Poticanje rezilijencije, a time i kvalitete života kod stresom i traumom uzrokovanih poremećaja putem kriznih intervencija

/ Encouraging Resilience and Thus Also Quality of Life in Trauma and Stressor-induced Disorders Through Crisis Interventions

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Ubrzani ritam života donosi sve veći stres koji može dovesti do iscrpljenja i sloma prilagodbenih kapaciteta, a kod nekih pojedinaca s vremenom uzrokovati dugotrajne posljedice te psihotraumatizaciju. Novija istraživanja sve veću pozornost usmjeravaju podizanju kvalitete života oboljelih raznim intervencijama koje potiču rezilijenciju. Kriznim intervencijama, psihoterapijskim i farmakoterapijskim metodama u sklopu rada Dnevne bolnice specijalizirane za provođenje preventivnog i terapijskog programa stresom i traumom uzrokovanih poremećaja (DB STUP) potičemo zdrave snage ličnosti odnosno rezilijenciju što omogućava oporavak, odnosno vraćanje na premorbidno funkcioniranje i kvalitetu života. Cilj rada je pokazati kako su intervencije koje primjenjujemo u Dnevnoj bolnici utjecale na kvalitetu života i time povećale rezilijenciju. Prikazat ćemo evaluaciju našega rada tijekom četiriju godina (od 2015. do 2019.). Uzorak čini 129 pacijenata. Primijenjen je upitnik WHOQOL-BREF (*World Health Organization Quality of Life Brief Version questionnaire*) na početku i na kraju programa/hospitalizacije. Istraživanje je pokazalo statistički značajno poboljšanje kvalitete života pri izlasku iz programa/hospitalizacije. Našli smo poboljšanje u svim četirima domenama kvalitete života i to sljedećim redoslijedom: poboljšanje psihičkog zdravlja, fizičkog zdravlja, percepcija utjecaja okoline te društvenih odnosa. U aspektu sociodemografskih čimbenika kao značajan pokazao se isključivo spol – žene koje su izvještavale o značajnijem poboljšanju u aspektu društvenih odnosa, dok su u preostalim domenama spolovi izjednačeni. Naše je istraživanje pokazalo da se intervencijama u kriznim situacijama povećava rezilijencija pa time i kvaliteta života što je neodvojivo povezano.

/ The accelerated rhythm of the modern lifestyle has resulted in growing levels of stress, which can lead to exhaustion and a breakdown of a person's capacity for adjustment, sometimes even causing lasting effects and psychological trauma. Newer studies have increasingly focused on improving patient quality of life through various interventions that improve resilience. Crisis interventions as well as psychotherapy and pharmacological treatment are used in our Day Hospital, which specializes in the implementation of preventative and treatment programs for trauma and stressor-induced disorders (TSRD) in order to encourage healthy psychological strength, i.e. resilience, enabling recovery and return to premorbid functioning and quality of life. The goal of this study was to show how the interventions we apply in the Day Hospital have influenced the patient quality of life and thus increased their resilience. We will present an evaluation of our work over a period of four years (from 2015 to 2019). Our sample comprises 129 patients. We applied the WHOQOL-BREF (World Health Organization Quality of Life Brief Version) questionnaire at the start and at the end of the patients' hospital stay or program. The results show a statistically significant improvement in quality of life at the end of the program. We found improvements in all four quality of life domains, in descending order of magnitude: improvement in mental health, physical health, environment, and social relationships. Sex was the only sociodemographic factor that was significant – women reported more significant improvements in the social relationships domain, whereas the results were equal between the sexes in the other domains. Out study demonstrated that crisis interventions improve resilience and therefore also quality of life, as the two are unquestionably related.

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UVOD

Ubrzani ritam života donosi sve veći stres, koji kod nekih pojedinaca može dovesti do iscrpljenja i sloma prilagodbenih kapaciteta, a vremenom bez adekvatne intervencije i liječenja uzrokovati i dugotrajne posljedica te psihotraumatizaciju.

Stres definiramo kao skup psihičkih, fizičkih i ponašajnih promjena koje nastaju kada vanjski i/ili unutrašnji čimbenici (stresori) remete homeostazu, tj. fiziološku ravnotežu organizma. Stresor je svaki unutarnji ili vanjski podražaj, događaj ili situacija koji može dovesti do poremećaja u svakodnevnom funkcioniranju i zahtijeva prilagodbu. Način na koji će se pojedinac nositi sa stresorom rezultat je međudjelovanja osobina ličnosti, genetike, iskustva i karakteristika stresora. Reakcija na stres ne mora uvijek biti negativna. Stres koji ne nadvladava prilagodbene kapacitete može imati učinak cjepiva, tj. povećavati kapacitet za prihvaćanje i toleranciju budućih sličnih štetnih događaja. Međutim, ekscesivan stres može preplaviti kompenzacijske mehanizme i uzrokovati iscrpljenje s pojavom psihopatologije, traumatizacije uključujući i PTSP (1,2). Procjena pojedinca ključna je da se neki događaj ili situacija okarakteriziraju kao stresni. S druge strane, traumatski događaji malo ovise o procjeni pojedinca, toliko su teški da neizbježno pogađaju gotovo svaku osobu koja im je izložena. To su događaji koji izlaze izvan okvira uobičajenog

INTRODUCTION

The accelerated rhythm of the modern lifestyle brings increasing levels of stress, which can lead to exhaustion and a breakdown of a person's capacity for adjustment, sometimes even causing lasting effects and psychological trauma if timely intervention and treatment are not forthcoming.

Stress is defined as a group of psychological, physical, and behavioral changes that take place when external or internal factors (stressors) disturb the homeostasis, i.e. the physiological balance of the organism. A stressor is any internal or external stimulant, event, or situation that can lead to a disorder of everyday function and requires adjustment on part of the individual. The way an individual copes with a stressor is dependent on the interaction of personality traits, genetics, experience, and the characteristics of the stressor itself. The reaction to stress does not always have to be negative. Stress that does not overpower the person's capacity for adjustment can have an inoculative effect, i.e. increase their capacity to accept and tolerate such harmful events in the future. However, excessive stress can overcome a person's compensatory mechanisms and cause exhaustion coupled with the manifestation of psychopathology, traumatization, and even PTSD (1,2). The individual's own assessment of a situation is crucial in determining whether an event or

ljudskog iskustva i gotovo uvijek izazivaju patnju. Vrsta i jačina reakcije na traumatski događaj ovisi o osobinama pojedinca, dimenzijama traumatskog događaja i osobinama socijalne podrške (3). No što je trauma intenzivnija to je utjecaj prethodnog iskustva i osobina ličnosti na njegov učinak manji. Dakle, odgovor na traumu ili značajnu količinu stresnih događaja i situacija određen je interakcijom između individualnih značajki (kao što su genetika, epigenetika, rani razvoj, neurobiološki čimbenici) u određenom socijalnom okruženju (obitelj, kultura, ekonomski čimbenici, politički sustav) (4). Intenzitet reakcije na stresni ili traumatski događaj ovisi o kognitivnoj obradi situacije od pojedinca, tj. o doživljaju. Krizna situacija može biti izazov i mogućnost za brzo rješavanje problema i „rast", no krizna situacija može dovesti do psihičke neravnoteže, neuspješnih *coping* obrazaca, poremećaja u ponašanju i disfunkcionalnosti (5).

MKB-11 definira poremećaj prilagodbe kao neadekvatnu reakciju na psihosocijalni stresor ili višestruke stresore (kao što su razvod, bolest, socioekonomski problemi, konfliktne situacije u obiteljskom ili poslovnom okruženju i sl.). Prema MKB-11 poremećaj prilagodbe pojavljuje se unutar mjesec dana od pojave stresora i ne traje dulje od šest mjeseci. Poremećaj karakterizira zabrinutost uzrokovanu samim stresorom ili njegovim posljedicama, ponavljajuće uznemirujuće misli ili ruminacije o njegovim posljedicama te nemogućnost prilagodbe na stresni događaj. Poremećaj obilježava i značajno oštećenje na osobnom, obiteljskom, socijalnom, radnom i drugim područjima života.

Dijagnostička obilježja poremećaja prilagodbe u DSM-5 su prisutnost emocionalnih simptoma ili simptoma u ponašanju koji su odgovor na prepoznatljiv stresor. Subjektivne tegobe ili oštećenja funkcioniranja povezana s poremećajem prilagodbe često se manifestiraju kao smanjena učinkovitost na poslu ili školi te privremene promjene u socijalnim odnosima. Prema navedenom klasifikacijskom sustavu

situation will be perceived as stressful. On the other hand, traumatic events do not significantly depend on the individual's own assessment, as they are so severe that they unavoidably affect any person exposed to them. These are events that are beyond the scope of normal human experience and almost always cause suffering. The type and severity of the reaction to a traumatic event depends on the characteristics of the individual, the severity of the traumatic event, and on the characteristics of available social support (3). However, the more intense the trauma, the less influence a person's previous experience and personality can exert on its effects. The response to trauma or a significant number of stressful events and situations is thus determined by the interaction between individual characteristics (such as genetics, epigenetics, early development, neurobiological factors) in a given social environment (family, culture, economic factors, political system) (4). The intensity of the reaction to a stressful or traumatic even depends on the cognitive processing on part of the individual, i.e. their experience. A crisis can be a challenge and an opportunity to quickly resolve the problem and experience "growth", but a crisis can also lead to psychological disbalance, failed coping patters, behavior disorders, and dysfunctionality (5).

ICD-11 defines adjustment disorders as an inadequate reaction to a psychosocial stressor or multiple stressors (such as divorce, illness, socioeconomic problems, conflicts in the family or work environment, etc.). According to ICD-11, adjustment disorders manifest within a month of the appearance of stressors and does not last longer than six months. An adjustment disorder is characterized by anxiety caused by the stressors themselves or their consequences, recurrent upsetting thoughts or ruminations on the consequences of the stressful event, and the inability to adjust to the event. Adjustment disorders are also characterized by significant damage in personal, family, social, occupational, and other areas of the person's life.

poremećaj prilagodbe može se dijagnosticirati i nakon smrti voljene osobe kada intenzitet, kvaliteta ili trajanje reakcije tuge prelaze ono što se normalno može očekivati kada se uzmu u obzir kulturalne, vjerske ili dobi primjerene norme. Dijagnostički kriteriji za postavljanje poremećaja prilagodbe u DSM-5 su sljedeći:

A) Razvoj emocionalnih simptoma ili simptoma u ponašanju koji su odgovor na prepoznatljiv stresor;

B) Ti simptomi ili ponašanja klinički su značajni na što upućuje jedno ili oboje od sljedećeg:

   1. Značajna patnja koja nije proporcionalna težini ili intenzitetu stresora, uzimajući u obzir vanjski kontekst i kulturalne čimbenike koji mogu utjecati na ozbiljnost simptoma i prezentaciju.
   2. Značajno oštećenje u socijalnom, radnom ili drugim važnim područjima funkcioniranja;

C) Nisu ispunjeni kriteriji za neki drugi psihički poremećaj;

D) Simptomi u sklopu tog poremećaja ne predstavljaju normalno žalovanje;

F) Simptomi ne perzistiraju dulje od šest mjeseci.

Kao i MKB-11 i DSM-5 navodi da stresor može biti jedan događaj ili se može raditi o višestrukim stresorima, mogu biti ponavljajući ili kontinuirano prisutni, a neki mogu pratiti specifične razvojne događaje (polazak u školu, napuštanje roditeljskog doma, ulazak u brak, roditeljstvo, nepostizanje profesionalnih ciljeva, umirovljenje). Poremećaji prilagodbe prema DSM-5 počinju unutar tri mjeseca od pojave stresora, za razliku od MKB-11 gdje je za postavljanje dijagnoze potrebno javljanje simptoma unutar mjesec dana. Oba klasifikacijska sustava ograničavaju trajanje poremećaja prilagodbe na šest mjeseci.

Postotak osoba u izvanbolničkom programu liječenja psihičkih bolesti s glavnom dijagnozom

Diagnostic characteristics of adjustment disorders in DSM-5 comprise the presence of emotional or behavioral symptoms that are a response to a recognizable stressor. The subjective difficulties or damage in functioning associated with adjustment disorders often manifest as reduced efficiency at work or temporary changes in social relationships. According to this classification system, an adjustment disorder can also be diagnosed after the death of a loved one when the intensity, quality, or duration of the grief are beyond what can normally be expected considering the culturally, religiously, and age-appropriate norms. Diagnostic criteria for adjustment disorder in DSM-5 are as follows:

A) The development of emotional or behavioral symptoms in response to an identifiable stressor.

B) These symptoms or behaviors are clinically significant, as evidenced by one or both of the following:

   1. Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
   2. Significant impairment in social, occupational, or other important areas of functioning.

C) Criteria for a different mental disorder are not met.

D) The symptoms do not represent normal bereavement.

F) The symptoms do not persist for more than an additional 6 months.

As in ICD-11, DSM-5 indicates that a stressor can be a single event or multiple stressors which can be repeating or continuously present, with some perhaps accompanying specific developmental events (starting school, leaving the parental household, entering marriage, parenting, failure to achieve professional goals, retirement). According to DSM-5, adjustment disorders mani-

poremećaja prilagodbe kreće se otprilike od 5 do 20 %, dok je u bolničkom psihijatrijskom okruženju to najčešća dijagnoza koja doseže 50 %, navodi DSM-5. Istraživanja su pokazala da u cjelokupnoj populaciji 50 – 60 % doživi tešku traumu, a prevalencija bolesti povezanih s traumom kreće se oko 7,8 % (6). U svrhu sprječavanja toga krizne intervencije postaju područje aktivnijeg pristupa u radu psihijatara. Intervencije u kriznim situacijama imaju za cilj smanjenje intenziteta krize, lakše podnošenje i integriranje traumatskog događaja u vlastito iskustvo, ponovno uspostavljanje kontrole, psihičke ravnoteže i funkcionalnosti pojedinca prije krize te sprječavanje emocionalnog sloma i razvoja PTSP-a.

S obzirom na to da je kvaliteta života kod oboljelih redovno narušena, oporavak neminovno sa sobom donosi i podizanje kvalitete života (7). Pojam kvaliteta života subjektivni je doživljaj i osjećaj pojedinca što podrazumijeva postojanje osjećaja radosti, životnog zadovoljstva, postojanje unutrašnjeg mira. Ona se odnosi na život bez posebne opterećenosti, na život bez straha i neizvjesnosti (8).

U novije vrijeme znanstvenici se sve više okreću od rizičnih čimbenika za razvoj psihopatologije prema čimbenicima koji promoviraju rezilijenciju, tj. otpornost i blagostanje te se usmjeravaju na istraživanje intervencija u području životnog stila, psiholoških i bihevioralnih metoda koji tome mogu doprinijeti (9). Rezilijencija, iako ovisi o biološkim i psihološkim čimbenicima, ovisi i o naučenim *coping* mehanizmima, socijalnoj okolini i stilu života te se može potaknuti na razne načine. Također, može se mijenjati tijekom vremena kao funkcija razvoja i interakcije s okolinom. Rezilijencija se u bolničkim uvjetima može potaknuti raznim intervencijama u području životnog stila, psihološkim, biološkim (farmakoterapija) i bihevioralnim metodama (9).

Tijekom programa Dnevne bolnice koja je specijalizirana za rad sa stresom i traumom uzro-

fest within three months of the appearance of the stressors, as opposed to ICD-11 where diagnosis requires presentation of the symptoms within a month. Both classification systems limit the duration of adjustment disorders to six months.

The percentage of outpatients treated for mental illnesses with a primary diagnosis of adjustment disorder is between 5 to 20%, whereas this is the most common diagnosis in the inpatient setting, reaching 50% according to DSM-5. Studies have shown that 50-60% of the total population experiences a severe trauma, and the prevalence of illnesses associated with trauma is approximately 7.8% (6). In order to prevent this, crisis interventions have become an area where a more active approach is employed in psychiatric work. The goals of crisis interventions are to reduce the intensity of the crisis, improve tolerance and integration of the traumatic event into the individual's experience, regaining control, mental balance, and functionality on part of the individual before the crisis, and prevent emotional breakdowns and development of PTSD.

Given that quality of life is reduced in such patients, recovery always results in an improvement in quality of live (7). The concept of quality of life is a subjective perception and feeling of the individual that includes the presence of a feeling of joy, life satisfaction, and the presence of inner peace. It refers to life with no special burdens, life without fear and uncertainty (8).

Recently, the focus of scientists has increasingly shifted from risk factors for developing psychopathologies to factors that promote resilience, i.e. fortitude and wellbeing, focusing on studying interventions in the areas of lifestyle habits and psychological and behavioral methods that can contribute to it (9). Resilience, despite being dependent on biological and psychological factors, also depends on learned coping mechanisms, the social environment, and one's lifestyle, and can be encouraged in many different ways. It can also change over time as a function of development and inter-

kovane poremećaje (DB STUP) temeljimo se na kriznim intervencijama, psihoterapiji te socioterapijskim postupcima uz ostale metode koje mogu pridonijeti jačanju rezilijencije što će biti opisano u tekstu. Oboljeli koje primamo i liječimo pokazuju teškoće koje se uklapaju u dijagnozu poremećaja prilagodbe (krizna stanja) i traumom uzrokovanih poremećaja. Program je sastavljen od progresivne mišićne relaksacije, grupne psihodinamske psihoterapije, psihoedukacije po kognitivno-bihevioralnim principima i socioterapije što uključuje radno-okupacijske terapije, terapijski-rekreativni izlaz, radionicu posttraumatskog rasta, tj. radionicu „Zdravi ja" i terapijsku zajednicu. Uspješnost programa mjerimo baterijom testova prije i nakon uključenja u program. U Dnevnoj bolnici radi tim koji se sastoji od šest članova: dva psihijatra educirana iz područja grupne analize, psihologa koji se bavi kognitivno-bihevioralnom terapijom, dvije medicinske sestre educirane iz grupne terapije te radno-okupacijskog terapeuta. U programu je sudjelovao i educirani socijalni pedagog koji je primjenjivao pristup *mindfulness*.

INTERVENCIJE

Uspješna krizna intervencija početna je točka na kontinuumu skrbi. Ciljevi intervencija u krizi su (3):

a) Smanjenje psihološke napetosti i uznemirenosti (tjeskoba, očaj, zbunjenost, nemir);
b) Vraćanje na razinu funkcioniranja i aktivnosti prije krize;
c) Poticanje korištenja dostupnih vanjskih i unutarnjih *copinga* i socijalne podrške;
d) Razvoj novih načina percepcije, suočavanja s problemima i njihovog rješavanja.

Potrebno je paziti na vrijeme kada se pruža intervencija koja se treba prilagoditi potrebama i kapacitetima pacijenta. Intervencije koje pojačavaju i poboljšavaju rezilijenciju mogu se primijeniti tijekom i nakon stresne ili traumatske situ-

actions with the environment. In a hospital setting, resilience can be encouraged through various interventions aimed at lifestyle habits and using psychological, biological (pharmacotherapy), and behavioral methods (9).

The program of the Day Hospital, which specializes in working with trauma and stressor-induced disorders (TSRD), is based on crisis interventions, psychotherapy, and social therapy procedures along with other methods that can contribute to building resilience, as will be described below. Patients treated in our program suffer from adjustment disorders (states of crisis) and trauma-induced disorders. The program comprises progressive muscle relaxation, group psychodynamic psychotherapy, psychoeducation based on cognitive-behavioral principles, and social therapy, which includes occupational therapy, therapeutic recreational outings, a posttraumatic growth workshop, i.e. the *Zdravi ja* workshop, and a therapy community. The success of the program is measured using a battery of tests before and after a patient has been included in the program. The Day Hospital employs a team comprising six members: two psychiatrists with an education in group analysis, a psychologist working with cognitive-behavioral therapy, two nurses educated in group therapy, and an occupational therapist. A social pedagogist who applied the mindfulness approach also participated in the program.

INTERVENTIONS

Successful crisis intervention is the starting point on the treatment continuum. The goals of crisis interventions are (3):

a) Reducing psychological tension and agitation (anxiety, despair, confusion, restlessness).
b) Returning to the level of functioning from before the crisis.
c) Encouraging the use of available external and internal coping mechanisms and social support.

acije. Neke intervencije mogu biti učinkovitije u jednom, a neke u drugom razdoblju. Neke osobe primarno su kognitivne u kriznim situacijama (tj. teže ponovnoj uspostavi kontrole i rješavanju problema), a druge su afektivne (iskazuju potrebu za suosjećanjem, podrškom i ventilacijom) o čemu ovisi i pristup pacijentu (3).

Za razliku od uobičajenog funkcioniranja u kojem prevladava kognitivna domena, osoba u stanju krize toliko je preplavljena emocijama da kognitivno ne funkcionira adekvatno te se ne može koristiti mehanizmima suočavanja s problemima koje inače koristi (10,11).

Intervencije u kriznoj situaciji treba usmjeriti na pomoć kako iz krizne situacije izaći ili nositi se s njom. Intervencijama se pruža emocionalna podrška, prihvaćanje i razumijevanje te se potiče emocionalno rasterećenje. Potrebno je s pacijentom definirati problem, tražiti konkretne informacije te vremenom i postavljati konkretne zahtjeve u smjeru prilagodbe ponašanja. Također, treba potaknuti pacijenta da razvije strategije suočavanja što uključuje prihvaćanje situacije. Pružanje psihoedukacije o bitnim činjenicama iz područja stresa i traume pokazala se korisnom pacijentima kako bi razumjeli svoje reakcije. Kod traumatiziranih pacijenata najvažnije su intervencije koje potiču strukturirano i detaljno prorađivanje stresne/traumatske situacije uz usmjeravanje na emocionalne, kognitivne i ponašajne reakcije. Verbalizacija doživljaja, misli i stanja te pokazivanje osjećaja vezanih za traumatsko iskustvo pomaže pacijentima bolje procijeniti bolne traumatske i posttraumatske reakcije te ih integrirati u životno iskustvo (5). Pacijente je potrebno potaknuti da promijeni referentni okvir, tj. da se situacija zaista i shvati kao nesvakidašnja te da se reakcije prihvate kao karakteristične za traumatsko iskustvo. Ipak, inzistiranje na ventilaciji i otvorenom razgovoru o traumi u određenom broju traumatiziranih dovodi do preplavljivanja traumatskim iskustvima što se pokazalo kontraproduktivno (12). Naime,

d) Developing new ways of perceiving, facing, and solving problems.

The timing of the intervention must be considered and tailored to the needs and capacities of the patient. Interventions that build and improve resilience can be applied during or after stressful and traumatic situations. Some interventions can be more effective before the stressful or traumatic situation, while others can be more effective after has already taken place. Some persons are primarily cognitive in crisis situations (i.e. they strive to reestablish control and resolve the problem), while others are affective (expressing the need for empathy, support, and venting), which should inform the approach taken towards the patient (3).

As opposed to normal functioning where the cognitive domain is not dominant, a person in a state of crisis is so overwhelmed by emotions that they do not function adequately at a cognitive level and cannot employ the coping mechanisms they normally use (10,11).

Crisis interventions should be focused on leaving or coping with the crisis situation. Interventions provide emotional support, acceptance, and understanding and encourage emotional unburdening. It is important to define the problem together with the patient, looking for concrete information and in time setting concrete demands with regard to behavior adjustment. The patient should also be encouraged to develop coping strategies, which includes accepting the situation. Providing psychoeducation on important facts regarding stress and trauma has shown to be beneficial to patients in allowing them to understand their own reactions. In traumatized patients, the most important interventions are those that encourage structured and detailed processing of the stressful/traumatic situation with a focus on emotional, cognitive, and behavioral reactions. Verbalization of experiences, thoughts, and states and expressing feelings tied to the traumatic experience helps patients assess their painful traumatic and posttraumatic reac-

nisu svi pacijenti odmah spremni na strukturiranu i detaljnu proradu traume s obzirom na to da je izbjegavanje podsjetnika traumatskog događaja jedan od glavnih simptoma PTSP-a, kao i ponovno proživljavanje traumatske situacije što izaziva uznemirenosti. Kada je pacijent spreman za strukturirano prorađivanje traumatskog događaja možemo početi govoriti o putu prema izlječenju. Kod traumatiziranih osoba bitno je brzo uspostavljanje terapijskog odnosa uz neutralni i neosuđujući stav u cilju psihičkog smirivanja, stvaranja povjerenja u odnosu i osjećaja sigurnosti (13).

Nakon uspješne krizne intervencije može uslijediti psihoterapija. Psihoterapijske intervencije u krizi treba prilagoditi ovisno o težini poremećaja i strukturi ličnosti pacijenta.

U kriznim situacijama izrazito je bitna podrška okoline, obitelji i prijatelja te se intervencije trebaju usmjeriti na poticanje socijalnog povezivanja i resocijalizaciju, pružanja podrške i ohrabrenja da se ta podrška traži u socijalnoj okolini (među obitelji i prijateljima) (14). Grupne terapije u tom smislu pružaju oboljelima utočište i razumijevanje da u krizi nisu sami.

U grupnoj psihoterapiji radi se na uspostavljanju bazičnog povjerenja empatijskim razumijevanjem, kontejniranjem, sadržavanjem teških osjećaja te osiguranjem konstantnosti terapeuta i tima. Terapeut se usmjerava na rad s osjećajima i emocijama uz aktivno slušanje, pokazivanje zainteresiranosti i korištenje ohrabrujućih formulacija, refleksije i parafraziranja. Potiče se pozitivan način razmišljanja, instalacija nade i motivacije uz ohrabrenje i poticaj za rješavanje nelagodnih životnih situacija. Istražuju se alternativne mogućnosti za prevladavanje trenutačne situacije uz identifikaciju ranijih uspješnih mehanizama. Voditelj treba prihvatiti osjećaje pacijenta bez umanjivanja njihovog značenja, ali raditi na mijenjanju referentnog okvira da ih pacijent može vremenom integrirati u vlastito iskustvo (15). Također,

tions more clearly and integrate them in their life experience (5). Patients should be encouraged to change their frame of reference, i.e. actually perceive the situation as out of the ordinary and accept their own reactions as characteristic of a traumatic experience. However, insisting on venting and open conversation on the trauma can cause some patients to become overflown with traumatic experiences, which has shown to be counterproductive (12). Not all patients are immediately ready for structured and detailed processing of their trauma, given that avoiding reminders of the traumatic event is one of the main symptoms of PTSD, as is reliving the traumatic situation that causes anxiety. When the patient is ready for structured processing of the traumatic event, we can start saying that they are on the path to recovery. In traumatized individuals, rapid establishment of the therapeutic relationship with a neutral and non-judgmental stance is very important for achieving a calmer state of mind, trust in the relationship, and a feeling of security in the patient (13).

A successful crisis intervention can be followed by psychotherapy. Psychotherapy interventions during the crisis should be adjusted based on the severity of the disorder and the personality structure of the patient.

Receiving support from one's environment, family, and friends is extremely important during crisis situations, and interventions should focus on encouraging social connections and resocialization, providing support and encouragement, and searching for that support in the patient's social environment (among family and friends) (14). In this sense, group therapy can provide patients with a refuge and help them understand they do not have to face the crisis alone.

Group therapy aims to establish basic trust through empathetic understanding, functioning as a container for difficult emotions, and ensuring constancy in the therapist and team. The therapist focuses on working with feelings and emotions with active listening, showing

pacijenta treba potaknuti da smanji one misli koje su previše samokritične i nisu racionalne. Time radimo na osnaživanju pojedinca kako bi se lakše nosio sa životnim nedaćama. Pravila u grupnom procesu između ostaloga zahtijevaju povjerljivost, odsutnost kritike, vrednovanje tuđih izjava tijekom govora, neophodnost da svi sudjeluju u iznošenju činjenica, svatko govori za sebe i preuzima odgovornost za izrečeno. Navedenim se potiče vraćanje osjećaja sigurnosti, djelujemo na ublažavanje psihopatologije, resocijalizaciju i jačanje ego snaga te u konačnici pogodujemo rezilijenciji pogođene osobe kao i kvaliteti života.

U osnovi cilj je intervencija integracija traume, ublažavanje utjecaja kriznog događaja, ubrzavanje oporavka te sprječavanje nastanka nepoželjnih dugoročnih posljedica. Drugim riječima, cilj je prevencija problema koju pacijenti mogu imati u obiteljskom, poslovnom i socijalnom okruženju kao i sprječavanje retraumatizacije i kronificiranja stresom i traumom uzrokovanih poremećaja.

ŠTO JE REZILIJENCIJA I KAKO JE POTAKNUTI?

Rezilijencija se definira kao sposobnost da se pod utjecajem štetnih čimbenika osoba ne slomi iako padne, ustane i prilagodi se novonastaloj situaciji (1). Rezilijencija je povezana sa sposobnošću da se angažira cijeli spektar *coping* strategija na fleksibilan način ovisno o specifičnom izazovu te da se potom koriste korektivne povratne informacije za prilagodbu tih strategija. Nedavna istraživanja ukazuju da je rezilijencija u ljudi aktivan, adaptivni proces, na koji se može utjecati, a ne jednostavno odsustvo patološkog odgovora, koji se inače javlja u osjetljivijih osoba nakon stresnog događaja (16).

Rezilijencija na neki traumatski ili stresni događaj definira se kao zdrav, stabilan, adaptivan način funkcioniranja nakon što je osoba bila

interest, and using encouraging formulations, reflections, and paraphrasing. Positive thinking is encouraged, as is installing hope and motivation with encouragement in dealing with difficult situations. Alternative methods to overcome the current situation are explored, along with identification of mechanisms that were previously successful. The group therapist should accept the patient's feelings without attempting to diminish their meaning, instead working on changing the reference frame in order to allow to patient to gradually integrate them into their own experience (15). The patient should also be encouraged to reduce those thoughts that are overly self-critical and irrational. This strengthens the individual, helping them cope with life's difficulties. Among other things, the rules of the group process require confidentiality, absence of criticism, respecting the statements of others when speaking, the necessity of everyone participating in presenting facts, everyone speaking for themselves, and taking responsibility of what one says. This encourages returning to a feeling of security, ameliorates the psychopathology, encourages resocialization and improves ego strength, and ultimately benefits the resilience and thus the quality of life of the affected person.

The basic goal of these interventions in integrating trauma, ameliorating the effects of the crisis event, quickening recovery, and preventing the development of adverse long-term consequences. In other words, the goal is preventing problems that patients can have in family, occupational, and social environments as well as preventing re-traumatization and chronification of disorders induced by stress and trauma.

WHAT IS RESILIENCE AND HOW TO ENCOURAGE IT?

Resilience is defined as a person's ability to not break under the influence of harmful factors, to get back up after falling down and adapt to the new situation (1). Resilience is associated with

izložena stresnom događaju (17,18). Dakle, ona uključuje svjesni trud da se krene naprijed, uključuje motivaciju da se nešto nauči iz stresne situacija s uvidom i integracijom pozitivnih aspekata te situacije kao lekcije koja je naučena nakon nekog stresnog iskustva (19,20). Rezilijencija se također odnosi na kapacitet osobe da izbjegne negativne socijalne, psihološke i biološke posljedice ekstremnog stresa koji bi inače kompromitirali psihičko i fizičko zdravlje.

Neke osobe mogu pokazivati veću otpornost/rezilijenciju u nekim područjima svog života u usporedbi s drugim. Također mogu pokazivati veću rezilijenciju tijekom jednog razdoblja života u usporedbi s drugim. Kada definiramo rezilijenciju, često se pokušava zauzeti stajalište je li rezilijencija prisutna ili odsutna. U realnosti rezilijencija može biti prisutna na kontinuumu u različitim stupnjevima u različitim područjima života (21). Recimo, osoba koja se dobro adaptira na stres na radnom mjestu može imati teškoće adaptacije u ljubavnim i emotivnim vezama. Rezilijencija se također može mijenjati tijekom vremena kao funkcija razvoja i interakcije s okolinom.

Rezilijencija se treba razgraničiti od vulnerabilnosti na stres i posttraumatskog rasta (22). Vulnerabilost na stres zbraja rizične čimbenike za razvoj PTSP-a, dok rezilijencija obuhvaća i pozitivan i negativan učinak izlaganja stresu. Rezilijencija dakle, kao i vulnerabilnost, obuhvaća predispoziciju za razvoj PTSP-a nakon traumatskog događaja, međutim zbraja i pozitivne učinke. Posttraumatski rast uključuje samo pozitivne promjene koje se pojavljuju u osobe nakon stresnog događaja (23-25). Moglo bi se reći da vulnerabilnost na stres kao i posttraumatski rast pripadaju u podskupinu rezilijencije te da je rezilijencija širi pojam. Ovdje bi trebali spomenuti da rezilijencija može koegzistirati s PTSP-om, omogućujući pomicanje prema integraciji i uvidu u pozitivnom smislu (26-28).

the ability to engage the whole spectrum of coping strategies in a flexible way depending on the nature of the specific challenge as well as the ability to then use corrective feedback to adapt those strategies to the situation. Recent studies have shown that resilience is an active, adaptive process that can be influenced, and is not just the absence of a pathological response that manifests in sensitive persons after a stressful event (16).

Resilience to a traumatic or stressful event is defined as healthy, stable, and adaptive functioning after being exposed to the stressful event (17,18). It therefore includes a conscious effort to move forward as well as being motivated to learn from the stressful situation using insight into and integration of positive aspects of the situation as a lesson that has been learnt after the stressful experience (19,20). Resilience also refers to a person's capacity to avoid negative social, psychological, and biological consequences of extreme stress that would otherwise compromise a person's physical and psychological health.

Some individuals can show greater resilience in some aspects of their lives than in others. A person can also show greater resilience at one point in their lives than at another. In defining resilience, resilience is often dichotomized as present or absent. In reality, the presence of resilience is on a continuum with different levels of resilience in different aspects of life (21). For example, an individual who adapts well to occupational stress may have issues adapting in romantic and emotional relationships. Resilience can also change over time as a function of personal development and interaction with the environment.

Resilience should be differentiated from vulnerability to stress and posttraumatic growth (22). Vulnerability to stress is the sum of risk factors for developing PTSD, while resilience also encompasses both the positive and negative effect of exposure to stress. Resilience, like vulnerability, encompasses the predisposition to develop PTSD after a traumatic event, but

Što determinira rezilijenciju i dalje je vrlo diskutabilno. Od čimbenika koji se jasno povezuju s rezilijencijom u odrasloj dobi najvažniji su zdrava privrženost, sposobnost emocionalne regulacije, samosvjesnost, kapacitet za vizualizaciju budućnosti i motivacijski sustav koji omogućuje osobi da uči iz iskustva, raste i adaptira se na okolinu.

Odrednice rezilijencije uključuju puno bioloških, psiholoških, socijalnih i kulturalnih čimbenika koji utječu jedna na drugu (29). Mnoga istraživanja pokazuju da psihološka rezilijencija dobrim dijelom ovisi o uvjetima odrastanja i razini skrbi tijekom ranog djetinjstva (tj. okolišu koji je pun ljubavi, emocionalno raspoloživ, dosljedan i pouzdan) (30). Adekvatni socijalni i okolišni uvjeti mogu podržavati razvoj individualnih osobina i vještina povezanih s rezilijencijom što uključuje sposobnost regulacije emocija, samoumirivanje, sposobnost rješavanja problema pod stresom, oblikovanje sigurne privrženosti, održavanje prijateljskih i intimnih odnosa, postizanje pozitivnih osjećaja i samoostvarenja. Međutim, kada je okolina u kojoj dijete odrasta kaotična i stresna, dolazi do neurobioloških, emocionalnih i ponašajnih odgovora na buduće stresore koji se mogu zadržati do odrasle dobi (31). Istraživanja pokazuju da izlaganje umjerenoj razini stresa tijekom života zahtijeva stalnu primjenu *coping* strategija što vodi stjecanju vještina, doživljaju uspješnog savladavanja prepreka, stavu da se sa stresom može izaći na kraj te se time potiče doživljaj kontrole nad nepredviđenim situacijama što promovira rezilijenciju u budućnosti (32,33). Navedeno upućuje da održavanje optimalne razine izloženosti stresu (što možemo nazvati i eustres, tj. stres koji se uspješno svladava i koji ne dovodi do slamanja prilagodbenih kapaciteta) može spriječiti razvoj većih psihijatrijskih poremećaja, no potrebna su daljnja istraživanja na tom području (34,35).

Istraživanja na području psihološkog razvoja ljudi u zadnjim dvama desetljećima pokazala su da je rezilijencija ponajprije rezultat adaptiv-

also includes the positive effects. Posttraumatic growth only includes the positive changes that appear in a person after a stressful event (23-25). It can be said that vulnerability to stress and posttraumatic growth are subsets of resilience, which is a wider concept. It should also be noted that resilience can coexist with PTSD, allowing movement towards integration and insight in the positive sense (26-28).

What determines resilience is still very much open to discussion. Among factors that are clearly associated with resilience in adulthood, the most important are healthy attachment, capacity for emotional regulation, conscientiousness, capacity to visualize the future, and a motivational system that allows the person to learn from experience, grown, and adapt to their environment.

The determinants of resilience include many biological, psychological, social, and cultural factors that influence one another (29). Many studies have shown that psychological resilience greatly depends on the circumstances an individual grew up in and the level of care during early childhood (i.e. a love-filled environment, emotional availability, consistency, and reliability) (30). Adequate social and environmental factors can support the development of individual traits and skills that are associated with resilience, which include the ability to regulate emotions, self-calming, the ability to solve problems under stress, shaping of safe attachment, maintaining friendships and intimate relationships, achieving positive feelings, and self-realization. However, if the environment a child is growing up in is chaotic and stressful, this can lead to neurobiological, emotional, and behavioral responses to future stressors that can be retained in adulthood (31). Studies have shown that exposure to a moderate level of stress during life requires the constant application of coping strategies, which leads to the acquisition of skills, experience in successful overcoming of obstacles, and the be-

nog *coping* odgovora na stresni čimbenik, a ne isključivo rijetka osobina, iako jedno ne isključuje drugo (36,37). Nasljedne osobine koje se povezuju s rezilijencijom su ekstraverzija i optimizam s obzirom na to da su povezani s kapacitetom za traženje i korištenje socijalne podrške.

Neke obitelji pokazuju veću rezilijenciju nego druge. „Rezilijentnije" obitelji pružaju objašnjenje za životnu patnju, daju osjećaj smisla, nade i reda te se okreću budućnosti. U „rezilijentnim" obiteljima prevladava stav da život zaista ima smisla unatoč kaosu, brutalnosti, stresu i očaju te se fokusiraju na ono što je ostalo, a ne što je izgubljeno. Ta nada ili smisao esencijalna je za takozvanu kulturalnu perspektivu rezilijencije (38-40).

Socijalna podrška izrazito je važna za održavanje i jačanje rezilijencije neke osobe. Sama spoznaja da imamo nekoga na koga se možemo osloniti, tko nam može pružiti pomoć i utjehu, posebno tijekom stresnih razdoblja, vrlo je značajna za psihološku otpornost (41,42). Rezultati meta-analiza pokazuju da je slaba posttraumatska socijalna podrška konzistentan rizični čimbenik za razvoj PTSP-a (12).

Učinkovitost socijalne podrške ovisi o vrsti podrške koja je pružena te dužini trajanja, a što bi odgovaralo individualnim potrebama koje se mogu mijenjati tijekom vremena. Govorimo o nekoliko aspekata socijalne podrške (43):

1. strukturalna socijalna podrška (veličina socijalne mreže pojedinca, frekvencija socijalnih interakcija),
2. funkcionalna socijalna podrška (percepcija da su socijalne interakcije korisne, tj. da omogućuju ispunjenje određenih emocionalnih potreba),
3. emocionalna socijalna podrška (ponašanja koja potiču osjećaj ugode, doživljaj da je osoba voljena i respektirana),
4. instrumentalna/materijalna socijalna podrška (pružanje dobara i usluga koje služe da se pomogne riješiti određeni problem),

lief that stress is something that can be handled, thus encouraging a feeling of control over unforeseen situations that promotes resilience in the future (32,33). This indicates that maintaining the optimal level of exposure to stress (which we can call *eustress*, i.e. stress that is successfully overcome and that does not lead to the breakdown of adaptive capacity) can prevent development of major mental disorders, but further research on this topic is needed (34,35).

Over the last two decades, studies on the psychological development of humans have shown that resilience is primarily the result of an adaptive coping response to the stressor, and not exclusively a rare characteristic, although one does not exclude the other (36,37). Hereditary characteristics associated with resilience are extroversion and optimism, since they are associated with the capacity to seek out and use social support.

Some families show greater resilience than others, and "more resilient" families provide an explanation for suffering, provide a sense of meaning, hope, and order, and are future-oriented. The attitude that life truly has meaning despite the chaos, brutality, stress, and despair is predominant in "resilient" families, and they focus on what remains rather than on what is lost. This hope or meaning is essential for the so-called cultural perspective of resilience (38-40).

Social support is extremely important for maintaining and building resilience in a person. Just knowing that we have someone we can rely on who can offer us support and consolation, especially during stressful periods, is very important for psychological resilience (41,42). The results of several meta-analyses show that poor posttraumatic social support is a consistent risk factor for the development of PTSD (12).

The effectiveness of social support depends on the type of support being provided and its duration, which must also suit the individual's needs that can change over time. There are several aspects of social support (43):

5. informacijska/kognitivna socijalna podrška (pružanje savjeta ili uputa s ciljem/namjerom da se pomogne osobi boriti se s trenutačnom situacijom).

Navedeni aspekti socijalne podrške mogu se unaprijediti i održavati u različitim sustavima kao obiteljskom, u području socijalne zajednice, države, nacije ili na razini međunarodnog sustava u raznim programima (43). Potpora koju pruža neka (šira) socijalna zajednica može pomoći jačanju rezilijencije pojedine osobe programima koji promiču sigurnu životnu okolinu, pristupačnim cijenama domova, stabilnošću u dostupnosti hrane i zaposlenosti, pristupom zdravstvenoj zaštiti, učinkovitim školstvom, pripremljenošću i osposobljenošću u slučaju katastrofe te raspoloživim i bogatim javnim prostorom koji se može koristiti za relaksaciju i vježbu (44).

Pokazalo se da je socijalna podrška poticanjem da se usvoje zdravi i reduciraju rizični oblici ponašanja, osjećajem da se osoba razumije te pomoću u procjeni da potencijalne stresne situacije nisu toliko opasne povezane s rezilijencijom na psihopatologiju. Socijalna podrška može povoljno utjecati na osjećaj kontrole ili sposobnosti za rješavanje potencijalno vrlo stresne situacije, može pojačati samopoštovanje te potaknuti korištenje adekvatnih *coping* strategija.

Što se tiče farmakoterapije, bitno je spomenuti da je utvrđeno značajno preklapanje između gena koji reguliraju rezilijenciju i onih koji su regulirani dugotrajnom uporabom antidepresiva (45). Navedeno može upućivati na to da antidepresivi potiču u pacijenata one adaptacije koje se prirodno pojavljuju u osoba koje posjeduju nasljednu sposobnost rezilijencije, tj. koji su rezilijentni. Smatra se da farmakoterapijom također možemo utjecati na epigenetsku modulaciju (46). Neka istraživanja pokazala su da primjena selektivnih inhibitora ponovne pohrane serotonina (SIPPS) odmah nakon traume može dovesti do redukcije rizika

1. Structural social support – the size and extent of the individual's social network, frequency of social interactions.
2. Functional social support – the perception that social interactions have been beneficial, i.e. that they meet certain emotional needs.
3. Emotional social support – behavior that fosters feelings of comfort, leading the person to believe that they are loved and respected.
4. Instrumental/material social support – providing goods and services that help solve concrete practical problems.
5. Informational/cognitive social support – provision of advice or guidance with the intent to help individuals cope with the current situation.

These aspects of social support can be improved and maintained in different social systems, such as in the family, at the level of the community, the state, the nation, or at the level of an international system with different programs (43). The support provided by a (wider) social community can strengthen the resilience of an individual through programs that promote a safe living environment, affordable housing, stability in access to food and employment, access to healthcare, effective education, readiness and training in case of a disaster, and the availability and richness of public spaces that can be used for relaxation and exercise (44).

It has been found that social support consisting in encouraging an individual to apply healthy and reduce risky forms of behavior, making the individual feel understood, and helping them assess potentially stressful situations as less dangerous than they first appear was associated with resilience to psychopathology. Social support can have a beneficial effect on an individual's feeling of control or ability to solve potentially very stressful situations, can improve self-respect, and can encourage the use of adequate coping strategies.

od razvoja poremećaja povezanih s traumom (47-49).

Također je utvrđeno da kognitivno-bihevioralna terapija kontroliranim izlaganjem stresnim situacijama, kognitivnom restrukturacijom/rekapitulacijom i tehnikama relaksacije nakon traumatskog događaja može pomoći osobama s PTSP-om u bržem oporavku (50). Psihofarmaci zajedno s psihološkim intervencijama i *mindfulness* programom mogu pomoći reducirati psihopatologiju koja je povezana s traumom (51-53). *Mindfulness* programi za redukciju stresa koji se temelje na usmjeravanju neosuđujuće pažnje na sadašnji trenutak i pozitivne emocije često se upotrebljavaju kao pomoć u promoviranju blagostanja i dobrog osjećanja (54,55).

ISTRAŽIVANJE

CILJ: Cilj istraživanja pokazati je kako su intervencije koje primjenjujemo utjecale na rezilijenciju i povećale kvalitetu života. Učinkovitost program dnevne bolnice STUP procjenjujemo baterijom testova prije uključivanja u program i na kraju programa/hospitalizacije. U ovom radu prikazat ćemo rezultate dobivene na upitniku kvalitete života SZO-a WHOQOL-BREF. Upitnik WHOQOL-BREF (*World Health Organization Quality of Life Brief Version questionnaire*) upitnik je koji pokriva četiri domene kvalitete života: fizičko zdravlje, psihičko zdravlje, društvene odnose te utjecaj okoline.

REZULTATI: Uzorak na kojem smo provodili istraživanje čini 129 pacijenata. Istraživanje smo provodili tijekom četiriju godina, od 2015. do 2019. godine. Upitnik o sociodemografskim podatcima ispitanici ispunjavaju samo na početku programa/hospitalizacije, dok upitnik koji mjeri kvalitetu života ispunjavaju pri ulasku i na kraju liječenja.

Od 129 pacijenata 96 (74,4 %) je u program Dnevne bolnice primljeno pod dijagnozom

As far as pharmacotherapy is concerned, it is important to note that significant overlap has been found between genes that regulate resilience and those that are regulated by long-term use of antidepressants (45). This can indicate that antidepressants stimulate those adaptations that naturally appear in persons who have hereditary resilience, i.e. who are resilient. It is believed that pharmacotherapy can also influence epigenetic modulation (46). Some studies have shown that the application of selective serotonin reuptake inhibitors (SSRIs) immediately after trauma can lead to reduced risk of developing trauma-related disorders (47-49).

It has been established that cognitive-behavioral therapy consisting of controlled exposure to stressful situations, cognitive restructuring/recapitulation, and relaxation techniques applied after a traumatic event can facilitate faster recover in persons with PTSD (50). Psychiatric drugs, together with psychological interventions and mindfulness programs, can help reduce trauma-related psychopathology (51-53). Mindfulness programs for stress reduction based on focusing non-judgmental attention on the present moment and on positive emotions are often used to facilitate promotion of well-being and comfort (54,55).

STUDY METHODS AND RESULTS

AIM: The aim of this study was to determine how the interventions we apply influenced patient resilience and improved their quality of life. The effectiveness of the Day Hospital TSRD program is assessed using a battery of tests administered before inclusion in the program and at the end of the program/hospitalization. Herein we will present the results gathered with WHOQOL-BREF (World Health Organization Quality of Life Brief Version questionnaire). WHOQOL-BREF is a questionnaire that covers four quality of life domains: physical health, mental health, social relationships, and the environment.

poremećaja prilagodbe (F43.2), jedan pacijent (0,8 %) primljen pod dijagnozom druge reakcije na težak stres (F43.8), a 32 pacijenta (24,8 %) u program su ušla zbog posttraumatskog stresnog poremećaja.

Sociodemografski podatci: Pogledaju li se podatci za spol ispitanika može se uočiti (grafički prikaz 1) kako je 48,8 % muškog, dok je 51,2 % ispitanika ženskog spola.

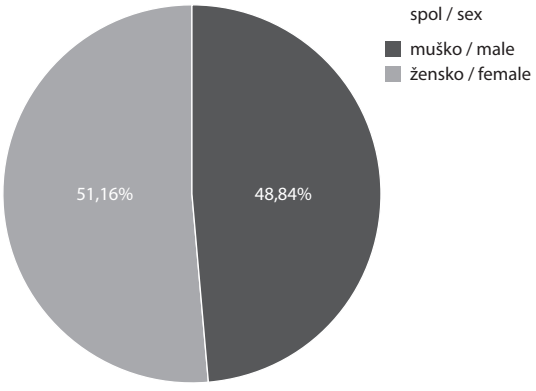
U odnosu na stupanj obrazovanja našlo se da 0,8 % ispitanika ima nezavršenu osnovnu školu, 8,5 % osnovnu školu, 64,3 % završilo je srednju školu, 24,8 % višu školu/fakultet, dok 1,6 % ima magisterij/doktorat (grafički prikaz 2).

Što se tiče radne aktivnosti (grafički prikaz 3) 67,4 % ispitanika navodi da su u radnom odnosu, 1,6 % ispitanika privatni su poduzetnici, 0,8 % studenti, 0,8 % domaćice, 12,4 % su umirovljenici. Nezaposlenih je 12,4 %, a 4,7 % navodi ostalo.

U odnosu na bračni status (grafički prikaz 4) 58,1 % ispitanika u bračnoj su zajednici, 12,4 % živi s partnerom, 4,7 % su udovci/udovice, 7.8 % su razvedeni, a 17,1 % nisu nikada bili vjenčani.

Rezultati obrade na upitniku kvalitete života - WHOQOL-Bref:

U tablici 2 prikazani su rangovi odgovora ispitanika kad su u pitanju rezultati za prvo i drugo



GRAFIČKI PRIKAZ 1.
FIGURE 1.

RESULTS: The sample on which the study was conduced comprised 129 patients. The study was conduced over four years, from 2015 to 2019. Participants completed the questionnaire on sociodemographic data only at the start of the program/hospitalization, whereas the questionnaire measuring quality of life was completed both at the start and at the end of the treatment.

Out of the total 129 patients, 96 (74.4%) were admitted to the Day Hospital program under the diagnosis of adjustment disorder (F43.2), one patient (0.8%) was admitted with the diagnosis of a second reaction to severe stress (F43.8), and 32 patients (24.8%) entered the program due to PTSD.

Sociodemographic data: based on the data the sex of the participants (Figure 1), we can see that 48.8% participants were men and 51.2% participants were women.

With regard to the level of education, we found that 0.8% of participants had not completed primary school, 8.5% had a primary school degree, 64.3% finished secondary school, 24.8% completed higher education/university, and 1.6% had a master's/doctorate degree (Figure 2).

As for occupational activities, 67.4% were employed, 1.6% were self-employed, 0.8% were students, 0.8% were housewives, 12.4% were retired, 12.4% were unemployed, and 4.7% selected "Other" (Figure 3).

Regarding marital status (Figure 4), 58.1% participants were married, 12.4% lived with their partner, 4.7% were widowed, 7.8% were divorced, and 17.1% had never been married.

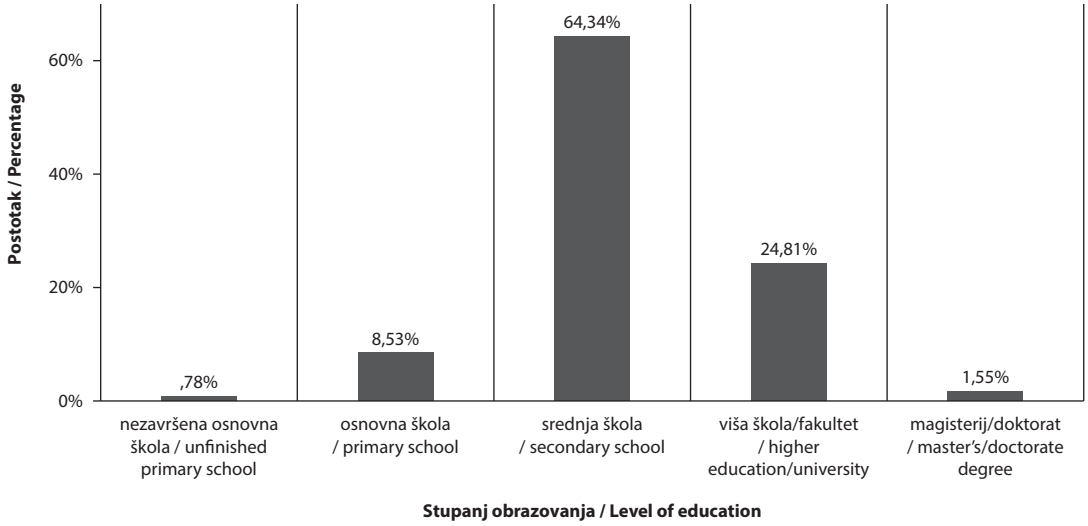
Results on the WHOQOL-BREF questionnaire:

Table 2 shows the response rankings for participants in the first and second measurement. We can see that responses in the *Physical Health domain* had a positive rank in 83 cases and a negative rank in 32 cases, with the response

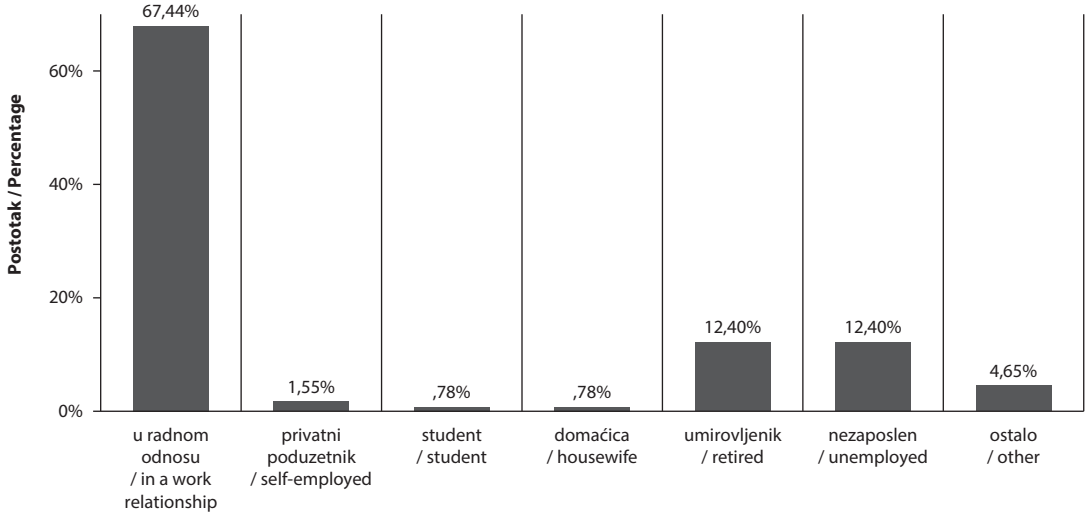
mjerenje. Opaža se da je za domenu *fizičko zdravlje* u 83 slučaja zabilježen pozitivan, a u 32 slučaja negativan rang, dok je u 14 slučaja jednaka vrijednost odgovora (jednak rezultat u početnom i izlaznom upitniku). Navedeno ukazuje trend *poboljšanja fizičkog zdravlja* pri izlazu iz programa.

Za domenu *psihičko zdravlje* u 88 slučajeva bilježi se pozitivan rang, tj. vrijednost odgovora pri izlazu iz programa kao veća od vrijednosti pri ulazu. U 29 slučajeva rang je negativan, dok 12 slučajeva izvještava o jednakoj vrijednosti values being equal in 14 cases (equal results in at baseline and endline). This indicates a trend towards improvement of physical health by the end of the program.

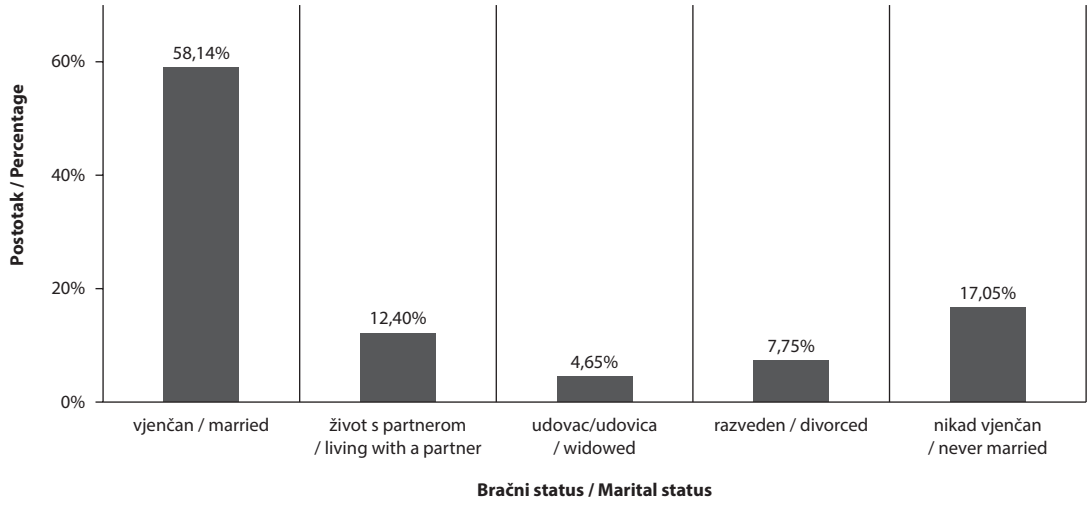
The Mental Health domain had a positive rank in 88 cases, i.e. the response values when exiting the program were higher than upon entry into the program. The rank was negative in 29 cases and equal in 12 cases. Consequently, we can conclude that mental health has *improved over the course of the program*.



GRAFIČKI PRIKAZ 2.
FIGURE 2.



GRAFIČKI PRIKAZ 3.
FIGURE 3.



GRAFIČKI PRIKAZ 4.
FIGURE 4.

TABLICA 1. Deskriptivni pokazatelji ispitanika za prvo i drugo mjerenje
TABLE 1. Descriptive indicators in participants for the first and second measurement

	N	$\bar{x}$	Sd	Min	Max
Fizičko zdravlje – ulaz / Physical health – baseline	129	11,2292	2,81529	5,14	18,86
Psihičko zdravlje – ulaz / Mental health – baseline	129	10,8837	3,00943	4,67	18,00
Društveni odnosi – ulaz / Social relationships – baseline	129	12,4651	3,14754	5,33	18,67
Utjecaj okoline – ulaz / Environment – baseline	129	12,9225	2,59841	7,00	18,50
Fizičko zdravlje – izlaz / Physical health – endline	129	12,7730	3,42455	5,71	20,00
Psihičko zdravlje – izlaz / Mental health – endline	129	12,5323	3,38130	4,00	20,00
Društveni odnosi – izlaz / Social relationships – endline	129	13,3230	3,24250	4,00	20,00
Utjecaj okoline – izlaz / Environment – endline	129	13,8953	2,57897	6,50	19,00

odgovora. Posljedično, može se zaključiti o *poboljšanju psihičkog zdravlja*.

U domeni *društveni odnosi* bilježi se 65 slučajeva pozitivnog, a 35 slučajeva negativnog ranga, dok 29 slučajeva bilježi jednaku vrijednost.

Domena *utjecaj okoline* u 83 slučaja bilježi pozitivan rang, tj. vrijednost pri izlazu viša je od ulazne vrijednosti. U 31 slučaju bilježi se negativan, a u 15 slučajeva jednak rang vrijednosti.

Dobivena je statistička značajnost testa manja od 0,05 ($p < 0,05$) za *psihičko zdravlje, fizičko zdravlje, društvene odnose, utjecaj okoline* kod prvog i drugog mjerenja, što znači da, s razinom pouzdanosti od 95 %, možemo reći da je zamjetna statistički značajna razlika prvog i drugog mjerenja.

In the Social Relationships domain, there were 65 cases of positive and 35 cases of negative rank, while the values were equal in 29 cases.

The Environment domain had positive rank in 83 cases, i.e. a higher endline than baseline value. There were 31 cases of negative ranks and 15 cases of equal ranks.

The statistical significance of the tests was lower than 0.05 ($p<0.05$) for the *Physical Health, Mental Health, Social Relationships, and Environment domains* at the first and second measurement, which means that we can say with 95% confidence that there was an observable statistically significant difference between the first and second measurement.

TABLICA 2. Rangovi mjerenih domena
TABLE 2. Ranking of the measured domains

		N	Aritmetička sredina rangova / Arithmetic mean of the ranks	Suma rangova / Sum of the ranks
Fizičko zdravlje – izlaz – Fizičko zdravlje – ulaz / Physical health – endline – Physical health – baseline	Negativni rangovi / Negative ranks	32[a]	37,73	1207,50
	Pozitivni rangovi / Positive ranks	83[b]	65,81	5462,50
	Jednako / Equal	14[c]		
	Ukupno / Total	129		
Psihičko zdravlje – izlaz – Psihičko zdravlje – ulaz / Mental health – endline – Mental health – baseline	Negativni rangovi / Negative ranks	29[a]	38,10	1105,00
	Pozitivni rangovi / Positive ranks	88[b]	65,89	5798,00
	Jednako / Equal	12[c]		
	Ukupno / Total	129		
Društveni odnosi – izlaz – Društveni odnosi – ulaz / Social relationships– endline – Social relationships – baseline	Negativni rangovi / Negative ranks	35[a]	43,26	1514,00
	Pozitivni rangovi / Positive ranks	65[b]	54,40	3536,00
	Jednako / Equal	29[c]		
	Ukupno / Total	129		
Utjecaj okoline – izlaz – Utjecaj okoline – ulaz / Environment – endline – Environment – baseline	Negativni rangovi / Negative ranks	31[a]	47,21	1463,50
	Pozitivni rangovi / Positive ranks	83[b]	61,34	5091,50
	Jednako / Equal	15[c]		
	Ukupno / Total	129		

a. Mjerenje_2 <Mjerenje_1 / Measurement_2 < Measurement_1.
b. Mjerenje_2 >Mjerenje_1 / Measurement_2 > Measurement_1
c. Mjerenje_2 =Mjerenje_1 / Measurement_2 = Measurement_1

TABLICA 3. Testna statistika ulaznih i izlaznih rezultata
TABLE 3. Test statistics of baseline and endline results

	Fizičko zdravlje – izlaz – Fizičko zdravlje – ulaz / Physical health – endline – Physical health – baseline	Psihičko zdravlje – izlaz – Psihičko zdravlje – ulaz / Mental health – endline – Mental health – baseline	Društveni odnosi – izlaz – Društveni odnosi – ulaz / Social relationships – endline – Social relationships – baseline	Utjecaj okoline – izlaz – Utjecaj okoline – ulaz / Environment – endline – Environment – baseline
Z	-5,953[b]	-6,404[b]	-3,519[b]	-5,146[b]
Asymp. Sig. (2-tailed)	**,000**	**,000**	**,000**	**,000**

a. Wilcoxon Signed Ranks Test / Wilcoxon Signed Ranks Test
b. Based on negative ranks / Based on negative ranks

Iduća razlika koju smo htjeli ispitati odnosila se na utjecaj sociodemografskih karakteristika, stoga smo ispitivali postoji li utjecaj spola, stupnja obrazovanja, radne aktivnosti te bračnog statusa na kvalitetu života.

U domeni *društveni odnosi* bilježi se vrijednost p manja od 5 % (p = 0,024) što znači da (uz ra-

The second effect that we wanted to evaluate was the influence of sociodemographic characteristics, so we analyze whether there was any influence of sex, level of education, occupation, and martial status on quality of life.

The p value in the Social Relationships domain was lower than 5% (p=0.024), which means

TABLICA 4. Deskriptivna statistika mjerenih domena upitnika kvalitete života u odnosu na spol
TABLE 4. Descriptive statistics of quality of life questionnaire domains with regard to sex

	Spol / Sex	N	$\bar{x}$	Sd
Fizičko zdravlje (izlaz – ulaz) / Physical health (endline-baseline)	Muško / Male	63	1,1406	2,54886
	Žensko / Female	66	1,9286	2,79136
Psihičko zdravlje (izlaz – ulaz) / Mental health (endline-baseline)	Muško / Male	63	1,4603	2,56208
	Žensko / Female	66	1,8283	2,67514
Društveni odnosi (izlaz – ulaz) / Social relationships (endline-baseline)	Muško / Male	63	,2328	2,91863
	Žensko / Female	66	1,4545	2,78435
Utjecaj okoline – (izlaz –ulaz) / Environment (endline-baseline)	Muško / Male	63	,6190	2,19918
	Žensko / Female	66	1,3106	1,82032

TABLICA 5. Rangovi
TABLE 5. Ranks

	Spol / Sex	N	Aritmetička sredina rangova / Score mean	Suma rangova / Score sum
Fizičko zdravlje (izlaz – ulaz) / Physical health (endline-baseline)	Muško / Male	63	58,58	3690,50
	Žensko / Female	66	71,13	4694,50
	Ukupno / Total	129		
Psihičko zdravlje (izlaz – ulaz) / Mental health (endline-baseline)	Muško / Male	63	62,82	3957,50
	Žensko / Female	66	67,08	4427,50
	Ukupno / Total	129		
Društveni odnosi (izlaz – ulaz) / Social relationships (endline-baseline)	Muško / Male	63	57,50	3622,50
	Žensko / Female	66	72,16	4762,50
	Ukupno / Total	129		
Utjecaj okoline – (izlaz – ulaz) / Environment (endline-baseline)	Muško / Male	63	58,91	3711,50
	Žensko / Female	66	70,81	4673,50
	Ukupno / Total	129		

TABLICA 6. Testna statistika
TABLE 6. Test statistics

	Fizičko zdravlje (izlaz-ulaz) / Physical health (endline-baseline)	Psihičko zdravlje (izlaz-ulaz) / Mental health (endline-baseline)	Društveni odnosi (izlaz-ulaz) / Social relationships (endline-baseline)	Utjecaj okoline - (izlaz-ulaz) / Environment (endline-baseline)
Mann-Whitney U	1674,500	1941,500	1606,500	1695,500
Wilcoxon W	3690,500	3957,500	3622,500	3711,500
Z	-1,912	-,651	-2,254	-1,815
Asymp. Sig. (2-tailed)	,056	,515	,024	,070

GroupingVariable: spol / Grouping variable: Sex

zinu pouzdanosti od 95 %) postoji statistički značajna razlika s obzirom na spol ispitanika – više rangove postižu ispitanici ženskog spola.

that (with a 95% confidence level) there was a statistically significant difference with regard to the sex of the participants – higher ranks were achieved by female participants.

Nadalje, ispitali smo postoji li utjecaj stupnja obrazovanja, radne aktivnosti te bračnog statusa, ali su vrijednosti statističkih značajnosti testa bile više od 5 % što implicira da se nisu pokazali kao statistički značajan čimbenik u istraživanju.

RASPRAVA

Temeljem naše obrade našli smo da pri izlasku iz programa/hospitalizacije pacijenti izvještavaju o statistički značajnom poboljšanju, a najviše u domeni psihičkog zdravlja, potom fizičkog zdravlja, zatim percepciji utjecaja okoline te kao zadnje poboljšanje u društvenim odnosima. U aspektu sociodemografskih čimbenika kao značajan pokazao se isključivo spol – žene su izvještavale o značajnijem poboljšanju društvenih odnosa, dok su u preostalim domenama spolovi izjednačeni. Stupanj obrazovanja, radna aktivnost te bračni status nisu se pokazali kao statistički značajni čimbenici za kvalitetu života. Takav rezultat tumačimo utjecajem dnevnobolničkog liječenja na jačanje rezilijencije na svim razinama.

Najveći broj pacijenata - 96 (74,4 %) u program Dnevne bolnice primljen je pod dijagnozom poremećaja prilagodbe (F43.2), a jedan pacijent (0,8 %) pod dijagnozom druge reakcije na težak stres (F43.8).

Ukupno 32 pacijenta (24,8 %) u program su ušla zbog posttraumatskog stresnog poremećaja pri čemu ih se 23 (17,8 %) može povezati s proživljenim ratnim traumama (te imaju dodatnu dijagnozu trajnih promjena ličnosti nakon katastrofe), dok ih je 9 (7 %) povezano s civilnom traumom.

Od 129 ispitanika 63 (48,8 %) je na ulazu imalo komorbiditet, tj. više od jedne dijagnoze. Dakle, gotovo polovica uzorka imala je komorbidne psihičke poremećaje. Od popratnih dijagnoza koje se pojavljuju u uzorku najveći dio zauzimaju trajne promjene ličnosti nakon

We also examined the effect of the level of education, occupation, and marital status, but the statistical significance test values were above 5%, implying that these were not statistically significant factors in the study.

DISCUSSION

Based on our data, we found that patients reported a statistically significant improvement upon ending the treatment program, with the greatest improvement being observed in the mental health domain, followed by physical health, perception of environmental influences, and lastly in social relationships. As for sociodemographic factors, only sex was significant – women reported a more significant improvement in social relationships, whereas the sexes had equal results in the other domains. Level of education, occupation, and marital status were not found to be statistically significant factors for quality of life. This result can be explained as the effect of day hospital treatment improving resilience at all levels.

The greatest number of patients – 96 (74.4%) – were admitted to the Day hospital program with the diagnosis of adjustment disorder (F43.2), and one patient (0.8%) was admitted with the diagnosis of a second reaction to severe stress (F43.8).

A total of 32 patients (24.8%) entered the program due to PTSD, of which 23 (17.8%) had PTSD that could be associated with wartime trauma (and who had the additional diagnosis of permanent personality changes after a trauma), and 9 (7.0%) in whom PTSD was associated with civilian traumas.

Of the total 129 participants, 63 (48.8%) had a comorbidity at baseline, i.e. more than one diagnosis. This means that almost half of our participant sample had comorbid mental disorders. Among the comorbid diagnoses present in the sample, most prevalent were permanent personality changes after a trauma (23

doživljene katastrofe (23 pacijenta ili 17,8 %), slijede poremećaji raspoloženja (19 pacijenata ili 14,7 %), zatim poremećaji iz anksioznog spektra (14 pacijenata ili 10,8 %) te poremećaji ličnosti (5 pacijenata ili 3,9 %). Jedan pacijent imao je dodatnu dijagnozu neorganske psihoze u remisiji (0,8 %) te je jedan pacijent imao dijagnozu štetna upotreba alkohola u svrhu samomedikacije (0,8 %).

Nešto više od polovice pacijenata (55,5 %) kojima je postavljena dijagnoza poremećaja prilagodbe uključeni su u program dnevne bolnice vrlo brzo nakon postavljene dijagnoze što je stvorilo mogućnost brzog intervenira nja u svrhu sprječavanja daljnjeg pogoršanja psihičkog stanja. Većina pacijenata s dijagnozom poremećaja prilagodbe dolazi na liječenje zbog stresa u radnom okruženju. Za vrijeme liječenja pacijenti su na bolovanju, izvan nepodržavajuće sredine ili izvora stresa te se mogu programom i podrškom članova tima posvetiti rješavanju i sagledavanju problema u jednom drugačijem svjetlu. Nešto malo manje od polovice pacijenata (44,5 %) liječenih zbog poremećaja prilagodbe imali su dodatnu dijagnozu ili komorbiditet što je ukazivalo da su pacijenti zaprimljeni u težem psihičkom stanju, nakon izlaganja višestrukim prolongiranim stresnim situacijama te su se razvili poremećaje iz anksioznog spektra ili poremećaja raspoloženja. Liječenje pacijenata s komorbidnim dijagnozama pokazalo se zahtjevnijim te je primijenjena i psihofarmakoterapija.

Kod pacijenata s traumatskim iskustvom radili smo na proradi misli i osjećaja vezanih uz traumatsku situaciju. Pristup pacijentima zahvaćenim civilnim i ratnim PTSP-om nešto se razlikovao. Kod ratnog PTSP-a usmjerili smo se na smirivanje emocionalne napetosti i korištenje dostupne socijalne podrške. Pacijenti kod kojih je postavljena dijagnoza civilnog PTSP-a postupcima u Dnevnoj bolnici, prije svega detaljnom proradom traumatske situacije uz em-

patients, 17.8%), followed by mood disorders (19 patients, 14.7%), anxiety disorders (14 patients, 10.8%), and personality disorders (5 patients, 3.9%). One patient had a comorbid diagnosis of non-organic psychosis in remission (0.8%), and one patient was diagnosed with alcohol abuse as self-medication (0.8%).

Slightly over half of the patients (55.5%) diagnosed with adjustment disorder were admitted to the day hospital program very soon after the diagnosis was established, which allowed rapid intervention with the goal of preventing further exacerbation of their mental state. Most patients with adjustment disorder came to treatment due to stress in their work environment. During treatment, patients are on sick leave and away from the non-supporting environment or source of stress, allowing them to use the program and support from team members to start working on resolving and understanding their problems in a different light. Slightly less than half (44.5%) of the patients treated for adjustment disorder had an additional diagnosis or comorbidity, which indicates that these patients were admitted with severe mental distress after multiple prolonged exposures to stressful situations that caused them to develop anxiety or mood disorders. Treating patients with comorbid diagnoses was more demanding, and psychopharmacotherapy was used as well.

In patients with traumatic experiences, we worked on processing the thoughts and feelings connected with the traumatic situation. The approach to patients with wartime and civilian PTSD was somewhat different. For wartime PTSD, we focused on ameliorating emotional tension and using the available social support. Treatment of patients with a diagnosis of civilian PTSD at our day hospital primarily includes detailed processing of the traumatic situation with empathetic understanding and a supportive therapy relationship, which provides space to reconstruct the traumatic event in a safe and supportive environment in order

patijsko razumijevanje i podržavajući terapijski odnos, dobivaju prostor za rekonstrukciju traumatskog događaja u sigurnoj i podržavajućoj okolini kako bi traumu mogli integrirati u vlastito iskustvo i u konačnici zacijeliti.

Niska posttraumatska socijalna podrška konzistentan je rizični čimbenik za razvoj PTSP-a (56), a socijalna povezanost i podrška bitan su čimbenik održavanja i podržavanja rezilijencije zbog čega nam je fokus rad u grupi. Naime, grupni *setting* Dnevne bolnice predstavlja suportivnu socijalnu okolinu koja daje osjećaj prihvaćenosti i sigurnosti što potiče rezilijenciju. Tijekom programa potičemo socijalno povezivanje i resocijalizaciju te ohrabrujemo pacijente da tu podršku traže u socijalnoj okolini (među obitelji i prijateljima). Grupnim terapijama oboljeli dobivaju utočište, razumijevanje da u krizi nisu sami te stručnu pomoć kako iz krizne situacije izaći ili se s njom nositi (57).

Psihološke intervencije za povećanje individualne rezilijencije utjecale su na naše pacijente poticanjem osjećaja prihvaćenosti i razumijevanja, učenja/stjecanja novih socijalnih vještina, poticanja promjene životnih stilova (s naglaskom na tjelesnu aktivnost), kognitivnog reprogramiranja i pomoću programa *mindefulness*. Sve sastavnice terapijskog programa/hospitalizacije potiču stjecanje uvida, samorazumijevanja i prihvaćanja vlastitih osjećaja, misli i ponašanja.

Cilj nam je bio ublažiti psihopatologiju, u prvom redu anksioznost, jačanje osjećaja bazične sigurnosti i jačanje ego snaga, poticanje korištenja dostupne socijalne podrške uz razvoj novog načina percepcije. Navedeno je dovelo do ponovnog uspostavljanja kontrole, vratilo psihičku ravnotežu i funkcionalnost pojedinca. Zbog toga je najznačajniji rezultat našeg istraživanja poboljšanja kvalitete života u domeni psihičkog zdravlja što smatramo dobrom povratnom informacijom u evaluaciji našeg programa. Program koji traje šest mjeseci pokazao se dostatnim za ublažavanje psihičkih smetnji i

to integrate the trauma into their own experience and ultimately heal.

Low post-trauma social support is a consistent risk factor for PTSD development (56), and social connectedness and support are also an important factor in maintaining and supporting resilience, which is why we have focused on group work in our treatment. The group setting at the Day Hospital represents a supportive social environment that creates a feeling of safety and acceptance, which improves resilience. During the program, we encourage the formation of social connections and resocialization as well as encouraging patients to seek out such support in their social environment (among family and friends). Group therapy provides a sanctuary for our patients, helps them understand that they are not alone, and provides professional help in escaping or coping with the crisis situation (57).

Psychological interventions to increase individual resilience influenced our patients by increasing their feelings of acceptance and understanding, learning/acquiring new social skills, encouraging lifestyle changes (with an emphasis on physical activity), cognitive reprogramming, and through the mindfulness program. All elements of the treatment program/hospitalization encourage achieving insight, understanding oneself, and accepting one's feelings, thoughts, and behavior.

Our goal was to ameliorate the psychopathology present in our patients, primarily anxiety, to strengthen the feeling of basic safety and ego strength, and to encourage the use of available social support by developing of a new way of perceiving the situation. This leads to recovery of control and a return to mental balance and functionality in our patients. This is why the most important result in our study is the increase in the domain of mental health, which we consider very positive feedback in evaluating our program. The program, which lasts six months, was found to be sufficient to reduce mental issues and improve patients at the mental level and their perceived quality of life.

poboljšanje na psihičkom planu te percipiranoj kvaliteti života.

Općenito se u Psihijatrijskoj bolnici „Sveti Ivan" promovira integrativni pristup u liječenju, a Dnevna bolnica specijalizirana za provođenje preventivnog i terapijskog programa stresom i traumom uzrokovanih poremećaja pruža intervencije upravo u kriznim situacijama. Intervencije su prilagođene (individualizirane) kapacitetima i potrebama traumatiziranih osoba ovisno o težini poremećaja i psihološkoj strukturi ličnosti pacijenta. Provodimo psihoterapiju s naglaskom na psihodinamsko razumijevanje stresa i traume te psihoedukaciju pacijenta.

Psihoterapiju radimo u grupnom *settingu* male (8 – 12 članova) do srednje grupe (12 – 15 članova) po principima grupne analize. Iako se u Dnevnoj bolnici njeguje grupni rad, u vidu imamo i individualne značajke i različite kapacitete pojedinaca te po potrebi provodimo i individualne suportivne psihodinamske psihoterapije. Psihoedukacija se primjenjuje po principima kognitivno-bihevioralne terapije također u grupnom *settingu* kao i *mindfulness*. Primjena kognitivno-bihevioralnog pristupa s naglaskom na osvješćivanje procesa mišljenja, negativnih interpretacija i katastrofičnog promišljanja koji utječu na emocije, pomaže pacijentima sagledati problematiku iz drugog kuta. Također, primjenjujemo psihofarmakoterapiju ponajprije iz skupine anksiolitika i antidepresiva. Što se tiče farmakoterapije, antidepresivi potiču u predisponiranih osoba one adaptacije, tj. adaptivne mehanizme koji se prirodno pojavljuju u osoba koje posjeduju nasljednu sposobnost rezilijencije (45). Primjena farmakoterapije pomogla je našim pacijentima s težim simptomima i komorbiditetom brže ublažiti intenzitet simptomatologije kako bi se stekli preduvjeti za rad na sebi i za psihoterapiju.

Dobili smo i poboljšanje kvalitete života u domeni fizičkog zdravlja. Smatramo da je radionica „Zdravi ja" temelj našeg preventivnog rada u smislu fokusiranja, osvješćivanja zdra-

The Sveti Ivan Psychiatric Hospital promotes an integrative approach to treatment in general, and the Day Hospital is specialized in conducting a preventive treatment program for stressor- and trauma-induced disorders and specifically in providing interventions in crisis situations. The interventions are tailored (individualized) based on the capacities and needs of the traumatized persons, depending on the severity of the disorder and the psychological personality structure of the patient. We conduct psychotherapy with an emphasis on a psychodynamic understanding of stress and trauma and psychoeducation of the patient.

Psychotherapy is performed in a group setting with small (8-12 members) to medium groups (12-15 members) according to the principles of group analysis. Although our Day Hospital values group work, we also consider the individual characteristics and differing capacities of our patients and engage in individual supportive psychodynamic psychotherapy if necessary. Psychoeducation is also performed according to the principles of cognitive-behavioral therapy in the group setting, as are mindfulness exercises. The application of the cognitive-behavioral approach with an emphasis of being aware of thought processes, negative interpretations, and catastrophic thinking that influence emotions helps patients see their problem from a different angle. We also apply psychopharmacotherapy, primarily using anxiolytic and antidepressant medication. Regarding pharmacotherapy, antidepressants stimulate those adaptations, i.e. adaptive mechanisms, that naturally occur in parsons with a hereditary disposition towards resilience (45). Application of pharmacotherapy has helped those of our patients who presented more severe symptoms and comorbidities to more rapidly reduce the intensity of the symptoms to lay the groundwork for self-improvement and psychotherapy.

We also achieved improvement in quality of life in the physical health domain. We are of

vih dijelova ličnosti. U radionicama „ponovno otkrivamo“ kreativnost, tj. potičemo da se pacijenti izražavaju raznim kanalima kao npr. fotografijom, crtežima, esejima, pjesmama, glazbom i slično. Također, potičemo zdrave stilove života, te stavljamo naglasak na fizičko zdravlje koje je u konačnici bitno i za psihički oporavak.

U našem istraživanju na zadnjem mjestu našli smo poboljšanje kvalitete života u domeni društvenih odnosa, što je naizgled paradoksalni rezultat. Međutim, znamo da krizna situacija po definiciji sa sobom donosi i niz poremećenih društvenih odnosa pa je jasno da je u toj kategoriji i promjena najmanja, odnosno traži duže vrijeme za povratak na razdoblje prije krize ili traume. U našem uzorku ispitanika žene su dobile bolje rezultate, odnosno značajnije poboljšanje u aspektu društvenih odnosa što objašnjavamo većim kapacitetima žena za psihologiziranje, tj. empatiziranje (58).

Ograničenje našeg istraživanja slabija je distribucija našeg uzorka po edukaciji i dijagnostičkim entitetima. Većina ispitanika našeg uzorka ima završenu srednju školu (stupanj obrazovanja), zaposlena je (radna aktivnost) te su vjenčani (bračni status). U odnosu na dijagnostičke entitete većina, tj. dvije trećine pacijenata iz uzorka liječeno je zbog poremećaja prilagodbe, dok se jedna trećina odnosila na pacijente s proživljenim traumatskim iskustvom. Polovica pacijenata iz uzorka imala je komorbidne dijagnoze što je bila otegotna okolnost u postizanju postavljenih terapijskih ciljeva.

ZAKLJUČAK

Naše istraživanje pokazalo je statistički značajno poboljšanje kvalitete života pri izlasku iz programa/hospitalizacije. Našli smo poboljšanje u svim četirima domenama kvalitete ži-

the opinion that the *Zdravi ja* workshops form the basis of our preventive work in the sense of improving focus in our patients and awakening the healthy parts of their personality. In the workshops, we “rediscover” creativity, i.e. encourage the patients to express themselves through various channels such as photography, drawing, essays, poems, music, etc. We also encourage healthy lifestyles and place an emphasis on physical health, which is ultimately of significant importance for mental recovery as well.

In our study, the social relationships domain was the one with the least improvement, which is a seemingly paradoxical result. However, we know that a crisis situation intrinsically includes numerous disordered social relationships, so it is understandable that the change would be the smallest in that category, or rather that this category requires the longest time to return to the state before the crisis or trauma. In our sample, women had better results, i.e. a more significant improvement in the social relationships aspect, which can be explained by the higher capacity for empathy in women (58).

A limitation of our study was the weaker distribution of our sample regarding education and diagnostic entities. Most participants in our sample graduated from secondary school (education level), were employed (occupation), and were married (marital status). Regarding diagnostic entities, most patients, i.e. two thirds of the sample, were treated for adjustment disorder, while one third of the participants were patients who underwent a traumatic experience. Half of the patients from the sample had comorbid diagnoses, which represented an additional difficulty in achieving treatment goals.

CONCLUSION

Our study showed a statistically significant improvement in quality of life at the end of the treatment program/hospitalization. We

vota i to sljedećim redoslijedom: poboljšanje psihičkog zdravlja, fizičkog zdravlja, percepciju utjecaja okoline te društvenih odnosa. U aspektu sociodemografskih čimbenika kao značajan pokazao se isključivo spol – žene koje su izvještavale o značajnijem poboljšanju u aspektu društvenih odnosa, dok su u preostalim domenama spolovi izjednačeni.

Pokazalo se da rezilijencija ne ovisi samo o nasljednim čimbenicima, već i o naučenim *coping* mehanizmima, socijalnoj okolini i stilu života te se može mijenjati tijekom vremena kao funkcija razvoja i interakcije s okolinom. Rezilijencija se u bolničkim uvjetima može potaknuti raznim intervencijama u području životnog stila, psihološkim, biološkim (farmakoterapija) i bihevioralnim metodama. Navedeno primjenjujemo tijekom liječenja u Dnevnoj bolnici koja je specijalizirana za rad s poremećajima uzrokovanim stresom i traumom (DB STUP).

Tijekom programa baziramo se na kriznim intervencijama, psihoterapiji te socioterapijskim postupcima. Psihoterapiju radimo u grupnom *settingu* po principima grupne analize. Iako njegujemo grupni rad, u vidu imamo i individualne značajke i različite kapacitete pojedinaca te po potrebi provodimo i individualne suportivne psihodinamske psihoterapije. Psihoedukacija se primjenjuje po principima kognitivno-bihevioralne terapije također u grupnom *settingu* kao i *mindfulness*. Također se po potrebi primjenjuje psihofarmakoterapija.

Psihološke intervencije za povećanje individualne rezilijencije utjecale su na naše pacijente poticanjem osjećaja prihvaćenosti i razumijevanja, učenja/stjecanja novih socijalnih vještina, poticanja promjene životnih stilova (s naglaskom na tjelesnu aktivnost), kognitivnog reprogramiranja i pomoću programa *mindfulness*. Sve sastavnice terapijskog programa/hospitalizacije potiču stjecanje uvida, samorazumijevanja i prihvaćanja vlastitih osjećaja, misli i ponašanja.

found improvements in all four quality of life domains, in descending order of magnitude: improvement in mental health, physical health, environment, and social relationships. Sex was the only sociodemographic factor that was significant – women reported more significant improvements in the social relationships domain, whereas the results were equal between the sexes in the other domains.

It has been shown that resilience does not depend solely on hereditary factors but also on learned coping mechanisms, the social environment, and the individual's lifestyle, all of which can change over time as a function of personal development and interaction with the environment. Resilience in the hospital setting can be encouraged using various interventions on the patient's lifestyle and various psychological, biological (pharmacotherapy), and behavioral methods. All of the above is applied during treatment at the Day Hospital, which specializes in the implementation of preventative and treatment programs for trauma and stressor-induced disorders (TSRD).

We base our treatment program on crisis interventions, psychotherapy, and social therapy procedures. Psychotherapy is conducted in a group setting based on the principles of group analysis. Although we foster group work, we also consider the individual characteristics and differing capacities in the patients we work with and conduct individual supportive psychodynamic psychotherapy sessions as needed. Psychoeducation is applied according to the principles of cognitive-behavioral therapy in the group setting, as is mindfulness therapy. We also apply pharmacotherapy if necessary.

Psychological interventions to increase individual resilience influenced our patients by encouraging feelings of acceptance and understanding, learning/acquiring new social skills, encouraging lifestyle changes (with an emphasis on physical activity), cognitive reprogramming, and through the mindfulness program.

Liječenje u programu Dnevne bolnice traje šest mjeseci što se pokazalo dostatnim vremenom da se postigne osnaživanje pacijenta i ponovno vraćanje u socijalnu i radnu okolinu.

Pravovremene primjene intervencija u krizi koje su prilagođene potrebama i kapacitetima svakog pojedinog pacijenta podigle su i / ili pojačale rezilijenciju djelujući na ego snage pacijenta, vraćanje funkcionalnosti a time i percepcije kvalitete života.

All elements of the treatment program/hospitalization encourage achieving insight, understanding oneself, and accepting one's feelings, thoughts, and behavior.

Treatment in the Day Hospital program last six months, which has shown to be sufficient to strengthen the patients and reintroduce them to the social and work environment.

Timely application of crisis interventions that are tailored to the needs and capacities of individual patients have increased and/or improved their resilience by influencing the ego strength of the patient and restoring functionality and therefore also improving perceived quality of life.

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