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Doprinos neprilagođenog dnevnog sanjarenja razini psihološkog distresa i suočavanju sa stresom

/ *Contribution of Maladaptive Daydreaming to the Level of Psychological Distress and Coping Strategies*

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Ciljevi ovog istraživanja bili su provjeriti povezanost neprilagođenog dnevnog sanjarenja (NDS) s psihološkim distresom (subjektivna dobrobit, problemi, funkcioniranje i rizična ponašanja) i stilovima suočavanja u stresnim situacijama odnosno ispitati može li se na osnovi stupnja izraženosti NDS-a i spola predvidjeti razina psihološkog distresa i preferirani stilovi suočavanja sa stresnim situacijama. Istraživanje je provedeno na studentima i studenticama prve godine Sveučilišnog odjela zdravstvenih studija Sveučilišta u Splitu (N=80) prosječne dobi 21,2 godine. U istraživanju su korišteni sljedeći mjerni instrumenti: Upitnik neprilagođenog dnevnog sanjarenja (NDS), Upitnik suočavanja sa stresovima (CISS) i Upitnik za ispitivanje općih psihopatoloških teškoća/psihološkog distresa (CORE-OM). Utvrđena je značajna pozitivna povezanost neprilagođenog dnevnog sanjarenja s problemima i rizičnim ponašanjima. Neprilagođeno dnevno sanjarenje također je bilo pozitivno povezano s emocijama usmjerenim suočavanjem te negativno s problemu usmjerenom suočavanju. Ispitanici koji su skloniji NDS-u imaju veću vjerojatnost izloženosti psihičkim problemima i razvoju rizičnih ponašanja te se sa stresom suočavaju na manje učinkovite načine. Provedene regresijske analize potvrdile su prediktivno značenje NDS-a razini psihološkog distresa i stilovima suočavanja sa stresovima. Muški spol predviđa veću sklonost rizičnijim ponašanjima.

/ *The aim of this study was to verify the association between maladaptive daydreaming (MD) with psychopathological distress (subjective well-being, problems, functioning and risk behaviors) and coping strategies in stressful situations and to examine whether the levels of MD and gender can predict levels of psychological distress and the preferred coping strategies. The participants were first-year students at the University Department of Health Studies, University of Split (N = 80) with an average age of 21.2 years. The following measurement tools were used: Maladaptive Daydreaming Scale (MDS), The Coping Inventory for Stressful Situations (CISS), and the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM). Significant positive correlations were determined between maladaptive daydreaming and both the Problems and the Risky behaviors criteria according to CORE-OM. Maladaptive daydreaming was also positively associated with Emotion oriented coping strategies and negatively associated with Problem-oriented coping strategies in CISS. The respondents who were more inclined to maladaptive daydreaming had a greater likelihood of exposure to different mental problems and the development of risky behaviors, with less efficient coping strategies. The regression analyzes confirmed the predictive significance of maladaptive daydreaming for the level of psychological distress and the choice of coping mechanism for dealing with stressful situations. Male gender predicted higher levels of risky behaviors.*

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UVOD

Dnevno sanjarenje je uobičajena, normalna mentalna aktivnost koja je prisutna kod gotovo svih ljudi (1). Dnevno sanjarenje je rezultat funkcionalnog povezivanja moždane aktivnosti prema zadanom načinu rada [engl. *default mode network* (DMN)] koje se aktivira kada je mozak u stanju mirovanja i osoba nije fokusirana na vanjski svijet ili kada je okupirana mentalnim zadacima (npr. razmišljanje o sebi i drugima, razmišljanja o prošlim iskustvima ili planiranje zadataka) (2-4). Prema tome, dnevno sanjarenje vjerojatno ima evolucijsko značenje, jer omogućuje planiranje aktivnosti, donošenje odluka, omogućuje mentalno opuštanje, ublažava osjećaj dosade i/ili potiče kreativnost (5-7). Za vrijeme sanjarenja misli slobodno naviru, manje su cenzurirane, otvoreniji smo za nove ideje i spremniji razmišljati o svojim pogreškama (8).

Dnevno sanjarenje ne smatra se patološkim iako postoji sve više empirijskih dokaza o tome da ono može poprimiti razmjere koji doprinose neprilagođenom funkcioniranju. Studija iz 2011. godine je pokazala da su ispitanici osjećali užitak dok su bili uronjeni u svoje unutarnje svjetove, ali su istodobno bili uznemireni količinom i nekontroliranošću njihovog visoko strukturiranog sanjarenja i njegovih posljedica (9). Koncept neprilagođenog dnevnog sanjarenja (NDS) (engl. *maladaptive daydreaming*) je

INTRODUCTION

Daydreaming is a common, normal mental activity that is present in almost all people (1). Daydreaming is the result of a functional linking of brain activity to the default mode of network (DMN), which is activated when the brain is at rest and the person is not focused on the outside world or occupied by mental tasks (i.e. thinking about oneself and others, reflections on past experiences, or task planning) (2-4). Daydreaming probably has evolutionary importance because it enables activity planning, decision making, mental relaxation, alleviates feelings of boredom and/or promotes creativity (5-7). During daydreaming, thoughts flow freely and are less censored; we are more open to new ideas and more willing to think about our mistakes (8).

Daydreaming is not considered pathological, although there is increasing empirical evidence that, if too pronounced, it can contribute to maladaptation. The results of a study by Bigelsen showed that respondents felt pleasure while immersed in their inner worlds, but at the same time were disturbed by the amount and uncontrollability of their highly structured daydreaming and its consequences (9). The concept of maladaptive daydreaming (MD) was first used by Eli Somer, who stated that MD characterizes individuals who spend

prvi put upotrijebio Eli Somer navodeći kako NDS karakterizira pojedince koji provode sate u živim, maštovitim sanjarenjima pri čemu zanemaruju stvarne odnose i odgovornosti što rezultira kliničkim distresom i oštećenjem funkcionalnosti u akademskom, socijalnom i radnom okruženju (10,11). Za razliku od uobičajenog dnevnog sanjarenja NDS osobu navodi na konstantno ponavljanje procesa sanjarenja koje traje više od četiri i pol sata dnevno odnosno četvrtinu vremena u budnom stanju (11).

Osoba sklona NDS-u je potpuno svjesna svog ponašanja i nikada ne miješa stvarnost i fantazije. Uobičajeni simptomi uključuju iznimno živopisna sanjarenja koja je teško prekinuti, otežano obavljanje svakodnevnih poslova, poteškoće sa spavanjem, sanjarenja koja se javljaju na vanjski poticaj poput gledanja filma ili slušanja muzike, te izvođenje ponavljajućih i nesvjesnih pokreta za vrijeme sanjarenja (pravljenje grimasa, šaputanje, ljuljanje naprijed-nazad, trzanje) (12). Prema dosadašnjim saznanjima NDS se ne uklapa u dijagnostičke kriterije bilo kojeg postojećeg mentalnog poremećaja, ali se preklapa s većim brojem različitih psihopatoloških stanja. Procjena psihijatrijskog komorbiditeta kod osoba s NDS-om ukazuje da ih čak 74,4 % zadovoljava kriterije za više od tri psihijatrijska poremećaja, dok 41,1 % zadovoljava kriterije za više od četiri psihijatrijska poremećaja. Najčešći komorbidni poremećaj je ADHD (76,9 %), zatim anksiozni poremećaji (71,8 %), depresivni poremećaj (66,7 %) i OKP (53,9 %) pri čemu spol ne objašnjava značajan dio varijance rezultata (13). U longitudinalnom istraživanju na međunarodnom uzorku osobe s NDS-om imale su izraženije simptome opsesivno-kompulzivnog poremećaja, generalizirane i socijalne anksioznosti, disocijacije i više negativnih emocija te manju izraženost pozitivnih emocija (11). Somer navodi da NDS može nastati kao posljedica proživljenih trauma ili iskustava zlostavljanja pri čemu služi kao strategija suočavanja s proživljenim neugodnim iskustvima i stresovima (10). Kako bi izbjegli

hours in vivid, imaginative daydreaming while neglecting real relationships and responsibilities, resulting in clinical distress and impaired functioning in academic, social, and the work environment (10,11). Unlike usual daydreaming, MD forces the person to constantly repeat the daydreaming process, which takes up more than four and a half hours a day, i.e. a quarter of the time spent in a waking state (11).

A person prone to MD is fully aware of their behavior and never confuses reality and fantasy. The common symptoms of MD include extremely vivid daydreaming that is difficult to interrupt, difficulty in performing daily activities, sleeping disturbances, daydreaming contents that occur on exterior stimulus (such as watching a movie or listening to music), and performing repetitive and unconscious movements during daydreaming (grimacing, whispering, jerking, rocking back and forth) (12). To date, MD does not fit the diagnostic criteria of any existing mental disorder but it overlaps with a number of different psychopathological conditions. Assessment of psychiatric comorbidity in people with MD indicates that as many as 74.4% meet the criteria for more than three psychiatric disorders, while 41.1% meet the criteria for more than four psychiatric disorders. The most common comorbid disorder is ADHD (76.9%), followed by anxiety disorders (71.8%), depressive disorder (66.7%), and OCD (53.9%) (13). The findings of a longitudinal international study indicated that people with MD had more pronounced symptoms of obsessive-compulsive disorder, generalized and social anxiety, dissociation, more negative emotions, and a lower expression of positive emotions (11). Furthermore, Somer stated that MD can arise as a result of traumatic experiences or abuse, serving as a strategy to cope with unpleasant experiences and stress (10). To avoid stress, people with MD create their own inner world of daydreaming, where they stay for hours. They thus enter a vicious cycle in

stres, ljudi s NDS-om stvaraju vlastiti unutarnji svijet sanjarenja u kojemu ostaju satima. Tako upadaju u začarani krug u kojemu neprilagođeno sanjarenje omogućuje olakšanje od psihološkog distresa i zamjenjuje bolne interakcije u stvarnom životu. Kao rezultat pretjeranog sanjarenja može doći do narušavanja subjektivne dobrobiti, teškoća u akademskom i radnom postignuću, pojačanog stresa i narušavanja cjelokupnog funkcioniranja. Iz navedenih istraživačkih nalaza je evidentno kako NDS može biti povezan sa stanjima psihološkog distresa te služiti kao način suočavanja sa stresnim stanjima što je predmet interesa ovog istraživanja. Pojam psihološkog distresa obuhvaća široki raspon doživljavanja, od normalnog osjećaja ranjivosti, tuge i straha do problema koji mogu uzrokovati disfunkcionalnost, poput depresije, anksioznosti, ekstenzivnih briga, negativnih misli i socijalne izolacije (14). Jedan od postojećih trijažnih upitnika za utvrđivanje općih psihopatoloških poteškoća odnosno razine distresa je CORE-OM (engl. *Clinical Outcome in Routine Evaluation – Outcome Measures*) Evansa i sur. (15). Upitnik je u brojnim istraživanjima pokazao značajne razlike u rezultatima kliničke i nekliničke skupine na svim dimenzijama, ukupnom rezultatu i nerizičnim česticama, pri čemu su viši rezultati dobiveni u kliničkoj skupini sudionika (16-19). CORE-OM ispituje četiri dimenzije psihološkog distresa: subjektivnu dobrobit, postojanje problema/simptome, svakodnevno funkcioniranje te sklonost rizičnim ponašanjima. Pri validaciji CORE upitnika na uzorku hrvatskih građana učestalija rizična ponašanja na kliničkom uzorku pronađena su češće kod muškaraca nego kod žena, dok su u nekliničkom uzorku žene češće izvještavale o psihološkim problemima (17). Navedene karakteristike ovaj upitnik čine izvrsnim alatom u istraživanjima različitih područja psihičkog zdravlja (20) što je razlog za njegov odabir i u ovom istraživanju. Osoba u stanju distresa svoja disfunkcionalna doživljavanja i ponašanja pokušava prevladati, tj. suočiti se s percipiranim stresorima na različite načine. Koncept suočavanja (engl. *coping*) odnosi

which maladaptive daydreaming provides relief from psychic distress that replaces painful real-life interactions. Excessive daydreaming can lead to impaired subjective well-being, difficulties in academic and work achievement, mental health problems, and impairment of overall functioning. The research findings indicate that maladjusted daydreaming can be related to psychological distress and serve as a way of coping with stressful conditions, which is the subject of this study. The concept of psychological distress encompasses a wide range of experiences, from normal feelings of vulnerability, sadness, and fear to problems that can cause dysfunctionality, such as depression, anxiety, extensive worries, negative thoughts, and social isolation (14).

One of the existing questionnaires for identifying general psychopathological difficulties or levels of distress is the CORE-OM (Clinical Outcome in Output Measures) by Evans et al. (15). In a number of studies, the questionnaire showed significant differences in clinical and non-clinical group scores across all dimensions, total score, and risk-free items, with higher scores being obtained in the clinical group of participants (16-19). CORE-OM examines four dimensions of psychological distress: subjective well-being, existence of problems/symptoms, functioning, and risky behaviors. In the Croatian version of CORE-OM, more risk behaviors were found in men than in women in the clinical sample, while in the non-clinical sample women reported more frequent psychological problems (17). This questionnaire is recognized as an excellent tool in research in various fields of mental health (20), which is the reason for its selection in this study.

A distressed person tries to overcome their dysfunctional experiences and behaviors, i.e. to deal with perceived stressors in different ways. The concept of coping styles refers to a wide range of behaviors that an individual applies in response to stressful situations with the

se na širok spektar ponašanja koje pojedinac koristi kao odgovor na stresne situacije, a kojima je svrha umanjivanje neugodnih učinaka takvih događaja (21). Prema Lazarusu i Folkmanu (22) određeni događaj predstavlja samo potencijalni izvor stresa, dok o subjektivnoj procjeni ovisi hoće li se on doživjeti kao stresan, te je ova procjena i preduvjet za pokušaj suočavanja sa stresnom situacijom. Svaki pojedinac posjeduje različite stilove suočavanja koje dosljedno koristi u nizu sličnih stresnih situacija (23). Endler i Parker razlikuju tri stila suočavanja: *suočavanje usmjereno na problem* koje podrazumijeva poduzimanje konstruktivnih aktivnosti za rješavanje stresnog događaja, zatim *suočavanje usmjereno na emocije* pri čemu se ulaže napor za prevladavanje emocionalnih posljedica stresora i *suočavanje izbjegavanjem* koje se odnosi na kognitivne, emocionalne ili ponašajne pokušaje udaljavanja od izvora stresa i/ili psihičkih i tjelesnih reakcija na stresor. Izbjegavanje se može odnositi na izbjegavanje usmjereno na ljude, tj. pojačano druženje s ljudima iz vlastitog socijalnog okruženja (*socijalna diverzija*) i usmjeravanje na novi zadatak koji nije povezan sa stresnom situacijom (*distrakcija*) (23). Lazarus i Folkman (22) smatraju da strategije suočavanja nisu same po sebi dobre ni loše, a njihova učinkovitost ovisi o percepciji konkretne situacije te o vrednovanju vlastite mogućnosti suočavanja (24). Ipak, nalazi se da neki stilovi suočavanja više doprinose funkcionalnom ponašanju od drugih. Emocijama usmjereno suočavanje češće je povezano s emocionalnim i ponašajnim problemima te psihološkim distresom (25), dok je problemu usmjereno suočavanje povezano s manje emocionalnih i osobnih problema (26,27). Endler i Parker naglašavali su važnost rodnih razlika u korištenju različitih stilova suočavanja pri čemu žene više koriste suočavanje usmjereno na emocije, dok se muškarci češće služe problemu usmjerenom suočavanju (23,28). Veća nejednoznačnost nalaza postoji kod istraživanja suočavanja usmjerenog na problem. Neki nalazi ukazuju kako muškarci više koriste ovaj stil suočavanja (29), dok drugi

purpose of minimizing the unpleasant effects of such events (21). According to Lazarus and Folkman (22), an event is *per se* only a potential source of stress, while whether or not it will be perceived as stressful depends on the subjective appraisal. The results of the subjective appraisal determine whether a person will or will not cope with a stressful situation. Each individual has different coping styles that they consistently use in a range of similar stress situations (23). Endler and Parker distinguish three coping strategies: *problem focused* coping that involves use of constructive activities to deal with a stressful event, *emotion focused* coping which includes efforts to overcome the emotional consequences of stressors, and *avoidant coping* related to cognitive, emotional, or behavioral attempts to distance oneself from the source of stress and/or mental and physical reactions to the stressor. Avoidance can be related to avoidance focused to people, i.e. increased socializing with people from their own social environment (*social diversion*) and focusing on new tasks unrelated to a stressful situation (*distraction*) (23). Lazarus and Folkman (22) state that individual coping strategies are neither good nor bad *per se*, while their effectiveness depends on the perception of a particular situation and on the evaluation of one's own coping capacity (24). Nevertheless, some coping styles have been found to contribute more to functional behavior than others. Emotion focused coping is more often associated with emotional and behavioral problems and psychological distress (25), while problem-centered coping is associated with fewer emotional and personal problems (26, 27). Endler and Parker emphasized the importance of gender differences in the use of different coping styles, whereby women are more likely to use emotion focused coping while men are more likely to use the problem focused coping style (23, 28). Greater inconsistency of findings was found in problem focused coping research. Some findings indicate that men are more likely to use

nalazi upućuju na veću zastupljenost ovog stila suočavanja kod žena (30). U novijem istraživanju nisu pronađene rodne razlike u suočavanju usmjerenom na problem (31).

Racionala ovog istraživanja naslanja se na nalaze Somera (10) koji NDS povezuje s intenzivnijim doživljavanjem stresa i psihološkim problemima. Stoga smo pretpostavili pozitivnu povezanost NDS-a s postojanjem psiholoških problema i rizičnih ponašanja. Uzimajući u obzir da NDS može imati funkciju strategije suočavanja (10) također smo pretpostavili pozitivnu povezanost NDS-a s emocijama usmjerenim suočavanjem i distrakcijama te negativnu povezanost s problemu usmjerenim suočavanjem. Temeljem rezultata ranijih istraživanja nismo očekivali značajan doprinos rodnih razlika objašnjenju varijabli psihološkog distresa i stilova suočavanja. Pregledom literature nisu pronađena istraživanja u kojima se ispitivao odnos NDS-a i stilova suočavanja sa stresom. Stoga smo u ovom istraživanju željeli provjeriti povezanost NDS-a s razinama psihološkog distresa (subjektivna dobrobit, problemi, funkcioniranje i rizična ponašanja) i stilovima suočavanja u stresnim situacijama odnosno ispitati može li se na osnovi stupnja izraženosti NDS-a i spola predvidjeti razina psihološkog distresa i preferirani stilovi suočavanja.

METODA ISTRAŽIVANJA

Sudionici

Istraživanje je provedeno na prigodnom uzorku studenata prve godine Sveučilišnog odjela zdravstvenih studija u Splitu. U ispitivanju je sudjelovalo 80 studenata (N=80) od toga 65 žena, te 15 muškaraca (N=15). U gotovo svim ispitivanim varijablama nisu utvrđene statistički značajne rodne razlike, osim na podljestvici rizičnih ponašanja CORE-om upitnika (t=3,09, p<0,01) pri čemu su kod muškaraca takva ponašanja izraženija nego kod žena. Dobni raspon ispitanika iznosio je 19 do 40 godina s prosječ-

this coping style (29), while other findings indicate a greater prevalence of this coping style in women (30). A more recent study found no gender differences in problem focused coping (31).

The rationale of this research relies on the findings of Somer (10), who associated MD with more intense psychological distress. Therefore, we assumed a positive association of MD with psychological problems and risky behaviors. Given that MD can serve as a coping strategy (10), we also hypothesized a positive association of MD with emotion focused coping and distractions and a negative association with problem focused coping. Based on the results of previous research, we did not expect a significant contribution of gender differences to the explanation of psychological distress and coping styles. The literature review did not find any research examining the relationship between MD and coping styles.

In this study we therefore wanted to investigate the association of MD with levels of psychological distress (subjective well-being, problems, functioning, and risk behaviors) and coping styles in stressful situations and to examine whether the level of psychological distress and preferred coping styles could be predicted based on the degree of MD and gender.

RESEARCH METHODS

Participants

The subjects were the freshmen students of the University Department of Health Studies at the University of Split. The study involved 80 students (N = 80), of which 65 were female (N = 65) and 15 were male (N = 15). No statistically significant gender differences were found for almost all of the examined variables, except in the risky behaviors subscale of the CORE-OM questionnaire (t = 3.09, p <0.01), with such be-

nom dobi M=21.24, σ=3.71. Sudjelovanje ispitanika je bilo dobrovoljno uz potpisani pristanak i zajamčenu anonimnost. Provođenje istraživanja odobrilo je Etičko povjerenstvo Sveučilišnog odjela zdravstvenih studija u Splitu.

Instrumentarij

Za odgovor na postavljene ciljeve primijenjeni su sljedeći mjerni instrumenti:

1. Sociodemografski podatci – tijekom istraživanja prikupljeni su podatci o dobi i spolu ispitanika.
2. Za mjerenje stupnja neprilagođenog dnevnog sanjarenja korišten je Upitnik neprilagođenog dnevnog sanjarenja (engl. *Maladaptive Daydreaming Scale –MDS-16*) (32). U ovom istraživanju korištena je validirana hrvatska verzija upitnika (33). Upitnik se sastoji od 16 čestica na koje ispitanici odgovaraju na ljestvici od 0 do 100 % pri čemu 0 znači da se u potpunosti ne slažu sa sadržajem čestice, a 100 da se u potpunosti slažu sa sadržajem čestice. Ukupan rezultat se izražava kao prosječna vrijednost postotaka na svim česticama. Viši rezultat označava veći stupanj neprilagođenog dnevnog sanjarenja. Primjeri čestica su: „Neki ljudi će radije sanjariti nego li raditi većinu drugih stvari. U kojoj mjeri Vi radije sanjarite nego što se uključujete s drugim ljudima u društvene aktivnosti ili hobije?" „Sanjarenje ometa neke ljude u postizanju njihovih najvažnijih ciljeva. U kolikoj mjeri sanjarenje Vas ometa u ostvarenju Vaših životnih ciljeva?" Rezultati eksploratorne faktorske analize na uzorku hrvatskih građana upućuju na tri ekstrahirana faktora. Dva dobivena faktora sadržajno se uglavnom podudaraju s faktorima izvorne ljestvice - interferencija s dnevnim funkcioniranjem; kompulzija/kontrola, dok treći faktor opisuje sadržaj/kvalitetu i percepciju koristi od dnevnog sanjarenja.

haviors being more pronounced in men than in women. The age range of the subjects ranged from 19 to 40 years with an average age of M = 21.24, σ = 3.71. The participation of the respondents was voluntary with signed consent and guaranteed anonymity. The research was approved by the Ethics Committee of the University Department of Health Studies in Split.

Research instruments

The following measuring instruments were used to respond to the set goals:

1. Sociodemographic data – data on age and gender were collected during the survey.
2. The Maladaptive Daydreaming Scale – MDS-16 (32) was used to measure the degree of maladaptive daydreaming. This study used a validated Croatian version of the questionnaire (33). The questionnaire consists of 16 items to which the respondents respond on a scale of 0-100%, with 0 indicating that they do not completely agree with the content of the item and 100 that they completely agree with the content of the item. The total result is expressed as the average percentage value on all items. A higher score indicates a higher degree of maladjusted daydreaming. Examples of items are as follows: "Some people will rather daydream than do most other things. To what extent do you rather dream than engage with other people in social activities or hobbies?"; "To what extent does daydreaming hinder you from achieving your life goals?" The results of an exploratory factor analysis on a sample of Croatian citizens point to three extracted factors. The two factors obtained mainly correspond to the factors of the original scale – interference with daily functioning; compulsion/control, while the third factor describes the content/quality and perceived benefits of daydreaming.

Pouzdanosti podljestvica kreću se u rasponu od 0,77 do 0,92, dok pouzdanost ukupne skale iznosi Cronbach α=0,91 (33). Pouzdanost izražena putem Cronbachovih α koeficijenata upitnika NDS-a u ovom istraživanju iznosi α=0,93.

3. Upitnik suočavanja sa stresnim situacijama (engl. *Coping Inventory for Stressful Situations - CISS*) (23). Za ispitivanje stilova suočavanja sa stresom korišten je hrvatski oblik Upitnika suočavanja sa stresnim situacijama (34). Upitnik se sastoji od 48 tvrdnji koje čine tri podljestvice (po 16 tvrdnji) od kojih svaka ispituje određeni stil suočavanja: suočavanje usmjereno na problem (npr. „Analiziram problem prije nego reagiram.“), suočavanje usmjereno na emocije (npr. „Naljutim se.") te suočavanje izbjegavanjem (npr. „Idem prošetati.“). Podljestvica Izbjegavanje se sastoji od dvije podljestvice: Distrakcija (npr. „Gledam TV.“) i Socijalna diverzija (npr. „Provodim vrijeme s osobom koju cijenim."). Ispitanici odgovaraju na ljestvici od 5 stupnjeva tako da procjene u kojoj mjeri koriste određene vrste ponašanja pri susretu s nekom stresnom situacijom, pri čemu rezultat 1 označava "*uopće ne*", a rezultat 5 *"u potpunosti da"*. Rezultati se izražavaju kao suma čestica na svakoj podljestvici. Viši rezultat na pojedinoj podljestvici upućuje na češće korištenje određenog stila suočavanja sa stresom. Koeficijenti pouzdanosti u ovom istraživanju po svakoj podljestvici CISS upitnika iznose: Problemu usmjereno suočavanje Cronbach α=0,84, Emocijama usmjereno suočavanje Cronbach α=0,87, Izbjegavanje-Distrakcija Cronbach α =0,70 i Izbjegavanje-Socijalna diverzija Cronbach α =0,72.

4. Hrvatski oblik Upitnika za ispitivanje općih psihopatoloških teškoća CORE-OM (17) (engl. *Clinical Outcomes in Routine Evaluation – Outcome Measure CORE-OM* (15) korišten je kao mjera opće psihičke uznemirenosti odnosno psihološkog distresa ispitanika. Upitnik sadrži 34 čestice na kojima ispitani-

The reliability of the subscale ranged from 0.77 to 0.92, while the reliability of the total scale was Cronbach α = 0.91 (33). Reliability expressed by Cronbach's α coefficients of the MDS in this study was α = 0.93.

3. Coping Inventory for Stressful Situations (CISS) (23). The Croatian form of the questionnaire (34) was used to examine coping styles (34). The questionnaire has 48 statements consisting of three subscales (16 statements each) examining a particular style of coping: problem focused coping (e.g. "I analyze the problem before responding."), emotion focused coping (e.g. "I am angry."), and avoidant coping (e.g. "I'm going for a walk."). The subscale of avoidance consists of two subscales: Distraction (e.g., "I watch TV.") and Social Diversion (e.g., "I spend time with a person I value."). The subjects respond on a 5-point scale to assess the extent to which they use certain types of behavior when encountering a stressful situation, with a score 1 indicating "not at all" and a score of 5 indicating "completely agree". The results are expressed as the sum of items on each subscale. A higher score on a particular subscale indicates a more frequent use of a particular coping style. The reliability coefficients in this study for each subscale of the CISS questionnaire are as follows: problem focused coping Cronbach α = 0.84, emotion focused coping Cronbach α = 0.87, avoidance-distraction Cronbach α = 0.70, and avoidance-social diversion Cronbach α = 0.72.

4. The Croatian version of the CORE-OM (The Clinical Outcomes in Routine Evaluation Outcome Measure) (17) was used as a measure of general psychological distress. The questionnaire consists of 34 items by which the respondents assess how often they have felt in the described manner

ci procjenjuju koliko često su se osjećali na opisani način tijekom protekla dva tjedna (0 – nikada, 1 – vrlo rijetko, 2 – ponekad, 3 – često, 4 – gotovo uvijek). Čestice se odnose na četiri dimenzije: Subjektivna dobrobit (4 čestice, npr. "Bio/la sam optimističan/na u vezi svoje budućnosti."); Problemi (12 čestica, npr. "Uznemiravale su me neželjene misli i osjećaji."); Svakodnevno funkcioniranje (12 čestica, npr. "Mogao/la sam se nositi s poteškoćama.) i Rizična ponašanja (6 čestica; npr. „Razmišljao/la sam kako bi bilo bolje da me nema".). Ukupni rezultat na pojedinim dimenzijama prikazuje se kao ukupni prosječni rezultat (ukupni rezultat podijeljen s brojem čestica koje čine ljestvicu ili dimenziju). U hrvatskoj verziji upitnika potvrđena je zadovoljavajuća unutrašnja konzistencija i test-retest pouzdanost, te dobra konvergentna valjanost. Kritični rezultat je 1,38 za muškarce i žene na temelju kojeg je moguće prepoznavanje osoba s emocionalnim smetnjama (17). Ukupan koeficijent pouzdanosti CORE-OM upitnika u ovom istraživanju je: Cronbach's α=0,95. Podljestvica Subjektivna dobrobit ima koeficijent pouzdanosti α=0.97, Problemi α=0,9 a nešto nižu imaju čestice Funkcioniranje α=0.66 i Rizična ponašanja α=0,57.

REZULTATI

Razine izraženosti dnevnog sanjarenja i psihološkog distresa studenata ispod su graničnih vrijednosti koje ukazuju na patološka odstupanja. Općenito, studenti se u suočavanju sa stresovima u većoj mjeri koriste problemu usmjerenim suočavanjem, distrakcijom i socijalnom diverzijom nego emocionalnim suočavanjem (tablica 1).

Varijabla spola značajno je negativno povezana samo s rizičnim ponašanjima ukazujući na veću sklonost muškaraca prema rizičnim samodestruktivnim i heterodestruktivnim ponašanjima (tablica 2).

over the past two weeks (0 – never, 1 – very rarely, 2 – sometimes, 3 – often, 4 – almost always). The items refer to four dimensions: Subjective well-being (4 items, e.g. "I was optimistic about my future."); Problems (12 items, e.g., "I was disturbed by unwanted thoughts and feelings."); Daily functioning (12 items, e.g., "I could...". and Risky Behaviors (6 items; e.g., "I thought it might be better to be gone."). The overall score on each dimension is displayed as the overall average score (total score divided by the number of items that make up a scale or dimension). The Croatian version of the questionnaire confirmed satisfactory internal consistency and test-retest reliability, as well as good convergent validity. The critical score is 1.38 for men and women, based on which individuals with emotional disabilities can be identified (17). The overall reliability coefficient of the CORE-OM questionnaire in this study was Cronbach's α = 0.95. Subscale Subjective well-being had a coefficient of confidence α = 0.97, Problems α = 0.9, and items with a slightly lower coefficient were Functioning α = 0.66 and Risky behaviors α = 0.57.

RESULTS

The levels of expression of students' daydreaming and psychological distress are below thresholds indicating psychopathology. In general, in facing stressful situations, the students use the problem focused coping style, distraction, and social diversion to a greater extent than emotional coping (Table 1).

Gender was negatively associated only with risky behaviors indicating men as more prone to risky self-destructive and heterodestructive behaviors (Table 2).

Maladjusted daydreaming was positively associated with problems, risk behaviors, and emo-

TABLICA 1. Aritmetičke sredine i standardne devijacije varijabli neprilagođenog sanjarenja, stilova suočavanja sa stresom i psihološkog distresa
TABLE 1. Arithmetic means and standard deviations of maladjusted daydreaming, coping styles, and psychological distress

Ljestvice / Scales		M	SD	Teorijski raspon rezultata / Theoretical range	Minimalni i maksimalni raspon rezultata / Minimal and maximal range
NDS		20,41	15.48	0-100	1,25-81,25
CISS	Problemu usmjereno suočavanje / Problem focused coping	3,59	0,51	1-5	2,25-4,91
	Emocijama usmjereno suočavanje / Emotion focused coping	2,61	0,64	1-5	1,56-4,25
	Izbjegavanje- Distrakcija / Avoidance- Distraction	3,07	0,57	1-5	1,50-4,38
	Izbjegavanje- Socijalna diverzija / Avoidance- Social diversion	4,12	0,58	1-5	2,80-5,00
CORE-OM	Subjektivna dobrobit / Subjective wellbeing	2,09	0,33	0-4	1,25-3,00
	Problemi / Problems	1,01	0,65	0-4	0,00-3,17
	Svakodnevno funkcioniranje / Daily functioning	2,10	0,26	0-4	1,5-2,92
	Rizična ponašanja / Risky behaviors	0,11	0,27	0-4	0,00-1,83

TABLICA 2. Povezanost između spola. neprilagođenog dnevnog sanjarenja (NDS), psihološkog distresa (CORE) i stilova suočavanja sa stresovima (CISS)
TABLE 2. Association between gender, maladaptive daydreaming (MD), psychological distress (CORE), and coping styles (CISS)

	CORE SD / CORE SW	CORE F	CORE P	CORE RP / CORE RB	CISS PUS / CISS PFC	CISS EUS / CISS EFC	CISS D	CISS SD
SPOL / GENDER	.04	0.19	-0.04	-0.33**	0.11	0.01	0.08	0.10
NDS / MDS	-0.06	-0.09	0.52**	0.38**	-0.25*	0.45**	-0.03	-0.14
CORE SD / CORE SW		0.59**	-0.06	-0.09	-0.23*	0.01	-0.17	-0.19
CORE F			-0.14	-0.17	-0.18	-0.04	-0.1	-0.09
CORE P				0.48**	-0.34**	0.69**	-0.09	-0.32**
CORE RP					-0.33**	0.35**	-0.06	-0.36**
CISS PUS / CISS PFC						-0.14	0.18	0.62**
CISS EUS / CISS EFC							0.26*	0.36**
CISS D								0.29**

Legenda: *p<0.05 **p<0.01
/ Legend: *p<0.05 **p<0.01

Neprilagođeno dnevno sanjarenje pozitivno je povezano s problemima, rizičnim ponašanjima i emocijama usmjerenom suočavanju te je negativno povezano sa suočavanjem usmjerenim na problem. Ovi rezultati ukazuju kako studenti koji više sanjare istodobno imaju više stupnjeve distresa te u većoj mjeri koriste suočavanje

tion focused coping, and negatively associated with problem focused coping. These results indicate that students who daydream more also have higher levels of psychological distress and use emotion focused more often when coping with stressful situations compared to students who dream less (Table 2). The correlation coef-

emocijama u stresnim situacijama, u odnosu na studente koji manje sanjare (tablica 2). Koeficijenti korelacije prikazani u tablici 2 također ukazuju na trend većeg korištenja problemu usmjerenog suočavanja studenata s nižim stupnjevima distresa, dok studenti s višim razinama distresa preferiraju suočavanje emocijama i manje koriste druženje s ljudima (tj. socijalnu diverziju) kao stil suočavanja.

Da bismo provjerili mogućnost predviđanja psihološkog distresa i stilova suočavanja na temelju dnevnog sanjarenja i spola napravljen je veći broj regresijskih analiza pri čemu su kao prediktori korišteni rezultati na NDS-u i spola (tablica 3). Kriterijske varijable bile su podljestvice na upitnicima CORE i CISS. Vrijednosti β pondera i pripadajućih t-testova prikazane su u tablici 3. za svaku kriterijsku varijablu posebno. Rezultati regresijske analize ukazuju da se temeljem rezultata postignutog na NDS upitniku može predvidjeti postojanje problema (β=0,52, p<0,01) i rizičnih ponašanja (β=0,38, p<0,01) kod studenata. Drugim riječima, ispitanici koji su skloniji NDS-u imaju veću vjerojatnost razvoja različitih psihičkih problema i rizičnih po-

ficients shown in Table 2 also indicate a trend toward greater use of problem focused coping by students with lower levels of distress, whereas students with higher levels of distress prefer emotion focused coping and also use socializing as a coping style (i.e. social diversion) to a lesser extent.

A number of regression analyzes were performed to test the possibilities of predicting psychological distress and coping styles based on MD scores and gender, in which the results on MDS and gender were used as predictors (Table 3). The subscales of the CORE-OM and CISS questionnaires were used as criterion. The value of the β weights and the corresponding t-tests are shown in Table 3 for each variable separately. The results of the regression analysis indicate that one can predict the psychological problems (β = 0.52, p <0.01) and risky behaviors (β = 0.38, p <0.01) in students based on the MDS results. In other words, respondents who are prone to MD were more likely to develop various psychiatric problems and risky behaviors. Furthermore, it was possible to predict the coping style with stressful situa-

TABLICA 3. Predviđanje općeg psihičkog statusa (CORE) i strategija suočavanja (CISS) temeljem izraženosti neprilagođenog dnevnog sanjarenja (NDS) i spola
TABLE 3. Predicting general psychological distress (CORE-OM) and coping styles (CISS) based on maladaptive daydreaming (MD) and gender

Prediktori / Predictors	Spol / Gender				NDS / MDS			
Kriteriji / Criterion	R_c	β	t	p	R_c	β	t	p
CORE – Subjektivna dobrobit / Subjective wellbeing	0.00	0.04	0.31	0.76	0.00	-0.06	-0.56	0.57
CORE – Funkcioniranje / Functioning	0.04	0.19	1.74	0.09	0.00	-0.09	-0.83	0.40
CORE – Problemi / Problems	0.00	-0.04	-0.31	0.76	0.26	0.52	5.32	0.00*
CORE – Rizična ponašanja / Risk behaviors	0.11	-0.33	-3.09	0.00*	0.14	0.38	3.65	0.00*
CISS – Problemu usmjereno suočavanje / Problem focused coping	0.01	0.11	0.95	0.35	0.06	-0.25	-2.27	0.02*
CISS – Emocijama usmjereno suočavanje / Emotion focused coping	0.00	0.01	0.13	0.90	0.20	0.46	4.50	0.00*
CISS – Izbjegavanje-Distrakcija / Avoidance-Distraction	0.00	0.08	0.75	0.46	0.00	-0.03	-0.22	0.82
CISS – Izbjegavanje-Socijalna diverzija / Avoidance-Social diversion	0.01	0.10	0.90	0.37	0.02	-0.14	-1.24	0.22

Legenda: *p<0.05 **p<0.01 / Legend: *p<0.05 **p<0.01
R_c - koeficijent multiple determinacije / multiple determination coefficient
β - standardizirani regresijski koeficijenti / standardized regression coefficient
t – t-test

našanja. Nadalje, na osnovi rezultata na NDS-u moguće je predvidjeti strategiju suočavanja sa stresnim situacija. To znači da će se ispitanici s izraženijim dnevnim sanjarenjem u manjoj mjeri suočavati sa stresovima na problemu usmjeren način (β=-0,25, p<0,05), a u većoj mjeri će iskazivati emocijama usmjereno suočavanje (β=0,46, p<0,01) u odnosu na ispitanike kod kojih je sanjarenje manje izraženo. Koeficijenti multiple determinacije R ukazuju da rezultati na ljestvici neprilagođenog dnevnog sanjarenja objašnjavaju najveći dio varijance varijabli problema (26 %) i emocionalnog suočavanja (20 %).

RASPRAVA

Nalazi ovog istraživanja potvrđuju dosadašnja saznanja o povezanosti NDS-a s različitim oblicima psiholoških problema odnosno s psihološkim distresom. Varijabla spola predviđa samo sklonost rizičnim ponašanjima kod muškaraca.

Novost koju istraživanje donosi ukazuje na pozitivnu povezanost NDS-a sa suočavanjem usmjerenim na emocije te na negativnu povezanost sa suočavanjem usmjerenim na problem. Ovaj nalaz većim dijelom potvrđuje postavljenu hipotezu o pozitivnoj povezanosti NDS-a sa suočavanjem usmjerenim na emocije i korištenjem distrakcije te negativnoj povezanosti NDS-a sa suočavanjem usmjerenim na problem. Dobiveni nalazi mogu se objasniti pretpostavkom da su osobe sa izraženim neprilagođenim sanjarenjem sklone preispitivanju na mentalnom planu poput samookrivljavanja, osjećajima emocionalne uznemirenosti i brigama, odnosno pažnja im je fokusirana na negativne emocije izazvane stresom, te su sklone nepoduzimanju konkretnih aktivnosti za rješavanje problema. Kako Somer neprilagođeno sanjarenje smatra strategijom suočavanja sa negativnim osjećajima, nalaz o negativnoj povezanosti NDS-a sa suočavanjem usmjerenim na problem, te pozitivnoj povezanosti s emocionalnim suočavanjem dobiva logičan smisao. U

tions based on the MD results. This means that subjects with more pronounced daydreaming were less likely to cope with stress in a problem focused style (β = −0.25, p <0.05) but more likely to apply an emotion focused style (β = 0.46. p <0.01) compared with subjects who had less pronounced daydreaming. Multiple determination coefficients R^2 indicated that MDS scores explained most of the variance in problem focused coping (26%) and emotion focused coping (20%).

DISCUSSION

The findings of this study confirmed the current knowledge about the association between maladaptive daydreaming and psychological distress. The gender variable predicted only a tendency to risky behaviors in men.

The novelty in the study was the indication of a positive association of MD with emotion focused coping and a negative association with problem focused coping. This finding mostly confirms the hypothesis about the positive association of MD with emotion focused coping and use of distraction and the negative association of MD with problem focused coping. The findings can be explained using the assumption that people with pronounced MD tend to experience mental challenges such as self-blame and feelings of emotional distress and anxiety, i.e. their attention is focused on negative emotions caused by stress, and that they are prone not to engage in concrete actions to solve problems. Given that Somer considers MD a strategy for coping with negative emotions, finding a negative association of MD with problem focused coping and a positive association with emotional coping makes sense. In this context, the explanation would be that the results did not confirm the use of distractions, which imply focusing to other specific tasks not related to the stress event (23), while MD is a mental activity.

tom kontekstu se može objasniti i to što rezultati nisu potvrdili korištenje distrakcija koje podrazumijevaju usmjeravanje na druge konkretne zadatke koji nisu povezani sa stresnim događajem (23), dok se NDS odvija na unutarnjem planu. Rezultati provedene regresijske analize potvrđuju mogućnost predviđanja suočavanja usmjerenog na emocije temeljem izraženosti dnevnog sanjarenja. Dnevno sanjarenje također predviđa suočavanje usmjereno na problem, ali u negativnom smjeru, budući da sanjarenja ispunjavaju veliki dio vremena tijekom dana kada bi trebalo poduzimati akcije usmjerene rješavanju problema. U literaturi se navodi da su strategije usmjerene na problem češće povezane s dobrom prilagodbom, dok su suočavanja usmjerena na emocije i izbjegavanja češće povezane sa slabijom prilagodbom pojedinca (35). Međutim, ljudi se nikada ne opredjeljuju isključivo za jednu od postojećih strategija suočavanja od kojih ni jedna nije ni „dobra" ni „loša" , a ni jedna isključuje drugu (36). Zato ljudi najčešće kombiniraju različite strategije pri čemu se međusobno razlikuju u stupnju preferiranja, za njih, dominantnih strategija. Tako neki ljudi općenito češće pronalaze i primjenjuju rješenja svojih problema, dok drugi češće preferiraju suočavanje s emocijama i tako ublažavaju stres. Zato veća sklonost emocionalnom suočavanju kod ispitanika s izraženijim dnevnim sanjarenjima ne znači nužno nastanak psihijatrijske bolesti već se može promatrati kao preferirani oblik suočavanja u stresnim situacijama.

Prema očekivanjima, utvrđena je povezanost podljestvica *Problemi i Rizična ponašanja* sa neprilagođenim sanjarenjem. Studenti koji imaju veću sklonost sanjarenju više izvještavaju o osjećajima napetosti, krivnje, bezvoljnosti, nesanici, neželjenim mislima i osjećajima te sklonosti rizičnim ponašanjima. Ovaj nalaz podupire postojeća saznanja o različitim oblicima psihopatologije (anksiozni poremećaji, depresivni poremećaji, generalizirana i socijalna anksioznost, disocijacija, više negativ-

The results of the regression analysis confirmed the possibility of predicting emotion focused coping based on the severity of daily daydreaming. MD also predicted problem focused coping, but in a negative direction, considering that daydreams occupy much of the time during the day when problem focused actions should be taken. The literature sources suggest that problem focused styles are more often associated with good adjustment, whereas emotion focused coping and avoidance are more often associated with poor adjustment (35). However, people never actually employ one of these coping strategies exclusively, neither of which is in itself either "good" or "bad" (36). People often combine different strategies in dealing with their own stress, and they differ in the degree to which they prefer a dominant strategy. For example, some people are more likely to find and apply solutions to their problems, while others more often prefer to deal with emotions and thus relieve stress. Therefore, a greater tendency for emotional coping in subjects with more pronounced daydreaming in this sample does not necessarily mean the onset of psychiatric illness but can be seen as the preferred form of coping in stressful situations.

As expected, a relationship between the Problems and Risky Behavior subscales with MD was identified. Students who had a greater tendency to daydream more often reported feelings of tension, guilt, unworthiness, insomnia, unwanted thoughts and feelings, and a tendency to take risky behaviors toward themselves and others. This finding supports current knowledge on various forms of psychopathology (anxiety disorders, depressive disorders, generalized and social anxiety, dissociation, and more negative and less positive emotions (11, 13) that may be in comorbidity with MD. The sample in this study included students whose average scores did not exceed the cutoff values for MD or psychological problems,

nih te manje pozitivnih emocija (11, 13) koji mogu biti u komorbiditetu s NDS-om. Kako se u ovom uzorku radi o studentima čiji prosječni rezultati ne prelaze granične vrijednosti neprilagođenog dnevnog sanjarenja ni psihopatologije, utvrđena povezanost može ukazivati na isti smjer veze koja bi mogla postojati i kod osoba s psihijatrijskim dijagnozama. Posebno značenje treba pridati povezanosti rizičnog ponašanja (posebice u smislu autodestruktivnih tendencija) i neprilagođenog sanjarenja koja je utvrđena u ovom istraživanju. Naime, Somer i sur. su među osobama sa NDS-om utvrdili čak 28,2 % pokušaja suicida (13). Provedena regresijska analiza potvrđuje neprilagođeno sanjarenje kao značajni prediktor psiholoških problema (anksiozno-depresivnih, psihosomatskih simptoma i traumatizacije) i rizičnih ponašanja (ponašanja rizična za pojedince i za druge) kod studenata. Ovaj nalaz može imati svoju praktičnu primjenu za rano otkrivanje stupnja NDS-a s ciljem preveniranja psihičkih smetnji, posebice suicidalnih rizika.

Pronađeno je samo jedno istraživanje u kojemu je ispitivana povezanost između sklonosti fantaziranju [definirana kao „sklonost učestalom dnevnom sanjarenju i bujnoj mašti"(37)], stilova suočavanja i psihopatologije. U tom istraživanju, za razliku od nalaza u našem istraživanju, nije utvrđena povezanost sklonosti fantaziranju ni s jednim stilom suočavanja, već samo sa somatizacijama i agresivnošću. Emocijama usmjereno suočavanje bilo je pozitivno povezano samo sa lošom prilagodbom (38). Nedostatak istraživanja u kojima se ispituje značaj NDS-a za odabir strategija suočavanja ukazuje na potrebu daljnjeg ispitivanja ovih fenomena i njihove povezanosti.

Sukladno očekivanju, nije potvrđen doprinos varijable spola razini psihološkog distresa i stilovima suočavanja. Rodne razlike su utvrđene samo na podljestvici rizičnih ponašanja CORE upitnika kojima su skloniji muškarci. U istraživanju provedenom u RH učestalija rizična

and the established correlation may only indicate the same direction of connection that may exist in persons with psychiatric diagnoses. Of particular importance is the established relationship between risky behaviors (especially in terms of self-destructive tendencies) and MD. Specifically, Somer et al. have found as many as 28.2% of suicide attempts among people with maladaptive daydreaming (13). The performed regression analysis confirms MD as a significant predictor of psychological problems (anxiety-depressive, psychosomatic, traumatization) and risky behaviors (for individuals and others). This finding may have practical applications for the early detection of the degree of maladaptation and the prevention of serious mental disorders, especially suicidal risks.

Only one similar study was found examining the association between the tendency to fantasize (defined as "the inclination to frequent daydreaming and imagination" (37)), coping styles, and psychopathological symptoms. In the present study, unlike the findings in that study, no association was found between tendencies to fantasize and any coping style. The association was established only between fantasizes and somatization/aggression as forms of potentially pathological behaviors. Emotion focused coping was only positively associated with poor adaptation (38). The lack of research examining the importance of maladaptive daydreaming for the selection of coping strategies indicates the need for further examination of these phenomena and their mutual correlations.

As expected, no significant contribution of the gender variable to the level of psychological distress and coping styles was confirmed. In this study, gender differences were found only for the risk behaviors subscale of the CORE questionnaire, which were more pronounced in men. In a study conducted in the Republic of Croatia, more frequent risk behaviors in

ponašanja muškaraca utvrđena su samo u kliničkom uzorku, dok su u nekliničkom uzorku žene češće izvještavale o problemima (17). U ovom se istraživanju muški spol također pokazao značajnim prediktorom rizičnih ponašanja. Značenje rodnih razlika za učestalost dnevnog sanjarenja nije potvrđeno ni u ranijim istraživanjima (39). Nalazi ovog istraživanja ne podupiru nalaze Endlera i Parkera prema kojima žene više koriste suočavanje usmjereno na emocije te suočavanje izbjegavanjem (23). Budući da je u ovom uzorku prevladavao broj žena, moguće je da rezultati većim dijelom odražavaju karakteristike žena što može biti razlog izostanku značajnih učinaka spola u ispitivanim fenomenima.

Rezultati ovog istraživanja unaprjeđuju znanstvene spoznaje o relativno novom i nedovoljno istraženom konceptu NDS-a i njegove povezanosti s psihopatološkim fenomenima i stilovima suočavanja. U praktičnom smislu nalazi ukazuju na potrebu utvrđivanja stupnja NDS-a u svrhu preveniranja negativnih posljedica na psihičko stanje, posebice samodestruktivnih ponašanja. Ovo istraživanje ima i nekoliko ograničenja: prvo, u istraživanju je sudjelovao relativno mali broj ispitanika dostupan u vremenu provedbe istraživanja, od kojih je većina bila žena (80 %). Prevelika zastupljenost žena navodi na pretpostavku da rezultati većim dijelom opisuju karakteristike žena na ispitivanim varijablama. U sljedećim sličnim istraživanjima treba planirati podjednak broj muškaraca i žena u uzorku. Ispitanici su bili homogeni prema dobi i svi su bili studenti što umanjuje mogućnost generalizacije rezultata na druge nekliničke i kliničke skupine. Sljedeće ograničenje je uporaba samoprocjenskih upitnika koji mogu odražavati trenutno stanje ispitanika, a ne njihove trajne osobine. U budućim istraživanjima bi se samoprocjenske mjere mogle kombinirati s drugim metodama procjene poput uspoređivanja sa postojećom psihijatrijskom dokumentacijom, ako ona postoji. Specifičnije razumijevanje ispitivanih fenomena, posebice

men were identified only in the clinical sample, while in the non-clinical sample women reported problems more frequently (17). In this study, male gender was a significant predictor of risky behaviors. The significance of gender differences in the incidence of MD has not been confirmed in previous studies (39). The findings of this study do not support Endler and Parker's findings that women are more likely to use emotion focused coping and avoidance coping (23). As women were the majority in our study, it is possible that the results of this study largely reflected the characteristics of women, which may be the reason for the absence of significant effects of gender in the phenomena examined.

The results of this study improve the scientific knowledge on the relatively new and under-researched concept of MD and its relation to psychopathological phenomena and coping styles. In practical terms, the findings indicate the need to determine the degree of MD in order to prevent its adverse effects on the mental state, in particular potential self-destructive behaviors. There are several limitations in this survey: first, the sample consisted of a relatively small number of respondents who were available at the time of the survey, most of which were women (80%). The over-representation of women suggests that the results largely describe the characteristics of women for the variables examined. In future similar studies an equal number of men and women in the sample should be planned. The subjects were homogeneous in age and all of them were students, so those facts may reduce the generalizability of the results to other non-clinical and clinical demographic groups. Another limitation is the use of self-report questionnaires that may reflect the current state of the respondents but not their more stable characteristics. In future research, self-assessment measures could be combined with other assessment methods such as comparison with existing psychiatric re-

nedovoljno istraženog NDS-a, bilo bi omogućeno korištenjem fokus grupa. Naposljetku, zbog nedostatka studija u kojima je korišten NDS nije bilo moguće uspoređivati dobivene rezultate s ranijim istraživanjima. U budućim istraživanjima bilo bi potrebno uključiti reprezentativniji uzorak koji bi uključivao veći broj ispitanika različitih dobnih skupina i različitog psihopatološkog statusa.

ZAKLJUČAK

U provedenom istraživanju utvrđene su povezanosti varijabli NDS-a, psihološkog distresa i stilova suočavanja u stresnim situacijama. Na osnovi rezultata na ljestvici NDS-a moguće predvidjeti stilove suočavanja pri čemu studenti koji više sanjare imaju više psihičkih problema i rizičnih ponašanja. Izraženija sklonost neprilagođenom dnevnom sanjarenju predviđa manju sklonost problemu usmjerenom suočavanju, te veću sklonost emocijama usmjerenom suočavanju u stresnim situacijama. Muški spol predviđa veću sklonost rizičnim ponašanjima prema sebi i drugima.

cords, if they exist. A more specific understanding of the phenomena examined, especially the under-researched MD, could be achieved by the use of focus groups. Finally, due to the lack of studies on MD, it was not possible to compare the results with previous studies. Future research should include a more representative sample that would include a larger sample of subjects with different ages and different psychopathological status.

CONCLUSION

An association between MD, psychological distress, and coping styles in stressful situations was identified in this study. Based on the results on the MDS scale, it was possible to predict coping styles, with students who daydream more having more psychological distress and risky behaviors. A more pronounced tendency to maladaptive daydreaming predicted a lower tendency to problem focused coping and a greater tendency to emotion focused coping in stressful situations. Male gender predicted greater propensity for risky behaviors.

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Obilježja prekida partnerske zajednice roditelja sa simptomima emocionalno nestabilne ličnosti

/ *Characteristics of Intimate Partnership Breakups in Parents with Symptoms of Emotionally Unstable Personality Disorder*

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Osobe s emocionalno nestabilnom ličnosti imaju značajne poteškoće u partnerskim odnosima. Njihovi odnosi su nestabilni i burni, obilježeni nepovjerenjem, razdobljima prekidanja i mirenja, ali i visokom stopom razvoda. Prekid partnerske zajednice, zbog osjetljivosti na odbijanje i straha od napuštanja, potencijalni je okidač koji može dovesti do aktivacije postojeće emocinoalno nestabilne ličnosti roditelja, intenziviranja njegovih simptoma, a posljedično i do različitih oblika neprikladnog i manipulativnog ponašanja. Svrha ovog rada je dobiti uvid u obilježja prekida partnerskih zajednica roditelja sa simptomima emocionalno nestabilne ličnosti. U radu su prikazani rezultati kvalitativnog istraživanja obilježja prekida bračne i izvanbračne zajednice roditelja sa simptomima emocionalno nestabilne ličnosti u kojem je sudjelovalo 12 socijalnih radnika i psihologa iz Odjela za zaštitu djece, obitelji i braka centara za socijalnu skrb na području grada Zagreba i Zagrebačke županije. Istraživanje je provedeno metodom polustrukturiranog intervjua. U obradi podataka korištena je tematska analiza. Prema rezultatima istraživanja prekidi partnerske zajednice roditelja sa simptomima emocionalno nestabilne ličnosti obilježeni su visokom razinom sukoba među roditeljima, nemogućnošću postizanja sporazuma oko ostvarivanja sadržaja roditeljske skrbi, manipulativnim ponašanjem i manipulacijom djetetom, drugim roditeljem (bivšim partnerom), stručnjacima i sustavom. Najčešći oblici manipulacije su onemogućavanje susreta i druženja djeteta s drugim roditeljem i članovima njegove obitelji, ocrnjivanje drugog roditelja i članova njegove obitelji pred djetetom i stručnjacima, neutemeljene prijave protiv drugog roditelja, učestali prigovori i prijave protiv postupanja nadležnih socijalnih radnika i drugih stručnjaka.

/ *Persons with emotionally unstable personality disorder have significant difficulties in intimate partnerships. Their relationships are unstable and intense and are marked by distrust, periods of temporary breakups and reconciliation, and a high rate of divorce. Breakups are, due to sensitivity to rejection and fear of abandonment, a potential trigger that can lead to the activation of existing emotionally unstable personality disorder in the parents and increase in the intensity of their symptoms, consequently leading to different forms of inappropriate and manipulative behavior. The goal of this study was to achieve insights in the characteristics of breakups in parents with symptoms of emotionally unstable personality disorder. The present article describes the results of a qualitative study on the characteristics of dissolution of martial and non-marital partnerships of parents with symptoms of emotionally unstable personality disorder, with the participation of 12 social workers and psychologists from the Department for the Protection of Children, Family, and Marriage of social welfare centers in the area of Zagreb and Zagreb County. The study was conducted in the form of semi-structured interviews. Data processing consisted of thematic analysis. According to the results of the study, breakups in parents with symptoms of emotionally unstable personality disorder are marked by a high level of conflict among the*

parents, inability to reach an agreement about organizing parental care, manipulative behavior, and manipulation of the child, the other parent (i.e. the ex-partner), social care professionals, and the system as a whole. The most common forms of manipulation are preventing the child from meeting and spending time with the other parent and members of their family, disparaging the other parent and members of their family in front of the child and social welfare professionals, unfounded accusations and reports against the other parents, and repeated complaints and reports against the conduct of social workers and other experts.

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UVOD

Osobe s emocionalno nestabilnom ličnosti[1] imaju značajne poteškoće u partnerskim i bliskim odnosima. Njihovi odnosi su burni i nestabilni, obilježeni nepovjerenjem, strahom od napuštanja, impulzivnim ponašanjem, kretanjem između krajnosti idealizacije i podcjenjivanja (1), razdobljima prekidanja i mirenja te visokom stopom razvoda (2-4). Nestabilnosti odnosa pridonosi polariziran, ali promjenjiv pogled koji se očituje u sagledavanju druge osobe kao isključivo dobre ili loše (1) što u situacijama kada ponašanje bliske osobe narušava idealiziranu sliku te osobe može rezultirati intenzivnim i primitivnim gnjevom (5) i impulzivnim ponašanjem koje se očituje u sklonosti suicidalnim pokušajima, samoranjavanju, riskantnim životnim stilovima (1,6),

[1] Prema MKB-10 sustavu. koji se službeno koristi u Hrvatskoj, emocionalno nestabilna ličnost obuhvaća nestabilno raspoloženje, nepredvidljivo ponašanje, impulzivnost i problematične emocionalne odnose (F60.3). U DSM klasifikaciji taj sesindrom naziva granični poremećaj ličnosti (engl. *borderline personality disorder*).

INTRODUCTION

Persons with emotionally unstable personality disorder[1] have significant difficulties in intimate partnerships and other close relationships. Their relationships are intense and unstable, marked by distrust, fear of abandonment, oscillation between extremes of idealization and disparagement (1), periods of temporary breakups and reconciliation, and a high rate of divorce (2-4). The instability of their relationships is exacerbated by a polarized, but changeable perspective that manifests as perceiving the other person exclusively as either good or bad (1), which can result in intense and primitive rage in situations where the behavior of the partner disrupts the idealized image of them (5) or in impulsive behavior that manifests in a tendency towards suicide attempts, self-harm, and risk-prone lifestyles (1,6), yelling, aggressive behavior, running away, etc.

[1] According to the MKB-10 system which is in official use in Croatia, emotionally unstable personality disorder comprises emotional instability, unpredictable behavior, impulsivity, and problematic emotional relationships (F60.3). DSM classifies this syndrome as borderline personality disorder.

vikanju, agresivnom ponašanju, bježanju i sl. (4). Sukladno tome smatra se da brojni simptomi emocionalno nestabilne ličnosti proizlaze iz poteškoća u interpersonalnim odnosima, hipersenzibilnosti i intenzivnog straha od napuštanja i odbacivanja (7) koji korespondira s panikom, emocionalnom nestabilnosti, dugoročnom napetosti, manipulacijom, ljutnjom i impulzivnosti (4,8).

Agresivno i nasilno ponašanje često je povezano s emocionalnom nestabilnosti, pristranosti emocionalne obrade, stilovima privrženosti, osobito s anksioznim i izbjegavajućim stilom privrženosti, zlouporabom sredstava ovisnosti i impulzivnosti (9). Sukladno tome, veća vjerojatnost izražavanja agresivnog ponašanja prisutna je kod osoba koje doživljavaju višu razinu anksioznosti i izbjegavanja u partnerskim ili intimnim odnosima, ljutitost i razdražljivost povezane su s osjećajem tjeskobe zbog odnosa, a izbjegavanje sa samoranjavanjem (10). Zbog osjetljivosti na dinamiku odnosa i straha od napuštanja neke osobe s emocionalno nestabilnom ličnosti mogu koristiti agresiju i emocionalne ucjene s ciljem kontrole druge osobe i izbjegavanja napuštanja, neke kako bi izbjegle bliskost i na taj način minimalizirale rizike napuštanja, a neke kako bi agresijom pokazale svoju moć i važnost (6,10-12). Ovi simptomi ukazuju na unutarnji konflikt između potrebe za bliskosti i straha koji osobe s emocionalno nestabilnom ličnosti osjećaju u interpersonalnim odnosima. One mogu istovremeno željeti bliskost i intimnost i biti nepovjerljive i u strahu (npr. da će biti povrijeđene, napuštene i sl.). Sukladno tome, izraženiji simptomi emocionalno nestabilne ličnosti povećavaju vjerojatnost doživljaja bračnog stresa, obiteljskog nasilja i razvoda (3,4).

Za razumijevanje straha od napuštanja i osjetljivosti na odbijanje važna je teorija privrženosti. Začetnik teorije privrženosti John Bowlby već je 70-ih godina prošlog stoljeća istaknuo važnost razumijevanja unutarnjih radnih mo-

(4). It is therefore believed that many symptoms of emotionally unstable personality disorder stem from difficulties in interpersonal relationships, hypersensibility, and an intense fear of rejection and abandonment (7) that corresponds to panic, emotional instability, long-term tension, manipulation, anger, and impulsivity (4,8).

Aggressive and violent behavior is often associated with emotional instability, biased emotional processing, some attachment styles, especially anxious and avoidant attachment styles, abuse of addictive substances, and impulsivity (9). Consequently, there is a higher likelihood of expressing aggressive behavior in persons who experience a higher level of anxiety and avoidance in partnerships or intimate relationships, while anger and irritability are associated with the feeling of anxiety due to the relationship, and avoidance is associated with self-harm (10). Due to their sensitivity to the dynamics of the relationship and the fear of abandonment, some persons with emotionally unstable personality disorder can use aggression and emotional blackmail as an attempt to control the other person and avoid abandonment, to avoid intimacy and thus minimize the risk of abandonment, or to use aggression to demonstrate their power and importance (6,10-12). These symptoms point to an inner conflict between the need for intimacy and the fear that persons with emotionally unstable personality disorder feel in interpersonal relationships. They might simultaneously yearn for intimacy and be distrustful and in fear (e.g. of being hurt, abandoned, etc.). Therefore, more pronounced symptoms of emotionally unstable personality disorder increase the likelihood of marital stress, family violence, and divorce (3,4).

Attachment theory is crucial to understanding fear of abandonment and sensitivity to rejection. Attachment theory was originated by John Bowlby in the 1970s, who pointed out the importance of understanding the inner working models of attachment in the context of explaining different modes of emotional anxiety

dela privrženosti u kontekstu objašnjenja različitih oblika emocionalne uznemirenosti i poremećaja ličnosti. Smatrao je da se formirana privrženost u djetinjstvu nalazi u pozadini sposobnosti ostvarivanja emocionalnih odnosa te cijelog niza poremećaja u odrasloj dobi uključujući bračne probleme, probleme s djecom, poremećaje ličnosti i neurotične simptome (13). Većina osoba s emocionalno nestabilnom ličnosti u djetinjstvu doživjela je traumu, najčešće neki od oblika zlostavljanja (14-17) što povećava vjerojatnost razvijanja negativnog unutarnjeg radnog modela i poremećaja privrženosti. Sukladno tome, osobe s ovim poremećajem ličnosti zbog doživljenog nasilja i zlostavljanja u djetinjstvu, imaju veću vjerojatnost da će sebe percipirati kao osobe koje nisu vrijedne pažnje i ljubavi, koje nisu sigurne ni sposobne, a druge kao opasne i prijeteće osobe kojima se ne može vjerovati. Posljedično, zbog internalizacije zlostavljanja i zanemarivanja u obliku relacijskog predloška s potencijalom da se u budućim odnosima očekuju zlostavljanje i odbacivanje, mogu razviti nesiguran stil privrženosti (10,17-19). Osim nesigurnog stila privrženosti, kod osoba s emocionalno nestabilnom ličnosti zabilježene su preokupirana, neriješena (17,19,20), odbijajuća (17,20,22,23), anksiozna (24,25) i tzv. CC privrženost (nemogućnost klasificiranja stila privrženosti)(17).

Na teoriju privrženosti nadovezuje se teorija mentalizacije Fonagyja i sur. prema kojoj se smanjena sposobnost mentaliziranja nalazi u pozadini interpersonalnih poteškoća, afektivne nestabilnosti i smetnji identiteta koje su karakteristične za emocionalno nestabilnu ličnost (26-28). Teorija mentalizacije osmišljena je s namjerom da se objasni psihopatologoija graničnog poremećaja ličnosti. Prema ovoj teoriji mentaliziranje se odnosi na proces pomoću kojeg određujemo smisao svojih i tuđih subjektivnih stanja i mentalnih procesa. Pri tome se razumijevanje ponašanja drugih i njihovih vjerojatnih misli i osjećaja smatra

and personality disorders. He believed that the attachment formed in childhood is at the foundation of the ability to form emotional relationships and a whole series of adult disorders that includes marital problems, problems with children, personality disorders, and neurotic symptoms (13). Most persons with emotionally unstable personality disorder experienced a trauma in childhood, usually some form of abuse (14-17), which increases the likelihood of developing a negative inner working model and an attachment disorder. Due to the violence and abuse experienced in childhood, persons with this type of personality disorder have a greater likelihood of perceiving themselves as unworthy of love and attention and as unsure and incompetent, while perceiving others as dangerous and threatening persons who cannot be trusted. They can consequently develop an insecure attachment style by internalizing the abuse and neglect as a relationship template that potentially leads them to expect abuse and abandonment in future relationships (10,17-19). Other than the insecure attachment style, persons with emotionally unstable personality disorder exhibit preoccupied, unresolved (17,19,20), dismissive (17,20,22,23), anxious (24,25), and the so-called CC attachment (cannot classify) style (17).

Attachment theory spurred the development of mentalization theory by Fonagy et al., according to which reduced ability to mentalize is at the core of interpersonal difficulties, affective instability, and identity disorders characteristic for emotionally unstable personality disorder (26-28). Mentalization theory was created with the goal of explaining the psychopathology of borderline personality disorder. According to this theory, mentalization is a process through which we determine the meaning of subjective states and mental processes in ourselves and others. Understanding the behavior of others and their likely mental states and emotions is considered a developmental achievement that stems from the child-caregiver relationship (26), i.e. the caregiver's "marked consistent represen-

razvojnim postignućem koje proizlazi iz odnosa dijete-skrbnik (26), odnosno skrbnikovog (majčinog) „obilježenog dosljednog predočavanja“ (zrcaljenja) djetotovih unutarnjih stanja u kontekstu sigurne privrženosti, a obuhvaća majčino zrcaljenje emocionalnog stanja djeteta, njezinu re-prezentaciju i ispravno tumačenje djetetovih osjećaja i potreba. Tako dijete razvija doživljaj vlastitog unutarnjeg svijeta i svijest o mogućnosti da svojim osjećajima izazove promjenu u majčinom ponašanju (29). Sukladno tome poremećaji ranih odnosa privrženosti, traumatična iskustva, zlostavljanje, neosjetljivost i neempatičnost skrbnika mogu negativno utjecati na djetetovu sposobnost mentaliziranja (29-31). Deficiti u mentaliziranju (funkcioniranja na predmentalizacijskim i nementalizacijskim razinima razmišljanja) povezuju se s modelima nesigurne privrženosti, a iskustva osobe su tada prekonkretna, potpuno beznačajna ili je razumijevanje motiva za ponašanje potpuno fizičko (29).

VISOKOKONFLIKTNI RAZVODI

Postojeća emocionalno nestabilna ličnost roditelja zbog straha od napuštanja i osjetljivosti na odbacivanje, može se aktivirati i doći do izražaja tijekom i nakon prekida partnerske zajednice te rezultirati neprikladnim i manipulativnim ponašanjima. Osobe s ovim poremećajem ličnosti mogu se obećati partneru, prijetiti samoubojstvom ili pokušati samoubojstvo (4,32). Prijetnje samoubojstvom ponekad su poziv u pomoć, a ponekad posljedica emocionalnog kraha. Procjenjuje se da 10 % osoba na kraju izvrši samoubojstvo. U takvim situacijama partneri ponekad dobivaju oproštajno pismo s porukom da su oni „krivi“ zbog počinjenog samoubojstva (4). Zbog osjećaja usamljenosti neke osobe pažnju usmjere na djecu (2) kako bi na taj način umanjile osjećaj usamljenosti. Ponekad stvaraju nezdrav i ovisan odnos s djecom koja mogu biti zamjena za partnera. Također,

tation” (mirroring) of the child’s inner states in the context of secure attachment, and comprises the mother’s mirroring of the child’s emotional state, her representation and correct interpretation of the child’s feelings and needs. The child thus develops a mental image of their own inner world and becomes conscious of their ability to change the mother’s behavior through their feelings (29). Disorders in early attachment relationships, such as traumatic experiences, abuse, and insensitivity and lack of empathy in the caregiver can negatively influence the child’s ability to mentalize (29-31). Mentalization deficits (functioning at the pre-mentalization and non-mentalized levels of thought) are associated with insecure attachment models, and the experiences of such persons are too concrete, completely insignificant, or their understanding of motives for behavior is completely physical (29).

HIGH CONFLICT DIVORCES

Due to the fear of abandonment and sensitivity to rejection, a dormant emotionally unstable personality disorder in a parent can be activated and manifest during and after the dissolution of an intimate partnership, resulting in inappropriate manipulative behavior. Persons with this personality disorder can threaten or commit suicide (4,32). Threats of suicide are sometimes a call for help and sometimes the consequence of an emotional breakdown. It is estimated that 10% of such threats ultimately result in suicide. In such situations, partners sometimes receive farewell letters indicating that the suicide is their “fault” (4). Some persons focus their attention on children (2) to reduce the feeling of loneliness. They sometimes create an unhealthy and dependent relationship with the children who serve as a replacement for the partner. They also have a tendency to use the children to blackmail and punish the ex (bad) partner (4). This is most common in high conflict divorces that are marked by highly

sklone su djecu koristiti kako bi ucjenjivale i kažnjavale bivšeg (lošeg) partnera (4). Najčešće je riječ o tzv. visokokonfliktnim razvodima koji se javljaju u situacijama obilježenim snažno izraženim sukobom koji je posljedica nesuglasica koje roditelji (bivši bračni partneri) ne mogu riješiti i zbog kojih kreću u „rat" koji se odražava na njih, njihovu djecu, ostatak obitelji, prijatelje, ponekad čak i zajednicu (33). Procjenjuje se da je oko jedna trećina svih razvoda obilježena visoko izraženim konfliktom koji se kod 8-12 % roditelja nastavlja i nakon razvoda braka. Riječ je o roditeljima koji su emocionalno uznemireniji, manje stabilni te s više poteškoća u funkcioniranju ličnosti (33,34).

Kao obilježja trajnog sukoba prije razvoda braka Johnston (34,35) navodi izražavanje izrazite ljutnje i nepovjerenja partnera, kontinuirano verbalno zlostavljanje, povremenu tjelesnu agresiju, teškoće u komunikaciji s djecom, teškoće supružnika u komunikaciji oko odgoja djece te ometanje odnosa roditelja s djetetom od drugog roditelja koje, također, možemo pokušati razumjeti u kontekstu emocionalno nestabilne ličnosti. Osobe s emocionalno nestabilnom ličnosti sklone su verbalnoj (9,36) i fizičkoj agresiji (3,9,31,38,39), obiteljsko okruženje karakterizira visoka razina sukoba i niska razina kohezije (6), postoje broje poteškoće vezane uz izvršavanje roditeljske uloge, uključujući nemogućnosti postizanja sporazuma oko odgoja djece i izvršavanja roditeljske skrbi, stoga možemo zaključiti da emocionalno nestabilna ličnost roditelja povećava vjerojatnost pojave trajnog sukoba prije i nakon razvoda, odnosno prekida izvanbračne zajednice.

MANIPULATIVNA PONAŠANJA I MANIPULACIJA

Manipulativna ponašanja roditelja često se javljaju u situacijama visokokonfliktnih razvoda i prekida izvanbračne zajednice, a obuhvaćaju niz različitih ponašanja, verbalnih i

prominent conflicts that are the consequence of disagreements which the parents (previously partners) cannot resolve and over which they go to "war", affecting them, their children, the rest of the family, friends, and sometimes even the community as a whole (33). It is estimated that about a third of all divorces are marked by high levels of conflict, which continues even after the divorce in 8-12% of the parental couples. These happens for parents who are more emotionally agitated, less stable, and have more functional difficulties in their personalities (33,34).

Johnson (34,35) identifies expressing anger and distrust towards the partner, continuous verbal abuse, intermitted physical aggression, difficulties in communicating with children, communication difficulties between partners on how to raise the children, and disrupting the other partner's relationship with a child as indicators of long-lasting conflict before divorce, all of which we can attempt to understand through in the context of emotionally unstable personality disorder. Persons with emotionally unstable personality disorder are more prone to verbal (9,36) and physical aggression (3,9,31,38,39), their family environment is characterized by a high level of conflict and low levels of cohesion (6), and they tend to have numerous difficulties in performing parental care and raising children, which allows us to conclude that emotionally unstable personality disorder in parents increases the likelihood of long-lasting conflict before and after the divorce or cohabitation dissolution.

MANIPULATIVE BEHAVIORS AND MANIPULATION

Manipulative behaviors in parents often manifest during high conflict divorces and cohabitation dissolution and comprise a number of different behaviors and verbal and non-verbal messages to the children that paint a negative picture of the other parent, with the goal of excluding them from the child's life and alienating the child from

neverbalnih poruka roditelja koja djetetu šalju negativnu poruku o drugom roditelju s ciljem njegova isključivanja iz života djeteta i otuđivanja djeteta od roditelja bez postojanja razloga koji proizlazi iz odnosa roditelj – dijete. Kod roditelja koji živi s djetetom manipulativna ponašanja manifestiraju se otežavanjem ili onemogućivanjem susreta i druženja djeteta s drugim roditeljem, što u kombinaciji s negativnim porukama i kvalifikacijama roditelja s kojim dijete živi o roditelju s kojim dijete ne živi može dovesti do djetetove nevoljkosti i odbijanja susreta s roditeljem s kojim ne živi. S druge strane, roditelj s kojim dijete ne živi može koristiti susrete s djetetom kao prigodu za slanje negativnih poruka o drugom roditelju (roditelju s kojim dijete živi), komentiranje odgojnih zahtjeva koje drugi roditelj postavlja pred dijete u negativnom kontekstu te prikupljanje informacija o drugom roditelju uz negativno komentiranje čime se dijete stavlja u nepovoljan položaj, zlouporabljuje pravo na susrete s djetetom i potiče otpor djeteta u odnosu na roditelja s kojim živi.

Neutemeljene prijave zlostavljanja i zanemarivanja djeteta usmjerene protiv drugog roditelja poseban su oblik manipulativnih ponašanja (40) pri čemu je važno razlikovati nedokazane optužbe od namjerno proizvedenih. Nedokazane optužbe mogu biti rezultat dobre namjere roditelja koja proizlazi iz sumnjive ozljede djeteta, njegovog čudnog ponašanja, pogrešno protumačene izjave djeteta, nedovoljnog poznavanja djetetove reakcije na razvod i njezinog pogrešnog tumačenja te publiciteta spolnog zlostavljanja koji može rezultirati preosjetljivošću roditelja na mogućnost i simptome potencijalnog zlostavljanja. S druge strane, namjerne optužbe imaju za cilj manipulaciju pravnim, zdravstvenim i socijalnim sustavom radi dobivanja skrbništva i osvete bivšem partneru (41).

Lažnim optužbama sklone su majke s histrionskom strukturom ličnosti, strukturom ličnost

that parent without a valid reason to exclude them from the life of the child stemming from the parent-child relationship itself. In parents living with the child, the manipulative behaviors manifest as attempts to hamper or prevent the other parent from meeting and spending time with the child, which in combination with the negative messaging directed towards the child regarding the parent they are not living with can lead to reticence or refusal on part of the child to meet that parent. On the other hand, the parent not living with the child can use meetings with the child as an opportunity to send negative messages about the other parent (with whom the child is living) and comment on the parental demands placed on the child by the other parent in a negative way, putting the child in an unfavorable position and abusing the parental right to meet the child as well as encouraging resistance towards the parent the child is living with.

Baseless reports of abuse and neglect of the child directed at the other parent are another form of manipulative behavior (40), where it is important to differentiate unproven accusations from intentionally fabricated ones. Unproven accusations can be made in good faith as a result of suspicious injuries, uncharacteristic behavior, misunderstood statements, and insufficient understanding of the child's reaction to the divorce and consequent interpretation of this behavior, as well as the general publicity of sexual abuse, all of which have the potential to create oversensitivity in the parent to the possibility and symptoms of potential abuse. On the other hand, intentionally fabricated accusations are made with the goal of manipulating the legal, healthcare, and social welfare system in order to gain custody and achieve revenge against the ex-partner (41).

Mothers with a histrionic personality structure are prone to false accusations, i.e. the "righteous avenger" personality structure, as are mothers with emotionally unstable personality disorder, which is characterized by a highly dysfunctional mode of behavior in divorces that includes

„pravedna osvetnica“ (varijacija histrionske ličnosti) te emocionalno nestabilnom ličnosti koju karakterizira visoko disfunkcionalan način funkcioniranja u situacijama razvoda, gubitak dodira s realitetom, osebujni i bizarni opisi događaja iz prošlosti koji su nemogući i nemaju veze s realnošću (41,42). Muškarci s emocionalno nestabilnom ličnosti skloniji su nasilnom ponašanju i pokretanju sudskih sporova zbog čega je njihovo ponašanje lakše uočiti, dok su žene sklonije manipulativnom ponašanju i kontroli zbog čega njihovo ponašanje nerijetko ostaje neprepoznato kao takvo. Primjerice, majke često neće odgovoriti na telefonske pozive i pisma očeva u vezi dogovora zajedničkog vikenda ili godišnjeg odmora oca s djetetom, a ako se otac samo jednom ne složi s majčinim zahtjevom vezanim uz njezino provođenje vremena s djetetom, ona će se odmah obratiti nadležnim stručnjacima i stvoriti sliku oca kao osobe koja odbija suradnju, s kojom nije moguće postići dogovor i koja se nije spremna prilagoditi. Također, sklone su lažno optužiti očeve za različite oblike nasilja, uključujući fizičko i seksualno nasilje s ciljem dobivanja skrbništva nad djetetom (5).

Kao posljedica manipulativnih ponašanja roditelja kod djeteta se može razviti sindrom otuđenja od roditelja. Riječ je o psihološkom stanju djeteta koje je uvjetovanom manipulacijom od roditelja koji ima skrbništvo, odnosno s kojim dijete živi, i koji intenzivno nastoji okrenuti dijete protiv drugog roditelja potičući kod djeteta mržnju prema drugom roditelju (43). Krnić (44) razlikuje sindrom otuđenja od roditelja i sindrom zlonamjernog roditelja. Za sindrom otuđenja od roditelja karakteristična je djetetova opsjednutost negativnim aspektima jednog roditelja pri čemu su djetetove optužbe ili netočne ili djelomično točne, ali s velikim pretjerivanjem. Kod djeteta je prisutan osjećaj trajne krivnje tijekom kontakta s roditeljem s kojim ne živi, a koji je posljedica ponašanja drugog roditelja. Za sindrom zlonamjernog roditelja

losing touch with reality and idiosyncratic and bizarre descriptions of past events that are impossible and have nothing to do with reality (41,42). Men with emotionally unstable personality disorder are more prone to violent behavior and to starting court battles, making their behavior easier to spot, while women are more prone to manipulative and controlling behavior, often resulting in their behavior going unrecognized for what it is. For example, mothers will often ignore letters and phone calls from the father attempting to arrange spending a weekend or vacation with the child, but if the father ever disagrees with the mother's requests regarding her spending time with the child she will immediately report him to the relevant authorities and create an image of the father as a person who is refusing to cooperate, with whom an agreement cannot be reached, and who is not willing to compromise. They are also prone to falsely accusing fathers of various types of violence, including physical and sexual abuse, with the goal of winning custody over the child (5).

Manipulative behaviors in the parents can lead to the development of parental alienation syndrome. This is a psychological state in the child that is conditioned through manipulation on part of the parent with custody, i.e. the parent the child is living with, when the manipulation is an intensive attempt to turn the child against the other parent and encourage hatred towards them (43). Krnić (44) differentiates between parental alienation syndrome and malicious parent syndrome. Parental alienation syndrome is characterized by the child's obsession for the negative aspects of one parent, where the child's accusations are either incorrect or partially correct but severely overblown. A constant feeling of guilt is present in the child during contact with the parent with whom they do not live, which is the consequence of the behavior of the other parent. Malicious parent syndrome is characterized by one parent becoming obsessed with (maliciously) punishing the other parent, which manifests as attacks on the other parent

karakteristična je opsjednutost jednog roditelja (zlonamjernog) kažnjavanjem drugog roditelja koja se očituje napadima na drugog roditelja i/ili njegovu imovinu, ocrnjivanjem drugog roditelja, manipulacijom drugim ljudima pa i kršenjem zakona, odnosno lažnim optužbama za spolno zlostavljanje djece od drugog roditelja, krađom dokumenata drugog roditelja i sl.

U opisanim situacijama stručnjaci centara za socijalnu skrb (CZSS) imaju važnu ulogu u zaštiti dobrobiti maloljetne djece i postizanju sporazuma među roditeljima oko ostvarivanja sadržaja roditeljske skrbi, međutim, nerijetko su i oni žrtve manipulativnih ponašanja roditelja. Roditelji u slučaju lažnih optužbi o spolnom zlostavljanju na pitanja stručnjaka često odgovaraju općenito, navodeći kako ne znaju što se je točno dogodilo, istovremeno dajući informacije na koje stručnjaci, prema profesionalnoj dužnosti, moraju reagirati i sukladno tome, prijaviti zlostavljanje mjerodavnim institucijama (41). Iskustva iz prakse pokazuju da su korisnici usluga i prava u sustavu socijalne skrbi, osobito roditelji tijekom postupka razvoda i odlučivanja o roditeljskoj skrbi, skloni učestalim (neopravdanim) prigovorima i prijavama protiv postupanja nadležnih socijalnih radnika i drugih stručnjaka.

CILJEVI I ISTRAŽIVAČKA PITANJA

U ovom radu usmjereni smo na obilježja prekida partnerske zajednice roditelja sa simptomima emocionalno nestabilne ličnosti što je dio opsežnijeg istraživanja upoznatosti stručnjaka iz centara za socijalnu skrb s emocionalno nestabilnom ličnosti i poteškoćama koje imaju u radu s korisnicima sa simptomima ovog poremećaja ličnosti.[2]Sukladno tome, postavljena su sljedeća istraživačka pitanja:

[2] S obzirom da je ovaj rad dio šireg istraživanja svrha i ciljevi rada, istraživačka pitanja, uzorak, postupak prikupljanja podataka, metodološka ograničenja i dio postupka obrade podataka opisani su na sličan način kao u radu Maljuna, Ajduković i Ostojić (45)

and/or their property, denigrating the other parent, manipulating other people, and even breaking the law such as making false accusations of child sexual abuse on part of the other parent, stealing documents from the other parent, etc.

In these kinds of situations, experts working in social welfare centers (SWC) have an important role in protecting underage children and achieving an agreement between parents on how to provide parental care, but they themselves can sometimes become victims of the manipulative behavior on part of a parent. When making a false accusation on sexual abuse, the parent will often give general answers in response to the expert's questions, claiming that they do not know what happened exactly but still providing sufficient information for the experts to be professionally required to react and report the abuse to the responsible institutions (41). Experience has shown that those availing themselves to the services and rights within the social welfare system, especially in the case of parents in divorce or custody proceedings, are prone to repeated (unwarranted) complaints and reports against the social workers and other experts involved in the process.

GOALS AND RESEARCH QUESTIONS

In this article, we focus on the characteristics of parental partnership dissolution in parents with symptoms of emotionally unstable personality disorder, which is part of a larger study on the awareness of social welfare center professionals with emotionally unstable personality disorder and difficulties they face when working with those who exhibit symptoms of this disorder.[2] Therefore, the following research questions were posed:

[2] Given that this article is part of a larger study, the aim and goals, research questions, sample, data collection procedure, methodological limitations, and part of the data processing are described in similarly to Maljuna, Ajduković, and Ostojić (45).

1. Koje simptome emocionalno nestabilne ličnosti roditelja stručnjaci Odjela za zaštitu djece, braka i obitelji pri centru za socijalnu skrb prepoznaju u situacijama ugrožene dobrobiti djeteta?
2. U kojim situacijama prema mišljenju stručnjaka Odjela za zaštitu djece, braka i obitelji simptomi emocionalno nestabilne ličnosti roditelja dolaze do izražaja?
3. Koje intervencije poduzimaju stručnjaci Odjela za zaštitu djece, braka i obitelji prema roditeljima kod kojih su prisutni simptomi emocionalno nestabilne ličnosti u situacijama ugrožene dobrobiti djeteta?
4. S kojim poteškoćama se susreću stručnjaci Odjela za zaštitu djece, braka i obitelji u radu s roditeljima kod kojih su prisutni simptomi emocionalno nestabilne ličnosti?
5. Koje su potrebe stručnih djelatnika Odjela za zaštitu djece, braka i obitelji koji rade s roditeljima kod kojih su prisutni simptomi emocionalno nestabilne ličnosti?

METODOLOGIJA ISTRAŽIVANJA

Uzorak

Istraživanjem je obuhvaćeno 12 socijalnih radnica i psihologinja zaposlenih na Odjelu za zaštitu djece, obitelji i braka pri centrima za socijalnu skrb na području grada Zagreba i Zagrebačke županije. Odabir sudionika temeljio se na načelima kompetentnosti, dobrovoljnosti i motiviranosti za sudjelovanjem u istraživanju. Sudionik istraživanja trebao je biti dobar informator, zaposlen kao socijalni radnik ili psiholog na Odjelu za zaštitu djece, obitelji i braka pri centru za socijalnu skrb. Raspon dobi sudionika kreće se između 30 i 60 godina (prosječna dob je 45 godina). Svi sudionici istraživanja su ženskog spola. Od ukupnog broja sudionika, 9 sudionika su socijalne radnice, a 3 sudionika psihologinje. Prosječno trajanje ostvarenog

1. Which symptoms of emotionally unstable personality disorder does the staff of the Department for the Protection of Children, Family, and Marriage at the social welfare center recognize in situations in which the welfare of the child is endangered?
2. In which situations do the symptoms of emotionally unstable personality disorder in parents manifest, in the opinion of the staff at the Department for the Protection of Children, Family, and Marriage?
3. Which interventions does the staff at the Department for the Protection of Children, Family, and Marriage employ when symptoms of emotionally unstable personality disorder manifest in situations in which the welfare of the child is endangered?
4. Which difficulties does the staff at the Department for the Protection of Children, Family, and Marriage face in working with parents who present with symptoms of emotionally unstable personality disorder?
5. What are the needs of the staff at the Department for the Protection of Children, Family, and Marriage working with parents who present with symptoms of emotionally unstable personality disorder?

RESEARCH METHODOLOGY

Sample

This study included 12 female social workers and psychologists employed at the Department for the Protection of Children, Family, and Marriage at social welfare centers in the area of Zagreb and Zagreb County. Participant selection was based on the principles of competence, voluntary participation, and motivation for participation in the study. Study participants had to be good informants and be employed as a social worker or psychologist at the Department for the Protection of Children, Family, and Marriage in a social welfare center.

ukupnog radnog staža u struci sudionika je 18 godina (od 2 do 35 godina), a radnog staža na Odjelu za zaštitu djece, obitelji i braka 8 godina (od 1 do 10 godina). Uzorak je namjerni.

Postupak prikupljanja podataka

Podatci su prikupljani metodom polustrukturiranog intervjua[3] temeljem suglasnosti ravnatelja CZSS, u sklopu aktivnosti programa „Sustavna podrška obiteljima s djecom: Procjenjivanje i smanjivanje rizika za dobrobit djece" UNICEF-a, Društva za psihološku pomoć i Ministarstva za demografiju, obitelj, mlade i socijalnu politiku. Prije svakog intervjua ispitaniku je objašnjeno tko provodi istraživanje, u koju svrhu i s kojim ciljevima. Navedeno je očekivano trajanje intervjua te da će intervju, uz njihovu prethodnu suglasnost, biti sniman aplikacijom diktafona na mobilnom uređaju. Sudionicima istraživanja zajamčena je dobrovoljnost, povjerljivost, anonimnost, pravo na odustajanje od razgovora tijekom intervjua te pravo ne odgovaranja na pojedina pitanja. Intervjui su u prosjeku trajali 31 minutu. Devet intervjua provedeno je u prostorijama centara za socijalnu skrb, a tri intervjua u ugostiteljskom objektu (kafiću). Postupak prikupljanja podataka trajao je od travnja do srpnja 2019. godine.

Postupak obrade podataka

Dobiveni zvučni zapisi su transkribirani uz minimalno jezično uređivanje. U obradi podataka korištena je kvalitativna analiza podataka koja je provedena postupkom tematske analize, a koja ima eksplorativni karakter. Teme se definiraju kao dijelovi u cjelini prikupljenih podataka koji su važni za istraživačka pitanja te predstavljaju obrasce određenog sadržaja. Pomoću tematske analize moguće je opisati, ali

[3] Predložak s pitanjima za polustrukturirani intervju može se dobiti na upit od prve autorice teksta.

The age range of participants was between 30 and 60 years of age (average age 45). All participants were women. Nine participants were social workers, and 3 participants were psychologists. Average total work experience in the field for the participants was 18 years (between 2 and 35 years), and employment at the Department for the Protection of Children, Family, and Marriage was 8 years on average (between 1 and 10 years). Sampling was purposeful.

Data acquisition

Data was acquired via a semi-structured interview[3] approved by the director of the SWC, as part of the "Systematic Support for Families with Children: Assessing and Reducing Risk to Child Welfare" program by UNICEF, the Society for Psychological Aid, and the Ministry of Demography, Family, Youth, and Social Policy. Prior to each interview, each participant received an explanation of who was conducting the study and of its goals and purpose. The expected duration of the interview was indicated, and the participant was informed that the interview will be recorded with using a mobile phone recording application. Participants in the study were guaranteed voluntary participation, confidentiality, anonymity, the right to terminate the conversation during the interview, and the right to decline to answer individual questions. Interviews lasted 31 minutes on average. Nine interviews were conducted in the offices of the social welfare centers, and 3 were conducted in a coffee shop. The data acquisition process lasted from April 2019 to July 2019.

Data processing

The acquired recordings were transcribed with minimal language editing. Data analysis used exploratory qualitative analysis using thematic

[3] The template for the semi-structured interview is available upon request form the first author of this article.

i dodatno interpretirati različite aspekte istraživanog konstrukta (46).

U ovom radu bit će prikazane tematske cjeline „Situacije u kojima do izražaja dolaze simptomi emocionalno nestabilne ličnosti roditelja“ s naglaskom na prekide bračnih i izvanbračnih zajednica i – „Manipulativna ponašanja“.

Podatci o tematskim cjelinama „Situacije u kojima dolaze do izražaja simptomi emocionalno nestabilne ličnosti roditelja“ i „Manipulativna ponašanja“ dobiveni su analizom odgovora sudionika istraživanja na slijedeće pitanja iz predloška za intervju: *„Sjetite se i opišite jedan Vaš slučaj u kojem su, prema Vašem mišljenju, kod roditelja postojali simptomi emocionalno nestabilne ličnosti ili je bila postavljena dijagnoza emocionalno nestabilne ličnosti. Kako su se, prema Vašem mišljenju, u ovom slučaju kod roditelja manifestirali simptomi ovog poremećaja ličnosti? Jeste li u nekim drugim slučajevima uočili neke simptome emocionalno nestabilne ličnosti kod roditelja? Ako da, u kojima*?, *„Što Vam predstavlja izazov/teškoću u radu s roditeljem kod kojeg su, prema Vašem mišljenju, prisutni neki simptomi emocionalno nestabilne ličnosti?“*

Svakom sudioniku istraživanja dodijeljena je zasebna oznaka koja se sastoji od slova i brojčanog zapisa (npr. S1) te se nalazi uz izjave sudionika. Na taj način osigurana je anonimizacija prikupljenih podatka.

Metodološka ograničenja istraživanja

Ovo istraživanje ima određena metodološka i spoznajna ograničenja koja su najviše povezana s organizacijskim poteškoćama. Zbog prostornih uvjeta rada, nekoliko intervjua provedeno je u prisutnosti druge osobe (kolegice koja sa sudionikom istraživanja dijeli ured) što dovodi u pitanje povjerljivosti koju smo jamčili sudionicima istraživanja prilikom traženja usmenog informiranog pristanka za sudjelovanje u istraživanju, ali i otvara pitanje međusobnog utje-

analysis. Themes were defined as parts in the totality of the gathered data that were relevant to the research question and represented patterns of specific content. Thematic analysis allows both the description and the additional interpretation of different aspects of the analyzed construct (46).

The present article describes the theme “Situations in which symptoms of emotionally unstable personality disorder in parents manifest” with an emphasis on divorce and cohabitation dissolution and the “Manipulative behaviors” theme.

Data on these themes were acquired by analyzing the responses of the study participants to the following questions from the interview template: “*Recall and describe on of your cases in which, in your opinion, parents presented with symptoms of emotionally unstable personality disorder or had an established diagnosis of emotionally unstable personality disorder. In your opinion, how did the symptoms of this personality disorder manifest in the parents in this case? Did you notice some symptoms of emotionally unstable personality disorder in other cases? If yes, in which?*” and “*What represents a challenge/difficulty for you when working with parents who, in your opinion, present some symptoms of emotionally unstable personality disorder?*”

Every study participant was assigned a code based on a letter and numeral (e.g. S1) that accompanies the responses of the participants. This assures the anonymization of the acquired data.

Methodological limitations of the study

This study had certain methodological and epistemological limitations, mostly related to organizational difficulties. Due to location, some interviews were conducted in the presence of another person (the colleague with whom the participant shared the office), which threatens the confidentiality we guaranteed the participants during acquisition of oral consent but may have also caused undue influence between

caja sudionika u onim situacijama kada su obje kolegice sudjelovale u istraživanju. Također, tri intervjua provedena su u ugostiteljskom objektu. Iako su intervjui provedeni u dijelu ugostiteljskog objekta u kojem u trenutku provođenja istraživanja nije bilo drugih gostiju, postojali su distraktori (npr. glazba u pozadini, zvonjenje mobitela) koji su se možda negativno odrazili na pažnju sudionika.

participants in situations where both colleagues took part in the study. Furthermore, three interviews were conducted in a coffee shop. Although they were conducted in areas where there were no other guests at the time, some distractions were present (e.g. background music, phone ringing) that may have adversely affected the concentration of the participants.

REZULTATI

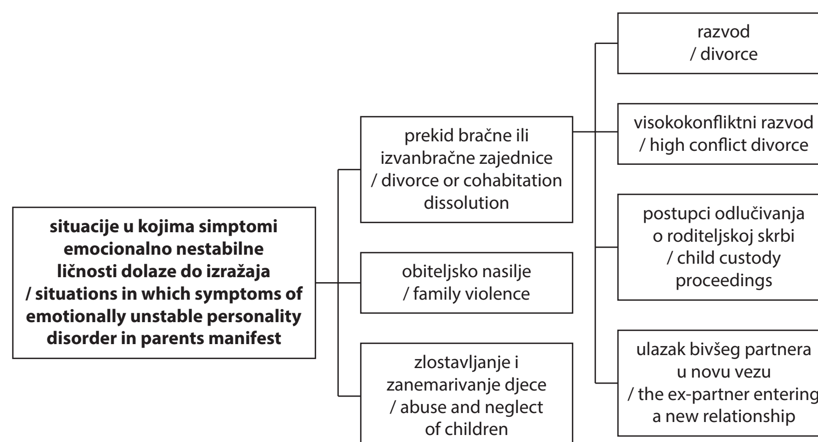
Sukladno postavljenim ciljevima i istraživačkim pitanjima dobiveni su sljedeći rezultati teme „Situacije u kojima dolaze do izražaja simptomi emocionalno nestabilne ličnosti roditelja".

Simptomi emocionalno nestabilne ličnosti roditelja prema iskustvu stručnjaka, najčešće se očituju u **situacijama narušenih partnerskih odnosa** *„kada Centar prvi puta reagira, dakle na njihovu svađu."* (S2), *"kod bračnih odnosa koji dođu u fazu da moraju potražiti savjetovanje"* (S6), *„ili kad krenu učestali sukobi"* (S10), **prekida bračne ili izvanbračne zajednice** *„Kad je žena odlučila otić, onda se to u njemu probudilo…"* (S4), *„Znači u trenutku prekida zajednice"* (S10) koji nerijetko imaju obilježja **visokokonfliktnih razvoda** *„Evo mogu počet sa slučajem du-*

RESULTS

Based on our study goals and research questions, the following results were obtained for the topic "Situations in which symptoms of emotionally unstable personality disorder in parents manifest".

According to the opinions of our participants, symptoms of emotionally unstable personality disorder most commonly manifest in **situations in which the relationship between the partners has deteriorated**, "*when the Center first reacts, i.e. after they have had a fight.*" (S2), "*in marriage relationships that get to the point where they have to seek counselling*" (S6), "*when the constant fights start*" (S10), **divorce or cohabitation dissolution** "*When the woman decided to leave, that was when this woke up inside him…*" (S4), "*So at the point when they broke up*"



SLIKA 1. Situacije u kojima simptomi emocionalno nestabilne ličnosti roditelja dolaze do izražaja. U ovom radu prikazani su rezultati koji se odnose na situacije prekida bračne i izvanbračne zajednice.

FIGURE 1. Situations in which symptoms of emotionally unstable personality disorder in parents manifest. This article presents the results pertaining to situations related to divorce and cohabitation dissolution.

gotrajnog razvoda braka. To je bio jedan konfliktni razvod." (S4) *"Najčešće, meni se čini, u tim razvodima braka koji su baš izrazito konfliktni to ispliva na površinu."* (S3) i **postupcima odlučivanja o roditeljskoj skrbi**„*...to se dosta često ovdje očituje u situaciji razvoda ili odlučivanja o roditeljskoj skrbi...*" (S1), *"Došli su trenutku prekida te zadnje vanbračne zajednice radi dogovora oko roditeljske skrbi."* (S3), „*i kad su u tijeku postupci donošenja odluke s kojim roditeljem će dijete živjeti pa su najintenzivnije te njihove osobine ličnosti i ta njihova ponašanja*" (S10). Prema iskustvu stručnjaka, okidač može biti i **ulazak bivšeg partnera u novu vezu** „*Vrlo često bude aktivirano u situacijama kada bivši partner nađe novog partnera pa se tu javljaju opet nekontrolirana ponašanja...*" (S8).

Druga tematska cjelina koju ćemo prikazati u ovom radu odnosi se na obilježja prekida partnerske zajednice roditelja sa simptomima emocionalno nestabilne ličnosti - „Manipulativna ponašanja".

Prema iskustvu stručnjaka prekidi partnerskih zajednica osoba kod kojih su prisutni neki simptomi emocionalno nestabilne ličnosti obilježeni su manipulativnim ponašanjem i manipulacijom djetetom, drugim roditeljem, stručnjacima, policijom, pravosudnim, socijalnim i zdravstvenim sustavom. O manipulaciji zdravstvenim sustavom detaljnije pišu Maljuna, Ajduković i Ostojić (45).

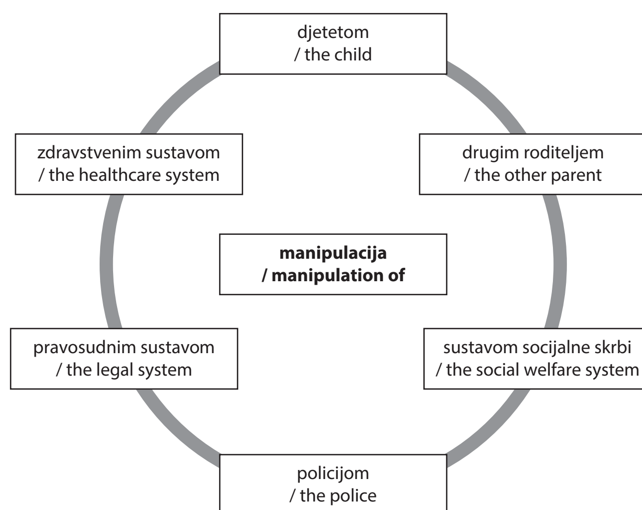
Manipulacija djetetom uskom je povezana s **manipulacijom drugim roditeljem**, osobito kada je riječ o **onemogućavanju kontakta i druženja djece s drugim roditeljem** „*zbog onemogućavanja susreta djece i oca...*" (S1), „*sprječavanje kontakta, susreta i druženja djeteta s ocem*" (S2), *"Ta majka vrlo lijepo razgovara, vrlo lijepo prikazuje svoj odnos s djetetom, stoji na raspolaganju tom ocu, a djetetu šalje poruke pa nemoj s njim, ti imaš pravo odlučiti, imaš sada druge obveze i posla, pa ljepše nam je da idemo teti, strini i tako dalje." (S10)*, **kupovanju naklonosti i ljubavi djece** „*Sa skupim poklonima ih je pokušavao pridobit, ono kupovao je dječ-*

(S10) that often have characteristics of **high conflict divorce** "*Well I can start with the case of a lengthy divorce. It was a divorce full of conflict*" (S4) "*Usually, I'd say, it's in these divorced that really have a lot of conflict that this rises to the surface.*" (S3), and **during child custody proceedings**, "*...here that's pretty common in divorces or during child custody proceedings...*" (S1), "*They came at the point where their cohabitation ended and they had to agree on child custody*" (S3), "*and when child custody is being decided so these aspect of their personality and those behaviors are most pronounced*" (S10). According to participant experience, a trigger can also be **the ex-partner entering a new relationship** "*This can very often trigger when the ex-partner finds a new partner, so these uncontrolled behaviors manifest again...*" (S8).

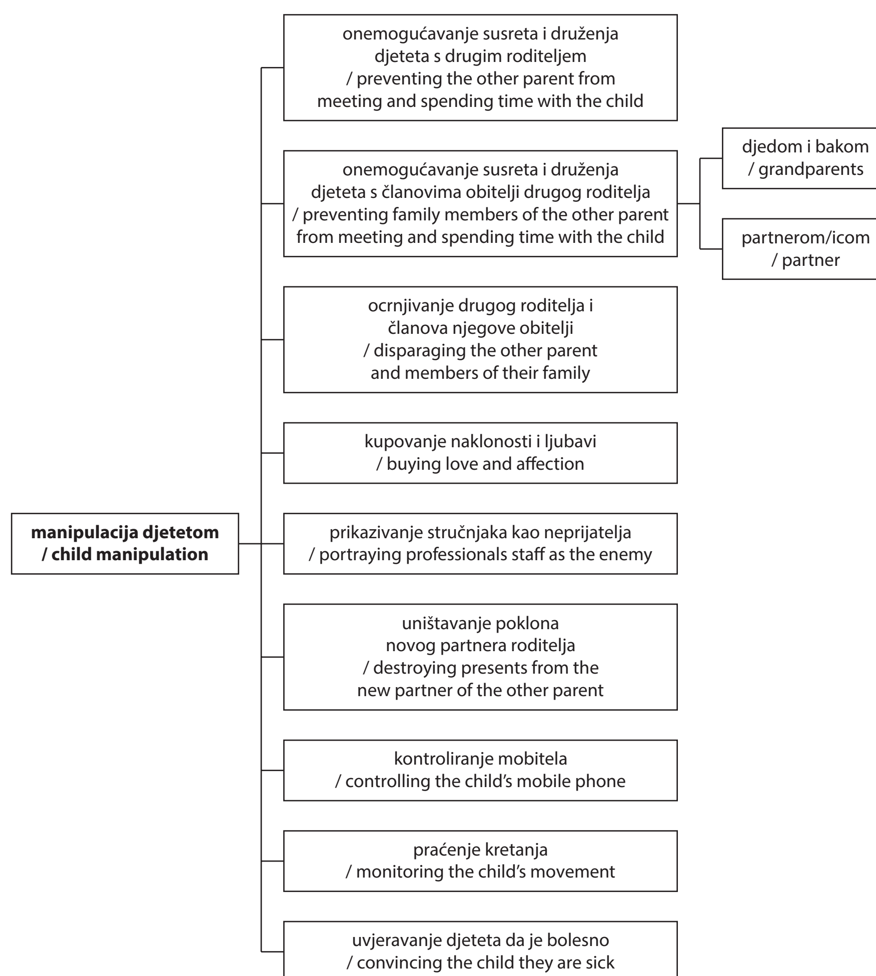
The second theme we will describe in this article relates to "Manipulative behavior" in characteristics of partnership dissolution in parents with symptoms of emotionally unstable personality disorder.

According to the study participants, intimate partnership breakups in persons who exhibit some symptoms of emotionally unstable personality disorder are characterized by manipulative behavior and manipulation of the child, other parent, social welfare professionals, the police, and the legal, social welfare, and healthcare systems. Healthcare system manipulation is described in more detail by Maljuna, Ajduković i Ostojić (45).

Child manipulation is closely related to **manipulation of the other parent**, especially through attempts to prevent the other parent from meeting and spending time with the child "*due to the prevention of meetings between the father and the children...*" (S1), "*preventing the father from contacts, meetings, and spending time with the child*" (S2), "*This mother talks very nicely, describes her relationship with the child very nicely, she claims to cooperate with that father, but she sends messages to the child saying 'don't go with him', 'you have the right to decide', 'you have other work and obligations*



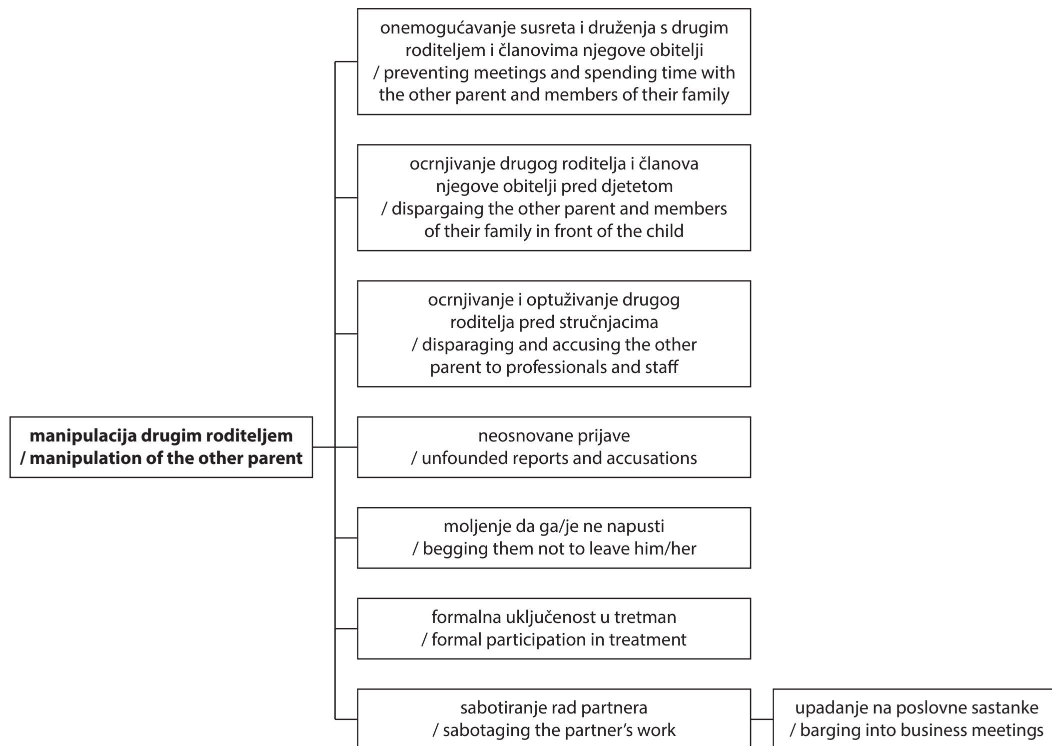
SLIKA 2. Obilježja prekida partnerske zajednice: *Manipulativna ponašanja*
FIGURE 2. Characteristics of intimate partnership breakups: *Manipulative behavior*



SLIKA 3. Manipulacija djetetom
FIGURE 3. Child manipulation

ju ljubav zapravo.“ (S4), **ocrnjivanje drugog roditelja** „*..obilato iznosila pred djecom niz, niz tih podataka o, iz njihovog partnerskog odnosa...*“ (S1),,”*...oca je prikazivala u negativnom svjetlu pri čemu je zapravo koristila i uvredljive riječi i prenosila detalje sukoba s bivšim partnerom.*” (S10), **članova njegove obitelji** *„ocrnjivanje njegovih članova obitelji“* (S2) i **novog partnera/ice** *“...prikazivala je novu partnericu u negativnom svjetlu...”* (S10), **onemogućavanje druženja djeteta s djedom i bakom** *„Kako često unutar obitelj postoje više članova, onda se tu znalo postupati i u odnosu na baku i dedu na način da im se brani viđenje na način da se djeci strogo zabranjivalo viđenje s bakom i djedom.*“ (S10) te novom **partnericom drugog roditelja** *“... i preko djece je majka imala informacije o očevom privatnom životu, odnosno o činjenici da je nova partnerica posrijedi. Dakle, ponašanje majke u odnosu na tu djecu je bilo na način da im je zabranjivala druženje s tom osobom.*” (S10). Roditelji kod kojih su prisutni simptomi emocionalno nestabilne ličnosti skloni su **uništavati poklone novog partnera/ice drugog roditelja** *“Onda kad bi se djevojčica pohvalila da je dobila špangicu ili nešto drugo od te druge partnerice, majka je to znala agresivno čupati, trgati, bacati...”* (S10), **kontrolirati dječje mobitele** *“...da se kontroliralo dječje mobitele...”* (S10), **pratiti kretanje djece** *„da im se stavljao GPS kako bi se pratilo gdje djeca borave za vrijeme kad su kod tog drugog roditelja tako da je to zapravo sve skupa znao biti pritisak na djecu.*“ (S10) i **prikazivati stručnjaka kao neprijatelja** *„Tu su neka ponašanja roditelja koja su neprimjerena, pa nas dijete doživljava kao neprijatelja jer mu je to roditelj tako prezentiraju.*“ (S12),. Jedna stručnjakinja navodi kako je majka kod koje uočava simptome emocionalno nestabilne ličnosti **uvjeravala dijete da je bolesno** *„Obzirom da on nije bolestan, doista nije, mama mu stalno imputira da je nešto s njim i da nešto s njime nije uredu... On izrazito želi biti pilot i da mu mama i dalje priča da je on bolestan na srce i da ne može bit pilot.*“ (S1).

now', 'we'll have a nicer time if we go to our aunt, etc.” (10), **buying the love and affection of the child** “*He tried to get them on his side with expensive gifts, he was basically buying the children's love.*” (S4), **disparaging the other parent** “*she would tell the children lots and lots of that stuff about, from their intimate partner relationship...*” (S1), “*...she would paint the father in a negative light where she would even use insulting words and talk about the details of the conflict with the ex-partner.*” (S10), **disparaging members of the other parent's family** “*disparaging his family members*” (S2) and **the other parent's new partner** “*...she would pain the new partner in a negative light...*” (S10), **preventing the child from spending time with grandparents** “*Since there are often several members in the family, sometimes the behavior was aimed at the granny and grandpa by preventing the from seeing the children by strictly forbidding the children from seeing their grandparents.*” (S10), and **preventing the child from seeing the new partner of the other parent** “*...and the mother would get information on the father's private life through the children, i.e. the fact that he had a new partner. So, the mother's behavior towards that children was such that she forbade them from spending time with that person.*” (S10). Parents in whom symptoms of emotionally unstable personality disorder are present are prone to **destroying presents from the new partner of the other parent** “*And then when the little gird proudly showed the hair pin or something that she got from the other partner, the mother would aggressively grab that, break it, throw it away...*” (S10), **controlling the child's mobile phone** “*...that the child's mobile phones were controlled...*” (S10), **monitor the child's movement** “*that GPS was used to monitor where the children were staying while they were with the other parent so all of that really put a lot of pressure on the children.*” (S10) and **painting professionals and staff as the enemy** “*There were some behaviors from parents that are inappropriate, so the child sees us as enemies because the parents present us that way.*” (S12). One participant said that a mother in whom she noticed symptoms



SLIKA 4. Manipulacija drugim roditeljem
FIGURE 4. Manipulating the other parent

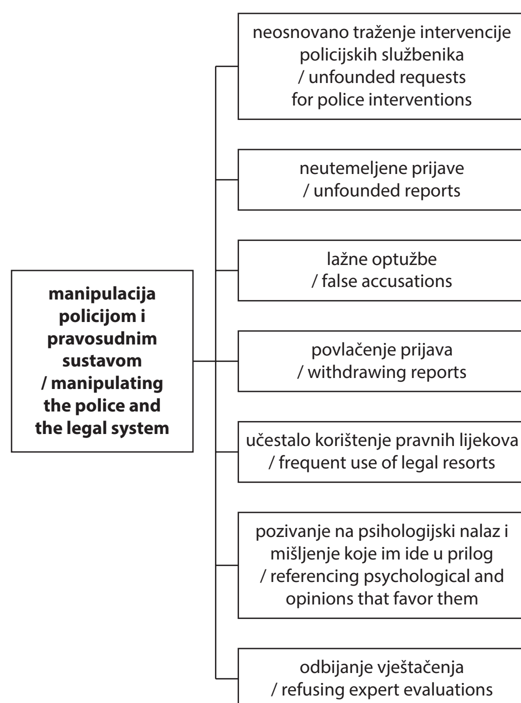
Stručnjaci izvještavaju o različitim **pokušajima manipuliranja ponašanjem partnera** *„gdje žene manipuliraju s ponašanjem partnera...“* (S2), *„U odnosu s partnerom pokušava stalno manipulirati. U principu na djelu sam vidjela taj pokušaj utjecaja na partnera...“* (S8) koji osim prethodno navedenih oblika manipulacije (npr. onemogućavanju susreta i druženja roditelja i članova njegove obitelji s djetetom, ocrnjivanje drugog roditelja i članova njegove obitelji pred djetetom i dr.) uključuju **moljenje partnera da ih ne napusti te formalno uključivanje u tretman** *„Nemoj me ostaviti, ići ću na tretman...prividno su spremni na tretman da ispune obveze i utječu na partnera...“* (S12), **sabotiranje rada** partnera koje ponekad uključuje **upadanje na poslovne sastanke** *„On je išao toliko daleko da je znao njoj u njezinoj firmi upadat na sastanke, minirat njezin rad, tražit od nje ne znam, nisi mi poslala gaće za dijete, doslovce usred sastanka.“* (S4),**ocrnjivanje** i **optuživanje drugog roditelja/bivšeg partnera pred stručnjacima** *„...tu*

of emotionally unstable personality disorder attempted to **convince the child they were sick** “*Since he wasn't sick, he really wasn't, but the mother was always telling him that there was something wrong with him... He really wanted to be a pilot and his mother kept telling him that he had a weak heart and couldn't be a pilot.*” (S1).

Our participant reported different **attempts to manipulate the behavior of partners** “*where women manipulate the behavior of their partners...*” (S2), “*They constantly try to manipulate in their relationship with their partner. I've seen this attempt to influence the partner in practice...*” (S8) that in addition to the previously indicated forms of manipulation (e.g. preventing a parent and their family members in meeting spending time with the child, disparaging the other parent and their families in front of the child, etc.) also include **begging the partner not to leave them and formal participation in the treatment** “*Don't leave me, I'll go to treatment... they are seemingly prepared to go to treatment to fulfill their obligations and influence the partner...*”

bi ona, znači pobrojavala niz njegovih nekakvih negativnosti.." (S1) „*...onda idu vrlo optužujući. Onda ih optužuje za koje kakve radnje, da su oni nasilnici, ovisnici ili da nisu prema djeci adekvatni da bi se onda to mišljenje mijenjalo za...*" (S7), „*...a druga koja mi pada na pamet je davno razvedeni brak i nastojanje majke prikazati oca u negativnom svjetlu ne bi li ga onemogućila i u onom minimalnom obimu osobnih odnosa što ima s djetetom prikazujući ga sa svih aspekata nasilnim.*" (S10)

Manipulacija policijom očituje se u **učestalom neosnovanom traženju intervencija policijskih službenika** zbog neutemeljenih pritužbi na drugog roditelja „*Znao je zvat policiju ženi ako djeca nisu bila točno u 6 sati pred zgradom nego je on morao sjedit u autu i čekat 5 minuta da žena s drugog kata siđe s dvoje male djece.*" (S4), „*...prijavljivala ga policiji da ju je fizički zlostavljao, čak i da ju je silovao...*" (S5), "*Ona je pozivala policiju tako radi, jer je smatrala da se netko miješa u njezin život, u njezin odnos sa djetetom, da otac ne brine dobro o djetetu pa mu je slala policiju doma.*" (S6), ali i



SLIKA 5. Manipulacija policijom i pravosudnim sustavom
FIGURE 5. Manipulating the police and the legal system

(S12), **sabotaging the partner's work** which sometimes includes **barging into business meetings** "*He went so far as to barge into meetings in her firm, undermine her work, ask of her to I don't know, 'you didn't send me underpants for the child', literally in the middle of the meeting.*" (S4), **disparaging and accusing the other parent/ex-partner in front of experts** "*... this is where she would, so she would list a number of some kind of negative things about him...*" (S1) "*...and then the get very accusing. Then she accused them of all kinds of things, that they are violent, addicts, or that they are not adequate towards the children in order to change that opinion to...*" (S7), "*...and the other one that comes to mind is a marriage that ended a long time ago and the attempts of the mother to present the father in a negative light so as to prevent him from even the minimal range of personal relationships he has with the child by presenting him as violent in every aspect.*" (S10

Manipulating the police manifests in **repeated unfounded requests for police interventions** due to unfounded police reports against the other parents "*He would call the police on his wife if they were not in front of the building exactly at six o'clock so he had to wait for 5 minutes in the car for the wife to come down from the second floor with two small children.*" (S4), "*...she reported him to the police, that he had physically abused her, even that he raped her...*" (S5), "*She called the police just because, because she believed someone was interfering with her life, in her relationship with the child, that the father wasn't taking good care of the child so she would send the police to his house.*" (S6), but also in complaints against the work of social welfare center staff "*She tried to manipulate me. She called the police to our meetings a few times.*" (S6), and it is also associated with **manipulation of the legal system** through **false accusations** and **unfounded reports** against the ex-partner "*...I don't know, like reporting violence against the children, so every time the children returned from contact with the father there would be some new experiences,*

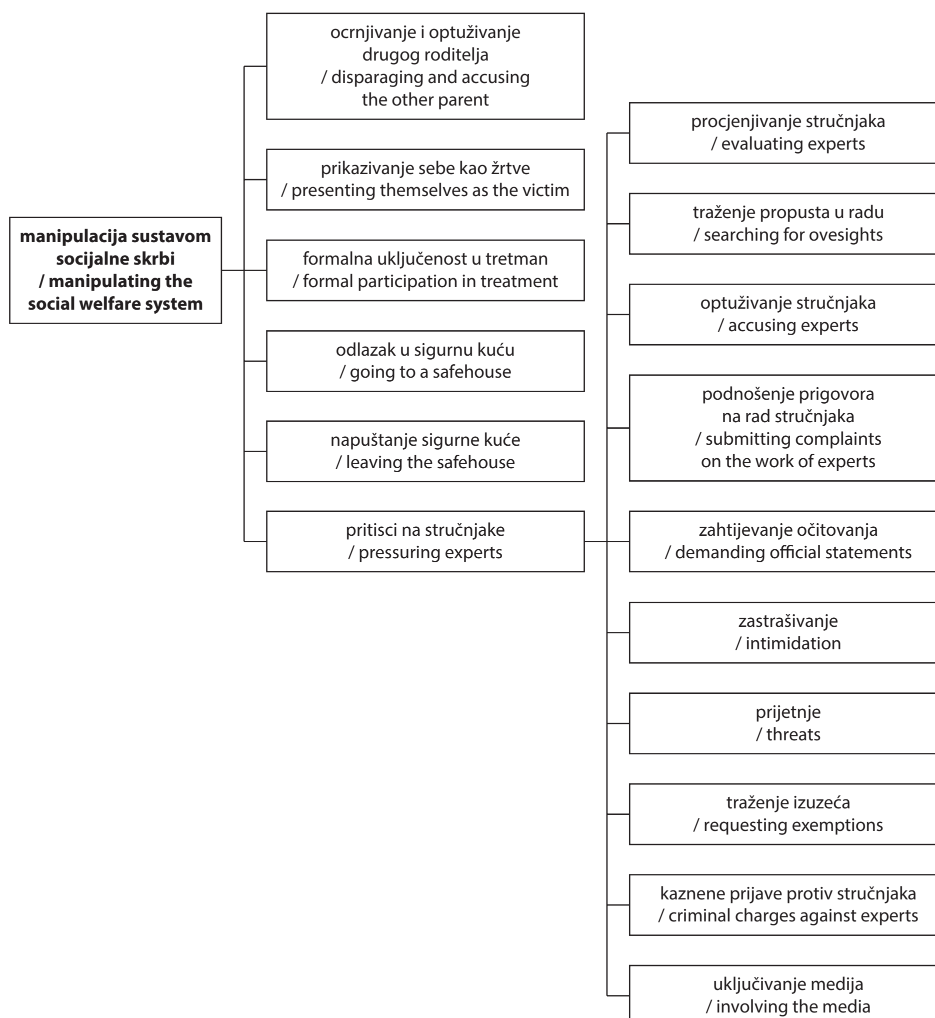
pritužbi na rad djelatnika centara za socijalnu skrb *"Htjela je sa mnom manipulirati. Zvala je par puta na susrete policiju."* (S6), a povezana je s **manipulacijom pravosudnim sustavom** kroz **lažne optužbe** i **neutemeljene prijave** protiv bivšeg partnera/ice *„..ne znam prijava nasilja u odnosu na djecu, pa svaki put kad bi djeca se vratila s kontakta s ocem bi bilo nekakvih novih doživljaja, događaja zapravo, je l' za koje bi ona navodno saznala od djece… Prva prijava se odnosila na to da ju je silovao…" "* (S1) *„I tamo ste mogli vidjeti nekakve stvari gdje su dolazili prijavljivat nasilja koja su lažna, nasilja koja ne postoje, ali je naša dužnost da sve prijavimo, a onda kad na kraju vidite da od toga nema ništa…"* (S4), *„…ali zapravo ona ima namjeru istisnuti toga oca iz života djeteta. Do sada je jedno četiri pet prijava protiv njega podnijela za nasilje. On je nama donio rješenje iz kojeg je vidljivo da je odbačena svaka takva prijava. Uredno funkcionira, uredno doprinosi i stvara uvjete za svoju djecu."* (S10) i stručnjaka iz sustava socijalne skrbi (vidi „Manipulaciju sustavom socijalne skrbi"), **povlačenje prijava** *„Da bi onda na kraju nakon par tjedana povukla sve te izjave, da su oni bili malo u sukobu, ali ljubav cvijeta."* (S5), **učestalo korištenje pravnih lijekova** *„..al doduše, i jedan i drugi roditelj su obilato koristili pravne lijekove. Znači obostrano bi se žalili na svaku odluku koja je bila donesena, u svakom postupku, a bilo ih je jako dugo."* (S1), *"Onda je išla tu sudska odluka na koju se je bunila…"* (S3), *„I nakon što je bila odbačena prijava protiv mene, onda je drugostupanjskom tijelu Komore gospođa uložila žalbu, onda je i na drugostupanjskom tijelu komore isto to bilo odbačeno."* (S10), **pozivanje na nalaze i mišljenja psihologa koji im idu u prilog** *"…ali je ipak otišla kod privatnog psihologa koji je obavio nekakvo testiranje i tu je ona ispala nadprosječno inteligentna. S tim je ona mahala po svuda, po sudovima i govorila kako ona nije bolesna. Smatrala je da ako je ona inteligentna ne može, da ja ona sposobna za sve. I voditi brigu o djetetu i procjenjivanje."* (S6) i **odbijanje vještačenja** *„Sad je sud bio odredio*

events rather, right, which she had allegedly found out about from the children… The first report was that he had raped her…" (S1) *"And there you could see things like people making reports of violence that were false, violence that was nonexistent, but it's our duty to report everything, and then in the end you could see that there was nothing to it…"* (S4), *"…but she actually wanted to push the father out of the child's life. She has made four or five reports of violence against him so far. He brought us a document which shows that each of these reports was dismissed. He functions just fine; he properly contributes and ensures good conditions for his children."* (S10) and against the staff of the social welfare center (see "Manipulating the social welfare system"), **withdrawing reports** *"So in the end after a few weeks she withdrew all those statements, that they had a bit of a fight but now love was blooming."* (S5), **frequent use of legal resorts** *"…however, both parents gratuitously used legal resorts. So they would both appeal every court ruling that was made, in every court process, and there were very many."* (S1), *"And then there was that court ruling which she challenged…"* (S3), *"And after the report against me was dismissed, then she made an appeal at the higher court body of the Chamber, and then that higher court also dismissed it."* (S10), **referencing psychological evaluations and opinions that favor them** *"…but she still went to a private psychologist who performed some kind of testing and there she turned out to be above-averagely intelligent. She would wave that around everywhere, in court, and would say she wasn't sick. She believed that if she was intelligent, that she couldn't, that she was capable of everything. Taking care of the child and assessments."* (S6) and **refusing expert evaluations** *"Now the court had mandated an expert evaluation of that mother and her husband with regard to the youngest child because we put in a request for removal of the child. However, when these parents were summoned to appear to a judge for the expert evaluation, they appeared on the day, at the scheduled time and stated that they do not want to undergo the evaluation."* (S5).

postupak vještačenja te mame i tog njenog supruga u odnosu na najmlađe dijete jer smo postavili zahtjev za lišenje. Međutim, kad su ti roditelji dobili poziv da se jave sucu vještaku radi provođenja vještačenja, ono su se uredno odazvali na dan, na termin i izjavili da ne žele pristupit vještačenju." (S5).

Manipulacija sustavom socijalne skrbi i stručnjacima zaposlenim ovom sustavu očituju se **ocrnjivanjem i optuživanjem partnera/drugog roditelja** „*Znači kad sam pričala o ovom ocrnjivanju i ....i partnera odnosno oca djece, i izvlačenju svih tih negativnosti.. .Znači samo bi nadograđivala tu svoju priču o njemu kao nasilniku. Znači samo bi slagala mozaik tih njegovih nedostataka i neadekvatnih*

Manipulating the social welfare system and experts that are part of it manifest with **disparaging and accusing the partner/other parent** "*So when I was talking about this disparaging and ...and the partner or rather the father of her children, and bringing out all that negative stuff... So she would just keep building up that story of hers of him as a violent man. She would just build a mosaic of his failures and his inadequate actions*" (S1), "*She would bring up and blame the father for some kind of mistakes in raising the child, some kind of neglect for the child's health... that he wasn't taking care of the child's education, that he wasn't including the child in some other forms of, I don't know, afterschool activities, that he doesn't spend time with him, that the child is alone all the time. This did not*



SLIKA 6. Manipulacija sustavom socijalne skrbi
FIGURE 6. Manipulating the social welfare system

njegovih postupanja" (S1), "*Iz toga je izvlačila i okrivljavala tog oca za nekakve pogreške u odgoju djeteta, o nekakvoj zdravstvenoj zanemarenosti...da ne vodi brigu o obrazovanju djeteta, da ne uključuje dijete u nekakve druge oblike, ne znam, vanškolske aktivnosti, da ne provodi s njim vrijeme, da je dijete stalno samo. To sve nije odgovaralo realitetu.*" (S6) „*Onda ih optužuje za koje kakve radnje, da su oni nasilnici, ovisnici ili da nisu prema djeci adekvatni da bi se onda to mišljenje mijenjalo za...*" (S7), **formalnu uključenost u tretman** „*...ovaj je čak išao na prijedlog naše psihologinje na KBT, kognitivno-bihevioralnu terapiju, to je išlo tek tolko da donese papir da je priloži u naš i sudski spis tek tolko da je bio...*" (S4), „*...ali onda su prividno spremni na tretman da ispune obveze...*" (S12)i **prikazivanje sebe žrtvom** „*...ona sebe svugdje gdje bi išla prikazivala s žrtvom, oštećenom, iznevjerenom, ostavljenom, financijski ugroženom...*" (S1), „*...i sebe je uvijek prikazivao ko žrtvu. Eto vidite ja sam kupio kuću u elitnom djelu grada, ja sam vidite zarađivao puste tisuće kuna i to nije bilo dovoljno...*" (S4) pri čemu ponekad **traže smještaja u sigurnoj kući** „*...ona je iz tog stana samostalno otišla u sigurnu kuću gdje je rekla da je on nasilnik, da je bio nasilan prema njoj. Mi za to nismo znali... U sigurnoj kući su je pitali da li želi da joj djeca dođu. Obično žene zlostavljane bježe s djecom, ona je otišla sama i nije htjela da joj djeca dođu.*" (S2), ali i samostalno **napuštaju sigurnu kuću** „*I kako je sama otišla u sigurnu kuću, tako je i sama izašla iz sigurne kuće.*" (S2).

Skloni su činiti **pritiske na stručnjake** koji se očituju kroz **procjenjivanje stručnjaka** „*...koji je, svaku riječ važe, glede tolke detalje da spominje način na koji ga gledate, način na koji sjedite. Bitno mu je, znači bitno mu je sve od neverbalne komunikacije do verbalne, do toga na koji način ste se obratili njemu, na koji ženi.*" (S4), "*Procjenjivala je nas stručnjake, nije imala povjerenja u nas i smatrala je da smo svi vezani koruptivno. Znači često je, stalno je ona procje-*

fit the reality of the situation." (S6) "*Then she accused them of all kinds of things, that they are violent, addicts, or that they are not adequate towards the children in order to change that opinion to...*" (S7), **formal participation in treatment** "*...this one even went so far that he attended CBT, cognitive-behavioral therapy, at the advice of our psychologist, that was just to bring a document to add to our and the court's archive just so he could prove he went...*" (S4), "*...but then they were seemingly prepared to go to treatment to fulfill their obligations...*" (S12), and **presenting themselves as the victim** "*...wherever she goes she presents herself as the victim, as harmed, betrayed, abandoned, financially threatened...*" (S1), "*...and he would always present himself as the victim. 'So you see I bought a house in an elite neighborhood in the city, I made thousands of kunas and it wasn't enough...*" (S4) which sometimes includes **seeking shelter in a safehouse** "*...she left that apartment of her own free will and went to a safehouse where she said he was violent, that he was violent towards her. We didn't know about that... In the safehouse they asked her if she wanted her children to visit. Abused women usually run away with the children, she left on her own and didn't want her children to visit.*" (S2), but also **leaving the safehouse on their own** "*So just like she went to the safehouse on her own, she also left the safehouse on her own.*" (S2).

Parents in question are prone to **pressuring experts** which manifests as **evaluating experts** "*...so he, he weighed every word, looked at things in so much detail he'd mentioned the way you looked at him, the way you sat. It was important to him, everything was important to him, from non-verbal communication to verbal communication, the way you addressed him and the way you addressed the wife.*" (S4), "*She would evaluate us the experts, she didn't trust us and believed we were all tied together in a corrupt network. So she would often, she would evaluate our professional work all the time.*" (S6), **searching for oversights in the work of experts** "*...and then she would come here and say she got support somewhere else, how others noticed*

njivala naš stručni rad." (S6), **traženje propusta u radu stručnjaka** *„...onda bi došla tu i ispričala kako je negdje doživjela potporu, kako su drugi zamijetili nešto drugo što mi nismo, tražila je, ajmo reč, nekako naše propuste tražeći potporu negdje drugdje..."* (S1), **optuživanje stručnjaka** *„I onda su tu neki koji optužuju za nemar, za idolopoklonstvo, za potpuno vjerovanje drugoj strani, naprosto puni su ideja kako vas mogu okriviti, osramotiti, blatiti...neradnici, foteljaši, ne radite ništa, ne razumijete ništa, ništa niste učinili da meni pomognete i tako dalje."* (S8), *"U odnosu na stručne radnike Centra bi se to manifestiralo kroz vrlo agresivno ponašanje u smislu optužbi za pristranost..."* (S10), **zahtijevanje očitovanja stručnjaka** *„Spis koji je bio zatrpan mailovima, predstavkama odvjetnika, predstavkama gdje smo se mi morali očitovat svim mogućima instancama, njemu se očitovat, pobrojat sve kronološki što smo radili, objašnjavat sto puta jednu te istu stvar: vi ste roditelj, vi ste odgovorni."* (S4), **podnošenje prigovora na rad stručnjaka različitim institucijama** *„I ovaj, opet smo ispali, opet je po nama da mi nismo shvatili da je on nju tukao, a on... čovjek je dolazio kod nas da pita gdje je ona, ne javlja se po tri dana, ne zna gdje je."* (S2) , *"Bilo je različitih prijava, pritužbi ministarstvu na naš rad i tako. " (S9) „Dakle, prijava predstavniku, prijava ravnatelju, prijava Ministarstvu, a onda i ove prijave policiji i tako dalje."* (S10), **podnošenje kaznenih prijava protiv stručnjaka** *„Kazneno nas je prijavila."* (S8), *"...čak i kaznenih prijava..."* (S9) *"... podnose kaznene prijave protiv djelatnika optužujući nas za pristrano ponašanje, za diskriminaciju po spolu, po nacionalnosti, po ne znam čemu."* (S10), *„...reagirao je na način da se žalio na voditeljicu mjere, da ju je kazneno prijavio, naravno neosnovano."* (S12)**, traženje izuzeća** *„Mama je isti tren zatražila novog socijalnog radnika. Odmah, isti tren je htjela mijenjati."* (S2), *„Tražio je izuzeće naše podružnice..."* (S12), **prijetnje stručnjacima** *„I onda je znao prijetiti iz pozicije moći je l' vi znate ko sam ja, ja poznam ministra Peru Perića, sad idem k njemu something we did not, she was searching for, let us say, our omissions and looking for support elsewhere..."* (S1), **accusing experts** *"And there were some who accused us of neglect, of idol worship, of totally trusting the other side, they are just full of ideas on how to blame you, shame you, badmouth you... 'lazy, couch warmers, you don't do any work, you don't understand anything, you never did anything to help me' and so on."* (S8), *"In relation to the staff of the center this would manifest in very aggressive behavior along the lines of accusations of bias..."* (S10), **demanding official statements** *"A file that was overflowing with mails, lawyer statements, documents in which we had to make official statements on all kinds of instances, make a statement to him, chronologically list everything we had done, explain the same thing a hundred times over: you're the parent, you're responsible."* (S4), **submitting complaints on the work of experts to different institutions** *"And again, making us seem, again accusing us that we didn't realize he was beating her, and he... the man kept coming to us to ask where she was, she wouldn't respond for three days, he didn't know where she was."* (S2), *"There were different complains, complaints to the Ministry, and then those police reports and so on."* (S10), **filing criminal charges against experts** *"She submitted a criminal charge against us."* (S8), *"...even criminal charges..."* (S9) *"...they submit criminal charges against the staff accusing us of biased behavior, discrimination based on gender, nationality, on who knows what."* (S10), *"...reacted by filing a complaint against the person in charge of the process, by filing criminal charges against her, of course completely unfounded."* (S12), **requesting exemptions** *"The mother immediately requested a new social worker. Immediately, she wanted to switch right away."* (S2), *"He asked for an exemption from our local office..."* (S12), **threatening experts** *"And then he would threaten from a position of power, 'do you know who I am, I know minister Pero Perić, I'm going to go see him now' – go ahead."* (S4), *"That they would crush us, that they would sue us..."* (S8), *"...I mean what it we told now told you 'we're gonna kill ya'"* (S8) and **involving the media** which

– odi.“ (S4), *„Da će nas samljeti, da će nas tužiti ...“* (S8), *„...a kaj da mi sad vama kažemo mi vas bumo vubili...“* (S8) i **uključivanje medija** koje je poseban oblik manipulacije djetetom, stručnjacima i sustavom *„Pred kućom naravno kako to ide, bile smo nas troje iz Centra, policija, sudac ovršitelj, mediji RTL, Nova, isti taj dan smo bili na televiziji. Mislim, to je stvarno bilo do te mjere izloženo takvim nepovoljnim utjecajima koji su se kasnije reflektirali na djecu, znate škola, prijatelji. Svi su to gledali, svi su to vidjeli.... Dakle puna kuća je bila žena iz Baba, ja uopće ne znam broja, ali sigurno 10-tak ljudi, 10-tak žena...“* (S1).

RASPRAVA

Rezultati istraživanja pokazuju da stručnjaci Odjela za zaštitu djece, obitelji i braka u CZSS simptome emocionalno nestabilne ličnosti roditelja najčešće prepoznaju tijekom postupka razvoda i odlučivanja o roditeljskoj skrbi koji su obilježeni visokom razinom sukoba među roditeljima, nemogućnošću postizanja sporazuma oko ostvarivanja sadržaja roditeljske skrbi, manipulativnim ponašanjem i manipulacijom djetetom, drugim roditeljem (bivšim partnerom), stručnjacima i sustavom. Među najčešćim oblicima manipulacije su onemogućavanje susreta i druženja djeteta s drugim roditeljem i članovima njegove obitelji, ocrnjivanje drugog roditelja i članova njegove obitelji pred djetetom i stručnjacima, neutemeljene prijave protiv drugog roditelja zbog navodno počinjenog obiteljskog nasilja, zlostavljanja i zanemarivanja djeteta te učestali prigovori i prijave protiv postupanja nadležnih socijalnih radnika i drugih stručnjaka.

Aktivacija postojeće emocionalne ličnosti roditelja u situacijama prekida partnerske zajednice i postupcima odlučivanja o roditeljskoj skrbi može biti potencijalno povezana sa strahom od napuštanja i osjetljivosti na odbacivanje te kretanja između krajnosti idealizacije i podcje-

is a specific way of manipulating the child, the experts, and the system *"In front of the house of course as it goes there were three of us from the Center, police, an enforcing judge, media from RLT and NOVA TV, we were on TV the very same day. I mean that was really under such bad influences that later reflected on the children, you know, school, friends. Everybody watched that, everybody saw it... so the house was full from women from the Baba organization, I don't know how many, but certainly 10 or so people, 10 or so women..."* (S1).

DISCUSSION

The results of our study show professionals at the Department for the Protection of Children, Family, and Marriage of SWCs usually recognize symptoms of emotionally unstable personality disorder in parents during divorce and child custody proceedings, which are characterized by a high level of conflict between the parents, inability to reach agreements on achieving parental care, manipulative behavior, and manipulation of the child, the other parent (ex-partner), experts, and the system. The most common forms of manipulation include preventing the other parent and members of their family from meeting and spending time with the child, disparaging the other parent and members of their family in front of the child and social welfare professionals, unfounded reports against the other parent for alleged family violence or child abuse and neglect, and frequent complaints and reports against the actions of social workers and other experts.

Activation of existing emotionally unstable personality disorder during breakups of intimate partnerships and child custody decisions can be associated with fear of abandonment and sensitivity to rejection as well as with oscillations between the extremes of idealization and disparagement. Persons with this disorder present a tendency towards impulsive behavior and dichotomization, which manifests as difficulties in synthesizing contradictory perceptions and

njivanja. Osobe s ovim poremećajem ličnosti pokazuju sklonost impulzivnom ponašanju i dihotomizaciji koja se očituje poteškoćama sintetiziranja suprotnih percepcija i osjećaja drugih i unutar sebe i crno-bijelom pogledu (1,6) zbog čega mogu imati značajnih poteškoća u sagledavanju partnera kao osobe koja ima svoje vrline i mane. One partnere najčešće vide kao isključivo dobre ili isključivo loše osobe što u situacijama kada ponašanje osobe narušava idealiziranu sliku te osobe, može rezultirati intenzivnim i primitivnim gnjevom (5). Sukladno navedenom, partnera mogu percipirati kao jedinog odgovornog i „krivog" za prekid partnerske zajednice. U situacijama kada imaju dojam da stručnjaci brinu za njih i da su na njihovoj strani, mogu ih percipirati kao izvor podrške. S druge strane, u situacijama kada stručnjaci ukazuju na njihove propuste i na potrebu preuzimanja osobne odgovornosti, kao osobe koje ih kažnjavaju i koje su na strani bivšeg partnera što može dovesti do potrebe za osvećivanjem i manipulativnog ponašanja. Osim osvete, manipulativna ponašanja mogu za cilj imati sprječavanje separacije od djeteta i otuđenja djeteta od drugog roditelja. Neke osobe s emocionalno nestabilnom ličnosti nakon prekida partnerske zajednice svu pažnju usmjere na djecu razvijajući nezdrav i ovisan odnos s djecom (2,4).

Rezultate našeg istraživanja u određenoj mjeri možemo usporediti s rezultatima domaćih istraživanja. Hercigonja Novković i sur. (47) analizirale su 80 postupaka vještačenja provedenih tijekom 2009. i 2010. u kojima se tražila procjena roditelja i roditelja i djece u sudskim postupcima kada nije postignut dogovor između roditelja. Rezultati istraživanja ukazuju da je kod 37,5 % obitelji bilo prisutno manipuliranje djecom u obliku; onemogućavanja kontakta djeteta s drugim roditeljem, ocrnjivanja drugog roditelja, informiranja o drugom roditelju neprimjereno djetetovom uzrastu, traženju savezništva s djetetom postavljajući

feelings in themselves and others and consequently a black-and-white view of the world (1,6), which may result in significant difficulties in viewing their partner as a person with both virtues and faults. Such persons usually perceive their partners as either exclusively good or exclusively bad, which can result in intensive and primitive rage in situations when the behavior of that person goes against their idealized image (5). The partner can therefore be perceived as solely responsible and "guilty" for the breakup. When persons with the disorder are under the impression that professionals are taking care of them and are on their side, they can perceive them as a source of support. On the other hand, in situations where professionals point out their faults and the need to take personal responsibility, they may be perceived as someone who is punishing them and are on the side of the ex-partner, leading to a need for revenge and manipulative behavior. In addition to revenge, manipulative behavior can be employed with the goal of preventing separation from the child and alienating the child from the other parent. Some persons with emotionally unstable personality disorder focus all their attention on the children after a breakup, developing and unhealthy and dependent relationship with the children (2,4).

To an extent, the results of our study can be compared with the results of other Croatian studies. Hercigonja Novković et al. (47) analyzed 80 expert evaluation procedures between 2009 and 2010 that assessed parents and children in court proceedings where no agreement could be reached between the parents. The study results indicated that manipulation of children was present in 37.5% of the families, in the form of preventing contact between the child and the other parent, disparaging the other parent, providing the child with information on the other parent that was not age-appropriate, and attempting to create an alliance with the child by placing themselves in a position where the parent needed support from a child

se u poziciju roditelja koji treba podršku djeteta bez koje ne može živjeti. U 20 % slučajeva djeca su iskazivale izrazite teškoće koje nisu dozvoljavale separaciju od manipulirajućeg roditelja, a otpori prema bilo kakvim kontaktima s drugim roditeljem bili su izraziti, te su intenzivirali već prisutne poteškoće kod djeteta. Unatoč tome izostala je adekvatna intervencija sustava, a djeca su ostala živjeti s manipulirajućim roditeljem.

Uvidom u vještačenja Poliklinike za zaštitu djece grada Zagreba o prilagodbi djece na razvod roditelja utvrđeno je da je u 33,7 % slučajeva visokokonfliktnih razvoda bilo prisutno aktivno (od čega 82,1 % majke), a u 29 % pasivno ometanje kontakta i odnosa s drugim roditeljem od jednog ili obih roditelja. Neosnovane optužbe za zlostavljanje uvidom u slučajeve obrade u Poliklinici za zaštitu djece grada Zagreba sa sumnjom na spolno zlostavljanje djeteta znatno su veće tijekom postupka razvoda braka (47).

Navedeni podatci u skladu su s podatcima Ministarstva za demografiju, mlade i socijalnu politiku za 2017. godinu. Tijekom ove godine 1826 djece nije ostvarilo pravo na susrete i druženje s drugim roditeljem ili ga je ostvarilo u manjem opsegu od onog određenog sudskom odlukom, a 284 djece bilo je izloženo manipulaciji od roditelja s kojim ne živi za vrijeme održavanja osobnih odnosa (48). Iako u ovim podatcima nije fokus na roditeljima s dijagnozom i/ili simptomima emocionalno nestabilne ličnosti, s obzirom na rezultate našeg istraživanja, možemo pretpostaviti da su roditelji sa simptomima ovog poremećaja ličnosti u određenoj mjeri zastupljeni u populaciji roditelja čiji su razvodi obilježeni viskom razinom konflikta, manipulativnim ponašanjima i manipulacijom koja se očituje u onemogućavanju susreta i druženja djeteta s drugim roditeljem.

Navedeni oblici manipulativnog ponašanja oblik su emocionalnog zlostavljanja djeteta koje može imati značajne posljedice za djete-

without whom they could not live. In 20% of cases, the children expressed severe difficulties that did not allow separation from the manipulating parent, and resistance towards any contact with the other parent was pronounced and exacerbated the existing difficulties in the child. Nevertheless, there was no appropriate intervention on part of the system, and the children continued living with the manipulating parent.

Examination of the expert evaluations from the City of Zagreb Child Protection Polyclinic on adjustment of children to the divorce of their parents showed that in 33.7% of high conflict divorces there was active (of which 82.1% on part of the mother) and in 29% passive disruption of contacts and relationships with the other parent on part of one or both parents. Unfounded accusations of abuse, based on the cases with suspicion of child sexual abused processed at the City of Zagreb Child Protection Polyclinic, were significantly more common during divorce proceedings (47).

The data above is in agreement with data of the Ministry of Demography, Youth, and Social Policy for 2017. In that year, 1826 children did not achieve full visitation rights with one parent or visitation was reduced compared with the court decision, and 284 children were exposed to manipulation from the parent they do not live with during visitations (48). Although these data do not focus on parents with a diagnosis and/or symptoms of emotionally unstable personality disorder, based on the results of our study we can assume that parents with symptoms of this disorder are to an extent represented in the population of parents whose divorces are marked with a high level of conflict, manipulative behavior, and manipulation that manifests as preventing the other parent from meeting and spending time with the child.

These forms of manipulative behavior are a form of emotional child abuse that can have significant adverse consequences to the child's psychosocial development. Some study results indicate that

tov psihosocijalni razvoj. Rezultati nekih studija upućuju na snažniji utjecaj razvoda roditelja kod djece predškolske dobi, a neki na povezanost dobi djeteta u vrijeme razvoda s različitim tipovima razvojnih rizika. Utjecaj razvoda za većinu (2/3) djece proteže se na razdoblje od dvije godine, ali većina studija nalazi dugoročne posljedice (49).

Pod utjecajem manipulativnog roditelja koji potiče dijete da se okrene protiv drugog roditelja bez postojanja opravdanog razloga, može se javiti roditeljsko otuđenje koje je obilježeno djetetovim odbijanjem drugog (ciljanog) roditelja i priklanjanjem manipulativnom roditelju (50,51). Simptomi koji ukazuju na roditeljsko otuđenje su neprekidno ocrnjivanje drugog (ciljanog) roditelja, racionalizacija odbijanja drugog (ciljanog) roditelja, tvrđenje da otpor protiv odbijanog roditelja proizlazi iz vlastitog razmišljanja (tzv. fenomen neovisnog mislioca), nedostatak osjećaja krivnje zbog postupanja prema ciljanom roditelju, postojanje lažnih ili iskrivljenih opisa događaja koji uključuju ciljanog roditelja (tzv. posuđeni scenarij) i pokušaji utjecanja na stavove drugih o ciljanom roditelju (51,52).

Djeca čiji su roditelji razvedeni u odnosu na djecu čiji su roditelji u braku, postižu slabije rezultate na mjerama emocionalne, ponašajne, socijalne i školske prilagodbe te su češće slabijeg zdravlja, a utjecaj razvoda roditelja vidljiv je i u odrasloj dobi. Osobe čiji su roditelji razvedeni, češće navode bračne probleme, osjećaju manju bliskost s roditeljima, osobito s očevima, te su u većem riziku da se same razvedu (49).

Sukladno navedenom, važno je stručnjacima osigurati instrumente koji će im olakšati procjenu ugroženosti dobrobiti djeteta i manipulativnih ponašanja roditelja. Dobar primjer takvog instrumenta je „Lista za procjenu ugroženosti psihosocijalne dobrobiti djeteta u situacijama konfliktnog razdvojenog roditeljstva“ (53) koja se sastoji od tri dijela: (1) Opći podatci i okolnosti procjene ugroženosti psihosocijalne

the effects of divorce are stronger in preschool children, while some studies found an association between child age and different types of developmental risks. The influence of divorce lasts for two years in most (2/3) children, but most studies found long-term consequences (49).

The influence of a manipulative parent who encourages the child to turn against the other parent without a valid reason can result in parental alienation that manifests as the child’s refusal of the other (targeted) parent and siding with the manipulative parent (50,51). Symptoms that indicate parental alienation are constant disparaging of the other (targeted) parent, rationalization for the rejection of the other (targeted) parent, insistence on part of the child that the rejection stems from their own thoughts (the so-called independent thinker phenomenon), lack of guilt for behavior towards the targeted parent, presence of false or distorted descriptions of events that include the targeted parent (so-called borrowed scenarios), and attempts to influence the opinions of others on the targeted parent (51,52).

Compared with children whose parents are married, children whose parents are divorced achieve poorer results on measures of emotional, behavioral, social, and educational adjustment and are usually in poorer health, with the effect of divorce observable even in adulthood. Persons whose parents are divorced are more likely to report marital problems, they feel less close to their parents, especially their fathers, and are at greater risk of divorce themselves (49).

Based on the above, it is important to provide social welfare professionals with instruments to facilitate evaluating danger to the welfare of the child is in danger and recognizing manipulative behavior in parents. A good example of such an instrument is the “List for the Assessment of Danger to Psychosocial Welfare of Children in High Conflict Parental Separation” (53) that comprises three parts: (1) General data and circumstances for the assessment of danger to the

dobrobiti djeteta, (2) Procjena neprikladnih i/ili manipulativnih ponašanja roditelja u situacijama konfliktnog razdvojenog roditeljstva i (3) Procjena ponašanja i funkcioniranja djeteta u situacijama konfliktnog razdvojenog roditeljstva.

S obzirom da roditeljsko otuđenje može dovesti do osjećaja izoliranosti, očaja, frustriranosti i psiholoških poteškoća nemanipulativnog (ciljanog) roditelja (44,47-49) važno je da stručnjaci navedeno uzimaju u obzir pri planiranju i provođenju psihosocijalnih intervencija. Također, važno je da pravosudni djelatnici manipulativna ponašanja i roditeljsko otuđenje prepoznaju kao oblik emocionalnog zlostavljanja djeteta i da takvo ponašanje sankcioniraju. Prema iskustvima nemanipulativnih (ciljanih) roditelja pravni sustav je spor, neučinkovit i pridonosi roditeljskom otuđenju (44,49). Sudski postupci traju od jedne do deset godina, a pravosudni djelatnici ne pokazuju razumijevanje roditeljskog otuđenja i njegovih posljedice (51,57). Sukladno navedenom potrebne su daljnje edukacije pravosudnih djelatnika o emocionalnom zlostavljanju djece uključujući roditeljsko otuđenje i njihovim posljedicama. S obzirom da su manipulativni i otuđujući roditelji često osobe s poremećajem ličnosti (npr. 41,51,58,59), izricanje mjere obveznog psihosocijalnog tretmana moglo bi doprinijeti redukciji simptoma poremećaja ličnosti i manipulativnog ponašanja, međutim konačni ishod u značajnoj mjeri ovisi o intrinzičnoj motivaciji osobe za sudjelovanjem u tretmanu i promjenom ponašanja.

psychosocial welfare of the child, (2) Assessment of inappropriate and/or manipulative behavior of parents in high conflict parental separation, and (3) Assessing the behavior and functioning of the child in in high conflict parental separation.

Given that parental alienation can lead to feelings of isolation, despair, frustration, and psychological issues in the non-manipulative (targeted) parent (44,47-49), it is important that social services professional take it into consideration when planning and implementing psychosocial interventions. Additionally, it is important that the courts are able to recognize manipulative behaviors and parental alienation as a form of emotional child abuse and reflect that in their rulings. The experience of the non-manipulative (targeted) parents is that the court system is slow, ineffective, and contributes to parental alienation (44,49). Court procedures last between one and ten years, and the courts do not appreciate the seriousness of parental alienation and its consequences (51,57). Therefore, further education is needed for court employees on the emotional abuse of children, including parental alienation and its consequences. Given that manipulative and alienating parents are often persons with personality disorders (e.g. 41,51,58,59), mandatory psychosocial treatment could contribute to reducing the symptoms of personality disorder and manipulative behavior, but the final result is significantly influenced by the person's intrinsic motivation for participation in the treatment and adjusting their behavior.

ZAKLJUČAK

Sukladno dosadašnjim spoznajama osobe s emocionalno nestabilnom ličnosti imaju značajne poteškoće u osobnom, partnerskom i roditeljskom funkcioniranju. Zbog straha od napuštanja i osjetljivosti na odbacivanje, prekid partnerske zajednice može biti okidač koji dovodi do aktivacije postojećeg poremećaja lič-

CONCLUSION

Based on our knowledge so far, persons with emotionally unstable personality disorder have significant difficulties functioning in their personal lives, in relationships, and parental roles. Due to fear of abandonment and sensitivity to rejection, dissolution of a romantic relationship can be the trigger that leads to the acti-

nosti i različitih oblika manipulativnih ponašanja koja se nastavljuju postupcima odlučivanja o roditeljskoj skrbi.

Ako povežemo rezultate dosadašnjih istraživanja koji ukazuju na učestalost visokokonfliktnih razvoda i manipulativnih oblika ponašanja roditelja te na zastupljenost roditelja s poremećajem ličnosti među onima čiji su razvodi visokokonfliktni s rezultatima našeg istraživanja koji pokazuju da su prekidi partnerskih zajednica roditelja kod kojih su pristuni neki simptomi emocionalno nestabilne ličnosti obilježeni visokom razinom sukoba među roditeljima i različitim oblicima manipulativnih ponašanja koja su ugružavajuća za dobrobiti djeteta, ali i nemanipulativnog roditelja, važno je da stručnjaci prepoznaju simptome emocionalno nestabilne ličnosti i manipulativna ponašanja roditelja. Navedeno ukazuje na važnost edukacije stručnjaka iz sustava socijalne skrbi o poremećajima ličnosti i potrebu za instrumentima koji će stručnjacima olakšati procjenu ugroženosti dobrobiti djeteta i prepoznavanje manipulativnih ponašanja roditelja.

vation of an existing personality disorder and various forms of manipulative behavior that continue into the custody process.

Taken together with previous studies that show the frequency of high conflict divorces and manipulative behavior in parents and the prevalence of parents with personality disorders among those in high conflict divorces, the results of our study show that breakups in parents who exhibit some symptoms of emotionally unstable personality disorder are marked by a high level of conflict between the parents and different forms of manipulative behavior, representing a threat to the welfare of both the child and the non-manipulative parent, therefore emphasizing the importance of experts being able to recognize symptoms of emotionally unstable personality disorder and manipulative behavior in the parents. The above indicates the importance of educating social welfare works on personality disorders and the need for instruments that will facilitate evaluating danger to the welfare of the child and recognize manipulative behavior in parents.

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Što su emocije? – Suvremene neuroznanstvene teorije

/ *What Are Emotions? – Contemporary Neuroscientific Theories*

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Prikazujemo četiri neurobiološko-psihološke teorije emocija kojih su autori neuroznanstvenici. Emocije su jedan od temelja ljudskog ponašanja bez kojih ne možemo zamisliti čovjeka, društvo, psihičke poremećaje ni psihoterapiju. Teško da se može naći neki psihički poremećaj da u njega nisu uključene emocije kao uzrok psihičke boli. U radu prikazujemo doprinose suvremene afektivne neuroznanosti važne za razumijevanje čovjeka i psihoterapijske prakse.

/ In this paper we will present four neurobiological and psychological theories of emotions proposed by neuroscientists. Emotions form the foundations of human behavior, without which we cannot imagine man, society, mental disorders, or psychotherapy. It is difficult to find a mental disorder which does not include emotions as a cause of suffering. We will present the contributions of modern affective neuroscience important for understanding both man and psychotherapy.

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UVOD

Istraživanje emocija kao psihološkog fenomena ima svoju dugu povijest, no u ovom smo se radu odlučili prikazati novije neuroznanstvene doprinose jer smatramo da je um, kao temelj mentalnih fenomena, nedovoljno istraživati samo iz perspektive psihologije već je nužan

INTRODUCTION

The study of emotions as a psychological phenomenon has a long history, but in this paper we have decided to present only the latest neuroscientific contributions. We have done so because we believe that it is insufficient to study the mind as the basis of mental phenomena

i neuroznanstveni pogled. Nažalost, povijesni pregled neuroznanstvenog istraživanja emocija bio bi preopširan za opseg ovog rada pa zainteresirane čitatelje upućujemo na sljedeće članke: „*Brain and emotion: Cognitive neuroscience of emotions*" (1), "*Affective Neuroscience: Past, Present, and Future*" (2) te "*Historical pitfalls and new directions in the neuroscience of emotion*" (3). Smatramo da će autori predstavljeni u ovom članku pružiti osuvremenjen okvir teorijskih znanja o afektima, koja će omogućiti bolje razumijevanje psihoterapijskog rada kao i opće psihologije ponašanja ljudi. Rad započinjemo kratkim prikazom Pankseppove teorije s posebnim osvrtom na nedostatke u njegovoj teoriji, koje ćemo elaborirati u raspravi. U ovom su radu dani skraćeni prikazi relevantnih neuroznanstvenih teorija emocija te je za njihovo temeljitije studiranje potrebno proučiti izvornu literaturu. Ipak, vjerujemo da će i ovaj kratki prikaz pomoći stručnjacima u psihoterapijskom, psihijatrijskom i savjetodavnom radu.

Pankseppovih sedam emocionalnih sustava

Jaak Panksepp tvorac je termina afektivna neuroznanost. U svojim se istraživanjima poglavito oslanjao na MacLeanov koncept trijunskog mozga (4,5), doduše uz odgovarajuće razlike s obzirom na lokalizaciju procesa.

Općenito govoreći, ljudski se um ili, kako ga Panksepp zove, um-mozak može podijeliti na tri sustava (6). Prvi je primarni afektivni sustav koji uključuje senzorne, homeostatske te emocionalne afekte. Na višoj razini nalazimo sekundarni bihevioralno kondicionirajući sustav koji se nalazi u podlozi implicitnog učenja i pamćenja te je posve nesvjestan. Tercijarni kognitivno-jezični sustav je najsloženiji. Uključuje kognitivne funkcije, planiranje i refleksiju te regulaciju emocija i slobodnu volju. Sačinjen je dominantno od kortiko-talamičkih područ-

from the perspective of psychology alone. A neuroscientific view is also necessary. Unfortunately, a historical overview of neuroscientific research on emotions would be too broad for the scope of this paper, but we refer interested readers to the following articles: "Brain and emotion: Cognitive neuroscience of emotions" (1), "Affective Neuroscience: Past, Present, and Future" (2), and "Historical pitfalls and new directions in the neuroscience of emotion" (3). As for the authors featured in our paper, we believe they provide an up-to-date framework of theoretical knowledge about affects, which will allow for a better understanding of psychotherapeutic work as well as the general psychology of human behavior. Our paper begins with a brief presentation of Panksepp's theory with special reference to its shortcomings, which will be further developed in the discussion. This paper provides an overview of relevant neuroscientific theories of emotion, but it is necessary to study the original literature for a more thorough understanding. However, we believe that this brief account will also help professionals in psychotherapy, psychiatry, and counseling.

Panksepp's seven emotional systems

Jaak Panksepp is the author of the term "affective neuroscience". In his research, he mainly relied on MacLean's triune brain concept (4,5), albeit with the appropriate differences in terms of process localization.

Generally speaking, the human mind, or as Panksepp calls it, the mind-brain, can be divided into three systems (6). The first is the primary affective system which includes sensory, homeostatic, and emotional affects. At a higher level, we find the secondary behavioral conditioning system. It underlies implicit learning and memory and is completely unconscious. The tertiary cognitive-linguistic system is the most complex. It includes cognitive function, planning and reflection, emotion regulation,

ja. U njemu se odvija sva mentalizacija te se tu nalazi više sebstvo. Tako je primarni sustav emocionalno-nagonski te pruža temelj životu, sekundarni sustav utemeljen je na znanju i učenju, dok je tercijarni utemeljen na samorefleksiji.

Panksepp smatra da postoji sedam primarnih emocionalnih sustava smještenih u supkortikalnim regijama. One su uglavnom homologne, posebno kod sisavaca, pri čemu svaka emocija ima različiti neuroanatomski korelat te shodno tome i različitu fiziologiju (6). Najstariji od tih sustava je sustav POTRAGE. On je ujedno i u podlozi svih drugih sustava te ga odlikuje sustavna želja za eksploracijom te anticipacija uzbuđenja. On potiče neokorteks na izvođenje ponašanja koja će zadovoljiti naše želje i potrebe. BIJES je sustav koji se aktivira kada dođe do frustracije, tj. kada dođe do blokade sustava POTRAGE. U kognitivnom smislu BIJES se očituje u obliku ljutnje i mržnje. To se najbolje primjećuje u socijalnim sukobima gdje se otkriva još jedan kognitivni aspekt BIJESA – ljubomora. Sustav koji čuva čovjeka od boli i smrti naziva se STRAH. Nalazi se blizu sustava BIJESA te zbog njihove interakcije njegova aktivacija može dovesti do reakcije „bori se ili bježi“ („*fight-or-flight*“). POŽUDA je sustav najsličniji konceptu libida u klasičnoj psihoanalizi. Njezino neregulirano pobuđivanje vodi do različitih neurotskih smetnji i parafilija te antisocijalnih ponašanja. Majčinska ponašanja i osjećaji pod kontrolom su sustava BRIGE. Temeljni zadatak ovog sustava je osigurati emocionalni rast u interpersonalnim odnosima te pomaganje drugima (bilo poznatima, bilo strancima). On je važan za pozitivan učinak psihoterapijskog tretmana. Sustav PANIKA/ŽALOST u osnovi je formiranja privrženosti. Kako se aktivira pri separaciji nalazi se u podlozi depresivnih smetnji i fobija (7,8). Konačno, Panksepp izlaže sustav IGRE primjećujući kako i ljudi i životinje osjećaju radost pri igri. Taj sustav igra važnu ulogu u

and free will. It consists mostly of corticothalamic regions. It is where most of the mentalization process takes place and also where the higher self is located. Thus, the primary system is emotionally-instinctive and provides the foundation for life, the secondary system is based on knowledge and learning, while the tertiary is based on self-reflection.

Panksepp believes there are seven primary emotional systems located in subcortical regions. They are mostly homologous, especially in mammals, whereby each emotion has a different neuroanatomic correlate and consequently different physiology (6). The oldest of these systems is the SEEKING system. It underlies all other systems and is characterized by a systematic desire for exploration and excitement anticipation. It encourages the neocortex to perform behaviors that will satisfy our desires and needs. RAGE is a system activated when it comes to frustration, i.e. when the SEEKING system is blocked. In a cognitive sense, RAGE manifests itself in the form of anger and hatred. This is best observed in social conflicts, where another cognitive aspect of RAGE is revealed – jealousy. The system that protects man from pain and death is called FEAR. It is located close to the RAGE system and, because of their interaction, its activation can lead to a “fight-or-flight” reaction. LUST is a system most similar to the concept of libido in classical psychoanalysis. Its unregulated stimulation leads to various neurotic disturbances, paraphilia, and antisocial behaviors. Maternal behaviors and feelings are controlled by the CARE system. The basic task of this system is to ensure emotional growth through interpersonal relationships and helping others (both familiar and unfamiliar). It is essential to achieving the positive effect of psychotherapeutic treatment. The PANIC/GRIEF system provides the foundation of attachment. As it is activated during separation, it creates a basis for depressive disturbances and phobias (7,8). Finally, Panksepp introduces the PLAY system by noticing how both humans and animals feel joy while partici-

socijalnoj adaptaciji pojedinca te omogućuje epigenetske konstrukcije viših funkcija socijalnog mozga.

Pankseppovi emocionalni sustavi dijelom se preklapaju s Damasiovim akcijskim programima, koji razdvajaju nagone/motivaciju i emocije. Pankseppova teorija emocija može se shvatiti kao teorija emocija prvog reda, što znači da se svjesnost emocija javlja paralelno s tjelesnim uzbuđenjem i ponašanjem, dok drugi autori zagovaraju teoriju emocija višeg reda (Damasio, Barrett, LeDoux) koja razdvaja ponašanje i fiziologiju od osjećaja emocije koji se javlja tek nakon aktivacije generalne kognicijske mreže (GNC) (9,10).

Interoceptivna teorija i homeostatski osjećaji

Inspiriran jednom od najpoznatijih teorija emocija Williama Jamesa, Antonio Damasio postulira svoju neuroznanstvenu teoriju emocija koja počiva na pretpostavci da je percepcija tjelesnih stanja ključna za razvoj emocija. Razlikuje afekte, emocije i osjećaje (11). Afekt je krovni termin koji podrazumijeva i emocije i osjećaje. Emocija je neuralna reakcija na određeni podražaj, bilo vanjski, bilo unutrašnji, koja se ostvaruje putem aktivacije određenih neuralnih puteva. Osjećaji su mentalna iskustva promjene u tjelesnom stanju. Posljednja dva fenomena nalaze se na kontinuumu procesiranja koji uključuje tri moguća stupnja: emocionalno stanje koje može biti nesvjesno, osjećajno stanje čija reprezentacija također može biti nesvjesna te osviješteno osjećajno stanje (ili temeljna svijest). Iz toga jasno proizlazi kako osjećati nešto i imati svijest o tom osjećaju nisu ekvivalentna stanja. Za Damasia je upravo ta razlika ključna u definiranju odnosa između emocija, osjećaja i svijesti, a ona se očituje u njihovoj povezanosti s tijelom (12).

Ovdje je bitno naglasiti da za Damasia ne postoji dualizam uma i tijela, tj. racionalnog i

pating in playful activities. This system plays an influential role in the social adaptation of the individual and enables the development of epigenetic structures of higher social brain functions.

Panksepp's emotional systems partly overlap with Damasio's action programs, which separate drives/motivations and emotions. Panksepp's theory can be understood as a first-order emotion theory, which means that emotion awareness occurs in parallel with physical arousal and behavior, while other authors advocate a higher-order emotion theory (Damasio, Barrett, Adolphs, LeDoux) that separates behavior and physiology from the feelings of emotion which occur only after the activation of the General Network of Cognition (GNC) (9,10).

Interoceptive theory and homeostatic feelings

Inspired by William James's famous theory of emotion, Antonio Damasio postulates his neuroscientific theory based on the assumption that the perception of bodily states is crucial to the development of emotion. He differentiates between affects, emotions, and feelings (11). Affect is an umbrella term that includes both emotions and feelings. Emotions are neural responses to a particular stimulus, either external or internal, achieved through activation of specific neural pathways. Feelings are mental experiences of changes in the physical condition. The latter two phenomena spread across a continuum of processing with three possible degrees: an emotional state that may be unconscious, a state of feeling whose representation may also be unconscious, and a state of conscious feeling (or fundamental consciousness). It becomes clear that feeling something and being aware of that feeling are not equivalent states. For Damasio, that distinction is crucial in defining the relationship between emotions, feelings, and consciousness, and it manifests in their connection with the body (12).

This chronological order can be demonstrated by a banal example. During an encounter with

emocionalnog. Za njega um i tijelo nastupaju kao jedinstvena organizmička jedinica, te se prethodno spomenuta percepcija tjelesnog stanja ne promatra kao objekt odvojen od uma ili tijela već kao mentalni aspekt te jedinstvene organizmičke jedinice (12). Priroda tog „odnosa“ uma i tijela lijepo je oslikana u strukturi smještenoj na produljenoj moždini poznatoj pod nazivom „*area postrema*“ gdje ne postoji krvno-moždana barijera. Isto vrijedi i za ostale cirkumventrikularne organe smještene u telencefalonu. Upravo na tim mjestima tijelo ima direktan pristup živčanom sustavu kao što i živčani sustav ima direktan pristup tijelu (13). Isto vrijedi i za dualizam racionalnog i emocionalnog. Emocije su potrebne za kvalitetno rasuđivanje kao što i emocionalna neravnoteža može otežati kvalitetno rasuđivanje. Još jedan relativno zanemaren aspekt jedinstva uma i tijela očituje se u funkcioniranju enteričkog živčanog sustava. Radi se o formaciji od oko 300 milijuna neurona smještenih u gastrointestinalnom traktu. Većina tih neurona je intrinzična, tj. ne projicira se u centralni živčani sustav. Enterični i centralni živčani sustav nezavisni su u djelovanju, ali mogu komunicirati (13).

Nastavljajući se na logiku jedinstva uma i tijela Damasio se poziva na kontinuirani evolucijski razvoj emocija koji je usko vezan s pojmom homeostaze. Upravo je težnja za stabilnim unutrašnjim uvjetima glavni motivator ponašanja različitih organizama, od bakterija pa do samog čovjeka. Tako Damasio uvodi dvije vrste osjećaja: spontane ili homeostatske osjećaje te izazvane osjećaje. Homeostatski osjećaji potječu iz pozadinskog tijeka tjelesnih procesa i signaliziraju trenutačno stanje života kao dobro, loše ili nešto između. Signalizacija o kvaliteti stanja života naziva se valencija i ona je konstitutivni element svakog afekta. Osjećaji ovdje postaju mentalna reprezentacija homeostaze. Izazvani osjećaji posljedica su širokog raspona emotivnih odgovora na

an angry superior, a mental representation of the superior appears in the mind of the employee. The body of the employee responds to the representation by changing bodily states: increasing heart rate, sweating, altering facial expression, etc. This response constitutes an emotion. The feeling will only occur when the mind detects the changes in the bodily state and compares them with the mental representation. Neither emotions nor feelings relate to the outer object. Instead, they relate precisely to the perception of the bodily states.

Here it should be emphasized that, for Damasio, there is no dualism of mind and body, i.e. the rational and emotional. He sees both the mind and the body as a single organism, and the aforementioned perception of the physical state is seen not as an object separate from the mind or the body but as a mental aspect of this particular unit of the organism (12). The nature of this “relationship” between mind and body is nicely exemplified in a structure located in the medulla known as the “area postrema” where there is no blood-brain barrier. This also applies to circumventricular organs located in the telencephalon. It is precisely in these places that the body has direct access to the nervous system, just as the nervous system has direct access to the body (13). The same holds for the dualism of the rational and the emotional. Emotions are needed for good reasoning but an emotional imbalance can thwart proper reasoning. Another relatively disregarded aspect of the unity of mind and body manifests itself in the functioning of the enteric nervous system. This is a formation of about 300 million neurons located in the gastrointestinal tract. Most of these neurons are intrinsic, i.e. they are not projected to the central nervous system. The enteric and the central nervous system are independent in action but can communicate (13).

Expanding on the logic of the unity of mind and body, Damasio draws upon the continuous evolutionary development of emotions as closely related to the concept of homeostasis. It is precisely

senzorne podražaje ili pak aktivacije akcijskih programa. Akcijski programi setovi su instinktivnih akcija potaknutih promjenama u unutrašnjoj ili vanjskoj okolini organizma. Njihova je funkcija održavati homeostazu (13,14). Oni uključuju promjene u radu unutrašnjih organa, promjene u radu poprečno prugastih mišića te promjene u kogniciji. Dijele se na nagone (npr. gladi), motivacije (npr. igra) ili emocije u širem, konvencionalnom smislu. Igraju važnu ulogu u društvenim odnosima. Sreća, strah, ljubomora, zavist i ostali osjećaji definiraju socijalni kontekst te su značajni kako za pojedinca tako i za društvo, a većina aspekata homeostaze vezanih uz socijalna ponašanja ovise o supkortikalnim regijama tako da se jasno očituje interakcija biološkog i socijalnog. Ako se radi o širokom odgovoru na senzorne podražaje vjerojatnija je blaga promjena u stanju organizma, dok će, ako se pak radi o aktivaciji nagona, motivacija ili emocija, doći do velikih promjena te je moguć i mentalni preokret (13,14). Interesantno je da LeDoux (15) koristi sličnu podjelu, naglašavajući da su nagoni/motivacija krugovi za preživljavanje („*survival circuits*") ili bihevioralna reakcija na opasnost, a osjećaj i spoznaju emocije uključuju drugi kognitivni krugovi. Dakle, ne trebamo imati emociju da bi se ponašali na neki način, dovoljno je imati nagon/motivaciju.

Sam emocionalni odgovor, neovisno o tome kako je izazvan, potječe iz točno određenog neuralnog sustava. Parabrahijalna jezgra, jezgra solitarnog trakta, periakveduktna siva tvar te gornji kolikuli mapiraju tjelesna stanja dok hipotalamus, periakveduktna siva tvar, amigdala te ventralni strijatum (*nucleus accumbens*) stvaraju emocionalni odgovor. Na razini korteksa insularni i somatosenzorni dijelovi također mapiraju tijelo te tako pružaju supstrate osjećaja (16). Određena vrsta podražaja aktivirat će određenu regiju, a neke od tih regija djelovat će direktno, dok će neke

the aspiration for stable internal conditions that predominantly motivates behaviors of different organisms, from bacteria to man himself. Thus, Damasio introduces two kinds of feelings: spontaneous or homeostatic feelings and induced feelings. Homeostatic feelings spring from bodily processes and signal the current state of life as good, bad, or something in between. Signalizing the quality of life states is called valence and it is the constitutive element of each affect. Feelings become a mental representation of homeostasis. Induced feelings are the result of a wide range of emotional responses to sensory stimuli or activation of action programs. Action programs are sets of instinctive actions triggered by changes in the internal or external environment of the organism. Their function is to maintain homeostasis (13,14). They include changes in the workings of internal organs, changes in transverse muscle tissue, and changes in cognition. They are divided into drives (e.g. hunger), motivation (e.g. play), or emotions in a wider, conventional sense. Actions programs play an important role in social relationships. Happiness, fear, jealousy, envy, and other feelings define the social context and are important for both the individual and the society, and most aspects of homeostasis related to social behavior depend on the subcortical regions, so the interaction of the biological and the social is clearly manifested. If there is a broad response to sensory stimuli, it is more likely that mild changes will occur in the body's condition, while if drives, motivation, or emotion are activated, major changes can occur and a mental upheaval is possible (13,14). Interestingly, LeDoux (15) uses a similar division, emphasizing that drives/motivation are survival circuits or behavioral reactions to danger, while feeling and awareness of emotions include other cognitive circuits. Therefore, we do not need to have an emotion to behave in a certain way – it is enough to have the drive/motivation.

The emotional response itself, regardless of how it was induced, stems from a specific neural system. The parabrachial nucleus, the tractus soli-

zahtijevati posredovanje korteksa. Aktivacija tih regija posve je nesvjesna. Ti emocionalni odgovori razlikuju se od situacije do situacije u obliku primarnih visceralnih promjena u različitim tjelesnim sustavima (krvožilni, endokrini, probavni, imunološki, respiratorni, itd.), količinama izlučenih neurotransmitera, itd. Emocionalni odgovori nisu kopija svojih prethodnika te podliježu do neke mjere okolišnim faktorima. Tako, primjerice, njemački studenti prije ispita osjećaju „leptiriće u trbuhu", dok kineski studenti osjećaju glavobolju (13).

Osim prethodno nabrojanih makroskopskih supstrata emocija, postoje i oni mikroskopski. To se najbolje očituje u činjenici da se većina informacija o tjelesnim stanjima prenosi ili putem C vlakana koja su posve nemijelinizirana, ili pak putem A delta vlakana koja su slabo mijelinizirana. Zbog evolucijske prednosti ubrzanog prenošenja impulsa putem mijeliniziranih vlakana, naizgled se čini neobično da bi tako važan regulacijski sustav kao što je homeostaza ostao nezahvaćen mijelinizacijom. No, nemijelinizirana vlakna omogućuju evolucijski stariji oblik efaptičkog prijenosa koji karakterizira lateralni prijenos impulsa. Ona omogućavaju slobodnu razmjenu iona. Evolucija je zapriječila mijelinizaciju onda kada je dostupnost iona membrani bila važnija od brzine prijenosa (16). Dorzalna grana vagusa, glavnog živca zaduženog za prijenos visceralnih signala, nemijelinizirana je.

Mentalne reprezentacije tijela koje potječu iz homeostatskih osjećaja tvore integriranu reprezentaciju cijelog organizma koju Damasio naziva proto-sebstvo. Proto-sebstvo nalazi se primarno u supkortikalnim strukturama što odgovara evolucijskom slijedu jer se radi o starijim strukturama koje dijelimo s mnogim životinjama. U trenutku interakcije proto-sebstva i okoline javlja se svijest i tek tu možemo govoriti o osviještenom osjećaju ili pojmu temeljne svijesti (16-18). Ta svijest daje organizmu tre-

tarius nucleus, the periaqueductal gray matter, and the upper colliculi map the state of the body while the hypothalamus, the periaqueductal gray matter, the amygdala, and the ventral striatum (nucleus accumbens) create an emotional response. At the cortical level, the insular and somatosensory parts also map the body and thus provide the substrates of feelings (16). A certain type of stimulus will activate a particular region, and some of these regions will act directly while some will require mediation of the cortex. The activation of these regions is completely unconscious. These emotional responses differ from situation to situation in the form of primary visceral changes through different bodily systems (vascular, endocrine, digestive, immune, respiratory, etc.), quantities of secreted neurotransmitters, etc. Emotional responses are not a copy of their predecessors and are subject to environmental factors, to an extent. Thus, for example, German students feel "butterflies in their stomach" before an exam while Chinese students feel headaches (13).

In addition to the previously mentioned macroscopic substrates of emotion, there are also microscopic ones. This is best seen in the fact that most of the information about bodily conditions is transmitted either via C fibers that are completely unmyelinated or using A delta fibers that are poorly myelinated. Because of the evolutionary advantage of accelerated impulse transmission through myelinated fibers, it seems unusual for such an important regulatory system, such as homeostasis, to remain unaffected by myelination. However, unmyelinated fibers allow for an evolutionary older form of ephaptic transmission characterized by lateral transmission of impulses. They allow free ion exchange. Evolution prevented myelination when the availability of ions to the membrane was more important than the transfer rate (16). The dorsal branch of the vagus, one of the major nerves responsible for the transmission of visceral signals, is unmyelinated.

Mental representations of the body originating from homeostatic feelings form an integrat-

nutačni osjećaj sebstva te je i ona zajednička mnogim drugim organizmima.

Osjećaji, a samim time i emocije, preuzimaju ključne funkcije u regulaciji homeostaze. Također, konstitutivne su u razvoju svijesti. Prisutne su u svim aspektima života, te ih je nemoguće odvojiti od razmišljanja ili bilo kakvog oblika kreativnosti te imaju snažan utjecaj na proces donošenja odluka.

Damasiova teorija preklapa se s Berrettinom teorijom u obliku interoceptora i tijela, tj. homeostatskih osjećaja (koje Barrett naziva afekti) i njihove oštre diferencijacije od emocija. Obje teorije smatraju da je za emocije potrebna i kortikalna aktivacija, a ne samo supkortikalane jezgre, za razliku od Pankseppa (13, 19).

Emocije kao konstrukcije

Psihologinja Lisa Feldman Barrett u svojoj teoriji emocija propitkuje klasičnu paradigmu emocija kao reakcije čvrsto definiranog limbičkog sustava (3,19). Ona smatra da emocije nisu lokalizirane u određenim anatomskim strukturama ili krugovima, već da ih mozak stvara u velikim mozgovnim mrežama, široko distribuiranima u mnoštvu supkortikalnih i kortikalnih regija. Za razliku od klasične paradigme emocija koja naglašava supkortikalne strukture moždanog debla i limbičkog sustava, Barrett ističe da se emocije dizajniraju iz trenutka u trenutak na «zahtjev» tijela i interakcije s okolinom. Drugim riječima, bez (određenih dijelova) korteksa nema emocionalnog stanja te je time kognicija uvedena u afektivnu neuroznanost. Također naglašava da emocije nemaju biološku esenciju, tj. čvrst neuralni potpis ili otisak prsta, kao što nemaju ni druge mentalne kategorije (planiranje, sjećanje, odlučivanje). Ne radi se o esenciji već o konstrukciji (10).

Barrett smatra da je neispravno emocije smatrati univerzalnima (poput ideja o 5 ili

ed representation of the entire organism that Damasio calls the proto-self. The proto-self is primarily found in subcortical structures which correspond to the evolutionary sequence because they are older structures we share with many animals. Consciousness emerges at the moment of interaction between the proto-self and the environment, and it is only here that we may speak of a conscious feeling or the concept of core consciousness (16-18). This awareness gives the organism a momentary sense of self, and it is also common to many other organisms.

Feelings, and thus emotions, take on key functions in regulating homeostasis. They are also constitutive in the development of consciousness. They are present in all aspects of life and have a strong influence on the decision-making process, and it is impossible to separate them from thinking or any form of creativity.

Damasio's theory overlaps with Barrett's theory in terms of interoceptors and the body, i.e. homeostatic feelings (which Barrett calls affect) and their sharp differentiation from emotions. Both theories posit that emotion also requires cortical activation, not just subcortical nuclei, unlike Panksepp (13,19).

Emotions as constructions

In her theory of emotions, psychologist Lisa Feldman Barrett questions the classic paradigm of emotion as the reaction of a strongly defined limbic system (3,19). She believes that emotions are not localized in certain anatomical structures or circles. Instead, the brain creates them through large brain networks, widely distributed through a multitude of subcortical and cortical regions. Unlike the classic paradigm of emotion that emphasizes subcortical structures of the brain, Barrett points out that emotions are designed from moment to moment as "requested" by the body-environment interaction. In other words, there is no emotional state without (certain parts) of the cortex, and thus cognition is introduced into

7 bazičnih emocija) te navodi da uz tjelesnu jezgru afekta, neophodnu za emociju, postoje i kognitivna konstrukcija, socijalno učenje pojedinih emocija, te su one dijelom kulturološki oblikovane. Ne postoje primarne i sekundarne emocije, već samo različite palete emocija. Primjerice, neke pacifičke plemenske kulture nemaju emociju tuge i žalosti (premda i one imaju depresivne reakcije i poremećaje), već u svojem jeziku to stanje opisuju kao neku infektivnu bolest. Također ističe da kod životinja možemo istraživati afekte (homeostatske osjećaje) i ponašanje, ali ne i emocije, jer čak ni majmuni nemaju tako razvijene neuralne kognitivne kapacitete, ni socijalno-jezičnu kulturu da bi mogli graditi sofisticirane koncepte emocija. Drugim riječima, jezično kodiranje je važno za emocije kao i za sposobnost apstraktnog mišljenja i stvaranja socijalnog realiteta. Jedino ljudski mozgovi mogu izgraditi, održavati i crpiti svoju (civilizacijsku) snagu iz socijalnog realiteta (19).

Barrett time naglašava umjetnu granicu između različitih subdisciplina neuroznanosti – afektivne, kognitivne i socijalne. Provodeći meta-analizu velikog broja istraživanja emocija u ljudi kroz snimanje mozga, zaključuje da je teško izdvojiti zasebne anatomske strukture i neuralne krugove koji se mogu vezati isključivo za generiranje određenih emocija (izolirano od kognicije i socijalnog ponašanja), i precizno diferencirati u uzorcima moždane aktivnosti određene emocije, recimo strah i bijes ili žalost i radost. Tu postoji puno potpunih i djelomičnih preklapanja. Uspoređuje mozak s kuhinjom u kojoj imamo desetak istih namirnicama (brašno, sol, šećer, itd.) s kojima se po potrebi može stvoriti jedno, drugo ili pak mnoštvo jela. U njezinoj teoriji ne ističu se neke velike razlike između emocije i kognicije. Smatra se da u pravilu ljudi mogu imati kogniciju bez emocije, no da je emocija uvijek vezana za kognitivni koncept i šire razumijevanje situacije i socijalnog

affective neuroscience. She also emphasizes that emotions do not have a biological essence, i.e. a firm neural signature or fingerprint. That is a trait common to other mental categories (planning, memory, decision making). It is not about essence; it's about construction (10).

Barrett finds the idea of universal emotions (e.g., 5 or 7 basic emotions) inappropriate and states that alongside the bodily core of affects essential for an emotion there are also cognitive constructions and social learning of certain emotions and that they are partially culturally-shaped. There are no primary and secondary emotions, but only a variety of emotional palettes. For instance, some Pacific tribal cultures have no emotion of sadness and sorrow (although they have depressive reactions and disorders), but in their language, they describe this condition as an infectious disease. She also points out that in animals we can investigate affects (homeostatic feelings) and behavior, but not emotions, because not even monkeys have such developed neural cognitive capacities nor social-linguistic culture to build sophisticated concepts of emotion. In other words, linguistic coding is important for emotions as well as the ability to think abstractly and the creation of social reality. Only human brains can build, sustain, and draw their (civilizational) strength from social reality (19).

Barrett thus emphasizes the artificial boundary between the various sub-disciplines of neuroscience – affective, cognitive, and social. By conducting a meta-analysis of a multitude of research in humans through brain imaging, she concludes that it is difficult to distinguish between separate anatomical structures and neural circuits that can be linked exclusively to the generation of certain emotions (isolated from cognition and social behavior). She also concludes it is difficult to precisely differentiate between certain emotions (e.g. fear and anger or sorrow and joy) in brain activity patterns. There are many full and partial overlaps. She compares the brain to a kitchen with about a dozen of the

realiteta. Emocija je kao bilo koja druga mentalna kategorija (19).

Mnoge sinapse stvorene su po pravilu «mnoštvo prema jednom» ili po pravilu «jedan prema mnoštvu». Posljedica toga je da su neuroni čak i iste skupine (čak i supkortikalni poput amigdala) te njihovi krugovi stvoreni za mnogostruke svrhe. Drugim riječima, mozak stječe svoju kompleksnost kapacitetom da različite reprezentacije (npr. različiti skupovi neurona) stvaraju primjere iste kategorije (npr. ljutnja) u različitim kontekstima. U istraživanju emocija to znači da su pojedine emocije (npr. strah) kreirane pomoću mnogostrukih spacijalno temporalnih uzoraka u različitoj populaciji neurona. Stoga je manje vjerojatno da svi slučajevi jedne emocionalne kategorije dijele skupove temeljnih osobina, kao što su pojedinačna facijalna ekspresija, uzorci aktivacije autonomnog živčanog sustava ili anatomski određenog seta neurona („*neural fingerprints*“) (10).

Još jedno važno obilježje Barrettine teorije, slično Damasiovom gledištu, je postojanje veze mozak – tijelo preko interoceptora i mozgovne regulacije resursa tijela („*body budget*a“) koji održavaju alostazu.

Mozak nije evoluirao da bi bili racionalni, sretni ili točno percipirali, već izvršava svoj temeljni zadatak tako da efikasno osigura resurse za fiziološke sustave unutar tijela kako bi životinja (čovjek) mogla rasti, koristiti prilike, zaštititi se, preživjeti i reproducirati. Taj čin zove se alostaza. Ona nije stanje tijela, već proces kojim mozak regulira tijelo prema analizi troškova i koristi („*cost-benefit*“). Što god da mozak radi - misli, osjeća, percipira, stvara emocije – on također regulira autonomni živčani sustav i ostale tjelesne sustave kao resurse koji se troše pri traženju i osiguravanju dodatnih resursa. Alostaza je regulacija internalnog miljea pomoću anticipacije fizioloških potreba prije njihova javljanja. Da bi mozak mogao efektivno regulirati tijelo u svijetu, on

same ingredients (flour, salt, sugar, etc.) with which a multitude of meals and desserts can be created. In her theory, there are no significant differences between emotion and cognition. It is generally believed that people can have cognition without emotion, but that emotion is always linked to a cognitive concept and a wider understanding of social reality. Emotions are like any other mental category (19).

Many synapses are created according to the rule of “many-to-one” or “one-to-many” mapping. Consequently, even neurons in the same group such as subcortical neurons of the amygdala and their circles are created for multiple purposes. In other words, the brain gains its complexity through degeneracy, the capacity for different representations (e.g. different sets of neurons) to produce examples within the same category (e.g. anger) in different contexts. In researching emotions, this means that particular cases of emotion (e.g., fear) are created by multiple spatial-temporal patterns in different populations of neurons. Thus, it is less likely that all cases of one emotional category share a set of basic features, such as individual facial expression, autonomic nervous system activation patterns, or anatomically determined neural fingerprints (10).

Another important feature of Barrett’s theory, similar to Damasio’s point of view, is the existence of a brain-body connection via interoceptors and the body budget, which maintain allostasis.

The brain has not evolved so that we could perceive accurately or be rational or happy. It performs the basic task of effectively providing resources for the physiological systems within the body to allow for the animal to grow, protect itself, survive, and reproduce. That is called allostasis. It is a process by which the brain regulates the body by cost-effectiveness analysis. What it is not, is a bodily state. Along with thinking, feeling, perceiving, or creating emotions, the brain also regulates the autonomic

održava internalni model tijela u svijetu (okolišu) (3).

Ta regulacija objašnjava zašto su, u sisavaca, regije koje su odgovorne za implementiranje alostaze (amigdala, ventralni striatum, insula, orbitofrontalni korteks, anteriorni cingularni korteks, medijalni prefrontalni korteks, hipotalamus i jezgre moždanog debla, kolektivno zvane «visceromotorne regije») obično smatrane regijama koje sadrže neuralne krugove za emocije (17,19). Tu treba dodati i generator (nagonskih ili bihevioralnih) uzoraka (*pattern generators*) koji implementira sekvence akcija za koordinirano bazično biološko ponašanje. Akcija je pojedinačni pokret, no ponašanje je događaj. Vidimo ga u pseudo afektivnom ponašanju dekortikaliziranih životinja.

Premda se u psihologiji većinom govori o emocijama kao odgovorima na neki vanjski događaj u okolini jedinke, u stvari unutarnji model mozga uključuje, ne samo relevantne statističke regularnosti u vanjskom svijetu, već i statističke regulacije internalnog miljea – interoceptore (20-22).

Fiziološka stanja jedinke se konstantno mijenjaju tijekom dana te njihova neposredna prošlost determinira trenutačne aspekte senzornog svijeta koji uzastopno utječu na vlastitu nišu u neposrednoj budućnosti. Ukratko, osjećaji primarno niču preko interoceptora, visceralnih stanja trenutačne homeostatske regulacije internalnog miljea tijela, oni su dnevna dinamika organizma koja je stalno pod utjecajem interoceptivne mreže mozga koja predikcijski gleda na tijelo, simulacijama testira ulazne senzorne informacije iz tijela i ažurira reprezentaciju tijela u okolišu. Ti osjećaji najčešće su u pozadini svijesti, stvaraju temelj svakodnevnog raspoloženja te su neophodni gradivni element za emocije (10,23).

Komunikacija mozga i tijela neophodna je za nastanak afekata (emocija). Kako će mozak

nervous system and other body systems as resources that are being consumed while seeking and providing additional resources. Allostasis is the regulation of the internal mile by anticipating physiological needs before their emergence. For the brain to effectively regulate the body in the world, it maintains an internal model of the body inside the world (the environment) (3).

This regulation explains why in mammals regions responsible for the implementation of allostasis (the amygdala, ventral striatum, insula, orbitofrontal cortex, anterior cingulate cortex, medial prefrontal cortex, hypothalamus, and the nuclei of the brain stem, collectively referred to as "visceromotor regions") are considered regions containing neural circuits for emotions (17,19). Additionally, pattern generators implement action sequences for coordinated basic biological behavior. Action is an individual movement, but behavior is an event. We see it in the pseudo-affective behavior of decorative animals.

Although psychology mostly talks about emotions as responses to an external event in an individual's surroundings, in fact the inner model of the brain involves not only the relevant statistical regularities in the outside world but also the statistical regulation of the internal mile – interoceptors (20-22).

The physiological states of the individual are constantly changing throughout the day, and their immediate past determines the immediate aspects of the sensory world, which perpetually affects its own niche in the immediate future. Briefly, emotions primarily arise through interceptors, the visceral states of the current homeostatic regulation of the inner body mile. They are the daily dynamics of the organism, constantly under the influence of the brain's interoceptive network. The network observes the body predictively, tests the sensory inputs from the body via simulation, and updates the brain's model of the body inside the world. These feelings are most often in the background of consciousness as a basis of everyday mood, and are a necessary building element of emotions (10,23).

«očitati» signale interoceptora ne ovisi toliko o nekim realnim fiziološkim homeostatskim osciliranjima tjelesnih sustava, koliko o njihovoj predikciji u neprestanim regulatornim oscilacijama – mozak kontinuirano anticipira događaje u senzornom okolišu te tijelu. Ta se predikcija još naziva i aktivna inferencija ili prediktivno kodiranje (24).

U prediktivnom kodiranju senzorna predikcija proizlazi iz motorne predikcije. Simulacije niču kao funkcije visceromotorne predikcije (koje kontroliraju autonomni živčani sustav, neuroendokrini i imunološki sustav) i voljne motorne predikcije, koje zajedno anticipiraju i pripremaju se za akciju koja će biti zahtijevana u nekom neposrednom momentu. Te opservacije pokazuju da je «podražaj– reakcija» model uma netočan, kaže Barrett. Nadalje, pokazuje se da mehanicistički detalji prediktivnog kodiranja pružaju drugi duboki uvid. Mozak implementira internalni model pomoću *koncepata*, kojim *kategorizira* senzacije kojima daje smisao. Predikcije su koncepti, a kompletirani koncepti su kategorizacije koje održavaju fiziološku regulaciju, vode akciju i konstruiraju percepciju (i pažnju). Značenje senzornog događaja uključuje visceromotorni i motorni akcijski plan kojim se organizam nosi s događajem (19,20).

Mozak konstruira svaku emociju u *on-line* konceptu, ali prema određenim ciljevima i kontekstu situacije. Prema tome emocije nisu refleksi, već su konstrukcija, ovisna ne samo o biologiji tijela i mozga, već i o procesu učenja (razvoja) i psiho-socijalnim kontekstima koji su često promjenjivi.

Tako Barrett zaključuje da u svakom budnom trenutku mozak koristi sveukupna prošla (naučena, ne infantilna) iskustva organizirana kao koncepte da bi vodio akciju (ponašanje) i dao osjetima značenje koje se neprestano kategorizra i time diferencira emocije (25). Tako, um nije samo funkcija odnosa mozga-tijela, već i umova-mozgova-tijela drugih

The communication between the brain and the body is essential for affects (emotions). How the brain "reads" the interoceptor signals does not depend so much on real physiological homeostatic oscillations of the physical system as much as their prediction in continuous regulatory oscillations. The brain continuously anticipates events in the sensory environment and body. This prediction is also called active inference or predictive coding (24).

In predictive encoding, sensory prediction stems from motor prediction. Simulations emerge as a function of visceromotor predictions which control the autonomic nervous system, the neuroendocrine and the immune system, and volitional motor predictions, which together anticipate and prepare for an action that will be required at an immediate moment. These observations show that the "stimulus-reaction" model of the mind is inaccurate, according to Barrett. Furthermore, it appears that the mechanical details of predictive coding provide another deep insight. The brain implements the internal model using *concepts* by which it *categorizes* meaningful sensations. Predictions are concepts, and complete concepts are categorizations that maintain physiological regulation, drive actions, and construct perceptions (and attention). The significance of the sensory event includes the visceromotor and the motor action plan that cope with the event (19, 20).

The brain constructs every emotion in an online concept, but with references to certain goals and the context of the situation. According to this, emotions are not reflexes but constructions, largely dependent not only on the biology of the body and the brain but also on the process of learning (development) and on psycho-social contexts that are often changeable.

Thus, Barrett concludes that in every waking moment the brain uses overall past (learned, non-infantile) experiences organized as concepts to guide actions (behavior) and give the senses constantly categorized meaning (25).

ljudi, fizičkog okruženja, kulture i socijalnog realiteta.

Emocije kao funkcionalna stanja

Damasiov doktorand Ralph Adolphs i njegov suradnik David J. Anderson ističu dva problema u vezi emocija (26). Prvi je taj kako su ljudi skloni sebe same smatrati emocionalnim ekspertima. Uzrok toga je dostupnost samog fenomena emocije koji sačinjava veliki dio ljudskog iskustva i često je sveden isključivo na subjektivni doživljaj. Međutim, pri kardiovaskularnim problemima ne oslanjamo se na vlastite osjećaje i senzacije, već na znanje (i dijagnostičke uređaje) kardiologa. Naše socio–kulturno okruženje potiče dojam ekspertnosti jer smo neprestano izloženi emocijama drugih bilo u stvarnosti ili putem medija. Ipak, subjektivno doživljavanje i mišljenje o emocijama ne mora biti točno, već može biti rezultat pretjeranih uopćavanja, krive intuicije, prenaglašavanja ili socijalnih očekivanja. Drugi problem je utjecaj našeg pervazivnog zdravorazumskog shvaćanja emocija na znanstvena pitanja o tom polju. Naglašavaju kako njihov pristup nije teorija, već razmišljanje o načinu pristupanja istraživanju emocija gdje zahtijeva jasnije i preciznije definiranje te kauzalna objašnjenja. Na tom putu razotkriva neke mitove o emocijama. Primjerice, smatraju pogrešnim razdvajati emocije na primarne i sekundarne isto kao dijeliti emocije s obzirom na kategoričku vrstu (26).

Ideja da se primarne emocije ne mogu miješati ni preklapati jedne s drugima te imaju stabilne identitete i funkcije a da ne dijele gradivne komponente netočna je, jer nam neuroznanstvena istraživanja pokazuju suprotno. Narativna priroda ljudskog mozga je da stalno kreira različite priče i uvjerenja čvrsto se oslanjajući na njih bez obzira bile one točne, djelomično točne ili potpuno netočne.

Daljnja diskutabilna ideja je da su emocije potaknute nekim vanjskim podražajem. Ta slika

The mind is therefore not merely the function of the brain-body, but also the brain-bodies of other people, the physical environment, culture, and social reality.

Emotions as functional states

Damasio's PhD student Ralph Adolphs and his associate David J. Anderson highlight two issues regarding emotions (26). The first is that people tend to consider themselves emotional experts. The reason for this is the availability of the emotional phenomenon that constitutes a large part of the human experience and is often limited to subjective experience. Yet when having cardiovascular problems we do not rely on our feelings and sensations but instead on the knowledge of cardiologists (and diagnostic devices). Our socio-cultural environment encourages an impression of expertise because we are constantly exposed to the emotions of others either in reality or through the media. However, subjective perception and emotional thinking does not have to be true, but may be the result of excessive generalization, false intuitions, over-estimation, or social expectations. The second problem is the impact of our pervasive commonsense understanding of emotions on scientific issues in this field. They emphasize that their approach is not a theory, but a reflection on the mode of engaging in emotional research, demanding clearer and more precise definitions of these causal explanations. In doing so, they reveal some myths about emotions. For example, they consider separating emotions into primary and secondary emotions a mistake, as well as classifying emotions with regard to their categorical type (26).

The idea that primary emotions cannot mix or overlap with one another and instead possess stable identities and functions without sharing their building components is inaccurate. Neuroscientific research shows quite the opposite. The narrative nature of the human brain is to constantly create different stories and beliefs, firmly

čini emocije jednostavnim i gotovo refleksnim fenomenima. Prema toj ideji emocije kontroliraju naše ponašanje, što također vidimo da nije točno jer su ljudi sposobni ponašati se suprotno emociji koju u nekom trenutku osjećaju (npr. unatoč strahu učiniti nešto čega se bojimo). Specifične emocije ne izazivaju fiksirana i specifična ponašanja.

Također postoji ideja da su različite emocije lokalizirane u različitim diskretnim regijama mozga (npr. strah u amigdalama, a bijes u hipotalamusu). Suvremena neuroznanost tvrdi da emocije ovise o znatno više distribuiranim regijama mozga.

Sljedeća pogrešna ideja je viđenje mozga kao stroja unutar kojeg se nalazi čovječuljak koji gleda vanjski svijet, reagira na njega i tada prenosi reakcije na nas. Drugim riječima, naše subjektivno iskustvo emocije je kreirano i utjelovljeno subjektivnim iskustvom minijaturne verzije nas samih u našem mozgu – takozvani homunkulus. Također je upitno gledati na emocije kao na čisti subjektivni doživljaj. Kako mozak kreira internalne reprezentacije vanjskog svijeta te ih prevodi u misli, osjećaje i akcije, centralno je, te još uvijek otvoreno, pitanje u neuroznanosti (27).

Adolphs i Anderson ističu da su emocije fundamentalno biološki fenomeni te stoga trebaju biti shvaćene u biološkim terminima. Nadalje, treba razlikovati tri temeljito različita stanja koja se često izjednačuju: emocionalno stanje, svjesno iskustvo ili osjećaj emocije i razmišljanje (u konceptima i riječima) o emociji. U svojem radu fokusiraju se uglavnom na prvo te smatraju da se emocije mogu proučavati bez subjektivnih osjećaja, tj. bez mjerenja verbalnog iskaza i bez posezanja za teorijama svijesti. Emocije su implementirane pomoću neuralnih mehanizama koji se mogu otkriti i manipulirati pomoću neuroznanstvenih metoda. Studije na miševima otkrivaju da i relativno male regije mozga, kao što je centralna jezgra amigdala, ne obavljasju unitarnu funkciju, već prije sadrže

relying on them regardless of whether they are accurate, semi-accurate, or completely incorrect.

Another disputable idea is that emotions are triggered by some external stimuli. This view makes emotions seem like simple and almost reflexive phenomena. According to it, emotions control our behavior. However, that is not true because certain human behaviors ignore emotions, and individuals sometimes exhibit behaviors contrary to those emotions (e.g. doing something we are afraid of despite the fear). Specific emotions do not cause fixed and specific behaviors.

Furthermore, there is the idea of different emotions being localized in different discrete regions of the brain (e.g. fear in the amygdala and anger in the hypothalamus). Contemporary neuroscience tells us that emotions depend on significantly more distributed brain regions.

The next misconception is seeing the brain as a machine within which a tiny human is looking at the outside world, reacting to it, and then transmitting the reactions to us. In other words, our subjective experience of emotions has been created and embodied by the subjective experience of the miniature version of ourselves in our brain – the so-called homunculus. It is also questionable to view emotions as purely subjective experiences. Exactly how the brain creates internal representations of the outside world and translates them into thoughts, feelings, and actions is a central, and still unanswered, question in neuroscience (27).

Adolphs and Anderson stress that emotions are fundamentally biological phenomena and therefore need to be understood in biological terms. Furthermore, three distinctly different states (that are often equated) should be distinguished: emotional states, conscious experience or feeling of emotion, and thinking (through concepts and words) about emotion. In their work, they focus primarily on the first and suggest emotions can be studied without subjective feelings, i.e. without measuring the verbal report and without resorting to theories

mnogostruke tipove živčanih stanica koje različito utječu na (čak i u suprotnom smjeru) dano emocionalno stanje.

Kada gledamo emocionalno stanje različito od osjećaja emocije, koncepta emocije i riječi za emocije, oslobađamo se naglaska na iskustvu ili konceptu u kojima se reflektira antropocentrična sklonost u mnoštvu emocionalnih studija. Kada laici govore o emocijama upotrebljavaju različite etikete (strah, tjeskoba, ispunjenost, itd.) koje nas mogu informirati o kulturnoj varijabilnosti te razvojnom aspektu emocionalnih koncepata, no to ne treba izjednačavati sa studijama emocionalnog stanja.

Emocije su adaptivno funkcionalno stanje čiji je stupanj kompleksnosti između refleksa i slobodne volje, premda i refleksi i slobodna volja mogu biti regrutirani u emocionalni odgovor (26).

Treba razlikovati dva svojstva emocija: građevne blokove koji su neophodni u pojavi emocije, nasuprot osobinama, koje su više elaborirana, derivirana i varijabilna svojstva. Primjer za građevne blokove je valencija, sva emocionalna stanja su u relaciji s pozitivnom ili negativnom valencijom, ugodom ili neugodom, nešto što izaziva priležanje ili izbjegavanje. S druge strane, primjer osobina emocije je socijalna komunikacija, što je vrlo važna osobina pogotovo u sisavaca, jer bilo koja emocija može igrati funkcionalnu ulogu u socijalnoj komunikaciji pod nekim okolnostima i nikakvu ulogu u nekim drugim okolnostima. To je ono što zovemo kontekstualna ovisnost emocija. Osim valencije postoji još nekoliko građevnih blokova: skalabilnost (koliko emocionalno stanje varira u intenzitetu), trajnost (različite emocije imaju različita trajanja te uglavnom traju od nekoliko sekundi do nekoliko minuta), generalizacija (mogućnost da se mnoštvo različitih podražaja veže za jedno emocionalno stanje, što posljedično uzrokuje mnoga različita ponašanja, ovisno o kontekstu), globalna koordinacija (angažira se čitavo tijelo, za razliku od

of consciousness. Emotions are implemented through neural mechanisms that can be detected and manipulated by neuroscientific methods. Studies on mice reveal that relatively small brain regions, such as the central nucleus of the amygdala, do not perform a unitary function, but in reality contain multiple neural cell types that have different effects on (even in the opposite direction) a given emotional state.

When we view the emotional state as different from feelings, concepts of emotion, and words for emotions, we are liberated of the emphasis on experience (or concept) that reflects the anthropocentric tendency in a multitude of emotional studies. When laypersons talk about emotions, they use various labels (fear, anxiety, fulfillment, etc.) that can inform us about cultural variability and the developmental aspect of emotional concepts, but this does not need to equate to emotional state studies.

Emotions are an adaptive functional state whose degree of complexity is somewhere between reflex and free will, although reflexes and free will can be recruited into an emotional response (26).

Two emotional features need to be distinguished: building blocks essential to the appearance of emotion versus traits that are more elaborate, derived, and variable. An example of building blocks is valence. All emotional states stand in relation to positive or negative valence, pleasure or discomfort, causing attachment or avoidance. On the other hand, an example of emotional traits is social communication, which is a very important feature especially in mammals because various emotions can play a functional role in social communication under certain circumstances and no role in other circumstances. This is what we call contextual dependence of emotions. In addition to valence, there are several building blocks: scalability (how much the emotional state changes in intensity), persistence (different emotions have different persistence and mostly last from several seconds to several minutes), generalization (the possibility that a multitude of different

refleksa) i automatizam (jedinstvena ljudska pojava gdje emocije imaju veći prioritet nad kontrolom ponašanja, nego što ima voljna namjera, što zahtijeva napor u cilju emocionalna reguliranja).

Na centralno emocionalno stanje utječu određeni podražaji (ulazne senzoričke informacije, interoceptori) posredovani varijabilnim kontekstom i voljnom kontrolom, a izlazne informacije emocionalnog stanja (neke određene emocije) su opažena ponašanja, subjektivni iskaz, psihofiziologija, kognitivne promjene i somatski odgovor. Ti odgovori mogu u svakom trenutku postati novi, daljnji podražaji. Tako funkcionalna koncepcija emocija također ukazuje na kriterije za razumijevanje psihijatrijskih poremećaja. Ponekad emocije nisu adaptivne i emocionalno ponašanje je neispravno, što vidimo u poremećajima poput depresije, fobija, PTSP-a, itd. (27).

Postoje svjesno neprimijećeni senzorni stimulusi koji induciraju emocionalno stanje te nesvjesni utjecaji poput kondicioniranja, no ne postoji nesvjesni osjećaj emocije, ako je bilo koje emocionalno stanje aktivno u punom intenzitetu. Eventualno je moguće ne biti svjestan neke potencijalne emocije koja se na trenutak pojavila u vrlo niskom intenzitetu (u začetku) a da se ne razvije u puno emocionalno stanje.

Adolphs naglašava da su emocije određeno funkcionalno stanje mozga. One ne niču iz neurotransmitera ni iz anatomskih struktura poput amigdala. Ako anatomske strukture stavimo u posudu i inerviramo ih neće nastati emocije. Da bi se pojavile emocije kao funkcionalno stanje, anatomske strukture treba staviti u intaktni mozak i tijelo.

No na pitanja što su temeljni neurobiološki mehanizmi koji generiraju emocije te kako određena emocionalna stanja mijenjaju ostala ponašanja, pažnju, memoriju i donošenje odluka, ne može se odgovoriti samo putem razmišljanja o

stimuli bind to one emotional state, resulting in many different behaviors depending on the context), global coordination (the whole body being engaged, as opposed to reflex), and automaticity (a unique human phenomenon where emotions prioritize behavioral control over volitional deliberation, which requires effort to exert emotional regulation).

The central emotional state is influenced by stimuli such as sensory inputs and interoceptors, mediated by variable context and voluntary control. The outputs of the emotional state (of a particular emotion) are observed behavior, subjective report, psychophysiology, cognitive changes, and somatic response. These responses can at any time become new, further stimuli. Thus, a functional concept of emotion also suggests criteria for understanding psychiatric disorders. Sometimes emotions are not adaptive and emotional behavior is incorrect, as seen in disorders such as depression, phobia, PTSD, etc. (27).

There are conscious, unnoticed sensory stimuli that induce an emotional state as well as unconscious influences like conditioning, but there is no unconscious emotion if any emotional state is active in full intensity. It is possible that one may not be aware of a potential emotion that appears transiently at very low intensity (at the beginning) without having to develop into a full emotional state.

Adolphs emphasizes that emotions are defined functional states of the brain. They do not stem from neurotransmitters or anatomical structures like the amygdala. If we put the anatomical structures in a jar and innervate them, they would not produce emotions. To create emotions as functional states, the anatomical structure should be placed in an intact brain and body.

But questions about the underlying neurobiological mechanisms that generate emotions and how certain emotional states change other behaviors, attention, memory, and decision making cannot be answered only by thinking about our own emotions. It should also be not-

svojim emocijama. Također treba napomenuti da samo funkcionalni efekt emocije ima svoju adaptivnu ili neadaptivnu svrhu, to je ono što evolucija «vidi». Kognitivizacija emocija, beskrajna razmišljanja i ruminiranja o emocijama nemaju takav utjecaj na ponašanje, mentalnu stabilnost i sam život (26,27).

RASPRAVA I ZAKLJUČAK

Ove suvremene neurobiološko–psihološke teorije emocija su značajni okvir za opće razumijevanje afekata i njihovih mehanizama te za razumijevanje psiholoških poremećaja, jer je teško naći poremećaj u kojem osjećaji i emocije nemaju značajnu ulogu kao vodeći simptomi na koje se pacijenti žale (8,28). Važno je da ove teorije prikazuju zdravo emocionalno funkcioniranje i stanja disfunkcije.

Svi navedeni autori, kao i mnogi drugi (9,29), ističu da treba odbaciti uporabu termina limbički sustav. Smatra se da je danas taj termin zastario - nije dobro definiran, nema jedinstvenog dogovora koje strukture u njega ulaze, i nije moguće precizno mapirati svaku specifičnu mentalnu funkciju.

U prikazu je navedeno nekoliko značajki koje treba istaknuti. Prvo, razlika između homeostatskih osjećaja i emocija, koji se i u psihopatologiji često miješaju, daje nam jasniju sliku u konceptualizaciji mozga-uma te pokazuje da nije sve što osjećamo emocija. Premda su osjećaji neophodni «građevni materijal» za emocije, oni im nisu ekvivalentni. Emocije spadaju u akcijske programe te se često nadovezuju i prate nagonsko/motivacijska ponašanja (glad, žeđ, traganje, socijalne interakcije, seksualnost, itd.) (13,30,31). Ova diferencijacija pomaže ukidanju panemocionalnosti (da se u životu i psihoterapijskoj seansi u svemu vide emocije) koja vodi do pogrešnih kauzaliteta i korelacija (19). Emocije su povremeni fenomeni u pravilu kratkog trajanja dok su homeostatski

ed that only the functional effect of emotion has its adaptive or non-adaptive purpose; that is what evolution "sees". Cognitivization of emotions, endless thinking, and ruminating about emotions have no such influence on behavior, mental stability, and life itself (26,27).

DISCUSSION AND CONCLUSION

The reviewed contemporary neurobiological and psychological theories of emotions represent a significant framework for a general understanding of affects and their mechanisms. They also contribute to the understanding of psychological disorders, as it is difficult to find a disorder in which feelings and emotions are not included as the predominant symptoms patients complain of (8,28). It is important that the theories encompass both healthy emotional functioning and dysfunctional states.

All the aforementioned authors, like many others (9,29), emphasize that the term "limbic system" should be rejected. The term is considered to be outdated – it is not well-defined, there is no unique agreement on what structures comprise it, and it is not possible to precisely map each specific mental function.

There are several features to highlight in this review. First, the difference between homeostatic feelings and emotions, terms which are often confused in psychopathology, gives us a clearer picture of the mind-brain conceptualization and clarifies that not everything we feel is an emotion. Although feelings are necessary "building blocks" for emotions, they are not equivalent to them. Emotions belong to action programs and are often supplemented and accompanied by instinctive/motivational behaviors (hunger, thirst, pursuit, social interactions, sexuality, etc.) (13,30,31). Differentiating between feelings and emotions helps to abolish pan-emotionality, as emotions are seen in everything in both life and psychotherapy, which

osjećaji stalnost koja je većinom „centrirana“ između tri osjećajne dihotomije (ugoda/neugoda, napetost/opuštenost i energiziranost/iscrpljenost). Dugotrajna stanja određenog raspoloženja su homeostatski osjećaji, prije nego emocije.

Damasio i Barrett drže da su homeostatski osjećaji (za Barrett afekti) stalno prisutni. Na tom tragu Adolphs ističe nužnost valencije i skalabilnosti koje on naziva građevnim blokovima emocija, ali suštinski odgovaraju konceptu homeostatskih osjećaja. Svo troje slažu se da se emocija stvara ili gradi od više različitih elemenata, te da ni jedna emocija nije ultimativno esencijalni fenomen.

Drugo, suprotno Pankseppu, ne treba dijeliti emocije na primarne (bazične) i sekundarne i socijalne, ni taksativno navoditi točan broj koje čovjek treba imati u svom repertoaru. Za mozak-um nema podjele na primarne i sekundarne, to je dogovorni jezični koncept koji nema utemeljenja u neuroznanstvenim istraživanjima, a individualne razlike u emocionalnom repertoaru uvijek postoje te neki ljudi barataju s većim repertoarom emocija, a neki s manjim.

Treće, emocije, koliko god bile „pogonsko gorivo“ našeg uma, u stvari su samo jedan od tri mentalna nazivnika za sadržaje koje možemo imati na (svjesnom) umu – percepcija, kognicija i afekti. Drugi mentalni fenomeni, poput kognicije (mišljenje, učenje i sjećanje, odlučivanje, itd.) su također iznimno važni za razumijevanje funkcioniranja uma. Ne samo da emocije izazivaju misli i ponašanje, već i misli i ponašanje mogu izazivati emocije (20). Postoje kružne petlje među tim pojavama, a naš mozak koristi sve kapacitete uma da bi stvorio optimalnu adaptivnu situaciju u životnim (ne)prilikama (32,33).

LeDoux (9,15) sukladno s ostalim navedenim autorima ističe zastarjelost termina „limbički sustav“ i njegovo izjednačavanje s emocional-

leads to erroneous causality and correlations (19). Emotions are intermittent phenomena, usually of short duration, while homeostatic feelings are largely “centered” between three sensory dichotomies (pleasure/discomfort, tension/relaxation, and energization/exhaustion). Long-term states of a certain mood are homeostatic feelings rather than emotions.

Damasio and Barrett maintain that homeostatic feelings (for Barrett, affects) are constantly present. Along those lines, Adolphs emphasizes the necessity of valence and scalability, which he calls the building blocks of emotions, but that essentially correspond to the concept of homeostatic feelings. All three authors agree that emotion is created or constructed from many different elements and that no emotion is ultimately an essential phenomenon.

Second, contrary to Panksepp’s theory, one should not divide emotions into primary (basic) and secondary or social, nor specify the exact number one should have in one’s repertoire. For the brain-mind, there is no division into primary and secondary; it is a contractual construct that is unfounded in neuroscientific research, and individual differences in the emotional repertoire are always present. Some people possess larger repertoires of emotions while others possess smaller ones.

Third, emotions, despite being the “propulsion fuel” of our mind, are in fact only one of three mental denominators for the content we can have on our (conscious) mind – perception, cognition, and affect. Other mental phenomena, such as cognition, including thinking, learning, memory, and decision making and are also extremely important for understanding how the mind functions. Not only do emotions cause thoughts and behaviors, but thoughts and behaviors can also trigger emotions (20). There are circular loops between these phenomena, and our brain uses all the mind’s capacities to create an optimal adaptive situation through life and both its opportunities and predicaments (32,33).

nim sustavom, kao i MacLeanov trijunski mozak (4) koji se često ponavlja i u suvremenoj literaturi. Emocionalno stanje, svjesnost koncepta emocije i razmišljanje o emociji su tri odvojena fenomena, koji potječu iz kombinacija različitih neuralnih krugova i mreža, a LeDoux smatra da se emocija straha samo odnosi na kognitivnu reprezentaciju, a da ponašanje i neuralni uzorak i fiziologiju i ponašanje treba zvati sasvim drugim terminom (zbrka u verbalnim konceptima i jezičnim kategorizacijama emocija i drugih mentalnih fenomena) – „neuralni krugovi za preživljavanje“ što nije isto što i riječ koja spada u verbalni repertoar „strah“, „tjeskoba“, „bijes“.

Luiz Pesoa ističe da je najbolje emocije gledati ne kao na zasebne fenomene, već kao „pakete“, kognitivno – emocionalne sheme (29). Ističe da bez obzira na privlačnost dihotomija za ljudski um dihotomizirati emocije i kogniciju je pretjerana simplifikacija, stoga Pessoa uvodi kontinuirani okvir u emocionalno-kognitivnom procesuiranju. U takvom dinamičkom okviru, „emocija“ i „kognicija“ mogu se označiti u kontekstu određenog ponašanja, ali se ne može precizno mapirati kompartmentalizacijske dijelove mozga. Emocije-kognicija, unatoč našem subjektivnom doživljaju, nisu nikada u konfliktu, već u kompleksnom kontinuitetu. Nadalje, Pessoa ističe integraciju različitih supkortikalnih i kortikalnih krugova za doživljaj emocije. Primjer te integracije je ventralni emocionalni sustav (amigdalno-orbitofrontalni dio). Te strukture sudjeluju u prepoznavanju emocionalnog podražaja i proizvode trenutačni automatski emocionalni i autonomni odgovor.

Uz ventralni postoji i dorzalni emocionalni sustav (hipokampalno–posteriorno cingularni dio) zadužen za integriranje svjesnosti. Efikasna integracija informacija ventralnog dijela u dorzalni nužna je za transformaciju opaženih objekata u one koji se doživljavaju emocionalno (31). Takvu istaknutu integraci-

LeDoux (9,15), similarly to other authors, considers the term “limbic system” and its equation with the emotional system obsolete, as well as MacLean’s Triune Brain, which is often mentioned in contemporary literature. Emotional state, awareness of the concept of emotion, and thinking about emotion are three separate phenomena that arise from combinations of different neural circuits and networks. LeDoux states that the emotion of fear should only refer to cognitive representation, and that behavior, neural patterns, physiology, and behavior should be described by completely different terms (confusion in verbal concepts and linguistic categorizations of emotions and other mental phenomena) – “neural circuits for survival” is not the same as a word belonging to the verbal repertoire of “fear”, “anxiety”, and “anger”.

Luiz Pessoa postulates that it is best to contemplate emotions not as separate phenomena, but as “packets” or cognitive-emotional schemes (29). Regardless of the appeal of dichotomies to the human mind, dichotomizing emotions and cognition is an over-simplification. Therefore, Pessoa introduces a continuous framework in emotional-cognitive processing. In such a dynamic framework, “emotion” and “cognition” can be labeled in the context of a particular behavior, but the compartmentalization parts of the brain cannot be mapped precisely. Emotions and cognition, despite our subjective experience, are never in conflict, but in complex continuity. Furthermore, Pessoa emphasizes the integration of different subcortical and cortical circuits needed to experience emotion. An example of this integration is the ventral emotional system (the amygdala-orbitofrontal part). These structures participate in the recognition of an emotional stimulus and produce an immediate automatic emotional and autonomous response.

In addition to the ventral, there is a dorsal emotional system (hippocampal – posterior cingulate part) in charge of integrating consciousness. Effective integration of the ventral

ju nalazimo kod svih navedenih autora osim Pankseppa.

Četvrto, emocije esencijalno nisu nesvjesni, već svjesni fenomen; evolucija se za to pobrinula (5,34). Takvo shvaćanje nije isključivo moderna neuroznanstvena pojava već se nadovezuje na psihoanalitičku tradiciju Jacquesa Lacana koja kaže da se potiskivanje može javiti prekidanjem veze između afekta i njemu pripadajuće misli te je misao ta koja može biti nesvjesna, ali nikada afekt (35,36). To se također slaže s nalazom da su emocije velikim dijelom kognitivizirane; više mislimo i pričamo o emocijama nego ih osjećamo. Taj kognitivni aspekt emocije može biti nesvjestan kao što vidimo u psihoanalitičkim psihoterapijama gdje je dio zadatka terapeuta upravo osvijestiti, tj. povezati emociju s njenim disociranim kognitivnim aspektom. Peto, afekti su primarno vezani uz tijelo te tu najbolje vidimo povezanost tjelesnog i mentalnog koja se ogleda i u somatoformnim i konverzivnim poremećajima. Barrett ističe da su tijelo, periferni i središnji živčani sustav snažno povezani u procesuiranju mentalnog, te da osjećaji i emocije nisu samo reakcija na fizičku bol već je to druga strana iste medalje (npr. separacijska bol ili bol u jakoj žalosti). Sterling i Laughlin smatraju da je „temeljni zadatak mozga [je] da regulira internalni milje (tijela)….anticipirajući potrebe i pripremajući se da ih zadovolji i prije nego što niknu“ (37).

Možemo zaključiti da nemamo samo jedan strah, bijes ili žalost već mnoštvo dijelom različitih emocija ovisno o kontekstu doživljaja. Emocije su konstrukcija svijeta, ne direktna reakcija na svijet, te nisu izazvane samo eksteroceptivnim putevima koji zahtijevaju amigdale (38). Emocije bi trebale biti modelirane kao fenomen mozga i tijela u interakciji s kontekstom. Um nije samo funkcija mozga-tijela, već fizičkog okruženja i socio-kulturnog realiteta.

Ovdje bismo istakli da je emocije najbolje gledati u homeostatskim osjećajima i akcijskim

portion of information into the dorsal is necessary for the transformation of observed objects into those experienced emotionally (31). Such prominent integration is found in all of the above authors except Panksepp.

Fourth, emotions are not essentially unconscious, but rather conscious phenomena; evolution took care of that (5,34). This notion is not just a modern neuroscientific phenomenon but rather continues the psychoanalytic tradition of Jacques Lacan, who stated that repression may occur by interrupting the connection between affect and its corresponding thought. A thought can be unconscious while affect cannot (35,36). This also agrees with the finding that emotions are largely cognitivized; we think and talk about emotions rather than feel them. This cognitive aspect of emotion may be unconscious as we see in psychoanalytic psychotherapies, where part of the therapist's task is precisely to make conscious and link the emotion with its suppressed cognitive aspect, or what Lacan calls "the signifier". Finally, affects are primarily related to the body and it is here that we can best observe the connection between the physical and the mental, reflected in somatoform and conversion disorders. Barrett points out that the body, both the central and peripheral nervous system, is strongly linked to mental processing, and that emotions and feelings are not just a reaction to physical pain but "the other side of the coin", including separation pain or pain during intense sadness, for instance. Sterling and Laughlin believe that "the basic task of the brain is to regulate the internal mile (of the body)… by anticipating needs and preparing to satisfy them even before they arise" (37).

We can say that we do not have only one fear, anger, or sadness but a multitude of partly different emotions depending on the context of the experience. Emotions are a construction of the world, not a direct reaction to the world, and they are not triggered only by the exteroceptive pathways that require the amygdala

programima koji čine nagone/motivacije i emocije te razumjeti da su to sve diferencirani fenomeni. Recimo nagoni/motivacije mogu pokretati ponašanje bez ikakve emocije, krugovi za preživljavanje („*survival circuits*") (9,15) mogu aktivirati bihevioralnu (re)akciju u opasnosti, a drugi sustavi mozga-uma stvaraju eventualni osjećaj straha ili bijesa.

Napredak u afektivnoj neuroznanosti u zadnjem desetljeću značajan je te je s drugim granama neuroznanosti, kao što je kognitivna znanost, glavni okvir za stvaranje bolje psihološke teorije uma koja bi obuhvatila i psihoanalitičku psihoterapiju. Nova paradigma uma stvorila bi jasniju sliku i točnija tumačenja kako općih psiholoških fenomena, osjećaja, emocija, kognicije, pamćenja i percepcije, tako i bolje objašnjenje psihoterapijskih procesa i njihove učinkovitosti u liječenju, od psiholoških problema do psiholoških poremećaja (39). Tako bi psihoanalitičku psihoterapiju mogli definirati kao specifičnu, interpersonalnu (socijalnu), verbalnu i neverbalnu, svjesnu i nesvjesnu, afektivnu i kognitivnu komunikacijsku igru kojom postižemo emocionalnu ravnotežu i kognitivni sklad (40).

Što su emocije? Emocije su biološki akcijski programi, utemeljeni na interakciji tijela i mozga pod stalnim utjecajem kognitivne obrade pomoću koncepata i kategorizacija, snažno vezane za memorijske sustave mozga-uma (41), do neke mjere «plastične» tako da su pod utjecajem i procesa učenja i iskustva, te se odvijaju u određenoj socio-kulturi sa svim svojim pozitivnim i negativnim kondicioniranjima.

(38). Emotions should be modeled as a brain-and-body phenomenon interacting with the context. The mind is not only a function of the brain-body, but of the physical environment and socio-cultural reality.

We would like to emphasize that emotions are best viewed through homeostatic feelings and action programs that create drives/motivations and emotions, and that we should understand that these are all differentiated phenomena. For example, action programs can trigger behavior without any emotion, so we can have survival circuits (9,15) as a behavioral (re)action in danger while other brain-mind systems create a possible sense of fear or anger.

Advancements in affective neuroscience in the last decade have been significant and together with other branches of neuroscience such as cognitive science build the main framework for creating a better psychological theory of the mind that would also include psychoanalytic psychotherapy. This new paradigm of the mind would create a clearer picture and more accurate interpretations of general psychological phenomena, feelings, emotions, cognition, memory, and perception, as well as a better explanation of psychotherapeutic processes and their effectiveness in treatment, from psychological problems to psychological disorders (39). Thus, psychoanalytic psychotherapy could be defined as a "specific, interpersonal (social), verbal and nonverbal, conscious and unconscious, affective and cognitive communication play that achieves emotional equilibrium and cognitive harmony" (40).

What are emotions? Emotions are biological action programs based in the interaction between the mind and the body, constantly influenced by cognitive processing through concepts and categorizations, strongly linked to brain-mind memory systems (41), to some extent "plastic" so that they are also influenced by learning and experience processes and take place in a particular socio-culture with all its positive and negative conditioning.

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Depresija u svjetlu nekih psihoanalitičkih teorija

/ *Depression in the Light of Some Psychoanalytic Theories*

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Cilj je ovoga selektivnog preglednog članka sažeti neke od najpoznatijih psihoanalitičkih teorija o depresiji. Od Freudovog *Tugovanja i melankolije* 1917. psihoanaliza je ostvarila značajne iskorake u tumačenju depresije. Depresija je tumačena kao očajnički krik za ljubavlju, autoagresija, konflikt ega, fiksacija na iskustva bespomoćnosti, ekspresija neurotične strukture ličnosti i patološki ishod depresivne pozicije. Depresija je često povezana s agresijom, anksioznošću, krivnjom i narcizmom. U klasičnom psihoanalitičkom pristupu depresiji oralnost igra značajnu ulogu. S razvojem psihoanalitičkih teorija pojavili su se neki važni pojmovi: kognitivna trijada kao važna varijabla u depresiji koja uključuje negativnu percepciju sebe, svijeta i budućnosti, „sociotropne" (društveno ovisne) i „autonomne" vrste depresije, dominantni drugi i uloga terapeuta koji može postati dominantni ili značajni treći. Psihoanalitičke teorije s kraja 20. stoljeća dijele depresiju na anaklitnu i introjektivnu. U 21. stoljeću autori su opisali neurohormonsku, neurokemijsku i neuroimunološku pozadinu depresije potvrđujući na određen način neke od klasičnih psihoanalitičkih teorija.

/ *The aim of this selective review article is to summarize some of the best-known psychoanalytic theories regarding depression. Since Freud's Mourning and Melancholia in 1917, psychoanalysis has made considerable steps forward in the interpretation of depression. Depression was seen as a despairing cry for love, aggression towards the self, a conflict of the ego, a fixation on experiences of helplessness and powerlessness, an expression of the neurotic personality structure, and depressive position. Depression is often linked with aggression, anxiety, guilt, and narcissism. In the classic psychoanalytic view of depression, orality plays a significant role. As psychoanalytic theories evolved, some important concepts emerged: the cognitive triad, which includes negative perceptions of the self, world, and future as an important variable in depression, "sociotropic" (socially dependent) and "autonomous" types of depression, the dominant other, and the role of the therapist who can become the dominant or significant third. Psychoanalytic theories from the end of 20th century divide depression into anaclitic and introjective based on psychopathology. Authors in the 21th century showed the neurohormonal, neurochemical, and neuroimmunological background of depression, in a way confirming some of the classic psychoanalytic theories.*

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UVOD

Depresija, kao patološka varijacija tuge, prožima i uključuje cijelu osobu, od njezine srži do najviših i duhovnih manifestacija (1). Procjene životne prevalencije uvelike variraju, od 3 % u Japanu do 16,9 % u SAD-u, a većinom u rasponu od 8 % do 12 %. Žene imaju višu stopu velikih depresivnih epizoda od muškaraca s omjerom koeficijenata od 1,2 u Češkoj do 2,5 u Japanu (2).

Depresija, prema Bleichmar, može biti: a) Samostalan entitet koji dominira cjelokupnim mentalnim životom: osjećaj bespomoćnosti/nemoći prožima reprezentaciju i funkcioniranje ličnosti pri čemu želja doživljena kao neispunjiva ima važnu ulogu u libidinalnoj ekonomiji subjekta. Takva depresija uključuje depresivno stanje, restorativne pokušaje, komplikacije depresije i sekundarnu dobit. Valja naglasiti da se etiologija depresije ne može svesti samo na neispunjenu želju jer bi ispunjenje želje dovelo do nestanka depresije, što kliničko iskustvo ne potvrđuje. Depresija kao poremećaj može koegzistirati s drugim poremećajem, ali ima neovisno podrijetlo. b) Aspekt različitih vrsta poremećaja, gdje je depresija simptom koji proizlazi iz pacijentova osjećaja bespomoćnosti / nemoći da prebrodi teret koji proizlazi iz temeljnih elemenata poremećaja. Komponente temeljnog poremećaja u prvom su planu, dok depresija oslikava poremećaj kao pozadinsko raspoloženje, mada povremeno može biti istaknuta (3).

Danas postoje dvije glavne etiološke hipoteze, biološka i psihosocijalna. Prva uključuje potencijalne neurotransmisijske mehanizme, hormonsko, imunološko i genetsko objašnjenje razvoja depresije, a druga predlaže psihodinamički, socijalni, bihevioralni i kognitivni utjecaj na etiologiju depresije (4,5). Treća etiološka hipoteza mogla bi biti psihoanalitička perspektiva ili depresija u svjetlu nekih psihoanalitičkih teorija.

INTRODUCTION

Depression, as a pathological variety of sadness, penetrates and involves the whole person, from their core to their highest and spiritual manifestations (1). Lifetime prevalence estimates vary widely, from 3% in Japan to 16.9% in the US, with the majority in the range of 8% to 12%. Women have higher rates of major depressive episodes than men with an odds ratio ranging from 1.2 in the Czech Republic to 2.5 in Japan (2).

Depression, according to Bleichmar, may be: a) An entity in itself which dominates the whole mental life: the feeling of helplessness/powerlessness permeates the representation and functioning of the self, where the wish that is felt as unfulfillable has an important role in the libidinal economy of the subject. This depressive condition includes the depressive state, restorative attempts, complications of the depression, and secondary benefits. Depression as a disorder can coexist with another disorder but have an independent origin. The etiology of depression cannot be reduced to unfulfilled desire alone, because fulfillment would lead to the disappearance of depression, which clinical experience does not confirm. b) A component of different kinds of disorders, where depression is a symptom resulting from the patient's sense of helplessness/powerlessness to overcome the burdens occasioned by the disorder's principal elements. The components of the main disorder are in the foreground, while depression colors the disorder as a background mood, although it can occasionally take prominence (3).

There are currently two main etiological hypotheses for depression: biological and psychosocial. The former includes potential neurotransmission mechanisms and hormonal, immunological, and genetical explanations for development of depression, whereas the latter proposes a psychodynamic, social, behavioral, and cognitive influence on the etiology of depression (4,5). A psychoanalytic point of view or depression in

Arieti je dao kratki pregled područja interpretacije depresije: od klasičnih pionirskih djela psihoanalize (6, 7) u tumačenju depresije značajni su iskoraci. Na primjer, Radova (8,9) koncepcija melankolije kao očajničkog krika za ljubavlju, kao pokušaj ega da se kazni kako bi se spriječila roditeljska kazna, izricanjem krivnje, iskupljenja i oproštenja; Melanie Klein (10, 11) interpretirala je depresiju kao patološki ishod depresivne pozicije; Bibringov koncept depresije kao konflikta ega, stanja bespomoćnosti povezanog s gubitkom samopoštovanja (12) važni su doprinosi bilo freudovske, bilo kleinijske škole. Značajan je doprinos u kulturnoj školi Bonimeov (13,14), koji depresiju doživljava kao praksu. Prema Bonimeu: "Depresivan je pojedinac krajnje manipulativna osoba koja bespomoćnošću, tugom, zavodljivošću i drugim sredstvima usmjerava ljude prema ispunjenju zahtjeva za različitim oblicima emocionalno utješne reakcije." (1,14).

Psihoanalitičke teorije depresije počele su Freudovim *Žalovanjem i melankolijom* (7), a prema nekim su autorima još uvijek široko prihvaćene (15). Prema Freudu, patološka depresija ima nepatološki analog: tugu i žalovanje za voljenom osobom ili objektom koje je čovjek izgubio smrću ili odvojenošću. Freud je depresiju opisao kao reakciju na gubitak stvarnog ili imaginarnog objekta. U nekim slučajevima gubitak može biti stvaran, primjerice, neki pacijenti postanu patološki depresivni nakon gubitka supružnika ili voljene osobe, pogotovo ako su imali ambivalentne emocije prema toj osobi.

Češće je pacijent iz bilo kojeg razloga ljut na voljenu osobu i želi da voljena osoba bude mrtva, u nesvjesnoj fantaziji ubije tu osobu i oplakuje gubitak, makar zamišljen. Analogijom depresije i žalovanja Freud je ponudio objašnjenje zašto je epizoda depresije često ograničena u trajanju. Kad netko tuguje, to obično traje ograničeno vrijeme - nekoliko mjeseci ili godinu dana. Zatim završava s tugovanjem i vraća se, barem u mnogim slučajevima, u stanje prije gubitka,

the light of some psychoanalytical theories could be considered the third etiological hypothesis.

Arieti gave a short overview in the field of interpreting depression: since the classic pioneer works of psychoanalysis (6,7) considerable advancements have been made in the interpretation of depression. For example, Rado's (8,9) conception of melancholia as a despairing cry for love, as an attempt of the ego to punish itself in order to prevent the parental punishment, by enacting guilt, atonement, and forgiveness; Melanie Klein's (10,11) interpretation of depression as a pathological outcome of the depressive position; Bibring's (12) concept of depression as a conflict of the ego, a state of helplessness connected to the loss of self-esteem, are important contributions from either the Freudian or the Kleinian schools. A remarkable contribution in the cultural school is Bonime's (13,14), who sees depression as a practice. According to Bonime: "The depressive is an extremely manipulative individual who, by helplessness, sadness, seductiveness, and other means, maneuvers people toward the fulfillment of demands for various forms of emotionally comforting response." (1,14).

Psychoanalytic theories regarding depression began with Freud's *Mourning and Melancholia* (7) and are, according to some authors, still widely accepted (15). Freud advanced the idea that pathological depression has a nonpathological analogue: grief and mourning for a loved person or thing that one has lost by death or separation. Freud characterized depression as the reaction to the loss of a real or an imaginary object. In some cases the loss can be a real one, as when some patients become pathologically depressed after the loss of a spouse or loved one, especially when having ambivalent feelings for them. More often a patient is angry at a loved one for whatever reason and wishes the loved one dead, kills that person in some unconscious fantasy, and mourns the loss, imaginary though it is. By analogizing depression to mourning Freud of-

pred žalovanje, baš kao što se depresivni pacijent vraća u premorbidno stanje nakon razdoblja depresije. Glavna svrha analogije između tugovanja i depresije bila je, međutim, tvrdnja da je depresija posljedica gubitka voljene osobe, da je rezultat gubitka objekta. Gubitak možda nije stvaran, može biti zamišljen. Pacijent možda nije ni svjestan bilo kakvog osjećaja gubitka, pa percepcija gubitka može biti prilično nesvjesna (15). U razradi Freudove teorije depresije važno je naglasiti i ulogu identifikacije. Umjesto žalovanja, odnosno prihvaćanja gubitka objekta, objekt se sačuva tako da postane dio nesvjesne reprezentacije selfa. Internalizacijom reprezentacije izgubljenog objekta u reprezentaciju selfa (u Freudovo vrijeme – ega), u stvari se izbjegava žalovanje, odnosno, prihvaćanje činjenice gubitka objekta. Nakon toga se tako internalizirani objekt napada agresijom, što dovodi do depresije.

U *Inhibiciji, simptomu i anksioznosti*, Freud ističe "nezadovoljavajuću kateksu čežnje" kao afektivno stanje s ideativnom i afektivnom komponentom (16). U prvom je želja za objektom predstavljena kao neizvediva. U drugom osjećaj boli nastaje kao rezultat reprezentacije želje kao neostvarive. Ovakav depresivni afekt ima specifičnu kvalitetu, različitu od anksioznosti kao anticipacije opasnosti (3,17,18).

Prema nekim autorima, bespomoćnost igra središnju ulogu u konstituciji depresivnog fenomena (12,19,20). Ti autori smatraju da je definirajuća karakteristika depresije reprezentacija nesposobnosti za postizanje ciljeva, tj. predispozicija za depresiju određena je fiksacijom na iskustva bespomoćnosti i nemoći, iskustva koja ostavljaju tragove na psihi (3).

AGRESIJA

Psihoanalitička istraživanja depresije vrlo često povezuju agresiju s depresijom (6,7, 10, 21-23). Bez obzira na to je li agresija glavni

fered an explanation of why an episode of depression is often limited in duration. When one mourns, this usually lasts for a limited period of time – several months or a year. Then one is through with mourning and returns, at least in many cases, to one's pre-loss, pre-mourning state, just as a depressed patient returns to his premorbid state after a period of depression. The main point of the analogy between mourning and depression, however, was the assertion that depression is a consequence of losing a beloved person, that it results from object loss. The loss may not be a real one; it could be only a loss in fantasy. The patient may not even be aware of any feeling of loss, so the perception of a loss may be quite unconscious (15). In elaborating Freud's theory of depression, it is also important to emphasize the role of identification. Instead of mourning or accepting the loss of an object, the object is preserved so that it becomes part of the unconscious representation of the self. By internalizing the representation of the lost object into the representation of the self (in Freud's time – the ego), one actually avoids mourning, that is, accepting the fact of losing the object. Subsequently, the aggression attacks the internalized object, which leads to depression.

In *Inhibitions, Symptoms and Anxiety* (16) Freud points out the "unsatisfiable cathexis of longing" as an affective state with a ideative and affective component. In the former the desire for the object is represented as unfulfillable. In the latter the feeling of pain arises as a result of representing the desire as unfulfillable. This depressive affect has a specific quality, different from anxiety as an anticipation of danger (3,17,18).

According to some authors, helplessness and powerlessness play the central role in the constitution of the depressive phenomenon (12,19,20). They suggested that the defining characteristic of depression is the subject's own representation of his incapacity to attain goals, i.e. predisposition to depression is determined by a fixation to experiences of helplessness and powerlessness, experiences that leave imprints on the psyche (3).

uzrok depresije klinička iskustva ukazuju da je to jedan od važnih puteva koji vode do nje (3). Postoje različiti oblici agresije koji vode do osjećaja bespomoćnosti i nemoći, npr. do nemoći ispunjenja želja i ugrožavanja selfa. Agresija može biti *acting out* protiv unutarnjeg objekta, vanjskog objekta ili protiv sebe. *Acting out* je potrebno definirati i razgraničiti od agresije. *Acting out* može izražavati i agresiju, ali taj način izražavanja nije sinonim za agresiju. Na primjer putem *acting outa* mogu se manifestirati i libidne želje, svjesne i nesvjesne. U slučaju da je agresija reakcija na unutarnji objekt, subjekt može doživjeti promjenu značenja objekta, na primjer, osjećajem krivnje vezano uz uništenje objekta (21). Agresija samo u ekstremnim slučajevima dovodi do uništenja objekta, a gubitak vrijednosti objekta ne označava njegovo uništenje nego promjenu njegovog značenja za osobu. Kada subjekt ovisi o objektu za održavanje uravnoteženog samopoštovanja objekta, to ima utjecaj na narcizam subjekta. Uništavanje osobi do tada važnih objekata koji su bili nosioci ideala rezultira činjenicom da se ništa ne čini vrijednim subjektovog poštovanja, što vodi u svijet lišen vrijednih ili stimulirajućih objekata. Međutim, moguće je uništenje nekog objekta, a da ostali objekti ostanu sačuvani, tj. uništeni objekt ne mora nužno biti reprezentant subjektivnih ideala. No, uništenje unutarnjih objekata, ako je masivno, dovodi do osiromašenja unutarnjeg svijeta. Prema self–psihologiji (Kohut i ostali autori) self–objekti univerzalno utječu na održavanje samopoštovanja, odnosno ni psihički zdrave osobe nikad ne postižu apsolutnu neovisnost o socijalnoj okolini i potpunu autonomiju regulacije samopoštovanja, koja bi bila u potpunosti neovisna o okolini. Međutim, važno je u kojoj mjeri osoba koristi ili mora koristiti socijalnu okolinu za održavanje uravnoteženog samopoštovanja. Kada je agresija usmjerena prema vanjskom objektu, ona djeluje u vanjskom svijetu subjekta u smislu uništava-

AGGRESSION

Psychoanalytic studies of depression very often link aggression with depression (6,7,10,21-23). Whether or not aggression is the main cause of depression, clinical experience suggests that it is one of the important pathways leading to it (3). There are different forms of aggression leading to feelings of helplessness and powerlessness, i.e. to the impotence of wish fulfillment. Libido desires, conscious and unconscious, can also manifest through acting out. In case the aggression is acted out against the internal object, the subject feels as though he destroyed, ruined, or annihilated the object, consequently changing the value of the object (21). When the subject depends on the object to maintain a balanced self-esteem, the subject's narcissism is affected. According to self-psychology (Kohut and other authors), self-objects universally influence the maintenance of self-esteem. In other words, even mentally healthy persons never achieve absolute independence from the social environment and complete autonomy of self-esteem regulation which would be completely independent of the environment. However, it is important to what extent a person uses or has to use the social environment to maintain balanced self-esteem.

The "destruction of the object" results in the fact that nothing appears to be worthy of the subject's esteem, which leads to a world devoid of valued or stimulating objects. However, it is possible for an object to be destroyed with other objects being preserved, i.e. the destroyed object may not necessarily be representative of subjective ideals. But the destruction of internal objects, if massive, leads to the depletion of the inner world. When aggression is directed to the external object it acts out in the subject's external world in the sense of destroying friendships and family relations, opportunities, and so on. In these cases, the depression results from a failure in the creation of conditions that allow the realization of wishes that are central to the

nja prijateljstava i obiteljskih odnosa, prilika i tako dalje. U tim slučajevima depresija može biti posljedica neuspjeha u stvaranju uvjeta koji omogućuju ostvarenje želja koje su središnje za subjekt (3). Napominjemo pritom da su mnoge depresije posljedica povrede selfa, pada samopoštovanja, a ne samo izostanka zadovoljenja želje. Ako je self očuvan, samopoštovanje suštinski ne ovisi o zadovoljenju želje. Kliničko iskustvo pokazuje da zadovoljenje želje samo po sebi može izazvati samo ograničeno i kratkotrajno stabiliziranje samopoštovanja. Agresija u nekim svojim manifestacijama može postati destrukcija, međutim, u svojim zrelijim manifestacijama agresija je važna sastavnica bliskih odnosa, a sublimacija agresije je važna za postizanje razgraničavanja selfa i objekta, za separaciju, izražavanje autonomije, rast i razvoj osobnosti. Autoagresija pogoršava reprezentaciju selfa, ali i funkcioniranje ega. Subjekt troši svoju energiju u unutarnjem sukobu, okupiran mržnjom samog sebe napada i inhibira funkcioniranje svog ega, ispada da nije u stanju krenuti prema ispunjenju svojih želja. Neispunjenje želje nije jedino što se povezuje s depresijom, već je osjećaj bespomoćnosti i nemoći povezan s cjelokupnim funkcioniranjem osobe, ozljedama samopoštovanja i nekoherentnim selfom. Ako u nekom trenutku subjekt dovede u svijest napad na sebe, self ili neku reprezentaciju selfa, ali i somatski ili disocirani dio selfa može razviti osjećaj krivnje (3). Krivnja se javlja i kad se radi o nesvjesnim procesima. Iracionalna, patološka krivnja je više povezana s nesvjesnim nego svjesnim procesima.

KRIVNJA

Budući da je odnos između agresije i krivnje složen, u Freudovim djelima postoji nekoliko ideja o podrijetlu krivnje. Za krivnju je presudna kvaliteta superega koji određene želje prihvaća, tolerira, dozvoljava ili ne. Patološki

subject (3). Note that many cases of depression are the result of self-harm or a decline in self-esteem, not just a lack of gratification. If the self is preserved, self-esteem is essentially independent of gratification. Clinical experience says that satisfying desire in itself can only cause a limited and short-term stabilization of self-esteem. Aggression directed against the self plays a very important role in depression. Self-aggression damages the representation and the functioning of the self. The subject consumes their energies in an internal war, occupied with hating themselves, attacks and inhibits the functions of their ego, and turns out to be incapable of moving towards fulfillment of their wishes. Not fulfilling a desire is not the only thing associated with depression, but a feeling of helplessness and powerlessness is associated with the overall functioning of a person, self-esteem injury, and incoherent self. If, in some point, the subject brings to consciousness the attack on themselves, they may develop a sense of guilt (3). Guilt also occurs when it comes to unconscious processes. Irrational, pathological guilt is more related to unconscious than conscious processes.

GUILT

Because the relationship between aggression and guilt is complex, there are several conceptions of the origin of guilt within Freud's work. Guilt is determined by quality of the superego which accepts, tolerates, or does not tolerate certain wishes. The pathological superego is austere, intolerant, and unrealistic in the demands it places on a person. A person's conscious attitude (ego function) to these desires is also important. Freud said that "superego knows more about the unconscious id than the ego", therefore, guilt is the natural, logical consequence of the quality of the desire (3,24). Guilt due to the codification of the wishes presents differently in every individual because it is formed through the ideal every person sets for themselves and

superego je strog, netolerantan, nerealan u zahtjevima koje postavlja na osobu. Također je važan svjesni stav osobe (funkcija ega) prema tim željama. Freud je rekao da "superego zna više o nesvjesnom idu nego o egu", stoga je krivnja prirodna, logična posljedica kvalitete želje (3,24). Krivnja zbog kodifikacije želja različito se manifestira kod svakog pojedinca, jer se formirala idealom koji svaki čovjek postavlja za sebe po kojem mjeri svoj ego. Stoga neki pojedinci mogu osjetiti krivnju jer superego kodificira njihove želje kao agresivne ili štetne (3,25). Nesvjesne seksualne i agresivne želje su prisutne u nesvjesnom svih osoba, na čemu se i temelji osnovna psihodinamska hipoteza o edipskom kompleksu kao dinamičnoj jezgri svih neuroza.

Osjećaj krivnje također može biti proizvod identifikacije ega i ida s objektom koji se i sam osjeća krivim, što se naziva i "posuđenom" krivnjom. To je poremećaj u samoreprezentaciji, a subjekt zaključuje da je u svakoj situaciji loš (3,24). Krivnja može biti posljedica introjekcije agresije. U tom je slučaju ego identificiran s vanjskim objektom prema kojem je agresija usmjerena. Za krivnju je važno 'kodificiranje' agresije kao štetne, odnosno stav prema agresiji, a ne sama agresija, prema kojoj osoba može imati i tolerantan stav, a njen superego ju prihvaćati kao prihvatljivu u određenim okolnostima. Patološkim mehanizmom projektivne identifikacije odbačene osobine selfa induciraju se u bliskim osobama.

NARCIZAM

Prema Milrodu, značajan pad razine libidinalnog ulaganja u reprezentaciju selfa obično prati depresiju podvlačeći njezinu narcističnu osnovu (26). Taj gubitak libidinalne kateksije stvara nisko samopoštovanje i zamjenjuje ga neprijateljska kateksa. Isključen je protok libidnih zaliha za ulaganje u samoprezentaciju uključujući ljubavni objekt, ego i superego.

by which they measures their ego. Thus, some individuals can feel guilt because their superego codifies their wishes as aggressive or harmful (3,25). Unconscious sexual and aggressive desires are present in the unconscious of every person, which underlies the basic psychodynamic hypothesis of the Oedipus complex as the dynamic nucleus of all neuroses. Sense of guilt can also be a product of the identification in the ego and the id with an object which itself feels guilty, also called "borrowed" guilt. It is often present in those individuals who identify with guilt-ridden parents. This is a disorder in the self-representation from which the subject concludes through projective identification that they is bad in every occasion (3,24). Guilt can be the result of the introjection of aggression. In that case there is an identification in the ego with the external object towards which the aggression is directed. "Codification" of aggression as harmful is important, and is an attitude towards aggression, not aggression itself, according to which a person may have a tolerant attitude, and their superego accepts it in certain circumstances. The pathological mechanism of projective identification causes the rejected traits of the self to be induced in people close to the subject.

NARCISSISM

Significant reduction in the level of libidinal investment in self-representation, according to Milrod, usually accompanies depression, underscoring its narcissistic basis (26). This loss of libidinal cathexis produces low self-esteem and is replaced by a hostile cathexis. The flow of libidinal supplies for investment in self-representation, including the love object, ego, and superego are shut down. These three sources of libidinal supplies are related to the different structural configurations a depression may take. The simplest structural form of a depression is one in which the narcissistic injury is caused by the self-representation which is far away from the individual's wished-for self-image (27), i.e. a

Ova tri izvora libidinalnih izvora povezana su s različitim strukturnim konfiguracijama koje depresija može imati. Najjednostavniji strukturni oblik depresije je onaj u kojem je ozljeda narcizma uzrokovana samoreprezentacijom koja je daleko od idealne slike o sebi (27), tj. širi se jaz između pojedinčevog doživljaja sebe i slike onoga što on želi biti. Kad se to dogodi, pojedinac će se osuditi zbog toga što ne može ispuniti svoje ambicije. Primjeri su depresije potaknute karijernim ili financijskim razočaranjima, kao i velika skupina depresija povezanih s procesom starenja. Narcistične zalihe ega su prekinute, a libidinalna kateksa samo-reprezentacije zamijenjena je neprijateljskom kateksom potaknutom slabljenjem funkcije selfa nakon što samo-reprezentacija padne na kritičnu razinu ispod željene slike sebe. To uključuje proces unutar sustava bez sudjelovanja superega, samoodricanje nema moralno značenje i može se prevesti kao osjećaj "Ja sam neuspjeh" (26), što upućuje na slabljenje funkcije selfa.

Druga vrsta depresije, različito strukturirana, javlja se kada je ozljeda narcizma uzrokovana samo-reprezentacijom daleko od moralnih i etičkih vrijednosti ugrađenih u ego ideal, tj. pojedinac se osuđuje za neki moralni ili etički neuspjeh (26). Kad god osoba ne uspijeva ispuniti očekivanja svoga ega, libidinalne zalihe samoreprezentacije od superega bivaju zamijenjene neprijateljskom kateksijom, što rezultira depresijom kao stanjem raspoloženja (28). Ovaj unutarsustavni proces uključuje superego koji sudjeluje kažnjavanjem, proizvodeći neprijateljsku kateksu samo-reprezentacije. Samoobjava nosi konačno moralno značenje i može se prevesti kao: "Ja sam loš!" ili "Zaslužujem kaznu" (26).

Treći oblik depresije javlja se kada je ambivalentni ljubavni objekt i dalje osnovni izvor libidinalnih pomagala za samoreprezentaciju (26). Gubitak objekta ili ljubavi od objekta proizvodi narcistični udarac koji je odgovoran

wide gap develops between the individual's view of themselves and the image of what they desires to be. When that happens, the individual will condemn themselves for not being able to fulfill their ambitions. Depressions triggered by career or financial disappointments as well as the large group of depressions related to the aging process serve as examples of this structure. Narcissistic supplies from the ego are cut off and the libidinal cathexis of the self-representation is replaced by a hostile cathexis induced by the self-critical function of the ego once the self-representation falls to a critical level below that of the wished-for self-image. This involves a system process without superego participation; the self-condemnation carries no moral flavor and can be translated as the feeling "I am a failure" (26), suggesting a weakening of the function of the self.

A second type of depression, differently structured, occurs when the narcissistic injury is caused by the self-representation being distant from the moral and ethical values built into the ego ideal, i.e. the individual condemns themselves for some moral or ethical failure (26). Whenever a person fails to live up to their ego, ideal libidinal supplies to the self-representation from the superego are cut off and replaced by a hostile cathexis, resulting in depression as a mood state (28). This intersystemic process involves the superego which participates via punishment, producing a hostile cathexis of the self-representation. The self-condemnation carries a definite moral flavor and can thus be translated to: "I am bad!" or "I deserve punishment" (26).

A third form of depression occurs when an ambivalent love object continues to be the essential source of libidinal supplies for the self-representation (26). Loss of the object or of the object's love produces the narcissistic blow responsible for the loss of libidinal investment in the self-representation and its replacement by a hostile cathexis, all experienced as a loss of self-esteem. Because the object plays such a vital role in the psychic economy of the person, diminution of the object is intolerable.

za gubitak libidinalnog ulaganja u samoreprezentaciju i njezinu zamjenu neprijateljskom kateksom, a sve to doživljava se kao gubitak samopoštovanja. Budući da objekt igra tako vitalnu ulogu u psihičkoj ekonomiji ovih ljudi, umanjenje objekta je nedopustivo. Kada se to dogodi, stvara obrambeni pomak libida od samo-reprezentacije do reprezentacije objekta što rezultira prenaglašavanjem propusta subjekta kako bi se vratile vrline ambivalentnog objekta. Ali ako proces ide predaleko ili traje predugo, narcistični libido (libido uložen u samo-reprezentaciju) može postati iscrpljen i osoba možda neće biti u mogućnosti vratiti reprezentaciju objekta na bivšu uzvišenu razinu, što će dovesti do neprijateljske devalvacije i objekta i samoreprezentacije, što rezultira osjećajem bezvrijednosti. Na ovom se stupnju razvija depresija. Subjekt osjeća da ga je vanjski svijet iznevjerio, stoga se povlači iz njega apsolutnom dekateksijom reprezentacije objekta (26).

Koncept „narcističnog posjedovanja" (25) uključuje sve objekte (ljude ili objekte) čija vrijednost ili nedostojnost izravno utječe na samo-reprezentaciju. Narcistično posjedovanje može doći u obliku kuće, automobila, supružnika, prijatelja, statusa ili bogatstva, skupine kojoj pojedinac pripada (politička stranka, vjerska organizacija). 'Objekt narcistične aktivnosti' je onaj koji subjektu omogućuje obavljanje aktivnosti koja mu daje narcističnu vrijednost. Gitara za glazbenika, student za profesora, tj. bilo koji posao, hobi ili profesija koja dopušta funkciju narcistične vrijednosti može biti objekt narcistične aktivnosti (3). Narcizam je važna sila u ljudskoj motivaciji i zato posjeduje određene objekte. Nepostojanje „objekta narcistične aktivnosti" može objasniti neravnotežu koju su određeni ljudi doživjeli tijekom vikenda ili odmora. Neki pojedinci napadaju svoje „objekte narcistične aktivnosti", na primjer, ocrnjuju svoj posao ili svoju profesiju navodeći njegove nedostatke

When this happens, it produces a defensive shift of libido from the self-representation to the object-representation which results is an exaggeration of the subject's flaws in order to reinstate the virtues of the ambivalent object. But if the process goes too far or lasts too long, the narcissistic libido (libido invested in the self-representation) may become drained and the person may be unable to restore the object representation to its former exalted image, leading to a hostile devaluation of both object and self-representations resulting in a sense of worthlessness. This is the stage at which depression develops. The subject feels that the external world has failed them, and therefore they retreat from it by a total decathexis of the object representation (26).

The concept "narcissistic possessions" (25) includes all objects (people or things) whose worth or unworth directly influences the representation of the self. Narcissistic possessions can come in the form of a house, a car, a spouse, a friend, status or fortune, the group to which an individual belongs (a political party, a religious organization). An "object of narcissistic activity" is one that enables the subject to perform an activity that grants them narcissistic worth. The guitar for the musician, the student for the professor, i.e. any job, hobby, or profession that allows a function of narcissistic worth to be carried out can be an object of narcissistic activity (3). Because narcissism is an important force in human motivation, it possesses specific objects. The absence of "objects of narcissistic activity" may explain the imbalance experienced by certain people during weekends or vacations. Some individuals attack their "objects of narcissistic activity'" for example by badmouthing their job or their profession by citing its lack of importance, or by listing the poor conditions under which it is carried out, causing impotent feelings towards the fulfillment of personal narcissistic wishes which are dependent upon these objects. The profession or activity in question appears unworthy in comparison with others

ili nabrajajući loše radne uvjete, izazivajući osjećaje nemoći prema ispunjenju osobnih narcističnih želja koje ovise o tim objektima. Profesija ili djelatnost o kojoj je riječ čini se nedostojnom u usporedbi s drugima (idealizirani objekti) koji se smatraju nedostižnim. Taj jaz stvara „nezadovoljivu kateksu čežnje“ koju spominje Freud (16). To je često korijen kroničnih depresija opaženih kod pacijenata koji ostaju vezani za posao ili vezu koju smatraju ponižavajućom. Samopoštovanje subjekta i mentalna organizacija trpe kad se napadne ili obezvrijedi „objekt narcistične aktivnosti“ (3). Prema psihologiji selfa, osjećaj frustracije u postizanju narcističnih težnji selfa je srž depresije.

Hartmann je kao otac ego psihologije pomaknuo psihoanalizu izvan intrapsihičkog fokusa na nagone i obrane u opću teoriju ljudskog razvoja. Naglasio je primat ega u razvoju, ne samo u upravljanju konfliktima koji nastaju između ida, ega i superega, već i u prilagođavanju okolini. Pretpostavio je da se tijekom razvoja nagoni ne sukobljavaju i prolaze kroz transformaciju kojom se neutraliziraju njihove seksualne i agresivne kvalitete (29).

Prema Hartmannu, središnja uloga ega u razvoju bila je olakšati ne samo sukob između ida, ega i superega, već i prilagodbu okolini (30). Hartmann navodi da razvoj ega nastaje „kao rezultat tri skupa čimbenika: naslijeđenih karakteristika ega (i njihove interakcije), utjecaja instinktivnih nagona i utjecaja vanjske stvarnosti“. Ego može mobilizirati obranu da se zaštiti od četiri vrste opasnosti, uključujući konflikt između ida, ega i superega, konflikt u međuljudskim odnosima, konflikt u odnosu na društvene norme i poremećaj koji nastaje kao odgovor na traumu. Da bi se pojedinac uspješno prilagodio Hartmann je hipotezirao četiri zadatka ega koji uključuju pomirenje međusistemskih i unutarsistemskih konflikata: održavanje ravnoteže između individualne i vanjske stvarnosti, uspostavlja-

(idealized objects) that are viewed as unattainable. This gap gives rise to the “unsatisfiable cathexis of longing” mentioned by Freud (16). This is often at the root of chronic depressions observed in patients who remain attached to a job or a relationship that they perceive as denigrating. The subject’s self-esteem and mental organization suffer when the “object of narcissistic activity” is attacked or devaluated (3).

According to the psychology of the self, the feeling of frustration in the attainment of narcissistic aspirations of the self is what constitutes the core of depression.

Hartmann, as the father of ego psychology, moved psychoanalysis beyond the intrapsychic focus of drive and defense to a general theory of human development. He emphasized the primacy of the ego in development, not only in managing conflicts that occur between the id, ego, and superego, but also in adapting to the environment. He proposed that during development drives are free from conflict and undergo a transformation through which their sexual and aggressive qualities are neutralized (29).

According to Hartmann, the ego’s central role in development is to facilitate not only conflict among various agencies of the mind that is the id, ego, and superego, but also adaptation to the environment. Hartmann said that ego development comes about “as a result of three sets of factors: inherited ego characteristics (and their interaction), influences of the instinctual drives, and influences of outer reality” (30). The ego can mobilize defenses to protect itself from four types of dangers, including conflict among the id, ego, and superego, conflict in interpersonal relationships, conflict in relation to social norms, and the disruption that occurs in response to trauma. For the individual to successfully adapt, Hartmann hypothesized four ego tasks involving the reconciliation of inter and intrasystemic conflicts: maintaining a balance between individual and external realities; establishing harmony within the id among its

nje sklada unutar ida među konkurentnim instinktivnim nagonima; održavanje ravnoteže između triju mentalnih djelovanja: ida, ega i superega; održavanje ravnoteže između njegove uloge u pomaganju idu i vlastite neovisne uloge koja nadilazi instinktivnu gratifikaciju (31).

Kohut je definirao i opisao koncept selfa, objekta koji se doživljavaju kao dio selfa, objekata koji čovjeku pružaju nešto psihološko što ne može pružiti sama osoba. Čvrsti self proizlazi iz optimalnih interakcija između djeteta i njegovih objekata selfa i sastoji se od tri glavna sastojka: temeljne težnje za moći i uspjehom; temeljnih idealiziranih ciljeva i međupredmetnog područja temeljnih talenata i vještina koje aktivira napetost uspostavljena između ambicija i ideala (32).

Ovisno o kvaliteti interakcije selfa i njegovih objekata u djetinjstvu self nastaje ili kao čvrsta i zdrava struktura ili kao manje ili više ozbiljno oštećena struktura. Odrastao self može postojati u stanju različitih stupnjeva koherentnosti, vitalnosti i funkcionalne harmonije. Značajan neuspjeh u postizanju kohezije, vitalnosti ili sklada ili značajan gubitak tih kvaliteta nakon što su uspostavljeni mogao bi predstavljati stanje poremećaja selfa. Prema Kohutu, self je možda stekao stupanj kohezije, ali zbog interakcije organskih čimbenika i nedostatka radosnih reakcija na njegovo postojanje i asertivnost, self će biti osiromašen samopoštovanjem i vitalnošću što bi moglo rezultirati 'praznom' depresijom. Kad samoodbacivanje i samookrivljavanje postanu slaba točka organizacije selfa, to može rezultirati „krivnjom – depresijom“ (32). U formulaciji “tragičnog čovjeka” Kohut je sažeo razliku između krivnje i narcistične patnje (33).

Lax tvrdi da „u narcističnoj depresiji prevladavaju osjećaji srama i poniženja umjesto krivnje“ (34). Stvarna ili zamišljena prisutnost značajnog drugog kao svjedoka narcističnog

competing instinctual drives; maintaining a balance among the three competing mental agencies: id, ego, and superego; maintaining a balance between the role of the ego in helping the id and its own independent role that goes beyond instinctual gratification (31).

Kohut introduced the term “selfobjects” which provide something psychological for a person that cannot be provided by the person itself. A firm self is the result from the optimal interactions between the child and his selfobjects and is made up of three major constituents: one pole are the basic strivings for power and success; another pole are the basic idealized goals; and an intermediate area of basic talents and skills that are activated by the tension-arc that establishes itself between ambitions and ideals (32). Depending on the quality of the interactions between the self and its selfobjects in childhood, the self emerges either as a firm and healthy structure or as a more or less seriously damaged one. The adult self may exist in states of varying degrees of coherence, vitality, and functional harmony. A significant failure to achieve cohesion, vitality, or harmony, or a significant loss of these qualities after they had been established, could constitute a state of self disorder. According to Kohut, the self may have obtained a degree of cohesion but because of the interaction of inherent organic factors and a serious lack of joyful responses to its existence and assertiveness, it will be massively depleted of self-esteem and vitality which could result in “empty” depression. When self-rejection and self-blame become a serious central weak spot in the organization of the self, this can result in “guilt-depression” (32). In the formulation of the “tragic man”, Kohut (33) summarized the difference between guilt and narcissistic suffering.

Lax maintains that “In a narcissistic depression, feelings of shame and humiliation, rather than guilt, predominate” (34). The presence, real or fantasized, of a significant other who is witness to the subject’s narcissistic failure is essential for the feeling of shame: “shame as a result of conflict

neuspjeha subjekta ključna je za osjećaj srama: „sram kao rezultat konflikta koji utječe na osjećaj selfa i narcistično vrednovanje u prisutnosti značajnog objekta“ (35); „Da bi se sram pojavio, mora postojati odnos između selfa i onoga tko brine o procjeni drugih“ (3,37). Doživljavajući sram pojedinci ga mogu pokušati suzbiti, što može dovesti do tuge i depresije (37,38). Sram, koji karakterizira želja da se oštećeni self sakrije od drugih i da „nestane“, može biti povezan sa socijalnom izolacijom i povlačenjem, rizičnim čimbenicima za depresiju (38-41).

IDENTIFIKACIJA

U *Tugovanju i melankoliji* Freud je pisao o "identifikaciji ega s napuštenim objektom", "sjena objekta pala je na ego", a objektna kateksija zamijenjena je identifikacijom (7). U *Grupnoj psihologiji* navodi da je identifikacija izvorni oblik emocionalne povezanosti s nekim objektom (42). Razlikovao je dvije vrste identifikacije, jednu je nazvao jednostavno identifikacija, dok je drugu nazivao "stavljanjem objekta na ego ideal". Time je prvi put ego identifikacija odvojena od superego identifikacije. Danas se identifikacija definira kao složen proces kojim pojedinac u stvarnosti postaje više kao objekt (26). Kvalitete reprezentacije objekta mogu postati dio reprezentacije selfa na manje ili više stabilan način.

Reprezentacija selfa izmijenjena je na način da identifikacija predstavlja proces koji gradi strukturu. Iako je fokus usmjeren na promjenu reprezentacije selfa, to također uključuje promjene u funkcijama, interesima i aktivnostima ega. Hartmann i Loewenstein naveli su da je identifikacija složena jer se odnosi na proces kao i na rezultat, a komplicira ju činjenica da proces prolazi kroz razvojnu evoluciju (43). Proces identifikacije prolazi u tri glavna koraka (26). U prvom koraku identifikacija i objek-

affecting the sense of self and narcissistic evaluation in the presence of the significant object" (35); "In order for shame to occur, there must be a relationship between the self and the other in which the self-cares about the other's evaluation" (3,37). When experiencing shame, individuals may try to suppress it, which may lead to sadness and depression (37,38). Shame, which is characterized by a desire to hide the damaged self from others and to "disappear", may be associated with social isolation and withdrawal, which are risk factors for depression (38-41).

IDENTIFICATION

In *Mourning and Melancholia* (7) Freud wrote about "identification of the ego with the abandoned object", "the shadow of the object fell upon the ego", and an object cathexis being replaced by identification. In *Group Psychology* (42) he spoke of identification being the original form of emotional tie to an object. He distinguished two kinds of identification, one which he simply called identification, while he referred to the other as "putting the object in the place of the ego ideal". This was the first time ego identification was separated from superego identification. Today identification is defined as a complex process by which the individual becomes more like the object in reality terms (26). Qualities of the object representation can become part of the self-representation in a more or less stable ongoing way. The self-representation is altered through identification as a process that builds structure. Although the focus is on the change in the self-representation, this also involves changes in ego functions, ego interests, and ego activities. Hartmann and Loewenstein (43) said that identification was complex because it referred to the process as well as the result and it is complicated by the fact that the process goes through a developmental evolution. The process of identification goes through three major steps (26). In the first step identification and object relations begin at

tni odnosi počinju istodobno i motivirani su identičnim razvojnim događajem, diferencijacijom od non-selfa prema selfu, od vanjskog prema unutarnjem, od objektnih slika do selfa. U početku je diferencijacija rudimentarna i privremena, ali s vremenom se diferenciraju dva razvojna cilja. Prvi je cilj vratiti izgubljeno nediferencirano stanje (povratak u poznato) i razvojna je linija identifikacija koja se vremenom odvija u sve zrelijim oblicima. Druga ima za cilj prilagodbu novom stanju ega s prikazima selfa i objekata koji se razdvajaju i razlikuju jedan od drugog (27). Sljedeća faza naziva se imitacija u kojoj postoji poželjna fantazija spajanja s objektom koji je idoliziran u vrijeme kada sazrijevanje i razlikovanje ometaju stvarno spajanje, bez promjene strukture reprezentacije selfa. Na primjer, dijete koje se pretvara da je idol poput Batmana ili Spidermana. Završna faza u razvojnoj liniji događa se nakon formiranja željenog samopouzdanja i selektivna je zrela identifikacija utemeljena na realnoj promjeni reprezentacije selfa u skladu s odabranim kvalitetama idoliziranih voljenih objekata (27).

Identifikacije ega obično se bave vrijednostima koje se tiču gratifikacije, snage, brzine, posjedovanja i faličnih kvaliteta. Identifikacije superega obično se bave samo moralnim i etičkim vrijednostima. Može se reći da identifikacije ega vežu agresiju, a identifikacije superega oslobađaju agresiju. Fokus utjecaja ili krajnji proizvod identifikacije može varirati i može uključivati reprezentaciju selfa, željenu sliku selfa ili superego. Osim toga, prema Milrodu, identifikacije mogu biti aktivne ili pasivne, svjesne ili nesvjesne (26).

U melankoliji ili psihotičnoj ciklotimskoj depresiji nastajanje introjekcije dekateksiranog objekta prema Milrodu je univerzalno, ali ne može se smatrati identifikacijom u uobičajenom smislu. Kod neurotičnih depresija, s druge strane, identifikacija s ambivalentnim ljubavnim objektom može se dogoditi ili se ne mora

the same time and are motivated by the identical maturational event, the differentiation from nonself to self from outer to inner, from object images to self. At first the differentiation is rudimentary and temporary, but two developmental lines emerge over time. The first one aims at regaining the lost undifferentiated or merged state (a return to the familiar) and is the developmental line of identification which unfolds in increasingly mature forms with time. The second developmental line has the aim of adapting to the new state of the ego with self and object representations separating and differentiating from one another (27). The next stage is called imitation, in which there is a wishful fantasy of merging with the object that is idolized, at a time when maturation and differentiation hinder actual merging, without altering the structure of the self-representation; for example a child pretending to be an idol such as Batman or Spiderman. The final stage in the developmental line occurs after the formation of the wished-for self-image and it represents a selective mature identification based on realistic change of the self-representation to conform with admired selected qualities of idolized love objects (27).

Ego identifications usually deal with values concerned with gratification, power, speed, possessions, and phallic qualities. Superego identifications usually deal only with moral and ethical values. It could be said that the ego identifications bind aggression and the superego identifications release aggression for the use of the superego. The focus of influence or the end product of identification may vary and may include the self-representation, the wished-for self-image, or the superego. In addition, according to Milrod, identifications may be active or passive, conscious or unconscious (26).

According to Milrod, in melancholia or psychotic depression of a cyclothymic type the formation of an introject of the decathected object is universal, but it cannot be considered an identification in the usual sense. In neurotic depressions, on the other hand, identification

dogoditi, ali ako se dogodi, kateksija reprezentacije objekta stalno se održava (26). Opsesivno-kompulzivna žalujuća osoba također bi mogla razviti depresiju i u procesu se identificirati s omraženim aspektom ambivalentnog izgubljenog objekta u svojoj osudi selfa. No, kateksija tog objektnog predstavljanja obično se neprekidno održava, ne postoji introjekcija ni prekid sa stvarnošću. Međutim, ako opsesivno-kompulzivni simptomi napreduju i dobiju psihotičan karakter, to je svojevrsni prekid sa stvarnošću. S druge strane, kada osoba prkosi moralnim standardima u svom idealu ega ili ne uspije ostvariti vrijednosti svoje idealne slike selfa, uslijedit će neki oblik samo-usmjerenog neprijateljstva od superega ili ega, i to može dovesti do depresije, ali identifikacija s objektom neće imati značajnu ulogu u tom procesu. Iz toga slijedi da se, prema Milrodu, identifikacija može ili ne mora dogoditi u neurotičkim depresijama (26). Kernberg rezimira identifikaciju kao internalizaciju reprezentacije objekta koji je u interakciji s reprezentacijom selfa pod utjecajem intenzivnog afekta. *„Što je afekt intenzivniji, to je značajniji odnos prema objektu; što je značajniji odnos prema objektu, to je intenzivniji utjecaj afekta"*. Prema Kernbergu, ova se teorija identifikacije preklapa s teorijom središnjeg utjecaja depresije u normalnom i patološkom žalovanju: intenzivna predispozicija za reakciju s depresivnim afektom na odvajanje ili gubitak rezultira snažnom identifikacijom s napuštajućim objektom i s napuštenim selfom. Iskustvo odbacivanja ili gubitka pozitivnog vanjskog ili unutarnjeg objekta rezultira većom potencijalom za depresiju (44).

Psihoanalitički teoretičari razlikovali su dvije vrste depresije: depresiju usredotočenu na međuosobna pitanja poput ovisnosti, bespomoćnosti, osjećaja gubitka i napuštenosti, i depresiju proizašlu iz oštrog, kažnjavajućeg superega, usredotočenog na samokritičnost, zabrinutost zbog vlastite vrijednosti i osjećaje neuspjeha i krivnje (45).

with the ambivalent love object may or may not occur, but if it does, cathexis of the object representation is constantly maintained (26). An obsessive-compulsive mourner could also develop a depression and in the process identify with the hated aspect of the ambivalent lost object in his self-condemnation. But the cathexis of that object representation is usually constantly sustained, so there is neither an introject nor a break with reality. However, if the obsessive-compulsive symptoms progress and acquire a psychotic character it is a kind of break with reality. On the other hand, when a person defies the moral standards in their ego ideal or fails to live up to the values in their wished-for self-image, there some form of self-directed hostility form the superego or ego will follow, and this may develop to a mood state producing a depression, but identification with the object will play no significant role in the process. It follows that, according to Milrod, identification may or may not occur in neurotic depressions (26). Kernberg summarizes identification as the internalization of a representation of the object interacting with a representation of the self under the impact of an intense affect. "The more intense the affect, the more significant the object relation; the more significant the object relation, the more intense the affect state". According to Kernberg, this theory of identification overlaps with the theory of the centrality of depressive affect in normal and pathological mourning: the intense predisposition to react with depressive affect to separation or loss results in powerful identification with an abandoning object and with an abandoned self. The profound experience of rejection or loss of a good external or internal object results with greater potential for depression (44).

Psychoanalytic theorists differentiated two types of depression: depression focused on interpersonal issues such as dependency, helplessness, feelings of loss, and abandonment; and depression derived from a harsh, punitive superego, focused on self-criticism, concerns about self-worth, and feelings of failure and guilt (45).

TRAUMATIČNA VANJSKA STVARNOST

Proživljena iskustva nužno su subjektivno obojena. Iako je vanjska stvarnost pojedinaca posredovana unutarnjom, postoje situacije u kojima je vanjska stvarnost obuzimajuća i ima presudnu ulogu u stvaranju osjećaja beznadnosti i nemoći (3). Situacije dugotrajne izloženosti patološkim, sadističkim ili tiranskim ličnostima (46, 47); ozbiljne i onesposobljavajuće bolesti, osobito u ranom životu; napuštanje i roditeljski neuspjesi (48-50), ili se drugi oblici fizičke i psihološke boli mogu ugraditi u psihu (12).

ORALNOST

U svom velikom doprinosu psihologiji depresije Abraham je dao značajan dodatak Freudovim idejama povezujući depresiju s oralnošću (21). Abraham tvrdi da predispozicija za depresiju kasnije u životu ima korijene u psihološkoj traumi i posljedičnoj fiksaciji u oralnoj fazi razvoja, tj. prvih 18 mjeseci života. Prema Abrahamu, može se pretpostaviti da ako pacijent postane depresivan kasnije u životu, jedna od mogućnosti je da ga je majka napustila ili ga zapostavljala u dojenačkoj dobi.

Prema Bibringu (12) i Brenneru (51-54) narcistični udar s bilo koje razine libidinalnog razvoja (oralni, analni, falični ili edipalni) može potaknuti depresiju. Brenner (51, 52) ukazuje da su falični edipalni sukobi značajniji u depresiji. Unatoč tome, empirijski nalazi generacija analitičara svjedoče o važnosti oralnosti u snovima, maštarijama i strukturi ličnosti ovih pacijenata (55). U okvirima self psihologije napori za obnavljanje izgubljenog samopoštovanja u osnovi su oralne naravi, a u okvirima teorije nagona oralno inkorporativne fantazije povezuju se s introjekcijom i melankolijom. Prema nekim autorima za najraniji osjećaj vrijednosti odgovorna je dijada majka-dijete u kojoj je majka nježna i preokupirana svojim novorođenče-

TRAUMATIC EXTERNAL REALITY

Lived experiences acquire their psychological significance on the basis of the fantasy from which they are perceived. Although an individual's external reality is mediated by the internal one, there are situations in which the external reality is overwhelming and plays a crucial role in creating the feeling of hopelessness and impotence (3). Situations of prolonged exposure to pathological, sadistic, or tyrannical personalities (46,47), to serious and disabling illnesses, particularly early in life, to conditions of abandonment, to parental failures (48-50), or to other forms of physical and psychological pain can be incorporated into the psyche as an underlying feeling that nothing can be according to reality (12).

ORALITY

In his major contribution to the psychology of depression, Abraham made a significant addition to Freud's ideas linking depression to orality (21). He said that the predisposition to depression later in life has its roots in the psychological trauma and consequent fixation at the oral phase of development, i.e. the first 18 months of life. It can be assumed, according to Abraham, that if the patient becomes depressed later in life he was abandoned or neglected by the mother in infancy (15).

According to Bibring (12) and Brenner (51-54), a narcissistic blow from any level of libidinal development (oral, anal, phallic, or oedipal) may trigger depression. Brenner (51,52) suggests that phallic oedipal conflicts are more significant in depression. Despite that, the empirical findings of generations of analysts testify to the prominence of orality in these patient's dreams, fantasies, and character structure (55). The restorative efforts due to the lost self-esteem are basically oral in nature and even the oral incorporative fantasies which accompany the setting up of an introject in melancholia are one form of these efforts. A proud and loving

tom (26). Introjekcija dobrog objekta i dobar emocionalni odnos prevencija su depresije. Depresija ne nastaje jer je dijete bilo kronično gladno (hrane). Teško je objasniti samopoštovanje putem nagonske teorije i pritom ne isključiti self psihologiju. Klinički se opaža da neravnoteža između frustracije i gratifikacije može dovesti do pada samopoštovanja. Aktivnosti majke u velikoj mjeri organizira dojenče i vezane su uz iskustvo hranjenja, a registriraju se kao mnemičke slike povezane s prsima. Prema Milrodu depresivni pacijenti izgubili su osjećaj vrijednosti te poduzimaju napore kako bi ga vratili. Depresija je kratkotrajna i teško će postati klinički problem, ako se osjećaj vrijednosti može lako vratiti. Kada napori za obnavljanje nisu uspješni ili su blokirani, dolazi do regresije na ranu oralnu fazu (26). Milrod kaže: "Budući da su depresije stanja raspoloženja, a devalvacija reprezentacije selfa se generalizira, osjećaj potpune bezvrijednosti zahtijeva snažne mjere za obnavljanje samopoštovanja. Zbog toga je regresija duboka i prelazi na rane oralne faze. To također snažno ukazuje da rana trauma i fiksacija imaju ulogu u predispoziciji za depresiju. Iako oralnost ima univerzalnu ulogu u naporima da se obnove samostalno usmjerene libidinalne zalihe, očiglednija je u težim depresijama. Iz tih razmatranja treba biti jasno da oralnost, baveći se naporima na vraćanju samopoštovanja, nema nikakve veze sa strukturom depresija "(26).

Melanie Klein prva je definirala pojam "depresivne pozicije" kao jednog od važnih razvojnih momenata koji se prvi put doživljava krajem prve godine života. Prema Melanie Klein normalan razvoj djeteta i njegova sposobnost za ljubav uvelike počiva na djelovanju ega. To se opetovano revidira i usavršava tijekom ranog djetinjstva i povremeno tijekom života. Središnja pozicija u razvoju ostvarenje je osjećaja mržnje i fantazija o voljenom objektu, prototipično prema majci. Tomu prethodi doživljaj dvaju odvojenih objekata, idealnog i voljenog;

mother who overwhelms her newborn with affection (26) instills the infant's earliest sense of worth in the setting of the mother-child dyad. Introjection of a good object and a good emotional relationship prevent depression. Depression does not occur because the child was chronically hungry (for food). It is difficult to explain self-esteem through the theory of instincts while not excluding self-psychology. It is clinically observed that an imbalance between frustration and gratification can lead to a decline in self-esteem. Mothering activities are largely organized by the infant around the experience of feeding and are registered as mnemic images and affects related to the breast. According to Milrod, depressed patients have lost their sense of worth and undertake efforts to regain it. The depression is short-lived and will rarely become a clinical problem if the sense of worth can be easily regained. When restorative efforts are unsuccessful or blocked, regression to early oral modes takes place (26). Milrod said: "Since depressions are mood states, and the devaluation of the self-representation is generalized, the feeling of being totally without worth or value calls for powerful measures to restore self-esteem. It is for this reason that the regression is deep and carries to early oral and restitutive devices. It also strongly suggests that an early trauma and fixation play a role in the predisposition to depression. Although orality plays a universal role in the depressive's efforts to restore self-directed libidinal supplies, it is more obvious in more severe depressions. It should be clear from these considerations that orality, dealing as it does with efforts at restoring self-esteem, has nothing to do with the structure of depressions" (26).

Melanie Klein first defined the term of "depressive position" as the central position in the child's development, which is normally first experienced towards the middle of the first year of life. According to Melanie Klein, the normal development of the child and its capacity for love rests largely on how the ego works through this

progonjenog i nevoljenog. U ovom ranom razdoblju glavna uznemirenost odnosi se na opstanak selfa. U depresivnoj poziciji tjeskoba se osjeća i u ime objekta. Izraz "depresivna pozicija" također se koristi na različite, ali povezane načine. Može se odnositi na infantilno iskustvo razvojne integracije, ali općenitije odnosi se na iskustvo, u bilo kojoj životnoj fazi, krivnje i tuge zbog izraza mržnje i nad oštećenim stanjem vanjskih i unutarnjih objekata, ovisno o stupnju osjećaja katastrofe na ljestvici od uobičajenog tugovanja zbog gubitka do teške depresije. Izraz se također koristi za "depresivno funkcioniranje" u smislu depresivne pozicije, što znači da pojedinac može preuzeti osobnu odgovornost i percipirati sebe i druge kao odvojene (10, 23).

MENTALIZACIJA

Mentalizacija je proceduralna i uglavnom nesvjesna temeljna čovjekova sposobnost razumijevanja ponašanja u odnosu na mentalna stanja, poput misli i osjećaja i osnova je zdravih odnosa i samosvijesti (56). Osnovna pretpostavka mentalizacijskog pristupa depresiji je da su depresivni simptomi odgovor na prijetnje odnosima privrženosti i prijetnje sebi zbog razdvajanja, odbacivanja, gubitka ili neuspjeha (57). Mentalizacija kod depresivnog pacijenta može ovisiti o kontekstu (u vezi s iskustvima zbog gubitka, odvajanja), a na njega može utjecati trenutno raspoloženje, posebno u pacijenata s depresijom ili pacijenata s jakom reaktivnošću raspoloženja na pozitivne i negativne događaje. Depresija je povezana s poremećajima u socijalnom i međuljudskom funkcioniranju, što se može djelomično objasniti činjenicom da pojedinci osjetljivi na depresiju aktivno biraju i evociraju neadaptivne međuljudske odnose, što dovodi do konflikta, ambivalencije u odnosima te do socijalne isključenosti i izolacije. Može se reći da je depresija jednako interpersonalni koliko i intrapersonalni poremećaj (58).

position. This is repeatedly revisited and refined throughout early childhood and intermittently throughout life. The central position in the development is the realization of hateful feelings and phantasies about the loved object, prototypically the mother. Earlier there were felt to be two separate part-objects; ideal and loved; persecuting and hated. In this earlier period the main anxiety is concerned with the survival of the self. In the depressive position, anxiety is also felt on behalf of the object. The term "depressive position" is also used in different but related ways. It can refer to the infantile experience of the developmental integration, but more generally it refers to the experience, at any stage of life, of guilt and grief over hateful attacks and over the damaged state of external and internal objects, varying in the level of percieved catastrophe on a scale from normal mourning for loss to severe depression. The term is also used to refer to "depressive position functioning", meaning that the individual can take personal responsibility and perceive themselves and the other as separate (10, 23).

MENTALIZATION

Mentalizing is the procedural and mostly unconscious fundamental human capacity to understand behavior in relation to mental states, such as thoughts and feelings, and it represents the basis of healthy relationships and self-awareness (56). The basic assumption of the mentalization-based approach to depression is that depressive symptoms are responses to threats to attachment relations and threats to the self because of experiences of separation, rejection, loss, or failure (57). Mentalizing in depressed patient can be context-dependent (regarding experiences off loss, separation) and it can be influenced by current mood, especially in severely depressed patients or patients with strong mood reactivity to either positive or negative events. Depression is associated with impairments in social and interpersonal functioning, which can

Istraživanja su otkrila negativnu vezu između poremećaja u mentalizaciji kod depresivnih pacijenata i humora (59). Iz mentalizirajuće perspektive humor se može smatrati strategijom suočavanja jer ima najvažnije obilježje istinskog mentaliziranja: "sposobnost igranja s idejama". Zanimljivo je da je dokazano da primjena oksitocina kod ljudi dovodi do viših razina mentalizacije izražene u povećanoj sposobnosti čitanja misli drugih osoba na temelju izraza lica (60). U jednoj su studiji pacijenti s depresijom pokazali značajno niži kapacitet za mentalizaciju u usporedbi sa zdravim sudionicima kontrolne skupine (61). Korelacije s trajanjem bolesti i brojem hospitalizacija ukazuju da kronični tijek depresije rezultira daljnjim oštećenjem mentalizacije. Nedavno objavljeno istraživanje pokazalo je da je mentalizacija kod djece djelomično posredovala u odnosu između seksualnog zlostavljanja i depresivnih simptoma (62).

Aleksitimija je definirana kao nesposobnost prepoznavanja i izražavanja emocija i može se povezati s depresijom. Također je povezana s neuspjehom korištenja adaptivne regulacije afekta poput moduliranja pobuđenosti, primjerenog izražavanja ili suzbijanja emocija, toleriranja bolnih emocija i kognitivne asimilacije (63,64). Neki autori sugeriraju genetsku vezu između aleksitimije i depresije (65).

ANAKLITIČKE I INTROJEKTIVNE PSIHOPATOLOGIJE

Razvoj ličnosti tijekom života, od djetinjstva do starosti, uključuje razvoj selfa u sve više diferenciranom, integriranom i zrelom smislu, što je bitno za uspostavljanje zadovoljavajućih međuljudskih odnosa (66-69). Što se tiče razumijevanja organizacije ličnosti, McAdams (70,71) i drugi (72-75) utvrdili su da teme intimnosti (osjećaj bliske, tople veze i komunikacije s drugima) i teme moći (osjećaj snage i značajnog utjecaja na okolinu) imaju značajnu ulogu.

be partially explained by the fact that individuals who are vulnerable to depression actively select and evoke maladaptive interpersonal environments, leading to conflict, ambivalence in relationships, and social exclusion and isolation. It can be said that depression is as much an interpersonal disorder as it is an intrapersonal disorder (58). Studies have found a negative relationship between impairments in mentalizing in depressed patients and the appreciation of humor (59). From a mentalizing perspective, humor can be considered a coping strategy because it has the most important feature of genuine mentalizing: "the ability to play with ideas". Interestingly, it has been shown that oxytocin administration in humans leads to higher levels of mentalization expressed in increased ability to read the mind of others on the basis of facial expression (60). According to one study (61), patients with depression showed a significantly lower capacity for mentalization compared with the healthy controls. Correlations with illness duration and number of admissions suggest that a chronic course of depression results in further mentalizing impairments. A recently published study showed that child mentalization partially mediated the relationship between child sexual abuse and depressive symptoms (62).

Alexithymia is defined as the inability to recognize and express emotions and can be linked with depression. Alexithymia is also associated with a failure to use adaptive affect regulation such as modulating arousal, appropriately expressing or suppressing emotions, tolerating painful emotions, and cognitive assimilation (63,64). Some authors suggest a genetic link between alexithymia and depression (65).

ANACLITIC AND INTROJECTIVE PSYCHOPATHOLOGIES

Personality development throughout life, from infancy to old age, includes the development of the self in an increasingly differentiated, inte-

Primarna preokupacija interpersonalnim pitanjima kao što su povjerenje, briga, intimnost i seksualnost uključena je u konfiguraciju poremećaja koji su označeni kao anaklitičke psihopatologije (69). Anaklitička depresija izvorno je opisana kao psihijatrijski poremećaj u djetinjstvu kao posljedica nedostatka majke u drugoj polovici prve godine života (76). Pacijenti s anaklitičkim poremećajima snažno su zaokupljeni problemima odnosa na različitim razvojnim razinama, u rasponu od nedostatka diferencijacije između sebe i drugih, preko ovisnih (tj. infantilnih) privrženosti, do zrelijih vrsta poteškoća u interpersonalnim odnosima. Prema Blattu, anaklitički poremećaji uključuju neparanoidnu shizofreniju, granični poremećaj ličnosti, infantilni (ili ovisni) poremećaj ličnosti, anaklitičku depresiju i poremećaje histerije (77). Ovi poremećaji dijele temeljnu zaokupljenost libidnim pitanjima interpersonalne povezanosti i u prvom redu koriste izbjegavajuće obrane (npr. povlačenje, poricanje, represiju) za prevladavanje psiholoških konflikata i stresa (77).

U drugoj skupini poremećaja, označenih kao introjektivna psihopatologija, pacijenti su preokupirani ponajprije uspostavljanjem i održavanjem održivog osjećaja selfa na različitim razvojnim razinama, u rasponu od temeljnog osjećaja odvojenosti, brige o autonomiji i kontroli, pa sve do složenijih internaliziranih pitanja o vrijednosti selfa (77). Introjektivni pacijenti manje se brinu o kvaliteti interpersonalnih odnosa i postizanju osjećaja povjerenja, topline i privrženosti, a više o uspostavljanju, zaštiti i održavanju održivog koncepta selfa. Ljutnja i agresija, usmjereni prema sebi ili drugima, obično su središnji dio njihovih teškoća. Introjektivni poremećaji uključuju paranoidnu shizofreniju, shizoidnu ili emocionalno nezrelu ličnost (45), paranoju, opsesivno-kompulzivni poremećaj ličnosti, introjektivnu depresiju i falični narcizam. Pacijenti s ovim poremećajima dijele preokupaciju pitanjima samoopre-

grated, and mature sense which is essential for establishing satisfying interpersonal relationships (66-69). Regarding the understanding of personality organization McAdams (70,71) and others (72-75), found that themes of intimacy (such as feeling close, warm, and in communication with others) and themes of power (such as feeling strong and of having a significant impact on one's environment) play a significant role.

Primary preoccupation with interpersonal issues such as trust, caring, intimacy, and sexuality are involved in the configuration of disorders labeled as anaclitic psychopathologies (69). Anaclitic depression was originally described as a psychiatric disturbance in infancy which results from maternal deprivation in the second half of the first year of life (76). Patients with anaclitic disorders are strongly preoccupied with issues of relatedness at different developmental levels, ranging from a lack of differentiation between the self and the other, dependent (i.e. infantile) attachments, to more mature types of difficulties in interpersonal relationships. According to Blatt, anaclitic disorders include nonparanoid schizophrenia, borderline personality disorder, infantile (or dependent) personality disorder, anaclitic depression, and hysterical disorders (77). These disorders share a basic preoccupation with libidinal issues of interpersonal relatedness and use primarily avoidant defenses (e.g. withdrawal, denial, repression) to overcome the psychological conflict and stress (77).

In the second series of disorders labeled as introjective psychopathologies, patients are preoccupied primarily with establishing and maintaining a viable sense of self at different developmental levels, ranging from a basic sense of separateness, through concerns about autonomy and control, to more complex internalized issues of self-worth (77). Introjective patients are less concerned with the quality of their interpersonal relations and achieving feelings of trust, warmth, and affection than they are about establishing, protecting, and maintaining

djeljenja i instinktivno se usredotočuju na asertivnost i agresiju te koriste u prvom redu kontraaktivne obrane koje transformiraju, a ne izbjegavaju konflikte (npr. projekcija, racionalizacija, intelektualizacija, činjenje i poništavanje, formiranje reakcija, prekompenzacija) (77).

Anaklitičku ili ovisnu depresiju karakteriziraju osjećaji usamljenosti, bespomoćnosti i slabosti, pacijenti imaju snažan, kronični strah da će biti napušteni, ostavljeni nezaštićeni (77). Imaju veliku želju biti voljeni, njegovani i zaštićeni. Blatt je rekao: „Budući da malo internalizacije iskustava zadovoljstva ili kvaliteta pojedinaca pruža zadovoljstvo, drugi su cijenjeni u prvom redu zbog neposredne njege, udobnosti i zadovoljstva koje pružaju. Odvajanje od drugih i gubitak objekta stvaraju značajan strah, a često se rješavaju primitivnim ponašanjima kao što su poricanje i / ili očajnička potraga za zamjenama (78-83).

Introjektivnu ili samokritičnu depresiju uglavnom karakteriziraju osjećaji nedostojanstva, inferiornosti, neuspjeha i krivnje (77). Ove se osobe konstantno ispituju, procjenjuju i imaju kronični strah od kritike i gubitka odobrenja od strane značajnih drugih. Teže pretjeranom postignuću i savršenstvu često su vrlo konkurentni i naporno rade, postavljaju brojne zahtjeve sebi i često postižu puno, ali s kratkoročnim zadovoljstvom. Blatt je rekao: "Zbog svoje intenzivne konkurentnosti, oni mogu biti kritični prema drugima. Prekomjernom kompenzacijom nastoje postići i održati odobravanje i prepoznavanje "(78-83).

Razlika između anaklitičke i introjektivne konfiguracije psihopatologije leži u primarnom instinktivnom fokusu (libidinalni nasuprot agresivnom), prirodi svjesnih i nesvjesnih sukoba, vrstama obrambene organizacije (izbjegavanje nasuprot neutralnosti) i prevladavajućem stilu karaktera (npr. orijentacija objekta naspram samo-orijentacije, naglasak na utjecaje ili na spoznaju) (80,84).

a viable self-concept. Anger and aggression directed toward the self or others, are usually central to their difficulties. Introjective disorders include paranoid schizophrenia, schizotypal or overideational borderline disorder (45), paranoia, obsessive-compulsive personality disorder, introjective (guilt-ridden) depression, and phallic narcissism. Patients with these disorders share a preoccupation with issues of self-definition and an instinctual focus on assertion and aggression, and use primarily counteractive defenses that transform conflicts rather than avoid them (e.g. projection, rationalization, intellectualization, doing and undoing, reaction formation, overcompensation) (77).

Anaclitic or dependent depression is characterized by feelings of loneliness, helplessness, and weakness; the patients have strong, chronic fears of being abandoned, left unprotected and uncared for (77). They have a strong desire to be loved, nurtured, and protected. Blatt said: "Because there has been little internalization of the experiences of gratification or of the qualities of the individuals who provided satisfaction, others are valued primarily for the immediate care, comfort, and satisfaction they provide. Separation from others and object loss create considerable fear and apprehension, and are often dealt with by primitive means such as denial and/or a desperate search for substitutes" (78-83).

Introjective or self-critical depression is mainly characterized by feelings of unworthiness, inferiority, failure, and guilt (77). These individuals engage in constant self-questioning and evaluation and have a chronic fear of criticism and of losing the approval of significant others. They seek excessive achievement and perfection, are often highly competitive and work hard, make many demands on themselves, and often achieve a lot, but with short-term satisfaction. Blatt said: "Because of their intense competitiveness, they can also be critical and attacking toward others. Through overcompensation they strive to achieve and maintain approval and recognition" (78-83).

Prema Bowlby (85,86), postoji sklonost depresiji kod anksiozno privrženih i kompulzivno samozatajnih pojedinaca. Anksiozno privrženi pojedinci zahtijevaju interpersonalni kontakt i pretjerano ovise o drugima. Prisilno samostalni pojedinci vrlo su autonomni i izbjegavaju bliske i intimne međuljudske odnose.

DOMINANTNI DRUGI, DOMINANTNI CILJ, DOMINANTNI TREĆI

Arieti i Bemporad (87,88) razlikuju dvije vrste depresije vezane uz interpersonalne odnose, dominantni drugi i dominantni cilj. Depresija može rezultirati time što je dominantni drugi izgubljen ili dominantni cilj nije postignut. Ovi autori također navode da u depresiji postoje dvije intenzivne i temeljne želje: „biti pasivno zadovoljen od dominantnog drugog“ i „biti uvjeren u vlastitu vrijednost, biti oslobođen tereta krivnje“.

Prema Becku kognitivna trijada koja uključuje negativne percepcije sebe, svijeta i budućnosti, važna je varijabla depresije (89). Beck je iz kognitivno-bihevioralne perspektive razlikovao „sociotropne“ (društveno ovisne) i „autonomne“ vrste depresije (90). Prema Becku sociotropija se "odnosi na ulaganje osobe u pozitivnu razmjenu s drugim ljudima ... uključujući pasivno-receptivne želje (prihvaćanje, intimnost, razumijevanje, podršku, smjernice)". Visoko sociotropni pojedinci „posebno su zabrinuti zbog mogućnosti da ih drugi ne odobravaju, pa često pokušavaju ugoditi drugima i održati svoje privrženosti (91). Depresija bi se kod ovih osoba mogla pojaviti kao odgovor na uočeni gubitak ili odbacivanje u društvenim odnosima. Ovu vrstu depresije karakterizira ranjivost na smetnje zadovoljavanja interpersonalnih odnosa i izražava se ponajprije u disforičnim osjećajima gubitka, napuštenosti i usamljenosti (77).

The difference between anaclitic and introjective configurations of psychopathology lies in primary instinctual focus (libidinal versus aggressive), the nature of conscious and unconscious conflicts, types of defensive organization (avoidant versus counteractive), and predominant character style (e.g. object orientation versus self-orientation, an emphasis on affects or on cognition) (80,84).

According to Bowlby (85,86), there is a predisposition to depression in anxiously attached and compulsively self-reliant individuals. Anxiously attached individuals demand interpersonal contact and are excessively dependent on others. Compulsively self-reliant individuals are exceedingly autonomous and avoid interpersonal relationships which are close and intimate.

DOMINANT OTHER, DOMINANT GOAL, DOMINANT THIRD

Arieti and Bemporad (87,88) distinguished two types of depression from an interpersonal perspective, the dominant other type and the dominant goal type. Depression can result when the dominant other is lost or the dominant goal is not achieved. They also said that there are two intense and basic wishes in depression: "to be passively gratified by the dominant other" and "to be reassured of one's own worth, to be free of the burden of guilt".

According to Beck, the cognitive triad, which includes negative perceptions of the self, the world, and the future is an important variable in depression (89). From a cognitive-behavioral perspective, Beck differentiated between the "sociotropic" (socially dependent) and the "autonomous" type of depression (90). According to Beck, sociotropy "refers to the person's investment in positive interchange with other people… including passive-receptive wishes (acceptance, intimacy, understanding, support, guidance)". Highly sociotropic individuals are "particularly concerned about the possibility of be-

Individualnost (autonomija), prema Beckovoj ili kognitivno-bihevioralnoj psihoterapiji, odnosi se na "ulaganje osobe u očuvanje i povećanje neovisnosti, mobilnosti i osobnih prava; slobode izbora, djelovanja i izražavanja; zaštite svog područja,... i postizanje smislenih ciljeva "(90). Prema Becku, autonomno depresivni pacijent „prožet je temom poraza ili neuspjeha", optuživši „sebe da stalno pada ispod svojih normi" i „posebno je samokritičan zbog„ neispunjenosti "svojih obaveza. Visoko autonomni pojedinci orijentirani na dostignuća izričito su zabrinuti zbog mogućnosti osobnog neuspjeha i često pokušavaju maksimizirati svoju kontrolu nad okolinom kako bi umanjili vjerojatnost neuspjeha i kritike. Depresija se obično javlja kod ovih osoba kao odgovor na uočeni neuspjeh ili nedostatak kontrole nad okolinom. Ovu vrstu depresije karakterizira ranjivost na poremećaje učinkovitog i pozitivnog osjećaja selfa, a izražava se ponajprije disforičnim osjećajima bezvrijednosti, krivnje, neuspjeha i osjećajem gubitka autonomije i kontrole (77,90).

Depresija je reakcija na unutarnji gubitak, a također i na nemogućnost popravka. Vanjski događaj može potaknuti kolaps svjesnih ili nesvjesnih pretpostavki. Kognitivne konstrukcije koje se naglo ili postupno podvrgavaju dezintegraciji općenito imaju dualan entitet - psihološku podjelu na sliku o sebi i interpersonalne odnose. Arieti navodi: "Uništavanje konstrukta podrazumijeva novu procjenu nečijeg i vlastitog života, sa svim skrivenim značenjima, implikacijama i razrađenjima, uzrokujući tremor čitavog psihološkog tkiva pojedinca, dubok intrapsihički proces". Dominantni drugi predstavlja interpersonalnu granu koja ima veze s drugom osobom, vrlo važnom za pacijenta (92,93). Dominantni drugi do sada je pružao pacijentu osjećaj priznanja od strane barem jedne osobe. Može se reći, prema Arietiju, da je interpersonalni aspekt povezan sa slikom o sebi.

ing disapproved of by others, and they often try to please others and maintain their attachments (91). Depression could occur in these individuals in response to perceived loss or rejection in social relationships. This type of depression is characterized by the vulnerability to disruptions of gratifying interpersonal relationships and is expressed primarily in dysphoric feelings of loss, abandonment, and loneliness (77).

Individuality (autonomy), according to Beck or cognitive behavior psychotherapy, refers to the person's "investment in preserving and increasing his independence, mobility, and personal rights; freedom of choice, action, and expression; protection of his domain,... and attaining meaningful goals" (90). An autonomously depressed patient is, according to Beck, "permeated with the theme of defeat or failure," blaming "himself continually for falling below his standards," and being "specifically self-critical for having 'defaulted' on his obligations". Highly autonomous, achievement-oriented individuals are extremely concerned about the possibility of personal failure and often try to maximize their control over the environment in order to reduce the probability of failure and criticism. Depression usually occurs in these individuals in response to a perceived failure to achieve or a lack of control over the environment. This type of depression is characterized by vulnerability to disruptions of an effective and positive sense of self and is expressed primarily in dysphoric feelings of worthlessness, guilt, failure, and a sense of a loss of autonomy and control (77,90).

Depression is the reaction to inner loss, and also to the inability to repair it. The external event can trigger the collapse of conscious or unconscious assumptions. Cognitive constructs that abruptly or gradually undergo disintegration generally have a double entity – a psychological bifurcation, with a self-image branch and an interpersonal branch. Arieti said: "The destruction of the construct implies a new evaluation of one's self and of one's life, with all the hidden meanings, implications, and ramifications,

Dominirajući drugi može biti utjelovljen kao supružnik, majka, osoba s kojom je pacijent u romantičnom odnosu, odraslim djetetom, sestrom, ocem ili skupinom ljudi prema kojima pacijent osjeća pripadnost (93). Prema Arietiju svi ti dominantni drugi često su simbolika uskraćene majke koja nije voljna dati obećanu ljubav. Ako je prava majka još uvijek živa i predstavlja dominantnog drugog, bit će prisutna na dva načina – u svojoj stvarnoj, vremenski realnoj slici, te u simboličkoj slici sebe iz prošlosti. Prevladavajući faktor psihotične depresije često je povezan s dominantnim drugim: ako dominantni drugi ode ili umre, pacijent vjeruje da mu je uskraćena ljubav, posebno kad postoje ambivalentni osjećaji. S vremenom depresija postaje obuzimajuća i preuzima praktički cjelokupnu psihu. Pacijenti ponekad ne mogu odgovoriti na pitanje o razlozima depresije. Kognitivne komponente ideja i misli koje su pokrenule depresiju su potisnute, ali bolna emocija vrlo se intenzivno doživljava na razini svijesti. Prema Arietiju, dubok osjećaj krivnje prati depresiju i pacijent se osjeća odgovornim za psihološki kolaps. Preostala energija koristi se za samokažnjavanje kako bi se vratila prihvatljiva slika o sebi. Ovaj osjećaj krivnje može s vremenom postati nesvjestan (93).

Kad analitičar uđe u život vrlo depresivnog pacijenta, nudeći nadu i pomoć, često će biti prihvaćen, ali samo kao dominantni treći (92,93). Budući da pacijent vidi u analitičaru nov i pouzdan objekt ljubavi, možda će odmah osjetiti olakšanje. Kada analitičar ima ulogu dominantnog trećeg moglo bi doći do novog napada depresije kada pacijent shvati ograničenje ove vrste terapijske intervencije. Arieti je rekao: “Analitičar ne mora biti dominantni treći, već značajna treća osoba, treća osoba izravnog, iskrenog i nedvosmislenog tipa ličnosti, koja želi pomoći pacijentu bez prijetećih zahtjeva”. Istinska empatija, stanje komplementarnog svjesno-nesvjesnog kontakta utemeljenog na

causing a tremor to the whole psychological fabric of the individual, a profound intrapsychic process”. The dominant other represents an interpersonal branch which has to do with another person very important to the patient (92,93). Up to that point, the dominant other had provided the patient with the feeling of acknowledgement by at least another person. It can be said, according to Arieti, that the interpersonal branch of the bifurcation is connected with the self-image. The dominant other can be impersonated by the spouse, the mother, a person to whom the patient is romantically attached, an adult child, the sister, the father, or by a group of people the patient considers themselves belonging to (93). According to Arieti, all these dominant others are often symbolic of the depriving mother who was unwilling to give the promised love. If the real mother is still living and is the dominant other, she will be present in two ways – as her present role actually is and also symbolically of her old one. The precipitating factor of psychotic depression is often connected to the dominant other: If the dominant other leaves or dies, the patient believes that they has been deprived of their love, especially when there ambivalent feelings exist. With time the depression becomes overwhelming and it takes possession of practically the entire psyche. Patients sometimes cannot answer questions on the reason for their depression. The cognitive components of the ideas and thoughts that triggered the depression are repressed, but the painful feeling is very intensely experienced at the level of consciousness. According to Arieti, a profound feeling of guilt follows the depression and the patient feels responsible for psychological collapse. The remaining energy is used for self-punishment in order to restore an acceptable self-image. This idea-feeling of guilt can become unconscious with time (93).

When the analyst enters the life of a very depressed patient, offering hope and help, he will often be accepted but only as a dominant third (92,93). Because the patient sees in the analyst

odvojenosti i dijeljenju, trebali bi biti prisutna između terapeuta i pacijenta (94). Analitičar treba pomoći pacijentu da se odrekne starih konstrukcija i izgradi nove. Analitičar bi mu trebao pokazati da, ako bi ostao vezan za staru ideologiju ili prošli način života, oni bi fosilizirali njegovo postojanje. Prema Arietiju moguća je obnova i samo-nastajanje, a s njima i potencijal za smisleniji život (1).

DEPRESIJA KAO EVOLUCIJSKI STEČEN MEHANIZAM

„Depresija je evolucijski stečen mehanizam u mozgu sisavaca, selekcioniran kao mehanizam za zaustavljanje dugotrajne razdvojenosti (prototipsko emocionalno stanje sisavaca), koja bi, ako se održi, bila opasna za dojenčad sisavaca.“ (95). Bowlby je sindrom razdvajanja / nevolje opisao kao niz psiholoških reakcija na socijalni gubitak u kontinuitetu od protesta do očaja i, konačno, odvojenosti (85). Biološki determinirana osjetljivost na depresiju odražava se genetski određenom preosjetljivošću u kombinaciji s pretjerano negativnim utjecajem kao odgovor na gubitak socijalne potpore - napuštanje osnovnih izvora fizičke i psihičke sigurnosti. Ova ranjivost postaje veća nakon psiholoških iskustava koja dodatno povećavaju prijetnju socijalnim gubitkom ili psihološkim napuštanjem i čine psihodinamičku sklonost depresiji (44).

Prema nekim autorima, depresivni afekt kao temeljna psihofiziološka reakcija pokreće se ranim odvajanjem od majke što izaziva lančanu reakciju bijesa, očaja i omalovažavanja i njihovih neurohormonskih korelata kod ljudi kao i kod drugih primata (96,97). Ova veza između emocija i neurokemijskog odgovora (98) spaja psihoanalitičku teoriju internaliziranih objektnih odnosa s biološkim istraživanjima genetskih i neurobioloških odrednica agresivnog i depresivnog utjecaja.

a new and reliable love-object, he may achieve an immediate relief. The analyst playing the role of the dominant third can lead to a new attack of depression when the patient realizes the limitation of this type of therapeutic intervention. Arieti said: “The analyst must be not a dominant third, but a significant third, a third person with a straightforward, sincere, and unambiguous type of personality, who wants to help the patient without making threatening demands”. Genuine empathy, a state of complementary conscious-preconscious contact based on separateness and sharing, should be present between the therapist and the patient (94). The analyst should help the patient give up the old constructs and build new ones. The analyst should show the patient that if they had remained fixated to the old ideology or to the past ways of life, this would have fossilized their existence. According to Arieti, renewal and self-emergence are possible, and with them the potential for a more meaningful life (1).

DEPRESSION AS AN EVOLUTIONARILY CONSERVED MECHANISM

“Depression is an evolutionarily conserved mechanism in mammalian brains, selected as a shutdown mechanism to terminate protracted separation distress (a prototype mammalian emotional state), which, if sustained, would be dangerous for infant mammals.” (95). Bowlby described the separation/distress syndrome as a series of psychological responses to social loss on a continuum from protest to despair and, finally, to detachment (85). Biologically determined vulnerability to depression is reflected by genetically determined hypersensitivity combined with excessive negative affect in response to the loss of social support – abandonment by essential sources of physical and psychic security. This vulnerability becomes greater through psychological experiences that further enhance the threat of social loss

Neurobiološke studije na ljudima i drugim sisavcima potvrdile su aktivaciju osi hipotalamus-hipofiza-nadbubrežna žlijezda (HPA), hiperkortizolemiju i, u novije vrijeme, dugotrajne posljedice u smislu sniženog kortizola u krvi kod bolesnika s depresijom. Pretjerano stresni odgovor na traumatične podražaje i smanjenje volumena hipokampa, moždane strukture izravno uključene u eksplicitnu afektivnu memoriju ima određenu ulogu u depresiji (95,99-101). Neka istraživanja pokazuju da stres smanjuje ekspresiju neurotrofičnog faktora (BDNF) što dovodi do atrofije neurona hipokampusa (102). Količina gubitka volumena hipokampusa proporcionalna je trajanju depresivne bolesti, što ukazujre da kaskade stresa progresivno prorjeđuju dendritičke bodlje hipokampusa (103,104).

Što se tiče čimbenika depresije koji se danas istražuju, neki autori ističu sinergiju svih tih čimbenika dajući pregled ponašanja i simptomatskih korelacija s određenim depresivnim čimbenicima (105). Povećani faktor oslobađanja kortikotropina (CRF), hiperkortizolemija, kolecistokinin (CCK) i smanjeni BDNF povezani su s disforijom, snom i gubitkom apetita, smanjenim kratkoročnim pamćenjem i drugim kognitivnim deficitima. Povećani acetilkolin mogao bi biti odgovoran za negativan utjecaj i prekomjernu pažnju negativističkim percepcijama i mislima.

Smanjeni opioidi i oksitocin smatraju se odgovornim za anhedoniju i tugu, smanjen pozitivan utjecaj i smanjen osjećaj povezanosti, pa čak i suicidalnost. Smanjena serotonergička sklonost ili ranjivost povezana je sa slabom afektivnom regulacijom, impulzivnošću, opsesivnim mislima i suicidalnošću. Smanjeni kateholaminergički tonus povezan je s umorom, disforijom i poremećenom koordinacijom kognitivne i emocionalne obrade informacija. Psihoterapija, s druge strane, potiče opioidni i oksitocinski sustav. Zanimljivo je da vježbanje pomaže u promicanju serotonina, VGF-a i

or psychological abandonment and constitute the psychodynamic disposition to depression (44). According to some authors, depressive affect as a basic psychophysiological reaction is triggered by early separation from the mother that provokes a chain reaction of rage, despair, and despondency and their neurohormonal correlates, both in humans and in other primates (96,97). This link between the experienced emotion and neurochemical response (98) merges the psychoanalytic theory of internalized object relations with biological research into the genetic and neurobiological determinants of aggressive and depressive affect.

Neurobiological studies in humans and other mammals have confirmed activation of the hypothalamus-pituitary-adrenal (HPA) axis, hypercortisolemia, and, more recently, resulting long-range consequences in terms of lowered blood cortisol in patients with depression. Excessive stress response to later traumatic stimuli and reduction in the hippocampal volume, the brain structure most directly involved in explicit affective memory, has a particular role in depression (95,99-101). Some studies show that stress decreases expression of brain-derived neurotrophic factor (BDNF), which leads to atrophy of hippocampal neurons (102). The amount of hippocampal volume loss is proportional to the duration of the depressive illness, suggesting that stress cascades progressively thin out hippocampal dendritic spines (103,104).

Regarding factors leading to depression that are currently being researched, some authors emphasize the synergy of all those factors, giving an overview of behavioral and symptomatic correlates to certain depressive factors (105). Increased corticotropin-releasing factor (CRF), hypercortisolemia, cholecystokinin (CCK), and reduced BDNF are correlated with dysphoria, sleep and appetite loss, reduced short-term memory, and other cognitive deficits. Increased acetylcholine could be responsible for negative affect and excess attention to negativistic perceptions and thoughts. Decreased opioids and

ostalih faktora rasta, BDNF u hipokampusu, opioidima i dopaminu (105).

Prema nekim istraživanjima imunološki sustav također bi mogao imati ulogu u patofiziologiji depresije. Istraživanja su pokazala da usprkos snažnom protuupalnom učinku glukokortikoida postoji povišena razina cirkulirajućih protuupalnih citokina uključujući interleukin-1, interleukin-6, faktor nekroze tumora alfa i neke topljive interleukinske receptore u bolesnika s depresijom (5,106-112). Prema posljednjim istraživanjima upala je u mnogim slučajevima uzročno povezana s promjenama u jezgrovitim afektivnim i kognitivnim procesima (npr. anhedonija; negativna reaktivna reakcija) i njihovim neuronskim krugovima koji su snažno uključeni u trenutne modele etiologije i liječenja depresije (113).

Pacijenti s velikim depresivnim poremećajem pokazuju povećanu koncentraciju periferne krvi i cerebrospinalne tekućine (CSF) u C-reaktivnom proteinu akutne faze (CRP) u akutnoj fazi i druge biljege upale za koje je utvrđeno da predviđaju daljnji razvoj depresije, kao i otpornost na standard terapije antidepresivima. CSF biljezi upale koji su povezani s visokom CRP u plazmi koreliraju s ozbiljnošću depresivnih simptoma (114).

Disfunkcija cirkadijurnog ritma ima mnoge negativne učinke na periferne organe poput promjena u metabolizmu, pretilosti, pa čak u ekstremnim slučajevima smanjenog životnog vijeka (115,116), pa bi se moglo pretpostaviti da i on ima utjecaj na mozak. Istraživanja su pokazala da je cirkadijalni ritam promijenjen kod pacijenata s depresijom (117). Promjenom glukokortikoidne sekrecije disfunkcija u cirkadijalnom ritmu može biti uzrok, ali i posljedica depresije kod nekih bolesnika. Prema Selvi i sur., snažna povezanost između kvalitete spavanja, depresivne simptomatologije i cirkadijalnih sklonosti postoji u velikoj depresiji (118). Stoga bi poboljšanje cirkadijurnog sustava

oxytocin are held to be responsible for anhedonia and sadness, reduced positive affect, and reduced sense of connection, and even suicidality. Reduced serotonergic drive or vulnerability is connected with poor affective regulation, impulsivity, obsessive thoughts, and suicidality. Diminished catecholaminergic tone is correlated to fatigue, dysphoria, and impaired coordination of cognitive and emotional information processing. Psychotherapy, on the other hand, promotes the opioid and oxytocin system. Notably, exercise helps the promotion of serotonin, VGF, and other growth factors, BDNF in the hippocampus, opioids, and dopamine (105).

According to some studies, the immune system could also have a role in pathophysiology of depression. Studies have shown that in spite of the potent anti-inflammatory effect of glucocorticoids there were elevated levels of circulating proinflammatory cytokines including interleukin-1, interleukin-6, tumor necrosis factor alpha, and some soluble interleukin receptors in patients with depression (5,106-112). According to recent studies, inflammation is linked, in many cases causally, to changes in core affective and cognitive processes (e.g. anhedonia, negative reactivity bias) and their neural circuits that are strongly implicated in current models of the etiology and treatment of depression (113).

Patients with major depressive disorder exhibit increased peripheral blood and cerebrospinal fluid (CSF) concentrations of the acute phase reactant C-reactive protein (CRP) and other markers of inflammation, which have been found to predict future development of depression and are resistant to standard antidepressant therapies. CSF inflammatory markers that were associated with high plasma CRP correlate with depressive symptom severity (114).

Dysfunction in circadian timing has many downstream effects on peripheral organs such as changes to metabolism, obesity, and even in extreme cases decreased life span (115,116), so it can be assumed that it also has an impact on

moglo biti povoljan tretman za ove pacijente (119).

ZAKLJUČAK

Depresija može imati samostalno podrijetlo ili se može javiti zajedno s drugim poremećajem. Može dominirati čitavim mentalnim životom ili može obojati poremećaj kao pozadinsko raspoloženje. Psihoanalitičke teorije o depresiji počele su Freudovim *Žalovanjem i melankolijom* 1917. Freud je depresiju objasnio kao patološki analog žalovanja pri čemu je glavna poanta analogije među njima bila da obje proizlaze iz gubitka objekta, koji možda nisu stvarni. Od početka 20. stoljeća psihoanaliza je učinila značajne iskorake u tumačenju depresije. Depresija je promatrana kao očajnički krik za ljubavlju, agresija prema selfu, kao konflikt ega, fiksacija na iskustva bespomoćnosti i kao izraz neurotične strukture ličnosti. Depresija se vrlo često povezuje s agresijom, tjeskobom, krivnjom i značajnim padom libidinalnog ulaganja u reprezentaciju selfa što podvlači njegovu narcističnu osnovu. Narcizam također igra ulogu u samopredstavljanju konceptima „narcistične pozicije“ i „objekta narcistične aktivnosti“.

Prema nekim autorima osjećaj frustracije u postizanju narcističnih težnji selfa čini jezgru depresije. Freud je prvi pisao o tome da je identifikacija izvorni oblik emocionalne povezanosti s nekim objektom. Psihoanalitički teoretičari diferencirali su dvije vrste depresije temeljene dijelom na freudovskim idejama o identifikaciji: depresija usmjerena ponajprije na interpersonalna pitanja poput ovisnosti u odnosima, bespomoćnosti, osjećaja gubitka i napuštanja, i depresiju koja proizlazi iz strogog, kažnjavajućeg superega, usredotočena u prvom redu na samokritičnost, zabrinutost zbog vlastite vrijednosti i osjećaja neuspjeha i krivnje. U klasičnom psihoanalitičkom prikazu depresije oralnost ima univerzalnu ulogu u nastojanjima da se obnovi samostalno usmjereni libidinalni

the brain. Studies have shown that circadian timing is altered in depressed patients (117). By changing the glucocorticoid secretion, dysfunction in the circadian timing could be the cause and also the result of depression in some patients. According to Selvi et al., robust associations between sleep quality, depressive symptomatology, and circadian preferences exist in major depression (118). Thus, the improvement of the circadian system may be a beneficial treatment for these patients (119).

CONCLUSIONS

Depression can have an independent origin or it can coexist with another disorder. It can dominate the whole mental life or it can color a disorder as a background mood. Psychoanalytic theories regarding depression began with Freud’s *Mourning and Melancholia* in 1917. Freud explained depression as a pathological analogue of mourning, where the main point of analogy between them was that both result from object loss that may or may not be a real one. Since the beginning of 20th century, psychoanalysis has made considerable advancements in the interpretation of depression. Depression was seen as a despairing cry for love, aggression towards the self, as a conflict of the ego, a fixation to experiences of helplessness and powerlessness and as an expression of the neurotic structure of personality. Depression is very often linked with aggression, anxiety, guilt and a significant fall in libidinal investment in self-representation, which underscores its narcissistic basis. Narcissism also plays a role in the self-representation through the concepts of “narcissistic possesions” and “objects of narcissistic activity”. According to some authors, the feeling of frustration in the attainment of narcissistic aspirations of the self is what constitutes the core of depression. Freud was the first who wrote about identification being the original form of the emotional tie to an object.

obol u bolesnika s depresijom. Kako su se psihoanalitičke teorije razvijale, pojavili su se neki važni koncepti. Prema Becku kognitivna trijada koja uključuje negativne percepcije sebe, svijeta i budućnosti važna je varijabla depresije. Beck također razlikuje, iz kognitivno-bihevioralne perspektive, između "sociotropske" (društveno ovisne) i "autonomne" vrste depresije. Arieti uvodi koncept dominantnog drugog kao interpersonalnu granu kognitivne konstrukcije koja je povezana s intrapsihičkom i sa samopouzdanjem, koncept sličan psihološkom konceptu self objekta. Self objekt je izrazito važan u regulaciji samopoštovanja, odnosno za stabilnost selfa, ali je on sam po sebi osobi koju stabilizira nevažan, ne postoji kao odvojena autonomna jedinka. Koncept dominantnog drugog ima dosta sličnosti sa self psihološkim konceptom self objekta. Self objekt je izrazito važan u regulaciji samopoštovanja, odnosno za stabilnost selfa, ali on sam po sebi je osobi koju stabilizira nevažan, ne postoji kao odvojena autonomna jedinka. Arieti naglašava ulogu terapeuta koji može postati dominantna treća osoba. Psihoanalitičke teorije s kraja 20. stoljeća dijele depresiju s obzirom na psihopatologiju na anaklitičku i introjektivnu, s primarnom instinktivnom usredotočenošću, prirodom svjesnih i nesvjesnih konflikata, vrstama obrambene organizacije i prevladavajućim karakterom kao glavnom razlikom. U 21. su stoljeću autori dokazali neurohormonsku, neurokemijsku i neuroimunološku pozadinu depresije, na neki način potvrđujući neke od klasičnih psihoanalitičkih teorija.

Psychoanalytic theorists differentiated two types of depression based partly on Freudian ideas about identification: depression focused primarily on interpersonal issues such as dependency, helplessness, feelings of loss, and abandonment and depression derived from a harsh, punitive superego, focused primarily on self-criticism, concerns about self-worth, and feelings of failure and guilt. In the classic psychoanalytic view of depression, orality plays a universal role in the efforts to restore self-directed libidinal supplies in patients with depression. Some important concepts emerged as psychoanalytic theories evolved. According to Beck, the cognitive triad, which includes negative perceptions of the self, the world, and the future is an important variable in depression. From a cognitive-behavioral perspective, Beck also distinguishes between "sociotropic" (socially dependent) and "autonomous" types of depression. Arieti introduced the dominant other as the interpersonal branch of cognitive construction which is connected with the intrapsychic and with the self-image, a concept similar to the psychological concept of a self-object. The self-object is extremely important in the regulation of self-esteem, i.e. for the stability of the self, but it is irrelevant in itself to the person it stabilizes and does not exist as a separate autonomous entity. The concept of the dominant other has many similarities with the self-psychological concept of the self-object. Arieti also emphasized the role of the therapist, who can become the dominant third. Psychoanalytic theories from the end of 20th century divide depression in anaclitic and introjective based on psychopathology, with the main difference between them lying in primary instinctual focus, the nature of conscious and unconscious conflicts, types of defensive organization, and predominant character. Authors in the 21th century showed the neurohormonal, neurochemical, and neuroimmunological background of depression, in a way confirming some of the classic psychoanalytic theories.

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Suhe oči, problemi s vidom i psihijatrijski simptomi: propuštamo li nešto?

/ Dry Eyes, Vision Problems, and Psychiatric Symptoms: Are We Missing Something?

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Problemi vida i patologija oka često su u komorbiditetu s psihijatrijskim stanjima. Ovaj rad pruža pregled dostupnih istraživanja o takvim vezama i podiže osviješćenost o mogućem značenju i učincima različitih očnih simptoma i oštećenja vida na psihijatrijska stanja i psihičke simptome. Dodatno, psihološke karakteristike i psihijatrijska stanja razmatraju se kao mogući uzroci problema oka i vida. Većina istraživanja otkriva povezanost između problema oka i vida s psihijatrijskim stanjima i psihičkim smetnjama. Blaži oftalmološki problemi najčešće su povezani s poremećajima raspoloženja, a manje s ostalim psihijatrijskim stanjima. Ozbiljni oftalmološki problemi, poput gubitka oštrine vida, povećavaju rizik za reaktivnu depresiju. Manji broj istraživanja potvrđuje vezu između psihotičnih poremećaja i vida, koja uglavnom mijenja vidnu percepciju. Zaključno, razmotrene su moguće interakcije i odnosi između psihijatrijskih stanja i problema oka i vida te preporuke za buduća istraživanja. U preporukama za usmjeravanje i zbrinjavanje pacijenata naglašen je holistički pristup u tretmanu pacijenata.

/ Vision problems and eye pathology are often comorbid with psychiatric conditions. This paper provides a review of available studies about these associations and raises awareness on possible causes and impacts of different eye symptoms and vision impairment on psychiatric states and psychological symptoms. Additionally, psychological characteristics and psychiatric conditions are considered as a possible cause of eye and vision-related problems. Most of the studies found an association of eye and vision problems with psychiatric conditions and psychological disturbances. Ophthalmic problems of a milder nature are mostly associated with mood disorders and less commonly with other psychiatric conditions. Serious eye conditions, like a loss of visual acuity, increase the risk for reactive depression. Fewer studies presented a connection between psychotic disorders and vision, which mostly alters visual perception. In the concluding section, possible interactions and relationships between psychiatric conditions and eye and vision problems are presented, along with recommendations for future research. The importance of holistic professional care in patient treatment is particularly emphasized in the recommendations for patient management.

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UVOD

Psihijatrijski poremećaji mogu imati oftalmološke manifestacije. Poznato je da teška psihijatrijska stanja poput shizofrenije mijenjaju percepciju stvarnosti i utječu na vidnu kogniciju. Mehanizam koji uzrokuje takve aberacije još nije u potpunosti poznat. Međutim, kod poremećaja raspoloženja relativno česti očni simptomi, poput bolnih očiju, umora ili suhoće oka, uglavnom prođu nezapaženi ili su zanemareni, iako mogu barem djelomično uzrokovati psihijatrijske smetnje. Takvi simptomi mogu narušiti kvalitetu života i na taj način pridonijeti psihološkim problemima. Poteškoće vida zasigurno utječe na kvalitetu života (1) i po svojoj prilici izazivaju depresiju koja kod pacijenata često prolazi nezapaženo (2). Gotovo polovica brojnih pacijenata očnih klinika različitih oftalmoloških dijagnoza moglo bi imati poremećaje raspoloženja (3).

Psihološke i očne smetnje se, bez sumnje, često primjećuju zajedno. Neke od njih su toliko dojmljive da se pretpostavlja i raspravlja o posebnim psihijatrijskim stanjima. Najbolji primjer toga je keratokonusna ličnost o kojoj se još uvijek debatira i još nije potvrđena (4).

Sindrom suhog oka (SSO) jedan od zdravstvenih problema očiju koji je u najvećem porastu i zahvaća trećinu opće populacije (5), u posljednjem je desetljeću često povezivan s različitim psihološkim čimbenicima (6-18).

Trijažni dijagnostički postupci otkrivaju da samo 22,7 % pacijenata sa suhim okom otpornih na terapiju nema simptome psihičkih poremećaja (19). Simptomi suhog oka uže su povezani s psihičkim simptomima i ne-okularnom boli, nego s objektivnim parametrima suznog filma (6). Shimura, Shimazaki i Tsubota (20) su na velikom uzorku usporedili pozitivno i negativno dijagnosticirane pacijente prema njihovim izvješćima o simptomima SSO-a. Svaka osoba s pozitivnom dijagnozom izvjestila je barem o nekim od simptoma, a samo je 14 %

INTRODUCTION

Psychiatric disorders can have ophthalmologic manifestations. Severe psychiatric conditions like schizophrenia are known to alter the perception of reality and affect visual cognition. The mechanism that causes such aberrations is not yet completely known. However, relatively common eye symptoms in mood disorders like eye pain, fatigue, or dryness, are generally unnoticed or disregarded but may at least partially cause psychiatric disturbances. These symptoms can disturb the quality of life and thus contribute to psychological problems. Vision impairment certainly affects the quality of life (1) and is likely to cause depression which is mostly undetected among patients (2). Almost half of the numerous eye clinic patients with different ophthalmic diagnoses may have a possible mood disorder (3).

Psychological and eye disturbances are, without a doubt, frequently noticed together. Some of them are so striking that special psychiatric states have been discussed and hypothesized. The best example is keratoconus personality, which is still under debate and has not yet been confirmed and a separate entity (4).

Dry eye disease (DED) is one of the most rapidly increasing eye health problems which affects one-third of the general population (5) and has been frequently associated with a variety of psychological factors in the last decade (6-18).

Screening diagnostic procedures reveal that only 22.7% of therapy-resistant patients with dry eye are not diagnosed with symptoms of psychological disorders (19). Dry eye symptoms were more closely associated with psychological symptoms and non-ocular pain than with objective tear film parameters (6). Shimura, Shimazaki, and Tsubota, (20) compared the self-reported symptoms of DED between positively and negatively diagnosed groups in a large sample. Every positively diagnosed person reported at least some of the symptoms, but only 14% of the negatively diagnosed had no symptoms at all. Almost the same symptoms were listed as the top five most

negativno dijagnosticiranih bilo bez simptoma uopće. Gotovo isti simptomi navedeni su kao pet najčešćih u obje skupine s time da je umor očiju bio na prvom mjestu (kod 80 % pozitivno i 42 % negativno dijagnosticiranih). Svi ovi rezultati upućuju na drugačije uzroke očnih problema koji nadilaze patofiziologiju oka, a neki od njih mogli bi biti i psihološki.

SSO sasvim sigurno nije jedini problem oka povezan sa psihičkim problemima. Različite vrste problema vida i oka mogu uzrokovati psihijatrijske simptome. Neki od njih su prilično neočekivani, poput velikog postotka poremećaja spavanja (37,4 %) kod pacijenata s različitim očnim problemima (3). Međutim, čini se da je SSO ipak najčešće u komorbiditetu s psihološkim smetnjama i najbolje je istražen. Ovaj pregled će se stoga najviše usredotočiti na SSO zbog njegove relevantnosti za psihičke simptome, ali će se baviti i nekim drugim mogućim problemima oka i vida u vezi s psihičkim smetnjama.

SVRHA

Ovaj rad daje pregled empirijskih dokaza iz dostupne literature o povezanosti problema oka i vida s psihičkim poremećajima.

Posebni cilj ovog pregleda je povećati osviješćenost o mogućim značenjima i utjecaju očnih simptoma i oštećenja vida na psihijatrijska stanja, psihičke simptome i opću kvalitetu života. Drugi cilj je predočiti znanstvene dokaze da se psihološke karakteristike i psihijatrijska stanja mogu razmatrati i kao mogući uzroci problema oka i vida. Oba cilja bi trebala naglasiti važnost bavljenja s ovim simptomima holističkim pristupom tretmanu pacijenata.

Shizofrenija

Neke od očnih smetnji kod pacijenata sa shizofrenijom, poput abnormalnog treptanja i pokreta očiju, dugo vremena su poznate u

frequent in both groups, with eye fatigue in the first place (80% of positively diagnosed and 42% of the negatively diagnosed group). These results suggest the existence different causes of ocular problems other than eye pathophysiology, some of which may be psychological.

DED is certainly not the only eye problem associated with psychological problems. Different kinds of visual and eye problems can lead to psychiatric symptoms. Some of them are quite unexpected, like a surprisingly large percentage of sleep disturbances (37.4 %) in patients with different eye problems (3). However, DED appears to be the most common comorbidity with psychological disturbances and has been most widely studied. That is why this review will mostly focus on DED and its relevance to psychological symptoms but will also address some other possible eye and vision problems associated with psychological disturbances.

PURPOSE

This paper provides a review of empirical evidence from available literature about associations between eye and vision problems and psychological disturbances.

A special goal of this review is to raise awareness of the possible causes and impacts of eye symptoms and vision impairments on psychiatric states, psychological symptoms, and general quality of life. Another goal is to present the scientific evidence that psychological characteristics and psychiatric conditions can also be considered as the possible cause of eye and vision-related problems. Both goals should emphasize the importance of dealing with these symptoms in a holistic approach to the treatment of patients.

Schizophrenia

Some of the ocular disturbances in patients with schizophrenia, like abnormal blinking and eye movements, have been known in psy-

psihijatriji i mogu se povezati s različitim fazama bolesti. Akutna pogoršanja u shizofreniji povezana su sa smanjenim treptanjem, kod kronične shizofrenije zbog mirovanja simptoma treptanje je kontinuirano u porastu, a zog psihotičnih epizoda javlja se naglo i napadno brzo, ritmično treptanje (21).

Zurenje ili izbjegavanje kontakta očima može se javiti zbog perceptivnih promjena kod pacijenata koji nisu pod terapijom lijekovima (21).

Još od prvih prepoznavanja shizofrenije kao psihijatrijskog poremećaja, poznato je da shizofrenija značajno mijenja vidnu percepciju i kogniciju (22). Mehanizme ovih odstupanja često je teško razdvojiti. Pacijenti sa shizofrenijom često doživljavaju perceptivne anomalije, koje nisu isto što i halucinacije i slični pozitivni psihotični simptomi poput povećanja kontrastne osjetljivosti koja se javlja i kod tek dijagnosticiranih i neliječenih pacijenata (23), ali i kod pacijenata liječenih psihofarmacima (24). Pojedini istraživači navode i odstupanja u perceptivnom procesiranju kontekstualnih efekata (25), pokreta (26) i boja (27).

Silverstein i Rosen (27) su razmatranjem različitih poremećaje vidne percepcije u shizofreniji donijeli nekoliko glavnih zaključaka. Višestruke strukturne i fiziološke promjene u očima izravno su povezane sa shizofrenijom, lijekovima ili pak komorbiditetom s drugim medicinskim stanjima. Ekscesivne i smanjene dopaminske aktivnosti u mozgu pacijenata sa shizofrenijom mogu se također pojaviti i u njihovim mrežnicama i tako imati značajnu ulogu u smetnjama vizualne obrade. Promjene u retinalnoj strukturi i funkciji mogu poslužiti kao biomarkeri shizofrenije. Mnoštvo naprednih dijagnostičkih metoda i tehnika u oftalmologiji, poput optičke koherencijske tomografije (OCT), elektroretinografije (ERG) ili digitalnog snimanja mrežnice, može dati nalaze upotrebljive kao neizravne mjere kognitivnog funkcioniranja i oštećenja, te razvoja bolesti. Još jedan klinički znak, disfunkcija pokreta očiju (EMD),

chiatry for a long time and can be associated with the different stages of illness. Acute exacerbations of schizophrenia are associated with a decrease of blinking, whereas in chronic schizophrenia with resting symptoms blinking continuously increases, and sudden and rapid rhythmical blinking occurs during the psychotic episodes (21).

Staring or avoiding eye contact may occur due to perceptual change in unmedicated patients with schizophrenia (21).

Since the first recognition of schizophrenia as a psychiatric disorder, it has been well-known that schizophrenia significantly alters visual perception and cognition (22). Mechanisms of these alterations are often difficult to separate. Patients with schizophrenia often experience perceptual anomalies different from hallucinations and other positive psychotic symptoms such as an increase in contrast sensitivity which occurs in both unmedicated newly diagnosed (23) and medicated patients (24). Researchers also reported aberrations in contextual effects (25), abnormal motion processing (26), and color processing (27).

Silverstein and Rosen (27) considered different visual perception disturbances in schizophrenia and reached a few major conclusions. Multiple structural and physiological changes in the eyes are directly related to schizophrenia, medication, or comorbidity with other medical conditions. Dopamine activity excesses and reductions in the brain of patients with schizophrenia are also likely to occur in their retinas and thus play a significant role in visual processing disturbances. Changes in retinal structure and functions can serve as biomarkers of schizophrenia. Many advanced diagnostic methods and techniques in ophthalmology like optical coherence tomography (OCT), electroretinography (ERG), or digital retinal imaging can provide results useful as indirect measures of cognitive functioning and impairment and disease development. Another clinical sign, eye movement

pod određenim metodološkim uvjetima može poslužiti kao biološki marker za shizofreniju s obzirom da je velika prevalencija te disfunkcije prisutna kod bolesnika sa shizofrenijom i njihovih srodnika prvog stupnja (28).

Mnoge studije izvještavaju o pogoršanju finih pokreta očnog pretraživanja kod pacijenta sa shizofrenijom (21,29) koje može poslužiti čak i kao genetički marker shizofrenije (30). Ljudi sa shizofrenijom u odnosu na ostale pokazuju i različiti glabelarni refleks. Na glabelarno tapkanje treptaji izostaju i javljaju se u paroksizmalnim naletima ili pak izostaje habituacija refleksa, ovisno o fazi poremećaja (21,31).

Psihološko testiranje otkriva povećanu razinu shizofrenih simptoma kod muškaraca i žena s keratokonusom u usporedbi s kontrolnom skupinom bez keratokonusa (32). Pacijenti s keratokonusom na glasu su da slabo poštuju stručnjake za zdravlje oka, odbijaju suradnju i ne pridržavaju se plana liječenja, te se prije svega u terminima ličnosti često opisuju kao neobični (33).

Koliko je poznato, nema istraživanja koja su ispitivala vezu između SSO-a i shizofrenije. Osim što ima određenih neizravnih zapažanja da infracrvena skleralna refleksija (IR), dijagnostička tehnika za detekciju EMD u shizofreniji, može izazvati iritaciju i sušenje oka i time rezultirati povećanom frekvencijom treptanja (28).

Imajući u vidu određenu patologiju oka specijalisti za zdravlje očiju mogu identificiranjem dostupnih kliničkih znakova imati važnu ulogu u ranoj dijagnostici shizofrenije i slične psihopatologije, a pravilnom njegom očiju mogu se ublažiti neke perceptivne anomalije i posljedično poboljšati kvaliteta života psihijatrijskih pacijenata.

Depresija

Problemi oka ili vida mogu uzrokovati reaktivnu depresiju. Većina starijih slabovidnih pacijenata zadovoljava kriterije za veliki depresivni

dysfunction (EMD), may serve as a biological marker for schizophrenia under certain methodological conditions since a high prevalence of it is present in patients with schizophrenia and their first-degree relatives (28).

Many studies have reported impaired smooth pursuit eye movements in patients with schizophrenia (21,29) which can even serve as a genetic marker of schizophrenia (30). People with schizophrenia also display different glabellar reflex than others. Blinking in response to glabellar tapping is either absent, occurs in the paroxysmal bursts, or fails to habituate depending on the phase of the disorder (21,31).

Psychological testing revealed increased levels of schizophrenia in patients with keratoconus, both in women and men, compared with controls without keratoconus (32). Keratoconus patients are known to be less respectful of eye care providers, uncooperative, and noncompliant with treatment plans, and above all are often described as unusual in terms of personality (33).

To the best of our knowledge, there have been no studies that examined the association between DED and schizophrenia. There were only some indirect observations that infrared scleral reflection (IR), a diagnostic technique for detection of EMD in schizophrenia, can irritate and dry eyes and thus result in increased blinking frequency (28).

With a certain eye pathology in mind, eye care specialists may play an important role in early diagnosis of schizophrenia and similar psychopathology by identifying available clinical signs, and proper eye care might mitigate some altered perceptual symptoms and consequently improve the quality of life of psychiatric patients.

Depression

Eye or vision problems may cause a reactive depression. Most older patients with low vision meet the criteria for major depression (34). Older adult male patients with vision impair-

poremećaj (34). Stariji odrasli muški pacijenti s oštećenjima vida posebno su rizični (35). Pacijenti s glaukomom pokazuju najteže depresivne simptome (3), a depresija je prisutna i kod pacijenata s keratokonusom (36).

Stariji pacijenti s kataraktom, najčešćim uzrokom oštećenja vida, često su skloni depresiji. Za očekivati je da operacija katarakta može smanjiti simptome depresije. Međutim, kirurški zahvat ne smanjuje depresiju kod tih pacijenata (37). Drugi rezultati pokazuju da depresija povezana s oštrinom vida kod katarakte ovisi samo o ishodu operacije. Ako rezultira poboljšanjem oštrine vida, depresija se smanjuje, a ako se oštrina vida pogoršava, pogoršava se i depresija (38).

Uzevši ove rezultate u obzir možemo razmotriti nekoliko mogućih zaključaka o povezanosti depresije i katarakte: 1) koegzistiraju zbog još nepoznatih čimbenika; 2) moguće je da katarakta nema uzročne učinke na depresiju, ali da percepcija mogućeg oštećenja vida ima; 3) katarakta se razvija sporo, pa je moguće da su promjene u oštrine vida suviše postupne da bi izazvale naglu pojavu depresivnih simptoma.

Blaži problemi oka također mogu rezultirati depresivnim simptomima. SSO, osobito s čestim zamućenjem vida, povezan je sa simptomima depresije (39), jer nestabilnost suznog filma tipična za suho oko može izazvati optičke aberacije. Stanje suhog oka uključuje promjene u funkciji i sastavu suza te pogoršava kvalitetu i performanse vida što može dovesti do depresije (14). Općenito, SSO je često povezivan s depresijom, što je dobro potvrđeno na različitim uzorcima (3,6,11,14-18,35,39-43) uključujući i velike (44,45). Neki od rezultata čak pokazuju da je SSO dominantno povezan s porastom simptoma depresije u usporedbi s različitim poremećajima oka (9).

Unatoč prevladavajućim dokazima da su problemi oka poput oštećenja vida mogući uzrok reaktivne depresije, postoje dokazi da je mo-

ment are particularly at risk (35). Patients with glaucoma reach the highest scores in depression (3). Depression is also present in keratoconus patients (36).

Older patients with cataracts, the most frequent cause of vision impairment, are often prone to depression. It is reasonable to expect that cataract surgery may decrease depressive symptoms. However, the surgery does not reduce depression in those patients according to one study (37). Other results found that depression related to visual acuity in cataract cases depends only on the outcome of the surgery. If it results in improvement of visual acuity, depression decreases, and if the visual acuity worsens so does depression (38).

Looking at these results, we can consider few conclusions about the relation between depression and cataracts: 1) They coexist due to yet unknown factors; 2) it is possible that cataracts have no causal effects on depression, but the perception of possible impairment does, and 3) given the fact that cataracts are developing slowly, it is possible that the changes in visual acuity are too gradual to cause rapid expression of depressive symptoms.

Even milder eye problems may result in depressive symptoms. DED, especially with a high frequency of visual blurring, is associated with symptoms of depression (39). Visual bluring is due to tear instability typical for dry eye conditions which can induce the optical aberrations. The dry eye condition includes tear-related changes and worsens visual performance and quality that may lead to depression (14). Generally, DED is quite often associated with depression as has been well-confirmed in many different samples (3,6,11,14-18,35,39-43) as well as in very large ones (44, 45). Some results even indicate that DED is also dominantly associated with an increase of depression symptoms in comparison with different ocular disorders (9).

Despite prevailing evidence that eye problems like vision impairment are a possible cause of reactive depression, there is also empirical

guće i suprotno. Sklonost depresiji može uzrokovati da se problemi vida percipiraju lošijima nego što realno jesu ili čak uzrokovati takve probleme. Teško depresivni pacijenti skloni su percipirati okolinu mračnijom u usporedbi s umjereno i blago depresivnim pacijentima (46). Imaju i smanjenu osjetljivost subjektivne percepcije kontrasta koja bi mogla biti posljedica promjena dopaminergičke aktivnosti u mozgu (47). Ove perceptivne promjene mogu se objektivno mjeriti u očima i na taj način poslužiti kao biološki biljezi depresije, iako njihova uzročna priroda još nije sasvim poznata (48).

Prilično neočekivano, rizik od pojave depresivnih simptoma ne povećava se smanjenjem oštrine vida, nego sa subjektivnom percepcijom vizualne disfunkcije (35). Kada je u pitanju SSO, depresija može povećati osjetljivost na percepciju simptoma suhog oka (49). Povišeni simptomi depresije prisutni su zajedno s jasno subjektivnim simptomima suhog oka poput zamućenja vida, ali ne i s objektivnim rezultatima testova za suho oko (39). Slični rezultati pronađeni su i u drugim istraživanjima (35,40,41). Dio rezultata ukazuje da neliječeni, novo-dijagnosticirani pacijenti s depresijom ne pokazuju depresivne i anksiozne rezultate psihološkog testiranja u značajnoj vezi sa samoprocjenom simptoma suhog oka (50), ali ti rezultati još nisu replicirani.

Za sada nije jasno jesu li ozbiljni simptomi SSO-a mogući uzrok depresije kod postojanja kronične boli i negativnog učinka na svakodnevne aktivnosti, ili depresija i primijenjeni lijekovi uzrokuju SSO, ili je pak neki drugi faktor uzrok simptoma oba poremećaja (41), što je i moguće jer imaju iste rizične čimbenike (49).

Dodatna potvrda da depresija može uzročno djelovati na oko, barem u slučaju SSO-a je činjenica da kronična depresija može pospješiti proizvodnju protuupalnih citokina i tako pogoršati simptome SSO-a (49). Galor i dr. su predložili da je povezanost između DED i depresije i PT-

support that the relationship may be in the other direction. Tendency to depression may cause visual problems to be perceived as worse than they really are or even be the cause of it. Severely depressed patients are more likely to perceive their ambient environment dimmer than usual in comparison with moderately and mildly depressed patients (46). They also experience reduced sensitivity of subjective contrast perception which might be due to altered dopaminergic neurotransmission (47). These perceptual alterations can be measured objectively in the eyes and thus provide measurable markers of depression, but the causal nature of this phenomenon is still unknown (48).

Rather unexpectedly, risk of having depressive symptoms does not increase with a decrease in visual acuity, but rather with the subjective perception of visual dysfunction (35). In the case of DED, depression can increase sensitivity to the perception of dry eye symptoms (49). Increased depression symptoms are present together with clearly subjective dry eye symptoms like blurring, but not with the dry eye objective test results (39). Similar results were found in other studies (35,40,41).

There are also results suggesting that unmedicated, newly-diagnosed depressive patients show no significantly correlated depression and anxiety based on test results with self-reported dry eye symptoms (50), but they have not yet been replicated.

It is not yet clear whether severe DED symptoms are a possible cause of depression through chronic pain and negative impact on daily activities, or if depression and its medication causes DED, or if some other factor is causing symptoms of both disorders (41). The latter is possible because they share some same risk factors (49).

Additional corroboration that depression may have a causal effect on the eye, at least in case of DED, lies in the fact that chronic depression can promote the production of proinflammatory cytokine and thus worsen DED symptoms (49).

SP-a možda uzrokovana sličnom fiziološkom etiologijom ili je nuspojava lijekova korištenih za ove poremećaje (44).

Uz dužan metodološki oprez pri donošenju zaključaka, čini se da istraživanja ukazuju da komorbiditet očnih i vidnih problema sa simptomima depresije funkcionira na najmanje tri načina:

1. depresivni simptomi su reaktivno stanje na teškoće vida, osobito ozbiljnije;
2. depresija kao osobina ili depresivno stanje može utjecati na vidnu percepciju i probleme oka ili barem osobu učiniti osjetljivijom za percepciju očnih simptoma, i
3. oba problema mogu biti uzrokovana nekim trećim čimbenikom ili dijeliti zajedničku etiologiju, vjerojatno povezanu s disbalansom živčanog sustava ili lijekovima.

Anksioznost

Za sada još malobrojni i nesigurni dokazi pokazuju da ozbiljno napredujuća patologija oka poput keratokonusa može biti povezana s anksioznošću. Rezultati psihološkog testiranja pacijenata s keratokonusom pokazali su povećane rezultate psihastenije i osjetljivosti (32). Međutim, keratokonus zahvaća mlađe odrasle osobe i značajno utječe na njihovu kvalitetu života (51,51) što može biti jedan od mogućih uzroka njihovih psiholoških problema s obzirom da to stanje ozbiljno narušava oštrinu vida.

Empirijski dokazi o povezanosti SSO-a i anksioznosti replicirani su i potvrđeni u različitim istraživačkim nacrtima i na različitim uzorcima uključujući i velike (3,8,14,16-19,35,40-45).

Hallak, Tibrewal i Jain ukazivali su da zdravstvena i opća anksioznost i/ili depresija mogu utjecati na razvoj simptoma suhog oka i biti mogući razlozi nesklada između simptoma i znakova SSO-a (41). Szakáts i dr. otkrili su značajno više rezultata u zdravstvenoj anksi-

Galor et al. proposed that the association between DED and depression and PTSD could be caused by similar physiological etiology or as a side-effect of medications for these disorders (44).

With due methodological caution in drawing conclusions, it seems that studies suggest that comorbidity of eye and vision problems with depression symptoms works in at least three ways:

1. Depressive symptoms are a reactive condition to vision difficulties, especially more serious ones.
2. Trait depression or a depressive state can affect visual perception and eye problems or at least make a person more sensitive to the perception of eye symptoms.
3. Both problems may be caused by some third factor or share a common etiology, probably related to neural system disbalance or medication.

Anxiety

There is sporadic and still uncertain evidence that seriously deteriorating eye conditions like keratoconus may be associated with anxiety. The psychological testing results of keratoconus patients showed increased levels of psychasthenia and sensitivity (32). However, keratoconus affects younger adults and significantly affects their quality of life (51,52) which may be one of the possible causes of their psychological problems as the condition worsens their visual acuity.

Empirical evidence of the association of DED and anxiety has been replicated and confirmed in different designs and samples including large ones (3,8,14,16-19,35,40-45).

Hallak, Tibrewal, and Jain suggested that health and general anxiety and/or depression may affect the development of dry eye symptoms and be some of the possible reasons for discordant DED symptoms and signs (41). Szakáts et al. discovered significantly worse scores in health anxiety, depression, and anx-

oznosti, depresiji i anksioznosti u simptomatskoj skupini pacijenata s SSO-om nego u SSO skupini bez simptoma, iako se skupine nisu razlikovale prema rezultatima objektivnih kliničkih testova za SSO (53). Nedavno istraživanje pokazalo je povezanost neurotizma kao osobine ličnosti sa simptomima SSO-a, ali ne i s kliničkim znakovima (8). Navedeni rezultati podržavaju često ustanovljenu neusklađenost između stvarnih znakova i subjektivnih simptoma SSO-a i upućuju da ličnost pacijenta može imati ulogu u percepciji simptoma SSO-a. Može se pretpostaviti da dispozicijske osobine ličnosti moderiraju ili posreduju percepciju očnih simptoma tako da osoba postaje osjetljivija na njih i reaktivno postaje sve zabrinutija očekujući pojavu istih simptoma. Mogući konstrukt ličnosti koji bi se učinkovito uklopio u ovaj model je anksiozna osjetljivost. Reiss i McNally definirali su je kao sklonost strahu od simptoma povezanih s anksioznošću (npr. palpitacije, fiziološko uzbuđenje i sl.) zbog uvjerenja da će se nakon tih simptoma pojaviti neke štetne fizičke, socijalne ili mentalne posljedice (54).

Precizni mehanizmi u podlozi učinaka SSO-a na mentalno zdravlje još nisu poznati, no moguće je da SSO dovodi do neuropatske bolesti koja rezultira kroničnom boli i tako utječe na kvalitetu života što može dovesti do depresije i/ili anksioznosti (13,14).

Uzevši u obzir relevantnost anksioznosti za probleme oka i vida, mogu se oprezno povući neki zaključci, ili radije pretpostavke, kako bi se potakla buduća istraživanja:

1. u usporedbi s depresijom čini se da je anksioznost manje reaktivno stanje na oštećenja vida i probleme oka;
2. anksioznost može, moguće i više od depresije, povećati osjetljivost osobe na probleme oka i vida;
3. neka očna stanja mogu dijeliti etiologiju s anksioznim stanjem ili biti posljedica još neutvrđenog neurofiziološkog stanja.

iety in the symptomatic DED group compared with the asymptomatic group even though both groups were not different according to objective clinical DED tests (53). Recent research showed that neuroticism as a personality trait is associated with the DED symptoms but not with clinical signs (8). All these results support the commonly confirmed discordancy between actual signs and subjective symptoms of DED and suggest that the personality of a patient can play a role in the perception of DED symptoms.

It may be assumed that a constitutional personality trait is moderating or mediating the perception of eye symptoms in such a way that person becomes more sensitive about them and thus reactively becomes more anxious expecting those eye symptoms to occur. Anxiety sensitivity is a possible personality construct that would fit well in this model. Reiss and McNally defined it as a tendency to fear anxiety-related symptoms (e.g. palpitations, physiological arousal, etc.) due to the belief that some harmful physical, social, or mental consequences will occur as a consequence of these symptoms (54).

The precise mechanisms underlying the effects of DED on mental health are yet uncertain, but it is possible that DED results in neuropathic disease, resulting in chronic pain and thus impacting quality-of-life in a way that may result in depression and/or anxiety (13,14).

Considering anxiety in the light of its relevance in eye and vision problems, some conclusions or rather assumptions might be carefully drawn in order to encourage future research:

1. Compared with depression, it seems that anxiety is a less reactive state regarding vision impairment and eye-related problems.
2. Anxiety can, perhaps even more than depression, increase sensitivity to eye and vision problems.
3. Some eye conditions may share common etiology with state anxiety or be a consequence of a yet undetermined neurophysiological state.

Psihološki stres

Razine kortizola, hormonskog korelata psihološkog stresa, više su kod pacijenata s bržom progresijom keratokonusa u usporedbi s pacijentima sa stabilnim keratokonusom i zdravim osobama (55). To znači da stres može na više načina dovesti do keratokonusa i njegovog pogoršanja složenom fiziološkom neravnotežom uzrokovanom velikom koncentracijom kortizola (55). Opet, psihološki stres je najbolje istražen zajedno sa SSO-om (7,14,18,40,43). Međutim, stres se tek usputno i prikladno uključuje u istraživačke nacrte koji su više usredotočeni na depresiju ili anksioznost. Čini se da između tih triju varijabli stres ima najmanji utjecaj na SSO (40). Neki rezultati ukazuju da bi SSO mogao biti učestalo prisutan u stresnim zanimanjima poput bolničara (7) te među ženama (7,43), ali je navedeno još nedostatno za sigurne zaključke. Psihološki stres utječe na aktivnost autonomnog živčanog sustava koji regulira nevoljnu sekreciju suza, stoga je prirodno pretpostaviti da bi stres lako mogao uzrokovati SSO. Budući da pacijenti sa suhim okom koje je otporno na terapiju često imaju anksiozne i depresivne simptome, moguće je da njihovo psihološko stanje utječe na živčani sustav tako da potiskuje suznu žlijezdu od lučenja suza (19). Međutim, autonomna regulacija sekrecije suza nije nimalo jednostavna i očekivana. Pomalo iznenađujuće, suzna žlijezda je anatomski i funkcionalno pretežito inervirana parasimpatičkim živcima (56). Stoga je produkcija suza vjerojatno u funkciji faze oporavka od stresa kako bi se ponovno uspostavila homeostaza očne površine. Tijekom akutnog stresa produkcija i sekrecija suza je inhibirana stoga očna površina isparava, postaje suha i uzrokuje znakove SSO-a. Nakon što neposredni stresor nestane dominantno parasimpatički regulirana aktivnost potiče sekreciju suza kako bi očistile, oporavile, dezinficirale i izliječile očnu površinu. Ipak, autonomni odnos SSA-a sa stresom nije jednostavan i trenutno jasan, jer s druge

Psychological stress

Cortisol, a hormonal correlate of psychological stress, has been found to be higher in patients with higher progression of keratoconus compared with stable keratoconus patients and healthy controls (55). Stress may therefore lead to keratoconus and its progression through a complex physiological disbalance caused by the high concentration of cortisol in more than one way (55).

To reiterate, psychological stress is best investigated together with DED (7,14,18,40,43). However, stress has been included in research designs that focus more on depression or anxiety only sporadically and based on convenience. It seems that among those three variables, stress has the lowest impact on DED (40). Some results suggest that DED might be aggravatedly present in stressful professions like paramedics (7) and amongst women (7,43) but this is still insufficient to reach any certain conclusions.

Psychological stress affects the activity of the autonomic nervous system which regulates involuntary tear secretion, and it is therefore natural to assume that stress could easily cause DED. Because patients with DED resistant to therapy often have anxiety and symptoms of depression, it is possible that their psychological state affects the nervous system to suppress the lacrimal gland from tear secretion (19). However, autonomic regulation of tear secretion is not nearly that simple and predictable. A bit surprisingly, the lacrimal gland is anatomically and functionally predominantly innervated by parasympathetic nerves (56). Thus, tear production is probably a function of the stress recovery phase in order to restore homeostasis of the ocular surface. Tear production and secretion is suppressed during acute stress and consequently ocular surface evaporates, dries off, and causes DED signs. After the immediate stressor disappears, dominantly parasympathetically regulated activity stimulates tear

strane izravni kontakt oka s fizičkim i kemijskim stresorima izaziva trenutno suzenje, te su potrebna daljnja istraživanja.

Nedavno korejsko istraživanje ukazalo je na blisku povezanost psihološkog stresa i SSO-a i predložilo nekoliko plauzibilnih i razumnih objašnjenja (7):

1. pojačani psihološki stres može pojedinca učiniti osjetljivijim i time povećati vjerojatnost da će percipirati okularnu bol kao simptom suhog oka;
2. psihološki stres može povećati sustavnu upalnu aktivnost koja može zahvatiti očnu površinu i izazvati simptome SSO-a;
3. percipirani stres može povećati somatizaciju što može pojačati simptome SSO-a;
4. psihološki stres može rezultirati depresijom za koju je utvrđeno da je rizični čimbenik za SSO;
5. socio-kulturni pritisci mogu dovesti do psihološkog stresa i time do veće prevalencije DED-a u nekim zemljama (uglavnom azijskim).

Svakako ne treba zanemariti način na koji očne bolesti mogu utjecati na socijalne interakcije. Često treptanje, trljanje očiju, upotreba kapi za oči, pretjerano suzenje, svakodnevna nelagoda, česti posjeti oftalmološkim klinikama - sve su to primjeri kako očne bolesti mogu utjecati na ponašanje, socijalne interakcije te smanjiti kvalitetu života i proizvesti određenu količinu psihološkog stresa.

Posttraumatski stresni poremećaj (PTSP)

Još jedan psihijatrijski korelat SSO-a je PTSP i posebno se često pronalazi kod starije i veteranske populacije (6,49,57). Pacijenti s PTSP-om imaju simptome očne površine koji nisu u potpunosti objašnjivi objektivnim kliničkim znakovima i slični su onima kod depresivnih pacijenata (57). Budući da se skupina

secretion to clean, recover, disinfect, and treat the ocular surface. However, the autonomic relation of DED with stress cannot currently be easily understood because, on the other hand, direct eye contact with physical and chemical stressors causes immediate tearing, and thus further studies are needed.

A recent Korean study indicated a close relationship between psychological stress and DED and proposed several plausible and reasonable explanations (7):

1. Increased psychological stress may make an individual more sensitive and likely to perceive ocular pain as a dry eye symptom.
2. Psychological stress can increase systemic inflammatory activity which can affect the ocular surface and result in DED symptoms.
3. Perceived stress can increase somatization which can intensify DED symptoms.
4. Psychological stress can result in depression that has been found to be a risk factor for DED.
5. Possible socio-cultural pressures can lead to psychological stress and thus a larger prevalence of DED in some countries (mostly Asian).

The way that eye diseases may affect social interactions should certainly not be neglected. Frequent blinking, eye-rubbing, eye-drop usage, excessive tearing, daily discomfort, frequent visits to ophthalmic clinics – these are all examples of how eye disease can affect behavior and social interactions as well as decrease the quality of life and produce a certain amount of psychological stress.

Posttraumatic stress disorder (PTSD)

Another psychiatric correlate of DED is PTSD. This is especially common in the elderly and veteran population (6,49,57).

pacijenata s PTSP-om, depresivni pacijenti i kontrolna skupina ne razlikuju u objektivnim znakovima SSO-a, znači da se mogući psihološki čimbenici nalaze u pozadini doživljavanja simptoma. SSO možda dijeli isti patološki mehanizam kao PTSP i depresija, ali može biti i posljedica lijekova koji se koriste za te poremećaje (49). Prema većini istraživanja, čini se da PTSP i depresija imaju sličan učinak na očne simptome, što i nije neobično zbog čestog komorbiditeta koji otežava identifikaciju vjerojatnijeg korelata SSO-a. Kako su istraživanja koja uključuju depresivne sudionike mnogobrojnija, razumno je pretpostaviti da je to ipak depresija. Buduća istraživanja trebala bi uključivati nacrte koji bi omogućili analizu sličnosti i razlika između depresije, stresa i PTSP-a u odnosu na SSO.

Ostali psihički problemi

Od ostalih poteškoća problemi oka i vida (posebno SSO) uglavnom su dovođeni u vezu s vidom povezanom te općom kvalitetom života (12,14) ili sličnim mjerama poput subjektivne sreće (10). Unilateralna oštećenja vida uzrokovana kataraktom imaju mjerljivi učinak na kvalitetu života starijih osoba (1). Zanimljivo je da među različitim oftalmološkim pacijentima najviše pacijenti sa SSO-om imaju problema s kvalitetom spavanja (3). Kvaliteta spavanja povezana je s SSO-om i posebno njegovim simptomima te može biti rizični faktor za SSO (58). S obzirom na činjenicu da je depresija također povezana s poremećajem spavanja (59), potrebno je provesti daljnja istraživanja očito prilično složenog odnosa SSO-a i depresije. Nedavno je čak pronađena i povezanost rizika od suicidalne ideacije s SSO-om (15). Samo nekoliko istraživanja se bavilo bipolarnim poremećajem i SSO-om i rezultati ne otkrivaju mnogo, ali sugeriraju da je SSO kod bipolarnog poremećaja nuspojava lijekova. Pacijenti s bipolarnim poremećajem koji koriste različite stabiliza-

In one study, patients with PTSD experienced ocular surface symptoms that cannot be completely explained by objective clinical signs, and these patients had symptoms with similar expression as depressive patients (57). Since the PTSD and depression groups as well as the control group had no differences in objective DED signs, this may mean that psychological factors underlie the experience of symptoms. DED may share the same pathological mechanism as PTSD and depression but it can also be a consequence of the medication used for these disorders (49).

According to most studies, it seems that PTSD and depression have a similar impact on eye symptoms, which is no surprise due to common comorbidity that makes it harder to identify a more likely correlate of DED. Since the studies involving depression are more numerous, it is reasonable to assume that depression is the one with a correlation to DED. Future studies should include designs that would allow the analysis of similarities and differences between depression, stress, and PTSD in relation to DED.

Other related psychological problems

Among other difficulties, vision and eye problems (particularly DED) have mostly been associated with vision-related and general quality-of-life (12,14) or similar measures like subjective happiness (10). Unilateral visual impairment caused by cataracts has a measurable impact on health-related quality-of-life of elder (1).

Interestingly, among different ophthalmologic patients, patients with DED have the most sleep quality problems (3). Sleep quality is associated with DED and especially its symptoms, and it might be a risk factor for DED (58). Given the fact that depression is also associated with sleep disturbance (59), further investigations of the obviously rather complex relationship between DED and depression should be performed. Recently, even higher risk of suicidal ideation was

tore raspoloženja imaju manje stabilan suzni film od onih koji ne koriste iste lijekove, što znači da su im objektivno bile suše oči (60). Međutim, ovo istraživanje nije uključivalo procjenu subjektivnih simptoma SSO-a za koje se pokazalo da su povezaniji s drugim psihološkim poremećajima. Prema rezultatima psiholoških testiranja pacijenata s SSO-om otpornima na terapiju Nepp je pronašao samo rijetke pojedince s mogućim bipolarnim poremećajem (19).

Očigledno su istraživanja problema oka i vida u kontekstu psihijatrijskih stanja, uz iznimku poremećaja raspoloženja, još su relativno rijetka, ali svakako intrigantna.

Psihijatrijski lijekovi i simptomi povezani s očima

Razumno je pretpostaviti da su lijekovi za psihijatrijska stanja glavni razlog vidnih poteškoća i problema povezanih s očima. Međutim, dokazi u prilog tome su dvosmisleni i nejasni.

Antipsihotici, osobito korišteni s antidepresivima, mogu imati negativne učinke na vidnu funkciju u vizualnom procesiranju kod shizofrenije, a povećavaju i rizik od katarakte (27). Međutim, ove nalaze ne potvrđuju sva istraživanja (61). Unatoč tome preventivni periodički pregledi pacijenata koji su dugo na psihofarmakološkoj terapiji razuman su potez te se preporučuju (62).

Depresivni pacijenti liječeni psihofarmacima, ali i neliječeni, pokazuju značajno smanjenu osjetljivost percepcije subjektivnog kontrasta što znači da je ovo perceptivno odstupanje neovisno o lijekovima (47).

Dugorajno liječenje bipolarnog poremećaja stabilizatorima raspoloženja značajno utječe na stabilnost suznog filma i rezultira suhoćom oka (60). Klinički testovi su dokazali da upotreba antidepresiva može doprijeti znako-

found to be associated with DED (15). Only a few studies dealt with bipolar disorder and DED, and the results were not particularly revealing, but they suggest that DED in bipolar disorder is a side-effect of medication. Medicated bipolar patients using different mood stabilizers have lower stability of tear film than unmedicated patients, meaning that their eyes were objectively dryer (60). However, this study did not include assessment of subjective symptoms of DED which were proved to have more associations with other psychological disturbances. According to psychological test results, Nepp found only rare possible bipolar disorders in patients with therapy-resistant dry eye (19).

Apparently, studies on eye and vision problems in the context of psychiatric conditions other than mood disorders are still relatively rare but intriguing.

Psychiatric medication and eye-related symptoms

A reasonable assumption is that medication for psychiatric conditions is the main reason for visual difficulties and eye-related problems. However, there is ambiguous and unclear evidence in support of this.

Antipsychotics, especially used with antidepressants, can have negative effects on visual function in visual processing in schizophrenia but can also increase the cataract risk (27), although not all studies corroborate these results (61). Nevertheless, preventive periodic eye examinations of patients on long-term medication treatment are recommended and reasonable (62).

Unmedicated and medicated depressive patients showed significantly reduced sensitivity of subjective contrast perception, which means that this perceptual aberration is medication-independent (47).

Long-term mood stabilizer medication for bipolar disorder significantly affects the stability of the tear film and results in eye dryness (60).

vima suhog oka (63,64) i to neovisno o trajanju korištenja antidepresiva (63). Ali ove studije su samo ispitivale kliničke znakove suhog oka i nisu otkrile kako je to povezano s očnim simptomima koje percipiraju pacijenti. Druga studija otkrila je da tek dijagnosticirani i još uvijek neliječeni bolesnici (neki od njih s komorbiditetom anksioznosti) u usporedbi s kontrolnom skupinom imaju teže kliničke znakove SSO-a izmjerene objektivnim testovima, ali nisu različiti prema samoprocijenjenim simptomima suhog oka (50). Međutim, to još uvijek nije sasvim jasno, jer su drugi rezultati potvrdili suprotno (11). Budući da antidepresivi mogu interferirati samo s objektivnim znakovima, a ne i simptomima, može se s oprezom zaključiti da psihološki čimbenik samostalno objašnjava najčešće prijavljene percipirane simptome SSO-a kod depresije. Buduća istraživanja bi trebala potražiti objašnjenje uočenih simptoma suhog oka kod pacijenata s dugom poviješću depresije, mogući utjecaj antidepresiva ili vjerojatnost da se u pozadini simptoma SSO-a nalazi neki drugi psihijatrijski poremećaj ili karakteristika. Kim i sur. su na primjer predložili da SSO simptomi mogu biti simptomi somatizacijskog poremećaja (11).

Preporuke za zbrinjavanje pacijenata

Bez sumnje je da je dobrobit pacijenata najvažnija stručnjacima za zdravlje oka i vida kao i stručnjacima mentalnog zdravlja. Obje skupine u svome radu mogu napredovati od poznavanja komorbiditeta i odnosu između problema oka i vida s psihijatrijskim poremećajima, a to se posebno može odraziti na dobrobit korisnika zdravstvene skrbi. S pozicije zdravstvenog sustava vrijedno je razmotriti moguće smanjenje troškova koje bi točne dijagnoze i adekvatno liječenje pacijenata moglo proizvesti. Mogu se učiniti barem neke praktične i financijski povoljne intervencije:

Clinical tests proved that antidepressant usage can contribute to dry eye signs (63,64) independently of the duration of antidepressant usage (63). But these studies only examined clinical signs of dry eye and did not reveal how this is related to eye symptoms experienced by patients. Another study found that newly-depressed and yet not medicated patients (some of them with comorbid anxiety) had more severe clinical signs of DED compared with the control group measured by objective tests, but there were no differences according to self-reported dry eye symptoms (50). However, these results are not yet fully established because other results showed the opposite (11). Since antidepressants may only interfere with the objective signs and not the symptoms, it can be tentatively concluded that the psychological factors alone mostly explain the perceived subjective symptoms of DED in depression. Future studies would have to explain the perceived dry eye symptoms in patients with a long history of depression, the possible impact of antidepressant medication, and address the probability that some other psychiatric disorder or characteristic underlies the DED symptoms. For example, Kim et al. proposed that DED symptoms might be symptoms of a somatization disorder (11).

Patient management recommendations

Patient well-being is, without a doubt, the primary goal for both eye and vision and mental health experts. In their work, both can benefit from knowledge about comorbidities and relationships between eye problems and psychiatric disorders, and this can be especially beneficial to health-care recipients. From the health system's point of view, it is worth considering a possible reduction of medical expenses that accurate diagnoses and adequate treatment of patients could produce. At least some practical

1. adekvatna obuka stručnjaka za mentalno zdravlje i zdravlje oka o komorbidnim psihijatrijskim i očnim simptomima;
2. uvođenje kratkih trijažnih testova za oči u psihijatrijskoj praksi, odnosno za psihičke simptome u oftalmološkoj praksi;
3. uzajamni konzultativni rad oftalmologa i psihijatara;
4. poboljšanje rehabilitacijskih i tretmantskih pristupa.

Trening stručnjaka za mentalno zdravlje i zdravlje očiju prvi je korak u boljem prepoznavanju koreliranih simptoma u obje prakse. Neki se faktori rizika depresije povezani s oštećenjem vida mogu lako prepoznati u primarnoj zdravstvenoj zaštiti i općim bolnicama te pravilno uputiti stručnjaku i na taj način omogućiti bolji oporavak i prognozu obih stanja ili barem poboljšati kvalitetu života pacijenta (35). Rees i sur. pokazali su da su stručnjaci za očno zdravlje postaju sigurniji i skloniji da reagiraju na depresiju kod pacijenata s oštećenjem vida zahvaljući provedbi jednostavnog i kratkog usavršavanja koje se sastojalo od razumijevanja depresije, detekcije depresivnih simptoma, te razvoja i primjene načina upućivanja pacijenata (2). Osviještenost i znanje o učincima antidepresiva na suho oko može omogućiti oftalmolozima, optometristima i drugim liječnicima da bolje zbrinu pacijente s SSO-om (63).

Trijažni testovi su obično jeftini, laki za primjenu i posebno vrijedni u prevencijskoj medicini. Simptomi suhog oka mogu biti prvi ulaz u medicinsku skrb za pacijente kojima još nije dijagnosticirana depresija ili anksioznost (45). Analogno tome, osviješćenost o mogućoj povezanosti SSO-a i depresije može pomoći stručnjacima očnog zdravlja da učinkovito usmjere potencijalne psihijatrijske bolesnike koji su u zdravstveni sustav ušli prvo u u službe za zdravlje očiju (14). Pacijente s psihijatrijskim dijagnozama potrebno je pitati o simptomima suhog oka i, ako se pokaže nužnim, upu-

and inexpensive interventions could be introduced:

1. Proper training of mental health and eye health professionals about comorbid psychiatric and eye symptoms.
2. Mutual introduction of short screening tests for eye and psychological problems in both practices respectively.
3. Consultations between both practices.
4. Rehabilitation and treatment strategies.

Training of mental health and eye health professionals is the first step in better recognition of the correlating symptoms in both practices. Some depression risk factors associated with vision impairment can be easily recognized in primary health care and general hospitals and properly referred to a specialist, thus enabling better recovery and prognosis of both conditions or at least improving the patient's quality of life (35). Rees et al. demonstrated that simple and short training of eye health professionals consisting of understanding depression, detecting depressive symptoms, and developing and implementing the referral pathway made them more confident and likely to respond to depression in their patients with vision impairment (2). Awareness and knowledge about the effects of antidepressant medication on dry eye disease can enable ophthalmologists, optometrists, and other physicians to better manage patients with DED (63).

Screening tests are usually inexpensive, easy to administer, and especially valuable in preventive medicine. Dry eye symptoms may be the first entrance into medical care for patients with undiagnosed depression or anxiety (45). By analogy, awareness of a possible association between DED and depression may help eye-care professionals to efficiently refer possible psychiatric patients first admitted in eye care services (14). Patients diagnosed with psychiatric conditions should be asked about

titi stručnjaku za zdravlje očiju bez obzira na uzrok (44). Na primjer, na jednostavan način može se primijeniti kratak, ali često korišten, Indeks bolesti očne površine (engl. *Ocular surface disease index©*, OSDI©) (65,66) koji se pokazao solidno pouzdanim i valjanim (67). Također, stručnjaci za očno zdravlje mogu jednostavno do neke mjere primijeniti određene trijažne postupke kako bi identificirali pacijente s rizikom za psihijatrijska stanja i adekvatno ih usmjerili. Na primjer, rizični faktori za depresiju povezanu s oštećenjem vida mogu se lako identificirati sa samo dva jednostavna pitanja (35).

Konzultacije i timski rad dobro su utvrđene prakse u medicini, ali u ovom slučaju mogu se dodatno naglasiti. Vjerojatno bi se većina liječnika upoznatih s problemima o kojima je riječ u ovom radu složila da je tijesna suradnja očnih i psihijatrijskih odjela ili klinika u medicinskim ustanovama ključna. Kako bi se pacijentima očnih klinika s psihijatrijskim simptomima pružila bolja zdravstvena zaštita, preporučuju se izravne konzultacije s psihijatrijskim službama (3) uz naglasak da bi takva praksa trebala biti obostrana.

Iako bi se psihološka stanja tek u budućnosti mogla pokazati uzrokom nekih problema oka, trebalo bi istovremeno primijeniti adekvatnu medicinsku skrb oka zajedno s psihijatrijskim ili psihoterapijskim tretmanom kako bi se pacijentu osigurala najbolja moguća kvaliteta života koja će mu omogućiti da se osjeća bolje i lakše nosi sa svojim mentalnim stanjem.

Zbrinjavanje psiholoških simptomima kod pacijenta s oštećenjem vida može biti izrazito važno i učinkovito u njihovoj rehabilitaciji, jer se vidno oštećenje može percipirati lošijim nego što jest (68). I posljednje, ali ne i najmanje bitno, pacijenti s nepovratnim i ozbiljnim gubitkom vida svakako trebaju svu moguću podršku i skrb o njihovim reaktivnim psihičkim stanjima što ima veliko značenje za njihovu prilagodbu.

dry eye symptoms and, if necessary, referred to eye care professionals whatever the cause may be (44). For example, the widely used Ocular Surface Disease Index© (65,66) is a short questionnaire that can be easily applied and has proven itself to be of decent reliability and validity (67). Furthermore, eye care professionals could easily apply some screening procedures to identify patients with a risk of psychiatric conditions and to refer them to proper care. For example, risk factors for depression associated with vision impairment can be easily identified with only two simple screening questions (35).

Consultation and teamwork are well-established practices in medicine, but they can be additionally emphasized on this issue. It is likely that most of the practitioners familiar with the problems discussed in this paper would agree that close cooperation of eye and psychiatric departments or clinics in medical institutions is crucial. Direct consultations with psychiatry services are recommended in order to provide better health care for the eye clinic patients with psychiatric symptoms (3). However, this practice should be mutual.

Even though psychological conditions could prove to be a cause of some eye problems in the future, proper eye care should be applied together with psychiatric or psychotherapeutic treatment in order to assure the best possible quality-of-life, which in return will make the patients feel better and cope with their mental condition more easily.

Addressing the psychological symptoms in patients with visual impairments can be extremely important and effective in their rehabilitation since visual disability may be perceived as worse than it is (68). Last but not least, patients with irreversible and serious vision loss certainly need all possible support in dealing with their reactive psychological conditions is of significant importance to their adaptation.

ZAKLJUČNA RAZMATRANJA

Problemi s vidom i patologija oka često su u komorbiditetu s psihijatrijskim stanjima ili barem s psihološkim problemima. Na temelju brojnih istraživanja, problemi oka i vida, osobito blaže prirode, najviše su povezani s poremećajima raspoloženja, posebno depresijom, anksioznošću i PTSP-om, a rjeđe s psihološkim stresom i drugim stanjima. Ozbiljnija patologija oka, koja rezultira značajnim gubitkom oštrine vida, povećava rizik za reaktivnu depresiju. Manje istraživanja pokazuje da određeni psihotični poremećaji mijenjaju vidnu percepciju strukturno i fiziološki utječući ne samo na mozak, već i na mrežnicu oka.

Prema predloženim objašnjenjima u literaturi, veza između problema oka i vida s psihijatrijskim problemima funkcionira na nekoliko načina:

1. psihijatrijska stanja mogu biti reaktivna na probleme s očima i vidom;
2. problemi oka i vida mogu uzrokovati psihičke smetnje;
3. moguće je postojanje osobina ličnosti koje mogu moderirati ili posredovati u percepciji problema oka i vida;
4. obje skupine problema mogu dijeliti barem djelomično zajedničke faktore rizika, etiologiju i patofiziologiju;
5. psihijatrijski lijekovi mogu utjecati na stanje oka i vizualnu percepciju.

Razni i brojni nalazi ukazuju da svaki od razmatranih zdravstvenih problema u ovom radu može biti barem djelomično uzročan, ali i posljedičan čimbenik, ili mogu istovremeno koegzistirati ili biti posljedica nekih vanjskih čimbenika, poput medikacije. Ipak, potrebno je provesti mnogo više istraživanja kako bi se te veze preciznije istražile. Neke od smjernica za buduća istraživanja koja najviše obećavaju su identifikacija osobina ili osobine ličnosti koje doprinosi osjetljivosti na probleme s očima i vidom te identifikacija neuropatskog

CONCLUDING CONSIDERATIONS

Vision problems and eye pathology are often comorbid with psychiatric conditions or at least with psychological problems.

Based on numerous studies, eye and vision problems, particularly of milder nature, are mostly associated with mood disorders, especially depression, anxiety, and PTSD, and less with psychological stress and other conditions. More serious eye conditions resulting in a significant loss of visual acuity increase the risk of reactive depression. Fewer studies indicate that some psychotic disorders alter the visual perception structurally and physiologically by affecting not only the brain but the retina as well.

According to proposed explanations in the literature, the relationship between eye and vision problems and psychiatric problems works in several ways:

1. Psychiatric conditions can be a reactive state as a result of eye and vision problems.
2. Eye and vision problems can cause psychological disturbances.
3. There may be personality traits that can moderate or mediate the perception of eye and vision problems.
4. Both groups of problems may at least partially share common risk factors, etiology, and pathophysiology.
5. Psychiatric medication can affect eye conditions and visual perception.

As presented in this paper, various and numerous findings suggest that both eye and vision problems and psychiatric conditions can be at least partially a causal and consequential factor, or can coexist at the same time, or can be the consequence of some other external factors such as medication therapy. However, much more research is needed to investigate these links more closely. Some most promising directions for future research are the identification of a personality trait or traits that contribute

mehanizma koji bi mogao biti zajednička osnova nekim psihičkim i očnim problemima. Najnovije istraživanje ukazuje na alternativnu ideju da osobinski koncept ličnosti anksiozna osjetljivost povećava tendenciju zamjećivanja i doživljavanja simptoma SSO-a, jer objašnjava više varijance nego kumulativna mjera stresa, depresije i anksioznosti (69). Bez obzira na temeljne uzroke koji stoje iza ovog odnosa, problemima oka i vida psihijatrijskih pacijenata treba se baviti, jer ispravan i sveobuhvatan tretman može poboljšati njihovo stanje, a vjerojatno i prognozu bolesti. Vrijedi i obrnuto, prepoznavanje psihičkih simptoma i mogućih psihijatrijskih problema u kontaktu s pacijentima koji se primarno javljaju u očne klinike zbog problema oka ili vida može biti prvi ulaz pacijenta u sustav psihijatrijske skrbi. Također, uporaba suvremene dijagnostičke oftalmološke opreme koja može otkriti neke biološke biljege psihijatrijskih poremećaja može biti od izrazite vrijednosti u dijagnostičkim postupcima.

to sensitivity to eye and vision problems and the identification of a neuropathic mechanism that could be a common basis for some psychological and eye problems. Most recent research suggested an alternative idea: that the anxiety sensitivity trait increases the tendency to detect and experience DED symptoms, as it explains more variance than the cumulative measure of stress, depression, and anxiety (69).

Regardless of the underlying causes behind this relationship, eye and vision problems need to be addressed in psychiatric patients, as correct and comprehensive treatment can improve their condition and probably also their prognosis. Conversely, recognizing the psychological symptoms and possible psychiatric problems in contact with patients who initially present to eye clinics due to vision or eye problems may be the first entry to psychiatric care. Furthermore, the use of modern diagnostic ophthalmologic equipment that can detect some biological markers of psychiatric disorders can be of exceptional value in diagnostic procedures.

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Grupna terapija za psihoze

/ Group Therapy for Psychoses

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U knjizi *Grupna terapija za psihoze* 38 autora iznosi svoja praktična iskustva i teorijske pretpostavke o grupnoj terapiji pacijenata s psihotičnim iskustvima. Posebnu vrijednost knjige vidimo u tome da autori prikazuju svoja iskustva iz grupnih liječenja psihotičnih bolesnika što je bilo moguće, jer se u praksi bave tim oblikom liječenja. Svi autori imaju i adekvatnu edukaciju iz raznih grupnih psihoterapijskih pravaca. Prikazi koji se oslanjaju na vlastito praktično iskustvo, a ne temelje se samo na teorijskim pretpostavkama, koje se mogu znatno razlikovati ovisno o temeljnoj izobrazbi iz psihoterapije, dobivaju na autentičnosti. S druge strane, praktična iskustva ukazuju na zajedničke temelje svih uspješnih metoda liječenja, bez obzira na teorijske pretpostavke.

Svim autorima je zajedničko da se terapije odvijaju u grupnom okviru, da uključuju psihotične bolesnike i prikazuju pozitivne učinke grupnog terapijskog okvira za te bolesnike. Grupa kao terapijski medij ima svoje specifičnosti. U grupi su prije svega prisutni drugi ljudi koje nije moguće isključiti iz doživljaja ukupne grupne situacije, bez obzira na obrambene manevre koji su kod psihotičnih osoba intenzivni. Neki spominju i moguće negativne učinke grupnog terapijskog okvira i potrebu modifikacije tera-

In the book *Group Therapy for Psychoses*, 38 authors present their practical experiences and theoretical assumptions on group therapy for patients with psychotic experiences. The book is especially valuable because the authors describe their own experiences in group therapy for patients with psychoses, as they use this form of treatment in practice. All the authors are also appropriately educated in the various approaches to group psychotherapy. Reports that rely on the author's personal experience provide greater authenticity compared with those based on pure theoretical assumptions that can significantly differ depending on the author's original education in psychotherapy. On the other hand, practical experiences point to the shared foundations of all successful treatment methods, regardless of the theoretical assumptions.

All the authors in the book share the following commonalities in their reports: the therapy takes place in a group setting, it includes patients with psychoses, and it describes the positive effect of the group therapy setting on these patients. There are some particularities to group therapy as a therapeutic medium. Firstly, other people are present in the group and cannot be excluded from the perception of the group setting as a whole regardless of the defensive maneuvers that are so intensive in psy-

pijskih metoda koje nisu primjerene za psihotične bolesnike, a mogu biti metoda izbora kod drugih bolesnika.

Knjiga ima 20 poglavlja, koja su podijeljena u dva dijela. U knjizi je 38 autora prikazalo svoja iskustva. U prvom dijelu knjige prikazan je pregled grupnih psihoterapija za pacijente s psihotičnim poremećajima, a u drugom su prikazani različiti pristupi u različitim situacijama liječenja psihotičnih pacijenata.

Već po opsegu materijala koji knjiga pokriva jasno je da u ograničenom okviru od 194 stranice nije bilo moguće iscrpno prikazati velik broj grupnih psihoterapija za psihotične pacijente, kao ni detaljniji prikaz tehnike u različitim pristupima njihovog grupnog liječenja. Ono što je bilo moguće, je i ostvareno: čitalac dobiva dosta informacija o grupnim psihoterapijama i neke detalje iz raznih tehnika, a ako bude zaintrigiran, može potražiti podrobnije informacije u navedenim referencama.

Svako poglavlje je interesantno na svoj način. Neka poglavlja će čitaocu biti poticajnija, jer će u njima prepoznati i svoja iskustva i razmišljanja iz terapija i odnosa sa psihotičnim pacijentima, uz proširenje tih spoznaja.

U prvom poglavlju knjige, Povijesni pregled razvoja grupne psihoterapije za pacijente s psihotičnim poremećajima Manuel Gonzales de Chavez opisuje drugačiji trend koji suzbija negativne stavove prema grupnoj psihoterapiji u području psihoza i koji je rezultirao širom primjenom grupnih terapija specifično posvećenima psihotičnim pacijentima. Psihotični doživljaj se može promatrati i kao sanjanje koje se ne dešava u snu nego na javi, u kojem nesvjesni sadržaji dominiraju, a realitet se povlači u drugi plan, te time ukazuje na znatan poremećaj psihičkog funkcioniranja.

U 10. poglavlju Ontologija i fenomenologija sanjanja u psihozi: grupno analitički pristup iz neuropsihijatrijske perspektive, Anastassios Koukis vrlo interesantno ukazuje na psihoana-

chotic persons. Some also mention the potential negative effect of the group therapy setting and the need to modify therapy models that are not appropriate for patients with psychoses but can be the method of choice in other patients.

The book has 20 chapters divided into two parts. Thirty-eight authors share their experiences in the book. The first part of the book contains overviews of group psychotherapy sessions for patients with psychotic disorders, while the second part describes different approaches to different situations in treating patients with psychoses.

Given the scope of the contents covered in the book, it is clear that the limited framework of the 194 pages it contains is not sufficient to provide a exhaustive presentation of the large number of group psychotherapies for patients with psychoses or a detailed description of the techniques employed in different approaches to their group therapy. The book does achieve what is possible given its size, however: the reader receives a significant amount of information on group psychotherapy and some detail from various techniques, and more detailed information can be found in the references if that piques one's interest.

Every chapter is interesting in its own way. Some chapters will be more stimulating to different readers, because they will recognize their own experiences and thoughts on therapy and relationships with patients with psychoses and see those these insights expanded upon.

In the first chapter titled *History of group therapy for patients with psychoses*, Manuel Gonzales de Chavez describes a different trend that allays negative opinions on group psychotherapy in the field of psychoses that resulted in broader application of group therapy specifically directed at patients with psychoses. Psychotic experiences can be viewed as dreams that take place while awake, in which unconscious elements dominate and reality takes a backseat, indicating a significant disorder of psychological functioning.

litičko mišljenje prema kojem oboljeli od psihoze ne uspijevaju sanjati – u snu. Ali oni 'sanjaju' na javi. Grupna terapija im može pomoći da ponovno uspostave svoju sposobnost sanjanja – u snu, a time i smanjuje potrebu psihotičnog doživljaja 'sanjanja na javi'.

Olga Runciman u poglavlju 19. Grupe osoba koje čuju glasove: Samoosnaživanje – 'pokret osoba koje čuju glasove' opisuje radikalno novi pristup i potpuno drugačije gledanje na simptome koji su se tradicionalno povezivali sa shizofrenijom – slušanjem glasova. Radi se o grupama samopomoći u kojima psihotični bolesnici koji čuju glasove pomažu jedni drugima. Runciman navodi da je prema istraživanjima 'najmanje 75 % onih koji čuju glasove imalo neko traumatsko iskustvo povezano s tim glasovima'. U mnogim slučajevima u temelju glasova je disocijacija aspekata selfa zbog traumatskih iskustava. Terapijska integracija slušnih halucinacija u život i self osobe koja čuje te glasove označava integraciju disociranih aspekata selfa koji nemaju drugog načina komunikacije sa svjesnim egom osobe.

Čitanje knjige, možda i više puta, preporučujemo svim čitaocima koje intrigira čudesni i opasni svijet psihoze u kojem je osoba nekontrolirano i brzo suočena s dubokim slojevima psihe, koji izranjaju na vidjelo kako se rastaču mehanizmi obrane koji te slojeve i procese drže pod kontrolom. Psihotično s jedne strane rastače psihu, a s druge time otvara pristup dubokim nesvjesnim sadržajima s kojima oslabljeni ego psihotične osobe uglavnom samostalno, bez pomoći okoline, ne može izići na kraj. Aspekti selfa i traumatski doživljaji koji su odcijepljeni nisu nestali. U psihotičnom doživljaju, kad obrane postanu neučinkovite, imperativno se nameću pacijentu, okupiraju svijest osobe, a svjesni ego je prema njima nemoćan. Bavljenje psihotičnim sadržajima i osobama kod kojih takvi doživljaji privremeno ili trajnije dominiraju njihovim psihičkim funkcioniranjem u grupnom okviru omogućava pacijentima naj-

The 10th chapter is titled *The ontology and phenomenology of dreaming in psychosis: A group-analytic approach with a neuropsychiatric perspective*, in which Anastassios Koukis present a very interesting overview of the psychoanalytical belief that persons suffering from psychosis are incapable of dreaming – while asleep. But they "dream" while awake. Group therapy can help the reestablish their ability to dream while they sleep, thus reducing the need for the psychotic experience of "waking dreams".

In the 19th chapter titled *Voice-hearing groups: Empowering ourselves – The Hearing Voices Movement*, Olga Runciman describes a radically new approach and completely different way at looking at symptoms traditionally associated with schizophrenia – hearing voices. The movement consists of self-help groups in which patients which psychosis who hear voices help each other. Runciman states that according to research "at least of 75% of those who hear voices had a traumatic experience related to these voices". In many cases, dissociation of aspects of the self due to a traumatic experience is at the core of the voices. Therapeutic integration of auditory hallucinations into the life and self of the person who hears them marks the integration of the dissociated aspects of the self that have no other way to communicate with the conscious ego of the person.

We recommend reading this book, perhaps even several times, to all those intrigued by the fascinating and dangerous world of psychosis in which a person is rapidly and uncontrollably faced with the deeper layers of the psyche that come to light as the defenses which would normally keep those layers and processes at bay start to dissolve. Psychosis dissolves the psyche on the one hand, but it also opens up access to deep, unconscious content with which the weakened ego of the person with psychosis generally cannot handle without outside help. Aspects of the self and traumatic events that have been suppressed are still present in the unconscious. As mental defenses become ineffective during the psychotic experience, these suppressed con-

prije njihovo lakše podnošenje i toleriranje, a tijekom daljnjeg liječenja barem ograničeno, ako ne i potpuno, integriranje tih doživljaja u self, vraćanje samo kontrole i eventualnu integraciju dijela tih doživljaja u cjelokupnost doživljaja sebe. Time se olakšava i (ponovna) integracija osoba s psihotičnim doživljajima u socijalnu okolinu. Oboljele osobe na taj način rehabilitiraju mogućnost funkcioniranja u 'normalnom' realitetu, odnosno postižu distancu od njihovog subjektivnog psihotičnog realiteta, koji iako može biti u funkciji obrane od nepodnošljive stvarnosti, ipak je nikad u potpunosti ne može nadomjestiti i zamijeniti. Međutim, terapijska okolina mora biti 'dovoljno dobra'. Terapijska grupa uz pridržavanje osnovnih terapijskih postulata grupne psihoterapije, koji su prilagođeni potrebama i mogućnostima psihotičnih pacijenata je takva okolina.

Prva i uobičajena reakcija osobe prema psihotičnom doživljaju pogođene osobe je pokušaj snažnog odbacivanja tog doživljaja, nesvjesnim angažiranjem radikalnih obrana, takozvanih vrlo regresivnih obrana selfa. Stav neprihvaćanja, izbjegavanja, odbacivanja psihotičnog doživljaja se nažalost lako može proširiti i na odbacivanje cijele osobe koja ima psihotične doživljaje ili boluje od psihoze. Takav stav često se manifestira kod samog bolesnika, koji tada odbacuje samog sebe, odnosno gubi nadu u vezi sebe, svoje budućnosti, planova, ostvarenja ciljeva. Negativan društveni stav prema psihotičnom doživljaju može se manifestirati i u pacijentovoj obitelji, na radnom mjestu, u široj društvenoj zajednici. Time je blisko povezana i stigmatizacija psihotičnih pacijenata, pojava koju se nastoji suzbiti, a temelji se na strahu i neznanju. Najbolje suzbijanje stigmatizacije je uklanjanje predrasuda, koje je potrebno zamijeniti stvarnim poznavanjem intimnih proživljavanja psihotičnih osoba, što se postiže u raznim vrstama grupne psihoterapije.

tents of the psyche imperiously impose themselves on the subject, occupying the person's consciousness, and the ego is powerless before them. Addressing the psychotic contents and persons with psychosis in whom these experiences temporarily or more lastingly dominate their psychological functioning using a group setting allows patients to firstly more easily cope and tolerate them, and during the course of the treatment also at least partially if not completely integrate these experiences into the self, returning control and potentially integrating part of these experiences in the experience of the self as a whole. This facilitates (re)integration of persons with psychotic experiences into the social environment. In this way, persons with psychosis rehabilitate their ability to function in "normal" reality, i.e. achieve a distancing from their subjective psychotic reality, which while in the service of defending them from an unbearable reality still cannot ever completely replace it. However, the therapeutic environment must be "good enough". A therapy group with adherence to the basic postulates of group psychotherapy, adapted to the needs and abilities of patients with psychosis, is such an environment.

The initial and common reaction to a psychotic experience manifesting in a person is a strong attempt to reject the experience by unconsciously engaging radical defenses, i.e. so-called very regressive defenses of the self. Unfortunately, the state of denial, avoidance, and rejection of the psychotic experience can easily spread to rejecting the person with the psychotic experience or suffering from psychosis as a whole. This state often manifests in the patient themselves, who then reject themselves, i.e. looses hope in regard to themselves, their future, and achieving their plans and goals. The negative social view of psychotic experiences can also manifest in the patient's family, workplace, or wider social community. The stigmatization of patients with psychosis is also closely related to this and is a phenomenon based on fear and lack of knowledge that should be suppressed. The best way to

Ova knjiga približavanjem svijeta psihotičnih bolesnika suzbija negativan stav i predrasude o njima i ukazuje na velike terapijske potencijale grupnog liječenja psihotičnih bolesnika.

Terapeuti koji uglavnom nemaju osobno iskustvo psihotičnog doživljaja, te ga ne mogu u potpunosti razumjeti, ipak mogu psihoterapijski liječiti psihotične pacijente u grupnom okviru. Oni komunikacijom, interakcijama, boravljenjem i bavljenjem s psihotičnim pacijentima na razne načine upoznaju njihove doživljaje, uvijek s motivom razumijevanja i olakšavanja njihovih patnji. Učesnici grupe, psihotični pacijenti su ustvari pravi poznavaoci, eksperti za psihotične doživljaje drugih učesnika grupe. Oni kod drugih bolesnika lako prepoznaju što je psihotično i što odstupa od realiteta. Možda oni kod sebe neko vrijeme i dalje ne prepoznaju psihotično, ali ga jasno vide kod drugih članova grupe. Na taj način psihotični pacijenti postepeno s pomoću drugih pacijenata prepoznaju psihotično kod sebe, što je opisano u knjizi.

Jedna od osobina psihotičnog doživljaja je izolacija osobe koje je zarobljena tim doživljajem, te postaje nedostupna interakciji s drugim osobama. Psihotična osoba je intenzivno involvirana u unutrašnji svijet psihotičnih proživljavanja te ona privremeno ili dugotrajnije gubi kontakt s vanjskim realitetom. Psihotični doživljaj, koji pacijent ne može prenijeti svojoj socijalnoj okolini, koja takav doživljaj ne može razumjeti, pojačava već prisutan doživljaj izoliranosti, jedinstvenosti, usamljenosti te osobe. Boravljenje u grupi s osobama koje su i same imale takve doživljaje, koji ih kod drugih najbolje mogu prepoznati znatno smanjuje izolaciju i doživljaj trajnog gubitka kontakta i razumijevanja s drugim ljudima, što su bitni elementi patologije psihotičnog doživljaja.

Osnovna ljudska datost je temeljna potreba za povezivanjem s drugim ljudima. Potreba za povezivanjem s drugim ljudima je toliko temeljna da ju svaka uspješna terapija mora uključivati.

suppress stigmatization is to reduce prejudices and replace them with real knowledge of the intimate experiences of the person with psychosis, which can be achieved through different types of group psychotherapy. This book familiarizes the reader with the world of patients with psychosis and thus suppresses negative views and opinions on them, indicating the great therapeutic potential of group treatment for patients with psychosis. Therapists who mostly did not personally go through a psychotic experience and thus cannot completely understand it can still provide psychotherapy for patients with psychosis in a group setting. Using communication, interaction, spending time together, and working with patients with psychosis they can familiarize themselves with their experiences in various ways, always with the motive of understanding and alleviating their suffering. The members of the group, i.e. the patients with psychosis themselves, are the true experts on the psychotic experiences of other participants. They can easily recognize what is psychotic and what deviates from reality in other patients. They may still not recognize the psychotic in themselves for a while yet, but they can see it clearly in other members of the group. In that way patients with psychosis gradually recognize psychotic elements in themselves with the help of other patients, which is described in the book.

One of the characteristics of a psychotic experience is isolation of the person trapped by the event, who therefore becomes unavailable in interactions with others. A psychotic person is intensely involved in their inner world of psychotic experiences and temporarily or lastingly looses contact with the outside reality. Psychotic experiences that the patient cannot transmit to their social environment that cannot comprehend further exacerbates the already present feeling of isolation, uniqueness, and loneliness in the person. Spending time in a group with people who also had such experiences and who can recognize them best in other significantly reduces the feelings of isolation and permanent

Grupna psihoterapija u velikoj mjeri pomaže smanjivanju socijalne izolacije psihotičnog bolesnika, koji se liječi u grupi s osobama koje su i same imale (ili i dalje imaju) psihotične doživljaje, pa neposredno vide da u tim doživljajima nisu jedinstveni, a osim toga ostali članovi grupe ih zbog vlastitih iskustava psihotičnog mogu razumjeti.

Grupa bolesnicima vraća izgubljenu nadu u pozitivan ishod liječenja, jer očigledno je da su drugi u grupi uspjeli prevladati mnoge probleme koje donosi psihoza, a u grupi postaju transparentni i načini putem kojih su našli rješenja. Pozitivna rješenja i iskustva pacijenata, njihovi osobni doživljaji, postaju model. Ostali učesnici grupe saznaju što je pomoglo i što njima može pomoći u njihovim problemima.

Nije dovoljno psihotičnom bolesniku samo dati lijek, ma kako taj lijek bio farmakološki napredan i učinkovit. Lijek može uspješno kontrolirati simptome, međutim liječenje nije samo uklanjanje simptoma, nego i obnavljanje kvalitete života, što uključuje odnose s važnim drugima i sa širom socijalnom okolinom. U grupnim psihoterapijama psihotični pacijent ima mogućnost obnavljanja osobnog i socijalnog funkcioniranja, za razliku od liječenja isključivim kočenjem psihičkog funkcioniranja, kako bi se time postiglo i suzbijanje psihotičnih doživljaja.

Grupna psihoterapija psihotičnih osoba, kako je prikazano u ovoj knjizi, omogućava rješavanje teškog izazova psihotičnih proživljavanja velikom broju psihotičnih osoba. Ona čini mogućim inače gotovo nemogući zadatak s kojim su suočene psihotične osobe: nošenje s problemima u vezi psihotičnih proživljavanja, jer imaju grupu koja im u tome pomaže.

Zahvaljujući nizu grupnih terapija i drugih grupnih načina bavljenja s psihotičnim bolesnicima koji su prikazani knjizi, mnoge osobe koje se na razne načine bave s njima, bilo da se radi o samim bolesnicima, njihovim obiteljima,

loss of contact and comprehension with other people, which are important elements of the pathology of psychotic experiences.

Connecting with other people is a basic aspect of humanity. The need to connect with other people is so fundamental that it must be a part of every successful therapy. Group psychotherapy significantly helps reduce social isolation in the patient with psychosis, who is treated together with persons who themselves had (or are still having) psychotic experiences, allowing the patient to clearly see that hey are not unique in having these experiences, with the added benefit of other members of the group being able to understand them due to their own experiences.

The group also gives back lost hope in the positive outcome of the treatment, because it is obvious that others in the group were able to overcome many problems brought on by psychosis, and the group therapy also clarifies the ways in which they found solutions. Positive solutions and experiences of patients, their personal experiences, become models. Participants can learn what helped others and what may be able to help them with their own issues.

It is not enough to prescribe medication to a patient with psychosis, however pharmacologically advanced and effective that medication may be. The medication can successfully control the symptoms, but treatment does not consist just of symptom removal but also included restoring quality of life, which includes relationships with significant others and the wider social environment. In group psychotherapy, patients with psychosis are provided the opportunity to restore their personal and social functioning, as opposed to treatment that consists purely of blocking psychological functioning in order to suppress the psychotic experiences.

Group psychotherapy for persons with psychosis, as described in this book, provides a solution to the difficult challenge posed by psychotic experiences for a large number of

profesionalcima koji ih liječe dobivaju efikasnu metodu liječenja i zbrinjavanja. U suvremenom liječenju osoba s iskustvom psihoze, kao i onih kod kojih to iskustvo dominira njihovim životima, grupna psihoterapija, koja se grana u niz pojedinačnih terapijskih pristupa postala je nezaobilazna. Grupni način bavljenja, liječenja i pomaganja osobama s psihotičnim doživljajem u ovoj je knjizi uvjerljivo prikazan.

Vedran Bilić

persons with psychosis. It makes it possible to surmount the otherwise nearly impossible task of coping with psychotic experiences, because the patients have a group that helps them in this difficult challenge.

Thanks to the numerous group therapies and other group-based approaches to patients with psychosis described in the book, many persons who deal with such patients in various ways, whether the patients themselves, their families, or professionals who treat them, will be provided with an effective method of treatment and care. Group psychotherapy, which further branches into several therapeutic approaches, has become unavoidable in modern treatment of patients with a psychotic experience and those whose lives are dominated by such experiences. The group approach to working with, treating, and helping persons with psychotic experiences is very convincingly described in this book.

Vedran Bilić

In memoriam

Vera Folnegović-Šmalc

Prof. dr. sc., dr. med. / *Professor, MD, PhD*

(28. srpnja 1943., Eminovci -1. siječnja 2020., Zagreb)
(July 28, 1943, Eminovci – January 1, 2020, Zagreb)

Profesorica Vera Folnegović-Šmalc rođena je 1943. godine u Eminovcima u Slavoniji, a osnovnu i srednju školu završila je u Požegi. Na Medicinskom fakultetu Sveučilišta u Zagrebu diplomirala je 1968. godine. Obavezni liječnički staž obavila je tijekom 1969. godine u Medicinskom centru Sisak. Specijalizaciju iz neuropsihijatrije obavila je od 1971. -1975. u Medicinskom centru Varaždin i Psihijatrijskoj bolnici Vrapče. Poslijediplomski studij iz javnog zdravstva i epidemiologije završila je 1977. godine. Magistar znanosti postala je 1978. godine, a doktorirala je na Medicinskom fakultetu Sveučilišta u Zagrebu 1979. Naziv Primarius stekla je 1987. godine. Potom slijedi razvoj njezine izvanredne karijere sveučilišnog nastavnika. Godine 2004. postaje redoviti profesor u trajnom zvanju. Imala je dvije subspecijalizacije: subspecijalizaciju iz biologijske psihijatrije i iz forenzičke psihijatrije. I u jednom i u drugom području postigla je vrhunske rezultate. Iako se još za vrijeme studentskih dana uključila u znanstveno istraživački rad u duši je uvijek bila kliničar, voljela je pomagati pacijentima i bavila se u stvari translacijskom znanošću, zanimale su je primjenjive spoznaje. Zahvaljujući prof. Folnegović u Klinici za psihijatriju Vrapče brojni inovativni pristupi u psihofarmakoterapiji bili su bez odgode dostupni našoj populaciji bolesnika, pa su tako brojni današnji standardni lijekovi kliničkim

Professor Vera Folnegović-Šmalc was born in 1943 in Eminovci in the region of Slavonia, and completed primary and secondary school in the town of Požega. She graduated from the University of Zagreb Medical School in 1968. She completed her medical internship in 1969 at the Sisak Medical Center. Between 1971-1975, she finished her residency in neuropsychiatry at the Varaždin Medical Center and the Vrapče Psychiatric Hospital. She completed a postgraduate course in public health and epidemiology in 1977. She became a Master of Science in 1978 and received her PhD at the University of Zagreb Medical School in 1979. She became a chief physician in 1987. This was followed by the development of her outstanding career as a university professor. In 2004 she became a tenured full professor. She had two subspecializations: in biological psychiatry and in forensic psychiatry. She achieved outstanding results in both fields. Although she had already engaged in scientific research as a student, she was always a clinician at heart who loved helping patients and focused on translational science, as she was primarily interested in applied knowledge. Thanks to Prof. Folnegović, numerous innovative psychopharmaceutical approaches became available to our patient population at the University Psychiatric Hospital Vrapče without delays, and as a result many medications that are the standard today were available to those in need via clinical studies up to 5-10 years earlier.

studijama bili dostupni potrebitima i 5-10 godina ranije.

U forenzici je, osim činjenice da je bila dugogodišnji član Odbora za sudbena mišljenja Medicinskog fakulteta gdje je sudjelovala u izradi najsloženijih psihijatrijskih ekspertiza, svakako značajno za istaknuti da je u više navrata bila pozivana da vještači za potrebe Haškog tribunala.

Prof. Vera Folnegović-Šmalc bila je istaknuti predavač, znala se prilagoditi slušačima bilo da se radi o studentima medicine, specijalizantima, polaznicima doktorskih studija, kolegama drugih struka ili kolegama iz područja. lzrazito je značajna za razvoj edukacije iz psihijatrije u domovini Hrvatskoj. Osim na Medicinskom fakultetu u Zagrebu bila je predavač predmeta Psihijatrija i na studiju psihologije Filozofskog fakulteta i na Edukacijsko rehabilitacijskom fakultetu Sveučilišta u Zagrebu, te na medicinskim fakultetima u Rijeci i Osijeku. Na poslijediplomskom studiju na Medicinskom fakultetu u Zagrebu bila je predavač većeg broja kolegija: Socijalna psihijatrija, Forenzička psihijatrija, Farmakoterapija, Epidemiologija, te je bila mentor u većem broju magisterija i doktorata na Sveučilištima u Zagrebu i Rijeci.

Sudjelovala je kao istraživač ili kao voditelj u četrdesetak domaćih i međunarodnih istraživačkih projekata. Od toga sudjelovala je u tri projekta financirana od vlade SAD koji su pridonijeli publiciranju radova u međunarodnim publikacijama o prevalenciji i konstantnosti incidencije shizofrenije. Aktivno je sudjelovala u američko-hrvatskoj kolaboraciji istraživanja genetike shizofrenije, te je radi toga boravila na *Columbia University* u New Yorku i *John Hopkins University* u Baltimoru, SAD.

Znanstveni projekti vezani za događanja u Domovinskom ratu rezultirali su sa četiri monografije na hrvatskom i engleskom jeziku, te jednim poglavljem u udžbeniku psihijatrije

In the field of forensics, other than the fact that she was a long-time member of the Committee for Court Opinions of the Medical School where she participated in the creation of the most complex psychiatric evaluations, it is certainly important to note that she was invited multiple times to provide an expert opinion for the Hague Tribunal.

Prof. Vera Folnegović-Šmalc was a distinguished lecturer who knew how to adapt to her listeners, whether they were medical students, medical residents, postgraduate students, colleagues from other fields, or colleagues from her own field. She was instrumental in in the development of psychiatric education in the Republic of Croatia. Other than at the Medical School in Zagreb, she was also a lecturer for the Psychiatry course at the Psychology Department of the Faculty of Philosophy and the University of Zagreb Faculty of Education and Rehabilitation Sciences as well as the medical schools in Rijeka and Osijek. At the postgraduate course at the Zagreb Medical School, she taught a number of courses: Social Psychiatry, Forensic Psychiatry, Pharmacotherapy, and Epidemiology, in addition to mentoring a large number of master and doctorate theses at the universities in Zagreb and Rijeka.

She participated as researcher or project head in about of about forty Croatian and international research projects. Of these, three were financed by the US government and contributed to the publication of articles on the prevalence and incidence constant for schizophrenia in international journals. She actively participated in the Croatian-American collaboration on researching into the genetics of schizophrenia, which included spending time at *Columbia University* in New York and *John Hopkins University* in Baltimore, USA.

Various scientific projects she undertook related to the events of the Croatian Homeland War resulted in four monographies in Croatian and English and a chapter in the psychiatric handbook of the European Union (in English and

Europske zajednice (na engleskom i njemačkom jeziku). Bila je plodan autor, pisala je s lakoćom. Objavila je preko 350 stručnih i znanstvenih radova u domaćim i svjetskim časopisima, zbornicima i udžbenicima, uz veliki broj citata. Bila je koautor, suurednik i urednik 9 udžbenika, priručnika ili stručnih knjiga iz psihijatrije. Bila je glavni urednik hrvatskog prijevoda DSM-IV (1996. godine) i MKB-10 (1999. godine).

Na Komemoraciji koja je održana u Klinici za psihijatriju Vrapče dekan Medicinskog fakulteta u Zagrebu prof. dr. sc. Marijan Klarica, posebno je istaknuo da je prof. Folnegović aktivno sudjelovala s projektima i prijedlozima dugoročnog programa Hrvatskog instituta za istraživanje mozga Medicinskog fakulteta Sveučilišta u Zagrebu od samog osnivanja 1990. godine. Imala je svoje istraživačke projekte u okviru inicijativnog programa Neurobiološke osnove duševnih i kognitivnih bolesti, kao i programa Neurofarmakologija. Nakon osnivanja Hrvatskog instituta za mozak osmišljeni su programi, te je prof. Vera Folnegović-Šmalc bila koordinator u programu «*Neurobiological basis of mental and cognitive disorders*». U sljedećoj fazi dugoročnog programa HIIM-a, prof. Folnegović sudjelovala je u programu Neurobiologija neuroloških i duševnih bolesti s kognitivnim poremećajem s projektom «Funkcionalne psihoze kao nozološki entitet». Prof. Folnegović imala je važnu ulogu u radu Poliklinike Neuron, kćeri-ustanove Medicinskog fakulteta, gdje je bila dugogodišnja predsjednica Upravnog vijeća, a kao psihijatar i istraživač omogućila je da se dio kliničkih ispitivanja odvija preko te ustanove. Posebna zasluga prof. Folnegović jest širenje tema iz područja biološke psihijatrije pri HIIM-u pa su uz nju stasali suradnici koji danas vode međunarodno evaluirane projekte, a koji su izabrani i kao voditelji odsjeka na HIIM-u.

Nadalje, prof. Folnegović sudjelovala je u radu Odjela za informiranje i istraživanje Medi-

German). She was a prolific author who wrote with ease. Prof. Folnegović-Šmalc published over 350 professional and scientific papers in Croatian and international journals, monographies, and handbooks, all of which received a large number of quotations. She was a coauthor, co-editor, and editor of 9 handbooks, guidebooks, or professional books on psychiatry. She was the main editor of the Croatian translation of DSM-IV (in 1996) and ICD-10 (in 1999).

At the Commemoration held at the Vrapče Psychiatry Clinic, Prof. Marijan Klarica, MD, PhD, the dean of the Zagreb Medical School, emphasized that Prof. Folnegović had actively participated in the projects and project proposals of the long-term program of the Croatian Institute for Brain Research of the University of Zagreb Medical School since the institute's foundation in 1990. She also had her own research project as part of the Neurobiological Basis of Mental and Cognitive Diseases initiative program and the Neuropharmacology program. After founding the Croatian Institute for Brain Research and the creation of its research programs, Prof. Folnegović was the coordinator of the Neurobiological Basis of Mental and Cognitive Diseases program. In the next phase of the long-term program of the institute, Prof. Folnegović participated in the Neurobiology of Neurological and Mental Diseases with Cognitive Disorders program with her project titled "Functional Psychoses as Nosological Entities". Prof. Folnegović had an important role in the work of the Neuron Polyclinic, an affiliate institute of the Medical School, where she was a long-time president of the Board of Directors, and as a psychiatrist and researcher she organized part of the clinical testing to take place in that institution. Prof. Folnegović deserves special merit for introducing the topics from biological psychiatry in the Croatian Institute for Brain Research and participating in the maturation of colleagues who now head internationally evaluated projects and who have been chosen to be department heads at the institute.

cinskog fakulteta koji je bio dio Glavnog sanitetskog stožera Republike Hrvatske. U rad tog Odjela bila je uključena od njegovog osnivanja. Bila je zaslužna za koordinaciju psihološke pomoći obiteljima nestalih. Ovaj oblik pomoći kasnije je prerastao u poseban projekt psihološke pomoći obiteljima identificiranih iz grobnice na Ovčari. S obzirom da su identifikacije poginulih na Ovčari bile među prvim identifikacijama posmrtnih ostataka u Domovinskom ratu, prof. Folnegović je svojim znanjem i iskustvom bila od presudne pomoći u svim narednim projektima ove vrste. Također, projekt koji je vodila u suradnji s nizozemskim istraživačima, a vezan za pružanje psihosocijalne pomoći zlostavljanim žena u ratu, izbjeglicama i prognanicima iz BiH, bio je od iznimne vrijednosti.

U struci je imala mnoge odgovorne funkcije i bila član brojnih nacionalnih i međunarodnih povjerenstava, te većeg broja stručnih društava. Bila je dugogodišnja predsjednica Hrvatskog društva za kliničku psihijatriju Hrvatskog liječničkog zbora i Kolegija psihijatrijskih znanosti Akademije medicinskih znanosti Hrvatske.

Poseban doprinos razvoju psihijatrije dala je kao aktivan sudionik, pozvani predavač niza domaćih i međunarodnih skupova, kao član organizacijskih i stručnih odbora brojnih kongresa i simpozija, sudjelovala je na preko 60 domaćih i inozemnih kongresa i simpozija.

Njezina potpuna posvećenost struci, kliničkom radu, znanosti i medicinskoj edukaciji rezultirala je velikim i značajnim opusom u području psihijatrije. Iznimno je dugačak popis njezinih znanstvenih i stručnih radova, udžbenika i priručnika koji su svojom kvalitetom i relevantnošću bitno utjecali na odgoj naraštaja studenata medicine, a i danas utječu na školovanje specijalizanata i doktora biomedicinskih znanosti, te budućih nastavnika Medicinskog fakulteta poglavito iz područja psihijatrije.

Furthermore, Prof. Folnegović participated in the work of the Department for Information and Research at the Zagreb Medical School, which was part of the Main Medical Headquarters of the Republic of Croatia. She was a part of that department from its foundation, and was tasked with coordinating psychological assistance for the families of missing persons. This form of assistance later grew into a special project of psychological assistance to familied of identified victims from the Ovčara mass grave. Given that the victims from Ovčara were among the first victims of the Homeland War identified forensically from their remains, the expertise and experience contributed by Prof. Folnegović was of crucial value in all later projects of this type. Additionally, she also headed a project in cooperation with Dutch researchers that was related to providing psychosocial assistance to women molested in war and refugees from Bosnia and Herzegovina and was also exceptionally valuable.

Prof. Folnegović held many highly responsible functions in her field of work and was a member of numerous Croatian and international committees as well as a large number of professional societies. For many years, she was the president of the Croatian Society for Clinical Psychiatry of the Croatian Physicians Association and the Collegium of Psychiatric Sciences of the Croatian Academy of Medical Sciences.

She provided an outstanding contribution to the development of psychiatry as an active participant and invited lecturer at many Croatian and international conferences, as a member of organization and expert panels at many congresses and symposia, and through participation in over 60 Croatian and international congresses and symposia.

Her total devotion to her profession, clinical work, science, and medical education resulted in a large and significant opus in the field of psychiatry. The list of her professional and scientific articles, handbooks, and guidebooks is extremely long. Their quality and relevance

Prof. Folnegović bila je prisutna u medijima gotovo na dnevnoj bazi, kamera ju je voljela, znala je približiti psihijatrijsku problematiku laicima, sudjelovala je u velikom broju TV i radio emisija u kojima je popularizirala struku, autor je više od 60 članaka u novinama o psihijatriji. Na taj način znatno je doprinijela destigmatizaciji psihijatrije, ali i Bolnice Vrapče.

Iza izvanrednog sveučilišnih nastavnika, kliničara koji ostavljaju trajan trag u struci i znanosti kao što je bila naša profesorica, ostaju stručni i znanstveni radovi, ali i učenici koji nastavljaju njezin rad. Profesorica je uvijek bila okružena velikim brojem mlađih kolega, koji su danas mahom ugledni stručnjaci, na istaknutim, šefovskim i sličnim odgovornim pozicijama, unutar Bolnice, ali i diljem Hrvatske. Na svima nama je sada težak zadatak, letvicu je profesorica visoko postavila. Hvala profesorici Veri Folnegović-Šmalc na svemu što nam je dala, na svemu što nas je naučila. Ostat će trajno u srcima nas koji smo je poznavali i koji smo s njom surađivali, a njezino ime ostat će upisano zlatnim slovima u povijesti restoljetnog Medicinskog fakulteta Sveučilišta u Zagrebu i u 140-godišnjoj povijesti Bolnice Vrapče.

Profesorica Vera Folnegović-Šmalc preminula je 1. siječnja 2020., a njezinom smrću Medicinski fakultet Sveučilišta u Zagrebu izgubio je iznimnog nastavnika i znanstvenika koji je bitno utjecao i pridonio ugledu zagrebačkog Medicinskog fakulteta, ne samo u domovini već i u Europi i svijetu. Klinika za psihijatriju Vrapče, kao stožerna psihijatrijska ustanova i dio Medicinskog fakulteta odnosno nastavna baza Medicinskog fakulteta, ponosna je i zahvalna da je prof. Folnegović upravo tu provela 37 godina rada.

Po čemu ću osobno pamtiti profesoricu Folnegović - sigurno po veselom duhu, silnoj energiji i predanosti poslu. Oko sebe je širila pozitivnu energiju, bila je neumorna i puna elana, a dan joj je uvijek bio prekratak. Njena avangardnost

significantly influenced the education of many generations of medical students, and they still contribute to the education of residents and post-graduate students in biomedical sciences as well as future teachers at the Medical School, especially in the field of psychiatry.

Prof. Folnegović was present in the media almost on a daily basis, the camera loved her, and she knew how to make psychiatric issues approachable to the general public; she participated in a large number of television and radio shows in which she popularized her field, and she authored over 60 newspaper articles on psychiatry. In this way, she significantly contributed to the destigmatization of psychiatry as well as the Vrapče Hospital.

The legacy of excellent university teachers and clinicians that leave a lasting mark on their profession such as our professor is in their professional and scientific work, but also in her students who continue her work today. The professor was always surrounded by many younger colleagues who subsequently became respected experts in prominent supervisor and other positions of responsibility within our hospital but also around Croatia as a whole. All of us now face a difficult challenge, for the professor has set the bar very high. We would like to thank Professor Vera Folnegović-Šmalc for everything she has given us and everything she has taught us. She will remain in the hearts and minds of all of us who knew her and worked with her, and her name will be written in gold lettering in the hundred-year history of the University of Zagreb Medical School and the 140 years of the Vrapče Hospital.

Professor Vera Folnegović-Šmalc died on January 1, 2020, and with her death the University of Zagreb Medical School lost an exceptional lecturer and scientist who significantly influenced and contributed to the reputation of the Zagreb Medical school, not only in Croatia but in Europe and across the globe. The Vrapče Psychiatry Clinic, as the psychiatric headquarters and part of the Medical School as is its teaching

očitovala se u mnogočemu, nisu ju bez razloga zvali «prva dama hrvatske psihijatrije». Naime, vinula se do samog vrha i utrla put drugim kolegicama. Bila je međunarodno eksponirana u brojnim aktivnostima kao što su psihološka podrška izbjeglicama, prognanicima, zlostavljanim i silovanim ženama, u kliničkim ispitivanjima lijekova, u zapaženim publikacijama i prezentacijama na skupovima, a pri čemu je uvijek s ponosom promovirala Psihijatrijsku bolnicu Vrapče.

Što se tiče publikacija, profesorica će biti upamćena i po dva tematska broja časopisa Socijalne psihijatrije u kojima je objavila svoja istraživanja o shizofreniji. Značajnim smatram njeno poglavlje u tro-tomnom udžbeniku psihijatrije, prestižnog njemačkog izdavača Springer. Također i poglavlje psihijatrije u knjizi «Interna medicina u praksi» koje je značajno približilo psihijatrijsku tematiku i ohrabrilo obiteljske liječnike u liječenju psihijatrijske kazuistike. U kasnim 80-ima i početkom 90-ih godina prošlog stoljeća, u doba kada su psihijatri s ovih prostora rijetko publicirali u međunarodnim stručnim časopisima, pamtim da je profesorica objavljivala svoja istraživanja o epidemiologiji shizofrenije u utjecajnom časopisu *British Journal of Psychiatry*, To je dakako bilo poticajno za mnoge mlade koje je oko sebe okupljala. Poticala je mlađe kolege da pišu i aktivno sudjeluju na stručnim skupovima, a isto se najbolje može vidjeti u Knjizi postera stručnjaka Psihijatrijske bolnice Vrapče gdje se profesorica bilježi kao koautor najvećeg broja postera u razdoblju od 1978. do 2006. godine. Nadalje, nitko nikada u Hrvatskoj nije vodio toliko kliničkih studija psihofarmaka, s tolikim brojem participanata, te nitko u nas nije sudjelovao u stavljanju na tržište toliko novoregistriranih psihofarmaka kao prof. Folnegović-Šmalc. Posljedično tome, sjećam se također dva FDA posjeta našem Kliničkom centru u Vrapču, kada se potvrdila kvaliteta sakupljenih poda-

base, is proud and grateful that Prof. Folnegović spent 37 years of her career as part of it.

How will I personally remember Prof. Folnegović – surely for her cheerful spirit, boundless energy, and dedication to her work. She always spread positive energy around her, was tireless and driven, and days were always too short for her. Her avantgarde style manifested in many ways, and there was a reason she was called "the first lady of Croatian psychiatry". She had risen to the very top and paved the way for her other colleagues. She had an international presence in many activities such as psychological support for refugees, survivors of rape and abuse, clinical testing of drugs, and through notable publications and conference presentations in which she always proudly promoted the Vrapče Psychiatric hospital.

As for publications, the professor will also be remembered for two thematic issues of the Social Psychiatry journal in which she published her research on schizophrenia. I consider her chapter in the three-volume psychiatry handbook by Springer, the prestigious German publisher, to be very significant. The chapter on psychiatry in the book "Internal Medicine in Practice" also significantly contributed to making psychiatry more approachable to family doctors and encouraging them in the treatment of psychiatric casuistry. In the late 80s and start of the 90s, when psychiatrists in this region rarely published in international journals, I can remember the professor was publishing her research on the epidemiology of schizophrenia in the influential *British Journal of Psychiatry*. This was of course inspiring for the many young colleagues she would gather around her. She would encourage them to write and actively participate and professional conferences, which can be seen in the Book of Posters of the Vrapče Psychiatry Hospital, where the professor is a coauthor on the largest number of posters in the period between 1978 and 2006. Furthermore, no one in Croatia

taka, a što je u konačnici rezultiralo registracijom dvaju danas standardnih antipsihotika. Imao sam prigodu pročitati i *mailove* koji su naknadno uslijedili, a u kojima joj predstavnici jedne velike američke farmaceutske tvrtke zahvaljuju na izvrsnom radu u kliničkim studijama te navode da se time Hrvatska visoko pozicionirala na svjetskoj karti istraživanja inovativnih lijekova u psihijatrijskim indikacijama. Pamtim i odlaske na prestižne zimske radionice o shizofreniji u švicarski Davos, gdje smo mi njeni suradnici, u to doba mladi istraživači i specijalizanti, dobili više nagrada za prezentirane postere. U živom sjećanju su mi profesoričina putovanja tijekom ratnih godina na kongrese u Badgastein, Regensburg, Innsbruck, Pulu, Štokholm, Firencu, odnosno svugdje gdje je trebalo promicati hrvatsku psihijatriju, hrvatske interese i istinu o Hrvatskoj.

Naša draga profesorica Folnegović zasigurno sve rečeno ne bi mogla postići da nije imala veliku podršku svoje obitelji, u prvom redu supruga Zdenka, koji je kao metodičar bio i koautor brojnih radova. Profesorica je često spominjala svoje kćeri Ernu i Petru, zetove Vladu i Sašu, a poglavito je bila ponosna na svoje petero unučadi Martu, Jakova, Vjeru, Saru i Martina pritom žaleći što nije u mogućnosti s njima provoditi više vremena.

Dozvolite da kao njen učenik, mlađi kolega, suradnik i nasljednik funkcije pročelnika Zavoda i predstojnika Klinike za psihijatriju Vrapče, ustvrdim da je prof. Folnegović od svega što je radila, u stvari najviše voljela (pa ako hoćete i stavljala na prvo mjesto) - rad s psihijatrijskim pacijentima, pomaganje svim potrebitima, uključivo oboljelim braniteljima. Iako po vokaciji i edukaciji biologijski psihijatar, znala je da lijek sam po sebi nije dovoljan, stoga je za svakog bolesnika imala toplu riječ ohrabrenja, stručni savjet, empatiju, davala je nadu, svojim vedrim duhom svakodnevno je prakticirala pozitivnu psihijatriju - po tome će je pamtiti

ever conducted so many clinical psychopharmacological trials with such a large number of patients, and none of us ever participated in placing so many newly registered psychopharmacological medications on the market as Prof. Folnegović-Šmalc. Consequently, I also remember two FDA visits to our clinical center in Vrapče which confirmed the quality of the data we had gathered, ultimately resulting in the registration of two now standard antipsychotics. I also had the opportunity to read the email exchange that followed, in which representatives of a large American pharmaceutical company thanked us for excellent work in clinical studies, saying that it had secured a prominent position for Croatia on the global map for the exploration of innovative medication for psychiatric indications. I also remember trips to prestigious winter workshops on schizophrenia in Davos in Switzerland, where we, the professor's collaborators and young researchers and residents at the time, received multiple awards for the posters we presented. I still have a vivid memory of the professor's wartime trips to congresses in Badgastein, Regensburg, Innsbruck, Pula, Stockholm, Florence, or anywhere where we could promote Croatian psychiatry, Croatian interests, and the truth about Croatia.

Our dear Professor Folnegović certainly could not have achieved all this without the great support of her family, firstly her husband Zdenko, who coauthored many of her papers as a expert in methodology. The professor often mentioned her daughters Erna and Petra, sons-in-law Vlado and Saša, and was especially proud of her five grandchildren Marta, Jakov, Vjera, Sara, and Martin, always regretting she could not spend more time with them.

As her student, younger colleague, collaborator, and successor as to the position as head of the Department and head of University Psychiatric Hospital Vrapče, allow me to claim that among all the things she did, what Prof. Folnegović really loved the most (and always put

kolege, medicinske sestre, stručni suradnici, svi zaposlenici Vrapča, njeni pacijenti i njihove obitelji.

Neka joj je laka hrvatska zemlja koju je toliko voljela!

Vječna slava i hvala profesorici Veri Folnegović-Šmalc!

Ninoslav Mimica

first, if you will) – was working with psychiatric patients and helping those in need, including war veterans. Although she was an biological psychiatrist by vocation and education, she knew medications alone were not enough, so she had a warm word of encouragement, expert advice, and empathy for every patient, providing hope and practicing positive psychiatry every day with her cheerful spirit – this is what we, her colleagues, collaborators, nurses, all the employees of Vrapče Hospital, her patients, and their families, will remember her by.

May our Croatian soil which she loved so dearly rest lightly on her!

Everlasting praise and thanks to Professor Vera Folnegović-Šmalc!

Ninoslav Mimica

In memoriam

Vladimir Gruden

Prof. dr. sc., dr. med. / *Professor MD, PhD*

(Osijek, 21. lipnja 1939. – Bjelovar, 11. siječnja 2020.)
(Osijek, June 21, 1939 – Bjelovar, January 11, 2020)

Vladimir Gruden rođen je 1939. godine u Osijeku. Nakon završene realne gimnazije upisuje se 1957. godine na Medicinski fakultet Sveučilišta u Zagrebu, na kojem diplomira 1963. godine. Specijalizaciju iz neuropsihijatrije završava 1969. godine. Na zagrebačkom Medicinskom fakultetu doktorirao je 1979. godine s temom „Objektivna validacija subjektivnog doživljaja topline kod autogenog treninga“. Završio je edukaciju iz grupne analize. God. 1980. postaje primarius, 1983. docent (u tadašnjoj) Katedri za psihijatriju i medicinsku psihologiju Medicinskog fakulteta Sveučilišta u Zagrebu, a 1986. godine redoviti profesor. Predavao je medicinsku psihologiju (kasnije psihološku medicinu), psihijatriju i psihoterapiju u diplomskoj i poslijediplomskoj nastavi na matičnom fakultetu. Predavao je i na Medicinskom fakultetu Sveučilišta u Mostaru te Visokoj zdravstvenoj školi u Zagrebu i Poslovnoj školi Experta. Bio je mentor u brojnim diplomskim, magistarskim i doktorskim radovima.

Svoj radni vijek proveo je na Rebru u Centru za mentalno zdravlje Klinike za psihijatriju, odnosno Klinici za psihološku medicinu. Bio je voditelj Odjela za stacionarnu psihoterapiju Centra za mentalno zdravlje od 1980. do 1987. godine, a zatim voditelj Psihoterapijskog centra za parcijalnu hospitalizaciju Klinike za psihološku medicinu. Predstojnik te Klinike bio je od 1995. do 2003. godine.

Vladimir Gruden was born in 1939 in Osijek. After graduating from a general-education secondary school, he enrolled in the University of Zagreb Medical School in 1957, from which he graduated in 1963. He completed his residency in neuropsychiatry in 1969. In 1979, he completed his PhD at the University of Zagreb Medical School on the topic “Objective Validation of the Subjective Experience of Warmth in Autogenic Training”. He also completed his education in group analysis. He became the chief physician in 1980 and an assistant professor in 1983 at what was at the time the Department of Psychiatry and Medical Psychology of the University of Zagreb Medical School, and in 1986 he became a full professor. He taught medical psychology (later psychological medicine), psychiatry, and psychotherapy in graduate and post-graduate classes at his university. He also taught at the University of Mostar Medical School, the University of Applied Health Sciences in Zagreb, and the Experta Business School. He mentored many graduate, magister, and doctoral theses.

He spent his career working at the Rebro Clinical Hospital Center at the Center for Mental Health of the Psychiatry Clinic, i.e. the Clinic for Psychological Medicine. He was head of the Inpatient Psychotherapy Ward at the Center for Mental Health from 1980 to 1987, and then the head of the Psychotherapy Center for Partial Hospital-

Redoviti je član Akademije medicinskih znanosti Hrvatske od 1994. godine.

Stručni rad i znanstveni interes prof. Grudena bili su usmjereni prema psihoterapiji i psihodinamici. Razvio je nekoliko psihoterapijskih tehnika (analitički autogeni trening, psihoterapiju autoopservacijom, terapiju agnostičkim optimizmom). Najviše se bavio autogenim treningom i hipnozom. Autogeni trening je razvijao, popularizirao, podučavao i postavio u rang samostalnog, gotovo paradigmatskog psihoterapijskog modela. Tečajevi autogenog treninga koje je organizirao za građanstvo, predavanja, tribine, nastupi u javnim medijima najbolji su dokaz uspješnosti njegove životne misije – poboljšanja psihičke kvalitete života velike skupine ljudi. Tome je doprinijela i njegova sposobnost vođenja grupe i grupne terapije. U tome je bio nenadmašan. Bio je supervizor i trening analitičar iz grupne analize brojnim generacijama specijalizanata.

Kao terapeut bio je iznimno uspješan, cijenjen i omiljen. Svoju je smirenost prenosio na sugovornika, klijenta, bolesnika. Dogodilo bi se da bračni par dođe na terapiju, uđu u njegovu ordinaciju posvađani i ljuti, a nakon sat i pol izađu zagrljeni. Znao je umiriti i najagresivnije osobe. Imao je empatiju za svakoga tko mu se obratio za pomoć.

Objavio je preko 200 znanstvenih i stručnih radova. Autor je više poglavlja u temeljnim udžbenicima psihološke medicine i psihijatrije. Samostalno je objavio knjige „Osnovne vježbe autogenog treninga“, „Vježbom do sreće: autogeni trening“, „Budućnost je u nama“, „Srećom do uspjeha ili Veliki igrač“, „Uspjehom do istine: sloboda kao ljubav“, „Istina je u prirodi“, „Psihoterapija“, „Psihomenadžment“, „Obitelj za obitelj“.

Sa suprugom Zdenkom Gruden, koja je bila dječji psihijatar, napisao je knjige „Dijete, škola, roditelj“ i „Ožiljci na duši Hrvatske“. Sa su-

ization of the Clinic for Psychological Medicine. The was head of that clinic from 1995 to 2003.

He was a full member of the Croatian Academy of Medical Sciences since 1994.

The professional work and scientific interests of Prof. Gruden were focused on psychotherapy and psychodynamics. He developed several psychotherapy techniques (analytic autogenic training, self-observation psychotherapy, agnostic optimism treatment). He worked primarily on autogenic training and hypnosis. Autogenic training was something he developed, taught, and raised to the level of an independent, almost paradigmatic psychotherapeutic model. The workshops on autogenic training that he organized for the general population, as well as lectures, panels, and media appearances are the best evidence of the success of his life mission – improving the psychological quality of live in a large group of people. His abilities in leading groups and group therapy also contributed significantly, as his skill at this was unsurpassed. He was also a supervisor and training analyst in group analysis for many generations completing their residencies.

As a therapist, he was exceptionally successful, respected, and beloved. His sense of calm would spread to any interlocutor, client, or patient. There were cases of married couples coming to him for therapy, entering the office angry and in the middle of a fight, and leaving in an embrace after an hour and a half. He could calm down even the most aggressive persons. He had empathy for anyone who turned to him for help.

Prof. Gruden published over 200 scientific and professional articles. He was the author of multiple chapters in basic handbooks for psychological medicine and psychiatry. He independently published books titled: “Basic Autogenic Training Exercises”, “Through Exercise to Happiness: Autogenic Training”, “The Future is in Us”, “Through Happiness to Success or The Great Player”, “Through Success to Truth: Freedom as Love”, “Truth is in Nature”, “Psychotherapy”, “Psychomanagement”, and “Family for Family”.

prugom i sinom imenjakom napisao je knjigu „Primijenjena psihoterapija".

Sudjelovao je na brojnim domaćim i međunarodnim skupovima. Bio je voditelj nekoliko projekata pri Ministarstvu znanosti. Bio je glavni istraživač projekta „Integralni psihoterapijski pristup ratnim stradalnicima Hrvatske". U Domovinskom ratu je sudjelovao u edukaciji djelatnika za pružanje psihološke pomoći vojnicima, prognanicima i ranjenicima.

Prof. Gruden bio je predsjednik Društva za psihoterapiju Hrvatskog liječničkog zbora, prvi predsjednik Hrvatskog saveza za psihoterapiju, predsjednik Hrvatske udruge za autogeni trening te član mnogih nacionalnih i međunarodnih udruga.

Jedino što mu je bilo važnije od posla je njegova obitelj. Supruga Zdenka, djeca Vladimir i Sanja Josipa bili su mu radost i podrška. S njima je živio u skladu sa svojim vrijednostima. Znao je od kuda potiče i kuda ide. Krasila ga je nacionalna osviještenost, vjera, empatija i briga. Brinuo je za one koji pate. Zalagao se za svakoga. I za psihijatra i za psihijatrijskog bolesnika.

U mom odnosu s prof. Grudenom, koji je trajao više od trideset godina javljale su se razne emocije. Radilo se zapravo o nizu odnosa: učitelja i učenika, mentora, supervizora i superviziranog, grupnog analitičara i edukanta, nadređenog rukovodioca i djelatnika, kako u dnevnoj bolnici, tako i šire na tadašnjoj Klinici za psihološku medicinu. Naime, prof. Gruden mi je bio sve to: edukator iz grupne analize, supervizor iz individualne psihoanalitičke psihoterapije, mentor magisterija, učitelj autogenog treninga, nadređen u Dnevnoj bolnici kao šef i na Klinici za psihološku medicinu kao predstojnik, a kasnije kolega s kojim sam povremeno surađivao i nakon njegovog odlaska u mirovinu. Prof. Gruden obično nije inzistirao ni na čemu, te nije kontrolirao ljude i događaje, nego ih je prihvaćao kako su dolazili, razvijao s njima odnose, a

With his wife Zdenka Gruden, who was a child psychiatrist, he co-authored the books "Children, School, Parents" and "The Scars on Croatia's Soul". He wrote the book "Applied Psychotherapy" together with his wife and his son who was his namesake.

He participated in many Croatian and international congresses. He was the head of several projects at the Ministry of Science. He was head researching in the project titled "The Integral Psychotherapy Approach to War Victims in Croatia". In the Croatian Homeland War, he participated in the education of personnel for providing soldiers, refugees, and the wounded with psychological aid.

Prof. Gruden was the president of the Psychotherapy Society of the Croatian Physicians Association, the first president of the Croatian Psychotherapy Association, the president of the Croatian Autogenic Training Association, and a member of many Croatian and international associations.

The only thing more important to him than his work was his family. His wife Zdenka and his children Vladimir and Sanja Josipa were his joy and support. He lived his life with them according to his values and principles. He knew where he was from and where he was going. He was marked by patriotic awareness, faith, empathy, and care. He cared for those who suffered and supported everyone – both for psychiatrists and psychiatric patients.

There are many different emotions elicited by my relationship with Prof. Gruden that lasted more than thirty years. It was really a series of relationships: teacher and student, mentor, supervisor and supervisee, group analyst and trainee, and supervising director and employee, both in the day hospital and more broadly in what was then the Clinic for Psychological Medicine. Prof. Gruden was all of that to me: an educator in group analysis, a supervisor from individual psychoanalytic psychotherapy, mentor for my magisterial thesis, teacher

tolerirao je mirno i njihove odlaske, držeći se svojih vodećih principa slobode i spontaniteta.

Smrt prof. Grudena, kao teško prihvatljiva, ali ipak nepobitna činjenica ponovno je prizvala te donekle zaboravljene emocije, a njegov posljednji ispraćaj, koji je bio u raznim detaljima izuzetno dojmljiv, potaknuo je proces žalovanja, suočavanje s nerazriješenim osjećajima, i prihvaćanje realnosti onakvom kakva je. Ili kako bi prof. Gruden rekao prihvaćanje 'istine' odnosno 'buđenje iz budnog sanjanja'.

Sloboda i spontanost bile su temeljne vrijednosti za prof. Grudena. On je nastojao obzirno 'probuditi' svoje pacijente i klijente, pomoći im da ostvare slobodu od nesvjesnih utjecaja koji koče kreativnost i realizaciju njihovih potencijala. Međutim, nas njegove učenike je ujedno upozoravao: 'Ne analiziraj bližnjega svoga' svjestan mogućih neugodnih posljedica 'buđenja'.

Kant je bio filozof kojeg je prof. Gruden često citirao u svojim knjigama. Krajnju suštinu i istinu nije moguće spoznati mislima i emocijama jer se suština bilo čega ili koga 'stvar za sebe' ne može reprezentirati, prikazati putem psihičkih slika, misli i emocija. Ali moguće je biti prijemčiv za poruke koje dolaze iz dubina nesvjesnog u formi spontanih impulsa. Upravo tu senzibilnost za poruke nesvjesnih slojeva psihe, ali i za poruke tijela njegovao je i podučavao prof. Gruden.

Prof. Gruden je nastojao tražiti i vidjeti pozitivno u svemu. U skladu s time prihvatio je koncepte prema kojima nesvjesno nije samo stovarište potisnutih, nepoželjnih, manje vrijednih i bolnih sadržaja, nego i izvor najvrjednijih impulsa i potencijal kreativnosti.

Prof. Gruden je i u praksi, a ne samo u teorijskom poimanju prihvatio koncept spontanosti u kojem osoba nastoji ostati prijemčiva na unutrašnji kreativni poticaj, bez obzira na logiku. Jedna kreativna metoda psihoterapije koju je razvio i nazvao agnostički optimizam temelji se upravo na nepokolebljivom optimizmu.

in autogenic training, my supervisor in the day hospital and at the Clinic for Psychological Medicine, and later a colleague with whom I occasionally worked with even after he was retired. Prof. Gruden rarely insisted on anything and did not seek to control people and events but rather accepted them as they came, developed relationships with them, and calmly tolerated their departures, adhering to his guiding principles of freedom and spontaneity.

The death of Prof. Gruden, a fact that is hard to accept but is unavoidable, recalled these half-forgotten emotions, and his funeral, which had some very touching moments, initiated a process of grief, confronting unresolved feelings, and accepting reality as it truly is. Or, as Prof. Gruden would say, accepting "truth" i.e. "waking up from a waking dream".

Freedom and spontaneity were the core values for Prof. Gruden. He tried to gently "awaken" his patients and clients, helping them achieve freedom from the unconscious influences that stifle creativity and the realization of their potentials. However, he would also warn us, his students: "Do not analyze your neighbor", aware of the potential negative consequences of "awakening".

Kant was the philosopher Prof. Gruden would often quote in his books. The ultimate essence and truth cannot be known through thoughts and emotions because the essence of anything or anyone is a "thing-in-itself" and cannot be represented or viewed though mental images, thoughts, and emotions. But one can be receptive to messages coming from the depth of the unconscious in the form of spontaneous impulses. This sensibility to the messages of the unconscious layers of the psyche, but also the messages of the body, was what Prof. Gruden nurtured and taught.

Prof. Gruden tried to find and see the positive aspects of everything. In line with that, he accepted concepts according to which the unconscious is not just a repository of repressed, unwanted, less valuable, and painful mental

Također ga je zanimala teorija kaosa, kao nerazdvojna dinamička i neizbježna komponenta svakog uspostavljenog poretka, koji remeti, ali tako ujedno priprema novi, napredniji poredak. Kreativan, ponekad nepredvidljiv, pronicav, prof. Vladimir Gruden bio je uvijek zanimljiv. 'Shvatimo život kao igru, jer jao si ga onome tko život uzima ozbiljno' jedna je od njegovih važnih poruka.

Kao jedan primjer igre sjećam se situacije kad sam ga susreo prije vježbe. Trebao sam sa studentima razgovarati s pacijentom. Međutim, pacijent s kojim sam dogovorio intervju nije došao. Slučajno je hodnikom naišao prof. Gruden. Kao njegov učenik, poprimio sam neke njegove osobine, te sam tako, neplanski, spontano, pozvao profesora, svog tadašnjeg šefa i predstojnika Klinike da on odigra ulogu pacijenta. A on je, opet spontano, pristao. Tako smo od jedne profesionalne potencijalno nezgodne situacije napravili zajedničku igru, u kojoj su sudjelovali i studenti. Naravno, to je bio vrlo interesantan intervju, kako studentima, tako i meni. A i profesoru, koji je dobio prigodu da ga se sasluša i razumije neke njegove probleme.

Ta situacija pokazuje koliko slobode je prof. Gruden omogućavao u interakcijama, koliko nije bilo straha ni tjeskobe u odnosu s njim, što nije ugrozilo radni učinak kao ni duboko poštovanje, a u ovoj situaciji usuđujem se reći i sublimiranu ljubav prema njemu, omiljenom učitelju. Dapače, takvi odnosi djelovali su poticajno na rad, što je i teorijski utemeljeno u istraživanjima čimbenika uspjeha najuspješnijih tvrtki.

Igra je aktivnost, a okvir igre je cijeli život. U stavu koji naglašava važnost igre i prijelaznog prostora kulture, mašte i fantazije, koji je u praksi provodio prof. Gruden, moguće je prepoznati implementaciju ideja D. Winnicota.

Igra je zanimljiva. Igra je kreativna. Prof. Gruden nije odvajao rad od života, te je za njega

contents, but also the source of the most valuable impulses and potential for creativity.

Not just in theory but in practice, Prof. Gruden accepted the concept of spontaneity in which one tries to remain receptive to inner creative impulses, regardless of logic. A creative method of psychotherapy he developed and named agnostic optimism was based on unfaltering optimism.

He was also interested in chaos theory as an integral dynamic component of every system, which disrupts it but thusly also prepares the ground for a new, more advanced system. Creative, sometimes unpredictable, and insightful, Prof. Vladimir Gruden was always interesting. "Let us see life as a game, because woe is to him who takes life seriously" was one of his most important messages.

As one example of his playfulness, I remember a situation when I met him before a medical training session. I was supposed to join some students in talking with a patient. However, the patient with whom I had arranged the interview had not arrived. Right then, Prof. Gruden happened to be coming down the hallway. As his student, I had acquired some of his habits, so without any planning I spontaneously invited the Professor, my current boss and the head of the Clinic, to play the role of the patient. And he, again spontaneously, accepted. This is how we transformed a potentially uncomfortable situation into a game we played together, with the students participating as well. Of course, this was a very interesting interview, both for the students and for me – and for the Professor as well, who got an opportunity to be listened to and for some of his problems to be heard and understood. This anecdote shows how much freedom Prof. Gruden allowed in interactions with him, how little fear and anxiety there was in his professional relationships, but without jeopardizing professional efficacy and the deep respect, and in this case also a sublimated feeling of love I felt towards him, my favorite teacher. On the contrary, such relationships in the workplace

rad s pacijentima, poslovnim ljudima, edukantima i s drugim ljudima bio kreativna igra. Svaka osoba i odnos s njom je za njega bila poticajna zagonetka, a dobar odnos je prirodno slijedio iz dobrog razumijevanja i rješavanja te zagonetke.

U radu s pacijentima integrirao mnogobrojne psihoterapijske pravce i utjecaje, a istraživao je i ideje, prakse i fenomene povezane s psihom i izvan striktnih znanstvenih psihoterapijskih okvira. Iako je u znatnom dijelu svoje ličnosti bio vrlo usmjeren na unutrašnji svijet, njegov životni put, njegova životna igra je uvijek uključivala ljude. Puno ljudi. Bliske, njegovu obitelj, ali i edukante, kolege, stranačke kolege, prijatelje, pacijente, branitelje, poslovne ljude, široku populaciju u Zagrebu, Osijeku, Bjelovaru, Karlovcu, Valpovu i u nizu gradova koje je često obilazio i zainteresiranima prenosio svoja iskustva i poruke. Držao je predavanja o raznim zanimljivim i ljudima važnim temama. Neke od tema predavanja su istina, osobna vrijednost, samopoštovanje. Naslov njegovog zadnjeg najavljenog predavanja, koje je bilo predviđeno za kraj ovog mjeseca je *Nadilaženje pogrešaka*. Redovno je održavao i tečajeve autogenog treninga.

Ispred njegove ordinacije na Klinici za psihološku medicinu je uobičajeni prizor bio puno ljudi koji strpljivo čekaju na svoje vrijeme s prof. Grudenom.

U psihoterapijskim znanstvenim krugovima prof. Gruden je posebno prepoznat po implementaciji i kreativnoj primjeni psihoterapijske metode autogenog treninga. Prof. Gruden se bavio i raznim drugim vrstama i metodama psihoterapije, na primjer, individualnom psihoanalitičkom psihoterapijom, grupnom analizom, grupnom psihoterapijom.

Važan dio identiteta prof Grudena bio je aspekt učitelja. Kao učitelj prof. Gruden je ljudima na jednostavan i pristupačan način nudio inače

had a positive influence on our work, which has also been established by research on success factors in the most successful companies.

Play is an activity, and the framework of play is life as a whole. In his position that emphasized the importance of play and the intermingling of culture, imagination, and fantasy, that was practiced by Prof. Gruden, one can recognize the implementation of the ideas of D. Winnicot.

Play is interesting. Play is creative. Prof. Gruden did not separate work from life, and for him working with patients, professionals, students, and other people was a creative game. Every person and relationship was for him an inspiring puzzle, and a good relationship followed naturally from a good understanding and solution to this puzzle.

In working with patients, Prof. Gruden integrated may influences and approaches in psychotherapy while also exploring ideas, practices, and phenomena related to the psyche outside the strict scientific framework. Although a large part of his personality was very focused on the inner world, his life, his game, always included people. Many people. Those close to him, his family, but also his students, colleagues, members of his political party, friends, patients, veterans, businessmen, the broader populations of Zagreb, Osijek, Bjelovar, Karlovac, Valpovo, and may other cities he often visited and shared his experience and wisdom with those who were interested. He held lectures on various interesting and relatable topics. Some of these topics include truth, self-wroth, and self-respect. The title of his last lecture that was to be held at the end of this month was *Overcoming Mistakes*. He also regularly held autogenic training workshops.

Outside his office at the Clinic for Psychological Medicine, it was common to see many people patiently waiting for their time with Prof. Gruden. In the psychotherapy science community, Prof. Gruden was especially respected for the implementation and creative application of autogenic training as a method of psychother-

prilično komplicirane, a time i nepristupačne psihoterapijske i psihološke koncepte spoznaje, kao i životnu mudrost koju je stekao vlastitim iskustvima. Time se približio idejama M. Balinta.

Osim čestih putovanja i gostovanja, prof. Gruden se široj publici često obraćao i putem medija. U novinarskim krugovima je poznato da im je prof. Gruden gotovo uvijek bio ljubazno na raspolaganju. Na internetu možemo pogledati niz video prikaza u kojima je prof. Gruden na razne načine i u raznim okvirima nastojao psihoterapijske i psihološke spoznaje učiniti pristupačnima široj publici.

U jednom od gradova koje je obilazio, u Bjelovaru, je i preminuo. Njegova smrt je gotovo ahetipska. Nakon tri sada predavanja, nakon zadnje šale, koju je rekao za rastanak, kad su ljudi već ustajali i spremali se na odlazak, rekao je 'Nije mi dobro...to nije srce...' i bez ikakvih drugih reakcija, znakova boli, patnje, borbe koje često prate umiranja je sjedeći izdahnuo.

Carlos Castaneda, čije knjige su prije dvadesetak godina bile hit, a prof. Gruden je i te knjige čitao, piše da smrt besprijekornom ratniku, koji je tijekom života zbog svoje besprijekornosti prikupio puno osobne snage, daje priliku da otpleše svoj zadnji ples, u kojem prikazuje cijeli svoj život. Dok traje ratnikov zadnji ples smrt strpljivo sjedi i čeka. Ako prihvatimo tu metaforu, smrt je sjedila u publici u Bjelovaru, dozvolila je prof. Grudenu da se bez njenog uplitanja posljednji put izrazi na način koji mu je bio najprimjereniji i koji je obilježio njegov život.

U prvom vremenu nakon odlaska voljene osobe, ostaje praznina, osjećaj unutrašnje rupe. Ali 'praznina', koja označava gubitak odnosa uskoro nestaje, jer unutrašnji prof. Gruden ostaje. Dapače, vrlo je aktivan kroz svoje učenike koji na raznim mjestima svakodnevno vježbaju. Temeljna pretpostavka vježbanja autogenog

apy. He also worked with various other types and methods of psychotherapy such as, for example, individual psychoanalytical psychotherapy, group analysis, and group psychotherapy. The aspect of the teacher was an important part of Prof. Gruden's identity. As a teacher, Prof. Gruden would present otherwise very complicated and inaccessible concepts and insights in psychotherapy and psychology, as well as his own wisdom based on his experiences, in a way that was simple and accessible to others. This brings him close to the ideas of M. Balint.

Other than his regular trips and visiting lectures, Prof. Gruden often addressed the general public via the media. In media circles it was well-known that Prof. Gruden was almost always courteously at their disposal. Many videos can be found on the internet where Prof. Gruden attempts to make insights from psychotherapy and psychiatry accessible to the general public in various ways and in various formats.

Bjelovar, one of the cities he often visited, was where he died. His death is almost archetypal. After three hours of lectures, after a last joke that he said as a farewell, as people were already rising to depart, he said "I don't feel well… it's not the heart", and without any other reaction, signs of pain, suffering, or struggle that so often accompany death, the passed away seated in his chair.

Carlos Castaneda, whose books were a hit about twenty years ago and whom Prof. Gruden had read, said that to a flawless warrior who has in his life gathered much personal strength because of his flawlessness, Death provides an opportunity to dance a last dance that represents the warrior's whole life. As long as the dance lasts, death patiently sits and waits. If we embrace this metaphor, Death was seated in the audience in Bjelovar, allowing Prof. Gruden to express himself for the last time in the way that was most suited to him and that marked his whole life.

Initially, after the departure of a loved one, there is a feeling of emptiness, of an inner void.

treninga je postizanje unutrašnjeg mira. Prof. Gruden, učitelj autogenog treninga, je sada ušao u trajni mir, potpuni mir.

Vedran Bilić

But the “emptiness” that marks the loss of a relationship soon disappears, because the inner Prof. Gruden remains. In fact, he is very active through his many students who train every day. The fundamental assumption of autogenic training is achieving inner peace. Prof. Gruden, the teacher of autogenic training, is now fully and forever at peace.

Vedran Bilić

Upute autorima

O časopisu

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

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