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MEĐUNARODNI NAUČNI SKUP

ALOS 20

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**PRIMENA TEORIJSKIH MODELA U PRAKSI:
MOGUĆNOSTI I OGRANIČENJA**

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PREFACE

Demands for continuous reflection on the relationship between theory and practice stems from the very fluid nature of modern societies. At the same time, fluidity is becoming more intense and noticeable - a vast amount of information and new knowledge is constantly and rapidly changing the nature of the modern world, continually directing it in some new directions. That is why we cannot dispute Alain Badiou when, in *Logic of Worlds*, he says that we live in an “atonal world”. In a world where there is no "centre", some kind of universal principle that would connect things into a stable totality. The absence of any "centre" inevitably produces increased fluidity in all areas of social life - from fluidity in economics and business, through fluidity in culture, to fluidity in theory.

This growing complexity of the world of life represents the possibilities and limitations of theoretical knowledge. Namely, ideas of social and humanistic theories should constantly take into account the circularity of social knowledge. In that sense, the social world is emerging as an unstable and changeable structure of actions. Therefore, the problem of practical relevance of theoretical constructions can be solved only by its continuous analysis.

The belief that social and humanistic theories do not have a solid foundation has been confirmed during the COVID-19 pandemic. It is an epochal event that surpasses all others in its real and symbolic significance. An event in which the whole structure of life in the world has been reversed. An event in which the conditions of its analysis have been reversed. However, this gigantic aberration, this regressive slide into a state of elemental uncertainty, is crystallising the possibility of gaining new theoretical and practical experiences through perceiving and examining the complex nature of the pandemic. Since, in addition to the medical-epidemiological aspect, the pandemic undoubtedly has a social, economic, political, psychological, educational, symbolic-communicative, and cultural dimension.

Therefore, in this Book of Proceedings, we have paid great attention to the thematisation of various aspects of the pandemic. Respecting the multidimensionality of this phenomenon, it was necessary to cover a wide range of

topics, but at the same time to find appropriate theoretical approaches to its successful understanding. More than thirty authors from Serbia, Bosnia and Herzegovina, Croatia, Romania, Montenegro, Russia and the United States have contributed to the understanding of the relationship between theory and practice in various helping professions (social work, speech therapy, occupational therapy). In the name of the Editorial Board, we would like to thank all the authors. We would also like to thank the Chamber of Social Welfare, which has provided full support to the realisation of the Book of Proceedings this year as well.

Prof. dr Milorad Đurić
Doc. dr Vesna Dukanac

PREDGOVOR

Zahtev za kontinuiranim promišljanjem odnosa teorije i prakse nedvosmisleno proizilazi iz same fluidne prirode savremenih društava. Pri tome, fluidnost je sve intenzivnija i očiglednija – ogromna količina informacija i novih saznanja konstantno i sve brže menjaju prirodu savremenog sveta upućujući ga stalno u nekim novim pravcima. Zbog toga i ne možemo protivrečiti Alenu Badjuu kada, u *Logici svetova*, kaže da živimo u atonalnom svetu, kojem nedostaje "centar", nekakav univerzalni princip koji bi stvari povezivao u stabilni totalitet. Odsustvo bilo kakvog "centra" neminovno proizvodi povišenu fluidnost u svim oblastima društvenog života – od fluidnosti u ekonomiji i poslovanju, preko fluidnosti u kulturi, do fluidnosti u teoriji.

Ova rastuća kompleksnost sveta života istovremeno predstavlja i mogućnosti i ograničenja teorijskog saznanja. Naime, u ideju društvenih i humanističkih teorija trebalo bi stalno uračunavati ono što Gidens naziva cirkularnošću društvenog znanja. Mada ga ljudi svojim interakcijama (re) produkuju, društveni svet se iznova pojavljuje kao krajnje nestabilna i promenljiva struktura delovanja i saznanja. Zbog toga, problem praktične relevantnosti teorijskih konstrukcija moguće je razrešiti samo neprekidnom samorefleksijom ove veze.

Uverenje da ne postoji invarijantna osnova društvenih i humanističkih teorija ubedljivo je potvrđeno tokom (još uvek) aktuelne COVID-19 pandemije. Radi se o epohalnom događaju koji u svom realnom i simboličkom značaju nadilazi sve druge; događaju u kojem ne samo da je čitava struktura života sveta preokrenuta, već su preokrenuti i sami uslovi njegove analize. Međutim, u ovoj gigantskoj aberaciji, u ovom regresivnom klizanju u stanje elementarne nesigurnosti, kristalizuje se i mogućnost da, kroz sagledavanje i ispitivanje kompleksne prirode pandemije, steknemo nova teorijska i praktična iskustva. Jer, pored medicinsko-epidemiološkog aspekta, pandemija nesumnjivo ima i socijalnu, ekonomsku, političku, psihološku, obrazovnu, simboličko-komunikativnu i kulturološku dimenziju.

Zbog toga smo u ovom Zborniku radova veliku pažnju posvetili upravo tematizaciji različitih aspekata stanja generisanog pandemijom. Poštujući multidimenzionalnost pojave, bilo je neophodno obuhvatiti širok spektar tema, ali istovremeno i naći odgovarajuće teorijske pristupe za uspešno razumevanje pandemije. Više od trideset autora iz Srbije, Bosne i Hercegovine, Hrvatske, Rumunije, Crne Gore, Rusije i Sjedinjenih Američkih Država dalo je svoj doprinos u sagledavanju odnosa teorije i prakse u različitim pomažućim profesijama (socijalni rad, logopedija, okupaciona terapija). U ime Redakcijskog odbora, zahvaljujemo se svim autorima. Takođe, zahvaljujemo se Komori socijalne zaštite koja je i ove godine dala punu podršku u realizaciji Zbornika.

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COVID-19 PANDEMIC IN THE LIGHT OF COMPLEX CONCEPT OF RISK

Abstract: In recent decades, risk has emerged as the unavoidable term for understanding modern societies and the challenges they face. Risk is a term that refers to fears and anxieties of each individual, as it has the connotation of threat, danger, uncertainty, which psychologically overrides the one of challenge. It turns out that this concept is all the more complex because it combines two dimensions that are difficult to assess: the severity of the consequences and the probability of the occurrence of a threatening event. In addition, given the consequences, not only is the individual is endangered, but the whole society. Contemporary risks, which the German sociologist Urlich Beck calls risks of new modernity, are threats that elude our senses: we do not see, hear or feel them. This is the case with viruses, pollution or atomic radiation. Beck often explains them as externalities of production activities that produce tangible and valuable goods but at the same time also risks whose invisibility and inaudibility facilitate their proliferation. In social sciences risks are considered as social constructs in the sense that the view of a particular event determines it as a crisis. For example, the Spanish flu, which killed between 20 and 50 million people at the end of the First World War, was not, at that time, defined as a risk, because no one foresaw the threat or tried to prevent and control it. Contrary to that, influenza H1N1 or Covid-19 are risks, because they have been anticipated and authorities and competent services have reacted and taken measures to detect dangers and respond to them. The subject of this paper is to reflect on Covid-19 pandemic in the light of the complex concept of risk and from several disciplinary angles, as well as to emphasize its connection, even its origins, in the increasingly developing safety culture.

Keywords: *Covid-19, risk, safety culture, externalities, precautionary principle*

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THE CONCEPT OF RISK

Risk is a complex and transversal term that has been increasingly applied in social sciences since the 1980s. According to social theories, risks are social constructs in the sense that the perception or representation of an event defines the event as risky. For example, the Spanish flu that killed between 20 and 50 million people at the end of World War I was not (perceived as) a risk at the time as no one had predicted it, nor were there any organized attempts by institutions to control and suppress it. Countries took a laissez-faire attitude (Neveux, 2020). In contrast, influenza H1N1 or coronavirus are risks, as they are anticipated epidemics, and state and health authorities have sought to respond to the danger by taking measures to detect, keep track of, and suppress it. Thus, a threat, a danger, turns into a risk when a certain group of people becomes aware of its likelihood or presence and when the group actively embarks on controlling it using preventive or security mechanisms.2 The notion of threat rests upon expert research, and risk is objectified by statistical calculation of the likelihood of occurrence of danger, effect, intensity, and extent of damage it can cause in the health, economic, financial, social, political domain.

The unavoidable risk theorist, Ulrich Beck, highlights that risks are not the discovery of a new age in themselves. Anyone who set out to discover new countries and continents – like Columbus – was aware of "risks". But these were personal risks, not global dangers for all of humanity, (...). In that period, the word "risk" had a hint of courage and adventure, rather than the possible self-destruction of life on Earth (Bek, 2001, p. 34). In this sense, risk is a category of discourse of modernity, characterized by orientation to the future and greater control of the future. The center of risk awareness is not in the present but in the future (Bek, 2001, p. 50). Traditional cultures were not aware of the concept of risk. Risk is not the same as hazard or danger. The concept of risk is becoming widely used in forward-looking societies. Risk is present in societies that are actively striving to break up with their past, and that is an attribute of industrial civilization (Kozić, 2018, p. 338).

Throughout the twentieth century, especially with the establishment of welfare states, more and more situations and events were put in a risk frame (illness, disability, loss of job…) and the field of insurance expanded (against theft, floods, fires, traffic accidents…). Awareness of risk, therefore, occurs and strengthens within the so-called "security culture" in modern societies. However, one of the "risky society" paradoxes Beck pointed to is that thanks to scientific

[2] A threat, after all, can be irrational and imaginary, as in the case of Protestants who fear going to hell after death and the way their religion secures them against that "risk".

and technical progress, societies are becoming safer as they are able to control increasing numbers of dangers, but at the same time they create new risks. Their multiplication is also sparked by international exchanges and the advancement of means of transport (Beck, 2001). This certainly also applies to the risks of transmitting various diseases that are rapidly spreading due to the more intense and faster circulation of goods and people on the planet.

PLACE AND NATURE OF RISK IN MODERN GLOBALIZED SOCIETIES

The sociology of risk includes numerous works that cover very different fields, with a special interest in individual behavior versus risk, and within that, especially in the perception of risk and the so-called risky behaviors, as well as how a risk structures a group of people. Giddens (1991, 1998) studied the individual attitude of man towards risk and the place that risk occupies in their daily decisions. According to Giddens, modernity is characterized by the dominance of a "culture of risk". In modern societies, everyone is asked to be aware of the risks and to control their own lives, to, according to Giddens, "colonize the future", relying on available professional knowledge, especially on statistical data. Individuals are encouraged to take their lives into their own hands, to become entrepreneurs or managers of their own existence, being cautious about everything in their environment that could pose threats or opportunities for their future wellbeing, including health. While throughout history the disease and its causative agent have been fatalized, in the modern Western context, the responsibility for health and its maintenance has been firmly handed over to individuals (Lypton, 1995; Brant, 1990). Numerous authors have noticed that in the time we live in, there is a major preoccupation with health that has not existed to such an extent in any period before: health is today one of the central topics discussed more than ever, health knowledge is increasing, while ensuring being healthy has become a *moral obligation and duty* of every individual (Vukićević, 2015, p. 109).

Referring to individual conscience and responsibility in managing one's own risks is in agreement with Foucault's works on the society domination over the body: the authorities increasingly strive to control bodies remotely instead of using force. In order for individuals to adopt desirable behaviors, they are defined as subjects of social practices. Risk discourse not only defines the norms that should guide individual behavior but also attaches moral value to the way of behaving (…). Thus, by producing fear and insecurity in society, risk discourse justifies condemnation, stigmatization, marginalization, monitoring, and controlling of individuals who practice risky forms of behavior (Vukićević, 2015, p. 11).

However, not all individuals agree with this constitutive norm of risk culture, so the research aims to show the social diversity of behavior versus risk and

future. One of the most notable achievements in health promotion to date is the extent to which its messages have been successfully conveyed to laypeople (…) most people can competently state what they (and others) should do to reduce the risks of future ill health. However, therein lies the paradox: although most age and social groups are well acquainted with disease prevention messages, few people implement "healthy" lifestyles in practice in whole or in part (...) translating health promotion messages into actual practice remains a stumbling block for those engaged in promoting positive change to a healthier lifestyle (Lawton, 2002, p. 715).

DIFFICULTIES IN HEALTH RISK MANAGEMENT - UNPREDICTABLE "HUMAN FACTOR"

Crises caused by risks in the field of public health are characterized by uncertainty: uncertainty about the scope of the threat, the effectiveness of treatment, and consequences, regardless of the fact that such threats occur regularly and that a healthwatch is established and scientific expertise is developed to prevent them. Crisis management experts point that most often the first victim of a crisis is a crisis plan, as it is developed on unknown terrain, and on the basis of known schemes and with known criteria, which leads to errors in forecasting and misassessments of new risk (Lagadec, 2008). Political scientist Claude Gilbert (Gilbert & Raphael, 2011), who researched the concept of public health risk, underlined the gap that arises between common sense notions of the crisis with the phenomena of excessive or insufficient public reactions, and the reality of the crisis. He associates crises with the failure of expertise due to the great uncertainties surrounding emerging diseases, but also due to the review of applied measures and practices throughout the expertizing process.

Not surprisingly, the public is therefore confused and distrustful. In such crises, one of the particularly important challenges for researchers is the human factor, which the competent authorities and institutions are not sufficiently aware of at the beginning, but which, however, turns out to be a key factor in crisis management. Public health crisis management plans contain the assumption that people will cooperate, but their reaction, in fact, is not always what is expected. For example, during the H1N1 flu epidemic, the authorities of many European countries did not anticipate the extremely low population response to the call for vaccination. The prevention plan failed only because people did not respond as expected (Peretti-Watel, 2020).

In short, one of the key dimensions of the crisis is uncertainty on many levels, and especially uncertainty about how the population will react. This is one of the classic and major issues in the field of crisis management.

PRECAUTIONARY PRINCIPLE IN SITUATIONS OF UNCERTAINTY

The precautionary principle comes from the law of environmental protection and has been largely deviated from over time. In the last fifteen years, the term has entered common use. It is used unselectively and imprecisely, often to attribute responsibility for a given risk to an instance or man, including controversies between two opposing parties that both invoke the precautionary principle.

In the first legal texts, it was formulated in such a way that it should be applied only against major threats that can produce serious and irreversible damage to the environment, and at an acceptable price.[3] The theoretical determination and practical application of this principle is conditioned by the role of science which should use its evidence to control and direct society in a direction that will be less risky for present and future generations. The dominance of science in the theoretical and practical determination of the precautionary principle is also limited by the role that politics and economics currently play in modern societies (Nadić, 2008, p. 159).

The application of the precautionary principle at the national and international levels can be viewed dually: as “weak” and “strong” precaution. “Weak” precaution does not mean the selective application of this principle, but its restriction to the most toxic substances and activities threatening to human life (…). In contrast, the interpretation of “strong” precaution shows society’s unconditional obligations to the so-called “inanimate world” and to future generations, whether or not such a form of precaution would directly mean limiting the needs of present generations. Ethically, “strong” precaution has a theoretical and human advantage behind it. At the same time, it is utopian, economically unpopular, politically subversive, and, in general, unenforceable in practice. National governments, the economic sector, and the public cannot accept the radicalism of this version, just as they cannot see the danger posed by society's previous attitude towards nature. Applying the “strong” precaution would definitely mean raising the question of the meaning of the past social development and its limitation, and, having in mind the state of awareness of human society, it is not yet able to accept it (Nadić, 2008, pp. 162-163).

Reviews of the precautionary principle say that it should not be applied to all issues of individual health and that it should include measures to avoid the actions taken being unsustainably costly. It should also be temporary, i.e. be applied until scientific progress ensures the availability of sufficient knowledge about the existence and severity degree of risk. Overcoming situations of uncertainty by producing knowledge enables the transition to a prevention regime that is a more

[3] Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation (UN Rio Declaration, 1992). Available at: https://www.bastabalkana.com/2013/08/rio-deklaracija-o-zivotnoj-sredini-i-razvoju-un-deklaracija-iz-rio-de-zaneira-1992/

traditional risk management method. The principle of prevention applies to all known risks: smoking, flu epidemics, delinquency, etc. Prevention then comprises taking measures aimed at reducing the likelihood of a given risk and minimizing its consequences, as in the example of influenza vaccination (Moatti & Peretti-Wattel, 2009).

COMPETITIVE RISK PROBLEMS

The emergence of competitive risks is one of the main difficulties in risk management. Prevention or suppression of one favors the emergence of other risks, which can be economic, political, social, health, or all together.[4] The competitive risk assumption is what motivates parents to decide to refuse some types of *vaccines* for *their children*. In that case, parents believe that secondary side effects of the vaccine, although very rare, pose a more serious risk to their children's health than the risk of getting the disease from which the vaccine protects them or the possible complications associated with the disease.

Covid-19-induced health crisis management by restricting movement, i.e. locking down the population and stopping many economic and social activities creates or increases other risks which are gradually revealed and which also need to be prevented and treated. Health crises are also political, economic, and social, as they have a political, economic, and social effect but also political, economic, and social causes. For example, today's difficulties in managing Covid-19 in hospitals, clinics, and health facilities in a number of countries are an obvious effect of declining investment in that, as well as in other public sectors. The pandemic crisis has also revealed excessive dependence on foreign countries, especially China and India, for a number of products strategic and vital in this crisis, such as protective masks, ventilators, or medicines.

In addition, crises are also political, economic, and social opportunities for social change, as they allow making decisions that have not been made yet and could not be made in different circumstances. For example, the reconstruction of water supply and sewage networks in London and Paris was used by the authorities to change the appearance of the capital.[5]

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[4] A typical example in healthcare is the prevention of the risk of breast cancer recurrence after a successful intervention. To reduce this risk, women take hormone therapy for five years. As this preventive treatment is also carcinogenic, it is estimated that after that period, the risk of getting another cancer exceeds the reduction of the breast cancer recurrence risk.

[5] The construction of water supply and sewage, which allows the population to maintain much-needed personal and collective hygiene, is at the frontline of preventing the spread of infectious diseases. It is a known fact that one of the major cholera epidemics hit London in the middle of the 19th century, and that Paris still smelled for miles in those decades due to the lack of quality sewage. Available at: https://www.gradnja.rs/arhitekturom-i-urbanizmom-protiv-zaraze-istorija-higijene-gradova/13/04/2020

As for the coronavirus, some predict radical social changes, such as the end of globalization, but it is, for now, a too ambitious, ideologically colored projection, rather than a sufficiently grounded prediction. Less spectacular changes, such as teleworking or strengthening national independence in the production of basic goods vital in the event of an epidemic crisis are more likely.

DIFFERENT SOCIAL ACTORS, DIFFERENT RISK PERCEPTIONS

Specialists, and especially laypeople, often have different perceptions of risk, which leads experts and policymakers to stigmatize the irrational fears of ordinary citizens or to condemn irresponsible attitudes and behaviors of resistance to preventive bans. However, a more in-depth analysis of the lay perception of risk shows that citizens who do not make good decisions in the eyes of experts or who doubt their expertise are not always and necessarily irresponsible or irrational. They often construct their idea of a new threat relying on experiences and ideas of previous critical events, that is, how they were managed. When it comes to Covid-19, in the absence of scientific certainty, individuals compare it to previous epidemics, wondering if this virus is more or less dangerous, more or less contagious than some already known flu.

Research in the field of hesitation or refusal of vaccination has shown that only a very small minority of the population, hypersensitive and susceptible to information spreading through social networks and conspiracy theories, refuse vaccination completely. However, a significant part (from 20% to 40%, depending on the research), does not question the principle of vaccination but is concerned about certain vaccines. The typical profile of people with such an attitude is highly educated, well-informed individuals, very interested in health issues, especially for their children. These are people who fully adhere to Giddens' "culture of risk", who take responsibility for their health and pay attention to the risks. They are far from being irrational. On the contrary, they strive to make the best decisions based on available information (Peretti-Watel, 2020). They publicly confirm their commitment to the principle of vaccination, and their suspicions are focused only on controversial vaccines or substances they contain. These patients, doctors, activists are closer to social movements that advocate for patients' rights, their status of active partners in relationships with doctors when it comes to their health and life, environmental protection, etc. than to radical anti-vaccine movements advocating alternative medicine, conspiracy theories and the like.

Another factor that characterizes modernity and influences public opinion in health crises, such as the Covid-19 crisis, is the phenomenon of exposing science with itself. According to Beck, throughout the 19th and 20th centuries, science constantly applied its inherent methodological suspicion to beliefs and superstitions to dismantle them. However, after some time, it started self-reflexively

questioning itself too, which allowed creating a multitude of fragmented, contradictory, provisional scientific theories and the growth of scientific controversies. Disagreements among scientists make it difficult to identify and manage modern risks (Bek, 2001).

In this light, the restraint or resistance that laypeople offer to preventive restrictions and bans is a well-thought-out and reasonable choice from their point of view. This is evident in the milder or stronger opposition to vaccination, depending on the country and the individual, and is far from always being a radical and firm anti-vaccine movement. In the last ten years, the social sciences have been interested in the notion of vaccine hesitancy, which is not the same as refusal. The recent spread of these doubts in the public sphere is most often explained by the development of the Internet and the growing distrust in institutions, and even in science. It is true that the Internet facilitates access to critical arguments and that, for the last twenty years, health authorities have been at the heart of a series of public scandals that have permanently tarnished their reputation. The share of the population that has reservations about vaccines has begun to grow, especially since the controversy over the *2009* H1N1 *Influenza Vaccination Campaign* (although there was also controversy in the late 90s over the hepatitis B vaccine). This was followed by incessant debates about the papillomavirus vaccine, multivalent vaccines, and the presence of aluminum in vaccines. Public suspicion has been heightened by the fact that some doctors also have certain doubts about some vaccines or think that they are injected against too many diseases. This reflects the deteriorating relationship between health workers and health authorities in the context of a growing number of scandals, followed by the crisis of financing public hospitals and the always tense negotiations about health insurance (Ward et al., 2019).

In short, on the one hand, we have scientific and professional knowledge that is subject to criticism, and on the other hand, we have lay knowledge that is much less absurd than one might think at first glance. In some areas, informed and vigilant laypeople may even acquire counter-expertise and play the role of whistleblowers. In other words, in risk discussions, the cracks and gaps between scientific and social rationality towards the civilizational potentials of danger become clear. Discussions are in vain. On the one hand, questions are asked that the other side does not answer at all, while the other side gives answers to questions that do not touch at all on the essence of what was actually asked and what arouses fears. Scientific and social rationality, admittedly, separate, but at the same time, they remain woven into each other and face each other. Strictly speaking, this distinction becomes less and less possible. Scientific dealing with the risks of industrial development remains just as directed to social expectations and value horizons as, on the other hand, social discussion and perception of risk are directed to scientific arguments. (….) Public criticism and unrest largely live off the dialectic of

expertise and counter-expertise. Without scientific arguments and anti-scientific criticism of scientific arguments, it is not sharp; moreover, it often cannot even notice the usually “invisible” object and event of its critique and fears. To reverse the familiar phrase: scientific rationality without social rationality remains empty, but social rationality without scientific rationality remains blind. The above should not create an image of general harmony. On the contrary, it is a matter of multiple competing and conflicting rights to rationality, which are struggling to be accepted (Bek, 2001, p. 46).

REASONS FOR LIMITED EFFICIENCY OF HEALTH MESSAGES

The field of healthcare tends to neglect the social and cultural environment of individuals and their role in understanding risks. For this reason, prevention messages are less effective. Influenced by the work of sociologist Bruno Latour (1995), Peretti-Watel (2004) explored the effects of the prevailing “epidemiological paradigm” in the approach to understanding risky behaviors and defining health prevention policies. Epidemiology focuses on researching individual “risk factors” and their statistical association with a particular health problem, such as the association between smoking and lung cancer. This scientific approach, especially the model of multifactorial causation, has spread widely in many disciplines as well as outside the scientific field itself.[6] The meanings attached to health and other forms of risk are culturally conditioned - they are never exclusively and completely based on objective, neutral, scientific facts, but are always shaped according to the premises of a given cultural context in a given period of time (…). Therefore, the meaning of risk is a product of the influence of beliefs, values, norms and practices characteristic of a certain society at a certain moment, and not (only) a scientific calculation of the effects of various factors (Vukićević, 2015, pp. 2-3).

It follows from all the above that health risk should not be understood only as a medical, but as a comprehensive cultural concept. After all, biomedicine, like any other medical system, is a socio-cultural system, shaped under the influence of cultural values and beliefs, rooted in a broader social and historical context (Vukićević, 2015, p. 3). In addition, the epidemiological perspective contains numerous methodological problems and often gives insufficiently reliable results. It primarily favors predicting risky behaviors based on biological causal relationships at the expense of understanding human phenomena and behaviors. It therefore seeks to biologize behaviors falling into a social and cultural context. In contrast, the works of sociologists, anthropologists, psychologists show that risky behaviors have meaning for individuals that is related to their beliefs, rituals, the need for self-realization, affirmation of identity, social integration, etc.

[6] Philip Morris even relied on epidemiological research in the 1990s to relativize the risks of secondhand smoking.

Research on smoking, especially in socially disadvantaged groups, and their resistance to prevention policies shows that such attitudes and behaviors are better understood if smoking is not understood as a disease (addiction) or deviant behavior, but as a social practice that contains meaning, is the result of social learning, which meets some needs (combating stress, dissatisfaction, isolation…), creates and maintains social cohesion for people in a situation of exclusion (Peretti-Watel, 2012). Individuals in a precarious situation are not less receptive to anti-smoking campaigns because they are unaware of the risks to their health or do not understand prevention messages, but because of distance from the dominant culture (Hoggart, 1957) and distrust of science, politics, and institutions. This example also shows that attitudes towards risk often considered irrational by experts and authorities are justified in the eyes of individuals who have a whole host of reasons to behave that way. After all, isn't the position they are in (except for some strictly individual factors) the result of the structural and systemic irrationality of social systems and policies?

SOCIAL INEQUALITIES AND ATTITUDES TOWARDS RISK

It is important to keep in mind that in crises like the current one, individuals are faced with competitive risks, which are the key to understanding reactions to certain health threats. This is confirmed by many studies. For example, research on smoking in France and the UK has focused on the motives of single mothers who smoked even though they had very low incomes. They lived under enormous amounts of daily stress and explained to the interviewers that they could only endure it thanks to cigarettes. Between the two competing risks, depression if they stop smoking now and harm to their health in the distant future, they chose cigarettes because they met their current need (Peretti-Watel, 2012). Poor individuals, as well as societies, do not have capitalized material and non-material resources that would allow them to project into the future and to sacrifice their short-term needs and interests for the long-term ones, no matter how significant the latter.[7]

The individual feeling that one can or cannot control a certain risk depends on their material and cultural resources. In her works, British anthropologist Mary Douglas (1990) also emphasized the importance of resources, i.e. the role of social inequalities in risk exposure and the difference between the risk suffered and the risk chosen. According to her, the rich can choose what they are exposed to, while the poor do not choose to live in a polluted area, where crime flourishes, in cramped apartments and the like. They mostly suffer risks. This was confirmed in the United States, where the first available statistics showed a disproportiona-

[7] Also, during the HIV epidemic, it was noticed that many adolescents avoided the use of condoms. The reason they gave was that the risk of contracting a sexually transmitted disease was less important in their eyes than the competitive risk of not having sex if they required a potential sexual partner to use a condom.

tely large representation of the African-American population among hospitalized and deceased victims of Covid-19.[8] Their greater exposure to the disease is clearly related to their living conditions. However, with the boomerang effect, the infection flourishing in oppressed social strata spreads and threatens those strata and social and political actors whose attitude towards multiply discriminated groups significantly contributes to increasing the risk for all.

Today, hundreds of people are ready to expose themselves to the risk of contracting coronavirus by not adhering to protection measures because they are more afraid of immediate competitive risks: losing their jobs, income, not completing an important life project, having a hard time being alone, etc. Health risk managed by authorities is not necessarily a priority for everyone. Many people are more afraid of the consequences the adopted protection measures have on their habits and way of life. The rise of psychological distress, such as anxiety and depression, during the pandemic and state of emergency clearly testifies to this.

CONCLUSION

The current Covid-19 virus, as well as the H1N1 flu, unequivocally belongs to the risk category on several grounds, primarily because, unlike the Spanish flu, these were epidemics that were anticipated. When the H1N1 flu arrived in Europe, in the fall of 2009, the threat had been known since the spring as it was present in Mexico at that time. Preparations for danger had been made for months, and the WHO had designed scenarios by constructing mathematical models.

Furthermore, this virus belongs to the category of invisible risks typical of a "risk society", although Beck was primarily interested in major technological, chemical or radioactive risks rather than infectious ones. This is all the more the case because many carriers of the infection, especially children, are usually asymptomatic or do not show any symptoms, which is one of the reasons why the first measure was to close schools to protect adults and the elderly population in contact with children.[9] The invisibility of risk makes it more demanding and complicated to manage. Ignoring already inconspicuous risks (...) is a cultural and political ground on which risks and dangers *grow, flourish, and move forward*. In overlapping and competition between the problems of class, industrial and market society on the one hand and those of risky society on the other, the logic of producing goods in accordance with power relations and criteria of relevance wins - *and it is for that very reason that the risky society eventually wins* (…) denied risks succeed especially quickly and well. At one particular stage of social production (...) the dominance of logic and the conflicts of production of goods and therefore the

[8] More African-Americans among the deceased due to Covid in the United States (2020). Available at: https://www.danas.rs/svet/medju-preminulima-od-posledica-korone-u-sad-vise-afroamerikanaca/.
[9] However, Covid-19 virus is still shrouded in mystery, so the latest research shows that children are poor spreaders of the infection.

social invisibility of a risky society are not proof of its inexistence. On the contrary, it is even the driver of the emergence of a risky society, and thus proof that it is becoming a reality (Bek, 2001, p. 67).

This risk is also an *externality* to the modern model of development as the rapid spread of coronavirus is due to the intensity of the flow of goods and people in the world. In 1917-1918, the comparable Spanish virus took two or three years to travel around the world, while today it took several weeks for Covid-19 to spread to every or almost every corner of the world.

We are at the dawn of an era, of a kind of epidemiological century, as we have viruses that "attack" at regular intervals. According to some authors, this coincides with the entry into the Anthropocene era[10] in which human intervention directly destroys nature, wildlife and causes the spread of viruses. New environmental and health crises are producing classic economic, financial and social crises. A risky society is a society of catastrophes. In it, the state of emergency threatens to become normal (Bek, 2001, p. 37).

Many think that this health crisis is unprecedented in many ways. Although it has been predicted that we will be hit by a pandemic of a virus from the subgroup of already known coronaviruses (MERS-CoV, SARS-CoV), we were surprised by this new virus, its brutal expansion, and effects. The exceptional nature of this pandemic, its transnational and social universality reveal many dysfunctions, raise many questions, raise hope for essential changes, but also fears. The hope is based on that the universality and depth of the Covid-19-induced crisis indicate that it cannot remain just a passing episode without a sobering and constructive influence on the future. On the opposite, pessimistic end, it is pointed out that the current crisis clearly shows and encourages the dominant characteristics of the political regime of each country, which become, in fact, reinforced versions of themselves. Thus, it could happen that this crisis, instead of being the announced turning point in politics and economy on a global level, which will direct the world to a completely new path, in fact only strengthens the existing tendencies. Major historical risk events, such as the current pandemic and the general crisis caused by it, create their own confirmation bias.

It is possible that in the coronavirus crisis everyone will see the confirmation of their own view of the world and notice the omens of the future economic, social and political order they have long hoped for or feared.

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[10] The term "Anthropocene" refers to the geological age that is predominantly influenced by humans, most often those that cause major and irreparable damage to the planet.

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PANDEMIJA KOVIDA-19 U SVETLU KOMPLEKSNOG POJMA RIZIKA

Sažetak: Poslednjih decenija, rizik se nametnuo kao nezaobilazan pojam za razumevanje savremenih društava i izazova sa kojima se suočavaju. Rizik je pojam koji upućuje na strahove i strepnje svakog pojedinca, jer sadrži konotaciju pretnje, opasnosti, neizvesnosti, koja psihološki nadjačava značenje izazova. Ispostavlja se da je taj pojam utoliko kompleksniji što spaja dve dimenzije koje je teško proceniti: ozbiljnost posledica i verovatnoća izbijanja pretećeg događaja. Osim toga, s obzirom na posledice, nije samo pojedinac ugrožen, već celo društvo. Savremeni rizici, koje je nemački sociolog Urlih Bek nazvao rizicima nove modernosti, pretnje su koje izmiču našim čulima: ne vidimo ih, ne čujemo, ne osećamo. To je slučaj sa virusima, zagađenjem ili atomskim zračenjem. Bek ih često objašnjava kao eksternalije proizvodnih aktivnosti koje, istovremeno, produkuju opipljiva i vredna dobra: ali i rizike čija nevidljivost i nečujnost pogoduje njihovom širenju. U društvenim naukama se rizici smatraju socijalnim konstruktima, u smislu da pogled koji se baca na dati događaj određuje isti kao krizu. Na primer, španski grip koji je ubio između 20 i 50 miliona ljudi na kraju Prvog svetskog rata nije, svojevremeno, bio definisan kao rizik, jer ga niko nije predvideo niti pokušao da predupredi i kontroliše. Nasuprot tome, grip H1N1 ili Kovid-19 jesu rizici, zato što su anticipirani i što su vlasti i nadležne službe reagovale i preduzele mere da detektuju opasnosti i odgovore na njih. Predmet rada je promišljanje pandemije Kovida-19 u svetlu kompleksnog pojma rizika iz više disciplinarnih uglova, kao i isticanje njegove povezanosti, čak i proishođenja iz sve razvijenije kulture bezbednosti.

***Ključne reči**: Kovid-19, rizik, kultura bezbednosti, eksternalije, načelo opreznosti.*

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CHALLENGES OF THE SOCIAL PROTECTION SYSTEM IN RESPONDING TO THE CRISIS CAUSED BY THE PANDEMIC

Abstract: After the World Health Organization declared a global coronary virus pandemic in March 2020 and the Council of Ministers of Bosnia and Herzegovina (BiH) declared a state of natural or other disaster throughout the country, due to the danger of contagious disease caused by this virus, the Government both entities and the Brčko District of BiH, and the cantonal governments in the Federation of BiH as well as local authorities have taken a number of urgent measures to reduce the risk of coronavirus spreading in collectives. Measures of physical distancing, along with measures of closure of certain economic entities, schools and social welfare institutions, are one of the first measures taken by governments to combat the spread of coronavirus. The introduced measures have particularly affected certain industries in which a large number of people are left without employment, which directly affects their families. Families with children, especially families at risk and dysfunctional families, poor families as well as those living in rural remote areas face new problems and become even more vulnerable with the risk of poverty due to job loss and / or other permanent sources of income. The short-term as well as long-term consequences of the pandemic lead to a negative impact and increase the risk of family functioning, family care, family existence, domestic violence, especially violence against children, neglect and educational neglect of children. The declared pandemic leads to a crisis that directly affects the functioning of social protection institutions, disrupts the “regular” functioning of the system and poses a challenge to the overall social protection system. The paper presents a study conducted in Zenica-Doboj Canton during the pandemic. The way of functioning of social protection institutions in the period of crisis, ie pandemic, but also the process of providing social services is analyzed. The research is

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based on a holistic approach in considering the real needs and complexity of the problems faced by users but also professionals in social protection institutions, and the overall social protection system.

Keywords: *pandemic, social protection, institutions, family*

INTRODUCTION AND METHODOLOGY

After the World Health Organization declared a global coronavirus pandemic in March 2020, the Council of Ministers of Bosnia and Herzegovina (BiH) reacted immediately. At the extraordinary session held on March 17, 2020, it passed the Decision on declaring the occurrence of a natural or other disaster on the territory of Bosnia and Herzegovina (BiH Official Gazette, No. 18/20) due to the danger of a possible occurrence of infection caused by this virus. This Decision of the Council of Ministers of BiH also activates the Coordination Body of BiH for Protection and Rescue from Natural or Other Disasters in BiH in order to focus its activities on the protection and rescue of people and material goods, in accordance with the legislation. It is the obligation of all institutions and bodies in BiH to provide support and make all their capacities available to the Coordination Body of BiH. At the same time, a recommendation was given to the Civil Protection Headquarters of the Entities and the Brčko District of BiH, as well as to other lower level staffs to take action to fully implement measures to prevent the spread of infectious disease (COVID - 19) caused by this virus. The governments of the entities and the Brčko District of BiH may adopt individual measures in accordance with the legislation, in order to prevent the spread of coronavirus with the obligation to inform the Coordination Body of BiH about the measures taken.

In the past, the entity governments, the Brčko District of BiH, and the cantonal governments in the Federation of BiH and local authorities have adopted a series of emergency measures to reduce the risk of coronavirus spread and reduce the effects of these measures on a significant population. The measures taken are of a public health nature and are primarily aimed at preventing the spread of coronavirus and the development of COVID-19 disease. Among the first measures taken are the closure of schools, social welfare institutions, business facilities, the closure of borders, the introduction of quarantine / isolation, travel restrictions, travel bans for people over 65 and under 18, protection measures at work, etc.

Due to the new situation and the introduced measures, certain branches of the economy, such as tourism, services, trade, production, small and medium enterprises, are in a particularly difficult position, and a large number of people in these areas remain unemployed. How many people lost their jobs due to coronavirus cannot be determined exactly due to the lack of a single register, but the reports of the competent institutions can help us.

According to the data of the Agency for Labor and Employment of BiH on March 31, 2020. There are 398,504 unemployed in the entire territory of BiH, which is 1.09% less than in the previous month. The number of unemployed increased significantly next month and on April 30, 2020. was 419,582. Compared to the previous month, the number of unemployed persons increased by 5.35%, ie in just one month, 21,312 persons were registered in the records of the competent services. The trend of increasing the number of unemployed persons continued next month, so that on 31.5.2020. This number amounted to 421,474, which is 0.45% higher than in the previous month. In the following months, there were some oscillations because some industries continued to operate and already in June there was a slight decrease in the number of unemployed in BiH by 0.04%, but unemployment since the beginning of the pandemic ended on 30.6. In 2020, it increased by 4.57%. At the end of year 31.12.2020. there were 413,627 unemployed persons in BiH, so that unemployment increased by 2.66%. Unemployment growth is a direct result of reduced economic activity due to the Covid-19 pandemic (Agency for Labor and Employment of BiH, Statistics).

To determine the extent to which the pandemic affected the social protection system, a survey was conducted in five cantons in the FBiH. The research was supported by UNICEF. The research had several goals, among which were to analyze the social protection system and detect system weaknesses; to examine the capacities of institutions, staffing, organization of work during the pandemic, pronounced problems; to determine the total number of beneficiaries, the number of new beneficiaries who came to a state of social need due to the consequences of the pandemic. Such a comprehensive survey required a holistic approach that included analysis of legislation and participation in the survey through specially prepared questionnaires of managers (n1 = 11) and professionals (n2 = 77) and beneficiaries of rights in the field of social protection (n3 = 853). In addition, the survey was conducted on a representative sample of persons (n4 = 183) who lost their jobs at the time of the pandemic in order to gain a better insight into the socio-economic status of these persons and assess how many of them are in social need and whether they exercised any of the associated rights. Through such defined goals, it is possible to determine how much the social protection system provides social security to the most vulnerable individuals and families, especially in times of crisis, in order to mitigate the negative effects that necessarily affect family relationships where children, the elderly, and people with disabilities. The research conceived in this way provides a realistic picture that is important for policy makers and service providers in order to overcome the identified problems. The analysis provides a realistic basis for assessing one's own strengths and weaknesses, which is especially important for future work given the fact that the epidemiological situation is not improving and that various measures are still being introduced, including bans on certain activities, which poses a potential threat to the social system protection due

to loss of employment, because among workers who lose their jobs it is completely certain that one number will be in a state of social need.

CHARACTERISTICS OF THE SOCIAL PROTECTION SYSTEM IN THE FEDERATION OF BOSNIA AND HERZEGOVINA

The social protection system in the FBiH is very complex due to the division of competencies between the entities and the cantons. At the entity level, the area of social protection is regulated by the The Law on Basics of Social Protection, Protection of Civilian War Victims and Protection of Families with Children (FBiH Official Gazette, No. 36/99, 54/04, 39/06, 14/09 3/15, 45/16). The Law defines the basic rights and services with the obligation of the cantons to enact their own laws which can expand the basic rights in accordance with the economic possibilities of the canton. This situation has led to the economically richer cantons significantly expanding the scope of rights and services, while the poorer cantons have retained the basic rights defined by the entity law, which has led to discrimination of the population in relation to the place of residence.

The key institutions for exercising the rights from social protection are the centers for social work, ie the municipal social protection services. In addition to them, there are other institutions in the field of social protection such as: institutions for children without parental care, institutions for neglected and neglected children, institutions for children with special needs, institutions for the protection of mentally disabled persons, institutions for social and health care disabled and other persons, day care institutions of different categories of social protection beneficiaries, institutions for accommodation of the elderly, as well as other institutions depending on the needs and possibilities of cantons and municipalities. In addition to public institutions in the field of social protection, a significant number of private institutions providing accommodation and care services for the elderly have recently been established. Also, non-governmental institutions have a significant role in solving a number of problems faced by particularly marginalized and socially excluded individuals, families and social groups.

WORK ORGANIZATION AND PERSONNEL EMPLOYMENT

The Federal Ministry of Labor and Social Policy has adopted the Rulebook on Standards for Work and Provision of Services in Social Protection Institutions in the Federation of Bosnia and Herzegovina (FBiH Official Gazette, No. 15/13, 44/16), which defines the conditions for the work of institutions and the required number of professionals and other workers. The results of the research showed that, in general, there is a shortage of skilled workers in social welfare institutions. It is true that there are significant differences between individual institutions, but there is a very small number of institutions in which there is no lack of experts

of certain profiles. The shortage of skilled workers is particularly pronounced in smaller places. Thus, in some centers for social work, a total of less than ten workers are employed, which clearly shows the insufficient number of professional workers. The lack of financial resources and the pronounced deficit of some experts have the consequence that a small number of institutions (27%) have harmonized internal acts on the organization and systematization of jobs with the Rulebook on Standards for Work and Provision of Services in Social Protections institutions in FBiH. Among the missing skilled workers, the lack of social workers, psychologists and pedagogues is particularly pronounced. A total of 351 people are employed in social protection institutions in the area of Zenica-Doboj Canton, among which are 151 professional workers who work directly with beneficiaries, of which 50 are social workers. The majority of employees in social welfare institutions are women, which is an additional confirmation of the pronounced feminization among employees in social welfare institutions. The lack of professional staff inevitably reflects on the quality and timeliness of services provided to customers, especially in times of crisis. An additional problem is that the analysis of financial plans of social protection institutions shows that the issue of continuing education is not given enough attention because funds for this purpose are not allocated or allocations are insufficient, which inevitably affects the expertise and motivation of professionals. Strengthening professional competencies through continuous education and supervision is of special importance for motivating employees and increasing work productivity. The lack of skilled workers and continuous education as well as supervision are some of the weaknesses of the social protection system, and the management of institutions imposes the need to pay much more attention to these issues in order to make the social protection system more functional.

ORGANIZATION OF WORK OF SOCIAL PROTECTION INSTITUTIONS DURING A PANDEMIC

The research sought to determine how the pandemic affected the organization of work in social protection institutions. According to the statements of the heads of institutions in most institutions (82%) there have been changes in the work of institutions and they mainly relate to a different organization of working hours, inability to work directly with clients and switch to alternative communication with them by phone, viber, e-mail, post offices, etc. Only 18% of the heads of institutions stated that there were no changes in the organization of work and communication with the parties compared to the period before the pandemic. In addition to changes related to the organization of work and work with clients, some institutions have established new types of cooperation with other institutions to help users exercise their rights. The research showed that more than half of the institutions (55%) simplified the approach to users and citizens in exercising

certain rights. In order to better adapt to the current situation and respond to the expressed needs of users and citizens, 36% of institutions have established some new forms of services. Thus, thanks to the volunteers, help was organized in the procurement of food and medicine for people older than 65 who live alone and who were subject to a restraining order. As a new service, the collection of documentation was officially established instead of the personal request of the user, which was realized thanks to cooperation with other institutions. Also, food packages were distributed as one-time assistance to vulnerable users who were delivered to the address, and informing users and the population by phone about their rights and how to exercise them, as well as receiving applications via e-mail and viber. The survey found that all institutions had multiple channels to communicate with customers. The necessary information for users and citizens was provided through the advertising space in the institution, through the official website of the institution, through the media and direct telephone contacts.

PLANS AND PROCEDURES FOR ACTION IN EMERGENCY SITUATIONS

Risk assessments and action plans are extremely important for the overall organization of the work of social protection institutions in emergency situations. Therefore, the research sought to determine whether social welfare institutions have developed these plans and risk assessment, ie vulnerability of users and employees. The findings of the research show that the management of institutions did not pay the necessary attention to this issue because only two institutions (18%) according to the statements of the heads of institutions have an Emergency Management Plan. Almost half of the institutions (45.5%) do not have a plan of action, while other institutions have initiated the development of the Plan. The situation is even more unfavorable with the Risk Assessment, which no institution has, but activities are underway in two institutions to make a risk assessment. The security aspect in social welfare institutions is very important during a pandemic. The research findings show that the majority of institutions (73%) met the safety requirements for performing activities within their competence. The heads of the institutions that did not meet these conditions point out that because of that, the health and physical safety of the workers was endangered.

COOPERATION AND SUPPORT WITH AUTHORITIES

During emergencies, cooperation and coordination with the authorities is of special importance. The support provided by these bodies to social protection institutions directly affects the work and functioning of the institutions themselves and the quality of services they provide to beneficiaries. The research sought to determine which type of support was provided to institutions and whether the heads of institutions were satisfied with the type and scope of support provided.

Generally speaking, the heads of institutions are not satisfied with the cooperation with the authorities and the support provided. True, they state that they had some support, but it mainly consisted of the allocation of financial resources for the purchase of protective equipment, disinfectants and hygiene products, and regular disinfection of the premises, which was free of charge. However, the allocated funds did not enable the procurement of sufficient quantities of protective equipment and other necessary resources, which led to the fact that 45% of institutions did not have sufficient protective equipment and disinfectants. Working without adequate protective equipment and applying other measures during a pandemic increased the risk of infecting employees. In addition, the heads of institutions state that the budget revision reduced the financial resources for social protection institutions, despite the fact that due to the pandemic, the volume of work and material costs increased. As a lack of cooperation and coordination, the negligible involvement of the directors of the centers for social work in the crisis headquarters was stated (9%). Managers state that they are only executors of tasks and that they almost never consult on some issues that are especially important for the work of institutions, which is best shown by the fact that only one institution was contacted for advice and opinion on possible work of the institution and access to users during a pandemic. Despite these shortcomings, the survey showed that the majority of institutions (73%) fully complied with the recommendations of the crisis staffs, and other institutions, due to insufficient material and technical resources, only partially complied with these recommendations. Unlike the cooperation and support of the authorities, the heads of the institutions are satisfied with the cooperation with non-governmental organizations. They state that they provided significant support by hiring volunteers who delivered food packages to people in a state of social need, providing protective equipment and disinfectants, assistance in procuring technical equipment for online classes for children from vulnerable families, etc. The research also sought to determine how satisfied the heads of the institutions are with the overall work of the institution they headed at the time of the pandemic. Thus, 82% of managers are satisfied with the work of the institution, and 18% are partially satisfied with a number of difficulties they have faced. It is an interesting fact that none of the managers is dissatisfied with the organization of work and the provision of services during the pandemic.

WORKING WITH USERS DURING A PANDEMIC

In order to make a valid analysis of the assessment of the impact of the pandemic on the functioning of the social protection system, it was necessary to investigate the attitudes and opinions of professionals who work directly with users in social protection institutions. The majority of skilled workers (83%) believe that their work responsibilities were difficult during the pandemic.

The reasons given are the lack of direct contact with users (46%), difficulties in obtaining the necessary documentation in a timely manner through official channels (35%), increased, more demanding and more difficult workload (27%). A number of professionals (16%) stated the rudeness of parties and users who did not have an understanding for the new circumstances. The analysis of the research results showed that 27% of skilled workers find it harder to concentrate on their work obligations, which can also be reflected in the quality of work.

The research sought to determine whether professionals are familiar with the existence of plans and procedures for dealing with emergency situations in the institutions in which they work. The results show that 58% of professionals claim that there is no Contingency Plan in their institution, while 33% think that there is but did not participate in its development. Only 9% stated that this plan exists and that they participated in its development.

Procedures for dealing with users during the pandemic are extremely important and research findings show that the majority (79%) of professional staff of institutions is familiar with the procedure. It is a worrying fact that one fifth (21%) are not informed about the procedure because they can endanger their health, especially when it comes to working with clients who are infected with coronavirus. Further analysis showed that 72% of professionals pointed out that there were significant or partial changes in their personal work in relation to users and colleagues. These changes in work relate to the performance of daily work duties and include access and contact with users, contact and communication with colleagues and other services.

Regarding the organization of work during a pandemic, research findings show that the majority (79%) of skilled workers are satisfied with the organization of work. Partial satisfaction with the organization of work was expressed by 16%, and complete dissatisfaction by 5% of professionals, and they believe that there is room for improving the organization of work and providing services during a pandemic.

Working in emergency circumstances is very specific and often different methods of work, access and communication with users and citizens are necessary. The research sought to determine whether and in what way alternative methods of work were used in accessing users. The results of the survey show that 36% of professionals used some of the alternative methods of work, 24% partially used, while 28% did not use any alternative methods of access and communication with users with the explanation that users or institutions do not have technical capabilities (Viber, Skype, Zoom, e-mail, etc.). In institutions where there are plans and procedures, professional workers acted better and more adequately and applied alternative methods of work in accessing users.

The research aims to determine whether there was an increase in the demand for services in social protection institutions at the time of the pandemic.

Based on the research findings, it can be concluded that there are significant differences between institutions. In 24% of institutions the number of requests increased significantly, in 40% it remained unchanged, and in 36% of institutions there was a decrease in the number of requests. Institutions in which the number of applications has increased are centers for social work, which are key institutions of the social protection system and have a great responsibility for the social security of the population, especially during emergencies. In terms of the structure of requests, most of them were requests for financial assistance, followed by child allowance, disability benefits and other people's care, maternity benefits, public kitchen services, solving the problem of domestic violence, etc. These data suggest that the pandemic significantly affected the socio-economic position of citizens.

FUNCTIONING OF THE SOCIAL PROTECTION SYSTEM DURING A PANDEMIC FROM THE BENEFICIAL PERSPECTIVE

Centers for social work are the main bearers of activities in the social protection system and the research sought to determine the opinion of users about the organization of social centers during the pandemic and the quality of services provided. Satisfaction with the organization of the work of social work centers was expressed by 84% of users, 13% were partially satisfied, and 3% were dissatisfied. Satisfaction with the quality of services provided was expressed by slightly fewer users, 73%, partially satisfied by 24%, and complete dissatisfaction by 3% of users. However, these findings should be taken with a grain of salt because a significant number of users who expressed satisfaction with the services provided in their answers put an additional comment such as “I have to be satisfied, there is no better” etc. The satisfaction of users with the services provided is affected by the regularity of social benefits payments. Among the users who expressed dissatisfaction with the services provided, they point out that they are dissatisfied with the amount of realized financial income and non-receipt of material assistance, such as: food and hygiene packages, one-time financial assistance, protective equipment. In addition, these users expressed dissatisfaction that none of the competent authorities visited them and saw their needs during the pandemic.

A large number of beneficiaries, in addition to the rights they already exercise, expressed the need for additional rights in the field of social protection. The need for additional financial assistance was expressed by 55% of users, for natural assistance by 42%, the need for home care services and home help by 12%, the need for professional assistance to settle family relationships was expressed by 3% of users. Some of the users expressed the need for more additional rights. Some of the users pointed out the need for material, ie financial assistance for the purchase of household appliances, heating, renovation of housing, procurement of medicines, etc. Beneficiaries who have school-age children almost all (95%) expressed

the need for technical equipment and support so that children can follow online classes, which includes Internet access, computer procurement and the provision of assistants for children with disabilities who attend online classes. The survey found that in the user population, 65% own a mobile phone, 27% own a landline phone, and 18% do not own a cell phone or landline phone. As many as 84% of users do not have Internet access. This situation is very unfavorable and further complicates communication with users during an emergency situation due to the impossibility or limited possibilities of establishing contact with them by professional workers of social protection institutions, which can affect the exercise of certain rights and timely information. In such circumstances, the children of users are in a particularly difficult position due to the lack of basic conditions for monitoring online classes, which endangers their right to education.

SOCIO-ECONOMIC CHARACTERISTICS OF PERSONS WHO LEFT UNEMPLOYMENT DURING THE PANDEMIC

The measures taken, which included a ban on the operation of some activities, were reflected in an increase in the number of unemployed throughout BiH. According to the data of the Employment Bureau in Zenica-Doboj Canton, the total number of unemployed persons in March was 54,262, which is 14.89% of the total population of this canton. During the month of March 2020, a total of 1,642 newly registered persons were registered.

A survey conducted on a sample of people who lost their jobs during the pandemic shows that most of them are people with secondary education (75.1%), 15.6% of respondents have a university degree, 8.1% have completed primary school, and 1.2% have a master's degree. Among the respondents, most are persons belonging to the age group of 26 to 35 years of age (36%), followed by the age group of 36 to 45 years of age (27%), while in other age groups there is a smaller number of persons. In terms of marital status, the largest number is married 48.6%, unmarried is 38.7%, divorced is 8.1%, and other persons live in an extramarital union or their spouse has died. The majority of respondents live in a three-member household (31%), followed by a four-member household (23%), a two-member household (20%), while the least number of those living in a household with five or more members (9%). Among the people who lost their jobs due to the pandemic, 17% are single.

The survey showed that most of these people do not have children, 67%. One child has 21%, two have 10% of respondents, and the others have three or more children.

The research findings show that 60% of respondents have their own apartment, and the rest live as tenants or with relatives. These data indicate that 40% of people who lost their jobs do not have an adequately resolved housing issue and an

increase in the number of social protection beneficiaries can be expected in the coming period.

Among the people who lost their jobs during the pandemic, most of them worked in the private sector (92.5%) and most lost their jobs at the beginning of the declaration of the pandemic in March 2020 (73%). The research established that among the people, who lost their jobs during the pandemic, there were more people with secondary education and most of them worked in service industries. The dominant occupations are: merchant, waiter, cook, tailor, carpenter, baker, and driver. Among people with a university degree, most are economists. A significant number of respondents (77%) are of the opinion that they will return to their jobs after the situation normalizes. Others feel they will not return to their jobs. The reasons given are the reduction in the volume of work even after the pandemic or due to going abroad.

The survey sought to determine whether employers informed workers who lost their jobs about their rights under the Law on Mediation in Employment and Social Security of Unemployed Persons in FbiH (FBiH Official Gazette, No. 41/01, 22/05, 9/08). The Law prescribes the conditions and criteria for receiving cash benefits during unemployment. The research findings show that as many as 62% of respondents state that their employers did not inform them about these rights, 5% state that their employers partially informed them, and 33% state that their employers fully informed them about the exercise of these rights.

Out of the total number of respondents, 27% exercised the right to unemployment benefit, 37% submitted a request and expect a positive outcome because they meet all legal requirements. The other 36% of respondents did not exercise this right because they do not meet the conditions. In such circumstances, it is realistic to expect that a number of these persons will find themselves in a state of social need, especially those living in households where no one is employed. The survey shows that 42% live in households where none of the members earn income. Among the respondents living in households where one of the members earns income (58%) there are significant differences in the amount of income. Respondents living in households where one of the household members earns income but they are insufficient are potential beneficiaries of some of the rights from social protection. The need for financial assistance was expressed by 37% of respondents, and 5% for child allowance. Other respondents believe that they still do not need financial assistance and that they expect the situation to normalize and return to work. However, the fact that 86% of respondents are not familiar with the procedures for submitting requests for exercising rights in the field of social protection further confirms the fact that citizens are uninformed about their rights, how to exercise them and activities of social protection institutions, especially social work centers. However, the fact that 86% of respondents are not familiar with the procedures for submitting requests for exercising rights in the field of social protection

further confirms the fact that citizens are uninformed about their rights, how to exercise them and activities of social protection institutions, especially social work centers.

CONCLUSION

The social protection system in the Federation of Bosnia and Herzegovina is burdened with numerous problems, including the division of competencies between the entities and cantons, which has led to significant differences in the scope of rights and services as well as the amount of cash benefits between cantons. These differences are a consequence of the differences contained in the cantonal laws on social protection and are directly related to the economic possibilities of the cantonal budgets from which most of the prescribed rights are financed. Insufficient number of employees, especially professional workers, is expressed in almost all institutions and a small number of institutions have harmonized internal acts on organization and systematization with the entity regulation. Not enough attention is paid to the issue of continuing education, which can have a negative impact on employee motivation and work results. Therefore, management must pay more attention to human resource management and employee motivation. The research showed that most institutions do not have work plans in crisis circumstances. The analysis established that the centers for social work organize their work using ad hoc models without a well-founded expert analysis of the needs and adequate support of the founders and other levels of government. This situation significantly reflects on the quality of services provided to customers and employees.

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IZAZOVI SISTEMA SOCIJALNE ZAŠTITE U ODGOVORU NA KRIZU UZROKOVANU PANDEMIJOM

Sažetak: Nakon što je Svjetska zdravstvena organizacija u martu 2020. godine proglasila globalnu pandemiju uzrokovanu koronavirusom, a Vijeće ministara Bosne i Hercegovine (BiH) proglasilo nastanak stanja prirodne ili druge nesreće na području cijele države, zbog opasnosti od moguće pojave zarazne bolesti prouzrokovane ovim virusom, Vlade oba entiteta i Brčko Distrikta BiH, te kantonalne vlade u Federaciji BiH kao i lokalne vlasti donijele su niz hitnih mjera kako bi smanjile rizik širenja koronavirusa u kolektivima. Mjere fizičkog distanciranja, uz mjere zatvaranja određenih privrednih subjekata, škola i ustanova socijalne zaštite jedne su od prvih uvedenih mjera koje su vlade preduzele u borbi protiv širenja koronavirusa. Uvedene mjere posebno su pogodile pojedine privredne grane u kojima veliki broj ljudi ostaje bez zaposlenja, a što se direktno odražava na porodice. Porodice sa djecom, posebno porodice u riziku i disfunkcionalne porodice, siromašne porodice, kao i one koje žive u ruralnim udaljenim sredinama susreću se sa novim problemima i postaju još ranjivije sa pojavom rizika od siromaštva zbog gubitka posla i/ili drugih stalnih izvora primanja. Kratkoročne kao i dugoročne posljedice pandemije dovode do negativanog utjecaja i povećavaju rizik funkcionisanja porodice, porodičnog staranja, egzistencije porodice, do pojave nasilja u porodici, a posebno nasilja nad djecom, zanemarivanja i odgojnog zapuštanja djece. Proglašena pandemija dovodi do krize koja direktno utiče na funkcionsanje ustanova socijalne zaštite, narušava „redovno” funkcionisanje sistema i predstavlja izazov ukupnog sistema socijalne zaštite. U radu je prikazano istraživanje provedeno u Zeničko-dobojskom kantonu u periodu pandemije. Analiziran je načinu funkcionisanja ustanova socijalne zaštite u periodu krize, odnosno pandemije, ali i proces pružanja socijalnih usluga. Istraživanje se zasniva na holističkom pristupu u sagledavanju realnih potreba i kompleksnosti problema sa kojima se suočavaju korisnici ali i stručne osobe u ustanovama socijalne zaštite, te ukupan sistem socijalne zaštite.

Ključne riječi: pandemija, socijalna zaštita, ustanove, porodica

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INITIAL RESPONSE OF THE SOCIAL PROTECTION SYSTEM TO THE COVID-19 PANDEMIC*

Abstract: On January 30, 2020, World Health Organization proclaimed the spread of the new Corona virus as the Public Health Emergency of International Concern, and on March 11, 2020, the spread of Covid-19 was characterized as the outbreak. The crisis caused by the SarsCoV-2 virus pandemic, and the infectious disease Covid-19 caused by the aforementioned virus, brought great temptations to the social protection system and pushed the boundaries of expectations of both the beneficiaries and the general public. Social protection system entered this challenge with the burden of certain limitations – with deviation of the number and the structure of employees from the prescribed standards, a large number of unoccupied work positions, a large number of beneficiaries of social protection rights, insufficiently established cooperation with other systems, the absence of socio-medical institutions, as well as the lack of regulations related to emergency situations. At the moment of proclaiming of Public Health Emergency of International Concert, national legal frame relevant for this issue, consisted from the provisions of Constitution and several laws in health, social and other sectors. For the fast and specific reaction in the social care area, the adoption of the line of by-law regulations was required, as well as fast reorganization of capacities. By defining the protection of health and life of beneficiaries as the primary goal, preventive protection measures were adopted even before the healthcare system reacted, as well as the regulations appropriate to the situation were adopted, in purpose of preventing the spread of the epidemic. Capacities have been developed within the normative activity, as well as the activities related to the protection of the beneficiaries in terms of accommodation, records and reporting, control, support and cooperation with other systems. New ways of work organization have been established. This mode of action has yielded results – a very favorable epidemiological state in the system during the first wave of epidemic, and an established system of preventive and beneficiary protection-focused measures.

Keywords: social protection, epidemic, beneficiaries, measures of protection, legal regulation

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INTRODUCTION

On January 30, 2020, the Director General of the World Health Organization (hereinafter: WHO) declared a public health emergency of international concern (hereinafter: PHEIC). This is the sixth time that the WHO has declared the PHEIC, since its International Health Regulations (hereinafter: IHR) came into force in the form in which it now exists (2005). Following the proclamation of the PHEIC, the WHO Director-General issued interim recommendations based on the IHR, which included the obligation of states to provide a sufficient public health base and justification to the WHO on all additional measures in addition to those recommended by the WHO. This was to enable the international response to be evidence-based, measured and balanced, in order to avoid unnecessary interference in travel and trade.[2] A large number of countries have taken action in various sectors, including the social protection sector. The Ministry of Labor, Employment, Veteran and Social Affairs of the RS (hereinafter: MLEVSA) soon after declaring a public health emergency of international concern began to adopt legal acts and prescribe emergency measures to regulate the social protection system in terms of prevention and protection against proliferation of epidemic, by issuing by-law regulation.

The objective of this paper is to give the review and the personal attitude on the international, comparative and national legal frame and activities related to the pandemic situation. Method used in the paper will be analysis of the international, comparative and national legal sources and attitudes related to the pandemic and their qualitative analysis.

REGULATION OF WORLD HEALTH ORGANIZATION INTERNATIONAL HEALTH REGULATIONS

The International Health Regulations (World Health Organization, 2005a) are "primarily a legally binding global agreement dealing with the risks of the international spread of communicable diseases". IHR were singed by 196 signatory states, the Republic of Serbia on June 15, 2007 (World Health Organization, 2005b). It aims to "help the international community prevent and respond to acute public health risks that have the potential to cross borders and endanger people around the world". The Regulations define the rights and responsibilities of the signatory countries and requires the WHO to report certain events related to public health.

The Regulations contain three main requirements in relation to the signatory states. First, states have to establish a functioning "national contact point for IHR". This is a national organization designated by the state, which will

[4] 2019-nCoV outbreak is an emergency of international concern. Retreived on January 3, 2021 from http://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/news/news/2020/01/2019-ncov-outbreak-is-an-emergency-of-international-concern

be “available at all times for communication with the WHO IHR contact points” according to the International Health Regulations. Second, states are required to demonstrate that their public health systems comply with the requirements of the International Health Regulations regarding the reporting and verification of events of public importance. Third, states have to assess and strengthen their national capacity to detect, assess, report and report events in accordance with the International Health Regulations (Tiede, Sjenicic, & Schulte, 2013). All these requirements were set precisely in order to prevent the spread of infectious diseases, and to prevent a public health threat from becoming a threat of international importance. This pandemic is a test of how much IHR have been applied and how well the prescribed mechanisms really work. This test provides a basis for each state and each system to improve crisis response mechanisms.

EUROPEAN UNION REGULATIONS

EU regulations do not go deep into the health systems of the member states, because the health field is, in principle, under the national competence of each member state (Sjeničić, Miljuš, & Milenković, 2016, p. 332). However, it is important for the member states to be harmonized with EU law and with each other on this issue, because infectious diseases know no borders. The legal framework of the European Union in the field of serious cross-border threats to health are: 2000/96/EC: Commission Decision of 22 December 1999 on the communicable diseases to be progressively covered by the Community network under Decision No 2119/98/EC of the European Parliament and of the Council[3]; Decision 2002/253/EC: Commission Decision of 19 March 2002 laying down case definitions for reporting communicable diseases to the Community network under Decision No 2119/98/EC of the European Parliament and of the Council[4] and the Decision 2012/506/EU: Commission Implementing Decision of 8 August 2012 amending Decision 2002/253/EC laying down case definitions for reporting communicable diseases to the Community network under Decision No 2119/98/EC of the European Parliament and of the Council[5]; Decision No 1082/2013/EU of the European Parliament and of the Council of 22 October 2013 on serious cross-border threats to health and repealing Decision No 2119/98/EC[6]; Regulation (EC) No 45/2001 of the European Parliament and of the Council of 18 December 2000 on the protection of individuals with regard to the processing of personal data by the Community

[5] Retreived on January 4, 2021 from https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32000D0096

[6] Retreived on January 5, 2021 from https://eur-lex.europa.eu/eli/dec/2002/253/oj

[7] Retreived on January 4, 2021 from https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32012D0506

[8] Retreived on January 3, 2021 from https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex%3A32013D1082

institutions and bodies and on the free movement of such data[7]; Council Recommendation of 22 December 2009 on seasonal influenza vaccination[8]; Council conclusions on childhood immunization: successes and challenges of European childhood immunization and the way forward[9]. Although it is not a member of the EU, for Serbia, as for other European countries, harmonization with this regulation is important, because it ensures that all countries in the region, and beyond, are guided by the same or similar principles in preventing and combating infectious diseases.

The Covid-19 virus pandemic has posed a challenge to public health and the age we live in. Therefore, at the beginning of November 2020, the European Commission proposed a new security framework that would correspond to the health challenges of tomorrow.[10] However, the proposals followed several months after the first wave of the pandemic in Serbia, so in accordance with the topic of this paper, they will not be discussed here.

RELEVANT EXISTING NATIONAL LEGAL FRAMEWORK PRIOR TO THE DECLARATION OF THE COVID-19 PANDEMIC

Constitution of the Republic of Serbia

According to Article 200 of the RS Constitution (Official Gazette, 98/2006) the National Assembly declares a state of emergency, when the public danger endangers the survival of the state or citizens. By declaring a state of emergency, the National Assembly may prescribe measures derogating from the human and minority rights guaranteed by the Constitution. When the National Assembly is unable to meet, measures derogating from human and minority rights may be prescribed by the Government, through decree, with the co-signature of the President of the Republic. Measures of derogation from human and minority rights prescribed by the National Assembly or the Government shall be valid for a maximum of 90 days, and after the expiration of this period they may be renewed under the same conditions. When the decision on the state of emergency has not been made by the National Assembly, the National Assembly shall confirm it within 48 hours from its adoption, i.e. as soon as it is able to meet. According to the described procedure, a state of emergency was introduced in mid-March 2020.

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9 Retreived on November 23, 2020 from https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=celex:32001R0045

8 Retreived on November 22, 2020 from https://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX%3A32009H1019

9 Retreived on November 19, 2020 from https://eur-lex.europa.eu/legal-content/LT/TXT/?uri=uriserv:OJ.C_.2011.202.01.0004.01.ENG

10 Retreived on January 4, 2020 from https://ec.europa.eu/health/security/overview_en

Relevant laws of the Republic of Serbia

The Law on Protection of the Population from Infectious Diseases (Official Gazette RS, no.15/2016, 68/2020 and 16/2020) has been harmonized with the International Health Regulations since 2016, by stipulating Article 12 which prescribes that the Institute of Public Health of Serbia performs the activities of the National Center for the Application of the International Health Regulations. In the event of emergency (public health risk), the Institute exchanges information with the WHO, checks and reports the case to WHO and adopts an *Action Plan for the implementation of the IHR*. In case of an emergency, the Minister of Health forms a joint body, for the purpose of preventing and suppressing the emergency. In accordance with the IHR, the Institute submits a notification on the occurrence of an infectious disease, epidemic or other public health emergency of international concern to the WHO Regional Office for Europe and other international organizations or countries, in accordance with accepted international obligations. These opportunities of the Institute should be used more in communication with actors from other sectors. Although the International Health Regulations are nominally acts in the field of health, they essentially cover the entire system and its response to public health risks. In this sense, when drafting the *Action Plan for the implementation of IHR*, the Ministry of Labor, Employment, Veterans and Social Affairs and local governments should be involved in its drafting.

The law stipulates that every legal entity, entrepreneur and natural person is obliged to act in accordance with the measures for protection of the population from infectious diseases determined by this law and to enable unhindered supervision and taking prescribed measures, as well as regular and emergency measures to protect the population from infectious diseases as a set of all activities planned, organized and carried out by the authorities of the Republic of Serbia (hereinafter: RS), autonomous provinces, local self-government units, economic entities and legal entities, institutes and institutes for public health and other health institutions, health workers and associates and individuals, in order to protect the population from infectious diseases. The law is, therefore, conditionally speaking of a sectoral nature (health sector), but, given the subject it regulates and the entities it covers, it is relevant for all sectors and all natural and legal persons, regardless of their field of activity.

Article 13 of the ***Law on Disaster Risk Reduction and Emergency Management*** (Official Gazette RS, no. 87/2018) defines the subjects and strengths of the disaster risk reduction and emergency management system. The unity of action of the subjects of the disaster risk reduction and emergency management system at the RS level is ensured through the National Risk Reduction Platform. The role of the National Platform is played by the Republic Headquarters for Emergency Situations. In the work of the National Platform, in addition to the members of the

Republic Emergency Headquarters staff, representatives of the academic community, local self-government and civil society organizations, as well as other subjects of the disaster risk reduction system should participate. Emergency headquarters are established to monitor disaster risk reduction activities and to coordinate and manage emergencies (Article 41), vertically at all levels.

Many of these provisions also apply to the social protection system in the RS, regardless of whether it is about service providers or users, community services or residential services. These are all "subjects and forces of the system" and all have the obligation and the right to be involved in disaster risk reduction. The crisis caused by the outbreak of the SarsCoV-2 virus pandemic, and the infectious disease Covid-19 caused by it, brought great challenges to the social protection system and pushed the expectations of users and the general public. The system entered this challenge with the burden of certain limitations - deviation of the number and structure of employees from the prescribed standards, a large number of vacancies, a large number of social care service users, insufficient cooperation with other systems, lack of socio-health institutions and lack relevant bylaws relating to emergency, crisis situations. Although the crisis is the framework in which social protection moves and acts, reacts with its measures and activities, nevertheless, the system of social protection in Serbia, and no one else in the world, not all crisis situations are known or predictable.

Article 57 of the ***Law on Social Protection*** (Official Gazette RS, no. 24/2011) prescribes that the Minister responsible for social protection shall adopt more detailed conditions and standards for the provision and realization of social care services. These standards have been adopted through the *Rulebook on detailed conditions and standards for the provision of social care services* (Official Gazette RS, no. 42/2013, 89/2018 and 73/2019). In crisis situations, such as the Covid-19 epidemic, where it is necessary to maintain a distance between users, the number of caregivers and other staff must be higher, because each user must be treated individually in a large number of situations. In that sense, for the social care sector, it is necessary to lift the ban on employment in the public sector, i.e. to ensure that the relevant Commission approves the employment of a larger number of required profiles.

Other, and in particular, provisions on cross-sectoral services (58-60) of the Law are relevant in crisis situations, such as the state of the pandemic. The Law on Social Protection does not specifically regulate crisis situations, but in order for the system to respond adequately in such situations, it is necessary to harmonize the practice with the provisions of the Law in terms of compliance with standards, development of community services and other provisions.

Articles 50-63 of the ***Labor Law*** (Official Gazette RS, no. 24/2005, 61/2005, 54/2009, 32/2013, 75/2014, 13/2017, 113/2017 and 95/2018) regulate, among other things, working hours. During the first wave of the pandemic, fifteen-

day, i.e. multi-day shifts of professional workers in social protection institutions were introduced (preventive, or as a measure of isolation after the outbreak of an epidemic in the institution). It was difficult to bring them under any of these provisions of the Labor Law, so this Law should involve this kind of work for the emergency situations, such as the Covid-19 virus epidemic, if it is considered to be efficient and, from the point of view of employees, sustainable and feasible way of user protection. Regardless of whether the fifteen-day shifts will be based on the consent of the employees, or on the legal regulation as a type of redistribution of working hours or as another form of work, employees should be adequately paid for overtime work and compensation for separation from their families.

Decisions of the Government and the ministries, relevant for the work of institutions and other social care providers – adopted during the state of emergency

MLEVSA/Minister, Ministry of Health and the Government of the RS passed instructions and other acts referred to the institutions over which the Republic exercises its founding rights, as well as to the centers for social work, to which the Republic transferred public authorizations.

On March 10, 2020, the Government passed (and subsequently amended several times, in accordance with the epidemiological situation) the Decision to declare the Covid-19 disease caused by the SARS-COV-2 virus a contagious disease (Official Gazette RS, no. 23/2020, 24/2020, 27/2020, 28/2020, 30/2020, 32/2020, 35/2020, 37/2020, 38/2020, 39/2020, 43/2020, 45/2020, 48/2020, 49/2020, 59/2020, 60/2020, 66/2020, 67/2020, 72/2020, 73/2020, 75/2020, 76/2020, 84/2020, 98/2020, 100/2020, 106/2020, 107/2020, 108/2020 and 116/2020). The Decision calls for the application of measures prescribed by the Law on Protection of the Population from Infectious Diseases, the Law on Health Care, the Law on Public Health, as well as other measures. Ill people or only positive for Covid-19 are isolated and treated in facilities that are specially designated and prepared for the isolation and treatment of ill or infected. After the treatment, based on the Decision, isolation at home follows. Employees in the health and social protection system of RS are recommended not to travel to countries with intensive transmission of Covid-19, i.e. to countries with hotspots of the epidemic. On the same day, the Minister of Labor, Employment, Veteran and Social Affairs (hereinafter: the Minister) passed (no. 500-01-2/2020-09), and later amended (no. 021-01-00016/6/2020-05), the Instruction recommending hygienic measures of space and equipment; waste discharge; supply of hygiene products, pointing out the need for regular hygiene, as well as postponing celebrations and gatherings. The instruction was sent to all employees of the MLEVSA and administrative bodies within the MLEVSA, the Chamber of Social Protection, all institutions in the social protection system and

the Centers for Social Work. A day later, the Minister passed an Instruction (no. 021-01-00016-6/2020-05) recommending hygiene measures and hygienic rules of conduct in all institutions under the jurisdiction of the MLEVSA, the need to hold educational meetings on the issue of necessary hygiene measures, as well as postponing meetings. The challenge in the implementation of measures was that the institutions did not have adequate means for disinfection.All residential institutions had funds planned for these purposes, but few conducted public procurement during January and February and purchased the necessary funds. The shortage on the market and the inflexibility of the existing financial system in the conditions of the state of emergency have led to the fact that many institutions were not able to fulfill these requirements to the end and on time. Good practice has shown that institutions lend to each other.[11] In the later phase of the first wave, the Ministry procured funds for both private and state institutions. On the other hand, this was a challenge for both community service providers and social work centers, as they generally did not have the funds earmarked for these purposes, and the MLEVSA delegated the procurement of these funds to local governments as founders.[12] Thus, centers for social work and service providers were left to local crisis headquarters that had different practices in meeting these conditions. It should be borne in mind, as mentioned, that social protection representatives were involved in a small number of crisis headquarters at the local level.

The instructions also referred all employees, employees and appointees in the administrative bodies within the MLEVSA to cancel planned trips outside the territory of the RS while the previously mentioned Decision of the RS Government on declaring Covid-19 disease caused by the SARS-CoV virus is in force. If it was not possible for them to cancel the trips, it was necessary to obtain the prior consent of the Minister for the trips. Since these were instructions issued before the declaration of the state of emergency and the epidemic, from the constitutional and legal point of view, a recommendation to cancel the trip should have been issued, and no consent should have been sought. As already mentioned, the state of emergency provides a basis for restricting freedom of movement. Without this basis, there should be no restrictions. Of course, in terms of life and practice, the MLEVSA reacted sensibly in the context of preventing the outflow of staff in social protection, when it seemed that the institutions would need more staff and when

[11] Solidarity among social welfare institutions is already immanent to the social welfare system, and was especially developed during the Covid-19 pandemic. Institutions that had disinfectants at their disposal lent and gave certain quantities to those who did not. Viber groups, established for rapid reporting of institutions on the epidemiological situation, were, among other things, used for agreements on rapid interventions of this type.

[12] According to the Law on Social Protection, local self-government units are the founders of centers for social work and they are in charge of community services. At the beginning of the state of emergency, MLEVSA established cooperation with most local self-government units and their crisis headquarters, so some local self-government units undertook regular and frequent disinfection of the yards of residential institutions, even though their founder is RS or Autonomous Region Vojvodina.

it was necessary to think about preventing the spread of infection within institutions. However, in such extraordinary circumstances, individual legal acts must be in accordance with the umbrella regulations and this should be kept in mind for future similar situations.

Furthermore, the MLEVSA issued instructions and orders, which will be grouped below by institutions, user groups or types of activities to which they referred.

On March 12, 2020, the Minister issued an **Instruction sent to social protection institutions for accommodation of beneficiaries** (no. 500-01-2/2020-09), which, in order to protect beneficiaries and prevention, orders to: ban visits to accommodation institutions until the establishment of a favorable epidemiological situation in RS, in accordance with the instructions of the Ministry of Health, except in the case of a written order of the Minister responsible for social protection; restrict the stay and movement of persons who are outside the social protection system, in the facilities of institutions, exclusively for performing of jobs and activities that ensure the continuity of the provision of accommodation services; admission of new users of the accommodation service is performed exclusively with a negative Covid test; the newly admitted user of the accommodation service is preventively placed in quarantine for a period of 14 days within the institution; immediately inform the competent health institution, as well as MLEVSA, in case of possible symptoms of viral infection, with employees and users of accommodation services. A day later, the ministry sent a Note to social protection institutions for accommodation of beneficiaries (no. 500-01-2/2020-09), which, in order to prevent the spread of disease in social protection institutions on the territory of RS: recommended that users should not leave the institution unnecessarily and without justified reasons; point out to the user the risk of going out of the institution and the real possibility of being placed in isolation, and, in the future, to quarantine and hospital treatment; consult a professional or on-duty worker before leaving the institution; provide mandatory use of a protective mask and gloves when moving outside the institution and the use of public (city) transport; recommend that communication with other persons, especially outside the institution, be done at the recommended distance; to procure for the personal needs of users through institutions.

These recommendations were followed an Order banning visits and restricting movement in the facilities of institutions for the elderly until the danger of spreading the infectious disease Covid-19 ceases on the territory of RS, issued by Ministry of Health on March 14, 2020, and amended on May 6, 2020 (Official Gazette RS, no. 28/2020 and 66/2020). It is essentially clear why users are forbidden to leave institutions. It should be borne in mind, however, that at that time no state of emergency had been declared, nor a ban on the movement of persons over 65 or over 70 (in smaller places), and in that sense, formally, it should have

been a recommendation. Regarding the restriction of movement, an Order was subsequently sent (March 28, 2020, no. 500-01-5/2020-05) to the residential institutions which, until the establishment of a favorable epidemiological situation on the territory of RS: prohibits the stay and movement of persons from outside of social protection system, in social protection institutions (this ban excludes the persons who provide services necessary for the functioning of institutions, for the purpose of performing jobs and actions that ensure the continuity of the provision of accommodation services); direct contact with the user at the residential institution (while respecting protection measures) can only have a doctor, nurse and caregiver/educator, and a professional worker only when necessary to protect the personality and rights of the user. In essence, when issuing such orders, the needs and characteristics of different user groups placed in institutions should/should have been taken into account - children, young people, people with disabilities, the disabled, the elderly.

The Decision to declare a state of emergency (Official Gazette RS, no. 29/2020) was passed on March 15, 2020 (confirmed by the decision of the RS National Assembly, April 29, 2020). On March 19, 2020, the Minister of Health passed the Order on declaring the epidemic of the infectious disease Covid-19 an epidemic of greater epidemiological significance - for the territory of RS (Official Gazette RS, no. 37/2020).

After the declaration of the state of emergency, the Minister of MLEVSA issued several instructions, including the **Instruction on the organization of work of centers for social work** (March 16, 2020, no. 500-01-2/2020-09) which ordered all directors of Centers for Social Work (hereinafter: CSW) to: organize work schedule, working from home employees, as well as to provide a minimum of work processes in CSW in accordance with the assessed needs of users. Through this Instruction, the Republic addressed the CSW and, indirectly, local governments. However, in the coming period, contact with local governments and community service providers should be more direct and connected vertically, because it is a system of social protection at all levels, regardless of who the founder is. Experience shows that more necessary services at the local level have been abolished due to the epidemic. As the social protection system cannot stop due to the epidemic, but can find an adequate way of taking care of the users, they should work in synchrony and with adequate information.

There were challenges in the consistent application of the instruction.[13] In the future, it is necessary to think about more precise criteria when it comes to the organization of centers for social work in emergency circumstances (which situations require going to the field, the way of accepting requests, the way of communicating with parties, etc.). It seems that the directors who are members of the crisis headquarters in their local communities and who have previously had

[13] The most common challenges were Instruction suitability for user groups and insufficient staffing.

many years of experience in the social protection system have “better managed” in the application of the instruction. On March 21, 2020, the RS Government passed the Decree on the composition, manner and organization of the work of emergency headquarters (Official Gazette RS, no. 27/2020). The composition of crisis headquarters at all levels clearly indicates the need for a multisectoral approach, as indicated by the WHO in its recommendations. Such situations indicate the necessity of constant vertical and horizontal multisectoral work. Practice shows that the representatives of the social protection system were not represented in all headquarters, and above all, the representatives of institutions and services of the social protection system located on the territory of a specific local self-government were not represented. The procurement of protective equipment was diverse and depended on local self-governments, which should be regulated in a harmonized manner in the coming period.

On March 17, 2020 (later amended), the Minister issued an **Instruction on the organization of the work of centers for family accommodation and adoption** (no. 500-01-7/2020-01, i.e. no. 021-01-73/2020-01), which obliges the directors of the centers to: organize work from home and ensure a continuous and uninterrupted work process; organize and ensure that employees make direct contact with the foster child when necessary, and provide monitoring and insight into the work of foster carers and support to the child and family (mainly by electronic means of communication); ensure the postponement or suspension of the implementation of foster care preparation and training programs; ensure the reduction of contacts of employees until further notice, and make available information on the services of the center in appropriate public places; ensure the use of protective equipment by employees; ensure that children and caregivers receive the necessary information on the current situation and behave in accordance with the standards; ensure that the centers establish adequate cooperation with CSW and other relevant entities in order to protect the personality, rights and interests of foster children.

The instructions were mostly issued in a timely manner. After retrospectively reviewing the course of the first wave of epidemic and reacting to it, it could be suggested that any further instruction in times of crisis be accompanied by an order to establish cooperation with CSW and community service providers, in order to protect the rights and interests of users. Also, it could be suggested that, even in regular circumstances, it should be worked more on the development of services in the community, for the purpose of their strengthening and the continuous provision of such services in the emergency situations and relieving of residential institutions. The instructions sent to the Centers for Family Accommodation and Adoption were changed several times within 24 hours, where they were treated as institutions once and as CSR the second time, which was confusing for the employees. In that sense, in these subsequent waves of epidemic,

it would be expected that, before the instruction is issued, and on the basis of previous experience, measures will be precisely determined and things that are important for preventing the spread of the epidemic will be specified.

Relevant is, also, the **Instruction for performing work outside the employer's premises** (March 19, 2020, no.500-01-2/2020-09), which orders to residential institutions to make decisions approving the work from home for employees who are assigned to administrative tasks. Decisions shall be be valid until the cessation of extraordinary circumstances due to which decisions are made. Decisions were issued if the director of the institution assessed that the performance of work in that way does not jeopardize the continuous and uninterrupted process of work of the residential institution in the current circumstances. This instruction was not easy to apply, as it depended on the individual case: there were situations where a parent of minor children had to respond to a work obligation due to the expiration of a 15-day quarantine and a lack of employees for another 15-day quarantine, while the other parent also had a work obligation. In addition, such 15-day shifts should be regulated in the Labor Law, Special Collective Agreement, etc. When it comes to working from home, it is necessary to define the criteria in terms of proving the need for it. Also, the way of using annual vacations was not clearly defined, and everything was given in the form of a recommendation.

In further regulating the specific way of work, on April 13, 2020, the Minister issued a Recommendation for the introduction of 15-day preventive shift work to residential institutions and organizations (no. 500-01-7/2020-09). After that, on April 15, 2020, the Instruction on the manner of acting in the circumstances of the preventive introduction of fifteen-day shift work within the residential institutions was passed (no.500-01-7/1/2020-09). On April 24, 2020, the Government of the RS amended the Special Collective Agreement for Social Protection in RS (Official Gazette RS, no. 60/2020), which provided ill or isolated employees with salary compensation in the amount of 100% of the average salary in the previous 12 months. On April 29, 2020, the Minister issued the Instruction on the procedure for changing shifts in the circumstances of the established two-week shift work - preventive isolation within the institution/organization (no. 500-01-7/5/2020-09) which regulates the dynamics and manner of changing shifts.

After the abolition of the state of emergency, on May 7, 2020, the Minister issued an Order addressed to residential institutions and organizations for adults and the elderly (no. 021-00-00014/2020-01/38) related to the need to consider the current epidemiological situation, decide on further work organization (related to continuing of two-week preventive isolation or transition to normal shift work) and drafting a Proposal for a plan for introduction into normal shift work.

As already mentioned, regardless of the manner in which the fifteen-day shifts will be legally regulated, employees should be adequately paid for overtime work and compensation for separation from families, having in mind such exceptional work effort.

By amending the Decree on the procedure for obtaining consent for new employment and additional employment with users of public funds (Official Gazette RS, no. 50/2020), on April 4, 2020, the Government of RS, prescribed that “during the state of emergency, users of public funds may, without the consent of the Commission, retain employees (at the level of March 15, 2020) engaged on the part-time basis, due to the increased volume of work, on the basis of service contracts, contracts on temporary and occasional jobs, through youth and student cooperatives and on other basis.

On March 29, 2020, Minister issued the Instruction on the implementation of **hygienic and protective measures in residential institutions** (no.500-01-6/2020-09). In addition to hygienic and protective measures, it also extended the preventive quarantine of the newly admitted service user from 14 to 28 days, within the institution. When it comes to hygienic and protective measures, two more instructions have been issued. Instruction on the implementation of protective and hygienic measures in the residential institutions for adults and the elderly (March 31, 2020, no.500-01-2/2020-09), which regulates further procedures regarding the admission of new users. Secondly, by the Order of the Minister from April 2, 2020 (no. 500-01-2/2020-09), the use of protective clothing and footwear at work and obligatory clothes changing in the residential institutions is regulated. Regarding the organization of work within the MLEVSA, the Minister issued the Instruction for the work of employees in the **Sector for Family Care and Social Protection** who perform work outside the employer's premises during the state of emergency (March 30, 2020, no.500-01-11/2020-01), by which he ordered that: Sector performs daily control of work of CSW and child protection services at the municipal and city administrations; the control is performed by anonymous telephone calls, according to the principle of random sampling; the subject to control is: answering employees on a phone call, providing the requested information, accuracy of information, professionalism and kindness of persons answering the phone, etc.

During the current epidemic, the Social Welfare Inspection played a very important role - monitoring the situation in the system, controlling the implementation of measures and following instructions, keeping records of infected and potentially infected users and employees, reporting on the situation in the system, mediation with other bodies and support availability to all institutions and organizations of social protection seven days a week, 24 hours a day. Since the number of employed inspectors was not sufficient in relation to the number of supervised entities even in the time before the epidemic, in order to control service standards in a qualitative manner, it is necessary to increase the number of employed inspectors, so that service provision in “regular” (Zekavica, 2016), but also in crisis situations, can be controlled directly, as there are objections that a large number of community services were missing.

On April 3, 2020, the Minister passed the Instruction on the activities of social care institutions in the conditions of the declared state of emergency caused by the Covid-19 virus pandemic, **in the area of protection of children without parental care** (no. 500-01-2/2020-09). The instruction establishes the obligation of social care institutions to put all their professional, material, technical and other resources, immediately after the declaration of a state of emergency, in operation towards executing protection measures for children without parental care, and that the work of these institutions is performed in accordance with instructions of MLEVSA, and in coordination with the Headquarters for emergency situations in local self-government. At the end of state of emergency, on May 13, 2020, the Minister issued an Instruction on the manner of work of residential institutions for children and youth in planning and implementation of the movement of beneficiaries - children and youth outside the institution (no. 560-00-00264/2020-09), which stipulates that until a favorable epidemiological situation, it is necessary to regularly inform and educate children and youth about the importance of respecting current prevention and protection measures, develop, with their participation, a plan of activities of children and youth in the community, develop individual daily and/or weekly plans, and record departures and entries into institutions, etc., all in accordance with health security measures.

From April 6, 2020, residential institutions are required, according to the Order of the Minister (no. 500-01-0/2020-09), to develop a **Plan of measures and activities to prevent and prevent the spread of Covid -19 infection**, based on the form and protocols provided in the Order, while on April 10, 2020, the RS Government passed the Decree on organizing the work of residential institutions and organizations during a state of emergency (Official Gazette RS, no. 54/2020). The specificity of this Decree, in relation to all acts issued by Minister, is that it regulates the special manner and organization of work of all social protection residential institutions and organizations, regardless of the founder: Republic, Autonomous Region, local self-government, other legal or natural person.

From April 20, 2020, the MLEVSA began to regulate the **re-admission of residential institution users upon return from treatment to institutions** (no. 500-01-7/3/2020-09), as well as testing of users and informing about the test results (no. 560-01-233/1/2020-09). It has also initiated regulation of gradual inclusion in the society of users of residential institution services (no. 500-01-7/4/2020-09). Related to the admission and testing, on May 18, 2020, the Minister issued an Instruction on the manner of work of residential institutions and organizations for adults and the elderly in the procedure of receiving accommodation service users (no. 500-00-00023/2020-09). This Instruction regulates which documents (beside basic documentation) should be submitted related to testing for Covid -19 and what else needs to be done in case that the person needs to be accommodated in

the residential institution (no.500-00-00023/2020-09).[14] Also, on May 20, 2020, Minister issued the Instruction regulating that in residential institutions for adults and the elderly (no. 021-00-00014/2020-01/52), employees that have been absent from work for a long time or have stayed abroad during their absence, and persons whose spouse/partner has returned from abroad and are at risk of developing Covid-19, have to notify the employer electronically and are tested by PCR test. This procedure shall be on force until a favorable epidemiological situation is created. It was, however, expedient to apply this instruction to every member of the family household, and not only to the spouse.

With the partial opening of institutions, on May 4, 2020 Minister issued an Instruction on handling of items that users in residential institutions receive from relatives/guardians (no. 110-00-152/2020-19), which refers to the procedure of receiving, disinfecting and handing over items to users, as well as the manner of their use. Instruction on the implementation of inspection surveillance in the institution/organization (no.500-00-00023/1/2020-09)[15] from June 4, 2020 was passed in accordance with the improvement of the epidemiological situation in the system, as the Instruction on the manner of work when organizing visits to users (no.500-00-00023/2/2020-09)[16] and the Instruction of June 18, 2020 (no.021-01-94/2020-09)[17], which regulates the manner of work of the institution/organization during voting of users of residential institution services related the elections held on June 21, 2020. Both instructions were issued in the circumstances of improved epidemiological situation, but, regardless of that, on June 22, 2020 Minister passed an Order (no. 500-00-28/2020-09) to all institutions and organizations of social protection on further strict compliance with all orders, measures and instructions issued by the Ministry, and epidemiological measures, until more favorable epidemiological situation. The last one indicated to the system the seriousness of the present epidemiological crisis and the necessity of continuous application of all protection measures.

In the first wave of the Covid pandemic, the ministry issued a total of 32 instructions, orders and recommendations[18], related to the social protection system.

Experiences and facts from the field

Since the adoption of the Decision on declaring a state of emergency in the Republic of Serbia, and in accordance with the instructions of the MLEVSA,

[14] coauthor B.Z. contributed drafting of instruction

[15] coauthor B.Z. contributed drafting of instruction

[16] coauthor B.Z. contributed drafting of instruction

[17] coauthor B.Z. contributed drafting of instruction

[18] Instructions, Orders and Recommendations of MLEVSA. Retreived on March 2, 2020 from https://www.minrzs.gov.rs/sites/default/files/vanredno-stanje/minrzsv19.pdf

all residential institutions and organizations for adults and elderly are obliged to report on the situation in institutions and health conditions, appearance of virus symptoms, measures taken and current needs for staff, daily, and if necessary, more often, to report to the ministry electronically, for the purpose of monitoring the situation and providing support and protection measures. For the purpose of controlling the control the measures implementation, all service providers have the obligation to seek consent for the entry of third parties, in situations of urgent nature, which primarily concern the users health care, but also the technical equipment needed for the functioning of institutions. The required consents also apply to the entry of disinfection services, and each consent is given on the condition that all protection measures are implemented and the instructions of the ministry are followed. For this purpose, and in the described manner, the twenty-four-hour availability of employees in the ministry was provided. The prove of such behavior are the numbers of received reports, letters, requests for consent or giving instructions, which were counted in hundreds at one e-mail address in the weeks of epidemic peak in the Republic of Serbia.[19]

For the purpose of monitoring situation in the system and timely reacting, fast ways of communication have been set. Four Viber groups were established, which, by the activity criterion, covered all accommodation providers, and in which providers were obliged to inform, in the form of brief information, at least twice a day, and if necessary more often, about the situation in the institution, the health status of users and employees, the measures implementation, as well as the needs for protective equipment and disinfectants. In the communication with the service providers established in this way, the employees available in the MLEVSA, the Sector for Family Care and Social Protection, as well as the Minister, are included 24 hours a day, and in this way had information on the social protection system relevant to the epidemiological situation, but also on the users health status in general.

MLEVSA has been keeping records of infected and potentially infected users and employees in the social protection system since the beginning of March 2020, i.e. since the first recorded case of infection in the Republic of Serbia, and has been publishing announcements on its official website[20], and submitting information to the Ministry of Health, for the purpose of informing the public.

The total capacity of residential institutions and organizations for adults and elderly at the beginning of the epidemic amounted to about 23,000 places. The number of employees residential institutions founded by the Republic of Serbia and AP Vojvodina and residential organizations for adults and the elderly is 8,875 (vacancies - 1,394 out of a total of 9,266 systematized jobs - with health workers

[19] Report on the work of Sector for Family Care and Social Protection for period 16.03 – 06.05.2020. Retreived on June 17, 2020 from www.minrzs.gov.rs.

[20] Ministry for Labor, Employment, Veterans and Social Affairs, News. Retreived on March 3, 2020 from https://www.minrzs.gov.rs/sr/aktuelnosti/vesti/

financed by Republic Health Insurance Fund). The number of employees in private homes for the elderly is about 3,000.[21]

The appearance of the virus in the first wave/peak was recorded in only cca 14% of residential institutions, which is a far lower percentage than the one in surrounding and other countries. The highest number of affected users was 574, or 2.48% of the total number of users, and it was recorded on April 30, 2020.[22]

The highest number of sick employees was 149 or 1.25% of the total number of employees, and it was recorded on April 26, 2020. The last registered outbreak of the virus among employees in the first wave was recorded on May 3, 2020.[23] The lowest number of infected users in the first wave was recorded on July 11, 2020 - 7 users.[24] The lowest number of infected employees in the first wave was recorded on June 29, 2020 - 18 employees.[25] In the period from the first infection case in social protection institutions to the day with the highest number of infected beneficiaries in the first wave, the infection was confirmed in 43 institutions. In the period from the first infection case in social protection institutions to the day with the lowest number of infected beneficiaries in the first wave, the infection was confirmed in 66 institutions/organizations.[26]

In line with the Decree on the organization of work in residential institutions and organizationsfor adults and elderly, until April 6, 2020 a two-week shift work in isolation within the institution organized a total of 35 residential institutions (slightly more than 10% of the total number) and 23 institutions whose founder is the Republic of Serbia or Autonomous Province of Vojvodina - the so-called state residential institutions and 12 private residential institutions.[27]

In addition to these institutions, on the recommendation of the MLEVSA, by April 6, 2020, a total of 81 institutions out of 303 (21 so-called state institutions and 60 private old people's homes) or 27% of accommodation providers, in which the presence of the virus has not been registered, entered the two-weeks isolation status within the institution.[28]

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[21] Ibid.

[22] Ibid.

[23] Ibid.

[24] Records on ill and potential ill users and employees in the social care system - MLEVSA

[25] Ibid.

[26] Ibid.

[27] Report on the work of Sector for Family Care and Social Protection for period 16.03 – 06.05.2020. Retreived on June 17, 2020 from www.minrzs.gov.rs.

[28] Ibid.

CONCLUSION

Decisions adopted by the MLEVSA represent a serious framework for the working of residential institutions and organizations, centers for social work and centers for family accommodation and adoption, especially bearing in mind that the MLEVSA did not have formal support from health sector, until a certain point in the epidemic.[29] There are some legal inconsistencies in the field of labor law and employee salary financing, which, for this and other crisis situations, should be changed, and which are mentioned in the text itself.

A bigger challenge, however, was the insufficient representation of intersectoral cooperation, both horizontally and vertically, and above all with the health sector. The challenge was also the under-representation of the social protection system in decision-making bodies in crisis situations.

When it comes to the social protection sector, it is inevitable to mention the insufficiency of community services in regular circumstances, and their critically small number in a crisis situation[30], as indicated by the remarks from the field.[31] Social care system is considered a comprehensive whole, regardless who is founder or service provider. In crisis situations such as an epidemic, the most important thing is to save lives from infection, but it is also important to sustain lives by providing services, which have been largely lacking in the community during this epidemic. In addition, the development of community-based services will contribute considerably to reducing the pressure for admission to residential institutions.

It should be noted that the instructions of the MLEVSA were sent to institutions that had an insufficient number of employees for such situations. In this context, employees were under great pressure, so in the future a realistic assessment of human resource in social care for "regular", as well as for crisis situations

[29] Ministry of Labor, Employment, Veterans' and Social Affairs has addressed the Ministry of Health, the Institute of Public Health of the Republic of Serbia "Milan Jovanović Batut" since the first appearance of the virus in residential institutions (Home for adults and the elderly "Doživeti stout" Zemun) and the Medical Crisis Headquarters of the Government of the Republic of Serbia and the Crisis Headquarters of the City of Belgrade (March 31, 2020) in order to establish cooperation related to the protection of residential institutions/organizations users, especially the elderly, on which occasion it did not receive a response. The first 6 weeks of the fight against the epidemic in residential institutions/organizations were conducted by MLEVSA, together with providers of residential services, without sufficient support from other systems (Report on the work of the Sector for Family Care and Social protection for period from March 16 to May 6, 2020).

[30] Decision on providing these services in the epidemy is under the authority of local self-governments (in accordance with the Social Care Law). MLEVSA has recommended to local self-governments that the service – home care – should be provided also during the state of emergency.

[31] Remarks followed during the meeting of the Working Group of MLEVSA for analyzing of the response to Corona virus in the social care system. Retreived on November 20, 2020 from https://www.minrzs.gov.rs/sr/aktuelnosti/vesti/odrzan-prvi-sastanak-radne-grupe-za-analizu-odgovora-na-korona-virus-u-sistemu-socijalne-zastite

should be made, taking into account the obligation of institutions to act in accordance with prescribed standards.

Finally, it should be mentioned that in the social protection system, inspection is of key importance, since there are many service providers both institutions and community services. For the purpose of quality control of service standards, it is necessary to increase the number of employees in the Department for Inspection Supervision of the Sector for Social Protection of the MLEVSA.

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INICIJALNI ODGOVOR SISTEMA SOCIJALNE ZAŠTITE NA PANDEMIJU COVID-19[32]

Sažetak: Svetska zdravstvena organizacija je širenje novog korona virusa proglasila javno-zdravstvenom opasnošću od medjunarodnog značaja 30. januara, 2020. godine, a 11. marta, 2020. godine proglašena je pandemija. Kriza nastala pojavom pandemije virusa SarsCoV-2, i njime izazvane zarazne bolesti Covid-19, donela je velika iskusenja sistemu socijalne zaštite i pomerila granice ocekivanja korisnika i šire javnosti. On je u ovaj izazov ušao sa teretom izvesnih ograničenja – odstupanjem broja i strukture zaposlenih od propisanih standarda, velikim brojem upražnjenih radnih mesta, velikim brojem korisnika prava iz oblasti socijalne zaštite, nedovoljno uspostavljenom saradnjom sa drugim sistemima, izostankom sociozdravstvenih ustanova, i nedostatkom propisa koji se odnose na vanredne situacije. U trenutku proglašenja javno-zdravstvene pretnje od međunarodnog značaja, nacionalni pravni okvir značajan za ovo pitanje, se sastojao od odredbi sadržanih u Ustavu Republike Srbije, kao i u nekoliko zakona u zdravstvenom, socijalnom i drugim sektorima. Za brzu i konkretnu reakciju u socijalnoj zaštiti je, međutim, bilo potrebno donošenje niza podzakonskih akata i brza reorganizacija kapaciteta. Definisanjem zaštite zdravlja i života korisnika socijalne zaštite kao primarnog cilja, donete su preventivne mere zaštite pre nego što je reagovao i zdravstveni sistem, doneti propisi primereni situaciji, u svrhu sprečavanja širenja epidemije. Razvijeni su kapaciteti u okviru normativne delatnosti, aktivnostima na zaštititi korisnika na smeštaju, evidencije i izveštavanja, kontrole, podrške i saradnje sa drugim sistemima. Uspostavljeni su novi načini organizacije rada. Takav način delovanja dao je rezultate – veoma povoljna epidemiološka slika u sistemu u toku prvog talasa epidemije, i uspostavljen sistem preventivnih i mera zaštite korisnika.

Ključne reči: socijalna zaštita, epidemija, korisnici, mere zaštite, pravna regulativa

[32] Rad je napisan kao deo istraživačkog projekta Instituta socijalnih nauka uz podršku Ministarstva obrazovanja, nauke i tehnološkog razvoja Republike Srbije, 2020.

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SOCIAL MODEL OF DISABILITY IN THE 21ST CENTURY-LIMITATIONS AND POSSIBILITIES IN APPLICATION

Abstract: Throughout the history of human civilization, people with disabilities have been more or less excluded from almost all social events. These groups had less chance of survival because only the most capable and resilient succeeded in the struggle for survival. Therefore, it can be stated that persons with disabilities were at a disadvantage compared to other groups of the population. Different models of the notion of disability have emerged from the continuous analysis of the position of persons with disabilities. Some of them are: The Charity model, The Medical model, The Deficit model, The Social model, The Human rights model. All of them also serve as the basis for various practical approaches, defining policies, regulatory measures and legal regulations for the position of persons with disabilities in society. In modern societies, the social model of disability is most advocated model. The basic of social model starting point is to put the individual at the center of decision-making when making decisions related to him, but also, more importantly, to see the problem in society, not in a person with a disability (Quinn & Degener, 2002). However, the application of this model in practice is not enough. The basic reasons for that situation are crises that marked 21st century. The first is economic crises, which marked the first decade, and the second, the so-called “COVID 19 crises” that certainly marked the second decade of the 21st century. Among the crises that marked the new century, the migrant crisis that is tied to 2015is inevitably mentioned, which escalated during the pandemic crisis. As a result of the negative changes resulting from the crisis, there is a continuous disenfranchisement that is, increasingly present, within persons with disabilities.

Keywords: disability, person with a disability, social model of disability, crises, disenfranchisement

INTRODUCTION

Throughout the history of human existence, different models of disability have been affirmed, which mainly differ in the way people with disabilities are

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approached, and also in the understanding of the disability as a phenomenon. In modern societies, one of the most advocated models of disability is the social model according to which society as a whole is responsible for all the limitations that people with disabilities face daily. According to some authors (Mihanović, 2010), this model of disability is a progressive political concept that opposes the medical model most often used in health professions. The same author points out that the social model of disability makes an important difference between the concepts of impairment and disability, emphasizing that the difference is embedded in social constructivism (the philosophical foundation of the social model). According to the author, 'disability is a social construct that exists in reality outside language within a complex organization of common meanings, discourses, and limitations imposed by the environment at a certain time and place (Mihanović, 2010, according to UPIAS, 1976, according to BRAIN. HE., 2010). This model for people with disabilities requires the same rights, benefits, and obligations that other members of society enjoy. Furthermore, the social model of disability offers observations and research on disability issues from a new perspective, which should replace the way these issues have been observed so far. However, although, at the end of the 20th and the beginning of the 21st century, there were intentions to create a society tailored to each individual, regardless of the limitations faced, such idea quickly encountered many obstacles, mainly related to negative changes resulting from crises marked the first decades of the 21st century. The first crisis is from an economic aspect, which is tied to the early summer of 2007. Thus, the first crisis of the new century marks the crisis of banking and money in the United States of America, and it's expressed in the global losses and bankruptcies of companies in the financial sector, and the large number of bankruptcies recorded during 2008 in the real sector. The main cause is the rapid decline in real estate prices in the United States, which have developed to unrealistic proportions after a long period of price growth. The period after 2010 was marked by a slight stabilization to be followed by a migrant crisis in 2015[2], and then in early 2020, a corona virus

[2] The European Migration Crisis 2015 is a name associated with the migration of people from African and Asian countries to the countries of the European Union. Migrants were initially from war-torn countries created by the Islamic State of Iraq and the Levant, that is, Iraq and Syria, but over time, economic migrants from other Asian and African economically underdeveloped countries joined out of need other migrants. Since 2016, the countries of the Western Balkans, i.e. the countries of Southeast Europe that are not members of the European Union, have also been affected by this crisis. Migrants remained in some of these countries (e.g. Bosnia and Herzegovina) for more than two years (Čilić; Arnautović, 2018), and in all Western Balkan countries affected by this crisis, the situation gained special proportions during the pandemic, where migrants, although reluctantly, had to stay longer than planned. Namely, the pandemic further restricted the movement of migrants, which disrupted their frequent organized attempts to illegally cross into EU territory. In such an environment, the governing structures in a large number of Western Balkan countries, especially in Bosnia and Herzegovina, which otherwise found it difficult to find quality solutions to manage the crisis. Bosnia and Herzegovina faced (Soldo, 2020) additional difficulties reflected in the application of strict discipline measures on those migrants who by force of circumstances found themselves in

pandemic caused a global crisis that drastically and irreversibly changed the world, but also destabilized the established social order. All of the above has led to a series of negative changes, but also to unfavorable projections that particularly affect the most marginalized groups, among which people with disabilities have a special place, who were disenfranchised and discriminated against even before the crisis. Thus, there is no doubt that the crises of the 21st century have only led to a greater disenfranchisement of this population group.

ATTITUDE TOWARDS PERSONS WITH DISABILITIES THROUGH HISTORY

Throughout the history of human civilization, members of the community with disabilities have had less chance of survival because only the most capable and resilient have succeeded in the struggle for survival. As a result, it is unsurprising that people with mental and/or physical disorders are regarded as a burden and are often sacrificed to the gods or abandoned to fate, without treatment or safety, all in the name of surviving as healthier and stronger members of society. In this context, some authors (Cockes, 2001; Wolfensberger, 1998, 2000; Schwartz, 2010) state that individuals with disabilities were considered beings with fewer human characteristics, and as such were threats, objects of fear, ridicule, and pity, burden charities, eternal children, sick organisms or dying people. With such signs, members of the community with disabilities were inevitably assigned a negative social role, which was also related to their social devaluation. Different cultures have differently explained the occurrence of disability in some of the family members, especially children, sometimes given attributes as the supernatural or the divine. Thus, for example, in Mexican culture, it was believed that God, by putting his parents to the test, “gave” a child with a disability. Also, in China, there was a belief that blindness was evidence of a “sick” family, while in Spain a child with a disability was a “test of faith” and some kind of “cross” (Heath & Levin, 1991, according to Lewis, 1995). Such or a similar way of belief, to a greater or lesser extent, still exists today in some countries of the world, because “the individual carries the invisible cross” of social sin which makes it difficult for him to function in society, and shows others to avoid it (so it would not be loaded his cross), complain or expose to discriminatory action” (Hromatko & Matić, 2008, p. 79, according to Mihanović & Krampač-Grljušić, 2012, p. 331).

Historically, in different epochs, the attitude of society towards people with disabilities was determined as much by the perceptions of a given environment as by the cultural, material, and spiritual attitudes of the time in which the person with disabilities lived. Therefore, it can be said that the social attitude towards people

a territory where the domicile population is affected by many social problems, especially specific categories of people with disabilities, and whose position at the time of the pandemic also required additional attention and assistance from ruling actors.

with disabilities was determined by various factors, depending on the nature of cultural and moral level at which the society has been so that as the dominant factors can be emphasized: social organization, legislation, level of economic power, religion and the development of science (Gadžo-Šašić, 2018, p. 91).

To a greater or lesser extent, inhumane treatment of people with disabilities was a feature of the time until the 20th century, which is characterized by great scientific discoveries about the etiology, especially mental illness. However, all these findings were not sufficient for the full equality of people with disabilities. Therefore, inhumane treatment of community members with disabilities continues, especially in Nazi Germany[3], where it has been adopted the Law for the Prevention of Offspring with Hereditary Diseases (i.e. law on sterilization of people with mental disorders) in 1933, and then six years later, in 1939, the regulations governing people with disabilities treated as less valuable and unproductive members of society, passive objects of other people's care and alms, those who represent only a burden.

However, despite the above-mentioned events in the period after the end of World War II, due to a large number of wounded during its duration, there is an increase in the number of people with disabilities, which results in disability being seen as a community problem for the first time. This, in addition to the emergence of the anti psychiatry movement, leads to the strengthening of social orientation, or the beginnings of non-institutionalization with increasingly present knowledge about the negative consequences of social segregation of people with disabilities. This period can be explained as a period in which the possibilities of people with disabilities begin to be publicly highlighted. Later, especially in the 1970s, with the increased interest in solving the problems of people with disabilities, the idea of their full integration into all spheres of life in the community emerged, which can be considered a precursor to the introduction of a social model of disability. This period is also characterized by the fact that the intention of social integration is accepted by all developed countries of the world, which was especially influenced by various international documents. Awareness of the achievements and opportunities for equal participation in the life of the community of people with disabilities with other members of society is increasingly present in all countries of the world today. It is especially reflected in the development of knowledge that people with disabilities can contribute to society's development, according to their abilities, and that they can live from their work. This attitude was largely contributed by the people with disabilities themselves, as certain historical figures gave an immeasurable contribution to society's development at a

[3] In Nazi Germany, people with disabilities were considered a dangerous social ballast that "spoils the purity of the Aryan race", and in accordance with that, they were exterminated as well as Jews, Roma, Slavs ... The ironic paradox is that some of the leaders of Nazi Germany were people with disabilities, eg Hitler, according to a subsequent analysis by experts, suffered from serious mental disorders, and Goebbels had the consequences of polio ...(Tatić, 2011, p. 23).

certain time and in a certain culture.[4]

All of the above undoubtedly points to the shift of different models of disability throughout history. It can be inferred that there is a slight substitute of intolerance and tolerance towards people with disabilities, implying that the background of relations with them spans from specific (essential) forms of security to an approach of protection that can be defined as coordinated protection and increased social care for these members. However, it seems that only after the end of World War II, with the development of human rights, the awareness of the possibilities of people with disabilities and their right to a dignified life became more and more present in most modern societies. This trend continues in the first decade of the 21st century when the UN Convention on the Rights of Persons with Disabilities (CRPD) was adopted. Therefore, for this period it can be linked continuous advocacy of everything that arises from the social model of disability. However, despite all the above, even today in many countries across the world, the realization of everything that comes from the social model of disability and of course from the CRPD seems to be a 'dead letter' and something that for many countries, despite signing international conventions unattainable. The reason for this can be found in the fact that in most countries of the world the cult of beauty and youth is still mostly promoted because these are, by all means, qualities that “guarantee” that an individual will be able to respond to all challenges facing modern society.

SOCIAL MODEL OF DISABILITY-THEORETICAL REVIEW

Throughout history, different models of disability have emerged from the different treatment of people with disabilities. In the literature, the most frequently mentioned model of charity, medical model, the model of deficit, the social model, a model of human rights. Later through the analysis of various findings in the field of disability, and Nagy's bio-psychosocial model emerged, a model of the process of disability and a socio-ecological model were created. All models aim to point out the specifics of the relationship with people with disabilities.

The social model emerged from the struggle of various activist groups for human rights, who condemned the deficit model and the medical model. Its emergence and replacement of the medical model had a special impact in the field of mental health care through the emergence of the so-called “antipsychiatry movement”. It has enabled a new approach and insight into the needs of users in many fields, not just medicine, but also other helping professions (Urbanc, 2005, p. 322).

[4] “The great Greek poet, creator of the Iliad and the Odyssey, Homer was blind. Cervantes, the writer of Don Quixote, lost his arm in the battle of Lepanto in the 16th century ... the great painter Van Gogh, towards the end of his life and work, showed signs of severe mental disorder that did not interrupt his activity ... Ludwig van Beethoven 10 years of creativity, the period in which his magnificent "Ninth Symphony" was composed, he composed despite complete deafness” (Milosavljević, 1989, pp. 1-2).

The social model of disability also served as a theoretical basis for the requirements for equality and full social inclusion, and the participation of people with disabilities in all areas of social life. According to this model, peoplewith disabilities, in partnership with allies, are active fighters for equality and for the creation of a society that is inclusive (Gadžo-Šašić, 2020). The adoption of the UN Convention on the Rights of Persons with Disabilities (2006) is a step forward in creating an inclusive society. It can therefore be concluded that the provisions of the Convention are entirely based on the social model of disability. In this regard, the Convention (Article 2) specifically emphasizes the so-called universal design, which means designing products, environments, programs, and services so that they can be used as much as possible by all persons, without the need for adaptation or special design, without excluding, when necessary, assistive devices for certain groups of people with disabilities. Therefore, to achieve the described design, active social action is needed to bring about changes that would enable the full participation of people with disabilities in all aspects of society, which is the basic starting point of the social model of disability. As some authors point out (Leutar et al, 2015), this includes providing equal opportunities to all individuals, increasing the participation of people with disabilities in social life, identifying possible activities of society to increase independence and choice of individuals, raising living conditions and quality of life, as well as raising awareness and encouraging changes in social behavior.

Table 1
Overview of existing and universal design

Existing design	Universal design and social model
Painful hands that cannot open the door	Install an automatic door. This facilitates the movement of people with disabilities, but also all other citizens who, for various reasons, cannot always open the door with their hands.
The impossibility of standing and waiting in public places	Make a larger and better-equipped stand with benches designed for all people.
Inability to use stairs	Install affordable and more luxurious elevators designed so that they can be used by all persons, whether with or without disabilities.

Source: Adapted from SCIL CIC, 2010, according to Mihanović, 2010.

Following the content of the table (Table 1), it is not difficult to see the advantages of universal design arising from the social model of disability, the development of which would overcome many existing barriers faced by a large number of people, which are particularly pronounced in less developed countries the

medical model of disability dominates. To promote universal design, but also the social model of disability, it is necessary to first work on changing the attitudes of the immediate and wider community about the capabilities and abilities of people with disabilities. It is the only way for people with disabilities to remove guilt from themselves and become active members of society. Besides, it is important to include state authorities, which in modern societies have a key role in providing social protection, the improvement of which is necessary on the way to the application of the social model of disability (Koprić & Marčetić, 2000). In this regard, some authors (Turčić, 2012) point out that the social model implies that the problem of the individual is not individual limitations, but the failure of society that should provide appropriate measures needed by people with disabilities to fully integrate into the social environment by creating a universal design. Regardless of the disease or organic damage, each person can be evaluated according to this model concerning the impact of the damage on functioning according to social, economic, and environmental factors. Following all of the above, it is not difficult to foresee that the revival ofa social model can only be deliveredby investing in universal design or dynamic investment effort for the realization of all that prescribes the UN Convention on the Rights of Persons with Disabilities.

IMPLICATIONS OF THE CRISIS ON THE SOCIAL MODEL OF DISABILITY

In the broadest sense of the word, crises are understood as a deep, comprehensive disturbance in the functioning of society or the life of an individual with strong and more or less severe and lasting consequences. In this context, the crisis can be considered and negative change which hinders social and economic development. In the social sciences, there was a view that every society had to go through five stages of development (tradition, transition, rise, maturity, and consumerism), and although development in the second half of the 20th century began to be understood differently, it was expected that regardless of different approaches to interpretation, to record an upward or at least static course in the 21st century. Expectations of continuous development were especially related to the period after the global economic crisis (2008) which, as some authors point out (Miljenović, 2013), made visible the deconstruction of collective entities and shifting responsibility to the individual in a world where resources are increasingly available only to some parts of society. However, continuous social development has been shaken by new crises. The first migrant, and then the so-called “Corona” crisis that has led to unprecedented social inequality. According to the member of the Board of Directors of the Federation of German Trade Unions, Anja Pil, the pandemic crisis acts as a magnifying glass for social inequalities and has particularly affected workers with lower incomes and lower levels of education (Šorić,

2020). Socially excluded groups of society, among which people with disabilities have a special place, are also particularly affected. The reason for this can be found in the continuous disenfranchisement, and thus less opportunity to achieve greater social inclusion, primarily since people with disabilities represent a group of residents who are known as the least educated in society. Also, it is a mostly unemployed part of the population. This is confirmed by the data of some studies according to which the unemployment rate is several times higher in people with disabilities than in the regular population (Urbanc, 2005, p. 325). Therefore, people with disabilities are the poorest group in society. The cause of extreme poverty of people with disabilities can be, on the one hand, related to poor education and low employment rate within this population, and on the other hand, because it is a group of people who have much higher living costs due to disability. All this makes them a highly disenfranchised and socially isolated part of the community.

Taking all this into consideration, it is only possible to guess the consequences that have left the COVID 19 crisis, which is also to blame for the reduced application of the social model that is in the past depended on the level of economic development of certain countries. A somewhat more enviable position of peoplewith disabilities can be said only in countries with developed economies because in them there are preconditions for the development of the social dimension of society. However, as some authors point out (Lakićević & Gavrilović, 2009, p. 19), even in the most developed societies there is not necessarily an automatism of mutual influence of social and economic development, and that many other factors affect the quality of life of people with disabilities and other socially excluded groups.

Considering the classification of countries according to the human development index (countries with high HDI from 0.800 to 1,000, with medium from 0.500 to 0.799 and low human development below 0.500) creation of a favorable environment for the application of a social model of disability is directly correlated with the level of human development which sums up three indicators, namely life expectancy, level of education, and income level (Lakićević & Gavrilović, 2009). Therefore, monitoring the human development of a particular country is inextricably linked to the quality of life of the entire population, including people with disabilities.

In addition to the crises that can be defined as negative changes in the 21st century, which to a greater or lesser extent left negative traces in the life of every individual, for people with disabilities the adoption of the UN Convention on the Rights of Persons with Disabilities (2006) is a positive change, which marked the first decade of the new century.

The UN Convention on the Rights of Persons with Disabilities is the first act on universal human rights that imposes an obligation on states to take appropriate measures to eliminate discrimination on the grounds of disability.

The Convention ensures that people with disabilities enjoy the same human rights as everyone else to be able to live as full citizens (Turčić, 2012). Therefore, if we consider the fact that the content of the Convention is based on the basic principles of the social model, then it is certainly one of the basic obligations of all states that have ratified it to develop measures that strengthen the social model of disability.

Also, in the light of the social model at the beginning of the 21st century, the International Classification of Functioning, Disability, and Health - ICF (World Health Organization, 2001) was adopted. The classification is based on human functioning in which functioning and disability are seen as the results of the interaction of the physical or mental state of persons and the social or physical environment. This classification is a synthesis of biological and social models of disease and functioning and thus combines the medical and social models. According to some authors (Turčić, 2012, p. 112), the main reason for accepting this classification as social can be found in the fact that it includes UN rules on equal opportunities for people with disabilities.

Although, after the adoption of the UN Convention on the Rights of Persons with Disabilities, most countries in the world intended to make greater efforts to create measures whose implementation means the greater application of the social model of disability in the 21st century, there is no doubt that negative changes have slowed the process until the outbreak of the crisis, was more or less primary, and which was reflected in the creation of conditions for the full inclusion of people with disabilities in society. Thus, this process was stopped by a series of negative changes that resulted especially from the pandemic crisis. This is evidenced by the data of the World Bank, according to which 93% of countries suffered a recession in 2020, which is the highest percentage ever, while in 2020 it was lost for growth, which is also projected for 2021. It is also estimated that global GDP in the next two years, more precisely until the first quarter of 2022, will not reach the level of the first quarter of 2020 (World Bank, 2019). The logical question is, how many possibilities remain for the actual application of the social model of disability given the global pandemic crisis, which has no end in sight, especially in countries that did not record rapid economic development even before the crisis? Guidance on the response can be found in the World Bank's 2020 data on the development of the Human Capital Index (HCI), which consists of the knowledge, skills, and well-being that people accumulate throughout their lives, enabling them to reach their potential as productive member's society. In this regard, if we consider that the development of every society depends on this index and given that all components accumulated by the human capital index are questionable due to crises, especially due to "pandemic", it is not difficult to conclude that full application of social disability model will remain on a "stand by" arrangement. Such conclusion is supported by the assessment of the World Bank (2019), according

to which the young people in transition countries due to gaps in education and health, will lose almost half of the productive lifetime. Because the education of young people does not provide the knowledge needed in the market, and health care does not provide a healthy and productive life. Therefore, it can be stated that the crisis resulting from the pandemic only increased the urgency of action to stop the loss of human capital globally and that the consequences arising from it further jeopardized the trend in this area. Following the above, it is obvious that shortly, especially after the pandemic, the focus of interest of all societies in the world will be investments in improving the welfare of the entire population, and in such an atmosphere, at least when it comes to people with disabilities better-living conditions for that group of inhabitants. People will be valued in the future according to how much they can contribute to society, and since negative projections regarding people's productivity are linked even to community members without disabilities, one can only assume the problems that these people will face in the future.

Therefore, it is not difficult to conclude that in the context of people with disabilities, social actors will pay the least attention to ideas whose realization means the application of a social model. This is especially true because many ideas arising from the social model have proved expensive at least for countries that due to several circumstances do not record enviable economic development and in which, as some authors point out (Bežovan, 2008; Ostojić Baus, 2016), combined at an unenviable level social policy (welfare mix) which means a system in which the government, local authorities, civil society organizations, companies (profit sector), the family (informal sector) and other stakeholders act instead of the former monopoly position of the state. According to the Glossary of Social Policy (Bežovan et al., 2005, according to Ostojić Baus, 2016), this model of social policy is expressed in the so-called social triangle, in which the social policy system is presented as the result of three sectors: the government or state sector, private profit and non-profit sector, and whose application allows the application of a civic approach based on the social model of disability according to which people with disabilities are equal members of society with all rights and obligations that belong to them.

In the professional literature (Leutar, Buljevac, & Milić-Babić, 2011), the civic approach places emphasis on participation, integration, support, and social justice, and is therefore compatible with the social model. However, each country, even the most developed ones, facing the new situation, offered different measures as a fight against crises. Among these measures, some authors (Krtalić, 2004) advocate the creation of a new entrepreneurial culture, but also the assumption of responsibility of the individual for himself. It is certain that these measures will be increasingly applied in all countries of the world, and that the social model, which implies social responsibility for the problems faced by people with disabilities, will remain for some other better times.

INSTEAD OF CONCLUSION

Social protection systems throughout history have undergone continuous changes in the sense that they were very modest in the beginning, and with the development of society, they became more complex and comprehensive, to reach their peak in the 20th century, insuring almost the entire population from possible social risks such as disability, illness, unemployment, old age, etc. Funding for the area flourished between the 1950s and late 1960s. However, according to some authors (Krtalić, 2004), the asymmetry in the financing of this area is related to the 1970s, when oil crises were recorded. The above stated is enough to understand that the negative changes resulting from the crisis are the reason for the reduced allocation to achieve the greater well-being of the most exclusive groups. It should also be beard in mind that the level of social protection depends on the level of economic development, demographic change, unemployment rate, and other institutional, social, and economic factors, and that accordingly in times of crisis the life of socially excluded groups depends on the current level of development. In this regard, the application of the social model of disability in modern societies depends on the level of development of a particular country, but also on the interest of social actors to create actions whose implementation means its greater application. Therefore, it is logical that in countries where there is less interest in social protection, better living conditions of any socially excluded population in times of crisis cannot be expected. However, where there was before the outbreak of the crisis the greater focus on the development of the protection system of the entire population, certainly, the social model of disability has long ago reached a higher level of application. This is confirmed by the findings that countries that have previously made greater efforts to strengthen the safety net are better in implementation, in terms of GDP per capita or external balance than countries whose segment was secondary, or which had a weaker safety net (Krtalić, 2004). However, although many countries in the world have been forced, partly due to political pressure to increase spending above tax limits, but also due to structural changes to reduce investment in social segments, there remains an obligation to commit to one of the key functions of the system. Social protection, which is to ensure those who cannot work and to provide them with a dignified life by international regulations. Furthermore, if we consider the fact that one of the basic determinants of the time in which we live is commodification, that is, the expansion of the market to those aspects of life that are otherwise governed by non-market values (Gómez-Baggethun, 2016) then surely, in the future, we can talk about the crisis of both welfare states and social model of disability because these are areas that, unfortunately, belong to non-market values.

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SOCIJALNI MODEL INVALIDNOSTI U 21. VIJEKU OGRANIČENJA I MOGUĆNOSTI U PRIMJENI

Sažetak: Osobe s invaliditetom su kroz cjelokupnu historiju ljudske civilizacije bile u manjoj ili većoj mjeri isključene iz gotovo svih društvenih zbivanja. Ove skupine imale su manje šanse za preživljavanje jer u borbi za opstankom uspijevali su samo najsposobniji i najizdržljiviji. Stoga se može konstatirati da su osobe s invaliditetom bile u nepovoljnijem položaju u odnosu na druge skupine stanovnika. Iz kontinuirane analize položaja osoba s invaliditetom proizašli su različiti modeli poimanja invalidnosti. Neki od njih su: model milosrđa, medicinski model, model deficita, socijalni model, model ljudskih prava. Svi oni služe i kao osnov različitih praktičnih pristupa, definiranja politika, mjera za uređivanje pravne regulative položaja osoba s invaliditetom u društvu. U suvremenim društvima jedan od najviše zagovaranih modela je socijalni model invalidnosti čije je osnovno polazište da stavlja pojedinca u centar odlučivanja pri donošenju odluka koje se odnose na njega, ali i da, što je još važnije, problem vidi u društvu, a ne u osobi s invaliditetom (Quinn & Degener, 2002). Međutim, prema suvremenim analizama kontinuirana primjena svega onoga što proizlazi iz tog modela je na nezavidnom nivou. Razlozi za navedeno su mnogobrojni, a ka onaj važniji bitno je spomenuti krize koje su obilježile prve decenije 21. vijeka. Prva je ekonomska koja je obilježila prvu deceniju i druga tzv. "korona ili COVID 19" koja je zasigurno obilježila drugu deceniju 21. vijeka. Među krizama koje su obilježile novi vijek važno je spomenuti i onu migrantsku koja se veže za 2015. godinu, a koja je, može se reći eskalirala u vrijeme pandemijske krize. Kao rezultat negativnih promjena proizašlih iz svih spomenutih kriza je kontinuirana obespravljenost koja je, sveprisutnija, unutar populacije osoba s invaliditetom.

Ključne reči: invaliditet, osoba s invaliditetom, socijalni model invalidnosti, krize, obespravljenost

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THE COVID-19 PANDEMIC EXPERIENCED BY YOUNG PEOPLE IN ROMANIA

Abstract: The quarantine imposed by the COVID-19 virus pandemic has an impact on young people' mental health. This was shown after 1,207 young people across Romania responded to an online survey. The subjects were 72.4% female and 27.6% male and they had an average age of 21.93 years. The results show increased consumption of tobacco, alcohol and food during this period, more worried and anxious young people. Female participants experienced significantly more ($p < 0.001$) anxiety than males. Furthermore, young people who used the Internet in excess reported a higher percentage (43.9%) of sleep disorders, compared to people who do not use the Internet excessively (21.2%). Data suggest the need for psychological interventions tailored on young people's needs.

Keywords: young people, corona virus, anxiety, social isolation, alcohol, tobacco

INTRODUCTION

Romania, like other countries around the world, faced a period of real national crisis, insecurity and economic and financial instability, with strict measures instituted on the country's population - children, adults and elderly - that finally culminated on March 16, 2020 with the institution of the state of emergency which lasts sixty days in total and continued with the state of alert.[2] The impact of this period affected to the country's population on multiple areas: economic, social, cultural, medical, religious, professional and emotional. Based on a ministerial order, schools, kindergartens and universities were abruptly closed. Population access to services was suspended whether we are talking about the hospitality industry (hotels, restaurants, and cafes), public relations of local administrations or services provided by private companies. Most Romanians worked from home. We were not allowed to attend religious services, not even on Easter, or go to the seaside on May 1, or visit our grandparents. Weddings were suspended, public concerts and sports activities were cancelled, and in unfortunate cases like death, only closest family members (not more than six people) were allowed to take the deceased to the grave with no chance to mourn.

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[2] Available at: https://www.presidency.ro/ro/media/decret-semnat-de-presedintele-romaniei-domnul-klaus-iohannis-privind-instituirea-starii-de-urgenta-pe-teritoriul-romaniei

The country borders were closed and the communal territories were strictly monitored. Romanians who returned home, whether because they lost their jobs or were homesick, had to accept accommodation in quarantine centers, sometimes away from their family. Hospitals admitted serious medical cases only, which affected those who were afraid to turn to medical services and chose to stay at home. At the same time, the authorities have created new treatment centres for people infected with Coronavirus. The feeling was one of state of war or at least a sad novel. The worst impact was on the financial stability. Considering that Romania is still a poor country in Eastern Europe, it faced wage cuts for some employees, temporary furlough for others and unfortunately layoffs for thousands of Romanians (Istrate & Serban Horea, 2018). The shortage in salary incomes affected the whole family.

Although we initially received rather impersonally the news coming from the Asian media and announcing about the thousands of dead and infected patients there and not here, not even in Europe, we suddenly found that it was our turn to be in lockdown, to be left jobless, our children not attending school, and to bear the most anxious thought of not knowing what our near future would look like, for how long this crisis would last and how we would find resources to deal with it.

Fortunately, and I emphasize fortunately, Romania did not suffer severe damage during this pandemic. In June 2020, our country was occupying the 45th place in the world ranking. An actual explanation consists of the efficient measures implemented by the Romanian government. Compared to other European countries, the death rate was low in Romania with 1,500 deaths recorded by June 20 (6% of all the infected cases). At the same date, other countries were recording higher death rates as follows: Great Britain 42,000, Italy 34,000, France 29,000, Spain 28,000, and Sweden 5,000. Other countries registered a very small number of deaths, for example Greece with 190, Bulgaria 190, Slovenia 109 or Georgia 14 and the explanations are not easy to identify.[3] The number of infected people also decreased in our country, over 23,000 confirmed cases and over 16,000 treated cases (71% of the total). The average age of the infected people is 46.[4]

However, we had unfortunate exception, this being the case of Suceava County which actually occupied the first place in Romania both in terms of confirmed cases (3,250) and number of deaths (236), which is highly more than in Bucharest.

But I want to emphasize a different aspect concerning the lockdown. Although in theory we referred to a period of lockdown, in fact, the pandemic did not institute a state of total isolation in the strict sense of the word. For example, we were allowed to still leave the house either for a walk around the house, or for

[3] Available at: https://ourworldindata.org/coronavirus
[4] Available at: https://covid19.who.int/

rightful reasons like shopping for food, working, pharmacy, provided that we filled in and signed a statement or supporting documents. Even the elderly was allowed to go out in a timeframe well established by government ordinances.

Moreover, thanks to the digital era we are living in, we were able to communicate with anyone in this world, friends or family. On the phone or online, we could see and hear each other and had access to news, reading, movies, religious services, etc. Theatres and philharmonics moved their performances online. A series of conferences, webinars, and interviews were transferred to the online environment. Here we include school education. So, we were not completely isolated. For a certain category of people, those with a generally low level of social interaction, this period was not a tragedy at all. They lived in complete comfort. Then, there were people who were already familiar with working from home and people who did not have high social interaction needs. They went through the pandemic period without much trouble. On the contrary, it was a good opportunity for self-analysis and meditation, for reading and indoor activities. If we followed the instructions of the authorities, we could keep our health and life.

As for me, I focused on what I could control and do and I had a lot to do. Honestly, I seem to have had even more tasks, ideas and projects than before the onset of the pandemic. I spent more time of the day or night for the activities I was interested in. Using modern technology, I interacted and worked online much more than I did in February 2020. I continued to teach online courses to my college students and found that the attendance for bachelor and master classes increased compared to classrooms. Because they lived in different localities, it was much easier for students to attend university courses from their homes with a phone / laptop at hand. The exams in the session were also conducted online, each student remaining at home. Unfortunately, there were no public end-of-year events, ceremonies, banquets, pictures, meals, dancing and moments of celebration and fun.

FIRST ROMANIAN STUDY WITH OVER 1,000 ADOLESCENT PARTICIPANTS

During the lockdown period due to the Covid-19 pandemic, I enounced the hypothesis that young people experienced more pronounced feelings of loneliness, that they had a more tensed relationship with their family, that they felt more worried and did not get enough sleep at night, they spent time on the internet in excess and consumed more alcohol, tobacco and food (Copăceanu, 2020).

Studies carried out during the pandemic suggest that although some families are coping well, others are facing financial adversity, struggling to home school, and risk experiencing vicious cycles of increasing distress

The impact of COVID-19 on the mental health of adolescents and youth has been well studies in many studies across the entire world (Newlove-Delgado et al., 2021; Waite et al., 2020; Stanton et al., 2020).

METHOD

In April-May 2020, an online questionnaire was distributed containing 75 questions referring to the impact of the COVID-19 crisis on Romanian young people. The questionnaire was distributed on the online platforms most used by young people, namely Instagram and Facebook, but I also used WhatsApp. Participants were asked to complete these questionnaires anonymously and were informed on the purpose of the study, the methods used, confidentiality and data retention and analysis.

RESULTS

I was surprised to find that with little effort on my part, 1,207 young people from all across Romania participated in this study. In the end, the analysis of the statistical data was carried out on a sample of 1,201 subjects. The survey included 72.4% (869) girls and 27.6% (332) boys, with an average age of 21.93 years; the predominant age was 18. In terms of education, most of the respondents were upper secondary school students (48.1%) and university students (40.3%), but there was also a small percentage of postgraduates (7.6%) and lower secondary school students (3.8%). Regarding the number of people living in the same house, 33.6% of the subjects lived with three other people, 29.2% with two other people, 8% with more than four other people, 11.8% lived with one other person and 2.7% lived alone. In terms of family income, 50.3% reckoned their family had average income, 37.4% above average income, and 4.8% below average income.

Family relationship

What I wanted to analyse was how the Covid-19 pandemic affected the family life of young people before anything else. Thus, during the crisis 45.2% of respondents said that there was more stress in their lives, 35.6% said the crisis has not brought anything good in their family life, 22% acknowledged that there were more quarrels and misunderstandings than before, and 33.1% showed concern about financial stability and family income. The comparison of the respondents by age showed a higher percentage of secondary education young people who reported that this crisis did not bring anything good in their family life, while a high percentage of those with more years of education said that this statement was false. Generally speaking, 51.4% said that their parents were more stressed than them, 19.2% believed that someone in their family would need some form of psychological intervention. What is also surprising is that the number of parents who were stressed did not differ significantly depending on the family income level. In accordance with the common thinking, it is considered that those with

high financial incomes have fewer worries, which is not true judging by this study. Concerns entered all families regardless of their financial situation.

Psychological and emotional aspects

Although 70.9% said that they communicated almost daily with their friends during the crisis, to a later question, 35.7% said that their social life was affected by the crisis. Moreover, 56% of the total number of respondents experienced feelings of isolation, of which **a higher percentage** of secondary education students (58%) **felt isolated** compared to university students (33.7%) ($p < 0.001$). Involvement in a relationship does not lead to a stronger feeling of isolation, compared to not being involved in a relationship.

Since the beginning of the COVID crisis, 46.9% of participants had felt unhappy, 41.3% felt more tired than usual, 35.1% got angry more easily, 33.2% had experienced anxiety, 29.2% had been worried more than usual, 28.2% had had fears about the future, 22.6% had cried more than usual and 6% had used medication to cope with these conditions. There were no statistically significant differences between secondary school students and university students in reporting anxiety during the crisis. Regardless of the level of family income, the percentage of those who said they began experiencing anxiety during the crisis is close in value, ranging between 31.1% and 40%.

Comparing by gender, 22.9% of the girls in the study said they were very scared, even anxious, compared to 7.5% of the boys, **the difference being statistically significant**. Nevertheless, experiencing anxiety does not differ depending on the number of people living in the same house with the subjects. ($\chi 2 = 2.09$; $df = 4$; $p = 0.718$). It was also found that there are no significant differences depending on the level of education and age in terms of anxiety (17.4% of young people in lower secondary school, 19% of young people in upper secondary school, 19% of young students and 14.6% of higher education graduates). The results show that 20.3% of the young people involved in a relationship consider themselves anxious, while 16.9%. of those not involved in a relationship also consider themselves anxious. The two rates are not significantly different ($\chi 2 = 2.19$; $df = 1$; $p = 0.139$).

Sleep disorders

Of the total number of participants, almost 40% said they experienced sleep disorders. It seems that the share of girls who could not sleep at night is significantly higher (42.9%) compared to boys (30.1%). The association between gender and the presence of sleep disorders is one of low intensity (Cramer's $V = 0.117$).

The presence of sleep disorders does not differ significantly depending on the level of family income. It was found that 61.1% of the people who smoke more than before the COVID-19 crisis could not sleep at night as compared to the categories who do not smoke or smoke just as much and who had sleep disorders in percentages ranging from 36.1% to 47%.

The percentage of those who could not sleep at night differ significantly between people who did not consume alcohol (36.3%), those who consumed just as much as before the COVID-19 crisis (40.5%) and those who consumed more alcohol than before the COVID-19 crisis (49.1%).

Internet usage

As far as the excessive use of the Internet is concerned, the majority of the respondents, regardless of education, said that they used it largely for socializing (54%), on a significantly distanced 2nd place being music (11.7%), followed by video games (8.4%) while a very low percentage of the subjects used the Internet for gambling (2.3%). As for the excessive use of the Internet for sexual purposes, 8.1% of the boys answered affirmatively as compared to the significantly low 1.4% of the girls who declared they used the Internet excessively in this purpose. Comparing results of secondary education students with those of university students, the former used the Internet excessively for other purposes such as music and video games, while the latter used the Internet rather for information and documentation.

A very high percentage of both the girls (80.4%) and the boys (78.9%) declared that they used the Internet in excess during this period. There is no difference based on gender from this point of view. Regarding the time spent online, a higher percentage of boys (63.6%) considered that they spent more than 6-8 hours a day on the Internet, compared to a percentage of 55.8% of the girls. Although the difference is statistically significant, the association between gender and spending more than 6-8 hours a day on the Internet has an extremely low intensity.

A higher percentage of secondary school young people use the Internet in excess (86.2%), compared to people with postgraduate studies (52.8%). Regarding the number of hours/days, 27% of postgraduate respondents spent more than 6-8 hours a day on the Internet, compared to 54.3% of the lower secondary education respondents.

What is worrying is the high 35.2% of the subjects who admitted being addicted to the Internet.

It is noted that young people with postgraduate studies and those with lower secondary education are those who are considered in a high proportion as severely dependent on the Internet, compared to people with upper secondary education and university education.

Smoking and alcohol consumption during the crisis

Of the total participants, 32% of respondents were smokers at the time, 12.2% said they smoked more than before the crisis, and 8.4% of them with at least five more cigarettes a day. Only 21% wanted to quit smoking.

The percentage of young people smoking more than before the COVID-19 crisis does not differ significantly based on the respondents' gender (6,6% boys and 5.8% girls, $\chi 2 = 0.61$; df = 3; p = 0.892) nor in terms of the number of cigarettes smoked daily: 6,9 % smoked at least five cigarettes more during the crisis 6,9% boys and 8.9% girls, and at least 10 cigarettes/day - 2.7% boys and 2,5% girls, respectively at least 15 cigarettes/day, 1.8% boys and 1% girls. Also, 6.9% of the boys and 10.9% of the girls said they had given up smoking since the crisis began. A higher percentage (12.2%) of the subjects who lived with one other person in the household report they smoked more than before the COVID-19 crisis compared to those who lived alone or with more than one person in the same house.Regarding the number of cigarettes, they smoked extra, the same respondents who lived with only one more person in the house said in a higher percentage (12.9%) that they smoked at least five extra cigarettes compared to the other respondents living alone or with more than one person in the household (6.2%).

Alcohol use

Since the crisis began, only 44.8% said they were abstainers. 4.3% of the young people reported daily alcohol consumption and 18 participants considered that they consumed excessively.

Concerning alcohol consumption, there are statistically significant differences between boys and girls. Thus, 15.1% of boys had consumed more alcohol since the COVID-19 crisis began, while among girls, only 6.4% say they started consuming more alcohol.

Study participants living alone, living with another person or living with four or more people stated in slightly higher percentages, between 10.1% and 12.5%, that, since the beginning of the COVID-19 crisis, they had been consuming more alcohol. Respondents living with two or three people in the house stated in slightly lower percentages (8.3% and 6.7%, respectively) that they had consumed more alcohol since the COVID-19 crisis began.

Food in excess

Of the total respondents, 50.9% said they ate more than usual and 17% gained at least 5 kg, while 13.8% lost weight. The percentage of girls who ate more than usual during this period (52.6%) is higher than that of boys (45.5%).

School

The questionnaire included questions about the school. Only 46.7% said that their school adapted very well to online education, 32.6% acknowledged that education suffered during this period and 25.6% said that" school is a disaster when it comes to managing online education."

Girls are also much more concerned about the future of education (53%) than boys (39,8%).High concern about the future of education does not differ significantly depending on the level of family income. Thus, 50% of young people who said that their family had an average income and 47% of young people who said that they had above average income been worried about their educational future.

Regarding the aftermaths of the COVID-19 crisis, 87.7% of the boys are more optimistic about their future, while 80.3% of the girls showed optimism about their future

Qualitative answers

The most important part in any field research, beyond the quantitative statistical analysis is that represented by the direct, detailed, sincere answers of the participants. Although there are hundreds of answers received, I want to give here 15 answers that I consider relevant about the experiences of adolescents during the pandemic. I invite you to read them carefully.

1. Quarantine made me realize how little I appreciated life before and how much I "made fun" of everything I had, in the sense that I didn't appreciate enough all the things I had and how lucky I was, first of all that I had healthy parents. I will definitely look at life differently and enjoy the most insignificant things more.
2. Looking at this period in its entirety, I am trying to see only the good side, to consider it a vacation, to put my thoughts in order, even if at first I didn't want to accept the situation and even if I still have moments when I worry, get angry and agitated or feel anxiety.
3. We should make the most of this time; it is a period that others have never had: be able to stay with their families, be able to sleep as much as they want, to relax. The whole idea is to be optimistic: I haven't left the house since March 15, but I don't feel much quarantined. Anyway, the internet or electricity could have been interrupted and then it would have been dramatic for some, I think. The idea is to enjoy what we have, to look at the positive side: it could be much worse, much harder and worse times can come. Live your life with no regrets, no matter the conditions! :D

4. Yes, I would like to say that I am optimistic that everything will be fine, life must resume its natural course at some point. And I also believe that in all this madness we have the unique chance to rediscover and improve ourselves from all points of view (spiritual, professional, etc.). We have the chance to work to become better every day. As Blaga used to say: “I have only one prayer: God, don't let me be satisfied with myself”. We have all the qualities we need to grow and achieve each of our goals and we should not let ourselves limited by a virus.
5. Born to lose, live to win! That is, you should live your life to the fullest now. Stop thinking about the consequences ... I don't care about the rules. I have nothing to lose. I live my life and the only option is to earn my happiness and everything I want no matter what obstacle comes my way. I will not be affected by anything, neither by the Coronavirus, nor by anything else, as long as I know what I want to do next and I will continue my life and everything as if it were nothing.
6. We need to be positive. I think this period will help each of us even if we do not realize how and when. We now have time to do everything we set out to do, but we couldn't because we were caught in daily stress. We must love and respect each other. I trust that everything will be fine. I don't know how long this period will last. Like everyone close to me, I want it to be over as soon as possible, but to be over for good and remember this period only when we tell it to our grandchildren.
7. I was aware, even before the pandemic broke out, that those around me deserved to be appreciated, loved and helped, and I was trying to do that to the best of my ability. What I realized, however, during this period, is that we must support each other, be by each other’s side and not try to always find a culprit. Oh, and one more thing ... I realized how inappropriate it is to express an opinion, without being properly informed (see all the posts on Facebook, in which one is smarter than the other). Anyway, I'm confident we'll get through this together, and I hope that maybe at least we'll learn something from it.
8. I would like to say that hope is what keeps us alive and it is the one without which we cannot continue in life. It is the engine of our soul and it is something that always remains when darkness is around you. It's something that can't be easily stolen. Let’s use it!! There is always a well-founded purpose and motive for everything that happens in the world, although not everyone knows it. We, the “ordinary”, just have to take the good side in it and be confident.
9. Each of us should find something or someone to inspire them to be better, to do better, something or someone to awaken in them a sincere desire for personal development, and then to realize that they can motivate and inspire themselves, even in the worst days, and to be patient with themselves, to take every day in turn, to do something no matter how small every day that brings

them joy and a sense of satisfaction, of personal success, to make the bed after they wake up and let fresh air in, allow themselves to be creative, have confidence that as soon as something changes for the worse, it can change for the better, and we just have to be patient, take advantage to the fullest of the present moment, and to take all precautions to take care of ourselves and our loved ones. I want this crisis to bring about a change for the better in our country, to improve the health system, education, etc. I hope it will bring a change in the hearts of Romanians as well, so that we show more care and respect for each other. Let's take care of our minds.

10. All in all, I think this virus has given us the greatest life lesson. Namely ... to appreciate the things we have and to live with more passion. For there may come a day when all that you had will be taken from you, and only then will you realize how much you miss those things which you took "for granted."
11. Despite the deaths, this crisis is a time to strengthen family or couple life. It is an opportunity that everyone should take advantage of to pay more attention to themselves. At the same time, it makes us appreciate life more, look at the world with different eyes, think more about those around us. The fact that we are currently deprived of everything that means socialization, education, etc., I think is somewhat a way to meditate on life sitting in the house, at least until everything is resolved. And it is a difficult time in which we can realize a lot, especially what we have around us, and appreciate life more because we do not know what lies ahead. This virus made me a little proud that everyone can stay in the house because in the past I was complaining about the planet being polluted and going downhill. Well, according to statistics the planet is currently breathing and global warming has slowed down :) And I still hope that after Easter, God will work a miracle for us and we will all be fine.
12. I want all young people to be honest and say everything they think because that helps a revolution. And as a gift, our rights and opinions will be taken into account as in a civilized state just like I want Romania to be! I am changing day by day. All young people must be the same. Stop admitting all the shit that happens to you. Speak up and use your rights guaranteed by the Constitution! I wish you well and stop wasting your time on Facebook :))
13. In the future I hope that people learn something from this crisis, we all need to learn something and that something is goodness, we need to learn to be good. When a person gets a virus, his temperature rises to fight the virus. The same thing happens with the planet. We are the virus that harms the planet, the better and fewer we are the quieter the planet is. At the moment, if I had a magical power, I would like to read the thoughts of all influential people in the world, they certainly know better what is happening with the virus, and I would like to inform all citizens, get rid of panic and misinformation. Always feed your soul with positive things! Be good, it costs nothing.

14. I spend my time doing things I love but don't normally have time to do. For example, I am drawing, I am decorating my room, I am playing with my little sister, I spend my time in the hammock reading, I write about anything that comes to my mind and I find it important, interesting or funny.
15. I mainly read, I decided to read all the books I have put aside because I didn't have the time for during school, I read personal development books, biographies, I read books I choose, not books from the school curriculum that I don't consider relevant for our days (Copăceanu, 2020).

15 GENERAL RECOMMENDATIONS FOR COPING WITH THE PANDEMIC

General recommendations on hygiene, washing hands repeatedly, correctly and efficiently, keeping physical/social distance, wearing gloves and masks were displayed constantly for the information of the Romanian citizens (Matrajt & Leung, 2020). Instead, I noticed too few recommendations for the mental and emotional balance, too little concern for reducing anxiety or panic.

That is why I am rendering below a list of some essential recommendations collected from various psychologists in Romania and abroad as well as some recommendations made by international organizations.

1. Maintain our mental hygiene, limit any distressing information caused by false news, with no scientific basis, scary theories, news abounding on the COVID-19 topic or other toxic content (Carrion-Alvarez & Tijerina-Salina, 2020). We become much more insecure and anxious if we read news that induces insecurity or proposes catastrophic scenarios. In fact, some fake-news websites have been shut down in Romania. I recommend avoiding statements that come from specialists but are no more than just assumptions and personal opinions.
2. Use only official sources of information from press releases of the Government, the Ministry of Health, the Ministry of Internal Affairs, the Romanian College of Physicians, etc.; In this sense, I want to criticize the fact that the Ministry of Health released information too often during the course of a day which only increased the insecurity (Hernández-García & Giménez-Júlvez, 2020) fear and panic among Romanians while specifying medical diagnoses of the deceased (Ko et al., 2020). Based on this, I do not recommend repeated, daily reading of news, even if from official sources.
3. Give up talking with people who infect us emotionally with their toxic, frightening, negative, gloomy opinions; avoid excessively critical and ill-willed people;
4. Use social support by talking with our family, relatives or friends, whether they are near or far. Emotional support is essential in the fight against stress

and nowadays we have the advantages of the technology that provide many mobile phone applications through which we can hear, view or send text/voice messages.

5. Understand the difference between the probable risk and the unfounded, exaggerated fears and scenarios that only accentuate our negative feelings (although very unlikely). Let's differentiate between rational and irrational thoughts (Cramer & Kupshik, 1993). For example, "If you stay too long in the house, you will not go insane; on the contrary, you will have more time to rest, quality time with your family" or "If all stores will be closed, what will we eat?" - "What covers basic needs will never be closed: supermarkets, pharmacies, hospitals, etc." or "Everything is uncertain" when the truth is that "there are many certainties, I can't control everything that happens around me, but I can control what I do."
6. Pay attention to our own needs and feelings. Also pay attention to children and the elderly because their emotional needs are higher during this period;
7. Get enough sleep, avoid consuming alcohol, tobacco, internet in excess, do not consume psychoactive substances, eat healthy and diversified food;
8. Develop new activities (How many the people thought these days to colour books for adults, write a diary, paint, etc.?)
9. Get rid of the routine because diversifying activities is much more relaxing than routine. Create new habits which is really important (Arlinghaus & Johnston, 2018). Of course, we do not have access to outdoor activities and frequent visits at friends, we cannot go to restaurants, bars, clubs but no one stops us to prepare a dinner as if we were at a restaurant.
10. There are online libraries that have made their books available, and there are also free online movies. What keeps us from accessing them?
11. Use what we already have: you can take online courses, you can do online business, you can work online (for money) and one more important thing: to dedicate your time to those in need for whom you can do something good. The more you focus on yourself, the more you suffer.
12. Get involved in healthy activities that bring us joy and relaxation (I do not have a list, everyone can choose and decide according to their personal preferences); The Internet has once again shown us how much you can do at home, in your own room.
13. We should accept that negative emotions are natural whether we are talking about fear, anger, dissatisfaction or frustration but the way they manifest themselves beyond certain limits is relevant (Ford, Lam, John & Mauss, 2018) Quarrels that can intensify during this period, conflicts with family or friends/ at work, insecurity about the job or the future, all these can lead to a state of conflict or even aggressive reactions. In this case it is necessary to develop techniques of prevention and management of these risk situations.

14. For people with anxiety disorders or high anxiety tendencies, histrionic, obsessive people, absorbed by paranoid ideas, where we are dealing with extremely high stress levels, instability, psychomotor agitation, I recommend turning to psychologists and psychotherapists.
15. Finally, we should not ignore the signals our body sends to us. If we have serious concerns about our health, we should call doctors and medical services with confidence.

CONCLUSIONS

As we have found, young people have suffered during the pandemic whether we are talking about their emotional state or about worries regarding their educational future, family stability, sleep disorders, feelings of anxiety, quarrels with family. There are also concerns about the excessive consumption of food, the internet, tobacco and alcohol. However, we appreciate the very high level of optimism of the young people that participated in this study which indicates an essential psychological resource. In this study, we found that family income and the number of family members do not influence stress and anxiety. However, more in-depth research is needed to understand how young people are successfully coping with new challenges such as the Covid-19 pandemic.

DISCUSSION

We know that young people use the internet a lot, and also the telephone and social media applications because they are attractive and easy to use. Such tools can be used to transmit relevant information and especially as specialized support to cope with emotional issues (stress, anxiety) or to reduce risk behaviour (internet, alcohol, tobacco, food). This is not happening in Romania. For example, we have a single application in Romanian to reduce alcohol consumption. We do not have applications to help young people get in touch with psychologists. On the other hand, at national level, the Ministry of Health or the Romanian College of Psychologists do not show much interest to the matter and do not take action for specialized intervention to support young people during the pandemic. There were several NGOs, universities, psychiatric hospitals in Romania that voluntarily provided psychological assistance but these services were not focused on young people. For example, psychologist could have been offered to chance to register in volunteer databases. Finally, the pandemic has shown that the pre-university and university education system has major problems and has not been able to adapt quickly or efficiently. The above recommendations are worth following.

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ISKUSTVO PANDEMIJE COVID-19 MEĐU MLADIMA U RUMUNIJI

Sažetak: Karantin koji je nametnula pandemija virusa COVID-19 utiče na mentalno zdravlje mladih. To se pokazalo nakon što je 1.207 mladih širom Rumunije odgovorilo na mrežnom istraživanju. Ispitanici su bili 72,4% žena i 27,6% muškaraca sa prosečnom starošću 21,93 godine. Rezultati istraživanja pokazuju povećanu konzumaciju duvana, alkohola i hrane tokom ovog perioda, više zabrinutosti i uznemirenosti među mladim ljudima. Ženski ispitanici su iskusil znatno više ($p < 0,001$) anksioznosti nego muški. Dalje, mladi ljudi koji su prekomerno koristili Internet prijavili su veći procenat (43,9%) poremećaja spavanja u poređenju sa ljudima koji Internet ne koriste prekomerno (21,2%). Podaci ukazuju na potrebu za psihološkim intervencijama prilagođenim potrebama mladih.

Ključne reči: mladi, virus korone, anksioznost, socijalna izolacija, alkohol, duvan

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JUNGIAN ANALYSIS IN THE TIME OF COVID 19

Abstract: A psychotherapeutic process based on the theory of C.G. Jung and his followers has a lot of common elements, but also a certain amount of differences while being compared with other types of depth psychotherapy. The time of COVID/19, which people all over the planet are being faced with, the analysts as well as patients, carry with itself additional features. Some of them are expected and others are, at least in a certain measure, surprising. The analytical process, held in a temenos of a virtual psychotherapeutic room, opens the door to new experiences connected with lot of important aspects of analysis, such as: the experience of oneself, the experience of the Other in analysis, (virtual) space in which the analysis is being held, the input of the personal space of a patient who, until then, has been coming to the analyst`s room, the absence of the "ritual" of traveling towards the analyst and a gradual moving from the real into the world of imagination, the enlargement/reduction of the intensity of communication, the absence of the body, etc. The aim of the paper is to explore how above mentioned and many other elements connected with online and modified in vivo psychotherapy during COVID pandemic are reflecting onto the way how the psychotherapeutic process will unfold, what it will be focused on and what will be the consequences of the newly established circumstances onto the psychotherapeutic relationship. During their research of the mentioned issues, the author is using a hermeneutic approach, well known within the field of analytical psychology. Transference and countertransference, as well, could not stay immune to these new aspects which the online communications carries with itself, such as: the face in the first plane, the other person that is being seen paradoxically (although being in the other part of the city, a country or a world) very closely, the reduction or the enlargement of the psychological distance and the implicit (or explicit) anxiety or a fear that a face to face relation could threaten the health situation of the other member of a dyad, carrying the mask that covers a big part of the face. The analytical process has always been a very complex and dynamic entity. The inclusion of new technologies and the ways of performing enlarges and makes visible, until then, not recognized spectrum of possible experiences and thoughts connected with oneself and the other. All of that has a very valuable influence on the shaping and the transformation of the psychological images which find their expression through symbols that are emerging from the unconscious.

Keywords: Jungian analysis, psychological image, psychotherapeutic process, virtual communication, Covid-19

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INTRODUCTION - DIVING INTO LIMINALITY?

Life in the times of COVID-19, as once life in the times of cholera or some other pandemic, brings with itself specific features that evoke different changes in peoples' everyday life. Until then, the usual way of organizing the work of many institutions, school and educational system, transport, way of spending a free time, making friends, traveling and lot of other areas and activities are being faced with the necessity of adaptation to newly established circumstances.

Nevertheless, it is not an easy task to overcome a first shock, a disbelief, a sense of being somewhere between the reality and dreams, a reduction of certainties and an increase of uncertainties, a feeling of endangerment etc. - everything that the new way of life evoked by COVID-19 brings with itself. Old, well established patterns of functioning are not efficient enough anymore, and new, stable ones are not jet well designed and proved in practice. On the individual, as well as on the collective plane, the "uncertain ground under the feet" is being created, the uncertainty is being increased and the stability and certainty are missing. We are being dived, not with our own will, into, what Jungian psychologists call, liminality (Stein, 2003). We entered or, even better, we were thrown into the period signed by the sense of shaken personal identity, the impression of being betwixt and between, left alone and to our individual ability of adapting to the new and insufficiently known situation. The sense of insecurity, the lack of confidence in ones' own capacities, the feeling of being threatened and exposed are either growing or being diminished and negated. Contradictory data are circulating within the individuals, in their families, at their work, in the schools and media. Nothing is as it used to be and for how long it would be as it is now, we can only guess; it is the same with the fact how will the life be organize if and when the pandemic is being put under the control. Until a year ago, stable supports and the ways of communicating with others were not functional anymore and could even represent the source of danger to the health. Completely safe ways of protection do not exist, except perhaps, a total isolation that is usually impossible to achieve. On the other side, even if possible, its consequences on the psychological health would be immense. Even in the situations of the partial and occasional isolation, a psychological pressure is growing, as well as a sense of deprivation and frustration because of the lack of exchange with others.

NOT SEEING THE WHOLE FACE *IN VIVO* OR SEEING THE WHOLE FACE VIRTUALY?

Depth psychotherapeutic approaches always implied a clear setting. Its justification was supported by the clinical practice as well as by the theory and research. Jungian analysis is not an exception in that sense. Nevertheless, the changes

conditioned by the pandemic brought with itself the necessity of online sessions, as well as bringing masks (at least) in the health institutions where the psychotherapeutic treatment is being held. Newly established aspects of the psychotherapeutic setting became *sine qua non* of knowing oneself and of working on oneself, at least for a period of time with the unknown length. Certain patients still prefer face to face contact, even if wearing masks cover a significant part of the face of the patient and the analyst. For them, a physical (bodily) presence on the both members of a dyad, unmediated by technology, is something that give them security and confidence necessary for connecting with a psychotherapist and a complete dedication to the psychotherapeutic work. Some of them begin to feel anxious; fearing that the face to face relation could potentially endangered the health of the other member of the psychotherapeutic dyad or themselves. To others, wearing masks and thus, mot seeing a complete face and its expression, leaves such an unnatural impression that they rather choose online sessions so that a whole face of tem and their analysts could be seen.

The virtual space where analysis is unfolding brings with itself the novelties and the paradoxes which the analyst and the patients are being faced with – one more in a conscious manner and with understanding and the other more unconscious and with a confusion. Like in the previous way of working, a psychotherapist try to register and discuss with a patient not enough visible and clear aspects of their inner world, as well as those ones connected with a world that surrounds them. In that way, newly established working conditions and a confusion they evoke could be used for the benefit of the patient.

FAR AWAY CLOSENESS OR CLOSE DISTANCE?

In the case of online analysis, one of the dimensions on whose ends we can put a distance and a closeness, evokes unusual situation where what was far away is being represented as close – an analyst and a patient were faced with a distant closeness. On one side, really, a distance is increased since, regarding the analyst, a patient is located at the other side of the city, in another town, in another country or in another part of the world. On the other side, virtually, a patient in respect to the analyst, is at the same time much closer that *in vivo* situation when they sit in the same room. Although virtual, this closeness seems very real and striking. A paradox of the mentioned situation could evoke a sense of confusion and a variety of feeling within the analyst and the patient. Of course, that could be reflected on the transference and countertransference phenomena.

UNFOLDING THE INDIVIDUATION PROCES?

Jung defines the notion of individuation as: "the process by which individual beings are formed a d differentiated… it is the development of the psychological individual as a being distinct from the general, collective psychology…. It is a process … having for its goal the development of the individual personality" (Jung, 1986, p. 119). Here, a question could be raised – could a patient's individuation process continue in a good enough way in these newly established circumstances in the times of COVID? Does transferring onto online sessions and/or work in vivo, but with masks, in spite of the changes, satisfy the minimum of conditions necessary for the continuation of the mentioned process? Although the period of working in these different circumstances is relatively short, it looks that the process of individuation in psychotherapy continues its journey. It could be seen that it is a natural process that, in the presence of an experienced psychotherapist, almost nothing can stop. Difficulties and additional challenges do exist for sure, but they are talked about on each session with a continuous effort to be overcame and used for furthering the development of a patient`s personality.

VISUAL AND/OR AUDITIVE CHANNEL OF COMMUNICATION?

Valuable novelty in the virtual psychotherapeutic room represents a fact that the visual channel of communication is mostly in the first plane – a face or a face with shoulders. Those are usually the parts of that could be seen via mobile or computer. Instead of the whole figure of an analyst and a patient that were until then being visible in the same room as whole persons, mostly an upper half of the body remains visible. All patient and analysts do not react in the same way while seeing the face of the other in analysis amplified and in a shorter distance. Some of them feel and behave in a more relaxed way. Others prepare more and put additional make up. To the third group the dominance of the face in the first plane seems quite uncomfortable and even intrusive. They have an experience of being more exposed. With a face in the first plane, different nuances of feelings could be registered easier; everything could be seen as amplified, because of the additional closeness of the face – like under the magnifying glass. Such situation could evoke uneasiness with a feeling that it is impossible to "hide" something that a person does not want to show in that moment.

To the people that have a lot of experience in using virtual communication, online sessions do not represent an issue. Programmers, web designers, e.g., the ones that spend the majority of their working hours in the virtual reality, accept online sessions as something completely natural.

INVISIBLE AND ABSENT CORPOREITY?

At the same time with the overemphasized presence of the face, it could be sense a overemphasized absence of the body and the bodyness (corporeity) of an analyst as well as of a patient. Very important *aspects of the nonverbal communication* become hidden and insufficiently visible. The non-spoken communication between the body of an analyst an the body of a patient is being excluded. Only the possibility remains that both members of the dyad would register the experiences going on in their bodies for themselves. A body posture, a relaxation of a contraction of muscles, arms and legs position become the subject of assumption; or there remains the possibility for an analyst to sense and to confirm or negate his experience through bringing it up in front of a patient. Of course, if a patient himself is capable of experiencing, recognizing and sharing the sensations in his body with the analyst, the gain for the psychotherapeutic work would be immense. Besides that, the issues of the absence of the analyst`s body and the question if and how patients react in the situation where they can not see or could never see (if it was an online analysis from the beginning) their analysts as a whole person – their head, but their whole body too. Individual differences are huge even in this case. Persons, especially younger, accustomed on “being” and communicating in virtual reality, do feel good. Ones that are confronting online analysis for the first time could feel a certain amount of uneasiness and insecurity. Nevertheless, in the majority of cases, a good enough relationship with the analyst create a favorable circumstances for overcoming the initial resistance.

PRIVACY – REDUCED AND/OR ENLARGED?

Virtual way of communication directed towards a face and an upper part of a body, often does not include in to the visible field the rest of the space in which patients (and the analyst) find themselves during analysis. Some are entering the analysis from their kitchens, other from their bedrooms or living rooms, others from their bed. Certain persons, that live in very small apartments with lots of family members, could find a calm enough place only in their car or in the park. Some individuals feel uncomfortable, although in their rooms, being afraid that other members of the household could hear what they are talking about. Besides that, a *sense of threatened of insufficient privacy and intensified exposure*. That could lead to reduced sincerity in order to diminish the risk of “information leakage” towards persons that were not supposed to hear them.

Because of that, certain patients rather choose only the *auditive channel of communication*. They feel more free and relaxed if they hear the psychotherapist`s and their voice, but without a visual component. Even without seeing the other`s face, they feel enough attachment and confidence in his psychotherapist and in the psychotherapeutic process.

LOST TACTILITY?

Tactile contact is either disabled or significantly reduced – shaking hands can not be performed (in a virtual world) or is being avoided during in vivo communication. Some patients report that they miss this kind of communication as well as hugging, kissing and shaking hands with their friends. In the pandemic circumstances, a body and the bodily exchange of closeness suffer a lot and to huge number of people that is quite hard to bare. Nevertheless, this state of affairs and intensified sense of deprivation and a lack of bodily exchange of closeness are common topics in psychotherapeutic sessions.

SILENCE AND PAUSES IN SPEECH?

During the last year, some patient were having the additional pressure during online communication – *the pressure to talk more* than usual in order to keep the communication going and/or to avoid focusing on the, perhaps, exaggerated closeness of the other in a dyad. As a consequence, there is the *avoidance of silence and reduction of the pauses in speech*. C.G. Jung, in his: „Red book" emphasizes the necessity of „going into the desert" – of the introversion of psychic energy, of pulling back from the extraverted world of others and the world of words, in order for the person to be able to face her own „soul", her psychic life. „ A desert is within you. A desert calls you and drags you backwards and if you are tide up with the world of this time with an iron, a call of the desert will break the chains. Sincerely, I am preparing you for the solitude" (Jung, 2009b). Besides Jung and his words, everyday clinical experience and research reveal a great importance of the silence and the pauses in speech during psychotherapy (Zdravković & Jovičić, 2020). Pauses during psychotherapeutic process could give lot of very valuable data connected with the patient`s personality, his experiences and problems they are being faced with. They could also help psychotherapist to get into contact with their countertransference feelings more quickly and easily. The researches are showing that, during making pauses in speech, persons recognizes more easily and efficiently various sensations in their bodies that could be connected with the tension, excitement, sadness, anger, joy and other intense feelings (Rajković, Jovičić, Grozdić, Zdravković & Subotić, 2018).

What is the quality of pauses, their frequency and length, are the questions that could give us answers about the conflict that is bothering a patient who is maybe trying to hide it (from himself and/from the analyst). While working on dream analysis and the history of a person, pauses in speech are, besides what someone speaks about, a valuable source of information, about the emotionally charged ideas and images that influence our way of experiencing and behaving, i.e. about complexes that are being activated (in the Jung`s sense of the word – Jung,

1969, pp. 92-129). Getting closer to a complex often brings with itself the intensification of the resistance which is being followed by the pauses with higher frequency of appearance and longer duration as well as the difficulty to speak about the contents in question. Besides that, a lot of material could be gathered about the existing transference feelings. All of these data important for the and about the patient could be less approachable because of the intensified pressure of maintaining the verbal contact during online psychotherapy.

TYPOLOGY AND NEW ASPECTS OF UNFOLDING A PSYCHOTHERAPY?

It is well known Jung`s division into introverted and extraverted personality type as well as into 4 psychological functions: intuition, sensation, thinking and feeling Based on the clinical experience, one gets the impression that it is less unusual for introverted persons to have an online session from their own space (Von Franz & Hillman, 1998). On the other side, they could feel embarrassed than extraverts because of the fact that their face is in the first plane and that every change in their expression could quickly and easy be noticed. For the extraverted individuals, in general, it is more difficult to bare the sense of isolation, since it prevents them to be in contact with the external world in which they are usually much more invested than into the inner one.

It may be easier for the persons with the intuition as dominant function to wear masks that cover a part of the face since they, in general, pay more attention to the whole experience comparing to the people with a dominant sensation function who are more focused on details and sensory perception.It is possible that individuals with dominant feeling function find it more difficult to ware masks, because they get less visible data about the emotional state of another person, since the majority of the face could not be seen. This situation may be a bit easier for the people with a dominant thinking function since they, in general, take less into account emotional data and come to their conclusions based more on their attitudes and thoughts about what other person tells them.

THE LOSS OF THE RITUAL?

A process that includes getting out of one`s own space, traveling to the psychotherapist, arriving to his(her) office and entering into the analyst`s space, is of a great importance to the majority of patients. In the virtual world, the transition is happening instantly. Pressing the key on the mobile phone or the computer “teleports” a person directly to the analyst. Getting out end entering from one into the other physical and psychical space does not unfold gradually. Everything happens in few seconds. A valuable ritual of the “journey” towards the analyst and through a gradual transitions from the real into the world of imagination is being

canceled. One "jumps" from one world in order to "jump" into the other. There is no more "crossing the threshold" from the "real", external world filled with other people, obligations, fuss into the world of analysis, the inner world of a patient. Besides that, there is no more a gradual transition from the world dedicated to the patient and his imagination back into the "real" world by walking out of the analyst`s room toward some other destination. A „switch" is happening in a second by canceling the mobile connection, by pressing the computer`s key. The world is been changed by simply getting out of Skype, Zoom, WhatsApp or some other application. A ritual of transition is been "stolen". That demands from patients a much faster adaptation to the next faze and does not leave a lot of space nor time for a psychological preparation for the world of imagination, as well as for the gradual processing the contents he was facing during the session while walking back to his "real" world. We are robbed from micro fazes of liminality that were enabling people to stay for some time somewhere in between, without clarifying and defining to quickly oneself and the other.

NEW SPACE – NEW *TEMENOS*?

There appears a necessity of creating a new safe place of analysis - a new *temenos*. The safety of the psychotherapeutic room needs to be substitute by the "safety" of the virtual room of the analyst. It is not an easy task to achieve, but it is not an impossible one. There is the relationship between an analyst and a patient in the center of everything. That represents the essential feature of psychotherapy. Nevertheless, it is necessary to take into account the individual differences. Here, we can rise a question in what way different patients experience the fact that, now, behind them we can see their space and that that space, together with the space of a psychotherapist, create their common "space". Some individuals feel better and more comfortable in their own place. To others, it is quite odd. To the third, that seems too intrusive. Certain persons have an impression of changing and loosing clear boundaries. Some people have a desire to ask the analyst to "look around their flat" and to show the whole place. Others feel embarrassed because of the untidiness or bursting in of family members. Some individuals do not have a place where they could be alone so they call the analyst from the park or a car. The information about the personal space of a patient and about his choice of a things he wants to show is an additional source of information to the analyst. Patients that feel more confident in their personal space dare to reveal stories or details from their life that they did not have the strength to do before.

On the other side, patients themselves could have an additional insight into analyst`s personal space – a place that exists out of his working room. If the analyst works via computer that is not mobile and is set in a room different from the usual one where patient is coming, the change of space appears to which a

patient is not accustomed. Problems could have analysts that have little children or a small apartment. Working from home can create a difficulty of finding a space where their work with patients will not be disturbed.

INTENSIFIED AWARENESS OF ONESELF?

Different from working in vivo when analysts see only patients, in a virtual space, they, for the first time, see themselves (at the screen) as well. This new situation with the continuous presence of one`s own image in the first plane, could evoke various consequences. It can attract and redirect the attention. Besides that, it could be an addition feature of reflection. With certain psychotherapists, it could lead to emphasizing the awareness of themselves. The image of analysts could "evoke" the need of checking the way they look and what impression they can make to themselves and to their patients. This situation could create a sense of greater exposure to the eye of a patient.

ACTIVE IMAGINATION – POSSIBLE OR NOT?

Active imagination represents an important method of Jungian analysis. Connected with that Jung emphasizes that "the dynamic principle of fantasy is play, a characteristic also of the child, and as such it appears inconsistent with the principle of serious work. But without this playing with fantasy no creative work has ever jet come to birth. The debt we owe to the play of imagination is incalculable". (Jung, 1921, par. 93). In the work of analytical psychologist (active) imagination represents "the mother of all possibilities, where, like all psychological opposites the inner and outer worlds are joined together in living union" (Jung, 1921, par. 78).

Is it possible to work with active imagination in the newly established circumstances of the virtual session? A clinical experience shows that it is. Of course, this could not be applied to the people that just started with analysis, as well as on those with serious psychiatric disorders. But, with the patients that have problems of living of milder psychiatric disturbances and are involved in the psychotherapeutic process for a certain period of time, a work with active imagination could be performed. If individuals have at home a clay, a paper and a pan, colors, a musical instrument of prefer to move and dance, the creative play could begin. Especially making figures from clay, drawing of painting gain their materiality and thus, could be of an immense importance. Starting from the dream image that a patient shared with the analyst, from the unclear bodily sensation about which he talked, from a dominant feeling in which he finds himself of a thought that appeared in that moment, active imagination can begin. During online session, the analyst can follow together with a patient the whole process of creating the symbolic image.

At the end, both of them could look at the products of active imagination and talk about them (Zdravković, 2020).

CONCLUSION – NEW 'NORMALITY' OF THE PSYCHOTHERAPEUTIC PROCESS?

Implementing new technologies and the ways of performing, enlarge and make visible until then unrecognized spectrum of the possible experiences and thoughts connected with oneself and the other in the analytic process. The authors` analysis and research showed that some essential elements of psychotherapy, such as psychotherapeutic relationship, transference/countertransference issues, dream analysis, working with fantasies and patient`s history, remain the basic support. Their place and influence are modified in a certain measure by the changes evoked by performing online analysis and unfolding the psychotherapeutic process in the virtual *temeno*s. A dominance of the visual and then auditive channel of communication, the absence of the body in the analytical space, the absence of the ritual of traveling to the analyst, the image of the analyst besides the image of the patient, the appearance of the personal space of a patient, a reduction of the pauses in speech and of the possibility of registering the nonverbal communication, are some of the new elements that require further following and analyzing. Wearing masks during in vivo sessions that diminish the possibility of gathering all the data from the whole face expressions, could not be overlooked. The reduction and absence of the touch in psychotherapy and in life in general, as a significant way of sharing closeness are leaving their consequences. All above mentioned, as well as the things analysts and patients are about to discover during COVID pandemic, influence significantly shaping and transforming the psychological images that find their expression in symbols that are emerging from the unconscious. "New online normality" of the psychotherapeutic process, without any doubt gives a possibility for the psychotherapy to unfold and for the patients to know themselves. Is it better from a classical psychotherapeutic setting? The authors think - not. Nevertheless, in the pandemic circumstances, when in liminality, more or less successfully, have to swim all of us, online analysis, as well as modified in vivo analysis, represent the important modalities of psychotherapeutic work that is enabling huge number of analysts to start or continue their work with their patients. It will enable the patients to know themselves better and to face and overcome the problems that are the source of their suffering as well as a chance for healing.

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JUNGOVSKA ANALIZA U VREME COVID-19

Sažetak: Psihoterapijski proces zasnovan na teoriji K.G. Junga i njegovih sledbenika ima dosta zajedničkih elemenata, ali i veliki broj različitosti posmatran u odnosu na druge pravce dubinskih psihoterapija. Vreme COVID-a 19 sa kojim se mesecima suočavaju ljudi širom planete pa tako i analitičari i pacijenti, nosi sa sobom dodatne specifičnosti. Neke od njih su očekivane dok su druge, bar u izvesnoj meri, iznenađujuće. Odvijanje analitičkog procesa u temenos-u virtuelne psihoterapijske sobe otvara vrata novim iskustvima vezanim za mnoge bitne aspekte analize, kao što su: doživljaj samog sebe, doživljaj onog Drugog u analizi, (virtuelni) prostor u kojem se odvija analiza, upliv ličnog prostora pacijenta koji je do tada dolazio u analitičarevu radnu sobu, nepostojanje rituala „putovanja" do analitičara i postepenog prelaženja iz realnog u svet imaginacije, povećanje/smanjenje intenzivnosti komunikacije, odsustvo tela i telesnosti itd.During their research of the mentioned issues, the author is using a hermeneutic approach, well known within the field of analytical psychology. Cilj rada je da se istraži na koji način se navedeni i mnogi drugi elementi povezani sa online i modifikovanom in vivo psihoterapihom tokom COVID pandemije odražavaju na to kako će se psihoterapijski proces odvijati, na šta će biti usmeren fokus i kakve će biti posledice novonastalih uslova rada po terapijski odnos. Tokom istraživanja i diskutovanja navedenih tema, autorkoristi hermeneutički pristup, dobro poznat unutar oblasti analitičke psihologije. Transfer i kontratransfer takođe ne ostaju imuni na nove aspekte koje online komunikacija nosi sa sobom, kao što su: lice u prvom planu, druga osoba koja se, paradoksalno, iako zapravo na drugom kraju grada, države ili sveta, vidi sasvim blizu, smanjenje ili povećanje psihološke distance, kao i tinjanje ideje ili strepnje da bi odnos face to face potencijalno mogao da ugrozi zdravlje drugog člana psihoterapijske dijade, nošenje maske koja prekriva deo lica. Analitički proces je oduvek bio izuzetno složena i dinamična pojava. Uvođenje novih tehnologija i načina odvijanja, povećava i čini vidljivim do tada neprepoznat spektar mogućih doživljaja i razmišljanja vezanih sa sebe i za Drugog. Sve to značajno utiče na oblikovanje i preobražaj psiholoških predstava koje svoj izraz nalaze u simbolima koji se pomaljaju iz nesvesnog.

Ključne reči: jungovska analiza, psihološka predstava, psihoterapijski odnos, virtuelna komunikacija, Covid 19

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HUMAN SAFETY IN SOCIALCRISES

Abstract: For millennia, a man has encountered numerous dangers, which have been complicated by the development of society and human beings and disrupted the continuous natural aspiration to live in safe conditions. Thus, it is security that has been accompanying society since its inception. It is based on the drive for self-preservation, which encouraged people and human communities to take different protection solutions. To be safe means to be free from fear of danger, threats, uncertainty, to be safe, protected, to preserve one's values, to be free, which is why the security process is based on assessment, protection, detection and responses. Events that violate human security are constantly changing. Some of them are modified, but new ones always appear. The latter, as a threat to security, are the result of events and their consequences both on an individual and global levels. We are, perhaps, at the end of a profound all-encompassing disturbance in the life of an individual and the functioning of society. The strong and more or less severe and lasting consequences of the crucial and so far transient severe state of action of Covid19 are still not clear. As an individual being a key object of human security, his insecurity and vulnerability, freedom from fear, freedom from deprivation and freedom to live with dignity are at the forefront. Along with it there are social communities, nations, subnational and supranational entities.

Keywords: human security, Covid-19, social crisis, crisis solving

INTRODUCTION

The concept of human security basis lies in the events of the late 80s and early 90s of the last century. The end of the Cold War, the disappearance of the bipolar balance of power, fear and arms race, the implosion of the USSR and the collapse of communism, as well as the integration processes in Europe, and NATO's strategic concept caused an explosion of neoliberal ideas. The initial optimism of the constitution of human security is supported by the idea of the “Peace Dividend” of the United Nations (Sanjeev, Clements, Bhattacharya & Shamit, 2002).

The United Nations Development Program (UNDP) first promoted the concept of human security in its 1994 Annual Report on Human Development and described it as a “people-oriented” approach, the basic components of which

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are "human liberation from fear and scarcity." This type of security offers a person security that frees him from the fear of chronic threats, such as hunger, illness and political repression, as well as "protection from sudden and painful disturbances of everyday life patterns." According to the UNDP, the new model of societies in the world requires two levels of urgent change setting, the change that involves crossing the path "from an exclusive emphasis on territorial security, to a much stronger emphasis on human security ..." and to the security provided by weapons.

In a narrower sense, this security means the protection of the personal security of an individual, the absence of direct and indirect threats of violence. Its broader meaning comprises much more of the stated above and includes respect for human rights, the existence of good governance, the possibility of education and the use of health care, as well as creating conditions in which each individual will have the opportunity to choose their path and realize their own potential. There are people and communities being the reference object of this security. Therefore, this relatively new approach to security carries its specificity in the primary focus on the individual level and on the personal sense of security. In the sphere of individual security, the area of human rights is a category that is not static. The struggle for them is as old as history. An important element through which the realization and protection of human rights is observed is the individual-state relationship in which the individual has guaranteed rights that must be respected. Today we are talking about civil human rights that imply the autonomy of the human being in relation to the state, about economic human rights that include the right to work, equal compensation and compensation in temporary unemployment, about social rights based on solidarity, about cultural rights based on concepts of diversity and identity and environmental rights, rights to development, to a healthy environment, to food. All of the above is aimed at the just and equal social position of all human beings on economic human rights that include the right to work, equal and temporary unemployment benefits, on social rights based on solidarity, on cultural rights based on the concepts of diversity and identity and environmental rights, rights to development, to a healthy environment, to food. All of the above is aimed at the just and equal social position of all human beings on economic human rights that include the right to work, equal and temporary unemployment benefits, on social rights based on solidarity, on cultural rights based on the concepts of diversity and identity and environmental rights, rights to development, to a healthy environment, to food. All of the above is aimed at providing the just and equal social position of all human beings.

Therefore, human security in its broadest sense encompasses far more. Every step in this direction is also a step towards reducing poverty, achieving economic growth and preventing conflict. Freedom from deprivation, freedom from fear and freedom for future generations to inherit a healthy environment are interconnected cores of human, and therefore national security (Annan, 2000).

There is the question arising in the form of a hypothesis: whether and to what extent human security is endangered in the Covid19 social health crisis?

SOCIAL CRISIS, HUMAN SECURITY AND COVID19

Societies exposure to crises marks both history and modernity. They are characterized by specificity, unexpectedness, events outside the routine through events that produce a high level of uncertainty and threats or perceived threats. They cause dysfunction in the mechanism of social functioning, endanger the normal social order and security. In general, social crises are complex systems that operate in families, economies, societies ... At an individual level, they are often associated with psychological stress, due to a frightening experience. Because of the above, a crisis is a stressful time in an individual's life when one experiences a breakdown or disturbance in normal or normal daily activities or family functioning

It is also connected with social systems, “with a complex society which understands an increasing number and diversity of its parts, diversity of specialized social roles, number of present different social personalities and diversity of mechanisms for their organization into a coherent, functional society as a whole” (Tainter, 1988). This indicates a few terms that refer to such diverse connotations of the crisis that implies a disturbance of order and instruments for its solution.

Today, the modern human being lives in a “society of risk”, obsessively worried about his or her safety and very sensitive to the slightest sign of its endangerment. It is the risks that have transformed the modern world. If they are ignored, their growth and expansion are encouraged. However, they are not only naked dangers, but are also a chance for profit, increasing tensions between those who profit from the risk and those who are affected by it (Bek, 2011).

As a broad term, human security has not been sufficiently defined. Beyond the approach related to the protection of people from violence and crime, this security, among other things, includes aspects of health insurance, and is aimed at the security of the individual, his or her protection and empowerment. The absence of this significantly undermines people's living conditions and leads to an increase in life-threatening phenomena, such as living in fear and social exclusion.

Therefore, the security of an individual implies the elimination of dangers that threaten his or her physical integrity, privacy, status in society, his or her freedoms and rights. The concept of human security shows interest in how people live, how much and whether they have a choice, how many social opportunities are available to them. Therefore, the goal of human security is to guarantee a set of life rights and freedoms for all people that does not unnecessarily jeopardize their ability to achieve their goals (Bašić, 2014). Many societies and countries of the world put the safety of an individual first. In line with the above, human security has entered the security strategies of many countries. The approach to it is based

on human rights whose center is human rights and an individual, and both concepts place the human being at their center.

Today, we are facing a global Covid19 health crisis that is causing human sufferings and killing them. This crisis is affecting the entire population of the planet. In addition to the health crisis, it is an economic and social crisis that, in the form of a pandemic, attacks societies at their core and endangers security. From the aspect of human security, the Covid pandemic19, as a crisis, has endangered everything that implies human security, endangered security, created vulnerabilities and the issue of protection that come to the fore, which allow to understand some of the main processes taking place and which are endangering the lives of people day by day.

Security refers to personal security. It is the feeling of a human being that he or she is protected from physical, social, spiritual, financial, political, economic, professional, psychological danger, damage, injury or any other threat, any event that can be interpreted as unwanted. Therefore, it is the control of uncertainty, whereby the identified danger is reduced to the limits of acceptable risk. Security is the removal of exposure from loss of health, tangible and intangible goods, property, people ... Thus security is a social situation of a human being, his individual, group and collective, in which important aspects of personal integrity are protected from injury and threat.

The vulnerability of human beings makes them absolutely and relatively incapable of defending and safeguarding their interests, when it comes to security. However, understanding it is the first step in risk management. In terms of security, understanding helps efficiency in designing a framework for identifying potential threats, detecting, and addressing vulnerabilities to reduce risk.

The Covid19 crisis has raised the question of protection, a passive component of security, in which being safe understands being deprived of the fear that is the guardian of security. If it were not so, humans would not survive as a species. This primary emotional reaction, which arises from the expectation or perception of a real or imagined danger, has implications for security in all important spheres of life. Whether fear is rational or irrational depends not only on its intensity, but also on its consequences. The issue of protection in the Covid pandemic19 has been reduced to the recommendations of the World Health Organization for the use of personal protection, family protection, the work of health systems, all with an assessment of the current health crisis at the global level.

In addition to the above, the element of human security - the absence of danger - is also threatened by this crisis. Danger is a real category of everyday life, especially one that cannot be predicted. It has a key impact on a person's normal life, because it can cause the loss of certain values by acting independently or together. There is ignorance and uncertainty on the stage, which is always the hardest to bear. They bring with them uncertainty based on a lack of knowledge

about what will or will not happen in the future. This health crisis also risks the economic sphere of security in terms of unemployment, job insecurity, poor working conditions, income inequality, and poorly developed social security networks. Socio-economic shocks hit hard at vulnerable and marginalized groups who have fewer resources to protect themselves from health risks and access health care...

THE AIM OF WORK

In relation to the above, the Covid19 pandemic has caused unprecedented circumstances, becoming a global problem in endangering health security. The entire population is exposed to infection and disease, increased levels of stress with the threat of serious consequences for mental health. This is especially clear in the conditions of obligatory home isolation. There are fears for their own health and well-being, fears for the well-being of family members, fears of lack of personal protective equipment, fears of lack of social support or social networking, fears of absence or lack of information on long-term consequences of exposure to infected persons. Fear of getting infected at work and transmitting disease to your family can be an additional source of stress.

METHODOLOGY

At the very beginning of the Covid19 pandemic, Infostud conducted a survey that showed that out of 4,329 employees, 12% lost their jobs, while of the employees who are still employed, 70% do their job unhindered, but 30% of them are under under the influence of the employer he had to take annual leave, sick leave, paid or unpaid leave. The pandemic of the disease caused by Covid19 is of unprecedented proportions. The spread of the virus takes the lives and livelihoods of families struggling to survive. This health crisis threatens to become a crisis in terms of children's rights, their safety, their well-being, their future (UNICEF, 2020). European Commission (2020) - The Directorate General for Health and Food Safety also appeals to consumers to protect themselves and others in the process of purchasing and handling food, in terms of proper storage, that is, monitoring key information about the shelf life of food. In the concept of human security, as he says (SeCons, 2019), insecurity and vulnerability of individuals are in the foreground. Given that human security implies three “pillars”, freedom from fear, freedom from deprivation and the freedom to live with dignity, it is considered to be ensured if all three types of freedom are achieved, if human lives are not endangered in any way, if decent living conditions are provided even if individuals feel safe and respected in their immediate and wider environment. This concept of security is not just a theoretical construct. It has a wide application in practical

terms as well. Given that human security implies three "pillars", freedom from fear, freedom from deprivation and the freedom to live with dignity, it is considered to be provided if all three types of freedom are achieved, if human lives are not endangered in any way, if decent living conditions are provided even if individuals feel safe and respected in their immediate and wider environment. This concept of security is not just a theoretical construct. It has a wide application in practical terms as well.

DISCUSSION

In contrast to the cessation of work in the economy, private and public sector, we are witnessing an increased intensity of work in the activities of health, hygiene products, and there is a greater involvement of the police and the army. On the other hand, employees are affected by psychosocial dangers that arise due to existing and future uncertainty about work or due to changes in the organization of work and work processes.

Nanci Fraser (Pulignano & Mara, 2020) points out that creating and maintaining social ties is essential to guaranteeing "sustainability" in society. The result of the weakening of social ties is a "crisis society" - a systemic condensation of financial, political, environmental, social and health challenges that we face and experience today, and which are strongly connected. The Covid19 crisis is exacerbating the increasingly precarious working conditions of some social groups. Insecure workers are most at risk of a pandemic because they lack social and human rights, while enjoying little or no social protection. This is the case for those who cannot work, who do not have guaranteed work or working hours, as well as for all those who are poorly paid.

There is also the aspiration to protect human dignity, which is the core of the concept of human rights and which places the human person in the center of attention based on a common general value system.

Kovačević (2020) claims that the spread of Corona virus is expressed by the number of infected people in a given period of time, it is the least dependent on the development of the health system. Spread depends on many factors that are not necessarily health - population density, dependence on public transport, length of travel to work, public gatherings ... The success of measures to combat the spread of the virus - personal hygiene, social distancing, quarantine depend on the already mentioned dimensions of human development-education, equality, living standards of the population, solidarity, cohesion, access to the Internet and, to a large extent, the quality of state and social institutions and the trust of citizens in them.

In any case, on the other hand, the question arises: "How to compensate for the culture of welcoming, handshaking, hugging?" This old experience is very

difficult to forget. Proximity, solidarity and care are usually expressed by a hug or an offer to someone to enter your house. In this crisis, all that has stopped. That reversal is difficult for all human beings. The resulting disciplined society imposes separation, division, control and control over the individual. All spaces in theaters or public spaces are closed. There is no meeting, there is only a private space. In contrast, there is increasing connectivity with the family, to which working from home contributes. Solidarity with the elderly is being sought at the moment. Unlike other social crises, the crisis caused by Covid19 is an action all over the world. The world has mobilized against one enemy (Flaspeler, 2020)

CONCLUSION

The Covid pandemic19 has endangered human security, leading to insecurity and vulnerability of individuals. The three pillars of human security: freedom from fear, freedom from deprivation and the freedom to live with dignity are threatened in this crisis, bringing insecurity. In addition, human lives are endangered, and decent living conditions are endangered. The absence of the above has significantly undermined the living conditions of people and led to an increase in phenomena that endanger their lives. Living in fear, living in social exclusion, fearing for health and uncertain elimination of dangers that threaten physical integrity, strongly affect human security.

This pandemic has further heightened insecurity in terms of poverty, inequality and vulnerability to which the individual and many families are exposed. The offered research by Infostud, and at the very beginning of the pandemic, showed that due to various economic, psychosocial and health factors, this time of crisis is very stressful for individuals and for many people. As one of the priorities to limit the spread of the virus was to reduce the free movement of people, the impossibility of social activity, due to regulations on social distancing, is a risk factor for human security. However, social distancing has a significant impact on the economic slowdown, leading to recession and poverty. There is another side, although different societies react differently to the crisis, the whole planet shares the same concerns. It seems that in times of general isolation there are, more than ever, connections with the rest of the world.

The famous Israeli author and theorist, Harari (2020) is probably right claiming that the choices we make during this crisis (which will inevitably pass) will define the future of our societies. Therefore, when choosing between different alternatives, as a society we must keep in mind not only how we will overcome the current challenges, but what the world will look like after the crisis passes. As one of the key choices that is currently being imposed on us, Harari singles out the choice between privacy and health. He believes that this choice is false and that we must be able to preserve our health and our privacy.

Because, although the extraordinary circumstances of the situation in which most of the world finds itself today are temporary, there is a possibility that at least a part of that emergency will become an integral part of our future everyday life. This is perhaps the most dangerous possible consequence of this crisis.

If we look back, we can say that no country in the world was ready enough to face the Covid pandemic19. Differences between countries in terms of human security, the development of health systems, hospital capacities and the number of professionals did not help much so that the Covid19 crisis did not become a systemic crisis and did not affect human security.

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LJUDSKA BEZBEDNOST U DRUŠTVENIM KRIZAMA

Sažetak: Milenijumima unazad čovek se susretao s brojnim opasnostima, koje su se razvojem društva i ljudskih bića usložnjavale i remetile kontinuiranu prirodnu težnju za život u bezbednim uslovima. Samim tim, bezbednost prati društvo od samog njegovog postanka. U njenoj osnovi je nagon za samoodržanjem, koji je podsticao ljude i ljudske zajednice na različita rešenja zaštite. Biti bezbedan znači biti lišen straha od opasnosti, pretnji, neizvesnosti, biti siguran, zaštićen, očuvati svoje vrednosti, biti slobodan, zbog čega se proces bezbednosti zasniva na proceni, zaštiti, otkrivanju i odgovorima. Događaji koji narušavaju ljudsku bezbednost se permanentno menjaju. Neki od njih se modifikuju, ali uvek se javljaju novi. Ovi poslednji, kao ugrožavanje bezbednosti rezultat su dešavanja i njihovih posledica na pojedinačnom i globalnom nivou. Na kraju smo možda, dubokog sveobuhvatanog poremećaja u životu pojedinca i funkcionisanju društva. Još uvek nisu jasne snažne i više ili manje teške i trajne posledice prelomnog i za sada prolaznog teškog stanja delovanja Covida-19. Kako je pojedinac ključni objekat ljudske bezbednosti, njegova nesigurnost i ranjivost, sloboda od straha, sloboda od deprivacije i sloboda da se živi dostojanstveno su u prvom planu. Zajedno s njom su i društvene zajednice, nacije, podnacionalni i nadnacionalni subjekti.

Ključne reči: ljudska bezbednost, Covid-19, društvena kriza, njihovo rešavanje

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COVID 19 AND CRISIS MANAGEMENT WITHIN THE EDUCATIONAL INSTITUTIONS

Abstract: One of the new experiences of the whole world is the crisis in the form of the Covid-19 pandemic. In addition to this health crisis, which no country in the world has been prepared for, the crisis of human development of young people in educational institutions is on the scene. These institutions are particularly interesting areas of crisis, due to the vulnerability of underdeveloped human beings. Awareness of the crisis requires prepared potential scenarios, problem research, identification, isolation, followed by the beginning of the implementation of the crisis management plan, the end of which is the analysis of the situation and solutions. The stated above is the central part of crisis management, as an inseparable part of modernity, necessary for efficient functioning in educational institutions. Today, the time of the Covid-19 pandemic, brings crisis management that is more specialized and complex that requires planning in terms of survival. By its actions it requires management actions that are developed and operate within a complex dynamic system. Therefore, its role in educational institutions is to organize, prepare measures, protect and allocate resources. There is the point in the practical significance of decision-making in crisis situations. This paper deals with the preparation of crisis management in educational institutions during the Covid-19 crisis, the creation and implementation of plans that provide students with educational awareness of roles and responsibilities during crisis response.

Keywords: management, crisis management, educational institutions, Covid-19

INTRODUCTION

Management is an inseparable part of modernity. As a complex and elaborate phenomenon it finds its place in society, science, human skills, abilities, managerial functions, profession and in art. It is the only mechanism for controlling or directing in certain situations. It involves the process of making and implementing decisions while accepting responsibility. At its most basic level it is a discipline that consists of the management necessary for efficient functioning.

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Most modern definitions show management as a complex process of guiding a group of people in performing certain tasks in order to achieve predetermined, common goals, where this process includes several different subprocesses, such as: planning, organizing, staffing, leadership and control (Jovanović & Lukić, 2010).

Planning is the selection of appropriate goals and actions to be used. The next step is to identify the strategies to be used, the actions to be taken, and to decide what resources are needed to achieve the goals. The process of organizing is establishing relationships with others in terms of achieving goals. Leading functions include articulating vision, energizing employees, inspiring and motivating people using vision, influence, persuasion, and effective communication skills. There is also recruitment, selection of employees, and finally control in terms of assessing how well the goals are being achieved and performance is being improved.

On the other hand, unlike earlier phases of management that focused on strategies, structure, size, and technology, modern management emphasizes the importance of employees, their knowledge and skills, leadership styles.

Crises, as chaotic and unpredictable events, do not fit into pre-set patterns and patterns, so the question arises as to how it is at all possible to plan a response to chaotic events that do not behave in a regular way. However, all crises have certain common characteristics, and certain types of crises have greater similarities, and can be covered by similar types of plans and preparations. Crisis plans must take maximum account of the current reality and take all the difficulties present into account (Kešetović, Toth & Toth, 2014)

However, the situation changes a lot, when social health crises are on the scene. The Center for Crisis Management (2020) evaluates the modern concept of crisis that originates from the medical literature and indicates a dangerous state of health of the organism from which it cannot recover without permanent damage, external intervention or basic restructuring since the body's self-defense mechanisms are not enough to pulled out of the crisis. In relation to this, crisis management is needed, which this Center defines as a set of functions or processes that aim to identify, study, anticipate possible crisis situations, to establish special ways that will prevent the crisis, to deal with it and to overcome it.

The point is to minimize the consequences of its action and return to normal as soon as possible. In that manner, crisis management includes all types of activities aimed at dealing with the system of disorders: prevention, preparation, mitigation and recovery. It is about shaping the procedures, agreements and decisions that affect the course of the crisis, including the preparation of measures and the allocation of resources to overcome it. Crisis management usually takes place in conditions of organizational chaos, under the pressure of numerous media in stressful circumstances and lack of accurate information.

It also includes educational institutions that strive to create a safe environment for their students, which try to prevent harm to any human being in them, given the daily exposure to risks and threats to their physical and mental development.

YOUTH HEALTH

The World Health Organization (1946) defined health as a state of complete physical, mental and social well-being, and not just the absence of disease and disability. Therefore, it implies the quality of the human body, the absence of disease, normal and adequate functioning in physical, mental, social and emotional aspects.

Young human beings, by United Nations definition, represent the future. They are the most profitable long-term investment of a society, the source of ideas for innovation, they are today's thinkers, problem solvers, catalysts of peace, the strongest advocates of justice and dignity in the world. They are recognized all over the world as a group of special interest in the general population, so their health is imperative. Due to the specificity of their needs, their health is one of the main preoccupations of all state policies (Bokova, 2016).

All young people on the planet should have the opportunity to grow up healthy. A special review is on adolescence, the phase of their life between childhood and adulthood. For this unique phase of human development, time is important to lay the foundations of good health. During this time, they establish patterns of behavior that can protect their own health and the health of others or put their health at risk now and in the future. To grow and develop in good health, young people need information, comprehensive education, opportunities to develop life skills, health services that are acceptable, fair, appropriate and efficient, and safe and supportive environments.

Emergency health situations that suddenly appear over time also bring problems to young people, creating unexpected crises that know no boundaries. Kešetović et al. (2014) report that educational institutions are, as a rule, well-established, predictable and safe places where work is routine. However, despite that, they are exposed to different types of crises. The fact that there are children and young people in these institutions makes them extremely vulnerable and prone to crisis events. This particular vulnerability makes them “soft targets” and an ideal target for various types of health threats. In this context, crisis planning in educational institutions is of particular importance. In addition to the general principles of crisis planning, when making contingency plans in these institutions, the specific characteristics of young people must be taken into account.

CRISIS MANAGEMENT

In relation to the above, crisis management in educational institutions consists of four basics. In the first place, there is the awareness of a health crisis being present and the possibility that it will recur. It requires prepared potential scenarios and potential solutions, it requires a plan. Current problems need to be investigated and identified. Then, the implementation of the crisis management plan should begin, after which the situation and solutions would be analyzed, and the damage would be minimized. In the end, everything would be recorded and introduced into the system in order to avoid the same crisis in the future.

Pilar (2016) says that planning in advance is the key to survival, which is why there should be potential scenarios for it before the crisis occurs. Therefore, crisis management requires thinking about how to manage the crisis, thinking about possible answers in the best and worst cases. Designing procedures or elements of a crisis management plan provides flexibility in management. After designing the answers, a concrete crisis management plan should be made. Each crisis management team should have a trained spokesperson with adequate skills, position and training, who will make statements. As the target points of the plan are protective, the public must be informed in an adequate way. It is imperative on honesty and non-concealment of information, transparency and social networks, as the most important channels of communication today. Crisis management requires calmness, professionalism and correctness in order to maintain morale and motivation. In the end, there is a formal analysis of what was done properly and what was not, as well as what could have been done better.

The current generations in educational institutions have experienced a drastic and almost completely unforeseen crisis with Covid-19, which signals the arrival of a changing world. Together with them, the employees of these institutions know that the digital world is transforming life more and more. The use of the Internet and mobile phones has triggered these changes, so online education is playing an increasing role in the current crisis. They face the challenge of rapidly transitioning to distance learning, reorganizing the evaluation process and distance support, as almost all educational institutions in the world have had to close.

Therefore, crisis management in educational institutions needs plans. In addition to consulting with school security advisors, principals of these institutions should make preparedness plans. Teachers should have fun with their students. The Ministry of Education should join forces with teachers who will help schools get through the crisis. Today, the role of crisis management lies in educational institutions that have the task of teaching students what Covid-19 is, how it is transmitted, how much it can survive on the surface, who is most endangered, what are the symptoms of the disease, what is testing and when to look for it. what is needed when it is confirmed, but also that it can be killed by simple disinfectants.

At the same time, the fact that relatively few cases of Covid-19 have been recorded so far among young people should not relax them. They must be prepared and compliant with the fact that receiving early care by health professionals can make the disease less dangerous. In this regard, students in educational institutions must fully understand public health measures

The purpose of this is to provide clear and effective guidelines for safe operations through the prevention, early detection and control of Covid-19 in educational institutions. These guidelines provide key messages and considerations for engaging school staff as well as children themselves in promoting safety and health. Education can encourage students to become advocates for disease prevention and control at home, at school, and in their community. Maintaining the safe operation of the school or reopening them requires many considerations (Unicef, 2020).

Today's health crisis with Covid-19 presents an opportunity for young people to learn, while at the same time giving them a chance to build a more secure future. What is learned helps them reduce fear and supports their ability to cope with any secondary influences in their lives.

All of the above stated, along with quality crisis management has shortcomings, today, which is also the answer to the question in the form of a hypothesis. It seems that we are not even close to a formal analysis of what was done and what was not, as well as what could have been done better.

THE AIM OF THE WORK

Due to the fact that it cannot be postponed immediately, the health crisis of young people in Covid 19 has demanded and still requires permanent interventions and solutions. Given that the current health crisis came before pre-crisis preparations were made, preparations and experiences on how to deal with it, how to take precautions to avoid recurrence, and getting out of it require minimal damage or even positive results. Therefore, crisis planning must be an integral part of effective management in educational institutions. Because of the above, and instead of a hypothesis, today the question arises what are the assumptions, reasons, causes, forces that serve to solve the problem of Covid-19 in young people?

METHODOLOGY OF WORK

UNICEF (2020) states that due to Covid 19 there are 1.6 billion children in 145 countries who have been affected by the closure of schools. They are in a health crisis like everyone else, surrounded by hard times in all countries, between them and the crisis of societies and lives. Tokel et al. (2017) define this crisis as a situation of tension that threatens existing values, goals and assumptions, making

adjustment mechanisms inadequate, which requires prevention, prediction, quick and urgent responses, because due to unexpectedness and unpredictability, this crisis disrupts and disrupts healthy human functioning beings, in general.

And young people are at risk of being among the victims of the Covid-19 pandemic, as a crisis. All ages of young people feel the consequences of not leaving home, physical distancing and closed educational institutions. In the ensuing excess of time, the constant presence on the Internet puts them at greater risk of being exposed to harmful content. Therefore, the resulting disruptions in the functioning of society in the Covid-19 crisis have a major impact on their security, well-being and future.

This crisis also violates their rights. In it, young people also experience sudden changes which they cannot get out of with the usual methods. Paunović (2020) points to the fact that the Covid-19 crisis also disrupted the lives of parents and children, who are facing many shortages, deprivations and restrictions indoors, without the elderly, friends and games. In these conditions, children and young people do not cope, show resistance and ask for help from their parents. They need to be taught how to guard against infections. Wearing masks and distance are a special preventive problem for young people whose lessons about them are the most difficult to explain.

DISCUSSION

The World Health Organization (2020) provides data that suggest that cases of critical images of Covid 19 have also been reported in young people, and that these conditions have been suggested as a risk factor. Their ongoing research assesses risks and transmits them to young people in educational institutions. In collaboration with them and scientists from around the world, the World Health Organization has developed protocols that states can use to study the transmission of Covod-19 in educational institutions. As young people generally have a milder clinical picture of the disease and fewer symptoms, cases can sometimes go unnoticed, so early data from studies suggest that their infection rate could be higher. Therefore, it was estimated that the long-term effects of keeping educational institutions open suggest that this could have an effect on the spread of infection. They recommend several elements of assessment; Covid-19 epidemiology at the local level, assessment of transmission intensity in a given area, overall impact of educational institutions closing / opening, general health, well-being, effectiveness of distance learning strategy, assessment of whether local health authorities are able to act quickly capacity of educational institutions to work safely, cooperate and coordinatesafely.

In addition to the above, there are other public health measures that are implemented outside school; providing the necessary resources, policies and

infrastructure to protect the health and safety of students and staff in educational institutions. In addition, the WHO (2020) recommends; conducting early detection, testing, contact search, quarantine, cluster research, ensuring physical distance, hand hygiene and the use of age-appropriate masks and protecting vulnerable groups. When it comes to the use of masks, children under 5 should not wear them, for children between 6 and 11 years the decision to use a mask should be based on the risk of transmission intensity in the area where they are, children and adolescents of 12 years and older should follow national guidelines on adult masks obligatory wearing, and teaching and support staff may be required to wear masks when they cannot guarantee a distance of 1 meter at least.

CONCLUSION

The health, safety and well-being of young people is of a top priority. Therefore, they need to be provided with a safe environment in educational institutions. The complex structure of these institutions makes young people vulnerable, which belongs to the sphere of security phenomena. Their particular vulnerability is during the outbreak of infectious diseases that involve a direct impact on their health and social functioning.

Guidelines on how to protect young people from Covid-19 today follow the guidelines of the WHO (2020), and they ask educational institutions to establish plans that will ensure the health of young people, their safety and psychological well-being. On the other hand, there is distance learning that maintains the level of knowledge

Today's environment in the world with Covid 19 has caused a health crisis situation that required educational institutions to be prepared and have operational plans. Since it was not possible to predict a crisis in this sense, actions were taken that required cooperation with health departments in the first place, and guidelines that needed to be followed in order to determine a safe environment for young people and their education. At the center of the events is the sensitivity of young people to life in quarantine, closing schools, forcing them to study at a distance without previous experience and losing social contacts

As the pace accelerates in crisis situations, the situation required a rapid response of crisis management whose role in the field of education is to identify and monitor possible causes of the crisis, to prevent, prevent, reduce the consequences and enable recovery, and to allow further operation of educational institutions.

As planning ahead is the key, crisis management required thinking about crisis management, about possible answers in the best and worst cases. This gave him flexibility in crisis management. A concrete crisis management plan has been made. Social networks were used. This gave a certain essence of crisis management in order to achieve a lasting solution.

The near or distant future requires calmness, professionalism and correctness in order to maintain the morale and motivation of young people.

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COVID 19 I KRIZNI MENADŽMENT U USTANOVAMA OBRAZOVANJA

Sažetak: Menadžment, kao neraskidivi deo savremenosti neophodan je za efikasno funkcionisanje i razvoj svakog društvenog sistema i društva, za efikasan rad svakog kompleksnijeg posla. Svest o tome da postoji mogćnost izbijanja neke krize ili problema traži pripremljene potencijalne scenarije, rešenja i plan za krizni menadžment. Kada se problem desi potrebno ga je istražiti, identifikovati i izolovati, a zatim početi sa sprovođenjem plana za upravljanje krizom. Kraj kriznog menadžmenta zahteva analizu situacija i rešenja. Nastalu štetu je potrebno dovesti na minimum, posle čega sledi evidencija i uvođenje u sistem za izbegavanje eventualnih budućih kriza. Današnje vreme, vreme pandemije Covid 19, krizni menadžment čini specijalizovanijim i složenijim. Njegovo delovanje zahteva upravljačke akcije, koje se razvijaju i deluju u složenim dinamičkim sistemima. U odstupanju od normalnog poretka u uslovima krize, krizni menadžment zahteva organizaciju, pripremu, mere i raspoređivanje resursa. Poenta njegovog praktičnog značaja je donošenje odluka u kriznim situacijama. Ustanove obrazovanja su posebne interesne sfere, obzirom da njih čine mladi koji su ranjivi na krizne događaje, pa krizni menadžment ima specifičan značaj. Ovaj rad se bavi pripremama školskog osoblja tokom krize Covid-19, pravljenjem i implementacijom planova koji obezbeđuju učenicima svest o ulogama i odgovornostima tokom reagovanja u vanrednim situacijama.

Ključne reči: menadžment, krizni menadžment, ustanove obrazovanja, Covid-19

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ONLINE SPEECH THERAPY TREATMENT AND APPLICATION OF THE METHOD CONSCIOUS SYNTHESIS OF DEVELOPMENT DURING COVID-19

Abstract: During the epidemic caused by COVID-19, when communication and socialization are limited and reduced, normal functioning of every person can be disrupted, especially of a person who stutters. Due to the inability of clients to leave their homes, to travel and come for continuous and planned speech therapy treatments in the Institute's outpatient clinic, we conducted online individual and group treatments for people who stutter via video calls via Viber, Messenger, and Instagram applications. In this paper, we will present the results of a survey about the reactions and observations of clients to this type of online speech therapy and the possibility of applying the method of Conscious Synthesis of Development online. Methodology: The online individual and group speech therapy treatment was conducted with 42 patients, aged from early school age to adulthood. All patients had previously been included in the treatment of stuttering by the method of Conscious Synthesis of Development and were at different stages of treatment with this method at that time. This type of speech therapy primarily ensured the continuity of the therapy. It was possible to monitor the client's speech as well as his basic biological rhythms (quality of sleep and dream), mood, the fulfillment of daily tasks, and giving new ones. Clients had better speech control, and they were able to share their experiences, thoughts, fears, and to receive adequate advice and exercises, as well as monitor progress in the use of fluent speech techniques. Based on the results obtained and experiences gained during the COVID-19 pandemic, it can be concluded that online speech therapy can be successfully implemented not only during a state of emergency but also during other situations that prevent clients from traveling or in situations when movement could lead to endangering their health, especially of persons from risk groups.

Keywords: stuttering, method of Conscious Synthesis of Development, online speech therapy treatment

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INTRODUCTION

Stuttering represents a disorder that is a multidimensional problem in both diagnosis and therapy. We have known about it for thousands of years, and it has probably existed since the beginning of the human race. It affects people of all races, cultures, social classes. To harmonize the diagnostic criteria for various diseases and disorders, including stuttering, two classifications of diseases and disorders are used in the world. These are the ICD-10 and DSM-IV classifications. According to the International Classification of Diseases (World Health Organization, 2008), stuttering is: "a speech disorder characterized by frequent repetitions and prolongations of voices, syllables and/or words, as well as frequent hesitations and pauses that disrupt the rhythm of speech. It can only be classified as a disorder if its severity is such that it visibly interrupts the speech flow".

The fourth revision of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-IV, 1994) classifies stuttering as a communication disorder. It emphasizes that this speech fluency disorder interferes with academic and professional achievement and social communication. This classification also includes the subjective experience of a person who stutters and uses extra effort to utter words, accompanied by a feeling of distress and disrupts everyday expression.

Depending on the author's professional and scientific profile, were created theories about the origin of stuttering. Research in stuttering has not yet sufficiently explained the causes of this problem, so today, there are many theories about stuttering. Most authors, however, agree that stuttering is a multidimensional character for the emergence and development of which several factors are responsible at the same time. Among these factors are specific physiological deficits, psychological and environmental factors, which by their interaction can cause the onset and, later, maintenance of stuttering.

Stuttering treatment has also changed over time in different ways, depending on the prevailing opinion about its etiology. There is no single treatment for stuttering today. Many therapeutic approaches treat only one symptom or group of symptoms. However, as the prevailing opinion is that the etiology of stuttering is multicausal and that stuttering itself is a multidimensional problem in its manifestation, there is also a tendency to develop comprehensive therapeutic approaches (Manning, 2001).

In the seventies of the 20thcentury, under the leadership of Prof. dr Cvetko Brajović at the Institute for Psychophysiological Disorders and Speech Pathology in Belgrade has been developed a multidimensional approach to the treatment of stuttering. The Method of Conscious Synthesis of Development includes fluency-shaping and similar techniques and the cognitive-behavioral part of the treatment. Therapy consists of three phases and is conducted individually and in groups, outpatient and inpatient (Tadic & Soster, 2012).

Critical periods for the occurrence of stuttering are, among others, periods of some natural disasters and social events such as wars, floods, earthquakes, pandemics and the like, so an increase in the frequency of stuttering in children and adults can be expected. At the time of various epidemics, such as the pandemic caused by COVID-19 in March 2020 and the state of emergency in our country, every person's normal functioning could be disrupted, especially the person who stutters, because then communication and socialization are limited and reduced.

During this critical period, due to the inability of clients to leave their homes, travel and come for continuous and planned speech therapy treatments in the Institute's outpatient clinic, we conducted online individual and group treatments for people who stutter via video call using the Method of ConsciousSynthesis of Development. In conducting online treatment, we were guided by the experiences of countries conducting this type of treatment for several years (USA, Australia). In Australia, attempts have been made to conduct more well-known stuttering programs in children and adults, such as the Lidcombe and Camperdown programs remotely (Theodoros, 2011).

TELEREHABILITATION AND ITS APPLICATION IN THERAPY OF STUTTERING

The American Speech, Language, and Hearing Association (ASHA) has defined telerehabilitation (telepractice) as the application of technology to provide professional distance services by connecting the client and the clinician for assessment, intervention, and/or consultation (ASHA, 2005, p. 1).

Telerehabilitation's primary idea is to provide cost-effective access for all clients, regardless of geographical distance, physical disability, social or economic status. Research on the telerehabilitation's benefits has included its application in various speech and language disorders and disorders in childhood and adulthood (neurogenic communication disorders, voice disorders, stuttering, articulation disorders, language and literacy in children) (Theodoros, 2011).

Considering treating stuttering in this way, some studies have shown successful rehabilitation in children and adults (Sicotte, Lehoux, Fortier-Blanc, & Leblanc, 2003; Kully, 2000; according to Theodoros, 2011). In Sydney, a group of experts developed specially designed applications to treat stuttering at a distance (Carey et al., 2010; O'Brian, Packman, & Onslow, 2008; Wilson et al., 2004; according to Theodoros, 2011).

METHOD

Research subject and aim

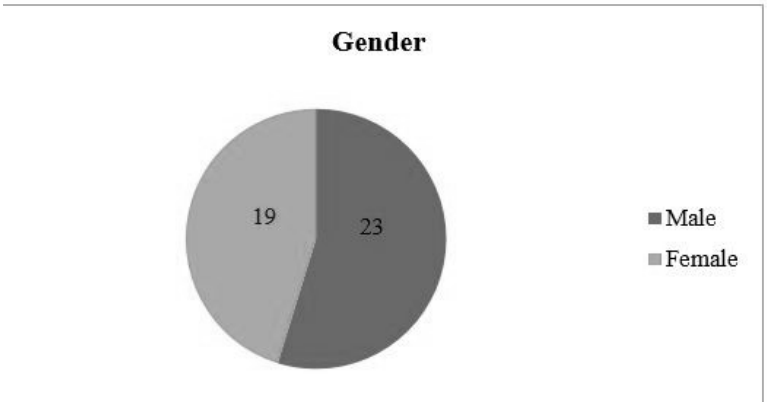
The subject of this paper is to present the possibility of applying the Method of

Conscious Synthesis of Developmentthrough online treatment individually and in groups in people who stutter.

The presentation aims to present the results of a survey that monitored the reactions and observations of clients to this type of online speech therapy and their speech during such an approach and application of the Method of Conscious method Synthesis of Development.

Sample

Online individual and group speech therapy treatment was conducted with 42 clients in the period from 24.03.2020.to 08.05.2020. Clients had previously been included in the Method of Conscious Synthesis of Development for stuttering correction and were at different stages of that method. The criteria for selecting clients are not strictly defined, as it is a therapeutic group, not a research group. The basic condition is that every person has speech disorders defined as stuttering and that they are clients of the Institute for Psychophysiological Disorders and Speech Pathology.



Graph 1 *Characteristics of the sample concerning gender*

Graph 1 shows the sample concerning gender. 19 male subjects (45.24%) and 23 female subjects (54.76%) participated in the study. The mean age of the group is M = 21 years, 11 months and 12 days. The oldest respondent was 40 years, 9 months and 1 day old, while the youngest was 9 years, 6 months and 10 days old.

Material and method

Instruments

Online speech therapy was primarily related to video interaction between clients and therapists and was performed via video calling via Viber, Messenger and Instagram.

At the end of online speech therapy treatment and clients' return to the Institute's outpatient clinic in May 2020, clients filled out a survey containing 12 questions. They served therapists to understand better how people who stutter deal with their problems and the importance of online speech therapy during the COVID-19 pandemic.

Therapeutic program

During the period of emergency and the inability of clients to come to the Institute's outpatient clinic, the therapeutic program was implemented individually and, in a group, and it included:

a. Method of Conscious Synthesis of Development (by author Prof. dr Cvetko Brajović) for the correction of speech disorders;
b. Cognitive-behavioral part of the program to reduce anxiety and establish emotional stability and develop social competence with particular emphasis on keeping a diary that included length of sleep, quality of sleep and dreams, speech and speech situations during the day, and mood during the day.

RESULTS

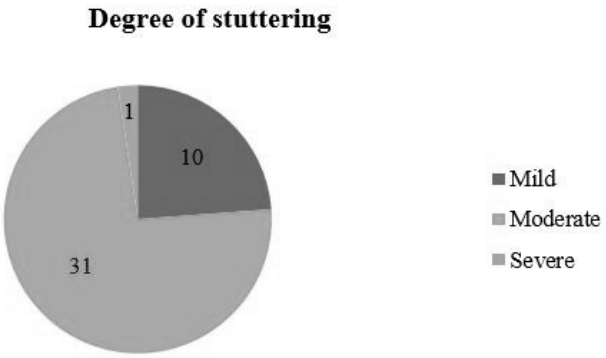
After careful analysis, the results of the survey are presented in tables, graphs and text.

1. Indicate the degree of stuttering you had before the COVID-19 pandemic.

Table 1
Characteristics of the sample concerning to the degree of stuttering

n=42	**N**	Percentage
Mild	10	23,81%
Moderate	31	73,81%
Severe	1	2,38%
Total	42	100%

The most significant percentage of respondents who participated in the survey was classified in the category of moderate stuttering severity (73.81%), then mild (23.81%) and only one respondent had a severe form of stuttering (2.38%).



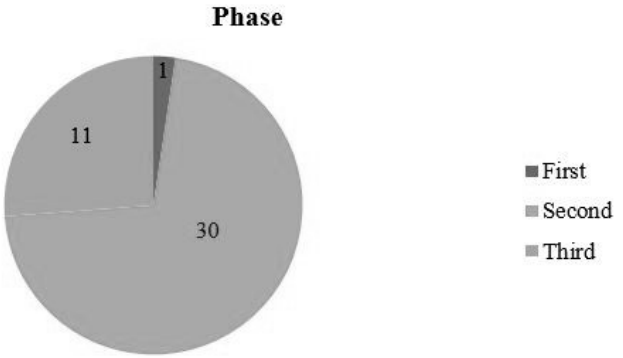
Graph 2 *Characteristics of the sample concerning the degree of stuttering*

2. State the treatment phase of the Method of Conscious Synthesis of Development during the COVID-19 pandemic.

Table 2
Characteristics of the sample concerning thephase of the method of Conscious Synthesis of Development

n=42	N	Percentage
First	1	2,38%
Second	30	71,43%
Third	11	26,19%
Total	42	100%

About the phases of the method, the most significant percentage of respondents at the time of completing the survey was in the second phase (71.43%), then the third (26.19%) and only one respondent was in the initial phase of the method (2.38%).



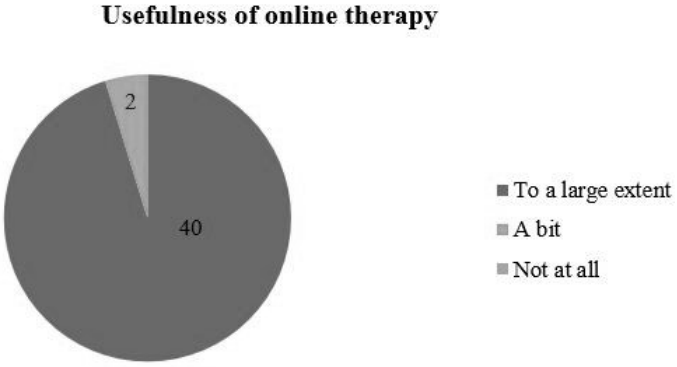
Graph 3 *Characteristics of the sample concerning thephase of the method of Conscious Synthesis of Development*

3. How much did you benefit from the speech therapy treatment conducted online during the COVID-19 pandemic?

Table 3
The usefulness of online therapy

n=42	N	Percentage
To a large extent	40	95,24%
A bit	2	4,76%
Not at all	/	/
Total	42	100%

From Table 3 we can conclude that the most significant percentage of respondents rated online therapy as useful at the time of the pandemic (95.24%), while a smaller percentage of respondents rated online therapy as not very useful (4.76%). None of the respondents marked online therapy as useless



Graph 4 *Attitudes of respondents to usefulness of online therapy*

4. During the COVID-19 pandemic, did you use any of the Method of Conscious Synthesis of Development techniques?

Table 4
Use of techniques

n=42	N	Percentage
Used all the time	10	23,81%
Frequently used	28	66,67%
Very rarely used	4	9,52%
Did not use	/	/
Total	42	100%

From Table 4 we can conclude that the most significant percentage of respondents frequently used some of the techniques (66.67%), and in a smaller percentage all the time (23.81%). The smallest percentage of respondents stated that they very rarely (9.52%) used any of the techniques.

5. Which of the therapeutic techniques of themethod did you use the most?

Table 5
The most commonly used techniques

n=42	N	Percentage
Breathing techniques	14	33,33%
Rhythm and tempo techniques	12	28,57%
Voice with easy onset	7	16,67%
Breathing and rhythm and tempo	6	14,29%
Breathing and voice with easy onset	3	7,14%
Total	42	100%

The most commonly used techniques are breathing techniques (33.33%), then rhythm and tempo techniques which include reading, storytelling and conversation on a free subject (28.57%), voice with easy onset(16.57%). Since the answer to this question did not require checking only one of the offered answers, some of the respondents stated that they most often used two methods: breathing and rhythm and tempo (14.29%) and breathing and voice with easy onset (7.14%).

6. And which of the therapeutic techniques of the method did you use the least?

Table 6
The least used techniques

n=42	N	Percentage
Breathing techniques	14	33,33%
Rhythm and tempo techniques	10	23,81%
Voice with easy onset	18	42,86%
Total	42	100%

The least used techniques in the respondents in this sample are voice with easy onset (42.86%), breathing techniques (33.33%) and then rhythm and tempo techniques (23.81%).

7. The degree of severity of stuttering during speech therapy treatment conducted online during the COVID-19 pandemic?

Table 7
Subjective sense of progress

n=42	N	Percentage
Deteriorated severity	2	4,76%
Slight deterioration	4	9,52%
At the same level	22	52,38%
Improving the degree of severity	14	33,33%
Total	42	100%

More than half of the respondents (52.38%) stated that the severity of stuttering remained at the same level as before the introducing online therapy, and the lowest percentage (4.76%) that the severity deteriorated.

8. If there has been a deterioration, estimate the degree of intensity of deterioration on a scale of 1 to 5 (1 - very little, 5- very much).

If there was a slight or significant deterioration, the subjects had at their disposal a five-point Likert-type scale on which they could indicate the degree of intensity of the deterioration. 6 respondents stated that they felt worse during the pandemic period (significant deterioration - 4.76% and slight deterioration - 9.52%), which is 14.29% of the total sample. Two respondents marked number 1 on the scale, two number 2 and two number 3.
Since the following questions were formulated as open-ended questions, respondents were free to write more comments on the questions asked.

9. In your opinion, what are the positive aspects of online speech therapy treatment and explain them?

Table 8
Positive aspects of online therapy

Answers		
1	They have more time because they do not have to travel	20
2	Continuity in therapy	9
3	Group work	6
4	Possibility to organize treatment as in the institution	4

5	Overcoming speech anxiety related to technology	3
6	There is no time spent on the administrative part of the treatment	3
7	Exercise more often	3
8	Easier arranging treatment appointments	3
9	Relaxation in a home atmosphere	3
10	More time to complete tasks	2
11	More frequent counseling by therapists	2
12	Preventing the spread of infection	2
13	More freedom in choosing exercise materials	2
14	Smaller groups	1
15	Practicing a new speaking situation	1
16	Increased self-confidence and security	1
17	Adequate replacement in emergency circumstances	1
18	Availability to a larger number of patients	1
19	No answer	1

Table 8 shows the respondents' answers to the question about the positive aspects of online therapy. It seems that the greatest advantages of such organized therapy are that they have more time for themselves and their free activities and do not waste that time on the travel to the Institute, continuity during exercise, group work and successful organization of therapy sessions regardless of patients were not physically present in the institution.

10. In your opinion, what are the negative aspects of online speech therapy treatment and explain them?

Table 9
Negative aspects of online therapy

	Answers	
1	Bad internet connection	16
2	No negative side	11
3	Less effective than live therapy	9
4	Less direct contact with other people	7
5	Poorer visibility of speech disorders	2
6	Lack of group therapies and activities	1

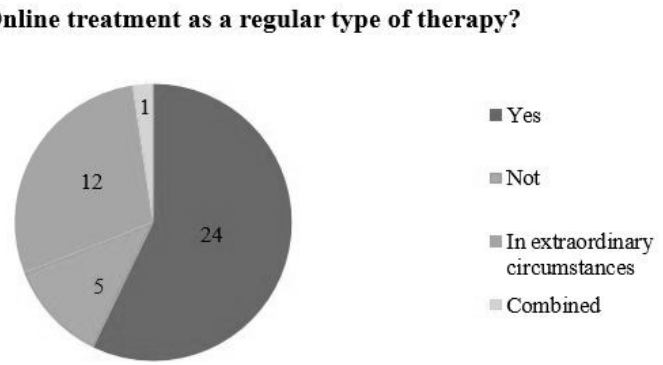
As the biggest obstacle to performing online therapy, the respondents mentioned the objective interference of a bad internet connection (weak signal, bad sound, picture interruption, etc.). The most answers were that there were no negative sides. Respondents also believe that this type of therapy is less effective than live therapy and that the lack of direct contact with other people prevents the complete and successful implementation of the method.

11. Do you think that online speech therapy should be introduced as a regular treatment method in the Institute?

Table 10
Inclusion of online treatment as a regular type of therapy

n=42	N	Percentage
Yes	24	57,14%
No	5	11,90%
In extraordinary circumstances	12	28,57%
Combined	1	2,38%
Total	42	100%

More than half of the respondents (57.14%) believe that online treatments should be included as a regular type of therapy in the institution.



Graph 5 *Attitudes of respondents towards the introduction of online therapy as a regular form of therapy*

12. Your other observations about online speech therapy treatments you consider relevant and not covered by the previous questions?

Table 11
Additional observations on online speech therapy treatments

1	No other observations	23
2	Gratitude to the therapist	7
3	Exercising independently of attendance at the Institute	3
4	Mutual interaction and patient counseling	3
5	Good organization in a short time	2
6	Discipline when maintaining online therapy	1
7	Organizing group therapies online	1

Most respondents (23) have no additional observations about this type of speech therapy. Some respondents notice the importance of exercise when they are physically distant from the Institute, as well as discipline in these types of therapy and the possibility of organizing group online therapies and mutual interaction and counseling.

DISCUSSION

Erickson and colleagues (2016) see the benefits of an Internet program modeled on the Camperdown program for people who stutter, in that a person can always re-access the program (or only some parts) if relapses occur, which are inevitable when stuttering question; the financial burden is negligible; a person independent of the therapist can assess their success and decide on treatment; success is considered to be better with greater client engagement. The results of their study indicate that in some clients there was a decrease in the frequency and severity of stuttering (especially in those who logged in into the program more often) even without contact with a therapist (Erickson et al., 2016), which coincides with the results we also obtained in our research.

By comparing the Camperdown program's success online and directly face-to-face with a therapist, it was found that clients spent significantly less time working with a speech therapist online than when working directly with him. Also, the elderly less used the program, while people with more severe stuttering and those who had previously gone for treatment participated more often in the program (Carey et al., 2010; according to Brignell et al., 2020).

As our clients stated in the survey, the advantage of this approach and online application of the Method of Conscious Synthesis of Development is providing services in the natural environment for clients and reducing travel costs.

There is evidence that this approach is better than the traditional one because there is a greater generalization of what is learned and clients are more satisfied (Legg & Langhorne, 2004; Von Koch, Wottrich & Holmqvist, 1998; according to Theodoros, 2011).

The possibility of video calling allows the therapist and the client to see each other, which to allow the establishment of intimacy. The therapist can observe the client stuttering and notice physiological reactions and subtle behaviors and covert stuttering.In younger children, observing parents as they implement treatment guidelines allows for counseling and feedback (Lowe, O'Brian & Onslow, 2013).

The advantage of this type of therapy is that it takes less time to provide services than face-to-face and has the same degree of success in reducing stuttering symptoms. This model of service delivery can be significant only if it does not affect patient satisfaction (Carey et al., 2010; according to Brignell et al., 2020).
The benefits of providing services this way (such as flexibility, availability, and reduced costs) lose some of their significance if clients do not access the program regularly and complete tasks, which our clients pointed out in the survey (Erickson et al., 2016).

Lowe et al. (2013) point out that not every patient is suitable for using online therapy. Other factors should be taken into account, such as individual characteristics, lifestyle, financial situation, availability of technology, etc. Even if all socio-economic factors are suitable, some clients will prefer therapies directly in the institution, which was also pointed out in our survey.

CONCLUSION

Based on the results obtained in this research and what we found in the literature, we can report several conclusions:

1. Our experience gained during the COVID-19 pandemic indicates that online speech therapy can be successfully implemented during a state of emergency and other situations that prevent clients from traveling or when their movements could endanger their health status, especially persons from risk groups.
2. This type of speech therapy treatment primarily ensured the continuity of the started therapy. It was possible to monitor the client's speech and primary biological rhythms (quality of sleep and dreams), mood, fulfillment of daily tasks, and giving new ones. Clients had better control of their speech and were able to share their experiences, thoughts, fears, and receive adequate advice and exercises, and monitor progress in using fluent speech techniques.
3. Theodoros (2011) warns that although telerehabilitation has certain advantages, there are also challenges that must be addressed before it becomes com-

mon practice. These challenges relate to professional issues, cost recovery, data on clinical outcomes and costs, and available technology.

4. For most speech therapists, direct communication with the client "face-to-face" is the gold standard in therapy. Of course, many therapists need to be trained on how to provide professional services this way adequately.
5. Telerehabilitation is a new way of providing services in speech therapy. In order to become an integral part of the usual practice of providing services in this domain, it is necessary to engage the profession by making efforts and researching this area in more detail.

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ONLINE LOGOPEDSKI TRETMAN I PRIMENA METODE SVESNE SINTEZE RAZVOJA TOKOM EPIDEMIJE IZAZVANE KORONA VIRUSOM

Sažetak: U vreme epidemije izazvane korona virusom, kada su komunikacija i socijalizacija ograničene i smanjene, može doći do ometanja normalnog funkcionisanja svake osobe, a posebno osobe koja muca. Usled nemogućnosti klijenata da napuštaju svoje kuće, putuju i dolaze na kontinuirane i planirane logopedske tretmane u ambulantu Zavoda sprovodili smo online individualne i grupne tretmane osoba koje mucaju putem video poziva preko aplikacija Viber, Mesinger i Instangram. U ovom radu predstavićemo rezultate ankete kojom su praćene reakcije i zapažanja klijenata na ovaj vid online logopedske terapije i mogućnost primene metode Svesne sinteze razvoja. Metodologija: Online individualni i grupni logopedski tretman realizovan je sa 42 klijenta od ranog školskog uzrasta do odraslog doba. Svi klijenti bili su od ranije uključeni u program metode Svesne sinteze razvoja za korekciju mucanja i bili su u različitim fazama te metode. Ovaj vid logopedskog tretmana pre svega obezbedio je kontinuitet započete terapije. Bilo je omogućeno praćenje govora klijenta kao i njegovih osnovnih bioloških ritmova (kvalitet spavanja i sna), raspoloženje, ispunjavanje svakodnevnih zadataka i davanje novih. Klijenti su imali bolju kontrolu govora, a mogli su da podele i svoja iskustva, razmišljanja, stahove i da dobiju adekvatne savete i vežbe, kao i da prate napredak u korišćenju tehnika za fluentan govor. Na osnovu dobijenih rezultata i iskustava stečenih u periodu pandemije COVID-19 može se zaključiti da online logopedska terapija može uspešno da se realizuje ne samo za vreme vanrednog stanja, već i tokom drugih situacija koje onemogućavaju putovanje klijenata ili kada bi njihovo kretanje moglo da dovede do ugrožavanja njihovog zdravstvenog stanja, posebno lica iz rizičnih grupa.

Ključne reči: mucanje, svesna sinteza razvoja, online logopedski tretman

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THERAPEUTIC TECHNIQUES AND ACTIVITIES IN ORDER TO MINIMIZE THE NEGATIVE EFFECTS CAUSED BY THE COVID-19 PANDEMIC

Abstract: Covid-19, as a total unknown on a global level, has affected all segments of our lives, affecting us, as therapists and employees, as well as users of social care institutions, one of the most vulnerable categories of society. Faced with the challenges of the new situation, and in order to mitigate all the negative consequences caused by the Covid-19 virus pandemic, certain therapeutic activities and techniques were applied in the work with patients through workshop work. Adequate selection, application and delivery of activities and therapeutic techniques, had a positive effect on waking, directing and retaining attention, improving mood, improving voluntary activity and motivation, psychomotor activities, increasing relaxation, releasing, braking and controlling negative impulses or states and maintaining or improving working ability. In order to examine the success of the implemented activities, a questionnaire (“Questionnaire for the assessment of therapeutic techniques and activities to minimize the negative effects caused by the Covid-19 pandemic”) was used, consisting of 20 combined questions (double choice and open questions), classified in four categories: workshops of cultural and entertainment character, psychological workshops, work-occupation activities and tablet video call. A representative sample of the research consisted of 44 patients of permanent accommodation services of a social protection institution, female, in a homogeneous population of persons with mental disorders. The results of the research obtained by quantitative analysis speak in favor of the expected outcomes (the worst result is 68%) and indicate the positive effects of the applied techniques on the overall psychophysical condition of the patient. Qualitative analysis provided insight into the quality of the workshops and novelties in the fields of feelings that arose during them, giving us guidelines for further professional work and new research in this field.

Keywords: Covid-19, social protection, therapeutic techniques, mental disorders, negative effects

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INTRODUCTION

The Covid-19 virus has spread across the planet, crossing from one continent to another, killing hundreds of thousands of people, attacking the organisms of several million people, seeking fear in billions of the inhabitants of our planet. It is a systemic crisis of human development, which reflects our disturbed interaction with nature and its ecosystem, indefinite inequalities between people and indefinite economic activities. All that the medical "profession and science" offer us at this moment is: to wash our hands and move away from each other, and the safest isolation (Mićunović, 2020)

An old proverb says: "It does not snow to cover the shore, but for each animal to discover its trace." The pandemic has revealed all the weaknesses and all the failures in the "development strategy" of modern societies and opened space for re-examining many of the prevailing values of the system in our civilization. The Covid-19 virus pandemic is not over yet, so all its consequences have not been registered and measured. This vicious chain of insecurity and panic threatens to emerge as one of the most severe consequences of a pandemic affecting a multitude of social events - visibly weak social cohesion, solidarity and tolerance, and growing intolerance. Although not everything is over and clarified with the corona pandemic, impatient commentators are in a hurry to conclude that "nothing will be like before the corona pandemic". The fact is that people, as social beings, who are accustomed to direct communication, find it difficult to experience isolation, spatial distance and reduced greater mobility due to reduced traffic, with "limited freedom of movement", for many categories of the population. Although everyone is, in one way or another, potentially affected by this pandemic, some individuals and groups are more vulnerable, suffer much more damage, and have a much longer path to recovery.

One of the explanations from the patients is that the outside world has finally started to look like their inner world, and that this is a situation that they have been preparing for all their lives.

The pandemic has both short-term and long-term consequences for the mental health of residential accommodation patients. Increased depression, post-traumatic stress disorder, anxiety, loneliness and many other behavioral problems occur. All major world crises, even previous epidemics and pandemics, have the consequences of many problems in the field of mental health (Neria & Galea, 2008). Examples include global catastrophes and the effects of major climate change: the SARS epidemic, the attack on a shopping center in New York, hurricanes and earthquakes around the world, oil spills in ocean areas, and a new pandemic. Psychiatrists warn of a "kuna" of mental illness from problems that accumulate during time constraints, especially among children and the elderly (Cohen et al., 2017) Both experts and the users of residential accommodation themselves

state that their mental health has deteriorated, as their daily routines have been disrupted, which has made them feel good and safe. Psychotic episodes, mania and depression occur, as they themselves state, due to the separation of family and friends, as well as the fact that their movement is the most difficult. All this leads to the appearance of worsening of the basic symptoms of the disease, as well as new symptoms within the already present mental disorders. A new “corona psychosis” is emerging (McRae, 2010). It is now crystal clear that mental health must be treated as a central element of our response to the Covid-19 pandemic and recovery.

In addition to the additional emotional pressure, the corona virus also affected the functioning of the social welfare institution. The main problem was related to the uncertainty that arose because it was not known how long the emergency measures would last and when exactly they could rely on in case the crisis lasted longer. It cannot be said that this was a favorable situation, because for many meanings, the pressure was increased and uncertainty was added and facing completely new challenges. Wilcock describes mental health as a state in which people can be creative and through research can experience all human emotions, adapt appropriately and meet life's needs without difficulty. When a person is in a new situation, as is the case with a pandemic, he tries to deal with it with the help of the skills he possesses, and if that is not enough, he tries to learn and develop new useful skills. However, if the situation remains out of his control, he seeks a crisis. If he is not able to overcome all the challenges of the crisis on his own, help is provided by structural persons, in our case therapists and psychologists, through various types of work-occupation or workshop activities (Wilcock, 2006). The basic philosophy of occupational therapy speaks of man as an active being who, through purposeful activities, interacts with the environment and manipulates it. Therapists believe that occupation is the highest level of human functioning, ie to develop and integrate human physical, mental and spiritual potentials through the process of performing activities (Creek, 2003). Activity in man creates certain functional requirements that cause neuroplastic changes and organization, and therefore the occupation defines us in a physical, mental, social and spiritual sense. The uniqueness of therapeutic techniques and methods is in the belief that they are the focus tool for maintaining mental health, fulfilling free time, as well as bringing well-being to the individual (Petrović, 2017). All activities within these techniques meet the numerous needs of each patient (needs for achievement, belonging, respect, self-esteem, respect ... or simply basic human needs for support, understanding, comfort and overcoming problems).

Faced with the new situation and all its challenges, the users of our institution were additionally involved in a series of work-occupation activities and psychological workshops, all in order to overcome the negative effects caused by the pandemic. Patients needed to regain self-confidence, calm psychomotor restlessness, reduce tension, release negative energy, help build relationships with

individuals or groups, and preserve work habits. Very often, recreational and work activities need to improve their physical condition. Working ability should also be observed and assessed based on the patient's maximum ability to resist stress and cope with unexpected situations (Townsend & Wilcock, 2004). In addition to cultural and entertainment workshops (literary section, thematic workshops, interesting geography, associations, quiz), psychological workshops (workshops on emotions, empathy, tolerance, interpersonal relationships at home, addictions, music therapy), occupational activities (handicrafts) , decoupage, arranging both the interior space and arranging the yard circle). We paid special attention to telemedicine, in our case, organized in the form of a video call via the Viber application on a tablet computer.

Widespread isolation and social distancing have led many to rely on Internet access from home to continue working or studying and to maintain communication with, ie. contact with family and friends. Telemedicine is defined as the use of information technology — tablets, telephones, and computers — to provide health care services when the health care provider and the patient are not in the same location (Creek, 2003b).

The Covid-19 pandemic has led to the expansion of telemedicine in many countries and can serve as a catalyst for its more frequent use. It enables the continuity of providing health care to patients with Covid-19 who meet the conditions for it, with a lower risk for both patients and health care workers. In the long run, it provides a more cost-effective model that can be easily adapted to the epidemiological profile of the Western Balkans. The use of digital technology is a link, that invisible bridge between people and alleviates social distance.

METHOD

Sample and procedure

The sample in this research consisted of 44 females, permanent users of the Home for Adults and Elderly "St. Vasilije Ostroški - Miracle Worker" from Novi Bečej. All patients are long-term residents of the home and are people with mental disorders (primarily with a diagnosis of disorders from the psychotic spectrum). It should be noted that the number is small when taking the total number of patients, but due to the use of these techniques in the research, as well as awareness and ability to honestly answer questions, this is still a representative sample in relation to the home population.

Tools

The research used a questionnaire specially made for this research and it is a questionnaire for the assessment of therapeutic techniques and activities in order to minimize the negative effects caused by the Covid-19 pandemic). It consists of 20 combined questions, adapted to the possibilities of understanding the special population. The questions are mostly with the possibility of double choice yes / no, there are also open questions, which opens the possibility of qualitative data processing. By extraction, four categories were obtained that measure the instrument, namely: success of realized workshops of cultural and entertainment character, then psychological workshops, work-occupation activities, but also the degree of satisfaction and success in minimizing the negative consequences of the virus using video calls from home tablet.

Draft work

Based on the goal of the research, as well as the initial hypotheses, independent variables can be reported in this research, and they represent the workshops themselves, occupational therapy, as well as the possibility of video calling via tablets. The dependent variable is precisely the reaction to the mentioned stimuli, which are sedative and distractible effects, the feeling of belonging to the group, the feeling of usefulness and motivation. The initial assumptions concerned precisely the increase in the intensity of these constructs in patients who were exposed to the mentioned independent variables. At the same time, the aim of the research was also to increase the intensity of the constructs.

THE RESULTS

The results of the conducted research speak in favor of the positive impact of the applied techniques and activities on overcoming the crisis during the isolation caused by the Covid-19 pandemic. Of the 44 respondents selected for the representative sample, as the most conscious, stable and thus able to give relevant answers to the questions, the highest percentage of them is satisfied with the feeling of usefulness in performing occupational therapy, as can be seen in Table 1.

Table 1
Types of activities and percentage of patients who reported positive or no effect of applied therapeutic activities.

	effects of techniques	percentage of positives	percentage of negatives
Cultural-entertaining and educational workshops	pleasure	88.63	11.37
	sedative	68.18	31.82
	distractible	77.28	65.23
	motivational	86.36	13.64
	increase cohesion	68.18	31.82
	no impact (-)	18.18	81.82
Psychological workshops	sedative	90.90	9.1
	distractible	90.90	9.1
	increase in calmness	90.90	9.1
	pleasure	90.90	9.1
	increase cohesion	68.18	31.82
	no impact (-)	11.36	88.64
Occupational therapy	sense of usefulness	95.45	4.55
	sedative	81.81	18.19
	distractible	81.81	18.19
	no impact (-)	18.18	81.82

Note: percentage of positive - percentage of patients who answered about the effective and positive effect of techniques and activities; percentage of negative - the percentage of patients who estimated that the applied activities had no effect on them

DISCUSSION

Adequate selection, application and dosing of activities and therapeutic techniques, had a positive effect on waking, directing and retaining attention, improving mood, improving voluntary activity and motivation, psychomotor activities, increasing relaxation, releasing, braking and controlling negative impulses or states and maintaining or improving working ability. It was noticed that the patients who managed to fill the time with quality behaved more functionally. Patients were less concerned with misinformation and conspiracy

theories, respected the rules and more easily accepted the official interpretation of events. The impression is that the users of psychiatric services have endured this much better than the ordinary population. The results of the research obtained by quantitative analysis speak in favor of the expected outcomes (the worst result is 68%) and indicate the positive effects of the applied techniques on the overall psychophysical condition of the patient. Qualitative analysis provided insight into the quality of the workshops and novelties in the fields of feelings that arose during them, giving us guidelines for further professional work and new research in this field.

A quote from a street graffiti from Hong Kong reads: “There is no going back to 'normal', because 'normal' was the problem in the first place.” However, the fact that we are all exposed to danger should unite us and, through compassion, solidarity, and creativity, come out stronger, more resilient and more humane. It is difficult to predict how life will change, but it is time for change. A global pandemic is something that has great traumatic potential, but the consequences will largely depend on how we as individuals and society organize ourselves in response to it.

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ANNEX

Questionnaire layout for the assessment of therapeutic techniques and activities in order to minimize the negative effects caused by the Covid-19 pandemic.

In front of you is a short questionnaire. Next to each question, you are given answers that you need to complete. You will write the answer to some questions in the form of a sentence. The questions relate to the period of isolation during the corona virus pandemic. Please read carefully and answer as honestly as you can. If you have questions or ambiguities, feel free to ask the examiner. Thanks!

1. How did the cultural and entertainment workshops affect your mood? (literary section, thematic workshops, interesting geography, associations, quiz ...)

- I felt more satisfied YES NO
- I'm less upset YES NO
- I diverted my thoughts from the epidemic YES NO
- I had more will YES NO
- I became closer to other patients YES NO
- the workshops did not affect me YES NO
- something else? _____

2. How did psychological workshops affect your mood? (workshops on emotions, empathy, tolerance, interpersonal relationships at home, addiction, music therapy ...)

- I'm less upset YES NO
- I diverted my thoughts from the epidemic YES NO
- I'm calmer YES NO
- I felt more satisfied YES NO
- I became closer to other patients YES NO
- the workshops did not affect me YES NO
- something else? _____

3. How has occupational therapy affected your mood? (knitting, crocheting, decoupage works, arranging the interior, arranging the yard circle ...)

- I felt useful YES NO
- I'm less upset YES NO
- I diverted my thoughts from the epidemic YES NO
- occupational therapy did not affect me YES NO
- something else? _____

4. How did you feel after the video call via tablet during the isolation period?

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TERAPIJSKE TEHNIKE I AKTIVNOSTI U SVRHU MINIMIZIRANJA NEGATIVNIH EFEKATA IZAZVANIH COVID 19 PANDEMIJOM

Sažetak: Covid 19, kao totalna nepoznanica na globalnom nivou, pogodila je sve segmente naših života, uticala kako na nas, kao terapeute i zaposlene, tako i na korisnike ustanova socijalne zaštite, jednu od najvulnerabilnijih kategorija društva. Suočeni sa izazovima novonastale situacije, a u cilju ublažavanja svih negativnih posledica izazvanih pandemijom Covid 19 virusa, u radu sa korisnicima primenjene su određene terapijske aktivnosti i tehnike kroz radioničarski rad. Adekvatan izbor, primena i doziranje aktivnosti i terapijskih tehnika, pozitivno je delovalo na buđenje, usmeravanje i zadržavanje pažnje, poboljšanje raspoloženja, poboljšanje voljne aktivnosti i motivacije, psihomotorne aktivnosti, povećanje relaksacije, oslobađanje, kočenje i kontrolu negativnih impulsa ili stanja i održavanju ili poboljšanju radne sposobnosti. U svrhu ispitivanja uspešnosti realizovanih aktivnosti, korišten je upitnik (“Upitnik za procenu terapijskih tehnika i aktivnosti u svrhu minimiziranja negativnih efekata izazvanih Covid 19 pandemijom”) koji se sastoji od 20 kombinovanih pitanja (dvostrukog izbora i otvorena pitanja), svrstanih u četiri kategorije: radionice kulturno-zabavnog karaktera, psihološke radionice, radno-okupacione aktivnosti i tablet video poziv. Reprezentativni uzorak istraživanja činile su 44 korisnice usluga trajnog smeštaja ustanove socijalne zaštite, ženskogpola, u homogenoj populaciji osoba sa mentalnim poremećajima. Rezultati istraživanja dobijeni kvantitativnom analizom govore u prilog očekivanim ishodima (najlošiji rezultat 68%) i ukazuju na pozitivne efekte primenjenih tehnika na celokupno psihofizičko stanje korisnika. Kvalitativnom analizom dobijen je uvid u kvalitet samih radionica i novine na poljima osećanja koja su se javila tokom istih, dajući nam smernice za dalji stručni rad i nova istraživanja na ovom polju.

Ključne reči: Covid-19, socijalna zaštita, terapijske tehnike, mentalni poremećaji, negativni efekti

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PSYCHODYNAMIC VIEW OF THE CHANGING WORLD

Abstract: Is the world we live in changing at high speed? What do those changes mean at the indvidual, family and societal level? Challenges are everywhere around us, now increased by the speed of new technology, new ways of communication, and social networks set value systems different from those in the past. Day-to-day psychiatric and psychotherapeutic work faces challenges of a different form of understanding that these changes and transference phenomena speak in supporting the stability of current psychodynamic thoughts. This paper analyzes some individual and group phenomena we encounter in psychotherapeutic practice and some specific situations we face as psychiatrists often exposed to a whirlwind of economical and political influences our patients are exposed to. They ask of us not only understanding but also advice and direction, things that should guide them back to their lost stability. The conclusion emphasizes the view that the psychodynamic framework represents an important support for our work and can provide for explanations better than numerous other theories.

Keywords: mental health, psychodynamic interpretation, psychoanalysis

The emergence of psychoanalysis in the late 19th and early 20th centuries had its roots in the atmosphere of the world at that time. Sigmund Freud, a Viennese doctor, started a new revolutionary chapter, not only in the treatment of people with mental health disorders, but also in medicine, culture, anthropology, and history, and became one of the most-cited scientists in history. The basic premise of Sigmund Freud, who began his career as a neurologist was to explain the influence of unconscious mental processes on human behavior and to apply a neural model of behavior in an attempt to develop scientific psychology (Kendel, 2005). The science of the brain at that time was not sufficiently developed, it abandoned the neural model, replacing it with a purely mentalistic one based on verbal reports of subjective experiences (Kendel, 1999). The medical basis of psychoanalysis became overlooked, as Freud's method of free associations, theory of sexuality, and other areas of psychoanalysis moved into social sciences and arts.

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In this way, I believe that although the position of this theory is important during the 20th century, we must not forget the basic thinking of Sigmund Freud, who stepped from the laboratory into the entire human existence, that the human brain is the center of our mental, spiritual, and emotional processes. That any mystification of this revolutionary method, which was later the basis for psychodynamic thought, would lessen our outlook on life.

There are a number of ethical and professional issues considered in connection with public commenting on the mental health of public figures (Stamatović Gajić, 2020), but also contemporary products of our civilization that affect those issues. In addition, the social environment and, above all, the influence of the group is the place of most intensive changes that affect the individual. By understanding sociotherapy as a therapeutic method of group influence on the individual with an emphasis on environmental and interpersonal factors that affect adaptation (Gajić & Stamatović Gajić, 2016), we open new chapters in a very intense time ahead of us.A psychiatrist and psychotherapist should be an engaged intellectual. In terms of psychoanalytic reflections on a changing world, Halina Brunning in 2012, with a group of authors, looked back at: the world of work, fantastic object desires, the world of interconnectedness, and the psychoanalytic reflections on the world around us (Brunning, 2012).

In the world of work, one of the modern problems is burnout syndrome, which is the main threat to the physical and psychological. It is the result of growing expectations, workloads, and blurring the boundaries between work and leisure. Burnout as a form of depression is becoming a serious problem. Risk factors are personality and lifestyle on the one hand and on the other only the work environment called organizational risk (Lohmer, 2012). Lohmer emphasizes the importance of organizational combustion so that different organizations produce different combustion. He also points out that special personalities, of the compulsive profile, fit into the bureaucratic types of organization and often overlook the dangers due to the unconscious relationship of their personality structure and the organization itself. This is followed by a loss of motivation, disorganization, disappointment, loss of courage, and physical symptoms (Lohmer, 2012).

For this, a nowadays common problem, we can see it as a gap between cognitive and the demands of existential, economic thought. Without asking about human capacities at the moment, it seeks solutions for economic development and sets new demands. I believe that today's man fits his personality according to the organization and the moments of the market, and unconsciously activates a series of defense mechanisms that spend his energy.

In the same book, Claudia Nagel, a banker and Jungian-trained analyst, shows money as a fantastic object of desire. There is an attraction between money and its significance for the individual and society by analyzing some historical moments. The financial crisis of 2008 is not the fault of the bankers themselves and

the desire for investments, but it is a broad social phenomenon that is almost like a perverse attitude of our time towards it. Money has always been and is a fetish of society, but also much more: a “fantastic object” of desire as she says (Nagel, 2012). What makes money so “special” and what causes the polarization of attitudes towards it that we may not even think about. The very notion of “fantastic object” in this area is introduced into the psychoanalytic discussion of market phenomena by Tuckett and Taffler describing gradual emotional phases. From excitement over innovation, manic reactions, to panic and guilt. This excitement, they say, contributes to people beginning to believe that something is happening in the market, which gives them a sense of “fantastic” and, on the other hand, they are unable to assess the existing ones (Tuckett & Taffler, 2008). Their notion comes from two psychoanalytic concepts, “object” as a mental representation of something and “fantastic” as imaginary desires and speaking actions and investment means (Nagel, 2012).

The economic aspect, on the other hand, is important in the system of maintaining the mental health of both society and the individual in concrete financing. Mental disorders make up 5 of the 10 main causes of disability, with those numbers, society is impacted in a way in which these disorders create a 10% financial burden on society. The costs that arise are real, but there are also intangibles due to the loss of quality of life (Gajić & Stamatović Gajić, 2016). The lack of a real “object” related to the potential threat of obtaining health care is upgraded to a “fantastic” performance by intensifying existential anxiety.

Money gives ambivalence according to the basic structure, says Claudia Nagel, and points out that it contains a divine-creative and diabolical-destructive aspect that are in dialectical opposition. Money can transform us, enable the development of more individuality, but it can also destroy the soul in the direction of obsessive desire for more wealth (Nagel, 2012).

Psychodynamically, all processes at this time that are related to changes in the threat to existence from the satisfaction of the general that implies survival, to those that are an upgrade or the result of the process of sublimation, change their course and lead to crises. As mentioned, money is an object, a mental representation of our life, a part of our mental representation. The absence of that object, which carries individual meanings, carries an affective response. I will cite an example from a relatively recent event in the USA related to protests across the country after the murder of a black man by the police. That situation of brutality that surfaced as a social media video of Officer Derek Michael Chauvin standing propped up on George Floyd's neck after which he died on May 25, 2020, triggered the writing of protests through the “Black Lives Matter” across the USA which they consider to be the most massive in the history of the country (Buchanan, Patel & Bui, 2020).Of course, racial problems have existed in the USA for a long time, and citizens have protested in various ways, but I think that the moment of the coming

economic crisis and job loss in the midst of the Covid-19 epidemic had a significant impact on mass aggression from all sides.

Both research and media during that period considered whether the protests affect the rise in the number of infected. Only rarely they analyze if there is an interaction between the situation in American society, in which millions of people lose their jobs, and an already reduced threshold for reacting to problems of racism that has existed for years. It seems to me that this is a confirmation of what we have mentioned, money is an object, mental representation and the removal of its existence at that moment moves in the experiential to other weak links of our existence. We fear poverty and hunger, we fight for survival, but we do not notice the subtle mental mechanisms of changing our affective and cognitive interactions with the world around us.

Philip Boxer considers, in the light of psychoanalytic reflection in a changing world, the Internet and the Twitter revolution. It considers our relationship to an increasingly dynamic environment and how it changes us as an individual, psychotherapist, or company (Boxer, 2012). Boxer says that psychotherapists are comfortable studying the relationship between conscious and unconscious phenomena, that is, "surfaces" or "below the surface". But their way shows difficulties including the dynamic impact of changes in the way their environment is organized. The Twitter revolution is compared to Gutenberg's printing revolution (Boxer, 2012).

Let us try to understand the following. The Twitter revolution is not just another way of accessing information. It is not an approach like in books where there is an exchange of ideas, desires, and creations of the writer with others through the individual when he is alone at the moment. Many of our patients read in their loneliness, depressed looking for comfort, anxious-looking for an explanation. They read for many other reasons which give them pleasure, expands knowledge of course. But we are also witnessing their loneliness. In our studies, psychiatric patients in Serbia were more family-focused than those in the United States (McCormick et al., 2008). Fighting in that way against that loneliness, many of them today almost shyly participate in social networks because they are afraid of exposing themselves to an environment that can strongly discriminate against them.

The Internet is an interactive experience in which privacy is not possible, it is excluded in various ways, especially through social networks. Twitter interactivity leads to extremes. A 140-character text message goes to the social network feeds of a large number of people. Thus begins the call to interaction (Boxer, 2012). But let's think further. Do you think lonely individuals, who due to their fears, depression, or personality, spent days reading books, on their social media, would be more active, open or not? Has this method changed anything or introduced just another dimension of the disorder? One of the questions relies on our comparative

study with the United States which showed that those patients who have severe mental disorders by their very condition in different cultural settings have reduced physical activity (McCormick et al, 2009). Empirical results in terms of psychotherapy, according to what we get during psychotherapy, show that the Internet itself brings more fun, and decreases physical activity. Of course, this requires a study that would qualify our observation.

Another clinical experience that I notice is that not much positive has come with social networks in solving the problem of loneliness and more importantly, authentic interactivity. In some cases, the exchange of information has accelerated the contacts of individuals who were not allowed to look for partners in the usual way, and it is now easier for them because it is more socially acceptable. However, isolated individuals have become more isolated with the false impression that they belong to groups of similar interests and in that way participate in life. Several times the social network was a mirror of pathological paranoidogenesis, where with an external stressor and event, the patient interprets the messages of the social network to the level of psychotic decompensation. Finally, as professionals through the Internet, we got a faster and better exchange of professional information, but we also accelerated our lives.

The Internet is changing rapidly and is a very dynamic concept that is constantly evolving and is a place where different patterns of communication and social relations take place. Some claim that the Internet itself can lead to social isolation of psychological disorders such as depression (Mihajilović, Hinić, Damnjanović, Gajić & Djukić Dejanović, 2008). Whether the interactions are just that simple, I'm not sure. One of the important bases for understanding the influence of external factors in the development of depression is certainly the personality (Gajić & Pejović, 2001) who, even in the case of the influence of the Internet and social networks, must be considered in the new research. Also, the Internet, as we previously guessed, has become a basic form of human interaction and a major factor in socializing and constituting one's psychological integrity (Mihajilović, Hinić, Damnjanović, Gajić & Djukić Dejanović, 2008).

What seems important to me is to say, noting that it takes a long time to pass but also to do quality research, that the new age of Internet and social networks in human history have begun the selection of our species to something new. I don't know if we will survive, but I'm sure we won't be the same.

Social networks are becoming a part of our lives and in a subtle way, they take our time and modify our communication. We cannot help but think whether our world of objects and relations, which in its early development did not arise through social networks but through the real relationship between mother and child, began to create a new interactive relationship and how much the object world changes in our experience.In this way, new papers see the importance of psychodynamic understanding of the specifics of online communication in telepsychiatry (Stamatović Gajić, 2020).

Earlier research indicates ways in which the intensity of internet addiction and the symptoms of anxiety, separation and depressive symptoms are related. Thus, Cheng-Fang Yen and co-workers researched in a group of adolescents with ADHD these aspects as well as self-esteem. He came up with results that indicate that higher physical symptoms and lower self-esteem are present and related to Internet addiction in this category (Cheng-Fang, Wen-Jiun, Tai-Ling, Pinchen & Huei-Fan Hu, 2014). Bahrainian and co-workers scored as much as 40.7% of those with internet addiction among the surveyed group of students, but there was also a significant correlation between depression, self-esteem and internet addiction (Bahrainian, Alizadeh, Raeisoon, Gorji & Khazaee, 2014).

Studies of the relationship between psychopathology and personality in people with problems using the Internet (Roma et al., 2019) show that respondents with problematic use of the Internet showed a higher result on psychopathological scales. That is, a lower level of kindness and emotional stability could predict problematic Internet use (Roma et al., 2019).

These studies show that the problem of Internet addiction exists in various categories of patients, but also that the use of the Internet itself leads to certain symptoms. However, this medium may be interesting for understanding the function of some aspects of the physiological and psychological of our mental space, and that we should conduct more serious research than those based only on phenomenological aspects and correlative relations. In everything, it is important to mention that social networks, Facebook, Twitter, and Instagram play a significant role in informing but also misinforming so that our knowledge is beginning to be measured in some social circles through them.

In a professional sense, we can say that this is the age of the information boom, which has given many of us the opportunity to get the most relevant information from science and the field we are dealing with in the most optimal time. Also, mutual exchange through words, lectures, video conferencing, direct contact with colleagues and experts around the world accelerates the progress of science and perfects our practice. Telemedicine, i.e. telepsychiatry and telepsychotherapy, occupy a practical aspect of providing help to those who could not reach it before. In the latter, many questions are opened for some future research (Stamatović Gajić, 2020). Searching the literature, I was not able to find any relevant data, study, or article that considers the characteristics of the psychotherapeutic process, transfer, and countertransference in the use of the telepsychotherapeutic method. We have to admit that it is unusual not to talk about it.

Bearing in mind that every fourth person at some point in their life has a problem or disorder in the field of mental health, we concluded that in this century, the media have a great role in better understanding and promoting mental health. Also, this attitude leads to the conclusion that it results in the improvement of the same and consequently in the improvement in this area (Stamatovic Gajic, Gajic &

Maksimovic, 2008). However, experience in practice has shown that the media are not ready for a positive attitude and help in promotion and destigmatization, but for sensationalism that brings them profit, thus maintaining the negative attitude of the majority towards this topic (Gajic, 2020).

Guided by the idea of the possibility of conducting research on issues related to the psychodynamic view of the world in chaos in our environment, William Meyers in his monograph tries to expand the roots of irrationality that come to him from fantasies, beliefs, and feelings beyond our conscious life. Through the methods and concepts of the social sciences, he tried to place psychodynamic research on a more scientific basis (Meyers, 2015).

We are witnessing many social and individual changes that are in the environment around us. In this paper, I use part of previous research and observations related to the integration of psychoanalytic and psychodynamic concepts.

Yuval Noah Harari, a historian from Israel, in his bestseller Sapiens, reminds us that Homo Sapiens, this modern man who rules the planet, was “just an insignificant animal” about 70,000 years ago and lived in one part of Africa. In the years ahead, he gradually transformed the world in which he lives and became the master of the planet, reaching the edge of “becoming a god”, trying to gain eternal youth but also the ability to create and destroy, as this author states. As much as we have mastered the world, increased food production built states, and cities, we have not reduced the amount of suffering around us (Harari, 2018).

What is behind the constant impotence of our species, observing history and the present time? What is this force that we have not mastered or have not understood enough? How vulnerable is man really in the present moment?

Only a few years before this time, Mayers analyzed the problem we were facing and highlighted it as an important, widespread irrationality. Many conflicts around the world, mentioning the Balkans, in episodes of blind destructiveness, confirm that among the intense emotional forces and those beyond our consciousness, is the deep irrationality of the political scene (Meyers, 2015).

That part of the revolution that lasted until 30,000 years ago is called the cognitive revolution, and as a result of possible gene mutations in the internal synapses of the brain of Homo sapiens. The possibility of thinking and communication develops and the new language enables us to conquer the world around us (Harari, 2018).

Here, I would like to refer to the mentioned changes that are happening with the information revolution, and that is a significantly greater possibility of exchanging information. Today, they are available to everyone, to a larger number of individuals and not just to the chosen ones, for example, as only a few hundred years ago when only privileged groups could enable their children to go to school and find out what information was circulating in a limited group of people. Did that group of individuals have a sufficient number of those who could use them in a creative direction?

What is the point I am getting across? Science has already hypothesized that one biological change, a gene mutation, enabled communication and exchange between a group. It accelerates civilization, and man gradually dominates the world. Today, an interested, creative individual, hungry for knowledge, comes out of his anonymity, and perhaps evolution and competition are fairer thanks to that. Of course, if we provided more people on the planet with computers, tablets, and the Internet, we would get more progress. That is the positive aspect of the modern world that needs to be talked about.

There is two sides to every coin, and by thinking that critically could help us deal with in time, with the hope of our product not destroying us. To understand what the Internet and information in rapid acceleration can change. From chance to caution!

Finally, reflecting through a psychodynamic view of a changing world, let's look at Rene Spitz's 1945 work "Hospitalism," which is a revolution in understanding the importance of early child interaction with mother and environment and the negative outcomes that would occur if that interaction would not exist. Spitz studied children in an orphanage whose physical nutritional needs were met and they were deprived of nurturing relationships. Over time, these children become nervous first, anxious, then depressed, withdrawn, and sick. Long "emotional starvation," says Spitz, leads to motor retardation. By the end of the second year, one part of the children died and those who survived could not sit, stand, walk and talk. However, if the mother returned within three months this tendency of deterioration would disappear and the children would stabilize (Palombo, Bendicsen & Koch, 2009).

Relation is one of the things that makes us human and provides the basis for our entire personality. We function first in the family circle, then in the wider environment through communication and exchange of information about each other.During the cognitive evolution, this exchange of information and the functioning of the group moves towards sociological research up to a group of 150 individuals. Today, it is known that this is the critical limit of human organization that is functional (Harari, 2018).This is how certain communities, companies, the army, but also social networks are functionally maintained, through acquaintance and gossip as a formof exchange about the information on others in the group. Anything beyond that requires something else. And that something is myth. The myth through religion, the myth of law and order, the myth of the state, the myth of political order and democracy in the last resort. According to Harrari, modern businessmen and lawyers are powerful sorcerers and the difference between them and shamans is that they tell far stranger stories (Harari, 2018).

Let's look at a few changes in a changing world. Ask the question about social networks, what keeps the cohesion of those groups that are far greater than the magic number of 150? The question is what myth, magic sustains these groups?

Influencers are essentially those delegated sorcerers and leaders, who maintain the cohesion of large groups and modern marketing, through its brand placement, social media advertising and control one of the key myths of the human race, money.

The second change that is now before us, and the consequence that follow, I think are not easy to understand. But we do have to think deeply about them. The Covid-19 pandemic is one that is directly aimed a closeness of the human individual. The closeness which, according to the knowledge of Rene Spitz and the psychoanalysts and theorists of object relations at the time, is something that develops the child's central nervous system and forms the individual, is now in some way limited. The basis of psychotherapeutic treatment, transfer, countertransference, and changes in the therapeutic process is based on the relationship between two people, a psychotherapist and a patient in psychodynamic psychotherapy.

The drug itself, pharmacotherapy in this treatment has the same dynamic and symbolic meaning (Lopicic, Gajic, Stamatovic-Gajic & Mihajlovic, 2008). Today, all that is moved to another setting and requires an understanding of that change, about which the results are already appearing (Stamatović Gajić, 2020). Our group, friends, and even family, up to the number of 150, are gradually being replaced by a social network, the Internet. Due to the danger of spreading the virus, we are changing the framework of life.Covering the face, keeping our distance, reducing socializing, cultural events, teaching at colleges, and providing medical care is changing.

Where are we? On social networks, we communicate and receive messages through the tools of the mythical, the one long conceived in the cognitive revolution of man thousands of years ago. Where we are going, time will tell. How long does it take for the changes to take place to change the world? I consider it much longer than what is expected to impose insulation as a model. But the current situation for psychiatrists, psychologists, and psychodynamically educated professionals should be a research challenge for other times. Above all else, we have to understand human capacity for change, and the plasticity of our central nervous system which is the basis of our world domination as a species.

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PSIHODINAMSKI POGLED U SVETU KOJI SE MENJA

Sažetak: Da li se svet u kome živimo ubrzano menja i šta te promene znače na nivou pojedinca, porodice i društva? Izazovi su svuda oko nas, ubrzani tehnologijom, novim putevima komunikacije, društvenim mrežama koji postavljaju neke sasvim drugačije sisteme vrednosti od onih sa kojima smo do sada živeli. Svakodnevni psihijatrijski i psihoterapijski rad se nalazi pred izazovom drugačijeg razumevanja ovih promena i transfernih fenomena koji govore u prilog stabilnosti psihodinamičke misli u sadašnjem vremenu. Rad analizira neke individualne ali i grupne fenomene sa kojima se susrećemo u psihoterapijskoj praksi ali i neke specifične situacije pred kojima se nalazimo kao psihijatri često na vetrometini ekonomskih i političkih uticaja kojima su naši pacijenti izloženi. Oni traže ne samo razumevanje, nego i savet i putokaz koji treba da ih vrati ponovo u stabilnost koju su već izgubili. U zaključku se ističe da psihodinamički okvir predstavlja značajan oslonac u našem radu i da može da pruži mnoga objašnjenja pre brojnih drugih teorija.

Ključne reči: mentalno zdravlje, psihodinamička interpretacija, psihoanaliza

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SOCIAL POLICY IN NEOLIBERALISM AND NEOLIBERALISM IN SOCIAL POLICY: THE PROBLEM OF TRANSFER OF RESPONSIBILITY

Abstract: The economic crisis that gripped the most developed countries in the 1970s heralded the end of the concept of the welfare state and, at the same time, the establishment of neoliberal socio-economic doctrine. A decade later, there is an epochal collapse of the socialist state, that is, communist regimes that have long been a serious alternative to the capitalist world. At the same time, the process of globalization has seriously called into question many classical conceptions related to the nation-state. The common characteristics of these three processes can be summarized in the undoubted weakening of the functions of the state in the field of social policy. In other words, all three processes result in the complete domination of neoliberalism. Faced with economic, social, environmental, and security crises, the modern state had to permanently exclude certain topics for which the given system was simply no longer competent. The state gradually declared itself incompetent, continuously limiting its own operation, thus transferring responsibility to individuals/citizens.In this paper, we will analyze the consequences of this process, that is, we will advocate the thesis that the transfer of agreement opens the problem of deep social vulnerability because the sum of resources and opportunities available to individuals does not provide an adequate response to upcoming social challenges. In this sense, it is necessary to consider the new position of social policy in neoliberalism…

Keywords: social policy, neoliberalism, transfer of responsibilities, social vulnerability

INTRODUCTION: INDIVIDUAL AND/OR COMMUNITY

Behind every social practice there is necessarily a certain ideology. And at the core of every ideology is the relationship between the individual and the community. The relationship between the individual and society. The relationship between the individual and the community is already at the center of modern theories about society. Ernst Cassirer draws our attention to the fact that Thomas

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Hobbes was one of the first theorists to bring the structure of a complex whole to its ultimate consequences: "Here, too, an understanding of the whole can only be obtained by returning to the parts they also concluded on the forces that maintain them in that connection" (Kasirer, 2003, p. 317). In accordance with that, Hobbes does not understand the community as an organic totality, but rather as a set of elements whose basic characteristics exist beyond totality. The basic question that arises from this attitude is the following - since the necessity of a community is not immanent to its parts, how is any unity possible at all?How to prevent the state of chaotic pluralism from resulting in a war of all against all, bellum omnium contra omnes? The answer is in the necessity for individuals, beyond their own nature, to constitute a community by a rational act, that is, a social contract (Hobs, 1961). The social contract thus fixes the boundary between the natural (status naturalis) and civil status (status civilis). The basic consequence of a social contract, according to Hobbes, is to ensure a secure existence. On the other hand, the obligation of the society/state is to ensure that through law enforcement. Thus, politics (after a long Middle Ages) loses its transcendent character and draws legitimacy from its own effectiveness.

The political community, as the final result of the mutual consent of individuals, represents the central place, and Locke's theory expressed in Two Treatises of Government (Locke, 1978). The political community is constituted by a social contract by which individuals leave their natural state (in other words, they renounce freedom, equality, and independence) in order to ensure the security of their own existence. The basic social contract is based on the consent of all, while the consent of the majority constitutes the government, which is thus given the mandate to fulfill the goals of the association, that is, to contribute to the common good.The principle of the majority is necessary because it is impossible to always have complete consent, but "the act of the majority is considered an act of the whole that certainly decides since according to the law of nature and mind it contains the power of the whole" (Locke, 1978, p. 96). From this, it follows that all citizens have an obligation to obey the majority will of one community. However, here Locke introduces a very important moment, that obedience is not unconditional: a government that does not contribute to the common good does not deserve the support and consent of its own citizens, who in such cases have the right (and duty) to rebel[2].

[2] The American Declaration of Independence, adopted in 1776, also has a provision defined in this spirit: "Of course, prudence dictates that the long-established government does not change for unimportant and transient reasons; and consequently, all the experiences of mankind have shown that it is more inclined to suffer as long as the evils are bearable than to be freed from injustice by abolishing the forms to which it is accustomed. But when a long series of abuses and violence that always have the same goal proves to be an intention to subject the people to absolute despotism, it is their duty to overthrow such a government and provide new guardians of its future security" (according to Temelji moderne demokratije, 2011, p. 186).

In that way, with the attitude that no one can be subordinated without their own consent, Locke irrevocably stands on the side of the citizens and the idea of the sovereignty of the individuals.

Jean-Jacques Rousseau also defines the political community as an organic unity, established by the agreement of its members. However, unlike Locke, Rousseau gives absolute primacy to the community: “Just as nature gives every man power over all his limbs, so the social contract gives the political body unlimited power over all its members; it is the same government which, guided by the general will, is called sovereignty” (Ruso, 1993, p. 47). Rousseau's initial position differs from Hobbes's - individuals do not make a contract with each other, they practically do not exist before the formation of the community. The individual is only an individual mediated by the social community. Individuality, therefore, arises in correlation with the community, as a self-conscious particularity that emerges from its unreflected individuality and becomes aware not only of its differences from others (which is simply a matter of mere records) but of its uniqueness within a frame of a collective body. Thus Rousseau, in a paradoxical way, resolves the relationship between the individual and the community - the individual becomes free only by renouncing freedom, by renouncing his natural rights, that is, he becomes free only by submitting to the community and its laws.Cassirer also reminds us of this when he points out that through the rule of law, the demands of individuals are directly realized, in a double sense - “… that they can no longer appear as independent demands, but that, on the other hand, their true meaning is a law (state) takes over and protects” (Kasirer, 2003, p. 326). In doing so, Rousseau proclaimed the absolute primacy of the community over the individual.

This, introductory, theoretical situation of the individual-society relationship is not only aimed at considering the history of one concept but also allows us to systematize the development of the modern concept of society and state, as a precondition for understanding the genesis of different ideologies.In other words, ideology is a set of complex normative frameworks and mechanisms, which represent the political results of basic notions of responsibility for the basic security and well-being of community members. In that sense, therefore, the paradigm of the social contract represents a welcome signpost in the interpretation of the dynamics of the modern world, which is once again at a turning point. The consequences of the theory of the social contract will, therefore, branch in two basic directions. On the one hand, Francis Fukuyama will advocate the thesis that about the connection between Hobbes and Locke with the development of liberalism. On the other hand, Hannah Arendt will recognize the consequences of Rousseau's teachings not only in the French Revolution but also in all subsequent revolutions that will follow. In other words - in totalitarian political systems.

More than half of the twentieth century took place in giant conflicts (war or Cold War) between the two worlds - the so-called “free world” and the world

of different totalitarian systems. In the Second World War between liberalism and fascism, nazism, and after that between liberalism and communism. In particular, the antagonism between liberalism and communism had a distinctly ideological dimension, as a conflict between freedom and equality. In doing so, "the logic of freedom is summarized in the formula: equal opportunities to become unequal. The logic of equality goes in the opposite direction: unequal opportunities to become equal" (Sartori, 2001, p. 61).

Between the two endpoints of this ideological continuum, an attempt was developed in Western Europe to "resolve the antinomic relationship of freedom and equality in social democracy as a great, practical undertaking of synthesis" (Đurić, 2016, p. 82). This synthesis, embodied in the "welfare state" was a serious attempt to alleviate the sharpness of liberal-capitalist indifference to social issues, as well as to respond to the challenges of socialist states.At the end of the twentieth century, however, profound changes took place that called into question everything that made modern societies so attractive - above all the promises of a community based on an order of justice in which were implemented mechanisms for protecting vulnerable groups[3]. The final victory of liberal democracy and the collapse of the communist bloc, led by the Soviet Union, not only brought about the collapse of the socialist state in the East but also caused the withdrawal of the welfare state in the West. This, at first glance, paradoxical outcome opened the horizon of new challenges. The crisis came from victory. The economic crisis that gripped the most developed countries in the 1970s heralded the end of the concept of the welfare state and, at the same time, the establishment of a neoliberal socio-economic doctrine. The neoliberal concept has become the dominant model for most societies in the (post) transition period.

But it was not just a matter of changing economic policy. The entire world of life has practically changed fundamentally. It is not an exaggeration to say that the attitude of communities towards their own values, which until then regulated social action, has changed, the self-perception of those communities has changed, as well as the attitude towards their own past and future. The citizens of these societies have found themselves in the conditions of "fluid modernity" (Bauman, 2009), in conditions in which patterns of action change faster than necessary to consolidate and routinize these modes of action. The conditions of action became obsolete before individuals even got a chance to adopt them. Reliance on past experience and strategies has lost all relevance. In the fluid world, the absence of any pivot, a universally structuring principle that would connect the world of life into a stable totality, is noticeable. Instead of a stable totality, as Lyotard once announced, there are many diffuse micro-narrations at work that cannot have a claim to

[3] For more details see in Milorad Đurić, "Global inequality and local solidarity: a new approach to social policy", in Social policy in Serbia at the crossroads of centuries, Belgrade: College of Social Work, 2019, pp. 33 - 53.

the interpretation of the whole (Liotar, 1988). Anthony Giddens also pointed out the deficit of the main signifier, using the metaphor of the dragon chariot. He believes that modern society cannot be a stable environment, because new knowledge (concepts, theories, innovations) constantly produced changes (Gidens, 1998, p. 147).

Therefore, the basic question of this paper is related to the possibility of constituting a sustainable social policy in the neoliberal context, that is, to the possibility of applying the neoliberal concept in the context of social policy. Our assumption is that in the current circumstances it is no longer possible to interpret the world from the position of binary schematism - individual/society, capitalism/socialism, etc. Such “clear relations” do not stabilize or solve the problem, but contribute to further complicating the situation. In other words, the change that is necessary refers to a kind of deconstruction of the mentioned paradigms and the establishment of understanding between irreconcilable and distant positions. Ideological patterns have a strong impact on people's real lives and only by overcoming them can we release a new complexity - the ability of society to respond to this type of challenge.

SOCIAL POLICY IN NEOLIBERALISM?

At first glance, the process of transferring responsibility seems to have come to an end. In neoliberalism, a man really becomes the measure of all things: in politics as a voter, in economics as a consumer, in social politics - as a user of various forms of state aid. Despite numerous problems, the liberal package has far better results than any other alternative. Most people have never enjoyed greater peace and prosperity than under the shield of the neoliberal order at the beginning of the 21st century.For the first time in history, more people die from old age than from infectious diseases, more from obesity than from hunger, they die more in various accidents than from violence (Harari, 2018). Aren't the principles of a reliable market, responsible governments and democracies, human rights, and international law the strongest foundation of progress in this century as well?

However, neoliberalism has no solutions to the biggest challenges we face: global economic crises, migration, environmental crises, population aging, or pandemics. The liberal political order was formed during the industrial era, in order to govern the world of steam engines, oil refineries, and television sets. It is now having difficulty coping with the ongoing information and communication revolution and will have even more problems with the upcoming biotech revolution.

Also, the liberal order is shaped in the context of nation-states. In this context, the problems are situated within the borders of the states, while today the states are within the problems. The processes of globalization have relativized the

importance of state borders. Global problems require global coordination so that the problem of legitimation deficit inevitably arises, that is, the circle of those who make decisions does not refer to the circle of those to whom those decisions apply. This also raises the question of the possibility of conceiving social policies in the context of the nation-state.

Global communication gives birth to a global society. And in a global society, global problems inevitably arise. These problems have strongly influenced the place and role of the modern state. "The inability of nation-states to solve global problems is the basic driving mechanism of global governance" (Orlović, 2010, p. 279). Consequently, the borders of nation-states no longer represent the absolute border between internal and external relations. Nation-states are no longer able to be the dominant controllers of social relations, nor to protect their citizens from the chain effects of processes that take place outside their borders. Modern communication networks and new information technologies have enabled the expansion of social relations on a global level, exceeding the previous administrative, legal, technological, and organizational boundaries.

"The nation-state," says Ulrich Beck, "is a territorial state: that is, its power is based on attachment to a particular place (on controlling membership, current legislation, border protection, etc.). The world society, which took the form of globalization in many (not only economic) dimensions, undermines the importance of the nation-state because the borders of the nation-state are now opposed by many social circles, communication networks, market relations, and lifestyles, and none is peculiar to any particular locality.This is evident in each of the pillars: tax collection, police responsibilities, foreign policy, and military security" (Bek, 2003, p. 133). The idea of closed societies has become illusory because no social group or idea can be excluded from the influence of others. Different economic, cultural, and political forms compete with each other, so nothing is implicit anymore. New global challenges require answers different from those that "old" states could provide.

This primarily refers to the classical idea of state sovereignty, which in the era of globalization has not only been reduced but also qualitatively changed. The reason for this lies in the changing relationship of topics/problems and boundaries. In order for the system of social interaction to be maintained within the set boundaries, certain topics for which the given system is simply no longer competent must be permanently excluded. The nation-state system is thus gradually declaring itself incompetent, continuously self-limiting its own operability. This reduction of complexity is an attempt to maintain the principle of differentiation. But, the difference between one system (nation-state) and its environment (set of other nation-states) becomes less and less important because more and more problems become common (global), deprived of any exclusivity, that is, deprived of potential for the difference. Thus, borders acquire more symbolic meaning. Territoriality

becomes a completely atypical principle. An exotic moment of limiting something that has been moved to other levels of real existence by its own dynamics.

In any case, the economy is undoubtedly one of the most powerful generators of global challenges that systematically shake the world. Regardless of the attempts to curb recessions with state interventions, it is obvious that no one is protected and that today's economy is, in the true sense of the word, a global phenomenon that affects everyone. This primarily refers to changes in the concept of social security.By abandoning the idea of the welfare state, on the one hand, and the collapse of socialist states, on the other hand, a space of deep social vulnerability has been opened.

Ulrich Beck defines social vulnerability as a collective term that encompasses the means and opportunities available to individuals, communities, or entire populations to be able (or unable) to deal with risks — “unknown unknowns” —and (social) insecurities in their lives” (Bek, 2011, p. 242). Although the effects of economic liberalization are different in each country, and although there is no consensus among economic experts, the link between globalization, economic growth, inequality, and poverty is indisputable. Poverty is primarily the result of the relationship of one socio-economic environment with another, with networks of causes spreading across the geographical and state borders of the affected population. Social vulnerability cannot be precisely located, neither spatially nor temporally – a global perspective is necessary for its perception.

Therefore, it is necessary to rethink new paradigms of social policy. The new meaning of social security must rest on society’s ability to provide answers to three main challenges: implosiveness, fluidity, and individualism. At the heart of this ambitious demand lies the need to build adequate mechanisms to regulate conflict situations in the field of social security. Inequality and poverty do not occur only in the old patterns of social conflicts. The current constellations take on new forms, so it is extremely important to raise the level of public perception of social insecurity and needs.

NEOLIBERALISM IN SOCIAL POLICY?

Neoliberal systems are constituted on the basis of open social communication, which is the essential content of the political dynamics of civil society. This dynamic is ensured by individual and group autonomy, the rule of law and the system of institutions. There is no pre-projected “agreement” about the type of identity that should be accepted. The liberal-democratic state is indifferent to the process of constituting any kind of identity – these processes take place in a space devoid of institutional and ideological control in which citizens realistically express their interests. At the same time, it mainly means that the neoliberal state is indifferent to the social problems of its citizens.

In a fluid world in which the search for political answers has no particular locus, the trend of new individualization comes as no surprise. According to Ulrich Beck, the main reason for the new shift in individualization is the uncertainty of the global world. In such circumstances, the individual must make his own decisions.Neither science, nor ruling politics, nor the mass media, nor the economy, nor the legal system, nor even the military, are able to rationally define or control risks. As a result, people turn to themselves...(Bek, 2011). And they are trying to become better and more competitive. Therefore, we should not be surprised by the mass obsession with self-learning, fitness, yoga, cosmetic surgery, fashion, in general, all forms of self-improvement.

Thus, stable ideological configurations are no longer formed, but rather "clouds of narrative elements" (Liotar, 1988, p. 6), and each of them, in itself, has its own pragmatic value. This dyssynchrony greatly minimizes the prospect of a possible agreement on basic topics. Old ideologies are no longer able to master the diversity of life, while at the same time eluding any centering or striving towards a certain goal. This is also pointed out by Kate Nash: "In the postmodern age, society dissolves into a plurality of narratives in which science takes its place as one of the other narratives so that it no longer has an advantage over them as a confluence of truth and value" (Neš, 2006, p. 270).

Totality has been replaced by separate elements and diffuse micro-narratives that cannot have a claim to the interpretation of the whole. Instead of universal meta-stories about freedom, equality, or justice, micro-projects are localized in time and space. These micro-projects transform the former homogenous transcendental center into a heterogeneous field of sub-legitimation projects.The emphasis is on the perspective from which a particular subject is analyzed, and not on some stable, "objective" method or "historical logic".

All these are the consequences of the forty-year focus of top science and technology on the problem of communication, cybernetics, informatics, computer languages, compatibility of machine languages, the problem of computer memory and intelligent terminals, etc. "The impact of these technological transformations," says Lyotard, "seems to be significant. It can rightly be concluded that the multiplication of information machines acts, and will act, on the circulation of knowledge in the same way as the development of means of transport for people did, and then the transmission of sounds and images through the media. In that general transformation, the nature of knowledge also changes" (Liotar, 1988, p. 10). Information is exteriorized in relation to its own "author". It is also exteriorized in relation to the nation-state as a privileged, relevant community within which information is produced and disseminated. The destabilization of the nation-state will be much more drastically continued with information technologies. The nation-state is becoming obsolete. Created on the idea of controlled territory, it now faces the flow of information that cannot be completely controlled. Instead

of information controllers, the nation-state becomes their user. In the context of new technologies, the nation-state is forced to revise its own position.

Lyotard's argument is based on two basic models of understanding society, two basic discourses about society - Parsons and Marx. The idea of society as an organic whole, created during the nineteenth century, in Parsons' version turns into the idea of society as an autoregulated system. Instead of a living organism, a cybernetic model is at work, in which the basic goal is the optimal ratio of total input and output. Even when the rules change within the system when there are spontaneous innovations, or destabilization (political revolutions, economic crises, and strikes), the system is not fundamentally questioned, but it is a process by which it improves. Each part of the system is an instrument for optimizing its performance. In contrast, Marx's critical model sees Lyotard as a sharp dualism that does not presuppose any synthesis or reconciliation within the system. In the critical model, knowledge is not a functional element of society but is always involved in the processes of separation, in the class struggle. However, Lyotard goes beyond this dichotomy, believing that it has ceased to be valid in the postmodern situation.Ideologies, nation-states, and parties - no longer have any appeal. The time of political heroes is over. And it will not be renewed.

In the general disintegration of great ideologies, the individual citizen is left to himself. But the disintegration of social ties does not mean that society has been transformed into a mass of atomized individuals. Lyotard remains optimistic: “The man himself is small, but he is not isolated, he is encompassed by a more than ever complex and mobile web of relationships. Whether young or old, man or woman, rich or poor, he is always placed on the “nodes” of communication circuits, no matter how small.Rather, it should be said: placed in places through which various messages pass. And it is never, even when it is the poorest, deprived of the influence of those messages that pass through it, placing it either in the place of the sender, or the recipient, or the reference object” (Liotar, 1988, p. 29).

In this communication game of “atomized” individuals, elastic communication networks are created that experience shifts with each new information and message. These networks are not limited by the set of rules and procedures characteristic of institutional communication. In this sense, there is no metalanguage according to which everyone else must adapt or evaluate. Complete identification with any ideology is practically impossible.

This heteromorphism is an essential step towards preventing terror (ideological and any other) which is immanent to isomorphism (uniformity). Therefore, Lyotard rejects the possibility of any privileged historical subject, who would legitimize particular goals as universal in the name of some metanarrative (ideology). Lyotard's optimism (the book was published in 1979!) Is related to the information revolution. Although there is a risk that information technology will become an instrument of control and regulation, the situation is far more realistic

in which information technology will be extremely useful for participants in communication because it will supply them with inexhaustible amounts of information. And that, in his opinion, promises the establishment of a policy "in which the aspirations for justice and the aspirations for the unknown will be equally respected" (Liotar, 1988, p. 110).

A NEW PARADIGM OF SOCIAL POLICY

The implosion of the modern state is reflected in the strong trend of deregulation and withdrawal, reduction of public expenditures, and thus the reduction of the capacity to act in the area of social protection. Fluidity, as "raising social relations from local contexts of interaction and their restructuring within an indefinite time-space", is visible in capital mobility, precarious jobs, the need for continuing education, global crises that transcend national borders, but also migratory movements that they further destabilize both emigration and immigration societies. Finally, the trend of individualization clearly indicates the strengthening of individual responsibility, which "... takes the place of state or public care and collective solidarity. Basically, the new social policy is based on the idea that the individual is responsible for his own well-being. The role of the state is to help it or to encourage it to develop its potentials. Services are legitimized by the need to strengthen the capacity of individuals to deal with the dangers (risks) of the market, and individuals are expected to take an active part in protecting their own interests and developing diversified individual strategies. Individuals are expected to create active strategies to strengthen their own potentials and to protect themselves from the negative effects of social change (for example, lifelong learning, learning new skills, strengthening self-confidence, and empowerment).

The intersection of these trends opens space for a change of perspective, but also opportunities for multiple transformations that would lead to the profiling of a new social policy. This refers to the transformation of the state, which must be transformed from a system that finances and provides social services through the mobilization of a cumbersome administrative apparatus into an institutional structure that delegates tasks and concludes contracts with various social service providers. On the other hand, non-governmental organizations must transform from actors operating in spheres of social policy that are not in the focus of the state into partners of state institutions.It also means that NGOs must take responsibility, both to the state and to social service users.

This double transformation does not represent anyone's intention or political decision. These are the consequences of social changes that create a new social horizon. It is a kind of socio-evolutionary response of the system to new and unexpected changes in the environment[4].In that sense, the stabilization of new

[4] For more details on the relationship between the system and the environment see: M. Đurić / Đ.

social action that is adequate to the needs of transitional societies is conditioned by abandoning the previous traditional bureaucratic models of social protection. This deviation from outdated paradigms, however, must be accompanied by the constitution of a new model that will be based on the principle that the number of possible answers depends proportionally on the degree of differentiation and complexity of the system itself. This, in our case, includes the inclusion and strong encouragement of individual initiatives and actions of citizens' associations, that is, the creation of a hybrid model that could integrate an already weakened state structure with the impulses of civic bottom-up activism.

Such a hybrid social policy in which the government, local authorities, non-governmental organizations, and families cooperate with each other, operates in a space that was once a monopolized space of the state. In such a model, the state, public administration, recognizes civil society organizations and other participants as partners and cooperates with them. Both in the process of preparation and decision-making and in the process of realization of social programs. The growing role of civil society is an expected response to the increasingly pronounced heterogeneity of social demand. In addition, NGOs have undoubted potential in mobilizing additional local resources, as they are far more rooted in local communities than “classical” state organizations. This undoubtedly strengthens their position in the process of changing the “culture” of social policy in (post) transitional societies.

Finally, an important part of the mission of civil society social organizations is to influence the creation of social policy. Although it is difficult to accurately capture and quantify the real impacts of civil society organizations on the process of preparing, adopting and implementing important social policy measures, there is no doubt that NGOs will play an increasingly important role in the future.In any case, the development of a hybrid social policy would greatly contribute to the modernization of social protection in Serbia. However, the unclear responsibilities of the various ministries, as well as the politicization that occasionally burdens the social sector, make this area even more fragile. Nevertheless, the implementation of a hybrid social policy could certainly contribute to further progress in the process of European integration, public administration reform, as well as the maturation of new generations of experts in this field.

CONCLUSION: TOWARDS A “NEW SOCIAL CONTRACT”

It is quite understandable that the separation of the individual and the community is a hypothetical fiction and it has only a temporary methodological character. Because humans are social beings. The power of togetherness is of in-

Stojanović (2020), „Niklas Luhman’s Social System Theory: The Issue of System Autonoy”, Serbian Political Thought 4/2020, Bvograd: Institute for Political Studies, pp. 151-170.

stinctive origin and encompasses the need for another human being, as a sense of connection with another person or group. This power of togetherness can also manifest as people's emotional pressure on each other to meet those needs. On the other hand, the power of individuality is also instinctively rooted, as the urge to be an independent organism, a human individual with its own rights and life goals. Both forces represent an integral part of all people and thus, necessarily, of all interpersonal interactions. The fact that they are instinctive also means that they are automatic and continuous in their actions, unconscious in their character, and that also indicates how deeply rooted they are in every human being. However, this does not mean that one principle or another does not prevail in certain political systems.

On the other hand, the changes caused by the communication and information revolution have relativized our understanding of the world based on simple, binary schematism. It is, in essence, an epochal change that has transformed our understanding of the individual-society-state relationship. In order to fully understand the nature and significance of this change, we have begun this article with an analysis of social contract theories, which have crucially shaped both practical and theoretical political architecture in the previous three centuries. What the different versions of social contract theory had in common was the implicitness of the mutual obligation between the individual and society. This mutual relationship implied the renunciation of the individual's natural rights in exchange for the existential security provided by the collective.

This was, without a doubt, the basis for the later constitution of the socialist state, as well as for the establishment of the welfare state, models that tried to realize the ideals of equality and solidarity. However, the processes of globalization have jeopardized the concept of the nation-state, and thus the model of the welfare state. The transition of the welfare state to a neoliberal state created an atmosphere of new insecurity, which was characterized by the reduction of state capacities and the abandonment of citizens to themselves.

In the conditions of implosion, fluidity and forced individualization, in which transitional societies find themselves, a possible answer is the creation of a "new social contract". In other words, the systematic introduction of civil society in the field of social activity. In that way, additional actors and resources would be mobilized in the process of functional integration and the permanent renewal of mutual solidarity would be intensified.This operation would create a kind of hybrid social policy that connects the state structure, citizens and their associations. Although this still does not call into question the role of the state, as an institutional set that transfers content and (financial) resources, the circle of participants in the process of proposing, deciding and implementing social protection measures is significantly expanded. This increases the level of complexity within the field of social policy, as well as the ability of society to adequately respond to

increasingly complex problems.In any case, societies in the period of transition are facing a serious (both theoretical and practical) restructuring. The response of these societies to increasingly serious global and local social risks must involve a high degree of participation of community members in implementing the necessary changes. This encourages citizens to strengthen their position in this fluid world through active engagement.

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SOCIJALNA POLITIKA U NEOLIBERALIZMU I NEOLIBERALIZAM U SOCIJALNOJ POLITICI: PROBLEM TRANSFERA ODGOVORNOSTI

Sažetak: Ekonomska kriza koja je, sedamdesetih godina dvadesetog veka, zahvatila najrazvijenije države najavila je kraj koncepta države blagostanja i, istovremeno, uspostavljanje neoliberalne socijalno-ekonomske doktrine. Deceniju kasnije, dolazi i do epohalnog sloma socijalističke države, odnosno komunističkih režima koji su dugo bili ozbiljna alternativa kapitalističkom svetu. Istovremeno, proces globalizacije ozbiljno je doveo u pitanje mnoge klasične koncepcije vezane za nacionalnu državu. Zajedničke karakteristike ova tri procesa možemo sumirati u nedvosmislenom slabljenju funkcija države u polju socijalne politike. Drugim rečima, sva tri procesa rezultiraju potpunom dominacijom neoliberalizma. Suočavajući se sa ekonomskim, socijalnim, ekološkim i bezbednosnim krizama, savremena država je morala da permanentno isključuje određene teme za koje dati sistem jednostavno više nije bio kompetentan. Država se postepeno oglašavala nenadležnom, kontinuirano je ograničavala sopstvenu operativnost, transferišući, na taj način, odgovornost na pojedince/građane. U ovom radu analiziraćemo konsekvence ovog procesa, odnosno, zastupaćemo tezu da je transferom o dgovornosti otvoren problem duboke socijalne ranjivosti, jer zbir sredstava i mogućnosti kojima raspolažu pojedinci ne obezbeđuje adekvatan odgovor u odnosu na nadolazeće socijalne izazove. U tom smislu, neophodno je razmotriti novu poziciju socijalne politike u neoliberalizmu…

Ključne reči: socijalna politika, neoliberalizam, transfer odgovornosti, socijalna ranjivost

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EXAMINATION OF STEREOTYPES AND PREJUDICE TOWARDS THE ELDERLY IN SERBIA

Abstract: Intergenerational solidarity can be defined as existence of mutual relations between individuals within multigenerational families, if we consider it as solidarity within families, but also can be described as relations between different age groups within the community. But it also can be, essentially, described as a social contract between different generations. The aim of the research was to examine the level of intergenerational solidarity between younger age group participants and the participants in elderly age group, as well as to examine the extent to which ageism is represented in the attitudes of its members. The results of the study showed that both younger and older groups participants believe that the dominant image of the elderly is mostly positive, and that society sees the elderly primarily as warm, but less as competent. Stereotypes and prejudices towards the elderly are moderately expressed in both younger and older participants. However, the results also show that there is significant space for decrease. The obtained results indicate that older people do not consider themselves as elderly, that younger participants perceive them as warm, but not too competent, which indicates the existence of certain stereotypes towards older people. It is especially important that there are relatively frequent contacts between younger and older age group members, which is an excellent basis for improving the quality of intergenerational contact and decrease of stereotypes. Studies have shown that there are three types of interventions aimed at reducing the ageism that exists. These are education programs, constant improvement of intergenerational contacts and their quality, and combined programs.

Keywords: ageism, intergenerational solidarity, stereotypes, elderly people

INTRODUCTION

All the countries in the world are faced with significant demographic changes. United Nation estimates that, until 2050, world population will increase from present 7.7 billion to 9.7 billion, while until the end of this century it will reach

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maximal number of 11.18 billion and after that population will start to decrease (United Nations, World Population Ageing 2017). At the same time population are getting older. People older than 65 represent age group with the fastest pace of increasement today. In 2018, for the first time in history number of people older than 65 was bigger than number of children up to 5 years old, while until 2050 number of elderlies will be higher than number of adolescents and young people between 15 and 24 years old (United Nations, 2019). Beside these changes we are faced with major migrations. It is estimated that in 2019, 279 million people lived outside countries of their origin, which make up 3.5% of the world population. This percentage in 2000 was 2.8 (UN, 2017).

All the demographic changes we are fronting represent a great challenge that all countries in the world are facing. The changes put a lot of pressure, primarily on the social and health care systems, but they also considerably affect all other segments of society. For these reasons, great attention must be dedicated to intergenerational solidarity, and especially to intergenerational solidarity within families. Generally speaking, intergenerational solidarity can be understood as the existence of mutual ties between individuals within multigenerational families, when viewed as solidarity within families, but also as ties between different age groups within the community (VanderVen, 2012). In this sense, intergenerational solidarity is essentially a social contract between different generations. In the considerations of how important family ties are and how much they contribute to intergenerational solidarity, the division of responsibilities towards the elderly between the family, the state and others who contribute to it can be observed. The majority understanding is that over time, the family decrease level of thecare, which is especially expressed among the inhabitants of the southern part of Europe. The most common reason is the modernization of society and the growing emphasis on individualism, which leads that inhabitants of modern states are being viewed more and more as narcissistic and self-centered. However, research has shown that intergenerational solidarity within families does not differ significantly between countries with different understandings of relationships within families, such as those in northern and southern Europe, but that the nature of these relationships differs, primarily because in richer countries there are more choices to assist the elderly who, than, have to rely less on the family. However, the ties within the family are equally strong (Daatland & Lowenstein, 2005). In any case, the importance of intergenerational solidarity can be seen through the contribution to the sustainability of the social and health care system, better understanding and overcoming problems within the wider community and families, promoting the same values, and ensuring the exchange of knowledge and cultural values between different age groups.

Dr. Vern Bengston has made a huge contribution to the concept of intergenerational solidarity. His work focused at identifying and finding ways to

measure patterns of cohesion between members of three generations within the family (Bengtson & Black, 1973). Many researchers later viewed this model as a model of solidarity and conflict in intergenerational relations, primarily because it determined the position of individuals within different generations, viewing that model as a single analytical unit.Such an analytical unit was used to measure family cohesiveness. Thus, six dimensions of measuring cohesion within the family are defined, namely emotional solidarity, association solidarity, consensual solidarity, functional solidarity, normative solidarity and structural solidarity (Bengtson & Schrader, 1982).

In the earlier period, older people were seen as people who reduced the number of their social contacts and remained alone and isolated.However, people's propensity to associate and form social support networks was described in the 1980s when Kahn and Antonucci developed a model of a social support convoy (Kahn & Antonucci, 1980). It looks at age and other characteristics that both older people and their environment have, which significantly helps to study social relations. They are observed on several levels including dimension, structure, type and quality of relationships. Research has concluded that the most important quality is these relationships (Antonucci, Fuhrer & Dartigues, 1997) and that it plays a very important role in the physical and mental health of the elderly. Special attention is paid to the individual characteristics of individual contacts of the elderly and their importance in relation to the relationships that the elderly has within the group. It was also pointed out that quality social contacts are extremely important regardless of when they occur, even in cases when their duration is not long.

If we look at the trends in examining the health and well-being of the elderly, we increasingly come to the conclusion that their social contacts are extremely important. Their significance can be observed from the earliest childhood. It has been shown that people who had a warmer and better relationship with their parents in childhood had a better and longer partnership in old age, which was somewhat influenced by the quality of those relationships in middle age (Waldinger & Schulz, 2016). This trend continues throughout life and studies focus on social relationships, but more and more attention has been paid to the relationship between the genetic basis of the individual and the factors of his environment, as well as the impact of each of them on the health and well-being of the elderly (Wanke, Partridge & Antonucci, 2011). This especially refers to the connection between the quality of social contacts and the preservation of the cognitive functions of the elderly, especially in terms of prevention of dementia.

Although important, intergenerational solidarity is not the only one through which relations between members of different age groups are observed. Much attention must be paid to the intergenerational balance, ie reciprocity that exists within the relationship between generations. It is often that members of younger age groups overestimate their contribution to the development of

intergenerational relations, while older people feel that they are neglected and that their participation in decision-making is small or non-existent. Such an imbalance can pose a threat to the development of intergenerational solidarity (North & Fiske, 2012). However, the mere existence of an intergenerational imbalance does not necessarily jeopardize intergenerational solidarity itself. It is much more complicated and is influenced by a number of different factors.

Ageism can be defined as "a negative attitude or behavior toward an individual that is based solely on person's age". It turned out that the frequency of contacts between young people and the elderly alone is not enough for contacts to have a greater impact on the existence of a positive attitude towards them. However, the positive perception of the elderly by younger people is significantly influenced by the quality of the relationship between them. In this way, a quality intergenerational relationship affects the reduction of ageism. Some research has shown that only a third of older people have contact with people under the age of 30, and that even a smaller percentage of young people have contact with older people. The existence of contacts between members of different age groups provides a chance for the development of quality intergenerational contact. In that sense, it is necessary to have an environment in which such contact can be made.

The negative health consequences of older people who are exposed to ageism can be significant and are given increasing importance (Officer et al., 2016). Research has shown that negative attitudes towards older people are very pronounced in many countries. Within countries, it has been shown that population aging in many countries is accompanied by negative attitudes towards the elderly. It has also been shown that cultural differences between countries significantly affect the degree of ageism faced by the elderly population (North & Fiske, 2012). In addition, studies show that the negative attitudes that members of other age groups have towards the elderly and towards aging in general are associated with poorer health and well-being in the age when these people become older (Wurm, Diehl, Kornadt, Westerhof, & Wahl, 2017)

We live in a society in which segregation based on age is increasingly present. There is a frequent and significant intergenerational misunderstanding in it, and it can lead to the emergence of ageism. The role of the whole society is to ensure the existence of an environment that stimulates the establishment of contacts between young and old, affects their better quality and thus reduces the prejudices that exist.

METHODOLOGY

The aim of the research was to examine the level of intergenerational solidarity between members of the younger age group and the elderly, as well as to examine the extent to which ageism is represented in the attitudes of members of this age group.

The research was conducted on a sample of 30 young and 30 elderly people. The group of young people consisted of 17 young women and 13 young men between the ages of 18 and 27 (average age M = 23.24, SD = 2.73). The qualification structure shows that half of them have completed IV degree, while 37% of them have completed college or university. 13% of them had only completed primary school.

The group of older participants consisted of 14 women and 16 men aged between 58 and 79 years (average age M = 68.59, SD = 5.02). The educational structure shows that 55% of them finished high school, while 34% of them graduated from college or university.

Respondents completed a questionnaire developed specifically for this occasion while the level of existence of ageism was examined using the Fraboni scale of ageism.

RESULTS

The degree of identification of the respondents with the age group to which they belong was examined. Younger respondents were found to strongly identify with the "young person" group. On a scale where 1 means "I do not belong to the group at all" and 10 "I strongly belong to the group", the average answer of younger students is M = 9.31 (SD = 0.93). In contrast, older participants do not show strong identification with the group of "older people" and their average response M = 4.75, while individual differences are more pronounced (SD = 2.67).

When observing stereotypes that exist in relation to the elderly, Stereotype Content Model was used. It is organized in a way that is observed through two dimensions, through warmth and competence. Both groups of respondents believe that the dominant image of the elderly is mostly positive, and that society sees the elderly primarily as warm, and less as competent.Older respondents see bias because they feel that society perceives them as more positive in both dimensions than younger respondents see (F-warmth(1.59) = 6.00, p = .02, M-older = 6.44, SD = 1.45; M-young = 5.53, SD = 1.36; F-competent(1.59) = 4.94, p = .03, M-older = 5.40, SD = 1.78; M-young = 4.47, SD = 1.41)[2]. The results show that the second dimension - heat, does not show statistically significant differences in the stereotypes of older and younger respondents (F(1.59) = 2.22, p = .15) and both groups agree that the elderly are moderately warm (M- older = 5.37, SD = 1.03; M- young = 5.03, SD = 0.70)[3]. In both groups, the scores on the characteristics of warm, good, honest, sociable, etc. are most pronounced.

When examining stereotypes through the competence dimension, both younger and older groups of respondents see older people as somewhat

[2] A scale from 1 to 8 was used where 1 = unlikely, 8 = very likely

[3] A scale from 1 to 7 is used where 1 = they are not like that at all, 7 = they are completely like that

competent. A group of older respondents' rate older people as more competent than younger respondents ($F(1.59) = 6.57$, $p = .01$; M-older = 4.95, SD = 1.03; M- young = 4.37, SD = 0.65). For a group of older respondents, older people, to whom they also belong, are healthier, stronger, tidier, more useful, more attractive, more independent and more productive, compared to how younger respondents see them[4].

When younger and older respondents assessed the social status that today in society in the Republic of Serbia occupy different age groups, both groups of respondents believe that the highest social status (moderately high) have people in their 40's, while the social status of people in their 20's year of age, as well as a person over the age of 65 is assessed as significantly lower, somewhere on the border between favorable and unfavorable.

The perception and experiences that the respondents have towards discrimination against the elderly in the Republic of Serbia were also examined. Contrary to expected results, younger respondents reported that during the last few years preceding the survey, they were more likely to have experienced that someone did not respect or respect them enough because of their age compared to older people. ($F(1.59) = 15.95$, $p < .01$; M-older = 1.76, SD = 0.82; M-young = 2.77, SD = 0.81). When observing the frequency of verbal or physical violence to which the respondents were exposed as a result of their age, no statistically significant differences were found. ($F(1.59) = 2.29$, $p = .14$; M-older = 1.44, SD = 0.96; M-young = 1.80, SD = 0.77). When assessing the extent to which discrimination against the elderly is pronounced, both younger and older respondents assess the discrimination as low to moderate.

Given the exceptional importance of maintaining contact between members of different age groups, respondents stated their contacts with members of another age group.The largest number of younger respondents, 76% of them say that they see the elderly every day, 14% of them state that they see the elderly several times a week, while 10% of the elderly see them once a week or less often. Regarding the communication of younger respondents with the elderly, 51% of them communicate with them every day, 33% of them do it several times a week, 13% once a week, while 3% of them communicate with the elderly less than once a week. The relationship of younger people with older people from their family (grandparents) is especially important, given the importance of intergenerational solidarity within the family. The results of the research showed that younger respondents stated that they were very close to them (M = 3.90, SD = 0.92), then that they saw them several times during the month (M = 3.53, SD = 0.92). They state that they enjoy during these contacts (M = 4.34, SD = 0.51).

Finally, part of the research related to the existence of prejudice against the elderly. Prejudice was measured using the Fraboni scale of ageism. The strength of

[4] A scale from 1 to 10 is used where 1 = they are not like that at all, 10 = they are completely like that

prejudice, ie ageism, was measured through the summative score on the Fraboni scale. The score can have a numerical value between 29 and 145, where the lowest score represents the complete absence of prejudices, and the highest score of 145 on the strongest age bias. The overall scores of both groups of participants show that both groups of respondents do not cultivate strong prejudices against the elderly and there are no statistically significant differences in the intensity of prejudices in both groups of respondents. ($F(1,59) = 0.34$, $p = .56$; M-older = 74.72, SD = 12.67; M-young = 72.80, SD = 14.77).

DISCUSSION

Ageism, in the form of stereotypes and prejudices against older people based on their age, has significant negative consequences for the physical and mental health of older people and their well-being. The World Health Organization has identified reducing ageism as a key goal for improving the health and well-being of the elderly (WHO, 2015).

The results of the study showed that stereotypes and prejudices towards the elderly are moderately expressed in both younger and older respondents. However, the results also show that there is significant opportunity for its reduction. The obtained results indicate that older people do not consider themselves to be old, that younger respondents perceive them as warm, but not too competent, which indicates the existence of certain stereotypes towards older people. It is especially important that there are relatively frequent contacts between younger and older respondents, which is an excellent basis for improving the quality of intergenerational contact and reducing stereotypes.

Studies have shown that there are three types of interventions aimed at reducing the ageism that exists. These are education programs, constant improvement of intergenerational contacts and their quality, and combined programs (Burnes et al., 2019). The implementation of these programs is especially effective among groups of educated adolescents and young adults, as well as among women. Educational programs should be specifically targeted at those who expand knowledge about the aging process, in order to reduce anxiety due to aging and promote the image of the elderly with the least possible stereotypes and prejudice. Such programs should exist from an early age because it is a guarantee that future generations will have a different and more positive attitude towards the elderly, but also towards the aging process itself. There should also be an educational campaign aimed at middle-aged people. This type of intervention should be aimed, in addition to providing information about the aging process, to the development of those personal characteristics that are important for a successful aging process, such as self-esteem, self-efficacy and control over life events. By developing these characteristics, it can be expected that individuals will adopt behavioral models aimed

at prevention, timely treatment, as well as that they will not believe in negative stereotypes about the inevitable poorer health condition they will have when they are older (Nelson, 2016). It is especially important that when adopting various measures of social and health policy, the implications they may have on intergenerational solidarity are always taken into account.

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ISPITIVANJE STEREOTIPA I PREDRASUDA PREMA STARIJIM OSOBAMA U SRBIJI

Sažetak: Međugeneracijska solidarnost je postojanje međusobnih veza između pojedinaca u okviru višegeneracijskih porodica, kada je posmatramo kao solidarnost unutar porodica, ali i kao veze između različitih starosnih grupa unutar zajednice. U tom smislu, međugeneracijska solidarnost, suštinski predstavlja socijalni ugovor između različitih generacija. Cilj istraživanja bio je da se ispita nivo postojanja međugeneracijske solidarnosti između pripadnika mlađe starosne grupe i starijih osoba kao i da ispita koliko je zastupljen ejdžizam u stavovima pripadnika ove sve starosne grupe. Rezultati studije su pokazali da i mlađa i starija grupa ispitanika smatraju da je dominantna slika o starijim osobama uglavnom pozitivna i da društvo vidi starije osobe pre svega kao tople, a manje kao kompetentne. Stereotipi i predrasude prema starijim osobama su umereno izražene i to kako kod mlađih tako i starijih ispitanika. Međutim, rezultati pokazuju i da postoji značajan prostor za njihovo smanjenje. Dobijeni rezultati ukazuju na to starije osobe sene ne smatraju starijim, da ih mlađi ispitanici doživljavaju kao tople, ali ne i previše kompetentne, što ukazuje na postojanje određenih stereotipa prema starijim osobama. Posebno je važno da postoji relativno česti kontakti između mlađih i starijih ispitanika što predstavlja odličnu osnovu za unapređenje kvaliteta međugeneracijskog kontakta i smanjenje stereotipa. Studije su pokazale da postoje tri vrste intervencija koje su usmerene na smanjenje ejdžizma koji postoji. To su programi obrazovanja, stalno unapređivanje međugeneracijskih kontakata i njihovog kvaliteta i kombinovani programi.

Ključne reči: ejdžizam, međugeneracijska solidarnost, stereotipi, starije osobe

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LONG-TERM CARE FOR OLDER PEOPLE IN THE REPUBLIC OF CROATIA

Abstract: Current world trends and challenges most countries face raise the need to change the legislative framework and expand the service system to provide quality of life in older people. Data from the last census conducted in 2011 rank the Republic of Croatia among the ten oldest countries in the world. This is due to several factors, some of which are related to an increase in quality of life and overall life span, the continued decline in fertility rates and the disintegration of the traditional family structure i.e. the transformation of the family structure from extended to nuclear. Challenge in the field of older people care indicates the need for the development of institutional and non-institutional forms of care which are underdeveloped in Croatia. According to the Social Welfare Act (The Official Gazette, 157/13, 152/14), the emphasis is placed on state older homes, decentralized homes under the jurisdiction of local (regional) self-government units, family homes and foster families. Some of the researches (Bađun, 2016) show a lack of transparency in exercising the accommodation service right and accommodation financing right in homes for older people and the infirm as well as big financial cost to the state budget. Most of the researches conducted so far in the field of older people care assess the quality of life in older people living in homes, question overall satisfaction with living in a home and satisfaction with home services, show self-assessment of physical and mental health, and identify characteristics of older people with particular needs for care services. The texts of the Croatian authors indicate care for older people as a social risk which has spread across Europe and question how to find new models of functioning of the system to ensure the quality of life in older people. The role of social work is to actively participate in the development of long-term care, to advocate for and represent the interests of the individual, to assess his or her needs to create a quality and sustainable model of older people care. The aim of this paper is to present an overview of foreign and domestic literature on the issue of long-term care for older people and the quality of life of older people in the Republic of Croatia.

Keywords: demographic ageing, social services, care for older people, long-term care

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INTRODUCTION

We live in a time that, according to census indicators on a global scale, speaks of an increase in the share of older population and creates new predictions about the upward trajectory of this trend. The reasons for the current demographic picture, both in the world and in the Republic of Croatia, are found in different areas, which are the development of health care (Bouillet, 2003; Mali, Flaker, Urek & Rafaelič, 2018). Aging as a social phenomenon is an indicator of life expectancy, which is an exceptional achievement of mankind (Mali, 2012; Mali & Grebenc, 2019), although on the other hand, aging in society has a negative connotation (Mali, 2012), in premodern society, older people were a symbol of wisdom, and today they represent something outdated and undesirable and find it difficult to accept the aging process itself (Giddens, 2007). We are witnessing daily exposure to the glorification of youth and potential solutions on how to look youthful in the long run in the marketing space as something desirable and good, which raises the question of where our society is developing, if more (Murgić, Jukić, Tomek-Rosandić, Ljubičić, & Kusić, 2009). It is interesting to see a comparison between 1910 when a person over the age of 65 was somewhere around 5%, and in 2001 around 16% (Gelo, 2003). According to the last Census of the Republic of Croatia (National Burreu of Statistics, 2013) it was determined that 17.7% of the population is over 65, the aging index was 115%, and the aging rate was 24.1%, which greatly indicates that parameters defined by experts, entered the aging process that evidently began in the last century in 1953 when the aging coefficient was 10.3%. In addition to the aging process that has become a global phenomenon in recent decades, there has been a change in family structure, the traditional family that played the role of caring and caring for older family members has slowly disintegrated into a nuclear family, family members have shrunk and care on older members were taken over by institutions (Jedvaj, Štambuk & Rusac, 2014). The Republic of Croatia faces two related risks in parallel. And these are the aging population and care for older people. Like most European countries, Croatia is developing strategies and policies to adequately respond to new social risks, so the Social Welfare Strategy for older people in the Republic of Croatia (2017) was adopted, which based on assessments of the situation in society brings a number of strategic proposals to improve the life of older people. According to the Social Welfare Act (The Official Gazette, 157/13, 152/14), older people in the social welfare system exercise a number of rights and services in order to enable them a dignified and quality life, and the Act itself defines a clear goal in which the main determinant is assistance to one who are at a disadvantage. In conclusion, it is very clear that the aging of the population began several decades ago, but that the system has not adequately responded to the needs of older population, long-term care system for older people has not yet developed. The aim of this paper is to present

the process of developing care for older people and to define the level to which it has reached and what is its importance and what is happening to the older people today. According to the Social Welfare Act (The Official Gazette, 157/13,152/14), the older people in the social welfare system exercise a number of rights and services in order to enable them a dignified and quality life, and the Act itself defines a clear goal in which the main determinant is assistance to older people who are at a disadvantage. The paper will provide a detailed overview of global, European and domestic research on the applicability of current rights and quality of services for older people in long-term care in the Republic of Croatia.

DEVELOPMENT OF CARE FOR OLDER PEOPLE

In order to understand the current situation, it is necessary to look back to the way in which the social welfare system has developed throughout history and what has influenced it. Šućur states (2003) that until 1990, the concept of social protection was represented in the system, which included measures that were targeted at vulnerable groups such as, older people, while social assistance refers to transfers in cash or in natural form. In the introductory part, the emphasis is clearly placed on the aging process of the population, which already in 1953 showed the beginning of the aging population in the field of development of social care and care for older people, a number of changes took place. At the turn of the 1940s and 1950s, the Ministry of Social Welfare of the People's Republic of Croatia took over the affairs of social and assistance and care, and it became known that the first professional social worker was then employed. In the period between the fifties and sixties, the growth of older people was noticed; in 1969 the Law on Social Protection was adopted, which still does not meet the needs of the population. Tomorad and Galoguža (as quoted by Dobrotić, 2016) state that a Fund was established in the 1950s whose funds were intended for the construction of social institutions, and in parallel with this phenomenon the number of homes for older people increased, for example in 1945 there were 11 homes for older people and in 1960 35 and at that time advocated non-institutional care (Dobrotić, 2016).

At the turn of the 1970s and 1980s, one of the categories of vulnerable groups was people of socially unacceptable behavior and people who for some reason needed social assistance or care, daily centers for older people are being established at the same time. The redistribution of non-institutional forms of services is most prevalent in Zagreb, as much as 90%, which marginalizes the rest of Croatia, especially rural areas (Dobrotić, 2016). The foster families we have today (Social Welfare Act, The Official Gazette, 157/13, 152/14, 99/15, 52/16, 16/17, 130/17, 98/19, 64/20) appeared in the 1970s, but the accommodation of older people, given the needs, was insignificant (Dobrotić, 2016).

In the 1990s, War in Croatia disrupted the already disrupted standard of living of the population, and in 1993 the adoption of the Social Program by the Government greatly contributed to the development of social care for older people in Croatia. It is important to emphasize that the Social Welfare Act was adopted in 1998, which was primarily aimed at strengthening support and support within the family, some new forms were then introduced as forms of support, namely assistance and care allowance, home help services and care outside one's own family (social care homes for older people and infirm). This Act opened the possibility of private and non-governmental organizations to provide various care services, and the Act further developed the interest of society in establishing homes for older people and infirm (Jurčević, 1998; Šućur, 2003; Dobrotić, 2016). The principle of subsidiarity stands out as an important concept related to the exhaustion of support and assistance within the family, and when all possibilities are exhausted, it is necessary to seek the help of the system (Puljiz, 2001).

The conference on "Strategies for the development of care for older people in the Republic of Croatia" was held in 1999 in Dubrovnik and left a very important role in the development of care for older people and opened space for discussion and development on long-term care (Balaband, 1999). This year is marked as the International Year of Older Persons as directed by the United Nations. In September of the same year, an expert meeting on the topic of "Social care for older people" was held in Opatija, which brought together experts who are directly involved in social work with older people. The conclusions of the conference were aimed at connecting and coordinating between the systems that care for older people (health and social care), the emphasis was placed on non-institutional care that is better and more humane, extending retirement and examples of good practice of care for older people (Štambuk, 1999). The proclamation and celebration of the International Year of Older People began the process of developing ideas, thinking and scientific contribution in this area intensified the research of care and quality of life of older people and raised awareness of the aging process. After the enactment of the laws, from 2000 onwards, the interest in the development of institutional care for older people, especially private care, increased, which certainly calls into question the non-transparent funding and unavailability of services for all older people equally. The example of the development of the home help service in the rural area of eastern Croatia shows a positive example and the need to develop such a service. The research of the pilot project of home help service in the Municipality of Drenovci (Vukovarsko-Srijemska County) revealed the need to connect and network with social care centers, the price of the program is affordable, provides older people with social support and reduces loneliness, and on the other hand opens a space to employ people to care for older people (Bouillet, 2003). In the Republic of Croatia, attention has shifted from the development of care for older people to the unemployment parameter explained (Flaker, 2011)

in two ways as recruiting the unemployed into the profession of helpers and carers and as reducing unemployment that contributes to the sustainability of the pension and health insurance system. The program of home help services was based on care for older people and employment of people who will care for older people, which was developed in the Program for the development of services for older people in the system of intergenerational solidarity from 2008 to 2011 (Government of the Republic of Croatia, 2007). The basic criticism of such a program is reflected in the unclear coordination of service providers and social welfare centers, many service providers have bypassed cooperation with the centers and there has been a difficult assessment of real needs and capacities and the procedure belonged to social welfare centers (Dobrotić, 2016). In this period of service development, it is obvious that the projections of population growth are not in line with the development of services, because due to the impossibility of monitoring the development of services, a way was found to abolish services that were an aggravating circumstance for the state treasury. Shutting down and closing services for older people does not represent a solution, but raises the question of what reduced the need for this service if Croatia has already entered the aging process, whether decisions were made based on a real assessment of the needs of older people and what needs older people have. Ramovš (2003) developed a list of specific needs of older people that are focused on social character, namely the need for material support, the need for exercise, the need for mental and work freshness, the need for interpersonal relationships, the need to transfer life experiences and insights into them to the younger and middle generations, the need to experience a sense of old age, the need to care in helplessness, and the need for immortality. On the other hand, the authors Flaker, Mali, Kodele, Grebenc, Škerjanc and Urek (2008) in the book on long-term care define the categories of emancipation and belonging, shame and dissatisfaction and institutional career, the needs that can be analyzed in each person are classified into the following categories: housing, work and income, contacts and sociability, life events, stress and risks and organization of everyday life including leisure. The needs categories of different authors indicate similarities between each other, indicate the uniqueness of the needs of all people when we talk about human life and dignity, and create a need for synthesis, uniting the needs of each human being, not segmentation by age. Given the situation in Croatia, the question arises about the justification of abolishing this type of service for older people if the aging population and care for them is classified in the category of new social risks (Babić & Baturina, 2016). After 2000, legally clearly defined forms of care for older people are institutional, social care homes and private homes, and non-institutional forms, foster care, family homes, home help services, gerontology centers, day care for older people, etc. (Žganec, Rusac & Laklija, 2008). In 2007, members of the Government of the Republic of Croatia and representatives of the European Commission signed the Joint Memorandum,

making one of the priorities the expansion of the network of services for older people at risk of poverty and social exclusion (Government of the Republic of Croatia, 2007). The Social Welfare Strategy for Older People in the Republic of Croatia for the period from 2014 to 2016 emphasizes the importance of expanding the network of social services for older people, which mainly relate to home help services because it is unevenly distributed throughout Croatia (Ministry of social policy and youth, 2014). The latest Social Welfare Strategy for Older People in the Republic of Croatia for the period 2017-2020 which also envisages the expansion of social service networks (Ministry of demographics, family, youth and social policy, 2017) which provides data on the increase in the number of family homes, foster families and the provision of home help services given the data from the previous strategy. In the last three years, the project "Zaželi-Employment Program for Women" has been active in the country, through which it is possible to employ hard-to-employ groups (50+) who cared for older people in their local communities (Government of the Republic of Croatia, 2020). This project is time-bound and there is no solution in the long-term form of its implementation and financing.

LONG-TERM CARE FOR OLDER PEOPLE

Long-term care is defined as an area of care for a person who cannot take care of himself or herself or has limited abilities (Puljiz, 2000). Demographic changes, population aging announce changes in society that are already happening, long-term care is a response to these changes (Mali, 2013) in this context long-term care is a topic that applies to the whole world regardless of health and social system, except known to all, it encourages the development of new forms of care for older people and recalls those existing but neglected forms of living. According to the Organization for Economic Co-operation and Development (OECD), long-term care is a policy area that includes a cross-section of services needed by people dependent on assistance when it comes to performing daily activities over a long period of time (Jedvaj et al., 2014) where it is crucial man's subjective and objective (Mali, 2013) need for support and assistance in coexistence with the community. "Long-term care refers to activities taken by others to ensure that persons at risk of significant continuing loss of certain abilities can maintain a level of functional ability in accordance with their fundamental rights, fundamental freedoms and human dignity" (WHO, 2015, p. 127). Defining the area that provides a response to demographic changes that have affected the world, population aging and declining birth rates and mortality (Mali, 2014), opens space for the development of social welfare both worldwide and in Croatia (Šućur, 2003). According to previous research, it has been established that in Croatia the needs for care services for older people are extremely important and need to be developed (Bouillet, 2003).

In the research on the quality of aging and self-assessment of health and the need for care services (Despot-Lučanin, Lučanin & Havelka, 2006) one of the goals was to determine the characteristics of older people who need care and care and the results showed that the need for services grows age, people living alone expressed significantly higher needs for care services than people living with someone, older men living alone show a greater need for care services than women living alone and older people suffering from chronic diseases. Research conducted on the quality of life of people in homes for older people and infirm in Zagreb (Lovreković & Leutar, 2010) found that people, who have better quality home services, assess their quality of life better. Such results contribute to the further development of care for older people from the perspective of the quantity and quality of services and the need for their availability. Long-term care for older people in the Republic of Croatia is still not legally regulated, there is no special pillar of insurance and allocation of funds for it as it exists in some other European countries, for example in Germany where long-term care is defined as the fifth pillar of insurance separate from health insurance (Žganec et al., 2008). According to the above data, it can be concluded that Croatia is developing a system of care for older people that has not yet been legally formalized, based on the available services prescribed by the Social Welfare Act (The Official Gazette, 157/13, 152/14, 99/15, 52/16, 16/17, 130/17, 98/19, 64/20), but that there is still a lack of dynamics in the development of services that will be a more permanent solution in providing care to older people in order to enable them a dignified and quality life. As early as the 1950s, projections of an aging population were clearly indicated, and decades later debates were introduced, laws, ordinances, and regulations developed. The risk of aging is still not approached holistically, not all aspects of service delivery are evenly distributed, the expansion of unattended and quality control service networks opens up space for the illegal service market, which can often be found in research television shows. In the last decade, several surveys have been conducted in the field of care for older people that contribute to the development of long-term care, in addition to checking the quality of services, user needs and analysis of the current situation in care. (Rako & Krišto, 2019) and the results showed that almost half of the student population hopes that they will not need this form of care or that they should not bother about it. These results indicate the need to intensify activities related to the raised levels of awareness of old age prescribed by the Strategy (2017) and the need to introduce a long-term care system that is defined by law.

OLDER PEOPLE TODAY

We are in the 21st century which brings new challenges and social risks that society faces, given that the anticipated difficulties, society is facing an aging

process and the process of introducing and expanding the network of services for older people has not developed to the extent that needed today. The position of older people in society indicates that they are often marginalized, socially excluded and exposed to poverty (Žganec et al., 2008). Older people are expected to strike a balance between the security provided by their environment and the independence for which they are motivated by a supportive environment (Schaie & Willis, 2011). If an older person does not have informal support from the family in their environment and there is no support from the community in which they live, it is necessary to develop a care service for that person. A positive example of intergenerational connections can be seen in neighboring Slovenia, which at the Faculty of Social Work in Ljubljana is implementing a project with the local community where it involves students, future social workers, in analyzing the needs of older people and creating responses to the need (Šabić, 2014). In Croatia, the Ministry of the Family, Veterans' Affairs and Intergenerational Solidarity advocated the need for intergenerational interaction between young people and older people, which was realized through a program of home help services where women of different ages cared for older people. According to the last Strategy (2017), there was a development of home help service financed from social funds, but the institutional form of accommodation for older people in the form of homes for older people and infirm, family homes is still represented, and 2020 is an indicator the need to advocate for older people to stay in their homes for as long as possible. In 2020, the whole world was affected by the COVID-19 pandemic, where experts pointed out responsible behavior and gave guidelines on how to behave during the pandemic, in homes for older people and infirm visits were banned or maintained under strict conditions, almost every day data on the number of infected and statistics on the number of years of death are regularly presented, older people are expected to stay at home, avoid physical contact with other persons (Nastavni zabod za javno zdravstvo Dr. Andrija Štampar, undated). An interesting approach to considering the COVID-19 virus and older people housed in institutions, especially nursing homes, is presented in Slovenia (Flaker, 2020) where the analysis of data on deaths during the pandemic led to a conclusion that the virus affects all age groups, but that most of those who died were older people placed in an institution. According to the recommendations of health institutions, the population is directed to maintain distance, avoid physical contact and not stay in places where there are high concentrations of people, and what about older people who are accommodated in institutions, nursing homes, where there is a high concentration of people violates their security and ability to have the same rights as other persons outside the institution. It was COVID-19 that showed the need to develop a long-term care system, the need for older people to remain in the home environment because it was the institutions that proved to be the foci of the virus (Flaker, 2020).

CONCLUSION

Starting from the need to develop long-term care, the aging process has affected Croatia in the last century and its trend continues. The approach to more intensive development of care for older people appeared in the 1990s, when the Law regulated services for older people, but still insufficiently with regard to needs. Access to services is not equally developed in the country. The development of care has been recorded since the 1950s until today, although the intensity of development is not in line with the data on the growth of older population. A number of services that developed during the 1990s and in early 2000 were mainly focused on the development of institutional forms of care for older people, which was further accompanied by questionable quality of accommodation and care for older people and lack of control in the development of services were already large then. In the Republic of Croatia today there are various forms of care for older people for whom we can attribute the system of long-term care for older people, homes for older people and infirm, family homes, foster families, home help, day care for the elderly, etc. The long-term care system is an important segment for social development if it is developed in accordance with the needs of older people and at the same time advocates a longer stay in the home environment. The author Flaker (2020) warns about this issue of the development of long-term care and the necessary implementation of deinstitutionalization, emphasizing that institutions are hotbeds of the virus and that the older people are at risk of infection. In Croatia, according to the Central Bureau of Statistics and preliminary data on population mortality, no increase in mortality was recorded compared to the previous year, but data on mortality in institutions are not available. In the further development of care for older people it is necessary to carry out a process of deinstitutionalization that will develop services that are in line with the needs of older people, advocate for longer stay of older people in the home environment and provide them with services based on intergenerational cooperation a dignified and quality life.

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DUGOTRAJNA SKRB U REPUBLICI HRVATSKOJ

Sažetak: Trenutni trendovi u svijetu i izazovi s kojima se susreće većina zemalja najavljuju potrebu za promjenom zakonodavnog okvira i širenje mreže usluga kako bi se omogućila kvaliteta života osoba starije životne dobi. Podaci s posljednjeg provedenog Popisa stanovništva 2011. godine svrstavaju Republiku Hrvatsku među deset najstarijih zemalja u svijetu. Uzrok tome nalazi se u mnogobrojnim izvorima, a neki od njih se odnose na povećanje kvalitete života i ukupnog životnog vijeka, kontinuirani pad stope fertiliteta i raspad tradicionalne obitelji gdje se dogodila transformacija obitelji sa proširene na nukleusnu. Izazov u području skrbi o starijim osobama ukazuje na potrebu razvoja institucionalnih i izvaninstitucionalnih oblika skrbi koja je u Hrvatskoj nedovoljno razvijena. Prema Zakonu o socijalnoj skrbi (Narodne novine, 157/13 i 152/14) naglasak je stavljen na državne domove za starije osobe, decentralizirane domove u nadležnosti područne (regionalne) samouprave, obiteljske domove i udomiteljske obitelji. Dio istraživanja (Bađun, 2016) ukazuje na nedostatak transparentnosti u ostvarivanju prava smještaja i financiranja smještaja u domovima za starije i nemoćne osobe te preveliki financijski teret za državni proračun. Većina dosadašnjih istraživanja (Lovreković, Leutar, 2010) provedena u području skrbi o starijim osobama odnose se na procjenu kvalitete života starijih osoba smještenih u domove za starije i nemoćne osobe te pitanje općeg zadovoljstva boravkom u domu, zadovoljstvom uslugama doma, samoprocjena tjelesnog i psihičkog zdravlja te utvrđivanje obilježja starijih osoba s osobito izraženim potrebama za uslugama skrbi. U tekstovima hrvatskih autora jasno je naznačena skrb o starijim osobama kao socijalni rizik koji je zahvatio cijelu Europu, a pitanje se postavlja na koji način i s kojeg aspekta je potrebno pristupiti u pronalaženju novih modela funkcioniranja sustava na osiguranje kvalitete života osoba starije dobi. Uloga socijalnog rada je aktivno sudjelovanje u razvoju dugotrajne skrbi, zagovaranje i zastupanje interesa pojedinca, procjena njegovih potreba kako bi se stvorio kvalitetan i održiv model skrbi o starijim osobama.

Ključne riječi: demografsko starenje, socijalne usluge, dugotrajna skrb

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REDUCING SOCIAL AND EMOTIONAL LONELINESS AMONG THE ELDERLY IN A SMALL ROMANIAN CITY

Abstract: The acceleration of population aging across Europe forced the scientists, politicians and practitionners to join their effortsin designing and implementing social policies aimingto achieve active ageing. Agrowing awareness aboutthe increased socio-emotional loneliness among the beneficiaries of a daycare centre in a small city from the Nort-Western part of Romania motivated this research aimedto identify the factors associated to loneliness and find ways to determine passive elders to engage in social activities promoted by the daycare centre, as a means for loneliness aleviation. Following a quantitative research methodology, 30 beneficiaries aged 63 to 84 years, among whom 7 were women, completed a questionnaire via telephone. The 15 questions were designed to investigate possible factors associated with subjective loneliness. The descriptive and inferential analyses reflected that age, female gender, a lower level of education, lack of companionship, the perceiving of a poor health status and infrequent attendance of religious services are associated with socio-emotional loneliness. However, only gender, poor health status and religiosity were found to influence the level of loneliness in a statistically significant way. Possible means of intervention in the daycare centre asa result of this research would imply to promote theactive participation of women in inter-generational projects transmitting traditional crafts to young generations, and involvement of community professionals such as doctors, nurses and priests in conducting activities or increasing awareness on benefits related to diet changes, sport activities, reflection on the meaning of life and death. Beside these, identifying means to apply system models for resilience in gerontology might be a useful tool for recovery after the disruption caused by the global COVID-19 pandemic.

Keywords: active ageing; socio-emotional loneliness; old people; day care social services; Romania.

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INTRODUCTION

Worldwide, the number of people aged 60 or over is projected to increase from 901 million in 2015 to 1.4 billion in 2030. A quarter of Europe's population will fall into that category. By 2050, the global weight of older population will reaching about 2.1 billion. The percentage of people aged 80 and over is expected to groweven faster, projections showing a tripling of their number by 2050 (UN, 2015).

By 2015 persons over 60 years of age were already 24.4% of the Romanian populationand the elders' percentage in the general population is expected to reach 36.4% by 2050. For the 2010-2015 reference interval, life expectancy at birth was higher in women (78.1 versus 70.9 in men). In 2015, retirement age was 64 for men and 59 for women. By that year, 21.6% of the men and 17.7% of the women aged 65 or over were actively employed, the highest rate of elders in the workforce in Eastern Europe, except for Ukraine (UN, 2015).

Scientists, politicians and practitioners are increasingly concerned with the phenomenon of ageing, the most important social and economic challenge of the new century. Ageing is a dynamic process that requires an adequate response in terms of public policy, social security and health care. A longer life-span, the possibility of early retirement, the growing long-term care needs, question the capacity of a social security system to ensure the sustainability of the nowadays living standards for the older people. To overcome such a burden, a better understanding of the complex interconnections between economic, health and social factors that influence the elders' quality of life is needed (Börsch-Supan, Hank & Jürges, 2005). In their search to describe the process of "ageing well", scientists have used various terms, like: successful ageing, active ageing, healthy ageing, positive ageing, productive ageing or competent ageing. These concepts are neither synonymous, nor exhaustive. Successful ageing was the most prevalent term employed in the United States, while the concept of active ageing prevailed in Europe (Foster & Walker, 2015). The later is seen as a process through which elders attempt to preserve their well-being by participating in activities consistent with their objectives, abilities, and opportunities in the community: what they want, can and have opportunities to accomplish (Lak, Rashidghalam, Myint & Baradaran, 2020).

An effective ageing strategy should involve all stakeholders: citizens, NGOs, business interests, policy makers. In promoting active ageing, social policies should implement more active interventions to diminish the loss of function and skills in older individuals. Maintenance of physical and mental capacities could encourage a prolonged working career, while also ensuring healthier and more accomplished post-employment years (Walker & Foster, 2013). The multidimensional concept of successful ageing added four other dimensions to the physical health dimension of the elders' well-being: social well-being, psychological

well-being, spirituality and transcendence, and environment and economic security, respectively (Zanjari, Sharifian Sani, Hosseini Chavoshi, Rafiey & Mohammadi Shahboulaghi, 2017).

Studies carried out in Romania after 2010 reflect that the concepts of active and successful ageing are more of a desideratum than a reality. It has been shown that Romanian elderly are the poorest in EU (Crăciun, 2014), they are exposed to social exclusion (Precupetu, Aartsen & Vasile, 2019) and share negative views onageing (Crăciun, 2012). A study on a Romanian representative sample of 3,132 people aged 60 to 80 years revealed that a poor self-perceived health status was significantly more prevalent among less educated septuagenarian women from urban areas not involved in religious activities, living alone and unable to make ends meet (Faludi, 2015). The same study found out that socio-emotional loneliness was significantly present among lone septuagenarians dissatisfied with their retirement status, facing material deprivation. Weekly attendance of religious services was the onekey factor which reduced by half the sense of loneliness.

During 2000-2015, a series of legislative acts designed to reconcile national public policies for the elderly with the European standards were produced. One of the most ambitious ones has been the Romanian Government's Decision No.566/2015 on the approval of the National Strategy in promoting active ageing and protection of the elderly as part of the Regional *Implementation* Strategy of the Madrid International Plan of Action on Ageing (MIPAA/*RIS)* for 2016-2020, as well as of the mechanism for their integrated monitoring and assessment. One of the objectives of this strategy was to provide enough financial, human and material resources to develop a system of long-term care for people aged 65 and older. In pursuing this objective, the national strategy encouraged projects for community daycare centers covering a wide variety of activities, such as: physical and mental recovery, preservation and promotion of health, occupational therapy, music therapy, leisure activities, different types of counseling, etc. European Structural and Investment Funds were the vehicle for promoting such projects. Due to the regional character of ageing in Romania, with a lesser percentage of elders in the North-Eastern region, daycare centers and seniors' clubs have spread particularly in Central and Western Romania cities.

The aim of this paper is to explore thelevel of socio-emotional loneliness of elder inhabitants of Zalău in relation to possible explanatory factors of this condition, in the context of local social services already available. TheMunicipality of Sălaj County in Transylvania (North-Western Romania), Zalău has about 56,000 inhabitants, 15% of which aged 60 or older.

The main objectives of this study are:

a. to describe the participants in terms of socio-demographic variables and the scale of socio-emotional loneliness;
b. to identify thefactors associated with socio-emotional loneliness among the elderlybenefiting of the services provided by the "Forever Young"Multifunctional Center, subordinated to the Directorate of Social Assistance (DSA) in Zalău;
c. to revealthe ways in which the programs and social services offered to the elderly in the city of Zalău contribute to reducing their loneliness;
d. to identify new intervention strategies able to elicit the interest of the passive single elders in the local communityto get involved in the activities offered by the daycare centers of DSA Zalău.

In the empirical research designed to meet the first two objectives, the following research hypotheses were formulated:

1. The age correlates with loneliness. The level of self-perceived loneliness is expectedto increase with age.
2. Certain gender differences in loneliness levels are observed.
3. Lower loneliness levelsare reported for highly educated elders compared to those with a lower level of education.
4. Living arrangementsinfluence loneliness levels. Elderly people who do not live alone in the household report lower values of socio-emotional loneliness, compared to the elderly who live alone.
5. Self-perceived health statusinfluencesthe state of loneliness. Elderly peoplewith a poorhealth perception report a higher level of socio-emotional loneliness compared tothose witha good perception of their own health.
6. Religiosity also influencesthe level of loneliness. The higher the involvementin religious services, the lower the level of loneliness would be.

After thebrief literature review on loneliness in elderspresented in this introductive part, methodological aspects of the research and interpretation of the quantitative results, a presentation of the activities and social services offered to the elderly in Zalău andplans to overcome passive involvementare dealt with in the next sections. Future research directions and intervention lines suiting the needs of the Romanian small town elderly are further discussed. The paper ends with some concluding remarks.

RESEARCH METHODOLOGY

Study participants

The group of subjects investigated consisted of a number of 30 people aged between 65-84 years recruited from the beneficiaries of the “Forever Young” Multifunctional Center who agreed to participate in the research. Upon DSA approval, the Center’s managerial staff provided contact data for the Zalău seniors registered in their database. Most of the recruited elders were already familiar with the researcher due to her position as civil servant in Zalău’s DSA Preliminary Assessment Department.

Data collection procedure

The empirical research method involved a sociological survey, a questionnaire with predefined multiple choice answers beingadministered by the survey operator or self-administered by the participants, the respondents’answers being recorded and analyzed (Chelcea, 2007).

The questionnaire was created by selecting and adapting 15 items relevant to the topic. The Short Scale of Socio-Emotional Loneliness constructed and developed by De Jong Gierveld and Tilburg (2010) was used to measure the state of subjective loneliness, encompassing two distinct dimensions: social loneliness, reflecting the number of social relationships that oneconsiders less than desirable, and emotional loneliness, indicatingthe insufficiency or lack of intimacy in one’s most significant relationships. The loneliness scale containing three items for each of the two dimensions was used in the “Generations and Gender Survey” (GGS) applied in Romania in 2005. The scale contains 6 interspersed statements regarding a series of ordinary events that the respondent experienced shortlybefore the interview. The six items admitted three possible answers: “yes”, “more or less” and “no”, the second being indicative forthe presence of loneliness. The items designed to measure social loneliness were formulated in positive termsas follows: “There are plenty of people that I can lean on in case of trouble”, “There are many people that I can count on completely” and “There are enough people that I feel close to”. The items designed tomeasure the emotional dimension of loneliness were expressed in negative termsas follows: “I experience a general sense of emptiness”, “I miss having people around” and “Often, I feel rejected”. One can observe that none of the items directly refer to loneliness or mention the term explicitly.

The GGS questionnaire investigated the concept of self-perceived health making use of the question”How would you describe your general health?”Respondent scores measured on an ordinal Likert scale ranged from 1 (very good) to 5 (very bad).

The questions in the omnibussurvey focused on socio-demographic variables selected toexplain the level of loneliness in the elderly, including gender, age, marital status, education, living arrangements, perceived satisfaction with being retiredand frequency of religious services' attendance.Four itemsdefinedmarital status: married, widowed, unmarried, and other. Education level was assessed based on the 1997 International Standards of Classification of Education: from Level 0 – Pre-primary education to Level 6 – Second stage of tertiary education (Fokkema, De Jong Gierveld & Dykstra, 2012). The two variablesrelated to living arrangementsconcerned whether the respondentlivedalone or along with other people in the household.If the later was the case, the elderly person was asked who he lives with, possible answers including: partner, children or someone else.

Perceived satisfaction with being retired was assessed as a dichotomous variable admitting the"high" and "low"categories. Finally, involvement in religious activitieswas measured by frequency ofchurch service attendance: weekly, monthly, annualy, never (Faludi, 2015).

An accessible vocabulary was used in designing the questionnaire so that the questions and pre-determined answers could be easily understood by the respondents, preventing the loss of interest due to difficulties encountered in its completion. Additionally, the intervieweeswere encouraged to request explanations for any unclarities.

Data collection and research ethics

The selection of the study participants process followed the research ethics principles of accessibility and voluntary participation. Prior to questionnaire administration respondents were informed about the legal provisions regarding the protection of personal data, according to EU Regulation 679/2016. They werealsoinformed that they did not need to answer any uncomfortable question(s) and given guarantees regarding their anonymity.

The participants were briefly presented with the purpose and objectives of the research, the content of the questionnaire and usage of the collected data prior to being requested to participate in the research. Insurances that any information obtained from the application of the questionnaire will only be used for research purposeswere formally provided.

Data were collected between December 16, 2020 and January 19, 2021. In accordance with Government Decision no. 1065 of December 11, 2020, regarding measures to prevent and combat the effects of the COVID-19 pandemic, the questionnaire was applied viatelephone.Respondents were informed that completion time will not exceed thirty minutes.

Data analysis procedure

The processing of personal data has been carried out in accordance with the relevant European legislation (GDPR). The collected answerswere included in a SPSS database. Analyzing procedures for descriptive and inferential statistics were applied. Frequency tables and frequency percentage distributionswere generated in the descriptive analysis. Significance tests specific to inferential statistics, namely bivariate correlation and independent-samples t-test, were used when testing the hypotheses, after the variables' classes and values were recoded to meetthe criteria of each test applied.

The loneliness scale served as dependent variable in the inferential analysis. Testing of the research hypotheses aimed to identify factors that can influence the level of loneliness in the elderly. In this pursuit the level of loneliness was assessed based on the total score of loneliness, calculated by reversing the answers in one of the scales and allocating values of 0 (indicating the absence of loneliness) or 1 (presence of loneliness) to each answer, considering neutral responses as indicative of socio-emotional loneliness.Thus, the overall score resulted by summing the six answers ranged from 0 or 1 (indicating a harmonious socio-emotional integration) to 6, a score indicating extreme loneliness (De Jong Gierveld, Dykstra & Schenk, 2012).

Responses to the self-perceived health variablerequired restructuringas the extreme scores 1 (very good) and 5 (very bad) were not reflected in the participants' options.The answers were subsequentlydistributed in two categories: good health (a score of 2) and poor health (scores of 3 or 4).

Initially including sevenpossible values from 0 to 6, the education variable was recodedto reflect three levels of education: low, medium and high.For the inferential analysis, the level of education was reorganized in two categories: 12 classes at the most versus at least a Bachelor's degree.

RESULTS

Descriptive analysis

The socio-demographic data (age, marital status, level of education, housing arrangements, acceptance of retiree status and religious involvement) collected from the 30 interviewees were subjected to descriptive analysis.Study participants were 63 to 84 years old, the average age being 72.13 years. The group included 7 women (23.3%) and 23 men.Regarding their marital status, 37% were widowed, 27% were married, 13% were single, and 23% were in another situation. According to education, 47% of the respondents reported university studies, 43% werehigh school graduates, while 10% reported a lower level of education. In regard to the living arrangements, 14 (47%) of the elderly investigated stated that they lived alone. Of the 16 remaining, 8 lived with their spouse, 4 with their children, and 4 with someone else.

When asked about acceptance of the retiree status, 60% of the respondents declared they were satisfied with their current situation. A similar percentage (60%) perceived that they had a satisfactory state of health, 30% of the participantsreported their health status was good, while 10% considered that they were in a bad state of health. None of the respondents selected the extreme ("very good"/"very bad") options. Regarding church service attendance, 33% of respondents declared they attended religious services weekly, 30% of them monthly and 27% annually, while 10% admitted theydid not attendreligious services at all.

Table 1 illustrates the distribution of absolute and percentage frequencies for each of the 6 items tested on the Short Scale for Socio-Emotional Loneliness (De Jong Gierveld & Tilburg, 2010). The items admitted three possible answers: "yes", "more or less" and "no", the second being also indicative for the presence of loneliness. The answers recorded on the scale of subjective loneliness indicated that 67% of the elderly felt the need to be surrounded by other people and that there were enough people they felt close to. However, when asked whether they can depend on those around them in case of need, for more than half of the respondents the answer was "more or less". Low levels of perceived emptiness (23%) and rejection (13%) were reported within the studied group.

Table 1
Distribution of responses to the Scale of socio-emotional loneliness

No.	Question	Yes		More or less		No	
1	Are there plenty of people that you can lean on in case of trouble?	13	43%	17	57%	-	-
2	Are there many people that you can count on completely?	14	47%	16	53%	-	-
3	Are there many people you feel close to?	20	67%	10	33%	-	-
4	Do you experience a general sense of emptiness?	-	-	7	23%	23	77%
5	Do you miss having people around you?	20	67%	10	33%	-	-
6	Do you often feel rejected?	-	-	4	13%	26	87%

Inferential analysis

In order to test the research hypothesessocio-emotional lonelinessscoresresulted whensumming the respondents' answers to the six items of the scale as a dependent variable was used. Score values ranged from 2 to 6.

To determine if there is a link between the level of loneliness and the age of the respondents (*research hypothesis 1*), the Pearson correlation coefficientwas determined. Test results are presented in Table 2.

Table 2
Correlation between age and level of loneliness

	Loneliness score	
Respondents' age (years)	Pearson Correlation	0.153
	Sig. (2-tailed)	0.420

The value of the coefficient (0.153) was indicative for a weak positive correlation. As the significance level of the test (0.42) was well above the critical value of 0.05, confirming the absence of a correlation between the two variables, the researched hypothesis wasinfirmed. In regard to the sampled group, an older age did not significantly correlate with a higher level of loneliness.

The Independent-Samples t-test was used in testing hypotheses 2, 3, 4, 5 and 6 as for each hypothesis the independent variable was dichotomous, while the dependent variable (loneliness score) was quantitative. Results are synthetically illustrated in Table 3.

Table 3
Hypotheses 2, 3, 4, 5 and 6 results following the successive use of Independent-Samples t test

The independent variable	**The independent groups**	**N**	**Mean loneliness score**	**t**	**Sig.**
Gender	male	23	4.26	**3.010**	**0.009**
	female	7	2.57		
Education level	≤high school	16	4.13	0.857	0.399
	≥ Bachelor's degree	14	3.57		
Living arrangement	living alone	14	4.36	1.458	0.156
	living along other people	16	3.44		
Self-perceived health status	satisfactory/bad	21	4.24	**1.841**	**0.076**
	good	9	3.00		
Church service attendance	low (annually/never)	11	5.00	**3.050**	**0.005**
	frequent (monthly/ weekly)	19	3.21		

When testing *research hypothesis 2* the results showed that the average loneliness score among women was significantly lower than among men (2.57 versus 4.26). This highly significant finding (a *t* value of 3,010, at a significance level p = 0.009) was validated, confirmingthat there is a statistically significant difference among genders in regard to the state of subjective loneliness (Table 3).

Research hypothesis 3 stated that educated elders tend to report a lower level of loneliness and, indeed, the average loneliness score for those with a Bachelor's degree was 3.57, while for high school graduates it was 4.13. However, the Independent-Samples t-test turned out to be insignificant as it recorded a value of 0.857 at a significance level of 0.399, exceeding the 0.05 limit. The research hypothesis was therefore rejected. In other words, education did not seem to influence the level of loneliness in the studied group as no significant differences in terms of subjective loneliness could be attributable to this factor.

Research hypothesis 4 that living arrangementsinfluenced loneliness levels seemed to be confirmed as elderlypeopleliving alone recorded higher scores of perceived socio-emotional loneliness (4.36) compared to those not alone (3.44). However, whentesting the differences between the loneliness score averages according to the presence or absence of other members in the household (Table 3), statistical results were yet again found to be not significant. The t-test value of 1,458 determined at a significance level of 0.156 refutes the existence of a statistically significant difference between the two groups. In other words, the level of loneliness was not significantly influenced by the presence of absence of otherhousehold members.

Research hypothesis 5 implied that loneliness was influenced by the perceived health status. Mean values of the loneliness scoresindicated that older people who reported a satisfactory or poor health status recorded a higher average score (4.24) than those who perceived themselvesto be in good health (an average score of 3). The result of the t-test (a value of 1,841 for a significance level of 0.076), as illustrated in Table 3, indicates that this difference was statistically significant, rejection of the null hypothesis being acceptable for a $p \leq 0.1$. Therefore, poor health was found to be associated with a higher level of subjective loneliness. Similarly, the elderly in good health experienced a lower level of loneliness.

The *testing of hypothesis 6* requiredthe analysis of loneliness score averages for the two categories selected to reflect the levels of religious involvement: frequent (weekly, monthly) or infrequent (annually, never). The Independent-Samples t-test indicated that seniors who frequently attended religious services exhibited lower levels of loneliness compared to those who did this rarely or never (average scores of 3.21 versus 5). This difference proved to be very significant, the t value being 3.050 at a significance level of 0.005 (Table 3). To conclude, highly significant differences in the level of socio-emotional loneliness can be observed in regard to frequency of the participants' involvement in religious services.

DISCUSSION

Social services for the elderly in the city of Zalău

In the city of Zalău two daycare centers provide integrated social services for the elderly. They were established under the provisions of Law 197/2012 on quality of social services, in compliance with the Ministry Order 29/2019 regarding minimal quality standards mandatory for the accreditation of social services for the elderly, as well as integrated community services and social canteens.

The “Forever Young” and “Second Family” daycare centers provide several services for the elderly, such as psychological counseling, medical assistance, legal counseling, and occupational therapy activities. The “Forever Young” center has 66 beneficiaries enrolled. Before the pandemic, 70-80% of them paid daily visits. A social laundry operates within the “Second Family” Daycare Center for the Elderly, volunteers from the beneficiaries' ranksbeing involved in collecting, washing, drying and distributing the laundry of the center's non-displaceable beneficiaries.

In addition to the activities and services mentioned above, in these centersthe elderly can engage in club-type activities such as board games (chess, backgammon, rummy), in cooking or painting classes, in language learning courses, birthday parties, etc. Through a collaboration with the Sălaj County Library, the elderly can train in operating on social platforms, enabling world-wide communication with family members and friends.

Periodical meetings with various personalities revealing their life experiencesare much appreciated. “Inter-generation exchanges”, as the pupils' visits to the “Forever Young” Daycare Center under the supervision of schoolteachersare called, are eagerly awaited by elders and youngsters alike. Day trips to tourist or historical places of interest are also organized, as well as visits to the city's museums.

During the pandemic, the services and activities of the “Forever Young” Daycare Center needed to be adapted in accordance with measures to prevent the spread of SARS-COV-2 virus. Therefore, psychological, social, legal and medical counseling were provided by telephoneonly. Also, center employees relayed Sălaj County Public Health Directorate's decisions regarding isolation and monitoring of the home-based isolated persons, while distributing standard food packages to isolated personswith no relatives. Activities requiring physical presencewere carried out in small groups, obeyingsocial distancing and protection measures at all times. Various activities including painting, cooking, foreign language courses or religious services were provided on online platforms.

A protocol between the Social Assistance Directorate and the Sălaj Red Cross enabled volunteers among the beneficiaries of bothdaycarecentersto be actively involved in providing assistance to the temporarily or permanently unmovableelderlywith no relatives in purchasing medicines or food, in paying bills and so on, along with the centers' employees.

Implications of the research results for elders' programs and social services

The research conducted among the beneficiaries of the "Forever Young" Multifunctional Center in the context of restrictions imposed due tothe COVID-19 pandemic were motivatedby awareness of the risk of accentuatedsubjective loneliness that affected elderlyin particular.The research was marked by a number of limitations, the size of the investigated group due to difficulties in interviewing beneficiaries of daycare centers in the context of reduced activities during the 2020 state of emergency/alertbeing the most prejudicial. Data collection over telephone interviews wassensibly more difficult than the application of the questionnaire within the center. Gender disparities were another limitation of the research, old women being less willing to attend the activities provided to the beneficiaries of daycare centers. It is documented that male elders have a consistently higher participation rate in the daily activities of these centers, this trend being also demonstrated in a study conducted in a center subordinated to the Directorate of Social and Medical Assistance within the City Hall of Cluj-Napoca (Marcovici, 2012).

Three of the six research hypotheses of the present study were confirmed: hypotheses 2, 5 and 6, concluding that the most important factors of subjective loneliness are gender, self-perceived health and religious involvement. The results of the research indicated that older and less educated elders living alone tend to exhibit a higher level of socio-emotional loneliness. These later results were not statistically significant, but one can assume that the investigation of a larger lot or sample could have brought significancefor these study hypotheses as well.

The state of loneliness can be influenced by the extent to which the elderly get involved in collective activities like those organized by daycare centers orcity clubs for seniors.Participating in group activities is beneficial and contributes to reducing loneliness. However, many elders, women in particular, fail to overcome the psychological barriers needed to get them out of the house boundaries and are deprived of the benefits of group activities involving people of the same age. The social workers' ability to determine elderly people living alone to get involved in such activities is instrumental in diminishing therisk of accentuated loneliness this group is most exposed to. One toollikely to elicit the elders' involvement could prove to be projects to restore intergenerational links between children and the elderly. Daycare centers for both groups could design joint projects in which the life experiences and professional skills of the elderly to serve as educational resources in informalactivities for children from dysfunctional families. Although to a lesser extent than in rural areas, traditional crafts are passed down from generation to generation in small urban areas as well. A display of such skills may be appealing to children intrigued by the novelty ofsuchextracurricular activities and to elders mastering them, the ability to capture the interest of the young audience acting as incentive for involvement in daycare centers' activities.

The most relevant results of this study argued that poor health and a low religiosity level are associated with a high level of socio-emotional loneliness. Given that these conclusions were reached among the beneficiaries of the “Forever Young” Center, the study’s primary usefulness resides in certain specific measures that could be taken by employees and volunteers of the centerin orderto change self-perceptions of the health status and increase the importance of the religious dimension in the lives of the elderly. In this regard, new activities can be proposed within the center, involving community professionals such as doctors, nurses and priests. They could lead activities orincrease awareness on topics related to dietchanges, involvement insport activities, reflection on the meaning of life and death, etc.

CONCLUSIONS

The present research revealed that the most important protective factors in reducing loneliness in the elderly beneficiaries of a daycare center in Zalău are a good self-perceived health status and a higher religious involvement.

These results do not meet the rigors of a probabilistic sample survey and cannot be generalized for all elderly attending daycare centers or senior clubs, but they may be relevant for the local community and may influence the quality of social services offered to the elderly.Thisstudy design and analysis can provide a model for professionals who want to investigate the factors of subjective loneliness in order to adapt or improve their psycho-social intervention.

In the light of the study results, as well as those of previous studiesregarding Romanian elderly, the measures to reduce the state of loneliness should start with identifying the preferences of the elderly. Their voice should be heard through qualitative studies - individual interviews and focus groups based on semi-structured interview guides - and it should be kept in mind that the elderly are by no means a homogeneous category, on the contrary, they constitute a very diverse age group. For example, in a qualitative study based on focus groups, applied in urban andrural areas, the existence of several categories of elderly women over 70 years oldwas revealed: leader, independent, child-supportive, centered in the past or children-dependent women (Faludi, 2012). In the design and development of new social services and activities for the elderly, determining the characteristics of this category of population, identifying their real needs and,whenever possible, atracting their active participation as a resource for mutual aid and support activities, are instrumental in capturing their interest in favor of such activities.

To conclude, in order to become an effective policy tool, active ageing should be a “dynamic, life course-driven concept that taps into people’s perceptions and enables them to create their own forms of activity, instead of focusing on a

pre-determined, limited number of domains, usually developed from an 'expert' perspective" (Boudiny & Mortelmans, 2011, p. 12). Active ageing implies the capacity to create supportive and "age friendly" contexts, shaped by individual choices, and to provide an easy access to a widerange of services according to specific perceived needs (Paúl & Lopes, 2017, apud Paúl, Teixeira & Ribeiro, 2017).

The concept of active ageing has its own strengths and limits. It can catalyze the interests of different social actors in order to design regional and local strategies concerning population ageing (Walker & Foster, 2013). It is a concept which promotes flexibility in retirement and acknowledgement of a diversity of activities, including volunteering. However, its critics underline the over emphasize on employment and the focus on "youthful" activities, neglecting the particularities of the "fourth age" - marked by biological decline and the need for long-term care facilities which absorb welfare resources (Moulaert & Biggs, 2013). Also, the approach of active ageing is sensitive to the structural context of each country in particular. From a macro-level perspective, prolonged economic hardships in Eastern Europe can jeopardize the implementation of such activities for the elders (Foster & Walker, 2015).

Romanian eldersexhibit a poorer mental well-being compared to younger populations. In order to enhance the social inclusion of this disadvantaged category, public social transfers should be directed to increase their access to services and to strengthen their social network. The main concerns the government is called to answer relate to improving the material status of the elderly, providing integrated socio-medical services, further development of long-term care, facilitating older people's access to these services, and enhancing stability and sustainability of such services. In order to diminish the social exclusion ofthe Romanian elders, the public discourse on active ageing needs to shift from deficit, decline, disability and dependency to well-being, activity and independence (Precupetu, Aartsen & Vasile, 2019).

The COVID-19 global pandemic producedseriouseconomical challenges which affected older adults more than other age groups. In this context, recovery after such a disruption can prove to be as important as maintenance of the general health or risk management. Hence, the complex system models for resilience in gerontology developed by Klasa, Galaitsi, Wister, and Linkov (2021) provide an approach which switchesthe focus on care from a preventive dimension towards recovery following unpreventable, arbitrary or usual ageing disruptions.

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SMANJENJE SOCIJALNE I EMOCIONALNE SAMOĆE STARIJIH U MALOM RUMUNSKOM GRADU

Sažetak: Ubrzanje starenja stanovništva širom Evrope primoralo je naučnike, političare i stručnjake da se pridruže svojim naporima u dizajniranju i sprovođenju socijalnih politika s ciljem postizanja aktivnog starenja. Razvijanje svesti o povećanoj socio-emocionalnoj usamljenosti među korisnicima dnevnog boravka u malom gradu iz severozapadnog dela Rumunije motivisalo je ovo istraživanje da identifikuje faktore povezane sa usamljenošću i pronađe načine da odredi pasivne starešine za bavljenje društvenim aktivnostima koje promovišu u dnevnom boravku, kao sredstvo za ublažavanje usamljenosti. Nakon metodologije kvantitativnog istraživanja, 30 korisnika starosti od 63 do 84 godine, među kojima je bilo 7 žena, popunilo je upitnik putem telefona. Petnaest pitanja dizajnirano je da istraži moguće faktore povezane sa subjektivnom usamljenošću. Opisne i inferencijalne analize odražavale su da su uzrast, ženski pol, niži nivo obrazovanja, nedostatak druženja, opažanje lošeg zdravstvenog stanja i retko pohađanje verskih službi povezani sa socio-emocionalnom usamljenošću. Međutim, utvrđeno je da samo pol, loše zdravstveno stanje i religioznost utiču na nivo usamljenosti na statistički značajan način. Mogući načini intervencije u dnevnom boravku kao rezultat ovog istraživanja podrazumevali bi promociju aktivnog učešća žena u međugeneracijskim projektima prenošenja tradicionalnih zanata mladim generacijama i uključivanje stručnjaka iz zajednice kao što su lekari, medicinske sestre i sveštenici u vođenje aktivnosti ili povećanje svesti o prednostima vezanim za promene ishrane, sportske aktivnosti, razmišljanje o smislu života i smrti. Pored toga, identifikovanje sredstava za primenu sistemskih modela za otpornost u gerontologiji moglo bi biti korisno sredstvo za oporavak nakon poremećaja izazvanog globalnom pandemijom COVID-19.

Ključne reči: aktivno starenje; socio-emocionalna usamljenost; Stari ljudi; socijalne usluge dnevnog boravka; Rumunija

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CONSEQUENCES OF POVERTY DUE TO TRANSITION PROCESS IN MONTENEGRO

Abstract: In this review, we provide a descriptive overview of the presence of poverty and in Montenegrobased on available and official data. Poverty in Montenegro shows the characteristics of relative present sustainability and regional dispersion. The fact that certain aspects of transition processes are still in Montenegro further complicates the reduction of this social problem. In the first part of this paper, we describe the transition process and the consequences on social structuring in Montenegro. We also describe the trends of the presence of absolute poverty in Montenegro. In the second part of the paper, we test the impact of independent variables such as age, employment status, level of education and health status. Additionally, we describe the movement of the consumer basket price in recent years as a one-dimensional indicator of the socio-economic status of citizens in Montenegro. The official data presented in this paper indicate the need to implement more proactive social reforms especially on the field of social and child protection.

Key words: *risk of poverty, transition, absolute poverty, consuming basket*

INTRODUCTION

While it existed in the framework of the Socialist Federal Republic of Yugoslavia (SFRY), Montenegro belonged to the so-called “club of underdeveloped republics and regions”. Consequently, it can be inferred that existing in a non-stimulating socio-economic ambience is not a novelty for Montenegro and its citizens.

Following the collapse of the former SFRY, the negative socio-economic aspects of the process of transition led to inevitable and radical changes in the social structure of the Montenegrin society (Janković, 2013). The development of social policies in Montenegro was highly diffuse. The lack of organised treatment of social problems is among the main causes of the fact that scientific and analytical data on poverty, unemployment, social inequality, social stratification etc. cannot be described as exhaustive.

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The socialist ideology shaped the socio-economic development of Montenegro in the years that followed the collapse of the former state. The former socialist societies functioned upon the principle of unconditional egalitarianism, i.e. equality of all in the sense of needs. "Such egalitarianism, fundamental in its character, implied equality in terms of poverty in the given point in time in order to have a better future. Naturally, such a principle never worked in practice" (Stropnik, 1993). Social policies were integrated in the generally accepted ideology, and presented a means of legitimising the social structures of the time (Šućur, 2001, p. 134). Citizens were guaranteed employment, which was used to contribute to social insurance, while the main and practically the only implementer of socio-political measures was the state. For years, the basic task of social policies was to "permanently" and "consistently" lead to improvements in all the indicators of people's wellbeing. Deviation from utopian ideas that socialism was a system that could accommodate for the needs of all people was not frequent (Čekerevac, 1999, p. 151). However, social differences were evident in the society even at that time.[2]
Social services implemented activities in line with principles of inclusivity and universality, and they were assisted by well-developed state enterprises. The dependence on the stability of the economic structure of the society as a whole put these services in jeopardy with the first signs of social crisis and the need to transform the social system. The process of transition is normally characterised by changes and formation of new institutions, changes in the role of the state, creation of significantly different government institutions, and promotion of private enterprises, markets, and independent financial services. The common citizen could not avoid these radical changes, since the change of the social structures implied a change in the value system, and the way of thinking and living in the new conditions. Transition was imposed as an inevitable result of the crash of the socialist concept of life, and its consequences had a significant effect on the social stability of citizens.

TRANSITION PROCESS IN MONTENEGRO

The end of the 80s and beginning of the 90s was the period mostly referred to as the starting point of transition processes in Montenegro, when the socialist system started withdraw from the historical stage in most European countries, where it had previously been dominant for decades. That part of the Montenegrin history is marked by processes of changing the old socialist regime government, and the state model that characterised Montenegro, followed by the introduction of a multi-party system, eruption of nationalism and the emergence of a civil war

[2] Social differences were founded in social inequalities that implied unequal conditions of the people that functioned in the system of reproduction (nut just material, but also social). These differences came in different forms: amount of income, differences in the social and political position, availability of funds, different starting positions in the society, etc. (Šefer, 1974, p. 123).

that further worsened the social situation in the - already not particularly advanced - Montenegrin society. Montenegro entered the transition process, marked by an overall social crisis, which was a result of a long-lasting genesis of social problems, weighed upon by these social changes. The problems were directly related to the characteristics of the former Yugoslav economic system, which was fading away alongside the former Yugoslav state. The economic system was no longer capable of repaying the accumulated debt, and the political system was not capable of generating positive economic and political change (Milosavljević, 2003, p. 43). According to Lakićević (1997), the social crisis of the then Yugoslav society was caused by a lack of flexibility of the economic, technological and political systems, and the inability to adapt and change, which resulted in degradation of the overall social situation, especially in comparisonwith the developed countries in that period.

The Serbian author Miloš Bešić states that, in the context of transition in Montenegro, we must bear the following two situations in mind: *the changes of the political structure of the society* and *the property transformation process* (Bešić, 2000, p. 197). A one-party system was being transformed into a parliamentary democracy. New political parties emerged, with a clear goal of securing a leading position in the process of managing social changes. In the socialist society, property was not only the foundation of an efficient economy, but also a mechanism for reproducing ideology in all spheres of life. Inevitably, the process of transition had to imply a transition to mechanisms of private property. Pečujlić (1996) argues that privatisation in post-socialism had two forms: formal ownership, and non-ownership privatisation.[3] The process of re-concentration of social property into private property was, unfortunately, marked by the latter type of privatisation, which has proven to be detrimental not only to the economy, but the overall social and cultural system as well. The reasons for this are the accompanying characteristics of the process of transition, such as: slow implementation of transformation, lack of definition of the methods of privatisation, lack of limitations, the effects of external and internal political and economic issues, etc. The political and economic ambient of the time, typified by sanctions of the international community and war in the region, did not facilitate the transformation of the Montenegrin society; on the contrary, it drove the socio-economic development of the country in the direction of great uncertainty.

The transition period in Yugoslavia (and, therefore, Montenegro) had four phases: a) macro-economic stabilisation; b) liberalisation; c) privatisation; d) re-structuring (Lazić, 1994). Many were hoping that political pluralism and the

[3] Formal ownership, or legal and legitimate privatisation, encompasses several different models, and the most popular model is the voucher privatisation. Non-ownership, i.e. using one's position in management, encompassed the elite that belonged to party nomenclatures, who became semi-legal owners of state property. Pečujlić calls this phenomenon the bourgeoisieing of the bureaucracy (Pečujlić, 1996, in Bešić, 2000, p. 10)

market economy were tested paths that the citizens of Eastern and Central Europe would run down on their way to a society of abundance and freedom (Lazić, 2011). Surges of social and economic problems that came about as a result of the process of transition have prevailed up to the present-day, despite certain optimistic expectations. Transition theoreticians argue that the period of transition was affected by the following: the economic structure as a limiting factor of transition, reproduction of the state bureaucracy, reproduction of the class structure, reproduction of cultural patterns, social expectations of the population, reproduction of collectivism, reproduction of authoritarianism, the methods of realisation of transition, and international relations (Bešić, 2000, pp. 125-131). Additionally, Bešić emphasises another important characteristic of real-socialism: its grounding in the traditional society, and the existence of a strong historical-traditional foundation with a tendency of reproduction (Bešić, 2000).

"The final effects of transition were reflected by the system of social stratification. Certain elements of modernisation that were present in the socialist society (in the sphere of health, education and housing policies etc.) were lost. The evident polarisation of the society resulted in a division of the population into *winners* and *losers* of the transition processes. Naturally, the percentage of "winners" was negligibly small compared to the vast number of "losers" in the process. However, this numerical minority grew to become the majority in terms of its economic power, and evolved into the dominant class on the social scale. Members of the newly formed economic elite have become a significant social subject in Montenegro, who have held a strong sway on political decision-making. On the other hand, the "losers" in the process of transition faced problems in terms of existential functioning, and their low position on the social scale was marked by a rapid reduction of opportunities for adequate social participation.The measures employed by policy creators by the end of the 90s were short-term, and mainly aimed at "putting out fires" (Filipovič-Hrast, Janković & Rakar, 2020, p. 691).

Social policies were not adequate for facing serious challenges, nor was there a tradition in applying the mechanisms of social policies to address poverty (Madžar, 2000, p. 97). The GDP dropped by a half in the 1990-2000 period, and the influx of refugees and migrants placed additional strains on the exhausted social funds (Ardarenko & Đurović, 2004, p. 4). "All social positions were ossified. The *winners* in the process of transition aimed at preserving or increasing the wealth accumulated in the transitional currents. The poor struggled to escape the vicious cycle of poverty, especially due to a lack of extensive state policies with long-term effects. A wide range of social activities became inaccessible to a vast number of people, and the implementation of significant activities that were not *ad-hoc* in character, and that aimed at mitigating these consequences started only in 2000" (Filipovič-Hrast, Janković & Rakar, 2020, p. 692).

POVERTY IN MONTENEGRO - OFFICAL DATA

According to data in the Table 1, expenditure associated with household consumption that determines the poverty line in Montenegro, grew between 2006 and 2013 - from 144.68€ in 2006, to 186.45€ in 2013[4]. Simultaneously, the number of poverty-stricken people (poverty rate) decreased by almost a half between 2006 (11.3%) and 2010 (6.6%). However, the trend of the deteriorating social situation continued from 2010, and the rate of poverty was at 8.6% in 2013. The depth of poverty shows how much income should be transferred to poverty-stricken population in order for household income growing to the poverty line. Accordingly, the number of people who should be subject to these transfers increased from 1.9% in 2006 to 2.4% in 2013. Additionally, the number of people who are the farthest away from the poverty line in relation to those who are the closest to the line (severity of poverty) reduced in the period between 2006 (from 0.6%) and 2010 (to 1.1%). When it comes to the Gini coefficient, which is used to measure inequality in expenditure, its value increased from 24.4 in 2006 to 26.2 in 2013.

Table 1
Poverty line[5]

Year	National absolute poverty line	Poverty rate (%)	The depth of poverty (%)	The severity of poverty (%)	G i n i (%)
2006.	144,68	11,3	1,9	0,6	24,4
2007.	150,76	8,0	1,4	0,4	26,4
2008.	163,57	4,9	0,9	0,3	25,3
2009.	169,13	6,8	1,4	0,5	26,4
2010.	169,98	6,6	1,1	0,3	24,3
2011.	172,25	9,3	2,0	0,7	25,9
2012.	182,43	11,3	2,8	1,4	26,5
2013.	186,45	8,6	2,4	1,1	26,2

Source: MONSTAT, Department of labour market statistics, living conditions, social services and household consumption

[4] According to data of UNPD, absolute poverty rate during 2018th is 8.6% in total population of Montenegro. Absolute poverty rate is biggest on the North region of Montenegro (10.3%).

[5] Zoran Šućur, a Croatian author, points to three functions of the poverty line. Firstly, it serves as a foundation for assessing the rate of poverty. Secondly, the poverty line is necessary to monitor the dynamics of poverty in a certain period of time. Thirdly, poverty line is needed to identify the composition of the poor, and the risk of poverty (Šućur, 2006, p. 239). Montenegro uses a one-dimensional method for determining the objective poverty threshold, used to assess the number of people living in absolute poverty.

According to the hitherto implemented strategies for poverty reduction (2003, 2007 and 2013), poverty is more prevalent in households with more than four family members. According to that indicator, they make up for 94.3% of the poor in Montenegro. According to the indicator of age, the poorest category is the age group 65 and older. Households in which an adult female or a person over the age of 65 is the sole or main income provider, are at a particular risk of poverty. Household providers mostly hold a high school degree (any high school); and they are mostly employed, male, between 25 and 49 years old; most of them were born in Montenegro, and live in the municipality in which they were born (83%). A higher degree of education reduces the risk of poverty; families whose providers are unemployed or retired are at a greater risk of poverty; ownership of agricultural property does not contribute to reducing the risk of poverty, but the risk is not particularly high for those who own it; the safest and most stable families are those whose providers are economically active, and between 25 and 47 years old; the place of birth of the provider is not a particularly important factor in driving poverty rates in household (Development and Poverty Reduction Strategy, 2003 and 2007). Essentially, it is age, education, status and type of employment that drive the risk of poverty.

In Table 2. we can see that the number of poor below the poverty line increases dramatically with the median increase in average income in the average household. Also, if we use the European criterion (EU), 60% of the median of average incomes, the number of the absolutely poor in Montenegro is growing above European standards.

Table 2
Dispersion around the threshold of risk of poverty

	2013	**2014**	**2015**	**2016**	**2017(p)**
Risk of poverty:					
40% of median	16,2	11,9	13,5	12,9	11,9
50% of median	21,9	17,4	19,9	18,7	17,2
70%of median	33,4	32,5	31,9	31,2	30,4

Source: MONSTAT, 2018

The overall number of family members has increased by 10% in Montenegro, which is a direct cause of the drop in per capita expenditure by 5%. Regionally, the north shows the lowest rate of elasticity in expenditure at 48%, and the south reaches the rate of 75%. The trend can be explained by the fact that the increase in the number of family members narrows down economic activity since the income of those who are employed is being distributed to a greater number of household members (Development and Poverty Reduction Strategy, 2003, p. 22).

POVERTY INDEX IN MONTENEGRO

In the continuation of this paper, we want to examine the factors of poverty in Montenegro in the period after restoration of Montenegro independent. For this purpose, we will test age, employment status, level of education, health status and housing conditions as key determinants of poverty in Montenegro. As a measure of poverty, we used the constructed scale of housing conditions, based on data from the SEESSP survey conducted in 2006 in Montenegro. This research, among other things, measured certain aspects of housing conditions, ranging from basic conditions such as owning a bathroom, owning a library with more than 100 books etc. (16 different items were measured). Reliability analysis shows that all 16 items measure a unique score (Crombach's Alpha coefficient 0.781) that we could define as a household *poverty index* relative to housing conditions. We will use this score for the purposes of analysis as a measure of poverty. According to composition of the index, we can say that households on the lower scale of the index (this means that they exist in very low housing conditions) are in poverty status. Contrary, households at the top of the index scale (meaning that in addition to the aforementioned such households have mobile phones, internet connection, two vehicles, a library with more than 100 books) are at risk of poverty. At the beginning of our analysis, we want to present the created Household Poverty Index in which Montenegrin citizens live.

Table 3

Poverty index

Statistics		
N	Valid	749
	Missing	1100
Mean		.4010
Std. Error of Mean		.00584
Median		.3750
Mode		.38
Std. Deviation		.15977
Variance		.026
Skewness		.251
Std. Error of Skewness		.089
Kurtosis		.658
Std. Error of Kurtosis		.178
Percentiles	5	.1250
	25	.3125
	50	.3750
	75	.5000
	95	.6875

SEESSP, 2006

A review of the percentile (Table 3) shows that 25% of households are between value 0 and 0.31 while the next 25% are concentrated between values 0.31 and 0.375. It is interesting to note that 75% of households have an index value between zero and 0.5, while only 25% of households are above 0.5 on the poverty scale. Two thirds of Montenegrin households are below the imaginary mean between 0 and 1 poverty distribution. In addition, the 95th percentile, which value is 0.69, because shows that only 5% of households are above this value, illustrates a similar picture. Therefore, 5% of Montenegrin households enjoy the privilege of wealth according to the data from the created Household Poverty Index.

Factors of poverty in Montenegro

According to measurement by index of housing condition (SEESSP, 2006) ageing is an important factor of poverty. Namely, young people from 18 to 35 years have the highest index value of 0.428, followed by persons aged 36 to 55 0.465, while the lowest index value of persons older than 55 is 0.348 ($F(2, 746) = 13{,}840$, $p < .001$.

Table 4
Poverty index vs. age

Age	N	Poverty index	Standard deviation
People up to 35	272	0.428	0.150
People from 36 to 55	306	0.405	0.155
People over 55	171	0.348	0.171

SEESSP, 2006

Employment status is an inevitable poverty factor ($F(8, 735) = 7.189$, $p < .001$). Employment persons have a lower value of the index regardless of the type of employment ((permanent employment (0.441) or fixed-term employment contract (0.438)). Unemployed persons have lower index values, both those unemployed persons who are actively seeking employment (0.384) and those persons who are not actively seeking employment (0.380). Finally, older people (pensioners) have the lowest value of the index (0.354).

Table 5
Poverty index vs. employment status

Age	N	Poverty index	Standard deviation
Employment – permanet	276	0.441	0.153
Employment – fixed term contract	13	0.438	0.179
Unemployment – actively seeking	137	0.384	0.139
Unemployment – not actively seeking	62	0.380	0.142
Older people	148	0.354	0.169

SEESSP, 2006

According to available data, education has been proven as a very important factor of poverty, resulting in largest differences in the level of poverty or wealth between different categories of education level ($F(2, 744) = 63.747$, $p < .001$).

The average value of the poverty index for people with primary education or less is 0.286. People with secondary education have a value of index 0.417 while people with higher education have a value of index 0.498. Thus, a lower level of education creates the conditions for a higher risk of entering in poverty zone. On the contrary, a higher level of education reduces the chances of entering in poverty risk.

Table 6
Poverty index vs education

Education level	N	Poverty index	Standard deviation
Primary education or less	142	0.286	0.137
Secondary education	521	0.417	0.151
High education	84	0.498	0.150

SEESSP, 2006

Peoples health status has been shown to be an important factor in poverty ($F(2, 737) = 26.312$, $p < .001$). People who rated their health as good have a living conditions index of 0.427 while persons who rate their health as average have an index value of 0.373. Additionally, index value for people who rate health as poor is 0.297.

Table 7
Poverty index vs. health status

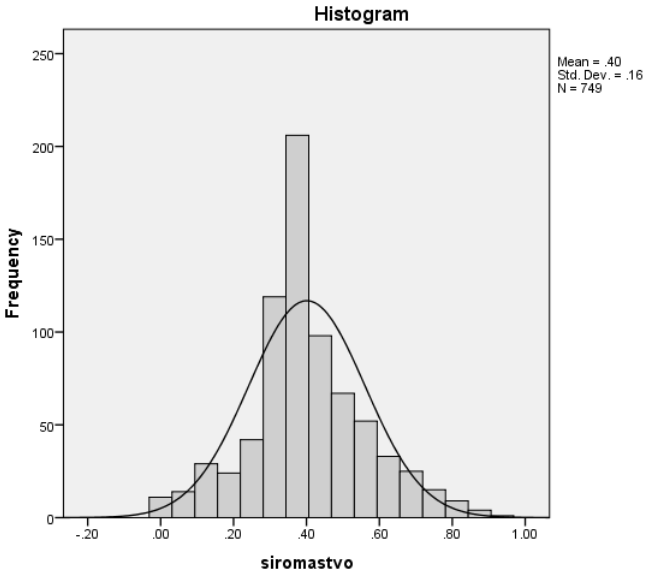
Health	N	Poverty index	Standard deviation
Good health	471	0.427	0.152
Medium health	197	0.373	0.155
Poor health	72	0.297	0.165

SEESSP, 2006

In histogram 1, on a scale of 0 to 1, where zero represents the highest level of poverty and 1 the highest level of wealth, the average value at the level of the entire population is 0.40. Therefore, we can state that the distribution is below the middle of the scale, and indicates a slightly higher level of poverty. When it comes to population distribution, we see that it is curved to the right (skjunes is 0.25) which means we have a higher frequency of below-average values compared to above-average ones. In addition, the courtesy is extremely positive (0.658), which tells us that the distribution is sharp, and that the frequency of households is

higher around the arithmetic mean than at the ends of the distribution. This data indicates that the circumstances of living for majority of Montenegrin households are more conducive to the possibility of entering the risk of poverty.

Histogram 1. *Distribution of the household poverty index*



SEESSP, 2006

CONSUMER BASKET IN MONTENEGRO

Regular research is conducted on the consumer basket for families of four, and the results of these research efforts are a particular point of focus in Montenegro. The total value of a minimal consumer basket is comprised of monthly expenditure on food, non-alcoholic beverage and non-food items and services. According to data in the Table 8, we can see the trends of consumer basket movement in Montenegro. If we compare the relationship between the price of the consumer basket and the minimum wage in Montenegro, we can conclude that the price of the consumer basket is growing disproportionately to the growth trends of the cost of living. In recent years, about 70,000 employees in Montenegro received a minimum wage that for a long time (until 2019) amounted to 193 euros. Increasing the minimum wage during 2020 to a net amount of 222e is unlikely to have a more drastic effect on the standard of Montenegrin citizens. Montenegro's minimum wage is in the net amount of 222 euros, without taxes and contributions, which is among the lowest in the world, according the latest report by the International Labor Organization (ILO, 2020).

Table 8
Minimal Consumer Basket in Montenegro

Minimal consumer basket, July 2019			
Year	Expenditure on food and non - alcoholic beverages in EUR	Expenditure on non - food products and services in EUR	Total value of the minimum consumer basket in EUR
2019[1)]	270,9	370,7	641,6
2018[1)]	262,9	375,4	638,3
2015[2)]	252,9	353,2	606,1
2014[2)]	246,7	349,5	596,2
2013[2)]	259,5	350,2	609,7
2012[2)]	250,7	348,9	599,6
2011[2)]	251,1	335,8	586,9
2010[2)]	249,2	329,9	579,1

Source: MONSTAT (2019)

The yearly increase in the price of products that comprise the consumer basket is evident. Average monthly income has grown in parallel with the increase in the value of the consumer basket. At the moment, the average gross salary in Montenegro is 516€, which means that the total value of the consumer basket significantly exceeds the value of the average monthly salary.

INSTEAD OF CONCLUSION

The ongoing social structuring and social stratification in Montenegro is a result of a lack of link between economic, cultural and social capital. There is no reliable data on the standard of living, apart from surveys that encompass data on expenditure. The ways in which individuals, families, households and local communities react to frequent shocks in terms of income and earnings have not been researched systemically. The majority of findings are based on the so-called “strategic approach”, whereby in the moment when key objectives are being implemented, key effects are mostly missing. Statistical systems are also not developed enough to enable serious and successful tracking of poverty and its development, which is why research on this social problem is irregular, and frequently conducted with the help of international organisations (Filipovič-Hrast, Janković & Rakar, 2020).

Social and child protection in Montenegro (material benefits and social services) are based on the activities of centres for social work that have key authorisations in granting material benefits to the poor people[6]. Support to the poor

[6] In approving material benefits relating to material support, personal disability allowance, care su-

in Montenegro in the coming period will directly depend on the flexibility of the social and child protection system. There is space for NGO activities, but people at risk of poverty predominantly rely on state interventionism.

In the past ten years, Montenegro has conducted a comprehensive reform of the system of social and child protection. The initial impetus for reform was driven by the UN agencies in the country (UNICEF, UNDP), and through significant financial support provided by the European Union (IPA 2010, 2014), resulting in consolidation of the legislative and strategic frameworks with international obligations and standards. Consequently, Montenegro has founded the Institute for Social and Child Protection, implemented comprehensive reform of its centres for social work, and intensified the processes of deinstitutionalisation and decentralisation, which contributed to a significant reduction in the number of users of residential accommodation, and an increase in the number of services provided to families and communities (IDEAS, 2019). Additionally, these reforms resulted in the creation of a system of social welfare – the social card (Social Welfare Information System - SWIS). In this moment SWIS is mostly focusing on monitoring of material benefits.

Creating an adequate model of sustainable financing of the system of social and child protection in Montenegro in the coming period is one of the key challenges for the system.The problem is further complicated by the fact that the system for social and child protection in Montenegro is mainly based on financial support for the population that meets the requirements for this type of support, whereas social services are somewhat marginalised in the system. Such a configuration of the system can provide temporary relief in terms of mitigating the risk of social marginalisation, but cannot provide a long-term strategy for protecting the population from slipping into the poverty zone. A long-term outlook on the matter should entail limiting financial support, and enhancing provision of non-financial forms of support to users.

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pport and benefits and one-off material support, centres for social work ought to register evidence and provide analyses and conclusions that would later be used as evidence. Through this mechanism, Montenegro provides a wide range of material benefits that can serve as significant support to children and other users. Naturally, the issue of the strain due to processing requests relating to such a vast number of different types of support prevails. In that sense, it would be recommendable to merge some of these forms of support.

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POSLEDICE SIROMAŠTVA UZROKOVANE TRANZICIONIM PROCESOM U CRNOJ GORI

Sadržaj: U ovom pregledu pružamo opisni pregled prisustva siromaštva i u Crnoj Gori na osnovu dostupnih i zvaničnih podataka. Siromaštvo u Crnoj Gori pokazuje karakteristike relativne sadašnje održivosti i regionalne disperzije. Činjenica da su određeni aspekti tranzicionih procesa još uvijek prisutni u Crnoj Gori dodatno komplikuje smanjenje ovog socijalnog problema. U prvom dijelu ovog rada opisujemo proces tranzicije i posljedice na socijalno strukturiranje u Crnoj Gori. Takođe opisujemo trendove prisutnosti apsolutnog siromaštva u Crnoj Gori. U drugom delu rada testiramo uticaj nezavisnih promenljivih kao što su starost, radni status, nivo obrazovanja i zdravstveni status. Pored toga, kretanje potrošačke korpe poslednjih godina opisujemo kao jednodimenzionalni pokazatelj socijalno-ekonomskog statusa građana u Crnoj Gori. Zvanični podaci predstavljeni u ovom radu ukazuju na potrebu sprovođenja proaktivnijih socijalnih reformi, posebno u oblasti socijalne i dečje zaštite.

*Ključne reči***:** rizik od siromaštva, tranzicija, apsolutno siromaštvo, potrošačka korpa

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RISKS AND CHALLENGES OF AGING IN THE NEXT DECADE

Abstract: United Nations have declared the decade of 2020-2030 as the – "Decade of healthy aging". This represents the imperative for all countries to plan and undertake activities for betterment of life of elderly, their families and communities in which they live. The accent is on "active aging" which was introduced as a concept by the World Health Organization in 2002 in order to answer the challenges of increased number of elderly persons and the risks that aging brings with it. According to this concept, conditions of life of elderly persons significantly reduce the risks by which they are affected. Accordingly, "cities adapted to the elderly" are those in which citizens, service providers, public services and government officials recognize the individual needs of the elderly persons, promoting their inclusion in various spheres of social life, respecting their decisions, striving to improve all aspects of affect on quality of life of the elderly. Within the concept of the World Health Organization, a research was conducted the aim of analyzing the adaptability of cities to the elderly persons, in 847 cities and local communities in 41 countries. Following the methodology of the World Health Organization, a research was carried out in organization of Institute for public policies which aimed at analyzing adaptability of city of Belgrade to the needs of elderly.[2] Research was conducted from October 2018 to July 2019. In the quantitative part of the research 5600 elderly persons took part and 16 focus groups were realized for the needs of the qualitative research. Eight different fields important to elderly persons were examined showing the extent to which the city is adapted this group: public space and public buildings, transportation, housing, participation and support within society, respect and social inclusion, civic engagement and employment, communication and information, development of social and health community services. The key findings of the research show that the elderly are mostly satisfied with living conditions in Belgrade, care within community, that they feel safe in the city and they want to live as long as possible in their communities, but have also identified numerous fields that can be improved to make Belgrade a city adap-

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[2] The research was conducted within project "Belgrade – Age-friendly City", which is founded on the basis of the Annual Competition for the Improvement of the Social Protection System in the Republic of Serbia in 2018.

ted for the elderly. The authors gave their recommendations for improvement in all of these fields. In this work, the findings of qualitative research will be presented. The research has values for other cities as well, as these recommendations for improvement of position of elderly persons can be adapted in every local community.

Keywords: elderly, risks, quality of life, local community, community services

INTRODUCTION

The world has been facing major demographic changes for decades. The estimated number of inhabitants in the world in 2019 is around 7.8 billion. By increasing life expectancy, population aging and declining birth rates, the number of the elderly is increasing. Our country is also in a phase of distinctly aging of the population. The estimated number of inhabitants in the Republic of Serbia in 2019 is 6,926,70 (Statistical Office of the Republic of Serbia, 2019a). According to the data of the Statistical Office of the Republic of Serbia, the share of the population older than 65 is 20.2%, while the average age of the population is 43.2% (Statistical Office of the Republic of Serbia, 2019b). This data indicates that our country is seriously affected by the trend of population aging and is among the ten countries in which the population is expected to decrease by more than 15% by 2050 (Brkić, Vesić, Perić & Jakšić, 2020).

Modern societies strive to create conditions for the implementation of strategies that are directed toward the elderly, their well-being, health, satisfaction and quality of life. Quality of life is defined as the general well-being of individuals, families and the community as a whole. The quality of life is also affected by the risks that affect the elderly. Indicators of quality of life can be different and have different individual significance for certain categories and age groups of the population. Responding to demographic changes that led to an aging population as well as longer life expectancy, new measures, which are most often based on state intervention, are aimed at improving the quality of life of the elderly and reducing risks that accompany this age. Most certainly among the most important indicators and factors that affect the quality of life of the elderly, are socio-economic factors, health factors, housing conditions, lifestyle and physical activity, social support and participation within the community.

Demographic changes that have taken place in recent decades have caused a new way of thinking about the elderly. Today, the concept has been changed so that old age is viewed as a normal and healthy part of life with many good sides to it. Aging is accompanied by numerous and complex interactions that have diverted researchers' attention from the physiological basis of aging to the environmental factors that affect functional ability at all levels. Observing old age in this way, attention is focused toward preserving and strengthening the

competencies of the elderly and alsoadapting living conditions within community to the needs of the elderly.

This is set as an imperative for all modern societies, and thus also for our country. This approach does not negate the fact of the existence of aging, but creates protective factors in the environment to encourage the independence of the elderly and raise the quality of their lives.

CHARACTERISTICS OF AGING - QUALITY OF LIFE OF THE ELDERLY AND SAFETY

Aging and old age as phenomena are often in the focus of interest of the general and scientific public. Even after a large number of scientific studies and papers, there is still no single position on what old age is, how aging exactly takes place, what phases it is made up of, and so on. Aging is an inevitable biological phenomenon, which begins to be realized immediately after birth. Therefore, we can view old age as a condition, while aging is a process.

We can define aging as “a progressive disorder of physiological functions that eventually leads to death” (Plećaš, Živković & Potparević, 2009). Yet, aging is not a disease.

The quality of life of the elderly is increasingly in the focus of scientific research, given the demographic characteristics of modern societies in which there is a noticeable trend of increase of the share of the elderly in the total population. Many factors have been found to affect quality of life of the elderly. In earlier periods, researchers mostly associated quality of life with health and relied on the medical model, while the focus later shifted to demographic factors in terms of the relationship between gender and place of residence of respondents in relation to the quality of life of the elderly (Despotović, Trifković, Kekuš, Despotović, & Antić, 2018). In recent years, emphasis has been placed on the living conditions of the elderly, socio-economic factors, but also lifestyle, social support, participation within the community, as well as the position of the elderly in a society (Despotović et al., 2018). One of the key factors is the way of organizing the life of the elderly, the degree of satisfaction of needs and the level of well-being (Milanović, Perić & Brkić, 2014).

On the other hand, there are numerous risks that are conditioned by the processes and outcomes of aging. Risk is a term from social theory and represents one of the basic companions of modern society. Risk means the possibility of “occurrence of events with negative consequences” that occur in connection with the undertaken activity, or process (Marković, 2005). Old age itself carries with it a number of changes that make older people more susceptible to different types of risks. The state, local governments and community service providers should all be geared towards creating conditions for the safety of the elderly.

A key feature of risks is that they can be avoided. Closely related to risks is the concept of security, which in modern society is seen as one of the key values.

Historically risk in not a new concept, it has already existed in traditional societies. But risk research has emerged relatively recently, with hazard avoidance issues and safety research issues. Initially, these researches were aimed at accident research and improving safety in the workplace, and later the risks began to be studied at the global level, as global phenomena (Marković, 2005).

Risk research has great value in prevention of risk appearance and reduction of consequences if unwanted occurrences do happen. Through risk research a culture of safety is developed. It is seen as a process of "preservation and development of goals, ideals, values, norms and traditions of human and society, securing constant and constructive connection between people and their protection from endangerment, risks and challenges" (Marković, 2005). Research conducted in 2019/2002 in Republic of Serbia, indicates that crisis situations that create insecurity among members of a society, have a positive effect on strengthening all types of solidarity, both intergenerational and intra-generational (Vesić, Brkić, Jakšić & Perić, 2020). This way of understanding safety and risk has a great impact on the quality of life of elderly (Bek, 2001).

In order to increase the quality of life of the elderly, but also to reduce the risks that accompany old age, the World Health Organization in 2002 launched activities related to the promotion of active aging. The aim of these activities is to support local communities to recognize, develop and improve support for older people, in response to the phenomenon of global aging. By seeing local communities as places where "organized social activities are taking place, providing support to local population in satisfying many of their needs" (Milosavljević & Brkić, 2010), this concept is based on the fact that in local communities, policies, programs, projects, services and all offices in the community should be designed in such a way as to enable elderly people to live safely, to have different services available to them, to participate in everyday activities within the community and to participate in decision-making (World Health Organization, 2007).

The World Health Organization defines that a local community that is adapted to the needs of the elderly means that citizens, decision makers and all public services recognize the needs of the elderly, promote their inclusion, integrationand participation, respect the decisions of the elderly, accept their lifestyle and plan various activities to respond to the needs of the elderly (Brkić et al., 2019).

Cities and local communities adapted to the elderly, according to this concept, accept "active aging" as an imperative, which means creating preconditions for good health of the elderly, integration of the elderly and increasing their safety, all in order to improve the quality of life of the elderly (Public Health of Canada, 2015). Cities adapted to the elderly are those that direct their development and activities towards the construction of a safe environment, development and

availability of services intended for the elderly. This has multiple benefits for both the elderly and their families but also the community as a whole.

To this end, the World Health Organization has developed a unique methodology for assessing the adaptation of cities to the needs of senior citizens. This unique methodology has so far been used in research conducted in 847 local communities and cities in 41 countries around the world (Brkić et al., 2019).

RESEARCH – METHODOLOGY

The main goal of the research was to determine how much the living conditions in the City of Belgrade are adjusted to the needs of elderly citizens, to point out the availability of services and support they have, but also the existence of risks to which they are exposed, in relation to the following domains:

- Public space and public buildings
- Traffic
- Housing
- Participation in social activities and social support (social participation)
- Respect and social inclusion
- Civic participation and employment
- Communication and information
- Community support
- Access to health and social care services

The first phase of the research was related to the development of adaptation indicators for eight areas of the city adapted to the elderly - which are defined in the documents of the World Health Organization and the analysis of data availability.

In the second phase, a research was conducted that referred to the collection of data from secondary sources, from institutions that possess the requested data, primarily the city administration. The research was realized as a mix-method.Within the quantitative part, data were collected on a sample of 5600 elderly, in all municipalities of the City. The qualitative part of the research was related to the implementation of 16 focus groups with the elderly, service providers and representatives of municipal and city authorities.

The third phase referred to the analysis of the obtained data, comparison with similar research in other European cities in which the same methodology was applied and formulation of recommendations.

This paper will present the findings of qualitative research that was realized within the project. Within the qualitative research, focus groups were realized for each area that was defined in the goal. A total of 16 focus groups were implemented,

in which the participants were elderly citizens, service providers and local decision makers. Qualitative research was conducted after the collection of secondary data and parts of data collected and analyzed in quantitative research.

The sample consisted of representatives of the elderly, evenly represented in relation to gender, age, functional efficiency, but also in relation to the type of local community in which they live. The limitation of this research is that the sample does not include the elderly who are seriously ill and immobile.

The research was conducted during 2019, on the territory of the City of Belgrade, on a representative sample and included elderly people from all Belgrade municipalities - central and suburban.

KEY FINDINGS - QUALITY OF LIFE OF THE ELDERLY AND RISKS

Public space and public buildings

The mobility of the elderly in the external environment is one of the key factors in preserving the independence of the elderly, reducing risks and increasing the quality of life. Public areas such as public spaces and public buildings are of great importance for the mobility of elderly people, which by all criteria affects the general functionality of the elderly and thus on the quality of their lives. Research often cites obstacles and barriers that are an aggravating factor in the movement of the elderly in the external environment (Aspinall et al., 2010).

The adaptation of public areas to the needs of the elderly was examined through the adaptation of roads and sidewalks for walking, access and accessibility to public facilities, but also through a sense of security and safety in public places. Within this topic, through focus groups, we got a perspective on assessing the adaptation of housing conditions for the elderly through information on what the life of an elderly person in Belgrade looks like outside their living space, when walking through the city or using public institutions, parks, etc.

The experiences of the elderly are different when it comes to their mobility. Most of them point out the obstacles they face when walking on the sidewalks - from dilapidated and collapsed sidewalks, high sidewalk shoulders to parked cars on the sidewalks that make it difficult for them to move and create a risk of tripping, falls and injuries. Physical barriers stand out as the biggest problem. Elderly people complain about slippery sidewalks, but also the negligence of fellow citizens and public services to clean snow and ice from the sidewalks in the winter.

Also, there are noticeable differences in the parts of the city where the elderly move. The most problematic are the central city municipalities, with busy narrow streets, parked cars on both sides of the street, which requires elderly people to get on the road to bypass obstacles, cars parked on sidewalks. To the elderly with difficulties for movement, this is sometimesimpedes movement at all.

As for the good sides, the elderly people state that low curbs have been built on all newly built roads. They saw the lowered sidewalks and sidewalks at intersections as positive because it makes it easier for them to cross the road and makes the process faster.

The existence of promenades and bicycle paths is positive if we look at creating conditions for practicing the physical activity of the population, and leading a healthy lifestyle. But there are also risks to which the elderly are exposed and which relate to contacts with cyclists whose movement can put them in danger. It is recommended that bike paths be built separately from the sidewalks. Elderly think that there are enough green areas and parks, but that it is always good to have more of them. The parks are mostly adapted to the needs of the elderly, but some places, such as with the popular promenade – Ada Ciganlija, due to the large number of fellow citizens, as well as pets, are not always safe for the elderly.

What they point out is the need for resorts and benches during the walk where they can sit down to rest. The city center is mostly assessed as a place where there are a sufficient number of benches, while this is not the situation in other parts of the city. The elders did not complain about the height of the bench, but they point out that they are bothered by their lack of maintenance, wear and tear, etc. Although it seems like a less important item, the lack of resorts can have a negative effect on motivation and physical ability of the elderly to walk and participate in activities of the community, which can lead them into social isolation and reduced participation in the community.

In relation to public institutions, the elderly estimate that their approach is good, but they also point out that there is a positive trend lately with largest number of institutions, of an increasing number of those with installed ramps. Old people like to use this way of climbing because it is easier for them than using stairs.

Traffic

An appropriate transport system is one of the preconditions for a better quality of life for the elderly, it can increase their social inclusion in community activities and increase the possibility of using certain services. In relation to the importance of this area, the important characteristics were the availability of means of transport, the absence of traffic jams, but also the presence of other people who can help them when moving whenever necessary.

However, there are numerous barriers that hinder the movement of the elderly, both physical (ticket price, availability and frequency of public transportation, adaptation of public transport entry, culture and behavior in public transport, safety of the elderly in transport) but also mental (the elderly areoften in fear that something will happen to them, fear of falling, lack of help, etc.)

Within the focus groups, public transport was generally assessed as good, given that the public transport network is well developed and that there is organized transport everywhere. Participants also positively assess the fact that the number of buses with a low-floor entrance is increasing (currently 50% of buses have such entrance) (Brkić et al., 2019) and they hope that there will be even more of them in the coming period. However, as a limitation, they state that the seats in public transport are too high and that it is difficult for the elderly to sit and get up from them, they also complain about the lower frequency of certain public transport lines and the lack of information when change to transport lines occur. They immediately point out the solution to this problem, and that is to prominently display the lines of public transport at the stops, to be written in capital letters and numbers so that it is visible to everyone.

Transport congestion for passengers also poses a risk to the elderly when using public transport. While there are bus benefits for the people over the age of 65, this does not apply to taxi transport, so this type of transport is too expensive for the elderly.

The biggest problem when it comes to traffic is safety, not only in public transport, but also when moving on the street. Almost all participants stated that they had experience with theft in public transport, especially in central city municipalities. But in addition to this type of risk, the elderly also feel unsafe when they participate in traffic as pedestrians, since their movement is slower, harder, reflexes are slower, they see and hear less, and it often happens that they need help when crossing the street. These facts increase the risk in traffic, especially if we take into account the speed at which vehicles move, as well as the fact that drivers are often intolerant and careless, that traffic lights often do not work or do not exist, and so on.

Housing

It is known that housing conditions have a great impact on physical and mental health, especially if we take into account that a number of elderly people have difficulties in movement or are immobile and spend most of their time at home. Accommodation conditions affect the increase of the quality of life of the elderly by increasing the possibility for the elderly to take care of their needs for as long as possible and be as functional as possible. Elderly people spend more and more time in their homes, as much as 80% so with aging life conditions become all the more important (Handler, 2014). As the population ages, increasing investment will be needed in adapting the spaces in which the elderly live (Janković, Todorović, Zajić & Vračarević, 2018).

The quality of housing is observed through how the elderly perceive the architectural adaptation of the buildings in which they live, but also the financial burden.

By analyzing the data obtained in the focus groups, they are found to speak in favor of the fact that the elderly are satisfied with the living conditions. As a good side of living in the capital, they state that they have lived in one part of the city for a long time, they have adapted, they are used to that place and they manage well. The entrances to the buildings are estimated as appropriate. They emphasize that the problem is when they live on higher floors, especially when the elevators break down, which is often the case in old buildings. Those living in solitaires with over 20 floors emphasize the negative side of life on the ground floor.

The old people state that they are comfortable in the apartments in which they live, but one gets the impression that it is more because of the decades-long habit of living in that space than because of the adjustment of living conditions.

Everyone points out that they have no difficulties in moving and functioning in the apartment, as well as that they would like to stay and live in their apartments and houses for the rest of their lives. However, we can interpret this data in the light that the participants in the focus groups were old and mobile and more functional, respectively the sample did not include old people who are completely dependent on the help of others.

Despite the lack of communication with neighbors, the elderly feel integrated into their community. However, a number find it harder to cope with changes in the structure of the neighborhood and often feel unsafe because of it. Also, fear for safety is expressed by the elderly who live in buildings that have many inhabitants.

They see positive changes in the introduction of professional building managers, they see security in that. Also, they believe that the costs of maintaining their apartments are high, as well as the maintenance of buildings, but despite that pensioners are the most regular in paying the costs.

The elderly believe that the local community can have a positive impact on improving the living conditions of the elderly, by developing programs that will reduce household maintenance expenses. As an example of good practice municipality of Vracar has introduced a free service for the elderly comprise of minor house works, smaller repairs, painting etc.

Respect

The area of respect and appreciation of the elderly is the basis for the full inclusion of the elderly in society. It refers to the behavior of individuals and groups, but also to public attitudes and the way in which the elderly are represented in society, on which often depends the satisfaction of the elderly and their involvement in society. This domain refers to all forms of discriminatory attitudes, behaviors and beliefs in relation to the old, which are often less visible, but which exist (WHO, 2015).

In our country, all forms of discrimination are prohibited, and yet we are witnesses that such behaviors exist. Age can be a reason for discrimination. This is also stated in the reports of the Commissioner for Discrimination, which indicate that age is one of the most common grounds for discrimination according to the frequency of allegations in complaints. In 2020, the number of complaints on this basis increased significantly compared to 2019, in such a way that the largest number of complaints was filed due to discrimination against persons over 65 years of age (Regular annual report of the Commissioner for the Protection of Equality for 2020, 2021).

Most of the participants in the focus groups emphasize respect as the most important aspect in the social functioning of the elderly. They report that this issue is present in all areas - from the family, the neighborhood, the community in which they live, in public transportation, in institutions, trade. In the last few decades, the attitude of society as a whole, has drastically deteriorated in regards to the issues of aging and old age and as such creates a feeling of discomfort and inferiority.

The elderly say that they are not appreciated enough by their family members, but they do not see that as a big problem. It often happens that the old help the young financially. They see the help they provide as part of their responsibilities and do not see any problem with that.

Participants point out that they have often been exposed to disparagement when using health services, at public service counters and in public transportation. Most of the focus group participants report on these unpleasant events, citing public transportation as the most common places where this takes place. A portion of the focus group even says that they were not exposed to inconveniences by younger people alone, but also by the elderly themselves.

The most common reason that the elderly see as the cause of such behavior by younger people is the lack of upbringing, the busyness of parents to take care of their children, the lack of educated programs and their inadequacy.

Elderly usually complain about the bad treatment by health workers, and also about the unavailability of the emergency service, which often refuse to come out when age of the caller is reported.

Participants believe that it is of great importance that their former profession is respectedand this is especially important to the highly educated, who were valued in a professional environment when they were younger.

Intergenerational or *intra-generational solidarity* is emphasized and has great importance as an example of good practice. It often happens that the elderly who are more functional help the elderly who are ill. Intergenerational solidarity is exist, but it is not so pronounced and it doesn't perform its basic function. The elderly should get to know the needs of the young, as well as the young of the elderly. The most common misunderstandings arise due to the lack of communication and

misunderstanding of the other party. Therefore, recommendations for improving cooperation are always directed towards both sides.

However, respondents note that the community shows respect for them. As positive example of the reaction of the community, in which they pointed out how much the elderly are valued, is the traditional marking of various manifestations and important dates for the elderly, which is characteristic for Belgrade. They give examples of the celebration of Women's Day, free entrance to the museum on a certain day, some theaters, flovers distribution, etc.

Just as the elderly think that they are not respected enough as individuals it is similar with respect of their opinion. They point out that they are not asked enough about things that are important and that there is not much opportunity for their voice to be heard, which diminishes the chance of their full inclusion.

Social inclusion

In addition to the culture of respect for the elderly, social inclusion is a basic condition for calling a community one that is inclusive and adapted to the needs of the elderly (World Health Organization, 2015). On the other hand, the need for inclusion in society is not only the need of the community, but also of its members. One of the basic human needs is the need to belong, which implies participation and interaction with others and as such affects the quality of life of the elderly.

Maintaining different contact with close people makes elderly feel as part in various social relations, integrated in primary and secondary networks, be equal members of the family, peer groups, neighborhood and local community. This status of elderly people is a precondition of their participation in community, participation in different activities, communicating to others, providing and relying on outside support.

In this way, through intergenerational or intergenerational cooperation, and through social activities, the focus is placed on personal values that connect individuals and the community. The characteristic of cities adapted to the elderly is that they focused on the degree of involvement of the elderly in everyday activities, on the intensity and spread of social networks of the elderly.

Numerous researches show to the positive effect of social participation on active aging. Persons that have developed social networks are more satisfied with their life, the less often turn to a doctor for worsening of their health or depression (Novak, Menec, Tran & Bell, 2013).

Through focus groups, it was examined how elderly people can get involved in community activities, whether their services and facilities are reachable and accessible, whether they are accessible cultural, entertainment or recreational facilities, whether they are adapted to the needs of the elderly, whether they have

the right to free choice of services and how they spend their free time.

Most of focus group participants are members of one of the associations of pensioners on the territory of the city, and that is also the most common form of organizing the elderly. Membership is voluntary and free. One of the bigger problems is the rooms in which the retirement homes are located, because these rooms are mostly inaccessible and not adapted to the elderly, so some are not able to join the meeting.

The general public is of the opinion that the financial moment is crucial for the insufficient involvement of the elderly in community activities. Despite the fact that the financial moment is important, not all the elderly are equally affected by insufficient income, nor is it the dominant cause of the inactivity of the elderly. Many have a lack of time, motivation, company, a passive partner, illness and the like. Untimely and inadequate information is often the cause of non-involvement in certain activities. Also, they point out that activities, performances, concerts, etc. organize at times that are not suitable for the elderly (walks at night, etc.), mostlyintheevening.

The elderly do not have many choices when it comes to recreational activities that are tailored to their needs. Most of the participants in the focus groups believe that they were not previously aware that certain services existing in the local community.

Research indicates direct and obvious connection between social participation in old age and physical and mental health as well as overall quality of life (Glei, Landau, Goldman, Chuang, Rodriguez, & Weinstein, 2005). The need for social support increases in old age. Old people in Belgrade usually receive social support from their family members, neighbors and peers. The family has kept its basic, traditional function here.

Despite this necessity, when comparing research findings with the general population, social networks in old age show a declining trend, especially among people with lower incomes and members of minority ethnic groups. The rate of social exclusion of the elderly is constantly growing. At the level of public policies, the problem of loneliness of the elderly is increasingly opening up. It is justifiably assumed that with the extension of life expectancy, the social isolation of the elderly will also increase.

Political and civic participation

Political and civic participation is yet another area that affects greater integration of elderly in local communities. It was examined through participation in associations and informal groups but also through different voluntary activities.

Almost none of the old people are formally employed after retirement, and the term volunteer work in old age is quite unknown to them and they do not

understand what it encompasses. They do not recognize their activism as volunteer work for the benefit of community members.

The fact is that the dominant way of including the elderly is through the association of pensioners. Many of them want to join the association of pensioners, as something that is available and useful, while on the other hand valuing that it is voluntary.Information about the association is most often obtained through friends, acquaintances, or family members.

Although solidarity was discussed in the previous part, it is seen here as a form of civic activism of the elderly. There is a great deal of intergenerational solidarity - most often the elderly who are more functional help their peers in exercising certain rights and services. This kind of solidarity is more pronounced among those elderly people who were active during their professional career and now have a need to help someone. Their motives for this behavior are different - from altruistic and the desire to help someone to the need to feel useful and productive. Most of the participants in the focus groups point out that they are engaged in caring for their grandchildren and do not see this as work, but as an obligation to help children. This is their obligation which they voluntarily accept and after which they feel mentally stronger.

In a narrower sense, we can observe civic activism through political engagement. In focus groups, most of the elderly state that they actively participate in the political life of their community - by going to the polls, advocating for certain ideas, discussions, going to protests, but also by engaging in local committees of political parties.

Within the focus groups, the participants also tried to formulate recommendations for greater activism of the elderly. These recommendations refer to increasing the information of the elderly, increasing cooperation among various actors dealing with the elderly, but also strengthening the capacity of health and social services in the community.

Use of social and health care services

The social and health care system is the most important support system for the elderly, in order to ensure the longest possible functionality of the elderly and their active aging. Community services were examined through the availability and possibility of choice of services.

When it comes to health care services, participants state that services are mostly available, but there is still a gap between health care staff and the elderly.

Complaints and risks are most often directed at the rudeness of health care staff, insufficient information, as well as the complexity of the procedure, which they consider to be a consequence of the health system reform. There are problems because everything needs to be scheduled and there is no doctor in some health

centers. There is a noticeable lack of health care specialists in health centers, and that is something that leads to deterioration in the quality of life of the elderly. The only positive thing they mention is the introduction of an "electronic prescription" which has reduced waiting times, appointments and the like.

On the other hand, they are mostly familiar with social protection services. They are informed about the services that exist in that territory, and they are most often informed through people close to them. They generally have a positive opinion about the employees in the centers for social work, but also about the social protection system as a whole. Criticisms are mainly directed at the lack of timeliness in the response, indiscriminate response and the lack of exchange of information between different services dealing with the protection of the elderly.

Special attention should be paid to services that support the elderly in order to live as long as possible in their own household and in their community, which can be seen in the answers that the elderly gave. When it comes to social protection services, they believe that they could participate in the home help service and personal companion service, while none of the participants wants to be accommodated in a home for the elderly.

In general, the elderly are well informed about services, but more at the level of what exists in the community, while they are less informed about ways to exercise certain rights and about the procedures of certain services. They do not have a clear idea of who finances certain services, but it is important for them to know which services exist.

CONCLUSION

The findings of the qualitative research suggest that the elderly are generally satisfied with the living conditions in Belgrade, but areashave been identified that can be improved to make the city more adapted to the needs of the elderly. There is no difference in subjective experience of quality of life in relation to gender, but it has come to notice somewhat less favorable position of the elderly over the age of 80, who need constant help and support due to limitations.

If we look at the development of programs, the inclusion of the elderly into the community, incentives that contribute to active aging, we can say that a number of programs do exist in the City of Belgrade. The biggest problem is the availability of these programs to all members of this population. In addition to benefits, there are a number of factors that can pose a risk to the safety and impairment of the quality of life of the elderly in each of the areas examined. In order to reduce these risks, increase the positive impacts, and to make the community as adapted as possible to the needs of the elderly, recommendations were given in relation to each area:

Public areas and buildings:

- Provide space for the movement of the elderly by regulating parking spaces, regular maintenance of sidewalks, especially in winter period and lowering sidewalk shoulders on all city streets.
- Arrange and green the areas around buildings and parks in order to increase the space for walking and motivate the elderly for physical activity.
- Make public facilities accessible to the elderly, open a service counter on the ground floor, and adding ramps at the entrances of all institutions. This way, older people will be less dependent on others when using different types of services in the community.
- Protect public transport stops from rain and wind by closing them on all sides, and provide benches at each stop.
- Timetable notices should be written in letters and numbers with a larger font, and the boards should be on eye level.
- In order to improve safety when walking the elderly, it is recommended to arrange the space for walking pets in parks as well as to separate bike paths from sidewalks for walking

Traffic:

- Increasing the number of buses in public transportation, both due to the increase in the speed of mobility and due to the increase in safety. In vehicles that are less crowded, the possibility of the elderly being victims of theft is reduced. It also increases the possibility that the elderly can sit while driving and thus prevent falls and injuries while driving.
- Increase control in order to regulate the timetable so that all lines would run according to a predetermined timetable, and if there is a change of transport lines, inform passengers in a timely and appropriate manner
- Increasing the number of low-floor buses, but also public transportation stops adapted for their usage
- Adjust the seats in buses to the needs of the elderly, high enough as not to produce difficulties when sitting and getting up.
- Increase the number of traffic lights and continuously develop awareness of compliance with regulations for the safety of road users.

Housing:

- Introduction of financial support for the adaptation of housing intended for the elderly in order to adapt them to the needs of the elderly who have limited mobility.

- Introduction of subsidies to increase the energy efficiency of elderly households in order to encourage the elderly to improve the energy efficiency of the facilities in which they live.
- Reduction in cost of utility bills for the elderly, which represents a reduction in the burden on the budget of the elderly.
- Construction of social housing for the elderly whose prices would not be too burdensome for the budget of the elderly.
- Encouraging the development of local shops where the elderly could buy groceries on a daily basis and ensure the availability of various contents in their neighborhood.
- Introduction of free or subsidized home repair services
- Development of the network of social services, considering that the majority expresses the desire to continue living in their own household, and that they do not want to go to the home in the future.

Respect and social inclusion:

- Introducing the topic of the elderly, their needs and values in primary and secondary school curricula in order to promote tolerance and develop respect.
- Involvement of seniors as guest lecturers in schools where they will talk about professional and personal experience, and events they witnessed.
- Organizing campaigns that promote the role and importance of the elderly and their contribution to the community in the past and in the future, as well as organizing local events that will promote respect for the elderly and their contributions to the development of the society.
- Increasing the presence of the elderly in the media with an emphasis on the needs of the elderly.
- Encouraging intergenerational cooperation, development of projects in this area, recording shows, etc. Promotion of good neighborly assistance, especially in urban areas.

Social inclusion:

- Conduct research to identify the needs of the elderly for various events and accordingly organize these activities and events
- Adjusting the time and place of events in the morning or early afternoon. Ensure that events are organized in such a way that they are accessible in all municipalities.
- Target isolated elderly, those living alone and provide support for their inclusion.

- Provide discounts for the elderly for visits to cultural events, providing transportation for the elderly.
- Provide architecturally adapted facilities for senior citizens when it comes to cultural institutions and entertainment and recreational facilities.
- Improving the various and accessible channels of communication and information in order for elderly to be informed about the events that are intended for them.

Political and civic participation:

- Consider activating local community offices or establishing new municipal offices in municipalities, within which the elderly would receive all the information that is important to them, but also to participate in decision-making processes at the local level.
- Encourage the development and promote volunteer work of the elderly, thus promoting active and healthy aging. This promotion is necessary to be realized in cooperation with education, culture, and social protectioninstitutions.
- Encourage the development of citizens' associations that bring together the elderly.
- Promote the digital inclusion of the elderly from all backgrounds and thus improve their use of various services.

Use of social and health care services:

- Regularly conduct public campaigns on the importance of active and healthy aging, promote activities and develop content and services for the elderly,
- Development of social protection services within the community to ensure that the elderly stay in their household as long as possible. Increase the capacity and availability of services for the elderly and the development of new, innovative services.
- Development of mechanisms for identifying the elderly who need help and networking of all institutions at the local level in order of adequately protecting the elderly.
- Improve the availability and quality of health care for the elderly, primarily in the area of home treatment, palliative care, development of mobile teams, etc.
- Introduction of preventive measures, education on healthy lifestyles, promotion of physical activity, and promotion of personal responsibility for active and healthy aging.

- Strengthening human resources for providing services to the elderly, through increase of number of employees in the health and social care system, but also by continuous education of employees in the health and social care system on the needs of the elderly and the appropriate response to them.

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RIZICI I IZAZOVI STARENJA U NAREDNOJ DEKADI

Sažetak: Ujedinjene nacije su proglasile dekadu 2020-2030 – „Dekadom zdravog starenja". Ovo predstavlja imperativ svim državama da planiraju i preduzimaju aktivnosti za unapređenje života starih, njihovih porodica i zajednica u kojima žive. Akcenat je na „aktivnom starenju" koje je uvedeno kao concept Svetske zdravstvene organizacije 2002. godine, kako bi se odgovorilo na izazove povećanja broja starijih osoba i rizike koje starenje sa sobom nosi. Prema ovom konceptu, uslovi života starih u znatnoj meri utiče na smanjenje rizika kojima su stari pogođeni. U skladu sa tim „gradovi prilagođeni starim osobama" su oni u kojima građani, pružaoci usluga, javne službe i predstavnici vlasti prepoznaju individualne potrebe starih osoba, promovišući njihovo uključivanje u različite sfere društvenog života, poštujući njihove odluke, trudeći se da poboljšaju sve aspekte koji utiču na kvalitet života starih osoba. U okviru koncepta Svetske zdravstvene organizacije sprovedeno je istraživanje koje je za cilj imalo analizu prilagodljivosti gradova starijim osobama, u 847 gradova i lokalnim zajednicama u 41 zemlji sveta. Polazeći od metodologije Svetske zdravstvene organizacije, u organizaciji Instituta za javne politike, sprovedeno je istraživanje u cilju analize prilagodljivosti grada Beograda potrebama starih. Istraživanje je sprovedeno od oktobra 2018. do jula 2019. godine. U kvantitativnom delu istraživanja učestvovalo je 5600 starijih osoba, a za potrebe kvalitativnog istraživanja realizirano je 16 fokus grupa. Ispitano je osam različitih područja važnih za život starijih osoba, koji ukazuju u kojoj je meri grad prilagođen starima: javni prostori, javne zgrade, prevoz, stanovanje, učestvovanje u društvu i podrška, poštovanje i socijalna uključenost, građansko angažovanje i zapošljavanje, komunikacija i informiranje, razvoj usluga u zajednici u području zdravstvene i socijalne zaštite. Ključni nalazi pokazuju da su stari u Beogradu uglavnom zadovoljni životnim uslovima i brigom u zajednici, osjećaju se sigurno u gradu, žele da žive što duže u svojim zajednicama, ali su identfikovala i brojna područja koja se mogu poboljšati kako bi Beograd postao grad prilagođen starijim osobama.U svakom od navedenih područja autori su dali preporuke za poboljšanje trenutne situacije. U radu će biti prezentovani nalazi kvalitativnog istraživanja. Ovo istraživanje ima značaj i za druge gradove, jer se preporuke za poboljšanje položaja starih mogu koristiti u svakoj lokalnoj upravi.

Ključne reči: stare osobe, rizici, kvalitet života, lokalne zajednice, usluge u zajednici

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DEVELOPING A MODEL OF WORKING WITH FAMILIES IN CRISIS: EMPOWERMENT THROUGH THE FAMILY GROUP CONFERENCE MODEL

Abstract: Family group conference is a model that has been applied for many years in the social welfare system of individual countries and is based on the concept of empowerment of family members. It was created in response to stressful situations in family lives, and empowers the individual, family members, and the entire community. The family is given the right to choose the solutions and steps that need to be taken to make progress in the family. The family group conference seeks to make the family aware that decision-making is in her hands, that she has power. The biggest advantage of a family group conference is the participation of children or young people whose voice can be heard. Everyone is an expert on their own life, and the family becomes their own expert on problem solving (Pakura, 2005) as resource availability increases. The method can be modified and adapted to the needs of the family by introducing new dimensions into the work model, and the participation of members increases the future resistance of the family to go through difficulties more easily. Resilience can be viewed as an adaptation to a new situation, despite negative circumstances (Metze, Abma, & Kwekkeboom, 2015). Resilience is strongly associated with empowerment and is based on a person's strength and capacity to overcome obstacles in life. Resilience is influenced by the personal characteristics of the individual but also by interpersonal factors such as family and community. In crisis situations, an empowered family more easily applies the concepts adopted through the family conference, more easily overcomes new difficulties and a customized model can help in emergencies when family coherence is important. The pandemic posed an exceptional challenge for families who faced difficulties of various kinds in extremely stressful conditions. Self-help models could be developed from available effective models of working with families that nurture values such as a family group conference, which is based on working with the whole family (Dijkstra, 2019).

Keywords: family group conference, family, models in social work, resiliance

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INTRODUCTION

Numerous changes in society have led to the non-traditional development of the family structure as a community. Accordingly, the family today is a different concept compared to the past, where it is necessary to apply appropriate methods of work and adapt to these changes by developing methods of working with families. The current form of the family, their diversity, history and tradition in understanding the family are often overlooked. An individual approach to each family is increasingly needed in working with families as well as a comprehensive approach that includes working with the whole family (Morris et al., 2008). In Croatian social work practice, the development of new models of working with families, in which family outcomes are explored, is more than necessary. Previous solutions for the family are focused on supervision, on the individual or on the evaluation of experts. The Family Group Conference (FGC) model is based on understanding changes within family relationships and managing them through working with the whole family and its wider network.

OVERVIEW OF THE RESEARCH AREA - FAMILY GROUP CONFERENCE MODEL

The family group conference originated in New Zealand in the 1980s. Faced with a large number of Maori children without adequate parental care, the authorities were forced to find a solution. The New Zealand government contacted the Maori community to jointly determine the cause of the problem and they faced the fact that the system at the time did not view children in the context of their extended family (Dijkstra, 2019).

Thanks to the Maori community, there is today a method of working with the family, called a family group conference because community members have strongly advocated their views and emphasized the value that the extended family should have far greater decision-making power for the benefit of children. In order to meet the needs of families, the authorities have developed a family group conference approach to ensure the maximum well-being of children, enable joint decision-making in families and respect different cultural values (Maxwell & Morris, 1992, according to Dijkstra, 2019).

The welfare of the child and the provision of certain needs are of great importance in social work, so it is important to emphasize the legal framework that protects this. The Children, Youth and Their Families Act 1989 is a key factor when it comes to decisions regarding children. Based on the analysis of the state of the country and the mentioned problem, New Zealand passed the Oranga Tamariki Act 1989 - Children's and Young People's Well-being Act 1989, which would translate as the "Child and Youth Welfare Act". After the enactment of the law, there is

the development of a family group conference that constitutes a new dimension of family work and approach (Oranga Tamariki Act, 1989).

DEVELOPMENT AND APPLICATION OF FAMILY GROUP CONFERENCE

Since the beginning of the development of the family group conference began about forty years ago, it is not surprising that it has come to life and been implemented in a large number of countries around the world. Unfortunately, the countries of southern Europe have not yet accepted the FGC, while in some other European countries this method has been working for many years. More developed countries, such as the Scandinavian ones, were implemented by the FGC between 1995 and 2003, so in Norway government organizations manage a system that is responsible for the way family group conferences work (Straub, 2012). Apart from Scandinavia, FGC was accepted in other parts of Europe, and the development of FGC in the Netherlands began in 2001 under the name "Eigenkracht Conference". The difference between the family group conference in the Netherlands and Norway is the sector in charge of coordination. As mentioned, in Norway the state sector is in charge of implementation, while in the Netherlands the FGC belongs to NGOs. It is important to point out the positive development of the method which is visible in the extremely high number of conferences held, even more than 5000, the diversity of social spheres in which it is conducted and the legal basis it has in the Netherlands (Straub, 2012). A few years after the implementation in the Netherlands, the development of FGC also took place in Germany. The advantage of implementation in Germany is the prevalence in various jobs and governmental and non-governmental organizations, and therefore a greater number of services provided by the FGC. However, an obstacle in the quality development of the method is the lack of an organization that would have the role of coordinator, ie there is still no official organization that would deal with the implementation of FGC (Straub, 2012). The countries of the United Kingdom provided family group conference services through a large number of organizations, but today the situation is slightly different as organizations and associations focused on the work and implementation of FGC are united and work together to improve its implementation. The area of neighboring countries of the Republic of Croatia has also accepted the family group conference as an innovative method of working with families, so Serbia through the NGO FICE Serbia (International Federation of Educational Communities) enabled development in Belgrade and Novi Sad. The Serbian authorities support the development of the FGC, and it is important to emphasize the desire for international cooperation which, in addition to friendly relations between neighboring countries, would jointly contribute to quality programs in the system (Straub, 2012). Bosnia and Herzegovina provided an opportunity for a family group conference that found its place through the association Infondacija

in charge of strengthening the social inclusion of children and youth in BiH. Their collaboration with the donor foundation "Kinderspotzegles" from the Netherlands has enabled faster development and implementation of the FGC. Bosnia and Herzegovina began implementing the FGC in the state system in 2010 in Sarajevo and Banja Luka, with the exceptional support of the state sector, but the state itself does not implement it in its organizations. Shortly after the initial steps and the positive results of the first round of conferences, the method was adopted in other areas of Bosnia and Herzegovina (Božić, 2017).

PHASES OF WORK IN THE FAMILY GROUP CONFERENCE MODEL

The implementation of the family group conference is held with the initiator of the family group conference, the independent coordinator and, most importantly, the family itself and its social network (Božić, 2017). The initiators of a family group conference or the initiators of a family group conference are usually employees of the social welfare center, but they can also be other people who play an important role in family life. Often the initiators of the conference can be employees of the school attended by children, employees of various institutions such as health, the social welfare system in general, the judiciary and the like. Experts in the field of family group conference have the opportunity to initiate the same for the purpose of jointly solving family problems. Accordingly, these experts submit an invitation to families and independent coordinators to participate in the conference. The role of social workers is to provide all family members and help and support to achieve the desired outcomes (Božić, 2017). For the implementation of the family conference, the participation of the project coordinator is essential, who, with the organization and logistical support, represents the link between the family and the initiator. The coordinator's tasks include responsibilities such as coordinating and implementing activities in the method, maintaining relationships with the local community and the social worker, and working to develop and promote a family group conference model. Including the above, the role includes the preparation and supply of the necessary information, materials and documentation as well as the evaluation of the implementation (Božić, 2017). The coordinator is an independent person, more precisely, a person who is not in the service of any institution that has the right to decide regarding the family. The tasks of the independent coordinator are to research the family and its social network, to determine the time, date and place of the FGC in agreement with the family. The coordinator provides support and support to the members of the conference and moderates the meeting itself. When it comes to the implementation of the plan, the responsibilities relate to clarifying the items of the plan and providing feedback to conference members (Božić, 2017). Family members sometimes need help and support in resolving certain disagreements, conflicts, inadequate functioning in

the community, etc. Such families become beneficiaries of a family group conference, regardless of whether they are one or more family members. Many families who are provided with FGC services are in the system such as the Center for Social Welfare, educational homes for children and adults, health centers, schools, but this is not a prerequisite. As important as the involvement of all family members, an indispensable part is the members of the social network which includes extended family members and relatives, friends, neighbors, co-workers, teachers, or all persons who can contribute to a positive outcome of the conference.

The FGC model is implemented through five phases. The first step that needs to be taken for the conference to take place is to initiate the implementation of a family group conference. After the initiation, the planning, division of tasks and preparation of the course of the conference take place. The central part is the most complex and refers to the meeting and holding a conference with family members and this part can be divided into three phases, the first of which would be providing information on how and need to work, the second phase leaves personal time for family, and at the end of the central phase, there is an evaluation, ie decision-making and joint agreement regarding the family plan. If the central phase ended in a positive outcome, the fourth step is the implementation of the plan. For the realization to be successful, it is necessary for the family to jointly determine the person who will be in charge of monitoring the changes, fulfilling the tasks agreed in the plan. The last step in the implementation is an evaluation in which the success of the implementation of the family plan is monitored, which is carried out by an independent coordinator in cooperation with the family, and sometimes with experts (Božić, 2017).

AIM OF THE RESEARCH

The aim of the research is to present the model of the Family Group Conference, its development and implementation in the science of social work. One of the goals is to present the Family Group Conference during the Covid-19 pandemic as a method of working in crisis interventions. In a survey of experts' views on the Family Group Conference in Croatia, the aim was to inform social workers about the Family Group Conference method and to check whether experts see the possibility of applying this method in practice. The results of the research will show the advantages and disadvantages of the Family Group Conference method as well as the views of experts in the Centers for Social Welfare on the acceptability of this method in the field of working with users.

RESEARCH PROCEDURE: METHODOLOGY, SAMPLE AND DATA COLLECTION

The research included data collection which includes analysis of available literature, interpretation of previous research in this area, recent research conducted during the Covid-19 pandemic and a survey questionnaire for social workers in the Republic of Croatia. There are 146 Social Welfare Centers in Croatia (including Family Centers and Branches). The survey was conducted in September 2020 throughout Croatia. The directors of all Centers for Social Welfare were sent a letter and a request for approval and forwarding of the online questionnaire to social workers with an accompanying letter on the purpose and objectives of the research. 1,060 social workers are employed in 146 institutions of the Centers for Social Welfare in Croatia (Ministry of Labour, Pension System, Family and Social Policy, 2020), which makes up the total research population. Of the total number of social workers, 193 employees completed the questionnaire, which is 18.20% of the total population. The questionnaire was formed as a Google form, which consists of the first initial part in which the Family Group Conference is presented as a method, method of implementation and purpose. In the continuation of the questionnaire, the questions are divided into socio-demographic characteristics of the respondents and questions about the expression of attitudes towards the application of the Family Group Conference. All respondents, before completing the questionnaire, were told that the data collected were anonymous, and what the purpose of the research was and how the data would be interpreted.

RESULTS AND DISCUSSION

Aplication of the method = crisis and family

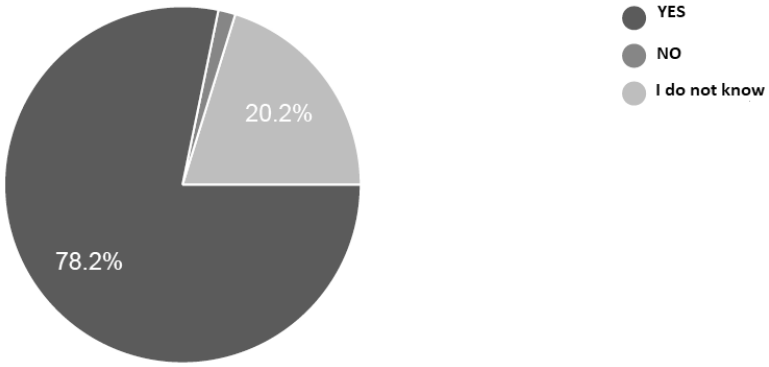
The Family Group Conference views the family as unique, self-determined, unique to each child, and reflects variables such as class, culture, race, ethnicity, and religion. The FGC model belongs to approaches that involve the whole family while understanding the family is the starting point for practice and service development. Family reality as perceived by family members needs to be explored (Williams, 2005). Family reality in stressful or crisis situations is a space for perceiving family resilience. The concept of resilience is a theoretical and conceptual framework that is implied in various approaches such as family-led planning and family group conferences, about which there is a range of theoretical and empirical research. Resilience can be viewed as a process of adapting to new situations where families may be more or less resilient or in some circumstances show more or less resilience (Mackay, 2003). Research into the concept of family resilience and its application in practice shows two significant segments (Kalil, 2003, according to

Morris et al., 2008). The first is based on the family's ability and potential for resilience, while the second is based on working with the individual in a family context where the family is seen as a solution to the problems of individual members (Walsh, 2003).

The research of Mutter et al. (2002, according to Morris et al., 2008) at the Family Group Conferences conducted in families with mental disabilities is the basis on which they made several important conclusions. In the surveyed families, a decrease in hospital admissions in crisis situations was observed when support involving the family was provided early. They also found that family reunions in crisis situations significantly contributed to increased support for the family and its members, communication was better, and families contributed to finding solutions. The family belief system, family cohesion, and coping strategies are three resilience processes that strengthen the family through the application of FGC (Kalil, 2003, according to Morris et al., 2008).

Coping strategies are contributed by social support in the form of a network of formal and informal relationships, which contributes to greater resilience of either parents or children (Kirk, 2003). The task of the FGC is to empower families, increase the resilience of family members, work on better communication, and focus on problem solving. As the family becomes an expert in their lives, each new challenge addressed in this way gives the family the opportunity to learn something new and to empower themselves for future challenges. By creating such preconditions for the family, the crisis caused, for example, by today's pandemic, was a period in which families could use the acquired knowledge and more easily overcome certain difficulties. When a family finds itself in a situation where institutional support is not possible or available, it is important that they can rely on their own resources. Mental health crisis is a term associated with the current pandemic when the necessary professional intervention is not possible and therefore it is important to provide the family with enough of its own resources to enable each family member to successfully manage their difficulties (Polak 1971, according to Bridgett & Polak, 2003).

A survey conducted with social workers in Croatia in September 2020 showed that social workers are familiar with the method of the Family Group Conference and in answer to the question Are you familiar with the term "Family Group Conference"? 78.2% of respondents or 151 social workers claim that they know the method, while 20.2% or 39 social workers are not sure or do not know (n = 193).



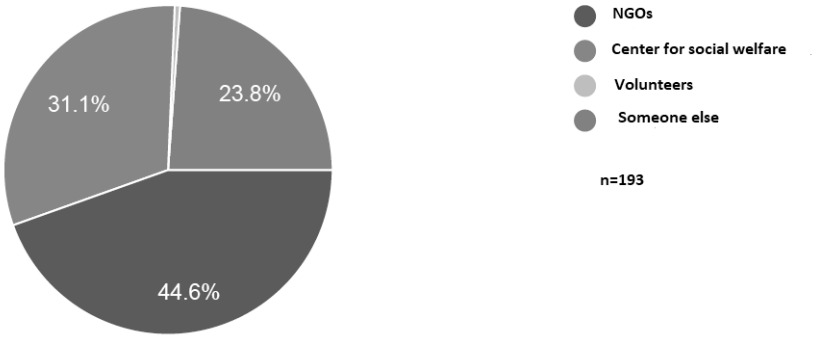
Graph 1 *Familiarity of social workers with the method of Family Group Conference*

Integration of the method into the social welfare system

The family group conference is most often in the domain of NGO work, so it is clear that it has not yet found its permanent place in the social welfare system. For example, the Republic of Croatia still does not apply FGC in any sector, while neighboring countries have only state support, but no action. In order to develop in a positive direction, a family group conference implies a partnership in the form of formal state and professional systems with informal family systems and communities whereby equalization of both parties occurs for the benefit of users (Doolan, 2011). On the one hand, informal organizations in the NGO sector have exceptional knowledge and strengths to which they can provide the necessary assistance and support, but most often they lack the resources for the desired endeavors. There is unavailable knowledge in state systems, but they have the necessary resources, so a partnership between the state and NGOs is inevitable (Bell, 1999). The previously described cooperation would be the best way to act, but in reality, this is usually not the case. Research shows that there are great difficulties of social workers who are often at the center between the desire for professionalism and help to the user and bureaucracy and limited legislation (Bell, 1999). As mentioned above, the family group conference method can be implemented regardless of whether it is a governmental or non-governmental organization but more often we find FGC in civil society organizations with state support, but this does not mean that in the future the method will not take root in the state system.

Attitudes of social workers in relation to the issue of conducting the Family Group Conference, ie the question Who do you think should use this method in practice? answer 44.6% NGOs, 31.1% Centers for social welfare or 23.8% someone else. Practice in EU countries also shows that the implementation of the Family

Group Conference is most often in the domain of NGOs. Given the overcapacity of social workers in the Centers for Social Welfare, it is understandable that most of them opt for NGOs, while the reason may be the relocation of certain services through the process of deinstitutionalization in the community.



Graph 2 *Attitudes of social workers towards who should conduct the Family Group Conference*

The majority of respondents, as many as 84.5%, state that they see the possibility of applying theFamily Group Conference in their work, and if there were organizational possibilities for implementation, that they would like to apply the method in one of the segments of work. In answer to the question: To what extent do you find the method useful? Answers on the Likert scale from 1 (I do not consider it useful) to 5 (I consider it extremely useful) show that 39.9% of respondents consider it useful (4 on the scale), while the rest of the respondents consider it neutral or extremely useful (a total of 57, 5%).

ADVANTAGES AND DISADVANTAGES

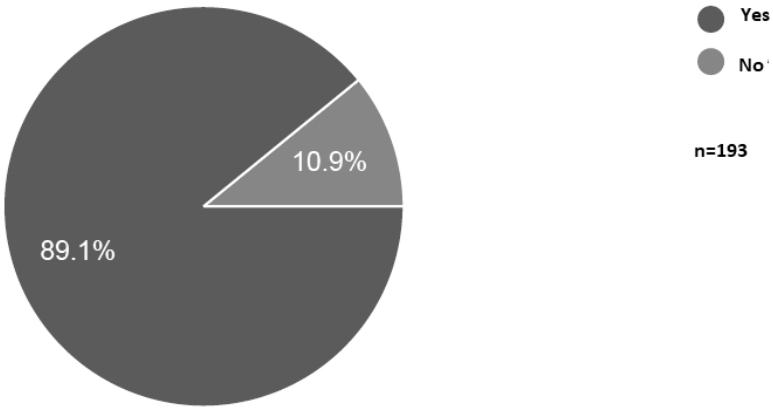
The family group conference has been implemented in more than twenty countries around the world, but the question of its effectiveness remains a frequent topic of research (Maluccio, Ainsworth & Thoburn, 2000, according to Dijkstra, 2019). Using the FGC method for the first time in New Zealand, it is argued whether this method contains a different approach to decision making that will prove effective. New Zealand experts followed the concept of “what is right” instead of the concept of “what works” in creating social policy in the child welfare sector (Doolan, 2011). Numerous studies have been conducted based on checking the effects of FGC. SkaaleHavnen and Øivin Christiansen (2014) have put together a research paper in collaboration with 10 international studies in which they permeate in various ways the question of what the effect of a conference for the family actually is. Seven out of ten studies compared with other methods and

decision-making procedures resulted in a positive outcome, and only three studies showed a neutral result.

One of the main characteristics of a family group conference is the way it is performed, ie the need for the presence of all family members, because otherwise the primary function of strengthening and connecting family members cannot be achieved. Thus, the family has the right to choose the next step for the purpose of family progress (Morris et al., 2008). An extremely important item refers to the interest and well-being of the child as well as the child's right to vote in the process itself. One of the principles of FGC is that experts try to make the family their own experts in resolving difficulties and have the opportunity to better understand the doubts that arise in the service for the protection and welfare of children, which sources they manage and the possibilities of using them (Dijkstra, 2019). Emphasis was placed on the way the FGC works, which creates and builds cooperation and requires joint investment in relationships by family, professionals and the community itself. Of course, the most important element of FGC is that through this model, children also make increased contact with extended family members and that their voices, problems, and desires are heard by adults (Morris et al., 2008).

Research to date has shown that, given that the FGC's overarching goal is to leave leadership to the family itself, there are sometimes possible shortcomings in implementing the concept without expert guidance. The possibility is that there will be a negative impact on the experience of the family involved in the procedure, mostly for the reason stated, the non-interference of experts. Difficulties can arise due to insufficient information and ignorance, which would lead to non-execution of the process itself. For some families, the time provided for the development of the plan may be insufficient and affect the development of a quality family plan, and thus the poorer results achieved (Morris et al., 2008).

What is, perhaps, the most important part of the research conducted in Croatia with social workers in Social Welfare Centers is the fact that most respondents are interested in knowing more about the Family Group Conference method. This is a consequence of the lack of methods in working with users that are poorly developed, do not develop sufficiently and often the practice does not have an adequate tool for working with users. A total of 89.1% of respondents want to learn more about the FGC method, which is important data for further planning the development of working methods and education of social workers.



Graph 3 *Overview of the number of social workers who want to know more about the Family Group Conference method*

CONCLUSION

The development of new models of assistance in the social welfare system is a slow, time-consuming or often impossible process. Practice clearly shows the need for new approaches in the work of social workers that will say “how” and focus on change in power relations and empowerment for further independent growth and development. The Family Group Conference model approached the needs of practice with its concept. The model is focused on the whole family, equal respect for each member, viewing the family as their own expert who knows their life best and strengthening the resilience of the whole family. Applying the model can prevent potential crisis interventions, and through family empowerment, family resources are channeled to achieve positive change. A holistic approach aims to involve the community and integrate the whole family into the environment.

Despite the need to develop and introduce new methods and approaches to the family, it could be concluded that the integration of the Family Group Conference in the social welfare system should wait some time since the systems, at least in the Republic of Croatia, are largely focused on bureaucracy and less on direct work. with users. Social care centers have insight into family situations and families at risk, and children who come from such families are much more likely to develop forms of risky behavior. It is the Centers for Social Welfare that have the opportunity to encourage and participate in advocating for the Family Group Conference, which needs to be worked on continuously, and based on that, quality cooperation between experts from various systems could be built. Social care

centers are a very important link in protecting and promoting the well-being of children, young people and their families because they have the opportunity for broad cooperation with all those who, depending on the type and severity of the problem, care for them. In this way, social workers should make positive use of the opportunities they have and focus on advocating for positive changes in the social welfare system.

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RAZVOJ MODELA RADA S OBITELJIMA U KRIZI

Sažetak: Obiteljske grupna konferencija model je koji se duži niz godina primjenjuje u sustavu socijalne skrbi pojedinih zemalja, a temelji se na konceptu osnaživanja članova obitelji. Nastao je kao odgovor na stresne situacije u životima obitelji, a osnažuje se pojedinac, članovi obitelji i cijela zajednica. Obitelj dobiva pravo na izbor rješenja i koraka koje je potrebno poduzeti da bi se ostvario napredak u obitelji. Obiteljskom grupnom konferencijom nastoji se osvijestiti obitelj da je odlučivanje u njenim rukama, da ona ima moć. Najveća prednost obiteljske grupne konferencije je sudjelovanje djece ili mladih osoba čiji se glas može čuti. Svatko je stručnjak za svoj život, a obitelj postaje vlastiti ekspert za rješavanje poteškoća (Pakura, 2005) dok se dostupnost resursa povećava. Metodu je moguće modificirati i prilagoditi potrebama obitelji unoseći nove dimenzije u model rada, a samim sudjelovanjem članova povećava se buduća otpornost obitelji da lakše prolazi kroz teškoće. Otpornost možemo promatrati kao prilagodbu novonastaloj situaciji, unatoč negativnim okolnostima (Metze, Abma, Kwekkeboom, 2015). Otpornost je snažno povezana s osnaživanjem i temeljena je na snazi i kapacitetu osobe da prevlada prepreke u životu. Otpornost je pod utjecajem osobnih karakteristika pojedinca ali i međuljudskog faktora poput obitelji i zajednice. U kriznim situacijama, osnažena obitelj lakše primjenjuje koncepte usvojene kroz obiteljsku konferenciju, lakše savladava nove poteškoće i prilagođenim modelom može pomoći u izvanrednim situacijama kada je koherentnost obitelji važna. Pandemija je predstavljala izniman izazov za obitelji koje su se u iznimno stresnim uvjetima suočavale s poteškoćama različitog karaktera. Modeli samopomoći mogli bi se razviti iz dostupnih učinkovitih modela rada s obiteljima koji njeguju vrijednosti poput obiteljske grupne konferencije, koja se bazira na radu s cijelom obitelji (Dijkstra, 2019). U radu s obiteljima povezivanje teorijskih modela s praksom od iznimne je važnosti, a iz prakse razvijaju se novi koncepti za praksu.

Ključne reči: obiteljska grupna konferencija, kriza

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PSYCHODYNAMIC UNDERSTANDING OF ONLINE COMMUNICATION CHARACTERISTICS IN TELEPSYCHIATRY

Abstract: The lack of professionals providing psychiatric and psychotherapeutic treatment is evident throughout the world. At the same time, the current pandemic with limited personal contacts and social distancing cause additional limitations in this field of work. Development of technology and better cybersecurity and information protection lead to a possibility of adequate online treatment, offering those with limited resources in their communities a chance for psychotherapeutic work. This paper describes some of the dilemmas and discusses some issues we encountered, working above all with patients with borderline personality disorder

Keywords: telepsychiatry, psychotherapy, borderline personality disorder

One of the serious aspects when discussing problems and quality of mental healthcare is the lack of psychiatric resources, that is evident throughout the world (WHO, 2019). Even the assessment of Serbian resources we presented in 2011 shows that there is a difference in access to care, with concentration of professionals in larger cities (Stamatovic Gajic, 2011). Over time there were a number of different approaches to deal with this issue, some of them are discussed in a recent paper, regarding the US (Johnson & Possemato, 2019). Today, when remembering our words from an earlier paper, saying:"…We must again consider something that is in the core of our professional identities– the concern for the benefit of our patients. Thecontinuous improvement of the mental healthcare quality,together with education and scientific development,provides good enough basis for the future benefit" (Stamatovic Gajic et al., 2007), we can add that technology development offered us new means to benefit even more.

For a long time, from the 1950s (Doarn, 2018), telemedicine and telepsychiatry are considered as ways to improve access to care for people with little or no

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resources for in – person help (Kaonga & Morgan, 2019). The results of such interventions were studied as well, in different societies (Campbell et al., 2015; Borders, 2017), confirming their usefulness.Shore in his recent paper suggests that instead of telepsychiatry, we should use term telemental health, since it is more inclusive, covering not only psychiatric diagnostic process and treatment, but also treatment and therapy modalities provided by other professionals in the field (Shore, 2015). Currently, it is not only that we use new technologies for telepsychiatry – telemental health, it is that we now have many mobile phone applications or other software solutions aiming to treat or help in treatment of different psychiatric conditions, even the most challenging ones such as borderline personality disorder or BPD (Helveg-Joergensen et al., 2019). In this paper, in contrast to a narrow definition of Shore (Shore, 2015), we shall use the term broadly, covering not only online video communication, but also cell phones, with text messaging, and different applications for video communication – Viber, WhatsApp..., similar to the approach ofthe review article by Kaonga and Morgan (Kaonga & Morgan, 2019).

The current pandemic, with recommended physical distance and stay at home requests, makes the question of telehealth more pressing. There is a number of papers published during 2020 about this issue (Chen et al., 2020; Lodha & De Sousa, 2020), some even attempting to regulate the field (Ramalho et al., 2020). It does not require much to understand the usefullness of telemental health in such a time. Keeping this in mind, I would like to underline one more reason for use of contemporary technology. It provides a way to maintain communication and a relationship with a patient/client whenever spatial distance gets in the way, regardless of the pandemic. This might be even more evident with BPD patients or patients with some BPD traits, where splitting provoked by the sence of abandonment, if the in-person treatment is interrupted, can endanger the therapeutic process.

In order to maintain confidentiality and protect privacy and identity of our patients, names and basic information of our patients have been changed. The following vignette is my first experience with the use of "modern" technologies in treatment. For the purpose of this paper I shall focus only on parts of the treatment that are relevant for the topic. At that time cell phones were already present enough, providing easier communication, but we were debating whether we should give patients our phone numbers or not. It was possible to understand it as a violation of borders within psychotherapy, and on the other hand it was providing a patient with a thin thread of hope – possibility of contact in the time of need. In all these years since, I have never had a patient, especially borderline patient, misuse my phone number for anything else than contact in the time of real need, and never at odd hours. And as for this dilemma back then, I was fortunate enough to address this issue in supervision, and thanks to the supervision process I now have this material to share.

Jelena, at that time (2006) at the age of 16, in intermittent treatment for mixed disorder of conduct and emotions, started after a suicide attempt (with harmless mucolytic pills which she took from her grandmother) at the age of 12, too young to be diagnosed with borderline personality disorder. The trigger for the attempt was conflict with parents, over inappropriate relationship (the full contents of the case would require much more space than we have available). At the time of the event described in this vignette Jelena was student of the secondary school, living in a small town nearby.

During holidays her mother called me to tell me that Jelena left home and stopped responding to calls from her family members. The last thing she told them is that she is in another city, she is going to return, and that they should not call the police. The mother also told me that their family gathered, and that everybody is against calling Jelena, saying that she is going to return when hungry, or that she just is behaving badly. Mother “did not know what to do”, as many times before, and was asking for help, fearing Jelena might harm herself.

Jelena stopped answering their calls, at some point she even switched her phone off. In therapy she was complaining that her family does not understand her, and fantasized of killing them, without ever being discovered.

Even thou her leaving home could be considered as her punishing her family, I was still worried that she might indeed cause harm to herself. I tried to text her, hoping she will be responding. As several times before, when I had to “put down the fire”, again it wasjust relying on the trust and good relationship Jelena and I had built over time. Only this time I had to turn to texting, and hope that Jelena will be checking her phone, at least from time to time. She did, and here are text messages we exchanged during three days.

Therapist (3:59 pm): Jelena, I would like to know if you are ok and safe, and that you are in no danger. If you want, you can always text me, I am here. (I signed my name)

Jelena (4:53 pm): I am great, having fun. It is beautiful. I am not in danger in any way. I could write a book about this feeling of freedom. I am glad you sent the text.

T (4:57pm): Thank you for replying. Please send me a text message from time to time.

J (5:05 pm): Of course I shall. Regards.

T (7:58 pm): Do let me know if you have a place to stay for the night. I can understand that freedom can be enchanting, but I am not sure if running away is truly liberating. I am worried.

J (8:17 pm): To be precise – I have no place to stay for the night. But I get into a building, climb to the top floor. There I am not cold, and it is completely safe. Don't worry.

T (8:22 pm): I don't know how safe it is. I don't know how long you can do it this

way. Thank you for answering my texts, this way I worry a bit less.
J (next day, 2:07 pm): I am coming home tomorrow at noon. Precisely for the lunch with my parents. You have no idea how glad I am that you texted me yesterday.
T (6:33 pm): I was not able to answer before. Thank you for texting. It would be good to continue to stay in contact.
J (next day, 5:01 am): Wow, how great I feel... The only bad thing is that my family is worried, and that hurts me. It looks selfish from my side, but you know it is not like that. I am not an emotionless bastard and I love my family and friends. And what I am feeling now is called happiness. I am not upset at all, I have to admit I expected to feel a little bad about everything, but I am not. When I return, I'll drop by the hospital to retell about adventures and about my thoughts and feelings.
At 10.59 am she called me, I did not hear the phone, so I texted her when I saw the missed call.
T (12:36 pm): I saw you called, but the sound was off. Are you ok?

She called back, to tell me she'll be home by six pm, and will call soon to schedule a session. And she thanked me for being there. (I'll add that she came after several months, following the earlier pattern of coming to and from treatment. She still does the same, and further on I'll use one more situation with the same patient.)

Later on, we talked about this texting episode, and she was very appreciative of my concern for her wellbeing. It provided her with the feeling someone is caring enough for her.

(As time passed by, she reached all the diagnostic criteria for BPD, and kept switching between fully functional state, being extra successful undergraduate student, and fully blown disorganized episodes with autoagression, substance abuse, conflicts.)

Another issue I would like to address is an isssue of a therapeutic alliance in online treatment. With Jelena I had bulit a therapeutic aliance in our in-person meetings, and texting or online contact was just an extension, in specific circumstances.

As Kate Dunn discusses in a chapter of the book dealing with psychotherapy and technology, now we have terapeutic relationships built entirely online (Dun, 2014). I would like to add that with BPD patients sometimes online therapy, with emails or messages, provides basis for much stronger therapeutic alliance. As discussed elsewhere, BPD patients process information somewhat differently. Neutral facial expression they perceive as negative (Unoka et al., 2011; Schulze et al., 2013), so therapeutic neutrality can be a basis for negative reactions and acting out.

Marija, age 40, could be a good example. She entered treatment at a private facility, after switching psychiatrists for years. She started coming weekly, full

of anger. Each session she would be complaining about psychiatrists in general, expecting something to be „really done” for her, instead of only taking her money, and just „pretending to care”, and that I am so uninterested in her, and not even „pretend to care”, being „the coldest and most distant of all”, almost inhuman (later on she described me as “an algorithm”). I tried to explain that I should be neutral, objective, in the process of evaluation, and that my involvement in the treatment shows that I am not distant.

She lived most of the time in another city, on the money her parents and sister were giving her, providing for everything. She had one job, for a couple of months, and did not work after that, nor did she look for a job, explaining that there are no jobs for her (description for a job was such that it was obvious she can never find it). When I said it looks like she does not realy want or need a job, otherwise she would look for it (and she would have to accept any kind, if her existence depended only on her), she became enraged, started insulting, and left. Having had my phone number, she sent me a message on Viber, wishing me, among other things, “dead, and not mourned after, but cursed forever”. (By the way – a good illustration of splitting.) I answered that I understand her anger, and her need to end our communication. To that I added that she can contact me again, in case she needs help.

She did send a message relatively soon, (“OK doctor, you have definitively seen my worst side” that was all about the previously described situation), almost as if nothing happened, and with that message started a long communication between her in-person visits. Sometimes, when I was not able to immediately respond to her messages, especially in crisis, she would write, and I would respond when possible. She described it like this: “I am writing to you when things get too heated, and it is complex in itself..., but somehow it is good, I never opened myself like this before to a shrink...” I believe that communication in such circumstances might give us a chance to respond in perfect moment, in time when it is most needed, or as soon as possible. Like a good-enough mother...

Often, regardless of the fact that I was not able to respond yet, she would write in the end of those messages that it helps her feel better. One of her messages started like this: “Doctor!!! I am going to write... you answer whenever... I need to write this down”. Soometimes she would write: “Doctor, could you write back, I need comfort and some hope. I am desperate.”Or just: “Could you just write that you are there...” Sometimes, when I responded later, she would send just a smiley. She often vented successfully, (once she wrote: “Now I don't know anymore what I was going to whine about...”) but I also believe that writing down her thoughts helped her to clarify them, and often see them from a different angle. In her case, I suppose, it was even more important that writing also provided a way to think about her emotions, rather than act on them. Numerous conflicts with her sister actually calmed down with our correspondence.

But, to return to already mentiond words of Kate Dunn, of "therapeutic relationships built entirely online" (Dunn, 2014), Marija's online relationship with me today is usually much more positive. Sometimes she would comment that she does not understand why do I differ online and offline, that online I seem more engaged. I understand this as a manifestation of difference in her perception of written words and of facial expressions. She would question the same verbal content offline as insincere, or lacking interest in her, understanding my "serious face" (my usual facial expression when I am focused) asa distancedor, even worse, as a judgmental atitude. When offered online the content was accepted at it's face value, words have their true meaning and intentions are seen as positive and supportive. It helped her reassess our relationship, and recently she wrote that she would like to come to the office, to see me, so I can stop being "a good ghost from the Viber lamp". This option is always available, and we managed to have several sessions, where she was able to reassess the way she sees our communication.

With another patient, who lives in a geographicly distant town, I have started therapy offline, and after a while, we agreedto do intermittent online/offline therapy. With this one and with a number of other patients from other cities I am using an online telemedicine platform, for video-calls. Maybe it is a usefull way to keep up with weekly sessions, otherwise it could become more demanding in time and money to travel every week. And with the Covid-19 pandemic, it is definitely a safer way. With this patient, Milica, it was also important that I was able to monitor her closer for her pharmacotherapy, and discuss medication and observe for eventual side effects. The relatioship between medication and psychotherapy we discussed elsewhere (Lopicic et al., 2008), so this time we shall only emphasize the importance of a continuous contact, especially at the beginning of treatment, in dealing with pharmacotherapy during psychotherapeutic process. As psychiatrists we should be bound to take care of both (Gajic et al., 2012).

As was illustrated already before, negative transference develops online too. It is usefull to have it in writing, to be able to discuss it, though sometimes it is too shamefull, and Maria once wrote: „Here I am, Doctor, although I already feel ashamed, well, honestly, the fuss prevails, so here I am. You did not deserve what I wrote, I forgot what it was, I apologize", after one particularly offensive message. So it will remain there, to be discussed later.

Jelena, the already mentioned patient, was very carefull in the content of her messages. At difficult times, she would sometimes "disappear", until well enough to be as eloquent as usual, but sometimes she would send a photo of her injured hand ("last night, in sleep, I hit the wall"), or head ("... and then I was hitting my head against the door"). Those images gave me the opportunity to "see" her in those situations, because she would rarely come to my office in such a state. She sent photos and videos when she was well too, as an illustration how well and active she is, and the short video of her vigorously jumping the rope allowed us to discuss eventual manic switch or hipomanic defenses.

There is another aspect of these online – offline differences worth mentioning – availability. Not only that Maria, for example, was able to send a message when she needed to, it was also possible to reread what is written and what were my answers. I have the impression that this constancy of the written messages is helping maintaining positive and strong therapeutic relationship, in a way the therapist becomes more constant. On the other hand, keeping in mind the fact that online information is practically imperishable, we can use them easily for supervision and case presentation. This paper is a proof of that, largely depending on online information.

We might discuss the benefit of this availability, if it is too much, but since most of the borderline patients have had problems with object constancy and availability of the important figures, this might also serve as a corrective experience. With patients free of personality pathology this issue is not so important. They stick to the schedule, as much as they would do with the offline modality, but they highly value the possibility of having contact in case of need.

Another potential problem surfaced in another treatment. Ana, who lives in a distant town, and used to come to the office every two weeks, (due to pandemic those intervals are now much longer) differed a lot in online and offline communication. When talking online she was almost always smiling, everything was good or getting better. In the office she would incessantly complain about everything. I tried to get her to think about it, and we came to a "simple" answer – it was the camera. "In front of the camera you have to look your best", which is the extension of the "glowing façade" she kept when facing the world. She is now more in contact with her genuine feelings when online, aware of the need to be truthfull.

A patient who was coming in person opened another important question. When coming to the office, she would request to leave her cell phone in another room. We are going to put aside her reasons, it is beyond the scope of this paper, but her concern highlights the question of confidentiality and data protection. In psychiatry and psychotherapy it is very important question, in telepsychiatry/telepsychotherapy even more. It has been addressed by other authors extensivelly, for example recent papers by Lustgarten et al. (2020), and MacMullin et al. (2020). Since there are only general requests for confidentiality existing in Serbia, not specified for telepsychiatry/telepsychotherapy, maybe we should consider using platforms that are compliant with the United States and European Union regulation (e.g. Health Insurance Portability and Accountability Act, known as HIPAA, or in Europe General Data Protection Regulations, known as GDPR), hoping that it is safe enough for our patients as well, and initiate development of national regulation for telemedicine. Paying attention to this issue, protects rights of psychiatric patients, that are endangered in more than half of domains in Universal Declaration of Human Rights (United Nations, 1948), as we described elsewhere (Stamatovic Gajic et al., 2019), most of all rights to privacy and adequate treatment.

In the end I would like to offer an encouraging quote from recent review by Poletti et al. (Poletti et al., 2020) who wrote:"...despite therapists and public's skepticism, telepsychotherapy is a trustworthy alternative to be adopted, which canbe used efficaciously to treat common mental-health disorders…" With this in mind I hope that this paper managed to highlight some aspects of importance for future telepsychiatric and telepsychotherapeutic work.

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PSIHODINAMIČKO RAZUMEVANJE SPECIFIČNOSTI ONLINE KOMUNIKACIJE U TELEPSIHIJATRIJI

Apstrakt: Manjak profesionalaca koji bi se bavili psihijatrijskim i psihoterapijskim radom evidentan je u svetu. Pored toga, aktuelna pandemija, sa ograničenjem ličnih kontakata i socijalnim distanciranjem, nametnula je dodatna ograničenja u radu. Sa razvojem tehnologije i mogućnošću bolje zaštite poverljivosti informacija, pojavila se mogućnost adekvatnog online tretmana na daljinu, nudeći onima koji iz raznih razloga ne mogu da takvu pomoć dobiju u mestu gde žive, šansu za psihoterapijski rad. U radu se prikazuju neke nedoumice i razmatraju pitanja sa kojima smo se susretali, posebno radeći sa pacijentima sa graničnim poremećajem ličnosti.

Ključne reči: telepsihijatrija, psihoterapija, granični poremećaj ličnosti

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ADOLESCENTS IN CRISIS IN A STATE OF EMERGENCY

Abstract: The subject of this paper are older adolescents, aged 20 to 25, belonging to the group of students of the University of Belgrade. The Covid 19 virus pandemic, following bans arising from the state of emergency, disrupted their previous way of life. Temporarily, faculties as well as student dormitories were closed and many students had to return upcountry to their primary families. In such a delicate situation, they had no choice. The whole state of emergency brought on by the Covid 19 virus pandemic invoked them into crisis. At the beginning of the emergency situation at one of the faculties of the Belgrade University, an electronic psychological counseling center for crisis interventions was launched. The main topics that the students needed help with concerned several crisis areas: issues of identity, separation, of the future and the meaning of life, issues of academic success. During the period that psychological support was given, many of them reconsidered their own needs and reformulated their former life plans and decisions. We know that crisis always present a risk for a step backwards, but also a chance to take a step forward. Adolescents who used the psychological help in crisis, made some insights into the perception: himself, himself and others and their relationships with the world around them. In the first part of this paper we aim to provide a theoretical model of adolescents in crisis in a state of emergency which includes many of the accompanying fears that have risen. The second part of the paper is casuistic with four short presentations. The conclusion recommends follow up action.
Key words: adolescents, crisis, crisis interventions, state of emergency, counseling

INTRODUCTION

Modern concepts view adolescence as a special phase of psychosocial development of a human being, lasting almost a full decade of life. Characteristic of adolescence today is that lower limit of its onset is permanently shifted to earlier age, however, the same is not applicable for its end. The end of adolescence is considered to be the age of 22, but in our country the reality is that the completion of

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basic and master studies lasts until the age of 23 to 25, which inevitably moves the limit of the end of adolescence for academic citizens. Only after studies completion does a person embark on an uncertain "adventure" of searching for one's own existence, which enables physical but not other types of separation. It is expected that before the financial independence, the psychological separation from the parental figures would be gradually completed, which enables the adolescent to be a being "for himself" and a being "by himself".

"Adolescent crisis, inevitably a part of maturing and growing into mature, responsible and healthy people, usually incorporates several types of crises, such as: crisis of intimacy, crisis of addiction, crisis of work and creativity, crisis of decision-making, confusion in perception of times, crises in the family, gender identity perplexity , crisis of financial and economic dependence. One of them being dominant at any one time, and the resolution of one is usually followed by the beginning of another" (Veljković, 2014, p. 69).

The founder of crisis theories, Gerald Caplan, did a lot in the field of systematizing the concept of crisis. He pointed out that a crisis situation arises when an individual is faced with situations that threaten to interrupt the established flow and balance of emotional relationship, especially if the threatening situation is so intense that it is not easy to overcome the issue using usual problem ssolving methods. This is actually the moment when a crisis arises (Caplan, 1963).

In adolescence, as a result of different types of crises that a young person inevitably goes through, there are phases of ups and downs, of emotional organization and disorganization. Conflicts accompanyied by anxiety occur at all levels of the adolescent's emotional experience. Internal as well as external pressures to which adolescents are exposed create significant disturbances in the personality balance, or imbalance, and gradual learning through experience sometimes brings gratification and sometimes disappointment. Getting to know the painful facts of real life, discarding the protective "child's shirt" often leads to a feeling of fear and questions the meaning of life. "As the pearl is a shellfish disease, so the adolescent crisis is a disease of adolescence" (Veljković & Stojimirović, 2019, p. 207).

All adolescents oscillate ambivalently between longing for another close person and their own autonomy, they find it difficult to tolerate loneliness as well as closeness, while they are sensitive to the level of hypersensitivity to the views of others if inconsistent with theirs.

It is important to point out the relevance of social and economic circumstances at both minor and major social and socio-political level the adolescent lives in through his adolescence and its' crises. The constitutive phase of identity is precisely the period of adolescence. According to Veljković and Stojimirović, "the coherence of personal identity depends on whether the value patterns in one society are harmonized or confusing. In Serbia, in terms of values, processes of forming value orientations are ambivalent: a mixture of liberal, traditional and

authoritarian value patterns“ (Veljković & Stojimirović, 2019, p. 202; Golubović, 1999, p. 136).

Being an adolescent in our country, where no generation has bypassed war, revolutions and social crises, has never been easy. The parents of today's adolescents “went through” a complicated adolescence thanks to all the war and post-war events in the former Yugoslavia. Their parents experienced the horrors of World War II and the parents of their parents World War I in their adolescence. “significantly changed social structure, change of dominant social actors, a new functioning “logic” and some new social problems and contradictions are present in present day Serbian society” (Mojić, 2016, pp. 245-258).

COVID-19 VIRUS, ADOLESCENTS AND THE STATE OF EMERGENCY IN SERBIA

The first cases of SARS-CoV-2 virus (COVID-19) appeared in the city of Wuhan, in China, in December 2019. Welcoming the New 2020, we had no idea what awaits us. On March 11, 2020, the World Health Organization (WHO) declared a pandemic of the Covid 19 virus. At that time, European countries such as Spain, Italy, Germany and England had already recorded thousands of deaths caused by this virus. Very little was known about it in Serbia until the beginning of March 2020, when the situation suddenly became disturbing and tense. As the news about the virus and the unfavorable situation in the world began to spread, the first cases of infection emerged in our country. Within a few days from the appearance of the first case, emergency state was announced. This meant the immediate temporary closure of colleges and schools, dormitories, as well as many other institutions, limited movement for citizens with curfew measures as well as social distancing. Another significant event was the disruption to intercity and long-distance traffic. There was a mass exodus, among other things, of students from dormitories in Belgrade and the search for a “ticket more” for the first bus leading to their respective hometowns. The proclamation of a state of emergency due to a life-threatening pandemic brought many changes to people's daily functioning, both externally and internally. Externally, a significant change in behavior was required in order to prevent the spread of the contagious virus that has reached Serbia. The change of behavior meant extreme caution with respect to hygienic measures, reduction of contacts, withdrawal from social life, and for elderly fellow citizens even complete quarantine.

The focus of this paper is adolescents who are students of the University of Belgrade, reality being that two thirds of them originate from other parts of the country. The columns of students were reminiscent of the columns of refugees known to us from the 1990s. Students “rolling” their over filled travel bags containing few years of life, left the city under the compulsion of a sudden emergency.

Let's not forget that this situation contains a threat, is a risk of illness or death. The students left the city, that they gradually, during the years of studies, began to adopt as "their own". Belgrade has been "emptied" of its youth. Not only were the studies temporarily suspended, but their social microcosm, such a significant part of their social identity, was abolished. The social microcosm we primarily belong first of all signifies the support of the group to which we belong and through which we achieve our needs for contact and belonging. In this case, it is the faculty they belong to, the student groups they hang out with as well as informal friendship groups. Their style and way of life, which they may have created on their own for the first time, has come to halt. Belgrade students had the advantage that they were not forced to return to their homes, but their student life was also put on "break", the word "student" being the basis of their current identity.

On the other hand, students from the upcountry had the experience of several years of independent living, outside their parents' house, planning home visits for a "limited" time, unlike their Belgrade colleagues who did not have such an experience. Therefore, psychologically speaking, the positions of these two groups of older adolescents, although not the same, had as the lowest common denominator - the compulsion to return completely to their primary families in a way they had never encountered before. Circumstances of the emergency situation predominantly necessitated stay in the house, which implies "close gathering" in a limited space with members of the primary family.

We know that for adolescents there is no worse "punishment" than coercion and that the range of reactions to coercion is a wide range, depending on the personal characteristics but also the previous experiences of the individual. In the given circumstances, the question of (im) possibility to have their "personal" space was raised, which further aggravated the already existing stressful situation, caused by the occurrence of the pandemic.

The transition to adulthood as an integral component also implicates a gradual separation from the primary family. The emphasis is that returning home in the "Covid 19 situation" was dictated by situational reasons and not by one's own desire.

The consequence of all these circumstances is that many adolescents have entered a state of regression, to a greater or lesser degree, in accordance with the basic constitutions of personality as well as defense mechanisms arising from the given constitutions. In addition, the family situations of students are different, as well as the psychological reactions of their family members to the emergency situation. The phenomenon of "emotional induction" among family members is well known, when one member experiancing fear transfers his fears to other family members. Not everyone's return was marked by a "welcome", but by inevitability and often by discomfort. In families of lower socio-economic status, the return of the member considered to have "left" required economic and spatial

reorganization. A significant number of students had temporary jobs during their studies, allowing them partial independence in terms of being able to meet some of their personal needs. That independence was suddenly disintegrated.

During the state of emergency, it seemed to many that “time” had stopped, as if they were “trapped” in their homes and”as if life did not actually go on. Quarantine, which is not a natural circumstance for people, meant physical isolation from other people, reduction of physical movement in the conquest of space, especially important for adolescents, but also for all human beings. It forced people to turn “towards themselves” and what they carry inside…

A statement from an upcountry student reads: “Quarantine-winter sleep ... I stagnated ... as if I had stopped growing ... or fell asleep in March, woke up in June. Prison is so scary, because we human are social beings “...
Statement of a girl who spent the quarantine at home in Belgrade: “It was hard for me, I live in Belgrade, I don't have a house, I don't have a yard, I have a very small terrace that can only accommodate one chair and one person ... I went out on the terrace, looking at a ray of sunshine ... I took the opportunity to take a walk, but I couldn't escape from the “Corona story”, because everyone I met, talked only about it ... I was trying to study, I could not remember anything, I didn't do anything with pleasure, but out of compulsion to forget Corona. “

Some of the students did not return to their homes, but stayed to live in a “limbo” space, where they felt uncomfortable, lonely and often lost. In forced communion, all the suddenly gathered family members were bound by the same fear, the fear of being infected with the Corona virus, equaled with the fear of severe and painful illness as well as possible death.

THE APPEARANCE OF THE “INVISIBLE ENEMY” AND THE FEAR OF DEATH

In early 2020, lives of people around the world had changed. An invisible but life-threatening enemy, the Covid 19 virus, “attacked” planet Earth, and once such a large world, suddenly became small and fragile. But what does the notion of the “invincible” enemy contain? All people experience fears throughout their lives but most of these fears (unless they are everyday and of high intensity) remain below the surface of consciousness. The development of a child is accompanied by certain fears in certain phases of life and they intensify, decrease and disappear over time. Children at different ages are afraid of different things. They are most afraid of “invisible” things, which they fantasize in their imagination stimulated by stories and fairy tales. The more “invisible” the more dangerous, because we cannot touch it with our sense organs. Let's not forget, the virus is dangerous, but

invisible. According to Ksenija Kondić, "the development of fears is directly related to the development of intellectual abilities in children, but also imagination and abstract thinking. Smaller children are afraid of tangible things, and older children are more afraid of abstract things such as: punishment, illness, revenge, death" (Kondić, 1989, p. 367). We are protected from fears by the mechanisms of ego defence, which are triggered by anxiety. Individuals differ in the dominant set of defense mechanisms they possess and more or less successfully "fight" anxiety and fear. However, in certain difficult and provocative situations, in states of serious crises that bring the experience of existential endangerment, our "old" fears, "surface". easier. "Every event is accompanied by a subjective interpretation of the one who experienced it, and we are actually aware of the fact that different people experience the same situations in different ways" (Veljković, 2018, p. 183). In crisis circumstances, fears from earlier stages of life are reactivated, especially those that were difficult or traumatic for the person. Then their manifestation often does not correspond to the age of the person who expresses that fear and the person behaves regressively, one being far younger than one is. The fear of death is a universal human fear.

"Death is an existential issue that constitutes survival as a whole and accompanies a person from one's "Gate of Life" entry through to the exit, that occurs at a certain moment, unknown to anyone. The question of what death is is one of the most difficult questions that one ask oneself in one's life, and one is the only living being knowing that one day one will die" (Veljković, 2020). With the cessation of the usual way of life, distancing oneself from dear people, breaking off (especially forced) contacts that are important to us, we also "die" a little, because our life is not the same without people significant to us?

Our peoples have a saying, there is a term "die of fear" which refers to a situation when people are very scared and when they are unable to control their fear, whether it arises from circumstances of an objective or subjective nature. The everyday disorder that has occurred with the Corona virus pandemic has triggered "new" emotions that, although vague and confusing, produce anxiety for which the existing defense mechanisms are not sufficient to "reduce" them. Additional defense mechanisms need to be engaged. But how do we find out do we have them? Also, in such states, deeply repressed or "frozen" emotions belonging to another time and other situations that were traumatic are reactivated.

Due to all of the above, the mental health of the general population in a state of emergency is at risk, as it still is, because the pandemic has lasted for the whole year and the end of it is uncertain. We emphasize a special risk for the two most fragile populations in every society: the populations of young and old people. It is certainly very important what current life circumstances has the occurrence of the pandemic found the affected individuals in, especially our students, who are the target group of this paper. The pandemic triggered a universal psychological

crisis to which especially vulnerable are those who were already experiencing a kind of personal crisis, as well as those who had prolonged unresolved emotional situations, solution of which they have postponed for a “better tomorrow”.

According to Vlajković, “the crisis has its duration, which is limited in time to six weeks. If it is not resolved within this period, and especially if the threatening external circumstances continue, the crisis is transformed into trauma, ie traumatic neurosis” (Vlajković, 2009, p. 141).

After the traumatic experiences of the First World War that affected all mankind, in 1920, Freud wrote his famous essay entitled “Beyond the Principle of Pleasure”. Then he spoke about the concept of trauma, which includes the mental organization of the person in which our spirit is. When we are affected by a serious situation of great intensity, then normal mental activity is devastatingly “paralyzed and reduced”, and the task of our spirit is to gather all available energy to bind or immobilize huge amounts of excitation leaking through the cracks of the “predictive membrane” (Freud, 2006, p. 26). Since that time, attention is being given to external disturbing factors that disrupt our vital functioning, the Covid 19 virus pandemic being exactly that.

It is clear that in the given circumstances, psychological “first aid” was necessary for everyone, but in accordance with the main goals of this paper, we focus on the problem of students - older adolescents who reported for help in crisis caused by Covid 19 virus.

WAYS OF COMMUNICATION WITH STUDENTS “IN CRISIS”

At the beginning of the state of emergency, several interactive lectures aimed at providing support to students were given via electronic platforms. This was a kind of psycho-educational group. Students were also given the opportunity to openly ask questions which disturbed them and at the time they had no answers to. The lectures were attended by a significant number of students who expressed an authentic need to receive psychological help and support.

In some other circumstances, group work would certainly be the method of choice, due to its many advantages, especially in working with the adolescent population. Sullivan also believed that a group of peers in which harmonious relations prevail encourages a sense of personal value and altruism” (Veljković & Stojimirović, 2019, p. 281; Sullivan, 1974, p. 28). However, in these very specific circumstances, live group work was contraindicated given the existing “Corona virus” situation and the need to avoid group gatherings.

At one of the faculties of Belgrade University, a decision was made to establish an electronic psychological counseling center for psychological help and support and crisis interventions. The application process was simple: interested students applied by email to the e-mail address of the professor-psychologist.

There was a certain ethical dilemma concerning the issue of "double" roles, ie the role of the professor and the role of the assistant. In a given situation, decisions must be made quickly, according to priority, the priority at that time being the mental health of the students. Sometimes practice cannot "keep up" with theory. The educational part was not live at that moment. Interviews were conducted via electronic platforms at pre-scheduled times and students were clearly instructed that each interview would last half an hour and that the number of sessions would depend on their needs. The number of individual interviews with students during the state of emergency ranged from 1 to 6 . After the end of the state of emergency, this Counseling Center unfortunately stopped working, and the students who continued to apply were redirected to other, free of charge psychological counseling centers, which are extremely few in our city, but are more than necessary. Even after the cessation of the work of this counseling center, e-mails of students have been arriving for months, expressing the need for free psychological help due to various psychological conditions causeing them to suffer, such as: increased anxiety, panic attacks, poor concentration while studying academic material. The reality is that in many European countries, especially at the faculties where the humanities are studied, free psychological counseling is provided to all students.

ELECTRONIC COUNSELING FOR CRISIS INTERVENTIONS AND PROBLEMS WE HAVE ENCOUNTERED

The number of students who applied for help during the state of emergency was around 20. The youngest students were aged 20 and the oldest 25. The way they first established contact, ie reply by e-mail, was different. Some of them wrote long emails with a lot of personal details, a lot of anxiety and current worry; some of them just asked for a conversation, without going into any details.

For a specialist clinical psychologist, the form and content of emails had differential-diagnostic significance in terms of the first hypothetical assessment of the current psychological state of the student, the degree of suffering, but also the assessment of objective bias. It is important to note that some of the parents of students by profession are health workers working in institutions where hospitalized patients were infected by Covid 19 virus. These parents, at that time, were forced to work with very inadequate protection items 12-hour shifts after which they returned to their homes. In that sense, an objective threat was posed to their family members. They tried to avoid communication and meeting with their children in an average two-room apartment, measuring 50 to 70 square meters, in order to protect them from the risk of getting sick. In such conditions, and in the absence of an "apartment for the quarantine situation" (because there is no such one), real isolation was usually not feasible. There was a fear among household members of the transmission of the infection by working family members, who inevitably

established potentially risky contacts by going to work. This fear among students has always been associated with feelings of guilt due to the appearance of avoiding contact with parents, but also the opposite need to “throw” themselves into the arms of parents.

Some of the parents, due to the nature of their work (working with at-risk populations, especially for example working in social welfare institutions with elderly beneficiaries, etc.), were forced to be in quarantine, thus not returning to their homes, which lasted longer period of time. This was particularly difficult for both them and their families that developed a fear of their parents not returning home and a fantasy of a possible fatal outcome if they contracted the Covid 19 virus.

A number of students who returned from Belgrade to the upcountry, ie the place of their origin, after many years of absence from home, had pronounced problems of adaptation to the home environment. Conflicts between them and their parents occurred often, which emphasized their experience of helplessness in relation to the parents under whose roof they were placed in this situation.

A number of students made the decision to “acquaint” parents with long-hidden parts of their own personality and to tell them important, not always pleasant, truths. There are, above all, issues related to one's own gender identity and orientation.

A number of students had serious emotional suffering due to separation issues in the partnership, which had its duration and was abruptly “interrupted” by the emergence of this situation. For some of them, separation from their partner was perceived as a “small death”. They could not share that with their parents, who did not even know that their “child” lived in a partnership, in a rented studio, and not, say, in a student dormitory.

Some of the students experienced the departure from the city and their student dormitories as an attack on their own hard-earned adolescent identity and the experience of themselves as an independent, separate and independent being suddenly “collapsed”, like a cards tower. The jobs that supported them, were immediately lost once state of emergency was established.

The best students were desperate because the studies were abruptly stopped. They wondered - what consequences will this interruption of studies have for their learning and how much will this break affect the length of their studies. Many of them faced a sudden loss of motivation for further work, as well as the experience of terrible fatigue, loss of concentration and sleep disorders in the form of insomnia or hypersomnia, which made them feel so “standing still”, helpless and feeling they can not go forward because they see nothing there.

Some students experienced a serious depressive shift, caused by the experience of terrible loneliness in which they found themselves and alienation from the family in which they felt “like strangers”

Questions were asked about the meaning of life, which was extremely hard work to situate crisis intervention through electronic communication platforms. Topics such as: the goals of their lives, the insecurity and uncertainty of living, the potential authenticity of death in the immediate vicinity, issues of freedom and non-freedom, as well as many other issues, crystallized.

Common to all of them was the statement that there is no escape from this situation; that they have to endure this, survive and process it in the best way for themselves so that they can move on. And they want to move on, they just don't know how. For most of them, this was perceived as the first situation in life in which they have practically no choice

Fear of an uncertain future hovered over them like a "dark" cloud. Youthful optimism has "decreased" and serious and mature existential concerns about physical, economic, psychological and social survival have grown, not only in their own country, but in the world in which they live in general. In fact, the fantasy of a potentially beautiful future, in a "better or more beautiful" world, have disappeared, because the whole world has become a very "dangerous place", regardless of the political, economic and social situation of the country.

We divided the dominant topics for clarity in four areas:

Identity issues
Separation issues
Academic crisis
Questions of the meaning of life.

CASUISTIC VIEWS:
Identity issues

A young man, a successful student at the University of Belgrade, nearing the end of his studies. He was born in a city in Serbia, where he lived with his mother and her sister before coming to study. His parents are divorced, his father re-marryed following a divorce and he had two children, but he passed away suddenly a couple of years ago. The main figures in the identification of this young man are his mother and aunt, who alternated the role of father and mother in his growing up. He has been out of his hometown for five years, he is finishing his basic studies. He formed his sexual identity as a homosexual. It is not a question that confuses him, he is clearly determined. He has a stable emotional relationship for about a year and is satisfied in his partnership. He returned home because he had nowhere to go in this situation. He lost his job. The dormitory is closed. His partner with whom he shared a room returned to his house 300 km away. He misses it. However, as he spent "never more time" since his studies with his mother and aunt, they began to ask him questions

about girls, plans for the future, and possible marriage. This was an extremely bad experience of himself, as the culprit, a bad person who hides and deceives his loved ones, those who raised him and enabled him to study. That was the reason for e-mail reply. He was visibly moody and sad. He wanted to tell all this to his mother and aunt, but he wondered if it was okay, as he feared the possible consequences, he saw it as the greatest chance to inflict severe emotional injury on the people he loves. After several conversations that focused on his current situation as well as his relationship with his mother and aunt, he did not make contact for more than a week. The emphasis is on the fact that this work was not therapeutic, but was focused on "here and now", that is, on resolving the current emotional crisis. After about ten days, he made contact again and asked for an interview. He was relieved ... He announced that he shared his long-hidden truth with his mother and aunt. They accepted it without drama. They emphasized that his sexual orientation was his choice and that it did not change anything in their relationship of love and affection for him. In the final conversation, the insight crystallized that he needed to psychologically process certain traumas from his own life, especially the loss of his father, which was first caused by his parents' divorce, then the father's neglect compared to the children his father had in the next marriage, his death he never worked on overcaming.

As it is well known, the final adolescent and postadolescent period is a period of a definite formation of the experience of one's own identity. A person who has successfully realized his identity has an experience of inner unity, which brings a sense of self-satisfaction. This allows for realistic views on what is, what is not, what others think is, what is expected of him or her, and what can or cannot be done about it all. The identity crisis does not impoverish the person, but gives one a chance to "work through" his previous crises and traumatic experiences and reconsider own choices. This is a chance for further development. The Covid 19 virus and pandemic were hardly ever mentioned in the conversations.

- Separation issues and fear of death

A young 24-year-old man lives alone in Belgrade. He is finishing his studies. He comes from a small place in the south of Serbia. He is a graduate student with several exams until the end of his studies. Until the beginning of the state of emergency, he worked as a waiter in a cafe, and now he has lost his job. He decided not to return home because the situation in his primary family has changed significantly since he went to study (the last five years). The father went to work abroad, did not return because he lives with another woman, far younger than himself, with whom he has a small child. The older brother got married and had two children. Brother with his family lives in the house with his mother. Since he went home for short stays of 2-3 days, primarily to see his mother, brother and his family. His room has now become a

children's room. During the visits he was given a guest bed in the living room through which all the household members pass. He doesn't feel like he belongs there anymore, he wouldn't want to "disrupt" their established life, but he misses them all. Since the dormitory was closed, he decided to spend his hard-earned savings on renting a small semi-comfortable garage, on the outskirts of Belgrade, hoping that the state of emergency would not last as long as the pandemic, and that he would return to the dormitory soon. He replied to e-mail because disturbing symptoms for him began to appear in his mind: the experience of tightness in the area of the larynx, sweating, attacks of sudden weakness, difficulty falling asleep, the experience of heavy pressure on the chest and difficult breathing. He is alone and his apartment is on the low ground floor. At night, dogs bark and he hears the footsteps of occasional passers-by. He is afraid, he says, "as if" he is a small child in darkness and keeps the table lamp on all night. He is afraid that he will die or that someone from outside will somehow find him asleep and kill him for an unknown reason. He goes out, just to buy food, he doesn't see anyone because all his friends have gone home.

During the four conversations we had, the young man talked about his difficult childhood, domestic violence by his father towards his mother, which he suffered and he and his brother watched. About the anger towards the father, who left not only his mother but also him and his brother. About the experience of losing his own place in the house with a re-examination of whether he ever actually had it. About missed emotional relationships with girls. About the desire to find a close person, whom he will be able to trust, and about the fear of establishing closeness. He was referred to a psychiatrist at the Health Center and was prescribed anxiolytic therapy, which partially reduced his existing symptoms. He made regular telephone contact with his mother, brother and his family, who invited him to come home in repeated conversations. The last time he called from his house and said that he was quite well because he was with his family. He found a way to travel home. He thanked for the conversations and clearly defined the need to work on the problems, when the pandemic is over. He realized that he has, above all, problems in relations with his parents, In this case, the separation from the family was successful and lasted for almost five years. However, in the circumstances of the crisis, the unresolved separation issue in the relations with the parental figures declanched the very difficult feelings and led to the onset of psychological decompensation, which was reduced, but not resolved, by the conversations. Psychotherapy was advised for further work. The Covid-19 virus and the situation with the worsening pandemic in Serbia as well as in the world were not touched upon at any of these talks.

- Academic crisis and fear of the future

A 22-year-old girl, an outstanding third-year student, with an average grade of over 9, comes forward because she is unable to organize herself to study. She wants

it and tries every day, but she doesn't succeed. Her attention is scattered, she sits down to study, then "goes" to the Internet, first researches the situation around the pandemic in the world and in our country, then "goes" to social networks, where she spends a lot of time. She doesn't notice that almost two hours have passed, because she is glad to share her opinions with famous people. Then she listens to music… she is constantly asleep… Her parents allowed her boyfriend to come to the house in the afternoon every day and she is eagerly waiting for him from the noon time. They spend little time together, as long as he can return home before "curfew". Then she is left alone… she doesn't want to spend time with her parents and sister… she tries to study again but … We had three meetings and already in the second the main emotion that appeared was repressed anger, that she is affraid of and does not know what to do with.

After the "ventilation" of anger and the cathartic expression of emotions, a feeling of helplessness appeared, which referred to the experience of the impossibility of managing one's own life and the impossibility of planning for the near future. The need to control the situation, a strict plan that she will fulfill and which she has always consistently implemented and fulfilled. Achievements that were great and ambitions that were realistic, disenabled this girl to function in her usual way. They created work inhibition for her, which is a reactive mental disorder, not uncommon in the period of late adolescence. In this case, it was brought on by the quarantine circumstances and state of emergency.

- Acute crisis of the meaning of life

The 21-year-old girl sent a short email, asking for a conversation, does not say anything about herself and her problems, she just says that it is urgent. I realize that the situation is urgent, I schedule an appointment the same day. In crisis interventions, the usual psychotherapeutic rules regarding setting do not apply. The only goal is to help people who are in an acute crisis. She appears, crying non-stop for the first 5-6 minutes. Her mother is a medical worker. She worked shifts of 24 hours each. Then she was infected with the Covid 19 virus. She is being treated in a Belgrade health institution. Her condition is changeable. It is difficult to get information about a mother who is currently unable to communicate by mobile phone. The father is not present because the parents are divorced, but there is a younger sister, primary school upper grades student. The two of them are now completely alone. She takes care of her nine-year-old sister, helps her with school, procures groceries and, for the first time in her life, tries to cook something. She tries not to show her sister what she feels, encouraging her that their mother will recover and she will return home soon, but she is not sure if it will happen. She thinks that her life has no meaning in case "something happens". She verbalizes that she could not bear the responsibility of taking care of

her sister. He doesn't even know how to support her and take care of her. It turns out that the father divorced his mother six years ago and "divorced" his daughters. They have had no contact for years.

Our talks were held for several days in a row. The eruption of difficult feelings, such as fear, anger, sadness and feelings of helplessness, were most pronounced. During our conversations, the mother's health condition stabilized. Stories about the loss of the meaning of this girl's life have receded on the manifesto level. Active engagement around the sister grew and connected them in communication, which was weak before, because she perceived the sister as a "kid" until then. It turned out that this "kid" helped her a lot in stabilizing and establishing better controls, finally regaining currently shaken meaning of her own life.

CONCLUSION

The prolonged duration of the Covid 19 virus pandemic has caused significant changes in living conditions around the world and has triggered many psychological as well as psychic crises. Until then, the existing mechanisms of psychological defense in many people were not "enough" to protect them from high anxiety, fears and other symptoms. It was necessary to engage additional and different defense mechanisms, requiring communication with experts in the field of mental health. The crisis caused by the Covid 19 virus gave us all the opportunity to make a kind of "encounter with ourselves".

Apart from the people of old age, the young population is an age group that needs to be watched attentivlly both in the circumstances of normal living, and especially in the circumstances of accidental crises which, if of a prolonged duration, turn into a traumatic experience and trauma. Objectively threatening pandemic circumstances brought with it - the danger of illness and death to trigger not only the existing but also the suppressed fear of death that broke out on the surface, but also triggered many repressed hitherto untreated and significant traumas from previous live and traumatic experiences. Adolescents who were in an insufficiently stable balance, who had insufficiently stable family supports and those with the mentioned untreated psychological traumas, had fears in facing their own feelings of inability to cope "with themselves" in this crisis situation. The range of psychological reactions of adolescents was wide and the regression that occurred to them was of very different degrees and dependant on the previously achieved level of personality integration. The dominant areas addressed by adolescents in crisis were the following issues: separation issues, problems of identity, meaning, future and urgency. Crisis intervention enabled adolescents to recover from accumulated affects and to enable themselves to use the cognitive apparatus (functioning of which was difficult), in order to establish or restore the function of rational

thinking and logical reasoning. Also, crisis interventions detected a number of psychological problems that were suppressed and unresolved. The mechanism of defense, repression, in situations of intense crisis, ceases to be effective and then, at the time of its occurrence, much more primitive defense mechanisms appear, which do not correspond to the age of the adolescent, but to a much younger age. If these adolescents managed to think and face their problems, they also benefited from this difficult crisis. Therefore, working with the adolescent population in the specific situation of the existing pandemic was necessary.

Unfortunately, a pandemic that has a prolonged duration, such as the Covid 19 virus pandemic, which has so far resulted in many casualties, bears and will bear significant psychological consequences for a long time to come. We see these consequences in the form of trauma and traumatic experiences for all of humanity, and especially for the population of children and youth. Older citizens are in a similar, difficult situation. We emphasize that these are the two most fragile populations in any society. Therefore, numerous, intensive programs and preventive measures are necessary in order to overcome the serious psychological consequences of the current pandemic in time.

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ADOLESCENTI U KRIZI U SITUACIJI VANREDNOG STANJA

Sažetak: U ovom radu bavimo se kategorijom starijih adolescenata, uzrasta od 20 do 24 godine. Svi oni pripadaju grupi akademskih gradjana, beogradskog univerziteta. Epidemija Covid 19 virusa, za zabranama koje su prostekle iz situacije vanrednog stanja, prekinula je njihov dotadašnjih način življenja. Privremenim zatvaranjem fakulteta i studentskih domova, mnogi od njih bili su morali da se vrate svojim kućama. Po prvi put u svom adolescentnom periodu u ovakvoj situaciji nisu imali izbora i bili su praktično prinudjeni da vreme provode sa **članovima svojih primarnih porodica. Proces separacije od roditeljskih figura, kod ove grupe** adolescenata, započet je pre više godina i povratak kući sa nepoznatom dužinom trajanja izolacije uveo ih je u njima dotle nepoznata stanja. Početkom vanredne situacije na Fakultetu političkih nauka u Beogradu, pokrenuto je elektronsko savetovalište za intervencije u krizi, prouzrokovane pandemijom covid 19 virusa. Glavne teme sa kojima su se javljali studenti za pomoć ticale su se nekoliko kriznih područja, koje ćemo klasifikovati na sledeći način: pitanja identiteta, separaciona problematika, pitanja budućnosti i smisla življenja. Tokom trajanja perioda psihološke podrške, kod mnogih od njih je došlo do preispitivanja sopstvenih potreba i preformulacije nekadašnjih životnih planova. Poznato nam je da je kriza uvek rizik za korak unazad ali i šansa za pravljenje koraka unapred. Adolescenti koji su koristili uslogu psihološke pomoći u krizi, načinili su izvesne uvide u sagledavanju: samog sebe, sebe i drugih i svojih odnosa sa svetom oko sebe.

Ključne reči: adolescenti, kriza, univerzitet, smisao, covid 19

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SPEECH LANGUAGE PATHOLOGY IN THE UNITED STATES OF AMERICA

Abstract: The paper presents the specifics of the educational system of Speech Language Pathology (SLP) in the United States, as well as the possibilities of legal regulation and the validity of the diploma of a SLP from the Republic of Serbia. Procedures and requirements of professional organizations for obtaining professional licenses in order to independently work as Speech Language Pathologists are presented. The importance of the American Speech-Language-Hearing Association (ASHA), as the umbrella organization in the Speech Language Pathology, as well as the licensing procedures of the Florida Department of Health, were emphasized. The aim of the paper was to make a comparison of academic programs for SLP education between Serbia and programs in the United States of America (USA). It was concluded that academic programs aimed at the education of Speech Language Pathologists in the United States aspire to a larger number of classes focused on professional practice, but also the acquisition of skills of independent writing of professional papers in basic academic studies.

Keywords: education, Speech Language Pathology license, American Speech-Language-Hearing Association.

EDUCATION OF SPEECH SPEACH LANGUAGE PATHOLOGISTS IN THE UNITED STATES OF AMERICA

Speech Language Pathology as a science is extremely recognized in USA. The study program includes Bachelor (Undergraduate), Master's (Graduate) and Doctoral studies - two levels of Doctoral studies. SLP belongs to the health profession and after completing the studies, the student can be employed in a hospital, school, private practice, nursing home or rehabilitation institution.

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The SLP program can be found at many Universities and each Department is engaged in scientific research in various fields of SLP. For example, the Department of a Speech Language Pathology at one University is researching new techniques for the rehabilitation of children with an autism spectrum, while another Department of a Speech Language Pathology at the University is engaged in research in the field of bilingualism in the early developmental period and later.

If a student completes Undergraduate studies in another country and wishes to pursue a Master's degree in SLP in the USA, he/she will first need to take one of the standardized English language tests such as the TOEFL or GRA. The TOEFL has four segments of English: writing, reading, conversation and listening, while GRE covers English and mathematics. Which exam will be required to take is determined by the University individually.

Bachelor of Science in SLP in the USA lasts 4 years, after which the student can obtain a license of Speech Language Pathology Assistant (SLPA). During the first two years of college, the program consists of general academic subjects that contain half of the natural and half of the social classes. The other two years consist of professional SLP classes in addition to general academic subjects. Redirection of the profession is also possible, which means that if a student has already completed Bachelor Degree and wants to switch to speech therapy studies, he has the opportunity to take approximately 10 more classes (depending on the University) to obtain a Bachelor degree in SLP.

Based on the acquired education in Undergraduate studies lasting 4 years, the student has the opportunity to apply for a license of Speech Language Pathology Assistant (SLPA) at the Ministry of Health of the country in which he would like to work. ASHA does not issue licenses to SLPAs. "The work activities of a SLPA are limited to working with patients under the supervision of a licensed SLP, keeping professional documentation, maintaining materials, limited assistance in the administration of standardized tests and collecting the necessary data to improve practice. A SLPA CANNOT: test a patient with a standardized or non-standardized test, diagnose a patient's condition, or interpret test results. The assistant CANNOT give advice to parents without a licensed SLP, write or change a treatment plan, sign a treatment plan or report. The SLPA is not even allowed to suggest completion of treatment, recommend the patient to another specialist, as well as to do swallowing therapy" (Rosberry-McKibbin, 2011, p. 655). A SLPA must have a supervisor a licensed SLP, who is responsible for training and monitoring the work of a SLPA who cannot work independently. A licensed SLP and SLPA do not have to be together in the same room throughout the working day but must be in the same building. If the licensed SLP is not physically present in the building where the therapies are performed, the SLPA cannot legally perform professional activities.

Master's studies are 2 or 3 years, depending on the University and the intensity of a program. If the program is more intensive, for example, that the year consists of 3 semesters with a full fund of classes per semester, it is possible to be completed in 2 years, and if you study at a slower pace, it ends in 3 years. The length of study is not determined by the student himself, but by the Department of SLP at the University where he/she is studying. In addition to academic classes, the student is required to attend professional practice for 4 semesters:

- One semester the student completes a professional internship at the school; Elementary (preschool age up to 5 grades), Middle (6-8 grades) or High School,
- the second semester at the hospital,
- the third semester in a geriatric facility
- the fourth semester the student performs a professional internship in a private clinic.

The student has the opportunity to choose certain SLP areas where he will do professional practice in accordance with the interests. For example, as part of a hospital internship, a student has the opportunity to request an internship to work with patients with voice, swallowing, developmental, speech, language, or other disorders. Professional practice is performed in the morning full time, and in the afternoon theoretical classes are held. Theoretical classes are conducted similarly as in Serbia, except that students are required to have at least one seminar paper, presentation, project or similar during the semester. Exams are exclusively written and scored with a unique system of points. A student can complete a master's degree by writing a master's thesis or passing two additional exams if he does not want to write a master's thesis.

After completing the master in SLP there are two more academic levels above, “Doctorate in Speech Language Pathology- SLP.D” and “Doctor of Philosophy- PhD”. The first mentioned program lasts 3 years and the second one 5 years. Title SLP.D. it is not similar to a Serbian doctorate or a medical doctorate but is a program somewhere in between a Master (MS) and a PhD. This program does not exist in our region or in Europe, but it exists in the USA, Australia and Great Britain. The mentioned program was made for the purpose of SLP's professional growth in large medical corporations. A SLP clinician can complete the program and progress in the profession, but does not have a Ph.D. It gives the possibility of advanced professional growth in the field with SLP.D. The title reflects the fact that the expert has the opportunity to work in positions above the SLP clinician, which means to become, for example, the head of the SLP department of a larger clinic or the manager of a SLPs at larger medical centers. It is made for clinicians who want higher professional growth in clinical work, but not in academic areas.

This program can be found at certain Universities, mostly not at highly ranked Universities where the primary academic program of Doctoral studies is, actually PhD. The PhD program is similar to the Doctoral program in Serbia, except that it lasts 5 years. The PhD in SLP in the USA is based on an academic upgrade of knowledge with a focus on research work. Upon completion of the program, the expert acquires the right to employment at higher academic institutions or research centers. The focus is greater on research and academic work, and less on clinical work. It consists of academic SLP classes, professional practice and Doctoral dissertation.

It should be noted that the ASHA and the Department of Health do not issue licenses for the above titles, SLP.D and PhD. Acquired titles are recognized and can be used in corporate professional and academic institutions according to the needs of the workplace.

TRANSFER SLP DEGREE FROM ANOTHER COUNTRY TO USA

Transfer SLP degree is necessary for all foreign SLP professionals if they want to practice in the United States. There are numerous agencies that do evaluations of diploma of foreign nationals, but it is important to choose an agency that is recognized by ASHA and by the Department of Health of the country in which the person wants to work. Before applying for a license, it must be checked on the website of the Department of Health of the state which agency is recognized. Most states in the U.S. recognize evaluations of all agencies that are recognized by a federal agency, the National Association of Credential Evaluation Services (NACES). From the personal experience of one of the authors of this text, Educational Record Evaluation Services, Sacramento California, is recommended. That agency evaluates diplomas ready to apply for an ASHA license. It is recognized not only in California but in all U.S. states. One of the authors of this text personally used it to obtain ASHA and a license from the Florida Department of Health.

In order for foreign diploma be recognized as a Master, it is generally necessary for a person to have completed a Master's thesis. Some agencies will not give the equivalency of a Master's degree without a final thesis.

There is a possibility that different agencies evaluate the diploma differently. If you are not satisfied with the evaluation, it is not a bad idea to do it again in another agency.

CONDITIONS FOR OBTAINING SLP LICENSE BY THE DEPARTMENT OF HEALTH

After completing the evaluation of the diploma and in accordance with the outcome, the person can apply for a SLPA or SLP license in the Department

of Health if he meets all the criteria. After obtaining a license, a person is able to perform professional work in the field. An expert who has received a SLP license receives a provisional license for 9 months while he/she completes an internship. After 9 months of internship, he/she will apply for a SLP license at the Department of Health and the opportunity to apply for an ASHA license.

The requirements for getting a SLPA License from the Department of Health (Florida) after completing the Undergraduate Degree are:

- Completed basic academic studies with at least 24 credits of SLP classes.
- 9 credits in classes that provide basic knowledge about normal human growth and development, psychology and normal development of speech, language and hearing.
- 15 credits in classes that provide information and observation of speech, language, hearing, general phonetics, articulation, screening and therapy, basic audiometry and auditory training.
- Completed plan of activities by the supervisor, licensed SLP.

The requirements for getting a SLP license from the Department of Health (Florida) after completing Master's Degree:

- The candidate must have a minimum of seventy-five (75) credits (one class course carries 3 credits) of which at least thirty-six (36) credits at the master level.
- 300 hours of practical work under the mentorship of a licensed SLP, of which a minimum of 200 must be in the field of SLP.
- Internship lasting 9 months under the supervision of a licensed speech therapist.
- Passed the exam on HIV / AIDS and mistakes in medical practice. The lecture on each topic lasts about one hour after which the exam is taken.

The SLP license, which is issued by the Department of Health, is renewed every two years when 30 hours of classes in the profession are completed.

REQUIREMENTS FOR ASHA SPEECH LANGUAGE PATHOLOGIST'S LICENSE

After completing the Master program, 9 months of internship and passing the Praxis test, a person can apply for an ASHA license. In addition to all of the above, a person who wants to apply for an ASHA license must have passed four (4) classes from the group of natural sciences at undergraduate level not related to speech therapy: Physics, Statistics, Biology or any other exam that may be part

of biology, e.g. anatomy, physiology, etc.) and Sociology (or other exam in social sciences). A SLP from Serbia would have to take statistics and physics, but not biology and sociology, because those classes are part of undergraduate program in SLP in Serbia. An ASHA license is not required in order to work as SLP but is recommended. It is recognized in the United States, Canada, Australia and the United Kingdom. The maintenance of ASHA licenses is renewed every year by paying the participation to the ASHA organization, while the renewal of the license is done every three years, provided that a total of 30 hours of additional training in SLP in those three years is completed.

ASHA's activities are as follows: scientific research, prescribing high ethical, academic and practical standards, promoting and adopting new knowledge and skills in practice, encouraging research, diagnosis and prevention in speech therapy, supporting the development of clinical practice, stimulating information exchange, informing the public about speech therapy activities and experts of similar profiles, advocating for the rights and interests of people with speech and language difficulties and supporting members of their organization. (Hedge & Davis, 2009).

Within the ASHA organization, there is an advisory body that deals with the accreditation of SLP Departments at various Universities (Council of Academic Accreditation (CAA)). In order for a SLP Department of a University to be accredited by ASHA, it must meet certain criteria: satisfactory quality and number of scientific staff at the department, satisfactory curriculum, adequate spatial conditions for academic and practical activities, administrative support and satisfactory staff for conducting hands-on teaching (Hedge & Davis, 2009).

Continuing education hours may overlap between ASHA and the Ministry of Health license, but care must be taken as their conditions are not the same. The Ministry of Health requires experts to have 30 hours of professional training during 2 years, and ASHA during 3 years.

PRAXIS exam is a professional standardized test that can be taken during the final year, after completing Master's program in SLP or during the internship. Without passing the Praxis exam, the SLP will not be able to apply for an ASHA license. The exam contains thematic units of all professional classes in SLP as the final accumulative professional test. It has between 135-150 questions (which can be changed from year to year). The duration of the exam is 150 minutes, but a person whose second language is English (who did not study in USA in English) can request to get another 60 minutes more, which means that for that person the exam would last 210 minutes. There is a book of approximately 800 pages for the preparation of the Praxis exam issued by the company who is making the test. The book also contains examples of exam questions.

The internship (Clinical fellowship year-CFY) lasts 9 months and must be completed under the supervision of a licensed SLP. There is a form that needs to

be filled-work plan with the time for the Department of Health and for ASHA in particular. The SLP intern is able to do the practice independently, but consultations are necessary as well as the supervision of a licensed SLP. The intern is not able to have an assistant for whom he is responsible. After completing an internship of 9 months (full time) or longer if not full time, passing the Praxis exam and meeting all academic requirements, the candidate applies for a license as a SLP at the Department of Health and ASHA. After obtaining licenses, a licensed speech therapist has the right to perform professional activities independently without an official supervisor, but does not have the right to have an assistant. After two years of full-time practice in the SLP profession, a licensed SLP can be a supervisor of 2 assistants and 1-2 SLP interns.

According to the information above, an accredited University SLP degree can be evaluated by an accredited evaluation agency may be recognized in the United States. If the number of credits obtained during studies does not match the number of credits or the choice of exams according to American standards, a person can take additional classes as a part-time student at any general (eg mathematics, statistics, etc.) or SLP Department (professional exams).

ADDITIONAL RECOMENDED CLASSES FOR INTERNATIONAL SLPs

From the author's experience, it is recommended that the certain classes should be taken again in English due to the nature of the profession. Phonetics in English should be taken as the most important exam due to the difference in the pronunciation of some sounds and the different number of vowels present in Serbian and English. In addition, it is recommended to take an extra class in the Diagnostics in SLP due to its exceptional importance because it trains staff to use standardized tests and write professional evaluations. At the very beginning, it would be extremely helpful to take additionally the class “English Composition” at undergraduate level because it trains students in academic writing in English, which is the basis for writing academic papers and projects during later studies.

The differences in the phonetics of Serbian and English are huge. Repetition of that exam is of exceptional importance both for practical work in the profession and for academic training. For example, in Serbian there are five vowels while in American English there are fifteen vowels and five diphthongs (Bernathal, Bankson, & Flipsen, 2013). A lot of practice is “transcript”, writing as it is read, which is different from written English. Transcript knowledge is required to collect data using standardized articulation tests. Spectrographic record analysis is another topic among many that is covered within phonetics.

Diagnosis in speech therapy is a crucial subject. During the semester, the student is trained to apply various standardized tests and to write a SLP report after the evaluation. Standardized tests for the assessment of speech and language

abilities are measuring instruments of precise results and rules of use. Also the interpretation of the results, the writing of the report and the presentation of the cases must be fully professionally prepared. It is necessary for the speech therapist to be trained for this complex process, after which the patient is offered speech-language therapy in accordance with the test results. "The ultimate goal of a standardized test in speech therapy is to make a speech-language assessment of the individual being tested" (Shipley & McAfee, 2004).

"English composition" is a class at undergraduate level and the authors of this text believe that it is very important for all students who come from abroad to take that class. This subject is not compulsory, it is not required anywhere, but it is very useful because the student during the classes masters the skills of academic writing in English as well as the style of writing that is necessary for any highly educated profession.

SLP IN PRIVATE PRACTICE

SLP work in private practice can be a in pediatric or private practice that provides services to adults. Pediatric private practice is organized in accordance with the type of services and the place where the practice takes place. SLPs can work in a private pediatric practice, in a school or kindergarten with which the practice has a contract, and can also provide services in both places. Some practices prefer to have patients in their premises from the beginning to the end of the working day. The SLP may be employed in a private practice, but provide professional services in the school too (school system). The third option is for the speech therapist to travel in the morning to various kindergartens or schools, while he/she would spend the afternoon in private practice providing SLP services to patients who would come there. In addition, there is a possibility for the SLP to go to the patients' homes and perform therapy there, but this is charged separately.

The length of therapy session is usually 30-60 minutes, which depends on the results of the standardized test and the age of the child. If the result is lower, the duration of therapy is longer and vice versa. In private practice, the therapy is always individual. Generally, therapy services are paid for through insurance that the patient has, but it has to be authorized by the insurance. The number of SLP services depends on the insurance plan as well as the amount of approved sessions by the insurance, which can negatively affect the quality of therapy. For example, insurance may approve 5 or 10 speech therapy classes after which a time-consuming authorization must be sought, so there may be pauses between blocks of approved sessions. Rarely a patient covers speech therapy services with his own money. Therefore, it can be concluded that speech therapy services in private practice are financed by insurance companies, which conditionally speaking determine the price of work. Professional evaluation and progress of work must be

available to the insurance in case of verification. Reevaluations are done every 6 months. The inspection of the speech therapy activity by the insurance company or the state insurance has been announced in advance and a period of one month has been given when it may happen that the inspection comes without notice to check the work of the practice. In private practice, mostly SLPs and SLPAs work according to the contract without benefits (health and pension). They are paid according to the hour of the performed therapy, so that if the patient is absent from the therapy, the SLP will not be paid for that time.

When a patient turns to a practice for the necessary speech therapy services, the insurance company is first contacted to check the benefits of speech therapy sessions. There are too many insurance companies and different plans on the market which further complicates the start-up process. When the authorization is obtained, the patient is scheduled to be tested with one of the standardized tests, after taking the anamnesis of the previous development of speech and language, as well as medical data. After that, the speech therapist has 2 weeks to write a professional report and work plan, which is sent to the insurance company for approval. This process can last up to a month, after which it starts with therapy. As previously mentioned, only a licensed SLP is able to write a report, calculate test results, interpret what has been done and propose a work plan. Therapy can be performed by both an assistant and a speech pathologist, as well as test administration. Evaluations, testing of the child is done every 6 months. The progress of the therapy is recorded in each session in percent. The objectives to be worked on must be in accordance with the data from the standardized test. This means that questions that the patient has not answered correctly become goals that need to be worked on. Standardized tests are very precisely designed to indicate problematic parts of speech or language. The use of instruments used in private practice is very limited due to the strict hygiene laws of medical waste. Mostly creative games, toys, book assignments are used. The lollipop is used when articulation is done after which the child eats it and thus there is no medical waste or need to sterilize the material. Parents are not able to attend the therapy, but they can watch it through the window that is in the hallway and they can observe the speech therapy session. In this way, the work of SLP is representative. Before the end of the session, the speech therapist has the opportunity to talk to the parent about progress, homework and expectations.

Within pediatric private practice, in addition to speech therapy, physical and occupational therapy services are generally available, since most patients need these types of therapies as well.

Private speech therapy practice that deals with the pathology of speech, language or voice of adults is organized differently from pediatric private practice. In this type of practice, speech therapists go to patients' homes and work with patients on individual therapy. It is mainly financed by health insurance.

All patients over the age of 65 have state insurance, which covers the costs of speech sessions. Professional evaluation and progress of work must be available to the insurance in case of verification. Reevaluations are done every 6 months.

SLP IN THE SCHOOL SYSTEM

Speech therapy in the school system has a special model of work. It is strictly regulated by the laws of labor in education. Each Elementary, Middle and High school, in addition to teachers, has additional staff that includes a speech therapist. Their goal is to help students achieve the highest possible academic goals. "Most scientific research indicates that the more students focus on learning and success, the easier and more successful they will be in mastering the material." (Jones, 2013, p. 65). Additional staff is a professional team that helps students reach their maximum potential. Speech therapy work at the school is more complicated than work in a private practice. Administrative documentation and evaluations are much more complex. Group therapies are performed depending on the pathology. For each child who receives SLP services, an annual meeting must be organized at which an individual educational plan (IEP) is proposed for the next year, which must be approved by the entire team. The IEP team consists of different specialists, depending on the pathology. Specialists who may be at the IEP meeting are a SLP, occupational therapist, physical therapist, audiologist, teacher, parents of the child who can bring a lawyer or advocate, and the school principal. The meeting is held by a special responsible person called the ESE specialist who organizes the meetings. The IEP is an extremely important legal document on the basis of which additional services are provided to a student above the regular school program.

CONCLUSION

There are differences in the academic education of SLPs in Serbia and the USA, but some classes are very similar. Assessment in SLP is much more complex in the United States because standardized tests are used, of which there are many on the market. Also, writing an expert report is more complex. During the studies, students master the skills of implementing standardized tests as well as writing professional reports. These processes are slow but very efficient. The experience gained in writing reports can be applied to various tests and evaluations.

During SLP studies in the USA, students are exposed to more independent work, a practice that is supervised by a mentor and must go through as many different areas as possible. Students must have a professional internship of at least 4 semesters of professional practice in a different professional environment with different pathology. Although he will do an internship under the mentorship of a supervisor, the SLP performs independent professional activities and meets

with the mentor several times a week for consultations and further work plan. It is important to note that after obtaining an ASHA license and a license from the Department of Health, a SLP is not able to be a supervisor to an assistant, student or an intern for the next 2 years. In addition, he must complete additional training on supervision in order to be able to perform that part of the job. A SLP who has passed the PRAXES exam, gained 2 years of work experience and passed the supervision exam is able to have two assistants and an intern student under his license. As for opening a private practice, the SLP is able to open it immediately after obtaining the licenses, ASHA and the license of the Department of Health. Work in different places and with different pathologies is extremely different and not comparable.

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LOGOPEDSKA DELATNOST U SJEDINJENIM AMERIČKIM DRŽAVAMA

Sažetak: U radu su prikazane specifičnosti obrazovnog sistema logopeda u Sjedinjenim Američkim Državama, kao i mogućnosti pravnog regulisanja i validnosti diplome logopeda iz Republike Srbije. Predstavljene su procedure i zahtevi strukovnih organizacija za sticanja stručnih licenci u cilju samostalnog obavljanja logopedske delatnosti. Istaknut je značaj Američke asocijacije logopeda i audiologa, kao krovne organizacije u logopedskoj profesiji kao i procedure licenciranja Ministarstva Zdravlja države Floride. Cilj rada bio je da se napravi komparacija akademskih programa za obrazovanje logopeda između Srbije i programa u SAD. Zaključeno je da je akademski programi usmereni na obrazovanje logopeda u SAD pretenduju ka većem broju časova usmerenih na stručnu praksu ali i sticanju veština samostalnog pisanja stručnih radova na osnovnim akademskim studijama.

Ključne reči: obrazovanje, logopedska licenca, Američka asocijacija logopeda

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DEVELOPMENT OF LOGOPEDIA IN SERBIA

Abstract: Logopedia has been known and recognized as a science in the world for 85 years, and in Serbia it has a forty-five-year tradition of higher education, professional and scientific work. The education and professional work of logopedia in Serbia have always followed the trends and development of speech and language therapy in the world throughout history, and the diploma of logopedia from Serbia is recognized in most developed countries of the world. However, the classification of logopedia as a science and profession in Serbia is still not adequately resolved and harmonized with Europe and the world. In most countries of the European Union, the logopediaactivity is recognized and legally regulated in a way that eliminates the shortcomings that we encounter in Serbia. The adoption of the Law of logopedist work would regulate the content and manner of operation, standard education, conditions for performing logopediaactivities, duties, professional supervision over the work of masters of logopediaand graduate speech therapists, and professional supervision over the implementation of logopedics activities in the Republic of Serbia.

Keywords: logopedia, education, logopedics work

INTRODUCTION

Although the complete history of logopedia in Serbia has not been processed to this day, some authors, such as Keramitčijevski (1990), have left us records on the world traces of logopedia. In the chapter *History of Logopedia*, this author wrote about the world development of logopedia as well as about the development of logopedia in Yugoslavia.

Logopedia as a very young science was founded in Europe at the end of the 18th century, while the historical beginnings of logopedia, but still not as independent scientific discipline, in our area, are connected to the period after the Second World War when the first department of formal education was formed in 1947, at the departments for special pedagogy of higher pedagogical schools in Belgrade and Zagreb.

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Before this period, logopediaas a subdiscipline or independent discipline did not exist in Yugoslavia. Doctors and pedagogues wrote and dealt with logopediaof that period. Far from the truth that the need for a speech therapist did not exist. The fact is that speech disorders, or "speech defects" at the time, especially stuttering, have been a concern since ancient times. Thus, in the historical records of world speech therapy, we find the first interests in the treatment of "speech defects" in the time of Herodotus (484-425 BC), Hippocrates (460-377 BC), and Aristotle (348-322 BC) and other scientists and philosophers of ancient peoples who have certainly laid the groundwork and contributed to the study of speech and voice disorders, especially stuttering.

In fact, until the 15th century, people who stuttered were worked according to the settings of Hippocrates, Galen, and Aristotle. In the period immediately before the basic description of the speech organs and the mechanism of breathing, we find that among the important features is "beautiful speech". Thus Leon Batista leaves a trace: "Without flaws in front of people in three things: in walking, riding and speaking" (Keramitčijevski, 1990, according to Burchart, 1953).

With the development of general literacy and other sciences, logopediagained its first outlines. Universal genius Leonardo da Vinci (1452-1519) was the first to describe in detail the speech organs, as well as the influence of jaw deformity on speech, and put the first foundations of the anatomy and physiology of speech in front of humanity. He discovered that speech can be read from the lips and set new approaches in teaching the deaf to understand speech. Roughly speaking, the contribution of Leonardo da Vinci is considered exceptional, considering that his work contributed to raising the practice of working with speech and language disorders to a higher level.In the further period, with the development of anatomy and physiology, medicine in general, in addition to stuttering, other disorders such as aphasia, articulation disorders, etc. are defined. Different directions developed through the development of the phonetic, nosological, pathological, pre-pedagogical, and psychological schools during the 18th century. The problem of stuttering and loss of speech ability has been researched by a large number of scientists. In that period, many misconceptions that arose in the middle ages were overcome, and the most significant rise in the development of logopediatook place during the 18th and 19th centuries in parallel with the development of non-medical sciences that treat man, that is, part of his psychophysical pathology. Health but non-medical professions are emerging thanks to the development of social theories, but also the development of medical doctrines, primarily to doctors who have actualized the problem of speech abilities and disorders and insisted that other profiles be included in the treatment.

This era of flourishing medicine and social practice lasted until the early phase of industrialism, when the practice of observing health from the point of view of the interests of the state, which is committed to preserving and improving

the abilities of workers, began. Thus health became a concern of public policy on a class basis and remained in that status until the end of the 20th century until the development of the private sector and further defined on a class basis.

At the international level, logopediawas fully established by 1945, so that after the end of World War II and in the following period, the theory of logopediawas satisfactorily developed; university institutions have been established where the program of logopediais realized; practice of logopediais realized institutionalized in health, educational and social institutions; a job description for the profession of speech and language therapist/logopedists was made; there are several basic speech disorders in the international classifications of diseases; registers with the nomenclature of logopediaservices in prevention, diagnosis, treatment, and prosthetics have been prepared on national plans; standards and norms of logopediapractice were developed, and speech therapists were organized through the work of national and international associations;

Today, there are a large number of scientific journals in the field of logopediain the world, and practice of clinicallogopediais being intensively updated, especially in parallel with technological development. In most countries of the world, practice oflogopediais normatively based and protected (Keramitčijevski, 1990; Savić, 1966, 1999).

LOGOPEDIA IN SERBIA

In our area, the first traces of logopedia can be found in the Kingdom of Serbia, in an article published by the pedagogical press, whose author is Maksimović J, with a request to find a cure for students who stutter. This opinion was presented by the author of the article as a teacher-practitioner without knowledge of the theoretical thought of Europe at the beginning of the 20th century. Before this period, there were attempts to solve the problems of children with speech disorders in an organized and systematic way. Thus, S. Čuturilo sent to the Ministry of Education and the Main Education Council, a translation of Fock's work from 1897: *Die BehandlungstotternderSchuller - Care of Stuttering Children*, with a request to study and recommend it for the benefit of all children. The education authorities sent the proposal for evaluation to Dr. V. Đorđević, the secretary of the medical service, who gave a negative report and was not put into practice by the Ministry of Education.

In Serbia, greater interest in speech disorders appeared in the 1930s when the publication appeared: Speech defects, causes, and their elimination (collection of translations of works by Sikorski, Kristina, and the author). The manual was printed in 1928. This collection of works talks about beating, stuttering, snoring (tingling), haste, aphasia, and also brings knowledge of phonetics and physiology of speech. It was a manual (compendium) of knowledge in the field of physiology

and pathology of speech. In 1930, a translation of Frechels's book: *The Science of Speech Treatment* (Lehrbuch der Sprachheilkunde, Wien, 1925) and *Stuttering* (Das Stottern, Wien, 1925) appeared. In the social-medical examination, Belgrade in 1939, the work of IldikaSulejmanpašić was published: On measures to suppress stuttering, where it is stated that stuttering is not a disease of an individual but a man as a social being. Frechels' view of speech disorders departments is accepted to introduce it in Serbia (Čauševac & Milošević, 2018).

A significant period of development of logopediain our country occurs in the fifties of the twentieth century and is associated with Prof. dr Miodrag Matić when he published the first papers in the Serbian language in the field of logopedia concerning the correction of the pronunciation of voices.

At the end of the fifth and the beginning of the sixth decade of the 20th century, the Institute for Experimental Phonetics and Speech Pathology was established in Serbia under the auspices of the Serbian Academy of Sciences. The Institute for Experimental Phonetics and Speech Pathology was an institution in which, through professional practice, scientific development, and technological innovations, logopediacould be developed following the example of European and world speech and language therapy/logopedia. In 1952, the Institute made and perfected an individual device for speech and language therapists and hearing impairments, the so-called SAFA device (selective auditory filter amplifier). With its professional staff and organization, the Institute develops departments of logopediain primary schools and some hospital departments both in Belgrade and in Serbia. SpasenijaVladisavljević, a speech therapist, and Smiljka Vasić, a psycholinguist, make an exceptional contribution to the development of logopedia science and profession by working at the Institute. Apart from her scientific work at the Institute, Spasenija Vladisavljević also contributed to the development of logopediaby educating the logopedia staff at the highest level, as a professor of logopediaat the University of Belgrade. Smiljka Vasić gave her scientific contribution to the development of logopediathought the study of children's speech and language development, as well as by creating the first test instruments for examining children's speech. In the early eighties, another organization was formed in Serbia, which will deal with speech pathology within the health system. By the decision of the Government of the Republic of Serbia, the Institute for Psychophysiological Disorders and Speech Pathology was established in 1971. It is a specialized health institution that deals with "monitoring and studying the state of developmental disorders, hearing impairment in children and youth, speech disorders of persons of all ages; researches and discovers the causes and occurrences of disorders and the ways and measures of their detection, efficient and quality treatment and rehabilitation; provides health care in outpatient and hospital conditions; monitors and implements professionally and scientifically determined methods of diagnostics, treatment and rehabilitation, and especially professional-methodological

and doctrinal criteria-protocols". Since its establishment, the Institute has been managed by Professor CvetkoBrajović, a pediatrician and psychologist, later one of the initiators and a member of the Main Commission for the Establishment of the Faculty of Defectology. Professor Brajović in the Institute implements the method of treating stuttering and other speech and developmental disorders with the method of which he is the creator of the idea. It is a method of "Conscious synthesis of development" which is clinically tested in the Institute and through projects is scientifically verified and becomes a technique applied in their work by the generation of speech and language therapists (Čauševac & Milošević, 2018).

This period can be presented as one of the most effective in the field of logopedia. Research work in the field of speech and language of the general population, development of measuring instruments as well as innovation in the methodology of work has given future generations a difficult task of reflecting the formed trend. In the spirit of innovation, the least that was expected was a further development, however, in the Republic of Serbia the development of the logopediaprofession and science seems to stop and to this day the instruments formed in the seventies of the last century are used in this activity.

HIGHER EDUCATION OF LOGOPEDIA IN SERBIA

Logopediahas been known and recognized in the world for 85 years, and in Serbia, it has a sixty-four-year tradition of staff education, professional and scientific work. The education and professional work of logopedia in Serbia have always followed the trends and development of logopediain the world throughout history, and the diploma of logopediafrom Serbia is recognized in most developed countries of the world. However, the classification of logopediaas science in Serbia is still not adequately resolved and harmonized with Europe and the world.

Studies of logopedia (basic and master academic studies) in the Republic of Serbia educate experts - speech therapists for work on prevention, detection, diagnosis, treatment of verbal and/or nonverbal communication disorders and disorders of oral-laryngeal functions in persons of all ages following regulations and programs states the World Health Organization (2013), the American Speech-Language-Hearing Association (ASHA) and the European Speech and Language Therapy Association (CPLOL/ESLA). In addition to clinical activities, speech and language therapists also deal with applied and fundamental scientific research in these areas.

Historically, when it comes to educating experts in the field of logopedia, the Government of the Kingdom of Yugoslavia passed the Decree on the Higher Pedagogical School in 1936 with the necessary curriculum, but it remained unrealized until 1948 when the plan of the Higher Pedagogical School was adopted and implemented. After the Second World War, the curriculum of the II Department

for the Preparation of Teachers for Defective Children was implemented at the Higher Pedagogical School, which included: pedagogy with pedometry; experimental psychology; speech psychology and phonetics; psychopathology; treatment pedagogy and pedagogical psychology. Thus, the Higher Pedagogical School educated logopediastaff in the Republic of Serbia. The education of speech therapists through academic education began at the Faculty of Defectology in 1975 with the first enrolled generation of speech therapists. Thus, logopediabegan to be studied and developed as a science at the Faculty of Defectology. In that period, the curricula were modern and in trend with the achievements and level of development of logopediain Europe and the world. In that period, students of logopedia, in addition to basic sciences (physiology, anatomy, neurology, psychology, linguistics, sociology, pedagogy), also studied clinical logopedia, phonopedia, aphasiology, logometry, and speech prosthetics. In 2005, the Faculty of Defectology changed its name to the Faculty of Special Education and Rehabilitation, and in that period the Department of Logopedia advocated that logopedia in Serbia should survive within the social-humanistic field and under the auspices of special education and rehabilitation.

The development of logopediain Serbia within higher education until today is accompanied by a wave of defectology and later renamed sciences of special education and rehabilitation, classifying logopediaas a subdiscipline of these areas. So, unlike international events, Serbia is educationally establishing logopediaas a defectologysubdiscipline together with typhlology, surdopedagogy, somatopedia, and the professional name of speech and language therapist/logopedist appear in legal documents only after 2015.

At the University of Novi Sad, the Faculty of Medicine in 2008 accredited the study program of logopedia, which is based on the existing program, which is implemented at the University of Belgrade and there was no significant reform, relying on "defectological" practice and knowledge acquired before 1990. At the Faculty of Medicine, the Department of Logopediahas not yet been independently established but exists within the Department of Special Education and Rehabilitation.

Since 2017, logopedia has been studied at the College of Social Work (private higher education institution) within the framework of basic academic studies and master studies. The study program of logopediaat BAS and MAS of this highly educated institution is conceived on modern scientific theories of fundamental sciences and modern theoretical and applied principles of logopedia. The study of logopediaconceived in this way is realized by staff competent both scientifically (doctors of logopediaand related sciences) and professionally, with rich clinical practice. The goal is for future students to master the basic, modern theoretical knowledge and practical skills that today's logopediascience requires.

Analyzing the program concepts of logopediastudies at the Faculty of

Special Education and Rehabilitation, University of Belgrade, the Medical Faculty of the University of Novi Sad, and the College of Social Work, it is obvious that all study programs in logopediaare interdisciplinary.

In all programs, basic subjects are studied, which are defined as biomedical, psychological-pedagogical, linguistic, and sociological. Compulsory practical classes are conducted within state higher education institutions in health and social care institutions, less so in educational institutions. The College of Social Work has enabled students of logopediato realize their practical classes in state and private logopediainstitutions that have developed in the last decade as very professional and technologically modern logopediainstitutions.

THE TITLE OF A LOGOPEDIST AND LOGOPEDIC PRACTICE

He has been formally acquiring his professional title or title, speech and language therapist/logopedist (graduate, master speech and language therapist/logopedist, PhD of logopedia) since 2018. The National Council for Higher Education expands the list of professional, academic, and scientific titles when logopedia remains within the social-humanistic field in the field of special education and rehabilitation no longer as a graduate defectologist-logopedist but as a graduate logopedist after basic academic studies in logopedia. This title also enters the National Catalog of Professions. The question of the place of logopedia profession in the classification of scientific fields remains to be resolved. Logopediashould and must be classified as an independent scientific field of humanities as defined in the countries of Western Europe, and not as a scientific discipline of special education and rehabilitation.

One of the unresolved issues that worries the logopedia profession is the mandatory professional exam, which is missing from the current legislation. The question was whether this is unnecessary for this profession today or the legislator considers that the basic academic study of logopediais sufficient for independent and professional work as given in the National Qualifications Framework in Serbia[2].

[2] Levels and descriptors qualification in NQFS/NOKS states that person with lessons level Qualification 6:

- **of knowledge possesses**: academic or professional knowledge related to theories and principles and processes including evaluation, critical understanding, and application in the field of learning and/or work
- **of skills has**: time setup of complex problems in the areas of learning and/or work in unexpected situations.
- The skills of successful communication in interaction and cooperation with others from different social groups are applied. Uses equipment, instruments, and arrangements relevant to the field of learning and/or work.student and/or work.
- **of attitude and ability**: is enterprising in solving problems in unpredictable situations. He manages medium- complex projects independently and with full responsibility.

In disposing of communication disorders in Serbia today in the public sector (health, education, and social activity) of their professional services provide about 350 speech therapists (speech therapist according to the Association of logopedists of Serbia from 2010), and more than 300 logopedists in the private sector, according to the Business Registers Agency in Serbia (according to the Business Registers Agency, speech therapists register their activity in the category code 8690 - other education).

Logopediapractice existed even before the beginning of formal education of logopedists in the Republic of Serbia. The need for an expert to "cure" speech defects appeared at the beginning of the 20th century. In the middle of the 20th century, the state reacted to solving communication disorders by founding the Institute for Experimental Phonetics and Speech Pathology, and later another institution (1971), the Institute for Psychophysiological Disorders and Speech Pathology, was founded (Brajović, Popović, & Šešum, 2010). Within the framework of primary health care for the care of communication disorders and early developmental disorders, the state forms developmental counselling centers in which speech therapists have their place. The development of logopedia in the first decade of the 21st century will be provided by the work of the Sector for the Development and Improvement of Logopediaat the Institute for Psychophysiological Disorders and Speech Pathology. At the level of primary health care, the sector, through education of speech therapists and technological innovations, has enabled the care of communication disorders to be more accessible and efficient. With its activities at the level of primary health care, this service included more than 20 logopedists as permanent employees.

After 2010, there was intensive development of the private sector and the rapid development of the profession at the scientific and professional level. Logopedists try not to lag technologically by following and adopting information technology innovations in their professional work. Logopediapractice today is using the digital technology, electro-acoustic devices of the new generation, and new technological advancement both single electric and manual instruments. Logopedists have access to a large number of practicums and several modern diagnostic instruments. In 2020, in cooperation with the publishing house "Sinapsa Edicije" and the engagement of 27 logopedists from all over Serbia, the first relevant research on language development in children of the typical population and children with language pathology is being conducted, which leads to the standardization of the world's most famous logopediatest: New Reynell Development Language Scales (NRDLS–SR).Reynell is currently the only standardized measuring instrument in the Serbian-speaking area. A plan for

- He applies the ethical standards of his profession. Organizes, controls, and trains others to work. Analyses and evaluates simple concepts, models and theories, and practices by improving existing practice. It shows a positive attitude towards the importance of overall learning in personal and professional development.

the development and standardization of several other logopedics instruments is being formed, and various types of education in the field of logopedia are being conducted.

Milošević and Arsenijević (2021) state that the New Reynell Development Language Scales - Serbian version (NRDLS–SR) are the answer to the decade-long lack of an objective and standardized test for assessing language abilities in terms of understanding and production in the Serbian language. So far, in Serbia, apart from the adaptation and free translations of certain measuring instruments such as the Peabody picture dictionary test (PPVT-III-HR) or MacArthur-Bates Communicative Development Inventories (MB-CDI), no standardization has been done to assess the speech or language ability of children or adult Serbian speakers. Hence, the importance of introducing Reynell's developmental language Scales into the logopedics profession in Serbia is incalculable.

Logopedia profession today is performed in:

- otorhinolaryngological, pediatric, neurological, psychiatric clinics, hospitals, and health centers,
- mental health institutions and counselingcenters,
- geriatric institutions,
- medical rehabilitation centers,
- centers and special institutions for upbringing, education, and rehabilitation, such as:
- speech pathology rehabilitation centers,
- rehabilitation institutions for persons with cerebral palsy and intellectual disabilities,
- autism centers,
- preschool institutions,
- primary schools,
- research centers,
- private practice (private institutions).

The issue of logopedists work in private practice is related to the non-existence of logopedia acts as a legally regulated area and registration as such. Therefore, today, too, there are three professional associations that bring together logopedists with a relatively similar goal, and that is the initiative for the adoption of the Law of logopedist work.

LAW OF LOGOPEDIST WORK

The constitutional basis for the adoption of the Law of logopedist work is contained in Article 97, Paragraph 1, Item 10 of the Constitution of the Republic of Serbia (Official Gazette of the RS, No. 98/2006), which stipulates that the Republic of Serbia regulates and provides, inter alia, a system in the fields of health, social protection, veterans and disability protection, child care, education, culture and protection of cultural goods, sports, public information; public service system.

In most countries of the European Union, logopediaactivity is recognized and legally regulated in a way that eliminates the shortcomings that we encounter in Serbia.

Logopedist work in Italy, France, Belgium, Finland, the Netherlands, and Norway is related to the ministry responsible for health, in Germany and Austria to the ministry responsible for health and/or social protection, in Hungary and Spain to different ministries depending on the place of speech therapy.

Logopedia workin the legislation of the Republic of Serbia indirectly occurs in several regulations governing the field of health, education, and social protection.

The legislation of the Republic of Serbia vaguely and abruptly defines or omits logopedia acts as a health associate.

The need for certain collaborative activities in the health care system has been scientifically and practically proven, which inevitably includes speech therapists with their preventive, supportive, and (re) habilitation orientation in order to apply the principle of comprehensiveness in the prevention and treatment of physical and mental disorders.

It has been scientifically proven that the ability to communicate (verbal and/or nonverbal) is a determining function in human life and that its impaired development or loss of communication skills due to various impairments and diseases make a person more or less dysfunctional and disabled from independent daily activities. For the process of (re) habilitation of dysfunctional persons to be successful, logopediaactivity also has its professional place in the process of medical rehabilitation.

Population health, both physical and mental health, is a strategic goal included in many declarations of the United Nations (UN) and the World Health Organization (International Classification of Diseases). Speech and language disorders of developmental age and language disorders in adults are classified in a document of the World Health Organization (WHO). Speech therapists as experts in communication disorders (voice, speech, language, auditory processing, drinking, chewing, and swallowing disorders) can and must offer the most that can be achieved to achieve the proclaimed global and national goal. In order for the logopediaprofession to mobilize all its capabilities in the most effective way, and

with the maximum protection of the population that needs and benefits their protection, by providing affordable and high-quality services, its operation should be based on rules that are regulated by law. The adoption of a Law of logopedist work would allow that.

The Law of logopedist work would regulate to the greatest extent issues such as:

- general and special conditions for performing logopediaactivities
- level of required education; standards of equipment for professional work, space for performing activities;
- conducting supervision over the work of speech therapists - trainees and quality control of provided logopediaservices,
- the conditions for lifelong vocational education and renewal of approvals for independent work are regulated;
- establishment of the Serbian Chamber of Logopediaas an independent professional organization with the status of a legal entity and public authorizations.

The enactment of the Law would regulate the content and manner of operation, the standard of education, conditions for performing logopediaactivities, duties, professional supervision over the work of masters of logopediaand graduate speech therapists, and professional supervision over the implementation of logopediaactivities in the Republic of Serbia as activities of public interest.

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RAZVOJ LOGOPEDIJE U SRBIJI

Sažetak: Logopedija je kaonaukapoznata i priznata u svetuvećpunih 85 godina, a u Srbiji ima četrdesetpetogodišnju tradiciju visokog obrazovanja kadrova, stručnog i naučno grada. Obrazovanje i stručni rad logopeda Srbije oduvek su kroz istoriju pratili trendove i razvoj logopedije u svetu, a diploma logopedije iz Srbije priznata je u većini razvijenih zemalja sveta. Međutim, klasifikacija logopedije kao nauke i struke u Srbiji još uvek nije adekvatno rešena i usklađena sa Evropom i svetom. U većini zemalja Evropske unije logopedska delatnost je priznata i zakonodavno uređena na način kojim su uklonjeni nedostaci sa kojima se susrećemo u Srbiji. Donošenjem Zakona o logopedskoj delatnosti uredili bi se sadržaj i način delovanja, standard obrazovanja, uslovi za obavljanje logopedske delatnosti, dužnosti, stručni nadzor nad radom mastera logopedije i diplomiranih logopeda, i stručni nadzor nad sprovođenjem logopedske delatnosti u Republici Srbiji kao delatnosti od javnog interesa za Republiku Srbiju.

Ključne reči: logopedija, obrazovanje, logopedska delatnost

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VISUAL - MOTOR INTEGRATION OF DEAF AND HARD OF HEARING STUDENTS OF PRIMARY SCHOOL AGE

Abstract: Visual-motor integration represents the ability of visual perception and motor performance of the observed. The aim of the research is to examine the connection between school success in the Serbian language, mathematics and achievements on the test of visual-motor integration in deaf and hard of hearing children of primary school age. The sample consisted of thirty deaf and hard of hearing students aged eight to sixteen. The Visual Motor Coordination Test (Beery VMI – Keith E. Berry, Norman A. Buktenica and Natasha A. Beery), the Visual Perception Test (Test Visual Perception - Keith E. and Natasha A. Beery), the Motor Coordination Test (Keith E. and Natasha A. Beery) were used for data collection. The results showed that there is a statistically significant difference in student achievement in solving the Test for Visual Perception in relation to success in the Serbian language, while the Test for Motor Coordination and Visual-Motor Integration Test did not show a statistically significant difference. There are no statistically significant differences in the success of deaf and hard of hearing students on the Visual Perception Test, the Motor Coordination Test and the Visual-Motor Integration Test in relation to the success in mathematics.

Keywords: deaf and hard of hearing students, visual perception, motor coordination, visual-motor coordination

INTRODUCTION

Visual-motor integration is the ability of the eyes and hands to work together in smooth, efficient, and fine movements. This includes visual perception and eye-hand coordination, ie the ability to integrate visual perception as input and motor skills as output (Centers For Disease Control and Prevention, 2010).

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All the activities of the hands performed by a child at an early age are closely related to the development of the brain and thus man is singled out as a special species that is drastically different from all other living beings (Čuturić, 2008, according to Krstić, Dukić, & Kovačević, 2010). From the first month, the grip develops in babies and integrates with visual perception, which grows into properly organized motor activities, which are influenced by the maturation of cortical functions. The activities that a small child performs are a prerequisite for successfully developed visual-motor skills. Vision and hand motor skills are closely related elements (Frostig, 1992).

Visual-motor functions in a child are defined as the coordination of movement and perception, which enables the child to construct in space and to express himself graphomotorically. They represent the integration of visual perception and motor performance of the observed. If there are difficulties in performing activities that require hand movements under visual control, then there are problems in the development of visual-motor functions (Frostig, 1992). Difficulties in performing visual-motor functions are reflected in the movements of the hands that are under visual control. Problems related to difficulties in visual-motor functions are poor and untidy handwriting, difficulties in the spatial organization of writing, which means that it also affects success in school (Krstić et al., 2010; Stepanović, 2021).

Children who have problems with writing and drawing are poorly motor coordinated, but that does not mean that every child who has problems with drawing and drawing also has poor motor coordination. When a child can recognize shapes, sizes, and relationships, only then we talk about perception, while we can talk about true visual-motor integration only when we can transfer what is perceived into motor activity (Golubović & Rapaić, 2008). To perform tasks such as writing and drawing, paper-pencil tasks, drawing from the board, and drawing, a developed eye-hand coordination is required.

As deaf and hard of hearing children grow up in conditions where one of the important stimuli from the external environment, sound, is missing, some aspects of its psychomotor activity may be at a lower level compared to hearing children, which again negatively affects their social functioning. environment (Radovanović et al., 2013).

The results of some studies show that deaf and hard of hearing children score lower on the visual-motor integration test compared to children of typical development (Lotz et al., 1986) and that early deafness is associated with atypical development of visual-motor skills such as copying, drawing shapes, and capturing (Savelsbergh et al., 1991; Erden et al., 2004). In contrast, the results of other researchers show that the achievement on the visual-motor integration test is similar to the achievement of their peers of typical development (Spencer & Delk, 1989; Dodd et al, 1992, according to Radovanović et al., 2013).

Difficulties of fine visual-motor integration are reflected in writing, drawing, organization in the space of paper, ie searching for necessary information, such as paragraphs in a book, maps, charts, and the like.

Visual-motor abilities require the ability to translate visual perception into motor functioning and include control and accuracy of motor skills, motor coordination. Visual-motor integration as an important aspect of psycho-motor development of children requires monitoring and creation of favorable conditions for its stimulation, especially in the period up to the age of ten, when it develops the fastest (Radovanović et al., 2013).

The paper presents a part of the research results in which the abilities of visual-motor integration in deaf and hard of hearing students and the specifics of deaf and hard of hearing students in the development of visual-motor integration abilities at primary school age were examined.

METHODOLOGICAL FRAMEWORK

The aim of the research

The research aimed to examine the differences in the achievement of deaf and hard of hearing students on the tests of visual-motor integration, visual perception, and motor coordination, as well as the connection between school success of deaf and hard of hearing students in Serbian language and mathematics and achievements on the visual-motor integration test.

Sample

The research sample consisted of 30 deaf and hard of hearing students aged 8 to 16 who attend inclusive schools and specialized schools for deaf and hard of hearing children.

The structure of the sample to age consisted of 33% of students aged 8 to 10 years (10) and 67% of students (20) aged 11 to 16 years. To the degree of hearing impairment, there were 7% (2) students with mild hearing impairment, 17% students (5) with moderate hearing impairment, 13% students (4) with moderate hearing impairment, 46% students (14) with severe hearing impairment. hearing impairment and 17% of students (5) with practical deafness. The classification of the degree of hearing impairment is under the International Classification of Diseases ICD - 10.

With the schooling model that students attend, the sample consisted of 73% of students (22) who attend a specialized school for deaf and hard of hearing students and 27% of students (8) who attend regular school.

With school success in the Serbian language, there were 27% of students (8) with excellent results, 43% of students (13) with very good results, 23% of students (7) with good results.

Instruments and techniques

The following instruments were used for the research: a) Visual Perception Test (Keith E. and Natasha A. Beery), which consists of 30 tasks, with children of this age starting to work from the fourth task. In the fourth, fifth, and sixth tasks, the child is shown a darkly drawn and framed shape. The child is expected to show which of the two shapes offered (which are below the framed shape) is the same as the framed shape. If he makes a mistake, explain to him why that form is not the same as the given form and why the other form offered is the correct answer. In tasks from the seventh to the thirtieth, the child is required to do the same as in the fourth, fifth and sixth tasks, but the child is no longer explained why he made a mistake, but only his answers are recorded as correct (1 point) or incorrect (0 points). From the seventh to the thirtieth task, stopwatch time is measured. The time allowed for solving these tasks is 3 minutes. After 3 minutes, the test is stopped, as well as when the child makes three consecutive incorrect answers. The maximum number of points is 30; b) Motor Coordination Test (Test Motor Coordination - Keith E. and Natasha A. Beery) which consists of 30 tasks, and as in the previous test, children of this age start working from the fourth task. The fourth, fifth, and sixth tasks are used for rehearsal. The child is required to connect the dots, ie to draw a line from the black to the gray dot, without going outside the framed space. He received one point for each correctly completed task and zero points for the incorrectly completed task. From the seventh task, time begins to be measured and the procedure is the same as in the previous three tasks. The allowed time for this test to work is 5 minutes. Although the child makes three consecutive mistakes, the test continues until 5 minutes have elapsed when the test is stopped. The maximum number of points is 23; c) The test of visual-motor integration (Beery VMI - Keith E. Berry, Norman A. Buktenica, and Natasha A. Beery) consists of thirty tasks that are presented on the test on the principle of easier to harder task. The child is required to draw a given shape in a specially framed space below the given shape. The rules of the test are: the child must sit correctly, hold the pencil correctly, hold the paper correctly with one hand and draw with the other hand. The child gets one point: if he crosses the given shape completely correctly, if he crosses the given shape halfway, for the task done with the help of an examiner (the examiner draws on paper next to the same shape, and the child draws that shape in his space), and if the child draws set the shape so that it does not cross the edges of the framed space. The maximum number of points on this test is 24. The test ends if the child incorrectly crosses three consecutive shapes. Test reliability coefficient, Cronbach's alpha coefficient is 0.813. Testing was used as a research technique.

Procedure

The research was realized individually in the premises of the school that the students attend. Each student was explained in spoken and sign language what

was expected of him. After the students were given instructions for work, the students worked independently on tasks with occasional additional explanations by the examiner on the tasks on which the Instructions for the application of the test provide support for students. Data on the age, degree of hearing impairment, and school success of students in the subject of Serbian language and mathematics were obtained from pedagogical documentation.

RESULTS

1. Differences in student achievement on the test of visual perception, motor coordination and visual-motor integration

Table 1
The success of the student in the test of visual perception, motor coordination and visual-motor integration

	N	MIN	MAX	AS	SD
Visual perception	30	7	30	21.60	6.179
Motor coordination	30	6	23	16.33	4.887
Visual-motor integration	30	6	24	16.13	6.061

2. Achievements of students on the test of visual perception, motor coordination and visual-motor integration in relation to school success in the Serbian language

Table 2
The success of the students in the test of visual perception in relation to academic achievement in Serbian language

	N	AS	SD	F	df	p
Great	8	26.38	4.90			
Very good	13	21.62	4.59	6.143	2	.006
Good	9	17.33	6.52			

Table 3
The success of the students in the test of motor coordination in relation to academic achievement in Serbian language

	N	AS	SD	F	df	p
Great	8	18.88	4.39			
Very good	13	17.08	4.55	4.018	2	.030
Good	9	13.00	4.33			

Table 4
The success of the students in the test of visual-motor integration in relation to academic achievement in Serbian language

	N	AS	SD	F	df	p
Great	8	19.88	4.39			
Very good	13	16.08	6.10	3.521	2	.054
Good	9	12.89	5.88			

3. Student achievement on the test of visual perception, motor coordination and visual-motor integration in relation to success in mathematics

Tabel 5
The success of the students in the test of visual perception in relation to academic achievement in mathematics

	N	AS	SD	F	df	p
Great	5	24.80	6.10			
Very good	8	24.13	4.29	2.860	3	.056
Good	12	21.00	4.86			
Sufficient	5	15.80	8.58			

Table 6
The success of the students in the test of motor coordination in relation to academic achievement in mathematics

	N	AS	SD	F	df	p
Great	5	17.60	4.72			
Very good	8	19.00	3.51	2.641	3	.070
Good	12	15.83	4.02			
Sufficient	5	12.00	6.67			

Table 7
The success of the students in the test of visual-motor integration in relation to academic achievement in mathematics

	N	AS	SD	F	df	p
Great	5	16.60	3.21			
Very good	8	20.88	3.60	3.769	3	.023
Good	12	14.83	6.44			
Sufficient	5	11.20	6.22			

The analysis of the obtained results (Table 1) shows that deaf and hard of hearing students are the most successful on the Visual Perception Test, somewhat less successful on the Motor Coordination Test, and the least successful on the Visual-Motor Coordination Test. The analysis of the obtained results (Table 2) shows that there are statistically significant differences in the success of the Visual Perception Test about the success in the Serbian language ($F = 6.143$; $df = 2$; $p = .006$). The most successful were students with excellent results, less successful were students with a grade of four, while poorer results were achieved by students with a grade of three. Subsequent tests indicate that students with a grade of five ($AS = 26.38$, $SD = 4.90$) are significantly more successful than students with a grade of three ($AS = 17.33$, $SD = 6.52$) on the visual perception test. The analysis of the results (Table 3) shows that there is a statistically significant difference between the success achieved by deaf and hard of hearing students on the Motor Coordination Test about the success in the Serbian language ($F = 4.018$; $df = 2$; $p = .030$). The most successful were students with a grade of five from the Serbian language ($AS = 18.88$, $SD = 4.39$), while the weakest results were achieved by students with a grade of four from the Serbian language ($AS = 13.71$). Subsequent tests indicate that students with a grade of five ($AS = 18.88$, $SD = 4.40$) are significantly more successful than students with a grade of three ($AS = 13.00$, $SD = 4.33$) on the motor coordination test. The analysis of the results (Table 4) achieved by deaf and hard of hearing students on the Visual-Motor Integration Test about the success in the Serbian language shows that there are no statistically significant differences ($F = 3.251$; $df = 2$; $p = .054$). As the result is very close to statistical significance, we will also take into account subsequent tests which indicate that students with a grade of five ($AS = 19.88$, $SD = 4.39$) were significantly more successful than students with a grade of three ($AS = 12.89$, $SD = 5.88$). The analysis of the results (Table 5.) achieved by deaf and hard of hearing students on the Visual Perception Test about the success in mathematics shows that there is no statistically significant difference ($F = 2{,}860$; $df = 3$; $p = .056$). Subsequent tests indicate that students with a grade of five ($AS = 24.80$, $SD = 6.10$) are significantly more successful than students with a grade of two ($AS = 15.80$, $SD = 8.59$). Students with a grade of four ($AS = 24.18$, $SD = 4.29$) are significantly more successful than students with a grade of two ($AS = 15.80$, $SD = 8.59$). The analysis of the results (Table 6) achieved by deaf and hard of hearing students on the Motor Coordination Test about the success in mathematics shows that there is no statistically significant difference ($F = 2.641$; $df = 3$; $p = .070$). The most successful on the Motor Coordination Test with 19.00 points were students with a grade of four, less successful, were students with a grade of five, then students with a grade of three, and the lowest level of achievement were students with a grade of two (Table 6). The analysis of the results (Table 7) shows that there is a statistically significant difference between the achieved success of deaf and hard of hearing students on the Visual-Motor Integration Test about the

success in mathematics shows (F = 3.769; df = 3; p = .023). Subsequent tests indicate that students with a grade of four (AS = 20.88, SD = 3.60) had more significant achievement on the test of visual-motor coordination compared to students with a grade of three (AS = 14.83, SD = 6.44) and students with a grade of two (AS). = 11.20, SD = 6.22).

DISCUSSION

Visual-motor integration is the process of integrating visual perception and motor performance of the observed (Sanghavi & Kelkar, 2005). Visual-motor integration greatly contributes to the successful motor development, as well as the school achievement of children. Thus, problems in the development of visual-motor functions lead to difficulties in performing activities that require hand movements under visual control (Krstić et al., 2010).

As deaf and hard of hearing children grow up in conditions where one of the important stimuli from the external environment is missing, sound, as well as some aspects of its psychomotor activity may be at a lower level than hearing children, which again negatively affects their functioning in a social environment (Radovanović et al., 2013). Visual-motor integration as an important aspect of psycho-motor development of children requires monitoring and creation of favorable conditions for its stimulation, especially in the period up to the age of 10, when it develops the fastest (Radovanović et al., 2013).

This research was related to determining the specifics and differences in the development of visual-motor integration abilities in deaf and hard of hearing students of primary school age, with special emphasis on examining the variable school success.

The first research problem of this research was related to the examination of the difference in the achievement of deaf and hard of hearing students on the tests of visual-motor integration, visual perception, and motor coordination. The obtained results showed that deaf and hard of hearing students are the most successful on the Visual Perception Test.

Another research problem was to examine the relationship between the results achieved by deaf and hard of hearing students on the Test of Visual Perception, Test of Motor Coordination, and Test of Visual-Motor Coordination and Success in the Serbian language. The obtained results showed that deaf and hard of hearing students achieved significant results success on the Visual Perception Test and the Motor Coordination Test, while the result on the Visual-Motor Coordination Test was not statistically significant. Visual, motor, and visual-motor integration are sensory abilities, which can directly affect reading, writing and classroom monitoring skills (Sanghavi & Kelkar, 2005), which is a challenge for teachers and students to achieve their intended teaching goals, even when they have developed

cognitive abilities. Visual-motor integration is significantly associated with writing quality (Comhill & Case-Smith, 1996; Tseng & Murray, 1994; Weintraub & Graham, 2000). Although the subject of this research was not the quality of writing, an indirect result was obtained which shows a high correlation between success in the Serbian language and visual perception.

The third research problem was to examine the relationship between the results achieved by deaf and hard of hearing students on the Visual Perception Test, the Motor Coordination Test, and the Visual-Motor Coordination and Mathematics Success Test. The analysis of the results showed that there is no statistically significant correlation between the success of deaf students in mathematics and the results they achieved on the Test of Visual Perception and the Test of Motor Coordination, while the results obtained on the Test of Visual-Motor Coordination were statistically significant. The results of this research show that students with excellent results were the most successful only on the Visual Perception Test, while the students with a grade of four showed the most success on the Motor Coordination Test and the Visual-Motor Integration Test. The lowest number of points on all three tests are students with a grade of two. Beery (1982) argues that there is a high association between visual-motor integration and success in mathematics, which is consistent with our study where we found statistical significance between the Visual-motor Coordination Test and success in mathematics.

Also, the literature states that the execution of certain tasks in reading, writing, mathematics, can depend on visual, motor, and visual-motor integration (McHale & Cermak, 1992). Similarly, Kulp (1999) points out that students have difficulty perceiving the teacher's tasks, which relate to reading, writing, speaking, and arithmetic. Although Kalp's study was not of great importance, the results indicate that visual-motor coordination affects school success. Thus, visual perception, motor integration, and visual-motor integration affect the fulfillment of everyday school obligations and the achievement of school achievements.

CONCLUSION

The results of this research showed that visual-motor integration is related to the school success of deaf and hard of hearing students. Therefore, the findings indicate the importance of encouraging the development of visual perception and motor coordination of deaf and hard of hearing students in the period before starting school, as well as during primary education, through adequate activities conducted by special educators and other professionals involved in the rehabilitation and education of deaf and hard of hearing children. Also, the specificity of deaf and hard of hearing students in the development of visual-motor integration skills implies the importance of prevention and early intervention, and educating parents to timely identify irregularities in the psychomotor development of the child

and provide adequate support. Also, the results of this research represent useful guidelines for the implementation of new research in the field of visual perception and motor coordination of deaf and hard of hearing students.

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VIZUO-MOTORNA INTEGRACIJA GLUVIH I NAGLUVIH UČENIKA OSNOVNOŠKOLSKOG UZRASTA

Sažetak: Vizuo-motorna integracija predstavlja sposobnost vizuelnog opažanja i motoričkog izvođenja opaženog. Cilj istraživanja je da se ispita povezanost školskog uspeha iz srpskog jezika, matematike i postignuća na testu vizuo-motorne integracije kod gluve i nagluve dece osnovnoškolskog uzrasta. Uzorak je činilo trideset gluvih i nagluvih učenika uzrasta od osam do šesnaest godina. Za prikupljanje podataka korišćen je Test vizuomotorne koordinacije (Beery VMI – Keith E. Berry, Norman A. Buktenica i Natasha A. Beery), Test vizuelne percepcije (Keith E. i Natasha A. Beery) i Test motorne koordinacije (Keith E. i Natasha A. Beery). Rezultati su pokazali da postoji statistički značajna razlika u postignuću učenika pri rešavanju Testa za vizuelnu percepciju u odnosu na uspeh iz srpskog jezika, dok na Testu motorne koordinacije i Testu vizuo-motorne integracije nije utvrđena statistički značajna razlika. Ne postoje statistički značajne razlike u uspehu gluvih i nagluvih učenika na Testu vizuelne percepcije, Testu motorne koordinacije i Testu vizuo-motorne integracije u odnosu na uspeh iz matematike.

Ključne reči: gluvi i nagluvi učenici, vizuelna percepcija, motorna koordinacija, vizuelno-motorna koordinacija

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DIGITAL PLATFORMS IN APHASIA TREATMENT

Abstract: Aphasia is an acquired language disorder resulting from an injury to the brain. About 21-33% of stroke survivors experience aphasia, and about 16-50% of patients who suffered from a traumatic brain injury are diagnosed with aphasia (Čauševac, n.d.). Once the patient has been diagnosed with aphasia, and the specific areas of language and communicative functions that are affected and require treatment have been identified, language therapy is determined in order to restore the quality of functional communication. The treatment is usually carried out by a speech and language therapists and aphasiologist. However, due to the rising adoption of innovative technologies in everyday lives, digital platforms are developed worldwide to be used in aphasia treatment. Researches show that these platforms are beneficial to both the patient and the therapist. In Serbia, there are currently no available digital platforms for Serbian language that could be used in aphasia therapy. As a result, neither the patients nor the therapists can benefit from their features. Thus, the main subject of this research study is the descriptive analysis of the digital platforms that are most commonly used in the treatment of aphasia patients, which have been tested and recognized by the relevant official instructions such as The National Aphasia Association (NAA). The platforms are also categorized according to the criteria which is based on the data obtained from the analysis of their functionalities, technical features, availability, and most importantly, the type of exercises and assistance they offer. The results are systematized in this manner with the scope of defining the common features of these platforms alongside their most prominent characteristics, and used as a foundation for further research in the development of this type of platforms for Serbian language. The interdisciplinary approach to this research was applied in its final stage, when IT experts were engaged in estimating the technical capacities required for the development, implementation and maintenance of this kind of platform, based on the results obtained from the analysis. Their estimation can further be used in operational planning of the development of this kind of platforms for the Serbian language.

Keywords: aphasia, aphasia treatment, digital therapy, mobile and computer applications, VR platforms

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INTRODUCTION

According to Benson (1979), aphasia is the loss or harm to the language function caused by brain damage. The most common etiological factor of aphasia are cerebrovascular accidents, and they are the cause of 80% of aphasic syndromes (Ardila, 2014). After locating the lesion and determining the type of speech disorder, the aphasia treatment is approached for the purpose of restitution of speech and language abilities and the reestablishment of functional communication. The treatments are most often performed by a speech therapist.

Patient recovery is thought to be based on two basic mechanisms - re-learning and compensatory techniques (Levin & Grafman, 2000; Luria, 1980). During the process of re-learning the key role is played by exercises or the adequate application of therapy through different types of language tasks. Such tasks are selected according to the leading speech and language disorder with the aim of restoring the quality of language use (Stemmer & Whitaker, 2008). We call such an approach cognitive-linguistic treatment (CLT – Cognitive-Linguistic Treatment). Compensatory techniques involve the use of alternative strategies for speech processing and production in order to compensate for language deficits and achieve functional communication in everyday situations.

After a stroke, the neuroplasticity of the brain responsible for reorganizing and restoring the functions of the damaged cerebral area decreases. The process is time consuming and requires continuous exercises and learning. The therapy is primarily aimed at stimulating neurons in order to maintain activity and restore neuroplasticity. The goal is to create new neural connections in the brain, which will act as compensatory and take over the functions that have been lost due to damage (Stemmer & Whitaker, 2008). Digital therapy that encourages the use of special softwares in treatment is based precisely on the stimulation of neuroplasticity, by providing the opportunity for frequent exercise through a variety of tasks and interactivity. The results are analyzed and systematized, so it is very easy to follow the course of therapy and adjust the type and difficulty of tasks in accordance with the patient's needs and progress.

In the world today, there are digital platforms for different speech areas, primarily English, that are used in the treatment of aphasic patients. Such platforms are the software programs intended for patients and aphasiologists to use on computers or/and mobile devices during treatments. They are used: 1) in cognitive-linguistic treatments to improve communication skills through numerous systematized programs of interactive exercises available in digital form; 2) as a compensatory technique meant to facilitate communication of patients with the environment in everyday life situations, in which case the platform is a communication tool or an alternative mean of communication (e.g. by touching a specific symbol offered within the application the device says the word that corresponds

to that symbol). It has been established that such existing platforms, recognized by the relevant official institutions dealing with the research and treatment of aphasia, provide benefits to both the aphasiologists and the patients. These benefits are reflected primarily on the comfort for patients, because therapeutic exercises and aids in communication are always available via devices on which the platform is installed. Convenience for the aphasiologists reflects on the more efficient record keeping and reporting on progress during therapy, as well as the easier updating of the statistics on the status of the aphasic patients, because there are databases integrated into the platform software that are updated during therapy.

Such softwares also facilitate social interaction within digital systems (Stocco & Valentin, 2017). Feelings of boredom, apathy and social isolation are typical during the rehabilitation process after a stroke, which adversely affects recovery. After the introduction of therapy with the use of smartphones and tablets, therapists have noticed that these feelings their patient experienced were less intense, and that their mood generally improved (Ameer & Ali, 2017). With its accessibility and interactivity, the technology gives the patient the opportunity to be more actively involved in the recovery process, which has a stimulating and positive effect on his self-confidence.

Currently, in Serbia there are no available digital platforms developed for the Serbian language speakers, that aphasic patients and aphasiologysts could use during treatment. They are therefore potentially deprived of the conveniences these platforms provide. At the same time, access to the relevant and up-to-date statistical data on the status of aphasic patients is very difficult as a result of non-connected record systems kept by the competent institutions.

Considering the above-mentioned identified problems, the subject of this research study are the characteristics of the information systems in the treatment of aphasia, as well as the classification and analysis of the most successful recognized digital platforms in the treatment of aphasia in the world, based on their functionality and the benefits they provide. The aim of the data systematized in this way is to define both the universal and the specific features of the analyzed platforms, so that they can latter be used as a basis for further research in the development of similar platforms for the Serbian speaking area, and to raise awareness of the importance of innovative technologies in therapy. At the same time, the data obtained through an interdisciplinary approach, that includes IT experts who presented their predictions for the technical capacities needed to develop such platform, could later be used in the operational planning for the development of a digital platform for use in the Serbian language.

RESEARCH METHODS AND TECHNIQUES

This scientific research presents the characteristics of the information

systems in the treatment of aphasia and then analyzes and classifies some of the most common digital platforms which, according to the results of studies, have positively influenced the course of treatment - improvement of the patients' language skills, greater independence and reduced sense of isolation.

The analyses was performed on a deliberate sample of typical units. The sample for analyses was selected according to the following criteria ranked by the degree of importance: 1) recognition by the official relevant institutions dealing with the treatment and research of aphasia, such as e.g. *The National Aphasia Association* (NAA); 2) popularity and frequent use by patient or therapists; 3) availability for downloads from the app stores and compatibility with operating systems. Platforms are classified based on their functionalities, whether they are used in cognitive-linguistic treatments to improve speech and language skills, or as a means of augmentative and alternative communication.

In the category of software used in cognitive-linguistic treatment two platforms are described, one is the mobile application *Tactus Therapy - Language Therapy 4-in-1*, while the other is based on VR technology (Virtual Reality) - *EVA Park*. Such platforms are used to improve communication skills through a number of systematized interactive exercise programs available in digital form.

The *Vocalyx* mobile application is described in the category of software used as a communication aid. This application is an alternative mean of communication that facilitates the communication of patients with the environment in everyday life situations.

The analysis of the platforms was performed by the method of description and the results were systematized according to:

a. technical features (the complexity of the interfaces that the operating systems and devices support);
b. availability (how and where they can be acquired, which language they are intended for, what their price is);
c. types of exercises (naming, repetition, matching, etc.), with a description of the exercise format (picture, audio, video and multimedia), and speech and language difficulties which they treat (speech, comprehension, writing, reading);
d. the way in which they systematize patient's and therapeutic status data;
e. additional benefits and functionalities;
f. results of research on the use of these platforms (all the researches were conducted by software developers in cooperation with the official certified research centers and institutes, or at universities);
g. form of the alternative communication that they enable (speech, comprehension, writing) if it is an AAC (Augmentative and Alternative Communication) device.

The research approach is interdisciplinary in the part related to the research of the technical capacities necessary for the development of a mobile application in the treatment of aphasia for the Serbian-speaking area. The research was conducted through a group interview, on a deliberate sample of 17 experts from the IT sector for the development, implementation and maintenance of web and mobile platforms, within the working collective of one of the members of the Science Technology Park in Belgrade. The questions were based of the obtained conclusions on the functional characteristics of the platforms that are the subject of the research, in order to obtain information on the technical capacities necessary for the development of such functionalities. The summarized data obtained from the interview was used as a proposal and a set of guidelines for potentially more detailed research of such capacities, with the goal to develop a digital platform in the treatment of aphasia for the Serbian-speaking area.

CHARACTERISTICS OF INFORMATION SYSTEMS IN APHASIA TREATMENT

A welldesigned and functional software in the treatment of aphasia is required to have the following characteristics shown in table No 1. - Characteristics of softwares in aphasia treatment.

Table 1
Characteristics of information systems in aphasia treatment

	Characteristics	**Description**
1	Appropriate interface	The interface has to be not only visually attractive, but also adequately functionally organized to enable a facilitated user experience that will encourage the patient to interact.
2	Controlled interaction	If the patient uses the software without the therapist's supervision, it is necessary for the program's algorithm to recognize the results, and based on the success in solving the tasks, offer the next exercise or alternative tasks, if the patient encounters difficulties. In this way, the entire course of therapy is improved, and the risk of the patient being demotivated by doing tasks that are too difficult or too easy is reduced.
3	Reliable databases	In order for the software to offer as diverse exercises as possible, as well as accurate statistics, it is necessary for it to have a well-developed database that will be able to store a large amount of multimedia material and process information about the status and progress of patients.
4	Flexibility	Patients' needs vary, so the software should enable efficient adjustment of treatment according to their specific needs through appropriate data processing algorithms, as well as easy-to-upgrade base of exercises.

5	Adequate content	The software architecture, reliable databases and functional interface build the system for the organization and delivery of what is essential for treatment, and that is - quality content. It has to be carefully designed and selected to provide patients with exercises that will treat their problem in the best way.
6	System stability	Any complex software is subject to occasional system crashes and so-called bugs - malfunctions. In order to successfully overcome them, it is necessary for such software to be continuously tested and improved, and that the team working on it provides a 24-hour support to users.

MOBILE APPLICATIONS IN COGNITIVE-LINGUISTIC TREATMENT

In the 1980s and 1990s, the growing penetration of personal computers in households opened the door to aphasiologists and software engineers for new research and improvement of treatment using technology. The arrival of smartphones and portable devices has further encouraged an interdisciplinary approach to therapy. The fact that in 2020 the number of smartphones users reached 3,5 billion (Statista, 2020) indicates a growing trend in the use of such devices, which has affected the expansion of mobile technology in healthcare, as well. With the development of new technologies and the integration of digital devices with most life activities, the awareness of their advantages in clinical practice is growing, and therefore their use in this area is becoming more common.

Tactus Therapy – Language Therapy 4-in-1

a) Technical features

- The application is intended for use on smartphones and tablets. It is available for Android and iOS operating systems;
- The interface is designed to facilitate the independent use in home conditions via the touchscreen. It is reduced and clear, with a small amount of content per page or work surface in order to minimize distraction and potential confusion that users may experience. The command keys are clear and highlighted, so the moving through the user interface does not require more than one or two keys. Each exercise category is assigned a specific colour for easier orientation.

b) Availability

- **Language:** English, Spanish, French, German;
- **Where to acquire it:** Application can be downloaded from the Google Play

Store for users of the Android operating system, or from the App Store for users of the iOS operating system;

- **Price:** One time fee for download is 74.99 US dollars. There is also a free version of this application called Language Therapy Lite, offering limited functionalities compared to the paid version;
- **Creators:** Tactus Therapy Solutions Ltd. (Vancouver, Canada).

c) Types of exercises

The company Tactus Therapy Solutions Ltd. has created a digital therapy consisting of 20 applications developed to restore various speech and language skills, whose deficit followed as a result of brain damage.

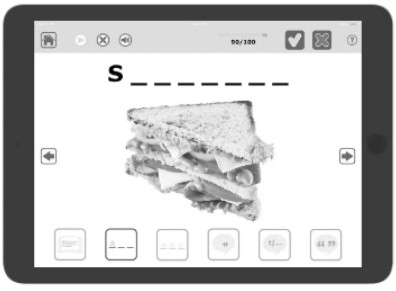
Applications are divided into the following: speech comprehension and production, Writing and reading, Articulation, Cognitive exercises, Swallowing exercises. By filling out a short questionnaire on the website, users are recommended to use the application that suits their specific needs.

The application that primarily deals with the treatment of aphasia is called Language Therapy 4-in 1.It is made of 4 applications: Comprehension Therapy, Naming Therapy, Reading Therapy, Writing Therapy.

The exercises are divided into levels, but they can be additionally personalized in accordance with the patient's progress - e.g. whether 3 or more answers will be offered within the tasks, which category of words will be practiced.

Comprehension Therapy: Listening and reading exercises - matching heard speech with a picture, written text with a picture, and heard speech with written text;

Naming Therapy: Naming exercises, sequences and image descriptions;

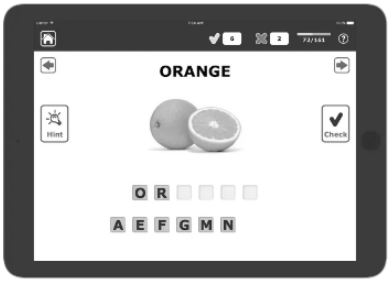


Picture 1 *Language Therapy 4-in-1 Comprehension exercise interface. Retrieved from https://tactustherapy.com/app/language/*

Picture 2 *Language Therapy 4-in-1 Naming exercise interface. Retrieved from https://tactustherapy.com/app/language/*

Reading therapy: Matching a phrase/expression with a picture, completing expressions, matching a sentence with a picture, completing a sentence by reading aloud;

Writing therapy: dictation, write what you see, rewriting, fill in the blanks.



Picture 3 *Language Therapy 4-in-1 Reading exercise interface. Retrieved from https://tactustherapy.com/app/language/*

Picture 4 *Language Therapy 4-in-1 Writing exercises interface. Retrieved from https://tactustherapy.com/app/language/*

d) Systematization of patient data and therapeutic status

- Integrated system for monitoring and analyses of achieved results on tasks, with the possibility of creating detailed reports;
- Within the offer, there are also specially designed applications for therapists, with modules for the organization of therapy, records and reporting on treatment results.

e) Additional advantages and functionalities

- User interface is designed according to the patient's needs – easy-to-navigate, well organized, intuitive and suggestive (first letter or sound is given), in order to direct the patient's attention to specific tasks and encourage interactivity;
- Rich multimedia content;
- The material in the form of pictures can be further personalized by adding photos from private life.

f) Results of research on the use of the application Tactus Therapy – Language Therapy 4-in-1

A study conducted at the University of Cambridge in England (Star & Warburton, 2016) showed that patients diagnosed with aphasia, with which they had been living for over a year (aged 45-87), after the independent use of the application for 20 minutes per day for 4 weeks, made significant progress in CAT (Comprehensive Aphasia Test) and CTPD (Cookie Theft Picture Description).

VR PLATFORMS IN COGNITIVE-LINGUISTIC TREATMENT

Virtual reality, VR is a term used for computer generated 3D environments that allow the user to access and interact with alternative reality (Merriam-Webster, n.d.). It involves a set of technologies used to synthesize different sensory experiences, primarily visual, auditory and tactile experiences. In another direction, these technologies are used to authentically record human movements, sounds and other possible input data for computer processing, to enable an interactive interface between the user and the virtual environment.

Virtual reality is one of the fastest growing technologies and is widely used in many fields. Its importance has long surpassed the gaming industry, where it was primarily used for entertainment, and found its place primarily in education, training, medicine and therapy (Egaji, Ashgar, Griffiths, & Warren, 2019). The key advantage of this technology is that is provides an interactive experience, so therapy can simulate personalized environments that give the patient the opportunity to practice and improve communication skills through those situations that are closest and most necessary to him/her.

EVA Park

Eva park is a non-immersive VR platform (it includes only the use of a screen, microphone, and speakers, without the VR glasses) developed specially for the treatment of aphasia. It is an online virtual world accessible via computer, that allows aphasia patients to practice speaking skills and communicate with other users. It is designed in collaboration with IT professionals and therapists alongside patients with the goal to create a program tailored to their needs and capabilities. This cooperation started in 2012 in the first phase of the project, and has continued to this day with continuous improvements.

The platform offers different virtual environments - at the hairdresser's, at home, in a restaurant, etc., occasionally enriched with fantastic elements for a fun effect. Each user has their own digital protagonist - avatar who represents him/her in the virtual world. Avatar is enabled to move through a 3D designed environment, to explore, to swim, to play, and even to fly.

Picture 5 *EVA Park example of a VR environment at the hairdresser's. Retrieved from https://evapark.city.ac.uk/?page_id=577*

Picture 6 *EVA Park example of a home use. Retrieved from https://evapark.city.ac.uk/?page_id=577*

a) Technical features

- The software is intended for use on a computer. It is available for Windows and MAC operating systems;
- EVA park works with the help of the Open Simulator 3D application server, and it is available on computers via one of the 3D world viewers, out of which Firestorm is recommended;
- Interface is designed to facilitate the independent use of the software by people with aphasia. To use it you need an Internet connection, speakers and a web camera connected to your computer.

b) Availability

- **Language:** English;
- **Where to acquire it**: It is currently in the experimental phase and is not in commercial use. It is only available for research purposes;
- **Price:** It is not currently in commercial use. Once it is launched the goal is to offer it for free;
- **Creators:** EVA Park Project, City University of London (London, EN).

c) Types of exercises

EVA Park is a multi-user platform, accessed by multiple users on-line at the same time. They can communicate with each other thanks through avatars. In this way, this software gets a valuable social or inclusive component, because it provides an opportunity for people facing similar problems to improve their language skills through interaction and free themselves of the acquired fear of communication. When they create their account on the platform and create an avatar, each time they log in they can choose one of the offered environments in which

they want to practice and communicate with other users. Communication is done via microphones and speakers integrated with the platform, and the moving through the virtual space via a keyboard or a mouse. It necessary, specially designed keyboards can be used for people with difficulties in using the standard ones.

In selected simulated environments, users begin to communicate on topics that are relevant in their lives, such as children, weather, what they like to eat, general interests, or they share experiences about the difficulties they encounter due to aphasia. In the virtual world, users can also go to group meetings with a therapist who also has an avatar, or such meetings can be led by patients themselves. Topics discussed within the support groups are most often music, sports, news or celebrities.

Picture 7 *EVA Park example of a fantastic VR environment. Retrieved from https://evapark.city.ac.uk/?page_id=577*

Picture 8 *EVA Park a VR group support environment. Retrieved from https://evapark.city.ac.uk/?page_id=577*

d) Systematization of patient data and therapeutic status

Since the software is in the experimental phase there is no data on whether the functionality for monitoring the course of therapy has been developed.

e) Additional advantages and functionalities

One of the advantages of this software is that the patients are given the opportunity to participate in activities such as the organization of excursions and parties with other users, where they can practice using language structures with which they would otherwise have limited contact in traditional therapy.

f) Results of research on the use of EVA Park software

The first study conducted at the University of London included 20 people with aphasia. They used the software for 5 weeks, an hour a day, 5 times a week. The treatment also included a therapist who through an avatar initiated certain conversational topics in accordance with the goals of the therapy and participated in dialogues.

The results of the research (EVA Park, 2020) showed that these patients, after using the EVA Park software, made progress in functional communication and gained positive social and emotional experiences. The tests used for examining and measuring the progress were CADL-2 (Communication Activities of Daily Living test), The Communication Confidence Rating Scale and The Friendship Scale. The creators and collaborators on the EVA Park project continuously examine the impact of this software on the course of therapy and the patient's progress, in order to drive investing in it's improvement and upgrades.

DIGITAL PLATFORMS AS MEANS OF AUGMENTATIVE AND ALTERNATIVE COMMUNICATION

The augmentative or alternative communication involves different methods to facilitate communication of people with impaired speech and language skills. Technological advances have encouraged the development of various communication aids that belong to hi-tech devices in the form of computers, smartphones and tablets, designed to enable their users both oral and written communication.

One of these platforms is Vocalyx, the application intended for use on smartphones. These platforms are primarily conceived and designed with the aim to facilitate everyday communication of people who have speech and language difficulties, and therefore the items c), d), e) and f) related to the therapeutic effects are omitted.

Vocalyx

a) Technical features

- The application is intended for use on smartphones and tablets. It is available for Android and iOS operating systems. Features are available even without the Internet connection;
- The interface is reduced, and it's clearly defined keys are arranged to allow easy movement and command.

b) Availability

- **Language:** French, English, German;
- **Where to acquire it:** Application can be downloaded from the Google Play Store for users of the Android operating system, or from the App Store for users of the iOS operating system;
- **Price:**One time fee for download and the unlimited use is 189.99 US dollars.

There is also the option to pay according to the number of clicks, i.e. the frequency of use - 8.99 US dollars for 1000 clicks, and for larger packages there is an additional discount. During the trial period, once the application is downloaded, the first 200 clicks are free;

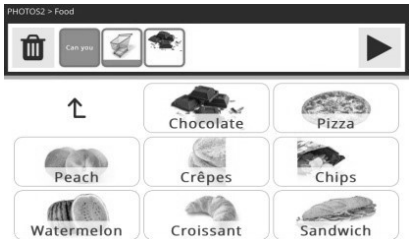
- **Creators:** Capanovi (Le Chesnay, France).

g) Form of the alternative communication

The application is for people with difficulties in speech production, reading or writing. By clicking on the pictogram, image or a photo, that symbolically represents the message that the user wants to convey, the corresponding text is printed - in the form of an SMS or an email, if it is a written communication, or the application pronounces the text, if it's oral communication. The voice can be generated by the system, or pre-recorded by the user or someone close to him/her.

The visual content through which users are able to communicate is organized by thematic units in accordance with the communication goals, and is available for the user in the form of keyboards – e.g. keyboard for expressing emotions, keyboard for ordering in a restaurant, etc. After downloading the application, the user has at his/her disposal a set of predefined keyboards, which can be supplemented and modified. If the user wishes, he/she can create new keyboards tailored to his/her needs. In addition to image keyboards, standard keyboards are also available - ABCD and QWERTY.

Picture 9 *Vocalyx interface of the picture messaging. Retrieved from https://www.vocalyx.com/en/*



Picture 10 *Vocalyx interface of the keyboard forgrocery shopping. Retrieved from https://www.vocalyx.com/en/*

All content, as well as the user interface, can be further adjusted to facilitate the user experience as much as possible - the size and number of pictograms and images displayed on the screen font, the duration of the finger press on the desired option (this feature is specially developed in case the user has hand tremor), the gender and age of the genetic voice, or the user can record his/her own voice or voice of another person. The application offers a data base of 1000 pre-created messages intended for everyday communication, that can be upgraded with the

messages created by the user. In addition to the existing base of 800 images and 1200 pictograms, the user can also add images from personal life and in that way personalize the application, which makes the communication with the AAC device more natural.

SYSTEM COMPONENTS NECESSARY FOR THE DEVELOPMENT OF THE A MOBILE APPLICATION IN APHASIA TREATMENT

To create a mobile application that can be used in the treatment of aphasia patients, it's necessary to develop a system that will consist of the following components:

- Server database
- Application server
- Client side of the application (user interface for the patient)
- API (Application Programming Interface) that enables the communication between the client and the server part of the application
- Web module for the therapists

The application server integrates all the components of the system: the database, the web module and the communication with the client application via API. API (Application Programming Interface) is a protocol for communication between the applications. The protocol is presented by rules of conduct and the form of communication. Thus, for example, it is necessary for the client's application to first confirm its identity to the application server (authentication), and after the successful authentication, for example, to request exercises for that day for the patient who identified himself through the application in a certain form. The server is a so-called servant, it serves to the authenticated clients by responding in a predefined form to the requests in an also predetermined form.

The client application is intended for use on smartphones or tablets, and it's available for Android and iOS operating systems. This part of the application communicates with the server via API, from where it takes exercises for a particular patient. It also sends the results of the exercises to the application server via the same API system. Patient data on their therapy, exercise tasks and results are stored in a database.

The therapist can monitor the patient's progress and achievements through a special web module that communicates directly with the database. The therapist can assign to the patient additional exercises and tasks through this module.

CONCLUSION

The development of digital technologies opens up new opportunities for the improvement of the quality of life of the aphasia patients. Devices which people use in digital aphasia therapy include smartphones, VR devices (e.g. virtual reality glasses), tablets and personal computers with specially developed softwares, which are used to improve the availability and frequency of the treatment. Today, these softwares, along with the advance devices and growing quality of the Internet connection, greatly contribute to the therapy.

Greater availability of exercises and aids for alternative forms of communication that are enabled by digital platforms, provide patients with the comfort of practicing therapy in the circumstances when they can't attend traditional treatment. Patients' needs vary, so the software, through special data algorithms and flexible and easy-to-upgrade databases, provide access to a wide variety of multimedia exercises carefully arranged by category and complexity, enabling efficient treatment to suit the patient's specific needs. In addition, the technology, with its accessibility and interactivity, helps the patient to be more actively involved in the recovery process, which eliminates the feelings of social isolation and positively affects self-confidence. Aphasia is a speech-language disorder that affects the quality of communication with other people, so the VR platforms are the most advanced in compensating for the real-life communication in treatment.

The mobile applications which are used in cognitive-linguistic treatment offer exercises that are divided into listening and naming exercises, phonological and syntactic exercises, writing and reading exercises. Exercises are most often given in the form of tasks in which the user is asked to match what he/she has heard or read with a picture or other verbal content, fill a gap in a word or a sentence, with or without offered answers depending on how difficult the task is, create meaningful sequences, describe the picture or rewrite the given text. Exercises are given hierarchically, from easier to more difficult ones, depending on the status of the patient. Graphic solutions form a user interface that is not only visually attractive, but also adequately and functionally organized, to facilitate the user experience that that will encourage him/her to interact. The categorization and layout of the navigation features and commands are clear and simplified, with clearly designed contours and contrast colours in respect to the background, that suggest the user where it is necessary to click for the desired command. It usually takes no more than one click to navigate the user interface. The platforms also enable the personalization the work environment by changing the colours and the size of images and letters, as well as the content of the exercises, by adding images and texts from their private life.

Billing models are based on a one-time payment (for downloading the application or the software license) with a free trial period. In addition to the stan-

dard paid version, a free version of the same application but with limited features can be used instead of the trial period.

The platforms which are used in cognitive-linguistic treatment have a developed functionality for systematization and analyses of data on the status and progress of the patient, which can be accessed by both the patient and the therapist. The integration of such feature, with the scope of forming a database through a digital platform, could enable aphasiologists in Serbia to access and systematize data on the general status of patients in the country as well as a better insight into the progress of their patients. The application of digital platforms in the treatment of aphasia creates a database of useful data dealing with number of aphasic patients and trends in their progress, and effectively updates statistics in this area. Regular updating of the data bases and features of the platform could enable aphasiologists in Serbia to offer their patients additions to the therapy in accordance with the latest standards in the patients' progress.

By pointing out the platforms and the success of their application in the treatment of aphasia worldwide, we raise awareness about the importance of continuous implementation of innovation in aphasia treatment, both in the therapeutic procedures, and also in the record keeping and reporting. At the same time, the possibility of competent institutions in Serbia participating in gathering professional staff and forming a budget for the development of such application for Serbian speaking area opens.

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DIGITALNE PLATFORME U TRETMANU AFAZIJE

Sažetak: Afazija je stečeni poremećaj govora i/ili jezika koji nastaje kao posledica moždanog oštećenja. Učestalost afazije kod cerebrovaskularnih oboljenja kreće se oko 21-33%, a kod povreda glave 16-50% (Čauševac, n.d.). Nakon uspostavljanja dijagnoze i ukazivanja na specifične oblasti jezičkog i komunikativnog funkcionisanja osoba koje zahtevaju stručnu pomoć, određuje se logopedsko-afaziološki tretman radi obnove kvaliteta upotrebe jezika i funkcionalne komunikacije. Sam tretman najčešće sprovodi logoped-afaziolog, ali se, usled sveprisutnijih tehnoloških inovacija u svakodnevnom životu, u svetu razvijaju i digitalne platforme za upotrebu u terapiji osoba sa afazijom. Utvrđeno je da ovakve platforme pružaju pogodnosti u tretmanu kako za pacijenta, tako i za terapeuta. U Srbiji trenutno nije dostupna nijedna digitalna platforma za srpski jezik, koja bi se mogla koristiti u terapijske svrhe, pa su i pacijenti i afaziolozi uskraćeni za pogodnosti koje one pružaju. Stoga, osnovni naučni cilj ovog rada jeste deskriptivna analiza najčešće upotrebljavanih digitalnih platformi u tretmanu afazičnih pacijenata, testiranih i priznatih od strane relevantih zvaničnih utanova kao što je The National Aphasia Association (NAA), a potom i njihova kategorizacija prema kriterijumima koji će biti utvrđeni na osnovu podataka dobijenih deskripcijom njihovih funkcionalsti, tehničkih osobenosti, dostupnosti i pre svega vrsti vežbi i podrške koju nude. Ovako dobijeni i sitematizovani podaci imaju za cilj da definišu univerzalne i specifične osobenosti analiziranih platformi, kako bi se kasnije one mogle koristiti kao osnov za dalja istraživanja u razvoju sličnih platformi za srpsko govorno područje. Ujedno, imajući u vidu da se israživanju pristupa interdisciplinarno, u finalnoj fazi učestvovali su i IT stručnjaci, koji su na osnovu podataka dobijenih analizom digitalnih platformi izložili svoja predviđanja za tehničke kapacitete potrebne za razvoj, implemenaciju i održavanje ovakve platforme. Ovakvi podaci mogu kasnije imati svoju primenu u operativnom planiranju razvoja ovakvih platformi za sprsko govorno područje.

Ključne reči: afazija, logopedsko-afaziološki tretman, digitalna terapija, mobilne i računarske aplikacije, VR platforma

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ASSESSMENT OF INHIBITORY CONTROL AND SELECTIVE ATTENTION IN PERSONS WITH APHASIA[1]

Abstract: Aphasia is broadly defined as a neurogenic communication disorder that manifests itself in impaired linguistic and cognitive processes, including executive functions (Vuković, 2016). Inhibitory control and selective attention are important for executive functions, as they allow us to select the content we want and to focus on them while ignoring other irrelevant information. The study aimed to evaluate the ability of inhibitory control and selective attention in individuals with aphasia. The study included a total of 20 subjects: 10 of them with the classic form of aphasic syndrome formed the experimental group, while the 10 subjects participated in the control group. The diagnosis of aphasia was given to the participants by implementing the Boston Diagnostic Aphasia Examination (BDAE). A two-month testing was conducted at the Institute for Psychophysiological Disorders and Speech Pathology "Prof. Dr Cvetko Brajović" in Belgrade. The Stroop test (Victoria version) was used for evaluation. The results indicated that individuals with aphasia exhibited the poorer ability of inhibitory control and selective attention than subjects from the control group. In the group of people with aphasia, people with non-fluent type took longer to complete all three parts of the test, but on average they showed fewer errors than people with fluent aphasias. Since aphasia is accompanied by other disorders, including disorders of executive functions, it is necessary to recognize and treat them promptly. Seeing a person as a biopsychosocial being, instead of observing them through the prism of his language disorder, enables experts to create more adequate treatment strategies, which would enhance the results of traditional language therapy.

Keywords: fluent aphasia, non-fluent aphasia, executive functions, inhibitory control

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INTRODUCTION

Aphasia is broadly defined as a neurogenic communication disorder that manifests itself by impaired linguistic and cognitive processes. At the linguistic level, aphasia is manifested by phonological, lexical, grammatical, and semantic deficits, while at the cognitive level, disorders are manifested in the areas of attention, memory, judgment, and executive functions. Besides disorders of language structure, aphasia is accompanied by prosodic deficits–deficits of melody, intonation, pause, rate, rhythm, and intensity (Vuković, 2016). Aphasia can occur as a consequence of all factors that lead to damage of the central nervous system, and it most often occurs as a consequence of cerebrovascular diseases. It is thought to occur in 20–38% of people who have suffered a stroke (Berthier, 2005). Other causes include tumors, gunshot wounds and other focal traumas, degenerative diseases of the central nervous system, inflammations, and more (Kohnert & Peterson, 2012, p. 89; Vuković, 2016).

In clinical practice, according to the method of language production, aphasia is divided into fluent and non-fluent. Fluent types of aphasia include Wernicke's aphasia, Conduction aphasia, Anomic aphasia, Transcortical sensory aphasia, and Subcortical sensory aphasia. Non-fluent types are Global aphasia, Broca's aphasia, Transcortical motor aphasia, Mixed transcortical aphasia, and Subcortical motor aphasia.

Executive functions represent abilities involved in complex cognitive processes such as new problems solving, modifying behavior to towards new information, generating strategies, or sequencing complex actions (Elliott, 2003). They have the most crucial role for successful functioning in daily activities (Snyder, Miyake, & Hankin, 2015).

According to contemporary understandings, three essential executive functions are singled out: inhibition, working memory, and cognitive flexibility. Multiple cognitive functions such as planning, reasoning, and problem-solving are based on them (Collins & Koechlin, 2012). It has been found that efficacy in these abilities decreases with age (Yoon et al., 2015). The frontal areas of the brain, and especially the prefrontal lobes, which are most developed in the human species, have a key role in executive functions (Funahashi & Andreau, 2013; Vuković, 2019). Functional integrity of other brain regions is also required, including subcortical areas such as the limbic cortex, basal ganglia, thalamus, hypothalamus, midbrain, and the posterior parts of the parietal and temporal lobes (Cummings, 1993; Pavlović, 2012).

Inhibitory control refers to the ability to prevent unimportant stimuli and behaviors. Two aspects of inhibitory control have been singled out: 1) inhibition of the response (i.e., opposition to the initial motor response) and 2) interference/interference effect (i.e., resistance to interference from the environment) (Tiego,

Testa, Bellgrove, Pantelis, & Whittle, 2018). It includes four components: 1) interference (prevention of distractors or competitive stimuli); 2) flexibility of response (ability to switch to stimulus characteristics to which the individual will respond); 3) interruption of already initiated behavior, and 4) restraint or inhibition of response before it has begun (Sinopoli & Dennis, 2012). These components are considered to be particularly important for verbal communication (Douglas, 2010). Inhibitory control allows control of attention, thoughts, behaviors, and/or feelings to overcome external stimuli. Otherwise, we would succumb to inner instincts, more immature ways of judgment or behaving (conditioned reactions), or different stimuli in the environment that attract us in different ways. Inhibitory attention control (executive attention) allows us to select and focus on what we want selectively and ignore other information (Diamond, 2013).The prefrontal cortex (PFC) is thought to play a crucial role in inhibition. Different prefrontal regions have roles in different aspects of inhibition depending on the nature of the association with other brain regions and the content of the information presented (Munakata et al., 2011).

The ability to maintain attention and perseverance until the task is completed is also an important executive function. Maintaining attention relies on working memory. Interrupting a task before it is completed implies that the person has problems with perseverance. Selective attention represents the ability to select and prefer the processing of specific information while overcoming the processing of irrelevant, competing distractors (Isbell et al., 2017).

RELATION BETWEEN LANGUAGE DISORDERS AND EXECUTIVE FUNCTIONS

Examining the relation between language and executive abilities in neurologically healthy individuals, it was concluded that executive functions' role increases proportionally with the increasing complexity of language functions. In other words, the more complex are the language skills, the greater the involvement of executive functions is required. This relation is also present in individuals with different brain lesions. It is pointed out that with the increase in the severity of brain injury, the participation of executive functions in language production increases in an attempt to compensate for the deficit in language processing (Goncalves et al., 2018). It is pointed out that impairment of executive functions is common in people with severe aphasia (Olsson, Arvidsson & Johansson, 2019).

Disorders in the vascularization zone of the left middle cerebral artery (arteria cerebri media), which irrigate the main cortical speech areas, cause aphasia in most cases. Infarct in the vascularization zone of this artery can also cause disturbances in executive functioning, given the neuroanatomical reliance of executive functions on the prefrontal cortex and the connections between the frontal lobes and other brain areas (Keil & Kaszniak, 2002).

Deficits in executive functions can result in a reduced ability to organize judgments and thus linguistic expression. Such impairment can lead to the production of irrelevant information, word-finding difficulties, disturbed word sequence and propositional level, tangential language and excessiveness, which all lead to communication disorders (McDonald, Togher & Code, 2013).

The cognitive processes responsible for language production imply selecting an adequate lexical unit from many similar representations. Inhibitory control is thought to have a greater impact on word-finding in people with aphasia because lexical representations are weakened or mechanisms are increased/decreased as a result of brain damage (McCarthy & Kartsounis, 2000; Wilshire & McCarthy, 2002; according to Faroqi-Shah, Sampson, Baughma & Pranger, 2014). Impaired inhibition can lead to communication disorders. Thus, a person may make inappropriate comments or not wait to take their turn during a conversation (Vuković, 2019).

METHOD

Aim, objectives and research hypothesis

This study was conducted to determine the ability of inhibitory control and selectivity of attention in individuals with fluent and non-fluent aphasia. The objectives of the research arising from the problem and goal of this research are the following:

1) To examine the selectivity of attention and inhibitory control in persons with aphasia; 2) Compare these abilities in people with fluent and non-fluent aphasia; 3) Compare these abilities in persons with aphasia to the control group.

The hypotheses derived from the aim and objectives of the study are as follows: 1) It was assumed that individuals with aphasia would show the poorer ability of inhibitory control and selective attention compared to the control group of subjects; 2) It is assumed that persons with the non-fluent type of aphasia will show greater impairment of inhibitory control and selective attention compared to persons with the fluent type of aphasia;

SAMPLE

This study included ten subjects with aphasia who constituted the experimental group. The diagnosis of aphasia was made using the Boston Diagnostic Aphasia Examination (BDAE) (Goodglass, Kaplan & Baressi, 2001). The examination was performed in the Institute for Psychophysiological Disorders and Speech Pathology " Prof. Dr. Cvetko Brajović" in Belgrade, in the period from May to July 2019. All respondents were familiar with the purpose and method of testing and gave written consent to participate in this study. To form an experimental group,

the following criteria have been set: 1) That the person has brain damage that causes the classic form of the aphasic syndrome; 2) That a complete aphasiological assessment has determined the type of aphasia; 3) That all patients have their mother tongue as Serbian; 4) That the respondent is an adult, i.e., older than 18 years;
The mean age of the subjects in the experimental group was 61.90 (SD = 11.58). The youngest respondent was 37 and the oldest 77 years old. The characteristics of the sample of the experimental group concerning socio-demographic variables are shown in Table 1.

Table 1
The subsample structure of the experimental group concerning socio-demographic variables

n = 10		f	P	χ^2
Sex	Male	7	70%	
	Female	3	30%	1.600
	Total	10	100%	
Age	30-49	1	10%	
	50-64	2	20%	
	60-69	4	40%	2.000
	70-79	3	30%	
	Total	10	100%	
Education	High School	4	40%	
	Academy	4	40%	
	Faculty	2	20%	0.800
	Total	10	100%	
Group	Fluent	5	50%	
	Non-fluent	5	50%	0.000
	Total	10	100%	
Aphasia	Broca's	3	30%	1.000
	TMA	2	20%	
	TSA	1	10%	
	Wernicke's	2	20%	
	Conduction	2	20%	
	Total	10	100%	

Note: f - frequency; P - percentage; χ^2 - results of χ^2 test; TMA – Transcortical motor aphasia; TSA – Transcortical sensory aphasia;

The control group consisted of ten neurologically healthy subjects, with no data on language development disorder. The groups were statistically gender-ba-

lanced ($\chi 2$ (1) = 0.000, p = 1.000). The average age of the control group examinees was 63.00 years (SD = 12.06). The Mann Whitney U-test excluded the statistical significance of the difference in age (Mdn = 63.50 versus Mdn = 65.00, z = -0.303, p = 0.762). The groups were also statistically equalized in relation to the education of the respondents ($\chi 2$ (2) = 2,578, p = 0.276).

INSTRUMENT

For this research was used the Stroop test - Victoria version (Regard, 1981) which was adapted to the Serbian language. The test measures the ability to change perceptual sets, i.e., the presence or absence of cognitive inertia in tasks where conditions change, provoking the usual response versus the unusual one. The tasks are arranged on three white cards. In the first part of the test, the subject has a task and, as quickly as possible, names the colors with which the dots are printed (there are a total of 24 dots in blue, green, yellow, and red). In the second part of the test, the subject is required to name the colors with which certain words are printed (when, hard, and, over), regardless of the verbal content. In the third part, the respondent has the task to name the colors with which the names of colors are printed (blue, green, red, and yellow) but so that the colored word does not correspond to the name of the color (e.g., "red" is printed in blue). The time required to complete the task is recorded and the number of errors while naming (Pavlović, 2013).The last task requires an automatic answer (what the person read). The effect of interference is determined by calculating the quotient between the color naming time in the third part of the test and the color naming control task in the first part of the test (Strauss, Sherman & Spreen, 2006).

RESULTS

The analysis and data processing were performed using a Statistical Package for the Social Sciences (SPSS) for Windows, version 23.0, 2015. In data processing were used methods of descriptive and inferential statistics, namely absolute frequency, percentage, arithmetic mean, standard deviation, median, and range (in the minimum-maximum format). Differences in the distribution of respondents concerning socio-demographic characteristics were examined using the $\chi 2$-independence test. Due to the smaller number of respondents and the lack of normal distribution, value comparisons between groups were performed using the Mann-Whitney U-test. An α level of 0.05 is given for all statistical analyses. The obtained results are presented in tables and textually.

After statistical processing of the data, the following data were obtained:

Table 2
Mean values on parts of the test in the experimental and control group

	First part		Second part		Third part	
	Time	Errors	Time	Errors	Time	Errors
Group	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Experimental	51.30(67.91)	0.50(0.70)	84.60(72.67)	0.20(0.63)	84.60(67.05)	2.90(2.92)
Control	15.40(4.22)	-	20.40(6.50)	-	29.10(11.76)	1.20(1.39)

Note: M – mean; SD - standard deviation

From Table 2 we can conclude that the subjects from the experimental group needed took longer to complete all three parts of the test than the control group of subjects as if they had a higher number of errors in the third part of the test.

The Mann-Whitney U-test confirmed the statistical significance of the difference between the results of the experimental group compared to the control group on the following Stroop test scores: First part (color naming): Time (U ($N_{experimental}$ = 10; $N_{control}$ = 10) = 7.00, z = -3.25, p <.05) and Errors (U ($N_{experimental}$ = 10; $N_{control}$ = 10) = 30.00, z = -2.16, p <.05); Second part (naming words): Time (U ($N_{experimental}$ = 10; $N_{control}$ = 10) = 16.00, z = -2.57, p <.05); Third part: Time (U ($N_{experimental}$ = 10; $N_{control}$ = 10) = 13.50, z = -2.76, p <.01); No statistically significant difference was observed in the number of errors in the second and third part of the test.

Using the Mann-Whitney U-test was examined the difference between the experimental and control groups in the interference effect. The results did not indicate a statistically significant difference between the groups (U ($N_{experimental}$ = 10; $N_{control}$ = 10) = 45.00, z = -0.37, p> .05; M = 2.10 vs M = 1.94).

When considering the total amount of time it took for the subjects to complete all three parts of the test, a statistically significant difference was shown between the groups (U ($N_{experimental}$ = 10; $N_{control}$ = 10) = 12.00, z = -2.87, p <.05). A statistically significant difference for errors was not proven.

Table 3
Mean values on the parts of the test in subgroups of fluent and non-fluent aphasia

	First part	Second part	Third part			
	Time	Errors	Time	Errors	Time	Errors
Group	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Non-fluent	79.40(91.52)	0.80(0.83)	104.0(64.76)	-	128.0 (71.29)	2.60 (3.20)
Fluent	23.20(5.26)	0.20(0.44)	65.20(82.15)	0.40(0.89)	41.20 (18.01)	3.20 (2.95)

Note: M – mean; SD - standard deviation;

When comparing the descriptive values in terms of the time required to complete the third part of the test, it is noticed that the mean values are higher in subjects with non-fluent aphasia (128.00 versus 41.20). The range of results is larger in subjects with non-fluent aphasia, which indicates a greater dispersion of values. Statistical analysis here confirmed the existence of statistical significance of the given difference ($U (N_{non\text{-}fluent} = 5; N_{fluent} = 5) = 3.00, z = -1.98, p < .05$).

From Table 3 we can conclude that the subjects with the non-fluent form of aphasia took longer to complete all parts of the test, but on average, they showed fewer errors in the third part compared to the subjects with fluent aphasia. Using the Mann-Whitney U-test, the difference between the subgroups of fluent and non-fluent aphasia in the interference effect was examined. The results did not indicate a statistically significant difference between the groups ($U (N_{non\text{-}fluent} = 5; N_{fluent} = 5) = 7.00, z = -1.14, p > .05$; M = 2.10 vs M = 1.94).

DISCUSSION

Assessment of inhibitory control and selective attention in this sample was performed using the Stroop test. Careful qualitative analysis has shown that differences between subgroups exist but that this difference in some cases is not large enough to show statistical significance.

It was statistically significant that people with aphasia took longer to complete all three parts of the test (First part - average achievements in the experimental group were 51.3 and in the control group 15.4; Second part - 84.6 versus 20.4; Third part 84.6 versus 29.1 in the control group). Also, persons with aphasia had more errors than the experimental group in all three parts of the test. This finding is in line with the opinion that language performance in a disruptor's presence is significantly slower in people with aphasia than neurologically healthy subjects. These individuals are thought to manifest cognitive impairment even when language requirements in tests are reduced (Keil, 2002; Kuzmina & Weekes, 2016a; Pompon, McNeil, Spencer & Kendall, 2015).

When comparing these abilities in a subsample of people with aphasia, from the analysis of descriptive values can be concluded that people with non-fluent aphasia on average took longer to complete not only the third but also other parts of the test, (First part - average time required to complete the task in the group of patients with non-fluent aphasia it was 79.4 versus 23.2 seconds in the fluent subgroup; Second part - 104 versus 65.2seconds). They also had more errors in the First part of the test (0.8 versus 0.2). Subjects with fluent aphasia had more errors in the Second and Third part of the test (0.4 in the Second part, while persons with non-fluent form did not had errors; and in the Third part of test 3.2 versus 2.6). In Keil's study (2002), subjects with anterior subjects had poorer achievement than subjects with posterior lesions.

Several researchers examining the relationship between aphasia and executive functions have found that deficits with initiation, planning, and generalization often result in an inadequate, poor response to language therapy (Beeson, Bayles, Rubens & Kaszniak, 1993; Purdy, 1992; according to Mikola, 2010). While some authors suggest that impairments of executive function in people with aphasia are independent of their linguistic and visuospatial deficits and that they are specific for lesions in the left frontal and prefrontal region (Glosser & Goodglass, 1990), other authors point out that in some patients executive functions are a better indicator of functional communication abilities than language impairment itself (Fridrikkson, Nettles, Davis, Morrow, & Montgomery, 2006).

Although some patients do not show clinical signs of impaired executive function after impairment of frontal lobe, they may reflect impairment on specially designed tests that measure these abilities (Glosser & Goodglass, 1990; Purdy 2002). Manifestation of disorders on tests that measure cognitive abilities are an important indicator for the necessity of assessment and treatment of other disorders, in addition to language disorders, in persons with aphasia. Since verbal inhibition is related to the nomination ability in persons with aphasia, Kuzmina and Weekes (2016b) suggested that the treatment of cognitive deficits should be aimed at improving verbal selective attention and the ability to distinguish competitive stimuli in the domain of lexical-semantic abilities.

CONCLUSION

This study aimed to determine the ability of selective attention and inhibitory control in individuals with fluent and non-fluent aphasia. Based on the analysis and discussion of the obtained results, the following conclusions were drawn: 1) Persons with aphasia show greater impairment of inhibitory control and selective attention than subjects from the control group; 2) Persons with the non-fluent type of aphasia show greater impairment of inhibitory control and selective attention compared to persons with the fluent type of aphasia; 3) For a more precise interpretation of the disturbances of inhibitory control and selective attention in the group of persons with aphasia, a careful qualitative analysis is necessary.

The most significant limitation of this study concerns the sample size. Therefore, based on the obtained results, no general conclusion can be made about the differences in these abilities between fluent and non-fluent types of aphasia. The basic recommendations for future research in this area concern the sample size and sample homogeneity based on the aphasic syndrome to draw more adequate conclusions about the examined abilities and the differences between different types of aphasic syndrome.

Considering the data on the connection between language and executive functions, more detailed research of disorders, and providing theoretical fra-

meworks for this issue, more modern strategies in remediation of deficits in this population can be constructed. This would enable maximum utilization of the remaining capacities in people with aphasia and a better quality of life.

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PROCENA SPOSOBNOSTI INHIBITORNE KONTROLE I SELEKTIVNOSTI PAŽNJE KOD OSOBA SA AFAZIJOM[2]

Apstrakt: Afazija se u širem smislu definiše kao neurogeni poremećaj komunikacije koji se ispoljava oštećenjem lingvističkih i kognitivnih procesa, uključujući i egzekutivne funkcije (Vuković, 2016). Za egzekutivne funkcije su važne inhibitorna kontrola i selektivnost pažnje, koje nam omogućavaju da odaberemo sadržaje koje želimo i da se na njih fokusiramo, zanemarujući druge, nevažne informacije. Cilj ovog istraživanja je bio da se procene sposobnosti inhibitorne kontrole i selektivnosti pažnje kod osoba sa afazijom. Istraživanjem je obuhvaćeno ukupno 20 ispitanika, od kojih je 10 ispitanika sa afazičkim sindromima koji su činili eksperimentalnu grupu, dok je 10 ispitanika predstavljalo kontrolnu grupu. Dijagnoza afazije je postavljena Bostonskim dijagnostičkim testom za afazije (BDAE). Testiranje je sprovedeno u Zavodu za psihofiziološke poremećaje i govornu patologiju '"Prof. dr Cvetko Brajović'" u Beogradu, u periodu od dva meseca. Za procenu je korišćen Stroop test (Viktorija verzija). Rezultati su ukazali da osobe sa afazijom ispoljavaju lošiju sposobnost inhibitorne kontrole i selektivnosti pažnje u odnosu na kontrolnu grupu ispitanika. U grupi osoba sa afazijom, osobama sa nefluentnim tipom je bilo neophodno duže vremena da kompletiraju sva tri dela testa, ali su u proseku ispoljili manje grešaka u odnosu na osobe sa fluentnim afazijama. S obzirom da afaziju prate i drugi poremećaji, među kojima su i poremećaji egzekutivnih funkcija, neophodno jenjihovo pravovremeno prepoznavanje i tretiranje. Posmatranje osobe kao biopsihosocijalnog bića, a ne samo kroz prizmu njenog jezičkog poremećaja, omogućava stručnjacima da kreiraju adekvatnije strategije u tretmanu, koje bi pospešile rezultate tradicionalne jezičke terapije.

Ključne reči: fluentna afazija, nefluentna afazija, egzekutivne funkcije, inhibitorna kontrola

[2] Napomena: Rad je nastao kao rezultat istraživanja na projektu „Evaluacija tretmana stečenih poremećaja govora i jezika” (ON 179068)“, koji finansira Ministarstvo prosvete, nauke i tehnološkog razvoja Republike Srbije.

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SYMPTOMS OF DEPRESSION IN PATIENTS WITH APHASIA OF CEREBROVASCULAR ETIOLOGY

Abstract. Stroke occurs due to damage to the blood vessels in the brain leading to restricted supply of oxygen and nutrients to the affected part of the brain. Aphasia, as a consequence of a stroke, represents a multimodal communication disorder. Depression has been identified in research studies as another consequence of stroke, which may have detrimental effects on the quality of life and the process of aphasia treatment. Therefore, a thorough research into depression in people suffering from aphasia was required. Objective of the research was identification of symptoms of depression in people who suffer from aphasia of cerebrovascular etiologies and who have been undergoing aphasia treatment in Serbia. The selected research sample proved to be adequate and is comprised of 40 subjects, out of which 24 men and 16 women who have been diagnosed with aphasia using Boston Diagnostic Aphasia Examination test (BDAE). For establishing physical disability, objective physiatrist's findings taken from patient files have been used, whereas a five-point Likert-type scale was used to determine the family support. The Beck Depression Inventory (BSD) was used for determining the presence of depression symptoms and the degree of their severity. Results showed that more than half of the subjects showed symptoms of depression. Significant predictors for depression proved to be the fact that a subject was employed (as opposed to retired), had no children, and lacked family support. The results indicate the importance of several factors that, in addition to aphasia, may trigger the symptoms of depression, emphasizing the significance of a multidisciplinary approach to the treatment of aphasia, namely involvement of experts such as psychiatrists and psychotherapists.

Keywords: aphasia, depression, aphasia treatment.

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INTRODUCTION

Aphasia develops as a result of a stroke or neurological conditions, tumors and brain trauma, and is characterized by a neurolinguistic deficit. Aphasia commonly affects several modalities of language functions: speech, comprehension, writing, reading, sign language, and is therefore considered a multimodal communication disorder. The main etiological factors of aphasia are: cerebrovascular conditions (covered herein), brain trauma, inflammatory disease of CNS, intracranial tumors, progressive disease of CNS, intoxication, metabolic disorders, and nutrition disorders (Vuković, 2003). Post-stroke aphasia affects as much as 22 to 38% of stroke survivors (Townend, Brady, & McLaughlan, 2007). Contemporary approach to aphasia is based on Boston Classification, namely on four basic speech elements: spontaneous speech, speech comprehension, speech repetition, naming. Aphasia disorders manifest in various ways depending on the size, localization, depth, and etiology of the lesion, as well as other factors (Pavlović, 2016). In the broadest possible sense, aphasia can be divided in fluent and non-fluent aphasia based on the clinical picture, depending on the prevalence of motor or sensory difficulties in the production of speech.

Depression is a group of symptoms which include cognitive, affective and somatic symptoms. Affective symptoms may comprise various unpleasant emotions such as intense sadness, feeling of emptiness, despair, anxiety, rage, guilt, helplessness, unhedonia. Cognitive symptoms of depression may include poor concentration and attention, thoughts of self-harm and suicidal thoughts, etc. As for the physical symptoms, the following have been noted: poor appetite, insomnia, body weight fluctuations, loss of sexual desire, drop in energy, amenorrhea, headaches, etc. Aaron Beck, an American psychiatrist, described depression as a cognitive triad of negative views on oneself, negative views on the world, and negative views of the future.

Appearance of symptoms of depression in patients with aphasia of cerebrovascular etiology is rarely mentioned in the literature. Meta-analyses of 108 studies indicate that the so-called major depression accounts for as much as 17.7% of cases, whereas other forms account for 33%. Out of 108 studies, merely five studies discuss the appearance of depression in individuals with aphasia although they account for 22 to 38% of the total number of people that survived a stroke (Townend et al., 2007). Furthermore, studies have established that an adjusted and corrected depression measuring instrument was used only in 48% of cases (Mitchell, Sheth, & Gill, 2017). It is highly probable that, without an adjusted instrument, the individuals with aphasia were not able to fully understand the questions due to neurolinguistic deficits. Across different studies, depression has been described as a consequence of a stroke (Ayerbe, Ayis, Wolfe, & Rudd, 2013). Having in mind the negative consequences of depression in terms of quality of life and

the rehabilitation process, a thorough research into depression in individuals with aphasia is required. Etiology of depression in individuals with aphasia caused by a cerebrovascular event has not been fully clarified and there are theories to the effect that it is multifactorial in origin (Whyte & Mulsant, 2002). There are also studies describing physical disability as one of the risk factors of depression and arguing that physical disability implies a state of stress, which, in the case of stroke survivors, is reflected in the urgency of having to adapt to the new situation in order to continue functioning in everyday life (Bruce, 2001). Studies indicate that the frequency of depression is higher in individuals with physical disability than in the general population, thus designating physical disability as a risk factor of depression (Noh, Kwon, Park, Oh, & Kim, 2016). There are also studies substantiating the fact that people with higher level of education tend to notice the symptoms of depression at an earlier stage and thus seek help. However, the same studies indicate that the protection against depression in the form of higher educational level drops with age (Bjelland et al., 2008).

Aphasia as a condition that affects one family member involves a spectrum of issues that affect the functioning of a family as a whole. Stroke mostly occurs suddenly, without any advance notice and leaving no time to prepare, thus being perceived as a direct attack on the family (Davis, 1983).

The Serbian Healthcare System includes only one outpatient clinic where one can seek treatment for aphasia. Available information on the possibilities of aphasia treatment is scarce, so the question is how to inform people with post-stroke aphasia and refer them for treatment?

RESEARCH METHOD

Research Purpose, Objectives, and Hypotheses

The purpose of the present research was to establish the onset of symptoms of depression in individuals with aphasia of cerebrovascular origin, who are undergoing aphasia treatment in Serbia.

The objectives of the present research were as follows: 1) determine the appearance of symptoms of depression in individuals with aphasia of cerebrovascular origin, 2) investigate the gender-based differences in the appearance of symptoms of depression in individuals with aphasia of cerebrovascular origin, 3) investigate whether age has any impact on the appearance of symptoms of depression in individuals with aphasia of cerebrovascular origin, 4) investigate whether educational level and employment status have any impact on the appearance of symptoms of depression in individuals with aphasia of cerebrovascular origin, 5) investigate whether parental status has any impact on the appearance of symptoms of depression in individuals with aphasia of cerebrovascular origin, 6) investigate

whether family support has any impact on the appearance of symptoms of depression in individuals with aphasia of cerebrovascular origin, 7) investigate whether a clinical picture of aphasia (fluent, non-fluent) has any impact on the appearance of symptoms of depression, 8) investigate whether physical disability has any impact on the appearance of symptoms of depression in individuals with aphasia of cerebrovascular origin.

Hypotheses stemming from the purpose and objectives of the present research are as follows: 1) it was assumed that half of the respondents would present with symptoms of depression, 2) it was assumed that female respondents would obtain higher BDI scores, 3) it was assumed that there would be a statistically significant difference in BDI scores between respondents with physical disability and respondents without physical disability, 4) it was assumed that there is a statistically significant correlation between BDI scores and educational levels, 5) it was assumed that BDI score correlates with age of respondents, 6) it was assumed that there is a statistically significant difference in BDI scores between respondents with children and respondents without children, 7) it was assumed that BDI scores correlate with the degree of family support that the respondents have, 8) it was assumed that there is a statistically significant difference in BDI scores between respondents with different employment status, 9) it was assumed that there is a statistically significant difference in BDI scores between respondents with fluent and respondents with non-fluent aphasia, 10) it was assumed that there is a statistically significant difference in the BDI scores between respondents with different marital status.

RESEARCH SAMPLE

This research included 40 respondents with aphasia of cerebrovascular origin, who were undergoing aphasia treatment. Aphasia was diagnosed using the Boston Diagnostic Aphasia Examination – BDAE (Goodglass, Kaplan & Baressi, 2001). The research was carried out in the period from October 2019 to February 2020 at the Terapika Center in Belgrade. All the respondents had been introduced with the purpose and method of research and all of them furnished a written consent for participation in this study. The inclusion criteria were: 1) stroke within 12 months before the commencement of the study, 2) aphasia as a result of a stroke, 3) individuals of age, both sexes, 4) Serbian language as a mother tongue, 5) individuals who did not demonstrate cognitive decline on the MoC test, 6) individuals undergoing aphasia treatment.

The age of the respondents ranged from 50 to 84, while the average age was 65.38. The characteristics of the experimental group in terms of sociodemographic variables are shown in Table 1.

Table 1
Sample Structure

GENDER		N			Percentage	
Male		24			60%	
Female		16			40%	
MARITAL STATUS						
Married		27			67.5%	
Single		9			22.5%	
Widow/widower		4			10%	
EDUCATION						
No education		3			7.5%	
Elementary school		2			5%	
High-school		18			45%	
Tertiary education		5			12.5%	
Higher education		12			30%	
EMPLOYMENT						
Employed		14			35%	
Unemployed		1			2.5%	
Retired		25			62.5%	
PARENTAL STATUS						
W/children		33			82.5%	
W/o children		7			17.5%	
TOTAL		40			100%	
	Minimum		Maximum	AS		SD
AGE	50		84	65.38		8.69

Note: N frequency; AS – arithmetic mean; SD – standard deviation

The sample of respondents was a convenience sample that incorporated 40 respondents, out of which 24 (60%) were male respondents and 16 (40%) were female respondents. 27 of them were married (67.5%), 9 of them were single (22.5%) and 4 respondents were widowed (10%). The sample included 3 respondents with no education (7.5%), 2 respondents were with elementary education (5%), 18 respondents with high school education (45%), 5 with tertiary education (12.5%) and 12 with higher education (30%).

The numeric distribution within the employment status category indicates that only 1 respondent (2.5%) was unemployed, while 14 of them (35%) were employed, and 25 of them retired (62.5%). As the unemployed category only included 1 respondent, such respondent's answers were not included in the calculation of

differences in the severity of depression between respondents with different employment status.

INSTRUMENT

A structured questionnaire with closed-ended answers was used to evaluate depression in individuals with aphasia of cerebrovascular origin who were undergoing aphasia treatment. The Boston Diagnostic Aphasia Examination – BDAE battery of tests (Goodglass, Kaplan & Baressi, 2001) was used to assess the type of clinical manifestation of aphasia, i.e. the findings from the medical files of patients who were diagnosed with a specific type of aphasia. In order to establish the existence of a physical disability, objective findings of a physiatrist, recorded in the patient's medical file, were used. 5-Point Likert Scale was used for determining the level of family support. A standardized questionnaire, i.e. Beck Depression Inventory (BSD), was used for determining the symptoms of depression and the degree of their severity. The symptoms of depression and/or their severity are represented by BDI scores.

RESULTS OF THE RESEARCH

Data analysis and processing were carried out by means of the Statistical Package for the Social Sciences – SPSS for Windows, version 23.0, 2015. The research study used descriptive and inferential statistics. Parametric tests were also used, including t test, variance analysis, regression analysis, as well as Pearson's correlation coefficient. The α level of 0.05 was defined for all statistical analyses. The obtained results are presented in the form of tables and text.

Table 3
Descriptive data on research variables (depression, aphasia and physical disability)

		Minimum		Maximum	AM	SD
Depression		1.00		29.00	14.28	7.73
Depression categories		No symptoms	Mild symptoms	Mild to moderate symptoms	Moderate to severe symptoms	Severe symptoms
N		16	5	10	9	0
Percentage		40%	12.5%	25%	22.5%	0%
Clinical manifestation of aphasia		Fluent aphasia			Non-fluent aphasia	
	N	8			32	
	Percentage	20%			80%	
Physical disability		YES			NO	
	N	8			32	
	Percentage	20%			80%	

Note: N – frequency; AM – arithmetic mean; SD – standard deviation

Note: N – frequency; AM – arithmetic mean; SD – standard deviation

Data obtained through an analysis of the respondents' answers, shown in Table 3, indicates that the BDI scores of the research sample range from 1 to 29, while the average BDI score is 14.28. Having divided the respondents, based on their BDI scores, into the ones having no symptoms (from 0 to 9 points), the ones with mild symptoms (from 10 to 19 points), with mild to moderate symptoms(20 to 29 points) and the ones with severe symptoms(from 30 to 63 points), we arrived at a data distribution indicating that 40% of respondents showed no symptoms (16) and, out of the ones presenting with symptoms, 12.5% (5 respondents) showed mild symptoms, 25% (10 respondents) mild to moderate symptoms, and 22.5% (9 respondents) with moderate to severe symptoms. None of the respondents presented with severe symptoms of depression.

With respect to the clinical manifestation of aphasia, 20% of respondents (8) were diagnosed with fluent aphasia and physical disability, while 80% (32) were diagnosed with non-fluent aphasia and had no physical disability.

Table 4
Difference in BDI scores based on gender variable

		AD	SD	t-statistic	df	ASdifference	p
Gender	Male	15.29	7.39				
	Female	12.75	8.20	1.02	38	2.54	0.31

Note: AM – arithmetic mean; SD – standard deviation; t statistic – coefficient of calculated difference; p – statistical significance; df – degree of freedom

Table 4 shows that there is no statistically significant gender-based difference ($t = 1.02$, $p > 0.05$) in depression severity.

Table 5
Differences in BDI scores based on physical disability variable

		AM	SD	t-statistic	df	AM difference	p
Physical disability	YES	12.13	4.94				
	NO	14.81	8.25	- 0.88	38	- 2.69	0.39

Note: AM – arithmetic mean; SD – standard deviation; t statistic – coefficient of calculated difference; p – statistical significance; df – degree of freedom

Table 5 shows that no statistically significant difference has been recorded between the respondent with physical disability and the ones without physical disability ($t = - 0.88$, $p > 0.05$).

Table 6
Difference in BDI scores based on parental status variable

	AM	AM	SD	t-statistic	df	AM difference	p
Parental status	W/ children	12.76	7.51				
	W/o children	21.43	3.87	-2.95	38	- 8.67	0.01

Note: AM – arithmetic mean; SD – standard deviation; t statistic – coefficient of calculated difference; p – statistical significance; df – degree of freedom

Table 6 shows a statistically significant difference in the severity of symptoms of depression based on parental status variable ($t = -2.95$, $p < 0.05$). Namely, the respondents without children are more depressed than the respondents with children, as indicated on the BDI scale.

Table 7
Difference in BDI scores based on the clinical aphasia manifestation variable

		AM	SD	t-statistic	df	AM difference	p
Clinical manifestation of aphasia	Fluent aphasia	16.00	10.60				
	Non-fluent aphasia	13.84	6.99	0.70	38	2.16	0.49

AM – arithmetic mean; SD – standard deviation; t statistic – coefficient of calculated difference; p – statistical significance; df – degree of freedom

Table 7 shows no statistically significant difference in BDI scores between respondents with different clinical manifestations of aphasia ($t = 0.70$, $p > 0.05$).

Table 8
Difference in BDI scores based on the employment status variable

		AM	SD	t-statistic	df	AM difference	p
Employment status	Employed	18.36	7.59				
	Retired	12.48	6.81	2.48	37	5.88	0.02

Note: AM – arithmetic mean; SD – standard deviation; t statistic – coefficient of calculated difference; p – statistical significance; df – degree of freedom

Table 8 shows statistically significant difference in the depression severity based on the employment status variable ($t = 2.48$, $p < 0.05$). This means that the employed respondents reported higher BDI scores than the retired respondents. The employed respondents are more depressed than the respondents who are retired.

Table 9
Difference in BDI scores based on the marital status variable

Marital status		AM difference	p	F statistic 3.63 p 0.04
Married	Single	-4.44	0.12	
	Widow/widower	-9.42	0.02	
Single	Widow/widower	-4.97	0.26	

Note: AM – arithmetic mean; F statistic – coefficient of calculated difference; p – statisticalsignificance

Table 9 shows, based on the statistical significance of the F statistic ($F = 3.63$, $p < 0.05$), that there is a statistically significant difference in the severity of depression symptoms between respondents with different marital status. A comparative analysis between each of the categories showed that there is a statistically significant difference between the respondents who are married and those who are widowed in that the respondents in the widowed category are more depressed than the ones in the married category.

Table 10
Correlation between BDI scores and respondents' age

		Age
BDI score	Pearson's correlation coefficient	**- 0.36**
	p	**0.02**

Table 10 refers to a statistically significant, medium-intensity, negative correlation between BDI scores and age of the respondents ($r = -0.36$, $p < 0.05$). Such correlation, therefore, indicates that the older respondents are more depressed than the younger ones.

Table 11
Correlation between BDI scores and level of education

		Level of education
BDI score	Pearson's correlation coefficient	0.01
	p	0.93

Table 11 shows no statistically significant correlation between BDI scores and the level of education of the respondents ($r = 0.01$, $p > 0.05$).

Table 12
Correlation between BDI scores and the level of support the respondents are receiving from family

		Family support
BDI score	Pearson's correlation coefficient	**- 0.61**
	p	**0.00**

As seen in Table 12, a statistically significant, medium-intensity, negative correlation was established between BDI scores and family support that the respondents are receiving ($r = - 0.61$, $p < 0.01$). Such correlation indicates that the respondents lacking family support are more depressed than the ones having such support.

We used Linear regression to examine whether the BDI score may be predicted based on the degree of family support received. The regression model indicated that the BDI score may be predicted based on the degree of family support ($\beta = -.605$; $t = -4.678$; $p < 0.01$).

DISCUSSION

Aphasia as a condition that affects one family member involves a spectrum of issues that affect the functioning of a family as a whole. Stroke mostly occurs suddenly, without any advance notice and leaving no time to prepare, thus being perceived as a direct attack on the family (Davis, 1983). Appearance of symptoms of depression in persons with aphasia of cerebrovascular etiology is rarely mentioned in literature. Research studies into depression in individuals with aphasia oftentimes administer questionnaires which are not properly customized to the subject population (Mitchell et al, 2017). Etiology of depression in individuals with aphasia caused by a cerebrovascular event has not been fully clarified and there are theories to the effect that it is multifactorial in origin (Whyte & Mulsant, 2002).

Aphasia as a condition that affects one family member involves a spectrum of issues that affect the functioning of a family as a whole, for which reason the purpose of the present research is to establish the symptoms of aphasia in individuals with aphasia of cerebrovascular origin, undergoing aphasia treatment in Serbia. The analysis of data collected on a convenience sample showed that:

First hypothesis–*Half of the respondents will present with symptoms of depression* – is confirmed**.** By establishing categories based on BDI scores, ranging from *no symptoms* to *severe symptoms* and by classifying the respondents into these categories, it was found that the score from 0 to 9 (no symptoms of depression) accounts for 40% of respondents. This suggests that 60% of respondents with aphasia exhibit some symptom of depression.

This is certainly substantiated by previous research studies claiming that the percentage of the respondents with depression may range from 20 to 65% (Shuoet al., 2018). The cause of a depressed mood, as well as depressive disorder, may be essentially multifactorial, which is exactly the subject of the present research which was carried out by proving further hypotheses.

The data obtained by way of analysis indicates that the second hypothesis (*There is a statistically significant difference in BDI scores between male and female respondents. Female respondents record higher BDI scores.*) and the third hypothesis (*There is a statistically significant difference in BDI scores between respondents with physical disability and respondents without physical disability.*), as well as the ninth hypothesis (*There is a statistically significant difference in BDI scores between respondents with fluent and respondents with non-fluent aphasia*) was not confirmed. Furthermore, the analyses indicate that the respondents without children, as well as the employed respondents recorded higher BDI scores and are more depressed than the respondents with children and the ones that are retired, thus the sixth hypothesis (*There is a statistically significant difference in the BDI scores between respondents with children and respondents without children.)*and the eighth hypothesis (*There is a statistically significant difference in the BDI scores between respondents with different employment status)* were confirmed. Higher BDI scores obtained by the respondents who do not have children may be accounted for by that fact that individuals having no children worry about having no one to take care of them due to the condition they are in. The difference in depression severity between the employed and retired respondents (where the employed are more depressed) may be partially explained by the existential fear stemming from uncertain income. The investigation into the relationship between employment status and depression in the general population substantiates the results of the present research study (Porić et al., 2017). The results of the present study are also substantiated by a study of the general population where the results indicate that the individuals who retired showed no increase in the symptoms of depression (Butterworth et al., 2006). There is a statistically significant difference between the married respondents and widowed respondents in that the widowed respondents are more depressed than the respondents in the married category, whereby the tenth hypothesis (*There is a statistically significant difference in BDI scores between respondents with different marital status)* is confirmed**.** The onset of depression can in this case be associated with the results of research studies that examined the correlation between stressful situations, such as the loss of a partner, in the general population (Hoeksem & Ahren, 2002).

The obtained correlation indicates that the older respondents and respondents lacking family support are more depressed than younger respondents and respondents with family support, whereby the fifth hypothesis (*The BDI score correlates with age of respondents)*and the seventh hypothesis (*The BDI score correlates*

with the degree of family support that the respondents have) are confirmed. This fact is substantiated by general population studies indicating that depressive symptoms increase with age (Stordal, Mykletun, & Dahl, 2003).

A statistically significant correlation between the BDI scores and the level of education of the respondents was not recorded, thus failing to confirm the fourth hypothesis (*There is a statistically significant correlation between BDI scores and educational levels*). This is substantiated by a research study arguing that individuals with higher level of education notice the symptoms at an earlier stage and seek help (Bjelland et al., 2008).

CONCLUSION

A general conclusion that may be drawn based on a summary of the results used in testing the hypotheses is that wherever a statistically significant difference was expected but did not appear (gender, physical disability, clinical manifestation, and educational level), it may be the case that aphasia is one of the risk factors for the appearance of symptoms of depression and that these symptoms are not influence by other, external factors. This research may serve as an introduction to more extensive and complex research studies where the sample of respondents would include people with depressive symptoms who do not exhibit symptoms of aphasia. The results emphasize the importance of a multidisciplinary approach in treatment of aphasia, which would involve experts such as psychiatrists and psychotherapists.

The Serbian Healthcare System includes only one outpatient clinic where one can seek treatment for aphasia. Available information on the possibilities of aphasia treatment is scarce, so the question is how to inform people with post-stroke aphasia and refer them for treatment? It is this fact that accounts for a small sample of respondents included in this research study, which is deemed its disadvantage.

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POJAVA SIMPTOMA DEPRESIJE KOD OSOBA SA AFAZIJOM CEREBROVASKULARNE ETIOLOGIJE

Sažetak: Moždani udar nastaje usled oštećenja krvnih sudova mozga i dolazi do otežanog ishranjivanja tog dela mozga kiseonikom i hranjivim materijama. Afazija, kao posledica moždanog udara, podrazumeva multimodalni oblik poremećaja komunikacije. Depresija je u istraživanjima opisana kao još jedna od posledica moždanog udara i može imati negativne posledice na kvalitet života i proces afazиološkog tretmana. Zbog toga je bilo potrebno detaljno istraživanje depresije kod afazičnih osoba. Cilj istraživanja je utvrđivanje pojave simptoma depresije kod osoba koje imaju afaziju cerebrovaskularne etiologije, a koje su obuhvaćene afaziološkim tretmanom u Srbiji. Uzorak istraživanja je prigodan i čine ga 40 ispitanika, od kojih je 24 muškaraca i 16 žena sa postavljenom dijagnozom afazije pomoću Boston baterije testova (BDAE). Za ispitivanje postojanja fizičke onesposobljenosti korišćen je objektivni nalaz fizijatra preuzet iz dokumentacije pacijenta, a za ispitivanje podrške porodice korišćena je petostepena Likertova skala stavova. Za utvrđivanje simptoma depresije i stepena izraženosti simptoma depresije korišćena je Bekova skala za procenu depresivnosti (BSD). Rezultati su pokazali da više od polovine ispitanika je pokazalo simptome depresije. Kao značajni prediktori za pojavu simptoma depresije pokazali su se ispitanici koji su u radnom odnosu, u odnosu na one u penziji, kao i oni bez dece i oni kojima nedostaje porodična podrška. Rezultati govore u prilog značaja više faktora koji mogu biti, uz afaziju, okidači za razvoj simptoma depresije i ukazuju na značaj multidisciplinarnog pristupa u afaziološkom tretmanu koji podrazumeva uvođenje stručnjaka poput psihijatra i psihoterapeuta.

Ključne riječi: afazija, depresija, afaziološki tretman

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OBJECTIVE ASSESSMENT OF VOICE QUALITY IN PATIENTS WITH ONE-SIDEDVOCAL PARALYSIS

Abstract: Unilateral vocal cord paralysis is most often a consequence of a peripheral lesion. It can be caused by various traumas, tumors, neurological and systemic diseases, but also of unknown origin. It most often occurs after surgery on the neck (thyroidectomy), which results in a lesion of the recurrent laryngeal nerve. In unilateral paralysis, the vocal cords are unable to take an intermediate position, which impairs the quality of the voice. One of the basic symptoms is dysphonia, and it is characterized by a narrowed range, reduced intensity, the endurance time of the tone is shortened, and in more severe cases, aphonia can occur. The aim of this study is to objectively assess the voice in patients with unilateral vocal cord paralysis before and after vocal rehabilitation. This study included 21 female subjects and a control group of 19 subjects. An objective voice assessment was performed by the Computerized Voice Analysis Laboratory of the company "Kay Elemetrics". 5 parameters of multidimensional voice analysis were analyzed: parametric signal (percentage of jitter (%), noise parameters (noise/harmonic ratio - NHR), percentage of shimmer Shim%, voice turbulence index - VTI and tremor analysis (intensity index Fo- tremor - FTRI%). The results of the research before and after vocal rehabilitation differ significantly. The observed difference for the parameter of short-term and long-term frequency disorders: percentage of jitter Jitt (%) and percentage of shimmer Shim (%), was high statistically significant, the VTI voice turbulence index and the noise/harmonic ratio - NHR also improved significantly, the observed difference was statistically significant and highly statistically significant. However, analysis of tremor through the FTRI intensity index showed no significant improvement. Conclusion: The results showed that patients with unilateral vocal cord paralysis can improve their voice by applying vocal therapy, which strongly affects their psychophysical condition, return to normal life activities, and better quality of life.

Keywords: unilateral vocal cord paralysis, vocal rehabilitation, acoustic voice analysis

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INTRODUCTION

Damage to the central and peripheral nervous system can cause unilateral paralysis of the vocal cords n. vagus, ie its branches, upper and lower laryngeal nerve (Milutinović, 1997). To lesion n. vagus can occur due to fracture of the base of the skull, tumors, gunshot and stab wounds. The laryngeal nerves conduct motor and sensitive innervation of the larynx, ie the upper laryngeal nerve gives sensitive innervation to the lumen of the larynx, but also to the motor for the cricothyroid muscle. All unilateral paralysis is mainly a consequence of peripheral lesions (Katić, & Prgomet, 2009), whose causes are divided into four groups: idiopathic, trauma, tumors, neurological and systemic diseases (Bothe et al., 2014).

Unilateral vocal cord paralysis most often occurs after thyroidectomy, where the nerve is often cut or crushed. Paralysis of the left vocal cord occurs much more often than the right one, the reason being the anatomical position of the left laryngeal nerve, ie the left recurrent nerve is longer and thus more prone to injuries (Ahmad et al., 2002). In unilateral paralysis of the vocal cords, it is not able to take an intermediate position, which results in neither phonation nor abduction of the vocal cords during phonation (Finck, 2006).

One of the basic symptoms of unilateral vocal cord paralysis is dysphonia. The voice is characterized by noise, especially in the early phase of paralysis, the range is narrowed, the intensity is reduced and the time to maintain the tone is shortened. In some patients, a high-pitched voice is sometimes heard, as well as a false voice (Schindler et al., 2008), and in more severe cases, aphonia may occur. Phonosurgery and vocal rehabilitation are effective methods of treating unilateral vocal cord paralysis. In some patients, recovery may be spontaneous in the first six to twelve months after paralysis (Boone, & McFarlane, 2000). Treatment of unilateral vocal cord paralysis should begin with vocal rehabilitation. Surgical treatment is performed if the rehabilitation does not achieve satisfactory results and when a certain period of time has passed since the onset of paralysis, not less than a year (Milutinović, 1997). Vocal rehabilitation is based on breathing exercises, strengthening the vocal muscles and improving speech technique.

The aim of this study is to objectively assess the voice in patients with unilateral vocal cord paralysis before and after vocal therapy.

METHOD OF WORK

In this study participated 21 female subjects and 19 subjects made up the control group. The age ranged from 49 to 69 years. An examination by an otorhinolaryngologist diagnosed all subjects with unilateral vocal cord paralysis, which occurred after a total thyroidectomy. After the diagnosis was made, the patients were referred to a speech therapy clinic.

In this research, an objective assessment of the voice was conducted. Objective assessment of the voice was conducted by the Computerized Voice Analysis Laboratory of the company "Kay Elemetrics". Vocal (A) was recorded and analyzed in all subjects. The acoustic structure of the vocals (A) was analyzed from at least 3 seconds, from 3 attempts in a room isolated from noise in a comfortable sitting position, with the usual pitch and intensity of the speech voice. 5 parameters of multidimensional voice analysis were analyzed: parametric signal (percentage of jitter (%), parametric noise (noise/harmonic ratio) - NHR, percentage of shimmer Shim%, voice turbulence index - VTI and tremor analysis (intensity index Fotremor - FTRI%). This method of assessment (acoustic analysis) is non-invasive and provides objective data on voice quality and allows monitoring of voice changes over a longer period of time (Dejonckere et al., 2001).

Descriptive and analytical statistics methods were used in describing and analyzing the obtained data. From the methods of descriptive statistics, the arithmetic mean with the corresponding standard deviation was used, as well as the minimum and maximum. Then measure of central tendency, measure variability, and tabulation. Frequency and percentages were used. In analytical statistics, the Student-t test was used to assess the significance of the difference for parametric, and the Wilcoxon test of equivalent pairs for nonparametric data. Since the sample size consisted of 21 subjects, the significance of the difference in the Wilcoxon test was determined by the Zed-Z test, because the data behaved according to the normal distribution. Statistical processing and analysis was done in the computer program SPSS ver. 20 (Statistical Package for the Social Sciences).

RESULTS

21 female respondents participated in the study, and the control group consisted of 19 respondents. The age of the respondents ranged from 49 to 69 years (Table 1).

Table 1
Presentation of respondents by age and gender.

Age	Gender- F	Gender- M	Total
49-69	21	0	21

Analyzing the results, we first compared the value of acoustic parameters of subjects before vocal rehabilitation and subjects of the control group (Table 2). We notice that the values of all processed parameters are highly statistically significant, which indicates that the voice of the respondents was significantly damaged. The obtained parameter values were as follows: Jitter (%): W = 479; Z = -4,359; p<0.01; Shimmer (%): W = 466; Z = -4.153; p < 0.01; NHR (db): W = 457; Z = -4,261; p < 0.01; VTI: W = 459; Z = -4,497; FTRI (%): W = 471; Z = -4,518; p<0.01.

Table 2
Results of vocal parameters of patients before vocal rehabilitation and control group.

Vocal parameters	Patients with vocalcord unilateral paralysis n=21		Control group n=19		Diversity		p
	M	SD	M	SD	Absolute	%	
Jitter (%)	2.004	1.475	0.498	0.221	1.509	7.36	$p < 0.01$
Shimmer (%)	5.645	2.519	1.843	0.436	3.809	67.31	$p < 0.01$
NHR (db)	0.161	0.050	0.111	0.012	0.114	71.71	$p < 0.01$
VTI	0.071	0.025	0.042	0.015	0.019	32.29	$p < 0.01$
FTRI (%)	1.189	0.848	0.317	0.316	0.870	73.20	$p < 0.01$

Table 3 shows the value of acoustic parameters before and after vocal rehabilitation. The results of the acoustic parameters of the vocals (A) before and after the vocal rehabilitation differed significantly. Observed difference for parameters: percentage of jitter Jitt (%) and percentage of shimmer Shim (%) is statistically significant. The obtained parameter values were: Jitter (%) $W = 484$, $Z = -4.881$, $p < 0.01$; Shimmer (%) $W = 451$, $Z = -4.755$, $p < 0.01$). The presence of noise in the analyzed signal - noise/harmonic ratio of NHR, changed significantly after the therapy, the observed difference was statistically significant ($W = 128.1$, $Z = -2.153$; $p < 0.05$).
The VTI voice turbulence index also improved significantly, the observed difference was highly statistically significant ($W = 129.0$, $Z = -2.157$, $p < 0.05$). The analysis of tremor through the FTRI intensity index did not show a significant improvement, the observed difference was not statistically significant ($W = 164$, $Z = -1.258$, $p > 0.05$).

Table 3
Results of vocal parameters before and after vocal rehabilitation

Vocal parameters	M	M	p
	Before vocal rehabilitation	After vocal rehabilitation	
Jitter (%)	1.990±1.387	0.560±0.249	$p < 0.01$
Shimmer (%)	5.521±5.455	1.981±0.641	$p < 0.01$
HNR (db)	0.156±0.040	1.395±0.390	$p < 0.05$
VTI	0.070±0.025	0.110±0.007	$p < 0.05$
FTRI	1.201±0.848	0.316±0.146	$p > 0.05$

The obtained results of the subjects after vocal rehabilitation and the subjects of the control group did not differ significantly (Table 4), except for one parameter

FTRI (%). The observed difference was not statistically significant. The obtained parameter values were as follows: Jitter (%) W = 146; Z = -1.359, p > 0.05; Shimmer W = 165, Z = -1.152, p > 0.05; NHR (db): W = 157, Z = -1.261, p > 0.05; VTI W = 158, Z = 1.197, p > 0.05; FTRI W = 136.3, Z = -2.207, p < 0.05.

Table 4
Results of vocal parameters in patients after vocal rehabilitation and control group

Vocal parametres	SD		Diversity		p
	Patients after vocal rehabilitation (n=21)	Control group (n=19)	Absolute	%	
Jitter %	0.560± 0.249	0.507 ± 0.166	0.051	9.40	p > 0.05
Shimmer %	1.981± 0.641	1.843 ± 0.437	0.136	6.94	p > 0.05
NHR (db)	1.395 ± 0.390	1.100 ± 0.365	0.293	21.10	p > 0.05
VTI	0.110± 0.007	0.110 ± 0.007	0.001	0,88	p > 0.05
FTRI %	0.320± 0.144	0.317 ± 0.146	0.001	0.91	p < 0.05

DISCUSSION

Unilateral vocal cord paralysis is one of the most common complications of thyroidectomy (Finck, 2006; Zakaria et al., 2011), which can lead to hoarseness, impaired pitch, and voice fatigue. Hoarseness of the voice has different effects on the mental and emotional state of the patient and thus the quality of his life. The main goal of vocal rehabilitation is to improve or restore the patient's voice for adequate social and professional functioning, which will have a positive impact on improving the quality of life.

In our study, unilateral paralysis was mainly present in female respondents, which is in line with previous research (Jakelić, Bonetti, & Šimunjak, 2015; Blatančić, Bonetti, & Živković-Ivanović, 2017).

Before the beginning of vocal rehabilitation, all analyzed parameters were disturbed (Stojadinović, et al., 2002), which negatively affected their quality of life. After completing the vocal rehabilitation of five analyzed vocal parameters (A) statistically significant and highly statistically significant improvement was observed in four parameters: jitter Jitt%, shimmer percentage Shimm%, noise parameter (noise / harmonic ratio) - NHR and voice turbulence index - VTI, which is consistent with other research (Doyle, Perkell, Hammatberg, & Hillmam, 2003; Schindler et al., 2008; Petrović-Lazić, & Babac, 2009; Cantarella, Viglione, Forti, & Pignataro, 2010; Jakelić, Bonetti, & Šimunjak, 2015; Bunijevac, Petrović-Lazić, Jovanović-Simić, Kulić, & Maksimović, 2017). Studies by other authors

(Chowdhury, Saha, Saha, Pal, & Chatterjee, 2013; Jesus, Martinez, Hall, & Ferreira, 2015) show that there is no significant difference between patients with unilateral vocal cord paralysis and the control group, indicating the great importance of vocal rehabilitation in achieving a quality voice. However, the analysis of tremor (Fo-tremor intensity index - FTRI%) showed no significant improvement, which can be explained by the shorter duration of vocal rehabilitation or the longer period between the onset of vocal cord paralysis and the beginning of voice therapy.

Computerized voice analysis as an objective method is not a substitute for medical history, but in monitoring patients with voice disorders, it shows a high degree of precision in monitoring the course of therapy.

CONCLUSION

Unilateral vocal cord paralysis leads to voice disorders, which impairs the patient's quality of life. Vocal rehabilitation aims to repair or restore the patient's voice in such a way that he is able to use it adequately in everyday life activities, which will affect positive on his quality of life. The results of this research indicate changes in the measurement variables in the direction of their improvement, despite the shorter duration of vocal rehabilitation or the longer period between the onset of vocal cord paralysis and the beginning of voice therapy. That is, patients with unilateral vocal cord paralysis can correct their voice by applying vocal therapy.

The voice results of patients undergoing vocal therapy program can be documented by pre-therapy and post-therapy analysis. These analyzes can be used as an aid in diagnosis, and also in the

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OBJEKTIVNA PROCENA KVALITETA GLASA KOD PACIJENATA SA JEDNOSTRANOM PARALIZOM GLASNICE

Sažetak: Jednostrana paraliza glasnice najčešće je posledica periferne lezije. Može da bude uzrokovana raznim traumama, tumorima, neurološkim i sistemskim bolestima, ali i idioptaskog porekla. Najčešće je uzrokovana hirurškom intervencijom na vratu (tireoidektomije) pri čemu dolazi do lezije povratnog laringealnog nerva. Kod jednostrane paralize glasnica nije u mogućnosti da zauzme intermedijarni položaj što narušava kvalitet glasa. Jedan od osnovnih simptoma je disfonija, a karakteriše je sužen raspon, smanjen intenzitet, vreme izdražvanja tona je skraćeno i kod težih slučajeva može da se javi afonija. Cilj ovog istraživanja je objektivna procena glasa kod pacijenata s jednostranom paralizom glasnice pre i posle vokalne terapije. U ovom istraživanju učestvovala je 21 ispitanica ženskog pola, a kontrolnu grupu činilo je 19 ispitanika. Objektivna procena glas sprovedena je Kompjuterizovanom laboratorijom za analizu glasa firme „Kay Elemetrics". Analizirano je 5 parametara multidimenzionalne analize glasa: parametric signal (procenat jitter-a (%), parametri šuma (odnos šum/harmonik - NHR), procenat shimmer-a Shim %, indeks turbulencije glasa – VTI i analiza tremora (indeks intenziteta Fo-tremor – FTRI %). Rezultati istraživanja pre i posle vokalne rehabilitacije značajno se razlikuju. Uočena razlika za parametar kratkotrajnih i dugotrajnih poremećaja frekvencije: procenat jitter-a Jitt(%) i procenat shimmer-a Shim(%), je bila visoko statistički značajna, indeks turulencije glasa VTI i odnos šum/harmonik - NHR su se takođe značajno poboljšali, uočena razlika je bila statistički značajna i visoko statistički značajna. Međutim, analiza tremora kroz indeks intenziteta FTRI nije pokazao značajno poboljšanje. Rezultati su pokazali da pacijenti sa jednostranom paralizom glasnice mogu da poboljšaju svoj glas primenom vokalne terapije, što snažno utiče na njihovo psihofizičko stanje, povratku normalnim životnim aktivnostima, odnosno boljem kvalitetu života.

Ključne reči: jednostrana paraliza glasnice, vokalna rehabilitacija, akustička analiza glasa

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CONNECTION OF INHIBITOR CONTROL AND RECEPTIVE SPEECH OF CHILDREN WITH TYPICAL DEVELOPMENT

Abstract: Cognitive development is a necessary condition for speech development, but it is not enough. It has been shown that some complex syntactic structures arise only at a certain cognitive level, but on the other hand, some constructions the child begins to use before he can understand what is meant by them. Executive functions direct and regulate cognitive functions. They are used for daily performance of various tasks. Inhibitory control is one of the basic mechanisms of executive functions, which enables the control of attention, thoughts, emotions and behavior, through overcoming automatic responses to external or internal stimuli. During communication, executive functions, mediated by a network of frontal, parietal and subcortical structures, act by selecting the right words in language production by suppressing alternative ones, as well as by selecting the most probable interpretation of more complex sentences in language understanding. Executive control is involved in various aspects of language processing, which includes activation and inhibition of information. For example, in language production, the speaker will use executive functions to select a word that fits the concept in mind. Objective of the research was to determine the connection of individual components of executive functions, with special emphasis on inhibitory control, with language processing. The sample consisted of 72 children, preschool age, from five to seven years of age. Inhibitory control was tested with the Strup 1 and Strup 2 tests, as well as the Go / Stop test, and receptive speech with a Peabody picture vocabulary test. Results showed that inhibitory control may be a predictor of receptive speech. It is possible to predict the ability to understand speech in 35.2% of cases based on both inhibition tests, while the percentage is higher and is 56% when we do the analysis of individual inhibition tests. The Strup 2 and Go/ Stop test 1 stood out as the best predictors.

Keywords: executive functions, inhibitory control, receptive speech, preschool children

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INTRODUCTION

After a period of perfect protection inside the mother's body, the child is adequately equipped to adapt to the outside world. In order to adapt to it as much as possible, years of intensive interaction are necessary, through which his potentials will be gradually realized.

The development is fastest by the age of three, and it proceeds rapidly until six. This sensitive age is influenced by numerous factors. The experiences that a child acquires in the earliest childhood affects his further development and they are the result of the interaction of the child and those who take care of him, and what society and the environment provide for the growing-up child. Each person has a special, unique potential for development that will manifest and take advantage of diversity depending on a number of other factors (Golubovic, 2017).

During the development the child goes through certain developmental stages. They are connected to each other and the next stage cannot occur until the previous one completes its development and maturation. It should certainly be born in mind that the course of development is not linear, that is, before a certain type of behavior begins to occur, a certain level of neural growth and organization must be reached. Although a child's personality is an indivisible whole, it is common that when assessing the development, certain areas that make that person are considered separately: psychomotor, speech, sensory and cognitive areas.

SPEECH DEVELOPMENT

Speech is learned from birth, from the first cry. In order for the development of speech to be correct, certain preconditions must be met: organic, mental and social. Thus, the organic preconditions are formed oral-motor skills, good hearing, morphological and functional maturation of the cerebral cortex. Certainly, psychological factors are also important, which are related to the development of speech, such as: thinking, perception, attention, memory, learning, but also emotional stability. A speech pattern that is close to the child, as a social factor, is of great importance. Lately, great emphasis has been placed on the influence of the environment on speech. Thus, the development of speech is impossible without a social speech model that is close to the child, without a speech environment, as well as the overall activity and motivation of the child himself. Today, the prevailing opinion is that the acquisition of the mother tongue, or speech, is a compromise between biological preconditions and environmental factors (Hoff-Ginsberg, 1986).

The biological basis of speech, according to Keramitchievski (1989) in the broadest sense consists of:

- Receptor system (auditory, visual, tactile kinesthetic),
- Sensor system,
- Transmitter system,
- Integrator system,
- Effector system,
- Feedback system.

Speech - language development can be roughly divided into two periods:

- Prelinguistic period (starts from birth and lasts until the appearance of the first word)
- Linguistic period (since the appearance of the first word, increase in vocabulary)

The prelinguistic period begins at birth and lasts until the appearance of the first word. It includes the following phases:

- a) respiration (first cry / cry) - after birth and rupture of the umbilical cord, there is a reflex expansion of the chest, which causes a sudden penetration of air into the lungs. The air passes over the vocal cords and causes flickering. The first cry is a natural reflex reaction. It is, in fact, the earliest form of vocalization. Later, it is conditioned and the child learns to use crying as a form of communication with adults.
- b) cooing - voices appear spontaneously, as they mature. In the first months, all the speech sounds that the human voice system can produce appear (French thrillers, Arabic throat consonants, etc.). Under the influence of the environment, learning by imitation (mother tongue), the voices that are heard and repeated in the child's environment will be established, and the rest will be gradually lost.
- c) syllable (chatter) - in the fifth month the child coordinates the work of the diaphragm, vocal cords, tongue, lips and jaw - which regulates the quality of spoken voices and this allows the transition to syllable - pronouncing vowels and consonants together.

At the same time, the perception of speech and understanding of messages develops, first of all on the basis of recognizing the melodic structure - intonation. Parents quickly find that the newborn responds to their voice, e.g. intense twitching, twisting, swaying. At the end of the first year, the message of others is understood. Speech comprehension develops earlier and faster than its creation. Infants often, until they learn to speak, respond to questions and requests with gestures and actions.

Linguistic period

Before the first word appears and expressive speech develops (production), the child enriches receptive speech and understanding of others. It is very difficult to determine the exact time of the appearance of the first word, the norms range from 12-14 months, although there are also cases of speaking even before the first year. The first word is a spoken group of voices that must have meaning and be related to something that appears when it is spoken: a person, object or action / situation. It also expresses an emotional state of the child: desire, aspiration, need.

Vocabulary growth depends on whether speech is encouraged, nurtured or not nurtured. More than 55% of children's speech consists of nouns, pronouns and verbs. In the second year, the child uses nouns the most. Combining two words (noun and verb) occurs at the end of the second year. These sentences are also reduced and can only be understood in the context in which the child speaks. In the third year, the pronoun first appears in the third person in the sentence ("He wants…"), and only in the second half of the third year in the first person ("I would ..."). Gradually, articles, adverbs, suffixes, auxiliary verbs appear in the child's sentences. A child's passive vocabulary is always bigger than the active one, because the passive vocabulary contains all the words he knows and understands, but does not actively use them. The phase of a complete sentence occurs in the fourth and fifth year and is characterized by the use of all types of words.

Cognitive development is a necessary condition for speech development, but it is not enough. It has been shown that some complex syntactic structures arise only at a certain cognitive level, but on the other hand the child begins to use some construction before he can understand what is meant by them.

The development of the concepts of a preschool child is related to the development of vocabulary. That development must be from the concrete to the abstract, from the simple to the complex, from the general to the special. However, sometimes the development of vocabulary can influence the development of concepts, that is, the child first hears the word, and then acquires the concept. The difference between word comprehension (language competence) and the ability to use words in speech (language performance) decreases with age (Golubovic, 2012).

EXECUTIVE FUNCTIONS: INHIBITOR CONTROL

The term executive function refers to a various skills and abilities that enable us to achieve a certain activity. Mostly, they are cognitive, control mechanisms, encompassing the skills needed for goal-oriented behavior, such as planning, strategy development, maintaining initiated behavior, and flexible action change (Stuss, 2000).

Executive functions direct and regulate cognitive functions. They are used for daily performance of various tasks. Lezakova (1995) describes four components of executive functions:

- Will - the process of determining goals, desires and needs. In other words, it is a process of formulating intentions in accordance with the subject's needs and desires and designing their realization in the future.
- Planning - defining and organizing the elements and sequence of actions for the implementation of an activity that leads to achieving the goal. Planning includes the ability to specify a strategy that will implement the intentions and achieve the goal, while recognizing the differences between desires and real circumstances.
- Purposeful action - translating a plan into a productive activity that requires a person to start, maintain, change or stop the activity according to the circumstances and goal.
- Effective implementation of activities - the ability to monitor, correct and regulate activities in relation to their pace, intensity and other qualitative aspects of performance.

Some authors believe that the main difference between children and adults is the development and maturation of executive functions. The course of the development of executive functions can be related to the large anatomical changes that occur in the frontal lobe, as well as to the phases described by Piaget. However, this development is not homogeneous, but different executive functions have different developmental paths and different maturation times. Phylogenetically, the prefrontal cortex has evolved more than other parts of the brain. From a developmental point of view, the prefrontal cortex takes up to two decades to reach full morphological and functional maturity.

Executive functions are of great importance for developing the abilities and skills needed for the learning process. They are the ones that help the student to assess their abilities, but also to inhibit irrelevant stimuli. The selection of what is important, to be decoded and memorized first, is crucial. Awareness of “how I did something” in the learning process is important, because it leads to a change in the pattern of work and the correction of procedures.

Inhibitory control is one of the basic mechanisms of executive functions, which enables the control of attention, thoughts, emotions and behavior, through overcoming automatic responses to external or internal stimuli. Inhibitory control is manifested in two basic types (Diamond, 2013):

1. through inhibition of actions, i.e. complete delay of the reaction to a certain stimulus and
2. by suppressing one action and performing another (desired) instead.

It is extremely important for adaptive behavior, because the possibility of adaptation in different life situations depends on the inhibition of unwanted behaviors. The ability to inhibit the predominant response plays an important role in the process of learning, establishing relationships with others, respecting the rules in the social environment.

Research on inhibitory control has shown that, although three-year-olds have the cognitive ability to learn the rules needed to control responses, developmental limitations prevent them from maintaining an accurate response (Bell et al, 1985). Also, studies have shown that re-exposure to tasks can improve inhibitory control, even in children as young as three years old. The rapid development of inhibitory control, between the ages of three and five, leads to an increase in the child's capacity to suppress an inappropriate response.

Russell Barkley (1997) believes that inhibitory control is the basis for the proper functioning of other executive functions. It is necessary for the control of impulses and disturbances, working memory, regulation of emotions, etc. For example, poor inhibition is one of the major problems of ADHD. Insufficient inhibition can manifest at three different levels:

- Motor level - poor control of movement is manifested by hyperactivity.
- Level of attention - manifested by distractibility
- Behavior level - impulsive behavior (Barkley, 1997).

Studies show that inhibitory control is improved by everyday experiences, especially those involving movement. In all types of physical activities, children not only use the body, but also build the mind and develop cognitive skills, such as inhibitory control (Diamond, 2002).

RELATIONSHIP BETWEEN LANGUAGE DEVELOPMENT AND DEVELOPMENT OF EXECUTIVE FUNCTIONS

Executive control is assumed to be involved in various aspects of language processing, which includes activation and inhibition of information (Lev-Ari, 2014). For example, in language production, the speaker will use executive functions to select a word that fits the concept in mind. Some authors (Ye & Zhou, 2009) understand language processes and executive functions as a network, i.e. intertwined brain functions. They believe that during communication, executive functions, mediated by a network of frontal, parietal and subcortical structures, act by selecting the right words in language production, suppressing alternative ones, selecting the most probable interpretation of more complex sentences in language understanding. Most of researches that talk about the relationship between executive functions and language are related to special groups, such as bilingual

people, children with special language disorders or they are related to language acquisition. In hearing impaired children, less developed executive functions were attributed primarily to auditory deprivation. However, when sign - speaking children were isolated, it was shown that they did not differ from the control group of hearing children, which suggests that the cause of poorer results in executive functions could be language deprivation rather than auditory deprivation (Hall et al., 2016) although there has been a lot of contradictory research in this area as well.

Executive functions play a prominent role during language development. Research (Weiland, Barata & Yoshikawa, 2014) has shown that they are predictive for vocabulary development in preschool. Large differences in vocabulary knowledge during language development are attributed to the different capacity of phonological working memory and are considered directly related to the acquisition of new words. Cognitive inhibition and planning have been shown to be significant predictors of language comprehension at the ages of four and five, and cognitive flexibility at the age of four but not five. Research (Gooch et al., 2016) shows that the connection between executive functions and language continues during the lower grades of primary school.

THE IMPORTANCE OF EARLY SPEECH ASSESSMENT AND INHIBITOR CONTROL

Timely recognition and early diagnosis, inclusion in the organized system of interventions in early childhood, give improvements in children's cognitive development, create conditions for reducing negative side effects in future development. Early detection of developmental delays can prevent more serious problems. Not any area of development is progressing in an isolation, disruptions in one area would cause disruptions in other domains. When assessing psychomotor development, one should keep in mind the basic laws of development: a certain order, from simpler to more complex functions, then, unevenness in the rhythm of development of individual functions, individual differences in development and finally, plasticity in child development.

Some children are more at risk of having a certain developmental disorder than others. Risk factors are diverse and can act in any period of development: before birth, intrauterine, as well as after birth. Of course, the presence of any risk factor does not mean that the child will show any disturbance, but they only increase the chance of it happening. The role of protective factors, which are there to facilitate development, should not be neglected. These are all those opportunities for early learning in a stimulating environment and providing adequate care.

OBJECTIVE OF THE RESEARCH

The aim of this research is to determine the connection of individual components of executive functions, with special emphasis on inhibitory control, with language processing. Based on the studied literature, as well as the goal of the research, we started from the assumption that is based on the assessment of inhibitory control we can predict the level of receptive speech of the child.

METHODOLOGY

The final sample was formed of 72 children, from the age of five to seven, of the preschool institution "Danica Jaramaz" in Kosovska Mitrovica. The sample of children was selected based on the criteria that were important for the research (calendar age-years of age).
The following measuring instruments were used:

- Peabody picture vocabulary test (PPVT-IV) is a wide range test that serves as a measure of vocabulary knowledge. The test contains 17 sets of 12 tasks arranged by difficulty, from easy to difficult. Each task consists of 4 black and white illustrations that the examiner shows to the examinee while saying the word. The task of the respondents is to choose the picture that best shows the meaning of the given word. Of the four images offered, three are distractors (phonologically or semantically). The test does not begin with the first set of tasks, but the initial sequence is assumed with respect to the age of the respondents, and then tested. If the examinee in the sequence corresponding to his age does not make a mistake more than once, the examination is continued according to the more difficult series. If he makes a mistake, switching to easier strings requires the respondent's initial string, in which the respondent does not make a mistake more than once. After finding the initial sequence, the test is continued until the subject makes eight or more errors in the first following sequence.
- Tests for examining executive functions (Gligorović, 2015), namely: Strup test which evaluates verbal inhibitory control. Children are asked to say "day" every time they see a picture of the moon and stars, or "night" when they see a picture of the sun. It consists of a total of 50 items (thumbnails) arbitrarily arranged on two A4 maps. The task consists of two parts. In the first part, the respondent is given an assignment to name the light maps on which the sun is drawn as "day", and the dark maps on which the moon and stars are named as "night". In the second part of the test, the child is expected to ignore the content of the picture and use oppositions when naming

(a picture representing a day to be called “night” and vice versa). For each part of the test, the time and number of errors are recorded; as well as the “Go / Stop” Task, which consists of two parts, based on which the motor inhibition of conflicting motor responses and the omission of the motor response to the agreed signal are assessed. In the set “Conflict motor responses”, the respondent is required to answer the opposite of the one presented (e.g. if the examiner struck once on the table, the examinee should strike twice and vice versa). In the set “Delay of motor response” the examinee is required to, during the imitation of the examiner's beats, to postpone the reaction to the agreed signal (e.g. when he hears two beats). The number of incorrect answers is recorded (errors of the commission - non-response to the stimulus and errors of the commission - reaction to the wrong stimulus); responses with a latency longer than two seconds are also considered incorrect. Each set consists of 30 items. A higher number of errors indicates greater difficulties in the field of inhibitory control.

RESEARCH RESULTS AND DISCUSSION

Analysis based on total scores shows that it is possible to predict the ability to understand speech in 35.2% of cases based on both inhibition tests. The Go/Stop inhibition test shows a slightly higher correlation, that is, the higher the scores on the inhibition tests, the higher score is on the Peabody picture vocabulary test, which is also shown in Table 1.

Table 1
The possibilities of prediction of the ability to understand speech based on both inhibition tests

	Beta	t	Sig.	Correlation	Partial
Struptest	0.33	3.19	0.002	0.47	0.35
Go/Stoptest	0.38	3.70	0	0.50	0.40

However, the analysis based on individual tests shows that it is possible to predict the ability to understand speech in 56% of cases based on the test Strup 2 and Go Stop 1, that is, these two tests are the best predictors. The fewer errors on Strup 2 and the higher score on Go/Stop 1, the higher is total score on the Peabody picture vocabulary test. The results are shown in Table 2.

Table 2
The possibilities of prediction of the ability to understand speech based on individual inhibition tests

	Beta	t	Sig.	Correlation	Partial
Strup 1 time	-.06	-.46	0.64	0.39	-.05
Strup 1 error	-.02	-.25	0.79	-.41	-.03
Strup 2 time	0.14	1.00	0.31	0.48	0.12
Strup 2 error	-.47	-4.21	0.00	-.63	-.46
Go/Stop 1	0.30	3.32	0.001	0.52	0.38
Go/Stop2	0.14	1.67	0.09	0.27	0.20

Researches that tried to explain the link between executive functions and language have confirmed this connection to a greater or lesser extent, although most research are focused on specific groups, such as bilinguals or children with hearing impairments.

In our study, both inhibition tests, Strup test and Go / stop, proved to be predictive for receptive speech in 35.2% of cases. However, if the tests were observed individually, the degree of correlation is higher and its amount is 56%. The Strup 2 and Go / Stop 1 tests proved to be the best predictors. The fewer errors on Strup 2, and higher score on Go / Stop 1, shows the higher total score on the Peabody picture vocabulary test. These results also tell us that receptive speech is influenced by executive functions by enabling the selection of the right words, while suppressing alternative ones. Like other cognitive skills, inhibitory control can be learned and improved, with the help of a "professional tool". Stimulation and work on inhibitory control can improve the performance of receptive speech.

With these results, we can confirm the assumption that achievement in inhibitory control tests may to some extent be a predictor of receptive speech. Research should certainly be continued, in order to precisely specify the mechanisms of activation of executive functions in language processing. It is necessary to elaborate in more detail the role of each component of executive functions, as well as their interaction with the elements of language processing.

CONCLUSION

This research was aimed at examining how inhibitory control, as a mechanism of executive functions, can be predictive for the development of receptive speech. In our area, this is still an insufficiently researched topic and results that would give a clearer insight into this issue are missing. Therefore, the aim of this research was to confirm the hypothesis and offer the obtained results as a small contribution to this scientific field.

Based on the results obtained by the research, we can conclude that it is

possible to predict the ability to understand speech in 35.2% of cases based on both inhibition tests, while the percentage is higher and is 56% when we do the analysis of individual inhibition tests. The Strup 2 and Go/ Stop 1 tests stood out as the best predictors, i.e. the fewer errors on Strup 2, and the higher score on Go / Stop 1,made the total score on the Peabody test higher (PPVT). Thus, we confirmed the first hypothesis, that the inhibitory control variables are predictive for receptive speech.

Knowing that by improving abilities in one area we can improve functioning in another, can help us with the application and planning of different models of early intervention, and so by stimulating inhibitory control it is possible to improve the performance of receptive speech in children.

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POVEZANOST INHIBITORNE KONTROLE I RECEPTIVNOG GOVORA KOD DECE TIPIČNOG RAZVOJA

Sažetak: Tokom komunikacije izvršne funkcije, posredovane mrežom frontalnih, parijetalnih i subkortikalnih struktura, deluju tako da pri jezičkoj proizvodnji selektuju prave reči potiskujući alternativne, kao i da pri jezičkom razumevanju selektuju najverovatniju interpretaciju složenijih rečenica. Izvršna kontrola je uključena u različite aspekte jezičke obrade, koja uključuje aktivaciju i inhibiciju informacija. Na primer, kod jezične proizvodnje govornik će koristiti egzekutivne funkcije kako bi odabrao reč koja odgovara konceptu koji ima na umu. Cilj istraživanja bio je utvrđivanje povezanost pojedinih komponenti egzekutivnih funkcija, sa posebnim naglaskom na inhibitornu kontrolu, sa jezičkim procesuiranjem. Uzorak su činila 72 deteta, predškolskog uzrasta, od pete do sedme godine života. Inhibitorna kontrola ispitana je testovima Strup 1 i Strup 2, kao i testom Kreni/Stani, a receptivni govor Peabody slikovnim test rečnikom. Rezultati pokazuju da inhibitorna kontorla može biti prediktor za receptivni govor. Moguće je predvideti sposobnost razumevanja govora u 35.2% slučaja na osnovu oba testa inhibicije, dok je procenat viši i iznosi 56% onda kada radimo analizu pjedinačnih testova inhibicije. Kao najboji prediktori izdvojii su se testovi Strup 2 i Kreni Stani 1.

Ključne reči: egzekutivne fukcije, inhibitorna kontrola, receptivni govor, deca predškolskog uzrasta

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DEVELOPMENT OF PHONEMATIC PERCEPTION AND SOUND ANALYSIS THROUGH PLAY IN SENIOR PRESCHOOLERS WITH PHONETIC-PHONEMATIC UNDERDEVELOPMENT

Abstract: The article discusses issues relevant to modern speech therapy of the development of phonemic perception and sound analysis through plays in senior preschoolers with phonetic-phonemic underdevelopment. An analytical analysis of theoretical and methodological approaches in the study of this problem in speech therapy is presented. The features of the pronunciation aspect of speech in children with phonetic-phonemic underdevelopment are considered. It is noted that an important place in corrective work with children with phonetic-phonemic speech underdevelopment is occupied by games and playing techniques, as basic methods in the leading type of activity in the ontogenesis of this age group. The use of games and play techniques in working with children with phonetic–phonemic speech underdevelopment as a variety manifests itself in the generality of the leading mental processes that underlie them. We used analytical methods of the study of phonetic and phonemic processes in senior preschoolers, literature on speech therapy and methodology of research topic, methods of high formation - neuropsychological diagnostics of preschool children Zh.M. Glozman, A.E. Soboleva, A.Y. Potanina, the method of phonemic hearing examination by E.F. Arkhipova, the method of “substitutional ontogenesis” by A.V. Semenovich; as well as methods of statistical data processing - Mann-Whitney U-test and the Wilcoxon signed rank test. The results of the empirical research showed positive shifts in the dynamics of the formation of phonetic-phonemic perception, namely, the reproduction of rhythmic structures improved, the results of tests for acoustic gnosis improved, as well as the prosody, the speech of children became more detailed with more pronouns and adjectives in the active speech, which shows significant shifts in the study of spontaneous speech; understanding of logical and grammatical structures improved, understanding the meaning of a story plot and a series of plot also improved. Indicators of the state of auditory-speech memory and mnestic sphere improved, which was manifested in motoric memory and memorization of a story, and also deficiency in intellectual and speech functions decreased.

Keywords: speech therapy, phonetic-phonemic disorder, play techniques.

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INTRODUCTION

In recent years, more and more children have appeared with speech disorders such as phonetic and phonemic underdevelopment. Describing children with phonetic-phonemic underdevelopment, authors (Gorodilova & Glazirina, 2018; Levina, 2005; Filicheva, Cheveleva, & Chirkina, 1993) emphasize the following features of the pronunciation side of speech: incompleteness of the processes of formation of articulation and sound perception, distinguished by subtle acoustic-articulatory features; violation of sound pronunciation, manifested in the absence, replacement, mixed, unstable use, distorted pronunciation of sounds; compressed articulation; general blurred speech, indistinct diction. Many researchers (Babieva et al., 2016; Boskis, 1988; Kashe et al. 1960; Levina, 2005) assign the leading role in the correction of speech disorders to the formation of phonemic perception, that is, the ability to perceive and recognize the sounds of speech (phonemes), the ability to analyze and synthesize them. Without sufficient formation of the foundations of phonemic perception, it is impossible to assimilate sound analysis, where operations of mental division into elements (phonemes) take place (Fomicheva, Volosovets, & Kutepova, 2002). The enormous practical experience of the authors confirms that the development of phonemic perception has a positive effect on the formation of the entire phonetic side of speech.

Phonetic-phonemic speech underdevelopment is a violation of the processes of formation of the pronunciation system of the native language in children with various speech disorders due to defects in the perception and pronunciation of phonemes. Without special corrective action, the child cannot learn to distinguish and recognize phonemes by hearing, analyze the sound-syllabic composition of words, which will lead to the appearance of persistent errors in mastering written speech.

The pathophysiological mechanisms of phonetic-phonemic disorders can be associated with impaired activity of various brain factors, in the organization of which the formation of spatial representations is of great importance (Luria, 1997). This is also confirmed by studies that reveal disorders of optical-spatial gnosis in children with phonetic-phonemic disorders. As L.S. Vygotsky (1966; 1983), A.A. Leontiev (1969), V.I. Lubovsky (2016), A.R. Luria (1997), and A.A. Lublinskaya (1977) noted, optical-spatial gnosis is one of the main mental processes that create the initial basis for the formation of a child's speech. This may indicate significant neuropsychological disorders in children with phonetic-phonemic disorders. In this regard, it is necessary to include neuropsychological studies and methods of neuropsychological correction in the complex of classes for the correction of speech disorders in examination of children with phonetic-phonemic disorders (Beisenova, 2017; Vizel, 2005)

Many researchers pay great attention to finding the most effective ways to

achieve results in correctional work, including an integrated approach, i.e. when working with children with speech disorders, it is rational to rely on research not only in the field of speech therapy and pedagogy, but also in the field of neuropsychology, neurophysiology and neurolinguistics.

A special role in corrective work with children with phonetic and phonemic speech underdevelopment have games and playing techniques.

Throughout human development, in the life of both a child and an adult, play has been used as one of the main means of education and training. Therefore, play has a special place in various educational systems, since it flourishes in childhood and accompanies a person throughout his life (Krupskaya, 1980). After analyzing the literature on this topic, we came to the conclusion that the features of play and teaching techniques are essential in speech therapy, and they fundamentally differ from other methods and techniques. The use of games and play techniques in working with children with phonetic – phonemic speech underdevelopment as a variety manifests itself in the generality of the leading mental processes that underlie them (imagination, emotions). It is known that these processes most easily arise and develop during a play. Thus, the formation of full-fledged speech in children with phonetic-phonemic speech underdevelopment with the help of play is an urgent problem.

METHODOLOGY
aim of the reseach, hypothesis, methods and sample

The aim of the research is to identify the effectiveness of play tehniques in correctional work on the development of phonematic perception and sound analysis during speech therapy with senior preschoolers with phonetic-phonemic speech underdevelopment.

The object of the research is phonetic-phonemic disorder in senior preschool children with phonetic-phonemic underdevelopment. **The subject of research** is play in the correction of phonemic perception and sound analysis in senior preschool children with phonetic-phonemic underdevelopment.

The hypothesis of research. Plays based on the laws of development and activating the potentials of the sinking structures of phonetic-phonemic disorders, allow to activate the integrative sensorimotor basis in the process of forming the intentional optimization of stable connections, which ensure the operation of more complex processes in the functional system of phonetic-phonemic gnosis and praxis in senior preschool children with phonetic and phonemic disorders.
The following research **methods and techniques** were used in the work:

- analytical methods of study of phonetic and phonemic processes in senior preschoolers, speech therapy and methodological literature on the research topic:

- methods of high formation: neuropsychological diagnostics of preschool children Glozman, Potanina and Soboleva (2008), the method of phonemic hearing examination by Arkhipova (2008), the method of "substitutional ontogenesis" by Semenovich (2004, 2017).
- methods of statistical data processing: Mann-Whitney U-test and Wilcoxon's signed rank test;
- quantitative and qualitative analysis of research results.

Sample. The study involved children with phonetic-phonemic disorders. One group of children was defined as experimental, another group of children - as control. Such sample allowed us to carry out the comparison of the results.

EXPERIMENTAL STAGES AND RESULTS

The experimental study included three stages: diagnostics, correcton and control.

I experimental stage – diagnostics

To identify existing neuropsychological disorders affecting the development of phonemic perception and sound analysis, we applied the diagnostics proposed by Glozman, Potanina and Soboleva (2008).

Neuropsychological examination was carried out according to the following criteria: correction test; reciprocal coordination; praxis posture; oral praxis; dynamic praxis; copying; conditioned choice reaction; reproduction of rhythmic structures; subject gnosis; acoustic gnosis; spatial gnosis; emotional gnosis; spontaneous speech in dialogue and describing pictures; tests for naming; tests for understanding logical and grammatical constructions; comprehension tests (word pairs); auditory speech memory; memorizing a story; motor memory; visual memory; understanding the meaning of the story; understanding the meaning of a plot and a series of plot; analogies.

The diagnostics of the formation of phonemic hearing in preschoolers was carried out according to the method of Arkhipova (2008). The tested system of examination of phonemic hearing included the traditional methods for assessing the speech of children in speech therapy practice. The system was of a test nature, with standardized implementation procedure and the scoring system, which made it possible to identify and determine the severity of phonemic hearing impairment.

In order to distribute respondents by levels of neuropsychological status, we used the method of statistical analysis using the standard deviation formula.

Table 1
Comparative table based on the results of neuropsychological diagnostics

№	Levels	Experimental group (%)	Control group (%)
1	High	25	25
2	Medium	67	67
3	Low	8	8

According to the results of diagnostics of the state of phonemic hearing, the children in control group manifested errors identical to those in the experimental group when performing tasks. We can say that both groups are under same conditions.

Table 2
Comparison of levels of hearing formation in children od experimental and control group

№	Level	Experimental group (%)	Control group (%)
1	Very low	17	17
2	Low	83	83
3	Medium	0	0
4	High	0	0
5	Very high	0	0

For a practical substantiation of the results obtained at the first stage of practical work and confirmation of the conclusions made, we compared the indicators of the control and experimental groups using the Mann Whitney U-test.

As a result of the diagnostic stage of the experiment, we found that the children in both experimental and control groups had a mild deficiency in the mental functioning of all three brain blocks. The results of neuropsychological diagnostics, based on qualitative and quantitative analysis, made it possible to identify in children strong and weak links which need to be formed. In children of the experimental group, the weakest links include: poor concentration of attention, impulsivity in all activities, decreased mental performance, insufficient formation of interhemispheric interaction, insufficient formation of speech and intellectual functions. But also, we identified strong links we can rely on when organizing corrective work: visual perception, auditory-speech memory, spatial representations.

When assessing the results of examining phonemic hearing in children, it was revealed that children have low ability to analyze and synthesize speech sounds, as well as a low ability to navigate in non-speech sounds. This means that phonemic hearing in children is insufficiently developed, i.e. the ability to distinguish between phonemes. For the majority of respondents, phonemic hearing

is impaired primarily. In case of primary impairment of phonemic hearing, the prerequisites for mastering sound analysis and the level of formation of the action of sound analysis are lower than in the case of secondary hearing. The results of the examination of phonemic hearing differ in three indicators: recognition of non-speech sounds, distinction of pitch, strength and timbre of a voice, distinction of words that are similar in sound composition. We reduced the deficiency of sound pronunciation of children in experimental group to the following characteristic manifestations:

a. replacing sounds with simpler ones in articulation, for example: sounds *s* and *sh* are replaced by the sound *f*;
b. the presence of diffuse articulation of sounds, replacing a whole group of sounds;
c. unstable use of sounds in various forms of speech;
d. distorted pronunciation of one or more sounds.

In children with phonetic-phonemic underdevelopment, it was revealed that the level of formation of sound pronunciation depend of the state of phonemic hearing. However, there was not always an exact correspondence between pronunciation and sound perception. Thus, for example, a child could make distorted pronounciation of 2-4 sounds, and could not distinguish a larger number of sounds by hearing, moreover, from different groups of sounds. The relative well-being of sound pronunciation could mask a deep underdevelopment of phonemic processes. In such cases, only the use of specialized tasks revealed a complex pathology.

Analysis of the results of the diagnostic stage of the experiment made it possible to draw the following conclusions:

1. In the children of the experimental group, a mild deficiency of the mental functioning of all three brain blocks was revealed.
2. Children with phonetic and phonemic underdevelopment have a low ability to analyze and synthesize speech sounds, a low ability to navigate in non-speech sounds.
3. Children with phonetic-phonemic underdevelopment have insufficiently developed phonemic hearing, i.e. the ability to distinguish between phonemes or meaningful language units.
4. Children of the control group had the same indicators of mental functioning deficiency of three brain blocks and the level of formation of phonemic hearing, as the experimental group.
5. The average scores of children in the control group did not have significant differences in comparison with the indicators of children in the experimental group.

Based on the processing of the results of neuropsychological diagnostics, we found that the majority of the respondents in the experimental and control groups were dominated by errors in increasing the latency period for entering the task and the manifestation of impulsivity with self-correction or by attracting attention of an adult to the correctness of the task. In this regard, it can be assumed that the morphological structure of disorders is characterized by deficiency of all three functional blocks of the brain according to A.R. Luria (1997). This formed the basis for the next stage in the development of phonemic perception and sound analysis in this category of children.

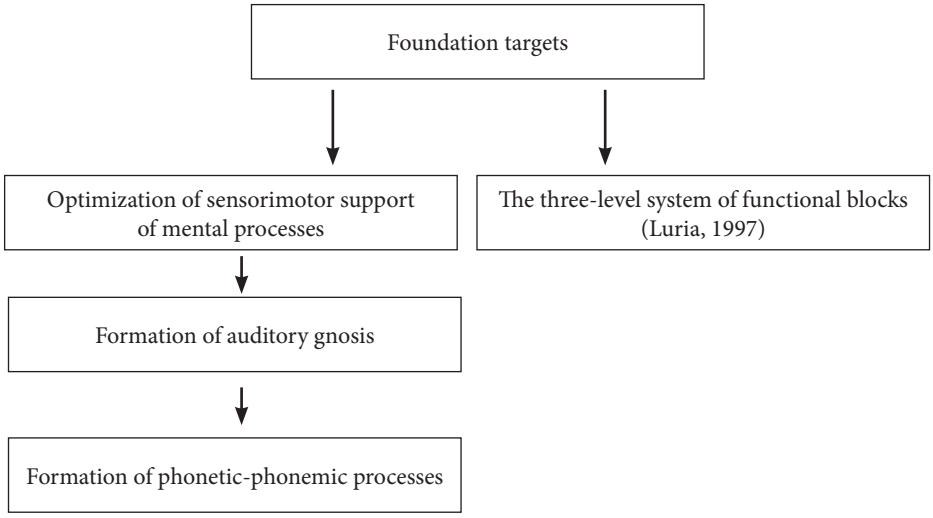
II experimental stage - correction

The methodological basis of the correctional stage of the study was the method of “substitutional ontogenesis” by A.V. Semenovich, which prepresents a neuropsychological diagnostics, containing a complex of phases (diagnostics-prevention-correction-habilitation-prognosis) of psychological and pedagogical support of children with different types of development: from normal and deviating to gross forms of pathological development (Semenovich, 2004; 2017).

The selection of playing techniques is based on the patterns of formation of phonetic-phonological competence in ontogenesis, hierarchically progressive potential from subcortical to cortical structures and from primary to secondary and tertiary structures of functional systems of phonetic-phonemic gnosis and praxis. The content and selection of plays was carried out on the basis of understanding speech and non-speech sounds, based on the work of other analyzers participating in the functional system of phonemic perception with retrospective reproduction of those areas of ontogenetic development of phonemic perception that, for one reason or another, are functionally immature.

The phases of correctional work involved the following components, united by a single play plot:

1. Optimization of sensorimotor support of mental processes:
   - breathing exercises;
   - massage and self-massage;
   - work with muscular dystonia, pathological rigid attitudes towards body and synkinesis;
   - formation and correction of basic sensorimotor (simultaneous and reciprocal) interactions;
   - formation of attention skills and overcoming stereotypes.
2. Formation of auditory gnosis.
3. Formation of phonetic-phonemic processes



Picture 1 *The Schema of Centric Correction Model*

We have developed a correctional program for overcoming disorders in children with phonetic-phonemic disorders, which includes plays with a neuropsychological component. Our correction program includes three blocks:

1. Stabilization and activation of the body's energy potential:

- breathing exercises;
- massage and self-massage;
- stretching and relaxation;
- expansion of the sensorimotor repertoire;
- formation and correction of basic sensorimotor, reciprocal interactions.

2. Formation of operational support for verbal and non-verbal mental processes that regulate the gnostic and praxical components of these processes:

- somatognostic, tactile and kinesthetic processes;
- visual gnosis;
- spatial and "quasi-space" representations;
- kinetic processes;
- auditory gnosis and phonetic-phonemic processes;
- visual memory;
- auditory speech memory;
- nominative processes.

3. Formation of the meaning function of mental processes and voluntary self-regulation:

- communication skills;
- causal relationships, sequence;
- synesthesia;

As shown by the results of the study, children with phonetic-phonemic disorders are observed to have poorly formed optical-spatial representations, reciprocal coordination, impaired visual gnosis and auditory-motor coordination. Based on this, a complex correction is required to eliminate these disorders. Timely and personality-oriented influence on the impaired links of the speech function will allow the child to return to the ontogenetic developmen path.

II experimental stage - control

Comparing the samples after the correctional work, were observed positive shifts in both groups, but significant results in both groups were the indicators of the test for copying figures, tests for naming (according to the results of examination of auditory-speech memory), motor memory and the allocation of analogies. In the children of the experimental group, significant shifts were observed in such criteria as the reproduction of rhythmic structures, the test results for acoustic gnosis improved, the prosody was improved, the children's speech became more detailed with more pronouns and adjectives in the active speech of children, which shows significant shifts in the study of spontaneous speech, also there were improvements in understanding of logical and grammatical constructions, understanding the meaning of a story plot and a series of plot. Indicators of the state of auditory-speech memory and mnestic sphere improved, this was manifested in motor memory and memorization of a story, and also deficiency in intellectual and speech functions decreased.

Graph 1 *Comparison of state of phonemic hearing in children from the experimental (EG) and control group (CG) at the control stage of the experiment*

To determine the indicators of the effectiveness of correctional work and to identify statistically significant differences, the Wilcoxon sign rank test was used.

Table 3
The results of Wilcoxon sign rank test

№	Evaluation criteria	Experimental group		Control group	
		level of significance	shift	level of significance	shift
1	recognition of non-speech sounds	-2.762	0.0057	-2.646	0.0082
2	distinction of pitch, strength and timbre of a voice	-2.810	0.0050	-3.051	0.0023
3	distinction of words that are similar in sound composition	-2.646	0.0082	-2.646	0.0082
4	differentiation of syllables	0.0082	0.0011	-2.887	0.0039
5	differentiation of phonemes	-3.276	0.0011	-2.972	0.0030
6	elemental sound analysis skills	-3.127	0.0018	-2.810	0.0050

DISCUSSION AND CONCLUSION

The analysis of the results showed that the inclusion of an integrated approach using various types of plays contributes to the successful development of phonemic perception and sound analysis in senior preschoolers. As a result of experimental studies, the effectiveness of structural and functional changes in phonemic perception was revealed. Changes occurred in both groups, however, in the experimental group, the set of parameters of neuropsychological status was much wider and qualitatively internally differentiated in the functional structure of phonemic perception. The morphological structure of the second functional block of the brain according to Luria (1997) has significantly improved. Indicators of the state of auditory-speech memory and the indicators of the mnestic sphere improved, this was manifested in motor memory and memorization of a story; also the deficits in intellectual and speech functions and reciprocal coordination decreased. These changes speak about a qualitative shift in intrasystem and intersystem connections and the elimination of the weakness and immaturity of previously identified violations of phonemic perception.

The use of play methods based on the patterns of development of the leading type of activity at a given age and the spontaneous emotional-positive play

plots, allowing to maintain activity goals, control behavior and actions, increase the quality of corrective actions when working with senior preschoolers with phonetic and phonetic underdevelopment due to activation of structural and morphological previously immature cortical and subcortical structures of the brain in this category of children. Thus, the importance of play as a leading, comprehensively developing type of activity for preschoolers makes it possible to widely use play techniques in the practice of speech therapy. This brings play to the fore among various methods in corrective work.

The play, as a method of corrective speech therapy, has undergone a practical test, which has confirmed its effectiveness. This indicates that the hypothesis of our research has been confirmed, the goal and objectives set for the research have been achieved. The empirical study of the development of phonemic perception and sound analysis through plays in senior preschoolers with phonetic-phonemic underdevelopment has shown its importance and effectiveness and will help both parents, speech therapists, and kindergarten teachers.

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RAZVOJ FONEMATIČKE PERCEPCIJE I ANALIZA ZVUKA KROZ IGRU U STARIJIM PREDŠKOLCIMA SA FONETIČKO-FONEMATSKIM RAZVOJEM

Sažetak: U radu se govori o pitanjima relevantnim za savremenu logopedsku terapiju razvoja fonemske percepcije i analize zvuka kroz igru kod starijih predškolaca sa fonetsko-fonemskom nedorazvijenošću. Prikazana je analiza teorijskih i metodoloških pristupa u proučavanju ovog problema u logopediji. Razmatrane su osobine izgovornog aspekta govora kod dece sa fonetsko-fonemskom nedorazvijenošću. Ističe se da važno mesto u korektivnom radu sa decom sa fonetično-fonemskim nerazvijenim govorom zauzimaju igre i tehnike igara, kao osnovne metode u vodećoj vrsti aktivnosti u ontogenezi ove starosne grupe. Upotreba igara i njihovih tehnika u radu sa decom sa fonetičko-fonemskim nerazvijenim govorom kao raznolikost manifestuje se u opštosti vodećih mentalnih procesa koji leže u njihovoj osnovi. Koristili smo analitičke metode proučavanja fonetskih i fonemskih procesa kod starijih predškolaca, logopedske literature i metodologije vezane za teme istraživanja, metode visoke formacije - neuropsihološku dijagnostiku predškolske dece Ž.M. Glozman, A.E. Soboljeve, A.J. Potanine, metoda fonemskog pregleda sluha E.F.Arhipove, metoda „supstitucione ontogeneze” A.V. Semenovich; kao i metode statističke obrade podataka - Mann-Whitney U-test i test rangova Vilkoksona. Rezultati empirijskog istraživanja pokazali su pozitivne pomake u dinamici formiranja fonetsko-fonemske percepcije, naime poboljšala se reprodukcija ritmičkih struktura, poboljšali rezultati testova za akustičnu gnozu, kao i prozodija, govor dece je postao detaljniji sa više zamenica i prideva u aktivnom govoru, što pokazuje značajne pomake u proučavanju spontanog govora; poboljšalo se razumevanje logičkih i gramatičkih struktura, takođe se poboljšalo razumevanje značenja radnje i niza radnji. Poboljšali su se pokazatelji stanja slušno-govornog pamćenja i mnestičke sfere, što se manifestovalo u motoričkom pamćenju i pamćenju priče, a takođe se smanjio nedostatak intelektualnih i govornih funkcija.

Ključne reči: logopedija, fonetsko-fonemski poremećaj, tehnike igre

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FAMILY AND ADDICTION – WHY IT TAKES SO LONG?

Abstract: Aim of this paper is to present various pathological entitities of addiction diseases, prevalence, bi-drectional interaction of an addiction and family. Today, addictions are a global phenomenon, the group of the most frequent contemporary diseases. Data show that 3% to 5% of the world population is addicted to alcohol, and 1% to 3% bring about the criteria for a gambling addiction. Either we talk about psychoactive substance abuse or some kind of activity, addictional behaviour in each family member and a family as a whole is recognizable. In a complex relationship of an addiction and a family there is a mutual entunement of the two entities, which are reproducing themselves and transmit to next generation. Accordingly, introductory part of this paper gives the basic data on addiction diseases (alcoholism and gambling), their distribution in the world and in Serbia, and the most frequent issues when family asks for help. Second part is concerned with processes which family endure, changes in family members and ways in which family reacts to addiction problem. Due to differences in the development of an addiction and a burden of consequences, families with partner adddiction and familes with young adult addicts are addressed separately. The third part of the paper is concerned with the most frequent methods and techniques in practice of a social worker with addiction families.

***Keywords**:* alcoholism, gambling, family, social work

ADDICTION DISEASES IN GENERAL

Addiction is a form of excessive attachment stemming from psychological or biological need, which causes various health, family, professional and social effects. First step of entering the addiction is personal choice, but, when addiction is developed, behaviour control is lost, with consequences to the health of a person – there is no more „choice” but urgent need only. Final aim of occupied

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consciousness is – pleasure, „here and now" (Welte, Barnes, Wieczorek, Tidwell, & Parker, 2001).

Division to chemical and non-chemical addiction is represented in majority of papers. In the first group are addictions to psychoactive substances, which alter the consciousness, thinking, mood, behaviour. Among them are tobacco, alcohol, sedation drugs and other substances. Non-chemical addictions comprehend addictions to gambling, betting, internet, video-games, cell phones.

Alcoholism is one of the mostly spread addiction diseases, where alcohol is most ubiquitous and the most achievable psychoactive substance, with socialy accepted abuse (legalized, controlled and taxed). It counts as a social-medical disease, due to great impact of social environment in the beginning of disease, as well as of consequences – behaviour disturbances and functioning in work and environment of the affected individual. In domestic literature, apart from WHO definition, Gacic definition is mostly employed (1988): „Every repetitive drinking, no matter of quantity and frequency, which causes certain problems and difficulties (health and/or social), is a sign of a alcoholism which demand professional help."

Gambling represent a cluster of games of chance, activities and behaviours, where player risk money expecting to retrieve or multiply initial investment. Pathological gambling is most studied bihevioural addiction which give insight to relationship between bihevioural addctions and psychoactive substances addiction. It is characterized by stubborn continuance of gambling, no matter the losses, impoverishing and serious social and legal problems, as well as disturbed familial and personal life. (Đukanović & Tasić, 2015)

Both addictions start and are represented mostly in the period of adolescence and young adulthood. No matter of the type of addiction, common feature which is recognizable is addictional behaviour. Addictional behaviour is characterized by:

- continuous engagement in a certain activity, in spite of awareness of its negative consequences;
- permanent wish and need to perform certain activity; one or more attempts to stop, lessen or control certain behavior which became addiction;
- consuming more and more time in performing certain activity, planning or recovering of consequences of this activity;
- absorbedness by activity which became an addiction and by preparations to accomplish it;
- neglecting responsibilities such as work, school or family;
- isolating from family and friends, in order to peform such activity without their knowledge;
- increasing frequency and intensity of engaging in such activity, in order to achieve the same effect;

- emergence of very unpleasant physical and psychical symptoms (restlessness, irritation, insomnia, headache, loss of appetite) after activity which became addicitive is performed. (Atkinson, Glaser & Weigle, 2018; Hammond, 2018)

ALCOHOLISM

WHO estimates that worldwide approximately 2 billion of people consume alcoholic beverages, approximately 76,3 millions are diagnosed with abuse or addiction to alcohol (WHO, 2004). Addiction to alcohol affect small but relevant part of adult population (3-5% in developed countries), and risky and harmful drinking affect much bigger percentage of general adult population (15-40%) (Babor & Higgins-Biddle, 2001). Alcohol is a fifth risc factor for disease and incapability in the world. 55 million Europeans consume alcohol on daily basis in dangerous quantities. Approximately 118 million Europeans drink to the phase of stupor, at least once a month. 23 milion Europeans – 5% of adult man and 1% of adult women are addicted to alcohol (Anderson & Blumberg, 2006; WHO, 2006).

Based on epidemiological research a higher prevalence of alcoholism is established in industrialy developed environments (which is the resultt of socio-economic factors). Alcoholics, in average, took their first drink between 13 and 15 years, and first alcoholic intoxication is experienced between 15th and 17th year. Every tenth treated alcoholic is younger than 30 (10%) (Popović, 2015).

Prevalence of alcoholism in different age groups, according to *Substance abuse and mental health services administration* (SAMHSA): 18–24: men 25%, women 14%; 25–34: men 24%, women 14.75%; 35–44.: men 20.50%, women 8.50%; 45–55: men 17.50%, women 6,50% and 55+: men 9%, women 2,25% (SAMSHA, 2014).

Drinking of alcohol in Serbia is socialy acceptable behaviour characterized by high incidence of consumption, in youth especially, since it is frequently treated as a part of tradition, custom and culture. It became almost normal in last few years to drink a lot every time when going out.

In the WHO report for 2014, Serbia is at 12th position in alcohol consumption in Europe (total pure ethanol per capita/l) (WHO, 2014). ESPAD Research on various forms of behaviour in youth (consumption of nicotine, drugs and alcohol in 15 years old children and risk behaviours in their close environment) finds that tendency to drink alcohol in Serbia too is moving to younger age (ESPAD, 2012).

National research on life styles of Serbian citizens in 2014, conveyed by Institute for Public Health of Serbia „Dr Milan Jovanović Batut”, section regrding psychoactive substance consmption and engaging in games of chance, shows that Serbian citizens, generally, don’t experience alcohol as a problem bigger than other

societal problems. As much as 64% population regards violence and aggression in society as a remarkable problem, when the alcohol consumption is at the 7th place (Kilibarda, Mravčik, Sieroslavski, Gudelj Rakić, & Sebastian Martens, 2014).

According to Krstić (2018), in 2013. in Serbia 53,9% of population consumed alcohol (ocasionaly or every day), approximately 50% of young is drinking sporadicaly, 20% were intoxicated from time to time, and 7% are regular drinkers. The biggest percentage of alcohol consumers are 25–34 old (66%). In average, first drunkedness in Serbia is experienced at age of 13,5 years, and the latest in 20th year. Signs of addiction are evident, in average, at 21, and young people come to treatment between 25th and 27th year. In Belgrade, almost half of treated alcoholics are younger than 30 years.

A special risk is excessive drinking (more than six alcoholic beverages) at one ocacion (binge drinking) registered in Serbia too, in general population as well as in adolescents. Such habit has, at least once a week, 4,3% of Serbia citizens (7,8% men and 1% women), with greatest incidence in age grup 25–34 years (5,4%). At least once a month excessive drinking is registered in 27% men and 6% women, 16% of total population, which is percentage, according to available WHO data, higher than in most surrounding countries (Krstić, 2018).

ALCOHILSM IN WOMEN

Changes in societal role of women in last years made impact to sex differences in addiction diseases. Prevalence of addiction diseases related to male-female distribution is significantly lower, in two directions. First: onset of the disease (first contact, problematic drinking, problematic gambling) is detected in earlier age. Second: addiction trend of women regarding alcohol is more dramatic than in men: not only that women aproach to disease earlier but addiction is getting more progressive. Earlier estimations of 8:1 and 4:1 are now 3:1 or even 2:1 (Krstić, 2018).

According to some authors, number of women alcoholics is much bigger in countries with better life standard and their more favourable societal status. Others regard that the numbers are equaly distributed in almost all socio-cultural environments. Current research shows that alcoholism is frequent in women of all professions and societal status, of „solo drinking" type, which mean that women are eager to hide the habit even from their closest friends and family members.

Normaly, women begin drinking somewhat later than men. Concequences of alcoholism are more severe and more complex in women than in men. Data show that most women start to get drunk at age of 31 to 40 years, then in age cluster of 21 to 30 years. It is pretty obvious that it is the time when majority of women starts family life, gives birth and have children, resolving her other existential issues. It is considered that the alcoholism in women is most prevalent in Great

Britain (in three men there is one women alcoholic), in Norway (5:1), Germany (5:1), USA (5:1), France (6:1), Canada (6:1) etc. (Panoski, Nastasić, Lažetić, & Filipović, 2006).

GAMBLING

Gambling is umbrella name for all games of chance where investment of money is included, with risk and hope for positive outcome (gamer will get what is invested, or more than that) (Koić, Filaković, Đorđević, & Nađ, 2009). Gambling addiction is a consequence of usual gambling activity which take years, when activity from problematic gambling move to pathological one. Gambling itself is not a pathology.

To define it as a pathological, incapability to control the impulse is necessary, overwhelming thinking of gambling – gambling is getting a priority compared to other life domains (family, friends, school, work, hobbies), increased tolerance – stakes are becoming bigger in time, to achieve enough adrenaline to content an addict. It is estimated that approximately 1-3% of population fulfill medical criteria for pathological gambling, but these estimates are based too on „estimate of an authority", not on clear data. Confusion in this area is best explained maybe by the fact that estimations vary from 0,1 to as far as 10% population which are subject to diagnose of pathological or problematic gambling.

According to research of Pasternak and Fleming (1999), pathological gambling usualy begin in early adolescence in men and later in life in women. Adolescents are at risk due to natural development and growing up issues, followed by curiosity and challenging their borders. In age group from 17 to 35 years man are represented with 28%, and women with 10%. Gamblers are most visible in age goup from 35 to 45 years (54-58%), whereas in group from 55 to 65 years men are represented by 16%, and women in 18% cases. Two to four percent of gamblers are in age group older than 65 years.

Research in several countries have shown that availability and easy access to gambling cause bigger number of gamblers with problems. Although that relation is not necessarily proportional, expansion of gambling is a significant risk to public health which need attention (Griffiths, 2004). In most cases, this addictin begin in adolescence and in young adulthood. In male gamblers more frequent social isolation is registered, comparing to female gamblers.

GAMBLING IN WOMEN

In last few years, like with alcohol and substance abuse, there is obvious growth of figures in female pathological gambling. According to various research, ratio is 2:1, 4:1, 7:1 in favour of men. Research in female gambling is scarce and

often with nonconcordant results (Afifi, Cox, Martens, Sareen, & Enns, 2010; Stark, Zahlan, Albanese, & Tepperman, 2012). For example, just a few women joined to *Gamblers Anonimous*, which can lead to conclusion that there are less women who suffer from compulsive gambling. In fact, it is a problem of social stigmatization only which is much stronger for female gambler than for male. Women are one third of total number of gamblers, but they attend treatment programs only in 2-4%, comparing to men (Li, 2007).

Research of Potenza, Steinberg, McLaughlin, Wu, Rounsaville, O'Malley (2001) show that female are represented by 2-8% of members of *Gambling Anonymous of New Jersey* in treatment program of gamblers, and on hotline for help are 30% calls from women. Women are engaged mostly in lottery, loto, bingo and slot machines. They begin later than man with gambling, but ask for treatment in the same age, mostly between 30 and 49 years. Equal number is of married and with children, or free women, with high or higher level of education. Men are gambling for money and competition, while women begin later, but their gambling is maximum time consuming.

Strachan and Custer (1993) regard that in primary families of female gamblers we more often see feelings of contempt, rejection or loneliness, especially from mother who was significantly dominant, cold, cruel, punishing, perfectionst, aimed to material values, or extremely week personalities, inefficient, not prone to protect children from their father. Number of women gamblers has bad experience with father, including rape. Women are more prone to self-accusation due to gambling and have distorted picture of themselves, comparing to men. In fact, by means of their own behaviour they achieve again a position of contempted, lonely and rejected person. Female gamblers are frequently prone to distorted thought, fortune-telling, superstition, horoscopes and predictions for future, beliving that they have mystic powers (Piquette & Stevens, 2012). Such a cognitive distortion is frequent in general population of gamblers, mostly in form of unfunded optimism, feelings of exagerated trust, or power, or control (Hodgins, el-Guebaly, Casey, Schopflocher, Smith, Williams, & Wood, 2010). Typical female gambler is identified between 30 and 49 years, she is married, with children, with high school, mostly engaging in video-poker games (Martins, Lobo, Tavares, & Gentil, 2002).

After Bosnia and Herzegovina, Serbia is country with highest number of gambling and gaming houses per capita in Europe. From 2007 there is officially first female casino in Novi Sad, where men are banned (Marković, 2008).

IMPACT OF ADDICTION DISEASE TO FAMILY

Complexity of approach to the family with addiction could be sensed from the fact that a great number of families who suffer from addiction of their member/s, in spite of crises, stays together in years. There is strong relation of addiction

and family, with fine tuning of the two entities all the time, while they continue to reproduce and tranfer themselves through generations.

Addiction diseases have direct or indirect impact to all phases of a life cycle of a person and the family, disabling functioning in personal, familial, professional and social sphere. These families are characterized by various shortfalls. There is no togetherness, support, cooperation and consent of family members in all spheres of family life, family roles and relationships are distorted, communication is one- sided or became „laying the blame to others and sacrifice”, and verbal and physical conflicts are not rare (Filipović, 2010).

Communication is burdened by establishing a favourable relation to the reality – in one hand, and in the other – explaining the reality of the addict. Communication in family with addiction is characterized by impersonality, incompleteness, vagueness, indistinctions, ambiguity and rejecting the resposibility for what is said. Usualy, every communication is to convince an alcoholic/gambler to quit addiction, but it is with low effect and qualified as „nagging” and persecution. Communication of this sort in the family causes altered and confused family roles, lacking clear and stout concept of meaning and performance, they are converted and one family member plays more than one roles (Filipović, 2010). For children, this is a wrong model of family-marriage models with contort hierarchy and inadequately establish parents' authority.

Family life with addiction is characterized by emotional relations oscilating between extreme love and extreme hatred. What is most remarkable and what family members complain to is lack of closeness and feeling of „emptiness”. Family with a addict member dont have neither clear orientation of values nor healthy life philosophy. System of values is distorted, and different in both partners, i.e. they are „two worlds”. Family members does not have common interests, do not spend time together and they are lonely; social contacts are severely lessen, even those with the closest relatives and friends (Filipović, 2010).

There is no agreement or planning in familly regarding finances. There is no common family budget, partners are hiding money from each other and live from day to day. Addicts, by rule, save a portion of salary for alcohol or gambling. In gamblers money often disapers from home or from bank account, there are frequent loans from other family members, unpaid bills are heaping or calls from bank or people whom they owe money. When a gambler does have money it is not sure how wil she/he use it – by paying debts or by investing money in gambling again, hoping for better outcome. Addict frequently have one more job but additional paychecks are not visible, he/she is all the time complaining to lack of money. Financial relations are one more training ground for marital conflicts.

In these families all forms of violence are more rule than exception. Due to intensive anger and stress, as well as to lower tolerance to frustration, verbal or physical aggresion of an addict ocures. Victims of abuse are mostly partners,

parents, ex-partners and children (41). According to Filipović (2007) 70% husbands are drunk in abuse situation; children are in 90% cases present in family abuse situation. Studies show that it is 10,5 times more probable that women, if their partner has a gambling problem, will be victim of partners' abuse than women with partner who does not have gambling problem. Surge of gambling houses in cities caused child abuse and course language surge of 42%, respectively 80%, due to increase of gambling practices (Balci & Ayranci, 2005). Research with 144 families with pathological gambler show that 50% of family members were physicaly and verbaly abused and 12% of them attempted suicide (Koić, 2009).

In families with addiction obvious readiness or proneness of their members to reorganize their behaviour is obvious, so that such behviour become, in fact, adapted to addicts' needs.

In the beginning of family adaptation (*Denial phase*), partners are not capable to clearly differentiate drinking/gambling problem of other problems which are present too. Social comparissons are visible in both partners: alcohol abuse/gambling does not seem so explicit comparing to other persons whom the family perceive as problematic ones. In this way drinking/gambling are justified and explaines as ocasional incidents and illusion of a perfect family is pertained in outer world. Consequeces of addiction of alcoholic/gambler for family are still not very visible and threatening, and drinking/gambling continues.

In the next phase, *Attempts to eliminate the problem*, addiction consequences are clearly visible. This phase is characterized by unsucessful efforts to control problematic behaviour – talking, arguing, fights, hiding and spilling of alcohol, disruption of communication in times, paying back gambling debts, blackmailing by leave or divorce, asking help from wider family, treaths... There are „sober" periods of alcoholic and discontinuations of gambling, in the liking of idillic farce, serving to overcome previous behaviour as well as to prepare the grounds, making excuses and „alibi" to drink/gamble again. In situations where family member get lucky in gambling, he/she brings family to expensive restaurants, buys gifts, jewelry and convince them that it is possible to win the game. As much as this idyllic period is pleasant, even when it is longlasting, it is more probable that next period will be more difficult, more unpleasant, with much sorrow, fear and aggression. Insomuch an addict is more successful in making of these plastic idyllas, traumatic effect of preiod after is more difficult. Family feels responsible, tries to help although it does not believe any more to promises and, from the past experience, there is no much hope. Conflict are unremitting and escalating, and children often became witnesses of aggression of parents and their impulsive reactions when tying to solve problems. There are still unsucessful tries to cover up the situation from wider family, neighbours and at workplace; tendency of „hiding" is characteristic to wives especially, who in these periods take over responsibilities and roles which husband does not fulfil. Consequences of drinking/gambling step by step cause isolation of family in social environment.

Disorganization of family – in this phase drinking/gambling is certain and foreseeable way of life, i.e. addiction become central developmental core or central developmental principle. Consequences of addiction are bluntly manifest in every sphere of life. Family is emotionaly and financialy exhausted. Disorganisation is obvious and family is divided to wife who seize children to her side, and wider family circle and addict, from whom family still demand full responsibility for his behaviour and deeds.

Phase is characterized by resolve and decidedness of wife, in spite of the problem, to „take over" family (in literature, phase is nicknamed „matriarchy", Gačić, 1988), combining role of mother and father and, with other family members, put an addict in complete „isolation" (*outsider* position). By suach a disbalance relative stability is achieved, with attempt to minimize inflence of addiction; family begin to live its „paralel life" with addict, which can take years, with or without tendency of official separation.

Familial abyss or Collective abyss – fighting with chronical stress and neglecting their own needs, almost every family member is burned-out, when they don't have any more strength and energy to fight future problems. In his phase final dissolution of family is often – separation of wife with children, or asking for a professional help. According to statistics, divorces in alcoholic families are 7 times more often than in non-alcoholic (Begić, Jukić, & Medved, 2015; Torre, 2015). According to data from Gerstein, Volberg, Toce, Harwood, Johnson, Buie, Sinclair (1999), divorce is imminent in 65% marriages where one partner gambles, whereas in The National Gambling Impact Study (2009) percentage is slightly lower, 53.5%.

PARTNERS' RELATIONS IN MARRIAGE WITH AN ADDICT

In Serbia there is a high percentage of divorce only if women are addicts, not in cases when addicts are men. Continuance of marriage, in spite of various problems, persists due to economical dependency of woman, to traditional attitude towards need to maintain the family, at any cost, but also to „gains" achieved in dependant marital relationship. When gain is understood as a way to realise and keep the power, i. e. achieve sacrificial micro-matriarchate (Blagojević, 1997), we are comming around the psychological and psychiatric to sociological field. „Gain" of women in dependant partnership (Svetozarević, 2013) means belief that her husband cannot live without her because she takes care of him and children, and his parents, takes care of household, earns. That is the reason why everyone address to her and expect her to help in solving problems.

When it comes to wifes of addicts, there is literature confirming that they often have self-degrading beliefs, they are prone to seclusion from social contacts

to the point of social isolation, they develop a permanent experience of exhaustion and manifest various forms of psychological and somatic diseases and disorders. Wife often take over role of both parents accompanied by related responsibilities. Overengagement result in inconsistency of her behavioural patterns, oversized demands, often with neglect of children. This victimized position of wife is subject of denial too in some studies. They regard that wives often have their own bagagge in marriage with an addict – personal psychopathology – often related to their primary family and certain psychical problems (Svetozarević, 2013).

In attempt to solve drinking problems, wives are in various roles. Whalen (1953) gives distribution to four types of wives of an alcoholic, which help to seize a picturesque image of possible forms of their behaviour and relationships with alcoholic husband. These are: sufferer-martyr (experiences herself as a victim), totterer (between love and rejection – changeable tolerance to drinking), controler (upper hand in marriage) i „moralist" (applying various punitive measures but never takes marriage in question).

Wifes of gamblers rarely leave their husbands too, although family dynamics and existence are severely jeopardized. It is especially expressed when they are dependant from husband. Dominant emotions are anger, severe fear and anxiety, as well as betrayal.

Husbands of female drinkers, in great percentage, ignore the problem. Literature mention husbands whose wives drank before marriage too, husbands significantly older then wives and husbands with rigid, secluded behaviour. There is no data on husbands of female gamblers. Common to these couples is that adjustment to an addiction is much shorter and they in early phase ask for treatment. Majority is more likely to divorce than to ask for tretment.

CHILDREN IN ADDICTIVE FAMILIES

Children are affected by addiction most severely, most numerous and in most unpredictable ways. Children in familieas with addiction grow up usualy lonely, often taking over role of „parent" to their parents, participate in familial chaos, protect mother or express unusual behaviour to divert attention from father (Eckenrode, Powers, & Garbarino, 1997).

Children are faced to very unstable atmosphere in family, inadequate roles and unacceptable bahaviour, emotinal neglect, fear of stigma which follows addiction, fear of rejection in their peer group (McCrady & Epstein, 1996). 80% of attemped suicides in adolescents are commited by children from an alcoholic family; low level of self-esteem, feeling of inadequacy, inferiority (Filipović, 2010), insecureness, stereotypias, experiencing family as incomplete, her/himself as not loved, keeper of a family secrets, with weaker social contacts (Cowlishaw, Suomi, & Rodgers, 2016; Darbyshire, Oster, & Carrig, 2001).

Black C. (1982) and Wegscheider-Cruse S. (1985) describe behaviour of children from alcoholic family by „roles” they necessary choose, trying to fit in alcoholic family. These are: Family Hero, „White Knight”; Black Sheep, Looser, Black Knight; Scapegoat, Lost Child, „Regular Culprit” and Family Fool.

Accomodation of family to addiction, disfunctionality and changed roles and relationships child accept later as a permanent behavioural model and transgenerationaly convey it to their children (Cox, Janssen, Lopez-Vergara, Barnett, & Jackson, 2018; McComb & Sabiston, 2010).

FAMILY WITH YOUNG ADDICT

Young adullts are in risk due to nature of development and growing up itself, followed by curiosity and probing their limits. They are characterized by hedonism, wish to experiment and to be in the group of peers, by curiosity, rebellious towards authority and tradition, all of which is without firmly established values and healthy life style patterns. Therefore, adolescents are population most vulnerable to all forms of risk behaviour and acceptance of new challenges (Beaver, Hoffman, Shields, Vaughn, DeLisi, & Wright, 2010; Williams, Smith, Gotman, Sabri, An, & Hall, 2008).

Adolescents and young adults differ from adults in level of emotional and intelectual maturity, and their awareness of their behaviour and responsibility for this behaviour in this period of life is lesser than in adulthood. Insufficiently developed personality makes young adult vulnerable and prone to influences which could direct his/her developmment to negative behaviour.

ALCOHOLISM IN YOUNG ADULTS

It is estimated that alcohol consumption among young adults in the world is twice bigger than in generation of their parents (Hingson, Heeren, & Winter, 2006). Alcohol is in European youth the most frequent cause of premature deaths and morbidity. Intoxication is for young people important risk factor of casual and deliberate injuries (Kuntsche & Gmel, 2013).

Alcoholism of young people is certainly specific in relation to alcoholism of adults. In great number of young adults almost every drinking episode is oversized, followed by intoxication and excessive behaviour. Parties are frequently organized for that exact reason. Weekend intoxications, which became new „must have”, are frequently organized in parks, school-yards, parking lots of shopping malls, and in vicinity of night clubs. Intoxications occure late in the night, and last through night. (Jackson, Roberts, Colby, Barnett, Abar, & Merrill, 2014)

Drinking is most frequently competitive – who can drink more. Lately, most popular is to combine several types of alcoholic beverages or combine

alcohol and other psychoactive substances. Oversized drinking is often connected with aggressive and violent behaviour, involvement in risk sexual relations and various criminal activities (thefts, fights, etc.). Alcohol is a frequent cause of driving accidents in young people. Young adult offers various „causes" for drinking: alcohol relaxes them, idleness, belief that everyone drink, easier making friends with others or easier access to the opposite sex. (Jackson et al., 2014) Young adult with alcohol problem is often out of temper, nervous, coarse, with abrupt reactions – which in time causes destructive relationships with family and friends. They are prone to inexplainable mood chaneges, sorrow and lethargy, which are then „cured" by alcohol, making a bad circle of alcoholism, often accompanied by depression.

GAMBLING IN YOUNG ADULTS

Although entrance of minors to gambling places is forbidden, and these places should be at least 200 meters apart from schools, majority of gamblers began to gamble in adolescence, even in elementary school. Gambling houses and betting places, as traditional space for games of chance, are followed by new areas too – the internet.

Research in Serbia in 2017. show that approximately 20% boys in high school every day visit sport betting places, and present number of 45.000 pathological gamblers and those who are at severe risk to became pathological gamblers. According to these data, we are at European average (0,6 to 0,8%) of adult population addicted to roulette, jack-potts, slots-machines, betting... and at world average (0,4-1% of pathologilac gamblers) (Krstić (2018).

Adolescent is most frequently moved to gambling world because of: lack of structure – boredness, plenty of free time, idleness; negativity – depression, bad day at work, anxiety, anger at society; anything that remind gambling and promotes it – advertising, sports on television; when money is achievable – salary, gains, or when it is not acessible – expences, losses (Campbell, Derevensky, Meerkamper, & Cutajar, 2011).

FAMILIES WITH ADDICTION PROBLEM WITH THEIR ADOLESCENTS

Speaking of perception of the family, various empirical studies report that young adults believe that their parents are not too concerned with their gambling activities. In that sense, we can conclude that presence of certain level of parents' acceptance and tolerance to alcoholism and gambling of children contribulte to the development of addiction in adolescents.

Living with a young addict in family is very difficult, confusing, even scary. Others have to be alert all the time for unpredictable circumstances and urgent

reactions. Unfortunately, more frequently, family members adapt themselves to addiction of their member, learn to live with it, creating a pathological balance of family system. They in many aspects begin to act like an addict, they deny problem, diminish it, find excuses. These ways of accomodation to addiction result in dysfunction and progressive destruction of whole family. While addiction, which is not properly addressed, progress and getting worse.

Families with addiction of their adolescent often are not willing to react to challenge, due to insufficient information, disinformations, familial dysfunctions, enormous tolerance of social environment, possible stigmatization. Parents are often last to learn that their adolescent is addict, not because of successful hiding the fact from them, but because they unconsciously reject to see and admit to themselves what is obvious to every other person, because they find and accept false explanations for what can not be anymore denied and because they deny that one family member addiction has consequences for whole family (Filipović & Milošević, 2019).

Accomodation of family to addicition of an adolescent is going through several phases.

First: *denial of a problem*, when adolescents begin to intoxicate themselves or to gamble. Parents often deny reality, looking for other reasons of changed behaviour of their adolescent, due to fear to recognize real problem, always connected with feeling of parents' guilt and responsibility. These situations are mostly explained by adolescent's immaturity, curiosity, lack of experience in drinking, transient excesses. Finding the tickets from sports betting places is equaled with interest in sports. Parents often accuse „bad company" who persuaded their children into such behaviour. Pleading for youthflness and comparing to their peers, drinking and gambling are seen as a temporary phase in growing up which will pass. Shame and fear of stigmatization keep this denial in place.

Second phase: *pseudo-solutions or stress phase* is characterized by attempts to eliminate problem, when consequences of drinking and gambling are already clearly visible. There are unsuccessful attempts to hide problem from wider family, neighbours and friends; more frequent intoxications and paying back gambling debts, acceptance and believing explatanations of drinking and sudden financial crises, false promises. Trying to understand „reasons", parents accuse the other partner for oversized scrutiny or tolerance in upbringing, and taking to their back responsibilities and erances of addictive child, protecting it from consequences of what he/she does. Parents excuse their absence from school, buying off pawned or buying already sold objects, they buy alcohol to child, protect it from legal consequences, pay back debts, buy vitamines or special food to prevent physical deterioration of an addict, free him/her of chores at home and in other spheres where

addict is not capable any more, buy medications for sleep and calming downd or analgetics to help addict to heal his/her crises. These forms of behaviour in family just prolong addiction period, which makes an illusion in adolescent that his/her behaviour is without consequences.

Third phase – *tiredness* – family finally accept that their adolescent has a problem with addiction and that all previous attempts to help are temporary solutions only, which worsen already stalemate situation. Families in this phase decide to ask for professional help.

SOCIAL WORK WITH FAMILY WITH ADDICTION

Work with family members on motivation for treatment

Addict's family asks for help after (several) years of unsuccessful attempts to solve the problem. Emotionaly exhausted but still in the same household with addict, they often ask for help with an idea that „someone else" should ask for treatment and „force" addict to accept it. „Force" is possible only if there is violence in family, when addict is recommended for treatment based on judical decision. After that mandatory treatment decision (not institutionalization), if it is not conducted, imprisonment follows.

Although belated disclosure and beginning of treatment is often evident, family is still the gereatest motif/ reason of the treatment. There is no way in doing nothing in family and expecting that something miraculous will happen. Addict wil not commence treatment if family supports his/her addictive life style (Orford, Templeton, Velleman, & Copello, 2005).

The essence of councelling process is giving help by listening and communication. Basic goal is to give chance family to help itself. Therefore, councelling is recommended method in social work with families with addiction, before as well as after treatment.

In the beginning of work with family, education of family members on alcoholism and gambling is necessary. Sometimes, deluded by way of drinking or gambling, abstinency periods, family members believe that addiction will somehow vanish. Family members need to understand it is a disease and that addictt need a professional help. This is also way to help family in destigmatization.

Social worker often begin with encouraging family members to communicate. Sometimes, they don't talk to each other for months. Social worker act as a neutral, third party, helping family membes to share their fears, conccerns or disillusionments. This time in a new way, without blaming each other. Talking with family, social worker help them to undersand conflicts and that each family member recognize his/her role in lasting addiction. Putting an addiction in

a family ontext, family members can be directed to more constructive ways of problem solving (Daley & Feit, 2013).

It should be mentioned that in the family of an addict, except for this basic problem, there are many others. These problems may stem from addictions, but to solve these is more urgent. Social worker, in the course of councelling, helps family to selve these problems too.

Working with family, social worker counts to healthy parts of family members and family as a whole. When whole family is empowered sufficiently, solving of addiction problem is possible.

Pressure on family for treatment of an addiction implies that social worker present to family various treatments and need for collaboration of whole family. If that is not possibe due to familial decision for marital therapy only, family members should be directed, depending on their needs, to individual treatments (Rogers, 2013).

Addiction disease treatment

Family psychotherapy sees family as a whole, greater that total of their members. Change in one family member affect others, which cause changes in whole family system. Family psychotherapy does not deem one family member a problem, or that problem is in him/her, but in relatioships and interactions in family. That's why family psychotherapy is form of psychological councelling oriented to solve problems in interpersonal familial relationships, removing a conflict between marital partners, achievig harmony. Is it therapy of one family, or group work with family of a addict, social worker is a part of a team working with them. To work with families with addiction problem, each member of the team, regardless to basic profession, has to have education to work with these families.

Work with family members after treatment of addiction

Aim of this work with family is to fasten achieved changes and new patterns of funcioning, as well as to enable family to move forward.

After treatment, social worker follow changes in family. Rehabilitation of family is a protracted process. Follow up of abstinence by enforcement and obeying its rules, bettar communication in family, giving support to family as a whole and to their members – all of that makes further empowerment. Work with family by way of their perceiving in new light results in discovering hidden powers and resources, which make a new angle of the situation, enhance positive beliefs and directs family to discover new way to solve difficulties. (Lažetić, Panoski, Filipović, Svetozarević, 2010; Straussner, 2001)

In families with adolescent addict, it is necessary to pay special attention to ways in which adolescent spend free time and ways in which materialize new social contacts.

Strategies to empower family include: securing emotional and social support to family, encouraging self-respect and increasing personal efficiency, help to reconsider life situation and present problems, enabling elaboration of general strategy for encountering the problems, and enabling family members to find out their own systems of support.

CONCLUSION

Family system is one of the maintenance factors of addiction disease. Initial familial tolerance is a projection of the tolerance in society as a whole to alcohol drinking and gambling, while later phases of adaptation to them are way of the family to „fight" their family member addiction. It is important to understand that addiction does not change an addict only, but every family member who is in time exhausted, and sometimes give up with attempts to help. Comprehensive perceiving of an addiction as a disease and activities of all family members are necessary to shorten the time of treatment to commence. Although there is an evident delay in disclosure and commencing the treatment, family is still a greatest reason/motif for the treatment. Nevertheless the „power" of the family in its struggle with an addiction, we consider that bigger support and collaboration with subsystems of the society is necessary. Social work should be that important link to connect the family and mentioned subsystems, not permitting the family to be alone in struggle with addiction.

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PORODICA I BOLESTI ZAVISNOSTI - ZAŠTO TAKO DUGO TRAJE?

Sažetak: Cilj ovog rada je da prikaže različite patološke entitete bolesti zavisnosti, prevalencu, dvosrnernu interakciju zavisnosti i porodice. Bolesti zavisnosti su danas globalni problem i predstavljaju grupu najčešćih bolesti savremenog čoveka. Podaci pokazuju da je 3% do 5% svetske populacije zavisno od alkohola, dok 1% do 3% ispunjava kriterijume zavisnosti od kockanja. Bilo da je reč o psihoaktivnoj supstanci ili nekoj aktivnosti, ono što se prepoznaje je zavisničko ponašanje koje utiče na sve članove porodice i porodicu kao celinu. Iako je veza između zavisnosti i porodice kompleksna, u kojoj se vrši međusobno usaglašavanje ova dva entiteta, koji nastavljaju da se reprodukuju i prenose kroz generacije, Shodno tome, u uvodnom delu rada dati su osnovni podaci o bolestima zavisnosti (alkoholizam i kockanje), rasprostanjenost u u svetu i Srbiji, te najčešći problemi zbog kojih se porodica obraća za pomoć. U drugom delu su opisni procesi kroz koje prolazi porodica, promene kod članova i načini na koji porodica reaguje na problem zavisnosti. Zbog specifičnosti u razvoju bolesti i težine posledica, odvojeno su opisane porodice u kojima je partner zavisnik i porodice u kojima su zavisnici mlade osobe. U trećem delu rada navedene su najčešće metode i tehnike rada koje socijalni radnici koriste u radu sa zavisničkim porodicama.

Ključne reči: alkoholizam, kockanje, porodica, socijalni rad

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MOTIVATIONS OF INIATION OF SELF RECOVERY IN CASE OF ABUZIVE SLOT MACHINE USERS

Abstract: The use of electronic gaming devices has seen a significant expansion worldwide due to the substantial gains from this economic activity. This paper explores factors associated with initiating and sustaining the process of natural recovery in the case of this category of addicts. In this context is the present research that aimed to determine the factors that support the motivation for recovery from abusive or addictive gambling in the case of slot machines players. In order to achieve the goals of this research, 21 interviews were conducted with players from the city of Alba Iulia. These interviews allowed us to gain a deep understanding of the motivations and life context of the subjects in which the problem was recognized and the recovery process began. The results obtained in the research showed that the impetus for initiating recovery came according to the results obtained from the participants' need to achieve certain personal goals in life, fulfilling social roles, significant changes in life, and the inconsistency between personal values and excessive gambling.

***Keywords**:* addiction, natural recovery, electronic gambling machines

INTRODUCTION

Slot machine games are the most popular gambling games in the Romanian profile industry, providing 70% of the profits of the gambling sectoraccording to the data provided by the National Gambling Office. In Romania, according to the Association for the Prevention and Treatment of Addiction (Naghi, 2012) over 1 500 000 Romanians participate in various types of gambling such as poker, bingo, sports betting, roulette, slot machines and others and about 150,000 of them they developed addiction. A study conducted in Romania by GFK (2019), shows an average of 0.6% of gambling practitioners, a percentage located at the lower limit of the European average which is 0.5-2%.

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Excessive gambling mainly affects vulnerable groups of the population, being associated with other social problems. For this reason, a better knowledge of the phenomenon of addiction and the process of recovery of addicts has a great utility for improving therapeutic practices.

THE RESEARCH PROBLEM

The idea that recovery from various types of addictions can be achieved without professional help is increasingly accepted by specialists in the field. In his paper "The truth about addiction and recovery," Professor Stanton Peele of New York University said, citing the results of a Gallup survey that "people are about ten times as likely to change on their own as with the help of doctors, therapists or self-help groups." (Peele, 2004, p. 78) According to this author, the help of professionals is much less important than is believed in making changes in life, support came from a spouse (29%), parents or siblings (21%) or friends (14%).A study conducted by Wendy Slutke (Slutke, 2006) in the United States also showed that natural recovery might be common, 30-40% of players who crossed the border of entertainment recovered themselves without the help of professionals.

Given this recognition of the high share of self-recovery, addiction research has focused on identifying strategies used to overcome addiction, the factors and motivations that lead to initiating this process on their own and at the same time identifying differences in addiction. gender and lessons that can be learned (Petry & Weiss, 2009).

In this context, knowing and understanding the motivations that determine the initiation of the self-recovery process and the factors that support this process is very important for improving support for people addicted to slot machines and gambling in general.

LITERATURE REVIEW

Given the serious problems that gamblers face, it would seem obvious that there is a strong motivation for overcoming addiction, but this does not happen. On the contrary, most remain trapped in the addiction cycle of gambling: negative feelings associated with gambling losses, debt accumulation, the mirage of recovering losses, combined with the positive experience of socializing with friends and the need to keep up appearances, hiding the size of the participation to gambling to family, employer or others.British psychologist Jim Orford showed in his study on alcohol addicts that addiction also offers some benefits: relaxation, fun and pleasant social experiences (Orford et al., 2013).

Studies on gambling have focused on several forms of motivation: motivation to participate in the game, stages of change and changing excessive gambling behavior.

An attempt to explain the genesis of motivation for behavior change in addicts is provided by Higgins (1998), author of Self-discrepancy theory.According to this theory, the difference between the actual self and the ideal self produces feelings of shame, internalization, and depression, and creates the desire to annihilate cognitive dissonance.

A study by Johansen and colleagues (Johansen, Pål, Dag, Hendenc & Brendryen, 2019) identified three major sources of behavior change motivation for those who played online games: (1) empathy with concerned significant others, real or fictional, (2) cognitive dissonance due to positive feelings towards sports and athletics, (3) cognitive dissonance due to gambling among family members.

A study conducted from the perspective of Prochaska and Di Clemente's Transteoretic model of change on 200 game addicts who were thinking of giving up the game in the next 6 months (contemplation stage) or 30 days (preparation stage) showed that higher autonomous motivation for quitting gambling predicted greater likelihood of being in the preparation stage compared to those with higher external motivation for change who were less likelyto go further in the process of change (Kushnir, Godinho, Hodgins, Hendershot & Cunningham, 2015).

The discrepancy between personal values and norms and self-destructive behavior such as substance or behavioral addictions may motivate a person to initiate change (Miller & Rollnick, 2013). This is the principle on which the Brief Intervention and Motivational Interview technique developed by William Miller works.

American psychologist Stanton Peele shows that an important role in motivating addicts to initiate behavioral change and overcome addiction is to pursue an important purpose in life. According to him: "*when a habit or an addiction interferes with accomplishing a goal you want to attain, or something larger youa are committed to, you are more inclined to quit*" (Peele, 2004, p. 194).

Sophie Vasiliades and Anna Thomas (2017) conducted a study in the United States in which they tried to determine the process by which gamblers recognize problems and initiate the recovery process but also the experiences and factors that support this process. The results obtained showed that most participants initiated a natural recovery approach rather than resorting to professional services or support groups. The motivation for recovery was represented by the dissonance between the desired self-image and the reality caused by the abusive game and a life event or decisive intervention of someone affected by the excessive slot machine game of the individual.

Some authors (Granfield & Cloud 2001; Stall & Biernacki 1986; White, 2007) have highlighted two ways of recovering gambling addicts similar to the situation of substance addicts: avoid oriented and approach oriented. A temporal relationship between the two recovery pathways was also highlighted, informal recovery is initiated by the avoidance of gambling-related stimuli and harms, and

maintenance recovery is predominantly achieved with approach-oriented strategies, including involvement with family, friends and pursuing personal goals in life (Stall & Biernacki 1986; White, 2007).

The negative effects of excessive gambling on significant people can also play an important role in motivating addicts to initiate the process of self-recovery (Choong, Loo & Sheng 2014).

Reaching rock bottom has been identified as another factor that provides the initial motivation for starting the recovery process and seeking resources to support this process (Reith & Dobbie, 2012).

Studies that have investigated the motivations and factors that determine and support the initiation of the self-recovery process have revealed mainly discrepancies between the ideal self and the current self distorted by gambling, the inconsistency between personal values, goals in life and addiction that interferes with their realization but and external factors such as affecting significant people in their lives or hitting the bottom that causes a backlash of trying to regain control.

Studies on the natural recovery of gambling addicts are still quite few and inconclusive. Most of them were done on some clients of the recovery services. Few are made on game addicts. In this context, there is a clear need to investigate more focused on the experiences of gambling addicts who have started a self-recovery process in order to better understand how the self-recovery process is initiated and supported.

OBJECTIVES AND METHODOLOGY OF THE STUDY

In order to investigate the motivations for initiating the self-recovery process and the factors that support this process, we conducted a qualitative research. The aims of the research were:

- To determine the context of the initiation of gambling;
- Determine what the context was and how they became aware of the issue of the game;
- To determine what were the motivations that determined the initiation of the self-recovery process;
- To identify the factors that supported the self-recovery process.

The method used was the interview based on a semi-structured interview guide that contained a series of guided research questions. The main topics of the interview guide were the context of initiating gambling, the context and the way in which they realized that they have a problem with gambling, the motivations that generated the change in behavior and the factors that supported this process. During the interviews, additional questions were added depending on the course of the discussion.

The study was conducted on a group of 21 gamblers from the cities of Alba Iulia and Sebeș in Alba County, Romania. They were recruited using the snow ball method, starting from a few cases of gamblers known to the authors. Players over the age of 18 were accepted, identified themselves as abusive or addicted players and tried at least once to reduce playing time or give up completely. When we did not get any more information, we stopped looking for new people to interview.

The method of analysing the data obtained from interviews was the content analysis through we identified themes and patterns regarding the inition of gambling, the context and awareness of the problem, the motivations for initiating the self-recovery process and the factors that supported this process.

RESEARCH RESULTS – THE CONTEXT OF GAMBLING INITIATION

The context can be defined as the social circumstances or events that influenced the initiation of gambling.Play is a social activity and the initiation of the game is done in the context of social interactions (Reith & Dobbie, 2011).The context in which the game was initiated helps us understand the needs and problems of the individual who determined and maintained participation in the game and the requirements for changing this behavior.The results obtained in the interviews show the following:

Table 1
The context of gambling initiation

Social context of gambling initiation	Illustrative quotes
1. Socializing in networks of friends	“*I first played slot machines in a lottery agency in Petrila, when I was 12 years old. It was close to school and I went with the boys after school. Nobody told us we weren't allowed. That's how we used to spend our time together.*”, men 28 years old.
2. Lack of leisure opportunities	“*After I finished my program at school, I went to the bar next to the block where I live. I know everyone there, one always stops me from drinking a beer. You don't have much else to do. The first time I played with the machines, I did it with ambition. I was sure that I would be lucky and give it to the others, but it wasn't like that. Unfortunately, out of ambition, I continued, a stupid ambition.*”, men 54 years old.
3. Spatial proximity of gaming rooms to the respondents' living, working or shopping area	“*The games room was right next to my block. I passed her hundreds of times at work or at home, ignoring them. But one day it happened and I went inside. I met a lot of acquaintances. And that's how I started playing machines. The devil put them in my way ...*”, men, 33 years old.

3. Chance and curiosity	"*I came to a Casino in Bucharest by chance a few years ago, I liked the atmosphere, the lights, the music, it was select. At home I tried to relive the atmosphere there. It wasn't the same, but the game of machines caught me and I became a loyal customer.*", man 35 years old.
4. The influence of the family	*"My parents gave me all kinds of games when I was little, the house was full and I used to play. When I got older I discovered slot machines, I was used to playing, so I started playing", women, 26 years old.*

The most common situation is socialization within the group of friends in which the interest in the game is acquired and the pleasure of playing develops. The way time is spent by the group of friends offers opportunities to play slot machines and learn the necessary techniques.

Lack of leisure opportunities is a constraint that causes some people to accept the offer of gambling organizers. The retirees were among the respondents who justified gambling to the slot machine as a leisure option. The search for a way to spend free time is the context of starting the gambling, especially for retirees.
The proximity of the game rooms is a factor that may explain the initiation of playing at slot machines. The game rooms are meeting and socializing spaces at community level.

Chance and curiosity were also mentioned as the context in which they started playing the machines. Some players accidentally discovered slot machines, liked the atmosphere in the game rooms and felt the need to experience the game. In the case of other players, the initiation of the game took place in the family context where they learned the taste for gambling and where they also had the model of the parents who played.

AWARENESS AND RECOGNITION OF GAMBLING PROBLEM

Awareness and recognition of the problem of excessive gambling precedes and determines the impulse for action.For this reason, knowing the context and how this has been done allows us to better understand the motivation for change.The answers received from interviews showed us the followingwarning signs:

1. Inability to stop playing;
"*It's a misfortune for me, there are times when I don't play on machines, but I can't do without gambling. Now I put these tickets in the Polish lottery, sometimes I win, but here I don't think it's such a big loss.*", man 28 years old.

2. Accumulation of debts that have exceeded revenues:
"*If you can't stop playing when you win, you lose for sure. And I couldn't stop. I borrowed money, I ended up totally neglecting myself and I was in constant depression because after I had large sums earned, because I couldn't stop, I lost them very quickly every time I earned working days in a row.*", man 30 years old.

3. Chronic fatigue, lack of energy for other activities:
“*For a while I couldn't, I felt drained of energy like a lemon, I couldn't do anything else* “, women 31 years old.

4. Incongruence with self-image:
“*I wondered why I couldn't stop. And it wasn't the addiction, but the fact that I was stupid and I didn't understand that playing daily I was getting worse and worse and with the debts I lost my dignity*.” man, 29 years old.

5. The threat of job loss:
“I started to be late for work or even to be absent, the boss threatened to fire me. I realized that it was not a joke, I already had debts and I had to pay them”, women 26 years old.

6. Compromising the relationship with the life partner or other significant persons:
“*I realized that gambling was a problem when I lost my friends, I couldn't pay the bank loans and that I could lose my family and my life*,” the 37-year-old man.

7. Failure to achieve personal goals in life:
“*Financially, maybe I managed to be zero, but I realized that after months, I did not work at all, I did not progress in other areas of life and I am still zero or even minus.*”, man 37 years old.

8. Chasing losses or wins:
“*As a player, you have this idea in your head that you go back to the game and get your money back, the more you lose the more you want to go back to get it back, but I was convinced that it's just an illusion. So I wasted a lot of time and money and just gained stress, nerves and more. When you understand that you can end the game, I think it is possible without playing.* “ Man, 38 yeras old.

Warning signs were recognized as indicators of a problem by participants, their family members, friends, or employers. If the warning signs appeared in all cases there were differences in terms of whether the gambler recognized the problem (self-recognized pathway), or whether another person confronted them with their problem or a significant uncontrollable event compelled the gambler (and others) to recognize the severity of the problem (externally recognized pathway). The answers received from the interviews showed us that the warning signs were not recognized from the beginning, there was a period of denial or ignorance. Players sought to keep up appearances and hide the scale of the problems created by excessive gambling. Recognition of the problem arose over time after a significant degree of severity was reached. This was the turning point in initiating the recovery process.

MOTIVATIONS FOR INITIATING THE SELF-RECOVERY PROCESS

In the addiction literature, problem recognition is treated separately from impetus for behavior change. In the case of the alcohol addiction overcoming model, self-awareness is followed by the implementation of informal behavior change strategies (Mohatt et al., 2008). The results obtained from the interviews show us the following situation:

Table 2
Motivations for initiating self-recovery

Motivations for initiating self-recovery	***Illustrative quotes***
1. Achieving personal goals in life	"*I understood that gambling deceives me, steals my time and money, makes me lose things important to me and does not give me opportunities in life. I wanted to work. to make money, to have family, children, to be in line with the world.*", man 51 years old.
2. Restore self-identity	"*I thought it wasn't hard to let go, I looked in the mirror and told myself that this was not the man I was. I promised to leave, I want to resume my business and the profits I once had, I want to be normal, I want to be smart.",* man 30 years old.
3. Changing the life circum stances	"*I fell in love and had a serious relationship with a girl I later married. She made me give up gambling. Otherwise, who knows what was chosen of me, I was lucky with her.*" Man 34 years old.
4. The search for a new, more satisfying and fulfilled life	"*If I were to summarize in one sentence, I got rid of the addiction to the game when real life began to seem more beautiful, more attractive and more challenging than life in the game.*" Women 30 years old.
5. Life events	"My best friend died. That upset me. I realized I could die too. I swore then that I would give up completely.", Man 33 years old.

The most important factor that motivates the initiation of the process of self-recovery in gambling is the pursuit of personal goals in life whose achievement is endangered by gambling addiction.

The inconsistency between the authentic self and gambling self appears in many of the answers received as an important factor for initiating the process of self-recovery.This conflict seems to occur when increased participation in gambling intensifies and begins to harm the integrity of the self.

Changing living circumstances, mainly playing new social roles such as husband / wife in the case of the young or grandparents in the case of the elderly also seem to play an important role in the genesis of the motivation for change.

In other cases, the urge to overcome addiction came from the need to change one's life in order to enjoy a new quality of life that addiction denies.

Maintaining relationships with significant people in their lives appeared as a motivating factor in situations where these relationships were valued by respondents.

The motivation for initiating the self-recovery process for gambling addicts came from many sources and was not always activated immediately after the problem was recognized. In most cases, a significant worsening of the player's situation was needed, which accumulated over time until a turning point appeared when the change could not be postponed.

FACTORS THAT SUPPORT THE PROCESS OF SELF-RECOVERY

Recognizing the problem of gambling makes people responsible for the recovery process. However, supporting this process requires the mobilization of individual resources.Recognizing the problem is not immediately followed by the beginning of the self-recovery process, some of the problem players continue to make significant efforts to hide their gambling from others for a number of reasons, including to continue gambling without judgment or obligation to stop. This delays the mobilization of resources to support the recovery process. The onset of the recovery process is facilitated by a number of factors. In this regard, in the present research we obtained the following results:

The most important factor that supported the self-recovery process in the case of the interviewed subjects was the support provided by family or friends.This support has helped to restore social relations and especially to prevent relapses.
An important role in supporting the process of self-recovery seemed to be, according to the answers received, the ability of individuals to regain control over their own lives. Gambling addiction caused the reverse reaction of regaining freedom from gambling.

Taking responsibility for others was present in the cases of those who were married or who intended to get married. In order to reach this decision, however, it was necessary to aggravate the problems generated by gambling to the point where they could no longer be hidden and a change became necessary.

A more special situation encountered in the case of the interviewed respondents was that in which the experience of gambling addiction led to the discovery of a personal vocation that generated goals to pursue in life that served as a motivation for change and a support to support this approach. of recovery.

Table 3
Factors that support the process of self-recovery

Factors of recovery process	***Illustrative quotes***
1.Support from family and friends	"*My friends, few and very close, were there for me to offer me a part of life lived in the true sense of the word. Their presence and especially their unconditional acceptance helped me to get through the trials and tribulations that might have crushed me.*", Man, 34 years old.
2. Self capacity	*"But because the debts per month that are higher than my income I started to despair and lose even more money. But recently I think I have gained the strength not to enter a game room. All I have to do is work harder to pay off the debts I have."* Man, 23 years old.
3. Accountability to others	"*For me, family is important, I have nothing else more important. Do my kids need me and I'm a bastard who gives all his money to the slot machine? I told myself this wouldn't happen again. I want to be where I need to be, this nonsense has stolen many years of my life. It doesn't matter, maybe they saved all the other years of my life.*", Man 45 years old.
4. Involvement in meaningful activities.	"*I had discovered my vocation and passion for psychology. It was still a kind of game, only it was a real life game. To write books, to make a website, to meet new people, to work with people, to grow and evolve in real life. It's just that you can't save and resume if you screw it up.", W*omen 31 years old.

DISCUSSIONS

The present study was conducted on gambling addicts in Alba Iulia and Sebeș who tried on their own to overcome this addiction. They self-appreciated as problematic players, clearly going beyond the entertainment area and entering the area of abusive and addictive play. Some of them managed to get rid of addiction, others continue the fight. The recovery process is by its nature one that contains multiple trials and relapses.The responses received from the interviewed respondents provided us with relevant information about the experience of gambling players who have seen their lives devastated by addiction and who have managed to begin a recovery process on their own.

Key findings in the current study regarding the motivations for initiating the self-recovery process highlighted the role of social support and the pursuit of personal goals in life as the main motivational factors. These findings are consistent with similar studies conducted on alcohol and drug addicts (Granfield & Cloud, 2001; White, 2007; Peele, 2004).The desire to restore self-identity in engaging in the process of self-recovery also seems to have played an important role. Players caught in the trap of addiction have reached a critical moment in which they no longer recognize themselves in the image of gambling players, enslaved to

this game of chance and felt the need to regain the freedom to restore their true self and control over own life.

In other cases, especially for young people without a purpose in life for whom gambling was only a means of spending time and fun, the negative experience of addiction was an opportunity to reflect on their own lives and find goals in life. This seems to be the main trigger of the behavior change process.

The research conducted on gambling addicts in Alba Iulia and Sebeș brought some relevant information about their experience in initiating the self-recovery process. A strong point of the research was that the sample was one close to the gambling community in Romania and not one based on the clients of a recovery clinic.On the other hand, among the limitations of the research is the fact that we did not address a number of relevant aspects of the self-recovery process such as assessment of relapse capital, lapse and relapse events, relationship with other destructive behaviors or other types of addictions, the influence of social capital or social status and others.It remains for future research to analyze these aspects and to improve the knowledge of the phenomenon of natural recovery so useful for therapeutic practice.

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MOTIVACIJE ZA POKRETANJE PROCESA PRIRODNOG OPORAVKA KOD NASILNIH IGRAČA NA AUTOMATIMA ZA KOCKANJE

Sažetak: Upotreba automata za kockanje doživljava značajnu ekspanziju širom sveta usled ogromnih dobiti od ove ekonomske aktivnosti. Ovaj rad istražuje faktore povezane sa pokretanjem i održavanjem procesa prirodnog oporavka kod ove kategorije zavisnika. U ovom kontekstu je sadašnje istraživanje koje je imalo za cilj da utvrdi faktore koji podržavaju motivaciju za oporavak od nasilnog ili zavisnog kockanja u slučaju igrača na automatima za kockanje. Da bi se postigli ciljevi ovog istraživanja, obavljen je 21 intervju sa korisnicima automata za kockanje iz grada Alba Julije. Ovi razgovori omogućili su nam duboko razumevanje motivacija i životnog konteksta subjekata kod kojih je problem prepoznat i proces oporavka je započet. Rezultati dobijeni u istraživanju pokazali su da je iz vremenske perspektive podsticaj za pokretanje oporavka došao na osnovu rezultata dobijenih iz potrebe učesnika da postignu određene lične ciljeve u životu, ispune svoje društvene uloge, značajnih promena u životu, neusklađenosti između ličnih vrednosti i prekomernog kockanja.

Ključne reči: zavisnost, prirodni oporavak, automati za kockanje

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PROTECTION OF CHILD VICTIMS AND WITNESSES IN CRIMINAL PROCEEDINGS - CHALLENGES OF CHILD-FRIENDLY JUSTICE

Abstract: The protection of child victims and witnesses of violence in criminal proceedings is based on an individual approach to each injured party and the implementation of a series of protective measures aimed at preventing their secondary victimisation and traumatisation. The legislation of the Republic of Serbia includes regulations aimed at ensuring the individual assessment and protection of child victims and witnesses of criminal offences in criminal proceedings in accordance with the guaranteed standards of child-friendly justice. The individual approach and application of child-friendly justice standards in practice requires the provision of conditions for conducting good individual assessment, preventing secondary victimisation and providing support. It includes institutional capacities, a high level of knowledge and capacities of professionals from different systems and their efficient coordination and cooperation. However, research shows that in practice there are a number of challenges in the application of child-friendly justice standards, which call into question the efficiency of the protection of child victims and witnesses of violence. This paper analyses the provisions of the relevant laws of the Republic of Serbia related to the protection of child victims of violence in criminal proceedings from the perspective of the international standards of child-friendly justice. The findings of the research on child-friendly justice in the Republic of Serbia are also presented and analysed, indicating a number of challenges in the application of child-friendly justice standards in practice. Finally, this paper presents the recommendations for improving the protection of child victims and witnesses of violence in criminal proceedings.

Keywords: child-friendly justice, child victims of violence, juvenile justice

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INTRODUCTION

The protection of child victims and witnesses in criminal proceedings implies the application of a series of measures aimed at preventing secondary traumatisation and victimisation. At the same time, it requires an individual approach to every child and the application of protection and support measures that are tailored to the child's personality and needs. The rights of child victims and witnesses in criminal proceedings are based on the application of child-friendly justice standards, which implies a judicial system that guarantees the respect for the rights of children at the highest possible level (Banić & Stevanović, 2015, p. 5). The protection of child victims and witnesses in criminal proceedings is guaranteed by numerous international documents. The national legislation also contains regulations aimed at achieving child-friendly justice and the protection of children in criminal proceedings. However, the question arises as to what extent the prescribed provisions are applied in practice and whether there are challenges that call into question the respect for the rights of child victims and witnesses of violence in criminal proceedings. The aim of this paper is to review the standards of child-friendly justice by considering the most important aspects of the protection of child victims and witnesses of violence in criminal proceedings, and to point out a number of challenges in practice that call into question the efficient application of child-friendly justice in criminal proceedings.

RIGHTS OF CHILD VICTIMS AND WITNESSES OF CRIME

The rights of child victims and witnesses of crime in judicial proceedings are regulated by numerous international and national documents. The Convention on the Rights of the Child guarantees protection to children during criminal proceedings (Law on Ratification of the UN Convention on the Rights of the Child, 1990). The Council of Europe Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse requires its States Parties to take measures to protect children in criminal proceedings, in particular with respect to the manner of hearing children (Law on Ratification of the Council of Europe Convention on the Protection of Children Against Sexual Exploitation and Sexual Abuse, 2010, Articles 35 and 36). Directive 2012/29/EU establishing minimum standards on the rights, support and protection of child victims and witnesses of crime guarantees a number of rights to victims, including the right to information, access to support services, participation, protection, legal aid, protection of privacy and prevention of secondary victimisation and traumatisation of victims during hearing. As regards child victims, these measures include their right to be heard in premises designed or adapted for that purpose, without the presence of the public, with the presence of professionals trained for that purpose, through the use of communication

technology to avoid visual contact with offenders and unnecessary questioning concerning the victim's private life not related to the criminal offence (Directive 2012/29/EU establishing minimum standards on the rights, support and protection of child victims and witnesses of crime, 2012, Articles 22-24). The Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime stress the importance of the child victim's right to dignity, safety, protection against discrimination, information, expression of views, prevention of secondary victimisation and traumatisation and the provision of efficient support, including legal, psychological, financial, health care, educational and other necessary support (ECOSOC Resolution 2005/20 Guidelines on Justice in Matters involving Child Victims and Witnesses of Crime, 2005). The Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice contain the standards that need to be established, such as respect for the basic principles of the best interests of the child, dignity, participation, protection against discrimination and the rule of law, as well as respect for numerous rights, such as the right to information, protection of private and family life, urgency of proceedings, legal aid and expression of opinion. They also define measures to prevent secondary victimisation and traumatisation of the child during hearings and the right to psychosocial and health care support, especially post-trial support for child victims of violence (Committee of Ministers Council of Europe Guidelines of the Committee of Ministers of the Council of Europe on child-friendly justice, 2010).

The Law on Juvenile Criminal Offenders and Criminal Protection of Juveniles (hereinafter: Law on Juveniles) prescribes measures aimed at preventing secondary victimisation of minor injured parties during hearing, such as hearing by using technical devices for transmitting images and sound, without the presence of the parties and other participants in the proceedings in the room in which the witness is located, and asking questions through a judge, psychologist, pedagogue, social worker or other professional; hearing minors at their home or other premises, institution or organisation that is professionally qualified for questioning of minors; prohibition of confrontation with the offender, etc. (Law on Juvenile Criminal Offenders and Criminal Protection of Juveniles, 2005, Article 152). The Criminal Procedure Code also prescribed such measures for the hearing of particularly sensitive witnesses, which is especially important when the minor injured party is heard in criminal proceedings conducted against adults (Criminal Procedure Code, 2011, Article 104)

INDIVIDUAL APPROACH IN THE PROTECTION OF CHILD VICTIMS AND WITNESSES OF VIOLENT CRIMES

An individual approach implies treating every child victim and witness of crime in accordance with his or her specific characteristics and providing the

protection and support he or she needs in an individualised manner. Every child should receive a timely and professional assessment of how the crime has affected his or her life and what support he or she needs to recover (Winterstein, Stein, Knapp & Ryan, 2001).

The Law on Juveniles recognises the importance of individual approach and prescribes the obligation of competent authorities to treat the injured party taking into account his or her age, personality traits, education and living circumstances and to make special effort to avoid harmful consequences of the proceedings to the personality and development of the juvenile (Article 152). The implementation of an individual approach requires a child assessment carried out by trained professionals. In criminal proceedings, this type of assessment is conducted by expert witnesses, and in criminal proceedings against minors, it is conducted by the expert team of a social welfare centre and, if necessary, by expert witnesses.

The Law on Social Protection (Law on Social Protection, 2011) and the Rulebook on the organisation, norms and standards of social welfare centres (Rulebook on the organisation, norms and standards of social welfare centres, 2008) regulate the procedure of assessment conducted by social welfare centres. In cases of violent crimes, unlike in other criminal offences, the initial assessment of child victims in social welfare centres is obligatory, i.e. it is carried out in all cases and a plan of protection and support is developed on the basis of such assessment. The assessment conducted by social welfare centres includes an initial assessment and, if necessary, a targeted assessment. The initial assessment includes: 1) assessment of the situation and needs of the child and the family including the child's safety, risks, social history, information on the incident that caused concern or difficulty; 2) working with the family to create a safe situation for the child and overcome the current difficulty and 3) conducting procedures to protect the child and organising access to the necessary services. If, after conducting the initial assessment, more information is needed to provide the child with adequate support, the social welfare centre may conduct a targeted assessment procedure lasting a maximum of 30 days from the completion of the initial assessment (Law on Social Protection, Articles 56 and 59).

An individual assessment may also be conducted by an expert witness if the court decides to appoint an expert witness during criminal proceedings in order to establish certain facts or circumstances. An expert assessment may be ordered in criminal proceedings whenever professional knowledge is required for establishing or evaluating a certain fact (Criminal Code Procedure, Article 113). An expert assessment in criminal proceedings includes mainly the assessment of whether the child is able to give a statement or is prone to confabulation. The assessment conducted by an expert witness usually does not include opinions based on the assessment of child's safety, developing a protection plan or further support, and in that sense it is narrower than the assessment carried out by social welfare centres.

HEARING THE CHILD AND PREVENTING SECONDARY VICTIMISATION

One of the most important aspects of the protection of child victims and witnesses of criminal offences is the prevention of secondary victimisation and traumatisation of the child during his or her hearing. Children can be reliable witnesses and are significant participants in court proceedings (Milosavljević-Đukić & Tankosić, 2016, p. 113). However, participating in court proceedings is a disturbing and stressful experience for children (Milosavljević-Đukić & Tankosić, 2018, p. 37). Children, as a particularly vulnerable group, belong to the category of victims who are more exposed to the risk of secondary victimisation (Nikolić-Ristanović, 2007, p. 5). Hearing children requires a specific approach that is tailored to their developmental abilities and needs (Pejović-Milovančević, 2018), but also some additional measures to prevent secondary victimisation and traumatisation related to child preparation, the manner of hearing in a child-friendly environment in the presence of specially trained persons, as well as providing post-testimony support.

Preparation is a type of psychoeducation of the child in which the child learns and is informed about the trial process, the appearance of the courtroom, his or her rights, but also learns to recognise emotions that he or she may have during the testimony and how to normalise them. This process should also include talking to parents so that they can prepare for the child giving a statement and be able to provide support to the child (Milosavljević-Đukić, 2019).

The way in which a professional conducts an interview with the child as well as the environment in which the interview with the child takes place are crucial for the outcome of the interview with the child, the quality of the child's testimony and prevention of the child's traumatisation. For example, Mayers considers that the outcome of an interview with the child depends only one third on the interviewed child or young person, and two thirds on the adult interviewer and the situation in which the interview takes place (Mayers, 1997), while Šarac believes that the quality, validity and reliability of collected data largely depend on the interviewer's knowledge and skills (Šarac, 2014, p. 91). Preventing secondary victimisation and traumatisation of the child during his or her testimony largely depends on the manner in which the hearing will be conducted. This refers not only to the hearing in a child-friendly manner and environment, but also to how many times the child will be heard in connection with the same criminal offence and whether he or she will have to participate in other court proceedings in addition to the criminal proceedings. Thus, for example, the court may instruct the victim to exercise his or her right by filing a compensation claim in civil proceedings, which in practice means initiating a new procedure, repeated contact with the court, hearing, expert assessment and further traumatisation.

Providing support to the child after his or her hearing is also an important step in preventing secondary victimisation, but also one of the important ways of support in overcoming the consequences of the crime suffered. It implies the provision of counselling support in the form of psychoeducation immediately after the hearing of the child, as well as providing further continuous psychosocial support for his or her reintegration and socialisation.

INFORMING THE CHILD

The standards of child-friendly justice require that a child should be informed about his or her rights and the procedure upon the first contact with the justice system. Professionals have to address children in a way adapted to them, their age and maturity, and should use the gender and culturally sensitive language. This right includes informing the child about the procedure, the mechanisms available to him or her including appeal mechanisms, explaining his or her role in the procedure, available support during the hearing, the consequences of the court decision, protective measures, available ways to obtain compensation, available support services including health care, psychosocial and other support or organisations providing such support, as well as informing the child about the progress of court proceedings (Committee of Ministers Council of Europe Guidelines of the Committee of Ministers of the Council of Europe on child friendly justice, para 1-5). The information has the potential to create a complete change in the way in which a child will experience court proceedings (Stalford, Marshall & Cairns, 2017, p. 216). The right to information is one of the foundations of child-friendly justice because it allows young people to know their rights and ways to protect them and thus become justice advocates (Smith, 2011, p. 252).

RESEARCH ON CHALLENGES IN PRACTICE RELATED TO THE PROTECTION OF CHILD VICTIMS AND WITNESSES OF VIOLENT CRIMES IN THE REPUBLIC OF SERBIA

The standards of child-friendly justice are guaranteed to child victims of violent crimes at both international and national levels. However, the question arises as to whether the prescribed standards are applied in practice. This research focuses on the challenges in practice related to the protection of child victims and witnesses of violence in criminal proceedings from the perspective of child-friendly justice standards. The aim of the research was to establish to what extent the standards of child-friendly justice are applied in practice in the Republic of Serbia related to child victims of violent crimes and whether there are challenges in practice that call into question the application of guaranteed standards. The basic research assumption is that the national legislation is largely in line with

international standards in this area, but that there are challenges in practice that significantly contribute to the inefficient implementation of domestic regulations. The methodology of this research is based on a comparative content analysis that includes available research in this area, relevant legislative framework and available databases. In addition to this method, the regulatory and comparative legal method was used in part of the research related to reviewing and analysing international documents and national regulations.

The research findings indicate that the national legislation is in line with international standards in this area, but in practice there are a number of challenges in conducting individual assessments and applying an individual approach, preventing secondary victimisation and traumatisation of the child and informing the child, which significantly contribute to the inefficient implementation of national regulations.

One of the main problems in conducting individual assessments and applying an individual approach is the lack of individualised support programmes. This leads to the situation where the necessary support measures determined by individual assessments cannot be implemented because there are no specialised support programmes (Banić & Miković, 2020), but child victims of crime are included in the available support programmes that often do not meet the specific needs of each child.

An individual assessment is obligatory as late as in the phase of criminal proceedings when the judge asks the opinion of the guardianship authority or expert witness, but not in the phase of preliminary investigation from the moment of identifying the juvenile victim of crime. The Law on Police (Law on Police, 2016) and the Instruction on the Treatment of Juveniles and Young Adults by Police Officers (Ministry of Interior, 2006) do not contain the obligation of individual assessment in the phase of collecting information from a child as citizen. This is a serious omission that can lead to secondary victimisation and traumatisation of the child, in particular if the child is a victim or witness of violence as especially vulnerable because the child was not previously prepared to go to the police and give a statement, nor did the child receive adequate support during statement giving or after the hearing.

As regards the prevention of secondary victimisation and traumatisation of child victims and witnesses of violent crimes, the research findings reveal a number of problems related to the provision of support to the child before, during and after criminal proceedings, hearing of the child and filing a compensation claim.

In practice, the support to victims of crime in criminal proceedings is provided by various institutions and organisations, in particular the Services for Assistance and Support to Witnesses and Injured Parties established at higher courts and higher prosecutor's offices, civil society organisations and social welfare centres. The main task of the Services for Assistance and Support to Witnesses

and Injured Parties is to provide witnesses with assistance and support before, during and immediately after their hearing, to provide them with all the necessary information regarding their participation in the proceedings, to assess their psychological, medical, social and logistical needs and to provide logistical and emotional support (High Judicial Council, 2015, Articles 5 and 7). Research shows that the support provided by the Services for Assistance and Support to Witnesses and Injured Parties is based mainly on informing (Government of the Republic of Serbia, 2016, p. 14) and that it is provided only during the investigation or main trial and does not include the phase of preliminary investigation or support after criminal proceedings (Victim Support Europe, 2017. p. 5). This type of support does not adequately prepare the child for testifying, i.e. does not provide complete psychoeducation of the child and his or her parents.

Civil society organisations also provide support to victims and witnesses of crimes. This support does not specifically target child victims and witnesses of crime and is often aimed only at certain vulnerable groups. For example, some organisations that are specialised in working with Roma and people with disabilities provide support to people from these vulnerable groups if they become victims (Nikolić, 2007, p. 29). Also, support is not equally available in all communities. Out of all civil society organisations that provide support to victims and witnesses of crimes, 25 are in Belgrade, 18 in the Autonomous Province of Vojvodina (Northern Serbia), 14 in Southern Serbia, 13 in Šumadija (Central Serbia) and Western Serbia and 3 in Eastern Serbia (Victim Support Europe, p. 12). Support is also provided by social welfare centres, mostly to child victims of violence, pursuant to the Law on Social Protection. However, this support is not specifically aimed at preparing children for hearing before the court.

It can be concluded that currently none of the mentioned institutions or organisations provide full support to child victims and witnesses of violent crimes in terms of preparing the child to testify at the level of proper psychoeducation and providing such support to all children.

The research findings indicate the low level of counselling support in the form of psychoeducation immediately after the hearing of the child, and further continuous psychosocial support for his or her reintegration and socialisation. This support is provided to some extent by the Services for Assistance and Support to Witnesses and Injured Parties established at higher courts and higher prosecutor's offices, civil society organisations and social welfare centres. However, none of these institutions are focused on providing the child with full psychoeducation immediately after giving a statement, and there are no sufficient specialised support programmes. This leads to the situation where children are included in the programmes that are available, rather than those suitable for their specific needs (Victim Support Europe, p. 12). As regards the application of the child-friendly justice standards related to the manner of hearing the child in a child-friendly

environment, the research findings show that despite good legal provisions that allow the hearing of the child in the environment and in a manner in compliance with child-friendly justice standards, a serious problem is the implementation of the prescribed provisions in practice.

Most hearings of child victims and witnesses of crimes are conducted in the premises that are not adapted to children and in a way that is not in compliance with child-friendly justice standards. Most courts do not have child-friendly rooms, and children are heard in courtrooms. Equipping courts is a very slow process, and support is financed mainly on a project basis without ensured sustainability. For example, in 2014, with the help of a donation from the Kingdom of Norway, the International Management Group (IMG) provided the Higher Courts in Belgrade, Niš, Novi Sad and Vranje and the Basic Court in Leskovac with equipment for the premises designated for children and other particularly vulnerable groups (Government of the Republic of Serbia, p. 41). However, a part of this equipment is not used at the moment due to various logistical reasons that arose within the framework of judicial reform.

An example of good practice in providing support and preparing children for court is the work of the Units for Support of Child Victims and Witnesses in Criminal Proceedings, which provided child victims and witnesses of crimes with comprehensive support in accordance with all standards of child-friendly justice. These Units were established in four cities - Belgrade, Niš, Novi Sad and Kragujevac as part of the project "Advancing the Rights of the Child through Strengthening the Judicial and Social Welfare Systems in Serbia", funded by the European Union and implemented by UNICEF in partnership with the Ministry of Justice and the Ministry of Labour, Employment, Veteran and Social Affairs of the Republic of Serbia in the period August 2014 - March 2017 (Banić & Miković, p.19). The teams of experts were formed in these Units to prepare children for hearing, provide support during hearing, conduct a forensic interview and provide counselling support after giving a statement. The Units conducted forensic interviews with 41 children both in and outside the court. Fifty-three (53) children received counselling support as a type of psychoeducation after giving a statement. This service was usually provided in cases of the following criminal offences: domestic violence under Article 194 paragraph 1 of the Criminal Code, prohibited sexual acts under Article 182, paragraph 3 of the Criminal Code and sexual intercourse with a child under Article 180 paragraph 1 of the Criminal Code (Milosavljević & Tankosić, 2017, pp. 54-57). Research shows that the Units were very important in the prevention of secondary victimisation and traumatisation of children and that it is crucial to ensure the continuation of their work and their integration in the system (Banić & Miković, 2020). However, this service was project-based and ceased to be provided after the project ended because it did not become part of the state system of services financed from the state budget.

One of the major challenges in preventing secondary victimisation and traumatisation of the child is the manner of dealing with compensation claims. In fact, research shows that damages are decided in criminal proceedings in a small number of cases (Drobnjak, 2020, p. 103). In most cases, the injured parties are instructed to file their compensation claims in civil proceedings, which in practice means initiating another procedure and a new contact of the child with the court and further victimisation. This practice is a serious problem in terms of respecting the standards of child-friendly justice and protecting the victim from secondary victimisation and traumatisation and should be changed, especially since criminal proceedings include instruments that could be used for getting compensation upon claims filed in criminal proceedings (Sinanović, 2011).

The research findings show that the child's right to information is not sufficiently respected. For example, the research "Child-friendly Justice - The Perspectives of Children and Youth" has shown that only half of the respondents who were in contact with the criminal justice system believe that they received a full explanation of the reasons for being summoned and what the procedure would look like, and one third of the respondents believe that their rights were fully explained to them. Part of the problem may also lie in the fact that professionals do not use child-friendly language sufficiently in their interaction with children. Almost half of the respondents report that they are not satisfied or are minimally satisfied with the way of being provided with the information and that they could not fully understand it (Banić, 2020, pp. 5-10). One of the challenges in exercising the child's right to information in criminal proceedings is the fact that children are insufficiently informed about child-friendly justice or about their rights if they come into contact with the judicial system. According to the same research, only 9% of respondents from the general population are fully acquainted with their rights in criminal proceedings in case of being a victim or witness of crime. Most respondents do not know their rights or have minimal knowledge about them (Banić, 2020). The problem of using legal terminology and non-child-friendly language was recognised also in the research on child-friendly justice conducted by the European Union Agency for Fundamental Rights and published in 2017. One of the recommendations of the European Union Agency for Fundamental Rights for improving child-friendly justice refers to the use of child-friendly language, in order to provide children with understanding and full and adequate participation in proceedings (European Union Agency for Fundamental Rights, 2017, p. 24). The low level of children's awareness about their rights in criminal proceedings is not only contrary to the guaranteed standards of child-friendly justice, but also leads to an additional risk of further violations of children's rights in criminal proceedings and a continuation of the practice that significantly deviates from the guaranteed standards of child-friendly justice.

CONCLUSION

Although the legislation of the Republic of Serbia is largely harmonised with the requirements of child-friendly justice and includes a number of measures aimed at providing protection to child victims and witnesses of violent crimes in criminal proceedings, the application of these provisions in practice is deficient and almost worrying. The challenges in practice are mainly related to the insufficiently developed system for protecting children from secondary victimisation and traumatisation in criminal proceedings, including a lack of adequate preparation, the manner of hearing that does not meet the requirements of child-friendly justice and a lack of psychosocial or any other support programmes after giving a statement and upon termination of criminal proceedings. It is necessary to take urgent measures for overcoming this challenge and ensure conditions for hearing in premises specially adapted for that purpose, in the presence of specially trained experts and by using communication technology to avoid visual contact with the offender. The child should also be provided with support before and after the hearing in the form of complete psychoeducation.

Another challenge is a lack of programmes for support after criminal proceedings, including counselling, psychological, health, educational, financial and all other forms of support that would ensure adequate reintegration and resocialisation of the child. Considering the importance of support for the empowerment of child victims of violence, the further development of child-friendly justice and support for child victims and witnesses of violent crimes should be directed towards developing specialised support programmes and strengthening the capacity of professionals for their implementation.

An individualised approach is also one of the major challenges, particularly because of the lack of specialised support programmes. We should work on the further improvement of the system of individual assessment and strive for greater individualisation of support and protection of child victims of violence. It is particularly important to improve the way of assessment and support from the first moment of the child's contact with the justice system and the police.

More work should be done to further increase children's awareness of child-friendly justice and their rights as victims or witnesses of crimes in criminal proceedings, and also to strengthen their capacity and knowledge required to recognise all forms of violence and familiarise with the system and ways of protection.

Protecting children from violence in criminal proceedings requires a good and coordinated response of several different systems. It also requires continuous harmonisation of legislation with international standards and a clear strategic commitment of the state to build child-friendly justice and overcome the challenges identified in practice. Above all, protecting children from violence in criminal proceedings requires dedicated professionals who have a good understanding of

the mechanisms of violence, who value and understand the importance of child-friendly justice standards, act efficiently and professionally and respect the rights of every child victim and witness of violence in contact with the criminal justice system.

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Milena Banić

ZAŠTITA DECE ŽRTAVA I SVEDOKA NASILJA U KRIVIČNOM POSTUPKU – IZAZOVI U PRIMENI STANDARDA PRAVOSUĐA PO MERI DETETA

Sažetak: Zaštita dece žrtva i svedoka nasilja u krivičnom postupku zasniva se na individualnom pristupu svakom oštećenom i sprovođenju niza zaštitih mera radi sprečavanja njihove sekundardne viktimizacije i traumatizacije. Zakonodavstvo Republike Srbije sadrži niz propisa koji imaju za cilj da se obezbedi individualna procena i zaštita dece žrtava i svedoka krivičnih dela u krivičnom postupku u skladu sa garantovanim standardima pravosuđa po meri deteta. Individualni pristup i primena standarda pravosuđa po meri deteta u praksi zahteva obezbeđenje uslova za sprovođenje dobre individualne procene, sprečavanje sekundarne viktimizacije i pružanje podrške. Ovo podrazumeva institucionalne kapacitete, visok nivo znanja i kapaciteta profesionalaca iz različitih sistema i njihovu efikasnu koordinaciju i saradnju. Međutim, istraživanja ukazuju da u praksi postoji niz izazova u primeni standarda pravosuđa po meri deteta koja dovode u pitanje efikasnost zaštite dece žrtava i svedoka nasilja. U radu se analiziraju odredbe relevantnih zakona Republike Srbije u odnosu na zaštitu dece žrtava nasilja u krivičnom postupku iz ugla međunarodnim standarda pravosuđa po meri deteta. Predstavljaju se i analiziraju rezultati istraživanja o pravosuđu po meri deteta u Republici Srbiji koja ukazuju na niz izazova u sprovođenju individualnog pristupa i primeni standarda pravosuđa po meri deteta u praksi. Na kraju rada daju se preporuke za unapređenje zaštite dece žrtava i svedoka nasilja u krivičnog postupku.

Kjučne reči: zaštita dece žrtava i svedoka u krivičnom postupku, maloletničko pravosuđe

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HOW DO MATERIAL RESOURCES AND SOCIAL STATUS OF A FAMILY COMBINED WITH INCLUSIVE EDUCATION HELP REDUCE ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)?

Abstract: This study considers the relationship of inclusive teaching environment, socioeconomic status, and the likelihood of reducing hyperactivity disorder in children. Although most children experience a change in hyperactive behavior through the process of growing up, the likelihood of decreasing this disorder varies across different socioeconomic statuses and teaching environments. This study shows that a child with a lower socioeconomic status is more likely to reduce the impact of hyperactivity on their behavior if they attend inclusive education. In contrast, for children who are more advanced, the chances of reducing hyperactive behavior do not depend on the level of special education and inculsion. This paper suggests that the implementation of inclusive teaching can reduce behavioral differences, especially for children who are less advanced. By doing so, this study would contribute to this scientific field because it shows how institutional environments can overcome socioeconomic status in reducing hyperactive behavior.

Keywords: ADHD, inclusion, special education, socioeconomic status, institutional environment

INTRODUCTION

Three out of four children diagnosed with Attention Deficit Hyperactivity Disorder will no longer meet the diagnostic criteria for ADHD by adulthood (Agnew-Blais et al., 2016). Evidence about the importance of family context and economic advantage on long-term outcomes of children with ADHD is mixed (Agnew-Blais et al., 2016; Faraone, Biederman, & Mick, 2006). To date, little is known about how institutional and educational environments may influence the likelihood of ADHD remission. ADHD remission is known to be associated

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with improved cognitive functioning such as better attention-vigilance and error detection (Cheung et al., 2016; Michelini et al., 2016). Given the long-term consequences of persistent ADHD, further research investigating whether and how socioeconomic advantage and social context may translate into an increased likelihood of remission is warranted.

A voluminous literature has documented a link between socioeconomic status and health outcomes. For the vast majority of conditions there exists a negative socioeconomic gradient such that individuals with fewer economic resources are more likely to experience adverse health outcomes or early mortality (Link, Northridge, Phelan, & Ganz, 1998; Link & Phelan, 1995). Individuals of higher socioeconomic status draw upon their relatively greater income, education, and social connections to access new services and disproportionately benefit from medical advances (Chang & Lauderdale, 2009; King & Bearman, 2011). This literature would anticipate that economically advantaged children should be more likely than their less advantaged peers to experience ADHD remission.

Institutional environments can also profoundly affect individuals' physical and mental health, and thus have the ability to exacerbate or attenuate health inequalities (Freese & Lutfey, 2011). Research examining the social determinants of health has documented the significant role that prisons, schools, and work environments have on health outcomes (Cutler & Lleras-Muney, 2012; Moen, Kelly, Tranby, & Huang, 2011; Schnittker & John, 2007). Schools themselves have been demonstrated to have an important impact on myriad children's health outcomes including: weight and body mass (Martin, Frisco, Nau, & Burnett, 2012; Miller, 2011; Mueller, Pearson, Muller, Frank, & Turner, 2010), substance use (De Clercq, Pfoertner, Elgar, Hublet, & Maes, 2014; Turner, West, Gordon, Young, & Sweeting, 2006), risk behaviors (Pavic Simetin, Kern, Kuzman, & Pförtner, 2013), stress (Oberle & Schonert-Reichl, 2016), psychosomatic and depressive symptoms (Elovainio et al., 2011; Walsemann, Bell, & Maitra, 2011), and emotional and behavior problems (Dufur, Parcel, & Mckune, 2008; Nielsen et al., 2015; Saab & Klinger, 2010). With respect to ADHD, schools in particular play an important role in both the diagnosis and treatment of ADHD. In the absence of biomarkers or blood tests for ADHD, diagnoses are made based on symptomatic presentation and evaluations by teachers and parents. Teachers are often the first to suggest a diagnosis of ADHD. Beyond the level of the classroom, scholar have documented that school accountability policies, which scrutinized schools academic performance, are associated with an increased likelihood of ADHD diagnosis and subsequent medication use. Work by King, Jennings, and Fletcher (2014) found that economically advantaged children were more likely than their less advantaged peers to selectively use ADHD medications in response to academic pressure and school accountability. Thus, schools may play a key role in explaining variation in ADHD prevalence and remission.

The past decade has seen a dramatic rise in behavioral disorders diagnosed in childhood. Prevalence rates of ADHD, autism, and bipolar disorder have increased precipitously (Blumberg et al., 2013; Hinshaw & Scheffler, 2014; Visser et al., 2014). Consistent with the fundamental cause literature, strong SES gradients exists for each of these conditions (King & Bearman, 2011; Visser et al., 2014). Our work adds to a growing body of literature that highlights the importance of social context and institutional conditions for understanding both the steep increase in prevalence of childhood behavioral disorders, as well as their socioeconomic gradients (Hinshaw & Scheffler, 2014). While this literature has expanded our understanding of how social contexts have contributed to rising prevalence rates, little research has examined the role that social and institutional conditions play in remission rates. Our study contributes to the literature by showing that special education can either mitigate or exacerbate health inequalities depending on how institutions execute the provision. Understanding how institutions may exacerbate or mitigate health inequalities through differential remission patterns has important implications for the literature on health and inequality, as well as public policy. This study examines the association between socioeconomic status, educational environments and ADHD remission. Educational environments profoundly shape the likelihood of ADHD remission- but only for less advantaged children. Remission rates of socioeconomically advantaged children do not vary significantly across special education regimes. Creating more inclusive special education environments appears to be a key step towards reducing ADHD disparities.

ADHD PREVALENCE AND REMISSION

ADHD is defined as a “persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequently displayed and is more severe than is typically observed in individuals at comparable level of development” (DSM IV [American Psychiatric Association, 2000]). ADHD is the most common psychiatric disorder among children in the United States. Nationally, more than 11% of school-aged youth have been diagnosed with ADHD (Visser et al., 2014). Prevalence rates have risen remarkably in recent years, increasing by more than 40% between 2003 and 2011 alone. There is also considerable geographic variability in how frequently children are diagnosed with ADHD. The percent of school-aged children diagnosed with ADHD varies from a high of 18.7 percent of children in Kentucky to a low of 5.6 percent of children in Nevada (Visser et al., 2014). A large body of work has documented higher rates of ADHD among lower-SES youth (see Russell, Ford, Williams, & Russell, 2015 for review). For instance, data from the National Center of Health Statistics found that.

ADHD prevalence was higher (10.4%) for children whose family's annual income is less than 200% of the federal poverty level than for higher SES children

whose families were above the 200% threshold (8.8%). Evidence of rapidly rising prevalence rates, geographic variability, and a strong socioeconomic gradient suggest that social and institutional factors are important drivers of ADHD diagnosis. Despite considerable scholarly effort directed toward understanding the diagnostic variability, very little is known about what social and institutional conditions are associated with ADHD remission. To explain rapid changes in the measured prevalence of any health-condition, one needs to account for not only how patients obtain the diagnosis but also how they lose the diagnosis. This paper aims to suggest that socioeconomic status — an individual-level factor — and educational environment — an institutional factor — interact to shape remission rates of children with ADHD. Socioeconomic status has long been identified as a fundamental cause of health conditions, creating negative gradients for most health outcomes (Link & Phelan, 1995). This is not only because lower socioeconomic status groups likely have greater exposure to risk factors but also because they lack access to treatment options. Accordingly, we expect that lower SES families will have difficulties accessing and negotiating treatment options. When families lack the resources to secure adequate treatment for their children, behavioral interventions available at school could potentially help mitigate disparities.

Our work highlights the potential role of educational environments in creating ADHD remission gradients. Many treatment modalities of ADHD require parental engagement. However, the sociology of education literature has established that parental engagement may effective for children's educational achievements only when the parents have an adequate cultural understanding of classroom expectations (e.g., McNeal Jr., 2001), thereby producing disadvantages for less advantaged families. In the case of special education, parents with lower socioeconomic status are less likely to participate in school activities and to have expectations that their children will successfully graduate from high school, which has a positive impact on children's academic achievement (Zhang, Hsu, Kwok, Benz, & Bowman-Perrott, 2011). Because of these differences in parental engagement, when families must individually negotiate to obtain the best possible accommodations for their children, children from less advantaged families are less likely to benefit. On the other hand, if special education regimes are more inclusive and prone to provide adjustments for children's individual needs, children from lower socioeconomic backgrounds will benefit.

Roughly, 80 percent of children diagnosed with ADHD no longer meet the full diagnostic criteria by the end of adolescence (Agnew-Blais et al., 2016; Biederman, Petty, O'Connor, Hyder, & Faraone, 2012; Faraone et al., 2006; Kessler et al., 2005). Risk factors associated with ADHD persistence are childhood symptomatic severity (Agnew-Blais et al., 2016; Biederman et al., 2012; Cheung et al., 2015; Kessler et al., 2005), psychiatric comorbidity and family history of mental disorders (Biederman et al., 2011, 2012), and IQ (Agnew-Blais et al., 2016; Cheung et al., 2015).

Evidence of an association between family socioeconomic status and remission is mixed. Cheung et al. (2015) found that higher socioeconomic status is associated with a decline in ADHD symptoms over time, while others did not find such association (Agnew-Blais JC et al., 2016; Biederman et al., 2011; Biederman et al., 2012; Kessler et al., 2005).

Treatment of ADHD, however, is of vital importance since ADHD poses serious academic and social challenges (Arnold, Hodgkins, Kahle, Madhoo, & Kewley, 2015; Loe & Feldman, 2007). Successfully managing ADHD symptoms not only contributes to successful schooling but also may affect employment outcomes.

TREATMENT OF ADHD AMONG CHILDREN AND ADOLESCENTS

Treatment of children and adolescents with ADHD can be broadly classified into medical treatment and psychosocial interventions (Chronis, Jones, & Raggi, 2006). Meta-analyses have found that medication combined with behavioral interventions are the most successful treatment for managing ADHD symptoms. Medication is the most common method of addressing ADHD symptoms. In 2011, 69 percent of children with ADHD took at least one prescription medication to manage symptoms (Visser et al., 2014). Most research on ADHD treatment has consistently shown that medication manages ADHD symptoms effectively (for review, see Swanson, Baler, & Volkow, 2011). Stimulants improve academic performance, decrease aggression and inappropriate behavior (Chronis et al., 2006) and facilitate social relationships with peers (Whalen et al., 1989). These effects of pharmacological treatment of ADHD, however, tend to be short-lived.

Medication only suppresses symptoms of ADHD instead of curing the underlying disorder. Little is known about long-term effectiveness of medication (Chronis et al., 2006; Craig, Davies, Schibuk, Weiss, & Hechtman, 2015; Smith, Waschbusch, Willoughby, & Evans, 2000), suggesting that pharmacological treatment alone may be insufficient to cause ADHD remission.

There are three major modes of psychosocial treatment: family-, peer-, and school-based interventions. Family-based interventions target parents as the foci of behavioral treatment and are designed to train parents to promote accurate understanding of ADHD symptoms and treatment as well as to modify parenting behaviors. Second, peerbased interventions such as social skills training and summer treatment programs are designed to help improve the social functioning of children and adolescents with ADHD (Chronis et al., 2006). Finally, schoolbased interventions are designed to improve student's performance at school. Teachers can use behavioral modification strategies to cater special needs of students with ADHD. Specifically, teachers can help students with ADHD to perform academic tasks better by giving them additional academic

instructions or materials, structuring homework time, modifying instructions, collaborating with parents as well as having children with ADHD use goal-setting, peer tutoring, computerassisted instruction, and strategy training (Chronis et al., 2006). Successful implementation of classroom behavior management depends on teachers' willingness to give additional academic instructions and to implement special accommodations and modifications as well as environmental factors that enable teachers and paraeducators to help students with special needs.

School-based interventions may help ameliorate or exacerbate treatment disparities. Other treatment modalities are often stratified by socioeconomic status. First, pharmacological treatment trajectories differ for low and high SES children. That is, low SES children are less likely to adhere to prescribed medications (Brown, Borden, Wynne, Spunt, & Clingerman, 1987; Firestone, 1982). Second, the outcomes of behavioral treatment are also stratified by SES. Low SES children did not show substantial improvement when receiving a combination of medication and behavioral treatment, whereas high SES children's symptoms where significantly improved when they received combined treatment, rather than medication alone (Rieppi et al., 2002). Such differential outcomes may partially have driven by the level of parental engagement. Note that some, if not most, of the school-based treatment methods require a fair amount of collaboration between teachers and parents. However, consistent participation in parental training has been found to be more difficult for parents with fewer economic resources (Firestone & Witt, 1982). They are also less likely to engage in school activities (Zhang et al., 2001). As a result, the effect of family-based interventions is stratified (McMahon, Forehand, Griest, & Wells, 1981). When greater familial advocacy or participation is necessary for children to receive optimal behavioral interventions in school, less economically advantaged children may not fully benefit. On the other hand, schools can be an important arena for less advantaged children to receive behavioral therapy and have the opportunity to develop skills. In this paper, we focus on how differences in school-based treatment processes across states could affect low and high SES children differently, thereby, contributing to SES gradients.

School-based interventions The Individuals with Disabilities Education Act (IDEA) governs the provision of all special education services in the United States (deBettencourt, 2002). IDEA ensures that students with disabilities are provided with the same educational opportunities as their non-disabled peers. IDEA requires public schools to offer free services to meet the educational needs of children with disabilities and provides federal funding to states. At the heart of the IDEA is the individualized education program (IEP). For each child eligible for special education services, public schools are required to develop and implement an individualized education plan in order to meet her unique special needs. An IEP details the current status of a child including academic performance and obstacles stemming from her disability as well as a special education plan including services,

special accommodations and modifications to be provided, the schedule, and measurable annual goals and objectives (Drasgow, Yell, & Robinson, 2001). A child is eligible for special education services under the IDEA if her IEP team finds that she has one or more disabilities. Although ADHD alone does not constitute a distinct disability category, it is listed as a condition under the “other health impairment.” One of the important decisions in an IEP development is where to place the child. The IEP team determines the educational environment based on the child's IEP – i.e. unique educational needs of the child (34 C.F.R. 300.116(b)(2)). Importantly, the federal law, Part B of the IDEA, requires that schools must pursue full inclusion of children with disabilities in regular classroom with their non-disabled peers by providing appropriate accommodations, modifications, and supplementary aids and services. If such attempts do not work, schools may place children in separate classrooms while ensuring the children are educated along with their non-disabled peers to the maximum extent appropriate. The least restrictive environment, along with the IEP, is an important principle of special education provision under the IDEA. Accordingly, the implementation of an IEP and its least restrictive environment provision is one basis of the federal funding allocation.

SCHOOL-BASED INTERVENTIONS

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THE LEAST RESTRICTIVE ENVIRONMENT, INCLUSIVE SPECIAL EDUCATION, AND REMISSION FROM ADHD

Research suggests that for children with various types of disabilities inclusive special education has positive effects on academic achievement (Banerji & Dailey, 1995; Cosier, Causton-Theoharis, & Theoharis, 2013; Waldron & McLeskey, 1998), social functioning (Fisher & Meyer, 2002; Fryxell & Kennedy, 1995; Kennedy, Shukla, & Fryxell, 1997; Rea et al., 2002), affective gains (Banerji & Dailey, 1995), and behavioral outcomes (Rea et al., 2002). Whereas children in restrictive environments are self-contained in special education classrooms, those educated in inclusive environments can generalize principles learned from behavioral interventions to broader, more general academic and social settings as they interact with peers with no disabilities (Chronis et al., 2006), resulting in improved academic achievement, social functioning, and behavioral outcomes.

THE INTERPRETATION OF THE LEAST RESTRICTIVE ENVIRONMENT, PARENTAL INVOLVEMENT IN SPECIAL EDUCATION PROVISION, AND THE GEOGRAPHIC VARIATION IN ADHD GRADIENT

The least restrictive environment guideline is a guiding principle rather than a specific requirement. Because the least restrictive environment is open for interpretation, one would expect the degree of inclusive placement could vary across geographic areas. Empirical examinations of placement of children with disabilities found that inclusion varies widely across states (Danielson & Bellamy, 1989; McLeskey & Henry, 1999). Existing, taken-for-granted practices of educational communities drive placement decisions (Kurth & Mastergeorge, 2010).

Parents are another driver of placement decisions. Parents of children with disabilities play a significant role in writing and implementing IEPs and their cooperation with teachers is of great importance in the IDEA provision (Palley, 2004). Parents can influence the special education provision process in numerous ways: they can initiate an evaluation of their children's eligibility under the IDEA, influence the IEP eligibility decision, negotiate disability labels, and advocate for more inclusive educational environments for their children, and so forth.

Although all parents have the right to advocate for better educational environments for their children, not all parents are able to do so. For example, Lalvani (2012) found that high SES parents are more likely to be aware of inclusive education, successfully negotiate access to inclusive education, and expend time, effort, and resources to negotiate the IEP. As a result, the extent to which special education services meet the needs of students with ADHD is stratified by socioeconomic status such that low SES children with ADHD are more likely to have unmet needs than high SES counterparts (Bussing, Zima, Perwien, Belin, & Widawski, 1998) when inclusivity is not the default.

Therefore, we expect that high SES children's remission likelihood will be invariant across educational regimes. This is because, on the one hand, high SES parents educating their children in restrictive environments likely negotiate their children's placement and increase time spent in regular classrooms. On the other hand, even when their children are placed in self-contained classrooms, high SES parents can seek alternative treatment options outside the school. It is, however, unlikely that low SES parents negotiate placement or provide quality care outside the school. For low SES children, the institutional environment of special education regime can be critical.

DATA AND METHODS

We analyzed data from the National Survey of Children's Health (NSCH). The NSCH is a telephone survey designed to provide national and state-specific prevalence estimates for non-institutionalized children ages 0–17 on physical, emotional, and behavioral health indicators, as well as indicators of children's experiences with the health care system. Repeated cross-sectional data were collected in 2003–2004, 2007–2008, and 2011–2012. The total sample sizes in these respective years were 102,353, 91,642, and 95,677, with approximately 1800 surveys per state per year.

The outcome of interest is ADHD remission. Ideally, we would want to observe a child with ADHD over time and identify whether and when the child drops ADHD symptoms. However, because NSCH data is crosssectional, we do not have repeated observations of same children. Instead, we exploited the survey design of the NSCH. In 2007–2008 and 2011–2012, the NSCH included two different questions about ADHD diagnostic status. The first question asks whether a surveyed child has ever been diagnosed with ADHD. For children who have been diagnosed, the second question asks if they still maintain diagnosis at the time of survey. Previous research has established that parental reports of ADHD diagnosis are extremely accurate and reliable measures of physician diagnosis with a sensitivity of 94 and a positive predictive power of 98 (Faraone, Biederman, & Milberger, 1995). We excluded 2003–2004 survey from analysis because the second question

about the current diagnostic status was not asked. We further restricted our sample to 2007–2008 data because some state-level control variables are only available for 2007. Among respondents of 2007–2008 survey, we limited our analyses to children who have ever been diagnosed with ADHD and estimated the likelihood of losing diagnosis. We consider children who report having ever been—but not currently—diagnosed with ADHD as experiencing remission. Overall, 22 percent of our sample experienced remission. Among 17-year-olds, the remission rate was 70 percent. Prior research has found similar remission rate for adolescents. For instance, a recent study by Agnew-Blais JC and colleagues (2016) found roughly 75 percent of children with ADHD lose their diagnosis by adulthood.

Of central interest are the relationship between socioeconomic status, educational environment, and ADHD remission. The NSCH provides socioeconomic status (SES) information as a categorical variable. Eight SES categories were defined with respect to the federal poverty line (FPL): below 100 percent of FPL, above 100 percent to at or below 133 percent, above 133 percent to at or below 150 percent, above 150 percent to at or below 185 percent, above 185 percent to at or below 200 percent, above 200 percent to at or below 300 percent, above 300 percent to at or below 400 percent, and above 400 percent of FPL. Out of these eight categories, we aggregate six middle categories into one group. That is, we defined a family as low SES if its household income falls between 0 and 99 percent of the FPL, as high socioeconomic status if its income exceeds 400 percent of the FPL, and as middle socioeconomic status otherwise. We chose to aggregate the middle groups because our interest lies in examining comparing how low SES children respond to inclusive education and whether their reaction differs from high SES children's. To ensure that our choice of trichotomy does not affect the results, we ran additional analysis using eight categories for socioeconomic status as provided in the NSCH data and found that the results do not change. We report the results using three SES categories for conciseness (Ristić & Savić Kukolj, 2020).

As a potential source of variation in the likelihood of remission, we examine special education environments. To this end, we further restricted our analyses to school-aged children and adolescents. To measure special education environment, we used data available in the U.S. Department of Education's online data archive (U.S. Department of Education, 2010). The online archive provides information about special education provisions submitted annually by states to the Department of Education in compliance with Section 618 of the IDEA. To classify inclusive special education environments, we relied on the time children with disabilities spent in regular versus self-contained special education classrooms. States report the number of children belonging to each of the following three categories: inside regular classroom 80 percent or more of the day, inside regular classroom 40 percent to 79 percent of day, and inside regular classroom less than 40 percent of day. We included all fifty states and the District of Columbia in our analyses.

To collect information on potential state-level confounders, we relied on several external sources. First, to measure academic accountability policies, we borrowed Dee and Jacob's (2011) coding of accountability systems. Their coding scheme identifies 30 states that had their own accountability systems in place prior to the introduction of No Child Left Behind (NCLB) in 2002. Second, we account for statelevel variation in bills and resolutions that prohibit teachers and school personnel from coercive labeling of children with mental disorders and recommending psychiatric treatment including psychotropic medication. This information came from AbleChild's website. We coded whether each state passed a bill or resolution prior to the introduction of a federal-level ban in 2004. Fourteen states instituted bans before the federal act. In addition, we included data on the percent of the population in a state with health insurance from the 2010 census. The number of psychiatrist per 1000 which was calculated with data from the American Medical Association.

DESCRIPTIVE ANALYSES

First, we describe ADHD prevalence among children with different socioeconomic backgrounds. To do so, we plotted the percent of children who were currently diagnosed with ADHD, stratified by socioeconomic status. Next, we examined ADHD remission rates by socioeconomic status and special education environment. We coded a state's special education environment as inclusive if children with disabilities spend considerable amount of time in general classrooms and little time in self-contained, separate classrooms. Specifically, we measured the proportion of children spending less than 40 percent of the day in general classroom and reverse-coded the proportion to denote inclusiveness. The Department of Education provides breakdown of time spending data by thirteen disability categories. Children with ADHD are eligible for special education service under the “other health impairment” category. However, we aggregated information across all the disability categories. This is because of the high rate of co-morbidities of ADHD with other disabilities. In fact, two thirds of students in the “other health impairment” category had ADHD as did almost 60 percent of children in the emotional disturbance category, one fifth of students in intellectual disability category, and four percent of students in the specific learning disability category (Schnoes, Reid, Wagner, & Marder, 2006). Because children with ADHD are likely to receive care under other categories due to co-morbidities, we used the overall placement pattern as an indicator of a given state's general stance toward inclusive special education. We log-transformed “inclusive special education environment” because of skewness and mean-centered to facilitate interpretation. For plotting, we categorized states into three groups based on the extent to which their special education is inclusive. Top third states ($0.20 \leq$ and ≤ 1.27) were coded as the “most inclusive” and the bottom third states ($-0.90 \leq$ and < -0.176) as the “least inclusive.”

LOGISTIC REGRESSION MODELS

To examine whether special education environments are associated with the likelihood of ADHD remission, we estimated logistic regressions for school-aged children and adolescents. Our aim in this analysis is to examine whether low and high SES children's remission rates are associated with special education environments after controlling for confounders.

The dependent variable, "remission from ADHD," is an indicator variable that takes one if a surveyed child, who had been diagnosed with ADHD, no longer has ADHD at the point of survey. Our independent variables of interest are the inclusiveness of a state's special education and child's SES. To examine whether special education environments are more or less important for children from less advantaged backgrounds, we include an interaction between individual SES and state special education environment.

We included several individual-level covariates that are expected to correlate with special education environment, SES, and remission of children with different SES. First, we included demographic variables such as age, sex, and race as control variables in all models. Research has been documented that remission rate increases with age (Biederman, Mick, & Faraone, 2000). We included an indicator variable for sex and a categorical variable of race because different groups might have varying levels of access to treatment and adherence to treatment. Female and white were reference groups. Second, we controlled for insurance type because high SES children are more likely to have insurance with better coverage, which in turn, increases the odds of remission. There were three types of insurance in the NSCH data: private, public, and not-insured. Privately insured is the reference category. Third, family structure was included because of its potential association with children's educational outcomes. Living with two biological parents was the reference category. Fourth, we controlled for type of school because high SES children are more likely to attend private schools and public and private schools provide different services and contexts for children with ADHD. Four types of school were used: attending private school, attending public school, home-schooled, and not enrolled. Attending public school was the reference category. Last, co-morbidity was included in the analysis as a proxy for a child's severity of behavioral disorder. To control for co-morbidity, we included indicator variables that for each of the following mental and behavioral disorders: depression, anxiety problems, behavioral or conduct problems, autism spectrum disorders, developmental delay, speech problems, and learning disability. The indicator variables were coded as one if a child has been diagnosed with the respective disorder.

In addition, we controlled for potential state-level confounders. First, we included the NCLB treatment as a control variable. The NCLB treatment is an indicator variable and was coded as one if a state had no accountability system

prior to the NCLB and hence, the NCLB was a “treatment” to the state's education regime. When accountability pressure is recently introduced, teachers and school personnel might want to keep distracted children in self-contained environments to increase the academic performance of “regular” students (Cawelti, 2006). Such tendency will affect both the inclusiveness of special education and remission rates. Second, we controlled for the psychiatric service recommendation ban. This is an indicator variable and was coded as one if a state had had any prohibition bill or registration against teachers' and school personnel's recommendation of psychiatric diagnosis, treatment, or medication before the federal ban was introduced in 2004. When school personnel's or teachers' recommendation is permitted, they might do so to parents in order to manage classrooms more easily and improve the academic performance of children. States that had prohibited treatment recommendations before the federal ban are likely to have been favoring the use of behavioral treatment and accommodations for children with special needs, and therefore, may already have narrowed the remission gap between low and high SES children. Third, we controlled for several potential confounders that can affect low SES children's access to treatment. These variables include the proportion of insured children, the number of psychiatrist per 100,000 children, and income per capita (i.e., overall resourcefulness of the state).

To examine the relationship between remission rates, SES and special education regimes, we ran three sets of analyses to ensure our findings are robust to modeling choices. We first ran a set of logistic regressions stratified by SES. In the stratified models, our goal is to determine whether the association between the odds of remission and inclusive special education are different among high and low SES samples. Next, to ensure the same pattern holds with the complete sample, we ran a logistic regression model using cases across all SES levels and added interaction terms between SES and inclusive special education. The goal of this analysis is to test whether the odds ratio of the interaction term between inclusive education and low SES category is significantly greater than one, which would suggest that the odds of low SES children's remission increase at a faster rate as a function of inclusive education than those of high SES children's. In both stratified and interaction models, we clustered standard errors by states because our independent variable as well as some s control variables are statelevel covariates. Finally, we ran a random-intercept multilevel logistic regression to account for the facts that children are nested in states. In estimating the interaction effect between an individual-level and a state-level covariate – in our case, the interaction between low SES and inclusive education –, multilevel modeling accounts for the fact that children are nested in states and therefore, error terms are likely correlated as such. In the interaction and multilevel models, we use high SES as the reference category.

RESULTS

To explore whether ADHD gradient exists, we first plotted the percent of children with ADHD by SES group. In 2007–2008 survey, 8 percent of children were reported to currently have ADHD. Figure 1 indicates that higher fraction of low SES children has ADHD than their more advantaged peers. Of families with household income below thefederal poverty line (low SES families), 11.33 percent reported that their children currently have ADHD whereas 7.19 percent of families with household income above 400 percent of the federal poverty line (high SES families) reported that their children have the diagnosis. This difference in ADHD prevalence between high and low SES groups was statistically significant ($t = 10.98$, $p < 0.001$), suggesting that the overall gradient in ADHD prevalence be negative.

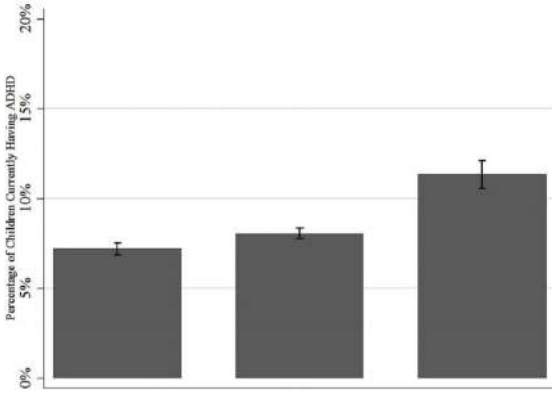

Fig. 1. Percent of school-aged children currently having ADHD by socioeconomic status.
Note: Authors' calculation based on data from the National Survey of Children's Health, 2007–2008

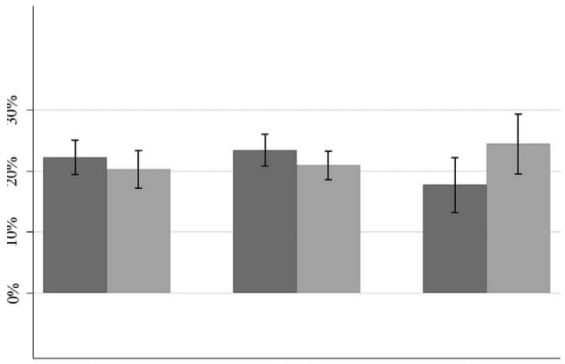

Fig. 2. Percent of school-aged children remitted from ADHD by socioeconomic status and special education environment.

Note: Authors' calculation based on data from National Survey of Children's Health, 2007–2008. Based on the inclusiveness of special education, we labeled top third of states as most inclusive states. Bottom third of states was coded as least inclusive states. High SES children's remission rates in least and most inclusive states are not statistically different ($t = -0.92$, $p = 0.179$). Low SES children's remission rate is higher in inclusive states than in restrictive states ($t = 1.97$, $p < 0.05$)

Next, we plotted remission rates of high and low SES children by special education regime. Fig. 2 shows that low SES children's remission rates are higher in most inclusive states than in least inclusive states. Although the confidence intervals for the inclusive and restrictive states overlap, a t-test with independent samples revealed that the group means for the two group were significantly different form each other ($t = 1.97$, $p < 0.05$).

In contrast, high SES children's remission rates did not significantly differ in more and less inclusive states ($t = -0.92$, $p = 0.179$). Finally, to ensure that the relationship between remission, SES, and special education environment holds after controlling for potential confounders, we turned to regression models. Table 1 summarizes descriptive statistics of variables used in statistical analysis. The overall remission rate was 22 percent. For the purpose of easier interpretation of effect sizes, we standardized inclusive education. To put the standardized measure into perspective, mean inclusive education indicates that special-education children in those states spend roughly 11 percent of their time at school in self-contained classrooms. One-standard deviation above the mean translates into roughly 8 percent of time in selfcontained environments, and one-standard deviation below the mean stands for roughly 18 percent of time in such restrictive settings.

We employed three sets of logistic regressions:

1. stratified models,
2. an interaction model, and
3. a random-intercept multilevel model.

Table 1
Descriptive statistics

Individual-level variables	Obs.	Std. Dev	Min	Max
Remission	5967	0,220		
Sosioeconomic status				
High	5967	0,348		
Middle	5967	0,507		
Low	5967	0,144		
Age	5967	12,719	6	17
Sex				
Female	5967	0,710		
Male	5967	0,290		
Race				
White	5967	0,732		
Black	5967	0,103		
Multiracial	5967	0,165		
Insurance				
Private	5967	0,631		
Public	5967	0,313		
Non (Cash)	5967	0,056		
Family structure				
Two parent-biological or adopted	5967	0,659		
Single mother-no father present	5967	0,237		
Other famiky tyoe	5967	0,103		
School				
Public	5967	0,866		
Private	5967	0,109		
Home-schooled	5967	0,022		
Comormidity				
Depression	5967	0,216		
Anxiety	5967	0,257		
Behavioral disorders	5967	0,273		
Autism	5967	0,082		
Developmental problem	5967	0,214		
Spechhch disorder	5967	0,132		
Tourette syndrome	5967	0,020		

Models 1 and 2 of Table 2 shows that among high and middle class children, there are no significant differences in remission rates across special education regimes. In contrast, Model 3 suggests that the remission rate of low SES children of inclusive states is on average by 1.3 times higher than that of restrictive states (OR: 1.259, $p < 0.01$).

We find the same pattern in a logistic regression model with interaction effects. Model 4 of Table 2 indicates that the effect of inclusive special education on remission rate is much larger among low SES children than among high SES children (OR: 1.294, $p < 0.01$).

Table 2

Factors associated with the odds of remission from ADHD among school-aged children.

	Model 1	Model 2	Model 3	Model 4	Model 5
	High SES	Middle SES	Low SES	Interaction	Multi-level
Inclusive education	0,989	0,959	1,259	0,969	0,965
Middle SES				1,168	1,175
Low SES i Inclusive education				0,995	1,001
High SES i Inclusive education				1,294	1,290

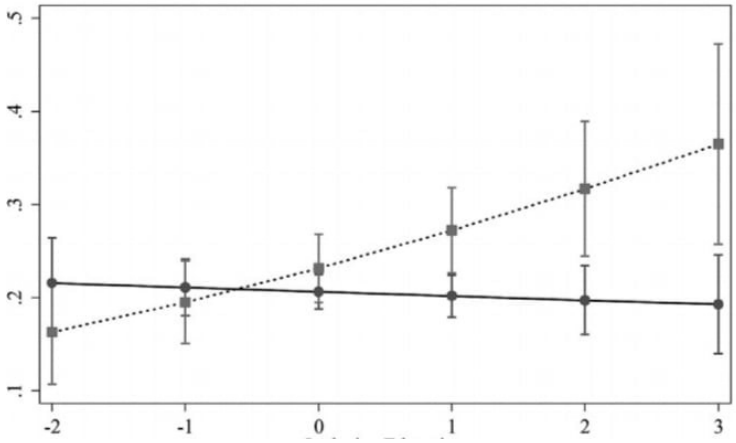

Fig 3. Odds of remission by special education environment, stratified by socioeconomic status.

DISCUSSION

Special education environments are associated with differential remission rates among more and less advantaged children. While high SES children do not

respond significantly to special education environments, low SES children educated in inclusive settings have a better prognosis than their peers in restrictive environments. This suggests that schools may be particularly important in ameliorating disparities in childhood behavioral disorders.

Our study has several limitations. First, we rely on cross-sectional data on ADHD remission at the individual level in conjunction with educational environment data at the state level. Ideally, we would use repeated observations of same individuals over time and trace their ADHD diagnosis and remission as well as their placement in special education environments, rather than relying on reported changes in diagnosis. The cross-sectional nature of the NSCH data and our measure of special education environments at the state level limit our ability to identify clear causal relationship. With longitudinal observations on children's mental health in combination with their placement data, one could make stronger causal claim about the relationship among differences in the utilization of special education services by families with different socioeconomic background, remission from ADHD, and geographic variation in gradient. However, using data at the state level helps assuage some potential selection concerns. If our analysis examined whether or not an individual child was placed in a more or less restrictive environment, we worry that the characteristics determining placement would be associated with the likelihood of remission. While using state level data on restrictiveness has limitations, it helps us overcome individual selection issues.

Second, our measure of special education environment might be capturing other factors. We interpreted the proportion of students in restrictive placements in a given state as a measure of access to better special education services. Alternatively, our measure could indicate overall quality of special education in the region – i.e. the financial and human resource availability of schools in a state to provide special service, accommodations, and modifications that would cater special needs of children with disability. We attempt to address this issue by controlling for the Individuals with Disabilities Education Act (IDEA) determination. Released by the U.S. Department of Education's Office of Special Education and Rehabilitative Services, the IDEA determination assesses each state's special education performance. We used the IDEA determination of 2006 (U.S. Department of Education, 2007) and created an indicator variable of whether a state met the requirements of the statue. Even after the IDEA determination was included in the models, the effect of inclusive education environment on low SES children's remission was positive and significant (results available upon request). This suggests that inclusive education has a direct relationship with the remission rate among low SES children net of its indirect influence on the remission rate through the effectiveness of overall special education provision. In addition to this analytic strategy, interpreting our measure of inclusive environment as overall quality of special education cannot explain the empirical pattern of geographic variability by SES.

That is, if inclusive education environment translates to higher levels of resources availability and capacity to provide special education services, we would expect to see higher remission rates among all children in inclusive states compared to their peers in more restrictive states. The quality-of-service-provision intervention alone cannot explain the unequal remission rates between low and high SES children in states with more and less inclusive special education practices. Third, it is also possible that children from more advantaged backgrounds would prefer to maintain their diagnosis in order to access medication and other benefits afforded by a diagnosis. If this were the case, we would expect them to have lower remission rates in general. While we do not observe this, their invariant response to educational environments is consistent with this explanation. While our study focuses on the benefits of more inclusive environments for lower SES children, further work should examine why these benefits do not accrue to higher SES children.

Finally, it may be important to note that ADHD can be mis-diagnosed and that individual or environmental characteristics, such as SES, can drive over- or under-diagnosis (Bruchmüller, Margraf, & Schneider, 2012; Morley, 2010; Reyes, Baumgardner, Simmons, & Buckingham, 2013). In this regard, one might be concerned that misdiagnosis may confound our results. That is, low SES children that do not actually meet the diagnostic criteria are more likely to be mis-diagnosed with ADHD in inclusive states than in restrictive states (i.e., false positives), and their higher remission rates in inclusive states may result from the mis-categorization of low SES children whose behavior only mildly resembles the symptoms of ADHD. In other words, low SES children diagnosed with ADHD in inclusive states are easier to “fix” than those in restrictive states.

Unfortunately, our data do not include information regarding children's symptoms and their diagnostic processes. We, however, believe that inclusive education would not be associated with over-diagnosis of low SES children. First, healthcare professionals, working outside education systems, have no reason to be more biased in inclusive states to produce false positive diagnoses. Second, nether inclusive nor restrictive regimes have an incentive to push low-SES children for diagnosis. If anything, the reason for schools and education systems to push for diagnosis would be for the ease and effectiveness of classroom management. Such a tendency toward effective classroom management is likely high when the academic pressure is present. To address this concern, in our statistical models, we controlled for the presence of academic pressure at the state level, by including an indicator variable that denotes whether No Child Left Behind policy increased pressure for academic accountability for the given state around 2007. Our results show that even after controlling for the presence of academic pressure, inclusive states had higher remission odds of low SES children. Furthermore, for inclusive states, ease of classroom management wouldn't be an incentive to push low SES children's diagnosis at all.

Recall that inclusive regimes will place children with disabilities in regular classrooms to the maximal extent. Given that children most vulnerable to over-diagnosis would have only mild behavioral problems, they will likely remain in regular classrooms with their peers even if they obtain ADHD diagnosis. At the other extreme is restrictive states. We contend that the primary reason that restrictive regimes place special education students in self-contained classrooms is the lack of resources. Note that education systems are evaluated by the federal agency, and federal funding is allocated according to the evaluation. One important evaluation criterion is the degree of inclusiveness of special education provision. Therefore, a concern for losing federal funding likely counteract the incentive to push for ADHD diagnosis even if the separation of special education children from regular students may make it easier to manage classrooms. That is, for restrictive states, a concern of losing federal funding likely triumphs a desire for ease of classroom management.

This article makes three contributions. First, to our knowledge our study is the first to link ADHD remission and schooling. Estimates of remission (Agnew-Blais JC et al., 2016; Biederman et al., 2011; Biederman et al., 2012; Faraone et al., 2006; Kessler et al., 2005) as well as studies of behavioral interventions in schools exist (Banerji & Dailey, 1995; Fryxell & Kennedy, 1995; Kennedy et al., 1997; Rea et al., 2002; Waldron & McLeskey, 1998). However, little attention has been drawn to the context in which treatment and intervention are delivered. We highlighted special education environments as an important context in which behavioral treatments takes place. The significance of schooling in treatment of mental health and behavioral disorders is paramount because children and adolescents spend the majority of time at school or doing school-related activities and tasks. Second, our findings contribute to the fundamental cause tradition by empirically examining how an institutional environment can interact with individual's socioeconomic status to produce gradients in a health outcome. Finally, our study sheds light on a potential implication of special education regimes in the reproduction of social inequality. Schools are of critical importance in reducing disparities in access to treatment because other treatment modalities, such as medication, psychiatric treatment, and family-based interventions, are stratified by socioeconomic status. In our study, higher SES children are invariant in their response to educational environment suggesting they may have access to treatment outside of the school system. Institutional environments, on the other hand, impact low SES children's prognosis, increasing or decreasing disparities in health. Our study suggests that inclusive special education environments may help reduce mental health disparities among children and adolescents. Health gradients in children's health can reproduce, if not amplify, social stratification because they affect other important outcomes such as educational attainment, occupational choice, and income. Therefore, it is important to ensure that our institutions provide adequate

social arrangements from which children with little family resources can receive otherwise unavailable care and services.

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KAKO MATERIJALNA SREDSTVA I DRUSTVENI STATUS PORODICE U SPREZI SA INKLUZIVNIM OBRAZOVANJEM DOPRINOSE SMANJENJU POREMECAJA PAZNJE I HIPERAKTIVNOSTI (ADHD)?

Sažetak: U ovom istraživanju je razmatran odnos inkluzivnog nastavnog okruženja, socioekonomskog statusa i verovatnoće smanjenja poremećaja hiperaktivnosti kod dece. Iako ećina dece doživi promenu u hiperkativnom ponašanju kroz proces odrastanja, verovatnoća za ublažavanje ovog poremećaja varira kroz različite socioekonomske statuse i nastavna okruženja. Ovom studijom je pokazano da dete nižeg socioekomskog statusa ima veće šanse za smanjenje uticaja hiperaktivnosti na njegovo ponašanje ukoliko pohađa inkluzivnu nastavu. Nasuprot tome, za decu koja su naprednija, šanse za smanjenje hiperaktivnog ponašanja ne zavise od nivoa specijalne edukacije i inkulzije. Ovim radom želi da se pokaže da sprovođenjem inkluzivne nastave mogu da se smanje razlike u ponašanju posebno kod dece koja su manje napredna. Time bi ova studija doprinela naučnoj građi jer pokazuje kako institucionalna okruženja mogu da prevaziđu socioekonomski status kod redukcije hiperaktivnog ponašanja.

Ključne reči: ADHD, inkluzija, specijalna edukacija, socioekonomski status, institucionalno okruženje

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INDIVIDUAL PLANNING IN SOCIAL WORK – WHERE ARE WE TODAY?

Abstract: The paper presents the reflections on current theoretical understanding and experience from practice related to the application of individual planning in social work. The reflections are based on the author's experience from the perspective of a supervisor, educator and researcher. The aim of the paper is to: (1) deepen the understanding of theprofessional context and position of professionals employed within the social welfare system in the Republic of Croatia from the aspect of their capacities to conduct individual planning; (2) deepen the understanding of the significance of the user's perspective and active participation of users in the process of individual planning, and (3) raise awareness for the need to contemplate and connect theoretical, value and experiential resources of social work to the benefit of the users and professionals related to the application of individual planning.

Keywords: individual planning, reform, social welfare system

„The thing I like the most about my social worker is that she takes time for me and tells the others not to interrupt us.”
“We made the individual plan together, my social worker and I, with some good ideas for the future, how to cope with crisis after leaving the hospital, how to get back on my feet…”
“My social worker told me that sometimes she has problems as a parent too, that it is normal and that it is not easy to be a mother. I never thought the two of us had something in common.”
(From the author's personal communications with the users during work in counselling centre)

INTRODUCTION

During the 1970s and 1980s, new theoretical concepts of the work method and approach to users in social work were contemplated in the USA and Great Britain, and thus the concept called *care management* appeared in the USA, and the concept of *care management* in Great Britain (Ajduković & Urbanc, 2009; Lesički, 2011).

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Case management, translated into the Croatian language as '*vođenjeslučaja*', is applied when the user needs several services from the area of social or health care. The role of the case manager is to assess the user's needs, strengths, limitations and available resources together with the user, and based on that assessment, to make an individual plan of the change which defines priorities, desired outcomes, strategies, resources and those responsible for the realisation of certain activities. The focus is on the collaborative relationship between the user and social worker, clear definition of the roles of each individual stakeholder, continuous monitoring and revising the plan taking into consideration current changes in the life of the user and evaluation of the achieved (Ajduković & Urbanc, 2009).

In *care management*, translated into the Croatian language as '*vođenje skrbi*', the role of the social worker is to find service providers in the community outside the system (with non-governmental, non-profit and profit organisations that have a special permit for that), and to enter into contracts with them. The focus is on services. In practice, *care management* implied the user's adjustment to services and the introduction of the market model in service provision, and the role of the social worker was reduced to management and control, i.e. case monitoring. Within this approach, the focus was not on the user, and in its essence it did not reflect the theoretical and value paradigm of modern social work, such as empowerment, respecting the user's perspective and the development of collaborative relationship, and it has never taken root in practice (Ajduković & Urbanc, 2009).

The essential difference between these two approaches lies in their different value and paradigmatic basis: from professional responsibility to the user and his/her needs in case management to the managerial approach to service provision and control in care management, with an attempt to introduce market principles into the provision of social services. Experiences of introducing care management approach in Great Britain have shown a significant increase of bureaucratisation of social work, reduced share of time that the social worker spends in direct work with the user and the lack of service providers in the community. That meant that services were accessible only to the users who met rigid, high criteria, and the social worker was more involved in the organisational aims of social work, rather than the professional ones (Adams, Dominelli & Payne, 2009).

During the 1990s, a new approach appeared in the USA, and it came to be known as 'person-centred planning', i.e. planning focused on a person, which was initially applied in the work with the disabled, but later expanded to all the users (Lesički, 2011). Planning centred on a person emphasised basic principles of social work more since it was based on independent decision-making of the users about services they considered to be the most appropriate ones, as well as on maintaining their control over the course and contents of the service provision process (Ajduković & Urbanc, 2009; Mahoney, 2011; Lengyl, 2017). The aim of the person-centred approach in individual planning was to ultimately increase the

user's quality of life and his/her influence on the process of planning and providing services (Lesički, 2011).

Theoretical and value rationale for the application of individual planning is nowadays recognised in modern social work through its basic principles: (1) provision of services tailored to the users (contrary to the attempt to adjust the user to the existing needs and market principles of service provision); (2) respecting the user's perspective and keeping "their voice", and (3) the process of agreement, co-operation between the social worker and the user, nourishing the motivation for change and collaborative relationship (Spicker, 2012).

Furthermore, advantages of individual planning include enabling the user the experience that they are "visible" in the system, that they are unique in their efforts to improve the quality of their lives (Landhammer et al., 2015). Čačinović Vogrinčić, Kobal, Mešl and Možina (2007) use the term "individualised collaborative project of assistance", emphasising the importance of the individualised approach and the development of collaborative relationship directed towards a good result and desired outcome.

DEVELOPMENT OF INDIVIDUAL PLANNING IN CROATIA

The development and application of these approaches had an impact on the social work practice and theory in Croatia too. Thus during 2009 the social welfare system reform came into the focus of the professional public. The long-awaited reform included the introduction of a new concept of the organisation of social welfare centres (so-called "backbone" of the social welfare system) according to the principle of "one-stop office" (MZSS, 2010). The reform was preceded by a decade of various preparations, so that from 2002 to 2003 the Ministry of Health and Social Welfare implemented a project called Strategy of Social Welfare System in Croatia, with a financial aid from the World Bank, Department for International Development of the Government of Great Britain and the government of Japan (MZSS 2009a; 2009b; 2011). Although changes in the organisation and manner of work of social welfare centres were initiated within this project, they did not take root until 2009, when they started to be implemented within the international Project of the development of social welfare system, realised on the basis of the loan from the World Bank and the Swedish Agency for International Development. One of the central ideas of the social welfare system's reform was the one of creating a system centred on the needs of users and adapted to them (Ajduković & Urbanc, 2009). This idea is not new in social work, and in other helping professions it can be observed that since 1970 there has been a trend of changing the helping paradigm towards the criticism of so-called medical[2], and in favour of

[2] Medical model is characterised by the approach to the patient as the patient, s/he is observed through theprism of illness, it is oriented towards what the individual cannot do, and the helper knows what is best for the user (Urbanc, 2006).

the social model[3] (Urbanc, 2006). Ethical, i.e. value level of these changes could be explained by a shift of focus from so-called salutogenesis (instead of former pathogenesis), or towards strength and potentials, enhancing resources and resilience of individuals, families and community, as well as changing the perception of the users as problematic and incompetent to participate in the decisions which affect their lives (Ajduković & Urbanc, 2010; Bojtor, 2019).

Until then the individual planning and case management approach existed in Croatia within some other professions (special education, psychiatry and medical profession in general), so the case manager's role was to assess the user's needs, his/her resources and risk factors, and to decide about the course and content of the rehabilitation program, aims and inclusion of the environment (Gruber, Štrkalj Ivezić, Agius & Đorđević, 2007). Consequently, until the 1990s case management and individual planning were not based on considering and ensuring the user's perspective, since the paradigm that the expert is the one who has the power to decide and make decisions which are important for the user's life and well-being was the dominant one in theory and practice alike.

Only after the 1990s the new paradigms of helping approaches, which were already present in the Anglo-Saxon context and which promoted various mechanisms of social participation of the users, started to be taken into consideration in social work education and practice. Different user movements that influenced the development of power and knowledge in practice, but also in research, contributed to this (Foucalut, 1991; Oliver, 1996; Šugman Bohinc, 2007; Urbanc, 2009; Škerjanc, 2010; Beresford, 2012), as well as the appearance of the interpretative paradigm and action component and research that promoted the inclusion of users in the research and the application of obtained results in the planning of social and other services. In spite of that, the paradigm itself and professional values based on re-examination of the distribution of power in the helping relationship changed slowly and erratically, in the beginning through educational, research and action projects, and later through the inclusion of the newly acquired knowledge into the education and practice of social work through courses which promote representation of the user's perspective[4].

With the social welfare system's reform of 2009, professional employees of social welfare centres became managers of the individual plan implementation in teams (Ajduković & Urbanc, 2009). In social work, the plan represents a detailed picture of the user's life situation, a survey of activities which can be undertaken and persons who can undertake them in order to realise the user's needs. Under the Social

[3] Social model brought a change in the manner of thinking – the emphasis is on the dialogue between the user and the professional, at which the user has the right not to agree with the professional (Urbanc, 2006).

[4] From 2007-2009 the Department of Social Work, University of Zagreb conducted an international project Service users as experience experts in social work education and researh. The project was led by the author, with thefinancial support from IASSW.

Welfare Act (OG 157/13, 152/14, 99/15, 52/16, 16/17), Article 4, an individual plan is defined as "… a plan of changes in the life situation, or behaviour of the user prepared on the basis of a comprehensive assessment of the needs, difficulties and resources, in agreement with the user and his family members, with the aim to overcome unfavourable life circumstances." Furthermore, Article 11 of the aforementioned Act stipulates that every user realises the rights from the social welfare system in accordance with his/her individual needs and with active participation, and Article 17 determines the right of every user to participate in the procedures related to the assessment of the condition and needs, as well as decision-making related to usage of services.

The task of the manager is to coordinate the activity of all participants, placing the user in the central position so that he/she could participate in all phases of the individual plan preparation. The case manager leads the professional team, ensures services to achieve the desired outcomes, assesses and defines the user's needs during the entire procedure, in co-operation with the participants makes decisions about conducting interventions, monitors and analyses the individual plan (Urbanc, 2015).

Work on individual plan preparation is a long-lasting process which demands building a relationship with the user, and it is important that the social worker uses words and language which is understandable to the user (Landhammer et al., 2015). The most significant characteristic of an individual plan is its orientation towards the user. Individual plan preparation is a process in which the user has an insight into the individual plan and can revise it in accordance with current changes in his/her life. The final result of an individual plan is an empowered user who has control over his/her life and influence in the decisions which are important for him/her (Urbanc, 2015). Respecting the user's perspective as one of the basic values of reform activities within social welfare system represents a step towards democratisation and a change of perception of users as passive recipients of help (Slettebo, 2013; Urbanc, 2015).

Co-operation with Slovenian colleagues and a possibility to learn from their projects and the literature focused on the application of individual planning had an impact on the development of individual planning in Croatia (Zaviršek, Zorn & Videmšek, 2002; Škerjanc, 2006; Šugman Bohinc, Rapoša Tanjšek & Škerjanc, 2007; Flaker, Nagode, Rafaelič & Udovič., 2011). These experiences have shown that, in comparison with some other methods which are more administrative in their essence, individual planning enables the user to take responsibility for his/her life and to exert influence on the decisions which are important to him/her. Contrary to the approach which is based on difficulties, shortcomings and defects that have to be superseded and in which the user's needs are defined to fit into the existing system of services and help at all costs, individual planning is focused on aims as the key concept and as an element of taking a step in a constructive direction.

At this point it is important to state that the aims do not derive solely from problems, difficulties and shortcomings – if they are defined exclusively on that level, then there is no so-called second order change and we remain on the first order change, if any progress is made at all.[5] Defining the aim from this paradigm includes the user's needs, current difficulties, but also much more than that – the aim includes the outcome, not only "improving the existing situation", but also the creation of something new (Flaker et al., 2011).

The Croatian social work practice has shown that the most frequent obstacles the users have in defining aims are the lack of knowledge, information or skills, followed by the lack of help and support and the lack of motivation (Urbanc, 2015). Obstacles in individual plan preparation by professionals, according to the research included: the lack of experience with individual plans, failure to motivate the user to take a greater responsibility for his/her behaviour, work with involuntary service users and the lack of opportunities for community-based interventions (Ajduković & Urbanc (2010).

EXPERIENCE IN THE APPLICATION OF INDIVIDUAL PLANNING IN PRACTICE

Hereinafter I will reflect on the experience in the application of individual planning in Croatia. The overview is based on the results of very few national research studies and professional papers, and on the author's experience in leading numerous supervisory groups and educations for social welfare system professionals. I would also like to present the course of the process of introducing changes in social work practice which was crucial for co-creating new applicable knowledge for social work and in social work, and which was a result of the agreed co-operation between the Ministry of Health and Social Welfare and the Department of Social Work. Namely, although it was long-planned and expected, social welfare system reform did not include the co-operation with the academic community from its

[5] A system which undergoes all possible internal changes, regardless how they are combined, and which does not reach the second degree change is said to be a system caught in a neverending game. The second degree change is often regarded as something that is impossible to control, something unpredictable after a long, frustrating effort (a new solution). However, the second degree change cannot be expressed in the language appropriate for the first degree change. In order to change the second degree, it is necessary to go to the meta level (f.e. in relation to a dream and behavioural changes in the dream, which are changes of the first degree, while the awakening is a meta-level, and it is a second degree change), Watzlawick et al., 1974). These authors discuss the situations in which, during the process of change, the solution becomes the problem, i.e. when the strategy „more of the same" occurs. In some situations, more of the same leads to the desired outcome (f.e., when we are cold, more warm clothes has positive outcomes). However, in other situations more of the same does not lead to the desired outcome, as for example in the case of prohibition and the attempt to solve the problem of alcoholism. It has been proved that, as the problem of alcoholism intensified, so the prohibition intensified, so that the „solution" became a greater evil than the problem itself (smuggling, corruption, and the continued high rate of alcoholism), Watzlawick, Weakland & Fish, 1974).

beginning, so the co-operation was established at the initiative of university teachers during the implementation of the pilot project on the new model of social welfare centres, so-called “One-stop office”, after which the implementation of this model was expected in the rest of Croatia.

It is important to mention that the experiences of some other countries (e.g. Great Britain) have shown the advantage of the gradual introduction of individual planning, i.e. planning centred on the person, with designing training and various aspects of support for professionals, from mentoring and coaching to specialised teams for solving problems and supervision (Routledge, Sanderson & Grieg, 2002). These understandings were partly applied in the stage of the pilot project implementation for the first five centres, but not in the period after the end of the pilot project, which resulted in the resistance of professionals *(“We do not have the time for novelties”; “We are used to work in the old ways”; “They just send us new instructions from above”; “We do not have the opportunity to communicate or to check how to move on…”; “This just means more work for already overburdened social workers”)*[6].

Research component: conducting research, publication of results and relevant papers based on them

Taking into account these experiences, the Department of Social Work conducted a qualitative research with the social welfare centre employees who were included in the pilot project of introducing the new work model under the principle “one-stop office”. The aim of the research was to analyse the experience with the new work model of the centres as a contribution to the evaluation of changes in the approach and work methods of the centres. The results have shown that the employees believe that the efficiency of the centres’ work is higher because the introduction of the so-called front or reception office ensured a relatively quick assessment of needs and further channelling of the users, and the so-called back office enabled a disburdening of employees for the purpose of ensuring time for the direct work with the users. With regard to the application of individual planning and the preparation of individual plans, many difficulties were encountered, both conceptual and organisational ones, and primarily the fear of imposing an even higher burden on social workers was experienced. Individual planning with involuntary users was pointed out as a particular challenge, as well as the lack of service providers in the local community in order to ensure undertaking of activities anticipated by the plans (Ajduković & Urbanc, 2010).

Within our reflections on the social welfare system reform, apart from this research two review papers were published, which together with the empirical part form a whole (Ajduković & Urbanc, 2009; Urbanc & Ajduković, 2010; Ajduković

[6] From the communication between the author and the members of supervisory groups.

& Urbanc, 2010). Through this 'trilogy' we attempted to enable the knowledge acquired by analysing the users' perspective (in this case the perspective of social workers who applied the reform ideas in practice) to be translated into the practice according to the principles of action research.

Action component: education and support of centre employees

The action component manifested itself in the education of the first 60 employees according to the model "train the trainer" on the topic of individual planning, and it has been conducted by the Department of Social Work of the Faculty of Law, University of Zagreb in partnership with the Ministry of Health and Social Welfare since 2010. Parallel to educational processes, standards and quality of social services were developed, and the key consideration was the recognition of the need for change management and gradual introduction of changes, assuming the existence of well informed and educated professionals. It is important to note that the education was based on the results of empirical research through which educational needs of the participants were expressed and that "*ex cathedra*" was not planned. The participants were informed about the research results, report for the Ministry and the publications that resulted out of it, and they were asked to give their overview on the value, theoretical, content and procedural level considering the applicability of the materials in practice.

The education proved to be an exceptionally valuable area for opening a dialogue between 'theory and practice', moreover because it was based on the principles of participation, active learning and critical thinking, which was considered very good by the participants. Furthermore, the workshop represented a good model of mutual creation of a good practice, which is characteristic of and significant for social work as a profession. As a result of that, within the education, recommendations were generated about the universal elements which individual plans should contain, what should professionals be guided by and what specific features should be taken into account.

In the following years the process of dissemination of the acquired knowledge was continued, so that in 2018 and 2019 four more workshops in the duration of three days were organised for more than a hundred social welfare system employees within the education "Case management in the assessment of well-being of adults and the application of individual planning in social work" (Urbanc & Kletečki Radović, 2019). Apart from that, smaller workshops were conducted within various projects and educations for individual social welfare institutions, including professional teams and members of regional associations of social workers (also including around one hundred participants).

In the initial period of the reform introduction, it was customary for social workers to request a form to be designed as a substitute to the individual plan in

order to avoid wasting already reduced time for talking with the user. This initiative can be understood in the light of highly unfavourable conditions in which social workers work in many social welfare centres in Croatia which, apart from the shortage of staff and a large number of public powers, have inadequate space for the reception of users in which it is difficult or impossible to care about the dignity and confidentiality during a meeting between the social worker and the user. This demand was an indicator of the basic misunderstanding of the process of individual planning, so it was necessary to ensure further education and support for practitioners.

Although supervisory support was not systematically introduced and ensured for all interested social workers, there is an increasing number of practitioners who are included in various aspects of group supervision (method, developmental-integrative, educational etc.), which also contributes to the exchange of experience and constructive integration of theory and practice, but also to the reflection on conceptual and organisational issues related to the application of individual planning and efficiency of work models.

Paradigmatic component: acquisition of new theoretical approaches and introduction of new knowledge into the education of future social workers

Comprehensive experiences in the application of individual planning and learning and teaching this contents were included in the first university textbook on that topic entitled “Individual planning in social work” (Urbanc, 2015). It is intended for the graduate students of social work and for practitioners. The unity of theory and practice in the creation of applicable knowledge and the principles of its application proved to be exceptionally important in this case as well, so the textbook has taken root in practice. Since an interdisciplinary approach was used in writing the textbook (from the perspective of social work, law and psychiatry, but also from the academic and practical perspective), harmonisation and reconciliation of different helping paradigms (which in the case of health care and legislation largely rely on objectivist starting points, while in social welfare system they rely on constructivist starting points of helping) represented a great challenge. Apart from that, during the writing of the textbook, several new legislations crucial for this subject matter were in the process of preparation, and their amendments had to be taken into consideration (Family Act, Act on Protection of Persons with Mental Disorders, Social Welfare Act, and it was particularly difficult to track very dynamic changes within the Family Act, which was challenged and revoked by the Constitutional Court of the Republic of Croatia shortly after it came into force).
Today the concept of individual planning is an integral part of the theoretical, experiential and practical part of the education of social work students, especially within the compulsory graduate study course *Integrative social work* (Ajduković,

Urbanc, & Rezo Bagarić, 2020), as well as of the practice that the students spend in social welfare centres. Within the course, graduate student are obliged to prepare individual plans based on current cases from practice, after which they spend a month of practice in local social welfare centres where they have an opportunity to get involved in the preparation of individual plans for certain users and then reflect these experiences in their supervisory groups that are organised within the course of study.

IN CONCLUSION: WHERE ARE WE NOW – EXPERIENCES SIGNIFICANT FOR PLANNING FURTHER STEPS

Several types of individual plans can be distinguished conceptually, with regard to the needs and life circumstances of the users: (1) long-term individual plan of change is related to a longer period in the life of the user, because it is prepared for the realisation of complex and broader aims; (2) short-term *ad hoc* plan of change is prepared together with the user in case of simpler and individual aims which do not require great adjustments, financial means or additional professional help and (3) plan of change for some risky situation or condition is related to a more distant future when a reduced participation of users is expected due to deterioration of their health condition or old age (Škerjanc, 2007; Urbanc, 2015).

However, during the education of social welfare centre employees on the topic of individual planning, it was shown that in the centres' practice the long-term individual plan of change is used almost exclusively, while the other types of individual plans are named and registered by social workers in the form of their own notes, official notes or in some other manner. It was also shown that different forms of notes contain the elements of individual plans, and in many ways follow their structure. At the beginning of educations, when we would ask social welfare centre employees whether they used individual planning as a method, we frequently received responses which reflected a resistance towards the use of this concept (from unwillingness to anger, or from sporadic application to the apology and regret because they lack resources for the continuous preparation and application of individual plans).

When we asked the participants in the next meeting to send us their examples and try to structure them into a form that corresponds with an individual plan, it was evident that they largely already contain substantial elements and preparatory steps of individual plans (needs assessment, resources and difficulties of the user and his environment, short-term and long-term aims, those responsible for activities, deadlines and monitoring the implementation). The elements which were less represented or which were lacking included the procedural and value aspects of individual planning as a manner of approaching the user and contemplating the aims and outcomes. Many social workers told us on these occasions

that they prepare individual plans under the manager's pressure to have a coverage in case of control, and that in fact many individual plans greatly resemble one another, so that their service value, real involvement of the users, their participation in the process and the possibility to monitor and evaluate implementation and outcome remain questionable. Faced with the lack of time for direct work with the users, the user's perspective is often reduced to his/her signature at the end of the individual plan, while the essential participation in the creation of aims and outcomes is missing, and it is disputable how individual users understand and follow the content and the process.

In conclusion, obstacles which are still present in the application of individual planning can be divided into: (1) general work conditions and work burden (insufficient number of professionals in the centres, inadequate spatial capacities and the lack of IT support, professional stress as a reaction to the discrepancy between work demands and the environment, as well as possibilities and expectations of the professionals; (2) lack of consistency between the changes within the system and those outside of it; (3) competences and willingness of professionals to apply individual planning (lack of knowledge and skills, habits and attitudes of professionals), and (4) we could add to this the excessive scope of work and marked administrative work component to the detriment of direct work with the user (Ajduković & Urbanc, 2010; Štambuk, Sučić & Vrh, 2014; Urbanc, 2015; Urbanc & Kletečki Radović, 2019).

Considering all that was mentioned above, it has proved necessary to carry out a comprehensive evaluation of the outcomes and processes of individual planning, with the participation of all stakeholders (professionals, users, educators and decision makers), and to ensure education for and supervisory support to practitioners. The education should be conducted continuously, but with an appropriate generational sensitivity, since the new generations of social workers acquired the knowledge about individual planning in the university study, while older generations learnt about it during additional training. It could therefore be said that the newer paradigmatic approaches in social work are theoretically and in terms of value closer to those who have recently completed their university study and who have brought with them an approach based on strengths and resources and not on difficulties only. However, experience in the workshops with social workers of different generations did not confirm this unequivocally. What proves to be crucial in the acquisition of new knowledge is the willingness of professionals to learn and to change, to be open to dialogue worldview, to have their own visions and ideas and to experience education as an opportunity to renew their strengths and as an inspiration for the future. This finding places before us, the educators, the responsibility to be guided by the principle of isomorphism in planning and conducting educations for practitioners – what we expect them to give their users (empathy, empowerment, collaborative approach and language of respect), they have to experience themselves while acquiring new knowledge and skills.

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ISKUSTVA PRIMJENE INDIVIDUALNOG PLANIRANJA U SUSTAVU SOCIJALNE SKRBI REPUBLIKE HRVATSKE

Sažetak: U izlaganju će biti iznijeta iskustva uvođenja i primjene koncepta individualnog planiranja u sustavu socijalne skrbi u Hrvatskoj tijekom posljednjih deset godina. Cilj rada je dati kritički osvrt na procesne i sadržajne aspekte uvođenja ovog koncepta iz istraživačke, supervizijske i edukativne perspektive. Individualno planiranje predstavljalo je jednu od najznačajnijih inicijativa reforme sustava socijalne skrbi pokrenute krajem 90-ih u Hrvatskoj. Iako ideja o individualiziranom pristupu i individualnom planiranju svakako nije nova u socijalnom radu, pokazalo se da profesionalna javnost nema jednoznačno mišljenje o individualnom planiranju kao upotrebnom znanju. Zagovaratelji individualnog planiranja isticali su potrebu individualizacije usluga socijalne skrbi, suprotstavljajući se tipiziranim rješenjima, dok su se protivnici uvođenja ovog koncepta suprotstavljali novim obavezama koje će u još većoj mjeri opteretiti socijalne radnike. Iskustva primjene individualnog planiranja pokazala su kako za uvođenje ovakvih promjena nisu dovoljne promjene zakona kao ni nekritično usvajanje inozemnih modela prakse, već suštinska promjena paradigme rada te plansko upravljanje procesom tih promjena. Teorijski okvir za analizu ovih iskustava je koncept integrirativnog socijalnog rada (Adams, Dominelli & Payne, 2009) te paradigma refleksivnosti i procesnog znanja prema Sheppard (2000).

Ključne riječi: individualno, planiranje, integrirajući socijalni rad, refleksivnost, procesno znanje

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CODIFYING BUSINESS AND ETHICAL PRACTICE IN CRISIS SITUATIONS

Abstract: The development of modern society, accompanied by the changes brought by the industrial revolution with new technologies, scientific discoveries, technical innovations and globalization, has influenced the creation of a new organization that these contemporary social changes have to adapt not only in organizational and functional terms, but also in ethical. The paper analyzes the theoretical approaches of modern business practice where the concepts that create and improve the ethical principles of advertising are applied, as well as customer orientation and organization development through crisis situations. Ethical values are not abstractly concepts and their articulation must be closely related to the whole corporate culture of an organization. Therefore, the paper pays special attention to ethics in crisis situations, which represent the most complex circumstances in the business of an institution. The aim of this paper is to point out the need for business ethics and objectivity in reporting on crisis situations in which professional principles, objectivity and ethics, are often not respected. It is necessary to see from internal and external communication how the organization wants to serve the common good, to separate the public interest from the partial one and to strive in everyday activities to recognize a common measure of acceptability of competing interests. In recent decades, this issue has stimulated wider public interest, not only in highly developed countries, but also in countries in transition, which are still trying to build some new value systems, and thus values related to business ethics. In crisis circumstances, in practical business behavior, more and more attention is paid to responsibility in all types of activities, and business ethics becomes a scientific discipline without which business cannot survive successfully and responsibly.

Keywords: ethics, communication, crisis situations, public relations, codification

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INTRODUCTION

The impetus for working on this topic is certainly in the current crisis situation caused by the virus pandemic, which has raised numerous issues related to the understanding of the crisis situation, changes in business and interpersonal relationships and the possibility of timely response in ethical terms. In order to answer the problem of the topic concerning the codification of business ethical practice, the paper is divided into three parts that will multidimensionally penetrate into the core of the crisis situation, and thus give educational answers to the importance of codifying business ethical practice in times of crisis. The first part of the paper deals with the conceptual definition of crisis, the phase of the crisis process and ways of managing a crisis situation that is not necessarily pejorative in nature.The corporate culture of an institution based on internal and external communication and public relations in crisis conditions will be perceived in a different continent work, while same values of a society embodied in moral standards, translated into business ethical practices and timely response are part of the last segment of work.

The theoretical and methodological framework permeates through the whole work, and the theory deals with the basic concepts and problems of the topic being investigated, while the methodological aspect of the work is based on comparative and sociological approach with a hint of induction of specific cases in practice.

CRISIS AND CRISIS SITUATION

The term of crisis, which originates from the Greek language, quite generally means any sudden interruption of the hitherto continuous development and, in a narrower sense, a situation of development which marks a turn or peak of dangerous development. At the same time, it reflects a situation with extreme ambivalence of development possibilities. A crisis signifies a special state in the development of a phenomenon; turnover of things in relation to the previous course (Senic & Lukic, 2008, p. 25).

Crisis management is also information management. Successfully overcoming the crisis requires proactive and consistent implementation of crisis communication. Crisis communication is an essential element of overcoming the crisis. Through it, the company, another organization or institution has the opportunity to present itself to the external environment. Since each crisis has its own characteristics, there is no general recipe, and the prepared concepts must be constantly adapted and individually formulated.

In crisis communication is necessary to bear in mind a number of principles to the situation before the crisis, during the crisis and after the crisis.

The goal is to inform the public quickly on the basis of existing facts. In case of crisis, it is necessary to pursue an active, timely, convincing and open information policy. In the acute phase of a crisis, one must speak with one voice. The scope and content of information must be adapted to the needs for information and public understanding. Crisis responsibility needs to be clearly clarified and everyone should accept part of their own responsibility, if any exists.

Crisis management has direct and indirect effects. The direct effects of crisis management are observed during public relations in the crisis period, while the indirect effects of crisis management are manifested in the post-crisis period. Successful communication in crisis situations is the communication that has made a full contribution to crisis management to turn a crisis situation into success. Speed is the essence of crisis management. Crisis situations are universal categories, general - present, which have their phases of action and ways of overcoming through management in each of the defined phases.

In order for the company to have forces ready to anticipate possible crisis points, it is necessary to plan a crisis management strategy whose unavoidable segment is crisis communication. Crisis communication requires structure, respect for the established organization, good internal communication and understanding that public relations is part of the management structure, a very important part of the strategy that is never left to the elements in crisis. In order for organizations facing crisis situations to be able to adequately manage crisis communication, it is necessary to understand the process of media framing of stories in which they are mentioned as main or secondary participants, so that they can offer new stories that will be attractive enough for the media and the public is convincing enough.
From all the above, it can be concluded that we must be ready for the crisis every day. What is crucial is that one should never be silent and wait for the crisis to pass. A crisis situation is easier to manage well with good preparation. First, it is important to put together a crisis communication plan. Secondly, we need to prevent crisis situations when possible. When a negative story emerges, the organization automatically finds itself in a reactive situation. Once the organization recognizes the threat, it is necessary to take control. This is the key to all good business and ethical practices of an organization in times of crisis.

With strategic communication planning, the crisis situation can be successfully overcome, and even reversed in favor of the organization. Although the outcome of the crisis is influenced by many factors, by applying basic principles in crisis communication management, organizations can improve their ability to manage the crisis, on which their business depends when the crisis is over.

The public is ready to forgive a mistake, but not bad business management in conditions of noticeably sharpened contradictions. Thus, with good preparation of strategic communication and thoughtful use of public attention, the crisis can turn into a chance for a new step forward.

Communication is the basis of every business transaction and successful business relationships, not only in the local environment, but also globally. A well-designed internal communication strategy will greatly contribute to the achievement of corporate goals. A key part of crisis management is communication during and after the crisis. Communication in a crisis is the most difficult task, but it is extremely important to prevent insincerity (where credibility is at risk) and lawsuits (where there is a risk of losing a work permit or large fines).

Institutions should develop their own crisis communication strategies, with scenarios for potential crises and crisis communication procedures. These documents should clearly define the place, obligations, manner of work and responsibility of the crisis communication team. It is necessary that each institution has more experts trained for public appearances, who will be prepared for communication in crisis situations. The position was confirmed that the management of crisis communications, as well as the continuous functioning of the organization / institution in bad circumstances has a great impact on preserving its reputation and improving its reputation in the public.

STRATEGY PLANNING OF CRISIS SITUATION

The communication process is put to a very serious test in crisis situations, which can occur in several forms. The most common problem is the lack of crisis management plans even in cases of a "smoldering" crisis. The reactions of organizations range from defensive to helpful. Corporate culture and other constraints may prevent the adoption of an appropriate strategy (Karovic & Komazec, 2014). Strategies that companies use in practice are divided into five main groups:

1. Recognition strategy
2. Legal aid strategy
3. Strategy of silence
4. Withdrawal and attack strategy
5. Strategy of searching for broader reasons for the crisis.

The role of crisis management is to help companies avoid the crisis, but if a crisis does occur, the role changes and now it becomes possible to get out of the crisis as quickly as possible with as few consequences as possible.
According to Jeffkins, the company should perform three tasks:

1. Prevention - to do everything to prevent a crisis,
2. Planning - the company should assess the danger of a crisis, as well as plan the procedure and management methods in case of crisis. In doing so, we should start from the scenario for the worst case scenario,

3. Formation of a crisis management team - the team should be small, have decision-making authority and the right to use the necessary funds. The composition of the team should correspond to the type of crisis, and it must include a public relations expert.

CRISIS STAFF

An important element of crisis management is the teamwork of the crisis staff. The importance of this segment comes to the fore in the program creation phase, as well as in the operational phases of crisis management. Although it has been pointed out that there is no pattern of crisis management, “key components” can be assumed within crisis management teams.

The crisis management system established by an organization may have different approaches (OEEB, 2010). Namely, the crisis team for crisis situations can consist of: senior managers from various fields, which will include individuals with experience, education and responsibility in areas such as media relations, public relations, personnel, financial, operational, intelligence and logistics issues, staff to provide technical, logistical and administrative support to the crisis team, if required, and special working groups dealing with specific management issues in emergency teams, such as concentrating on the long-term strategic planning issues needed to respond to and recover from a specific incident (eg humanitarian aid).

Another approach is to form a crisis team of people from the organization who are not in the highest managerial positions. The head of such a team is a person who knows all the functions of the organization and must be in direct line with the top management. It is important that the crisis team includes representatives of all organizational units within the organization. People who are part of the team should, in addition to managerial, have the ability to communicate effectively, as well as logical reasoning. These skills enable them to facilitate the exchange of ideas between different sectors within the organization, define and monitor measures that may affect the belief system within the crisis plan, collect employee opinions on potential crisis and crisis management and encourage new experiments that can help prepare the organization for the crisis.

EXAMPLES OF CRISIS SITUATIONS

The outbreak of a new corona virus pandemic was difficult for organizations to predict. No one expected Covid-19 to spread across the entire planet in less than three months and infect over 500,000 people worldwide. Measures of self-isolation and physical distancing quickly changed the way most companies work and function. Although working from home is nothing new for a good part of the companies, it is rare that any company and institution (especially in the region)

worked completely remotely. In just a few days, everyone had to adjust to working from home.

The consequences that the "age of the corona virus" will leave on the world and domestic economic situation are inconceivable at this moment. How sensitive and far-reaching they will be will largely depend on the size of the organization, as well as the type of activity that a particular organization is engaged in.

Models of work and service delivery are changing and rapidly digitizing. Companies are forced to react quickly and innovate faster than ever. In contrast, budgets are revised and costs are reduced.

There are two reactions to a crisis situation: the organization can continue to work in essentially the same way as before, and it can also try to turn the situation in its favor. As the company decides to react, it will greatly affect its results on the market during the crisis period, but also when things return to normal. It is now necessary for companies to be agile and ready to face possible challenges in the coming period. If an organization wants to stand out in the market and stand out from the competition, its employees must possess advanced knowledge and skills in order to successfully support the organization itself. This is far more important in the post-crisis period, in which it will be clear which companies have managed to respond to new market demands.

CRISIS SITUATIONS IN THE EDUCATIONAL INSTITUTION

If at school (pre-school, boarding school for students) happens:

- Natural death of students (at school or outside, on excursions, recreational classes)
- Murder of students (inside or outside school)
- Student suicide (at school or outside)
- A traffic accident in which a student or teacher is seriously injured (near the school, but also far from it)
- Large-scale violence (mass fight at school, abuse of any kind)
- Natural death, murder or suicide of a teacher
- Teaching after an intense disaster that affected the whole community or a significant part of it (Vlajkovic, 2014).

Fortunately, crises are still relatively rare events that happen suddenly and which, due to their intensity, can disrupt life and work in an educational institution for a longer or shorter period of time. Experience shows that such events significantly change the functioning of the entire school community and affect both children / students and adults. In both cases, as a reaction to such events, the internal balance is disturbed, which usually includes the experience of loss - whether it is the feeling of threat of loss or the actual loss of persons or things and

values that are important to individuals or the community. In such a situation, strong feelings appear that overwhelm the individual (shock, disbelief, strong fear, sadness, helplessness, anger, guilt, etc.). Also, there are changes in the mental plane (inability to concentrate and make decisions, difficulties in making decisions and solving problems, etc.). In addition, somatic problems may occur (headaches, appetite disorders, difficulty breathing, heart and blood pressure problems, a "knot" in the stomach, etc.). All these reactions (emotional, mental, physical) can lead to disorganized behavior (the person is upset, there is a sleep disorder, reactions are often impulsive, decisions change or there is an inability to make them). All this shows that in serious crisis situations, there is general confusion, in which emotions overwhelm the members of the collective, while the ability to make rational decisions becomes very limited. In school conditions, this can be seen in the inability of students and teachers to concentrate on teaching, in severe difficulties in learning and memory, strong fear and concern about the possibility of the event recurring and taking on a wider scale, excessive sensitivity, outbursts of aggression, clumsy communication with media and the wider community, etc. As the normal functioning of the institution is difficult or even impossible, in adults there is a loss of autonomy and control over events, which all causes a feeling of helplessness and hopelessness. If these reactions last longer, they significantly disrupt the mental health of all persons (children, adults) affected by this event. In such situations, the educational institution needs help.

In the opinion of many, crisis events are considered an isolated accident that affects only the educational institution in which such a crisis event took place. However, this is not the case. Crisis events, if they are intense and outside the expected and usual events, affect not only a certain institution but also the entire community. Some authors compare the influence of such events with concentric circles that are created when we throw stones on the surface of a river. When it comes to crisis situations, these concentric circles are called vulnerability and vulnerability circles. (Vlajkovic, 2014). In the central circle, in this model of circles of vulnerability and vulnerability, there are always the immediate victims of events that are exposed to the greatest degree of vulnerability. In addition to them, the primary victims include the victims' families and witnesses to the crisis event, which belongs to the second round of vulnerability. Secondary victims of the crisis event are on the following rounds. These are relatives, friends, rescue services and co-workers, and finally the entire local community, which learns about the crisis event through the media.

In order for the situation to normalize and for the educational institution, as well as the local community, to continue to function normally, it is necessary to recognize in a timely and professional manner the reactions to such an event that are symptoms of crisis and, if necessary, with specially trained professionals to implement some of the techniques of crisis intervention.

The term "trained professionals" refers to experts from the so-called circle. helping professions (psychologists, psychiatrists, pedagogues, social workers) who have been specially trained - in specialized seminars - to conduct some of the crisis interventions. Currently, there are several dozen psychologists in Serbia trained to apply even the most complicated crisis interventions, and that is the Concise Psychological Integration of Trauma. However, as there are no conditions for their full engagement yet, professionals trained for this type of crisis intervention are engaged when necessary and when the crisis intervention team, which exists in educational institutions, cannot "cope" with psychological reactions of adults and children.

A SUCCESSFUL EXAMPLE FROM PRACTICE

Escherichia coli in Odwalla Foods juices

In 1996, representatives of the Public Health Institution in Washington confirmed the link between the epidemic of Escherichia coli and Odwalla Foods fresh, unpasteurized apple juice. Then one child died and 60 people fell ill, and Odwalla Foods faced 20 lawsuits. Odwalla lost a third of her market and was found guilty of the epidemic for which she had to pay a $ 1.5 million fine.

Odwalla Foods readily responded to the crisis. Company CEO Stefan Williamson immediately withdrew all Odwall products that contain apples, which cost them as much as $ 6.5 million. In a statement to the media, he accepted responsibility and promised that the company would pay all medical expenses for those affected by this epidemic. They used daily meetings in the media to inform the public about the development of the situation and news, and in advertisements that they published on entire pages in newspapers and through their website, they explained the situation to the public.

In the following months, they focused on building relationships with consumers and restoring their trust. They eliminated the source of the epidemic and improved their quality and safety control system, and two months later they relaunched their apple juice. Thanks to its readiness and good and quick response to the crisis, Odwalla survived and managed to regain its market share. In 2001, Odwalla bought Coca-Cola for $ 186 million.

PRIVATE TWEET ON THE OFFICIAL RED CROSS ACCOUNT

One of the employees of the American Red Cross in charge of communication on social networks, Gloria Hunag, accidentally sent an informal tweet from the official Tweeter account of the Red Cross, instead of from her private account. Tweet related to dogfish head beer consumption This tweet was on the Red Cross

account for about an hour when the director of the social media communications department Wendy Herman was alerted in the middle of the night and immediately deleted it and then reacted with a humor tweet to prevent the outbreak of a crisis situation, writing that the tweet was deleted, because the Red Cross is sober. The beer factory responded in the same style, calling for donations and humanitarian work[3].

CODIFYING BUSINESS AND ETHICAL PRACTICE IN CRISIS SITUATIONS

The science of morality and moral philosophy, deals with the assessment of moral principles and the evaluation of behavior, while the business ethics deals with the assessment of business-ethical behavior. In the area of public relations business practice in which persuasive techniques are used for economic or political reasons, public relations practitioners are in daily danger of violating some of the moral principles by applying manipulation techniques. Adzis emphasizes that the power of public relations to influence people's opinions and behaviors can be used for benign but also malicious purposes, and that for this reason the organization must take into account issues of consent, transparency, accountability, decency and respect (Adavis, 2005). Adizes explains the saying that “PR has never sold a bad product” through the necessity of the existence of healthy content on which PR relies, because the truths about the crisis cannot be hidden in the long run. Selective and calculated communication of the truth, as well as its avoidance through ambiguous messages or silence, does more damage to the organization's reputation than open communication of bad news with sincere regret and active efforts to overcome problems. Presenting the truth is a basic principle of any organization in crisis situations, because when the organization tells the truth and when it is not pleasant, it gains greater credibility. Although the crisis can be overcome by manipulative action, it usually leads to a loss of trust by the target public and, consequently, to poor business results..

When an organization has the opportunity to influence its target public, it obliges it to take responsibility for such influence. “As Sam Black noted, the ethics of a company are determined by everything it does, not just what it says in an effort to secure public support. It is necessary to see from the business how the organization wants to serve the common good, to separate the public interest from the partial one” (Pavlovic, & Aleksic, 2011).Thus, in crisis situations, the organization is been expecting to have people and social values in the first place, and only then material goods and economic interests.

An ethical guide for all organizations can be the famous five principles of ethical strength (Five P’s) published in the book “The Power of Ethical Management”.

[3] Available at: https://www.biznis-akademija.com/blog/krizni-pr-uspesni-primeri-iz-prakse

Those are:

1. Purpose: Our organization is guided by values, hopes, and visions that help us determine which behaviors are acceptable and which are not.
2. Pride: We are proud of ourselves and our organization. We are sure that if we feel that way, we can resist the temptation to behave unethically.
3. Patience: We believe that if we stick to our ethical values in the long run, we will succeed. This implies balancing the desire to achieve results and the way they are achieved.
4. Persistence: Our commitment is ethical principles. We stick to them, taking care that our activities are always in line with our purpose.
5. Perspective: Let our managers and all employees stop to think and evaluate how far we have come and where we are going, and determine how we will get there. (Pavlovic & Aleksic, 2011, p. 89).

In addition to these general principles that can be applied by any organization, associations of professionals in certain fields, as well as a large number of companies have their own codes of ethics aimed at establishing acceptable standards of professional conduct for their members or employees. Thus, journalists regulate their own work with moral norms based on journalistic ethics and the principles of truthfulness, impartiality, independence and responsibility. Different journalists' associations define codes of journalistic ethics which state desirable professional behavior in the process of journalistic work, from the selection of information and shaping messages to their dissemination. Likewise, PR professionals around the world, within various associations, define codes of professional ethics in the field of public communication. Some of the well-known codes of public relations professionals and journalists are: International Code of Ethics - Athens Code, European Code of Professional Conduct in PR Practice - Lisbon Code, Code of Ethics for Members of the American Public Relations Society (PRSA), Munich Declaration of Rights and Responsibilities journalists, etc. The following are known in Serbia: the Code of Journalists of Serbia, the Code of Professional Ethics of the Serbian Public Relations Association and the Code of Ethics for Electronic Media.

CONCLUSION

The crisis as a companion of business and life in general is a great challenge for all leaders of the organization in crisis. With the development of society and technology, crises are becoming more diverse and there is no industry or organization that can be isolated from them, because crises are an integral part of the environment in which they operate. Although some crises appear very slowly,

sudden ones usually do not choose the time, so they often happen at night and during the holidays, which further complicates the situation. In addition, the crisis is a stressful and emotional event for every individual, even for the organization and its target public. Then there is panic and confusion, not only among people who are direct participants in the crisis or its observers, but also among those who need to manage such a crisis.

In addition to the challenges of the crisis related to the disrupted business continuity, the modern age brings higher expectations of the public than the organization in crisis. With the development of information technologies and digital media, new and much faster channels of communication have opened up. Nothing can go unnoticed anymore. Thus, an organization in crisis becomes an object under public scrutiny. Everything that an organization says and does in a crisis is observed with much greater attention than usual, which is why its reactions must be well thought out. This is exactly the most difficult task, because when a crisis occurs, there is not enough verified information, and the need for it grows exponentially. Although information in a crisis is mostly spread at the speed of light, it takes a lot of effort to fill the information gap adequately so that there is no room for speculation and rumors.

Checking the truthfulness of all information, respecting business and ethical practices and quick reaction are necessary to establish control over communication in a crisis. However, the known facts about the crisis can be quickly revealed to the public in many ways. Which version of the crisis event will be told depends on the source of the story. If an organization goes public with its version, it is more likely that that version will be accepted and as such will affect the interpretation and fate of all further information.

Through transparent action, unambiguous messages and clear argumentation of its actions, while respecting the codification of business and ethical practices, the organization successfully manages the crisis. Modern organizations, as well as their management functions, have the main task of protecting the so-called soft capital, ie the reputation of the organization that represents the most sensitive category susceptible to negative influences. And a lot depends on the way in which the organization will solve the crisis, as well as on the way in which it will communicate about it.

After analyzing the basic theoretical concepts of crisis communication, the examples explain the possible causes of individual crises and show the process of strategic planning of communication in crisis situations.

When it comes to crises and crisis communication, the safest way to learn is from other people's mistakes, that is, from the lessons of other organizations that have gone through crises. We have seen that organizations that had a well-prepared crisis communication strategy managed to get out of the crisis without damaged their reputation, and even to improve their business in order to prevent

the recurrence of similar crises. These organizations used different strategies in response to the crisis, but they all had in common that they were well prepared for the crisis.

By applying the codification of business-ethical practice, the crisis situation can be successfully overcome, and even reversed in favor of the organization. Although the outcome of the crisis is influenced by many factors, by applying the basic moral and ethical principles in crisis communication management presented in this paper, organizations can improve their ability to manage the crisis, on which their business depends when the crisis is over. The public is ready to forgive a mistake, but not bad business management in conditions of noticeably sharpened contradictions. Thus, with good preparation of strategic communication, business-ethical practice and thoughtful use of public attention, the crisis can turn into a chance for a new step forward. Therefore, every organization has the opportunity to emerge victorious by well-prepared crisis communication and the way it solves the crisis.

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KODIFIKOVANJE POSLOVNO-ETIČKE PRAKSE U KRIZNIM SITUACIJAMA

Sažetak: Razvoj savremenog društva, praćen promenama koje je sa sobom donela industrijska revolucija sa novim tehnologijama, naučnim otkrićima i tehničkim inovacijama, promenama koje sa sobom nosi globalizacija, uticao je na oblikovanje nove organizacije koja se tim savremenim društvenim promenama morala prilagoditi i to ne samo u organizacionom i funkcionalnom smislu, nego i u etičkom. U radu se analiziraju teorijski pristupi savremene poslovne prakse gde se primenjuju koncepti koji kreiraju i unapređuju etičke principe oglasavanja, kao i usmerenost ka klijentima i razvoj organizacije kroz krizne situacije. Etičke vrednosti nisu apstraktni pojmovi i njihova artikulacija mora biti u tesnoj vezi sa celinom korporativne kulture jedne organizacije. Stoga se u radu posebna pažnja posvećuje etici u kriznim situacijama koje predstavljaju najsloženije okolnosti u poslovanju jedne institucije. Cilj rada je da se ukaže na potrebu postojanja poslovne etike i objektivnosti u izveštavanju o kriznim situacijama u kojima se profesionalna načela, objektivnost i etika, često ne poštuju. Nužno je da se iz interne i eksterne komunikacije vidi kako organizacija želi da služi opštem dobru, da javni interes odvaja od parcijalnog i da u svakodnevnom delovanju teži prepoznavanju zajedničke mere prihvatljivosti konkurentskih interesa. Poslednjih decenija ova problematika podstiče šire interesovanje javnosti i to ne samo u visoko razvijenim zemljama, nego i u zemljama u tranziciji, koje tek pokušavaju da izgrade neke nove sisteme vrednosti, pa samim tim i vrednosti vezane za poslovnu etiku. U kriznim okolnostima, u praktičnom poslovnom ponašanju sve se više vodi računa o odgovornosti u svim vrstama aktivnosti, a poslovna etika postaje naučna disciplina bez koje poslovanje ne može uspešno i odgovorno da opstane.

Ključne reči: etika, komunikacija, krizne situacije, odnosi s javnošću

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