for all parties involved (17). Nevertheless, it is important to keep a completely open mind and embrace the fact that science is alive and dynamic; new insights are published daily and something that is currently of questionable scientific validity may be confirmed by future research. However, the burden of proof lies with those who advocate a

raju neku teoriju ili tehniku, a ne na njihovim kritičarima (18).

Što dosadašnji dokazi govore o znanstvenoj utemeljenosti „otuđenja“? Svi se stručnjaci slažu da u praksi, naročito kad rade s djecom roditelja koji prolaze kroz složeni razvod, često opažaju ponašanja odbijanja jednog roditelja i preferencije drugog roditelja. Manipulacija je jedno od mogućih objašnjenja opaženog ponašanja i u ovoj fazi predstavlja opisni, teoretski koncept. No, da bi postao znanstveno potvrđeni konstrukt, pogodan za korištenje u praksi, potreban je cijeli niz istraživanja koja trebaju dokazati, ono što se u znanosti naziva konstruktnom valjanosti tog koncepta (jer je ona temelj znanstvene valjanosti). Konstrukt treba biti definiran u opažajnim terminima kako bi se mogao objektivno mjeriti i procjenjivati (19). Da pojednostavimo, da bi „otuđenje“ bilo znanstveni, psihološki konstrukt potrebno je definirati koja to ponašanja i obilježja imaju „otuđena“ djeca kako bi se to moglo jasno i jednoznačno procjenjivati. Pri tome su dvije važne odrednice konstruktne valjanosti – konvergentna valjanost i diskriminativna valjanost. Dva komplicirana termina koja opisuju jednostavne odrednice. Konstrukt, u ovom slučaju „otuđenje“, mora imati očekivanu povezanost sa sličnim konstruktima te istovremeno mora imati jasna distinktivna obilježja koja omogućavaju da se razlikuje od sličnih koncepata. Dakle, „otuđenje“ mora biti opisano na način da smo u procjenama sigurni da se radi o njemu, a ne o nečem drugom kao npr. separacijskoj anksioznosti, slaboj privrženosti djeteta i roditelja ili nečemu trećem. Da bi „otuđenje“ bilo priznato kao znanstveni konstrukt, istraživanja moraju utvrditi njegovu konvergentnu i diskriminativnu valjanost.

Ako se zbog jednostavnosti zadržimo na samo dva ponašanja koja Gardner navodi kao ona koja ukazuju na „otuđenje“ - ocrnjivanje jednog roditelja i fenomen djeteta „nezavisnog mislitelja“, znanstvena istraživanja trebaju jasno

particular theory or technique, and not with their critics (18).

What does current evidence say about the scientific rationale of “parental alienation”? All experts agree that in practice, and especially when working with children of parents going through a complex divorce, they often perceive behaviours such as rejection of one parent and preference of the other. Manipulation is one of possible explanations of the observed behaviour and, at this stage, it represents a descriptive, theoretical construct. However, in order to become a scientifically validated concept suitable for use in practice, a whole series of research avenues is needed to prove something that science calls the construct validity of a construct (which is the very basis of scientific validity). A concept should be described in observable terms in order to be objectively measured and assessed (19). To simplify, in order for “parental alienation” to be a scientific psychological construct, it is necessary to define what behaviours and characteristics “alienated” children have in order to be able to provide clear and unambiguous assessment. In doing so, two important determinants of construct validity have to be taken into account, i.e., convergent validity and discriminant validity. These are two complicated terms used to describe simple determinants. The concept of “parental alienation”, therefore, has to be linked with similar concepts and, at the same time, it has to have clear and distinctive characteristics that allow it to differ from similar concepts. Thus, “parental alienation” has to be described in a way that allows us to be certain of it while making our assessments so that we do not confuse this construct with, for example, separation anxiety, poor attachment relationship between child and parent or something else. In order for “parental alienation” to become recognized as a scientific concept, research has to determine its convergent and discriminant validity.

If, for simplicity, we take into consideration only two types of behaviour to which Gardner points out as the behaviours indicating “parental alienation”, i.e., the campaign of denigration of one

dokazati da su opisana ponašanja nešto što je specifično i jedinstveno za „otuđenje“. I da nisu prisutna u nekim drugim slučajevima, kao što su npr. loši roditeljski postupci. Može li odbijanje i ocrnjivanje roditelja biti posljedica loših iskustava djeteta s roditeljem koji s njima ne provodi vrijeme, ne reagira na njihove potrebe i ne iskazuje nježnosti? Vjerujemo li djeci kad nam kažu da su to njihova iskustva, a ne da ih je na to nagovorio drugi roditelj? Možemo li to i kako dokazati? Jer upravo činjenica da negiraju da ih je na to nagovorio drugi roditelj stručnjacima je dokaz da je fenomen nezavisnog mislioca prisutan.

U pokušajima dokazivanja znanstvene utemeljenosti koncepta „otuđenja“ često se koriste anegdotalni primjeri, odnosno iskustva žrtava „otuđenja“. Apsolutno je važno razumjeti da anegdotalni dokazi mogu biti početak konceptualizacije nekog koncepta (kao što je slučaj s „otuđenjem“) i da su iskustva žrtava važna. Međutim, istraživači moraju vrlo jasno dokazati da se u opisanim primjerima radi o „otuđenju“, a ne o prethodnom zlostavljanju ili reakciji na loše roditeljstvo. Korištenje primjera slučaja kao znanstvenih dokaza je uvijek rizično jer se prikazuje individualno iskustvo pojedinca, njihova perspektiva te njihovo tumačenje slijeda i uzroka događaja. U slučajevima „otuđenja“ moramo biti sigurni da se ne radi o reakciji na razvod roditelja ili na pojačavanju prijašnjih problema, odnosno da nije moguće ni jedno drugo alternativno objašnjenje. Upravo zbog toga, jednaku znanstvenu rigoroznost treba primijeniti na ove podatke kao i na podatke prikupljene znanstvenom metodologijom.

Druga vrsta dokaza su dokazi proizašli iz znanstvenih istraživanja. Ni oni do sada nisu uspjeli dokazati konstruktnu valjanost otuđenja. Uz prisutnost značajnih metodoloških poteškoća (nepostojanje adekvatnih mjernih instrumenata, pristranost u regrutaciji sudionika, izostanak kontrolnih skupina, korištenje neadekvatnih statističkih analiza i korištenje cirkularnih

parent and the “independent-thinker” phenomenon, scientific research should unambiguously prove that those behaviours are specific and unique to “parental alienation”. In addition to that, they should not be characteristic for other cases, such as poor parental practices. Can rejection or denigration of one parent result from bad experiences that the child has experienced with the parent who does not spend time with him or her, fails to react to the child’s needs and does not show affection? Do we believe children when they tell us that these are their experiences and that they were not talked into it by the other parent? Can we prove it and how? For professionals, the fact that the child denies being persuaded by the other parent is a proof of the “independent-thinker” phenomenon.

The attempts to prove the scientific rationale of the concept of “parental alienation” oftentimes use anecdotal examples, i.e., experiences of victims of “parental alienation”. It is absolutely important to understand that anecdotal evidence can be used in the beginning of the conceptualization of a concept (as is the case with “parental alienation”) and that victims’ experiences are important. However, researchers have to unambiguously prove that the examples they use are cases of “parental alienation” and not cases of previous abuse or a reaction to poor parenting practices. Using case examples as scientific evidence is always risky as it presents an individual experience, a certain perspective and interpretation of a sequence and causes of events. To establish a case of “parental alienation”, we have to be certain that certain behaviour is not a reaction to divorce or amplification of previous problems, or, in other words, that no other alternative explanation is possible. For this reason, the same scientific rigor should be applied to this kind of data as to the data collected from scientific examination methodologies.

Evidence emerging from scientific research is the other category of evidence and, so far, such evidence has not been able to prove the construct validity of alienation. Due to significant methodological flaws (lack of adequate measuring instru-

objašnjenja), konvergentna i diskriminativna valjanost „otuđenja“ nisu potvrđene (20). Najviše je poteškoća u razgraničavanju „otuđenja“ od psihološkog zlostavljanja. Nakon akumulacije dokaza da je „otuđenje“ nemoguće razlikovati od psihološkog zlostavljanja, zagovornici „otuđenja“ navode da je „otuđenje“ zapravo oblik emocionalnog zlostavljanja (21,22). Do sada istraživanja nisu dokazala kako je „otuđenje“ povezano sa zlostavljajućim ponašanjima (odbijanjem, teroriziranjem, izoliranjem, iskorištavanjem, uskraćivanjem emocionalne pažnje i zanemarivanjem) te koje su posljedice „otuđenja“ koje bi ukazivale da se radi o emocionalnom zlostavljanju (23).

Posebni su problemi vezani uz razvoj mjernih instrumenata za procjenu „otuđenja“. Pregled dosadašnje literature pokazuje da, do sada razvijeni mjerni instrumenti [od kojih neki npr. Bakerov upitnik otuđenja (21), Upitnik prihvaćanja-odbijanja roditelja (24)], nisu uspjeli zadovoljiti kriterije kojima bi dokazali da mjere ono što bi trebali mjeriti, odnosno da mjere „otuđenje“ te da je s njima moguće jasno dokazati, odnosno potvrditi „otuđenje“.

Jedno od prijepornih pitanja u stručnoj i znanstvenoj raspravi je i korištenje kvalitativne metodologije kao osnovne metodologije u konceptualizaciji, operacionalizaciji i potvrđivanju ovog koncepta. Važno je istaknuti da kritičari „otuđenja“ ne kritiziraju kvalitativnu metodologiju *per se* kao izvor znanstvenih podataka, već način na koji tu metodologiju koristi prvo Gardner, a onda kasnije i ostali istraživači koji njima potvrđuju „otuđenje“. Radi se o neadekvatnom korištenju pristupa utemeljene teorije (engl. *Grounded theory method*), triangulacije, regrutacije sudionika i sl. koji nažalost ukazuju na nedovoljno poznavanje znanstvene teorije i metodologije samih autora (za detalje pogledati ref. 25), a ne na poteškoće s kvalitativnom metodologijom koja može biti iznimno vrijedan izvor znanstvenih podataka. U posljednjem objavljenom sustavnom pregledu

ments, bias in the recruitment of participants, absence of control groups, use of inadequate statistical analyses and use of circular explanations), the convergent and discriminant validity of “parental alienation” have not been confirmed (20). The biggest problem is how to distinguish “parental alienation” from psychological abuse. After having accumulated evidence that “parental alienation” is impossible to distinguish from psychological abuse, those who advocate “parental alienation” see it as a form of emotional abuse (21:22). So far, research has neither proven that “parental alienation” is associated with abusive behaviours (rejection, terrorisation, isolation, exploitation, denial of emotional attention and neglect) nor what are the consequences of “parental alienation” that would indicate emotional abuse (23).

Moreover, there are particular problems related to the development of instruments for the assessment of “parental alienation”. An overview of the current scientific literature indicates that the instruments developed so far (e.g. the Baker Parental Alienation Syndrome Questionnaire (21), Parental Acceptance-Rejection Questionnaire (24)) have failed to meet the criteria to prove that they measure what they are supposed to measure, i.e. “parental alienation”, and that by using them it is possible to clearly prove or confirm “parental alienation”.

One of the controversial questions in professional and scientific discussions is the question of the use of qualitative methodology as the basic methodology in the conceptualization, operationalization and validation of this concept. It is important to point out that critics of “parental alienation” do not criticize the qualitative methodology *per se* as a source of scientific data, but the way in which this methodology has been used, first by Gardner, and later on by other researchers who have been using it to corroborate “parental alienation”. This is a case of inadequate use of the grounded theory method, triangulation, recruitment of participants, etc., which, unfortunately, indicates that the authors lack knowledge in scientific theory and methodology

literature objavljenom 2019. godine opisana su 42 provedena istraživanja od 2000. do 2018 godine koja su bila dominantno kvantitativna. Rezultati pokazuju da dominantna istraživačka metodologija posljednjih godina više nije kvalitativna, međutim da objavljena istraživanja pate od ozbiljnih metodoloških nedostataka (26).

Dodatan problem vezan uz pregled literature u ovom području su izvori citirane literature. Mnogi zagovornici „otuđenja" kao relevantne izvore citiraju radove koje su objavili Gardner te Bernet i suradnici, uključujući i knjigu koja predstavlja temeljnu literaturu u ovom području – Roditeljsko otuđenje, DSM-5 i ICD11 objavljenu 2010. godine. Međutim, kad se pogleda popis literature te knjige vidljivo je da su najveći dio njegovih referenci filmovi, TV emisije, knjige i članci koje nisu pisali stručnjaci te je vidljiv izostanak referenci koje ne podržavaju ovu dijagnozu, kao i manjak recenziranih istraživanja koji podržavaju dijagnozu. Citirano je jako malo istraživanja koja su objavljena u recenziranim istraživačkim časopisima. Rasprave u javnosti nisu dovoljan kriterij da se nešto uvede u dijagnostičke priručnike niti je dokaz znanstvene valjanosti. Upotreba neznanstvenih citata kao dokaza znanstvene valjanosti pojma je potpuno neprihvatljiva (25).

Zaključno, kada zagovornici koncepta „otuđenja" o njemu govore, navode da se radi o globalno prihvaćenom dijagnostičkom, znanstvenom, psihološkom i pravnom konceptu a da se ne osvrću na jednako tako globalne kontroverze koje se uz njega vežu (7). Lilienfeld i suradnici (12) iznose znakove upozorenja pomoću kojih razlikujemo znanstvene od pseudoznanstvenih metoda i koncepata. Neki od njih su izostanak samokorekcije, izbjegavanje recenzija kolega stručnjaka, naglasak na potvrđivanju umjesto na opovrgavanju, obrnuta logika tereta dokaza, pretjerano oslanjanje na svjedočenja i anegdotalne primjere, izostanak jasnih granica (jasnih određenja kad nešto jest, a kad to nije). Kon-

(see ref. 25), rather that there are difficulties with a qualitative methodology that can serve an extremely valuable source of scientific data. The last published systematic review of literature from 2019 describes 42 studies conducted from 2000 to 2018 that are predominantly quantitative. The results show that the dominant research methodology applied in recent years has no longer been qualitative, but that published studies suffer from serious methodological deficiencies (26).

An additional problem related to the review of literature in this area emerges from the sources of the cited literature. Many proponents of "parental alienation" quote papers published by Gardner and Bernet et al., as well as the fundamental book in this field published in 2010 - *Parental Alienation, DSM-5 and ICD-11* – as the relevant source. However, a closer inspection of the references in that book reveals that the majority of references are films, TV shows, and books and articles that have not been written by experts in the field. There is a noticeable absence of references to support the diagnosis in question, as well as a lack of peer-reviewed research. Very few studies published in peer-reviewed research journals have been quoted. Public discussions are not sufficient criteria to introduce something into diagnostic manuals, nor is it evidence of scientific validity. The use of unscientific quotations to establish evidence of scientific validity of the term is completely unacceptable (25).

In conclusion, when proponents of "parental alienation" talk about the concept, they state that it is a globally accepted diagnostic, scientific, psychological and legal concept, neglecting to address controversies associated with it, which are equally global (7). Lilienfeld et al. (12) list warning signs that can be used to distinguish between scientific and pseudoscientific methods and concepts. Some of those signs include the absence of self-correction, evasion of peer-review by fellow experts, an emphasis on confirmation rather than refutation, reverse logic of the burden of proof, overreliance on testimonial and anecdotal evidence, absence of boundary conditions (well-articulated limits under which predicted phenomena do and do not

cept „otuđenja“, promatrajući ove znakove, još je uvijek bliži pseudoznanosti nego znanosti.

PROBLEMI S DEFINICIJOM POJMA

Pojam sindroma „otuđenja“ djeteta od roditelja uveo je Richard Gardner 1985. godine i prvi ga je put predstavio u neznanstvenom časopisu *Academy Forum* (6). Od tada, unatoč nekoliko promjena imena, od sindroma poremećaja do samo „otuđenja od roditelja“, sama definicija i dijagnostički znakovi te značenje pojma nisu se puno promijenili (27).

Sindrom „otuđenja“ djeteta od roditelja, kasnije promijenjen u poremećaj „otuđenja“ djeteta od roditelja (PAD) u dva se navrata pokušalo uvesti u službene dijagnostičke sustave, a najrecentniji je pokušaj da se uvede u Međunarodnu klasifikaciju bolesti – 11 izdanje (MKB-11, koji izdaje SZO) te u 5. izdanje DSM-a koji izdaje Američka psihijatrijska organizacija (APA). Kolege okupljene oko Williama Berneta napravile su pregled razloga zašto bi PAD trebao biti službena dijagnoza i ti su argumenti kasnije objavljeni u ranije spomenutoj knjizi Roditeljsko otuđenje, IDC11 i DSM-5 (28). Prema navodima samog autora ta je knjiga do tada najbolji i najopsežniji skup dokaza o valjanosti, pouzdanosti i prevalenciji „otuđenja“. Pokušat ćemo detaljno analizirati koje su sve poteškoće s ovim pojmom, njegovom definicijom i operacionalizacijom te zašto su upravo ti problemi, kad se sagledaju u kontekstu znanstvenih dokaza, racionala za odbacivanje ovog termina i zabranu korištenja u sudskim postupcima i kliničkim procjenama.

Prema definiciji osnovni kriterij prema kojem bi se „otuđenje“ trebalo dijagnosticirati je snažno povezivanje djeteta s jednim roditeljem i odbacivanje drugog bez legitimnog opravdanja i objašnjenja. Za zaključak da se radi o „otuđenju“ treba biti prisutno i „otuđujuće“

apply). If these signs are taken into consideration, the concept of “parental alienation” is still closer to pseudoscience than to science.

PROBLEMS WITH THE DEFINITION OF THE TERM

The concept of “parental alienation syndrome” was introduced by Richard Gardner in 1985 and first introduced in an unscientific journal - *Academy Forum* (6). Ever since, despite several changes of the name, from disorder syndrome to simply “parental alienation,” the very definition, diagnostic signs and meaning of the term have not changed much (27).

There were to attempts to introduce “Parental alienation syndrome” (PAS), later changed to “parental alienation disorder” (PAD), into the official diagnostic systems. The most recent one concerns the effort to introduce it into the 11th revision of the International Classification of Diseases (ICD-11, WHO 2022) and in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Organization (APA). Colleagues gathered around William Bernet have prepared an overview of the reasons why the PAD should become an official diagnosis and these arguments were subsequently published in the aforementioned book titled *Parental Alienation, IDC-11 and DSM-5* (28). According to the author, this book provided the best and most comprehensive set of proofs on the validity, reliability and prevalence of “parental alienation” up to that time. We will try to provide a detailed analysis of various difficulties related to the term, its definition and operationalization, and explain why these problems, in the context of scientific proof, represent the rationale for its rejection and prohibition of use in judicial proceedings and clinical assessments.

According to the definition, the basic criterion according to which “parental alienation” should be diagnosed is the strong association of the child with one parent and rejection of the other without legitimate justification and explanation. In order

ponašanje preferiranog roditelja. Osim toga, osnovno psihičko obilježje djeteta je iracionalna anksioznost i/ili hostilnost prema roditelju kojeg odbija (28). U kontekstu kliničke prakse i procjene, ali i znanstvenih dokaza, Bernet i suradnici ne nude nikakve tehnike ni smjernice kako odrediti ima li dijete *legitimno objašnjenje* kao ni je li prisutna *iracionalna* anksioznost ili hostilnost (25). Kako onda procjenjujemo jesu li djetetove reakcije opravdane? Ili se radi o simptomima „otuđenja"? Ako nema jasnih kriterija legitimnih objašnjenja, kliničari se mogu osloniti jedino na vlastita uvjerenja i vlastite pretpostavke o tome što je prihvatljivo odbijanje drugog roditelja. A u tim se uvjerenjima kliničari sigurno međusobno razlikuju. Jednom kad se postavi hipoteza „otuđenja" teško ju je opovrgnuti, jer hipoteza kaže da će dijete, ako je „otuđeno", pokazivati opisana ponašanja. Ako su opisana ponašanja prisutna, dijete je „otuđeno". Ovo jasno ukazuju na pristranost u zaključivanju koje se zove *potvrđivanje posljedica* (25). Za razliku od toga, kad postoje legitimna objašnjenja djetetovog ponašanja, govori se o udaljavanju (engl. *estrangement*) ili odbijanju kontakta (29).

Ako prihvatimo pretpostavku o nepostojanju legitimnog objašnjenja djetetovog ponašanja, moramo prihvatiti i pretpostavku o tome da je ranije postojao zadovoljavajući odnos između djeteta i „otuđenog" roditelja te da pokušaj narušavanja tog odnosa nema nikakvo opravdanje ni objašnjenje. Ponovno smo u prilično subjektivnoj zoni prikupljanja informacija o tome kakav su odnos prije imali roditelj i dijete te utvrđivanja postojanja motivacije „otuđujućeg" roditelja za takvim ponašanjem. Oba ta procesa vrlo često uključuju i rad sa žrtvama zlostavljanja (i djece i majki), što znači da bi stručnjaci trebali biti educirani za rad s djecom žrtvama zlostavljanja te poznavati dinamiku i posljedice rodno uvjetovanog nasilja. Osim toga, „otuđenje" polazi od pretpostavke da se, ako za takvo ponašanje ne postoji legitimno

to establish "parental alienation", the "alienating" behaviour of the favoured parent also needs to be present. In addition to that, the basic mental characteristic of the child is irrational anxiety and/or hostility towards the rejected parent (28). In the context of clinical practice and assessment, as well as scientific proof, Bernet et al. fail to provide any techniques or guidance on how to determine whether a child has a legitimate explanation or whether irrational anxiety or hostility is present (25). So how do we assess whether the child's reactions are justified? Or, how do we conclude that the child expresses the symptoms of "parental alienation"? If there are no clear criteria for legitimate explanations, clinicians can rely only on their own beliefs and assumptions about what presents an acceptable rejection of the other parent. And when it comes to such beliefs, clinicians certainly differ amongst each other. Once the hypothesis of "parental alienation" has been established, it is difficult to refute it, because the hypothesis says that the alienated child will exhibit the described behaviours. If the described behaviours are present, the child is "alienated". This clearly indicates a bias in reasoning called *confirmation of consequences* (25). In contrast, when there are legitimate explanations of the child's behaviour, the term "estrangement" or refusal of contact is used (29).

If we accept the presumption that there is no legitimate explanation of the child's behaviour, we also need to accept the premise that a satisfactory relationship between the child and the "alienated" parent existed previously and that the attempt to hamper that relationship has no justification or explanation. This implies a rather subjective approach in gathering information about what kind of relationship the parent and child used to have and determining if the "alienating" parent is motivated to express such behaviour. Very often, both processes involve working with victims of abuse (both children and mothers), which implies that professionals need training in order to be able to work with children victims of abuse and understand the dynamics and consequences of gender-based violence. Furthermore, "parental alienation" starts from the premise that if there is no legitimate explanation

objašnjenje, radi o namjernoj manipulaciji zbog koje dijete daje iskrivljenu, netočnu sliku stvarnog stanja. No, rezultati dosadašnjih istraživanja pokazuju da djeca najčešće govore istinu, naročito kad su izložena nasilju i agresiji (27).

Podsjetimo, „otuđenje“ se pripisuje djeci koja iskazuju set od osam ponašanja (za detalje vidjeti ref. 4). Jedan od problema s navedenim simptomima „otuđenja“ je što mnogi od njih mogu biti reakcije npr. potpuno psihički zdravog adolescenta čiji roditelji prolaze kroz razvod, kao i reakcije djeteta na obiteljsko nasilje. Ako nemamo jasna distinktivna obilježja što razlikuje tu vrstu reakcija od „otuđenja“, a nemamo, onda ne možemo o „otuđenju“ ni zaključivati.

Dijagnostički kriteriji navedeni za „otuđenje“ ne uzimaju u obzir razvojne osobitosti u privrženosti roditelja i djece. Manja djeca češće su privržena jednom roditelju u odnosu na drugog, a odrastanjem može doći do promjena u privrženosti roditeljima. Međutim, prema konceptu „otuđenja“ očekuje se da će ista vrsta roditeljskog ponašanja imati iste učinke na djecu različite dobi te da će djeca različitih dobi pokazivati iste simptome. Ponašanje je, kako znamo, rijetko tako razvojno nepromjenjivo (30).

Opisivanje i imenovanje opaženog nije dokaz da je koncept valjan ili prihvaćen. Da ponovimo, nema opće prihvaćene definicije „otuđenja“ koja bi bila objektivna i provjerljiva. Samim time, rasprava o rezultatima koji potvrđuju roditeljsko „otuđenje“ kao mehanizam koji je u podlozi opaženog ponašanja je u najmanju ruku sumnjiva. Jer ista ta ponašanja koja se pripisuju otuđenju mogu se pripisati nekim drugim uzrocima vezanim uz privrženost (31), zlostavljanju djece i nasilju u obitelji (32). Nažalost, rasprava o diferencijalnoj dijagnostici „otuđenja“ u odnosu na druga objašnjenja je slaba i u literaturi zagovornika „otuđenja“ se spominje tek usput.

for this type of behaviour, the child gives a distorted and inaccurate description of the actual situation as a result of deliberate manipulation. However, the results of previous research show that children most often tell the truth, especially if they have been exposed to violence and aggression (27).

Let us not forget that “parental alienation” is attributed to children who exhibit a set of eight (see ref. 4) symptoms. One of the problems with the aforementioned symptoms of “parental alienation” is the fact that many of them can be reactions to something, e.g. a completely mentally healthy adolescent might react to a divorce, or a child might react to domestic violence. If we do not have a set of clear and distinct characteristics to distinguish such reactions from “parental alienation”, which is currently the case, it is impossible to reach conclusions about “parental alienation”.

The diagnostic criteria for “parental alienation” do not take into account the developmental specificities of the parent-child attachment. Younger children are more likely to be attached to one parent than the other, and growing up the attachment might change. However, according to the concept of “parental alienation”, the same type of parental behaviour is expected to have the same effects on children of different ages and children of different ages will show the same symptoms. As it is known, behaviour rarely remains developmentally unchanged. (30).

Describing and naming something that has been observed is not a proof that the concept is valid or accepted. To summarize, there is no generally accepted definition of “parental alienation” that is objective and verifiable. Therefore, the discussion about the results confirming “parental alienation”, as a mechanism underlying an observed behaviour is, to say the least, dubious. The same behaviours attributed to alienation can be attributed to a number of other causes related to attachment (31), child abuse or domestic violence (32). Unfortunately, the discussion about the differential diagnosis of “parental alienation” in relation to other explanations is rather weak and the literature written by its proponents mentions it only casually.

Sam Bernet (29) navodi da je u forenzičkoj praksi ključno razlikovati „otuđenje“ od udaljavanja jer to ima značajne posljedice u sudskim procesima. U literaturi se navodi da se opažena ponašanja mogu pripisati cijelom nizu razloga - dječjoj lojalnosti jednom roditelju, prisutnom zlostavljanju, separacijskoj anksioznosti, specifičnoj fobiji, poremećaju ophođenja, poremećaju prilagodbe, poteškoćama u povezanosti između roditelja i djeteta (33). Dodatno, otpor prema roditelju može biti razvojna faza, posljedica razvoda roditelja, reakcija na roditeljski stil, reakcija na percepciju djeteta da je jedan roditelj ranjiviji i „slabiji“ te reakcija na ulazak drugog roditelja u novi partnerski odnos. Zagovornici „otuđenja“ iznose različite hipoteze i načine kako razlikovati udaljenu od „otuđene“ djece. Tako Kelly i Johnston (34) navode da „otuđena“ djeca osjećaju nerazumnu ljutnju i/ili strah; Bernet i Freeman (35) navode čimbenike koje je potrebno razmotriti pri postavljanju diferencijalno-dijagnostičkih hipoteza, Lee i Olesen (36) navode da je prvi korak u razlikovanju procjena djeteta, zatim procjena oba roditelja i na kraju procjena odnosa djeteta s oba roditelja. Na kraju, Drozd i Olesen (37) navode korake potrebne za donošenje procjene da se radi o „otuđenju“. No, upravo prema navodima Berneta i suradnika (9) nitko od njih ne nudi jasne smjernice kako razlikovati „otuđenje“ od ostalih objašnjenja. Dakle, literatura o „otuđenju“ ne daje smjernice kako bi stručnjaci trebali razlikovati radi li se o konfliktu lojalnosti kod djece, prisutnosti zlostavljanja u obitelji (i u situacijama kad nema fizičkih dokaza, svjedoka ili priznanja), „otuđenju“ ili nečem četvrtom. U pregledu istraživanja koje su proveli Saini i suradnici (38) navodi se da je prisutan jasan izostanak istraživanja vezanih uz diferencijalnu-dijagnostiku „otuđenja“. Takvo usko i pristrano fokusiranje samo na jedno objašnjenje je jasna pristranost vidljiva u istraživačkim metodama, citiranju literature i zaključcima zagovornika „otuđenja“.

Bernet himself (29) states that it is crucial to distinguish between “parental alienation” from estrangement in forensic practice because of significant consequences in judicial proceedings. The literature states that the observed behaviours can be attributed to a whole range of reasons, i.e., loyalty to one parent, abuse, separation anxiety, specific phobia, conduct disorder, adaptation disorder, or difficulties in the parent-child relationship (33). Furthermore, resistance to one parent can be linked to a developmental stage, a consequence of divorce, reaction to a parental style, perception that one parent is more vulnerable and “weaker” or a reaction to the other parent’s new partnership relation. Proponents of “parental alienation” have various hypotheses and ways to distinguish estranged from “alienated” children. Kelly and Johnston (34) state that “alienated” children feel unreasonable anger and/or fear; Bernet and Freeman (35) cite the factors to consider when setting differential diagnostic hypotheses, Lee and Olesen (36) explain that the first step in establishing the distinction is to assess the child, then to assess both parents and ultimately to assess the child’s relationship with both parents. Finally, Thrush and Olesen (37) list the steps to be taken to make an assessment and establish a case of “parental alienation.” However, according to Bernet to et al. (9), none of them provides clear guidance on how to distinguish “parental alienation” from other explanations. Thus, the literature on “parental alienation” does not provide clear guidance to professionals on how to distinguish between a conflict of loyalty, domestic abuse (in cases where there is no physical evidence, witnesses or confessions), “parental alienation” and something else. A review of research conducted by Saini et al. (38) established a clear absence of research on the differential diagnosis of “parental alienation”. Such a narrow and biased focus on only one explanation indicates a clear bias in research methods, literature quoting and conclusions reached by the proponents of “parental alienation”.

The new editions of classification systems have not accepted their arguments, stating that not enough scientific evidence has been accumulated

Gore navedena nova izdanja klasifikacijskih sustava nisu prihvatila argumente zagovaratelja „otuđenja“ i navode da nisu akumulirani dovoljno snažni znanstveni dokazi koji bi potvrdili „otuđenje“ kao dijagnozu. Naime, čak su i neki zagovornici „otuđenja“ radnu skupinu upozorili da nema još dovoljno znanstvenih dokaza za uključivanje u DSM-5 (39). Dokazi iz kvalitativnih istraživanja nisu dovoljni, potrebni su snažni kvantitativni dokazi kako bi se novi poremećaj uveo u klasifikacijski sustav. Jedan od argumenata zagovaratelja je bio da će se ti dokazi sigurno akumulirati ako se „otuđenje“ uvede kao dijagnoza. Za sada, „otuđenje“ nije doseglo ni razinu znanstvene utemeljenosti da ga se uključi kao „stanja koja zahtijevaju dodatna istraživanja“ (engl. *condition requiring further study*) na način na koji je npr. uključena ovisnost o internetskim igrama (40).

KORIŠTENJE KONCEPTA „OTUĐENJA“ U STRUČNIM I FORENZIČKIM PROCJENAMA I SUDSKIM POSTUPCIMA U KOJIMA SU UKLJUČENE ŽRTVE RODNO UVJETOVANOG NASILJA

Još je jednom važno pažljivo razmotriti zašto je korištenje koncepta „otuđenja“ u kliničkoj praksi pogrešno i može imati štetne posljedice. Jasno je dokazano da „otuđenje“ nije znanstveno valjan konstrukt. To znači da su sve njegove pretpostavke još uvijek na razini hipoteza, koje u posljednjih 36 godina nemaju dovoljno znanstveno uporište da bi ih sa sigurnošću proglasili točnima ili valjanima. Najveća je poteškoća u tome da nema jasnih kriterija prema kojima možemo dokazati da je ono što opažamo „otuđenje“, a ne nešto drugo. To znači da se u kliničkoj praksi radi o tome da stručnjaci o „otuđenju“ trebaju zaključivati na temelju svojih uvjerenja, stavova i intuicije. Namjerno smo izostavili znanje – jer postojeći fundus znanstvenih činjenica ukazuje da se o „otuđenju“ ne

to confirm “parental alienation” as a diagnosis. Indeed, even some proponents of “parental alienation” have warned the task force that there is not yet enough scientific evidence to include it in the DSM-5 (39). Evidence from qualitative research is insufficient and strong quantitative evidence is yet needed to introduce a new disorder into the classification system. One of the arguments that the proponents used was that the evidence would surely accumulate if “parental alienation” was to be introduced as a diagnosis. So far, “parental alienation” has not even reached the appropriate level of scientific validity to be included as a condition requiring further study in the same way that, for example, video game addiction (40) is included.

USE OF THE CONCEPT OF “PARENTAL ALIENATION” IN PROFESSIONAL AND FORENSIC ASSESSMENTS AND COURT PROCEEDINGS INVOLVING VICTIMS OF GENDER-BASED VIOLENCE

Once again, it is important to carefully consider why the use of the concept of “parental alienation” is unsuitable for clinical practice and can result in harmful consequences. It has been unambiguously proven that “parental alienation” is not a scientifically valid construct. This implies that all assumptions about it are still at the level of hypotheses, as they lack sufficient scientific support in the last 36 years to declare them accurate or valid with certainty. The biggest difficulty is that there are no clear criteria according to which what is perceived as “parental alienation” can be proved as such and not something else. This means that in clinical practice professionals have to reach conclusions about “parental alienation” based on their personal beliefs, attitudes and intuition. Knowledge has been deliberately omitted here as the existing scientific facts indicate that “parental alienation” cannot be established with certainty because there are no clear criteria for how to distinguish it from similar conditions. We can all agree that once we enter the field of reasoning based on our

može sa sigurnošću zaključivati jer nema jasnih kriterija kako ga razlikovati od sličnih stanja. Jednom kad smo na području zaključivanja temeljem vlastitih uvjerenja, stavova i intuicije, složit ćemo se, ne radimo kliničku procjenu temeljenu na dokazima, već smo u zoni cirkularnog zaključivanja u kojem očekivanja utječu na opažanja, i obrnuto, opaženo potvrđuje očekivanja.

Zamislimo samo slučaj u kojem nam dolaze roditelji i dijete u procesu razvoda. Majka opisuje da je u obitelji bilo prisutno rodno uvjetovano nasilje (RUN) – psihičko, emocionalno te ekonomsko nasilje. Fizičkog nasilja nije bilo. Nasilje traje već neko vrijeme, a u posljednjih je godinu dana bilo učestalo i pred djetetom. Opisuje ponižavanje, omalovažavanje, kontrolu kontakata i mobitela, prijetnje supruga i oca djeteta da će joj oduzeti dijete i proglasiti je ludom te da joj nitko neće vjerovati, jer je ona nitko i ništa. Majka nije nasilje prijavila jer ju je suprug uvjerio da joj nitko neće vjerovati. I da bi on, kad bi policija i došla, sve porekao i rekao da ona njega vrijeđa, te da nema razloga da policija vjeruje njoj više nego njemu. Majka na kraju, baš zbog toga jer je nasilje postalo učestalije pred djetetom, izlazi iz nasilne veze. Stručnim službama navodi da želi da se dijete i otac, zbog nasilja, viđaju pod nadzorom. Otac sve opovrgava i tvrdi da ona laže. Da on nije nasilnik i da majka samo želi udaljiti/"otuđiti" dijete od njega. Dijete odbija kontakte s ocem, govori da ga ne voli, vrlo je privrženo majci, sramežljivo, ustrašeno, stoji čvrsto uz nju, tiho odgovara na pitanja.

Situacija 1 – Stručnjaci prepoznaju da se radi o rodno uvjetovanom nasilju

Majka na prvi razgovor dolazi kod stručnjaka koji prepoznaje da se radi o RUN-u. U razgovoru zaključuju da će majka prijaviti RUN, a oni upućuju zahtjev za privremenom mjerom

own beliefs, attitudes and intuition, a clinical assessment cannot be done based on evidence but rather based on a circular reasoning where expectations impact observations, and vice versa, what has been observed confirms expectations.

Let us just imagine a case in which parents and a child seek professional help during a divorce. The mother describes that gender-based violence (GBV) occurred in the family in the form of psychological, emotional and economic violence. Physical violence did not occur. Violence has been going on for quite some time, and in the last year, it frequently took place in front of the child. The mother describes humiliation, belittling, control over contacts and mobile communication, threats from the father and her husband that he would take away the child and declare her insane and that no one would believe her, because she was nothing and nobody. The mother has not reported the violence because her husband assured her that no one would believe her. He also said that if the police came, he would deny everything and say that she was insulting him, and that there was no reason for the police to trust her more than him. Since violence became more frequent in front of the child, the mother finally decided to leave the abusive relationship. She tells the professional services that she wants that the father and the child have supervised contact. The father denies everything claiming that the mother is lying. He is not a abuser and the mother just wants to keep the child away from him. The child refuses contact with the father, says that she does not love him, and is very affectionate with the mother, shy, frightened, while standing firmly by her side, quietly answering questions.

Situation 1 - Professionals recognise that this is a case of gender-based violence

The mother comes to the first interview with a professional who recognizes a case of GBV. During the interview, they reach a conclusion that the mother will report GBV and file a request for a temporary measure according to which the child will stay with the mother and see father under

u kojem će dijete, do okončanja razvoda, biti s majkom i oca viđati pod nadzorom. Stručnjak poziva dijete na razgovor i dijete mu opisuje što se u obitelji događalo. I da sad ne želi vidjeti oca jer ga se boji i da mu ne može, na primjer, reći da ne želi jesti meso. Otac se poziva na razgovor odvojeno i objašnjava mu se odluka. Na svaki daljnji razgovor poziva odvojeno majku i oca. Majka na sljedećem razgovoru opisuje kako je otac nastavio s pozivima i porukama u kojima joj se prijeti. Pokazuje poruke stručnjaku. Stručnjak poziva oca ponovno na razgovor i objašnjava mu da se radi o opetovanom nasilju koje će oni prijaviti. Odbacuju njegove tvrdnje da majka sve to radi namjerno i jer mu se osvećuje.

Situacija 2 – Stručnjaci ne prepoznaju da se radi o rodno uvjetovanom nasilju, već zaključuju da se radi o „otuđenju"

Majka na prvi razgovor dolazi stručnjaku koji NE prepoznaje da se radi o RUN-u. Na sljedeći razgovor ona i suprug pozvani su zajedno. Tijekom tog razgovora otac tvrdi da mu majka djeteta namjerno onemogućava da vidi dijete, da laže djetetu protiv njega i da izmišlja da je ikad bio nasilan prema njoj. Majka, potpuno izbezumljena situacijom u kojoj je ponovno u istoj prostoriji s nasilnikom, pokušava objasniti što se sve događa, ima dojam da joj stručnjak ne vjeruje i da se ostvaruje upravo onaj scenarij s kojim joj je suprug prijetio. Stručnjak, nakon nekoliko razgovora, postavlja hipotezu o „otuđenju". Analizira ponašanje majke i djeteta prema simptomima koje opisuje Gardner (6) – dijete govori loše o ocu (kampanja ocrnjivanja), navodi da ne želi ići njemu jer ga otac tjera da jede meso koje ono ne voli (neozbiljne racionalizacije), dijete navodi da mu otac ne nedostaje i da ga ne želi vidjeti (nedostatak ambivalencije i krivnje jer ne ide ocu), navodi da mu mama ne priča ništa loše o ocu (fenomen nezavisnog mislioca), navodi da je bolje sad kad su se mama

supervision until the divorce is completed. The professional invites the child to an interview and the child describes what has been happening in the family. The child states that she does not want to see her father because she is afraid of him and that, for example, she cannot tell him that she does not want to eat meat. The father is invited to a separate interview and the decision is explained to him. To each further interview, the mother and the father are invited separately. During the next interview, the mother describes that the father continued with threatening calls and messages. She shows the messages to the professional. The professional invites the father again for an interview and explains to him that this is a repeated violence that the services have to report. The professional rejects the father's claims that the mother was doing this on purpose to seek retaliation.

Situation 2 –Professionals fail to recognize that this is a case of gender-based violence, concluding that it is a case of "parental alienation"

The mother comes to the first interview with the specialist who does NOT recognize a case of GBV. She is invited to attend the next interview together with her husband. During the interview, the father claims that the child's mother deliberately prevents him from seeing the child, that she has been lying to the child about him and that she invents all claims about him being violent towards her are false. The mother, completely distraught by the situation where is forced to be in the same room as the abuser, tries to explain what has been happening, has the impression that the specialist does not trust her and that the very scenario with which her husband threatened her is now coming true. After a few interviews, the professional establishes the hypothesis of "parental alienation". The professional analyses the behaviours of both the mother and the child using the symptoms described by Gardner (6), i.e., the child speaks ill of the father (denigration campaign), states that she does not want to see the father because he always makes her eat meat that she dislikes (frivolous rationalizations), the

i tata razdvojili, jer tata nije bio dobar prema mami (podrška protiv „otuđenog“ roditelja), prepričava situacije nasilja koje su se događale na način sličan onom kako to čini majka (posuđeni scenariji) i ne želi vidjeti ni baku ni djeda, jer su i oni govorili protiv mame (širenje animoziteta prema široj obitelji). Kako ne postoji jasan kriterij koji diferencira što „otuđenje“ jest, a što ono nije, stručnjak koji postavi hipotezu o „otuđenju“ sve znakove reakcije djeteta na RUN može interpretirati kao „otuđenje“. I svako daljnje inzistiranje majke da je nasilje bilo prisutno (ali nije ga prijavila pa nemamo dokaze) i da se nastavlja i dalje (putem poruka i poziva) promatra kao dokaz „otuđenja“. Kao i njeno inzistiranje da se kontakti odvijaju pod nadzorom. Nažalost, u toj situaciji nema toga što majka ili dijete mogu reći a da se ne može interpretirati kroz prizmu „otuđenja“.

Zagovornici „otuđenja“ smatraju da je ono oblik emocionalnog zlostavljanja djeteta koji ima, za dijete, jednako štetne posljedice kao i svaki drugi oblik nasilja (35). U skladu s tim smatraju da je jednom kad je ono utvrđeno, potrebno ići na hitnu zaštitu djeteta od roditelja koji ga zlostavlja (odnosno onog koji ga „otuđuje“ od drugog roditelja). Stoga daju preporuke za donošenje sudskih odluka za hitnim izdvajanjem djeteta i davanje na skrb, najčešće onom roditelju od kojeg je dijete „otuđeno“. U temeljitoj analizi Jean Mercer (33) jasno navodi da ne postoje dokazi da je „otuđenje“ oblik obiteljskog nasilja. Stoga opisano postupanje nije opravdano. A u slučaju drugog opisanog primjera, najjednostavnije rečeno, značilo bi da se dijete oduzima majci i daje na skrb ocu koji je zlostavljač.

U javnosti se, nažalost, često spominju teze o tome da je „uplitanje“ RUN-a u priču o „otuđenju“ stavljanje interesa majki ispred interesa djece. Kao argument se navodi da zagovornici „otuđenja“ jasno navode da se o njemu ne može govoriti kad se radi o dokazanom RUN-u (4). Međutim, na taj način govoriti o RUN-u znači

child states that she does not miss the father and does not want to see him (a lack of ambivalence and guilt because she does not sees the father), the child states that her mother is not saying bad things about the father (the “independent thinker” phenomenon), she also claims that it is better now that her parents have separated, because the father was not nice to the mother (support for the “alienating” parent), she recounts situations of violence that have happened similarly as the mother (borrowed scenarios) and does not want to see the grandparents because they also spoke against the mother (spreading animosity towards the extended family). Having in mind that there is no clear criterion to distinguish what is and what is not “parental alienation”, the professional who establishes the hypothesis of “parental alienation” might interpret all signs of the child’s reaction to GBV as “parental alienation”. Any further insisting on the mother’s behalf that the violence was present (but that she did not report it and consequently there is no evidence) and that it still continues (via messages and calls) is perceived as the proof of “parental alienation”, as well as her insistence that the contacts take place under supervision. Unfortunately, in this situation there is nothing that the mother or the child can say that could not be interpreted through the prism of “parental alienation”.

Proponents of “parental alienation” believe that it is a form of emotional abuse of the child with equally harmful consequences as any other form of violence (35). Accordingly, they consider that once “parental alienation” has been established, it is necessary to provide urgent protection from the abusive parent (that is, the one who is “alienating” the child from the other parent). Therefore, they give recommendations to proceed with court decisions resulting in immediate separation of the child and giving the child, in most cases, to the “alienated” parent. In a thorough analysis, Jean Mercer (33) clearly indicates that there is no evidence that “parental alienation” is a form of domestic violence. Consequently, the above-described course of action has not been justified. In the case of the second example described, in the simplest terms, it would mean that the child is taken away from the mother and given to the care of the abusive father.

ne poznavati okolnosti i dinamiku RUN-a. Podatci Svjetske zdravstvene organizacije govore o 27 % žena u dobi od 15 do 49 godina koje su bile žrtve partnerskog nasilja (41) i pri tome se smatra da je manje od polovine prijavljeno (42). Recimo, podatci za Englesku i Wales 2018. godine ukazivali su na to da se u razdoblju od jedne godine prijavi samo 18 % doživljenog nasilja (43). Istraživanja pokazuju da je u sudskim procesima prisutno više slučajeva u kojima žene ne prijavljuju nasilje ili ga umanjuju od onih u kojima iznose lažne tvrdnje o nasilju (44). Isto tako pokazuju da nije neuobičajeno da o nasilju počnu govoriti tek kad iz veze izađu (45). Podatci o lažnim prijavama, na primjer, seksualnog nasilja pokazuju da su one rijetke i da se događaju u manje od 6 % slučajeva (46). Svi navedeni podatci ukazuju da se u svom radu stručnjaci u postupcima rastave braka puno češće susreću sa ženama koje su nasilje doživjele i nisu ga nikad prijavile, nego s onima koje su nasilje i ranije prijavljivale. Dodatno, istraživanja potvrđuju da zlostavljana djeca iznimno rijetko lažu o zlostavljanju koje su doživjeli i s njima nije jednostavno manipulirati (27).

Kao što je gore opisano, sve što žene žrtve nasilja i djeca opisuju može se pogrešno smatrati dokazom i taktikom „otuđenja“. Opisani slučaj i njegove posljedice jasno ilustriraju da izdvajanje djeteta od majke i davanje na skrb ocu koji je zlostavljač ima negativne posljedice, ne samo za ženu, nego u prvom redu za dijete koje je dano na skrb zlostavljaču i kojem je poslana jasna poruka da mu se ne vjeruje. Stoga su teze o stavljanju interesa žena ispred interesa djece, a da se pri tome mirno i svjesno zastupaju znanstveno neutemeljene koncepti, pogrešne i nepoštene.

U kontekstu rasprave o korištenju koncepta „otuđenja“ u sudskim procesima važno je istaknuti da je Europski parlament, 6. listopada 2021. usvojio Rezoluciju o posljedicama nasilja koje čine partneri u intimnim vezama i prava skrbništva po žene i djecu u kojoj je

Unfortunately, in public life we often hear about theses that “involving” GBV in the narrative about “parental alienation” means that the mothers’ interests are put before those of children. One of the arguments is that proponents of “parental alienation” clearly state that if GBV is proven, “parental alienation” cannot be established (4). Talking about GBV in this way indicates a lack of knowledge about the circumstances and dynamics of GBV. Information published by the WHO estimates that 27% of women aged 15-49 have been victims of partner violence (41) and less than half of the cases are thought to have been reported (42). For example, information for England and Wales in 2018 indicated that only 18% of violence cases were reported over a period of one year (43). Research shows that in judicial proceedings there are more cases where women do not report violence or diminish it than those where they make false claims of violence (44). Research also indicates that it is not uncommon for them to start talking about violence only when they come out of a relationship (45). Information on false reports of, for example, sexual violence demonstrates that such cases are rare and occur in less than 6% of cases (46). All the above information points to the conclusion that professionals involved in divorce proceedings are much more likely to encounter women who have experienced violence and have never reported it, than those who have reported violence before. In addition to that, research confirms that abused children rarely lie about the abuse they have experienced and that they are not easy to manipulate with (27).

As described above, anything that women and children victims of violence describe can be mistakenly considered as evidence or tactics of “parental alienation”. The described case and its consequences clearly illustrate that separating the child from the mother and giving it to the care of the abusive father has negative consequences, not only for the mother, but, most importantly, for the child given to care of the abuser and who, thus, received a clear message that he or she was not believed. Therefore, the theses on putting the interests of women before those of children, while at the same time calmly and consciously propagating scientifically unfounded concepts, are wrong and unfair.

istaknuo da sporovi oko skrbništva nad djetetom mogu biti oblik RUN-a u situacijama kad ih nasilni bivši partneri koriste kako bi i dalje nanosili štetu ženama (47). Jedna od taktika u takvim slučajevima je i korištenje koncepta „otuđenja" (48-50), što je u svojoj Rezoluciji potvrdio i EU parlament koji navodi da državne agencije i svi oni koji odlučuju o skrbništvu nad djecom moraju promatrati optužbe očeva zlostavljača o tome da majke od njih „otuđuju" djecu načinom održavanja moći i kontrole. Zagovornici „otuđenja" navode da ono nije rodno uvjetovana priča i da „otuđeni" roditelji mogu biti i majke i očevi. Međutim, odluke iz sudske prakse upućuju na drugačije nalaze. Meier i suradnici (17) analizirali su preko 2000 sudskih odluka u desetogodišnjem razdoblju (od 2005. do kraja 2014. godine) u SAD-u. Rezultati su pokazali da su sudovi skeptični prema majčinim optužbama za zlostavljanje i da ponekad dodjeljuju skrbništvo nasilnicima, a ta je skepsa najveća kad majke prijavljuju seksualno nasilje nad djecom. Te prijave su najčešće završavale gubitkom skrbništva za majke. Ako su majke opisane kao „otuđujuće", to za pola umanjuje vjerojatnost da će im se vjerovati da su žrtve zlostavljanja, a udvostručit će vjerojatnost da izgube skrbništvo. Isto nije slučaj kad se radi o muškarcima. Ministarstvo pravosuđa Engleske i Walesa u svom izvještaju 2020. godine analizirajući sudsku praksu iznosi slične rezultate. Navode da se u sudskim postupcima vezanim uz skrbništvo obiteljsko nasilje često ignorira, odbacuje ili umanjuje i odluke donose kao da postojanje nasilja nije relevantno. Čak i kad za nasilje postoje dokazi, žrtve se potiče da preko njega prijeđu, osiguraju kontakte djeteta za zlostavljačem i uspostave suradnju s njim vezanu uz te kontakte, bez očekivanja da zlostavljač preuzme ikakvu odgovornost za svoja ponašanja. Lorandos (51) iznosi podatke da je od 1985. do 2018. na američkim sudovima prisutan značajan porast slučajeva u kojima se spominje „otuđenje" te da su među „otuđiteljima" 75 % žene. Takvu rodnu razliku u učesta-

In the context of the discussion on the use of the concept of "parental alienation" in judicial proceedings, it is important to point out that on 6 October 2021 the European Parliament adopted a resolution on the impact of intimate partner violence and custody rights on women and children, emphasising that child custody disputes may institute a form of GBV in situations where abusive former partners use them to continue to harm women (47). One of the tactics in such cases is the use of the concept of "parental alienation" (48-50), which the EU Parliament reaffirmed in the Resolution, states that state agencies and actors deciding on child custody must consider accusations of "parental alienation" by abusive fathers against mothers as a continuation of power and control. Proponents of "parental alienation" claim that it is not a gender-based and that both mothers and fathers can be "alienated". However, case law points to somewhat different findings. Meier et al. (17) analysed over 2,000 court decisions over a 10-year period (from 2005 to the end of 2014) in the USA. The results of the analysis showed that courts were sceptical of the mother's charges of abuse and that in some cases they granted custody to abusers, which is also the greatest source of scepticism for mothers reporting sexual violence against children. In most cases, such charges resulted in the loss of custody for mothers. If mothers are described as "alienating," the likelihood that they will be believed to be victims of abuse is reduced by half, while the likelihood of them losing custody is doubled. The same is not the case when it comes to men. In the 2020 report,the Ministry of Justice of England and Wales presented similar results in the analysis of case law. The Report states that domestic violence is often ignored, rejected or downplayed in custody court proceedings and that decisions are made as if the factuality of violence is irrelevant. Even if there is evidence of violence, victims are encouraged to look the other way, provide contacts between the child and the abuser, and cooperate with the abuser to organise contacts, without expecting the abuser to take any responsibility for his behaviour. Lorandos (51) presented data indicating that from 1985 to 2018, there was a significant increase in

losti „otuđenja“ objašnjavaju lažnim prijavama obiteljskog i seksualnog nasilja među ženama. I pri tome se za to ne iznose nikakve znanstvene dokaze. S druge strane, stručnjaci koji rade sa zlostavljanom djecom i ženama žrtvama nasilja već dugo i ekstenzivno pišu o znanstvenim, pravnim, forenzičkim i etičkim problemima upotrebe „otuđenja“, naročito kad se koristi u slučajevima u kojima postoji sumnja na obiteljsko nasilje (52-56). Uzimajući u obziru gore opisanu sudsku praksu ističu da je u sudskim procesima prisutna rodna diskriminacija žena i da se na taj način nastavlja strukturno nasilje nad ženama.

Kako je ovo postao „sukob“ između udruga civilnog društva koje se bave ženama žrtvama RUN-a i stručnjaka koji su uključeni u postupke donošenja odluka o skrbništvu nad djecom? Kako su se stručnjaci koji, s obje strane, žele najbolje za svoje klijente našli na suprotstavljenim stranama? Kako je briga za žene žrtve nasilja postala „nebriga“ za njihovu djecu? I kako se pomaknuti s tih pozicija?

Kao što smo na početku opisali, nitko ne negira da postoje djeca koja odbijaju kontakte s jednim od roditelja i da postoje roditelji koji u razvodima koriste neprimjerene roditeljske postupke. I u tome se obje strane slažu. Međutim, razilaženja nastaju kad se za te postupke, korištenjem koncepta „otuđenja“, okrivljuju majke koje su žrtve RUN-a. Jer, udruge civilnog društva koje se bave ženama žrtvama RUN-a u svojoj praksi vide sve više slučajeva u kojima se zlostavljanje umanjuje i/ili zanemaruje pri donošenju odluka o skrbi djeteta, u kojima se njihovo zaštitničko ponašanje tumači kao „otuđujuće“ i u kojima se donose odluke s dalekosežnim posljedicama za djecu. Istraživanja pokazuju da je slučajeva u kojima su prisutne lažne prijave nasilja malo (44) i da je, kad nam žena priča o RUN-u, neusporedivo veća vjerojatnost da nam govori istinu nego da laže (bez obzira je li nasilje ranije prijavljivala ili ne). Zamislite samo situaciju u kojoj djetetu koje nam

cases mentioning “parental alienation” in US courts with 75% of women mentioned as “alienating” parents. The gender gap in the frequency of “parental alienation” is explained by false reports of domestic and sexual violence amongst women. In doing so, no scientific evidence has been presented. On the other hand, professionals working with abused children and women victims of violence have extensively written about the scientific, legal, forensic and ethical problems related to the use of “parental alienation”, especially if the term is used in cases where domestic violence is suspected (52-56). Taking into account the case-law described above, they point out that gender discrimination against women is evident in judicial proceedings and that in this way structural violence against women persists.

How has this issue resulted in a “conflict” between civil society organisations dealing with women victims of GBV and professionals involved in child custody decision-making processes? How have the professionals with best intentions for their clients on both sides ended up on opposing sides? How has caring for women victims of violence turned into “disregard” for their children? And how to move from these positions?

As we stated in the beginning of this paper, no one denies that there are children who refuse contact with one of the parents and that there are parents who use inappropriate parental methods in divorce. Both sides agree on this. However, divergences arise when those methods, due to the use of the concept of “parental alienation”, are blamed on mothers victims of GBV. Civil society organisations dealing with women victims of GBV see in practice that there is an increasing number of cases in which abuse is downplayed and/or ignored while making decisions on the care of children, where protective behaviour is interpreted as “alienating”, resulting in decisions with far-reaching consequences for children. Research shows that the cases with false reports of violence are few (44) and that when women talk about GBV, it is incomparably more likely that they are telling the truth than lying (no matter if the violence has been previously reported or not). Just imagine a

opisuje iskustvo *bullyinga* u školi pristupamo s nepovjerenjem. Propitujemo je li siguran da su se stvari zaista tako dogodile, je li on to možda malo pretjeruje i pokušavamo mu objasniti da „XY" nije tako mislio. Možemo samo pretpostaviti kako će se to dijete osjećati. Upravo se tako osjećaju žene kojima ne vjerujemo kad nam pričaju o doživljenom RUN-u. Sigurni smo da nitko od stručnjaka mentalnog zdravlja ne želi da se njihovi korisnici zbog njih tako osjećaju. Ono što može biti posljedica ovakve prakse je daljnje nepovjerenje žrtava u sustav i nesklonost prijavljivanja nasilja.

Stoga bi stručnjaci koji su uključeni u postupke donošenja odluka o skrbništvu nad djecom trebali biti otvoreni prema objašnjenju da je „otuđenje" koncept kojeg se trebaju odreći. Ne zato što netko tvrdi da odbijanje kontakta s roditeljima, ponašanje koje često vide u praksi rada s djecom čiji roditelji prolaze kroz „visoko konfliktan" razvod, ne postoji, već zato što teorijske postavke koje stoje iza tog koncepta nemaju znanstvenu osnovu. I zbog toga što ono što zovemo "visoko konfliktan razvod" najčešće uključuje obiteljsko nasilje i zlostavljanje djece (32), koje je, kako smo naveli, vrlo često neprepoznato, odbačeno ili umanjeno. Žrtvama nasilja treba pristupati s povjerenjem i stručnjaci u sustavima zdravstva, pravosuđa i socijalne skrbi koji dolaze u kontakt s žrtvama nasilja trebaju biti educirani o RUN-u, jer bi tada mnoga ponašanja koja vide kod žena i djece koji su preživjeli RUN prepoznali kao simptome traumatizacije i proživljenog nasilja. S druge strane, trebamo biti otvoreni prema objašnjenju da većina stručnjaka obavlja svoj posao vjerujući da su postavke teorije „otuđenja" točne. Jer im zvuče logično, jasno i čini se da se poklapaju s onim što vide u praksi. Najveći broj stručnjaka, najčešće pretrpan svakodnevnim poslom, ne prati suvremene znanstvene spoznaje i vjeruju da je ono što su naučili od autoriteta i primijetili u svojoj praksi točno. Nažalost, u ovom slučaju nije.

situation in which we approach the child describing the experience of bullying at school with distrust. The situation in which we are questioning whether the child is certain that things actually happened that way, if he or she might be exaggerating a little bit, while trying to explain that "XY" did dot mean it that way. We can only assume how that child would feel. That is exactly how women we do not trust feel when they tell us about their experiences of GBV. We are certain that mental health professionals do not want their patients to feel that way because of them. What may result from this practice is a continued distrust of victims in the system and a reluctance to report violence.

Therefore, professionals involved in child custody decision-making procedures should be open to the explanation that "parental alienation" is a concept they should renounce. Not because someone argues that refusing a contact with parents, a type of behaviour they often see in practice while working with children whose parents are going through a "high-conflicted" divorce, does not exist, but because the theoretical settings behind this concept have no scientific foundation. And because what we call a "high-conflicted divorce" most often involves domestic violence and child abuse (32), which, as we have explained, very often remains unrecognized, disregarded or downplayed. Victims of violence should be approached with confidence and professionals in the health, justice and social care systems who come into contact with victims of violence should be educated about GBV. Consequently, many types of behaviours they see in women and children who have survived GBV would then be recognized as symptoms of traumatization and experienced violence. On the other hand, we should be open to the explanation that most professionals do their job believing that the theoretical settings of "parental alienation" are valid as they sound logical, clear and seem to match what they see in practice. Most professionals, swamped with daily work, do not follow modern scientific findings and believe that what they have learned from authority and noticed in their practice is correct. Unfortunately, this is not the case with "parental alienation".

ZAKLJUČAK

U ovom trenutku, korištenje pojma „otuđenje“ u kliničkoj praksi i socijalnoj skrbi bliže je pseudoznanosti nego praksi temeljenoj na dokazima. Dosadašnje znanstvene spoznaju ne daju jasan odgovor na pitanje na koji način „otuđenje“ razlikovati od drugih razloga odbijanja roditelja i ne nude zadovoljavajuće psihodijagnostičke instrumente koji bi pomogli u toj diferencijalnoj dijagnostici. S obzirom na sudsku praksu u kojoj se i prema Rezoluciji EU, „otuđenje“ koristi kao sredstvo prisilne kontrole i nastavka zlostavljanja žena žrtava nasilja, potrebno je u kliničkoj praksi i radu sa strankama u socijalnoj skrbi biti iznimno oprezan pri procjeni ponašanja roditelja. Pred zagovarateljima pojma „otuđenja“ još je dug put prikupljanja čvrstih znanstvenih dokaza koji podržavaju njihovu konceptualizaciju tog ponašanja. Do tada, na nama kao stručnjacima pomagačkih struka je da se prisjetimo da praksa temeljena na znanstvenim dokazima čuva nas i naše korisnike od pristranosti u zaključivanju koje mogu imati dalekosežne posljedice. Drugim riječima, vrijeme je da se do daljnjeg otuđimo od „otuđenja“!

CONCLUSION

Currently, the use of the term “parental alienation” in clinical practice and social welfare is closer to pseudoscience than to evidence-based practice. Current scientific findings do not provide a clear answer to the question of how to distinguish “parental alienation” from other reasons of rejection of parents and do not offer satisfactory psycho-diagnostic instruments that would help in the differential diagnosis. Taking into account the case-law and also according to the EU Resolution, “parental alienation” is used as a means of coercive control and continued abuse of women victims of violence, it is necessary to be extremely careful in clinical practice and working with the parties in social welfare when assessing the behaviour of parents. Proponents of the term “parental alienation” still have a long way to go to gather solid scientific evidence to support their conceptualization of this type of behaviour. Until then, it is up to us professionals in the auxiliary professions to bear in mind that a practice based on scientific evidence prevents us and our patients from biased reasoning that can result in far-reaching consequences. In other words, the time has come to alienate ourselves from “parental alienation” until further notice!

LITERATURA / *REFERENCES*

1. Regier DA, Kuhl EA, Kupfer DJ. The DSM-5: Classification and criteria changes. World Psychiatry 2013; 12(2): 92–98. doi: 10.1002/wps.20050
2. Potenza MN. Non-substance addictive behaviors in the context of DSM-5. Addict Behav 2014; 39(1): 1-2. doi: 10.1016/j.addbeh.2013.09.004
3. Bernet W. Introduction to parental alienation. In: Lorandos D & Bernet W (eds.), Parental alienation – Science and Law. Springfield IL: Charles C Thomas, 2020, pp. 5–43.
4. Buljan Flander G, Roja Đapić M. Dijete u središtu (sukoba) – razvod roditelja, visoki konflikt i otuđenje: Znanost, teorija i klinička praksa. Zagreb: Geromar d.o.o., 2020.
5. https://www.euroweeklynews.com/2021/04/17/spain-approves-pioneering-child-protection-law/ Preuzeto 01. 11. 2021.
6. Gardner RA. Recent trends in divorce and custody litigation. Academy Forum 1985; 29(2): 3-7.
7. Milchman M, Geffner R, Meier J. Ideology and rhetoric replace science and reason in some parental alienation literature and advocacy: A critique. Fam Court Rev 2020; 58(2): 340-361. https://doi.org/10.1111/fcre.12476
8. Bernet W. Response to “Ideology and Rhetoric Replace Science and Reason in Some Parental Alienation Literature and Advocacy: A Critique,” by Milchman, Geffner, and Meier. Fam Court Rev 2020; 58(2): 362-7.
9. Bernet W, Rohner RP, Reay KM. Rejecting the rejection of parental alienation: Comment on Mercer. J Fam Trauma Child Custody Child Dev 2021; 18(3): 210-16, 2021. DOI: 10.1080/26904586.2020.1856752
10. Toby GK. Commentary: Use of the term “parental alienation” may be part of the problem, J Fam Trauma Child Custody Child Dev 2021, 18(3): 217-20. DOI: 10.1080/26904586.2021.1937439
11. Susman D. (2018) ‘How do you Diagnose a Mental Illness?’ Psychology Today [online]. available from https://www.psychologytoday.com/gb/blog/the-recovery-coach/201804/how-do-you-diagnose-mental-illness. P Preuzeto 15. 10. 2021.

12. Lilienfield SO, Lynn SJ, Lohr JM. Science and pseudoscience in clinical psychology. New York: Rhe Guilford Press, 2015.
13. Baker TB, McFall RM, Shoham V. Current status and future prospects of clinical psychology: Toward a scientifically principled approach to mental and behavioral health care. Psychol Sci Public Interest 2008; 9: 67–103.
14. Lilienfeld SO, Ritschel LA, Lynn SJ, Cautin RL, Latzman RD. Why many clinical psychologists are resistant to evidence-based practice: Root causes and constructive remedies. Clin Psychol Rev 2013; 33: 883–900.
15. Pignotti M, Thyer BA. Use of novel unsupported and empirically supported therapies by licensed clinical social workers: An exploratory study. Soc Work Res 2009; 33: 5–17.
16. Mercer J. Rejecting the idea of rejection as a measure of parental alienation: Comment on Bernet, Gregory, Rohner, and Rohner. J Fam Trauma Child Custody Child Dev 2021; 18(3): 201-9.
17. Meier JS, Dickson S, O'Sullivan C, Rosen L, Hayes J. Child Custody Outcomes in Cases Involving Parental Alienation and Abuse Allegations (2019). GWU Law School Public Law Research Paper No. 2019-56; GWU Legal Studies Research Paper No. 2019-56. Dostupno na: http://dx.doi.org/10.2139/ssrn.3448062. Preuzeto 15. 11. 2021.
18. Emery RE. Proponents Bear the Burden of Proof. Fam Court Rev 2005; 43: 8-13. https://doi.org/10.1111/j.1744-1617.2005.00002.x
19. Shaughnessy J, Zechmeister E, Zechmeister J. Research methods in psychology (10th ed.). New York: McGraw-Hill, 2014.
20. Milchman M. How far has parental alienation research progressed toward achieving scientific validity? J Child Custody 2019; 16(2): 115-139. https://doi.org/10.1080/15379418.2019.1614511
21. Baker AJL, Verrocchio MA. Parental bonding and parental alienation as correlates of psychological maltreatment in adults in intact and non-intact families. J Child Fam Stud 2015; 24 (10): 3047-57.
22. Harman JJ, Kruk E, Hines DA. Parental alienating behaviors: An unacknowledged form of family violence. Psychol Bull 2018; 144(12): 1275-99.
23. Mercer J. Critiquing assumptions about parental alienation: Part 2. Causes of psychological harms, J Fam Trauma Child Custody Child Dev 2021; 1-18, DOI: 10.1080/26904586.2021.1957058
24. Khaleque A, Rohner RP. Perceived parental acceptance-rejection and psychological adjustment: A meta-analysis of cross-cultural and intracultural studies. J Marriage Fam 2002; 64(1): 54–64. https://doi.org/10.1111/j.1741-3737.2002.00054.x
25. Pepiton MB , Alvis LJ , Allen K, Logid G. Is Parental Alienation Disorder a Valid Concept? Not According to Scientific Evidence. A Review of Parental Alienation, DSM-5 and ICD-11 by William Bernet. J Child Sex Abus 2012; 21(2): 244-253.
26. Marques TM, Narciso I, Ferreira LC. Empirical Research on Parental Alienation: A Descriptive Literature Review. Child Youth Serv Rev 2020; 119: 105572. doi: https://doi.org/10.1016/j.childyouth.2020.105572
27. Clementea M, Padilla-Racerob D. When courts accept what science rejects: Custody issues concerning the alleged "parental alienation syndrome". J Child Custody 2016, 13(2–3): 126–133. http://dx.doi.org/10.1080/15379418.2016.1219245
28. Bernet W. Parental Alienation, DSM-5 and ICD-11. Springfiled IL: Charles Tomas, 2010.
29. Bernet W. Recurrent Misinformation Regarding Parental Alienation Theory. Am J Fam Ther 2021: 1-15. DOI: 10.1080/01926187.2021.1972494
30. O'Donohue W, Benuto LT, Bennett N. Examining the validity of parental alienation syndrome. J Child Custody 2016; 13(2–3): 113–125. http://dx.doi.org/10.1080/15379418.2016.1217758
31. Garber BD. Parental alienation in light of attachment theory: Consideration of the broader implications for child development, clinical practice, and forensic process. J Child Custody 2014; 1(4): 49-76.
32. Bruch CS. Parental Alienation Syndrome and Parental Alienation: Getting It Wrong. Child Custody Cases. Fam Law Q 2001; 35(3): 527-52.
33. Mercer J. Critiquing assumptions about parental alienation: Part 1. The analogy with family violence, J Fam Trauma Child Custody Child Dev 2021: 1-17. DOI: 10.1080/26904586.2021.1957057
34. Kelly JB, Johnston JR. The alienated child: A reformulation of parental alienation syndrome. Fam Court Rev 2001; 39(3): 249-66. doi:10.1111/j.174-1617.2001.tb00609.x
35. Bernet W, Freeman BW. The psychosocial assessment of contact refusal. In: Lorandos D, Bernet W, Sauber SR. (eds.). Parental alienation: the handbook for mental health and legal professionals Springfield, IL: Charles C Thomas, 2013, pp. 47-73.
36. Lee SM, Olesen NW. Assessing for alienation in child custody and access evaluations. Fam Court Rev 2001; 39(3): 282-298.
37. Meier JS. Getting Real About Abuse and Alienation: A Critique of Drozd and Olesen's Decision Tree. J Child Custody 2010; 7(4): 219-52.
38. Saini M, Johnston JR, Fidler BJ, Bala N. Empirical studies of alienation. In: Kuehnle K & Drozd L (eds.), Parenting plan evaluations: Applied research for the family court. Oxford: Oxford University Press, 2012, pp. 399-441. https://doi.org/10.1093/med:psych/9780199754021.003.0013
39. Faller KC. Evolution of Parental alienation syndrome (PAS)-Parental alienation disorder (PAD)-Parental alienation (PA) and rejection by DSM-5 and ICD-11. Clinical perspectives 2021; 60(10): 19-20. DOI:https://doi.org/10.1016/j.jaac.2021.07.093
40. Potenza MN. Non-substance addictive behaviors in the context of DSM-5. Addict Behav. 2014; 39(1): 1-4.
41. https://www.who.int/news-room/fact-sheets/detail/violence-against-women. Preuzeto 12. 11. 2021.
42. Gracia E. Unreported cases of domestic violence against women: towards an epidemiology of social silence, tolerance, and inhibition. J. Epidemiol Community Health . 2004; 58: 536-7.
43. https://www.womensaid.org.uk/information-support/what-is-domestic-abuse/how-common-is-domestic-abuse/ Preuzeto 12. 11. 2021.

44. Johnston JR, Lee S, Olesen NW, Walters MG. Allegations and Substantiations of Abuse in Custody-disputing Families. Fam Court Rev 2005; 43: 283-94.
45. Faller KC. Possible explanations for child sexual abuse allegations in divorce. Am J Orthopsychiatry 1991; 61(1): 86-91. https://doi.org/10.1037/h0079227
46. Lisak D, Gardinier L, Nicksa SC, Cote AM. False Allegations of Sexual Assault: An Analysis of Ten Years of Reported Cases. Violence Against Women 2010; 16(12): 1318-34.
47. https://www.europarl.europa.eu/doceo/document/TA-9-2021-0406_EN.html Preuzeto 10. 11. 2021.
48. Meier JS, Dickson S. Mapping Gender: Shedding Empirical Light on Family Courts' Treatment of Cases Involving Abuse and Alienation. Law & Ineq. 2017; 35(2): 311. Dostupno na: https://scholarship.law.umn.edu/lawineq/vol35/iss2/10
49. Milchman MS. Commentary: Implicit cultural arguments affect the science of shared parenting. J Child Custody 2018; 15(3): 218-27.
50. Nielsen L. Joint Versus Sole Physical Custody: Children's Outcomes Independent of Parent–Child Relationships, Income, and Conflict in 60 Studies. J Divorce Remarriage: Part I: Special Issue on Shared Physical Custody: Recent Research, Advances, and Applications 2018; 59(4): 247-81.
51. Lorandos D. Parental alienation in U. S. courts 1985 to 2018. Fam Court Rev 2019; 58(2): 322-39.
52. Geffner R, Sandoval AH. Parental Alienation Syndrome/Parental Alienation Disorder (PAS/PAD): A Critique of a 'Disorder'Frequently Used to Discount Allegations of Interpersonal Violence and Abuse in Child Custody Cases. APSAC Advisor 2020; 32 (1): 28-39.
53. Meier JS. Parental alienation syndrome and parental alienation: Research reviews. Harrisburg, PA: VAWnet, a project of the National Resource Center on Domestic Violence/Pennsylvania Coalition Against Domestic Violence. Preuzeto 22. 11. 2021. na http://www.ncdsv.org/images/VAWnet_PAS_Meier_1-2009.pdf
54. Milchman M. How far has parental alienation research progressed toward achieving scientific validity? J Child Custody 2019; 16(2): 115-39. https://doi.org/10.1080/15379418.2019.1614511
55. Pepiton MB, Zelgowski BR, Geffner R, Pegolo de Albuquerque P. Ethical violations: What can and does go wrong in child custody evaluations?. J Child Custody 2014; 11(2): 81-100.
56. Saunders DG, Oglesby KH. No way to turn: Traps encountered by many battered women with negative child custody experiences. J Child Custody 2016; 3(2-3): 154-77.

Slobodno vrijeme u prevenciji problema u ponašanju djece i mladih

/ Leisure time in the Prevention of Problematic Behavior of Children and Adolescents

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Problemi u ponašanju djece i mladih razvijaju se u interakciji više različitih rizičnih i zaštitnih čimbenika koji se nalaze u pojedincu i njegovom okruženju. Slobodno vrijeme dio je mikrosustava pojedinca te kao takvo ima snažan odgojno-formativni i prevencijski potencijal. Ovaj rad ima za cilj dati pregled pojedinih teorija i recentnih empirijskih spoznaja o ulozi slobodnog vremena u suvremenoj prevencijskoj praksi. U radu se analizira organizacija i implementacija aktivnosti slobodnog vremena te njihov utjecaj na djecu, napose u dijelu strukturiranih i nestrukturiranih aktivnosti. Daju se neki od primjera kvalitetne prakse iz zapadnih zemalja te se kritički osvrće na hrvatsku praksu u ovom području. Navedene spoznaje stavljaju se u odnos sa suvremenom prevencijskom znanošću i pripadajućim empirijskim rezultatima koji idu u prilog važnosti slobodnog vremena u prevencijskim intervencijama.

/ Problems in the behavior of children and young people develop in the interaction of several different risk and protective factors found both in individuals and their environment. Leisure time is part of an individual's microsystem and as such has a strong educational and preventive potential. This paper aims to provide an overview of certain theories and recent empirical knowledge about the role of leisure time in modern prevention practice. The paper analyzes the organization and implementation of leisure activities and their impact on children, especially in the part of structured and unstructured activities. Some examples of quality practice from Western countries are given, and Croatian practice in this area is critically reviewed. The aforementioned knowledge is put into relation with modern prevention science and associated empirical results that support the importance of leisure time in prevention interventions.

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UVOD

Djetetov razvoj uvijek se odvija u nekom kontekstu, okruženju pri čemu je dijete aktivna i dinamična figura koja na to okruženje utječe i mijenja ga (1). Riječ je o dvosmjernom, recipročnom odnosu djeteta i okruženja. Jedno od važnih okruženja koje po ekološko sustavnoj teoriji pripada mikrosustavu djeteta, jer neposredno utječe i važno je za djetetov razvoj jest - slobodno vrijeme. Postoji snažan konsenzus znanstvenika i praktičara o važnosti istraživanja slobodnoga vremena djece i mladih s obzirom na to da je upravo slobodno vrijeme jedan od važnih čimbenika odrastanja koji utječe na cjelokupan razvoj djeteta (2, 3, 4). Međutim, poimanje slobodnoga vremena razlikovalo se tijekom povijesti i njegova uloga uvijek se preispitivala kroz njegovu korisnost i/ili štetnost. Dijete slobodno vrijeme može provoditi na različite načine koji mogu pozitivno utjecati na njegovo fizičko i mentalno zdravlje. Pozitivnim korištenjem slobodnog vremena reduciraju se rizični, a jačaju zaštitni čimbenici (5). Način i organizacija provođenja slobodnog vremena, ali i njegovo poimanje razlikuju se i kulturološki. Iz toga proizlazi važnost istraživanja slobodnoga vremena različitih kultura kako bi se dobila šira i jasnija slika čimbenika zaštite i rizika koji proizlaze iz područja slobodnoga vremena. Veliki broj znanstvenika diljem svijeta (4-7), a raste i broj onih u Hrvatskoj (8,9) uvidjeli su potencijal slobodnog vremena u području prevencije problema u ponašanju. Ovaj rad želi teorijski doprinijeti hrvatskoj prevencijskoj literaturi te dati pregled pojedinih teorija, klasifikacija i domena slobodnog vremena, kao i recentnih empirijskih spoznaja o ulozi slobodnog vremena u prevencijskoj praksi.

INTRODUCTION

A child's development always takes place in a context, an environment where the child is an active and dynamic figure that influences and changes that environment (1). It is a two-way, reciprocal relationship between the child and the environment. One of the important environments that, according to the ecological system theory, belongs to the child's microsystem, because it directly influences and is important for the child's development, is leisure time. There is a strong consensus among scientists and practitioners on the importance of researching children's and youth's leisure time, given that it is one of the important factors of growing up that affects the overall development of a child (2, 3, 4). However, the concept of leisure time has differed throughout history and its role has always been reexamined through its usefulness and/or harm. A child can spend his or her leisure time in different ways that can positively affect his or her physical and mental health. Positive use of leisure time reduces risk factors and strengthens protective factors (5). The way and organization of spending leisure time, as well as its concept, differ culturally. From this stems the importance of researching the leisure time of different cultures in order to get a broader and clearer picture of the protection factors and risks arising from that area. A large number of scientists around the world (4-7), and a growing number of those in Croatia (8,9) have seen the potential of leisure time in the field of behavioral problem prevention. This paper aims to theoretically contribute to Croatian prevention literature and provide an overview of individual theories, classifications, and domains of leisure time, as well as recent empirical findings on the role of leisure time in prevention practice.

SLOBODNO VRIJEME

Slobodno vrijeme kao ideja, koncept, odgojni konstrukt plijeni pažnju filozofa, sociologa, psihologa, pedagoga, socijalnih pedagoga

LEISURE TIME

Leisure time as an idea, concept, or educational construct has been attracting the attention of philosophers, sociologists, psychologists,

i drugih struka već dugo vremena. Iako se u ovom radu neće se davati povijesni prikaz poimanja slobodnog vremena, važno je naglasiti kako su postojala razdoblja u kojima se cijenio isključivo rad kao vrijedno ljudsko djelovanje, dok se slobodno vrijeme čak smatralo moralno dvojbenim (10). Percepcija slobodnog vremena mijenjala se tijekom povijesti, od nepoželjnog do izuzetno važnog dijela ljudskog života da bi se krajem 20. stoljeća i tijekom 21. stoljeća sve se više počeo istraživati i njegov preventivni potencijal, odnosno njegov doprinos jačanju kapaciteta i dobrobiti pojedinca (11).

Shodno tome, postoje brojne definicije slobodnog vremena koje su se kroz povijest mijenjale sukladno društvenoj percepciji slobodnog vremena. Slobodno vrijeme uglavnom je stavljano u suodnos s radom i radno-formalnim obvezama. Navedene promjene percepcije i poimanja slobodnog vremena podijeljene su unutar tri teorije: teorija kontrasta, teorija proporcije i teorija neutralnosti (12). Istraživanja usmjerena na promatranje slobodnog vremena izvan odnosa s radom pripada teoriji kontrasta. Kontrastna teorija smatra kako su rad i slobodno vrijeme ravnoteža kod čovjeka, dok teorija proporcija slobodno vrijeme objašnjava povezivanjem sličnosti rada i slobodnog vremena, bez isključivog odvajanja. Smjer u kojem je slobodno vrijeme kroz povijest bilo istraživano kao koncept koji nema utjecaj na rad spada u teoriju neutralnosti, smatrajući kako rad i slobodno vrijeme imaju svoje kvalitete.

Suvremene klasifikacije poimanja slobodnog vremena uglavnom su se grupirale na „pozitivne“ i „negativne“ definicije (12). Negativne definicije slobodno vrijeme promatraju kao konstrukt koji podrazumijeva vrijeme izvan radnih obveza, hranjenja, spavanja, vožnje do posla i slično. U poimanje slobodnog vremena uzima se vrijeme koje je izuzeto od navedenoga. Daljnjim istraživanjem slobodnog

pedagogues, social pedagogues, and other professions for a long time. Although this paper will not provide a historical account of the concept of free time, it is important to emphasize that there were periods in which work was valued exclusively as a valuable human activity, while leisure time was even considered morally dubious (10). The perception of leisure time changed throughout history, from an undesirable to an extremely important part of human life, so that at the end of the 20th century and during the 21st century, its preventive potential, i.e., its contribution to strengthening the capacities and well-being of the individual, began to be increasingly explored (11).

Consequently, there are numerous definitions of leisure time that have changed throughout history according to the social perception of leisure time. Leisure time is mostly placed in correlation with work and work-formal obligations. The mentioned changes in the perception and concept of leisure time are divided into three theories: the theory of contrast, the theory of proportion and the theory of neutrality (12). Research focused on the observation of leisure time outside the relationship with work belongs to the contrast theory. The contrast theory considers that work and leisure time are in equilibrium in a person, while the proportion theory explains leisure time by connecting the similarities of work and leisure time, without exclusive separation. The angle from which leisure time has been explored throughout history as a concept with no influence on work belongs to the theory of neutrality, where work and leisure time are considered to have qualities on their own.

Modern classifications of the concept of leisure time are mainly grouped into “positive” and “negative” definitions (12). Negative definitions view leisure time as a construct that includes time outside of work duties, eating, sleeping, driving to work, and the like. The

vremena znanstvenici su uvidjeli kako se slobodno vrijeme ne može promatrati isključivo kao vrijeme u kojem pojedinac nema nikakvu obvezu, dakle, kroz „negativističku perspektivu“ odvojivu od rada. Suvremeni pristup tzv. negativno definiranje zamjenjuje pozitivnim. Ono se odnosi na aktivnosti koje pojedinac provodi u skladu s vlastitim željama. Aktivnosti slobodnog vremena smatraju se prostorom napretka za pojedinca te se dovode u suodnos s radom. Aktivnosti koje su obuhvaćene tzv. pozitivnim definiranjem slobodnog vremena ne odvajaju se od rada i formalnih obveza pojedinca nego istražuju njihov utjecaj, kako na poslovni i formalni aspekt ljudskog života, tako i na cjelokupno zadovoljstvo životom (13).

Osim toga, slobodno vrijeme koncept je podložan subjektivnoj percepciji pojedinca. Caldwell i Faulk (14) navode kako slobodno vrijeme, kao subjektivan koncept pojedinca, sačinjavaju sljedeće domene:

- Osobno slobodno vrijeme (engl. *personal leisure)*,
- Društveno slobodno vrijeme *(*engl. *social leisure)* i
- Ekološko slobodno vrijeme (engl. *ecological leisure)*.

Domene se, kako navode autorice, odnose se na ulogu slobodnoga vremena u životu pojedinca. Osobno slobodno vrijeme (engl. *personal leisure)* svodi na intrapersonalnu razinu, to jest način na koji pojedinac proživljava i doživljava aktivnost u kojoj provodi vrijeme. Istraživanja navedene domene pokazala su utjecaj na subjektivnu dobrobit, akademska postignuća, emocionalne kompetencije i vještine povezane s donošenjem odluka (15-17). Ona se pojavljuje u društvenom slobodnom vremenu (engl. *social leisure),* ali uz kombinaciju s interakcijskom domenom slobodnog vremena. Unutar domene društvenog slobodnog vremena naglasak je na interakciju pojedinca s grupom. Istraživanja su

concept of leisure time includes time that is excluded from the above. By further researching free time, scientists realized that it cannot be viewed exclusively as a time in which an individual has no obligation, therefore, through a “negativistic perspective” separable from work. The modern approach replaces the so-called negative definition with a positive one. This refers to the activities that an individual carries out in accordance with his or her own wishes. Leisure activities are considered a space of progress for the individual and are brought into relation with work. Activities that are included in the so-called positive definition of leisure time are not separate from the work and formal obligations of the individual, but they rather investigate their influence both on the business and formal aspects of human life, and on the overall satisfaction with life (13).

In addition, the leisure time concept is subject to the subjective perception of the individual. Caldwell and Faulk (14) state that leisure time, as a subjective concept of an individual, consists of the following domains:

- Personal leisure,
- Social leisure and
- Ecological leisure.

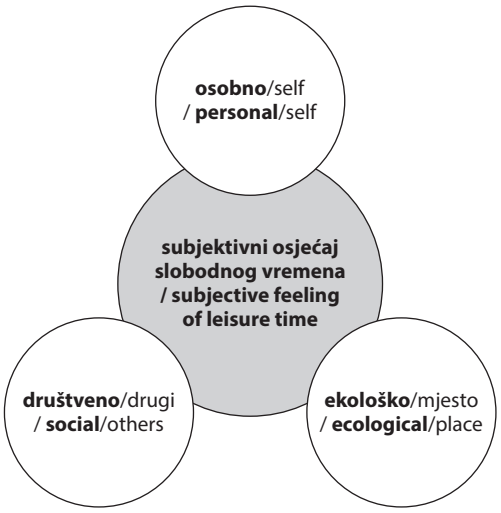
The domains, as stated by the authors, refer to the role of leisure time in an individual’s life. Personal leisure is brought down to the intrapersonal level, that is, the way in which individuals live and experience the activity in which they spend their time. Research in the mentioned domain has shown an impact on subjective well-being, academic achievements, emotional competence, and decision-making skills (15-17). It appears in social leisure, but in combination with the interaction domain of leisure time. Within the domain of social leisure, the emphasis is on the interaction of the individual with the group. Research has shown that its influence is visible in the development

pokazala kako je njezin utjecaj vidljiv u razvoju osjećaja pripadnosti i stvaranju novih odnosa s vršnjacima (18,17). Ekološko slobodno vrijeme (engl. *ecological leisure*) odnosi se na mjesto provođenja aktivnosti za koje se smatra da ima utjecaj na sam odabir aktivnosti (19). Navedeni utjecaji svake pojedine domene važni su pokazatelji zaštite unutar slobodnog vremena. Iako se navedene domene promatraju zasebno, u slučaju istraživanja utjecaja aktivnosti slobodnoga vremena na djecu i mlade, preporuka je navedene domene promatrati kao cjelinu (slika 1.). Na takav način dobit će se bolji uvid u uzroke, posljedice i utjecaj slobodnog vremena općenito (20).

Unatoč rastućem broju istraživanja slobodnog vremena i njegovih aktivnosti znanstvenici nemaju usuglašenu definiciju koja bi bila univerzalna za sve znanstvene discipline i društvene aspekte koji su prožeti slobodnim vremenom (21,22). Suvremena paradigma slobodnog vremena u pedagogijskim znanstvenim krugovima odnosi se na vrijeme provedeno u aktivnostima koje je pojedinac izabrao slobodno, prema vlastitoj želji (23). Za potrebe ovog rada, konstrukt slobodnog vremena promatrat će se uvažavajući potonju definiciju.

of a sense of belonging and the creation of new relationships with peers (18,17). Ecological leisure refers to the place where activities are carried out, which is considered to have an influence on the very choice of activities (19). The listed influences of each individual domain are important indicators of protection within leisure time. Although the mentioned domains are observed separately, in the case of research on the impact of leisure activities on children and young people, it is recommended to observe the mentioned domains as a whole (Figure 1). In this way, a better insight into the causes, consequences and impact of leisure time in general can be obtained (20).

Despite the growing number of research on leisure time and its activities, scientists do not have an agreed definition that would be universal for all scientific disciplines and social aspects that are imbued with leisure time (21, 22). The contemporary paradigm of leisure time in pedagogical scientific circles refers to the time spent in activities that individuals chose freely, according to their own desire (23). For the purposes of this paper, the construct of leisure time will be observed respecting the latter definition.



SLIKA 1. Prikaz sheme slobodnog vremena kao subjektivnog doživljaja uz njegove domene (14)
FIGURE 1. Presentation of the scheme of leisure time as a subjective experience along with its domains (14)

Preventivni potencijal slobodnog vremena

Polazeći od Bronfenbrennerove teorije ekološkog razvoja (1) slobodno vrijeme može se promatrati kao mikrosustav s obzirom na to da je riječ o okruženju koje ima neposredan utjecaj na pojedinca. Slobodno vrijeme kao dio ekološkog sustava „prostor" je brojnih rizičnih i zaštitnih čimbenika za funkcioniranje pojedinca pa tako i za razvoj problema u ponašanju. Za potrebe ovog rada polazi se od definicije prema kojoj su problemi u ponašanju djece i mladih skupni naziv za sva ona ponašanja biološke, psihološke, pedagoške ili socijalne geneze, kojima dijete/mlada osoba značajno odstupa od ponašanja primjerenog dobi, situaciji, kulturnim i etničkim normama te štetno ili opasno utječe na sebe i/ili druge pojedince ili društvene sustave (24).

Istraživanja preventivnog potencijala koji se nalazi u slobodnom vremenu mogu se organizirati, uglavnom, u dva područja. Prvo područje obuhvaća recentna istraživanja u kojima se kvaliteta slobodnoga vremena promatra kao jedan od glavnih indikatora kvalitete života pojedinaca (25), te se istražuje povezanost aktivnosti slobodnog vremena s mentalnim zdravljem (26) i fizičkim zdravljem (27). Zbog svoje sveobuhvatnosti i velikog utjecaja na pojedinca, Kuykendall i suradnici (28) smatraju kako upravo slobodno vrijeme ima presudno značenje za životno zadovoljstvo. Smatraju kako slobodno vrijeme doprinosi kvaliteti života zbog intrinzične motivacije i slobode u izboru onoga čime se pojedinac želi baviti. Problem može nastati kada motivacija nije intrinzična nego pojedinac bira aktivnost zbog toga što nema ništa drugo raditi. U tom slučaju benefit aktivnosti može biti upitan te donijeti više štete nego koristi (29). Iz toga je razvidna važnost intrapersonalnog aspekta slobodnog vremena koji objašnjava kako je bitan doživljaj pojedine aktivnosti. Ako je ona percipirana kao dobra i poželjna, veći su bene-

The preventive potential of leisure time

Starting from Bronfenbrenner's theory of ecological development (1), leisure time can be viewed as a microsystem since it is an environment that has a direct impact on an individual. Leisure time, as a part of the ecological system, is the "space" of numerous risk and protective factors for the functioning of the individual and also for the development of behavioral problems. For the purposes of this paper, the starting point is the definition according to which problems in the behavior of children and young people are a collective name for all those behaviors of biological, psychological, pedagogical or social genesis, in which the child/young person deviates significantly from the behavior appropriate for the age, situation, cultural and ethnic norms and has a harmful or dangerous effect on oneself and/or other individuals or social systems (24).

Research into the preventive potential found in leisure time can be organized mainly in two areas. The first area includes recent research in which the quality of leisure time is viewed as one of the main indicators of the quality of life of individuals (25), and the connection between leisure time activities and mental (26) and physical health (27) is investigated. Due to its comprehensiveness and great influence on the individual, Kuykendall, and colleagues (28) believe that leisure time has a crucial meaning for life satisfaction. They believe that leisure time contributes to the quality of life due to intrinsic motivation and freedom in choosing what the individual wants to do. The problem can arise when the motivation is not intrinsic, but the individual chooses the activity because there is nothing else to do. In this case, the benefit of the activity may be questionable and bring more harm than good (29). This shows the importance of the intrapersonal aspect of leisure time, which explains how important the experience of a particular activity is. If it is per-

fiti pojedinaca (14). Rastući je broj empirijskih istraživanja koji konstrukt slobodnog vremena promatraju kao model pozitivnog razvoja mladih potvrđujući povezanost kvalitetnog i konstruktivnog provođenja slobodnog vremena s pozitivnim razvojnim ishodima kod djece i mladih (8,9,30,31).

U drugom području nalaze se istraživanja slobodnog vremena koja su više fokusirana na selektivnu i indiciranu razinu prevencije. Riječ je o empirijskim istraživanjima koja aktivnosti slobodnog vremena promatraju u odnosu na stres (32), probleme u ponašanju (33) i/ili korištenje opojnih sredstava (34).

Bez obzira o kakvoj je perspektivi riječ znanstvenici su složni da se u „okruženju" slobodnog vremena nalaze brojni rizični i zaštitni čimbenici koji imaju važnu ulogu za razvojne ishode pojedinaca (35,36). Polazišna točka većine istraživanja prevencijskog potencijala slobodnog vremena jest razina strukturiranosti aktivnosti slobodnog vremena pa se tako razlikuju nestrukturirane i strukturirane aktivnosti slobodnog vremena (33).

Nestrukturirane aktivnosti slobodnog vremena odnose se na provođenje vremena bez točnog plana i rasporeda u kojem su djeca u velikom broju slučajeva bez nadzora. Primjeri takvih aktivnosti jesu druženje s prijateljima, gledanje TV-a, igranje virtualnih igara i slično. Istražujući utjecaj nestrukturiranih aktivnosti pokazalo se kako dječaci kod takve vrste aktivnosti pokazuju znakove problema u ponašanju i lošiji školski uspjeh (33). Do sličnih rezultata dolaze i Barnes i suradnici (37) koji naglašavaju kako djeca i mladi koja nisu uključena u aktivnosti pod nadzorom imaju veću mogućnost razvoja problema u ponašanju kao i korištenje opijata. Druženja s vršnjacima mogu biti pozitivna kod stvaranja boljih socijalnih vještina, ali sa starijom dobi djece dolazi do povećanog broja druženja bez nadzora što predstavlja rizik za razvoj problema u ponašanju. Navedeno se posebno odnosi na povećan broj večernjih druceived as good and desirable, the benefits for individuals are greater (14). There is a growing number of empirical studies that look at the construct of leisure time as a model of positive youth development, confirming the connection between quality and constructive spending of leisure time and positive developmental outcomes in children and youth (8,9,30,31).

In the second area, there is research of leisure time that is more focused on the selective and indicated level of prevention. These are empirical studies that look at leisure activities in relation to stress (32), behavioral problems (33) and/or the use of intoxicants (34).

Regardless of the perspective, scientists agree that the "environment" of leisure time contains numerous risk and protective factors that play an important role in the developmental outcomes of individuals (35,36). The baseline of most research into the preventive potential of leisure time is the level of structuredness of leisure time activities, thus distinguishing between unstructured and structured leisure time activities (33).

Unstructured leisure time activities refer to spending time without an exact plan and schedule, in which children are often unsupervised. Examples of such activities are hanging out with friends, watching TV, playing virtual games and the like. Investigating the impact of unstructured activities, it was shown that boys with this type of activity show signs of behavioral problems and poorer school performance (33). Barnes and colleagues (37) have reached similar results, emphasizing that children and young people who are not involved in supervised activities have a greater possibility of developing behavioral problems and using opiates. Socializing with peers can be positive for creating better social skills, but as children get older, there is an increased number of unsupervised socializing, which poses a risk for the development of behavioral problems. The above refers in particular to the increased number of

ženja s vršnjacima koja mogu rezultirati ranim korištenjem opijata (29).

Mahoney, Stattin i Magnusson (38) proveli su longitudinalno istraživanje u trajanju od 20 godina u švedskim centrima za rekreaciju. Navedeni centri pružaju aktivnosti generalno niske razine strukturiranosti. Dokazali su kako polaznici kao grupa pokazuju antisocijalno ponašanje u usporedbi sa svojim vršnjacima koji nisu bili polaznici centara. Osim toga, zabilježena je veća vjerojatnost pojave kriminalnih radnji polaznika. Slične rezultate dobili su Badura i suradnici (39) na uzorku (n=6935) čeških učenika između 13 i 15 godina. Autori navode kako polaznici nestrukturiranih aktivnosti imaju veće izglede za pušenjem, opijanjem i ulaskom u nepoželjne seksualne odnose. Primijetili su kako nestrukturirano provođenje slobodnog vremena utječe na negativan školski uspjeh. Rezultati istraživanja Spillanea i sur. (40) slični su i jednako zabrinjavajući pokazujući povezanost nestrukturiranog provođenja slobodnoga vremena s povećanim konzumiranjem alkohola i marihuane. Koliko negativan učinak može imati nestrukturirano provođenje slobodnoga vremena pokazuje istraživanje Prieto-Damma i suradnika (41) koji objašnjavaju kako se pokazalo da djeca koja su polaznici strukturiranih aktivnosti ne bilježe pozitivne učinke zbog vremena koje provode nestrukturirano. Navedeno implicira kako unatoč visokoj razini strukturiranosti pojedinih aktivnosti one ne mogu pružiti dovoljnu otpornost naspram riziku koji se javlja u nestrukturiranom obliku provođenja vremena. Osgood i Anderson (42) navode kako nestrukturirane aktivnosti bez nadzora doprinose i razvoju maloljetničke delinkvencije.

Rijedak, pozitivan utjecaj nestrukturiranog slobodnog vremena, kako navode Abbot i Barber (43), razvidan je kod mladih konzumenata opojnih sredstava tako da hobijima i sportskim aktivnostima pronalaze i ostvaruju vlastiti identitet. Uz to, pozitivni aspekti vezani su i za

evening socializing with peers, which can result in the early use of opiates (29).

Mahoney, Stattin, and Magnusson (38) conducted a 20-year longitudinal study in Swedish recreation centers. The mentioned centers provide activities of a generally low level of structuredness. They proved that the participants as a group showed antisocial behavior compared to their peers who were not participants of the centers. In addition, a higher probability of occurrence of criminal acts of participants was recorded. Similar results were obtained by Badura et al. (39) on a sample (n=6935) of Czech students between the ages of 13 and 15. The authors stated that participants of unstructured activities were more likely to smoke, drink, and engage in unwanted sexual relations. They noticed how the unstructured spending of leisure time had a negative effect on school performance. The results of the research of Spillane et al. (40) are similar and equally worrisome, showing the association of unstructured leisure time with increased consumption of alcohol and marijuana. The research by Prieto-Damma et al. (41) shows how negative an effect the unstructured spending of leisure time can have, explaining how it was shown that children who attended structured activities did not experience positive effects due to the time they spent in an unstructured way. The above implies that despite the high level of structure of certain activities, these cannot provide sufficient resilience against the risk that occurs in an unstructured way of spending time. Osgood and Anderson (42) state that unstructured unsupervised activities also contribute to the development of juvenile delinquency.

The rare, positive influence of unstructured leisure time, as stated by Abbot and Barber (43), can be seen in young users of intoxicating substances, where that they find and realize their own identity through hobbies and sports activities. In addition, positive aspects are also

sklapanje prijateljstava koji dovode do toga da se dijete osjeća sretno i zadovoljno (44).

Viša razina strukturiranosti aktivnosti slobodnog vremena podrazumijeva uključivanje mladih u sportska udruženja, klubove mladih, umjetničke radionice vođene pod stručnim nadzorom kvalificirane osobe, glazbene škole i slično. Takve aktivnosti većinom su organizirane kao izvanškolske aktivnosti. Upravo viša razina strukturiranosti prema navedenim istraživanjima ima ključnu ulogu u ostvarivanju preventivnog potencijala kao i osnaživanju pojedinca. Pokazalo se kako djeca i mladi u izvanškolskim aktivnosti pronalaze priliku za vlastiti izričaj i pronalazak identiteta što takve aktivnosti čini značajnima i vrijednima (45).

Poznato je kako je izvanškolske aktivnosti, ponajviše one sportskog karaktera, utječu na tjelesno zdravlje (46), no novija istraživanja dovode izvanškolske aktivnosti u odnos s mentalnim zdravljem. Badura i sur. (39) navode kako njihovo istraživanje na uzorku adolescenata ukazuje kako aktivnosti više razine strukturiranosti doprinose njihovom fizičkom, ali i mentalnom zdravlju. Osim toga, organiziranim i kvalitetnim aktivnostima, izvan školskog okruženja, djeca i mladi uspijevaju graditi bolje odnose sa svojim vršnjacima.

Istraživanja strukturiranih aktivnosti slobodnog vremena u odnosu na korištenje alkohola pokazuju različite rezultate. U tom području uvijek se promatra i utjecaj vršnjaka s obzirom da konzumacija alkohola počinje u vršnjačkom okruženju (47,48). Sportaši uključeni u klubove i druge oblike sportskih udruženja imaju veći rizik za rano konzumiranje alkohola od ostatka vršnjaka koji se bave drugim izvanškolskim aktivnostima (49). S druge strane, aktivnosti slobodnog vremena više razine strukturiranosti, u ostalim istraživanjima, dobar su otpor prema korištenju alkohola kod djece od 12 i 13 godina (50). Iako participiranje u strukturiranim, stručno nadziranim sportskim aktivnostima pozitivno utječe na školski uspjeh i angažman

related to making friends that lead to the child feeling happy and satisfied (44).

A higher level of structuredness of leisure activities implies the inclusion of young people in sports associations, youth clubs, art workshops conducted under the expert supervision of a qualified person, music schools and the like. Such activities are mostly organized as extracurricular activities. It is precisely the higher level of structuring that, according to the mentioned research, plays a key role in realizing the preventive potential as well as empowering the individual. It has been shown that in extracurricular activities, children and young people find an opportunity for self-expression and finding their identity, which makes such activities significant and valuable (45).

It is known that extracurricular activities, especially those of a sporting nature, affect physical health (46), but recent research brings extracurricular activities into a relationship with mental health. Badura et al. (39) state that their research on a sample of adolescents indicates that activities with a higher level of structure contribute to their physical and mental health. In addition, through organized and high-quality activities outside the school environment, children and young people manage to build better relationships with their peers.

Studies of structured leisure activities in relation to alcohol use show mixed results. In this area, the influence of peers is always observed, given that alcohol consumption begins in a peer environment (47,48). Athletes involved in clubs and other forms of sports associations have a higher risk of early alcohol consumption than the rest of their peers who engage in other extracurricular activities (49). On the other hand, in other studies, leisure time activities with a higher level of structuredness show a good resilience in respect of the use of alcohol in children aged 12 and 13 (50). Although participation in structured, professionally supervised sports activities has a positive effect on

te borbu s pretilosti, ono nije univerzalna zaštita od ranog korištenja alkohola (51). Kada je u pitanju konzumacija duhana i marihuane kod djece i mladih koji su uključeni u strukturirane slobodne aktivnosti, zabilježena je manja konzumacija (51,52).

Izvanškolske aktivnosti, kao strukturirano korištenje slobodnog vremena, doprinose razvoju socijalnih vještina polaznika strukturiranih aktivnosti (53-55). Istraživanje provedeno na velikom uzorku ispitanika (56) pokazalo je kako i intenzitet provođenja aktivnosti utječe na pojedinca. Strukturirane aktivnosti koje je pojedinac percipirao subjektivno pozitivnim nazvane su „zdravim slobodnim vremenom". Vrijeme provedeno u aktivnostima u kojima se polaznika „pronalazi", a provode se u grupi značajno je, jer je pripadnost grupi dodatan zaštitni čimbenik (57). Pojačavanjem takvih aktivnosti smanjivalo se konzumiranje alkohola, duhana i marihuane. Iz navedenoga je vidljiva i važnost slobodnoga odabira aktivnosti i domene osobnog slobodnog vremena koja se bazira na doživljaju aktivnosti pojedinca i njegovoj percepciji.

Prethodno navedena istraživanja pokazuju kako je strukturiranost aktivnosti slobodnog vremena važan element u prevenciji problema u ponašanju. Međutim, istraživanja pokazuju kako, kada je u pitanju prevencija, treba biti svjestan spolnih razlika djece i mladih. Za dječake je značajno kako će njihovo uključivanje u sportska udruženja rezultirati dobrim odnosima s vršnjacima (58). Kod djevojčica, uključenost u strukturirane izvanškolske aktivnosti rezultira smanjenjem internaliziranih (15) i eksternaliziranih problema u ponašanju (59, 60) i razvijenijim socijalnim vještinama (61-63). Osim toga, djevojčice su sklonije provoditi vrijeme u nestrukturiranim aktivnostima kao što je druženje s vršnjacima. Dječaci vrijeme više provode na aktivnostima u kojima se mogu natjecati i strukturiranog su karaktera.

school performance and engagement and the fight against obesity, it is not a universal protection against early alcohol use (51). When it comes to the consumption of tobacco and marijuana among children and young people who are involved in structured leisure activities, lower consumption was recorded (51,52).

Extracurricular activities, as a structured way of spending leisure time, contribute to the development of social skills of participants of such activities (53-55). Research conducted on a large sample of respondents (56) showed that the intensity of carrying out the activity affected the individual. Structured activities that the individual perceived as subjectively positive were called "healthy leisure time". The time spent in activities in which participants are "found", and are spent in a group, is significant, because belonging to a group is an additional protective factor (57). By enhancing such activities, the consumption of alcohol, tobacco and marijuana decreased. The importance of free choice of activities and the domain of personal leisure time that is based on the individual's experience of the activity and their perception is evident from the above.

The aforementioned research shows that the structuredness of leisure activities is an important element in the prevention of behavioral problems. However, research shows that, when it comes to prevention, one should be aware of gender differences in children and young people. For boys, it is significant that their involvement in sports associations will result in good relations with their peers (58). In girls, involvement in structured extracurricular activities results in a reduction of internalized (15) and externalized behavioral problems (59, 60) and more developed social skills (61-63). In addition, girls are more likely to spend time in unstructured activities such as socializing with peers. Boys spend more time on activities in which they can compete, and which are of a structured character.

PREVENTIVNI PROGRAMI BAZIRANI NA AKTIVNOSTIMA SLOBODNOG VREMENA

Sve veći broj autora (14,64) ističe značenje prevencije problema u ponašanju u aktivnostima slobodnog vremena. Unatoč prepoznatoj važnosti rijetki su primjeri uspješnih preventivnih programa s naglaskom na aktivnosti slobodnog vremena (5). Kriterij odabira preventivnih programa i pozitivnih primjera iz prakse koji će biti prikazani u ovom poglavlju je korištenje slobodnog vremena kao ključnog alata za prevenciju problema u ponašanju. Jedan od takvih preventivnih programa jest *TimeWise: Taking Charge of Leisure Time* koji je razvila Caldwell (65), a ima za cilj prevenirati konzumaciju opijata kod djece i mladih. Unutar programa djecu se ne poučava o štetnosti opijata već o prepoznavanju vlastitih interesa za aktivnosti slobodnog vremena te kako organizirati vrijeme poslije škole. Aktivnosti programa usmjerene su jačanju samosvijesti, samoanalize i samoregulacije polaznika. Pored toga, osnažuju se kompetencije planiranja aktivnosti te donošenja odluka te osvještavanje motivacije za aktivnostima slobodnog vremena. Jedna od važnih tema jest reguliranje dosade s obzirom na to da se upravo dosada povezuje s mnogim rizičnim ponašanjima djece i mladih (66,67). Evaluacija programa pokazala je pozitivne rezultate u odnosu na smanjenje korištenja marihuane, alkohola, duhana (68). Program *TimeWise* kasnije je kulturološki prilagođen za djecu Afrike i kao takav implementiran u afričke škole. Pod nazivom *HealthWise South Africa* proveden je u afričkim školama s ciljem prevencije korištenja opijata kao i ranog ulaska u rizične seksualne odnose. Prevencijska intervencija se odvijala poučavanjem učenika o pravilnom korištenju slobodnog vremena (69). Rezultati su pokazali kako su djevojčice nakon programa uočile mogućnosti provođenja slobodnog vremena, dok su dječaci prestali s aktivnostima koje su radili zbog dosade (70). Također, rezultati su

PREVENTIVE PROGRAMS BASED ON LEISURE TIME ACTIVITIES

An increasing number of authors (14,64) emphasize the importance of prevention of behavioral problems using leisure activities. Despite the recognized importance, there are few examples of successful preventive programs with an emphasis on leisure activities (5). The criterion for selecting preventive programs and positive examples from practice that will be presented in this chapter is the use of leisure time as a key tool for the prevention of behavioral problems. One such preventive program is *TimeWise: Taking Charge of Leisure Time*, developed by Caldwell (65), aims to prevent opiate consumption in children and young people. Within the program, children are not taught about the harmful effects of opiates, but about recognizing their own interests in leisure activities and how to organize their time after school. The activities of the program are aimed at strengthening the self-awareness, self-analysis, and self-regulation of the participants. In addition, the competencies of activity planning and decision-making are strengthened, as well as awareness of the motivation for leisure activities. One of the important topics is the regulation of boredom, given that it is precisely boredom that is associated with many risky behaviors of children and young people (66,67). The evaluation of the program showed positive results in relation to the reduction of the use of marijuana, alcohol, and tobacco (68). The *TimeWise* program was later culturally adapted for African children and implemented as such in African schools. Under the name *HealthWise South Africa*, it was carried out in African schools with the aim of preventing the use of opiates as well as early entry into risky sexual relations. The preventive intervention took place by teaching students about the proper use of leisure time (69). The results showed that after the program, the girls noticed opportunities to spend their leisure time, while the boys stopped the activities they were doing

pokazali kako je važno percipiranje onoga čime se pojedinac želi baviti. Navedeno je u skladu s definicijom slobodnog vremena koja potiče slobodan odabir aktivnosti prema vlastitom interesu. Navedeno implicira kako je motivacija jedan od glavnih čimbenika koji doprinosi kasnijim benefitima koji proizlaze iz aktivnosti slobodnoga vremena.

Respektirajući rezultate postignute preventivnim programima, napose u dijelu prevencije ranog odustajanja od škole, konzumacije alkohola i opojnih sredstava, američka obrazovna politika započela je sa značajnijim stručnim i financijskim ulaganjima u promociju slobodnog vremena, izvanškolskih aktivnosti, te općenito odgoja za slobodno vrijeme. Uviđajući važnost strukturiranosti slobodnog vremena započinju se financirati izvanškolske aktivnosti poslije nastave u školama, a na kraju svake školske godine evaluira se njihov utjecaj na svako pojedino dijete te njegov napredak od uključivanja u pojedinu aktivnost (71). Izvanškolske aktivnosti uklapaju se u cilj američkog javnog školstva koji promovira ulaganje u djecu i mlade kako bi odrasli u odgovorne i informirane pojedince s naglaskom na razvoj građanskih vrlina i moralnosti (72). To je jedan od pozitivnih primjera povezivanja škole i pružatelja izvanškolske aktivnosti, ali i prepoznavanje i upućivanje mladih u strukturirani oblik provođenja slobodnog vremena.

U Republici Hrvatskoj, prema saznanjima autora ovog rada, ne postoji sveobuhvatna i sustavna praksa povezivanja škole i provoditelja izvanškolskih programa, kao predstavnika organizatora strukturiranih aktivnosti slobodnog vremena. Financiranje organizatora aktivnosti slobodnoga vremena provodi se projektnim natječajajima različitih, uglavnom državnih, institucija. Za sportske aktivnosti slobodnog vremena najznačajnija su financiranja Središnjeg državnog ureda za sport (73). Cilj ovakvih natječaja jest osigurati financijsku potporu udrugama i provoditeljima sportskih sadržaja

due to boredom (70). Also, the results showed how important it is to perceive what the individual wants to do. This is in accordance with the definition of leisure time, which encourages the free choice of activities according to one's own interest. The above implies that motivation is one of the main factors that contributes to later benefits resulting from leisure activities.

Respecting the results achieved by preventive programs, especially in the area of prevention of school dropout, consumption of alcohol and intoxicants, American educational policy began with significant professional and financial investments in the promotion of leisure time, extracurricular activities, and general education for leisure time. Recognizing the importance of structured leisure time, they began to finance extracurricular activities after classes in schools, and at the end of each school year, they began to evaluate the impact on each individual child and their progress from when they first joined a particular activity (71). Extracurricular activities fit into the goal of American public education that promotes investment in children and youth to grow into responsible and informed individuals with an emphasis on the development of civic virtues and morality (72). This is one of the positive examples of connecting the school and extracurricular activity providers, but also recognizing and directing young people to a structured way of spending their leisure time.

In the Republic of Croatia, according to the knowledge of the authors of this paper, there is no comprehensive and systematic practice of connecting the school and the implementers of extracurricular programs, as representatives of the organizers of structured leisure time activities. Financing of leisure activity organizers is carried out through project tenders of various, mostly state, institutions. For leisure time sports activities, the most significant funding is provided by the Central State Office for Sports (73). The goal of such tenders is to provide financial support to associations

za njihove aktivnosti, no ne navodi se teorijska podloga ili znanstveno uporište na osnovi kojeg se objavljuju navedeni natječaji. Osim sporta, u Hrvatskoj djeluju i organizacije civilnog društva koje se bave prevencijom i tretmanom problema u ponašanju kroz aktivnosti slobodnog vremena. Primjeri takvih organizacija su udruga Igra iz Zagreba (74) i udruga Most iz Splita (75). Obje organizacije djeluju na različitim razinama prevencije problema u ponašanju (univerzalnoj, selektivnoj i indiciranoj) i promociji mentalnog zdravlja oslanjajući se, između ostalog, na aktivnosti slobodnog vremena. Njihovim korisnicima, osim psihološke podrške, osigurana je pomoć učenju, ali i različite aktivnosti slobodnog vremena (kreativne radionice, sportske, društvene igre, filmske i dr.).

Osim toga, u Hrvatskoj djeluje mnogo centara mladih koji svojim aktivnostima i projektima nude mladima mogućnost korištenja slobodnog vremena u aktivnom članstvu. Svi navedeni pozitivni primjeri djelovanja u prostoru korištenja slobodnog vremena djece i mladih fokusirani su na „pozitivističko" korištenje slobodnog vremena isključujući tako vrijeme kao što su vožnja, hranjenje i sl. što je u skladu sa suvremenim poimanjima slobodnog vremena. Iako se direktno ne navode ključne domene (14) takve organizacije slobodnog vremena, iz njihovih programa vidljivo je kako one respektiraju osobno slobodno vrijeme kao dominantan aspekt polaznika te ekološko i socijalno slobodno vrijeme kao važne indirektne činitelje slobodnog vremena.

Iako se u ovom radu promatraju izvanškolske aktivnosti, za istaknuti je pozitivna promjena u poimanju slobodnog vremena u kontekstu odgojno-obrazovnog sustava u Republici Hrvatskoj. Reformom obrazovanja *Škola za život* donose se međupredmetne teme koje uz interakciju s učenicima, učitelji implementiraju unutar plana i programa predmeta koji poučavaju. Koncept slobodnog vremena za-

and providers of sports content for their activities, but the theoretical or scientific basis on which the said tenders are published is not specified. In addition to sports, there are civil society organizations in Croatia that deal with the prevention and treatment of behavioral problems through leisure activities. Examples of such organizations are the Igra association from Zagreb (74) and the Most association from Split (75). Both organizations operate at different levels of prevention of behavioral problems (universal, selective, and indicated) and promotion of mental health relying, among other things, on leisure activities. Their users, in addition to psychological support, are provided with learning assistance, as well as various leisure time activities (creative workshops, sports, board games, film, etc.).

In addition, there are many youth centers operating in Croatia, which, through their activities and projects, offer young people the opportunity to use their leisure time in active membership. All the mentioned positive examples of action in the field of children and young people's use of leisure time are focused on the "positivist" use of leisure time, excluding thus time such as driving, eating, etc., which is in line with modern concepts of leisure time. Although the key domains (14) of such leisure time organization are not directly specified, it is evident from their programs that these respect personal leisure time as a dominant aspect of participants, and ecological and social leisure time as important indirect factors of leisure time.

Although extracurricular activities are considered in this paper, it is worth highlighting a positive change in the concept of leisure time in the context of the educational system in the Republic of Croatia. The educational reform of *Schools for Life* introduces cross-curricular topics that teachers, by interacting with students, implement within the curriculum of the subjects they teach. The concept of leisure time is represented in the cross-curricular topic called *Health*

stupljen je u međupredmetnoj temi pod nazivom *Zdravlje* (76). Jedan od glavnih ciljeva navede međupredmetne teme jest „pružanje znanja i potpore učenicima za razumijevanje povezanosti tjelesnoga, mentalnoga i emocionalnoga zdravlja“ (76). Navedeni cilj ostvaruje se ishodima učenja koji su implementirani unutar nastavnih predmeta prema odabiru učitelja. Navedeno implicira kako se slobodno vrijeme prepoznaje kao važan čimbenik djetetovog razvoja i to ne samo za razvoj fizičkog nego i mentalnog zdravlja što je u skladu s trenutnim aktualnim istraživačkim interesima. Pozitivno je što se učenika na takav način može potaknuti za prepoznavanje vlastitih interesa što se u dosadašnjim istraživanjima, uz strukturiranost, pokazalo kao ključan aspekt koji donosi dobrobit za pojedinca (66). Može se smatrati kako se navedenim odgaja dijete za slobodno vrijeme što je sustavan početak stvaranja kulture slobodnog vremena. Iako je ovime slobodno vrijeme deklarativno priznato kao važan čimbenik razvoja, postavlja se pitanje jesu li učitelji i praktičari osposobljeni za odgoj za slobodno vrijeme. Kako bi se konkretnije pristupilo odgoju za slobodnog vremena važna su istraživanja utjecaja aktivnosti slobodnog vremena, ali i općenito poznavanje čime se točno djeca u Hrvatskoj bave u sklopu svog slobodnog vremena. Prvi korak detektiranja aktivnosti djece proveden je u nekolicini radova hrvatskih autora (8,76), no korak u kojemu se istražuje njihov utjecaj i preventivni potencijal, prema saznanjima autora ovog rada, rijetko je istraživan. Strana istraživanja daju smjernice i poticaj hrvatskoj istraživačkoj praksi, ali treba imati na umu kako dobiveni rezultati preventivnog potencijala slobodnog vremena ne moraju nužno vrijediti za različite zemlje i kulture (64). Respektirajući ključne domene osobnog doživljaja slobodnoga vremena (14) važna su daljnja istraživanja onoga što na području Hrvatske djeluje preventivno i osigurava poticajno okruženje slobodnog vremena za djecu i mlade.

(76). One of the main goals of the mentioned cross-curricular topic is “providing knowledge and support to students to understand the connection between physical, mental and emotional health” (76). The stated goal is achieved through learning outcomes that are implemented within the teaching subjects according to the teacher’s choice. The above implies that leisure time is recognized as an important factor in a child’s development, not only for the development of physical but also mental health, which is in line with current research interests. It is positive that in such a way students can be encouraged to recognize their own interests, which in previous research, along with structuredness, has been shown to be a key aspect that brings benefit to the individual (66). It can be considered that the aforementioned is used to raise a child for leisure time, which is the systematic beginning of creating a culture of leisure time. Although leisure time is hereby declaratively recognized as an important factor in development, the question arises as to whether teachers and practitioners are trained in education for leisure time. In order to take a more concrete approach to education for leisure time, it is important to research the impact of leisure time activities, as well as general knowledge of what exactly children in Croatia do in their leisure time. The first step in detecting children’s activities was carried out in several papers by Croatian authors (8,76), but the step in which their influence and preventive potential is investigated, according to the knowledge of the author of this work, has rarely been investigated. Foreign research provides guidance and encouragement to Croatian research practice, but it should be kept in mind that the obtained results of the preventive potential of leisure time are not necessarily valid for different countries and cultures (64). Respecting the key domains of the personal experience of leisure time (14), further research into what works preventively in Croatia and ensures a stimulating leisure time environment for children and young people is important.

ZAKLJUČAK

Hrvatski i svjetski znanstvenici prepoznali su slobodno vrijeme kao važan čimbenik odgoja i obrazovanja. Međutim, značajna razlika leži u činjenici da se svjetska empirijska istraživanja već dugi niz godina usmjeravaju na prevencijski potencijal slobodnog vremena, njegovu važnost za dobrobit djece i mladih, dok hrvatskih istraživanja ima malo i uglavnom su usmjerena otkrivanju onoga čime se djeca i mladi bave u slobodnom vremenu (77). Istraživanjem onoga čime se djeca i mladi bave u Hrvatskoj napravilo se važan korak prema daljnjem istraživanju i analizi rizika i zaštite koji proizlaze iz aktivnosti slobodnog vremena. Polazišna točka razgraničenja između zaštite i rizika, prednosti i nedostataka slobodnoga vremena jest razina strukturiranosti aktivnosti (33), ali i sama motivacija za aktivnošću (66). Kao što se može vidjeti iz rezultata istraživanja inozemnih autora, doprinos razvoju djeteta koji proizlazi iz aktivnosti slobodnog vremena jest višestruk. S druge strane, pokazalo se kako postoje i brojne aktivnosti, većinom nestrukturiranog načina provođenja slobodnog vremena koje su rizične za dijete. Kako se rezultati ne mogu generalizirati (64), važno je istraživati navedeno područje i na području Hrvatske kako bi bilo razvidno što pomaže djeci i mladima u njihovom razvoju te što je otežavajući čimbenik razvoja. Također, bilo bi važno u budućim hrvatskim istraživanjima ispitati kako prevencijski programi koji se baziraju na slobodnom vremenu utječu na specifične probleme u ponašanju, primjerice, na ovisnička ponašanja ili druge eksternalizirane ili internalizirane probleme u ponašanju, ali i na osjećaj dobrobiti pojedinca. Poticaj za daljnja istraživanja o slobodnome vremenu daje i međupredmetna tema „Zdravlje“ donesena reformom hrvatskog školstva. Ona potiče poučavanje djece i mladih pravilnom korištenju slobodnog vremena, organizaciji i planiranju.

CONCLUSION

Both Croatian and international scientists have recognized leisure time as an important factor in upbringing and education. However, a significant difference lies in the fact that for many years worldwide empirical research has been focused on the preventive potential of leisure time, its importance for the well-being of children and young people, while Croatian research is scarce and mostly aimed at discovering what children and young people do in their leisure time time (77). By researching what children and young people do in Croatia, an important step has been taken towards further research and analysis of risks and protection arising from leisure activities. The baseline for the demarcation between protection and risk, advantages and disadvantages of leisure time is the level of structuredness of the activity (33), but also the motivation for the activity itself (66). As can be seen from the results of research by foreign authors, the contribution to child development resulting from leisure activities is multiple. On the other hand, it was shown that there are also numerous activities, mostly unstructured ways of spending leisure time, which are risky for the child. As the results cannot be generalized (64), it is important to research the mentioned area in the territory of Croatia as well, in order to make it clear what helps children and young people in their development and what is a complicating factor in development. Also, it would be important in future Croatian research to examine how prevention programs based on leisure time affect specific behavioral problems, for example, addictive behaviors or other externalized or internalized behavioral problems, as well as the individual's sense of well-being. The incentive for further research on leisure time is also provided by the cross-curricular topic "Health", brought about by the reform of the Croatian education system. It encourages teaching children and young people the proper use of leisure time, organization, and planning. In or-

Kako bi navedena međupredmetna tema zaživjela u životima djece i mladih, potrebno je poučavati praktičare o njegovoj implementaciji u nastavi kao i dati znanstveni doprinos u smislu prepoznavanja zaštita i rizika u navedenim aktivnostima.

der for the mentioned cross-curricular topic to take root in the lives of children and young people, it is necessary to teach practitioners about its implementation in classes, as well as to make a scientific contribution in terms of recognizing protection and risks in the mentioned activities.

LITERATURA / *REFERENCES*

1. Bronfenbrenner U. The Ecology of Human Development. Cambridge: Harvard University Press, 1979.
2. Fattore T, Mason J, Watson E. Children's Understandings of Well-being. Dordrecht: Springer, 2017.
3. Fatou L, Bárcenas Viñas A. Reflexiones etnográficas sobre el ocio infantil. Revista Latinoamericana de Metodología de las Ciencias Sociales 2014; 4(1): 1-21.
4. Caldwell L, Witt P. Leisure, recreation, and play from a developmental context. New Directions for Youth Development 2011; 130: 13-27.
5. Weybright E, Caldwell L, Weaver R. Preventing leisure from being overlooked: Intersecting leisure and prevention sciences. J Leisure Res 2019; 50(5): 394-412.
6. Barber B, Stone M, Eccles J. Adolescent Participation in Organized Activities. In: Moore KA, Lippman, LH (eds.) What Do Children Need to Flourish? Conceptualizing and measuring indicators of positive development. Boston: Springer, 2005, p. 133-146.
7. Fredricks J, Eccles J. Developmental Benefits of Extracurricular Involvement: Do Peer Characteristics Mediate the Link Between Activities and Youth Outcomes? Journal of Youth and Adolescence 2005; 34(6): 507-20.
8. Belošević M, Ferić M. Contribution of Leisure Context, Motivation and Experience to the Frequency of Participation in Structured Leisure Activities among Adolescents. Int J Environ Res Public Health 2022; 19(2): 877.
9. Belošević M, Ferić M. Quality of Leisure time as protective factor for the development of behavioral problems: project preliminary data. 2th EUSPR Conference and Members' Meeting: Prevention in a COVID Recovery Society. 2021.
10. Schröder K. Freizeitverhalten und Freizeiterleben von Jugendlichen mit geistiger Behinderung. Eine empirische Studie aus personenzentrierter und subjektbezogener Forschungsperspektive. Fakultat Rehabilitionswissenschaften der Universitat Dortmund, 2006.
11. Livazović G. Uvod u pedagogiju slobodnog vremena. Osijek: Filozofski fakultet, 2018.
12. Tokarski, W, Zarotis, G. Definition, concepts and research about leisure time. Int J Innovative Res Knowledge 2020; 5(2): 139-49.
13. Edginton C, Jordan D, Degraaf D, Edginton S. Leisure and life satisfaction. New York: McGraw-Hill, 2012.
14. Caldwell L, Faulk M. Adolescent Leisure from a Developmental and Prevention Perspective. In: Freire T (eds.) Positive Leisure Science. Dordrecht: Springer, 2013.
15. Bartko W, Eccles J. Adolescent Participation in Structured and Unstructured Activities: A Person-Oriented Analysis. Jf Youth Adolescence 2003; 32(4): 233-41.
16. Della Fave A, Bassi M. Italian Adolescents and Leisure: The Role of Engagement and Optimal Experience. New Directions for Child and Adolescent Development 2003; (99): 79-94.
17. Dworkin J, Larson R, Hansen D. Adolescents' Accounts of Growth Experiences in Youth Activities. J Youth Adolescence 2003; 32(1): 17-26.
18. Kleiber D. Leisure experience and human development. Boulder: Westview Press, 1999.
19. Jack G. Place Matters: The Significance of Place Attachments for Children's Well-Being. Br J Soc Work 2008; 40(3): 755-71.
20. Caldwell L. Recreation and youth development. In: Witt P, Caldwell L (eds.) Recreation and youth development. Pennsylvania: Venture Publishing, 2005.
21. Zarotis G, Tokarski W, Kontakos A, Katsagolis A. Free time. Physical activity, Health and Quality of Life. Athens/Zefyri: Diadrasi, 2011.
22. Dux G. Die Zeit in der Geschichte. Wiesbaden: Springer, 2017.
23. Alla J, Ajibua M. Pattern of Leisure-time physical. Activity involvement of Academic and non-Academic staff in tertiary Institutions in Ondo State, Nigeria. Choregia; 2012; 8(8): 56-67.
24. Koller-Trbović N, Žižak N, Jeđud Borić I. Standardi za terminologiju, definiciju, kriterije i način praćenja pojave poremećaja u ponašanju djece i mladih. Zagreb: Ministarstvo obitelji, branitelja i međugeneracijske solidarnosti, 2011.
25. United Nations. The Universal Declaration of Human Rights, 1984.
26. Conley C, Durlak J, Kirsch A. A Meta-analysis of Universal Mental Health Prevention Programs for Higher Education Students. Prevention Science 2015; 16(4): 487-507.
27. Gavin A, Thompson E, Rue T, Guo Y. Maternal Early Life Risk Factors for Offspring Birth Weight: Findings from the Add Health Study. Prevention Science 2011; 13(2): 162-72.

28. Kuykendall L, Boemerman L, Zhu Z. The importance of leisure for subjective well-being. In: Deiner O, Oishi S, Tay L (eds.) Handbook of well-being. Salt Lake City: DEF Publisher, 2018.
29. Walker G, Scott D, Stodolska M. Leisure matters. Pennsylvania: Venture Publishing, 2016.
30. Lerner R, Lerner J, Lewin-Bizan S, Bowers E, Boyd M, Mueller M *et al.* Positive Youth Development: Processes, Programs, and Problematics. J Youth Development 2011; 6(3): 38-62.
31. Overton W, Müller U. Metatheories, Theories, and Concepts in the Study of Development. In: Irving B, Weiner RM, Lerner M, Easterbrooks A, Jayanthi M (eds.) Handbook of Psychology, Second Edition. New York: John Wiley & Sons, 2012.
32. Matos M, Camacho I, Reis M, Costa D, Galvão D. Worries, coping strategies and well-being in adolescence: highlights from HBSC study in Portugal. Vulnerable Children Youth Studies: 2016; 11(3): 274-80.
33. Martins P, Oliveira V, Mendes S, Fernández-Pacheco G. After-school time use of urban adolescents: Effects on achievement, problem behaviors, and happiness. J Leisure Res 2020; 52(3): 286-306.
34. Nagata S, McCormick B, Piatt J. The Impact of Decreased Capacity to Experience Pleasure on Leisure Coping Strategies among Individuals with Major Depressive Disorder. Leisure Sciences 2018; 44(1): 36-54.
35. Habib E, Zimmerman M, Ostaszewski K. International note: Prevailing with extracurricular activities in an alcohol-dominated environment: Sex differences in resilience among middle school youth. Journal of Adolescence 2014; 37(6): 901-4.
36. Taheri S, Welsh B. After-School Programs for Delinquency Prevention. Youth Violence and Juvenile Justice 2015; 14(3): 272-90.
37. Barnes G, Hoffman J, Welte J, Farrell M, Dintcheff B. Adolescents' time use: Effects on substance use, delinquency and sexual activity. J Youth Adolescence 2006; 36(5): 697-710.
38. Mahoney J, Stattin H, Magnusson D. Youth recreation centre participation and criminal offending: A 20-year longitudinal study of Swedish boys. Int J Behavioral Development 2001; 25(6): 509-520.
39. Badura P, Madarasova Geckova A, Sigmundova D, Sigmund E, van Dijk J, Reijneveld S. Can organized leisure-time activities buffer the negative outcomes of unstructured activities for adolescents' health? Int J Public Health 2018; 63(6): 743-51.
40. Spillane N, Schick M, Kirk-Provencher K, Hill D, Wyatt J, Jackson K. Structured and Unstructured Activities and Alcohol and Marijuana Use in Middle School: The Role of Availability and Engagement. Substance Use & Misuse 2020; 55(11): 1765-73.
41. Prieto-Damm B, de la Rosa P, Lopez-del Burgo C, Calatrava M, Osorio A, Albertos A et al. Leisure activities and alcohol consumption among adolescents from Peru and El Salvador. Drug and Alcohol Dependence 2019; 199: 27-34.
42. Osgood D, Anderson A. Unstructured socializing and rates of delinquency. Criminology 2004; 42(3): 519-50.
43. Abbott B, Barber B. Not Just Idle Time: Adolescents' Developmental Experiences Provided by Structured and Unstructured Leisure Activities. The Australian Educational and Developmental Psychologist 2007; 24(1): 59-81.
44. Greco C. Las emociones positivas: su importancia en el marco de la promoción de la salud mental en la infancia. Liberabit 2010; 16(1): 81-93.
45. Knifsend C, Juvonen J. The Role of Social Identity Complexity in Inter-group Attitudes Among Young Adolescents. Soc Development 2012; 22(3): 623-40.
46. Gaetz MB, Iverson GL. Sex differences in self-reported symptoms after aerobic exercise in non-injured athletes: Implications for concussion management programmes. Brit J Sport Med 2009; 43(7): 508–13.
47. Brenner A, Bauermeister J, Zimmerman M. Neighborhood Variation in Adolescent Alcohol Use: Examination of Socioecological and Social Disorganization Theories. J Studies Alcohol Drugs 2011; 72(4): 651-9.
48. Elkington K, Bauermeister J, Zimmerman M. Do parents and peers matter? A prospective socio-ecological examination of substance use and sexual risk among African American youth. Journal of Adolescence 2011; 34(5): 1035-47.
49. Modecki K, Barber B, Eccles J. Binge Drinking Trajectories Across Adolescence: For Early Maturing Youth, Extra-Curricular Activities Are Protective. J Adolesc Health 2014; 54(1): 61-6.
50. Chen C, Wang I, Wang N, Lu M, Liu C, Chen W. Leisure activity participation in relation to alcohol purchasing and consumption in adolescence. Addictive Behaviors 2019; 90: 294-300.
51. Le T. Does Participation in Extracurricular Activities Reduce Engagement in Risky Behaviours? Youth in focus project discussion paper series [Internet]. 2013 [cited 10 January 2022];. Available from: http://youthinfocus.anu.edu.au
52. Crispin L, Nikolaou D, Fang Z. Extracurricular participation and risky behaviours during high school. Applied Economics 2016; 49(34): 3359-71.
53. Miller B. Critical hours: After-school programs and educational success. New York: Nellie Mae Education Foundation, 2003.
54. Durlak J, Weissberg R, Pachan M. A Meta-Analysis of After-School Programs That Seek to Promote Personal and Social Skills in Children and Adolescents. Amn J Community Psychol 2010; 45(3-4): 294-309.
55. Farb A, Matjasko J. Recent advances in research on school-based extracurricular activities and adolescent development. Development Rev 2012; 32(1): 1-48.
56. Sharp E, Coffman D, Caldwell L, Smith E, Wegner L, Vergnani T *et al*. Predicting substance use behavior among South African adolescents: The role of leisure experiences across time. Int J Behav Development 2011; 35(4): 343-51.
57. Ruvalcaba N, Gallegos J, Borges A, Gonzalez N. Extracurricular activities and group belonging as a protective factor in adolescence. Psicología Educativa 2017; 23(1): 45-51.
58. Sagatun A, Søgaard A, Bjertness E, Selmer R, Heyerdahl S. The association between weekly hours of physical activity and mental health: A three-year follow-up study of 15–16-year-old students in the city of Oslo, Norway. BMC Public Health 2007; 7(1).

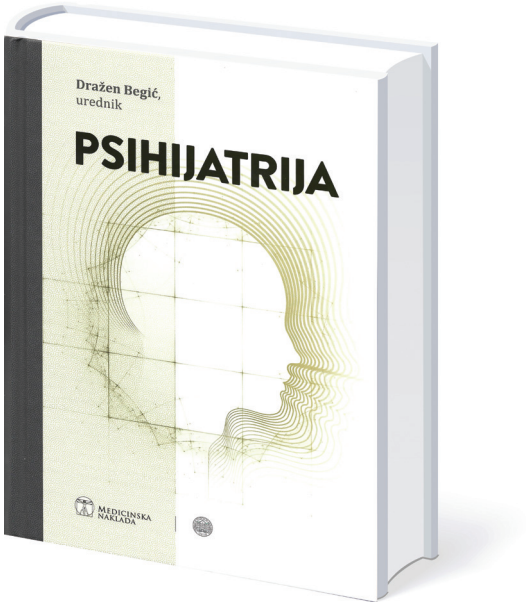
59. Bohnert A, Garber J. Prospective Relations Between Organized Activity Participation and Psychopathology During Adolescence. J Abnorm Child Psychol 2007; 35(6): 1021-33.
60. Hofferth S, Sandberg J. How American Children Spend Their Time. J Marriage Family 2001; 63(2): 295-308.
61. Fletcher A, Nickerson P, Wright K. Structured leisure activities in middle childhood: Links to well-being. J Community Psychol 2003; 31(6): 641-59.
62. Mahoney J, Larson R, Eccles J. Organized activities as contexts of development: Extracurricular activities, after-school and community programs. Mahwah: NJ: Lawrence Erlbaum and Associates, 2005.
63. Livazović G, Kakuk S. Odgoj i socijalizacija u slobodnom vremenu: korelati sociodemografskih obilježja i aktivnosti slobodnog vremena. Didaktički izazovi III. Osijek: Fakultet za odgojne i obrazovne znanosti, Sveučilište Josipa Jurja Strossmayera u Osijeku, 2019.
64. Weybright E, Caldwell L, Ram N, Smith E, Wegner L. Trajectories of adolescent substance use development and the influence of healthy leisure: A growth mixture modeling approach. Journal of Adolescence 2016; 49: 158-69.
65. Caldwell L. TimeWise: Taking Charge of Leisure Time curriculum for middle school students. Scott Valley: CA:ETR Associates, 2004.
66. Wegner L. Through the lens of a peer: Understanding leisure boredom and risk behavior in adolescence. J Occup Therapy 2011; 41: 18-24.
67. Walker G, Scott D, Stodolska M. Leisure matters. Pennsylvania: Venture Publishing, 2016.
68. Caldwell L, Baldwin C, Walls T, Smith E. Preliminary Effects of a Leisure Education Program to Promote Healthy Use of Free Time among Middle School Adolescents. J Leisure Res 2004; 36(3): 310-35.
69. Wegner L, Flisher A, Caldwell L, Vergnani T, Smith E. Healthwise South Africa: cultural adaptation of a school-based risk prevention programme. Health Education Research 2007; 23(6): 1085-96.
70. Motamedi M, Caldwell L, Weybright E, Jones D, Wegner L, Smith E. Doing a leisure activity because there is nothing else to do: Related outcomes and intervention effects for adolescents. J Leisure Res 2019; 51(1): 1-15.
71. U. S. Department of Education. 21st Century Community Learning Centers (21st CCLC) analytic support for evaluation and program monitoring: An overview of the 21st CCLC performance data: 2013-14. 2015.
72. Kalin J, Zuljan M. Teacher perceptions of the goals of effective school reform and their own role in it. Educational Studies 2007; 33(2): 163-75.
73. Ministarstvo turizma Republike Hrvatske [Internet]. Mint.gov.hr. 2021 Available from: https://mint.gov.hr/izdvojeno-21564/sportski-natjecaji/poticanje-lokalnog-sporta/21597 posjećeno 29.4.2021.
74. Udruga Igra. Tko smo [Internet]. Udrugaigra.hr. 2022 [cited 10 January 2022]. Available from: https://udrugaigra.hr/o-igri/o-udruzi/
75. Udruga Most. O udruzi [Internet]. Udruga Most. 2021 [cited 10 January 2022]. Available from: https://www.most.hr/o-udruzi
76. Ministarstvo znanosti i obrazovanja. [Internet]. Skolazazivot.hr. 2020 Available from: https://skolazazivot.hr/wp-content/uploads/2020/06/ZDR_kurikulum.pdf
77. Valjan Vukić V. Izvannastavne i izvanškolske aktivnosti učenika - višestruke perspektive. Školski vjesnik [Internet] 2016 65(1): 33-57. Dostupno na: https://hrcak.srce.hr/177319

Dražen Begić, urednik

Psihijatrija

/ *Psychiatry*

Zagreb, Medicinska naklada, 2022, str. 648
/ Medicinska naklada, 2022, p. 648



Udžbenik „Psihijatrija“ nastao je kao autorski rad urednika prof. dr. sc. Dražena Begića i devetnaest psihijatara nastavnika u Katedri za psihijatriju i psihološku medicinu Medicinskog fakulteta Sveučilišta u Zagrebu. Oni su svojim tekstovima napisanima u 48 poglavlja pokrili gotovo u cijelosti sva područja suvremene psihijatrije, a u 49. poglavlju je Dodatak koji uspoređuje MKB-10 i MKB-11 klasifikaciju mentalnih poremećaja i bolesti. Udžbenik završava opsežnim kazalom pojmova.

U ovom najnovijem udžbeniku na početku su opisane specifičnosti psihijatrije kao struke, razlikovni pojmovi i specifičnosti psihički normalnog i poremećenog (abnormalnog), a nakon toga slijede tekstovi iz opće psihopatologije s preglednim definicijama i izvanrednim opisom poremećaja psihičkih funkcija pružajući na taj način čitatelju detaljan i suvremeno opisan uvid u osnovu psihopatoloških fenomena različitih kliničkih entiteta u spektru psihijatrijskih poremećaja.

Posebna je pažnja posvećena psihijatrijskoj epidemiologiji, koja je u ne baš dugoj povijesti suvremene psihijatrije često puta bila zanemarivana i nepravedno zaobilažena, a koja će u da-

The textbook titled *Psychiatry* is a result of joint efforts of the editor and professor Dražen Begić and nineteen psychiatrists teaching at the Department of Psychiatry and Psychological Medicine of the Zagreb School of Medicine. With their texts divided in 48 chapters, they have almost entirely covered all areas of contemporary psychiatry. The chapter 49 also delivers an appendix comparing the ICD-10 and ICD-11 classifications of mental disorders and illnesses. The textbook ends with an extensive index of medical terms.

The latest edition of the textbook starts with a description of specific features of psychiatry as a profession, distinctive concepts and special characteristics of the “mentally normal” and “disturbed” (abnormal), followed by the texts focusing on general psychopathology and providing very clear definitions and a noteworthy description of mental function disorders. In this way, the reader can get a detailed and comprehensive modern insight into the basis of psychopathological phenomena of various clinical entities falling under the category of psychiatric disorders.

Special attention was paid to psychiatric epidemiology, which has often been neglected and unfairly omitted in contemporary psychiatry. It is psychiatric epidemiology that will stand as

našnjoj i u psihijatriji budućnosti predstavljati razdjelnicu koja će omogućiti planiranje potreba i potrebnih resursa kako za liječenje tako i za zaštitu i unaprjeđenje mentalnog zdravlja u zajednici, stvarajući na taj način i sve preduvjete za razvoj ekološke psihijatrije.

U poglavlju o etiologiji psihičkih poremećaja na vrlo pregledan i jasan način predstavljene su suvremene teorije o nastanku psihičkih tegoba i poremećaja. Značajan i nezaobilazan dio udžbenika predstavlja teorijski pristup i konkretan prikaz iskustvenog načina vođenja psihijatrijskog intervjua koji je svojevrstan abecedarij za ono što smo nekad zvali anamnestičkim i heteroanamnestičkim podatcima tijekom razgovora s bolesnikom kao osobom.

Osobito je važno poglavlje o dijagnostičkim pretragama i primjeni ocjenskih ljestvica u kliničkoj praksi, što je važan doprinos kvalitetnom podučavanju.

Poglavlje o klasifikaciji u psihijatriji daje osvrt na povijesni pregled nastanka i razvoja klasifikacijskih sustava u psihijatriji. Ovo je po prvi puta u našoj kliničko-udžbeničkoj medicinskoj praksi da tekst namijenjen studentima medicine u dodiplomskoj nastavi donosi sustavno iznesene promjene koje je donijela DSM-5 klasifikacija, ali po prvi puta u hrvatsku medicinsku udžbeničku literaturu donosi i promjene koje će sa sobom donijeti MKB-11 klasifikacijski sustav, koji je trebao postati važeći u siječnju 2022. godine. Ovo je iznimno važan *novum* u našoj suvremenoj edukacijskoj praksi.

Slijedi niz poglavlja koja se bave različitim terapijskim pristupima, od primjene psihofarmaka, primjene drugih suvremenih tehnoloških izuma, ali i modifikacija onih koji su ranije korišteni u kliničkoj praksi.

Posebno je bogato poglavlje o psihoterapijskim intervencijama pri čemu je naglasak na psihoanalitičkoj, bihevioralno-kognitivnoj, obiteljskoj i partnerskoj psihoterapiji, ali i uz navođenje

the dividing line in today's and future psychiatry and allow the planning of needs and necessary resources both for the treatment and the protection and improvement of mental health in the community, thus paving the way and creating all necessary preconditions for the development of ecological psychiatry.

The chapter on the aetiology of mental disorders presents a number of modern theories about the emergence of mental ailments and disorders in a very transparent and clear way. A significant and unavoidable part of the textbook is dedicated to a theoretical approach and a concrete overview of the experiential way of conducting a psychiatric interview that works as a kind of glossary of terms for what used to be called anamnestic and heteroanamnestic information during a conversation with the patient as an individual.

The chapter on diagnostic tests and the application of rating scales in clinical practice is particularly important as it significantly contributes to quality teaching.

The chapter on classification in psychiatry provides a historical overview of the emergence and development of classification systems used in psychiatry. This is the first time in our clinical and textbook medical practice that a textbook intended for undergraduate medical students provides a systematic overview of changes brought about by the DSM-5 and ICD-11 classification systems, which were supposed to enter in force in January 2022. This is an extremely important novelty in modern-day educational practice in Croatia.

A series of chapters that follow deal with various therapeutic approaches, including the application of sychopharmaceuticals and other modern technological inventions, as well as modifications of those previously used in clinical practice.

The textbook also includes a very comprehensive chapter on psychotherapeutic interventions, with the emphasis on psychoanalytic, behavioural-cognitive, family and couple psychotherapy, but also listing over four hundred other psychotherapies that currently exist.

svih drugih psihoterapija kojih je danas preko četiri stotine.

U udžbeniku se nalazi i prikaz socioterapije i rehabilitacije radu s osobama sa psihijatrijskim poremećajima, a što je nezaobilazan i vrlo značajan segment u psihijatriji danas, ali i u zaštiti i unaprjeđenju mentalnog zdravlja općenito.

Uloga forenzičke psihijatrije te osobito pitanje prisilnih hospitalizacija nezaobilazan je dio psihijatrije, pa tako i ovog udžbenika.

Dugi niz godina znamo i da je u povijesti psihijatrije bilo zloupotreba te je stoga poglavlje koje se bavi etikom u psihijatriji posebno važno zbog današnjeg trenutka, ali i zbog godina koje dolaze.

Važno je da se u udžbeniku provlači činjenice da smo iz paternalističkog modela odnosa liječnik-pacijent u kliničkoj praksi odavno izašli i prihvatili model suradnog partnerstva, ali taj model nije događaj nego proces koji se ponegdje još uvijek ne događa i zato ga je važno naglašavati u podučavanju. Suvremena medicina naglašava danas važnost medicine usmjerene prema osobi, o čemu i poglavlje o etici u psihijatriji ima itekako puno za reći. U tom su kontekstu odlično obrađena pitanja informiranog pristanka, etike vezane uz klinička istraživanja, pitanja liječničke tajne kao i javnog istupanja psihijatara.

Posljednje poglavlje o transkulturalnoj psihijatriji donosi probleme svjetske globalizacije, ali i problem migracija iz perspektive psihijatrije. U 21. stoljeću transkulturalna psihijatrija nije novi, već svakodnevni problem, jer smo svjedoci otvaranja novih i intrigantnih područja koje u prošlosti ne samo da nismo prepoznavali nego nam se i nisu činila toliko značajnim. Psihijatrija migracija će postati područje koje ćemo trebati detaljno izučavati kako bismo mogli pomoći svim ljudima koji trebaju pomoć u području mentalnog zdravlja.

Najnovije djelo „Psihijatrija“ autora prof. dr. sc. Dražena Begića i suradnika je svojom jednostav-

It also presents a demonstration of sociotherapy and rehabilitation methods used in working with people with mental disorders, which is an essential and rather significant segment in psychiatry today, but also in the protection and improvement of mental health in general.

The role of forensic psychiatry and the issue of forced hospitalizations in particular make an indispensable part of psychiatry, as well as this textbook.

For many years, in the history of psychiatry, we have been aware of the cases of abuse and for that reason the chapter on professional ethics in psychiatry is especially important, not only because of the current moment but also because of the years to come.

What is particularly important is that the textbook presents the facts about the long-ago transition of our profession from the paternalistic model of the relationship between the physician and the patient in clinical practice to the collaborative one. However, the collaborative model is not a single event, but rather a process that is still not put in practice everywhere and, therefore, needs to be emphasized in teaching. Modern medicine puts a strong accent on the importance of health care directed towards the person and the chapter on professional ethics in psychiatry elaborates on the topic extensively. The issues such as informed consent, ethics related to clinical research, medical secrecy as well as the public appearance of psychiatrists are well addressed in that context.

The last chapter on transcultural psychiatry brings together the problems of world globalization and the problem of migration from the perspectives of psychiatry. In the 21st century, transcultural psychiatry is not a new, but rather a problem we encounter every day, as we witness the opening of new and intriguing areas that have not been recognized by the profession or seemed insignificant in the past. Migrant psychiatry will become an area that will require detailed study so that we can help everyone who needs help in the field of mental health.

The latest edition of *Psychiatry* by Prof Dražen Begić and his associates, with its simplicity in pre-

nošću prikaza i originalnim pristupom suvremenim psihijatrijskim temama udžbenik koji na najbolji način prati kretanja i napredak u ovom sveobuhvatnom području psihijatrije 21. stoljeća. Ovaj udžbenik u načinu komuniciranja s čitateljima čini velike iskorake prateći napredak psihofarmakologije, neuroznanosti, psihoterapije, ali i rane dijagnostike i liječenja u psihijatriji, ne zaboravljajući da su najvažniji čimbenici u očuvanju zdravlja, ali i nastanka bolesti i poremećaja biološki, psihološki, socijalni i duhovni.

Velikim brojem primjera iz vlastite kliničke prakse ova knjiga je i ogledni primjer udžbenika za iskustveno učenje i kliničko prosuđivanje kako studentima medicine tako i studentima drugih srodnih studija.

Ovaj udžbenik načinom prikaza različitih područja psihijatrije danas ima sva obilježja suvremeno koncipiranog udžbenika iz psihijatrije za studente na sveučilišnom integriranom studiju medicine, obrađujući sve suvremene teme iz psihijatrije 21. stoljeća koje sebe s ponosom naziva stoljećem uma.

Do sada smo imali udžbenike koji su slijedili i opisivali dosadašnja dostignuća u struci. Ovim udžbenikom krećemo u korak s promjenama, od nove klasifikacije do obrade i objašnjenja nekih tema koje sada dobivaju novu, suvremenu konotaciju. Time ovo djelo ne slijedi ranija dostignuća psihijatrije, nego ide s njima u korak. Djelo je napisano pregledno i jasno, kako u sadržajnom tako i u jezičnom smislu, a metodološki je dobro osmišljeno.

Prof. dr. sc. Dražen Begić uspio je ovim udžbenikom još jednom ujednačiti različita poglavlja, stilove pisanja i vokaciju autora, tako da se ova knjiga unatoč brojnim autorima čita kao jedna cjelina. Načinom predstavljanja suvremenih psihijatrijskih problema i metoda njihovog podučavanja ovaj udžbenik psihijatrije će zasigurno biti čitan i vrlo citiran, što svojom sveobuhvatnošću i aktualnošću svakako i zaslužuje.

Veljko Đorđević

sentation and original approach to contemporary topics in psychiatry, is a textbook that best follows various developments and progress in the comprehensive field of psychiatry of the 21st century. In the way it communicates with its readers, this textbook makes great strides by following the progress of psychopharmacology, neuroscience, psychotherapy, as well as early diagnostics and treatment in psychiatry, not forgetting that the most important factors in both the preservation of health and the emergence of illnesses and disorders are biological, psychological, social and spiritual.

Providing a large number of examples from clinical practice, it is also a model example of a textbook for experiential learning and clinical judgment intended for both medical students and students of other related studies.

By presenting different areas of modern-day psychiatry, *Psychiatry* has all the characteristics of a modernly conceived textbook for students in the integrated undergraduate and graduate medical studies, covering all modern topics from the field of psychiatry in the 21st century, also known as the century of the mind.

Previous textbooks have followed and described the achievements in the profession. With this textbook, our profession keeps up with changes, as it brings the new classification and explanation of certain topics in new and modern connotations. Thanks to this approach, *Psychiatry* is a textbook that does not merely follow the earlier achievements of psychiatry but keeps pace with them instead. It is written in a structured and clear manner, both in terms of content and language, and is methodologically well thought out.

Once again, in this textbook Prof Dražen Begić managed to systematize different chapters, writing styles and professional angles of numerous authors, editing it as a comprehensive whole. With the way of presenting modern problems and methods of teaching, this textbook in psychiatry will surely be read and highly quoted, which it certainly deserves due to its comprehensiveness and topicality.

Veljko Đorđević

Upute autorima

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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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