THE ROLE OF PSYCHIATRIST IN PALLIATIVE MEDICINE

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Palliative care is comprehensive, active care of patients with serious uncurable illness and their families. The aim of palliative medicine is to improve quality of life based on patients and family needs and demands and is practiced by a competent multidisciplinary palliative care team. The transition to palliative care is a significant adjustment for patients and their families. Liaison psychiatry has significant role in palliative medicine. Psychiatrist is important for understanding and treatment of the social, psychological, emotional, quality of life and functional aspects of illnes, accros the illness trajectory (from time of diagnosis of uncurable serious illness until the bereavement period for the members of the family). It is important to recognize individual strength and coping skills in the patient and his family, personality structure of the patient and his/her level of distress. Also, it is necessary to identify vulnerable individuals through various psychological and social factors as predictors of adequate or inadequate adjustment towards the disease and pain. Mental health issues are still underdiagnosed and remain undertreated in palliative medicine. Patients with significant distress are best treated by a combination of psychotherapy and medication. Research is needed into the effectiveness of different psychological and psychopharmacological interventions in palliativne medicine. Palliative mental health issuess should be included in the trainig of professionals in all areas of medicine, psychology and social work to meet the demands of a patients. The author will also present Croatian national strategies for Palliative Medicine and the current role of psychiatrists in palliative medicine in Croatia.

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PROFILE AND SEVERITY OF CONDUCT DISORDERS IN ADOLESCENTS WITH JUVENILE DELINQUENCY

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Background: Conduct disorders (CD) in adolescents, accompanied by unlawful acts (UA), differ in the mechanisms and conditions in which they are formed.

The aim of the study was to study the profile and severity of CD in adolescents who have committed UA, including those brought up in different conditions.

Methods: criteria ICD-10; adapted Russian-language questionnaire "The Nisonger Child Behavior Rating Form: typical IQ version" (NCBRF). Surveyed 130 adolescents (15.75-17.74 years), 96 boys, 34 girls-teen.

Results: most of the surveyed – 92 people (70.8%, x^2=22.431; p<0.0001) at the time of the survey lived in orphanages (full orphans and children of parents deprived of rights) (1 subgroup). The rest – 38 people (29.2%) were officially registered as living in incomplete or full families (2 subgroups). The predominant number of the surveyed (95 people, 73.1%) were registered in the children's room of the police (x^2=27.692; p<0.001). The smaller part of the sample (45 people, 34.6%) was brought to criminal responsibility (x^2=12.308; p<0.001) and all of them were registered in the children's room of the police. According to the criteria of ICD-10 it was found that in 6 cases (4.6%) the condition of patients corresponded to mild RP, in 111 cases – moderate (85.4%), and in 13 cases (10.0%) – severe. All patients with severe RP were children from orphanages. The mean values of the following NCBRF scales were significantly higher than the reference values: "Conduct disorders" (t=16.99), "Opposition" (t=8.28), "Sensitivity" (t=13.39), "Hyper-activity" (t=4.46), "Inattention" (t=3.83) and "Emotional disturbances" (t=12.64). In subgroup 1, the average values of composite scales "Conduct disorders" (t=3.515) and "ADHD" (t=2.145) were significantly higher compared to subgroup 2.

Conclusions: The results confirm the assumption of heterogeneity of mechanisms of CD formation in adolescents with UA and their different severity depending on the patient's environment (family or children's closed institution).