



Покрајински заштитник грађана
ОМБУДСМАН
Аутономна покрајина Војводина



The seventh international scientific
and professional conference

THE RIGHT TO ACCESS (MENTAL) HEALTH CARE

Conference Papers

November 3-4, 2023
Novi Sad, Serbia



Republic of Serbia
Autonomous Province of Vojvodina
Provincial Protector of Citizens - Ombudsman

Faculty of Medicine
of the University of Novi Sad



ISBN
[Provincial Protector of
Citizens - Ombudsman]



ISBN
[Faculty of Medicine of the
University of Novi Sad]



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3th and 4th of November 2023
The building of the Rectorate of
the University of Novi Sad
Novi Sad

Organizers of the Conference:
Provincial Protector of Citizens - Ombudsman and Faculty of Medicine
of the University of Novi Sad

Novi Sad, 2024

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CONFERENCE PAPERS

ISBN: 978-86-89417-22-7 [Provincial Protector of Citizens - Ombudsman]

ISBN: 978-86-7197-773-9 [Faculty of Medicine of the University of Novi Sad]

PUBLISHERS:

Provincial Protector of Citizens - Ombudsman

Faculty of Medicine of the University of Novi Sad

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COVER DESIGN AND PREPRESS:

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PRESS:

Vojvodina Provincial authorities Common Affairs Department

Novi Sad, Republic of Serbia

YEAR: 2024

CIRCULATION: 150 pcs

Any opinions, claims or positions expressed in this publication are those of the papers' authors and do not necessarily represent an official position of the Provincial Protector of Citizens – Ombudsman and Faculty of Medicine of the University of Novi Sad.

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Dejan Matić²

THE PROTECTION OF MENTAL HEALTH AS HUMAN RIGHT

Abstract: According to World Health Organization(WHO), mental health is “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community”³. It is more than absence of mental disorders, and more than mere enumeration, such as the way of dealing with stressful situations, resistance to external stimuli that can influence a person to behave in the usual way, the amount of stress, sad, unexpected or other negative situations, other people that someone can bear and the like. There are factors that more or less affect one’s mental health. Mental health, however, depends more than any other acquired human trait on the immediate or indirect environment. An unsupportive environment, which often expresses distrust in a person’s abilities and knowledge, can significantly shake that person’s self-image and damage their mental health, in addition to certainly endangering their physical health. That is why it is important to remember that the achievement of mental health and its preservation and improvement, both at the level of the individual and the entire society, is a human right, which unfortunately began to be given more importance only after the COVID-19 pandemic.

In this article, the authors present shortly both the legal framework and personal observations on the importance of this topic.

Keywords: mental health, human right, protection.

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³ Mental health, <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response>, 01.12.2023.

The protection of mental health as human right

When marking World Mental Health Day in 2023, World Health Organization (in further text:WHO) under the motto of “Our minds, our rights”, promoted the right to mental health as a universal human right:

“Mental health is a universal human right, which includes the right to be protected from mental health risks, the right to available, accessible, acceptable, and good quality care, and the right to liberty, independence and inclusion in the community. Recognising mental health as a universal human right empowers people to stand up for their rights – and for those around them. If people are not aware of their human rights, they are not able to advocate for them. By including people with lived experience of mental health conditions in decision-making on mental health issues, new policies, laws and service planning can be positively influenced and guided by their expertise”⁴.

The same was stated a year earlier in the publication of WHO: World mental health report: transforming mental health for all⁵. “Having good mental health means we are better able to connect, function, cope and thrive”⁶; when we’re not in control of our mental health, all our abilities can be diminished. Everyone is at the risk, some at higher, but risk is always there. As we deepen the value and commitment we give to mental health as individuals, communities and governments, the mental health will be more protected, cherished and we will be heading to the mutual well being⁷. It also means that mental health care and services connected with it must be strengthened in any means.

The stigma that surrounds the talk about mental health and the state of the mind and the soul has begun to slowly come off. The proof of this is the first such open and direct campaign to advocate the rights of all people

⁴ <https://www.who.int/campaigns/world-mental-health-day/2023>, 01.12.2023.

⁵ “World mental health report: transforming mental health for all”, World Health Organization 2022, 12.

⁶ Ibid.

⁷ Ibid,20.

and at the same time the obligation of states to protect mental health. Mental health care has become extremely important, suddenly, because the previous narrative was negative for so long.

The legal framework dealing with mental health appeared to be modest, whether at the international or national level. However, a more careful search reveals numerous documents that directly or indirectly regulate the issue of preserving health and, therefore, mental health itself.

*The Constitution of the World Health Organization (1946)*⁸ defined access to protection of health as one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. This norm is a reminder of the horrors committed during the Second World War, of the camps in which the civilian population of other nationalities was tortured in the most inhumane ways and killed in the most monstrous ways, often by doctors and other medical personnel, of the denial of health care and torture of the civilian population in the territories under occupation, and non-compliance with the international law of war towards military prisoners. Because of all this, WHO has established an umbrella non-discriminatory norm for access to health care and preservation of life for every person, regardless of inherited or acquired characteristics.

We can find mentioning of health also in *Universal Declaration of Human Rights*(1948)⁹:

Article 25 (1)

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

⁸ The great collection of all international treaties, conventions and other important documents, regarding protection of health and protection of mental health can be found on: <https://www.ohchr.org/en/special-procedures/sr-health/international-standards-right-physical-and-mental-health>, in text : Special Rapporteur on the right to health ,International standards on the right to physical and mental health. Access: 01.12.2023.

⁹ International standards on the right to physical and mental health, *ibid*.

Also, The International Covenant on Economic, Social and Cultural Rights(1966) says similar in Art 12:

1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
 - a) *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
 - b) *The improvement of all aspects of environmental and industrial hygiene;*
 - c) *The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
 - d) *The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

Here we see the direct mentioning of mental health and need for its protection, and also, mentioning of certain situations in which it is likely, in that period, detected that there is the greatest risk to the health and to the development of a human being. It indirectly talks about the need to monitor the pregnancy and the appropriate conditions for giving birth that will result in the birth of a living child; that working conditions should be always improving, as well as conditions in which medical care should be provided. The special emphasis was on prevention and treatment of epidemic, endemic and other diseases, as some epidemics and pandemics were active precisely in the period after the Second World War until the day of the adoption of this convention, such as : United States polio epi-

demic 1948-1952 (9000 deaths), Asian flu pandemic 1957-1958 (1-4 million people infected), Ethiopia yellow fever epidemic 1960-1962, Seventh cholera pandemic (1961-1975), etc¹⁰.

International Convention on the Elimination of All Forms of Racial Discrimination (1965)¹¹ in Art. 5 guaranteed the right to public health, medical care, social security and social services; Convention on the Elimination of All Forms of Discrimination against Women (1979) make obligatory for every state to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning (Art. 12). This Convention set a special attention to ensuring to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation. Convention on the Rights of the Child (1989) proclaims in Art 24 child's right to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health, can be deprived of his or her right of access to such health care services. Special attention was given particularly to ensuring special measures:

- a) To diminish infant and child mortality;
- b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
- c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
- d) To ensure appropriate pre-natal and post-natal health care for mothers;

¹⁰ Chronology of all epidemics and pandemics in the world, https://en.wikipedia.org/wiki/List_of_epidemics_and_pandemics, 01.12.2023.

¹¹ International standards on the right to physical and mental health, access: 01.12.2023.

- e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
- f) To develop preventive health care, guidance for parents and family planning education and services.

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families(1990)¹² is giving all those rights to protection of health to migrant workers and members of their families, especially access to any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment(Art 28).

Convention on the Rights of Persons with Disabilities (2006)¹³ protects specially persons with disabilities and guarantees them the highest attainable standard of health without discrimination on the basis of disability and access to all health services that is gender-sensitive, including health-related rehabilitation.

Declaration of Alma Ata on Primary Health Care (1978)¹⁴ established the right to access protection of health in conditions of primary health care, which must be :

universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing

¹² Ibid.

¹³ Ibid.

¹⁴ Ibid.

health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.

Our national legal frameworks is also impressive. It consists of more than 20 laws, regulations and rules regarding general health care, and a lots of regulations and rules regarding specialized health care¹⁵. In Republic of Serbia there is also a specialized *Fund for the treatment of diseases, conditions or injuries, which cannot be successfully treated in the Republic of Serbia*¹⁶, which exists from 2014. and successfully provides help for children and even adults who suffer from rare diseases or have any rare health conditions.

This framework, when turned into practise, represents a network of health institutions - hospital centers and health centers that have specialized centers or services that deal with the protection of mental health and the treatment of conditions that arise due to the deterioration of mental health in general¹⁷, or are separate, independent institutions that exclusively deal with the improvement of mental health¹⁸. There are also a lots of non governmental organizations¹⁹ or other people's initiatives, such as

¹⁵ Zakoni i pravilnici u domenu zdravstvene zaštite, <https://www.zdravlje.gov.rs/tekst/354638/zakoni-i-pravilnici-u-domenu-zdravstvene-zastite.php>, 01.12.2023.

¹⁶ <https://www.zdravlje.gov.rs/tekst/333539/uputstvo-za-prijavu-dece.php>, 01.12.2023.

¹⁷ For example, in Niš there is specialized center for mental health: <http://www.kcnis.rs/index.php/klinike-klinickog-centra-nis/centri-kcnis/centar-za-zastitu-mentalnog-zdravlja>, 01.12.2023., or similar in Kragujevac: <https://dzkg.rs/savetovalishte-za-mentalno-zdrave1.html>, 01.12.2023. In Novi Sad there is also recently opened new centre or mental health.

¹⁸ For example, Clinic for psychiatric diseases „Laza Lazarević“, who also founded National service for protection of mental health in Republic of Serbia, which gives advices and supports people 24/7 through toll-free phone calls. More about it: <https://www.laz-alazarevic.rs/>, 01.12.2023.

¹⁹ OPENS started the project of peer support for adolescents, where young people are educated how to support their peers, under the name “Constellation of support”(Sazvežđe podrške), <https://opens.rs/sazvezdje-podrske>, 01.12.2023.

Centar SRCE in Novi Sad²⁰, or Mental HUB²¹ in Belgrade, which also they provide help and support to people who need it. Their significance was finally recognized in state of emergency in 2020, when their advices appeared to be crucial in every area of social life²², and when the whole network provided its maximum in support of people who, due to pandemic circumstances, experienced enormous stress and other consequences of endangering their physical and mental health.

We can conclude that this theoretical framework finally found its application and, even now, should always be ready to be improved more. Still there is hesitation when it comes to mental health issues, whether discussing the present problems one has, or in terms of prevention of any threats. Consistent application of the legal framework, constant education of both medical staff and other specialized staff in hospitals and health centers, as well as ordinary citizens and all state authorities about the importance of preserving mental health are extremely important. No law is made just to sit on the shelves of possible application, but to be actively applied. Mental health regulations, perhaps more than ever before, deserve our full attention in terms of decisive and explicit application. The decisive actions of the state will significantly affect the reduction of prejudices towards mental health issues and will act as an incentive for ordinary citizens not to hesitate to seek this kind of help when they need it.

How COVID 19 taught us great lessons about self-care and protection of mental health

The mental health is something you don't talk about in public. Or else, if you talk about it, it seems that you have problems with it, there is something wrong with you or, you should be treated in special hospital and probably you would be considered danger immediately dangerous for your

²⁰ Centar SRCE is specialized for support to people who feel suicidal and depressive, <https://www.centarsrce.org/>, 01.12.2023.

²¹ Psihološka pomoć za mentalno zdravlje u zajednici, <https://www.mentalhub.org/>, 01.12.2023.

²² Савети стручњака Института – Поддршка здрављу у време пандемије, <https://imh.org.rs/page.php?id=96>, 01.12.2023.

environment. There was no way to ensure people that talk about mental health could be preventive and can help people more in advance than later, when it is embedded or its violation has already begun.

But, in the end of 2020. the virus COVID 19 started to spread around the world, with its devastating consequences, with lots of people who were so fast infected with it and with fast progression of illness, that there was in most cases almost no time to help those who were infected. The fear , one of two basic people's emotion was in raise, the fear for our own lives and lives of others around us. That fear generated two ways of dealing with the pandemic wave that was dast spreading around the world: the first was denial that anything is happening, that pandemic isn't real and that some conspiracy to reduce the number of inhabitants on earth is unfolding before our eyes; the second way was launching a fight against an unknown virus, a race against time to save many lives and establishing preventive measures that will prevent further spread of the virus. The second way of dealing with the situation proved to be more correct; reason has prevailed and all available forces are focused on treating the sick, and looking for ways to prevent the spread of the same virus.

One of the measures that caused the greatest resistance among people was the ban on the movement of citizens for a limited period of time and their ,kind of ,confinement inside their homes. prevented from having daily interactions with other people in face-to-face contact, from spending time outside during leisure hours, or from doing any work outside at all, without certain safety measures such as wearing medical masks at all times in public and maintaining physical distance, are began to cause panic attacks, aggression, anxiety and many other negative consequences in numerous citizens. The conversation about mental health had to be started, now in different circumstances, because in addition to the danger of endangering physical health, mental health began to deteriorate even faster, followed by even more serious consequences for physical health than the virus itself threatened. Fnally the time has come to talk about mental health as an integral part of health in general, as defined by the WHO itself in its Constitution:

“Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”²³.

It was quite clear that statements about mental health, that can be found on the WHO website, become very important:

“Mental health is more than the absence of mental disorders.

Mental health is an integral part of health; indeed, there is no health without mental health.

Mental health is determined by a range of socioeconomic, biological and environmental factors.

Cost-effective public health and intersectoral strategies and interventions exist to promote, protect and restore mental health”²⁴.

Preservation of people's mental health in pandemic conditions has become more important than all other preventive measures that have been undertaken. Anxiety, panic attacks, depressive and other episodes may doubly damage people's physical health, directly (for example, to an increase in blood pressure)) and indirectly (by disregarding other preventive measures and putting a person at risk of getting sick and having serious consequences of this disease). So successful control, treatment and prevention of all of these situations are crucial.

According to the World Health Organization data, during 2020. the number of people who suffered from anxiety and depression increased by as much as 25%. Before pandemic, in the Republic of Serbia, in 2017, 5% of the population lived with depression, and 3.8% with anxiety disorder. Many studies indicate, done after the first year of pandemic, indicated that the state of emergency and quarantine during the COVID-19 pandemic had an impact on the mental health: 28.9% of adults had moderate to severe depression, and slightly more than 1/3 had anxiety and stress symptoms.

²³ Constitution of the World Health Organization,
<https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1>, 01.12.2023.

²⁴ Health and well-being, <https://www.who.int/data/gho/data/major-themes/health-and-well-being>, 01.12.2023.

N.Kovačević, reasearcher from City Health Institute Belgrade, in her reasearch²⁵ stated that :

“During the state of emergency, out of 1103 young people aged 15-30²⁶, 19% felt vulnerable, and 16.3% very vulnerable. Young women, young people living in cities, and young people with higher level of education expressed greater vulnerability.

During the state of emergency, 33.4% of respondents indicated that they felt their safety was threatened, 42.7% that their health was threatened, and most often they had fear related to the possibility of infecting family members, close friends and themselves. ¼ of respondents did not feel optimistic about the future, ⅓ felt completely useless, and 14.3% considered that their mental health had deteriorated greatly.

Younger people felt that their mental health worsened less during health emergency, in comparison to older people. During the state of emergency, 11.1% of young people experienced violence, mostly verbal and online, and 10.4% physical violence”.

Similar studies, conducted during the state emergency and right after had similar results: increase of stress, anxiety and depression, uneasiness related to the news about COVID-19 and helplessness , and lots of them felt the higher risk of death and the presence of symptoms of COVID-19.²⁷ Some further reasearches dealt with people who were infected with

²⁵ Nevenka Kovačević , “Uticaj COVID-19 pandemije na mentalno zdravlje stanovnika Srbije”, *Zdravstvena zaštita* 2023, vol. 52, br. 1,82-93.

²⁶ Ibid. A study, which was conducted from August to October

²⁷ “The psychology of pandemics is diverse and complex, and its study is of vital importance for clinical practice and public health guidelines for COVID-19 and future pandemics”, *ibid*,91.

virus COVID 19²⁸, students in general²⁹ and medical students especially³⁰, but also specific consequences of measures³¹ that were active during the state of emergency, such as suicidal tendencies and self harming³². Also, the topic in some researches were also medical staff, directly or indirectly³³ involved in saving people's lives during the state of emergency.

The most important lesson that this pandemic taught us is that mental health is truly important and is something that we should always talk about. “Asking for help is a sign of strength – it shows self-awareness and the courage to ask for support in difficult times. Getting the right professional support and healing becomes easier when you share it with someone”.³⁴ No one should be ashamed of asking for help, support, even medication to feel better. Also, communication and connecting to other people can help build a sense of belonging and self experience, and also, you have someone to share with all sorts of experiences- good or bad. Connecting to people during the state of emergency in Serbia was limited or in some moments completely disabled. This is where the Internet came into play, as an auxiliary means of maintaining contacts during the long hours or days of isolation to which people were exposed.

²⁸ Marina Malobabić et alia, “Da li je čin obaveznog i produženog bolničkog karantina faktor rizika za narušeno mentalno zdravlje kod osoba sa potvrđenom infekcijom COVID-19?”, *Acta Facultatis Medicae Naissensis* 2023, vol. 40, br. 3, 344-351.

²⁹ Gordana Ristevska, et alia, “Depresija i nesanica među studentima tokom pandemije kovida 19 - studija preseka”, *Srpski arhiv za celokupno lekarstvo*, 2023, vol. 151, br. 5-6, 278-284. Also: Nikola Mirilović, Janko Janković, “Mentalno zdravlje studentske populacije tokom pandemije COVID-19”, *Medicinski podmladak*, 2023, vol. 74, br. 2, 38-43.

³⁰ Marija Božović, et alia, “Mentalno zdravlje studentske populacije tokom pandemije COVID-19”, *Glasnik javnog zdravlja* 2023, vol. 97, br. 1, 79-95.

³¹ Vesna Barzut et alia, “Povezanost psihološke nefleksibilnosti i mentalnog zdravlja tokom trećeg talasa pandemije izazvane virusom kovid 19”, *Zbornik radova Filozofskog fakulteta u Prištini*, 2023, vol. 53, br. 3, 361-375.

³² Darja Šegan et alia, “Samopovređivanje kod dece i omladine - uticaj pandemije kovida 19”, *Srpski arhiv za celokupno lekarstvo*, 2023, vol. 151, br. 5-6, 285-289.

³³ Radomira Aničić, et alia, “Uticaj pandemije kovida 19 i socijalne izolacije na mentalno zdravlje medicinskog i nemedicinskog osoblja - iskustvo iz jedne ginekološko-akušerske klinike”, *Medicinska istraživanja* 2023, vol. 56, br. 1, 51-59.

³⁴ <https://www.unicef.org/serbia/kako-da-brine%C5%A1-o-svom-mentalnom-zdravlju>, 01.12.2023.

The state of emergency helped a lot of people to found out that they have enough time for family, to read, do gardening, or just learn new skills-only it was done online, not in personal. Employing the brain with some other activities and preventing it from being constantly in the drive of thinking about the virus, the dangers it carries and the possible severe consequences of infection, reduced fear many times over and thus stress, anxiety and depression. All those lectures, about paying more attention to the present moment (mindfulness) and not to think about the future in terms what can else go wrong and that we are going to die(but not that day), finally made sense. If you are just here and now, you cannot fear of what is going ahead, especially when there are a lot of thing that are not in your control.

Mental health finally become issue for everyone –any of us can be in situation that this kind of support is needed this cause. It needs multisectoral support³⁵ and true devotion to prevention and protection of mental health. One of the devastating consequences of compromised mental health is , unfortunately suicide. Suicide prevention became an international priority, with a Sustainable Development Goal (SDG) target to reduce the suicide mortality rate by one third by 2030³⁶.

The last conclusion must be that only when we all engage as the community, we can succeeded and make better future for all. The issue of mental health and its protection is that kind of cause, where we must be united in response.

³⁵ World mental health report: transforming mental health for all, 17.

³⁶ Ibid, 19. “To help countries reach this target, WHO has developed the LIVE LIFE approach to suicide prevention, which prioritizes four interventions with proven efficacy: limiting access to the means of suicide; interacting with the media for responsible reporting on suicide; fostering social and emotional life skills in adolescents; and early intervention for anyone affected by suicidal behaviours”.

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MENTAL HEALTH AT AN OLDER AGE: THE SIGNIFICANCE OF SOCIAL CONTACTS

Abstract: *The multidimensional nature of the definition of health, according to which health is described as a state of complete physical, mental and social well-being, and not exclusively as the absence of disease, emphasizes the importance and indispensability of mental health for the overall health of the individual, as well as the prosperity of society. Mental health enables an individual to utilize personal potentials and abilities, with functional coping with everyday stressful life situations, with fruitful and productive work, as well as contribution to one's own community throughout life. In the context of the global acceleration of the demographic aging of modern society, where the demographic profile of the Republic of Serbia does not deviate from the global trend, recognizing the factors that contribute to preserving the mental health of the elderly population has multiple personal and social benefits, but also theoretical and practical importance in order to create public health policies and interventions that lead to the optimization of living conditions and increase in the quality of life of individuals in old age. In this paper, we will deal with the importance of social contacts in elderly, within the discourse of active aging, with special reference to the concepts of social participation, that is, the involvement of the individual in activities that ensure interaction at different levels, as well as the concept of social isolation, which indicates inadequate quantity and/or quality of interactions with other people.*

Keywords: *mental health, elderly, social contacts, social participation, social isolation.*

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1. Mental Health

The international consensus on the widely accepted definition of health as a state of complete physical, mental, and social well-being and not merely the absence of disease highlights the multidimensional nature of health and positions mental health as an essential and inextricable element of the general health of an individual (WHO, 2001). Good mental health allows people to make full use of their potential and abilities, optimally manage everyday stress situations, engage in fruitful and productive work, and give back to their community (Keyes, 2007). The non-negative definition of mental health based on distinctive characteristics challenges the belief that the absence of mental illness points to the presence of mental health, especially in the light of findings speaking in favor of mental health's significant positive correlations with aspects such as a person's education level, productiveness at work, social support, social participation, and closeness to others and negative correlations with aspects such as the feeling of helplessness, a lack of clear life goals, and low resilience (Vuletić et al., 2018). Furthermore, the complex link between physical and mental health indicates that good mental health diminishes risks and consequences for physical health, functioning, and comorbidity (Prince et al., 2007). At the individual level, this can translate to psychological well-being and effective social participation, that is, improved quality of life, while at the community level, it contributes to prosperity in the economic, social, educational, and judicial sense (European Commission Green Paper). Hence, mental health promotion constitutes a global development challenge.

Distancing from unipolar and pathocentric conceptualizations of mental health in the domains of theory, research, and practice has given birth to the idea of shifting the focus from treating symptoms to actively nurturing and fostering mental health, especially in terms of the three components of positive mental health, namely, subjective well-being, effective individual functioning, and effective functioning for a community (Westert-hof et al, 2010). The multidimensionality of mental health stemming from hedonic and eudaimonic traditions, which emphasize the feelings of happiness, satisfaction, and interest in life (i.e., emotional well-being) along

with self-actualization and optimal individual and social functioning (i.e., psychological well-being), provided the basis for the conceptualization of sociological well-being, which emphasizes the importance of inclusion and connectedness with others, encompassing dimensions such as acceptance, actualization, contribution, coherence, and integration (Keyes, 2007).

2. Population Aging as a Global Demographic Phenomenon

In the context of the global demographic transformation of contemporary society and the increasing share of the elderly in the general population, which is projected to reach 30% of the EU population (Devedžić, Stojilković Gnjatović, 2015) and 22% of the world population (Fuster, 2017) by 2050, the 21st century could be described as a century of population aging. The extension of the human lifespan is commonly seen as one of humanity's great triumphs. However, it opens up questions regarding the quality of life and the state of mental health at an older age, considering that changes are seldom reflected in a better quality of life, but rather the growing dependency of the elderly in relation to other segments of the population.

The characteristics of Serbia's demographic landscape are in line with current demographic trends, including declining birth rates, high death rates, natural decrease, low fertility, depopulation, and substantial population aging, which together lead to a population decline and result in a small and ever-declining share of the youth and a large and ever-growing share of the elderly in the general population (SORS, 2021a). Although many studies have drawn a parallel between the acceleration of demographic aging and the higher prevalence of mental disorders, the issue of interrelations between these processes is complex, bearing in mind the dissonant findings of certain studies illustrating a linear decrease in all mental disorders after the age of 55 (Streiner et al., 2006). According to recent statistical data, mental and neurological disorders (excluding headaches) affect more than 20% of adults above the age of 60, accounting for 6% of all forms of disability (WHO, 2017), with the number of elderly individuals with mental disorders projected to double by 2030. Hence, it is surprising that epidemiological research on mental disorders in Serbia has been

scarce, with a particularly small number of studies encompassing participants above the age of 60, despite demographic projections and the potential contributions of the elderly within families, local communities, and society as a whole.

The recognition of factors that contribute to mental health preservation among the elderly has multifold theoretical and practical significance, from shaping the perception of old age as a natural developmental process that differs from youth and adulthood in terms of priorities, goals, possibilities, and risks to the creation of fruitful, acceptable, and sustainable evidence-based interventions in the context of age-specific characteristics (decline and loss of bodily functions, reduced social roles, activities, and interactions, and different kinds of psychological losses) (Petrović, Jović, 2018). Conventional norms of evaluation of the elderly take the age of 65 as a rigid criterion, even though the age threshold is not a fixed category due to great interindividual differences at the physiological, psychological, and social levels, along with the fact that chronological criteria are often more significantly shaped by socio-economic discourses, primarily withdrawal from economic activities (retirement), than by actual years of age. Simultaneously, the shift towards a higher age threshold (65+) diminishes the alarming implications and observed tendency of growth in demographic fear, especially in the context of the increasing vitality of the elderly. In light of the extension of the human lifespan and lower mortality, defining old age is not only a matter of chronological age and functional status but also the context of life quality, value system, and characteristics of the environment in which a person lives.

3. Changes in the Social Relations of the Elderly

With age come changes in the nature of social roles and relations, both in immediate surroundings (within the family and among friends and neighbors) and in the wider context of work, retirement, and social participation (Despot Lučanin, 2022). Empirical studies have shown that social contact has a significant effect on the maintenance of mental health, especially at an older age, although it seems that, quite paradoxically, this effect has remained insufficiently recognized by the general public and the healthcare community (Antonucci, 2001; Krause, 2001; Pinquart &

Sorensen, 2000; Schwartz & Litwin, 2019a; Cacioppo & Patrick, 2008; Cacioppo & Cacioppo, 2014; Holt-Lunstad & Smith, 2012). The definition of the process of reciprocity as the degree of balance in social exchanges implies that the elderly are in an unfavorable position, bearing in mind age-related changes in health, everyday functioning, and the specific process of establishing and maintaining reciprocity in different relations, such as relationships with friends and acquaintances or spouses and children, in which the perspective of reciprocity is adopted and revised throughout the lifespan (Antonucci, 2007). The elderly usually need greater and/or additional help (i.e., they are in a dependent or receiving position), which combined with less power and prestige can lead to imbalanced relations and social isolation and consequently shape future social interactions (Fyrand, 2010).

The undoubted specificities of age-related changes result in the need of the elderly for the support of their family and local or wider social community, especially in cases of potential threats to mental health, which is seen as national capital and an integral element of an individual's health and well-being. Still, what is evident is the prevailing culture of neglect and marginalization, especially of elderly individuals with mental problems. In the same vein, social relationships can act as protective factors, providing a basis for developing and nurturing a sense of belonging or perceived social support (Barry et al., 2019), although trends point to a reduction in the quantity and/or quality of social relations in industrialized societies (fewer multigenerational communities, greater social mobility, delayed marriage, and more dual-career families) (McPherson, Smith-Lovin, 2006). Such findings bring social integration into question, despite technological advances and globalization, positioning loneliness and social isolation as high-priority aging issues that significantly affect the elderly's general life satisfaction.

Furthermore, empirical studies focusing on variously defined and measured social relations have commonly been plagued by criticism directed at the impreciseness of the very variable. Most often, social relations (networks) are perceived as a collection of ties formed and maintained throughout the lifespan, whose support can potentially positively contribute to a person's sense of well-being (Antonucci et al., 2014). In terms of

mental health outcomes, the effects of social networks depend on structural aspects (e.g., larger networks lead to better outcomes), functional aspects (e.g., greater contact frequency and member closeness lead to better outcomes), and/or qualitative aspects (e.g., perceived closeness and support in relations can help prevent mental issues) (Litvin, 1996). Likewise, the subjective perception of social support available is often more important than the actual support received (especially in the context of psychological well-being), with the common presence of hierarchical compensation through which adults seek to ensure social support and help from the most necessary and available sources (e.g., persons who do not have partners expect help from their closest relatives; in urban areas, persons commonly use formal forms of help, while in rural areas, they more greatly rely on close persons) (Brkić-Jovanović, 2020; Despot Lučanin, 2022).

Quality mental health protection is a legitimate human right and it is both important and relevant to all segments of the population (Barry et al., 2019), especially the elderly. Interventions based on social interactions yield a multitude of personal and social benefits. Hence, it is crucial to understand the concepts that rest upon social interaction, primarily social isolation and social participation.

3.1. Social Isolation

The multidimensionality of the construct of social isolation pertains to the inadequate quantity/quality of interactions with others, including interactions at the individual, group, and/or community level (Nicholson, 2012; Smith, Lim, 2020; Umberson, Karas Montez, 2010; Zavaleta et al., 2017).

Research on social isolation has predominantly focused on the elderly (Nygqvist et al., 2016), although most individuals experience feelings of loneliness and isolation at some point during their lives. These feelings are usually temporary and do not necessarily have long-term consequences on individuals' physical and/or mental health. On the other hand, the research agenda sees prolonged social isolation as a physical and mental health risk factor, pointing to higher levels of morbidity and mortality in comparison to more socially integrated individuals (Cacioppo, Cacioppo, 2014; Coutin, Knapp, 2017; Dahlberg, McKee, 2018) and a higher risk of

developing inflammatory, neuroendocrine, and cognitive disorders (Hodgson et al., 2020). Increased social isolation has been shown to correlate with decreased life satisfaction, higher levels of depression, and lower levels of psychological well-being (Cacioppo, Cacioppo, 2014; Coutin, Knapp, 2017; Dahlberg, McKee, 2018), bearing in mind the effects of objective characteristics of social networks as well as perceived isolation (loneliness), which is reflected in the perceived discrepancy between a person's desired and obtained level of social interaction (de Jong Gierveld et al., 2012). It is accompanied by a painful, disturbing, anxious longing for other people as a result of feeling rejected, alienated, and misunderstood. For example, older adults suffering from depression and anxiety tend to report low levels of social participation and perceived social support, for which they long, coupled with intense feelings of loneliness and isolation. In turn, this can place them at an increased risk of suicidal thoughts, self-harm, and death (Chen et al., 2020).

The sensitivity of the elderly population concerning the likelihood of social isolation is reflected in the synergistic effect of predisposing factors, considering the decline and loss of bodily functions, reduced social roles, activities, and interactions, and various psychological losses (e.g., the death of a spouse or sibling, limited physical mobility, retirement, lower income, and/or greater dependence on others in multiple ways) (Umberson, Karas Montez, 2010; Petrović, Jović, 2018; Lukić, 2023).

Due to the complexity associated with the subjectiveness of the concept of loneliness, since individuals can have subjective experiences of isolation despite frequent contact with others or not perceive isolation despite limited contact with others (Hughes et al., 2004), loneliness and social isolation have commonly remained unseparated in research, which further obscures the mechanisms underlying effects on health and acts as a hindrance in elderly support interventions (Beller, Wagner, 2018a, b). The existing literature indicates that it is necessary to make a distinction between social loneliness, which implies a lack of inclusion and poor social networks (Domenech-Abella et al., 2017), and emotional loneliness, which is defined by a lack of high-quality close and intimate relationships (Masi et al., 2011). The distinction points to different forms of risk for the elderly's health, requiring quantitatively and/or qualitatively different interventions.

For example, the loss of a romantic partner or close friend primarily leads to emotional loneliness, while acute or chronic incapacitation or illness affects the level of mobility, thus increasing the risk of social loneliness.

Although social isolation affects both individuals and wider social communities, it often goes undiagnosed, even within positions that are able to identify high-risk individuals (such as primary healthcare), which leads to an increase in the use of healthcare and social protection services, due to health issues stemming from isolation and loneliness (Vasiliadis et al., 2013). The mapping of risk factors provides prerequisites for preventive action, adequate evaluation, and timely intervention for both individuals and groups at risk of or affected by social isolation.

At the individual level, certain personal characteristics and life course transitions have been linked to a higher risk of social isolation, such as age (75+) and independent living (Victor et al., 2005), limited financial resources and retirement (Savikko et al., 2005), belonging to a minority group and associated language barriers (Victor et al., 2012; Miyawaki, 2015), general health decline and diminished functional ability (Lukić, Karaman, 2023), retirement, and children leaving the family home or moving to a retirement home (Cotterell et al, 2018; Milana Ljubičić, 2023). At the network and relationship level, studies have found that elderly individuals with limited family and/or friend contacts or poor contacts more commonly experience social isolation (Umberson, Karas Montez, 2010). Living in socially deprived areas (Victor et al., 2005), high crime rates (Nicholson, 2012), and limited access to social activities or services, content, and public transportation (Lucas, 2012) constitute local or wider community factors that magnify the risk of social isolation. At the population level, the quantity of social interactions can be partially or fully limited by experiences of discrimination and socio-economic policies that support social inequalities, do not foster social cohesion, and discourage social activity (Beller, Wagner, 2018a, b).

3.2. Social Participation

Social participation is one of the cornerstones of the socio-political framework of active aging. Despite inconsistencies in theoretical and operative definitions of the concept, social participation is most commonly defined as the involvement of individuals in voluntary activities that ensure

interaction with others (Lariviere, 2008), either in the public or private sphere, that is, in formal and/or informal contexts (Rashedi et al., 2014). It has been described using diverse attributes, including a wide range of community activities (religious, cultural, leisure, or sports activities), interpersonal interactions, and sharing resources (e.g., time, knowledge, or skills) (Aroogh, Shahboulagh, 2019), which implies the existence of a continuum with social participation at one end and social isolation at the other (de Jong Gierveld et al., 2009).

Thus far, research findings have pointed to the absence of a consistent pattern of correlations between social participation and health outcomes, partly due to discordant concept definitions and partly due to cultural authenticity, which explains the specificities and intensity of the relationship between health and social participation by the time, localization, and characteristics of the given population (Rasheidi, 2014). For example, the highly positioned values of Western cultures such as independence, autonomy, and self-confidence could clash with other systems' values of mutual help and reciprocity), which shapes the mode of social involvement.

Most studies have found that involvement in social participation activities yields multiple social and personal benefits in both physical and mental domains by lowering the risk of bodily and cognitive function decline (Gutierrez et al., 2013). In the context of low perceived support and social participation, elderly individuals with mental health issues (such as depression or anxiety) tend to report higher levels of emotional stress, which can sustain and reinforce the primary symptomatology, along with additional avoidance of social interactions, social withdrawal, anhedonia, and the development of negative cognitive bias (Cacioppo et al., 2015). Increased sensitivity to social rejection intensifies implicit hypervigilance for social threats and biased evaluation of other people's intentions and behaviors (Cacioppo & Cacioppo, 2014). In turn, this can affect an individual's motivation to participate in social interactions or elicit maladjusted behavior in a wide range of social interactions (Pepin et al., 2021).

On the other hand, the elderly's social participation has a protective effect in terms of loneliness, social isolation (Niedezwiedz et al, 2016), and depression (He et al, 2017), while specific, collective, conscious, and

voluntary actions at the core of social participation lead to self-actualization, promoting health, and preventing disability (Levasseur et al., 2020). The elderly's social participation activities often shape the way they seek support and/or treatment, including all aspects of health (especially mental). Hence, it is not surprising that studies have found strong correlations with positive self-care outcomes (Holmes & Joseph, 2011) and estimated life quality and satisfaction (He et al., 2017). The perceived instrumental and/or emotional support stemming from contact with others can shape attitudes, values, and norms related to ways of seeking help (supportive or responsive), which in case of poor social connectedness and reduced social participation can lead to suboptimal treatment outcomes (Chen et al., 2021). Taken together, these findings highlight the significance of increasing personal motivation for ensuring greater participation and not only providing and developing opportunities for social involvement.

4. Interventions

The link between social networks and improved mental and physical health has been well-documented in the literature, serving as a framework for the adoption of a holistic approach emphasizing the vital significance of the establishment and maintenance of high-quality social relations throughout the lifespan and the promotion of social and emotional competence from an early age, with a focus on resilience building within communities, as a solution for preventing isolation and promoting participation (Webber et al., 2017). Cotterrell and colleagues systemized intervention types at different levels aimed at including high-risk individuals (Cotterrell et al, 2018). One-on-one interventions are based on befriending schemes, where individuals are paired with volunteers or professionals for the purpose of maintaining regular contact. Program validations have found positive health effects, with significantly increased social support and reduced depression and anxiety symptoms in elderly individuals with chronic health conditions (Siette et al., 2017). Bearing in mind the common coexistence of mental health problems and difficulties in applying social skills psychological interventions aimed at mitigating cognitive biases (that promote negative thinking and social withdrawal) have been shown to result

in lower measures of objective and subjective social isolation as they improve individuals’ ability to cope with negative feelings, thus enabling re-integration.

Group interventions have the goal of gathering individuals around a common interest, with research evidence especially speaking in favor of group activities with a creative, therapeutic, or discussion-based focus (e.g., bereavement support for widows and widowers and cognitive and social support group interventions). Group interventions have had particularly high success rates among ethnic minority groups who may have difficulties interacting with the wider community due to language or cultural barriers. Such interventions enhance individuals’ sense of belonging while simultaneously alleviating social isolation (Platt, 2009).

Service provision interventions ensure support for socially isolated individuals, establishing a link between hard-to-reach individuals and local services through the work of volunteers such as students who provide free computer training to elderly individuals living in retirement homes or rural areas. Technology-based interventions constitute a related form of support, bearing in mind future advances in the domains of artificial intelligence and robotics.

The concept of *age-friendly cities and communities* developed by the World Health Organization materializes the idea of an age-friendly environment that provides a good place to grow old with the goal of preserving the elderly’s autonomy and dignity. Community interventions foster social participation and integration by mitigating logistic difficulties and obstacles when leaving home or within the neighborhood (e.g., greater availability of seating areas, safety and priority seating in public transport vehicles, and the availability of recreational activities (Buffel et al., 2018).

Finally, structural interventions are implemented at the population level and include the application of prevention strategies through modifications to public health policies, attitudinal changes, and the promotion of positive and active aging. Thus, they obliterate the perception of the elderly through the prism of vulnerability and burden in relation to other segments of the population. Contemporary healthcare paradigms promote interventions that emphasize the quality of relations outside the formal system, bearing in mind the gap between fostering and preserving mental health

(preventive) and providing treatment (curative). This gap could be bridged by social interventions that link people outside the formal sector, focusing on sources of support within the community (e.g., by organizing support groups or other groups based on common interests) (Batrićević, 2023). The heterogeneity of the elderly population challenges the validity of a limited, one-size-fits-all approach tailored to users’ stigmatized identities rather than access to a wide range of services within the community that contribute to the active role of the elderly with the aim of expanding and diversifying their social networks.

5. Conclusion

The demographic trend of the increasing share of the elderly in the general population has become a high-priority social development challenge in many countries. To address this challenge, it is necessary to change both individual and social paradigms, considering that adaptation to old age does not only depend on biological and psychological aspects but also social factors such as relationship networks and the support of legal, healthcare, and social policies (Elena Tilovska-Kechedji, 2023).

Mental health protection systems need to cover the entire range of needs, from the promotion and initiatives in mental disorder prevention to more effective control of the course of illness and recovery, since quality mental health protection is a legitimate human right. The research agenda has confirmed the potential of interventions based on social relations. The understanding of the nature and scope of the potential of the fastest-growing segment of the general population stemming from complex interactions between individual aspects, relational circumstances, and subjective perceptions constitutes the basis for interventions that foster subjective well-being, affective balance, and maximizing individuals’ potential through social participation and contributions to society.

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MINORITY STRESS AND MENTAL HEALTH AMONG LGB INDIVIDUALS

Abstract: *Meyer's minority stress model assumes that in addition to the stressors experienced by all persons, LGB faces unique minority stressors that are often related to social environment stress and negatively affect the mental health of LGB persons. The challenges LGB persons face change throughout their life span but are most often associated with experiencing and expecting discrimination and victimisation, concealment of sexual orientation, and internalised homophobia.*

This paper aims to present the documents concerning the mental health of young, adult, and elderly LGBT people. It can be concluded that LGB persons continue to experience pronounced stress in all life cycle phases and that the assumptions of the minority stress model are confirmed. The processes and developmental tasks are the same for LGB as for heterosexual persons, but that social environment stress makes LGB persons cope with additional stressful content within these processes.

Keywords: *LGB, minority stress, mental health, resilience*

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1. Minority stress model

It is known that LGB persons, in addition to the stressors that all people experience during development, are exposed to various stressors related to belonging to a minority group (Puckett et al., 2016). This minority stress is directly and indirectly associated with multiple health outcomes, especially problems in the mental health domain. Issues related to mental health range from impaired well-being and quality of life and difficulties in social functioning to the appearance of psychiatric conditions. The highest prevalence of these problems is related to the occurrence of depression, anxiety, suicidal ideation, and suicide attempts, as well as substance use and risky behaviour (Cochran, 2001).

Science has documented that the mentioned mental health problems occur more often in LGB people than in people of heterosexual orientation. Most of the research does not explain this difference with the internal characteristics of LGB persons but with the social position and challenges in the course of life. It also describes it with social stigmatisation and minority stress (Cochran, 2001).

The most well-known model that represents a comprehensive theoretical basis for understanding minority stress and mental health problems in LGB persons is the Mayers minority stress model (Meyer, 2003). This model was created to explain the development and functioning of people whose sexual orientation is different from homosexuals. Still, it was later confirmed in other minority populations, such as substance users and transgender people (Hendricks, Testa, 2012).

1.1. LGB minority stress model

After numerous studies and examinations of the basic postulates of the concept of minority stress, a group of essential characteristics was defined to determine whether a person's stress can be viewed as minority stress. The described features are: Minority stress is unique and is added to usual stressors, and stigmatised minorities need extra effort for adaptation; Minority stress is stable because social and cultural social structures maintain it; It is socially based because it takes place within social processes, institutions and other systems that are outside the individual (Meyer, 2003).

Mayers minority stress model is a social theory of stress and health, which assumes that LGB people, in addition to the usual stressors experienced by all people, also have additional challenges in the form of stressors specific to life within a minority group. These other challenges often originate from the person's social and social environment. The dominant discourse and social narrative are undoubtedly part of minority stress, where in addition to the stigma, prejudice, and discrimination that LGB people face, there is also a conflict with social norms and expectations within a culture. Such a hostile environment harms a person's health.

According to the minority stress model, four primary factors that create stress in minority groups are distinguished: experiencing victimisation and discrimination, expecting discrimination and adverse reactions from society and the environment, hiding sexual orientation, and internalised homophobia (Meyer, 2003). Numerous studies confirm the assumptions of this model (Birkett, Newcomb, Mustanski, 2015; Pachankis, 2018)

Sexual stigma leads to the formation of sexual minority groups, negative attitudes, and lower value status of minority groups (Herek, 2007). Structural stigma was developed as an extension of this model, representing macro-social forms of stigma. Within the framework of structural stigma, aggravating factors for minority groups originate from institutional policies and other factors that limit a minority group within societies (Hatzzenbuehler, 2016).

Chronic stressors in the life of LGB persons lead to internalised stigma in which the stigmatised person accepts negative attitudes and feelings. He feels and recognises negative social attitudes toward himself and his group and behaves contrary to himself to avoid discrimination (Herek, 2007).

The minority stress model postulated the existence of a continuum of minority stressors that range from distal to proximal processes. Distal processes that imply objective events or demands (Diamond, 2000), such as exposure to homophobia, victimisation, and discrimination by other people, can later lead to proximal processes, individual perceptions, and attitudes related to self-identity, such as fears of other people's reactions, anxiety in contacts with others as well as internalised homophobia. Proximal stressors refer to the evaluation of experiences and events that an LGB

person faces, which he perceives as related to his sexual identity. Proximal stressors include expected stigmatisation, concealment of sexual orientation, and internalised homophobia (Meyer, 2003).

The assumption of the dual nature of the process connects the social structure and the individual's inner capacities. Such distal and proximal methods are not standard in the heterosexual population and represent an additional risk for the mental health of LGB persons. As these stressors are initially of social origin, coping strategies and social and community support can reduce the negative consequences of minority stress on health (Meyer, 2003). Research shows that distal pressure predicts psychological distress (Hatzenbuehler, 2016).

1.2. A model of the relationship between minority stigma and mental health outcomes

Mayers minority stress model assumes that social support and stress coping mechanisms moderate the relationship between minority stigma and mental health outcomes (Meyer, 2003). Understanding this risk and how minor stress affects mental health is necessary. Figure 1 shows the relationship of the mentioned concepts according to the Mayer minority stress model.

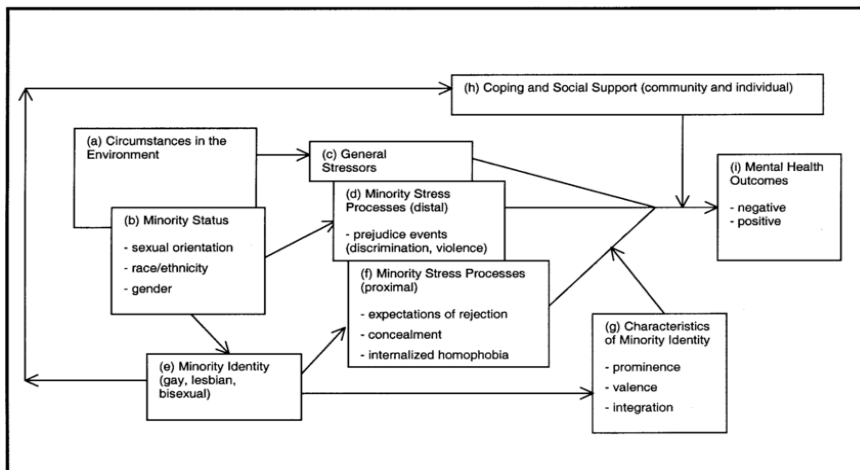


Figure 1. Minority stress processes in lesbian, gay, and bisexual populations (Meyer, 2003)

The picture shows the model of stress and coping strategies for mental health outcomes. According to the model, minority stress belongs to general circumstances in the environment, including numerous other social categorisations such as gender, race, socio-economic status, and the like. Events in the climate also determine exposure to stress, both normative stressors and stressors unique to the minority group to which a person belongs. The factors mentioned are interdependent and lead to a unique structure and minority stress process.

These processes, as mentioned, can be distal in terms of the experience of violence and victimisation and proximal, where the expectation of adverse reactions, internalised homophobia, and hiding of sexual identity belong. Very often, the product of these processes is the creation of a minority identity, which leads to additional exposure to stress due to the person's self-perception as stigmatised and as a member of a devalued group. Minority identity is also an essential modifier of the stress process that can weaken or strengthen the impact of minority stress. Also, LGB identity can be a source of resilience and coping strategies if a person achieves social support and good belonging to a group. Mental health outcomes depend on the interaction of the above factors (Meyer, 2007).

2. LGB minority stress and mental health issues

As mentioned, social environment and environment play an essential role and are predictors of the mental health and well-being of LGB persons. Social stigma and prejudice act directly and indirectly. Direct influences are easier to recognise and include exposure to violence and discrimination, while indirect ways are less visible but pervasive and chronic. Indirect methods include unequal health care and health treatment of LGB persons (Malebranche et al., 2004; Meyer, 2007), insensitivity to cultural aspects of belonging to the LGB group, poorer quality of life, and limitations in social behaviour and expression of love (Brkić et al., 2013).

LGB people have a lower degree of satisfaction within their partner relationships because regardless of the same processes that take place in all relationships regardless of the person's sexual orientation (Brkić, 2016). LGB couples have significant social limitations in the expressive

and instrumental expression of love, and it has been shown that satisfaction directly depends on the possibility of dyadic exchange in this way (Brkić-Jovanović et al., 2020; Brkić-Jovanović et al., 2022).

Herek also talks about the concept of sexual stigma, which refers to the inferior status, negative attitudes, and lower social power of those persons who do not behave by heterosexual social norms (Zulević, 2015).

Herek (2004) also defines three ways an individual can experience and express sexual stigma (Herek, 2004): The first form is enacted stigma, open negative behaviour directed towards members of a minority group. Another form is felt stigma, which means awareness of stigma and the expectation of stigmatisation in certain social situations and circumstances. The third form is internalised stigma, which implies the acceptance of the individual's internalisation of a certain stigma. In this last form, the individual accepts a certain negative stigma as part of his value system and perceives it as accurate. In this way, he stigmatises himself and individuals similar to him. This type of stigma often implies low self-esteem, shame, and a sense of guilt due to one's own minority identity (Zulević, 2015).

The concept that integrates knowledge about minority stress and psychological processes assumes three steps in the development of mental health issues among LGB persons: LGB persons suffer additional stress due to existing stigmatisation; Stigmatization affects the processes of social relations and conflicts, cognitive processing, regulation of emotions, increasing the risk of adverse mental health issues. These processes mediate between stigma-related stress and negative mental health outcomes such as anxiety, suicide, and depression (Mongelli et al., 2019).

Numerous studies have documented the higher risk for mental health issues of LGB persons compared to heterosexual persons. (Kidd et al., 2016; Semlyen et al., 2016) Mental health problems often recognised in LGB persons are mood disorders, anxiety, and substance abuse (Semlyen et al., 2016). LGB people are twice as likely to suffer from a mental disorder as heterosexual people (Sandfort et al., 2014).

Sexual minorities engage in risky behaviours such as the use of alcohol and cigarettes more often in adolescence (Meyer, Dietrich, Schwartz, 2008), while in adulthood, they exhibit low well-being (Sandfort et al., 2014). LGB persons are twice as likely to attempt suicide during

their lifetime, while the chance of developing depressive and anxiety symptoms is 1.5 times higher. This strong connection between minority sexual orientation and poorer mental health is observed in adolescence and persists over time (Sandfort et al., 2014).

Impaired mental health is the most common predictor of suicidal behaviour, especially in adolescence. Depression, anxiety, and substance abuse are the most common reasons for suicide. Studies show that LGBT people are at greater risk for poorer mental health throughout all periods of life (Russell, Fish, 2016). When we look at the existence of gender differences, LB women have three times more frequent problems with addiction compared to women of heterosexual orientation. In contrast, GB men significantly more often have panic attacks and depressive episodes (Haas, 2011).

2.1. Violence and LGB persons

LGB persons report a higher degree of lifelong violence experienced (Blais, Gervais, Hébert, 2014). In adulthood, LGB persons also report a higher rate of psychological and physical violence perpetrated by their intimate partners and a generally higher level of sexual abuse compared to heterosexual persons of the same age group (Balsam, Rothblum, Beauchaine, 2005). LGB people more often suffer bullying during their childhood and go through emotional, physical, and sexual abuse by peers and adults (Charak et al., 2019), and previously the connection between neglect, abuse, and bullying in childhood and poorer mental health in adulthood has been very firmly demonstrated (Chandan et al., 2019).

The most common mechanism of young people's struggle with stress is hiding by trying to live a heterosexual life, leading to isolation, dissatisfaction, and constant fear of discovery. Such contacts do not lead to a fusion of sexuality and emotionality, which encourages further isolation and feelings of inferiority and creates additional problems with a person's well-being and mental health (Brkić, 2016).

Young people who question their sexuality psychologically react worse to bullying and victimisation (Russell, Fish, 2016) and are at greater risk of violence, bullying, discrimination, problems in the educational process as well as problems with mental health (Birkett, Espelage, Koenig, 2009). Sexual violence is also widespread in the LGB population. Let's

take into account that the sexual activity of young people is on the rise. Young people enter into sexual relations earlier and earlier before clearly defining their sexual and personal identity (Tomašević et al., 2017); we can assume that vulnerability is also increasing.

2.2. Mental health of LGB people

Bisexual behaviour and identity are a factor of extreme vulnerability for mood disorders and anxiety in bisexual women and men (Birkett, Espelage, Koenig, 2009). Bisexual people are at greater risk for mental health problems than heterosexual people and people who are attracted to the same sex (Russell, Fish, 2016). Bisexual people are often rejected and excluded from the LG community, with which they are the least connected. Bisexual identity is often seen as inauthentic and as if it is not a “real” identity, which often produces insecurity, questioning one’s identity and the need to defend one’s identity (Bostwick, Hequembourg, 2014).

Previous research in the region confirms the model of minority stress and the clause that LGB people who have experienced violence and discrimination have worse mental health, that hiding a minority sexual identity reduces the possibility of bias and victimisation but lowers a person’s self-esteem and quality of life. It was also confirmed that openness, self-esteem, involvement in the minority community and activism positively predict adaptation to stress. It is essential to point out that bisexual people are doubly marginalised in society and within the minority group.

Compared to gay people and lesbians, bisexual people show poorer mental health and more depression and anxiety (Dobinson, 2007). Also, bisexual people are at a higher risk of self-harm and suicide than heterosexual people and lesbians and gay people (Dobinson, 2007). Although bisexual people are more often in a legal marriage and have children more often than lesbians and gay men, they also have unique issues, they rarely have solved primary health care, they do not turn to the LG community for help, and bisexual men live significantly more often alone (Fredriksen-Goldsen et al., 2011). In contrast to gay men and lesbians, bisexuals are less likely to open up to the environment, friends, family, colleagues, and the degree of their loneliness and isolation is significantly higher, as is the feeling of marginalisation and mental distress (Travis, Kimmel, 2014).

Gay men are twice as likely to have depression as heterosexual men. One significant reason for this is their experiences with HIV/AIDS infection, both personally and facing close friends. Lesbians also more often report depression than heterosexual women (De Vries, 2014). Multiple marginalisations are also noticeable, and the stress level increases as marginalisation increases (De Vries, 2014). Lower economic status, race, and HIV infection make coping with minority stress difficult for LG people.

The age of the LG person also determines the coping with minority stress, such as stigma, discrimination, and internalised homophobia, so younger LG people use different coping mechanisms than older ones (David, Knight, 2008), Mental health of gay men who are socially isolated, especially those who have remained “in the closet” and who have problems with the “coming out” process is especially vulnerable and have more frequent suicidal ideas and attempts (Cahill, Valadez, 2013). Gay men who are married have better mental health than single or cohabiting men (Wright, Owen, Catalan, 2012).

Coming out is also very important for the mental health of lesbians, but according to research, many lesbians prefer to conceal their sexual identities. They are at greater risk of suicide and substance abuse, especially alcohol (Fredriksen-Goldsen et al., 2013).

3. Resilience and coping in the minority stress model

The physical and mental health of adult LGB persons were positive with social support, social network size, material and leisure activities, substance nonuse, employment, and a positive sense of sexual identity (Dobinson, 2007). Stress resistance includes everything that can lead to positive outcomes in a particularly stressful situation. Resilience represents the ability to adapt successfully to stressful situations, and coping with stress describes an individual’s efforts to adapt. Using pressure coping mechanisms does not guarantee a person’s resilience. Resistance to stress and dealing with minority stress help preserve the physical and mental health of LGBT people by removing or reducing the impact of stress on the individual (Meyer, 2015).

Masten (2007) defined stress resistance indicators. Three indicators stand out: successful adaptation and growth, development in a problematic environment, good functioning under challenging circumstances, and the possibility of recovery after exposure to a traumatic experience (Masten, 2007).

The last part of Meyer's scheme of minority stress presents ways of dealing with minority stress. Within the theoretical model, we can distinguish between resilience and coping. Resilience and coping can occur at the individual, community, or group levels (Meyer, 2015).

Resilience at the individual level refers to specific characteristics that help the individual cope with stress. Positive predictors of personal resilience are a sense of control and power, boldness, consistency, commitment, etc., while negative predictors are a sense of hopelessness, fatalism, and powerlessness (Turner, Roszell, 1994). The importance of individual resilience is strongly expressed in situations where the individual is not autonomous and where there is no public LGB community, such as various organisations for psychosocial support of LGB people. It is also essential to consider the legal regulations and the legitimacy of LGB extramarital unions (Ilić, 2021).

Relying on the individual resistance to stress of LGB persons is especially problematic for those persons who belong to the middle and higher social class or are members of another minority group because homophobia, sexism, racism, and social inequality limit resistance at the individual level (Meyer, 2015).

Elderly LGB people are particularly vulnerable, and minimal research deals with the mental health of this group of people. Old age is more frequently seen as a problem, and prejudice and negative attitudes towards the most senior members of the community are ever more present, as well as the inhumane opinion regarding their needs and the lack of solidarity between the generations (Solarević, Pavlović, 2018). Ageism is also very prevalent in the health and social context (Ljubičić, 2021), and combined with LGB discrimination, represents a multiple challenge for older LGB people due to double marginalisation.

Social support at the micro and macro level stands out as one factor that strongly predicts better mental health of LGB persons, especially support related to sexual identity and its acceptance (Doty et al., 2010). A more extensive social support network is associated with less minority stress and consequently less loneliness, depression, and externalising disorders of LGB persons (Lehavot, Simoni, 2011).

Suppose we accept that people can create sufficient resistance to stress independently. In that case, there is a danger that we focus only on the individual's response, which is a consequence of stress, and not on the source of tension in the community (Meyer, 2015). Resistance to minority stress at the community level is defined as a way in which the community supports the individual, strengthens and expands the individual's possibilities for resilience and coping with stress. This is often achieved through various organisations and associations, where multiple activities include counselling, networking, support groups, help overcoming specific crises, etc.

Another type of community action is raising awareness and sensitising the public against discrimination. Resilience at the community level is also developed through defining, adopting, and changing legal regulations. This community resilience is connected with the minority identity; thus, these two levels of strength, individual and environmental, are intertwined and form one connected system. All of the above belong to the community's tangible resources, including access to information, positive role models, policies that help LGBT people, and so on. Intangible resources can be changes in attitudes, values, norms, and expectations towards developing an LGB-affirmative environment (Meyer, 2015).

4. Conclusion

The above indicates that the LGB population is at greater risk of mental health problems. Also, these difficulties pervade the entire lifespan of an LGB person. It is essential to support all age groups by strengthening the individual capacities of the person and through the support of the community and the environment to create sustainable resilience. The minority stress model has been confirmed in most research and provides an essential

framework for a better understanding of the processes and factors that contribute to greater exposure to stress as well as the appearance of mental health issues, and provides a reasonable basis for all experts to be more sensitive and successful in providing mental health support to all people from minority groups, and especially LGB persons.

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MENTAL HEALTH AND COGNITION - TWO SIDES OF THE SAME COIN?

Abstract: *Cognition refers to the mental capabilities or thinking skills that allow a person to perceive, acquire, understand, and respond to information from their environment. Cognitive health refers to brain functions such as attention, learning, memory, language, and executive function. This includes higher-order functions, like decision-making, goal-setting, planning, and judgment. Cognitive health as a general term can refer to brain and mental health. Research studies suggest that cognitive deficits significantly contribute to poor mental health and low functional outcomes. Without good cognitive health, there is a risk of mental health problems, and struggles with mental health conditions can affect cognitive well-being. So, cognitive and mental health are interrelated, and cognitive health is a necessary prerequisite for mental health. To preserve and improve cognitive health, it is important to build and sustain cognitive reserve. Higher cognitive and brain reserve may be protective factors for mental health issues.*

Keywords: *cognition, mental health, cognitive reserve, brain health.*

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1. About cognition

Cognition in a broad sense means information processing. Also, cognition or cognitive functioning refers to multiple mental abilities, including attention, memory, remembering, perception, motivation, skilled movements, language, problem-solving, reasoning, and decision-making. Throughout an individual life, cognitive performance changes in response to environmental demands and changes (Morozova et al., 2022). Cognition is the process of receiving and storing information for further use in behavior management (Morozova et al., 2022). It is the ability to perceive and react, to process information, and to make sense of it. It also involves making adequate decisions and generating effective and adaptive behavioral patterns. In other words, better cognitive skills provide a better understanding of the environment to interact with it most efficiently and safely (Morozova et al., 2022).

Cognition commonly refers to the perceptual/gnostic and intellectual aspects of mental functioning (Trivedi, 2006). Among the specific mental abilities that may be assessed in determining the adequacy of preserved cognition are orientation, the ability to learn, solve problems, think abstractly, reasoning, make judgments and decisions, the ability to retain and recall events, mathematical ability, different forms of symbol manipulation, control over primitive reactions and behavior, language use and comprehension, attention, perception and praxis (Trivedi, 2006).

Cognition includes all forms of knowing and awareness, such as perceiving, conceiving, remembering, reasoning, judging, imagining, and problem-solving. Along with affect and conation, it is one of the three traditionally identified components of the mind (VandenBos, 2007). Cognition includes all of the conscious and unconscious processes involved in thinking, perceiving, and reasoning. Cognition examples include paying attention to something in the environment, learning new skills, making decisions, processing language, adapting behavior, sensing and perceiving environmental stimuli, solving problems, and using memory capacity.

During childhood cognition develops, and eventually, cognitive decline occurs as a part of aging. Because central nervous system (CNS)

regeneration processes are imperfect, some cognitive functions may become impaired as a part of normal aging due to neuronal degeneration and death (Morozova et al., 2022).

Higher cognitive ability predicts a lower incidence of psychiatric disorders (Batty et al., 2005) and lower levels of self-rated mental health problems, such as depressive symptoms (Khandaker et al., 2018). Cognitive ability has also been associated with higher psychological well-being measured with concepts such as happiness, positive affect, and life satisfaction (Ali et al., 2013).

Cognitive functions are essential for the normal functioning of every individual, and if they are impaired, everyday life is extremely difficult and unproductive (Morozova et al., 2022). Some domains of cognitive functioning somehow decrease with the presence of mental illness. In other words, some mental health illnesses contribute to a lack or loss of cognitive abilities. However, each psychiatric or neurological disease commonly contributes to a certain cognitive domain disruption.

The mechanisms accounting for the associations between cognitive ability and mental health remain poorly understood. The association between cognition and mental health mainly may be explained by strict biological factors, such as chronic inflammation which has been associated with both mental health and cognitive ability (Khandaker et al., 2018). The mental health associations of cognitive ability might reflect the underlying integrity of the nervous system and the efficiency of information processing. Cognition may be indirectly associated with mental health, to the extent that it is an indicator of “system integrity” (Whalley, Deary, 2001), i.e., integrity of the nervous system, or of its underlying physiological processes that influence mental health. Cognition also may be associated with mental health because it may be part of a causal chain that modifies mental health risk (Hatch et al., 2007). Cognitive development partly determines educational level, social and occupational status, and income (Feinstein, Bynner, 2004; Richards, Sacker, Deary, 2013).

Studies have reported an association between low cognitive ability in childhood or early adulthood and adverse mental health outcomes in mid-adulthood (Batty et al., 2006; Batty et al., 2005). While the reasons for

this association are not fully understood, many dynamically interactive processes may be involved.

Also, some studies claim that children and adolescents with high cognitive abilities (called gifted children) have sometimes been portrayed as being more vulnerable to mental health issues (Lavrijsen according to Silverman, 1994). Such negative perceptions about the psychological adjustment of cognitively gifted individuals are dominant among the general public, who anticipated those individuals to be less emotionally stable when they were described as intellectually/cognitively gifted (Lavrijsen according to Baudson 2016; Weyns, Preckel, Verschueren, 2021). By contrast, empirical studies comparing the prevalence of psychological problems between gifted and non-gifted youth generally do not seem to confirm such negative stereotypes (Lavrijsen, Verschueren, 2023). Overall, these studies did not find indications that high cognitive ability would increase risks for psychological maladjustment (Lavrijsen according to Lein 2021).

1.1. Cognitive health

Cognitive health is the development and preservation of the multidimensional cognitive structure that allows older people to maintain social connectedness, an ongoing sense of purpose, and the abilities to function independently, permit functional recovery from illness or injury, and cope with residual functional deficits (Hendrie et al., 2006:13). Cognitive health can be defined as the overall state of an individual's cognitive functions, which include different cognitive abilities. It is an important aspect of overall well-being and plays a fundamental role in everyday functioning, personal relationships, and quality of life.

Cognitive health is an essential part for every individual to adapt and navigate through their daily lives effectively. Healthy cognitive functioning allows an individual to retain and recall information, focus on different kinds of tasks, make decisions, and solve problems efficiently. Moreover, cognitive health contributes a lot to emotional well-being, as it helps to regulate emotions and manage everyday stress effectively. Good brain health enables individuals to comprehend their abilities and adjust their cognitive, psychological, emotional, and behavioral functioning according to various life events to cope optimally (Puri, Shaheen, Grover, 2023).

Multiple factors affect the brain’s health, such as age-related changes in the brain, injuries, mood disorders, substance abuse, and diseases (Anstey, Cherbuin, Herath, 2013). Some factors cannot be changed, such as genetics, and age, but others can be modified and changed through lifestyle choices and interventions. Those modifiable lifestyle factors include diet and physical activity, sleep, social engagement, stress management, cognitive activity, smoking, and alcohol consumption. All of these may stabilize or improve declining cognitive function.

So, several factors can influence cognitive health throughout an individual’s lifespan.

1. *Genetics: Genetic factors play a significant role in cognitive health. Certain genetic variations can increase the risk of cognitive decline/impairment and neurodegenerative diseases such as Alzheimer’s disease (Bugarski, Semnic, 2009). However, genetic predisposition does not determine an individual’s cognitive health entirely, as environmental factors also can play an important role in shaping our cognitive health.*
2. *Individual’s Age: As individuals age, cognitive functions tend to decline physiologically with time. Less functional memory capacity, slower processing speeds, shorter attention spans, and a reduction in working memory capacity are characteristics of age-related cognitive decline. Other things like lifestyle factors and cognitive stimulation can help slow down this decline and help to maintain cognitive health, specifically in older age (Bugarski Ignjatović et al., 2015).*
3. *Lifestyle Factors: Various lifestyle factors play a significant role in shaping cognitive health. Regular physical exercise and adequate sleep can help to improve cognitive function. A healthy food known as a “Mediterranean diet” which is rich in fruits, vegetables, whole grains, and omega-3 fatty acids also provides support to cognitive health. Some other factors like stress management, and social engagement can contribute a lot to cognitive well-being.*
4. *Role of Education and Cognitive Stimulation: With education and cognitive engagement, there is a lower chance of cognitive decline*

and better cognitive performance. Continuous learning, and engaging in mentally stimulating activities can help maintain cognitive health.

The World Health Organization defines health as a positive state of “physical, mental, and social well-being” (World Health Organization, 1948). With this definition of health came a focus on positive practices such as the proactive prevention of disease and cultivation of health-related strengths through efforts such as physical exercise, cognitive challenge, and social skills training (Gaines, 2021).

Although the concepts of *cognitive health* and *mental health* may sometimes seem to be connected, they concentrate on separate facets of well-being. Memory, attention, perception, problem-solving, and decision-making skills are all included in cognitive health, which describes the general condition of a person’s cognitive functioning. Mental health encompasses a broader range of psychological well-being like a person’s emotional, psychological, and social well-being and their ability to cope with the challenges and stresses of life. Although different, these concepts are traditionally interrelated and often have to be seen as a unity.

While cognitive health has often been included as a dimension of health and well-being, its study as a singular focus is a more recent development (Aidman, 2020). Cognitive health is one dimension of having a healthy brain. Many different terms are used to describe the basic idea related to cognitive health - cognitive fitness, mental fitness, brain fitness, cognitive readiness, etc. For example, the concept of mental fitness has emerged in the mental health and positive psychology literature (McCarthy, 1964, Seligman, 2008) to promote a positive and proactive notion of mental health. The mental health literature is focused on identifying protective factors, such as cognitive flexibility, implicated both in the prevention of mental illness and the promotion of “flourishing” (Robinson et al., 2015).

It is important to maintain cognitive health through regular mental challenges because cognitive capacity is associated with one’s ability to perform both complex and basic activities of daily living (Gaines, 2021). Regular, challenging cognitive activity can be considered neuro-protective

in that it produces increased connections between neurons in the brain, which can help compensate for encroaching Alzheimer’s disease or other age-related disorders (Wilson et al., 2002; Volarov et al., 2020; Kovač et al, 2020a). The “use it or lose it” theory of cognitive health holds that the brain is like a muscle whose cognitive strength increases with use and declines if idle. There is ample evidence supporting this theory and one of the well-known is a “Nun study” (Wilson et al., 2002).

Stimulating cognitive capacity helps individuals to stimulate new connections between nerve cells in the brain – a phenomenon known as neuroplasticity. In this way, those areas of the brain are more capable of various activities and more resistant to brain degeneration (Mateos-Aparicio, Rodríguez-Moreno, 2019). Besides stimulating cognitive capacity, positive emotions also play a protective role in cognitive health. Negative emotions tend to narrow our perspective on a situation to only its most threatening aspects (Kovač et al, 2020). On the other hand, positive emotions like pride tend to broaden and enhance cognition (Isen et al., 1987; Kovač et al, 2020). Based on such arguments, positive neuropsychology advocates an approach in which the cognitive assessment would primarily focus on cognitive strengths and not weaknesses. Focusing on cognitive strengths and promoting cognitive health has two key advantages. Focusing on cognitive strengths helps individuals accurately assess what they can do, which in turn allows for the proper deployment of strengths (Gaines, 2021). In focusing on our cognitive strengths, we are more likely to experience positive emotional states such as pride and self-confidence, which are known to enhance thinking (Gaines according to Isen, Daubman, & Nowicki, 1987). Because cognitive health is an integral part of general health, most recommendations that can be applied to improve overall health can be used for the stimulation of cognitive health such as good sleep routine and exercise.

1.1.1. Cognitive reserve

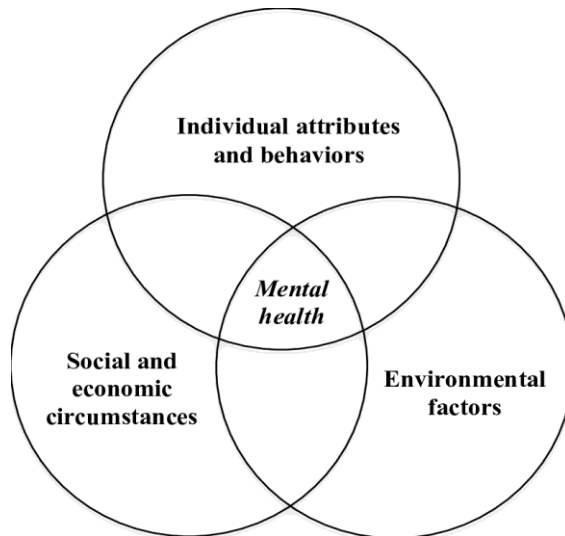
Cognitive reserve is defined as the ability to optimize or maximize the usage of neural networks when facing tasks with greater cognitive load serving as a protective factor from cognitive decline (Volarov et al., 2020:11). In the clinical population, it is assumed that cognitive reserve

has the role of minimizing the effects of brain pathology on cognitive functioning through more flexible alterations between engaged neural networks. In the earliest stages of the construct development, it was predominantly expressed via levels of education or verbal intelligence (Volarov et al., 2020:11). However, accumulated research evidence suggests that cognitive reserve is a multidimensional construct and that various lifelong activities should be taken into account when assessed (Volarov et al., 2020:11). Cognitive reserve reflects the effectiveness of the internal connections of the brain and it is a protective factor in brain damage, slowing cognitive aging or reducing the risk of mental health disorders. Cognitive reserve enables the brain to adjust and compensate for the challenges it faces. People with higher cognitive reserve have more efficient brain networks that allow them to actively cope with pathology using compensatory mechanisms (Stern, 2002). Previous studies suggested the role of cognitive reserve as a moderator effect in mental health problems such as depression (Opdebeeck et al., 2018). Thus, cognitive reserve plays a vital role in protecting the brain against cognitive decline, age-related cognitive disorders, and mental health problems. Because of this, strengthening and stimulating the cognitive reserve is one of the protective factors for overall mental health.

2. Mental health

Mental health is according to the World Health Organization “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community” (World Health Organization, 2021). Reference to this definition makes it clear that mental or psychological well-being is influenced not only by individual characteristics or attributes but also by the socio-economic circumstances in which persons find themselves and the broader environment in which they live (World Health Organization, 2012).

Figure 1. Contributing factors to mental health and well-being
(World Health Organization, 2012).



- *Individual attributes and behaviors*: These relate to a person’s innate as well as learned ability to deal with thoughts and feelings and to manage in daily life, as well as the capacity to deal with the social world around by partaking in social activities, taking responsibilities or respecting the views of others. An individual’s mental health state can also be influenced by genetic and biological factors (World Health Organization, 2012:3).
- *Social and economic circumstances*: The capacity for an individual to develop and flourish is deeply influenced by their immediate social surroundings – including their opportunity to engage positively with family members, friends, or colleagues, and earn a living for themselves and their families – and also by the socio-economic circumstances in which they find themselves (World Health Organization, 2012:4). Restricted or lost opportunities to gain an education and income are especially pertinent socio-economic factors (World Health Organization, 2012:4).

- *Environmental factors*: The wider sociocultural and geopolitical environment in which people live can also affect an individual's, household's, or community's mental health status, including levels of access to basic commodities and services (water, essential health services, the rule of law), exposure to predominating cultural beliefs, attitudes or practices, as well as by social and economic policies formed at the national level (World Health Organization, 2012:4). Discrimination, loss of basic human rights, social or gender inequality, are examples of adverse structural determinants of mental well-being (World Health Organization, 2012:4; Ivanović, Petrović, 2022, Radaković, 2020; Savić, 2019).

Table 1 presents a list of factors that may be risk or protective for mental health status.

Table 1. Mental health determinants – risk and protective factors

Level	Adverse factors		Protective factors
Individual attributes	Low self-esteem	↔	Self-esteem, confidence
	Cognitive/emotional immaturity	↔	Ability to solve problems and manage stress or adversity
	Difficulties in communicating	↔	Communication skills
	Medical illness, substance use	↔	Physical health, fitness
Social circumstances	Loneliness, bereavement	↔	Social support of family & friends
	Neglect, family conflict	↔	Good parenting / family interaction
	Exposure to violence/abuse	↔	Physical security and safety
	Low income and poverty	↔	Economic security
	Difficulties or failure at school	↔	Scholastic achievement
Environmental factors	Work stress, unemployment	↔	Satisfaction and success at work
	Poor access to basic services	↔	Equality of access to basic services
	Injustice and discrimination	↔	Social justice, tolerance, integration
	Social and gender inequalities	↔	Social and gender equality
	Exposure to war or disaster	↔	Physical security and safety

Mental health is a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life (VandenBos, 2007). It is a key aspect in peoples' lives, but also necessary for economic growth and social development (World Health Organization, 2021). This concept is directly related to quality of life and well-being. Its decrease or deficit

results in health issues, deprivation, and relationship problems but also in problems concerning education, employability, and job performance. Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes (World Health Organization, 2021).

2.1. Cognitive dysfunction in mental health problems

Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning, or risk of self-harm. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case. Mental illnesses/disorders are health conditions involving changes in emotion, thinking, or behavior (or a combination of these). Mental illnesses can be associated with distress and/or problems functioning in social, professional, or family activities.

All types of mental disorders come with a hidden cost in the form of cognitive dysfunction, including deficits in memory, attention, executive functions, and processing speed (Abramovitch, Short, Schweiger, 2021). Abramovitch, Short, and Schweiger (2021) analyzed data from all existing meta-analyses and systematic reviews of cognitive function across all disorders recognized by the Diagnostic and Statistical Manual of Mental Disorders. They included 97 meta-analyses covering 29 mental health disorders and incorporated data from more than 200,000 individuals (Abramovitch, Short, Schweiger, 2021). This research team found that both diagnosable mental disorders, as well as some common symptoms such as anxiety and worry, carry a “cognitive price.” They termed this phenomenon “The C Factor”. It is short for *cognitive dysfunction*. According to this interpretation “The C Factor” can be defined either as lower performance on cognitive tests or reduction in cognitive abilities, such as a lower level of attention or impaired executive functions. Abramovitch et al. study (2021) suggests that it can be found across disorders and that it constitutes an integral part of poorer mental health. Several studies demonstrated that cognitive dysfunction is associated with the presence of psychopathology and with overall psychopathology-related severity/burden, but not with a

specific diagnosis or disorder-specific symptom severity, in both adults and youth samples (David et al., 2008; McGrath et al., 2016). Cumulative evidence emerged in the last decade suggesting that in the context of any psychopathology, cognitive deficiencies across domains may be the rule rather than the exception (Bloemen et al., 2018, Doyle et al., 2018, East-Richard et al., 2020; Castaneda et al., 2008).

3. Conclusion

Mental health and cognition are inextricably linked and cannot be considered separately. To maintain mental health, we need cognitive health and vice versa. As it is shown, a multitude of factors contribute to each of the given phenomena, which further highlights the complexity of this relationship. Therefore, it should always be considered that cognitive health is equally important for mental health and overall well-being as all other factors that are more often highlighted as cognitive ones. The importance and place of cognitive reserve as a key resource that contributes to cognitive strength and acts as a very important protective factor should be highlighted here. Although often neglected and occasionally forgotten, the cognitive reserve has an important place in the maintenance of both cognitive and mental health. Higher cognitive and brain reserve may be protective factors for mental health issues. Future considerations should certainly be directed toward promoting the given protective factor.

Funding

This literature review was supported by the Science Fund of the Republic of Serbia (#7744418, Genetic and environmental influences on psychological adaptation of children and adults - GENIUS)

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IMPORTANCE OF RESOLUTION OF A CHILD’S DIAGNOSIS FOR PARENTAL MENTAL HEALTH

Abstract: *Parents who receive a diagnosis of a serious medical condition or developmental disability for their child often experience strong emotional reactions such as sadness, disappointment and fear. Resolution of the child’s diagnosis refers to achieving acceptance, putting an end to active grieving, and refocusing on present and future realities. In time some parents are able to come to terms with their child’s chronic condition. Conversely, for unresolved parents, strong negative emotions persist through time. They are more depressed, anxious, and stressed compared to those that are resolved. This paper presents key indicators of resolved vs. unresolved parental status, as well as the relationship between resolution and parental mental health. Parents need support, either in a one-on-one or group setting in order to preserve their mental health and the general well-being of the family. A brief description of the support program created and implemented in Serbia is also provided.*

Keywords: *parents; resolution of diagnosis; mental health; support.*

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1. Introduction

Raising a child brings an abundance of pleasure, joy and gratification for parents. However, learning that a child is attained by a serious chronic illness or a developmental disorder represents a highly traumatic experience for most parents. They tend to exhibit numerous intensive negative emotional reactions, such as shock, disbelief, disappointment, anger, fear, but also guilt and shame (Sher-Censor, Shahar-Lahav, 2022). These emotions do not occur in all parents and in the same intensity, but the common thread is that almost all parents experience grief which is observed as a universal parental emotion. Along with coping with difficult emotions, parents face countless other challenges over a long period of time i.e. physical or financial. Parents are often unsure of the prognosis for the child's medical condition and future development; they are burdened with medical procedures and specific requests elicited by the child's illness. Insecurity experienced by parents when facing their child's medical condition can minimize their ability of coping successfully with the situation. Therefore, it is not surprising that studies confirm parental psychological and physical health and general family wellbeing is greatly influenced by the child's medical condition and that parental stress is enhanced by multiple demands placed upon parents (e.g., Cohn et al., 2020, Raina et al., 2005). Due to the prolonged stress and feeling of insecurity with regard to the child's condition, parents of chronically ill children in comparison with parents of healthy children have a higher probability to develop mental health issues. The anxiety they experience is just one of many mental health problems which make it harder for them to adapt to new demands, leading to a poorer quality of life. On the other hand, the new demands derived from the child's condition or specific treatment plans require quick parental adaptation to different situations depending on their child's challenging needs which further burden the parents and require great flexibility within the family system. For that reason, parents experience other unwanted mental health outcomes alongside anxiety, such as depression, guilt, hopelessness, but also indicators of posttraumatic stress disorder (Britner et al., 2003; Duffy, 2011).

Multiple factors can increase or decrease stress in families with a child that is ill. These are associated with individual characteristics of the child, parental characteristics and different forms of available support. Each of these factors can influence family circumstances and a thorough examination of a family indicates that parents need to be understood in a wider context and not only as providers of care for a child with an illness.

The following stand out as key factors associated with intensity of family stress:

1. Parental characteristics (e.g., age, marital status, coping ability);
2. Individual characteristics of a child (e.g., the degree of severity of the medical condition, a child's temperament, behavioral problems);
3. Social factors (e.g., available social support, quality of marital relations);
4. Economic factors (e.g., socioeconomic status, parental employment status);
5. Cultural context (e.g., acceptance of disability in the community) (Raina et al., 2005).

Although parents of children with different health conditions experience higher levels of stress in comparison with parents of typically healthy children, it is important to point out that many of them adapt successfully to newly developed conditions, with positive family functioning being linked to lower levels of parental anxiety and stress (Nabors et al., 2013). This underlines the importance of recognizing and supporting the observed positive aspects of raising a child with a chronic health condition which include enhanced emotional closeness between family members, personal development, sensitivity towards other people, enjoyment of typical family activities, connecting with other parents in the community, development of amicable relationships with professionals etc. (Green, 2007). Thus, in spite of all the difficulties they experience, many parents find pleasure in their parental role. This point of view allows us to make a shift from the exclusive focus on negative aspects of family life to promoting

family strengths and resources as well as the happiness that can be experienced. This encourages family resilience and desirable aspects of each parent’s mental health (Ćorić, 2022; Naicker, Bury, Hedley, 2023).

Baring in mind the challenges that accompany parenting a child with a chronic health condition, this paper aims to portray the process of parental resolution of their child’s diagnosis, as a key concept in understanding parental emotional adjustment. Resolution is viewed as a protective factor for parental mental health and consequently for parental ability to provide sensitive child care.

2. Parental resolution

Parental reactions to the child’s diagnosis have been a largely debated topic in scientific literature. In contrast to earlier approaches that stressed the linear nature of parental adaptation (from shock, disbelief, and denial to complete parental adaptation), the concept of resolution does not insist on a final stage of absolute parental acceptance of their child’s condition (Barnett et al., 2003). This implies that a parent who has accepted their child’s diagnosis can still occasionally experience sadness and other painful emotions, but the key difference is that these feelings are not overwhelming to a degree to which they used to be at the beginning when the parent was first confronted with information on their child’s diagnosis. Parental resolution is an ongoing process of changing one’s expectations and dealing with emotions that are associated with the reality of parenting a child with a specific diagnosis. Thus, resolution of diagnosis represents a process of acceptance, the end of active grieving, and a refocus on present and future realities (Poslawski, 2014).

Resolution includes cognitive and emotional managing of what was experienced. On a cognitive level, parents must understand the meaning and implications of their child’s diagnosis. All new information concerning the child’s medical condition needs to be incorporated into the parents’ internal mental representations of themselves as parents and of their child. However, some parents find it difficult to accept unwanted information. They tend to deny or minimize the reality of their child’s actual condition or are excessively preoccupied with the past, e.g., investigating why the illness has occurred in their child. As to the emotional level, it is

important for parents to accept and express their emotions, such as disappointment, grief, sadness, anger and guilt so as they could adequately accept their behavior and adjust it to the fact that their child has a serious medical condition. After having experienced intense negative emotions, parents who accept the actual reality of their child's condition can experience satisfaction, enjoyment and a sense of being connected to their child. This does not mean that they will no longer feel distress with regard to their child's condition, but their feelings will not be as strong or overwhelming as they used to be at the beginning. It has been demonstrated that parents differ in the degree to which they overcome their initial emotional responses, primarily sadness but also some other painful emotions, and focus on the present. Parents who succeed in this process are categorized as resolved to their child's diagnosis. Conversely, unresolved parents experience difficulties in emotional adjustment and accepting the reality of the child's diagnosis, and therefore exhibit pronounced and constant grief (Pianta et al., 1996; Reed et al., 2019). After the initial papers by Marvin and Pianta (Marvin & Pianta, 1996) which focused on the relationship between resolution and the development of secure emotional bonding in a child, many authors continue their studies aimed at fully understanding the concept of resolution. Many authors have confirmed a strong relationship between resolution and emotional bonding of children, and have also pointed to the importance of resolution for mental health and wellbeing of parents (e.g., Di Renzo et al., 2020; Krstić, Mihić, Mihić, 2015; Reed, Osborne, 2019).

Pianta and Marvin (Pianta, Marvin, 1992) have developed a standardized procedure for the assessment of parental resolution which was named *Reaction to Diagnosis Interview*. The aim of this interview is to examine parental resolution of trauma connected to receiving information that their child has a chronic illness or developmental difficulties. It takes approximately 15 minutes to conduct the interview. During the interview parents are asked questions about the period of time when they began noticing that something was not right in their child's development (“When did you first realize that your child had a problem?”) and how they felt at the time (“What were your feelings at the time of this realization?”). Parents are also requested to share in detail what they experienced when they

received the final diagnosis (“Tell me exactly what happened when you learned of your child’s diagnosis, where were you, who else was there, and what were you thinking and feeling at that moment?”). The key question is aimed at registering how parental feelings change over time (“How have these feelings changed over time?”). Aside from that, parents are asked whether they had and/or have any thoughts about possible causes for their child’s condition. Parental answers depict different personal stories and challenges. Apart from their contribution to understanding parental resolution process, they can serve as a basis for psychotherapeutic interventions and allow professionals to fully grasp the possibilities and difficulties that parents encounter on personal and family level (Orme, 2005).

As already stated, we view resolution as a process of integrating information about the child and the parental emotional reactions they lead to, into parental mental representations of themselves as parents, of their child and their relationship with him/her. Therefore, the aim of the questions asked during the Reaction to diagnosis interview is to determine these parental representations, as well as the patterns characterizing these representations (Marvin, Pianta, 1996; Pianta et al., 1996). The way parents answer these questions portrays their representations of themselves as caregivers, of their child and of their relationship with the child with regard to the experienced trauma. These answers contain elements of resolution or lack of resolution. It is also worth mentioning that, although the interviews classified as resolved can have some elements of lack of resolution and vice versa, it is crucial to observe the dominant pattern in parental answers.

3. Indicators of resolution and lack of resolution

Indicators of resolution include parental acknowledgment of difficulties they experienced upon finding out about their child’s health issues, but also recognizing positive changes that occurred in their feelings towards that particular experience over time. Parents state that they had moved on in life, which includes coping with the condition and focusing on the present and the future. In spite of expressing hope for improvement, they accept their child’s current condition. Resolved parents recognize their child’s difficulties and their role as caregivers in a realistic and objec-

tive manner. Pianta and associates (Pianta et al., 1996) highlighted the specific elements present in parental narratives which are indicative of their resolved status towards the child's diagnosis:

1. *Recognition of change since the diagnosis.* Parents emphasize the emotional difficulties they experienced at the time of finding out the child's diagnosis, but point out that these feelings have changed so that they now experience a certain amount of relief. This means that a parent can still occasionally feel sadness or other painful emotions, but these are not as pronounced or as frequent as they used to be at the initial phase of getting to know and understand their child's condition.
2. *Assertion of moving on in life.* After a period of grief and crisis, the common daily routines and activities are reestablished. Parents declare having moved on with their lives and coped with the information that their child has a chronic medical condition. They manage to focus on the present and turn to the future.
3. *Suspending the search for a reason.* Although parents are interested in the cause for the child's condition, the active search for answers to that question stops. A parent consciously suspends looking for answers acknowledging that this draws attention away from the present reality.
4. *Accurate representation of the child's abilities.* Parental description of the child's abilities is in line with the observations made by professionals. A parent can have high but not unrealistic expectations. There can be some uncertainty concerning the future implications and the prognosis for the child's condition later in life.
5. *Balanced statements regarding benefits of the experience to the self.* Certain ambivalence towards the experience of raising a child with health issues is acknowledged. Parents can mention what they gained (e.g., “I have become a more patient and more accepting parent.”), but also state the difficulties caused by the child's condition. A parent is able to focus on the positive as well as on the negative aspects of the parenting experience.

Key elements pointing to the lack of resolution have also been determined and they are mainly associated with pronounced parental grief and sadness. With regard to this, parental attention is not primarily focused on the cognitive and emotional reality linked to the child's condition, but on distorting reality. Therefore, parents can neither recognize their child's psychological needs accurately nor bond with him/her. The most important indicators of unresolved parental status include the following:

1. *Cognitive distortions*. Parents exhibit unrealistic beliefs, denial and insisting on the desired reality (to have a “perfect child”, i.e. a child that is psychophysically healthy). Cognitive distortions can be viewed as a search for contradicting evidence with regard to the child's condition (e.g., looking for a confirmation that the diagnosis was wrong) and a belief that the illness would go away.
2. *Active search for reasons*. The process involves an active search for causes and reasons for the child's disability. Even when the parents are explicitly told that finding out the exact cause for the child's condition would not alter the prognosis, parental focus remains on searching for a cause. This draws the parents away from dealing with painful emotions, but also from connecting with their child on a psychological level.
3. *Stuck in the past*. Parental attention is focused on the past instead the present in several ways. One of them pertains to parental sadness remaining an ongoing emotional crisis which can intensify over time as the child gets older. Typically, when talking about past parents use the present tense, discussing it with sorrow and pain “as it was yesterday”. Parents can also be preoccupied with anger over the entire experience they have with their child. Finally, parental perception of themselves as parents can be such that their identity is defined through the trauma of their child's diagnosis, while simultaneously viewing themselves as helpless.
4. *Cut off from the experience of the diagnosis*. Insisting on not having any recollection of the emotions experienced at the time of diagnosis. They remember events and details accurately, but minimize their

own emotional response (e.g., “Finding out my child’s diagnosis has not upset me or had any importance for me.”).

5. *Confusion and mental disorganization.* Parents’ answers and incoherent and disoriented which makes their story and emotional experience hard to understand. This process involves losing one’s train of thought, experiencing difficulty in finding answers and contradicting oneself (e.g., parent gives extremely positive and extremely negative descriptions of a particular experience in the same sentence). This is an indicator of absence of organized mental strategies for dealing with the diagnosis.

4. Resolution and parental mental health

Studies that investigated the relationship between parental wellbeing and resolution have confirmed that parents with unresolved status reported poorer mental and physical health than parents with resolved status and that their health had deteriorated over the first year following the diagnosis (Lord, Ungerer, Wastell, 2008; Reed, Osborne, 2019). Unresolved parents reported suffering from higher parenting stress in comparison to resolved parents, as well as more social strain (Dolev et al., 2016; Krstić, Mihić, Mihić, 2015; Grogan et al., 2023). They also exhibited lower parenting morale, and lower sense of coherence (comprehensibility, manageability, and meaningfulness in life), than parents with resolved status (Goldberg, 2015; Sealy, McMahon, Sweller, 2023). A confirmation of the importance of resolution for parental wellbeing was also obtained from a study which found a more significant increase in parental efficiency in parents who managed to come to terms with their child’s diagnosis after an initial period of unresolved status (Poslawsky et al., 2014). It was also established that grief brought on by learning the child’s diagnosis, and the onset of depression in mothers can have a negative impact on maternal coping and achieving resolution (Kearney et al., 2011). Multiple studies have confirmed that parents who are unresolved towards their child’s diagnosis have higher levels of depression in comparison to those who are resolved (e.g. Dolev et al., 2016; Krstić, Mihić, Mihić, 2015). However, a small number of studies found no significant association between resolution and parents’ psychological distress or symptoms of depression (Popp

et al., 2014; Poslawsky et al., 2014) which implies that the link between resolution and mental health is a complex one and that several factors can pose a potential risk for parental resolution, and mental health in general. Also, the nature of this relationship is difficult to establish, i.e. whether parental wellbeing is a contributing factor or the outcome of resolution, and this is being widely debated in longitudinal studies (Yaari et al., 2017; Reed, Osborne, 2019). Nevertheless, a review of literature indicates that the majority of studies show resolved parental status to be significantly associated with better parental wellbeing overall (Sher Censor & Shahar-Lahav, 2022).

As to the family functioning, unresolved parents reported poorer marital relationships (Leblond et al., 2019). There are numerous risk factors in the family environment that hamper parental resolution including the accumulation of demands in childcare, which are due to his/her condition, that need fulfilling (Krstić, Mihić, Mihić, 2015). Studies examining general coping styles in the face of stressors found no significant links between coping and resolution, although the specific coping style of escape-avoidance was shown to be more prevalent in unresolved parents (Krstić, Mihić, Oros, 2017; Lord, Ungerer, Wastell, 2008).

Also, lower parental educational level was singled out as one of the risk factors for not achieving resolution (Krstić et al., 2016).

Even though in this paper we are primarily interested in parental mental health and resolution, the indisputable significance of parental state of mind for the child's wellbeing is also worth mentioning. Studies conducted on parents of children with different types of health conditions have shown lack of resolution to have negative effects on parental behavior and the parent-child relationship. Accordingly, unresolved mothers were found to be less sensitive towards their child compared to mothers with resolved status, and the children of parents with unresolved status were more likely to form insecure attachments than the children of parents whose were resolved (e.g., Di Renzo et al., 2020; Sher-Censor et al., 2017).

5. Support for parental resolution

Although parents are under significant strain and stress, the support aimed directly at them and their mental health is generally absent. The

support is primarily directed at the child while the parent receives it sporadically, only if they seek help on their own initiative from a therapist or psychiatrist for the emotional pressure they are under. This kind of attitude is mainly derived from the dominant medical model of illness which supports the patients' right to be cared for. However, since the parents are not direct patients, the gradual change towards the social model of illness would give a wider context and take into account the needs of all family members (Ivanović, Petrović, 2022; Milićević, 2019).

Since parental resolution of their child's diagnosis has proven to be significant for parental mental health and their relationship with the child, it is important to support the parents in the process of coming to terms with diagnosis upon learning that there are problems in the child's developmental or health status. Professionals working with children can be instrumental in facilitating the resolution process, with likely positive effects for both parents and children (Oppenheim et al., 2007).

As the family experience and the need for information change, professionals must be prepared to provide new information, as well as make it easier for parents to redefine their situation since this has proven to be a successful coping strategy. Understanding parental coping and steering them towards more adaptive coping strategies also has an effect on strengthening quality interaction between parents and counselors/therapists (Barak-Levy, Paryente, 2023; Krstić, Oros, 2012).

There are several ways of working with parents, and these can be carried out individually or in group sessions. Commonly, in the beginning phases of coming to terms with the diagnosis, individual meetings with parents are recommended. The support does not necessarily come from psychologists or therapist, but it can also come from other professionals treating the child, such as doctors, special education and rehabilitation professionals and therapists of various profiles. Clear information and guidance as to what they should do to encourage their child's development helps parents a great deal. They also find it very important that professionals show empathy towards them so that they would know they hadn't been left to fend for themselves. Help from institutions and support services has been particularly valuable to families whose child has a more serious form of illness or developmental delay (Krstić, Oros, 2012; Krstić, Mihić, Oros,

2017). Moreover, the help obtained from informal sources, from relatives, friends and other persons from their social surrounding can have great benefits for parents. Resolved parents maintain that they enjoy the support of their extended family (Leblond et al., 2019).

Taking into account all the difficulties parents are facing, professionals are increasingly aware of the need to create adequate, goal driven psychotherapeutic interventions. It is very important to recognize parental feelings and thoughts towards the child's condition so that the support could be directed at parents of children with chronic health conditions, especially unresolved parents (Krstić et al., 2013). Therefore, accepting parental grief and other painful emotions is an important aspect of psychotherapy and counseling. Parents need to be allowed to express their feelings and to be told that they are normal and expected. Support in the early stages of facing the information that their child has developmental difficulties or a serious chronic illness means a great deal to parents, particularly when they find it hard to adapt to this information. It is important to speak openly with parents during the initial period of adaptation, but also at all later stages. Some parents minimize the need for support and insist on not having negative experiences or unpleasant emotions regarding their child's condition. However, the minimizing attitude is not appropriate because it interferes with the parental ability to sensitively interpret and respond to their child's needs (Krstić et al., 2021; Steinberg, Pianta, 2006). Parents need to be encouraged to explore different emotions that they experience towards their child and allowed to express extreme or contradictory feelings since most parents often feel insecure or frustrated with regard to their child's condition or diagnosis. Parents can insist on asking how the diagnosis and the health complications would affect their child's future as well as that of the entire family, but the professionals can be unable to provide a clear answer especially at their child's young age. Therefore, it is important to understand parental insecurity. They need to be provided with professional support in order to overcome difficulties caused by the uncertainty of their child's future development and possible implications of the child's diagnosis (Krstić, Mihić, Branković, 2021; Krstić et al., 2017).

Apart from working in a one-to-one setting, support groups have also been very helpful. Parents can benefit from meeting with other parents

who have children with health conditions so that they would feel less isolated. Members of parental groups are an important source of information for each other and parents should be encouraged to share their resources with one another (Orme, 2005). Also, in a group parents validate the emotions felt by other parents, compare them to their own experience and benefit from learning useful coping strategies. This allows them to gradually accept the specific circumstances of their life. Although several authors have confirmed the importance this type of interventions would have on supporting parental resolution, so far only two programs of group interventions intended to support resolution have been developed. One of these programs was created and is being continuously applied in Serbia.

The program created by Barnett and associates (Barnett et al., 2003) titled “*Building New Dreams*” is an 8-session program that implements interventions promoting family well-being by focusing on parental emotional, cognitive and behavioral adaptation to their child’s condition. Authors of the program consider eight sessions to be enough to begin a process that would help parents move forward towards a healthier type of adaptation.

At the end of this paper, we will give a brief presentation of the program created and applied in Serbia. The name of the program is “*Our Story*”, and it is intended for parents of children with developmental difficulties or chronic health issues (Krstić, Mihić, Branković, 2021; Krstić et al., 2017). The main goal of the program is aimed at promoting and supporting resolution in order to provide quality care for the child and achieve a state of wellbeing for the entire family. The program “Our story” is a structured psycho-educational program. Psycho-education was chosen as the key method since it is an approach that includes both educational and counseling components. The educational component refers to the exchange of important information with regard to the aim of each session so as to provide the participants with a framework for their personal experiences. The counseling component refers to encouraging each participant to recognize the process they are going through, by means of exchange with other participants. The program is conducted in six thematic sessions, each lasting 90 minutes. It is recommended that the group includes 4-6 partici-

pants which allows plenty of interaction between parents. The sessions follow the parents' life story from getting ready for parenthood, through learning the diagnosis, up to the present moment. The accent is placed on promoting and supporting parental sensitivity and resolution. At the end of each session parents are given handouts in a form of a short essay written in a simple and understandable manner. Their aim is to reiterate key information and processes presented during a session to allow parents to recapitulate their own processes and maintain continuity till the next session. These are the sessions:

Session 1: *Parenting and the development of a care system: How I became a parent*

The session takes the parents back to the beginning of their parenting life story. Parents are instructed to think about how they prepared to be parents and the optimistic expectations they had built. Parents share their personal experiences with other parents and notice that the gradual development of the parenting role is in the function of preparing each parent to provide adequate care for their child.

Session 2: *How I became the parent of my child*

In this session the accent is placed on the fact that the parents are not mentally prepared for parenting a child with a serious health condition. Therefore, learning the diagnosis represents a specific experience for them, one that is often followed by painful emotions such as sadness. The spectrum and the intensity of parental emotions vary and the parents share their experiences with each other.

Session 3: *Travel through experience: How I understood and experienced caring for my child*

This session is aimed at recognizing and describing parental process of adaptation. Key elements of resolution are recognized, such as the development of constructive coping strategies. The main goal is for parents to identify strategies which can help them personally in the process of adaptation.

Session 4: *Change: When and how the change in understanding my role as a parent has occurred*

In this session the accent is placed on the desired change in parental emotions and way of thinking so as to facilitate adaptation and resolution. It is also intended that the parents recognize the effects of these changes on the quality of childcare, but also how the change they experienced has affected their own wellbeing.

Session 5: How I became the parent of my child

This session is aimed at parental sensitivity, as an ability to recognize and understand the child's needs and to react to them in a timely and adequate fashion. The importance of strengthening the support network and preserving parental mental health is also highlighted. This will decrease anxiety and the sense of loneliness, but also facilitate the provision of quality care for the child.

Session 6: Acceptance: How can I become a resolved and sensitive parent to my child

The final session is aimed at accentuating all key processes involved in the process of resolution by means of summarizing the participants' experiences. The attention is turned to rounding up each participant's life story with an emphasis on the present moment, i.e. focusing on the cognitive and emotional acceptance of the child's condition and parental wellbeing.

6. Conclusion

Learning that one's child has a significant medical condition or developmental delay can provoke a spectrum of intense negative emotions in parents. The emotional response of parents to their child's diagnosis has been widely debated by researchers and clinicians. Over time, researchers established the concept of resolution with the child's diagnosis as a process of acceptance and coming to terms with the child's health condition. Resolution implies the integration of parents' emotions and information regarding their child's condition within the parents' mental representations of themselves, their child and their relationship with their child. The resolution process of parents of children who receive a diagnosis of a chronic disease or developmental disability is profoundly important both for the parents and for the children. Studies have established strong associations between parental resolution and better outcomes for children with various

health conditions as well with parental well-being and family adaptation and functioning. Parents who have persistent unresolved feelings about their child's diagnosis experience considerably higher distress than parents who are more resolved about the diagnosis. The process of coming to terms and being resolved can be a long-term one because parents may need to readjust and come to resolution with each new challenge or new developmental stage of their child. Therefore, professional support offered to parents is not less important than the one provided to the child. It is imperative to raise awareness in professionals working with children with health conditions on the importance of resolution and on the role they can have in supporting parents in the often difficult and painful resolution process. Coming to terms with and being resolved towards the child's diagnosis should be targeted in prevention and intervention programs in order to facilitate healthy adaptation of parents and strengthen their abilities of coping with the stress within the family.

Funding

This research was supported by the Science Fund of the Republic of Serbia (#7744418, Genetic and environmental influences on psychological adaptation of children and adults - GENIUS)

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Danijela Štimac Grbić¹

PROMOTION OF THE RIGHTS OF PERSONS WITH MENTAL DISORDERS IN THE REPUBLIC OF CROATIA

Abstract: *Recognizing mental health as one of the public health priorities Croatia intensified the processes of adopting important political documents related to the improvement and protection of mental health. The goals of the Strategic Framework for the development of mental health until 2030 are: Improving the mental health of the entire population, reorganization and reorientation of the mental health care system, from the system that is mostly based on hospital care, in a system that provides most of its services in the community, in accordance with user needs. Reorientation of care implies the organization of mental health care to a greater extent on primary level of health care, greater availability of psychological support in primary care social communities such as: family, school, workplace and organizing mobiles psychiatric teams to provide all interventions, including: pharmacotherapy, psychotherapy and social therapy, in the community, that is, in the user's home with respecting human rights.*

Keywords: *mental health, human rights, recovery, empowerment*

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Introduction

Mental health is a basic human right of all people. Everyone, wherever and wherever they are, has the right to the highest possible standard of mental health. These include the right to protection from mental health risks, the right to available, affordable, acceptable and quality care, and the right to freedom, independence and inclusion in the community. Good mental health is essential to our overall health and well-being. Yet one in eight people globally live with mental health problems, which can affect their physical health, well-being, the way they relate to others and their livelihoods. Mental disorders also affect an increasing number of adolescents and young people.

A mental disorder should never be a reason for denying human rights or excluding a person from making decisions about their own health. However, people with mental disabilities continue to experience a wide range of human rights violations around the world. Many are excluded from community life and discriminated against, while many more do not have access to the mental health care they need or can only access care that violates their human rights.

According to Global Declaration on Achieving Equality for Mental Health in the 21st Century: Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. However, too often people with mental disorders and other mental health conditions are marginalized in society. This can be addressed by implementing strategies to progressively realize the rights of persons with mental disorders and other mental health conditions, particularly those who face a greater risk to their mental health and wellbeing, such as individuals belonging to underrepresented and marginalized groups.

Mental health cannot be separated from physical health. Treating the two as linked and equal is critical for progress towards Universal Health Coverage (UHC) as described in the Sustainable Development Goals (United Nations Sustainable Development Goal 3, Ensure healthy lives and promote wellbeing for all at all ages (2015).

Good mental health and wellbeing contributes positively to a person’s capacity to learn, work, grow, relate to other people and environments, adapt to change, and cope with the normal stresses of life.

People with mental disorders and other mental health conditions around the world may experience inequalities on multiple levels, many of which can be felt more sharply in low resource settings. Inequalities include material inequality (e.g. poverty, inadequate housing, income-inequality and under-employment), social inequality (e.g. stigma and discrimination in society and the workplace, criminalisation), and health inequality (e.g. prevalence of long-term physical health conditions). In addition, poverty and inequality among other social and economic factors, have been found to increase the risk of mental health conditions (Mental Health Foundation, Health Inequalities Manifesto (2018)).

Each person’s mental health is impacted by many factors, including social and environmental influences, in particular during early life. Chronic stress (poverty, familial mental illness and/or substance misuse) and experiences of trauma (violence, discrimination) can disrupt early brain development and future mental and physical health. Adverse childhood experiences can have a significant impact in later life.

Early detection, intervention, and care of mental health disorders and other mental health conditions promote mental health and wellbeing. This is particularly true when children are exposed to conflict and crisis.

Making progress on mental health requires countries to work together to support research and innovation. Additionally, partnering with people with lived experience of mental disorders and other mental health conditions, family members, healthcare providers, communities and others is integral to implementing best practices on a sustainable basis.

Stigma, prejudice and discrimination experienced by individuals with mental disorders and other mental health conditions cause harm and exclusion from society and the workplace. Practical policies such as anti-stigma campaigns may be implemented to tackle these biases.

It’s necessary for global community to take action to address the social determinants of mental health, in a cross-sectoral and holistic manner in order to reduce both health and mental health disparities so that the most marginalized and vulnerable individuals have an equal chance to lead

healthy lives, both physically and mentally. Also, it is important to support people with mental disorders and other mental health conditions to help lead change in mental health policy, service design and delivery, and to be meaningfully engaged in ensuring accountability.

The World Health Organization points out that well-integrated community mental health services are associated with better treatment outcomes refer to increased quality of life, better treatment collaboration, less stigma, housing stability, and work opportunities (World Health Assembly, 2013). To achieve the good quality of care and better outcome for mental health of persons with mental health difficulties, a multidisciplinary and multisectoral collaboration should be established to create a meaningful network of connected mental health, social, employment, NGOs and other services relate to mental health. It should include inpatient, outpatient as well as the housing options for persons with complex mental health needs.

Community mental health is the integrated approach to mental health that uses social resources to ensure that people with mental health problems have the right to accessible care and is supported in their own environment to work on their recovery. Community mental health requires a combination of complementary pharmacological, psychological, somatic and social interventions. This involves an approach within one's own context, and this requires the willingness to use successful interventions in a flexible manner to do justice to a specific situation and the availability of. Together with the user, where possible with their support group, a treatment plan is written from their own context resources.

Mental Health Care cannot do this alone and requires good cooperation with the client and his informal network, the municipality, the general practitioner, and other relevant stakeholders (Keet, et al. 2019). Various mental health services and interventions should be used according to patient's clinical condition and assessed social and psychological factors that contribute to mental health problems and are obstacle to recovery. That is why the information exchange and collaboration between various stakeholders should be established and maintained on continuing basis. Established networks between different mental health care services and relate

services provide the opportunity for patients to use services and interventions that fit his/ her needs in recovery. It is essential that the whole network of services share the vision of recovery.

Collaboration and coordination between different mental health departments with the aim to help recovery for each individual patient is a creative process to find out what and for whom works best. When needed continuity of care should be guaranteed. Acute hospital services and outpatient mobile team services as well as housing, employment services, programs implemented by NGOs must be linked and transparent. Mental health service users and all stakeholders must be informed about the existence of these services, the content of their work and methods of admission to those services. Mental health professionals have also an important role in linking service users with NGOs services in the community as well as with housing and employment services and other resources in community relevant to recovery of mental health. This requires an ongoing relationship with all stakeholders responsible for improvement of mental health from different, but complementary role.

Non-Governmental Organizations (NGOs) are non-profit organisations, or civil society organisations which play a key role as advocates, service providers, activists, and researchers on a range of issues pertaining to human and social development. For good functioning mental health system with expected recovery outcome cooperation between public and non-governmental organisations should take place on complementary basis and their role within the mental health care system should be transparent. NGO activities have included treatment, rehabilitation, community care, research, training and capacity building, awareness and lobbying. Service-oriented, non-profit mental health organisations often tend to rely on professional knowledge and are to a great extent organised similar to professional organisations.

Mutual exchange between users and professionals is recognised today in many NGOs where members rely on the professional skills, as well as in the mental health care systems, where interest in “experts by experience” is growing. NGOs often offer with a self- help group or other kind of service such as families and relatives support groups, homeless people or other groups provide different kind of workshops. Some of them

have activities in cooperation with the mental health system, aiming to represent the user-movement on director boards or committees, or to participate in staff training.

Mental health in Croatia

Mental disorders due to relatively high prevalence, frequent occurrence in young adulthood, possible chronic course, impairment of the quality of life of the patient and his environment and of a significant share in the use of health care are one of the public health priorities problems in the Republic of Croatia.

At the level of inpatient health care, a group of mental disorders and disorders behavior participates with a share of about 6% in the total number of hospitalizations in the Republic of Croatia. The largest number of hospitalized persons is between the ages of 20 and 59, which is this group disorders among the leading causes of hospital morbidity in the working age. In addition, every fourth or fifth day of hospital treatment is used for mental disorders, and they are in the leading group of hospital morbidity according to the use of days of hospital treatment.

Mental disorders caused by alcohol are the leading diagnostic category in causes hospitalization within the group of mental disorders in Croatia.

Current challenges

According to the analysis carried out by the Croatian Institute of Public Health, 80% of all hospitalized patients due to mental disorders, he undergoes hospital emergency admission, which shows that these diseases and the risks for their occurrence, are almost not recognized at the primary level of health care. There is insufficient diagnostic and therapeutic care at the primary level of health care. Different stakeholders and sectors are not connected and there is not enough intersectoral or interdisciplinary cooperation and stigma is very high. Analysis showed that for one person who is in the psychiatric care system, there are two who are not seen, i.e. they are not recognized by the health system.

Reform of the health care system in the Republic of Croatia

Recognizing mental health as one of the public health priorities in the period of the COVID-19 epidemic, Croatia intensified the processes of adopting important political documents related to the improvement and protection of mental health. Draft Strategic Framework for the development of mental health until 2030 was adopted in November 2022. The goals of the Strategic Framework are: Improving the mental health of the entire population, reorganization and reorientation of the mental health care system, from the system that is mostly based on hospital care, in a system that provides most of its services in the community, in accordance with user needs.

Reorientation of care implies the organization of mental health care to a greater extent on primary level of health care, greater availability of psychological support in primary care social communities such as: family, school, workplace and organizing mobiles psychiatric teams to provide all interventions, including: pharmacotherapy, psychotherapy and social therapy, in the community, that is, in the user's home.

Mental health care is intersectoral and multidisciplinary with user involvement and members of their families in active participation in the creation of mental health protection policy health and the creation and implementation of interventions. The principles of treatment of mental disorders are based on an individualized approach and respect human rights and a partnership with the user in order to fully recover. In order to care was adequately provided, it is necessary to introduce programs for the early detection of psychological risks disorders at the primary level of health care and to strengthen mental literacy the health of the entire population, especially those employed in education, the social system social welfare and justice.

In order to achieve all these goals of the Strategic Framework, several action plans are being developed for the protection of mental health: Action plan for mental health in the community, Action plan for mental health protection of children and young people, Action Plan for Dementia and Action Plan for improvement and promotion of mental health and prevention and treatment of mental disorders.

The Republic of Croatia also participates in numerous international activities aimed at improvement of mental health. The EU Joint Action project is being implemented from 2021 IMPLEMENTAL, in which HZJZ is a partner and leader of the work package WP2-Dissemination. IN 21 countries are participating in this joint EU action, and the goal of the project is to implement the best European practices in the organization of community mental health care systems and programs suicide prevention. The goals and activities of JA Implement are aligned with the goals Strategic framework for the development of mental health in the Republic of Croatia until 2030.

The Republic of Croatia has already started the process of implementing the system redirection program of mental health care to the care system in the community, by preparing the organization of the two mobile psychiatric teams for interventions in the patient's home, which will be organized by KB Sparrow. Activities to establish these mobile teams began in September 2023. According to Action Plan for the protection of mental health in the community, it is planned to organize 30 mobile teams on the territory of the Republic of Croatia.

Accordingly, amendments to the Law on Health Care were adopted, in which states that within the framework of psychiatric activity at the primary, secondary and tertiary levels health care can be organized by mobile teams and dispensers for protection of mental health in health centers in order to make care as accessible as possible.

In order to recognize the risk of psychological disorders and increase as early as possible mental health literacy of the entire population, and especially of professional associates teachers in schools, Croatian institute of Public Health (CIHI) launched a project within the framework of the national program Living Healthy “Help To” which educates employees in the education sector to be trained for carrying out interventions aimed at strengthening the social and emotional skills of children and young people and for early recognition of mental health risks. So far it is through this program educated more than 2000 employees in the education system.

Also, with the aim of early recognition of risks for mental health and early application adequate interventions for prevention and treatment, during the academic year 2022/23. screening of children's mental health

risks in primary and secondary schools in the framework began systematic examinations in school medicine clinics, and in cooperation with services for mental health of county public health institutes and other services and stakeholders in to the mental health care system.

An important part of the Strategic Framework for the Development of Mental Health until 2030 is dedicated to the protection of rights persons with mental disorders, reducing discrimination and destigmatization. For this purpose, CIHI in cooperation with Clinical hospital Vrapče and with the support of the WHO, it implements the WHO Quality Right program, which has for the goal is to raise the awareness of the general population and experts about the protection of the rights of people with mental disorders disturbances.

An important partner in the implementation of all activities of CIHI related to the protection of mental health are citizens' associations and SUMEZ (Croatian Association of Mental Health Associations). as an umbrella organization, and in accordance with WHO guidelines and all international documents, the representative of SUMEZ was also a member of the Commission for the development of the Strategic Framework of mental health until 2030 and is a member of the Commission for the creation of the Action Plan mental health care in the community (*Štimac Grbić D, 2023*).

A key role of recovery services is to support people to gain/regain their place in the communities where they live and take part in mainstream activities and opportunities along with everyone else. All provided interventions should empower people with mental health difficulties and their families to build resilience to stress, develop and sustain social support network, improve employment opportunities, and engage in community according to their choice and preferences.

Interventions involve social skill training in real life situations self-management, employment support, family interventions, coping with stigma and self- stigma may empower the person and facilitate the social inclusion. Access to a well-developed social network may have benefits for individuals over and above improving their subjective sense of 'belonging'. These networks may also facilitate access to economic, cultural and information resources, which then benefit the individual.

Socially inclusive and recovery-oriented services must have strong strategic relationships with the necessary range of social care agencies, for example housing, employment, or community networks. People generally do better in services that embrace social inclusion, with mental health professionals who are able to minimize the impact that illness has on social functioning and with opportunities for people to be included in key social roles, such as employment and personal and social relationships. Delivery of care that uses socially inclusive and recovery approaches, in line with service users’ preferences and choices, is likely to lead to better outcomes for service users and enable them to live the lives they want to lead.

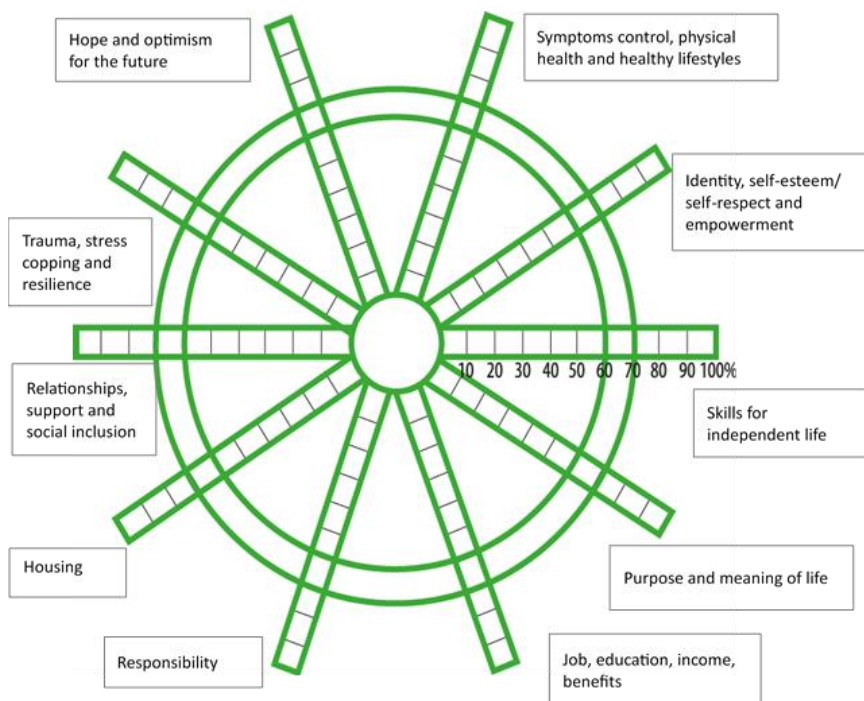
Helm of recovery in mental health is a tool that helps in determine the recovery goals and develop an individual treatment or recovery plan for people with mental health difficulties, as well as to select the interventions which can help to achieve the identified treatment/recovery goals. Helm of recovery is founded on holistic approach of understanding the protective and risk factors that influence mental health, principles of recovery defined by SAMHSA, assessment of functioning according to the WHO international classification of functioning and recommendations from WHO QualityRights. It includes three areas of recovery: recovery from the symptoms, recovery of functioning, and recovery of identity.

With the Helm of recovery, it is possible to evaluate the conditions in life areas that are important for recovery, to assess the areas that need improvements or changes, to choose priority areas for improvement, follow the advancement toward defined goals in different time periods, as well as evaluate the results and modify the goals. It can be used by experts in assessment of psycho-bio-social factors that contribute to development of mental health difficulties and in developing the treatment plan, and by people with mental health difficulties in developing the personal recovery plan.

All people that use the helm of recovery should be familiar with the principles of recovery. Recovery is not the same as medical term remission relate to full recovery from symptoms and functioning, but relate to the process of personal strengthening and managing one’s life in a way that enables the achievement of personal goals, living with the sense of purpose and experience of belonging to the community, whether the person

still has some of the symptoms of mental health difficulties or/and some of the difficulties in functioning. (Štrkalj Ivezić S, Radić K. 2023.)

Helm of recovery



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Conclusion

The path of recovery is a personal path, through which each person strengthens their strengths and personal capacities for health, and the task of the entire society is to provide resources in the community and build an inclusive and supportive society, through respect for the rights of each person. the mental health workforce at each level of the health care system needs to be developed and trained to ensure that all people have access to

good quality mental health services that promote recovery and respect for human rights (WHO,2023).

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SOCIAL RISKS AND SUPPORT IN ACHIEVING MENTAL HEALTH PROTECTION

Abstract: *The right to health protection is a universal human right, and the goal of its realization is equal and adequate access and continuous and high-quality health care. When it comes to mental health, which is an increasingly common topic in the public eye, practice faces numerous challenges such as the role of the local community/family, prevention, promotion, confidentiality of information, respect for the dignity and protection against discrimination.*

The focus of this Paper is on a special and pronounced challenge in Bosnia and Herzegovina related to the ability and willingness of individuals to recognize and seek support in the protection of mental health (their own and/or family members), but also on general information about service providers and support modalities, as well as risks of stigmatization. Solving the challenges implies a comprehensive approach and priority intervention, with a focus on the population that is already facing certain social risks and vulnerabilities.

Keywords: *Bosnia and Herzegovina, mental health, support, risks, vulnerable population.*

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*Everyone, whoever and wherever they are, has
a deserving and inherent right to the highest
attainable standard of mental health.*

World Health Organization

INTRODUCTION

Mental health care is at the top of the policy priorities of countries around the world. Mental health and its preservation is part of the overall protection of human health, and the theme is increasingly present in the public and everyday life. Although mental health policies are regulated at the state level, their implementation is realized at the local level, so it largely depends on local capacities and resources how preventive and promotional programs will be implemented and how health care services will be provided.

Mental health care policies in Bosnia and Herzegovina are aimed primarily at empowering individuals to seek support in mental health care, not only for themselves, but also for their family members. The activities of mental health centers, awareness building and empowerment in this context is a continuous direction, and special challenges are present in the field of mental health protection of vulnerable populations that are already exposed to certain social risks.

Social risks often occur together and affect a large number of people, which makes it even more difficult to provide support, which does not mean that maximum efforts should not be made to protect the overall health of all people. Also, mental health care does not only mean providing adequate services, but also protecting against stigmatization and discrimination.

1. MENTAL HEALTH

There are a large number of definitions of the concept of mental health, its scope and meaning in the narrower and broader sense. The leading organization dealing with mental health at the global level is the World Health Organization (WHO).

Mental health is defined as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in and it is crucial to personal, community and socio-economic development. Mental health is more than the absence of mental disorders. It exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes (World Health Organization, 2022).

Mental health is a basic human right for all people. Everyone, wherever and wherever they are, has a deserving and inherent right to the highest attainable standard of mental health which includes the right to available, accessible, acceptable and good quality care and the right to liberty, independence and inclusion in the community (World Health Organization, 2023). Also, mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well and contribute to their community. Mental health is determined by a complex interplay of individual, social and structural stresses and vulnerabilities (World Health Organization, 2022).

According to the Organisation for Economic Co-operation and Development (OECD), before the COVID-19 pandemic, at least 84 million people across the EU suffered from mental health disorders which means that it is more than one in six people in the EU (17.3%). A Eurobarometer survey conducted in June 2023 showed that almost one in two people (46% of the EU population) had emotional or psychosocial problems, such as feeling depressed or anxious, in the previous 12 months (European Parliamentary Research Service, 2023:3).

Bosnia and Herzegovina has 74 mental health centres with multi-disciplinary teams in communities, and some of them have additional specialists (European Commission, 2023:96). The Mental Health Project in Bosnia and Herzegovina pointed to the fact that in Bosnia and Herzegovina, the burden of mental health problems is significant, primarily due

to the still present psychological scars of war experiences, social deprivation and the difficult economic situation. In response to this problem, health authorities in the country have initiated a reform of the mental health care system, which focuses on decentralization of the system and the development of services at the level of primary health care, i.e. in the community. Today, there is a network of community mental health centers in the country which have multidisciplinary teams that provide services to their population. However, there are still some shortcomings in the system of providing services that need to be overcome in order to respond sustainably and effectively to the needs of people with mental health problems.

The mental health project in Bosnia and Herzegovina³, which has been implemented for many years, has contributed to improving the quality of services provided in the community for mental health, and the rate of referral of patients to hospital treatment has been reduced by 30%. More than 2,700 patients with severe mental health disorders are involved in coordinated care, there is a new approach to service delivery, and 69% of these patients recovered successfully and have a better quality of life. Over 2,500 people at risk of developing mental health problems are enrolled in prevention programs, while 463 people with mental health problems are included in social inclusion programs in their communities (Swiss Agency for Development and Cooperation, Western Balkans Division, 2021:2).

Some research show that mental health is an issue with relevance beyond the health portfolio, with implications for many domains of social policy and service delivery (Butterworth, 2003: 441). This topic certainly deserves a special space and dedication, and can be a direction of future research which would include researchers of different profiles and areas.

2. BOSNIA AND HERZEGOVINA- REALITY AND POSSIBILITIES

In the field of mental health care in Bosnia and Herzegovina there are numerous strategic documents and policies, but it is necessary to make additional efforts in the implementation of these solutions in practice.

³ Financed by Swiss Agency for Development and Cooperation (SDC) Cooperation with Eastern Europe, 2009-2023

There are currently 74 mental health centers operating in the country, implementing various long-term projects and networking with the support of international donors. Also, various trainings for professionals are organized in order to improve their capacities and provide adequate support not only to final beneficiaries but also to the professionals as direct service providers.

The analysis of the situation and needs for the implementation of promotional and preventive programs in mental health in Bosnia and Herzegovina showed that the most represented groups with whom mental health centers/hospitals/clinics work are people suffering from depression/anxiety and people suffering from psychosis. One of the important recommendations, recognized by the institutions, is the education of the general population, but also of health professionals about the importance and role of centers for mental health. In addition to emphasizing the importance of establishing cooperation with other institutions at the local community level, but also cooperation and exchange of experience among institutions dealing with mental health, the importance of continuous implementation of preventive activities is emphasized. Unlike other medical fields, mental health services rely most on human resources, significantly more than technological means. When it comes to treatment, communication skills and therapeutic relationship significantly affect whether beneficiaries will accept the recommended measures and interventions (Vučina and others, 2017: 23).

Figure 1 shows what mental health covers and what should be taken into account. First of all, promotion and prevention are essential, then respect for the dignity of the person in need, building and preserving trust. Next, it is important to take into account the responsibilities, the role of the family and the local environment, and the recognition of protective and risk factors. In this process, multisectoral cooperation and exchange of experiences at different levels (national and regional) are indispensable. Cooperation between different institutions is understood and related to the relationship between health institutions- centers for social work- schools- police- NGOs.

Mental Health

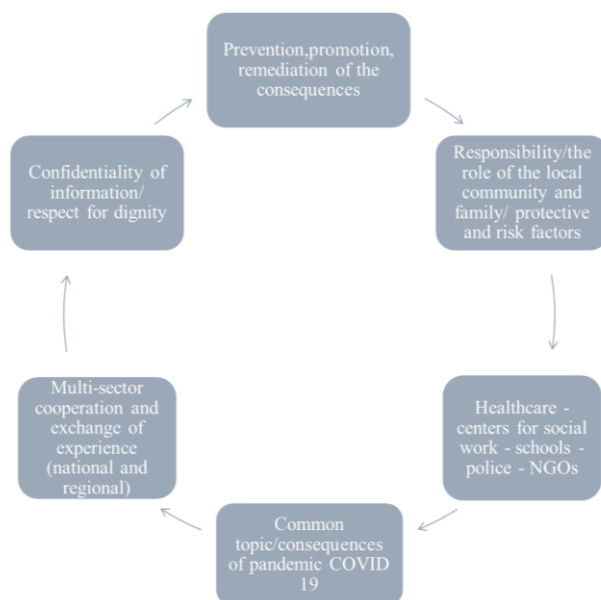


Figure 1

2.1 Legal framework

When looking at the situation in the field of mental health, it is important to identify relevant policies and strategies in the field of mental health.

The Law on Health Care of the Republic of Srpska⁴ defines health care as an organized and comprehensive activity of a society whose goal is to achieve the highest possible level of preservation and improvement of the health of citizens. Health care includes a set of social, individual and group measures, services and activities to preserve and improve the health of citizens, prevent and combat diseases and injuries, early detection of health disorders, timely diagnosis, timely and effective treatment, health and palliative care and rehabilitation of sick and injured citizens.

⁴ Official Gazette of the Republic of Srpska No. 57/22

According to the Law on Mental Health Protection of the Republic of Srpska⁵, mental health protection includes measures and activities in the promotion of mental health, prevention and early detection of mental health disorders and the implementation of medical interventions for mental health disorders, in accordance with modern achievements of medical science and practice. The promotion of mental health is achieved through:

1. raising awareness of the importance of mental health as a fundamental part of general health,
2. understanding mental health care and mental health disorders,
3. understanding risk factors that can lead to mental health disorders and reducing risk factors, and strengthening protective factors,
4. reducing stigma and discrimination relating to all forms of mental health disorders and other aspects of mental health;
5. strengthening multisectoral and intersectoral cooperation in order to implement campaigns to promote mental health in the social environment,
6. implementation of measures aimed at achieving a better quality of life, social functioning and well-being, and the inclusion of citizens and/or vulnerable groups in the family, work and social environment.

According to the Strategy for mental health development in the Republic of Srpska for the period 2020-2030 (Government of Republic of Srpska, 2020:18), the connection of social protection with mental health can be traced in two directions. A person who is in a state of social need is at a higher risk of having problems in mental health and vice versa, a person who has serious mental health disorders, almost as a rule comes into a state of social need. The entire community should continuously develop resources that improve and protect the mental health of the population and reduce risk factors for the development of disorders. The outcomes of promotional initiatives in mental health are usually not visible for the first few years after implementation, as it takes time to change attitudes and to establish new patterns of behaviour of citizens and the actions of institutions.

⁵ Official Gazette of the Republic of Srpska, No. 67/20

The vision of the Program for the Promotion of Mental Health of Citizens in the Republic of Srpska for the period from 2021 to 2023 (Government of Republic of Srpska, 2021:4) is the Republic of Srpska as a country in which respecting culture, fairness, social equality and personal dignity of all citizens of the Republic of Srpska, individual, social conditions have been created that enable optimal psychological development of each individual and in which its citizens enjoy emotional and social well-being as a result of improved mental health. The objectives of the Program are to strengthen multidisciplinary, multisectoral and intersectoral cooperation in the social environment, to raise awareness of citizens about the importance of mental health, to develop skills for improving mental health among citizens, to reduce the impact of stress on individuals and implement anti-stress programs, to improve mental health of pregnant women, newborns, parents and preschool children, to improve mental health of school children and adolescents, to improve mental health at workplace and to improve the mental health of the elderly.

The consequences of undetected and untreated mental health problems in the adolescent period extend to maturity, which threatens physical and mental health and limits the opportunities for young people to lead a fulfilling life as adults. The results of research in the field of working with children and adolescents in Bosnia and Herzegovina between the ages of 14 and 18 have shown that the most common symptoms in young people are anxiety, depression, self-harm, personality disorders, addictions, attention problems, as well as peer violence. In addition to the above mentioned problems, the problems of disconnection with adults at all levels were highlighted (Lakić, Rizvan, 2023:7, 22).

The Program for Early Growth and Development of Children in the Republic of Srpska for the period from 2022 to 2028 (Ministry of Health and Social Welfare of the Republic of Srpska, 2022:23) emphasizes that early childhood as well as the age of adolescence represent an important moment for the prevention of mental health problems, for the promotion of a healthy lifestyle, due to the fact that a large number of these problems, including behavioral disorders and abuse of addictive substances, begin precisely during this period.

The Law on Health Care of the Federation of Bosnia and Herzegovina⁶ defines health care as a system of social, group and individual measures, services and activities for the preservation and improvement of health, disease prevention, early detection of diseases, timely treatment, and health care and rehabilitation, as well as the application of health technologies.

According to the preliminary draft of the Law on Mental Health Protection of the Federation of Bosnia and Herzegovina (Federal Ministry of Health, 2023), citizens have the right to mental health protection through measures to promote mental health and prevention of mental disorders, diagnosis, treatment and psychosocial rehabilitation. It is stated that every person with mental disorders has the right to protect and improve their health. A person with mental disorders is entitled to the same treatment conditions as any other person who is provided with health care. A person with mental disorders must be treated humanely and with respect for the dignity of the human person. In accordance with the principle of mutual assistance and respect for family members, as well as mutual duties established by regulations, the family of a person with mental disorders takes care of that person, provides him with all the necessary assistance, protection and support during all stages in which the person needs help, especially during the process of treatment and psychosocial rehabilitation, and recovery and inclusion in the community.

In accordance with the Law on the Protection of Persons with Mental Disorders⁷, every person with mental disorders has the right to protection and improvement of his health. It is stated that a person with mental disorders is entitled to equal conditions of treatment as any other person who is provided with health care. Also, the freedoms and rights of a person with mental disorders may be restricted only by law if this is necessary to protect the health or safety of that or other persons. Persons with mental disorders must not be put in an unequal position due to their mental

⁶ “Official Gazette of the FBiH”, No. 46/2010 and 75/2013

⁷ “Official Gazette of the FBiH”, No. 37/01, 40/02, 52/11 and 14/13

disorders. Specific measures taken to protect rights or to ensure the improvement of the health of persons with mental disorders shall not be considered a form of unequal treatment.

In the Development Strategy of the Federation of Bosnia and Herzegovina 2021-2027 (Government of the Federation of Bosnia and Herzegovina, 2020), prosperous and inclusive social development is defined as development that strengthens trust in society, personal and economic security and dynamism, fairer distribution of income, better social and political cohesion (especially through the involvement of marginalized groups), better access to education, training and science, better opportunities for acquiring knowledge, skills and competences needed for the 21st century, and good mental and public health.

In recent years, various population analyses have been carried out more and more, covering the aspect of mental health. One of them showed a steady but slow decline has been observed in the proportion of the population with any mental health or substance use disorder, such as depression, anxiety, bipolar disorder, eating disorders, alcohol or drug use disorders and schizophrenia (UNFPA, SeConS, 2020:106)

The establishment of legislation and the systematic regulation of the mental health field is the basis for further steps to preserve it. The next question that arises is how we assess the adequacy of (mental) healthcare and what resources we have available. It is also necessary to think about the available programs to combat stigma and discrimination and whether and how we accept that we need help. Working to promote the importance of mental health implies continuous work to strengthen social awareness.

3. SUPPORT AND VULNERABLE POPULATION

In Bosnia and Herzegovina in 2022 there were more than 500 000 beneficiaries of social protection (Agency for statistics of Bosnia and Herzegovina, 2023). Numerous health, social and economic problems in the country have deepened, and new ones have appeared, to overcome them it is necessary to strengthen the existing ones and provide new resources. Consequences of the COVID-19 pandemic are visible, there is an increase in social problems, alienation of families, aging of the population, insecurity, uncertainty and loneliness as a characteristic of today's society.

Providing support implies the coverage of all levels - system level, family and individual level.

When it comes to vulnerable categories, an additional challenge is the prevention and suppression of stigmatization that can hinder an individual's desire to seek help. Considering how difficult it is for people to admit that they need help, this population is even more pronounced. A large number of programs are focused on prevention of human rights violations in mental health care and this topic is a topic per se, about which much could be written, and even more done in practice.

Mental Health Action plan 2013-2030 (World Health Organization, 2021:4) vision is a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally- appropriate health and social care in a timely way to promote recovery, in order to attain the highest possible level of health and participate fully in society and at work, free from stigmatization and discrimination. Its overall goal is to promote mental well-being, prevent mental disorders, provide care, enhance poverty, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

One of the most damaging effects of stigma is that it can interfere with an individual's desire to seek help. Stigma can even prevent children and young people from revealing their symptoms to those closest to them (UNICEF Croatia, 2023). With this in mind, it is unthinkable the number and degree of consequences that can occur from not seeking help, especially from young people.

Figure 2 shows possible directions of future action related to regional uniformity (cities and villages, developed in relation to underdeveloped municipalities), the need to create and implement priority interventions and activities in the direction of strengthening the general public awareness of the importance of preserving mental health. Also, it is necessary to familiarize the general public with protective mechanisms, and maintain continuity of information. Timely, professional and continuous support to individuals and their families is a must. When it comes to vul-

nerable categories, it is necessary to have adequate approach (in consultation with professionals) to the needs and specifics of the vulnerable (different vulnerable categories have different needs). In this direction, the engagement of representatives of various vulnerable categories could be demonstrated as a good practice. Public policies and practices should be directed on the population that is already facing certain social risks and vulnerabilities (associated social risks).

What next?

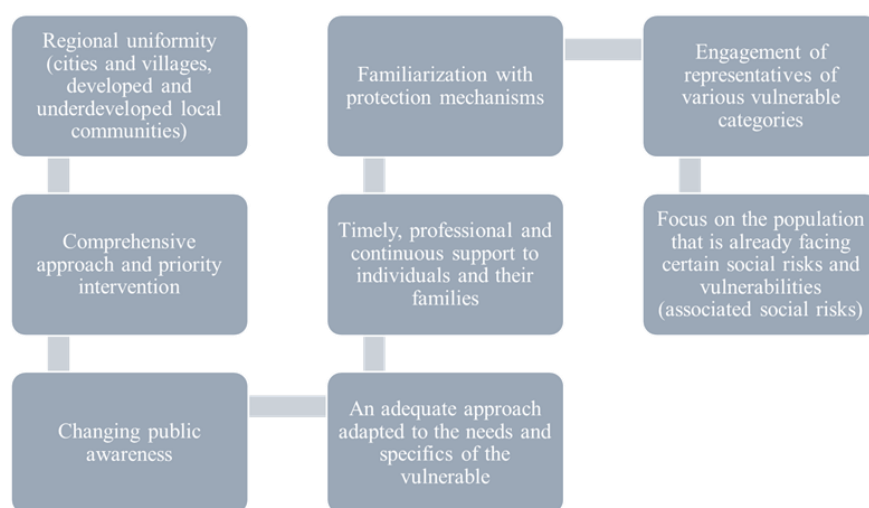


Figure 2

CONCLUSION

Mental health care is a priority. The consequences that can arise if enough time, planning and resources are not devoted to this issue are immeasurable for the whole society. We are witnessing many examples where lack of care for mental and overall health has led to poor outcomes. In addition to the official statistics, dark figures are in favor of the above,

which leads to the conclusion that it is necessary to act immediately, targeted, locally and long-term.

From the aspect of mental health, the question arises whether the existence of a right enable the enjoyment of that right (insufficient number and capacity of professionals, insufficient institutions, lack of information, stigma, low budgets...)? The answers to this question certainly vary from context to context, but from the perspective of Bosnia and Herzegovina can be a good starting point for planning adequate measures, public policies and different programs.

Certainly, one should use the momentum in which the topic of mental health has become common place in today's society and not forget about the consequences of the pandemic that are felt, but will also have long-term negative effects on the overall health of people.

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MENTAL HEALTH IN ADOLESCENCE: RELATIONS BETWEEN EMOTION REGULATION AND LIFE SATISFACTION

Abstract: *Previous studies of mental health among youth have indicated that emotional processes are very important indicators of subjective well-being, especially in the period of adolescence. Considering that adolescents face developmental and accidental crises, coping with stress through adequate regulation of emotions is a significant factor for a mentally healthy life in this period. The aim of this research was to examine the relationship between emotion regulation and life satisfaction in adolescents. The sample of 155 adolescents from Serbia filled out the emotion regulation questionnaire (ERQ) and the life satisfaction scale (SWLS). The results indicate that a higher degree of emotion suppression, as well as a lower degree of cognitive reappraisal of a stressful event, significantly compromises life satisfaction in adolescents. The mentioned mechanisms were discussed in the paper, and the need for greater access of young people to institutions for the protection of mental health was pointed out.*

Keywords: *adolescence, emotion regulation, life satisfaction, mental health.*

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1. Introduction

According to WHO³, up to 50% of all mental health conditions start before the age of 14, and up to 20% of adolescents experience a mental disorder each year, although it remains largely unrecognized and untreated. Adolescent mental health issues are predictive for a number of high-risk behaviors, such as self-harm, drug abuse, risky sexual behavior, violence, etc. These behaviors have long-lasting consequences that affect adolescents throughout their lives (Kessler et al., 2009; Patel et al., 2008). Bearing in mind that suicide is one of the main reasons for adolescent mortality, the topic of mental health seems very important to both - scientists and practitioners in the field of mental health intervention and promotion.

In Serbia, 10.8% of adolescents report having a “bad” mood, and 21.9% report feeling anxious at least once a week. According to UNICEF⁴, just 18% of adolescents in Serbia seek help from mental health professionals, and that 30% of adolescents are unsure of where to look for psychological support. In addition, various events that occurred in Serbia earlier in the past years, such as the lockdown during the COVID-19 (Nguyen et al., 2022), and the mass shooting at the Vladislav Ribnikar primary school (Pejuskovic, Lecic-Tosevski, 2023), had certainly compromised the mental health of Serbian adolescents. Still, there is no clear research results that can reliably indicate the prevalence of symptoms of compromised mental health after these events.

Adolescence is a sensitive developmental period which can be marked by different types of discomfort such as unpleasant emotions (e.g., anxiety) at home or at school (Crandon et al., 2022; Franić et al., 2010; Milovanović, 2020), or exposure to different types of peer violence (e.g., Busch et al., 2015; Dinić et al., 2016). Bearing in mind these research results, mentioned events in Serbia, the nature of prevention provided by health and other institutions, as well as contemporary expert tendencies to emphasize positive indicators of mental health (such as life satisfaction and functional emotion regulation), this topic deserves greater research and

³ <https://www.who.int/data/>

⁴ <https://www.unicef.org/serbia/en/mental-health-and-well-being>

public attention, but also greater attention of counselors who deal with the mental health of adolescents. The additional need arises from the lack of research on this topic specifically on the adolescent population in Serbia

2. Life Satisfaction and Emotion Regulation as Mental Health Indicators – Definitions and Relations

Increasing number of research suggest that positive indicators should be prioritized above the absence of psychopathological symptoms in defining mental health. According to Diener (1984), there are three components of subjective well-being: a high level of positive affect, a low level of negative affect, and life satisfaction. The majority of experts agree that life satisfaction is recognized as an essential element of mental health. Satisfaction with life is a cognitive aspect of subjective wellbeing that relates to an individual's assessment of the value of their own life path (Diener et al., 1999), and although it is partially genetic influences, it is also influenced by environmental circumstances (Sadiković et al., 2018). According to the findings of earlier research, having a high level of happiness and life satisfaction is highly and positive correlated with mental health (Lombardo et al., 2018; Marquez et al., 2023), especially in adolescence (Freire, Ferreira, 2020; Von Soest et al., 2020).

Adolescence is also considered a crucial developmental period for managing emotions, as indicated by the results of numerous studies (Schweizer et al., 2023; Silvers, 2022). Compared to adults and children, adolescents have higher levels of emotional fluctuation, bad mood, and heightened sensitivity to pleasant and fulfilling experiences (Riediger et al., 2011; Spear, 2011), and non-adaptive emotional regulation has been prospectively associated with poor mental health in adolescence (e.g., McLaughlin et al., 2011). Emotion regulation is a crucial component of emotional processes that mediates between many prerequisites for reporting feelings and the actual emotional reaction (Gross, John, 2003). This kind of regulation starts either from an externally triggered activating event or from an individual's evaluation of a mental representation, independent of the externally triggered event. Evaluation of the event or the mental representation further sets off a chain reaction of behavioral and physiological

symptoms that can be controlled prior to the actual expression of an emotion. Authors differentiate two fundamentally distinct forms of emotional regulation: emotional suppression and cognitive reappraisal (Gross, John, 2003). Emotional suppression is the process of controlling one's own emotional reaction to prevent its expression, whereas cognitive reappraisal is a process of reinterpreting a triggering event that modifies the emotional response in an appropriate way (Gross, 1988).

Numerous researches have examined the relationship between emotion regulation and life satisfaction on different levels – from genetic (e.g., Milovanović, Sadiković, Kodžopeljić, 2018) to phenotypic (e.g., Chervonsky, Hunt, 2019). The majority of these studies have found that life satisfaction has negative relationships with emotional suppression and positive relationships with cognitive reappraisal (Perrone-McGovern et al., 2015; Randal et al., 2014; Yiğit et al., 2014). Hu, Zhang, and Wang (2015) in their meta-analysis study support these results, although other research indicates that these effects may not exist (Liliana, Nicoleta, 2014). A number of study findings (e.g., Richards, Gross, 2000; Srivastava et al., 2009) suggest that emotional suppression is mostly dysfunctional type of emotion regulation strategies. Emotion suppression results in reduced memory function, a rise in insufficient physiological reaction, and a decline in the quality of interpersonal connections. Adolescents who often use emotional suppression are likely to experience poor mental health and reduced social functioning (Chervonsky, Hunt, 2019; Schäfer et al., 2017; Verzeletti et al., 2016). On the other hand, cognitive control was linked to higher cognitive reappraisal tendencies throughout adolescence (Lantrip et al., 2016) which frequently produces better mental health through stress reduction, adequate fear management, and higher general resilience (Kuhlman et al., 2021; Shapero et al., 2019; Willner et al., 2022).

3. Current Study

Recently, a lot of attention has been paid to adolescents and children in Serbia, mostly in the context of school mental health, but also their status in civil and criminal proceedings (Bačićanin, Hubić Nurković, 2022; Ćorić, 2019; Kostić, 2022; Obradović, 2019). Bearing in mind the recent events in Serbia, it seems that the mental health of adolescents is one of the

significant phenomena that deserves additional attention. If the dimension of the philosophical-legal discussion regarding the right to happiness (Ćorić, 2022) is included, this problem can be seen as multi-layered. From a psychological point of view, mental health should also be studied at the level of individual differences in some personal traits such as subjective well-being and emotional regulation, especially since scientific works dealing with adolescents in Serbia on this topic are very rare. If we add to all this the gender differences in the expression of emotions as well as the decreasing trend of satisfaction with life in adolescence (e.g., Gross, John, 2003; Rogier, Garofalo, Velotti, 2019), this topic is gaining importance both in the scientific and in the practical field.

The main aim of this research is to examine the relations between life satisfaction and two dimensions of emotion regulation in the sample of adolescents. We assume that cognitive reappraisal will positively, and emotional suppression negatively contribute to the level of life satisfaction in adolescence. Additionally, the relationships of the mentioned variables with the socio-demographic characteristics of the sample, such as gender and age, will also be examined.

4. Method

4.1 Sample and Procedure

The sample consisted of 155 adolescents (45% males) from Serbia. The average age of participants was 13.44 years ($SD = 1.65$). The examination took place through an online platform that was developed as part of the project activities. Adolescents received a link to their parents' e-mails with a unique code, after which they could access the platform and answer the questions from the questionnaire completely anonymously, after giving consent from their parents and themselves. The research was approved by the ethics committee of the author's institution (submission ID: 202010291658_SyRk). The GENIUS project activities were based on the previous cycle of projects (see Smederevac et al., 2019) in which authors had already made a significant contribution to understanding the mental health of young people. The research took place in the period 2021-2023.

4.2. Instruments

In the research, two instruments were used to measure certain indicators of the mental health of youth:

4.2.1. Satisfaction With Life Scale (SWLS: Diener et al., 1985). This one-dimensional rating scale consists of 5 items (e.g., 2. *Everything in my life is great.*), with 7-point Likert response type (from 1 - *not at all true for me* to 7 - *completely true for me*). We used 5-point form of SWLS in accordance to previous research with children and adolescents (e.g., Bendayan et al., 2013).

4.2.2 Emotion Regulation Questionnaire (ERQ: Gross, John, 2003). ERQ contains 10 items that measure two strategies: cognitive reappraisal - CR (6 items; e.g., *When I want to feel happier, I think about something different.*) and emotional suppression - ES (4 items; e.g., *I keep my feelings to myself.*) through seven-point Likert-type answering scale (from 1 - *strongly disagree* to 7 - *strongly agree*). We used 5-point form of ERQ in accordance to previous research with children and adolescents (e.g., Gong et al., 2021).

5. Results

Descriptive parameters are shown in Table 1. All variables are normally distributed, according to the Tabachnick and Fidell (2016) criteria: $-1.00 < Sk \text{ and } Ku < 1.00$. The reliability (α) of the used measures is also at a satisfactory level ($>.70$).

Table 1: Descriptive statistics for SWLS and ERQ

	<i>M</i>	<i>SD</i>	<i>Sk</i>	<i>Ku</i>	<i>α</i>
SWLS	20.14	4.24	-0.83	0.33	.87
Cognitive Reappraisal	21.54	4.60	-0.05	-0.26	.80
Emotional Suppression	10.87	3.91	-0.04	-0.62	.78

Note. *M* – mean; *SD* – standard deviation, *Sk* – skewnees; *Ku* – kutrosis; *α* – reliability.

Correlations between measures are low, but mostly significant. SWLS achieves a positive correlation with cognitive reappraisal ($r = .16, p$

<.05), and negative with emotional suppression ($r = -.25, p < .01$). Two ERQ measures are not significantly correlated ($r = .07, p = .34$). Age is positive correlated with emotional suppression ($r = .23, p < .01$), but negative with SWLS ($r = -.17, p < .05$), and cognitive reappraisal ($r = -.22, p < .01$). Gender differences are detected only on the dimension of emotional suppression in favor of males ($t = 3.09, p < .01$).

5.2. Regression analysis

By looking at the results of multiple regression analysis, it is concluded that the regression model is significant. ERQ dimensions explain 10% of the variance in life satisfaction among adolescents (Table 2).

Table 2: *Emotion regulation and satisfaction with life: Regression analysis*

$F = 8.24, p < .01, R = .31; R^2 = .10$	β	t	p
Cognitive Reappraisal	.19	2.40	.01
Emotional Suppression	-.27	-3.45	.00

Multiple regression analysis suggested that both ERQ dimensions are significant predictors of life satisfaction among adolescents. Cognitive reappraisal has positive, and emotional suppression negative contribution to life satisfaction in this developmental period. Thus, life satisfaction, as one measure of mental health, appears to be much higher among adolescents who are less likely to conceal emotions and who are more adept at reframing stressful events.

6. Discussion

The main aim of this research was to examine the contribution of emotion regulation to the life satisfaction level in Serbian adolescents. We assumed that in adolescence, emotional suppression will have a negative contribution on life satisfaction and cognitive reappraisal a favorable one. Furthermore, we also wanted to examine the associations between the aforementioned variables and the socio-demographic attributes of the sample (age and gender).

We got the result that male adolescents are more prone to suppress their emotions in comparison to female adolescents. The explanation of

this result could be fined in the proces of socialization. While male gender socialization would have caused males to suppress their emotions, women may have been taught to intentionally pay attention to their feelings (Gross and John, 1998). Indeed, most research suggest that male replace unpleasant emotion reactions with the expression of anger through violent and aggressive behavior (Gratz et al. 2009). Moreover, long-term suppression of emotions can therefore also lead to excessive situations, where anger is expressed uncontrollably and to the detriment of others (Rogier, Garofalo, Velotti, 2019). Therefore, it seems that psychological treatments aimed at emotion management are of key importance in the period of adolescence for boys. There is also a decreasing trend of life satisfaction and cognitive reappraisal, and a growing trend of emotional suppression with age. Adolescence is a sensitive developmental period which can be marked by different types of discomfort, and emotional variation, even on a daily basis (Larson, Lampman-Petratis, 1989; Reitsema et al., 2022). It is possible that over time, adolescents suppress emotional variations more often than reframing them, which over time reduces resources for dealing with stressful life circumstances and compromises life satisfaction. For these reasons, with the first physiological changes in adolescents, it is necessary to approach them with caution and counseling in the context of emotional reactions and coping with emotions, which is especially important for parents, teachers, and mental health practitioners.

Our hypothesis that cognitive reappraisal will positively contribute to the level of life satisfaction in adolescence was confirmed. Adolescents who more use the strategy of cognitive reappraisal when dealing with stressful circumstances, are also more satisfied with their life. Positive associations between the reappraisal strategy and measures of positive psychological functioning are very common in psychological literature (e.g., Gross, John, 2003). That research suggested that reappraisal strategy reduces every-day negative sentiments, and also raise positive sentiments and adaptive behaviors. Bearing in mind that the evaluation of one's own life implies an insight into everyday life, this finding is not surprising. Re-interpreting negative emotions and stressful events appears to significantly improve well-being, through improving intrapersonal and social functioning in adolescence (e.g., Balzarotti, John, Gross, 2010; Gross, John, 2003),

which essentially constitute the main domain of adolescent life. Our assumption about negative associations of suppression strategy with life satisfaction in adolescence were also confirmed. This result is also very common in previous studies (e.g., Gross, John, 2003), and it can be explained through the process model of emotion regulation (Gross, 2001). According to this model, the use of suppression strategy, which is a response-focused strategy, inhibits the emotional reaction instead of altering it. If it takes place on a daily basis, emotional suppression can significantly compromise daily functioning, and in the long term, mental health, as well as life satisfaction. That is why the adolescent period is very important in the context of mental health promotion, as well as primary and secondary prevention of behavioral disorders. Therefore, our research demonstrates that although emotional suppression has a more prominent and discriminating influence on wellbeing than cognitive reappraisal, which has more extensive repercussions, control through reappraisal strategy is more adaptive than emotional suppression strategy in terms of life satisfaction in adolescence.

6.1. Limitations, future directions and practical implications

This study has several limitations. First of all, it seems that a larger sample, which includes not only adolescents, but also children, would be more suitable for examining the relationship between emotional regulation and life satisfaction. This is primarily related to monitoring the socio-emotional development of an individual, which should be started in the earlier stages of development, and not exclusively in adolescence, although adolescence is an emotionally turbulent period. Therefore, a longitudinal study could more clearly provide conclusions about the specific development of emotional regulation and life satisfaction, but also data about specific influences, and not exclusively relationships, as is the case in this study. On the other hand, self-reports were used as the main source of assessment in this study. Given the socially desirable response, which is often a flaw in psychological research, it seems that in subsequent attempts, the mentioned constructs should be examined in an experimental way, or in a way of more objective assessment, e.g., by others or through some semi-standardized interview or checklist.

Finally, it is necessary to mention the practical implications of this study. This study primarily aims to indicate the trend of the relationship

between emotional regulation and life satisfaction in adolescents with typical development. In healthcare institutions, most of the attention is given to adolescents who have certain psychosocial difficulties and emotional problems. On this place, we are talking about secondary and tertiary prevention carried out by institutions responsible for the mental health of the population. Nevertheless, our study indicates that even in adolescents with typical development who do not have psychosocial difficulties, a relatively complicated situation of emotional management of turbulent changes occurs, which can significantly threaten the life satisfaction, especially in boys, which intensifies with age. Therefore, it seems that institutions that work with adolescents, primarily schools, must be equipped with significant human resources that can contribute to realizing the right of adolescents to functional emotional development in this period and mental health. The relatively worrying prevalence of various mental states among adolescents from the beginning of this paper, suggests that significant improvements are needed in psychological and pedagogical work with adolescents, above all transparent work of these services within school institutions and centers that could contribute to a higher percentage of adolescents who appear mental health worker in situations where there are certain emotional problems or dissatisfaction with the current life satisfaction. Additional investments in the development of human resources that would deal with the mental health of young people within the institutions, would contribute significantly to young people exercising their right to mental health in.

Funding

This research was supported by the Science Fund of the Republic of Serbia (#7744418, Genetic and environmental influences on psychological adaptation of children and adults – GENIUS).

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THE BASIC CHARACTERISTICS AND SIGNIFICANCE OF HEALTH INSURANCE IN THE REPUBLIC OF SERBIA

Abstract: *The need for health is one of the essential needs in the life of any individual. The right to protection of one's mental and physical health is a universal human right and a right that has been guaranteed by the Serbian Constitution. The health care system in Serbia, social care for the population's health, the general interest in health care and health insurance as well have been regulated by the Health Care Law and the Health Insurance Law. In our country, the health insurance system is basically compulsory, but the introduction of voluntary health insurance is also possible. In other countries, there are various forms of health care system organization, which differ from one other in the method of the collection of funds for health care, the inclusion of population in health care and health care rights. There is no health system that is regarded as accepted by all. In principle, Serbia applies the Bismarck health insurance model. The subject of this research is the basic characteristics of normative regulation and the importance of health insurance in our country. The paper includes research based on the study and analysis of theoretical sources and shall apply, in addition to the analytic and synthetic method, the method of deduction and induction in the analysis of general and specific issues.*

Keywords: *health care, compulsory health insurance, voluntary health insurance, the Bismarck model*

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1. Introduction

Health care is a delicate system of social policy and it deserves special attention. Apart from health institution activities, the health care system includes other sectors as well that make an active contribution to health improvement. In its broadest sense, “the health care system includes health insurance as well, which incorporates the social security of citizens. In the narrowest sense, the health care system implies measures aimed at combatting and preventing diseases and also at treatment and rehabilitation” (Ristić et al, 2016: 81). According to Jurković, “the health care system elements include health care capacities, medical staff, health care technology and health care procedures” (Jurković, 1986: 153). Art. 2 of the Health Care Law (Official Gazette RS, No. 25/19) defines health care as “an organized and comprehensive activity of society with a view to achieving the highest possible level of preservation of the health of citizens. Health care, in the sense of this Law, includes the implementation of measures and activities for the preservation and improvement of the health of citizens of the Republic of Serbia, the prevention, control, and early detection of diseases, injuries and other health disorders and timely and efficient treatment and rehabilitation”.

In addition to the medical, social and health protection aspect and the aspect of rights within health care and social security of citizens, health care has important economic implications, i.e. it has a positive impact on the economic development of a country. In the past fifty years, a global growth of health care cost has been perceived, which is a challenge faced by the national economies; also, the difficult economic situation exerts a considerable negative influence on the quality of the health system and health care in a country. In that context, the financial sustainability of the health system, with health services being available to as many citizens as possible is certainly a goal that every country is striving to achieve.

Janković emphasizes that the reasons for the exceptionally fast growth of health care costs in the past fifty years are definitely the “demographic changes (population ageing), the development of engineering and technologies, the increasing level of education among the population, the occurrence of new diseases and administrative costs. That said, the growth

of costs, in addition to health itself and health care, focuses on health insurance as one of the major social, economic and, consequently, political issues” (Janković, 2011: 70).

In the Republic of Serbia, the health insurance system has been regulated by the Health Insurance Law (Official Gazette RS, No. 25/19). We shall deal herein below in more detail with the basic characteristics and the importance of health insurance in the Republic of Serbia and also with other significant issues related to this field.

2. Basic characteristics, significance and forms of health insurance organization

The right to health care is a universal human right. In its documents from 1948, the World Health Organization “proclaimed that the need for health is one of the essential needs in the life of every individual. Therefore, most of the needs of the population for health care have been given the character of a right established by the constitution and by the law” (Ristić et al, 2016: 90).

Every country has to apply at least a minimal set of regulations pertaining to health care financing. This implies that “in every country, regardless of its social order, economic development, political setting, etc., the health care financing policy must be regulated with laws and by-laws and with adopted international documents, if any” (Sovilj, 2018: 145). Thus “no line shall be drawn under the limited financial funds required for health care, but, on the contrary – the method of payment and distribution of financial funds among various socio-economic groups, i.e. health care beneficiaries, is being regulated” (Totić, 2012: 43).

Health care financing is a very important issue, especially if one bears in mind the fact that health care costs have been considerably growing – even continuously so in the past several decades. As mentioned in the introduction, this is not an important social and economic question only, but also a political one – of interest both at the national and at the regional and international levels. According to Totić (2012: 45), “health care financing entails a sustainable and permanent process of securing the necessary funds from available resources at all the levels, regardless of

their possible respective exposure to various influences of political, economic, social and technical factors”.

The trends in health care costs as a percentage share in the gross national product (GNP) for ten countries, as selected by the OECD, have been provided in the table below.

Table 1. The trends in health care costs as a percentage share in the gross national product (GNP) for ten countries, as selected by the OECD

Country	1960	1970	1980	1990	2000	2007
Belgium	3.4	4.0	6.4	7.4	8.6	10.2
France	3.8	5.4	7.1	8.6	9.6	11.0
Germany	4.8	6.2	8.7	8.5	10.3	10.4
Greece	...	6.1	6.6	7.4	7.8	9.6
Hungary	...	...	...	7.1	6.9	7.4
Spain	1.5	3.6	5.4	6.7	7.2	8.5
Sweden	4.7	6.9	9.1	8.4	8.2	9.1
Switzerland	4.9	5.5	7.4	8.3	10.3	10.8
Italy	...	...	...	7.9	8.1	8.7
Poland	...	...	...	4.9	5.5	6.4

Source: Janković, 2011: 76-77

There are basically two models of health insurance organization. Those are: 1. the World Health Organization’s model and 2. the European and American model. Each of the models has its own classification, both of which shall be described in more detail hereinbelow.

The World Health Organization underlines classification “according to the method of financing, administration, deciding on rights and obligations, involvement of the population in care, solidarity and planning of the insurance field, into the following forms of health insurance: the Bismarck model, the Beveridge model, the Semashko (Socialist) model and

the market (entrepreneurial) model” (Janković, 11: 70). That said, it should be emphasized that there are no “pure” models and that, especially in recent years, the models have been assuming mutual characteristics. As a result of that, in many countries the dominant characteristics of, for example, two or even several models can be recognized.

The following table displays the characteristics of the aforesaid models of health insurance organization and financing.

Table 2. Characteristics of models of health insurance organization and financing according to the World Health Organization’s classification:

	Model	Characteristics
1	Bismarck model	The Bismarck model is a form of compulsory health insurance which provides universal coverage. It is financed from the contributions of employees and employers alike. The contributions are proportionate to the amount of income, i.e. have been specified in the form of an income percentage. This model is based on the principles of non-profit and solidarity among all the insured persons. The financing is conducted by several independent, mostly non-profit funds, agencies, hospital funds, etc. They are run by insured persons’ representatives, who conclude contracts with health care providers, thereby providing health care for their respective clients. The model is applied in Germany, Austria, France, Belgium, Luxemburg, The Netherlands, Switzerland, Slovenia, etc.
2	Beveridge model	The Beveridge model provides health care financing from taxes, i.e. from the state budget. It is based on solidarity and it provides universal coverage of the population through health care in state or private health institutions. Unlike the Bismarck model, the Beveridge model does not involve insured persons – it is the state that is in charge of health insurance. The model is applied, above all, in Great Britain, then in Ireland, Iceland, Finland, Norway, Sweden, etc.
3	Semashko (Socialist) model	The Semashko model applied in the Soviet Union and in other Socialist countries. In East European countries, there are still vestiges of the way of thinking among the population that it is the state that should provide high-quality and

		free health care for all. In this model, it is the state that is responsible for the organization and financing of health care of the entire population and any possibility of private health care is excluded. The Semashko model is similar to the Beveridge model and some believe that it is just a special variant of the Beveridge model.
4	Market (entrepreneurial) model	The market (entrepreneurial) model means that health insurance is organized and implemented by private organizations (insurance companies and agencies) on a profit basis. It is financed from the insured persons' private funds, most often from insurance premiums. It is not based on solidarity and it does not provide universal coverage. The best-known form of this model is the one applied in the USA.

Source: Čolaković, 2013: 26-27

The European model is applied in EU member-states. Health insurance is “based on compulsory (social) insurance, which is financed from contributions on the income of employees and employers and from taxes. The basic principles are solidarity and equality in access to health care services. This model provides a set of basic health care services for the entire population. Voluntary health insurance is a supplement to compulsory health insurance in various forms and scopes and it differs from country to country. The differences stem from the differences in the respective laws and regulations” (Janković, 11: 72).

There are “three basic forms of voluntary health insurance in EU member-states:

- Alternative – usually provided for members of the population who, due to high incomes, have been excluded from compulsory health insurance (The Netherlands) or to those who, due to high incomes, are able to choose whether they will continue using compulsory health insurance or opt for voluntary health insurance (Germany);
- Supplementary – supplementary and additional voluntary health insurance are open for the entire population and exist in every EU member-state;

- Additional - additional voluntary health insurance is more favourable for members of the population with a high professional status and high incomes” (Čolaković, 2013: 28-29).

Finally, the American model is present in the United States of America, “where the health insurance system is based on private health insurance. Health insurance is provided through private insurance companies, which operate on the basis of market principles. An insurance premium is the basis for health care financing. This model is a voluntary one and does not provide universal coverage” (Janković, 11: 74).

On the basis of the aforesaid, we may conclude that the Republic of Serbia basically “applies the Bismarck model of health insurance as over 90% of funds for the exercise of the compulsory health insurance right is provided from compulsory health insurance contribution funds. However, the law envisages health care financing from the Republic of Serbia’s budget for specific vulnerable groups (refugees and internally displaced persons, uninsured persons, unemployed persons, social aid beneficiaries, monks and nuns) who are not included in compulsory health insurance and who are more exposed to risk of disease. Thereby the health insurance system has incorporated certain elements of the Beveridge model” (Sovilj, 2018: 148).

3. Health insurance laws and regulations in Serbia

The main task of the health care system is “the constant promotion and improvement of people’s health care, including all the other factors which have an impact on health” (Jovanović et al, 2015: 76). According to data from 2018, the Republic of Serbia’s health care system occupies the 18th position in Europe” (Radivojević, Vesić, 2020: 153).

The health care system in Serbia is based on the “principle of universality and solidarity, i.e. it implies that citizens are guaranteed equal rights to health care. A number of citizens, on the basis of a decision from the Health Care Law, are entitled to health insurance financed by the country through tax and contributions, i.e. from the budget” (Jovanović et al,

2015: 78). The Republic of Serbia's health care system falls within the competence of three most important institutions, which are the Serbian Ministry of Health, the Serbian Institute for Public Health *Dr Milan Jovanović-Batut* and the Republic Health Insurance Fund (Mitrović, Gavrilović, 2013: 146).

According to the provisions of Art. 1§2 of the Health Insurance Law, “health insurance in the Republic of Serbia implies compulsory health insurance and voluntary health insurance”. Sovilj (2018: 147) comments on this by remarking that, “in the Republic of Serbia, the health insurance system is basically compulsory, but that the introduction of voluntary health insurance is also possible”. Art. 4 and 5 stipulate that “compulsory health insurance includes the following: insurance in case of an illness or injury out of work and insurance in case of an injury at work or a professional illness and that it has been organized on the following principles:

- The principle of being compulsory entails compulsory health insurance, which is provided through the payment of contributions to compulsory health insurance according to the law.
- The principle of solidarity and reciprocity entails a compulsory health insurance system in which the compulsory health insurance costs are borne by insured persons and other contribution payers through the payment of contributions to the realized incomes, whereas the compulsory health insurance rights are exercised by the insured persons who have fallen ill or who have experienced any other of the insured events.
- The principle of publicity entails that insured persons are entitled to all the information related to compulsory health insurance issues and to the publicity of work of the Republic Health Insurance Fund according to the law.
- The principle of protection of insured persons' rights and of public interest entails that, in the process of the exercise of compulsory health insurance rights, the Republic Health Insurance Fund shall enable insured persons to exercise and protect their rights as easily as possible and shall ensure that the exercise of their rights is not

detrimental to the rights of other persons or contrary to the public interest established by the law.

- The principle of continuous improvement of the quality of compulsory health insurance entails the monitoring of the latest achievements in the field of compulsory health insurance and the promotion of the compulsory health insurance system.
- The principle of economy and efficacy entails that the compulsory health insurance rights are exercised in their full scope, content and standard and with as few financial or other funds as possible”.

The compulsory health insurance beneficiaries may exercise “the following rights on the basis of compulsory health insurance: the right to health care, the right to a monetary allowance in the period of their provisional incapacity for work and the right to a compensation of costs of transport related to the use of health care. The aforesaid rights are exercised through the payment of contributions of insured persons and employers, through the contribution funds of the Republic Fund for Pension and Disability Insurance for pension beneficiaries, through the contribution funds of the National Employment Bureau for persons receiving a compensation and through the Republic of Serbia’s budget funds for persons regarded as insured persons according to the Insurance Law” (Kočović, Rakovac Antić, Rajić, 2013: 542).

Art. 11 of the aforesaid law defines compulsory health insurance beneficiaries, whereas Art. 49 defines compulsory health insurance rights, namely: the right to health care and the right to monetary allowances.

Art. 110 of the same law regulates the issue of the health care which is not provided in compulsory health insurance.

Art. 6 of the same law stipulates that “voluntary health insurance is, actually, a type of non-life insurance and that it represents the following:

- 1) insurance covering the health care costs which emerge when an insured person supplements their rights from compulsory health insurance in terms of content, scope and standard;

- 2) insurance covering the health care costs, namely the costs of health care services, medicines, medicaments, rehabilitation and monetary compensations which are not included in compulsory health insurance;
- 3) insurance of citizens who are not included in compulsory health insurance according to this law, i.e. who have not registered for compulsory health insurance”.

Art 7 stipulates that “compulsory health insurance is provided and implemented in the Republic Fund, whereas voluntary health insurance may be organized and implemented by the legal persons performing the insurance activity and also by the Republic Fund”.

Art. 170, § 1 stipulates that “voluntary health insurance, regardless of its type, is contracted for a period that may not be shorter than 12 months from the insurance start date”.

Art. 174 of the Health Insurance Law defines the following types of voluntary health insurance:

- 1) “supplementary health insurance—insurance that covers the health care costs emerging when an insured person supplements their rights from compulsory health insurance in terms of content, scope and standard;
- 2) additional health insurance- insurance covering participation in the health care costs, namely the costs of health care services, medicines, medicaments, rehabilitation and monetary compensations which are not included in compulsory health insurance rights;
- 3) private health insurance - insurance of persons who are not included in compulsory health insurance, for the purpose of coverage of costs for the type, content, scope and standard of the rights contracted with the insurer”.

According to the provisions of the same article, the insurance company or the Republic Fund may organize and implement any type of voluntary health insurance or a combination of voluntary health insurance types.

According to Gajić Stevanović and associates (2010: 397), “the Republic Health Insurance Fund was a dominant financier in the public sector of financiers in health care, with participation as high as 93% in

2006. Most of the funds were directed to hospitals and for medical services. In Serbia, allocation per capita amounted to 356 dollars in 2006. Years later, the situation has not changed significantly”.

The organization and implementation of voluntary health insurance, the conclusion of health care contracts, the control of the implementation of the concluded contracts and the payment of damages in compulsory health insurance, as well as health insurance organization have been each regulated separately, in respective chapters of the law.

4. Conclusion

In order that a health system should function successfully, it is necessary to fulfil several key conditions, which relate, above all, to adequate organization, direction, financing and an appropriate structure. One of the major parameters here is certainly a well-regulated management of health system growth and development, namely planning, organization, health concept implementation, development and an adequate allocation of resources, the enactment of appropriate decisions, etc.

An important issue in the health care system of a country is the financing of that system. As the paper shows, the health care system in Serbia is primarily based on the Bismarck model of financing, i.e. on the contributions paid by the employees and employers alike, on a solidarity basis. Thus, the citizens realizing an income have been bound by legal provisions to pay contributions to health insurance. Those citizens are employees, founders of companies, entrepreneurs, agricultural workers and retired persons.

The selection of a health system financing model in a country depends on several major parameters, such as the degree of the country's social and economic development, an efficient and well-organized economic capacity of a country (which includes efficiency in the raising of funds) and political support and will.

It is important to mention that, in addition to compulsory health insurance, there is also voluntary health insurance, which has been regulated by the law and which allows the citizens to decide on their own whether they will purchase health insurance.

Finally, the health care and health insurance system in Serbia faces the same challenges as that of other countries does, regardless of the degree of development. Some primary ones are the technical and technological innovations in the field of health care, which impose new tendencies and requirements in terms of equipment and readiness of health institutions, then the costs stemming from population ageing and also an ever increasingly demanding orientation in the selection of medical treatment on the part of the educated population, which has been continuously growing. These and all the other reasons that are compatible with the aforesaid certainly impose the need of reform of the health care and health insurance system in Serbia.

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Nenad Stefanović¹

LEGAL ASPECTS OF DAMAGE CAUSED BY MEDICAL ERROR

Abstract: *The subject of this paper is a presentation of the legal aspects of medical error and material and non-material damage that occurred as a result of a medical error. The aim of the research is to use analytical, comparative, and statistical scientific methods to determine the correlation and causation between medical errors and resulting damage, viewed through the prism of current legislation, both in the Republic of Serbia and in other countries that keep statistical records of the number of registered and proven medical errors. From a historical point of view, medical error has existed since the period of ancient Greece. However, the impression is that the issue of medical error is more relevant than ever. There are a large number of questions regarding this issue. Can a medical error affect the patient's (mental) health? Can immaterial damage also occur as a result of a medical error? Is there only the doctor's responsibility or is the medical institution also responsible? Can a medical error be caused by inaction? These are just some of the questions to which the author will try to provide answers regarding this extremely current topic.*

Keywords: *medical error, damage, obligation law, patient, responsibility of the medical institution.*

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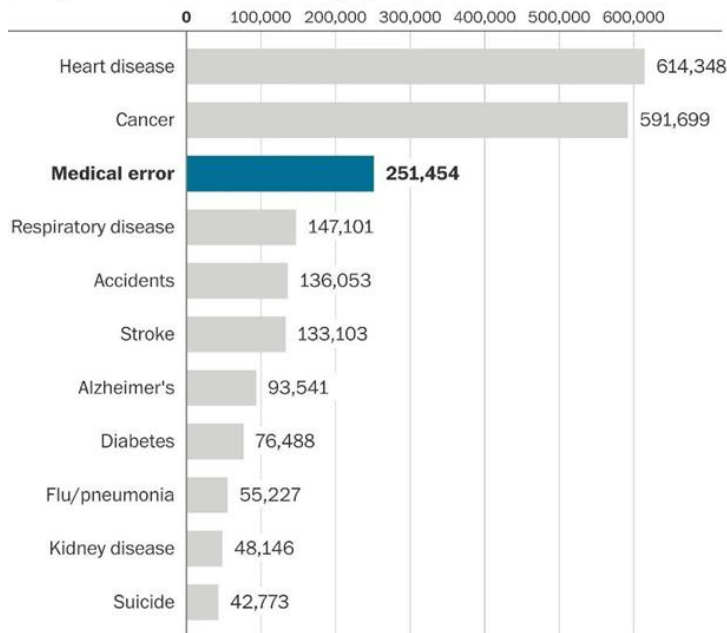
1. Introduction

We have witnessed the progress of medicine in all fields, from virology to gynecology cardiology. Mostly thanks to the development of these branches of medical science, the number of people on the planet which was one billion at the beginning of the 19th century, has now exceeded eight billion. (World Population: Past, Present, and Future) However, it turns out that the progress of medicine has its own negative consequences. One of them is the more frequent occurrence of medical errors when providing medical care help during medical interventions, as evidenced by the statistical data of the leading countries' accurate records. (Makary, et. al 2016: 1) There are no mortality records related to medical error in the Republic of Serbia. The only statistical source on mortality in Serbia can be found on the website of the Bureau of Statistics, however, this refers merely to the annual comparison of mortality rates, without specifying the causes that led to death. In some countries research on the causes of population mortality is conducted with the aim of prevention *pro futuro*. According to the study conducted at Johns Hopkins University, medical error is the third leading cause of death, after cardiovascular diseases and cancer. “Using hospital admission rates from 2013, the researchers extrapolated that based on a total of 35,416,020 hospitalizations, 251,454 deaths stemming from medical error. According to the CDC, in 2013, 611,105 people died of heart disease, 584,881 died of cancer and 149, 205 died of chronic respiratory disease - the top three causes of death in the U.S. The newly calculated figure for medical errors puts this cause of death behind cancer but ahead of respiratory disease.” (*Study Suggests Medical Errors Now Third Leading Cause of Death in the U.S.*)

Chart 1. *Medical errors are now the third leading cause of death in the United States*

Death in the United States

Johns Hopkins University researchers estimate that medical error is now the third leading cause of death. Here's a ranking by yearly deaths.



Source: National Center for Health Statistics, BMJ

THE WASHINGTON POST

Questions arise: what is the reason and why do errors in the provision of medical care and diagnostics occur more frequently? Do mistakes really happen more frequently in practice or is it just a result of better-held records? Do the media intentionally use sensational headlines to create a false image of the frequency of medical error? It is evident that since the 20th century, every individual has been more concerned about their health, which in parallel follows a better quality and way of life. However, “to modern medical practice, the threat of disputes for committed medical errors is a greater threat than that of shifting the boundaries between good and bad. Sometimes the disputes also arise against a doctor who acts in

accordance with the full vision of the Hippocratic Oath and renders assistance to someone who is not in such a financial situation to be able to afford the intervention, which leads to another absurdity.” (Ćorić, 2014: 311)

In medical and legal theory, there are numerous opinions and attitudes regarding the causes and reasons for increasingly frequent mistakes by doctors. Thus, Cvetković and Nikolić believe that: “With the development of medicine the risk of diseases decreases significantly, but at the same time the risk increases during the treatment. It is caused not only by professional mistakes of medics but also by medical procedures that are risky in themselves.” (Cvetković, Nikolić, 2014: 352) However, the causes can be sought in the approach, i.e. methodology. Namely, in the past, there were fewer doctors, but the doctor-patient relationship was different, more personalized. Doctors had more of a personal relationship with their patients, they knew the history of their family illness and had more time to devote to patients. “Thanks to modern medical devices, the diagnosis is made faster and more precisely treatment and rehabilitation are carried out more efficiently, successfully and safely. Mass use of the technique also affects the change in the relationship between doctor and patient in terms of its increasing depersonalization and turning it into a relationship between the device and the patient.” (Radišić, 2008: 205; Klarić, 2002: 68)

Medical error is not a new phenomenon in society. Sanctions for mistakes in surgical interventions can be found in one of the oldest codes – Hammurabi’s code, passed almost four millennia ago. For example, in Article 218 of the aforementioned Code, it is stipulated that: “If a doctor with a bronze knife inflicts a severe wound on someone and kills him or opens an eye and destroys him, that both his hands should be cut off.” (Simić, 2018: 72) The ancient Greeks were particularly concerned with this phenomenon, and Claudius Galen (Greek: Κλαύδιος Γαληνός) is considered the progenitor of medical error and its definitions. Therefore, we are talking about a phenomenon whose harmful consequences and causes have been noticed and studied since the ancient period, and the principle of *primum non nocere* ie. to do no harm first, becomes the primary standard in the medical profession and practice.

Chronologically, “in England, year 1374 was marked as the year in which the first case of a dispute against a surgeon who wrongly treated

a patient's injured hand (case: Stratton vs. Swanlond). The court concluded that the doctor is responsible in the event that the patient's health is harmed due to the doctor's negligence. However, if the doctor has performed his duty carefully and conscientiously, he will not be held responsible even if he failed to cure the patient.” (Palmer, 2001: 192) Over time, the practice spread to continental court practice, so that from the middle of the XVIII century, a new term was introduced into legal terminology - *malpractice*, in the sense of unconscionable and non-professional procedure, originating from the Latin words: *male* and *praxis*, which represented all forms of professional medical negligence.

2. Concept and types of medical error and damage in civil law

2.1. Concept and types of medical error

Medical malpractice is a current problem and not only a medical problem, but also a legal problem. Since its inception, medicine has been changing, developing and improving its methods by introducing more effective methods in diagnosis and therapy. However, despite the increasing expertise of doctors, medical errors have not lost their relevance, but the problem of defining medical error remained controversial and varied in the interpretation of both lawyers and in the understanding of doctors. Errors when providing medical advice assistance have been defined by researchers and scientific workers in different ways as: incidents, mistakes, carelessness, violations, harmful events that can be prevented, etc.

In an attempt to precisely define medical error, Simić emphasizes three controversial issues: “The main differences regarding the concept of medical error are reflected in the answers to three disputed questions: does the term medical error have to include the fault of the specific doctor or should it be understood regardless of fault; whether the concept of medical error is limited to non-observance of generally recognized rules as the rules of medical science or does it refer to the rules of the profession that have not yet gained general recognition, and finally, whether the concept of medical error also includes damage to the patient's life or health or is it independent of damage?” (Simić, 2018: 99) Depending on the answers to these questions, it is easier to more precisely define the concept of medical

error, that is, other terms and expressions used in the same context: professional error, medical malpractice, professional error, mistake in treatment and medical error.

“Professional medical malpractice” is a term that chronologically preceded the concept of medical malpractice. It was created in the ancient period, and derived from the Latin phrase: *lege artis*, as a doctor acting *contra legem artis* (contrary to the rules of the profession). The first definition of professional medical malpractice was created on those grounds, by the distinguished German doctor and politician Karl Wierhoff (Karl Virchow) at the end of the 19th century. According to him, the following is considered a professional medical error: “violation of the generally known rules of the art of treatment, due to the absence of the necessary care or caution.” (Virchow, 1879: 514.) Numerous objections have been raised to this definition, from the fact that it is not specialized enough and “that it does not differ in any way from other professional responsibilities” (Merz, 1980: 66), to of the opinion that the medical profession must not be dogmatic, tied to immutable rules, meaning the definition of professional medical malpractice together with its conceptual definition has several meanings, it is unclear, and therefore needs to be fundamentally redefined, which was done in the German legal system doctrine and judicial practice, so the term “professional medical malpractice” was replaced by a new term: “treatment error” (Behandlungsfeler). (Klarić, 2002: 73) When it comes to courts in Serbia, recent judicial practice under medical error means “every measure of the doctor, which is not in accordance with good medical practice, i.e. the current medical standard”. (Marković, 2021: 30) In the explanation of the judgment of the Court of Appeal in Belgrade it is written: “Submedical error means negligent treatment, dangerous neglect of professional duties, non-provision of health care, i.e. non-observance or ignorance of established rules and professional skills in the provision of health care, which lead to violations, deterioration, injury, loss or damage to the health or parts of the patient’s body.”²

² The judgment of the Appellate Court in Belgrade Gž. 6861/13 from 15.05.2014. and the verdict of the First Basic Court in Belgrade, P. 10786/10 dated 03.24.2013.

In legal theory, we come across different classifications of medical malpractice. One of them shares mistakes, taking as a criterion the damage that occurs as a result of the wrong action of the doctor. “These are medical errors, serious errors, minor errors and near misses. These were defined as follows: Medical error: The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Serious error: An error that causes permanent or transient injury but life threatening harm. Minor error: An error that causes harm that is neither permanent nor potentially life threatening. Near misses: An error that could have caused harm but did not either by chance or timely intervention.” (Bari et. al 2016: 523.) Determining the existence of a medical error is conditioned by the fulfillment of certain prerequisites that must be fulfilled cumulatively in that sense as well, the legal literature also mentions these conditions in detail: “In order to establish responsibility for delict committed by negligence during treatment, it is necessary to establish four elements: the standard of deserved care with which the doctor had to act in accordance to the specific case, violation of that standard during treatment, the causal connection between the doctor’s procedure and the harmful consequences that the patient experiences, and the fact that the suffered harm.” (Počuča et. al 2013: 212)

Based on everything presented, it could be agreed upon the definition of medical error in the legal literature as stated by Simić: “Medical error is any action taken by a doctor towards a patient that is not in accordance with the current medical standard or duty of care, which is useless for patient or could be harmful to his life or health. The error may consist of a certain action or inaction.” (Simić, 2018: 252)

If we take Schmitt’s definition of medical error as a reference, which “manifests itself in doing or in omission, in undertaking unindicated or not undertaking indicated medical captures; in wrong measures or in improper dispositions of the physician” (Schmidt, 1939:45), it is possible to observe different types of medical errors using different criteria. It is evident that errors cannot be the same in different forms of medicine. So, for example, the surgeon’s mistakes can not happen to a pediatrician due to the scope of work he performs. That is why the following occurs in practice classification of medical errors: 1) errors in diagnosing; 2) tactical mistakes; 3) technical errors; 4) mistakes in the organization; 5) mistakes in

keeping medical records; and 6) errors in the behavior of medical personnel in health institutions.

2.2. Concept and types of damage in civil law

Damage can come in many forms. Trivial ie. everyday meaning and the use of the word “damage” in the Serbian language is usually used as a term that should describe something inconvenience, e.g. “too bad I missed the train”. However, such a meaning is not the subject of this work. We are interested in damage from a legal point of view. Defining the concept of property damage does not pose as a great difficulty. In real theory, property damage appears in two forms: as simple damage and as lost profit. Ordinary, simple damage (*damnum emergens*) is defined as a reduction of the existing property, and the lost profit as not an increase in property that would under regular circumstances happen or could be expected (*lucrum cessans*). As opposed to property (material) damage which is easily determined, determining non-property (moral, non-material) damage is much more difficult. “Determining the concept of non-property damage is of primary importance, because without a proper understanding the concept of non-property damage cannot be properly determined by its legal nature, and without this it is impossible to find a correct solution of the basic issues that trigger the compensation of non-property damage in money.” (Stanković, 1998: 23) Some authors define non-property damage negatively as “every damage that does not affect the individual in his property and body” (Baudry-Lacantinerie, 1902: 599) i.e. “when monetary reparation is unable to be adequate to the damage, to be objectively assessed.” (Givord, 1938: 8) However, the negative definition of non-property damage suffers a lot of criticism and defining non-pecuniary damage as “damage that is not material” is not enough.

Non-material damage is related to the subjective feeling of pain and suffering, and it can be manifested through mental pain or mental suffering due to disfigurement or due to loss, i.e. disfigurement of a close person. Mental suffering can also be endured because of shame or deprivation of pleasure. That intimate suffering consists of fear, worry and restlessness. According to Stanojević: “All of them have in common that for us they mean a certain suffering, a certain pain, an unpleasant feeling and that as

such, they disrupt our emotional or psychological balance. As an instrument of rationality of the organization of social relations, the law cannot remain indifferent to something like this in an abnormal situation just as it does not remain indifferent to the balance in our property. The problem of compensation for non-property damage is precisely how to eliminate or alleviate the imbalance introduced into our psychological life by suffering some mental or physical pain, and the problem of monetary compensation for non-property damage is how to achieve this with money.” (Stanković, 1998: 26) Mental suffering can take different forms, nature and intensity, just as it is the case with physical pain. However, there are big differences between physical and mental pain, both in terms of the cause and the nature of the pain. Physical pains are the result of pathological changes in the body and organism, which are most often visible, which is not the case with psychological pain and suffering.

3. Current legislation on medical malpractice in the Republic of Serbia and rights to compensation for damages related to medical malpractice

Medical error in the current law of the Republic of Serbia is regulated under the term “professional error” in the Law on Health Care: “Professional error means negligence performance of health activities in the form of neglect of professional duties in providing health care, carelessness or omission, i.e. non-observance of established rules of the profession and professional skills in the provision of health care, which leads to injury, damage, deterioration of the patient’s health or loss of body parts. Liability for professional error is determined in disciplinary proceedings before the competent body of the chamber, in regular and extraordinary proceedings checking the quality of professional work, i.e. in other procedures established by law.” (Health Care Act of the Republic of Serbia, article 186, paragraph 1-2.) This legal definition of medical error is based on the provision of the Constitution of the Republic of Serbia which stipulates that: “Everyone has the right to protection of their physical and mental health” (Constitution of the Republic of Serbia, article 68), however, the legal definition is set quite broadly, and the legislator had not made an effort to regulate more precisely the civil law consequences of professional medical

error, so beside the broad definition, disciplinary responsibility is defined merely for the health workers. As a sanction for a mistake made in Article 185 of the same law, a punishment of temporary license revocation is defined (six months to five years): “Temporarily ex officio Chamber revokes the license of a healthcare worker if he becomes a professional in the performance of healthcare activities a mistake that impairs or worsens the patient’s health condition” (Ibid, article 185)

More specific provisions regarding compensation for medical errors are provided in Article 31 of the Serbian Law on Patients’ Rights: “A patient who, due to a professional medical error of a medical worker, i.e. healthcare associate, suffers damage in the provision of healthcare to his body, or professional error causes deterioration of his health condition, has the right to compensation for damage according to the general rules on liability for damage. The right to compensation for damage cannot be excluded or limited in advance.” (Law On Patients' Rights, article 31) This legal norm, when it comes to compensation for damage, refers to the general rules on liability for damage, which can be found in the Law on Obligations. However, that law does not contain the term professional or medical errors, neither as a general nor as a special concept, meaning the Law on Obligations contains only general rules on compensation for damage, therefore, only broadly defined, and not specifically related to medical error. Thus, Article 154 of the Law on Obligations stipulates that: “Whoever causes injury or loss to another shall be liable to redress it, unless he proves that the damage was caused without his fault.” (Law of Contract and Torts, article 154) This law also regulates attention of a good expert, which regulates professional conduct. By analogy, it can also be applied to errors i.e. duty of medical workers: “In carrying out his obligation, a party to obligation relations shall be bound to act with the care required in legal transactions of the kind of obligation relations involved (the care of a good businessman, or respectively the care of a good master of the house).” (Law of Contract and Torts, article 18)

4. Causal connection between the medical error and the damage caused

The causal link between the medical error and the resulting damage is a condition for the doctor's liability. In other words, if a doctor's error occurs, there will be no liability on his part if there was no damage. “The general attitude is that if a patient suffers damage during medical treatment, he has a right to compensation, which can be achieved both on the basis of contractual and tort liability.” (Mujović Zornić, et. al, 2012: 693) Without the resulting damage, there is no responsibility of the doctor for the mistake. The question of determining causation is the main question, because it provides an answer to the question: is the patient's bad condition the result of the natural outcome of the disease or the doctor's error and wrong treatment. However, the causes of illness and death are not always clear because every patient is different, so no one can be sure in determining what is the cause of the worsening of the disease in a specific case or the if a new disease appeared, why the body suffered damage or what led to the premature death. “It is difficult to prove that the damage suffered by the patient would not have occurred if the medical error had not been made.” (Radišić, 2008: 202) Nevertheless, despite all the problems in determining the causal link between the mistake and the damage, the court must determine that. It is his duty to accept or reject the existence of a causal relationship, but since he does not possess adequate medical knowledge and education, the court's assessment is based on medical opinion an expert.

According to Radišić, “Determining the causal relationship, in the proceedings before the court, takes place on the basis of the hypothetical question of what the outcome of the treatment would be if the doctor had acted as he should have. Then the patient must prove that the damage he suffered would not have occurred without the doctor's error.” (Radišić, 2010: 48) “On liability for damage caused by non-application of medical means, proving the causal link is very difficult, because it is about the damage that was caused by inaction, i.e. by missing a duty. The patient is asked to prove that by applying the necessary medical means, the damage would have been avoided or at least reduced, which in itself boils down to the

establishment of an assumed causal relationship, which, otherwise, can only be judged on the basis of indirect evidence, which leaves room for the health institution to prove that there is damage the consequence of some other cause, which is not related to the non-application of the medical product, or that it is not a typical consequence of the non-application of a medical device.” (Cvetković, Nikolić, 2014: 366) point of view, the answer to one of the disputed questions regarding medical malpractice is obtained, namely that although medical error refers to an active act, it can also be done passively, i.e. by doing nothing.

5. Disputed issues regarding damages and medical malpractice

It has been repeatedly emphasized that in relation to medical error and compensation for damage arising from the error, there are many questions to which it is not easy to give a precise answer. The first of those questions relates to the consequences of a medical error and the question: can a medical error affect mental health the patient? Taking into account the judicial practice and the cases before the courts, for damage due to errors when diagnosing the disease and informing the patient of the existence of the disease from which he is not suffering, it is easy to conclude that all these situations can negatively affect the mental the health of “patients”. The approach of the doctor to the person when communicating such bad news, by which a person is being informed that he is suffering from the most serious and incurable diseases, can leave permanent consequences on the psyche and mental state. However, when that announcement is the result of a misdiagnosis the negative effect is doubled, because after the stress of receiving such news, a person experiences renewed stress when he finds out that she is healthy after all, with constant doubt and questioning: “What if he is really sick and what is the real truth?”

The answer to the previous question regarding patients’ mental health provides an answer to the second disputed question: can immaterial damage also occur as a result of a medical error?

The problem of non-material damage due to medical error is not disputed. Non-material damage can and does occur as a result of medical error. It is disputed whether it is non-material damage arose, whether it

arose precisely because of a medical error and, if so, to what extent it is non-material damage. As judges do not have adequate knowledge and skills in the field of medicine, they are forced to they rely on the opinions of experts.

The third question regarding medical malpractice and damages resulting from it is: is there only the doctor's responsibility or is the medical institution also responsible for the resulting damage? Responsibility of health institutions exists when it comes to organization: “The biggest group consists of risks that originate from the area of coordination and organization of the treatment itself, such as hygiene standards and safety of support staff in hospitals. The security of that area is the only thing he is obliged to guarantee a doctor, that is, a health institution.” (Radišić, 2012: 17) “Responsibility of a health institution is always subjective and not objective in nature and is related to presumed guilt. Assumption of guilt is rebuttable, because the responsibility of the health institution can exist “only if it is proven that the harm to the patient was caused because the doctor and the medical staff of the medical institution did not act as they should (in accordance with the rules of medical science and with the appropriate attention)” (from the explanation of the judgment of the Supreme Court of Serbia, Rev. 1659/84). Therefore, “when it is established if the surgical intervention was necessary and performed according to all the rules of medical science, then the health organization in which the surgical intervention was performed is not obliged to pay compensation to the injured party for the damage he suffered as a result of the surgical intervention” (verdict of the Supreme Court of Serbia, Rev. 1832/85). However, the institution's responsibility can be objective for all damages caused to a dangerous thing.” (Počuča et. al 2013: 210)

A medical institution can be liable for damage caused by a breach of duty of care professional secrets, which is a duty that is imperatively prescribed for health workers in Article 54 of the Law on Health Care. “Health care institutions and private practices are obliged to protect the patient's medical documentation from unauthorized access, copying and misuse, regardless of the form in which the data from the medical records

are saved, in accordance with the law on patients' rights and the law regulating health documentation and records in the field of healthcare.” (Health Care Act of the Republic of Serbia, article 54, paragraph 3)

6. Conclusion

The relationship between the patient and the doctor has varied throughout history. In the beginning, doctors served each other medicinal herbs and using their knowledge in the field of botany helped the sick. Over time, with the acquisition of scientific knowledge and advances in medicine, doctors have become experts which patients blindly trust, and leave their lives and bodies to doctors to decide their fate. In the last couple of decades, the patient has also become the subject of medicine, so the relationship between the doctor and the patient evolves from a purely medical to a legal and ethical relationship, based on the code medical ethics and the Hippocratic Oath.

The responsibility of doctors for the wrong treatment of patients has always existed, but it has not been for a long time determined in detail due to the lack of adequate techniques for their determination. Over time improve medical techniques, introduce social insurance and liability insurance. Like as a result, lawsuits against doctors and health institutions often appeared in the middle of the 20th century. First in the USA, and then in some European countries, primarily Germany and France. Number of legal disputes due to medical error is not so large before the Serbian courts, however, on based on the inscriptions in the press and media, it is evident that the number of medical errors is much higher than number of lawsuits submitted to Serbian courts. What is the cause of this can only be assumed: is it in terms of patients' insufficient legal awareness, mistrust of the judiciary or perhaps fear of failure in litigation?

Considering that the judges do not have adequate knowledge of medical law, they were referred to the reports, opinions and expertise of medical experts, who very often answer questions about a possible medical error they provide vague, vague answers that are not specific. We see the solution in formation specialized court panels for disputes in the field of medical law, as well as in better education and specialization of judges and

lawyers. In this way, patients would have a truly equal position in lawsuits against doctors and health institutions.

The subjective responsibility of the doctor has no significance because it is both in tort and in contract law the present objective concept of inattention, i.e. there are standards by which (in)attention is valued. Civil liability of doctors exists only for errors that could have been avoided. That's where it lies problem, because the possibility of avoiding a specific error is appreciated from the point of view of “good medical practice”, a not from the point of view of the doctor who made the mistake in the specific case.

The main goal of determining the doctor's responsibility lies in prevention and striving to prevent future ones cases and repeating identical mistakes, because we must agree, the patient in the lawsuit against the doctor is the weaker side that is always on the side of the injured party, the victim, and not the other way around.

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ACCESS TO MENTAL HEALTH CARE IN ASSISTED REPRODUCTION: A LONG JOURNEY³

Abstract: *With the advent of in vitro fertilization and other assisted reproductive technologies (ART), the integration of mental health professionals in fertility clinics has become increasingly important. Over the past few decades, psychological interventions for women and couples undergoing assisted reproduction have been developed and evaluated. Recently, there has been a growing focus on treatment “dropout” and compliance in the field of ART. Despite recommendations from leading organizations such as the European Society of Human Reproduction and Embryology and the American Society for Reproductive Medicine, psychological counselling remains limited to and mandatory only for third-party reproduction in many countries. However, research clearly indicates the necessity of safeguarding the mental health of individuals before, during, and after any infertility treatment.*

Keywords: *mental health, psychological counselling, infertility, in vitro fertilization, assisted reproduction*

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³ The article is part of the project supported by the Science Fund of the Republic of Serbia, #1568, Identity Crisis in Women Facing Infertility: Mixed Methods Approach - InsideMe

1. Mental Health in Assisted Reproduction: Why it Matters

The background and significance of mental health in assisted reproduction lie at the intersection of reproductive medicine and psychology. Assisted reproduction technologies (ART) encompass a range of medical procedures designed to help individuals or couples who face difficulties conceiving naturally. The most common form of ART is in vitro fertilization (IVF), which involves fertilizing eggs with sperm in a laboratory setting and then transferring the resulting embryo(s) into the uterus. However, difficulties with conceiving are not exclusively of medical nature. Infertility, and reproductive health in general, have very pronounced psychosocial aspects, which have been recognized by the European Society of Human Reproduction and Embryology (ESHRE) since 1993, when the Special Interest Group Psychology and Counselling was founded. An article summarizing the proceedings of the first campus workshop of this Special Interest Group states that infertility is a biopsychosocial crisis, and infertility counselling is recommended as an integral part of a multidisciplinary approach to treatment (Van den Broeck et al. 2010; Opsenica Kostić & Mitrović, 2022).

The journey through assisted reproduction can be emotionally and psychologically challenging. A common metaphor used to describe this process is “emotional rollercoaster”. The analogy lies in repeated patterns of rising expectations and hopes during treatment followed by disappointment when a pregnancy does not occur (Alesi, 2005; Van den Broeck et al. 2010; Jestrović, 2023). The visual image of a rollercoaster also points out the feeling of not being able to get off, the feeling of not being in control (Van den Broeck et al. 2010; Mitrović et al., 2022). The significance of mental health in this context arises from several key factors, which we can single out on the basis of highly cited studies in the field of psychological effects of infertility (Cousineau, Domar, 2007; Frederiksen et al., 2014; Pasch et al., 2012; Peterson et al., 2006; Read et al., 2014; Rooney, Domar, 2018; Van den Broeck et al., 2010; Ying et al., 2016):

- Emotional impact of infertility: The diagnosis of infertility and the challenges associated with unsuccessful attempts to conceive can cause significant emotional distress. Individuals and couples may

experience feelings of sadness, grief, anxiety, and a sense of loss, which can impact their overall well-being.

- Stress of treatment: Undergoing fertility treatments like IVF can be physically and emotionally demanding. The medications, procedures, and uncertainties involved can add to the stress and anxiety experienced by those seeking to conceive through ART.
- Decision-making and coping: Infertility treatments often require individuals and couples to make complex decisions about the number of treatment cycles, the use of donor gametes or embryos, and the pursuit of other family-building options. The decision-making process can be overwhelming, and mental health support is crucial in helping patients-prospective parents navigate these choices.
- Relationship strain: The experience of infertility and fertility treatment can put strain on relationships. Couples may face communication challenges, differences in coping mechanisms, and changes in intimacy, which can all affect the emotional well-being of both partners.
- Psychological impact of success and failure: Success in achieving pregnancy through ART can bring immense joy, but it can also create new anxieties related to the pregnancy and parenting. Conversely, repeated treatment failures can lead to feelings of hopelessness and depression, requiring appropriate psychological support.
- Ethical considerations: Assisted reproduction also raises ethical dilemmas related to issues such as embryo selection, genetic testing, and third-party reproduction. Mental health professionals play a crucial role in helping individuals and couples navigate these ethical complexities.

Related to third-party reproduction, there is another increasingly relevant factor that reflects the importance of mental health:

- Postpartum mental health: Previous studies indicate that couples who have successfully conceived through ART using their own gametes do not have mental health problems during the transition

to parenthood (e.g. Repokari et al., 2005). The only thing that singles out these parents is somewhat more expressed emotional over-involvement, which can be observed during the early childhood period (Opsenica Kostić, 2017). However, the use of donated gametes/embryos or parenthood achieved through surrogate mothers can influence the postpartum period and may require tailored psychological support (Opsenica Kostić, 2023a).

Considering these factors, mental health support in assisted reproduction is not only beneficial but also essential. The overall well-being of individuals and couples going through fertility treatments can significantly impact treatment outcomes, adherence to protocols, and overall satisfaction with the process.

2. Historical Development of Psychological Interventions in Assisted Reproduction

How much progress has been made in understanding the relationship between mental health and infertility can best be seen throughout the evolution of infertility-specific theoretical frameworks (Hammer Burns, Covington, 2006; Mitrović, 2023). In the 1930s, the *psychogenic infertility model* (sometimes referred to as the *psychosomatic medicine approach*) was established. This approach, built on the basis of the Freudian psychoanalytic approach postulates that psychopathology plays an etiological role in infertility. This model was very popular during the 1950s and 1960s, particularly in the United States. It should be taken into account that these understandings originated and were persevered at a time when a significant number of infertility problems could not be accurately medically diagnosed or treated, and that today they primarily have historical significance. A significant shift was made when *psychological sequelae* or *psychological consequences theories* appeared during the late 1970s. Within this model, it is emphasized that the experience of infertility and treatment for it are emotionally difficult and all-encompassing, impacting all aspects of an individual and couple's life. Hence, infertility is the *consequence* and not the cause of involuntary childlessness –where the name of the model stems from. A

very important person of this period is Barbara Eck Menning, a representative of the nurse advocacy movement, who advocated for the availability of psychological support services within infertility treatments (Boivin, Gameiro, 2015; Menning, 1980). The psychological sequelae approach expanded the understanding of infertility, showing this phenomenon through the interrelationships of individual, couple, family, society and reproductive medicine. The model integrated different approaches into psychology and conceptualized infertility as a major life crisis involving stress and grief. Ultimately, all of this was important as a framework for the provision of counselling services. With the emergence of the psychological consequences model came the increased awareness of the importance of mental health, the first support organizations and psychological interventions. A significant achievement of this model is also legitimizing adjustment to infertility as a problem worthy of empirical study. The main criticism of the psychological sequelae approach is that it continues to apply a medical model to the complex psychosocial experience of infertility and that it does not include social and cultural factors that have an effect on the experience of infertility and treatment. Subsequently, several different approaches have been suggested to overcome these limitations - *psychological cyclical model*, the *psychological outcome approach*, and the *psychosocial context approach*.

A historical overview can also be provided (relatively) independently of theoretical frameworks of study, with the focus on the context and practical work of mental health professionals. In their article *Evolution of psychology and counseling in infertility*, prominent experts in the field, Jacky Boivin and Sofia Gameiro, outline five key paradigm shifts (Boivin, Gameiro, 2015). The first two paradigms that these authors single out overlap with the early theoretical frameworks that were previously discussed, but the following ones shed light from a new angle on the topic we are dealing with.

I Psychosomatic concepts and psychogenic infertility. This paradigm was present from the 1930s to the 1970s and, as previously mentioned, it arose in the historical context of a high rate of unexplained infertility, and emphasized the psychological causes of infertility.

II Nurse advocacy and the psychological sequelae model of infertility. This paradigm stood out in the 1970s and was created within the historical context of a high failure rate of available treatments and emphasized the psychological consequences of infertility. In this period, two processes of inestimable practical and theoretical importance were initiated. The first process is the emergence of support groups, which provided individuals and couples with space to share their experiences, emotions, and coping strategies. These groups played a significant role in reducing the isolation felt by many facing infertility and offered emotional support from others who could relate to their struggles. The second process was the initiation of a pioneering research of that time. As infertility-related distress became evident, researchers began to explore the psychological impact of infertility and the effects of fertility treatments on patients' mental health. Early studies focused on understanding the emotional experiences of individuals undergoing fertility treatments and the factors influencing their coping strategies.

III IVF and the integration of mental health professionals in fertility clinics. With the first successful IVF pregnancy in 1978, the era of new reproductive technologies began. (That first IVF was homologous; the first successful report of an IVF pregnancy achieved via donor oocytes appeared in 1984; Melnick, Rosenwaks, 2018; fertilization with donated sperm has a much longer history.) New fields and issues were opening up, such as pretreatment psychological assessment, challenges of third party reproduction, welfare of the child and monitoring of child outcomes. This paradigm/period lasted until the very end of the last century. It is not convenient to determine the exact moment, but somewhere in the 1990s, fertility clinics started recognizing the importance of addressing the psychological needs of patients. Mental health professionals, including psychologists, counsellors, and social workers, began to be integrated into fertility clinics and collaborative care teams. As infertility can strain relationships, couples counselling became a vital aspect of psychological support in assisted reproduction. Couples counselling focused on improving communication, reducing conflicts, and supporting partners in navigating the challenges of infertility as a team.

IV Evidence-based medicine and the quality of psychological support. With the integration of mental health professionals into fertility clinics, specific psychological interventions tailored to the needs of infertility patients were developed. These interventions included counselling, psychotherapy, and support groups aimed at addressing emotional distress, improving coping mechanisms, and enhancing overall well-being during fertility treatment. It is important to point out that at this moment that since the very beginning of the 21st century it has become possible to practice evidence-based medicine using the best research evidence as the basis of all clinical decision-making. This paradigm/period too opens up new questions, such as the development and evaluation of psychological interventions. In fact, in the late 20th century researchers already began investigating the impact of psychological interventions on fertility treatment outcomes. Studies examined how mental health support influenced treatment adherence, emotional well-being during treatment, and the overall success rates of fertility treatments. This paradigm/period includes, approximately, the first decade of the 21st century.

V Integrated approach to fertility care (Boivin, Gameiro, 2015), that is, **holistic approaches**, which started to appear in the second decade of the 21st century. Fertility clinics all over the world have increasingly embraced a holistic approach to care, recognizing that addressing patients’ emotional well-being is essential for optimizing overall fertility treatment outcomes and patient satisfaction. One of the chief factors that influenced the creation of this new direction is the data which show that a significant number of individuals/couples discontinue fertility treatment before completing the entire treatment protocol or achieving the desired outcome, such as a successful pregnancy or live birth – and that is the problem of premature treatment discontinuation (i.e., noncompliance). It can occur at any stage of the fertility treatment process, from initial consultations and diagnostic testing to medication protocols, cycle monitoring, or embryo transfer. Treatment “dropout” has significant implications for individuals, such as exacerbated emotional distress, disruption of family-building plans, and potential regret. In addition, the phenomenon of premature treatment discontinuation is significant for the implementation of fertility policy. For a country, such as the Republic of Serbia, which is facing a depopulation

trend, not only the availability of ART, but also compliance with treatments is of the utmost importance. Investing money in free treatments that will potentially be prematurely abandoned is not a good solution for either the state or the future parents. An adequate approach is to invest in supporting individuals and couples involved in ART. What is new in this holistic paradigm is the awareness that good mental health during treatment is not just a matter for the attention of specialized mental health practitioners but for the fertility staff as well. “Accordingly, it assumes that all fertility clinic staff with patient contact (e.g., embryologists, receptionists, nurses, doctors) needs to be involved in the provision of psychosocial care” (Boivin, Gameira, 2015, p. 256). In order to achieve this, it is necessary to educate staff, develop such treatment protocols that can reduce the burden of treatment yet maximizing the success and quality of life and overall patient-centred care approach in health. On the other hand, the need for educating the general population (including infertile couples) regarding reproductive health and fertility is also clearly visible. Levels of fertility knowledge and awareness and knowledge of how to seek help are related to decision-making during the ART treatment. Educational efforts of mental health professionals are actually preventive work in the field of infertility and are no less important than efforts invested in interventions.

As evidence supporting the benefits of psychological interventions in assisted reproduction accumulated, leading organizations in reproductive medicine, such as the European Society of Human Reproduction and Embryology (ESHRE) and the American Society for Reproductive Medicine (ASRM), released guidelines recommending the integration of mental health support in fertility clinics. We will refer to these recommendations in the next section.

In connection with the historical development of psychological interventions in assisted reproduction, one more significant moment should be added - **advancements in telehealth**. The COVID-19 pandemic accelerated the adoption of telehealth services in various healthcare fields, including reproductive medicine. Telehealth platforms provided convenient access to psychological support for patients undergoing fertility treatments, especially during periods of restricted in-person visits. This form of service provision remains extremely important even after the pandemic, because

in this way support is also available to people who live at a greater distance from fertility clinics and/or cannot make time for face-to-face meetings. Also, in cases of crossborder reproductive care, psychological support in native language through telehealth services can be valuable in overcoming language and cultural barriers and preventing negative experiences.

In conclusion, the historical development of psychological interventions in assisted reproduction reflects a growing recognition of the importance of addressing the emotional needs of infertility patients. From early support groups to the integration of mental health professionals in fertility clinics, the focus on emotional well-being has become an integral part of comprehensive fertility care. Today, in addition to emotional well-being, attention is particularly focused on compliance with treatment. The ongoing research and advancements in psychological interventions and their outcomes continue to shape the way mental health support is provided to individuals and couples facing the challenges of infertility and assisted reproductive technologies.

3. International Guidelines and Recommendations: ESHRE and ASRM

The European Society of Human Reproduction and Embryology (ESHRE) provided guidelines for counselling in infertility, although those recommendations were penned a little more than two decades ago. As it can be read on the ESHRE website⁴, the guidelines are the result of expert meetings in 1999. The Guidelines were intended for both medical and mental health professionals to help maintain good practice with regard to psychosocial care for infertile couples. The Guidelines have been accepted by the Executive Committee of the European Society of Human Reproduction and Embryology and the short version of the document has been published in the journal *Human Reproduction* (Boivin et al., 2001). It is interesting

⁴ <https://www.eshre.eu/Specialty-groups/Special-Interest-Groups/Psychology-Counselling/Archive/Guidelines.aspx>, (Accessed on 4 August, 2023). On the site you can also find a list of articles, according to the field, which are recommended reading of the Special Interest Group Psychology and Counselling <https://www.eshre.eu/Specialty-groups/Special-Interest-Groups/Psychology-Counselling/Recommended-reading> - there are also more recent studies (Accessed on 4 August, 2023).

that even such old guidelines mentioned telehealth, which was discussed a while ago, in a way that was possible at that time – preparatory written or videotaped information and telephone counselling (ESHRE Guidelines for counselling in infertility, p.117-120). Here we will convey only some basic ideas of the ESHRE document.

First of all, infertility consultation differs from any other symptom – or disease-oriented consultations in obstetrics and gynaecology. Four main reasons support this claim. First – the focus of the consultation is unfulfilled desire, unachieved life goal, which result in subjectively defined suffering. Second – a “not-yet-existing third person” (Boivin et al., p. 1301) must be involved in decision-making – a child. Particularly complex ethical issues can arise here in the cases of third party reproduction (Opsenica Kostić, 2023a; Opsenica Kostić et al., 2021). Third - infertility treatment can be a long-lasting process that creates specific emotional distress. Fourth – treatment can have a significant impact on the intimate life of patients and this must be taken into account when making (medical) decisions related to treatment. This leads to the conclusion – “Fertility clinics should therefore aim to address the psychosocial and emotional needs of their patients as well as their medical needs. This aim can be achieved by ensuring that psychosocial care is provided throughout the treatment experience.” (Boivin et al., p. 1302). Guidelines provide specific objectives which should be achieved in certain situations. For example:

- Infertility patients experiencing high distress. In this case, the goals of counselling are as follows: enabling the expression of emotions; identifying the cause(s) of distress; providing interventions to minimize distress and to acquire more adequate coping strategies; discussing individual high-risk factors for triggering high distress; help the individual/couple cope with repeated treatment failure.
- Pregnancy after infertility. The goal of counselling is to encourage the transition from infertility to pregnancy and incoming parenthood and to normalize feelings of disbelief and ambivalence.
- Facing the end of medical treatment. This is a particularly sensitive issue. The finding from the very beginning of this century is even

more relevant today: “With the diversity of medical treatment options available today, deciding to stop treatment can be more difficult than to continue it” (ESHRE Guidelines for counselling in infertility, p. 69). After every unsuccessful treatment, counselling should facilitate consideration of new perspectives and/or options for the future. This may mean pausing the treatment, intensifying the treatment, or considering other ways of starting a family. Special attention should be paid to differences between spouses regarding in/fertility plans. Also, the couple can decide to stop the treatment – in that case, the transition into involuntary childlessness begins (Opsenica Kostić, 2023b). In any case, patients should be encouraged to actively participate in the decision-making process.

- Cross-border reproductive care – patients in migration. This can be quite a complex issue, because medical practice, including counselling, should be adapted to patients’ sociocultural background.

These are just some guidelines. Particularly complex issues are related to third party reproduction and will not be discussed here. In general, the main goal of any infertility counselling “is to ensure that patients understand the implications of their choice of treatment, receive sufficient emotional support and can cope in a healthy way with the consequences of the infertility experience.” (Boivin et al., 2001, p.1304). In this way, a holistic approach to in/fertility care will be achieved, which will improve health outcomes, increase patient satisfaction with treatment and overall well-being, reduce negative psychosocial reaction, and also increase the satisfaction of the team working at the fertility clinic.

The American Society for Reproductive Medicine (ASRM) has a guidelines document with somewhat different content (ASRM, 2021⁵). The guidelines offered here were developed by the Mental Health Professional Group (MHPG) in partnership with the Practice Committee of ASRM and they refer to the qualifications and training of mental health

⁵ Available at https://www.asrm.org/globalassets/_asrm/practice-guidance/practice-guidelines/pdf/qualifications_for_infertility_counselors.pdf (Accessed on 5 August, 2023).

professionals working in reproductive medicine. In accordance with the current information about the different needs and situations in which infertile couples find themselves, a qualified fertility counsellor should be able to provide, or refer patients appropriately to the following services (ASRM, 2021, p.1411):

- Diagnosis and treatment of mental disorders
- Grief counselling
- Supportive counselling
- Crisis intervention
- Education/information counselling
- Decision-making counselling
- Third-party evaluation and implications counselling
- Psychometric test administration and interpretation
- Sexual counselling
- Support group counselling
- Psychotherapy
- Couples and family therapy
- Referral/resource counselling
- Reproductive endocrinology and infertility staff education and consultation

There is certainly no need to put the contents of the ASRM document here. What is interesting to mention, considering that being a fertility counsellor is a professional orientation that is yet in development in the Republic of Serbia, is the formal education that a counsellor can/should have. That includes a master's or doctoral degree from an accredited university in the fields of psychology, psychiatry, social work, psychiatric nursing, counselling, or marriage and family therapy. It is important that the curriculum and training include psychopathology, personality theory, life cycle and family development, family systems theory, bereavement and loss theory, crisis intervention, psychotherapeutic intervention, and individual, marital, and group therapy. Also, “It is mandatory that all fertility

counselors have and maintain a comprehensive knowledge of contemporary human reproductive technologies, the legislative frameworks within which these technologies are practiced, and the emotional and psychological experiences and needs of fertility patients and other invested parties.” (ASRM Guidance, p.1412). At the end of the document, as with the guidelines given by ESHRE, what is underlined is the global need for qualified mental health professionals to work side by side with medical personnel to provide care to fertility patients.

Other important documents, which contain recommendations for work in this field, Guidelines for professional standards of practice in infertility counselling, Australian and New Zealand Infertility Counsellors Association (ANZICA), Assisted human reproduction counselling practice guidelines, Canadian Fertility and Andrology Society Counselling Special Interest Group (CSIG) and How to become an infertility counsellor, British Infertility Counselling Association (BICA). All these guidelines can be found on the respective websites of associations.

4. Challenges in Accessing Mental Health Care for Infertility Patients

There are some barriers to mental health counselling in assisted reproduction - challenges and obstacles that may hinder individuals or couples from seeking or accessing psychological support during their fertility journey. These barriers can vary depending on personal, social, and systemic factors. The summary of some common barriers is as follows:

- Stigma and taboos: The topic of infertility and assisted reproduction may still carry societal stigma and taboos in some cultures or communities. This stigma can discourage individuals from seeking mental health counselling due to fear of judgment or misconceptions about counselling.
- Lack of awareness: Some individuals or couples may not be aware of the availability and benefits of mental health counselling in assisted reproduction. They may not realize that psychological support can help them cope with emotional challenges and improve their overall treatment experience.

- Limited resources: Access to mental health professionals with expertise in fertility counselling may be limited in certain regions or countries. There might be a shortage of trained professionals specializing in the psychosocial aspects of assisted reproduction.
- Financial constraints: Mental health counselling, especially when not covered by insurance, can be expensive. The cost of counselling sessions may be a barrier for some individuals or couples who are already facing financial strain due to fertility treatments.
- Misconceptions about counselling: Misconceptions about counselling or therapy, such as the idea that seeking counselling is a sign of weakness, can deter individuals from seeking support.
- Fear of emotional vulnerability: Some individuals may hesitate to open up emotionally to a counsellor, fearing that doing so could make them feel more vulnerable or expose deeper emotional pain.
- Time constraints: Fertility treatments often involve multiple appointments, monitoring, and procedures. Finding time for counselling sessions on top of the treatment schedule can be challenging for some patients.
- Lack of integrated care: In some fertility clinics, mental health counselling may not be seamlessly integrated into the overall treatment plan. This lack of coordination might make it less likely for patients to seek or be referred to counselling services.
- Language and cultural barriers: Language barriers or cultural differences may make it challenging for individuals from diverse backgrounds to access counselling services that align with their cultural values and language preferences.
- Previous negative experiences: Some individuals may have had negative experiences with mental health professionals in the past, leading them to avoid seeking counselling in their current fertility journey.
- Reluctance of partners: In couples undergoing fertility treatments, one partner's reluctance or disinterest in counselling may deter the other partner from pursuing counselling on their own.

Addressing these barriers requires a multi-faceted approach, including raising awareness about the benefits of mental health counselling in assisted reproduction, increasing accessibility to counselling services, reducing stigma, and providing integrated care that recognizes the importance of psychosocial support in the fertility treatment process. By addressing these barriers, individuals and couples can receive the emotional support they need to navigate the challenges of infertility and assisted reproduction more effectively. Individuals have legal rights to a free and dignified life, but these rights should also be supported (Ćorić, 2020, 2021, 2022).

5. Current State of Mental Health Services in Assisted Reproduction in Serbia

In the Republic of Serbia, in accordance with the necessary pronatal policy, in April 2017, the Law on Biomedically Assisted Fertilization (hereinafter the Law on BMAF, “Official Gazette of RS”, No. 40/2017) was adopted. This Law, as the name suggests, regulates the activity of BMAF, which “includes testing, obtaining, processing, freezing, unfreezing, preservation, storage and distribution of reproductive cells, zygotes and embryos, as well as the import and export of reproductive cells” (Article 13 of the Law on BMAF). An important step forward for assisted reproduction in Serbia and hope for many infertile couples is the permission to use donor reproductive cells “in cases when the treatment of infertility by other methods is not possible or has a significantly lower chance of success, including cases of threatened infertility as a result of the development or treatment of a disease” (Article 4 of the Law on BMAF; Opsenica Kostić, 2023a). Also, the use of “donated embryos” of “partners created in the procedure of homologous fertilization⁶, when the spouses, i.e. extra-marital partners from whom the embryos originate, do not want to use them for their own fertilization, with their express written consent” has been allowed (Article 29; the Law *does not* provide for the option of ‘creating’ embryos from donated cells). The implementation of this Law was awaited

⁶ Homologous fertilization means that the gametes of the partners, the intended parents, were used.

for a long time – until the very end of 2022. For the topic we are dealing with, it is significant that *the law, for the first time, foresees the participation of psychologists in the ART process*, but only within the framework of the Expert commission for the use of reproductive cells. The Article 26 states: “Before starting the procedure of BMAF with donated reproductive cells, i.e. embryos, a graduated psychologist referred to in Article 31, paragraph 3 of this Law, is obliged to inform the spouses, i.e. extramarital partners, i.e. the woman referred to in Article 25, paragraph 2 of this Law together, about the possible psychological consequences of BMAF procedures.” Previously, Article 26 also mentions “mandatory psychosocial counselling” in connection with the use of donated gametes, but the duration and the content are not specified. A psychologist should make a record of his work. At this moment, all this is without organized education. It is unjustifiably expected that psychologists have informed/educated themselves about, as the Law says, “psychological consequences of BMAF procedures”. It is not clear where and at whose expense, but this kind of education, for the time being, does not exist in the Republic of Serbia. In addition, if we look at the largest (state) clinical centres, the Gynaecology-obstetrics Clinic in Niš does not have its own psychologist, nor does it have a person with a permanent position at that clinic, unlike the clinics in Belgrade and Novi Sad.

In recent years, the Republic of Serbia has truly made great strides regarding the availability of assisted reproduction techniques to its citizens: an unlimited number of IVF procedures financed by the state for the first child, for women up to the age of 45, and enabling the use of donated gametes. However, the availability of medical care and treatment is not accompanied by the availability of psychological support in the area of in/fertility. As can be seen from this article, psychologists, mental health experts – fertility counsellors are equal members of modern teams dealing with infertility treatment. The services of such specialists should be available to all individuals/couples struggling with infertility, not only those who consider using donated gametes. Current state of mental health services in assisted reproduction in Serbia is such that psychological counselling is usu-

ally financed by individuals/couples with their own funds. This current situation is not in accordance with international guidelines and recommendations in this field.

Conclusion

From the 1930s until today, a long way has been covered in understanding the role and importance of mental health in the field of infertility and assisted reproduction. Caring for the mental health of patients/intended parents has been considered a necessary and inseparable part of infertility treatment since the very beginning of this century. However, there are many countries, including the Republic of Serbia, which still fail to implement the integration of mental health professionals into fertility clinics. Psychological counselling should be free and available to all infertile couples. Achieving pregnancy is the ultimate goal of the fertility journey, but maintaining mental health on that potentially long and exhausting journey is necessary in order to really say that success has been met.

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(UN)AVAILABILITY OF HEALTHCARE, WITH A SPECIAL FOCUS ON MENTAL HEALTH

Abstract: *In the paper, the authors deal with the legal framework for the protection of mental health rights, with a special focus on the non-availability of mental health care at the primary level of health care, the lack of representation of territorial mental health care, as a basis for discrimination based on place of residence. In this regard, the authors first of all point to the discrimination of persons with mental disorders, in exercising the right to health care in stationary health institutions, based on their health condition. In addition to this, the paper deals with the shortcomings of the current organization of mental health care in the Republic of Serbia, and the characteristics of the state of mental health and the organization of mental health care in other countries. In the final part of the work, the authors present their view on the improvement of human rights of persons with mental disorders, and the improvement of the normative and institutional framework of mental health protection, as well as possible directions for its further development.*

Keywords: *citizens' rights, patients' rights, discrimination, health care and mental health.*

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Introduction

The right to the highest attainable standard of health (hereinafter referred to as the “right to health”) is the right of every human being to enjoy the highest attainable standard of both physical and mental health. The right to health implies accessibility and quality of capacities, equipment and services in the best interest of the patient. In other words, the states under this right have the obligation to provide a sufficient number of health facilities, equipment and services and to be accessible to everyone, physically, materially and without discrimination. Health facilities, equipment and services must be in accordance with medical ethics, culturally acceptable, scientifically and medically appropriate and of high quality. The right to health refers not only to adequate and affordable health care, but also to basic health factors, such as safe drinking water, an adequate supply of healthy food and adequate housing conditions.

The International Covenant on Economic, Social and Cultural Rights and other relevant international legal documents state that the right to health is not limited to physical health, but also includes the right to the highest attainable standard of mental health. The Convention on the Rights of the Child and the International Convention on the Rights of Persons with Disabilities, for example, guarantee both aspects of the right and explicitly prohibit discrimination based on disability. States, even those with very limited resources, should adopt measures to protect the rights of psychiatric patients, such as: recognition, care and treatment of mental disorders in health personnel training programs, promotion of public campaigns against stigma and discrimination of persons with mental disorders.

1. Mental health throughout history

Mental health implies the ability to establish harmonious relationships with other people and the ability to realize one’s own intellectual and emotional potential in constructively changing social and physical environments, a subjective sense of well-being, self-efficacy, independence and competence. The concept of mental health is also defined as an opportunity for a person to express his individual duality, achieve the goals he

has set for himself, cope adequately with stress, work, enjoy the benefits of his work and contribute to the community (Vlajković, 1990).

In all cultures and the history of civilization, there were activities to preserve the mental health of the community and prevent mental illnesses, represented in customs and achievements that were reflected through the current order of society and religion. The first written historical sources from Mesopotamia talk about the role of priests in the care of the mentally ill, while doctors in this role are described in the Ayurvedic writings of ancient India.

Society's attitude towards mental disorders was influenced by the degree of development of scientific knowledge, but also by liberal achievements, unlike dogma, religion and superstition, and developed from magical and empirical concepts, cruel and uncivilized, through ancient Hippocrates' holistic perception of body and soul, Galen's medicine which accepts human Stoic ethics, up to the concept of psychosomatics of Franz Aleksander (1891-1966) (Milovanović, 2000). The development of scientific knowledge about the nature of mental disorders as well as the development of the general culture of society and free philosophical thought during the Renaissance led to the organization of shelters for the mentally ill in Braunschweig, Cologne, Uppsala and Florence, and then to the organized action of mental health protection two centuries ago, when is Pinel (Philippe Pinel, 1745-1826), by interpreting the Declaration on the Rights of Man and Citizen, as an achievement of the French Revolution, he removed the shackles from the mentally ill in the Bicetre and Salpetriere asylum in 1793, and his student Esquirol (Jean Dominique Esquirol 1782-1840) helped create the first Law on the Protection of the Mentally Ill. In the century behind us, the works of Freud (Sigmund Freud, 1856-1939) and Mayer (Adolf Mayer, 1866-1950), the progenitors of the development of psychiatry, lead a more open attitude towards mental illness in society, but on the contrary, the Euthanasia Law in Hitler's Germany during the Second World War II led to the deaths of over a quarter of a million mentally ill people across Europe (Milovanović, et al., 2009). In the middle of the last century, first in France and then in our country, the use of psychopharmaceuticals from the group of neuroleptics began, which completely changed the course of serious mental illnesses that had been treated with modest

success until then (World Health Organization. Strengthening mental health: re-resolution of the Executive Board of the WHO. Geneva: WHO; 2002. EB109.R8). This great scientific contribution of pharmacology and clinical psychiatry opens up a new field for the activity of mental hygiene, which, in addition to primary prevention, gets the task of contributing to more successful social rehabilitation and improving the quality of life of psychiatrically treated patients.

No social group or individual is immune to mental disorders, but the risk of mental health impairment is higher among the poor, unemployed and people with low educational status, as well as among victims of violence, migrants and refugees, children and adolescents, abused women and the elderly. Today, mental health problems permeate society as a whole, and improving mental health is a challenge of global development.

2. Development of mental health care at our environment

The medicine of the Byzantine era and the Middle Ages in the territory where the beginnings of our statehood appeared was under the influence of religious canonical and apocryphal Eastern Christian influence as a rich domestic experience and the secular European influence of Greece and Italy. The treatment of the mentally ill was done by folk healers, but also by the church as a state institution. In the Dečani monastery near Peć, frescoes can be seen depicting the healing of paralyzed and agitated mental patients through prayer. Saints Kuzman and Damian (Saints) apart from the spiritual dimension, were also involved in the free treatment of all sick people. The first organized hospital institutions, whose work clearly recognizes care for mental health, were created in the Hilandar monasteries, where Stefan Nemanja founded an asylum for the poor and infirm in 1198, and Studenica, where St. Sava founded the first asylum for the mentally ill in 1208, where later, the original medical records from Salerno and Montpellier were translated into Serbian. King Milutin founded a Serbian hospital and asylum in Constantinople near the monastery of Saint John the Baptist, and in 1308 a medical school. Emperor Dušan and later Prince Danilo in Montenegro fought against pagan customs of magic and sorcery in treatment with legal measures. (Vlajković, 1990).

The care of the mentally ill in Serbia came out of the church in 1861. When the Doctor's Tower building on Guberevac in Belgrade, by decree of prince Mihajlo Obrenović, became the Home for the Infirm (at the same time, the first state fund was formed for the purpose of caring for the mentally ill), and 20 years later on the initiative of Dr. Vladan Đorđevića, this institution grew into the Hospital for Mental Illnesses. Laza K. Lazarević (1851-1891) marks the end of the 19th century with the fruitful activity outside of the entire medicine in Serbia, which unfortunately ended too soon, who promoted mental hygiene with his personal ethical example and study of neuropsychiatric case studies as a doctor in Guberevac, but also with his valuable literary work.

In Belgrade, since the beginning of the 20th century, organized mental hygiene activities have gradually started. The public also notes the promotional forums of Dr. Jovan Danić, the first Serbian psychiatrist specialist, later the long-time manager of the Guberevac Hospital and the president of the Serbian Medical Association, who founded the Society for the Prevention of Alcoholism. The development of psychiatry at that time in Serbia was connected with the establishment of mental hospitals. In 1923, the Psychiatric Clinic was founded, the headquarters of which was in the premises of the Mental Hospital in Belgrade. It becomes a teaching base and represents the foundation of the future Neuropsychiatric Clinic in Belgrade, which over time becomes a nursery for staff to work in psychiatry throughout Serbia. The hospital for mental illnesses was founded in Kovin in 1924, and in Gornja Toponica near Nis, three years later. The creation of a new state of the Kingdom of Serbs, Croats and Slovenes necessitates new integration of medical experts, so in 1930 the All-Slavic Medical Congress was held in Split, where a report on the conclusions of the First World Congress for Mental Hygiene held in the same year was referenced. On that occasion, discussions were held on the future directions of development and activities of mental hygiene in Yugoslavia. Soon after that, in 1932, the Yugoslav Society for Mental Hygiene was founded in Belgrade. Grga Bogić is the author of the title: *The study of health*, one of the first publications dedicated to mental hygiene, published as part of the endowment of the Serbian Academy of Sciences in 1936. Before the beginning of the Second World War, a conflict of progressive social ideas from the

field of mental hygiene with the National Socialist right-wing and extreme left-wing communist movement emerged.

The post-war period in Yugoslavia brought new problems of caring for a large number of orphaned children who had developmental disabilities and the appearance of a specific post-traumatic conversion reaction of ex-combatants. As a leading institution for prevention and all types of treatment, the Institute for Mental Health was founded in 1963, and in parallel, Dispensaries for Mental Health with specialized services and counseling centers in Zagreb, Split, Maribor, Ljubljana, Sarajevo, Skopje and Niš. The Congress of Neuropsychiatrists of Yugoslavia held in Ohrid in 1964 initiated the creation of special sections of the Serbian Medical Society dedicated to psychotherapy, and later of the Union of Psychotherapy Societies of Yugoslavia, with which they established fruitful cooperation through the Yugoslav seminars held in Mokrice and then in Plitvice. That time, followed by the fruitful cooperation of our experts with the world, which brings us all the scientific news, represents the flowering of mental hygiene. Prof. Dr. Jovan Veljković accepted the current concept of mental hygiene during his specialist training in France and Switzerland and in 1962 published the first domestic book in that field: “Introduction to mental hygiene and social psychiatry”. Later, he founded and then taught this field for many years to students of medicine, special education and at the Higher Medical School in Belgrade (Backović, 2010).

3. The right to equality and freedom from discrimination in the context of mental health

The Constitution of the Republic of Serbia (“Official Gazette of the RS” no. 98/2006 and 115/2021) stipulates that everyone is equal before the Constitution and the law, that everyone has the right to equal legal protection and prohibits any discrimination, direct or indirect, by anyone, including mental or physical disability. The Law on the Prohibition of Discrimination (“Official Gazette of RS” no. 22/2009 and 52/2021) regulates the general prohibition of discrimination, forms and cases of discrimination and the procedure for protection against discrimination and prohibits discrimination on the basis of disability. The Law on Prevention of Discrimination of Persons with Disabilities (“Official Gazette of RS”

No. 33/2006 and 13/2016) regulates the general regime of prohibition of discrimination on the basis of disability, special cases of discrimination against persons with disabilities, the procedure for the protection of persons exposed to discrimination on the basis of disability, as well as measures taken to encourage equality and social inclusion of persons with disabilities. This law also prohibits harassment, victimization, solicitation, solicitation, and aiding and abetting discriminatory practices. Labor Law (“Official Gazette of RS”, no. 24/2005, 61/2005, 54/2009, 32/2013, 75/2014, 13/2017 - Decisions, 113/2017 and 95/2018 - authentic interpretation), Law on Vocational Rehabilitation and Employment of Persons with Disabilities (“Official Gazette of the RS” No. 36/2009, 32/2013 and 14/2022 - second law), Law on Health Care (“Official Gazette of the RS” No. 25/2019 and 92/2023 - authentic interpretation), Law on the Basics of the Education System (“Official Gazette of RS” no. 88/2017, 27/2018 - second law, 10/2019, 27/2018 - second law, 6/2020, 129/2021 and 92/2023), Law on Patients’ Rights (“Official Gazette of the RS” no. 45/2013 and 25/2019 - another law), Law on the Protection of Persons with Mental Disorders (“Official Gazette of the RS” no. 45/2013), Law on Movement with the help of a guide dog (“Official Gazette of RS” No. 29/2015), the Law on the Use of Sign Language (“Official Gazette of RS” No. 38/2015), the Law on the Rights of Users of Temporary Accommodation Services in Social Protection (“Official Gazette of the RS” No. 126/2021), Law on Planning and Construction (“Official Gazette of the RS” No. 72/2009, 81/2009 - corrected, 64/2010 - Decision of the US, 24/2011, 121/2012, 42/2013 - US Decision, 50/2013 - US Decision, 98/2013 - US Decision, 132/2014, 145/2014, 83/2018, 31/2019, 37/2019 - Other Law, 9/2020, 52/2021 and 62/2023), contains anti-discrimination provisions against persons with disabilities. The Family Law (“Official Gazette of RS” no. 18/2005, 72/2011 - second law and 6/2015) and the Law on non-litigation procedure (“Official Gazette of SRS”, no. 25/82 and 48/88 and “Official Gazette of RS”, No. 46/95 - other law, 18/2005 - other law, 85/2012, 45/2013 - other law, 55/2014, 6/2015, 106/2015 - other laws and 14/2022), which, among other things, regulate the deprivation of business capacity and whose reform and improvement are necessary, as well as many other legal regulations.

The right to equality and freedom from discrimination protects people with mental disabilities from various forms of stigma and discrimination. For example, people with mental disabilities often face discrimination in accessing basic health care services or stigmatization by health professionals, which can deter them from seeking help. The right to equality and freedom from discrimination prohibits the stigma that leads to the inappropriate institutionalization of persons with mental disabilities against their will. According to this right, decisions to isolate or separate persons with mental disorders, including unnecessary institutionalization, are fundamentally discriminatory and contrary to the right of these persons to integrate into the community, which is guaranteed to them by international standards. Isolation itself can deepen the stigma that exists around mental disabilities. Freedom from discrimination on the basis of disability is the essence of the International Convention on the Rights of Persons with Disabilities (Act on the Ratification of the Convention on the Rights of Persons with Disabilities, “Official Gazette of RS - International Treaties”, No. 42/2009) - without it, persons with disabilities are not in opportunities to enjoy all human rights and basic freedoms. Under Article 25, States Parties must “take all appropriate measures to enable persons with disabilities to have access to health services, taking into account gender, including health-related rehabilitation.” The contracting states should also guarantee that health workers “provide disabled persons with the same quality of treatment as others, on the basis of free and informed consent.” This, among other things, implies raising the level of awareness of human rights, dignity, autonomy and needs of persons with disabilities through noise and the adoption of ethical principles for state and private health care. “Other international and regional treaties, such as the International Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child (Law on the Ratification of the United Nations Convention on the Rights of the Child, “Official Journal of the SFRY - International Treaties”, No. 15/90 and “Official FRY Gazette - International Agreements”, no. 4/96 and 2/97), prohibit discrimination on the basis of disability. The International Covenant on Economic, Social and Cultural Rights (Law on the Ratification of the International Covenant on Economic, Social and

Cultural Rights “Sl. list SFRJ” No. 7/71) does not refer directly to disability as a prohibited ground for discrimination, but the Commission for Economic, social and cultural rights adopted documents that interpret the Convention as a prohibition of discrimination under that base. The Commission, in fact, defined discrimination on the basis of disability as “any distinction, exclusion, restriction, preference or denial of reasonable facilities to a person because of his disability, which has the effect of nullifying or jeopardizing the recognition, enjoyment or exercise of economic, social or cultural rights.” The Commission further emphasizes the need to “ensure that both the public and private health sectors adhere to the principle of non-discrimination against persons with disabilities.” The commission also criticizes governments for providing inadequate treatment to poor patients and requires states to subsidize expensive drugs needed by the chronically and mentally ill.

3.1. Initiating access to health care for persons with disabilities

Article 6 of the Law on Patients’ Rights establishes the right to access to health care, as the right to available health care of the highest possible level of quality, in accordance with the patient’s health condition, without discrimination in relation to financial capabilities, place of residence, type of illness, time of access health service or in relation to some other difference that can be a cause of discrimination.

Health care for people with disabilities is at a very low level when it comes to accessibility, which directly affects the low quality. Therefore, less than half, i.e. 41% of health care institutions have the ability to provide health care to people with disabilities. This attitude is also confirmed by the fact that only 37% of health institutions have a ramp at the main entrance, while 83% of health institutions do not have a ramp for people with disabilities at the side entrances. An important fact is that a large percentage, i.e. 79%, of health institutions do not have adapted entrance doors for people with disabilities. Only 21% of the total number of monitored health institutions in primary health care have entrance doors adapted to people with disabilities. Of the 43% of health care facilities located in multi-story buildings, 33% do not have an elevator. Based on the above data, it can be concluded that only 10% of observed health institutions have an elevator, and the question arises as to how health care is provided to people with

disabilities. The results of the website research show that none of the observed health centers have an option for audio reading of the text to blind and partially sighted people. On the other hand, only 3% of health centers on their website have an option to adjust the text in terms of increasing/decreasing the text, gray scale and negative contrast (State of primary health care in Serbia, November 2020 (https://www.pravni-skener.org/pdf/sr/Stanje_primarne_zdarstvvene_zastite_u_Srbiji.pdf)).

According to domestic regulations, citizens can exercise their right to mental health care in primary health care institutions (health centers, clinics), unfortunately this is a dry letter on paper, because due to the abolition of the organizational units of health care centers, and the lack of professional staff, the stated right to mental health care is unachievable. The only way in which citizens can exercise the aforementioned right is in tertiary health institutions (Institutes, Centers, Institutes, Clinics...). On the basis of which it can undoubtedly be determined that citizens are denied the right to access to health care or the right to mental health protection by place of residence, which is unconstitutional, because it does not guarantee all citizens the guaranteed constitutional right to equal protection of rights.

Also, based on the above, we must point out that the term “de-institutionalization” is one of the most frequently used terms in the transformation of psychiatric care in developed countries, because it describes the process that all developed countries have gone through in recent decades. Although at its core it has the idea of reducing capacity and gradually closing hospitals, this process cannot be reduced to just that. De-institutionalization is associated with a change in the treatment system for the mentally ill, from treatment in hospitals (hospital or institutional treatment) to treatment in the community, that is, in new, more open, inclusive treatment and support systems that seek to improve access to the most severely affected, while protecting their rights. Which is the goal to involve the community to help citizens, in realizing the right to mental health protection, by adapting formal and informal services for mental health.

Formal mental health services (hereafter referred to as FHS) in the community include: community rehabilitation services, mobile crisis teams, treatment and housing services, special community services, special community services (FHS) trauma victims, children, adolescents, old).

Community-based HCWs are not located in a hospital setting, but they need strong links with general hospitals and psychiatric wards. The most effective HCWs in the community are closely related to primary health care and informal services in the community. These services require a certain number of specialized professionals, if most functions can be performed by health workers with short training in mental health. Well-developed formal community-based FHS's have numerous advantages. First of all, they enable people with severe mental disorders to continue living in the community and thus improve their integration into the community, but a high degree of satisfaction with community FHS is also associated with their availability, a reduced level of stigma associated with seeking help in such situations services and reducing the risk of human rights violations. These services are demanding in terms of costs and personnel; well-developed community-based FHSs that cover a wide range of services and cover different clinical needs can “pay for themselves” (reduce their costs to be comparable to large hospitals) only after many years (Manual for the establishment and development of mental health centers in the community, Belgrade, February 2016).

Informal FHS in the community is organized by members of the local community who are not necessarily health workers; they do not form the basis of FHS nor can they be the only support for the community, but they certainly form an important component and can contribute to better treatment results. They are usually well accepted precisely because they are part of the natural environment, but not all are free and caution is needed in relation to treatment methods, in order to avoid practices based on unscientific methods (healers, etc.) (Manual for the establishment and development of mental health centers in the community, Belgrade, February 2016).

4. Indirect discrimination of citizens with mental disorders and disorders in practice

An example of the threat to the human rights of citizens with mental health problems, or indirect discrimination on the basis of health status, is the Rulebook on Medical Rehabilitation in Inpatient Health Institutions Specialized in Rehabilitation (“Official Gazette of RS”, No. 47/2008,

69/2008, 81/2010, 103/2010, 15/2011, 48/2012, 55/2012 - corrected, 64/2013 and 68/2013 - corrected), which discriminates against people with mental disorders, by denying the right to use extended rehabilitation in health care institutions, even in the state of the most severe disorder - the state of coma. Against the said Rulebook, the co-author of the work, Ivan Petrović, while performing the duties of an adviser for the protection of patients' rights in the territory of the city of Kraljevo, submitted a Constitutional initiative for the evaluation of the constitutionality and legality of the Rulebook, in January 2016, based on the urgency of the then head of the Department of Neuropsychiatry, “Kraljevo” General Hospital, Dr. Negoslav Bradić (<https://www.rts.rs/lat/vesti/srbija-danas/2180007/ugroze-na-ljudska-prava-osoba-s-psihickim-tegobama.html>). A month after the initiative was submitted, the acting director of the Republic Health Insurance Fund (RHFO) formed a Commission of experts in the field of medicine, with the task of amending and supplementing the aforementioned Rulebook, so that persons with a psychiatric diagnosis could exercise their right to rehabilitation (<https://www.paragraf.rs/dnevne-vesti/220116/220116-vest1.html>). After which, on September 14, 2016, the Rulebook ceases to be valid, and on September 15, 2016, a new Rulebook on medical rehabilitation in inpatient health institutions specialized in rehabilitation was adopted (“Official Gazette of RS”, No. 75/2016). Although they did a noble and good deed, the co-author and head of the Department were declared “enemies of the Ministry of Health” by the authorities.

Conclusion

There are many negative stereotypes, on the basis of which prejudices are created about the use of services when exercising the right to mental health care.

What is most important is to work on raising public awareness of the very definition of mental health, to explain that it is no longer a taboo topic and that mental illness must be viewed like any other illness, without labeling or discrimination, and that a mentally ill person, need, has the same rights as, for example, a person with a broken leg or angina pectoris (none of them), they do not stay in the hospital longer than necessary, no one excludes them from society, their family does not reject them, etc.).

Also, it is necessary to work on improving accessibility, the availability of health care for people with mental disorders, disorders (disabilities), on the basis of which the accessibility of health care will increase:

- by improving the quality of services in primary health care;
- more appropriate personnel planning within primary health care;
- by improving the technical capacities (medical equipment) of health institutions at the primary health level in order to facilitate the provision of services to persons with disabilities;
- easier and more efficient access to information about the work of health institutions;
- adapting the internal presentation to persons with disabilities;
- by collecting data from health institutions about their needs in order to facilitate the provision of services to persons with disabilities;
- by establishing cooperation between the Ministry of Health and the Ministry of Labour, Employment, Social Affairs and Veteran Affairs in order to exchange data on the situation and needs of persons with disabilities;
- by implementing long-term recommendations on a comprehensive analysis of primary health care and their capacity to provide health services to people with disabilities based on territorial (health centers, branches, health stations, health clinics), functional principles (services, departments and divisions within organizational units) and health pictures of the population (health needs of the population);
- by analyzing primary health care, in such a way as to present an objective picture of its accessibility and availability in order to eliminate negative effects;
- organizing trainings for employees in health care institutions on the right to health care of persons with disabilities, as well as on the prohibition of discrimination against them in the provision of health services;

- by improving the technical capabilities of health institutions for external access to facilities and access within facilities for persons with disabilities (ramps, elevators, toilets);
- by improving the technical capabilities and health institutions in terms of medical equipment in order to provide a complete health service; and
- Legislation / by-laws - the issue of primary health care for persons with disabilities, given that it is not regulated by a separate law.

And finally, the community should adhere to the principle of efficiency, namely that FHS`s should minimize costs and increase the results of the services they provide to users, avoiding the use of ineffective forms of treatment or the application of effective forms of treatment at the wrong time.

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PSYCHIATRIC SECURITY MEASURES ACCORDING TO THE CRIMINAL CODE OF THE REPUBLIC OF SERBIA

Abstract: *The Criminal Code of the Republic of Serbia is based on the so-called pluralistic concept of criminal sanctions distinguishing punishments, warning measures, security measures and educational measures. In the system of security measures as a special type of criminal sanctions, the purpose of which is to eliminate states or conditions that may have influence on an offender to commit criminal offenses in the future, there are also two types of psychiatric measures. It is about security measures of mandatory psychiatric treatment and custody in a health facility from Art. 81 and mandatory psychiatric treatment at liberty from Art. 82 of the Criminal Code. These security measures are intended for two categories of perpetrators: 1) insane perpetrators of illegal acts that are defined by law as criminal acts and 2) substantially reduced to accountable perpetrators of criminal acts. Although we are talking about criminal sanctions, the security measures in question also contain a component of psychiatric treatment, which is their essential characteristic. Therefore, the paper will consider the material, procedural and executive aspects of the aforementioned psychiatric security measures.*

Keywords: *criminal sanctions, mandatory psychiatric treatment and custody in a health facility, mandatory psychiatric treatment at liberty.*

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1. Introduction

The Criminal Code of the Republic of Serbia (CC)³ rests on the so-called pluralistic system of criminal sanctions, differentiating punishments, warning measures, security measures, and educational measures (Article 4, paragraph 1, CC).⁴ Security measures are conceived as criminal sanctions aimed at eliminating criminogenic factors that can influence the perpetrator to repeat the crime (more: Ćorović, 2015: 188-190). In that sense, in Art. 78 of the Criminal Code of Serbia stipulates that their purpose is to eliminate “state” or “conditions” that may influence the perpetrator not to commit criminal acts in the future. It follows from this that security measures are set as criminal sanctions with a predominantly special preventive purpose because their application should act on the perpetrators themselves in order to prevent them from future criminal behavior by eliminating the corresponding causes (“states” and “conditions”) (more about that: Ćorović, 2015: 195-198).

Within the system of security measures (Art. 79 of the CC) there are also two measures of a psychiatric nature - mandatory psychiatric treatment and custody in a health facility (Art. 81 of the CC) and mandatory psychiatric treatment at liberty (Art. 82 of the CC), which are intended for the insane perpetrators of illegal acts that are defined by law as criminal acts and substantially reduced to accountable perpetrators of criminal acts. From the names of these security measures, as well as the addressees they refer to, it is clear that their content consists of appropriate medical, or more precisely, psychiatric treatment. Therefore, this paper will clarify the legal regulation of the security measures in question, primarily the provisions of the CC, but also the corresponding provisions of a procedural and enforceable character that enable their implementation in practice.

³ Criminal Code, *Official Gazette of the RS*, no. 85/2005, 88/2005 - corrected, 107/2005 - corrected, 72/2009, 111/2009, 121/2012, 104/2013, 108/2014, 94/2016, 35/2019.

⁴ Modern criminal law provides special criminal sanctions for minors (see: Kambovski, 2019: 21).

2. Conditions for the imposition of psychiatric security measures

Although we are talking about two security measures, the conditions for their imposition are set similarly (Articles 81 and 82 CC). First of all, two conditions are identically determined: first, they can be imposed only on insane and significantly less sane perpetrators and, second, the presumption for their imposition is an illegal act that is provided by law as a criminal offense - in the case of insanity, that is, a criminal offense - for a case of significantly reduced sanity. In order to impose mandatory psychiatric treatment and custody in a health institution, the following two conditions are also required: there must be a serious risk of committing a serious criminal offense, i.e. an illegal offense that is prescribed by law as a criminal offense, and that, in order to eliminate the perpetrator's danger, he needs to be treated in a health facility. On the other hand, two more conditions are also required for the imposition of mandatory psychiatric treatment in prison, which are slightly more lenient compared to the previous security measures. Thus, the perpetrator must have a serious risk of recommitting a criminal, i.e. illegal act, which is provided by law as a criminal act, with the fact that this measure does not have to be a more serious crime, and that in order to eliminate the perpetrator's danger, it is sufficient to treat him at freedom (Ćorović, 2015: 205, 210).

2.1. Condition of mental insanity/ significantly reduced mental capacity

For the determination of insanity and substantially reduced sanity, according to Art. 23 points 2 and 3 CC, a mixed, biological-psychological method is accepted. Namely, an offender is mentally insane who, as a result of one of the biological grounds defined by the law as mental illness, temporary mental disorder, retarded mental development, or other mental disorder, has been deprived of appropriate psychological functions, i.e. due to which the offender could not understand the significance of his act or he could not control his actions. Bearing in mind that sanity is an element of guilt according to Art. 22 of the CC, insanity leads to its exclusion, so that the insanity perpetrator does not act covertly. In the case of significantly reduced mental capacity, guilt is not excluded, but the perpetrator's ability

to understand the significance of his act or to manage his actions is significantly reduced due to one of the aforementioned biological factors. The issue of sanity (insanity, significantly reduced sanity) is assessed *tempore criminis*, i.e. at the time of the commission of the crime.⁵ In order to determine insanity and significantly reduced mental capacity, it is necessary to perform a psychiatric examination in the sense of Art. 131 point 1 of the Code of Criminal Procedure (CPC).⁶

Mental illnesses include what in psychiatry are called psychoses, which, in turn, are divided into endogenous, such as, for example, schizophrenia, manic-depressive psychosis, and paranoia, and exogenous, which include, for example, traumatic psychoses, intoxication psychoses, infectious psychoses (progressive paralysis), etc. Temporary mental disorders imply a disturbance of consciousness of a shorter duration, and they can be caused by effects, intoxication, exhaustion, fatigue, restlessness, somnambulism, hypnosis, some physical illnesses and brain injuries, sunstroke, etc. Retarded mental development corresponds to the term oligophrenia in psychiatry. It is a psychological condition characterized by insufficient development or abnormal constitution of the psychic apparatus, and its severity is graded according to the intelligence coefficient. Other severe mental disorders include those forms of mental disorders that cannot be classified

⁵ The existence of appropriate mental disturbances and disorders later, during criminal proceedings or serving a prison sentence, can only affect the course of the criminal proceedings and the position of the convict during the serving of the sentence (his rights and the need for treatment). In such cases, the specified psychiatric safety measures cannot be imposed. However, during the serving of the prison sentence, if there is a need for it, the convict must be provided with appropriate psychiatric treatment. In this regard, let us point out that in the case of *Murray v. the Netherlands* The European Court of Human Rights found a violation of Art. 3 of the European Convention on Human Rights (prohibition of torture) to the applicant who was serving a life sentence and who claimed that he was not provided with a special regime for prisoners with psychiatric problems, so that while serving his sentence he had no prospect of being released because he was never provided with psychiatric treatment due to the risk of reoffending. Although it was assessed that the applicant required treatment even before he was sentenced to life imprisonment, no further assessments were made as to the type of treatment required. The European Court particularly pointed out that states in their practice have a large field of free judgment in determining what measures are necessary to enable the rehabilitation of persons sentenced to life imprisonment (see: Paunović, Pavlović, 2021: 187).

⁶ Criminal Procedure Code, *Official Gazette of the RS*, no. 72/2011, 101/2011, 121/2012, 32/2013, 45/2013, 55/2014, 35/2019, 27/2021 - US decision and 62/2021 - US decision.

under the aforementioned, with the fact that it is not about any kind of disorder, but only one that can be qualified as severe. This term generally includes more serious cases of psychopathy, neurosis, sexual disorders, etc. (on the above see: Drakić, 2007a: 82-96; Deliće, 2009: 121-128; Stojanović, 2017: 128; Škulić, 2019: 47-48; Vuković, 2021: 236-238)

However, the mentioned biological bases are not sufficient by themselves for the existence of insanity or significantly reduced mental capacity. In the sense of the above, it is necessary that in the specific case, there is at least one of them that excludes (in the case of insanity) or substantially reduces (in the case of substantially reduced sanity) at least one of the two psychological functions - the ability to understand the significance of one's actions, which represents the ability to reason, or the ability management of one's actions, which represents the ability to make decisions.

It is important to note from the point of view of psychiatric security measures that from one of the mentioned biological bases arises the perpetrator's danger of repeating the act, which, in turn, is the basis of their application (Drakić, 2005: 22; Ćorović, 2015: 193). Given that these are appropriate “conditions” (from the point of view of legal terminology), by applying some of the psychiatric security measures, it is necessary to “remove” such conditions (according to Article 78 of the CC) so that the perpetrator does not behave criminally in the future. Nevertheless, the intended purpose of these criminal sanctions is set too ambitiously (Drakić, 2005: 21), because it is difficult to expect that a criminal sanction, even if it has a psychiatric content, can “remove” some, for example, mental illness or mental retardation.

2.2 The condition that a criminal or illegal act has been committed-which is provided by law as a criminal offense

Since security measures are criminal sanctions, for their imposition it is necessary that the perpetrator has committed a criminal act. In principle, this applies to all security measures, including those of a psychiatric nature. However, there is an exception in the case of unaccountable offenders. Namely, a criminal offense according to the letter of the law (Art. 14 CC) implies guilt. As insanity excludes guilt, the actions of such a perpetrator cannot be qualified as a criminal offense. For this reason, the

legislator calls the actions of insane persons illegal acts that are foreseen/determined by law as criminal acts (Art. 81 para. 2 and Art. 82 para. 1 CC). We are talking about behaviors that according to their characteristics correspond to the concepts of corresponding criminal acts, with the fact that they lack guilt to be considered criminal acts. On the other hand, in the case of significantly reduced mental capacity, the perpetrator exists so that in order to impose all criminal sanctions against them, including psychiatric security measures, it is necessary for them to fulfill the complete features of a criminal act.⁷ In any case, the mentioned wording implies that the perpetrator (incapacitated or significantly reduced mental capacity) has entered the criminal zone. If a person has not entered the criminal zone by his actions, and he has a certain mental disorder that requires compulsory treatment, treatment could be carried out according to the Act on the Protection of Persons with Mental Disorders⁸ (Turanjanin, 2023: 289).

2.3. The condition of the existence of a serious risk of committing a (serious) criminal offense, that is, an illegal act that is prescribed by law as a criminal act

Security measures are set as criminal sanctions that should prevent repeated criminal behavior by the perpetrators. Hence, we are talking about sanctions that are, in a way, oriented towards the future. Namely, the perpetrator is sanctioned with security measures not only because he committed a criminal or illegal act defined by law as a criminal act, but also because, due to some “condition”, he could continue to commit the same. That is why we are talking about criminal sanctions of prognostic character (Ćorović, 2015: 193). With psychiatric security measures, however, that

⁷ Therefore, the legal distinction between the concepts of “criminal act” and “illegal act provided for in the law as a criminal act” is based on the fact that insanity excludes guilt without which it is not possible to commit a criminal act in the full sense (Vuković, 2021: 514, fn. 1523). In this regard, in the judgment of the District Court in Niš, K. no. 119/06 states: “Given that it established that the defendant was insane at the time he committed the crime, the court found that his action cannot be qualified as a criminal offense, but as an illegal offense which is prescribed by law as the criminal offense of murder from Art. 113 of the CC” (propisonline.com court practice database).

⁸ Law on the Protection of Persons with Mental Disabilities, *Official Gazette of the RS*, no. 45/2013.

prognosis must be “serious.” Namely, with the security measures from Art. 81 and 82 of the CC, it is necessary to establish a “serious danger” of repeating the act, which in fact represents a “high degree of probability” of their future commission. At the same time, in the case of mandatory psychiatric treatment and custody in a health institution, “serious danger” does not refer to any crime, but to a high degree of probability of committing a crime, which is stipulated in the law as a “serious” criminal offense (Stojanović, 2016: 346). The court determines the serious risk of repetition of the act, according to the provisions of Art. 81 point 1 of the Criminal Code, considering the committed act and state of mental disorder (Soković, 2017: 68). But even so, bearing in mind that it is a condition of a prognostic nature, it is justified to point out that in this segment courts are given room for intuitive or arbitrary action (Drakić, 2007b: 316).⁹

The serious danger of re-committing criminal acts (illegal acts defined by law as criminal acts) represents, as has been said, the basis for the application of security measures. It was also said that this danger in psychiatric security measures originates in one of the mentioned psychological states, i.e. biological basis of insanity, i.e. significantly reduced sanity. However, it cannot arise from all these bases. Namely, by the very nature of things, a serious danger of repeating the act cannot arise from a temporary mental disorder precisely because it is a question of conditions that last temporarily, which means that in such cases the conditions for the imposition of psychiatric safety measures will not be met (Stojanović, 2014: 150 ; Bejatović, 2017: 14).

⁹ From the point of view of forecasting the perpetrator’s behavior, the case of *Hajdukova v. Slovakia*, in which the European Court of Human Rights found a violation of Art. 8 of the European Convention on Human Rights (right to respect for private and family life). In this case, it was about the fact that no psychiatric treatment was prescribed for the applicant’s ex-husband, after his conviction for abuse and threats, even though the experts found during the criminal proceedings that he suffered from a severe personality disorder, and his inpatient treatment in a psychiatric hospital was recommended. This omission led to repeated threats against the applicant and her lawyer by the ex-husband (see: Kolaković-Bojović, Grujić, 2020: 252-253).

2.4. The condition of the perpetrator's need for treatment and care in a health institution, that is, the sufficiency of his treatment at liberty

The last conditions for these two security measures indicate the forms of treatment that need to be carried out in order to eliminate the perpetrator's danger of repeating the criminal act, that is, the illegal act defined by law as a criminal act. The security measure from Art. 81 of the Criminal Code requires, in order to remove the offender's addiction, his treatment and custody in a health facility, while the measure from Art. 82 of the CC, also for the purpose of eliminating the established danger, his treatment at liberty is sufficient. From this, it can be concluded that the degree of danger of repeating the act determines the form of treatment of an insane, that is, a significantly reduced sanity perpetrator - in the first case, this degree is higher, and in the second case, it is lower (Ćorović, 2017: 187).

Depending on the success of the treatment applied to the perpetrator during the execution of these security measures, there may be a need to replace one measure with another, so that his treatment in a health facility is no longer necessary, but only treatment at liberty, and vice versa. That is why it is stipulated that compulsory psychiatric treatment at liberty can also be imposed on an insane offender (not significantly reduced to sane) according to which compulsory psychiatric treatment and care in an appropriate health institution has been determined when the court, based on the results of the treatment, determines that his care is no longer necessary and treatment in such an institution, but only his treatment at liberty (Art. 82 paragraph 1 of the CC). In this case, mandatory psychiatric treatment on release is imposed at the suggestion of the health institution (Special prison hospital or other institution) in which the measure is carried out, and on the basis of Art. 199 point 1 of the Law on Execution of Criminal Sanctions (LECS),¹⁰ in the procedure regulated in art. 531 points 1 and 2 of the CPC.

In the same way, when mandatory psychiatric treatment at liberty has been imposed, and the offender does not undergo treatment at liberty or voluntarily leaves it, or despite the treatment, there is a danger that he will commit another illegal act provided for in the law as a criminal offense

¹⁰ Law on Execution of Criminal Sanctions, *Official Gazette of the RS*, no. 55/2014, 35/2019.

so that his treatment and custody is necessary for an appropriate health institution, the court can impose mandatory psychiatric treatment and care in such an institution (Art. 82 paragraph 6 of the CC). About these circumstances, the health institution is obliged to inform the court that imposed mandatory psychiatric treatment at liberty, based on Art. 203 LECS. The procedure for replacing the imposed security measure in this case is regulated in Art. 532 of the CPC.

3. Independent and supplementary character of psychiatric security measures

Security measures are generally supplementary criminal sanctions, which means that they are generally imposed along with some other criminal sanctions. However, when it comes to unaccountable offenders, mandatory psychiatric treatment and custody in a health facility and mandatory psychiatric treatment at liberty are imposed independently. In that case, the following security measures may be imposed in addition to them: prohibition of calls, activities, and duties, prohibition of driving a motor vehicle, and confiscation of objects (Article 80, paragraph 2 CC).

When it comes to perpetrators with significantly reduced mental capacity, psychiatric security measures are imposed on them along with a sentence or a suspended sentence (Article 80, Paragraph 3 of the CC). Then it is about the so-called the cumulative imposition of the security measures in question with the mentioned criminal sanctions, and it is a consequence of insufficient special-preventive capacities of those sanctions in relation to certain perpetrators (Soković, 2017: 72). With a suspended sentence, only mandatory psychiatric treatment at liberty can be imposed (Art. 82 paragraph 3 of the CC), while mandatory psychiatric treatment and custody in a health institution can only be imposed with a prison sentence. For that situation, it is foreseen that the security measure is carried out first, and then the prison sentence (Art. 195 para. 3 ZIKS), with the fact that the time spent in a health facility is included in the duration of the imposed sentence (Art. 81 para. 5 CC). If the time spent in a health facility is shorter than the duration of the imposed sentence, the court will, after the end of the security measure, order that the convicted person be sent to serve the remainder of the sentence or be released on parole. When deciding on conditional

release, the court will, in addition to the conditions otherwise provided for conditional release, take into account the success of the convict's treatment, his state of health, the time spent in a health facility and the remainder of the sentence that the convict has not served (Art. 81 para. 5 CC). If the convicted person is released on parole, he can also impose mandatory psychiatric treatment at liberty (Article 82, Paragraph 3 of the CC).

Therefore, depending on whether they are imposed on insane or significantly less capable perpetrators, psychiatric security measures can have an independent or supplementary character.

4. Duration of psychiatric security measures

Mandatory psychiatric treatment and custody in a health institution is regulated according to a system of absolutely indefinite duration (Ćorović, 2015: 208), so its duration depends on the success of the treatment. In this sense, the court will suspend this measure when it determines that the need for treatment and custody of the offender in a health facility has ended (Article 81, Paragraph 3 of the CC).¹¹ Practically, this means that the perpetrator can be hospitalized for the rest of his life if his health condition does not improve during the execution of this measure. In the event that a significantly reduced sentence is imposed on a criminal offender with a prison sentence, the time spent in a health facility is included in the duration of the imposed sentence (Art. 81 paragraph 5 of the Criminal Code), with the exception that in this case mandatory psychiatric treatment and care in a health facility may last even longer than the imposed sentence (Art. 81 para. 4 CC). Compulsory psychiatric treatment in prison lasts as

¹¹ In the decision of the Higher Court in Kragujevac Kv-82 /10 dated August 4, 2010. year and the decision of the Appellate Court in Kragujevac K 2.1251/10 dated September 17, 2010. states: “The conditions for the suspension of the security measures of mandatory psychiatric treatment and custody in a health institution are not met when the opinion of the medical commission of the Special Prison Hospital states that the further potentially dangerous behavior of the defendant can only be eliminated by “continuous” outpatient treatment at liberty, and the defendant is appointed a guardian for care and treatment, namely his brother who lives in Banja Luka, while in the place where further outpatient treatment is proposed, the defendant is not accepted by the family members, and it is undoubtedly that taking care of the necessary treatment would be much more difficult” (base court practice regulations.com).

long as there is a need for treatment, but no longer than three years (Art. 82, paragraph 5 CC), which means that the legislator in this case accepted a system of relatively indefinite duration (Ćorović, 2015: 211). The acceptance of a system of indefinite duration (absolutely or relatively) results in the court decision imposing some of the security measures not specifying the time of their duration.

Considering the manner in which this issue is regulated, it is necessary to point out the appropriate procedural and executive legal provisions related to the periodic control of psychiatric security measures, because in this way the court receives information about the need for their suspension or, possibly, replacement.¹² According to Art. 531 point 1 of the CPC, the court that judged in the first instance will examine, on the proposal of the health institution, the guardianship authority or the defendant who has imposed a security measure, i.e. ex officio every nine months, whether the need for treatment and care in a health institution has ceased. If the control of the measure was carried out according to the proposal of the aforementioned authorities or persons, and the proposal for suspension is rejected by the court's decision, a new proposal can be submitted after six months have passed since the adoption of the aforementioned decision (Art. 531 paragraph 3 of the CPC). In addition to the above, in Art. 198 LECS stipulates that the health institution, i.e. the department to which a person is sent for treatment and custody, is obliged to inform the court that imposed the measure at least once a year about the state of health of the person according to which it is applied. When it comes to mandatory psychiatric treatment in prison, Art. 204 LECS stipulates that the health institution where the treatment is carried out is obliged to inform the court that imposed the measure about the state of health of the person undergoing treatment, as well as about the completion of the treatment, at least every six months.

¹² In this connection, in the decision of the High Court in Pozarevac 1 Kv 169/15 dated 24.12.2015. states: “When it follows from the report of the Special Prison Hospital that the person still suffers from paranoid psychosis and that there is a need for his further stay in the same institution, there is no requirement to replace the pronounced security measure of mandatory treatment and custody in a health institution with another measure security or repeal” (propisonline.com case law database).

5. The procedure for imposing psychiatric security measures

The CPC provides for a special procedure for the imposition of security measures of mandatory psychiatric treatment only if the perpetrator is insane (Art. 522-534). If the criminal offense was committed in a state of significantly reduced sanity, then these measures are imposed by a conviction in a general/regular or summary procedure, so in that case no special rules are needed (Brkić, 2018: 478). This is a consequence of the circumstances that in the latter situation, psychiatric safety measures are still imposed on the “guilty” perpetrator, even though his sanity has been significantly reduced, as additional sanctions in addition to a sentence or a suspended sentence. However, even in that case, in terms of Art. 131 point 1 of the CPC, it is necessary to perform a psychiatric expert examination, because significantly reduced sanity, as well as insanity, is determined through that means of evidence. Here, only a special procedure for unaccountable perpetrators will be presented.

The accusation in this procedure is called a proposal for the imposition of a security measure (Art. 2, paragraph 1, item 10 of the CPC), and the public prosecutor is exclusively responsible for its submission. The accusation in this procedure is called a proposal for the imposition of a security measure (Art. 2, paragraph 1, item 10 of the CPC), and the public prosecutor is exclusively responsible for its submission.¹³ Although we are talking about two security measures, the conditions for their imposition are set similarly (Articles 81 and 82 CC). First of all, two conditions are identically determined: first, they can be imposed only on insane and significantly less sane perpetrators, and, second, the presumption for their imposition is an illegal act that is provided by law as a criminal offense - in the

¹³ In the Conclusion adopted at the session of the Criminal Department of the Court of Appeal in Nis, held on September 23, 24 and 25, 2014. year, agreed with the conclusions of the Criminal Department of the Supreme Court of Cassation at the meeting of the Criminal Department of the Court of Appeal in Nis on 01.12.2014. year, it says: “Based on Art. 522 of the CPC, a proposal for the imposition of a security measure of mandatory psychiatric treatment for an insane offender can be submitted only by a public prosecutor, and the injured party as a prosecutor and a private prosecutor are not authorized persons to submit a proposal” (propisonline.com court practice database).

case of insanity, that is, a criminal offense - for a case of significantly reduced sanity. In order to impose mandatory psychiatric treatment and custody in a health institution, the following two conditions are also required: there must be a serious risk of committing a serious criminal offense, i.e. an illegal offense that is prescribed by law as a criminal offense, and that, in order to eliminate the perpetrator's danger, he needs to be treated in a health facility. On the other hand, two more conditions are also required for the imposition of mandatory psychiatric treatment in prison, which are slightly more lenient compared to the previous security measures. Thus, the perpetrator must have a serious risk of re-committing a criminal, i.e. illegal act, which is provided by law as a criminal act, with the fact that this measure does not have to be a more serious crime, and that in order to eliminate the perpetrator's danger, it is sufficient to treat him at freedom (Ćorović, 2015: 205, 210).

The imposition of psychiatric security measures on an insane offender can occur in two situations (Ilić et al., 2016: 1188): 1) by submitting a proposal for the imposition of a security measure (Art. 522 paragraph 1 of the CPC), 2) when the public prosecutor at the main trial changes an indictment or an indictment proposal, by submitting a proposal for imposing the specified security measures (Art. 522 paragraph 2 of the CPC). The public prosecutor's proposal may refer to the imposition or security measures from Art. 81 CC, or security measures from Art. 82 of the CC (Art. 522 para. 1 of the CPC), with the fact that the court is not bound by his proposal (Art. 526 para. 4 of the CPC).

In the proposal for the imposition of a security measure of mandatory psychiatric treatment, the public prosecutor may propose that the accused, who is at large, be detained. In addition to the general detention grounds provided for in Art. 211 of the CPC, in this procedure there is also one special ground - the existence of a justified danger that the defendant could commit a criminal offense due to mental disturbances. Before deciding on custody, the court obtains an expert's opinion, and after passing the decision on custody, the defendant, until the end of the proceedings before the court of first instance, is placed in an appropriate health facility or a room that corresponds to his state of health. In the event that the defendant was already in custody at the time of the submission of the proposal for the

imposition of a security measure of mandatory psychiatric treatment, the court will act in the manner described (Article 524 of the CPC).

An expert from the health institution that was entrusted with the expertise on the sanity of the accused is invited to the main hearing, which is held according to the submitted proposal for the imposition of psychiatric security measures. The presence of the accused is not mandatory, that is, he is summoned only if his condition is such that he can attend the main hearing. Before deciding on the possibility of the accused's presence at the main hearing, the president of the panel will, if necessary, question the expert who performed the psychiatric examination of the accused, and the accused will be heard if his condition allows it.¹⁴ If the accused is unable to attend the main hearing, the CPC stipulates that he will be considered to contest the charges. The legal representative of the accused is also informed about the main trial, and if he is not present, his spouse, i.e. the person with whom he lives in an extramarital or other permanent union of life, relatives by blood in the direct line, legal representative, adoptive parent, adoptee, brother, sister or foster parent (Art. 525 CPC).

In order to impose psychiatric security measures during the procedure, it is necessary to perform a psychiatric expert examination (Art. 131 para. 1, Art. 132 para. 1 and Art. 525 of the CPC).¹⁵ In art. 132 paragraph

¹⁴ In the decision of the Appellate Court in Novi Sad Kz. no. 1 831/13 of 17.06.2013. year, which annulled the decision of the High Court in Novi Sad K. no. 390/12 of 16.01.2013. year, it says “Based on the appeal of the defense attorney I.S. indicates that the first-instance court made an omission because during the proceedings it was not established whether the accused is capable of following the course of the trial and participating in it, as well as that the first-instance court's omission is also reflected in the fact that it did not ensure the presence of I.S. on the main hearing, and the procedure was conducted in his absence. This is because, in the opinion of the second-instance court, it is not enough that the court was informed by the Special Prison Hospital Administration that I.S. due to his health condition, is not able to attend the main trial, but about the capacity of I.S. to follow the course of the trial and to participate decisively in it, the expert doctors who were entrusted with providing findings and opinions on the mental health and sanity of I.S. which is why the contested first-instance decision was abolished” (propisonline.com court practice database).

¹⁵ In the decision of the High Court in Belgrade, Kz 1 no. 203/21, dated April 19, 2021. of the year, states: “The passing of a decision imposing the security measure of mandatory psychiatric treatment on the defendant without the presence of the expert who examined the defendant is included in a significant violation of the provisions of the criminal procedure” (propisonline.com court practice database).

1 of the CPC stipulates that the expert, if the expert opinion is determined to assess the sanity of the defendant, will determine whether the defendant had a mental illness, temporary mental disorder, retarded mental development or other serious mental disorder at the time of the commission of the criminal act, then he will determine the nature, type, degree and duration of the disorder and give an opinion on the impact of such a mental state on the defendant's ability to understand the significance of his act or manage his actions. If the purpose of the expert examination requires it, the defendant may be placed in a health facility for the purpose of performing the medical examination. The defendant may be kept in a health facility for 15 days for expert examination, with the exception that, upon the reasoned proposal of the expert and upon the obtained opinion of the head of the health facility, his stay in the same facility may be extended for a maximum of another 15 days (Art. 122 of the CPC).

Psychiatric security measures are imposed on an insane offender by a court decision in the form of a decision. With this decision, the court can also decide on a property claim if it has been filed (Art. 526 para. 1, 4 and 5 of the CPC). An appeal is allowed against the decision in question, within eight days of its receipt. The parties, the defense counsel of the accused, as well as his spouse, i.e. the person with whom he lives in an extramarital or another permanent union of life, blood relatives in the direct line, legal representative, adoptive parent, adoptee, brother, sister, and foster parent, have the right to file an appeal (Art. 528 in relation to Article 433 of the CPC).

This procedure can be ended in the following ways: a) by passing a verdict of rejection or acquittal under the conditions provided for by law (Art. 526 paragraph 2 of the CPC), with the fact that an acquittal cannot be passed for reasons of unenforceability (Ilic et al., 2016): 1093); b) by a decision on the suspension of the procedure for the application of the security measure, for the reason that the court determined that the accused *tempore criminis* was not insane (Art. 526 para. 3 of the CPC), after which the public prosecutor is authorized to file an indictment or an indictment proposal for the same offense (Art. 527 of the CPC), which means that the rule of *res iudicata* does not apply to this situation according to the CPC (Ilić et al., 2016: 1095).

A legally binding decision imposing a security measure of mandatory psychiatric treatment and custody in a health facility, i.e. mandatory psychiatric treatment at liberty, shall be submitted to the court competent to decide on the deprivation of professional capacity. The guardianship authority is also informed about the imposed security measure (Art. 530 of the CPC).

6. Implementation of psychiatric security measures

From the very name of the security measures in question, it can be concluded that mandatory psychiatric treatment and care in a health institution is carried out in a hospital, which means that the perpetrator, bearing in mind that this is a criminal sanction, is deprived of his liberty during its execution, while mandatory psychiatric treatment is carried out in freedom is carried out on an outpatient basis. However, compulsory psychiatric treatment at liberty can also be carried out occasionally in a suitable health institution, if it is necessary for more successful treatment, with the proviso that occasional treatment in the institution cannot continuously last longer than fifteen days, nor in total longer than two months (Art. 82 paragraph 4 CC).

In the previous presentation, some provisions related to the execution of the security measures in question were pointed out. Therefore, at this point, we will only point out some technical and organizational issues related to this area.

The court that imposed the measure in the first instance is competent to refer a person to the execution of a measure of compulsory psychiatric treatment and custody in a health institution (Art. 195, paragraph 1 LECS). It is primarily carried out in the Special Prison Hospital, as a special type of institution for the execution of criminal sanctions (Article 13, Paragraph 1, Item 4, LECS). Therefore, it is a “prison” and not a health institution, with the fact that the expertise of the work in its execution is supervised by the ministry responsible for health affairs (Art. 200 LECS). In addition, it is also foreseen that the same can, exceptionally, be performed in another health institution (Art. 195, paragraph 2 LECS). Also, at the proposal of the Special Prison Hospital, i.e. another health institution where mandatory psychiatric treatment and custody are carried out, the

court may, during its duration, upon the previously obtained opinion of the judge for the execution of criminal sanctions, decide to transfer the person against whom the measure is being carried out from one to another health care institution (Art. 195, paragraph 4 LECS). In art. 27 of the Regulation on the Plan of Networks of Health Institutions¹⁶ it is planned that in the special psychiatric hospitals in Novi Kneževac, Vršac, Kovin and Gornja Toponica, and part of the Clinic for Psychiatric Diseases “Dr. Laza Lazarević” in Belgrade¹⁷ a number of “hospital beds” refers to, among other things, forensic psychiatry (about it: Ćorović, 2015: 209, fn. 803; Dimovski, Kostić, Milić, 2016: 1445-1447; especially the study: Međedović, Petrović, Vujičić, 2019).

Bearing in mind that mandatory psychiatric treatment and custody in a health institution is a criminal sanction that implies the deprivation of liberty of the perpetrator to whom it is carried out, it is prescribed that it may contain only those restrictions on movement and behavior that are necessary for the purpose of treatment and custody of the person against whom this measure is imposed applies also to maintain order and discipline. A person subject to the security measure of compulsory psychiatric treatment and custody in a health institution has the same rights and obligations as a person serving a prison sentence unless the needs of treatment require otherwise (Art. 196 LECS). The specific legal position of the persons to whom this security measure is applied depends on whether it is carried out in the Special Prison Hospital or in another health institution. Namely, in the first case, the Rulebook on House Rules of the Special Prison hospital¹⁸ is applied, and in the second, the normative acts of those other health institutions. A problem can arise if one of these normative acts gives greater or lesser rights to the persons against whom this measure is carried out in relation to the rights provided for in the Rulebook on the

¹⁶ Decree on the Plan of Networks of Health Institutions, *Official Gazette of the RS*, no. 5/2020, 11/2020, 52/2020, 88/2020, 62/2021, 69/2021, 74/2021, 95/2021.

¹⁷ However, the Clinic for Psychiatric Diseases “Dr. Laza Lazarević” in Belgrade only carries out mandatory psychiatric treatment at liberty, not mandatory psychiatric treatment and care in a health institution, which is regulated by the internal regulations of this institution (see: Dimovski, Kostić, Milić, 2016: 1447; Ćorović, 2017: 191).

¹⁸ Rulebook on house rules of the Special Prison Hospital, *Official Gazette of the RS*, no. 145/2014.

House Rules of the Special Prison Hospital because this leads to a different position for these persons depending on where compulsory psychiatric treatment is provided, and custody in a health institution (see: Dimovski, Kostić, Milić, 2016: 1448-1452). After the dismissal of the person from the health institution where this security measure was implemented, care for him, if he is without family care, is taken over by the guardianship authority, whose jurisdiction is determined according to the place of residence, i.e. the place of residence of this person at the time when the decision by which the security measure was pronounced became legally binding (Art. 201 LECS).

The security measure of mandatory psychiatric treatment in prison is carried out in a health facility determined by the court that imposed this measure. The possibility of its implementation within the Special Prison Hospital is not foreseen (Vujičić, 2019: 87). The court shall refer the person to whom this measure was imposed to a health institution within eight days from the date of the finality of the decision by which the measure was imposed. This person is obliged to report to a health institution for treatment within the period determined by the court, and no later than within 15 days from the delivery of the decision on referral for treatment. The court delivers a copy of the final court decision to the health institution where the measure is carried out (Art. 202 LECS).

The obligations that the Special Prison Hospital or other health institutions have in terms of notifying the court about the state of health of the offender, about the need to replace one measure with another, that is, about the completion of treatment, were discussed in the previous presentation.

7. Conclusion

In this paper, our goal was to present the existing legal framework (*de lege lata*) that regulates two psychiatric security measures in the criminal legislation of the Republic of Serbia. Conceptually, it could be objected that our legislator envisages the criminal sanctioning of those persons, we mean unaccountable perpetrators, whose behavior is not formally and legally considered to be criminal acts and does not call them such (but

illegal acts provided by law as criminal acts). This deviated from the principle of guilt, as one of the fundamental principles of criminal law. However, this approach in suppressing the “criminal” activities of insane persons is accepted in most European countries (even beyond). Moreover, it would not be far from the truth if it were said that security measures as special criminal sanctions primarily exist because of unaccountable perpetrators. Also, numerous objections could be directed to certain legal solutions, but that was not the subject of our consideration either.

The specificity of psychiatric security measures is reflected in the fact that they have as their addressees persons who, on the one hand, suffer from appropriate mental disorders, but also, on the other hand, behave in a manner prohibited by criminal legislation, and at the same time between this there is a proper connection between the two sides. These are people who, as a result, are interesting both for criminal law and medicine, more precisely psychiatry. Therefore, in the entire procedure of sanctioning these persons through the subject security measures, the understanding and cooperation of criminal lawyers and psychiatrists is necessary, in order to achieve the protection of society from their criminality, but at the same time to provide them with adequate medical assistance.

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Milica Mitrović Marić¹

Mental health care of person living with dementia

Abstract: *As well as physical health care, mental health care is equally important. Having in mind that they have a bond, a huge impact on each other, therefore they should be treated equally. There are, for example, physical risk factors that can directly cause neurological issues such as dementia.*

In this paper, author will be focused on risk factors that can cause dementia, Alzheimer's disease in more than 60 percent of all dementias. Over 55 million people worldwide are living with this condition. The number of people affected is set to rise to 139 million by 2050, according to the latest reports of Alzheimer's Disease International. It can't be avoided to ask ourselves: "Are we treating only physical conditions, in this case risk factors of dementia, or we can see clearly a bigger picture and apply holistic approach in caring, treating and healing people with diverse mental health issues?"

Key words: *dementia, risk factors, mental health, care, increasing.*

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1. Dementia

Dementia is a term that refers to the loss of memory and other intellectual abilities. The specific symptoms a person living with dementia experiences will depend upon what parts of the brain are affected and/of specific disease that is causing their dementia. Symptoms may include:

- Loss of memory
- Difficulty in finding the right words or understanding what people are saying
- Difficulty in performing previously routine tasks
- Personality and mood change (www.alzint.org)

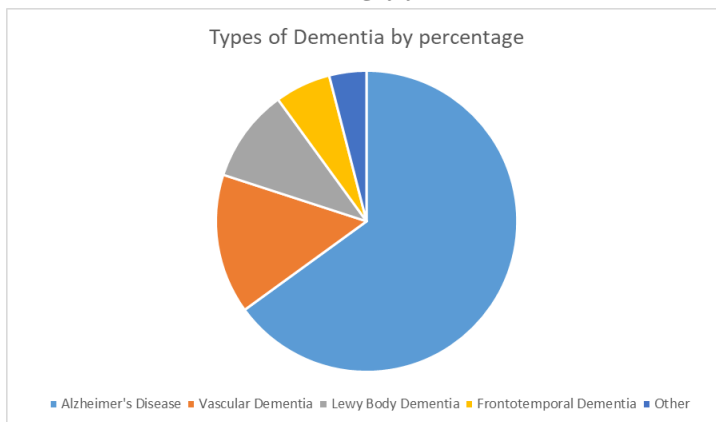
Their loss is pronounced enough to affect the daily life of the affected person.

Alzheimer's disease is the most prevalent with over 60%.

There are also:

- Vascular Dementia,
- Lewy Body Dementia
- Frontotemporal Dementia
- Other types of Dementia

Chart 1



1.1. Risk Factors for Dementia

- **Age**

The greatest risk factor for Alzheimer's disease and other dementias is increasing age. Although age increases risk, dementia is not a normal part of ageing. Women are more likely to develop Alzheimer's disease than men, even accounting for the fact that women live longer on average. (www.alzint.org)

- **Family history, genetics**

It's a fact that there are more than 20 genes which affect a person's risk of developing dementia. The gene APOE was the first known to increase a person's risk of developing Alzheimer's disease, and it's still the strongest risk gene known. There are also genes which directly cause dementia, but these deterministic genes are rare- they are estimated to account for less than 1% of dementia cases and cause young-onset forms in which symptoms usually develop before the age of 60. (www.alzint.org)

- **Air pollution**

There is an increasing amount of research evidence that can clearly show that air pollution is the risk factor of dementia.

- **Head injury**

Head trauma is often caused by car accidents, sports (boxing, football, hockey...), violent assaults and falls.

- **Condition of the heart and blood vessels**

Hypertension is one of the risk factors that generally appears in mid-life. It can also cause other health problems.

- **Diabetes**

Clear risk factor for development of future dementia is type 2 diabetes. Treatment of diabetes is important for other health reasons as well.

- **Obesity**

Obesity in mid-life is related to an increasing risk of dementia. Obesity is also associated with other habits that need change through lifestyle.

- **Depression**

Depression is associated with dementia incidence. Depression is part of the prodrome of dementia (a symptom that occurs before the symptoms that are used for diagnosis). It is not clear to what extent dementia may be caused by depression or the reverse, and both may be the case. In this case, it is important to manage and treat depression because it is associated with increasing disability, physical illnesses and worse outcomes for people with dementia. (www.alzint.org)

- **Lifestyle: physical activity, social life, consumption of alcohol and cigarettes**

One of the best ways to reduce the risk of dementia is regular physical activity. It is also benefit for heart condition, circulation, weight and mental health!

Social interactions reduce the risk of dementia. Social contact increases cognitive reserve and motivates behavior that gives us benefits back.

Alcohol is a risk factor for more than 200 diseases and conditions. There is a relationship between alcohol abuse and diversity of mental and behavioral disorders.

Smoking very much increases the risk of developing future dementia. In addition, there are also other diseases and conditions caused by consumption of cigarettes.

- **Lower level of education**

A low level of education in early life affects cognitive reserve and is one of the most significant risk factors for dementia. Policy should prioritize childhood education for all. (www.alzint.org)

1.2. Early symptoms of dementia

Memory loss

Especially short-term memory (remembering recent things) is the most common early symptom of dementia. They can still remember other facts related to the thing they have forgotten. Memories of things that happened a long time ago can be saved from corruption.

Difficulty performing familiar task

People affected by dementia find it difficult to complete everyday tasks that they used to do them without thinking. For example, steps in preparing meal, order of actions to complete more complex task.

Problem with language

From time to time everyone has a difficulty finding the right word, but person affected by dementia can often forget simple words or replace them with unusual words that makes speech and writing as well hard to understand. Trouble with following a simple conversation makes them become more withdrawn.

Disorientation in the time and place

Person affected by dementia can be lost in familiar places, can forget where they are, how they got there. They forget the way back home. Sometimes they may also confuse night and day.

Poor or decreased judgement

People affected by dementia can for instance be dressed inappropriately regarding to weather conditions.

Problems with concentration, planning or organising

Paying bills, making easy decisions, solving elementary problems-people affected by dementia find it difficult to cope with.

Misplacing things

People affected by dementia tend to put things in unusual places as keys in the fridge.

Changes in mood and behaviour

About these kinds of changes will be discussed furthermore in this paper. Dementia can cause emotional and mood swings or irritability for

no apparent reason. This is very much related to mental health of person living with dementia that needs careful and specific treatment!

Trouble with images and special relationships

Difficulty in reading, judging distance, seeing objects in three dimensions and in determining colour or contrast.

Withdrawal from work or social activities

Person affected by dementia may become very passive, sleeping more than usual during daytime, sitting in front of television for hours and also losing interest in hobbies and all activities that person uses to be engaged in.

2. Stages of Dementia

There are three stages in developing the state of dementia:

- Early stage
- Middle stage
- Late stage

Early stage

Dementia affects everyone differently and early symptoms are often relatively mild and not always easy to notice. Many people at this stage stay largely independent and only need a bit of assistance with daily living. It is important to focus on what the person can do and not to take over and do things for them. Instead, try doing things with them, for example helping the person develop a routine, reminder lists and prompts, and use technology.

The early stage of dementia is when many people choose to make plans for the future, while they still have the ability (‘mental capacity’) to do so. Changes in behaviour are not common in early-stage dementia, other than in FTD. A person with behavioural variant FTD may lose their inhibitions and behave in socially inappropriate ways. They may also act impulsively and lose empathy for others.

Middle stage

In the middle stage of dementia, symptoms become more noticeable, and the person will need more support in managing daily life. The person may now need frequent reminders and some help to wash and dress (for example, having their clothes laid out for them). Some people with dementia will benefit from a paid carer coming into their home. Or some may move into housing with dementia support (assisted living).

Changes in behaviour tend to start from the middle stage of dementia. These changes are common and individual symptoms may come and go. Changes in behaviour are some of the most challenging symptoms for people with dementia and for those who support them. Common changes that are seen in all types of dementia at this stage can include:

- agitation and restlessness – for example, fidgeting or walking up and down
- screaming or shouting
- repetitive behaviour – for example, repeatedly pulling at clothes or asking the same question over and over
- following a carer around (trailing) or constantly checking that they are near
- disturbed sleep patterns – sleep is particularly disrupted, and in a different way, in a person with DLB
- losing inhibitions – for example, saying things that aren’t appropriate or undressing in public (not just in FTD).

Late stage

By this stage dementia will have a severe impact on most aspects of a person’s life. The person will eventually need full-time care and support with daily living and personal care, such as eating, washing and dressing. This support can be provided by care at home but is more often given in a care home setting. Mood, emotions and perceptions in the later stages of dementia. Changes in mood remain in the later stages of dementia. Depression and apathy are particularly common. Delusions and hallucinations (especially of sight and hearing) are most common in the late stage of dementia. They are not always distressing but they can explain some changes

in behaviour, because the person’s perception of reality is altered. People with late-stage dementia often respond more to senses than to words. For example, they may like listening to songs or enjoy textures (for example, the feel of different types of material).

The changes in behaviour that can happen in the middle stage of dementia can also all happen in the late stage. Aggression at this stage is often a reaction to personal care. Someone may push away those trying to help them or shout out to be left alone. The person with dementia may have felt scared, threatened or confused. Restlessness is also very common. Sometimes the person may seem to be searching for someone or something. As in other stages, it is also important to consider whether the person has other needs that aren’t being met. Someone with late-stage dementia will often be unable to tell others how they are feeling. A sudden change in behaviour can point to a medical problem (for example, pain, infection or delirium). (www.alzheimers.org.uk)

Dementia - IT’S NOT JUST LOSS OF MEMORY, IT’S CHANGES IN BEHAVIOR, EMOTIONS, MOOD.

3. Changes in behavior and emotions (Warner, Graham, 2018)

VERY COMMON:

Apathy, restlessness, eating, sleeping, confusion, depression, anxiety, self-doubt.

OFTEN:

Verbal and physical aggression, agitation, shouting, sexual problems, paranoia.

RARELY:

Crying, repetitive activities, hallucinations.

3.1. Depression is *DIFFICULT* to diagnose in a person affected by one of the dementias. The lack of ability to verbally express feelings is certainly an aggravating circumstance.

Depression:

- *Forgetfulness*
- *Poor concentration*
- *Weak motivation*

3.2. Therapy

Pharmacotherapy is not, that is, it should not be the first thing that is resorted to in the problems of controlling the behavior of a person with dementia.

Only after examining the physical aspects (infections, pain) and making sure that the person is physically and socially active enough, only then should medication be considered.

There are several subtypes of behavioral and psychological symptoms of dementia, therefore an adequate approach is needed for each.

Regardless of the cause of dementia, behavioral and psychological symptoms change in type and degree as the disease progresses. For this reason, the therapy should be adjusted regularly.

3.2.1. Advice

A person with dementia may experience depression and be withdrawn, unhappy, speak slowly, and act and think in the same way. This can affect the daily routine as well as the appetite.

It would be good to:

- We talk to the chosen doctor who could help or suggest the help of a counsellor, psychologist or psychiatrist.
- We give the person even more love and support.
- We don't expect a person to “snap” out of depression just like that.

4. Possibilities

We can help to the patients and to their families in various ways:

- SUPPORT GROUPS
- DAY RESIDENCES
- WORK THERAPIES
- FAMILY THERAPY
- INCLUSION

4.1. Support groups

Support group can be made up of care partners, family members, and loved ones of those with Alzheimer’s disease or a related dementia. Although these people begin as strangers, they quickly become friends and, in a sense, a family. The support group leaders may be a community member and/or a health care professional. The meeting may focus on emotional support and sharing experiences, or it may focus on education, with experts speaking on topics such as legal issues, nutrition, caregiving techniques and community resources. The number of participants will vary, in some cases depending on the format. For instance, educational groups are usually larger. However, the ideal size for a support group is 6 to 12 members. Meetings are usually held monthly or bi-monthly at hospitals, churches, libraries, care facilities or senior centres. The purpose of support group is to offer individuals support and information that is specific to dementia. Some support groups, such as: early stage groups, groups for adolescents, male care partners, adult children caring for a parent, and care partners dealing with late stage issues. Support groups encourage members to share information, give and receive mutual support and exchange coping skills with one another. Support group members share practical suggestions for caring based on their caregiving experiences. Caring for an individual with dementia requires different techniques than those needed to care for someone who is not cognitively impaired. Experienced care partners have found that some methods of providing care, ideas that may not be found in books or articles, can make caregiving easier. Sharing those ideas in a support group can prevent care partners from having to “re-invent the wheel.” (www.alz.org)

4.2. Day Residences

Day residences or day care services provide dementia specific, person oriented care to meet the needs of the person with dementia in warm, welcoming and safe environment while providing support and stimulation. There is a wide range of activities, depending of residency organisation, such as:

- *-music session*
- *-gentle exercise*
- *-arts and crafts*
- *-personal care*

4.3. Family therapy

CFT (caregiver family therapy) is appropriate for aging families with caregiving responsibility for an adult. The therapy is designed for two family types: families caring for aging persons with late onset cognitive impairment due to dementia or other brain disfunction.

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The group as an opportunity to save mental health in the time of challenge

Abstract: *It is a neurobiological fact that human nature drives individuals to connect with others, resulting in the formation of groups. Groups act as “natural creations” that can both unite and divide. The processes within groups are intricate, multifaceted, and fascinating subjects for modern study and observation. They surpass the mere sum of individual contributions within the group. Group dynamics can be observed and studied across various levels, including individuals’ inclusion or exclusion from groups, families, organizations, and society as a whole. Scientific understanding of group processes and unconscious dynamics holds the potential for therapeutic effects on all these levels. We live in a time of rapid changes within a society that simultaneously fosters both the multiplication and division of groups. These divisions further amplify differences and disagreements. Undoubtedly, groups can be sites where problems arise, but they also serve as spaces where solutions can be found. In this paper, we will explore the possibilities that groups offer during times of change, and how contemporary group analysis can serve as custodians and nurturers of mental health, from the individual to society at large.*

Keywords: *Mental health, groups, matrix, group therapy*

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Preface

“One would say that Rabies has come to terms with the inequality among people, which Reason has struggled against in vain for thousands of years. That it has abolished traditional divisions into white and colored, men and women, rich and poor, strong and weak, intelligent and stupid, and replaced them with the universal difference between healthy and ill. (There is no real division. All ill people are potentially dead, all healthy are potentially ill. Therefore, in reality we are all dead. The world is finally united.) The battle, however, is not just against rabies. The disease causes another kind of rabies in us, a kind of rabies that casts a shadow over our lives, the kind we read, listen and learn about, the kind we have to face in both our lives and our history, the rabies that each and every one of us carries inside. That other rabies is a permanent disease of the current civilization and there is no real defense against it. In the century of progress and discoveries, in the century of humanism, our security is even less, our fears all the more, our confusion even deeper and our weaknesses more conspicuous.”

Borislav Pekić, “Rabies”

Introduction

“Complete mental and social wellbeing” is emphasized in the definition of individual health, as well as “organized efforts of the community” and “development of social mechanisms”, in public health definition, with the aim to enable public and individual health.

Hygiene, as a science of health (which deals with the environment factors that are significant for health: physical, chemical, biological and social), particularly emphasize mental hygiene, which seems to be unjustly neglected in the educational process, as well as in preventive medicine practice. Mental hygiene and group analytical psychotherapy could be seen as an opportunity to do research, study theory, but also an argument and tool to work in organisations, groups and societies (Jevtic M. 2019).

Mental health is not only the absence of disease, but the ability of a man to adjust to situations, which could be deemed unfavorable for mental health and to stay within the physiological optimum (WHO 2019).

Today's world is characterized by dynamism, mobility, speed and frequent changes, instability and insecurity. These challenges refer to individuals, and also to family, groups, organizations, institutions and societies. Technological development, digital era, internet, social networks, mobile phones, easier mobility, modern and numerous innovations, but also climate change, pollution, migrations, terrorism, wars and violence in family, violence among children, war conflicts, catastrophic events make a picture of the world in the XXI century. In such a world (and surroundings) the position and role of institutions, organizations and social groups are also changing. They become susceptible to influences of the outside environment and they become less stable and they are no secure places any more (Jevtic M. 2019).

Therefore, mental health strengthening demand wider approach, above borders of health system, and it is necessary for individual and population health, but also health of the society. World Health Organization (WHO) invests efforts in order to make mental health a significant priority at the national level of member states, especially insist on significance of mental health promotion at the workplace, as well in schools and educational institutions (WHO 2003, WHO 2022).

The indices for the state of mental health are very worrying. There are efforts to make it better in some segments with different strategies and action plans, measures and approaches within the health system and social protection system. However, these measures are at the level of problem solution, secondary or tertiary prevention. In parallel with secondary and tertiary prevention measures and treatment, it is essential to take measures that form part of primary prevention or that can lead to an improvement in a person's living and working environment of individuals and groups (WHO, 2017).

A special approach is necessary towards institutions and organizations, or certain segments of society “as separate organisms”, groups of individuals, that is, it is necessary to treat them as “clients” in a special way.

Health is also emphasised as a human right, despite the complexity of its realisation at the individual and population level. In this sense, mental health is also a fundamental human right. This short and simple sentence

entails a number of challenges, complexities and also obligations for societies with different quality of life, values, economic situations, financial capacities and awareness of the importance of mental health (WHO, 2023).

Extensive research conducted in the United States unequivocally supports the efficacy of group therapy across diverse clinical settings and populations. The findings demonstrate its effectiveness in addressing a wide array of challenges, ranging from managing chronic pain and adolescent addiction to aiding incarcerated individuals and veterans, highlighting its versatility.

Moreover, beyond its clinical effectiveness, group therapy holds significant social implications. By bringing individuals together in a supportive and interactive environment, it fosters a sense of community and shared understanding. Participants not only benefit from the therapeutic interventions but also experience the powerful impact of shared experiences and mutual support. This collective healing process extends beyond individual progress, contributing to stronger social bonds and a sense of belonging.

The culmination of numerous studies and meta-analyses affirming the efficacy of group therapy has played a pivotal role in the formal recognition of Group Psychology and Group Psychotherapy (GPGP) as a specialized area by the American Psychological Association in 2018. This recognition not only underscores the therapeutic efficacy but also acknowledges the profound social significance of group therapy, positioning it as a valuable tool in addressing various clinical needs while fostering communal well-being (Rosendahl et al., 2021; Whittingham et al., 2021).

Neurobiological basis of “social brain”

The inherent human inclination toward social connection, often termed the ‘social brain,’ is deeply embedded within our biological framework. When we engage in group dynamics, specific brain regions orchestrate crucial roles. The prefrontal cortex governs our comprehension of social norms and facilitates adaptive interactions, while the amygdala processes emotional responses, exerting profound influence on our social experiences. Simultaneously, pivotal regions such as the Basal Nucleus of the Stria Terminalis (BNST) and the Temporoparietal Junction (TPJ) emerge

as critical players in this intricate neural network. These neural ensembles collectively sculpt social behaviors within groups, significantly influencing how individuals decode social cues, foster connections, and navigate the intricate tapestry of social interactions (Molenberghs, 2022).

Jaak Panksepp, known as the founder of affective neuroscience, pioneered research that showcased the existence of seven fundamental emotional circuits across species. These circuits, including Seeking, Fear, Anger, Lust, Care, Panic/Grief, and Play, are hardwired in the brains of humans, mammals, and even birds. They form the basis for recognizing emotions within ourselves and others. Each of these emotional circuits is linked to specific cues like facial expressions, vocalizations, body language, and physiological responses. These cues create a neural foundation that underlies our shared emotional experiences. This not only connects us deeply within humanity but also highlights our commonality with other species, revealing a fundamental connection among living beings. Bhurruth (2019) suggested that these circuits could serve as the basis for a foundation matrix, representing the collective experiences of our species, encompassing both conscious and unconscious aspects (Bhurruth, 2019).

How group therapy works

A therapeutic group setting offers a rich tapestry of healing factors: universality, hope, and a profound sense of acceptance. Beyond surface-level interactions, it facilitates the formation of a nuanced social canvas for each participant, reflecting their individual understanding of the world. Detailed personal histories gradually unfold within the group’s dynamic. As each member engages, their unique interpersonal style becomes evident through their exchanges within the collective.

In an environment where members can express themselves freely, the group becomes a vivid reflection of their individual journeys. Precise mutual feedback in therapeutic groups empowers each participant to recognize their role as the architect of their interpersonal world, understanding their capacity for transformation. The more emotionally authentic the experiences shared within the group, the deeper the impact; intellectualized learning, while valuable, may hold less immediate influence (Yalom & Leszcz, 2020).

Participants navigate transformative journeys by taking interpersonal risks and exploring interactions within the group setting. The behavioral transformations witnessed within the group extend beyond its confines, impacting the way individuals engage outside the group. This initiates an adaptive cycle, influencing interpersonal dynamics both within and beyond the group’s boundaries. Through this process, maladaptive patterns gradually diminish, fostering enhanced social connections, boosting self-assurance, and reducing the compulsion to conceal one’s true self (Yalom & Leszcz, 2020).

A small therapeutic group not only acts as a microcosm that vividly illuminates individual behaviors but also functions as a laboratory, offering profound insights into the intricacies and dynamics of personal conduct. Each member’s repeated interactions allow for introspection and understanding. However, for deeply rooted beliefs to evolve, members must consistently receive clear and constructive feedback.

Ultimately, the therapeutic group serves as a crucible for communal growth, where individuals not only evolve personally but also contribute to the collective journey. Through shared experiences and insights gained in this community-like setting, participants navigate their personal paths while contributing to the wider fabric of social connectivity and transformation (Pesic, 2023).

Group and traumatic events

Engaging in group work with trauma in homogeneous groups that have experienced an attack or loss offers a unique therapeutic approach. Homogeneous groups, where members share a common traumatic experience, provide a supportive environment for collective healing and understanding. This shared understanding fosters immediate empathy and connection among members, creating a space where individuals feel seen and heard. In this setting, diverse emotions experienced after a traumatic event are normalized, alleviating the sense of isolation often associated with such experiences. Through group discussions, participants realize that their reactions are part of a common response to trauma, reducing self-blame and promoting self-compassion.

One significant advantage of the homogeneous group dynamic is the opportunity to explore and develop collective coping strategies. Members can share techniques that have helped them navigate the aftermath of the trauma, offering a range of perspectives and tools to enhance individual resilience.

Homogeneous groups contribute to the formation of a supportive community, fostering a sense of belonging and understanding among members who have experienced a similar trauma. Through shared experiences and mutual support, homogeneous groups cultivate resilience and post-traumatic growth among participants. The group becomes a platform for not just coping with trauma but also for transforming adversity into opportunities for personal and collective development (Weinberg et al., 2005).

Social and group shaping the individual from the start

Socially, according to Elias, it does not lie outside the individual to be determined by external factors, but the individual crystallizes from the social, and at the same time, the individual also constantly constructs the social. Elias’s concept of figuration relates to the pattern of connecting individuals that form societies. Figuration is tied to the relationship between parts and represents the same thing as social structure but from the perspective of the “whole.” Metaphorically speaking, this means that we are all interconnected by a series of elastic bands, which Elias calls “interdependence.” The elastic bands do not imply that we are mere helpless pawns of, for example, economic and linguistic forces, but that there is a “constraint” on individuals by society on what they are allowed to do, be, and think. However, individuals also contribute to the construction of these cultural and social forces. Elias constantly strives not to reduce society to the individual nor to make individuals mere pawns of society (Elias N. 1991, Dalal, 1998).

Power dynamics

The key aspect Elias addresses, which Fuks does not consider at all, is power relations as the main characteristic of interdependence. Power

is a structural characteristic of all human relationships, and the presence of power is an inevitable outcome of shared living (this thesis is in contrast to the liberal ideal that it is possible to live together in a sea of equality). Whether power differentials are large or small, power balances are always present wherever there is functional interdependence among people.

Ideologies, as the ruling ideas of a group, enable group equilibrium by creating a dichotomy that the powerful are in their position because they are superior and have charisma (the very superiority of power leads to the activation of feelings of human superiority and a sense of personal merit), and the less powerful are inferior to them. Therefore, the powerful can stigmatize the powerless (the reverse process is not possible), and they easily accept this due to the experience of inferiority, which has not only surface effects but also changes the structure of the psyche at a deep level. In the need for a scapegoat to be punished, it is necessary to consider both the context and power differentials (Dalal, 1998)

Rejection in the society

Abraham Maslow's theory of human needs, famously portrayed in his “hierarchy of needs,” highlights the intrinsic human desire for acknowledgment and belonging. Within this hierarchy, the need for recognition from others is positioned just above the need for safety and security, indicating its profound significance in human psychology. This need seems to be intertwined with our fear of rejection, a potent emotional driver.

Childhood represents a crucial phase where the need for security and belonging is most acute, and caregivers play a pivotal role in fulfilling these needs. As individuals mature, societal structures take on the role of providing a sense of security and acceptance. However, these external sources often fall short of offering unconditional support, resembling more an “extended mother” or stepmother rather than the unwavering nurturing typically associated with maternal care.

Tragically, throughout history, especially in the 20th century in countries like China, Germany, and Russia, there have been distressing instances where individuals faced rejection or ostracism within dictatorial regimes, emphasizing the devastating impact of societal abandonment on individuals.

We live in a time of rapid changes within a society that simultaneously fosters both the multiplication and division of different groups. These divisions further amplify differences and disagreements. Undoubtedly, groups are places where problems arise, but they also serve as spaces where solutions can be found.

Median and Large Group: humanization of society

Group analysis represents both a theoretical and methodological system. While specialized in analyzing group processes within small therapeutic systems, the knowledge derived from relationship research can be applied to the study of larger group systems, such as organizations, ethnic groups, and even society as a whole. Practical experience has also shown the importance of considering a broader context beyond the personal, as resonance occurs between the individual, interpersonal, and social within groups. Small groups develop their own culture, allowing for intimacy and openness, while social and political events are explored only in terms of personal significance (Pisani, 2013).

The concept of the “Medium Group” was introduced by Patrick de Mare in the 1990s to connect individual intimate work in a small group with the socio-cultural aspects of an individual. According to him, the medium group is ideal for practicing dialogue and exchanging thoughts, with a lesser emphasis on the individual history of each person. This group consists of fifteen to thirty members sitting in a circle and able to face each other. The facilitator facilitates free-flowing discussion, focusing on understanding hatred arising from differences. Their role is to facilitate communication and the desire to establish relationships with other members. The group’s task is to create a new culture of meaning and significance, expanding social awareness of the different cultures represented by its diverse members. The dialogue among members serves as an exercise in “democracy in action,” a challenging process that Mare describes as learning a foreign language. This group is applied as a sociotherapeutic group outside hospital settings, in education, and at group therapy conferences (Pisani, 2013).

The “Large Group” comprises forty to eighty members (sometimes around a hundred or more) sitting in concentric circles and unable to

face each other. This group allows exploration of what does not emerge in small and medium groups. Authors highlight its potential for dealing with psychotic anxieties and its significance as a tool in training group analysts and psychoanalysts. The culture of the large group spreads through therapeutic communities and group analysis conferences. Thematically, issues arising in the large group are linked to authority, organization, power, and questions of identity—ethnic, gender, political, and religious. Participants question whether to speak, how much influence their words have on the group, and whether it is wise to engage in conflict (the dilemma of belonging to society and citizenship versus remaining invisible). The large group is not suitable for addressing personal painful points and may increase a sense of isolation. While not a specific form of psychotherapy, it provides containment and enhances the capacity to understand group dynamics. Its role primarily lies in understanding social interaction and the social unconscious, and harmonizing the society, while the role of the small group is more focused on the socialization of the individual (Lenn & Stefano, 2018).

Examples of implementation in Society

In this paper, we presented the possibilities that groups offer during times of change, and how contemporary group analysis can serve as custodians and nurturers of mental health, from the individual to society at large. There are many examples of the importance of groups for community development and the preservation and improvement of mental health.

Support groups played a pivotal role in working with traumatized children and parents following the events in May 2023. in Serbia. Initial experiences are positive, highlighting that the group format, aside from its broader reach, allows for easier monitoring of the traumatized. Utilizing the healing properties of the group, such as mutual support and the principle of helping oneself by helping others, proves beneficial. Additionally, the cohesive nature of the group enhances overall effectiveness.

As an example the importance of working with groups it could be mentioned that the workshop Reflective Citizens in Novi Sad was launched as activity of the Psycho-Social Section of the Group Analysis Society Belgrade starting in 2014 (Jevtic M, Flasar I, Mojovic M. 2019, Jevtic M 2019, Mojovic M et al, 2020).

. Workshops have been organized in continuum using different cultural spaces with the desire to inspire a lot of associations that encourage cultural dialogue and civic awareness for the time we live in (Jevtic M, Flasar N 2023, Jevtic M, Flasar N. 2022).

Workshops “Reflective Citizens in Novi Sad” has a role in the initiative for new bridges among citizens, migrate through cultural spaces twice a year and they have become not only small and strong citizen’s tradition, but also some cultural shelter space where sharing is safe with a lot of trust, and acceptance of diversity with a lot of respect. Furthermore, from these workshops a few applied reflective workshops were born, as a Reflective weekend: Reflection by drawing/painting, Reflection on Health, Reflective walk, Reflective Dance. The workshops brought together different genders, generations, opinions, nationalities, professions and built a bridge in the divided everyday life (Jevtic M, Mojovic M. 2017, DGAB 2022).

Conclusion remarks

Mental health is increasingly in the focus of interest, as societies, communities and organizations finally recognize the importance of mental health. However, the public health importance of mental health is still not sufficiently accompanied by interventions in the community. The results of strategic efforts and actions in the field of improving mental health in the community require time.

The right to health and the right to mental health is unquestionable. However, the realization of the right to mental health is a complex challenge and requires the activation of the community as a whole, in cooperation with health professionals and collaborators dedicated to mental health. Group analysis represents one of the solutions, one of the modalities in psychotherapy, which can occupy a significant place in the mosaic dedicated to mental health.

In our experience, utilizing group therapy as a cornerstone for societal treatment offers numerous benefits. The group, as a natural environment, fosters an in-depth understanding of group dynamics, assisting team members in effectively managing counter-transference feelings and enhancing communication. This approach allows for the treatment of a larger

number of individuals, minimizing the risk of burnout and compassion fatigue among professionals.

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MENTAL HEALTH IN THE “AGE” OF SOCIAL NETWORKS

Abstract: *Since ancient times, mental health has been considered one of the main characteristics of a person's health, as such, it has inclined towards constant protection through adequate legislation as well as through a simple and effective approach to health care. Numerous laws passed by the Republic of Serbia that specifically address health care, and therefore correspondingly mental health, will be discussed in greater detail in this paper in support of the aforementioned claim.*

The human psyche, as one of the crucial elements of human health, can be considered one of the most vulnerable parts of each one of us. It is often involuntarily affected and threatened by different external factors, or different segments of life, and were somewhat easy to control while they were exclusively “offline”. One of the things that has influenced mental health, and consequently the human psyche, over the last few decades, is the emergence of the Internet and, with it, social networks. The significant increase in the use of both computers and the Internet has led to the frequent “consumption” of social networks, which especially in the last few years, have almost taken control over all segments of human life and become the main ally in everyday life. The question that is often posed is are we really ready to live in the virtual world and what are our options for defense against the consequences that threaten our mental health? The phenomenon of excessive use of Internet space and communication, via social networks, can be one of the causes of many mental health issues, and often serious diseases, which unfortunately are not known or spoken about enough. Therefore, the goal of this paper will be based on an analysis and commentary of different perspectives of the relationship between the use of social networks and mental health, focusing on the most vulnerable users, i.e., juveniles and teenagers, from the psychological, legal, social and personal opinion of the author.

Keywords: *mental health, healthcare, social networks, Internet.*

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1. About mental health

We consider mental health a personal trait that represents a set of different psychological and sociological components, “woven” from unique factors, which as a whole form a set of traits significant for defining the psychological, mental and sociological profile of each individual. It is extremely important to emphasize that despite the fact that various factors influence the formation of the aforementioned groups, they can still be classified into two main groups, the predestined ones that are difficult, that is, impossible to influence as they are genetically assigned to us, and the ones that surround us and influence our mental health throughout our lives.

Mental health refers to certain abilities that establish balanced relationships between people, as well as the possibility of realizing personal potentials and the manner in which they can be applied. The concept of mental health can be defined as the ability to express our personality, determine and achieve life goals, experience and deal with stressful situations, as well as the way each of us, as an individual, contributes to the community (Vlajković, 1990). Thus, we can say that mental health represents a form of harmonizing intellectual and emotional intelligence, that is, the ability to reason, communicate and adapt to the world around us.

According to the definition of the World Health Organization (WHO), mental health refers to a state of emotional and psychological well-being in which an individual is able to use his cognitive and emotional abilities to perform his functions within society, to respond to daily life needs, to establish satisfactory and mature relationships with others, to constructively participate in changes in the environment, and to adapt to external conditions and internal conflicts (World Health organization, 2013:7). The increasingly fragile mental health of adolescents and juveniles represents a great challenge for the entire community. Mental health is one of UNICEF’s priorities, as confirmed by numerous studies performed by this organization. It is interesting to note that 21.9% of students in Serbia report feeling nervous at least once a week (UNICEF, 2021), which is a serious warning sign that should prompt us to react immediately.

A juvenile, from the age of 10 until the early 20s, “passes” through a period of accelerated personal development, meaning that during that period the psyche, *i.e.*, mental health, is more sensitive and vulnerable to external conditions, *i.e.*, life factors such as violence, family relations, economic situation, school system, *etc.* This is extremely important from the aspect of forming personal, emotional, social and family relationships, which in the last 10 years or so have become increasingly virtual, meaning that the main role in the lives of juveniles is played by the excessive use of telephone devices and social networks, that have a direct cause-and-effect relationship both on mental health and on the development of psychological-sociological abilities. The influence of social networks on the mental health of juveniles is evident. The author believes that the majority of people have an account on some social network and are active on it, to some extent. However, we can wonder what is the difference between a mature person starting to use social networks as an individual with an already developed psychological and social profile and a person who spent his/her childhood and youth with minimal or no access to social networks, and what is the impact of social media on new generations who, practically from the first moment of consciousness, have had some kind of access to social media.

Social networks are considered by many as a medium for presenting our ideal “self” (Jerončić Tomić, Mulić, Milišić Jadrić, 2020: 2650). These platforms tap into our need for belonging, admiration, respect, acceptance, and similar feelings of worth. However, the moment that the author considers to be a double-edged sword is precisely the possibility that the user can create an image of himself, which can often be the trigger of many mental issues to be discussed in greater detail further down in the paper. Namely, the significant increase in the use of both computers and the Internet has led to the frequent “consumption” of social networks, which, especially in the last few years, have almost taken control over all segments of a person’s life, becoming his main ally in everyday life. The question is often asked, are we truly ready to live in the virtual world and what are our options for defending ourselves against the consequences that threaten our mental health? The phenomenon of excessive use of Internet space and communication via social networks can be one of the causes of

many mental difficulties, and often serious diseases, which unfortunately are not known or spoken about enough. Therefore, this paper will be based on an analysis and commentary of different perspectives of the relationship between the use of social networks and mental health, from the psychological, sociological, legal aspects, as well as the author’s personal opinion.

Psychological aspect

The human psyche, as one of the crucial elements of human health, can be considered one of the most vulnerable parts of each of us and is often involuntarily affected and threatened by various external factors or various life circumstances that were somewhat easy to control while they were exclusively “offline”. However, what happens now that a good percentage of our activities have moved to an online model?

Having said that, the advantages of social networks from a psychological point of view, reflected in easier communication, especially for introverts, are not negligible either. The speed and financial segment of communication play a relevant role, especially when maintaining long-distance relationships. In addition, many have met their partners, reestablished family ties, attended educational and informative content, precisely through social networks. Without neglecting the above, the author would place greater emphasis on the negative sides of frequent, and especially excessive, use of social networks, as the author believes that these are very grave and warrant attention.

This paper would like to single out the concept of depression as, perhaps, the most important challenge that juveniles face, because it arises as a consequence of various previous “silent” disorders often ignored by juveniles, its specificity being in that it has the ability to cause additional diseases that can have a negative impact on the general physical and mental health of an individual.

The term Facebook depression was introduced by the American Academy of Pediatrics to describe the impact of social networks on the mental health of juveniles, with depression considered a consequence of spending a lot of time on social networks. There is an interesting study conducted in six European countries, involving almost 11,000 adolescents, which showed the connection between frequent use of social networks and

depression. However, opposed to this, literature stresses that, apart from this research, other studies have not found a significant relationship between depression and the use of social networks (Bigglebauer, Korajlija, 2020: 410-411; Lin, et. al, 2016).

As an example, we single out juveniles with a lower level of self-esteem and self-confidence who try to make up for it through so called likes, positive comments, and a large number of “online” friendships. Some would say that this is not a negative as that “like” makes the individual experience satisfaction, however this begs the question as to whether this resolves the core of the problem or whether it has simply covered up and deepened the issue.

Numerous studies (Antheunis, Schouten, Krahmer, 2016; Shensa et. al. 2018) have proven that this kind of behavior leads to the deepening of an issue and, often, to the development of conditions such as depression, non-acceptance, sadness, and the like. This is especially pronounced among juveniles who do not know, or are not ready, to deal with negative comments, with the fact that someone does not “like” their content or, more importantly, is not aware that emotions and “likes” sent online are not real.

The concept of peer violence, which targets people with sensitive mental health, is also common. At this time, we wish to address the case of Mladen Dulić from Laktaši, who committed suicide precisely because he was subject to ridicule on social networks. The tragic example of this young man is a clear indication of how seemingly “unimportant” things, inappropriate insults, and mockery, be they malicious or “simply” reckless, can have serious consequences on health, and even life, depending on who they are directed at from the other side of the “screen”.

It also happens that people, without predetermined ailments, can develop health problems precisely because they are victims of some form of violence on social portals. The author would like to single out narcissistic disorder as another problem for juveniles on social networks. This severe form of personality disorder, although completely different from the previous one, makes the life and functioning of a person extremely difficult, and can also lead to a model of behavior where a person, for the sake of perfect presentation and self-admiration, can often publish, false, that is,

untrue content, on his social account. This form of behavior leads to another medical problem, which is the creation of a so-called false reality, which leads to a state of anxiety.

Munjiža, Kostić and Košutić (2019) conducted research on 80 subjects treated in the day hospital for adolescents of the Institute for Mental Health. An interesting fact is that 67.5% of respondents were female with an average age of 19, and 78.8% of respondents lived in urban areas. Of the total number of respondents, 90% used social networks, *i.e.*, Facebook or Instagram. A very large percentage of them, 60%, had some form of depressive symptoms. As concerns anxiety, only 22 out of 80 did not have any symptoms of anxiety. When we delve into these numbers and when we consider the fact that these are teenagers, we realize the gravity of the situation.

Sociological aspect

In addition to data confirming that the use of social networks improves interconnectedness, there is also contrary data based on the claims that the use of these networks is closely related to social isolation and loneliness. Therefore, we pose the question, which is the subject of eternal debate: do lonely people use social networks more often or do people generally become lonely as a result of using social networks (S. Milošević, D. Milošević, 2022: 31). I often point out that the number of juveniles on social networks is rising and they show increased antisocial behavior. Frequent communication, and so called hanging out on social networks, leads to distancing between people and their closing in on themselves. This also makes juveniles, often, unaware of the real world, the passing of time and the difference between what is important and what is not. As an example, we wish to cite a situation that many have probably encountered, or witnessed, for themselves, the social moment of having a coffee in a coffee shop. A group of juveniles sitting at the same table, in a coffee shop, each one with a phone on their hand. We also wish to single out the more frequent issue within families where children are often in their rooms, on social networks, or worse, sitting in the same room with their parents, with minimal communication between them. A most fascinating occurrence, which is increasingly common among juveniles, is a situation in which

people sit in the same room, not speaking to one another but exchanging content on social networks with each other.

Juveniles, as already mentioned, are a very vulnerable group. There is a fear expressed among the young users of social networks known as FOMO (fear of missing out) (Bigglebauer, Korajlija, 2020: 416). An example of the aforementioned is the concept of recording and publishing content from certain events, while the users are still at that particular event. This kind of behavior indicates that a large number of juveniles are essentially not present and enjoying a subject moment, as well as the realization that, today, if something has not been published and shared online, with a wider group of followers, then it is as if it has not happened at all.

Legal aspect

Article 23 of the Constitution of the Republic of Serbia stipulates that human dignity is inviolable and that everyone is obliged to respect and protect it, as well as that everyone has the right to free personal development, if this does not violate the rights of others guaranteed by the Constitution. This constitutional guarantee also ensures the protection of persons with mental disorders. However, the question can be raised as to whether people with mental disorders really enjoy adequate legal (normative) protection? The answer to this question will be proposed by an analysis of relevant legal, by-law and strategic acts that regulate the matter of mental health in our country.

The Law on the Protection of Persons with Mental Disabilities regulates in detail the basic principles, organization and implementation of mental health protection, method and procedure, organization, and treatment conditions, as well as confinement without the consent of persons with mental disabilities, in inpatient and other health institutions (Article 1). A person with mental disorders, in terms of this Law, is “a person with insufficient mental development, a person with mental health disorders, or a person suffering from an addiction” (Article 2, Paragraph 1, Item 1). The legislator foresees that persons with mental disorders are entitled to protection and improvement of mental health through prevention, care, treatment and psychosocial rehabilitation in adequate health and other institu-

tions, recovery and inclusion in the family, work, and the social environment, while respecting their choice (Article 7 of the Law on the Protection of Persons with Mental Disorders). On the other hand, Article 20 of the Law on the Protection of Persons with Mental Disorders, defines consent to hospital treatment, while Paragraph 4 foresees that a person with a mental disorder, who is not capable of giving consent, can be placed in a psychiatric institution upon request and with the written consent of an immediate family member or legal representative. It can be concluded, from the mentioned provision, that it is not a matter of voluntary placement of persons with mental disorders in a psychiatric institution. For this reason, we are of the opinion that it is necessary to modify this attitude making voluntary admission to a psychiatric institution truly possible.

When it comes to the development of mental health centers, the legislator prescribed under Article 12 that psychiatric institutions and health centers would form separate organizational units that would provide community-based mental health protection, as well as that the types and prerequisites for the establishment of these units would be prescribed by the minister with a by-law. This was defined and achieved in 2013 with the adoption of the Rulebook on the type and detailed conditions for the establishment of organizational units and providing for community-based mental health. The aforementioned Rulebook regulates the types and specific conditions in terms of space, equipment, and personnel for the establishment of organizational units and providing for community-based mental health (Article 1). The Rulebook specifies that by establishing and organizing a mental health center within a community, higher quality mental health care will be achieved, a variety of services will be made available to as many people as possible, and all with the aim of making these services as efficient and acceptable as possible to people with mental health issues. The aforementioned can be achieved through various daily services that can be organized as day centers for people with mental disorders, day centers for the elderly, and which completes the system of services and increases mental health protection services, shelter houses or apartments, associations of service users, *etc.* (Article 6). However, according to Brkić, mental health centers were not systematically established until 2018. At

that time, there were only three organizational units in the Republic of Serbia, namely in Niš, Kikinda and Vršac (Brkić, 2018: 57-58). We can say that the situation in this field is improving very slowly as illustrated by the fact that only two mental health centers have been opened, one in 2023 in Pančevo (RTV, Opened Center for Mental Health in Pančevo), and the other reopened in 2022 in Belgrade (Ministry of Health). In this sense, the Program on mental health protection in the Republic of Serbia for the 2019-2026 period, among the numerous shortcomings of the current organization of mental health protection, cites the absence of mental health protection centers in the local community and other non-stationary psychiatric services such as, *e.g.*, services for child and adolescent psychiatry, for early intervention in psychiatry, *etc.*, as one of the shortcomings, which means that these centers have not yet been systematically established.

The Law on Health Care, under a provision of Article 65, Paragraph 1, Item 11, foresees that health care, at the primary level, includes mental health care. The aforementioned provision provides a basis for the development of primary health care level activities, in the field of mental health. According to Sjenčić, “until primary health care takes over the function of one of the leading subjects of care in the community, it is necessary to assess human capacities, the possibilities of their education and changes in the attitude and activities of PHC in relation to persons with mental disorders, *i.e.*, after the decision on the model of care in the community, to undertake, in practice, preparatory actions that already have a legal basis in the Law on Health Care”, (Sjenčić, 2021: 57). When it comes to the right to health care, according to the provision of Article 3 of the aforementioned Law, “a citizen, as well as a foreign citizen and a stateless person who is permanently resident or resides permanently in the Republic of Serbia, has the right to health care, in accordance with the law, and the duty to protect and improve his and other citizens’ health, as well as the conditions of the living and working environment.” In addition, “a person who passes through the territory of the Republic of Serbia has the right to emergency medical assistance, in accordance with the law.”

It is relevant to state that in 2007 the Government of the Republic of Serbia adopted the Strategy for the Development of Mental Health Care,

which stated that, “mental health services should provide modern, comprehensive treatment that includes a bio-psycho-social approach, and which should take place in the community, as close as possible to the family of the sick individual.” The primary goal of this Strategy is to improve the mental health of persons with impaired mental health through the development of personal skills and empowerment by the environment, *i.e.*, people from the community. Although this document states precise action plans containing specific areas of action, goals, carriers, and even the time limits within which certain activities were supposed to be implemented, this did not happen.

The Law on Patients’ Rights regulates, “the rights of patients when using health care, the way of exercising and protecting those rights, as well as other issues related to the rights and duties of patients” (Article 1). When it comes to persons with mental disorders, an important role is played by Article 19 of the Law on Patients’ Rights, which stipulates that the relevant healthcare worker, *i.e.*, the healthcare associate, has the duty to enable a child, *i.e.*, a patient who is deprived of legal capacity, to be involved in making a decision on consent to a proposed medical measure, in accordance with his maturity and capacity for judgment.

In 2011, the legislator in the Republic of Serbia passed the Law on Social Protection, which regulates the activity of social protection, goals and principles, rights and services of social protection, procedures for the exercise of rights and use of social protection services, rights and obligations of users, establishment and operation of social protection institutions, conditions under which social protection services can be provided by other forms of organization, supervision over the work of social protection institutions, *etc.* Articles 46-56 are important, in terms of mental health, as they regulate and explain the types of services provided by this Law. The provision of Article 57 provided the basis for the adoption of a by-law that would regulate, in greater detail, the conditions and standards for the implementation and provision of social protection, which was done in 2013 with the adoption of the Rulebook on closer conditions and standards for the provision of social protection services. The aforementioned Rulebook

stipulates that one of the target groups of so-called respite accommodation,² are also children and juveniles up to the age of 26 with intellectual and mental difficulties or difficulties in psychological functioning. The purpose of this accommodation is to provide short-term and occasional care for children and juveniles with certain difficulties. This Rulebook precisely defines the accommodation for these beneficiaries, their nutrition, hygiene, as well as a detailed description of the personnel who should take care of children and juveniles. What is definitely missing is the practical implementation of almost everything contained in both this Rulebook and in other laws concerning the care of mentally unstable juveniles.

Author's opinion

Taking into account the above, the author believes that the principle of managing mental hygiene is crucial in the constant battle of mental health and social networks. In support of this, there are many studies that have shown that people who are genetically predisposed or predestined to develop some psychological weakness, often manage to successfully resist this challenge because they lead an orderly social life, pay a certain amount of attention to the correct way of eating, interpreting life, as well as moderately using and being exposed to technological devices, Internet platforms and social networks. Man, as such, is naturally taught, throughout life, and ready to deal with the dangers and risks that the real world carries for his physical and mental health, but he is still not aware of the dangers nor has he been sufficiently “trained” to recognize the risks that the virtual environment, in particular social networks, carry. We often encounter situations where people, especially at a younger age, easily surrender to the charms of the Internet, indulging in excessive consumption or use of social networks and thereby causing serious difficulties for themselves, both in terms of mental and physical health.

The author wishes to point out that not every person who visits and has social network accounts, follows other people's content, or is engaged

² Respite accommodation means accommodation service for no longer than 45 days during a calendar year, with the fact that it can last no more than 20 days continuously. (Article 27 of the Rulebook).

in activities closely related to the publication of content (YouTubers, bloggers, TikTokers,...) is potentially at risk for mental health. Some people simply develop a temporary or permanent addiction to social networks, which does not have to be connected, nor a trigger, for the development of some other psychological (mental problems, difficulties) issues. We also wish to emphasize that, in many cases, dependence on social networks never occurs. However, we wish to leave the opened discussion for another, equally interesting, opportunity and the topic of another paper.

We consider the sociological aspect to be closely related to the psychological one and it can be said that the social life of juveniles, who develop some kind of the aforementioned psychological conditions, often collapses. On the other hand, these two concepts can be completely separated, *i.e.*, persons who do not have developed psychological disorders or do not have a sensitive psychological profile may still experience or develop some form of social regression.

The modern way of life and the challenges it brings can also lead to various harmful outcomes such as alcohol and drug abuse, low self-esteem, health issues, self-harm and suicide. Impaired mental health has a negative impact on the life of adolescents and can lead to social exclusion, violation of their human rights and the inability to fit into society, earn a living and realize their potential.

The author is of the opinion that balance, that is, the harmonization of virtual and real life must become central, or a key, of social focus. Accordingly, we propose that the constant promotion of “working” on strengthening mental health, providing advisory assistance and support to the vulnerable, is crucial. We emphasize the need to establish so called schools, *i.e.*, educational centers, that would deal with various types of training and information on the harmful effects of excessive use of social networks, all with the aim of addressing the users, as well as their parents-guardians, teachers, *etc.* This type of training would promote the development of social skills, “healthy” interaction between individuals and the development of sportsmanship, all with the aim of improving and preserving the general mental health of each one of us. The strategy behind this idea is precisely the need to create a preventive approach to this contemporary issue, and it appears that the currently offered options are mainly based on

solving existing issues and not on preventing them from appearing. Accordingly, we firmly believe that the legislator is the key and has an indispensable role in this matter. With this, we wish to point out that the support of the legislator already exists, but that it should be expanded in the form of designing projects and practical support for its implementation.

Conclusion

In accordance with all of the above, we wish to point out that the goal of this paper is not to diminish or ignore the already mentioned advantages of technology, the Internet and social networks, but to point out to users of the same, especially juveniles, the consequences of excessive living in the virtual space and how important moderation is to everything we do. We believe that society, as such, accepts innovations lightly, without thinking about the challenges they bring, as well as that the need for transparency to the dangers of excessive use of social networks is constantly present. Information about the harmful consequences of this phenomenon must be applied both to potential and current users, as well as to their environment.

Concrete measures in the form of more precise and applicable laws, more precise introduction of stricter and controlled permissions for accessing social networks, as well as checks of accounts and their users, are necessary in order to prevent harmful consequences caused by their excessive use. On the other hand, it is necessary to take into account the right to privacy and the protection of personal data, especially when it comes to people of a sensitive age, more precisely teenagers, because it is often difficult to determine whether the rights guaranteed by law are to their detriment or benefit.

By analyzing the legal framework concerning the protection of mental health in the Republic of Serbia, we come to the conclusion that the legislation contains a series of legal and by-laws that regulate this field. However, we can say that there is a certain gap between the norm and practice and in order to reduce it, more precise strategic determinations are necessary, as is a greater degree of advocacy for the protection of mental health. We believe that special attention should be paid to the mental health of juveniles, which is damaged by the influence of social networks, and as

we have previously pointed out, the “key” to success in this fight lies, precisely, in prevention.

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THE MENTAL HEALTH OF CHILDREN AND PARENTS IN THE PROCESS OF DIVORCE IN SERBIA AND SLOVAKIA

Abstract: *In the second part of the 20th century, under the influence of the shift in the labor market, globalization and heightened awareness of human rights and freedom, came a rise in divorce rate across the European Union and its candidate countries. A change in lifestyle, a greater involvement of both parents in both family and work obligations, as well as the emancipation of women and men, meant that there was significantly greater need for both parents to be involved in the lives of their children after divorce. With both parents further influenced by the patriarchy on the one hand, and feminism on the other, conflict over assuming parental rights over the child/children became increasingly common, often escalating into a highly contentious divorce. The negative attitude of one or both parents has the greatest impact on the child/children, who are also often abused in this process. However, due to various behavioral factors of both the dominant parent - the predator, and the improper actions of the social-legal child welfare system, abuse also occurs towards the other - targeted parent. The triangle of violence forms the basis for concern about mental health, extending beyond just the immediate family, because the consequences of contentious and highly contentious divorce are reflected on both the extended family and society as a whole. The reduction in the consequences of this phenomenon has been observed in certain parts of the world, and the solution lies in the equal participation of both parents in the lives of children, even after divorce, as a mandatory legal model.*

Keywords: *alienation, powerlessness, misuse, inaction, abuse.*

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INTRODUCTION

Insight into the existing state of marriages and their divorce, specifically relating to the question of children from those marriages and their involvement in the proceedings, the rulings of the court with the involvement of social welfare systems in Slovakia and Serbia, provides the grounds for addressing the mental health of children and parents in divorce proceedings and improving the situation for all parties involved in this important life event.

The primary issue addressed in this paper is the phenomenon of child alienation - a mental state in which a child, usually one whose parents are involved in a highly contentious divorce, forms an alliance with the alienating parent and refuses a relationship with the other parent for no justified reason. In that sense, the following questions are considered: the definition of alienation as a form of emotional abuse; alienation strategies; children's reactions and the consequences of alienation on their emotional, mental and social development; as well as recommendations of preventative action in protecting this invisible vulnerable group of children of divorce.

Divorce of the parents exposes children to one of the most stressful life situations which can significantly influence their further developmental course. The expert foresight from the 1990s that states that “half of all marriages will end in divorce” (Bel and Hochman, 1991) is still applicable in the present times. Statistics show that every third marriage in Serbia and Slovakia ends in divorce, and that every third divorce reaches a high degree of conflict between the former partners. Previous research has emphasized the numerous negative effects parental separation has on child development. However, today, research and clinical practices clearly indicate the authenticity of the saying that “a good divorce is better than a bad marriage”. That is to say, that parental conflict has a greater impact on children than the divorce itself (Buljan Flander and Roje Đapić, 2020).

CUSTODY STATUS OF MINOR CHILDREN AFTER DIVORCE/ SEPARATION IN SLOVAKIA

A family should provide each of its members with a sense of security, protection, love, and unity. A functional family is capable of fulfilling all of its roles and resolving minor issues independently, with the support of its members. However, in modern times, many families in Slovakia, as well as elsewhere, experience frequent conflicts driven by anger and aggression. There is a lack of support, acceptance, and kindness towards children, which significantly affects the mental health of everyone involved and disrupts the balance of daily life activities.

In Slovakia (with a population of 5,447 millions of inhabitants), the trend of marrying to fulfill traditional family roles is still prevalent. However, there is a noticeable increase in cohabitation, which represents a new trend in partner relationships. Available statistics indicate that between 2020-2022 the number of marriages has increased, while the number of divorces has slightly decreased (table 1).

Table 1. Marriage and divorce rates in Slovakia between 2020-2022

	2020	2021	2022
Number of marriages	23 753	26 350	29 172
Number of divorces	8 295	8 131	8 180
For every 100 consummated	29.8	29.4	28

Source: Statistical Office of the Slovak Republic, 2023

Other data from the Statistical Office shows that almost 60% of divorce was filed by couples with minor children, and that the majority of divorced families had one child. Out of the total number of divorces in 2022, some of the marriages have lasted for over 20 years. Some of the primary reasons, given by 5,457 couples who went thru divorce, were differences in personalities, opinions, and interests. Infidelity and alcohol abuse were also common reasons mentioned.

Separation or divorce is difficult for adults to endure, but even more for their children. Children are often involved in the conflict between

their parents. They experience sadness from one parent leaving, often unexpectedly. Children carry scars from divorce into adulthood.

In the time leading up to the divorce, a child can experience a wide range of psychological troubles, which are reflected through their behavior and are difficult for them to deal with. Parents need to realize they are the ones divorcing or separating from one another, but the child is never divorced from their parents. In Slovakia, there is wide debate on contact and communication between the ex-spouses with the goal of raising their children together. Though some are able to find common ground, around a third of divorced couples fail to establish communication even after years of separation. This leads to many complications, bearing on the emotional state of adults, but to even more so on their children.

In Slovakia, the exercise of parental rights and responsibilities is governed by Law No. 36/2005 ‘Family Law’ (Family Act). Only the court can restrict or terminate these rights. Like in other European countries, Slovakia has adopted the institution of shared parental care of minor children by both parents (joint exercise of parental rights), providing that both parents have expressed a desire for such care. This respects the child’s right to maintain relationships with both parents, the right to education and care from both parents, the right to maintain regular, equally distributed, and equal personal contact with both parents. The best interests of the minor child are always taken into account.

Table 2 describes the status of parental rights exercise after divorce for the years 2020-2022 for the entire Slovak Republic.

Table 2. Court rulings regarding custody of minor children after divorce for the years 2020-2022.

The number of final rulings and children entrusted to parents for care	2020	2021	2022
To the Mother	5 455	5 391	5 361
To the Father	741	817	762
Joint exercise of parental rights (JEPR) awarded	809	863	815
Mutual agreement on JEPR	715	769	741

Source: Central Office for Labor, Social Affairs, and Family of the Slovak Republic, 2023

In Table 3, we present the percentage ratio derived from Table 2 on the allocation of the exercise of parental rights in Slovakia.

Table 3. The distribution of parental rights

	2020	2021	2022
The Mother	70,7%	68,8%	69,8%
The Father	9,6%	10,4%	9,9%
Jointly on both grounds	19,7%	20,8%	20,3%

This information is relevant for further comparison between Slovakia and Serbia.

In practice, however, it is often observed that one parent starts using the child/children to establish communication with the other parent. This causes extreme stress to children, which they cannot handle. They often become the mediators between the parents or a source of emotional support to the parent needs. In this way, the child exudes more strength than they naturally possess during developmental years, and in turn, this can lead to depression, anxiety, and even addiction in adulthood. Adults need to realize that children are not therapists. It is important that they acknowledge the fact that children have a sensitive perception of both of their parents and it is important that they can freely express their emotions and love towards both parents. A child does not want to feel guilt for loving both of their parents.

The stress a child experiences when their parents separate manifests itself in children acting younger than they actually are, experiencing frequent mood swings, displaying aggressive behavior towards those around them or towards one of the parents, they start manipulating the people around them, and experience a sense of sadness they cannot endure. In somatic terms, they begin to experience trouble with sleeping and eating, which can lead to more frequent morbidity. Academic achievements decline, and conflict with peers and teachers becomes more frequent. Psychologically, it manifests into irrational fears and compulsive behaviors.

The unjustified rejection of a parent after divorce or separation is defined as a problem in the parent-child relationship. The phenomenon of

the rejected parent syndrome is well defined in academic literature, observed by author Jedlička (In: Gradičak, 2020), who describes it as a form of psychological child abuse under the CAN (Child Abuse and Neglect) syndrome. The behavior is characterized by the child being triggered and manipulated by one parent to the point of them actively developing their own dynamic towards the other (alienated) parent, ultimately leading to complete rejection. From the perspective of potential criminal liability, according to legal experts, it is appropriate to consider the possibility of fulfilling the factual essence of the criminal offense of abuse of a close person and a person of trust (§208, paragraph 1 of the Criminal Code of the Slovak Republic).

The topic of conflict situations and violence in relation to family transformation after divorce or separation between spouses and parents is very complex and has an interdisciplinary nature. Meta-analytic studies show the strong relation between childhood trauma and later psychopathological development in adolescence and adulthood, including anxiety disorders. The most important thing is to create a safe and supportive environment for children, so that they can have a healthy upbringing despite the divorce of their parents.

STATUS OF PARENTAL RIGHTS EXERCISE OVER MINOR CHILDREN AFTER DIVORCE/SEPARATION IN SERBIA

Serbia, with its established family and traditional, and especially patriarchal values, presented an image of a strong community in public. The family, as the most important segment of society, served as the foundation for the development of each individual. Until recently, family matters were considered personal, and any deviation was disguised and concealed. With the onset of the industrial revolution in the early 20th century and the emergence of the second wave of feminism in the 1960s, the family itself began to change. The role of women in providing financial support to the family, instead of just through household chores, established new grounds for families, making them solid, stable, and financially stronger. With the emergence of the third wave of feminism in the 1990s, the role of the family changed drastically, not just in Serbia, but also elsewhere. At

that time, liberal single-parent families, children born out of wedlock, and children with an unacknowledged father became increasingly common.

In Serbia (with a population of 6,641 million of inhabitants), similarly to Slovakia, the tradition of marrying still remains important in society. The table 4 shows a lower number of marriages and divorces in 2020, as they were being postponed due to the pandemic of the SARS-CoV-2 virus. Statistics from 2021 and 2022 show a trend, observed in prior statistics as well, in stagnation in both marriages and divorces.

Table 4. Marriage and divorce rates in Serbia 2020-2022

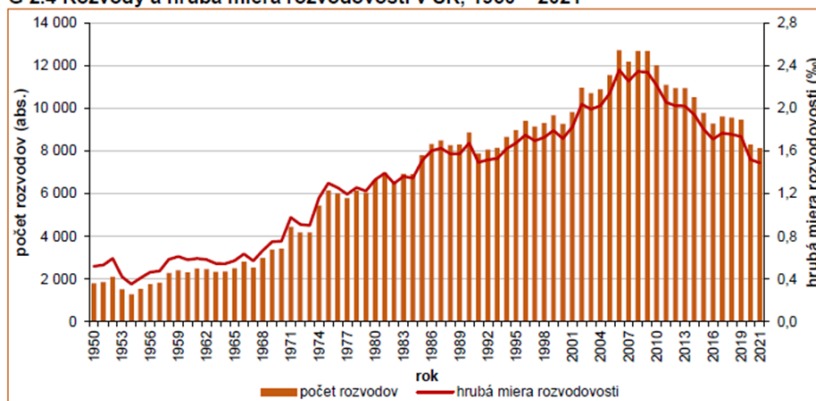
	2020	2021	2022
Number of marriages	23 599	32 757	32 821
Number of divorces	8 687	9 790	9 813
For every 100 consummated	36,8	29,9	29,9

Source: Statistical Office of the Republic of Serbia, 2023

Slovakia joined the EU in 2004 and the number of divorces suddenly increased, which is displayed in the following diagram.

Table 5. The diagram of divorce in Slovakia from 1950 to 2021

G 2.4 Rozvody a hrubá miera rozvodovosti v SR, 1950 – 2021



Zdroj údajov: ŠÚ SR

Source: Statistical Office of the Slovak Republic, 2021

Based on the researchers in Slovakia, the sudden increase in divorce rates can be explained by the huge migration of Slovak citizens to

western European countries. Since Serbia is a EU candidate, the same trend is expected to occur when Serbia joins the EU. From a scientific perspective, an important piece of information is that divorce rates have reached a peak in 2010, and have since then decreased.

The trends of child misuse in divorce, as described in Slovakia, are equivalent to those in Serbia. In addition to the rise in divorce rates, there has been a sudden rise in reports of domestic violence recorded within the social welfare system. The number of final rulings on reports and court decisions is a clear indicator of the imbalance and suspicion of the abuse of the phenomenon of domestic violence for the purpose of gaining an advantage in family proceedings.

In Serbia, 38,896 cases of family abuse have been filed to the National Institute for Social Protection in 2020. According to the Autonomous Women's Center, emergency police measures were issued in 21,137 cases. According to the Statistical Office of the Republic of Serbia, 5,531 criminal proceedings were initiated, and 2,179 indictments were filed. A total of 2,021 individuals were convicted (5.19%), of which 676 were sentenced to prison, accounting for 1.74% of the total reported violence. Comparing the number of imposed measures and convictions, we conclude that in 2022, police measures served their purpose in 9.56% of cases involving domestic violence offenses. We cannot determine their preventive purpose, but the data on the remaining 90.44% of imposed measures suggests that they were issued in a large number of cases and extremely strictly, raising doubts about their justification. Taking into account numerous international studies indicating the misuse of domestic violence reports, such statistical data in Serbia can confirm suspicions of abuse and unfounded reporting of violence aimed at benefiting one party to the detriment of all other family members, especially children. The misuse of reporting violence represents a direct attack on the child, thus constituting emotional abuse of the child, which remains invisible to the systems of social and legal protection.

Considering the fact that the number of highly contentious divorces in Serbia has exceeded 1/3 of all divorces, with the most common source of conflict being related to child custody and parental rights, the following data is significant for understanding the issues of mental health

of children and parents in divorce. In Serbia, records of the number of children and the allocation of parental rights after their parents' divorce have only been kept since 2021.

Table 6. Court decisions on the exercise of parental rights over minor children after divorce for the years 2021-2022 in Serbia

Number of final rulings and children entrusted to parents for care	2021	2022
Total	5 187	5 151
To the Mother	3 600	3 495
To the Father	620	595
Joint exercise of parental rights	938	1028
Other	29	33

Source: National Institute for Social Protection

In Table 7, we present the percentage ratio derived from Table 6 on the allocation of the exercise of parental rights in Serbia

Table 7. The distribution of parental rights.

	2021	2022
The Mother	69,4%	67,85%
The Father	11,98%	11,55%
Joint exercise of parental rights	18,08%	19,96%

In legal terms, according to Family law, parental law consists of just one parental right - the right to have children, the remaining rights are child rights. One of these rights is the involvement of both parents in the child's life. The child's stability is at greatest with the presence of both parents in their life, simultaneously or separately. In giving parental rights to one parent, the child loses stability and needs time to reestablish it. When considering the aforementioned data that 1/3 of divorces is highly contentious, involving a battle for parental rights that turns into denying a child its rights, then we can conclude that the allocation of these rights is, in fact, an allocation of power in the conflict between two parties. Taking away power, through the model of joint exercise of parental rights, various risks are lowered: child abuse, partner violence, trauma, and suicide, which numerous global research suggests. The model of joint exercise of parental

rights in Serbia, regulated by the Family Law from 2005, envisages the consent of the parent to allow the other parent to jointly exercise that role, which represents a misinterpretation of European laws and recommendations. In the EU, and therefore in Slovakia as well, a parent declares whether they themselves wish to participate in joint exercise of parental rights, without denying the other parent of the opportunity to participate. This is shown in Table 2, regarding court rulings in Slovakia on the allocation of parental rights, there are two types of rulings made: those awarded and those who mutually agreed to the joint exercise of parental rights.

In the social welfare system in Serbia, it is suggested that parents may consider this option, but the model of joint exercise of parental rights is not recommended by the court, as it is dismissed due to the interpretation mentioned above. Occasionally, good practice is applied where, when one parent does not want the other to exercise parental rights jointly, the social welfare system assesses that parent as less suitable because they do not consider the best interest of the child, and in turn, gives greater support to the other parent, which accepts joint parenting. Examples of this good practice show that children from those kinds of divorces have both parents, thanks to the decision of the conscious parent, and show signs of overcoming their parent's divorce easier. In these cases, parents are compelled to cooperate, reduce and eventually eliminate conflicts.

Insight into the data from 2013, when the percentage of joint exercise of parental rights in Serbia was less than 4%, the rise to 19.96% in 2022 shows significant progress in terms of the best interest of the child to have both parents. The high discrepancy between the genders assigned custody (85.45-14.55) is still a concern, but what is even more concerning is that in 2022, 4,090 children were assigned to only one parent, meaning they completely lost the support of the other parent.

The conclusion of all experts from around the world, including Slovakia and Serbia, that joint exercise of parental rights is not possible if there is actual domestic violence by either parent, cannot be overlooked. In such cases, it is justified to protect the child and separate them from the violent parent.

By entrusting parental rights, the legal system, along with the social welfare system, grants power to one parent, whereas by entrusting them for joint exercise, the systems share responsibility between parents, which is in the best interest of the child and serves as a protective factor for the mental health of both the child and the parents.

PROBLEM DEFINITION

According to the degree of conflict (Hetherington and Kelly, 2002), divorce is divided into: amicable divorce, divorce as a business deal and highly contentious divorce - in which partnership conflict does not cease and the child is in the middle of the conflict (Buljan Flander and Roje Đapić, 2020). Divorce can become highly contentious when the following occurs:

- marital partners are already separated;
- the child lives with one of the parents (most commonly the mother);
- both partners persist in the exhausting and long-lasting legal battle for custody assignment and determination of personal contacts between the child and the non-residential parent;
- the child is involved in the high-intensity conflict - exposed to difficult situations both emotionally, mentally and in terms of upbringing.

An important distinction of this kind of divorce is that the parents fail to separate the partnership (personal) conflict from the interests of the child, so, instead of divorcing in a friendly (peaceful) manner and creating a psycho-pedagogically adequate parental relationship after the divorce, they prolong the conflicts, losing sight of the child's needs.

With the growing frequency of divorce in which children are involved, a destructive parental behavioral pattern has surfaced, as well as a new phenomenon and type of emotional abuse, which is yet to be recognized sufficiently in both expert circles and the wider public, making this a vulnerable and invisible group of children and parents in divorce. The child psychiatrist and professor at Columbia University, Dr Richard A.

Gardner (1985), was among the first to recognize the phenomenon of one parent alienating the child from the other parent, by evoking an irrational hatred towards them in the child. He listed this behavior under the term “Parental Alienation Syndrome” or PAS.

There is terminological diversity of this phenomenon in academic literature and practice, including: alienation syndrome, parental alienation, disruption of attachment relationships, and, most commonly today, the phenomenon of alienation. In this paper, the term alienation will be used, as well as alienating parent, alienated child, alienated parent.

Parental alienation is most commonly defined as a situation in which the parent the child lives with, consciously or unconsciously, through a series of verbal and non-verbal manipulation tactics influences the child - programs the child to change their (positive) perception of the other parent, so that they could alienate them from them and gain their side in the custody battle and setting a visitation schedule. When the child is manipulated in the aforementioned way, it becomes preoccupied with belittling and criticizing that parent in an unjustified and/or exaggerated manner. (Gardner 1989, Turkat 1995). Kopetski (1998) defines alienation as a form of psychosocial pathology in which a parent psychologically exploits the child and abuses the social system to achieve the alienation of the other parent. Žegarac (2015) defines “the alienation of the child from the parent most commonly implies that one parent “programs” the child to criticize and blacken the other parent”. Other authors discuss the disruption of the child’s attachment with one parent under the influence of the other parent (Childress, 2016).

There is a broad consensus among prominent experts and practitioners that programming parental behavior (both conscious and subconscious), in which one parent influences the child to unjustifiably reject the other parent and terminate a personal relationship with them, constitutes serious emotional abuse, with severe and wide-spread consequences on the child’s emotional, mental and social development (Turkat, 2002; Warshak, 2008; Kruk, 2016; Childress, 2016; Woodall i Woodall, 2017; Buljan Flander i Roje Đapić, 2020). Despite the evidence, a wide number of experts that work with children and families still do not recognize this occurrence as an abusive parental behavior, which leads to many alienated children

receiving no social welfare assistance. Moreover, the alienated parent likewise receives no social protection.

Karen Woodall (2017) uses the terms “psychological splitting” and “loss of developmental perspective” to explain the essence of alienation stating: *“Children who are trapped in the mirror of a personality disorder or confined within poorly adapted reactions of the parent with whom they spend most of their time are at risk of losing perspective and viewing the world only through an unhealthy lens of that parent. When this happens, children enter a process of alienation from the parent because their ability to empathize with others is diminished, and a fused dyadic arrogant rage emerges.”* Woodall further states that Richard Gardner himself wrote about the alliance of arrogant rage followed by various symptoms: *“In reality, all children who are in a state of mind referred to as splitting, characterized by deep love and loyalty to one parent and complete rejection and demonization of the other, have lost their sense of developmental perspective. It can be said that, for them, it is not a matter of distancing from the parent, but rather of alienation”* (Woodall, 2017).

Most of the definitions of this phenomenon clearly recognize: the conscious or subconscious behavior of one parent targeted towards the fundamental disruption of the relationship between the child and the other parent, which constitutes emotional abuse of the child and the other parent.

HOW PARENTS ALIENATE

What to laymans and some experts appears as an attachment between the child and the “chosen” parent is in actuality a symptomatic manifestation of alienating behavior by the alienating parent. Instead of encouraging the child’s independence and autonomy, alienating parents do the opposite. They try to strongly, symbiotically bind the child to themselves and gain their side in the battle against their former partner with the goal of alienating them from the child. Based on academic literature and field experience, aiming to highlight the broad manipulative diversity and, consequently, affectiveness, a longer list of behavior patterns used by alienating parents as alienation strategies includes:

- Excessive indulgence of the child to gain their favor;

- Disrupting the child’s personal contact with the other parent and members of their extended family (prohibitions, reduction of frequency and time spent together, conditioning, limitations, non-compliance with established schedules, prohibition of overnight stays with the other parent, etc.);
- Prohibiting and minimizing the vacations the child spends with the other parent;
- Prohibiting and limiting conversations over the phone (when the child and the parent do not live together, phone calls and other means of electronic communication are very important)
- Prohibiting the child from bringing their things to the other parent’s place;
- Convincing the child that the other parent abandoned them;
- Depriving the other parent from the opportunity to participate in the child’s everyday life activities (preschool, school, recreational and leisure, religious, etc.);
- Withholding important information about the child (health, education, etc.);
- Depriving the other parent of the opportunity to care for the child when the parent with whom the child lives is temporarily prevented from doing so (due to illness, etc.)
- Undermining the authority of the other parent (presenting negative and false information to the child and others);
- Refusing parental cooperation and communication with the former partner;
- Moving to another city or country in order to prevent or hinder the other parent’s contact with the child;
- Encouraging the child to be disobedient and disrespect the other parent;
- Sending a message to the child that they possess the same negative characteristics the alienated parent has (“you are the same as them...”)

- Expressing sadness and prolonged goodbyes when the child is visiting the other parent;
- Handing over the child with no verbal contact (as if the child were a thing);
- Various threats to the former partner in the presence of the child, some of which can be psychologically highly disturbing (“you’ll never see the child again”);
- Passively allowing other members of their family to alienate the child;
- Disregarding court rulings and authority of the court;
- Demanding the child takes care of the feelings and other needs of the residential parent (switching child-parent roles);
- Replacing the biological parent with a new partner (demanding the child calls them mom/dad);
- Exaggerating and overemphasizing even the most minute oversights of the other parent;
- Conditioning contact with the child on paying child support and buying things;
- Sharing inappropriate information with the child (financial problems, legal proceedings, marital disagreements, abuse children did not witness);
- Various false accusations of the other parent, including all types of abuse, especially allegations of child sexual abuse (as the most destructive means of alienating the child);
- Finally, the manipulative parent can contribute to the further alienation in a “neutral” way, by telling the child they should be the one to decide whether or not they will have contact with the other parent.

When successful, these behaviors can lead not only to the child resenting the other parent, but possibly not seeing them for years. As Cartwright put it “the goal of alienation is crystal clear: not only deny the other parent time with the child, but childhood itself” (Turkat, 1995). This is why it is important to recognize alienating behaviors, and especially important

to assess parental competencies and planning and taking measures to protect the child from abuse.

It is important to emphasize that in most cases, almost the entire primary responsibility in alienation is on the alienating parent (Buljan Flander and Roje Đapić).

THE BEHAVIORS AND REACTIONS OF CHILDREN EXPOSED TO ALIENATION IN HIGHLY CONTENTIOUS DIVORCE

At the beginning it was said that divorce of the parents exposes children to one of the most stressful life experiences. No child is immune to divorce and its effects on the child's mental health must not be ignored. Children's reactions (on a mental, emotional and behavioral level) and the process of adjustment to parental separation will mostly depend on the quality of the parental relationship during and after the divorce. If the parents divorce amicably, prioritizing the needs of the children, the reactions of the children (appropriate to the given context) will be less intense, shorter-lived and easier to regulate. These reactions include:

- Confusion and uncertainty with regards to family structure and interpersonal relationships;
- Fear of separation and abandonment;
- Worry about the future;
- Longing for the missing parent;
- Shame, a sense of guilt and responsibility for the situation that has arisen;
- Feelings of alienation and rejection;
- If I am not ok, I am less valuable;
- Conflict of loyalty (divided sense of belonging);
- Sadness;
- Autosuggestive thinking and hoping that the parents will get back together.

These reactions also feature in the experiences of children in highly contentious divorce, but they are significantly more intense, frequent and enduring at that time - depending on the complexity and severity of the dynamics of the marital-divorce conflict.

Children whose parents partake in a highly contentious divorce in the beginning often balance between them, catering to each parent individually, in a desire to maintain mutual attention and love. However, when faced with the permanent and long lasting programming influence of the parent alienator, they do not succeed. The previously listed manipulative behaviors, which Jovanović, Magyar (2006) define as verbally and non-verbally portrayed (strategies of alienation), for a child's intuitive thinking, can only have the meaning and message - the other parent is not okay and is dangerous. On a child's cognitive level these messages have the following logic: “if a parent is not okay, then I am not okay”, “my parents are fighting because of me - it is my fault, I am not okay”. The existential attitude “I am not okay” can follow them for the rest of their life.

The other powerful nonverbal message, highly penetrating into the child's personality, that the alienating parent conveys to the child through their entire manipulative behavior and which the child intuitively easily recognizes is: “if you love the other parent, that makes me unhappy - I will abandon you, just as I abandoned them”. This message has a high level of threat and executive power can be attributed to it. This is a particularly powerful form of emotional blackmail to a child, one they cannot help but react to.

Fear of abandonment is a very prominent symptom of an alienated child, it is long lasting, repeating and it seems that these children permanently remain in a state of fear. It can be noted that the fear of abandonment from the parent the child lives with induces a strong emotional reaction (state) and forms an attachment.

In the alienating behavior of the parent, children recognize some more toxic messages:

- Your worth lies in pleasing me, in fulfilling my needs;
- I will love you if you love only me;
- People are always either good or bad (one parent is entirely good, the other is entirely bad); etc.

In the given circumstances, the child is indented into the program of alienating and cannot remain neutral. The normal course of dual attachment begins to weaken, then become entirely disrupted. Namely, the secure attachment of the child to the other parent is compromised and completely severed (Borišić, Marčanić, 2020). In order for the child not to lose the love of the residential parent and whose caregiving they entirely existentially depend on, the child chooses their side and, in collaboration with them, rejects the parent they used to love. This is a special state of complete emotional and intellectual bond and devotion to one parent and a complete rejection of the other - psychological splitting - one of the primary symptoms of alienation.

Despite the amount of research conducted by numerous experts, alienation from the parent still remains unrecognized as a serious form of emotional abuse, meaning many alienated children are deprived of essential indispensable protection against the abuse. This is why it is very important that, alongside recognizing the aforementioned behavioral patterns of alienating parents, the symptoms of an alienated child are identified, in order for a proper diagnosis to be made.

As part of the child symptomatology of alienation, based on which one can infer the behavior of the alienated child towards the other parent, Gardner emphasizes the following reactions and behaviors:

- Blackening the parent with offensive words and contradictory statements, turning into a smear campaign;
- Giving weak and absurd reasons for their rage;
- Displaying confidence, lack of affection towards the other parent, apart from emphasized resentment (one parent is viewed as entirely good, and the other entirely bad);
- The phenomenon of independent thinker occurs - insisting everything the opinions they have are entirely their own;
- Using lent scenarios - phrases identical to the ones the alienating parent uses, without understanding what they actually mean;
- Displaying no signs of guilt or sympathy towards the alienated parent;
- Always taking sides with the alienating parent;

- Alienating the extended family of the alienated parent, including pets and everything else that has to do with them. (Buljan Flander and Roje Đapić, 2020)

The symptoms of alienation in a child, as defined by Gardner and Warshak (2008), combine three basic criteria that need to be met in order to make a diagnosis of alienation (Selek Bagarić, Buljan Flander et. al. 2019);

1. Permanently blackening and rejecting one parent - not just temporarily;
2. Unfriendly and irrational stance toward the parent, not based on actual negative experiences with the rejected parent;
3. There is at least partial influence from the other parent or other significant individuals in the child's life.

Out of all symptoms that a child alienated from a parent displays, Dr Childress (2016) particularly emphasizes a lack of empathy: *“There are only three disorders that are characterized by a lack of empathy: autism, narcissistic personality disorder and antisocial personality disorder (psychopaths). That is why, when a child displays lack of empathy - the tendency toward ruthless callousness and cruelty - it is cause for concern.”*

Authors that deal with the problem of parental alienation divide this disorder into three categories based on the degree of alienation: mild, moderate and severe alienation, which is important to determine in order to provide adequate treatment (protection). It is important to note that alienation is not present when the child maintains a positive relationship with the other parent, despite the parent the child lives with blackening them.

THE DEVELOPMENTAL IMPLICATIONS IN RELATION TO THE EMOTIONAL, MENTAL AND SOCIAL HEALTH OF THE ALIENATED CHILD

Research that has explored specific factors leading to the most significant problems in children from divorced families (Lind, 1987, Waller-

stein and Kelly, 1980, Amato, 2000, Heteringston and Elmore, 2003) unequivocally confirms that the interruption of the child’s contact with the non-residential parent or when the contact is sporadic is a particularly important etiological factor, especially in terms of its duration (Žegarac, 2015).

It has been previously emphasized that a child exposed to the programmed actions of the alienating parent employs psychological splitting as a way of coping with the challenging situation after the breakdown of the family. The child forms a strong bond with the psychologically unhealthy parent, adopting their way of thinking and behavior towards the ex-spouse and completely rejects the parent they once loved. As a core characteristic of psychological state the child is in, Karen Woodall (2018) emphasizes the fundamental loss of developmental perspective and psychological splitting, *“When a child views the past, present and future in the eyes of the parent they are in coalition with, they have lost perspective and a sense of self and sovereign individuality”*.

The specific characteristics of psychological splitting in alienated children are: black-and-white thinking, where they view the people and world around them as either black or white; one parent is perfect, while the other is entirely bad; inability to recognize that a person can possess both positive and negative qualities. “Splitting is a cognitive distortion, a gateway into many psychiatric disorders like borderline personality disorder” (Roje, 2019).

“That closeness and attachment between parent and child (pathological enmeshment) to an untrained eye seems normal, healthy even. That could not be farther from the truth. In a dysfunctional relationship such as this, the alienated child loses their sense of self, suppressing their natural feelings of love and need for the other parent. They are abused to meet the needs of the alienating parent.” (Kruk, 2017)

Describing controlling parental behavior, Suzan Forward and Craig Buck (2002) explain that: *“As a consequence, the children of controlling parents often have an unclear sense of self. It is difficult for them to see themselves as being separate from their parents. They feel powerless.”* Children know that they are made up of both parents and believe that they are part mom, part dad, which is not only genetically accurate, but

also emotionally. That is why the negative messages they receive about the other parent make them question their sense of self and whether they are good. *“There is no surer way of building a personality with little self-respect and feelings of self worth.”* (Lynn Evans, 2010)

The psychological problems of alienated children and what they “believe about themselves deep inside” Baker and Ben-Ami (2011) interpret, in short, as:

1. *“I am unlovable”*

When a child grows up believing the other parent is bad, dangerous, does not care about them and that they do not love them, they come to the conclusion that they are unlovable and - who could love me when not even my own parent loves me.

2. *“No one can truly love me”*

Every child needs the unconventional love of both parents - loving them for who they are - for healthy development. However, in the case of an alienated relationship, the child perceives that one parent does not love them while being subjected to conditional love from the alienating parent - “I will only love you if you reject the other parent”. The child is, thus, compelled to earn the love of the remaining parent at any cost. To the child, any kind of love is preferable to a life without the love of either parent. Moreover, if the child were to lose the love of both parents, it would be perfectly clear - they truly are unlovable.

3. *“At least part of me is bad”*

The alienating parent often portrays the negative messages about their ex-spouse either directly or indirectly in a way that simultaneously defines the child as bad: you are the same as them. The child interprets that as: you are also unworthy or at least part of you is bad.

4. *“I must adapt”*

The alienating parent aims to make the child completely dependent on them, often forming a symbiotic relationship with the child. They make all the decisions regarding the child. The lack of independence and the fear of losing their love leads to the child accepting that kind of relationship (and adopting) that kind of behavior - I must adapt - I cannot make it on my own (Buljan Flander, Roje Đapić, 2020).

Various studies, as indicated by Kelly (2000), show that children whose parents are engaged in a prolonged highly contentious divorce experience the same difficulties as children who are victims of physical abuse and neglect. According to Roje (2019), they are two to five times more likely to have clinical difficulties in behavior and perception compared to children whose parents divorced amicably.

The results of many studies on the consequences of parental alienation are summarized by Kruk (2018), and categorized by Buljan Flander and Roje Đapić (2020) into the following groups:

- Low self-esteem, depression and self-loathing;
- Disrupted socio-emotional development: withdrawal, isolation, social anxiety;
- A lack of self-esteem and autonomy, dependence on a parent;
- Lower academic achievement;
- Poor impulse control;
- Difficulties in terms of mental health, addiction and self-harm.

The child psychiatrist Dr Milica Pejić - Milovančević (2020) in her work under the topic of “Splitting - the psychiatric perspective”, listed the following characteristics that children experience as a result of alienation:

- Cognitive distortion;
- Anger towards the non-residential parent;
- Loss of behavioral control;
- Lower self-esteem;
- Separation anxiety induced by the alienating parent;
- Developing fears, anxieties, obsessive-compulsive behaviors;
- Disordered eating and sleeping;
- Learning difficulties; enuresis and encopresis;
- Self-destructive behaviors and drug abuse;
- Weak peer relationships;
- Guilt, depression and suicidal tendencies.

More severe cases of child alienation often lead to significant psychological, psychosomatic and psychiatric impairments later in life (von Boch-Galhau, 2018, as cited in Selak Bagarić, Buljan Flander et. al., 2019). Turkat (2019) states that, according to statements from adults whose contact with the other parent was obstructed during childhood, this had a “lasting negative impact on their lives” (Pašiček, 2019).

ALIENATING PARENTS

Most research and practice indicate that child alienation most commonly arises from the context of highly contentious divorce. However, alienation can also occur outside the context of divorce-related circumstances. This is why Woodall (2019) states that highly contentious divorce should not be conceptually equated with alienation. Parental alienation is closely aligned with the behavior of the alienating parent.

Manipulation is the main characteristic of an alienating parent. Based on descriptive signs and in broader terms of pedagogical interpretation, their behavior can be described as a “manipulative type of upbringing”. Cowling (2004) states, and Rakoci (2018) confirms, that these kinds of parents, fueled by extreme manipulation, can even describe an event that never occurred in great detail, often unable to tell the difference between lies and the truth. That is one of the most notable challenges in accurately diagnosing alienation and protecting the child from this form of abuse.

Many behavioral indicators that play an important role in detecting this phenomenon have already been mentioned. However, an equally important challenge is reflected in the fact that there is no unique personality profile of an alienating parent that would aid in detecting alienation more accurately. Turkat (1995) states, that it is clear that many of the mistakes and imperfections of parenting have roots in the personality structure of the parents themselves and that those who alienate can, but not necessarily always do, have an accompanying mental disorder. Parents that alienate show a wide range of personality traits and behaviors. In that context, the significant characteristics that play a role in the foundation of their alienating behavior include:

- They do not recognize the problem of alienation as a form of abuse towards the child and the other parent, or that they are causing it;
- They lack insight in themselves as parents (they are unaware of their parental deficiencies);
- They are unaware of the damage they cause;
- They do not feel the need to question their parental opinions and behaviors, and refuse to cooperate in solving problems; they do not possess insight into the deeper emotional needs of the child;
- They possess a particular disregard for the fact that the involvement of both parents is necessary for a healthy upbringing;
- They have a need for control, power and domination;
- They are unable to distinguish between their personal needs and feelings and the needs and interests of the child;
- They have a strong need for revenge and punishment of their ex-spouse;
- They are emotionally unregulated and unstable.

Additionally, some of the more prominent manifestations of alienating parents, such as egocentrism, lack of empathy, narcissism - can have roots in deeper psychological - psychiatric personality disorders. The relationship between parental narcissism and child alienation is explored more extensively. When explaining the relationship between narcissistic parent - child, the famous expert, Dr Craig Childress (2016), uses clinical terms such as “regulatory other” and the concept of “reversed roles“. In short, he notes: *In the context of “parental alienation” the narcissistic parent uses the child as a “regulatory other” in order to regulate their own emotional and psychological state. The child is forced to always follow the inner psychological state of the narcissistic parent so that they can fulfill their need for constant admiration (narcissistic fulfillment) and avoid the unsettling narcissistic anger - rage. In a healthy child-parent relationship, the parent fulfills the needs of the child. When the roles are reversed, the parent uses the child to fulfill their own needs.*

Moor and Saliven’s (2006) research on the long-lasting effects of child abuse and the influence of parental lack of empathy shows that child

abuse and parental lack of empathy are the same thing - the two sides of the same coin.

In terms of the gender distribution of alienation, research and practice show that the alienating behavior is most commonly portrayed by the mother. Gardner (1989) described this phenomenon as a syndrome and noted that parental alienation most commonly occurs in mothers, despite it also being noticed to occur in fathers. Turkat (1995) repeats the same. Specifying the most common reasons behind false accusations of sexual abuse, Paul Stuckle (2004) places “divorces in which mothers seek to gain an advantage in court through false accusations” at the forefront. A California study on children of divorce led by Rand (1997) shows, in a non-clinical sample, that mothers are two or more times more likely to engage in alienation by falsely accusing their ex-spouses of child sexual abuse. In this type of alienation, mothers are involved in 67% of cases, fathers in 22%, and other individuals in 11% of cases. Men more frequently engage in physically abducting children to gain control over them, often as a form of revenge against their ex-wives. According to Rakoci (2008), of the total number of cases of physical alienation, fathers were the abductors in 60-70% of cases.

The provided data is statistically linked to the previously mentioned fact that the vast majority of children of divorced parents live with their mothers. However, for quite some time now, in the developed world, there have been increasingly notable positive changes in the perception of the quality of fatherly care for children (a shift from the presumption of the “sensitive early age” and the mother as the most suitable “primary parent” under the presumption of the “best interest of the child”), the education of judges on preventing gender bias, and amendments to family laws regarding the allocation of parental responsibilities. This has led to an increase in the percentage of fathers entrusted with custody of children in legal proceedings. Consequently, there has been an abuse of parental rights by fathers. This leads to the thesis that poor parenting is not a matter of gender, but is rather a result of one parent holding dominant power, and, typically, this power lies with the parent with whom the child lives.

Today, science recognizes that parenting (whether good or bad) is not causally connected to the gender of the parent. Successful child development requires equal care from both parents, regardless of whether they live together or separately (Kruk, 2012, Warshak, 2014, Childress, 2016, Buljan Flander, 2020).

THE ALIENATED PARENT

In the complex psycho-pedagogical dynamic of the interpersonal relationships within a family impacted by alienation, there are three primary roles: the alienating parent, the alienated child, and the alienated parent. The particularity of this phenomenon is the dual directionality of violence - towards the ex-spouse and child and the combination of parental influence and the programmed child behavior to participate in blackening the other parent, in a way that they mutually impact and amplify one another. In this way, the alienated parent is unjustifiably and continuously denied a regular and uninterrupted personal relationship with their child by the parent the child lives with, causing serious emotional abuse to both the child and the alienated parent.

These parents have not had visual contact with their child in months or years, let alone an emotional connection they had previously had. They are chronically frustrated because the system cannot provide adequate assistance in the matter. When they insist that the system take action, they are perceived as annoying, applying inappropriate amounts of pressure. They have strong feelings of parental injustice, misunderstanding and discrimination. There is a small sample of those interviewed, however, the global impression is unsettling. When talking about the situation they are in and how they are feeling, they often use the words “desperation”, “life without meaning”, and even express homicidal or suicidal thoughts. And, academic research shows, *“It is unsurprising that there is a large percentage of suicide and severe depression in alienated parents, and that many of them give up and leave”* (Woodall and Woodall, 2016). Pašiček (2009) states that, it seems that the parents alienated based on false accusations of sexually abusing their children take it even worse, often labelled as pedophiles, they are left with no children, family, friends, and even work.

Parental alienation is a serious form of psychological trauma experienced by the alienated parent. The trauma is imposed from the outside, simultaneously acute and chronic. It is a form of domestic violence directed at one parent. Moreover, the child bearing witness to said violence constitutes serious child abuse. This may well be the main cause for concern for the alienated parent, bearing witness to the abuse of their child, but unable to protect them. And the greatest obstacle for alienated parents, Kruk (2017) emphasizes, is that this problem is innately systemic, considering that support services and social aid for alienated parents practically do not exist. Similarly, support services for alienated children are very few and insufficient. Kruk (2017) notes that, when these parents do seek help from social work professionals (because alienation is a form of child abuse and is thereby a question of child welfare) these systems often neglect the fact that this is a matter of abuse and that the behavior of the alienated parent was within norm.

The intense and complex dynamic of extremely stressful events in the lives of alienated parents (repeating court proceedings, lawyers, social workers, therapists, forensic experts, and unfulfilled expectations) emotionally and psychologically drain these parents. In some cases, it takes on characteristics of the PTSD that people face post-war (Woodall, 2016; Kruk, 2017).

From the psychodynamic point of view, parental alienation presents itself as a kind of fake drama orchestrated by the pathology of the alienating parent. In said drama, the alienated parent plays the role of *abusive parent*, the child is forced to play the role of *child-victim*, and the alienating parent takes on the role of *parent-savior*. However, none of that is true. The parenting of the alienated parent is completely normal, the child is not in danger and does not require saving (Kruk, 2017).

Pašiček (2009) states that there is no doubt that standing in the way of a personal relationship between a parent and child, moreover, blackening said parent that has done no harm to the child or their ex-spouse (abuse or other), is an inconceivable act of cruelty, injustice and evil toward the child and alienated parent.

THE REACTIONS AND BEHAVIORS OF ALIENATED CHILDREN DURING THE EXAMINING OF THEIR TESTIMONIES

In practice, the social and legal protection of alienated children is difficult to identify and even more difficult to process as a form of violence. In addition to the limited knowledge of mental health and legal experts on the topic of alienation, significant challenges arise in examining children about the traumatic events they experienced. Reliable child testimonies have become an important and indispensable means of determining the best course of action in protecting children during divorce and preventing child abuse.

The level of cognitive development and speech comprehension begs the question - can children lie; when and under which circumstances are they most likely to tell the truth; are they susceptible to suggestibility and claim an action occurred, when in fact, it did not. It is clear, and backed by research, that children learn to lie at an early age. They lie no more and no less than adults. Bronson and Meriman (2009) list the most frequent developmental reasons that cause children to lie:

- Children lie because they learn it from us;
- To avoid being punished;
- To please their parents (to make them happy);
- To gain attention;
- To appear more powerful to themselves and others;
- To keep a secret (friendship);
- To seek revenge on someone (tattletale syndrome);
- As a means of staying in the game (child's play);
- To protect others from uncomfortable feelings (lies of courtesy, white lies); likely most common.

When questioned, children react differently and the accuracy of their testimonies depend on different factors: their age, their level of cognitive and speech development, how competent the interviewer is (especially the means of interrogation they use), the influence of other people,

the intensity of parental conflict, etc. For example, preschool children are more susceptible to the suggestibility of older children and grownups. Child beliefs can be modified under the influence of grownups, which results in them giving false testimonies believing they are true. During divorce proceedings, it is common for someone to advise the child on how to shape their story. The means of interrogation can play a key role in shaping a child's testimony (Stakić, 2019). Tavris and Aranson (2008) illustrate the argument with the famous case of a preschool teacher being accused of multiple criminal acts of sexual abuse of preschool children, sentenced to 47 years of prison. She was exonerated 5 years later, when the high court ruled that the children's testimonies were shaped by means of interrogation. This is what makes the interrogation process and evaluating the credibility of a child's testimony in highly contentious divorce proceedings a very complex and nuanced diagnostic task.

The aforementioned facts clearly point to the real possibility that a child will lie during testifying. Alienated children are particularly prone to this. Constantly in fear of the alienating parent abandoning them, these children, whether consciously or subconsciously, can describe events that did not take place in detail. Children give these false accusations of abuse from the alienated parent with one goal in mind - to retain the love and attention of the alienating parent, on whom they existentially depend.

Alienated children begin to lie as a means of surviving the drastic life changes brought upon by highly contentious divorce. *“Any kind of sudden torrent of lies or drastic increase in lying shows signs that some part of the child's life has changed, and that it is bothering them. Lying is a symptom - often of a much greater problem behavior”*, Talwar (2002) explains. *“It is a strategy that helps the child stay in the game”* (Bronson and Meriman, 2009).

To conclude: to alienated children, lying is not a common manifestation of the developmental age, but a consequence of alienation (lying as a symptom of a greater problem behavior).

There is undeniable evidence of the growing number of false accusations of an ex-partner sexually abusing their child as a successful means of alienating the child from that parent. Experts agree that wrongfully labeling a child as abused is as traumatic as failing to recognize that

an abused child was abused. Special training is required to distinguishing between real sexual abuse and wrongful accusations.

Cowling (2004, as cited in Rakoci, 2008) based on research and a national study, identifies some of the issues that can lead to mistakes, and consequently, incorrect judgment:

- Young children are simply unable to maintain a credible story of sexual abuse, even if they have actually experienced it;
- Children quickly realize what the interrogator expects them to say and modify their answers to meet those expectations;
- In many cases, due to repeated interrogations and hearings, and the positive reinforcements they receive during them, the child begins to believe that it was abused even if that did not actually happen;
- Inconsistency in testimony is often wrongfully assigned to child trauma (most often by the judge);
- The memory of a child is not the same as that of an adult in terms of gathering and storing information;
- Many experts reject behavioral indicators of sexual abuse, i.e. there are no inherent signs of sexual abuse;
- There is no clear distinction between a credible and reliable testimony. Credibility reflects whether a person is competent to stand trial. This means that a child's testimony can be credible despite their statements not being reliable (can be contaminated, etc.).

According to Ross and Blush (1987) alienated children exhibit various specific behaviors during forensic processing for allegations of sexual abuse, as noted by Rakoci:

- Providing conditioned and repetitive responses;
- Spontaneously initiating a conversation during interrogation in which they exhibit the same emotional state as the controlling parent;
- Providing verbal descriptions adapted to their age;
- Providing spontaneous and automated reports on the behaviors of the allegedly abusive parent without being directly prompted with questions about that information;

- Inconsistencies in different aspects of the report, particularly regarding specific details (who, what, where, when), frequency (once or twice, many times), and subjective perceptual experience (highly threatening, not scared; hurt, not hurt; etc.);
- An absence of trauma symptoms on both emotional and behavioral levels.

RECOMMENDATIONS FOR THE PREVENTION AND PROTECTION OF CHILDREN AND PARENTS OF EMOTIONAL ABUSE IN HIGHLY CONTENTIOUS DIVORCE

Unfortunately, the best therapeutic approach in treating alienation as a serious form of emotional abuse is still not established based on science. However, in the developed world, there are specialized programs for alienated children and alienated parents based on clinical and professional practice, opinions and guidelines of contemporary academic research and examples of successful practices. In the USA, there are Family Bridges (run by Dr Richard Warshak) and High Road Protocol (run by Dorcy Pruter, a program reviewer and expert consultant of Dr Daniel Craig), in Great Britain, there is the Family Separation Clinic (run by Karen and Nick Woodall). In Eastern Europe, the Clinic for Child and Adolescent Protection in Zagreb achieved significant results up until 2021, however, the Clinic has since been greatly influenced by feminist organizations, which completely reject this form of emotional child abuse, going so far as to forbid the use of the term “alienated child”, even forbidding their employees from participating in expert meetings where this topic is discussed. Since 2022, the program to protect children and parents from alienation has been carried out by Educa GBF in Zagreb (run by Prof. Dr. Gordana Buljan Flander, the former CEO of the Clinic for over 20 years).

When it comes to the treatment of child alienation from parents in Serbia and Slovakia, in the services of social, health, and legal protection of children of divorced parents, the problem becomes much more difficult and complex. Alienation as a phenomenon is difficult or almost impossible to recognize as a form of emotional abuse. As such, it is not officially cat-

egorized, and there is no formal data on it. Instead of a counseling-therapeutic approach and the protection of children and parents from abuse, the problem is primarily reduced to the formal-legal regulation of the child's and the other parent's right to personal contact in the circumstances of parental separation, with the application of traditionally rooted, rigid template practices – insufficiently successful. Expert experience and practice shows that the capacity for behavior change in alienating parents is highly questionable. They are uncritical regarding the socio-psycho-pedagogical needs of the child, reject professional help, and this is not a temporary condition but a constant behavioral pattern. With addition to the influence of uncontaminated dysfunctional notions about parenthood (the mystique of motherhood, etc.), still often present in those who deal with divorce in their practice, the problem becomes even more complicated. The chances of obtaining joint custody or for the father with high personal and parenting competencies to become the primary custodian is very slim, despite what might be in the child's best interest. From this, it can be noted that:

- We are unaware as to whether there is even one case in Serbia or Slovakia where, once alienation is already developed, emotionally close and purposefully educational relationships, similar to those existing before the alienation, have been restored through counsel/therapy and/or legal procedures between the alienated child and the alienating parent. (It is given that this does not take into account milder cases where alienation is not fully developed and the alienating parent is willing to cooperate and make changes);
- We are unaware of cases where, due to the alienating behavior of one parent, parental rights have been entrusted to the other, more adequate parent, or if the alienating parent has been sanctioned due to a false report of sexual abuse.

The aforementioned circumstances and substantial results in treating parental alienation further imply (and oblige) a need for primary preventative actions in the social and legal protection of children and parents from this type of emotional abuse and domestic violence. In said context, the three questions that have an indirect and/or direct meaningful influence in preventing alienation and its development will be briefly reflected on:

amicable divorce, shared parental care, and the distribution of time the parent spends with the child.

From a transactional analysis perspective, which involves the effective realization of the child's rights and comprehensive developmental needs, an amicable divorce, in the briefest and most general sense, encompasses the following essential components, guidelines, and recommendations from academic literature (Lin - Evans, 2009; Childress, 2016) and based on expert experience:

- Differentiating between (and separating) parental conflict from the parental role (interest of the child), as a prerequisite for creating a quality parental relationship between parent and child following divorce;
- Mutual (best joint) psychological preparation of the child for the changes that will occur in the child's life and the family - adjusted to the child's age - explaining what is happening and how things will change in the future - primarily aimed at reassuring the child that they are not to blame for the divorce and that it will continue to be loved, protected and provided for from both parents;
- Psycho-pedagogically adequate communication between the parents during and following the divorce (especially non-violent conflict resolution - as a pedagogical model for the child);
- Coming to a mutual agreement on shared parental care as the best solution for the child (and the choice between sole and shared care as determined by law);
- Creating a plan for parenting either independently or with the help of experts (before coming to a court agreement on the divorce), which defines parental obligations in terms of important rights and needs of the child in detail and, especially, the time the child will spend with both parents. The important rights and needs of the child most commonly imply: health, housing, upbringing, education, financial stability, etc. However, the plan should be personalized and adaptable to future change, as the child grows up. The purpose of the plan is to provide children with responsible and co-operative parenting that fulfills the developmental needs in all the

different phases of childhood and ensure regular, uninterrupted and equal personal relationships between both parents.

For divorce to proceed in the best way, and in the best interest of the child, parental agreement is crucial as an integral part of the parenting plan, acknowledging and committing to fully respecting the following Convention on the Rights of the Child, as presented by Woodall and Woodall (2007):

- Children have a right not to have to side with one parent and they do not need to choose which parent they want to live with;
- Children have a right to be protected from revenge and war between the parents and the have a right not to know about the details of the legal battle between them;
- Children have the right not to be told negative things about the other parent and their extended family;
- Children have the right to privacy in their relationship with each parent and their extended family, as well as the right not to be questioned by one parent about the other parent or how they spend time with that parent;
- Children have the right not to be asked to tell lies by either parent;
- Children have a right not to be confided in by a parent about matters related to the other parent and their extended family or connected with the other parent and their extended family;
- Children have the right not to be used by either parent to convey messages to the other parent;
- Children have the right to decide whether or not to express their feelings and have the right to behave in accordance with that decision;
- Children have the right to love their parents and have the right not to be put in a situation by either parent where they feel guilty for loving the other parent;
- Children have the right for all those deciding their fate to do so selflessly and with due care and respect, prioritizing the child's interests before their own.

Finally, as divorce poses an extremely difficult experience to children of all ages, parents rightfully ask: is there a time during childhood where the child is less sensitive to the emotional trauma caused by divorce. The answer to this question is provided by the renowned psychotherapist Mavis Klein (1994), and that is, contrary to the widespread belief that resilience to the emotional trauma increases with age, she believe that adolescents (between the ages of thirteen and eighteen) are the most sensitive in that context, while the least sensitive or more resilient children are those between the ages of six and twelve. This is a period of development, termed “latency” in psychoanalytic theory, and in TA theory, it is referred to as the “structuring” phase when intellectual and social development intensify, while emotional and sexual aspects are less pronounced (more latent). With that in mind, Mavis believes that this could be useful for their child: *“The child is now less emotional than they have ever been or ever will be, which is why they are less sensitive to the trauma and stress that can be inflicted on them and their family. This is why this is the safest time for a child’s parents to be separated or divorced (if needed), since the child is more capable of dealing with that kind of emotional blow than during other developmental stages”*. Similarly to this, the child psychologist Dr. Scott Carroll (2017) notes that, *“the older the child gets, the more traumatic the situation becomes, especially around the age of eleven”*.

It is clear that if the spouses were to separate in the manner described, it would largely constitute preventive protection in relation to the child’s emotional and mental health. And, in this case, the chances for healthy child development are equal between children from amicable divorce and those living with parents in a functional marriage/family.

Without diminishing the parent’s responsibility for effectively organizing the care of the child following the divorce, it is important to also reflect on the crucial institutional responsibility. In divorce proceedings, the court, with the expert opinion of social services, issue judgements on sole or shared parental care of children; in legal terms, this is referred to as the “entrustment of parental rights for the independent exercise” to one parent and the “entrustment of parental rights for joint exercise” for both parents. When it comes to the best interest of the child, there is a big difference between these two types of arrangements. In entrusting one parent

to independently exercise parental rights, that parent is given dominant power and influence on the child’s upbringing, while the other parent is in many ways excluded from the everyday life of their child. This is particularly common in cases of alienation. Due to this court ruling, most children with divorced parents permanently live with one parent, while they “visit” the other for no more than two weekends a month and, in some cases, one day of the week for a few hours. This imbalance between parental power creates the ideal circumstances for alienating parents to act according to their own whim towards their ex-spouse, using the child as a weapon. Kruk (2019) claims that children bearing witness to this sort of behavior is a form of severe emotional abuse, while Žegarac (2015) believes that choosing one primary parent following a divorce is contradictory to the contemporary research that shows that, in this way, the parental conflict is increased and prolonged, and decreased when a ruling for both custody has been made. Pašiček (2009) explains that conflict subsides with shared parenting, with neither parent fearing “losing” their child.

Joint exercise of parental rights is the arrangement of parental care after divorce in which both parents remain equally responsible for their children. They jointly make major decisions in the best interest of the child, cooperatively carry out basic parenting tasks, and the child spends approximately equal time intervals with both parents. They live in both of their homes, which they automatically gain through their parents' divorce, and where they feel mutually loved, safe, and protected by both parents.

Edward Kruk (2012), the internationally acclaimed expert in divorce and child alienation, analyzed 125 case studies, relevant to joint custody, and summarized the results into 16 arguments to support joint parental care:

1. Shared parenting preserves the child’s relationship with both parents.
2. Shared parenting preserves the relationship of both parents with their child;
3. Shared parenting reduces parental conflicts and prevents family violence.

4. Shared parenting maintain children’s preferences and views on their needs and their best interests;
5. Shared parenting maintains parents’ preferences and views on their children and best interests;
6. Shared parenting maintains parents’ preferences and views on their children and best interests;
7. Shared parenting enhances the quality of the parent - child relationship;
8. Shared parenting reduces the parents’ focus on “counting time” and reduces litigation;
9. Shared parenting provides parents with encouragement for agreement, mediation, and parenting plan development;
10. Shared parenting provides clear and systematic guidelines for making court decisions;
11. Shared parenting reduces the risk and frequency of child alienation;
12. Shared parenting enables the enforcement of court decisions, as parents are more likely to respect a decision that determines shared parental care;
13. Shared parenting fulfills the imperatives of social justice regarding the protection of children’s rights;
14. Shared parenting fulfills the imperatives of social justice regarding parental authority, autonomy, equality, rights, and responsibility for each parent;
15. There is no empirical evidence that the sole parenting model benefits the child’s well-being;
16. There is empirical evidence that the presumption of shared parenting, revocable in cases of proven violence towards the child, benefits the child’s well-being.

Similarly, Dr. Linda Nielsen (2014) from the University of North Carolina (USA), having analyzed 40 case studies (performed in the USA,

Canada and Europe) relevant to joint custody, determined, based on similar results, the following conclusions:

1. Shared parenting is associated with better developmental outcomes for children of all ages, across a wide range of issues related to emotional development, behavior, academic success, and physical health;
2. It has been proven that overnight stays with the father do not have a negative impact, even on very young children;
3. Positive outcomes are not observed in cases with a history of violence;
4. Although statistically, parents with joint custody have a higher socio-economic standard and lower levels of verbal conflict, these two factors alone are not a source of positive effects; the emphasis is on shared parenting itself.

When it comes to the distribution of parenting time with the child, those who closely deal with the problems of divorce are very familiar with the fact that unequal distribution between the parents poses a chronic source of disagreement, which often escalates in the most dramatic fashion. Žegarac (2015) states that, research (Fabricius and Hall, 2000; Fabricius, 2002) suggests that one of the primary needs children in divorce cases ask for is “essentially equal time spent with both parents”. Most children, from preschool to college age, are unsatisfied, and in some cases unhappy, with the amount of contact they have with their father after divorce and the time between contact (Kelly, 2012; Heterington and Kelly, 2002; Warshak and Santrock, 1983 as cited by Warshak, 2014). *“If a boy has little contact with their father or other men, he actually does not know how to be a man”* (Bidalf, 2003). Warshak (2014) emphasizes that numerous studies confirm the importance of the distribution of parenting time with the child between the two homes. In this regard, courts should allocate more time to fathers than traditional schedules allow.

However, in empirical research and academic literature, there is no conclusive opinion on the amount of time that should be allocated to each parent that would be in the child’s best interest. Bearing in mind that the

close relationships with both parents contribute to the emotional and psychological development of the child, Dr. Craig Childress (2016) suggests that in all cases exempt from child abuse and the need for protection from abuse, the distribution of parenting time with the child should be split 50-50. If, despite the equal distribution, family problems persist, the issues should be addressed in family therapy.

Also, globally recognized expert in the field of child development and divorce, Dr. Richard Warshak (2014), based on an extensive analysis of research results conducted over a period of 45 years, relevant to parenting schedules with children after divorce, compiled a summary analysis – Consensus Report supported by the signatures of 110 scientists and practicing experts from 15 countries. From this respected work regarding the importance of an equitable distribution of time with the child for both parents, the following conclusion should be highlighted: *“In the best interest of children, when two good enough parents more evenly divide time with the child between two homes, they maximize the child’s chances of having good and secure relationships with both parents. They have no reason to worry whenever it is feasible to go 50/50 with each parent.”*

In cases of parental separation, the closely-equal involvement of both parents in the life and upbringing of the child enables both parents to provide their complete love and support during the child’s development. Moreover, and more importantly, it enables the child to fully fulfill their fundamental need and right to belonging and love from both parents.

CONCLUSIONS AND RECOMMENDATIONS

Kruk emphasizes that Warshak’s consensual report and other meta-analyses clearly confirm that parental alienation is a far more common occurrence than it is typically thought to be, and there is no doubt - the leading experts on the topic of divorce have agreed. Dr. Joan Kelly and Dr. Janet Johnston have clearly stated: *“Regardless of whether such parents are aware of the negative impact on the child, these behaviors exhibited by the parent to whom the child aligns (or those who support them) constitute emotional abuse of the child”* (Warshak, 2018).

“A child one parent alienates through behavior against the other is a child whose emotional and psychological being is destroyed. Its wounds

cannot be seen as they are not visible, but if they were, they would be as severe as broken arms and legs. It is a dangerous and risky form of emotional and mental abuse inflicted by some parents, abusing the child in the deepest levels of their developing psyche, one of the most fatal experiences a child can have” (Woodall, 2017)

Kruk (2015) concludes that the bio-psycho-social consequences for the child are detrimental. Disrupting and hindering a personal relationship between a child and parent, blackening a parent that has done the child and partner no harm (abuse or other), constitute an unthinkable act of cruelty and injustice towards the parent and other parent. As a form of child abuse, alienation is a serious matter of child welfare, because it undermines the fundamental principles of social justice for children: the right to know and enjoy the care of both parents.

Unfortunately, as previously illustrated, social welfare policy, therapeutic, and judicial practice do not sufficiently meet the needs of the child and parents in need of protection from emotional abuse during and after highly contentious divorce, thus contradicting the principle of the best interest of the child. This is why, in the given circumstances, preventative social interventions are of critical importance. Proper actions include: educating high-conflict parents (before filing for divorce) on the best means of divorce, with the child’s best interest during and after the divorce in mind; therapeutic mediation aimed to help the parents differentiate between their former marital disagreements and their ongoing parental responsibilities; organized shared and cooperative parenting after divorce by creating a plan for shared parenting; etc.

At the achieved level of scientific grounding of the concept of the best interests of children of divorced parents, taking into account indisputable psychological and pedagogical knowledge about the importance of the natural role of both parents, whether they live together or separately, in caring for their child, and based on the results of numerous contemporary studies relevant to the developmental status of this vulnerable group of children, shared parenting is recognized as the best solution for children of divorce.

There is a broad consensus among internationally recognized scientists and expert practitioners that joint custody or, as it is properly legally

stated in Serbia, joint exercise of parental rights, which includes approximately equal time spent with each parent, has a strong positive impact on child development and a protective influence on the risk of emotional abuse and family violence (Kruk, 2012; Warshak, 2014; Childress, 2016; Woodall and Woodall, 2017, and many others).

Finally, as the concluding message to the creators of social welfare for children of divorced parents and decision-makers, a plea of one of the most renowned specialists in child and family policy, Professor Dr. Edwar Kruk (2012), will be cited: *“It is of vital importance to establish shared parenting of children as the foundation of family law, even when parents are in conflict over who will have custody of the children”*

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Impact of climate change on women's health and access to health care

Abstract: *The subject of the work is the impact of climate change on women's health. Women of developing countries are affected differently and more than men, their fellow citizens. They face multiple, synergistically combined health, economic, psychological and existential problems. The text includes also topics related to civic activism and global women's initiatives regarding climate change. The author indicates that gender-inclusive, non-discriminatory approach to climate change risk reduction can diminish health risks for women, families and communities. Education, civic activism, institutional support and alliances (especially of independent institutions) are highlighted as important elements of protection against climate changes. Women, in state structures where they have equal legal, political and economic opportunities, can perform multiplied functions validly as participants in all gender inclusive processes of building accessible health and other security institutions. When becoming leaders (not only victims) in the field of reducing the health risks of climate change, their contribution to building and strengthening the resilience of communities and countries to climate change, is to be significant.*

Keywords: *climate change, women's health, increase in gender-based violence, civil activism, independent institutions, gender-inclusive security processes.*

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1. Introduction

Climate change is a complex phenomenon caused by the interaction of numerous factors. The biggest contribution to climate change in recent decades is attributed primarily to human activities, such as, for example, greenhouse gas emissions, fossil fuel use and industrial processes. It is also important to note that natural factors, such as volcanic eruptions and fluctuations in solar radiation, can also affect climate change, but are currently less significant compared to anthropogenic (human) factors. All of these changes contribute to the global warming and climate change we are witnessing today.

Greenhouse gas emissions are considered the biggest cause of climate change (*Radio Free Europe*, 2022). These emissions are in carbon dioxide (CO₂), methane (CH₄) and nitrogen dioxide (NO₂). These gases are emitted by industry, traffic, fossil fuel-burning power plants and other human activities. The combustion of fossil fuels (coal, oil and gas) is the main source of CO₂, while industrial processes and animal husbandry are significant contributors of methane and nitrogen dioxide. The use of fossil fuels for energy production (hand-in-hand with the insufficient utilization of renewable energy sources), contributes significantly to greenhouse gas emissions. In addition to this, improper waste management, especially waste that decomposes anaerobically (i.e. without the presence of oxygen), can result in methane emissions.

Changes in land use, such as the conversion of forests to agricultural land or urban areas, can also affect climate change. This can cause changes in greenhouse gas emissions and affect the local and global climate. Intensive agriculture, especially that of livestock, contributes to methane and nitrogen dioxide emissions. The use of fertilizers leads to nitrogen oxide gas emissions. Deforestation contributes to climate change because forests usually function as carbon sinks; when they are cut or burned, a significant amount of carbon is released into the atmosphere.

Changes in climate conditions can affect local ecosystems and give rise to a loss of biodiversity, the addressal of which will be one of the priorities during the Belgian presidency of the EU in the first half of 2024, within the so-called “Green Transition” having been named as one of the

six thematic areas of priority activity, in which the EU must deal with the crisis of climate change, loss of biodiversity and pollution (*Euroactiv*, 2024).

Climate change can also have socioeconomic consequences, including job losses and increased costs of living. Women, who are often in a situation of reduced and more precarious employment due to various economic and political influences, as well as their specific role in the household and community, are at particular risk of being affected by this. It should not be overlooked that the occurrence and intensification of stress due to fear (so-called climate anxiety) (Kadka, 2023) of existential threats caused by climate change, such as the loss of jobs, crops or homes, can furthermore have a negative impact on women's mental health.

2. Consequences

Climate change can have varied and complex impacts on society, including special implications for the safety of women (Stojanović, 2022: 339). Climate change can lead to geopolitical instability and conflict, because prolonged droughts or intense, frequent flooding can affect agriculture, resources and living conditions, which, in turn, can contribute to social and economic instability. Such instability can increase the risk of conflict and violence, which often has a disproportionate impact on women's security. Furthermore, climate change often leads to increased migration rates, with people leaving areas that have become unlivable. During these migrations, women are often exposed to additional risk of sexual violence, human trafficking and other forms of abuse.

It is clear that climate change can affect the availability of and access to resources such as water and food. In societies where women are traditionally responsible for maintaining the family's needs in relation to these resources, their security may be threatened if resources become scarce or more difficult to access. All this leads to an increased vulnerability of women. Women often make up the majority of the population in the poorest communities. When affected by climate shocks, poor women become even more vulnerable, because they have fewer resources and opportunities to adapt or recover.

Climate change can lead to reduced agricultural yields, job losses and general economic instability. This can increase women’s economic vulnerability and make it difficult to provide the family with basic needs.

It is important to note, however, that such impacts are complex and depend on many factors, including social structures, economic conditions and political circumstances. Despite the challenges, recognizing these linkages helps our understanding of needs, and allows us to develop policies that adequately address the specific challenges women face as a result of climate change.

The geographic idiosyncrasies of a place affected by climate change can have a major influence on the consequences manifested, which include increases in the frequency and intensity of natural disasters, changes in the balance of ecosystems, rising temperatures (R.M., 2024)², breakouts of infectious diseases and their becoming endemic, lack of potable water, impact on agriculture, risks to reproductive health and pregnancy, and psychological impacts.

Perhaps the most striking impact of climate change is the increase in the frequency and intensity of natural disasters – such as floods, cyclones or fires – that can cause serious risks to human (and particularly women’s) health, including loss of homes, damage to communication, transport, production, energy and agricultural infrastructure, and increased rates of injury and stress.

Climate change leads to disruption of the balance of ecosystems, including those related to water. This can affect the availability of clean water sources, which is crucial for human and women’s health. Increasing water scarcity leads to increased dry periods, while changes in rainfall distribution can lead to chronic water scarcity, which can affect agricultural yields, hygiene (particularly in rural areas), and which, in turn, can have disproportionate impacts on women’s health. Negative impacts are reflected in the reduction of agricultural yields (CeSID, 2019: 71), which can have consequences on food availability and women’s nutrition.

² 2023 has been confirmed as the warmest year on record, due to a combination of human-induced climate change and the natural *El Niño* weather phenomenon.

The intensity of climate change impacts on women can vary significantly depending on a variety of factors, including – but not limited to – geographic location, socioeconomic conditions, education and access to resources. Urban and rural locations represent different risk contexts. But, generally speaking, it cannot be said unequivocally that women in cities suffer more intense impacts of climate change than women in the countryside or vice versa, because these impacts are manifested in different ways, depending on a variety of factors. It is crucial to pay attention to the specific circumstances and needs of women in each context in order to develop effective climate change adaptation and mitigation strategies. Both cities and rural areas can be affected differently by extreme weather events, such as floods or droughts. In some cases, cities are susceptible to urban flooding, while drought and water scarcity may be more of a problem in rural areas. Cities often have more developed infrastructure and better access to resources compared to rural areas. However, urban women can still be vulnerable, especially if they are socioeconomically disadvantaged or have limited access to basic resources such as water, food and healthcare.

Socioeconomic differences between urban and rural women’s livelihoods also play a key role. Women in urban areas usually have more opportunities for education and employment, but also challenges such as higher living costs, and greater difficulty in the acquisition of basic products in times of shortage. On the other hand, rural women may have different challenges, such as access to health care and education, reduced transport and communication possibilities. They also differ in terms of their ability to adapt and develop resilience. Women in rural communities often play a key role in agriculture and natural resource management, making them possible key actors in climate change adaptation. On the other hand, women in urban areas may have better access to information and infrastructure that allows for faster adaptation.

3. Impact on health

Climate change can have different impacts on people’s health, especially on women’s health. There are many aspects of the impact of climate change on the health of people of both sexes (with significant differences in those impacts between women and men). Increasing temperatures

can increase the risk of heatstroke and other heat illnesses, which can affect the general health of women. Climate change may also affect the distribution and incidence of certain infectious diseases that can significantly affect women's health.

Extreme temperatures (Gallagher, 2023) and changes in health conditions can pose a risk to the reproductive health of women, especially pregnant women. Psychological influences are also manifested. Namely, constant changes in the environment, frequent disasters and instability caused by climate change can also have a psychological impact, including increased stress and mental problems, which can affect women in particular. All these factors together can have a complex effect on women's health.

Climate change can increase the risk of various health problems, including the spread of vector-borne diseases (such as malaria or the Zika virus). Women can be particularly affected as they often have familial care responsibilities and health risks can have a direct impact on their well-being and safety.

An increase in extreme temperatures can also have a detrimental impact on the health of women who are exposed to extreme working conditions or live in adverse conditions. Extreme temperatures and environmental changes can affect the health of women's reproductive systems, including possible effects on pregnancy and childbirth. The increased frequency of other extreme weather events leads to an increased frequency of floods, droughts and other weather extremes, i.e. a significant deviation from the climatic average (Đurđević, 2019), which can directly affect the lives of women, including the risk of losing homes, property, sources and supplies of food, and also family members. Changes in rainfall and water distribution can affect the availability of clean water. Women often play a key role in household water management, so reduced access to water could have a significant impact on their daily lives. The chain of causation leads to changes in agricultural yields and problems in regular nutrition. Climate change may affect agricultural practices, which may have consequences for food availability. This can, in turn, negatively affect the nutrition of women and their families.

4. Serbia

Serbia, like many other countries, suffers the consequences of climate change. These consequences manifest themselves in a variety of ways, with a major effect being increased temperatures during the summer months in combination with an extended duration of the summer period. This can have a detrimental impact upon agriculture, water resources, the energy sector and the overall health of the population. Changes in the frequency and intensity of precipitation are also noticeable. Climate change can lead to changes in the distribution of precipitation, including more frequent extreme weather events, such as floods or droughts.

Alongside increased temperatures, another noticeable effect is the increased risk of flooding. An increase in the frequency and intensity of precipitation across wider areas can increase the risk of flooding. Serbia has already experienced serious floods in recent years, which has had devastating impacts on the population, economy and infrastructure. Changes in seasonal patterns have also been noticed, including lengthening or shortening of periods within the agricultural season. This can have consequences including endangering crops and livestock. Changes in the water regime are also more frequent: Changes in precipitation and temperature can affect water resources, including drinking water sources, rivers and lakes. This can lead to problems in the supply of water, both for agricultural use and for general consumption. The increased risk of forest fires should not be overlooked either. Namely, increased temperatures and prolonged droughts increase the risk of forest fires. This can have serious economic, environmental and health consequences.

The Environmental Protection Agency reports on the levels of air pollution in Serbia on a monthly basis. By compiling the monthly reports from 2023, a list of the 10 most polluted places/cities in Serbia (defined by the number of days in which the PM10 particulate matter level surpassed permissible amounts) has been created, with the list being as follows: Popovac - 137 days, Novi Pazar - 118 days, Valjevo - 118 days, Uzice - 91 days, Kosjerić - 75 days, Smederevo/Radinac - 71 days, Niš/Sveti Sava Elementary School - 67 days, Pirot - 56 days, Obrenovac - 49 days, Kragujevac – 49 days (B.C., 2024).

Data such as this is forming the basis for Serbia’s implementation of a series of measures in order to adapt to climate change and reduce its negative impacts. These measures include improving flood defense systems, development of sustainable agricultural practices, encouraging the use of renewable energy sources, and other activities aimed at preserving the environment and adapting to climate change.

5. Education

The school system, in essence, has the potential to shape future generations that are aware of, educated about and motivated to contribute to solving the challenges of climate change. The school system plays a key role in the fight against climate change at several levels, starting at the initial elementary level of education with awareness-raising, as this has been proven to have a significant impact on the formation of attitudes and values among young people, as well as the development of climate models and information databases (Đorđević & Jovanović, 2014: 118). Integrating the topics of environmental protection, sustainable development and climate change into the curriculum helps to raise awareness of these issues. Young people who are educated about the impact of human activity on the climate and ways to preserve nature can become future leaders in the field of sustainability.

School systems should also include the basics of developing sustainable practices. Schools can become examples of sustainability by implementing ecological practices throughout their catchment areas. These could include energy efficiency and recycling programs, use of renewable energy sources, conservation of biodiversity on school grounds, etc. Such examples not only contribute to reducing the negative impact on the environment, but also provide practical examples of sustainable behavior for students. The encouragement of research and innovation is also a component of schooling’s mandate; schools can encourage innovative thinking about solutions to climate change. Through various curricula and activities, students can develop an interest in scientific research, technology and innovation that can contribute to solving problems related to climate change. Curricula can be adapted to include current issues related to climate change, not only through the natural sciences, but also the social sciences,

economics, ethics, art and other disciplines, in order to look at the wider context of sustainability.

Finally, engagement in the community itself is best achieved, shaped, directed and supported through the school system. Schools can encourage students to become actively involved in environmental initiatives in the local community. This may include participation in clean-up programs, tree planting, educating citizens about sustainable practices, and other activities that contribute to reducing the ecological footprint.

6. Civic activism and women's activism

Global movements and organizations dealing with climate change often emphasize the importance of local actions and initiatives. It is crucial to develop adaptive strategies to reduce the potential negative effects of climate change on women's health and improve the resilience of communities to such challenges. Civic and organized women's activities can play a key role in the fight against climate change. Activism (Marušić Jablanović & Stanišić, 2020: 129) and lobbying are forms of activities of citizens and organizations to attract the attention of authorities and other relevant bodies in order to promote sustainable policies and measures. This may include organizing protests, writing open letters and meeting with government representatives.

Organizations can also play a key role in promoting a sustainable lifestyle. They can promote sustainable practices in everyday life, such as reducing consumption, recycling, reducing greenhouse gas emissions, etc. This can include promoting a plant-based diet, which often has a smaller ecological footprint. In this sense, organizations can work to strengthen local communities in order to become sustainable. These include promoting renewable energy sources, preserving local biodiversity, waste management and similar initiatives (*Mladi istraživači Srbije*, 2023).

Women's leadership and participation is particularly highlighted through the activities of organizations who affirm the role of women in the fight against climate change (*Mladi istraživači Srbije*, 2020). This can include promoting women's leadership in environmental organizations, women's participation in political processes related to climate change, and supporting women working on the ground to address climate challenges.

Such groups often also advocate so-called ‘ecofeminism’. Ecofeminism offers a perspective from which to explore the connection between ecology and feminism, raising questions about the role of patriarchy in environmental degradation (Galić, 1999: 44-45). Ecofeminist activities can explore these connections and advocate for just and sustainable practices.

As one of the main components of women’s environmental activism, education and awareness-raising activities are almost omnipresent. Organizations and activists can organize education campaigns to inform people about the causes and consequences of climate change. Such education may include workshops, lectures, distribution of informational materials and the like. In this context, climate justice education is particularly important, including activities aimed at raising awareness of the concept of climate justice, highlighting how climate change disproportionately affects the poorest communities and women around the world.

Women and women’s organizations are recognized as key actors in the fight against climate challenges for several reasons. Climate change has a specific impact on women, given their socioeconomic roles, especially in rural communities, where women often play a key role in managing natural resources and providing food. It is crucial to promote inclusivity and support the efforts of all communities in responding to global environmental challenges. Women often play a key role in environmental sustainability and preservation, both through traditional practices and through modern initiatives that promote environmental sustainability. Furthermore, it is important to note that women are often key actors in climate change adaptation and improving communities’ sustainability. These actions, alongside promoting gender equality and strengthening women’s capacities, can be key factors in reducing women’s vulnerability to climate change impacts. Also, the global community is increasingly coming to recognize the importance of inclusive approaches in the fight against climate change.

There are numerous women’s organizations and initiatives around the world that actively fight climate change. Women are recognized as key actors in fighting climate challenges for several reasons. Climate change has a specific impact on women, given their socioeconomic roles, espe-

cially in rural communities, where women often play a key role in managing natural resources and providing food. It is crucial to promote inclusivity and support the efforts of all communities in responding to global environmental challenges. Women also often play a key role in environmental sustainability and preservation, both through traditional practices and through modern initiatives that promote environmental sustainability.

It is important to note that women are often key actors in adapting to climate change and building the sustainability of communities. Improving adaptation to climate change, promoting gender equality and strengthening women’s capacities can be key factors in reducing women’s vulnerability to climate change impacts. Also, the international community is increasingly coming to recognize the importance of inclusive approaches in the fight against climate change.

7. Allies and support

Women have formed a variety of alliances and partnerships with different organizations and groups in the fight against climate change. Key allies include NGOs, women’s networks, global activist movements, international agencies, and both regional and local governments. Parts of the academic and private sectors have also proven to be key partners.

Various non-governmental organizations, especially those dealing with environmental protection, women’s rights, social justice, the fight against gender-based violence, and women’s safety, are often key allies of women in their fight against climate change. These organizations provide platforms for activism, education, and lobbying for policies that address climate challenges. Broader organizational models include women’s networks and organizations, such as the Women’s Environment and Development Organization (Women’s Environment and Development Organization, n.d.)³, which work to connect and support women in the fight against

³ For decades, feminist activists around the world have raised their voices to organize for climate justice and influence climate policy. WEDO has, across its over-thirty-year history, worked to bring feminist and environmental justice analyses into – and center the voices of frontline and grassroots women’s rights advocates and leaders in – climate policy spaces.

climate change. These organizations provide platforms for sharing experiences, support and capacity building. Women also often collaborate with wider global movements, such as Fridays for Future,⁴ Extinction Rebellion (Rejuvenate, n.d.) and others in the fight against climate change, to collectively raise awareness of the urgency of climate challenges and demand action to address it. They are often in synergy with international agencies, such as UN Women, which support initiatives linking gender equality with climate issues. They promote inclusive policies and support projects that address the specific needs and roles of women in the context of climate change.

Regional and local authorities play a key role in adapting and mitigating the impact of climate change (Milutinović, 2018: 87). Women are often themselves part of these local authorities or collaborate with them to influence policy, develop sustainable projects, and implement initiatives that contribute to the fight against climate change. Academia provides expertise and research resources that can support women’s arguments and initiatives in the fight against climate change. This partnership enables better-informed decisions and policies.

8. Independent institutions

Independent institutions such as ombudsmen and equality commissioners can also be allied institutions to women’s initiatives for protection against climate change.

Activists who fight against the negative effects of climate change can often cooperate with independent institutions in such activities, especially the ombudsman. The direct role of the ombudsman in the field of climate change may largely depend on the legislation and mandate assigned to them in a particular country. This institution can be part of a wider network of organizations, agencies and bodies dealing with issues of

⁴ FridaysForFuture is a youth-led and -organized movement that began in August 2018, after 15-year-old Greta Thunberg and other young activists sat in front of the Swedish parliament every schoolday for three weeks, to protest against the lack of action on the climate crisis. She posted what she was doing on Instagram and Twitter, and it soon went viral.

environmental protection and sustainability. The ombudsman, i.e. the protector of citizens, usually has a role in protecting the rights of citizens against abuses of power or administrative failures (Glušac, 2017: 62). However, in the specific context of the fight against climate change, this institution may have a certain role, but it is not directly focused on solving issues related to climate change.

The fight against climate change usually involves broader action that includes policymaking, implementation of measures, regulation of industry, public education and similar activities. The ombudsman can be involved in these topics in several ways, especially by monitoring the rights of citizens in relation to environmental protection. The ombudsman can investigate citizen complaints related to environmental issues, including those related to climate change. The ombudsman’s mandate includes monitoring the implementation of laws in order to see how the authorities apply laws and regulations related to environmental protection and climate change. The ombudsman’s activities include advocacy for fairness and transparency, to promote fairness in access to resources and justice in situations that affect citizens in connection with climate change. It can also insist on transparency in the decision-making process in instances where a potential impact on the environment is evident.

Finally, we should not lose sight of the parts of the private sector that increasingly recognize the importance of climate sustainability and climate social responsibility. Partnerships between women’s organizations and companies can foster innovation, support sustainable practices and work to reduce emissions.

The fight against climate change usually involves broader actions that include making all these allies work in unison to contribute to creating a stronger and more inclusive movement to fight climate change, with an emphasis on the rights and role of women in this process. Women around the world today have a key role in the fight against climate change, and their contributions are multiple and significant. Women’s marches around the world, e.g. Women’s March for Climate (*The International Hospital Federation*, 2023)⁵, dedicated to topics such as equality, women’s rights

⁵ Such as, for example a women march from the United Nations of Geneva to the Swiss capital city of Bern for climate commitments. A Swiss collective based in Vevey (Vaud)

and the fight against climate change, have become an important platform for raising awareness. Women have played a key role in the organization of and have participated in a large number of marches around the world, drawing public attention to the urgency of the climate crisis. Also worthy of mention is the Women4Climate initiative (Women4Climate⁶ n.d.), launched by the mayor of Paris, Anne Hidalgo, to bring together and support women leaders working on climate change solutions.⁶ The initiative provides a platform for sharing experiences, support and mentorship for women dealing with climate issues.

Of course, nothing can be written on this topic without mentioning the protest and activism of Greta Thunberg, a young Swedish activist who has become a global symbol of the fight against climate change (*BBC News*, 2023). Her leadership and courageous advocacy at the global level are helping to raise awareness of the urgency of climate issues, inspiring many, especially young women, to become involved in activism.

Outside of Europe, the Indian village “Solar Mamas” (Iqbal, 2017)⁷ movement has also gained significance. Barefoot College, an educational and sustainable development organization, runs a training program called “Solar Mamas”. This program trains women from rural communities, especially from India, to become solar engineers. The women then introduce these skills to their communities, giving them access to renewable energy sources and reducing their dependence on fossil fuels.

has launched a march to refocus Switzerland’s attention on the climate emergency and remind the federal government to abide by existing commitment. Switzerland ratified the Paris Agreement in October 2017 and committed to halving its emissions from 1990 levels by 2030. The event takes place a few days after the historic court case on climate policy and health brought forward by a Zurich-based group of over 2000 women at the European Court of Human Rights

⁶ Women4Climate was launched in 2016 by C40 Cities and the L’Oréal Foundation. Women4Climate emphasizes the connection between achieving climate justice and gender equality. The aims are to empower and inspire the next generation of climate leaders through a global mentorship program dedicated to women in C40 cities, and raise awareness through research on gender, cities and climate to highlight the key role women play in championing climate action in cities.

⁷ A college in Rajasthan teaches rural women – many of them illiterate – how to fabricate solar panels, lights and photovoltaic circuits.

The Women in Renewable Energy in Africa mentorship program addresses renewable energy issues in Africa, with a particular focus on women, aiming to empower them through renewable energy training, creating entrepreneurial opportunities and promoting sustainability in local communities (*Global Women’s Network for the Energy Transition*, 2021).⁸

These examples illustrate the significant role that women play in the fight against climate change, both locally and globally. Their contribution includes awareness raising, implementation of concrete projects and initiatives, as well as active participation in the global dialogue on climate issues.

9. Opponents and obstacles to women’s environmental activism

There are no globally engaged group opponents to women’s organizations fighting climate change. But there are certainly several factors and actors that can act as obstacles to or opponents of women’s efforts in this struggle. Above all, the main obstacle is the gender inequality still present in various forms and various spheres of society. General gender inequality and patriarchal social patterns can act as barriers to women’s activism in general, including those dealing with climate issues.

A lack of equality in access to education, resources and political influence can make it difficult for women to effectively express their views and participate in decision-making at levels that affect climate change. Standing as a significant opponent of global importance to this is the interest(s) of industries based on fossil fuels. Such industries can often prove to be a major impediment to sustainable energy changes. These industries often have a large influence on the political process and can lobby against

⁸ To advance the role of women as agents of change in the energy transition, IFC’s Women in Renewable Energy in Africa Network, in partnership with Energy2Equal and the Global Women’s Network for the Energy Transition, has launched a mentoring program for women professionals working in renewable energy in sub-Saharan Africa. The program aims to address the gender gap in the renewables sector and advance the careers of mid-career women working in the energy transition, with the specific goal of increasing women’s representation at managerial and decision-making levels, and ultimately advancing the pace of the energy transition.

policies and initiatives aimed at transitioning to renewable energy sources. Related to these are also financial interests, including those inextricably connected to the exploitation of natural resources, for example forestry, mining and oil prospection, which are opposed to sustainable practices that could limit their profits. These interests can also have a major influence over political decisions.

There is also the issue of political resistance at both national and international levels. Some political leaders and governments may express a disinclination for policies that focus on reducing greenhouse gas emissions or adapting to climate change. Such reluctance can make it difficult to make decisions and implement measures that could improve environmental sustainability. Part of that resistance can be attributed to so-called climate change skepticism. Namely, groups and individuals who deny the existence or importance of climate change can be an obstacle in directing social attention and resources towards solving these issues. This type of skepticism can contribute to procrastination in relation to the design and implementation of adequate measures (Štavljanin, 2022).

It is important to note that these opponents are often part of a wider context of economic, political and social dynamics, and that they are not necessarily groups that are directly “against” women. However, these factors can have a negative impact on women’s efforts to combat climate change. Organizations and individuals fighting for justice, equality and sustainability usually put sustained efforts into overcoming such obstacles.

10. Ending notes

It is to be particularly stressed that gender-inclusive, non-discriminatory approach to climate change risk reduction can diminish health risks for women, families and communities. Education, civic activism, institutional support and alliances (including with the independent institutions) are highlighted as important elements of protection against climate change. Various mentioned examples illustrate the significant role that women can play in the fight against climate change, both locally and globally. Their activities include awareness raising, implementation of concrete projects and initiatives, as well as active participation in the global dialogue on climate issues. Women, in state, professional and social structures where they

have equal legal, political and economic opportunities, can perform multiplied functions validly as participants in all gender inclusive processes of building accessible health and other security institutions. When becoming leaders (not only victima) in the field of reducing the health risks of climate change their contribution to building and strengthening the resilience of communities and countries to climate change, is to be significant.

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Providing emotional support to people in crisis

Abstract: *Center “Srce” is a non-governmental, non-profit and volunteer organization that deals with providing emotional support to people in crisis and suicide prevention via phone, chat and e-mail. A crisis situation can be defined as a sudden event that is very disturbing and stressful for most people, and it includes a certain threat, i.e. the feeling of loss or the actual loss of persons, things or values that are important to an individual or a group. Crises arise in moments when life values and systems in the community are threatened. There are many types of crisis situations and such events affect people to a greater or lesser extent, and their personal strengths, abilities and characteristics help them cope with them. In situations where personal resources are not sufficient, additional support is needed. The aim of this research is to determine the trend of change in the need for emotional support before, during and after the crisis situation in Elementary School “Vladislav Ribnikar” that occurred on May 3, 2023, as well as determin-*

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ing the potential impact of the crisis situation on the mental health and functionality of the population. Center “Srce” conducted research in the period from February to August of 2023. Statistical data show an increased need for support in the period from May to August 2023 over the phone, chat and e-mail.

Keywords: crisis situation, emotional support, mental health.

1. INTRODUCTION

The essence of mental health is presented in the definition of health defined by the World Health Organization (WHO): “Health represents complex physical, mental and social well-being, and not only the absence of disease and disability”. From the stated, it can be concluded that mental health is an integral part of general health, which the WHO further defines as “a state of well-being in which each person realizes his potential, copes with everyday stress, can work productively and is able to contribute to his community”. Mental health is therefore seen as a prerequisite and fundamental determinant of quality of life.⁸

In June 2022, the World Health Organization (WHO) published its largest ever review of mental health in a report titled “World Mental Health Report: Transforming Mental Health for All”. WHO reports that nearly one billion people worldwide have mental health problems, and that suicide is the cause of death in more than one in 100 deaths (WHO, 2022).

The 2013 Act, which is still in force, creates a legal right to mental health care.⁹ The 2019 Program on Mental Health Protection in the Republic of Serbia states that every person has the right to access mental health care and treatment in mental health services run or funded by the respective government. Such services include:

- provision of acute mental health care services such as outpatient and hospital services;

⁸ Official Gazette of the Republic of Serbia, no. 84/19, Official Gazette of the Republic of Serbia, no. 45/13.

⁹ Ibid.

- provision of halfway houses, sheltered accommodation, supported accommodation as may be prescribed;
- provision of mental health services to support the family of a person with mental illness or rehabilitation at home;
- provision of mental health services for children and mental health services for the elderly.

The Act also specifies that mental health services must be linked to general health services, as the Act requires the respective government to integrate mental health services into general health services at all levels of health care, including primary, secondary and tertiary health care, as well as in all health programs run by the respective government.¹⁰ There is no health without mental health, so linking all health services together makes sense: our minds are affected by our physical health, just as our bodies are affected by our mental health (Kelly, 2022).

1.1. Providing support at the Center “Srce”

Center “Srce”, based in Novi Sad, is a volunteer, non-governmental, non-profit organization that deals with providing emotional support to people in crisis and suicide prevention.

The “Srce” center was founded in 1991 on the initiative of a group of professors from the University of Novi Sad, among others, prof. Dr. Slobodanka Stanković and Prof. Dr. Slavica Selaković-Buršić, as a Counseling Center for psychological assistance to participants in the war. Although the Center’s services were originally intended for war victims, it was found that “ordinary” citizens, who were not directly threatened by the war, have a great need for psychological help. If taken into account the fact that, for decades, the high suicide rate, which characterizes Vojvodina, is the beginning experienced its greatest values in the nineties, it is clear that there was a need to activities of the Center redirected from one risk group, to the needs of the entire society under risk. Thus, in 1993, the Center changed its name to Srce - Psychological Counseling Center for Crisis conditions and victims of war, and becomes a member of the network of centers dealing with crisis interventions and suicide prevention – “Befrienders

¹⁰Official Gazette of the Republic of Serbia, no. 84/19.

International” (today “Befrienders Worldwide”). The network gathers around 40,000 volunteers in 350 centers from 32 countries and represents one of the largest associations of its kind in the world. Since that year, the working principles of “Srce” have been harmonized with internationally accepted methods. Since 1994, the Samaritan Center from Winchester and “Srce” have been brotherly centers. Through this type of cooperation, “Srce” receives support in the form of advanced volunteer education, advice and support when organizing larger activities, as well as material support. “Srce” has been developing regional cooperation in order to improve and protect the mental health of children since 1997 thanks to the organization for the promotion of volunteer work “Slovenska philanthropija” from Ljubljana, and since 2008 it has been an associate member of the International Association for Suicide Prevention “IASP”.

The current name of the Center dates back to 2000: Srce - Center for emotional support and suicide prevention. In that year, the first activities were started to introduce support via e-mail, and ten years later the possibility of communicating via chat appeared.

Every day of the year, the volunteers of the “Srce” Center talk to people who are lonely, anxious, hurt, sad, desperate, insecure, and - listen to them. They don’t give them moral sermons, they don’t belittle their problems, they don’t “comfort” them that their problems will pass and, most importantly, they don’t tell them what to do. Because they believe that each person knows best what is good for him, and that he has the right to decide about his own life, even if he decides to end it. All data received from users is strictly confidential and remains within the Center. The only exception to this rule is information about a criminal offense (committed or planned), which the Center has a legal obligation to report to the competent services. The values that Center “Srce” nurtures refer to the essential beliefs that form the basis of the work, namely that every person has the right to explore their own (difficult) feelings, that human contact, attention and compassion are basic emotional needs, and that listening in trust and acceptance without prejudice can alleviate human unhappiness and the feelings that lead to suicide.

The Center’s mission is reflected in emotional support for people in crisis and suicide prevention via phone, e-mail and chat. In this way, it

is believed that the discomfort felt by a person can be alleviated and the level of suicidal feelings can be reduced, while the vision of the Center is the existence of a society in which fewer people take their own lives, in which people can freely explore their feelings and in which people can acknowledge and respect the feelings of others.

An essential characteristic of the approach, which is used in contact with users, is non-directiveness, and the basic conversation technique is active listening. Active listening involves accepting the interlocutor completely, without prejudice, and providing an atmosphere that allows him to explore his feelings and talk openly about them. At the same time, the interlocutors are not given any advice, moral judgments or consolation that what is bothering them will pass. A conversation conducted in this way will not lead to the solution of current life problems and dilemmas, but it can lead to emotional relief and to the fact that it is easier to overcome the given moment, and in the best case, it can lead to observing the given problem from a different angle, which opens up the possibility of appearing new ideas that can contribute to overcoming it.

The working principle of the Center is very simple. When the number is called, which is free, someone who wants to listen to what the interlocutor has to say on the other end will answer, someone who openly approaches the most painful topics, tries to understand, does not judge, gives the opportunity to share the burden that accumulated in the chest, throat, head... Sometimes you need to say your thoughts out loud, to be heard and accepted, to know that someone cares.

If there is a certain difficulty or discomfort when talking about what is pressing and causing restlessness and it is easier to express feelings, thoughts and problems through the written word, there is the possibility of sending an email. The advantage of e-mail is that the interlocutor does not have to pay attention to the time of sending, and he can write the letter whenever he feels the need, regardless of the time of day or night. That letter will be answered within 24 hours.

If written communication is a mitigating circumstance for the interlocutor, but it is necessary to get an answer quickly, on the website of Center “Srce” there is the possibility of chatting via chat. Clicking on a certain field opens a chat window with one of our volunteers.

Many interlocutors are interested in talking live about the problems that bother them. Unfortunately, the technical conditions and the size of the space where the work takes place do not allow support to be provided by phone, e-mail, chat and live at the same time. We hope that this situation will change in the near future.

When everything we're dealing with becomes overwhelming and seems like it will never end, we need all the support we can get. Loneliness can grow into great suffering, but the Center's beliefs are that none of us need be alone when it's most difficult.¹¹

1.2. Defining terms: Differences between stress, trauma and crisis

Stress, trauma and crisis, although they are often used as synonyms in the literature, differ significantly in relation to the intensity and consequences they leave behind.

Stress is a reaction to changes or events (stressors) that are assessed as demanding, dangerous or frustrating, and which results in a person's physical, emotional and intellectual responses. Some events are universally stressful for all people, that is, everyone has the same or similar reactions to such events. These are the loss of a close person and the loss of financial security (leaving a job, being fired...). The consequences of such events can be changes in mood, sadness, anger, feelings of guilt and helplessness, as well as various other psychological and physiological conditions (Vlajković and Vlajković, 2014).

Behavioral responses to stressors can be diverse, including alcoholism and the use of psychoactive substances, aggressive and violent behavior, delinquency, running away from the environment (school, home...) various forms of destructiveness, up to attempted or committed suicide (Genc, 2021 according to Lacković- Grgin, 2004).

On the other hand, a traumatic event is an event that is more intense than a stressful event, is life-threatening and does not happen to everyone. War, natural disasters, terrorist attacks, violence, kidnappings represent various traumatic events that cause traumatic and post-traumatic reactions.

While people react to stressful situations depending on their personal assessment, reactions to traumatic events are the same for all people.

¹¹ Center Srce, accessed 21. 10. 2023. from <https://www.centarsrce.org/>

Psychological trauma is a psychological condition that occurs as a result of severe or extreme shock. Traumatic events and reactions to them can lead to permanent impairment of mental health. Traumatic reactions, when they last longer and significantly affect a person's value system and life philosophy, can lead to a state called a crisis (Vlajković and Vlajković, 2014).

A crisis situation can be defined as a sudden event that is very disturbing and stressful for most people, and includes a certain threat, i.e. a sense of loss or the actual loss of persons, things or values that are important to an individual or a group (Dragaš, 2023 according to Ajduković, 2000). Crises arise in moments when life values and systems in the community are threatened.

1.3. Crisis situations

A crisis situation is defined as a sudden event that is very disturbing and stressful for most people, and includes a certain threat (Dragaš, 2023 according to Ajduković, 2000). Crises arise in moments when life values and systems in the community are threatened. Depending on how these values are threatened, will determine how deep the crisis is. Although a crisis does not automatically involve casualties or damage, public fear can spread.

The consequence of a crisis event is a psychological state of crisis in people, where the public and survivors have a feeling of insecurity and are often looking for someone to blame for such a situation. Then people most often feel helplessness, loss of control and security and therefore can behave in a disorganized manner. A crisis can be defined as a state of psychological disturbance, which is at the turning point between normal and pathological reactions (Vlajković and Vlajković, 2014). Due to the fact that the event involves a threat to the individual, such reactions and a state of psychological crisis can be considered a normal reaction to an abnormal situation. As a consequence of dealing with a crisis, increased suicidality often occurs, which is usually preceded by the previously mentioned feeling of helplessness, depression, loss of control, and psychological crises. The research results of the Clinical Center in Banja Luka testify to the increased suicidality, but at the same time the importance of close relationships (Sulejmanović, D., Dragišić, T., 2014). Walsh F. states that individ-

uals who have difficulties in overcoming crisis reactions often show suicidal or, on the contrary, aggressive behaviors directed towards others (Walsh, F. 2007). The research conducted after the Covid-19 virus pandemic in the Republic of Croatia also speaks of the sensitivity of young people and women to crisis situations, as well as the degree to which the interrelationship of the consequences of the crisis affects the increase in self-destructive behavior and suicidal ideation (Rezo Bagrić I., Sušac N., Reichwein Bulat, L. 2023).

Many believe that a crisis event affects only the location and people affected by the event itself, however, the more intense and traumatic the crisis event is, the more people and institutions it will affect, and thus the entire community. In addition to the consequences for the mental health of individuals, crisis events can also have significant consequences for the entire society. In accordance with the aforementioned, there is also a significant impact of the crisis on the quality of family and partner relationships. Numerous studies conducted during the Covid-19 virus pandemic confirmed the sensitivity of these relationships to the crisis, including a study conducted in Bosnia and Herzegovina whose results unequivocally show an increase in negative aspects and destructive behavior between partners (Dudić, A., 2020). The importance of the stability and quality of family dynamics for maintaining mental health in a crisis is also discussed by the University of Zagreb research (Rezo Bagrić I., Sušac N., Rajhvajn Bulat, L. 2023). Hadžić A. explains the origin of the stressed sensitivity of families to crisis situations, stating that families with children face developmental crises every day, and that external crisis factors further collapse family dynamics (Hadžić, A 2015).

Many crisis situations can lead to traumatization. Traumatic experiences encompass a variety of events, including accidents, loss of loved ones, mass violence, war, terrorism, colonization, displacement, and natural disasters (Tedeschi, 2023). Such experiences can be individual and collective. Collective traumatic experiences refer to psychological reactions to traumatic events that affect the entire society. A school shooting is one such event, which is very disturbing and traumatizing. Given that school is seen as a safe place where children learn, grow and develop, but also spend

a large part of their time there, such traumatic events deeply affect the community and increase fear and mistrust among individuals.

When we look at individual and collective reactions to trauma, they are different, as are the coping strategies for such losses. Crisis, traumatic events have certain predictable consequences that are inevitable. When defining large-scale crisis events, the focus is on the consequences, where the community's ability to overcome these events exceeds their capabilities. For this reason, some psychiatric disorders, such as post-traumatic stress reactions, can be seen as normal reactions to abnormal situations. Post-traumatic stress disorders, depression, anxiety and suicidality increase after such events. Risk factors for the development of psychiatric disorders are numerous, such as personality factors and character traits, vulnerability, gender, age, number and intensity of stressors, level of exposure to trauma, psychiatric comorbidity or belonging to marginalized groups. In addition to the consequences concerning mental health, large traumatic events and collective reactions to them can cause significant challenges and consequences for society and the law, which have a negative impact on families and wider communities, inciting fear and distrust in the existing system (Pejušković and Lečić-Toševski, 2023).

Research has shown that in overcoming a crisis, social contacts play an important role, because in the absence of social contacts and in the absence of some kind of support, people feel difficult, depressed and become more closed. There is a possibility that as a result of the crisis, there may be an increase in violence, especially in families, or an increase in conflicts in families (Kušter, 2021).

How people react to crisis situations, but also whether they will seek help and in what way, will depend on many individual factors. When looking at a person's age, age will partly determine the reaction, but what all people have in common is that they will feel some kind of suffering and fear. In the manual Vlačković and Vlačković (2014) “Psychological crisis interventions in educational and educational institutions” the psychological reactions of adults, children and young people to crisis situations that can happen in educational and educational institutions are described. It is important to know what the expected reactions of persons in such crisis

situations so that we can better help the person and provide them with understanding and support.

Children of preschool age often have feelings of anxiety and concern for their own safety and the safety of close people, a greater fear than before of being separated from close people, such as parents, as well as concern and fear that such an event could happen again. There may be problems with concentration and attention, sleep problems, as well as waking up during the night, constant fatigue, and changes in appetite. Due to traumatization, it may happen that they withdraw into themselves, lose interest in activities they enjoyed before, regression may also occur. They feel constant restlessness, headaches, stomachaches, and may have a greater sensitivity to sounds. In addition to all that, they feel constant anxiety, more negative emotions, show more anger and aggression and oppose adults more.

Children in primary schools, given that they already have a little more knowledge and awareness about certain topics, can have more intense reactions. They also feel the fear of such an event happening again, with additional feelings of disbelief that the event happened at all, where the child doubts its reality. Children at this age may also feel guilty and obsessed with thinking that they could have prevented the event in some way. They feel tired all the time, have learning difficulties, forgetfulness, loss of enjoyment in activities such as hanging out with friends. They often cry and feel anger, but also shame that they cannot overcome the crisis situation. They feel the need to be alone or next to adults who love them, and at the same time, because of all the difficult feelings, they often fight and everything annoys them.

Younger children in secondary schools also doubt reality, do not believe that the crisis event really happened, feel senseless and superstitious, or do not want to discuss the event at all or only want to talk about it. As before, difficulties in memory and learning appear, sleep disorders, anxiety, they are not kept in place, they are prone to impulsive reactions. Interest in things that were previously attractive is lost, withdrawal and seclusion, as well as hypersensitivity (Vlajković and Vlajković, 2014).

However, not every child exposed to a traumatic event will necessarily develop symptoms of trauma. Many children have been shown to

exhibit resilience and the ability to overcome and thrive, even when faced with severe traumatic events (Little, Akin-Little & Somerville, 2011 according to Leckman & Mayes, 2007). What is common across cultures is that children mostly attend schools, and if they happen to experience traumatic events, the school and its teachers are most likely not trained to work with children in such a state (Little et al, 2011).

Adults and their reactions are not much different from children's. They often have painful feelings about the event itself, deny the event or avoid talking about it. Problems with concentration, forgetfulness and pre-occupation with those thoughts, insomnia and frequent nightmares about the event, sweaty hands, trembling hands, stomach pain, palpitations, changes in body weight, and loss or decrease of interest in usual activities. Mood changes, feelings of sadness, crying, uncontrolled outbursts of anger, anger, excessive fear, caution, vulnerability are also common, and withdrawal into oneself, pronounced self-criticism, listlessness and feelings of guilt are also common (Vlajković and Vlajković, 2014).

Among individual differences and tendencies to seek help in the field of mental health, there is a common difference between the sexes - one of the most common results in the literature is precisely that women report a mental health problem more often and seek help in this area more often than men. Researchers in this field agree that gender differences in help-seeking can be explained by the different influence of gender roles in given cultures, with a focus on family relationships and taking the lead in them. Cultures that attribute strict gender roles result in men assuming responsibility for making decisions and performing tasks, while women assume socio-emotional leadership by maintaining psychological well-being in the family (Doherty and Kartalova-O'Doherty, 2010 according to Rogler and Cortez, 1993). Studies suggest that traditional ideology of masculinity is a significant factor in seeking help, especially in the area of mental health and emotional problems (Doherty and Kartalova-O'Doherty, 2010).

Also, age can be a factor that affects seeking help in the field of mental health. Age can influence the desire to share personal information, where older people are less inclined to share than the younger population (Doherty and Kartalova-O'Doherty, 2010 according to Ward et al., 2007).

It has been mentioned several times that such reactions to traumatic experiences are not unexpected, but are, moreover, quite common and normal. All these reactions have a situation as a common cause, where the situation itself is not normal. Depending on the person's resilience and other factors, they can last several weeks or even several months. There is also a possibility that reactions occur immediately after the event, but also several months later (Vlajković and Vlajković, 2014).

So, as we can see from the literature, traumatic crisis events and reactions to them can leave lasting consequences for the mental health of individuals and the entire community. In order to alleviate or prevent traumatization, people are offered psychological crisis interventions, which focus on providing support and assistance, in order to reduce the feeling of helplessness and prevent the occurrence of more severe and long-term mental health consequences.

Getting out of the crisis is not easy, it is necessary to react and not ignore the crisis, thinking that it will resolve itself. This can only lead to even greater dissatisfaction and mistrust of people in the community. It is necessary for all institutions to work together and invest in solving the crisis in the long run.

1.4. School shootings

Although schools and educational institutions were once considered safe places, mass killings in schools are a social problem that has increased greatly in recent years. School shootings are not a new phenomenon. In 1974, an 18-year-old honor student started a fire at his school and set off the alarm, then shot the janitors and firefighters who responded to the alarm (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002; Wike & Fraser, 2009).. As statistics reveal that school violence has increased by 19% in the 21st century, parents, teachers, school counselors, and school administrators are seriously concerned about their safety and that of their students (Paolini, 2015).

School shootings, especially those of a dramatic nature, cause strong public outcry, and rightfully so. After an apparent series of incidents that occurred between 1997 and 2001, the US seemed to be on the verge of a moral panic about delinquency and nihilistic youth culture. Since then,

“Columbine” has become a catchword for a complex set of emotions surrounding youth, risk, fear, and delinquency in 21st-century America (Muschert 2007). One alarmist, Stein, went so far as to label Columbine as a metaphor for the contemporary crisis of youth culture (Stein, 2000; Muschert, 2007). From Columbine to Sandy Hook, to most recently Marysville-Pilchuck High School in Seattle, Washington, innocent and vibrant lives are being taken by senseless acts of gun violence. According to Koch (2012), a college student living in the United States, compared to the Scandinavian countries of Finland or Sweden, is 13 times more likely to be killed in a gun homicide (Paolini, 2015).

Violence in schools is viewed by some authors as part of a wider problem of American society, emphasizing the fact that children and adolescents are victims of more crimes than any other age group in the United States. Attacks of this type (generally called “rampage school shootings”, meaning crimes involving anger, rage and fury) occur, more or less frequently, in many countries, but most of the available data, analysis and literature comes from the USA. An even more important reason to analyze exactly these crimes committed in the USA is that these crimes committed in American schools stand out exceptionally and strikingly in terms of frequency and number. There were 120 such attacks in the world, of which 76 in the USA, or 63.33%, in all [33] other countries 44 (36.66%); in terms of the number of these crimes, Germany is in second place (8; 6.66%), while Canada is in third place (7; 5.83%). These three highly developed countries, therefore, cover as many as 91 cases out of a total of 120 (75.83%). As for the frequency of such events, there is a noticeable trend of accelerated growth in recent decades, on a global scale. So, in just three (last) decades, as many as 104 (86.67%) of a total of 120 attacks took place, with the fact that an increasing trend has been observed since the 1950s, which accelerates significantly with each decade. In addition to the growth trend, the fact that attacks are increasingly dangerous and deadly is also worrying because, for example, the number of people killed per attack has doubled in two decades (Bralić et al, 2016).

Until May 3, 2023, Serbia and the surrounding countries had no experience with mass school shootings, but that all changed on that fateful

day. Namely, an unprecedented tragedy occurred in the elementary school “Vladislav Ribnikar” around 8:36 a.m. local time on May 3, 2023.

After an armed attack with a gun, nine students and a security guard lost their lives, and 6 people were seriously wounded (five students and a teacher) by a minor student. Soon after, the police arrested the perpetrator, who was later found to be a thirteen-year-old student in the seventh grade of that school.

1.5. Why Center Srce?

As this news and the negative events that followed after May 3 shook the public, the question of collective concern for safety and the importance of mental health was raised. The story of mental health has become more and more prevalent in recent years. As stated by Stamatović-Gajić et al. (2008), the fact that one out of four people has a mental problem or disorder at some point in their life indicates a great need for health services (Stamatović-Gajić et al, 2008).

The challenges related to mental health, which are also faced by young people, are unfortunately often only discussed when a tragedy upsets the general public.

For this reason, the right to availability and access to mental care and health for people is of great importance. Thanks to the influence of the media and the high coverage of the event itself, people felt the need to turn to someone and get the support they needed at that critical moment. As the public realized the importance of centers that provide support of a psycho-social nature, the Srce center found itself in the first ranks. With a long tradition of 32 years in providing emotional support to at-risk groups, the Srce center itself was more visible, and people approached more. Thanks to the strict anonymity and confidentiality of the data, people felt safe to share their feelings and fears with the volunteers. Due to their competence in working with crisis groups, volunteers from the Srce center often had guest appearances and gave statements related to the very importance of support in crisis situations.

2. APPLIED METHODOLOGY

It was noticed by many volunteers that after the crisis event, the volume of work increased, that is, that we had more calls, emails and chats. As a result, there was a need to assess in the coming months whether there is a trend of increasing the volume of work, or whether the need for support has increased.

The aim of the research is to determine the trend of change in the need for emotional support before, during and after a crisis event, as well as to determine the potential impact of a crisis situation on the mental health and functionality of the population.

The sample refers to persons (inviters), of both sexes and of different ages, who contacted the Srce Center through various communication channels in the period from February to August. Communication is done via a free phone number, email and chat. The total number of contacts made in this period through all communication channels is 4749. The number of phone calls is 1283, the number of emails is 2307, and chats are 1159. Due to data privacy, the territory of the respondents is not known to us, but calls are free for the territory of Serbia, while people from all over the world contact us via e-mail and chat.

The age categories of the respondents range from under 15 to over 65 years old. The number of male contacts included in the research is 1455, and female contacts 2993. For many contacts, we do not have data on the sex of the respondents due to the need for anonymity 242.

The data were collected in the mentioned period through the Registry of the Srce Center. At the end of each month, they were processed for each category of the register individually. After the initial preparation, the obtained results were combined and further statistically processed. The register contains basic data: gender, age (grouped into age categories,), marital status, communication channel, type of support, risk assessment, type of problem, condition at the end of the call, how often they occur. The registry was constructed for the internal needs of the Srce Center, for the purpose of statistical reports on the volume of work.

3. RESULTS AND DISCUSSION

The “Srce” center is, after the tragic event that happened on 5/3/2023. in Serbia, received a significantly higher number of calls (phone, chat and mail) compared to previous months in the current year. The total number of calls made in April was 584, while in May there was an increase to 762. The trend of growth in the number of people contacting the center continued in June, when the total number of calls was 794, which was followed by a further decline in this indicator.

In the total number of callers, the increase of those who stated that they are contacting the “Srce” Center for the first time is also noteworthy. That number was 282 in April, while in June it was almost doubled and amounted to 505.

Although the events took place in May, the trend of increasing calls continued in June, when it reached its peak. Traumatic events have certain predictable consequences that are inevitable - these are mostly common, normal reactions to abnormal events. Strategies for coping with crisis events differ at the individual level (Pejušković and Lečić–Toševski, 2023). However, depending on resilience and other factors of an individual nature, reactions can occur immediately or several months later. Also, they can last several weeks or several months (Vlajković and Vlajković, 2014). Given the individual nature and multiplicity of factors that influence the exercise of different coping strategies, the time during which a person faces the consequences and remains in crisis can vary, therefore delayed reaction is not a rare case. However, what characterizes the state of crisis is the belief that it is not possible to overcome the current situation with the usual coping strategies, which leads people to search for external resources, where the “Srce” Center is recognized as a synonym for providing emotional support.

Within the age categories, a change was observed in the number of younger callers, up to 25 years old. In the categories of callers up to 15 years old, and those between 15 and 24, a significant increase in the number of calls was observed in May, which continued to grow in June and reached twice the value compared to April this year.

The authors find that age can be a factor influencing help-seeking for mental health problems, with older people less likely to share personal information than younger people (Doherty & Kartalova-O’Doherty, 2010 according to Ward et al., 2007). Also, among the reactions to the crisis event, there is concern that the event may happen again. Children of pre-school age often have feelings of anxiety and concern for their own safety and the safety of close people, a greater fear than before of being separated from close people, such as parents. Children in primary schools, given that they have more knowledge and awareness of certain topics, can have more intense reactions. They also feel fear that such an event will not happen again, with additional feelings of disbelief that the event happened at all, where the child doubts its reality. For the most part, the school population among young people can experience constant restlessness, weaker concentration and attention, learning difficulties, anxiety, and withdrawal. Adults and their reactions are not much different from children’s. (Vlajković and Vlajković, 2014). However, not every child exposed to a traumatic event will necessarily develop symptoms of trauma. The authors suggest that in fact many children demonstrate resilience and the ability to overcome the situation and thrive, even when faced with severe traumatic events (Little et al., 2011).

Bearing in mind that the specific events took place in the school environment and mostly affected the school population and people close to them, the similarity in terms of age categories and involvement in the school system additionally influenced the reactions of younger people to this event. Given the amount of time they spend in school, due to the fact that most school staff are not trained to work with children who have lived through traumatic experiences, children are more likely to turn to outside resources for help.

Therefore, the difference in the needs of older and younger people in such situations arises from the different needs of these age categories. Young people’s need for understanding both personal thoughts and feelings, as well as external events, combined with openness to sharing personal information, resulted in a greater need for support in this period.

The gender structure of the callers follows the existing difference between the sexes - the number of female persons who contact the Center

“Srce” is consistently higher than the number of male persons. Along with the increase in the number of total callers, there were greater differences in the gender structure. A significant increase in female callers compared to male callers was observed. However, it is necessary to mention that there are data on persons who did not declare their gender, and that this number also increased in the months of May and June.

Research into individual tendencies to seek help in the field of mental health, most often point out that women report mental health problems more often and seek help in this area more often than men, which is explained by established, traditional gender roles. Family dynamics, which are colored by these gender roles, generally result in men taking over making important decisions and performing tasks that provide resources, leaving little room for problems and needs of an emotional nature. On the other hand, the focus of women is being redirected to maintaining socio-economic well-being. Studies suggest that the traditional ideology of masculinity is a significant factor in seeking help, especially in the area of mental health and emotional problems (Doherty & Kartalova-O’Doherty, 2010). Cultivating traditional values, and therefore gender roles, is deeply rooted in our culture, where therefore women pay much more attention to the needs of an emotional nature and share them with other people in their environment. For these reasons, a greater number of women turn to external resources for psychological help and emotional support, especially in crisis situations when current coping strategies are not sufficient to deal with current events, i.e. crisis situations.

Among the types of problems reported by callers, an increase in problems of a partner and family nature was observed, where the presence of family problems increased by 58% compared to the period before the crisis situation, while the percentage of increase in the presence of partner relationships is 57%. Research shows that social contacts play an important role in overcoming the crisis. Lack of support or lack of close contacts can cause psychological consequences in the form of sadness, depressive feelings, and isolation. As a result of the crisis, there is a certain probability that due to the intense feelings that people experience, there may be an increase in conflicts or violence in the family (Kušter, 2021). Symptoms of

anxiety, substance abuse, and interpersonal conflicts often appear as a reaction to a traumatic experience.

What makes partner relationships particularly vulnerable is the fact that people simultaneously have to adapt to the crisis situation as individuals, but also as members of a partner relationship and/or family. The way one partner deals with stress and crisis can be a source of additional stress between partners. Confirmation of the obtained results can also be found in the results of research conducted in BiH during the Covid 19 virus pandemic, which indicate that the emphasized level of stress led to an increased presence of disagreements, arguments and partner violence (Dudić, A., 2020).

The importance of the quality of family relationships is also demonstrated by research conducted by the University of Zagreb, the results of which show that more rejection and less showing of warmth by parents are factors that significantly influence suicidal and self-destructive behavior (Rezo Bagrić I., Sušac N., Rajhvajn Bulat, L 2023). Families with children go through various developmental crises and stress every day, and when they are faced with an external, historical crisis or traumatic situation, they show a significantly higher level of anxiety in the family system, and as the crisis situation we are talking about in this paper has hit the hardest children and their families, we can understand the increase in the presence of family problems through the mentioned prism (Hadžić, A 2015). In accordance with the obtained results, research was carried out by the department of psychiatry, Clinical Center in Banja Luka, the results of which confirm the importance of the quality and quantity of family and partner relationships for the protection of the individual's mental health, while the protective role of these relationships should be emphasized and developed in occurrence and presence of suicidal thoughts (Sulejmanović, D., Dragišić, T., 2014).

Center “Srce” is a center for emotional support and suicide prevention, which is why special attention is paid to the topic of suicide. Recorded data in the registry shows an increase in callers' reporting of suicidal thoughts, which ranged from suicidal ideation to a concrete plan to commit suicide. Callers reporting Risk 1 - suicidal ideation, increased by %, while Risk 2 - suicidal ideation with a concrete plan, increased twice as much in

May and June compared to April 2023. Individuals who have difficulty overcoming trauma may maintain a state of grief through self-destructive behaviors or through aggressive behaviors directed toward other people (Walsh, F. 2007). Research conducted in the Republic of Croatia, which aimed to examine self-harm and suicidality among high school students during the Covid 19 virus pandemic, showed a similar pattern of results. The authors of the mentioned research state that the prevalence of self-harm in 2021 is twice as high as in 2016, and that there is a noticeable increase in the number of respondents who state that they have thought about suicide at least once. Further results confirm the presence of gender differences where female respondents reported twice as much about the presence of suicidal thoughts and self-harm (Rezo Bagrić I., Sušac N., Rajhvajn Bulat, L. 2023). We can potentially interpret the obtained results through findings that suicidal intentions can have the purpose of reducing psychological pain and suffering and that due to a stressful event that represents too much social demand for an individual, suicidality can have the function of reducing strong and unpleasant affective experience and social situations (Rezo Bagrić I., Sušac N., Reichwein Bulat, L. 2023).

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CIP - Каталогизација у публикацији
Библиотеке Матице српске, Нови Сад

613.86(082)
614(082)

INTERNATIONAL Scientific and Professional Conference “The Right to Access (Mental) Health Care” (7 ; 2023 ; Novi Sad)

Conference papers / The Seventh International Scientific and Professional Conference “The Right to Access (Mental) Health Care”, 3rd and 4th of November 2023, Novi Sad ; organizers of the conference Provincial Protector of Citizens - Ombudsman and Faculty of Medicine, University of Novi Sad ; [editors Dragana Ćorić, Stefan Todorović]. - Novi Sad : Provincial Protector of Citizens - Ombudsman : Faculty of Medicine, 2024 (Novi Sad : Vojvodina Provincial Authorities Common Affairs Department). - 360 str. : ilustr. ; 24 cm

Tiraž 150. - Napomene i bibliografske reference uz tekst. - Bibliografija uz svaki rad.

ISBN 978-86-89417-22-7 (PZG)
ISBN 978-86-7197-773-9 (MF)

а) Ментално здравље -- Зборници б) Здравствена заштита -- Зборници

COBISS.SR-ID 151034889



[Provincial Protector
of Citizens - Ombudsman]



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University of Novi Sad]

