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Upotreba anksiolitika kod studenata medicine na Medicinskom fakultetu u Osijeku

/ *Use of Anxiolytics in Medical Students at the Faculty of Medicine Osijek*

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Uvod: Anksiolitici su jedni od najčešće propisivanih lijekova te su veoma popularni zbog svoje široke terapijske primjene. *Cilj:* Cilj je ispitati učestalost korištenja anksiolitika kod studenata medicine.

Metode: U istraživanju je sudjelovalo 222 studenata od 1. do 6. godine Studija medicine na Medicinskom fakultetu Osijek rješavajući anonimni upitnik. *Rezultati*: Od 222 studenata 19,5 % koristilo je benzodiazepin. Djevojke ih koriste značajno češće od muškaraca. Najčešće indikacije za korištenje su osjećaj tjeskobe i anksioznost. Najčešće korišten benzodiazepin je alprazolam. Najviše ih koriste studenti 6. godine medicine, dok ih studenti 1. godine ne koriste. Razlozi za korištenje razlikuju se prema godinama studiranja; glavni razlog korištenja na 3. godini je nadolazeći ispit, dok su na 5. i 6. godini razlozi uzimanja benzodiazepina obiteljski i ljubavni problemi. Jednom u više mjeseci benzodiazepine koristi 59,1 % studenata, dok ih 5 % koristi svaki dan, 20,9 % studenata koristi i smatra korisnima biljne preparate za smirenje. Pomoć stručnjaka za svoje probleme potražilo je 32,6 % studenata koji su koristili benzodiazepine, dok ih je 41,9 % o tome razmišljalo. *Zaključci*: Unatoč tome što su studenti medicine izloženi velikom stresu te anksiolitike koriste češće nego opća populacija, njihova je uporaba racionalna i kontrolirana.

/ Introduction: *Anxiolytics are one of the most prescribed drugs due to their wide therapeutic use.*

Aims: *Our goal is to examine the frequency of anxiolytics use in medical students. Materials and methods: 222 medical students from 1st to 6th year at the Faculty of Medicine in Osijek participated in the research by solving an anonymous questionnaire. Results: Of the 222 students, 19.5% used anxiolytics. Women use them significantly more than men. The most common indication for use is anxiety. The most used benzodiazepine is alprazolam. They are mostly used by 6th-year medical students. Reasons for benzodiazepine use vary depending on the year of study; 3rd-year students use benzodiazepines due to upcoming exams, while for the 5th and 6th year students, family and love problems are more*

common reasons. 59.1% of students use benzodiazepines once every few months, while 5% use them daily. 20.9% use and consider herbal sedatives useful. 32.6% of students who used benzodiazepines sought professional help, while 41.9 % thought about it. Conclusions: Even though medical students are exposed to great stress and use anxiolytics more than the general population; their use is rational and controlled.

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UVOD

Benzodiazepini su najčešće propisivani anksiolitici koji imaju široku primjenu od 1959. godine kada je uveden prvi benzodiazepin, klordiazepoksid, pod tvorničkim imenom Librium. Godine 1963. uveden je diazepam (Valium) koji je postao najpropisivaniji lijek u svijetu zahvaljujući svojoj visokoj potentnosti, širokom spektru djelovanja i jakom miorelaksirajućem djelovanju (1-3).

Benzodiazepini su popularni zbog svoje široke terapijske primjene: anksiozni poremećaj, panični poremećaj, opsesivno kompulzivni poremećaj, socijalna fobija, posttraumatski stresni poremećaj, nesanica, epilepsija, motorički poremećaji, shizofrenija, agitirana stanja (1). Dobro se podnose, imaju brz početak djelovanja, nizak rizik za interakciju s drugim lijekovima, malo nuspojava te dostupan antidot (flumazenil) pri predoziranju, no nekontrolirana i neracionalna upotreba može dovesti do težeg stanja zbog razvoja ovisnosti i tolerancije (4,5).

Potentni lijekovi s kratkim poluvremenom eliminacije (tablica 1) imaju najveći rizik za stvaranje ovisnosti (5). Brzina djelovanja ovisi o lipofilnosti. Među najlipofilnijim benzodiazepinima je diazepam koji zbog brzog prolaska krvno-moždane barijere ima najbrži nastup (pola sata na-

INTRODUCTION

Benzodiazepines are the most prescribed anxiolytics that have been widely used since 1959 when the first benzodiazepine, chlordiazepoxide, was introduced under the brand name Librium. In 1963, diazepam (Valium) was introduced, which became the most prescribed drug in the world due to its high potency, broad spectrum of action, and strong muscle relaxant effect (1-3).

Benzodiazepines are very popular due to their wide therapeutic application; anxiety disorder, panic disorder, social phobia, post-traumatic stress disorder, insomnia, and agitated states (1). They are well tolerated, have a rapid onset of action, low risk of interaction with other drugs, few side effects, and available antidote (flumazenil), but uncontrolled and irrational use can lead to a more difficult condition due to the development of addiction and tolerance (4,5).

Potent drugs with a short elimination half-life (Table 1) have the highest risk of developing addiction (5). The onset of action depends on the lipophilicity of the drug. Among the most lipophilic benzodiazepines is diazepam, which has the fastest onset due to the rapid passage of the blood-brain barrier, but due to rapid redistribution into adipose tissue, the effect soon

TABLICA 1. Farmakokinetička svojstva nekih benzodiazepina (4,5,7-9)
TABLE 1. Pharmacokinetic properties of some benzodiazepines (4,5,7-9)

Benzodiazepini s kratkim djelovanjem / Short-acting benzodiazepines	T_{max} (sati) / T_{max} (hours)	$T_{1/2}$ (sati) / $T_{1/2}$ (hours)	Opis / Description	Uobičajena anksiolitička doza / Usual anxiolytic dose	Indikacije / Indications
Triazolam	1	2-3	Brz nastup i kratko trajanje učinka / Fast onset and short duration of effect	0.125-.025	Nesanica / Insomnia
Benzodiazepini sa srednje dugim djelovanjem / Intermediate-acting benzodiazepines					
Alprazolam	1-2	12-15	Brza oralna apsorpcija / Fast oral absorption	0,25-0,5 dva do tri puta na dan / 0,25 - 0,5 two to three times a day	Panični napadaj, anksioznost / Panic attack, anxiety
Lorazepam	1-6	10-20	Nema aktivnih metabolita / No active metabolites	1-2 mg jedanput ili dva puta na dan / 1 - 2 mg one or two times a day	Anksioznost, odvikavanje od alkohola, uvod u opću anesteziju / Anxiety, alcohol withdrawal, introduction to general anaesthesia
Oksazepam / Oxazepam	2-4	10-20	Nema aktivnih metabolita / No active metabolites	15-30 mg, tri do četiri puta na dan / 15 - 30 mg, three to four times a day	Anksioznost, odvikavanje od alkohola / Anxiety, alcohol withdrawal
Benzodiazepini s dugim djelovanjem / Long-acting benzodiazepines					
Flurazepam	1-2	40-100	Aktivni metabolit: dezalkilflurazepam / Active metabolite: N-Desalkylflurazepam	15-30 mg	Nesanica / Insomnia
Diazepam	1-2	20-80	Aktivni metabolit: dezmetildiazepam / Active metabolite: desmethyldiazepam	5 mg, dva puta/dan / 5 mg, two times a day	Anksioznost, odvikavanje od alkohola, sedacija, epileptički status, spazam mišića / Anxiety, alcohol withdrawal, sedation, status epilepticus, muscle spasms

T_{max}- vrijeme do vršnih vrijednosti koncentracije u krvi, $T_{1/2}$- vrijeme polueliminacije uključujući i poluvijek metabolita / T_{max}- time to peak blood concentration values, $T_{1/2}$- half-life including half-life of metabolites

kon oralne primjene, a maksimalni učinak nakon jednog sata), no zbog brze redistribucije u masno tkivo ubrzo dolazi do slabljenja učinka. Radi brzog prodiranja u SŽS ovisnici najčešće uzimaju diazepam zajedno s opijatima (1). Primijećene su spolne razlike u vremenu raspada i eliminaciji pri korištenju diazepama; u mlađih žena je brže nego u muškaraca, dok na primjeni alprazolama nisu zabilježene razlike (6).

U SAD-u je provedena nacionalna anketa u kućanstvima te je izvješteno da 4 % ispitanika koristi lijekove za smirenje, a 6 % ih koristi za spavanje. Slične procjene iz Velike Britanije izvještavaju da 3 % stanovništva koristi benzodiazepine (10). Njihova potrošnja dosegla je čak

weakens (1). Gender differences in disintegration and elimination times were observed with diazepam; it is faster in younger women than in men, while no differences were observed in the use of alprazolam (6).

In the United States (US), a national household survey was conducted, and it was reported that 4% of the respondents use them as tranquilizers and 6% use them for sleep. Similar estimates from the United Kingdom (UK) report that 3% of the population uses benzodiazepines (10). Their consumption reached as much as 30% for people over 65 in France, more than 20% in Canada and Spain, 15% in Australia, and between 9% and 12% in the United States.

30 % kod osoba starijih od 65 godina u Francuskoj, više od 20 % u Kanadi i Španjolskoj, 15 % u Australiji te između 9 % i 12 % u SAD. Studija provedena u Lleidi pokazala je godišnju prevalenciju prepisanih benzodiazepina od 18,8 % kod žena te 9,6 % kod muškaraca. Upotreba se povećavala s godinama dosežući 36,1 % kod osoba starijih od 65 godina. Najčešće indikacije za korištenje bile su anksioznost (24 %) i depresija (19 %), dok je nesanica zabilježena u 2 % ispitanika (11).

Prevalencija anksioznosti kod studenata medicine iznosi od 29,2 % do 38,7 %. Smatra se da je studij medicine psihički najzahtjevniji fakultet te da je prevalencija anksioznih poremećaja mnogo veća nego na ostalim fakultetima (12). Studija provedena na Medicinskom fakultetu u Zagrebu usporedila je konzumiranje psihoaktivnih tvari kod studenata. Prevalencija korištenja psihoaktivnih tvari barem jednom u životu, od kojih su najčešći benzodiazepini, iznosila je 33 % u 2000. godini u usporedbi s 15 % 1989. (13).

Prema izvješću HALMED-a iz 2019. godine diazepam je najčešće propisivani anksiolitik i zauzima sedmo mjesto (39,39 definiranih dnevnih doza na 1000 stanovnika na dan (DDD/TSD)) potrošnje svih lijekova. Zatim slijedi alprazolam koji zauzima deseto mjesto prema potrošnji lijekova (27,76 DDD/TSD) (14). Prema posljednjem višegodišnjem komparativnom izvješću o potrošnji lijekova 2018. godine 78/1000 stanovnika koristi anksiolitike, dok je taj broj u 2014. godini iznosio 73/1000 stanovnika. Bilježi se porast od 2,1 % godišnje od 2014. do 2018. godine (15).

Istraživanje u Americi pokazalo je da žene koriste anksiolitike dva put češće nego muškarci. Ista studija pokazala je kako čak ¼ ispitanika u svim dobnim skupinama dugotrajno uzima benzodiazepine (16). Nekoliko studija pokazalo je kako je više ljudi uzimalo benzodiazepin prepisan od liječnika opće prakse nego od psihijatra. Uvjeti koji povećavaju rizik za dugotrajnu pri-

A study conducted in Lleida showed an annual prevalence of prescribed benzodiazepines of 18.8% in women and 9.6% in men. Usage increased with age reaching 36.1% in people over 65 years of age. The most common indications for use were anxiety (24%) and depression (19%), while insomnia was reported in 2% of respondents (11).

The prevalence of anxiety in medical students ranges from 29.2% to 38.7%. It is considered to be the most psychologically demanding faculty and the prevalence of anxiety disorders is much higher than in other academic institutions (12). A study conducted at the Faculty of Medicine in Zagreb compared the consumption of psychoactive substances by students. The prevalence of psychoactive substance use at least once in a lifetime, of which benzodiazepines are the most common, was 33% in 2000 compared to 15% in 1989 (13).

According to the 2019 HALMED report, diazepam is the most prescribed anxiolytic and ranks seventh (39.39 defined daily doses per 1000 inhabitants per day (DDD/TSD)) of all drug consumption. It is followed by alprazolam, which ranks tenth in terms of drug consumption (27.76 DDD/TSD) (14). According to the last multi-year comparative report on drug consumption in 2018, 78/1000 inhabitants use anxiolytics, as compared to 2014 when that number was 73/1000 inhabitants. In the period from 2014 to 2018, there was an increase of 2.1% per year (15).

Research in the US has shown that women use anxiolytics twice as often as men. The same study showed that one quarter of subjects in all age groups took benzodiazepines over a longer period of time (16). Several studies have indicated that more people are prescribed benzodiazepines by general practitioners than by psychiatrists. Factors that increase the risk of long-term use of benzodiazepines in both sexes are age over 35 years, low education,

mjenu benzodiazepina u oba spola su: dob starija od 35 godina, nisko obrazovanje, niski prihodi, nezaposlenost, depresivno stanje (16-18).

Neprimjerena uporaba benzodiazepina svjetski je javnozdravstveni problem. Zbog velike potrošnje benzodiazepina u općoj populaciji cilj nam je istražiti učestalost i indikacije uzimanja ovih lijekova kod studenata medicine kao i njihovo poznavanje mogućih nuspojava. Mnogi pacijenti nisu svjesni rizika koji nose ove lijekovi, razvoja tolerancije i ovisnosti te ih koriste prečesto zbog njihovog trenutnog djelovanja koje im olakšava nošenje s problemima. Kako su studenti medicine budući liječnici, važno je ispitati njihove stavove i poznavanje nuspojava benzodiazepina kako bi sljedeće generacije doktora medicine bolje upoznali svoje pacijente s određenim nuspojavama, dužini liječenja te interakcijama.

ISPITANICI I METODE

U istraživanju, koje je ustrojeno po načelu presječnog istraživanja te provedeno u razdoblju veljače i ožujka 2021. godine, sudjelovalo je 222 studenata od 1. do 6. godine studija medicine na Medicinskom fakultetu Osijek.

Za potrebe istraživanja kreiran je anonimni upitnik kojim su se bilježili i ispitivali: spol, godina studiranja, korišteni lijekovi iz skupine benzodiazepina, dužina i razlozi uzimanja lijeka, poznavanje biljnih preparata za smirenje, poznavanje mogućnosti ovisnosti o lijeku te subjektivna procjena korisnosti lijeka. Upitnik je izrađen za potrebe ovog istraživanja. Odgovori na navedena pitanja bili su ponuđeni, a ispitanici su zaokruživali odgovor koji se odnosi na njih. Za stavove vezane uz upotrebu anksiolitika korištena je Likertova ljestvica, a ispitanici su izrazili slaganje na peterostupanjskoj ljestvici zaokružavajući odgovore od 1 (u potpunosti se ne slažem) do 5 (u potpunosti se slažem). Prije samog provođenja ankete ispitanici su bili

low income, unemployment, and depression (16-18).

AIM

The misuse of benzodiazepines is a worldwide public health problem. Due to the high consumption of benzodiazepines in the general population, our aim was to investigate the frequency and indications of taking these drugs in medical students, as well as their knowledge of possible side effects. Also, based on the use of benzodiazepines, we examine the frequency of anxiety disorders in medical students and their ways of dealing with them.

METHODS

Subjects and methods

The research was organized on the principle of cross-sectional research and conducted in the period from February to March 2021 and involved 222 students from 1st to 6th year of study at the Faculty of Medicine at the University of Osijek.

For the purposes of the research, an anonymous questionnaire was created to record and examine gender, year of study, drugs used from the benzodiazepine group, length and reasons for taking the drug, knowledge of herbal sedatives, knowledge of drug dependence and subjective assessment of drugs' usefulness. Respondents were offered responses to the above questions and asked to mark the appropriate answer accordingly. A Likert scale was used for the attitudes related to the use of anxiolytics, and respondents expressed their agreement on a five-point scale by marking the answers ranging from 1 (completely disagree) to 5 (completely agree). Before conducting the survey, respondents were informed about its content and the purpose of

upoznati s njezinim sadržajem i svrhom. Istraživanje je odobreno od Etičkog povjerenstva Medicinskog fakulteta u Osijeku.

Statističke metode

Kategorijski podatci su predstavljeni apsolutnim i relativnim frekvencijama. Razlike u kategorijskim varijablama testirane su χ^2 testom, a po potrebi Fisherovim egzaktnim testom. Normalnost raspodjele testirana je Shapiro Wilkovim testom. Razlike u kontinuiranim varijablama između dviju nezavisnih skupina testirane su Mann Whitneyevim U testom, a između više od dviju skupina Kruskal Wallisovim testom. Razina značajnosti je postavljena na Alpha = 0,05. Za statističku analizu korišten je statistički program *MedCalc® Statistical Software version 19.6 (MedCalc Software Ltd, Ostend, Belgium; https://www.medcalc.org; 2020) i SPSS (IBM Corp. Released 2013. IBM SPSS Statistics for Windows, Version 21.0. Armonk, NY: IBM Corp.).*

REZULTATI

Istraživanje je provedeno na 222 studenta od kojih je 80 (36 %) mladića i 142 (64 %) djevojaka. Najviše ispitanika je sa 6. godine studija, 53 (23 %). Anksiolitike su značajno češće koristile djevojke u odnosu na mladiće (χ^2 test, P = 0,007). Negativan stav prema upotrebi anksiolitika i stav da im nisu potrebni je najučestaliji stav prema anksioliticima kod onih ispitanika koji ih nisu koristili. Značajno više mladića, 15 (18,8 %) ima negativan stav prema upotrebi anksiolitika u odnosu na djevojke (χ^2 test, P < 0,001). Najčešće korišten benzodiazepin je alprazolam (Helex, Xanax, Misar), kako navode 22 (51,2 %) studenta, bez značajne razlike u odnosu na spol. Za 32 (14,4 %) studenata tjeskoba i anksioznost su najčešći razlozi uzimanja anksiolitika i to značajnije kod djevojaka u odnosu na mladiće (χ^2 test, P = 0,009), a za isti broj studenata nadolazeći ispit je većinom

conducting it. The research was approved by the Ethics Committee of the Faculty of Medicine in Osijek.

Statistical methods

Category data are presented in absolute and relative frequencies. Differences in categorical variables were tested by the $\chi 2$ test and, if necessary, by Fisher's exact test. The normality of the distribution was assessed using the Shapiro Wilk test. Differences in continuous variables between the two independent groups were compared using Mann-Whitney U test, and between more than two groups using Kruskal Wallis test. The significance level was set to Alpha=0.05. MedCalc® Statistical Software version 19.6 (MedCalc Software Ltd, Ostend, Belgium; https://www.medcalc.org; 2020) and SPSS (IBM Corp. Released 2013) were used for statistical analysis. (IBM SPSS Statistics for Windows, Version 21.0 Armonk, NY: IBM Corp.).

RESULTS

The study was conducted on 222 students, of whom 80 (36%) were male and 142 (64 %) were female. Anxiolytics were used significantly more often by female students than the male (χ^2 test, P = 0.007). Significantly more male students (18.8%) had a negative attitude towards the use of anxiolytics compared to the female students (χ^2 test, P < 0.001). According to 51.2% of students, the most frequently used benzodiazepine was alprazolam, with no significant difference in gender distribution. For 14.4% of students, anxiety was the most common reason for taking anxiolytics, which was more significant in female than in male students (χ^2 test, P = 0.009). The same number of students answered that an upcoming exam was in most cases the event that preceded taking anxiolytics, which was

događaj koji prethodi uzimanju anksiolitika, također značajnije kod djevojaka u odnosu na mladiće (χ^2 test, P = 0,009) (tablica 2).

also more significantly expressed in female compared to male students (χ^2 test, P = 0.009) (Table 2).

TABLICA 2. Obilježja ispitanika prema spolu
TABLE 2. Characteristics of respondents by gender

	Broj (%) / Number (%)			P*
	Mladići / Men	Djevojke / Women	Ukupno / In total	
Godina studija / Year of study				
1.	9 (11,3)	16 (11,3)	25 (11,3)	0,11
2.	20 (25)	23 (16,2)	43 (19,4)	
3.	8 (10)	17 (12)	25 (11,3)	
4.	12 (15)	26 (18)	38 (17)	
5.	19 (24)	20 (14)	39 (18)	
6.	12 (15)	40 (28)	52 (23)	
Koristili su bilo kada anksiolitike (benzodiazepine) / They have used anxiolytics at least once in a lifetime (benzodiazepines)	8 (10)	35 (24,8)	43 (19,5)	**0,007**
Postoji li razlog zašto niste koristili anksiolitike? / Is there a reason why you did not use anxiolytics?				
Bojim se kako će djelovati na mene / I am afraid it will affect me	3 (3,8)	11 (7,7)	14 (6,3)	0,24
Bojim se osude okoline / I am afraid of the condemnation of others	1 (1,3)	4 (2,8)	5 (2,3)	0,66†
Nisu mi dostupni / They are not available to me	4 (5)	3 (2,1)	7 (3,2)	0,26†
Imam negativan stav prema upotrebi anksiolitika / I have a negative attitude towards the use of anxiolytics	15 (18,8)	6 (4,2)	21 (9,5)	**<0,001**
Nisu mi potrebni / I do not need them	57 (71,3)	91 (64,1)	148 (66,7)	0,28
Koji ste benzodiazepin najčešće koristili? / Which benzodiazepine did you use the most?				
Alprazolam (Helex, Xanax, Misar)	4 (50)	18 (51,4)	22 (51,2)	0,69†
Diazepam (Normabel, Apaurin)	3 (37,5)	14 (40)	17 (39,5)	
Bromazepam (Lekotam, Lexaurin, Lexilium)	1 (12,5)	1 (2,9)	2 (4,7)	
Oksazepam (Praxiten) / Oxazepam	0	2 (6)	2 (5)	
Zbog čega najčešće uzimate anksiolitike? / What is the reason you take anxiolytics most often?				
Tjeskoba i anskioznost / Anxiety	5 (6,3)	27 (19)	32 (14,4)	**0,009**
Napadaj panike / Panic attack	0	7 (4,9)	7 (3,2)	0,05†
Nesanica / Insomnia	4 (5)	13 (9,2)	17 (7,7)	0,26
Bol / Pain	2 (2,5)	1 (0,7)	3 (1,4)	0,27†
Ostalo / Other	0	2 (1,4)	2 (0,9)	0,54†
Koji događaj većinom prethodi uzimanju anksiolitika? / Which event mostly leads to taking anxiolytics?				
Nadolazeći ispit / Upcoming exam	5 (6,3)	27 (19)	32 (14,4)	**0,009**
Obiteljski problemi / Family problems	1 (1,3)	7 (4,9)	8 (3,6)	0,26†
Problemi u ljubavnom odnosu / Relationship problems	1 (1,3)	3 (2,1)	4 (1,8)	>0,99†
Nezadovoljstvo samim sobom / Dissatisfaction with oneself	3 (3,8)	12 (8,5)	15 (6,8)	0,18
Ostalo / Other	2 (2,5)	4 (2,8)	6 (2,7)	>0,99†

*χ^2 test, †Fisherov egzaktni test
/ *χ^2 test, †Fisher exact test

Anksiolitike su značajnije koristili studenti 3. i 6. godine studija u odnosu na ostale godine (Fisherov egzaktni test, P < 0,001). Nema značajnih razlika prema godini studija na pitanje zašto anksiolitike ne uzimaju, te prema tome koji anksiolitik najčešće koriste. Ispitanici 3. godine studija značajno više koriste anksiolitike zbog tjeskobe i anksioznosti (Fisherov egzaktni test, P = 0,001), i to većinom zbog nadolazećeg ispita (Fisherov egzaktni test, P = 0,01), dok studenti 5. i 6. godine značajnije češće koriste anksiolitike zbog obiteljskih problema (Fisherov egzaktni test, P = 0,002) i problema u ljubavnom odnosu (Fisherov egzaktni test, P = 0,03) (tablica 3).

Aritmetička sredina dobi u kojoj su prvi puta probali anksiolitik je 20 godina (SD 2,2 godine) u rasponu od 14 do 24 godine. Svi su upoznati s mogućnosti razvoja ovisnosti i tolerancije pri svakodnevnom uzimanju benzodiazepina. Najviše studenata, 25/42 (59,1 %) koristi jednom u više mjeseci anksiolitik, dok samo 2 (5 %) anksiolitike koriste svakodnevno. U većini slučajeva anksiolitik je preporučio liječnik ili član obitelji, a oni su bili i najčešće osobe koje su im dale anksiolitik. Biljne preparate za smirenje nisu koristili, jer ih ne smatraju dovoljno djelotvornim 12 (27,9 %) studenata, a 17 (40 %) nije upoznato s njima, dok 9 (20,9 %) ispitanika navodi da koriste biljne preparate za smirenje i pomažu im. Pomoć stručnjaka za svoje probleme potražilo je 14 (32,6 %) ispitanika, 18 (41,9 %) je razmišljalo, ali nije potražilo pomoć, dok 11 (25,6 %) ispitanika smatra da im pomoć nije potrebna, bez značajne razlike u odnosu na spol (tablica 4).

Većina ispitanika slaže se s tvrdnjom da se osjeća opuštenije i sigurnije uz anksiolitike te da se s njima mogu bolje nositi sa svojim problemima. Većina ih se ne boji da će postati ovisni o njima te nisu primijetili da unazad godinu dana uzimaju češće nego ranije. Slaganje oko tvrdnje da ne govore drugima da uzimaju anksiolitike zbog straha od osude među ispitanicima je podijeljeno (tablica 5).

Anxiolytics were used significantly more by students in the 3rd and 6th year compared to other years of study (Fisher's exact test, P < 0.001). There were no significant differences by the year of study concerning the reasons why students did not take anxiolytics, and by which anxiolytic they used the most. Subjects in the 3rd year of study used anxiolytics significantly more due to anxiety (Fisher's exact test, P = 0.001), mostly due to an upcoming exam (Fisher's exact test, P = 0.01), while students in the 5th and 6th year used anxiolytics more often due to family (Fisher's exact test, P = 0.002) or love problems (Fisher's exact test, P = 0.03) (Table 3).

The arithmetic mean of the age at which students first tried an anxiolytic was 20 years (SD 2.2 years), ranging from 14 to 24 years. Everyone was familiar with the possibility of developing addiction and tolerance when taking benzodiazepines on daily basis. 59.1% of students used anxiolytics once in several months, while 5 % of respondents used anxiolytics every day. In most cases, the anxiolytic was recommended by a doctor or a family member, and they were also, in most cases, people who gave them the anxiolytic. Herbal sedatives were not used by 67.9% of the students because 27.9% did not consider them to be effective enough, whereas 40% of students were not familiar with them and 20.9% stated that they had used herbal sedatives and found them helpful. 32.6% of the respondents sought professional help for their problems, 41.9% of them thought about seeking help and 25.6% believed that they did not need help, without a significant difference in gender distribution (Table 4).

Most respondents agreed with the statement that they felt more relaxed and safer with anxiolytics and that they could deal with their problems better. Most of them were not afraid of becoming addicted to anxiolytic and responded that they did not notice taking them more often compared to the previous year. The respondents had divided opinions relating to the claim that they were not telling others that they used anxiolytics because of the fear of condemnation (Table 5).

TABLICA 3. Obilježja ispitanika prema godini studija
TABLE 3. Characteristics of respondents by year of study

	Broj (%) prema godini studija / Number (%) by year of study							P*
	1.	2.	3.	4.	5.	6.	Ukupno / In total	
Koristili su bilo kada anksiolitike (benzodiazepine) / They have used anxiolytics at least once in a lifetime (benzodiazepines)	0	4 (9,5)	10 (40)	5 (13,2)	6 (15,4)	18 (34,6)	43 (19,5)	**<0,001**
Postoji li razlog zašto niste koristili anksiolitike? / Is there a reason why you did not use anxiolytics?								
Bojim se kako će djelovati na mene / I am afraid it will affect me	4 (16)	4 (9,3)	0	1 (2,6)	3 (7,7)	2 (3,8)	14 (6,3)	0,19
Bojim se osude okoline / I am afraid of the condemnation of others	1 (4)	1 (2,3)	0	2 (5,3)	0	1 (1,9)	5 (2,3)	0,68
Nisu mi dostupni / They are not available to me	0	4 (9,3)	1 (4)	0	1 (2,6)	1 (1,9)	7 (3,2)	0,23
Imam negativan stav prema upotrebi anksiolitika / I have a negative attitude towards the use of anxiolytics	3 (12)	6 (14)	3 (12)	1 (2,6)	4 (10,3)	4 (7,7)	21 (9,5)	0,54
Nisu mi potrebni / I do not need them	20 (80)	28 (65,1)	12 (48)	30 (78,9)	28 (71,8)	30 (57,7)	148 (66,7)	0,06
Koji ste benzodiazepin najčešće koristili? / Which benzodiazepine did you use the most?								
Alprazolam (Helex, Xanax, Misar)	0	2/4	8/10	2/5	3/6	7/18	22 (51,2)	0,78†
Diazepam (Normabel, Apaurin)	0	2/4	2/10	3/5	3/6	7/18	17 (39,5)	
Bromazepam (Lekotam, Lexaurin, Lexilium)	0	0	0	0	0	2/18	2 (4,7)	
Oksazepam (Praxiten) / Oxazepam	0	0	0	0	0	2/18	2 (4,7)	
Zbog čega najčešće uzimate anksiolitike? / What is the reason you take anxiolytics most often?								
Tjeskoba i anksioznost / Anxiety	0	3 (7)	9 (36)	3 (7,9)	4 (10,3)	13 (25)	32 (14,4)	**0,001**
Napadaj panike / Panic attack	0	1 (2,3)	0	0	3 (7,7)	3 (5,8)	7 (3,2)	0,32
Nesanica / Insomnia	0	1 (2,3)	3 (12)	2 (5,3)	3 (7,7)	8 (15,4)	17 (7,7)	0,11
Bol / Pain	0	1 (2,3)	0	1 (2,6)	0	1 (1,9)	3 (1,4)	0,95
Ostalo / Other	0	0	0	0	0	2 (3,8)	2 (0,9)	0,55
Koji događaj većinom prethodi uzimanju anksiolitika? / Which event mostly leads to taking anxiolytics?								
Nadolazeći ispit / Upcoming exam	0	3 (7)	7 (28)	4 (10,5)	6 (15,4)	12 (23,1)	32 (14,4)	**0,01**
Obiteljski problemi / Family problems	0	0	1 (4)	0	0	7 (13,5)	8 (3,6)	**0,002**
Problemi u ljubavnom odnosu / Relationship problems	0	0	0	0	0	4 (7,7)	4 (1,8)	**0,03**
Nezadovoljstvo samim sobom / Dissatisfaction with oneself	0	1 (2,3)	3 (12)	2 (5,3)	1 (2,6)	8 (15,4)	15 (6,8)	0,05
Ostalo / Other	0	1 (2,3)	0	1 (2,6)	0	4 (7,7)	6 (2,7)	0,33

*Fisherov egzaktni test
/ *Fisher exact test

TABLICA 4. Učestalost i preporuka za korištenje anksiolitika u skupini studenata koji ih koriste (n=43)
TABLE 4. Frequency and recommendation for the use of anxiolytics in a group of students using them (n=43)

	Mladići / Men	Djevojke / Women	Ukupno / In total	P*
Koliko često koristite anksiolitike / How often do you use anxiolytics?				
1x u više mjeseci / Once in few months	4/7	21 (60)	25 (59,5)	0,92
Više od 1x mjesečno / More than once per month	0	1 (2,9)	1 (2,4)	
1x mjesečno / Once per month	2/7	5 (14,3)	7 (16,7)	
Više od 1x tjedno / More than once per week	0	1 (3)	1 (2)	
1x tjedno / Once per week	1/7	5 (14)	6 (14)	
Svaki dan / Everyday	0	2 (6)	2 (5)	
Ukupno / In total	7/7	35 (100)	42 (100)	
Tko vam je preporučio uzimanje anksiolitika / Who recommended you taking anxiolytics?				
Liječnik / Doctor	2/8	18 (51,4)	20 (46,5)	0,20
Član obitelji / Family member	2/8	9 (25,7)	11 (25,6)	
Prijatelji / Friend	0	1 (2,9)	1 (2,3)	
Kolege s fakulteta / Colleagues	1/8	0	1 (2)	
Pročitao/la sam u knjizi/ na internetu / I read it in a book /online	1/8	1 (3)	2 (5)	
Samoinicijativno sam odlučio / I decided on my own	2/8	6 (17)	8 (19)	
Ukupno / In total	8/8	35 (100)	43 (100)	
Tko vam je dao anksiolitik / Who gave you anxiolytics?				
Liječnik / Doctor	3/8	17 (48,6)	20 (46,5)	0,50
Član obitelji / Family member	4/8	17 (48,6)	21 (48,8)	
Prijatelji / Friends	1/8	1 (2,9)	2 (4,7)	
Ukupno / In total	8/8	35 (100)	43 (100)	
Dob u kojoj su prvi puta probali anksiolitik [Aritmetička sredina (SD)] / **Age at which they first tried the anxiolytic** [Arithmetic mean (SD)]	20,8 (2,1)	19,7 (2,2)	20 (2,2)	0,26†
Jeste li ikada koristili biljne preparate za smirenje i kako procjenjujete njihovu djelotvornost? / Have you ever used herbal sedatives and how do you evaluate their effectiveness?				
Jesam, pomažu mi / I have, they are useful for me	4/8	5 (14,3)	9 (20,9)	0,18
Jesam, ne pomažu mi / I have, they are not useful for me	0	5 (14,3)	5 (11,6)	
Nisam, ne smatram ih dovoljno djelotvornim / I have not, I do not find them effective enough	1/8	11 (31,4)	12 (27,9)	
Nisam, nisam upoznat/a s njima / I have not, I am not familiar with them	3/8	14 (40)	17 (40)	
Ukupno / In total	8/8	35 (100)	43 (100)	
Jeste li ikada potražili pomoć stručnjaka za svoje probleme? / Have you ever sought the help of an expert for your problems?				
Jesam / I have	3/8	11 (31,4)	14 (32,6)	0,61
Razmišljala sam o tome, ali nisam / I have thought about it, but I have not	2/8	16 (45,7)	18 (41,9)	
Nisam, smatram da mi nije potrebno / No, I do not think I need it	3/8	8 (22,9)	11 (25,6)	
Ukupno / In total	8/8	35 (100)	43 (100)	

SD – standardna devijacija, *Fisherov egzaktni test, †Studentov t test
/ SD – standard deviation, *Fisher exact test, †Student t test

TABLICA 5. Ocjena tvrdnji vezanih uz korištenje anksiolitika
TABLE 5. Evaluation of claims related to the use of anxiolytics

	Broj (%) ispitanika / Number (%) of respondents					
	U potpunosti se ne slažem / I totally agree	2	3	4	U potpunosti se slažem / I totally disagree	Ukupno / In total
Kada uzmem anksiolitik, osjećam se puno opuštenije i bolje. / When I take an anxiolytic, I feel much more relaxed and better.	1 (2,3)	3 (7)	5 (11,6)	29 (67,4)	5 (11,6)	43 (100)
Osjećam se sigurnije kada znam da imam uz sebe anksiolitik. / I feel safer when I know I have an anxiolytic with me.	12 (27,9)	2 (4,7)	11 (25,6)	12 (27,9)	6 (14)	43 (100)
Osjećam da se uz anksiolitike mogu bolje nositi sa svojim problemima. / I feel that with anxiolytics I can deal better with my problems.	5 (11,6)	3 (7)	12 (27,9)	18 (41,9)	5 (11,6)	43 (100)
Bojim se da ne postanem ovisan/na o anksioliticima zbog prekomjerne upotrebe. / I am afraid of becoming addicted to anxiolytics due to overuse.	24 (55,8)	9 (20,9)	4 (9,3)	3 (7)	3 (7)	43 (100)
Ne govorim drugima da koristim anksiolitike jer me strah osude. / I do not tell others that I use anxiolytics because I fear condemnation.	11 (25,6)	7 (16,3)	6 (14)	15 (34,9)	4 (9,3)	43 (100)
U posljednjih godinu dana anksiolitike uzimam češće nego ranije. / In the last year, I have been taking anxiolytics more often than before.	16 (37,2)	4 (9,3)	7 (16,3)	8 (18,6)	8 (18,6)	43 (100)

RASPRAVA

Naše je istraživanje pokazalo da je 19,5 % studenata probalo benzodiazepine, no najviše ih koristi jedanput u više mjeseci i upoznati su s rizicima dugotrajnog konzumiranja benzodiazepina. Studenti medicinskih fakulteta nose se s velikim pritiskom tijekom studija. Cilj je osposobiti se za daljnji rad, biti kompetentan i empatičan liječnik te neprestano unaprjeđivati svoje znanje. To sa sobom nosi velik stres i pritisak tako da se medicinski fakulteti smatraju jednim od akademskih i emocionalno najzahtjevnijim fakultetima. Prekomjerni stres djeluje na psihološko stanje studenata dovodeći do anksioznosti i depresije. Anksioznost privlači manje pozornosti od depresije i često ostane neprepoznata i neliječena. Osim intenzivnog osjećaja straha i panike anksioznost se može očitovati brojnim simptomima kao što su mučnina, tahikardija, vrtoglavica, otežano disanje, urinarna inkontinencija. Također narušava pažnju i koncentraciju što studentima medicine kao budućim liječnicima ometa pružanje efikasne medicinske

DISCUSSION

Our research has shown that 19.5% of students tried benzodiazepines, but most of them use benzodiazepines once every several months and were aware of the risks of long-term benzodiazepine consumption. Medical students were coping with a lot of pressure during their studies. The aim was to prepare them for further work and to train them to become competent and empathetic physicians. This implies an increased level of stress and pressure. For those reasons, medical studies are generally considered to be the most demanding, both academically and emotionally. Excessive stress has its impact on the psychological state of students leading to the development of anxiety and depression. Anxiety usually attracts less attention than depression and, in most cases, remains unnoticed and untreated. Aside from feelings of fear and panic, anxiety may also be manifested with numerous symptoms such as nausea, tachycardia, dizziness, heavy breathing, and urinary incontinence. Moreover, it decreases the level of attention and concentration, which

skrbi pacijentima. Prema meta-analizi koja je analizirala 69 studija i uključila oko 40 000 studenata medicine ustanovljeno je da je veća prevalencija anksioznosti među studenticama. Također, veća anksioznost primijećena je na klinici (posljednje godine studija) nego na pretklinici. Razlog tome je suočavanje studenata s teško bolesnim pacijentima i smrti što može svakako utjecati na pojedinca. Prevalencija anksioznosti veća je među studentima medicine u usporedbi s njihovim kolegama s drugih fakulteta. Procjenjuje se da iznosi oko 33 % (12,19). U studiji provedenoj među studentima medicine u Brazilu, 34,6% je prijavilo depresivne simptome, 37,2 % anksiozne te 47,1 % osjeća da su pod stresom (20). Smatra se da su mnogi studenti medicine perfekcionisti te neurotični što je velika predispozicija za razvijanje anksioznih poremećaja. Uz to, akademsko opterećenje, nedostatak sna, opsežni ispiti imaju veliku ulogu u razvoju poremećaja (12). Također, studenti medicinskog studija su skloniji konzumiranju benzodiazepina. Pretpostavlja se da su razlog poznavanje lijekova, lakoće nabavljanja. Većina ih koristi zbog anksioznosti, nesanice, stresa, prekomjernog rada te depresije, dok 3,5 % konzumira iz zabave, znatiželje ili eksperimentiranja (21).

Naše istraživanje potvrđuje češću konzumaciju benzodiazepina kod djevojaka. Žene su sklonije depresiji, distimiji i anksioznim poremećajima. Procjenjuje se da životna prevalencija depresije kod žena iznosi 21,3 %, a kod muškaraca 12,7 %. Također, prevalencija generaliziranog anksioznog poremećaja je 6,6 % kod žena u usporedbi s 3,3 % kod muškaraca (6). Zbog navedenih rezultata nije iznenađujuća ovolika razlika u konzumiranju benzodiazepina između spolova.

Dok je u Hrvatskoj najčešće korišten anksiolitik diazepam, studenti medicine najčešće koriste alprazolam. Istraživanje provedeno u

presents an excessive disturbance to future physicians. According to the meta-analysis that analysed 69 studies including approximately 40 000 medical students, it was determined that the prevalence of anxiety was higher among female students. Furthermore, higher anxiety has been noticed while attending clinical subjects in comparison to pre-clinical subjects. As the main reasons, dealing with illnesses of a patient and being faced with the death of a patient were considered. The prevalence of anxiety has been higher among medical students compared to their colleagues attending other studies. The estimated value is 33% (12,19). A study conducted among medical students in Brazil provided the following data: 34.6% reported symptoms of depression, 37.2% symptoms of anxiety, and 47.1% reported feeling under a lot of stress (20). It has been considered that the majority of medical students were perfectionists and neurotic, which leads to a higher predisposition of developing a anxiety disorder (12). Nevertheless, medical students were more prone to the consumption of benzodiazepines. It was well presumed that the key reason was related to general knowledge about medications and, generally speaking, a simple way of purchasing them. Most students reported that they used benzodiazepines because of anxiety, insomnia, stress, excessive work or depression, while 3.5% of them reported using benzodiazepines for fun, out of curiosity or just to experiment (21).

Female students at the Faculty of Medicine in Osijek reported more frequent consumption of benzodiazepines in comparison to male students, which is in accordance with previous research. Women were more prone to develop depression, dysthymia, and anxiety disorders. It has been estimated that the lifetime prevalence of depression in women is at 21.3% in comparison to 12.7% in men. Also, the prevalence of generalized anxiety disorder was at 6.6% in women, compared to 3.3% in men (6). Taking into account the above results, the difference between the consumption of benzodiazepines was not surprising.

Ujedinjenom Kraljevstvu (UK) pokazalo je da se prevalencija korištenja alprazolama značajno razlikuje ovisno o dobi (P < 0,001) te da ga najčešće koriste ispitanici u dobi od 16 do 24 godine što potvrđuje i naše istraživanje (22).

Razlozi zbog kojih ispitanici uzimaju benzodiazepine razlikuju se s obzirom na godinu studiranja; studenti 3. godine češće uzimaju zbog nadolazećih ispita, dok su kod starijih studenata češći obiteljski razlozi i problemi u ljubavnom odnosu. Prema istraživanju provedenom u Belgiji, svaki treći brucoš (34,9 %) prijavio je probleme s mentalnim zdravljem koji utječu na akademski život (23). Kod mlađih studenata češća je zabrinutost oko fakulteta i ispita, dok stariji studenti počinju brinuti o raznim egzistencijskim problemima, a zabrinutost oko fakulteta je manja (12).

Slično ranijim istraživanjima najčešće indikacije za uzimanje anksiolitika kod studenata su tjeskoba i anksioznost nakon kojih slijedi nesanica. Njihov učinak na organski sustav je višestruk; djeluju anksiolitički, sedativno, antikonvuzivno te dovode do relaksacije mišića. Također imaju hipnotički učinak; skraćuju latenciju za uspavljivanje, NREM (engl. *nonrapid eye movement*) faza je produljena, dok je REM (engl.*rapid eye movement*) skraćena. U zdravih osoba ne opaža se značajan učinak na kardiovaskularni sustav (4). Ipak, neke studije pokazale su povoljan učinak benzodiazepina na kardiovaskularni sustav; u bolesnika s infarktom miokarda benzodiazepini smanjuju razinu katekolamina u krvi, pripomažu inhibiciji agregacije trombocita te smanjuju vaskularni otpor koronarnih arterija (24). Također, uzrokuju anterogradnu amneziju ovisnu o dozi; mogu narušiti sposobnost učenja novih informacija i otežavati rad koji zahtijeva angažiran kognitivni proces. Nemaju utjecaja na prethodno naučene informacije. Ovaj učinak može biti koristan kod nekih pretraga kao što je endoskopija jer

In Croatia, diazepam is the most commonly used anxiolytic medicine, although, in general, medical students mostly use alprazolam. Research conducted in the UK has shown that the prevalence of alprazolam usage depends on age (P < 0.001) and that it was mostly used by respondents of 16 to 24 years of age, which confirms this research finding (22).

The reasons for taking benzodiazepines varied depending on the year of study, i.e., 3rd-year students used benzodiazepines due to upcoming exams, while older students used benzodiazepines due to family reasons or romantic relationship issues. According to research conducted in Belgium, every third first-year medical student (34.9%) reported mental health issues affecting their academic life (23). In younger students, there was a highly developed worry about studying and taking exams, while older students expressed worry about various existential problems and, on the contrary, the worry about faculty decreases (12).

Similar to earlier studies, the most common reason for the consumption of anxiolytics in students was anxiety followed by insomnia. They have multiple effects, such as anxiolytic and anticonvulsive effects, sedation, and muscle relaxation together with a hypnotic effect, as well as decreased latency of sleeping, prolonged nonrapid eye movement phase and shortened rapid eye movement phase. In healthy people, an effect on the cardiovascular system has not been observed (4). Some studies have also shown an advantageous effect of benzodiazepines on the cardiovascular system. In the patients who suffered a heart attack, benzodiazepines could decrease the level of catecholamines in the bloodstream, reinforce the inhibition of thrombocyte aggregation and decrease vascular resistance of coronary arteries (24). Moreover, benzodiazepines may cause dose-depending anterograde amnesia, impair the capability of learning new information and aggravate activities requiring ongoing cognitive processes. They do not have any effect on previously learned information.

osoba može surađivati, a kasnije ima amneziju na taj događaj (4).

U studiji u kojoj je sudjelovalo 997 žena u Quebecu, 18,5 % prijavilo je upotrebu biljnih pripravaka kao pomoć kod nesanice, od kojih je biljka kamilica bila najčešće korištena. Iz istraživanja u Sjedinjenim Američkim Državama (SAD) navedeno je kako 2,9 % (oko 1,05 milijuna) koriste biljne preparate za nesanicu. Među najkorištenijima izdvajaju se ašvaganda (lat. *Withania somnifera*), hmelj (lat. *Humulus lupulus*), matičnjak (*Melissa officinalis*), Njemačka kamilica (lat. *Matricaria recutita*) i valerijana (lat. *Valeriana*) (25). Njihova uporaba kod studenata medicine iznosi 20,9 %, dok 40 % nije s njima upoznato .

Svi su studenti upoznati s nuspojavama benzodiazepina. Najvažnija neželjena nuspojava je razvitak ovisnosti i tolerancije. Od ostalih nuspojava navode se pospanost, oslabljena pažnja, usporene psihomotorne reakcije, smetnje pamćenja, paradoksna ekscitacija, agresivnost, depersonalizacija (3). Zbog razvoja tolerancije savjetuje se maksimalno korištenje benzodiazepina četiri tjedna u kontinuitetu (1). Ovisnost se brže razvija pri uzimanju benzodiazepina s dugim poluvremenom eliminacije kao što je diazepam. Nakon prekida uzimanja benzodiazepina s kratkim poluvremenom eliminacije simptomi ustezanja pojavljuju se nakon jedan do dva dana, dok se nakon uzimanja benzodiazepina s dugim poluvremenom eliminacije simptomi javljaju kasnije i mnogo su blaži. Nakon dugotrajne primjene treba postupno isključivati lijek. Ako je osoba ovisna o kratkodjelujućem benzodiazepinu, treba uvesti dugodjelujući pa postupno snižavati dnevnu dozu do ukidanja. Preporuka je davati intermitentno svaka dva ili tri dana do potpunog ukidanja (5). Kombiniranje anksiolitičkih lijekova treba izbjegavati, kao i konzumaciju alkohola te istodobnu primjenu antihistaminika ili antikolinergičkih lijekova. Trebaju ih izbjegavati osobe koje imaju kroničnu plućnu bolest

This effect could be useful during certain types of examination, e.g., endoscopy (4).

In a study conducted in Quebec, 18.5% of female respondents reported usage of herbal remedies as helpful while coping with insomnia. In that study, the most used herbal remedy was camomile. In research conducted in the United States of America (USA), it was reported that 2.9% (around 1.05 million respondents) used herbal remedies for insomnia. Among the most used were ashwagandha (lat. *Withania somnifera*), hop (lat. *Humulus lupulus*), lemon balm (lat. *Melissa officinalis*), German camomille (lat. *Matricaria recutita*), and valerian (lat. *Valeriana*) (25). Their usage in medical students was estimated at about 20.9%, while 40% of medical student were not introduced to such herbal remedies.

All students were familiar with the side effects of benzodiazepines. The most important side effects are development of addiction and tolerance. Other side effects include drowsiness, impaired attention, slow psychomotor reaction, and depersonalization (3). Due to the development of tolerance, the longest advised usage is four consecutive weeks (1). Addiction develops more rapidly when taking benzodiazepines with a long elimination half-life such as diazepam. After stopping the usage of benzodiazepines with a short elimination half-life, withdrawal symptoms appear after one to two days, while after taking benzodiazepines with a long elimination half-life, the symptoms appear later and are much milder. After long-term use, the drug should be gradually discontinued. If a person is addicted to short-acting benzodiazepines, a long-acting benzodiazepine should be introduced, and the daily dose gradually reduced until discontinuation. It is recommended to give the drug intermittently every two or three days until complete discontinuation (5). A combination of anxiolytic drugs should be avoided, as well as alcohol consumption and concomitant use of antihistamines or anticholinergic drugs. They should be avoided by people with chronic lung disease and sleep apnoea

te simptome apneje u snu jer mogu pogoršati simptome (4).

Ova studija ima nekoliko prednosti. Na temelju korištenja benzodiazepina kod studenata medicine može se procijeniti psihičko stanje studenata, njihovo nošenje s problemima u životu te njihovo znanje i stavove o benzodiazepinima. Ovom studijom želimo podići svijest te potaknuti inicijativu medicinskih fakulteta o brizi za mentalno zdravlje studenata. Međutim, priznajemo i sljedeća ograničenja. Anksioznost nije mjerena u ovom istraživanju. Mnogi čimbenici koji mogu utjecati na mentalno zdravlje studenata, kao što su obiteljska anamneza, emocionalne traume nisu procijenjeni jer se studija odnosi na trenutno stanje studenata. Također, nema kontrolne skupine (studenti drugih fakulteta, vršnjaci iz opće populacije) za usporedbu stavova i učestalosti korištenja anksiolitika.

ZAKLJUČAK

Unatoč velikoj uporabi benzodiazepina, kod studenata medicine uočena je racionalna i kontrolirana upotreba. Većina ih koristi jednom u više mjeseci te su svi upoznati s mogućnošću ovisnosti i tolerancije. Važna je svijest i racionalno propisivanje kako ne bi došlo do neželjenih nuspojava, pogotovo kod starijih osoba i osoba s komorbiditetima. Studenti, kao budući liječnici opće prakse koji ujedno i najčešće propisuju ove lijekove, moraju dobro poznavati indikacije i duljinu trajanja liječenja benzodiazepinima.

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Autori izjavljuju da sukob interesa ne postoji.

symptoms as they may worsen the symptoms (4).

To summarize, this study has several advantages. Based on the usage of benzodiazepines in medical students, it was possible to assess students' mental state, way they are coping with life problems, their knowledge, and their thoughts about benzodiazepines. On the other hand, the study had certain limitations. Anxiety was not measured in this study. A variety of factors can impact the mental state of students, such as family history and emotional traumas, which were not estimated because this research only took into consideration the current state of students. Also, there was no control group (students from other academic institutions, peers from the general population) to compare attitudes and the frequency of the usage of anxiolytics.

CONCLUSIONS

Despite the large number of medical students using benzodiazepines, rational and controlled use was observed. Most students used benzodiazepine once every few months and were all familiar with the possibility of developing addiction and tolerance. The awareness and promotion of mental health care are important. Students, as future general practitioners who also most often prescribe these drugs, have to be aware of the indications and duration of treatment with benzodiazepines. At the same time, thay also have to be mentally healthy to cope with the burden of their profession.

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Conflicts of interest

The authors declare that no conflicts of interest exist.

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Ethics aproval

Research was conducted according to ethical principles and was approved by the Ethics Committee of the Medical Faculty in Osijek (reference number 602-04/21-08/07).

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Depresivnost, anksioznost i stres adolescenata prije i za vrijeme četvrtog vala COVID-19 pandemije

/ Depression, Anxiety and Stress of Adolescents Before and During the Fourth Wave of the COVID-19 Pandemic

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U ovoj transverzalnoj studiji trenda uspoređena je izraženost internaliziranih problema adolescenata u Gradu Zagrebu prije pandemije COVID-19 i u vrijeme 4. vala COVID-a. U istraživanju su sudjelovale dvije skupine srednjoškolaca: (1) učenici 1. razreda srednjih škola 2016. godine (N=267, M_{dob}=15,16, SD_{dob}=0,468, 61,6 % djevojke) i (2) učenici 1. razreda srednjih škola 2021. godine (N=353, M_{dob}=14,78, SD_{dob}= 0,468, 45,9 % djevojke). Korištenjem upitnika DASS-21 utvrđen je trend rasta internaliziranih problema. U prosincu 2021. godine ozbiljne i vrlo ozbiljne simptome depresivnosti imalo je 20,6 % učenika u odnosu na 15,0 % učenika 2016. godine. Ozbiljne i vrlo ozbiljne simptome anksioznosti imalo je 2016. godine 13,4 % učenika, a 2021. čak 33,0 %. Simptomi stresa ove razine 2016. godine bili su prisutni kod 20,2 % učenika, a 2021. godine kod 25,4 %. Kod djevojaka je utvrđena viša razina depresivnosti, anksioznosti i stresa kao i kod učenika čije su obitelji pretrpjele materijalnu štetu u zagrebačkom potresu. Također, učenici slabijeg imovinskog statusa izvještavaju o značajno višim doživljenim razinama anksioznosti i stresa. Neadaptabilne strategije suočavanja sa stresom su značajni prediktori depresivnosti, anksioznosti i stresa. Značajni prediktor depresivnosti je i niže samopoštovanje, roditeljsko odbijanje i veće nezadovoljstvo tjelesnim izgledom predviđaju višu anksioznost, a ženski rod viši stres. Podatci pokazuju da je mentalno zdravlje zagrebačkih srednjoškolaca bilo pod visokim rizikom i prije pandemije COVID-19 i potresa, a ove nepovoljne okolnosti su povećale taj rizik.

/ This cross-sectional trend study compared the intensity of internalised problems of adolescents in the City of Zagreb before the COVID-19 pandemic and during its 4th wave. Two groups of secondary school students participated in the research: (1) 1st grade secondary school students in 2016 (N=267, M_{age}= 15.16, SD_{age} = 0.468, 61.6% females) and (2) 1st grade secondary school students in 2021 (N =353, M age =14.78, SD_{age} = 0.468, 45.9% females). Using the DASS-21 questionnaire, a growing trend of internalised problems was identified. In December 2021, 20.6% of students had severe and very severe symptoms of depression compared to 15.0% of students in 2016. In 2016 and 2021, 13.4% and as many as 33.0% of students, respectively, had severe and very severe symptoms of anxiety. Symptoms of this level of stress were present in 20.2% of students in 2016, and in 25.4% in 2021. A higher level of depression, anxiety and stress was found in females, as well as in students whose families suffered material damage in the Zagreb earthquake. Students of lower financial status reported significantly higher levels of anxiety and stress. Maladaptive coping strategies are significant predictors of depression, anxiety and stress. A significant predictor of depression is also lower self-esteem, parental rejection and greater dissatisfaction with physical appearance predict higher anxiety, and female gender higher stress. The data show that the mental health of Zagreb secondary school students was at high risk even before the COVID-19 pandemic and earthquakes, and these adverse circumstances increased that risk.

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UVOD

Unatrag dvije godine na živote mladih globalno, pa tako i u Hrvatskoj, utjecala je pandemija COVID-19. Donošene su razne epidemiološke mjere koje su u značajnoj mjeri utjecale na adolescente i uvelike mijenjale njihove dotadašnje navike i živote – zatvarane su škole, nastava se odvijala online, ograničavalo se kretanje, poticala se socijalna izolacija i održavanje fizičke distance. Svakodnevna rutina bila je u potpunosti promijenjena, a promjene su bile evidentne i u mnogim drugim aspektima poput odnosa u obitelji, vršnjačkih odnosa ili prestanka vanškolskih aktivnosti. Također, za mnoge je dodatni izvor stresa bio strah od zaraze, bojazan za oboljele bliske osobe ili njihova smrt, promjena dinamike odnosa u obitelji. Djeca i mladi svih uzrasta i iz svih socioekonomskih okruženja izvještavala su o osjećaju socijalne izolacije, usamljenosti, frustracije, dosade, zbunjenosti i tjeskobe, nedostajanju rutine i bivanja s prijateljima te preuzimanju stresa iz obitelji (1-5). Uzevši u obzir osjetljivo i rizično razvojno razdoblje adolescencije, negativne posljedice za mentalno zdravlje mladih u tim su okolnostima bile očekivane. To su potvrdila mnoga svjetska istraživanja i meta-analize kojima je utvrđena povišena prevalencija psihičkih poteškoća i poremećaja kod mladih u odnosu na razdoblje prije potpunog zatvaranja (engl.

INTRODUCTION

The lives of young people globally, including in Croatia, were severely affected by the COVID-19 pandemic. Various epidemiological measures had a significant impact on adolescents and greatly changed their previous habits and lifestyle – schools were closed, classes were held online, and social isolation and maintaining physical distance were encouraged. Daily routine was entirely transformed, and changes were also evident in many other aspects, such as family relationships, peer relationships or the interruption of free-time out-of-school activities. For many, an additional source of stress was the fear of infection, fear for the closest ones, and changes in the dynamics of relationships in the family. Children and young people of all ages and from all socioeconomic backgrounds reported feelings of social isolation, loneliness, frustration, boredom, confusion and anxiety, lack of routine and not being with friends, and of taking over stress from the family (1-5). Taking into account the sensitive and risky developmental period of adolescence, negative consequences for the mental health of young people were expected in these circumstances. This has been confirmed by many worldwide studies and meta-analyses, which have demonstrated the increased prevalence of psychological difficulties and disorders in young people compared to the period before the full lockdown, significantly in-

lockdown), značajno povišene razine posttraumatskih simptoma (7,8) anksioznosti (4,7-12), depresivnosti (1,4,7-9,11,12) i stresa (10,12).

Uz pandemiju, zagrebački adolescenti u proteklom su razdoblju doživjeli dva snažna potresa – zagrebački 22. ožujka 2020. i potrese u sisačko-moslavačkoj županiji 28. i 29. prosinca 2020. To je također moglo izazvati osjećaje nesigurnosti, neizvjesnosti i intenzivnog straha te potencijalno djelovati nepovoljno na njihovo mentalno zdravlje (13,14). Naime, dobro je poznato da je izloženost prirodnim katastrofama povezana s povećanim rizikom od problema mentalnog zdravlja (15,16). Specifičnije, istraživanja pokazuju kako su kod adolescenata koji su doživjeli potres snažnijeg intenziteta evidentirane povišene razine posttraumatskog stresa (15,17-19), depresivnosti (15,17-19) i anksioznosti (17,19). Ti su simptomi bili izraženi i godinu dana nakon potresa (20), a posttraumatski simptomi i depresivnost i nakon 30 mjeseci (18). Također, simptomi su bili izraženiji u djevojaka (19) te u mladih iz obitelji nižeg socioekonomskog statusa (17).

U proteklom razdoblju i u Hrvatskoj je provedeno više istraživanja kojima je obuhvaćeno mentalno zdravlje djece u kontekstu specifičnih pandemijskih okolnosti. U publikaciji Poliklinike za zaštitu djece i mladih Grada Zagreba predstavljeni su rezultati probira mentalnog zdravlja djece u Zagrebu (21). Istraživanje je provedeno u siječnju i veljači 2021. godine, prikupljeni su podatci za čak 22.020 djece osnovnoškolske i srednjoškolske dobi, temeljem roditeljskih iskaza u *online* upitnicima. Prema rezultatima, roditelji su uočili kod 9 % djece prisutnost anksiozne i/ili depresivne simptomatologije, a prema njihovim procjenama 15 % djece suočavalo se sa značajnom razinom simptoma posttraumatskog stresa.

U okviru projekta „Nacionalno praćenje učinaka pandemije bolesti COVID-19 na sustav odgoja i obrazovanja u Republici Hrvatskoj“ (22) Institut za društvena istraživanja proveo

creased levels of post-traumatic symptoms (7, 8), anxiety (4, 7-12), depression (1, 4, 7-9, 11, 12) and stress (10, 12).

In addition to the pandemic, Zagreb's adolescents experienced two strong earthquakes – the Zagreb earthquake on 22 March 2020 and the earthquakes in Sisak-Moslavina County on 28 and 29 December 2020. This also potentially caused feelings of insecurity, uncertainty and intense fear which could have adverse effects on their mental health (13, 14). It is well known that exposure to natural disasters is associated with an increased risk of mental health problems (15, 16). More specifically, research shows that adolescents who have experienced an earthquake of greater intensity have higher levels of post-traumatic stress (15, 17-19), depression (15, 17-19) and anxiety (17, 19). These symptoms were expressed one year after the earthquake (20), and post-traumatic symptoms and depression were present even after 30 months (18). Symptoms were more pronounced in young females (19) and in young people from families of lower socioeconomic status (17).

Several studies have been conducted in Croatia covering the mental health of children in the context of specific pandemic circumstances. The Zagreb Child and Youth Protection Centre presented the results of the mental health screening of children in Zagreb (21). The research was conducted in January and February 2021, data were collected for as many as 22,020 children of primary and secondary school age, based on parental assessments in online questionnaires. According to the results, the parents reported the presence of anxiety and/or depressive symptoms in 9% of the children, and, in their perception, 15% of the children expressed a significant level of post-traumatic stress symptoms.

As part of the project "National Monitoring of the Effects of the COVID-19 Pandemic on the Education System in the Republic of Croatia" (22), the Institute for Social Research conducted an extensive study in May and June 2021,

je opsežno istraživanje u svibnju i lipnju 2021. godine usmjereno na mentalno zdravlje djece osnovnoškolske (šesti i osmi razredi) i srednjoškolske dobi (drugi i završni razredi). Istraživanje je provedeno u 161 školi s više od 27 000 učenika, 417 stručnih suradnika i 4796 učitelja i nastavnika. Očekivano, 39,6 % učenika osmih razreda navelo je kako je pandemija negativno ili izrazito negativno utjecala na njihovo mentalno zdravlje, 46,2 % učenika drugih razreda srednjih škola te čak 52,4 % maturanata. Istovremeno, stručni suradnici procjenjuju kako u odnosu na razdoblje prije pandemije primjećuju znatno više depresivnih stanja kod 26,2 % učenika, anksioznih stanja kod 25 %, fobija i strahova kod 19,8 %, vršnjačkog nasilja u virtualnom okruženju kod 18,8 % te znatno više provala bijesa kod 10 % učenika.

Na Odsjeku za psihologiju Filozofskog fakulteta Sveučilišta u Zagrebu u okviru istraživačkog projekta „Kako smo? Život u Hrvatskoj u doba korone“ ispitano je i iskustvo djece za vrijeme pandemije COVID-19 u Hrvatskoj (23). U istraživanju je sudjelovalo 1.400 učenika od prvog razreda osnovne škole do četvrtog razreda srednje škole iz ukupno 97 škola (57 osnovnih i 40 srednjih škola) iz svih regija Hrvatske. Prema rezultatima, svaki peti dječak (21,6 %) i svaka treća djevojčica (37 %) izvijestili su o teškoćama mentalnog zdravlja. Pritom starija djeca i djevojčice iskazuju više simptoma teškoća mentalnog zdravlja, pesimističniji pogled na svijet, zabrinutiji su za vlastitu budućnost i manje su zadovoljni životom nego što su to mlađa djeca i dječaci. Dio istraživanja usmjerio se i na roditeljske procjene teškoća svoje djece (24). Upitnik snaga i teškoća za svoju djecu u dobi od 4 do 18 godina ispunio je 171 roditelj (20 očeva i 151 majka) te je 17 % roditelja procijenilo prisutnost klinički značajnih emocionalnih teškoća djece, 11 % klinički značajne teškoće u ponašanju te klinički značajne teškoće s pažnjom i hiperaktivnošću 9 %. Pritom je važno napomenuti da podatcima čiji su izvor roditelji

with focus on the mental health of primary school children (sixth and eighth grade) and those of secondary school age (second and final grades). The research was conducted in 161 schools with more than 27,000 students, 417 school psychologists and pedagogues and 4,796 teachers. As expected, 39.6% of eighth-grade students, 46.2% of second-grade secondary school students and as many as 52.4% of final year secondary school students stated that the pandemic had a negative or extremely negative impact on their mental health. At the same time, school psychologists and pedagogues, compared to the period before the pandemic, noticed significantly more depressive moods in 26.2% of students, anxiety moods in 25%, phobias and fears in 19.8%, peer violence in the virtual environment in 18.8%, and significantly more outbursts of anger in 10% of students.

At the Department of Psychology of the Faculty of Humanities and Social Sciences of the University of Zagreb, as part of the research project “How Are We? Life in Croatia at the Time of Corona”, the experience of children during the COVID-19 pandemic was also examined (23). A total of 1,400 students, from the first grade of primary school to the fourth grade of secondary school from a total of 97 schools from all regions of Croatia participated in the research (57 primary and 40 secondary schools). According to the results, every fifth boy (21.6%) and every third girl (37%) reported mental health difficulties. At the same time, older children and females showed more symptoms of mental health difficulties, a more pessimistic view of the world, were more worried about their future, and were less satisfied with life than younger children and male students. Part of the research focused on parents’ assessments of their children’s difficulties (24). In all, 17% of parents assessed that their children express clinically significant emotional difficulties, 11% observed clinically significant behavioural difficulties, and 9% reported clinically significant difficulties with

treba pristupiti s oprezom, jer je iz prethodnih istraživanja poznato da su roditelji skloni socijalno poželjnom odgovaranju i umanjivanju postojećih problema djece (25).

Istraživanje subjektivne dobrobiti djece u Hrvatskoj (26) provedeno je 2019. godine kao dio međunarodnog projekta *„Children's World's Subjective Well-Being"* na reprezentativnom uzorku djece (8,10 i 12 godina). Istraživanje je ponovljeno u školskoj godini 2020./2021. u deset osnovnih škola Grada Zagreba i Zagrebačke županije s učenicima četvrtih, šestih i osmih razreda iz istih odjeljenja koji su sudjelovali u istraživanju godinu ranije. U velikom broju indikatora subjektivne dobrobiti nije bilo značajnih razlika, no 2019. godine učenici su češće bili u ugodnom raspoloženju u odnosu na neugodno, imali su bolje odnose u obitelji, bili su optimističniji oko budućnosti i zadovoljniji osjećajem vlastite sigurnosti u odnosu na godinu kasnije. Promjenama u načinu života bili su pogođeniji učenici mlađe dobi i djevojčice, a svi pokazatelji subjektivne dobrobiti bili su niži kod učenika koji su pretrpjeli štetu zbog potresa. Kod učenika je primijećena izražena potreba za stabilnim školskim okruženjem te visoka razina zabrinutosti koju autorice naglašavaju kao potencijalni rizik za razvoj anksioznosti, depresivnosti i agresivnosti. To je u skladu sa spoznajama da je zadovoljstvo životom povezano s mentalnim zdravljem, pogotovo s anksioznosti i depresivnosti (npr. 27,28).

Kratki prikaz ovih istraživanja pokazuje da su se potvrdili očekivani negativni učinci pandemije COVID-19 na mentalno zdravlje adolescenata, ali i da zbog metodoloških razloga postoji rizik precjenjivanja ili podcjenjivanja teškoća mladih u razdoblju pandemije ovisno o izvoru procjene (roditelji, nastavnici ili sama djeca), mjernim instrumentima (nevalidirana pitanja, prigodne ljestvice procjene ili standardizirani instrumenti) i vremenskoj točki kad je provođeno istraživanje (u vrijeme porasta boja zaraženih i visokih mjera ograničenja uključujući

attention and hyperactivity. At the same time, it is important to note that data sourced from parents should be approached with caution, as previous research showed that parents are inclined towards socially desirable responses or to downplay their children's problems (25).

Research on the subjective well-being of children in Croatia (26) conducted in 2019 as part of the international project "Children's World's Subjective Well-Being" on a representative sample of children (8, 10 and 12 years of age) provides relevant pre-COVID referent data. The research was repeated in the 2020/2021 school year in primary schools of the City of Zagreb and Zagreb County with students from the same classes that had participated in the year before the COVID-19 pandemic. There were no significant differences in a large number of indicators of subjective well-being, but in 2019 students were more often in a pleasant mood than in an unpleasant one, had better family relationships, were more optimistic about the future and were more satisfied with their sense of security compared to the following year. Younger students and female students were more affected by lifestyle changes, and all indicators of subjective well-being were lower in students who suffered damage due to the earthquake. Among the students, a pronounced need for a stable school environment was observed, as well as a high level of worry, which the authors emphasise as a potential risk for the development of anxiety, depression and aggression. This is in line with the findings that life satisfaction is related to mental health, especially anxiety and depression (e.g., 27, 28).

A brief presentation of these studies shows that the expected negative effects of the COVID-19 pandemic on the mental health of adolescents have been confirmed, but also that due to methodological reasons there is a risk of overestimating or underestimating the difficulties faced by young people during the pandemic, depending on the source of assessment (parents, teachers or the children themselves),

obrazovanje *online* ili u vrijeme normalizacije života i otvaranja škola uz odgovarajuće epidemiološke mjere).

Koliko nam je poznato, ono što nedostaje u hrvatskim istraživanjima je usporedba istih ključnih pokazatelja mentalnog zdravlja adolescenata prije i za vrijeme pandemije COVID-19. Polazeći od toga u ovom radu ćemo se usmjeriti na izraženost internaliziranih problema adolescenata – učenika prvih razreda zagrebačkih srednjih škola – prije pandemije COVID-19 i na vrhuncu četvrtog vala, u studenom i prosincu 2021. godine (29). U tu svrhu koristimo rezultate koje smo dobili u istraživačkom projektu „Ekonomske teškoće obitelji, psihosocijalni problemi i obrazovni ishodi adolescenata u vrijeme ekonomske krize" (FEHAP)[1] na uzorku učenika prvih razreda zagrebačkih srednjih škola i srednjih škola iz područja središnje Hrvatske 2016. godine, koje ćemo usporediti s podatcima zagrebačkih srednjoškolaca, također učenika prvih razreda srednjih škola, a koji su dobiveni u studenom i prosincu 2021. u okviru probne faze istraživačkog projekta „Međugeneracijski prijenos rizika za mentalno zdravlje adolescenata" (INTRAD)[2]. Dakle, upotrijebili smo mogućnost da koristimo podatke dva neovisna istraživanja kako bismo provjerili promjene u nekim značajnim pokazateljima mentalnog zdravlja na uzorcima iste populacije, a to su učenici 1. razreda srednjih škola Grada Zagreba, mjerenih istim standardiziranim trijažnim instrumentom DASS-21 (30) koji je korišten u brojnim međunarodnim i nacionalnim istraživanjima (31-35). To nam je omogućilo da temeljem dvaju transverzalnih istraživanja provedenima na uzorku iste populacije s istim mjernim instrumentima u razmaku od 5 godina napravimo tzv. transverzalnu studiju trenda i provjerimo je li za vrije-

[1] Istraživački projekt financiran od Hrvatske zaklade za znanost pod brojem IP-2014-09-8546.

[2] Istraživački projekt financiran od Hrvatske zaklade za znanost pod brojem IP-2020-02-5967.

the measuring instruments (non-validated questions, appropriate assessment scales or standardised instruments) and the point in time when the research was conducted (at the time of an increase in the number of infected persons and tight restriction measures including online education, or at the time of the normalisation of life and opening of schools with appropriate epidemiological measures).

To the best of our knowledge, a comparison of the same key indicators of adolescent mental health before and during the COVID-19 pandemic with comparable samples is missing in Croatia. This paper tries to bridge that gap by focusing on the intensity of internalised problems of adolescents – students in the first grade of Zagreb secondary schools – before the COVID-19 pandemic and at the peak of the 4th wave, in November and December 2021 (29). For this purpose, we use the results obtained in the research project "Family Economic Hardship, Psychosocial Problems and Educational Outcomes of Adolescents in the Time of Economic Crisis" (FEHAP)[1] on a sample of students in the first grade of Zagreb secondary schools and secondary schools from central Croatia in 2016, which we compare with the data from students in the first grade of Zagreb secondary schools, which were obtained in November and December 2021 as part of the pilot phase of the research project "Intergenerational Transmission of Risk of Adolescent Mental Health" (INTRAD).[2] We took advantage of the opportunity to use the data of two independent studies to assess the changes in some significant indicators of mental health on samples of the same population, namely students of the first grade of secondary schools in the City of Zagreb, measured with the same standardised triage mental health instrument DASS-21 (30), which has been used in numerous

[1] Research project financed by the Croatian Science Foundation under number IP-2014-09-8546.

[2] Research project financed by the Croatian Science Foundation under number IP-2020-02-5967.

me pandemije COVID-19 došlo do očekivanog pogoršanja mentalnog zdravlja zagrebačkih srednjoškolaca.

CILJ

Cilj ovog istraživanja je dobiti uvid u izraženost internaliziranih problema adolescenata u Gradu Zagrebu u vrijeme 4. vala pandemije COVID-19 2021. godine u usporedbi s adolescentima Grada Zagreba 2016. godine.

Polazeći od toga istraživačke hipoteze su:

Kod zagrebačkih srednjoškolaca 2021. godine bit će izraženiji internalizirani problemi u odnosu na uzorak zagrebačkih srednjoškolaca 2016. Internalizirani problemi će biti izraženiji kod djevojaka, mladih nižeg socioekonomskog statusa i onih čije su obitelji pretrpjele materijalnu štetu u potresima.

Ženski rod, pohađanje strukovnih škola, neprikladni roditeljski postupci, lošije samopoimanje i vršnjački odnosi te češće korištenje neadaptivnih strategija suočavanja sa stresom značajno će pridonositi izraženosti internaliziranih problema zagrebačkih srednjoškolaca.

METODA

Sudionici

Podatci prikazani u ovom radu odnose se na dvije skupine srednjoškolaca: (1) uzorak učenika 1. razreda srednjih škola Grada Zagreba iz 2016. godine, i (2) uzorak učenika 1. razreda srednjih škola Grada Zagreba iz 2021. godine.

Podatci za prvu skupinu prikupljeni su u sklopu istraživačkog projekta FEHAP - „Ekonomske teškoće obitelji, psihosocijalni problemi i obrazovni ishodi adolescenata u vrijeme ekonomske krize“. Radi se o dvoetapnom nepro-

international and national studies (31- 35). This enabled us to make a cross-sectional trend study based on two transversal studies conducted on a sample of the same population with the same measuring instruments, five years apart, to check whether during the COVID-19 pandemic there was an expected deterioration in the mental health of Zagreb secondary school students.

AIM

The aim of this study was to gain insight into the intensity of internalised problems of adolescents in the City of Zagreb during the 4th wave of the COVID-19 pandemic in November and December 2021 compared to adolescents in the City of Zagreb in 2016.

Specifically, the research hypotheses are:

Internalized problems will be more intense in Zagreb high school students in 2021 compared to the sample of Zagreb high school students in 2016. Internalized problems will be more intense in females, young people of lower socioeconomic status and those whose families suffered material damage in the earthquakes.

Female gender, attendance of vocational schools, inappropriate parenting practices, poorer self-concept and peer relationships, as well as more frequent use of non-adaptive coping strategies will significantly predict the intensity of internalized problems among Zagreb high school students.

METHOD

Participants

The data presented in this paper refer to two groups of secondary school students: (1) sample of 1st grade secondary school students of the City of Zagreb from 2016, and (2) a sample of 1st grade secondary school students of the City of Zagreb from 2021.

porcionalno stratificiranom klaster uzorku učenika 1. razreda srednjih škola provedenih u pet županija središnje Hrvatske i Gradu Zagrebu. U prvoj etapi odabrane su srednje škole (trogodišnje i četverogodišnje strukovne škole te gimnazije), a u drugoj etapi odabrana su razredna odjeljenja – klasteri koji su uključeni u uzorak. U istraživanju je sudjelovalo ukupno 1096 ispitanika, od tog 267 učenika prvih razreda srednjih škola Grada Zagreba (M_{dob} = 15,16, SD_{dob} = 0,468, 61,6 % djevojke). Podatci za drugu skupinu sudionika prikupljeni su u sklopu probnog istraživanja za istraživački projekt „Međugeneracijski prijenos rizika za mentalno zdravlje adolescenata“. Radi se o prigodnom uzorku, a sudjelovali su također učenici prvih razreda srednjih škola Grada Zagreba (N=353, M_{dob} = 14,78, SD_{dob} = 0,468, 45,9 % djevojke) iz tri škole. Od toga su učenici iz trogodišnje i četverogodišnje strukovne škole bili iz škola čiji su učenici sudjelovali i u prvom istraživanju 2016., dok su gimnazijalci bili iz škole koja nije bila uključena u prvo istraživanje. Obilježja uzorka prikazana su u tablici 1.

Data for the first group were collected in 2016 as part of the research project FEHAP. It is a two-stage disproportionately stratified cluster sample of 1st grade secondary school students conducted in five counties of central Croatia and the City of Zagreb. A total of 1,096 students participated in the research, of whom 267 were students from the 1st grade of secondary schools in the City of Zagreb (M_{age} = 15.16, SD_{age} = 0.468, 61.6% females). Data for the second group of participants were collected in November and December 2021 as part of a pilot study for the research project "Intergenerational Transmission of Risk of Adolescent Mental Health". This was a convenient sample, which also included students of the 1st grade of secondary schools in the City of Zagreb (N=353, M_{age} = 14.78, SD_{age} = 0.468, 45.9 % females) from three schools. Students from three-year and four-year vocational schools were from same schools whose students participated in the first research in 2016, while gymnasium students were from a school that was not included in the first research. The characteristics of the sample are presented in Table 1.

TABLICA 1. Karakteristike uzorka istraživanja
TABLE 1. Characteristics of the research sample

Grupa / Group	Rod sudionika / Gender		
	Mladići / Male	Djevojke / Female	
2016.	38,4%	61,6%	
2021.	54,1%	45,9%	
	Vrsta škole / Type of school		
	Strukovna škola / Vocational school	Gimnazija / Gymnasium	
2016.	49,4%	50,6%	
2021.	56,4%	43,6%	
	Socioekonomski status / Socioeconomic status		
	Niži / Lower	Prosječan / Average	Viši / Higher
2016.	12,1%	65,3%	22,6%
2021.	7,4%	64,7%	27,9%
	Veličina mjesta stanovanja / Size of place of residence		
	Selo / Village	Grad / City	
2016.	19,0%	81,0%	
2021.	20,5%	79,5%	

Instrumenti

Za procjenu izraženosti internaliziranih problema kod srednjoškolaca korištena je Ljestvica depresivnosti, anksioznosti i stresa – DASS 21 (30). Upitnik se sastoji od 21 čestice na koje sudionici odgovaraju na ljestvici od 0 (uopće se nije odnosilo na mene) do 3 (gotovo uvijek ili uvijek se odnosilo na mene). Sve čestice odnose se na doživljaje sudionika u proteklom tjednu, a primjer čestice je *„Bilo mi je teško smiriti se"*. Upitnik se sastoji od tri podljestvice – depresivnost, anksioznost i stres te je na svakoj moguće postići od 0 do 21 bod. Veći broj bodova označava veću izraženost problema. Rezultate je moguće kategorizirati prema kategoriji izraženosti simptoma u 5 kategorija – normalno, blago, umjereno, ozbiljno i vrlo ozbiljno.

Prediktorski sklop za internalizirane probleme kao kriterijsku varijablu su sociodemografska obilježja, roditeljska ponašanja, samopoimanje adolescenata te njihovo suočavanje sa stresom.

Za ispitivanje roditeljskih ponašanja korišten je Upitnik socijalnog konteksta roditeljstva - PASCQ (38), forma za djecu. Ovaj upitnik služi kao mjera za procjenu temeljnih značajki roditeljskog stila. Sudionici na ljestvici od 4 stupnja (1 – Uopće nije točno, 4 – U potpunosti je točno) procjenjuju točnost pojedinih roditeljskih ponašanja, zasebno se procjenjuju ponašanja svakog roditelja. Upitnik se sastoji od 24 tvrdnje koje se grupiraju u šest faktora: 1) toplina, 2) odbijanje, 3) struktura, 4) nekonzistentnost, 5) potpora autonomiji i 6) prisila. Pritom viši rezultat znači izraženije roditeljsko ponašanje na određenom faktoru.

Samopoimanje je mjereno Marshovim upitnikom samoopisivanja II – SDQ II (37). Iz upitnika smo za potrebe ovog istraživanja preuzeli četiri podljestvice. Podljestvica Odnosi s vršnjacima istog roda mjeri se sa 10 čestica (primjer čestice: *„Lako sklapam prijateljstva s osobama svog roda")*, podljestvica Odnosi s vršnjacima

Instruments

The Depression, Anxiety and Stress Scale – DASS 21 (30) was used to assess the severity of internalised problems in secondary school students. The questionnaire consists of 21 items to which the participants answer on a scale from 0 (did not apply to me at all) to 3 (almost always or always applied to me). All items refer to the experiences of the participants in the past week, and an example of an item is "I found it difficult to calm down". The questionnaire consists of three subscales – depression, anxiety and stress, each of which can be scored from 0 to 21 points. A higher number of points indicates a greater severity of the problem. The results can be categorised according to the severity of symptoms in five categories – normal, mild, moderate, severe and very severe.

The predictor set for internalised problems as a criterion variable is sociodemographic characteristics, parental behaviours, self-concept of adolescents and their coping with stress.

The Parents as Social Context Questionnaire – PASCQ (36), a form for children, was used to examine parenting behaviours. This questionnaire serves as a measure to assess the basic features of parenting style. On a scale of 4 (1 – It is not true at all, 4 – It is completely true), participants assess the accuracy of individual parental behaviours, and the behaviours of each parent are assessed separately. The questionnaire consists of 24 statements that are grouped into six factors: (1) warmth, (2) rejection, (3) structure, (4) inconsistency, (5) autonomy support, and (6) coercion. A higher score means a more pronounced parental behaviour on a certain factor.

Self-concept was measured by the Marsh Self-Description Questionnaire II – SDQ II (37). For the purposes of this research, we included four subscales from the questionnaire. The subscale Relationships with peers of the same gender included 10 items (example of an

suprotnog roda sa 8 („*Imam puno prijatelja suprotnog roda*“), Samopoimanje tjelesnog izgleda također se mjeri s 8 čestica („*Nitko ne misli da dobro izgledam*“) i Opće samopoimanje s 10 čestica koje se temelje na česticama Rosenbergove ljestvice samopoštovanja („*Većinu toga što radim, uradim dobro.*“). S obzirom na spomenuto u prikazu i raspravi rezultata podljestvicu Općeg samopoimanja imenovali smo kao Samopoštovanje koje je pojmovno bliže našem kontekstu, a kako je i sam autor naziva u kasnijim radovima (npr. 38,39). Sudionici na tvrdnje odgovaraju na ljestvici od šest stupnjeva gdje je 1 – netočno, uopće me ne opisuje, a 6 – točno, u potpunosti me opisuje. Rezultat za svaku podljestvicu računa se kao suma odgovora na pojedinim česticama, a pritom se one koje su u negativnoj formi (npr. „*Ružan sam*“) obrnuto boduju. Na podljestvicama Odnosi s vršnjacima suprotnog roda i Samopoimanje tjelesnog izgleda moguće je postići od 8 do 48 bodova, a na podljestvicama Odnosi s vršnjacima istog roda i Samopoštovanje od 10 do 60 bodova, pritom veći broj bodova označava pozitivniju samopercepciju.

Suočavanje sa stresom mjereno je njemačkim upitnikom suočavanja za djecu i adolescente – SVF-KJ (40). Upitnikom se mjere adaptabilne strategije suočavanja – usmjerenost na problem (kontrola situacije, pozitivne samoupute, traženje socijalne podrške) i suočavanje usmjereno na emocije (distrakcija/rekreacija i umanjivanje) te neadaptabilne strategije suočavanja (pasivno izbjegavanje, ruminacija, ravnodušnost i agresija). Upitnik se sastoji od ukupno 36 tvrdnji (4 za svaku podljestvicu) koje opisuju različite načine suočavanja sa stresom (primjer: „*Radim plan kako riješiti problem.*“), a na koje sudionici daju odgovore na Likertovoj ljestvici od 5 stupnjeva, od 0 – nikada do 4 – gotovo uvijek. Na svakoj podljestvici moguće je ostvariti rezultat od 0 do 16, pritom viši rezultat znači veću učestalost korištenja određenog načina suočavanja.

item: *“I easily make friends with people of my own gender”)*, the subscale Relations with peers of the opposite gender comprised 8 items (“*I have a lot of friends of the opposite gender*”), the subscale Self-concept of physical appearance also contains 8 items (“*Nobody thinks I look good*”) and General self-concept has 10 items (“*Most of what I do, I do well*”). Considering that the authors in their later works referred to General self-concept as self-esteem (e.g., 38, 39), in the present study we use also the concept of self-esteem. Participants respond to the statements on a 6-point scale where 1 is false, it does not describe me at all, and 6 is true, it describes me completely. The result for each subscale is calculated as the sum of responses on individual items, while those that are in a negative form (e.g., *“I’m ugly”*) are scored in reverse. On the subscales Relations with peers of the opposite gender and Self-concept of physical appearance, it is possible to achieve 8 to 48 points, and on the subscales Relations with peers of the same gender and Self-esteem 10 to 60 points, where a higher number of points indicates a more positive self-perception.

Coping with stress was measured by the German Stress and Coping Questionnaire for Children and Adolescents – SVF-KJ (40). The questionnaire measures adaptive coping strategies – problem-focused (control of the situation, positive self-instructions, seeking social support) and emotion-focused coping (distraction/recreation and minimizing), and maladaptive coping strategies (passive avoidance, rumination, indifference and aggression). The questionnaire consists of a total of 36 statements (4 for each subscale) that describe different ways of coping with stress (example: *“I’m making a plan to solve the problem”*), to which the participants give answers on a 5-point Likert scale, from 0 – never, to 4 – almost always. On each subscale, it is possible to achieve a score from 0 to 16, where a higher score means a higher frequency of using a certain way of coping.

Postupak

Prije provedbe obih istraživanja dobiveno je odobrenje Ministarstva znanosti i obrazovanja (MZO) Republike Hrvatske kojem je prethodilo odobrenje Etičkog odbora Pravnog fakulteta Sveučilišta u Zagrebu. Podatci za 2016. godinu prikupljeni su u razdoblju od veljače do svibnja. Podatci za 2021. godinu prikupljeni su tijekom studenog i prosinca. To je bilo razdoblje tzv. četvrtog vala pandemije COVID-19, a vrhunac je zabilježen 10. studenog 2021. godine kada je u Hrvatskoj evidentiran najveći broj oboljelih u jednom danu (7.315 zaraženih osoba) (29). Ipak Stožer CZ RH je, polazeći od činjenice da je u RH tada bilo cijepljeno više od 50 % odrasle populacije, ublažio mjere vezane uz okupljanja u odnosu na prva tri vala epidemije (29). U skladu s tim, MZO je odlučio 8. studenog 2021. godine da se odgojno-obrazovni rad za sve učenike osnovnih i srednjih škola Grada Zagreba organizira prema tzv. modelu A, odnosno uživo u školama. To je omogućilo da se istraživanje provede neposredno u razrednim odjeljenjima. U razdoblju kad je provedeno istraživanje došlo je do pada broja zaraženih pa je tako 14. studenog 2021. 14-dnevna stopa potvrđenih slučajeva za Grad Zagreb bila 2.044 slučaja, a u 12.12. 2021. cca 20 % slučajeva manje odnosno 14-dnevna stopa potvrđenih slučajeva 1.634[3]. Dakle, iako je u navedenom razdoblju došlo do popuštanja epidemioloških mjera, uključujući ponovno i odvijanje nastave uživo, COVID-19 je bio još uvijek vrlo ozbiljan zdravstveni problem.

Prije provedbe, stručni suradnici u školama održali su roditeljske sastanke u svim odabranim razredima s ciljem informiranja roditelja o svrsi istraživanja, dok su članovi istraživačkog tima educirali terenske istraživače za provedbu

[3] https://www.koronavirus.hr/uploads/14_11_2021_izvjesce_tjedno_novo_zadnje_3_docx_d0969633c4.pdf https://www.koronavirus.hr/uploads/12_12_2021_izvjesce_tjedno_novo_3e8a811eb1.pdf

Procedure

Prior to the implementation of both studies, the approval of the Ministry of Science and Education (MSE) of the Republic of Croatia was obtained, which was preceded by the approval of the Ethics Committee of the Faculty of Law of the University of Zagreb. Data for 2016 were collected in the period from February to May. Data for 2021 were collected during November and December 2021, which was the period of the 4th wave of the COVID-19 pandemic, where the peak was recorded on 10 November 2021 when Croatia recorded the highest number of patients in one day (7,315 infected persons) (29). Nevertheless, based on the fact that more than 50% of the adult population were vaccinated in the Republic of Croatia at the time, the Civil Protection Headquarters of the Republic of Croatia eased the measures related to gatherings as compared to the first three waves of the pandemic (29). In accordance with this, the MSE decided on 8 November 2021 that schooling for all students at primary and secondary level in the City of Zagreb was to be organised live in schools. This allowed the research to be carried out directly in classrooms. In the period when the research was conducted, the number of infected people had decreased, so on 14 November 2021, the 14-day rate of confirmed cases for the City of Zagreb was 2,044 cases, and on 12 December 2021 there were approximately 20% fewer cases, i.e., the 14-day rate of confirmed cases was 1,634.[3] So, although the epidemiological measures were eased, including the resumption of face-to-face classes, COVID-19 was still a very serious health problem in the mentioned period.

Before the implementation, school staff held parent meetings in all selected classes with the aim of informing parents about the purpose of the research, while members of the research team educated field researchers, senior social work stu-

[3] https://www.koronavirus.hr/uploads/14_11_2021_izvjesce_tjedno_novo_zadnje_3_docx_d0969633c4.pdf https://www.koronavirus.hr/uploads/12_12_2021_izvjesce_tjedno_novo_3e8a811eb1.pdf

istraživanja. Terenski istraživači informirali su sudionike o istraživanju, prikupili njihove suglasnosti za sudjelovanje te provodili istraživanje u odabranim razredima.

Podatci su analizirani korištenjem SPSS programskog paketa. Za odgovaranje na istraživačke probleme korištena je deskriptivna statistika, t-test, te hijerarhijska regresijska analiza u četiri koraka.

dents on how to implement the research. Field researchers informed the participants about the research, collected their consent to participate, and conducted the research in the selected classes.

The data were analysed using the SPSS software package. Descriptive statistics, t-tests and hierarchical regression analyses in 4 steps were used to answer the research problems.

REZULTATI

Izraženost internaliziranih problema

Kako bi se provjerila razlika u izraženosti internaliziranih problema zagrebačkih srednjoškolaca u prvoj polovini 2016. i krajem 2021. korišten je t-test za nezavisne uzorke (tablica 2), koji je pokazao statistički značajnu razliku u izraženosti simptoma anksioznosti. Zagrebački srednjoškolci su 2021. godine u prosjeku izvještavali o izraženijim simptomima anksioznosti u odnosu na zagrebačke srednjoškolce 2016.

Analiza ovih istih podatka provedena je i na drugačiji način pri čemu je umjesto središnjih vrijednosti korištena kategorizacija podataka. Tako su sukladno uputama za primjenu DASS-a dobiveni bruto rezultati kategorizirani u pet kategorija (1 – normalna razina izraženosti simptoma, 2 - blaga razina izraženosti simptoma, 3 – umjerena razina izraženosti simptoma, 4 – ozbiljna razina izraženosti simptoma, 5 – vrlo ozbiljna razina izraženosti simptoma) te su potom spojene dvije kategorije koje se odnose

RESULTS

Expression of internalised problems

In order to check the difference in the intensity of internalised problems of Zagreb secondary school students in the first half of 2016 and at the end of 2021, a t-test for independent samples was used (Table 1), which showed a statistically significant difference only in the intensity of anxiety symptoms. In 2021, Zagreb secondary school students on average reported more pronounced symptoms of anxiety compared to their peers in 2016.

Analysis of these same data was also carried out in a different way, where, instead of mean values, data categorisation was used. In accordance with the instructions for the application of the DASS, the obtained gross results were divided into five categories (1 – normal level of symptom expression, 2 – mild level of symptom expression, 3 – moderate level of symptom expression, 4 – severe level of symptom expression, 5 – very severe level of symptom expression) and then the two categories related to severe and

TABLICA 2. Izraženost internaliziranih problema zagrebačkih srednjoškolaca 2016. i 2021.
TABLE 2. Intensity of internalised problems of Zagreb secondary school students in 2016 and in 2021

	Depresivnost / Depression			Anksioznost / Anxiety			Stres / Stress		
	N	M	SD	N	M	SD	N	M	SD
Zagreb 2016.	264	5,72	5,467	264	5,05	5,373	264	7,75	5,744
Zagreb 2021.	330	5,64	5,728	330	5,90	5,649	331	7,90	5,887
t		0,36			-1,989*			-0,485	

*p<.05

na ozbiljnu i vrlo ozbiljnu izraženost simptomima. Kao što se može uočiti iz histograma (slika 1) primjetan je trend rasta internaliziranih problema. Dobiveni rezultati ukazuju da je u prosincu 2021. godini o ozbiljnim i vrlo ozbiljnim simptomima depresivnosti izvještava svaki peti učenik (20,6 %) u odnosu na 15,0 % učenika 2016. godine. O ozbiljnim i vrlo ozbiljnim simptomima anksioznosti izvještavalo je 2016. godine 13,4 % učenika, dok je 2021. o tome izvještavao čak svaki treći učenik (33,0 %). Ozbiljni i vrlo ozbiljni simptomi stresa 2016. godine bili su prisutni kod svakog petog učenika (20,2 %), a 2021. godine kod svakog četvrtog (25,4 %).

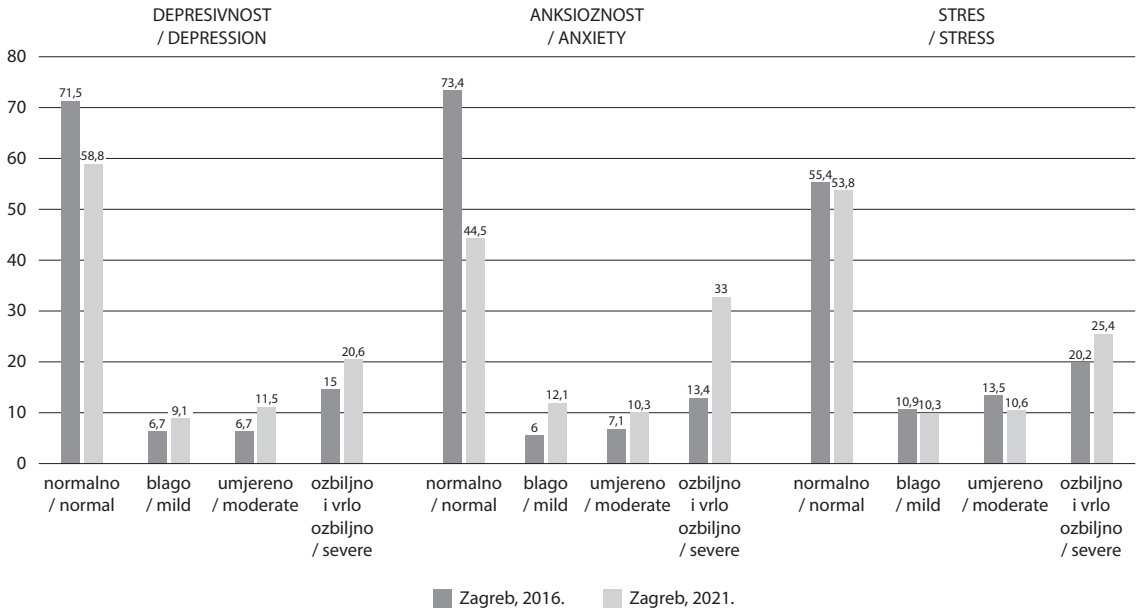
Kako bi se identificirala sociodemografska obilježja mladih u osobitom riziku testirane su rodne razlike, razlike u obrazovnim programima te materijalnim mogućnostima sudionika s obzirom na izraženost internaliziranih problema. Očekivano, rezultati t-testa ukazuju na veću izraženost internaliziranih problema u djevojaka u odnosu na mladiće (tablica 3). Djevojke izvještavaju o višim razinama depresivnosti, anksioznosti i stresa.

Jednostavna analiza varijance za nezavisne uzorke pokazala je da nema razlike u depresivnosti, ali da postoji statistički značajna razlika u anksioznosti i stresu.

very severe symptoms were combined. As can be seen from the histogram (Figure 1), there is a noticeable trend of growth of internalised problems. The obtained results indicate that at the end of 2021, every fifth student (20.6%) reported severe and very severe symptoms of depression compared to 15.0% of students in 2016. In 2016, 13.4% of students reported severe and very severe symptoms of anxiety, while in 2021, every third student (33.0%) reported this. Severe and very severe stress symptoms were present in every fifth student (20.2%) in 2016, and in every fourth student (25.4%) in 2021.

In order to identify the sociodemographic characteristics of young people at particular mental health risk, gender differences, and financial conditions of the participants were tested with regard to the intensity of internalised problems. As expected, the results of the t-test indicate a higher prevalence of internalised problems in female students compared to males (Table 2). Female students reported higher levels of depression, anxiety and stress.

A simple analysis of variance for independent samples showed that there was no difference in depression, but that there was a statistically sig-



SLIKA 1. Izraženost simptoma depresivnosti, anksioznosti i stresa kod zagrebačkih srednjoškolaca 2016. i 2021.
FIGURE 1. Expression of symptoms of depression, anxiety and stress among Zagreb high school students in 2016 and 2021.

TABLICA 3. Rodne razlike u izraženosti internaliziranih problema u grupi zagrebačkih srednjoškolaca. Podatci za 2021.
TABLE 3. Gender differences in the intensity of internalised problems among secondary school students

	Depresivnost / Depression			Anksioznost / Anxiety			Stres / Stress		
	N	M	SD	N	M	SD	N	M	SD
Djevojke / Females	159	7,48	6,054	158	7,97	6,034	159	10,35	5,731
Mladići / Males	171	3,94	4,831	172	4,00	4,514	172	5,63	5,079
t		5,894***			6,806***			7,929***	

***p<.001

nosti, ali da postoji statistički značajna razlika u anksioznosti i doživljenom stresu učenika ovisno o procijenjenim materijalnim mogućnostima (tablica 4). *Post hoc* testiranjem testom Bonferroni utvrđeno je da na anksioznosti i stresu učenici koji procjenjuju kako njihova obitelj ima manje novaca u odnosu na druge obitelji postižu statistički značajno više rezultate u odnosu na ostale dvije skupine. Između druge dvije skupine (prosječne i iznadprosječne mogućnosti) nije pronađena značajna razlika u izraženosti internaliziranih simptoma. Ako pogledamo deskriptivne podatke možemo vidjeti kako i rezultati za depresivnost prate isti trend, no po svemu sudeći nije se mogla postići razina statističke značajnosti zbog malog broja sudionika u skupini „manje od drugih". Tome u prilog idu i rezultati koji se odnose na pretrpljenu materijalnu štetu u potresu i izraženost internaliziranih problema (tablica 5). Oni učenici čije su obitelji pretrpjele materijalnu štetu u zagrebačkom potresu izvještavaju o višim razinama depresivnosti, anksioznosti i stresa u odnosu na njihove vršnjake čije obitelji nisu imale materijalnu štetu zbog potresa.

nificant difference in students' anxiety and perceived stress depending on the reported financial situation (Table 3). *Post hoc* testing with the Bonferroni test revealed that regarding anxiety and stress, students who assessed that their family had less money compared to other families achieved statistically significantly higher results compared to the other two groups. Between the other two groups (average and above-average conditions) no significant difference was found in the expression of internalised symptoms. If we look at the descriptive data, we can see that the results for depression follow the same trend, but apparently the level of statistical significance could not be reached due to the small number of participants in the "less than others" group. This is supported by the results related to material damage sustained in the earthquake and the intensity of internalised problems (Table 4). Those students whose families suffered material damage in the Zagreb earthquake reported higher levels of depression, anxiety and stress than their peers whose families did not suffer material damage from the earthquake.

TABLICA 4. Razlike prema procijenjenim materijalnim mogućnostima obitelji u izraženosti internaliziranih problema u grupi zagrebačkih srednjoškolaca. Podatci za 2021.
TABLE 4. Reported family financial situation as related to the intensity of internalised problems among secondary school students. Data for 2021.

Koliko novaca ima tvoja obitelj u odnosu na druge? / How much money does your family have compared to others?	Depresivnost / Depression			Anksioznost / Anxiety			Stres / Stress		
	N	M	SD	N	M	SD	N	M	SD
Manje od drugih / Less than others	23	8,30	7,320	22	8,64	7,094	24	10,58	6,613
Kao i drugi / Like others	208	5,39	5,439	209	5,56	5,569	208	7,42	5,751
Više od drugih / More than others	90	5,47	5,728	90	6,21	5,372	90	8,32	5,813
F		2,771			3,085*			3,468*	

*p<.05

TABLICA 5. Razlike prema pretrpljenoj materijalnoj šteti u zagrebačkom potresu u izraženosti internaliziranih problema u grupi zagrebačkih srednjoškolaca. Podatci za 2021.
TABLE 5. Differences of material damage suffered in the Zagreb earthquake in the intensity of internalised problems among secondary school students. Data for 2021.

Materijalna šteta ZG potres / Material damage ZG earthquake	Depresivnost / Depression			Anksioznost / Anxiety			Stres / Stress		
	N	M	SD	N	M	SD	N	M	SD
Da / Yes	102	6,61	6,018	102	7,08	5,760	102	9,25	6,012
Ne / No	228	5,21	5,552	228	5,38	5,531	229	7,31	5,742
t		2,058*			2,564*			2,809**	

*p<.05; **p<.01

Prediktori internaliziranih problema

Prije hijerarhijskih regresijskih analiza analizirana je matrica korelacija odabranih varijabli (tablica 6). Pokazalo se da su odabrane varijable povezane s pojedinim kriterijem u očekivanom smjeru u niskim do visokim međusobnim korelacijama. Zanimljivo je da varijabla koja se odnosi na nekonstruktivno suočavanje sa stresom jedina ima statistički značajnu povezanost sa svim drugim varijablama.

Kako bi se dobio odgovor na treći problem istraživanja provedene su tri hijerarhijske regresijske analize (HRA). Pritom su u prvi korak stavljene sociodemografske varijable (kao *dummy* varijable zbog svoje kategorijalne prirode), u drugi karakteristike roditeljskih ponašanja, treći samopoimanje adolescenata i u četvrti obrasci suočavanja sa stresom.

Rezultati (tablice 7,8 i 9) pokazuju da odabrani skupovi prediktora objašnjavaju 57,2 % varijance depresivnosti, 56,8 % anksioznosti i 59,2 % stresa. Što se tiče internaliziranih problema, od sociodemografskih varijabli značajnim se pokazuje samo ženski rod i to za sva tri kriterija, no ta se značajnost za depresivnost gubi uvođenjem varijabli samopoimanja adolescenata, za anksioznost uvođenjem varijabli suočavanja sa stresom, a jedino se za kriterij stresa ova varijabla održala kao značajni prediktor u svim koracima HRA. Također, za kriterij stresa u prva dva koraka značajnim se pokazala varijabla veličine mjesta života adolescenata

Predictors of internalised problems

Before the hierarchical regression analyses, the correlation matrix of the selected variables (Table 6) was analysed. The selected variables were shown to be related to a particular criterion in the expected direction in low to high mutual correlations. It is interesting that the variable related to non-constructive, maladaptive coping with stress is the only one that has a statistically significant connection with all the other variables.

In order to answer to the third research problem, three hierarchical regression analyses (HRA) were performed. Sociodemographic variables (as dummy variables due to their categorical nature) were entered in the 1st step, parental behaviour characteristics in the 2nd step, adolescent self-concept in the 3rd step, and stress coping patterns in the 4th step.

The results (Table 7, 8 and 9) show that the selected sets of predictors explain 57.2% of the variance in depression, 56.8% in anxiety, and 59.2% in stress. As far as internalised problems are concerned, of the sociodemographic variables, only the female gender is significant for all three criteria, but this significance is lost for depression by the introduction of the variables of adolescent self-concept, for anxiety by the introduction of the variables of coping with stress, and only for the stress criterion is this variable maintained as a significant predictor through all the HRA steps. For the stress criterion in the first two steps, the variable of the size of the ad-

TABLICA 6. Matrica korelacija varijabli uključenih u HRA
TABLE 6. Correlation matrix of variables included in HRA

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	11.	12.	13.	14.	15.	16.	17.	18.
Depresivnost / Depression	1																	
Anksioznost / Anxiety	,783**	1																
Stres / Stress	,778**	,809**	1															
Rod / Gender	-,309**	-,352**	-,401**	1														
Mjesto života / Place of residence	0,103	,120*	,168**	-,156**	1													
Škola / School	0,090	,125*	,197**	-,316**	,300**	1												
Roditeljska toplina / Parental warmth	-,389**	-,307**	-,238**	0,021	0,062	,149*	1											
Roditeljsko odbijanje / Parental rejection	,482**	,465**	,418**	-0,061	-0,073	-0,095	-,493**	1										
Roditeljska struktura / Parental structure	-,313**	-,282**	-,212**	0,106	-0,012	-0,120	,515**	-,348**	1									
Roditeljska nekonzistentnost / Parental inconsistency	,442**	,400**	,403**	-0,053	0,122	-0,033	-,387**	,630**	-,238**	1								
Roditeljska potpora autonomiji / Parental support for autonomy	-,403**	-,352**	-,290**	0,033	-0,082	0,079	,700**	-,537**	,585**	-,475**	1							
Rodiljska prisila / Parental coercion	,381**	,285**	,330**	0,079	0,075	-0,076	-,367**	,588**	-,202**	,701**	-,481**	1						
Samopoštovanje / Self-esteem	-,602**	-,515**	-,462**	,247**	-0,084	-0,027	,369**	-,385**	,337**	-,313**	,402**	-,245**	1					
Zadovoljstvo izgledom / Satisfaction with physical appearance	-,419**	-,388**	-,300**	,159**	0,069	0,044	,256**	-,243**	,266**	-,150*	,239**	-,145*	,700**	1				
Odnos s vršnjacima istog roda / Relationship with peers of the same gender	-,456**	-,369**	-,300**	,195**	-0,043	0,068	,353**	-,341**	,299**	-,263**	,314**	-,163*	,696**	,550**	1			
Odnos s vršnjacima suprotnog roda / Relationship with peers of the opposite gender	-,303**	-,316**	-,263**	,209**	-0,096	-,139*	,206**	-0,119	,283**	-0,072	,161*	-0,014	,536**	,552**	,552**	1		
Adaptabilne strategije suočavanja sa stresom / Adaptive strategies for coping with stress	-,125*	-0,087	0,025	-0,094	-0,038	,167**	,259**	-,213**	,205**	-0,072	,344**	-,179**	,354**	,272**	,255**	,151*	1	
Neadaptabilne strategije suočavanja sa stresom / Maladaptive strategies for coping with stress	,657**	,674**	,749**	-,465**	,206**	,346**	-,175*	,290**	-,235**	,399**	-,254**	,251**	-,501**	-,339**	-,279**	-,288**	,129*	1

*p<.05; **p<.01

prema čemu mladi koji žive u gradu Zagrebu doživljavaju više razine stresa u odnosu na one koji pohađaju zagrebačke srednje škole, ali žive u manjim sredinama.

Kada je riječ o roditeljskim ponašanjima, roditeljska toplina kao poželjno roditeljsko ponašanje pokazuje se kao zaštitni čimbenik za depresivnost, ali se taj efekt gubi uvođenjem varijable samopoimanja adolescenata. Nekon-

olescent's place of residence proved to be significant, according to which young people who live in the city of Zagreb experience higher levels of stress compared to those who attend Zagreb secondary schools but live in smaller communities.

When it comes to parental behaviours, parental warmth as a desirable parental behaviour is a protective factor against depression, but this effect is lost when the adolescent self-concept

TABLICA 7. Rezultati hijerarhijske regresijske analize predviđanja depresivnosti
TABLE 7. Results of hierarchical regression analysis in the prediction of depression

Varijabla / Variable	r_{pk}	vif	Korak 1 / Step 1	Korak 2 / Step 2	Korak 3 / Step 3	Korak 4 / Step 4
Rod sudionika / Gender of participants	-,309**	1,411	-,261**	-,210**	-,078	,000
Mjesto života / Place of residence	,103	1,263	,063	,049	,029	,014
Obrazovni program / Educational programme	-,233**	1,464	-,004	-,015	-,070	,018
Roditeljska toplina / Parental warmth	-,389**	2,236		-,218*	-,148	-,149
Roditeljsko odbijanje / Parental rejection	,482**	2,225		,014	,014	,017
Roditeljska struktura / Parental structure	-,313**	1,774		-,089	-,048	-,018
Roditeljska nekonzistentnost / Parental inconsistency	,442**	2,636		,289**	,249**	,098
Roditeljska potpora autonomiji / Parental support for autonomy	-,403**	2,907		-,007	,080	,026
Roditeljska prisila / Parental coercion	,381**	2,322		,081	,057	,061
Samopoštovanje / Self-esteem	-,602**	3,691			-,367**	-,217*
Samopoimanje tjelesnog izgleda / Self-concept of physical appearance	-,419**	2,307			-,190*	-,152
Odnos s vršnjacima istog roda / Relationship with peers of the same gender	-,456**	2,328			-,013	-,059
Odnos s vršnjacima suprotnog roda / Relationship with peers of the opposite gender	-,303**	1,826			,086	,093
Adaptabilne strategije suočavanja sa stresom / Adaptive strategies for coping with stress	-,125*	1,498				-,025
Neadaptabilne strategije suočavanja sa stresom / Maladaptive strategies for coping with stress	,657**	2,328				,423**
R			,315	,617	,709	,777
R^2			,099	,381	,502	,603
ΔR^2			,099***	,281***	,121***	,101***
R^2_{corr}			,086	,353	,469	,572

*p<.05; **p<.01; ***p<.001
Varijabla rod sudionika kodirana je na način Ž=1, M=2; mjesto života: selo=1, grad=2; obrazovni program: strukovna škola=1, gimnazija=2.
/ Variables are coded as follows, the participant's gender: F=1, M=2; place of residence: village=1, city=2; educational program: vocational school=1, gymnasium=2.

zistentnost u ponašanju roditelja pokazuje se kao rizični čimbenik za anksioznost i stres, no i taj se efekt gubi uvođenjem obrazaca suočavanja sa stresom. Za razliku od navedenog, roditeljsko odbijanje pokazuje se kao značajni prediktor anksioznosti i uz uvođenje varijabli u zadnjem koraku.

Iako su u razdoblju adolescencije iznimno značajni vršnjaci, odnosi s vršnjacima istog i suprotnog roda se nisu se pokazali kao značajni prediktori ni u jednom koraku, ni za jedan od pokazatelja mentalnog zdravlja.

variable is introduced. Inconsistency in parents' behaviour is a risk factor for anxiety and stress, but this effect is also lost by the introduction of patterns of coping with stress. In contrast to the above, parental rejection is revealed to be a significant predictor of anxiety even with the introduction of variables in the last step.

Although peers are extremely important in the period of adolescence, relationships with peers of the same or opposite gender did not prove to be significant predictors in any step, or for any of the indicators of mental health.

TABLICA 8. Rezultati hijerarhijske regresijske analize predviđanja anksioznosti
TABLE 8. Results of hierarchical regression analysis in the prediction of anxiety

Varijabla / Variable	r_{pk}	Korak 1 / Step 1	Korak 2 / Step 2	Korak 3 / Step 3	Korak 4 / Step 4
Rod sudionika / Gender of participants	-,352**	-,350**	-,276**	-,217**	-,121
Mjesto života / Place of residence	,120*	,099	,085	,096	,044
Obrazovni program / Educational programme	-,278**	-,049	-,082	-,100	,022
Roditeljska toplina / Parental warmth	-,307**		-,132	-,122	-,127
Roditeljsko odbijanje / Parental rejection	,465**		,179	,201*	,205*
Roditeljska struktura / Parental structure	-,282**		,008	,032	,068
Roditeljska nekonzistentnost / Parental inconsistency	,400**		,227*	,211*	,014
Roditeljska potpora autonomiji / Parental support for autonomy	-,352**		-,097	-,032	-,110
Roditeljska prisila / Parental coercion	,285**		-,077	-,132	-,127
Samopoštovanje / Self-esteem	-,515**			-,110	,073
Samopoimanje tjelesnog izgleda / Self-concept of physical appearance	-,388**			-,293**	-,251**
Odnos s vršnjacima istog roda / Relationship with peers of the same gender	-,369**			,046	-,010
Odnos s vršnjacima suprotnog roda / Relationship with peers of the opposite gender	-,316**			,075	,086
Adaptabilne strategije suočavanja sa stresom / Adaptive strategies for coping with stress	-,087				-,059
Neadaptabilne strategije suočavanja sa stresom / Maladaptive strategies for coping with stress	,674**				,534**
R		,358	,599	,660	,754
R^2		,128	,359	,435	,568
ΔR^2		,128***	,231***	,076***	,133***
R^2_{corr}		,115	,330	,397	,568

*p<.05; **p<.01; ***p<.001
Varijabla rod sudionika kodirana je na način Ž=1, M=2; mjesto života: selo=1, grad=2; obrazovni program: strukovna škola=1, gimnazija=2.
Variables are coded as follows, the participant's gender: F=1, M=2; place of residence: village=1, city=2; educational program: vocational school=1, gymnasium=2.

Od čimbenika samopoimanja adolescenata, za depresivnost i anksioznost značajnim se prediktorima pokazuju niže samopoštovanje i lošije samopoimanje tjelesnog izgleda, no uz dodavanje zadnjeg koraka HRA za depresivnost se značajnim održalo samo samopoštovanje adolescenata, a za anksioznost samopoimanje tjelesnog izgleda.

U zadnjem koraku, kao značajni prediktor za sva tri kriterija pokazuje se češće korištenje neadaptabilnih strategija suočavanja sa stresom.

Regarding adolescent self-concept factors, lower self-esteem and a worse self-concept of physical appearance are significant predictors of depression and anxiety, but with the addition of the last step of the HRA, only adolescent self-esteem remained significant for depression, and, for anxiety, the self-concept of physical appearance.

In the last step, the more frequent use of non-constructive, maladaptive strategies of coping with stress is shown as a significant predictor for all three criteria.

TABLICA 9. Rezultati hijerarhijske regresijske analize predviđanja stresa
TABLE 9. Results of hierarchical regression analysis in the prediction of stress

Varijabla / Variable	r_{pk}	Korak 1 / Step 1	Korak 2 / Step 2	Korak 3 / Step 3	Korak 4 / Step 4
Rod sudionika / Gender of participants	-,401**	-,356**	-,307**	-,250**	-,142*
Mjesto života / Place of residence	,168**	,182*	,151*	,129	,074
Obrazovni program / Educational programme	-,332**	-,047	-,078	-,100	,061
Roditeljska toplina / Parental warmth	-,238**		-,077	-,048	-,053
Roditeljsko odbijanje / Parental rejection	,418**		,079	,092	,095
Roditeljska struktura / Parental structure	-,212**		-,022	-,002	,036
Roditeljska nekonzistentnost / Parental inconsistency	,403**		,244**	,228*	-,012
Roditeljska potpora autonomiji / Parental support for autonomy	-,290**		,016	,049	-,054
Roditeljska prisila / Parental coercion	,330**		,146	,134	,145
Samopoštovanje / Self-esteem	-,462**			-,185	,018
Samopoimanje tjelesnog izgleda / Self-concept of physical appearance	-,300**			-,037	,006
Odnos s vršnjacima istog roda / Relationship with peers of the same gender	-,300**			,042	-,023
Odnos s vršnjacima suprotnog roda / Relationship with peers of the opposite gender	-,263**			-,008	,004
Adaptabilne strategije suočavanja sa stresom / Adaptive strategies for coping with stress	,025				,007
Neadaptabilne strategije suočavanja sa stresom / Maladaptive strategies for coping with stress	,749**				,620**
R		,417	,610	,653	,789
R^2		,174	,372	,426	,622
ΔR^2		,174***	,198***	,054**	,196***
R^2_{corr}		,162	,343	,387	,592

*p<.05; **p<.01; ***p<0.01
Varijabla rod sudionika kodirana je na način Ž=1, M=2; mjesto života: selo=1, grad=2; obrazovni program: strukovna škola=1, gimnazija=2.
/ Variables are coded as follows, the participant's gender: F=1, M=2; place of residence: village=1, city=2; educational program: vocational school=1, gymnasium=2.

RASPRAVA

Polazna hipoteza o pogoršanju internaliziranih problema kao pokazatelja mentalnog zdravlja je tek djelomično potvrđena. Naime, rezultati pokazuju da je na razini prosječnih vrijednosti došlo do statistički značajnog pogoršanja samo jednog od tri pokazatelja mentalnog zdravlja – anksioznosti - u razdoblju 4. vala pandemije COVID-19 kod zagrebačkih adolescenata učenika 1. razreda srednje škole u odnosu na njihove vršnjake u razdoblju prije pandemije i potresa. U izraženosti simptoma depresivnosti i stresa ta razlika nije dobivena. Ipak, iako ta razlika nije statistički značajna, postoji uočljiv trend

DISCUSSION

The initial hypothesis about the worsening of internalised problems as an indicator of mental health was only partially confirmed. The results show that, at the level of average values, there was a statistically significant deterioration of only one of the three indicators of mental health – anxiety – in the period of the 4th wave of the COVID-19 pandemic among Zagreb adolescents in the 1st grade of secondary school compared to their peers in the period before the pandemic and earthquakes. Nevertheless, although this difference is not statistically significant, there is a noticeable trend of an in-

porasta izraženosti simptoma svih internaliziranih problema kada se koristi kategorijska analiza dobivenih podataka. Tako je u odnosu na 2016. godinu, kada je o ozbiljnim i vrlo ozbiljnim simptomima depresivnosti izvještavalo 15,0 % učenika, anksioznosti 13,4 % i stresa 20,2 %, krajem 2021. godine čak ih je 20,6 % izvještavalo o ozbiljnim i vrlo ozbiljnim simptomima depresivnosti, 33,0 % o anksioznosti i 25,4 % stresa. Slično povećanje internaliziranih simptoma u odnosu na razdoblje prije pandemije dobili su kod kineskih adolescenata Zhang i sur. (41).

U cjelini podatci pokazuju da je mentalno zdravlje zagrebačkih srednjoškolaca bilo ozbiljno ugroženo i prije pandemije COVID-19, koja je samo povećala taj rizik. To ne iznenađuje, jer su anksioznost i depresivnost već godinama prepoznate kao značajni zdravstveni rizik (42), a ograničenja i promjene života koje je potaknuo COVID-19 su samo povećali socijalnu anksioznost i druge čimbenike rizika za mentalno zdravlje (43). To su potvrdila i istraživanja provedena u Hrvatskoj prije pandemije COVID-19. Tako je npr. u istraživanju Edukacijsko rehabilitacijskog fakulteta u okviru projekta „Pozitivan razvoj adolescenata u Hrvatskoj" (32) kojim je obuhvaćeno 10 138 učenika u dobi od 14 do 19 godina iz pet većih hrvatskih gradova (Zagreb, Split, Osijek, Pula, Varaždin), pokazalo da su ozbiljno i vrlo ozbiljno izraženi simptomi depresivnosti kod 21,3 % učenika, anksioznosti kod 32,5 % te stresa kod 20,3 %.

Iako su rezultati u skladu s navedenim istraživanjima vezanim uz COVID-19, na pogoršanje mentalnog zdravlja zagrebačkih adolescenata u proteklom razdoblju značajan su utjecaj mogli imati i doživljeni potresi. I u tom kontekstu su rezultati u skladu s dosadašnjim istraživanjima koja ukazuju na povišenu razinu simptoma PTSP-a, anksioznosti i depresivnosti u adolescenata nakon potresa (12,15,17,20). Također, podatak da srednjoškolci čije su obitelji pretrpjele materijalnu štetu u potresu i više

crease in the expression of symptoms of all internalised problems when a categorical analysis of the obtained data is used. Thus, compared to 2016, when severe and very severe symptoms of depression were reported by 15.0% of students, anxiety by 13.4% and stress by 20.2%, at the end of 2021 as many as 20.6% of them reported severe and very severe symptoms of depression, 33.0% reported anxiety and 25.4% stress. A similar increase in internalised symptoms compared to the period before the pandemic was found in Chinese adolescents by Zhang et al. (41).

Overall, the data show that the mental health of Zagreb's secondary school students was seriously threatened even before the COVID-19 pandemic, which only increased that risk. This is not surprising since anxiety and depression have been recognised as significant health risks for more than ten years (42), and the restrictions and life changes caused by COVID-19 only increased different mental health risk factors (43). This was also confirmed by research conducted in Croatia before the COVID-19 pandemic. For example, in the study of the Faculty of Education and Rehabilitation as part of the project "Positive Development of Adolescents in Croatia" (32), which included 10,138 students aged 14 to 19 from five major Croatian cities, symptoms of depression were severe and very severe in 21.3% of students, anxiety in 32.5%, and stress in 20.3%.

Although the results are in line with the research related to COVID-19, the deterioration of the mental health of Zagreb's adolescents in the past period could have also been significantly impacted by the experienced earthquakes. Namely, previous research indicated an increased level of PTSD symptoms, anxiety and depression in adolescents after an earthquake (12, 15, 17, 20).

Further, the fact that secondary school students whose families suffered material damage in the earthquake have more compromised

od godinu i pol od velikog potresa u Zagrebu imaju ugroženije mentalno zdravlje od svojih vršnjaka, ne iznenađuje. To je u skladu s međunarodnim istraživanjima koja su pokazala da oštećenja kuća i materijalne štete imaju utjecaj na prisutnost poteškoća mentalnog zdravlja i psihijatrijskih simptoma kod adolescenta (44-46). U tim istraživanjima se naglašava značenje angažmana država u obnovi s obzirom na produljeni rizik za mentalno zdravlje adolescenata.

Ovo istraživanje je pokazalo da su svi simptomi internaliziranih problema izraženiji u djevojaka, mladih iz obitelji nižih materijalnih mogućnosti te onih čije su obitelji pretrpjele materijalnu štetu u potresu. Što se tiče rodnih razlika i prethodno spomenuta istraživanja (31,32) pokazala su da su ovi simptomi izraženiji kod djevojaka. Što se tiče siromaštva kao čimbenika rizika za mentalno zdravlje i tu se dosljedno pokazuje da je psihosocijalna dobrobit djece i mladih koji odrastaju u siromaštvu ugrožena (npr. 31,48). O učincima socioekonomske deprivacije, ali i drugih kulturalnih razlika, sve se češće govori u suvremenom pogledu na razvoj problema mentalnog zdravlja (42,43). To su kontekstualne varijable koje je nužno pratiti kako u istraživanjima tako i u neposrednom radu s mladima koji imaju poteškoća mentalnog zdravlja (43,44).

Zanimljiv je i podatak da se za stres u prva dva koraka HRA kao značajni prediktor pokazala veličina mjesta života adolescenata, što pokazuje da su mladi koji žive u Gradu Zagrebu u potencijalno većem mentalno-zdravstvenim riziku od svojih suučenika koji također pohađaju zagrebačke srednje škole, ali žive u manjim sredinama, što nije u skladu s polaznim hipotezama. Razina urbanizacije kao čimbenik rizika pokazala se i u našem prethodnom istraživanju iz 2016. godine. Tada su kod zagrebačkih srednjoškolaca bili statistički značajno izraženiji svi internalizirani problemi u odnosu na njihove vršnjake iz središnje Hrvatske (47). Na urbanizaciju kao čimbenik rizika za mentalno zdravlje

mental health than their peers even more than a year and a half after the strong earthquake in Zagreb is not surprising. This is in accordance with international research that has shown that house and property damage have an impact on the mental health difficulties and psychiatric symptoms in adolescents (44-46). In these studies, the lack of government involvement in reconstruction was recognised as a risk factor for the mental health of adolescents.

The current study shows that all symptoms of internalised problems were more pronounced in females, young people from families with lower financial means and those whose families suffered material damage in the earthquake. Regarding gender differences, there is already well-established evidence that internalised problems are more pronounced in young females (e.g., 31, 32). As for poverty as a risk factor for mental health, it has been consistently shown that the psychosocial well-being of children and young people who grow up in poverty is at risk (e.g., 31, 48). The effects of socioeconomic deprivation, as well as other cultural differences, are increasingly discussed in the contemporary explanations of the development of mental health problems (42, 43). These are contextual variables that must be taken into consideration both in research and in direct work with young people who have mental health difficulties (43, 44).

An interesting fact is that, the size of the adolescent's place of residence proved to be a significant predictor for the level of stress in the first two steps of the HRA, which shows that young people who live in the City of Zagreb are possibly at a greater mental health risk than their classmates who also attend Zagreb secondary schools but live in smaller communities. This was not in accordance with the initial hypothesis. The level of urbanisation as a risk factor was also recognised in our previous research from 2016. At that time, all internalised problems were statistically significantly more pronounced among

jasno ukazuje analiza recentnih svjetskih istraživanja koju su proveli Hoare, Jacka i Berk (49). Njihova analiza je pokazala da pojedinci koji žive u urbanim područjima imaju povećan rizik od depresije zbog složene interakcije izvanjskih čimbenika koji uključuju povećanu izloženost buci, svjetlu i onečišćenju zraka, lošu kvalitetu stanovanja, smanjenu kvalitetu prehrane, sjedilački način života i tjelesnu neaktivnost, ekonomski napor i smanjene društvene mreže s jedne strane te povećano korištenje tehnologija s druge strane. U ovom je kontekstu potrebno napomenuti kako je taj prediktor u trećem koraku analize izgubio značajnost, no kako nije u korelaciji s novouvedenim prediktorima (varijable samopoimanja). Razlog tome je vjerojatno njegova granična značajnost u prva dva koraka i samo uvođenje većeg broja novih varijabli što je dovelo do gubitka stupnjeva slobode u cjelokupnoj analizi i povećanja p vrijednosti. Neovisno o tome, s obzirom na značajnu korelaciju samog prediktora i kriterija te spomenute rezultate istraživanja, svakako se radi o konstruktu vrijednom daljnjeg istraživanja. Polazeći od toga buduća bi istraživanja trebala identificirati jedinstvene rizike adolescenata, pogotovo ranjivih podskupina, povezane s razinom urbanizacije.

Rezultati HRA ukazuju na to kako niže samopoštovanje predviđa višu depresivnost, roditeljsko odbijanje i veće nezadovoljstvo tjelesnim izgledom višu anksioznost te ženski rod viši stres. Neadaptabilne strategije suočavanja sa stresom jedina su varijabla koja predviđa sva tri kriterija – depresivnost, anksioznost i stres. Ovi nalazi su u skladu s istraživanjem Zhang i sur. (41) koji su na uzorku kineskih adolescenata također utvrdili da su pasivne strategije suočavanja prediktori depresivnosti, anksioznosti i stresa mjereni upitnikom DASS-21. Doduše, kod kineskih adolescenata se pokazalo da aktivni, pozitivni obrasci suočavanja imaju zaštitnu ulogu, što se nije pokazalo u našem istraživanju. Kao i u našem istraživanju, neki

secondary school students from Zagreb compared to their peers from smaller communities in central Croatia (47). Urbanisation, as a risk factor for mental health, is clearly indicated by the meta-analysis (49) that shows that individuals living in urban areas have an increased risk of depression due to the complex interplay of external factors that include increased exposure to noise, light and air pollution, poor housing quality, reduced dietary quality, sedentary lifestyles and physical inactivity, economic strain and reduced social networks on the one hand and increased use of information technologies on the other. It should be noted that this predictor lost its significance in the third step of the HRA, and the reason for this is probably its marginal significance in the first two steps and the mere introduction of a larger number of new variables, which led to a loss of degrees of freedom in the overall analysis and an increase in the p value. Regardless of that, the significant correlation between the urbanisation predictor and the criteria and the aforementioned research results, indicates that this construct is worthy of further mental health research. Based on this, future research should identify the unique mental health risks of adolescents, especially vulnerable subgroups e.g., adolescents living in poverty, related to the level of urbanisation.

The HRA results indicate that lower self-esteem predicts higher depression, and parental rejection and greater dissatisfaction with body appearance predict higher anxiety, and female gender predicts higher stress. Maladaptive coping strategies such as passive avoidance, rumination, indifference and aggression are the only variable that predicts all three criteria – depression, anxiety and stress. These findings are consistent with the research of Zhang et al. (41) who, in a sample of Chinese adolescents, also determined that passive coping strategies were predictors of depression, anxiety and stress measured with the DASS-21 questionnaire. Admittedly, active, positive coping patterns were shown to have a

od čimbenika povezanih s povećanom anksioznošću su bili ženski rod, život u urbanim područjima i stil suočavanja usmjeren na emocije. No njihovo istraživanje je identificiralo i neke specifične čimbenike koji su bili povezani s pojačanim simptomima depresije kao što je npr. „ovisnost o pametnom telefonu“ i “ovisnost o internetu”. Po svemu sudeći to su varijable koje je potrebno unijeti u buduća istraživanja. Činjenica kako se adaptabilne strategije suočavanja koje se odnose na usmjerenost na problem (kontrola situacije, pozitivne samoupute, traženje socijalne podrške) i suočavanje usmjereno na emocije (distrakcija/rekreacija i umanjivanje) nisu pokazale kao značajan čimbenik zaštite upućuje da one možda još nisu dovoljno razvijene u ovom razdoblju adolescencije te bi se u budućim preventivnim programima mentalnog zdravlja trebalo usmjeriti na njih.

Podatak da su najsnažniji prediktori internaliziranih problema tri obilježja adolescenata - niže samopoštovanje, nezadovoljstvo tjelesnim izgledom i neadaptabilni, nekonstruktivni obrasci suočavanja sa životnim poteškoćama, te roditeljsko odbijanje, ponovno otvara prostor nužnosti sustavnog planiranja zaštite mentalnog zdravlja djece i mladih koje treba sezati od ranog djetinjstva i to u dva smjera: jedan je usmjeren na roditelje i na razvoj podražavajućeg, pozitivnog roditeljstva od ranog djetinjstva kao što je npr. program „Rastimo zajedno“ (50,51), a drugi na djecu i sustavni razvoj niza vještina kao što su to npr. emocionalna regulacija, vještine suočavanja sa životnim poteškoćama, socijalna osjetljivost i spremnost na pomaganje, što će sve pridonijeti pozitivnom samopoimanju i samopoštovanju kao moćnim čimbenicima zaštite mentalnog zdravlja u kriznim i visoko stresnim situacijama i razdobljima.

Istraživanje ima i određena ograničenja. Jedno od njih su relativno mali uzorci te manje razlike u njihovoj strukturi s obzirom na rod, vrstu škole i socioekonomski status sudionika

protective role in Chinese adolescents, which was not seen in our research. As was the case in the present study, in Zhang et al. (41) study some of the factors associated with increased anxiety were the female gender, living in urban areas, and an emotion-focused coping style. But they also identified some specific factors that were associated with increased symptoms of depression during the COVID-19 pandemic, such as “smartphone addiction” and “internet addiction”. It is highly likely that these are variables that need to be included in future research. The fact that adaptive coping strategies which refer to problem-focused (situation control, positive self-instructions, seeking social support) and to emotion-focused coping (distraction/recreation and reduction) were not a significant protective factor in our study may indicate that they have not been sufficiently developed in this period of adolescence, and that mental health prevention programmes should focus on them.

The fact that the strongest predictors of internalised problems are three characteristics of adolescents: lower self-esteem, dissatisfaction with physical appearance and maladaptive, non-constructive patterns of coping with life’s difficulties, and parental rejection, highlights the need for planning interventions for promoting the mental health well-being of children and young people that should begin from early childhood in two directions. One is focused on parents and on the development of positive parenting from early childhood, such as the “Growing Up Together” programme (50, 51). The second is aimed at children and the systematic development of a life-relevant skills such as emotional regulation, skills of coping with life’s difficulties, empathy, all of which will contribute to a positive self-concept and self-esteem as general powerful factors in mental health protection which is especially important in crisis and in highly stressful situations.

The research also has certain limitations. One of them is the relatively small size of the sam-

ka. S obzirom na to kako je u uzorku 2016. bio nešto veći udio djevojaka i mladih nižeg socioekonomskog statusa, što su rizični faktori za poteškoće mentalnog zdravlja adolescenata (52,53), moguće je kako je to utjecalo na rezultate zbog čega nije potvrđena statistička značajnost vidljivih razlika u izraženosti internaliziranih simptoma. Uz to, bez obzira na to što je u uzorku 2021. bio nešto veći broj mladih iz strukovnih škola, u analizu nisu bili uključeni učenici iz onih škola koje su nam se u prethodnim istraživanjima pokazale najrizičnijima i u kojima bismo očekivali najlošije rezultate. Također, prediktorski skup varijabli, zbog opsežnosti upitnika, nije mogao obuhvatiti sve relevantne varijable, npr. povijest poteškoća i poremećaja mentalnog zdravlja, povijest traume i mentalne bolesti roditelja ili visoka uznemirenost roditelja/skrbnika (41,44). Ograničenje je i činjenica da se ne radi o klasičnom longitudinalnom istraživanju već o studiji trenda te to što iz naših podataka nije moguće razgraničiti utjecaj pandemije i potresa na dobivene rezultate. S druge strane, u usporedbi s velikom većinom istraživanja provedenih tijekom pandemije COVID-19, prednost istraživanja je da su podatci u obje točke mjerenja prikupljeni „uživo“, istim mjernim instrumentom i na uzorku iste populacije.

Ovo istraživanje jasno ukazuje na moguća unaprjeđivanja i proširenja u budućim istraživanjima. Tako je npr. u nužnom post-COVID praćenju ključno voditi računa o mentalno zdravstvenom statusu i poteškoćama za vrijeme pandemije, usmjeriti se na neke potencijalno nove ranjive skupine kao što su npr. adolescenti kod kojih je dijagnosticiran post-COVID sindrom ili njegovi pokazatelji.

S obzirom na njihovu razvojnu ranjivost, mentalno zdravlje adolescenata treba sustavno pratiti i u post-COVID razdoblju, tim više što tzv. krivulja emocionalne epidemije ukazuje na veliku vjerojatnost povećanja problema mentalnog zdravlja u postpandemijskoj eri (54).

ples and minor differences in their structure with regard to the gender, type of school and socioeconomic status of the participants. The fact that in 2016 sample there was a slightly higher proportion of females and young people of lower socioeconomic status, which are risk factors for mental health problems (52, 53) might cause that in a relatively small sample the visible differences was not confirmed as significant. As well, the analysis did not include students from schools that in previous research showed to be at greater risk. In addition, due to the extensiveness of the questionnaire, we did not include all relevant predictor variables, e.g., a history of mental health difficulties and disorders, a history of trauma and parental mental illness, or high parental/caregiver distress (41, 44). Another limitation is that this was not a classical longitudinal study but a trend study. On the other hand, compared to the great majority of research conducted in COVID-19 times, the advantage of this study is that the data at both measurement time points were collected “live”, with the same measuring instrument and on a sample of the same population.

This work indicates the possibilities for improvement and expansion of future research. Thus, for example, in the post-COVID follow-up, it is crucial to take into account the mental health status and difficulties during the pandemic and to focus on some potentially new vulnerable groups such as, for instance, adolescents who have been diagnosed with post-COVID syndrome.

The results of this study also support the need for systematically monitoring the mental health of adolescents generally, and especially in the post-COVID period, since the so-called emotional epidemic curve indicates a high probability of an increase in mental health problems in the post-pandemic era (54). Childhood and adolescence are critical phases of life for the mental health and well-being of individuals in the long term. This is not only be-

Djetinjstvo i adolescencija su kritične faze života za mentalno zdravlje i dobrobit pojedinaca u životnoj perspektivi. Ne samo zato što tada mladi ljudi razvijaju autonomiju, samokontrolu, socijalnu interakciju i socijalno učenje, već i zbog toga što sposobnosti formirane u tom razdoblju izravno utječu na njihovo mentalno zdravlje do kraja života (43).

U cjelini ovi podatci pokazuju da je mentalno zdravlje zagrebačkih srednjoškolaca bilo pod visokim rizikom i prije pandemije COVID-19 i potresa, a ograničenja i promjene u svakodnevnom životu mladih zbog pandemije te izloženosti visokostresnim događajima su samo povećali taj rizik. Pri tome su posebno ugrožene djevojke, adolescenti čije su obitelji pretrpjele materijalnu štetu u zagrebačkom potresu, te čije obitelji imaju slabiji socioekonomski status. Neadaptabilne strategije suočavanja sa stresom su značajni prediktori depresivnosti, anksioznosti i stresa. Dodatni značajni prediktor depresivnosti je niže samopoštovanje, roditeljsko odbijanje i veće nezadovoljstvo tjelesnim izgledom prediktori anksioznosti te ženski rod prediktor stresa.

Dobiveni podatci su u skladu s međunarodnim istraživanjima u kojima se naglašava da je globalno pandemija COVID-19 pridonijela značajnom porastu poteškoća mentalnog zdravlja kako u općoj populaciji, tako i kod ranjivih skupina. Upravo su adolescenti prepoznati kao jedna od najranjivijih skupina (11,42,53,54). Također, u skladu je i s istraživanjima negativnih posljedica potresa na mentalno zdravlje adolescenata (15,17,18,20) te je utjecaj navedenih iznimnih stresogenih faktora u ovom istraživanju nemoguće razlučiti.

ZAKLJUČAK

Nisu svi adolescenti imali nepovoljne ishode za mentalno zdravlje. Istraživanje čimbenika zaštite pokazalo je da psihološka otpornost, kon-

cause at this time young people develop autonomy, self-control, social interaction and social learning, but also because the abilities formed during this period directly affect their mental health for the rest of their lives (43).

The data obtained are in line with international research, which emphasises that the global COVID-19 pandemic has contributed to a significant increase in mental health problems both in the general population and among vulnerable groups. Adolescents are recognised as one of the most vulnerable groups (11, 42, 53, 54). It is also consistent with research on the negative consequences of earthquakes on the mental health of adolescents (15, 17, 18, 20), and it is not possible to distinguish the influence of these exceptional stressogenic factors in this research.

CONCLUSION

Overall, the data show that the mental health of Zagreb's secondary school students was at high risk even before the COVID-19 pandemic and earthquakes, and restrictions and changes in the everyday life due to the pandemic and exposure to high-stress events additionally increased that risk. Females, adolescents whose families suffered material damage in the Zagreb earthquake, and those whose families have a weaker socioeconomic status are particularly at risk. Maladaptive coping strategies such as passive avoidance, rumination, indifference and aggression are significant predictors of depression, anxiety and stress. An additional significant predictor of depression is lower self-esteem, while parental rejection and greater dissatisfaction with physical appearance are predictors of anxiety, and female gender significant stress predictor. Still, not all adolescents had adverse mental health outcomes. Research into protective factors has shown that psychological resilience, constructive coping strategies and good family relationships could be key in

struktivne strategije suočavanja i dobri obiteljski odnosi mogu biti ključni u zaštiti mentalnog zdravlja djece i adolescenata. Te spoznaje treba koristiti u planiranju prevencije namijenjene svim adolescentima i planiranju širokog raspona ciljanih intervencija osnaživanja adaptabilnih strategija suočavanja što se odnosi na suočavanje usmjereno na problem (kontrola situacije, pozitivne samoupute, traženje socijalne podrške) i suočavanje usmjereno na emocije (distrakcija/rekreacija i umanjivanje), osobito za one najranjivije, a to su, kako je pokazalo ovo i druga istraživanja, u prvom redu djevojke i mladi koji odrastaju u siromaštvu. Sustavno se treba pristupiti i smanjivanju učinaka čimbenika rizika kao što su siromaštvo, prethodno identificirane teškoće mentalnog zdravlja, socijalna isključenost, razina urbanizacije i slično.

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protecting the mental health of children and adolescents. This knowledge should be used in the planning of prevention aimed at all adolescents and in planning of a wide range of targeted interventions aimed at strengthening adaptive coping strategies which refer to problem-focused (situation control, positive self-instructions, seeking social support) and to emotion-focused coping (distraction/recreation and minimizing). Especially for the most vulnerable ones, which, as this and other research has shown, are primarily females and young people growing up in poverty. A systematic approach should also be taken to reduce the effects of risk factors such as poverty, previously identified mental health difficulties, social exclusion, the level of urbanisation, and the like.

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Kulturološka prilagodba kognitivno-bihevioralne terapije – doprinos učinkovitosti

/ Cultural Adaptation of Cognitive-Behavioral Therapy – a Contribution to Efficacy

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Kognitivno-bihevioralna terapija (KBT) prva je linija tretmana indicirana za široki raspon poremećaja mentalnog zdravlja. Navedeni pristup reflektira europsko-američke vrijednosti, a potrebno je uvažiti kako i kultura pojedinca oblikuje percepciju zdravlja, uvjerenja o uzrocima tegoba te pristup njihovu liječenju. Upravo se stoga preporučuje kulturološka prilagodba psiholoških tretmana. Unatoč tome empirijski nalazi o učinkovitosti takvih tretmana još su skromni. Cilj ovog sustavnog preglednog rada bio je sintetizirati dokaze o učinkovitosti kulturološki prilagođene kognitivno-bihevioralne terapije u usporedbi s neprilagođenom formom u izvanbolničkom kontekstu te ocijeniti kvalitetu tih studija. Istraživanje je provedeno u skladu sa smjernicama PRISMA-P, a prikazana su randomizirana kontrolirana istraživanja objavljena na engleskom jeziku. Uključene su studije koje su ispitivale učinkovitost kulturološki adaptirane i standardne forme KBT-a, bez obzira na modalitet provedbe i vrstu teškoća. U pretraživanje su uključene elektronske bibliografske znanstvene baze, psychINFO i PubMed, registri primarnih studija, Cochrane knjižnica CENTRAL i Gov. Trial baza te izvori sive literature, www.opengrey.eu, DART. U pretraživanje je uključen i Web of Science. Unatoč malom broju studija koje su ispunile kriterij za uključivanje te evidentiranim metodološkim nedostatcima, nalazi ovog istraživanja idu u prilog učinkovitosti kulturološki adaptirane u odnosu na standardnu formu KBT tretmana.

/ Cognitive-behavioral therapy (CBT) is the first line of treatment indicated for a wide range of mental health disorders. This approach reflects Western values, and it is necessary to take into account the fact that the culture of every person also shapes the perception of health, beliefs about the causes of difficulties and the access to the treatment thereof. For that reason, cultural adaptation of psychological treatments is recommended. Despite this, empirical analyses on the effectiveness of such treatments are still scarce. The aim of this review paper is to synthesize evidence on the effectiveness of culturally adapted cognitive-behavioral therapy in comparison to standard form in an outpatient context as well as to evaluate the quality of these studies. The study was conducted in accordance with PRISMA-P guidelines and presents randomised controlled trials published in English. We have included studies that examined the effectiveness of culturally adapted and standard forms of CBT, regardless of the implementation modality or the type of difficulty. To identify studies, the electronic bibliographic databases psychINFO and PubMed, primary study registers, Cochrane Library CENTRAL and Gov.Trial database, and selected grey literature sources www.opengrey.eu and DART were screened. Web of Science was also included in the screening process. Despite a limited number of studies that met the inclusion criteria and methodological deficiencies, the findings of this study support the effectiveness of culturally adapted CBT treatment in comparison with the standard one.

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UVOD

Perspektive u kulturološki osjetljivoj kliničkoj praksi

Multikulturalnost u savjetovanju i psihoterapiji jedan je od istaknutijih pristupa u integraciji savjetodavne teorije i prakse (1) i zauzima sve važnije mjesto u području kliničke psihologije. Prema Pedersonu (2) upravo je multikulturalna psihologija (3) jedan od najznačajnijih pristupa u kontekstu razumijevanja ljudskog ponašanja. Potrebno je istaknuti kako postoje različite perspektive oko toga na koji način navedeno pretočiti u kliničku praksu. Naime, dio praktičara i istraživača naglašavao je potrebu za razvojem kulturološki osjetljivih tretmana, dok je dio inzistirao na univerzalnoj primjenjivosti znanstveno utemeljenih tretmana. Treća opcija donosi ravnotežu između fleksibilnosti u planiranju i primjeni kako bi tretman bio kulturološki osjetljiv te ujedno poštivao pretpostavke znanstveno utemeljene psihološke prakse (4).

Multikulturalno savjetovanje (MTC) (5) je metateorijski pristup koji prepoznaje kako su različiti pristupi tretmanu i njihovi ishodi uvijek pod utjecajem kulturnog konteksta. Iz navedenog proizlaze i opće pretpostavke samog pristupa poput uključivanja cjelovitosti svih kulturoloških utjecaja pri postavljanju

INTRODUCTION

Perspectives in culturally sensitive clinical practice

Multiculturalism in counselling and psychotherapy is one of the more prominent approaches in integrating counselling theory and practice (1) and occupies an increasingly important position in the field of clinical psychology. According to Pederson (2), multicultural psychology (3) is one of the most significant approaches in the context of understanding human behaviour. It should be noted that there are different perspectives on how to translate this into clinical practice. In other words, some practitioners and researchers have emphasized the need to develop culturally sensitive treatments, while others have insisted on the universal applicability of evidence-based treatments. The third option has introduced a balance between flexibility in planning and application in order to make the treatment culturally sensitive and at the same time respect the assumptions of evidence-based psychological practice (4).

Multicultural counselling (MTC) (5) is a metatheoretical approach that acknowledges how various approaches to treatment and their outcomes are always influenced by a cultural context. All of the above leads to the general assumptions about the approach, such as the in-

ciljeva i planiranja tretmana, uvažavanja klijentovog shvaćanja teškoća, naglaska na konzistentnosti s kulturološkim identitetom, životnom poviješću i iskustvima osobe koja dolazi na terapiju ili savjetovanje, uključivanje zajednice i resursa dostupnih u zajednici, poticanje svijesti o sebi u socijalnom kontekstu i dr.

Nasuprot metateorijskom pristupu postoje i istraživači koji promiču znanstveno utemeljene tretmane kao terapiju izbora i zadovoljavajućih ishoda u raznolikim kulturološkim okvirima. U tom kontekstu kulturološke prilagodbe kritizirane su kao dodatni ulog uz mali povrat dobiti. Tako su primjerice, Marchand i sur. (6) evidentirali kako je program prevencije depresije za adolescente po kognitivno-bihevioralnim principima producirao slične efekte za adolescente azijskog, latinoameričkog i europskog podrijetla. S druge strane, noviji empirijski nalazi idu u prilog učinkovitosti kulturološki prilagođenih tretmana, tj. potkrepljuju tezu o mogućnosti pomirenja ranije opisanih pristupa. Meta-analiza iz 2011. godine (7) evidentira kako je kulturološki prilagođeni tretman učinkovitiji od standardne forme (d = 0,32). I kasnije meta-analize, primjerice ona iz 2016. godine (8), potvrđuju višu učinkovitost kulturološki adaptirane u odnosu na neadaptiranu formu psiholoških intervencija (g = 0,52). Usto, meta-analiza iz iste godine (9) potvrđuje ranije nalaze i dodaje kako su tretmani koji su u većoj mjeri prilagođeni, tj. oni koji uključuju veći broj kulturoloških prilagodbi rezultirali statistički značajnijim učinkom.

Imajući u vidu tendencije globalizacije i internacionalizacije, kao i raznovrsnost ciljanih populacija i zajednica, jasna je potreba za kulturnim prilagodbama psiholoških tretmana (10). S tim ciljem su razvijeni različiti modeli kulturoloških adaptacija psiholoških tretmana, pa tako i kognitivno-bihevioralne terapije.

clusion of all cultural influences in setting goals and planning treatments, respecting the client's understanding of difficulties, an emphasis on consistency with cultural identity, life history and experiences of a person undergoing therapy or counselling, involvement of community and all resources available within the community, encouraging self-awareness in a social context, etc.

In contrast to the metatheoretical approach, there are also researchers who promote evidence-based treatments as a therapy of choice and satisfactory outcomes in diverse cultural frameworks. In this context, cultural adjustments have been criticized as an additional stake with a small return on profits. For example, Marchand et al. (6) recorded that the adolescent depression prevention programme following the cognitive-behavioral principles produced similar effects for adolescents of Asian, Latin American and European descent. On the other hand, recent empirical findings support the effectiveness of culturally adapted treatments, i.e., they support the thesis about the possibility of reconciling the approaches described earlier. A meta-analysis from 2011 (7) recorded that a culturally adapted treatment was more effective than the standard form (d = 0,32). Later meta-analyses, for example one conducted in 2016 (8), confirmed a higher efficacy of the culturally adapted compared to the unadapted form of psychological interventions (g = 0,52). In addition, a meta-analysis from the same year (9) confirmed earlier findings and added the finding that treatments that were more adapted, i.e., those involving a greater number of cultural adaptations resulted in a statistically more significant effect.

Bearing in mind the tendencies of globalization and internationalization, as well as the diversity of target populations and communities, there is a clear need for cultural adaptations of psychological treatments (10). To this end, different models of cultural adaptations of psychological treatments have been developed, including cognitive-behavioral therapy.

Potreba za kulturološkim prilagodbama psiholoških tretmana

Kessler i sur. su 2009. (11) proveli epidemiološku studiju koja je uključivala 28 zemalja te su evidentirali kako se cjeloživotna prevalencija mentalnih poremećaja kreće između 18 % i 36 % na globalnoj razini. Evidentno je kako kultura pojedinca oblikuje percepciju zdravlja i dobrobiti, uvjerenja o uzrocima i tretmanu, sklonost traženju pomoći, kao i ostala ponašanja vezana za zdravlje (12). Većina psiholoških tretmana razvijena je i evaluirana u zapadnim zemljama (13). Dodatno, etničke manjine su često manje zastupljene u randomiziranim kontroliranim ispitivanjima učinkovitosti tretmana (14).

Praksa utemeljena na dokazima u psihologiji uz integraciju empirijskih nalaza i kliničke ekspertize posebno ističe važnost karakteristika pojedinca, kulture i osobnih preferencija. Ova tri aspekta ostaju vodeći principi i u slučaju empirijski validiranih tretmana. Navedeni principi relevantni su i za područje psihološke procjene. Kulturološke osobitosti pojedinih kliničkih slika opisane su i navedene i u dijagnostičkim priručnicima (15). Stručnjaci u području psihičkog zdravlja trebaju poticati kulturalno osjetljive pristupe imajući na umu da kultura značajno utječe na tip simptoma i rizične faktore povezane s pojedinim psihičkim poremećajima.

Nalazi o učinkovitosti kulturoloških prilagodbi kognitivno-bihevioralnih tretmana

Kognitivno-bihevioralnu terapiju (KBT) možemo definirati kao: „Aktivan, direktivan, vremenski ograničen, strukturiran pristup utemeljen na teorijskoj pretpostavci kako su emocije i ponašanje neke osobe u velikoj mjeri određeni načinom na koji ta osoba strukturira svijet" (16). Navedeni terapijski pristup utemeljen je

The need for cultural adaptations of psychological treatments

In 2009, Kessler et al. (11) conducted an epidemiological study involving 28 countries and recorded that the lifelong prevalence of mental disorders ranged between 18% and 36% at the global level. It is evident that the culture of the individual shapes the perception of health and well-being, beliefs about causes and treatment, tendency to seek help, as well as other behaviors related to health (12). Most psychological treatments have been developed and evaluated in Western countries (13). Additionally, ethnic minorities were very often less represented in randomised controlled studies on treatment effectiveness (14).

In addition to the integration of empirical findings and clinical expertise, evidence-based practice in psychology particularly emphasizes the importance of an individual's characteristics, culture and personal preferences. These three aspects are still the guiding principles also in the case of empirically validated treatments. The above principles are also relevant for the field of psychological assessment. Cultural specificities of certain clinical images are described and listed in diagnostic manuals (15). Experts in the field of mental health should encourage culturally sensitive approaches, bearing in mind that culture significantly affects the type of symptoms and risk factors associated with certain mental disorders.

Findings on the effectiveness of cultural adaptations of cognitive-behavioral treatments

Cognitive-behavioral therapy (CBT) can be defined as: "An active, directive, time-limited, structured approach based on the theoretical assumption that a person's emotions and behavior are largely determined by the way that person structures the world" (16). This therapeutic approach is based on a cognitive model and a solid therapeutic alliance. It is focused

na kognitivnom modelu, čvrstom terapijskom savezu, usmjeren na problem s kojim klijent dolazi, održavajuće i rizične faktore, psihoedukaciju i osnaživanje pojedinca, strukturiran je i vremenski ograničen te se temelji na procesima sokratovskog propitivanja i „vođenog otkrivanja" (17). Osim kognitivnih principa integrirani pristup uključuje i principe bihevioralnih terapija koje se temelje na teorijama učenja (18).

Iako su fleksibilnost primjene KBT-a i jaka empirijska baza osigurale široku primjenjivost, važno je spomenuti da je KBT razvijana, ocjenjivana i revidirana pretežno u okruženjima i na populacijama koje odražavaju specifičan europsko-američki skup vrijednosti (19). KBT uključuje rad s posredujućim i bazičnim vjerovanjima, a istraživanja ukazuju u prilog zaključku kako se sadržaj automatskih misli i vezana vjerovanja znatno razlikuju ovisno o kulturološkom kontekstu (20). Imajući na umu spomenute spoznaje o povezanosti sadržaja kognicija i kulture, smjernice vezane za praksu i tretmane koji se temelje na dokazima (21), kulturološke adaptacije empirijski validiranih tretmana zasigurno mogu pridonijeti fleksibilnosti u pristupu klijentu ne ugrožavajući vjernost znanstveno provjerenim KBT protokolima.

Što se tiče kriterija i opravdanosti uvođenja adaptacija Castro i sur. (22) identificirali su četiri znaka koja ukazuju na potrebu prilagodbe i već prisutnost jednog od njih opravdava uvođenje kulturološke adaptacije: 1. slabiji odaziv i češće odustajanje od tretmana u ciljnoj skupini, 2. specifični rizični i zaštitni faktori, 3. specifični simptomi u kontekstu kulturoloških sindroma i općenito kliničke slike, 4. nepovoljniji nalazi o učinkovitosti tretmana s obzirom na očekivane na temelju ranijih empirijskih nalaza. Nadalje, kako bi se očuvali ključni elementi tretmana, a ujedno i uvele relevantne kulturološke adaptacije, istraživači i praktičari usmjerili su se na izradu okvira za adaptaciju koji bi olakšao sam proces (23). Trenutačno dostupni nalazi istraživanja ukazuju u prilog

on the patient's problem, maintenance and risk factors, psycho-education and empowerment of the individual. At the same time, it is structured and time-limited and based on Socratic questioning and "guided discovery" (17). In addition to cognitive principles, the integrated approach also includes principles of behavioral therapies based on learning theories (18).

While the flexibility of CBT application and a strong empirical base have ensured broad applicability, it is important to note that CBT has been developed, evaluated, and revised predominantly in environments and populations that reflect a specific European-American set of values (19). CBT involves working with intermediate and basic beliefs, and research suggests that the content of automatic thoughts and related beliefs vary considerably depending on the cultural context (20). Bearing in mind the aforementioned findings about the connection between the content of cognition and culture, the guidelines related to the practice and evidence-based treatments (21), the cultural adaptations of empirically validated treatments can certainly contribute to flexibility in approaching the client without compromising the adherence to scientifically proven CBT protocols.

As for the criteria for and justification of introducing such adaptations, Castro et al. (22) have identified four signs indicating the need for adaptation. The presence of one of the signs justifies the introduction of cultural adaptation: 1. lower response and more frequent discontinuation of treatment in the target group, 2. specific risk and protective factors, 3. specific symptoms in the context of cultural syndromes and the clinical picture in general, 4. less favourable findings on the effectiveness of treatment with regard to the expected ones based on the earlier empirical findings. Furthermore, in order to preserve the key elements of treatment and introduce relevant cultural adaptations at the same time, researchers and practitioners focused on developing an adaptation framework that would

zaključku kako je kulturološki adaptiran KB tretman učinkovitiji i s nižim stopama odustajanja u odnosu na neadaptiranu formu KB tretmana. Pregled meta-analiza iz 2018. (24) daje podatak o tome kako 12 meta-analiza koje su uključene u studiju izvještava o umjerenim do visokim efektima za kulturološki adaptirane forme tretmana. Većina studija se odnosila upravo na KB tretman. Na kraju je potrebno istaknuti kako su još uvijek rijetke studije koje bi uključivale usporedbu adaptirane i neadaptirane forme kognitivno-bihevioralnog tretmana (23). Upravo je stoga vrlo važno sistematizirati dostupne empirijske nalaze uz poticanje daljnjih primarnih istraživanja u tom području.

CILJ RADA

Cilj ovog sustavnog preglednog rada bio je dati detaljan pregled dokaza o učinkovitosti kulturološki prilagođenog kognitivno-bihevioralnog tretmana u usporedbi s neprilagođenom formom u populaciji izvanbolničkih pacijenata. U radu su prikazana randomizirana kontrolirana istraživanja te je ocijenjena i njihova kvaliteta prema standardiziranom protokolu za procjenu rizika od pristranosti RoB 2.0. (25). RoB 2.0 je namijenjen procjeni rizika od pristranosti u randomiziranim kliničkim ispitivanjima. Radi se o ljestvici koja uključuje pet domena s naglaskom na postupak randomizacije i odstupanja od planiranih intervencija. Sve odabrane randomizirane kontrolirane studije procijenjene su u odnosu na unaprijed definirane kriterije navedenog alata od dva neovisna procjenjivača. Nesuglasja u procjeni razriješena su kompromisom nakon detaljnog pregleda bilješki i ocjene algoritma uz refleksiju na kriterije.

METODE

Ovo je istraživanje sustavni pregled koji je planiran i proveden u skladu sa smjernicama PRISMA-P (26) i uključuje kvalitativnu sintezu

facilitate the process (23). Currently available research findings support the conclusion that a culturally adapted CB treatment is more effective and has lower withdrawal rates compared to an unadapted form of CB treatment. A 2018 review of 12 meta-analyses included in the study (24) reported moderate to high effects of culturally adapted forms of treatment. Most of the studies focused on CB treatment. Finally, it is necessary to point out that there is still a very limited number of studies which include a comparison of adapted and unadapted forms of cognitive-behavioral treatment (23). For that reason, it is very important to systematize the available empirical findings and encourage further primary research in this area.

AIM

The aim of this systematic review paper was to provide a detailed review of the evidence on the efficacy of culturally adapted cognitive-behavioral treatment compared to an standard form of treatment in a population of outpatients. The paper presents randomized controlled studies and evaluates their quality using a standardized risk of bias tool RoB 2.0. (25) RoB 2.0 is intended to assess the risk of bias in randomised clinical trials. It is a scale that includes five domains with an emphasis on the process of randomization and deviations from planned interventions. All selected randomised controlled studies were evaluated in relation to the predefined RoB 2.0 criteria by two independent assessors. The discrepancies in the assessment were resolved by compromise after a detailed review of the notes and evaluation of the algorithm while taking into account the criteria.

METHODS

This study is a systematic review that was planned and conducted in accordance with PRISMA-P guidelines (26) and it includes a

nalaza. Istraživanja su ograničena na kognitivno-bihevioralni tretman i randomizirane kontrolirane studije zbog zahvaćanja jedinstvenog doprinosa kulturoloških prilagodbi u konkretnom psihoterapijskom pristupu.

S obzirom na cilj istraživanja i elemente preglednog rada u probiru relevantnih studija uključene su studije koje: 1. se bave usporedbom učinkovitosti kulturološki adaptirane kognitivno-bihevioralne terapije (Ka-KBT-a) i standardne kognitivno-bihevioralne terapije (KBT-a) u izvanbolničkom tretmanu, 2. uključuju randomizirane kontrolirane studije, 3. opisuju individualni i grupni tretman, savjetovanje, psihoterapiju i različite modalitete provedbe (telefonski, *online* i dr.) u smislu validiranih protokola i/ili dijelova protokola, 4. su napisane na engleskom jeziku, bez obzira na datum objave i dob sudionika.

U pretraživanje koje je učinjeno u listopadu 2021. godine uključene su dvije elektronske bibliografske znanstvene baze, psychINFO i PubMed. Pretraživanje je provedeno kombinacijom MeSH termina *cultural adaptation, culturally adapted, cultural modifications, CBT, Cognitive Behavioral Therapy, Behavioral Cognitive Therapy* s prilagodbom pravopisnih varijacija te je prilagođeno svakoj od pretraživanih baza. Kako bi se osigurala što kvalitetnija pretraga, konzultiran je i znanstveni knjižničar. U procesu pretraživanja literature uključena su i dva registra primarnih studija, tj. kliničkih ispitivanja - *Cochrane knjižnica CENTRAL* i *Gov.Trial baza*. Pretraživanje je još uključilo i WoS (Web of Science) s prvih 100 relevantnih referenci.

Kako bi se povećao obuhvat potencijalno relevantnih izvora pretražena je i siva literatura. Siva literatura uključuje sve javno dostupne informacije iz različitih izvora, poput jedinica samouprave, istraživačkih instituta, obrazovnih institucija, realnog i drugih sektora koje su dostupne u tiskanom ili elektronskom izdanju kojima nakladništvo nije osnovna djelatnost (27). Tako su u pretragu uključeni i registri

qualitative synthesis of findings. The research has been limited to cognitive-behavioral treatment and randomized controlled studies due to the unique contribution of cultural adaptations in a concrete psychotherapeutic approach.

Having in mind the aim of the research as well as relevant elements of systematic review process primary studies were included based on the following criteria: 1. compared the effectiveness of culturally adapted cognitive-behavioral therapy (CA-CBT) and standard cognitive-behavioral therapy (CBT) in outpatient treatment, 2. included randomized controlled studies, 3. described individual and group treatments, counselling, psychotherapy and various implementation modalities (telephone, online, etc.) and validated protocols and/or parts of the protocol, 4. were written in English, regardless of the date of publication and the participants' age.

The research conducted in 2021 included two electronic bibliographic databases, psychINFO and PubMed. The search was conducted using a combination of the following MeSH terms: *cultural adaptation, culturally adapted, cultural modifications, CBT, Cognitive Behavioral Therapy, Behavioral Cognitive Therapy* where spelling variations were adapted to each database. In order to provide the highest quality of search, a scientific librarian was consulted. In the process of literature search, two registers of primary trials or clinical trials were also included, i.e., *Cochrane Library CENTRAL* and *Gov.Trial database*. The search also included the Web of Science (WoS) with the first one hundred relevant references.

To increase the scope of potentially relevant sources, grey literature was also searched. Grey literature includes all publicly available information from various sources, such as self-government units, research institutes, educational institutions, real and other sectors available in print or electronic editions, to which publishing is not the main activity (27). Thus, the search also included the registers www.opengrey.eu

www.opengrey.eu i *DART*. Dodatno, unakrsno su u bazi *Scopus* referencirane unaprijed i unatrag studije odabrane kao relevantne za istraživačko pitanje kako bi se obuhvatilo što više potencijalno relevantnih izvora.

Podatci o studijama izvezeni su u program za upravljanje referencama i pregledne studije *Rayyan* (28). Naslovi i sažetci svake reference identificirani u pretraživanju konvertirani su u odgovarajući format te su u dodatnom koraku identificirani duplikati. Potom su sve reference evaluirane u odnosu na unaprijed definirane kriterije za uključivanje i isključivanje od dvaju neovisnih procjenjivačica koje su ujedno i autorice rada (IM, NJB). Zatim se pristupilo pregledavanju potencijalno relevantnih radova u cjelovitom obliku. Budući da su pridružene heterogene kliničke slike, u pregled su uključena sva istraživanja koja su kao mjeru poboljšanja uključila rezultate na ljestvicama za evaluaciju ishoda tretmana.

U svrhu procjene kvalitete uključenih studija korišten je instrument RoB 2.0 (*Risk-of-bias tool for randomized trials*). Ovaj alat na raspolaganju je za procjenu rizika od pristranosti u randomiziranim kliničkim ispitivanjima (25). Sve odabrane studije procijenjene su u odnosu na unaprijed definirane kriterije navedenog alata od dva neovisna procjenjivača (IM, NJB).

REZULTATI

Dijagram tijeka probira i uključenja studija (slika 1.) daje kratak pregled procesa. Nakon identifikacije 69 istovjetnih izvještaja uz pomoć programa Rayyan (28) preostalo je 165 izvora pronađenih u bazama podataka PubMed i psycINFO te 72 izvora pronađenih u registrima randomiziranih kontroliranih studija. Pretraživanjem drugih izvora sive literature poput DART, WoS, kao i unakrsnom pretragom, evidentirano je dodatnih 98 izvora. Probirom pomoću sažetaka, a zatim pretragom punog teksta došlo se do rezultata od 128 izvora. Od

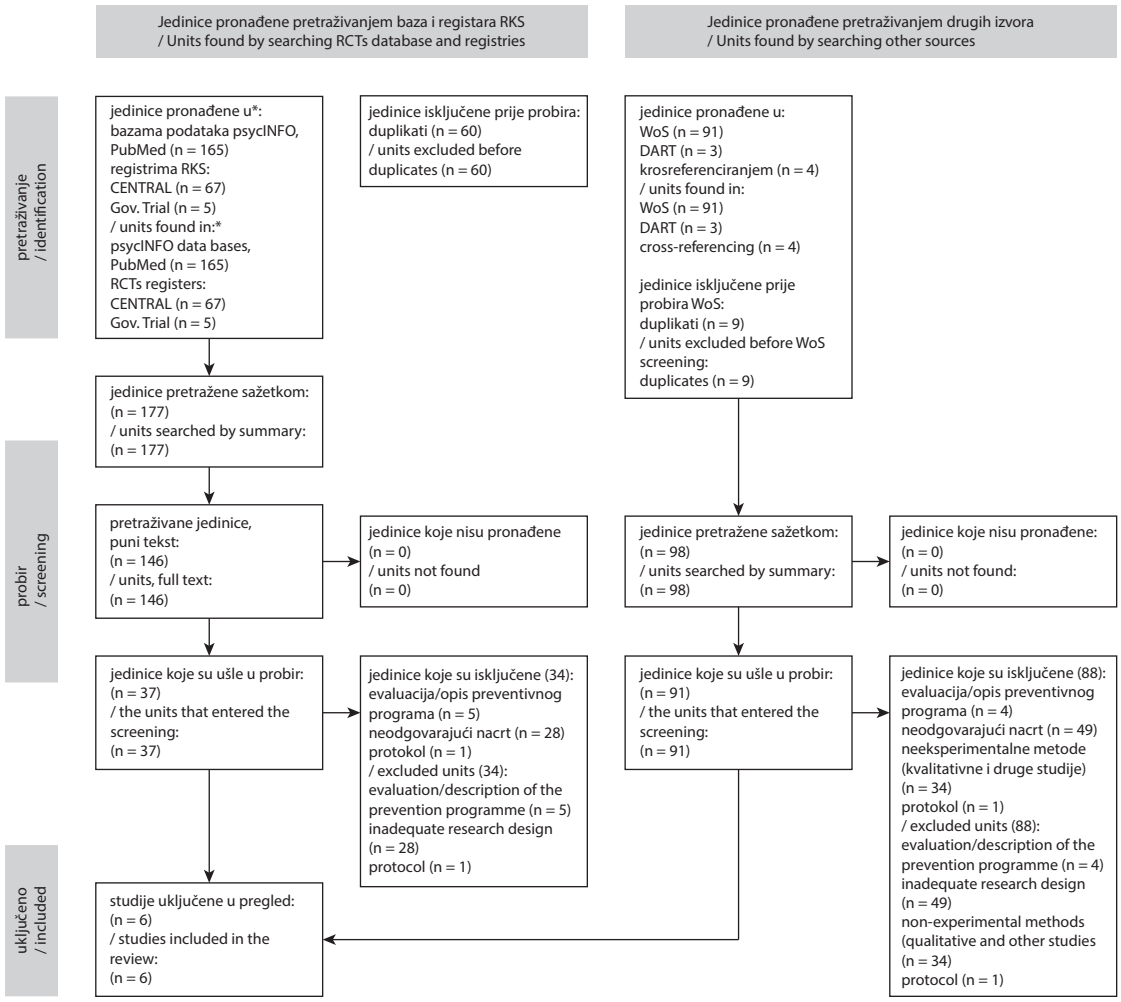
and DART. In addition, the trials relevant for the search were cross-referenced forward and backward in order to cover as many as possible potentially relevant sources.

The data were exported to Rayyan, a tool for reference and systematic literature reviews management (28). The titles and abstracts of each reference identified in the search were converted to the appropriate format and duplicates were identified in an additional step. After that, all references were evaluated against predefined inclusion and exclusion criteria by two independent assessors who are also the authors of the review paper (IM, NJB). The next step was to review all potentially relevant papers in a comprehensive form. Given that heterogeneous clinical presentations were also linked, we incorporated all studies that included results on the treatment outcome evaluation scales.

Risk of bias tool for randomized trials (RoB 2.0) was used to assess the quality of the included studies. This tool is available for the assessment of the risk of bias in randomised clinical trials (25). All selected studies were evaluated against the predefined RoB criteria by two independent assessors (IM, NJB).

FINDINGS

A flow diagram of the course of screening and inclusion of studies (Figure 1) provides a brief overview of the process. After identifying 69 identical Rayyan reports (28), 165 sources found in PubMed and psycINFO databases remained together with 72 sources found in randomised controlled study registries. After searching other grey literature sources such as DART, WoS, as well as cross-searching, additional 98 sources were recorded. Screening of abstracts and searching full texts resulted in 128 sources. Of these, 122 were excluded for the following reasons: 1. the programmes were preventive rather than treatment (7%), 2. re-



SLIKA 1. Dijagram tijeka probira i uključenja studija
FIGURE 1. Flow diagram of the course of screening and inclusion of studies

tog broja 122 ih je isključeno zbog sljedećih razloga: 1. preventivni, a ne tretmanski programi (7 %), 2. neodgovarajući nacrti istraživanja u smislu pasivne kontrole ili aktivne kontrole koju je predstavljala druga intervencija, a ne adaptacija standardnog protokola (60 %), 3. kvalitativne studije (27 %) i 4. protokoli (2 %). Nakon završnog probira uključeno je šest studija koje ispunjavaju kriterije uključenja i isključenja (29-34).

U nastavku je prikazan kratak pregled obilježja šest uključenih studija. Radi se o randomiziranim kontroliranim studijama od kojih su dvije bile nadogradnja na probne-studije. Postupak regrutacije i randomizacije detaljnije je opisan u polovici studija, kao i osipanje sudionika, te u dodatnim analizama vezanima za pridržasearch design was inadequate in terms of passive control or active control represented by an intervention other than the adaptation of the standard protocol (60%), 3. qualitative studies (27%) and 4. protocols (2%). After the final screening, six studies that meet the inclusion and exclusion criteria were included (29-34).

Below is a brief overview of the characteristics of the six included studies. These are randomised controlled studies, two of which were upgrades to pilot studies. The recruitment and randomization process was described in more detail in half of the studies, as well as the atrition of study participants, and in additional analyses related to adherence to protocols, i.e. procedures in treatments and potential moderator variables such as the quality of therapeutic

vanje protokola, tj. postupaka u tretmanima i potencijalnim moderatorskim varijablama poput kvalitete terapijskog odnosa, identifikacije s identitetom manjinske skupine ili stupnja akulturacije. Navedeno je u skladu i s nalazima ranijih metaanaliza, a u smjeru povoljnijih ishoda adaptiranih verzija tretmana za sudionike s nižom stopom akulturacije (35).

Studije su usmjerene na raznovrsne teškoće i poremećaje te uključuju zloporabu i ovisnost o opijatima, poremećaje raspoloženja i anksiozne poremećaje, a u postupku regrutacije i ulazne procjene u svim studijama korišteni su strukturirani intervjui usmjereni specifičnom tipu teškoća. Sve su studije uključivale i psihološke mjere ishoda poput standardiziranih psihologijskih upitnika. Uključene su u još dvije trećine studija i mjere specifične za određeni tip protokola i tretmana te indikatori povezani s akulturacijskim procesima i druge potencijalne moderatorske varijable. Od sekundarnih ishoda korištene su još ljestvice globalnog funkcioniranja.

Sva su istraživanja provedena u SAD-u na prigodnim populacijama i manjinskim grupama (Afroamerikanci, Latinoamerikanci i azijski Amerikanci) većinom srednje i kasne adolescentne dobi, dok jedna studija navodi samo interval od 18 do 65 godina bez jasnog izdvajanja podskupina. Navedene populacije ujedno su i najzastupljenije u kontekstu istraživanja povezanih s kulturološkim adaptacijama generalno. Tako novija meta-analiza iz 2020. (36) o kulturološki adaptiranim tretmanima depresije navodi kako se gotovo polovina uključenih studija odnosila na manjine u zapadnim zemljama od čega je većina provedena u Sjedinjenim Američkim Državama. Dodatno, radilo se o relativno malim i prigodnim uzorcima, posebice u probnim studijama koje čine trećinu uključenih sa studija, te o relativno kratkim tretmanima od kojih najdulji traje 16 sastanka, dok u polovini studija izostaju nalazi praćenja.

U polovini studija tretman su provodili bilingvalni stručnjaci sa sudionicima srodnog kulturološkog konteksta, studentima doktorskog

relationship, identification with the identity of a minority group of rate or degree of acculturation. The above-stated is in line with the findings of earlier meta-analyses and pointing to more favourable outcomes of the adapted versions of treatments of participants with lower acculturation rates (35).

The studies focused on a variety of difficulties and disorders including substance use disorders, mood disorders and anxiety disorders. All studies used structured interviews focused on a specific type of difficulty during the recruitment and entry assessment process. In addition to that, all studies also included psychological outcome measures such as standardized psychological questionnaires. Measures specific to a specific type of protocol and treatment, as well as indicators related to acculturation processes and other potential moderator variables were included in two thirds of studies. Global functioning scales were used as secondary outcomes.

All studies were conducted in the US on convenient samples and minority groups (African Americans, Latinos, and Asian Americans) comprised of mostly middle and late adolescents, while one study cited only the age interval of 18 to 65 years without clearly singling out any subgroups. These populations are also most represented in the context of the research related to cultural adaptations in general. A more recent meta-analysis conducted in 2020 (36) on culturally adapted treatments for depression stated that nearly half of the included studies focused on minorities in Western countries, most of which were conducted in the United States. In addition, the samples were relatively small and convenient especially in pilot studies that account for a trhird of those included in this research, and relatively short treatments, of which the longest lasted 16 sessions. In one half of the studies there were no follow-up findings.

Also, in one half of the studies, the treatment was carried out by bilingual experts with participants from a related cultural context, i.e.

studija psihologije koji su prošli dodatnu edukaciju s licenciranim stručnjakom. Dvije studije ne navode detalje o savjetnicima, ali sve uključene studije opisuju različita nastojanja oko pridržavanja protokola i priručnika kao što su ljestvice za praćenje, snimanje sastanaka, redovita supervizija i sl.

U trećini studija radilo se o intervencijama koje su propisane u okviru mjera pravnog sustava i sustava socijalne skrbi za značajan udio sudionika studija. Dvije studije ističu trend kako se manjinske skupine kasnije odlučuju za tretman, odnosno kada su već prisutne izražene teškoće te se primarni ishodi stoga odnose na klinički značajna poboljšanja, ali ne i potpunu remisiju (32,34). U nastavku je detaljniji opis uključenih studija.

Burrow-Sanchez i Wrona su 2012. (30) proveli probno istraživanje s ciljem utvrđivanja učinkovitosti kulturološki adaptiranog grupnog protokola u odnosu na neadaptiranu formu protokola vezano za zloporabu sredstava ovisnosti i ovisnost o psihoaktivnim supstancijama. Uzimajući u obzir skroman prigodni uzorak od 35 sudionika rezultati su upućivali na zaključak o relativnoj učinkovitosti adaptirane verzije u kojoj su sudionici s višim etničkim identitetom i većom privrženosti obitelji izvještavali o povoljnijim ishodima. Prvi je autor u nastavku proveo randomiziranu kontroliranu studiju (29) s dodatnim točkama praćenja nakon 6 i 12 mjeseci na uzorku od 70 Latinoamerikanaca adolescentske dobi, uz stratifikaciju sudionika koji su uzimali i farmakoterapiju tijekom tretmana. Rezultati obrade upućivali su, također, na superiornost adaptirane u odnosu na neadaptiranu verziju tretmana u praćenju i nakon 12 mjeseci nakon završetka tretmana, dok je privrženost obitelji u značajnoj mjeri moderirala ishod. Huey i Pan 2006. (31) proveli su probno istraživanje na prigodnom uzorku od 15 odraslih azijskih Amerikanaca radi evaluacije učinkovitosti kulturološki adaptiranog individualnog tretmana za fobije. U jednom

PhD students who underwent additional education with a licensed specialist. Two studies did not provide details about advisors, but all included studies described various efforts to adhere to protocols and manuals, such as monitoring scales, meeting recordings, regular supervision, etc.

One third of the studies involved interventions that were prescribed under the measures of the legal and social welfare system for a significant proportion of study participants. Two studies pointed out the trend where minority groups opted for treatment later on, i.e. when there were already experiencing considerable difficulties. Therefore, the primary outcomes were related to clinically significant improvements, but not to complete remission (32, 34). Below is a more detailed description of the included studies.

In 2012, Burrow-Sanchez and Wrona (30) conducted a pilot study with the aim of determining the effectiveness of the culturally adapted group protocol in comparison to an unadapted protocol focused on substance use disorders. Taking into account a modest sample of 35 participants, the results pointed to a conclusion about the relative effectiveness of the adapted version in which participants with a higher ethnic identity and greater attachment to the family reported more favourable outcomes. The first author conducted a randomized controlled study (29) with additional follow-up points after 6 and 12 months on a sample of 70 Latin American adolescents with the stratification of participants who also took pharmacotherapy during the treatment. Among other things, the results indicated superiority of the adapted in comparison to the unadapted version of the treatment in the follow-up even after 12 months following the end of the treatment. The attachment to the family significantly moderated the outcome. In 2006, Huey and Pan (31) conducted a trial study on a sample of 15 Asian American adults to evaluate the effectiveness of

sastanku u trajanju od 3 sata koji je utemeljen na izlaganju i modeliranju - OST (*One-Session Treatment*) naspram neadaptiranoj OST formi te priručniku za samopomoć. Izbjegavanje je bilo znatno niže za sudionike u situaciji kulturološki adaptiranog tretmana u usporedbi sa situacijom samopomoći (priručnik temeljen na KB principima), ali samo marginalno značajno u odnosu na standardni format. Osim toga, kulturološki adaptirana forma pokazala se superiornom u odnosu na ostale dvije situacije u smanjenju katastrofiziranja i izbjegavanja. Prvi autor je sa suradnicima, nakon 6 mjeseci, proveo još jednu randomiziranu kontroliranu studiju (32) na prigodnom uzorku od 30 odraslih azijskih Amerikanaca, s dodatnom točkom praćenja. Studija je dodatno uključila i evaluaciju potencijalnih moderatorskih varijabli. I u ovom se slučaju kulturološki adaptirana OST pokazala superiornom u odnosu na standardni protokol za skupinu sudionika s nižim stupnjem akulturacije. Hwang i sur. su 2015. (32) proveli istraživanje na 50 odraslih azijskih Amerikanaca s dijagnozom velike depresivne epizode radi utvrđivanja relativne učinkovitosti kulturološki adaptiranog individualnog protokola u odnosu na standardiziranu formu tretmana. Randomizacija je uključila i stratifikaciju sudionika koji su uzimali farmakoterapiju tijekom tretmana. Kod sudionika iz situacije kulturološki adaptiranog tretmana evidentirano je veće poboljšanje nego kod sudionika iz aktivne kontrole.

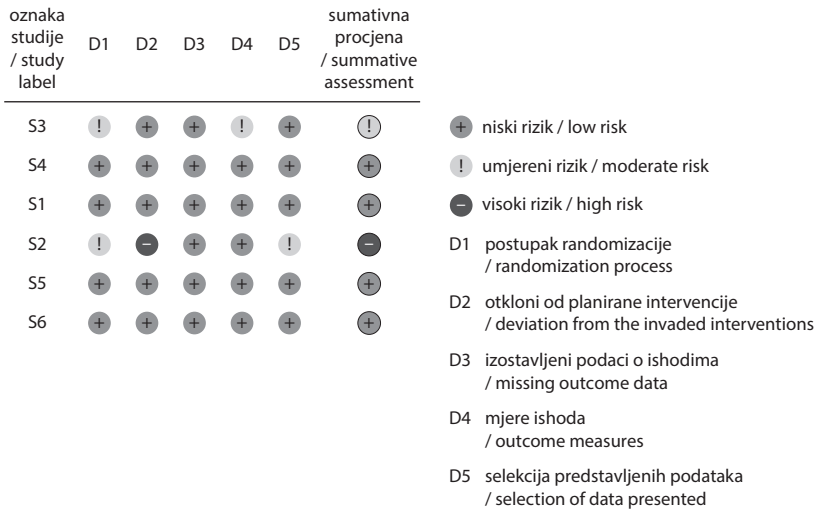
Na kraju, kontrolirana randomizirana studija koju su 2002. (34) na uzorku 20 Afroamerikanki s višestrukim teškoćama i izraženim depresivnim simptomima proveli Kohn i sur. također ukazuje u prilog kulturološki adaptirane verzije grupnog tretmana za depresiju u odnosu na standardnu formu. Potrebno je istaknuti kako su u obje skupine evidentirane perzistentne teškoće srednjeg intenziteta i nakon završetka tretmana.

Metodološka kvaliteta uključenih studija procijenjena je uz pomoć algoritma i smjernica navedenih u protokolu RoB 2.0. (slika 2.). Rando-

culturally adapted individual treatment for phobias. In one 3-hour meeting based on exposure and modelling - OST (*One-Session Treatment*) as opposed to an unadapted OST form and a self-help manual. It was observed that avoidance was much lower for participants in the culturally adapted treatment compared to the self-help situation (the manual was based on CB principles), but that was only marginally significant compared to the standard format. In addition, the culturally adapted form proved superior to the other two situations in reducing in terms of catastrophizing and avoidance. After 6 months, the first author and the collaborators conducted another randomized controlled study (32) on a sample of 30 Asian American adults, adding an additional follow-up point. The study additionally included the evaluation of potential moderator variables. In this case, too, the culturally adapted OST proved to be superior to the standard protocol for a group of participants with a lower degree of acculturation. In 2015, Hwang et al. (32) conducted a study on 50 Asian American adults diagnosed with major depressive disorder epizode to determine the relative effectiveness of a culturally adapted individual protocol as compared to a standardized form of treatment. Randomization also included the stratification of participants using pharmacotherapy during the treatment. In participants undergoing the culturally adapted treatment, greater improvement was recorded than in participants from the active control.

Finally, Kohn et al. conducted a controlled randomised trial in 2002 (34) on a sample of 20 African-American women with multiple difficulties and pronounced depressive symptoms also pointed to the superiority of the culturally adapted form of group treatment for depression compared to the standard form. It should be noted that persistent difficulties of moderate intensity were recorded in both groups even after the end of the treatment.

Methodological quality of the included studies was assessed using an algorithm and the



SLIKA 2. RoB 2.0 grafički prikaz
FIGURE 2. RoB 2.0 diagram

mizirane kontrolirane studije procijenila su dva neovisna procjenjivača (IM, NJB). Dvije trećine studija generalno su procijenjene niskim rizikom pristranosti, dok su procjene preostalih studija rezultirale jednom procjenom umjerenog rizika pristranosti, uz jednu studiju za koju je procijenjeno da ima visoki rizik od pristranosti.

guidelines specified in RoB 2.0 (Figure 2). The randomized controlled studies were evaluated by two independent assessors (IM, NJB). Two-thirds of the studies were generally assessed at a low risk of bias, while the assessments of the remaining studies resulted in one assessment of moderate risk bias and one assessment of a high risk of bias.

RASPRAVA

Cilj ovog istraživanja bio je dati detaljan pregled dokaza o učinkovitosti kulturološki prilagođenog kognitivno-bihevioralnog tretmana u usporedbi s neprilagođenom formom. Razmatrane su randomizirane kontrolirane studije te je analizirana kvaliteta navedenih studija. Usprkos metodološkim ograničenjima, prigodnim i relativno malim uzorcima, nalazi svih odabranih studija ukazuju na relativnu učinkovitost kulturološki adaptiranih verzija kognitivno-bihevioralnih tretmana u odnosu na neadaptiranu formu za različite dobne skupine i u slučaju heterogenih teškoća. Ovo je istraživanje jedno od rijetkih koje je metodom sustavnog preglednog rada istražilo učinkovitost kulturološki prilagođene KBT u usporedbi s neprilagođenom formom.

DISCUSSION

The aim of this study was to provide a detailed review of the evidence on the effectiveness of culturally adapted cognitive-behavioral treatment compared to an unadapted form. Focus was placed on randomized controlled trials and their methodological quality. Despite certain methodological limitations, convenient and relatively small samples, the findings of all selected studies indicated relative efficacy of the culturally-adapted versions of cognitive-behavioral treatments in relation to the unadapted form for different age groups also in case of heterogeneous difficulties. This study is one of the few that investigated the effectiveness of culturally adapted CBT compared to the unadapted form using a systematic review method.

Ovaj sustavan pregled prije svega ukazuje na vrlo mali broj radova koji se na valjan i pouzdan način bavio temom usporedbe kulturalno adaptiranih KBT pristupa i standardnog KBT-a u izvanbolničkom tretmanu. Ako se zna da KBT kao jednu od svojih vrijednosti ističe znanstvenu utemeljenost, onda ovaj mali broj istraživanja svakako ukazuje na brojne izazove koje ovakva istraživanja nose sa sobom. Navest ćemo neke od njih.

Iako su generalno nalazi preglednih radova vezani za učinkovitost kulturološki adaptiranih psiholoških tretmana obećavajući (34,37), česta je zamjerka kako nisu temeljeni na aktivnoj kontroli. Drugim riječima, nedostaju usporedbe kako sa standardiziranim protokolima, tako i s drugim vrstama kontrolnih skupina. Ujedno, učestalo je i uspoređivanje različitih oblika tretmana što umanjuje mogućnost generalizacije nalaza i zaključaka o učinkovitosti kulturoloških adaptacija.

Neki od ranije navedenih izazova u ovom području istraživanja evidentirani su i u ovom preglednom radu. Čak i u slučaju odabranih studija evidentno je kako su sva istraživanja provedena u SAD-u na prigodnim populacijama i manjinskim grupama različitog stupnja akulturacije (Afroamerikanci, Latinoamerikanci i azijski Amerikanci). Tako se primjerice u trećini studija radilo o intervencijama koje su propisane u okviru mjera pravnog sustava i sustava socijalne skrbi za značajan udio sudionika studija ili o prigodnom uzorku studenata, što ograničava mogućnost generalizacije zaključaka (30,31). Nadalje, i ovdje se radilo o pacijentima s različitim intenzitetom teškoća u izvanbolničkom kontekstu. U studiji autora Burrow-Sanchez (29) su tako uključeni sudionici koji ispunjavaju kriterije za zloporabu, ali i oni koji ispunjavaju kriterij za ovisnost, dok je u probnoj-studiji Hueya i Pana (31) navedeno kako je većina sudionika ispunila barem tri kriterija za specifičnu fobiju bez navođenja detalja. Proširivanje uzorka, kao i adaptacije

This review primarily points to a very small number of papers that compared culturally adapted CBT approaches and the standard CBT in outpatient treatment in a valid and reliable way. Given that one of the basic advantages of CBT is its scientific foundation, a small number of studies unequivocally points to numerous challenges that this type of research implies. Here we provide a list of some of them.

Although the findings of review papers focusing on the effectiveness of culturally adapted psychological treatments are considered to be promising (34,37) in general, it is a common complaint that they are not based on the active control. In other words, there is a general lack of comparisons both with standardized protocols and other types of control groups. At the same time, various forms of treatment are frequently compared, which reduces the possibility of making general findings and conclusions about the effectiveness of cultural adaptations.

Some of the above mentioned challenges in this area of research were also recorded in this review paper. Even in the case of the selected studies, it is evident that all studies were conducted on convenient populations and minority groups in the United States had varying degrees of acculturation (African Americans, Latinos, and Asian Americans). For example, one third of the studies involved interventions prescribed within the framework of the legal and social welfare system for a significant proportion of study participants or an appropriate sample of students, thus limiting the possibility of making general conclusions (30,31). Furthermore, this group of patients had a varying intensity of difficulties in an outpatient context. Burrow-Sanchez conducted a study (29) that included the participants who met the criteria for abuse as well as those who met the criteria for addiction, while a trial study conducted by Huey and Pan (31) found that most participants met at least three criteria for a specific phobia without specifying details. Ex-

protokola za različite tipove teškoća, a i homogenizacija prema izraženosti simptoma također bi doprinijeli većoj mogućnosti poopćavanja (generalizabilnosti) zaključaka.

Sve uključene studije opisivale su korištenje standardiziranih psiholoških mjera ishoda tretmana poput standardiziranih psihologijskih upitnika i strukturiranih intervjua pri regrutaciji i probiru. U dvije trećine studija uključene su još i mjere specifične za određeni tip protokola i tretmana te indikatori povezani s akulturacijskim procesima i drugim potencijalnim moderatorskim varijablama.

Većina navedenih mjernih instrumenata izrađena je i normirana na populacijama koje ne reflektiraju kulturološki kontekst i posebnosti uzorka sudionika koji su uključeni u opisane studije što može rezultirati nereprezentativnim ishodima. Na tragu toga istraživači u području ukazuju na potrebu za kulturološkim adaptacijama mjera korištenih u istraživanjima ovog tipa (38). Angažiranje nezavisnog kliničara u fazama regrutacije i samog tretmana doprinijelo bi metodološkoj kvaliteti budućih studija (33).

Kako je već ranije navedeno, nedostatak standardiziranog pristupa u kulturološkim adaptacijama dovodi u pitanje replikabilnost, učinkovitost i isplativost takvih adaptacija (39). U tom smjeru je jasnoća oko korištenog okvira, kao i procesa, elemenata te ishoda prilagodbe nužna za bolje razumijevanje ovog područja istraživanja, što nije eksplicitno navedeno u većem dijelu odabranih studija. Potrebno je istaknuti kako se u većini studija radilo o relativno malim i prigodnim uzorcima, posebice u probnim-studijama koje čine trećinu uključenih studija, te o relativno kratkim tretmanima od kojih najdulji traje šesnaest sastanaka, dok u polovini studija izostaju nalazi praćenja (31,32,34). U dvije se studije jasno navodi kako nije postignut oporavak, što bi išlo u prilog potrebi za duljim terapijskim tretmanima u budućim istraživanjima (32,34).

panding the sample, adapting protocols for different types of difficulties, and homogenizing according to the expression of symptoms would also contribute to a greater possibility of making general conclusions.

All included studies described the use of standardized psychological treatment outcome measures such as standardized psychological questionnaires and structured interviews during recruitment and screening. Two-thirds of the studies also included measures specific to a particular type of protocols or treatments, as well as indicators related to acculturation processes and other potential moderator variables.

Most of these measuring instruments were designed and standardized on the populations that did not reflect the cultural context and specificities of the sample of participants included in the described studies, which could have resulted in unrepresentative outcomes. In line with this, researchers in this field pointed to the need for cultural adaptations of measures used in this type of research (38). Engaging an independent clinician in the recruitment and treatment phases would contribute to the methodological quality of future studies (33).

As stated earlier, the lack of a standardised approach in cultural adaptations calls into question the replicability, effectiveness and cost-effectiveness of such adaptations (39). In that sense, it is necessary to introduce clarity regarding the framework, processes, elements and adaptation outcomes used in order to establish a better understanding of this area of research, which was not explicitly stated in most of the selected studies. It should be noted that most of the studies comprised relatively small and convenient samples, especially in pilot studies that made up one third of the included studies, as well as a relatively short duration of treatments, in which the longest lasted sixteen sessions. In one half of the studies there were no findings of follow-ups (31, 32, 34). Two studies clearly stated that no recovery was achieved,

Vezano za status i kvalifikacije savjetnika u tretmanu u polovini studija navedeno je kako se radilo o bilingvalnim stručnjacima srodnog kulturološkog konteksta, studentima doktorskog studija psihologije koji su prošli dodatnu edukaciju s licenciranim stručnjakom. S obzirom na to da su u većini studija autori ujedno bili i terapeuti u eksperimentalnoj i kontrolnoj situaciji postavlja se pitanje potencijalnih, u izvješću nevidljivih, adaptacija i jasnoće u odvajanju standardnog od adaptiranog oblika tretmana od istog provoditelja tretmana (30,31).

Na temelju dostupnih podataka i nalaza potrebno je izdvojiti i moguće praktične implikacije za klinički rad. Trenutačni nalazi su prilog važnosti eksplanatornog modela teškoća samog pacijenta (9) pa je potrebno kao praktičnu implikaciju ugraditi vrlo eksplicitno bavljenje pacijentovim viđenjem problema kao temeljem za istraživanje kulturološki osjetljivog pristupa tretmanu, kao i procjeni indikacija za tretman. Svakako je potrebno imati na umu potencijalne izvore pristranosti u slučaju kad se koristi dijagnostičkim instrumentima i mjerama za praćenje ishoda tretmana koji uključuju norme u kojima su podzastupljene manjinske skupine (40).

Pri samoj pripremi kulturološki osjetljivih tretmana potrebno je uzeti u obzir raznolike kontekstualne faktore poput postojećih sustava potpore u zajednici i sl. kako bi se pristup učinio kulturološki osjetljivim od samog početka i prvog kontakta s pacijentom i zajednicom (41). S obzirom na to da se većina kulturološki adaptiranih tretmana temelji na prilagodbama postojećih i validiranih protokola potrebno je prilagodbi pristupiti sistematično, s podlogom u kvalitativnim istraživanjima koja uključuju relevantne osobe u zajednici prije izmjene i testiranja protokola (41). S obzirom da se radilo o preglednom sustavnom radu, većina ograničenja ovog istraživanja povezana je sa strategijama pretraživanja. Treba istaknuti kako su uključeni samo radovi na engleskom jeziku i

which supports the need for longer therapeutic treatments in future studies (32, 34).

Regarding the status and qualifications of counsellors in the treatment in one half of the studies, it was stated that they were bilingual experts for a corresponding cultural context, i.e., PhD students in psychology who had underwent additional education with a licensed specialist. Given that the authors of most studies were also therapists in an experimental or control situation, the question arises of potential adaptations and clarity in distinguishing the standard from the adapted form of treatment on the behalf of the same person conducting the treatment, which was undetectable in the report (30,31).

Based on the available data and findings, it is also necessary to single out possible practical implications for clinical work. The current findings further underline the importance of the explanatory model of the patient's difficulties (9). Therefore, it is necessary to incorporate dealing with the patient's view of the problem very explicitly as a practical implication and a basis for research in culturally sensitive approaches to treatment, as well as in the assessment of indications for treatment. It is undoubtedly necessary to bear in mind all the potential sources of bias when using diagnostic instruments and measures to monitor treatment outcomes that include norms in which minority groups are underrepresented (40).

While preparing culturally sensitive treatments, it is necessary to take into account various contextual factors such as the existing support systems in the community, etc. in order to make the approach culturally sensitive from the very beginning and the very first contact with the patient and the community (41). Given that most culturally adapted treatments are based on adaptations of the existing and validated protocols, it is necessary to approach the adaptation systematically and based on qualitative research involving relevant persons

da strategija pretraživanja nije obnavljana nakon listopada 2021. godine. Unatoč različitosti algoritama pojedinih baza i izvora strategija pretraživanja, iako izrađena u suradnji s knjižničarem, nije kasnije evaluirana. Zbog ograničene dostupnosti baza CINAHL baza podataka nije bila uključena u pretragu. Dodatno, iako su obuhvaćeni neki izvori, nije bilo uključeno sustavno filtriranje sive literature.

ZAKLJUČAK

Kako bi se dobila cjelovitija slika o učinkovitosti adaptiranog tretmana u odnosu na standardnu formu KBT protokola, cilj ovog preglednog rada bio je sumirati dokaze o učinkovitosti kulturološki prilagođene KBT u usporedbi s neprilagođenom formom u izvanbolničkom tretmanu pacijenata. Generalni nalazi istraživanja idu u prilog učinkovitosti kulturološki adaptirane forme u odnosu na standardnu formu kao i kulturološki adaptiranih tretmana. Međutim, u pitanje dovodi replikabilnost, učinkovitost i isplativost takvih adaptacija što je rezultat nedostatka standardiziranog pristupa u kulturološkim adaptacijama. Kako bi se navedene tendencije ispunile potrebno je raditi na daljnjem razvoju i validaciji modela prilagodbe, sustavnom i transparentnom pristupu u evidenciji uvedenih kulturoloških prilagodbi, te sustavnoj procjeni njihove učinkovitosti.

in the community before modifying and testing the protocols (41). Having in mind that this was a systematic review paper, most of the limitations of this research were related to search strategies. It should be pointed out that only papers in the English language were included and that the search strategy has not been renewed after October 2021. Despite the diversity of algorithms in individual databases and sources of search strategies and although created in collaboration with the librarian, it was not evaluated later on. Due to the limited availability of databases, CINAHL was not included in our search. In addition, although some sources were covered, systematic filtering of gray literature was not included.

CONCLUSION

In order to obtain a more comprehensive picture of the effectiveness of the adapted treatment compared to the standard form of the CBT protocol, the aim of this review was to summarize the evidence on the effectiveness of culturally adapted CBT compared to the unadapted form in outpatient treatment of patients. The general findings of the research support the effectiveness of culturally adapted forms compared to the standard form. However, it questions the replicability, efficacy and cost-effectiveness of such adaptations, as the result of understandardized approach in cultural adaptations. In order to counter such tendencies, it is necessary to further develop and validate the adaptation model, apply a systematic and transparent approach in evidencing the introduced cultural adaptations and systematically assess their effectiveness.

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Kormilo oporavka kao alat za izradu individualnog plana oporavka u svakodnevnoj psihijatrijskoj praksi

/ The Helm of Recovery as a Tool for Developing an Individual Recovery Plan in Everyday Psychiatric Practice

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Individualni plan liječenja s ciljem oporavka temelji se na bio-psiho-socijalnom, holističkom pristupu osobama s poteškoćama mentalnog zdravlja u kojem je u fokusu osoba i njeno individualno iskustvo, a ne njena dijagnoza. Premda je individualni plan liječenja ključna kompetencija za specijalista psihijatra postoje poteškoće u njegovoj primjeni u praksi, osobito u primjeni principa oporavka. Stoga je važno razviti alate koji bi pomogli psihijatrima da primijene principe oporavka u svakodnevnoj psihijatrijskoj praksi. *Metodologija*: Kako bismo izradili kormilo oporavka za pomoć psihijatrima u izradi individualnog plana liječenja usmjerenog na oporavak pretražili smo literaturu koristeći ključne riječi: oporavak od mentalnih poremećaja, bio-psiho-socijalni pristup, psihosocijalne determinante mentalnog zdravlja i *WHO QualityRights*. *Rezultati*: Zaštitni psihosocijalni čimbenici za mentalno zdravlje, bio-psiho-socijalni pristup, načela oporavka i smjernice *WHO QualityRights* identificirani su kao ključni čimbenici za razvoj novog alata Kormila oporavka. Kormilo se sastoji se od 10 područja važnih za oporavak, pitanja koja treba postaviti da bi se učinila procjena koja postaje temelj za izradu individualnog plana liječenja. *Zaključak*: Kormilo oporavka je alat koji pomaže psihijatrima u izradi individualnog plana liječenja/oporavka, kao i osobama s mentalnim poteškoćama u izradi osobnog plana oporavka. U budućnosti bi bilo važno procijeniti primjenjivost Kormila u području istraživanja ishoda liječenja/oporavka.

/ The recovery approach is an internationally accepted standard of care for persons with mental illnesses. This approach includes a shift of perspective from a clinical focus on symptoms to a focus on strength, wellness, and social inclusion. However, in clinical practice, there are difficulties with its application, and, therefore, it is important to develop tools to facilitate the use of recovery approach in everyday practice.

Methods: In order to develop a new tool to assist psychiatrists in application of recovery practice we have searched the literature using the following keywords: recovery from mental disorders, biopsychosocial approach, psychosocial determinants of mental health and WHO's QualityRights to determine the key factors important for recovery.

Results: Protective factors for mental health, biopsychosocial approach, recovery principles and WHO's QualityRights guidelines were identified as key factors for developing the new tool named Helm of Recovery. Helm of Recovery consists of 10 areas with the description of each area, questions to facilitate the application and instructions for use.

Conclusion: Helm of Recovery is a new tool to assist psychiatrists in making an individual treatment/recovery plan as well as people with mental health difficulties in creating a personal recovery plan. In the future, it will be important to assess the applicability of the Helm of recovery in treatment/recovery outcome research.

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UVOD

Prema stručnim smjernicama liječenja osoba s problemima mentalnog zdravlja primjenjuje se biopsihosocijalni, holistički pristup razumijevanja nastanka mentalnog poremećaja s ciljem postizanja oporavka, u fokusu liječenja je osoba s jedinstvenim osobnim iskustvom, a ne njena dijagnoza (1,2). Liječenje s ciljem oporavka provodi se na temelju individualnog plana liječenja koji se izrađuje u suradnji s pacijentom, a glavna obilježja su postavljeni ciljevi liječenja, bio-psiho-socijalni postupci koji će pomoći u postizanju ciljeva i osobe koje će sudjelovati u liječenju (3). Službe orijentirane prema oporavku i oporavak kao cilj liječenja su danas internacionalno prihvaćen standard za organizaciju pružanja usluga u području mentalnog zdravlja i u smjernicama za liječenje osoba s različitim dijagnozama mentalnog poremećaja (4-6), međutim još uvijek postoje barijere u implementaciji (7) koje također uključuju pesimističke stavove psihijatara o mogućnosti oporavka i nedostatak edukacije iz oporavka u edukaciji za psihijatre za koje je potrebno pronaći rješenja (8). Jedno od rješenja je Inicijativa SZO-a *QualityRights* (9) koja snažno podupire države da transformiraju usluge mentalnog zdravlja prema načelima oporavka i poštivanja ljudskih prava. Orijentacija na oporavak traži transformaciju skrbi za mentalno zdravlje u kojoj postoji odmak od biomedicinskog modela pretjerano usredoto-

INTRODUCTION

According to the international guidelines for the treatment of people with mental health problems, a biopsychosocial holistic approach to understanding the origin of a mental disorder is applied where the focus of treatment is set on a person with a unique personal experience rather than their diagnosis and recovery is an expected outcome (1,2). Treatment whose goal is to result in recovery is carried out on the basis of an individual treatment plan that is agreed in cooperation with the patient. The main features of this plan are predefined treatment goals, selected bio-psycho-social interventions that will help in achieving the goals, as well as professionals and non-professionals who will participate in the treatment (3). Recovery principles and recovery as the goal of treatment are today an internationally accepted standard for the organization of mental health services and part of the guidelines for the treatment of persons with different mental disorders diagnoses (4-6). However, there are still barriers to implementation (7), including psychiatrists' pessimistic attitudes about the possibility of recovery and the lack of education about recovery in the training for psychiatrists, for which solutions need to be found (8). One of the solutions is the WHO QualityRights Initiative (9), which strongly supports countries to transform mental health services according to the principles of recovery and respect for human rights. Recovery orientation requires a transformation of mental health care with a shift from the biomedical model overly focused on symptoms and pharmacological

čenog na simptome bolesti i na farmakološko liječenje, a nedovoljno usredotočenog na cijelu osobu, njezinu snagu, nade i na poticanje osobe da se oporavi (5,9) Orijentacija na oporavak uključuje i poticanje korištenja alata za samopomoć (10).

ODNOS REMISIJE I OPORAVKA

Razlikovanje oporavka od remisije može potaknuti implementaciju principa oporavka u psihijatrijsku praksu. Oporavak nije isto što i medicinsko značenje remisije postizanja oporavka od simptoma i povrat na funkcioniranje prije bolesti, nego označava stanje osobnog osnaživanja i upravljanja svojim životom na način koji omogućuje postizanje osobnih ciljeva, život sa smislom i doživljaj pripadanja zajednici bez obzira na to ima li osoba još uvijek neke simptome mentalnog poremećaja i/ili neke od teškoća funkcioniranja (12). Pokazalo se da postoji razlika o značenju remisije simptoma između pacijenata, članova njihovih obitelji i stručnjaka. Remisija simptoma često za pacijente i članove njihovih obitelji ima sekundarnu ulogu (13), ona može ali ne mora biti povezana s funkcionalnim oporavkom ni s doživljajem dobrobiti, kvalitete života osoba oboljelih od mentalnih poremećaja (14), tj. oporavaka vođenjem zadovoljavajućeg života unatoč ograničenju koja ljudi imaju zbog bolesti i postaje glavni cilj (12,15,16). Osobni oporavak je jedinstveni individualni proces ili iskustvo koje se najbolje može opisati kao putovanje (15,16), kao i proces promjene kojim pojedinci poboljšavaju svoje zdravlje i dobrobit, žive samostalnim životom i nastoje postići svoj puni potencijal (16). U procesu oporavka stručnjaci se mogu promatrati suputnicima na tom putu što je kraće moguće, ali ipak onoliko dugo koliko je potrebno (16,17). Daljnja istraživanja o procesu oporavka dovela su do identifikacije principa oporavka (11,18). Prema konsenzusu SAMH-

treatment and insufficiently focused on the whole person approach, their strength and hope, as well as on facilitating the process of recovery (5,9), including the use of self-help tools (10).

RELATIONSHIP BETWEEN REMISSION AND RECOVERY

Differentiating recovery from remission may initiate the implementation of recovery principles in psychiatric practice. Recovery is not synonymous with the medical meaning of remission, i.e., recovery from symptoms and return to pre-disease state. It implies personal empowerment and lifestyle management leading to the achievement of personal goals, meaningful life and sense of belonging to a community, regardless of whether a person still shows certain symptoms of a mental disorder and/or some difficulties in functioning (12). Research has shown that symptom remission is interpreted differently by patients, their family members and professionals. For patients and their family members, symptom remission often has a secondary role (13); it may or may not be related to functional recovery or to the subjective experience of well-being, quality of life of persons diagnosed with mental disorders (14). People can lead satisfactory lives despite the limitations due to their condition (12, 15,16). Personal recovery is a unique individual process or experience that can best be described as a journey (15,16) or a process of change through which individuals may improve their health and well-being, live independent lives, and strive to reach their full potential (16). In the process of recovery, mental health professionals may be perceived as companions on the road to recovery for the shortest possible period of time, but as long as necessary (16,17). Further research on the process of recovery has resulted in the identification of principles of recovery (11,18). According to a consensus report issued by SAMHSA (11), there are ten principles that support the individual recovery process: hope, person-driven, many pathways, holistic, peer support, culture, trauma-informed, strengths and responsibility, and respect. One study (18) has found that con-

SA (11), individualni proces oporavka podržavaju deset načela: nada; vođenje osobnim ciljevima osobe; različiti individualni putevi oporavka; holistički pristup; vršnjačka podrška; poštivanje sustava vrijednosti osobe i kulturne pripadnosti; razumijevanje utjecaja traume; orijentacija na snage osobe i odgovornost; odnosi s drugima i podrška; poštovanje. Jedno istraživanje (18) je utvrdilo da su povezanost, nada i optimizam u pogledu budućnosti, identitet, smisao života i osnaživanje najvažniji za oporavak.

Cilj rada je prikaz novog alata za izradu individualnog plana liječenja/oporavka koji može pomoći psihijatrima kao i drugim stručnjacima da u liječenju pacijenata primijene holistički bio-psiho-socijalni pristup i principe oporavka.

Kako bismo izradili kormilo oporavka za pomoć psihijatrima, u izradi individualnog plana liječenja usmjerenog na oporavak pretražili smo literaturu koristeći ključne riječi: oporavak od mentalnih poremećaja, bio-psiho-socijalni pristup, psihosocijalne determinante mentalnog zdravlja i WHO *QualityRights*.

REZULTATI

Pretraživanjem literature identificirali smo psihosocijalne čimbenike važne za zaštitu mentalnog zdravlja (19-21), principe oporavka (11,18) i smjernice *WHO QualityRights* (9) te smo te informacije koristili za razvoj kormila oporavka. Na temelju dobivenih rezultata kreirali smo područja važna za oporavak u ormilu oporavka, opisali ta područja i sugerirali pitanja kako bismo olakšali procjenu (tablica 1), te smo izradili i upute za primjenu kormila. Procjena u navedenim područjima kormila služi kao osnova za izradu individualnog plana liječenja/oporavka prema smjernicama za izradu bio-psiho-socijalne formulacije i individualnog plan liječenja (3,22) (tablica 2).

nectedness, hope and optimism about the future, identity, meaning of life and empowerment are the most important elements of recovery.

Although, recovery approach has become an internationally accepted standard, there are still many difficulties related to its implementation in everyday psychiatric practice. It is, therefore, important to find ways to facilitate its implementation in everyday psychiatric practice.

Helm of Recovery is intended primarily for psychiatrists, but also for other mental health professionals to increase their competence in implementing the principles of recovery and respect for human rights in everyday psychiatric practice.

The aim of this paper is to present a new tool for creating an individual treatment/recovery plan that can be helpful to psychiatrists in the application of a holistic bio-psycho-social approach and principles of recovery in the treatment of patients.

In order to identify areas important for recovery to be used in developing Helm of Recovery, we searched the available literature using the following keywords: recovery from mental disorders, biopsychosocial approach to mental disorders, psychosocial determinants of mental health, as well as the WHO QualityRights guidelines.

RESULTS

Literature search has identified psychosocial factors relevant for mental health protection (19-21), recovery principles (11, 18), and WHO's QulityRights guidelines (9), which have been and used to develop a helm of recovery. Based on the obtained search results, we have established and described the areas important for recovery in the helm of recovery and suggested a number of questions in order to facilitate the assessment. We have also created instructions on how to use Helm of Recovery (Table 1). The assessment of various areas of the helm serves as the basis for creating an individual treatment/recovery plan according to the guidelines for creating a biopsychosocial formulation and an individual treatment plan (3,22) (Table 2).

TABLICA 1. Područja procjene i rezultati procjene. Napomena: prije procjene objasnite osobi što je to oporavak i pitajte što bi za njih značio oporavak. Procjenu učinio: Pacijent (P), Stručnjak (S); zajednička procjena između pacijenta i stručnjaka (Z)
TABLE 1. Areas of assessment and assessment results. Note: Before the assessment, explain to the person what recovery means and ask what recovery means to them. Definition of recovery: Recovery is not same as it is related to the process of personal strengthening and managing of one's life in a way that enables the achievement of personal goals, living with the sense of purpose and experience of belonging to the community, if the person has some difficulties related to a mental disorder. Assessment made by the patient (P); an expert (E); and (A) as the result of a joint agreement between the patient and the expert

Područja procjene / Area of assessment & description	**Pitanja koja treba postaviti za izradu plana liječenja/ oporavka i zabilježiti rezultat na ljestvici od 0 % do 100 % Napomena: pitanja su orijentacijska, prilagodite ih situaciji. Nakon procjene kako biste izradili plan oporavka pitajte Želite li nešto promijeniti u ovom području? Što bi vam u tome moglo pomoći? Također sugerirajte što vi mislite da bi moglo pomoći / Questions to ask to develop a treatment/recovery plan and record the result on a scale from 0% to 100% Note: the questions are indicative and have to be adapted to a specific situation. After the assessment, in order to develop a recovery plan, ask the following question: Do you want to change anything in this area? What might be helpful in doing that? Also suggest what you think might be helpful.**	**P1 1-100 %**	**P2 1-100 %**
Kontrola simptoma mentalnog poremećaja, fizičko zdravlje i zdravi životni stilovi – odnosi se na procjenu stanja prisutnosti simptoma bolesti/poremećenog mentalnog zdravlja, stanja tjelesnog zdravlja i zdrava načina života, kao i na procjenu što je potrebno poduzeti da se postigne poboljšanje u ovom području, tj. da se otklone ili ublaže simptomi bolesti, bilo lijekovima i/ili psihosocijalnim metodama, da se postigne ili poboljša ne samo suradnja u liječenju nego i bolja briga o fizičkom zdravlju te da se provode zdravi životni stilovi. Otklanjanje/ublažavanje simptoma i uspješno upravljanje njima važni su ciljevi za mnoge osobe u oporavku. / **Symptoms control, physical health and healthy lifestyles** – This area refers to the assessment of mental health difficulties /symptoms of an illness, physical health and a healthy lifestyle. It includes the control/managing symptoms of mental health difficulties with the help of medications and/or psychosocial methods, collaboration in treatment, taking care of one's physical health and a healthy lifestyle. Removal/reduction and successful management of symptoms are important goals for mental health of many people in recovery, as well as a healthy lifestyle.	Imate li neke od poteškoća mentalnoga zdravlja/simptoma bolesti? Koje su to poteškoće? Kako se s njima nosite? Što vam pomaže? Kako poteškoće mentalnog zdravlja utječu na vaš život? Kakvo je vaše tjelesno zdravlje? Primjenjujete li zdrav životni stil (pazite li na izbor hrane, tjelesnu težinu i fizičku aktivnost)? / Do you have any of the mental health difficulties/symptoms of illness? What are the difficulties? How do you deal with them? What helps you? How do mental health difficulties affect your life? How is your physical health? Are you physically active and do you follow the recommendations for a healthy diet?		
Nada i optimizam za budućnost – Nada u oporavak i optimizam za budućnost uvijek su prioritet, jer bez nade i optimizma da je promjena moguća, da se ljudi zaista mogu oporaviti, mnogi mogu odustati od oporavka. Nada potiče motivaciju suradnje u liječenju i individualnim planovima oporavka da se postignu ciljevi i da se ne odustane unatoč teškoćama. Vjerovanje da je oporavak doista moguć snažna je motivirajuća poruka za bolju budućnost. Vjerovanje u realnost oporavka mora imati ne samo osoba s problemom mentalnog zdravlja nego i osobe koje joj pružaju pomoć. Kada se osoba osjeća bespomoćno, kada je izgubila nadu, kada ne vjeruje u promjenu, prvi postupak formalnih i neformalnih pomagača mora biti obnavljanje nade da je oporavak moguć i poticanje motivacije za oporavak. / **Hope and optimism for the future** – Hope and optimism are always a priority, because without hope people can give up on recovery. Hope is the engine of motivation to change. Hope relates to the belief that change is possible as well as that there is always a solution for any difficult situation, no matter what happens. Hope and optimism for recovery is a prerequisite for those who receive help as well as for those who provide help. When a person feels helpless, when hope is lost, when there is no motivation for change, the first step that formal and unformal helpers take must be the renewal of hope that recovery is possible and encouraging the motivation to introduce change.	Vjerujete li, i koliko, da se možete oporaviti od mentalnoga poremećaja, vjeruju li druge osobe u vašem okružju (stručnjaci, obitelj, prijatelji i drugi, vama bliski) da se možete oporaviti? / Do you believe, and to what extent, that you can recover from a mental disorder? Do other people in your environment (mental health professionals, family, friends and others close to you) believe that you can recover?		
Svrha, smisao života i motivacija za promjenu odnosi se na prepoznavanje i poticanje osobnih vrijednosti, svjetonazora i tradicije povezanih sa svrhom i smislom života. Svrha i smisao života varira od osobe do osobe. Ljudi pronalaze smisao na različite načine: kod nekih je religija značajan izvor smisla, međutim niz dnevnih aktivnosti kao što su posao, školovanje, kreativni rad, obiteljski život, društveni aktivizam i drugo može biti značajan izvor smisla i motivacije za promjenu. Osobni planovi i želje mogu osnažiti ljude da pronađu smisao, svrhu i zadovoljstvo u svom životu, kao i motivaciju za promjenu. Svrha i smisao života snažni su pokretači procesa oporavka. Ljudi bez motivacije ne mogu donijeti odluku da pokrenu proces oporavka. Osobe s problemima mentalnog zdravlja mogu imati nisku motivaciju za promjenu ili su prema promjeni podvojeni/ambivalentni iz različitih razloga, stoga im je potrebno pomoći donijeti odluku da započnu proces oporavka i podupirati ih tijekom toga procesa. / **Purpose, meaning of life and motivation to change** refers to recognition and support of personal values, worldviews, traditions connected to the purpose and meaning of life. Purpose and meaning of life differ from one person to another. People find meaning in different ways, where for some religion is a significant source of purpose. Meaning is also included in a set of daily activities such as professional work, education, creative work, family life, social activism, and many others. Personal plans and wishes can empower a person to find meaning in their life. Purpose and meaning of life can be strong motivation to start the recovery process. Formal and informal support providers should support people to find meaning in life and motivation for change.	Koje su vrijednosti važne za vaš život, koje vašem životu daju smisao? Što vas motivira za postizanje životnih ciljeva i zadovoljstva u životu? Ako ih osoba ne navodi: Koje su bile prijašnje vrijednosti i smisao? Što biste željeli obnoviti? Je li je bolest utjecala na vaš smisao života ? (Pazite da ne namećete vlastite vrijednosti i smisao, nego da pomognete osobi da identificira svoje vrijednosti i poduprete je u ostvarenju.) / What are your values that drive your motivation to achieve life goals and satisfaction in life? If you don't see them now, what were your values before? Has the mental illness affected your sense of life? What would you like to restore? The supporter must be careful not to impose their own values, but to encourage the values of the person they support.		
Identitet, samopouzdanje/samopoštovanje, osnaženje – Identitet se može definirati kao način na koji se čovjek doživljava kao pojedinac u odnosu prema drugima i zajednici u kojoj živi. Pozitivna percepcija identiteta, samopouzdanje i samopoštovanje potiču proces oporavka; s druge strane, „identitet pacijenta" prepreka je oporavku. Pozitivan doživljaj sebe kao osobe koja je sposobna postići ciljeve vrijedne poštovanja, koja je prihvaćena i poštovana od drugih povezan je s dobrim mentalnim zdravljem i doživljajem osnaženosti, nasuprot doživljaju sebe kao manje vrijedne osobe, nesposobne da postigne ciljeve, neprihvaćene i nepoštovane od drugih, koji je povezan s lošim mentalnim zdravljem i rizikom od mentalnih poremećaja.	Kako biste ocijenili svoje samopouzdanje i povjerenje u svoje sposobnosti? Koliko je bolest utjecala na vaše samopouzdanje i samopoštovanje? Doživljavate li da vas drugi poštuju, prihvaćaju vaše mišljenje? Vjerujete li da ste manje vrijedni jer imate psihički poremećaj? Tretiraju li vas drugi ljudi drukčije jer znaju da imate psihički poremećaj?		

TABLICA 1. nastavak
TABLE 1. continued

Samo-stigmatizacija označava doživljaj manje vrijednosti osobe zbog toga što ima dijagnozu mentalnog poremećaja. Osnažena osoba ima pozitivnu percepciju svojeg identiteta, oslobođena je samostigmatizacije, doživljava teškoće mentalnog zdravlja kao samo jedno svoje obilježje koje nije dominantno u njezinu životu, jer osoba ima puno drugih obilježja, za razliku od „identiteta bolesnika", u kojem bolest postaje dominirajuće obilježje ličnosti povezano s negativnim doživljajem identiteta. Postupci koji potiču obnavljanje/izgradnju pozitivnog identiteta, samopouzdanja i samopoštovanja i preveniraju samostigmatizaciju ključni su za poboljšanje mentalnog zdravlja i oporavak. / **Identity, self-esteem/self-respect and empowerment –** Identity is connected to perception of oneself as a person in relation to others and the community in which a person lives. The assessment is related to a positive or a negative perception of one's own identity, as well as "patient identity", and regulation of self-esteem and self-respect in situations of perception of threat to self-esteem and self-respect. Positive experience of oneself as a person capable to achieve goals, worth of respect, accepted and respected by others is closely connected to mental wellbeing and feeling of empowerment, contrary to the experience of oneself as a person of less value and incompetent to achieve goals, as someone disrespected and unaccepted by others, which is connected to the risk of developing mental disorders. Personal perception of an individual with mental health difficulties is often connected with self-stigmatisation that marks the experience of negative, less valuable identity of a person based on identity transformation due to the fact that a diagnosis of a mental illness is experienced as a weakness of character. An empowered person is free from self-stigmatisation, experiences the difficulties in mental health as just one of his/her traits that is not a dominant trait of a personality in their life, because he/she has many other traits in comparison to the "patient identity" in which an illness becomes a dominant trait of his/her personality. The activities that encourage building/rebuilding of a positive identity and improve self-esteem and self-respect are crucial for the improvement of mental health and recovery from mental illness.	Da li postoji povezanost između vašeg samopouzdanja i bolesti? / How would you rate your self-confidence and belief in your abilities? How much has the mental health conditions affected your self-confidence and self-esteem? Do you feel that others respect you and your opinion? Do you believe that you are less valuable because you have a mental disorder? Do other people treat you differently because they know you have a mental disorder?
Utjecaj traume, stresa, sučeljavanje/otpornost prema stresu – odnosi se na utjecaj traumatskih iskustava osobe i/ili negativnih životnih događaja (u prošlosti i sadašnjosti) na mentalno zdravlje, na otpornost prema stresu, podnošenje uobičajenog stresa svakodnevnog života, načine reagiranja u stanjima tjeskobe i stresa (mehanizmi obrane i suočavanja), kao i na procjenu o potrebi postupaka za povećanje otpornosti na stres. Postupanje sa stresom, tj. tjeskobom koju izaziva, ključno je u zaštiti mentalnog zdravlja i u prevenciji mentalnih poremećaja, stoga je stres-menadžment i povećanje otpornosti na stres jedan od ključnih postupaka u zaštiti mentalnog zdravlja, oporavku i smanjenju rizika od mentalnih poremećaja uključujući i prevenciju ponovne epizode mentalnih teškoća. / **Trauma, coping with stress and resilience** – This area refers to the influence of traumatic experiences and/or negative life events (in the past and the present) on mental health, resilience to stress, tolerance of usual everyday life stress, reactions to anxiety and stress (defence mechanisms and coping skills), as well as the assessment of the need for interventions that increase the resilience to stress. Coping with stress and the anxiety it produces is key in the protection of mental health and prevention of mental health difficulties, therefore, stress-management and increasing resilience to stress is one of the key interventions in protecting mental health, promoting recovery and lowering the risk of developing mental health difficulties, including the prevention of episodes of mental disorder.	Je li tijekom života – u djetinjstvu, mladosti, odrasloj dobi, dakle u bliskoj prošlosti ili sadašnjosti – bilo negativnih iskustava koja su negativno utjecala na vaše mentalno zdravlje? Kako reagirate u stresnim situacijama? Jeste li tada uznemireni, povlačite se, ne možete funkcionirati i slično? / Have you had negative experiences in childhood, youth or adulthood that you consider having had a negative impact on your mental health? How do you usually react in stressful situations? How does stress affect your mental health? Are you scared, too worried, withdrawn or unable to function in those situations?
Vještine za samostalan život – odnosi se na posjedovanje vještina koje su važne za samostalno življenje u zajednici, što uključuje brigu o sebi, socijalne vještine, funkcioniranje u očekivanim socijalnim ulogama i korištenje resursa zajednice za socijalnu uključenost. Procjenjuju se sposobnosti (snage) i teškoće u različitim područjima, važnima za samostalnost. Briga o sebi uključuje sposobnosti obavljanja aktivnosti dnevne rutine, kao što su, primjerice, briga o osobnoj higijeni, odgovarajućoj prehrani i nabavci hrane, postupanje s novcem, urednost, održavanje vlastitog prostora i sigurnost u kući, briga o vlastitom zdravlju, samostalnost u kretanju i u korištenju prijevoznih i komunikacijskih sredstava te druge aktivnosti važne za svakodnevni život. Pod socijalnim vještinama podrazumijevaju se sposobnosti u komuniciranju i interakciji s drugima, uključujući izražavanje i kontrolu emocija, vještine rješavanja problema i konflikata, funkcioniranje u ulogama kao što su: obitelj, radno mjesto, školovanje i društvene uloge. Korištenje resursa zajednice odnosi se na procjenu koristi li osoba i kako resurse u zajednici te koje resurse želi koristiti da bi poboljšala svoje mentalno zdravlje i potaknula oporavak. Stjecanje vještina ključno je za oporavak – one omogućuju ljudima da preuzmu kontrolu nad vlastitim životom. Oporavak znači upravljanje teškim situacijama, a razvoj vještina potrebnih za upravljanje negativnim situacijama u životu poboljšava mentalno zdravlje i potiče oporavak. U procesu oporavka mnogi će trebati potporu u različitim područjima života kako bi mogli na ravnopravnoj osnovi s drugima živjeti u zajednici. / **Skills for independent life –** This area relates to one's capabilities and skills important for independent life in the community, including self -care, social skills, functioning in expected social roles, and using resources of the community for social inclusion. Self- care implies abilities to maintain daily routine activities such as personal hygiene, appropriate nutrition, buying groceries, keeping a budget, tidiness, maintaining order and safety in one's own house, taking care of one's own health and collaboration in a treatment, self- mobility, using means of public transport, and other activities important for everyday life. Social skills include abilities for communicating and interacting with others, including expressing and controlling emotions, problem-solving and conflict-resolving, functioning in various roles in family, at workplace, in education, and social roles. Use of community resources refers to assessing whether and how the person uses the community resources to feel that she or he belongs to the community that encourages recovery, as well as the action plan to use the community resources. Skills and independence are key factors for many people in recovery as they enable people to take control of their own lives. Recovery means managing difficult situations, and developing the skills needed to manage negative life situations improves mental health and promotes recovery. In the process of recovery, many will need support in different areas of life in order to be able to live in the community on an equal basis with others.	Kako procjenjujete svoje sposobnosti u obavljanju svakodnevnih zadataka, kao što je, primjerice, osobna higijena, odlazak u trgovinu, briga o kućanstvu, komunikacija s ljudima? Koliko ste samostalni u obavljanju tih aktivnosti, obavljate li ih sami? Trebate li potporu za obavljanje dnevne rutine, socijalnih kontakata i drugih aktivnosti? Jesu li vaše vještine povezane s vašim mentalnim zdravljem? / How do you assess your skills for carrying out the usual daily routine, such as personal hygiene, shopping, taking care of the household, communicating with people? How independent are you in performing these activities, and do you perform them yourself? Do you need support to carry out your daily routine, social contacts and other activities? How does your mental health affect your daily life skills?
Uvjeti stanovanja – procjenjuju se uvjeti stanovanja, uključujući beskućništvo, i kvalitetu međuljudskih odnosa u kućanstvu. Osiguravanje prikladnih uvjeta stanovanja, uz potporu u samostalnom životu i uključivanje u zajednicu kada je potrebno, potiče oporavak. / **Housing –** Housing conditions are assessed, including homelessness and the quality of interpersonal relationships in the household. Providing suitable living conditions, with support in independent living and inclusion in the community, when necessary, promotes recovery.	Koliko ste zadovoljni uvjetima stanovanja? Kako uvjeti stanovanja utječu na vaše mentalno zdravlje? Trebate li pomoć u održavanju kućanstva, druženju s drugim ljudima u zajednici, organizaciji slobodnog vremena ili za nešto drugo da biste mogli obavljati aktivnosti koje biste željeli, a ne možete bez potpore?

TABLICA 1. nastavak
TABLE 1. continued

	/ How satisfied are you with your living conditions and do they affect your mental health? Do you need help with household maintenance, socializing with other people in the community, organizing your free time or for something else to be able to do the activities you would like and cannot do without support?
Posao, školovanje, prihodi i dobrobiti – odnosi se na motivaciju za rad i školovanje, procjenu potreba za potporom u zapošljavanju/školovanju i održavanju posla, prava na pogodnosti na osnovi invaliditeta ili socijalnog stanja, na prihode dovoljne za život, kao i na utjecaj radne sredine na mentalno zdravlje. / **Job, education, income, and benefits** – This area refers to motivation to work and seek education, assessment of needs for support in employment/education, and maintaining a job, right to benefits according to one's disability or social status, incomes that are sufficient to live by, as well as the influence of work environment on mental health.	Kakav je vaš radni/obrazovni status i koliko ste njime zadovoljni? Imate li poteškoća na poslu? Ako ne radite, želite li raditi ili se školovati? Kako vaš radni ili obrazovni status utječe na vaše mentalno zdravlje? Imate li novčane prihode vezano za invaliditet? Koliko ste zadovoljni svojom financijskom situacijom i kako ona utječe na vaše mentalno zdravlje? / Do you have a job or are you in education? Do you have difficulties at work related to your mental health? Do you want to find a job, or do you want to get an education? How does your work status or schooling affect your mental health? Do you have any financial income related to mental health problems, disability, etc.? Does your financial situation affect your mental health?
Odnosi, potpora i socijalna uključenost – Kvaliteta odnosa i doživljaj povezanosti s drugim ljudima, emocionalna povezanost s obitelji i prijateljima, potpora iz različitih izvora, prihvaćanje i socijalno uključivanje važni su za oporavak. Odnosi i povezanost s drugima uključuje neformalne i formalne odnose, primjerice s članovima obitelji, bliskim prijateljima, intimnim partnerom, kolegama na poslu i susjedima, terapijske odnose sa stručnjacima, stručnjacima po iskustvu (engl. *peer workers*), pružateljima socijalnih i zdravstvenih usluga. Ljudi se teško mogu oporaviti bez potpore. Potpora uključuje razumijevanje, poštovanje, poticanje nade, ohrabrenje, ne-kritiziranje, poticanje na samostalno donošenje odluka, na aktivno sudjelovanje u liječenju i drugim životnim aktivnostima, kao i instrumentalnu potporu za aktivnosti koje osoba sama teško obavlja. Osobu se podupire uvijek u onim područjima u kojima ona treba, želi i traži potporu. Osobe koje pomažu ljudima s mentalnim teškoćama, bilo da su neformalni ili formalni pružatelji potpore, suputnici su na putu oporavka u razdoblju koje može biti dugo onoliko koliko je potrebno. Osobe koje sudjeluju na putu oporavka, uključujući stručnjake, moraju se uvijek pitati pomažu li svojim postupcima ili ometaju proces oporavka. Socijalna uključenost odnosi se na korištenje resursa zajednice koji su povezani s radom, aktivnostima slobodnog vremena, društvenim kontaktima, a uključuje aktivnosti koje osobu ispunjavaju zadovoljstvom. Aktivnosti u zajednici mogu biti sportske, kulturne, političke, hobiji, plaćeni posao, volontiranje, školovanje, uključenost u vjersku zajednicu ili grupu prijatelja, kao i sudjelovanje u različitim programima liječenja i socijalnog uključenja, bilo u formalnom ili neformalnom sustavu brige za mentalno zdravlje. / **Relationships, support and social inclusion** – This area includes the quality of relationships with others, experience of connectedness with others, including support, acceptance and social inclusion as important factors for recovery. Relationships and connectedness with others include informal and formal relationships such as members of family, close friends, intimate partners, work colleagues, neighbours, therapeutic relationships with mental health professionals, peer workers, social and healthcare providers. People can hardly recover without support. Support includes understanding, respect, encouraging hope, lifting-up, not criticising, support to independent decision-making, active collaboration in treatment and other life activities, as well as instrumental support in activities that the person has trouble performing alone. The person is always given support in the areas that she or he needs, wants or asks for support. People who help persons with mental health difficulties, whether they are informal or formal supporters, are fellow travellers on the path of recovery that can lasts differently, as long as it is needed. People who support the process of recovery, including mental health professionals, should always ask themselves whether they are helping or not in the process of recovery. *Social inclusion* refers to using the resources of the community connected to work, leisure time activities, social contacts. It implies prevention of social exclusion that is related to poor mental health. Activities in the community might be sports, cultural or political activities, volunteering, education, inclusion in congregation or a group of friends, as well as collaboration in treatment programmes and social inclusion in any formal or informal system of mental healthcare.	Kakvi su vaši odnosi s drugim ljudima (obitelj, prijatelji, posao, drugi)? Kakvi su vaši odnosi sa stručnjacima? Jeste li uključeni u život zajednice, ili ste više izolirani? Osjećate li se dijelom zajednice, socijalno uključeno ili isključeno? Kako odnosi s drugim ljudima utječu na vaše mentalno zdravlje? Želite li poboljšanja u ovom području, i koja? / How are you satisfied with your relationships with people: family, friends, colleagues at work, neighbours, relationships in treatment services, and other services? How do your relationships with others affect your mental health? Do you wish your relationships were different? What would you like to change? Do you feel that you belong to the community where you live? Do you feel excluded from the community?
Odgovornost – uključuje osobnu odgovornost osobe s teškoćama mentalnog zdravlja i odgovornost drugih dionika koji sudjeluju u zaštiti mentalnog zdravlja. Osobna odgovornost za svoj oporavak zapravo je u planiranju i sudjelovanju u provedbi postupaka i aktivnosti važnih za oporavak. Može se odnositi na suradnju u liječenju, preuzimanje odgovornosti za svoje zdravlje, odgovorno financijsko ponašanje, održavanje dobrih odnosa s ljudima, ispunjavanje obveza za stan/kuću u kojoj osoba živi, preuzimanje odgovornosti za svoje postupke i odluke, poštovanje zakona, sudjelovanje u aktivnostima zajednice i drugo. Također, uključuje pravo na rizik, ali i prihvaćanje posljedica rizika i učenje iz tih situacija. Uključuje pravo na donošenje odluka o svom životu i odgovornost za posljedice tih odluka. Odgovornost drugih dionika, primjerice službi za liječenje i zapošljavanje, socijalnih službi i cijele društvene zajednice povezana je s dostupnošću usluga koje potiču oporavak i omogućuju pravo na potporu i socijalno uključivanje. / **Responsibility –** This area refers to personal responsibility of every person with mental health difficulties in fulfilling obligations and participating in different activities that are important for recovery, including making decisions, relationships with others, treatment, social inclusion, as well as responsibility of others in providing the resources for facilitating recovery. Personal responsibility might refer to fulfilling different roles and activities, such as responsible financial behaviour, maintaining good relationships with people, fulfilling the chores in the apartment/house they live in, taking responsibility for their actions and decisions, health, medical procedures, way of life and obeying the law. It also includes the right to risk, but accepting the consequences of that risk, and learning from these situations. Running their own life, choosing between options and making decisions in important areas of life, including health and housing is key in recovery. It includes the right to make one's own decisions with or without the help of others. Assessment of others' responsibilities, such as health services and employment, are connected to the availability of services that facilitate recovery, including the availability of support in the community.	Kako procjenjujete koliko sudjelujete u svom liječenju/oporavku, u određivanju ciljeva i provedbi zadataka koji vode do ispunjenja ciljeva? Koliko vi možete utjecati na poboljšanje svojeg mentalnog zdravlja? Sudjelujete li aktivno u izradi svojeg plana oporavka i u provedbi dogovorenih ciljeva liječenja? / How do you assess your responsibility/ participation for improving your mental health in setting recovery goals, creating a recovery plan, and completing agreed-upon activities to achieve the goals?

TABLICA 2. Individualni plan liječenja/ oporavka. Napomena: Individualni plan liječenja/ oporavka je dogovor između pacijenta i psihijatra i/ili drugih stručnjaka o ciljevima liječenja/ oporavka, izboru metoda za postizanje ciljeva te osobama i drugim službama koje će sudjelovati u provođenju plana liječenja/oporavka.
TABLE 2. Individual recovery plan. Note: An individual treatment/recovery plan is an agreement between the patient and the psychiatrist and/or other experts on the treatment/recovery goals, choice of interventions to achieve those goals, and persons and other services that will be included in the implementation of the treatment/recovery plan.

Područja procjene / Area of assessment	Početno (%) / Baseline (%)	Prioritetna područja, ciljevi i postupci / Intervention priority and plan	Ponovna procjena (%) / Re-evaluation (%)	Primjedbe / Comments
Kontrola simptoma mentalnog poremećaja, tjelesno zdravlje i zdravi stilovi života / Control of mental health symptoms, physical health and healthy lifestyles				
Nada i optimizam za budućnost / Hope and optimism for the future				
Svrha, smisao života i motivacija za promjenu / Purpose and meaning of life				
Identitet, samopouzdanje/ samopoštovanje i osnaživanje / Identity self-esteem/ self-respect and empowerment				
Utjecaj traume, stresa i otpornost na stres / Trauma/stress coping and resilience				
Vještine za samostalan život / Skills for independent life				
Uvjeti stanovanja / Housing				
Posao, obrazovanje, primanja, beneficije / Job, education, income, benefits				
Odnosi, potpora i socijalna uključenost / Relationships, support and social inclusion				
Odgovornost / Responsibility				

Opis Kormila oporavka, ciljevi i upute za njegovu upotrebu

Kormilo oporavka mentalnog zdravlja je alat koji pomaže psihijatrima i drugim stručnjacima u izradi individualnoga plana liječenja/oporavka za osobe s teškoćama mentalnog zdravlja, što uključuje određivanje ciljeva oporavka i postupaka za postizanje identificiranih ciljeva liječenja/oporavka. Kormilo oporavka zasniva se na holističkom psiho-bio-socijalnom pristupu razumijevanja zaštitnih i rizičnih čimbenika za mentalno zdravlje, principima oporavka definiranim prema smjernicama SAMHSA za poticanje oporavka i poštovanja ljudskih prava prema *WHO QualityRights*, te procjene funkcioniranja prema Međunarodnoj klasifikaciji funkcioniranja Svjetske zdravstvene organizacije (23). Obuhvaća tri područja oporavka: oporavak od simptoma, oporavak funkcioniranja i oporavak identiteta.

Pomoću kormila oporavka može se procijeniti stanje u životnim područjima koja su važna za oporavak, stoga treba prikupiti podatke iz svih važnih područja kako bismo mogli planirati liječenje i oporavak, odrediti područja u kojima se želi postići promjena, pratiti napredovanje prema željenim ciljevima u različitim vremenskim razmacima, kao i evaluirati rezultate i modificirati ciljeve. Nezadovoljene potrebe u bilo kojem području kormila mogu biti povezane s lošim mentalnim zdravljem i rizikom od pojave ili pogoršanja mentalnog poremećaja. Mogu ga koristiti stručnjaci u procjeni psiho-bio-socijalnih čimbenika koji pridonose nastanku mentalnih teškoća, procjeni zaštitnih i rizičnih čimbenika za mentalno zdravlje u određivanju ciljeva liječenja i izradi plana liječenja, ali i osobe s teškoćama mentalnog zdravlja u izradi osobnog plana oporavka. Stručnjaci također mogu koristiti kormilo u postupku vještačenja različitih prava osoba s problemima mentalnog zdravlja.

Pri procjeni važnosti pojedinačnih područja kormila za oporavak osobe s problemima mentalnog zdravlja treba voditi računa da se percep-

Description of Helm of recovery, goals and instructions for use

Helm of Recovery in mental health is a tool that helps psychiatrists and other professionals in developing an individual treatment or recovery plan for persons with mental health difficulties, including recovery goals and interventions that are necessary to achieve those goals. Helm of Recovery is founded on holistic biopsychosocial approach in understanding certain protective and risk factors that have an impact on mental health, principles of recovery as defined by SAMHSA guidelines for fostering recovery and respecting human rights in line with WHO's QualityRights and the assessment of functioning according to the WHO International Classification of functioning, disability and health (23).

Helm of Recovery may be used to evaluate the conditions in the areas of life that are relevant for recovery, to define the areas that require change, to follow the advancement toward defined goals in different time intervals, to evaluate the results and to modify the goals accordingly. Unsatisfied needs in any area of the helm may be associated with poor mental health and the risk of developing or aggravating symptoms of a mental disorder.

Helm of Recovery can be used by experts for assessing psychobiosocial factors that contribute to the development of mental health difficulties and for developing a treatment plan, as well as by persons with mental health difficulties for developing a personal recovery plan. It comprises three areas of recovery: recovery from the symptoms, recovery of functioning, and recovery of identity. In this context, recovery is different from the medical term "remission", which implies full recovery from symptoms and returning to pre-disease functioning. Instead, it is related to the process of personal strengthening and managing one's life in a way that enables the achievement of personal goals, living with the sense of purpose and experience of belonging to the community, even if the person still has some of the symptoms of mental health difficulties

cija stručnjaka i osobe s teškoćama mentalnog zdravlja može razlikovati, ali u planu liječenja treba se voditi prioritetima osobnih ciljeva osobe s teškoćama mentalnog zdravlja. Važno je napomenuti da se poboljšanje funkcioniranja u bilo kojem području kormila može odraziti i na druga područja uključujući i smanjenje rizika od ponovne pojavu simptoma mentalnog poremećaja. Osoba u procesu oporavka može postići i opće poboljšanje funkcioniranja, koje može biti i bolje od onoga koje je bilo prije bolesti. Za oporavak osobe često će biti potrebno, osim zdravstvenih, uključiti i druge službe i resurse zajednice.

UPUTE ZA KORIŠTENJE KORMILA OPORAVKA

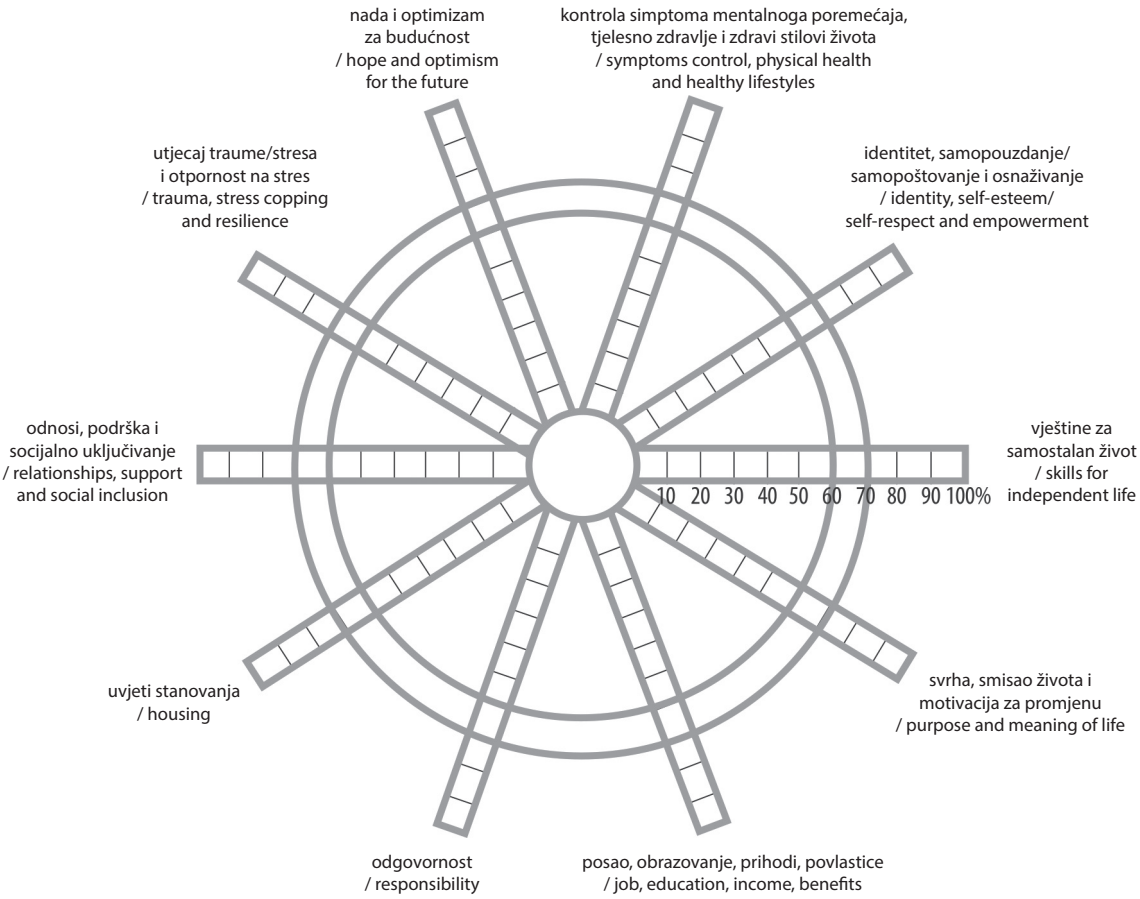
Procjena postojećeg stanja

Postojeće stanje u područjima obuhvaćenima u kormilu oporavka procjenjuje se na temelju različitih izvora podataka koji, osim izvora od osobe čije se stanje procjenjuje, mogu uključivati i druge korisne izvore za sagledavanje stvarnog stanja u području procjene. Procjena stanja u deset područja, opisanih u kormilu oporavka za svako područje, izražava se u postotku od 0 % do 100 %, gdje 0 % označava najlošije stanje u području, a 100 % najbolje moguće stanje. Točka usporedbe je očekivano funkcioniranje prosječno zdrave osobe u području koje se procjenjuje. Kada se kormilo koristi za planiranje liječenja/oporavka, postotak treba usuglasiti s osobom čije se stanje procjenjuje, ili treba navesti dva različita rezultata: procjenu osobe s teškoćama mentalnog zdravlja i procjenu stručnjaka. Opisi područja procjene i upisivanje rezultata procjene navedeni su u tablici 1. U tablici 1 označeno je tko je izvršio procjenu pacijent (P), stručnjak (S), a kada je procjena rezultat zajedničkog dogovora između pacijenta/korisnika i stručnjaka oznaka je (Z). Za upisivanje rezultata procjene može se koristiti i grafička shema kormila (slika 1).

and/or some of the difficulties with functioning. It should be noted that the assessment of the areas recovery included in Helm of Recovery might differ between the expert assessment and the assessment of the person with mental health difficulties. Depending on the purpose for which we use the helm of recovery in assessment, it can be improved if the assessment is coordinated together with the person with mental difficulties whose health state is being assessed when creating the plan of treatment/recovery where the person decides on the priorities important for his or her individual path of recovery that it is based on the expert's assessment or on the assessment of the person who has mental health difficulties exclusively when she/he creates her/his own plan of recovery.

INSTRUCTIONS FOR USING THE HELM OF RECOVERY

Assessment of the current condition in the areas included in Helm of Recovery is done based on various sources of data that may include other useful sources besides the information obtained from the person whose condition is being assessed. The assessment of the condition according to ten areas described in the helm of recovery ranges from 0% to 100% for each area, where 0% marks the worst condition, and 100% the best possible condition. The point used for reference comparison is expected functioning of an average healthy person in the specific area of assessment. When the helm of recovery is used for the planning of treatment/recovery, the percentage should be negotiated with the person whose condition is under assessment. Descriptions of the assessment areas and entry of the assessment results are provided in Table 1. Table 1 also indicates who performed the assessment, i.e., the patient (P), the expert (E), or (A) if the assessment is the result of a joint agreement between the patient/user and the expert. To enter the assessment results, one can also use the diagram of Helm of Recovery provided in Figure 1.



SLIKA 1. Procjena stanja u područjima oporavka. Upute za korištenje kormila: http://shorturl.at/arxY2
FIGURE 1 Assessment of the conditions in the Helm of Recovery areas. Instructions for use: http://shorturl.at/gyCDQ

Izbor prioritetnih područja promjene i ciljeva koji osoba želi ostvariti

Nakon određivanja područja u kojem osoba želi postići promjenu potrebno je u tablici 2 odrediti konkretne ciljeve i postupke koji mogu doprinijeti promjeni/oporavku.

Izbor postupaka koji doprinose promjeni/oporavku – postupci u individualnom planu liječenja/oporavka odnose na različite psiho-bio-socijalne postupke liječenja, potporu, suradnju s različitim službama (izvan zdravstvenih) i korištenje resursa zajednice koji pridonose oporavku. Izbor postupaka ovisit će o procjeni razloga (psiho-bio-socijalnih) koji doprinose utvrđenim teškoćama u određenom području kormila oporavka. Primjerice, razlozi mogu biti povezani sa simptomima bolesti, nedostatkom motivacije i

Choosing the priority areas of change and the goals that the person wants to accomplish

After deciding on the areas in which the person wants to see change, it is important to identify specific goals and actions that can contribute to change/recovery.

The choice of interventions that might contribute to change/recovery, or interventions in the treatment/recovery plan, include various psycho-bio-social modalities of treatment, support, collaboration with different services (other than health services) and the use of resources available within the community. The choice of interventions depends on the assessment of reasons (psycho-bio-social) that contribute to the difficulties in certain areas. For example, such reasons may be related to symptoms of an illness, lack of motivation, lack of skills, difficulties in interperson-

vještina, lošim međuljudskim odnosima, socijalnom izolacijom, nezaposlenošću, neprikladnim stanovanjem, stigmom, nedostatkom potpore i dr. Sve osobe koje se koriste kormilom oporavka i/ili provode bilo koji od postupaka koji potiču oporavak moraju poznavati principe oporavka i imati autentične stavove/vjerovanja da je oporavak realno moguć.

RASPRAVA

Individualni plan liječenja s ciljevima oporavka je obavezni standard za sve službe koje se bave pružanjem usluga u području mentalnog zdravlja, stoga psihijatri i drugi stručnjaci moraju imati kompetencije za izradu individualnog plana liječenja (2,24). Reorijentacijom skrbi za mentalno zdravlje prema oporavku i ljudskim pravima ciljevi liječenja se od fokusa na oslobađanje od simptoma pomiču prema osobnom oporavku, pa tako svi postupci koji se primjenjuju za poboljšanje mentalnog zdravlja imaju za cilj da potiču optimizam oporavka i osnažuju ljude da vode svoje živote u zajednici kojoj pripadaju. To je teško postići ako se psihijatrijska skrb pruža na „tradicionalni" način s pesimističkim očekivanjem oporavka u kojem je holistički bio-psiho-socijalni pristup samo deklarativan. Zaokret prema terapijskoj kulturi oporavka u praksi traži primjenu principa oporavka (11,18), ali, nažalost, postoje poteškoće u primjeni u svakodnevnoj psihijatrijskoj praksi zbog više razloga: tradicionalnog fokusa psihijatrije na kliničke ishode otklanjanja simptoma i prevladavanja biološkog pristupa u razumijevanju mentalnih poremećaja (9) kao i pesimističnih stavova psihijatara (8) prema oporavku koji nemaju podlogu u istraživanjima (25) i nedostatka edukacije iz oporavka (7). Svjetska zdravstvena organizacija razvila je cijeli niz preporuka za transformaciju sustava skrbi za mentalno zdravlje prema principima oporavka i poštivanja ljudskih prava (26) koji su korisni alati za transformaciju terapijske kulture. Kako bi

al relationships, social isolation, unemployment, inadequate housing, stigma, lack of support and other. Everyone using Helm of Recovery should be familiar with the principles of recovery. It is important to mention that the improvement/change in one area of the helm may influence changes in other areas, for example, employment may lead to the improvement of mental health, housing conditions and better relations with others.

DISCUSSION

An individual treatment plan with recovery goals is a mandatory standard for all mental health services that provide treatment in the field of mental health. Psychiatrists and other experts, therefore, must have the competence to create an individual treatment plan (2,24). By reorienting mental health care towards recovery and human rights, the goals of a treatment shift from a focus on relief of symptoms to personal recovery. Therefore, all interventions applied to improve mental health aim to encourage optimism in recovery and empower people to lead their lives in the community they belong to. This is difficult to achieve if psychiatric care is provided in a "traditional" way and with a pessimistic expectation of recovery in which the holistic bio-psycho-social approach is only declarative. The switch to a therapeutic culture of recovery in practice requires the application of the principles of recovery (11, 18). Unfortunately, there are many difficulties in applying it in everyday psychiatric practice due to several reasons. Psychiatry traditionally focuses on the clinical outcomes of eliminating symptoms and the prevailing biological approach in understanding mental disorders (9) as well as the pessimistic attitudes of psychiatrists towards recovery (8) that have not been confirmed by evidence in research (25) and the lack of education in recovery (7). The World Health Organization has developed a series of recommendations for the transformation of the mental health care system according to the principles of recovery and respect for human rights (26), which are useful tools for those who want to transform the therapeutic culture.

psihijatar što uspješnije izrađivao individualni plan liječenja u relativno novoj terapijskoj kulturi oporavka, potrebni su mu lako primjenjivi alati za izradu plana liječenja u svakodnevnoj kliničkoj praksi. Upravo zbog toga, a inspirirani asmjernicama *WHO QualityRights* za transformaciju terapijske kulture službi za mentalno zdravlje prema poticanju oporavka i poštivanja ljudskih prava odlučili smo se za izradu kormila oporavka kako bi povećali kompetencije psihijatra u primjeni principa oporavka u svakodnevnoj praksi. Kormilo oporavka stavlja pacijenta u fokus, jer je on taj koji određuje ciljeve liječenja u suradnji s psihijatrom, sudjeluje i ima odgovornost za njihovu provedbu. U odnosu na neke dostupne alate naše kormilo oporavka možemo usporediti sa zvijezdom oporavka, koja se koristi u praćenju oporavka osoba s teškoćama mentalnog zdravlja koji žele postići promjenu u različitim područjima života i kao mjera ishoda oporavka, temelji se na modelu promjene, te koristi ljestve promjene koje se sastoje od nekolika faza definiranih u stepenicama promjene (27). Kao i naše kormilo, zvijezda oporavka također uključuje poznate principe oporavka. Naše kormilo je namijenjeno za kliničku upotrebu u psihijatrijskoj praksi pa se zato temelji na holističkom bio-psiho-socijalnom modelu i obuhvaća tri područja oporavka: simptome, funkcioniranje i personalni oporavak.

ZAKLJUČAK

Kormilo oporavka je alat za izradu individualnog plana liječenja/oporavka koji uključuje sva područja relevantna za oporavak mentalnog zdravlja s ciljem da pomogne psihijatrima i drugim stručnjacima u području mentalnog zdravlja u implementaciji principa oporavka u svakodnevnoj psihijatrijskoj praksi. Mogu ga koristiti i pacijenti u izradi individualnog plana oporavka. U daljnjem tijeku bilo bi važno procijeniti primjenjivost kormila oporavka u istraživanjima ishoda liječenja/oporavka.

In order for a psychiatrist to create an individual treatment plan as successfully as possible in a relatively new therapeutic culture of recovery, he or she needs to have easily applicable tools for creating a treatment plan in everyday clinical practice. Precisely because of this and inspired by the WHO QualityRights guidelines for the transformation of the therapeutic culture of mental health services towards encouraging recovery and respect for human rights, we decided to create Helm of Recovery in order to increase the competence of psychiatrists in applying the principles of recovery in everyday practice. Helm of Recovery puts the patient in focus, as the patient becomes the one to determine the treatment goals in cooperation with the psychiatrist. Thus, the patient participates and has responsibility for their implementation. In relation to some available tools, our Helm of Recovery can be compared to the recovery star, which is used in monitoring the recovery of people with mental health difficulties who want to achieve change in different areas of life and as a measure of the outcome of recovery. It is based on a model of change, and uses a ladder of change, which consist of several phases defined in the steps of change (27). Like the recovery star, Helm of Recovery also incorporates the known principles of recovery. Our Helm of Recovery is intended for clinical use in psychiatric practice and is based on a holistic biopsychosocial model encompassing three areas of recovery: symptoms, functioning and personal recovery.

CONCLUSION

Helm of Recovery is a tool for creating an individual treatment/recovery plan that includes all areas relevant to mental health recovery. It can help psychiatrists and other mental health professionals in implementing the principles of recovery in everyday psychiatric practice, as well as people with mental health difficulties in creating a personal recovery plan. In the future, it would be important to assess the applicability of Helm of Recovery in treatment/recovery outcome research.

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Kongresi u 2023. godini
/ *Congresses in 2023*

International Conference on Cognitive Neuroscience of Ageing
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International Conference on Cognitive Psychology and Neuroscience
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Amsterdam, 21. – 22. siječnja 2023.

American Psychoanalytic Association National Meeting
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