Clinical Social Work

1/2012 Vol.3

www.clinicalsocialwork.eu

Clinical Social Work Journal

by International Scientific Group of Applied Preventive Medicine
I - GAP Vienna, Austria

This journal brings authentic experiences of social workers, doctors and teachers working for the International Scientific Group of Applied Preventive Medicine I-GAP Vienna in Austria, where they have been preparing students for the social practise over a number of years. Our goal is to create an appropriate studying programme for social workers. A programme which would help them to fully develop their knowledge, skills and qualification as the quality level in social work studying programmes is increasing along with the growing demand for social workers.

ISSN 2076-9741 / Online
ISSN 2222-386X / Print

CONTENTS No. 1, VOL 3, 2012

IMPRESSUM
CLINICAL SOCIAL WORK, 2012

Few words from the Editor-in-Chief

This journal brings authentic experiences of our social workers, doctors and teachers working for the International Scientific Group of Applied Preventive Medicine I-GAP Vienna in Austria, where we have been preparing students for the social practise over a number of years. Our goal is to create an appropriate studying programme for social workers, a programme which would help them to fully develop their knowledge, skills and qualification. The quality level in social work studying programme is increasing along with the growing demand for social workers.

Students want to grasp both: theoretical knowledge and also the practical models used in social work. And it is our obligation to present and help students understand the theory of social work as well as showing them how to use these theoretical findings in evaluating the current social situation, setting the right goals and planning their projects. This is a multidimensional process including integration on many levels. Students must respect client's individuality, value the social work and ethics. They must be attentive to their client's problems and do their best in applying their theoretical knowledge into practice.

It is a challenge to deliver all this to our students. That is also why we have decided to start publishing our journal. We prefer to use the term 'clinical social work' rather than social work even though the second term mentioned is more common. There is some tension in the profession of a social worker coming from the incongruity about the aim of the actual social work practice. The question is whether its mission is a global change of society or an individual change within families. What we can agree on, is that our commitment is to help people reducing and solving the problems which result from their unfortunate social conditions. We believe that it is not only our professional but also ethical responsibility to provide therapeutic help to individual and families whose lives have been marked with serious social difficulties.

Finding answers and solutions to these problems should be a part of a free and independent discussion forum within this journal. We would like to encourage you – social workers, students, teachers and all who are interested, to express your opinions and ideas by publishing in our journal. Also, there is an individual category for students' projects. In the past few years there have been a lot of talks about the language suitable for use in the field of the social work. According to Freud, a client may be understood as a patient and a therapist is to be seen as a doctor. Terminology used to describe the relationship between the two also depends on theoretical approach. Different theories use different vocabulary as you can see also on the pages of our journal.

Specialization of clinical social work programmes provides a wide range of education. We are determined to pass our knowledge to the students and train their skills so they can one day become professionals in the field of social work. Lately, we have been witnessing some crisis in the development of theories and methods used in clinical social work. All the contributions in this journal are expressing efforts to improve the current state. This issue of CWS Journal brings articles about social work, psychology and other social sciences.

Michal Oláh
Peter G. Fedor-Freybergh
Edition of journal

ETHICAL ASPECTS OF SOCIAL WORK WITH ELDERLY PEOPLE

[1]Jana Gabrielová, [2]Martina Hrozenská

[1]Constantine the Philosopher University in Nitra
[2]Department of Social Work and Social Sciences, Slovak Republic

Jana Gabrielová
After completing her university studies in the branch of study social work, she operated in the area of social services for elderly people and people with disabilities. Currently, she is an internal PhD. student at the Department of Social Work and Social Sciences of the Constantine the Philosopher University in Nitra. In her dissertation thesis, she addresses the issue of human rights in the field of social work. Her publishing activity also focuses on this issue.

Martina Hrozenská
She has been working at The Department of Social Work and Social Sciences of The Faculty of Social Sciences and Health Care in Nitra as professional assistant since 2002. She mainly focuses on the field of social gerontology and theory of social work. She is the author of several publications with the theme quality of life of the elderly, social work with the elderly and textbooks of gerontology for secondary professional schools. She currently addresses herself, from the scientific and research point of view, to issues of age disadvantage of the elderly and social protection of people suffering from Alzheimer´s disease. She is a member of The Slovak Alzheimer´s Society, The Slovak Gerontology Society and The Slovak Psychotherapeutic Society.

ABSTRACT

Social work as a socio-scientific discipline responds to the needs of society and to the processes and the changes that characterize it. In the 21st century these also include the worldwide phenomenon – demographic ageing. Ageing of the population brings with itself new performance requirements of social work. Based on new scientific knowledge and practical experience, the social workers` approach to their clients – elderly people has been changing, too. In our contribution we address selected aspects of social work with elderly people.

Key words: Ageing of the population. Elderly person. Ethical principles. Social work.

Introduction

Population ageing is one of humanity's greatest triumphs. It is also one of our greatest challenges and places increasing economic and social demands on all countries. Worldwide, the proportion of people aged 60 years and over is growing and will continue to grow faster than any other age group due to declining fertility and rising longevity. The number of older people over 60 years is expected to increase from about 737 million in 2009 to over 2 billion in 2050. Chart 1 indicates the situation in the field of ageing of the population in the world and in Eastern Europe in 2009 and 2050.

Chart 1 Population aged 60 years or over

Country or area	Number (thousands)		Percentage of total population		Share of persons 80 years or over		Sex ratio (men per 100 women), 2009		Life expectancy at age 60, 2005-2010	
	2009	2050	2009	2050	2009	2050	60+	80+	Men	Women
World	**737 275**	**2 008 244**	**11**	**22**	**14**	**20**	**83**	**59**	**18**	**21**
More developed regions	263 905	416 055	21	33	20	29	74	49	20	24
Less developed regions	473 370	1 592 188	8	20	11	17	89	70	17	20
Least developed countries	42 922	185 129	5	11	8	10	85	74	15	17
Europe	**158 503**	**236 426**	**22**	**34**	**19**	**28**	**70**	**46**	**18**	**23**
Eastern Europe	**55 486**	**80 624**	**19**	**34**	**16**	**20**	**58**	**36**	**15**	**20**
Belarus	1 748	2 548	18	35	16	19	52	29	13	19
Bulgaria	1 824	2 059	24	38	15	22	72	54	16	20
Czech Republic	2 255	3 547	22	34	16	23	73	44	18	22
Hungary	2 212	2 952	22	33	17	21	63	42	16	21
Republic of Moldova	563	854	16	31	13	16	65	43	14	17
Poland	7 174	12 175	19	38	17	22	66	43	17	23
Romania	4 256	6 391	20	37	15	20	72	55	16	20
Russian Federation	25 033	36 844	18	32	16	19	52	30	14	19
Slovakia	933	1 780	17	36	16	21	66	43	17	21
Ukraine	9 488	11 472	21	33	16	19	55	33	14	19

Source: Population Ageing and Development, 2009

Nowadays, ageing of the population is considered a global phenomenon that is affecting and will affect the population all around the world. Constant growth of the oldest age groups in national populations has a huge impact on social, cultural and economic aspects of social development, including lifestyle of families and the overall social climate (Bleha, Vaňo, 2008).

In the context of demographic predictions and other important social phenomena (e.g. globalization, social exclusion, changes in family structure, its reduction and change of its functions, etc.) new dimensions of old age, both as a social and as an individual problem are being formed. One of them is formed by expected changes in old age and its aspects (Matulayová, 2003). The most important include changes in the structure of old age, especially its feminization, singularization, high proportion of people from the oldest age groups (Karl, 1993 In *Komunitný plán…*, 2009). Accordingly, elderly people represent a highly differentiated social group due to age stratification, gender, educational, territorial and health differences and diversities and other differences. This is closely related to the position of elderly people in society and to their social status that is low in elderly people and they are attributed negative personal characteristics and competencies (Geist, 1992).

These (and many other) changes trigger the need to invest or, in certain cases, to fundamentally change the approach of the society (including social workers) to elderly people and social consequences of old age – economical, social, health, sociological and psychological.

Ethical aspects of social work with elderly people

According to Repková and Brichtová (2009, p. 9) „the concept "elderly person" is an implicit legal construct. It is not used in the social field as such in any legal form. Due to its nature it indicates the possible presence of handicaps related to older age of the individual, mainly in the combination with another disadvantageous factor. However, the older age limit is differently set in different legal systems and subsystems and for various purposes, although we usually associate it with age exceeding 65 years."
Elderly people can be considered citizens in post-productive age (they do not have to be gainfully employed) allocated by a statutory. This includes citizens of retirement age who are economically active or those who do not work anymore and have specific needs, common social experiences and commonly experienced historical facts. (Hrozenská et al., 2008).

Social work is a multidisciplinary and interdisciplinary scientific discipline (Tokárová, 2003; Strieženec, 2001). The concepts of multidisciplinarity and interdisciplinarity indicate that social work draws and applies knowledge from its bordering or related sciences – philosophy, psychology, sociology, ethics, politics, law, etc. This knowledge is used by social workers when working with a specific client and they use it as a base when assessing the client`s situation. To perform social work well, the social worker needs to be aware of the legislation in the social field. They should know if they follow the law when dealing with their clients, they have to know what services the clients are eligible for, they should apply the methods of social work properly, and they should also be particular about respecting the clients´ human rights and following ethical principles. In our contribution, we will mainly focus on the ethical aspect of social work with elderly people.

Ethics is an integral part of social work. Ethical awareness is a fundamental part of the professional practice of social workers. Their ability and commitment to act ethically is an essential aspect of the quality of the service offered to those who use social work services (Ethics in Social Work, 2004).

Ethical principles of social work are included in codes of ethics of social workers (The ethical code of social workers in the Slovak republic, The international code of ethics for social workers). In our contribution, we draw from the ethical principles of social work stated in the above-mentioned codes and we apply them to social work with elderly people.

Human rights and human dignity – social workers should promote and protect physical, psychological, emotional and spiritual integrity and well-being of everyone. This means to respect the right to self-determination, encourage participation, treatment of a person as a whole and to indentify and to develop the strengths (Ethics in Social Work, 2004).

Promotion and protection of human rights create conditions to respect human dignity; their violation can lead to destruction of the awareness of personal worthiness and dignity. Application of the ethical principle of respect to human dignity when working with an elderly person requires a definition of social macro- and micro-social conditions of its implementation, specification of the specific content of the concept of dignity and determination of criteria that guarantee the application of this principle in practice. This determination can be positive – how to act with respect to a person and his/her dignity or

negative – what to avoid in relation to the client, what behaviour or action is morally undesirable or unacceptable (Nemčeková, 2008).

Social justice – social workers are responsible for promoting social justice in relation to society in general as well as to people they work with. This means to face negative discrimination based on such characteristics as abilities, age, culture, gender or sex, marital status, socio-economic status, political views, skin colour, racial or other physical characteristics, sexual orientation or spiritual beliefs, to recognize diversity, to distribute fairly, to face unfair politics and practices and to work solidarily (Ethics in Social Work, 2004).

Autonomy – i.e. respecting the client as an individual, self-sufficient, independent personality. Respect to their free decision to provide personal (discrete) information, to accept proposed procedures and measures when saturating the social problem. It also is perception and respect to the client´s responsibility for his/her own decisions, behaviour and attitudes (Žilová, 2000). An elderly person´s autonomy is often compromised as a result of biological, psychological or social changes that may lead to a reduced ability of the individual to manage their living situation, to decide freely, to choose interventions, methods, help and thus to be autonomous (Hrozenská et al., 2009).

Their limited or reduced ability to decide passes to social workers who on one hand determine the way and the methods of work and on the other hand they lead the client, within his/her possibilities, to maximize their independence. Social worker in a social service facility must not abuse status of the client who is currently dependent on his/her care to decide on his/her future without his/her knowledge or against his/her will. It is important to encourage the client´s independence even in a situation like this (Varhaníková, 2009).

Discreetness – means to maintain confidential information secret, in social work it means secrecy of the social worker on facts, client´s behaviour, testimonies and circumstances that he/she must not talk about. The usage of these data is not always clearly set by a specific regulation; therefore, it is appropriate to respect the principle that it is possible to provide information about the client to other (organizations, institutions, people) only with the client´s consent (Žilová, 2000). Since the social worker has access to personal information and medical records of an elderly person it is necessary not only to maintain confidentiality of the established facts but also to ensure the saving of the documents.

Respect – is a moral value that is expresses trough justice and equality to all client regardless of their mental, physical, racial, religious and other differences. We also express respect trough decency, politeness, tact and considerateness towards clients (Žilová, 2000). Particularly elderly people belong to the target group of social work which requires respectful behaviour. During their lives, they have been in different positions, have gained experiences and therefore they expect that people, especially staff in helping professions, will treat them civilly and with respect.

Responsibility – is a category of ethics that characterizes the relationship of the individual to society according to how he carries out the moral demands that are placed on him/her. An expression of responsibility is e.g. to keep promises, agreements, etc. It is a responsible approach of the social worker to his/her work, provision of adequate and the most suitable services to the client in the required extent, quality and in specified time. It also is the quality of the social worker´s approach to the material values of the facility (institution, organization) in which he/she provides social work (Žilová, 2000).

Efficiency and usefulness – it is difficult to guarantee that the client´s situation will improve but the social worker should inform him/her about the results and he/she should use new

methods of work that could be more effective in this case. The social worker´s aim is to help the client so that he/she would be able to solve their problems on their own (Matoušek, 2003). Nowadays, the there is a very popular method of work with elderly people the so called validation therapy. The aim of this method is to solve outstanding past issues, to cope with the lived life and to reduce stress caused by life losses, to achieve satisfaction and to return the feeling of their own identity to the people (Haškovcová, 2010). When working with elderly people, social workers use different activation therapies: music therapy, ergotherapy, art therapy, zootherapy (canistherapy, feline therapy) and dance therapy.

Conclusion

Ethical principles are crucial to the helping professions including social work. The performance of social work is connected to ethical principles, such as human rights and human dignity, social justice, respect, responsibility, utility, discreetness, autonomy, etc. The current social work with elderly people is unthinkable without ethical principles.

REFERENCES

BLEHA, B. – VAŇO, B. *Očakávaný demografický vývoj v SR – príčiny, dôsledky, opatren*ia [online]. 2008. [cit. 2010–01–14]. Dostupné na: <http://www.profini.sk/index.cfm?Module=Activeweb&Page=WebPage&s=ocakavany_demografic>

Ethics in Social Work – Statement of Principles [online]. 2004. 5 s. [cit. 2011-10-23]. Available on the internet: <http://www.ifsw.org/cm_data/IFSW_code_of_Ethics_Slovak-1.pdf>

GEIST, B. *Sociologický slovník*. Praha: Viktoria Publishing a. s., 1992. 647 s. ISBN 80–85605–28–7.

HAŠKOVCOVÁ, H. *Fenomén stáří*. Praha: Havlíček Brian Team, 2010. 365 s. ISBN 978–80–87109–19–9.

HROZENSKÁ, M. a kol. *Sociálna práca so staršími ľuďmi a jej teoreticko-praktické východiská*. Martin: Osveta, 2008. 181 s. ISBN 978–80–8063–282–3.

HROZENSKÁ, M. a kol. *Praktická príručka pre sociálnych pracovníkov pracujúcich so staršími ľuďmi*. Nitra: Univerzita Konštantína Filozofa, 2009. 103 s. ISBN 978-80-8094-474-2.

Komunitný plán sociálnych služieb a rozvoja komunít mesta Prešov [online]. 2009. 317 s. [cit. 2011–01–19]. Dostupné na: <http://www.presovprevsetkych.sk/portal/content/article/file/00000013/komunitny_plan_mesta_presov.pdf>

MATULAYOVÁ, T. Dobrovoľnícka práca seniorov v sociálnych službách z aspektu andragogiky (výber z teoretickej časti): dizertačná práca. Bratislava: UK, 2003. 68 s.

NEMČEKOVÁ, M. a kol. *Etika v ošetrovateľstve.* Prešov: Filozofická fakulta Prešovskej univerzity, 2008. 142 s. ISBN 978-80-8068-812-7.

STRIEŽENEC, Š. Úvod do sociálnej práce. Trnava: Tripsoft, 2001. 199 s. ISBN 80–968294–6–7.

Population Ageing and Development 2009 [online]. 2009. [cit. 2011–10–24]. Available on the internet: <http://www.un.org/esa/population/publications/ageing/ageing2009.htm>

REPKOVÁ, K. – BRICHTOVÁ, L. *Sociálna ochrana starších osôb a osôb so zdravotným postihnutím – vybrané aspekty*. Bratislava: EPOS, 2009. 463 s. ISBN 978–0–8057–797–1.

TOKÁROVÁ a kol. Sociálna práca – Kapitoly z dejín, teórie a metodiky sociálnej práce. Prešov: Filozofická fakulta Prešovskej univerzity, 2002. 571 s. ISBN 80–8068–086–8.

VARHANÍKOVÁ, M. Vplyv intervencie sociálneho pracovníka na kvalitu života seniorov v DD a v DSSPD. In *Dni sociálnej práce: Sociálna sféra Slovenskej republiky a sociálna práca (Európa, právo a prax). II. časť. Zborník príspevkov z vedeckej konferencie s medzinárodnou účasťou konanej 12.-13. novembra 2008.* Nitra: Univerzita Konštantína Filozofa, 2009. ISBN 978-80-8094-454-4. s. 131 – 158.
ŽILOVÁ, A. *Kapitoly z teórie sociálnej práce I.* Žilina: Edis, 2000. 116 s. ISBN 80-7100-783-8.

Contact address:

Mgr. Jana Gabrielová
PhDr. Martina Hrozenská, PhD.
Department of Social Work and Social Sciences
Faculty of Social Sciences and Health Care
Constantine the Philosopher University in Nitra
Kraskova 1
949 01 Nitra
Slovak republic
e-mail: jana.gabrielova@ukf.sk
mhrozenska@ukf.sk

SOCIAL WORK AND OTHER SELECTED SCIENTIFIC DISCIPLINES IN PROFESSIONAL WORK WITH PEOPLE SUFFERING FROM DEMENTIA

[1]Martina Hrozenská, [2]Jana Gabrielová

[1]Department of Social Work and Social Sciences, Faculty of Social Sciences and Health [2]Care, Constantine the Philosopher University in Nitra, Slovak Republic

ABSTRACT

Occurrence of dementia in older people aged 65 years and older has become a problem of the present. Occurrence of dementia increases proportionally with age. It has been estimated that about 5-10% older people suffer from dementia, and occurrence of the disease increases from 0.4% in the age of 60 years to 40% in the age over 90 years (Krajčík, 2009, p. 99). In Slovakia, the number of the affected by the Alzheimer´s disease has been estimated up to 50 thousand people. About 100 thousand family members, relatives, and significant others who need professional assistance and support take care of the affected people (Humanita, Alzheimerova choroba, 2009, p. 2). The social workers[1] have the place and space in work with those clients. In the paper we present their roles.

Key words: Social Work. Dementia. Alzheimer´s disease. Professional assistance.

Introduction

Dementia is a label for a syndrome whose most significant manifestation is the decrease of the complex of the cognitive functions, especially intelligence and memory. Dementia causes the loss of the developed intellectual functions. The most frequent cause of dementia is the Alzheimer´s disease[2]. There are three basic theories of the development of the Alzheimer´s disease. The oldest – cholinergic hypothesis proposes that the Alzheimer´s disease is the result of reduced synthesis of the neurotransmitter acetylcholine. According to the amyloid hypothesis, the cause of the Alzheimer´s disease is the accumulation of the protein of beta-amyloid in the brain, which causes destruction of the neurons. This process results in formation of plaques. The tau hypothesis suggests that the abnormal (hyperphosphorylated) tau protein causes the disease as a result of the functional defect inside the nerve cell bodies, and the disintegration and collapse of the microtubular neurons transport system. According to the tau hypothesis, the process of formation of tangles is primary. The causes of the Alzheimer´s disease progress are not exactly known so far (Alzheimerova choroba, 2011).

The incidence of dementia increases proportionally with age; the incidence of dementia in population of people aged 75 years has been estimated at 15%, and in population of older people aged 80 years the incidence increases to 20-40% (Topinková, 2005). It has been estimated that 5-10% of older people suffer from dementia, and the occurrence increases from

[1] The terms a social worker, a special pedagogue and other professional workers refer to both males and females.
[2] The German psychiatrist A. Alzheimer started to work in the city mental asylum in Frankfurt am Main in 1888. In his patient Auguste D., he found strange behavioural symptoms that significantly limited her ability of logical thinking and memory. Then he described aphasia, disorientation, unexpected behaviours, acoustic hallucinations, and significant decrease of psychosocial abilities. After her death he started to examine the neuropathological aspects of her disease, and published all this case in 1906 (Cetlová, 2010, p. 35).

0.4% in the age of 60 years to 40% in the age over 90 years (Krajčík, 2009; p. 99). In Slovakia, the number of the affected by the Alzheimer´s disease has been estimated up to 50 thousand people. About 100 thousand family members, relatives, and significant others who need professional assistance and support take care of the affected people (Čo je Alzheimerova choroba, 2010).
The statistics suggest that approximately 1% of citizens of the developed countries suffer from this disease. The statistics also present that the overall ratio of older people will increase from the present 10% to 21% by 2050, which will result in the increased number of people affected by the Alzheimer´s disease and dementia in families and also of the clients with this disease in the social services and health care institutions. In this syndrome, other mental functions are affected to some extent and the whole personality is gradually degenerated. Dementia develops on the basis of the organic impairment of the central nervous system (CNS); the prognosis depends on the type and severity of the basic disease that caused this disease.
The epidemiologic studies show that mental activities reduce the risk for dementia. This effect was proved also in the experimental animals. Moreover, the beneficial effects of the environment rich in stimuli were found in the histological examination of the brain in the experimental animals (Young, Lawlor, Leone, et al, 1999).

The disease is highly destructive. In the first phase, dementia is barely noticeable. The eyes are clear and open, the mind is clear, and the patients walk and move as usually. In the final phase of the disease, the persons are dependent on others in all their needs and they forget everything they have once learned. In this stage, they only perceive the atmosphere in their environment and they meet only their most basic needs (Buijssen, 2006).
At the beginning, confusion occurs, and then it is followed by the impaired orientation in space, wandering, and impaired logical thinking (Mahrová, Venglářová, 2008, p. 71). In the later stage of the Alzheimer´s disease, the social consequences are extensive. The affected persons stop walking, or performing the basic activities, and become incontinent. The short-term and long-term memories gradually decrease. Mutism (the loss of verbal communication) can occur. Swallowing can worsen; artificial nutrition is necessary. The changes in personality and mood occur, e.g. the patients suffer from delusions, they talk with the imaginary friends, suffer from anxiety, inability to make decisions, etc. The risk for complications including malnutrition, dehydration, infectious diseases especially pneumonia and bedsores increases. The patients are completely dependent on assistance from other physical persons.

The scope of professional action is open for healthcare professionals as well as for other, so-called helping workers including social workers, special pedagogues, social pedagogues, psychologists, and others.
The centre of social pedagogy lies in the theory of education and educational programmes for children and youth in school facilities. Therapeutic pedagogy emphasises the medical and psychological aspects of life of the individuals, the developmental and problem diagnosis, the therapeutic and educational activities and programmes for the individuals in each age group. In therapeutic pedagogy, the therapeutic and educational assistance focuses on promotion of development, and restoration of psychosocial health of the person in difficult life situations. Therapeutic pedagogy belongs to general and special pedagogy, and the marginal medical, psychological and social sciences. It focuses on the therapeutic and educational assistance for the individuals who are not able to lead an adequate way of life because of their disability, disease or their consequences. They promote the competences of the individuals to be oriented, make decisions, develop relationships, communicate, find the meaning, receive and

apply the values. It is carried out through the activities and programmes with the therapeutic and educational use of the developing creative, self-applying and self-care activities. Individual education, psychosocial rehabilitation, crisis intervention, and accompanying are included. Special pedagogy has its own place in the modern society and care for the handicapped individuals in each age. The significance increases with the social need of the professionals in the area of early diagnosis, prevention and therapy of the disorders, as well as the need of the complex and community rehabilitation and counselling. Special pedagogy focuses especially on education of the handicapped children and youth. The emphasis in preparation and education of the students in this discipline is paid to the professional, practical and personal preparation in the individual therapeutic and educational disciplines. Social work focuses on social pathology, problem situations and forms of assistance – social management, outreach work, counselling, assistance in realisation of social needs and roles (Opis 1.1.7 Liečebná pedagogika).

Social work (3.1.14) as a study field is the part of the system of study fields in the group 3 Social, Economic and Legal Sciences, in the subgroup 3.1 Social and Behavioural Sciences. Social work is the part of the social needs that are up-to-date in the development of the tertiary sphere of social life. The professional who implements social work is the social worker. After finishing the studies, the social workers as the professional workers know the fundamentals of the theory and practice of social work, and they have knowledge on the tasks of the state administration, local authorities and non-state subjects of social policy. They are prepared to perform the social and administrative activities, social and legal counselling of the first contact, social diagnosis and prognosis, social prevention, social and legal protection and screening, and other forms of social assistance (e.g. crisis intervention, outreach work, resocialization, negotiation and representing the clients, assistance for the clients in material and social deprivation, etc.).

The social workers as graduates of the master´s degree studies have knowledge on the theoretical conception and methods of social work, on economics and legislation of social sphere, know the methods of social sphere management, and are able to analyse the social situations in the area, or the region. The social workers are able to design, receive and realise the conceptual solutions of the social problems, to cooperate with the bodies active in criminal proceedings, health care, education, and psychological and pedagogical counselling, to participate in dealing with the issues of quality of life and social and environmental problems, to deal with the issues of the minorities especially the Romany ethnic group, to deal with the issues of family policy and family life, poverty, homelessness, prostitution, drug addictions, and other social and pathologic situations in the residential and outreach social work, to plan and organise independently the activities of social assistance and social services (Opis 3.1.14).

In their professional work, the social workers play many roles that overlap. However, it is possible to describe several types that differ from each other. In practice, one of the types can be dominant in accordance with the required work of the workers, the character of the facilities, the style of organisation management, its goals, etc. The clear type most probably does not exist in practice. It is possible to define the following roles of the social workers:

Carers or *caregivers* assist the clients in their everyday lives in the areas in which the clients are not able to carry out the important activities because of their handicap, disease, weakness or other disabilities. Such services are provided in the long-term care facilities or in the client´s home. The carers are in direct daily contact with the clients suffering from dementia; it is provided for the clients with the residential or outreach type of services.

Mediators assist the clients to obtain the contacts with the social institutions, or other sources of assistance. Sometimes, the social services network is not coordinated sufficiently, the clients do not know the existing facilities; sometimes it is also necessary to set the hierarchy of the needs of the services in accordance with their priority. The social workers

have the roles of a situational diagnostician, an evaluator of the available sources of assistance, a client´s informant, a person who recommends the clients other facilities, an advocate of the client´s needs, and a coordinator of the persons participating in dealing with a client. The social worker in the position of a coordinator and mediator works with the families and relatives of the clients suffering from dementia. They provide them with the information on the options of the services and care for the clients, and are also the supportive elements in experiencing the new difficult situation connected with the disease of their relatives, etc. The mediators should have adequate knowledge on the new approaches and world trends in the area of providing the social services and should implement them in their work. For example, they should prefer providing the social services in the natural environment of the users, with support from their families and relatives using the outreach and short-term care services. The process of deinstitutionalisation leads to providing the social services that would address the individual needs of the individuals in their natural social environment. The social services migrate to the users in contrast to the period when the users came to the services (Vávrová, 2010, p. 73).

Counsellors or *therapists* assist the clients to get a view of their attitudes, feelings and the ways of dealing, with the goal to support their personal growth or more adaptable action. Specifically, they provide the information on accommodation, heritage and donation, consumer protection, employment, and in the scope of family and interpersonal relationships. The individuals with dementia and their family members can contact the counsellors personally, by telephone, via the Internet or by mail (Nováková in Vávrová, 2010). In this role, the social workers are seen through the functions of a psychosocial diagnostician, a counselling person, a social therapist, or a researcher in practice. In their work with the persons suffering from dementia and their relatives, the non-healthcare professionals use so-called non-pharmacological approaches to treatment of dementia, including reminiscence therapy, ergotherapy, validation and others.

Case managers – in this role the social workers provides arrangement, coordination, suitable choice and continuous provision of so-called continuum of services, especially in the clients with several social and health needs. Their functions include the case diagnosis, planning the services and therapies, developing the functional relations with other providers of social services, regular monitoring of the provided services, and advocating the clients´ interests. The essentials of the case manager role are to assist the clients and their families to facilitate in the network of helping services their effective coordination for the benefits of the previously set goals. This role is implemented especially in the problematic families and in the handicapped persons; it is a type of personal assistance provided for the clients.

Administrators, i.e. managers or heads of institutions, plan, develop and implement the ways of work, services and programmes in social and other facilities for the specific clients. The administrators´ roles include the functions of a manager, an internal and external coordinator, especially in a long-term plan for a facility development, a function of a planner and negotiator of development of a facility and its programmes, as well as the function of a professional programme evaluator.

The direct contact of the social workers with people suffering from dementia is probably the most common and the most intensive in the specialised facilities. The contact with the person suffering dementia is possible also from the position of the outreach social workers in the natural environment of the clients, and also in the position of the social workers working in healthcare facilities.

In the specialised facilities, the social services are provided for the natural person who is dependent on the assistance of another natural person, whose dependence level is at least V in accordance with the appendix No 3, and suffers from disability such as the Parkinson´s

disease, the Alzheimer´s disease, the pervasive developmental disorder, sclerosis multiplex, schizophrenia, dementia of various etiologies, deafblindness (Article 39 (1)).
The specialised facility is a facility that provides the social services designated to solve the negative social situation as a result of the serious disability or negative health condition of a citizen. In the specialised facilities, the assistance to the individuals dependent on the assistance of another natural person, social counselling, social rehabilitation, nursing care, accommodation, alimentation, cleaning, washing, ironing and care for linen and clothes, the ergotherapy, free-time activities, the conditions for education, and the deposit of valuables are provided.
This specific type of the social services requires the professionally prepared professionals. This fact is presented also in the Article, especially in its sevenths part there is the information on the qualification requirements and education in the system of social services. In accordance with this article (Article 84 (4) (a)), the basic social counselling and assistance in applying the rights and the interests protected under law are performed by a natural person with higher professional education and the finished study programme accredited in accordance with a special regulation in the study fields focused on social work, social pedagogy, special pedagogy, therapeutic pedagogy, andragogy, social and humanitarian work, social and legal work, and charity and missionary activities. In the same section, (b) presents the information on university education obtained in the bachelor or master´s study programmes focused on social work, social pedagogy, special pedagogy, therapeutic pedagogy, psychology accredited in accordance with the special regulation, or adequate document on such university education issued by a university abroad. It is also possible (Article 84 (4) (c)) to obtain qualified education in the accredited educational courses in the fields mentioned above (social work, social pedagogy and others) in the extent of at least 150 hours and the practice in the function in the scope of social work for at least three years, if the person has finished the second-degree university studies that are not stated in (b).
The specialised social counselling is performed by a natural person who has a three-year practice with the target group and has finished university studies in a bachelor study programme or a master study programme focused on social work accredited in accordance with the special regulation, i.e. the Act No 131/2002 Coll. on Higher Education, or a study programme focused on the activities that are provided in the specialised social counselling. The act further states the possible modification from the perspective of education to implement the special social counselling for a natural person with serious disability (Article 84 (5) and (6)).
In the special article (Article 84 (7)), the Act on Social Services defines a social worker as a natural person who has finished the university studies in the study field of social work in the first degree, the second degree, or has an adequate document on such university education issued by a university abroad.

Conclusion

In work with the clients suffering from dementia and their families, the pedagogic sciences and social work overlap. Each of the mentioned scientific disciplines has an exactly defined scope of action in relation to the clients, i.e. people suffering from dementia and their families. Social work implies an element of complexity that provides the space and also the obligation to cover so-called whitespace that occurs in the complex and continuous care for the persons with dementia. As Pavelová and Tomka (2010) suggest, social work is constantly confronted with the changes caused by the social system and people in it. The changes bring new problems that make people seek new approaches and methods in work of the social workers. The special implementation of the professionals in social work can be used in work

with the families through the professional counselling, assistance and support for the clients´ relatives, in communication and contacts with the authorities and the institutions such as the social insurance company, departments of labour, social affairs and family, self-governing regions, courts, etc. The social workers also provide the information on the system of services in accordance with the valid legal enactments. With appropriate qualifications and competences, the social workers can act sociotherapeutically and psychotherapeutically especially in the feelings of helplessness, frustration or overload of the family members of the persons suffering from dementia. Kasanová (2008, p. 65) presents that the relatives can learn how to cope with the emotional changes and the behavioural changes accompanying the disease, how to decrease the negative behaviours by responsiveness to the invoking causes or how to cope with the feelings of sadness and disappointments from the continual changes in the personality of the affected person. There is also the space in the management line in the non-profit organisations or the social services institutions for the elderly.

The paper is supported by the grants:
UGA No VIII/15/2011: Perception of Grandparenthood and Role of Grandmothers by Women in Presenium and Senium, and VEGA No 1/0221/11: Evaluation of the Results of Process of Resocialization of Clients in Resocialization Facilities in the Slovak Republic.

REFERENCES

Alzheimerova choroba. 2011. Accessed 12 October 2011, http://www.stemcellclinic.com/sl/clinic/treatment/2.html

BUIJSSEN, H. 2006. Demence : průvodce pro rodinné příslušníky a pečovatele. Praha : Portál, 2006. 136 s. ISBN 80-7367-081-X.

CETLOVÁ, L**.** 2010. *Kvalita života pacienta s Alzheimerovou chorobou.* In zborník príspevkov z konferencie: „Zdravie a kvalita života". Ružomberok: Fakulta zdravotníctva Katolícka Univerzita Ružomberok, 2010. ISBN 978-80-8084-532-2. s 34 - 38.

Čo je Alzheimerova choroba, 2010. Accessed 10 October 2011, http://jankompan.net/biorezonancia/?p=289

KASANOVÁ, A. 2008. Sprievodca sociálneho pracovníka II. Seniori a samospráva. UKF Nitra: Vydavateľstvo M. Vaška v Prešove. 2008. 162 s. ISBN 978-80-8094-254-0

KRAJČÍK, Š. 2009. Zhoršovanie kognitívnych funkcií ako jedna z kľúčových oblastí výskumu v dnešnej gerontológii. In: Geriatria 3/2009, roč. XV., ISSN 1335-1850.

MAHROVÁ, G . - VENGLÁŘOVÁ, M. a kol. 2008. Sociální práce s lidmi s duševním onemocněním. Praha : Tiskárny Havlíčkův Brod, 2008. 176 s. ISBN 978-80-247-2138-5.

NOVÁKOVÁ, R. 2009. Tradice péče v přirozeném sociálním prostředí z pohledu sociokulturní antropologie. In VÁVROVÁ, S. et al. Kontext transformace pobytových sociálních služeb, s. 27 – 53. Zlín: Fakulta humanitních studií Univerzity Tomáše Bati ve Zlíně, 2009. 118 s. ISBN 978-80-7318-869-6.

Opis študijného programu 1.1.7 Liečebná pedagogika. Accessed 9 October 2011, http://www.akredkom.sk/index.pl?tmpl=odbory.

Opis študijného programu 3.1.14 Accessed 9 October 2011, http://www.akredkom.sk/index.pl?tmpl=odbory.

PAVELOVÁ, Ľ. , TOMKA, M. Aké sú požiadavky na profesionálny profil absolventa študijného programu sociálna práca ? 2010. In: *Rizika sociální práce*: sborník z konference VII. Hradecké dny sociální práce. Univerzita Hradec Králové, 2010. ISBN 978-80-7435-086-3, s. 416-424.

TOPINKOVÁ, E. 2005. Geriatrie pro praxi. Praha: Galén, 2005, s.137-140.

VÁGNEROVÁ, M. 1999. Psychopatologie pro pomáhající profese: variabilita a patologialidské psychiky. Praha : Portál, 2002. 444 s. ISBN 80-7178-678-0.
VÁVROVÁ, S. Institucionalizace jako překážka sociální inkluze osob se zdravotním postižením. *Sociální práce*, 2010, roč. 10, č. 4, s. 67-75. ISSN 1213-6204.
YOUNG D, LAWLOR PA, LEONE P, DRAGUNOW M, DURING 1999. Environmental enrichment inhibits spontaneous apoptosis, prevents seizures and is neuroprotective. Nature Medicine. 5, 448-453.
Zákon NR SR č. 448/2008 Z. z. o sociálnych službách.

Contact address:

Mgr. Jana Gabrielová
PhDr. Martina Hrozenská, PhD.
Department of Social Work and Social Sciences
Faculty of Social Sciences and Health Care
Constantine the Philosopher University in Nitra
Kraskova 1
949 01 Nitra
Slovak republic
e-mail: jana.gabrielova@ukf.sk
mhrozenska@ukf.sk

LONG TERM CARE FOR THE ELDERLY IN SPECTRUM OF SOCIAL WORK, LAW, AND NURSING

[1]Martina Hrozenská, [2]Lada Cetlová, [3]Miroslav Pal'un

[1]Department of Social Work and Social SciencesConstantine the Philosopher University in Nitra Slovak Republic
[2]College of Polytechnics Jihlava, Department of Health Service Studies, Czech Republic
[3]St. Elizabeth University College of Health and Social science Bratislava, Slovak Republic

---

ABSTRACT

Contribution offers a look at the issues of population ageing and options of long - term care in Slovak Republic. Distinctively it focuses on funding of these services. It deals with objective problems from the aspect of social work, law, and nursing with stress on basic assumptions of mentioned subject area.

Key words: Long – term care. Social work. Law. Nursing.

Introduction

At the present time we are carrying out the research design INTERLINKS (Health system and long – term care for older people in Europe – Modelling the INTERfaces and LINKS between prevention, rehabilitation, quality of services and informal care). Slovakia is represented by The Institute for Labour and Family Research. The project is focused on development of concept and methodology describing long - term care and its links with health care for the elderly. The project is funded within the 7th framework programme of EU. It lasts 3 years and it is carried out from November 2008 to October 2011. INTERLINKS is carried out by 17 research institutes from 14 European countries. A part of dissemination strategy is the establishment of so called National Expert Panel consisting from 10 to 15 persons representing various key institutions interested in issues of long – term care for the elderly. They also have sufficient influence to initiate and make the necessary changes in this area. The role of strategy is, inter alia, to provide relevant information to solver, particularly in the available literary sources and practices in health and long – term care (Interlinks, Agency for Research and Development Agency: National Expert Panel).

Human life is extended, population ages. The population is ageing worldwide, it is recorded not only in developed but also in developing countries. „According to the prognosis of population development in the Slovak Republic until the year 2050, prepared by the Statistical Office of Slovak Republic in 2002, population development in our country in the first half of the 21st century will be characterised especially by reducing population growth and aging. The intensity of these processes will directly depend on the development of fertility, mortality and migration, but they will be indirectly affected by other demographic factors as well as social, political, economic and cultural factors" (EurActiv.sk, 2006, p.2). The need of long-term care and support for integration may arise in case of permanent functional disability. Short-term care is provided in case of a temporary change in health status or a temporary crisis of social relations. Providing long-term care and support of integration are continuous

with unknown date of their completion. Providing short-term care and crisis intervention have predetermined and expected end. The aim of long-term care is to provide permanent support to overcome functional limitations and promote integration into society. The result of long – term care is to promote independence of the client and also including his/her social and occupational integration (Legislative intent of the long-term care law and the integration of persons with disabilities, 2005).

"Long-term care and support of integration is coordinated providing health care, social and health counselling and social services, benefits and compensation aids to such an extent that the loss of ability to perform necessary life tasks and other social and occupational functions could be replaced. Long-term care and support of integration is provided to the individual needs of each client appropriate to his/her age and extent of possible malfunction in his/her natural social environment or in the long-term care home. Long-term care is provided directly via the provider or the provision of an aid or indirectly in the form of financial contributions and benefits, which the client may use to pay for social service or device "(Legislative intent of the long-term care law and the integration of persons with disabilities, 2005). Demand for care, including long-term care, among the elderly is increasingly growing. This mainly reflects the fact that more and more elderly people are living alone (Hrozenská et al., 2008). European countries face many common challenges due to aging and watch them with sustainable policy and reliable practices. Countries in the European Union have agreed on common objectives in solving the long-term care, the accessible, high quality, affordable and sustainable care (European Social Network, 2010). Long-term care for the elderly and ill people is provided in developed countries in two basic forms, domestic and institutional. Early 80's, most developed countries adopted a decision on the intensive support of home care and community care rather than support of institutional care. Thanks to this, many have reduced the proportion of institutional care, or at least significantly change the structure of its clients and to the benefit of clients with the most severe disabilities (Bohovicová, 2006). Alice M. Rivlin (1988) argues that although there are many older people who need long-term care with nursing service, the prevailing long-term care providers in the United States is the family. Most older people prefer to stay in their homes as long as possible. In social services homes are usually placed only older people with more severe disabilities. Long-term care and highlights the problem of access to women because it is mostly women who provide care such as informal carers within the family or as workers in home care services and residential services. It would be appropriate to allow women but also men to reconcile work and family life, maintain their position in the labour market and take responsibility for their own family.

Long-term care financing

Social Europe is based on human rights and solidarity. There is no doubt that human rights include the right to a decent life for the entire population, including long-term care for elderly people and that solidarity is a mean of securing this right (Hrozenská et al., 2008, p. 112). The bill on long-term care and support for integration enables to create an integrated long-term care system in Slovakia. The main objective of the draft proposal is also contribution to the efficient and effective use of public funds to support people with long-term functional disorders, severely disabled and older people with impairments. Quantification of the estimated impact of long-term care funding on the budgets of public administration within 10 years takes into account projected demographic development and the expected range of network of providers. With an aging population are claims on funding for relevant services directly proportionally increasing and in following years they will increase more and more. It is believed that if they create an integrated long-term care system with related linkages between assessment and funding, and the additional resources will be used more efficiently

and effectively for financing needs of those people who objectively need them (Clause of financial, economic, environmental impacts, impacts on employment and business environment). Constitutions of all countries, especially Visegrad Four countries have enshrined the right to social security. This right is not made with the same intensity. Recipients or their families can be share the cost. These systems of participation can be grouped into four groups. And if it is:

1. percentage of public subsidy is fixed
2. entire income of the recipient cover social care costs and the beneficiary receives only a small amount
3. maximum participation of the beneficiary's share is determined by law
4. share of participation is determined by examining the means and depending on the institution (Hrozenská et al., 2008)

Assuming that about 80% of the population over 65 years will be entitled to long-term care, we can assume a continuous increase of spending on it. The most significant expenditure pressure will be likely caused by a faster increase in population over 80 years (Clause of financial, economic, environmental impacts, impacts on employment and business environment).

The growth of long-term care expenditures will be influenced by the growing demands of clients on expanding and increase of services quality. Nevertheless, it is expected that total spending on long-term care may increase in the integrated system, possibly at the same pace as economic growth in current prices. The Ministry of Health proposes to introduce mandatory cover the costs of related services, such as costs for food, accommodation. In addition, however, the income and financial situation of clients are taken into account. Draft of long-term care and support of integration suppose the transformation of today's social institutions, eventually some appropriate health facilities for long-term care as a priority in promoting the development of community care with the resources from the state budget (Clause of financial, economic, environmental impacts, impacts on employment and business environment).

Long-term care for the elderly from the perspective of social work

Social work is a professional activity on a professional basis providing care for the client whose relationship with the environment in which he/she lives is disrupted. Social work is carried out mainly in social services and through them. Professional social workers are employed by social subjects to pursue their social objectives, programs, plans or projects, i.e. provide objects to social objects, the clients - benefits and services that lead to meeting certain social needs. A substantial degree of social - political intentions is carried out by performance of social work. Professional social workers provide information and services to clients in the most diverse living situations.

Social work emphasizes the client's social functioning. In practice this means that the social worker looks at man as a being who exists in the environment and must handle its demands. The role of social worker is thus support the client's social functioning (Matoušek et al., 2001). Social welfare is action focused on meeting the objective of the recognized needs of the individual, group or community. It is formally organized care, regulated by the form of social laws. To support the implementation of social welfare there are various institutions, organizations and civic associations. Social care for older people can be made by social workers provided by a number of types and forms of work with them. Social care for older people can provide for example social insurance companies, self-governing regions, offices of

labour, social affairs and family, day centres, social service facilities, specialized institutions, etc.
Caring for long-term ill and severely ill person is based on a holistic approach, and looking at the man and his needs. Social work includes four essential components

• individual, i.e. feeling of security and satisfaction
• social, family and relatives
• health, fair to health status
• emotional, some degree of emotional and spiritual support

The methodology of social work is based on the detection of status and knowing about the needs of seriously ill person and his family, the exact mapping, assessment and conclusions in the interest of most natural resolving problem of the older person.

One of the specifics of care for the elderly is the indivisibility of health and social components. The line between social and health care is often uncertain. In this context Krajčík (2000) notes that it is the lack of places in social services institutions that causes serious problems for the departments for long-term ill patients. Number of beds in social services institutions is insufficient and therefore the waiting times for placement are long. Caring for older people is in many cases less flexible. Many social services institutions are situated in buildings that have architectural barriers, which worsen the movement of hard mobile old man, another negative factor becomes a risk of institutionalization, which increases in proportion to the size of facility. It is therefore recommended that the facility should not have more than 40 beds. It is important to activate people, with possibility to adjust the daily regime according to the wishes of citizens. It is important to ensure health care for chronically ill and immobile patients. The most suitable environment for an older person is in most cases, his own household. Therefore, expanding home care, which is usually cheaper than institutional is actual. The growth in the number of elderly people who more frequently live until the old age increases the demands for financing. For this reason, services will have to be more flexible, facilities will unite into centres providing complex care, from home care via semi-institutional to the institutional care (Krajčík, 2000). Institutions and long-term care services are associated with the system of health and social care. However, it is very difficult to distinguish between health, social, institutional and community care. Health care systems play an important role in long-term care. Combined provision with various social security schemes answering for long-term care becomes the predominant trend.

Long-term care for the elderly from the perspective of law

Legislative changes in long-term care come from the Manifesto of the Government of the Slovak Republic and follow the guidelines of the Government with the goal to integrate overlapping of social and health services and their funding directed to the client. Government of the Slovak Republic with its resolution No.161 of 25th February 2004 approved the Concept of social and long-term care and the Minister of Health presented the legislative intent of the social and long-term care law (Legislative intent of the long-term care law and the integration of persons with disabilities, 2005). Current predicted changes in the population of Slovakia are the rationale for a separate long-term care system (Legislative intent of the long-term care law and the integration of persons with disabilities, 2005). According to Infostat (2002), the population over 65 years will increase annually, more markedly after 2011. In addition, aging is becoming a serious reason for growing public expectations for better quality of service (Legislative intent of the long-term care law and the integration of

persons with disabilities, 2005). Woleková (In: Bohovicová, 2006) there are three groups of long-term care services:

1. health care provided in the client's home
2. social care ensuring the client's daily personal needs and the needs of his household
3. health and social services of long-term term provided in the institution

"Health care and its provision are governed by Act No. 581/2004 Coll. on Health Care Insurance Companies and Surveillance over Health Care and on Amendment and Supplementation of Certain Acts, Act No. 580/2004 Coll. on Health Insurances, Act No. 578/2004 Coll. on Health Care Providers, Health Workers and Professional Organisations in the Health Service, Act No. 577/2004 Coll. on the Scope of Health Care Covered by Public Health Insurance and on the Reimbursement of Healthcare-related Services, and Act No. 576/2004 Coll. on Health Care and Healthcare-related Services." (Legislative intent of the long-term care law and integration of persons with disabilities, 2005).

Healthcare for older people has the importance in the society not only on the ethical level, but also in relation to the economic situation in the society. The increase number of elderly people who need and will need healthcare will result in increasing demands on the healthcare system. It is therefore necessary to support interest and participation of all generations in prevention programs and support for health care. The aim of the health policy must therefore be improving the health status of the population, increasing the operational capacity of the health system and ensure the financial protection of the individuals against catastrophic health care costs. Health care system should be developed to be able to cope with new demographic situation, increasing the efficiency and effectiveness of health care while maintaining its accessibility. It must respect the principle of equal access to health care, support measures related to primary and secondary prevention. It is required to improve the health of our aging population. The concept of social medicine in the literature usually expresses the concept of social and long-term care in democratic countries. As a result of demographic changes and because of the increasing number of long-term health and socially disadvantaged people in Slovakia, there is a growing need of long-term care. This represents a link to medical services with social performance. To the creation of long-term social and health care system while complex solving of needs of older people reliant on long-term socio-medical care another institutions will have to be actively engaged; such as non-profit organizations that could offer cooperation and experience. Nursing care enters to the long-term care from health care on condition that the person needs it in the long term. Nursing care is the care of nurses provided using the method of nursing process to a person or a group of persons in preventing diseases, health promoting and maintaining, disease treatment and dying. Health laws, in force since 1st January 2005, sufficiently define the basic conditions of nursing care providing, so the forthcoming act on long-term care and the integration of persons with disabilities can appropriately use mentioned provisions. (Legislative intent of long-term care law and support the integration of persons with disabilities, 2005). Integration of social services and health care is not in the legal system of the Slovak Republic systematically adjusted. Under the current valid legislation social services and health care for persons who should be under the newly proposed legislation to provide long-term care and support for integration, are self-regulated in different legislation.

Long-term care providers are:

- non-professional providers of selected performances of long-term care making the necessary acts of life, such as assistance in personal hygiene, getting out of bed, assistance in maintaining social relationships with the environment, guiding and interpretation services, transportation, which is performed under a written contract between the provider and the client involving reciprocal rights and obligations

- formal providers are natural and legal persons, such as community, non-profit organizations, nursing and care agency, interpreting services for deaf and hard of hearing persons, day care, integration centres, and residential institutions, mixed and combined facilities.

Ministry of Health of the Slovak Republic can not be a settlor or founder of any long-term facility. The settlor can be a natural or legal person, higher territorial unit or municipality. Providing the long-term care and support the integration of the place where the care is provided is divided into:

- in the client's home
- in the community
- in the integration centre of health insurance for people with disabilities
- in the long-term care facilities

Forms of long-term care and support for integration are:

- outpatient
- institutional

The system of care for older people in the Slovak Republic is realized under the current legislation and also under the Act No. 461/2003 Coll. on Social Insurance, as amended by later regulations. The scope of social insurance under the act is:

- health insurance
- annuity insurance – the old-age insurance and disability insurance
- accident insurance
- guarantee insurance
- unemployment insurance

The system of social services is governed by Act No. 448 Coll. on Social Services. Social services dealing with adverse social situations because of severe disability, ill health or because of retirement age are:

- provision of social services in the facilities for individuals who are dependent on another individual who reached the retirement age
- nursing service
- transport service
- guides and reading services
- interpretation services
- mediation of interpretation services
- mediation of personal assistance
- rental of devices

In the recent years are formed organizations, civic associations and foundations dedicated to the issue of the elderly people. The documents that seek to influence society-wide view of aging and old age document is the UN International Plan of Action on Ageing, which was adopted on 12th April 2002 in the second World Assembly on Ageing in Madrid (Klevetová, Dlabalová, 2008).

This document is divided into eleven chapters:

- aging population – demographic changes
- ethical principles
- natural social environment
- occupational activities
- material security
- healthy lifestyles and quality of life
- health care

- complex social services
- housing
- education
- social activities

Its ultimate objective is to ensure a balanced and integrated development of guaranteeing a satisfactory standard of living for an increasing number of elderly people and eliminate problems associated with longevity and its consequences. "The framework concept of long-term solution of the situation and living standards of older people based on an international - legal documents affecting the issue of aging in all its complexity" (International Plan of Action on Ageing).

Long-term care for the elderly from the perspective of nursing

Health is physical, mental and social well-being. It's the opposite of disease http://sk.wikipedia.org/wiki/Choroba, not its absence or dysfunction. WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and weakness." Health is the optimal functional status of a living system in totality of its active and reactive expressions of life (Health, 2011). Health care for older people over 65 years is provided as a geriatric care, which places great emphasis on prevention, diagnosis, treatment, rehabilitation and nursing of the elderly. Geriatric care is provided as a specialized care focused on maintaining self-sufficiency and the delay of dependence to the extent to enable older people to stay in their home environment as long as possible. Geriatric health care is provided through outpatient and inpatient care. Primary health care is provided by general practitioners for adults. Part of primary care as well as home healthcare agencies. Nursing care is provided by skilled nurses. Specialized outpatient care at the request of general practitioners for adults is provided by a specialist in geriatrics. Institutional geriatric health care is provided mainly to the acute geriatric ward beds at geriatric departments, acute gerontopsychiatric departments in hospitals and chronic hospital beds for long-term ill patients. Institutional care is provided as well as in hospices and palliative care (Health Care: Documents, 2004). "Gerontological Nursing is applied to clinical nursing, which focuses on care for the basic needs of an older person to maintain its self-sufficiency and independence in daily living activities, to prevent complications and to promote the mental, physical and social well-being. It is a complex nursing care for both healthy and ill elderly people, which leads to consolidation, to the alleviation of disease and achieving self-sufficiency "(Poledníková et al., 2006, p. 14). The objectives of gerontological nursing based on The Concept of Nursing and focus to help the geriatric patient and his family in those activities that contribute to health promotion, healing or a peaceful and dignified dying and death (Poledníková et al., 2006). "Geriatric Nursing is a complex nursing care for the ill elderly, taking into account their needs in relation to diseases at higher and high age, especially with specific geriatric syndromes and complications of diseases. It is care aimed at meeting the needs of older people and solving their problems. Old and seriously ill person is often not able to signal his needs, and therefore active approach of nursing staff in meeting the needs of older people is very important (Cetlová, 2009, p. 100). In the last ten years in healthcare emerged new philosophical ideas and trends that provide an individual approach to people as a whole. Understanding of health depends on the society's level of development and its culture. There are several models of understanding of health which can the older individual to varying degrees identify with. E.g. clinical model, role playing, adaptation model and the most complex of the models is eudaimonic. This model emphasizes that health is a state of development and application of personal potential, congenital and

acquired skills of a man. The disease is in understanding this condition, which prevents self-realization and application of a person's own abilities. The model is based on an idealistic philosophical direction "eudaimonism", which highlights the efforts to achieve human well-being and considers it a source of morality (Farkašová, et al. 2005). Boledovičová and Nádaská (In: Poledníková et al., 2006), emphasize the importance of communication in nursing work. Indicate that when confrontation with people without communicating is impossible. Therefore, communication is the first assumption for the implementation and functioning of interpersonal relationships. Effective communication is therefore the assumption for quality care for an elderly person. Thus, even in nursing practice, it is necessary to have not only expertise, but also communication skills, a great deal of patience, empathy and listening skills. Listening to an older person is a very important element in communicating with each other.

Also, even in nursing it is gradually withdrawn from the orientation on disease and to the forefront of the receive method of nursing process, community nursing and home care, which emphasize complex care for a man is preferred (Pavlíková, 2006). A characteristic feature of modern nursing is the systematic assessment and planned meeting the needs of healthy and diseased humans. It is meeting the needs carried out through the nursing process (Trachtová et al., 2005). Nursing team cares for patients with a complex holistic approach to the client (Cetlová, 2010, p.152). Even in Henderson´s model of nursing care a person is perceived as an independent being of biological, psychological, social and spiritual dimension that are associated with basic human needs (Žiaková et al., 2007). According to Hammar (In: Kalvach et al., 2008) it is important already at the community level to strive for complexity, continuity and coordination in long-term services and interventional inputs, the dispensary and screening of single or at high-risk patients and purposive support of lay caregivers, especially family members. Elderly man should participate in everyday life as long as possible, should work for something, should have interest, which physically or mentally does not exhaust, but constantly employ, such as work around the house, small home repairs, care of grandchildren. He has a particular interest in public affairs. Even at late old age it is recommended to cultivate some hobby activities at home and in the vicinity. It strengthens the mental balance (Bartko, 1984). Even Litomerický (In: Hegyi, 1994) states that the family is considered to be the most reliable support of an elderly person from each site. Even the family in many cases wants to take care of their oldest members. The older people themselves refuse the institutionalization. However, families often do not manage this care and need help. For these reasons, the care of an elderly person puts on the family great emotional and physical stress, which is a cause of tension especially when ill old people are disabled. Therefore, when treating an elderly person at home the caregiver must keep in mind that the health status of an elderly person who requires long-term care gradually worsens (The Ambulance Association, British Red Cross Society, 1988). M. Palát (In: Hegyi, 1994) as a model for long-term care in geriatrics, provides rehabilitation in the community. The term rehabilitation in the community defines the implementation of rehabilitation programs and other services for physically and mentally disabled people in their own environment in their community.

This project was initiated in the decade dedicated to persons with disabilities by the United Nations and World Health Organization. If we apply these principles of now widely accepted long-term program in the field of geriatrics and older people, then there is some solution to this long-term care, implementation of similar programs in the environment of the older man. The basic objective is to integrate people into all structures of society to ensure the necessary rehabilitation programs, social services and other measures within the local community. The total capacity of a nursing team is usually a critical factor in the quality of care in social services (White, Truax, 2007). Social service facilities recruit older people who are dependent on assistance from another person. M. Čunderlíková, O. Varsányiová (In: Hegyi, 1994)

indicate that the older person needs social and health care, but also quality life mean that in the case of institutional social care does not resemble a temporary collective accommodation.

The contribution was written within the project: VEGA No 1/0221/11 Results evaluation of the process of clients´ resocialisation placed in resocialisation centres in the Slovak Republic and within the project UGA VIII/15/2011 Women´ perception of old parenthood and grandmothers´ roles in presenium and senium.

REFERENCES

BOHOVICOVÁ, M. *Vývoj sociálnej práce : Formy poskytovania dlhodobej starostlivosti vo vybraných krajinách*. [online]. 2006, [cit. 2009-04-29]. Available on internet: <http://vssvapn.kx.cz/leto3/respirne_sluzby_a_prehlad_v_inych_krajinach.doc>

BOLEDOVIČOVÁ, M., VOROSOVÁ, G., KRIŠTOFOVÁ, E.: Rola sestry v aktivitách verejného zdravia a komunitného rozvoja v zmysle Mníchovskej deklarácie, 2007. In. *Nové trendy trendy v ošetřovatelství VI.*: sborník příspěvku z konference s mezinárodní účastí VI. jihočeské ošetřovatelské dny. České Budějovice : Jihočeská univerzita, 2007. ISBN 978-80-7040-992-3, p. 41-47.

CETLOVÁ, L.2009: *Péče o seniory na oddělení dlouhodobě nemocných a řešení jejich sociálních služeb.* In: zborník príspevkov z konferencie: ,,Dni sociálnej práce“ a ,,InteRRa 8“. Dni sociálnej práce. ,,Sociálna sféra Slovenskej republiky a sociálna práca (Európa, právo a prax)„ a ,,Rómske osobnosti“. Fakulta sociálnych vied a zdravotníctva Univerzity Konstantina Filozofa v Nitre, 2009, ISBN 978-80-8094-650-0.

CETLOVÁ, L., KOPÁČIKOVÁ, M. STANČIAK, J. 2010: *Péče o nemocné v psychiatrické léčebně.* In zborník príspevkov z konferencie: ,,Zdravie a kvalita života“. Fakulta zdravotníctva Katolická univerzita Ružomberok, 2010, ISBN 978-80- 8084-532-2.

ČUNDERLÍKOVÁ, M. – VARSÁNYIOVÁ, O. Je domov dôchodcov skutočne domovom. In: HEGYI, L. *Tretie Stredoeurópske sympózium o sociálnej gerontológii : Starostlivosť o starých ľudí v transformujúcich sa krajinách*. Bratislava : Informačné a dokumentačné stredisko o Rade Európy, Academia Istropolitana, 1994. ISBN 80-967477-4-6. p. 45-47.

Doložka finančných, ekonomických, environmentálnych vplyvov, vplyvov na zamestnanosť a podnikateľské prostredia : Odhad dopadov na verejné financie. [online]. [cit. 2009-04-29]. Available on internet: <http://www.health.gov.sk/redsys/rsi.nsf/0/b9b9bca9bb422fdec12570cf0031f801/$FILE/dolozka_fin.rtf>

EURACTIV.sk. *Zdravotníctvo : Starnutie obyvateľstva*. [online]. 2006, [cit. 2009-11-16]. Available on internet: <http://www.euractiv.sk/verzia-pre-tlac/zoznam_liniek/starnutie-obyvatelstva>

EUROPEAN SOCIAL NETWORK. *Long – Term Care for older people – Long – term Care & EU policy contex*. [online]. 2010, [cit. 2010-02-18]. Available on internet: <http://www.esn-eu.org/long-term-care-policy-context/index.htm>

FARKAŠOVÁ, D. et al. 2005. Ošetrovateľstvo – teória. Martin : Osveta, 2005. 216 p. ISBN 80-8063-182-4.

HEGYI, L. *Dlhodobá starostlivosť o seniorov*. [online]. 2007, [cit. 2010-03-30]. Available on internet: <http://www.szu.sk.sk/ine/verejnezdravotnictvo/2007/2007-2-3/editorial.htm>

HROZENSKÁ, M. et al. *Praktická príručka pre sociálnych pracovníkov pracujúcich so staršími ľuďmi*. Nitra : Univerzita Konštantína Filozofa, 2009. 103 p. ISBN 978-80-8094-474-2.

HROZENSKÁ, M. et al. *Sociálna práca so staršími ľuďmi a jej teoreticko – praktické východiská*. Martin : Vydavateľstvo Osveta, 2008. 180 p. ISBN 978-80-8063-282-3.
INTERLINKS. *Agentúra na podporu výskumu a vývoja : Národný panel expertov/tiek*. [online]. [cit. 2009-11-16]. Available on internet:
< http://www.sspr.gov.sk/texty/File/Interlinks/skladacka_IVPR.pdf >
KALVACH, Z. et al. *Geriatrické syndromy a geriatrický pacient.* 1. vyd. Praha : Grada Publishing, a.s., 2008. 336 p. ISBN 978-80-247-2490-4.
KLEVETOVÁ, D. – DLABALOVÁ, I. *Motivační prvky při práci se seniory*. 1. vyd. Praha : Grada Publishing, a.s., 2008. 208 p. ISBN 978-80-247-2169-9.
KRAJČÍK, Š. *Geriatria*. Trnava : SAP – Slovak Academic Press, 2000. 82 p. ISBN 80-88908-68-X.
Legislatívny zámer zákona o dlhodobej starostlivosti a podpore integrácie osôb so zdravotným postihnutím. [online]. 2005, [cit. 2009-11-16]. Available on internet:
<http://www.rokovania.sk/appl/material.nsf/0/9479BD613864756FC1257002600342D76/$FILE/Zdroj.html>
LITOMERICKÝ, Š. Starý človek a jeho rodina. In: HEGYI, L. *Tretie Stredoeurópske sympózium o sociálnej gerontológii : Starostlivosť o starých ľudí v transformujúcich sa krajinách*. Bratislava : Informačné a dokumentačné stredisko o Rade Európy, Academia Istropolitana, 1994. ISBN 80-967477-4-6. p. 52-54.
MATOUŠEK, O. et al. *Základy sociální práce*. 1. vyd. Praha : Portál, 2001. 312 p. ISBN 80-7178-473-7.
Medzinárodný akčný plán pre problematiku starnutia. [online]. [cit. 2010-01-03]. Available on internet:
<http://www.rokovania.sk/appl/material.nsf/0/A0EA1888197CA2B8C1256EF40029AB50/$FILE/material.rtf>
PALÁT, M. Rehabilitácia v komunite ako model dlhodobej starostlivosti v geriatrii. In: HEGYI, L. *Tretie Stredoeurópske sympózium o sociálnej gerontológii : Starostlivosť o starých ľudí v transformujúcich sa krajinách*. Bratislava : Informačné a dokumentačné stredisko o Rade Európy, Academia Istropolitana, 1994. ISBN 80-967477-4-6. 33-35p.
PAVELOVÁ, Ľ. 2008. Generácia 50+ v centre pozornosti komunitného plánovania. In. Kontakt. ISSN 1212-4117, Roč. 10, č.1 (2008), p.75-80.
PAVLÍKOVÁ, S. *Modely ošetrovatelství v kostce*. 1. vyd. Praha : Grada Publishing, a.s., 2006. 152 p. ISBN 80-247-1211-3.
POLEDNÍKOVÁ, Ľ. et al. *Geriatrické a gerontologické ošetrovateľstvo*. Martin : Osveta, 2006. 216 p. ISBN 80-8063-208-1.
RIVLIN, A. M. *Caring for the Disabled Elderly : Who will pay*. Washington, D. C. : The Brookings Institution, 1988. 318 p. ISBN 0-8157-7497-4.
THE AMBULANCE ASSOCIATION, BRITISH RED CROSS SOCIETY. *Caring for the Sick*. 2. vyd. London : Dorling Kindersley Publishers Ltd, 1988. 176 p. ISBN 13: 9780863183201.
TRACHTOVÁ, E. *Potřeby nemocného v ošetrovatelském procesu*. 2. vyd. Brno : Národní centrum ošetrovatelství a nelékařských zdravotnických oborů v Brně, 2005. 186 p. ISBN 80-7013-324-4.
WHITE, B. – TRUAX, D. *The Nurse Practitioner in Long – Term Care : Quidelines for Clinical Practice*. Canada : Jones and Bartlett Publishers, 2007. 536 p. ISBN 13:978-0-7637-3429-9.
Act No. 576/2004 on Healthcare
Act No. 577/2004 on the Scope of Healthcare Reimbursement
Act No. 580/2004 on Health Insurance and Amendment and Supplement to Acts

Act No. 581/2004 on Health Insurance Companies, Health Care Supervision and on Amendment and Supplement to Certain Acts
Act No. 448/2008 on Social Services
zdravie.[on-line]. Available on: http://sk.wikipedia.org/wiki/Zdravie [cit. 13.06.2011]
Zdravotná starostlivosť : Dokumenty. [online]. 2004, [cit. 2010-01-03]. Available on internet: <http://www.health.gov.sk/redsys/rsi.nsf/vdb_print/619bb40a9af97fb7c1256elc0039aace_OpenDocument&print=1&Click=>
ŽIAKOVÁ, K. et al. *Ošetrovateľské konceptuálne modely*. 1. vyd. Martin : Vydavateľstvo Osveta, 2007. 189 p. ISBN 978-80-8063-247-2.

Contact address:

PhDr. Martina Hrozenská, PhD.
Department of Social Work and Social Sciences
Constantine the Philosopher University in Nitra
Kraskova 1, 94974 Nitra, Slovak Republic
e-mail:mhrozenska@ukf.sk

PhDr. Lada Cetlová, PhD.
Department of Health Service Studies
College of Polytechnics Jihlava
Tolstého 16, 56701 Jihlava, Czech Republic
e-mail: l.cetlova@gmail.com

PaedDr. Ing. Miroslav Paľun, PhD.
St. Elizabeth University College of Health
and Social Sciences Bratislava, Slovak Republic
e-mail: mpalun@gmail.com

PREVENTION AND REDUCTION OF OCCURRENCE OF FALLS

[1] Lada Cetlová, [2]Miroslav Pal'un

[1] College of Polytechnics Jihlava, Department of Health Studies, Czech Republic
[2]St. Elizabeth University College of Health and Social Sciences Bratislava, Slovak Republic

ABSTRACT

Fall is an extraordinary/ unwanted event (very often a risky one) that results in the patient's rest unintentionally on the ground or on lower-lying surface. Falls should be given continuous attention. They often complicate or prolong treatment and cause injuries, especially in the case of seniors. In our article we analyse inner and outer factors which cause falls.

Key words: Prevention. Patient. Risk factors.

Patient falls in healthcare facilities

In 2002 in USA injuries caused by falls led to 587 888 hospitalizations or transfers to special care units. 30 – 40% of incidents in healthcare facilities are falls which threaten the safety of patients. In 30% of cases falls inflict injuries and 1 – 5% of those cases are considered as serious. 70% of falls occur without witnesses and they are revealed after the patient is found by the healthcare personnel on the ground. Fall prolong the hospitalisation approximately by 7.5 day (Barach, Small, 2000). 30% of seniors 65 years or older fall at least once a year. 25% of all injuries are trauma injuries of seniors 65 years and older. 33% of costs are used for the treatment of traumas.

Table No.1 **Places where occur falls which inflict injury or death** (Whitfield, 2008)

frequency in %	**Place**
70 %	**patient rooms**
11 %	**sanitary facilities for patients**
9 %	**corridors, examining and treatment rooms, nurses'**

Ageing generally causes involution, regression and reduction of structures and functions, loss of functional reserves of body organs, reduction of compensating mechanisms. Adaptability to the changes of inner and outer environment is generally reduced. Seniors have reduced resistance and increased sensitivity to illnesses. Falls of elderly people caused by the external causes are 25-30% of all falls, mostly in home environment.
Higher occurrence of senior falls is caused also by the inappropriate activities – work in heights (house cleaning, picking fruits), prolonged staying in the public transport (falls after sudden bracing), walking on ice, inappropriate activities in the state of confusion or heavy forms of depression (ČAS, 2008, p. 17).

Specific geriatric syndromes

Among somatic disorders belong walking disorders, mobility disorders – immobility, vertigo, instability, falls and injuries, incontinence, thermoregulation disorders, nutrition disorders, bed sores.

Psychical disorders involve – dementia, depression, delirium, behaviour disorders or maladaption.
Social disorders are loss of self care ability, addiction, isolation, torturing, misuse, family dysfunction.

Factors influencing occurrence of falls

Bad technical state of our healthcare facilities – insufficient equipment (bed, room). Low number of nursing staff. Insufficient education of healthcare professionals (insufficient prevention). Missing complex care for seniors. Non-functional community care and home care.

Aetiology of falls

Every fall of senior means a serious prognosis. Patients with falls have 4 – 6 times higher mortality (It increase with age, after 65 years it multiply ten times every decade). In case of elderly patients we can describe the fall as cause of sudden malfunction of static postural mechanisms when neither volitional nor reflex reaction can not re-establish the stability.
1. Collapsing falls – they are usually connected with the sudden worsening of a chronical illness. The causes may be cerebral – epilepsy, cataplexy, TIA, sudden increase of the intracranial pressure or extra cerebral – orthostatic hypotension, cardiac syncope.
2. Fainting falls – Caused by the serious balance disorders. Can be caused by ischemia and mezencefall hemorral, thalamus, lesion of the frontal lobe and white matter.
3. Trip-type falls – patient fall forward with extended upper limbs. Fall when patient encounters unnoticed raised object in his walking path. This can be caused by the peroneal paresis or by the reduced elasticity of leg, walking disorder with shuffle – Parkinson's disease or frontal apraxia.
4. Freezing-type falls – similarly as in the case of tripping the patient falls forward. The fall is caused by the "freezing" of leg during walking when the body continues in frontal movement without the making of step.
5. Unsorted falls – In some cases the fall can not be phenomenologically sorted. They can be caused by the carelessness, inadequate style of walking or by obstacles in the walking path. Such reactability errors are typical for the persons with dementia or with the lesions of frontal or parietal lobe. Sometimes it is connected with the age related disorders of sensory functions or with the condition of locomotion apparatus (CAS, 2008, p. 15)

Division of falls

Symptomatic falls are related to diseases. Mechanical falls are caused by the outer environment, especially by the technical disposition of patient room, environment in the healthcare facility or at home.

Inner risk factors connected with the physical ability of patient are – age when more falls occur to elderly patients; women fall more often because they suffer from osteoporosis; walking and stability disorders; polypragmasy (psychopharmacs); worsening of activities of daily living, dementia; depression; anxiety; reduced muscle strength; muscle weakness, fall in amnesia; worsened sight; hearing disorders; cognitive functions disorders; some medicaments (for example sedatives) increase risk of fall (ČAS, 2008, p. 17). Another factor is shortage of vitamin D. With the age is reduced the ability of skin to produce vitamin D. After 65 years it is reduced by three quarters. Usual problems connected with the lack of vitamin D are muscle

weakness, walking disorders or balance disorders. Insufficiency of vitamin D is a serious problem for patients in institutional care, for example long-term wards or long-term clinics that have the limited access to direct sun because 90% of vitamin D absorbs human body from sun light (Medical Tribune, 2011). Risk of fall increases the combination of inner factors.

Prevention of inner risk factors

Avoiding of application of sedatives and medicaments influencing central nerve system. Assisted exercise and walking (under supervision). Feet diseases – calluses, corns, blisters, deformations, calluses and corns removals, pedicure and proper footwear (insoles). Balance training (staying, walking), training of joint mobility, suitable locomotion aids, proper footwear, evaluation of risk factors on ward. Setting of right dosage of medicaments, rehydration, suitable changes of situational factors (nutrition, changes of position), optimization of drinking regime, exercises of lower limbs, compressive socks, sitting on bed. Try to reduce total amount of medicaments, evaluation of risks and benefits of every medicament, selection of medicaments with minimal central effect (least connected with postural hypotension and with shorter effect), prescription of medicaments with minimum of undesired effects (ČAS, 2008). Daily dosage of vitamin D higher than 400 IU reduce the risk of fractures of patients older than 65 years by 20%. Recovery of the concentration of vitamin D (in the case of normal income of vitamin D is serology concentration 80 nmol/l -30mg/ml) led to the reduction of falls of seniors by more than 20%; with daily dosage 800 UI even by 65%. The easiest way to provide human body with vitamin D is to expose to midday sunshine for 5 to 20 minutes twice a day. Vitamin D can be also provided by food supplements or by medicaments, especially in the case of elderly patients. Vitamin D is used in small doses, he is slowly absorbed by body fat so the long term usage is necessary (Medical Tribune, 2011).

Outer/ external risk factors are – malfunctioning communication between nurse and patient cause 17% of falls. Here belong also insufficient help of nursing personnel and using of compensating locomotion aids and also footwear – walking frames, canes, walking sticks, prosthetics causing 9% of falls. Technical conditions include unsafe environment which means 15.4%. Here belong also slippery surfaces, insufficient illumination, uneven surface of floor and unmarked elevated parts of corridors, inappropriate location of items of daily use, insecure stairways, inappropriate designed bathrooms (Whitfield, 2008).

Prevention of outer / external risk factors

Providing of the proper illumination, removal of sources of shade and dazzle, easily accessible light switches by room doors, night light in bedroom, in corridors and in bathroom. Anti slippery finishing on floors, anti slippery mats and carpets, sides of carpets nailed to floor, carpets with short hair, non slippery wax on floors, removal of cables from walking paths, removal of little items from floor (clothing, shoes) – spilled or dropped debris must be without delay cleaned. Sufficiently illuminated staircases, light switches on top and bottom of staircases, securely fastened rails on both sides protruding from wall, first and last stair marked with reflexive sticker, staircases should not be too steep, should be in good condition, no items should be placed on staircase. Items in kitchen should be stored in easily reachable places (no bending or extending), secure and solid chair, solid and unmovable table. In bathroom installed holders and rails by tub, shower and toilet, anti slippery stickers or rubber mats in shower and tub, seat in shower and hand held shower, extension on toilet, removal of door lock from door for the quick access in case of fall. Bed should be suitably set (not too high, not too low), use of proper aids and wheelchairs, ergonomically positioned night table

(in reach). Footwear with solid, non slippery and non tripping sole, low heels, avoiding of walking only in socks or in loose slippers (CAS, 2007).

How to avoid falls

Multi approach to the prevention of falls and injuries include many different professions, but nurses are playing the most important role. The role of physician in prevention of falls is in the evaluation of the risks of fall, changes in medications, prescribing of exercises, supplement of vitamin D. Physiotherapists are consulted when exercises are prescribed. Importance of holistic approach when fall prevention precautions are created and enforced with the focus to inner and outer risk factor.

Example – Prevention of falls in hospital facility

In the prevention of falls nursing staff should follow mainly those precautions:

- Identification of risk patient immediately after his hospitalisation – Colney method screening and marking with waistband with coloured marking "Patient with risk of fall".

Picture No. 1 **Identification of risk of fall on wristband** (Cetlova, 2011)

- Patient room walls painted in colour. Edges of walls (doors, windows) marked with contrast paint. Enough daylight in the room. Local illumination of bed area and nightlights in room. Floor with anti slippery surface. Parts of floor wet from mopping properly marked. Loose items on floor (bags, stools, bedpans).
- Safety precautions and increased supervision.
- Barrier free environment – removing of obstacles that must be overstep (furniture, cabling, unsuitable staircases), rounded corners and edges, chairs and armchairs with stable base, over bed tables, proper illumination (local lighting, night light).
- Adjustable height of bed, side constrains on the bed (divided, compact), automatic bed brake, holders, bed frame with restrictor holders, suitable place for personal belongings, call bell within reach of patient, bed without sharp edges, ergomically positioned night table.
- Anti-slip rugs in bedroom, supporting aids – holders, rails, walking frames, canes.
- Careful rising (especially after night rest).
- Care for the mobility apparatus: rehabilitation care and rehabilitation nursing.
- Enough time for the proper adaptation to the changed environment (ward walk through, mess halls, examining rooms and other areas).
- Educate patient about the risks of fall – for example about the combination of drugs (analgesics, anaesthetics, diuretics, antiepileptics, antihypertensics, antiparkinsonics, opiates psychotropic drugs and benzodiazephins) or risks connected with sense disorders and cognitive deficits.
- Revision of precautions in case of fall.

REFERENCES

BARACH P, SMALL, S.D. 2000: *Reporting and preventing medical mishaps: lessons learned from non-medical near miss reporting systems. BMJ.* 320 (7237): 759-763, 2000.
ČESKÁ ASOCIACE SESTER, 2008: *Prevence pádu a zranění pacienta/klienta a jeho řešení*. Praha: Galén, 44 s. ISBN 978-80-7262-585-7.
MEDICAL TRIBUNE, 2011: *Co všechno může způsobit deficit vitamin D. Nakladatelství* MEDICAL TRIBUNE, Praha, ISSN 1214-8911, 2011, roč. VII, č. 14, 2011, str. B4.
WHITFIELD, M., 2008: *Managing Quality in Health Care - Managers Perspective. Řízení kvality ve zdravotnictví - Manažeři výhled*. Krakow, Jagellonské University Press, 2000. ISBN 83-233-1419-5

Contacts address:

PhDr. Lada Cetlova, PhD.
College of Polytechnics Jihlava
Department of Health Service Studies
Tolsteho 16, Jihlava
Czech Republic
e-mail: l.cetlova@gmail.com
+420 739 05 48 73

PaedDr. Ing. Miroslav Paľun, PhD.
St. Elizabeth University College of Health
and Social Sciences Bratislava, Slovak Republic
e-mail: mpalun@gmail.com

NUTRITION DISORDERS OF PATIENTS HOSPITALISED IN HEALTHCARE FACILITIES

[1]Lada Cetlova, [2]Vlasta Dvorakova, [3]Miroslav Pal'un

[1]College of Polytechnics Jihlava, Department of Health Service Studies, Czech Republic
[2]College of Polytechnics Jihlava, Department of Health Service Studies, Czech Republic
[3]St. Elizabeth University College of Health and Social Sciences Bratislava, Slovak Republic

ABSTRACT

Therapeutic nutrition widely affects the structure of treatment process and helps to reduce the spending in the medication therapy. Risks related with the inappropriate diet can be compared with the unqualified health care (wrong diet, insufficient nutrition value). Proper nutrition should be considered as the essential part of treatment process. There exist many economical and medicinal reasons how the proper can help to the patients (especially in serious cases). The underestimation of proper nutrition can be even fatal (seniors, long-term patients, patients with mental disorders). Malnutrition can be caused by the lack of nutrients which are essential for the support of basic body functions. In a broader sense, this are all nutrition disorders including hypovitaminosis and lack of trace elements, in the narrower sense it is the lack of energy or high quality proteins. Providing of the sufficient nutrition state is important for the patient and for the physician. Although malnutrition in many cases do not threat the life of patient it can increase the risk of mortality, complications and re-operations, worsen the healing of wounds, increase the predisposition to infections, prolong the hospitalization period and increase treatment costs.

Key words: Malnutrition. Nursing care. Patient. Nutrition

Introduction

Risks related with the inappropriate nutrition can be compared with the unqualified health care (wrong diet, insufficient nutrition value). Proper nutrition support can help to patients, especially to the risk ones for which the underestimation of proper nutrition can be fatal (seniors, long-term patients, patients with mental disorders) (Starnovska, 2009).

Malnutrition

Malnutrition is understood as the deviation from the normal state of nutrition which is caused by the imbalance between the income of nutrients and the real need of organism (Kohout, 2004).
Provision of the satisfactory nutrition state is important for the patient and for the physician. Although malnutrition in many cases do not threat the life of patient it can increase the risk of mortality, complications, re-operations, worsen the healing of wounds, increase the predisposition to infections, prolong the hospitalization period and increase treatment costs.

Consequences of malnutrition

- Deterioration of the overall condition – fatigue, deterioration of self-care, quality of life, depressions
- Reduction of the muscle mass – immobility on bed, deteriorated coughing, risk of decubitus ulcers
- Infection complications – pneumonia, infections of urinary tract, decubitus ulcer infections, abscess, sepsis
- Post-operative complications – deterioration of wounds healing
- Deteriorated transmission and availability of medicaments – reduced effectiveness, increased risk of complications
- Increased morbidity, increased mortality (Kohout, Kotrlikova, 2005)

Causes of malnutrition

There are many causes of malnutrition:

- Digestive tract disorders – adhesion caused by the previous operation
- Resorption disorders – heart weakness - coronary artery disease
- Metabolism disorders - diabetes mellitus
- Inadequate food intake – self-care disorders, reduced taste recognition, reduced saliva production, dental problems (carries, periodontitis, missing dentices, dentures, casus socialis (junk food, alcoholism), poverty, depression, senile dementia (Topinkova, 2005)

Division of malnutrition

Energetic malnutrition

- Chronic state of adaptation to hunger
- Isolated protein malnutrition
- Insufficient amount of proteins in food
- Stress – inability to use the energy reserves
- Protein-energetic malnutrition
- Combination of the lack of energy and proteins

Diagnostics of malnutrition

1. Anamnesis

The most important indicator is the reduction of weight in time period. Among the other indicators belong dietary habits, for example vegetarianism, gluten-free diet, diabetes diet, enforced changes of diet, abdominal pain, amount and structure changes of feces (constipation, diarrhea), anorexia and vomiting, amount of food intake (or the changes in the time period enforced by the disease and condition of patient).

2. Physical examination

a) Height and weight – if possible measure and weight the patient. Do not trust the values provided by patient. Calculate the height-weight index and compare it with the tables corresponding the age and gender. The most used index is BMI (body-mass index)

BMI = weight (kg)/ height (m)

- under 18.5 cachexia
- 20-25 normal values

- 25-30 overweight
- over 30 obesity
- over 40 monstrous obesity

b) State of nutrition - cachexia, overweight, obesity

c)Composition of body – approximate evaluation of the muscle mass

d) Warning indicators of malnutrition – swellings of lower limbs, falling hair, condition of skin, healing of wounds, hematomas, indicators of hypovitaminosis (gum bleeding, dry skin), carention of the trace elements (perioral dermatitis) (Kohout 2004).

3. Anthropometric examination

Measuring of the circumference of the non-dominant arm in its half. Arm circumference smaller than 19.5cm in men and 15.5 in women indicates the reduction of muscle mass. Subcutaneous fat is measured by the special instrument – calliper over triceps. Heavy malnutrition is indicated by the height of skinfold over triceps lower than 8mm in men and 10mm in women. Detailed examination of the subcutaneous fat can be determined by the measuring of skinfold on the 10 points on body (Kohout 2004).

4. Laboratory examination

Serologic markers of malnutrition – albumin, prealbumin, transferin, overall cholesterol
Haematological markers – absolute number of lymphocytes
Endocrinological indicators – T3, T4, TSH

5. Further examination

Functional examination – it is the examination of muscle mass with the special instrument (dynamometer). Some dynamometers measure the strength of handgrip and some the strength of back muscles. The power of respiratory muscles can be measured by the speed of exhaled air (Kohout 2004).

NUTRITIONAL SCREENING

It is important to conduct the malnutrition screening to all newly hospitalized patients. Nutritional screening does nurse as the part of nursing history.

Risk of malnutrition

1. No intervention needed (**0 - 3** points).
2. Risk of malnutrition, the nutrition therapist examination is necessary (**4 – 7** points). From this moment the nutrition therapist is in the direct and permanent contact with patient.
3. Malnutrition confirmed, nutrition treatment is necessary (**8 - 12** points). Nurse inform physician and nutrition therapist. In the case of malnutrition risk the extended questionnaire "Examination of malnutrition patient by nutrition therapist" is filled. Patient can reach 8 pints of nutritional screening even when there is no risk of malnutrition, for example: not able to consider or stressed but eating normally.

Evaluation of nutrition state

It is suitable when the nutrition therapist visits risk patients on all wards every day including weekends and adjust diets and nutrition procedures. All those changes are consulted with the

attending physician. In case of long term hospitalizations the nutrition screening is repeated every 7 days. At some departments (internal medicine, long-term care) the monitoring of the amount and quality of eaten food per day is conducted (for example half of portion eaten, meat left). It is necessary to know and check the caloric values of respective diets.
Nutrition therapist also educates patient and his family.

MONITORING OF THE NUTRITION STATE

In moths October to November 2010 we monitored the state of nutrition on neurological ward. We searched for patients with malnutrition or with the risk of malnutrition. We filled the nutrition screening immediately after the hospitalization.

Table No.1 *Nutritional screening* (Starnovska, 2009)

Evaluation of the nutrition state		Points
1. Patient **can not be measured or weighted** – do not fill 4,5,6		2
2. **No information can be obtained** from patient – do not fill 4,5,6		3
3. **Age**	under 65 years	0
	over 65 years	1
	over 70 years	2
4. **BMI**	20 – 27	0
	over 27	1
	under 20	2
5. **Loss of weight** not intentional	None	0
	more than 3kg/3months(loose clothes)	1
	more than 6kg/3months	2
6. **Amount of food** last month	no changes	0
	half portion	1
	sometimes do not eat	2
7. **Indicators of disease**	None	0
	abdomen pains, anorexia	1
	vomiting, diarrhoea more than 6/day	2
8. **Stress factor**	None	0
	moderate	1
	High	2
Total points (INDEX)		

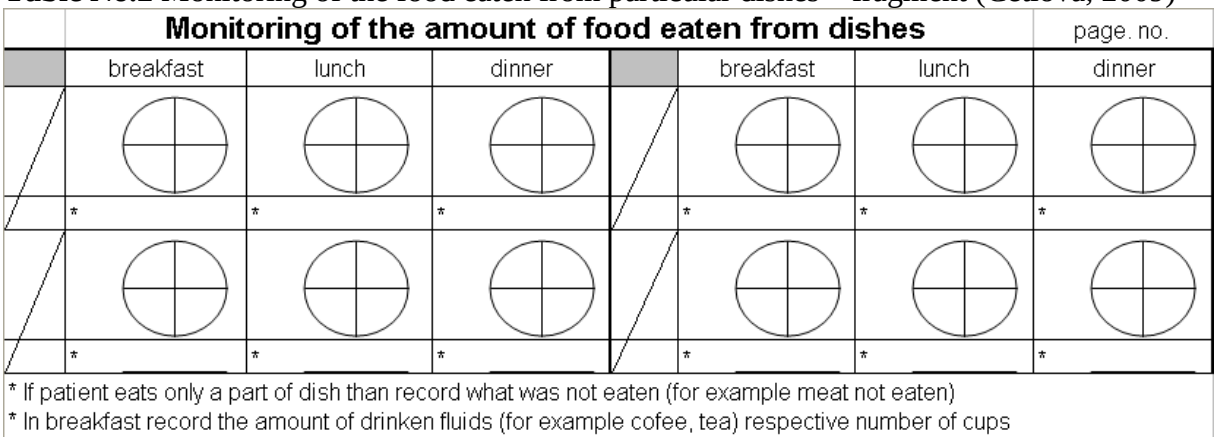
INDEX	**Precaution**	**Nutrition therapist**
0 to 3		**no intervention needed**
4 to 7	**report to nutrition therapist**	**examination is necessary, special diet**
8 to 12	**report to nutrition therapist**	**Malnutrition threatening life or treatment, special nutrition care needed!!!**

Note:
Moderate stress factor: chronic disease, smaller planed surgery, examination.

High stress factor: acute decompensated disease, major or unplanned surgery, after surgery complications, artificial lung breathing, burns, trauma, internal bleeding, hospitalisation on intensive care or anaesthesiology and resuscitation department.

After 7 days the new re-screening was conducted. Records were made into the workbook. In every case were recorded date, patient's name and surname, year of birth, index in the interval 4 -12 and measured mid arm circumference. Subsequently was consulted nutritive therapist. The amount of food eaten from particular dishes was recorded in the following form.

Table No.2 Monitoring of the food eaten from particular dishes – fragment (Cetlova, 2009)



Mid arm circumference can be used to estimate the changes of weight in time periods – it is suitable for immobile patients hospitalized in long-term care units. If the mid arm circumference is smaller than 23.5cm than BMI is probably under 20kg/m and the patient is underweight. If the mid arm circumference is greater than 32cm than BMI is probably over 30kg/m and patient is obese. If the mid arm circumference change by 10% than the BMI probably change by 10% too. Mid arm circumference is usually measured on the left (no-dominant) hand without clothes half way between acromium and olecranum. Measure tape is not pressed forcefully; the desired accuracy is 0.5cm. Mid arm circumference indicate the body muscle mass (Kohout, 2004). In the following table are values which indicate adequate, marginal and heavy depletion (reduction, insufficiency) of muscles.

Table No.3 Muscle mass according to the mid arm circumference (Kohout, 2004)

% of referring value	**mid arm circumference in cm**		**muscle mass**
	men	**women**	
100	**25,5**	**23**	
90	**23**	**21**	**adequate**
80	**20**	**18,5**	
70	**18**	**16**	**marginal**
60	**15**	**14**	**heavy**
50	**12,5**	**11,5**	**depletion**
40	**10**	**9**	

Table No. 4 BMI

	first screening	**re-screening**
total hospitalised patients	**217**	
BMI can not be determined - patient can not be weighted	**18**	**6**
score 0 – 3 points	**0**	**0**
score 4 – 7 points	**8**	**3**
score 8 points and more	**10**	**3**
nutrition therapist was called	**18**	**0**

Reasons why the nutrition therapist was not contacted
Re-screening was performed in **six** cases. In one case the nutrition therapist has not been called due to patient's transfer to another healthcare facility. In five cases was conducted re-screening but the nutrition therapist has not been called because patients died in evaluation period.

Table No.5 Screening – mid arm circumference

first screening	**men**	**women**	**muscle mass**
mid arm circumference in cm	**1x26**	**1x24**	**adequate**
	2 x 28	**1x26**	
	2 x 29	**2 x 27**	
	2 x 30	**1x28**	
	1x31	**2 x 31**	
	1x33	**1x35**	
	1x37		

Table No.6 Re-screening – mid arm circumference

re-screening	**men**	**women**	**muscle mass**
mid arm circumference in cm	**1x28**	**1 x 26**	**adequate**
	1x29	**1x30**	
	1x31		
	1x34		

In the time period October to December 217 patients were monitored. In 8.29% of cases was not possible to determine BMI.

DISCUSSION

Elderly people often say that they do not need to eat regularly, that coffee and bread are enough. Despite this the inefficient malnutrition can worsen their medical condition. We monitored the state of nutrition of patients hospitalised on the neurological ward. With the help of nutritional screening we sorted the patients to group which do not need the care of

nutrition therapist and to group which need consultation with him and subsequently need the measuring of muscle mass with method of mid arm circumference.
Out of the total number of 217 patients, 199 patients did not need the help of nutrition therapist and their nutrition score was really in interval 0 – 3 it means nutrition therapist or special intervention are not needed. In 18 cases was not possible to determine BMI due to their serious medical condition, but the nutritional screening was made. In 8 cases was index in interval 4 – 7 points and in 10 cases was index even 8 and more. This group of 18 patients needed the intervention of nutrition therapist.
Muscle mass measured with method of mid arm circumference was in monitored group within adequate values (see table No.5). During all evaluation period was by the nursing staff recorded the amount of nutrients into the form "Monitoring of food eaten from given dish". Those records were used by nutrition therapist to adjust respective diets and nutrition supplements and cooperation with nutrition physicist.
On neurological ward is provided acute care with the average hospitalisation time 6.5 days. From this reason was possible to conduct the re-screening only in six cases. In all cases was not possible to determine BMI, in three cases was index in interval 4 – 7 points and in three cases 8 and more points. Muscle mass measured with method of mid arm circumference was in monitored group within adequate values (see table No.6).
Nutrition therapist was not re-called from the following reasons:

- one patient was transferred to another healthcare facility
- five patients died

RECOMMENDATIONS FOR PRACTICE

From the point of view of healthcare professional we formulated recommendations which could reduce the risks of nutrition disorders and malnutrition of patients hospitalized in healthcare facilities.
Nutritional screening – nurses should conduct the nutritional screening to all new patients as the part of nursing history. Healthcare facilities can decide if they use the basic nutritional screening or the detailed nutritional screening. Screening should reveal patients with the risk of nutrition disorders or with malnutrition. In long-term hospitalization should be natural to repeat the screening because during the hospitalization can occur significant changes in area of nutrition. Intervals between screenings can be individual.
Cooperation with nutrition therapist – all staff must necessarily follow the recommendations of nutrition therapist.
Leaflet for seniors – for patients with the increased risk of nutrition disorder or malnutrition should nursing staff in cooperation with nutrition therapist create a leaflet that consist the basic instructions concerning the proper nutrition.
Periodical monitoring – for the monitoring of food eaten by patient should nursing staff use the special documentation into which is recorded the amount of food which was eaten and also the food which was not. This can be conducted three times a day (breakfast, lunch, dinner).
Cooperation with family – family members can help us with the proper nutrition of patients. After every visit of family members is in the senior rooms left miscellaneous food. In the majority of cases this foot is inappropriate. If nurse or physician find some time for dialogue with the family members than they can find cooperators in the patient's nutrition. We should inform the family which food and drinks are for patient suitable and which should be used for the positive motivation of patient to the proper nutrition.

Education of healthcare professionals – problematic of nutrition is nowadays a widespread topic. Nurses can be educated by seminars, training courses, professional literature, and university education. Id depends only on their will to educate themselves.
Hollistic attitude – respecting and satisfying of individual needs of patients. Nutrition need belong to the basic needs and it is essential to respect it. From medical professionals are requested empathy, tolerance and acceptance.

Conclusion

In our research we were dealing with the problematic of the nutrition of patients hospitalized in neurological ward and with the problematic of malnutrition. In the next part we describe the influence of hospitalization to malnutrition disorders and possibilities of nutrition support. By the evaluation of nutritional screening and by the subsequent measurement of the mid arm circumference we managed to identify the patients with malnutrition or with the increased risk of malnutrition. However despite the detailed measurement of the monitored group we **did not manage** to proof that there occurs the reduction of muscle mass. We found that it is necessary to join another department – laboratory – for the evaluation of nutritional screening (S global proteins, S – albumin, S – prealbumin etc.).

REFERENCES

KOHOUT, P. 2004. *Dokumentace a hodnocení nutričního stavu pacientů*. 1. vyd. Praha: Maxdorf, 2004, 39 s. ISBN 80-7345-030-5.
KOHOUT, P., KOTRLÍKOVÁ, E. 2005. *Základy klinické výživy*. Praha, Krigl, 2005, 114 s. ISBN 80-86912-08-6.
STARNOVSKÁ, T. 2009. *Výživa pacientů/ klientů*. 1. vyd. Praha: Galén, 2009, 21 s. ISBN 978-80-7262-596-3.
TOPINKOVÁ, E. 2005. *Geriatrie pro praxi*. 1. vyd. Praha: Galén, 2005, 270 s. ISBN 80-7262-365-6.

Contact address:

PhDr. Lada Cetlova, PhD.
College of Polytechnics Jihlava
Department of Health Service Studies
Tolsteho 16, Jihlava
Czech Republic
e-mail: l.cetlova@gmail.com
+420 739 05 48 73

Mgr. Vlasta Dvorakova
Department of Health Studies
College of Polytechnics Jihlava
Tolsteho 16, Jihlava
email: vlastadvorakova@seznam.cz

PaedDr. Ing. Miroslav Paľun, PhD.
St. Elizabeth University College of Health
and Social Sciences Bratislava, Slovak Republic
e-mail: mpalun@gmail.com

EDUCATIONAL PROGRAM FOR ROMA ASSISTANTS

Darina Wiczmándyová

St. Elisabeth´s University College of Health and Social
Separated workplace Blahoslaveného Metóda Dominika Trčku in Michalovce

ABSTRACT

Social categories, which for various reasons cannot be applied to the labor market or are totally excluded from it, and which get into position of socially vulnerable and marginalized groups of people, require a specific approach to finding effective solutions even in developed, European countries such as Slovakia. Citizens, who due to low levels of education and skills, do only occasional assistance work, or citizens who are unemployed, people with physical or mental disability, youth after completion of institutional or protective care, the elderly and single parents with children who find themselves in social need or loss of family environment are included among groups at risk of social exclusion. Such social categories without the help of society are more likely to get to marginalized groups.

Key words: Marginalized groups. Roma community. Roma assistants.

Marginalized groups

Marginalized groups are characterized by complete social exclusion because of the factors such as loss of residence, long-term unemployment, drug dependency, lack of social adaptability, membership of a particular ethnic group in regions with high unemployment, etc. In terms of all social indicators, the most numerous and specific marginalized groups in Slovakia are members of socially excluded Roma communities.

Demographic data

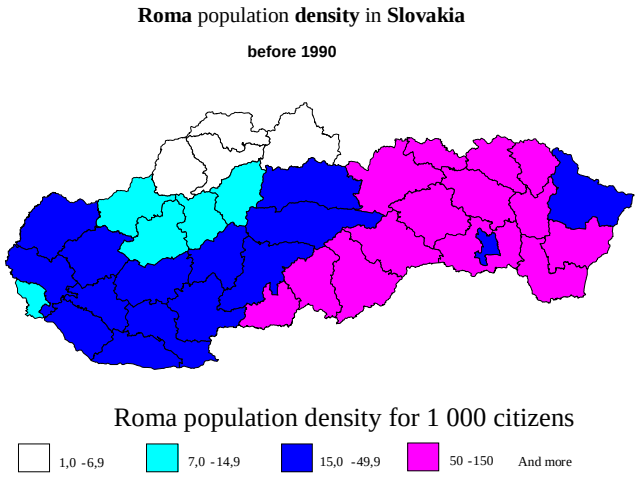
According to the census of population and housing census at 26 May 2001 the Slovak Republic had 5,379,455 permanent resident population, of which 89 920 people have signed up for the Roma. Due to the methodology of census, data on the number of Roma population don't represent the true situation; therefore, the real number of their population is based on the results of sociographic mapping of Roma settlements. Based on the results of sociographic mapping of Roma settlements, it is possible to estimate, that the number of Roma in Slovakia is close to the lower end of the demographic estimates, approximately 320 000. Out of the 320,000 Roma living in Slovakia, approximately a half of them live among the majority population and the remaining half live in Roma communities in the following types of settlements:

- urban and municipal merger
- settlements located on the outskirts of town or village
- settlements, which are geographically distant or separated from a city or town by natural or non-natural barrier. 1

The Roma community is defined as a group of people, which majority subjectively defines as Roma on the basis of anthropological characters, cultural affiliation, way of living - lifestyle, living space and also subjectively perceives this as a distinct group in the

positive but also in negative sense. The distribution of Roma communities in Slovakia is uneven; their highest concentration is observed in eastern Slovakia and southern districts of Slovakia, where about 2 / 3 of the Roma live. Roma are in fact very diverse group of people that can not be viewed as whole. Various segments of the Roma population face different problems, which are related to state region, type of segregation, levels of concentration, frequency and ratio of the Roma population in relation to health care, social welfare and educational level.

Roma population density in Slovakia



Major diseases of population in romasettlements

Most common diseases among Roma people in settlements are those, which are caused by low level of hygiene, lack of knowledge about transmission of infectious diseases such as infectious etiology of the disease, tuberculosis, bacillary dysentery and viral hepatitis.
Bad medical condition of people in marginalized communities is increasingly involved in the increased cost of the treatment, sick leave, hospitalization and disability.
Factors that affect the lower quality of health of Roma marginalized groups are:

- low level of health awareness
- low standard of personal hygiene, drinking water
- sewage, garbage disposal, toilet facilities;
- polluted, devastated environment
- unhealthy eating habits;
- increased use of alcohol, tobacco, drugs
- risk of infection, hepatitis B and C, HIV. 2

Angi mlyn – Michalovce

It is a suburban Roma community near the river Laborec, with an estimated population of 1500 -2000; it is located about 1-2 km from the bus stop in the village. Community members live in apartment buildings and shacks, they have water from public water supply, sewerage, electricity, garbage disposal ensures, but for some reasons they don't use toilets in the apartments. There is a basic school in their settlement, but no nursery school.

Ifsocially excluded Roma communities wanttobeintegrated into society and achieve an adequate standard of living including housing, they must be able to work and ensure a sufficient income. However, the possibility of employment depends on educational attainment and qualifications obtained, but also the overall rate of employment in a region and its level of development.

It is necessary to provide primarily education for members of socially excluded Roma communities. We can achieve preparing citizens from socially excluded Roma communities by creating conditions for social and societal development of the Roma population. Improving the social status of socially excluded Roma communities is a question of a comprehensive approach by the State in cooperation with involved ministries, especially education, culture, health, employment offices, social affairs and family, interested local authorities and non-government organizations. It is necessary to perform educational work and social assistance continuously, in long-term cooperation with local associations, churches, schools and community health, social workers, whoare trained for these activities.

For this purpose, it is recommended in locations where a larger number of people lives in socially excluded Roma communities tobuild community centers, which
would provide conditions for education, gaining knowledge of proper housekeeping and child care, obtaining needed health and work habits and necessary skills.

Educational program for Roma assistants

Organization of study

- Organized as a semestral daily study
- number of lessons 400
- completed by the final test
-

Characteristics of the study

- designed for those, who want to enter labor market
- completed high school
- know the internal structure of the Roma community
- have an influence on their clients about hygiene, eating and cultural habits

Graduate Profile

- Developing and maintaining client self sufficiency, developing his social and work habits;
- The influence on individual interests for improving physical condition of clients
- Knowledge of basic preventive and anti-epidemiological methods
- Knowledge and skills in caring for patients with the possibility of transmission of infectious diseases;
- skills in performing social activities, assistance with therapy clients;

- maintaining contacts with clients, institutions
- knowledge of primary care activities and procedures
- participation in institutional car
- acting in accordance with the principles of ethics and morality;
- applying knowledge of psychology, sociology and law; 3

Range of activities of Roma assistant in marginalized groups

Focus of the Roma assistants is inclusive and follows the current needs of the community such as health education, assistance to the child-adolescent doctor, tracking lifestyle and health condition of communities, in cooperation with schools, with partners (such as mayors, deputies, field social workers) and the organization of sports activities.3

Conclusion

Holistic philosophy of understanding human-being as the biological, psychological, social and spiritual being, requires close cooperation among health, social workers, public health, affordable health care, public administration, state administration with the various religious communities. Considering the need of health protection, it is necessary to focus on building the basic infrastructure (water, electricity, communication network, waste disposal ...) in the Roma settlements and improving the health conditions of families living in substandard living conditions. It is necessary to plan the reconstruction of shelters, which can be legalized.
Need for replacement or removal of defective housing and humanizing Roma settlements must be a mandatory part of municipal development plans, programs, economic and social development of municipalities and autonomous regions and housing development programs. By training of community workers in health, social, spiritual field also provide continuous advice to vulnerable individuals, families or entire communities.

REFERENCES

WICZMÁNDYOVÁ, D. 2008. *Význam edukácie pacientov/klientov v procese poskytovania ošetrovateľskej starostlivosti.* Bratislava: VŠZaSP sv. Alžbety, 2008. (habilitačná práca).
WICZMÁNDYOVÁ, D. 2003. *Komunitné ošetrovateľstvo zamerané na rómsku populáciu s výskytom tuberkulózy.* Trnava: Trnavská univerzita, FZaSP, 2003. (dizertačná práca).
Dlhodobá koncepcia bývania pre marginalizované skupiny obytateľstva a model jej financovania. [online]. Uznesenie vlády SR č. 397, 2004. [cit. 2010-12-23].dostupný z http://www.build.gov.sk/mvrrsr/source/comment/002317_04.doc

Contact address:

Darina Wiczmándyová, doc., PhDr. PhD.
VŠZaSP sv. Alžbety, Bratislava
DP Michalovce, Partizánska 23, 071 01
dwiczmandy@centrum.sk

SPECIFICS OF SOCIAL WORK WITH PERSONS WITH HEARING IMPAIRMENTS

[1]Petra Gajdošová, [2]Jana Gabrielová

[1]Constantine the Philosopher University in Nitra
[2]Department of Social Work and Social Sciences, Slovak Republic

Petra Gajdošová
After completing her university studies in the branch of social work, she continued on internal postgraduate study at the Department of Social Work and Social Sciences of the Constantine the Philosopher University in Nitra. In her dissertation thesis, she deals with the integration of people with hearing disabilities. Her publishing activity also focuses on this issue.

Jana Gabrielová
After completing her university studies in the branch of study social work, she operated in the area of social services for elderly people and people with disabilities. Currently, she is an internal PhD. student at the Department of Social Work and Social Sciences of the Constantine the Philosopher University in Nitra. In her dissertation thesis, she addresses the issue of human rights in the field of social work. Her publishing activity also focuses on this issue.

ABSTRACT

This article focuses on the specifics of social work with persons with hearing impairments that are primarily determined by a communication barrier. The specifics of work of a social worker are extremely important both, in terms of quality social services provided on a professional level, as well as in terms of the client´s protection by respecting equal rights. In the article, the authors address the definition of selected specifics of the social worker´s work with a given target group in connection with respect to equal rights.

Key words: Communication. People with hearing impairments. Social work.

Introduction

Persons with hearing impairments are included in the group of persons with disabilities. It is a group with its own characteristic determined by the form of the disability. It is the nature of the disability – absence of hearing – that makes it to a specific target group with its own needs and problems.
Social work with persons with hearing impairments should be based on principles of the *Standard Rules on the Equalization of Opportunities for Persons with Disabilities.* This document includes 22 rules that are divided into four chapters: I. Preconditions for Equal Participation, II. Target Areas for Equal Participation, III. Implementation Measures and IV. Monitoring Mechanism. The Rules recommend taking measures for the areas of human life, such as awareness-raising, medical care, rehabilitation, support services, accessibility, education, employment, income maintenance and social security, family life and personal integrity, culture, recreation and sports, religion, legislation, etc.
Persons with hearing impairments are especially related to rule 5 *"Accessibility"* that states that persons with disabilities or their families and supporters should have a permanent access

to detailed information on the diagnosis, rights and accessible services and programs. These information should be provided in a way comprehensible also to the persons with disabilities (*The Standard Rules, 1993).* There should be suitable technologies used for persons with hearing impairments to allow access to spoken word and accessible interpreting services in sign language should facilitate communication between deaf persons and other people.

We also consider rule 15 *"Legislation"* to be very important. According to this rule "states have a responsibility to create the legal bases for measures to achieve the objectives of full participation and equality for persons with disabilities" (*The Standard Rules*, 1993).

The concept of equal rights is the fundamental aspect of the social work with the deaf community because each person´s needs and the needs of all people are equally important and therefore, they have to became a standard of planning for the society and all resources have to be used to provide equal opportunities for the integration of all people. The right for equal access to services for all is based on fundamental human rights that are embedded in international and European documents ratified by the Slovak Republic as well as in the Constitution of the Slovak Republic and other legal standards in force in our country. The essential idea is that all people are equal and must not be discriminated for any reason (Cangar - Gallo, 2005). The social worker has to follow professional principles and has to provide help to all citizens who request it without distinction if it is in their competence to provide it. The role of the assisting staff is not to discriminate the clients, to accept and to understand everyone, to equally show interest for everyone.

Within the European Union, promotion and protection of right for equal opportunities for the deaf is advocated by The European Union of the Deaf. It was established in 1985 and its main philosophies are emancipation and creating of opportunities towards achieving equal position of the deaf in society as full citizens throughout Europe (*General Background*, 2008). Therefore, activities focusing on social help for the deaf community should be based on specific problems and specifics of this community that are primarily determined by a communication barrier. Hearing disability causes a lack of overall integrity of a certain organ or function. This causes difficulties and barriers in various areas of the individual´s life and therefore, it is extremely necessary to create opportunities to provide quality and accessible social services to citizens with hearing impairments. This type of disability has a far-reaching negative impact on the overall development of the personality because it precludes the supply of information as a result of limited communication.

According to Tarcsiova (1998) interventions in this type of social work should be directed towards complex and total communication. Measures should became a part of the opportunities and support process, which would persons with hearing impairment help to take total responsibility for themselves as full citizens, by means of full awareness, provision of a two-way flow of information and provision of accessible and free interpreting services.

Many experts in the given field (Tarcsiová, 1998; Tarcsiová, Hovorková 2002; Šmehilová, 2010; Jakabčič, Požár, 1995; Matoušek, 2005) regard communication as one of the most important social processes that form the whole personality of a person and help her/him to orientate in the outside world trough the provision of information. Important is the fact of the elimination of communication and information barriers in all aspects of human life. Therefore, in the lives of people with hearing impairments there are very important specific forms and measures that occurred for the purpose of better communication, education process or overall integration into the everyday life of the society. Limited communication has social consequences, which are understood by Matoušek (2005, p. 102) as "...inability to integrate into society, to exercise personal potential, possible (re-)socialization, provision of community support, social services and adaptation of local conditions."

Based on the notion that each person forms a unity of the bio-psycho-social system, each person and especially a person with hearing impairments needs the society for the overall

development of her/his personality. If there are any barriers in this access, the opportunities for her/his development are limited. The communication barrier of persons with hearing impairments is the most important area in the development of their personality in terms of the social field because communication is linked to the creation of good interpersonal relationships. This aspect is reflected in the identification of persons with hearing impairments with the society where "...the primary problem is not the hearing impairment but its social consequences that are linked to the possibility of acquiring the spoken language, education, occupational and social functioning" (Tarcsiová, 1998, p. 47). Tarcsiová and Hovorková (2002) include emotional and social consequences among the consequences of hearing disabilities. These are related to the social consequence of the communication barrier. Hearing impairments cause difficulties in socialization and integration of persons with hearing impairments that are particularly characterized by these problems: ability to communicate, ability of education and ability to work. Based on this, we can notice the impaired ability to live independently.

Communication is considered a very important social process, not only because it is used for transmitting and receiving information but mainly because communication creates communication relationships that allow better functioning of a person in society, thereby increasing her/his quality of life. It seems that people with hearing impairment are losing their contacts with the outside world which influences the overall healthy development of the personality in all its components. Therefore, education, care and total work for clients with hearing impairments are the subject of social work as well as special pedagogy. Through them, people with hearing impairments are mediated information needed for everyday life.

People with hearing impairments are confronted with the communication barrier and the linked information barrier in dealing with various life situations and insuring the compensation of social consequences of their disability. Social work by knowledgeable and professionally trained social workers encourage them to overcame the above-mentioned barriers. Training of a social worker concerns the acquisition of knowledge about the hearing impairment, the population of people with hearing impairments, individual needs within the subgroups of this minority. One of the significant specifics of the social worker´s work is the acquisition of the sign language (or at least its basics) as the most commonly used means of communication. The demands on the social worker´s training are with this minority group of people are much higher because besides sign language, knowledge from the field of special pedagogy, psychology, sociology, culture of deaf she/he has to have knowledge of legal disciplines.

People with hearing impairments are, within social work, provided social services, including social prevention, social counselling or social rehabilitation and they are mediated interpreting services.

According to §44 of Act No. 448/2008 Coll. on social services, interpreting services provide interpreting in sign language, articulatory interpreting or tactile interpreting to an individual who is dependent on:

a) interpreting in sign language if deaf or with severe two-sided hearing loss and the means of communication is sign language,

b) articulatory interpreting if deaf or with severe two-sided hearing loss acquired after the acquisition of speech or before it and she/he does not know the forms of communication of persons with hearing impairments, especially sign language, sign Slovak or

c) tactile interpreting if deafblind or with a congenital or acquired disability of two sensory organs that require a special communication system to communicate with society, bound on the degree of hearing loss and vision loss.

It is the social worker who should provide or mediate contact with institutions or access to information that are important for addressing the social problem of the client.

Ethics is an integral part of social work. Ethical awareness is a fundamental part of the professional practice of social workers. Their ability and commitment to act ethically is an essential aspect of the quality of the service offered to those who use social work services (Ethics in Social Work, 2004). In connection with the ethical principles of social work, it is important that the confidentiality of information stays consistently observed (Strieženec, 2001). It is the secrecy of the social worker on facts, client´s behaviour, testimonies and circumstances that he/she must not talk about. The usage of these data is not always clearly set by a specific regulation; therefore, it is appropriate to respect the principle that it is possible to provide information about the client to other (organizations, institutions, people) only with the client´s consent (Žilová, 2000). Since the social worker has access to personal information and medical records of the person with a hearing impairment, it is necessary not only to maintain confidentiality of the established facts but also to ensure the saving of the documents.

The social worker should be sympathetic, neutral and she/he should be able to consider their skills and knowledge, whether they are sufficient for a reliable mediation of information. The social worker has to approach the client as an equal partner without any sign of exaltation or underestimating of her/his abilities.

The social worker working with persons with hearing impairment should also be able to work in a team because social workers working with this target group are often a part of a multidisciplinary team. For example, in centres of special pedagogical counselling for people with hearing impairments, located predominantly in schools for children with hearing impairments, they cooperate with experts from the fields of psychology, special pedagogy, speech therapy, etc.

Conclusion

Social work with people with hearing impairments is extremely challenging, as it regards work with a specific target group. It is necessary to follow ethical principles derived from ethical codes for the work of social workers, so that their work keeps improving. Social workers are not only important in the removal of the communication and the information barrier but at the same time they are also mediators of information important for a full life of people with hearing impairments.

REFERENCES

CANGAR, M. – GALLO, D. a kol. 2005. *Osobnosť sociálneho pracovníka a manažment.* Bratislava: SOCIA, 2005. 84 s. ISBN 80–87–908–7–0.

Ethics in Social Work – Statement of Principles [online]. 2004. 5 s. [cit. 2011-10-23]. Available on the internet: <http://www.ifsw.org/cm_data/IFSW_code_of_Ethics_Slovak-1.pdf>

General Background [online]. 2011. [cit. 2011–07–05]. Available on the internet: < http://www.eud/EUD-i-14.html.>

JAKABČIC, I.- POŽÁR, L. *1995. Všeobecná patopsychológia,. Patopsychológia mentálne postihnutých*. Bratislava: Iris, 1995. 194 s. ISBN 80-88778-11-5.

MATOUŠEK, O. 2005. *Sociální práce v praxi – Specifika různych cílových skupin a práce s nimi*. Praha: Portál, 2005. 351 s. ISBN 80–7367–002–X.

TARCSIOVÁ, D. 1998. Ľudské práva z hľadiska potrieb občanov so sluchovým postihnutím. In *Ľudské práva a občania so zdravotným postihnutím.* Bratislava: Ministerstvo práce, sociálnych vecí a rodiny SR, Koordinačný výbor pre otázky zdravotne postihnutých občanov SR a Slovenská humanitná rada, 1998. s. 47–52.

TARCSIOVÁ, D. – HOVORKOVÁ, S. *Máme dieťa so sluchovým postihnutím... čo ďalej?* Bratislava: Effeta, 2002. 118 s. ISBN 80–968584–5–9.
STRIEŽENEC, Š. *Úvod do sociálnej práce.* Trnava: Tripsoft, 2001. 197 s. ISBN 80–968294–6–7.
ŠMEHILOVÁ, A. 2010. *Možnosti zamestnanosti občanov so sluchovým postihnutím po vstupe Slovenskej republiky do európskej únie.* Nitra:Effeta- Stredisko sv. Františka Saleského, 2010. S. 177. ISBN 978-80-89245-20-8.
The Standard Rules on the Equalization of Opportunities for Persons with Disabilities [online]. 1993. [cit. 2011–10–29]. Available on the internet: <http://www.un.org/esa/socdev/enable/dissre00.htm>
Zákon č. 448/2008 o sociálnych službách a o zmene a doplnení zákona č. 455/1991 Zb. o živnostenskom podnikaní (živnostenský zákon) v znení neskorších predpisov. 2008. s. 3844–3897.
ŽILOVÁ, A. *Kapitoly z teórie sociálnej práce I.* Žilina : EDIS, 2000. 119 s. ISBN 80–7100–783–8.

Contact address:

Mgr. Petra Gajdošová
Mgr. Jana Gabrielová
Department of Social Work and Social Sciences
Faculty of Social Sciences and Health Care
Constantine the Philosopher University in Nitra
Kraskova 1
949 01 Nitra
Slovak republic
e-mail: petra.gajdosova@ukf.sk
jana.gabrielova@ukf.sk

VALUES AND VALUE SYSTEM OF A YOUNG MAN IN CONTEMPORARY SOCIETY

Slavomír Laca

St. Elizabeth University College of Health and Social Work, Bratislava

ABSTRACT

In this paper we work to address the moral values of man, which is a form of xpression of the moral relations of society and are also subjective in the man himself. The aim of this diploma thesis is to analyze the system of values of a young man under the influence of contemporary social processes. The main attention is paid to the determinants of young people's system of values.

Key words: Value. System of values. Value orientation. Determinants of values. Globalization. Family.

Introduction

In this paper we work to address the moral values of man, which is a form of expression of the moral relations of society and are also subjective in the man himself. Our interest in attracting today's young people now living in the postmodern era. Sometimes we are more passive recipients of the various achievements of modern technology such as active creators, something that also forms the inner joy of everyone and also supports our health (Hudáková, 2007, p. 87).Our interest is to further deepen the understanding of the value orientation of young people this time. We will address the value of human life, a definition of values through which the man in your life decisions. To decide what is right and wrong, what is good and bad, as the place to be happy with himself and has to act so as to be satisfied with the company.

Historical and theoretical value of expression

Generally, when we understand something, we must first define it, describe the concept, look for the meaning of the term for man. Characterize the notion of value is a very difficult matter, because one still does not define the level of universal value, generally applicable definition.

Value is a term that is unknown in many fields of science, in philosophy, psychology, pedagogy, ethics, aesthetics and so on. But what we can determine how widely applicable is that the value of one man. During his life to create certain values we live by them. Another consideration on the concept of value we can say that distinguish natural values, civilization (culture), moral, material and spiritual, social and personal and other. From a philosophical standpoint, in terms of the existence of philosophical thought.

From a philosophical standpoint, in terms of the existence of philosophical thought man brings one of the many human problems, values. We will consider development axiological views of some philosophers. First, a brief overview of the development of lists axiological views of Western philosophy that forms the cornerstone of our civilization. Later we mention the views of American philosophers, because today is the world and our society greatly influenced by just "Americanism." Human values and the first assessment explained

by evolution. In the transition from inanimate nature to the forms of living organisms arise mental life. Entity appears on the one hand and the object on the other. A man from other living nature of the country differ in that transforms your relationship to reality, from the beginning of mankind is aware of the values necessary for their life (Márton, 2002).

In ancient philosophy, values unclear problem associated with the problem of being. Before Sokrat only distinguish positive and negative values. As we speak today about things that are good or bad, for example. when one says that the food is good, another turn that bad. Thus, things, events before Sokrat have not attributed the same moral qualities. Sophists, who turned attention to the man, turned the attention of the solutions axiological issues in a different direction, toward the subjective. This is best expressed his Protagoras, "man is the measure of all things." Protagoras, by implication, shows where to find a solution and evaluation of the values. Draws attention to the man. Socrates pushes interest entity further. His method (so-called Socratic irony) is constantly asking questions indirectly says that arise when the value of human knowledge. With increasing knowledge extends the horizon of man. The hierarchy of our values is dependent on knowledge.

Plato was the first attempt to give a personality psychology and thus a set of mental functions. Plato is representative of the theories that equate learning with assessment. He says that knowledge consists in defining the knowledge and assessment in defining evaluation. Each definition is done through the concept, the objective character of something. Plato drew attention to the ontological question of values. Ontological issues are also dealt with Aristotle. He praised the knowledge of the evaluation. Realizing that the level of attitude evaluation results from the level of knowledge of the subject. Sort cognitive (cognitive) and evaluation functions developed in the work of debate on the method of one of the greatest philosophers of modern times, René Descartes. Psychological examination of human attitudes to deal with rationalist Baruch Spinoza. While the difference between conscious and unconscious impulses to action revealed G. W. Leibniz. The fact that our actions are determined and influenced by social factors also aware of the French philosopher CH. de Montesquieu, and especially J. J. Rousseau (Pasternáková, 2010). The most important representative of German classical idealism in the work of Immanuel Kant Critique of practical reason developed the idea: "If a man has to act morally, must be free to decide." The term free to I. Kant understood "in proceedings to limit their selfishness, suppress it wisely." Because if we act humanely when not acting selfishly.

Significant is also the categorical imperative, rules of procedure, which acts in the human consciousness. Long considered the values contributed to the fact that in the second half of the 19th century was axiology as a separate science. Dilthey as a representative of the "philosophy of life" in the definition of value is based on life which is the only source of values. Value is thus kind of life experience. German philosopher F. Nietzsche looks at the issue of values through his idea of superman. Nietzsche says that all of today's human values and standards in relation to the values and standards applicable to the next man not only relatively but also reprehensible. We can say that Nietzsche's superman is superman as if our postmodern era. Young people review their values, rejects traditional values, only lives by those values that he brings considerable benefits in some way.

In the second half of the 20th century, Jacques Maritain in addition to the political ideas he also moral philosophy. According to him, moral experience is a prerequisite for understanding not only good but also values. Experience, we recognize the good deeds of evil, so we know what is good that "honor man". As mentioned earlier, today's man is particularly influenced by American culture, and to mention some of the American philosopher and axiological views. The creator of pragmatism W. James gives prominence to the practical aspects of evaluation. Valuable to man is only what is helpful for him also. Another philosopher who served in the U.S. Marshall Urban. Urban stresses the value of psychological

opinion. Value is the importance of building the body in different situations or attitudes, these attitudes are themselves different abilities and interests observable psychologically. Validity and binding force values was involved in the American philosopher D. H. Parker. He concluded that one's own complex value category. They maintain their own health, comfort, ambition, occupation, love, knowledge, play, art and religion.

The Slovak second half of the 20th century include Marian Váross and Vladimir Brožík. According to M. Várossa value of the function of identifying an adequate quality standard, based on the knowledge that the values are even starting to human activities. This brief overview of our axiological views "brought" to our problems.

Globalization and Values

The rapid evolution of our world, globalization in which we live calls for a return to the values and virtues. It calls for obedience, humanity, justice, fairness and sensitivity. The situation in which modern man in relation to their own values myself, contributed gradual seepage values in life. It is not about seepage values in the true sense, human values and they were here, there is a change in its view of human life, promotes the values of pluralism. The company is going to that disappearing value that would be accepted by all people. What the company held out together in the past is no longer co-ordination through common values, but the anonymity of the market. The process of global capital movements, trade globalization is accompanied by information technology. Information on the soil of the structural changes occur in human thinking and thus changes in its value orientation. Model of information society is a sort of "creating a virtual reality, where a man escapes from reality, and where you can create all the necessary to satisfy its needs without the slightest effort." (Šimo, 2002, p. 106).

These changes in values caused by disorders most tangible economic life. Slightly less impact on the value of human life, political disturbances, particularly through the media. It is paradoxical that the "state failure" occurred through general progress, whether advances in technology, transport, education and mobilization. Progress itself, but refers only to the same direction in which mankind is moving (Laca, 2004). Humanity receives progress because they are born into it. Paying attention to what awaits us at the end of progress, whether it's "human welfare" or complete extinction of mankind. From our present time that to satisfy themselves, their needs and their life values such as family, health and friendship become a back seat today is an important power, prestige and profit. The values now decide institutions, mass media, state authorities. The company has become the voice and the objectivity of norms, laws that would our values in this global world, it is undisputed that it was the current disorientation of values contributes to a considerable extent acceptable to the instability of our laws and standards, which allows us to escape from justice, some , exemption from liability. The value system of our society is the value system of the previous (past) and contemporary society, that also incorporates the value associated with the creation of a European identity and globalization. It is through globalization in the world opened the way to the free movement of ideas, people and goods (Márton, 2002). We could say that one side of globalization for freedom, on the other replaced the traditional values of its own values, values of profit and success. It offers value growth, opening new opportunities and gives people the power to the hands.

India has experienced growth at 80 the 20th century, and it'll be here began to change the nature of everyday life (Hrehová, 2001). Hut of mud bricks to replace the building rather paved road is now paved. Electricity became available to all dark alleys and street lamps illuminate today. The poor can buy clothes and shoes. Ordinary citizens are now turning to the bank and no one may remain outstanding at the end of life. People can apply for a job in

different locations. Parents in poor parts of the world do not send their children to work for pleasure, but because they need money to feed his family. (Norberg, 2006) on economic growth of this country to see an example of how gradually under the influence of prosperity the country has also changed in fair values of man. Externally, the primary is no longer a family, but as we wrote above, this is money, property, profits and power. And there is no way to be a man feeds on humans, has indicated that advertising trends in human life. A person becomes a consumer, not an adult, but since childhood.

India has experienced growth at 80 the 20th century, and it'll be here began to change the nature of everyday life. Hut of mud bricks to replace the building rather paved road is now paved. Electricity became available to all dark alleys and street lamps illuminate today. The poor can buy clothes and shoes. Ordinary citizens are now turning to the bank and no one may remain outstanding at the end of life. People can apply for a job in different locations. Parents in poor parts of the world do not send their children to work for pleasure, but because they need money to feed his family. (Norberg, 2006) on economic growth of this country to see an example of how gradually under the influence of prosperity the country has also changed in fair values of man. Externally, the primary is no longer a family, but as we wrote above, this is money, property, profits and power. And there is no way to be a man feeds on humans, has indicated that advertising trends in human life. A person becomes a consumer, not an adult, but since childhood.

Ethical value is the same factor of social life. Varies with time and cultural development. Index values depend on the company's structure, its layout, mentality (Storoška, 2008). The changes that take place in society is reflected in the value system and vice versa in the value system reflects social change. The company passed through a process of socialization of the younger generation such social entities such as social norms, values, attitudes, behavior patterns, life goals.

Good condition and healthy social relationships, leading to the integrity of ideas, traditions, customs and culture are thus virtues. Virtues are not separated from human life, rather as part of our lives. Not only the virtues but also education is a prerequisite for good social relations (Schavel, 2004). It fulfills the education of the transfer function of objective values in order to preserve the culture. The values of good and evil shape our views of the world and also apply to our own traditions and customs. From early childhood, the life journey of a man adapted to designs that are traditionally conveyed in his community where he grew up and lives. The fact that the child learns to talk, it's already created its culture. During adolescence, a man entirely acquires the habits, attitudes, traditions. Community culture in which one grows up has a major impact on shaping the value system of man. Lifestyle and environmental influences which determine the functioning of the culture. Each company pays a certain value system. In the world "...find a financial situation where social hierarchy depends on material goods, we will find artifacts and their production technology, various methods of sexual life, partnership and parenthood, find different societies or cults that give a company structure, we find the gods, supernatural rules, orders" (Benedict, 1999, p. 26).

People unconsciously adopt the values of the culture into which they are born. Another part of the values you already mastered the process of maturation directly and through their own experiences. Values refer to aspects of the culture that results from understanding the unity of the social and natural sites. No man born on the opposite side of the globe can fully understand another culture, its traditions and values which professes. Civilized man is difficult to understand the life of indigenous tribes of North America (Kučerová, 1996). For them to be an adult means to be a good fighter, be a winner over himself, over his own pain. The boys in the tribes themselves tortured, sculpted the pieces of skin from hands, just to prove they are adults. The civilized man would understand, but for them one of the

fundamental values of life is suffering, it gives them a sense of life. Every period in history, culture and each epoch has its own set of generally accepted ways of behavior and opinions.
Into another world, we can build human suffering today in relation to human health. Our grandparents only to a limited extent able to absorb the pain, heal wounds, maintain hygiene. Medical science in their time was still only beginning its progressive path (Šimo, 2001). At present, there was an explosion of some kind of cult of health, which is presented through a fitness center, a variety of ways of subsistence, or through a variety of drugs through the beauty of sports idol. Paradoxically, however, such care, sanitation, operations, different types of human drugs lead to the fact that health itself is for him only momentary matter. And at a time when a person becomes ill. “Life has become too easy. Moral pillars of a strong man if not to the well-being hijacked.” (Huizinga, 2002, p. 60).

Find the cause of human immorality is difficult. Behavior, conduct Western society was enshrined in Christianity and its moral law. We can not say it today around one sees that the validity of Christian moral law is now lost for many. Objectively this is reflected in the increasing divorce rate, appeared to abortion, free sex among young people and euthanasia. Decline of human morality does not apply to all people. It is important to take a person as an individual personality. Christian morality continues to operate even if the moral conduct can now be in a weakened form. A man with him personally, internally still feel somewhat tied. Although sometimes we think and act differently. What belongs and what does not is we get to looking and risk-taking, when we try to circumvent public policy. What belongs and what does not is we get to looking and risk-taking, when we try to circumvent public policy. Each of us in the lives of the difficulties is not ready (Hudáková, 2005, p. 88).
While globalization contributes to changing the value system of man, we must remember that European society recognizes values other than Western society, or even an Islamic society. The essence of this difference is in the progressive history department of politics and religion, it has to do with the advent of modernity.

European culture is based on several pillars, which were born in ancient Greece and Rome. Basic pillars of Europe derives from the ancient Greek individualism, which is from 19 century became the core of European worldview, human activism, which he actively, subjectively governed my life, humanism, freedom and objectivity of knowledge. In Roman civilization as an essential pillar of European culture was born right. We must not forget that European culture shaped by Christianity, the monotheistic belief in one God. Based on the integration processes from 2 a half. 20th century European culture began to globalize. When asked about the values of European culture, it is important that common values began to spread outside the European continent and new communities are nice or not. Globalization is in this direction but a kind of feedback process and thus the value of other communities permeate European culture. "Too much tolerance and openness (post-modern) can lead to spiritual vacuity and value, because it seems that everything is possible. But man needs a strong values and hierarchy of values, and today they will start searching again. We are in a situation of transition from the vacuity of value to the value fixovanosti. "(Mistrík, E. [online]. [Cit.2011-10–11]. s. 4th Available at: <http://www. erichmistrik / text / global.rtf>).

Culture is constantly changing and are changing more quickly, thus there are more options. When people have the opportunity to read in the newspapers or seen on television other lifestyles and values, usually does not take long and you can acquire them over time.
Globalization brings the mixing of cultures, which on the other hand, reduces the risk that people will remain trapped in a culture. Advocates of this tradition may condemn. But today, many people trying to break the stereotype, they want to live according to their own values, are determined to break rodinnútradíciu and start a career, what you wish for yourself.

Conclusion

The process changes the value orientation and value system of the current young generation is a process which is derived from actual social change. The total value of today's youth development indicative of the growing materialism, liberalism, the decline of traditional values. Value movements can be observed just in different age groups of youth. Where the youngest group of youth, that youth in adolescence its value orientation leads to a pragmatic life, focusing only on what is of benefit in life.

Today's young people understand that tolerance, respect and help others are the values that man needs for his life. Yet in his neighborhood often observed that the youth subculture, the report apparently behaved differently than previous generations of youth. Look for reasons why a young person lives with the values and apparently is common complex matter of human sciences, philosophy, sociology, psychology, theology and social work.

REFERENCES

BENEDICT, R.: *Vzory kultúry*. Bratislava: Kalligram, 1999. 232 s. ISBN 80-7149-293-0.
ČERNÁ, Ľ.: *Flexibilita a istota na trhu práce.* In: Hospodářská politika v členských zemích Evropské unie : Sborník příspěvků VIII. mezinárodní vědecké konference. 8. - 10. září 2010, Horní Lomná, ČR. - Opava : Slezská univerzita v Opavě, 2010. ISBN 978-80-7248-601-4.
HREHOVÁ, H.: *Filozofia hodnôt a aktualizácia cností v kultúre 21. storočia*. In : Človek, kultúra, hodnoty. Zborník príspevkov z medzinárodnej vedeckej konferencie konanej v rámci 4. stretnutia SFZ v dňoch 12. – 14. septembra 2001 v Píle pri Častej. Bratislava: Vydavateľstvo IRIS, 2002. ISBN 80-89074-07-3.
HUDÁKOVÁ, Z.: *Trauma – čo všetko nás môže zraniť.* In Komplexná ošetrovateľská starostlivosť o človeka v hraničných situáciách. Ed. Kovařová, M., Doncak, P., Akimjak, A. Prešov: Fakulta zdravotníctva a sociálnej práce,bl. P. P. Gojdiča v Prešove, GTF PU v Prešove, Lekárska fakulta UPJŠ v Košiciach, 2005. s. 242.ISBN 80-969449-1-6. s. 88-90.
HUDÁKOVÁ, Z.: *Spontánne tvorenie študentov pre podporu zdravia.* In Sborník Vliv mezinárodního ošetřovatelství na současnou ošetřovatelskou teorii a praxi : II. Příbramské ošetřovatelské dny. Ed. V. Tóthová, M. Kilíková, D. Kalátová, M. Trešlová. Příbram: SZŠ a VOŠ zdravotnická, 2007. 275 s. ISBN 978-80-239-8943-4, s. 87-89.
HUIZINGA, J.: *Kultúra a kríza.* Bratislava: Kalligram, 2002. 320 s. ISBN 80-7149-472-0.
KOLLÁROVÁ, A. 2009: *Bazálna stimulácia ako prostriedok socializácie viacnásobne znevýhodnených osôb.* In: Efeta – otvor sa - vedecko-odborný časopis o komplexnej rehabilitácii ľudí s postinutím. 2009, Martin: Osveta, 67 s. ISBN 80-8063-341-7
KOLLÁROVÁ, A., KOLLÁR, M. 2009: *Viacnásobné postihnutie ako sociálny problém.* In: PROHUMAN - Odborný internetový časopis - sociálna práca, psychológia, pedagogika, sociálna politika, zdravotníctvo, ošetrovateľstvo. Prohuman, 2009-2011, ISSN 1338-1415
KUČEROVÁ, S. : *Člověk, hodnoty, výchova.* Prešov : ManaCom, 1996. 229 s. ISBN 80-85668-34-3.
LACA, P.: *Masmédia a ich morálna hodnota*. In: Logos – Revue gréckokatolíkov na Slovensku, Prešov 4/2003, s. 12-13, *ISSN* 1335-5910.
LACA, P.: *S desatorom do Európskej únie.* In: Logos – Revue gréckokatolíkov na Slovensku, Prešov 2/2004, s. 6-9 *ISSN* 1335-5910.
MÁRTON, M.: *Globalizácia a niektoré hodnotové kontexty*. In: Človek, kultúra, hodnoty. Zborník príspevkov z medzinárodnej vedeckej konferencie konanej v rámci 4. stretnutia SFZ v dňoch 12. – 14. septembra 2001 v Píle pri Častej. Bratislava: Vydavateľstvo IRIS, 2002. ISBN 80-89074-07-3.

MISTRÍK, E.: *Kultúrna globalizácia Európy a súčasná civilizačnokultúrna situácia na Slovensku.* In: Demokracie a Evropa v době globalizace. Ed. M. Goňcová. Brno: MU, 2003. ISBN 80-210-3301-0. [online]. [s.a.]. [citované 2011-10-11]. 9 s. Dostupné na internete: http://www.erichmistrik.sk/texty/glbl.rtf.
NORBERG, J.: *Globalizace.* Praha: Alfa Publishing a Liberálni institut, 2006. 204 s. ISBN 80-86851-32-.
PASTERNÁKOVÁ, L.: *Metódy výchovy uplatňované v rodinách*. In: Vychovávateľ č. 6, roč. 58, Bratislava: Educatio, 2010. ISSN 0139-6919.
SCHAVEL, M. *Sociálne poradenstvo a supervízie v sociálnej práci.* Bratislava: Gerthoffer. 2004. ISBN1335-05378.
STOROŠKA, M.: *Filozoficko – teologický pohľad na dôstojnosť človeka a ľudské práva ako garancie bezpečnosti občanov*. In: *Securitologia.* Wysoka : European Association for Security, 2008, č. 7, s. 166-178. ISSN 1898-4509.
STOROŠKA, M.: *Vzťah fyzickej a duchovnej pomoci.* In. *Viera v moc a moc viery*. Banská Bystrica : TRIAN, 2007, s. 240-256. ISBN 978-80-88945-93-2.
ŠIMO, I.: *Človek v čase informačnej spoločnosti a virtuálna realita.* In:Človek, kultúra, hodnoty. Zborník príspevkov z medzinárodnej vedeckej konferencie konanej v rámci 4. stretnutia SFZ v dňoch 12. – 14. septembra 2001 v Píle pri Častej. Bratislava: Vydavateľstvo IRIS, 2002. ISBN 80-89074-07-3.

Contact address:

PaedDr. Slavomír Laca, PhD.
St. Elizabeth University College of Health and Social Work, Bratislava
slavomir.laca@gmail.com

SOCIAL WORKER IN MULTIDISCIPLINARY PROFESSIONAL TEAM TAKING CARE OF ONCOLOGY PATIENT

[1]Zlata Ondrušová, [2]Zuzana Ondrušová

[1] St. Elizabeth University College of Health and Social Work, Bratislava
[2]Ministry of Interior of the Slovak Republic, Department of Police Psychology

Zlata Ondrušová
She studied social work at the University of Trnava and graduated in 2006. She got her PhD. at the St. Elizabeth University of Health and Social Work in 2009. She is a university teacher at St. Elizabeth University College of Health and Social Work. The main fields of her interest are history of social work, basics of social work and further education of social workers.

Zuzana Ondrušová
She studied psychology at the University of Trnava where she graduated in 2011 and social work at St. Elizabeth University College of Health and Social Work where she graduated in 2010. She works as a psychologist. Her main fields of interests is psychooncology.

ABSTRACT

Nowadays oncology diseases are concerned to be second of the most frequent causes of death. We suggest it is important to give enough attention to patients, their relatives, doctors and other professionals helping them. With our contribution we want to emphasize the seriousness of work with oncology patients and their families according to many aspects that go with oncology diseases. As a very effective way of working with oncology patients we see multidisciplinary professional teams which should consist of doctors, nurses, psychologists, social workers, priests, volunteers and possibly other members. This is how modern medicine could practise the holistic approach and make every patient get exactly that kind of health, psychological and social care which he or she needs at the particular time the most.

Key Words: Oncology patient. Multidisciplinary professional team. Social worker.

Multidisciplinary Team

Multidisciplinary team is a group of people from various fields with different professional qualification and different attitudes to patients. Every member of the team sees a patient form a different point of view and can provide different kind of service to help patient. Finally, the whole team can help patient with almost every problem that might appear. To make the team work effective, all the members of the team must communicate together, exchange the information and experiences, inform each other about the state in which patient currently is. They should support and respect each other and most of all, do anything not to hurt patients.

In a multidisciplinary team there should be a doctor, nurses, physiotherapist, psychologist, social worker, volunteers, according to the state and needs of patient there might be also a priest and other professionals (Balogová, 2005). In a broader meaning, patient, family, relatives, friends, pets and other patients can be included in multidisciplinary team.

Doctor in Multidisciplinary Professional Team

With no doubts, doctors are the only really unnecessary members of the teams, the only who provide medical care to a cancer patient and nobody can replace them. Still, without other members of the team their help is not enough. Their role in the team is to diagnose the disease, to determine and provide treatment, monitor and reduce pain, predict the development of the disease and treatment, inform the patient and family about the disease and treatment.

From the medical point of view, from all members of the team doctor is absolutely necessary to take care of oncology patients. From psychosocial point of view, the emphasis is on psychosocial care of the patients which means the right to be informed about the health and the treatment procedure. In addition to this, patient has the right to decide whether to apply particular method recommended by doctors or not. Now the right to be informed is even more important because only appropriate information can make patient do the right decision. On the other hand, when patient's opinion is wanted and accepted, it increases his feeling of control over the situation which significantly increases psychical wellbeing of the patient.

To sum up, doctor should inform patient about his health and treatment in understandable way, explain pros and cons of particular treatment methods, recommend the one which is, according to doctor's opinion, the most appropriate and accept the decision of patient. To preserve the humanity, doctor should ask himself whether he would recommend the same method to his own relatives or to himself and why possibly is there a difference with what he recommends to patient (Baštecká, Goldmann, 2005).

Nurses in Multidisciplinary Professional Team

Nurses have the most frequent contact with patients. Thus they have to be qualified and attend the further education and trainings to be prepared to all the possible situations.

In the multidisciplinary professional team, the role of nurses is very specific. They provide psychical and mental support, perform the patient care itself, watch the state of the patient, watch the symptoms of pain and give medications as instructed by the doctor, watch the basic life functions, diagnose the changes of patient's state, provide tools for patients comfort, instruct a family taking care of the patient (Magurová et al., 2007). Nurses also help with fulfilling the basic need of the patient, for example bathing, going to the toilet, feeding, changing clothes etc.

The relationship between patient and nurse might be very close. Nurses, thus, should be supported by other members of the team, take care about the mental hygiene to prevent personal complications or burnout syndrome.

Psychologist in Multidisciplinary Professional Team

Clinical psychology is psychological discipline mostly focused on patients lying in hospitals. According to the Ministry of Health of the Slovak Republic (Conception of healthcare in psychology, 2006) the content of clinical psychologist's work is prevention, clinical psychological diagnosis, therapy, counselling, assessment and expert activity, scientific and research activities.

Basic activity is *prevention*, especially in the form of psychology of health. This means providing information to the public, propagation of healthy lifestyle, supporting the stress management, prevention of addictions, optimizing human relationships, crisis intervention etc.

Clinical psychological diagnosis helps to create a personality image of a patient, assess the psychological phenomenon and changes of the psychical state of the patient, watch reactions of the patient in particular states of treatment, assess the level of mental skill and their changes, consideration of psychical development and its disproportions, differential diagnosis.

Psychologists can apply different kinds of *therapy* – individual, groups, community and other kinds of psychological intervention. The aim is to modify mental states and behaviour of a patient. Within the methods we can mention training of psychical functions, neuropsychological rehabilitation, psychoprophylaxis, relaxation, biofeedback etc.

Counselling in psychology can help patients with their personal, social, professional, educational and other problems in relationship with their health. Counselling is usually provided in ambulance, crisis centres, helplines and daily stationeries. In Slovakia it is very rarely provided in hospitals. On the other hand, abroad it is quite usual.

Assessment and expert activities help to assess the mental state of patients, functions and skills of a personality, professional and specific skills, health etc. It can include consultation with doctors and other members of the team.

Scientific and research activities helps to categorise psychological aspects of health and sickness and treatment. It is especially important because of developing diagnostic methods and providing educational activities.

Probably the most important activities are therapy, counselling and diagnosis. As a therapist and counsellor psychologist can help patient to get through the situation from diagnosis to treatment and getting healthy again. In case of necessity psychologist can help to reduce pain and to reconcile possible death. The special help of psychological diagnosis is that it can signalize and possibly localize brain damage. We can see that psychologist is important member of the team.

Social Worker in Multidisciplinary Professional Team

Pioneers in psychooncological care were social workers (Holland, Weiss, 2010). Nowadays, their position in health care (or multidisciplinary team) is not defined enough. There is only very little acceptance to social work and social workers at all. Social work in health care is at the edge between streetwork and health care. On one hand this shows the wideness of social work, on the other hand, this might be the reason why social work is underestimated (Crabtree, 2005). Davis (2004) says that one of other possible reasons why social work is not favourite today might be the fact that the borderline between social work and nursing seems to be very slight.

The position of social worker taking care of oncology patients in hospital can be defined in two different ways. First is direct work with patient, second is work with family and relatives. For social worker it is very important to know and help family and relatives of the patient, because they are the social environment of the patient and they are one of the most important

contents of patient´s life. They are practically necessary during the treatment but especially after the treatment when patient needs to get back to his previous life. Or better, when patient needs to start a brand new life after getting second chance in life. Social worker gets another level of importance when the treatment is unsuccessful and family need help after patient´s death.

According to Slovak law (Act No. 448/2008 about the social services) we want to point out particular social services that could be provided to patients by social workers and their families:

A) Social services supporting family and children.
Personal assistance for children and household means to help with personal hygiene, feeding, dressing, preparing to school, taking children to school in case that parents are not able to do that (they might be hospitalized etc.). The reason to provide these services might be disease, injury or death of one of the parents or another person who is supposed to take care of a child.

B) Social services to solve unfavourable social situation caused by disability, unfavourable health or retirement age.
Patients can be provided many services, for example social counselling, social rehabilitation and other service activities. Oncology patients can be provided transportation service, especially when their moving ability is limited. In case of necessity, social worker can be a personal assistant to a patient or provide devices necessary for highest possible quality of life. Social assessment activities assess individual state of patient, state of family environment and other environments which influence integration of patient in society. The result is description and measure of disadvantage of patient with disability. In particular cases, oncology patient can get a disability pension etc.

C) Social services using telecommunication technologies.
In this case using telecommunication technologies include social counselling via telephone or internet.

According to the same Act we distinguish several activities included as social services. For care about oncology patient these are the most important:

Social counselling. Basic social counselling includes examination of the problem, provision of basic information, solutions, mediation of other professional support. Specialized counselling is searching for causes, character and range of the problem and providing specific professional help with solving them.

Support with applying rights and law protected interests. Social worker should help patient with dealing with official matters, special forms and official letter communication.

Social rehabilitation includes support of independence though training of basic abilities, mobilization of abilities and strengthening of habits. This should help patient to take care of himself, household and basic social activities.

Work therapy allows patient to learn work habits and skills with professional help. It can help patient to acquire, keep and evaluate physical, mental and work skills and integrate into society.

In case of necessity, it is possible to provide accommodation, food, housekeeping and laundry.

Slovak law does not state concrete social services to be provided to oncology patient. However, within the social services stated by the law we can many of those which could be provided to oncology patients. This shows the importance of social workers as a members of multidisciplinary professional teams in hospitals.

From another point of view, social worker in multidisciplinary team examinates social situation of patients, especially social needs, prepares and realizes individual plan of social care, defines social need of patient and his family, defines social diagnosis and provides individual social care, finds out alternative financial sources of the family, in case of death of the patient helps with all the formalities (Magurová, et al., 2007).

In Slovakia, social worker in health care system is in order of educational counselling, socialization and resocialization, providing professional social-legal counselling. Social worker might help patient to overcome health, moral and economic problems, help with integration of patient into society, point out negative effects on patient's health. Within the competences of social worker falls cooperation with medical staff, family of patient, school, employer, courts, other social workers as well as evidence of social documentation, participation in researches and scientific projects, official representation of the patient. (Mojtová, 2008)

We pointed out competences of social worker in Slovak health care system. The roles are either specific for profession of social worker or non-specific which are very similar to roles of other members of multidisciplinary teams. This makes the definition of social work and social work in health care system not clear at all not only in Slovakia but worldwide which confirm other authors too (Auslander, 2001; Davis, C., et al., 2004, 2005, Crabtree, 2005).

With our thesis we want to emphasis the need of multidisciplinary professional teams helping oncology patients. We shortly characterized the team which should be able to provide qualified support to oncology patient in all possible problems. Abroad this trend is being set and followed and it seems that Slovakia might go this way too.

REFERENCES

AUSLANDER, A. (2001): *Social Work in Health Care. What have we achieved.* In Journal of Social Work, 1, 2, pp. 201-222. ISSN 1369-1457.
BALOGOVÁ, B. (2005): *Seniori*. Prešov, Akcent Print. ISBN 80-969274-1-8.
BAŠTECKÁ, B., Goldmann, P. (2005): *Základy klinické psychologie*. Praha, Portál. ISBN 80-7178-550-4.
CRABTREE, S.A. (2005): *Medical social work in Malaysia*. Issues in practise. In Intenational Social Work, 48, 6, pp. 732-741. ISSN 0020-8728.
DAVIS, C., MILOSEVIC, B., BALDRY, E., WALSH, A. (2004): *Defining the role of the hospital social worker in Australia.* In International Social Work, 47, 3, pp. 346-358. ISSN 0020-8728.
DAVIS, C., MILOSEVIC, B., BALDRY, E., WALSH, A. (2005): *Defining the role of the hospital social worker in Australia.* Part 2. A qualitative approach. In International Social Work, 48, 3, pp. 289-299. ISSN 0020-8728.

HOLLAND, J. C., WEISS, T. R. (2010): *History of Psycho-Oncology*. In: Holland, J.C. - Breitbart, W.S. - Jacobsen P.B. - Lederberg, M.S. - Loscalzo, M.J. - McCorkle, R. (Eds.). *Psycho-oncology*. Second Edition. New York: Oxford University Press, 2010. ISBN 978-0-19-536743-0, pp. 3-12.
CONCEPTION OF HEALTH CARE IN PSYCHOLOGY (*Koncepcia zdravotnej starostlivosti v odbore psychológia*) (2006): In Zdravotnícke noviny, 11, 26, s. 52-57. ISSN 1335-4477.
MAGUROVÁ, D., LONGAUEROVÁ, A., WICZMÁNDYOVÁ, D. (2007): *Rola členov multidisciplinárneho tímu v rámci hospicovej starostlivosti.* In Zdravotníctvo a sociálna práca, 2, 1, s. 5-7. ISSN 1336-9326.
MOJTOVÁ, M. (2008): *Sociálna práca v zdravotníctve*. Bratislava, SAP. ISBN 978-80-89271-45-0.
Act No. 448/2008 Coll. on social services and on amendments of Act No. 455/1991 Coll. on trade business as ammanded.

Contact address:

PhDr. Zlata Ondrušová, PhD.
St. Elizabeth University College of Health and Social Work
zlatica.ondrusova@vssvalzbety.sk

Mgr. Zuzana Ondrušová
Ministry of Interior of the Slovak Republic, Department of Police Psychology
sue.ondrusova@gmail.com

BATTERED WOMEN AS A SOCIAL PROBLEM

Alena Kollárová

St. Elizabeth University College of Health and Social Work, Bratislava

---

ABSTRACT

The paper draws attention to a critical situation of battered women in our society having an alarming character in the course of recent years. It defines the principal terms and syndromes of battered women and characterizes domestic violence against women as a specific form of abuse. It analyzes the possibilities of social assistance to battered women from part of the assisting staff represented by crisis intervention, social counselling and social services.

Key words: Violence against women. Battered woman syndrome. Domestic violence. Social assistance.

Introduction

Violence against women is a grave and increasingly more apparent society-wide issue having ascending tendency even in the conditions of Slovakia. Pursuant to statistic figures women (approximately 95%) represent an overwhelming majority being battered in the partnership relationships. (Čírtková, 2011). The term of "violence against women" was defined in 1993 in the Declaration on the Elimination of Violence against Women according to which it means any act of gender-based violence and neglect that result, or is likely to result, in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty whether occurring in public or private life. (Sejčová, 2010).

In terms of the form violence (battering) is understood to encompass physical, psychological, emotional, sexual, social and economical violence. In compliance with classification of psychological disorders the results of violence might be diagnosed as a reaction or post-traumatic disorder. Battered women's post-traumatic reactions manifest themselves in the form of escaping tendencies (negation, apathy, numbness, separation, depression, dissociation). Extreme anxiety, oversensitiveness, panic, hyperactivity, nervousness, lower self-esteem occur. In battered women higher level of powerlessness and helplessness may be identified along with fear and depression as reactions to loss of illusions in relation to the world, deprivation of sense of strength and meaningfulness. The most frequent syndrome possible to be encountered in battered women might be depression. (Špatenková et al., 2004). Depression covering various levels is rather typical – including significant risk of suicide. An extreme fear for life they felt can lead to panic attacks. Of high occurrence are diverse physical difficulties such as stomach-aches, headaches, asthma, food intake disorder, etc. Allied syndromes are represented by addictions – the traumatized seek for escape and relief from painful feelings in alcohol, drugs or pharmaceuticals. In an untreated traumatized victim noticeable are deteriorating work and personal relationships, somatic difficulties, lower working performance and ascended risk of self-destruction. (Tomková, 2011). Battered woman syndrome is in fact a set of specific characteristics and results of battering causing a lower ability of woman to produce effective reactions to the violence being experienced.

As per Douglas (In: Čírtková, 2011) any symptom in battered women might be divided into three categories as follows:
1. Syndromes included in post-traumatic stress disorder (PTSD)
2. Learned powerlessness
3. Self-destructive reactions

As per Špatenková et al. (2004) a typical profile of a battered woman is possible to be created:

- materially dependent upon a partner,
- submissive and obedient,
- maintaining social contacts with low number of people,
- frequently justifying a man's behaviour by his mood or problems at work or by results of incidents he experienced in the childhood,
- with own feeling of powerlessness and worthlessness,
- with intensive sense of guilt and conviction that she deserved what had happened to her,
- thinking of the situation as of an impasse despite the fact she is not able to withstand the violence from a partner anymore,
- ashamed to talk about her experience and about the way a partner treats her,
- extreme emotional dependency on a partner.

Woman as a domestic violence victim

A specific phenomenon is domestic violence – occurring in intimate relationships among the immediate with an immense impact upon the entire family. As per Mühlpachr (2008) women are not abused or battered solely by their husbands yet at times by adolescent children namely by, but not limited to, sons even daughters. In this case battering involves burdening women with inappropriate requirements. Following younger children women are the most vulnerable family members who find it very difficult to resist the pressure of the surroundings to which biological constitution as well as so-called "learned powerlessness" being grown in women through still very influential patriarchal tradition contribute.

The main reasons for violence against women in the partnership relationships are both misuse of power from part of a partner and historically created and socially conditioned imbalance of power between men and women. Violence against women manifests itself in many forms. The most universally common instances cover physical violence (fight, kicking, strangling), psychological violence (emotional and verbal abuse, ridiculing, disparaging, outbursts of anger), sexual violence (rape, sexual abuse), economical violence (power abuse through disposition of financial means), and social violence (detention, prevention from coming into contact with family, friends).

The results of the aforementioned violence demonstrate themselves in the negative way both on the individual level of battered women (becoming ill due to a long-term physical and psychological stress, separation, loss of work and housing) and on the society-wide level (increase of the beaten and raped women healthcare costs or overall energy suppression and self-esteem undermining and health endangering hinder women from full participation in the life in society). (Crime Prevention Strategy, 2007).

Men endangering their partners dispose of similar psychological characteristics as fathers endangering their children do. Mühlpachr (2008) mentions the fact that battering of a woman represents an interaction matter: a woman may unconsciously provoke battering behaviour in a man and can be unaware of gaining a profit from being hurt. In such event disclosing psychotherapy focused on a woman's personal psychological problems might be promising.

In the year 2010 four hundred and thirty-two people received sentence for criminal offences related to violence against women out of which most cases referred to a close person battering (40%) and sexual abuse (43.5%). Data source on sexual harassment at workplace is represented by the outcomes of a selective research of working women performed in the course of the 2nd quarter of 2007 according to which 0.8% of working women was exposed to sexual harassment, mobbing or discrimination and 0.5% to violence or its threat at workplace (Statistical Office of the Slovak Republic, 2011).

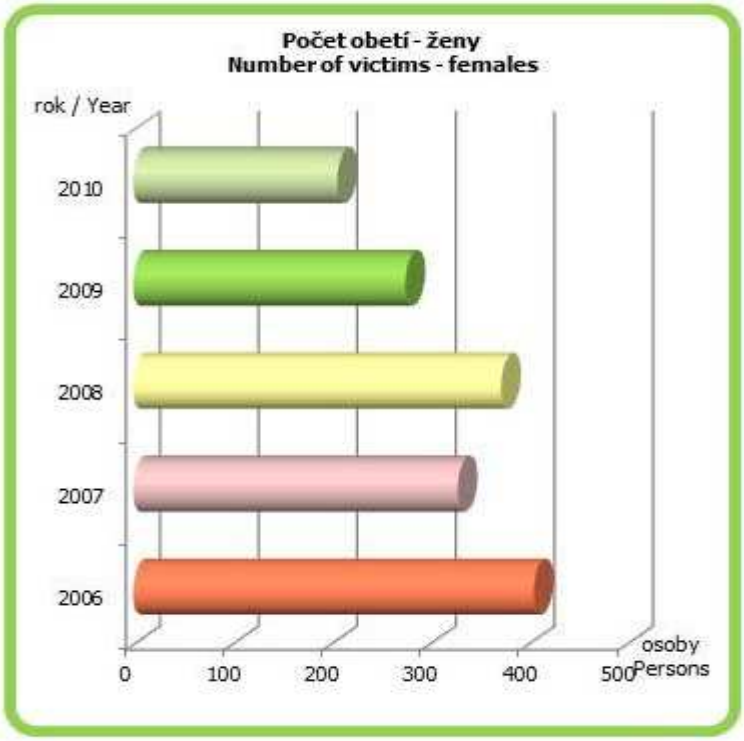


Figure 1: Number of victims – females
Source: The Ministry of Interior of the SR (2011)

Social assistance to battered woman

The chief presumption of effective assistance is to provide the women exposed to violence or to violence threat with diverse types of help and support. Within the frame of this sphere it is inevitable to generate available alternatives of living for women finding themselves in a crisis, to develop and to make accessible, in terms of geography, specialized advisory services including social, legal, and psychological counselling, to build information centres with appropriate security. The broad spectrum and multiplicity of the issue of violence against women presupposes engagement of experts from various fields. (Sejčová, 2010).

The assisting professionals should be mindful of the fact that many times a victim calling for help feels ashamed, humiliated, frightened or even responsible for the violence which they have become a target of. A victim needs support focused on restoring and building their inner strength up. They need to be reassured of not being alone, to be shown that a number of other women experienced the same and no reflections shall be cast on them for what happened. Eventually, conviction that the violence was not their fault is desirable to be evoked. Becoming a member of the self-help groups or groups of personal development conducted by a trained professional, i.e. welfare officer might represent substantial support for

a victim. (Matoušek, Kodymová, Koláčková, 2005). The solution of domestic violence against women is even divorce if a woman resolves to do so. As per Mühlpachr (2008) a battered woman should not be forced to get divorced yet they should be given a possibility to view their behaviour in relation to a man in a wider perspective and to make a free decision.

Within the frame of social assistance to the victims of domestic violence crisis intervention, social counselling, and social services are plausible to be distinguished. One of the most suitable forms of assistance to battered women is social counselling. Social counselling for battered women is a social counselling system developing at the fastest pace. This type of counselling is sheltered under the umbrella of non-governmental organizations which apart from direct social counselling aspire to legislative changes in this sphere, attempt to influence conventional attitudes of public opinion and to deepen perceptiveness of the issue by the involved professionals and broader community. (Gabura, 2005).

Except for counselling services within the frame of social service facilities or crisis centres, specialized advisory centres for battered women exist in Slovakia. Contrary to social service facilities with 24-hour operation these provide assistance and services through a daytime ambulant form. Important is to render consulting to women even in cases in which violence fails to reach a minimum of intensity of offences or crimes and who do not need any crisis accommodation. Within the frame of ÚPSVR (Central Office of Labour, Social Affairs and Family) Departments of Consulting and Psychological Services exist, the activities of which include consulting and therapy in cases of domestic violence. In the instances of domestic violence when women have nobody to turn to social assistance standards contain secured refuges represented in the international context by women's houses, asylum houses, intervention centres, shelters, crisis centres, and alike. At present, in Slovakia those are crisis centres (Section 31 of Act No. 305/2005 Coll. as subsequently amended), emergency housing facilities or even shelters (Section 26, 29 of Act No. 448/2008 Coll.). (Mátel, 2008).

In the states belonging to the European Union the issue of violence against women has not been elaborated on the equal level. Concerning the foreign experience with the follow-up action plans aimed at violence against women many countries have included or in the recent past included the issue in question within the frame of other complex plans. National action plans of the European countries of Denmark, Sweden, Germany, and Finland oriented towards the issue of violence against women besides assistance to the violence victims itself, and trainings of assisting professions and information distribution emphasize even the work with offenders. Some of these countries possess several continuation action plans focused on violence against women or on domestic violence. In principle, 4 spheres represent the essentials of their action plans – targeting at assistance to victims, working with offenders, education of assisting professions and spreading the knowledge on violence in the interest of prevention and change in attitudes towards violence.

National Action Plan for prevention and elimination of violence against women for the years 2009-2012 (hereinafter referred to as NAP) is a follow-up of operation objectives of National Strategy for prevention and elimination of violence against women and in families and develops these objectives in compliance with the latest facts and requirements of international documents and practice. NAP's tasks are chiefly formulated in the context of the preceding plan by particular provisions in the four formerly determined spheres while the sphere of science has been extended by the issues of statistical research and monitoring. In addition to the aforementioned the material has been amended by three extension spheres, i.e. education and sensitization of assisting professions, violence against women at workplace and work with offenders. (NAP, 2009-2012).

Conclusion

Domestic violence represents the most widespread form of abuse of women all over the world irrespective of their religion, culture, ethnic origin or education. The world statistics of UNO show that in the course of their life minimum one third of women has been beaten, experienced forced sexual intercourse or has been otherwise battered. The highest number of women being exposed to threat of domestic violence belong to lower social classes, in case of violence occurring "outside the home" the most jeopardized group includes younger women. According to researches up to one quarter of women does not talk about the situation to anyone, does not turn upon the police or other organizations providing assistance. In this point a space for multidisciplinary approach and collaboration of the individual institutions is generated to help battered women in terms of legislation, police, healthcare, psychology as well as institutions of state administration, self-government, non-governmental organizations and church. Domestic violence is a negative society-wide phenomenon not possible to be perceived as a private matter of an individual.

REFERENCES

ČÍRTKOVÁ, L. 2011. *Obete domáceho násli*a. [online] [citované 7.11.2011] dostupné na: http://www.help24.cz/index.php?page=clanky&view=obeti_domaciho_nasili
GABURA, J. 2005. *Sociálne poradenstvo*. Bratislava : Občianske združenie Sociálna práca, 2005. 222 s. ISBN 80-89185-10-X
KOLLÁROVA, A., HUČÍK, J. 2011. *Sociálna integrácia mladých dospelých z detských domovov.* Liptovský Ján: PROHU s. r. o., 2011. 90 s. ISBN 978-80-89535-02-6, EAN 9788089535026
LACA, S. 2011. *Základy sociálnej pedagogiky*. Bratislava : 2011, Beki desing, Vysoká škola zdravotníctva a sociálnej práce sv. Alžbety, s. 219, ISBN 978-80-8132-014-9
MÁTEL, A. 2008. *Poradenstvo ženám, ktoré zažili domáce násilie.* [online] [citované 7.11.2011] dostupné na:http://www.andrejmatel.info/Texty/Charita/Matel_Poradenstvo%20obetiam%20DN.pdf
MATOUŠEK, O. – KODYMOVÁ, P. – KOLÁČKOVÁ, J. 2005. *Sociální práce v praxi: specifika různych cílových skupin*. Praha : Portál, 2005. 352 s. ISBN 80-7367-002-X.
MPSVR: NÁRODNÝ AKČNÝ PLÁN NA PREVENCIU A ELIMINÁCIU NÁSILIA PÁCHANÉHO NA ŽENÁCH NA ROKY 2009-2012, [online] [citované 2.11.2011] dostupné na: http://www.rokovanie.sk/File.aspx/ViewDocumentHtml/Mater-Dokum-64141?prefixFile=m_
MÜHLPACHR, P. 2008. *Sociopatologie pro sociální pracovníky*. Brno: Vysoká škola zdravotníctva a sociálnej práce sv. Alžbety, Bratislava, Inštitút ďalšieho vzdelávania sociálnych pracovníkov, 2008. 165 s. ISBN 978-80-7392-069-2
SEJČOVÁ, Ľ. 2010. *Dieťa ako obeť násilia.* Bratislava:Album, 2010. 210 s. ISBN 978-80-969908-3-2
ŠPATENKOVÁ, N. a kol. 2004. *Krízová intervence pro praxi*. Praha : Grada Publishing, 2004. 197 s. ISBN 80-2470-586-9
STRATÉGIA PREVENCIE KRIMINALITY V SLOVENSKEJ REPUBLIKE NA ROKY 2007 – 2010. 2007. Bratislava: Rada vlády pre prevenciu kriminality.2007
ŠTATISTICKÝ ÚRAD SLOVENSKEJ REPUBLIKY. 2011. [online] [citované 5.12.2011] dostupné na: http://portal.statistics.sk/showdoc.do?docid=29766ň
TOMKOVÁ, E. 2011. *Násilie na ženách. Psychické následky.* [online] [citované 7.11.2011] dostupné na: http://www.bedekerzdravia.sk/?main=article&id=498
Zákon NR SR č. 305/2005 Z. z. o sociálno-právnej ochrane a sociálnej kuratele
Zákon NR SR č. 448/2008 Z. z. o sociálnych službách

Contact address:

PhDr. Alena Kollárová, PhD.
St. Elizabeth University College of Health and Social Work, Bratislava
kollarova.alena@gmail.com

The Necessity of Continuous Financial Education

[1] Marcela Paulovičová M., [2] Štefan Bugri

[1, 2] St. Elizabeth University of Healthcare and Social Work, Palackého 1, Bratislava,

---

ABSTRACT

This article deals with financial illiteracy and poor money management within families resulting from the absence of financial education. Firstly, it confronts issues leading to financial illiteracy in a broader context – history, influence and hidden causes behind financial illiteracy. Secondly, the author makes the case for establishment of proper financial education for broad strata of population and explains reasons why such actions have to be taken. Thirdly, the author tackles family influence on children's future financial behavior. Finally, this article includes a comprehensive list of causes and consequences of poor money management to support the necessity of implementing proper financial education.

Keywords: *financial illiteracy, poor money management, poverty trap, financial skills, financial education, financial training.*

In the today's atmosphere of recent major financial crises, I cannot help myself not taking a think about irresponsibility and recklessness in regard to financial issues. It is appalling that after decades of unprecedented steady economic growth, which are known in France as *the golden thirty years,* European countries are drowning in debts that they are unable to pay off. It is also grossly irresponsible not to build up reserves in good times that can help get one through bad times. In times of slowing economic growth it is namely difficult to repay money that was needlessly squandered in the past. If there are no back-up savings for a rainy day, situation in bad times might become very critical.

The fundamental question to rise is what has really caused that countries and individuals got caught in the debt trap. Was it irresponsibility, financial frivolousness or financial illiteracy? In this article, I do not want to write about governments' failures, but I would like to take a closer look on the topic of financial education among individuals.

In the past, the role of the state was narrowed down to oversight and regulation. Any striving in the field of financial education in the last 20 years has been thwarted by a massive consumption encouragement which served as a motor force of the nowadays consumer society. However, this is a very risky policy because according to sociologists and psychologists the people's appetite for purchasing is endless... It is inevitable that the state should take up the role of providing financial education to broad strata of population (children in schools, the youth, parents, all citizens in the productive age and the elderly) in order to improve their financial literacy that has been neglected for many years. Since no training can protect simple-minded people, there is also a need for establishment of mentoring and helping programs. It also goes without saying that building up a long-term co-operation with institutions, whose clients are mostly threatened by the debt trap (e.g. labor offices, associations of persons with disabilities, clubs for seniors, young families etc.), is vitally important for a successful implementation of financial education programs. In another words, there is a need for a broad, long-term enlightenment that has been missed for many years.

Information is not always equal to knowledge; hence, the value of education in schools and institutes should not be overestimated. Education might help get important information across, but in order to increase financial literacy an active individual approach of is needed. Financial literacy could be defined as a disposition of knowledge, skills and trust in oneself that is necessary for a responsible financial decision making. Thus, financial literacy is about responsible actions, active demeanors, decision taking, a proper orientation and flexibility, and these can be learned only in practical application of already gained theoretical knowledge in everyday life.

Because the family is the basic unit of society, I take the view that the first steps in financial education must be taken in a family. Children should learn in the family how to manage money properly and effectively. Parents represent with their behavior and actions a role model for their children, thereby knowingly or unknowingly form and educate their descendants. Advice from parents not backed up by feats is often frowned upon as sermonizing by their children and barely followed. On the contrary a personal example and daily agenda is the most valuable and most natural foundation that parents can give to their children. The children will be thankful to their parents and soon or later will appreciate their advice providing that it helps them find their true life values, the real value of money, learn to manage money properly and use the common sense by simple questioning and counting such as *what I have*, *how much I can spend* and *how much I should save up*. Financial literacy is not a rocket science – just simply mathematics. Following this approach, the next generation should be protected from overconsumption and running up huge debts, more resistant against aggressive advertisement creating false needs, and it also learns to understand and analyze upcoming events in a bigger connection and grasp. In other words, the next generation will be more resilient to a modern social disease of this age: affluenza which is characterized a disease of overconsumption.

Financial illiteracy poses a great threat not only to personal finance, but also to public finance and the economy of a country as such. Why? Because due to illiteracy people without financial education are more prone to make bad financial decisions which consequences might be ominous not only for them, but also for the whole society. Bad financial decision might cause high stress, work-related problems, or even destroy families which can result in one's inability to provide for basic needs. Such individuals often end up needing social care support which is financed from public funds.

Dolf de Roos, a real estate specialist, made a very wise and well-taken statement to this topic: "If you think that education is expensive, try ignorance". The more financially educated we are, the faster and easier we can recognize opportunities and threats. A great many companies and financial predators made namely a lucrative business from people's nescience and financial illiteracy. Therefore, the more financially educated we are, the easier it is for us to identify threats and swiftly avoid them, or if you like not to pass up a great life opportunity. To put it more simply, through financial education we learn to distinguish between good and bad ideas.

Thus, what are the most common bad habits, mistakes and decisions that can throw a person due to his or her own nescience and financial illiteracy into a poverty trap?

- Absence of basic mathematic skills;
- Absence of practical money skills;
- Absence of fundamental knowledge about civil law;

- Bad housekeeping habits and disregard for money;
- Wrong life values or no respect towards non-material and non-economic values;
- Financial frivolousness and nescience by managing one's wealth, eventually inability to protect oneself against financial frauds;
- Prodigality;
- Impulsive & compulsive shopping (mental disorders), shopping under time stress;
- Marginal propensity to consume and to run debts in different either evident, or hidden forms (e.g. consumer credit, credit card);
- Incompetence at distinguishing between "good debt" intended as an investment and "bad debt" meant for current consumption;
- Not reading information written on contracts (especially those written in small letters) by purchasing products (material or financial) and by signing a contract, for instance a contract on silent partnership or becoming a guarantor to someone etc.;
- Not asking questions by not fully understanding of contracts or ambiguity in contracts;
- Signing contracts in haste;
- Naïve reliance on advertisement other "trustworthy referrals" without making own checkups;
- Naïve reliance on employees of financial institutions whose best interest is to sell their products while any true financial advice might be secondary;
- Care-free trust in "well-meant advice" of one's acquaintances who have not been seen for years, but suddenly appear out of the blue to "help";
- No interest in becoming informed about financial issues and in becoming informed in one's professional field.

Consequences of insufficient financial education, poor money management and wrong financial decision can be seen in the list below:

- Little or no emergency savings;
- Little or no long-term savings;
- Absence of retirement savings and a high propensity to get trapped in the welfare system, consequently relying solely on claiming welfare benefits;
- Vulnerability of an individual and thereafter the whole economy system by various threats such as deterioration of the situation on the job market, real estate market, salary drop etc.;
- Vulnerability of an individual and families by sudden unexpected health problems, salary drop, loss of a breadwinner etc.;
- High indebtedness of households that borrowed too much or too expensive (their loans are burdened with high interest and penalty interest or any other dubious fees;
- Difficulties in loans repayments, consequently property execution and being on the brink of falling into poverty;
- Decrease of quality of life;
- Physical and mental health problems that hamper the ability to work and might even lead to invalidity;
- Family and marriage disintegration due to disagreements and disputes about money;
- Social exclusion.

As we will have seen, consequences might be very harsh and fatal. Therefore, we can conclude that the time dedicated to financial education and acquiring financial skills proves to be very well invested in the future and for this reason it is vitally important to make a plea to governments for taking actions in order to increase financial literacy among their citizen

REFERENCES

Dolf de Roos: Real Estate Riches, Wiley, 2004

Contact address:

Ing. Marcela Paulovičová
St. Elizabeth University of Healthcare and Social Work,
Palackého 1, Bratislava,
marcelle.marcelka@gmail.com

doc. Ing. Stefan Bugri, MPH, PhD.,
St. Elizabeth University of Healthcare and Social Work,
P.P. Gojdic, Institute of Social Sciences and Healthcare, Prešov,
bugri@usvaz.sk

THE INFLUENCE OF ENVIRONMENT ON SUSTENACE AND HEALTH OF THE ROMA IN SLOVAKIA

Zlata Ondrušová

St. Elizabeth University College of Health and Social Work. Bratislava

ABSTRACT

Roma population in Slovakia and in Europe represents isolated ethnic group with demographic, social and health specificities. Community of Roma belongs to the lowest level of education and economic status in Slovak society. Increasing of the population as well as the necessity to solve their problems holistically gains special importance. Nutritional factors and deficit of vitamins and other basic nutrients are closely related to social factors. Different ethnoculture, higher level of poverty, insufficient education, unemployment and problematic approach to a health care are generally known problems of Roma population in Europe. This contribution is devoted to the impact of environment on healthy life style of Roma population in Slovak Republic. The attention is focused on prevention and education of especially Roma women in accordance with their personal beliefs and traditions. Nutritional needs with emphasis on health problem of Roma children are discussed separately. Education is one of the basic preventive factors of poverty and vulnerability.

Key Words: Diet. Education. Environment. Ethnicity. Health. Hygiene. Illnesses. Life Style. Nutrition. Roma Community.

Basic idea in conception of human development speaks about broadening possibilities and opportunities for people to live a long and healthy life, importance of education and enjoy a certain appropriate level of material belongings. [3]

Today's progress and growth of economy is inextricably connected with population's good health, which anticipates further economic growth and sustainability of societal development. Good health of population is an outcome of simultaneous cooperation between many elements in society. Health has an irreplaceable status in lives of all humans. There are many factors constantly influencing people's health – determinants of demographical, biological, social, economical and medical nature. Population's health depends on intricate unison of genetic predispositions, economic and psycho-social conditions, sustenance and lifestyle along with the quality of health care and services, surroundings and work environment. There is mutual binding between all of the upper mentioned factors. In today's world we come across many serious health issues which are increased by occurrence of new types of illnesses – often caused by decreasing quality of environment. Rather big differences can be clearly seen in disposition of diseases and death causation diseases worldwide. The differences are most obvious between economically developed regions of the world (e.g. Europe, North America, and Australia), where civilization diseases emerging from a certain type of lifestyle are predominant, contrasting the less developed regions (e.g. Africa, parts of Asia), where most diseases are a consequence of malnutrition, infection and parasites.[4]

Well-balanced diet and dietary habits are basal essence of healthy lifestyle. Preserving and ensuring of quality potable water, heat processing, cold storage and canning of victuals,

[3] NÁRODNÁ SPRÁVA o ľudskom rozvoji SR. 2002.
[4] Health Promotion Program. 2007

packaging, manipulation and distribution of goods are among most important attributes of such lifestyle. When trying to prevent alimentary contagions, right manipulation with waste is important together with the disposal of faeces and litter, including remains of food. Also, treatment of sewage, germicide, disinfection, disinfestations, deratization and at last of course, complex health education of the population are all absolutely necessary.

Health promotion program that is being carried from 2007 to 2015 says, there is increasing tendency in differences between certain regions; common population and disadvantaged groups of people; that are reflected in inequality in health (in approach to prevention, to health care), inequality in consumption and lifestyle (inequality of life chances), status inequality, inequality in skilfulness and abilities on labour market, inequality in education and in approach to education, inequality in division of power and also income inequality. These types of inequality may be seen in each European country and developed states. Despite vast intervention precautions, there is an increasing tendency in occurrence of such inequalities and they prove to have significant influence on health. The efforts in reducing inequalities in health are primarily focused on strategic support of health care and health policies concerning most endangered groups of population (vulnerable groups).[5]

Demonstrably, in the Slovak Republic, it is groups of people living segregated in separated Roma settlements – groups that are rather disadvantaged in this country, whose health is most endangered. Roma live almost all around the world (approximately 8 – 12 mil. from which 7 – 9 mil. are in Europe) and their position is immensely complicated. In Europe, the biggest number of Roma may be found in Romania – 2.5 mil., Spain – 650 000, Hungary – 600 000, Bulgaria – 500 000, Slovak Republic – 400 000 and Czech Republic – 300 000. Low income, deficient education, high rate of unemployment, bad health conditions and overall disturbed environment are the cause of poverty and also exclude the inhabitants of the settlements from socially accepted minimal standard of living. Health of the Roma community is, and always was closely connected to its position in society and the observance of customs and traditions, which are reflected also in the approach to health prevention. Health becomes important only after evident symptoms of an illness or a disease are present. Woman is the caretaker for the family when it comes to health issues and this fact often makes it impossible for her to be a patient and to care about her own health. Health conditions are influenced by Roma lifestyle, part of which is, of course, sustenance, nutriment factors and deficiency of vitamins and other basic aliments. The history of Roma ethnic is marked by several substantial facts that reflect immediate impact on today's lifestyle and comportment of Roma, such as: Indian origin (language similarity), customs and traditions, nomadic way of life, holocaust of Roma during the Second World War, and also the Act No. 74/1958 on Permanent Settling of Nomadic Tribes[6]

Cradle of the Roma is India, more specifically the region of today's Panjabi. The Roma left India in the 4th century A.D. and came to territory of the Slovak Republic around 13th century as a nomadic tribe. As immigrants, they were reliant on mercy of the locals, who had let them set up settlements; however they had to isolate these settlements from the others. The Roma made their living as musicians, blacksmiths, craftsmen or mercenary soldiers.

Currently, there is approximately 400 000 Roma living in Slovakia, representing 6 – 7% of total number of population. Approximately half of the Roma population live in settlements, with prevalence of low level of health consciousness, high rate of health damaging behaviour, mirrored in poor quality of health conditions and lower mortality age. Roma population is heterogeneous and requires different approaches. When evaluating their health and social issues, differentiation of approach is also needed.

[5] TRÁVNIČKOVÁ, A. Vplyv výživy na zdravie dojčiat v rómskej komunite. 2010. 35 s.
[6] VILÍNOVÁ, K. Vybrané problémy zdravotného stavu obyvateľstva sveta a Slovenska. 2009. 10 s.

Based on societal integration, the Roma may be put in three basic groups: fully integrated – 20%, partly integrated 40%, and non-integrated – 20%. Majority of problems is connected with the non-integrated and partly integrated Roma.[7]

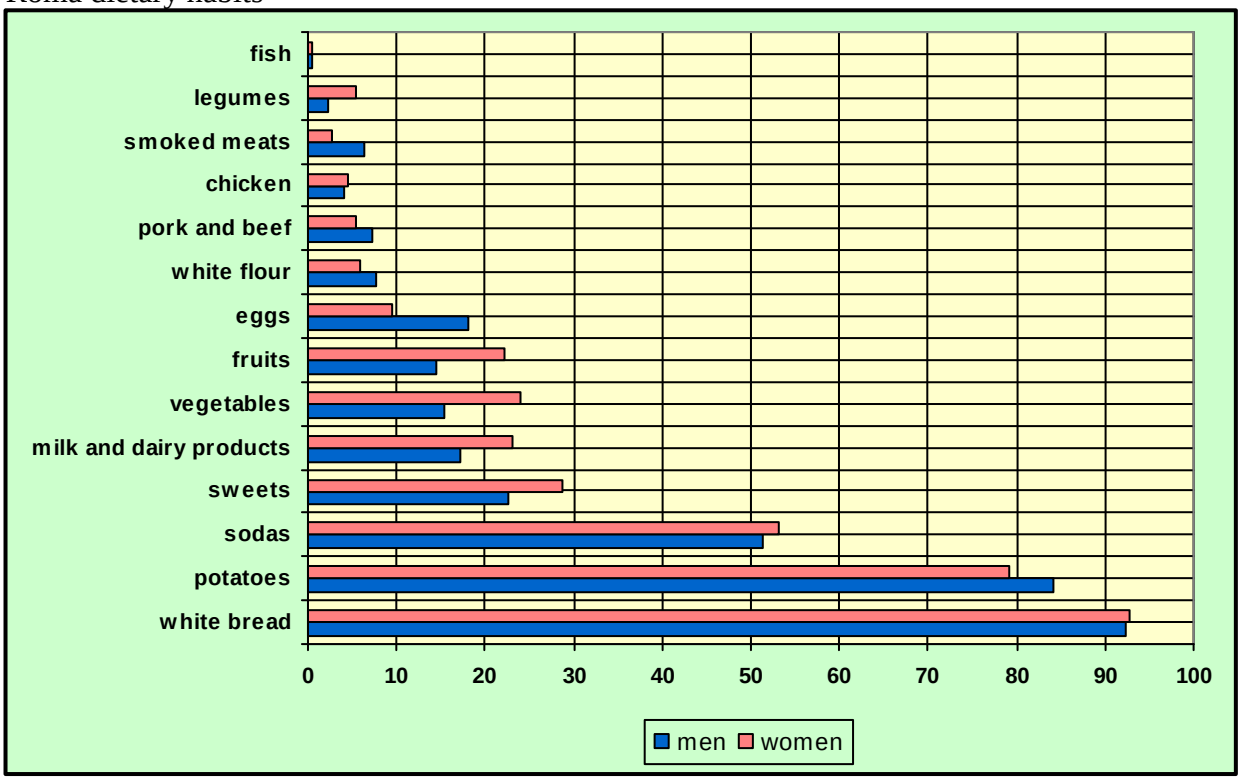
Population curve of the Roma is increasing. It is likely that approximately 520 000 Roma will live in the Slovak Republic in 2025; which represents the population growth of roughly 140 000 people (37%). Percentage of the Roma in the population of the Slovak Republic would thus increase from present 7.2% to 9.6% (in 2025). After 2015, long-range decrease of Roma population growth is anticipated.[8]

When studying health of the Roma ethnic, conditions are sometimes problematic due to socially and culturally distinct way of life and impossibility to collect data based on ethnical allegiance. Thus, comparing to the majority population of the Slovak Republic, Roma health conditions are not surveyed in such detail. According to domestic and foreign surveys, health conditions of Roma are worse compared to the majority population. Also, medium-length of life, according to demographic data, is much shorter in Roma ethnic than in the majority population. The difference is 7.5 year for men and 6.6 year for women. This difference depends on the extent of integration of the Roma. While more recent researches say the difference is smaller, health records show up to 10 years difference in the length of life of the Roma compared to majority population. Human life is qualified as highly risky when concerning health condition.

Nowadays, typical diet of the Roma is characterized by deficient consumption of dairy products, vegetables, fruits or low-quality white flour baked goods in opposition to often excessive consumption of alcoholic beverages, cigarettes and salt. Shacks in settlements are overcrowded, with lack of quality potable water – up to 42.5% of settlement inhabitants use water from unrefined sources. Approximately 77% of settlement inhabitants live without sewerage system or cesspits. Also high extent of unsorted waste which decays fast and might pollute the surroundings of settlements is always a problem.[9]

[7] TRÁVNIČKOVÁ, A. Vplyv výživy na zdravie dojčiat v rómskej komunite. 2010. 35 s.
[8] BEHARKOVÁ, N. Podmienenosť postojov rómskeho etnika k zdraviu a chorobe. 2009. s. 264-269.
[9] GONDÁŠOVÁ, I. Zdravie rómskych žien v osadách a možnosti zlepšenia. 2008. JURIŠ, P. a kol. Infektológia a vyšetrovacie metódy vo verejnom zdravotníctve. 2009. 115 s.

Roma dietary habits



Source: Public Health Authority of the Slovak republic. 2008

Health conditions are jeopardised by unsuitable lifestyle and environment the Roma live in together with high rate of addiction to alcohol and drug abuse. More than 58% of Roma smoke – men more than women. Researching dietary habits of the Roma, results show irregular times of consuming meals and prevalence of consuming unbalanced nourishment. Situation with water sources is neglected; settlements have no sewerage systems, garbage disposal (or at least rubbish dumps). Personal hygiene is on a very low level along with hygiene of the overall environment. One of the factors influencing the health conditions is problematic involvement of the parents in compulsory children's vaccination program. This is caused by higher migration of the Roma to foreign countries, lack of discipline and awareness from the side of the parents. Insufficient caring about children and low level of basic hygiene also contributes to higher rate of mortality in young age.[10]

"Person is born healthy. Illnesses come in with the food we consume", said Hippocrates already in 4th century B.C. Folk wisdom says: "A healthy child is the most precious gift". And really, we often encounter situations, in which a healthy child develops serious health problems due to unsuitable care of the parents and may carry the consequences of these problems for all his life. Most often it is allergies, eczema, respiratory problems, dysmicrobia, and anaemia, chronic malfunction of a digestive system, etc. Many serious diseases appearing in adult life have their roots in early childhood. There are several reasons for this fact. Often it is lack of awareness from the side of the parents and their lack of knowledge. In other cases, addictions drive parents away from caring about their offspring. Either way, a suffering child is the outcome. Children from Roma communities are frequently in such situations. Sickness rate of Roma children is very high; they are often hospitalized and overmedicated with antibiotics which cause further immunity weakening of a young organism. Unbalanced diet also contributes to development of diseases and slows down both

[10] JURIŠ, P. a kol. Infektológia a vyšetrovacie metódy vo verejnom zdravotníctve. 2009. 115 s.

– psychological and physical development of a child.[11]

Well-balanced diet represents a set of physiological and biochemical processes which human organism needs for its right functioning. Biologically good food covers physiological needs of a human in proportion to his environmental conditions (age, sex, occupation, physiological state). It should contain all nutrients our organism might need in sufficient quantity and optimized proportions. Sustenance not only conditions the existence of life, but also determines its quality. Amount, composition and conditions of sustenance have direct impact not only on health but also on person's productivity and performance and immunity to avoid civilization diseases, considerable is also the impact on reproduction and preservation of optimal mental and physical capacities from early childhood to old age. Diversity and alternation of sustenance is always given by physio-biological needs and, of course, socio-economical, psychological-social aspects, level of education, ethnical and religious rules, regional traditions or personal preference of certain foods. Government carried Health Promotion Program considers well-balanced diet and proper dietary habits to be the basic stone of healthy life. Consuming certain types of nutrients influences occurrence and development of most common infectious diseases.[12]

Certain diseases may only be cured after change of diet. Ideal and the only right composition of sustenance do not exist as notions on nourishment are constantly developing. Importance of healthy diet is often underestimated. Dietary habits are part of a lifestyle and they have significant influence on present health conditions of the Roma living in settlements. Their diversity and alternation are given by traditions, culture, geography and several other factors. Nutrients needed for growth and development of human organism come from the outside environment. Sustenance, one of the outside environment factors, greatly determines functionalities of the organism and natural balance between intake and outtake represent a precondition for its normal physiological functioning.

For Roma ethnic, a woman is valued and earns her societal status via children (and their number). Belief in the societal status of a fertile woman with many children plays its role in influencing many pregnancies during woman's fertile years. Thus it is important for governmental, non-governmental and international institutions to focus on structuring a strategy for long-term solution of minimizing risk factors such as: mothers ages under 18 years old, drug and alcohol abuse, insufficient weigh gain of a pregnant woman and also factors, such as: education, unemployment, living in settlements.[13]

Precautions in Roma communities in the Slovak Republic:

- National Action Plan for Roma (education, employment, health care, housing), national policy in sphere of education – tries to establish at least one year compulsory pre-school education by providing free pre-schools where children get a hot meal, milk and a financial contribution on clothing
- Basic universal social and health prevention with respects to distinctivness of Roma minority (distinct origin, mentality, culture)
- Selective and indicated social prevention thanks to Field social work
- University education in social work at St. Elizabeth University College of Health and Social Work in Bratislava – regional department of Hallow Z. G. Mall in Košice (app. 200 Roma and 400 social workers for field social work in Roma communities); and education in nursing – regional department of St. Barbora in Rožňava (Roma nurses)
- Pastors
- Specialized programs (care of Roma families, elimination of language barrier, health

[11] ONDRUŠOVÁ, Z. Základy sociálnej práce. 2009. 139 s.
[12] NOVÁKOVÁ, J. – KRÁĽOVÁ, V. Hodnotiaca správa o výsledkoch I. etapy Programu podpory zdravia znevýhodnenej rómskej komunity za roky 2007 a 2008. 2009. s. 248-251.
[13] PODPORA ZDRAVIA RÓMSKYCH ŽIEN. 2009.

promotion programs, etc.)
- Media – interviews, discussions

Roma lifestyle has a negative impact on their health and endangeres them as a community. Many countries deal with issues connected to the Roma communities, it is an international interest to help, which is only possible with active participation of the Roma in society. By forcedly promoting changes, it is unlikely to arise interest in Roma community; more likely it would bring an entirely opposite reaction. Positive changes may be reached only by mutual respect and cooperation, for benefits of the Roma communities and the society as a whole.

REFERENCES

BEHARKOVÁ, N. Podmienenosť postojov rómskeho etnika k zdraviu a chorobe. In Zborník vedeckých prác. Životné podmienky a zdravie. Bratislava. 2009. s. 264-269. ISBN 978-80-7159-173-3

GONDÁŠOVÁ, I. Zdravie rómskych žien v osadách a možnosti zlepšenia. In Revue ošetrovateľstva, sociálnej práce a laboratórnych metodík. Ročník XIV. Číslo 1/2008. ISSN 1335-5090

JURIŠ, P. a kol. Infektológia a vyšetrovacie metódy vo verejnom zdravotníctve. Košice. 2009. 115 s. ISBN 978-80-89082-17-9

NÁRODNÁ SPRÁVA o ľudskom rozvoji Slovenská republika 2002. Centrum pre hospodársky rozvoj. Bratislava. 2002. [citované 27.11.2009] Available at http:/www.cphr.sk/undp2002.htm

NOVÁKOVÁ, J. – KRÁĽOVÁ, V. Hodnotiaca správa o výsledkoch I. epaty Programu podpory zdravia znevýhodnenej rómskej komunity za roky 2007 a 2008. UVZ. Bratislava. 2009. s. 248-251. ISBN 978-80-7159-173-3

ONDRUŠOVÁ, Z. Základy sociálnej práce. MSD Brno. 2009. 139 s. ISBN 978-80-7392-109-5

PODPORA ZDRAVIA RÓMSKYCH ŽIEN. Nadácia otvorenej spoločnosti. Bratislava. 2009. Available at http://www.osf.sk

PROGRAM PODPORY ZDRAVIA znevýhodnených komunít na Slovensku I. etapa Rómskej komunity na roky 2007-8. Ministerstvo zdravotníctva SR. 2007

TRÁVNIČKOVÁ, A. Vplyv výživy na zdravie dojčiat v rómskej komunite. Záverečná práca VŠZaSP sv. Alžbety. Bratislava. 2010. 35 s.

VILÍNOVÁ, K. Vybrané problémy zdravotného stavu obyvateľstva sveta a Slovenska. 10 s. [quoted 01.9.2009]. Available at http://dam.fpv.ukf.sk/mod/resource

Contact address:

Zlata ONDRUŠOVÁ, PhDr., PhD.
St. Elizabeth University College of Health and Social Work in Bratislava
P.O.Box 104
810 00 Bratislava, SLOVAKIA
zlatica.ondrusova@vssvalzbety.sk

THE PRIORITIES OF THE DOCTOR'S COMMUNICATION FROM THE PARENT'S POINT OF VIEW

[1]Šárka Tomová, [2]Aneta Árpová

[1] Charles University of Prague, Department of pedagogy

[2] ST. Elizabeth University College of Healt and social work Bratislava, Slovakia

ABSTRACT

In this article authors focus on the theme of parental perception of the communication among doctor and patient, primary factors, which influence this mutual interaction. Based on the investigation made among the parents and children with Rett syndrome, the authors determinate the basic factors, which came of the respondent's answers and became the priorities in mutual contact. The part of watching the quality of the medical and nurse care is not only the communication on the doctor X patient level, but necessary part is mainly the communication on the doctor X parent level in the nurse care with the children. In common with this contact rise the bounds, which can positively affect the next evolution of the cooperation, which is nowadays characterized as a partner's cooperation. Rarely occurred paternalism in medicine is slowly fading and parent is percept as co-deciding part in the choice of therapy of the children.

Key words: Empathy; Communication; Skill; Parents; Understanding; Helpfulness

Introduction

Social interaction is defined as basic way of social behaviour, feeling, cognition and self-cognition, communication and mutual act of 2 people in minimum. For needs of this article we will focus on the communication as the solution of social contact. Communication in all ways of social life, but mainly in medical care is a topic, which is still the priority of lay and skilled public. The level of the communication is a part of the investigation of the quality of the care in the medical facilities. Not for nothing are some questions in interrogations of patient's satisfaction with nurse acre in the exist facility dedicated to the patient's point of view on the communication among the members of the nurse team, patient's informedness about the course of the treatments, understand ability of the information, correctly chosen language etc. (Rating of hospitals, Health Care Institute, 2011) This interest is connected also with the change of doctor's role and his access to a patient for last decades. Paternalistic access and its main characteristic sign- an absolutistic power over the patient, changes into a partner's access. It's applied not only in relationship to the patient, but also to the patient's parents. The proof is point 3 §3 of the Doctor's ethical codex, which says, that doctors should give up the paternal positions in attitudes to the patients and respect them as the equal partners with all their rights and obligations, inclusive of the responsibility of his life (Věstník ČLK, 2006).

The possibilities of self-deciding are from the law's point of view with a child patient much more lower than with an adult patient, the deciding is mostly inferior to the medicals and parents. Child at a school age is often influenced by the contemporary opinions. Suitable

access of the medicals to the child's parents has the main meaning for observing the medical regime and understanding of the child's disease (Mareš, Vachková, 2010).
Thanks to the entrance of patient (parent) to the doctor's surgery during the immediate meeting with the doctor starts to create the social-psychological atmosphere, the quality of relationship (Zacharová, 2007, p.82). There's plenty of factors, which have the primary affection to the level of the quality, beginning with the ambient, colour harmony of interior, length of waiting time in the waiting room, the atmosphere of mutual relationships, helpfulness and behavior of medicals before the entrance to the surgery. Parents entering to the contact and the interaction with doctor, does not need only a fulfil and understanding, but also the social support. Křivohlavý reports 2 levels of the interaction among patient and doctor:

- Professional level – use of somatic medicine angle
- Social, psychosocial level – sometimes called humane; the point is the understanding that among patient and doctor is in progress much more than it's presented in medical learning books

This model can be used in the interaction – doctor X patient. However, we can define 2 basic styles in the doctor's access. The first group are doctors oriented on patients. Second group represent doctors, who focus on the examination and therapy. Doctor, who focus on gaining the information from anamnesis, it's analysis, defining, the interpretation and planning in the following steps, is the way, which leads to medical accuracy, but there is not enough place for "human" understanding to the patient. This style is not surprising, because it is a way, which leads the doctors, who are more intent of patient's fear, problems, questions, feelings, hope and expectation than exact inconvenience. This access seems more comfortable at the beginning from the patient's point of view. In profession, we are in contact with, doctor, whose style lies somewhere between these 2 levels, in ideal example it is more resemble to one of them. It all depends on actual needs of patient and the present situation (Tate, 2005).
Professor J. Křivohlavý in his book Psychology if the disease rates the relationship among the doctor and his patient from the angle of patient's addiction level to the doctor. In this relationship the doctor becomes the mentor, tutor, monitor and teacher. This access can be applied also in the contact with the parents of patient. The role of teacher explains as doctor's access, which teaches the patient how to prevent the health inconvenience, patient should respect the orders and perform them. The role of mentor is described as a role, when doctor is a friend, also teaches how to behave. The role of the tutor means the more straight access to the patient, it is based on the patient's training in the right habits. The role of monitor is understood as a role, when doctor warns the patient of mistakes, he is an advisor, watching his charge and he is always available (Křivohlavý, 2002).
"It exists many of jobs, whose main content is helping people: doctors, nurses, pedagogues, social workers, health visitors, psychologists. Same as other jobs, every of these jobs has its own skill. The difference is the big attention on the next element – human relationship among the helping professional and his client. Patient needs to trust his doctor..." (Kopřiva, 2006, p.14)
According to the ways of medical's behaviour to the parents of little kids, K. Kopřiva defines four types of medical intervention – instructions, comments, asking questions and resonance. Instruction is a direct way of intervention. It has a recommendatory, advising, ordering or prohibitive form. However, medical assistant gives an introduction how to act in definite situation. Advice has to be exact and personal, because it needs to be helpful in the hard situation. The comments are less directive. The medical assistant answers to the patient's problem in his own opinion with his standpoint leading towards the new connections with a problem. This access gives to parents the possibility of clearance or specifying some

information. The comments does not contain the instructions how to behave, because it contains only the description of the situation. Asking the questions provides the next intervention, whose task is enable a different angle to a patient, evocate new minds, ideas. The difficulty in this way of intervention is the effective asking the understandable questions, which has to be learned if it has some meaning for the effectiveness. The last type of the intervention is the resonance, which comes from the humane psychology. In this situation are mirrored the words of medical assistant said to the patient. This "mirror progress", whose principle is temporary repeating of the meaning of said things (halo), is what patient says. Medical assistant shows by that, that he hears and understands the patient's shared feelings and information (Kopřiva, 2006). Information above create the basic structure in the doctor's access to the parents of the patient. From able sources, which deals with these problems follows, that giving the information by doctor is the main factor for parents. The way of sharing the information with parents is sometimes more important than main contents of the sharing. There are some introductions, which should be observed in dealing with the parents.

The conditions of communication with the parents

- Choice of suitable place
- Sufficient room of time
- Presence of other family member
- Empathic, sensitive access
- Understanding, clearance
- Repeating the information
- Patience
- Avoid the sympathy and antipathy
- Avoid the "halo effect"
- Confess, if we do not know the answer
- Plan of following care

The goal of interrogation

We presupposed that the basic rules of the communication among a doctor and a patient are respected and observed. We were interested how parents rate their communication with the doctors and what is the priority of their point of view in the present interaction.

The Research set and methodology

We did this interrogation among the parents, whose children have got a Rett syndrome (this syndrome is characterised by slow and abnormal evolution of apparently healthy born girls; between 6^{th} and 18^{th} month of life the evolution stops and the regression appears, the perimeter of a skull becomes bigger; a muscle tonus and the ability of moving reduce; the girls do not walk and the progress of speech stops (Vokurka, 2009, p.905)) In the interrogation have participated 72 respondents. The respondents had to complete the 6-level pyramid, whose point was marked as the most important factor in the communication with a doctor. The base was presented by the least important factor in the interaction. Those factors were not formulated before for the existence of truthful parent's answers.

The results of the interrogation

The resulting investigation is in the chart below. For clearance we show only the succession on the first two places. Other factors are relevant.

CHART 1 **First places of the factors**

Succession	Absolute frequency n_i	Relative frequency(%) f_i
First place		
Empathy	32	44,44
Listening	11	15,28
Skill	10	13,89
Ability of explaining	9	12,50
First impression	6	8,33
Room of time	2	2,78
Ambient	2	2,78
Sum	*∑ =72*	*∑=100%*

DIAGRAM 1 **First places of the factors**

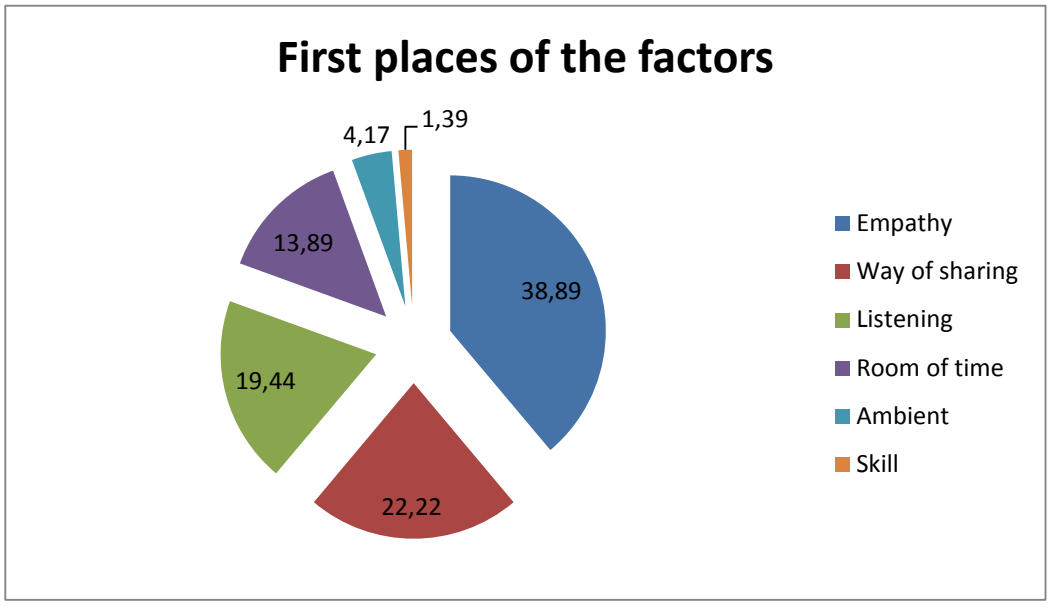
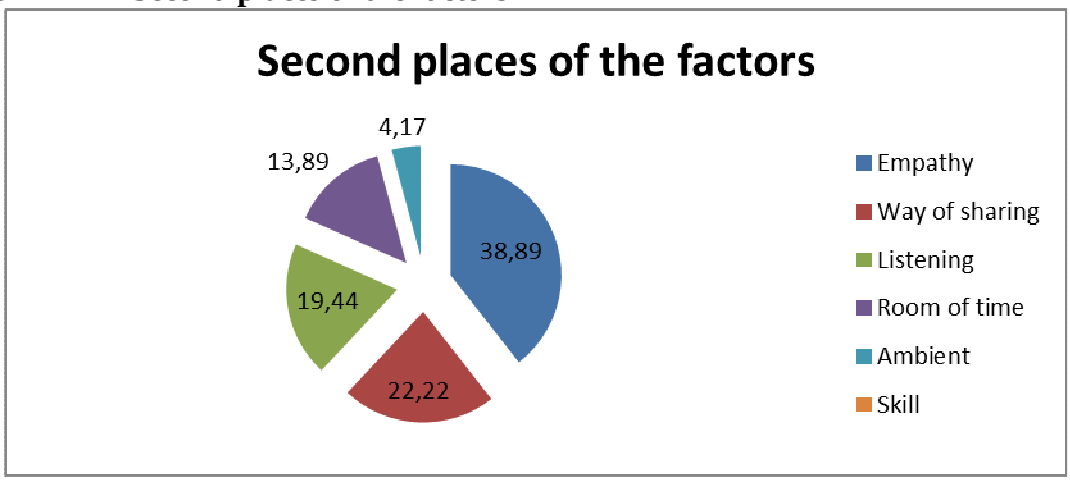


CHART 2 **Second places of the factors**

Succession	Absolute frequency n_i	Relative frequency (%) f_i
Empathy	28	38,89
Way of sharing	16	22,22
Listening	14	19,44
Room of time	10	13,89
Ambient	3	4,17
Skill	1	1,39
Sum.	∑=72	∑=100%

DIAGRAM 2 **Second places of the factors**



The discussion

From the interrogations clearly follows, that parents appreciate the doctor's empathy, as the most important factor in a mutual interaction. Empathy is the basic requirement not only for helping professions, but it has its own place in an everyday social life. For the first position it was chosen by 44.44% of parents. It is described as one of the communication skill not only in a medical service, but in a normal life of everyone of us. The ability of empathise with the other person's emotions or behaviour is required in all medical professions, because with the medical assistants are people in contact during the stressful situations of unknowing the future, psychological tension of waiting for the results of examination or therapy and more. As the second mostly chosen factor, which plays an important role in a mutual understanding, is the ability of listening (15.28%), Explanation, room of time, suitable place are the requirements, which equal the global conditions of the communication in a nurse care. A topic to think of is also the factor of the "doctor's skill" (13.89%), which parents chose on the first place. It is probable that it is a whole belief in a doctor's act, which creates the base of a partner access in a following nurse care. Surprisingly, we found out that 45% of respondents did not fill in all of 6 levels in the pyramid and they have filled in only first two places and the last one. The middle section of the pyramid was obviously hardest to think of and defining the next factors situated there. From the psychological point of view is the easiest defining the two outer factors and the hardest are the middle ones.

Conclusion

The willingness of medical assistants in the participation in the problems of the patient's family does not mean that it is their duty. The duty is suitable, sensitive way of acting and behaviour to the child, his parents and relatives. How it is mentioned in the part 2 §3 of the Doctor's ethical codex: "Doctor behaves to the patient correctly, with an understanding and patience. He does not decrease to the rude and gross behaviour. He takes regards to the patient's rights." (Věstník ČLK, 2006)

REFERENCES

GODOVÁ, D. ONDRUŠOVÁ, Z. 2008. Psychické obranné mechanizmy a ich význam v interakcii s pacientom/klientom. Odborný časopis MZ SR a SZU v Bratislave. Ošetrovateľský Obzor 2008. s. 71- 73. ISSN 1336-5606
BUJDOVÁ, N., DANCÁK, F. 2011. Služba v láske. Bratislava, VŠZaSP sv. Alžbety, 2011. 69 s. ISBN 97-80-8132-003-3
KOPŘIVA, K. *Lidský vztah jako součást profese*. 5.vyd. Praha: Portál, 2006, 147s. ISBN 80-7367-181-6
KŘIVOHLAVÝ, J. *Psychologie nemoci*. 1.vyd. Praha: Grada, 2002, 198s. ISBN 80-247-0179-0
MAREŠ, J., VACHKOVÁ, E. a kol. *Pacientovo pojetí nemoci II.* 1.vyd. Brno: MSD, 2010, 103s. ISBN 978-80-7392-150-7
MÁTEL, A., SCHAVEL, M. a kol. 2011. Aplikovaná sociálna patológia. Bratislava, VŠZaSP sv. Alžbety, 2011. 441 s. ISBN 978-80-8132-009-5
ONDRUŠOVÁ, Z. a kol. 2010. Základy sociálnej práce pre pomáhajúce profesie. Bratislava, VŠZaSP sv. Alžbety, 2010. 189 s. ISBN 978-80-89392-21-6.
TATE, P. *Komunikace pro lékaře*. 1.vyd. Praha: Grada, 2005, 164s. ISBN 80-247-0911-2
VALLOVÁ, J., ONDRUŠOVÁ, Z. 2008. Etika v zdravotníctve a význam etického kódexu zdravotníckeho pracovníka. Odborný časopis MZ SR a SZU. Ošetrovateľský obzor. Ročník 5/2008. Vyd. HERBA spol. s r.o. Bratislava. 2008. s.107-108. ISSN 1336-5606.
VOKURKA, M., HUGO, J. *Velký lékařský slovník*. 9. vyd. Praha: Maxdorf, 2009, 1160s. ISBN 978-7345-202-5
ZACHAROVÁ, E., HERMANOVÁ, M.,ŠRÁMKOVÁ, J. *Zdravotnická psychologie: teorie a praktická cvičení.* 1.vyd. Praha: Grada, 2007, 229s. ISBN 978-80-247-2068-5
Etický kodex české lékařské komory dostupný na:
http://www.lkcr.cz/document3.php?param=dokumenty_file,DOKUMENTY_FILE_ID,,TYPE NAME,DATE_AKT&id=81922

Contact address:

PhDr. Šárka Tomová
Institute nursing
Charles University of Prague 2. LF a FN Motol
V Úvalu 84
156 00 Praha 5 Motol
Czech republic

PhDr. Anna Árpová
ST. Elizabeth University College
of Healt and social work Bratislava
Department of Social Work
Palackého 1
811 01 Bratislava
Slovak republic

INSTRUCTIONS FOR AUTHORS

Allow me to introduce a new expert journal – Clinical Social Work. We would like to offer you an opportunity to contribute to its content as we would like to aspire to create a collection of real experiences of social workers, doctors, missionaries, teachers, etc. CWS Journal is published by the International Scientific Group of Applied Preventive Medicine I-GAP in Vienna, Austria.

The journal is to be published quarterly and only in English language as it will be distributed in various foreign countries.

We prefer to use the term 'clinical social work' rather than social work even though it is less common. In the profession of clinical social work, there clearly is some tension coming from unclear definitions of competence of social workers and their role in the lives of the clients; the position of social work in the structures of scientific disciplines especially in cases where people declare themselves to be professionals even though they have no professional educational background. These are only few of the topics we would like to discuss in the CWS Journal.

Your contribution should fit into the following structure:
1. Editorial
2. Interview, Case Reports
3. Review
4. Original article
5. Letters

Instructions for contributors:

All articles must be in accordance with the current language standards in English, current ISO and the law on copyrights and rights related to copyrights.

Your contributions are to be sent via e-mail (addressed to: michalolah@gmail.com) as an attachment or on a CD via regular postal service. In both cases written and saved in MS Word (no older version than year 2000).
Style Sheet Requirements:
Maximum length: 3500 words
Letter type: Times New Roman
Letter size: 12
Lining: 1

All articles must include:
Name of the article and author's address in English
Article abstract of 150 words in English
Brief professional CV of the author (100 words)
Publishing languages: English, German

Each article contains:
1. Name of the article and author's address in English
2. Abstract in English, which consists of at most 150 words
3. Short CV of the author in English, which consists of at most 100 words
4. Text of the article consisting of at most 3500 words

Each article must be an original never published before. When using references, parts of other articles or publications it is inevitable to quote them and provide information about the source.

We reserve the right to formally edit and reduce the text if needed. Academic articles undergo an anonymous critique. Each author will receive a prior statement of publishing his/her article.
When writing a review it is necessary to attach a copy of the cover of the book.

Thank you for your cooperation

Yours sincerely

Michal Oláh, Ph.D.
Edition of journal

ABSTRACTS OF THE 1-RD CONFERENCE CURRENT ISSUES IN SOCIAL WORK, BARDEJOV 15.12.2011

ECONOMIC CRISIS, UNEMPLOYMENT AND ITS IMPACT ON THE MINIMUM WAGE IN THE SLOVAK REPUBLIC

[1]Štefan Bugri, [2]Emília Pribišová

**Institute of Social Sciences and Health of Bl. P. P. Gojdic in Presov,
teachers in the study of social work**

Introduction: The economic crisis has reached a global scale, struck many countries around the world. Its impact is felt in almost every area of our lives. One of the most serious economic crisis is increasing unemployment. Many countries have experienced a rise in unemployment, including Slovakia. With the increasing trend of unemployment is closely related to the obligation to work only for the minimum wage. What is the relationship between minimum wage and the average monthly in Slovakia?

Main part: With the notion that the economic crisis comes, wonders how it hits ordinary people. One of the most important is that it probably affects many people and reduce their standard of living. The current economic crisis is significantly associated with unemployment. More and more people are unemployed, particularly in the region around Prešov and Košice in Slovakia. What is the possibility of finding work and employment? Does the state create sufficient space to creating new jobs? As unemployment is currently rising trend, everyone who has access to employment, accepts all the conditions imposed by the employer. Even agrees with the fact that he worked "only" the minimum wage. How can we influence this and bring wages about 60% of the population to the average wage? It is probably very difficult to answer.

Conclusion: Economic crisis is very difficult not only economic but also social problem. If we were to propose means and methods of dealing with unemployment, without government help, which has the greatest impact on job creation, it is not possible. Individually creation of the new jobs, mainly because of SZCO, is not a comprehensive solution to unemployment.

REFERENCES

SAMUELSON, P. A. - NORDHAUS, W.D.: Economics. II. works. Bratislava : Bradlo. The 1992nd, ISBN 80-7127-031-8.
MARES, P.: Unemployment as a social problem. Prague 1994. ISBN 80-901424-9-4.

The first author contact:

doc. Ing. Stefan Bugri, MPH., PhD.
e-mail: bugri@usvaz.sk

Ing. Emília Pribišová, PhD.
e mail: pribisova@usvaz.sk

CHILD'S STATUS IN CONTEMPORARY SOCIETY

Nataša Bujdová

St. Elizabeth University of Health and Social Work in Bratislava, teacher in the study of social work

---

Introduction: The child's status in society is derived from the relationship between child and adult. This is a significantly uneven relationship, based on the application of adult authority. Uneven, because in case of abuse of power, the adult child can not protect themselves. The fact that children have the same rights as adults, and that these rights should be protected by a special law was enshrined in the Geneva Declaration of the Rights of the Child of the year 1924 and the Declaration of the Rights of the Child in the year 1959, and which says that a child for his physical and mental immaturity, needs special safeguards and care including appropriate legal protection before birth and after birth. The core thesis: Despite the general trend of weakening the institution of the family remains the most widely accepted value in our society as one of the most stable social structures. The family continues to create the best environment for development and personal development as a social institution, and also best meets the needs of society. Recently, however, the family of the current socio-historical context and, within it shall, respectively, losing many specific characteristics. The perception of "stability in volatility" is necessary to adequately analyze at least the framework conditions in which the family located in the historical period. Situations in which the family passes the socio-historical changes do not necessarily mean a threat to families, but they also bring new opportunities for healthy development of families and society as a whole.

Conclusion: Today's unfavorable situation in the development of child care is burdened with the broader context of the development challenges of the current crisis of the family, due to globalization factors, not least the current global economic crisis.

REFERENCES

KECKESOVA, M.: 2005. Introduction to Family Law. Bratislava : Civic Association Social Work, 2005 133 p. ISBN 80-89185-13-4.

MATEJCEK, Z. et al.: 1999. Substitute family care. New York : Portal. The 1999th 183 p. ISBN 80-7178-304-7-8.

OLAH, M.: 2005. Social protection of children. Presov : Presov University, Faculty of Orthodox Theology, 2005. 205 p. ISBN 80-8068-349-2.

The first author contact:

PhDr. Nataša Bujdová, PhD.
e-mail: natasabujdova@gmail.com

WHERE IS MAN?

Anton Cerven

**St. Elizabeth University of Health and Social Work in Bratislava,
teacher in the study of social work**

Introduction: In my contribution for the latest issue of „The social aspects of a human in a postmodern world“ I deal with the very basic problem of people in today´s world.

Methods: Firstly, I question the human beings and their part in a society, taking into considerarion their integrity - greatness vs. littleness. My work basically points out a person who must set on a journey of discovering its uniqueness in the universe. Finding ourselves is the main task that we all have to accomplish. It is the starting point to see ourselves as a redeemed nation not as the animals. I also focus on a gradual reduction of a man into a working and reproductional tool, a tool of self – content without its own will.

Results: My work is devided into four chapters: from beginning of a human evolution to humanization, through slavery to self acknowledgement. From self acknowledgement to individualism and freedom, from freedom to a chinesse slavery. Through my work I have tried to define a concept how to create a safe social enviroment for people to live.

REFERENCES

ALLPORT, Q. W. The 1973rd Psichologia della personallita. PAS - Verlag. Zurigo.
ALTRICHTER, M., AMBROS, P., HOFIREK, P. 2002: Forum pastoralnik theologian II., 1. ed. Olomouc : Velehrad, 2002, ISBN 8086045-81-1.
DURDIAK, El., 2001th Psychology of a young man. 1. ed. Nitra : Enigma, 2001. ISBN 80-85471841.
FORDE, M. 2010 Desocializacia crisis of postmodernity. 1. ed. Bratislava : Luc, 148 p. ISBN 978-807114-806-7.

The first author contact:

PaedDr. ThDr. Anton Cerven, PhD.
College of Health and Social Work St. Elizabeth, Bratislava.
Branch of the Queen of Peace Message
Stefanikova 64, 085 01 Bardejov
e-mail: anton.cerven@post.sk

THE SOCIAL DIMENSION OF YOUNG PEOPLE IN TODAY'S WORLD

John Gurský

**St. Elizabeth University of Health and Social Work in Bratislava,
teacher in the study of social work**

Introduction: Young people were in every period exposed to pressures and influences of their surroundings and also they experienced a need of self-realization. A social value of young people we must perceive from their own sight and from the sight of their surroundings.

Main part: Influences of social surroundings could be more general, more specific or more multiliteral. Some influence to a qualities of a personality could be a nationality, some sort of social class and that sort of things. A big influence of forming a personality have small social groups, in which the personality occurs in a frequent and intimate interaction with others. It is particularly a family, a school group, a friendship group, working groups and that sort of things. People affect each other and even purposely, directly at a forming of a personality (a parent to a child, a teacher to a pupil, peers to each other). The current age marked by rapid progress of electronic communication devices brings along a loss of personal touches too and also changes and reduces the emotional and expressional sphere of a youth. A new phenomena are showing in the youth: over-sensitivity, a posing, an false expectations, a despair.

Conclusion: Young people that can recognize the right values in selves and in the world can change this world by changing their perspectives of themselves, of their peers, of their closest social group.

REFERENCES

MATOUSEK, O. The 2003rd Dictionary of Social Work. First ed. New York : Portal, 2003. 288 p. ISBN 80-7178-549-0.

MUHLPACHR, P. The 2008th Sociopatologie for social workers. Brno : Masaryk University, 2008. 194 p. ISBN 978-80-7392-069-2.

The first author contact:

Ing. John Gursky, PhD.
St. Elizabeth University of Health and Social Work, n. o.,
Detached office of The Queen of Peace from Medjugorje, Bardejov

FIELD OF SOCIAL WORK WITH UNEMPLOYED PEOPLE AND WITH PEOPLE IN MATERNAL NEED

[1]Eva Halušková, [2]Štefánia Derevjaníková

[1, 2] St. Elizabeth University of Health and Social Work in Bratislava. Detached office, Michalovce, teachers in the study of social work

---

Introduction: The article deals the most important policy system of measures within the labour market and with social work with unemployed people. In the substantial part of an article, there is given a short outline of legal claim of maternal need. In this part there is given also a view to activation measure for village as a form to acquire and keep habit of working for long-term unemployed people. The end of the article is aimed to analyse some specific examples how could be provided this benefits.

Target group and methods: Analysis of three practical cases is shown calculation of maternal need and other allowance of maternal need depending on persons who are considered jointly with this person and other rules. There is the comparison of these cases where are visible differences between person who apply for maternal need and whole family as well.

Results: The comparison of individual cases are shown that , there are different criteria of legal claim of maternal need and other allowance of maternal need. The amount of maternal need is influenced of this criteria ultimately or opportunity to claim activation measure and do have some activation work for municipalities.

Conclusion: Philosophy of maternal need is its short term using for people in need to go through their adverse life conditions due to losing their job. Common practice is shown there these families are in receipt of maternal need long term because of long term unemployment.

REFERENCES

MATOUSEK, O.: Social work in practice. New York : Portal, 2005.
VINCUR, P. et al.: Theory and practice of economic policy. Bratislava : Sprint, 2001.

The first author contact:

PhDr. Eva Halušková, PhD.
evah.haluskova@gmail.com
PhDr. Štefánia Derevjaníková, PhD.
stefania.derevjanikova@gmail.com
St. Elisabeth´s University College of Health and Social Social Work in Bratislava.
Detached office, Michalovce, teachers in the study of social work

A MAN AND ETHICAL PRINCIPLES

František Hanobik

**St. Elizabeth University of Health and Social Work in Bratislava.
Detached office of The Queen of Peace from Medjugorje, Bardejov,
teacher in the study of social work**

Introduction: A man – requires some place in the universe with his/her life, but a man overcomes both real time and space borders by his/her spiritual part. No present time is asolute for a man. He/she is a sensible and free being who consciously creates history. His/her life is a constant pilgrimage and by its spiritual activity it outgrows up to the eternity.

Main part: A man is responsible for his deeds to his own conscience and an authority. The inner voice of conscience is incorruptible and infallible. It praises for a morally good deed but it blames and unsettles for a morally bad deed until the smoothing a wrongdoing, unjustice or offence. Social responsibility refers to people and authorities whose responsibility is based on resolutions and state laws directing activites of individuals and smaller communities as well as on duties emerging from solidarity and natural moral duty.

Conclusion: Only in case we spread unchanging truth in the changing world the God will cause here, in the world full of problems and evil, an explosion – the explosion of truth, love and salvation; it will affect every innocent and open mind and every heart opened to love.

REFERENCES

SOKA, S.: A Brief Introduction to Philosophy Ethics, Bratislava 1985.
VRAGAS, S.: 1996. Basic issues of social teachings of the Church. Bratislava : Roman Catholic Theological Faculty of Comenius University, 1996. 173 p. ISBN 80-88696-13-5.
POPKIN, R. H. Stroll, A.: philosophy for everyone, Ivo Zelezny Prague 2005.
Coreth, E.: What is man? The bell-Czech Catholic publishing house, Prague 1996, ISBN 80-7113-170-9.

The first author contact:

doc. PhDr. Frantisek Hanobik, PhD.
Mickova 38, 085 01 Bardejov
hanobikf@stonline.sk

THE HOLY SPIRIT INSPIRES DOING GOOD IN MAN

Mary Hardy

**St. Elizabeth University of Health and Social Work in Bratislava,
Department of Social work od Divine Mercy, Zilina,
teacher in the study of social work**

Introduction: The Holy Spirit is active in removing the spiritual and every human disstress. The Holy Spirit developes the goodwill in humans to do good, to have an interest in each person. This paper is pointing on The Holy Spirit as a inspirator of doing good in man regardless of religion, on the protection against burn out syndrome, on the spiritual distress of man and on the dignity of human beings.

Methods: Survey sample consisted of 108 respondents. We used a random sampling technique. Targeted selection was made through selected social service and charity. We used a questionnaire survey as the data collection method.

Results: The survey was to obtain respondents' opinions on the action of the Holy Spirit in the lives of people working in the social sphere. We found that 86% of respondents agree with the statement that the Holy Spirit inspires everyone to do good, regardless of religious affiliation. The claim that a person who is dependent on the material and social support needs at the same time the spiritual help to be helped really, supported 64 % of respondents. 19 % of participants disagree with this expression, and 17 % can not decide. 84 % of respondents think that a person working under the guidance of the Holy Spirit has a humane approach to the client. 43 % believes that the believer is no longer protected from burnout syndrome. It is interesting that the respondents take a negative attitude in all social services and charities.

Conclusion: In addition to material and social disstress should be eliminated spiritual distress that it is the root of human problems. We wanted to indicate the possibility of extending the forms of assistance to social work, serving clients for the possibility of spiritual distress. Burn out syndrome is accompanied by all the helping professions. We believe that the Holy Spirit can lead a man to do good for others and to teach a man to rest and to restore the power.

REFERENCES

BUCKO, L. The 2003rd On the way to liberation. Bratislava : Divine Word Society, 2003. DOMINUM ET VIVIFICANTEM. The 1994th Encyclical of the Holy Father John Paul II. the Holy Spirit in the life of the Church and the world. Trnava : SSV, 1994.

The first author contact:

hardy@sopza.sk

SOCIAL (IR)RESPONSIBILITY FACE-TO-FACE THE CASES OF CHILD SEXUAL ABUSE

Slavka Karkoskova

**International school of management ISM Slovakia in Presov,
teacher in the study of social work**

Introduction: Research reveals that about twenty percent of women and five to ten percent of men worldwide were victims of child sexual abuse (CSA). CSA is understood as a serious crime in the majority of legislations all over the world. This crime represents massive violation of human rights and generates long-term negative impact in various aspects of victims´ lives. One could suppose that people have clearly negative attitude toward CSA which is manifested in practical actions in situations when people face to a particular case: so that they take steps to protect, support and rehabilitate the victims and somehow punish the perpetrator due to his trespass of the norms. However in reality such scenario is rather unique.

Main part: The paper points at some of the findings of social psychology that are explaining why people sometimes help and sometimes not; it introduces a brief overview of the development of social approach to the issue of child sexual abuse (CSA); and through the analysis of ethical dilemmas regarding the CSA cases it reveals individual values and motives from which diverse attitudes towards CSA spring.

Closing: The paper describes selected components of social irresponsibility in dealing with cases of CSA and inspires the reader to have a closer look on his/her attitude position toward such serious phenomenon.

REFERENCES

BATSON, C. D., FULTZ, J., SCHOENRADE, P. A. 1987. Distress and empathy: Two qualitatively distinct vicarious emotions with different motivational consequences. In: Journal of Personality, 55(1), p. 19-39.

BERKOWITZ, L., DANIELS, L. R. 1964. Affecting the salience of the social responsibility norm: effects of past help on the response to dependency relationships. In: Journal of Abnormal and Social Psychology Volume 68, Issue 3, March 1964, p. 275-281.

The first author contact:

ThDr. Mgr. Slavka Karkoskova, PhD.
International school of management ISM Slovakia in Presov
Duchnovicovo namestie 1, 080 01 Presov
karkoskova@ismpo.sk; ascend@azet.sk

UNDERSTANDING OF EDUCATION AND HUMAN IN POSTMODERN SOCIETY

Slavomír Laca

**St. Elizabeth University of Health and Social Work in Bratislava,
teacher in the study of social work**

Introduction: The ethical and moral values of man to put in different variations each time, but to the present social crisis it poses a much greater urgency. Whole life is filled with the same moral context. Currently, the media and, in particular television, produces its own moral context.

Methods: We want to draw attention to the relationship between education and ethical correlation, respectively. highlight the causes of post-modern society and its impact and its impact on individuals and society. It seems a vicious circle, the problem of human society, avoidable that are not relevant to deal with the consequences, but to address the existing nature and the challenge is to find incentives and paradigmatic assumptions made by the individual to the reality that you will realize within themselves .

Conclusion: Conclusions point to the danger of violent injection of freedom and creativity in life, which brings the company into crisis. The role of society is not only indicate different risks and hazards impact postmodern thinking on socio-social areas of human life, but it is important to present solutions to this situation in favor of human.

REFERENCES

GINDEV, P. The philosophy and social knowledge. Bratislava: The Truth, 1983.
KLECZEK, J.: The universe and man. Prague: Academia, 2004. ISBN 80-200-0649-4.

The first author contact:

PaedDr. Slavomír Laca, PhD.
slavomir.laca@gmail.com

INTEGRATION OF MENTALLY HANDICAPPED CHILDREN AND THE WORK INVOLVED WITH THEM

Igor Magera

**St. Elizabeth University of Health and Social Work in Bratislava,
teacher in the study of social work**

Introduction: Only when people understand that people with intellectual disabilities have the same problems and the same rights as others, then find their way and their income between themselves. All quality control must be used - be available to all its members without exception, people with disabilities being no exception.

Main part: There are parents who are discharged with the problem of birth of a child with mental disabilities. Such a child's parents from the community, ignore it, does not your child, and anyone refusing to talk about the child. Suggesting that education and childcare is only a burden for them and other people from around the disincentive to assist them. "The family should be the active element in the process of integration of children and adults with disabilities.

Conclusion: It is very important to remove prejudices against people with intellectual disabilities: to allow them access to education as well as people without disabilities, enabling them to obtain decent work and discriminate against them in employment, accept the fact that people with mental disabilities are also referred to as "people" who you like others to live a full life.

REFERENCES

LAMPARSKY, R the 2009th The quality of social workers help clients bring quality. In: Employment and social policy. ISSN: 13365 5053, 2/2009, p. 17th

NOVOSAD, L. The 2009th Consulting - for persons with disabilities and social disadvantage. 1. vyd. New York: Portal, 2009. 272 p. ISBN 978-80-7367-509-7.

The first author contact:

PhDr. Igor Magera, PhD.
magera.igor@centrum.sk

YOUTH UNEMPLOYMENT AS A SOCIAL PROBLEM

Radoslav Michel

**St. Elizabeth University of Health and Social Work in Bratislava. Detached office of The Queen of Peace from Medjugorje, Bardejov,
internal student in the study of social work**

Introduction: Young people after leaving school often in my life experienced by pocity social uncertainty (concern) of the future that require the immediate involvement of young people into work, which is for their personal identity "gateway" to the world of adulthood (responsibility). Reducing the labor of young people is a huge loss to the social system of each country.

Main part: High unemployment has a negative effect on the inclusion of young people into work (school leavers). Job loss and inability to find a job, a person can be reached at different stages of life. For the unemployed young person is very important to keep him in work habits and to create the necessary work.

Conclusion: Youth unemployment is a social problem, which has very complex implications for overall health. For this reason, access is necessary for social work that takes account of bio-psycho-social consequences of unemployment.

REFERENCES

DOCUMENTS OF THE SOCIAL DOCTRINE OF THE CHURCH. The 2007th First ed. Trnava : Association St. Adalbert, 2007. 600 p. ISBN 978-80-7162-694-7.

SCHAVEL, M. et al. The 2007th Social prevention. Second ed. Presov : College of Health and Social St. Elizabeth, Department of Social Sciences and Health bl. P. P. Gojdic, 2007. 141 p. ISBN 978-80-89271-22-1.

TOMES, I. The 2002nd Social Report. 1. ed. New York : Portal, the 2002nd 304 p. ISBN 80-7178-560-1.

The first author contact:

PhDr. Radoslav Michel
Osikov 82, 086 42 Hertnik
0908879951
michel.rado@centrum.sk

FAMILY TODAY – QUO VADIS?

Peter Tirpak

Presov University, Byzantine-Catholic Theological Faculty, lector

---

Introduction: Every family is a strong educational factor. As a source of a new human life it is the best and most natural environment, in which a healthy human personality can develop. Family is a natural means to introduce a human to the solidarity and social responsibility.

Main part: Primary task of a family is to faithfully live the reality of its unity and to continuously strive in creating a functional community of people. The first community is developing already among the husband and wife. The community of a husband and wife has its roots in a naturally complementary nature of a man and a woman, however, it is through Christ that the partnership of a husband and wife reaches its most perfect form. The community of a husband and wife is today influenced (both positively and negatively) by the society at large, in which it exists and lives. The outcome of a negative influence of the society is reflected by falling in various serious crises that are increasingly becoming a commonplace today.

Conclusion: The primary caise of a destruction of a common family life is in the fact that many people listen to their surrounding when choosing their way to live and act. This implies that the opinion of others (incl. public opinion) could become a strong influencing factor affecting the human behaviour. Nonetheless, it is also true that our surroounding is a matter of our choice. It is the people with whom one most frequently interacts who provide the decisive influence on any person.

REFERENCES

BENEDICTUS XVI. 2001. Encyklika Deus Caritas est – Encyclics on Christian Love. Trnava : SSV, 2001. 62 p. ISBN 80-7162-594-9.
JOHANNES PAULUS II. 1993. Familiaris consortio – Exhortation on the roles of a family in today's world. Trnava : SSV, 1993, p. 16-18. ISBN 80-7162-052-1.

The first author contact:

ThDr. Peter Tirpak, PhD.
University of Presov in Presov Greek Catholic Theological Faculty
Ul. Bishop Gojdic 2, 080 01 Presov
peter.tirpak@unipo.sk

SOCIAL THERAPY AS MEANS FOR QUALITY IMPROVEMENT OF SENIORS LIFE

Peter Vansač

**Institute of Social Sciences and Health of Bl. P. P. Gojdic in Presov,
teacher in the study of social work**

Introduction: The aim of social therapy is to help a client to renew his physical and mental capabilities as well as to communicate with him and give him a feeling he is not lonely in his pain.

Main part: Not every therapy is suitable for every senior so knowing an individual senior and communication with him is a precondition of a successful therapy. In the article we focus on and describe individual therapies which can be used as tools for the senior's quality life improvement. The aim of ergotherapy is a development of skills necessary for everyday routine activities which are the basis for the social integration. Therapy is also an educational means for seniors.

Conclusion: Social therapy is not the aim but the means for the senior to improve his self-confidence, for renewal of his capabilities, skills and social integration.

REFERENCES

BALOGOVA, B., Seniors. Presov : Akcent Print, 2005, ISBN 80-969274-9-3. JOHN PAUL II. Autumn of life, apostolic letter elders Publishing Don Bosco 1999, ISBN 80-88933-39-0.

The first author contact:

ThDr. Peter Vansač, PhD.
Institute od Social Sciences and Health of Bl. P. P. Gojdic in Presov
Dilongova n. 13, 080 01 Presov
pvansac@sinet.sk