Socijalna psihijatrija

UDC 616.89
SPSIDE 49 (2) 91-176 (2021)
ISSN 0303-7908

VOL. 49 – 2021
BROJ/NUMBER 2
ZAGREB, lipanj/June 2021.

SADRŽAJ / *CONTENTS*

Povezanost lucidnih snova, obrambenih mehanizama i psihičkih tegoba

/ The Relationship Between Lucid Dreams, Defense Mechanisms and Mental Difficulties

Marija Ivanović[1], Nataša Šimić[2]

[1]Osnovna škola Julija Kempfa Požega, Požega, Hrvatska; [2]Sveučilište u Zadru, Odjel za psihologiju, Zadar, Hrvatska

/ [1]Julije Kempf Elementary School in Požega, Požega, Croatia; [2]University of Zadar, Department of Psychology, Zadar, Croatia

ORCID ID: 0000-0002-8747-8036
ORCID ID: 0000-0002-4215-3668

Lucidni su snovi hibridni fenomeni između spavanja i budnosti, s velikim terapijskim potencijalom. Tako je moguće proučavati kontinuitet psihopatologije i emocionalne regulacije u budnosti i snovima putem obrambenih mehanizama. Dosadašnja malobrojna istraživanja potvrđuju da multidimenzionalan pristup lucidnom sanjanju posljedično ima drugačije implikacije u objašnjenju (mal)adaptivnosti ovog fenomena za psihičko zdravlje. Cilj ovog istraživanja bio je ispitati odnose pojedinih dimenzija lucidnog sanjanja s varijablama psihopatološkog distresa. Upitnik obrambenih stilova (DSQ-40), Kratki inventar simptoma (BSI) te Upitnik frekvencije i intenziteta lucidnosti (FILD) primijenjeni su u *online* uzorku od 665 sudionika. Prvi put primijenjen na hrvatskom uzorku, FILD upitnik je pokazao zadovoljavajuće psihometrijske karakteristike. Sukladno hipotezi kontinuiteta, utvrđene su značajne pozitivne povezanosti negativnih emocija, broja buđenja, tehnika indukcije te frekvencije lucidnosti sa simptomima psihopatologije. Štoviše, dobivene su negativne značajne povezanosti kvalitete spavanja, želje za novim lucidnim snom, pozitivnih emocija te intenziteta lucidnosti sa ispitanim simptomima, kao i različiti obrasci povezanosti obrambenih mehanizama s dimenzijama lucidnosti u snovima. Dobiveni rezultati pokazuju kako su, pored kvalitete spavanja, broja buđenja i želje za novim lucidnim snom, emocionalnost i tehnike indukcije važne odrednice psihološke dobrobiti lucidnih sanjača. Ovo ja bitan pomak u dosadašnjim istraživanjima i razumijevanju višedimenzionalnosti lucidnog sanjanja.

/ Lucid dreams are hybrid phenomena between sleep and wakefulness, with great therapeutic potential. Thus, it is possible to study the continuity of psychopathology and emotional regulation in wakefulness and dreams through defense mechanisms. Only few studies so far have confirmed that a multidimensional approach to lucid dreaming consequently has different implications in explaining the (mal)adaptability of this phenomenon to mental health. The aim of this study was to examine the relationships of different dimensions of lucid dreaming with variables of psychopathological distress. The Defense Style Questionnaire (DSQ-40), the Short Symptom Inventory (BSI) and the Frequency and Intensity Questionnaire (FILD) were applied online in a sample of 665 participants. First applied to a Croatian population sample, the FILD questionnaire showed satisfactory psychometric characteristics. According to the continuity hypothesis, significant positive associations of negative emotions, number of awakenings, induction techniques and frequency of lucid dreams with symptoms of psychopathology were found. Moreover, negative significant correlations between sleep quality, desire for a new lucid dream, positive emotions and intensity of lucid dreams with the examined symptoms were found, as well as different patterns of defense mechanisms with lucidity dimensions in dreams. The obtained results show that, in addition to the quality of sleep, the number of awakenings and the desire for a new lucid dream, emotionality and induction techniques are important determinants of the psychological well-being of lucid dreamers. This represents a significant shift in research and understanding of the multidimensionality of lucid dreaming so far.

ADRESA ZA DOPISIVANJE / *CORRESPONDENCE*:
Mag. psych. Marija Ivanović
Osnovna škola Julija Kempfa Požega
Dr. Franje Tuđmana 2
34 000 Požega, Hrvatska
E-pošta: marija.ivanovic667@gmail.com

KLJUČNE RIJEČI / *KEY WORDS:*
Lucidni snovi / *Lucid Dreams*
Obrambeni mehanizmi / *Defence Mechanisms*
Psihopatološki simptomi / *Psychopathological Symptoms*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2021.93

UVOD

Tijekom spavanja u odnosu na budnost, značajke svijesti bitno se mijenjaju. To je još Freud (1) opisao primitivnim, animalističkim mišljenjem, koje je danas neurobiološki potvrđen regresivnim oblikom kognicije. Snovi najčešće nastaju u REM fazi spavanja, kad se električna aktivnost mozga smanjuje u području prefrontalnog korteksa čime su onemogućene sposobnosti uvida, logičnog mišljenja i donošenja odluka (2). Spavač je tako pasivan, bez kontrole nad radnjom sna, a samo je iskustvo sanjanja dinamično i emocionalno intenzivno kao stvarnost (3). U odnosu na kvantitativne, ovakvi kvalitativni aspekti spavačeve svijesti, poput paralize spavanja, hipnagognih halucinacija i konfuzija pri buđenju (4), još uvijek su manje istraženi. Watson (5) je empirijski podijelio iskustva pri spavanju na mnoštvo netipičnih fenomena pri sanjanju (i prijelazima k budnosti) te na doživljaj lucidnosti u snovima, što je definirao kao svijest pojedinca da sanja tijekom sna te da ima kontrolu nad radnjom sna.

Ovaj fenomen odavno ima kulturološko i religijsko značenje (6). Udaljavanjem od spiritualizma i parapsihologije dvadesetim stoljećem počinju znanstvena istraživanja lucidnosti (7,8). Od 1970-ih, u sklopu transpersonalne psihologije ispituje se odnos s meditacijom i psihološkim blagostanjem (9). Hearne (10) je ubrzo demonstrirao da motorička aktivnost nije potpuno inhibirana tijekom REM spa-

INTRODUCTION

During sleep as opposed to wakefulness, the characteristics of consciousness change significantly. This was described by Freud (1) in primitive, animalistic thinking, which is today neurobiologically confirmed by a regressive form of cognition. Dreams are the most common in REM sleep, when brain activity decreases in the area of the prefrontal cortex, impeding insights, logical opinions and decision making (2). Therefore, the sleeper is passive, without control over the action of the dream, and the experience of dreaming is as dynamic and emotionally intense as reality (3). Compared with the quantitative aspects of sleep, these qualitative aspects of sleep consciousness, such as sleep paralysis, hypnagogic hallucinations and waking confusion (4), are still less explored. Watson (5) empirically divided sleep experiences into a multitude of atypical phenomena in dreaming (and transitions to wakefulness) and the experience of lucidity in dreams, which he defined as an individual's awareness to dream during a dream and to have control over a dream.

This phenomenon has long had cultural and religious significance (6). By moving away from spiritualism and parapsychology, scientific research into lucidity began in the twentieth century (7,8). Since the 1970s, as part of transpersonal psychology, the relationship with meditation and psychological well-being has been examined (9). Hearne (10) soon demonstrated that motor activity is not completely inhibited during REM sleep. His technique of signaling the onset of lucidity with

vanja. Njegovu tehniku signalizacije početka lucidnosti voljnim okulomotornim pokretima usvojio je i La Berge (11), čime je započela era psihofizioloških i neurobioloških ispitivanja. Daljnjim je istraživanjima lucidnost potvrđena kao hibridno stanje svijesti sa značajkama i budnosti i nelucidnog sna. U određenim su moždanim strukturama utvrđene strukturne i fiziološke razlike pri pojavi lucidnih u odnosu na nelucidne REM snove (12), što može objasniti njihovu različitu fenomenologiju. Lucidni su snovi tako popraćeni višom razinom dosjećanja, uvida, kontrole, refleksivnosti, disocijacije te pozitivnih emocija. Isto ne vrijedi za njihovu realističnost i popratne negativne emocije. Sadržajno gledano, postoji više sličnosti nego razlika pa u lucidnim snovima i dalje mogu perzistirati iracionalne misli, njihovo dosjećanje nije uvijek učestalije te je percepcija i dalje vrlo slična onoj u budnosti (13).

Moderna su istraživanja utvrdila osnovna obilježja lucidnih snova, a najvažnije je uvid, metakognitivna spoznaja o trenutnom stanju svijesti tijekom sna (14). Kontrola tijekom sna omogućava manipuliranje radnjom, a disocijativnim mišljenjem lucidni sanjač zauzima perspektivu treće osobe. Česti su izvještaji u kojima sanjači cijele scene lucidnosti vide poput filma na zaslonu (11). Pri uvježbavanju određenih radnji podudaraju se obrasci aktivnosti određenih kortikalnih regija i fizioloških parametara u lucidnom i budnom stanju (11), što može objasniti rezultate istraživanja (15) koji potvrđuju da je uvježbavanje određene radnje jednako učinkovito u oba stanja.

Lucidnost u snu doživi barem jednom tijekom života 55 % populacije, a 23 % barem jednom mjesečno (16). Incidencija spontane lucidnosti raste tijekom djetinjstva i adolescencije, s vrhuncem u dobi od 16 godina, a potom ubrzano opada. Okidači takve nenamjerne lucidnosti najčešće su noćne more i emocije poput srama i ushita (17). Zahvaljujući tehnikama indukcije, lucidnost može postati i dobro naučena vješti-

voluntary oculomotor movements was also adopted by La Berge (11), thus beginning the era of psychophysiological and neurobiological research. Further research confirmed lucidity as a hybrid state of consciousness, with features of both wakefulness and non-lucid sleep. In certain brain structures, structural and physiological differences were found in the occurrence of lucid versus non-lucid REM dreams (12), which may explain their different phenomenology. Lucid dreams are thus accompanied by a higher level of memory recall, insight, control, reflexivity, dissociation and positive emotions. This was not confirmed with regard to their realism and accompanying negative emotions. In terms of their content there are more similarities than differences, so irrational thoughts can still persist in lucid dreams, their recall is not always more frequent and the perception is still very similar to that in wakefulness (13).

Modern studies have established the basic characteristics of lucid dreams, the most important of which is insight, i.e. metacognitive cognition of the current state of consciousness during the dream (14). Control during dream ensures manipulation of actions, and the lucid dreamer takes a third-person perspective by dissociative thinking. There are frequent reports in which dreamers see the whole scene of lucidity like a movie on a screen (11). When practicing specific actions, the patterns of activity of corresponding cortical regions and physiological parameters in lucid and awake states (11) coincide, which may explain the results of studies (15) which confirm that practicing certain actions is equally effective in both states.

55% of the population experience lucidity in a dream at least once in life and 23% experience it at least once a month (16). The incidence of spontaneous lucidity increases during childhood and adolescence, peaking at age 16 and then declining rapidly. The triggers of such unintentional lucidity are most often nightmares and emotions such as shame and elation (17). Thanks to induction techniques, lucidity can also become a well-learned skill. In dreams, there are frequent

na. U snovima su česte distorzije u kvantiteti i kakvoći objekata iz budnosti, koje osviještene u snu naznačuju početak lucidnosti (17). Ipak, nijedna od poznatih tehnika nije dovoljno verificirana kao valjana metoda indukcije (18).

Istraživanja lucidnosti upitničkom metodom nedovoljno su česta. U ovom je području očita i heterogenost istraživačkog pristupa, koja proizlazi iz samih kriterija lucidnosti utemeljenih na uvidu i/ili kontroli nad radnjom sna. Prva su istraživanja lucidne snove ispitivala jednom česticom, npr. *„Koliko često doživljavate tzv. lucidne snove?“* (19) i *“Jeste li ikada imali san tijekom kojeg ste znali da sanjate?”* (20), što se ubrzo pokazalo nedovoljno osjetljivom mjerom. Prvu ljestvicu lucidnosti predložio je Watson (5), dok su Voss i sur. (14) konstruirali obuhvatniju mjeru. Najveći doprinos ipak su dale autorice Aviram i Soffer-Dudek (21), razvojem Upitnika frekvencije i intenziteta lucidnih snova (FILD), koji se temelji na opširnijoj definiciji ovog fenomena i mjeri četiri dimenzije: frekvenciju, intenzitet i emocionalnu valenciju lucidnih snova te frekvenciju korištenja sedam tehnika indukcije.

Nekonzistentni rezultati dosadašnjih istraživanja o povezanosti između lucidnosti s depresijom (22,23), posttraumatskim stresnim poremećajem (24,25), disocijacijom (5,23,25-27) i shizotipijom (5,27) mogu se, barem dijelom objasniti i različitim operacionalizacijama lucidnosti. Ispitujući ovaj fenomen s ostalim noćnim fenomenima povezanima sa shizotipijom i doživljajima disocijacije (5), lucidnost je promatrana kao intruzivna pobuđenost u snu (4,23), rani biljeg prikrivenog distresa (28) te indikator loše kvalitete spavanja (4). Međutim, 65 % lucidnih sanjača naglašava njene prednosti, poput psihičkog i duhovnog blagostanja (29). Prema istraživanjima, unutarnji lokus kontrole, psihološka otpornost (23), bolje opće mentalno zdravlje (30) te asertivnost, autonomija i samopouzdanje (31) također su bitne odlike lucidnih sanjača. Dimenzionalnim pristupom

distortions in the quantity and quality of objects from wakefulness, which indicate the beginning of lucidity (17). However, none of the known techniques has been sufficiently verified as a valid method of induction (18).

Questionnaire-based lucidity research is insufficiently common. The heterogeneity of the research approach is also evident in this area, which arises from the very criteria of lucidity based on insight and / or control over dream activity. The first studies examined lucid dreams with a single particle, e.g. “How often do you experience the so-called lucid dreams?” (19) and “Have you ever had a dream during which you knew you were dreaming?” (20), which soon proved to be an insufficiently sensitive measure. The first scale of lucidity was proposed by Watson (5), while Voss et al. (14) constructed a more comprehensive measure. However, the greatest contribution was made by the authors Aviram and Soffer-Dudek (21), with the development of the Frequency and Intensity of Lucid Dreams Questionnaire (FILD), which is based on a broader definition of this phenomenon and measures four dimensions: frequency, intensity and emotional valence of lucid dreams and the frequency of using seven induction techniques.

Inconsistent results of previous research on the association between lucidity with depression (22-23), post-traumatic stress disorder (24,25), dissociation (5, 23, 25-27) and schizotyping (5, 27) can be explained, at least in part, by different operationalizations of lucidity. By examining this phenomenon with other nocturnal phenomena associated with schizotypy and dissociative experiences (5), lucidity was observed as intrusive arousal in sleep (4, 23), an early marker of latent distress (28), and a poor sleep quality indicator (4). However, 65% of lucid dreamers emphasize its benefits, such as mental and spiritual well-being (29). According to studies, internal locus of control, psychological resilience (23), better general mental health (30), assertiveness, autonomy, and self-confidence (31) are also essential characteristics of lucid dreamers. With the introduction of the dimensional approach, the relationship

odnos između lucidnosti i mentalnog zdravlja postao je jasniji (21). Naime, potvrđeno je da frekvencija izazvanih lucidnih snova pozitivno predviđa simptome disocijacije i shizotipije, dok svijest u snu ne pridonosi psihološkoj dobrobiti ni distresu. Nadalje, ključnim se pokazala sanjačeva percepcija pobuđenosti, tj. lucidnost visokog intenziteta i pozitivnog afekta implicira manje distresa u odnosu na svijest bez kontrole, popraćenu negativnim afektima (21).

Prema psihodinamskom pristupu, snovi su kraljevski put do nesvjesnoga (32). Povezani su s obrambenim mehanizmima, najranijim oblicima emocionalne regulacije koji štite od anksioznosti zbog intrapsihičkih konflikata i doprinose psihološkoj prilagodbi. Kad su zreli, obrambeni mehanizmi predviđaju mentalno i tjelesno zdravlje (33). Međutim, predugim i rigidnim korištenjem postaju maladaptivni pa ne čudi njihov pozitivan odnos sa psihopatologijom (34). Odnos obrana i mentalnog zdravlja vrlo je dinamičan, a rad na snovima može potaknuti psihoterapijski napredak usvajanja adaptivnijih obrana jer se tako postiže manji otpor ega (35). Lucidni snovi omogućavaju sanjaču i aktivno suočavanje s npr. objektom straha, u sigurnim uvjetima. Tako sanjač integrira nove osjećaje prema sebi i okolini, umjesto da izbjegava suočavanje u budnosti i/ili se budi iz noćnih mora (18). Naime, procesiranje i regulacija emocija posebno su facilitirani tijekom REM snova, što podržava iste procese i tijekom budnosti (17). Prethodno navedeno objašnjava i tzv. hipoteza kontinuiteta, prema kojoj su snovi odraz vidljivih i prikrivenih aspekata budnosti. Ovu sukladnost budnih iskustava sa snovima moguće je proučavati na više razina. Jedna od njih je i zrelost osobne emocionalne regulacije koja se empirijski može ispitati pomoću obrambenih mehanizama (36). Stoga se odnos obrana, (lucidnih) snova i psihopatologije potencijalno može objasniti i kao kontinuitet emocionalne regulacije u budnosti i snovima.

between lucidity and mental health has become clearer (21). Namely, it was confirmed that the frequency of induced lucid dreams positively predicts symptoms of dissociation and schizotyping, while arousal in dreams does not contribute to psychological well-being or distress. Furthermore, the dreamer's perception of arousal has been shown to be crucial, i.e., high intensive lucidity accompanied by positive affects implies less distress compared with uncontrolled consciousness accompanied by negative affects (21).

According to the psychodynamic approach, dreams are the royal path to the unconscious (32). They are associated with defense mechanisms, the earliest forms of emotional regulation, which protect against anxiety due to intrapsychic conflicts and contribute to psychological adjustment. When mature, defense mechanisms predict mental and physical health (33). However, with too long and rigid use, they become maladaptive, so their positive relationship with psychopathology is not surprising (34). The relationship between defenses and mental health is very dynamic, and working on dreams can encourage psychotherapeutic progress in adopting more adaptive defenses, because less ego resistance is achieved in this way (35). Lucid dreams enable the dreamer to actively deal with, for example, the object of fear in safe conditions. Thus, the dreamer integrates new feelings towards himself and the environment, instead of avoiding confrontation in wakefulness and/or waking up from nightmares (18). Namely, emotion processing and regulation are particularly facilitated during REM dreams, which supports the same processes during wakefulness (17). The above also explains the so-called continuity hypothesis, according to which dreams reflect visible and veiled aspects of wakefulness (36). This consistency of waking experiences with dreams can be studied at multiple levels. One of them is the maturity of personal emotional regulation, which can be empirically examined using defense mechanisms. Therefore, the relationship between defenses, (lucid) dreams and psychopathology can potentially be explained as a continuity of emotional regulation in wakefulness and dreams.

Cilj ovog istraživanja bio je provjeriti psihometrijske karakteristike FILD upitnika te potom ispitati odnose različitih dimenzija lucidnosti sa simptomima psihopatologije i obrambenim mehanizmima u kontekstu hipoteze kontinuiteta.

METODA

Uzorak

Uzorak je činilo 665 sudionika, većinom studenti (59,70 %) i žene (72,93 %), raspona dobi od 17 do 44 godine (M=22,10; SD=3,53). Sudionici najčešće pate od simptoma nesanice (29,17 %), paralize spavanja (15,28 %), poremećaja ritma spavanja (13,19 %), noćnih strahova (6,25 %), sindroma nemirnih nogu (5,56 %), mjesečarenja (4,86 %) i narkolepsije (1,39 %).

Instrumentarij

Upitnik frekvencije i intenziteta lucidnih snova FILD (21) sadrži ukupno 21 česticu i obuhvaća četiri dimenzije: frekvencija (trenutna, produžena, spontana, pokušaji indukcije, uspješna indukcija), intenzitet (sigurnost, aktivnost, kontrola, trajanje u sekundama/minutama, broj scena) i emocionalna valencija lucidnih snova (pozitivna početak, negativna početak, pozitivna kraj, negativna kraj) te tehnike indukcije lucidnosti (dnevnik spavanja, čitanje, misli tijekom budnosti i prije spavanja, provjera stvarnosti, planiranje izmjena spavanja i budnosti, napredne tehnike). Na čestice vezane uz frekvenciju daju se procjene čestine u rasponu od 0 *(„Nikada.“)* do 7 *(„Dva puta tjedno i češće.“*), a uz intenzitet, u rasponu od 0 (nesigurnost/pasivnost/bez kontrole u 80-100 % slučajeva i *„Kad shvatim da sanjam, probudim se.*“) do 4 (sigurnost/aktivnost/kontrola u 80-100 % slučajeva i *„Obično moja lucidnost traje 6 minuta i duže./ Obično doživim 4 i više lucidnih scena.*“).

The aim of this study was to verify the psychometric characteristics of the FILD questionnaire and to then examine the relationships between different dimensions of lucidity and the symptoms of psychopathology and defense mechanisms in the context of the continuity hypothesis.

METHOD

Sample

The sample consisted of 665 participants, mostly students (59.70%) and women (72.93%), ranging in age from 17 to 44 years (M=22.10; SD=3.53). Participants most often suffer from symptoms of insomnia (29.17%), sleep paralysis (15.28%), sleep rhythm disorder (13.19%), night terrors (6.25%), restless legs syndrome (5.56%), somnambulism (4.86%) and narcolepsy (1.39%).

Instruments

The Frequency and Intensity of Lucid Dreams Questionnaire (21) contains a total of 21 items and includes four dimensions: frequency (momentary, prolonged, spontaneous, induction attempts, successful induction), intensity (confidence, activity, control, duration in seconds / minutes, number of scenes) and emotional valence of lucid dreams (positive beginning, negative beginning, positive ending, negative ending) and lucidity induction techniques (dream diary, reading, thoughts during and before sleep, reality checking, planning sleep time, advanced techniques). On frequency-related items, estimates are given ranging from 0 (*“Never.”*) to 7 (*“Twice a week and more often.”*), and on intensity items they range from 0 (uncertainty/passivity/no control in 80-100% of cases and *“When I realize I’m dreaming, I wake up.”*) up to 4 (confidence/activity/control in 80-100% of cases and “Usually my lucidity lasts 6 minutes and longer. / *I usually experience 4 or more lucid scenes*.”). On two emotion-related items estimates before the onset of lucidity are given ranging from 0 (“0% *None of my lucid dreams start positively/negatively.*”) to 10 (“100% *All my*

Na dvjema česticama vezanim uz emocije prije pojave lucidnosti odgovara se u rasponu od 0 *(„0 % Nijedan moj lucidni san ne započinje pozitivno/negativno.“)* do 10 *(„100 % Svi moji lucidni snovi započinju pozitivno/negativno.“)*. Na isti se način odgovara na čestice vezane uz emocije koje slijede lucidnost, od 0 *(„0 % Nikad se ne osjećam dobro/loše nakon postizanja lucidnosti.“)* do 10 *(„100 % Uvijek se osjećam dobro/loše nakon postizanja lucidnosti.“)*. Rezultati na podljestvicama formiraju se kao prosjek rezultata postignutih na pripadajućim česticama, s tim da se negativne emocije prije i nakon lucidnosti prvo rekodiraju. Viši rezultati ukazuju na veću učestalost doživljavanja i veći intenzitet lucidnih snova te pozitivnije emocije koje prethode/slijede lucidnost u snu. Na isti se način formiraju i interpretiraju rezultati podljestvice tehnike indukcije, a procjene se daju u rasponu od 0 *(„Nikada.“)* do 5 *(„Tri puta i više tijekom prošlog mjeseca.“)*. Za potrebe ovog istraživanja, dobiveno je odobrenje za korištenje FILD upitnika od strane autorica (21) a upitnik je preveden na hrvatski jezik.

S obzirom na neistraženost fenomena lucidnosti, za potrebe ovog istraživanja osmišljene su dodatne čestice kojima se ispitala želja za novim lucidnim snom, tipična radnja i dosjećanje lucidnih snova te broj buđenja i kvaliteta spavanja u tipičnoj noći u kojoj su sudionici lucidno sanjali. Na pitanje *„Biste li htjeli ponovno doživjeti novi lucidni san?“*, odgovaralo se u rasponu od *„0 - Ne.“,* preko *„1 - Nisam siguran/na.“* do *„2 - Da.“*. Viši je rezultat ukazivao na pozitivniji stav prema novom lucidnom snu. Pri opisu tipične radnje i dosjećanja, uz opciju *„Ostalo“*, dane su procjene u rasponu od 1 *(„Doživljavam kratkotrajne i apstraktne elemente lucidnosti bez konkretnog sadržaja kojeg se sjećam“)* preko 2 *(„Nasumične radnje nepovezane jedna s drugom tijekom jednog lucidnog sna.“)* do 3 *(„Jedna smislena radnja koja se nastavlja kroz bar dva lucidna sna“)* te na ljestvici s krajnjim vrijednostima 0 *(„0 % Ne sjećam se radnje svog lucidnog sna.“)* i 10 *lucid dreams start positively/negatively.*“). Items related to emotions that follow lucidity have the same range, from 0 (“0% *I never feel good/bad after achieving lucidity.*”) to 10 (“100% *I always feel good/bad after achieving lucidity.*”). The results on the subscales are calculated as the average of the results achieved on the corresponding items, with the negative emotions before and after lucidity being recoded first. Higher results indicate a higher frequency of experiences with lucidity, higher intensity of lucid dreams and more positive emotions that precede/follow lucidity in dreams. The results of the induction technique subscale are formed and interpreted in the same way, and estimates are given in the range from 0 (“Never.”) to 5 (*“Three times or more during the last month.”*). For the purposes of this study, approval was obtained for the use of the FILD questionnaire by the authors (21) and the questionnaire was translated into Croatian.

Considering the unexplored phenomenon of lucidity, additional items were designed for the purposes of this study to examine the desire for a new lucid dream, typical plot and recall of lucid dreams, the number of awakenings and sleep quality on a typical night in which participants lucidly dreamed. Possible answers to the question *“Would you like to experience a new lucid dream?”* ranged from *“0-No.”* through *“1-I’m not sure.”* to “2-Yes.”. The higher score indicated a more positive attitude toward the new lucid dream. When describing a typical plot and its recall rates, in addition to the *“Other”* option, estimates ranged from 1 (*“I experience short-lived and abstract elements of lucidity without a specific narrative I remember”*) and 2 (“*Random actions unrelated to each other during a lucid dream.*”) to 3 (“*One meaningful action that continues through at least two lucid dreams.*”) and on a scale with end values of 0 (“0% *I don’t remember the narrative of my lucid dream.*”) and 10 (“100% *I remember the narrative of my lucid dream.*”). The higher score indicated more meaningful narrative and their more frequent recall. When assessing the number of awakenings and the quality of sleep, estimates are given ranged from 0 (“*I have an un-*

(„100 % U potpunosti se sjećam radnje svog lucidnog sna.“). Viši je rezultat ukazivao na veću smislenost i češće dosjećanje sadržaja radnje. Pri procjeni broja buđenja i kvalitete spavanja procjene su dane u rasponu od 0 („*Imam neprekinut san cijelu noć*“) do 3 („*Budim se tri i više puta tijekom noći*.“) te od 0 *(„Osjećam se iscrpljeno i umorno.“)* do 4 *(„.Osjećam se svježe i odmoreno.“).*

Upitnik obrambenih stilova DSQ-40 (37) sadrži 40 čestica koje ispituju svjesne aspekte 20 obrana na koje se odgovara u rasponu od 1 *(„Uopće se ne slažem.“)* do 9 *(„U potpunosti se slažem.*“). Individualni je rezultat prosjek dviju čestica pripadajućih određenoj obrani, odnosno obrana pripadajućih određenom obrambenom stilu. Tako se ovim upitnikom dobivaju informacije o 20 obrana grupiranih kao: zrele (sublimacija, humor, anticipacija, supresija), nezrele (projekcija, pasivna agresija, izvođenje, izolacija, devaluacija, autistična fantazija, poricanje, premještanje, disocijacija, raščlanjivanje, racionalizacija, somatizacija) i neurotske (negiranje, pseudoaltruizam, idealizacija, reaktivna formacija). Upitnik je validiran na hrvatskom uzorku studenata (38), a koeficijenti Cronbach alfa pouzdanosti za zrele, neurotske i nezrele obrane (0,52, 0,50 i 0,71) nešto su niži od dobivenih u ovom istraživanju (0,67, 0,63 i 0,79).

Kratki inventar simptoma BSI (Brief Symptom Inventory) (39) sadrži 53 čestice i mjeri devet dimenzija trenutnih simptoma izazvanih stresnim događajima: somatizacija, opsesivna kompulzivnost, osjetljivost u međuljudskim odnosima, depresija, anksioznost, neprijateljstvo, fobičnost, paranoidne ideje, psihoticizam. Čestice se procjenjuju u rasponu od nula *(„Nimalo.“)* do četiri *(„Vrlo mnogo“).* Individualan je rezultat prosjek čestica pripadajućih određenoj dimenziji. Procjena je moguća i putem indeksa ukupnih teškoća, prisutnih simptoma nelagode i ukupnih prisutnih simptoma. Tri globalna indeksa, devet dimenzija i 53 čestice tako daju tri razine interpretacije, od opće mjere psihološkog statusa, preko reprezentacije sindroma

interrupted sleep all night”) to 3 (*“I wake up three or more times during the night”*) and from 0 (*“I feel exhausted and tired”*) to 4 (*“I feel fresh and rested.”*).

The Defense Styles Questionnaire DSQ-40 (37) contains 40 items that examine conscious aspects of 20 defenses, to which possible answers range from 1 (*“I completely disagree.”*) to 9 (*“I completely agree.”*). The individual result is the average of two items belonging to a certain defense, i.e. the defense belonging to a certain defensive style. Thus, this questionnaire provides information on 20 defenses grouped as: mature (sublimation, humor, anticipation, suppression), immature (projection, passive aggression, acting out, isolation, devaluation, autistic fantasy, denial, displacement, dissociation, splitting, rationalization, somatization) and neurotic (denial, pseudoaltruism, idealization, reactive formation). The questionnaire was validated on a Croatian sample of students (38), and the Cronbach alpha reliability coefficients for mature, neurotic and immature defenses (0.52, 0.50 and 0.71) were slightly lower than those obtained in this study (0.67, 0.63 and 0.79).

The Brief Symptom Inventory (BSI) (39) contains 53 items and measures nine dimensions of current symptoms caused by stressful events: somatization, obsessive-compulsiveness, sensitivity in interpersonal relationships, depression, anxiety, hostility, phobia, paranoid ideas and psychoticism. Estimates are given in a range from 0 (*“Not at all”*) to 4 (*“Very much”*). The individual result is the average of the items belonging to a certain dimension. Assessment is also possible through an index of total difficulty, present symptoms of discomfort and total present symptoms. Three global indices, nine dimensions, and 53 items thus provide three levels of interpretation, from a general measure of psychological status, through a representation of the syndrome, to individual symptoms. The one-factor structure of the inventory was confirmed on a Croatian sample of traumatized and general populations, and Cronbach’s alpha confidence coefficients for the general population ranged from 0.69 for psychoticism to 0.84

do pojedinih simptoma. Na hrvatskom uzorku traumatiziranih i opće populacije potvrđena je jednofaktorska struktura inventara, a koeficijenti Cronbach alfa pouzdanosti za opću populaciju kretali su se od 0,69 za psihoticizam do 0,84 za somatizaciju (40). U ovom istraživanju, s rasponom od 0,72 za psihoticizam do 0,87 za anksioznost, dobiveni su jednako zadovoljavajući koeficijenti kao i u ranijim istraživanjima (38).

Postupak

Online istraživanje *Google forms* oblika provođeno je tijekom travnja i svibnja 2020. godine. Putem *Facebook* grupa različitih interesa u najvećim gradovima RH, potencijalni sudionici dobi između 18 i 30 godina bili su obaviješteni o istraživanju o snovima i emocijama. Zajamčena im je anonimnost, povjerljivost i mogućnost odustajanja od istraživanja. Prvo su primijenjeni DSQ-40 i BSI upitnici. Sudionici su također pitani o poremećajima spavanja od kojih pate. Zatim su popunjavali FILD upitnik i to prvo pitanja koja se odnose na frekvenciju doživljavanja lucidnosti *(N=665*). Drugi dio FILD upitnika, koji je uključivao pitanja vezana za intenzitet i emocije, popunjavali su oni sudionici koji su doživjeli barem jedno iskustvo lucidnosti tijekom života *(N=479)*. Potom su uslijedila pitanja konstruirana u svrhu ovog istraživanja, kojima se ispitala želja za novim lucidnim snovima *(N=477*), njihova tipična radnja i dosjećanje *(N=467)* te broj buđenja *(N=265)* i kvaliteta spavanja *(N=284*) u tipičnoj lucidnoj noći. Na kraju samog istraživanja, sudionicima je zahvaljeno na sudjelovanju te je ostavljena mogućnost komentara.

REZULTATI

Prikupljeni su podatci obrađeni pomoću programa *Statistica 12*. Analize rezultata na FILD upitniku ukazuju da većina sudionika (59,33 %)

for somatization (40). Equally satisfactory coefficients as in previous studies that ranged from 0.72 for psychoticism to 0.87 for anxiety were obtained in the present study (38).

Procedure

An online Google forms survey was conducted during April and May 2020. Potential participants aged between 18 and 30 were informed about the research on dreams and emotions through Facebook groups of different interests in the largest cities of the Republic of Croatia. They are guaranteed anonymity, confidentiality and the possibility of exiting the study. DSQ-40 and BSI questionnaires were applied first. Participants were also asked about the sleep disorders they suffer from. Then they filled in the FILD questionnaire, first of all questions related to the frequency of experiencing lucidity (N = 665). The second part of the FILD questionnaire, which included questions related to intensity and emotions, was completed by those participants who had at least one experience of lucidity during their lifetime (N = 479). This was followed by questions constructed for the purpose of this study, which examined the desire for new lucid dreams (N = 477), their typical narrative and their recall (N = 467), the number of awakenings (N = 265) and quality of sleep (N = 284) in a typical lucid night. At the end of the study, the participants were thanked for their participation and provided the opportunity to comment.

RESULTS

The collected data were processed using the Statistica program 12. Analysis of the results on the FILD questionnaire indicated that the majority of participants (59.33%) wanted to experience a new lucid dream. More of them (44.11%) experienced random dream narratives than meaningful ones (34.05%) or short-term and abstract elements of lucidity (17.56%). The results on the measure of recalling the narrative of lucid dreams

priželjkuje novi lucidni san. Više ih (44,11%) doživljava nasumične radnje, nego jednu smislenu (34,05 %) ili kratkotrajne i apstraktne elemente lucidnosti (17,56 %). Rezultati na mjeri dosjećanja radnje lucidnih snova pomaknuti su prema višim vrijednostima (M=6,41; SD=2,62). Kada je riječ o induktivno lucidnim sanjačima, većina rezultata na procjeni broja buđenja pomaknuta je k nižim (M=1,05; SD=0,90), odnosno k višim vrijednostima kada je riječ o kvaliteti spavanja (M=2,46; SD=1,04).

U svrhu validacije FILD upitnika, slijeđene su preporuke autorica (21). Dobiveni indeksi asimetričnosti i spljoštenosti na podljestvicama upitnika uglavnom ne prelaze interval normalnosti distribucije u rasponu od -1 do +1, osim za varijable vezane uz izazvanu lucidnost (tablica 1.), što je u skladu s polazišnim istraživanjem (21). Nadalje, većina sudionika (59,40 %) nikada nije ili se jako rijetko upuštala u indukciju lucidnosti.

Prema trenutnim saznanjima još uvijek nema objavljenih istraživanja koja su provjerila faktorsku strukturu FILD upitnika pa je njegova latentna struktura u ovom istraživanju provjerena eksploratornom faktorskom analizom (metoda zajedničkih faktora). Nakon Varimax rotacije dobivena je interpretabilna četvero faktorska solucija. Prvi faktor, frekvencija lucidnosti objašnjava ukupno 20,68 % varijance. Drugi faktor, emocionalnost vezana uz lucidnost objašnjava 10 % varijance. Treći faktor, tehnike indukcije objasnio je 8,48 % varijance, a četvrti, intenzitet lucidnosti, 6,37 % varijance (tablica 2.).

Zbog malog broja sudionika istraživanja autorice originalnog upitnika (21) nisu mogle provjeriti faktorsku strukturu FILD upitnika. Budući da su zaključile da emocionalnost doživljena prije lucidnosti nije indikativna za doživljene emocije nakon pojave lucidnosti, konačni su rezultati u ovom istraživanju ipak formirani na pet podljestvica (frekvencija i intenzitet lucidnosti, emocije prije i nakon lucid-

were shifted towards higher values (M=6.41; SD=2.62). With regard to inductively lucid dreamers, most of the results in estimating the number of awakenings shifted to lower (M=1.05; SD=0.90), or higher values when it comes to sleep quality (M=2.46; SD=1.04).

In order to validate the FILD questionnaire, the authors' recommendations were followed (21). The obtained skewness and kurtosis indices on the subscales of the questionnaire generally did not exceed the interval of normality of the distribution in the range from -1 to +1, except for variables related to induced lucidity (Table 1), which is consistent with the baseline study (21). Furthermore, the majority of participants (59.40%) never or very rarely indulged in lucidity induction.

According to current knowledge, there are still no published studies that have verified the factor structure of the FILD questionnaire, so its latent structure in this study was checked by exploratory factor analysis (the common factors method). After Varimax rotation, an interpretable four-factor solution was obtained. The first factor, lucid dreams frequency, explained a total of 20.68% of the variance. Another factor, lucidity-related emotionality, explained 10.00% of the variance. The third factor, induction techniques, explained 8.48% of variance, and the fourth, the intensity of lucid dreams, explained 6.37% of variance (Table 2).

Due to the small number of participants in their study, the authors of the original questionnaire (21) could not verify the factor structure of the FILD questionnaire. Since they concluded that the emotionality experienced before lucidity was not indicative of the emotions experienced after the onset of lucidity, the final results in this study were calculated on five subscales (frequency and intensity of lucid dreams, emotions before and after lucidity in dreams and induction techniques), as suggested by the authors (21). Intercorrelations of items belonging to the subscales of frequency (r=0.30 to 0.79, p<0.01), intensity (r=027 to 0.65, p<0.01), emotion before (r=0.66 p<0.01)

TABLICA 1. Deskriptivni parametri analiziranih podljestvica upitnika FILD
TABLE 1. Descriptive parameters of the analyzed subscales of the FILD questionnaire

	N	Min	Max	M	SD	Asimetričnost (stand. pogr.) / Skewness (stand. error)	Spljoštenost (stand. pogr.) / Kurtosis (stand, error)	Cronbach α
Frekvencija / Frequency	665	0,00	7,00	1,95	1,53	0,74 (0,09)	0,05 (0,19)	0,84
Trenutna / Momentary	665	0,00	7,00	2,80	2,04	0,19 (0,09)	-0,93 (0,19)	
Produžena / Prolonged	665	0,00	7,00	2,11	2,04	0,56 (0,09)	-0,80 (0,19)	
Spontana / Spontaneous	665	0,00	7,00	2,76	2,10	0,26 (0,09)	-0,98 (0,19)	
Pokušaji / Attempts	665	0,00	7,00	1,29	1,95	1,44 (0,09)	0,94 (0,19)	
Uspjeh / Success	665	0,00	7,00	0,82	1,61	2,06 (0,09)	3,47 (0,19)	
Intenzitet / Intensity	479	0,00	4,00	1,77	0,95	-0,06 (0,11)	-0,67 (0,22)	0,78
Sigurnost / Confidence	475	0,00	4,00	2,04	1,38	-0,14 (0,11)	-1,20 (0,22)	
Aktivnost / Activity	473	0,00	4,00	1,81	1,36	0,08 (0,11)	-1,22 (0,22)	
Kontrola / Control	470	0,00	4,00	1,46	1,30	0,41 (0,11)	-1,05 (0,22)	
Trajanje / Length	472	0,00	4,00	1,90	1,21	-0,00 (0,11)	-0,99 (0,22)	
Scene / Scenes	475	0,00	4,00	1,69	1,19	0,46 (0,11)	-0,64 (0,22)	
Emocije prije / Emotions before	471	0,00	10,00	5,31	2,54	-0,16 (0,11)	-0,72 (0,22)	0,82
Pozitivno prije / Positive beginning	451	0,00	10,00	5,19	2,68	-0,25 (0,11)	-0,70 (0,23)	
Negativno prije / Negative beginning	471	0,00	10,00	5,45	2,82	-0,16 (0,11)	-0,94 (0,22)	
Emocije nakon / Emotions after	467	0,00	10,00	5,82	2,65	-0,37 (0,11)	-0,60 (0,23)	0,84
Pozitivno nakon / Positive ending	469	0,00	10,00	5,77	2,79	-0,41(0,11)	-0,68 (0,23)	
Negativno nakon / Negative ending	469	0,00	10,00	5,87	2,91	-0,34 (0,11)	-0,87 (0,23)	
Tehnike indukcije / Induction techniques	278	0,00	4,00	0,73	0,65	1,63 (0,15)	3,69 (0,29)	0,77
Dnevnik spavanja / Dream diary	278	0,00	4,00	0,59	1,08	2,14 (0,15)	3,89 (0,29)	
Čitanje / Reading	278	0,00	4,00	0,84	0,86	1,60 (0,15)	3,43 (0,29)	
Dnevne misli / Daily thoughts	275	0,00	4,00	1,17	1,14	1,00 (0,15)	0,29 (0,29)	
Provjera stvarnosti / Reality checks	274	0,00	4,00	0,62	1,03	1,94 (0,15)	3,26 (0,29)	
Planiranje spavanja / Planning sleep time	274	0,00	4,00	0,55	1,04	2,05 (0,15)	3,39 (0,29)	
Napredne tehnike / Advanced techniques	275	0,00	4,00	0,32	0,76	2,80 (0,15)	8,11 (0,29)	
Misli prije sna / Thoughts at bedtime	272	0,00	4,00	1,04	1,22	1,05 (0,15)	0,06 (0,29)	

nosti u snu i tehnike indukcije), kako predlažu autorice (21). Interkorelacije čestica pripadajućih podljestvica frekvencije (r=0,30 do 0,79, p<0,01), intenziteta (r=0,27 do 0,65, p<0,01), emocija prije (r=0,66, p<0,01) i nakon (r=0,66, p<0,01) pojave lucidnosti te tehnika indukcije lucidnosti (r=0,21 do 0,48, p<0,01) značajne su i pozitivne te su njihove vrijednosti u zadovoljavajućim rasponima. Kada je riječ o povezanosti rezultata na pojedinim podljestvicama, one

and after (r=0.66, p<0,01) occurrence of lucidity and lucidity induction techniques (r=0.21 to 0.48, p<0.01) were significant and positive and their values were in satisfactory ranges. The correlation of results on different subscales was also significant and positive and ranged from 0.15 (p<0.05) (between intensity and emotions that follow lucidity subscales) to 0.40 (p<0.01) (between frequency and intensity subscales), i.e. 0.44 (p<0.01) (between emotion before and after lucidity sub-

TABLICA 2. Rezultata eksploratorne faktorske analize (*Varimax normalized*) čestica FILD upitnika na hrvatskom uzorku mladih
TABLE 2. The results of exploratory factor analysis (Varimax normalized) of FILD questionnaire items on the Croatian youth sample

	Faktor 1 / Factor 1	Faktor 2 / Factor 2	Faktor 3 / Factor 3	Faktor 4 / Factor 4
Trenutna / Momentary	**0,69**	-0,09	0,04	-0,07
Produžena / Prolonged	**0,79**	-0,04	0,13	0,28
Spontana / Spontaneous	**0,78**	-0,04	0,02	0,10
Pokušaji / Attempts	**0,58**	0,19	0,20	0,22
Uspjeh / Success	**0,61**	0,09	0,17	0,38
Sigurnost / Confidence	0,14	0,07	0,07	**0,49**
Aktivnost / Activity	0,01	0,10	-0,02	**0,67**
Kontrola / Control	0,02	0,13	0,08	**0,74**
Trajanje / Length	0,33	-0,05	0,18	**0,61**
Scene / Scenes	0,28	-0,07	0,25	**0,51**
Pozitivno prije / Positive beginning	0,15	**0,67**	0,05	0,05
Negativno prije / Negative beginning	0,00	**0,70**	0,01	-0,08
Pozitivno nakon / Positive ending	-0,03	**0,66**	0,03	0,22
Negativno nakon / Negative ending	-0,13	**0,72**	0,03	0,07
Dnevnik spavanja / Dream diary	0,02	0,01	**0,56**	0,10
Čitanje / Reading	0,02	0,08	**0,67**	-0,03
Dnevne misli / Daily thoughts	0,13	0,03	**0,54**	0,14
Provjera stvarnosti / Reality checks	0,02	-0,08	**0,56**	0,22
Planiranje spavanja / Planning sleep time	0,03	-0,05	**0,49**	0,05
Napredne tehnike / Advanced techniques	0,09	0,05	**0,62**	-0,01
Prije sna misli / Thoughts at bedtime	0,23	0,21	**0,55**	0,03
Svojstvena vrijednost / Eigenvalue	4,34	2,10	1,78	1,34
% objašnjene varijance / % of explained variance	20,68	10,00	8,48	6,37

su također značajne i pozitivne te se kreću u rasponu od 0,15 ($p<0,05$) (između podljestvica intenziteta i emocija koje slijede lucidnost) do 0,40 ($p<0,01$) (između podljestvica frekvencije i intenziteta), odnosno 0,44 ($p<0,01$) (između podljestvica emocija prije i nakon lucidnosti). Dobivene su zadovoljavajuće vrijednosti koeficijenata Cronbach alfa pouzdanosti koje se nalaze u tablici 1 te iznose: 0,84 (frekvencija), 0,78 (intenzitet), 0,82 (emocionalna valencija prije/nakon) i 0,77 (tehnika indukcije). Dobivene vrijednosti odgovaraju vrijednostima o kojima izvještavaju autorice (0,88, 0,71, 0,83, 0,76, 0,72) (21).

scales). Satisfactory values of the Cronbach's alpha reliability coefficients are obtained, which are provided in Table 1 and were: 0.84 (frequency), 0.78 (intensity), 0.82 (emotional valence before / after) and 0.77 (induction technique). The obtained values correspond to the values reported by the authors (0.88, 0.71, 0.83, 0.76, 0.72) (21).

In further analyzes, Pearson correlation coefficients were calculated between lucidity dimensions and different types of defenses and psychopathological symptoms (Table 3). Prior to correlation analyzes, basic descriptive parameters were calculated and it was confirmed that the results were normally distributed.

U daljnjima analizama izračunati su Pearsonovi koeficijenti korelacija između dimenzija lucidnosti s različitim tipovima obrana i psihopatoloških simptoma (tablica 3.). Prije korelacijskih analiza izračunati su osnovni deskriptivni parametri te je potvrđeno da se rezultati normalno distribuiraju.

Kada je riječ o frekvenciji lucidnosti, sve su dimenzije, osim pokušaja indukcije, značajno i pozitivno povezane sa simptomima, posebno somatizacije, opsesivne kompulzivnosti i depresije. Više razine spontane lucidnosti značajno su povezane sa češćom uporabom zrelih, ali i nezrelih obrana. Isti su odnosi utvrđeni između anksioznosti i produžene te paranoidnosti i uspješno izazvane lucidnosti. Vezano uz intenzitet lucidnosti, utvrđene su značajne negativne povezanosti aktivnosti s neurotskim te sigurnosti s nezrelim obranama i simptomima neprijateljstva. Ipak, veći broj scena u lucidnim snovima popraćen je s češćim doživljavanjem simptoma fobičnosti (tablica 3.).

Bilo da su prethodile ili slijedile pojavu lucidnosti u snu, pozitivne emocije su značajno povezane sa češćom uporabom zrelih obrana. Nadalje, negativne emocije popraćene su češćim doživljavanjem nezrelih i neurotskih obrana te su također povezane sa svim ispitivanim simptomima, osim neprijateljstva. Iznimke od navedenog čine neznačajne povezanosti negativnih emocija prije pojave lucidnosti s nezrelim i neurotskim obranama kao i simptomima paranoidnosti i psihoticizma. Utvrđene su i negativne povezanosti pozitivnih emocija s određenim simptomima, npr. s fobičnosti kada je riječ o emocijama prije lucidnosti, odnosno sa somatizacijom, anksioznosti, paranoidnosti i psihoticizmom kada je riječ o emocijama koje slijede lucidnost u snu (tablica 3).

Vezano uz tehnike indukcije lucidnosti, korelacijske analize ukazuju da je učestalija provjera stvarnosti popraćena doživljavanjem viših razina svih ispitanih simptoma osim neprijateljstva. Isto je utvrđeno za misli prije

With regard to the frequency of lucidity, all dimensions except the attempt at induction were significantly and positively associated with symptoms, especially somatization, obsessive-compulsiveness and depression. Higher levels of spontaneous lucidity were significantly associated with more frequent use of mature as well as immature defenses. The same relationships were found between anxiety and prolonged, paranoid symptoms and successfully induced lucidity. Regarding the intensity of lucidity, significant negative associations between activity and neurotic defenses as well as between confidence and immature defenses and symptoms of hostility were found. Nevertheless, a greater number of scenes in lucid dreams were accompanied by more frequent experience of phobic symptoms (Table 3).

Whether they preceded or followed the onset of lucidity in dream, positive emotions were significantly associated with more frequent use of mature defenses. Furthermore, negative emotions were accompanied by more frequent use of immature and neurotic defenses and were also associated with all examined symptoms except hostility. Exceptions to the above were an insignificant association between negative emotions before the onset of lucidity with immature and neurotic defenses, as well as symptoms of paranoia and psychoticism. Negative associations of positive emotions with certain symptoms were also found, e.g. with phobia with regard to emotions before lucidity and with somatization, anxiety, paranoia and psychoticism when it comes to emotions following lucidity in sleep (Table 3).

Regarding lucidity induction techniques, correlation analyzes indicate that more frequent reality checking is accompanied by experiencing higher levels of all examined symptoms except hostility. The same was found for pre-sleep thoughts and obsessive-compulsiveness, anxiety and psychoticism; advanced techniques and somatization; alternation of sleep and wakefulness and paranoidity. However, according to the obtained results, more frequent reading about lucid dreams implied a lower level of use of neurotic defenses (Table 3).

TABLICA 3. Povezanost različitih dimenzija lucidnih snova s tri skupine obrambenih mehanizama i devet vrsta psihopatoloških simptoma
TABLE 3. Association of different dimensions of lucid dreams with three groups of defense mechanisms and nine types of psychopathological symptoms

	Z	NR	NZ	S	OK	O	D	A	N	F	P	PH
Frekvencija / Frequency	0,05	-0,03	0,09	0,15*	0,19**	0,07	0,17**	0,12	0,03	0,05	0,12	0,13
Trenutna / Momentary	0,05	0,01	0,09	0,13*	0,16*	0,04	0,10	0,12	0,01	0,02	0,05	0,09
Produžena / Prolonged	0,04	-0,03	0,06	0,15*	0,15*	0,10	0,17**	0,14*	-0,01	0,10	0,11	0,13
Spontana / Spontaneous	0,15*	0,03	0,13*	0,08	0,19**	0,04	0,15*	0,09	-0,01	-0,02	0,06	0,09
Pokušaji / Attempts	0,01	-0,05	0,06	0,07	0,08	-0,00	0,09	0,03	0,06	0,01	0,08	0,06
Uspjeh / Success	-0,04	-0,07	-0,00	0,13*	0,15*	0,11	0,13*	0,11	0,04	0,09	0,15*	0,11
Intenzitet / Intensity	0,04	-0,12	-0,14*	-0,05	-0,04	-0,05	-0,00	-0,02	-0,14*	0,04	-0,10	-0,05
Sigurnost / Confidence	0,07	-0,09	-0,15*	-0,05	-0,12	-0,10	-0,04	-0,04	-0,14*	-0,05	-0,12	-0,10
Aktivnost / Activity	0,07	-0,15*	-0,08	-0,12	-0,09	-0,09	-0,07	-0,10	-0,09	-0,03	-0,13	-0,09
Kontrola / Control	0,00	-0,12	-0,13	-0,09	-0,04	-0,06	-0,02	-0,06	-0,08	-0,04	-0,07	-0,03
Trajanje / Length	0,01	-0,03	-0,08	0,04	0,04	0,04	0,07	0,04	-0,10	0,12	-0,04	0,01
Scene / Scenes	-0,04	-0,04	-0,08	0,07	0,09	0,04	0,06	0,09	-0,09	0,16**	-0,01	0,02
Emocije prije / Emotions before	0,16**	-0,10	-0,08	-0,15**	-0,14*	-0,16**	-0,13*	-0,14*	-0,08	-0,22**	-0,14*	-0,14*
Pozitivne / Positive	0,18**	-0,09	-0,09	-0,09	-0,11	-0,13	-0,10	-0,10	-0,06	-0,16**	-0,12	-0,13
Negativne / Negative	-0,12	0,09	0,07	0,19**	0,14*	0,17**	0,14*	0,16**	0,09	0,24**	0,13	0,13
Emocije nakon / Emotions after	0,19**	-0,07	-0,08	-0,20*	-0,13	-0,25**	-0,19**	-0,19**	-0,07	-0,19**	-0,18**	-0,17**
Pozitivne / Positive	0,24**	0,02	-0,01	-0,15**	-0,06	-0,21	-0,13	-0,16**	-0,04	-0,13	-0,15**	-0,16**
Negativne / Negative	-0,11	0,14*	0,13*	0,21**	0,16*	0,25**	0,21**	0,20**	0,08	0,22**	0,18**	0,16*
Tehnike / Techniques	-0,02	-0,02	0,02	0,10	0,13	0,09	0,05	0,08	0,04	0,12	0,13*	0,13
Dnevnik spavanja / Dream diary	0,05	0,02	-0,01	-0,07	-0,06	-0,05	-0,08	-0,06	-0,11	0,03	-0,08	-0,02
Čitanje / Reading	-0,08	-0,14*	-0,10	0,02	0,10	-0,00	-0,03	-0,02	-0,02	0,01	0,08	0,06
Dnevne misli / Daily thoughts	-0,01	-0,03	0,02	0,04	0,06	0,03	-0,01	0,01	-0,01	0,03	0,06	0,05
Provjera stvarnosti / Reality checks	0,02	0,07	0,09	0,21**	0,15*	0,15*	0,15*	0,17**	0,10	0,20**	0,17**	0,15*
Planiranje spavanja / Planning sleep time	-0,03	0,03	0,08	0,06	0,10	0,13	0,00	0,07	0,06	0,10	0,19**	0,07
Napredne tehnike / Advanced techniques	-0,04	-0,05	0,00	0,14*	0,07	0,02	0,06	0,06	0,06	0,04	0,09	0,10
Prije sna misli / Thoughts at bedtime	-0,02	-0,02	-0,02	0,07	0,16*	0,10	0,12	0,14*	0,10	0,09	0,10	0,18**
Želja / Desire	0,23**	-0,04	-0,00	-0,14*	-0,02	-0,16*	-0,05	-0,18**	-0,03	-0,16*	-0,09	-0,09
Radnja / Plot	0,03	0,10	0,06	-0,04	0,03	-0,07	-0,00	-0,02	-0,10	-0,03	-0,04	0,03
Sjećanje / Recall	-0,03	-0,00	0,02	0,03	0,02	0,07	0,10	0,04	0,08	0,03	0,06	0,06
Buđenja / Awakenings	-0,13*	0,03	0,06	0,19**	0,18**	0,18**	0,18**	0,21**	0,15*	0,22**	0,10	0,15*
Kvaliteta / Quality	0,09	-0,10	-0,26**	-0,27**	-0,30**	-0,23**	-0,26**	-0,18**	-0,25**	-0,21**	-0,24**	-0,27**

Legenda / Legend : *p<0,05 **p<0,01 Z-zreli / mature, NR-neurotski / neurotic , NZ-nezreli / immature, S-somatizacija / somatization, OK-opsesivna kompulzivnost / obsessive compulsiveness, O-osjetljivost / sensitivity, D-depresija / depression, A-anksioznost / anxiety, N-neprijateljstvo / hostility, F-fobičnost / phobia, P-paranoidnost / paranoid, PH-psihoticizam / psychoticism

sna i opsesivnu kompulzivnost, anksioznost i psihoticizam; napredne tehnike i somatizaciju te izmjenu spavanja i budnosti i paranoidnost. Ipak, prema dobivenim rezultatima češće či-

Finally, higher desire for a new lucid dream was accompanied by more frequent use of mature defenses and less frequent experiences of somatization, sensitivity, anxiety and phobia symptoms.

tanje o lucidnim snovima podrazumijeva nižu razinu neurotskih obrana (tablica 3.).

Konačno, veća želja za ponovnim lucidnim snom popraćena je češćim zrelim obranama te rjeđim doživljavanjem somatizacije, osjetljivosti, anksioznosti i fobičnosti. Češća su buđenja povezana s rjeđim korištenjem zrelih obrana te višim razinama svih simptoma osim paranoidnosti. Kada je riječ o kvaliteti spavanja, dobiveni rezultati pokazuju negativne povezanosti s nezrelim obranama i svim ispitanim simptomima (tablica 3.).

RASPRAVA

S obzirom na manjak istraživanja lucidnih snova javila se potreba za validacijom upitnika lucidnosti na hrvatskom uzorku. Prema dosadašnjim istraživanjima, svaki drugi student doživio je barem jedan lucidni san tijekom života (41). Utvrđena odstupanja od normalne distribucije vezana za induktivnu lucidnost već su prethodno potvrđena (21). Ovaj je fenomen, posebno kad je izazvan, sam po sebi rijedak. Ipak, postotak sudionika koji nikada ili rijetko izaziva lucidnost manji je od onog dobivenog u originalnom radu (21). Koeficijenti pouzdanosti podljestvica upitnika, kao i povezanosti rezultata postignutih na pojedinim podljestvicama uglavnom su u skladu s polazišnim istraživanjem (21). Originalni FILD upitnik uključuje pet podljestvica (21). Premda njegove autorice, kao što je prethodno i rečeno, nisu provjeravale faktorsku strukturu upitnika, u ovom je istraživanju navedeno bilo moguće provesti zbog brojnijeg i heterogenijeg uzorka. Dobiveni su rezultati pokazali četvero-faktorsku soluciju, u kojoj su čestice vezane uz emocije prije i nakon lucidnosti formirale jedan jedinstveni faktor, umjesto dva faktora koja su bila očekivana s obzirom na polazišno istraživanje (21). Ovakvi rezultati dodatno ističu emocionalnost kao bitnu dimenziju lucidnosti. Ovo je korak unaprijed u odnosu na dosadašnje spoznaje o višedi-

More frequent awakenings were associated with less frequent use of mature defenses and higher levels of all symptoms except paranoia. With regard to sleep quality, the results showed negative associations with immature defenses and all tested symptoms (Table 3).

DISCUSSION

Considering the lack of research on lucid dreams, there was a need to validate the lucidity questionnaire on a Croatian population sample. According to previous studies, every second student has experienced at least one lucid dream in their lifetime (41). The deviations from the normal distribution related to inductive lucidity identified in the present study have already been previously confirmed (21). This phenomenon, especially when induced, is very rare. Nevertheless, the percentage of participants who never or rarely induce lucidity in dreams is lower than obtained in the original paper (21). These results indicate that our participants are quite familiar with inductive lucidity. The reliability coefficients of the subscales of the questionnaire, as well as the correlation of the results achieved on individual subscales, are generally in line with the initial research (21). The original FILD questionnaire includes five subscales (21). Although its authors, as previously stated, did not test the factor structure of the questionnaire, in the present study it was possible to do so due to a more numerous and heterogeneous sample. The obtained results showed a four-factor solution, in which the emotion-related items before and after lucidity formed a single factor, instead of the two factors that were expected with respect to the baseline study (21). Such results further emphasize emotionality as an essential dimension of lucidity. This is a step forward compared to previous knowledge of the multidimensionality of this construct, which assumes the separation of frequency from intensity of lucid dreams (21). Minor inconsistencies of the obtained results with those reported previously (21) can be ex-

menzionalnosti ovog konstrukta, koje pretpostavljaju razdvajanje frekvencije od intenziteta lucidnosti (21). Manje nesukladnosti dobivenih rezultata s postojećim (21) moguće je objasniti metodološkim razlikama koje se odnose na heterogenost i veličine uzoraka. U provedenom istraživanju sudjelovao je heterogeniji uzorak mlađe odrasle dobi (N=665), a valjanost upitnika provjerena je na temelju rezultata 231 sudionika. S druge strane, brojčano manji i homogeniji uzorak studenata (N=142) u istraživanju (21) nije omogućio provjeru faktorske strukture originalnog FILD upitnika (21).

Dobiveni rezultati ukazuju da je lucidnost povezana sa distresom samo kada je realizirana, što nije u potpunosti nesukladno dosadašnjim nalazima (21) o maladaptivnosti indukcije lucidnosti. Moguće je da samo visoko učestala indukcija može postati uspješna u doživljaju lucidnog sna, s cijenom na psihopatološkom planu, dok mu rijetka i nedosljedna primjena indukcije ne odmaže ni pridonosi. Pozitivni odnosi zrelih, ali i nezrelih obrana sa spontanom lucidnosti, anksioznosti s produženom lucidnosti, kao i paranoidnosti s uspješno izazvanom lucidnosti također pružaju bitne implikacije, koje bi trebalo provjeriti u daljnjim istraživanjima. Vezano uz intenzitet lucidnosti, negativni odnosi sigurnosti sa simptomima neprijateljstva i nezrelim obranama te aktivnosti s neurotskim obranama obećavajući su nalazi. Ipak, veći broj scena u radnji sna povezan je s češćim simptomima fobičnosti. Poznato je da je dinamičnost sustava obrana prediktivna za razne psihopatološke ishode, no tek kao krajnji rezultat, s vremenskim odmakom (33). Potencijalni doprinos intenziteta lucidnosti u smanjenju psihopatoloških simptoma trebalo bi provjeriti longitudinalnim istraživanjem.

Provedeno istraživanje pokazuje da je emocionalnost vezana uz lucidnost najznačajniji korelat psihopatološkog distresa. Dok je značajna i najveća povezanost dobivena sa simptomima fobičnosti, čija je glavna karakteristika upravo

plained by methodological differences comprising the heterogeneity and sample sizes. A more heterogeneous sample of young adults (N = 665) participated in this study, and the validity of the questionnaire was verified based on the results of 231 participants. On the other hand, a numerically smaller and more homogeneous sample of students (N = 142) in the previous study (21) did not allow verification of the factor structure of the original FILD questionnaire (21).

The obtained results indicate that lucidity is associated with distress only when it is achieved, which is not completely inconsistent with previous findings (21) on the maladaptiveness of lucidity induction. It is possible that only highly frequent induction can become successful in achieving lucid dreams, with a price on a psychopathological level, while infrequent and inconsistent application of induction neither helps nor hinders. The positive relationship of mature but also immature defenses with spontaneous lucidity, anxiety with prolonged lucidity and paranoia with successfully induced lucidity also lead to important implications, which should be verified in further research. Regarding the intensity of lucidity, the negative relationships of confidence in lucidity with symptoms of hostility and use of immature defenses as well as of activity with use of neurotic defenses are promising findings. Still, a greater number of scenes in the action of the dream were associated with more frequent symptoms of phobia. It is known that the dynamism of the defense system is predictive of various psychopathological outcomes, but only as an end result with a time lag (33). The potential contribution of lucidity intensity in reducing psychopathological symptoms should be examined by longitudinal research.

The present study shows that emotionality related to lucidity is the most important correlate of psychopathological distress. While the significant and greatest association was found with phobic symptoms, the main characteristic of which is precisely the excessive irrational emotionality associated with the object of fear (39), hostility is the only psychopathological symptom that was

pretjerana iracionalna emocionalnost povezana s objektom straha (39), neprijateljstvo je jedini psihopatološki simptom koji nije bio značajno povezan s emocionalnošću u ovom istraživanju. Moguće je da u iskustvu lucidnosti nema mjesta hostilnim ni njima suprotnim osjećajima. Većina lucidnih sanjača o tom iskustvu govori u smislu smirenosti, samorefleksije, usredotočene svijesti, uvida te otvorenosti k iskustvima (17,19,42), odnosno blago pozitivnih do izrazito neutralnih emocionalnih stanja. Izgledno je i da je etiologija simptoma više vezana uz emocije koje slijede lucidnost u snu, nego uz one koje joj prethode. Takve emocije, pritom negativne, prati i češća uporaba nezrelih i neurotskih obrana. Nadalje, tehnika misli prije sna pozitivan je korelat simptoma opsesivne-kompulzivnosti, anksioznosti i psihoticizma. Isto vrijedi za odnose izmjene budnosti i spavanja s paranoidnosti te naprednih tehnika sa somatizacijom. Međutim, od svih tehnika najveći je oprez nužno preusmjeriti na provjeru stvarnosti, čijim se izvođenjem brišu granice budnosti i spavanja, stvarnosti i mašte (21). Ipak, negativan odnos čitanja o lucidnosti s neurotskim obranama implicira da nisu sve tehnike indukcije maladaptivne. Od dodatnih varijabli koje su obuhvaćene ovim istraživanjem, kao glavni negativni korelati psihopatološkog distresa izdvojili su se želja za novim lucidnim snom te kvaliteta spavanja, dok se broj buđenja pokazao pozitivnim korelatom. Sukladno hipotezi kontinuiteta, prethodno navedeni nalazi ukazuju na dominantnu ulogu negativnih emocija nakon lucidnosti u snovima, broja buđenja, induktivne lucidnosti te frekvencije lucidnosti kao potencijalno rizičnih, a kvalitete spavanja, želje za novim lucidnim snom, intenziteta lucidnosti i pozitivnih emocija kao zaštitnih faktora psihološkog zdravlja. Međutim, za opravdanost ovakvih tvrdnji važno je provesti statističke analize koje omogućavaju zaključke o kauzalnim odnosima.

Postoje neka ograničenja, kao i prijedlozi za buduće istraživače. Prvo, nužno je razjasniti

not significantly associated with emotionality in this study. It is possible that there is no place for hostile or opposing feelings in the experience of lucidity. Most lucid dreamers describe this experience in terms of calmness, self-reflection, focused awareness, insight and openness to experiences (17, 19, 42), i.e. in terms of mildly positive to extremely neutral emotional states. It is also likely that the etiology of symptoms is more related to the emotions that follow lucidity in sleep than to those that precede it. Such emotions, especially when negative, are accompanied by more frequent use of immature and neurotic defenses. Furthermore, the pre-sleep thought technique is a positive correlate of the symptoms of obsessive-compulsiveness, anxiety and psychoticism. The same has been confirmed for the relationship between alternation of wakefulness and sleep and paranoia, and advanced techniques with somatization. However, of all the techniques, the greatest caution must be directed towards the verification of reality, which erases the boundaries of wakefulness and sleep, reality and imagination (21). Nevertheless, the negative relationship of reading about lucidity with neurotic defenses implies that not all induction techniques are maladaptive. Of the additional variables included in this study, the main negative correlates of psychopathological distress were the desire for a new lucid dream and sleep quality, while the number of awakenings proved to be a positive correlate. According to the continuity hypothesis, the above findings indicate the dominant role of negative emotions after lucidity in dreams, number of awakenings, inductive lucidity and frequency of lucidity as potentially risky, and sleep quality, desire for a new lucid dream, lucidity intensity and positive emotions as protective factors of psychological health. However, to justify of such claims it is important to conduct statistical analyzes that demonstrate conclusions about causal relations between these factors.

There were some limitations to are study as well as suggestions for future researchers. First, it is necessary to clarify whether lucidity is better thought of in terms of one type of dream and its

je li o lucidnosti opravdanije govoriti u smislu jedne vrste snova te s njima povezanim konstruktima poput obrambenih mehanizama ili u terminima zasebnog entiteta povišene svijesti, koji bi strategije suočavanja, kao svjesni oblici emocionalne regulacije, mogle bolje objasniti. Drugo, istraživanje je provedeno početkom prvog vala COVID-19 pandemije u RH te potresa u Zagrebu, što pogoduje mogućoj kontaminiranosti rezultata na mjerama psihopatoloških simptoma. Treće, mjere fizičkog distanciranja rezultirale su online provođenjem istraživanja, a kontrola pristranosti i reprezentativnosti uzorka nastojala se osigurati na način da je poziv za sudjelovanje u ovom istraživanju objavljen u tematski raznolikim *Facebook* grupama. Četvrto, prirodnu je lucidnost izazovno istraživati zbog njene nedovoljno visoke učestalosti. Raspon istraživačkih metoda za prikupljanje podataka o induktivnoj lucidnosti vrlo je širok, npr. vođenjem dnevnika spavanja, no postojeći podatci (21) upućuju na negativne trendove u mentalnom zdravlju tijekom ovakvih aktivnosti. Kako psihološka dobrobit sudionika ne bi bila upitna, nacrt ovog istraživanja bio je kros-sekvencionalni, nauštrb njegovim nedostatcima kao retrospektivnoj mjeri. Iskustvo lucidnosti u snu jedinstven je doživljaj koji je samim time distinktivno iskustvo pri spavanju. Stoga, pretpostavilo se da sposobnost dosjećanja nije toliko narušena te da ipak osigurava dovoljno informacija od trenutnog istraživačkog interesa, a da pri tome udaljuje ovo istraživanje od potencijalno socijalno osjetljivog.

ZAKLJUČCI

Primijenjeni FILD upitnik pokazao je zadovoljavajuće psihometrijske karakteristike na hrvatskom uzorku. Prema dobivenim rezultatima, negativne emocije, broj buđenja, tehnike indukcije te frekvencija lucidnosti pokazali su se značajnim i pozitivnim korelatima, a kvaliteta spavanja, želja za novim lucidnim snom, pozitivne

associated constructs, such as defense mechanisms, or in terms of a separate entity of heightened consciousness, which coping strategies, such as conscious forms of emotional regulation, could explain better. Second, the study was conducted at the beginning of the first wave of the COVID-19 pandemic in the Republic of Croatia and the earthquake in Zagreb, which favors possible contamination of the results on measures of psychopathological symptoms. Third, physical distancing measures resulted in online conduct of the survey, although control of the bias and representativeness of the sample was used to to ensure that the invitation to participate in this survey was published in thematically diverse Facebook groups. Fourth, spontaneous lucidity is challenging to investigate due to its insufficiently high incidence in the population. The range of research methods for collecting data on inductive lucidity is very wide, e.g., keeping a sleep diary, but existing literature (21) suggests negative trends in mental health during such activities. In order not to question the psychological well-being of the participants, the draft of this research was cross-sequential, to the detriment of its shortcomings as a retrospective measure. The experience of lucidity in sleep is a unique mental event that is thus a distinctive experience when sleeping. Therefore, it was assumed that the ability to remember is not so impaired and that it still provides enough information of current research interest, while distancing this study from what may be potentially socially sensitive.

CONCLUSIONS

The applied FILD questionnaire showed satisfactory psychometric characteristics in the Croatian population sample. According to the obtained results, negative emotions, number of awakenings, induction techniques and lucidity frequency proved to be significant and positive correlates, and sleep quality, desire for a new lucid dream, positive emotions and lucidity intensity were negative correlates of psycho-

emocije te intenzitet lucidnosti negativnim korelatima psihopatoloških simptoma. Ovakvi rezultati, jednako kao i dobivene povezanosti obrambenih mehanizama s različitim dimenzijama lucidnosti, sukladni su hipotezi kontinuiteta. Rezultati impliciraju da su, pored kvalitete spavanja, broja buđenja i želje za novim lucidnim snom, tehnike indukcije i emocionalnost povezane s lucidnošću u snovima dominantne odrednice psihološke dobrobiti lucidnih sanjača.

pathological symptoms. Such results, as well as the association of defense mechanisms with different dimensions of lucidity, are consistent with the continuity hypothesis. The results imply that, in addition to sleep quality, number of awakenings and desire for a new lucid dream, induction techniques and emotionality associated with lucidity in dreams are dominant determinants of the psychological well-being of lucid dreamers.

LITERATURA / *REFERENCES*

1. Freud S. Interpretation of dreams. In: Strachey J. (ed.) The Standard Edition of the Complete Works of Sigmund Freud (4-5). Hogarth Press, 1899.
2. Voss U, D'Agostino A, Kolibius L, Klimke A, Scarone S, Hobson A. Insight and Dissociation in Lucid Dreaming and Psychosis. Front Psychol 2018; 9: 21-64. Preuzeto 29.3.2021 https://doi.org/10.3389/fpsyg.2018.02164.
3. Hobson A, Voss U. A mind to go out of: reflections on primary and secondary consciousness. Conscious Cogn 2011; 2: 993-997. Preuzeto 29.3.2021. https://doi.org/10.1016/j.concog.2010.09.018.
4. Soffer-Dudek N. Arousal in Nocturnal Consciousness: How Dream- and Sleep- Experiences May Inform Us of Poor Sleep Quality, Stress, and Psychopathology. Front Psychol 2017; 8: 733. Preuzeto 29.3.2021. https://doi.org/10.3389/fpsyg.2017.00733.
5. Watson D. Dissociations of the night: Individual differences in sleep-related experiences and their relation to dissociation and schizotypy. J Abnorm Psychol 2001; 11: 526-35. Preuzeto 29.3.2021. https://doi.org/10.1037/0021-843X.110.4.526.
6. Osho. The book of secrets: 112 keys to the mystery within: a comprehensive guide to meditation techniques described in the Vigyan Bhairav Tantra. New York: St. Martin's Griffin, 1974.
7. Van Eeden F. A study of dreams. Proceedings of the Society for Psychical Research 1913; 26: 431-61.
8. Hervey de Saint-Denis L. Dreams and How to Guide Them. London: Duckworth, 1982.
9. Sparrow G. Lucid dreaming: Dawning of the clear light. Virginia Beach, VA: A.R.E. Press, 1976.
10. Hearne KMT. Lucid-dreams: an electrophysiological and psychological study. PhD Thesis. Liverpool: University of Liverpool, 1978.
11. LaBerge S, Nagel L, Dement WC, Zarcone V Jr. Lucid dreaming verified by volitional communication during REM sleep. Percept Mot Skills 1981; 52: 727-732. Preuzeto 29.3.2021. https://doi.org/10.2466%2Fpms.1981.52.3.727.
12. Voss U, Holzmann R, Hobson A, Paulus W, Koppehele-Gossel J, Klimke A *et al*. Induction of self-awareness in dreams through frontal low current stimulation of gamma activity. Nat Neurosci 2014; 17(6): 810-812. Preuzeto 29.3.2021. https://doi.org/10.1038/nn.3719.
13. Stumbrys T, Erlacher D, Johnson M, Schredl M. The phenomenology of lucid dreaming: an online survey. Am J Psychol 2014; 127: 191-204.
14. Voss U, Schermelleh-Engel K, Windt J, Frenzel C, Hobson A. Measuring consciousness in dreams: the lucidity and consciousness in dreams scale. Conscious Cogn 2013; 22: 8-21. Preuzeto 29.3.2021. https://doi.org/10.1038/nn.3719.
15. Erlacher D, Schredl M. Practicing a motor task in a lucid dream enhances subsequent performance: A pilot study. The Sport Psychologist 2010; 24(2): 157-67.
16. Saunders DT, Roe CA, Smith G, Clegg H. Lucid dreaming incidence: A quality effects meta-analysis of 50 years of research. Conscious Cogn 2016; 43: 197-215. Preuzeto 29.3.2021. https://doi.org/10.1016/j.concog.2016.06.002.
17. Rosenbusch KM. Lucid Dreaming: Exploring the Effects of Lucidity within Dreams on Emotion Regulation, Positive Emotions, Interoceptive Awareness, and Mindfulness. Diplomski rad. Arizona State University, 2016.
18. Stumbrys T. Bridging lucid dreaming research and transpersonal psychology: Toward transpersonal studies of lucid dreams. J Transpersonal Psychol 2018; 50(2): 176-193.
19. Schredl M, Erlacher D. Lucid dreaming frequency and personality. Pers Individ Dif 2004; 37: 1463-1473. Preuzeto 29.3.2021. https://doi.org/10.1177%2F0276236616648653.
20. Alvarado CS, Zingrone NL. Interrelationships of parapsychological experiences, dream recall, and lucid dreams in a survey with predominantly Spanish participants. Imagin Cogn Pers 2007; 27: 63-69. Preuzeto 29.3.2021. https://doi.org/10.2190%2FIC.27.1.f.
21. Aviram L, Soffer-Dudek N. Lucid Dreaming: Intensity, But Not Frequency, Is Inversely Related to Psychopathology. Front Psychol. 2018; 9: 384. Preuzeto 29.3.2021. https://doi.org/10.3389/fpsyg.2018.00384.
22. Taitz IY. Learning lucid dreaming and its effect on depression inundergraduates. Int J Dream Res 2011; 4: 117-26.Preuzeto 29.3.2021. https://doi.org/10.11588/ijodr.2011.2.9123.

23. Soffer-Dudek N, Shahar G. Daily stress interacts with trait dissociation to predict sleep-related experiences in young adults. J Abnorm Psychol 2011; 12: 719-29. Preuzeto 29.3.2021. https://doi.org/10.1037/a0022941.
24. Harb GC, Brownlow JA, Ross RJ. Posttraumatic nightmares and imagery rehearsal: the possible role of lucid dreaming. Dreaming 2016; 26: 238-49. Preuzeto 29.3.2021. https://doi.org/10.1037/drm0000030.
25. Van Heugten–van der Kloet D, Merckelbach H, Giesbrecht T, Broers N. Night-time experiences and daytime dissociation: a path analysis modeling study. Psychiatry Res 2014; 216: 236-41. Preuzeto 29.3.2021. https://doi.org/10.1016/j.psychres.2013.12.053.
26. Soffer-Dudek N, Shahar G. What are sleep-related experiences? Associations with transliminality, psychological distress, and life stress. Conscious Cogn 2009; 18: 891-904. Preuzeto 29.3.2021. https://doi.org/10.1016/j.concog.2008.07.007.
27. Knox J, Lynn SJ. Sleep experiences, dissociation, imaginal experiences, and schizotypy: the role of context. Conscious Cogn 2014; 23: 22-31. Preuzeto 29.3.2021. https://psycnet.apa.org/doi/10.1016/j.concog.2013.10.007.
28. Soffer-Dudek N, Sadeh A. Dream recall frequency and unusual dream experiences in early adolescence: Longitudinal links to behavior problems. J Res Adolesc 2013; 23: 635-51.Preuzeto 29.3.2021. https://doi.org/10.1111/jora.12007.
29. Stumbrys T, Erlacher D. Applications of lucid dreams and their effects on the mood upon awakening. Int J Dream Res 2016; 9(2): 146-50. Preuzeto 29.3.2021. https://doi.org/10.11588/ijodr.2016.2.33114.
30. LaBerge S. Lucid dreaming: paradoxes of dreaming consciousness. In: Cardeña EE, Lynn SJE, Krippner SE (ed.) Varieties of Anomalous Experience: Examining the Scientific Evidence. Washington, DC: AmericanPsychological Association. 2014; 145-73. Preuzeto 29.3.2021. http://dx.doi.org/10.1037/14258-006.
31. Doll E, Gittler G, Holzinger B. Dreaming, lucid dreaming and personality. Int J Dream Res 2009; 2: 52-57. Preuzeto 29.3.2021. https://doi.org/10.11588/ijodr.2009.2.142.
32. Freud S. The Interpretation of Dreams. London: Oxford University Press, 1990.
33. Vaillant GE. Adaptive mental mechanisms: Their role in a positive psychology. Am Psychol 2000; 55: 89-98. Preuzeto 29.3.2021. https://doi.apa.org/doi/10.1037/0003-066X.55.1.89.
34. Cramer P. Understanding defense mechanisms. Psychodyn Psychiatry 2015; 43: 523-52. Preuzeto 29.3.2021. https://doi.org/10.1521/pdps.2015.43.4.523.
35. Yu CKC. The mechanisms of defense and dreaming. Dreaming 2011; 21: 51-69. Preuzeto 29.3.2021.https://www.researchgate.net/deref/http%3A%2F%2Fdx.doi.org%2F10.1037%2Fa0022867.
36. Hall CS, Nordby VJ. The Individual and His Dreams. New York: New American Library, 1972.
37. Andrews G, Singh M, Bond M. The Defence Style Questionnaire. J Nerv Ment Dis. 1993; 181: 246-56.
38. Vulić-Prtorić A. Psihometrijska validacija Upitnika obrambenih stilova DSQ-40 –preliminarno istraživanje. Soc psihijat 2008; 36 (2): 49-57.
39. Derogatis LR. Brief Symptom Inventory (BSI) – Administration, scoring and procedures manual. Minneapolis: NCS Pearson INC, 1993.
40. Štibrić M. Psihometrijska validacija Derogatisovog Kratkog inventara simptoma. Neobjavljeni diplomski rad. Zagreb: Odsjek za psihologiju Filozofskog fakulteta Sveučilišta u Zagrebu, 2005.
41. Tkalčić M, Lončarić D. Značajke spavanja i sanjanja studenata psihologije. Psihologijske teme 1997; 6(7): 105-14.
42. Carhart-Harris RL, Leech R, Hellyer PJ, Shanahan M, Feilding A, Tagliazucchi E *et al.* The entropic brain: a theory of conscious states informed by neuroimaging research with psychedelic drugs. Front Hum Neurosci 2014; 8-20. Preuzeto 29.3.2021. https://doi.org/10.3389/fnhum.2014.00020.

Upotreba upitnika YP-CORE u procjeni mentalnog zdravlja djece s intelektualnim teškoćama

/ Use of YP-CORE Questionnaire in the Assessment of Mental Health of Children with Intellectual Difficulties

Nataša Tomljanović[1], Nataša Jokić-Begić[2]

[1]Centar za odgoj i obrazovanje Rijeka, Rijeka, Hrvatska; [2] Sveučilište u Zagrebu, Filozofski fakultet, Zagreb, Hrvatska

/[1]Centre for Education and Teaching Rijeka, Rijeka, Croatia; [2]University of Zagreb, Faculty of Humanities and Social Sciences, Zagreb, Croatia

Kod djece i mladih s intelektualnim teškoćama u prvom je redu karakteristična snižena razina intelektualnog, a potom i emocionalnog i socijalnog funkcioniranja. Takve osobe zaostaju u usvajanju akademskih znanja, učenju i usvajanju socijalnih vještina. Poznavajući aspekte funkcioniranja djece i mladih s intelektualnim teškoćama moguće je predvidjeti faktore rizika za razvoj teškoća ponašanja te narušavanje mentalnog zdravlja. Međutim, teško je utvrditi razinu ili barem postojanje mentalnih teškoća zbog nepostojanja standardiziranih testova za procjenu mentalnog zdravlja kod djece i mladih s intelektualnim teškoćama, iako stručnjaci koji rade s takvim osobama upozoravaju na njihovo često narušeno mentalno zdravlje. Cilj istraživanja bio je utvrditi primjenjivost YP-CORE upitnika za procjenu psihičke uznemirenosti kod djece i mladih s intelektualnim teškoćama. Ispitivanje je provedeno s učenicima Centra za odgoj i obrazovanje Rijeka, na uzorku 59 djece i mladih dobi od 7 do 21 godine. Dobiveni rezultati sukladni su prethodnim istraživanjima koja su pokazala kako 30 % djece i mladih s intelektualnim teškoćama imaju izražene psihičke teškoće. Iako naši rezultati odgovaraju onima dobivenim u drugim istraživanjima, postoje teškoće u primjeni upitnika, prije svega kod osoba s umjerenim intelektualnim teškoćama. No, rezultati su ohrabrujući u smislu valjanosti, koju svakako treba provjeriti u budućim istraživanjima.

/ Children and young people with intellectual disabilities are primarily characterized by a reduced level of intellectual as well as emotional and social functioning. Persons with intellectual disabilities lag behind in the acquisition of academic knowledge, learning and the acquisition of social skills. Knowing the aspects of cognitive functioning of children with intellectual disabilities, it is possible to predict risk factors for the development of behavioural difficulties and mental health disorders. However, it is difficult to determine the level or, at least, the presence of mental disabilities due to the lack of standardized tests to assess mental health in children and young people with intellectual disabilities. Experts who work with persons with intellectual disabilities warn of their often impaired mental health. The aim of the research was to determine the applicability of the YP-CORE questionnaire for assessing psychological distress in children and young people with intellectual disabilities. The survey was conducted with students of the Centre for Education and Teaching in Rijeka on a sample of 59 children and young people aged 7 to 21 years. The obtained results are in line with previous research indicating that 30% of children and young people with intellectual disabilities have severe mental disabilities. Although our results correspond to those obtained in other studies, there are difficulties in applying the questionnaire, especially in people with moderate intellectual disabilities. However, the results are encouraging in terms of validity, which should be the subject of further research in the future.

ADRESA ZA DOPISIVANJE /
CORRESPONDENCE:
Nataša Tomljanović
Centar za odgoj i obrazovanje Rijeka
Senjskih uskoka 2
51 Rijeka,Hrvatska
E-pošta: natasa.tomljanovic@skole.hr

KLJUČNE RIJEČI / *KEY WORDS*:
Intelektualne teškoće / *Intellectual Disturbances*
Faktori rizika za mentalno zdravlje / *Risk factors for Mental Health*
Upitnik YP-CORE / *YP-CORE Questionnaire*
Teškoće primjene / *Application Difficulties*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2021.113

UVOD

Intelektualne teškoće (IT) određuju se kao značajno ograničenje u ukupnom životu pojedinca karakterizirano bitnim ispodprosječnim intelektualnim funkcioniranjem koje je istodobno popraćeno smanjenom razinom u dvije ili više adaptivnih vještina. Kao stanje utvrđuje se prije 18. godine života (1).

Ispodprosječno intelektualno funkcioniranje podrazumijeva teškoće u „rasuđivanju, rješavanju problema, planiranju, apstraktnom razmišljanju, prosuđivanju, akademskom učenju i učenju iz iskustva“ – potvrđeno kliničkom procjenom i individualiziranim standardnim IQ testiranjem, koje značajno ograničava funkcioniranje djeteta (2). Adaptivne vještine uključuju konceptualne vještine, socijalne vještine i praktične vještine s cijelim nizom područja djelovanja i funkcioniranja, a koja su u određenom omjeru teškoće za dijete (3).

Kognitivno funkcioniranju djece s intelektualnim teškoćama uključuje usporeno i otežano učenje, iskustvena znanja su oskudna, teže se uspostavljaju uzročno-posljedične veze, stečena znanja se teže stavljaju u funkciju. Osim teškoća usvajanja akademskih znanja djeca s intelektualnom teškoćom zaostaju u učenju i usvajanju socijalnih vještina.

Ne tako davno, smatralo se da djeca i osobe s intelektualnim teškoćama ne mogu imati probleme psihičkog zdravlja, odnosno smatralo se

INTRODUCTION

Intellectual disability (ID) is defined as a significant limitation in the overall life of an individual characterised by significant below-average intellectual functioning that is simultaneously accompanied by a reduced level of two or more adaptive skills. The condition is determined before the age of 18 (1).

Below-average intellectual functioning involves difficulties in “reasoning, problem-solving, planning, abstract thinking, judgment, academic and experiential learning” - confirmed by clinical assessment and individualised standard IQ testing, which significantly limits a child’s functioning (2). Adaptive skills include conceptual, social, and practical skills with a range of areas of action and functioning that are to some extent difficult for the child (3).

The cognitive functioning of children with intellectual disabilities includes slow and difficult learning, experiential knowledge is scarce, cause-and-effect relationships are more difficult to establish, and acquired knowledge is more difficult to put into function. In addition to difficulties in acquiring academic knowledge, children with intellectual disabilities lag behind in learning and acquiring social skills.

Not so long ago, it was believed that children and people with intellectual disabilities could not have mental health problems, or it was believed that intellectual disabilities alone carried

da intelektualne teškoće već same po sebi sa sobom nose psihičke poremećaje. Zbog ove predrasude, psihičke smetnje ovih osoba se često zanemaruju ili se pogrešno pripisuju primarnoj intelektualnoj teškoći, što rezultira nepotrebnom patnjom koja se može ublažiti adekvatnim pristupom i podrškom (4).

Poznavajući zakonitosti razvoja i kognitivnog funkcioniranja djece s intelektualnim teškoćama moguće je predvidjeti faktore rizika za razvoj teškoća ponašanja te narušavanje psihičkog zdravlja. Suvremeni pristupi uzrocima psihičkih poremećaja/bolesti apostrofiraju važnost međuodnosa bioloških, socijalnih i psiholoških čimbenika objedinjenih u tzv. biopsihosocijalnom modelu (5). Pojava poremećaja objašnjava se modelom dijateza-stres, odnosno poremećaj nastaje zbog (i) biološke i/ili psihološke ranjivosti (npr. genetika, temperament, osobine ličnosti) i okolinskih i/ili psihosocijalnih stresora (npr. bolest, siromaštvo, zlostavljanje, trauma, nedostatak podrške, roditeljski stil) koji u kombinaciji nadmašuju adaptivni odgovor pojedinca. Čimbenici rizika u socijalnim odnosima su brojni, jer je često takvo dijete živjelo u tugaljivom i rezigniranom obiteljskom okruženju, često je bilo izolirano i zanemareno u školskom okruženju i društvu. Djeca s intelektualnim teškoćama zaostaju u usvajanju socijalnih vještina, otežano se prilagođavaju, otežano uspostavljaju komunikacije zbog čega su često izolirani i odbačeni. Značajno je zaostajanje u emocionalnom sazrijevanju zbog kojeg dolazi do neadekvatnog izražavanja emocija s obzirom na kronološku dob. Emocionalno su vrlo osjetljiva skupina jer su često zanemareni od prijateljskog okruženja, odbačeni, a često i zlostavljani.

Mentalno ili emocionalno zdravlje definirano je prema Svjetskoj zdravstvenoj organizaciji (SZO) kao stanje dobrobiti u kojem pojedinac ostvaruje svoje potencijale, može se nositi s normalnim životnim stresom, može raditi produktivno i plodno te je sposoban pridoalong mental disorders. Because of this prejudice, mental disorders of these individuals were often neglected or mistakenly attributed to primary intellectual disability, resulting in unnecessary suffering that could be alleviated by adequate approach and support (4).

Knowing the laws of development and cognitive functioning of children with intellectual disabilities, it is possible to predict risk factors for the development of behavioural difficulties and mental health disorders. Modern approaches to the causes of mental disorders/diseases emphasize the importance of the relationship between biological, social, and psychological factors subsumed under the so-called biopsychosocial model (5). The occurrence of the disorder is explained by the diathesis-stress model, i.e., the disorder occurs due to (i) biological and/or psychological vulnerability (e.g., genetics, temperament, personality traits) and (ii) environmental and/or psychosocial stressors (e.g., illness, poverty, abuse, trauma, lack of support, parenting style), which in combination overweigh the adaptive response of the individual. Risk factors in social relationships are numerous, as often such a child lived in a mournful and resigned family environment, and was often isolated and neglected in the school environment and society. Children with intellectual disabilities lag behind in the acquisition of social skills, find it difficult to adapt, and have difficulty establishing communication, which is why they are often isolated and rejected. There is a significant lag in emotional maturation which leads to inadequate expression of emotions with respect to chronological age. They are an emotionally very sensitive group because they are often neglected by a friendly environment, rejected, and often abused.

Mental or emotional health is defined by the World Health Organization (WHO) as a state of well-being in which the individual realises his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully and

nositi zajednici, Psihičko zdravlje dio je općeg zdravlja i temeljni je uvjet za kvalitetan život (6).

U kliničkoj psihologiji dugo je prevladavao bipolarni model odnosa psihičkog zdravlja i psihičkih poremećaja (7). Bipolarni model podrazumijeva da psihičko zdravlje i psihičke bolesti odražavaju suprotne krajeve istog kontinuuma i kretanje u jednom smjeru podrazumijeva odmicanje od drugog kraja te se tako zdravlje i bolest isključuju (8). Ovaj model iznimno je utjecajan sve do današnjih dana, iako je od početka bio izložen brojnim kritikama. Klinička psihologija i psihijatrija svoje su istraživačke i kliničke snage usmjerile isključivo smanjenju psihičkih tegoba jer je to, u kontekstu ovog modela, značilo ojačavati psihičko zdravlje. Ovaj model počiva na nekoliko pretpostavki koje su se pokazale netočnima i štetnima. Prva pretpostavka jest da je većina ljudi psihički zdrava, a samo manji broj psihički bolestan, te je važno utvrditi kriterije na temelju kojih se osobe mogu svrstati u skupinu zdravih ili bolesnih. Međutim, kako ne postoji jasna granica između zdravlja i bolesti, ona se morala odrediti arbitrarno ovisno o situaciji i socijalnom kontekstu, što odmah dovodi u pitanje valjanost i pouzdanost tako određene distinkcije. Arbitrarnost kriterija očituje se u stalnim promjenama dijagnostičkih klasifikacija i novim izdanjima dijagnostičkih priručnika.

Iz pretpostavke da postoje psihički „zdravi“ i „bolesni“ pojedinci, proizlazi i posebno poguban fenomen stigmatizacije zbog kojeg društvo odbacuje pojedince koji su označeni kao psihički bolesni. Druga pogrešna pretpostavka koja proizlazi iz bipolarnog modela jest da je pripadnost kategoriji zdravlja ili bolesti trajna, te da je ljudima koji pripadaju kategoriji „bolesti“, a pogotovo ako se radi o intelektualnim teškoćama, bezizgledna. No, zadnjih je desetljeća sve više primjenjiv tzv. *dualni model*, koji predlažu razni autori (slika 1). Psihičko zdravlje i psihički poremećaji/bolesti smatraju se povezanim,

is able to make a contribution to his or her community. Mental health is part of general health and is a precondition for a quality life (6).

The bipolar model of the relationship between mental health and mental disorders has long prevailed in clinical psychology (7). The bipolar model implies that mental health and mental illness reflect opposite ends of the same continuum and moving in one direction implies moving away from the other end, thus health and illness excluding one another (8). This model has been extremely influential to this day, although it has been the subject of much criticism from the beginning. Clinical psychology and psychiatry have focused their research and clinical efforts exclusively on reducing mental health problems because, in the context of this model, this has meant strengthening mental health. This model is based on several assumptions that have proven to be inaccurate and harmful. The first assumption is that most people are mentally healthy, and only a small number are mentally ill, and it is important to determine the criteria on the basis of which persons can be classified as healthy or ill. However, as there is no clear line between health and illness, this had to be determined arbitrarily depending on the situation and social context, which immediately calls into question the validity and reliability of such a distinction. The arbitrariness of the criteria is reflected in the constant changes in diagnostic classifications and new editions of diagnostic manuals.

The assumption that there are mentally “healthy” and “ill” individuals results in a particularly devastating phenomenon of stigmatization due to which society rejects individuals who are labelled as mentally ill. Another misconception arising from the bipolar model is that belonging to the category of health or illness is permanent, and that people belonging to the category of “illness”, especially if it is an intellectual disability, are in a hopeless situation. However, in recent decades, the so-called

ali različitim konstruktima, pri čemu pojedinci mogu doživjeti visoku razinu zdravlja, čak i uz dijagnozu psihičke bolesti.

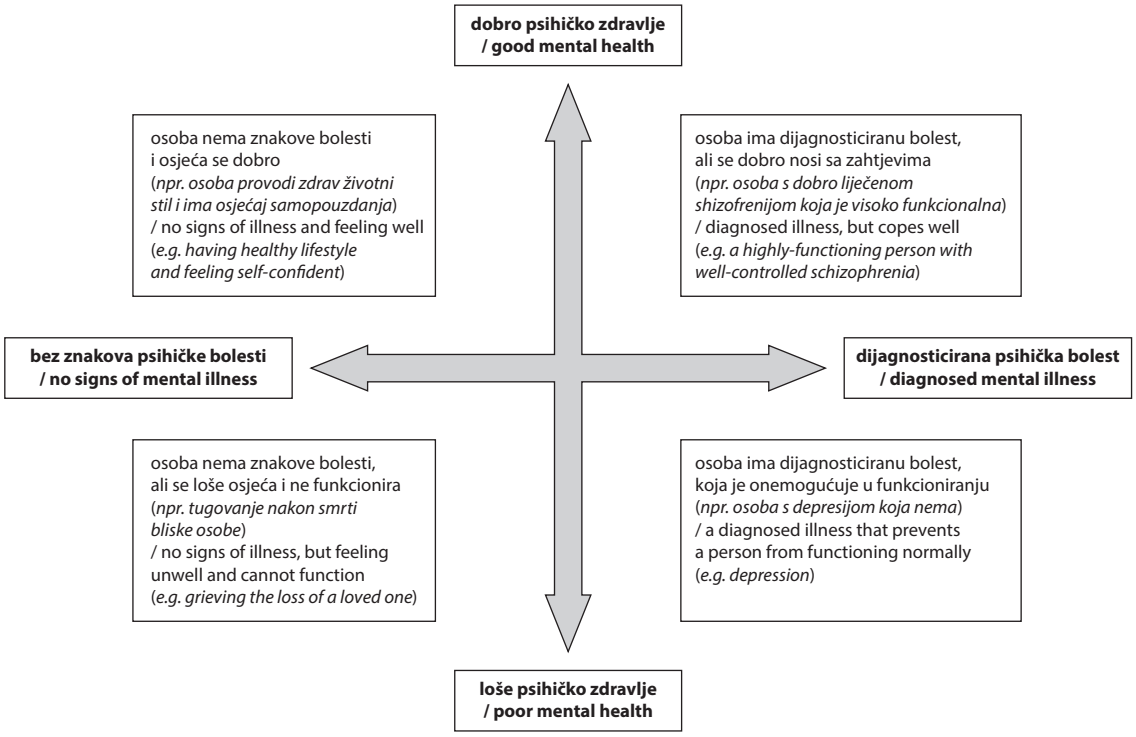
Promjena paradigme u pristupu psihičkom zdravlju i bolesti je iznimno važna u kontekstu rada s osobama s intelektualnim teškoćama. Naime, prema dualnom modelu svaki pojedinac ima kapacitet za razvoj osobnih potencijala, ali i rizike za razvoj poremećaja.

Djeca s intelektualnim teškoćama više i češće pate i obolijevaju od psihičkih poremećaja od svojih vršnjaka. Psihopatološke smetnje značajnije su izražene kod djece s umjerenom nego s lakom intelektualnom teškoćom i to zbog izraženijih smetnji adaptivnog ponašanja, zbog jezičnih i komunikacijskih barijera, teškoća socijalizacije, a rizik raste s niskim socioekonomskim statusom obitelji. Obiteljske karakteristike mogu uvelike doprinijeti razvoju psihičkih smetnji kod djece s IT-om. Poremećaji psihičkog zdravlja postaju veći i dublji što je dijete starije i dugotrajnije izloženo neadekvatnom pristupu od okoline (9).

dual model, proposed by various authors has been increasingly applicable (Figure 1). Mental health and mental disorders/illnesses are considered to be related but different constructs, with individuals being able to experience high levels of health, even with a diagnosis of mental illness.

A paradigm shift in the approach to mental health and illness is extremely important in the context of working with people with intellectual disabilities. Specifically, according to the dual model, each individual has the capacity to develop personal potentials, but also the risks to develop disorders.

Children with intellectual disabilities suffer more and more often from mental disorders than their peers. Psychopathological disorders are more pronounced in children with moderate than mild intellectual disabilities due to more pronounced adaptive behavioural disorders, language and communication barriers, socialisation difficulties, and the risk increases with low socioeconomic status of the family.



SLIKA 1. Dualni model psihičkog zdravlja i bolesti
FIGURE 1. Dual model of mental health and illness

Prema brojnim epidemiološkim ispitivanjima u mnogim zemljama, 30 do 50 % osoba s intelektualnom teškoćom pokazuju probleme ponašanja i pate od psihičkih poremećaja (10). Najčešći problem ponašanja je agresivnost (u oko 10 % osoba s IT-om), a od psihičkih poremećaja prednjači depresivnost (u 15 do 20 % osoba s IT-om).

Sagledavanje razvojne, funkcijske i adaptivne problematike osnovno je za razumijevanje patogeneze i aktualnog psihopatološkog stanja pacijenta. Tretman mora biti integrativan i posebno uzimati u obzir osnovne emocionalne potrebe, adaptacijske mogućnosti osobe i uvjete okoline (10). Unaprjeđenje psihičkog zdravlja osoba s intelektualnim teškoćama temelji se na izradi individualiziranog, sveobuhvatnog plana tretmana i pripadajuće podrške (engl. *Comprehensive Individualized Treatment and Related Support Plan,* CITSP), koji u sebi sadrži sve potrebne biološke, medicinske, psihosocijalne i razvojne postupke i pristupe potrebne za određenu vrstu i težinu problema ponašanja ili psihičkih poremećaja. Takav je individualizirani plan temeljen na individualnoj procjeni i integrativnoj dijagnostici koja je dio navedenih smjernica (11).

Kod djece s IT-om postoje teškoće dijagnosticiranja poremećaja mentalnog zdravlja. Klasifikacijski sustavi za psihičke bolesti kao što su DSM-IV i MKB-10 nisu upotrebljivi za klasifikaciju bolesti za teže i teške IT-e. Kod umjerenih IT-a ti su sustavi djelomično upotrebljivi, a kod lake IT-e najčešće su upotrebljivi (13). Poremećaji mentalnog zdravlja mogu jako smetati funkcioniranju djeteta s IT-om, njihovim obiteljima i osobama koje s njima rade. Teško je iz komunikacije s djetetom s IT-om utvrditi što ga smeta, ograničava i destabilizira. Stoga, brojni autori ističu kako je u dijagnostici potreban holistički, multidisciplinarni pristup uz uvažavanje mišljenja stručnjaka i važnih sudionika u životu djece.

Primjena standardnih dijagnostičkih kriterija kod djece s intelektualnim teškoćama otežava-

Family characteristics can greatly contribute to the development of mental disorders in children with ID. Mental health disorders become greater and deeper as the child gets older and is longer exposed to inadequate approach from the environment (9).

According to numerous epidemiological studies in many countries, 30 to 50% of people with intellectual disabilities show behavioural problems and suffer from mental disorders (10). The most common behavioural problem is aggression (in about 10% of people with ID), and depression is predominant among mental disorders (in 15 to 20% of people with ID).

Understanding the developmental, functional and adaptive issues is essential for understanding the pathogenesis and current psychopathological condition of the patient. Treatment must be integrative and take into account in particular the basic emotional needs, the adaptive capacity of the person and the environmental conditions (10). Improving the mental health of people with intellectual disabilities is dependent on the development of a Comprehensive Individualised Treatment and Related Support (CITSP), which contains all the necessary biological, medical, psychosocial and developmental procedures and approaches required for a particular type and severity of behavioural problems or mental disorders. Such an individualised plan is based on individual assessment and integrative diagnostics, which is part of the above guidelines (11).

There are difficulties when it comes to diagnosing mental health disorders in children with ID. Classification systems for mental illnesses such as DSM-IV and ICD-10 are not usable for the classification of illnesses in severe and very severe ID cases. In moderate ID, these systems are partially usable, and in light ID they are most often usable (13). Mental health disorders can severely interfere with the functioning of a child with ID, their families and the people who work with them. It is difficult to

na je zbog ograničene kognicije, nedovoljne razvijenosti govora, nemogućnosti uspostave komunikacije, prisutnosti raznih senzornih teškoća itd. Osobe s intelektualnim teškoćama često imaju poteškoće s izražavanjem svojih misli, osjećaja i problema, što otežava utvrđivanje njihovih zdravstvenih problema. Ovaj se problem mora uzeti u obzir tijekom procjene osoba koja nužno mora uključivati multidisciplinarni tim (14). Mjerni instrument koji bi omogućio brzu, ali valjanu i pouzdanu procjenu psihičkih tegoba bio bi od iznimne koristi u provjeri psihičkog stanja osoba s intelektualnim teškoćama.

Primjena standardiziranih upitnika u procjeni psihičkih smetnji osoba s intelektualnim teškoćama je tek u začetcima. Jedan od potencijalno zanimljivih i korisnih instrumenata je iz obitelji instrumenata za ispitivanje općih psihopatoloških teškoća CORE. CORE je kratica za kliničke ishode rutinskih evaluacija (*Clinical Outcomes in Routine Evaluation; https://www.coresystemtrust.org.uk/)*, a sustav CORE sadrži psihodijagnostičke alate za praćenje promjena i ishoda u psihoterapijskoj, savjetovališnoj i drugoj kliničkoj praksi koji pokušava promovirati psihološki oporavak, zdravlje i dobrobit. Kod nas je u standardnoj uporabi Upitnik za utvrđivanje općih psihopatoloških teškoća (*Clinical Outcomes in Routine Evaluation – Outcome Measure,* CORE-OM) (15) koji je mjera psihološke uznemirenosti koja nije fokusirana na utvrđivanje konkretnog problema, ali obuhvaća najvažnije aspekte mentalnog zdravlja. Upitnik je pokazao odlične psihometrijske karakteristike, te je validiran u našim uvjetima (16). Osim toga, u praksi je odnedavno i inačica za djecu i mlade, YP-CORE (*Young Persons CORE*) (17). Radi se o prilagođenoj inačici upitnika za ispitivanje općih psihopatoloških teškoća. Upitnik YP-CORE je namijenjen upotrebi kod djece od 11 do 16 godina. Struktura je slična strukturi CORE-OM, ali su čestice prilagođene dobi cilj-

determine from communication with a child with ID what bothers, limits and destabilizes him or her. Therefore, many authors point out that a holistic, multidisciplinary approach is needed in diagnostics, taking into account the opinions of experts and important participants in children's lives.

The application of standard diagnostic criteria in children with intellectual disabilities is difficult due to limited cognition, insufficient speech development, inability to establish communication, the presence of various sensory difficulties, etc. People with intellectual disabilities often have difficulty expressing their thoughts, feelings, and problems, which hampers the establishment of their health problems. This problem must be taken into account during the assessment of persons, which must necessarily involve a multidisciplinary team (14). A measuring instrument that would enable a quick but valid and reliable assessment of mental disorders would be extremely useful in examining the mental state of people with intellectual disabilities.

The application of standardised questionnaires in the assessment of mental disorders of people with intellectual disabilities is still in its infancy. One of the potentially interesting and useful instruments comes from the CORE family of instruments for examining general psychopathological difficulties. CORE stands for Clinical Outcomes in Routine Evaluation (https://www.coresystemtrust.org.uk/), and CORE contains psychodiagnostic tools to monitor changes and outcomes in psychotherapeutic, counselling and other clinical practice that attempts to promote psychological recovery, health and well-being. We use the Clinical Outcomes in Routine Evaluation - Outcome Measure (CORE-OM) questionnaire (15) as a standard measure of psychological distress that is not focused on identifying a specific problem but covers the most important aspects of mental health. The questionnaire showed ex-

ne skupine te se ispituju emocionalna stanja, razina funkcioniranja i rizik od autogresivnog ponašanja. Na dobru pouzdanost ukazuju koeficijenti pouzdanosti (Cronbach alfa) *r*=0,82 (18). U hrvatskim istraživanjima pouzdanost izražena Cronbach alfa koeficijentom iznosila je .85 i .86 (19,20).

CILJ ISTRAŽIVANJA

Cilj ovog rada je provjeriti primjenjivost Upitnika za ispitivanje općih psihopatoloških teškoća za mlade (*Clinical Outcomes in Routine Evaluation – Young Person,* YP-CORE) na uzorku mladih osoba s intelektualnim teškoćama. Upitnik je konstruiran kao panteorijska i pandijagnostička mjera opće psihološke uznemirenosti i priprema se njegova rutinska upotreba u hrvatskom javnom zdravstvu za probir mladih s psihičkim teškoćama koje zahtijevaju daljnju obradu (21)

U ovoj ranoj fazi pripreme YP-CORE-a za primjenu na hrvatskoj populaciji mladih osoba činilo nam se vrijednim provjeriti i njegovu upotrebljivost u procjeni psihičkih teškoća kod mladih s IT-om, uz modificiranu primjenu u kojoj bi odrasla osoba pomagala u ispunjavanju upitnika. Prema našim spoznajama u Hrvatskoj nema psihodijagnostičkog instrumenta za utvrđivanje psihičke uznemirenosti, koji je u redovitoj upotrebi u radu s osobama s IT-om, te provjera primjenjivosti upitnika YP-CORE ima i spoznajno i praktično značenje.

METODE ISTRAŽIVANJA

Sudionici

U istraživanju je ukupno sudjelovalo 59 djece i adolescenata dobi od 7 do 21 godine. Uzorak se sastojao od 38 dječaka i mladića (64,4 %). Prosječna dob uzorka iznosi *M*=13,5 godina (*SD*=3.59), a čine ga djeca i adolescenti koji su

cellent psychometric characteristics and was validated in our conditions (16). In addition, a version for children and young people, YP-CORE (Young Persons CORE), has recently also become standard practice (17). This is a customised version of the questionnaire for testing general psychopathological difficulties. The YP-CORE questionnaire is intended for use in children aged 11 to 16 years. The structure is similar to that of CORE-OM, but the items are age-appropriate and target emotional states, levels of functioning, and risk of auto aggressive behaviour. Good reliability is indicated by reliability coefficients (Cronbach's alpha) *r*=0.82 (18). In Croatian studies, the reliability expressed by the Cronbach's alpha coefficient was .85 and .86 (19, 20).

RESEARCH AIM

The aim of this paper was to test the applicability of the Clinical Outcomes in Routine Evaluation for Young People (YP-CORE) questionnaire on a sample of young people with intellectual disabilities. The questionnaire was constructed as a pantheoretical and pandiagnostic measure of general psychological distress. Its routine application in Croatian public health is being prepared for screening young people with mental disabilities that require further examination (21).

At this early stage of preparation of YP-CORE for use in the Croatian population of young people, we thought it worthwhile to check its usefulness in assessing psychological difficulties in young people with ID, with a modified application in which an adult would help complete the questionnaire. According to our knowledge, there is no psychodiagnostic instrument for determining mental distress in Croatia, which is in regular use in working with people with ID, and checking the applicability of the YP-CORE questionnaire has both cognitive and practical significance.

pristupili psihodijagnostičkoj obradi u Centru za odgoj i obrazovanje Rijeka. S obzirom na dijagnozu uzorak je činilo 78 % djece i mladih s lakim i 22 % s umjerenim intelektualnim teškoćama.

Mjerni instrument

YP-CORE je instrument namijenjen mjerenju psihičke uznemirenosti kod djece i mladih. Sastoji se od 10 čestica kojima se ispituje anksioznost (npr., 2 čestice), depresija (2 čestice), trauma (1 čestica), fizičke poteškoće (1 čestica), funkcioniranje (3 čestice) i rizik od autoagresivnog ponašanja (1 čestica).

Na čestice se odgovara označavanjem odgovora na ljestvici s 5 ponuđenih odgovora (0 – nikad, 1 – vrlo rijetko, 2 – ponekad, 3 – često, 4 – gotovo uvijek). Sudionici daju odgovor retrospektivno, za razdoblje od proteklih tjedan dana. Svakom odgovoru se pridaju odgovarajući bodovi (0-4), a 3 čestice se obrnuto boduju. Ukupan rezultat može se dobiti zbrajanjem svih bodova ili zbrajanjem svih bodova i dijeljenjem s 10. Veći rezultat znači da je sudionik izvijestio o više problema i emocionalnih teškoća te da se osjeća više uznemireno.

POSTUPAK

Ukupan broj učenika u Centru za odgoj i obrazovanje Rijeka u 2019/2020. godini je 153, u osnovnoj i srednjoj školi. U Centru se školuju učenici s lakom i umjerenom intelektualnom teškoćom do dobi od 21. godine prema Posebnom programu uz individualizirane postupke i Posebnom programu za stjecanje kompetencija u aktivnostima svakodnevnog života uz individualizirane postupke. U istraživanju je sudjelovalo 59 (38,5 %) učenika CZOO Rijeka. Prije samog ispitivanja dano je tumačenje i zatražen je pismeni pristanak roditelja. Istraživanje je bilo provedeno u skladu s Etičkim kodeksom istraživanja s djecom (22).

RESEARCH METHODS

Participants

A total of 59 children and adolescents aged 7 to 21 participated in the study. The sample comprised 38 boys and young men (64.4%). The average age of the sample was M = 13.5 years (SD = 3.59), and it consisted of children and adolescents who underwent psychodiagnostic treatment at the Center for Education and Teaching in Rijeka. Taking into account the diagnosis, the sample consisted of 78% of children and adolescents with mild and 22% with moderate intellectual disabilities.

Measuring instrument

The YP-CORE is an instrument designed to measure psychological distress in children and young people. It consists of 10 items that test for anxiety (e.g., 2 items), depression (2 items), trauma (1 item), physical difficulties (1 item), functioning (3 items) and the risk of autoaggressive behaviour (1 item).

The items are answered by marking the answers on a scale with 5 answers (0 - never, 1 - very rarely, 2 - sometimes, 3 - often, 4 - almost always). Participants respond retrospectively providing answers for the period over the past week. Each answer is given the appropriate score (0-4) and 3 items are scored in reverse. The total score can be obtained by adding all the points or by adding all the points and dividing the result by 10. A higher score means that the participant reported more problems and emotional difficulties and felt more disturbed.

Procedure

In the 2019-20 school year, the total number of students at the Centre for Education and Teaching in Rijeka in primary and secondary education was 153. The Centre educates students with mild and moderate intellectual disabilities up to the age of 21 who follow the Spe-

Učenici koji nisu pristupili testiranju, nisu to učinili iz tri razloga. Neki roditelji nisu dali pristanak te učenici nisu obuhvaćeni ispitivanjem. Nekolicina učenika nije željela pristupiti ispitivanju. S velikom većinom učenika nije bilo moguće ispuniti upitnik, jer su imali većih teškoća u razumijevanju, komunikaciji i ponašanju.

Učitelji su dobili pismenu uputu kako bi trebali provoditi ispitivanje. S obzirom da upitnik YP-CORE zahtijeva samostalno ispunjavanje, a velika većina učenika s intelektualnim teškoćama nije to u mogućnosti učiniti, pismena uputa trebala je osigurati što veću vjerodostojnost. Učiteljima je dana uputa da s učenikom prođu kroz pitanja na upitniku, provjere razumijevanje pitanja i odgovora, te ako je to nužno ponude predloške slikovnih odgovora ('smajlića') na ponuđena pitanja (slika 2). Stoga se rezultati YP-CORE u većini ispitanika, odnose na učenike s lakim intelektualnim teškoćama. Ako sudionik nikako nije mogao odgovoriti na pitanje, dana je uputa da se preskoči odgovor.

REZULTATI ISTRAŽIVANJA

U tablici 1 prikazani SU rezultati deskriptivne statistike, te usporedbi s obzirom na rod, dob i stupanj intelektualnih teškoća. Pouzdanost upitnika se pokazala zadovoljavajućom, Cronbach alfa za čitavu ljestvicu iznosi ,86, a u rodnim i dobnim skupinama, te kategorije IT-a kreću se od ,79-,87.

Nema statistički značajne razlike u ukupnom rezultatu s obzirom na rod, dob i IT status.

Na grafičkom prikazu 1. nalazi se distribucija ukupnih rezultata na YP-CORE iz koje je vidljivo da su rezultati normalno raspoređeni, što

SLIKA 2. Slikovni odgovori
FIGURE 2. Pictorial answers

cial programme with individualized procedures and the Special programme for the acquisition of competencies in everyday activities with individualized procedures. The survey comprised 59 (38.5%) students of the Centre for Education and Teaching in Rijeka. Before testing, the questionnaire was explained to the participants and a written consent from the parents was requested. The survey was conducted in accordance with the Code of Ethics for Research with Children (22).

Some students were not tested due to three reasons. Some parents did not give their consent and students were not included in the survey. Several students did not want to be tested. With a vast majority of students, it was not possible to conduct testing as they had considerable difficulties with understanding, communicating and behaving.

Teachers were given written instructions on how to conduct the test. Having in mind that the YP-CORE questionnaire requires individual response, and that the majority of students with intellectual disabilities were unable to provide answers individually, the aim of written instructions was to ensure as much accuracy as possible. Teachers were instructed to explain the questions on the questionnaire to the student, check their understanding of the questions and answers, and, if necessary, to provide templates of pictorial answers (smiley faces) to the questions (Figure 2). Therefore, the results of the YP-CORE in most respondents were obtained from the students with mild intellectual disabilities. If the participant was not able to answer the question at all, instructions were given to skip the answer.

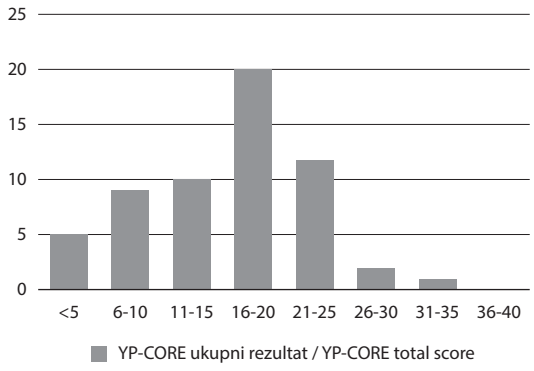
RESEARCH RESULTS

Table 1 shows the results of descriptive statistics and comparisons with regard to gender, age and degree of intellectual disabilities.

TABLICA 1. Prikaz rezultata deskriptivne statistike YP-CORE s obzirom na rod, dob i stupanj intelektualne teškoće sudionika te vrijednosti t-testa.
TABLE 1. Presentation of YP-CORE descriptive statistics results with respect to gender, age and degree of intellectual disability and t-test values.

		N	Alpha	M	SD	Raspon rezultata / Result range	t (p)
Rod / Gender	Muški / Male	38	0,86	15,5	7,61	1 – 33	0,243 (0,809)
	Ženski / Female	21	0,79	15,9	5,22	2 – 24	
Dob / Age	7-12	29	0,86	14,7	8,89	1 – 33	1,41 (0,162)
	13-21	29	0,87	16,9	6,92	1 – 33	
Stupanj intelektualne teškoće / Degree of intellectual difficulty	Lake / Low	46	0,87	15,5	7,01	1 – 33	0,288 (0,755)
	Umjerene / Moderate	13	0,82	16,1	6,88	2 – 24	
Ukupno / In total		59	0,86	15,6	6,96	1 – 33	

Legenda: N – broj sudionika; Alfa – vrijednost Cronbach alfa; M – aritmetička sredina; SD – standardna devijacija; t (p) – vrijednost t-testa i pripadajuća vjerojatnost slučajnog rezultata. Teorijski raspon rezultata je 1-40, a u ovoj skupini sudionika je pokriven raspon od 1 do 33.
/ Legend: N - number of participants; Alpha - Cronbach's alpha value; M - arithmetic mean; SD - standard deviation; t (p) - value of the t-test and the corresponding probability of a random result. The theoretical range of results is 1-40. This group of participants covered the range from 1 to 33.



GRAFIČKI PRIKAZ 1. Distribucija ukupnih rezultata na YP-CORE (N=59)
GRAPH 1. Distribution of total results on YP-CORE (N = 59)

pokazuju i koeficijenti asimetrije -.221 i spljoštenosti -.11.

U tablici 2.prikazana JE frekvencija pojedinog odgovora za svaku česticu upitnika. Na čestici 4 (*Padalo mi je na pamet da si naudim*) čak 8 (14 %) sudionika nije dalo odgovor, što vjerojatno ukazuje da im ta čestica nije razumljiva. Na česticu 5 (*Osjećao sam da imam koga pitati za pomoć)* nije odgovorilo 4 sudionika (7 %). Na ostalim česticama nedostaje samo pokoji odgovor.

U daljnjim analizama su podatci koji nedostaju zamijenjeni prosječnim rezultatom za svakog sudionika. Provedena je eksploratorna faktorska analiza s metodom zajedničkih komponenata. Jednim faktorom objašnjeno je 46,8 %

The reliability of the questionnaire proved to be satisfactory, Cronbach's alpha for the whole scale was .86. In the categories of gender and age, the results range from .79- to .87.

There is no statistically significant difference in the overall score with respect to gender, age, and ID status.

Graph 1 shows the distribution of total results on the YP-CORE indicating a normal distribution of results, as shown by the coefficients of asymmetry -.221 and flatness -.11.

Table 2 shows the frequency of each answer for each item of the questionnaire. Item 4 (*It occurred to me to hurt myself*) as many as 8 (14%) participants did not give an answer, which probably indicates that this item was not sufficiently understandable. Item 5 (*I felt I had someone to ask for help*) was not answered by 4 participants (7%). Only a few answers were missing for other items.

In further analyses, the missing data were replaced by the average score for each participant. An exploratory factor analysis was performed using the common components method. 46.8% of the variance was explained by a single factor, and according to the scree plot and the conducted parallel analysis, the

TABLICA 2. Prikaz frekvencija pojedinih odgovora na česticama YP-CORE (N=59)
TABLE 2. Display of frequencies of individual responses on YP-CORE particles (N = 59)

Čestica / Item	0 (%)	1 (%)	2 (%)	3 (%)	4 (%)	Nedostaje (%) / Missing (%)
1. Bio sam živčan ili nervozan. / I was nervous or nervous or anxious.	6 (10,2)	8 (13,6)	23 (39,0)	17 (28,8)	4 (6,8)	1 (1,7)
2. Osjećao sam da mi nije do razgovora. / I felt I didn't want to talk.	11 (18,6)	10 (16,9)	17 (28,8)	15 (25,4)	3 (5,1)	3 (5,1)
3. Mogao sam se nositi s problemima. / I could handle the problems.	4 (6,8)	10 (16,9)	24 (40,7)	16 (27,1)	3 (5,1)	2 (3,4)
4. Padalo mi je na pamet da si naudim. / It occurred to me to hurt myself.	35 (59,3)	6 (10,2)	6 (10,2)	4 (6,8)	0 (0,0)	8 (13,6)
5. Osjećao sam da imam koga pitati za pomoć. / I felt I had someone to ask for help.	19 (32,2)	21 (35,6)	6 (10,2)	3 (5,1)	6 (10,2)	4 (6,8)
6. Moje misli i osjećaji su me uznemiravali. / My thoughts and feelings disturbed me.	13 (22,0)	7 (11,9)	15 (25,4)	18 (30,5)	3 (5,1)	3 (5,1)
7. Osjećao sam se bespomoćno u vezi sa svojim problemima. / I felt helpless about my problems.	16 (27,1)	10 (16,9)	19 (32,2)	9 (15,3)	3 (5,1)	2 (3,4)
8. Imao sam problema sa spavanjem. / I had trouble sleeping.	20 (33,9)	11 (18,6)	17 (28,8)	7 (11,9)	2 (3,4)	2 (3,4)
9. Bio sam tužan ili nesretan. / I was sad or unhappy.	8 (13,6)	7 (11,9)	28 (47,5)	13 (22,0)	2 (3,4)	1 (1,7)
10. Napravio sam sve što sam želio. / I did everything I wanted.	15 (25,4)	14 (23,7)	23 (39,0)	2 (3,4)	2 (3,4)	3 (5,1)

Legenda: 1 – vrlo rijetko, 2 – ponekad, 3 – često, 4 – gotovo uvijek
/ Legend: 1 - very rarely, 2 - sometimes, 3 - often, 4 - almost always

TABLICA 3. Prikaz aritmetičkih sredina, standardnih devijacija i saturacije faktorom dobivene eksploratornom faktorskom analizom.
TABLE 3. Representation of arithmetic means, standard deviations and factor saturation obtained by exploratory factor analysis.

Čestica / Item	M (SD)	Λ
Bio sam živčan ili nervozan. / I was nervous or anxious.	1,9 (1,01)	0,674
Osjećao sam da mi nije do razgovora. / I felt I didn't want to talk.	1,8 (1,17)	0,738
Mogao sam se nositi s problemima. / I could handle the problems.	2,1 (.96)	0,494
Padalo mi je na pamet da si naudim. / It occurred to me to hurt myself.	0,6 (.91)	0,592
Osjećao sam da imam koga pitati za pomoć. / I felt I had someone to ask for help.	1,2 (1,24)	0,538
Moje misli i osjećaji su me uznemiravali. / My thoughts and feelings disturbed me.	1,8 (1,23)	0,864
Osjećao sam se bespomoćno u vezi sa svojim problemima. / I felt helpless about my problems.	1,5 (1,19)	0,733
Imao sam problema sa spavanjem. / I had trouble sleeping.	1,3 (1,16)	0,658
Bio sam tužan ili nesretan. / I was sad or unhappy.	1,9 (1,01)	0,700
Napravio sam sve što sam želio. / I did everything I wanted.	1,3 (1,00)	0,277

varijance, prema *scree plotu* i provedenoj paralelnoj analizi preporuča se ekstrakcija jednog faktora. Najviše saturacije se nalaze u česticama 1, 2, 6, 7, 8 i 9. Čestica 10 ima saturaciju manju od ,3, dok su čestice 3, 4 i 5 saturirane oko ,5.

extraction of one factor is recommended. The highest saturations were found in items 1, 2, 6, 7, 8 and 9. Item 10 had a saturation less than .3, while items 3, 4 and 5 were saturated around ,5.

RASPRAVA

Cilj ovog istraživanja bio je provjeriti primjenjivost upitnika YP-CORE za procjenu psihičke uznemirenosti kod djece i mladih s intelektualnim teškoćama. Prilagodba primjene upitnika je uključivala asistenciju učitelja koji su dobro poznavali djecu i mlade sudionike istraživanja. Ako sudionik nije dobro razumio odgovor, učitelj je ponudio slikovne odgovore (prikaze različitih izraza lica). Ako prema procjeni učitelja sudionik nije dobro razumio pitanje, učitelj je sam donosio procjenu na temelju opaženog ponašanja. Ako nije to mogao učiniti, tada nije odgovorio na pitanje. U tako prilagođenim uvjetima, pouzdanost upitnika je visoka (Cronbach alfa=,86), upitnik pokazuje jednofaktorsku strukturu, a distribucija je normalna, uz prosječnu vrijednost od 15,6 (SD=6,93)

Ako rezultate usporedimo s rezultatima dobivenim na hrvatskom srednjoškolskom uzorku adolescentica (19) možemo zaključiti o sličnosti što se tiče faktorske strukture, pouzdanosti instrumenta i izraženosti emocionalnih smetnji. Prosječna izraženost smetnji je daleko viša nego u originalnom istraživanju (17). Čak 15 (25 %) djece i mladih u našem istraživanju pokazuje rezultat ≥20, što je znatno više u usporedbi s nedavno provedenim istraživanjem na uzorku hrvatskih učenika prvog razreda srednje škole (23). Dobiveni rezultati sukladni su prethodnim istraživanjima koja nalaze 30 % djece i mladih s IT-om kod kojih se mogu pronaći izražene psihičke teškoće (24).

Usporedba rezultata prema rodu, dobi i intelektualnom statusu sudionika pokazala je da nema statistički značajnih razlika u izraženosti emocionalnih teškoća. Nedavno objavljena meta-analiza kojom je obuhvaćeno 19 istraživanja s preko 6000 djece i mladih s IT-om u dobi od 6 do 21 godine također nije pokazala razlike s obzirom na intelektualni status sudionika (25).

Sudionici u našem istraživanju postizali su u prosjeku najviše rezultate na česticama *Bio sam*

DISCUSSION

The aim of this study was to test the applicability of the YP-CORE questionnaire for assessing mental distress in children and young people with intellectual disabilities. Adaptation of the application of the questionnaire included the assistance of teachers who knew children and young participants well. If the participant did not understand the answer well, the teacher offered pictorial answers (depictions of different facial expressions). If, according to the teacher's assessment, the participant did not understand the question well, the teacher made his/her own assessment based on the observed behaviour. If he or she was not able to do that, then he or she did not answer the question. Under such adapted conditions, the reliability of the questionnaire was high (Cronbach alpha =.86), the questionnaire showed a one-factor structure, and the distribution was normal, with an average value of 15.6 (SD = 6.93)

If we compare the results with the results obtained on a Croatian high school sample of adolescent girls (19), we can conclude that there are similarities in terms of the factor structure, reliability of the instrument, and the severity of emotional distress. The average severity of distress is far higher than in the original study (17). As many as 15 (25%) children and young people in our study showed a score of ≥20, which is significantly more than the recent survey on a sample of Croatian first grade high school students (23). The obtained results are in line with previous research, which found 30% of children and young people with ID in whom severe psychological difficulties could be found (24).

A comparison of the results according to the gender, age and intellectual status of the participants showed that there were no statistically significant differences in the expression of emotional distress. A recently published meta-analysis covering 19 studies with over 6,000 children and young people with ID aged 6-21 years also showed no differences with regard to the intellectual status of the participants (25).

živčan ili nervozan i *Bio sam tužan ili nesretan*. Najrjeđa smetnja koju je zabilježena jest *Padalo mi je napamet da si naudim*, iako treba spomenuti da čak 14 % sudionika nije dalo odgovor niti su učitelji mogli procjenjivati koji bi odgovor najbolje opisao učenikovo stanje, te nisu mogli odgovorit na ovo pitanje. Na česticu *Osjećao sam da imam koga pitati za pomoć* nije odgovorilo 6 % sudionika. U budućim istraživanjima svakako treba razmotriti razumljivost ovih dviju čestica te njihovu prikladnost pri primjeni kod mladih s intelektualnom teškoćom. Iako naši rezultati odgovaraju onima dobivenim u drugim istraživanjima, pregled faktorske strukture, te broja neodgovorenih čestica ukazuje na moguće teškoće u primjeni upitnika, prije svega kod osoba s umjerenim intelektualnim teškoćama. No, rezultati su ohrabrujući u smislu valjanosti koju svakako treba provjeriti u budućim istraživanjima.

Ovo istraživanje ima niz ograničenja koja onemogućuju generalizaciju podataka i izvođenje sigurnijih zaključaka. Prije svega, provedeno je na prigodnom i relativno malom uzorku sudionika iz samo jednog centra za odgoj i obrazovanje. U skladu s etičkim načelima istraživanje je provedeno samo na djeci čiji su roditelji dali pristanak za sudjelovanje, a poznato je da su time obuhvaćena djeca čije su obiteljske prilike bolje nego one djece čiji roditelji nisu dali pristanak.

Sljedeće ograničenje proizlazi iz načina prikupljanja podataka koje je nužno uključivalo odrasle osobe, te pomoć pri ispunjavanju. Iako ovaj način nije idealan, za njega smo se odlučili kako bismo procijenili primjenjivost ovog upitnika i razumijevanje čestica. U obitelji instrumenata postoji inačica za osobe s IT CORE-OM (*Clinical Outcomes in Routine Evaluation – Outcome Measure, Learning Disability version*) i koja je razvijena u suradnji s osobama iz Velike Britanije koje imaju intelektualne teškoće i uključuju slikovni prikaz odgovora. Autori koji su provjeravanjem primjenjivosti ovog instrumenta zaklju-

The participants in our study achieved on average the highest scores on the items *I was nervous or irritated* and *I was sad or unhappy*. The rarest disorder noted was *It occurred to me to hurt myself*, although it should be mentioned that as many as 14% of participants did not give an answer and teachers could not assess which answer would best describe the student's condition and therefore could not answer this question. 6% of participants did not answer to the item *I felt I had someone to ask for help*. In future research, the comprehensibility of these two items and their suitability for use in young people with intellectual disabilities should certainly be considered. Although our results correspond to those obtained in other studies, a review of the factor structure and number of unanswered items indicates possible difficulties in applying the questionnaire, especially in people with moderate intellectual disabilities. Nevertheless, the results are encouraging in terms of validity that should definitely be examined in future research.

This research has a number of limitations that make it impossible to generalise data and draw more solid conclusions. First of all, it was conducted on a convenient and relatively small sample of participants from only one center for education. In accordance with ethical principles, the research was conducted only on children whose parents gave their consent to participate, and it is well known that this includes children whose family circumstances are better than those of children whose parents did not give their consent.

The next limitation stems from the way data were collected, which necessarily involved adults, and compilation assistance. Although this method was not ideal, we opted for it to assess the applicability of this questionnaire and the understanding of its items. In the family of instruments, there is a version for people with ID, CORE-OM (Clinical Outcomes in Routine Evaluation - Outcome Measure, Learning Disability version), which was developed in col-

čili su da su potrebna daljnja istraživanja kako bi se provjerile metrijske karakteristike (26)

Naši nalazi imaju implikacije na kliničku praksu i istraživanje. Narušeno mentalno zdravlje koje se očituje prije svega emocionalnim teškoćama svakako narušava dobrobit oko trećine djece i adolescenata s IT, a posredno i njihovim obiteljima. Pravovremeno prepoznavanje smetnji i pružanje točne kliničke dijagnoze i adekvatne skrbi pridonijelo bi kvaliteti života ovih osoba i njihove socijalne okoline, te stvorilo uvjete za uspješniju inkluziju (27).

Nekoliko je implikacija za buduća istraživanja. Svakako su nužne daljnje provjere psihometrijskih svojstava upitnika na drugim skupinama, te provjera slikovnih varijanti odgovora. Nužna je provjera i test-retest tipa pouzdanosti instrumenta, te njegove valjanosti. Dobiveni rezultati su ohrabrujući za daljnja istraživanja koja će polučiti standardizaciju upitnika za ranu dijagnostiku psihičkih teškoća djece i mladih s IT-om.

ZAKLJUČAK

Djeca i mladi s intelektualnim teškoćama, evidentno, imaju emocionalne teškoće kao i probleme mentalnog zdravlja. Za očekivati je da će se problemi mentalnog zdravlja s godinama povećavati, ako se ne intervenira u smislu prevencije i pomoći.

Pokušali smo ustanoviti primjenjivost upitnika YP-CORE na populaciji učenika s intelektualnim teškoćama, kao i pokušati detektirati djecu koja imaju teškoće mentalnog zdravlja. Važno je napomenuti da djeca i mladi s većim (umjerenim i težim) intelektualnim teškoćama nisu ni pristupili ispitivanju zbog nemogućnosti provedbe, iako su vrlo uočljivi njihovi manifesti ponašanja koji bi upućivali na moguće teškoće kao i na poremećaje mentalnog zdravlja.

Zanimljivo je konstatirati kako su i druga istraživanja primjene instrumenta YP-CORE na dje-

laboration with people from the UK who have intellectual disabilities and includes a pictorial display of the answers. The authors who tested the applicability of this instrument concluded that further research was needed to verify the metric characteristics (26).

Our findings have implications for clinical practice and research. Impaired mental health, which is manifested primarily by emotional difficulties, certainly impairs the well-being of about a third of children and adolescents with ID, and indirectly their families. Timely identification of disorders and the provision of accurate clinical diagnosis and adequate care would contribute to the quality of life of these individuals and their social environment and create the conditions for more successful inclusion (27).

There are several implications for future research. Further checks of the psychometric properties of the questionnaires in other groups, as well as checks of the pictorial variants of the answers, are certainly necessary. It is necessary to check and test-retest the type of reliability of the instrument, and its validity. The obtained results are encouraging for further research that will result in the standardisation of the questionnaire for early diagnosis of psychological difficulties of children and young people with ID.

CONCLUSION

Children and young people with intellectual disabilities obviously have emotional difficulties as well as mental health problems. Mental health problems are to be expected to increase with age if intervention is not provided in the form of prevention and support.

We tried to establish the applicability of the YP-CORE questionnaire to the population of students with intellectual disabilities, as well as in detecting children with mental health difficulties. It is important to note that children

ci i mladima s intelektualnim teškoćama ukazala na iste teškoće u primjeni koje smo opisali kao i jednak postotak populacije (30 %) djece koja imaju probleme mentalnog zdravlja.

Stručnjaci, najčešće edukacijski rehabilitatori, koji rade s učenicima s intelektualnim teškoćama uočavaju brojne teškoće i poremećaje mentalnog zdravlja. Često se traži psihijatrijska pomoć koja je uglavnom usmjerena na primjenu medikamenata. Za dublje razumijevanje nastanka i procesa razvoja mentalnih problema kao i pronalaženje konkretnih terapijskih rješenja za ovu populaciju, bilo bi odlično djelovati i razmišljati o specijalizaciji stručnjaka psihijatara.

Zato postoji nužnost preventivnog djelovanja kako bi se pomoglo djeci, obiteljima i društvu u cjelini. Postavlja se pitanje što učiniti da bi se prevenirali poremećaji mentalnog zdravlja kod djece i mladih s intelektualnim teškoćama?!

Na razini djeteta i mladih trebalo jačati emocionalne veze i stabilnost, jačati osjećaj prihvaćenosti, organizirati život s dnevnom rutinom, pred dijete staviti obveze i odgovornost, slati jasne i nedvosmislene poruke koje ga mogu zbuniti, osigurati uspjeh i doživljaj napretka djeteta, organizirati slobodno vrijeme itd.

Na razini društva potrebno je jačati obiteljsku strukturu (socijalno, ekonomski...), osigurati povezanost obitelji sa zajednicom i pružanje stručne potpore obiteljima koje imaju dijete s IT.

and young people with major (moderate and severe) intellectual disabilities did not even take the test due to inability to implement it, although their behavioural manifestations that would indicate possible difficulties as well as mental health disorders were very noticeable.

It is interesting to note that other studies of the application of the YP-CORE instrument on children and young people with intellectual disabilities indicated the same difficulties in application that we described, as well as the same percentage of the child population (30%) with mental health problems.

Professionals, most often educational rehabilitators, who work with students with intellectual disabilities notice a number of difficulties and mental health disorders. Psychiatric help is often sought, which is mainly focused on the use of medication. For a deeper understanding of the origin and process of development of mental problems as well as finding concrete therapeutic solutions for this population, it would be worthwhile to act and think about the specialisation of psychiatric professionals.

Therefore, there is a need for preventive action to help children, families and society as a whole. The question is what to do to prevent mental health disorders in children and young people with intellectual disabilities?!

At the level of the child and young people, emotional ties and stability, as well as a sense of acceptance should be strengthened, life should be organised with daily routine, obligations and responsibilities should be set before the child, clear and unambiguous messages should be sent, the child's success and the experience of making progress should be ensured, free time should be organised, etc.

At the level of society, it is necessary to strengthen the family structure (socially, economically ...), ensure the connection of families with the community and provide professional support to families who have a child with ID.

LITERATURA / *REFERENCES*

1. American Association on Intellectual Developmental Disabilities. Intellectual disability: Definition, classification, and systems of supports.Washington, DC: AAIDD, 2010.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. Fifth ed. Washington, DC: APA, 2013.
3. Carr A, Linehan C, O'Reilly G, Noonan Walsh P, McEvoy J. (ur.) The Handbook of Intellectual Disability and Clinical Psychology Practice: Diagnosis, Classification and Epidemiology. London: Routledge, 2016.
4. Mental Health Problems in People with Learning Disabilities. Prevention, Assessment and Managment, National Institute for Health and Care Excellence(UK), London, 2016. Preuzeto 26.8.2021. https://www.ncbi.nlm.nih.gov/books/NBK401811/
5. Synthesis of scientific disciplines in pursuit of health. The interactive biopsychosocial model. Preuzeto 12.01.2021. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1201376/
6. Begić D. Psihopatologija. Zagreb: Medicinska naklada, 2011.
7. Iasiello M, Van Agteren J. Mental health and/or mental illness: A scoping review of the evidence and implications of the dual-continua model of mental health. Evidence Base 2020; 1:1-45.
8. Trent LK. Nutrition knowledge of active-duty Navy personnel. J Am Dietetic Assoc 1992; 92.6:724-8.
9. Koskentausta T, Iivanainen M, Almgvist F. Risk factors for psychiatric disturbance in children with intellectual disability. J Intellect Disabil Res 2007; 51(1): 43-53.
10. Došen A. Dijagnostika i tretman poremećaja ponašanja i psihičkih oboljenja kod osoba s mentalnom retardacijom. Hrvatska revija za rehabilitacijska istraživanja 2004; 40(2): 765-74.
11. Sekušak-Galešev S, Kramarić M, Galešev V. Mentalno zdravlje odraslih osoba s intelektualnim teškoćama. Soc psihijat 2014; 42(1): 3-20.
12. Došen A. Practice guidelines and principles: assessment, diagnosis, treatment, and related support services for persons with intellectual disabilities and problem behaviour. European Association for Mental Health in Intellectual Disability, 2007.
13. Došen A. Mentalno zdravlje djece s mentalnom retardacijom. Medicina 2005; 41(1): 101-06.
14. Coiffait FM, Marshall K. How to recognise and respond to mental health needs. Learning Disability Practice 2011; 14(3): 23.
15. Barkham M, Mellor-Clark J, Connell J, Cahill J. A CORE approach to practice-based evidence: A brief history of the origins and applications of the CORE-OM and CORE System. Counselling and Psychotherapy Research 2006; 6(1): 3-15.
16. Jokić-Begić N, Lauri Korajlija A, Jurin T, Evans C. Faktorska struktura, psihometrijske karakteristike i kritična vrijednost hrvatskoga prijevoda CORE-OM upitnika. Psihologijske teme 2014; 23.2: 265-88.
17. Twigg E, Barkham M, Bewick BM, Connell J, Mulhern B, Cooper M. The Young Person's CORE: Development of a brief outcome measure for young people. Counselling and Psychotherapy Research 2009; 9(3): 160-8.
18. Connell J, Barkham M, Stiles Wb, Twigg E, Singleton N, Evans O *et al*. Distribution of Core-om scores in a general population, clinical cut-off points and comparison with the CIS-R. Br J Psychiatry 2007; 190: 69-74.
19. Kozjak Mikić Z, Jokić-Begić N, Bunjevac T. Zdravstvene teškoće i izvori zabrinutosti adolescenata tijekom prilagodbe na srednju školu. Psihologijske teme 2012; 21: 317-36.
20. Kozjak Mikić Z, Jokić-Begić N. Emocionalne teškoće adolescentica nakon tranzicije u srednju školu. Soc psihijat 2013; 41(4): 226-34.
21. Štimac D, Pavić Šimetin I, Istvanovic A. Early recognition of mental health problems in Croatia. Eur J Public Health 2019; 29 (suppl. 4): ckz 186.569.
22. https://mrosp.gov.hr/UserDocsImages/dokumenti/Socijalnapolitika/NEPID/Etickikodeksistrazivanjasdjecomrevidiranaverzija.pdf. Preuzeto12.2.2020.
23. Jureša V, Posavec M, Latković Prugovečki S, Musil V, Majer M, Vidović Petričević T. Adolescent mental health: analysis using YP-CORE test in School health services in Croatia. Eur J Public Health 2020; 30(S5): 166.1057.
24. Bramston, P., & Fogarty, G. The assessment of emotional distress experienced by people with an intellectual disability: A study of different methodologies. Res Development Disabil 2000; 21(6): 487-500.
25. Buckley N, Glasson EJ, Chen W, Epstein A, Leonard H, Skoss R *et al*. Prevalence estimates of mental health problems in children and adolescents with intellectual disability: A systematic review and meta-analysis. Austral & New Zealand J Psychiatry 2020; 54(10): 970-84.
26. Marshall K, Willoughby-Booth S. Modifying the clinical outcomes in routine evaluation measure for use with people who have a learning disability. Br J Learning Disabil 2007; 35(2): 107-12.
27. Whittle EL, Fisher KR, Reppermund S, Lenroot R, Trollor J. Barriers and enablers to accessing mental health services for people with intellectual disability: a scoping review. J Mental Health Res Intellect Disabil 2018; 11(1): 69-102.

Integrativni program s istodobnim tretmanom poremećaja ovisnosti i pridruženog psihičkog poremećaja

/ Integrative Model of Recovery of Persons with an Addiction Associated to Mental Disorder

Lidija Bandić

Terapijska zajednica Reto centar Zagreb, Zagreb, Hrvatska

/ Therapeutic Community Reto Center Zagreb, Zagreb, Croatia

Visoka prevalencija istodobnog postojanja ovisnosti o psihoaktivnim tvarima i drugog psihijatrijskog poremećaja veliki je izazov i za kliničare i za znanstvenike. Utvrđivanje psihijatrijskog komorbiditeta povećava teškoće u liječenju kao i rizik od kroničnosti, što dovodi do loše prognoze i za psihički poremećaj i za ovisnost o psihoaktivnim tvarima, s lošijim izgledima za oporavak. Ključne zapreke za liječenje komorbidne ovisnosti o psihoaktivnim tvarima su razdvajanje sustava za liječenje mentalnog zdravlja i ovisnosti o psihoaktivnim tvarima. Cilj rada je pregled razvoja i implementacije integrativnog modela terapijskog programa s istodobnim tretmanom poremećaja ovisnosti i pridruženog psihičkog poremećaja koji daje pozitivne pomake kod oba poremećaja i postoji već dvadeset osam godina u sklopu modificirane terapijske zajednice Reto centar. Inovativnost integrativnog modela terapijskog programa je povezivanje rehabilitacije psihičkog poremećaja i poremećaja ovisnosti koji uz biološki, psihološki, sociokulturni uključuje i duhovni aspekt. U radu su navedene komponente terapijskog programa, koncept integrativnog pristupa, koncept oporavka, terapijski potencijal i korektivna iskustva koja uzrokuju oporavak u integrativnom modelu što otvara mogućnost provođenja dodatno modificiranog, ciljano strukturiranog i personaliziranog terapijskog programa rehabilitacije osoba s poremećajem ovisnosti s pridruženim psihičkim poremećajem. Uspjeh provedene rehabilitacije osoba u problemu ovisnosti s pridruženim psihičkim poremećajem definiran je kao osjećaj osnaženosti, život sa smislom i iskustvom pripadanja u optimalnom obiteljskom i radnom funkcioniranju, kao i u integraciji u širu zajednicu. U radu je naveden primjer koji ukazuje na korake koji se poduzimaju kako bi u praksi zaživio istodobni tretman obih poremećaja.

/ High prevalence of simultaneous addictions to psychoactive substances and other psychiatric disorders represents a great challenge for both clinical experts and scientists. Defining psychiatric comorbidity increases curing difficulties and the risk of chronicity, which leads to bad prognosis in terms of both psychic disorder and the addiction to psychoactive substances with more limited prospects for recovery. The crucial obstacles related to curing comorbid addiction to psychoactive substances are the following: separating of the mental curing system from the addiction to psychoactive substances. The objective of this paper is to present the development and implementation of the integrative model of a therapeutic programme and the treatment of the addiction disorder and the associated psychic disorder with positive results in both disorders that has been persisting over twenty-eight years in a modified therapeutic community such as Reto Center. The innovation in the integrative model of the therapeutic programme relies on connecting the rehabilitation of psychic disorder with the addiction disorder, which, beside biological, sociological, cultural aspect, also includes the spiritual aspect. This paper comprises the main components of the therapeutic programme, concept of integrative approach, recovery concept, therapeutic potential and corrective experiences leading to recovery and the integrative model that opens up possibilities of additionally modified implementation aimed at structural and personalized therapeutic programme for the rehabilitation of persons with addiction disorders and associated psychic disorders. The success of the applied rehabilitation of persons with addiction problems and associated psychic disorders is defined as the feeling of empowerment, meaningful life and experience of belonging to an optimal family and working environment as well as integration in a broader community. This paper gives an example of the steps taken in an attempt to see treatments of both disorders applied in practice.

STRUČNI RAD / *PROFESSIONAL PAPER* Soc. psihijat. | 49 (2021) | 130-147

ADRESA ZA DOPISIVANJE /
CORRESPONDENCE:
Lidija Bandić, mag. psych.
Terapijska zajednica Reto centar Zagreb
Čulinečka cesta 134
10040 Zagreb, Hrvatska
E. pošta: bandic.lidija@gmail.com

KLJUČNE RIJEČI / ***KEY WORDS:***
Psihički poremećaj i poremećaj ovisnosti / *Psychic Disorder and Addiction Disorder*
Integrativni model terapijskog programa / *Integrative Model of Therapeutic Program*
Modificirana terapijska zajednica / *Modified Therapeutic Community*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2021.130

UVOD

Tijekom posljednjih desetljeća praktičari i znanstvenici sve više prepoznaju prisutnost psihičkih poremećaja kod osoba u problemu ovisnosti o psihoaktivnim tvarima. Europski centar za praćenje droga i ovisnosti o drogama (EMCDDA) je u Europskom izvješću o drogama iz 2015. godine ukazao na visoku prevalenciju komorbiditeta među ovisnicima o drogama, od kojih oko 50 % ima i psihički poremećaj (1). Visoka prevalencija istovremenog psihičkog poremećaja i ovisnosti o drogama glavni je izazov i za kliničare i za znanost. Prisutnost istovremenog psihičkog poremećaja i poremećaja ovisnosti povećava teškoće u liječenju kao i rizik od kroničnosti, što dovodi do loše prognoze i za psihički poremećaj i za ovisnost o psihoaktivnim tvarima, s lošijim izgledima za oporavak. Odvojenost tretmana psihičkog poremećaja i tretmana ovisnosti o psihoaktivnim tvarima stvara poteškoće u osiguravanju učinkovitog tretmana obih poremećaja (2). Ključne zapreke za liječenje komorbidne ovisnosti o psihoaktivnim tvarima su razdvajanje sustava za komorbidnu ovisnost potvrđuju i podatci *Substance Abuse and Mental Health Services Administration* (3). Osobe s istodobnim psihičkim poremećajem i ovisnosti o psihoaktivnim tvarima pokazuju težu psihopatologiju, imaju više hospitalizacija, povećan sucidalni rizik kao i psihosocijalna oštećenja. Navedeno ukazuje da je ovaj višedimenzionalni problem ujedno i

INTRODUCTION

Over the past few decades, practitioners and scientists recognized the presence of psychic disorders more and more among persons addicted to psychoactive substances. The European Monitoring Centre for Drugs and Drug Addition (EMCDDA) published a report on drugs in 2015 indicating high prevalence of comorbidity among drug addicts from which 50% had psychotic disorders (1). High prevalence of simultaneous physic disorder and drug addiction is a very important challenge both for clinicians and the science. The presence of simultaneous psychic disorder and addiction disorder results in increased difficulties related to the treatment and the risk of chronicity. Also, it can lead to inaccurate prognosis in both psychotic disorder and psychoactive substances addiction with a lower chance for recovery. Separation of the treatment of psychotic disorder and the treatment of addiction to psychoactive substances creates difficulties is securing efficient treatment of both disorders (2). SAMHSA - Substance Abuse and Mental Health Services Administration confirmed that the critical obstacle to curing comorbid addictions to psychoactive substances is the separation of the system for comorbid addiction (3). Persons with the simultaneous psychic disorder and addiction to psychoactive substances are exposed to harder psychopathology, more hospitalizations, higher suicidal risk and psychosocial damages. The topics listed indicate that this multidimensional problem rep-

ozbiljan izazov i za liječnike i ostale pomažuće struke.

U ovom radu bit će prikazan integrativni model terapijskog programa istodobno usmjerenog na oba poremećaja zasnovan na suvremenom pristupu liječenju koji daje naglasak na oporavak u terapijskoj okolini individualno prilagođenoj u skladu sa simptomima i slabostima, koji uz biološki, psihološki, sociokulturni uključuje i duhovni aspekt. Integrativni pristup u medicini i psihijatriji temelji se na pretpostavci da su ljudska bića u zdravlju i bolestima složeni sustavi dinamički interakcijskih bioloških, psiholoških, socijalnih, informacijskih i duhovnih procesa (4). Naglasak će biti na konceptu istodobnog tretmana poremećaja ovisnosti i pridruženog psihičkog poremećaja kojim su dobiveni pozitivni pomaci kod oba poremećaja na kojem tim stručnjaka i rehabilitiranih ovisnika radi istovremeno kao i na povećanju aktivnog sudjelovanja korisnika u tretmanu te jačanju motivacije za ostanak i zadržavanje u tretmanu. Uspjeh oporavka osoba u problemu ovisnosti u terapijskom programu modificirane terapijske zajednice je individualan, ovisi o pojedincu, vrsti psihičkog poremećaja i suradljivosti. U nekim slučajevima postiže se potpun oporavak, a u nekim slučajevima radi se o oporavku od problema ovisnosti i remisiji psihičkog poremećaja. Uspjeh provedene rehabilitacije osoba u problemu ovisnosti s pridruženim psihičkim poremećajem je osjećaj osnaženosti, život sa smislom i iskustvom pripadanja u optimalnom obiteljskom i radnom funkcioniranju, kao i u integraciji u širu zajednicu. Ovaj rad je plod sazrijevanja vremena za povećanje učinkovitosti liječenja komorbidne ovisnosti kreativnim na čovjeka usmjerenim pristupom koji daje nadu pružajući potrebne alate za osobni oporavak primjenom transdiciplinarnosti i integrativnosti (5). Dijagnoza se ne shvaća kao stanje nego kao dinamički proces. S obzirom na dosadašnja iskustva rada u ovoj problematici razvidno je da je klinička korist ograničena i da su ograničenja koja se pojavljuju tijekom liječenja u području u

resents a serious challenge to doctors and other professionals.

This paper presents the integrative model of therapeutic programme focusing on both disorders based on a modern approach that emphasizes recovery in the therapeutic environment adapted to individuals following their symptoms and weaknesses, which, beside biological, psychological, social and cultural aspects also include the spiritual approach. An integrative approach to medicine and psychiatry is based on the assumption that human beings are complex systems of dynamic intricate biological, psychological, social, informational and spiritual processes in health and sicknesses.

The accent is put on the concept of simultaneous treatments of addiction disorders and accompanying psychic disorders that give positive results for both disorders with which a team of experts and rehabilitated addicts works at the same time as well as on an increasingly active participation of users of the treatment and improving motivation for staying and continuing with the programme. The success rate of the recovery from an addiction in a therapeutic programme organised in a modified therapeutic community is individual and depends on an individual, type of psychic disorder and the level of cooperation. In some cases, a complete recovery occurs, whereas other cases indicate relapse of addiction and remission of psychotic disorders. Successful rehabilitation among the persons with the addiction associated with psychotic disorders manifested in the feeling of becoming stronger, having a more meaningful life and experiencing that one has the ability to optimally function in the family and work environment and integrate in a broader community.

This research is a product of a mature approach to increasing the efficiency of treatment of comorbid addiction through the application of creative and directed methods. It gives hope because it provides necessary tools for personal recovery in a transdisciplinary and integrative setting. (5). The diagnosis is not interpreted as a condition but rather as a dynamic process. Taking into consid-

koje treba ulagati da se istraži kako bi se mogle pomicati granice prema uspješnijem liječenju i daljnjoj znanstvenoj vjerodostojnosti i povećanju učinkovitosti liječenja integriranjem neurobiološke, intrapsihičke, interpersonalne, kulturne, društvene i duhovne procese u dijagnostici i terapijskim razmatranjima (6).

Cilj ovog rada je otvaranje mogućnosti za kreiranje integrativnog terapijskog programa istovremeno usmjerenog na oba poremećaja kao mjere za smanjivanje rizika od odustajanja i povećanja učinkovitosti rehabilitacije komorbidne ovisnosti. Pisanje ovog članka je generirano dugogodišnjim autoričinim iskustvom rada u terapijskoj zajednici s osobama u problemu ovisnosti i naglašavanjem da je život nevjerojatno složena pojava koju je nemoguće precizno obuhvatiti i istražiti bilo kojim znanstvenim metodama te da je svaka terapija stvarnost mogućega, a ne psihodinamički teorijski nacrt kako zdravi um treba funkcionirati kod zdrave osobe.

KOMPONENTE TERAPIJSKE ZAJEDNICE

Sama terapijska zajednica svojom organizacijskom strukturom predstavlja terapijsko okruženje koje čine korisnici, osobe s psihičkim poremećajem, i osobe ovisne o psihoaktivnim sredstvima, uspješno rehabilitirane osobe educirane za rad u terapijskoj zajednici te stručni tim čija međusobna interakcija u svakodnevnim situacijama i zajedničkom životu u zajednici pridonosi boljem razumijevanju svojih unutarnjih, psihičkih procesa i vlastitog funkcioniranja te učenju zdravih i učinkovitih obrazaca ponašanja i ophođenja prema drugima, pri čemu se isprepliću psihoterapijski i socioterapijski učinci terapijske zajednice (7).

Terapijska zajednica je mjesto odrastanja i korektivnog iskustva, mjesto uspješnog razrješavanja temeljnih psihosocijalnih i psihoduhovnih kriza (grč. krizis - prijelomna točka,

eration the experience in the field gathered thus far, it is evident that clinical benefits are limited and that clinical limitations appearing during the treatment lay in the domain that requires further investments directed at a more successful treatment and scientific authenticity as well as an increased efficiency of treatment through the integration of neurobiological, intrapsychic, interpersonal, cultural, social and spiritual processes in diagnostical and therapeutic considerations (6).

The objective of this paper is to open up various possibilities for the creation of an integrative therapeutic programme that simultaneously focuses on disorders as well as the criteria for the reduction of risk from discontinuing treatment in order to increase the efficiency of rehabilitation from comorbid addiction.

This paper is a result of the author's extensive therapeutical work with addicts. Emphasizing the importance of life is an incredibly complexed phenomenon which is very hard to grasp and explore by scientific methods. Every therapy needs to take into account what is possible and it is not psychodynamic theoretical blueprint how healthy mind should function in a healthy person.

COMPONENTS OF THERAPEUTICAL COMMUNITY

The organizational structure of a therapeutic community represents the therapeutic environment composed of users, persons with psychic disorders and persons addicted to psychoactive substances, successfully rehabilitated persons educated for the work in a therapeutic community, and a professional team whose mutual interaction in situations of everyday life in the community contributes to a better understanding of the inner psychic processes, independent functioning and learning about healthy and effective behavioural patterns and interactions with others whereas psychotherapeutic and social therapeutic effects interweaving within the therapeutic community (7).

Therapeutic community is a place of growth and corrective experience and a place of successful

izlazak). Uspješno razriješena kriza označava kraj jednog životnog razdoblja, razdoblja pogrešnih pokušaja razrješavanja psihosocijalnih i duhovnih kriza uzimanjem alkohola ili droga te početak nove perspektive o sebi i životu koji dobiva smisao kreiranjem osobnog identiteta, razvijanjem duhovnosti i prepoznavanjem prave svrhe života.

Sigurno okruženje. Terapijska zajednica Reto centar nalazi se su u odvojenim rezidencijalnim kućama i radnim prostorima, odvojena je od drugih institucionalnih programa i okruženja koja su povezana s drogom. Terapijska zajednica prenosi korisniku vrijednosti rada i aktivnog socijalnog učenja. Nudi mogućnost razvoja u sigurnom okruženju.

Terapijske aktivnosti modificirane za osobe s komorbiditetom ovisnosti. Terapijsko djelovanje osniva se na sveobuhvatnom pristupu koji je okrenut samoj osobi i uspješnosti oporavka korisnika. Sve terapijske aktivnosti su kolektivne. Iznimka su individualna savjetovanja. U središtu aktivnosti su Grupe za osobnu promjenu - tretmanske grupe. Organizirane su kao Grupe za osobni rast i razvoj kroz jutarnje sastanke, večernje sastanke. Suradnja osoblja koje nosi odgovornost da u određenim situacijama postupe u skladu s postojećim znanjima, iskustvima, vještinama i uvjerenjima u skladu sa svjetonazorom i programom terapijske zajednice organizirana je kroz Supervizijske grupe koje imaju za cilj učenje, podršku i dijeljenje odgovornosti (8) .Individualno nedirektivno i suportivno savjetovanje ima za cilj konfrontaciju, suočavanje osobe s realitetom ili nekim njegovim osobnim više-manje nesvjesnim reakcijama, ponašanjem, ali i odnosom prema drugima i sebi (9)

Pomoćne aktivnosti i postupci. Ove su aktivnosti uključene u učenje specijalnih vještina kao što je roditeljstvo.

Strukturirani dan. Strukturirani dan jako je važan za boravak korisnika. Rad, rutina i aktiv-

dismissal of fundament psychosocial and psycho spiritual crises (Greek: crisis – breaking point, exit). A crisis that has been successfully resolved implies ending of one period of life, i.e., a period of mistaken attempts at resolving psychosocial and spiritual crises through alcohol or drug abuse, and a beginning in terms of developing a new perspective about the self and a meaningful life by creating personal identity, opening to spiritual development and recognizing the true purpose of life.

Safe environment. Therapeutic Reto community is located in a number of residential houses and working facilities and separated from other institutional programmes and environments that are connected with drug abuse. The therapeutic community educates its beneficiaries about the values of work and active social learning. It provides the possibility of development in a safe environment.

Modified therapeutic activities for persons with comorbid addiction. The therapeutic impact is based on a comprehensive approach that deals with each person individually to achieve successful recovery. All therapeutic activities are collective. Individual counselling is an exception. The focus is on groups for personal change, or treatment groups. Those are organized as groups for personal growth and development and they hold regular morning and evening sessions. Responsible personnel applies knowledge, experiences, skills and beliefs based on the worldview and the programme of the therapeutic community to their work in the supervising group and reacts in various situations, offering their support and sharing the responsibility for achieving the goal (8). Individual indirect and supportive counselling uses methods such as confrontation with a problem, facing the person with reality and more or less unwilling reactions, behaviour, and relationships with others and oneself (9).

These activities are also included in learning about certain special skills, such as parenting.

Structured day. A structured day is very important for the beneficiaries to stay in the pro-

nosti su važni za ljude čiji su životi uglavnom bili neorganizirani. Također takav način života odvlači pažnju od dosade i negativnog načina razmišljanja što može izazvati potrebu za uzimanjem psihoaktivnih tvari. Isto tako strukturirane aktivnosti omogućuju učenje, planiranje, postavljanje i ostvarivanje ciljeva. Korisnike se podučava da iskorištavaju vrijeme i potiče ih se na odgovornost. Stoga svaki dan ima formalni raspored različitih terapijskih i obrazovnih aktivnosti koje imaju točno određeno vrijeme, način izvršavanja i rutinske procedure. Glavno sredstvo učenja samorazvoja su određeni dnevni zadatci koji se obavljaju u kontinuitetu. Da bi učenje bilo moguće, potrebno se čvrsto držati naputaka i postupaka. Važno je prihvaćanje i poštivanje nadzora kao i zrelo i odgovorno ponašanje članova jer svi ovise jedni o drugima.

Modeli ponašanja. Korisnici koji se ponašaju na očekivani način i koji odražavaju vrijednosti učenja zajednice imaju ulogu modela, uzora ponašanja. Snaga same zajednice očituje se u tome koliko su brojni i snažni ljudi koji podržavaju taj model ponašanja. Od svih članova zajednice očekuje se da budu takvi, bilo ulogama „zimmera" starijih ili mlađih članova zajednice i kao članova upravljačkog osoblja. Terapijska zajednica zahtijeva višestruke modele ponašanja jer to jača integritet zajednice i omogućava kvalitetno socijalno učenje.

Radno okupacijska terapija - rad kao terapija i obrazovanje podrazumijeva cijelodnevnu organizaciju radnih aktivnosti u terapijskoj zajednici. Korisnici imaju različita radna zaduženja u toku dana i od njih se očekuje adekvatno, racionalno i prije svega marljivo i odgovorno obavljanje svih aktivnosti. Cilj ove terapije je stjecanje radnih navika potrebnih za stvaranje optimalnih uvjeta za život. Za korisnike s težim dijagnozama cilj u prvoj fazi je pronalaženje okupacijskih aktivnosti u kojima bi korisnik s psihičkim poremećajem mogao sudjelovati i uključivanje u aktivnosti formacije uz pronalaženja prilagođenog načina izvedbe

gramme. Daily work, routine and activities are very important for people who in most cases lived unorganized lives. Also, this type of life distracts persons from boredom and negative thoughts that can lead to consuming psychoactive substances. Structured activities also provide the right setting for learning, planning, setting and realizing goals. Beneficiaries are trained to use their time efficiently and carry out responsibilities. Hence, every day is organised around a formal schedule including various therapeutic and educational activities at a set time, method of execution and a routine procedure. The main instrument for self-development comprises various daily tasks performed in continuity. In order to enable learning, it is necessary to strictly follow directions and procedures. It is also important to accept and value supervision and responsible acts of the members as they depend on each other.

Models of behaviour. Users behaving in expected ways and maintaining the values of the community teaching become role models looked by others as an example to be imitated. The community is as strong are the people who support that model of behavour. Those members of the community are expected to play the role of "room mates" to older or younger members of the group and the managing stuff. The therapeutic community requires multiple models of behaviour as they strengthen the integrity of the community and provide quality social skills.

Occupational work therapy – the work as therapy and education. This implies organization of all-day working activities within the therapeutic community. Beneficiaries have various working tasks during the day. They are expected to adequately, rationally, and, above all assiduously and responsibly perform their working tasks. The goal of this type of therapy is to acquire working habits necessary for creating the optimal conditions for life. The beneficiaries with more difficult diagnosis need to have occupational activities during the first phase where the beneficiary with a psychic disorder can participate and be involved in the activities that include finding of adjusted ways of performance. After the first phase, the

aktivnosti. Nakon prve faze slijedi uključivanje u produktivne aktivnosti uz pronalaženja prilagođenog načina izvedbe aktivnosti formacije na temelju prepoznavanja zapreka i prepoznavanja sposobnosti korisnika s dvostrukom dijagnozom. Korisnicima se omogućuje razvijanje vještina te osobni rast i razvoj izazovima i odgovornostima na poslovima bojanja, mehanike, restauracije namještaja, kreativnim poslovima umjetničkog ateljea, šivanja, agrokulture, hortikulture i ostalih poslova ovisno o sposobnostima i afinitetima korisnika.

Socioterapija - vježbanje samouvida. Socioterapija je terapijski postupak liječenja nefunkcionalnog načina života osobe, metoda korištenja životnog okruženja terapijske zajednice na planski način. Životno okruženje je instrument terapijskog djelovanja i postizanja promjena u osobi. Čovjek je biće odnosa i kao takav bez povezivanja s drugima ne može ostvariti svoju jedinstvenost. Pri dolasku u akutnoj fazi, kod težih dijagnoza psihoze, shizofrenije i bipolarnog poremećaja, tijekom dužeg razdoblja socioterapijski postupci su ograničeni što isključivo ovisi o stanju korisnika i vrsti poremećaja. Svi terapijski i obrazovni postupci uključuju individualnu svijest o tome kako naša ponašanja i stavovi djeluju na nas i naše okruženje. Isto tako važno je djelovanje ponašanja i stavova drugih na nas što se izražava introspektivnim razgovorima tijekom dana u svim aktivnostima. Socioterapija je liječenje psihičkih poremećaja sociodinamskim pragmatičnim pristupom i jača sve ono što osnažuje osobu, utječe na kvalitetu života i prevenciju bolesti i zaštitu zdravlja (10)

Socioterapija – vježbanje emocionalnog rasta i razvoja. Socioterapija djeluje putem realiteta i spada u rekonstruktivnu terapijsku metodu koja osobi omogućuje funkcioniranje na relaciji pojedinac – zajednica. Socioterapija bi se mogla sažeti u tri riječi: život – rad - komuniciranje kao mjere za strukturiranje života i unošenja pozitivnih promjena u doživljaju

beneficiary is involved in various productive activities including the adjustable method of performance of activities based on the recognition of obstacles and abilities related to the double diagnosis. The beneficiary has a chance to develop various skills, achieve personal growth and develop through challenges and responsibilities on the jobs such as painting, mechanics, furniture restoration, or creative jobs such as art, sewing, agriculture, horticulture and other depending on their abilities and affinities.

Social therapy – training in self-insight. Social therapy is a therapeutic treatment of dysfunctional life patterns and a method of using a living environment of the therapeutic community in a planned way. Living environment is used as an instrument of therapeutic procedure aimed at achieving changes from within a person. Human beings create relationships and cannot accomplish their unique personalities without connecting to others. When a beneficiary joins the community in an acute phase, with a difficult diagnosis, psychosis, schizophrenia, or bipolar disorder, social therapeutic approaches are limited over longer periods of time and a lot depends on the condition of the beneficiary and the type of disorder. All therapeutic and educational procedures include individual awareness that our behaviour and attitudes have an effect on us and our environment. On the other hand, other people's behaviour and attitudes also play an important role. Introspective interactions during the day are part of all activities. Social therapy is a treatment of psychic disorders that applies sociodynamic pragmatical approach aimed at strengthening a person, improving the quality of life, preventing illness and protecting health (10).

Social therapy – exercising emotional growth and development. Social theory belongs to a reconstructive therapeutic method which provides functioning at the level individual-community. Social therapy could be summarized in three words: life-work-communication as the basic guidelines for a structured life and positive changes in experiencing the self and the others in combination with corresponding reactions

sebe i drugih te odgovarajućih reakcija na životne izazove okruženja. Da bi osoba mogla ostvariti osobni razvoj i socijalizirati se mora naučiti prepoznavati svoje osjećaje, izražavati ih na prihvatljiv način i konstruktivno njima upravljati. To se ostvaruje u interpersonalnim i socijalnim događajima zajedničkog života. Sociodinamika otkriva, analizira i primjenjuje socijalne odnose kao pokretače psihičkih procesa (10)

Terapijski tim. Terapijski tim čine terapeuti školovani za rad u terapijskoj zajednici, monitori – uspješno rehabilitirani korisnici, psiholog, socijalni radnik i psihijatar kao vanjski suradnik. Bez obzira na profesionalnu funkciju i struku osnovna je uloga osoblja da budu racionalni autoriteti, moderatori i vodiči kroz samopomoć. Prijateljstva među osobama i osobljem neophodni su jer ohrabruju korisnika da se odvaži uključiti u proces promjene i da ustraje u njemu. Međusobni odnosi koji su se razvili u procesu liječenja temelj su za stvaranje socijalne mreže koja je potrebna za održavanje oporavka i nakon završetka tretmana. **Psihijatar** postavlja dijagnozu, stvara dijagnostički dojam i prati trag poremećaja. Procjenjuje emocionalno stanje bolesnika, proces razmišljanja, kognitivno funkcioniranje i testiranje realiteta. Na temelju dobivenih podataka i opserviranja ponašanja daje prijedlog farmakoterapije i psihološke podrške. Tijek terapije psihofarmacima je individualan i određen procjenom liječnika - konzilijarnog psihijatra koji prati osobu u procesu liječenja. Cilj psihofarmakoterapije je postizanje stabilnosti u funkcioniranju što je preduvjet nastavka i uspješnosti procesa oporavka. **Psiholog s kršćanskim pristupom** daje psihološku podršku te ju usmjerava u četiri pravca 1. Rad na svjesnosti (uvid, monitoriranje misli, osjećaja i ponašanja, mogućnost novog životnog puta 2. Naknadna socijalizacija/naknadno roditeljevanje/reparenting (stvaranje temeljnog povjerenja) 3. Reatribucija uvjerenja, mijenjanje nefunkcionalnih misli i emocija i modifikacija ponašanja 4. Iskustvo doživljaja mogućnosti novog životnog puta, pronalazak

on life challenges in a particular environment. In order to respond to personal development and to be socialized, a person must learn to recognize, express in an acceptable way and constructively manipulate his or her feelings. This can be done at the interpersonal and social level in everyday life. Social dynamic reveals, analyses and applies social relations to initiate psychic processes (10).

Therapeutic team. Therapeutic team is composed of therapists trained in working with a therapeutic community and supervisors – successfully rehabilitated beneficiaries, psychologists, social workers and psychiatrists in the role of external associates. Regardless of their role and profession, the personnel needs to establish authority in their roles of moderators and guides for self-help. Friendships beneficiaries between beneficiaries and the personnel are necessary because they encourage beneficiaries to be bold and involved in the process to the end. Mutual relationships developed during the treatment lay the foundations for creating a social network necessary for the recovery and life after the treatment. **The psychiatrist** establishes a diagnosis and monitors the disorder. The psychiatrist estimates the patient's condition, thinking-process, cognitive abilities and perception of the reality. Based on the obtained data and observation of behaviour, the psychiatrist suggests pharmacotherapy and psychological support. The course of psychopharmacotherapy is individual and determined by the doctor's assessment. The aim of psychopharmacotherapy is reaching functional stability as a precondition for the continuation of the treatment and successful recovery. **A psychologist using the Christian approach** provides psychological support comprising four directions 1. Working on awareness (insight, monitoring of thoughts, feelings and behaviour, possibility for a new way of life). 2. Subsequent socialization/subsequent parenting/re-parenting (the establishment of fundamental trust). 3. Reattribution of beliefs, changing dysfunctional thoughts and emotions, and modification of behaviour. 4. The experience of the possibility of a new life path, finding the meaning and solving existential crisis (11). Christian psychologists give

smisla i razrješenje egzistencijalne krize (11). Kršćanski usmjeren psiholog daje slavu Bogu, ali također priznaje vrijednost znanstvene evaluacije. Kršćansko područje može biti doticano, ako korisnik to želi. Tada terapeut integrira dijalog biblijskog teksta i životnog konteksta kao integracijski pristup stvarnosti u kojoj su zastupljene sve dimenzije čovjeka (12). Duhovnost je shvaćena u kršćanskom smislu kao odnos ljudske osobe s Bogom i bližnjim. **Terapeuti školovani za rad u terapijskoj zajednici** – rehabilitirani ovisnici s pozitivnim iskustvom promjene. Odgovorne osobe su i same uspješno završile program rehabilitacije u kojem su sada nositelji i izvoditelji aktivnosti terapijske zajednice, a njihovo iskustvo je od neprocjenjive važnosti. Pokazuju da postoji izlaz iz problema ovisnosti u kojem su se i sami nekoć nalazili. Svakodnevno pružaju podršku osobama u tretmanu u svim aktivnostima zajednice i svojim primjerom kvalitetnog i svrhovitog življenja i osobnom odgovornošću utječu na uklanjanje stigme - jednom ovisnik, zauvijek ovisnik. Pragmatični pristup terapijskog transdisciplinarnog tima je pristup osobi s poremećajem i njegovoj okolini, uključivanje društva u tretman osoba s poremećajem ovisnosti s pridruženim psihičkim poremećajem (1).

Planirano trajanje tretmana liječenja. Optimalno trajanje procesa liječenja mora se poklapati sa ciljevima oporavka. Koliko dugo će netko ostati u programu liječenja ovisi u kojoj je etapi oporavka, iako postoji minimalno razdoblje intenzivnog tretmana koji je potreban da bi se internalizirala učenja koja provodi terapijska zajednica (13) .

KONCEPT TERAPIJSKOG PRISTUPA INTEGRATIVNOG MODELA

Koncept terapijskog pristupa integrativnog modela: 1) u akutnoj fazi liječenja određuje se primjerena psihofarmakoterapija s ciljem postipraise to God in the same way they acknowledge the value of scientific evaluation. The Christian aspects can be included if the beneficiary wants it. Then therapists integrate Biblical texts and life context in the integrative approach representing various human dimensions (12). Spirituality in the Christian sense is understood as the relationship between God, a human being and his or her neighbour. **Therapists educated for the work in a therapeutic community** – rehabilitated addicts who have undergone positive change. Responsible persons who have successfully finished the rehabilitation programme are able to carry out activities within the therapeutical community and thus share their priceless experience. With their example, they show that it is possible to get out of addiction. They provide daily support in all activities to those who are in treatment by setting the example of quality, purposeful life and the importance of personal responsibility in terms of removing the stigma and the perception "once addict, always addict". The therapeutic transdisciplinary team uses a pragmatic approach to each person with a disorder as well as his or her environment, also involving the society in the treatment of the persons with addiction disorders and associated psychic disorders (1).

Planned duration of the curing treatment. The optimal duration of the curing treatment has to be aligned with the recovery goals. Duration of an individual stay in the treatment programme depends on the stage of recovery. However, there is a minimal period of intensive treatment necessary for the internalization of learning processes implemented by the therapeutic community.

CONCEPT OF THERAPEUTIC APPROACH ACCORDING TO INTEGRATIVE MODEL

The concept of the therapeutic approach according to the integrative model: 1) during the acute phase of treatment it is important to determine an adequate psychopharmacotherapy aimed at a faster and more complete remission; 2) in the

zanja što brže i potpunije remisije; 2) u fazi psihofarmakoterapije primarna je perspektiva životne priče usklađivanjem priče korisnika i priče terapeuta u zajedničku komplementarnu priču (10); 3) faza procjene egzistencijalno duhovnih potreba korisnika; 4) razvijanje reflektivne konverzacije u sigurnosti, poštovanja i povjerenja da se iznesu svi mentalni modeli i emocije; 5) mogućnost razvoja odnosa s Bogom životnom interpretacijom biblijskog teksta; 6) novo doživljavanje, novi stav, nova životna priča (14).

Integrativni model terapijskog programa rehabilitacije komorbidne ovisnosti osniva se na sveobuhvatnom pristupu svakom problemu i svakoj osobi objedinjujući sve njegove aspekte socijalne, psihološke, tjelesne, duhovne, radne i relacijske imajući u vidu cjelovitost svake osobe koja ima svoju prošlost, sadašnjost i budućnost. U metode rada integrirani su „koncept ispravnog življenja" - učenje osobnim i socijalnim odgovornostima i vrijednostima i „koncept ponašanjem kao da"- ponašanje kako bi se osoba trebala ponašati da bi naglasili važnost ispravnih stavova i ponašanja na pojedinca i njegovo socijalno okruženje (13). Terapijski program polazi od pretpostavke da su bez obzira na uzroke ovisnosti, posljedice gubitak osjećaja vlastite vrijednosti, osjećaj nesigurnosti, bespomoćnosti, pesimizma, beznadnosti i gubitak životnog smisla. Pomanjkanje životnog smisla rađa duševni nemir, noogenu neurozu, osjećaj besciljnosti, besmislenosti, unutarnje ispraznosti (15). Besmisao prati duševna praznina koja se očituje u „jurnjavi za užitcima" i upornim traženjem razonode (16). Smisao života ne traži se samo na psihološkoj razini, sagledava se i duhovnom dimenzijom. Integrativni model terapijske zajednice Reto centar temelji se na kršćanskom svjetonazoru koji govori o stvaranju popuno novog načina života temeljenog na kršćanskim vrijednostima i kršćanstvu kao stilu života uz istovremeno poznavanje i primjenu suvremenih spoznaja psihologije, sociologije i psihijatrije. Ovaj terapijski program rehabilitacije za oba poremećaja razvija se istodobno

psychopharmacotherapy phase, it is important to synchronize the beneficiary's personal and therapist's story into one complete story (10); 3) evaluation of the existential and spiritual needs of the beneficiary, 4) development of a reflective conversation in a safe and respectful environment filled with trust in order to express all mental models and emotions; 5) possibility of developing a personal relationship with God by way of interpretating Biblical texts and relating them to life; (6) new experiences, new attitudes, new life story. (14)

The integrative model of the therapeutical rehabilitation programme for the treatment of comorbid addictions is based on a comprehensive approach to every problem and every individual combinating all social, psychological, carnal, spiritual, working and relaxing aspects while taking into account the integrity of every person. Methods of work comprise the integrated „concept of righteous living", i.e., learning about personal and social responsibilities and values and the "concept of behaving as it is". This implies a number of models that emphasise the importance of correct attitudes and behaviours at individual and social levels (13). The therapeutic programme begins with the assumption that regardless of the cause of addiction, the consequences are loss of the feeling of self-esteem, insecurity, helplessness, pessimism, hopelessness and loss of belief in the meaning of life. The lack of meaning of life causes mental restlessness, noogenic neurosis – the feeling of aimlessness, meaninglessness and inner emptiness (15). Mental emptiness manifests in „running for pleasures" and persistent search for fun (16). The meaning of life is not explored only at the psychological level but also includes the spiritual dimension. The integrative model of the Reto therapeutical community is based on the Christian worldview which speaks about creating of a completely new lifestyle based upon Christin values and the Christianity as lifestyle combined with modern knowledge of psychology, sociology and psychiatry. This therapeutical rehabilitation programme for both disorders takes place in a safe surrounding of a modified therapeutic community. A multidisciplinary team of experts applies the

u sigurnom okruženju modificirane terapijske zajednice Reto centar, a provodi ga multidisciplinarni tim stručnjaka i uspješno rehabilitiranih osoba koji rade i na povećanju aktivnog sudjelovanja klijenta u tretmanu te jačanju motivacije za ostanak i zadržavanje u tretmanu.

TERAPIJSKI POTENCIJAL INTEGRATIVNOG MODELA

Psihijatrijski tretman – psihofarmakoterapija kao alat kreiranja put ka promjeni utemeljen na korisnosti lijeka u odnosu na uključene rizike.

Socioterapija – životno okruženje je instrument terapijskog djelovanja i postizanja promjena.

Radno-okupacijska terapija – cjelodnevna organizacija radno okupacijskih aktivnosti modificiranim načinom izvedbe, u posebnim radionicama i dućanima standardne terapijske zajednice kontinuiranim promatranjem, korisnik u vidnom polju odgovorne osobe.

Psihološka podrška – integrativni psihološki tretman s kršćanskim pristupom usmjeren na četiri pravca 1. Rad na svjesnosti (uvid, monitoriranje misli, osjećaja, ponašanja, mogućnost novog životnog puta 2. Naknadna socijalizacija/naknadno roditeljevanje/*reparenting* (stvaranje temeljnog povjerenja) 3. Reatribucija uvjerenja, mijenjanje nefunkcionalnih misli i emocija i modifikacija ponašanja 4. Iskustvo doživljaja mogućnosti novog životnog puta, pronalazak smisla i razrješenje egzistencijalne krize.

KONCEPT OPORAVKA U INTEGRATIVNOM PRISTUPU

Terapijski program rehabilitacije modificirane terapijske zajednice integrira pogled na poremećaj, pogled na ovisnika kao osobu, pogled na proces liječenja i razvoj korisnika. Problem koji

programme and successfully rehabilitates persons who actively participate in to strengthen motivation for staying in the treatment.

THERAPEUTICAL POTENTIAL OF INTEGRATIVE MODEL

Psychiatric treatment – the psychopharmaceutical treatment as a tool for creating the path towards change based on risks related to drug abuse.

Socio-therapy – living environment is an instrument for achieving therapeutic impact and change.

Working and occupational therapy- organization of working and occupational activities using the modified method of performance in special workshops and shops within the standard therapeutic community and constant observation of the beneficiary by a responsible person.

Psychological support – integrative psychological treatment applying the Christian approach with four directions 1. Working on awareness (insight, monitoring of thoughts, feelings and behaviours, possibility for a new way of life). 2. Subsequent socialization/subsequent parenting/reparenting (creation of fundamental trust). 3. Reattribution of beliefs, changing dysfunctional thoughts and emotions, modification of behaviour. 4. Experiencing the possibility of a new life path, finding the meaning and solving existential crises.

CONCEPT OF RECOVERY IN INEGRATIVE APPROACH

The therapeutical rehabilitation programme in the modified therapeutical community integrates the observation of a disorder, perception of an addict as a person, treatment and personal development. The whole person is treated at all levels of his or her personality and in all phases of change.

se tretira je upravo cijela osoba na svim razinama njene osobnosti i u svim fazama promjene.

Pogled na problem komorbiditeta ovisnosti i psihičkog poremećaja. Šira medicinska perspektiva stavlja naglasak na biološke i psihosocijalne čimbenike rizika, pri čemu se prihvaća stav kako se radi o složenom biopsihosocijalnom problemu kojem se pristupa višedimenzionalno (17). Pojava komorbiditeta objašnjava se posljedičnim djelovanjem predisponirajućih čimbenika poput genetskog utjecaja, osobina ličnosti, kategorije zrelosti i vanjske okoline, koji utječu na rizik razvoja multiplih stanja. Problematična uporaba psihoaktivnih tvari može biti okidač za razvoj drugog psihičkog poremećaja tako što se psihički poremećaj tada nastavlja razvijati u neovisnom smjeru (1). Jednako tako, uporaba psihoaktivnih tvari može biti okidač i za osnovni dugoročni poremećaj. Opetovana uporaba psihoaktivne tvari sigurno posreduje u pojavnosti psihičkog poremećaja (18). Prema anamnestičkim podatcima terapijske zajednice, ovisnost je poremećaj cijele osobnosti koji se odnosi na probleme u ponašanju i kognitivno-emocionalne probleme i aktivni bijeg od vlastitog života, koji ima duboki korijen u nedostatku smisla i egzistencijalnog razočarenja. U pozadini svih osobnih razloga i vanjskih okolnosti koje su dovele do problema ovisnosti, nalazi se osoba čiji život kontrolira potreba stalnog uzimanja psihoaktivnih tvari, vezanost i nemoć slobode.

Pogled na „korisnika“ kao osobu. Naglašava se činjenica da su osobe u problemu ovisnosti s pridruženim psihičkim poremećajem heterogena populacija što u prvi plan stavlja potrebu za personaliziranim i individualiziranim dijagnostičko-terapijskim pristupom. Svi elementi unutar kategorije individualnih razlika smatraju se važnima u pojavi komorbiditeta - osobito vulnerabilnost i nalazi o ranijim poremećajima - te osobna obilježja koja su ključna za pojavu problematične uporabe psihoaktivnih tvari. Istraživanja osoba s komorbiditetom ovisnosti i psihičkih poremećaja potvrđuju višu razinu dez-

Comorbid addiction and psychotic disorder. A wider medical perspective emphasises biological and psychosocial risk factors related to a complex biopsychosocial problem which requires a multidimensional approach (17). Comorbid appearance is explained by certain factors such as genetic impact, personality traits, maturity and external surrounding, which have an impact on the risk to develop multiple conditions. Problematic use of psychoactive substances can trigger development of other psychic disorders in a way that the psychic disorder continues to develop in an independent direction (1). Equally so, the abuse of psychoactive substances can trigger basic psychotic disorders. Repeated abuse of psychotic substances undoubtedly interferes with the incidence of psychotic disorders (18). According to the anamnestic data obtained from the therapeutic community, an addiction is a disorder of the whole personality. It is related to behavioural, cognitive and emotional problems that result in an urge to escape from one's own life. This is deeply rooted in the lack of a sense of meaning and purpose in life and existential disappointment. In the background of all personal reasons and external circumstances leading to addiction, there is a person whose life is controlled by the need for constant abuse of psychoactive substances.

Viewing of the "beneficiary" as a person. It emphases the fact that all persons with the addiction problem and associated disorders need a personalized and individualized therapeutic approach. All elements of individual differences are important, especially vulnerability related to earlier disorders and personal traits which are crucial in the context of psychoactive substances abuse. Research on comorbid addiction and psychic disorders confirms a high level of disinhibition, emotional instability, distrust (19) and tendency to seek excitements (20). Development, growth and organisation of emotions is stopped as there are no nuanced and more complex emotional experiences. The capability to modulate extreme feelings is underdeveloped as well as consciousness about own and other people's emotions.

inhibicije, emocionalne nestabilnosti, nepovjerenja (19) i sklonosti traženju uzbuđenja (20). Razvoj, sazrijevanje i organizacija emocija je zaustavljen, tako da se i emocionalnost izražava, na razini elementarnih emocija, bez iznijansiranih, složenijih emocionalnih doživljavanja, s nedovoljnom razvijenom sposobnošću modulacije ekstremnih osjećaja, kao i s nerazvijenom sviješću o emocijama svojim, ali i tuđim.

Pogled na proces oporavka i osobni razvoj. Plan tretmanskih i obrazovnih aktivnosti organiziran je u etapama. Naglasak je na inkrementalnom učenju i svaka faza učenja pomaže korisniku da ide dalje u procesu oporavka. Ove su etape određene protokolom liječenja:

1) Stabilizacija
2) Postupno uključivanje u radno-okupacijsku i socioterapiju
3) Oporavak - doživljaj osnaženosti i život sa smislom. Individualni čimbenici za proces oporavka su motivacija, spremnost i odluka. Oporavak ovisi o pozitivnim i negativnim pritiscima da bi se dogodila promjena. Da bi se liječenje nastavilo i oporavak bio moguć, motivacija mora biti unutarnja. Osobni razvoj vidi se u zrelosti i odgovornosti, postizanju duhovne zrelosti koja se očituje u odgovornom reagiranju osobe i prihvaćanju svih životnih situacija. Zrelost se odnosi na socijalno i emocionalno ponašanje koje je u skladu s dobi i koje je društveno prihvatljivo. Odgovornost uključuje ustrajnost i pouzdanost osobe (13) .

KOREKTIVNA ISKUSTVA KOJA UZROKUJU OPORAVAK

Emocionalno iscjeljenje u fizičkoj i psihološkoj sigurnosti. Terapijska zajednica daje sigurnost korisniku da su sve egzistencijalne potrebe zadovoljene, da nema više neizvjesnosti i osigurava liječničke, pravne i druge stručne usluge. Da bi se mogli suočiti sa svojim stanjem, istinom kakva jest, bili svjesni sebe,

A view of the recovery process and personal development. Treatment plan and educational activities are organized in several phases. The emphasis is on incremental learning and every phase of learning helps the beneficiary to move on in the recovery process. These phases are determined by the treatment protocol:

1) Stabilization
2) Gradual inclusion in occupational and socio-therapy
3) Recovery - experience of strength and meaningful life. Individual factors for the recovery process are motivation, readiness and decision-making. Recovery depends on positive and negative pressures for change. For treatment to continue and recovery to be possible, motivation has to be internal. Personal development can be seen through maturity and responsibility, achieving spiritual maturity manifested in responsible reactions of a person and acceptance of all living situations. Maturity refers to social and emotional behaviour in line with the age and socially acceptable. Responsibility includes the persistence and reliability of a person (13).

CORRECTIVE EXPERIENCES LEADING TO RECOVERY

Emotional healing in physical and psychological safety. The therapeutic community assures the beneficiary that all existential needs have been met and that there is no more uncertainty. It also provides medical, legal and other professional services. In order to face their condition, the truth as it is, become aware of themselves, beneficiaries have to feel psychological safety from other people who will support them in taking personal risks. A significant change in a person cannot happen without experiencing feelings, both of their own and those of other people. When a person recognizes, understands and accepts another member of the community while

moraju osjetiti psihološku sigurnost od drugih ljudi koji će ih podržati u poduzimanju osobnih rizika. Značajna promjena u osobi ne može se dogoditi bez doživljavanja osjećaja, kako svojih tako i osjećaja drugih ljudi. Kada osoba prepozna, razumije i prihvaća drugog člana zajednice dok on otkriva svoje osjećaje tuge, osamljenosti, boli i razočarenja, prirodno se bude osjećaji i raspoloženje koje iskonski postoje u osobi. Ova iskustva donose duboko iscjeljenje jer oslobađaju osobu njenih dugogodišnjih frustracija i strahova i potiču daljnji proces promjena.

Povjerenje. Proces liječenja ne može se dogoditi bez upoznavanja sebe i samootkrivanja. Istraživanja su pokazala da je sposobnost otkrivanja vlastitih osjećaja i misli drugoj osobi osnovna vještina potrebna za razvoj bliskih odnosa, a manjak samootkrivanja se često povezuje s nepovjerenjem i osjećajem odvojenosti. Samootkrivanje gradi povjerenje i intimnost, a bez njega je osoba izolirana u svom iskustvu. S obzirom da se radi o osobama koje nemaju povjerenja ni u sebe ni u druge, povjerenje je sastavni dio iscjeljenja. Povjerenje se razvija kao rezultat stalnih iskustava osobne tjelesne i psihičke sigurnosti koja se ponavljaju. Povjerenje jača osjećaj sigurnosti i razvija vjeru i nadu u proces promjena čak i kad je neizvjesno kakvi će biti rezultati njihovog oslanjanja na druge, kad povjerenje postane način razmišljanja i ponašanja.

Prihvaćanje sebe, život u istini i cjelovitosti. Nije dovoljno upoznati sebe; potrebno je prihvatiti sebe, to je bitan uvjet promjene. Zajednica izražava bezuvjetno prihvaćanje pojedine osobe na različite načine, uključuje ju u sve aktivnosti, grupe i odnose, ravnopravno se ponaša prema svima. Stalno podupire napore osobe da se promijeni i jasno izražava osjećaje prihvaćanja i ljubavi. Da bi počeo proces iscjeljenja zajednica kao zamjenska obitelj pruža korektivno iskustvo, osobu prihvaća i pokazuje osjećaj razumijevanja, osnažuje osobu da preispituje sebe i da želi mijenjati svoje ponašanje. Te promjene vode do internaliziranog učenja, terapijskih događaja koji vode do promjene identiteta.

discovering one's own feelings of grief, loneliness, pain and disappointment, the feelings and mood that are truly present in a person are naturally created. These experiences bring deep healing because they liberate the person of long-standing frustrations and fears and encourage a further process of change.

Trust. The treatment process cannot happen without getting to know oneself and self-discovery. Research has shown that the ability to reveal one's own feelings and thoughts to another person is the basic skill necessary for the development of close relationships, and the lack of self-discovery is often associated with distrust and a sense of separation. Self-discovery builds trust and intimacy, and without it, a person is isolated in his or her experience. Since these are persons who do not have confidence in themselves or others, trust is an integral part of healing. Trust is being developed as a result of repeated experiences of personal and psychological safety. Trust strengthens the sense of security and develops faith and hope in the process of change, even when it is uncertain what the results of their relying on others will be, when trust becomes a way of thinking and behaviour.

Acceptance of oneself, life in truth and integrity. It is not enough to know oneself; it is necessary to accept oneself as an essential precondition for change. The community expresses the unconditional acceptance of a particular person in various ways, includes the person in all activities, groups and relations, treats everyone equally. It constantly supports the person's efforts to change and clearly expresses the feelings of acceptance and love. In order to begin the process of healing, the community, as a replacement family, provides corrective experience. The person accepts this and shows a sense of understanding, which leads to empowering, reconsidering oneself and wanting to change one's behaviour. These changes lead to internalized learning and therapeutic events that lead to identity change.

Experience of being accepted and social connection with others. The therapeutic communi-

Iskustvo prihvaćenosti i socijalne povezanosti s drugima. Terapijska zajednica je mjesto gdje ovisnik uči graditi bliske veze i razvijati odnose s drugim ljudima s obzirom da se većina korisnika otuđila od svih prijatelja i obitelji. Privrženost u odrasloj dobi karakterizira tendencija da se traži i održi bliskost s drugom osobom, naročito kad je osoba pod stresom. Iskustvo prihvaćenosti uči se s važnim osobama koje osobu okružuju, kojima se može vjerovati, pouzdani su i imaju visoku razinu povjerenja koja se svakodnevno testira. Osjećaj da ih netko poznaje i voli umanjuje osjećaj izolacije i jača osjećaj pripadnosti zajednici. Povezivanje s ostalim članovima je važno jer daje slobodu za priznavanje svojih negativnosti i kajanje, a to osobu rješava osjećaja krivnje i straha opraštanjem sebi i drugima. Korisnici mogu prihvatiti ispravak negativno potkrijepljene i disciplinirane zajednice samo ako u isto vrijeme osjećaju brigu i suosjećanje, te ako osjećaju da ih drugi prihvaćaju i razumiju.

Iskustvo osobne uspješnosti i zahvalnosti dolazi interakcijom osobe i zajednice. Ponašanja i stavovi osobe uzrokuju pozitivne reakcije zajednice što uzrokuje objektivne posljedice kao što su privilegije, nagrade ili disciplinske mjere. Subjektivna iskustva uključuju subjektivne percepcije, razmišljanja i osjećaje. Kada osoba učini nešto dobro i uspješno, to povezuje s osjećajem vlastite vrijednosti. Osjećaj vrijednosti i osjećaj uspješnosti su duboko povezani s procesom izliječenja, oslobađaju unutarnju snagu osobe. To se ne odnosi samo na problem ovisnosti nego i na sva druga područja života (posao, socijalni odnosi, emocionalne veze i samokontrola u svim segmentima) (13) .

Osobna konverzija, sveobuhvatna promjena (*conversio continuata*). Uvažavanje duhovne dimenzije u psihičkim poremećajima važna je sastavnica integrativne psihijatrije, kako u razumijevanju bolesti tako i u liječenju (5). Sveobuhvatna promjena polazi od pružanja pomoći osobama da vide što jesu kao i ono što mogu

ty is a place where an addict learns to build close relationships and develop relationships with other people, since most users alienated themselves from all friends and family. The attachment in adulthood is characterized by a tendency to seek and maintain closeness with another person, especially when a person is under stress. Experience of being accepted is taught by important persons who can be trusted, are reliable and have a high level of trust, which is tested on a daily basis. The feeling that someone knows and loves them reduces the sense of isolation and strengthens the sense of belonging to the community. Connecting with other members is important because it gives freedom to recognise negativity and remorse, and this person resolves feelings of guilt and fear by forgiving him/herself and others. Beneficiaries can accept corrections only if they feel care and compassion that others accept and understand them.

Experience of personal success and gratitude. This experience comes through the interaction between the person and the community. Attitudes of a person cause positive reactions from the community, which causes objective consequences, such as privileges, awards or disciplinary measures. Subjective experiences include subjective perceptions, thoughts and feelings. When a person does something good, he or she can successfully connect that experience to the feeling of his or her own value. The sense of value and success are deeply rooted in the treatment process, which inspires inner strength in the person. This does not only apply to the problem with addiction, but also to all other areas of life (work, social relations, emotional connections and self-control) (13).

Personal conversion and comprehensive change (*conversio continuata*). Taking into account the spiritual dimension in mental disorders is an important component of integrative psychiatry, both in terms of understanding the disease and treating it (5). A comprehensive change starts from helping the persons see who they are and what they can be by realizing the potential for joy, gratitude and meaningful life.

biti realizacijom potencijala za radost, zahvalnost i život sa smislom. Sveobuhvatna promjena *conversio continuata* događa se u četiri etape. Počinje odbacivanjem lažne maske i priznavanjem svega što se nosi u sebi. Nastavlja se dopuštanjem izričaja potisnutih i prigušenih osjećaja pred Bogom s vjerom u njegovu spasiteljsku ljubav i moć. Treća etapa počinje izričitim i svjesnim prihvaćanjem svih osoba u svojem životu, ugodnih i neugodnih događaja, uspjeha i neuspjeha. Sve se završava potpunim opraštanjem sebi, drugima i Bogu kojeg se okrivljuje za nedaće ili bolest. U trećoj fazi pojavljuje se unutarnji mir i doživljaj obnavljanja unutarnjeg oporavka, a plodovi oporavka u svojoj nutrini vidno su prisutni nakon primljenog oprosta i potpunog opraštanja, prihvaćanja Božje volje i otkrivanja Božjeg plana za svoj život. *Konverzija - obraćenje* je ključni pojam u integrativnoj terapiji s kršćanskim pristupom, a uključuje duboke promjene u kognitivnom funkcioniranju, promjene u značenju emocija; životni ciljevi i vrijednosti bitno su izmijenjeni (21). Oprost je važan dio procesa konverzije i oblikovanja nove svjesne razine integracije. Povezivanjem osobe s Bogom kao izvorom mira i slobode, kršćanski shvaćeno Isusom Kristom, doživljajem oprosta uklanjaju se osjećaj krivnje i straha, te se potiče život u istini i zahvalnosti koja oslobađa životnu snagu i doživljaj osnaženosti. Vjera i duhovnost pomažu u nastajanju psihofizičke ispunjenosti. Poboljšavaju se emocionalne, kognitivne funkcije, pomažu osobi u prihvaćanju i razumijevanju drugih i individualnom sazrijevanju (22). Iskustva koja imaju terapijski učinak temeljena su na „*nadi i vjeri kao elementarnoj snazi koja pokreće osobu pogledati u budućnost i htjeti je*“ (23).

A comprehensive change in continued conversion occurs in four stages. It starts by letting go of a fake mask and acknowledging everything the person hold from within. It continues by allowing the expression of suppressed and attenuated feelings before God with faith in His saving love and power. The third phase begins with the explicit and conscious acceptance of all persons in the person's life, pleasant and unpleasant events, successes and failures. Everything ends with complete forgiveness to oneself, God and others who are blamed for hardship or disease. In the third phase, inner peace and the experience of renewal of inner recovery appear, and the fruits of recovery from within are evident after receiving complete forgiveness, acceptance of God's will and the discovery of God's plan for the person's life. Conversion is a key concept in the integrative therapy applying the Christian approach, and it includes deep changes in cognitive functioning, changes in the meaning of emotions. At this stage, life goals and values have been substantially changed (21). Forgiveness is an important part of the process of conversion and shaping a new conscious level of integration. By connecting a person with God as a source of peace and freedom, the experience of forgiveness removes the feeling of guilt and fear and encourages life in truth and gratitude that liberates the life force and the experience of empowerment. Faith and spirituality help to create psycho-physical fulfilment. Emotional and cognitive functions are improved, thus helping the person to accept and understand others and individual maturation (22). Experiences with therapeutic effect are based on "hope and faith as an elementary force that drives a person to look into the future and want it" (23).

ZAKLJUČAK

Osobe s psihičkim poremećajima povezanima s ovisnošću nailaze na poteškoće jer se ne uklapaju u uobičajene terapijske programe. Odvojenost tretmana za osobe s poremećajem ovi-

CONCLUSION

Persons with psychological disorders associated with addiction encounter difficulties because they do not fit the usual therapeutic programmes. The separation of treatment for persons with addic-

snosti i pridruženim psihičkim poremećajem posljedično utječe na kvalitetu i koordinaciju samog tretmana. Dosadašnja istraživanja preporučuju provođenje integrativnog pristupa terapijskom programu koji istodobno objedinjuje tretman obih poremećaja. Integrativni model terapijskog programa rehabilitacije oba poremećaja provodi se istodobno u sklopu modificirane terapijske zajednice Reto centar Zagreb i vodi ga multidisciplinarni tim sačinjen od uspješno rehabilitiranih osoba educiranih za rad u terapijskoj zajednici i struke. Integrativni model rehabilitacije komorbidne ovisnosti naglašava važnost liječenja cijele osobe u sve četiri dimenzije: somatskoj, psihološkoj, socijalnoj i duhovnoj. Temelji se na specifičnim potrebama i mogućnostima osobe u terapijskom programu, a karakterizira ju usmjerenost na dobrobit i posvećenost promjeni stila života. Terapijski cilj rehabilitacije osoba u problemu ovisnosti s pridruženim psihičkim poremećajem je da postanu emotivno uravnotežene, socijalno prilagođene i životno osnažene osobe. Pristup „životne snage“ uključuje rješavanje problema na svim razinama, ne samo rješavanje problema ovisnosti. Integrativni model terapijskog programa modificirane terapijske zajednice s kršćanskim pristupom vidi osobu s poremećajem ovisnosti s pridruženim psihičkim poremećajem kao aktivnog suradnika i u pristupu naglašava u svim fazama rehabilitacije vrijednost svakog života i mogućnost oporavka svake osobe koja je motivirana i spremna za liječenje vanjskim ili unutarnjim razlozima. Uspješno završen program rehabilitacije je kada osoba uspješno funkcionira na individualnoj, socijalnoj i univerzalnoj razini svoje osobnosti, koja ima svoju životnu svrhu. Koncept autentične osobe i kršćanstva kao životnog stila, otvorena zainteresiranost za svakog korisnika i sveobuhvatni pristup svakoj osobi povezivanjem tjelesne, psihološke, socijalne i duhovne dimenzije je učinkovit terapijski program koji daje rezultate već punih dvadeset i osam godina.

tion disorders and associated mental disorders affects the quality and coordination of the treatment itself. The research so far recommends implementing an integrative approach to the therapeutic programme that simultaneously combines treatment of both disorders. The integrative model of the therapeutic programme for rehabilitation of both disorders is implemented simultaneously within the modified therapeutic community Reto Centre and is led by a multidisciplinary team consisting of successfully rehabilitated persons educated for work in the therapeutic community and the profession. The integrative model of rehabilitation of comorbid addiction emphasizes the importance of treating the entire person in all four dimensions, i.e., somatic, psychological, social and spiritual. It is based on the specific needs and possibilities of each person in the therapeutic programme and is characterized by a focus on the well-being and dedication to changing the lifestyle. The therapeutic goal of rehabilitation of persons with addiction and associated mental disorders is to become emotionally balanced, socially adjusted and life-dependent persons. The “life force” approach includes solving problems at all levels, and not only addressing the problem of addiction. The integrative model of the therapeutic programme in a modified therapeutic community applying the Christian approach sees every person with a disorder dependent on an associated mental disorder as an active associate. This approach emphasizes the value of every life and the possibility of recovery of any person motivated and ready for the treatment at all stages of rehabilitation. The rehabilitation programme is successfully completed when the person has the ability to successfully function at individual, social and universal levels of personality in line with his/her life mission. The concept of authentic personality and Christianity as a lifestyle presupposes the interest in each beneficiary and a comprehensive approach to each person by way of connecting physical, psychological, social and spiritual dimensions in an efficient therapeutic programme that has been giving results over the past twenty-eight years.

LITERATURA / *REFERENCES*

1. Europski centar za praćenje droga i ovisnosti o drogama. Europsko izvješće o drogama: Trendovi i razvoj. Luxembourg: Ured za publikacije Europske unije, 2015.
2. Ness O, Borg M, Davidson L. Facilitators and barriers in dual recovery: a literature review of first-person perspectives. Advances in Dual Diagnosis 2014; 7(3): 107-17.
3. Substance Abuse and Mental Health Services Administration. Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings, 2011.
4. Jakovljević M. The brave new psychiatry: beyond modernism, antimodernism and postmodernism in psychiatry. Psychiatria Danubina 2007; 19: 122-9.
5. Jakovljević M. Transdiciplinary holistic integrative psychiatry – A wishful thinking or reality? Psychiatria Danubina 2008; 20: 341-8.
6. Jakovljević M. Creative, person-centered and narative psychopharmacotherapy or how to prevent and overcome treatment resistance in psychiatry. Psychiatria Danubina 2015; 27(3): 291-301.
7. Štrkalj-Ivezić S, Jendričko T, Pisk Z, Martić-Biočina S. Terapijska zajednica. Soc psihijat 2014; 42(3): 172-9.
8. Ajduković M. Grupni pristup u psihosocijalnom radu. Zagreb: Društvo za psihosocijalnu pomoć, 1997.
9. Janković J. Savjetovanje u psihosocijalnom radu. Zagreb: Etcetera, 2011.
10. Jakovljević M, Begić D. Socijalna psihijatrija danas: izazovi i mogućnosti. Soc psihijat 2013; 41(1): 16-20.
11. European Movement for Christian Anthropology. Psycho, 2006.
12. Gossmann HC. Die therapeutische Dimension Bibliodrama und Gestalttherapie. U: Naurath E, Pohl-Patalong U (ur.). Bibliodrama: Theorie – Praxis – Reflexion. Stuttgart: Kohlhammer, 2002.
13. De Leon G. The Therapeutic Community, Theory, model and method. New York: Springer Publishing Company, 2000.
14. Ljubičić Đ. Duhovnost i psihijatrija. Rijeka: Medicinski fakultet, 2009.
15. Frankl V. Zašto se niste ubili: Uvod u logoterapiju. Zagreb: Biblioteka Oko 3 ujutro, 1978.
16. Frankl V. Der Wiele zum Sinn. Beč: Huber, 1978.
17. Drake RE, Wallach MA. Dual diagnosis: 15 years of progress. Psychiatric services 2000; 51(9): 1126-9.
18. Bernacer J, Corlett PR, Ramachandra P, McFarlane B, Turner DC, Clark L i sur. Methamphetamine-induced disruption of frontostriatal reward learning signals: relation to psychotic symptoms. Am J Psychiatry 2013; 170(11): 1326-34.
19. Wilson, GT. Cognitive Processes in Addiction. Br J Addict 1987; 82(4): 343-53.
20. Antičević V, Jokić-Begić N, Britvić D. Spolne razlike u osobinama ličnosti ovisnika o heroinu i konzumenata marihuane na Eysenckovom upitniku ličnosti (EPQ). Društvena istraživanja 2012; 115(1): 203-18.
21. Sperry L. Spirituality in clinical practice: Incorporating the spiritual dimension in psychoterapy and counselling. Philadelphia: Brunner-Routledge, 2001.
22. Ljubičić R. Depresija i duhovnost. Rijeka: HIDP, 2012.
23. Meissner W. Život i vjera. Zadar: Filozofski fakultet, 2002.

Strah od odlaska stomatologu

/ Fear of Going to the Dentist

Kristina Surina[1], Jasmina Ruždijić[2], Ana Kuzinovska[3], Aleksandra Stevanović[4], Ika Rončević-Gržeta[5]

[1]Ordinacija dentalne medicine dr. Davor Milišić, Omišalj, Hrvatska; [2]Dom zdravlja Primorsko-goranske županije, Rijeka, Hrvatska; [3]Klinički bolnički centar Rijeka, Klinika za psihijatriju, Rijeka, Hrvatska; [4]Klinički bolnički centar Rijeka· Rijeka, Klinika za psihijatriju, Medicinski fakultet Sveučilišta u Rijeci, Katedra za psihijatriju i psihološku medicinu, Fakultet zdravstvenih studija Sveučilišta u Rijeci, Katedra za temeljne medicinske znanosti, Rijeka, Hrvatska; [5]Klinički bolnički centar Rijeka, Klinika za psihijatriju, Medicinski fakultet Sveučilišta u Rijeci, Katedra za psihijatriju i psihološku medicinu Fakultet zdravstvenih studija Sveučilišta u Rijeci, Katedra za kliničke medicinske znanosti, Rijeka, Hrvatska

/ [1] *Dental Practice, dr. Davor Milišić, Omišalj, Croatia;* [2] *Primorje-Gorski Kotar County Health Center, Rijeka, Croatia; Rijeka;* [3]*Clinical Hospital Center Rijeka, Psychiatric Clinic, Rijeka, Croatia;* [4] *Clinical Hospital Center Rijeka, Psychiatry Clinic, Faculty of Medicine, University of Rijeka, Department of Psychiatry and Psychological Medicine; Faculty of Health Studies, University of Rijeka, Department of Basic Medical Sciences, Rijeka, Croatia;* [5] *Clinical Hospital Center Rijeka, Psychiatry Clinic; University of Rijeka, Faculty of Medicine, Department of Psychiatry and Psychological Medicine, Rijeka, Croatia*

[2]ORCID ID: https:///orcid.org/0000-00023-7961-0391

[4]ORCID ID: https//orcid.org/0000-0002-1927500X

[5]ORCID ID: https://orcid.org/0000-0003-0497-6900

Strah od odlaska stomatologu može imati posljedice povezane s oralnim zdravljem, ali i sa zdravljem općenito. Zbog tog straha može izostati odgovarajuća i redovita stomatološka skrb (barem jednom godišnje). Dentalna anksioznost/fobija jedan je od vodećih čimbenika zbog kojeg pacijenti izbjegavaju odlazak stomatologu. Cilj ovog rada bio je ispitati je li osobe koje imaju loše iskustvo povezano s odlaskom stomatologu u ranoj dobi, tj. tijekom djetinjstva češće razviju dentalnu anksioznost/fobiju te je li je dentalna anksioznost/fobija povezana s povećanom osjetljivosti za dentalnu bol. Također, cilj je ispitati postižu li osobe koje imaju dentalnu anksioznost/fobiju više rezultate na ljestvici anksioznosti kao stanja (*Spielberger's State-Trait Anxiety Inventory* STAI-X-1) u odnosu na one bez dentalne anksioznosti/fobije. Rezultati ovog istraživanja potvrđuju hipotezu da osobe s lošim iskustvom povezanim s odlaskom stomatologu tijekom djetinjstva imaju višu razinu dentalne anksioznosti, višu trenutnu anksioznost odnosno anksioznost kao stanje na STAI-X-1 te veću dentalnu bol u odnosu na ispitanike koji svoje iskustvo povezano s odlaskom stomatologu tijekom djetinjstva ne percipiraju kao loše. Također, ispitanici s dentalnom anksioznošću/fobijom rjeđe posjećuju stomatologa.

/ Fear of a dental procedure can have consequences related to oral health, but also to health in general. This fear can result in a lack of adequate and regular dental care (at least once a year). Dental anxiety/phobia is one of the leading factors for why patients avoid going to the dentist. The aim of this study was to identify if people who had an unpleasant experience with a dentist in childhood are more likely to develop dental anxiety/phobia and to establish whether or not dental phobia is related to a greater sensitivity for dental pain. This study investigates if people with dental anxiety achieve higher results on the scale of anxiety state (STAI-X-1) than people who do not have dental anxiety/phobia. The results of this research confirm the hypothesis that people with an unpleasant experience with a dentist in childhood have a higher level of dental anxiety and higher anxiety state (STAI-X-1) and experience higher levels of dental pain than people who do not perceive their experience with a dentist during childhood as unpleasant or bad. Additionally, subjects with dental anxiety/phobia were less likely to visit the dentist.

ADRESA ZA DOPISIVANJE /
CORRESPONDENCE:
Izv. prof. dr. sc. Ika Rončević-Gržeta
KBC Rijeka
Klinika za psihijatriju
Krešimirova 42
51 000 Rijeka, Hrvatska
E-pošta: ika.roncevic.grzeta@uniri.hr

KLJUČNE RIJEČI / ***KEY WORDS:***
Anksioznost / *Anxiety*
Anksiznost kao stanje / *Anxiety State*
Dentalna anksioznost / *Dental Fear*
Dentalna fobija / *Dental Phobia*

TO LINK TO THIS ARTICLE: https://doi.org/10.24869/spsih.2021.148

UVOD

Anksioznost je očekivan odgovor na određeni tip stresora. Radi se o emociji koja se može manifestirati nizom psihičkih i somatskih simptoma. Izvor anksioznosti mogu biti prethodno doživljena traumatska iskustva, ali i anticipirana iskustva kada su izvor anksioznosti budući događaji. Pri tome se postavlja pitanje: „Što će biti, što će se dogoditi?“. Takav događaj može biti intervju za posao, prvi dan škole, prvi posjet ginekologu ili stomatologu. Dentalna anksioznost je vrlo česta pojava, osobito kod pacijenata koji se spremaju na stomatološki zahvat s kojim se nisu prije susretali. Strah od stomatoloških pregleda ili intervencija posljedica je osobnih iskustava ranije doživljene boli, ali vrlo često i nedoživljene, već samo očekivane boli (1). Tako odlazak stomatologu u većine pacijenata izaziva neugodan osjećaj, a situaciju u stomatološkoj ordinaciji doživljavaju kao neku vrstu opasnosti. U većini slučajeva anksioznost će prestati kada osoba prestane biti u blizini stresora. Tako je, u ovom slučaju, način ublažavanja tjeskobe zapravo izbjegavanje izvora opasnosti, tj. odlaska stomatologu. Fobija je pretjerana i iracionalna reakcija straha. Karakterizirana je dubokim osjećajem straha ili paničnim napadom pri susretu s izvorom straha. Strah može biti izazvan određenim mjestom, situacijom ili predmetom. Za razliku od općih anksioznih poremećaja, fobija je obično povezana sa specifičnim izvorom opasnosti. Fobi-

INTRODUCTION

Anxiety is the expected response to a certain type of stressor. It is an emotion which can manifest in a number of psychic and somatic symptoms. The source of the anxiety can be previous traumatic experience, but it can also be an anticipated experience, which is expressed in the question: “What is going to happen?” Such an event can be, for example, a job interview, the first day of school, the first visit to a gynecologist or a dentist. Dental anxiety is a very common and dominant event, especially with patients who are preparing for a dental procedure with which they have no previous experience. The fear of dental checkups or interventions is a consequence of a personal experience of pain which happened in the past or, very commonly, is only anticipated (1). Thus, having a dentist appointment creates a feeling of uneasiness in most patients, and the situation in the dental clinic is perceived as dangerous. In most cases, the anxiety will cease when the patient leaves the vicinity of the stressor. In this case, avoiding the source of the danger, visiting the dentist, is the chosen way of calming the anxiety. A phobia is an excessive and irrational reaction of fear characterized by a deep feeling of fear or a panic attack when faced with the source of the fear. The feeling of fear can be triggered by a certain place, situation or item. Unlike other anxiety disorders, phobia is usually linked to a specific source of

ja povezana s odlaskom stomatologu zove se odontofobija ili dentalni strah. Smatra se da za tu fobiju kod nekih pacijenata postoji genetska predispozicija (2). Ta je fobija popraćena nizom simptoma među kojima su: ubrzan rad srca (tahikardija), povišen krvni tlak, ubrzano disanje, suha usta, drhtanje. Dentalna fobija je najizraženji oblik straha s kojim se suočavaju stomatološki pacijenti. Strah može biti povezan s više specifičnih situacija kao primjerice strah vezan uz specifični dio pregleda, strah od boli, strah od anestezije, strah od dijagnoze. Nesumnjivo je da pojava takvog straha može biti rezultat traumatičnog iskustva od ranije, a takav strah može kasnije utjecati na neredovite posjete stomatologu, izostanak odgovarajuće i redovite stomatološke skrbi. Posljedica navedenog može biti pogoršanje oralnog zdravlja. Pacijenti koji već imaju dentalni strah izbjegavaju posjete stomatologu (3-5). Nemali broj odraslih ima određenu razinu dentalne anksioznosti, od blage do teške. Utvrđeno je da oko 3-16 % odraslih pati od dentalne fobije (6-8). Appukuttan i sur. (9) ustanovili su da 3 % populacije u Indiji pati od dentalne fobije, dok je Halonen (10) kod 11,3 % ispitanika u općoj populaciji u Finskoj našao da zadovoljavaju kriterije za dentalnu fobiju, a Humphris (11) u Velikoj Britaniji kod 11,6 % takvih ispitanika.

Odnos između pacijenta, stomatologa i medicinskog osoblja koje je u kontaktu s pacijentom, osobito onim koji ima dentalnu anksioznost i dentalnu fobiju, od velikog je značenja. Odnos može pogoršati ili poboljšati trenutnu situaciju i direktno utjecati na ponašanje pacijenta u budućnosti (12). Cilj komunikacije je pomoći pacijentu da se opusti i tako steći njegovo povjerenje. Tijekom razgovora treba pacijentu protumačiti postupak zahvata i pružiti mu bezrezervnu podršku. Kreativne tehnike od strane stomatologa mogu uključivati i tehnike disanja, progresivnu relaksaciju mišića, tehnike vođenih fantazija. Prema tome, pacijenti koji imaju dentalnu anksioznost značajan su izazov za stoma-

danger. Phobia linked to visiting the dentist is called odontophobia or dental phobia. It is believed that there exists a genetic predisposition to it in some patients (2). Some of its symptoms are: heightened heart rate (tachycardia), heightened blood pressure, rapid breathing, dry mouth, tremors or shivering. Dental phobia is the most prominent form of fear dental patients face. The fear can be linked to a number of specific situations, such as fear linked to a specific part of the checkup, fear of pain, fear of anesthesia or fear of diagnosis. There is no doubt that the emergence of such fear can be the result of a previous traumatic experience, which can cause irregular visits to the dentist and a lack of regular dental care. The consequence can be the worsening of dental health. The patients who already have a dental phobia avoid visiting the dentist (3-5). A large number of adults has a certain level of dental phobia ranging from mild to severe. It has been ascertained that around 3-16% of adults suffer from dental phobia (6-8). Appukuttan et al. (9) have found that around 3% of the population of India suffers from dental phobia. Halonen (10) found that 11.3% of subjects in Finland fit the criteria for dental phobia, while Humphris (11) observed the same for 11.6% of subjects in the UK.

The relationship between the patient, the dentist and the medical staff in contact with the patient, especially those with dental phobia, is of great significance. They can improve or worsen the situation and directly influence the patient's future behavior (12). The goal of communication with the patient is to help them relax and acquire their trust. During the conversation, the staff should explain the procedure and offer encouragement and support to the patient. Creative techniques can include breathing techniques, progressive muscle relaxation and guided fantasy. Patients with dental phobia pose a challenge to the dental team. It is important to be mindful of and be able to

tološki tim. Važno je imati na umu i prepoznati dentalnu anksioznost i sukladno s time djelovati i izabrati način primjene određenih tehnika, osobito kada su u pitanju pedijatrijski pacijenti. U tom bi slučaju trebalo dodatno zaslužiti njihovo povjerenje, preko kreativnih igara koristeći dječje igračke i male poklone u znak zahvale za njihovo strpljenje i suradljivost tijekom pregleda (13-15). Kod roditelja koji dolaze u pratnji s djecom s dentalnom anksioznošću, može se, također, kao kod pasivnih promatrača, javiti neka vrsta stresa (16). Dentalni strah kod djece povezuje se s povišenom anksioznošću kod roditelja, osobito majke, no, povezan je i s višom prevalencijom dentalne anksioznosti u obitelji (17). Dentalna anksioznost češće se javlja kod djece između 6 i 12 godina, što je direktno povezano s promjenama na zubima koji su, također, u razvoju (18). S obzirom da su dentalna anksioznost i strah multifaktorski i utječu na više subjekata: na pacijenta, stomatologa i roditelje, trebalo bi primjenjivati više tehnika, osim farmakoloških, kako bismo pomogli barem kod manje invazivnih zahvata i tako olakšali dentalni pregled. Slušanje glazbe tijekom intervencije ima umirujući učinak i smanjuje dentalnu anksioznost (19). Korištenje uređaja virtualne stvarnosti kao tehnike, koja je jednostavna za izvođenje, kod djece može otkloniti pozornost sa samog pregleda i time umanjiti bol i anksioznost (20,21). Ipak, upoznavanje sa stomatologom još od najranijeg djetinjstva te njegove dobre komunikacijske vještine i empatija, neovisno o njegovu radnom iskustvu, mogu direktno utjecati na stupanj dentalne anksioznosti, a posredno i na oralno zdravlje pacijenta (22).

METODE

Hipoteza

Osobe koje imaju ranije loše iskustvo (tijekom djetinjstva) povezano s odlaskom stomatologu češće razviju dentalnu anksioznost/fobiju, teže podnose dentalnu bol i više su tjeskobne u situ-

recognize the presence of dental phobia and act accordingly, which also includes choosing to apply the right techniques, especially with pediatric patients. In case of pediatric patients, their trust especially must be earned using creative games as well as using toys and small gifts as a sign of appreciation for their patience and cooperativeness during the checkup (13-15). Parents who escort the children with dental phobia, as well as other passive observers, can also show signs of some kind of stress (16). Dental phobia in children is linked to heightened anxiety in parents, especially mothers, but it is also linked to higher prevalence of dental anxiety within the family (17). Dental anxiety is more common in children aged between 6 and 12, which is directly linked to the changes in developing teeth (18). Dental phobia has many factors and affect a number of subjects: the patient, the dentist and the parents. Several techniques should be employed, including some that are not purely pharmacological, in order to help with less invasive procedures and to make dental checkups easier. Listening to music during the procedure has a calming effect and reduces dental phobia (19). Using VR (virtual reality) devices is a technique which is easy to apply and can divert attention from the checkup and thus reduce the pain and anxiety (20, 21). Still, a person's first encounter with a dentist in the earliest childhood and that dentist's communication skills and level of empathy, regardless of their work experience, can directly impact the degree of dental phobia and indirectly impact the oral health of the patient (22).

METHODS

Hypothesis

Subjects who have an unpleasant previous experience (that happened during childhood) with a dentist develop social phobia more often, are more susceptible to dental pain and are more anxious during a dental procedure in

aciji stomatološkog postupka u odnosu na osobe koje nisu imale ranije loše iskustvo vezano za odlazak stomatologu.

Ciljevi

Cilj ovoga rada bio je ispitati imaju li ispitanici s ranijim lošim iskustvom povezanim s odlaskom stomatologu jače izraženu dentalnu anksioznost/fobiju u odnosu na one bez takvog iskustva. Zatim, ispitati stupanj anksioznosti kao stanja kod ispitanika koji imaju ranije loše iskustvo povezano s odlaskom stomatologu u odnosu na one bez takvog iskustva te ispitati razinu podnošenja opće i dentalne boli kod ispitanika koje imaju dentalnu anksioznost/fobiju u odnosu na one bez dentalne anksioznosti/fobije. Na kraju, cilj je ispitati i razlike u učestalosti posjeta stomatologu između skupine ispitanika s dentalnom anksioznošću/fobijom u odnosu na one bez dentalne anksioznosti/fobije.

Ispitanici

Ispitivanjem je bilo obuhvaćeno ukupno 70 ispitanika koji su zatražili pomoć stomatologa zbog redovitog kontrolnog pregleda, terapije ili simptoma nastalih zbog patoloških stanja u orofacijalnom području. Ispitanici su bili podvrgnuti različitim stomatološkim zahvatima kao čišćenje kamenca, sanacija karioznog zuba, vađenje zubne pulpe, vađenje zuba i sl. Ispitanici su bili oba spola (35 muškaraca i 35 žena), dobi od 20 do 60 godina, prosječne dobi 39,46 godina. U istraživanje nisu uključene osobe koje nisu bile voljne sudjelovati ili nisu bile u stanju dati vjerodostojne podatke, npr. zbog jake akutne boli ili osobe s mentalnom insuficijencijom.

Tijekom godine koliko je trajalo istraživanje u stomatološku ordinaciju, u kojoj je provedeno istraživanje, javilo se 559 pacijenata. Od ukupnog broja pacijenata nisu uključeni mlađi od 18 godina, odnosno stariji od 60 godina kako bi se izbjeglo simptome povišene anksioznosti koji mogu biti generirani specifičnim razcomparison with the subjects who did not have such an experience.

Study aim

The aim of this study was to investigate if the subjects with an unpleasant previous experience with the dentist have more prominent dental anxiety/phobia in comparison with those without such an experience. Following that, the aim was to investigate the degree of anxiety in the subjects who had the unpleasant experience in comparison with those without it, and to investigate the capability to withstand oral pain compared between the subjects with and without dental anxiety/phobia. Finally, the goal was to investigate the difference in the frequency of visiting the dentist between the group of subjects with dental anxiety/phobia and the group of subjects without it.

Subjects

In total, 70 subjects who sought the help of a dentist about a regular dental checkup, therapy or symptoms that manifested due to pathological conditions in the orofacial area participated in the study. The subjects underwent different dental procedures such as calculus removal, taking care of a decayed tooth, pulp removal, tooth extraction, etc. The subjects were equally divided among both sexes (35 men, 35 women), aged from 20 to 60, with an average age of 39.46 years. Persons who were unwilling to participate or were not in condition to provide us with trustworthy data due to, for example, intense pain or persons with mental insufficiency, were excluded from the study.

Over a time of one year, which was the duration of the study, a total of 559 patients presented to the clinic where the research was taking place. Persons younger than 18 and older than 60 were not included in the study, in order to avoid symptoms of heightened anxiety which

dobljem života kao što je adolescencija odnosno specifični stresori u osoba starije dobi kao umirovljenje, separacija zbog odlaska djece, pad kognitivnih kapaciteta i sl. Od preostalog broja ispitanika 70 ih je pristalo sudjelovati u istraživanju. Oni su dobili verbalno objašnjenje o svrsi istraživanja nakon čega su potpisali informirani pristanak. Nakon toga su popunili samoprocjenske upitnike u posebnoj sobi, prije ulaska u ordinaciju. Ispitanici su podijeljeni u dvije podskupine: N1 = 44 ispitanika koji imaju ranije loše iskustvo vezano za odlazak stomatologu i N2 = 26 ispitanika koji nemaju ranije loše iskustvo vezano za odlazak stomatologu.

Instrumenti

Primijenjeni su sljedeći instrumenti: Opći upitnik, *Spielberger's State-Trait Anxiety Inventory* (STAI-X-1) - Upitnik anksioznosti kao stanja, Upitnik dentalne anksioznosti (DAS) te Upitnik procjene boli.

Općim upitnikom dobili smo sociodemografske podatke - spol, dob, zanimanje, bračni status, radni status, stručna sprema te podatke koji se odnose na zdravstveni status.

STAI-X-1 - Upitnik anksioznosti kao stanja sadrži 20 tvrdnji uz pomoć kojih se procjenjuje kako se ispitanik osjeća u trenutku ispitivanja. Ispitanici su imali zadatak uz svaku tvrdnju zaokružiti jedan odgovor na ljestvici Likertovog tipa od 4 stupnja (1 = uopće ne do 4 = jako) koji najbolje opisuje njihovo trenutno stanje. Ispunjavanje upitnika nije vremenski ograničeno. Ukupan rezultat se dobiva tako da se zbroje bodovi za svih 20 tvrdnji. Najmanji mogući rezultat je 20, a najveći 80. Veći rezultat ukazuje na viši stupanj anksioznosti. Ljestvicom anksioznosti kao stanja (STAI-X-1) procjenjuju se bitna obilježja anksioznosti kao stanja: strepnja, napetost, nervoza i zabrinutost u vrijeme ispitivanja. Utvrđeno je da je ljestvica osjetljiv pokazatelj prolazne anksioznosti koju pojedinci doživljavaju u određenoj situaciji (23).

may be generated by a specific period of life such as adolescence or the stressors specific to older age, like retirement, separation from children, lowering of cognitive capacities, etc. From the remaining number of subjects, 70 agreed to participate. They were given a verbal explanation of the purpose of the study and signed an informed consent slip. After that, they filled out self-assessment tests in a separate room before they entered the clinic. The subjects were divided into two groups, N1=44, which comprised subjects with a previous unpleasant experience with dentists, and N2=26, which comprised subjects who did not have such an experience.

Instruments

The instruments used in this study were the following: general questionnaire, Spielberger's State-Trait Anxiety Inventory (STAI-X-1) – questionnaire on state anxiety, questionnaire on dental anxiety (DAS) and a questionnaire on pain assessment.

A general questionnaire was used for sociodemographic data – sex, age, occupation, marital status, employment status, education and health status data.

The STAI-X-1 – Questionnaire on state anxiety contains 20 statements that is used to assess how the subject feels during the research. For each statement, the subjects had to choose a value on Likert scale (1=not at all, 4= very much so) which described their state at that moment. There was no time limit. The total score is the sum of points for all 20 statements. The minimal score was 20, the maximum score was 80. The greater the score, the greater the level of anxiety. STAI-X-1 is used to assess the important features of anxiety as a state: dread, tension, nervousness and worriedness at the time of doing the questionnaire. It has been shown that the scale is a sensitive indicator of temporary anxiety individuals face in a certain situation (23).

Za ispitivanje dentalne anksioznosti koristili smo Corahovu ljestvicu dentalne anksioznosti, odnosno *Dental Anxiety Scale* (DAS) koja sadrži četiri pitanja. Ukupna vrijednost rezultata kreće se od 4 do 20. Vrijednosti na testu od 4 do 7 smatraju se normalnom anksioznošću. Na blagu anksioznost upućuju vrijednosti od 8 do 11, na umjerenu anksioznost vrijednosti od 12 do 16, dok vrijednosti od 17 do 20 znače da se radi o dentalnoj fobiji. Instrument je jednostavan za primjenu, zahtijeva malo vremena za provedbu, a u usporedbi s mnogo složenijim testovima iste namjene pokazuje visok stupanj korelacije. Ljestvica je vrlo pouzdana i kod djece. Zbog toga je našla primjenu u znanstvenim istraživanjima, ali i u svakodnevnoj kliničkoj praksi (24-27). U ovom radu nismo posebno izdvojili dentalnu anksioznost i dentalnu fobiju već smo sve ispitanike koji su postigli više od 12 bodova na DAS promatrali zajedno, kao jednu skupinu "dentalna anksioznost/fobija".

Procjena boli učinjena je Upitnikom o boli koji je preuzet iz Sestrinske liste prema Procesu zdravstvene njege. Upitnik je samoprocjenski, odnosno ispitanik sam izabire vrijednost (broj) za koju smatra da najbolje odgovara jakosti boli koju doživljava. U upitniku se procjenjuje bol u raznim dijelovima tijela (uho, glava, ramena, leđa, zubobolja i općenito u tijelu) na ljestvici od 1 do 10 pri čemu 1 do 3 označava podnošljivu bol, 4 do 6 jaku bol, od 7 do 9 vrlo jaku bol i 10 nepodnošljivu bol. Za potrebe ovog istraživanja analizirani su odgovori na česticama „Označite do koje jačine trpite bol koja se pojavljuje općenito u tijelu" i „Označite do koje jačine trpite bol kod zubobolje kada se pojavi?". Rezultati su prikazani kao prosječne vrijednosti na ljestvici od 1 do 10.

Postupak

Ispitanici su najprije upoznati sa svrhom ispitivanja. Oni ispitanici koji su prihvatili sudjelovati u istraživanju dobili su na uvid informirani pristanak. Ispitanici su dobili i usmena pojaš-

Corah's scale of dental anxiety, the Dental Anxiety Scale (DAS), was used to probe dental anxiety levels. The scale contains four questions. The total score can range from 4 to 20. Scores 4-7 are considered normal levels, 8-11 indicate mild anxiety, 12-16 indicate moderate anxiety and 17-20 indicate dental phobia. The instrument is easy to use, takes little time to apply and it shows a higher level of correlation in comparison with more complex tests. The scale is very trustworthy when applied to children too, which is why it is used for both scientific experiments and everyday clinical work (24-27). In the present study, we did not separate dental anxiety and dental phobia, but we classified all the subjects who scored over 12 points on the DAS test together as one "dental anxiety/phobia" group.

Pain assessment was performed using a questionnaire from the Nursing assessment list according to the Nursing health process. The questionnaire is a self-assessment in style, meaning the subject chooses the value (numerical) for which they deem fits best the intensity of pain they are experiencing. The questionnaire asks the subjects to assess the pain in different parts of the body (ears, head, shoulders, back, toothache, general bodily pain) on a scale from 1 to 10, where 1 to 3 means a tolerable pain level, 4 to 6 indicates a strong pain level, 7 to 9 indicates a very strong pain level, and 10 means insufferable pain level. For the purpose of this research, the answers to the questions "Mark the pain level you endure when you feel pain in your body in general" and "Mark the pain level you endure when you feel toothache" were analyzed. The results are shown as average values on a scale from 1 to 10.

The procedure

The subjects were first informed of the purpose of the study. Those who agreed to participate were given the informed consent slip, the terms of which were also explained to them

njenja vezana za informirani pristanak. Cijeli postupak vodio je glavni istraživač, tada zubni asistent u stomatološkoj ordinaciji u kojoj je istraživanje provedeno. Svi podatci prikupljeni su prije ulaska u stomatološku ordinaciju, tj. prije stomatološkog zahvata tako da su svi ispitanici bili u očekivanju zahvata, tj. u anticipaciji ispitivanih osjećaja anksioznosti odnosno boli. Nakon potpisivanja informiranog pristanka zamoljeni su da popune samoprocjenske upitnike, predviđene za ovo istraživanje. Prethodno su dobili usmena objašnjenja za svaki upitnik. Upitnike su popunjavali u zasebnoj prostoriji, prije ulaska u stomatološku ordinaciju. Predviđene upitnike popunjavali su sljedećim redoslijedom: Opći upitnik, STAI X-1 , DAS – upitnik dentalne anksioznosti i Upitnik o boli.

Statistička obrada podataka

Podatci dobiveni tijekom istraživanja preneseni su na elektronički medij i obrađeni. Tekst je obrađen u programu Word 2007-365, a statistička obrada podataka učinjena je u programu "Statistica". Rezultati su prikazani u tablicama. Od statističkih metoda korišteni su t-test za ispitivanje razlika između skupina te Mann-Whitneyev test i hi-kvadrat test, kada nisu bili zadovoljeni uvjeti za korištenje parametrijskih testova. Statistički značajnom razlikom smatrane su vrijednosti p <0,05.

REZULTATI

U istraživanju je sudjelovalo 70 ispitanika, od čega 50 % (N=35) žena i 50% (N=35) muškaraca, u dobi 20-60 godina, prosječne dobi 39,46 godina. Oženjemo je bilo 57,4 % (N=39), a 36,8 % (N=25) neoženjeno. Od ukupnog broja 73,5 % (N=50) bilo je u trenutku ispitivanja zaposleno. Što se edukacije tiče 60 % (N=40) imalo je završenu srednju stručnu spremu (SSS), a 15,7 % (N=11) visoku stručnu spremu (VSS) (tablica 1).

orally. The procedure was led by the lead investigator, followed by the dental assistant at the dental office where the research took place. All data were collected before entering the dental office, i.e. before the dental procedure, so that all subjects were expecting the dental procedure, meaning they were in the state of anticipation of the feelings of anxiety and pain that were the topic of the study. Having signed the informed consent, patients were asked to fill out the self-assessment questionnaires prepared for this study. They were also given oral instructions for each questionnaire beforehand. They filled out the questionnaires in a separate room before entering the dental office. Patients filled out the questionnaires in the following order: the general questionnaire, STAI X-1, DAS – dental anxiety survey, and pain questionnaire.

Statistical analysis

The data obtained during the study were digitally processed. The text was typed in Microsoft Word 2007-365, and the statistical analysis was performed in Statistica. The results are shown in tables. The statistical methods used were: t-test for testing the difference between the groups and Manny-Whitney and Chi-squared test when conditions for use of parametric tests were not met. Statistically significant difference values were those where p<0.05.

RESULTS

A total of 70 subjects participated in the study, of which 50% (N=35) were men and 50% (N=35) were women, aged from 20-60, with the average age being 39.46 years. Among the subjects, 57.4% (N=39) were married and 36.8% (N=25) were not married, and 73.5% (N=50) were employed at the time of the study. With regard to education levels, 60% (N=40) had a high school diploma and 15.7% (N=11) had a university degree (Table 1).

TABLICA 1. Demografska obilježja ispitanika
TABLE 1. Demographic characteristics of the subjects

	N	%
Dob / Age		
20-29	15	21,4%
30-39	18	30%
40-49	23	30%
50-60	14	18,6%
Bračni Status / Marital status		
Neoženjen / Single	25	36,8%
Oženjen / Married	39	57,4%
Rastavljen / Divorced	4	5,9%
Udovac / Widowed	0	0
Radni status / Work status		
Zaposlen / Employed	50	73,5%
Nezaposlen / Unemployed	9	13,2%
Umirovljenik / Retired	5	7,4%
Student / Student	4	5,9%
Stručna sprema / Education		
KV / Elementary school	9	12,9%
SSS / High school diploma	42	60%
VKV / Associate degree	2	2,9%
VŠS / Bachelor's degree	4	5,7%
VSS / Master's degree	11	15,7%
Mr. Dr. Spec / Professional degree or higher	2	2,9%

Na upitnike STAI-X-1 i DAS odgovorilo je svih 70 ispitanika. Raspon odgovora na STAI-X-1 kretao se od 22 do 76 (M=44,06), a na upitniku DAS 4-20 (M=10,76). Na ljestvici opće boli odgovor je dalo 68 ispitanika koji su intenzitet opće boli ocijenili od 1 do 9 (M=5,04), dok je na ljestvici dentalne boli odgovor dalo 69 ispitanika koji su intenzitet dentalne boli ocijenili od 1 do 10 (M=5,54).

Ranije loše iskustvo povezano s odlaskom stomatologu doživjelo je 44 (62,8 %) ispitanika, dok ih je 26 (37,2 %) bez ranijeg lošeg iskustvo povezanog s odlaskom, stomatologu. Nelagodu kada moraju ići stomatologu osjeća 28 (40 %) ispitanika.

Ispitanici koji su doživjeli ranije loše iskustvo povezano s odlaskom stomatologu (M=11,7; SD=4,61) postižu statistički značajno veći rezultat na ljestvici dentalne anksioznosti (t =-2,419, ss= 68, p=0,018) u odnosu na ispitanike bez takvog iskustva (M=9,12, SD=3,9).

Ispitanici koji su doživjeli ranije loše iskustvo povezano s odlaskom stomatologu i imaju umjerenu do jaku dentalnu anksioznost postižu statistički značajno veći skor na ljestvici anksioznosti kao stanja (STAI-X-1) p<0,018 (tablica 2).

STAI-X-1 and DAS questionnaires were answered by all 70 subjects. The range of responses to STAI-X-1 was between 22 and 76 (M=44.06) and 4-20 (M=10.76) to DAS. As for the general pain scale, 68 subjects answered it with values ranging from 1 to 9 (M=5.04), while 69 subjects answered the dental pain scale that assessed their pain levels from 1 to 10 (M=5.54).

A total of 44 subjects (62.8%) had a previous unpleasant experience with the dentist, while 26 subjects (37.2%) did not have such an experience. When asked if they feel uneasiness upon going to the dentist, 28 subjects (40%) answered affirmatively.

The subjects who had a previous unpleasant experience with the dentist (M=11.7; SD=4.61) had statistically significant higher scores on dental anxiety scales (t =-2.419, ss= 68; p=0.018) in comparison with the subjects without such experience (M=9.12, SD=3.9).

The subjects who had a previous unpleasant experience with the dentist and a moderate to strong dental anxiety had statistically significant higher scores on the anxiety as a state scale (STAI-X-1) p<0.018 (Table 2).

TABLICA 2. Anksioznost kao stanje, opća i dentalna bol s obzirom na stupanj dentalne anksioznosti u ispitanika s lošim iskustvom povezanim s odlaskom stomatologu
TABLE 2. Anxiety (state), general and dental pain in relation to the level of dental anxiety in subjects with an unpleasant experience with a dentist during childhood

	Razina dentalne anksioznosti / Dental anxiety			
	Blaga (M ranga)[a] / Mild (M range)	Umjerena do jaka (M ranga)[a] / Moderate to strong (M range)	U[b]	p
Anksioznost kao stanje (STAI-X-1) / Anxiety (state) (STAI-X-1)	18,31	27,52	139,500	**0,018**
Opća bol / General pain	19,29	25,42	163,000	0,111
Dentalna bol / Dental pain	12,5	34,5	0,000	**<0,001**

Legenda: [a] aritmetička sredina ranga, [b] Mann Whitneyev U test

Ispitanici koji su doživjeli ranije loše iskustvo povezano s odlaskom stomatologu i imaju umjerenu do jaku dentalnu anksioznost postižu statistički značajno veći skor na ljestvici dentalne boli (DAS) p<0,001 (tablica 2).

S obzirom na stupanj opće boli, kod ispitanika koji su doživjeli ranije loše iskustvo povezano s odlaskom stomatologu, nije dobivena statistički značajna razlika između onih s blagom dentalnom anksioznosti u odnosu na one s umjerenom do jakom dentalnom anksioznosti (tablica 2).

Kako bismo ispitali odnos učestalosti odlaska na stomatološki pregled i razine dentalne anksioznosti primijenjen je hi-kvadrat test. Rezultati pokazuju da ispitanici s blagom dentalnom anksioznošću statistički značajno češće posjećuju stomatologa u odnosu na ispitanike s umjerenom do jakom dentalnom anksioznošću (χ^2=5,923, p=0,015).

RASPRAVA

Pošli smo od pretpostavke da ranije loše iskustvo povezano s odlaskom stomatologu (tijekom djetinjstva) utječe na porast dentalne anksioznosti odnosne dentalne fobije, da ispitanici s dentalnom anksioznošću/fobijom imaju niži prag za dentalnu bol te da ispitanici s višim stupnjem dentalne anksioznosti i dentalnom fobijom rjeđe posjećuju stomatologa. Ovo istraživanje učinjeno je na skupini ispitanika

The subjects who had a previous unpleasant experience with the dentist and had moderate to strong dental anxiety achieved statistically significant higher scores on the scale of dental pain (DAS) p<0.001 (Table 2).

Regarding the degree of general pain, there was no statistically significant difference in scores observed between the subjects with mild dental anxiety and strong mental anxiety, within the group of subjects who had a previous unpleasant experience with the dentist (Table 2).

The Chi-squared test was applied in order to examine the relation between the frequency of visiting the dentist for a checkup and the level of dental anxiety. The results showed that the subjects with mild dental anxiety visited the dentist statistically significant more often than those with moderate to strong dental anxiety (χ2=5.923, p=0.015).

DISCUSSION

The starting hypothesis of this paper was that a previous unpleasant experience with a dentist (during childhood) causes an increase in dental anxiety/phobia and that the subjects with dental anxiety/phobia have a lower level of pain tolerance. The subjects with a higher level of dental anxiety/phobia visit their dentist less often. This study was conducted on a group of subjects with average age of 39.46, married or single, most with high school diplomas and

prosječne dobi 39,46 godina, oženjeni ili samci, većina sa srednjoškolskim i visokoškolskim obrazovanjem te većina zaposleni (tablica 1).

Ranije loše iskustvo vezano za odlazak stomatologu povezano je s većom učestalosti dentalne anksioznosti/fobije

Rezultati ovog istraživanja pokazali su da ranije loše iskustvo povezano s odlaskom stomatologu utječe na stupanj dentalne anksioznosti (tablica 2). Rezultati ovog rada u skladu su s podatcima iz literature o dentalnoj anksioznosti. Dentalna anksioznost/fobija je neopravdan, nerealan, dugotrajan i pretjerano jaki strah (27). Neka istraživanja pokazala su da stupanj tolerancije nelagode (distresa) utječe na stupanj dentalne anksioznosti, na razinu straha od boli i osjetljivost na anksioznost kod stomatoloških bolesnika općenito (28). Dentalna anksioznost/fobija može utjecati na oralno zdravlje, izbjegavanje stomatološkog tretmana kao i na lošiju kvalitetu života povezanu s oralnim zdravljem (29). Xu i Xia kod skupine ispitanika ispitali su čimbenike koji utječu na dentalnu anksioznost pri vađenju trećeg molara i ustanovili da je razina dentalne anksioznosti, pored ostalog, veća kod onih s ranijim lošim iskustvom pri vađenju zuba te kod onih s lošijom samoprocjenom oralnog zdravlja (30,31).

Strah od odlaska stomatologu najčešće je stečeni strah temeljen na ranijim iskustvima u stomatološkoj ordinaciji. Ranije loše iskustvo uglavnom se odnosi a one pacijente koji su upoznali stomatologa kao djeca, kada je bila potrebna intervencija radi otklanjanja akutne boli: trauma, pulpitis (27). Rezultati našeg istraživanja podupiru pretpostavku da se loše iskustvo u djetinjstvu može upamtiti i da osobe s takvim iskustvom mogu imati posljedice i u odrasloj dobi. Važno je pažljivo se odnositi prema djeci korisnicima stomatoloških usluga kako bi se to izbjeglo.

some with university degrees, mostly employed and working (Table 1).

An earlier unpleasant experience with a dentist was connected to an increased frequency of dental anxiety/phobia

The results of this study show that an earlier unpleasant experience with a dentist influences the level of dental anxiety (Table 2). The results are congruent with the data about dental anxiety from the literature. Dental anxiety/phobia is an unjustifiable, unrealistic, long-term and overly strong fear (27). Some studies have shown that the level of tolerance to distress affects the level of dental anxiety, the level of fear of pain and the sensitivity to anxiety in dental patients in general (28). Dental anxiety/phobia can affect oral health, avoidance of seeking dental help and worse quality of life linked to oral health (29). Xu and Xia used a group of subjects to examine the factors that influence dental anxiety during extraction of the third molar and concluded that the dental anxiety levels, among other things, were greater among subjects with a previous unpleasant experience with tooth extraction and worse oral health self-assessment scores (30, 31).

The fear of visiting the dentist is most commonly an acquired fear based on earlier unpleasant experiences at the dental clinic. The unpleasant experience applies mostly to the patients who met the dentist as children, when they needed a treatment for soothing an acute pain: trauma, pulpitis (27). This study, as well as our own research results, support the hypothesis that an unpleasant experience during childhood can be remembered and that people with such an experience can suffer consequence even as adults. It is very important to carefully treat pediatric patients in order to avoid those consequences.

Na pojavu dentalne anksioznosti mogu utjecati i drugi čimbenici, kao na primjer drugi istodobno prisutni emocionalni problemi (27). Neka su istraživanja pokazala da negativno iskustvo povezano s odlaskom stomatologu uzrokuje direktno kondicioniranje, zatim, da značajan utjecaj može imati indirektno učenje iz iskustva drugih ljudi, utjecaj medija, doživljena bol, obilježja ličnosti kao i utjecaji iz obitelji i okoline (29,32,33).

U ovom smo radu ispitali anksioznost kao stanje, uz pomoć STAI-X-1 ljestvice koja mjeri različita obilježja anksioznosti unutar ličnosti pojedinca kao što je strepnja, napetost, nervoza i zabrinutost. Anksioznost izmjerena ovom ljestvicom ne odnosi se samo na dentalnu anksioznost već na anksioznost kao stanje u specifičnoj situaciji. U ovom istraživanju radi se o anksioznosti kao stanju u vrijeme ispitivanja. Dakle, ispitanici s višim stupnjem anksioznosti kao stanja pri posjetu stomatologu imali su viši stupanj strepnje, napetosti, zabrinutosti ili nervoze. Utvrdili smo da oni ispitanici koji imaju ranije loše iskustvo vezano za odlazak stomatologu i dentalnu anksioznost/fobiju imaju i viši stupanj anksioznosti kao stanja (tablica 2). U ovom istraživanju nisu učinjene analize koje bi potvrdile je li viši stupanj anksioznosti kao stanja rezultat ranijeg lošeg iskustva vezanog za odlazak stomatologu ili se radi o ispitanicima koji imaju viši stupanj anksioznosti kao crtu ličnosti (*trait*).

Dentalna anksioznost/fobija povezana je s višim rezultatima na ljestvici dentalne boli

Ispitanici s dentalnom anksioznošću/fobijom postigli su značajno više rezultate na ljestvici dentalne boli (tablica 2). Slične rezultate nalazimo i u literaturi. Viši stupanj anksioznosti povezan je s jačom očekivanom boli. Činjenica je da je ovakvih istraživanja malo na populaciji odraslih, dok su Lamarca i sur. ispitivanjem na

Other factors, such as concurrent emotional problems, may help cause the emergence of dental anxiety (27). Some studies have shown that negative dental experiences cause direct conditioning. Additionally, indirect leaning from the experience of others, the influence of the media, experienced pain, personality traits, family and surroundings can have a significant impact (29, 32, 33).

In the present study, we examined the level of the anxiety state using the STAI-X-1 scale, which measures anxiety traits within the individual's personality, such as dread, tension, nervousness and worriedness. The anxiety thus measured is not related to dental anxiety only, but to anxiety state in a specific situation. In the present study, what was measured was anxiety at the time of the test. Furthermore, the subjects with higher level of anxiety states, during the visit to the dentist had a higher level of dread, tension, worriedness and nervousness. The results of this study have shown that subjects with a previous unpleasant experience with the dentist and dental anxiety/phobia also have a higher level of anxiety state (Table 2). In the present study, no analyses were perform that would confirm or disprove whether the higher anxiety state was a result of a previous unpleasant experience with the dentist or if the subjects had higher levels of anxiety as a personality trait.

Dental anxiety/phobia is associated with higher dental pain scale results

In the present study, subjects with dental anxiety/phobia achieved statistically significant higher scores on the scale of dental pain (Table 2). These results are congruent with those in the literature. Higher level of anxiety was linked to the expected stronger pain. It is a fact that there have been few studies like this conducted on adults, while Lamarca et al. conduct-

uzorku djece dobili da su djeca s visokom razinom stresa i visokim stupnjem anksioznosti kao stanja i anksioznosti kao osobina ličnosti imali veću očekivanu bol. Očekivana bol bila je veća od percipirane boli tijekom zahvata. Anksioznost je utjecala na iskrivljenu procjenu očekivane boli (34,35). Slične rezultate nalazimo u radovima više autora uključujući Badela i sur. koji su našli da je orofacijalna bol povezana s višim stupnjem anksioznosti kao stanja (na ljestvici STAI-X-1), dok anksioznost kao obilježje ličnosti (na STAI-X-2 ljestvici) nije bila značajno povezana s orofacijalnom boli (36-38). De La Torre Canales u preglednom članku, temeljem 14 analiziranih radova, kod ispitanika s poremećajima u području temporomandibularnog zgloba koji su trpjeli bol (od čega ih 2,6 % do 24 % ima bol jakog intenziteta), našli su somatizacije umjerenog do teškog stupnja kod 28,5 % do 76,6 % te depresivnost umjerenog do teškog stupnja kod 21,4% do 60.1% ovih bolesnika (39). Iz ovog rada vidljivo je da je bol vezana za stomatognati sustav u vezi s nekim od emocionalnih stanja (somatizacije, depresivnost) slično kao što je i u našem istraživanju dentalna bol jače izražena kad je viša dentalna anksioznost/fobija.

Kod većine pacijenata je uvriježeno mišljenje da su mnogi medicinski zahvati povezani s određenom razinom boli ili nekim drugim oblikom nelagode. Smatra se da je stomatološka ordinacija na vrhu „top liste“ očekivane boli pa stoga i po broju ljudi koji imaju strah od odlaska stomatologu (27). Tako Dou i sur. nalaze da ispitanici s pulpitisom koji trpe jaku dentalnu bol u 83,1 % slučajeva imaju umjerenu do jaku dentalnu anksioznost (40). Bol ima krucijalnu ulogu u razvoju dentalne anksioznosti. Bol koja se javlja tijekom stomatološkog tretmana smatra se elementarnim razlogom za razvoj dentalne fobije (41-45). Osim čimbenika koji dolaze od bolesnika, važni su i čimbenici iz okoline. Više autora potvrdilo je dentalni strah kod roditelja važan čimbenik za razvoj dentalne anksiozno-

ed research on children and found that children with high levels of stress, high anxiety state and anxiety traits had greater expected pain scores. The expected pain was greater than the pain perceived during the procedure. Anxiety caused the patients to have a distorted view of the expected pain (34, 35). Other authors have reported similar findings, including Badel et al., who found that orofacial pain was linked to higher levels of anxiety state (STAI-X-1) while anxiety as personality trait (STAI-X-2 scale) was not significantly linked to orofacial pain (36-38). A review article by De La Torre Canales based on an analysis of 14 studies found that, for subjects with injuries associated with the temporomandibular joint that suffered pain (of which 2.6% do 24.0% suffered high intensity pain), somatizations of moderate to high levels were found in 28.5% to 76.6% of subjects and depression of moderate to high level in 21.4% to 60.1% of subjects (39). This paper shows that pain in the stomatognathic system is connected to some of the emotional states (somatization, depression), similarly to our own study where dental pain was also more prominent when the level of dental anxiety/phobia was higher.

Most patients think many medical procedures are associated with at least to some degree of pain or some other form of discomfort. In general, it is believed that dental clinics are at the top of the list of expected pain levels and the number of people who are afraid of going to the dentist (27). Dou et al. found that subjects with pulpitis that suffer strong dental pain have moderate to strong dental anxiety in 83.1% of cases (40). Pain plays a crucial role in the development of dental anxiety. Pain that emerges during a dental treatment is considered to be the elementary reason for development of dental phobia (41-45). Apart from the patient-related factors, environment factors matter too. Several authors have confirmed that dental fear in parents is an important fac-

sti/fobije (46,47), da je dentalna anksioznost/fobija povezana s dentalnom boli (48). Ova istraživanja idu u prilog povezanosti dentalne anksioznosti/fobije s dentalnom boli kao što smo i mi dobili našim istraživanjem.

Ispitanici s višim stupanjem dentalne anksioznosti i dentalnom fobijom rjeđe posjećuju stomatologa

Utvrdili smo da odrasle osobe s ranijim lošim iskustvom vezanim za odlazak stomatologu, a koje imaju viši stupanj dentalne anksioznosti i dentalnu fobiju rjeđe posjećuju stomatologa ($\chi 2=5{,}923$, $p=0{,}015$). Osim ovog istraživanja niz studija potvrdilo je da kod bolesnika s višim stupnjem dentalne anksioznosti postoji veća vjerojatnost da neće redovito odlaziti stomatologu ili će u potpunosti izbjegavati stomatološku skrb (14,49,50). Kao što je gore navedeno, ispitanici s ranijim lošim iskustvom povezanim s odlaskom stomatologu imaju veću razinu dentalne anksioznosti/fobije. U ovom istraživanju nisu rađene statističke analize kojima bismo dokazali da upravo oni ispitanici koji imaju ranije loše iskustvo povezano s odlaskom stomatologu rjeđe posjećuju stomatologa. Budući da ispitanici s ranijim lošim iskustvom povezanim s odlaskom stomatologu češće imaju dentalnu anksioznost/fobiju pretpostavljamo da bi loše ranije iskustvo moglo indirektno utjecati na učestalost posjeta stomatologu. Stoga želimo istaknuti da loše ranije iskustvo povezano s odlaskom stomatologu, kao i dentalna anksioznost/fobija može rezultirati lošijim oralnim zdravljem. Isto potvrđuje niz istraživanja. Na primjer, Doerr i sur. nalaze značajnu povezanost između dentalne anksioznosti i lošeg oralnog zdravlja (51). Eitner i sur. ustanovili su povezanost između povećane dentalne anksioznosti i karijesa (49). Izbjegavanje posjeta stomatologu, povezano s neugodnim iskustvima tijekom stomatološkog zahvata, počinje još u djetinjstvu (52,53).

tor in development of dental anxiety/phobia (46, 47), moreover, dental anxiety/phobia is connected to dental pain (48). These studies agree on the connection between dental anxiety/phobia and dental pain, similarly to our own findings.

The subjects with a higher level of dental anxiety and dental phobia visit the dentist less often

The results of this study have shown that adults with a previous unpleasant experience with the dentist visit the dentist less often ($\chi 2=5.923$, $p=0.015$). A number of studies confirmed that the patients with a higher level of dental anxiety have a higher probability of missing regular dentist appointments or of completely avoiding dental care (14, 49, 50). As mentioned above, the subjects with a previous unpleasant experience with the dentist have a higher level of dental anxiety/phobia, which can result in worse oral health, as confirmed by several research papers. No statistical analyses were perform as a part of this research that would demonstrate that exactly those subjects who had an unpleasant earlier experience with a dentist visit the dentist less often. Since the subjects with an unpleasant earlier experience with a dentist were more commonly found to have dental anxiety/phobia, we assume the earlier unpleasant experience could indirectly affect the frequency of the visits to the dentist. Therefore, we wish to point out that an unpleasant earlier experience with a dentist, as well as dental anxiety/phobia, can result in worsened oral health. The above has been confirmed in a number of studies. For example, Doerr et al. found a significant connection between dental anxiety and bad oral health (51). Eitner et al. established a connection between increased dental anxiety and dental caries (49). Avoiding dentist appointments linked to an unpleasant experience begins at an early age (52, 53).

Uzevši u obzir gore navedene nalaze može se zaključiti da prevencija dentalne anksioznosti počinje u dječjoj dobi prevencijom lošeg iskustva povezanog s odlaskom stomatologu. Osobe koje nemaju dentalnu anksioznost redovito će posjećivati stomatologa. Dakle, prevencija lošeg iskustva povezanog s odlaskom stomatologu na indirektan način utječe na zaštitu oralnog zdravlja.

S ciljem prevencije lošeg iskustva tijekom stomatološkog zahvata stručnjaci na području dentalne medicine primjenjuju različite tehnike, uključujući tehnike distrakcije pažnje, kao što je virtualna stvarnost (54-57) ili računalne igrice (58,59), kako u radu s djecom tako i u radu sa stomatološkim pacijentom u odrasloj dobi.

Smatra se kako će odrasli koji imaju dentalnu anksioznost/fobiju izbjegavati odlazak stomatologu kao i stomatološke zahvate. Epidemiološka istraživanja pokazuju da oko 5-10 % odraslih zbog straha ne odlazi na redovite preglede (20). Izbjegavanje posjeta stomatologu, osim na oralno zdravlje može utjecati i na kvalitetu života vezanu za oralno zdravlje, kao što su ustanovili Gisler i sur. Isti autori pronašli su da ispitanici s visokim stupnjem dentalne anksioznosti imaju 3,55 puta više izgleda za lošiju kvalitetu života povezanu s oralnim zdravljem u odnosu na one s nižim stupnjem dentalne anksioznosti (60).

Rezultati ovog istraživanja u skladu su s nizom gore citiranih istraživanja te potvrđuju kako je loše iskustvo vezano za odlazak stomatologu u djetinjstvu rizik za pojavu dentalne anksioznosti, a dentalna anksioznost je potom prepreka redovitim posjetima stomatologu. Isto može rezultirati lošijom skrbi za oralno zdravlje.

ZAKLJUČCI

Temeljem rezultata ovog istraživanja možemo zaključiti da ranije neugodno iskustvo povezano s odlaskom stomatologu utječe na pojavu

Taking the above into consideration, we can conclude that the prevention of dental anxiety begins in childhood by preventing unpleasant experiences with the dentist. Persons without dental anxiety will visit the dentist more often. Thus, prevention of an unpleasant experience with the dentist indirectly affects oral health.

Experts in the field of dental medicine employ different techniques with the goal of preventing an unpleasant experience with the dentist, including attention distraction, virtual reality (54-57) or video games (58, 59), both when working with children and when working with adults.

It is believed that adults with dental anxiety/phobia will avoid the dentist and dental procedures. Epidemiological research shows that 5-10% of adults miss regular appointments due to fear (20). Apart from influencing oral health, avoiding the dentist can have an impact on quality of life, as established by Gisler et al. These authors found that subjects with a high level of dental anxiety had a 3.55 times higher chance of having worse quality of life related to oral health in comparison with those with lower levels of dental anxiety (60).

The results of the present study are congruent with the results of a number of research papers mentioned above and confirm that an unpleasant experience in childhood poses a risk for developing dental anxiety, which itself becomes an obstacle to regular dentist visits. The abovementioned can result in worse dental care.

CONCLUSIONS

Based on the results of this study, we can conclude that a previous unpleasant experience with the dentist helps the development of dental anxiety and dental phobia. Persons with a previous unpleasant experience with

dentalne anksioznosti i dentalne fobije. Osobe s ranijim neugodnim iskustvom povezanim s odlaskom stomatologu i višom razinom dentalne anksioznosti odnosno dentalnom fobijom, imaju i viši stupanj anksioznosti kao stanja. Dentalna anksioznost/fobija kod osoba s ranijim neugodnim iskustvom povezanim s odlaskom stomatologu povezana je i s nižim pragom za dentalnu bol, ali ne i s nižim pragom za bol općenito. Viši stupanj dentalne anksioznosti i dentalna fobija povezani su s rjeđim posjetima stomatologu.

Za pretpostaviti je da ovakvo ponašanje može biti jedan od čimbenika za razvoj dentalne patologije budući da takvi pojedinci izbjegavaju preventivne preglede i pravovremene stomatološke intervencije s ciljem zaštite i održavanja zdravlja usne šupljine. Kako bismo izbjegli razvoj dentalne anksioznosti i dentalne fobije važno je prevenirati loše iskustvo povezano s odlaskom stomatologu tijekom djetinjstva. Dakle, potrebno se s pažnjom odnositi prema djeci pri stomatološkim intervencijama, a kod odraslih stomatoloških bolesnika imati na umu dentalnu anksioznost/fobiju pri planiranju preventivnih mjera kao i pri stomatološkim intervencijama.

OGRANIČENJA ISTRAŽIVANJA

Ograničenja ovog istraživanja odnose se na relativno mali uzorak ispitanika čime je generalizacija dobivenih rezultata upitna. Povezano s ispitivanjem anksioznosti kao stanja te ispitivanjem dentalne boli uzorak nije homogeniziran s obzirom da svi ispitanici nisu očekivali isti stomatološki zahvat. Skupinu nismo homogenizirali prema ovom kriteriju, jer smo smatrali da će skupina s ranijim lošim iskustvom imati viši stupanj anksioznosti kao stanja bez obzira na zahvat koji očekuje. Činjenica je da bismo dobili relevantnije podatke da je uzorak homogeniziran i prema stomatološkom zahvatu koji se očekuje. Povezano s učestalošću posjeta stomatologu naši su rezultati pokazali da ispi-

the dentist and higher levels of dental anxiety/phobia also have a higher level of state anxiety. Dental anxiety/phobia in persons with a previous unpleasant experience with the dentist is linked to lower tolerance to dental pain, but not with lower tolerance to pain in general. A higher degree of dental anxiety and dental phobia are associated with less frequent visits to the dentist.

This type of behavior can be one of the factors in the development of dental pathology, since such individuals avoid preventive checkups and timely dental procedures with the goal of protecting and maintaining oral health. In order to avoid the development of dental anxiety and dental phobia, it is important to prevent unpleasant experiences with dentists during childhood. Special attention and care must be given to children during dental procedures, and with adults it is necessary to bear in mind and be wary of dental anxiety/phobia when planning preventive measures as well as during dental procedures.

STUDY LIMITATIONS

The limitations of this study are tied to the relatively small subject sample, which makes the generalization of the results questionable. In terms of investigating state anxiety and dental pain, the sample is not homogenized, since not all subjects were awaiting the same dental procedure. The sample could not be homogenized according to this criterion because we were of the opinion that the group with an unpleasant earlier experience would have a higher degree of state anxiety no matter what dental procedure they were expecting. The fact is that we would have gotten more relevant data had the sample been homogenized according to the expected dental procedure. In terms of the frequency of visits to the dentist, our results have shown that the subjects with dental anxiety/phobia visit the dentist less often. We deem

tanici s dentalnom anksioznošću/fobijom rjeđe odlaze stomatologu. Smatramo važnim ispitati i utječe li loše iskustvo u djetinjstvu na učestalost posjeta stomatologu u odrasloj dobi, odnosno bilo bi vrijedno učiniti „analize traga" i ispitati je li ispitanici s lošim ranijim iskustvom povezanim s odlaskom stomatologu koji razviju dentalnu anksioznost/fobiju rjeđe odlaze stomatologu ili je loše ranije iskustvo direktno povezano s učestalošću posjeta stomatologu.

it important to investigate if an unpleasant experience in childhood has an effect on the frequency of visiting the dentist during adulthood, which means it would be worthwhile to do "trace analyses" and investigate if the subjects with an unpleasant earlier experience with the dentist who develop dental anxiety/phobia visit the dentist less often or if the earlier unpleasant experience is directly tied to the frequency of the visits.

LITERATURA / *REFERENCES*

1. Barauskas I, Barauskienė K, Janužis G. Dental anxiety and self-perceived stress in Lithuanian University of Health Sciences hospital patients: a cross-sectional study. Stomatologija 2019; 21(2): 42-6.
2. Randall CL, Shaffer JR, McNeil DW, Crout RJ, Weyant RJ, Marazita ML. Toward a genetic understanding of dental fear: evidence of heritability. Community Dent Oral Epidemiol 2017; 45(1): 66-73.
3. De Stefano R. Psychological factors in dental patient care: odontophobia. Medicina (Kaunas) 2019; 55(10): 678.
4. Singh H, Bhaskar DJ, Rehman R. Psychological aspects of odontophobia. Int J Dent Med Res 2015; 1(6): 210-12.
5. Facco E, Zanette G. The Odyssey of dental anxiety from prehistory to the present: a narrative review. Front Psychol 2017; 8: 1155.
6. Enkling N, Marwinski G, Jöhren P. Dental anxiety in a representative sample of residents of a large German city. Clin Oral Invest 2006; 10: 84-91.
7. Pohjola V, Rekola A, Kunttu K, Virtanen JI. Association between dental fear and oral health habits and treatment need among university students in Finland: a national study. BMC Oral Health 2016; 16: 26.
8. Quteish Taani DS. Dental fear among a young adult Saudian population. Int Dent J 2001; 51: 62-6.
9. Appukuttan D, Subramanian S, Tadepalli A, Damodaran LK. Dental anxiety among adults: an epidemiological study in South India. N Am J Med Sci 2015; 7: 13-18.
10. Halonen H, Salo T, Hakko H, Räsänen P. The association between dental anxiety, general clinical anxiety and depression among Finnish university students. Oral Health Dent Manag 2014; 13: 320-5.
11. Humphris G, Crawford JR, Hill K, Gilbert A, Freeman R. UK population norms for the modified dental anxiety scale with percentile calculator: adult dental health survey 2009 results. BMC Oral Health 2013; 13: 29.
12. Smith AJE, Bildt MM. Serie: Communicatie in de tandartspraktijk. Omgaan met angst in de tandartspraktijk [Series: Communication in the dental practice. Dealing with anxiety in the dental office]. Ned Tijdschr Tandheelkd 2019; 126(11): 571-8.
13. Costa LR, Bendo CB, Daher A, Heidari E, Rocha RS, de Sousa Costa Moreira AP *et al.* A curriculum for behaviour and oral healthcare management for dentally anxious children - recommendations from the Children Experiencing Dental Anxiety: collaboration on research and education (CEDACORE). Int J Paediatr Dent 2020; 30(5): 556-69.
14. Singh A, Shukla A, Gupta S, Srivastava R. Odontophobia and the cycle of avoidance: A review. J Clin Den Res Edu 2015; 4(11): 40-8.
15. Sheshukova OV, Polishchuk TV, Kostenko VG, Trufanova VP, Bauman SS, Davydenko VY. Consideration of childhood psychological factors at dental appointment. Wiad Lek 2018; 71(7): 1305-09.
16. Al Qhtani FA, Pani SC. Parental anxiety associated with children undergoing dental treatment. Eur J Paediatr Dent 2019; 20(4): 285-9.
17. Felemban OM, Alshoraim MA, El-Housseiny AA, Farsi NM. Effects of familial characteristics on dental fear: A cross-sectional study. J Contemp Dent Pract 2019; 20(5): 610-15.
18. Alsadat FA, El-Housseiny AA, Alamoudi NM, Elderwi DA, Ainosa AM, Dardeer FM. Dental fear in primary school children and its relation to dental caries. Niger J Clin Pract 2018; 21(11): 1454-60.
19. Packyanathan JS, Lakshmanan R, Jayashri P. Effect of music therapy on anxiety levels on patient undergoing dental extractions. J Family Med Prim Care 2019; 8(12): 3854-60.
20. Shetty V, Suresh LR, Hegde AM. Effect of virtual reality distraction on pain and anxiety during dental treatment in 5 to 8 year old children. J Clin Pediatr Dent 2019; 43(2): 97-102.
21. Khandelwal M, Shetty RM, Rath S. Effectiveness of distraction techniques in managing pediatric dental patients. Int J Clin Pediatr Dent 2019; 12(1): 18-24.
22. Kruse AB, Heil HK, Struß N, Fabry G, Silbernagel W, Vach K *et al*. Working experience is not a predictor of good communication: Results from a controlled trial with simulated patients. Eur J Dent Educ 2020; 24(2): 177-85.
23. Spielberger CD. Priručnik za upitnik anksioznosti kao stanja i osobine ličnosti STAI. Jastrebarsko: Slap, 2001.

24. Newton JT, Buck DJ. Anxiety and pain measures in dentistry: A guide to their quality and application. J Am Dent Assoc 2000; 131: 1449-57.
25. Smith, TA, Heaton LJ. Fear of dental care: are we making any progress? J Am Dent Assoc 2003; 134: 1101-08.
26. Armfield JM. How do we measure dental fear and what are we measuring anyway? Oral Health Prev Dent 2010; 8(2): 107-15.
27. Zarevski P, Škrinjarić I, Vranić A. Psihologija za stomatologe. Obrazac o dentalnoj anksioznosti. Jastrebarsko: Naklada Slap, 2005.
28. Addicks SH, McNeil DW, Randall CL, Goddard A, Romito LM, Sirbu C *et al*. Dental care–related fear and anxiety: distress tolerance as a possible mechanism. JDR Clin Trans Res 2017; 2(3): 304-11.
29. Carter AE, Carter G, Boschen M, Al Shwaimi E, George R. Pathways of fear and anxiety in dentistry: a review. World J Clin Cases 2014; 12(11): 642-53.
30. Xu JL, Xia R. Influence factors of dental anxiety in patients with impacted third molar extractions and its correlation with postoperative pain: a prospective study. Med Oral Patol Oral Cir Bucal 2020; 25(6): 714-19.
31. Tarazona-Álvarez P, Pellicer-Chover H, Tarazona-Álvarez B, Peñarrocha-Oltra D, Peñarrocha-Diago M. Hemodynamic variations and anxiety during the surgical extraction of impacted lower third molars. J Clin Exp Dent 2019; 11(1): e27-e32.
32. Locker D, Liddell A, Dempster L, Shapiro D. Age of onset of dental anxiety. J Dent Res 1999; 78(3): 790-6.
33. Drachev SN, Brenn T, Trovik TA. Prevalence of and factors associated with dental anxiety among medical and dental students of the Northern State Medical University, Arkhangelsk, North-West Russia. Int J Circumpolar Health 2018; 77(1): 1454786.
34. De A. Lamarca G, Vettore MV, Angela M, da Silva M. The Influence of stress and anxiety on the expectation, perception and memory of dental pain in school children. Dent J (Basel) 2018; 6(4): 60.
35. Reyes-Gilabert E, Luque-Romero LG, Bejarano-Avila G, Garcia-Palma A, Rollon-Mayordomo A, Infante-Cossio P. Assessment of pre and postoperative anxiety in patients undergoing ambulatory oral surgery in primary care. Med Oral Patol Oral Cir Bucal 2017; 22(6): e716-e722.
36. Badel T, Zadravec D, Bašić Kes V, Smoljan M, Kocijan Lovko S, Zavoreo I *et al*. Orofacial pain – diagnostic and therapeutic challenges. Acta Clin Croat 2019; 58(Suppl 1): 82-9.
37. Turp JC. Failure in chronic pain therapy across the disciplines. Craniomand Func 2017; 9: 197-208.
38. Badel T, Kocijan Lovko, S, Zadravec, D. Anxiety and temporomandibular disorders: a relationship in chronic pain development. In: Shiloh AR (ed.) Anxiety disorders - Risk factors, genetic determinants and cognitive-behavioral disorders. New York: Nova Science Publishers, 2014.
39. De La Torre Canales G, Câmara-Souza MB, Muñoz Lora VRM, Guarda-Nardini L, Conti PCR, Rodrigues Garcia RM *et al*. Prevalence of psychosocial impairment in temporomandibular disorder patients: a systematic review. J Oral Rehabil 2018; 45(11): 881-889.
40. Dou L, Vanschaayk MM, Zhang Y, Fu X, Ji P, Yang D. The prevalence of dental anxiety and its association with pain and other variables among adult patients with irreversible pulpitis. BMC Oral Health 2018; 18(1): 101.
41. van Wijk AJ, Hoogstraten J. Experience with dental pain and fear of dental pain. J Dent Res 2005; 84(10): 947-50.
42. Rohleder N, Wolf JM, Maldonado EF, Kirschbaum C. The psychosocial stress-induced increase in salivary alpha-amylase is independent of saliva flow rate. Psychophysiology 2006; 43(6): 645-52.
43. Lee KC, Bassiur JP. Salivary alpha amylase, dental anxiety, and extraction pain: a pilot study. Anesth Prog 2017; 64(1): 22-8.
44. Jeddy N, Nithya S, Radhika T, Jeddy N. Dental anxiety and influencing factors: a cross-sectional questionnaire-based survey. Indian J Dent Res 2018; 29(1): 10-15.
45. Wiener RC. Dental fear and delayed dental care in Appalachia-West Virginia. J Dent Hyg 2015; 89(4): 274-81.
46. Dahlander A, Soares F, Grindefjord M, Dahllöf G. Factors associated with dental fear and anxiety in children aged 7 to 9 years. Dent J (Basel) 2019; 7(3): 68.
47. Wu L, Gao X. Children's dental fear and anxiety: exploring family related factors. BMC Oral Health 2018; 18(1): 100.
48. Youn-Soo S, Ah-Hyeon K, Eun-Young J, So-Youn A. Dental fear & anxiety and dental pain in children and adolescents; a systemic review. J Dent Anesth Pain Med 2015; 15(2): 53-61.
49. Eitner S, Wichmann M, Paulsen A, Holst S. Dental anxiety - an epidemiological study on its clinical correlation and effects on oral health. J Oral Rehabil 2006; 33(8): 588-93.
50. Armfield JM, Stewart JF, Spencer AJ. The vicious cycle of dental fear: exploring the interplay between oral health, service utilization and dental fear. BMC Oral Health 2007; 7: 1.
51. Doerr PA, Lang WP, Nyquist LV, Ronis DL. Factors associated with dental anxiety. J Am Dent Assoc 1998; 129(8): 1111-19.
52. Alshoraim MA, El-Housseiny AA, Farsi NM, Felemban OM, Alamoudi NM, Alandejani AA. Effects of child characteristics and dental history on dental fear: cross-sectional study. BMC Oral Health 2018; 18(1): 33.
53. Ahmad A, Ayub Kazi MS, Ahmad I. Evaluation of dental anxiety among children visiting Paediatric Dental Department at Children Hospital. J Pak Med Assoc 2017; 67(10): 1532-5.
54. López-Valverde N, Muriel-Fernández J, López-Valverde A, Valero-Juan LF, Ramírez JM, Flores-Fraile J *et al*. Use of virtual reality for the management of anxiety and pain in dental treatments: a systematic review and meta-analysis. J Clin Med 2020; 9(10): 3086.
55. Ougradar A, Ahmed B. Patients' perceptions of the benefits of virtual reality during dental extractions. Br Dent J 2019; 227(9): 813-16.

56. Carl E, Stein AT, Levihn-Coon A, Pogue JR, Rothbaum B, Emmelkamp P *et al.* Virtual reality exposure therapy for anxiety and related disorders: a meta-analysis of randomized controlled trials. J Anxiety Disord 2019; 61: 27-36.
57. Raghav K, Van Wijk AJ, Abdullah F, Islam MN, Bernatchez M, De Jongh A. Efficacy of virtual reality exposure therapy for treatment of dental phobia: a randomized control trial. BMC Oral Health 2016; 16: 25.
58. Elicherla SR, Bandi S, Nuvvula S, Challa RS, Saikiran KV, Priyanka VJ. Comparative evaluation of the effectiveness of a mobile app (Little Lovely Dentist) and the tell-show-do technique in the management of dental anxiety and fear: a randomized controlled trial. J Dent Anesth Pain Med 2019; 19(6): 369-78.
59. Meshki R, Basir L, Alidadi F, Behbudi A, Rakhshan V. Effects of pretreatment exposure to dental practice using a smartphone dsental simulation game on children's pain and anxiety: a preliminary double-blind randomized clinical trial. J Dent (Tehran) 2018; 15(4): 250-8.
60. Gisler V, Bassetti R, Mericske-Stern R, Bayer S, Enkling N. A cross-sectional analysis of the prevalence of dental anxiety and its relation to the oral health-related quality of life in patients with dental treatment needs at a university clinic in Switzerland. Gerodontology 2012; 29(2): e290-e296.

Martina Barbiš

Psihijatrijska hospitalizacija: poštivanje etičkih načela i stigmatizacija

/ Psychiatric Hospitalization: Estimation of Ethical Principles and Stigmatization

Zagreb: Izvori, 2019, str. 234.
/ Zagreb: Izvori, 2019, p. 234.

Prava osoba s mentalnim poremećajima se često krše, stoga su zaštićena Konvencijom o pravima osoba s invaliditetom, kao i drugim internacionalnim i nacionalnim zakonima. Svjetska zdravstvena organizacija u okviru inicijative *Qaulity Rights* izradila je niz edukativnih materijala kako bi pomogla transformaciju institucija skrbi o mentalnom zdravlju prema oporavku i poštivanju ljudskih prava. U sklopu ove inicijative također je izrađen alat za procjenu stanja kvalitete liječenja i poštivanja ljudskih prava. Poštivanje ljudskih prava je usko povezano s kvalitetom liječenja i ishodom liječenja, stoga su istraživanja postojećeg stanja poštivanja ljudskih prava više nego dobrodošla da bi pomogla u implementaciji promjena koje imaju za cilj poboljšanje kvalitete i ishoda liječenja. U ovom kontekstu je značajno istraživanje Martine Barbiš objavljeno u ovoj knjizi koje u fokus stavlja iskustva pacijenata liječenih u psihijatrijskim institucijama. Istraživanje je provedeno tijekom 2014. i 2015. godine. U istraživanju je sudjelovalo 214 osoba s iskustvom hospitalizacije na različitim psihijatrijskim odjelima i bolnicama u Hrvatskoj, s različitim teškoćama mentalnog zdravlja (najviše zastupljene dijagnoze: alkoholizam, depresija i shizofrenija).

The rights of persons with mental disorders are often violated and are therefore protected by the Convention on the Rights of Persons with Disabilities, as well as other international and national laws. As part of the Quality Rights initiative, the World Health Organization has developed a series of educational materials to help transform mental health care institutions on their way towards recovery and respect for human rights. As part of this initiative, a tool has also been developed to assess the quality of treatment and respect for human rights. Respect for human rights is closely linked to the quality and outcomes of treatment. For that reason, a study on the current state of respect for human rights is more than welcome to help implement changes aimed at improving the quality and outcomes of treatment. In this context, Martina Barbiš published a very important study in this book, focusing on the experiences of patients treated in psychiatric institutions. The study was conducted during 2014 and 2015. It involved 214 persons who experienced hospitalization in various psychiatric wards and hospitals in Croatia due to various mental health problems (the most common diagnoses were alcoholism, depression and schizophrenia).

Cilj: Cilj istraživanja bio je dobiti uvid u poštivanje etičkih načela u psihijatrijskim institucijama ispitivanjem učestalosti etičkih prijestupa tijekom psihijatrijske hospitalizacije. Također, namjera je bila opisati pozitivne i negativne postupke zdravstvenih radnika i iznijeti preporuke pacijenata što pomaže u liječenju. Istraživanjem se također željelo utvrditi je li iskustvo hospitalizacije povezano sa samostigmatizacijom.

Metode: Za utvrđivanje etičkih prijestupa osoblja korišten je *Upitnik prijestupa etičkih načela u zdravstvenoj skrbi* (Brueggemann i sur., 2012), a za utvrđivanje samostigmatizacije *Inventar internalizirane stigme psihičkih poremećaja* (Boyd Ritsher, Otilingam i Grajales, 2003). U upitniku prijestupa etičkih načela opisana su 23 događaja koja operacionaliziraju prijestup pet etičkih načela u zdravstvenoj skrbi: *autonomija*, *pravda*, *tjelesna nepovredivost*, *integritet* i *seksualna nepovredivost* . Primjer čestice je „Jeste li ikada u psihijatrijskoj skrbi u Hrvatskoj doživjeli da niste bili adekvatno informirani?“. Inventar internalizirane stigme kojim se utvrđivala samostigmatizacija je dobro poznat instrument koji je već korišten u istraživanjima u Hrvatskoj, konstruiran za mjerenje subjektivnog doživljaja stigme, a sadrži pet podljestvica *Otuđenje* (subjektivni doživljaj obezvrijeđenosti kao člana društva); *Odobravanje stereotipa* (stupanj slaganja s općenitim stereotipima o ljudima koji imaju psihički poremećaj); *Doživljaj diskriminacije* (percepcija načina na koji ih drugi ljudi trenutno tretiraju); *Socijalno povlačenje* i *Otpornost na stigmu* (iskustvo odupiranja stigmi).

Rezultati: Nalazi dobiveni primjenom *Upitnika prijestupa etičkih načela u zdravstvenoj skrbi* pokazuju da je najveći broj prijestupa doživljen u području etičkog načela autonomije (neadekvatno informiranje, neuvažavanje mišljenja, nepružanje vremena za razmišljanje o npr. drugim opcijama, neslušanje), dok je najmanje prijestupa bilo u području načela seksualne nepovredivosti. Polovina sudionika istraživanja

Objective: The objective of this research was to gain insight into the observance of ethical principles in psychiatric institutions by examining the frequency of ethical breaches during psychiatric hospitalization. In addition to that, the intention was to describe both positive and negative actions undertaken by health professionals and present patients' recommendations to improve treatment. The study also sought to determine whether the experience of hospitalization was associated with self-stigmatization.

Methods: *The Transgressions of Ethical Principles in Health Care Questionnaire* (Brueggemann et al., 2012) was used to identify ethical transgressions by staff, and the *Inventory of Internal Stigma of Psychiatric Disorders* (Boyd Ritsher, Otilingam and Grajales, 2003) was used to determine self-stigmatization. The Transgressions of Ethical Principles in Health Care Questionnaire described 23 events that operationalize the transgression of five ethical principles in health care: *autonomy*, *justice*, *bodily integrity*, *integrity*, and *sexual inviolability*. One example of a question is "Have you ever felt inadequately informed while receiving psychiatric care in Croatia?" The Inventory of Internalized Stigma, which was used to determine self-stigmatization, is a well-known instrument already used in research in Croatia. It was designed to measure the subjective experience of stigma and it comprises five subscales: *alienation* (subjective experience of being devalued as a member of society); *approval of stereotypes* (degree of agreement with general stereotypes about people with mental disorders); *experience of discrimination* (perception of the way other people currently treat them); *social withdrawal* and *resistance to stigma* (experience of resisting stigma).

Findings: The findings of the *Transgressions of Ethical Principles in Health Care Questionnaire* indicate that the majority of transgressions were experienced in the domain of the autonomy principle (inadequate information, disregard

doživjelo je da nije bilo adekvatno informirano, a svaka treća osoba navela je da je osjećala kako mora prihvatiti tretman protiv vlastite volje zbog straha od prisile ili zlostavljanja ako to ne učini. Da je bolničko liječenje bilo protiv njihove volje navelo je 22 % osoba. Ovi rezultati upozoravaju na neusklađenost postupanja sa *Zakonom o pravima osoba s duševnim smetnjama* koji nalaže da osoba mora biti sveobuhvatno informirana o razlozima za prijam u psihijatrijsku ustanovu kako bi mogla donijeti svoju odluku o liječenju, koja mora biti slobodna i ničim uvjetovana. Glede načela pravde, 36 % osoba smatra kako nije dobilo skrb kakvu misle da im je potrebna, što ukazuje na potrebu planiranja liječenja na temelju individualnog plana liječenja. U području etičkog načela integriteta, gotovo svaka treća osoba se osjećala zaboravljeno ili zanemareno, a čak je 26 % doživjelo ponižavanje od osoblja. S obzirom na etičko načelo tjelesne nepovredivosti, 19 % osoba doživjelo je da je osoblje provodilo pregled/tretman na pretjerano grub način, a 8 % je doživjelo prijetnju da će ih netko udariti, 31 % sudionika je doživjelo da su zaboravljeni ili zanemareni, a 13 % je smatralo da je prekršena profesionalna tajna, 11 % ispitanika nije imalo privatnost kod svlačenja, a 10 % je doživjelo komentiranje svoga tijela sa seksualnim prizvukom. Žene su doživjele veći broj prijestupa etičkih načela od strane osoblja nego muškarci. Najmanje prijestupa doživjele su osobe koje su imale dijagnoze povezane s alkoholom, a najviše osobe koje su imale dijagnoze shizofrenije i psihoze. Više je prijestupa bilo na zatvorenim odjelima. Također, osobe najlošije financijske situacije i osobe koje su svoje opće zdravstveno stanje procijenile lošijim doživjele su veći broj prijestupa.

Istraživanjem samostigmatizacije utvrđeno je kako većina sudionika (70 %) sebe gotovo da i ne samostigmatizira, a 22 % iskazalo je blago internaliziranu stigmu. Osoba s umjerenom stigmatizacijom bilo je 6,5 %, a onih koji se snaž-

for opinions, failure to provide sufficient time for considering other options, failure to listen), while the least transgressions were found in the domain of the sexual inviolability principle. One half of the survey participants perceived that they were not adequately informed, and one third stated that they felt they had to accept treatment against their own will for fear of coercion or abuse. 22% of the participants stated that they were treated in hospital against their will. These findings point to non-compliance with the *Law on Protection of Persons with Mental Disorders* that stipulates that a person must be comprehensively informed about the reasons for admission to a psychiatric institution in order to be able to make his or her own decision on treatment, which must be free and unconditional. In regard to the principle of justice, 36% of the participants expressed that they had not received appropriate care, which points to the need to plan treatments based on individual treatment plans. In the domain of the integrity principle, almost every third person felt forgotten or neglected, and as many as 26% of the participants experienced humiliation from staff. In regard to the bodily integrity principle, 19% of the participants experienced that the staff conducted the examination/treatment in an excessively crude manner, 8% experienced the threat of being hit, 31% felt forgotten or neglected, 13% felt that professional secrecy had been breached, 11% of the respondents did not have privacy when undressing while 10% experienced commenting on their body with sexual overtones. Women experienced more transgressions of ethical principles by staff than men. The least number of transgressions were experienced by persons who had diagnoses related to alcohol, and the most by persons who were diagnosed with schizophrenia and psychosis. More transgressions took place in closed wards. Also, persons in a poorer financial situation and persons who assessed their general health condition as poor experienced a greater number of transgressions.

no samostigmatiziraju samo 2 %. Najmanji su stupanj samostigmatizacije iskazale osobe koje su imale dijagnoze povezane s alkoholom, dok su se najviše samostigmatizirale osobe koje su dobile dijagnoze shizofrenije i psihoze. Moguće je da su ovakvi nalazi niske samostigmatizacije povezani s odabirom ispitanika. Naime, gotovo polovina sudionika istraživanja pohađala je psihoterapiju ili savjetovanje koji mogu imati osnažujući učinak, dok je grupu podrške koja također može djelovati osnažujuće na svoje članove, pohađalo čak 55 % sudionika istraživanja. Utvrđeno je da je samostigmatizacija povezana s brojem doživljenih etičkih prijestupa od strane osoblja u psihijatrijskim insitucijama. Istraživanje je potvrdilo protektivni učinak socijalne mreže prijateljskih odnosa.

Zanimljivi dio ove knjige je također kvalitativno istraživanje. U ovom dijelu istraživanja od sudionika istraživanja je traženo da opišu pozitivno ili negativno iskustvo s osobljem unutar psihijatrijskog zdravstvenog sustava u RH. Također je traženo da iznesu svoje mišljenje kakvo postupanje osoblja pomaže u liječenju. Osobna iskustva pokazuju više od statističkih podataka i suočavaju nas s posljedicama našeg ponašanja na druge ljude te mogu stimulirati poželjna ponašanja koja su ne samo važna za etičko postupanje nego i za uspjeh liječenja.

Zaključno: Rezultati istraživanja prikazani u ovoj knjizi upozoravaju na važnost poštivanja etičkih načela / ljudskih prava u psihijatrijskim institucijama i kreiranje terapijske atmosfere dobrovoljnosti i oporavka koja se povezuje s najboljim rezultatima liječenja. Opisana osobna iskustva pacijenata pokazuju više od statističkih podataka i upozoravaju na obavezu postupanja baziranu na poštivanju ljudskih prava koja uključuju pravo na autonomiju u odlučivanju, poštivanje dostojanstva i individualni plan liječenja. Rezultati ovog istraživanja korisni su za promišljanje o transformaciji psihijatrijskih institucija prema oporavku i poštivanju ljudskih prava kao što to preporu-

The survey on self-stigmatization found that the majority of participants (70%) did not self-stigmatize themselves while 22% expressed a slightly internalized stigma. 6.5% of the participants expressed moderate stigmatization and only 2% expressed strongly self-stigmatization. The lowest degree of self-stigmatization was expressed by persons who had diagnoses related to alcohol, while the highest degree self-stigmatized was found in persons who were diagnosed with schizophrenia and psychosis. It is possible the findings related to low self-stigmatization result from the selection of respondents. Namely, almost half of the participants attended psychotherapy or counselling that can have an empowering effect, while the support group, which can also have an empowering effect on its members, was attended by as many as 55% of the participants in the study. Self-stigmatization was found to be related to the number of experienced ethical transgressions by staff in psychiatric institutions. The study confirmed the protective effect of the social network of friendships.

Qualitative research is also a very interesting part of this book. In this part of the study, the participants were asked to describe positive or negative experiences with staff within the psychiatric health care system in the Republic of Croatia. They were also asked to express their recommendations for the improvement of treatment. Personal experiences speak more than statistics and confront us with the consequences of our behaviour on other people as they can stimulate desirable behaviours that are not only important for ethical conduct but also for the success of treatment.

Conclusion: The results of the study presented in this book highlight the importance of respecting ethical principles/human rights in psychiatric institutions and creating a therapeutic atmosphere of benevolence and recovery that is associated with the best treatment out-

ča Svjetska zdravstvena organizacija. Premda kršenje ljudskih prava u psihijatrijskim institucijama može imati svoje pravne posljedice, za institucije liječenja je važno organizirati liječenje koje se temelji na oporavku i poštivanju ljudskih prava jer je to povezano s boljom suradnjom u liječenju i povoljnijim ishodima liječenja. Pozitivna i negativna iskustva tijekom liječenja koja su iznesena u ovoj knjizi kao i savjeti o tome što pomaže u liječenju i što bi trebalo promijeniti treba prihvatiti kao korisne informacije partnera – stručnjaka po iskustvu u liječenju bez čije suradnje nema uspješnog liječenja. Prevencija samostigmatizacije je važna za ishod liječenja, čemu također treba obratiti pozornost u individualnom planiranju liječenja. U Hrvatskoj očekujemo promjene u organizaciji sustava zaštite mentalnog zdravlja usvajanjem nacionalnog okvira za mentalno zdravlje, pa bi bilo zanimljivo u dogledno vrijeme istraživanje ponoviti.

Slađana Štrkalj Ivezić

comes. The described personal experiences of patients speak more than statistics and point to the obligation to act based on respect for human rights, including the right to autonomy in decision-making, respect for dignity and an individual treatment plan. The results of this study are useful for further consideration of ways to transform psychiatric institutions on their way towards recovery and respect for human rights as recommended by the World Health Organization. Although violations of human rights in psychiatric institutions may have legal consequences, it is important for treatment institutions to organize treatment based on recovery and respect for human rights, as these factors are associated with better cooperation in treatment and more favourable treatment outcomes. The positive and negative experiences during treatment presented in this book as well as advice on what helps in treatment and what should be changed should be accepted as useful information given by partners - experts in treatment experience without whose cooperation there is no successful treatment. Prevention of self-stigmatization is important for treatment outcome and this should also be considered in individual treatment planning. In Croatia, we expect changes in the organization of the mental health care system with the adoption of the national framework for mental health. It would therefore be interesting to repeat the research in the foreseeable future.

Slađana Štrkalj Ivezić

Upute autorima

O časopisu

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

Svi radovi trebaju biti pisani na hrvatskom i engleskom jeziku.

Svi zaprimljeni radovi prolaze kroz isti proces recenzije pod uvjetom da zadovoljavaju i prate kriterije opisane u Uputama za autore i ne izlaze iz okvira rada časopisa.

Uredništvo ne preuzima odgovornost za gledišta u radu - to ostaje isključivom odgovornošću autora.

Časopis objavljuje sljedeće vrste članaka: uvodnike, izvorne znanstvene, stručne i pregledne radove, prikaze bolesnika, lijekova i metoda, kratka priopćenja, osvrte, novosti, prikaze knjiga, pisma uredništvu i druge priloge iz područja socijalne psihijatrije i srodnih struka.

Iznimno Uredništvo časopisa može prihvatiti i drugu vrstu rada (prigodni rad, rad iz povijesti struke i sl.), ako ga ocijeni korisnim za čitateljstvo.

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

Urednici časopisa *Socijalna psihijatrija* također su obvezni osigurati integritet i promicati inovativne izvore podataka temeljenih na dokazima, kako bi održali kvalitetu i osigurali utjecaj objavljenih radova u časopisu, a sukladno načelima iznesenim u Sarajevskoj deklaraciji o integritetu i vidljivosti (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5209927/).

Uredništvo

Svaki rad zaprimljen u Uredništvu časopisa *Socijalna psihijatrija* pregledava glavni urednik. Ako rad ne zadovoljava kriterije opisane u Uputama za autore, glavni urednik časopisa rad vraća autoru. Radovi koji zadovoljavaju uvjete bit će upućeni na recenziju.

Recenzija

Radovi koji su pisani prema Uputama za autore, šalju se na recenziju.

Časopis *Socijalna psihijatrija* recenzentima savjetuje da se pridržavaju uputa u Uputama za recenzente koje su dostupne na mrežnim stranicama Časopisa.

Instructions to authors

Aim & Scope

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

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

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

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

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

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

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

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

Editorial board

Each received manuscript is evaluated by the Editor-in-Chief. The manuscripts that do not meet the main criteria listed in the Author guidelines are returned to the Author. Manuscripts that are qualified are processed further.

Peer-review

Manuscripts that meet the scope of the Journal and are prepared according to the Author guidelines are sent to peer-review.

Socijalna psihijatrija advises its reviewers to adhere to the Journal's Guidelines for peer-reviewers available on the Journal webpage.

Etički kodeks

Podrazumijeva se da su svi autori radova suglasni o publikaciji i da nijedan dio rada nije prije publikacije u *Socijalnoj psihijatriji* već bio objavljen u drugom časopisu te da nije u postupku objavljivanja u drugom časopisu.

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

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

Autorska prava i licence

Nakon što je rad prihvaćen autori moraju jamčiti da su sva autorska prava na rukopis prenesena u časopis *Socijalna psihijatrija*. Izdavač (Medicinska naklada d.o.o.) ima pravo reproducirati i distribuirati članak u tiskanom i elektroničkom obliku bez traženja dopuštenja od autora. Svi objavljeni rukopisi podliježu licenci *Creative Commons Attribution* koja korisnicima omogućuje čitanje, preuzimanje, kopiranje, distribuiranje, ispis, pretraživanje ili povezivanje punih tekstova ovih članaka u bilo kojem mediju ili formatu. Također, korisnici mogu mijenjati tekst pod uvjetom da je originalni rad pravilno naveden i bilo kakva promjena pravilno naznačena. Potpuna zakonska pozadina licence dostupna je na: https://creativecommons.org/licenses/by/4.0/legalcode

Sukob interesa

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

Otvoreni pristup

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

Naplata troškova prijevoda radova

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

Oprema rukopisa

Rad i svi prilozi dostavljaju se isključivo u elektroničkom obliku. Preporučena duljina teksta iznosi do 20 kartica (1 kartica sadrži 1800 znakova s razmacima). Tekstove treba pisati u Wordu, fontom postavljenim za stil Normal, bez isticanja unutar teksta, osim riječi koje trebaju biti u boldu ili italiku. Naslove treba pisati istim fontom kao osnovni tekst (stil Normal), u poseban redak, a hijerarhiju naslova može se označiti brojevima (npr. 1., 1.1., 1.1.1. itd.).

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

Naslovna stranica rada sadrži: naslov i skraćeni naslov rada, puna imena i prezimena svih autora, naziv ustanova u kojima rade. Sažetak treba sadržavati do 200 riječi. U sažetku treba navesti temu i svrhu rada, metodologiju, glavne rezultate i kratak zaključak. Uz sažetak treba navesti 3 do 5 ključnih riječi koje su bitne za brzu identifikacijsku klasifikaciju sadržaja rada.

Znanstveni i stručni radovi sadrže ove dijelove: sažetak, uvod, cilj rada, metode, rezultati, rasprava i zaključci.

Uvod je kratak i jasan prikaz problema; u njemu se kratko spominju radovi onih autora koji su u izravnoj vezi s istraživanjem što ga rad prikazuje.

Ethical code

All the submissions are accepted with the understanding that they have not been and will not be published elsewhere in any substantially format.

The Editorial board, with the agreement of the Author and Publisher, can republish previously published manuscripts.

The manuscript published in *Socijalna psihijatrija* can be published elsewhere without the permission of the Author, Editorial board and Publisher, with the note that it has already been published in *Socijalna psihijatrija*.

Copyright and publication licence

After a manuscript is accepted for publication, the Authors must guarantee that all copyrights of the manuscript are transferred to *Socijalna psihijatrija*. The publisher (Medicinska naklada d.o.o.) has the right to reproduce and distribute manuscripts in printed and electronic form without asking permission from Authors. All manuscripts published on line are subject to the Creative Commons Attribution License which permits users to read, download, copy, distribute, print, search, or link to the full texts of these articles in any medium or format. Furthermore, users can remix, transform, and build upon the material, provided the original work is properly cited and any changes properly indicated. The complete legal background of the license is available at: https://creativecommons.org/licenses/by/4.0/legalcode.

Conflict of interest

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

Open-access

Socijalna psihijatrija is an open-access journal, and all its content is free and available at the Journal’s webpage.

Article processing charges

The translation or language editing of the manuscript from Croatian to English (and *vice versa*) is funded by authors.

Manuscript preparation

Manuscripts, figures and tables should be submitted in electronic form. Normally, manuscripts should be no longer than 20 standard pages (one standard page is 1800 keystrokes – characters with spaces). Texts should be written in Microsoft Word, in a continuous font and style: the one set under the Normal style, with no additional font effects used other than words that should be in bold or italic. Tittles should be written in the same font as the rest of the text (Normal style) in a separate row, and title hierarchy should be shown using numbers (e.g. 1., 1.1., 1.1.1., etc.).

There should be a title, name and surname, address, town, state and e-mail indicated for the corresponding author.

The title page should contain: the full and shortened title of the article, full names and full surnames of all authors of the article, and the institution they work for. All the authors should also provide an ORCHID ID (please check the following website: https://orcid.org/register). The article should have a summary not exceeding 200 words. The summary should briefly describe the topic and aim, the methods, main results,

Cilj je kratak opis što se namjerava istraživati, tj. što je svrha istraživanja.

Metode se prikazuju tako da se čitatelju omogući ponavljanje opisanog istraživanja. Metode poznate iz literature ne opisuju se, već se navode izvorni literaturni podatci. Ako se navode lijekovi, rabe se njihova generička imena (u zagradi se može navesti njihovo tvorničko ime).

Rasprava sadrži tumačenje dobivenih rezultata i njihovu usporedbu s rezultatima drugih istraživača i postojećim spoznajama na tom području.U raspravi treba objasniti važnost dobivenih rezultata i njihova ograničenja, uključujući i implikacije vezane uz buduća istraživanja, ali uz izbjegavanje izjava i zaključaka koji nisu potpuno potvrđeni dobivenim rezultatima.

Zaključci trebaju odgovarati postavljenom cilju istraživanja i temeljiti se na vlastitim rezultatima.

Tablice treba smjestiti unutar Word-dokumenta na kraju teksta, a označiti mjesto njihovog pojavljivanja u tekstu. Ako se tablica daje u formatu slike (tj. nije izrađena u Wordu), za nju vrijede upute kao za slike. Svaka tablica treba imati redni broj i naslov.

Slike treba priložiti kao posebni dokument u .tiff ili .jpg (.jpeg) formatu, minimalne rezolucije 300 dpi. Uz redni broj svaka slika treba imati legendu. Reprodukciju slika i tablica iz drugih izvora treba popratiti dopuštenjem njihova autora i izdavača.

Rad može sadržavati i zahvalu na kraju teksta.

U tekstu se literaturni podatak navodi arapskim brojem u zagradi.

Literatura

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

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

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

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

1. Autori

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

2. Naslov i podnaslov rada

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

3. Naslov časopisa

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

4. Numerički podatci o časopisu

Arapskim brojkama upisuju se podatci koje se može pronaći u samom izvorniku ili u nekoj bibliografskoj bazi podataka i to sljedećim redom: godina, volumen ili svezak, sveščić ili broj (engleski *issue* ili *number* – no.), dio (engleski *part*), dodatak (engleski *supplement* ili *suppl.*),

and conclusion. The summary should be followed by 3 to 5 key words for easy identification and classification of the content of the article.

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

The Introduction section is a short and clear overview; it briefly mention Authors involved with the research of the paper.

The Aim section briefly describes the goals and intentions of the research, i.e. the point of the research.

The Methods section should be presented in such way as to allow the reader to replicate them without further explanation. Methods known from the literature need not be described but should simply be referred to by their generic names (trade names should be given in parentheses).

The Discussion section includes the results and their comparison with the results of other researchers and well known scientific knowledge in that area. It should also explain the significance of the results and their limitations, including implications regarding future studies, statements and conclusions that are not verified by the results should be avoided.

The Conclusions section should correspond to the aim of the study and be based on its results.

Tables should be placed at the end of the text in the Word document and with an indication where they are to appear in the published article. If the table is submitted as an image (i.e. is not constructed in Microsoft Word), the same instructions as for images apply.

Images should be submitted separately in .tiff or .jpg (.jpeg) format, with a minimum resolution of 300 dpi. Every image should have a number and caption. Reproduction of images and tables from other sources should be accompanied by a full reference and authorization by their Authors and Publisher.

The manuscript may have an acknowledgement at the end of the text.

References should be written with Arabic numerals in parentheses.

References

Socijalna psihijatrija applies the Vancouver referencing style according to the International Committee (ICMJE) standards. ICMJE recommends citation of the complete manuscripts, i.e. publicly accessible manuscripts, meaning that summaries, announces, etc. should be avoid.

Repeated citing of a manuscript should be marked by the same number as when it is mentioned for the first time.

Quotation marks should be used when citing another text. This mode of citation should only be used when the information cannot be properly reformulated or summarized (e.g. when referring to a definition).

Secondary citations refer to cases when Authors quote a passage from an inaccessible work to using a different text than the one where the quote originated. This kind of quotation should be avoided as much as possible i.e. always try to find the original scientific manuscript. In cases when it is not possible, the manuscript should cite the work that was used and not the work in which the information was primarily published.

1. Authors

In case the manuscript has six or fewer Authors, all of them should be listed. Should the manuscript have more than six Authors, the first six should be listed and the rest of them marked with the abbreviation *et al.* or i sur. First list the surname and then the initials of the first name(s). Multiple initials for the same person should be written without spaces.

2. Title and subtitle

Titles and subtitles are copied from the original and separated by a colon. Only the first word of the title and name are written in capital letters.

3. Journal title

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

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

Primjer:

Kingdon DG, Aschroft K, Bhandari B, Gleeson S, Warikoo N, Symons M et al. Schizophrenia and borderline personality disorder: similarities and differences in the experience of auditory hallucinations, paranoia and childhood trauma. J Nerv Ment Dis 2010; 10(6): 399-403.

5. Izdanje knjige

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

6. Grad izdanja

Upisuje se prvi grad naveden u izvorniku, za sve ostale se dodaje itd. (engleski *etc.*).

7. Izdavač

Prepisuje se iz izvornika.

8. Godina izdanja

Prepisuje se s naslovne stranice, a ako nije navedena godina izdanja, bilježi se godina copyright-a © koja se često nalazi na poleđini naslovne stranice.

Primjer:

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

9. Poglavlje u knjizi

Opisuje se prvo autorima i naslovom poglavlja, nakon čega slijede podatci o knjizi. Ispred navođenja urednika knjige stavlja se riječ u: (engleski *in:*), a iza u okrugloj zagradi ur. (engleski *ed.*)

Primjer:

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

10. Stranica knjige

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

Primjer:

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

11. URL/Web adresa

Obavezno se navodi za mrežne izvore.

12. Datum korištenja/pristupa

Obavezno se navodi za mrežne izvore.

13. DOI

Ako postoji, obavezno se navodi za mrežne izvore.

Primjer:

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

4. Numerical journal data

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

E. g.

Kingdon DG, Aschroft K, Bhandari B, Gleeson S,Warikoo N, Symons Metal. Schizophrenia and borderline personality disorder: similarities and differences in the experience of auditory hallucinations, paranoia and childhood trauma. J Nerv Ment Dis 2010; 10(6): 399-403.

5. Book issue

Book issue is indicated by the ordinary number and the abbreviation “Ed”. In case the book has more than one volume, use the abbreviation “Vol”.

6. City of issue

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

7. Publisher

Copy from the original.

8. Year of issue

Copy it from the main page. In case the year is not indicated, the copyright year should be written (it can be found at the end of the book).

E.g.

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

9. Book chapter

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

E. g.

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

10. Book page

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

E. g.

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

11. Web address

Required for online resources.

12. Date of use

Required for online resources.

13. DOI

If available, it is mandatory to cite online resources.

E. g.

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

SOCIJALNA PSIHIJATRIJA – ČASOPIS HRVATSKOGA PSIHIJATRIJSKOG DRUŠTVA

SOCIJALNA PSIHIJATRIJA – THE JOURNAL OF THE CROATIAN PSYCHIATRIC SOCIETY

Izdavač/Publisher
Medicinska naklada

Adresa Uredničkog odbora/Address of the Editorial Board
SOCIJALNA PSIHIJATRIJA
Klinika za psihijatriju i psihološku medicinu, Klinički bolnički centar Zagreb, Kišpatićeva 12, 10000 Zagreb, Hrvatska
Department of Psychiatry and Psychological Medicine, University Hospital Centre Zagreb, Kišpatićeva 12, 10000 Zagreb, Croatia

Tehnička urednica/Technical Editor
Dunja Beritić-Stahuljak (Zagreb)

Oblikovanje korica/Cover design
Andrea Knapić (Zagreb)

Prijelom/Layout
Marko Habuš (Zagreb)

Tisak/Printed by
Medicinska naklada d.o.o., Zagreb

Časopis je utemeljen 1973. u Klinici za psihijatriju Kliničkog bolničkog centra Zagreb i Medicinskog fakulteta Sveučilišta u Zagrebu, gdje je i sjedište Uredničkog odbora.
The journal was established in 1973. in Zagreb, in the Clinic for Psychiatry, University Hospital Centre Zagreb, School of Medicine, Zagreb and the Editorial board headquarters are situated there as well.

Socijalna psihijatrija indeksirana je u/Socijalna psihijatrija is indexed in: SCOPUS, PsychINFO, Excerpta Medica (EMBASE), Index Copernicus, Google Scholar, EBSCO, HRČAK, CiteFactor (https://www.citefactor.org/impact-factor/impact-factor-of-journal-Socijalna-psihijatrija.php).

Izlazi četiri puta godišnje.

Godišnja pretplata za ustanove iznosi **300,00 kn**; za pojedince **150,00 kn**. Cijena pojedinačnog broja **50 kn** (u cijenu su uključeni poštanski troškovi).
IBAN: HR2223600001101226715, Medicinska naklada, Cankarova 13, 10000 Zagreb, Hrvatska (za časopis Socijalna psihijatrija).

The Journal is published four times a year. Orders can be made through our office-address above.
The annual subscription for foreign subscriber is: for institutions **40 €**, for individuals **20 €**, and per issue **10 €** (the prizes include postage).
Payment by check at our foreign currency account:
Zagrebačka banka d.d., 10000 Zagreb, Croatia
IBAN: HR2223600001101226715, **SWIFT:** ZABAHR2X (for Socijalna psihijatrija).

Kontakt/Contact
socijalna.psihijatrija@kbc-zagreb.hr
http://www.kbc-zagreb.hr/soc.psi