She has been abstaining from substance abuse for 7 months, since the end of her treatment, and we have noticed improvements both at home and at her workplace. The team effort "Simbioza" (Symbiosis), which includes partial hospital psychiatric treatment, social work and group therapy (KLA) have shown good results in treating alcoholism.

ALKOHOLIZAM, USPJEŠNOST LIJEČENJA TIMSKIM RADOM, PRIKAZ SLUČAJA

U ovom radu dat je prikaz 35-godišnje pacijentice, koja je unazad godinu dana u psihijatrijskom tretmanu zbog problema u ponašanju i razvoja ovisnosti o alkoholu.

Također je u tretmanu socijalne skrbi, dodijeljena joj je mjera za zaštitu osobnih prava i dobrobiti djeteta, i to mjera intenzivne stručne pomoći i nadzora nad ostvarivanjem skrbi o djetetu, a uz to i suport i pomoć u adekvatnom rješavanju dnevnih problema. Od drugih bolesti prisutna je dugogodišnja hipotireoza, trenutno pod terapijom.

Pacijentica je završila školovanje po programu djece sa poteškoćama u razvoju. Zaposlena, neudata, majka jednog mladog djeteta. Kliničkom slikom dominiraju tjeskoba, emocionalna preosjetljivost, te blaža kognitivna reduciranost. Zbog pretjerane reaktivne tjeskobe na partnersku, egzistencijalnu i radnu problematiku dolazi do nefunkcioniranja na svim razinama koju kupira prekomjernom svakodnevnom konzumacijom alkohola. Bolesnica od ranije nije liječena psihijatrijski. Kod nas je bila uključena u jednomjesečni program liječenja kroz Dnevnu bolnicu za alkoholizam i druge ovisnosti, redovita u uzimanju propisane farmakoterapije, u tretmanu socijalne službe, redovito pohađa KLA.

Apstinira od završetka liječenja unazad 7 mjeseci, dolazi do vidnog poboljšanja funkcioniranja kod kuće i na poslu. Timski rad „Simbioza“ djelomično bolničkog psihijatrijskog liječenja, socijalnog rada i KLA ostvaruju dobre rezultate u liječenju alkoholizma.

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THE IMPACT OF RELIGIOSITY ON QUALITY OF LIFE OF ONCOLOGICAL PATIENTS AND OF PATIENTS SUFFERING FROM DIABETES MELLITUS

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The World Health Organization defines quality of life as a perception of a human being, taking into consideration specific environmental and societal aspects of an individual, together with the specific cultural context. Robert Cummins states that quality of life is defined in a multidimensional way, thus implying the objective and subjective components of quality of life. The subjective component includes: emotional well-being, productivity, safety, material wealth, health and the community.

Religion has always been a system of values in human life. Religion is considered to be external, public, objective, established and rational, while religiosity is internal, private, subjective and emotional.

The aim of this paper was to investigate the influence of religiosity on the quality of life of oncologic patients and patients with diabetes.

68 respondents participated in the research, and 60 of them (88%) fully completed the questionnaires. Subjects were divided into two groups: diabetic and oncological patients. The patients were asked to complete a demographic questionnaire and a questionnaire on quality of life and the appearance of depression according to the modified and standardized World Health Organization WHO WHOQ-100 BREF questionnaire.

The results indicated that there was no difference in the quality of life between diabetic and oncological patients. Furthermore, there were no differences in the symptoms and occurrence of depression in these two groups of patients. Statistically significant differences existed between those suffering from cancer who were Catholics and those with a diabetes disorder of the same religion. Also, differences were shown to exist in a group of cancer patients between Catholics and members of another religion.

From this, we can conclude that religiosity has more significant effect on the quality of life in oncological patients than in diabetic patients, and it would be interesting to investigate which factors arising from beliefs or religiousness affect the attitudes of the diseased.

UTJECAJ RELIGIOZNOSTI NA KVALITETU ŽIVOTA KOD ONKOLOŠKIH BOLESNIKA I BOLESNIKA OBOLJELIH OD ŠEĆERNE BOLESTI

Svjetska zdravstvena organizacija kvalitetu života definira kao percepciju čovjeka, pojedinca u specifičnom okolišnom i društvenom aspektu, te u specifičnom kulturološkom kontekstu. Robert Cummins navodi da se kvaliteta života definira multidimenzionalno, podrazumijevajući time i objektivnu i subjektivnu komponentu kvalitete života. Subjektivna komponenta uključuje: emocionalno blagostanje, produktivnost, sigurnost, materijalno bogatstvo, zdravlje i zajednicu.

Religioznost se oduvijek ubraja u sustav vrijednosti u ljudskom životu. Religija je vanjska, javna, objektivna, ustanovljena i racionalna, dok se religioznost smatra unutrašnjom, privatnom, subjektivnom i emocionalnom.

Cilj ovog rada bio je istražiti utjecaj religioznosti na kvalitetu života kod onkoloških bolesnika i bolesnika oboljelih od šećerne bolesti.

U istraživanju je sudjelovalo 68 ispitanika, a 60 (88 %) ih je ispravno ispunilo upitnik. Ispitanici su podijeljeni u dvije grupe: oboljeli od šećerne bolesti i onkološki bolesnici. U istraživanju je korišten upitnik koji se sastojao od demografskog upitnika i upitnika o kvaliteti života, te pojavnosti depresije prema modificiranom i standardiziranom upitniku Svjetske zdravstvene organizacije (SZO) WHPQOL-100 BREF.

Rezultati ukazuju da nema razlike u kvaliteti života između oboljelih od šećerne bolesti i onkoloških bolesnika. Nadalje, ne postoje razlike simptoma i pojavnosti depresije u te dvije skupine bolesnika. Postoje statistički značajne razlike između oboljelih od karcinoma kršćanske vjeroispovijesti i oboljelih od šećerne bolesti iste vjeroispovijesti. A postoje i razlike unutar skupine oboljelih od karcinoma i to između kršćanske i drugih vjeroispovijesti.

Iz navedenog možemo zaključiti da religioznost bitno utječe na kvalitetu života i to kod onkoloških bolesnika više nego kod oboljelih od šećerne bolesti, te bi bilo zanimljivo istražiti koji faktori iz raznih vjerovanja ili religija utječu na stavove oboljelih.

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IMPACT OF PSYCHOSOCIAL FACTORS ON DELAYED HELP SEEKING AT PATIENTS WITH MALIGNANT DESEASE

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Setting a diagnosis and starting a treatment in the earliest stage of a malignant disease is of great significance for successful treatment and surviving these diseases. Despite intensive preventive measures and educational efforts, a large number of patients are still seeking help too late. Efforts in fight against malignant diseases should be pointed at those factors which impact a delay in help seeking. Those are factors related to health system and those related to the patients themselves. It is a fact that through hospital visits, national preventive actions, media and similar activities, it has been done a lot for destigmatization of malignant diseases. Therefore, the focus of this paper are factors related to the patient himself. Some studies showed that the responsibility for late reports is on the patients, respectively, some features of their personality. Whether a patient will react in an active way (seeking help) or passive way (delayed seeking help) in situation when he is confronted with suspected change, his cognitive functions (cognitive discrimination) and emotions play an important role. Cognitive discrimination includes knowledge and experience related to cancer and ways of confronting disease and doctors in general. When talking about emotions, the way patient feels related to the new situation is significant, as well as the response from the social surroundings. Emotional reactions when confronting a malignant disease depend on specific characters of personality of an individual (defense mechanisms, coping mechanisms, personality type) as well as his interpersonal styles (characteristic of his cathectic attachments toward important objects, during life). To illustrate this problem, a case of a 51 year old patient with breast cancer who delayed doctor visitation for 3 years will be presented. She reported in stage of „metastatic malignant disease“, because of which therapeutic possibilities and survival length were limited.