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CLINICAL SOCIAL WORK

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Original Articles

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Research of the Level of Awareness of Patients with Glaucoma

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CLINICAL SOCIAL WORK

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 Internatioanl Scientific Group of Applied Preventive Medicine - 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.

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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

Introduction

„*Clinical SocialWork CSW*” periodical is the international, interdisciplinary magazine focused on the problem of the analysis of modern challenges in, above all, everything in the matter of social work and medicine. The latest part No. 2, Vol. 5, 2014, brings to the reader a range of interesting analyses and results of the research concerning the extended spectrum of health-social problems. Social problems touched upon in the issue concern mainly such areas as: inclusion of the unfavoured e.g. disabled people, including life conditions of these people, increase of the research efficiency in the matter of social work, work ethics referring to services dedicated for the oldest part of society, dilemmas connected with ethic conditions of realization of the tasks that support alleviation of social exclusion, effective practitioner training – social workers on the example of St. Elizabeth University of Health and Social Sciences in Bratislava, etiology of social inequalities deriving from belonging to ethnic minority (on the example of roma group). The content of the social part is completed with the article which is a question of the model of functioning of modern family in the post-modern society and challenges for the members of the family connected with it.

The second group of articles, however, is strictly connected with the determinants of occurrence of diseases and disorders and ways to diagnose and treat them (e.g. nonspecific chronic disease, endoprosthesis, HIV/AIDS, chemotherapy). Moreover, in the issue a few texts can be distinguished which connect the medical and social topic, which is another evidence for the importance of connecting ways of thinking, which cannot be confined only to the biological aspect. Triangulation of points of view increases the level of importance of the carried analyses, allowing one not only to learn about complex bio-socio-medical aspects but it also allows one to develop professional support models, which include the importance of the human factor.

The common part for the topics touched upon in the volume is an efficient work with a person demanding professional support, which is possible to achieve through interdisciplinary approach including the achievements of: social work, sociology, political science, ethics, pedagogy, law, medicine and biology studies.

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Clinical Research Nurse and her Roles

GÁLIKOVÁ, Mária: Clinical Research Nurse and her Roles. – The University of Healthcare and Social Work of St. Elisabeth, The Department of Nursing. Bratislava, 2014.

Key words: Clinical trial. Nurse's role. Clinical research nurse. Study nurse. Good Clinical Practice.

Abstract

The paper is a contribution to the knowledge about the role and responsibilities of the study nurse within the clinical trial, in practice. It presents the basic theoretical and practical sources of clinical research and basic principles of Good Clinical Practice. It analyses the specific roles of the clinical research nurse in practice, her responsibilities in each of the clinical trial stage and her value.

Introduction

Clinical research is part of the complex procedure to demonstrate the effectiveness and safety of drugs and other products of the pharmaceutical industry. None of medications can get on the market without clinical research. Every drug must be clinically tested before the licence is obtained from health authority, and the efficacy and safety must predominate the risks and side effects. It is necessary to have the qualified clinical research team besides the volunteers as the subjects of the research for the successful clinical trial conduct. Besides the investigators, co-investigators and the other clinical personnel, clinical research nurses are also an unsubstituted part of the team. The topic of the clinical research nurse importance, her roles, tasks and responsibilities is not sufficiently compiled in available literature in Slovakia – it should require more attention as it is highly specialized and prestigious activity in terms of nursing.

Clinical research of medications is inevitable step in procedure of development of new therapeutical possibilities and also in improvement of the care about the patient. Despite the large progress in medicine during the last century, there is a lack of effective treatments for more serious illnesses. There is a higher need for the new or better medication in some therapeutical areas, e.g. in oncology or neurology for dementia treatment.

Clinical research conducted by the commercial or non-commercial organizations, continues in finding the new treatments of different diseases. As an example - in 2008 there were more than 60 000 clinical trials conducted world wide. There is a summary of total number of new medications in research and development during the last 10 years in Appendix no. 1.

The new drug development can take up to 15 years and the price of research can reach billion of dollars. However, only one from three new substances that reach to be marketed will achieve the level of sale in such a level that the research expenses are covered. A chance to success and registration of licence depend on application quality and so on quality of clinical trial, as the final results are reported to regulatory authority.

The development of new drugs consists of many stages of the research. Pre-clinical studies are undertaken on a new compound to determine the toxicity, teratology and basic pharmacokinetics and pharmacodynamics. On the basis of initial tests, compounds are selected for further study in man, clinical trial.

The basic rules of clinical trial conducting

Each clinical trial must be conducted according the plan based on the well-designed study protocol. The study protocol contains at least the following topics:

- clinical trial objectives and purpose
- clinical trial design
- background information
- selection and withdrawal of subjects
- treatment of subjects
- assessment of efficacy
- assessment of safety
- statistics
- direct access to source data
- quality control and quality assurance
- ethics
- data handling and record keeping
- financing and insurance
- publication policy

Study protocol is a „recipe“, a main working tool for clinical study conduct. The possible changes in the procedures during the study are described in Protocol Amendment.

The other important document is Case Report Forms (CRF), where the relevant data about the subjects are completed. The mostly preferred CRF is electronic version today which saves both: time and paper. The data are sent directly on-line to Data management centre and statistical analysis is quicklier.

The essential key to the successful conducting and finishing of clinical trial is the site selection with the competent investigators team where the clinical trial will be performed. It does not matter if it is a clinic or an out-patient department – the most important task is on the personnel qualification: investigator, nurse or other staff. The potential number of suitable patients that might be enrolled into the study is also an important factor.

A Clinical Research Associate (CRA) visit the potential sites after the final site selection and prepares the basic documentation for the application to Ethics committee and Health authority. Each clinical trial must be approved by the authorities in written form before start of the study. There are independent Ethics committees at each hospital and also regional Ethics committees in case of the private practice. If a clinical trial is multicentric, the approval from Multicentric Ethics committee must be obtained.

Ethics committees and Health authority are independent authorities that review the relevant submitted clinical trial documentation according to Good Clinical Practice guidelines. They make a decision in case of the premature end of trial and they follow the ongoing of the clinical trial during the whole period by interim reports.

The sponsor is responsible for conducting of clinical trial, its proper monitoring and the final report preparation which is necessary for the successful registration of the study medication by the health authority.

The investigator is responsible for the correct patients enrollment according the inclusion and exclusion criteria described in the study protocol. Written informed consent has to be obtained from every subject who enters a clinical trial, before any study related procedures are undertaken. Every subject must be informed also verbally about all the details of the clinical trial and the conditions in case of his participation. The Patient Informed Consent form must be signed and dated by the patient himself. The investigator sign and date the form by the same way. A copy of the signed document is given to the subject and the original is archived in the patient's medical documentation. Any amendments of the protocol are documented in the updated version of Patient Information sheet and Patient Informed Consent form and it must be signed and dated by the same manner as at the beginning of the study.

Patient Informed Consent form in some cases, for example at children or mental disorder's patients, can be signed by the legal representative of the subject.

Patient Informed Consent form and Patient Information sheet should be written in uncomplicated language, avoiding jargon and medical terminology. It should also be in the native language of the patient, who must have a sufficient time for making decision about his participation in the clinical trial. He must not be forced to make the quick decision and he must sign it free before any procedure related to the clinical trial is performed, for example blood taking procedure or any other study related examination. It is not sufficient that the document is signed just before using the study medication.

The investigator can delegate the consent process to an appropriately qualified person, for example a study nurse.

The subject keep the terms of the scheduled visits and all the instructions obtained from the investigator and study personnel, including the using of study medication. In some cases he must complete the questionnaires or patient diaries. The study personnel must have the sufficient time for the communication with a patient at the time of his visit, so adverse reactions or events can be found. The relationship between the patient and the study personnel should be based on the responsible approach and bilateral confidence. A study nurse has a great role in the communication with the patient as she is often the first contact person for them.

Study medication must be kept in the safe storage at the room temperature or in the refrigerator by the temperature which is exactly determined by the study protocol. The actual temperature is monitored and documented at Temperature Log on daily basis (in the morning and in the afternoon). The expiration date and dispensation of study medication must be accurately documented. Drug compliance is checked by counting the amount of returned drugs and documented.

The sponsor should ensure that the clinical trial is adequately monitored. This is responsibility of a Clinical Research Associate (CRA) or a Clinical Monitor. Their role is the protection of the rights and well-being of the subjects and checking that the reported data are accurate, complete and verifiable from source documents. The other purpose is that the clinical trial conducting is in compliance with the approved protocol, GCP and regulatory requirements.

Besides monitoring, the study can be audited or inspected by the independent auditors or inspectors that evaluate trial conduct and compliance with the protocol, GCP and regulatory requirements. This is a quality control activity. Inspectors are usually from local health authorities, from the European Union (European Medicines Agency) or from FDA (Food and Drug Administration). The primary aim of the clinical trial audit is to be sure that the rights of the subjects are respected based on the Declaration of Helsinki and that the integrity of reported data are reliable.

It is expected that the sponsors of clinical trials will provide the systematic performing of all procedures according to the Standard operating procedures (SOP). That affects the quality

standard in all aspects of clinical research. SOPs are one of topics for quality control when an audit or inspection is performed.

Clinical trials have a different duration depending on the enrollment of the required number of subjects by the protocol. During the clinical trial the enrolled subjects's data are collected by the Clinical Research Associate in written or electronic form and they are sent to Data Management. The statisticians must ensure the integrity of the data during their processing and, in addition, that an account is made of missing, unused or spurious data during the statistical analysis. The results of the statistical analyses are presented in a statistical report which is usually integrated in the final report.

From the legislative point of view the clinical trials are conducted according the guidelines 2001/20/EC and 2005/28/EC within the European Union. In USA there are basic legislative requirements in document 21 CFR 50, 54, 56 and 312. During the last years each country has implemented its own legislative rules, so in Slovakia in 2011.

Good Clinical Practice

Good Clinical Practice (GCP) is an international ethical and scientific quality standard for designing, conducting, recording and reporting trials that involve the participation of human subjects. Compliance with this standard provides public assurance that the rights, safety and well-being of trial subjects are protected, consistent with the principles that have their origin in the Declaration of Helsinki, and that the clinical trial data are credible.

In 1990 relevant regulatory agencies and associations of pharmaceutical industry from USA, Europe and Japan have initiated International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) so the unified standard of drugs development will be achieved. ICH has approved ICH GCP Guideline in 1996. The guideline was developed with consideration of the current good clinical practices of the European Union, Japan, and the United States, as well as those of Australia, Canada, the Nordic countries and the World Health Organization (WHO).

The objective of this ICH GCP Guideline is to provide a unified standard for the European Union, Japan and the United States to facilitate the mutual acceptance of clinical data by the regulatory authorities in these jurisdictions.

This guideline should be followed when generating clinical trial data that are intended to be submitted to regulatory authorities. The principles established in this guideline may also be applied to other clinical investigations that may have an impact on the safety and well-being of human subjects.

ICH GCP Guidelines describe in details the rules, responsibilities of ethics committee, investigator and sponsor of clinical trial. The other topics are: study protocol requirements, Investigator's brochure and essential documents for the conduct of a clinical trial. All the clinical trials should be conducted according GCP rules and ethics committees and health authorities should follow it, too.

ICH GCP Guidelines highlights that the protection, safety and well-being of the clinical trial subjects is a priority and any of the study participants must not be harmed. This is also a reason why every member of clinical trial staff must attend GCP training every two years either as a classroom course or e-learning course which must be documented. The sponsor can refuse the investigator's participation in a clinical trial if he does not fulfill this requirement.

GCP training is recommended also for the other clinical trial staff especially for study nurses that directly participate in clinical trial. The experience is much different in Slovakia – study nurses do not attend the GCP training very often, in majority they do not attend it at all. The reason is lack of time, overworking, no interest or no information about the training possibility,

or demotivation as some of them participate in clinical trial because they must. GCP trainings are usually a part of the Investigator's meetings organized by pharmaceutical companies in different foreign countries and the majority of nurses have the language problem if they want to participate. English knowledge is essential for this kind of training.

Slovak Medical University organizes a certified course of GCP that consists of two parts with the final examination. Clinical research nurses are not informed about this possibility in most cases so they attend it very rarely.

Clinical research nurse and her roles

Clinical research nurse fulfills the important roles within the whole clinical trial site team. A nurse can participate on clinical research in various ways. She is destined by her unique qualification so she can associate her communication, clinical and administrative abilities that are necessary for successful clinical trial conducting.

Nurse closely cooperates with the investigator in clinical trials procedures while she carries out the complex, divergent and interesting work.

The basic background for work as a clinical research nurse is: sufficient and appropriate practice, master of basic theoretical clinical research knowledge, understanding of terminology used in clinical research and minimal basic knowledge of English as the most of documentation is written in this language. There is a problem if a nurse performs routinely the activities without proper understanding for example a Central Laboratory Manual with the procedures described, details of blood sample taking procedures, its treating and distribution etc. There might be also problems in communication with central laboratory, in case of lost shipping box, unclear test results and other acute issues as the central laboratories are located outside Slovakia and English is the common used language within communication.

Some of the study documents are translated into Slovak, e.g. Protocol Synopsis, Patient Information Sheet and Patient Informed Consent, Patient Diary, questionnaires, Patient Card. Though sometimes it might happen that study nurse need to review the other part of documentation in English and so the new problem arises.

It might happen that the investigator's site must contact the central IVRS (Interactive Voice Response System), a site for patient randomization and the acute problems need to be discussed, the investigator or the co-investigator is not available and the nurse might help but she cannot make herself understood. This short overview of English knowledge application refers to the importance of foreign language skills of study nurse, especially English that is often underestimated in practice.

According to the theoretical principles of nursing roles we demonstrate on the individual role samples that they can be applied also for a clinical research nurse not only globally but also in Slovakia.

1) Nurse - Provider of the care

Clinical research nurse performs: blood taking procedures, measurement and monitoring of vital functions, patient height and weight, investigator's orders and assessments according to the protocol (ECG, Holter monitoring, spirometry, densitometry etc.), study medication and other drugs administration, and in case of hospitalized patients she performs the complex nursing care.

2) Nurse – Educator

Clinical research nurse explains to patient the relevant information if the patient need some information obtained for the investigator to be reviewed, though the investigator must delegate this responsibility to the nurse by written form in Delegation Log.

A nurse often educates the patient how to complete the questionnaires of quality of life, Patient diary or how to proceed in case of adverse events reporting.

3) Nurse – Advisor

Nurse as an advisor fulfills this role not only for patients but also for other members of research team, e.g. nurses and other staff that do not understand completely the problems and who are in direct contact with patients.

4) Nurse – Representative of change

Clinical research nurse should support the initiatives for the change in her competency within clinical trials or within the following education. She can initiate a rise of an organization or a group of clinical research nursing team.

5) Nurse – Advocate

Nurse as the patient's advocate fulfills one of the most important roles in clinical research as the protection of subjects is the priority. She helps to patients to understand the Patient Information and Patient Informed Consent form and also to follow the adverse events and report them if there are any.

6) Nurse - Manager

Clinical research nurse coordinates and manages the daily clinical study activities though the final responsibility are a matter of Principal Investigator. This role anticipates perfect managerial, organizational and communication skills and also flexible and assertive approach.

7) Nurse – Leader

Study nurse in this role fulfills the similar tasks as the coordinator but the main aim is the correct communication with patients, colleagues or other team members.

8) Nurse – Coordinator

Clinical research nurse coordinates the patients' visits according the Study Protocol schedule as well as monitor's visits and distribution of the samples to the central laboratory.

9) Nurse – Researcher

Study nurse in this role cooperates with Clinical Research Associate who monitor the study according the study schedule. She can assist in case of an audit or inspection. She writes the articles to the specialized nursing journals, she works on her own additional education and actively participates in nursing research.

10) Nurse – Mentor

Study nurse with the longer experience in clinical research helps to trainees that need to be trained properly and often need a help and the professional advice, and she can also help to the new co-investigators with no practice in clinical research.

The foreign results of research and survey describe the basic requirements that every clinical research nurse should meet, e.g. managerial and organizational skills, ability to make independent decisions as they often work individually etc.

Experiences in abroad show that study nurses must be excellent specialists in their area of medicine but they must have a wide scale knowledge about research process, about relevant legislative procedures and a wide scale of computer skills. There are responsibilities for study nurse such as preparation of the protocol and other documentation, preparation for application for approvals, coordination of start-up, conducting and finishing of the study. Study nurse helps with screening of patients, mostly at the out-patient departments and at working team meetings. She cooperates in Patient Informed Consent obtaining procedures and she can ensure that the patient understood the Patient Information sheet's contents – this requires perfect communication and interpersonal skills. Study nurse can be responsible for the randomization, data collection and completion after patient enrollment. All the data must be reliable, precious and accurate when

completed into the relevant documentation – this requests a high sense for details and high level of integrity. Study nurse can play a very important role at adverse event reporting procedures as she is often the first contact person for the patient. Finally, study nurse can act as a teacher, mentor or advisor for the other healthcare personnel, or she can have lectures at the professional conferences or similar events.

Some authors of foreign literature mention the requirement of GCP training every two years which is a must not only for investigators but also for study nurses. They can participate in activities of the professional organizations - Royal College of Nursing (RCN), Association of Clinical Research Professionals (ACRP) and others where groups of clinical research professionals exchange their experiences on their meetings and so widespread their knowledge.

During the last 20 years the number of clinical research nurses has increased because the number of clinical trials has been increased, too. Nurses can influence the quality of clinical trials, but the general extent and portion of their role on the clinical trial is not known. Some of surveys with study nurses in multicentric clinical trials have proved the lack of job satisfaction, conflict of roles nurse and researcher, self-motivation problems and problems related with the cooperation with nursing staff when following the study protocol. Study nurses also identified fields of the insufficient treatment, management and care caused by the organizational and clinical aspects of nursing care. They expressed their expectations and observation. Study nurses participated in clinical trials without sufficient training and appropriate management – they were just „data collectors“ and informal „observers“. The results of these studies were used by investigators for finding the best optimization of clinical research nurses' skills and competencies.

The nurses' roles in clinical research include more activities, such as screening of potential patients, discussion about clinical trial with the participants, informed consent obtaining, registration and randomization, assessment plan, adverse events reporting and data collection. Study nurses with longer experience and specialization can take patient history, they can perform physical examinations, documentation of laboratory reports and order the study medication according to the protocol. Study nurses with more longer experience and higher education can work as project managers or programme managers as coordinators of the whole team within the large project. There are also study nurse positions in academic centres, in communities and in the pharmaceutical industry. Education and trainings are organized by academic centres and professional research organizations. Certification of clinical research professionals can be available at ACRP – Association of Clinical Research Professionals (www.acrpn.org) or Society of Clinical Research Associates (www.socra.org) .

We can find more differences in clinical research nurse job when comparing situation in Slovakia and other countries. According to available literature, the study nurses in other countries have more competencies than in Slovakia. They perform more specialized activities such as Patient Informed Consent obtaining, different administrative tasks, data collection etc. Nurses in USA or UK have no language problem as English is their native language. The level of nursing education is nearly the same but the level of clinical research and GCP knowledge as well as continuing education possibilities are better in foreign countries. The prestige of study nurse job is higher in abroad than in Slovakia, where the majority of nurses have no idea about the importance of their work performed besides their common daily duties and very often without the appropriate appraisal.

The availability of participation in professional organizations that care about the needs of their members and care about their professional growth is more common in other countries than in Slovakia. It is possible for nurses in Slovakia they can become members of ACRP but membership fee is rather high for them, they have no advantage if they cannot speak English as they are not able to participate in education, events, lectures and any trainings or reading the available

literature (The Monitor). There are certified courses available at ACRP for different levels of professionals in clinical research: Certified Clinical Research Associate – CCRA, Certified Clinical Research Coordinator – CCRC, Certified Principal Investigator - CPI. The certificate can be renewed every two years by the exam or by valid amount of credits obtained by continuing education. Certified experts are very haunted in abroad. Clinical research nurse can pass the CCRC exam (Certified Clinical Research Coordinator).

In 2012 an author of this article has performed a survey with the aim to find out the level of basic knowledge about clinical research of study nurses in Slovakia, also the level of their English knowledge and the level of their training experience within clinical research projects. Another aim was to find out the interest of study nurse's sample in systematic training before each new project and their interest in other continuing education and obtaining specialization degree in clinical research if possible.

A survey results have proven that clinical research nurses in Slovakia do not have sufficient basic knowledge about clinical reasearch, what is quite surprising considering their practice and experience. On the other hand, there is a fact that study nurses are interested in further education and improvement in this area – this is very positive fact and this information might be used as the motivation for study nurses in future. The similar condition is in their willingness to study English or improve their English. Contemporary prospects for the improvement of clinical research nurses education are relatively limited but the situation is solvable.

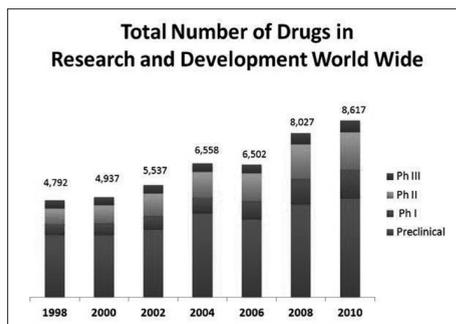
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Appendix No. 1

Total amount of drugs in research and development world wide



Source: Pharmaprojects (www.cisrnp.org)

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POSTER „THE TASKS AND RESPONSIBILITIES OF CLINICAL RESERACH NURSE“

ÚLOHY A ZODPOVEDNOSŤ SESTRY V KLINICKOM SKÚŠANÍ

Mária Gáliková
 Vysoká škola zdravotníctva a sociálnej práce sv. Alžbety
 Katedra ošetrovateľstva - externé doktorandské štúdium

Sestra plní významnú úlohu ako spopracovateľka kvalifikačného teória v rámci klinického skúšania

**STUDY NURSE
STUDY COORDINATOR
RESEARCH NURSE**

- Spolupracovníčka sestry pri monitorovaní klinického skúšania
- Spolupracovníčka sestry pri kvalifikácii a inštrukciách
- Práca s pacientmi
- Získavanie informácií o klinickom skúšaní
- Práca s pacientmi
- Administratívne úlohy
- Práca s pacientmi

ÚLOHY SESTRY V KLINICKOM SKÚŠANÍ

- Objasnenie cieľov klinického skúšania
- Práca s pacientmi

ĎALŠIE UPLATNENIE SESTRY V KLINICKOM SKÚŠANÍ

- Sestra ako člen Etickej komisie
- Sestra ako monitor klinického skúšania

PROBLÉMY VYSKYTUJÚCE SA V PRÁCI SESTRY V KLINICKOM SKÚŠANÍ

- Nedostatočné jazykové vedomosti (dokumentácia v anglickom jazyku)
- Nedostatočné odborné vedomosti o problematike klinického skúšania (štruktúra klinického protokolu, ICH GCP)



Life-Long Learning as a Way to Mainstreaming & Competencies: Competencies as a Way to Social Inclusion & Improvement in the Quality of Life of People with Disabilities

Libor Novosád

Introduction

Human health is generally defined as a harmony of bio-psycho-social factors and as a balanced state between physical, mental, emotional, spiritual as well as social contentment of a person. It is a bigger or smaller disorder or intrusion in this harmony, together with the self-determined restriction and the approach to life's events that transform health - (resp. functional) disorder or disability into a disadvantage - a handicap and a social exclusion threat. A disability or a handicap (or *restriction in activity and participation* – see WHO, 2007) are more or less social expressions, arising from the relationship between physical, intellectual, sensory or mental impairment and the social environment. For all individuals with various types of disabilities the term *people with disabilities* is used, though the disability does not necessarily eliminate the state of health according to the WHO definition. Often the role of *patient* is ascribed to people with disabilities. And, the role of a passive recipient of services and benefits which usually does not correspond with their situation and potential, designates them into a purposeless passivity.

Discrimination versus Civil Participation

In a number of cases, disability leads to a limitation in social activity and due to this to limitation of opportunities for lifelong learning. Solving this problem, as well as the support of emancipation of *people with disabilities* depends on the minimalization of not only architectural, but namely of social and psycho-social barriers and public prejudices. After all, the motto of the European Year of Equal Opportunities (2007) was „*Different in life, equal in rights!*” which indicates that the way to inclusion of people with disabilities (referred to as PWD hereafter) does not lead to their favoring but to the consideration of specifics of a person with disability; to the emphasis on his/her natural difference and uniqueness; to the compensation of possible inequalities; to the prevention of social exclusion; to elimination of discrimination in all its forms.

Nowadays, society is strongly focused on productivity, image and success. Anyone with a disadvantaging problem or difference (i.e. he/she is not like the beautiful, healthy and therefore so successful ones) is potentially as well as practically unsuccessful, pushed aside from social activity („marginalized“) and can be discriminated against in the approach to both social activities and self-realization (Novosád, 2006).

Wasting of human skills, abilities and talents occurs as a result of discrimination!

As a result of this, the *Council of the European Union* issued a Directive implementing Principles of Equal Treatment of People with Disabilities which states:

To ensure full participation of all people with disabilities, it is necessary to develop a specific activity, among others, in the following fields:

upbringing and education;

social protection including social security and healthcare;

access to goods, services and information and their provision, including delivery and transport, transport facilities, buildings, accommodation, banking and insurance services.

People who are unfavorably affected by the discrimination based on a disability are also often exposed to unfavorable impacts of discrimination arising from other reasons. Therefore, it is necessary for the member states to ensure that appropriate attention will be paid to the fight against multiple discriminations.

Within the given social and legislation context the following can be said:

Direct Discrimination - such behavior, where due to his/hers disability, the person is treated „less favorably” than any other person is, was or would be, treated in a comparable situation;

Indirect discrimination - such behavior where seemingly neutral provision, criteria or practice led a person with a disability into a concrete disadvantaged position compared with other people; unless the provision, criteria or practice are justified by a legitimate target; means of reaching this target are appropriate; necessary;

„Hidden” Form of Discrimination can be regarded the failure to provide an appropriate adjustment or measure in such a case that cannot be justified;

Harassment can also be considered as a form of discrimination, when an unwanted behavior in connection with a disability occurs leading to (or resulting in) degradation of dignity of an individual and creates an intimidating, unfriendly, humiliating, degrading and (or) offensive environment.

These mentioned principles of non-discrimination are included in the *Czech Act of Equal Treatment and Legal Means of Protection From Discrimination* (the Anti-discrimination Act 2009) which, besides other things, re-enforces the *UNO Convention about The Rights of People with Disabilities* (2006). The Convention, in addition, accepts two key concepts of approach to people with disabilities and their needs – *Mainstreaming* and *Design For All* which means life participating in social activities and taking place in the surroundings accessible to everyone.

The prevention and solution of discrimination and social isolation, as well as improvement of conditions for personal development of PWD lies, besides other, in consideration of possible lowering of their functional literacy and consequently in a **1)** gradual increase of their social literacy and **2)** development of necessary social skills so that they may adequately participate in social life.

Social participation is understood as an adequate and barrier-free engagement in social events or in the life of society including involvement in active citizenship i.e. an interest in trends and problems of society; participation in political life; involvement in dealing with the current questions or problems in the local community (*Blomberg, Novosád 2002; Novosád 2005*).

To become a participating citizen, one has to be a functionally literate citizen first. Connecting to this we understand social or functional literacy as the ability not only to read, write and count (trivia); but also to orientate within the society and its institutions; to manage the rules of interpersonal relations; to understand the legislation framework as well as the social context

of citizenship; to know how to fill a form; how to formulate a written request; to work with information; etc. All this creates better preconditions for social and economic integration of a person into a technically and scientifically developing civilization; into the society where he/she lives. The signs of lowered functional literacy can be seen in various forms in the cases of *PWD* and seniors – especially those who live or lived in institutional care; in care of overprotective or „enclosed” families; or in loneliness; in „stimulating poverty” caused by barriers and any other circumstances. Real and factual socially-economic poverty can - by reason of a reduced approach to their life chances and public sources - endanger *PWD* namely, and can be considered as a modern phenomenon where the mentioned social exclusion is its post-modern equivalent.

Client (User) Literacy versus Competence

The relationship between a Helping Professional and a client (*PWD*) should be symmetrical and respectful; characterized as an open partnership between two equal citizens – one who can help, support, convey; one who is in a difficult situation and needs support but wants to be informed; wants to cooperate and make „knowledgeable” decisions about accepted ways of facilitation. From the side of clients i.e. users of Health and Social Services, it means to create conditions for the development of their health and social literacy in ways which allow them to orient in an *Institutionalized* world and to cooperate actively in solving their challenges.

Social or functional literacy is – as mentioned above – an „equipping” of a person to manage day-to-day tasks; to carry out various activities required by his/her existence in present day society; which expects his/her full empowerment in relation to dealing with his/her own life; takes one’s responsibility; making decisions about/for him/herself.

Health Literacy (*altered in accordance with WHO*) represents cognitive and social skills that determine motivation and ability of people to understand medical information and consequently to use them for the support of their health. It means to be able to deal with medical findings and information; to orientate in the health care system; to display active interest in their own health; to cooperate in its protection.

Part of health and personal competencies of a person is the ability to recognize, reflect and meet his/her spiritual needs. The spiritual side of human existence is a natural component and should not be underestimated in the field of Healthcare. A person filled with spiritual needs is more adaptable and resistant to stress; is motivated to care for his/her health and rehabilitation. Conditions for spiritual life are in the process of health and social care for people with disabilities that actually contributes to a person to feel well and full-blown.

With both these literacy’s the competence and being competent are connected:

from the point of view of both the citizen and the helping person, *competence* is connected to power, rightfulness or authority; while being competent is to be understood more as an ability, capacity, expertness and good sense (loosely according to Krhutová, 2005). Effective acting between the citizen and the assisting person thus supposes the achievement of two-way competence; interconnection; communication compatibility. The above stated implies that only reasonably „literate” or oriented people with disabilities can communicate equally with the assisting Professionals; their opinions can be accepted; they can influence both the form and the quality of services they need. In this way, they can face an actual, or impending unequal position in obtaining, choosing or using Social or Healthcare Services. Only an understanding, informed and in the scope of powers oriented *PWD* can be full-fledged users of services which participate in creating his/her quality of life and to evaluation and forming of content and form of which he/she is fully competent.

Social Functioning

Social functioning and *life situations* are connected with competences for every person and probably still more for a person with disabilities. In the context of this article also the theory of construction of social reality in the concept of „situation definition” can be stimulating according to the **W. I. Thomas** thesis:

If a certain situation is defined by people as a real one, then it is real in its consequences (Berger, Luckman, 1999).

The term *social functioning* in Social Work and especially in the area of complete rehabilitation of *people with disabilities* where the Social Work represents an inseparable part is used for marking of interactions which are under way between the requirements of surroundings and people.

Ms. Bartlett adds to this:

Managing concerns a human effort to solve situations which can be understood as social tasks; life situations; or life problems. People go through these life tasks primarily as through pressures of their social surroundings. From this, two important thoughts come out: *human managing* on one side and requirements of the surroundings on the other side. To become a part of one compact concept these thoughts have to be interconnected through a dimension which is affected by the thought of social interaction” (Bartlett, 1970:100).

In this concept. the term of social functioning marks a complex of facts:

- 1) People and surroundings are in personal interaction.
- 2) The surroundings put certain requirements on a person (it forms expectations; defines social roles) and the person is forced to react to these.
- 3) There usually is a balance between the requirements of the surroundings and a person. In case that people do not manage the requirements of the surroundings sufficiently, the balance is disturbed and a problem may arise.
- 4) Some people are able to solve the problem and establish the balance themselves; others do not have this ability (or this ability is limited or disturbed for various reasons or event. These people cannot or do not want to use it – note of author) and they cannot manage their problemsituation.
- 5) The reason of problems, or lack of facility for managing them, may be caused by a deficiency of skills on the part of a client and inappropriateness of requirements of the environment towards him/her.
- 6) The subject of intervention of a Social Worker is the interaction between the capability of a client to manage and what is expected from him by the environment. His/her task is to support social functioning of a client by helping him/her to restore or keep balance between more or less sufficient capacity of managing, and to provide this capacity by more or less adequate requirements of the surroundings (Bartlett in Musil, Navrátil, 2000:14).

Carlton defines *Social Functioning* as:

Ability of people to carry out the tasks of daily life and to get involved in relations with other people in a way satisfying both themselves and others; and corresponding with the needs of an organized community (Carlton, 1984:7).

This is a key idea respecting the situation of people with disabilities.

Barker defines *Social Functioning* as:

Fulfillment of roles of a person in society, in relationship to people in his/her immediate

closeness as well as in the relationship to him/herself. This functioning includes satisfying of both basic needs and those on which his/her use in the society is dependent. Human needs include physical aspects (food, shelter, safety, Healthcare and protection); personal fulfillment (education, rest, values, aesthetics, religion, success achievement); emotional needs (sense of belonging, mutual care, community); adequate self-conception (self-confidence, self-respect and personal identity) (Baker, 1995:515).

According to **Musil** and **Navrátil** it is therefore in the interest of complexity and adequacy of intervention to become acquainted effectively with individual configurations of barriers and pre-conditions of social functioning of every client individually. This specific individual configuration is usually called by the term *life situation*. This term means:

- 1) Personal-layered and unrepeatable factors (*and also diversity considered as a casual, phenomenal and consecutive heterogeneity* - note of author) which protect or on the contrary facilitate social functioning of an individual client or a specific category of clients.
- 2) Specification of proper subject of intervention of a Social Worker (*and another assisting Professional* - note of author). Reflection of the life situation of a client (or a category of clients) is the first and necessary step to the choice of such targets and methods of intervention which can contribute to the change of the life situation of a client; to strengthen his ability to manage the requirements of the environment; to help in this way to restoration or sustaining of his/her social functioning” (Musil, Navrátil, 2000:20)

The concept of social functioning puts emphasis on the ability of a person to manage difficult life situations which arise as a result of his/her unbalanced interaction with the social surroundings. One of the important tools for strengthening of mentioned managing abilities is the *life long learning*.

Lifelong Learning as a Way to the Full Life of a PWD

In the context of this article, we understand learning as a lifelong process of often informal and „unguided” acquisition of recognitions and experiences as well as interactive use of gained knowledge or impulses for orienting in the world and the existence of a person in human society. The experience gained proves clearly that a disability can be an obstacle or a limitation in the lifelong learning process. Problematic in a similar way - in the consequences of uncertain life perspectives - can even be the motivation of a *PWD* for further self-education as a way to personal development, social integration and better quality of life in general. The advising on studies, and social advising, are becoming keys helping to solve this problem, reflecting the fact that the openness to a lifelong learning and education and the correctly grasped needs or interests of a person with a disability will lead to choosing an appropriate course, which can be profession-specialized, hobby, activating or „pro-social” one (focusing on social skills and competences development).

The adequacy or validity of a chosen educational program is thus becoming a tool for securing and utilizing achieved education of every *PWD*. This may concern any potential client or a client who does not want to study any regular study program any more. Such a client could gradually lose all of his/her acquired knowledge and skills by the influence of personal circumstances because he/she is not using them any more in entirety and does not have any need to develop further, harming him/herself secondarily on the level of personal as well as civic, or social, functioning.

The educational support of disadvantaged citizens has to respect the *holistic approach*, i.e. that phenomena, events and circumstances are intertwined into a net, in which everything is con-

nected to everything. Whoever is educating him/herself; or should be educated; has to have the conditions for his/her education; has to have a personal predisposition and motivation in addition to the perspective of his/her self-assertion; improvement of his/her position within the society. (Novosad, 2006). Such courses proved to be very useful; contribute to improvement of social orientation and safety of a *PWD*; in this way eliminate the risk of their loneliness and their lowered adaptation to the increasing dependence on civic competency as well as the changes of the world around them.

To illustrate the case, the following are the subjects of one of such courses:

Finances and household; managing energies; citizen in a legal state; home safety; computer literacy and electronic communication; work with information; health and lifestyle; psychology and human relationships; where can I get help in existential and personal difficulties; changes of society and global problems of the human race; how not to be alone - club and spare time activities; do we know our citizen rights and duties? Etc.

Final Word

We consider social inclusion as a process of removing of obstacles in inclusion of individuals and groups into the society; strengthening of elements of solidarity; reciprocity; co-responsibility; as well as common sharing and assumption of social cohesiveness. The diminished social inclusion and the civic participation of a *PWD* are undoubtedly factors which can influence the quality of life of these citizens negatively and are directly linked to their social acceptance. This means that if a citizen is capable to participate in the life of the society proportionately, he/she is (mostly) accepted despite to his/her personal specifics. However, if he/she is incapable of this, then he/she is not socially accepted and heads towards social exclusion - that is towards exclusion from the mainstream of life of society. The sense of the support of life long learning of *PWD* is to easily attain provision of their basic human rights, which are (Novosad, 2004):

- the right to be different
- the right to dignified and adequate lifestyle
- the right to integration within society - the right to have their own opinion; to express it; to apply it
- the right to fully-fledged citizenship;
- an independent choice of the way of life and place of residence.

Modern support for *people with disabilities* lies in a common search for ways to make life choices or opportunities accessible and reducing the risk factors. It does not only lie in realization of some special or advantageous measures accepting some „defect”, dysfunction or anomaly and creating in this way an imaginary parallel world for people with disabilities.

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The Level of Patient Satisfaction with Outpatient Chemotherapy Administration

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Summary

The authors deal with the statements of patients receiving outpatient chemotherapy administration. Through a Questionnaire survey they look for the level of satisfaction of patients with the approach of physicians and nurses in health and nursing care. They pay attention to feelings related to the nursing care; outpatient care environment; waiting times; telephone services in health facilities. Patients are undergoing a therapeutic process and therefore they expect a change for the better, so every positive stimulus associated with their treatment is very important.

Key words: patient satisfaction, outpatient chemotherapy administration, telephonic services in Health Facilities

Introduction

In our research, we focused on the patients themselves; their level of satisfaction with the provision of health and nursing care; to approach of medical staff; to the issue of information about their medical condition; to the ability of nurses and doctors to answer patient's questions. Waiting times, nursing care and other factors are just as important to patients as mere treatment and nursing care.

Research problem

To determine the level of satisfaction of patients receiving outpatient chemotherapy administration in OÚA in Bratislava with the quality of health and nursing care.

Objectives of the survey

- 1 Find out whether health care employees on ambulances meet the requirements of professionalism and moral of health care professional.
- 2 Identify the level of patient satisfaction with outpatient spaces in which was

administered, respectively is administered outpatient chemotherapy.

- 3 Find out the level of patient satisfaction with the level of telephone connection.
- 4 Find out the level of awareness of patients regarding their health.
- 5 Find out the level of patient satisfaction with the quality of nursing care at the clinic where chemotherapy is administered.

Research Methods

As a basic survey method, we chose a Questionnaire of our own design which we evaluated and showed our findings in tables and graphically. The Questionnaire was anonymous. It contained 15 closed-type questionnaire items and 1 item with free answers. The survey was conducted from 25 April 2008 to 16 November 2009.

Working Hypotheses

H1 We assume that most patients are satisfied with management, organization and location of outpatient facilities in which patients received chemotherapy treatment.

H2 We assume that medical and nursing care and holistic approach of health professionals in relation to the patient is at the professional level.

H3 We assume that most patients are satisfied with the level of information about their medical condition.

H4 We assume that most patients are satisfied with the availability and quality of telephone connection.

Characteristics of Survey Population

A core set of respondents were 250 patients treated with outpatient chemotherapy in OÚSA Bratislava. Age of the respondents was 29 - 65 years.

Demographic Data of Basic Sample of Respondents

Sex	n	%
Male	80	32,0%
Female	170	68,0%
N	250	100%

Table 17

Residence	n	%
Urban	200	80,0%
Rural	50	20,0%
N	250	100%

Table 18

Status	n	%
Single	40	16,0%
Married	150	60,0%
Devorsed	20	8,0%
Widower	30	12%
Companion	10	4%
N	250	100%

Table 19

Highest completed education	n	%
Basic	20	8,0%
Secondary	10	4,0%
Secondary with GCE	140	56,0%
College	80	32,0%
N	250	100%

Analysis of Survey Results

H1 We assume that most patients are satisfied with the organizational work placement and outpatient facilities

Table 1

Are you satisfied with waiting time for treatment in the clinic?	n	%
Yes, it is reasonable	150	60,0%
I do not know, I do not care	20	8,0%
I do not like it, it is too long	80	32,0%
N	250	100%

Table 2

How do you feel in the waiting room?	n	%
It is nice	160	64,0%
It is cramped and dark	90	36,0%
I do not know, I do not care	0	0,0%
Dingy and dirty	0	0,0%
N	250	100%

Table 3

Are you satisfied with ambulance office hours?	n	%
Yes	230	92,0%
No	0	0,0%
I do not know, I do not care	20	8,0%
N	250	100%

Table 4

How do you assess the organization of entry into the ambulance?	n	%
It is very well organized	40	16,0%
Passable	160	64,0%
It is very tedious	50	20,0%
Unsuitable	0	0,0%
N	250	100%

H2 We assume that medical and nursing care and approach of health workers in relation to the patient is at a high professional level.

Table 5

How do you rate the approach of nurse that brought you into ambulance?	n	%
Very good	200	80,0%
Good	50	20,0%
Passable	0	0,0%
Poor	0	0,0%
Do not know	0	0,0%
N	250	100%

Table 6

Are you satisfied with practicing physician?	n	%
Yes	210	84,0%
I do not know	40	16,0%
I am not satisfied	20	8,0%
N	250	100%

Table 7

How do you assess the willingness of nurses to address and answer your questions?	n	%
Very good	190	76,0%
Good	60	24,0%
Passable	0	0,0%
Poor	0	0,0%
I do not know, I did not have questions	0	0,0%
N	250	100%

Table 8

How do you assess the willingness of doctors to address and answer your questions?	n	%
Very good	230	92,0%
Good	20	8,0%
Poor	0	0,0%
I do not know, I did not have questions	0	0,0%
N	250	100%

Table 9

What is your overall impression of the level of patient care?	n	%
Very good	140	56,0%
Good	70	28,0%
Passable	0	0,0%
Poor	0	0,0%
Do not know	0	0,0%
N	250	100%

Table 10

Would you recommend our clinic chemotherapy, if necessary, to your friends?	n	%
Yes	210	84,0%
I do not know	40	16,0%
No	0	0,0%
N	250	100%

H3 We assume that most patients are satisfied with the level of information about their medical condition.

Table 11

Information from the doctor about your illness was?	n	%
Sufficient	190	76,0%
Can not judge	60	24,0%
Insufficient	0	0,0%
N	250	100%

Table 12

Have you been informed about the way of administration of chemotherapy and its side effects?	n	%
Yes	220	88,0%
I do not know	30	12,0%
No	0	0,0%
N	250	100%

Table 13

Do you understand all the information and instructions provided by your doctor?	n	%
Yes, I understand everything	190	76,0%
Yes, but I understood only certain information	60	24,0%
No, I do not understand everything	0	0,0%
N	250	100%

H4 We assume that most patients are satisfied with the accessibility and the level of telephone connection.

Table 14

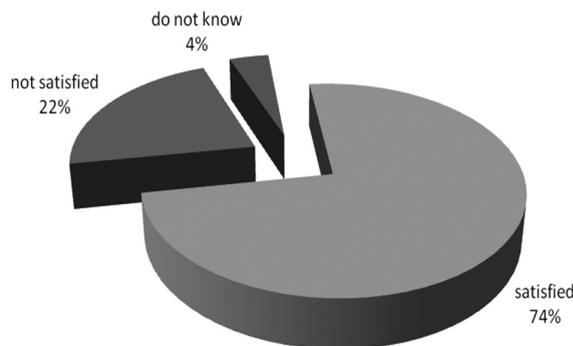
How do you rate telephone connection with ambulance?	n	%
Very good	170	68,0%
Good	60	24,0%
Passable	20	8,0%
Poor	0	0,0%
I do not know, I have not tried it	0	0,0%
N	250	100%

Table 15

How do you rate willingness of a worker's who took your phone call?	n	%
Very good	180	72,0%
Good	60	24,0%
Passable	10	4,0%
Poor	0	0,0%
I do not know, I have not tried it	0	0,0%
N	250	100%

In working Hypothesis **H1** we assumed that a majority of respondents - patients will be satisfied with the organizational work and with location of outpatient facilities in which they administered chemotherapy. This working hypothesis was verified in items 3, 4, 5 and 6.

Graph 1

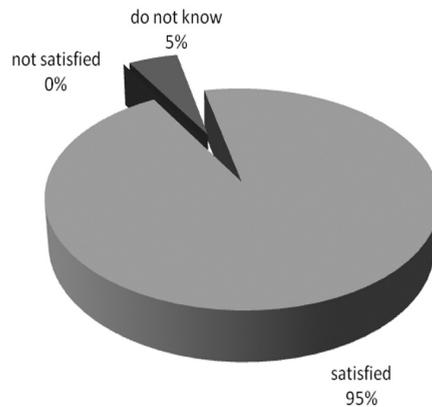


We found that 74% of respondents were satisfied with the organization of work, 22% expressed dissatisfaction - mainly with confined space prior to the administration of chemotherapy and 4% could not express.

On this basis, we can conclude that working hypothesis H1 is confirmed.

In the working Hypothesis **H2** we assumed that health care of workers to patients is at a high professional level. The working hypothesis was verified by items 7, 8, 12, 13 and 14.

Graph 2

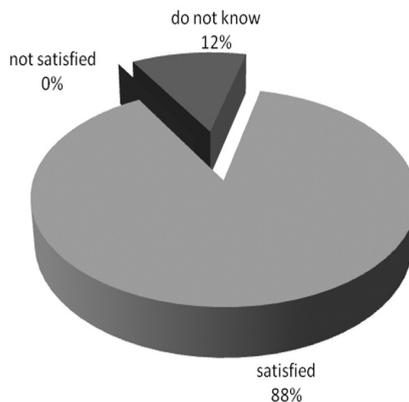


We found that 95% of respondents rated the medical and nursing care as very good and at a high professional level, 5% reported that medical and nursing care were at the professional level.

On this basis, we can conclude that working hypothesis H2 is confirmed.

In the working Hypothesis H3 we assumed that patients are satisfied with the information provided on their health. The working hypothesis was verified items 9, 10 and 11.

Graph 3

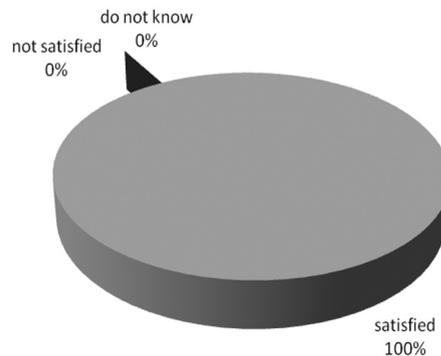


We found that 88% of respondents were satisfied with the level of provided information about their health and 12% were unable to comment on the issue.

On this basis, we can conclude that working hypothesis H3 is confirmed.

In the working Hypothesis 4 we assumed that most patients will be satisfied with the possibilities and the level of dial-up connection. The working hypothesis was verified in items 1 and 2.

Graph 4



We found that up to 100% of the respondents were satisfied with the level and options of telephone connection.

Based on our findings, we can conclude that working hypothesis H4 is confirmed.

Recommendations for Practice

Nurses and Doctors should treat the patient, so that right from the first contact patients should have confidence in them and should not feel that their multiple issues are a „burden or time consuming”

Nurses should be particularly attentive to nonverbal as well as verbal expressions in contact with patients
Ensure that there are enough information brochures in the waiting room including newsletters, journals about diseases, diet for patients that are an important source of information

Provide information panel (wall) with information on the nearest store with assistive devices, wig studies and the like

Nurses should pay attention to their behavior and demeanor even in telephone contact with the patients and their family members

Head Nurses and Nurses should implement surveys to monitor levels of patient satisfaction with health and nursing care; draw conclusions; thus constantly improve their nursing care and clinical practice.

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Ethics and Approach to the Patient in the ICU

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Summary

Patients in critical condition are sensitive to Ethical issues because they are completely powerless; this means that they do not have any control of their situation. Patients are dependent on Healthcare Professionals and their expertise and their moral qualities which include accountability, accuracy and thoroughness. In patients in critical condition many Healthcare Workers, who in conditions of stress, rotate to make and execute interventions saving patient's life. Therefore, it is necessary to create a good working atmosphere and smooth collaboration between those who control patient's fate. Such work atmosphere is dependent on the high expertise of Health Professionals because essential accuracy comes from them. Following serious operating interventions and in immediately life-threatening conditions, patients can be in a bad mood, sad and/or depressed. Therefore, it is necessary there be constant contact of the staff with the patient to make him/her certain that in any unexpected emergency situation help is at hand. When caring for patients in critical condition, the personal morality of staff is most often revealed. With post-operative conditions, accidents and sudden episodes there is associated acute pain of high intensity. It is *unethical* if the patient suffers unnecessarily and staff cannot ease the pain because every individual has the right to prevent and minimize his/her suffering and pain in all stages of disease.

Key words: Ethics, approach to patient, ICU, Nurse, Ethical issues in the ICU, Intensive Medicine

Ethics and Approaches to a Patient

Ethics (from the Greek word *Ethos - run to the light*, course of correct action, right attitude) is thinking about the correctness of morality and its regulations; addressing in particular the accuracy of the requirements of morals in various situations and areas.

• It is the branch of Philosophy that attempts to determine how human activities can be evaluated as right or wrong.

• The Principle of all Morality is to „do good” and „avoid evil”.

• It is a discipline whose subject is Morality.

• It is practical Philosophy.

• It is part of the Culture of Society (Anzenbacher, 1994) Originally Ethics meant living place determined by society or origin.

The Subject of Ethics Can Be Divided into the Following Sections:

• Normative Ethics

• MetaEthics

• Practical Ethics

• Heteronomous Ethics

- Autonomous Ethics - a person alone defines their own Ethical Principles
- Individual Ethics - deals with the moral profile of individuals
- Social Ethics - Ethics of social groups
- BioEthics

Normative Ethics asks questions that are directly related to the criteria and standards of proper and improper (bad) behavior.

MetaEthics is the examination of the second stage of the essence of Ethical Discourse itself.

Practical Ethics examines specific situations and decisions complexly or within the field (Professional Ethics).

Heteronomous Ethics - Ethical Principles are given from the outside, by Social Authority or by Higher Authority respectively (Anzenbacher, 1994).

BioEthics separates discipline that studies the Ethical Issues associated with the creation and end of life and with life itself.

Medical Ethics is Normative Ethics without clear binding Rules and Principles.

Ethics of Law - Theory according to which are first determined Rights or Moral Demands of individuals and then the hierarchy of those Rights. The advantage is the respect to importance of the Moral Rights of individuals; the disadvantage is that this theory does not determine how to proceed if the rights of individuals come into conflict with each other.

Ethical Theory - Process in which we collect information and mutually competing values and interests and formulate a response to the question „What should I do?”

Morality - A summary of the ways in which individuals in a society express all habits, customs, standards, laws and everything that should make human life easier with given decision making formulas and to regulate the way of life of the individual in society. It is a prerequisite for social life; it gives us confidence what we can expect from others; gives borders to our free behavior and acting. It gives us a sense of security.

Ethical Theory aims to create mechanisms to solve our moral problems in which three Principles apply:

- **Value of Life** - the value of the Moral
- **Quality of Life** - a subjective feeling when we ourselves are making an approximate idea which is influenced by our experiences and attitudes
- **Sanctity of Life** - results from religious attitudes (Munzarová, 2005)

The values of people are changing in their lives, mainly with regard Health status and values we consider to be secure; we may not realize that a change can occur.

„Ethics has to deal with three opponents - with the absence of thinking, with selfish self-preservation and with society.” (Albert Schweitzer)

Intensive Care Medicine is an interdisciplinary Medical field dealing with the monitoring of patients whose vital signs are failing; with acutely ill patients; with subsequent use of appropriate diagnostic and therapeutic procedures to improve the quality of life. A multi-disciplinary approach in the care and treatment of critically ill patients is required. Health Workers in Intensive Care implement treatment and care of the critically ill and try to contribute to restore a previous state of Health and quality of life (various authors, 2007). In critical situations, they are very often confronted with the issue of death and dying which require attributes of dignity. The treatment of critically ill patients places increased demands on them and they are at increased risk of mental and physical stress. Nurses working in an Intensive Care Unit (ICU) are put under intense demands because they must be able to respond immediately to any change in a patient's Medical condition which can negatively affect their mental, physical and especially emotional states. Nurses must make interventions which are unpleasant and repulsive and come with pain and

death, suffering, depression, uncertainty, and for severely ill patients who expect much more than just a good attitude and effective communication. Long-term effects of chronic stress can have a destructive effect on Nurses. She/he can become unpleasant to the patient; to her/his associates; dissociate from her/his surroundings; withdraw to solitude; reduce working efficiency. These Nurses can feel physically, emotionally and mentally exhausted; social roles become a burden which comes to the point that we can define as burnout. It is a serious Psychological and Medical problem affecting quality of life and performance. Its symptom is the loss of energy and ideals which in turn leads to stagnation, frustration and apathy. Burnout causes Nurses to lose interest in the people with whom they work and to emotional dryness in relation to patients. They do not feel pity for the patient and do not have the necessary respect.

ICU is mainly used for:

- Children who are staying in hospital and a sudden and serious deterioration in their clinical status occurs during hospitalization.
- Children on whom was performed procedures under general anesthesia (Bronchoscopy, Surgery) and there were complications that require intensive care or emergency treatment
- Patients who were transferred from another Healthcare Facility and need intensive care
- For pediatric patients in limited number from our catchment area.

On ICU are treated patients:

- With diseases of the central and peripheral nervous system
- With neuro-muscular diseases
- With disorders of consciousness and seizures
- With headaches
- With degenerative and demyelinating diseases of the nervous system
- With dementia
- With various causes of dizziness
- With diseases of peripheral nerves
- With neurological damages (Šimko, Babík, 1997)

Types of JIS

Specialized Types of ICUs include:

- Neonatal ICU
- Children's (Pediatric) ICU
- Psychiatric ICU
- Coronary Unit (Coronary ICU) for Cardiac Events
- Cardiac Surgery ICU
- Cardiovascular ICU
- Mobile ICU
- Surgical ICU
- Orthopedic ICU
- Gynecology and Obstetrics ICU
- Internal ICU
- Night-intensive Recovery ICU (for operations with short-term hospitalization)
- Neurological ICU
- Burns ICU
- Accident (Trauma) ICU
- Respiratory ICU
- Geriatric ICU
- Metabolic ICU

- Infectious ICU
- Neurosurgery ICU

ICU Patients (ICU Patient Concept)

As a result of a serious Health condition, a patient placed in such an environment, either as a result of the planned intervention when he is informed ahead about the possibility of ICU hospitalization or suddenly due to the deteriorated Health or other complications requiring surgical intervention.

Perceptions of patients differ mainly in connection with their previous experience with a stay in hospital. For some, the word ICU is characterized as a lot of tubes, monitors and whistling pumps. For another, who has already met this environment, it can be continuous monitoring, noise, direct contact with the Nurse or interference with privacy and intimacy. As a result, it is a most unpleasant experience for everybody.

These patients are usually continuously ECG monitored where electrodes must be attached to the chest; at intervals vital signs are monitored; state of consciousness which is needed to determine whether the patient is disoriented or whether response is adequate; whether the patient does not show dysarthria; failure of expression as a phatic disorder; whether pupils are of the same size; how much the patient drinks and urinates; when he was on the toilet; monitors the condition of his/her skin; and proper hygiene which usually is not done her/himself but assisted by a Nurse. All these performances are major interventions into intimate spheres of the patient and they can be most discomforting; she/he is subjected to constant commands of Nurses because she/he agreed with intervention and in this consent without having any idea of what it in the true sense involves (Dobiáš, 2007).

At this point, it is a Nurse who would be closest to her/him and most helpful; in this moment; a Nurse has to look at the patient as at a passive entity who submits to decisions, commands and care of Health Workers.

The most common problem we encounter in those workplaces (open type, e.g. ICU with 6 beds) is to *provide privacy*. For many of us, as for Health Professionals, it's a normal routine; to the patient the exposure of their body is an unpleasant experience. We apologize that in connecting a monitor, a patient is often uncovered to our eyes for minutes without us realizing our intrusion. Very often, the fact that these ICUs are mixed, with men and women, is ignored and we often forget that we may expose a patient to other patients.

Another common problem is *shame*. We are people of different natures and thus we are unique individuals. Some patients have problems to share their intimate wishes with anyone they know for only a very short time. This applies particularly to discharge of bodily fluids or matter. A very common problem in this type of open ICU is that patients initially obtain information where they can go to the toilet but after surgery, due to complications, they cannot leave their bed. After the introduction to the bowl they often refuse to eat and drink. It can be a big problem to explain to men that the only way to empty is into the bowl - it is often an humiliating feeling. Unfortunately, our ICUs have not a toilet and it is nearly impossible to ensure privacy for the individual patient. The patient can feel „impossibly” embarrassed in front of other patients and before staff. Often there is also a blunder on the part of Medical personnel who often solves this problem publicly and loudly regardless of the personal shame to the patient. We can encounter this sensitive subject in the care at every moment (Kapounová, 2007).

During examination by a Doctor, the Doctor takes it for granted to uncover the patient's chest; during the application of permanent catheters is also done during visits which interferes with

their discussions; often regardless of whether the patient likes it or not; Nurses should encourage Doctors to support the family of the patient.

There can be a lack of empathy; the ability to empathize with the situation in which patients are confined. It is an art for Health Care Professionals and very few of them ask questions: „How would I feel if I was in that position? What would I need most? What would help me the most?”

Empathy, respect and authenticity are referred to as basic factors for easier building of relationships. For Nurses, these are prerequisites to focus attention on the patient and everything connected with her/him. For a good Nurse, not only would it be the goal that she understands the patient and addresses the patient’s problem, but should think about it as a personal confidence (secret); as something that is shared between her/him and the patient; and the patient should see a human person with approximately equal feelings and needs.

A patient’s revelation is necessary and essential communication. Already, at the first contact with the patient, our behavior matters. The patient comes to the hospital, often for the first time in her/his life; she/he is full of fear, emotions and often perceives surroundings more sensitively than we can imagine.

The Health Professional in Departments moves with complete authority as they are in an environment they are familiar with.

Communication is defined as the human ability to use means of expression, both verbal and non-verbal; to create and maintain interpersonal relationships. Communication is made through media process in which a human being reveals their emotions, will and thoughts and communicates information. Communication with a patient is an important component of professional conduct, which is such form of expression that is characteristic of particular professions and which develops throughout its duration.

A person needs to talk; there needs to be someone who listens; there needs to be a sense of belonging with other people. Communication often, however, carries risk of misunderstanding, condemnation or disappointment.

Today’s Medicine has somewhat shifted the traditional role of the patient and his/her family. From a passive consumer of Healthcare, a person needs to become an active participant in the efforts of Health Professionals to maintain or return to their own Health and self-sufficiency in basic daily activities.

The traditional relationship of Health Professionals to the patient and his family was mostly characterized by an authoritarian approach. This is not the best way if we want to participate in the recuperation of the patient together with the family. It pre-establishes a relationship of domination and subordination which is antithetical to a healing partnership.

This partnership is characterized by (according to Křivohlavý, 2002):

- Authority and truthfulness in relation to the patient and those close to her/him
- Dignity and respect to the patient and those close to her/him
- Understanding and empathy for the patient and his loved ones

A Nurse must realize the distortion of stereotype by hospitalization; separation from loved ones; change in eating habits have a negative impact on patients. From this implies that treatment for patients puts extraordinary physical and mental demands on Nurses. What approach constitutes proper provided care? Nurse activates patients due to their reduced self-sufficiency and often satisfies their biological needs. It is important to support them in their state of helplessness, emotional suffering and psychological burden to awake in them again a taste for life.

When it comes to Medical Staff, there arises the demand for an individual approach to patients. If an individual approach is missing, work of Medical Professionals loses efficiency and Healthcare Professionals cannot take advantage of their contact with the patient in effective treatment.

In relations to the patient, Medicine is limited by orientation on the technical aspects of treatment; routine paperwork; often associated with a lack of thought-fullness; expertise and superiority to professional fatigue and stress (Gulášová, 2008). This leads to problems, failures, conflicts and disagreements. Very often there appears a vicious circle of routine ways of working; tapered dealing with patients; problems in relationships with them; unmet performance results; discontent over themselves and with the work performed.

Nurses and Ethical Issues

The assessment of whether Nurses solve Ethical Problems also is difficult because it is not easy for them to determine what the Ethical problem actually is. When questioned what Ethical Issues they face, Nurses have problems to answer; they do not know exactly; and they do not perceive many problems as Ethical problems. A typical example of a conflict of values when treating patients is the positioning of patients against their will. Nurses questioned over this issue spontaneously did not think about it; they usually do not use the terminology of principles and values but are following nursing standards, treatment procedures or prevention of pressure ulcers.

Nurses feel that if they have to make decisions in cases of so-called „great moral dilemmas” such as questions of euthanasia; disconnecting of life-sustaining apparatus; abortion; organ donation; assisted reproduction; etc., they should have the power - „No one asks them and the Doctor there always eventually decides”. On the other hand, they perceive that Doctors sometimes decide against the wishes of the patient or they do not provide patients with the ability to make decisions or to choose different options.

Nurses can of course use and combine different methods when solving problems. They can use the usual method of solving problems when providing the care through the nursing process or they can use models that offer assistance in examining the values and defining of needs of the client.

The Issue of Whether Nurses Address Ethical Issues Can Be Viewed From Two Angles:

- Whether Nurses systematically participate in the searching and identifying of problems; carry out analysis; plan interventions; implement activities that would lead to the solving of a particular problem or to prevent further problems (Gulášová, 2008).
- Slang expression of the fact that something is bothering me; that I cannot put up with it; that I am thinking about it; I'm not sure if I have enough power or powers to deal with this situation (Linhartová, 2007). In problem solving procedures, Nurses, of course, can use and combine different methods. In providing care, they can use a routine method of solution using the nursing process or can use models that offer support in examining the values and defining of needs of the client.

The most common problems reported by Healthcare Professionals are lack of time; the attitude of Doctors toward patients and Nurses; the general behavior of Nurses toward patients and toward each other.

Most Nurses in the Czech Republic do not recognize the theoretical models of Ethical Deliberation. Nurses solve Ethical problems in their daily practice. We can then say with certainty that our sisters „deal” with Ethical problems, at least in the sense that they reflect on the behavior of Health Workers, although they often judge more critically the behavior of 'others' than their own behavior. From my own experience they are familiar with the sense of moral distress.

The *term moral distress* was first used in 1984. Author **Andrew Jameton** defined moral distress as the suffering experienced by Nurses when the circumstances or environmental conditions

of the work environment do not allow them to act as they feel is Ethically correct (Vacínová, Langová, 2011). In the Czech Nursing Literature, the term moral distress does not appear, but it is, however, well known as **burnout** which is one of the manifestations and consequences of moral distress. Foreign Literature shows that Nursing Ethics, in addition to Abstract Principles, mainly deals with relationships between Health Professionals and patients and the Health Professionals themselves. **Verena Tschudin** in her book *Approaches to Ethics - Nursing Beyond Boundaries* states:

All nursing care is Ethical care and even the way we greet the patient counts.

It is also important to remember Patient's Rights. Patient's Rights are derived from Basic Human Rights. *The Universal Declaration of Human Rights* was issued in 1948 as a guarantee that there was no repetition of the abuse of Medicine which occurred during World War II. Patients' Rights were defined in 1950s of the 20th Century in the USA and Western Europe. The reasons were economic growth; education of the population; the interest of patients in information. Simultaneously, these aspects led to the fact that a personal approach

to the patient was lost; the disclosure of sensitive information; the related issue of protection of personal data of patients.

Basic Regulations that govern the issue of Patients' Rights in the Czech Republic is *The Convention on the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine* from 1997 (in force from 1 October 2001). This Convention contains basic Principles such as respect for human dignity; protection of the integrity of the individual; patient's consent with the intervention; privacy; prohibition of the use of the human body and its parts for commercial or other purposes.

We also consider it necessary to remember other legislation that relates to the position of patients; *The Declaration of Basic Rights and Freedoms*; notably the right to life, personal integrity and privacy; personal freedom; human dignity; and Health protection (Kýasová, Chalupová, 2001). Let us remember them.

Fundamental Rights of Patients

- The right to free choice of Doctor
- The right to accept or refuse treatment after he is adequately informed
- The right that the Physician will respect the confidential nature of his Medical and personal details
- The right to die with dignity
- The right to expect that the hospital, according to its ability, adequately accommodates the patient's request to a degree appropriate to the nature of the disease
- If necessary, the patient can be transferred to another Healthcare Facility or transported once she/he has been given full information about the justification and necessity of the transfer and other options that may exist. An institution that should take over her/him must first approve it.
- The right to expect that his treatment will be conducted with reasonable continuity. She/he has a right to know which Physicians, in which surgeries, in which working hours, and at what place is available to her/him.
- The right to accept or decline spiritual and moral comfort
- The right to detailed and comprehensible explanation if the Physician decides to use an unusual procedure or experiment. Written informed consent of the patient is a prerequisite for the initiation of therapeutic and non-therapeutic research. The patient may at any time and without cause withdraw from an experiment when she/he has been informed of the possible Health consequences of such a decision

- Close to the end of life, has the right to sensitive care from all Health Professionals who have to respect her/his wishes if those wishes are not in conflict with applicable laws.
- The right and responsibility to know and follow the rules of Medical Institutions where they are treated (Hospital Rules). The patient will have the right to check her/his billing account and require justification of its items regardless of the source of payment.

It is worth recalling that in *Article 9 of The Convention on Human Rights and Biomedicine* it is written: „There will be taken account of the patient's previously expressed wishes relating to a Medical intervention if a patient is at the time of the intervention in a state to express her/his wishes.” (Gulášová, 2009)

What Can We Say in Conclusion?

Perhaps we can recall some words from *The Code of Ethics for Nurses*:

A Nurse has a duty to take care of Health, to prevent illness, to restore Health and to alleviate suffering. An essential part of Nursing is respect for Human Rights, as the Right to Life, to dignity and to be treated with respect. We should not forget that Nursing Care is not limited to age, gender, skin color, nationality, political affiliation or social status. A Nurse respects confidentiality, protects confidential patient information and shares this information only with the consent of the patient and the Doctor. She is involved in the initiation and promotion of activities aimed at the fulfillment of the Health and social needs of citizens. She follows the rules of etiquette, is required to provide the highest possible level of Health care, etc.

Conclusion

It is necessary to highlight the need for an individual approach to each patient/person; it is necessary to identify needs and assist in their satisfaction; ensure security and safety; know the whole person, her/his background, interests, abilities from which she/he derives their dignity, self-determination and self-confidence; promote his/her self-sufficiency and independence; have respect for his/her privacy and intimacy.

Each patient is an individual, and during hospitalization, a partial degradation of his personality occurs.

Every day, we should think about the fact that a woman/man who lies before us also has her/his own feelings and wishes; that we are not just robots set to the same program; it is not any shame to show our understanding. We will be support to these patients and no scarecrow for other days. Sometimes where our patients are there, we can be there, too.

Everybody should endeavor, in the environment in which she/he lives, to manifest to her/his surroundings the true humanism on which the future of humanity depends!

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Unspoken Questions of Cancer Patients

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Summary

Cancer is currently linked with the notion of incurability and inevitable death. To accept the reality of the cancer is a gradual process which is the result not only of will or volition. And it concerns not only the patient. As regards the patient, the way she/he can absorb the disease process depends on several factors. Those mainly are character and personality of the patient; ability to cope with stressful situations; current life situations; as well as the degree of support of family or friends. Communication with cancer patients is one of the most important abilities of each Healthcare Professional. It differs, and is also specific to each development stage of the patient's response to disease. Above all, however, it is crucial in the establishing of mutual trust necessary to a successful partnership of Health Professionals with patients. The authors in this article deal with unspoken questions of cancer patients. One of the most common causes for unspoken questions is that after the announcement of diagnosis and receiving necessary therapeutic measures, suddenly under their impact, the patient needs some time to think through their situation.

Key words: Cancer patient, Nurse, communication, individual psychological approach, unspoken questions

Introduction

Communication with the patient, which is used effectively, can influence the patient the same as medications. Communication is needed in all aspects of curative and preventive care whether it is the first contact or in long-term care. In addition to expert Medical knowledge, Health Professionals are expected also to have knowledge of Psychology, Sociology and Ethics. Every patient is a bio-psycho-social being with her/his own priorities, needs, problems and diseases; therefore, everyone reacts differently in the same situation.

In this sense, we are talking about an holistic approach to the patient. These requirements translate into skills in communicating with patients and in informing the patients. We should be able to discern what information a patient expects from us; how to administer it to him; to understand it; what they need to know.

Certainly, with unpleasant information that we should give to a patient, we should approach her/him tactfully and empathically in a properly created atmosphere so that the information is the least devalued to a patient. In the field of Communication in Nursing, we still have much to learn and we should continually expand our knowledge because we have large reserves in it. Information about the communication in Healthcare is mainly at the theoretical level. From Science in Nursing, we further develop educational programs implemented in Secondary Health Schools and Universities – Departments of Nursing, Seminars and Training Courses. It is therefore in the interest of Nursing Practice, that we first develop the Science of Nursing. Nurses as an intermediary between Doctors and patients should in the future have to integrate more into the work of Doctors and into the suffering of patients. A state should

be created according to local conditions when patients have a better idea of what they can ask Nurses and Doctors about; what will Nurses and Doctors ask them about; as well as the fact that they should have full confidence in them with their problems and not to think that it bothers them; so that Nurses and Doctors would better understand them, meet their needs and satisfy them in their mental state of mind.

Oncological disease is one of the most challenging situations that may arise in the life of individuals and families. It is a heavy burden both physically and mentally; changing the situation of survival and co-existence; requires a lot of changes and adaptation; brings many questions that at the time of diagnosis are not easy to find a clear answer to (Gulášová, 2008).

How Important Is Communication

It can be assumed that sooner or later family and friends will learn about a cancer. Therefore, it is wiser to explain to them sooner so they are better able to offer support and assistance; to make time to allow them to adapt to the illness for the benefit of their close patient; for their own benefit. Severe disease is often an opportunity that uncovers and meaningfully addresses years of unresolved conflicts and misunderstandings. So it is possible to discover the source of aid where a patient does not expect it. The disease greatly changes their view of the world. Original values are converted and obtain different qualities. It happens that when the diagnosis is first known by the family, they often face the temptation to „protect” the patient from the reality of the disease. This situation can change into a game of inadequate compassion and pity. A most common motive is fear that a susceptible patient „could do something”. Family members who know the diagnosis are also exposed to a heavy burden. They themselves need to express their feelings and as the impact of this unbalanced, skewed situation they cannot afford to speak them (Linhartová, 2007). Subsequently, they cannot provide the necessary support and assistance to their loved one who has fallen seriously ill. During treatment, the patient generally learns the truth; may now believe that she/he was not told the truth; possibly followed by waves of anger, bitterness and loss of confidence.

Adoption to diagnosis is difficult and from a psychological perspective a crucial period that determines how the diagnosis and the treatment will be received. If the diagnosis is not told then it increases the patient's tendency to anxiety and hyper-sensitivity. A patient gradually ceases to be readable by his surroundings. He could hide behind a wall of his own feelings, his thoughts, prejudices and unrealistic expectations. Such an unconscious isolation state can gradually move a patient away from her/his surroundings and alone from her/himself, and may even jeopardize the successful course of treatment.

Conversely, explanation, confession and opening create a bridge not only to the understanding but also to the enduring of a difficult oncological treatment. The period of revealing the diagnosis deserves more attention because if one family member becomes ill in a way, then the entire family system becomes ill.

The pitfall of this period is different readiness of individual family members. Everyone has a different ability to respond to changes or different speed of adaptation. Often there arises a discrepancy between a patient and family in the need to talk about the illness. The important thing is to let the patient determine in her/his own way when is a good time to talk. Family members should support him in the belief that it is purely up to him; here can be significantly applied communication by touching, caressing or hugging. For the family, it is important to realize that a family member is exposed to an enormously huge burden. She/he is afraid of the disease, pain and experiences a life-threatening situation; anticipates side effects of the therapy; is often clue-

less about changing normal working life and personal life roles. The load itself is not decisive for the survival of the patient; the greater role plays how it is incorporated and what are her/his coping resources.

In therapy we often meet exhausted partners or parents of an adult cancer patient who fully take care of their sick close one and who reduce their own demands and needs to an essential minimum. Thus, we consider the provision of psychotherapeutic treatment for the family of an oncological patient because it is as important as providing it to the patient her/himself. There is a risky period after the informing about a diagnosis in the differing readiness of individual family members to hear. Each of them has a different ability to respond to changes and they have a different speed of adaptation.

Importance of Psychological Assistance in the Treatment of Cancer

Anyone who is informed about the cancer diagnosis experiences one of the worst periods of his/her life. And it is not so important whether the bad news comes totally unexpectedly or as an acknowledgment of long suspicions that something was not right. There does not exist a way to make preparation for such bad news. However, there can be affected their attitude towards it, toward the world and for themselves which can be a decisive factor in the success of treatment (Gulášová, 2008).

In most cases, patients describe the period of reception of diagnosis and initiation of treatment as „electric shock”, „discharge of fuses” or „like I was dropped in the jungle and did not have a map”. The initial shock is often accompanied by feelings of unreality; a person may feel as if it does not concern him because it could not be true. That reality is so unacceptable that there begin to function different unconscious psychological defense mechanisms which are a kind of buffer against reality. This is when a patient does not perceive or intentionally/consciously/or subconsciously „overheard” individual information. It is therefore appropriate that the patient may be accompanied to the Doctor by someone close who can remember or write down everything that the Doctor says. It is important for the patient to have the courage to repeatedly ask for what he did not understand; what is not clear. It is also helpful if the patient can stand up to active disease and fight disease *with* their Doctor. Also, there needs to be enough appropriate information from reliable sources which can help. But it is prudent to watch out for grandiose information from co-patients which works as a sort of „swapping” of the fear to the shoulders of another patient when the first one is relieved by unknowingly and unintentionally scaring of the other one (Gulášová, 2008).

Unfortunately, it sometimes happens that the cancer disease is just a sort of culmination of many difficult and protracted difficulties and problems in the life of the patient. And, if it was not enough, they may associate it with others problems - work, financial, family, etc. Then the person can have thoughts of resignation because it is hard to believe that it might get better.

During this period, it is appropriate for a patient to visit a Specialist - either a Psychologist or Psychiatrist - especially if there are problems with sleep; survival anxiety; feelings of panic; sadness; etc. It is possible that the patient does not think of a visit to a Specialist as a solution, so it could be sensitively suggested by close ones.

Oncological patients have to cope with many heavy emotions such as anger, helplessness, injustice, guilt, punishment, anxiety and fear, loneliness, etc. It is relevant to perceive their own feelings; recognize them; not to underrate them; talk about them; or express them in any other suitable manner. To help a patient become aware of these confusing emotions someone close or, even better, a qualified Psychologist can be supportive. Sometimes, a patient rather reveals his

thoughts to a qualified Psychologist than to close ones in order to protect them against his oppressive emotions. In any case, however, each should share their feelings because if the patient and relative alone try to pretend bravery to each other, eventually it becomes a difficult situation for everyone. Here, too, to facilitate joint communication by a third party, for example by a Psychologist can help (Gulášová, 2008).

Oncological disease brings many losses relative to the previous way of life. The patient's foundations of the vision of life and the world as a safe place where bad and unpleasant things happen to other people will shudder. Suddenly, the whole world is turned upside down. A patient somewhat loses her/his way and style of life to which she/he was accustomed and thus also loses some degree of independence and only can cope with the loss through sadness or mourning (Kvasová, Chalupová, 2001). It is a natural and necessary process.

What is very important to recognize is when sadness passes into depression which already requires Psychiatric intervention and the need for appropriate prescription drugs. If a person sometimes cries and feels sad, it is okay and even necessary in the process of grieving. But, if she/he is for some time unable to tune to any positive feelings; experience joy; look forward to something; is tired of activities previously liked; has trouble sleeping; has changed appetite; less energy; gets easily tired; is nervous; querulous; sees the world through „dark colored glasses” then it is necessary to visit a Specialist.

It Is Important to Realize that the Body and Psyche are Closely Linked.

When pain is in the body, the soul suffers, too. Likewise the soul reflects changes in the body. An example is a cancer patient who can suffer from psychogenic reasons returns during therapy: often when the patient changes her/his attitude on chemotherapy to positive and accepts it as a possible way to cure, pain stops completely or at least is significantly reduced. Another example might be the relationship of anxiety to tension in the body. When a person feels anxious, his body is not relaxed. But when it is released, anxiety disappears. Therefore, for cancer patients various release exercises; exercising and relaxation training are very suitable. The effect of the psyche to immunity is proven (Gulášová, 2008).

Diagnosing of oncological disease poses an exceptional burden on each patient. Specialists: Oncologists cure using available resources and knowledge of the body; Psychologist and Psychiatrist focus on the positive influence of the state of the psyche, especially Psychologist. Although seemingly they are separate activities they are, in fact, extremely closely linked by their consequences. Any improvement in the physical condition has, in fact, a positive impact on the psyche of the patient and vice versa. Qualified positive influences of the mind and emotions often help to overcome crises in oncological treatment. In the ideal state they are, therefore, two sides of the same coin - a coin that can significantly benefit a cancer patient in their balance of life (Gulášová, 2008).

Recommendations for Healthcare Facilities:

- Organize Seminars focused on communication in Nursing, Psychology and Ethics in Nursing on both constitutional and clinical levels.
 - Head Nurses should pay attention if Nurses are able to communicate effectively and with highly humane approaches with patients.
 - Head Nurses should implement surveys to monitor the level of patient satisfaction through communication of Nurses in their Department.
- (<http://zsf.osu.cz/dokumenty/sbornik04/gulasova.pdf>)

A question is a formulation and definition of a problem. A question is a statement that captures the elements of an unknown situation or task requiring explanation. In normal language it is expressed by interrogative sentences or combinations of words. A question has a complex structure and it implies also problematic and assertor sides. An assertor side characterizes the purpose of the question; highlights something which presupposes the existence of the issue and what features are still unknown; also outlines the possible meanings of the unknown. This side of a question goes sometimes to the forefront and receives independent significance (rhetorical, suggestive or provocative questions). In terms of truth, values divide properly built questions to meaningful (matching syntactic, semantic and pragmatic criteria of purpose) to one degree or another or to meaninglessness. Reasonableness and accuracy of a question are important aspects of sound and precise thinking. However, there are questions that are never expressed.

Why Are Questions Not Expressed?

When many questions remain unspoken between Doctors and patients, causes of conflict are diverse in nature. It depends on the nature of a patient or on a Doctor's working methods. The degree of confidentiality between Doctor and patient plays a large role. A lot also depends on the family of the patient; the education and training of the patient; the disease itself; many other factors. One of the most common motives for unexpressed questions lies in the fact that after the announcement of diagnosis and discussing of necessary therapeutic measures, the patient suddenly is under the compulsion that she/he needs some time to think through her/his situation. But, even when this is done and everything is shared with relatives and friends there arise ever more unspoken questions. A patient then must find a way to present them, especially if he fears that he is not mentally and professionally at the level of a Doctor and therefore will embarrass himself. But do not fear „dumb” questions! Each question has its own meaning; its background; it can also show the Doctor a hidden persistent problem. At this point, it should be emphasized that under certain circumstances, the Doctor also needs a little time for reflection as he adjusts the diagnosis quite individually to the personal life circumstances of this very specific patient.

„What I do not know, does not bother me” - with this slogan many patients preclude asking a potentially important question. In the depths of their souls, such patients suppose that some of the unspoken issues could result in unpleasant answers and their cooperation also would be required. (Vacínová, Langová, 2011)

Fear of Truth

Due to the fear of the truth many questions remain unspoken. There exists a variety of fears; the truths that are hidden in the patient her/himself; but also in her/his family, circle of friends and the work area. Many patients themselves have no trouble coping with the truth but they fear the reaction of their families. This may include loss of privileges that were previously granted to them because their condition was considered to be worse than it actually was. At the present time, a Doctor tries to express the whole truth but in the past it was different. Today, one of the most important set medical obligations is unconditional informing of the patient. In the majority of cases, it is good for the patient if the unpleasant truth is folded carefully into an appropriate cover and is considerably mediated through hope and ease.

Fear of consequences of an unalterable truth is another complex of unspoken questions.

Fear of the Content of a Question

Patients believe that their verbal skills are not sufficient to actually explain to a Doctor what they „really” want to know. Indeed, it is difficult for the patient to formulate some problems into words.

Fear That a Doctor Would Be Too Upset

Many patients do not dare to speak some questions because they think it would be an exag-

generated imposition on their Doctor. Often, it's just an excuse by which a patient justifies to her/himself because she/he is afraid of the truth which she/he does not often share. It is often stated that after a very long time, when a Doctor paid attention to a patient, he no longer has time for her/him. It is often thought that a Doctor should not be burdened by other issues because he it is not paid for them. The rules once were:

Doctor asks questions: Patient answers them.

Doctor decides. Patient accepts Doctor's opinion.

Doctor orders. Patient obeys.... during examinations and treatment a strong relationship between patient and Physician is thus created.

Do I Have to Die?

Although this issue hugely affects the patient, she/he is often controlled by personal shyness and more impactfully, fear to speak it. Conversation about death and dying is becoming a necessity because of our move away from the traditional way of thinking and living, and becomes a precarious mental problem both for patient and Doctor. Both parties lack natural openness. It is therefore necessary to let those questions, unspoken also from the side of Doctor who will not make them the subject of an interview unless requested to by the patient.

Will I Be Healthy Again?

When it becomes clear that the disease is not life threatening, this issue offers a high value for the patient. A patient knows that his personal future quality of life depends on the degree of recovery from any illness or injury. First, there is a vital interest not to stay permanently affected; namely to suffer pain; paralysis; permanent shortness of breath; to be confined to bed or a wheelchair; and much else that belongs to permanent and chronic disease. When this complex is explained, it generates new sub-questions such as whether he will be able to perform work activities, civic activities, sports, sex, hobbies, to change residence ...

Will Consequences Remain?

This unspoken question builds on the previous; sometimes they even cannot be separated at all. An affected patient would actually like to know the significance of the consequences of the disease especially for her/him. Many patients have a vague idea of how much of a lifelong burden there will; be after thyroid surgery and need to take a thyroid hormone; or to rely on hearing aids; orthopedic shoes; to maintain any special diet.

Can I Do Everything Again?

If a patient is thinking about this issue, he is essentially optimistic. He knows with certainty that the disease is not life threatening. Individual life planning by a patient who thinks about this unspoken question has received a relation of non-compliance with the disease; certain obligations; personal rights; popular customs; but also unpleasant tasks - all which may have been cancelled or delayed under the influence of disease. Patients devoted to God will accept the disease without too much trouble with the scheduling of appointments in the future when they will be able to do everything. On the other hand, impatient patients expose themselves to the pressure. If it can impede healing and rehabilitation, they should necessarily express questions about such contexts.

How long will it take?

How long will it take until ear disease strikes previously healthy hearing? How long will it take until failure of blood supply strikes the other foot? How long will it take for stiffness in a joint to complete immobility?

How can I live with it?

This question is true both for a depressing but otherwise harmless skin condition as well as for joint disease causing reduced mobility. Generally, a Physician provides a patient some helpful advice. But both Physician and patient know that the desire for knowledge of many patients is

never completely satisfied. Seemingly careless and harmless Doctor's words have consequences: „You just have to live with this!” Words just as useless as ruthless. An experienced, mainly tactful Doctor can somewhat alleviate the situation message by saying, „You will be able to live with this!” With these words a patient's hope will be increased. (Hagen, 1990)

Some Additional Unspoken Questions Include:

- „How long will my body survive it?”
- „How could all this happen?”
- „From what or where did my disease come?”
- „Am I a simulant being convinced I have it?”
- „Can a medicinal product be found?”

Special Questions:

Specifically mentioned unspoken questions have more exemplary character and are limited to particularly common, and therefore for most people familiar problem areas:

- Heart disease, circulatory problems,
- Stomach illness
- Symptoms of rheumatism and related difficulties
- Complex surgical measures

Some Other Unspoken Questions?

- „Is this surgery necessary?”
- „May we postpone this surgery?”
- „Can this operation succeeds in my case?”
- „Is anaesthesia dangerous for me?”
- „Is it cancer or could cancer develop from it?”
- „How about the smoking?”
- „What about sexual intercourse?” Patients are interested in the question of whether sexual activity is a danger for them. Discussions with Doctor about sexual behavior are not as taboo as it used to be before, but some patients find those topics sensitive.
- „Should I do anything else?” (Hagen, 1990)

Patients live in a modern world full of temporary hurry, stress at work, life worries and impotence, and difficulties in the family. Mass media informs patients about everything that is related to her/his disease, medical technologies, pharmaceuticals, Healthcare and many other things. Patients learn many things about diseases but almost nothing about a sick person. There is nothing about how a sick or ill person alone should cope with their situation; how an illness may incorporate into their life. This means that not only Physicians and Medicine have changed, but also patients, too. Treatment is very much linked to the power that a Doctor has when he provides a patient with dialogue, advice and ways to application (Křivohlavý, 2002).

Mental perception of a patient plays a very important role in every, not just in a serious or deadly disease; but the way a patient faces the problem in relation to her/himself; the very important relationship to her/his Doctor. A Doctor is, as a matter of fact, perceived by patients as a „Demigod in a white coat”. If a patient can fully trust her/his Doctor regarding her/his physical health and her/his body, then she/he also mentally should trust her/his Doctor and hand over also the her/his soul with its body to her/his Doctor.

**There are no bad questions if they are questions
whose answers relate to the patient's health.**

Any unspoken question, if spoken, may help to treat the patient or at least ease the pain and suffering of the patient. Numbers of issues, however, in most cases remain unanswered, especially due to a patient's indifference, or rather due to a kind of fear or concern if the question is correct

or if it does not bother her/his Doctor. And there are many others factors. Doctors often cannot explain why they lose patients; even though they treat them with the greatest willingness and attention; examinations were performed as professionally and reliably as possible but their enormous effort was still insufficient. So why was it all done for? There is a currently rooted problem that patients fail to recognize and so they can, from some personal conviction and without cause, change a Doctor. Thus problems remain unanswered; mostly answers to their unspoken questions. Any good Doctor will certainly not refuse the interests of the patient and his every question will be welcomed. Those questions are for the Doctor - patient relationship a sort of „gluing” measure and expression of confidence and commitment.

Health is perhaps the most important thing and we have only one; we also live only once so we should respect and protect it reasonably and not only in your own.

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Evidence-based Practice in Social Work Education

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This paper contains a review of the current literature around the dissemination of *evidence-based practice* (EBP), current Social Work models for dissemination of EBP, interviews with experts in the Field, and a synthesis of this combined knowledge into recommendations for future dissemination of research and EBP efforts.

Key words: evidence-based practice, Social Work, Education

Introduction

An *evidence-based practice* occurred in the time of medicine and health-care service as an option of incorporating recent advances in research into professional decision making (Ramsey et al. 1991; Sackett et al 1991) and has over the last 15 years developed rapidly across most areas of Healthcare. An evidence-based practice is considered any practice that has been established as effective through Scientific Research according to a set of explicit criteria (Drake et al 2001).

In 1998, the Robert Wood Johnson Foundation consensus panel concluded that research findings identify six evidence-based treatment practices for the treatment of persons with severe mental illness: assertive community treatment; supported employment; family psycho-Education; skills training and illness self-management; integrated dual-disorder treatment.

To be considered an evidence-based practice four selection criteria were used: the treatment practices had been standardized through manuals or guidelines; evaluated with controlled research designs; through the use of objective measures important outcomes were demonstrated; the research was conducted by different research teams (Torrey et al 2001). Accordingly, we can highlight that *evidence-based practices* or *best-practices* were identified for the diagnosis, treatment and other management of persons with severe illness through efficacy trials meeting these four criteria.

Initially, evidence-based practice was defined as ‘The conscientious, explicit and judicious use of current evidence in making decisions about the care of individuals’ (Sheldon 2002). The definition of *Evidence-based behavioral practice* from 1992 was the following:

Entails making decisions about how to promote health or provide care by integrating the best available evidence with practitioner expertise and other resources, and with characteristics, state, needs, values and preferences of those who will be affected. This is done in a manner compatible with the environmental and organizational context. Evidence is comprised of research findings derived from the systematic collection of data through observation and experiment and the formulation of questions and the testing of hypotheses (www.ebbp.org).

However, these definitions have thereafter been adapted in order to describe ‘a philosophy and process designed to forward effective use of professional judgment in integrating information regarding each client’s unique characteristics, circumstances, preferences and actions, and external research findings’ (Gambrill 2006b). Thus, EBP is now mostly described as ‘the integration of best research evidence with clinical expertise and patient values’, a process involving the following principles or steps (adapted Sackett et al 2000):

- Formulate focused and answerable clinical questions, based on service users’ needs.
- Search the literature for the best research-derived evidence in order to address the question previously framed.
- Critically appraise the identified evidence for validity and relevance.
- Integrate the selected evidence with clinical expertise and the service user’s values and preferences, and apply the result to clinical practice and policy decisions.
- Evaluate effectiveness and efficiency through planned review against agreed success criteria (Greenhalgh et al 2003) and seek ways to improve them in the future.

Accordingly, evidence-based practice is a decision-making process in which judgments are made on a case-by-case basis using best-evidence. In addition, evidence-based Social Work practice would incorporate the following characteristics.

A relationship in evidence-based practice is characterized by a sharing of information, observation and of decision-making. The Practitioner/ Social Worker or other Professional does not decide what is best for the client, but rather the Practitioner provides and guides the client with up-to-date information about what the best-evidence is regarding the client’s situation; what options are available; likely outcomes. With this information communicated in culturally, nationally and linguistically appropriate approaches clients/patients are supported to make decisions for themselves whenever and to the extent possible.

A critical, inquisitive attitude regarding the achievement of valued outcomes and undesigned negative outcomes rather than an unquestioning belief that only intended outcomes will be achieved and, therefore a failure to secure information about actual outcomes prior expectations to color achievements.

A focus on fidelity in implementation of client chosen interventions rather than assuming that selected interventions will be provided as intended. Fidelity of implementation requires that the specific evidence-based practice be provided as it was tested when research supported its effectiveness.

Too often, serious distortion occurs during implementation. An aggressive pursuit of new information about outcomes rather than relying on static prior beliefs. This new information is derived from: researching what occurs; when interventions are implemented; new research findings promulgated by others. The ongoing knowledge revision based on this new information which in turn is communicated to clients. A relative weighing of information, placing information derived from scientific inquiry as more important than information based on intuition, authority or custom (Roberts 2004).

Social Work Practitioners need to know what has been identified as best-practices and they need to be prepared to be evidence-based Practitioners. Social Workers can benefit greatly from clear identification of interventions that work, through such efforts as seen in the systematic reviews conducted and disseminated through the Cochrane and Campbell Collaborations, as well as the work of the many evidence-based practice centers around the world. These Collaborations and Centers are using systematic reviews to identify effective interventions. What is learned through reviews needs to be effectively implemented and made available to Professionals. Dis-

semination and implementation of evidence-based practices present special challenges when the intended users are Social Work Practitioners and their clients (Nutley 2000a; Nutley 2000b; Eisenstadt 2000).

Review and Evidence-based Approach

The first widespread push for EBP in Social Work emerged out of a series of studies that began to appear in the 1970s which called into question the effectiveness of existing Social Work interventions (Reid 1994).

The 1970s and 1980s witnessed a movement to develop evidence based models of practice in mental health and further the development of well researched psycho-social intervention models such as behavioral, cognitive, interpersonal, and social approaches, as well as the biological and bio-psycho-social theories of mental illness (Bellamy, 2006). Evidence-based researchers in many disciplines pioneered models used in Social Work Practice including: Psychology, Psychiatry, and Social Work. In the late 1980s and early 1990s substantial evidence regarding the treatment of common mental health disorders were high-lighted by the publication of the results of studies such as the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al. 1989). Over the past decade, the proportion and number of articles referring to EBP published in Professional Journals has risen in the disciplines focused on Mental Health Services, Health, and Social Welfare (Shlonsky 2004). For a more detailed description of the history of the development and use of EBP in Social Work see Kirk and Reid (2002).

Today, New York State's Office of Mental Health, identified as a progressive program by NIMH, is promoting the use of the following EBP for adults with serious mental illnesses (Bellamy 2006). These EBP interventions include: Assertive Community Treatment; supported employment; intensive case management; wellness self-management; family psycho-Education; integrated treatment for co-occurring substance abuse and mental health disorders; medication (and guidelines for Practitioners to promote optimal prescribing practices); self-help and peer support services; and post-traumatic stress disorder (PTSD) treatment (New York State Office of Mental Health, 2001). The President's New Freedom Commission (2003) report identified the following additional EBPs for the treatment of mental health disorders: cognitive and interpersonal therapies for depression; preventive interventions for children at risk for serious emotional disturbances; treatment foster care; multi-systemic therapy (MST); parent-child interaction therapy; collaborative treatment in primary care. The commission also recommended emerging best practices including: consumer operated services; jail diversion and community re-entry programs; school mental health services, trauma-specific intervention; wraparound services; multi-family group therapies; and systems of care for children with serious emotional disturbances and their families (New Freedom Commission 2003).

Two Approaches to Dissemination and Implementation of Evidence-based Practice

As published by Nutley and Davies, there have been used two major approaches to distribute and implement best-practices, namely *macro* and *micro*, or what I call *top-down* and *bottom-up* strategies.

In *top-down* strategies findings are disseminated for use by front-line Practitioners through agency directives; guidelines; manualized interventions; accreditation requirements; algorithms; toolkits and so forth. *Top-down* or *macro* strategies can serve to get the word out about what works or what is favored by those in authority; but such methods do not guarantee adoption of best-practices on the front lines.

To increase the likelihood of adoption a *bottom-up approach* is needed. In contrast to the *top-*

down approach, Social Work Practitioners need to be prepared to engage in a process of critical decision-making with clients; about what this information means when joined with other evidence, professional values and ethics, and individualized intervention goals. A bottom-up approach recognizes the importance of engaging the Practitioner and the client in a critical, decision-making process (Nutley 2000b).

Sackett et al (2000) have noted there may be insurmountable barriers to implementing evidence-based practice guidelines in individual circumstances. For successful implementation a number of components need to be in place. These include:

- Organizational culture, policies, procedures and processes must provide opportunities and incentives supporting evidence-based practice (e.g. financial incentives, funding; openness to change; workload adjustments; information technology supports; legal protection).
- The organization's external environment must provide similar opportunities and incentives supporting evidence-based practice (e.g. accrediting groups).
- Applied practice research and evaluation must provide scientific evidence about assessment, intervention and outcomes pertinent to the organization's practice domain.
- Systematic reviews which synthesize research findings must be conducted assessing the weight of the evidence generated by current research and evaluation studies.
- Prescriptive statements based on these syntheses must be developed and communicated in user-friendly forms (e.g. practice-guidelines, manuals, toolkits).
- Organizational procedures need to be put in place to assure fidelity of implementation of these prescriptions.
- Systematic, structured evaluation processes capable of providing timely feedback to various stakeholders as to the fidelity of implementation and outcomes must be designed and implemented as an ongoing process.
- The organization must have Social Workers available who are trained as evidence-based Practitioners capable of functioning in evidence-based practice organizations (Sackett 2000).

The wider Field of Social Science knowledge utilization is just beginning to build a theoretical framework that explains why research evidence, such as the EBPs listed above, is or is not utilized in Social Work Practice. While researchers have identified EBP Health Services, the implementation of these services into practice has been problematic. One of the greatest complaints has been backward of more than 20 years (in some European countries even more) between the identification and incorporation of EBP interventions into routine care (Balas 2000; Bellamy 2006). Furthermore, Social Work is a professional discipline that introduces expertise and specialized knowledge; ethics and skills aimed at addressing difficult human problems including various illnesses. However, many courses, experiences and training are not supported by evidence as necessarily related to helping clients through the use of evidence (Dawes, 1994; Gambrill 1999; 2000).

Very important consequence of increasing popularity of EBP among Professionals has been its expansion from Healthcare to other disciplines e.g. Social Work, historically particularly in English-speaking countries such as the UK, the US, Canada and Australia, where the new way is becoming increasingly influential (Gilgun 2005; Rosen 2002). Thus, in the UK the New Labour Government after its election in 1997, announced in its White Paper *Modernising Social Services*, the objective that Social Services should base its practice on research and other evidence of what works (Department of Health 1998); an aspiration that soon became one of the cornerstones of the Government's modernization agenda for Social Services (Bonner 2003).

In fact, the need for underpinning practice with an evidence base has consistently been em-

phasized in subsequent White Papers in the area of Social Care (Department of Health 2001, 2006) and also in major policy documents published in Northern Ireland (Northern Ireland Social Care Council 2002); Scotland (Scottish Executive 2006) and Wales (Welsh Assembly Government 2007). Examples of the initiatives undertaken in order to bridge the gap between research and practice include the creation of the Centre for Evidence-Based Social Services, which operated between 1997 and 2004; the Social Care Institute for Excellence, established in 2001; the Scottish Institute for Excellence in Social Work Education, created in 2003 and which in 2007 changed its name to the Institute for Research and Innovation in Social Services; the Social Services Improvement Agency, set up in 2006 to promote excellence within Social Services in Wales (Lishman 2011).

Beside the Anglo-Saxon countries, other regions are also witnessing a growing development of EBP in the area of Social Care. For instance, SFI-Campbell (the Nordic Campbell Centre) based in Denmark, has been producing and disseminating research - based knowledge – especially systematic reviews - in the Nordic countries since 2002; and the Institute for Evidence-Based Social Work Practice (IMS) was officially created in Sweden in October 2004. In the Netherlands, where outcome measurement and effectiveness in Social Services are increasingly demanded by Governments and service users (Mullen, 2004), the Verwey-Jonker Institute has been promoting evaluative research into social issues over the last decade (Morago 2006; Lishman 2011).

In this context, an evidence-based practice is also being incorporated as a component of professional competence and responsibility of Social Work across various European, American and Australian countries. For instance, in the USA, the Educational Policy and Accreditation Standards expect Social Workers to employ evidence-based interventions as well as research findings in their professional practice. In Australia Social Workers must demonstrate their ability to utilize research in practice (Australian Association of Social Workers 2008). In the UK, the critical evaluation and appropriate use of research findings has been formally recognized as a qualifying requirement in England and Wales (Training Organisation for the Personal Social Services 2002; Social Services Inspectorate for Wales 2004; General Social Care Council 2008) Northern Ireland (Northern Ireland Social Care Council 2003); Scotland (Scottish Executive 2003). Therefore, Social Work Education is now generally expected to provide students with appropriate knowledge and training in applying research evidence to practice.

Although EBP implementation is still emerging in Social Work Education, an increasing number of authors have reported that the notion of EBP is gaining momentum across Schools of Social Work, and they have also identified implementation issues and barriers as well as strategies to overcome them. In particular, the main themes arising from the literature in this area are:

1. Integration of EBP into the curriculum of Social Work Education.
2. Readiness of Social Work Academic Staff for EBP implementation.
3. The role of agency-based practice learning in the EBP implementation process.
4. Relevance of EBP implementation for the Social Work Profession ((Drake et al. 2007; Franklin 2007; Howard, McMillen 2003; Howard 2007; Howard et al 2009; Jenson 2007; Mullen 2005a; Mullen et al 2005b; Mullen et al 2007; Proctor 2007; Scheyett 2006; Shlonsky 2007; Soydan 2007; Springer 2007; Thyer 2007; Weissman et al 2006, Lishman 2011).

The main purpose of this paper is to provide an overview of these themes and discuss them with reference to the literature selected, using the author's previous experience as a Lecturer in Social Work at various important Universities in USA, Africa and Europe e.g. at the St. Elizabeth University of Public Health and Social Work (SEU) as an exemplar. SEU has explicitly been promoting an EBP approach within Social Work Programs and, in general,

the issues arising from the implementation of EBP in the curriculum are closely similar to those identified by the literature reviewed (Suvada 2010).

Integration of Evidence-based Practice into the Curriculum of Social Work Education

For some authors (Howard et al 2007), Social Work Education has traditionally adopted a generalist practice perspective in which students are trained to work effectively at different levels and in a variety of settings and client groups. Therefore, they are trim up with a broad, eclectic knowledge and skills base (e.g. interpersonal or ‘use of self’ skills and practical skills necessary to work effectively within organizational and interdisciplinary procedures (Jenson 2007). Notwithstanding, this model has been criticized on many levels for several reasons; for example, for including *officially approved* theories and interventions of unproven efficacy instead of empirical evidence across specific Fields of practice (Bledsoe et al 2007; Mullen et al 2007; Thyer 2007).

In this context, Gambrill (2006c) claims that students risk becoming *passive recipients of untested knowledge* who uncritically receive it and inappropriately apply it to practice. Another objection to the generalist model is that, by assuming that Social Work’s knowledge base is stable, it is ignoring the changing and somehow ambiguous nature of Social Work (Mullen et al 2007). Therefore, a didactic approach would seem insufficient to prepare Social Work students in training for the requirements of modern practice. Instead, and given the increasing availability of good quality empirical research, a rigorous evidence-based approach to Social Work’s knowledge base beyond lecture-based and opinion-based learning is regarded as the optimal tool for students to develop critical thinking skills and cope effectively with vast amounts of information; change; uncertainty (Franklin, 2007 Gambrill, 2006b; Shlonsky 2007; Soydan 2007; Howard et al 2007).

As mentioned before, it is a formal demand that Social Work trainee, as well as graduated Practitioners generally need to establish an appropriate use of relevant findings from research studies. But there is a question as to which EBP is being embedded within Social Work Programs. In point of fact, to integrate a new subject into an already dense curriculum like that in most Social Work trainings is a great challenge for Social Work Universities Education worldwide (Howard et al. 2003, 2009).

A short-term solution could be to try to include some teaching sessions and assessment tasks wherever there is some space for them and thus justify that accreditation requirements in relation to EBP teaching are met (Soydan 2007). However, such a patchy, almost tokenistic, presence of EBP in the curriculum is still far from the implementation levels that EBP promoters are advocating. For them, rather than a discrete subject, EBP is a coherent and systematic framework for critical inquiry that should, as implemented, for example, by the George Warren Brown School of Social Work at Washington University, inform the whole curriculum (Drake et al 2007). Such an ambitious plan requires a strategic redevelopment of Social Work curricula with specific action in, at least, two areas: a teaching of EBP skills and a teaching of effective methods of intervention across the different subjects or modules of the curriculum (Springer 2007; Suvada, 2010).

Evidence-Based Programs and Arguments for its Use in Daily Practice

Despite the numerous barriers which are facing Social Workers in the Health Services sector, we have a number of conclusive reasons to implement evidence into their practice with ill or another way affected clients. Practitioners have cited advantages of using EBPs such as:

- (1) Conceptualizing, planning, and guiding treatment,

- (2) Increasing knowledge and skills,
- (3) Improving treatment outcomes for clients,
- (4) Integrating and supplementing, not supplanting, clinical judgment & knowledge, (5) Complying with current practice, values & professional consensus,
- (6) Satisfying grant or managed care reimbursement requirements.

Overall, a basic tenet of EBPs is that clients should receive the benefit of the best technology that Social Work has to offer (Mullen 2004; Lishman 2011). It is difficult to imagine the basis on which structured, fact-based and well informed decision making and planning referenced to the best available published research can be viewed as counter either to the provision of effective outcomes for service users or Social Work Professional Staff (Barratt 2003). There are many questions as to what exactly should be addressed, disseminated and used as evidence to identify the best possible approach. Undoubtedly this argument will, and should, continue within the Field. Though, if some fact upon what is a *validated intervention* can be secured, the question becomes one of dissemination and implementation (Suvada 2010; Czarnecki 2013).

The Teaching of Effective Methods of Assessment and Intervention

Besides training students to develop EBP skills, EBP implementation also requires that Social Work students are informed about the effectiveness of the methods of assessment and intervention that are taught across the different components of the Social Work curriculum. In particular, Social Work Programs should always include in the curriculum the teaching of those interventions with the strongest empirical support from research studies (Howard et al., 2009). In fact, in the last two decades a considerable amount of evidence has been generated in areas relevant for Social Work Practice, such as mental health, learning and developmental problems, offending, poverty and social exclusion, work with children and families and the care of older people, to cite just a few examples (Weissman et al 2006). Such a body of evidence constitutes a powerful tool to achieve an old professional aspiration- namely, to base Social Work Practice on the best knowledge available in order to deliver effective interventions (Bledsoe et al 2007; Mullen et al 2007; Thyer 2007). However, some authors claim that evidence of empirical support has been integrated into Social Work Programs only to a modest extent that interventions and approaches of dubious efficacy continue to be prevalent within such programs. Furthermore, Lilienfeld et al (2003) and Howard et al. (2009) use the term *pseudoscience* to refer to a body of Social Work approaches and strategies based on ‘fashion’ rather than on rigorous empirical evaluation. This situation is not likely to change unless Social Work Academic Staff effectively engaged with the EBP implementation process, which is the second of the themes identified by the literature reviewed in this chapter and which will be examined in the next section.

Readiness of Academic staff For Evidence-based Social Work Practice Implementation

In addition to the lack of space in already tight Social Work Programs, another potential challenge for EBP implementation identified in the literature is that all Social Work Academic Staff may have the readiness or skills for teaching EBP (Franklin 2007). Perhaps discussion of this issue should be contextualized by looking at the debate that the expansion of EBP from Medicine to Social Work has originated within the Profession. As we know, along with strong enthusiasm from some Fields of the Social Work Profession, an EBP has also been received with considerable skepticism and a range of objections from other authors (Barratt 2003; Green 2006; Suvada 2010; Gambrill 2003, 2005, 2006a, b, c).

One of the main objections raised in discussion about EBP, is that it presents a deterministic version of rationality that ignores the complex processes of deliberation and choice that Social Workers must follow when making decisions (Webb 2001). Thus, concerns have been expressed that a narrow concept of evidence based on results from randomized, controlled trials may be appropriate for Medicine but not for such a complex and multifaceted Field as Social Work (Green 2006; Parton 2000; Webb 2001); and that such evidence cannot meet ‘the sometimes contested and divergent knowledge brought into play in the many places and ways in which Social Work is practiced’ (McDonald 2003).

Sackett et al (2000) describes EBP’s very nature as:

A philosophy and process designed to forward effective use of professional judgment in integrating information regarding each client’s unique characteristics, circumstances, preferences and actions, and external research findings.

Consequently, Gambrill (2006b) argues, EBP is not presented as a substitute for professional competence; along with the best and most updated information from research studies and service user’s values and preferences, professional skills, empathy and the ability to build human relationships are essential assets of Social Workers’ Practice. Equally, there seems to be wide acceptance that the sources of social care knowledge are diverse: for example; organizational knowledge; practitioner knowledge; user knowledge; research knowledge; policy community knowledge (Pawson et al 2003).

In relation to research evidence, the initial emphasis on results from randomized controlled trials has been gradually replaced by a broader, pluralistic approach that embraces contributions from different research designs as appropriate to the purpose of the enquiry (Braye 2007; Lishman 2000; Mullen 2004; Rubin 2005; Soydan 2007; Taylor 2007).

However, objections to EBP continue to be a significant feature of Academic debates within Social Work Schools (Rubin 2007; Suvada 2010), which for some authors (Gilgun 2005; Howard et al 2009; Magill 2006; Springer 2007; Thyer 2007) suggests the existence of certain misconceptions about EBP as well as a lack of information about how the notion of EBP

in Social Work has evolved over the last years. This is a serious difficulty for EBP implementation that may require the creation of appropriate training, information sharing and discussion spaces for the professional development of Academic Staff (Franklin 2007).

From our experience at SEU these kinds of initiatives have, in addition, a considerable potential for reinvigorating Academic debates often stifled by increasing administrative and course management-related demands (Suvada 2010; Czarnecki 2013). Yet, and despite its importance, promotion of EBP in the classroom, as so far outlined, is not sufficient for a fully effective implementation of EBP in Social Work Education.

Relevance of Evidence-based Practice Implementation for the Social Work as a Profession

As indicated earlier, some of the strongest objections traditionally raised against EBP are that it presents a deterministic version of rationality that ignores and replaces professional competence and is clearly insufficient to take into account the different sources of Social Work knowledge. The EBP extends the notion of reflective practice. What Franklin (2007) calls the *resourced self* is precisely the essence of EBP implementation in Social Work Education: to provide a systematic framework for critical inquiry that enables Social Work students to become resourced Practitioners able to make more informed and transparent decisions. MacDonald (1990), a pioneer of EBP in Social Work, has already argued that a more empirically based practice was required in order for Social Workers to take ‘correct decisions’ i.e. ‘Those for which appropriate information

is sought from diverse sources; appropriately weighed against available knowledge; whose outcomes are fed back into that knowledge base to inform future practice’.

A few studies have suggested that Field Instructors are far more influential than Faculty Instructors (Lager 2004). If Faculty Members are teaching EBP in the classroom, without having buy-in from Field Educators, students are likely to follow the lead of their Practice Educator by downplaying the need for EBP rather than adhering to the classroom instruction of Faculty who may seem disconnected from the realities of the Field. To counteract the apparent gap between research and practice, many have suggested students participate in integrative seminars and use tools such as Field Journals that are reviewed by both University and Field Instructors (Dettlaff 2002).

Field Instructors, even highly experienced Social Workers, require additional training before they are ready to supervise student’s Field Education. Recognizing this reality, most Social Work Education Programs provide ongoing training to their Field Educators (Miller 2005; Suvada 2010). These training activities may provide the opportunity to introduce EBP training to experienced Social Workers who likely were not educated within this framework. These seminars and workshops may also be the best place to introduce new methods of assessing student competencies using EBP. Importantly, Field Education experts have begun to develop measures for evaluating student learning and performance of both explicit skills and "implicit" practice wisdom, and these measures could be adapted to include EBP competencies (Bogo et al 2002, 2004; Czarnecki 2013).

In fact, the literature provides a few examples of how interventions, some of them very popular but the efficacy of which has not been rigorously evaluated, may have harmful consequences for Service users and the public in general. One example is *Scared Straight* programs, an approach that consists of inviting young people at risk of offending to visit a prison where they have the opportunity to talk to adult inmates and know *in situ* how life in prison is. The major assumption of this program is that such a scary experience will deter the youngsters from future criminal behavior. The model became popular in the US to the extent that it was adopted as public policy by several states. However, when nine different ‘Scared Straight’ interventions were evaluated, it was found that **crime rates were significantly higher** among participants in the program in comparison with their control counterparts who had received no intervention (Petrosino 2002). Therefore, Social Work students should be taught to avoid - or at least to be cautious about methods of assessment and intervention the efficacy of which has not been rigorously evaluated.

This is particularly relevant to those areas of practice where Social Worker’s activity is subject to intense scrutiny (e.g. child protection when it could be argued that, if after a professional intervention something goes wrong and the Social Worker and/or the agency are subject to inquiry, a decision strictly based on the integration of the different components of the EBP process is likely to be significantly more defensible than one based on wild information, opinions of colleagues or authorities).

Thus, rather than as an instrument to undermine Social Worker’s professional autonomy, EBP is presented as a vehicle for newly qualified Social Workers and Practitioners in general, to make more informed, effective and ethical decisions, which, in turn, should reinvigorate Social Worker’s Professional Practice against increasing bureaucratic control and loss of professional autonomy (McDonald 2003).

Indispensably because of the emergent spirit of EBP in Social Work Education, the evidence of its impact in preparing students for professional practice is limited on an excellent research opportunity for those interested in this area. It is probably too soon to provide any conclusive evidence of the effectiveness of an EBP approach in this Field but when it is discussed advantages

and disadvantages of EBP implementation in Social Work trainings, it would be advisable to clarify what are the outcomes on which the success of such study actually depend? While it seems reasonable to assume that teaching students about the level of effectiveness of major methods of assessment and intervention would result in more critical and informed professionals (the relevance of EBP becomes less clear when success is based on indicators such as achievement of funding targets, student numbers and student retention rates) (Czarnecki 2013).

Full adoption and implementation of EBP in Social Workers remains elusive. The studies on the professional socialization of student Social Workers remains sparse, particularly in comparison to the socialization literatures for professions such as Medicine or Nursing (Suvada 2010). The process by which Social Workers are socialized to value some knowledge innovations such as EBP and not others remains poorly understood. Interestingly, in one study encompassing four disciplines, Social Workers were unique among Professionals for reporting that new knowledge and innovations were valuable to them because they could use the information in encouragement of their client's needs, often invoking the word advocacy to describe their continuing Education activities.

General Review Conclusion and Recommendations for Practice.

Several researchers have made general and wide recommendations for dissemination of evidence into the practice. First of all, it is essential to secure organizational and practitioner buy-in (Mullen 2004). Before any real progress is made toward dissemination stakeholders and policymakers must both agree that EBP is valuable and important enough to make a commitment of time, space, staff, training, and other resources. Leadership is a crucial ingredient for change in this area (Barratt 2003).

Although the dissemination of EBPs must occur at all levels, important issues such as protecting practitioner time for research and training as well monitoring and following up on implementation activities must be guided by Administrators and other persons or agencies with authority. Also, some authors have described the importance of establishing a network of local organizations and implementers so that they can pool resources such as training and research; become actively involved; develop broad community goals (Anderson 1999; Howard 1999). McKay and colleagues stress the importance of training and the establishment of an „engagement team” consisting of intake workers, clinical and administrative staff, and Supervisors who oversee the implementation of interventions at each site (McKay 2004).

Commissions and Practitioners cannot be realistically expected to „go it alone” on tight budgets, timelines, and a research base that is a moving target. A much more efficient approach seems to be one of networking and sharing with other Social Workers, Community Organizations, Educational Institutions, and other stakeholders. In essence, the research evidence on the use of EBPs has not been well developed.

Researchers have been relatively oblivious to the processes by which knowledge, once developed, might be effectively disseminated and used (Kirk, 2002).

Conclusion

Evidence- based Practice would allow Social Work students to become competent and highly resourced Practitioners, more able to challenge ineffective practice and promote change within their organizations. However, EBP also involves dealing with the uncertainty derived from the existence of inconclusive or conflicting evidence, or just simply the lack of it, and this poses a

major challenge to 'a society that is uncomfortable with change and uncertainty'. In fact, factors such as risk aversion and the reinforcement of the role of students as consumers of higher Education services may result in standardized approaches to teaching that tend to make the learning experience as safe and satisfactory as possible but which might encourage students to become just passive customers instead of self-directed learners (Furedi 2004).

For example, University students are increasingly provided with user-friendly, digestible pieces of information as well as with prescriptive assessment guidance that, having the apparent advantage of minimizing uncertainty and unnecessary effort, are hardly compatible with a genuine development of critical thinking skills and the very notion of the evidence-based practitioner (Suvada 2010).

This is a challenge that like the others outlined in this paper faces Social Work Education in its efforts to implement EBP. As Austin and Claassen (2008) point out, EBP implementation is not a straightforward process but a complex one that requires considerable planning and resources.

However, in the literature reviewed, there is general agreement that if Social Work Education overcomes the difficulties involved in this process, it will be able to make a significant contribution not only to the Education of newly qualified Social Workers as resourced and critical Practitioners but also to increasing the influence, credibility and autonomy of Social Work as a profession (Lishman, 2011).

To encourage Practitioners to implement EBPs a unified approach that incorporates the best of all of the strategies outlined above and addresses the major barriers identified in this paper:

- 1) Increase EBP Education (particularly at the Master's level) as well as access to high quality Continuing Education based on EBPs.
- 2) Build partnerships toward sharing EBP resources, including technology, training, and technical assistance, between Agencies and Practitioners.
- 3) Facilitate buy-in and ownership of EBPs at all levels of stakeholders including Practitioners, Administrators, Researchers, Policy Makers, & Community Members.
- 4) Translate research into user-friendly, digestible, and specific approaches, providing tools such as tool kits, guidelines, and technical support to both support and encourage the use of EBPs.
- 5) Improve the communication, feedback loop and relationship between Researchers and Practitioners.
- 6) Increase the number of EBPs available to the Field.
- 7) Test the different types and mechanisms of dissemination, perhaps through analyses based on a taxonomic framework like the one proposed by Walter to organize future research efforts (Walter 2003).

The most important factor in facilitating change toward the use of research in Professional Practice is whether or not the profession wants to change (Bellamy 2006). As the call for EBP in Mental Health Services grows, Social Workers will benefit by being more research-minded and thereby improve services for their clients. The call for the use of research evidence in practice is not limited to a trend of policy, but is also aligned with a Professional Code of Ethics (NASW 1996) and meeting the expectations of an increasingly savvy consumer movement in Mental Health (Bellamy 2006).

Major national reports, which often shape federal and private funding streams, continually call for the use of research-supported interventions. However, policies that encourage, if not require, the use of EBPs cannot succeed without adequate training, resources, technical assistance and other infrastructure support necessary to deliver evidence based Mental Health interventions,

Even if Social Workers endorse the value of EBP, Practitioners and Administrators may not have the knowledge or the resources to implement research based practices.

The search for research evidence alone is difficult, and the more complicated the decision the less available the evidence (Gray 1997; Czarniecki 2013). Additional demonstration projects, and research and policy efforts aimed at moving EBPs into community based organizations thereby building professional and organizational capacity are needed to address these and other barriers. Social Workers are poised to move this work forward by transferring the increasingly broad and sophisticated body of research mindfully into the hands of the Community Agencies and Practitioners.

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Research of the Level of Awareness of Patients with Glaucoma

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Summary

The Authors present results of research on the level of awareness and practical skills of patients in application of medicines in their eyes; their knowledge and practical skills necessary in the treatment of glaucoma; to the finding of sources from which the patients gained information. The basic sample of respondents consisted of 40 patients hospitalized at selected clinical eye hospitals from November 2010 to October 2013. At the end of the article after discussion on their findings, the Authors evaluate working hypotheses and present several recommendations for Practice. Prognosis of this illness is always serious; it may cause blindness in one or both eyes (*g absolutum*), especially if the treatment and the nursing care is not appropriate.

Key words: Information, education, glaucoma, application of medicines, practical skills, observation, prevention

Survey Methodology

Subject of Research:

Subject of this survey is the awareness of patients with eye glaucoma (hereinafter referred to as glaucoma) hospitalized in an eye clinic.

Objectives of Research:

- Find out the level of knowledge of patients with glaucoma and their practical skills in the application of drugs into the eye.
- Increase the level of knowledge and practical skills necessary in the treatment of glaucoma.
- Compare knowledge and practical skills of patients with glaucoma.
- Find out the level of awareness of patients from other sources.

Working Hypotheses:

H1 We assume that patients do not have sufficient knowledge about glaucoma and its treatment and do not seek information from other sources (Internet, newspapers, magazines etc.).

H2 We assume that patients are interested in increasing their awareness about the disease (glaucoma) and its treatment.

H3 We assume that patients do not pay sufficient attention to the proper application of local therapy (eye drops, oils, gels) in affected eyes and they do not realize the importance

of local application of therapy by their Doctor precisely defined time intervals.

H4 We assume that patients do not know what to do when this disease deteriorate.

H5 We assume that patients will cooperate with caregivers and will be informed of the follow-up treatment after release from the hospital and have a responsible attitude to their own health and care of their eyes and try to remain in the role of an active, responsible co-creator of therapy aimed at the reduction of IOP and saving of vision.

Research Methods

Content analysis of documents (medical records, surgery and after-surgery protocols ...). These records have contributed to a closer understanding of the disease and related nursing activities. Research method - Questionnaire of our own design with which we surveyed the level of awareness, opinions and problems of respondents with glaucoma.

Observation Method

We used direct observation through Nurses who were in daily contact with the patient. We focused on the compliance with hygiene habits of patients and their practical skills when they applied local ocular therapy. The method was a non-standardized interview aimed at providing information to the patient about the disease and treatment and to determine the patient's knowledge. Quantitative and qualitative analysis of the Questionnaire responses of respondents – patients was made.

Organization of Survey

Our survey was conducted at the Eye Clinics in Bratislava and Trenčín and in selected private Eye Clinics in Bratislava. The survey period was from October 2010 to October 2013. The respondent sample size was chosen deliberately consisting of 40 respondents who were hospitalized at the Eye Department. It consisted of patients with glaucoma, regardless of the type of glaucoma, other somatic diseases, age, education or job.

Analysis of Survey Results

In the survey, from data from individual respondents, we came to the following conclusions and facts which are sorted in tables and graphs. Based on the analysis of the replies we present the conclusions of the individual hypotheses.

Quantitative Analysis

Table 1

What problems led you to visit the eye doctor?		
Answers	n	%
Routine check-up	12	30
Severe eye and head pain	16	40
Reddening, watery eye	4	10
Visual impairment	8	20
N	40	100

Table 2

Do you know why you were hospitalized at eye clinic?		
Answers	n	%
Yes	28	70
No	2	5
Probably yes, I just guess	10	25
N	40	100

Table 3

Do you know for which disease are you being treated?		
Answers	n	%
Yes	10	25
No	8	20
I am not sure	22	55
N	40	100

Table 4

How long have you been being treated for this disease?		
Answers	n	%
Newly diagnosed	12	30
From birth	0	0
1 – 5 years	18	45
6 – 10 years	0	0
11 – 20 years	4	10
21 years or longer	6	15
N	40	100

Table 5

Do you know the level of your inside eye pressure?		
Answers	n	%
Yes	10	25
No	8	20
Do not know exactly	22	55
N	40	100

Table 6

Can you correctly apply eye drops into the eye?		
Answers	n	%
Yes	8	20
No	8	20
I think probably yes	14	35
With the help of another person	10	25
N	40	100

Table 7

How often do you apply eye drops into the eye?		
Answers	n	%
As prescribed by doctor	18	40
When I think of them	8	20
I do not consider it as important	6	15
When there is somebody who can do it	10	25
N	40	100

Table 8

You know what to do in the deterioration of the disease (seizure ...)?		
Answers	n	%
I see a doctor immediately	16	40
I wait if it do not pass	10	25
I apply eye drops more often	6	15
I do not know what to do	8	20
N	40	100

Table 9

Do you know what glaucoma is?		
Answers	n	%
Yes	6	15
No	4	10
Partly	12	30
I mistake it with cataract	18	45
N	40	100

Table 10

Do you know the rules you should follow to live with glaucoma?		
Answers	n	%
Yes	8	20
No	10	25
Partly	22	55
N	40	100

Table 11

Do you visit a glaucoma counseling office?		
Answers	n	%
Yes, regularly	14	35
Sometimes	10	25
No	4	10
Not registered yet	12	30
N	40	100

Table 12

Has your lifestyle changed after the diagnosing of this disease?		
Answers	n	%
Yes	4	10
No	22	60
Partly	12	30
Total	40	100

Table 13

What would you like to be more informed about?		
Answers	n	%
Disease	8	20
Treatment	10	25
Consequences of the disease	36	15
Prevention	2	5
Rules for living with glaucoma	14	35
N	40	100

Table 14

Your age		
Answers	n	%
0 – 20 years	0	0
21 – 40 years	8	20
41 – 60 years	6	15
61 years and older	26	65
N	40	100

Table 15

Your marital status		
Answers	n	%
Single	6	15
Married	14	35
Divorced	2	5
Widowed	18	45
Total	40	100

Table 16

Living		
Answers	n	%
Village	18	45
City	22	55
N	40	100
Alone	12	30
With family	28	70
N	40	100

Table 17

Are you satisfied with medical staff?		
Answers	n	%
Yes	22	60
No	4	10
Partly	10	30
N	40	100

Table 18

Do you know where you have to report after discharge from the hospital?		
Answers	n	%
Yes	22	60
No	4	10
Partly	10	30
N	40	100

Table 19

Do you have information about medicines you are taking:		
Answers	n	%
Leaflets	20	50
Internet	8	20
Newspapers, magazines and literature	12	30
N	40	100

Table 20

Do you have information about your disease and the latest news regarding your treatment from:		
Answers	n	%
Internet	6	15
Newspapers and magazines	14	35
Journals	2	5
I do not seek such information	18	45
N	40	100

Qualitative Analysis

Table 1: From the data obtained, we found that 40% of patients surveyed had to visit an Ophthalmologist due to severe headaches and eye pain; 30% visited an Ophthalmologist for routine observation; 30% had to visit an Ophthalmologist with vision disorders problems; 10% had to visit an Ophthalmologist due to redness or tearing eyes.

Table 2: We searched whether respondents know the reason for their hospitalization in the Eye Department. Remarkably, 25% could not clearly answer; 5% did not know the reason of hospitalization at all; 70% knew why they were admitted to the Eye Department (the majority stated high eye pressure).

Table 3: Respondents were asked whether they know for which disease they are being treated. Only 25% knew for which disease they are treated; 20% did not know; 55% are not sure. Based on the obtained data, we suggest that respondents do not have sufficient information of a basic nature related to their disease.

Table 4: In length of treatment for their disease 45% have been treated 1-5 years; 30% that this disease is newly diagnosed with them; 15% have been treated for the disease 21 years and over (the longest is 32 years); 10% 11 to 20 years. During our research, we met no respondent being treated for this disease since birth or the treatment period from 6-10 years.

Table 5: On the value of their intraocular pressure: 35% knew the value of their intraocular pressure; a relatively high percentage to 50% do not know exactly what their IOP values are; 15% said they do not know the value of their intraocular pressure.

Table 6: 35% think that they know the right way to apply eye drops to the eye; 25% said they know how to properly apply eye drops into the eye with the help of another person; 20% know how to apply eye drops to the eye; 20% cannot properly apply eye drops into the eye. **It is alarming that 20% of respondents do not know how to properly apply eye drops and 35% think that “probably yes”, so also there is no certainty.**

Table 7: 40% apply eye drops to the eye as ordered; 25% when there is somebody who can do it; 20% applied eye drops in the eye when they remember it; 15% had not considered application of eye drops into the eye as important. **From the collected data the startling fact is apparent that 60% of respondents underestimate the frequency of application of eye drops to the eye.**

Table 8: 40% immediately visit an Ophthalmologist at the deterioration of the disease; 25% said they would wait if it passes; 20% do not know what has to be done in the deterioration of the disease; in the worsening of the disease 15% said they should apply eye drops more often. **For that we concluded that only 40% could correctly respond to the worsening of the disease.**

Table 9: 45% confuse glaucoma with cataract; 30% partially know what glaucoma is; 15% know what glaucoma is; 10% do not know what glaucoma is.

Table 10: 55% partly know the rules to be followed for life with glaucoma; 25% do not know the rules to be followed for life with glaucoma; 20% know the rules to be followed for life with glaucoma.

Table 11: 35% regularly attend a Glaucoma Counseling Office; 30% are not yet registered in a Glaucoma Office; 25% visited Glaucoma Counseling occasionally; 10% do not attend glaucoma counseling.

Table 12: 60% said that their lifestyle has not changed after the discovery of the disease; 30% that their lifestyle has changed partially; 10% it changed their lifestyle. The most common changes are as follows: the restriction of heavy work; avoiding stress; application of drops; check-up for eye surgery....

Table 13: In which areas respondents need to get more information: 35% would like to be more informed about the rules for living with glaucoma; 25% would like to be more informed about the treatment of the disease; 20% would like to be more informed about the disease; 15% would like to be more informed about the consequences of the disease; 5% would like

to be more informed about the prevention of disease. Responses of this nature are interesting. All respondents felt the need for greater awareness. **Here the Nurse can play an important role to supports the patient's healing process and correctly, on time and regularly educates her/him and supports her/his self-esteem which can result in improving communication between patients and Healthcare Professionals.**

Table 14: 65% are aged 61 and over; 20% between the ages of 21-40; 15% between the ages of 41-60; 0-20 years of age was not hospitalized during the study.

Table 15: 45% are widowed; 35% are married; 15% are single; 5% divorced;

Table 16: 55% live in cities; 45% live in a village. Furthermore, we found that 70% live with their family; 30% of those polled say they live alone.

Table 17: 60% are satisfied with the caregivers; 10% dissatisfied; 30% are partially satisfied with caregivers.

Table 18: 60% know where to report after discharge from the hospital; 10 % do not know; 30% know partly where they should report after hospital discharge.

Table 19: 50% obtained information about medicines from the leaflet; 20% from the Internet; 30% from newspapers, magazines and literature.

Table 20: Respondents obtained information about their medical condition and news related to the disease: 15% the Internet as a resource; 35% newspapers and magazines; professional literature 5%; 45% do not seek such information.

Conclusion: Evaluation of the Working Hypotheses

Hypothesis H1 confirmed: patients do not have sufficient knowledge about glaucoma and do not seek information about their treatment. We confirmed it mainly with the particular responses to Questions 3, 8, 9, 10, 11 and 20.

Hypothesis H2 confirmed: patients are interested in increasing their awareness about their disease. Evidence of this was proved in **Question 13** and in their attitudes and motivations identified during the interviews.

Hypothesis H3 confirmed: patients do not pay sufficient attention to the correct application of local therapy to the affected eye and do not realize the importance of local administration of therapy prescribed by their Doctor in exact time intervals. In **Question 6** 20% indicated that they know how to properly apply eye drops to the eye but observation showed that not a single respondent followed proper principles when applying drops.

The startling fact is apparent that 60% underestimate the frequency of application of eye drops to the eye, as seen in answers to Question 7.

Hypothesis H4 confirmed: 60% of patients do not know what to do in case of the worsening of the disease. It was confirmed by answers to the Question 8.

Hypothesis H5 confirmed: patients are willing to cooperate with caregivers and continue to take care of their vision and regularly report after discharge from the hospital with the attending Physician.

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Radiological Examination Methods of Cardiovascular Disease

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Abstract

Nowadays the methods of radiology are at a very high scientific level. In our presentation, we discuss the possibilities of better prevention using radio-diagnostic procedures. In spite of the several risk factors which restrict in many cases the patient's successful treatment process, there are progressive improving radiology examinations which contribute to early diagnosis. For achievement of these aims, it is necessary to increase the education level of the Radiology Staff and to innovate the equipment status in the Radiology Departments.

Key words: cardiovascular disease, prevention, risk factors, congenital heart defects, radiology

Introduction

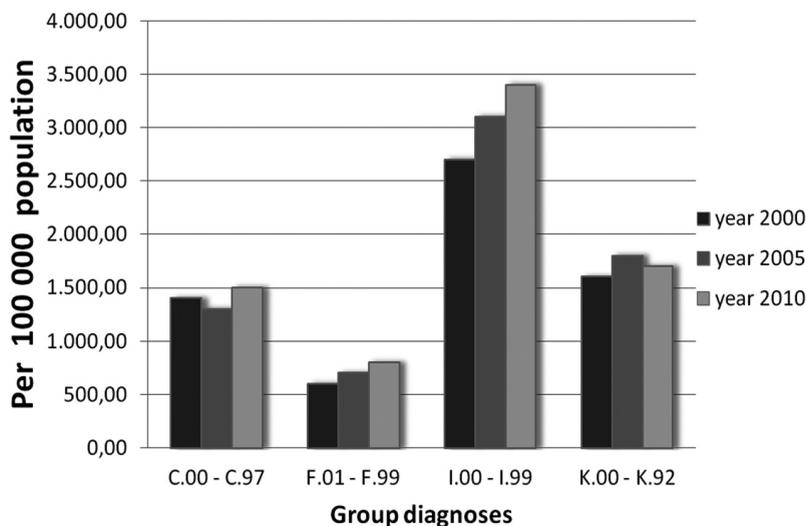
Health status is affected by genetic features; availability of health care; living and working conditions; as well as by socio-economic conditions. Health greatly affects the way of live of individuals and their lifestyle. Lifestyle and attitude to their own health are created during a person's life, depending on many factors such as education, culture, stereotype, comfort, etc. (Report on the Health Status of the Population of the Slovak Republic for the years 2009-2011, p. 60)

The most basic rule is mainly to maintain a healthy lifestyle; which is to eliminate smoking, obesity, lack of physical activity, as well as the impact of stress on the body. Known number of lifestyle are **0-30-5-140-90**, which means **0** - cigarettes, **30** minutes of physical activity a day, **5** - healthy level of total cholesterol and **140[^]90** means maximum blood pressure. Experience shows that there is a link between risk factors and their removal can reduce the incidence of cardiovascular disease, but it is not scientifically proven. (Dudeková, 2012)

Mačkinová (2013) indication that although Medicine, Nursing, Social Work and other Departments show considerable progress; a human approach should not be underestimated.

1. Hospitalization, Hospitalized Patients

In 2012, hospitalization for circulatory diseases, including patients with transient ischemic attack (TIA: G45) indicated 138,045 patients whose hospital stay was requested, all together 182,653 hospitalizations. For acute conditions within circulatory diseases, and for acute coronary syndrome (ACS: I 20 – I 22) 15,289 patients were hospitalized for stroke (stroke: I 60 – I 64), including patients with TIA 19,076 patients. (Health Statistical Yearbook Slovakia 2012, p. 40)



Graph. No. 1 Development of hospitalizations for selected groups of diagnoses ICD-10 (Source: Health Statistical Yearbook Slovakia 2012, p. 53)

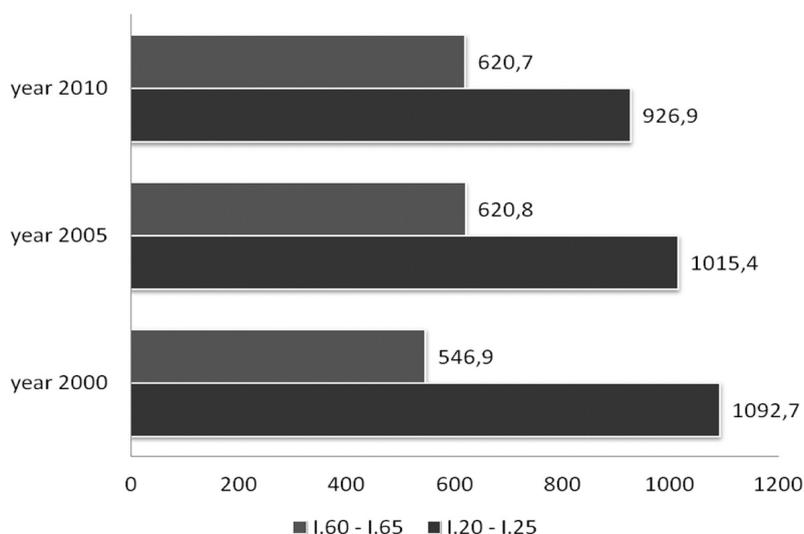
2. Incidence

The standardized incidence rate for ACS and stroke was on the 2009 level. The national health registries of ACS and stroke reported, 4,652 patients with ACS episode (only 30% of hospitalizations) and 7,713 patients with stroke (40% of relevant patients) in 2012. Due to the persistent low number of cases, the database of hospitalized patients is the most objective source of ACS and stroke incidence. (Health Statistical Yearbook Slovakia 2012, p. 40)

Caring for patients with cardiovascular disease (CVD) requires a comprehensive approach and an approach that consists of early diagnosis, evaluation of prognostic factors, and the introduction of adequate treatment and ongoing monitoring of the disease course. Protocols to ascertain the relationship between the specificities which arise at an earlier age are at high risk of disease.

Protocols for preventive examinations would bring enormous progress in the management of patients. Each patient in whom a diagnosis of some form of CVD was detected will be examined by available non-invasive examination methods. Genetic screening is complicated, but allows a preventative action without genetic risk of developing CVD. Therefore, it is important that investigations are carried out before the outset of the disease. With the consistent application of knowledge in practice, it can be expected that in the near future these patients will be recorded in Slovakia.

There is the assumption that the treatment will be carried out in future generations according to guidelines (recommendations) and thus will represent actual prevention of CVD.



Graph. No. 2 Number of hospitalizations for selected diagnoses diseases of the circulatory system (Source: Health Statistical Yearbook 2012, p. 53)

3. Stress and the Cardiovascular System

Stress

- The reaction of the organism to changes in internal or external environment
- The purpose of the stress response is the body adaptation to changes
- Inability to adapt to adjustment to causes of disorders with severe damage to and destruction of the body

The cause of the disease is a predisposing factor which increases the propensity to disease by reducing resistance; lack of recovery; inadequate efforts to adapt.

Stress reaction is accompanied by an increased level of catecholamines which have a significant affinity to the myocardium. The result is tachycardia and an increase in myocardial contractility, minute volume and oxygen consumption. During the stress response most frequent pathological responses of cardiovascular system disorders involve arrhythmias and regional coronary flow. (Kölbel, 1985)

Congenital Heart Defects

Congenital heart defects are defined as disorders affecting the structure and function of the heart that occur during intrauterine development, but usually do not become apparent until after birth.

Data processing that deals with the National Health Information Center:

A long-term purpose is to collect selected clinic-epidemiological data on patients with congenital heart disease; to process information on morbidity and mortality of cardiovascular diseases; on the trends of these diseases in population groups; and on the type and level of the healthcare in the Slovak Republic. Use Section of Health of Ministry of Health and appropriate Medical Societies use these data. Collected information on the incidence and distribution of congenital heart disease in the population result from mortality and survival of patients with that di-

sease. (National Health Information Center)

Since 1994, in Slovakia there is mandatory reporting and registration of all birth defects. This report falls within three categories:

- 1) Vascular disease in live births
- 2) Vascular disease in stillbirths
- 3) Prenatally detected vascular disease, which gave rise to abortion.

In 2007, the American Heart Association (AHA) made a declaration of non-heritable risk factors for congenital cardiovascular diseases according to previously available literature and studies collected worldwide. The statement listed the factors that may influence the occurrence of CVD in the preconception period (3 months before pregnancy) and in the first trimester of pregnancy when the fetus is most susceptible to the emergence of CVD.

- 1) Mother’s illness, Phenylketonuria, Diabetes, Rubella, febrile illness and flu
- 2) Drugs in pregnancy, Antibiotics (Ampicillin, Penicillin), Antivirals/Antiretroviral, Non-steroidal anti-inflammatory drugs (Ibuprofen)
- 3) Abuse of mothers, Alcohol, Cocaine, Marijuana, Nicotine
- 4) Environmental impacts, Organic solvents (chemical plants – paints and hair sprays, paints), Herbicides, Pesticides and Rodenticides (agricultural industry), Air pollution, Contamination of groundwater (trichloroethylene)
- 5) Socio-demographic factors, Age of partners (women and men)

Possibilities of Prevention in Reducing Cardiovascular Disease

To reduce the incidence of cardiovascular disease can reach the knowledge and targeted prevention aimed at influencing modifiable risk factors, particularly pharmacological influenced blood pressure, lifestyle changes and increased physical activity, and psychosocial factors.

Primary prevention	• protect the body from disease emergence	
	• population strategy	✓ identification and reduction of major risk factors in the population
		✓ identification of persons at high risk
	• individual strategy (high-risk strategy)	✓ reduce their individual risk level
Secondary prevention	• reduce the incidence of disease in the population	
	• slowing/stopping disease progression	
	• prevention of complications	
	• prevention of premature death	
	• prevention and control of chronic diseases	
	• use prevention options in non-invasive diagnostics	✓ non-invasive methods in radiology – USG, CT, CMRI

Table no. 1 Possibilities of prevention in reducing CVD

4. Noninvasive Imaging - Radiology

Paradoxically, currently living in populations with more adult congenital heart disease than children themselves, the majority of these patients have complex cardiac defects and require life-long monitoring as they occur in the form of complications of heart failure with possible pulmonary hypertension, thrombo-embolism, arrhythmias and sudden death.

4.1 Postnatal Diagnosis

Cardiologists use echo-cardiographic examination as part of their evaluation and since it is in the area of Cardiology, chest radiographs are currently used in long term follow-up of changes of heart and blood vessels.

4.2 Computed Tomography

Computer Tomography – Cardiac MSCT makes a particularly significant contribution to the diagnosis of coronary artery disease and disability has replaced angiography diagnostic imaging of coronary artery intervention. The diagnostic advantage of CT over angiographic intervention predestines prevention of ischemic complications. Early diagnosis allows appropriate treatment according to the finding of disability coronary artery. Cardio CT can also evaluate perfusion and disability of and valvular system then higher radiation exposure cardio MRI (CMRI – cardio magnetic resonance imaging) is perfected.

4.3 Cardiac catheterization

It reveals the anatomy of the coronary arteries; the degree of pulmonary artery constriction; pulmonary artery anatomy and the branches of the aorta; the extent of ventricular septal defect (VSD). Catheterization also should be defined for patients who are undergoing intervention (e.g. unstop of distal pulmonary artery stenosis, percutaneous valve implantation); or if the result of non-invasive tests is inconclusive. Another indication for catheterization is to determine the resistance of pulmonary vasculature.

4.4 Magnetic resonance imaging

CMRI may be an alternative for patients with TOF (Tetralogy of Fallot) conduit who have an implanted pacemaker or defibrillator, and also provides valuable information on coronary arteries, lung parenchyma and the extent of calcification.

In the last decade MRI has become a unique method of diagnosis. Its advantage lies in the complexity and nature of outpatient examinations. Cardiovascular magnetic resonance imaging has found wide application, especially due to non-invasive, accurate, comprehensive assessment of anatomy; the function of the heart without radiation which is particularly beneficial for patients with congenital heart disease who undergo repeated lifelong examinations.

Indications Cardiovascular MRI:

A. Congenital heart defects

1. Preoperative diagnosis
2. Monitoring of postoperative complications (most indications)

B. Acquired heart disease

1. Diseases of cardiac valves and their replacements
2. Myocardial diseases

- Coronary (postischemic cardiomyopathy)
- Acoronary (dilated cardiomyopathy, hypertrophic)

C. Other indications

1. Diseases of the pericardium
2. Tumors of the heart
3. Diseases of the aorta and great vessels

5. Advantages and Disadvantages of CMRI

Compared to other non-invasive modalities such as ultrasound and CT, MRI has several advantages:

- a) MRI examination without radiation, thus allowing retesting of children and of pregnant women, although it should not be indicated in the first 12 weeks of pregnancy
- b) A relatively high resolution 3D image of the heart and blood vessels
- c) Compared to echocardiography, MRI picture is limited interference with an adjacent shell and the ambient air
- d) Widespread diagnostic option compared to CT and echocardiography.

Disadvantages:

The risk of nephrogenic system fibrosis (NSF) is found only in the group of patients with kidney disease (severe acute or chronic renal insufficiency with a glomerular filtration rate < 30 ml/min./1.73 m²) with an incidence of 3-5% after administration of gadolinium contrast agent.

The length of the examination was significantly higher (30-120 minutes), as compared to CT and echocardiography.

Requires more cooperation of the patient and the fact that 2% of the population suffers from claustrophobia should not be neglected, which in certain cases completely prevents examination. In children sedation or general anesthesia are needed,

Material of various life support equipment is incompatible with MRI and the patient is isolated from direct care, therefore its use is limited in acute conditions.

Absolute contraindication are implanted pacemaker or defibrillator; aneurismal vascular clamps and electrical implants (insulin pump); unless it is written, the accompanied document is limiting compatibility with their MRI; metallic foreign bodies from non-demonstrable non-magnetic metal. Metal implants can be broken by a strong magnetic field and may distort the resulting image. At the present time, MRI compatible aneurismal clamps, stents, vascular filters and pacemakers are being built.

Disadvantage remains well below the spatial resolution compared to CT, which limits the assessment of small structures such as coronary arteries.

CMRI	CT
• possible view in any scan	◦ examination in the axial scan with the possibility of multiplanar reconstruction
• without radiation exposure	◦ radiation exposure +++
• longer period of the breath-holding during the examination	◦ relatively short period of the breath-holding during the examination
• generally longer time to examination	◦ relative short period for examination
• options for the post-processing +++	◦ options for the post-processing +++
• limited resolution 1-2 mm	◦ resolution is possible to 0,4 mm
• usefulness image without contrast medium +++	◦ limitation of meaningful images without contrast medium
• software for performance evaluation of right ventricular function	◦ is not adequate software for performance evaluation of right ventricular function
• possible to measure blood flow	◦ is not possible to measure blood flow
• viewing during the free breathing	◦ examination only with breath-holding
• local distortion of the image from metallic materials	◦ relatively minor artifacts from the metal
• poor visualization of calcium	◦ well visible calcium
• limitation imaging coronary artery	◦ properly imaging coronary artery
• very low percentage allergy reaction to contrast media	◦ relatively high percentage allergy reaction to contrast media
• small number of Departments (for CMRI – 1,5 and 3T)	◦ sufficient number of Departments

Table no. 2 The advantages and disadvantages between CMRI and CT Compared

Cardiovascular Magnetic Resonance Imaging (CMRI)

It is used in preoperative diagnosis of conditions rather exceptionally, mostly only in inconclusive findings, however, becoming increasingly important especially in the post-operative diagnosis of late complications in adults with congenital heart defects and where echocardiography results are borderline or ambiguous.

In terms of long-term management are critically important data on volumes and ejection fractions chambers and severity of valvular regurgitation are critically important.

Conclusion

In 2010, the European Society of Cardiology (ESC) published a document which lists indications, when the diagnosis by CMR preference to echocardiography in adult patients with congenital heart disease is used:

- a) Quantification of right ventricular volumes and ejection fraction of the right
- b) Quantification of valvular regurgitation pulmonary artery,
- c) Evaluation of the pulmonary arteries (stenosis, aneurism) and the aorta (aneurism, dissection, coarctation),
- d) Assessment of systemic and pulmonary veins (anomalous connection obstruction),
- e) Detection of collateral and arterio-venous malformations (CT is preferable),
- f) Diagnosis of coronary artery anomalies (CT is preferable),
- g) Assessment of intra- and extra-cardiac tumors (CT is preferable),
- h) Quantification of myocardial mass of the right and left ventricle,
- i) Defection and quantification of myocardial fibrosis or scarring,
- j) Assessment of the nature of tissue (fibrosis, fat, iron deposits).

Efficiency in the use of the MRI evaluation:

- Complex anatomy of the heart
- Cardiac function
- Myocardial viability and perfusion
- Valvular disease and pericardial disease
- Intracardiac tumors
- Congenital heart defects and postoperative complications

CT is primarily used for efficiency assessing coronary arteries. The use of MRI for cardiac diagnosis particularly needs the use of a paramagnetic contrast agent.

By its application, it is possible to detect and characterize intracardiac masses, thrombi, myocarditis and specific processes such as sarcoidosis.

Post-contrast examinations and evaluation bring advantages in many aspects, and according to the character of diagnosing, it is divided into the perfusions examination, late enhancement and angiography.

Radiological imaging methods significantly contribute to the diagnosis and prevention of cardiovascular diseases. Significant increase in cardiovascular CT and CMRI high standard hardware and software requires an increase in the educational process of Radiographers and Radiologists.

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Abstrakt

The Paramedic Profession makes high demands on individual characteristics. It is hard but beautiful, and offers continual professional growth as well as an honorary position in society due to its nature - saving lives. Therefore, we can say that personal ethics is very important in the work of a Paramedic. It is insufficient to acquire only theoretical and practical skills. Certain moral characteristics are needed in order to work optimally. The Paramedic Profession is connected with various moral characteristics which reflects on work quality. The most important are altruism, responsibility, commitment, conscience etc.

1. Paramedic

When choosing Paramedic studies, many do not realize the seriousness of this profession. Those who choose this profession because of inner beliefs or because of its humanitarian nature will have no problem adapting to high demands of study and consequently work which requires good psychic; physical condition; self-sacrifice; humanitarian approach; responsibility; conscientiousness. Work in Emergency Medical Services is composed of diverse situations in which the implementation of Nursing Care is limited by extreme urgency; lack of various diagnostic equipment; especially, any care that is provided is always realized in different conditions placing principal emphasis on preservation of a patient's dignity. (MAČKINOVÁ, M. 2011).

The Paramedic Profession includes care; development and recovery of health; minimalization of suffering while caring for patient; either singular, family or a group.

Paramedics often forget about themselves and they should keep in mind the following:

- Care about your health,
- Educate your brain
- Care for health of your community
- Keep education in mind

2. Factors Affecting Health

Health is affected by various factors which are called *the determinants of health*. The biggest influence on community health is lifestyle which is mostly affectable by primary prevention. Basic determinants of health are:

- **Lifestyle** (50-60%),
- **Genetic basis** (10-15%),
- **Socio-economic and environment** (20-25%),
- **Healthcare** (10-15%), (BIELIK, 2011).

The Lifestyle of Youth has been changing in recent years. They are less active; free time activities chained to computer and television; in combination with sleep deprivation; consumption of unhealthy food which results in growth of obesity. There is an increase in hypertension and Type 2 Diabetes in young people. Bad nutrition habits; insufficient physical activity; smoking or excessive consumption of alcohol are risk factors resulting in an increase of sudden death syndrome. Lifestyle risk factors in youth include bad food habits; sleep deprivation; psychosocial factors; smoking; alcoholism. Eating is not meant only to satisfy the feeling of hunger but also to provide essential substances for the body in order to maintain optimal health and efficiency. If we choose food not according to taste but quality, our body will reward us and we might be able to decrease the incidence of 'civilization diseases' such as obesity, cardio-vascular diseases, diabetes, some types of cancer and osteoporosis. It is essential to consume various food, fruits, vegetables and cereals. (OCHABA, ROVNÝ, BIELIK 2009). (GEBEOVÁ 2010, s. 9). It is a generally accepted fact that the health status of a population is the result of a complex operation of the four basic determinants.

3. Methods of Research

When deciding which method of research to use for assessment of health, we chose a Questionnaire which allows us to assess behavior of individuals and if it leads to functional or dysfunctional health. The Questionnaire is composed to reflect a presence of risk factors which can lead to dysfunction of health and illnesses if there is no change towards positive reinforcement of health. To acquire sufficient data, the Questionnaire was distributed by means of the Internet among students of Emergency Medical Care in Bratislava. The Questionnaire consists of open and closed questions. It is anonymous and voluntary.

The Questionnaire of personal design consists of 11 questions and its goal was to assess personal opinion; state of health of respondents; and to describe individual activities realized for health reinforcement.

Inquiry Question: Which risk factors are present in our group of respondents?

4 Characteristics of Inquiry Sample

The group consisted of 164 respondents who study a Emergency Medical Care Program and was distributed by means of the Internet from December 2013 – February 2014. Of these, 84 respondents aged 18 - 25 were applicable.

Table #1 Division of the group according to sex and type of study (Source: author)

Sex	Number	%	Type of study	Number	%
Male	114	76,51 %	Full time	68	64 %
Female	35	23,49 %	Part time	81	54.36 %
Together	149	100 %	Together	149	100 %

Graph #1 Division of the group according to sex and type of study (Source: author)

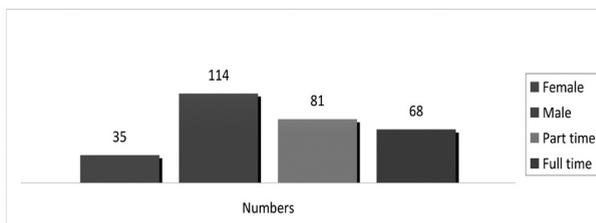


Table #2 Do you work during your studies? If yes, how long? (Source: author)

Options		Full time N %		Part time N %	
a) yes	n ₁	49	72.06	81	100
b) no	n ₂	19	27.94	0	0
Together		68	100	81	100
Up to 6 hours	n ₃	45	91.84	0	0
Up to 12 hours	n ₄	4	8.16	62	76.54
Over 12 hours	n ₅	0	0	19	23.46
Together		49	100 %	81	100 %

From total number of full time students n = 68 respondents (100%) answered n₁ = 49 respondents (72.06%), n₂ = 19 respondents (27.94%). Answer to second question n₃ = 45 respondents (91.84%) and n₄ = 4 respondents (8.16 %). Part time students n = 81 respondents (100%) answered n₄ = 62 respondents (76.54%) and n₅ = 19 respondents (23.46%).

Graph #2 Do you work during your studies? If yes, how long? (Source: author)

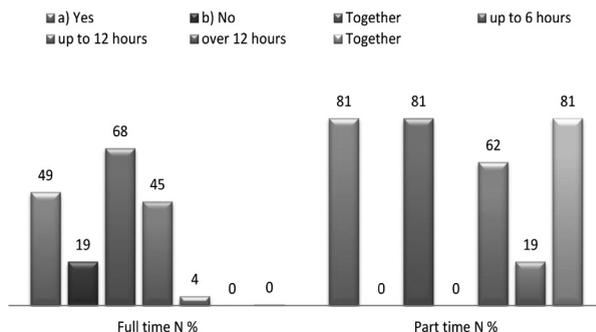
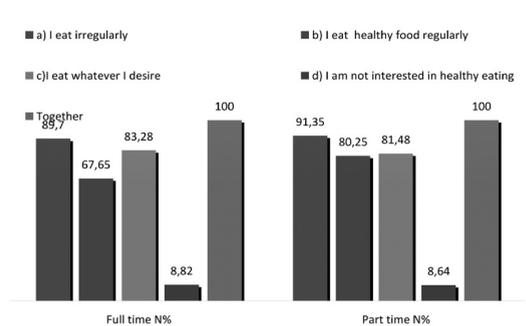


Table #3 Do you think that your meals fulfill conditions of healthy nourishment? (Question with multiple answers) (Source: author)

Options		Full time N %		Part time N %	
a) healthy but irregular	n ₁	61	89.70	74	91.35
b) healthy and regular	n ₂	46	67.65	65	80.25
c) I eat what I desire	n ₃	57	83.28	66	81.48
d) I do not care about healthy food	n ₄	6	8.82	7	8.64

Full time respondents answered n₁ = 61 respondents (89.70 %), n₂ = 46 respondents (67.65%), n₃ = 57 respondents (83.28%) and n₄ = 6 respondents (8.82%). Part time students answered n₁ = 74 respondents (91.35%), n₂ = 65 respondents (80.25%), n₃ = 66 respondents (81.48%) and n₄ = 7 respondents (8.64%).

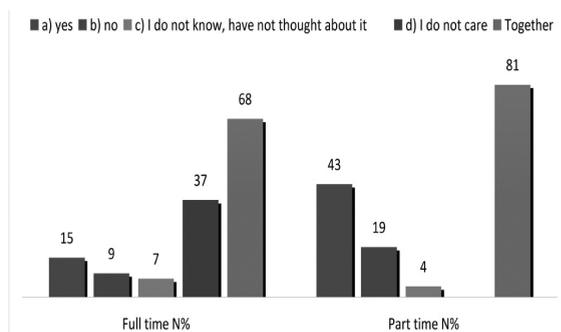
Graph #3 Nutrition (Source: author)

Inquiry Question: *Do you think that smoking, consumption of alcohol, lack of physical activity, overweight, increased values of blood pressure, blood sugar and lipids present in young age influence their quality of health in adulthood?*

Table #4 Risk Factors (Source: author)

Options		Full time N %		Part time N %	
a) yes	n ₁	15	22.06	43	53.08
b) no	n ₂	9	13.23	15	18.51
c) I do not know, have not thought about it	n ₃	7	10.24	19	23.45
d) I do not care	n ₄	37	54.41	4	4.93
Together		68	100	81	100

From total of full time students n = 68 respondents (100%) answered n₁ = 15 respondents (22.06%), n₂ = 9 respondents (13.23%), n₃ = 7 respondents (10.24%) and n₄ = 37 respondents (54.41%). External students n = 81 respondents (100%) answered n₂ = 43 respondents (53.08%), n₃ = 19 respondents (23.45%) and n₄ = 4 respondents (4.93%)

Graph #4 Risk Factors (Source: author)**Table #5 Do you eat breakfast regularly?** (Source: author)

Options		Full time N %		Part time N %	
a) yes	n ₁	5	7,35	7	8,64
b) no	n ₂	7	10,29	2	2,46
c) if I have time	n ₃	39	57,35	51	62,96
d) I do not eat breakfast	n ₄	17	25	21	25,92
Together		68	100%	81	100%

From total of full time students n = 68 respondents (100%) answered n1 = 5 respondents (7.35%), n2 = 7 respondents (10.29%), n3 = 39 respondents (57.35%) and n4 = 17 respondents (25.00%), Part time students n = 81 respondents (100%) answered n1 = 7 respondents (8.64%), n3 = 57 respondents (70.37%) and n4 = 21 respondents (25.92%).

Graph #5 Breakfast (Source: author)

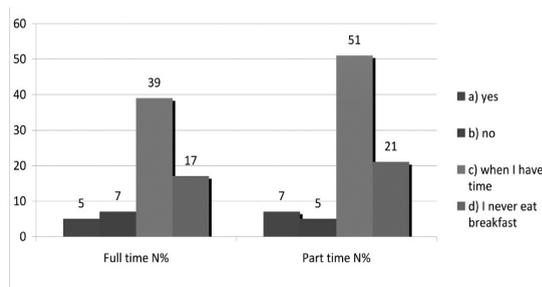
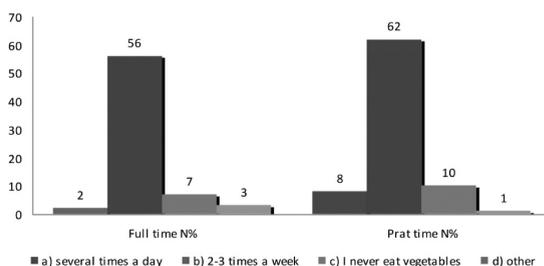


Table #6 How often do you consume fruits and vegetables? (Source: author)

Options		Full time N %		Part time N %	
a) few times a day	n ₁	2	2.94	8	9.87
b) 2 - 3 times a week	n ₂	56	82.35	62	91.17
c) I do not eat fruits and vegetables	n ₃	7	10.29	10	12.34
d) other	n ₄	3	4.41	1	1.23
Together		68	100%	81	100%

From total of full time students n = 68 respondents (100%) answered n1 = 2 respondents (2.94%), n2 = 56 respondents (82.35%), n3 = 7 respondents (10.29%) and n4 = 3 respondents (4.41%). Part time students n = 81 respondents (100%) answered n1 = 8 respondents (9.87%), n2 = 62 respondents (91.17%), n3 = 10 respondents (12.34%) and n4 = 1 respondent (1.23%).

Graph no. 6 Consumption of fruit and vegetables (Source: author)



5. Discussion

The Questionnaire showed a high incidence of cardio-vascular system risk factors, in preparation for a Profession which is hazardous by itself in accordance to lifestyle. At such a young age 30.88% of full time students and 70.37% of part time students marked their life as stressful. During studies 72.06% of daily students work by average up to six hours. In part time students average working time is up to 12 hours is in 100%.

In the nourishment results 89, 70% of full time students eat irregularly and part time students in 91. „Paradox of modern civilization is that 1/3 of population suffer from food deficiency; *World Health Organization designated obesity as the biggest health complication and warns of world epidemic.*”(SZO 2014).

Regular consumption of vegetables was marked by 82, 35% of full time students and 91, 17% of part time 2-3 times a week. The majority marked by breakfast that they do not skip it if there is time in 57.35% and 62.93%. According to our findings we can declare that there will be an increase in overweight and obesity.

Available statistics show that *Japan and South Korea lead with less than 4% of adult population being overweight.*

Most people with obesity live in USA (33.8%) and Mexico (30%).

OECD average in adult population is around 16, 9% (statistics from 2009 and before), which is present also in Slovakia.

In V4 Countries Czech Republic with 17% and Hungary with 19.5% rank a little bit higher. Poland with 12.5% is below the OECD average (OECD 2012).

Health Education is the basic fundamental of our society. If we want to improve the quality of life of individuals it is essential to cover all factors that affect health.

As we pointed out in our thesis, the state dominantly supports children and youth. But it is only aimed at the age when they are being prepared for a Profession. At ages 18-25 support is absent. This age span, according to (BIELIK 2011) is the age of top health but at the same time it is the age of character creation, self-finding and integration in adulthood.

It is the time in life where strong personality is required in order to resist the influences of the surrounding community. Life is the highest value to be protected (Mačkinová, 2009).

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The Analysis of HIV/AIDs Trend at Mary Immaculate VCT Nairobi-Kenya: Ten Years Evaluation Report, 2013.

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Abstract

The purpose of this study was to find the trends of HIV/AIDs after a ten year period after the establishment of the free voluntary testing and counseling services. It was a retrospective study and the national prevalence rate data of ten years period was compared with Mary Immaculate Testing Center prevalence rates for same period. Over 35,000 people have been tested there.

The findings demonstrated that the national prevalence rates for the HIV virus have remained stable e.g. nationally, the prevalence rate of HIV has been as follows: 2004 (7.5%), 2005 (7.3%), 2006 (6.9%), 2007 (7.4%), 2008 (7.8%), 2009 (6.3%), 2010 (6.4%), 2011 (6.2%), 2012 (either 5.6 %? or 6.3 %?), and 2013 was targeted to be 6.8% for ages 15-49. But for Mary Immaculate, the HIV testing site, the statistics has been: 2004 (15.2%), 2005 (14%), 2006 (11%), 2007 (10.2%), 2008 (7.8%), 2009(5.2%), 2010 (4.2%), 2011 (5.5%), 2012 (4.8%), and 2013 (3.72%). Furthermore, the finding indicated that before 2009, men were leading in taking the test as compared to women; from 2009 more women have taken the HIV test as compared to men.

In conclusion, the HIV prevalence rate for the country has remained stable, neither decreasing nor increasing. There is no established single Institution in the country that gives reliable statistics, as prevalence rate for 2012 was conflicting from different sources; either under reported or over reported. Likewise we don't know exactly how many people are living with HIV as the reporting's from different sources gave conflicting figures.

Key words: Analysis, HIV, Trend, Mary Immaculate VCT. Nairobi-Kenya, Ten Years, and Evaluation.

Introduction

People who are not utilizing the free voluntary counseling and testing services continue to put themselves and their partners at a greater risk of contracting HIV virus as many people still engage in risky behaviors. In 2012, results from National Aids Control Council in Kenya indicated that only 48% people have been tested for HIV/AIDs and know their status.

Despite the introduction of free voluntary counseling and free antiretroviral treatment to people, self-perception of the importance of knowing HIV status and management has not been valued by the people. Stigma and negligence remain keys areas of concern in the society

that still needs to be addressed. In Nairobi alone, it is being reported that 199,100 people are living with HIV/AIDs, making the county a home to the highest AIDs 'burden' in Kenya with a prevalence rate of 8.6% of the population (Samuel Siringi, 2013, p. 1-4).

For this reason, I decided to carry out a situational analysis of HIV/AIDS prevalence rates for a ten year period from Mary Immaculate and compare it with the prevalence rate of the country (Kenya). Voluntary counseling and testing has been the best model used in fighting the HIV virus among the Kenyan people although it still meets resistance from some people due to cultural values and perception about the existence of the virus. Therefore the study intends to:

- 1) Find out the trend of HIV prevalence rates of Mary Immaculate VCT as from 2004 to 2013.
- 2) Compare the HIV prevalence rates for Mary Immaculate VCT and for the country.
- 3) Compare the number of men vs. women tested in the center from 2004 to 2013.

This study has three areas:

- 1) The literature review which is focused on the early handling of HIV/AIDS victims in Kenya and the current achievements in its fight.
- 2) Methodology of the data gathering,
- 3) which is then followed by the result presentation, discussions, and conclusions.

Literature

It is now about three decades since the first Kenyan case of HIV/AIDs was reported. Information about the virus was propagated to the people with a lot of fear and misconception on modes of transmission. In the western region of the country any person who was perceived to have died from the HIV virus, relatives were not allowed to be near or bury the person. It was the duty of local government leadership together with the police dressed in aprons with gloves to wrap the corpse in black polythene paper and roll the remains to the graveside which was dug far from the homestead. This was the genesis of stigma which has been the biggest mountain to clear from the society. From that time, the epidemic has evolved to become one of the central impediments to national health, wellbeing and development. Since HIV began in 1984, it has claimed almost 1.7 million lives of Kenyans (NACC and NASCO, 2012, p.9). In addition, it is estimated that 1.6 million people are living with the virus.

Therefore to tame the spread of the virus, free Counseling and Testing Services were made available to all people willing to know their status and take cautious measure either to live positively and protect their partners or prevent themselves from contracting the virus. Testing of the HIV and Counseling has contributed significantly to the reduction of stigma associated with HIV/AIDS and the promotion of behavior change (NASCO, 2008, p.1-4). A person seeking HIV Testing and Counseling Services does so to guide his/hr personal life to lead to decision making; plan for one's future or the future of their family; to understand the symptoms one is experiencing; or support personal HIV prevention initiatives.

Through this initiative, it has helped to develop a realistic and relevant risk reduction plan (Ministry of Public Health and Sanitation, 2008, p.17). Therefore one seeking HIV Testing Services undergoes a confidential counseling that must be accompanied by pre-test information and post-test counseling including referrals to appropriate centers for more HIV Service.

The approach focuses on Cognitive-Behavioral Therapy, since much of the enabling risk factors for the spread of the HIV virus are associated with human behaviors. The services provided are geared towards specific risk factors, e.g. the clients are taught new skills such as interpersonal problem awareness; generating alternative solutions; evaluating consequences; resisting peer pressure; opening up and listening to other perspectives; soliciting feedback; taking other persons'

well-being into account; and deciding on the most beneficial course of action (Harvey Milkman and Kenneth Wanberg, p.5).

HIV Counseling and Testing has played a critical role in Kenya checking the spread of the HIV virus to individuals; providing them with information of their HIV status. The Counselor gives the counselee enough time (30-45 minutes) to address all the issues that affect his/her life.

The Counselor must be equipped with all HIV information plus the referral centers that provide HIV/AIDs Management Services like family planning; nutritional counseling; ART treatment; psychosocial support; treatment for opportunistic infections and prophylactic treatment.

The country's success in fighting the HIV scourge is attributed to external donors whom we remain heavily dependent on. Donor support accounts for more than 80% of all AIDS spending. The generosity of numerous International donors has benefited the country through prevention, treatment and care of positive cases. It is foreseen that if AIDS funding were to decline the rate of new HIV infection and AIDS in 2030 would be substantially higher than it is today (NACC and NASCOP, 2012, P. 97-122). This is because macro-factors that fuel the spread of HIV such as poverty, gender inequalities and capitalism, economic inequalities, racism, sexism, discrimination and stigmatization are still within the society (Kenya National AIDS Control Council, 2009, p.32).

Therefore it is important to understand the importance of strengthening the HIV Testing Services which has been advocating for behavior change in the society to fight the HIV menace with our willing external partners. As Scientists continue with the search for HIV vaccine or treatment, testing should continue to reach those who haven't made up their mind whether to test or not; to empower them to make rational informed decisions to protect themselves and their loved ones; Complacency on the gains made so far will take us back to unspoken days where the HIV topic could not be discussed in the community or any forum.

Methodology

This is a retrospective analysis of Mary Immaculate Voluntary Counseling and Testing data. The Center is an initiative of St. Elizabeth University from Slovakia. The program was set up in December 2003 to provide free HIV Services to the residence of Mukuru slums and it's environ.

The location is composed of a sub population with various risks such as: sex workers; casual heterosexual sex; men having sex with men; female partners of MSM; prison population; partners of the prison population; clients of sex workers; partners of clients of sex workers; drivers of trucks, taxis, buses/mini buses and their touts; and drug injecting users.

St. Elizabeth University is the sponsoring agency which has remained steadfast in ensuring that the people of Kenya get the right services for better lives by the Kenyans themselves. A project of this magnitude would not have served the people of Kenya were it not the huge and immense support of the St. Elizabeth University from Slovakia.

The Center has been operational for 10 years now. Providing Counseling Services in areas of HIV/AIDs, Sexual Transmitted Diseases and other health related issues affecting people. The people working in the VCT Center are Public Health Trained (Health Promotion Specialists).

The testing method is a rapid antibody test, where the *Determine Test Kit* and *Un-Gold Test* are used at the Center to test for HIV virus. The Counseling session takes between 30-45 minutes.

Reason? To give client enough time to ask questions and to explore all possible ways that will help him/her to work out his/her risky behaviors and to reduce the spread of HIV virus. The ten year period data was collated and analyzed using Excel Program and presented in graphs.

Results

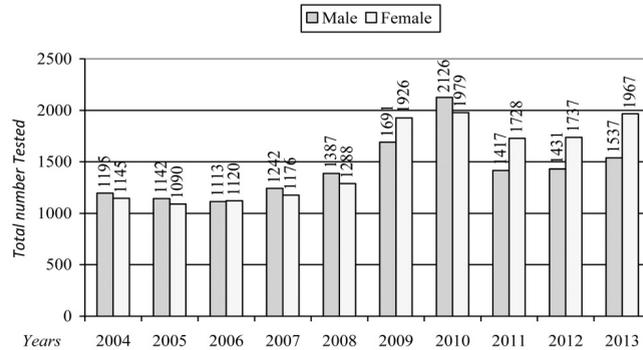


Figure 1: The Yearly Distribution of Clients' by Gender at Mary Immaculate VCT

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The Results presented focused on yearly distribution of HIV prevalence for the testing center and the national statistics which also included the gender distribution and the oldest and the youngest person to have been tested at the site.

When the free VCT Services were rolled out in 2000, it encountered much resistance from people to take the HIV test. This was due do stigma and discriminations that were attached to those people who were found to be HIV positive. In 2004, 2,157 people took the HIV test; 2005 2,232 people; 2006 2,233 people; 2007 were 2,418 people. And the figures increased minimally up to 2008 with 2,631 people tested. Then number went up to 3,517 in 2009. More women have surpassed men in testing and they have remained above 1,500 according to **Figure 1**. People are now making the individual decisions to know their HIV status either to benefit from ART Treatment to live longer or to prevent themselves and their loved ones from contracting the HIV virus. In 2010 where 4,105 people that took the test.

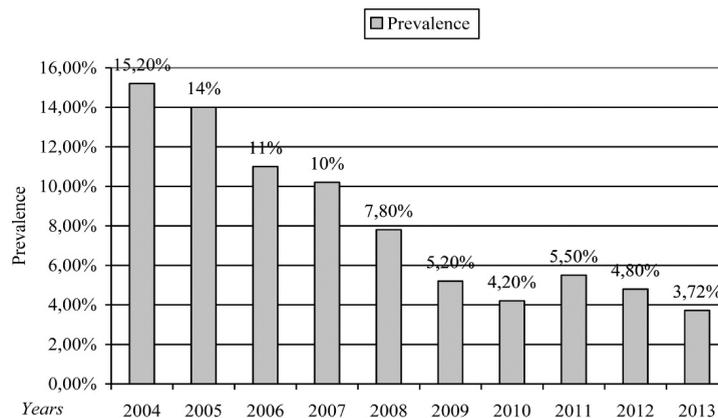


Figure 2: The Yearly Distribution of HIV prevalence at Mary Immaculate VCT.

At the time that Voluntary Counseling and Testing started offering free testing services, the prevalence rate was high. Mary Immaculate recorded a prevalence rate of 15.2% in 2004. For a

period of ten years the site has been recording decreasing prevalence rates for every year as follows: 15.2%, 14%, 11%, 10.2%, 7.8%, 5.2%, 4.2%, 5.5%, 4.8% and 3.72% for the years 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012 and 2013 in that sequence.

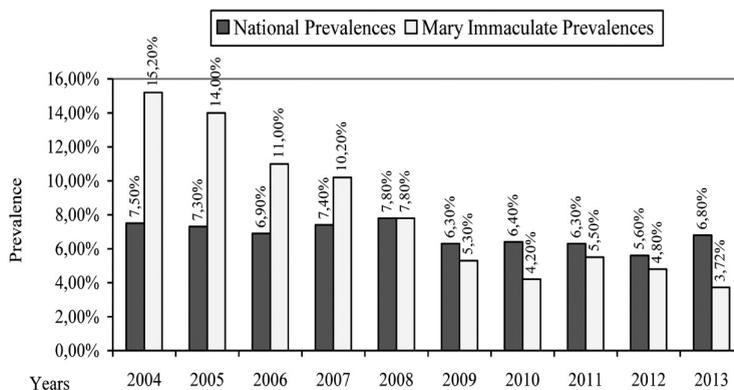


Figure 3: Comparison of Prevalence Rates between the National Statistics vs. Mary Immaculate VCT.

In 2004, the prevalence for the whole nation was 7.5%; but initially in 2000 it was 13.4%, 2001 (12.8%), 2002 (10.5%), and 2003 (9.4%). This drop in prevalence was as a result of many campaigns to raise HIV awareness. For this reason, the prevalence has remained stable for all this ten year period as it goes up and down between 7.5% (2004) and 5.6% (2012) . Compared to the Mary Immaculate VCT site which operates within the city center, the prevalence rate has dropped from the 15.2% to 3.72% after the ten year period.

Discussion

Free HIV Testing and Information to people has yielded positively good results in restraining its spread. This is credited to the International Agencies, Donors, Charitable Organizations and Philanthropist for rapid response initiatives through financial support and technical advice to the Government and Non-Governmental Organizations. Without this help the gains made would not have been successful to this level. In support of this concept, Peter Cherutich, is Head of Prevention at the National AIDS and Sexually Transmitted Infections Control Program as he acknowledges that, in the event that they (external funders) stop funding such programs, these interventions could stall and thus draw back the gains that have so far been realized in fighting the virus spread; this is according to Intergrated Regional Information Network (IRIN) report on 16 September 2013.

The oldest male tested at the center was 72 year; result negative. The oldest woman was 78 years old; result positive. While the youngest child tested was 2 weeks old, the result was indeterminate. HIV can infect any age group depending on the risks one is exposed to and not just the age interval of 15-64 Kenya has always been using leaving out those over 65 who could miss out on HIV Care Services. Both male and female have been tested in equal measure. Although more women were tested as compared to men due to the strengthening of the antenatal services which offer HIV Preventive Services to infants not infected from HIV positive mothers.

At the time the Testing Center was established in 2004, the HIV prevalence rate was 7.5%

nationally and prior to that in 2003 it was 9.4%. But for Mary Immaculate VCT, the first statistic was 15.2% as the prevalence rate for the site. But after ten years, the prevalence rate now stands at 5.6% nationally (KAIS, 2012, p.8 and Joseph Muraya 2013). Although there is a reporting conflict regarding the exact figure of the current prevalent rate for the country. For example, according to the Kenya AIDS Epidemic Update 2012 (p.6) released early this year still quotes the 2011 national prevalence rate of 6.2%. While Ben Ochieng reported Kenya's HIV/AIDS infection rate had declined to 6.3% in 2012, which is totally different from KAIS 2012 and Joseph Muraya figure as above. But Mary Immaculate VCT recorded 3.72% as the prevalence rate for 2013 according to those tested. This figure is closer to the 4.9 % HIV prevalence among persons aged 15-64 years tested in Nairobi according to Kenya AIDS indicator survey 2012 (p.9).

In comparison, there has been a significant drop of the prevalence rate for Mary Immaculate Center to 11.48% when we compare the starting prevalence rate in 2004 and the ending prevalence rate in 2013. But the national statistic which is used as a benchmark for the Mary Immaculate site, dropped by only 1.9% compared to 2004 statistics at the time the site was started and the 2013 as the ending statistics. This decrease in prevalence rate doesn't suggest a reduction in the risk of HIV infections, therefore people still are urged to behave responsibly.

The HIV prevalence rate has remained stable nationally. Meaning there still could be some risk factors/practices that could be sustaining the epidemic. E.g. of late, now wife/partners swapping at casinos especially by the youth generation without caring much about HIV risks. Secondly, brothels have been moved from the city centers to residential areas whereby some phone numbers are advertised in local newspapers if one wants to call; thirdly, beauty parlor massage centers; besides massaging services, some now offer additional services (sex) at a cost as a way of attracting and retaining their clients. You will only find the adverts in some local newspapers; gay lifestyle is on the increase; sugar mummy/daddy relationships are taking a toll; and the ever increasing sub-population of truck drivers who are vulnerable to contracting the virus; and of course, inmates in overcrowded prison cells whose conjugal rights are not guaranteed, meaning homosexuality is their only way to quench their sexual desires.

According to Kenya AIDS Epidemic Update 2012 (p.6) it is anticipated that by 2015 the number of people living with HIV/AIDS in Kenya would have increased to 1.8 million from the current 1.6 million. To support this, it is viewed that some of the risk factors making this happen are the booming sex industry which has become a lucrative entity as many places are now investing in exquisite lodges and resorts with modern facilities and value added services on offer plus other unique packages that are offered at the hotels to attract more people. This makes it possible for many cheating partners to take advantage of such facilities where they spend the holidays and weekends with cohabiting partners „*Mpango Wa Kando*”. It is now the common trend of behavior for some men and women who refer to themselves as married but available (MBA). In addition, some of the best buildings in the Central Business District in the city, specifically the first and second and maybe the third floors may be genuine exhibition shops known to the public, but beyond, some of them fourth floor have been turned into brothels known exclusively to their clients.

Furthermore, with the introduction of HIV post sex exposure prophylactics, evidently has led to irresponsible sexual behavior among teenagers. The young drunkard teens want short-cuts which are now becoming a danger to public morality. The demand for the prophylactic drug is high especially during holidays and weekends. Moreover, most of these young stars are also the common service users of the lodges and resorts mentioned above as they are given nice treatment with the wealthy rich sugar daddies and sugar mummies. What is the future for this generation?

Different sources have given different figures for the people living with HIV in the country.

For example, in the Kenya AIDS Epidemic 2012 (p.6), reported 1.6 million as the number of people who could be living with HIV/AIDS; the same views shared by USAID/Kenya HIV Fact Sheet September 2013; while Joseph Muraya reports 1.2 million Kenyans are living with HIV/AIDS. What does this imply? The data gathering bodies could not be ineffective. Either the data reporting systems could be under-estimating or over-estimating the actual number of people who could be infected thereby affecting the resource planning to tackle the HIV virus and its implication in the community or people affected.

Conclusion

The Center has played a pivotal role in the fight against HIV /AIDS in the Kenya. Furthermore, the role of International Agencies, Donors, Charitable Organizations and Philanthropists cannot just be wished away like that, they are the vessels that have brought social reforms and transformation of individuals and the society to stop human beings from destroying themselves by creating awareness to issues that affects their health.

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A subjective Perception of Poverty in the Podtatranský region

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Abstract

This paper presents the results of research the objective of which was to determine the subjective perception of poverty in the Podtatranský Region. The introduction addresses a theoretical outline of the issue with an emphasis on the subjective concept of poverty and statistical data from the measurements of the EU-SILC (*Survey on Income and Living Conditions*, hereinafter referred to as EU SILC). The empirical part investigates the views of citizens from the Podtatranský Region on issues of poverty through quantitative research, the results of which were unexpected since the vast majority of the respondents do not regard themselves as poor.

Key words: Poverty. Subjective poverty. Social exclusion. Indicators of poverty.

Introduction

Poverty is a global phenomenon. People know it in every country. Certainly, every one of us has already come into contact with poverty as a concept, or as a social phenomenon. It affects all people, even those who are not poor. As is known in Slovakia, we do not have an officially determined poverty threshold; the most commonly considered poverty threshold is the subsistence minimum for one adult person. In Slovakia, we consider a person to be poor who finds himself in material need (Vaňo, 2006). The concept of material need is described in §2 of the *Act of the National Council of the Slovak Republic No. 599/2003 Coll. on Material Need Assistance*. Within the European criterion, it denotes the concept of the poverty of a person, family, or a group of persons, whose material, cultural and social resources are limited to such an extent that it excludes them from the minimum acceptable lifestyle of the State in which they live (Levická, 2004). This assertion, that it is not just a lack of material resources, but also other resources, Rusnáková (2007) also tends towards those according to whom poverty is not only material deprivation, but also social deprivation (social exclusion and the exclusion from rights). According to Novotná and Žilová (2011), there is no absolute and ge-

nerally respected definition or threshold of poverty. Perceptions of poverty and its threshold may be different in individual countries, depending on their wealth and economic maturity. Therefore, from this perspective, poverty is always defined in relation to the standards of the given society. The authors further state the definition of poverty by Townsend which we shall shorten and which he understands as „A lack of resources for such nutrition, such activities and living conditions which are common in the society to which the people belong.” (Novotná, Žilová 2011, p. 17)

This definition seems very concise to us in the context of the preceding assertions. A person, who is poor in the developed countries of the world, may not be poor also in countries, which are poorer. Also, in this example, it is indicated by a certain relativity of the concept of poverty. The aforementioned perception of poverty and its thresholds, however, does not depend only on the wealth and economic maturity of individual countries, but also on every single person who lives in a given country. Authors, such as Mareš (1999), Tvrdň and Kasanová (2004), argue that the concept of subjective poverty is based on the feelings and evaluations of a person's own life experiences, regardless of the opinions of other people and the prescribed signs of poverty. This means that a person, who is poor, according to the objective characteristics, thus does not necessarily have to feel poor. Conversely, a person who, according to the objective characteristics, is not poor, thus might feel he is. This concept thus contains a high degree of the individuality of the perception of poverty which may have an impact on various factors of education; from the value orientation up to the environment in which a person grows; etc.¹ Interesting are the findings, which in their publication, A. Alesin and E. L. Glaeser present (2004) who describe the difference between the perceptions of poverty in America and in Europe.

People in America much more often think that poverty is a consequence of laziness and that they can get out of it through hard work.

In Europe, the opinion prevails that it is a matter of luck and we cannot influence poverty by ourselves.

Citizens of the United States, therefore, insert a greater confidence into their own abilities and here we can see a greater conviction of the possibility of influencing one's own unfavorable situation.

Citizens of Europe may, to a greater extent, rely on intervention from the outside, to wait and remain passive towards their situation because they believe that they are unable to resolve their situation.

Since in the area of research, we are focused on a specific Region (Podtatranský), we must not forget that the issue of poverty is closely related to this factor. As is generally known, Slovakia despite the fact that it has the area of a relatively small country is typical for its Regional differences. Especially Western Slovakia and the surroundings of Bratislava are, where poverty is concerned, doing better compared to the other Regions of Slovakia. Novotná and Žilová (2011) add that not only may the people be poor, but through them also the territories, which they inhabit. And vice versa, a specific poor territory can influence a particular person. Poverty is Regionalized; it begins to be territorially unevenly distributed and also starts becoming an attribute of the area. Regions of poverty are characterized in that they occur especially in territories with low economic growth; as a result of this funds do not remain for investment activity and capital accumulation; they have an underdeveloped economic structure; weak industry; long-term unemployment; a poorly developed market; an unfavorable demographic composition of the population; etc.

¹ Similarly, we cannot fail to mention the social inequalities, which have a significant affect both on poverty itself and also on its perception. More In Almášiová, 2009.

The concept of social exclusion is also related to poverty. Novotná and Žilová (2011), however, point out that there is no direct link between exclusion and economic poverty, but this link may arise between poverty and social exclusion. They add that social exclusion is conceptually a broader term than poverty. Social exclusion namely relates to the fact how individuals or groups are involved in their social environment. Therefore, it does not reflect only their economic poverty, but also a severance to the edge of society in other areas of life.

We can characterize it more as a consequence of the unequal access of individuals, or entire groups of the population, to the following essential resources of society:

- employment,
- housing,
- social protection,
- health care,
- education (Strategy solutions of poverty, 2010).

In literature, we can meet also with the concept of social disqualification, which is the equivalent of the concept of social exclusion.

2. Statistical indicators of EU SILC

Of course, poverty is an unwanted social problem and obviously no-one would want to live in such conditions. However, at present, while there prevails in Europe an economic crisis and a growing number of unemployed, not everyone will fail to avoid such a situation. This is evidenced also by statistical surveys, thanks to which we have more insight about such data and help in examining its signs. We have focused, therefore, on some of the results of the measurements of the EU SILC (*The European Union Statistics on Income and Living Conditions*), namely the European statistical survey on income and living conditions. We have focused mainly on data regarding the Slovak Republic. For a better orientation in the issue, it is advisable to familiarize with some of the indicators of poverty.

Total disposable household income was calculated as the sum of the components of the gross personal income of all household members; plus the gross income components at a household level (e.g. income from the rental of property; transfers received from other households) minus the regular taxes from property; the regular paid transfers between households (e.g. nutrition; regular financial assistance from other households); income tax and social insurance contributions.

The equivalent disposable income is calculated so that disposable household income is divided by an equivalent size of household. This income is then assigned to each household member. The median equivalent disposable income is the value of the equivalent disposable income, which is dividing the total, according to the amount of income, into two equal parts, according to the number of persons. According to the results of the EU SILC 2012, the median equivalent disposable household income per person, per month, was €577. This indicator is taken into account in calculating the at-risk-of-poverty threshold. People in the Bratislava Region had the highest income, where the median equivalent disposable income was €713 per person. In other Regions, this limit fluctuated between €516 to €624 per person/month. (INFORMATIVE REPORT OF THE STATISTICAL OFFICE... 2013).

With these figures, we can see that Regional inequalities in Slovakia are still relevant, in particular as regards the Bratislava Region in comparison with other Regions.

The at-risk-of-poverty threshold is defined as the value of 60% of the median equivalent disposable income. According to the results of the EU SILC 2012, 13.2% of Slovakia's population

were at risk of poverty, which are more than 715,000 people. The total annual at-risk-of-poverty threshold calculated from EU SILC 2012 was €4,156 for a one-person household, which represents an amount of approximately €346 per month. These numbers may seem very high, given the fact of how many inhabitants live in Slovakia and that poverty is generally perceived as an undesirable social phenomenon. However, next we shall learn that Slovakia falls amongst countries within the EU with a lower risk of poverty.

Risk of poverty rate - the share of persons with an equivalent disposable income below 60% of the national median equivalent income. The lowest risk of poverty rate was recorded amongst the inhabitants of the Bratislava Region (6.3%). The highest risk of poverty rate was recorded in the Prešov Region (19.9%). As we have already mentioned, Slovakia belongs to countries with a lower risk of poverty (13.0%). In 2011, Iceland (9.2%), the Czech Republic (9.8%), Norway (10.5%), the Netherlands (11.0%) and Austria (12.6%) had a lower risk of poverty rate. Denmark had the same risk of poverty rate as Slovakia, while Slovenia, Luxembourg and Finland (13.6% and 13.7%) had approximately the same value. The highest risk of poverty rate was in Bulgaria (22.3%), Romania (22.2%), Spain and Greece (21.8 and 21.4%). (INFORMATIVE REPORT OF THE STATISTICAL OFFICE, 2013).

It is gratifying that Slovakia is ranked among the countries least at risk of poverty. However, at the same time it is also surprising to find oneself in the company of Denmark, Luxembourg and Finland, who are considered as more advanced countries than Slovakia. One possible reason is that in Slovakia, compared to those States, there is a lower at-risk-of-poverty threshold.

With poverty, there is mainly related the idea of a lack of financial and material resources which is also reflected by the indicator of the rate of material deprivation. This indicator reflects the share of the population (in percentage) which is facing an enforced lack of at least three or four out of a total of nine deprivation items. In the calculation of the indicator, at least the following deprivation items are taken into account:

- 1) Arrears associated with mortgage or rent, payment for energy or repayment purchases on installment and other loans,
- 2) Ability to afford to go once a year for a one week holiday away from home,
- 3) Ability to afford to eat a meal with meat, chicken, fish (or vegetarian equivalent) every other day,
- 4) Ability to face unexpected expenses, equal to the amount set as the monthly national at-risk-of poverty threshold, for the period of the previous year,
- 5) Household cannot afford a telephone (including a mobile phone)
- 6) Household cannot afford a color TV,
- 7) Household cannot afford a washing machine,
- 8) Household cannot afford a car,
- 9) Ability of households to financially afford to keep the home adequately warm.

The overall rate of material deprivation, in the case of a forced shortage in at least 3 of the items, was 22.7%. Overall, we can say that the rate of a forced shortage among women was slightly higher than among men. In terms of age, persons 65 years and older (27.4%) and children aged 0-17 years (23.9%), were more exposed to an enforced shortage of at least three of the items. From all age categories, in at least four items, children were deprived at the highest rate (11.9%).

The unevenness of income distribution by the Gini Coefficient belongs among the best known indicators of income inequality. It includes the income of the whole of society. Theoretically, it can assume values of between 0 and 1, or in percentage terms, from 0% to 100%. If in a society there was absolute equality in income, the Gini Coefficient would assume the value of

0%. Conversely, if all the incomes in society belonged to just one person, the Gini Coefficient would have a value of 100%. Thereby, the higher the Gini Coefficient is, the greater the income inequality in society is. According to the Gini Coefficient, in Slovakia there are not very large income inequalities. The highest value was recorded in the Prešov Region (26.7%). Banská Bystrica (25.6%) and Nitra (25.7%) Regions still find themselves above the national average. The lowest values were recorded in the Trenčín and Trnava Regions (22.5% and 23.4%). (EU SILC 2012 Indicators of poverty/social exclusion 2013).

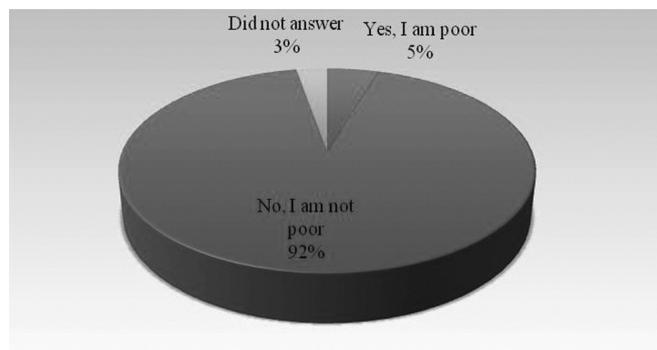
3. Research - subjective perception of poverty

By the means of a structured Questionnaire, research was conducted on the subjective perception of poverty by secondary school pupils in the Podtatranský Region, which was also the objective of the research. Since it was a quantitative data analysis, we collected and evaluated the statistical data by the means of which we mapped out the given issue.

The subjects of the research were students from the 1st, 2nd, 3rd and 4th year of the Secondary Technical School, in Poprad. We obtained 105 Questionnaires, which we evaluated sequentially using basic statistical methods (sum, percentage). We have used Microsoft Excel, in which we have compiled the data and we processed the results in graphs and tables. We chose the Questionnaire method because of the inspiration of the EU SILC Research which also processes the issue of poverty through quantitative methods.

Our first assumption concerned the personal perceptions of poverty by the respondents. We wondered, therefore, whether more than half of them would be assessed as poor. Since this is a subjective perception of poverty, the respondents were asked for their own opinion and feeling as to whether they consider themselves to be poor. The majority of the respondents do not feel poor, which in our case represents up to 97 responses. Five students considered themselves poor, and three did not respond to the question. Such a vast preponderance of one of the answers is rather unexpected since Slovakia is not among the wealthiest countries and neither does the Podtatranský Region rank amongst the wealthiest in Slovakia. It also is unexpected because of the lurking economic crisis and the high unemployment in Slovakia. We can see the percentage share of the results in the chart below.

Chart No. 1 The subjective perception of poverty by respondents



In the next question, we investigated how respondents perceive their own poverty in comparison with classmates. A large majority feel that they are on an equal footing with other classmates, specifically 95 respondents (90%). The remaining responses were represented by a small number. Six (6%) feel that they are wealthier and three (3%) feel that they are poorer. One did not answer

the question. From an evaluation of this question, it appears that the majority of respondents in this area do not feel inequality, which is good. On the other hand, it is again the question of whether it also corresponds to the actual condition, which we have not, however, already investigated, as this is a subjective perception of poverty. Our assumption was thus quite clearly not confirmed. Since the first question was half-open ended, and respondents were asked to reply also why they feel poor or do not feel poor, we can justify the fact that we list the most common answer of the respondents, as to why they do not feel poor. They justified it with the fact that they do not miss anything in life and they have everything they need.

Table No. 1 Perception of one's own poverty in comparison with classmate

	Wealthier	Poorer	Neither wealthier nor poorer	Did not answer	Total
Number	6	3	95	1	105
%	6	3	90	1	100

As an inspiration for the question, where respondents were asked to indicate whether they feel poor in the absence of each of the seven selected material items in the household, we used the statistical findings of the EU SILC (a measure of material deprivation). Due to the fact that they are young people and need a computer also for their education, we assumed that more than half of the respondents would consider themselves poor if they did not have a computer at home. We confirmed the assumption and we have summarized an overview of all the responses in the table.

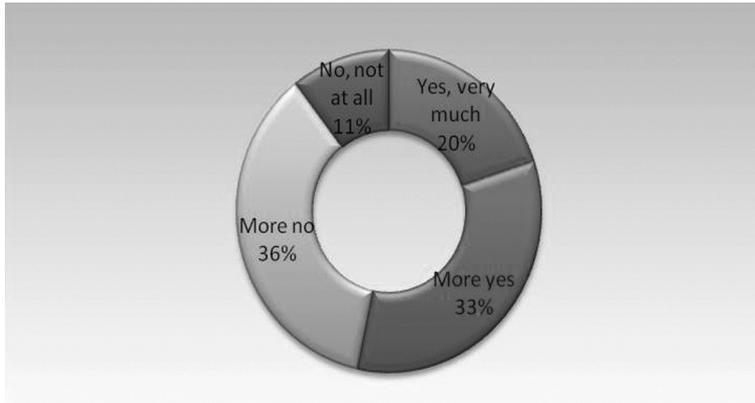
Table No. 2 The feeling of subjective poverty during the absence of some material things

	Yes		No	
	Number	%	Number	%
Washing Machine	89	85	16	15
Mobile Phone	75	71	30	29
Television	67	64	38	36
Computer	59	56	46	44
Car	52	50	53	50
A meal with meat every other day	42	40	63	60
Dishwasher	11	10	94	90
Total	105	100	105	100

Since, in recent times, the problem of poverty is becoming more topical and neither do the prospects in the upcoming period look good in connection with the improvement of the situation, we have assumed that more than half of the respondents have a fear that they could be poor. 21 (20%) answered that they have a great fear, and 35 (33%) were rather afraid that they might be poor. 38 answered in the negative (36%) are not particularly afraid of poverty, and 11 (11%) are

not at all afraid of poverty. We thus confirmed this assumption which may mean that poverty is, within the public, an often-discussed concept and selected respondents have noticed it and are aware of its risks.

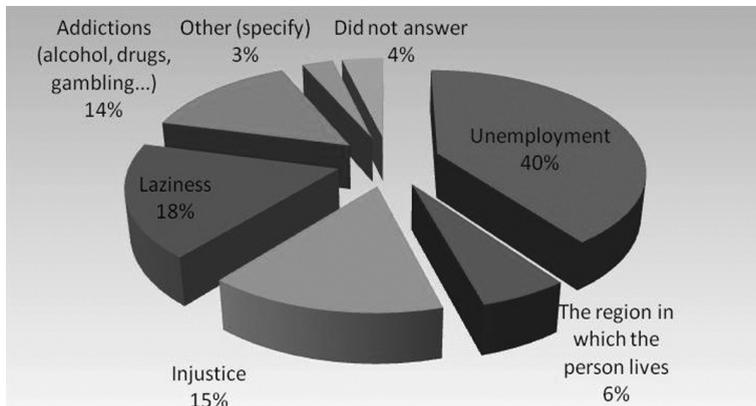
Chart No. 2 The fear of Poverty (N)



As is well known, Regional differences are significant in Slovakia. Therefore, we assumed that the respondents also would perceive this factor as crucial when naming the causes of poverty. We verified it through a closed question to mark from 6 different causes of poverty which the respondents consider as the most important cause of poverty. Unemployment was specified most frequently as a cause of poverty (42/40%); followed sequentially by laziness (19/18%); injustice (16/15%); addiction (15/14%); the Region in which one lives (6/6%); other (3/3%).

In the last option, one respondent did not specify the cause of poverty, and the remaining two specified the appearance of a person and a bad government system as the most important cause of poverty. Four respondents (4%) did not respond. We think it should be noted that in the question, which we shall analyze as the next in the order, 58 (55%) answered that the Region in which they live is poorer than other Regions of Slovakia. Despite this, as we have already mentioned, only 6% specified the Region as the most important cause of poverty which did not confirm our assumption. It may be due to the fact that even though more than half of the respondents believe that the Region in which they live is poorer than other Regions, they do not perceive this fact as important in comparison with other causes of poverty. In this regard, specifying unemployment as the most important cause of poverty appears in order to us considering its timeliness.

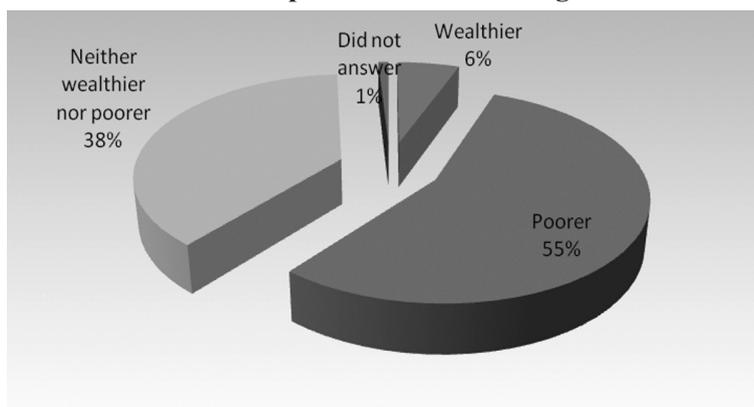
Chart No. 3 Causes of Poverty



In the next question, it was found how respondents perceive the Region in which they live, in comparison with other Regions of Slovakia from the perspective of wealth and poverty.

Up to 58 (55%), believe that the Region in which they live, is poorer than the other Regions in Slovakia. 40 (38%) do not perceive differences compared to other Regions and only 6 (6%) think that they are wealthier. It is also confirmed that the respondents questioned by us perceive Regional differences that are well known in Slovakia.

Chart No. 4 Opinions of the respondents on the poverty of the Region in which they live, in comparison with other Regions



Conclusion

Every person can perceive poverty differently. From this, also the subjective concept of poverty emanates which is based on personal feelings and the personal perception and assessment of the situation in which the specific person finds her/himself. Through the collection and processing of the statistical data on poverty, which is subjective in nature, we can get a more complete picture about this issue. Such statistical findings allow us to compare individuals and groups in terms of wealth and poverty. In the presented research, we have found that the vast majority of respondents do not feel poor (up to 92%). We consider this finding as the most important in terms of the examined issues. According to the EU SILC statistics in 2012 up to 13.2% of the population of Slovakia were at risk of poverty.

As we have learned in the article, poverty also has spatial differences. From this perspective, it is an interesting finding that 55% of respondents consider the Region in which they live as poorer in comparison with other Regions in Slovakia. It also is confirmed by the EU SILC 2012 statistics, according to which the highest at-risk-of-poverty rate was recorded in the Prešov district (19.9%) under whose territory belongs also the Podtatranský Region. The research was conducted on a specific, relatively small territory (Podtatranský Region), which gives the possibility of conducting other similar research in other Regions, and their comparison, or optionally to monitor the development of the subjective perception of poverty in the presented Region in the future.

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The need for Implementation of Business ethics to the Services used by the older Population

Jaroslava PAVELKOVÁ, Milan SCHAVEL

Abstract

This article deals with the need for consistent implementation of business ethics to the services used by older fellow citizens. Presented is a violation of the ethics in business (moral principles; ethics in dealing with customers and clients) in the provision of services to the public; in this case, misleading advertising for a showroom demonstration sales event used by the older generation. These activities are professionally focused on the target group of socio-economic disadvantaged fellow citizens (often Seniors) who then get into financial debt.

Key words : Ethics, morality, business, promotion events, socio-economic disadvantaged individual, prevention

Introduction

Since its prehistoric development humans need to live in communal societies. For this reason, various communities were formed to support survival (providing food, security, care for children, etc.). At present, these needs are met in the much more complex conditions that arise from the postmodern period of the 21st Century. Often with more diverse needs; with everything done in a much more complex way; this results in ethical and moral behavior being missing in the behavior of people in all areas of human activity.

Ethics

Ethics is referred to as the doctrine of morality (Bureš 1991 p 3). We can understand that morality is the Science of Responsible Negotiations Within the Human Being (in ordinary moral life acting within a reduced set of commands or norms of behavior. We introduce ethics in general; it is usually about ethical behavior, manners and morals from the perspective of examining its nature, origin and historical development in time and environment including patterns which are determined by moral standards (*Theory of Ethics*). If we mean good and evil, the issues of basic moral values deal with so-called *normative ethics*, which represents the *moral code of conduct* (explaining right or wrong behavior of the individual); what is possible to see in his/her sense of mission and fulfillment of human life (Synek et al 2003).

Also, part of the challenge is a *Code of Ethics*, which, according to A. Mátel (in Mátel et al 2010 p 53), in *Ethical Principles, Values and Standards* defines in writing relevant and normative guidelines for a specific Profession, Institution, or Organization.

The author indicates that within the typology of the *Deontological Codes of Ethics* which is

based on multiple criteria (eg. specifics to the Profession or Professional Activity, distinguishes the *Code of Ethics* of the Medical Worker, Social Worker, Police officer, Teacher of Ethics, Psychological Operations, etc. in terms of national territory, etc.). At present, as ethics gradually penetrates deeper into each professional area, it becomes part of the content and will take specific forms (e.g. Medical Ethics, Journalistic Ethics, the Ethics of Social Work, Ethics in Business, Management, etc.).

Business Ethics

One type of Professional Ethics, ***Business Ethics***, is dealing with the moral standards in the area of business; the generally accepted rules, in which compliance is not enforceable by Laws (Vaněk 1992; Kárníková 1997; Seknička 1997; Rolný 1998). It deals with „good” business conduct beyond the written Law of the existing links of the business entity in terms of ethical business in respect of the business entity (organizations, companies) against to the external environment; meaning ethical conduct in relation to customers, clients, customers, vendors, partners, competitive entities, state institutions, including the environment.

It solves relations within the organization or company itself; meaning ethical behavior toward colleagues, managers, subordinates, including the relationship of the organization as a whole. In this case, *The Code of Ethics* is processed in moral standards that contain a specific business activity which belongs to the basic organizational documents of the entity. Usually it includes e.g. respect for the Laws; the safety and quality of the products; conflicts of interest and their solutions; the morality of the conclusion of contracts of employment; safety and health in the enterprise; company relations with suppliers, customers, and clients; morality in setting of prices; treatment of information; etc. Acquaintance with the internal *Code of Ethics* and a warning on its subsequent application in the companies work belongs in the input of new worker training (e.g. a non-standard situation; determination of the solution increases the credibility of the company). The ultimate effect is a quality; consistent communication with customers; the standardization of procedures and negotiations; etc.¹

This activity is related to the adoption of *the Anti-discrimination Act No. 198/2009 Coll.*, whose adoption in the Czech Republic has fulfilled the obligation to the European Union.

As stated in the above mentioned document, the premium is the application „of the model *Code of Conduct for Entrepreneurs*” Directives and Regulations which the EU Member States incorporate. It includes the following priorities: protection of the environment; permanent building of corporate culture; improving the profile of the company; the responsibility for environmentally friendly products; truthful and open communication with the public (customers, business partners, shareholders); truthful information about the impact of the company's activities on the environment; social, moral and ecological responsibility.

Unethical business

This article is dedicated to the corporate culture² in an attempt to define what in business is unethical; in practice it is more unethical than ethical. As examples are provided:

- Non-payment of obligations to your partner.
- Unbalanced treaty with favorable terms and conditions containing a provision unilaterally, that the terms are mutually balanced.

¹<http://www.bosston.cz/clanek/eticky-kodex-etika-podnikani>

²<http://www.pomocpodnikateli.cz/etika-v-podnikani>

- Abuse due to the extension of customer's invoices.
- Non-compliance with oral or written arrangement.
- Deliberate non-compliance with applicable law standards.
- Submission of distorted or false information.

Economic-Socially Disadvantaged Groups

Many aspects of human life are influenced by the position of the human being in the socio-economic hierarchy. Economic disparities are, *inter alia*, created by the group, living in less favorable conditions of access to education, the quality of housing, dining, leisure time. We can consider groups that are relegated outside the common life of society as disadvantaged communities of the population. The process of gradual separation of individuals or groups from mainstream society can be understood as social exclusion (socio-economic slump).

The basic resources of society include employment, education, housing, healthcare and social protection. The process of the majority of society by which individuals, or an entire group of the population make it more difficult or completely prevent access to resources, positions and opportunities, which allow integration into social, economic and political activities, can be described as social exclusion (Schavel 2012). These groups include for example:

- The long-term unemployed
- Members of ethnic minorities
- People with disabilities
- Persons over-indebted
- Migrants
- Persons with low qualifications
- Persons for whom life „social benefits” is a normal lifestyle
- Persons with different kinds of dependencies
- Children living in vulnerable families, i.e. dysfunctional & poor families
- Persons released from imprisonment
- Mothers on maternity leave
- Mothers with small children
- Seniors

The risk of social exclusion is increasing for individuals which leads to the accumulation of the above disadvantages, e.g. individual long-term unemployed; low-skilled; living in less favored areas; with subsequent financial problems of debt accelerate its excretion from the common life of society making a return back difficult.³

The Older Population

In today's complicated world in which the adult population is difficult to understand, the most surprising appears to be the older generation of Senior Citizens - the elderly. In fact, with Democracy and the new sense of freedom, life under the pressure of the consumer society brings with it an urgent crisis in personal life when just for this age group - as a result of a reduction in the ability to handle its own power - their living situation is difficult.

Inappropriate Financial Expenses

Financial expenditures and the consequences for them to the people of the older age category are exposed. Retirees are the easiest target for non-banking companies who take advantage of their ignorance and inexperience with loans. Subsequently, thanks to complex contracts, amounts

for the keeping of accounts, the early repayment of loans and many other fees (irregular systems interest and contractual penalties), to the imposition of a property default are posted.⁴

In 2012, Executors in the Czech Republic had a unique study on the number of Seniors in default. The analysis showed that 45,241 old-age pensioners faced default. It was about 2% of the total number of Seniors facing old-age paid a pension. So, Seniors were only 7.5% of the total number of all persons against which the courts ordered the default.

Although the number of retirees in default in the last three years had a better average than the neighboring Czech Republic Slovakia, which in 2012, with five and a half million inhabitants had about 36,000 retirees in default.⁵ However, the Czech Social Security Administration said that in the year (to 1.10.2013), the situation had changed dramatically in the Czech Republic when the number of pensioners and people receiving sickness benefits, who were in default had increased, and the State had to control 67,614 benefit's pensioners (11% in 2011) and 3,700 (23%) patients.⁶

Most Seniors of a productive age who had problems with debt face default. Default is most common in 76% of cases concerning new pensioners, i.e. people aged 60 to 63 years (no dis-trainable amount of money from 1.1.2013 is according to the relevant legislation 6,064.66 Czech Crowns; plus 1,516.16 Czech Crowns for each dependant in family).⁷

Causes of defaults conducted against older people are different. These people become victims of the fairs (for example showroom sales), long-distance trips, advertisements - teleshopping, not serious street dealers, etc. They often also include subsidizing their children or grand-children. Executors from the Czech Republic are now focusing on prevention to help this age group. Homes for the elderly offer practical training in counseling free of charge giving priority to clients older than 60 years.⁸

Loans and purchases from above mentioned deals offer serious problems for the elderly (Pavelková 2012). Therefore, Consumer Organizations constantly warn Seniors not to purchase expensive goods or casually disregard unwanted loans and over-debt. Dealers psychologically pressure and manipulate potential buyers through developed tricks; create confusion; serve them alcohol; offer an option to sign an agreement which is, in fact, a purchase with a high price; and it's all professionally and quickly done. They also often offer a straight loan but at a high interest. Even the media started to be more interested in this problem. In 2013 an investigative documentary film made by Silvia Dymákovou, entitled „Suckers” on unfair practices at demonstrations). This documentary for the general public was broadcast by Public Television.

Unethical organizers use the following forms of psychological coercion:

- primarily a method of reciprocity (arouse a feeling of obligation);
- framing method, which induces the impression the general benefit to participants;
- the technique of ligature (as each sharply understands);
- divide-and-conquer method (buyer versus leech, sugar and honey);
- method of scaring with an incurable disease;
- an option to withdraw from the contract in cases of dissatisfaction which basically is not feasible as, the contract is valid.

⁴<http://www.koncimsdluhy.cz/oddluzeni-senioru>

⁵<http://www.zijemenaplno.cz/Clanky/a1173-Tisice-senioru-jsou-zatizeny-exekuci-na-duchod.aspx>

⁶<http://pujcky-sporeni.moneymag.cz/2897-temer-70-tisic-duchodcu-je-v-exekuci/>

⁷<http://www.duchodovareforma.cz/aktuality/seniori-v-exekuci/>

⁸<http://www.ekcr.cz/1/aktuality-pro-media/908-seniori-v-exekuci-13-11-2012?w=>

Even an amendment the *Consumer Credit Act* (in February 2013 under the *number 43/2013 Coll.*, proclaimed in the collection of Laws of the Czech Republic the amendment of *Act No. 145/2010 Coll.*, on consumer credit, protects consumers in the Czech Republic which seeks to punish some dishonest practices on the consumer credit market in the Czech Republic); allows a fine, which may be up to 100 thousand Czech Crowns. Criminals continue undeterred in organization of demonstration actions throughout the country to lure gullible Seniors, under psychological pressure at these sales activities. They are without any ethical principles, standards and approaches of corporate codes of conduct forcing Seniors to buy things they do not need. This is done through offering mediocre quality; of supposedly advantageous tours; handing out envelopes with discount coupons; super pillows; blankets; massage apparatus; utensils; or miraculously curative bio lamps. They use other unfair practices. Seniors then fail to fulfill the obligations incurred and come into complex financial situations. Even more is the dangers to which Seniors are exposed through overpriced phone lines (starting with the numeral 9), which attract the granting of loans or consumer loans.⁹

In financial distress (Pavelková 2012, 2013), you may get a Senior gambling that today represents a serious socio-pathological phenomenon. Another different way to problems is the reckless liability through children in a family.

On the other hand, it is necessary to state that despite the warnings, the family members, friends, community, or the media, many senior citizens (and not only the older fellow) repeatedly attend these demonstrations and deepen financial instability).

There are organizations which offer assistance to people in need (for example *Člověk v tísni*), which have been dealing with difficult life situations that arise as a result of the lack of knowledge of financial products. Its investigation led to the conclusion that a number of companies and individuals, offering supposedly „good” loans, in fact, speculated that their victims would not be able to effectively defend themselves. As a result of its work there is now an „**Index of predator lending**”.¹⁰

Since July 2006, The Council of Seniors has set up a free legal counseling service in the House of Trade Unions in Prague 3 (Churchill 2 Square). This offers practical Training in Counseling to Homes for the elderly; free orders to clients over 60; centralizing contacts to other Counseling Centers. In addition, it has a lawyer who specializes in Consumer Law.¹¹

Law No. 108/2006 Coll., on Social Services in the Czech Republic brought the long awaited activation of these targeted groups. Socially stimulating activities for Elderly Services are regulated in §66 of this Act; Section 31 of the implementing decree to this Act defines socially stimulating activities services such as outpatient, outreach and subsistence, provided to persons of retirement age; to persons with disabilities at risk of social exclusion (the area of taking care of the disabled; socially non-deficit population in the form of social prevention and screening of the aging and old population; socio-therapeutic activities- activities that provision leads to the development or maintenance of personal and social competencies and skills to support social inclusion of individuals suitable for the implementation of financial literacy information and its uses in practical life; assistance in the application of the rights, legitimate interests and in obtaining personal matters → assistance in communication; leading to the application of these rights; assistance in dealing with common issues → may use the acquired skills of financial literacy in normal life situations; peacefully implement financial literacy knowledge and skills in basic activities and operations to Social activated services.

⁹http://www.tyden.cz/rubriky/byznys/cesko/exekuce-senioru-prudce-rostou-kolik-jim-stat-musi-nechat_19_8620.html

¹⁰<http://www.clovekvtsni.cz/index2.php?id=113&idArt=1633>

¹¹<http://www.zijemenaplno.cz/Clanky/a1173-Tisice-senioru-jsou-zatizeny-exekuci-na-duchod.aspx>

Prevention of Financial Debt - the Acquisition of Competences in Financial Literacy

Due to the rapid aging of the Czech population in the coming decades, future retirees will not be able to rely on the state security as has been the case till now (Preuss 2012). Other forms of old-age security will play an increasingly bigger role. To ensure that citizens select the suitable pension plan of providing for old age, it is essential to have basic knowledge of financial issues, such as the prevention of collapse into the State Social Network.¹²

Nearly three-quarters of the Czech population are absolutely firmly convinced that people should care about pensions, rather than each person. The vast majority of people agree with a minor or in the future with more fundamental changes to the current system of pension schemes. The introduction of a completely different system, however, is losing support.

There are people who approve the increase in Social Security payments which strengthens solidarity. The reduction of pensions or extension of retirement age are still taboo. Research carried out by the STEM on a representative population of the Czech Republic over 18 years of age which took place from 31st of October to 7th of November 2011 cited the results. Respondents were chosen by quota sampling. The questions reflect an extensive set of 1,257 respondents. The opinions of our citizens whether it would be financially secure should be by age alone, or in order to take care of people, not at all. Almost three quarters of people would prefer that the State keep age a factor in order for them to ensure of their positions.¹³ Many aspects of human life are influenced by the position of people in the social stratification. Conditional socio-economic differences at the level of health and care for them, *inter alia*, created by the group below in the socio-economic hierarchy live in less favorable conditions in terms of access to education, quality of housing, dining, leisure, travel, etc. In recent years, Psychology of Health devotes considerable attention to the relationship between the status of a person in the social hierarchy and their own state of health.

Education of Seniors in the Area of Socio-economic Competences

- The purpose of the targeted activities to increase the chances of the older population to obtain and maintain socio-economic competence, therefore, financial literacy and other social skills.
- If a person gets into debt trap, i.e. the situation in which the repayment of one or more loans with the help of a loan further resolves, or imposed on him is default, it becomes more advantageous for him to reduce his legal income, from which the default or credit payment is calculated on the minimum and move its operations into the black economy.
- The concept of socio-economic competence includes financial literacy (i.e. monetary, budgetary and information literacy) and other soft skills (meaning communication and presentation skills that lead to an increase in the application in the labor market).

Prevention of Financial Debt & Social Exclusion

- Legal provisions and measures in the framework of the Czech Republic
- Activities of the Czech Trade Inspection
- The acceptance of ethics and morality, legal standards and their interpretations of business entities

¹² http://www.mfcr.cz/cps/rde/xbcr/mfcr/Narodni_strategie_Financniho_vzdelavani_MF2010.pdf

¹³ <http://stem.cz/clanek/2288>

- Cooperation with the media, with all of their options
- The largest role for a well-prepared Social Worker, an expert in the field of Social Work who is knowledgeable in financial literacy
- Social Counseling not only basic but also professional addressing the needs of conflict with society and ethics
- Intervention of lonely living Seniors
- Prevention, searching lonely Seniors
- Spiritual and pastoral activities
- University of the third age

The implementation of financial literacy is important is in the education of Social Workers and the helping professions for the possible education of the target group of older citizens. As noted by J. Pavelková (2011), the intention is an informal approach to implementation of basic competencies on financial over-debt into the awareness of Seniors (the provision of basic information on the nature of the personal and family finance for Seniors with simple methods to create and manage personal and family budgets; with solutions to the most common situations; prevention of insolvency; the methods of their solution to teach them effective and no-risk economic behavior). Prevention also lies in the detailed information about the risk of debt due to the activities of dishonest companies at sales demonstrations.

Conclusion

Only the consistent implementation of ethics and morality, the modified legal standards to the work activities of business entities, can become a real prevention protection of each client. What is fair, ethical and moral in the society depends only on people's awareness. The overall climate in society, whether the society is at the level of human characteristics and priorities of individuals are the determining criterion.¹⁴ Respect for the Principles of Ethical Conduct and good relations; a functioning extended family; effect of mass means of communication; consistently carried out social prevention; editing of existing legislation can help protect consumers from socio-economic descent.

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Ethical dilemmas in Social Work

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Abstract

Each person currently faces a number of Psychological and Social Issues and uses physical fitness, experience, skills or intelligence to be able to cope with such concerns. Social Workers encounter clients with these issues during their daily jobs and seek to address them using knowledge stemming from an interdisciplinary concept of Social Work with the help of Philosophy, Psychology, Sociology, Ethics, Legal, Economics and other approaches. Social Workers also need to have knowledge about a particular client's social background; understand; have their own views on current developments in their social environment.

Key words: Ethics, dilemma, client, morality, Social Worker,

Introduction

In recent years, Professional Ethics has become very real and also has become a topic in many technical discussions. Anglo-Saxon world authors agreed that Ethics could be the phenomenon that could bring together various systems in this area, including Social Work. Talks about the affairs of Social Workers who morally failed increased interest in Ethics. Marginal effect also is limiting the resources that flow into the social sphere; use of new technologies, especially Medical, which create Ethical dilemmas for all helping professions. Discussions devoted to Ethical issues, among other things, help Social Workers to navigate when they make decisions that fall within moral dilemmas and problems. Social Workers often have to make decisions in situations where they are moving between the poles of unilateral action and symmetrical cooperation with the client. (Matoušek et al 2003).

Social Workers are inevitably confronted with Ethical dilemmas when conflict makes more involved demands; often competing interests applies to multiple, often conflicting values. Typical examples of Ethical dilemmas in Social Work may be questions as to which Social Services with limited financial resources we should support, and which to reduce; how far we can overlook the quality of Social Services and not deal with its cancellation; how we will provide Social Services so they will lead to promoting independence and responsibility and do not lead to its abuse; when and under which circumstances to stop providing Social Services and Social Security benefits; etc.; subject to which decision to accept is therefore determined by the outside society and the final decision will depend not only on its ability to carry out the decision itself, but also on the willingness to accept it, knowing its different impacts on various parties to the conflict. Decision in this case, takes on a more multi-dimensional form as either, or considering of the impact of decisions on other parties to the conflict (Palovičová 2011).

Ethical dilemma

Ethics brings to a Social Worker not just Ethical Principles and Values but the situations in which she/he must make moral choices associated with Ethical dilemmas. Banksova (1995, In: Matoušek et al 2003) distinguishes between Ethical issues and Ethical dilemmas:

Ethical issues - arise in a situation where it is clear, how the Social Worker should decide, but this decision goes personally against her/him. An example of an Ethical problem is consequently a situation where the Social Worker believes that the client should receive the necessary assistance, but cannot give it to him because the client does not meet criteria established by the Institution in which the Social Worker acts.

Ethical dilemmas - arise when the Social Worker feels that she/he is faced with two or more equally unacceptable options that represent a conflict of Moral Principles (e.g. the conflict between a client's rights to self-determination and the Social Worker's duty to protect the health of the client). It is not clear which decision will be more acceptable.

As reported by Matousek (2003), what for one Social Worker may be a technical issue (Following the Rules), may be an Ethical problem for another Social Worker. The decision is obvious but it is difficult to decide; for another, a dilemma may be where it appears that *there is no acceptable solution*. It depends on the personality of the Social Worker, how she/he looks at that situation; how experienced in moral decision-making she/he is; and what are her/his personal hierarchy of values. Context, in which Social Work is realized, plays a big role in the welfare state; and more specifically; the employer organization.

Goals of Social Work include to improve living conditions in society; Social Workers and their activities towards reducing social injustice, discrimination, oppression and poverty.

One of the main objectives of Social Work which is closely linked with General Ethical Principles, are their clients, but also the public is very sensitive to possible Ethical disagreements. In Social Work, it is necessary to find a solution were Ethical problems, dilemmas and critical situations which are always present. In the course of evolution, Ethical issues and dilemmas become specific components of Social Work. (Filová, Levická 2010).

As a particular group, clients represent individual, group or community with distinctive socio-diagnostic features. Belonging to the client's social group or not, is usually not a problem. Social Workers are familiar with the specifics of the client group and based on their experience are able to work with them. When working with clients, it is necessary to respect the inherent dignity of the client; to comply with client confidentiality and self-determination.

It is necessary to see client's uniqueness; her/his ideas about problem solutions; to assist in the formation of self-confidence; to increase motivation for consideration of real possibilities.

If the term dilemma is understood as a questionable choice between opposing options, then the Ethical dilemma is a conflict between opposing Ethical priorities.

(Šaling et al 1997, In: Leškov 2010).

Ethical dilemmas are seen as situations in which the individual chooses between two or several ways of proceeding further which do not correspond to the hierarchy of values which are the result of the decision concerned.(Lešková 2010).

Resolution of Ethical dilemmas, according to Matousek (2003) recommends that Social Workers adhere to the following procedures:

- First we need to correctly identify an Ethical dilemma; the values and obligations that are in conflict,
- To think about which individuals, groups and organizations will be in any way directly or indirectly affected by resolution of Ethical dilemmas,

- Perform a thorough analysis of all possible courses of action, taking into account Ethical Theory, Ethical Principles and recommendations which are based on them, such as a Code of Ethic, Rules of Law, Social Work methods and personal evaluation,
- Any consultation with colleagues and supervisors.

On the basis of this sequence, it is usually possible to solve a dilemma; but solving the dilemma is not so simple. Social Work is cooperation with a client who has their own characteristics; with different dilemmas and their resolution; must respect the specific client while applying all the Principles under the Code of Ethics.

The Model Addressing Ethical Issues Consists of Five Steps (Bonda In: Lešková 2010):

- 1) Describe the problem and identify its components.
- 2) Obtain not only the Ethical Code of their own Organization, but other available codes as well.
- 3) Analyze the course of events.
- 4) Explore all other options that could come into play for progress and if possible ask your nearest colleague for help. This step compares: Ethical Principles of Value (best possible outcome); justice (the fairest result); respect for autonomy (for a particular client); not hurting (avoiding harm); consider all the implications,
- 5) Choose the best course of action and consider the best solution before it is implemented; analyze its result; ask the following questions: Is there success in my expectations? If not, what happens? Would a different solution be preferable?
How would it be possible to predict? What have I learned about myself?

Moral Action Involves Free and Voluntary Decision.

It is a clearly established duty to respect the Principles and act according to the Rules. A Code of Ethics also contains Rules and Penalties relating to a failure or a breach. According to Vajda (2004), where one side is morality, than morality must be associated with force; where the general morality only works with public opinion which is used as a instrument of force. Just the pressure of public opinion maintains valid moral rules and ensures inter-generational transmission.

According to Palovičová (2011), Ethical Issues are directly related to Social Work: concerning application of moral concepts and moral standards for deciding what is morally right or wrong, good or evil in Professional Practice; Moral Philosophers have traditionally identified three central questions of Normative Ethics, etc. that can subsume most Ethical problems:

- 1) Why do we observe moral standards as reasons which lead us to adopt a morality framework for our actions?
2. How to distribute resources and forms of goodness?
3. Which acts are considered valuable, good and desirable, and for what reasons?

Professional Ethics Build their own Ethics Committees for the Purpose of Control and Force.

Ethical Committees assess compliance with the Ethical Principles and Rules laid down by a Professional Community; they have the right to establish penalties for violations.

The Principle of Force Breaks the Freedom of Decision-making. If the Social Worker does not violate of the Principles and Rules of the Code of Ethics, we can question the extent of Ethical requirements of the Profession since we can not really judge whether its conduct was the result of moral values or the result of fear of possible sanctions. (Levická 2010).

Thompson (2004) sees solving of dilemmas as actions which will be judged in moral terms only to the extent to which someone is perceived to be free to accept, reject or challenge the order which has, or which fulfills the role expected of him. The Ethical Court is bound by self-determination.

Ethics in Social Work addressing issues of reason based on justification of moral decisions based on Ethical Principles, listed under Banksova (1995, In: Matoušek et al. 2003) are:

1. It is a solution concerning a good lifestyle (welfare) and should support the satisfaction of people in fulfilling their needs. It should be borne in mind that the definition of human needs is relative and depends on the type of company; the ideological system; the personality; variations in time and in place; etc. It is necessary to ask the questions: „What is a good and happy lifestyle for the client? How can it be achieved?”
2. Solutions include action. If we respect the client's decision, we must be prepared for subsequent action in accordance with this decision.
3. There should be universal guidelines in terms of similar procedures for clients who find themselves in similar situations. It is not a violation of an individual approach to each client, but the point is, no clients should be considered as favored and others denied.
4. The action should be justified by Professional and General Values (eg. Principle of Self-determination of the client).

As reported by Levická (2010), we could also partly find a solution in the newer Ethical Theories that emphasize a focus on character. It is believed that in the educational process, Social Workers already identify with the content of the Code of Conduct established by key members of the Professional Community which were gradually incorporated into their personal value pyramid. Nevertheless, we do not consider that the content of this document could be the reason for Ethical Dilemmas. But some of its parts can cause Ethical Dilemmas. The Social Security Code does contain some rules that can be seen as contrary to accepted Ethical requirements.

One of the most famous is client confidentiality. It is not easy for the client to talk to a stranger about sensitive information from life. If she/he does so, it is based on a decision that she/he has to trust the Social Worker. This *personal trust* refers to a specific Social Worker who takes responsibility for information from the client. There may be times when a Social Worker receives information from the client which may be under the obligation of Laws of Reporting. A dilemma occurs between the objective and the role of Social Work that is fulfilling and protecting the human rights of clients and the Law that must be respected by a Social Worker. Precisely for this reason, a working strategy must be gradually developed that aims to minimize the breach of client confidentiality and subsequent lose of confidence. At the beginning of their cooperation, Social Workers should inform their clients about their legal obligations in case of sensitive information which is subject to reporting. It can be assumed that if they provide such information clients will be aware of possible consequences. (Levická, 2010).

Confidentiality is Related to Protection of Personal and Health Data: a Social Worker refers mainly to health data and may provide information to relatives, neighbors, friends, or other patients. Social Workers are obliged by Sedlakova (2010) to carry out their work in accordance with Ethical Principles. Unlike Theory, in practice their application is also associated with vulnerable problems that require review of their procedures by other Social Workers. In Practical Social Work situations may arise where the Social Worker is in a dilemma between complying with legal obligations and respecting client confidentiality.

This happens in a situation where the Social Worker learns from the client that he/she has committed a crime, so must ask for a right to notify Law Enforcement, but the client demands secrecy be kept. The Criminal Code imposes guilt if the Social Worker is informed about a crime personally or through others and does not report the crime. Apart from those mentioned, exemp-

tion from this requirement applies when a Social Worker, or a loved one, is endangered for infringement of the seal of confession and the impossibility of committing a felony without significant difficulty (§341 of Act no. 300/2005 Coll.). From the wording of this Law, the Social Worker, on the offense, does not have the option to remain silent without violating the Law. (Sedláková 2010).

As stated by Žilínek (1997, In: Sedláková 2010), in Professional Communities which emphasize their reputation as a matter of honor, must fully apply and respect in practice requirements of the Ethics of the Profession which are expressed in codified form of Ethical (Moral) Codes. The Code has abilities to protect against unauthorized attacks and the public has explicit trust, respect and social recognition.

According to Sedlakova (2010), Right and Morality largely regulate the same social relationships. This means that human behavior is also governed by Morality and Law. Actions by individuals and other entities can be evaluated by both normative systems. Therefore, it is important to examine the relationship between Law and Morality. Legal Rules oblige us from the outside and are enforceable by State power. Čechotová (2005 In: Sedláková 2010) points out that Moral Norms oblige a person within and their maintenance - unless contained in a legal norm which is enforceable only by public opinion.

Sedláková (2010) notes that *Criminal Law* and the *Moral Code of Ethics* deal with the issue of mitigating the legal norm. There is a possibility to break the Rule of Law because of its conflict with the moral norm resulting from acting in conscience. But such an approach must necessarily deal with sanctions for infringements. Moral and Professional Duty of a Social Worker to respect the client's privacy and the confidentiality of the information does not need to be in conflict with the notification obligation under the Law. It's just the client's beliefs, what is and what is not in his own interest, so he does not require not disclosing a crime.

Currently, under Hanganoho (2010), to implement Practical Social Work, Ethics dilemmas of Social Justice which perceives a particular Social Worker in a particular social situation in which she/he can find her/himself also a client of Social Work. At the same time, she/he can find that certain legal standards are discriminatory or restrictive, and in terms of providing social assistance or services are not feasible while simultaneously favoring certain groups over other people finding themselves in similar social situations. Such Ethical dilemmas on Social Security are still applicable by legal standards. The guarantee of the freedom of deciding about providing Social Services occurs when citizens, against their will, are legislatively forced into taking certain Social Services. A typical example is the Law on Social Insurance, which forces unemployed citizens, even against their wishes, to register at the Office of Labor, Social Affairs and Family in order to be entitled to receive unemployment benefits; the benefits and unemployment services belonging to the support of the State for Social Events.

Another dilemma is the enormous number of clients in which a Social Worker not least through knowledge and social skills acquired by education and practice, as well as the Organization itself, does not perform the Social Work according to client expectations. A number of clients of a Social Worker do not fully develop Social Work with a specific client. Requirements on the personality of the Social Worker and the constant pressure to increase their professional competence can be recognized as Ethical dilemmas since some acquired professional skills, for objective reasons, cannot even be used in Social Work. This Social Worker subsequently loses the incentive to increase their professional competence which contributes significantly to still lower social valuation of Social Work.

According to Levicka (2010), it is important to make Educators of Social Workers aware of the fact that Social Workers are Professionals whose main Ethical Principles are just about re-

specting and promoting self-determination of service users. They are also employees of various Agencies and Institutions. Their daily work is within the constraints of the Legal and Procedural Rules, and in general, must also work to support the public good or well-being of society. In this spirit, they need to learn that despite various restrictions that come with the Practice of Social Work, to always bear in mind that in matters of an individual client the core Principle of Social Work to seek to remain within their decision-making role and to always act for the benefit of their client.

The current direction of Social Work raises a number of dilemmas facing a Social Worker who needs them in a certain way to cope in order to remove barriers which prevent full realization and improve the quality status of Social Work; to accept fair and also Ethical responsibilities in relation to the customer; to remain morally blameless and internally identify with their profession's anticipated personal and, private expressions of initiatives to Social Work. In order to be qualified as a Social Worker it is necessary for her/him to understand the Ethical conflict between Theory and Practice of Social Work. (Hangoni, 2010).

There are Gaps and Opportunities Social Ethics: precisely, based on the holistic complexity of conversion and transformation of those waiting in the wings looking at the matter. The truth about the value of life and also about being true and meaningful socially in interpersonal relationships; together with a preference for good in historical time contributes to a higher humanity. To benefit the world, there is kind of problem to maintain the existence of life itself which should be seen as a benefit without which humankind cannot exist. If the common „good” should work then the community needs to keep running Institutions: their functionality; compliance; codifying labor relations for an equivalent functioning community (Strieženec 2006).

The globalization process according to Navratilova (Sisáková, Cehelník, Navratilova 2007) affects the development of social capital, and the development of human potential. For this reason, some dimensions have a more social character in nature; others a more personal nature which cannot be strictly separated by the social dimension and personality. As a consequence, there are high rates in values in the individual's life and an unsettled human in a society where negotiation and missing values define social competence and orientation. Every single member of the community should have some kind of need to set a target and realize community specified values. It is therefore important to establish Global Institutions as a whole to address new global challenges which will be addressed directly to the problem from the perspective of the needs of society (Beno 2001).

Globalization Poses an Enormous Threat But Also a Chance: A threat because of failure to allow a deeper Ethical dimension which could lead to a distortion of conciliation between humankind in the world. That is why it is important to give Globalization a human shape that it can become the promising future of society (Kiss 2006).

The current dynamics of the management processes of social development on emancipation of the individual not only deepens, but also produces new forms of social relations. A retreat culture binds to the Ethical requirement of social life accompanied by the escalation of the debate on Ethical values; their relativity and pluralism in all spheres. Social pressure of globalization brings a new kind of Ethical discourse consisting in increasing consciousness of responsibility towards the future; support for the development of humanistic values can be called „*responsible individualism*”. **Responsible Ethics** seeks the optimum level of tolerance of different evaluations which includes the general interest of the individual; changes in assessment; approaches in particular terms of respect for the human being and the human dimension. This opens the way for a possible moral orientation - *habitus* - which can be defined as the transition to the Ethical Order. Rehabilitation of Ethical discernment, therefore does not eradicate personal interests or morali-

zing, but tends to balance and reasonably compromise the individual and society. The current culture is accompanied by a continuous transformation of values and its dynamic *ethos* and its forms require us not only to detect the trap of *moralism*, but especially challenging to develop *Humanistic Principles of Coexistence* associated with respect and dignity of man. (Bilasová 2010).

The Current Financial and Economic Crisis in Europe and in other parts of the world is primarily the result of a moral decline of humanity. It is a condition of morality and lack of accountability of the powerful. People should realize that to live at the expense of future generations is not an optimal premise. Moral decay of society today has reached a point that if in life you are encounter an honest man, most people will deem him as stupid or a naive idealist. The terms Ethics and Morality are not currently highly preferred; success, money, career, influence and power are more interesting for people.

Most Urgent and Most Serious Challenges for the Future Include National Security.

In the past, most of us did not need to have an interest in this topic. An increase in the use of extreme violence for political purposes in some countries coupled with increasingly harder reactions, fears of abuse of state power were mostly associated with totalitarian regimes, but now can be seen in the so called established democracies. We fear that the situation will not change. The rich continue to get richer; the poor get poorer; the political powers hold the country's wealth and mineral resources in their hands. While a change in thinking is absent, we should not lose hope to reverse a fall of civilization by supporting human mutuality and participation; trust that we can keep the core values of human rights; such as the right to life; liberty; dignity; justice; security; peace and freedom from fear and misery. Bujdová, Dancák (2011) states that to help and serve people means providing through the Ethics of Love and Attention to Morality.

With regard to the function of Codes of Ethics, according to Palovičová (2011), it would be helpful if Principles and General Principles on which the Codes and value-based and politically incompatible concepts from different philosophical traditions were explicitly declared; i.e. communitarian notions of common good and justice with liberal values (individual freedom and individual autonomy). Ethical Codes provide practical advice only if they are based on well-articulated and clearly defined Values and Moral Principles. Fuzzy definitions and values to differentiate between socio-political, legal, economic and Ethical values and some Principles to articulate more or less psychological aspects such as effective communication; decision-making in impossible situations; practical dilemmas faced by Social Workers in practice. Moreover, axiological foundations of Social Work in recent years faced pressure in economic efficiency and commodification of Social and Ethical Values and Standards, and in legislative changes which have important practical consequences for the whole profession of Social Work.

Conclusion

Ethics is manifested in everyday human life and helps us make decisions and take actions in difficult life situations, and at the same time, regulate our behavior so that it is morally right. Anyone forming an essential part of the Profession, who adopts Standards, Principles and Values of Social Work must act in accordance with them not only in their Professional life but private life as well. In their everyday work, Social Workers have encounters with humanity and dignity; on the one hand, the workers must respect the dignity of their clients, and on the other hand, they must respect their own dignity. Therefore, Social Work is entirely based on mutual respect for the dignity and worth of all people and the rights they entail.

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Epiphenomena of Marginalization and Discrimination of Roma in Contemporary Society

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Abstract

This report offers a picture of the Roma people in a majority society, their way of life and way of thinking which needs to be harmonized with the rules of civilized society. The whole process is extremely complicated; accompanied by many conflicts and misunderstandings on both sides. The lifestyle of the Roma, including their housing problems, employment and educational levels, have accompanied this minority since their arrival into the „other” culture in civilized Europe. In this work we look at the issue of enculturation of the Roma minority and manifest the discrimination by the majority society. Marginalized Roma community and Social Work in any form refers to activities that are made in favor of the Roma for the purpose of moral upheaval, successful integration and prevention of discrimination.

Key words: Discrimination, Roma, The Roma minority.

Introduction

Roma, their marginalization and problematic integration currently form perhaps one of the most contentious topics. Their life and position in society has been developing since their arrival to Europe and is constantly changing. Most of the majority population nourish prejudices against Roma. They cannot understand the Roma way of life, culture, customs, traditions and unconventional mentality. Those people who are dedicated to Roma issues and try to address the deficiencies relating to housing, education, social decline as well as poverty and unemployment of the Roma, are in for a very long haul. Marginalization is a phenomenon that degrades human dignity and every state should be anxious to help marginalized groups and promote their full integration.

Roma in Slovakia

The designation 'Roma' is a general name for many ethnic groups that share a common origin, a language and cultural features. Therefore, they can generally be divided into different aspects: an internal division, thus Roma, is used most often; an external division is used by non-Roma; professional divisions are used in ethno-linguistics (Rosinský, 2006).

Roma living in Slovakia are divided into several relatively distinct groups and subgroups: *Slovakian Roma* (Slovakian, *Servika* Roma) constitute the most numerous group, making up to 80-85% of the Slovak Roma population. An area around the southern border with Hungary is occupied by a subset group of *Hungarian Roma* (Roma *Ungrike*), which represents around 10% of the Roma population. Hence, more than 90% of the entire Roma population consists

of these two traditionally settled Roma subgroups, which were labeled by the former nomads as „*Rumungri*.” The group of *Wallachian Roma* (*Roma Vlachika*), which until February 1959 had lived a nomad way of life, represents a specific significant group. Together with the less numerous *Sinti* group from the Bratislava neighborhood, the *Olah* Roma represent the most closed community, which maintains an authentic way of life, values and other social norms and has specific cultural expressions (Poláková 2005). *Olah* Roma are internally divided into further subgroups, such as *Bougesk*, *Ferkosk*, *Lovari Drizdar*, etc. These groups have skin pigmentation and lighter, sometimes red hair (Rosinský 2006).

As reported by Rosinský (2006, p.23) „*It could be said that the Roma divide themselves also into Roma (zuze) and Gypsies (degeš).*” The Roma people are people who are decent, proud of Roma ethnicity and especially those who abide by Roma Principles. Gypsies (*degeš*) on the other hand refer to those members of the ethnic group who, by inappropriate behavior and actions, shame Roma. By such behavior they are creating an environment in which they are not liked by „*gadžo*”.

According to the way of life, before the ban for itinerancy in 1959: the Roma were divided into the nomadic, the semi-nomadic and the settled. When one is dividing externally, the level of knowledge about the Roma is very important. The most widespread is the general division based on the degree of assimilation. These are the „decent” and „indecent” Roma. Roma is also divided by external characteristics: lighter (*Olah*) and darker (*Rumungri*).

On the basis of inclusion in society, Roma are divided into:

a) Integrated - fully accepted by the majority, their actions are not specific, do not agitate attention and most of them have a standard economic status and stable employment.

b) Semi-integrated - who often face discrimination in all forms and their presence is perceived with prejudice by the majority of society. Specific for them are a reduced social status and unstable employment opportunities.

c) Non-integrated - the majority of Roma refuses to accept and integrate into the environment. Their behavior contains in many cases elements that indicate a culture of poverty, low levels of education, and hence a consequent inability to find a job.

Professional divisions of Roma mainly focus on linguistic characteristics and sway to three basic groups. 1) A group who speaks Romani in the proper sense of the word. 2) use Sinto-Manuš dialect which contains a large proportion of Germanic languages. 3) represent the Roma who speak in local dialects of other languages, containing only a certain fraction of Romani words (Rosinský 2006).

Roma in Slovakia after 1989

The change in the social system after 1989 significantly altered the standing of Roma within the ethnic, social, cultural, educational and economic spheres. Several political parties were created such as *The Roma Civic Initiative*; followed by other parties and cultural associations. In 1990, Roma were first elected as Members of Parliament. They got positions at major places such as the Government Office of the Slovak Republic, the Ministry of Culture and the Ministry of Education. On 9 April 1991, the Government of the Slovak Republic adopted *The Principles Governing the Approach to Roma*. The document emancipated Roma with other nationalities in Slovakia and promised support for the development of culture and education (Zeman 2006).

Currently, there are three ethnic groups in Slovakia that inhabit "Roma Settlements".

The First Group represents the *Olah Roma* (they refer to themselves as the *Valchike Roma*), who came from Romania to Slovakia during the 19th century. Some members of this group roamed until 1959, when the state prohibited the nomadic way of life. Trade in horses by men, and the reading of palms and cards provided their livelihoods.

The Second Group consists of *Slovak Roma* who label themselves as the Servika Roma and today the members of this group are simply called *Roma*. The first reference to this group within Slovakian Territory is from the 14th century in the Špis area. Livelihoods were provided by smithery, broom making and furriery.

The final tragedy for the *European Roma* was World War II when according to the Nazi racial theories they were considered - as the Jews - an inferior race. As a result, they were transported from various countries to a special Concentration Camp in Auschwitz - Birkenau where nearly 20,000 European Roma died. Although Third group, *Slovak Roma* were not deported to Concentration Camps, they were subjected to a number of discriminatory measures: they were not allowed to travel by public transport; could enter cities and towns only on specified days and hours; special labor camps were created for the men. In September 1944, during the German occupation of Slovakia, in several places the Roma population was executed *en masse* (History of the Roma Gipsy.sk).

Socialization of Roma Ethnicity

If one is talking about Gypsies and Nomads dwellings in different countries, here we can only provide information about the tendencies to search certain types of dwellings. In fact, the situation is very different and the possibility of movement remains largely critical for the adaptation to changing livelihoods, especially in housing and economic activity. Differences in the type of Gypsies and Nomads dwellings are dependent on the overall situation of the environment: negative approach of the local population over all seasons; different legislative regulations as determined by spatial factors, limitations, and laws (Liégeois 1995).

Discrimination and Prejudice in the Majority Society

Already in the past, there was lots of talking and writing about the Roma; the main topic the discrimination of Roma by the majority community. Not only in Slovakia, also worldwide, the Roma minority belongs among the most numerous ethnic groups. It is a community that despite the differences from the majority society struggles to survive in any society. The most widespread form of racism that affects the daily life of Roma is the latent form of racism. Iveta Radičová calls this broader perceived discrimination „*social exclusion*”. This exclusion in Slovak society is described as „a complete lack of social, economic and cultural life” (Radičová 2001 in: Šoltésová, Robertson 2004). Roma are a minority which suffered discrimination mostly based on their „*inferiority*”. Humiliation and dehumanization of the Roma minority for their „*gipsy-hood*” are essential elements of Romophobia. The Roma minority is perceived differently than other human beings, and accordingly "have no moral claims" for human rights (Government Office of the SR, 2008).

Section 2, Paragraph 1 of the Anti-Discrimination Act states:

Respect for the principle of equal treatment is based on the prohibition of discrimination on the grounds of sex, religion or belief, race, nationality or ethnic origin, disability, age, sexual orientation, marital status, family status, color, language, political or other opinion, national or social origin, property, birth or other status. (own translation)

Unfortunately, as Fejczko writes (2007 p.89) the Roma in Slovakia „are often victims of various forms of discrimination. The majority society suffers different kinds of prejudice towards the Roma population and is in varying degrees racist: in the latent, radical, or extreme form.” (own translation)

The data records of Roma nationalities that for some reason have formal relations with the Authorities of the Slovak Republic could be considered as a typical manifestation of the latent

discrimination against the Roma. In the past, it was a common practice of labor offices to record a letter „R” in the files of Roma job-seekers. In 1999, the Government of the Slovak Republic ordered to end such illegal practices, however many labor offices began to write a letter „B” (*biely* - white) for the majority population, so the situation has changed only cosmetically (Kusín et al in: Fejcz, 2007).

The Roma face discrimination even if they contact the municipality. It took several years before the villages of *Rokytovce* and *Nagov* in eastern Slovakia removed their discriminatory regulation which prohibited the Roma entry to the village. Additionally, some healthcare facilities also practice various forms of discrimination against Roma; by allocating office hours exclusively for Roma (Košice); separate rooms for Roma and non-Roma mothers (Krompachy). Similarly, in some cases restaurants and hotels prohibit Roma from entering (Fejcz, 2007).

The biggest problem is that Slovakia has currently no concept that would lead to the standardization of procedures that would monitor ethnic discrimination. Slovakia does not have a policy in the sphere of monitoring ethnic categories, and therefore in this complicated issue it maintains the status quo (Škobla et al 2008).

It is said that the prejudices have an irrational basis that rational arguments cannot change or disprove (Ondrejkovič et al 2001). Prejudices and stereotypes are ways in which societies evaluate the world around them. Prejudices appeals to fear, irrational feelings and antipathy. They can be perceived as filters that protect us against information overload and allow us to judge people who we don't know personally, or only know superficially. Thus, prejudices distort our perception in a certain way (Government Office of the SR 2008). Prejudice is very closely related to racism, which is pursued very often against the Roma. Also, in the dictionary of the majority society the term relates particularly to the Roma minority:

Racist-nationalist theories ascribe to nations specific, reportedly for them typical anthropological and psychological characters and confuse the concept of nationality with race. They emphasize both exclusivity and superiority of one and inferiority of other nations (Balogová et al 2003 p. 81-82).

Racism is basically an intolerance, which depends on many factors in general. It is not simply black and white; it is rather a complicated phenomenon of the human psyche, emotions, feelings, attitudes and behavior (Zelina 2005).

Roma men are portrayed to have bad characteristics: incompetent and unsuitable for taking part in any demanding activity. According to Poláková (2005 p.66), the majority usually creates the following picture of the Roma:

The Roma threatens Slovakia, he's a disruptive criminal element, non-working individual with a tendency to steal or beg, living at the expense of the majority population, a parasite of the social state system, representing an economic burden to society, unable to control the reproductive process, illiterate or semi-literate, poor without the possibility of finding a livelihood, unable to handle funds and unable to comply with work habits.(own translation)

Misleading media information describing the negative deeds of this minority often contributes to prejudices about the Roma and negative attitudes towards them. Another increasing problem represents the communication between the majority-minority societies. As presented by Rosinský (2006, p.43)

If we follow the communication in terms of its linguistics, we can define it as „transmitting and receiving messages” Each step in communication gives us a number of alternatives to make a mistake. (own translation)

Inaccurate reception of messages, improper verbalization, usage of offensive words, and bad gesticulation all lead to mutual misunderstanding, subsequent confusion and even in extreme

cases to conflict. This is also confirmed by the words of Gáborová (2007 p.75):

Communication is an essential component of interpersonal interaction and is carried out on the basis that within certain areas of social life, there is a consensus, thus an announced set of meanings by all. Based on this consensus people are able to communicate with each other. (own translation)

The style of communication among Roma is in many ways different from the style of communication of the majority society. The human intellect is affected by education, considerateness, politeness, tolerance, as well as economic status, which are also important factors in mutual communication and cohabitation. Members of the Roma community, whose actions and way of life does not correspond to the standards of the majority population, are involved in a high percentage of conflicts. Their actions are thus generalized to the entire community (Rosinský 2006).

Intolerance between the minority and majority population as indicated by Hanobík (2009 p.118) „will only escalate further if the Roma situation does not improve. Currently, efforts are needed for a comprehensive solution to the problem, because postponement will have a negative impact on the growth of tension between the majority population and the Roma.” (own translation)

Church on Discrimination Issues

The Bible clearly states: „God shows no partiality” because all people have equal dignity and are created in His own image and likeness. What applies in relation to an individual, applies in relation to nations, ethnic groups and cultures. Equality in recognition of the dignity of every person and every nation must be consistent with the consciousness that human dignity can be protected and developed only jointly by all mankind (Červeň 2010).

During the Conference of Bishops of Slovakia in 1993, led by the Archbishop of the Archdiocese of Košice (Mons. Bernard Bober) the *Commission for Pastoral Roma* was created. The main role of the Commission was to map the situation of the Roma and to evaluate the possibility of pastoral work and catechization. Pope John Paul II continued the movement started by his predecessor: he condemned the discrimination of Gypsies; called for respect for their identity; recognized them as a minority:

You belong to those minorities that lead a modest and unstable life, are faithful to your ethnicity, wandering way of life and long cultural tradition (Liégeois).

The Compendium of the Catechism of the Catholic Church stresses that:

All men are called to the same goal, which is God himself. There is a certain similarity between the community of the divine persons and the fraternity which people have to shape among each other in the truth and love. Love of thy neighbor is inseparable from love for God (KKC, 401)

The Second Vatican Council recalled the need to respect the dignity of every human being; avoid discrimination; respect all rights. It said:

It is necessary to overcome and eliminate every kind of discrimination that concerns basic human rights, whether in the social or cultural sphere, on the ground of sex, origin, skin color, social or cultural status, language, or religion because this is in contrary to God's plan (Červeň 2010).

Initiatives undertaken by the Church for the Roma population are based on implemented Principles that emerge from God's order and which are generally valid. They respect the human rights of the diversity. In the process of integrating Roma into society, in addition to the general Principles that the Church respects and accepts also offer other Principles, ie. in the sphere of human rights about a supernatural human dignity (Červeň 2010).

This teaching already is seen in the *First Encyclical* dedicated to social issues by Pope Leo XIII

in 1891. The encyclical *Revum Novarum* focused on social issues of that time in which he said:

The rights of the human person in respect to his dignity are inviolable, and no man can abandon them. No one is allowed to outrage the dignity of man, to which God himself approaches with a great respect, with impunity, nor cross his path for his improvement, which is focused at obtaining an eternal life (Košč).

The dignity of the human being is very closely related to the common good, which very well reflects not only the rights of members of society, but also their responsibilities. This means that an individual has to contribute according to their powers and abilities to making the life of society better (Červeň 2010). M. Uhál' says that the definition of the common good is all that belongs to all people in a society or in a particular state. These are all things, values or goods which an individual needs for its existence, in order to live and to act freely, carry out tasks, fulfill plans and goals (Uhál', 2006).

According to the Second Vatican Council:

The common good is a summary of common, social conditions that enable and help to facilitate the absolute development and ultimate achievement of own perfection of human communities as well as concrete human persons.

M. Uhál' identifies the concept of solidarity with the concept of social love. Basically, this means that man does not keep certain personal goods and values for himself alone, but are offered to society as a whole or to a particular individual who is in distress or need (Uhál' 2006). One of the important principles is solidarity. Solidarity is an active expression of love to a neighbor. This expression is closely linked to respect for dignity that is perceived according to the most important commandment *by faith*. The experience of people working directly in the field says that it is not possible to use the same approach effectively in every locality. It is necessary to transfer responsibility and support to the lowest levels. Different demands require different approaches; best reflected in the Principle of Subsidiarity (Červeň 2010). The best interpretation of this Principle states that it is „*a competence rule*”. It advocates building a social order from the bottom up in a natural sequence: individual - family - borough - region - state - the international community. It serves to prevent a greater social unit or society's restriction of the powers or rights of the lower social unit (Uhál' 2006).

Authentic human coexistence has respect for justice; a regulated hierarchy of values; subordinates material and instructive dimensions to the inner and spiritual dimensions. Integration of the Roma in Slovakia is a challenging and lengthy process. Also, a social church doctrine contributes to finding solutions and ways out. Their aim for the future should be a better coexistence of Roma with other citizens in Slovakia (Červeň 2010).

To compare, a quantitative survey on the socialization and perception of discrimination against the Roma ethnic group in the areas of Poštárka in Bardejov and Lunik IX in Košice, highlights associated problems. *Article 12 of the first section of the Chapter II of the Constitution of the Slovak Republic* states:

Basic rights and liberties on the territory of the Slovak Republic are guaranteed to everyone regardless of sex, race, color of skin, language, creed and religion, political or other beliefs, national or social origin, affiliation to a nation or ethnic group, property, descent, or another status. No one must be harmed, preferred, or discriminated against on these grounds. (own translation)

Both locations have very similar characteristics, they are located within the city, but have a specific locality. They have their own schools, spiritual centers managed by the Salesians of Don Bosco and their access to Social Services is similar to the majority population. We have investigated what are the biggest problems of socialization of the Roma minority; access to education,

hygiene, use of Social Services; the impact of socio-economic status and a social level; sense of discrimination.

The survey was launched in November and December 2013. In sequence, we visited Lunik IX in Košice and Poštárka in Bardejov. We approached the field Social Workers from the *Social Development Fund Project*, whose aim is to ensure a better life of the Roma minority; assistance with integration; help break down the various prejudices and discriminations.

The data obtained were processed first by summing Questionnaires; then summing responses and the attributes were processed in Excel. Interviewers distributed over 350 Questionnaires, 100 Questionnaires in Bardejov - Poštárka which is home to about 1,000 Roma and 250 Questionnaires in Lunik IX in Košice which houses about 5,000 Roma.

Poštárka Bardejov - 49% were 20-27 years old, 38% 28-37, 9% 38-48 over 4% 49 and over.

Lunik IX. Košice - 51% were 20-27 years old, 35% 28-37, 12% 38-48, and 2% 49 or over.

1: We assumed that the socio-economic status of Roma living in Lunik IX is higher than for the Roma living in the urban agglomeration of Poštárka, Bardejov.

Poštárka, Bardejov: household: 97% have electricity; 95% have drinking water from their own source; 0% have a public gas supply; 14% have gas cylinders; 99% have a toilet in the apartment/house; 1% have toilet outside the apartment/house; 0% have heating from public sources; ; 100% have heating from their own source.

Lunik IX, Košice: household: 37% have electricity; 95% have drinking water from a public source, 20% have a public gas supply, 4% have gas through gas cylinders, 97% have a toilet in their apartment/house; 3% have a toilet outside apartment/house; 10% have heating from public sources; 90% have heating from their own source. The survey clearly shows that the residents of Poštárka in Bardejov are better equipped as the paying discipline is better in the rented apartments. Community work and awareness of responsibility for their own living is dominant in this discipline. At Lunik IX in Košice, many apartments are disconnected from radio and television due to debts and a consequent chronic non-payment of subscriptions.

2: Care of education and child preparation for classes is more neglected in Lunik IX, because of the higher concentration of Roma than in Poštárka borough.

Attendance at school facilities - Bardejov - 56% of children attend school facilities; 20% do not attend school facilities; 24% answered that their children attend school establishments only sometimes (a kindergarten and pastoral center managed by Salesians of Don Bosco).

Attendance of school facilities - Košice - 26% of children attend school facility; 56% of children do not go to school; 14% children only sometimes attend school (a kindergarten and a school club, managed by the city and a pastoral center, managed by the Salesians of Don Bosco); 4% gave no answer.

Assistance for preparation in classes - Bardejov - 41% help their children with learning; 12% help only if asked by a child; 37% help their children only very little because they do not understand the homework; 10% do not help their children in their preparation for classes.

Assistance for the preparation in classes - Košice - 32% help their children with learning, 23% help their children if asked by a child; 27% help their children only very little because they do not understand the tasks; 18% do not help their children in preparation for classes. School attendance - Bardejov - 70% are inclined to believe that attending school has great importance for the future of their children; the remaining 30% of are in favor of completely different values than school. School attendance - Košice - 52% are inclined to believe that attending school has great importance for the future of their children; the remaining 48% are in favor of completely different values than school.

These survey results clearly show a better integration of the Roma in Poštárka Bardejov.

This result reflects the 20 years of Salesians presence in this locality. Systematic work with Roma bears fruit. Around 20 children from this area are already in their fifth year in a boarding school/high school/in Kremnica which represents another very good sign that the new Roma intelligentsia is growing.

3: Health care and the Social Services are sufficiently accessible in both locations.

Some Medical Studies confirm that Roma from the marginalized communities suffer exceedingly from a wide range of diseases. The high content of fat in the diet contributes to an increase in the percentage of obesity; an increase in the number of cases of diabetes; cardiovascular; oncological diseases. Obesity is also supported by a high consumption of sugary drinks, which was shown by some partial studies in Slovakia. Doctors from areas where the Roma represents a majority population again recorded an increased number of infectious diseases, especially hepatitis, scabies and lice. Periodically, meningitis occurs in these areas. The occurrence of TBC and respiratory diseases is higher in the Roma than in the majority population.

The research shows:

Health status - Bardejov - 55% rate their health as excellent; 25% + are quite satisfied with their health, but 20% are disabled. Health status - Košice - 25% rates their health as excellent; 45% are quite satisfied with their health status; but 22% are disabled; 8% did not answer. Regularity of preventive examinations - Bardejov - 38% regularly attend medical examinations; 56% do not remember when was the last time they were on a medical examination; 6% do not consider it a necessity to attend medical examinations. Regularity of preventive examinations - Košice - 29% regularly attend medical examinations; 66% do not remember when they attended a medical examination last time; 6% do not consider it a necessity to attend medical examinations. Hospitalizations in a Healthcare Institution - Bardejov - 62% were repeatedly hospitalized; 38% were not hospitalized or they are treated as outpatient. Hospitalizations in a Healthcare Institution - Košice - out of 250 Questionnaires, 58% were repeatedly hospitalized; 42% were not hospitalized or are treated as outpatient.

Also this issue of Healthcare dominates Poštárka Bardejov. Pointed to that, the high rate of morbidity and hospitalization is the result of a lack of prevention and care for personal health.

The main factors that affect the malignant health of Roma today are:

- lower level of education, which causes insufficient level of health awareness;
- low level of personal and communal hygiene;
- low standard of living;
- polluted and devastated environment;
- unhealthy eating habits and diet;
- increasing rate of alcohol and smoking, including during pregnancy;
- a growing rate of drug addiction and associated increased risk of infections.

Access to Social Services - Bardejov - 42% use commonly available services and assistance in filling in forms; 40% use a service that accompanies clients to various institutions (labor office, hospital, etc.); only 18% use interpretation assistance. No respondent used the service in mediating employment and consulting services.

Access to Social Services - Košice - 52% use commonly available services and assistance in filling in forms; 28% use a service that accompanies clients to various institutions (labor, hospital, etc.); only 8% use assistance in interpretation. Up to 12% expressed an interest in employment mediation and consulting services.

The use of Social Services - Bardejov - 15% use Social Services almost every week; 45% once a month/these are services to individuals who are dependent on the assistance of another

person and transportation; 25% use Social Services according to their needs; 15% do not know about Social Services. The use of Social Services - Košice - 65% use Social Services almost every week, 20% once a month/most used are support services in the laundry since the water flows only 4 hours daily and the provision of Social Services in a center of personal hygiene, the provision of Social Services to individuals who need the assistance of another person and transportation; 15% use Social Services according to their needs.

Visiting Facilities - Bardejov - 55% regularly attend the Office of Labor, Social Affairs and Family; 25% visit the Municipality; 15% visit the Social Insurance; 5% do not visit any Institution.

Visiting facilities - Košice - 45% regularly attend the Office of Labor, Social Affairs and Family; 35% visit the Municipality; 15% visit the Social Insurance; 5% visit other Institutions that help their integration in society.

4: Roma living in the City are more confronted with expressions of discrimination than the Roma living in rural areas.

Threat to the community - Bardejov and Košice - 100% confirmed that certain groups in Slovakia threaten the Roma community. Which group threatens you - Bardejov, Košice - up to 80% claim that the most threatening groups are non-Roma/Skinhead movement, nationalist parties; 15% are threatened by Roma/loan sharks; 5% reported other undefined groups. Manifestations of discrimination - Bardejov, Košice - 50% cited insults as the greatest expression of discrimination; insinuations of their uncultured behavior; 15% abusive language; 35% mentioned verbal attacks. According to the survey, the biggest problem of today's society is discrimination. Many citizens of the majority society judge negatively the marginalized Roma community, even if they have not had any personal negative experience with Roma.

Elimination of Discrimination by the State

In 1991, the Government of the Slovak Republic adopted the *Principles of government policy with respect to Roma*. This document equalized the Roma with other ethnic groups in Slovakia (Gallová, Kriglerová, Gallo et al 2009).

On 1 September 1992, the Slovakian National Council adopted the *Constitution of the Slovak Republic*, which unreservedly and imperatively governs the equality of all citizens, regardless of nationality, religion and social affiliation. Since 1991, the Government of the Slovak Republic initiated and adopted a number of adjustments of the lower legal framework related to Roma (Vašečka in: Fejcz 2007).

In 2004, the need to address the situation of the Roma minority within the scope of the European Union, led to the creation of the first international campaign that aims to change the situation of Roma in Europe. The initiative was accepted by the Governments of Bulgaria, Croatia, Czech Republic, Hungary, Serbia and Montenegro, Macedonia, Romania and Slovakia. At the same time, the initiative is supported by the European Commission, the World Bank and the Open Society Institute. In addition to support by national governments and the mentioned organizations, the initiative received support from the UN Development Program, OSCE, Rozvoj Bank and importantly also from the Roma representatives of each State (Gábor in: Lulud'i Romanes 2006).

In September 1995, the Government *Resolution # 668/1995* appointed a Government Commissioner to address the problems of citizens in need of special assistance. Its status defined that special assistance should be preferably directed to employment, social, housing, educational, health and hygiene problems.

Careful formulations of the term Roma (citizen - Roma) persisted until the adoption of *Conceptual Plans of the Government of the Slovak Republic* for addressing the problems of the Roma

in the current socio-economic conditions in November 1997. Part of this material was the allocation of means of the state budget to ensure the Conceptual Plans for the years 1998 to 2002; first for individual Departments and Regional Offices and also across the board in all areas (*The Slovak Government Plenipotentiary for Romani Communities*, 2008).

Government Resolution No. 126/98 approved the Development Housing Program for 1998, for which 30 million Slovak crowns was reserved. For the mentioned program 10 buildings for housing and technical infrastructure worth 38.312 million Crowns were assigned for citizens living in Roma settlements. From 1996 to 1998, the Ministry of Construction and Regional Development of Slovakia funded construction for the Roma in the areas of Špišská Nová Ves, Fiľakovo, Nálepkovo, Egreš and Rimavská Seč (Office of the Authority for Roma Communities, 2008).

Between 1999 and 2005, the Slovak Government approved 75 resolutions that were directly related to the Roma in Slovakia (Gallová, Kriglerová et al 2009).

The Ministry of Education of Slovak Republic Bill # 408/2002 introduced the position of Assistant Teacher into Teaching Practice. Currently, several projects are being implemented for the education of Roma children to increase the performance of those school children.

One of the long-term projects is the project of Preparatory Classes. Already in the school year 1996/97 56 zero grade classes were established in primary schools for nearly 700 children. A year later an additional 91 classes were established for 1,250 six years old children from linguistically disadvantaged and socially deprived environments (*The Slovak Government Plenipotentiary for Romani Communities*, 2008). In addition to support for Roma children in primary education, the Office of the Slovak Government Plenipotentiary for Romani Communities also provides funding for the support of Roma students in Secondary School (Zelina, in: Lulud'i Romanes 2006).

Since the beginning of 1997, the number of the Field Social Workers increased to 265 providing social assistance in a natural social environment, particularly in Districts with a higher proportion of Roma; in the Districts of Banská Bystrica, Košice and Prešov regions.

After 1998, several key documents were gradually adopted which constituted a 'roadmap' for the implementation of measures to integrate Roma communities; to reduce ethnic tensions in society; repress and prevent racist expressions (Gallová, Kriglerová et al 2009).

The Slovak government adopted a document called *The Strategy of the Government of the Slovak Republic for the Solution of the problems of Roma National Minority and the Set of Measures for its Implementation (first stage) stage from 27.9.1999 resolution # 821/1999*.

As stated in the draft report, the Processor and Presenter of the material also suggested that Ministries and Regional Authorities prepare a draft of measures to implement proposed strategy which would form a 2nd Stage In-process Strategy of the Government. The basic thesis of the SR Government conceptual policy in the integration of Roma, adopted by *Resolution #278* on 23 April 2003 states:

Temporary affirmative action serves to achieve equality and decent living conditions that are demonstrated by a widespread practice in many developed democratic countries.

In International Law, which is an important source of Law in the area of discrimination, affirmative action is considered as a legitimate measure aimed at achieving de facto equality for the disadvantaged groups. In 2004 to 2006, after joining the European Union, the Government adopted a number of documents concerning the politics in relation to Roma; important was the *National Action Plan for Social Inclusion*. The Plan also defined the groups that are most at risk of poverty and social exclusion (Gallová, Kriglerová et al 2009). In February 2005, Governments of several European Countries, including Slovakia adopted the program *The Decade of Roma Inclusion 2005-2015*, supported by the World Bank, the Open Society Institute and other Inter-

national and Non-Governmental Organizations (Zelina, in: Lulud'i Romanes 2006).

In 2008, the Government adopted a document entitled *Medium-term Concept of the Development of the Roma National Minority in the Slovak Republic: SOLIDARITY - INTEGRITY - INCLUSION 2008-2013* (The Slovak Government Plenipotentiary for Romani Communities, 2008).

In the second half of the 20th century the approach to Gypsies and Nomads has changed. Social control was strengthened. Its purpose was to prevent conflicts and limit violations of the Law. Therefore, several States formed Social Departments to deal with the problems of Gypsies and Nomads (Liégeois, 1995).

When working with the community it is necessary to respect the biological, ethnic, psychological, cultural, social and environmental needs of its citizens.

There are four basic types of approaches to work with the Roma minority, which can be used by a Social Worker

- **Despot access** - trying to mitigate the uncertainty of the unknown by manipulating the dealings of members of different groups.
- **Ally access** - trying to achieve understanding between minority and majority by rapprochement with the minority.
- **Leader access** - helping a minority group to promote their interests in society which binds them together.
- **Expert access** - trying to figure out what is causing problems in the lives of minorities, or in its relations with other groups, and on the basis of this knowledge to determine how these problems can be eliminated.

Several barriers exist in the field of Social Work.

The most serious is the communication barrier between representatives of communities, clients and among Field Social Workers. A major problem is a lack of supervision and a lack of opportunities for professional growth. The burden also represents administrative requirements, bureaucracy, excessive expectations and pressure from the clients (Institute of Ethnology SAV, 2009).

To completely raise the level of the Social Work Field, according to Strieženca (2006 p.93): *it is necessary to adjust the social field work, especially Social Work done in a natural social environment (Social Work with families, Social Work on the street) so that the opportunity to work longer with the family in its natural environment could be generated – to decontaminate the family environment, which would also create jobs or allocate employees to perform this formal social prevention. (own translation)*

A document of the Slovak Government Plenipotentiary for Romani Communities defines Objectives and Contents of the Field Social Work in Roma communities as *the program of the social field workers* (Rosinský et al 2006).

Social Work is also carried out through Institutions and is well-defined by legal standards. In addition to Private and Non-governmental Sectors it is mainly the government which provides a social assistance through the following:

- Ministry of Labor, Social Affairs and Family,
- Offices of Labor, Social Affairs and Family,
- District Office,
- Social insurance,
- Health insurance,
- Various State Institutions and Social Service Organizations.

Strieženec writes (2006 p.81):

The disadvantage of the Institutionalization of aid is the loss of solidarity; of belonging. It creates a large anonymity; shared responsibility is not produced; it is expected that the state will take care of everything; thus impersonal institution whose operation should be enforceable by law.

Conclusion

Most of the majority population have prejudices against the Roma minority. They cannot understand their way of life, customs, and therefore the position of Roma in society largely depends on the degree of integration with the majority. While the differences between the majority and minority will still exist, understanding and acceptance of the differences in value systems, housing, traditions and mentality can lead to mutual co-existence and the elimination of prejudices.

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Cohabitation or marriage: contemporary Family in present-day society. Where are we headed?

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In this article we deal with the issue of cohabitation, marriage and legalized coexistence of partners. Providing a comparison with views of selected world religions on the phenomenon of marriage, we offer a contemporary look at newly emergent forms of relationships. We believe, that these new forms of families, such as single, mingle, patchwork or same-sex families, a common result of cohabitation replacing the traditional family, empower irresponsibility in relationships. Reflecting on current challenges and perspectives regarding family in contemporary society, we provide relevant facts, suggestions and recommendations for practice.

Key words: marriage, cohabitation, registered partnerships, religion, adoption, family, parenting.

Introduction

We are witnessing situations where family as a fundamental educational environment for a child or an adolescent is becoming atomized. Family, the place where foundations of morals, politeness and etiquette are laid, is often facing the fast pace of time. We see new types of family cohabitation emerge, such as single, mingle, patchwork, same-sex families and others. More and more young heterosexual couples do not enter marriage as they consider it an unnecessary formality, claiming „no need for a piece of paper to represent [their] love”. On the other hand, almost as if in opposition to the aforementioned, young homosexual couples are demanding legalization of their relationships up to the same degree as that of marriage or registered partnership. We can thus conclude that the understanding of family formation in the traditional sense (specifically meaning heterosexual marriage) does already not require a „piece of paper to legalize the relationship”; whereas emerging forms of marital (as well as familial) cohabitation demand such a document. Consequently, we question why certain groups do not appear to have need for this so-called „piece of paper” while others seem to require it? This article reflects on the phenomenon of marriage in detail, putting it in contrast with the newly forming trends in family coexistence. Cohabitation which respects fundamental family life values, such as universality, traditionalism, conservatism, sacrality and protection, dominates in most Slovak families. Alongside classical means of family coexistence, new tendencies (types, models) have been appearing up to a remarkable degree. We focus on

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critically analyzing these new trends as well as describing views of selected world religions on the phenomenon of marriage.

1 COHABITATION OR MARRIAGE?

The phenomenon of marriage exists in almost all countries in the world, either in form of a marriage concluded by the Authority of the State or the Church, or in forms which are very different from our culture and mentality, but also affected by a different religion, as can be seen in primitive African polygamous tribes. The Latin word *matrimonium* translates as marriage. This term is composed of two words: „*mater*” (mother) and „*munia*” or „*munus*” (duty, mission). Marriage embodies the following aspects:

- **Legal aspect:** it is a covenant of man and woman
- **Natural aspect:** creating a communion, the married couple is primarily focused on the good of the marriage itself - the well-being of the spouses, bearing and raising of their children
- **Social aspect:** the communion is based on human nature
- **Cultural, religious aspect:** traditional marriage is considered a partnership of one man and one woman (equality: Roman and Greek Catholic Church, Orthodox Church and Protestant Church and Jewish Religion; inequality or caste system: Buddhism, Shintoism, Hinduism and Confucianism)

Marriage in Slovak Family Law is defined as a permanent communion of man and woman, and its main purpose is to found a family and raise children. This communion as a legal act is based on the Principle of FREE WILL and EQUALITY. In Slovak legislation there are two ways of concluding a marriage:

- 1) **Religious** or
- 2) **Civil Form** (also known as Civil Marriage).²

Marriage is a union of one man and one woman, which was concluded by the procedure determined or recognized by the Slovak Republic. No other union can be concluded by this procedure. The special protection which is granted to marriage by law cannot be granted to any other union except marriage. Marriage is mentioned also in the Code of Hammurabi³ which contains 282 Laws:

- **Law 144** states: „If a man marries a woman and she gives him her servant and this servant bears him children, but he wants to marry another woman, he cannot. He cannot have another wife.”
- **Law 145** states: „If a man marries a woman, but she does not bear him children, he can marry another woman and bring her to his house, but this second wife will not be equal to his first wife.”

Marriage is often defined as an institution which fulfills certain roles or functions in society. Marriage in this sense regulates the relationship between two persons, namely in terms of property

² The procedure before concluding a marriage is regulated by Act No. 154/1994 Coll. on Registry Offices, Part II, Articles 27-30.

³ Hammurabi was a king in the Ancient Babylonian Empire in 1782-1750 BC. The Codex of Laws dates back to about 1760 BC. The Pillar with the Laws was discovered in 1901 in Susa (today's Iran) and is currently installed in the Louvre of Paris. The upper part of the Pillar portrays King Hammurabi standing before the god Shamash and receiving Laws from him. This Code is not the only one or the first one. There is a more ancient Code of Ur-Namm, the King of the town Ur (2050 BC) or the Code of the Sumerian town Eshunna (1930 BC).

and Law. Regarding the rights of property⁴, it should be noted that the current trend of promoting legalized partnerships deals with the rights of property, but not the issue of bearing and raising of children (which can be perceived as a possibility of making such partnerships equal to the classical family). In other words, there is a tendency to focus on property rather than on family. Concluding marriage before a civil authority is possible for unmarried engaged couples, widowed persons, divorced persons (this is unacceptable when concluding marriage before a Church authority), as well as for minors (between 16-18 years of age) after submitting a permission to conclude marriage issued by a court.⁵

Cohabitation, Concubinage or (in some countries) Legalized Partnership is not a modern hit of the 21st Century. Legalized partnerships have been openly discussed since the end of the 19th century, while the phenomenon of homosexuality was boldly presented already between the end of the 17th and the beginning of the 18th Centuries. Legalized partnership is a legal way to form a union of two persons of the same sex, serving as an alternative to marriage. In those countries where partnerships of the same sex are not legalized (since legalized partnership can also exist between man and woman), people can only conclude marriage before civil or church authority. In such countries marriage is also anchored and defined in Legislation. However, this is not the case with legalized partnerships. Legislation lays down rights and obligations which spouses have towards each other, their children and the State. In countries which do not recognize legalized partnerships there is no legal framework for this phenomenon. If it is present, it is fragmented and such partnerships are not bound by any obligations, e.g. if a couple breaks up, there are no legal sanctions.⁶ The issue of legalizing same-sex partnerships (to the degree of being equal to the classical form of marriage) is a sensitive topic. Albeit traditional heterosexual relationships refuse to enter into marriage proclaiming „no need for a piece of paper to represent [their] love“; homosexual couples demand this „piece of paper“. This paradox leads us to contemplate what is so precious and at the same time so rejectable about this specific „piece of paper“. Considering long established conventions and family models in Slovakia and throughout the European region, this new kind of „basic unit of society“ is non-traditional not only in terms of biology and reproduction but also in terms of the common paradigm.⁷

Concerning legalized partnerships (cohabitation, concubinage), we perceive 4 aspects:

- **Legal aspect:** non-existent or largely fragmented legal framework in countries which do

⁴ When concluding marriage, the spouses also conclude joint or undivided ownership. Undivided ownership of spouses is regulated by Articles 143-151 of Act No. 40/1964 (Civil Code).

⁵ The engaged couple have to submit: birth certificate, identity card, (and possibly also death certificate, military record, valid divorce decision issued by a court, proof of eligibility to conclude marriage, residence document, proof of marital status – specifying if they are unmarried, divorced, widowed persons or foreign citizens – in such a case it is necessary to submit also certified and translated copies of the mentioned documents, as well as the proof of payment of the administrative fee in the Slovak Republic).

⁶ According to Act No. 461/2003 on Social Insurance as amended, the husband, wife and dependent child of a person who died due to a work-related accident or an occupational disease are entitled to a lump-sum compensation. A life partner is not entitled to widow's or widower's pension, or to care allowance, which is paid to an insured person who is taking care of their ill husband, ill wife, ill parent or an ill parent of their spouse. The Slovak legislation does not recognize life partner's mutual maintenance responsibility. The institution of joint ownership only applies to married couples. It is not possible to make tax deductions of non-taxable part of a base, as is possible in the case of spouses. There are only a few examples of life situations which are not regulated by current legislation. Persons of the same sex who share the same household are in this sense disadvantaged as compared with spouses, although they pay the same contributions and taxes.

⁷ We believe that an adolescent who is at the age when “their sexual identity is not yet stabilized” becomes a person with blocked sexual development, especially if they live only with people of the same sex.

not recognize legalized partnerships; no obligations accrued, meaning the dissolution of a couple results in no legal sanctions.

- **Social aspect:** man/woman relationships (cohabitation), man/man or woman/woman relationships (same-sex partnerships) are less durable according to statistical evidence.

- **Natural aspect:** not present.

- **Cultural, religious aspect:** an alternative to the traditional concept of marriage. Marriage, from the Latin word *matrimonium* translates as „mother” (*mater*) and „duty” or „mission” (*unus* or *munus*). For this reason, homosexual relationships can only be denoted as partnerships from the etymological point of view. Countries (Netherlands, Belgium, Denmark, ...) in which legislation uses the term „same-sex marriage” are currently dealing with applications to their respective Constitutional Courts on the grounds of an „*etymological paradox*”. No religion officially acknowledges homosexual relationships. Nevertheless, tolerance towards these relationships is expressed to a variable degree.

The traditional concept of marriage as a legalized union of man and woman with the goal of bearing and raising of children is gradually being replaced by a more liberal approach in Europe.⁸ Law on registered partnerships has already been passed in eighteen European Countries, enabling partners of the same sex to conclude a union similar to marriage. The Law regulates creation and termination of a homosexual union. Concluded at a Registry Office, the union grants partners the right to be informed about each other's health condition and the right of inheritance. It also regulates the partners' mutual maintenance obligation and allows them to take care of children but not to adopt them.⁹ Traditional marriage is protected in various ways in Constitutions of e.g. Poland, Lithuania, Latvia, Ireland and a number of States in the United States of America (Alaska, Hawaii, Nebraska, Nevada and Texas have passed their own Amendments to the Constitution, protecting the definition of marriage; Alabama, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Illinois, Michigan, Minnesota, Pennsylvania, Texas, Virginia and others have passed protection of marriage by law or referendum; an exception is the State of Massachusetts where same-sex marriage is legalized, similarly as in Canada and South Africa).

Table 1: Legislation on traditional marriage in some countries of the world

Form of protection	Countries or states
1. Countries where marriage is protected by the constitution of that Republic or State	e.g. Poland, Lithuania, Latvia, Ireland and some states in the USA
2. Countries which have passed their own amendments to the constitution to protect the definition of marriage	e.g. states in the USA: Alaska, Hawaii, Nebraska, Nevada, Texas
3. Countries which have passed protection of marriage by law or referendum	eg. Alabama, Arizona, Arkansas, Colorado, Delaware, Florida, Georgia, Illinois, Michigan, Minnesota, Pennsylvania, Texas, Virginia ¹⁰
4. countries with no protection of marriage	e.g. Slovakia

Source: TOMÁNEK, P. 2012a. Manželstvo, rodina a legalizované partnerstvá v EÚ. In *Rodina*

⁸ Cf.: <http://www.euractiv.sk/rovnost-sanci/clanok/registrovane-partnerstvo-uz-aj-v-cechach>

⁹ Ibid.

¹⁰ An exception is the state of Massachusetts, where homosexual marriage is legalized.

v treťom tisícročí – *Familiaris consortio* – nádej pre súčasnú rodinu, 2012. p. 308.

In Slovakia, as well as in other EU Countries, marriages are concluded before civil or Church authority (depending on the denominations which are recognized in that country, e.g. Roman Catholic, Greek Catholic, Orthodox, Islamic and others). When it comes to legalized partnerships, there is significant variation across the Member States (in legal terms).

There are three forms of legislation on homosexual partnerships in the EU and beyond:

- Factual Cohabitation - mutual rights and obligations of the partners arise on expiry of the fixed period of cohabitation, usually regardless of the sex of the partners,¹¹
- Registered Partnerships - a special legal institution which represents a nationally recognized cohabitation of partners of the same sex or regardless of their sex, providing similar or equal rights as in the case of marriage,
- Marriages - marriages of homosexual couples are equal to the marriages of heterosexual partners, including the possibility of raising children.

The first country which legalized same-sex marriages was the Netherlands (2001),¹² followed by Belgium (2003)¹³ and Spain (2005). The last country to recognize them up to this day was France (2013).¹⁴ The United Kingdom passed a law on same-sex marriages (2005) but in comparison with the aforementioned countries they are not officially recognized. The issue of legalization of homosexual marriages is often linked to the possibility of adopting children by these couples. Belgium, the Netherlands, Spain and also the United Kingdom have authorized this possibility. In Denmark, Norway, Germany and France (and others) a homosexual spouse can adopt the child of their life partner.

Table 2: Same-sex partnerships or marriages in Europe

Possibilities of same-sex partnerships or marriages in the EU and beyond	Countries where these possibilities are available
1. Countries where homosexuality is not subject to penalties, but registered partnerships are not possible and there is no anti-discrimination legislation	Cyprus, Estonia, Greece, Ireland, Latvia, Malta, Poland & Austria, Turkey
2. Countries where it is not possible to conclude registered partnerships, but law bans discrimination of homosexuals in their access to services or in the process of job recruitment	Lithuania, Slovak Republic, Slovenia, Italy, Bulgaria & Romania, Switzerland
3. Countries where homosexuals can conclude registered partnership	Czech Republic, ¹⁵ Finland, France, Luxembourg, Hungary, Germany, Portugal & Sweden, Croatia, Norway
4. Countries where homosexuals can conclude marriage, which gives them more rights, except the possibility to adopt children	Belgium
5. Countries which not only allow homosexuals to conclude marriage, but also to adopt children	the Netherlands, Spain, the United Kingdom
6. Countries where homosexual couples can adopt children	Denmark, Sweden

Source: TOMÁNEK, P. 2012a. Manželstvo, rodina a legalizované partnerstvá v EÚ. In *Rodina*

¹¹ Factual cohabitation of two persons of the same sex was recognized in the Netherlands already in 1979.

¹² The draft law was passed by the government of the former Prime Minister Wim Kok, chairman of the left-wing Labour Party. Christian Democrats were the only party which opposed the draft law.

¹³ The law was passed only due to the fact that Christian Democrats were not represented in the government, as was the case in Spain.

¹⁴ Among non-European countries, homosexual marriage is legalized e.g. in Canada, South Africa and even in some states of the USA, such as in Massachusetts.

¹⁵ Czech homosexuals can already conclude registered partnerships. In 2006 the Parliament overrode the veto

v treťom tisícročí - Familiaris consortio –nádej pre súčasnú rodinu, 2012 p.309-310.

A survey conducted by the Center for Opinion Polls¹⁶ in October 2005 and the data collected by survey agencies GEORG and Focus show that the Slovaks are less tolerant to homosexuals (including same-sex partnerships and marriages) than people from the Czech Republic. The survey covered 1,075 respondents. The results show that only 24% of Slovaks agree that homosexual couples should have the right to conclude marriage. The survey also found that a positive answer to this question was given (in terms of percentage) by 21% of Poles, 25% of Hungarians and as many as 42% of Czechs.

Table 4: Tolerance towards same-sex partnerships and marriages in the Visegrád countries

Country	Percentage
Poland	21%
Slovak Republic	24%
Hungary	25%
Czech Republic	42%

Source: Registrované partnerstvo už aj v Čechách [online]. c2006, last revised 27. 1. 2006 [cit. 2011-09-06]. Available at <http://www.euractiv.sk/rovnost-sanci/clanok/registrovane-partnerstvo-uz-aj-v-cechach>

Marriage and family have a special social status and an increased protection by society, not in order to fulfill individual goals of the spouses but mainly because they bring unique benefit to the society as a whole. We therefore believe that the state should prefer a union which is in its „vital interest“, i.e. marriage, which provides potential for creating a family, since childless marriages are not in the vital interest of our society. The main purpose of marriage is to found a family and raise children. The natural status and function of family and marriage are rooted in the basic needs of human beings. The appointed special protection¹⁷ results from the general benefits that family and marriage contribute to society. Consequently, everyone who enters into marriage also realizes the aspect of parenthood which is closely linked to marriage.

Registered partnerships (heterosexual and homosexual) and their propagation directly endanger the Institution of Marriage and the Institution of Family. Coexistence of heterosexual partners, denoted also as concubinage or cohabitation, fulfills the function of mutual enrichment of the partners, while other basic functions (reproduction or parenting) often remain neglected. This is due to the fact that many contemporary heterosexual partnerships are so exhausted by work-related and social obligations that they are not willing to further increase their burden by reproducing and raising children. Coexistence of same-sex partners does not even fulfill the basic function of procreation. Homosexual partners can become „parents“ only by means of:

- **Adoption** (in man-man or woman-woman relationships) or

of the Czech President Václav Klaus and it readopted the Law on Registered Partnership. The Czech law, however, does not allow e.g. the joint assessment to tax, i.e. to pay lower income tax if one of the spouses is unemployed. If one of the partners is a foreign citizen, they do not have the chance to acquire permanent residence or citizenship in a shorter period, as it is possible in the case of marriage. On the other hand, the Law grants partners the right to inheritance in the first line of succession, as well as the right to refuse to give testimony at court if it might harm their partner, and the right to act on their partner's behalf before authorities and offices.

¹⁶ Cf.: <http://www.euractiv.sk/rovnost-sanci/clanok/registrovane-partnerstvo-uz-aj-v-cechach>

¹⁷ Cf.: Draft Constitutional Law on Protection of Marriage (2006); Part II: The Role and Status of Family and Marriage.

- **Direct Lineage** (when a man or woman brings his/her own child, for which he/she has full custody from a previous heterosexual relationship into a homosexual relationship).

Child adoption by homosexual partners is not automatically permitted in all countries where it is legal to enter same-sex partnerships.

Table 3: Child adoption in some countries with legalized same-sex partnerships

Country	The year when legislation regarding child adoption was enacted
Spain	2005
The United Kingdom	2007
Denmark	1989, direct descendants only
Sweden	2003
Belgium	2005
Island	1996
Germany	2001, direct descendants only
Norway	1993, amended in 2009

Source: author

Homosexuality thus becomes a frequent transitional stage for the formation of same-sex registered partnerships. The Institution of Marriage becomes diminished by these processes, in spite of the fact that marriage has always been considered a conditional status of the „basic cell of society” - the family. By „basic”, we mean that it is capable of dividing or in other words consigning life; “cell” symbolizing the life it embodies and „society” denoting the fact, that without future population cultures will cease to exist. Family is the first environment where a child socializes and acquires its initial behavioral models. Moreover, it is the place where its character is formed for the first time. Finally, the personality of a child is always primarily influenced by its mother and its father.

2 The Phenomenon of Marriage in Some Religions

The phenomenon of marriage, as well as the primacy of family, its protection and promotion, form an integral part of all major religious and human systems and cultures. The protection of authority, dignity and social status of marriage and family is one of the fundamental values of the constitutional arrangements of the Slovak Republic but also one of the values of civilization and humanity. This chapter provides a brief overview of how some world religions understand marriage (in terms of Institution). It should be noted, however, that the phenomenon of marriage is in almost all religions demonstrated in the same way, i.e. marriage is perceived as a union between a man and a woman; it is always concluded with a ceremony or rite; with the aim of mutual love; bearing and raising of children; and last but not least, creating and preserving a social status (both in a broad and strict sense, e.g. family).

• Roman Catholic Church, Greek Catholic Church, and Orthodox Church:

According to CIC¹⁸ the matrimonial covenant has been raised by Christ the Lord to the

¹⁸ Cf.: CIC, Cann. 1055, Article 1.

dignity of a sacrament between the baptized. It lasts until the end - death of one of the spouses. The spouses administer the sacrament to themselves, and they have equal rights and obligations towards each other; which means that the wife is not her husband's slave or property, and vice versa, the husband is not just his wife's „property”. By concluding marriage, the engaged couple promise to each other not only their lifelong love,¹⁹ care, support and staying together for better - for worse, but also to bear children (which is a fulfillment of the biological and later also educational function of marriage).²⁰ Church marriage is concluded before a representative of the Church²¹ and two witnesses. Church marriage can be concluded only by mentally mature persons. It is administered in church, or possibly in another place (if it is permitted by the bishop, on request of the couple and on request of the local priest). Divorce is not allowed. However, if necessary conditions are met, it is possible to apply for annulment, i.e. declaration of invalidity of marriage from its beginning. In case of a crisis (or various socio-pathological events) in a Catholic marriage, the spouses are allowed to ask their bishop for a separation „from bed and board”, meaning they shall not share a common household for a certain time. The spouses cannot acquire new partners during this period as they are still married. In Greek Catholic Church we notice similar elements of concluding marriage. The only difference can be found in the liturgy (in choral songs). Merging elements of Roman Catholic Church and Greek Catholic Church can be found in the Orthodox Church regarding the procedures for administering of the sacrament of marriage.

• **Protestant Church** (specifically the Evangelical Church of the Augsburg Confession): Marriage in the Protestant Church has only a few elements similar to the Catholic procedure, and a lot more differences. Protestant churches do not consider marriage as a sacrament²² because it does not bear the signs of a sacrament, which are Christ's command and promise of spiritual saving grace. Another reason why marriage is not considered a sacrament is the fact that also non-Christians enter into marriage. It belongs to the Creator's order and not the Savior's order.²³ Marriage concluded between a Catholic and a baptized non-Catholic is not allowed in principle. It can only be concluded with the consent of a bishop. Without a bishop's consent such a marriage (concluded in a Protestant church) is valid, but not legitimate, thus it can be divorced. Mixed marriages must be concluded in accordance with Canon Law (i.e. in a Catholic Church), otherwise they are not legitimate. From the Church's point of view divorce is possible if the marriage was concluded in a Protestant church or just at a registry office.

• **Jewish Religion**: Marriage is considered to be a sacred union between man and woman which fulfills one of the main commandments of the Torah: „Be fruitful and multiply.” Jewish marriage is based on mutual trust and agreement. For millenniums this idea has been expressed in the nuptial covenant called in Aramaic „*ketubah*” which governs the rights and obligations of the spouses. The nuptial covenant is often written in ornamental letters and the married couple have it framed and keep it as a picture in their household. By signing the nuptial covenant the husband commits to treat his wife with respect and

¹⁹ Cf.: CIC, Cann. 1134.

²⁰ Cf.: CIC, Cann. 1055, Article 1.

²¹ Cf.: CIC, Cann. 1108, Article 1.

²² Cf.: <http://www.ecav.sk/info/ecav/manzelstvo.htm>

²³ Cf.: <http://www.ecav.sk/archiv/dokumenty/zakony.zip>

not to let her become destitute. *Ketubah* also provides for material security of a wife in case of death of her husband or divorce. Marriage need not take place in a synagogue. The condition is to use a wedding canopy known as „*Chuppah*”, which is stretched on four poles and symbolizes the future home of the newlyweds. Weddings do not take place on feast days or mourning days of Israel. In Roman Catholic countries there is an unwritten rule to conclude marriages on Saturday. In Judaism it is usually on Tuesday, which was proclaimed by God to be a „good day”. An important element is the so-called Rabbi’s blessing. After receiving Rabbi’s blessing, the bride and bridegroom drink wine from the same cup, the bridegroom puts a ring on the bride’s right index finger and utters the formula according to the Talmud: „You are consecrated to me, through this ring, according to the religion of Moses and Israel.” The second part of the wedding ceremony consists in reading out loud of the nuptial covenant, which has been signed by the bridegroom (like in a Roman Catholic ceremony).²⁴ After a week during which the engaged couple did not meet, the bridegroom together with his father and his fiancée’s father pays a visit to her in her house – this phase is called „*Bedekin*”. The future bride is sitting in an armchair, surrounded by her family and friends, waiting for her bridegroom to unveil her face and publicly recognize her as his future wife.²⁵

• **Islam:** Islamic marriage is not a „sacrament” but a simple legal contract, where each party has the freedom to define their conditions.²⁶ Marriage from the Islamic point of view is an agreement of two persons of opposite sex to live together; respect each other; show love and affection to each other; possibly to have children together. For these reasons, Islam is trying to take away any barriers which could destabilize this relationship in the future. It regulates e.g. financial circumstances between the spouses, which are often a crucial factor

²⁴ The newlyweds drink together a second cup of wine. In the end, the bridegroom breaks the cup and the present guests cry out: “Good luck!” The breaking of the cup symbolizes the destruction of the temple in Jerusalem. Sticking to traditions and celebrating various feasts is a typical feature of orthodox Jews. (See Annex 2). It should be noted, however, that not all Jews keep them strictly. Reformed Jews allow using another language than Hebrew at their ceremonies, e.g. the German language in Germany. They also accept differences in eating habits, celebrating the Sabbath etc. When teaching pupils about Jewish feasts, we should not focus only on the differences in comparison with Christianity, but also on what the two religions have in common. Nowadays there are a number of cases where a Jew marries a person from a different religion. Cf.: <http://www.infovek.sk/predmety/nos/prirucky/prirucka02.pdf>

²⁵ The public part of the wedding ceremony takes place under the canopy known as “Chuppah”, which is meant to symbolize the home that the couple will build together in their marriage. Chuppah is usually brought by the wedding guests. First the bridegroom with his father come under the Chuppah and wait for the bride. Then the bride with her parents comes under the canopy, accompanied by singing the Solomon’s song. The bride goes seven times around the bridegroom (sometimes she is followed by the mothers of the couple) in order to protect him against evil spirits and also to symbolically stick to her husband, and start a new life circle. Then the rabbi holding a cup of wine in his hand utters a thanksgiving formula and blesses the couple. Upon this the couple drink from the cup, they exchange rings and the bridegroom utters a formula in Hebrew: “Harei at mekudeshet li b’tabaat zu k’dat Moshe v’Yisrael”, which means: “Behold you are consecrated unto me with this ring in accordance with the Law of Moses and the People of Israel.” After that, the signed nuptial covenant is read out loud by a person chosen by the couple. Then there are seven blessings uttered over another cup of wine. The blessings are pronounced by the rabbi or by the people whom the bride and bridegroom have chosen. The seven blessings are meant to express thanks for the creation of vine, earth, man and the first married couple; for the miracle of a new life; for the fact that the bride and bridegroom have found each other; and for their common happiness. After the last blessing the couple receive the cup of wine wrapped in a cloth, they drink it together and then the bridegroom tramples it on the floor and the present guests cry: „Mazel tov!” (May the stars be good to you.) In the end, the couple goes into a private room where they stay alone for a while and take some rest, or they can refresh themselves and come back to the wedding reception which had started in the meantime. Cf.: <http://www.svadba.sk/article-zidovsky-svadobny-obrad.html>

²⁶ Cf.: <http://biankahasan.blog.sme.sk/c/125136/LISI-SA-ISLAMSKE-MANZELSTVO-OD-KRESTANSKEHO.html>

in case of misunderstanding or argument. It acknowledges the parents' right to express their opinion on the bridegroom or bride, because parents can sometimes be the reason for the breakup of a marriage.²⁷ When concluding marriage, the bridegroom gives his bride the arranged dower in expression of his affection. The wife keeps her own surname and does not take her husband's surname. Divorce is not frequent with Muslims, even though Islam allows it as the last alternative after everything else has failed. According to Islamic law nobody has the right to force an unmarried Muslim girl to marry against her own will.²⁸

• **Hinduism:** Hinduism also perceives marriage as a union of man and woman (through a ceremony). Adherents of this religion are divided into so-called castes. The caste system²⁹ limits social mobility and regroups people according to their social rank. There is an unspoken rule among Hindus that nobody can marry a person from a different caste,³⁰ they cannot even eat together at one table. Hindus do not deem this as discrimination; they perceive it as their fate. They do not practice any pre-marital sessions, as is the custom in Catholic religions. In most cases, they invite a Hindu monk to the wedding ceremony. It is forbidden to conclude marriage within blood kinship or to have relationships which would lead to incest. All major ceremonies, including marriage, usually take place at home in a domestic atmosphere rather than in public. Therefore, in most households there is a room or a corner with a domestic shrine. In this shrine, a statue or a symbol of a god is kept in front of which they meditate, burn incense and also conclude marriage. Newlyweds usually live in gigantic families where they share everything.

• **Confucianism:** Marriage is concluded between one man and one woman from different families, while the engaged do not need to belong to the same social class. Similarly to Hinduism, marriage is concluded in the family circle, at a place dedicated to honoring ancestors. The government respects this custom. Its uniqueness lies in the fact that the wife only becomes bride at a special ceremony - in the presence of her husband's parents - when she brings a sacrifice to the ancestors of her husband's family. By this ritual the marriage is deemed concluded.³¹ The status of women in a Confucian family is little respected, or

²⁷ Cf.: <http://www.koran.sk/Koran%20Sk%20stranky/Koran%20vase%20otazky/Koran%20vase%20otazky%20od1.htm>

²⁸ Cf.: <http://biankahasan.blog.sme.sk/c/125136/LISI-SA-ISLAMSKE-MANZELSTVO-OD-KRESTANSKEHO.html>

²⁹ The Indian constitution of 1950 grants equal rights to all citizens. In 1956 they adopted a law to remove discrimination based on castes. However, it is not respected by all.

³⁰ This ancient caste system, which keeps everyone in their place in the society, is actually also a racial system and comprises different racial types, from Aryan (people with pale skin) to pre-Dravid tribes (with darker skin). Varna, or caste, means "color". First three castes were Aryans, the palest people, and the fourth caste, including aboriginal inhabitants with darker skin, was non-Aryan. Although the caste system has been for many years considered illegal by the government, it lasts until today.

³¹ The position of bride is better than that of wife. Unless the wife gains the status of bride, she cannot be buried with the rest of the family after her death. If there is a conflict between the wife and the head of the family, the wife is punished to death if she has caused her husband's death; if she has injured him, she gets a year's sentence. Physical violence from the husband is punished less severely: death sentence if he has killed his wife - except death by misadventure; otherwise the husband is deemed innocent. A peculiar case is that of a concubine, whose status makes her devoid of almost all rights. If a man during his marriage concluded a union with another woman, this act would be deemed invalid and would be punished: the woman (concubine) would not be accepted into the family; she would not be able to gain the status of a bride; she would not be considered a relative; and her only family relationship would be with her children. She would not be able to participate in honoring the ancestors, she would not be buried among them after her death and she would have to obey the official wife. Her only advantage or certainty would be the fact that her children had been financially and existentially secured. Cf.: http://iuridica.truni.sk/fileadmin/user_upload/redactors/dokumenty/Doc/Medz/cina.doc

unequal. The wife has to obey her husband. When the husband dies, his property is inherited by his sons. The wife usually has to carry out all domestic chores and she seldom goes in public. Divorce as the termination of marriage is only possible from the husband's will or because of the wife's guilt. Reasons for divorce include: disobedience towards the husband's parents; infertility; incurable disease; theft; backchat; jealousy; etc.

3 Are New Forms of Family the Solution?

The term „family” (Tománek, 2012) mainly denotes a social group consisting of two or more people who are related by marriage, blood or adoption and who live together in one household. It is a primary, informal and intimate social group and the basic unit of society (Tamášová, 2007, p. 32) which is often considered to be the cradle of mankind and child-rearing.

Family also can be described (Prevendárová, 1998, p. 11) as a small social group created by two adult members of the opposite sex and their descendants. It is the initial social environment and the educational institution of primary importance to an individual. Family is a socially accepted form of partnership between two equal people who love each other and are bound by strong kinship. Its main features include intimate cohabitation in one household; commitment; cooperation and assistance among its members. The atmosphere of family environment is given by the correlation between parents and other family members. A child is formed accordingly to the family relationships and environment in which it grows up. It imitates what it sees in the family (Kostrub, 2007, p. 15). Moreover, adults, especially parents, are role models for any kind of behavior. Family is the natural social group and basic cell of society. It groups people into an intimate unity based on kinship. Every man and woman living together under one roof and raising children can be labeled a family. Consequently, the offspring creates its own identity and typical culture (Mátel, 2010), presented by specific traditions, values and conventions within the family. Kinship, economic interests and parenting alone do not express the essence of family sufficiently. This is due to the fact that family as such cannot stand isolated from society, or in other words, it is always a part of a larger social unit by whose norms, culture, tradition and notions it is affected. Family is the first preliminary environment (Tamášová, 2007, p. 37).

Some of the basic features of family (Tamášová, 2007, p. 10) are:

- **Universality** - family still fulfills its function as a basic social institution. It is known as mankind itself. A family has its own rules and boundaries. Individuals in a family have their own habits and express themselves originally to the outside world.
- **Traditionalism** - family is the traditional basic unit of society. Society has yet to offer anything better than the Institution of Family.
- **Conservatism** – family is characteristic by its values, culture and traditions. It has a regular structure which, in the most narrow sense, is comprised of parents and children.
- **Sacrality** - family bonds are sacred for its members. Family members cooperate, support and help each other.
- **Protection** - each and every family creates an own household, an own domestic community. Family members understand and respect each other's moods and opinions and know whom to turn to if they need something.

However, we observe that in present times, the traditional features of family seem as if being reduced, ridiculed or even atomized. Universality and Traditionalism are two basic characteristics that presumably persist up to this day. Conservatism is frequently pushed back by legalized heterosexual (i.e. concubinage) or even homosexual unions. Family sacrality is often atomized by

forms of cohabitation, which the current society calls by the terms *single family* or *mingle family*. Protection is the „Cinderella” feature of relationships which are supposed to be normal, balanced and meaningful. It is the typical feature of the so-called *patchwork family*. We will describe these contemporary family types in the following sections.

Development of the emotional aspect results in the development of the social aspect of the personality. Moreover, the interconnection of the cognitive, affective and psycho-motor areas projects itself into the axiological sphere; in other words, into the value system. In this Chapter, we will focus on specific types of family formation in the present. Our aim is not only to provide a descriptive characteristic of these family forms, but also to point out their negative impact on society, family and the individual.

Single family

In recent years, there is a growing trend of single mothers having children without a partner, or rather, not relying on the man whom they have the child with to assume the role of the father. Due to the fact that the divorce rate is rising, the number of people who have children but do not have a partner is also increasing. The logical outcome of this situation is the so-called single family, more and more frequently formed and often identified with the motto „*I want a child - I don't want a man.*” (Tománek, 2012, p. 84). It might seem reasonable to believe this form to be caused as a result of the lobbyist and hedonistic motives of women. On the contrary, women often choose this lifestyle because they haven't found anyone with whom they would be willing to share their life. Furthermore, they prefer this choice in order to evade potential problems basing their decision on the experiences of a large number of abused or divorced females. Finally, women want to emerge as pregnant victors from experimental relationships, which they entered out of pragmatic reasons. As a matter of fact, many women sign a „certain form of contract” (Patchworkfamilie, 2012) with men, agreeing not to demand their official acknowledgment of paternity nor require them to pay child support.

Based on acquired data, we conclude the advantages and disadvantages of single families:

Reasons for staying in *single families*:

- Young people nowadays reach psychological maturity much later, owing to the fact that they spend a longer time preparing for their future career; take more time to become independent; try to experience as many things as possible. It is difficult for young adults to imagine a first love or longterm relationship as the terminal station of their love life.
- Single people do not particularly attach themselves to a specific place. They desire to travel and get to know new cultures and people; learn new things; lead an active life. It is possible to accomplish all of this together with a partner as well, but not without having to submit to their interests and needs as well. Such compromises require the ability to adjust one's own priorities.
- People who settle down and have a family early on in their life may feel to have missed out on something or feel not to have enjoyed life enough. Such feelings can end up in clashes or even breakdowns of a family.

Disadvantages of single families:

- People, who have been without a partner for a longer period of time have a tendency of becoming depressed (their state becoming more severe with every approaching fall); having headaches; being tired more often; being more prone to contracting illness.

- Some people have an irresponsible attitude towards life and are not able to „take matters into their own hands” regarding freedom as an excuse to enter short-term relationships.
- People can also be less self-confident and as a result, refuse any intimate interaction. Alternatively, people exceedingly focused on building their career sometimes forget that they need to socialize or relate with others.

Mingle family

The term *mingle* was created by combining two mutually contradictory words *married* and *single* (derived from the phrase „married but single”). The *mingle* trend arrived to Europe at the beginning of the third millennium, emerging from North America, where it has already become a widely established family type. It can be simply described as living together in marriage but at the same time having freedom and not being committed. E. Beck-Gernsheim (2000, p. 33) adds that „It is not completely ruled out, that the husband [in these families] goes to a different woman (his mistress) with whom he has a child. The husband acknowledges his paternity of the child, pays child support but does not want to get a divorce. He often even forces his own wife to respect the situation and think of it as normal. Naturally, the wife suffers because of this and takes legal action. The husband comes home, sleeps, does his laundry, eats and then goes again to his mistress's, who is expecting him. Essentially, the responsibility in both relationships formed by the husband is a pretense.”

The phrase *mingle family* includes traditionally used terms which are contradictory. Hence, in families we can come across the denominations „married single woman [mother]” or „married single father” (from the German „*verheiratet, ledig Vater*“, and „*verheiratet, Single-Frau*”).

The function of the family becomes considerably complicated. The parents are, and yet are not together. They form, and yet do not form something together. The spouses live in a long-term relationship but each of them maintains their own household. Partners in the so-called *mingle* relationship meet when they have got the time and desire for one another. They organize moments shared together and inform each other about the time they have spent individually. In this sense they are just like other traditional couples. However, the difference is that when they are together, everything else is put aside.

Mingle families are very arduous with regard to trust and tolerance. They do not offer a feeling of safety and security for smaller children, who are in need of a stable family background. Mingle families can conceal extramarital affairs and are therefore rather a type of an open marriage. They are ideal for people working in different cities or caring for sick parents. The spouses forming these types of families are often called „sometimers”, „monthlies” or „weeklies” (Beck-Gernsheim, 2000, p. 11, 15–18), according to the frequency of „entering” their own family.

Based on the acquired data, we conclude the following advantages and disadvantages of *mingle families*:

Reasons for staying in *mingle families*:

- Retaining a certain degree of independence and irresponsibility
- Having time for one's career, friends and hobbies
- Relationship does not become stereotypical
- Coping with breakup is easier

Disadvantages of mingle families:

- Irresponsibility in relationships
- Indulgence in bringing up children
- Partners regard each other as a commodity rather than as a person
- Rapid fall in birth-rate (demographic fluctuations)
- Encouragement of hedonistic and egotistic behavior
- Gradual disappearance of mutual trust between the partners/spouses
- Lack of a cohabitation-related habits
- Confusion among younger children, who do not know how to address the new partners in the family

Patchwork family

Patchwork family is another specific type of family. The term *patchwork* itself usually describes a cover joined and fastened from several different pieces of fabrics. In spite of appearing to originate from English speaking countries, at first sight the term has actually spread in the EU from Germany, where the word designating bed sheets patched from multiple bits of cloth transferred onto the phenomenon of a certain emerging type of family. A patchwork family is a form of family that is „patched” from various family members, bound by blood or non-blood relationships. In most cases, members coming from previous families enter a new family, in which they are as if „patched” to a different piece of „fabric” - to a different family, either a functional or an atomized one. It is a „second try” family, since the first try did not turn out well for some reasons. *Patchwork* is a blanket happily sewn together.

Nevertheless, as far as cohabitation and family is concerned, there is always a piece of explosive matter sewn into the blanket as well (usually in the form of complicated social relationships). The divorce rate is constantly increasing, and the number of people looking for their next partner to enter the „marital second hand” is growing correspondingly. The number of children raised out of wedlock has grown sevenfold over the last fifty years, and this trend is still on the rise (Arlt, 1996, p. 34). Similarly, the Statistical Office of the Slovak Republic states that the number of divorces as well as the number of remarried people tripled in the past twenty years (Štatistický úrad SR, Demografia, rozvody, 2010).³²

What is it all about then? Let us provide a case study:

„Katka is forty years old. She married right after graduating from high school. She gave birth to two daughters. After ten years, Katka divorced her husband and found a new partner, Peter. Peter is also divorced and has two small children from his previous marriage. Katka and Peter move in together and live in a small town near Prague. They have a two-year old boy together. Ordinarily, Katka and Peter live in their house along with their son and with Katka's younger daughter from her first marriage. However, they take care of two small children from Peter's first marriage, as they share custody with Peter's first wife, Alena. Furthermore, Katka's older daughter, who attends school in Prague during weekdays and therefore lives with Katka's first husband, joins the family on weekends. Katka's former husband as well as Peter's ex-wife also have new life partners. The whole situation is very complicated regarding the issue of parenting, because all parents are strict to their own children but lenient towards the „other” children with whom they form the so-called patchwork family.”

³² Available at:

http://portal.statistics.sk/files/Sekcie/sek_600/Demografia/Obyvatelstvo/grafy_mapy/2010/sobasnost-rozvodovost2010.pdf [cit. 30.11.2012]

Similar cases have existed in Slovakia for a few years now. The divorce rate in Slovakia is currently 52%. Out of these 52%, approximately 9-10% of divorced people remarry and form a new family - mostly of the *patchwork* type. Additionally, up to 4% reenters marriage a third time and creates the so-called *patchwork* family again. By comparison, 12.5% of the population formed *patchwork* families in Germany (Patchworkfamilie, 2012), whereas in the Czech Republic it was as much as 14% in 2011. The Statistical Office of the Slovak Republic monitors the divorce rate only it does not observe whether there are more divorces coming from civil marriages, Catholic marriages or marriages formed under various Church or religious communities which have signed a contract with Slovakia (and are therefore acknowledged by the State). Since the divorce issue is a legal matter rather than a statistical one, the Statistical Office can acquire limited information about the divorce rate of civil and Catholic marriages only additionally and only at a district or regional level. Such inquiry represents not only a tedious and arduous process, data gained retrospectively would no longer be actual. Marriage dissolution is no longer considered a fatal failure; on the contrary, we are witnessing the so-called “normalization of divorce”. People make allowance for the possibility of divorce, adjusting their life strategies accordingly. For example, women only seldom dedicate themselves to their family to the extent that it stands as their sole mission in life. Paradoxically, coping strategies, which prepare a person for the eventuality of divorce, make divorces easier, thus supporting their growth. Furthermore, with the simplification of marital divorce or relationship dissolution, it is also easier to find a new partner, who is single. This leads to new attempts at having a family and new breakups, eventually resulting in more and more complicated *patchwork* families. Social (Artl, 1996, p. 36), existential, but also religious and cultural factors in *patchwork* cohabitation lead to severe complications. In Slovakia, *patchwork families* are often called „renewed” or „reconstructed” (Sisáková, 2011).

Based on the acquired data, we conclude the following advantages and disadvantages of patchwork families:

Reasons for staying in patchwork families:

- Mutual communication, especially elements of negotiation, problem-solving and finding compromises
- Only children gain a bigger family and siblings
- Economic function of the family is reestablished, patchwork families are economically more stable than single families
- Improved ability for social adaptation

Disadvantages of patchwork families:

- Extremely strict upbringing of own children
- Excessively lenient parenting of stepchildren
- Good parent/bad parent situations (step-father, step-mother, ...)
- Boundless tolerance (The “new” parents want to appeal to each other in the first place. However, they accomplish this through their own children and through the stepchildren. They influence the children's behavior by their own attitudes, demeanor and actions, in order to get closer to the new party (spouse, children from previous marriages, etc.)
- Cohabitation of siblings and step-siblings. In the example case mentioned above, common issues related to cohabitation arise.

E.g., „*Katka and Peter have got their previous relationships sorted out. Nevertheless, they constantly come across various problems. Katka's daughter from the first marriage was taught to turn on the TV only after having finished all of her duties. In comparison, children from Peter's first marriage are used to being allowed to turn the television on anytime, even if it's during lunch. From Katka's viewpoint, it seems correct to adhere to the rule of allowing her daughter*

to watch TV after attending to all of her duties. However, it is very difficult to do so as the television is constantly turned on. Peter, on the other hand, thinks that the upbringing of his own children should be stable – if the kids are allowed to watch the TV anytime they want when they're with his ex-wife, things should not be different at Katka and Peter's place.

- Rivalry with the ex-family: children who get in touch with their former parents often have the tendency to form a very competitive atmosphere in their new families. Distinction between who is a good and who is a bad parent is often made based on criteria such as „which of the parents had given me more” (in a materialistic way), „who had been the more lenient parent”, etc.

E.g., „*Our family is one happy household. Flowers are painted on the front gate, many clothes are hanging on the washing lines, a white dog is running around the garden. A big family with four children lives in this household. Everything seems to be ideal until you take notice of the doorbell. There are four surnames on it. As a matter of fact, these four children have two mothers and three fathers. Moreover, they have got one sister who lives with them only on the weekends, and they have two other step-siblings, who do not live with them at all as they are with their first parents - with their first father or mother. Things appear strange inside the household as well. Nothing seems out of the ordinary at first sight. All the boys, two aged seven, one aged two and one aged four, are playing in the kitchen while grandmother is sitting next to the stove. She has just finished preparing bread with spread for their morning snack and the boys are happily munching away. It doesn't seem to matter, that only two of the boys are her own grandsons.*”

- The sole essential purpose of parenthood is disappearing: i.e. being a full-time mother or a father. The role of mother and father is frequently divided between the other „parents” in these families. Responsibility also becomes fragmented.
- Firm boundaries of family traditions, belief and values are absent.
- Manipulation of parents by the children or vice versa.
- Jealousy among the children.
- Sexual harassment: people of the opposite sex live in close vicinity but are not protected by the bastion of the incest taboo. Man does not have to take on the active role, an adolescent daughter may try to seduce her stepfather or stepbrother (Beck-Gernsheim, 2000).

According to Swiss Psychologists and Sociologists, a minimum of two years is necessary for all individuals entering a *patchwork* family to gradually adapt (see more in Patchwork-familie. Ch, 2005). In other words, two years are a trial period for these families. If such a family acquits well, the upbringing of children and adolescents does not fall behind regular parenting in a traditional family setting. However, if the ideal state is not achieved within two years, the cohabitation usually dissolves and the desire to form a new relationship re-emerges. In contemporary society, this phenomenon is called family tourism, from the German „*Tourismus Familien*” (Beck-Gernsheim, 2000, p. 35). Parents visited by children in joint custody are usually addressed as „weekend parents”. The author E. Beck-Gernsheim (2000, p.35) adds that the usage of terms such as „ex-husband” and „ex-wife” in the newly-formed *patchwork* families is fading in society (she mainly means the German-speaking and French-speaking countries). These old terms are being replaced by the words „*Vorman*” and „*Vorfrau*”, i.e. „pre-husband” and „pre-wife (as identification of the ex-spouses).

4 The situation in Slovakia and in the EU

A family is a specific type of social environment (Tománek, 2012, p. 81), a cultural unit where upbringing and values (either material or spiritual) are passed on. Nevertheless, family and marriage have lately been exposed to a large number of changes, especially those of the demographic sort (Sekera, 2010). We believe that some of the most frequent of these changes are the following:

- Increasing age of women entering marriage;
- Noticeable decline in birth rate;
- Family structure reduction (a maximum of two children);
- Incomplete families;
- Divorce rate;
- Registered homosexual and heterosexual partnerships;
- Fear of having children;
- Lack of money;
- Accommodation space;
- Impotence;
- Deprivation (needs unmet for a long period of time);
- Atomization of family (dissolution of the traditional family);
- Entropy - disintegration of family, etc.;
- Workaholism;
- Prostitution and pornography;
- Addictions (internet, drugs, alcohol) and gambling (Fešková, 2007);
- Various deviations (Kuruc, 2006);
- Liberalism;
- Intergeneration issues;
- Rise of individualism;
- Contraception availability;
- Declining influence of churches and traditional religions on families;
- Induced abortion rate;
- Change in the position of women;
- Increased mobility;
- Dissolution of traditional unions (Tamášová, 2007, p. 38).

One of the main trends in today's society are the so-called *prenups*, or **prenuptial contracts**. The term itself is widely known to the public owing to its large popularity and presentation in the media. It is basically a contract between two people (the engaged couple, i.e. future spouses), which binds both parties to its contents. Apart from other matters, it deals with the amount and size of property of each of the partners entering the marriage. What this in reality means is that usually, when the engaged couple gets married, they „bring” their property into the marriage by means of the prenuptial agreement. In case of divorce, the prenup guarantees that they will not lose the property with which they entered the marital bond. Even if the prenuptial contract may not be unconstitutional, it is fundamentally unethical.

Living in heterosexual partnerships (so-called **concubinage**) is still probably the most promoted trend in contemporary society. Many young people do not want to confine themselves to a permanent relationship by means of marriage. They rather choose the option of „simply” living, buying things and acquiring property together. Moreover, they do not plan on having children. Were the relationship to break up, they divide the property accordingly with their contribution or

by judicial settlement. This behavior is usually rationalized by the following statements:

- We will not marry, so we eventually do not have to get a divorce;
- We will not have children, because to have children in today's society is a luxury which we cannot afford (having a child is expensive);
- We have to enjoy ourselves before entering marriage;
- We need to know, whether things will work out between us or not;
- We want to build our careers and marriage would be an unnecessary burden (spouse, children, food, etc.)

5 Actual facts regarding the issue in question - challenges, prospects and recommendations for real life

In this Chapter we will not only contemplate certain phenomena brought forward by the opposition to marriage and partnership, but also provide and discuss relevant facts.

• Countries which have yet to legalize heterosexual/homosexual partnerships often face ridicule for being backward, somewhat traditionalist and conservative.

We, however, object: „Not all that is modern is also good and ethical.”

• According to Swiss and German studies (2010-2011), which had 20.000 homosexual participants, more than **68% of homosexual people are actually bisexual**³³. *Yet, R. Uzel, a Czech sexologist, states that bisexuality does not exist - that which is called bisexuality is only a strange type of behavior.* This leads us to the following questions: What is homosexuality in reality? What attitude should we assume towards it?

• Not family, but marriage is facing a crisis. Young people do not marry; they do not enter or form marital communion; which frequently results in *single, mingle, patchwork or homosexual families* (Tománek, 2012b, p. 44-63).

• **The need to view the full picture:** countries with legalized homosexual partnerships (e.g. Netherlands for more than 12 years) are currently dealing with the issue of children brought up by homosexual partners. As many as 57% of the children from homosexual families have mental and social problems. Why? Do children from heterosexual families not have similar problems as well? The answer is ‘Yes’, but there is a big difference in their number. As Pastor mentions in his study (2012, p. 268), it is 74% of children from homosexual families and only 26% of children from heterosexual families who face these issues. Why is it so? While in heterosexual relationships a major crisis leading to breakups occurs between the period of 5-7 years after living in a marriage, homosexual relationships face this crisis between 1.5-3.5 years after living together (Pastor, 2012, p. 262-268). This means that a change in partners takes place 2 to 3 times earlier than it does in heterosexual relationships. Not to mention the topic of the actual upbringing of children (biological or adoptive), who lose the stability of any relationship due to their „parents” frequent breakups³⁴ (in Netherlands, Australia or Great Britain for example³⁵).

• **Every minority group which „enters the market”** (e.g. a new religion, sect, alternative

³³ *Protect the children:* www.lds.org/general-conference/2012/10/protect-the-children (cit. 4.6.2013)

³⁴ *Adoptive couple vs. Baby girl:* <http://www.law.ufl.edu/academics/centers/childlaw/> (cit. 4.6.2013); Also: The negative effects of same sex marriages: <http://christocentric.com/main/?p=992> (cit. 4.6.2013)

³⁵ *Protect the children:* www.lds.org/general-conference/2012/10/protect-the-children (cit. 4.6.2013). Also: Gay family?: www.sltrib.com/sltrib/news/...78/gay-family-parents-lgbt.html csp

to marriage, ...?) has to offer some benefit to society. What do heterosexual or homosexual partnerships bring?

- **Issue of concubinage** (cohabitation): *concubine* means a companion or prostitute. It is an older term for cohabitation of heterosexual partners. The word concubinage is derived from this term. Pastor (2012, p. 265-268), citing German studies from 2008, states that marriages formed after previous cohabitation of the spouses get divorced during the first 10 years.

Contemporary family is threatened by multiple external and internal factors, which are (Kovačič, 2002, p. 48):

- Social influence, trends, attitudes and intentions,
- Entrepreneur and market environment,
- Insufficient countermeasures on society's behalf,
- Modernization and liberalization of society,
- Decrease in positive influence of religion and piety,
- Degradation of culture,
- Destruction of family bonds,
- Instability of marriages,
- Unpreparedness to form a family,
- Consumer lifestyle,
- etc.

We often come across the opinion that contemporary family and parenthood are undergoing a crisis. The world provides us with information about the degradation of society's moral norms; about dissolution of marriages; families; about violence; brutality and so forth. Society is gradually losing control of its emotions; it is falling into solitude; emotional numbness; and disregard for not only familial but often also workplace relationships. Family is becoming a primary concern of the market. Moreover, family is opposed by virtual reality, a world represented by a fearless, „aggressive, emotionally unstable and labile” (Gálik, 2003, p. 16) virtual hero.

The basic grounds for potential family issues (school issues consequently related) chiefly consist of:

- Propagation of liberal relationships formed without a correctly concluded and legitimate marriage (partnerships of persons of opposite or same sex, trend of wanting to have a child but not wanting to have a husband, etc.),
- Degradation of human sexuality through billboard display (e.g. advertisements for building materials, eyeglasses, musical instruments, clothes or shoes with a partially or completely naked female or male in the background),
- Tolerating pets as family members (preference of animals to people, excessive attention to pet food, respect, care, clothing, walks in parks),
- Scandal-oriented news,
- Social Networking (Facebook, Skype, Icq, Pokey, etc.),
- Basic misunderstanding regarding the meaning of the terms „sex equality” and „gender equality”,
- etc.

Reasons behind these problems often lie in:

- Insufficient love between spouses and instability of families. Children have more and more difficulties perceiving and receiving love from their parents. This is due to the fact that children do not see or feel love between their parents

- Parents not having enough time (Ferrero, 2007, p. 64) to constantly pay worthwhile attention to their children and to reason with them in a patient and rational manner. Adults lack the time to instill values and other important things in their children. Additionally, they are unable to explain to their offspring certain procedures of how to do things, or the reasons behind and causality between specific processes - how things work and why.
- Indifferent attitude toward religion, practical atheism or even religious pluralism.

Recommendations for real life

Based on the previous chapters, we suggest the following preventive measures for families and family education in order to tackle the aforementioned issues:

- Provide more space for family and media education in school curricula. This will allow students to learn how to behave towards their parents and other people. Additionally, they will become better at accessing and using media as well as improve in identifying and evaluating relevant information.
- Encourage better cooperation between parents and teachers,
- Emphasize meaningful leisure-time use: limiting time spent on the computer to school-duty related activity, practicing sports more, playing a musical instrument, drawing, and pursuing visual or dramatic arts,
- Intensify pre-marital preparation: education for marriage and parenthood (lectures, presentations, discussions) along with education for responsible sexuality. Sexuality likewise plays an important part in media education. Attitude toward sexuality cannot be ignored, disregarded, neglected nor abolished as it is an inseparable element of human personality.
- Stress the importance of family, marriage, giving birth to, and raising children in the framework of subject curricula of religious, ethical and civic education in schools,
- Support preventive activities at schools (inviting guests competent to address the issue),
- File complaints to the local media regulation authority against inappropriate programs or advertisements: e.g. to the Arbitration Committee of the Slovak Advertising Standards Council (website: <http://www.rpr.sk/en>)
- Promote positive role models (not celebrities, etc.)

Conclusion

In spite of all the presented information, the topic of our article remains an open and unresolved issue. We would like to emphasize that although our aim was to objectively contemplate the phenomenon of marriage and registered partnership, new data regarding significant promotion of multiculturalism and multi-religionism in our environment still needs to be addressed. We have outlined current findings and facts relevant to marriage and registered partnerships in order to provide a framework for better reflection of these forms of cohabitation. Homosexual or heterosexual partnerships, regardless of their legitimacy, cannot be regarded as equivalent to matrimony. There is no adequate replica or alternative to the marital union, as marriage has always been defined as an equal communion between a man and a woman throughout all history of mankind.

It is said that “He who wants to build high towers must dwell with the fundament for a long time.” We must establish firm foundations to be able to build upon them. Family, society or an individual cannot simply build high-quality relationships on shallow ground. After all, the maturity of an adult person is measured by the quality of their relationships, and not by the quantity. If we start putting off “faulty” families or relationships, will then forgiveness, convergence, reve-

rence and respect towards others not disappear from society? What is more, are these not the fundamental features of a stable and balanced personality, one that is beneficial to society?

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Reflection & Possibilities of Expert Graduation of St. Elizabeth University of Health and Social Sciences Graduates in the Field of Social Work

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Abstract

St. Elizabeth University of Health and Social Sciences in Bratislava has been preparing students in Social Work for 10 years. We have considered it beneficial and important to provide some reflections on Social Work Graduates in several areas which often resonate in the settings of each University and to which the students do not receive the responses. It is about the quality of provided Education; study organization; content of study program; interest in the possibility of Continuing Education. Based on research performed, this paper provides several directions for the subsequent Education of Social Workers and Graduates and their participation in the Alumni Program.

Key words: Social Work. Study Graduate. Education. Study program content. Continuing Education.

Introduction

St. Elizabeth University of Health and Social Sciences (VSZaSP) has been presented in Slovakia and abroad as a non-profit organization for 10 years. The Founder is Prof. Vladimír Krčméry, M.D., DrSc., multi. Drhc. From the very beginning, the aim and the idea of the University itself has been to provide Education in the Professions that are inevitably connected with the activities focused on help to people with health problems and adverse life situations; particularity unique in the curriculum is the creation of projects in developing countries around the world. Currently the school is managing 62 projects focused on help to poor people; people in the threat to life; threat to existence itself. Education for Social Workers is naturally included in the University's mission frame; meaning is influenced by growing economic problems; family crises; providing social services for different client groups; increasing social - pathological effects and problems related to the field of social protection of children, youth and adults. VSZaSP St. Elisabeth in Bratislava was established at this stage of dynamic development of the study program. The first 340 Graduates in Bachelor Study finished in the Academic Year 2005/2006. VSZaSP gained accreditation for Education in Social Work at all levels of University Education and also gained the rights to grant Teaching Grades to Associated Professor and Professor in the Field of Social Work.

Social Work in Theory and Practice

The Foundation of Social Work as a field of study is undeniable. Social Work may be seen as a Science or a practical activity or an application of methods of various Social Sciences via Social Work Practice has been discussed in Academic environments for several years. It is important to realize that the relevance of Social Work also has been affected by the fact that social policy represents a new direction and distribution of responsibilities between the State and the citizen have significantly changed: with emphasis on empowering citizen's responsibility not only for the quality of his/her life, but, also for his/her family. It is very important to select appropriate applied methods of Social Work that should avoid personal and social disintegration of the citizen and should act against long term persistence in a situation of dependency on help from the others so that the State's limited resources are not inefficiently depreciated.

Basically, from a beginning of creation of Social Work as a field of study there has been ongoing discussion about anchoring the Profession in the practical environment where the Social Work is conducted and also about acceptance of Social Work as a Social- Scientific Specialization. Thus, at this point we highlight the following issues:

- For many years, there has been an on-going but poorly structured, and often particular debate about who is and who is not a Social Worker; who can perform this Profession; which Education and skills are essential for its performance; whether it is an independent scientific discipline and Profession or just a cover for a set of activities and knowledge from other disciplines, i.e. discussion about the nature, definition, character and limits of Social Work.
- In the previous decade, the dynamic growth in the number of Schools and Educational Institutions offering Education in Social Work was followed by fragmentation of the Education programs, contents, performance and quality of compulsory student practice as well as an absence of a comprehensive Institutional, Continuing Education System for Social Workers.
- Current Practice in employment of Social Workers in Public Administration and in Social Housing Facilities uses too wide a definition of Educational qualifications without standard definition of the qualification requirements, scope or sectional Education of Social Sphere Staff. This results in an insufficient competency for employees; backwardly, negatively affects the overall perception of Social Work as a Profession; doesn't lead to the creation of standardized conditions necessary for its Professional performance.

Results of the VSZPaSP St. Elisabeth Graduates Research in Social Work Field of Study

In accordance with Instructions from the *Ministry of Education, Science, Youth and Sports*, the University periodically organizes an Education Process Assessment by students; statistically evaluated; where the results are fairly favorable; creating conditions for continuous improvement of the Education quality in the various fields of study.

Evaluation of the Education in particular contexts by Graduates is relatively rare. In our findings, we did not note any relevant research results of Public or Private Universities, which would, at least, partially reflect the opinions of Social Work Graduates. Individual Universities find interesting those researches which monitor versatility of the Graduates and their satisfaction with the studied program.

In the Academic Year 2010/2011, we performed research via an electronically sent Question-

naire to 1,837 respondents. The research was focused on the following key areas:

- Motivation for Social Work Study
- Utilization of Knowledge and Skills in Professional Practice,
- Reflection on the Study Program Content in Social Work and the Quality of Educators,
- Interest in Continuing Education and Professional Graduation in Social Work.

Graduates of the 1st and the 2nd Levels of University Education in the field of Social Work had participated in the research. We supposed that the most of the respondents would be women, which confirmed in **Figure 1**.



Figure 1. Gender of the Respondents. Women 84.88% Men 15.12%

A similar composition of students is also present at other Public Universities. In fact, the statistics for Social Work student gender differentiation is recorded for a variety of reasons which we do not consider necessary to discuss at this point; women especially demonstrate interest to in Social Work.

When we followed the interest - the Graduates' motivation to study Social Work - the results surprised us with their spectrum of responses and also with quite high percentage oriented on obtaining the knowledge; interest in working with people; interest in the new field of study; etc.,. Respondents could mention more possibilities of their answers; we present results in Figure 2 in percentages See below.

- I'd like to enlarge knowledge in Social Work (54.3)**
- I am interested in helping to solve people's problems (46.6)**
- Nowadays it is important to have a University Degree to employ (44.6)**
- I am interested in Social Work as a field that has never been studied (35.1)**
- I want to earn a chance to assert on labor market (30.4)**
- If I want to hold my position, eventually get better, I have to start... (13.6)**
- I have not had possibility to study before (8.7)**
- I need to gain title for my social life (7.9)**
- The employer gave me the condition to start study (2.1)**

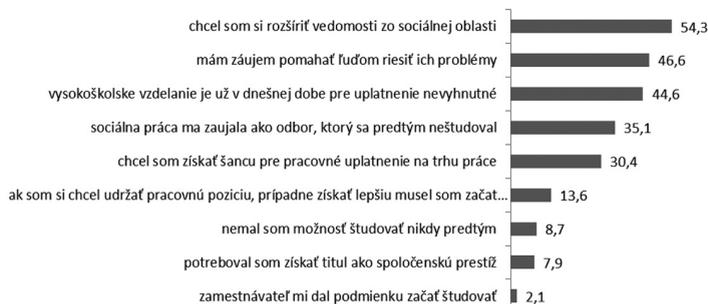


Figure 2. Reason to Study Social Work

Compared to previous years, the situation has changed, especially for motivation which was conditional for keeping the job; 13.6% responses or 2.1% depending on conditions from an employer when an employee must start studying. As a positive result can be considered a relatively low per cent of effort to get aimed to receive the social accreditation via University degree (7.9%), we could say this tendency is not so strongly preferred, despite being often discussed in the public community.

Evaluation of Education quality provided is quite complicated; during study the students have the opportunity to comment on the Education quality provided; results being evaluated yearly. In general, we could establish the Graduate's satisfaction with the Education (satisfaction expresses study organization itself; quality of teachers in the Educational process; as well as the level of knowledge and skills gained for further practical application). To these findings we formulated the question:

„Express your satisfaction with finishing the study in the field of Social Work.”

The results are presented below in **Figure 3**.

61,2 % Satisfied

20,8 % Neither satisfied nor unsatisfied

3,6 % Unsatisfied

0,4 % Very unsatisfied

14,5 % Very satisfied

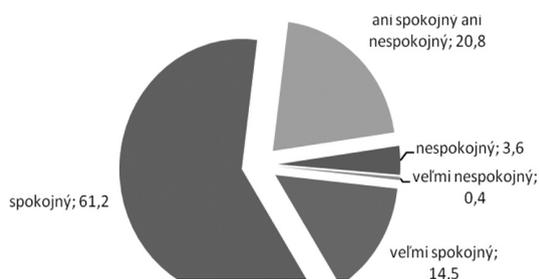


Figure 3. Expression of Satisfaction After Finishing the Studies in Social Work

We were also interested in the answers of respondents about their use of knowledge in Professional Practice. We found positive the fact that the Social Work Study Program compiled at VSZaSP achieved a very high per cent rate combined with the use of the acquired knowledge in huge scale (23.3%); „partly used” (58.2%). Partial use may be associated with the fact that candidates who study Social Work, especially in external form e.g. employees of Ministry of Interior, Health and other government entities, and may not be in contact with clients who have social problems. The results are presented in the following figure 4.

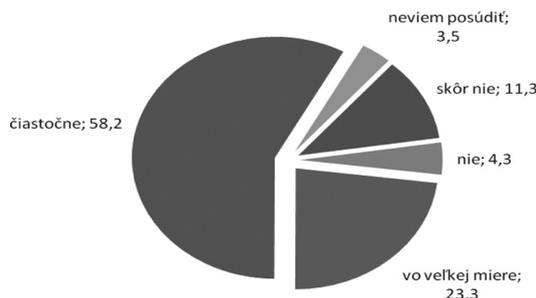


Figure 4. Use of Knowledge Gained During Study in Professional Practice.

Relating to of the study program content in the field of Social Work, we asked the question which was related to a preference for one of the modules (set of study subjects). Respondents rated on a prefer-scale from 1 to 5. The question was:

Which of modules do you consider the most important in Social Work Education?

Methods of Social Work (Methods of SW, Street work, Social Advising, and Supervision, etc.)

Social Skills Training

Social Policy (applied Soc. Policy, securing, employment policy)

Applied disciplines (SW with seniors, addicts, handicapped persons, etc.)

Theory of SW (TSW, introduction, basis of SW)

Law disciplines

Co-operating Science Disciplines (Psychology, Pedagogy, Sociology, Philosophy)

Student Practice

Final work and research procedure

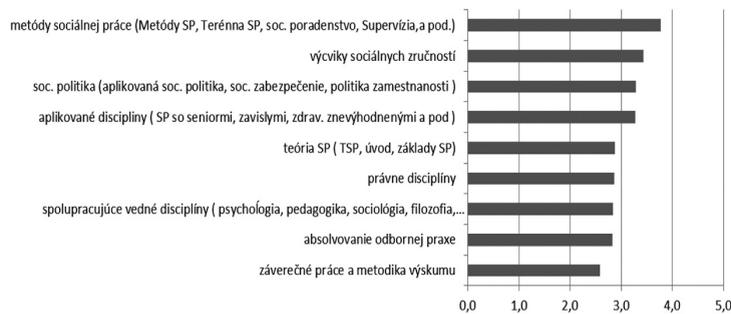


Figure 5. Preference of Some Modules of Study Content in the Field of Social Work.

Based on these results we state that Graduates find important to gain knowledge in the field of Social Work methods, in social skills training, social policy and in applied Social Work disciplines. Less preferred is a theory in field of Social Work, which may be associated with the severity of transmission of Social Work theoretical concepts in the application practice using the appropriate methods of Social Work. Less frequent responses were items related to social-science disciplines.

This fact, on the other hand, points on the need to orientate the teachers into the finding opportunities to bring different disciplines to Social Work and the possibilities of mutual enrichment of these disciplines together.

Linked with social practice, as well as with the Social Work students we are often warned of need for further Education of Social Work Graduates. At this point it should be noted that the Ministry of Labor, Social Affairs and Family in Slovakia has not created a system of continual Education for Social Workers yet, this need is not anchored in any legislation, notice or concepts. The problem is that the increasing expertise for performing activities in the field of Social Work does not create a premise for wage increase or career promotion. However, the respondents' interest for Education is evident. Respondents could assign several responses (Figure 6).

50,1 % Further Education in Accredited Study Programs

46,6 % Conferences and seminars

29,6 % Rigorous act

29,5 % Postgraduate Study

16,4 % Prepared attested Education

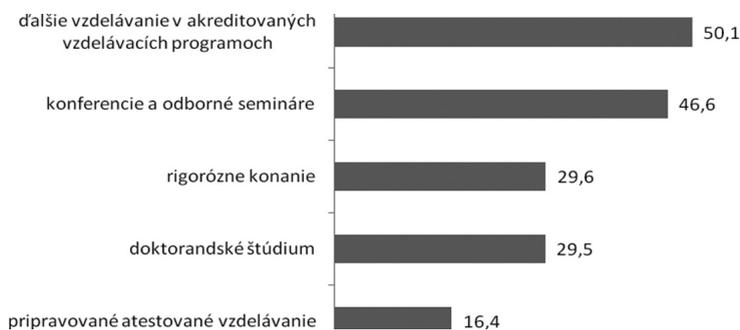


Figure 6. Respondents Interest in Expert Graduation.

Respondents would most prefer Continuing Education in Accredited Study Programs. The challenge to ensure Alumni¹ programs for Graduates is their interest at Conferences and Seminars. However, attested Education for Social Workers is not supported by any legal standards or legislation. In this type of Education, Graduates obviously see such a confirmation of better expert competence with a higher weight than the finishing of a study program. The concept of attested Education at St. Elizabeth University of Health and Social Sciences is in process².

Quite the same response per cent rate was interested in the Post Graduate Studies and rigorous procedures. Approximately 1/3 of Graduates are considering further study, which may be in compliance with the over all trend to make Post Graduate Study available for a wide group interested in a third level of University study.

Graduates declare to have a positive relation to their school even after graduation. This establishes a positive condition for potential cooperation of Graduates in Alumni Clubs and in the area of Continuing Education. It is necessary to utilize this potential and create a space for organizing Education events within lifelong study programs. The aim in this area should be to increase public awareness, especially for our University Graduates about the „Alumni” promotion together with Club activities as well as the benefits associated with the membership in this Club. Under the Alumni activities, mainly we plan:

- Improving mutual awareness,
- Sending e-newsletters,
- Cooperation in Lifelong Education,
- Common Organization of Professional and Social Events,
- Other Activities Resulting from the Mutual Needs.

¹ In Slovakia, the term Alumni Club is more connected with schools in the United States. There is still a very low level of knowledge about the nature of alumni and it's relations and the Graduates. This activity is one way, but it brings the benefit for both stakeholders: teachers and Graduates. It seems as this idea has nothing to do with reality of Slovak Graduates. Some representatives of Slovak Universities have notified the need to maintain contact with their own Graduates, a number of such initiatives has developed but with less success. The inspiration for Slovak Universities may not be only the Alumni - clubs at American Universities have the longest tradition and most sophisticated system of cooperation with their Graduates. In Central Europe there are several good examples in Germany, Austria and Hungary.

² Attestation is a verification of achieved competences defined by Professional standards for relevant category of specialized staff in field of Social Work that was achieved by continual Education, self-Education or providing specialized activities. Attestation can be done only by expert staff in the field of Social Work, who achieved a University degree at least a second degree and have at least 1 year of experience.

Conclusion

In our paper, we present research that pointed out several facts that have never been evaluated. We found that the majority of Graduates are satisfied with the Education at the VSZaSP St. Elizabeth in Bratislava; Graduates highlight the importance of some study subjects; and what is pleasing is that they are interested in further Professional development.

We have to realize that it is a question of existential heading and practical back-up of the Profession in current Slovak Society; in its development; it is not just a question of purely academic, often discrediting the level and quality of the practical application of knowledge and skills of Graduates in Social Work Practice.

The prospect of positive change in the empowerment of Social Workers and the Profession itself, is the Professionalization of Social Work in terms of fulfilling the declared interest of the Slovak Government itself in the *Manifesto*:

Create conditions to ensure the Professionalization of Social Work.

Forthcoming legislative action should meet the expectations of Social Workers in terms of their Professional position and status.

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Problem areas of Social communication in Nurse-patient interaction in Clinical practice

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Summary

Appropriate communication is necessary in the sphere of mutual relationship between Health Worker and patient as well as in all other areas of daily living. Communication underlies all Nursing Care. Nursing Practice attaches considerable importance to the abilities of interaction and communication with patients (1). Social communication belongs to Health Worker's fundamental capabilities. It is an essential component in caring for a patient. Its effectiveness is determined by two parties, i.e. the Health Worker and the patient (6). In Clinical Practice, the Health Worker is more responsible for its course. This paper analyzes survey results in the area of social communication in Nurse-patient interaction.

Key words: Nurse, patient, social communication, interaction.

Introduction

Social communication represents a theoretical base for communication in Nursing Care. Communication carried out between the Nurse and patient is necessary, unavoidable and unrepeatable (2). In diseases, which cause permanent changes and defects, there can be personality changes that can evoke a sense of inferiority; diminished self-confidence; egocentrism; lack of interest up to personality degradation (4). The starting point of the survey was a review of current conditions in the area of communication in Clinical Practice in Nurse-patient relationship. The empirical part points out the level of Social Communication in the Nurse-patient relationship. Problem areas in communication which were elicited in the survey can be applied to remove mutual mistakes in the communication process in daily Nursing Care. Due to the revealed information, options for solutions in the field of Health Worker's training in the sphere of communication with various groups of patients can be designed, both within the training for a future profession and during life-long education.

Methods

The survey was carried out in 2012 in five governmental and non-governmental facilities of the Moravian-Silesian Region involving 564 individuals at Inpatient and Outpatient Departments. Within the survey Questionnaire method with 22 items in the Nurse Set and 20 items in the patient set were used.

In order to evaluate the survey the following methods were used:

Quantitative methods (classification of data, sums of answers, specification of order);

Qualitative methods (analysis, synthesis of Questionnaire items, comparison of Nurse's answers in various spheres of the workplace, comparative method).

In connection with the survey aim, working hypotheses partial goals were determined.

The set Nurse – hypotheses: Nurses are supposed

H-S-1: to have no troubles in establishing contact to patients and keeping rules of conduct.

H-S-2: to appreciate time and content capabilities during patient interviews.

H-S-3: to provide patients with confidential information properly all the time.

H-S-4: to behave professionally towards patients and not to detract patient's health conditions.

H-S-5: to find their visits to patients rooms sufficient and to keep rules of proper communication.

H-S-6: to have participated in Educational Courses and Seminars to develop their communication skills during their Clinical Practice.

Results

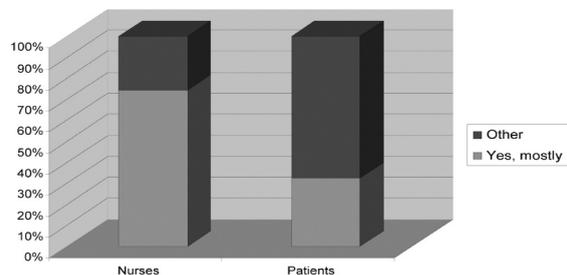
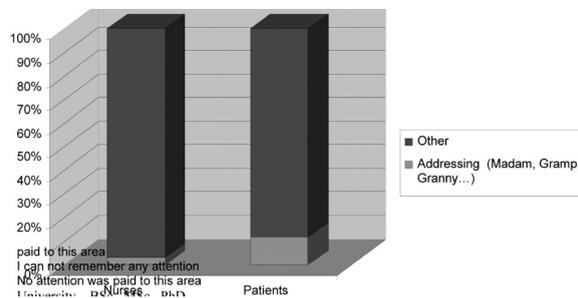
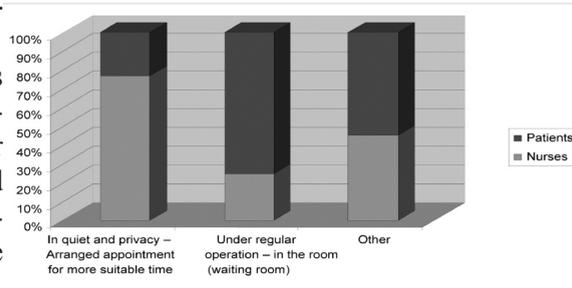


Figure 1. Addressing the Patient

97.0% of Nurses confirm that they address patients by their surname or degree and surname. 88.3% of patients confirm the Nurse's statement.



They encountered familiar addressing from Nurses 11.7%, which is 8.7% more than Nurses had said. From the table the Nurses do not indicate that they address the patients unprofessionally, according to their social role (Granny, Gramp...). On the other hand, some patients do not seem to be surprised and permit unprofessional addressing or they even wish it – maybe also to calm the uneasy situation and personify the relationship.

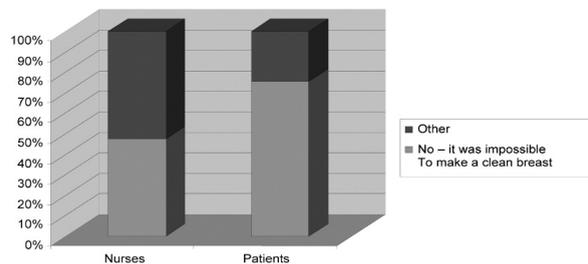
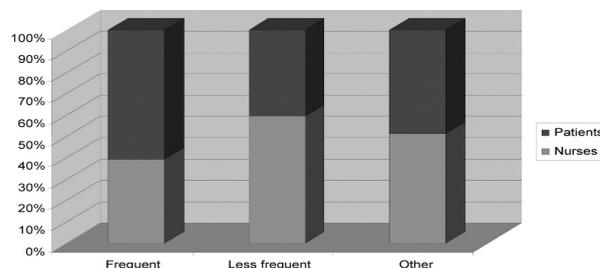


Figure 2. Time Capacity for an Interview

The Nurses indicate they communicate with patients and 74.4% devote enough time to the interview. Only 32.5% of the patients are satisfied with the time devoted to them by Nurses. Some patients claim that Nurses communicated only when explaining or educating; the Nurse was not able to communicate because they had much to do. Possibly some patients need more frequent communication with Nurses to discuss ordinary procedures of Nursing Care; education activity; or just want to have a chat.



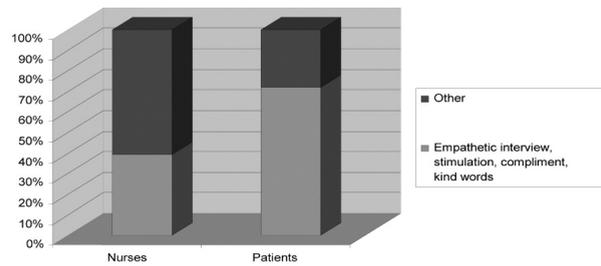


Figure 3. Telling Confidential Information

55.8% of Nurses responded that they provide information in peace and privacy and had arranged an appointment with the patients for the most suitable time. 16.2% of Nurses said that under normal circumstances they provided confidential information to the patient. Patients mention that 49.1% of the Nurses provided information under normal circumstances in the room or even in the waiting room.

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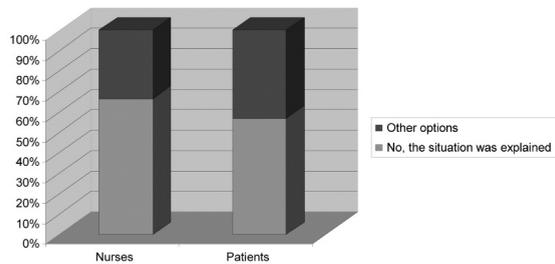


Figure 4. Detraction of Health Condition

The patients indicate that Nurses did not detract their health conditions but almost half of the Nurses listen to them; 47.3% of the Nurses let the patients talk and 52.7% work with the patients in the future.

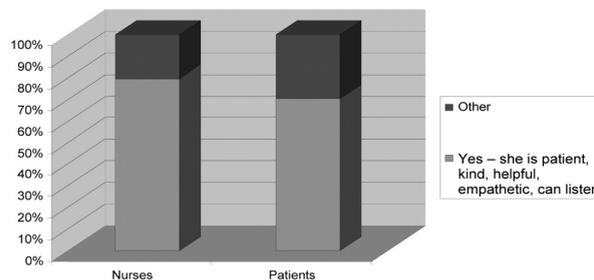
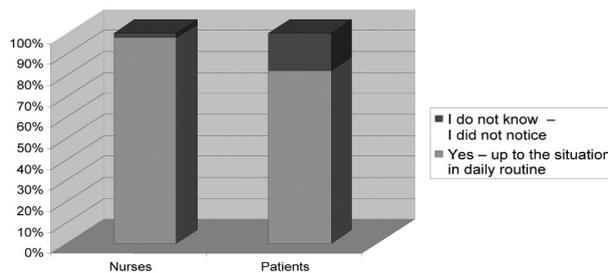


Figure 5. Nurse's Visits to the Room

50.9% of the patients-respondents wish frequent Nurse's visits to the room. 47.0% perceived Nurse's visits to their rooms to be sufficient. 53.8% of the Nurses tend to less frequent visits to patient's rooms. Only 33.0% of Nurses advocate frequent

visits to the room. 47.0% perceived Nurse's visits to their rooms to be sufficient. 53.8% of the Nurses tend to less frequent visits to patient's rooms. Only 33.0% of Nurses advocate frequent

visits to the room. Some Nurses give reasons for this situation because of Department Operations; too extensive Nursing documentation; they do not want to disturb the patients by entering their room.

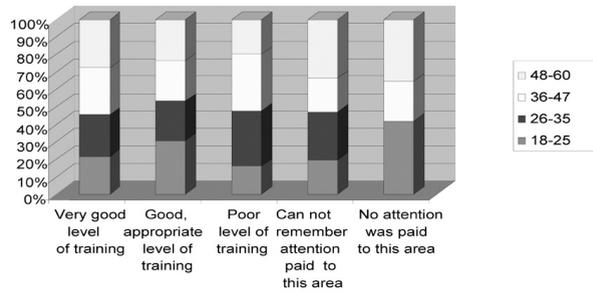
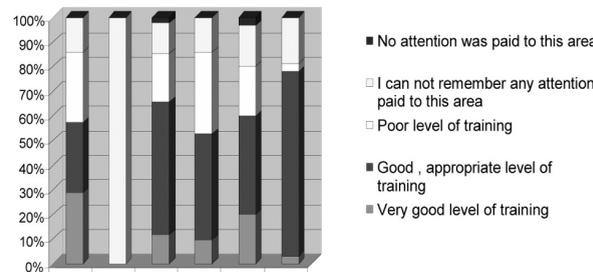


Figure 6. Interview to Overcome Anxieties

72.0% of patients highly appreciate this aspect of Nurse's Professionalism which is manifested by empathetic interview; pa-



tient's stimulation; smiles; kind words.

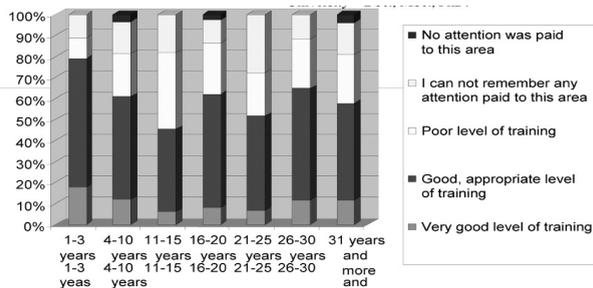


Figure 7. Engagement of Nurses

Within the study, it was confirmed that Nurses tried not to show their engagement to the patients or explain and give reasons for this situation.

Figure 8. Use of nonverbal communication

Nurses use nonverbal communication in their daily routine in contact with patients in Nursing Care almost 98% of the time. Patients confirm their statement 82.2%.

Figure 9. Ability to Listen

Patience, helpfulness, kindness and empathy belong to those traits which Nurses should apply in their Clinical Practice together with listening to patient's problems. Nurses are trying to listen to the patients almost 80% of the time.

Figure 10. Nurse's training for communication depending on age

Figure 11. Nurses' training for communication depending on education

Figure 12. Nurse's Training for communication depending on length of practice

In the sphere of socio-demographic data processing the Nurse set concerning evaluation of Nurse's Training for communication according to age, education and length of practice it can be stated that gathered data did not appear statistically significant.

To evaluate the hypotheses and determine most frequently occurring problem areas in Nurse-patient interaction a comparative method was used.

Evaluation of the Results of the Survey:

H-S-1 was confirmed. **Figure 1.** Nurses do not have any difficulties in establishing contact with patients and to keep Professional Rules of Conduct.

H-S-2 was confirmed. **Figure 2, 6.** Nurses try to make time for communication with patients in mutual interview and almost three quarters of them find it sufficient. In the area of content, they find empathic interview and acquiring patient's confidence most difficult which show better psycho-social characteristics by the Nurses. Patients would need more frequent communication with Nurses within professional and open discussion.

H-S-3 was confirmed. **Figure 3.** Mostly Nurses keep basic principles concerning patient's privacy. A part of the responding Nurses cope with this problem by shifting the problems to their Supervisors, avoiding conversation or regular contact.

H-S-4 was confirmed. **Figure 4, 8, 9.** Nurses do not detract the situation and use varied communication skills to improve the quality of Nursing Care.

H-S-5 was confirmed. **Figure 5, 7.** Nurses carry out regular visits to patient's rooms. Nurses find them sufficient. The set implies that the patients are of different opinions. Nurses keep basic rules of communication.

H-S-6 was confirmed. **Figure 10, 11, 12.** Nurses participate during their Clinical Practice studies through Educational Courses and Seminars. They are interested in the latest information.

Discussion

Health Workers are expected to accept patient's negative thoughts and provide them space, time and support (3). After analyzing gathered data it can be stated that the level of Social Communication between Nurse and patient has a range of problems. On a practical level, it means that it is necessary to anticipate these problem areas in their significance in Nursing Practice but especially included in communication schemes and gradually eliminated.

In the conducted survey, among the most frequently occurring problems are the time for interview; time engagement of the Nurse; telling confidential information; Nurse's visits to the rooms; assistance in overcoming patient's negative feelings.

Among problems in the level of Social Communication in Nurse-patient interaction, in the conducted survey, are social contact and addressing; ability to listen; ability to use nonverbal forms of communication; providing information in Nursing Care.

From the survey, it showed that the procedural aspect of communication is very sensitive. It means that in Clinical Practice greater attention must be paid to the level of the relationship between the patient, Health Worker and also the relatives. A lot of misunderstanding and communication barriers occur exactly in this area which prevent a mutual understanding between people. If communication is to be perceived as the ability to speak to other people; tell each other what we feel and think and say it clearly; listen to each other; understand each other; then communication must be perceived as a process in both directions. On a practical level it involves supporting and establishing partnership both to colleagues and especially to patients. Only in this way can the quality of Nurse-patient interaction be improved and we be actively enhanced in the Nursing Process.

Recommendation for Practice:

1. Educational Institutions – Universities, Colleges with specialization in Health, High Schools with Specialization in Health.
2. Clinical Practice.

Falls of patients in healthcare facilities as extraordinary incidents

Ad 1) Educational Institutions – Universities, Colleges with specialization in Health, High Schools with Specialization in Health.

– Psychology of a ill person, Medical Psychology, Psychology and Communication should be allocated with enough lessons at all stages of the educational process. The student must become acquainted not just with the theory of the given problem but in practical classes he/she must learn the procedures and practice the skills which will be carried out in Clinical Practice.

– In the University Sector. I suggest to implement teaching Ethics in Health Service, not only at the theoretical level but some attention should be paid to practical classes. Students could discuss problems and problem situations with experts.

– I recommend to involve Experts who work in the area of Application of Psychology in Health Service and Communication in Health Service, in Educational Programs for Health Workers in Clinical Practice.

ad 2) Clinical Practice

– To lead Health Workers to mutual and efficient communication with patients by keeping all Principles of Communication Process in Clinical Practice.

– To pay attention to young Health Workers.

– To allow the Health Workers in Clinical Practice continuing self-improvement (Seminars, Trainings, Courses, Professional Conferences with the aim to extend their expertise in Social Communication and Psychological Approach to patients).

Conclusion

Nurse's communicatory role is essential and interfaces with all areas of Nurse's activities. It can be used to a large extent and Nurses cannot carry out any of their duties without it. By communication he/she gathers information from the patient; keeps him/her informed; influences and persuades him/her. It allows him/her to establish contact with the patient; perceive; observe; understand the patient better (5). The conducted survey focused on the level of communication in Nurse-patient interaction has accomplished its aim and exposed some problem areas in Social Communication in particular Clinical Practice. The results were presented to Medical Facilities in which the survey was conducted. High quality of communication has become the basis for the Nurse-patient relationship. Good levels of communication aid in fulfilling the Nursing Process and improve the quality of Nursing Care.

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Summary

A patient's fall especially in the elderly population in connection with hospitalization presents a major problem. Recurrent falls and fear of them often confine the patient to bed with considerable negative consequences including progression of Disuse Syndrome. This report is focused on the issues of falls by hospitalized patients. The survey uses the quantitative method with evaluation of the data received, expressed in percentages. The research reveals the problems that occur in connection with patient's falls in Healthcare Facilities. Finally, there are some recommendations for practical application to improve the quality of the Nursing Care.

Key words: Hospitalization. Patient. Fall. Vertigo. Disuse Syndrome.

Introduction

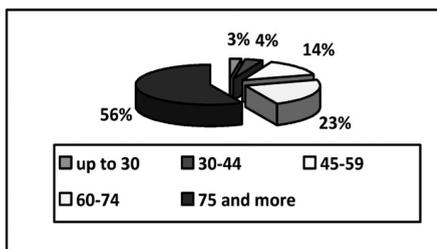
Aging is a long-lasting process which affects not only the Biological arena, but also Psychological and Social ones. It implies disorders of the physiological functions, namely of the cardiovascular and respiratory systems, as well as mobility disorders. There is a loss of motivation and a focus on the past. Elderly people can fail to adapt adequately to the new situation; both their mental and physical performances decline. Their movement activities diminish. Prescription of the medication, multi-morbidity and dependence increase the risk of a fall, as well as the use of Medical Care Services and recurrent hospitalization, and make the time of the treatment longer (2). The consequences of falls are the most serious and costly in the case of fractures.

Patient's falls belong to the most frequent extraordinary incidents in Healthcare Facilities. The consequences of a fall in hospital include complications of the basic illness; light or severe injuries; prolonged hospital stay; higher costs of treatment (4).

Fall-related injuries are reported to be the 6th or 7th most frequent cause of death in the population over 65 years (1). Up to 20% of Geriatric patients are reported to suffer a fall in hospital and more than 50% patients happen to fall in long-term Healthcare Facilities. 25% of the affected patients fall repeatedly. However, this problem occurs not only in hospitals, but also at home. Falls at home belong to specific Geriatric Syndromes. They represent a very important, but often ignored problem related to the elderly population. Affected elderly people often do not report the fall, the reason being, among others, that it reminds them of their own helplessness. They seek medical attention only if the fall leads to an injury or to the substantial deterioration of their autonomy. About a third of the population aged 65 living at home suffer a fall once a year. Frequency increases with age (an 85 year old falls five times more than that aged 65); as well as in the case of poly-morbidity and deterioration of the self-sufficiency. With regard to both internal and external demographic change, there are a growing number of the elderly patients; falls represent a serious concern from the point of view of Nursing Care, rehabilitation, diagnosing and treatment (5). While the elderly have undoubtedly the biggest share in the number of the falls in hospitals, there also are younger people among those who suffer a fall in hospital. In their case, however, the injuries imply better prognosis, healing and recovery.

In order to positively influence patient's safety and to reduce the risk of a fall to a minimum, Healthcare Workers have to be familiar with risk factors that could lead to such an incident; to target Nursing intervention to a set of preventive measures tailor-made to the specific patient's needs; to provide tools; instruct the patient and adequately motivate him/her through targeted communication. The way the hospital stay develops can be positively influenced by cooperation with both the patient and his/her family (6).

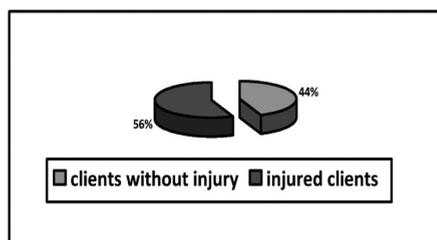
The proper administration of Nursing documentation, evaluation and providing information within the medical team also have important roles to play. According to Topinková, Neuwirth (2003), the most frequent causes of patient's falls include walking difficulties; balance difficulties; muscle weakness; failing eyesight; cognitive impairments; deterioration of the activity of daily living (ADL); depression; at age 80 and over; fall in case history; poly-morbidity; prescription of medication (5).



living (ADL); depression; at age 80 and over; fall in case history; poly-morbidity; prescription of medication (5).

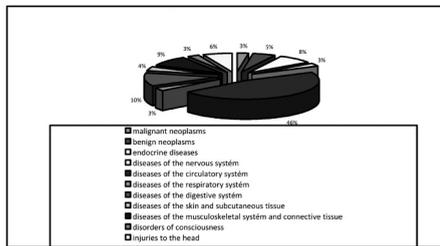
A large number of cases are formed by patients who are confined to bed and fully depend on a Healthcare Worker's aid; those who will use (or have already been using) locomotion aids (walking sticks, crutches, prosthetic devices) as well as glasses and hearing aids.

Adaptation to new environment; unfamiliar terrain; slippery surface; unsuitable footwear; nighttime lighting; obstacles in the way; inadequately located devices of everyday use; staircases; bathrooms; remote toilets are sources of mental strain for those people. The feeling of discomfort and the fear of falling restrict their movement and ways of fulfilling of their needs.



Another group is formed by patients who are confined to bed temporarily (injuries, postoperative treatment). They are provided with the information; know what their current capacities are; but most often overestimate their strength and fail to assess the difficulty of the intended activity and their current capacities. Also, patients who move around without any help may

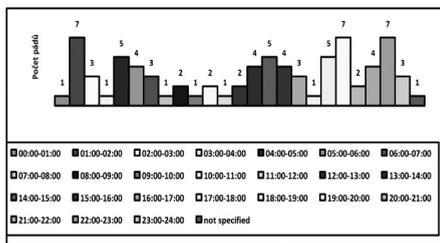
happen to fall as a consequence of a sudden change of health condition or collapse that may occur during the recovery process(3).



Children represent a particular group. Healthcare Workers must fully guarantee their safety. If children still happen to fall, it is usually the Worker who is fully responsible for such incidents. Nowadays, however, most Healthcare Centers enable parents or other relatives to stay in hospital with their child, and in that case, responsibility for the child's safety lies with the concerned family member.

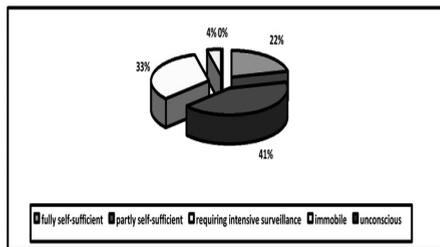
Safety, security and the ability to move belong to the fundamental needs of every person. As a rule, people satisfy these needs automatically themselves subject to their capacities and demands. However, in the case of an illness, patients wishing to satisfy their needs have to rely, partly or entirely, on the Healthcare Staff.

Practical Part



A lot of patients perceive an illness and hospitalization as a difficult situation which has a negative impact on the physical, mental and social state of a person and implies a lot of restrictions and unpleasant feelings. This research monitors a very specific area - patient's falls during hospitalization, i.e. an area which has not been examined in the selected Facility at a District level.

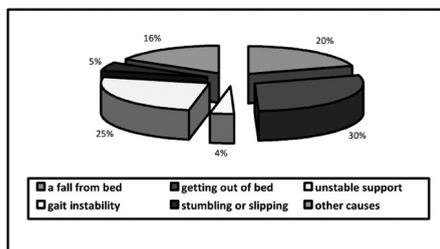
Research Objectives:



- 1) To find out which group of hospitalized patients has been the most vulnerable in the selected Healthcare Facility at the time of the research.
- 2) To determine the most frequent causes and risks of the hospitalized patient's fall.
- 3) To put forward some recommendations aiming at reducing

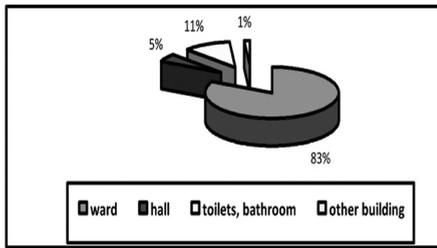
the number of falls and related injuries.

The Group of Respondents and the Methodology:



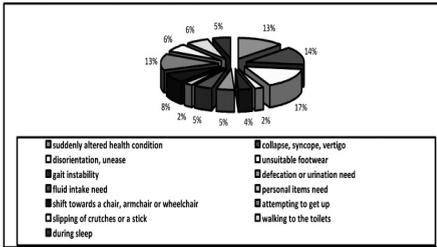
The group of respondents was comprised of patients of the selected Healthcare Facility during the designated period January to December 2012. The quantitative method with the evaluation of the data received, expressed as a percentage has been chosen as the main method. The monitoring has been realized in 11 Departments of the Healthcare Facility, including the Children's Department;

taking into account the fact that 80% of the hospitalized children were accompanied by their parents. The target group were the patients who fell during hospitalization in the Facility. In the designated period, 158 cases of a fall were reported in the Internal Medicine



Departments I, II and III, Surgery Departments I, II and III, as well as in Orthopedics, Neurology, Pulmonary, Gynecology and Otolaryngology Departments. The preparatory phase began in the Autumn 2011 with the objective to inform the Management of each Department of the importance and need to receive objective data on the situation relating to falls of the hospitalized patients; and, as a follow up, to take measures to improve the quality of the Healthcare provided; as well as the safety of the patients. The received information has been transformed into the charts using Microsoft Word Text Editor and Microsoft Excel Table Editor.

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The Research outcome:

Chart 1 Falls by Age

56% of the patients who suffered a fall belong to the age group 75 years and older; 23% 60-74 years; 14% 45-59 years; while the share of the patients of the age group 30-44 years and of the age group up to 30 years is 4% and 3%, respectively.

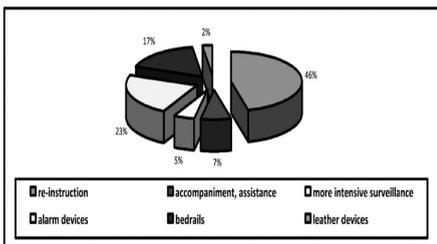


Chart 2 The Number of Falls in the Selected Facility

Out of the total number of the falls (158), 56% of the cases included injuries.

Chart 3 The main diagnoses of the patients in line with the ICD 10

The set of the main diagnoses stated in the records has been very extensive, that is why the diagnoses have been divided into 11 disease groups in line with the International Classification of Diseases 10: 46% of patients suffered from a disorder of the circulatory system; 10% of

the digestive system; 9% from the musculoskeletal system; 8% suffered from an endocrine disease; 6% from head injury; less than 4% had a skin-related problem; 17% of consciousness, malignant tumors, disorders of the central nervous system and the respiratory system.

Chart 4 The number of falls by hours

Most falls occurred in the period of 1:00-2:00 am, 7:00-8:00 pm, 10:00-11:00 pm.

Chart 5 The assessment of the self-sufficiency (according to Nurse)

22% were fully self-sufficient; 41% partly self-sufficient; 33% required intensive surveillance; while 4% were fully immobile.

Chart 6 The Circumstances of the Fall

50% fell when trying to stand up and fell from bed; 25% when walking as a consequence of instability; 4% tried to catch hold of an unstable support; 5% falls by stumbling or slipping; 16% of the patients reported other causes.

Chart 7 The location of the fall

83% of the falls happened on a ward; 11% in the bathroom or the toilets; 5% in the hall; 1% in another building.

Chart 8 The Cause of the Fall

42% were caused by a changes of the health condition; 39% wanted to satisfy their personal needs by themselves (defecation or urination when in bed, being thirsty, etc.); 11% when walking; 5% during sleep; 3% wore unsuitable footwear.

Chart 9 Measures Taken After the Fall

The measures taken after the fall included re-instruction (46%); more intensive surveillance (5%); 7% demanded being accompanied or assisted; 23% were provided with an alarm device to call Healthcare Staff; 17% were provided with bedrails; while leather restraint devices were applied for 2% of the patients who fell.

Discussing the concerned issues

Patient falls belong to very serious, even extraordinary incidents in Healthcare Facilities. Identification of the risk factors related in hospitalization and the possibility to influence them can lead to a higher quality level of Nursing Care, as stated in Charvátová and Jurásková (2007). This research confirms the theory stated by Topinkova and Neuwirth (2003) that concerning falls, the most vulnerable group are patients in upper age categories. In the designated period, these patients formed the largest group; 56% of people aged 75 and over; 23% aged 60 to 74 years. The average age of the hospitalized patients was 70. Thus, it may be stated that the patients over 60 years of age form the group which is at high risk of a fall during hospitalization. In my opinion, Healthcare Staff can reduce the number of falls of hospitalized patients of this age mainly by taking increased responsibility; paying attention to the Nursing Care Provisions; as well as extending instruction activities aimed at the selected patients to include fall prevention measures.

It is necessary to pay more attention to patients suffering from self-sufficiency deficit who are at a higher risk of a fall. The research has revealed that 41% of the fallers had been partially self-sufficient before; 33% had been in need of a more intensive surveillance; 4% had been totally immobile; whereas 22% had been self-sufficient. That means that before the fall, altogether 78% of the patients were, more or less, dependent on the assistance provided by Healthcare Staff.

One of the solutions to reduce the risk of falls of the patients with self-sufficiency deficit could be to target a higher degree of Nursing intervention. Attention should be paid particularly to prevention; self-sufficiency; movement promotion and encouragement; as well as to coopera-

Poverty & Poor Eating Habits are Two of the Essential Factors That Affect the Health Condition of Marginalized Roma Population

BARTOSOVIC, I., HEGYI, L., KRČMÉRÝ, V., HANOBIK, F., VASILJ V. (BIH), ROTHOVA, P.

Abstract

At the present time, we are facing challenges of poverty which has not just an economic dimension. By comparing, some social groups, poverty is more prevalent in the ethnic minority - Roma population. Poverty levels amongst Roma people are several times higher than amongst of the majority population. A different culture and way of life of the Roma minority leads to social exclusion which affects their employment opportunity, education and public services. Typical characteristic of Roma poverty are low education and skills; poor housing conditions; and lower living standards. Unemployment and poverty are closely related, which consequently leads to Roma's vast dependency on social benefits. It is generally known that the Roma population has less access to health care than in the general population. This is due to the poorer educational level of the Roma which negatively influences the perception of health and health care. This condition is also negatively influenced by the geographical distance of settlements from urban areas. Some studies conducted in the Roma communities in rural areas found that the inhabitants of most Roma settlements do not perceive it as an issue. However, complaints about the poor healthcare come from residents of the separated communities which live on better socio-economic levels. The inability of settlement inhabitants to determine the seriousness of diseases or injury hampers communication between Health Professionals and Roma people, often to the extent that some hospitals refuse to send an ambulance to these areas. Poor infrastructure in the Roma communities portrays a significant portion of the whole miscommunication between the two parties, for instance lack of roads complicates the work of rescuers especially during the winter season. Presently, charges for Health Services form an additional barrier and complicate the problem even more.

Key words: Characteristics of the Roma population. Community work. Eating habits. Healthcare.

Introduction

Roma have their somatic, socio-cultural and psychological differences. Somatic differences concerns health; anthropological features (color of eyes, hair, skin, height, longer type of face; more frequent occurrence of B blood type; low frequency of gen such as haptoglobin Hp1, et cetera). Socio-cultural differences involve their traditions; faith; values; social ties and social contacts; cohesion; internal hierarchy and division; Roma Rules and Laws, sym-

bols, language, and education. To work with Roma effectively, it is crucial to know their culture, customs, traditions, and psychological peculiarities.

Psychological Differences

Roma are distinguished by some psychological characteristics which differ from the majority of the population and hence influence their health and social problems.

Roma

- are more emotional: thus emotions influence their thinking, reasoning, evaluation of situations and actions; their temperament is more lively;
- are good in solving common practical situations, they are focused on a present situation that concerns their own or family related needs;
- distant values have no meaning for them, Roma live for the moment; do not make plans;
- have poorly developed self-control and desire, low motivation (low patience, diligence);
- have different social behavior (are open, easily establish contacts with people they trust);
- do not place emphasis on individual success and effort (are rather relying on help from others), are not supporters of competitiveness and personal ambitions;
- have different personality traits (self-indulgence, explosiveness, failure to recognize limits, sensitivity, tendency to demonstrativeness), some authors call it „Romska etnopatiá”;
- lifestyle has a tendency to irregularity and intensity;
- emphasize the group (= collectivism);
- tend to associate, all is shared, private ownership such as goods and properties are missing;
- are known for their mutual cohesion and solidarity.

Exclusive differences of Roma personality may appear from the perspective of the majority as abnormal, however these differences are not considered as abnormal or pathological. In the Roma hierarchy of values and traditions, the highest value represents Life. Everything that leads to the preservation, reproduction and continuation of life, has a high value. Everything that threatens life is perceived negatively. Additionally, family and the patriarchal family play an important value in the life of the Roma hierarchy (Hanobik, 2012). In the family everyone helps and supports each other. Expulsion from the family represents the highest punishment for Roma because the person loses social and human security. Children are the wealth of families.

One of the most positive features of the Roma culture is the respect for their parents and seniors. Higher age represents also a higher status in the family hierarchy and Roma society in general. Respect for old people and love to parents (especially the mother) are very essential. In the traditional community and family old people enjoyed a great respect. This devotion leads to the fact that the care of seniors in their community is usually provided by themselves and hardly by institutions. As a priest working in pastoral care within Roma population, I met only two residents of Roma origin who have been placed in The Home for Seniors. Besides the factors already mentioned, inadequate eating habits and also tragic housing conditions influence the morbidity of Roma in segregated communities. Some medical studies confirm that people from these communities suffer a wide range of diseases: high fat content in the diet contributes to the rise of obesity; to the increase in cases of diabetes, cardiovascular and oncological diseases. Some partial studies in Southern Slovakia show that obesity is also supported by a high consumption of sugary drinks. Inadequate diet is reflected in the slower growth of Roma children.

Doctors from areas where the Roma population is prevalent, recorded an increased number of infectious diseases, especially hepatitis, scabies, lice, and also periodically, meningitis. In ad-

dition, occurrence of *TBC* and respiratory diseases are higher than in the majority of the population. A particular situation arises when diseases occur almost exclusively in the Roma populated areas. For example, so-called *congenital glaucoma* (CG) which refers to severe developmental abnormalities of the eyes invoking blindness based on intraocular pressure increases. Among the most typical congenital diseases of the Roma community belong also: *phenylketonuria*; *congenital hypothyroidism* (a metabolic disorder that causes lifelong disability); congenital deformity of the skull; some cases of mental retardation.

At the moment, it is extremely complicated to talk about the health conditions of the Roma population. The reason is that the evidence of the diseases is not based on ethnicity, but, also due to the Law on Personal Data Protection. Most information comes from before 1989, respectively from sub-studies that reflect the situation in a particular location. It is, however, difficult to generalize these studies to the whole population. Already mentioned psychological individualities (weaker willingness, impatience, servility without families, temperament) may occur in cooperation and mutual communication during the illness of the Roma. Treatment of such patients is typically more challenging. Important is the communication with the patient's family; finding the hierarchy of the Roma family; any person who will act in the name of the family. Roma people possess a considerable fear of pain and death, they are emotional, and often lament loudly. Most medical decisions are consulted with the family. Every Roma patient should be treated individually. The cause and development of the disease should be explained. During the communication it is important to explain the need to change a lifestyle. Meanwhile, the most important challenge is to gain trust.

To have successful communication between Health Workers and Roma patients the following recommendations have been established:

- aim to gain the trust of Roma patient and the whole family;
- watch and monitor non-verbal communication of Roma population;
- respect Roma emotions, their emotional attacks cannot be taken personally;
- be patient, do not expect immediate results;
- criticize in private, not in front of a large collective;
- each Roma requires an individual approach;
- consult important decisions with the recognized representative of the family (24).

Demographic Characteristics of the Roma Ethnic Group

Changes after November 1989 had a social impact on the Roma population: the loss of social security; the growth of unemployment and poverty in marginalized Roma settlements; the inability to deal with existential problems; the escalation of relations between the Roma and the majority population. From a demographic point of view, the Roma population is characterized by higher birth rates and higher mortality, which depends on the integration of ethnic groups into society. The age structure of the Roma population differs significantly. The Roma population has a progressive type of age structure with a high proportion of children and a low proportion of old people. These differences are the cause of low aging index (56 of the Roma, 71.2 of the majority). Roma live shorter. Estimations of demographers talk about the difference in life expectancy (hope to live) compared to non-Roma population of about 2.5 years to the disadvantage of Roma for both sexes; for non-integrated Roma the difference is 3 years. Some authors argue that life expectancy at birth for men is 7.5 years and for women 6.5 years shorter than for non-Roma inhabitants. High mortality of Roma is mainly due to higher mortality during infancy. An average age of Roma at death is much lower than that of the majority group. In some cases, up

to twenty years to the detriment of Roma men, (60 and over) only 49% of Roma survived, compared to 78% of the majority population.

Reproductive behavior is different from the majority population and depends on the already mentioned social integration of Roma. Fertility of Roma population is about 2.5 times higher than in non-Roma population. In the Roma population, for each women of childbearing age there are about 3 children in Roma settlements; 4.6 children (in the Slovakian Republic; as a whole there are about 1.2 children for each woman of childbearing age). An average age at first birth is lower in Roma mothers (21.1 years, 19.6 years in settlements) than non-Roma population (24.6 years); the proportion of children born outside of marriage has been in the long term higher (37.4 %) compared to the non-Roma population (about 20%).

Poor Eating Habits, Lifestyle and Health Status of the Roma

According to available sources, the health status of the Roma is worse than the majority of the population. This is influenced by serious adverse social problems of the population (especially caused by poverty and low income; unemployment; low education level; and inadequate housing). According to *The Report on the Health of SR 2006*, the health status of the Roma minority is very bad. Roma represents a high risk group of our population as they are threatened by obesity, diabetes, cardiovascular disorders and certain types of cancer, for example lung cancer. In this area, specific measures will be required beyond the health sector.

The following considers actual factors that affect poor health in the Roma settlements:

- lower level of education which causes insufficient level of health awareness;
- low level of personal and communal hygiene;
- low standards of living;
- polluted and devastated environments;
- unhealthy eating habits and diets;
- increased rate of alcohol consumption and smoking during pregnancy;
- increased drug addiction and the associated increased risk of infections.

Roma Lifestyle

The lifestyle of Roma population can be considered as unhealthy, characterized by:

- poor eating habits,
- alcohol consumption,
- frequent smoking already at a very young age,
- higher weight
- less physical activity.

Studies found that Roma: tend to a high consumption of fatty meats; livestock and vegetable fats (due to its affordability); consumption of sweets; low consumption of vegetables and fruits. They favor sugary drinks with a high content of carbohydrates which contributes to obesity. Obesity among the Roma ethnic group is 34.2% and the prevalence of diabetes is getting close to 15-20% in the adult population. Addiction is very common: the consumption of alcoholic beverages (beer and spirits) is high; also the proportion of relatively young smokers. Ginter claims that according to officials of public health in many Eastern Slovakian Roma settlements, the occurrence of smoking among men and women is up to 100%. Other studies confirmed in the Roma population *hyperinsulinemia*, *hypertriglycerid-emia*, decreased HDL cholesterol, arterial hypertension, low serum concentration of vitamin C and beta-carotene (Vasilj, V. 2010).

Genetically Determined Diseases

One of the reasons for the higher occurrence of genetically determined diseases is the fact that Slovak Roma represent a population with the highest coefficient of inbreeding in Europe, which increases the likelihood of recessive hereditary diseases. Among 444 individuals from 101 families from Olas Roma in the district of Nitra City, researchers found the inbreeding coefficient of 0.017 and 0.084, which is the highest in the European population and similar to the situation in India. The rest of the population has a coefficient of 0.00008. The number of consanguine marriages increased to 30.7 % (mostly marriages between cousins). On average, such marriages have a significantly higher risk that children are homozygous for any disadvantageous recessive gene, to which the risk is proportional to the degree of kinship parents.

Research proves the higher prevalence of *primary congenital glaucoma* in the Roma population (incidence 1:1250, prevalence 1:2120) compared to the non-Roma population (incidence of 1:22 000, prevalence of 1:51 000). Pediatricians alert on a higher appearance of MCAD (acetyl - CoA Dehydrogenase of fatty acids with medium-chain) failure in Roma. This deficit is among the most common and most insidious hereditary metabolic disorders. It is characterized by a high mortality and morbidity; clinically manifested by life-threatening conditions; or sudden unexpected death.

Infectious Diseases

Roma represents a risk group in terms of *tuberculosis* (TBC) occurrence. In 2008, the National Registry recorded 652 cases of tuberculosis, which is an incidence of 12.07 per 100.000 inhabitants. The Roma population accounted for 115 cases (17.6%), which in comparison to 2007 (96 cases; 13.56% of Roma) represents an almost thirty percent increase. More alarming is the proportion of Roma in the total number of newly diagnosed cases in children under age 14 which already in recent years represents about 70%. Specific for the spread of infection and development of the epidemiological situation of the Roma are large differences in regional distribution; poor socio-economic conditions; high unemployment; multi-generational coexistence in settlements without basic sanitary standards; impossibility of a comprehensive examination of contacts (migration, concealing household members). Frequent recurrence of the disease is observed, caused by a shorter inpatient treatment (due to non-cooperation or rather arbitrary termination of hospitalization); non-compliance; a lack of understanding of subsequent treatment in outpatient conditions.

Adverse social conditions affect an increased incidence of other infectious diseases. When calculating the increased occurrence, all 18 infectious diseases were more common in the Roma population than in the non-Roma population²⁷: *Salmonellosis* was 3.8 times more frequent; *scabies* 33 times more frequent; *pediculosis* was 250 times more often; *hepatitis A* 58 x; *hepatitis B* 16.6 x; *hepatitis C* 15 x; *sypilis* 2.8 times more frequent.

Viral hepatitis type A (VHA) is a serious public health issue. For many countries its epidemic occurrence represents a big social, economic, and health problem. VHA morbidity in the Slovak Republic has a consistently downward trend, however Roma are far exceeding the morbidity of the rest of the Slovak population. They constitute 50-60% of the annual total number of VHA patients. Occurrence is predominant in areas with low hygienic standards, especially in Roma settlements and areas with a high concentration of Roma ethnic group. The highest age morbidity is observed in the age group of 5 to 9 year old children.

Child Diseases

Generally, Roma children have a higher prevalence of infectious diseases, injuries, poisonings and burns, related to environmental factors. Risk factors for *sudden infant death syndrome* (SIDS)

are: socioeconomic family status; hygienic standard of living; maternal smoking; education; related child care. In 1992-1994, an epidemiological study of risk factors was carried out in Slovakia. According to this study, Romani children with SIDS comprised 24.2% out of all SIDS cases; 73.9% of Roma mothers smoked; 83.3% of the Roma population lived in poor hygienic conditions.

Anthropometric parameters reflect genetic factors and socio-economic impacts.

A study of 420 Roma children ages 6-11 years from Lunik IX in Kosice, found that Roma children have lower weight, and their hips are smaller than at the national average. Thus, Roma children are lighter and smaller in comparison with non-Roma. The main causes include poor eating habits and poor economic situations.

Comparisons in Pediatric practice showed that Roma girls begin sexual life earlier; bear children more often; even to an old age. The possibility of interruption during the pregnancy is minimally used, contraception is not being requested. In regards to preventive care, children are treated and examined several times more often than their percentage representation in the population. In the morbidity there are significant differences by socio-economic and psycho-hygienic level of settlements and their individual parents. The number of Roma children as a proportion of the total number admitted to hospital is about 60%, in infants up to 80%.

Roma Mothers

Considering child breastfeeding in Slovakia, authors state that Roma mothers breastfeed for a long period and in a high percentage (at 6 months about 45% are still breastfeeding and after 6 months 32% of women). Authors were also observing the differences within the Roma ethnic group. Breastfeeding is still a traditional food of considerable part of the backward enclaves in the north, in contrast to the Roma in the south of Slovakia (those already prefer „modern” artificial nutrition).

Out of 854 Roma women in labor who gave a birth between 2000 and 2003 at a clinic in Kosice, the representation of young women in labor was sharp (7% under 18), predominantly single women (65%) with no education and 96% unemployed. It was observed that these women have a higher incidence of *hypotrophy* of the fetus and preterm birth (53%), 41.8% of mothers fled the clinic. Alarming is the fact that 82% of pregnant women did not attend prenatal counseling at all or attended only sporadically.

The health status of Roma children is characterized by lower birth weight; shorter gestational age; a higher occurrence of premature birth; frequent intrauterine growth retardation of fetus. Comparing the characteristics of Roma mothers with non-Roma mothers makes it obvious that Roma mothers were younger; single; had only primary or no education; lower height and weight; smoked more often before pregnancy and even in the first trimester.

Hazardous Sexual Behavior & Drugs

One of the taboo problems is sexual behavior. There is only little information about the drug use in the Roma communities. It is believed that some communities are using drugs based on organic solvents (toluene sniffing), especially in the socially weakest class, which is ranked also by the Roma very negatively. Alcohol and cigarettes are present to the a extend, however their use varies depending on the community. Excessive use of pharmaceuticals (mainly Ibuprofen, Paracetamol and Diazepam) was recorded in almost all Roma communities.

Unhealthy Diet & Nutrition

From the perspective of rational nutrition, traditional Roma cuisine, if it is possible to use that term, is absolutely unhealthy. It prefers fatty food, low meat quality, farinaceous foods and hardly contains fruits and vegetables. This however emerged from the way of life of marginalized Roma communities. For centuries such communities lived only on bits and pieces given by richer inhabitants of areas where they lived, respectively wandered.

Roma do not make food supplies and due to a nomadic way of life they neither breed domestic animals nor farm. This situation has not significantly changed even after the settlement of the Roma population, which in our country accounts for more than three centuries. Although in recent years Slovakia undertakes several projects focused on the self-sufficiency of Roma communities (grow vegetables, potatoes, breeding of goats and pigs), the shift to improve the current situation is barely visible, and thus in total perceptually low. Therefore, to talk of its health effects (and poverty) on Roma communities is impossible. An important problem of Roma children are their eating habits. A large part of Roma children lack health hygiene habits. A much bigger problem is the lack of knowledge of certain kinds of foods; unfamiliarity with fruits and vegetables. For instance children are not accustomed to consume soups and refuse certain foods (cooked vegetables, spaghetti, milk products, ...etc.). Roma children clearly prefer home cooked meals. The most popular dishes frequently include steaks and other differently prepared meat. Finding out the exact diet is problematic because this topic is considered by the Roma community as intimate information.

A particular problem in terms of higher health risks are an unsuitable environment and lack of drinking water. Many of Roma settlements are located near waste dumps, landfills or other health threatening areas. Up to one third of Roma communities have no access to drinking water and often use drinking water from contaminated sources and respectively for children unsuitable soft drinks. Apart from a very poor diet, Roma downplay their diseases and do not take them seriously. For example, many Roma have diabetes, but do not treat it at all.

A big problem of Roma settlements is child vaccination; mothers are often uninterested in vaccinating their children. Even if they come to see the doctor, they have difficulties with orientation there. Field Workers explain to Roma how to take care of their children; what to do with children addicted to smoking, chemicals or alcohol; help them also, for example, to obtain a health insurance. Many Roma lose their health insurance cards or once seeing a doctor do not carry them. The main objective of the Community Centers is a change in Roma thinking. Field Health Workers visit Roma communities twice a week and provide education especially to young Roma women and children in primary school (Vasilj, V.2010).

Conclusion

The health status of the Roma population is negative. Its improvement must be linked to fundamental social problems which require the involvement of all sections of society and active accession of Roma themselves and their organizations. However, this requires a respect of the Roma minority individuality; their different historical background, mentality and culture. Only then can future generations expect results.

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Compensation of a Disability After Arthroscopy & Total Ankle joint Replacement

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Abstract

The quality of life may involve questions about the meaning of life; characteristics of the natural and social environment of the human being; the physical and mental states of the human being; as well as subjective evaluation of life - personal comfort and satisfaction. The authors discuss the possibility of indications for surgical Arthroscopy for simple ankle injury and implantation of total endoprosthesis for complicated arthrosis. In addition to indicating the criteria, this article deals with the anatomy of ankle joint; description of the operational procedures; access ports in Arthroscopy; anterior approach of total endoprosthesis.

Key words: ankle Arthroscopy, total endoprosthesis of ankle joint

Introduction

Arthroscopy, as a method of diagnosis and surgery of intra-articular damage, achieved enormous development in the last 10 years; became superior to conventional surgical methods; has a firm place in Orthopedics and Traumatology mainly because of minimal limitations. In the magazine „*Arthroscopy*”, F.A. Barber indicates Arthroscopy as a method of minimally invasive surgery which allows for a thorough diagnosis and visual objectification of damage to the structures of ankle bends.

The number of ankle injuries is increasing with increased mechanization and propulsion. Also, elevated physical activity; with excessive obesity; increased demands on performance in sports and competitions; in today's accelerated pace of life, the number of work and domestic accidents is growing.

Physical examination and X-ray can give reliable diagnostic data of the ankle joint. Some authors - M.S. BURMAN (2001) indicate that the accuracy of basic X-ray examination diagnosis is only 50%, sometimes up to 80%; the method of Arthrography can have sensitivity of about 80%.

Another method of ankle examination is ultrasound. The results are encouraging - about 85% to 90% of successful diagnosis particularly when examining smooth structure of tendons and ligaments of the ankle (Johnson, LL 2000). MRI is a very reliable and accurate non-invasive method which achieves a very high success rate in determining a diagnosis. The correct results of indicated percentages of sensitivity are up to 95%. Non-invasive methods such as ultrasound, CT and MRI, however, depend on the availability and the experience of a Radiodiagnostic Doctor. MRI is limited either by cost and also by a limited number of tests.

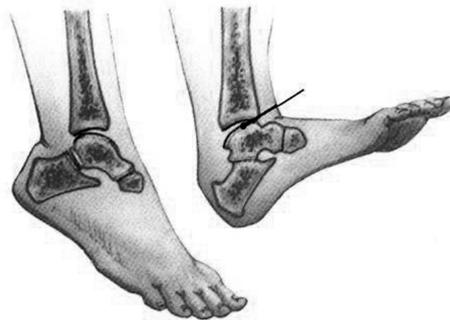
Embryonic Development

Cartilaginous distal ends of the tibia and fibula are differentiated in the 6th week and create a symmetric fork. At the same time, foundations of the talus are differentiated. Definitive form of the ankle is achieved in 4th month of fetal life, lateral malleolus even later (Chapman, 2004).

Ossification

Ossification occurs in the distal part of the tibia and fibula in fetal life and at the same time and similarly to embryonic development. Tibia and fibula in newborns does not have the distal epiphyseal ossification nuclei developed. Respective growth plates have a smooth transversal course. Ossification nuclei of the tibia occurs in the 3-24 months, stored in the central part of the epiphysis. Nucleus of fibula appears around 6-36 months. The core of tibia extends at the end of fifth year of life. In the 6th-7th year of life ossification nucleus of the tibia gradually extends to the base of the internal ankle. In the 8th-10th year already a big part of the inner ankle is ossified. This process is completed in puberty when gradual closure of physes appears (Harty, 1994). Ossification nucleus of the talus is clearly visible at birth, and in the first to third month the size increases and is hour-glass shaped. In 8th year of life it is visible via X-ray and the shape of talus is identical to adults.

Fig.1 - Motion range of the ankle



Indications and Contraindications

Arthroscopy of the ankle joint may be indicated whenever a physician suspects that a patient's discomfort is resulting from damage to the structure of the ankle: namely disorders of cartilage, ligaments and synovium. It can be indicated for diagnostic or therapeutic purposes, in the acute or chronic phase. Jackson states that 25% of diagnostic Arthroscopy also have a therapeutic effect. Arthroscopy may be indicated when we cannot reach a diagnosis by other, non-invasive means. Sometimes even negative X-ray findings are suggesting malfunction of synovium, cartilage or ligamentous apparatus. Generally we can summarize indications for Arthroscopy of the ankle joint to these points:

- Hemarthros of ankle of traumatic origin
- X-ray negative blockade of the ankle joint
- Removing lesions of meniscus
- Damage of chondral surfaces of joint
- Loose articular corpuscles
- Unclear chronic difficulties with ankle joint, unmanageable by conservative treatment
- Extraction of synovial for histology and overall synovialectomia
- Adhesiolysis

- Removal of osteophytes
- Debridement of primary or traumatic arthrosis
- Septic inflammation of the ankle joint
- Intra-articular assessment of clinically unstable ankles before stabilization

Additional indications include traumatic ankle pain with limited movement after injury; arthritis with free intra-articular corpuscles; intra-articular adhesions; osteochondral defects; impingement exostosis of the talus or tibia. Atraumatic are neoplastic lesions of tibia, fibula or metabolic disorders of the ankle such as diabetes.

Arthroscopic examination of the ankle joint has a minimum number of contraindications. Absolute contraindication is total damage of the articular case because of the possible occurrence of compartment syndrome. Relative contraindications are due to using avascular environment, for example deep venous thrombosis, severe atherosclerosis of lower limbs or vascular bypass in this area. However, without using of tourniquet, it is possible even in these vascular disorders to perform arthroscopic surgery. Other relative contraindications are systemic infections, significant osteoarthritis, Sudeck's Syndrome.

Complications of Ankle Joint Arthroscopy:

Each operation on the ankle is burdened by a number of complications which every Surgeon tries to eliminate to minimum; arthroscopic surgery is no exception. Main complications are:

- Hemarthros
- Septic arthritis
- Infection of surgical wounds
- Compartment Syndrome
- Tourniquet Syndrome
- Nerve disorders
- Vascular disorders
- Trombembolické complications
- Tool damage
- Iatrogenic damage to the cartilage of the ankle joint

General occurrence of complications is around 0.60% to 1.70% in literature. In the Central Military Hospital in Ruzomberok the rate is from 0.5% to 4% of complications. The most common complication at our Department is hematoma of the ankle joint, occurring in 4% of cases; thromboembolic disease recognized in 0.8% of cases; neurological disorders in 0.4%, 0.1% infections.

Table 1.

Hemathoma	4.0%
Thromboembolic disease	0.8%
Nerve disorders	0.4%
Infections	0.1%
Vascular damage	0
Tools damage	0

In general, we can state, that ankle joint Arthroscopy is an operation burdened only with a small percentage of complications. To reduce the incidence of complications this method requires good skills and operations management techniques by the Surgeon. Very important is correct and timely evaluation of the indication for surgery. Some authors are dividing complications to pre-operative and postoperative (Patty JE, 1996):

Preoperative Complications:

- Operations on the wrong ankle
- Tourniquet Syndrome
- Incorrect determination of operational approaches
- Technique of operation and damage to instruments
- Intra-articular bleeding
- Articulating cartilage damage
- Neurovascular damage
- Damage to ligaments and tendons

The Principle of repeatedly ensuring whether operating on the correct limb should always be paid attention to. Usually, for a clear view and for bleeding management, we use a tourniquet during the operation. Sometimes, as a complication, pain or paresis can occur on an operated limb in the area of tourniquet placement. We did not experience damage to instruments, however instruments with smaller diameter should be used, namely from 2.7 to 3.4 mm. Intra-articular bleeding usually occurs with removing synovia. If the bleeding is massive, we use electro-cautery in a non-conductive environment with a 5% glucose infusion. Intra-operative damage to cartilages are usually small abrasions of cartilages, therefore surgeons should be careful when using shavers and other sharp objects such as trocars. Neurovascular damage may potentially be realistic because the standard approaches to the ankle are near major nerves and blood vessels. Using an anterolateral approach may damage a branch of the peroneal nerve and using an anteromedial approach can damage the saphenous nerve. When a dorsal approach is used, surgeons should be aware of the details of the posterior tibial nerve and the sural nerve. Therefore, dorsal approaches must be conducted right next to the Achilles tendon.

Postoperative complications:

- Hemarthros
- Postoperative edema and effusion
- Infection in the joint
- Wound infection
- Thromboembolism
- Compartment syndrome
- Reflex sympathetic dystrophy
- Postoperative stress fracture

Hemarthros is one of the most common complications after arthroscopic surgery of the ankle. NSAIDs should be discontinued preoperatively, as well as Anopyrin, often used by Cardiologists. These drugs should be discontinued at least 3 days before surgery. Special attention should be paid to patients with known hemo-coagulation disorders, such as hemophilia. Usually only minimal edema and effusion after operation is present. It's usually benign and caused by extravasation of flushing solution into the subcutaneous tissue which is rapidly absorbed. In an occurrence of intra-articular swelling, puncture should be considered, especially when recurrent and a sample is usually sent for biochemical and microbiological analysis.

At our Center, a joint infection occurred once; managed by flushing with drainage of solutions and antibiotics. Most common are inflammations of small incisions, which are characterized by redness of the surrounding; sometimes slight swelling and itching is present. These are most commonly coped well by antibiotic therapy.

In our Department, postoperative inflammation of the veins was recorded in about 0.8% of the total operated. After verification by ultrasound of the venous system, inflammation is usually coped with treatment according to a diagram using of low molecular weight heparins. Compart-

ment Syndrome, reflex sympathetic dystrophy and postoperative stress-fracture have not been recorded at our Clinic. Reflex dystrophy is described in our literature as Sudeck Syndrome.

Severe Disability Compensations

In addition to health problems, severe disability (hereinafter referred to as „SD”) also has negative effects and impact on the exposed persons and the associated disadvantaged society. These states e try to compensate in different ways. Compensation of social consequences (hereinafter referred to as „compensation”) of disabled persons under *Act no. 447/2008* is done to mitigate or overcome the social consequences of severe disability by providing cash benefits to compensate for severe disability:

- financial compensation benefits,
- social services under the Act on Social Services.

Social consequences of severe disability are compensated in the following areas:

- Mobility and orientation,
- Communication,
- Increased expenses,
- Self-servicing.

In the field of *mobility and orientation*, compensation is for reduced physical orientation or for ability to alleviate or overcome disadvantages in access to personal items and to facilitate orientation and relocating in buildings (Slovak, 2009)

In the field of communication; compensation is for impaired communications to enable contact with the social environment; make access to information more available for a person.

In the field of *increased supplemental spending*, compensation is offered, for example, for a special diet; increased expenses related to hygiene; clothing, footwear and household equipment; operation of a motor vehicle; care of a specially trained dog. The aim is to mitigate the consequences of regular increased expenses associated for the severely disabled.

For the *self-servicing*, compensation is for the loss of limited ability of self-servicing in order to provide a person with a severe disability assistance for self-servicing acts in cases where such persons are alone as a result of damage or loss of physical, sensory or mental capabilities cannot ensure self-servicing operations; care of their home; basic social activities.

Assessment activity in order to compensate severe disability; the issuing of an ID Card for a person with a severe disability; parking card; and others, is under-medical activities and is carried out by the Medical Assessor and a Social Worker of the Office of Labor, Social Affairs and Family, or by other invited experts.

People with severe disabilities shall be entitled to various discounts and benefits. This are claimed with an ID Card of the person with severe disability. There is also a special license for disabled persons with need of an assistant, marked with red color.

For a person with a severe disability or who has partial or complete blindness of both eyes, who is considered dependant on a final decision for individual transport by car, the competent Authority on Parking Passes shall prepare a Parking Pass. A person with a severe disability is dependant on individual transport by car if him/her is not on an equal basis with other persons with respect for their inherent dignity:

- to move back and forth to a vehicle of public transport or rail transport,
- to enter a vehicle of public transport and rail transport; stay in it while driving; and step out of the vehicle,
- to handle the other severe health situations in the vehicle of public transport or rail transport, especially because of behavioral disturbances in mental disorders, vertebrobasilar in-

sufficiency with severe dizziness, loss of two and more limbs, severe cardiopulmonary insufficiency or severe sphincters disorders.

Request for a financial contribution for compensation should be made in writing to the competent Authority of the Office of Labor, Social Affairs and Family by a disabled person, or for a child by a parent or a person who has been awarded custody of him/her.

The application must include:

name and surname of the person applying for the grant of financial compensation benefits, including date of birth,
their personal identification number (if assigned), address of their permanent or temporary residence,
proof that they are citizen of the Slovak Republic with permanent or temporary residence in Slovakia, or an alien who meets the conditions,
medical record.

Conclusion

It's important for every patient after Arthroscopy to live a full life and to have a secured integration into society despite his/her health restrictions (Slovák, 2011). That is why compensation benefits were developed and their use significantly contributes to improving the quality of life.

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Level of anxiety and anxiousness with adult children based on their relationship to the parents diagnosed with nonspecific chronic disease

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Key words: chronic disease, parent, child, anxiety, anxiousness

Abstract

The study is aimed at searching and finding the differences in the chosen constructs of respondents: adult children and their parents diagnosed with nonspecific chronic disease, the group of adult children hospitalized with diagnosed chronic disease and the group of adult children with healthy parents. A part of the work deals with relationship of parents and children, characteristics of chronic disease and coping with strenuous life situation. The research sample was created by 88 respondents (N=88). Standardized questionnaire STAI was used for finding the significant changes of anxiety and anxiousness. The paper is aimed at patients diagnosed with chronic disease and the great influence of the disease to the nearest relatives.

Various scientific disciplines such as medicine, social work, psychology ...deal with chronic disease issue, where the impact of this type of disease on patient's life is undeniable. The person has to „fight” the changes and limitations bound with physical, but also mental health. Within treatment period, the patient has to face various obstacles, and due to treatment procedure and frequent medical consultations the person is often limited in social, labour as well as the private life.

The chronic disease course is lengthy, usually does not end with total recovery and irreversible changes are kept in the affected organ, so the chronic disease occurs with all the somatic, and psychological effects. The chronic disease can later come to the phase, called remission, where the disease symptoms are almost negligible. When the disease becomes active again, relapse may occur, symptoms return or there is an acute exacerbation, what leads to acute disease onset. The hallmark of chronic disease is alternation of relapses, remissions and acute exacerbations, leading to the gradual deterioration of affected organ functioning (Kopecká, Kopecky, 2003).

According to the Slovak Alliance for Chronic Diseases, 63% of chronic disease caused deaths (36 million people) in 2008, the most people succumbed to cardiovascular disease (48%) and cancer (21%). According to WHO projections on status quo maintenance in 2030, the number of deaths from chronic diseases reaches 55 million. In Slovakia, in 2008 passed away 53 164 people and of the number was 53% of cardiovascular disease and 23% as a result of cancer (http://www.hpi.sk/cdata/SACHO/medzinarodny_kontext.pdf).

Professional publications, journals, and scientific databases show chronic disease research, mainly focused on examining the patient's life. Researchers have come to a number of interesting facts in this area. Patients involved in various support programs during their treatment, are able to manage their disease better than those who are not involved in the programs (Bonsaksen et al., 2014). The same author examines the construct of self-efficacy in his research, mainly in patients with chronic obesity and chronic obstructive pulmonary disease. From the results comes out that the application of educational program for patients, both groups manifested higher levels of self-efficacy, prior to the beginning of the program, which contributes to the overall positive management of the disease. Other studies point towards the fact, that patients with chronic neurological disease have significantly lower levels of ability to suppress anger (Janowski et al., 2014).

The above mentioned research results show that chronically ill patient has to go through a number of life changes. In order to control the condition and reduce anxiety symptoms with chronic disease patients it is important to change their lifestyle. As a part of this change the social support of family members or close friends is inevitable (Bonsaksen et al., 2012). Chronically ill individual often seeks and finds support with the closest relatives, partner, parents, or own children. Relationship of a child and parents has being already built in the prenatal period, which is called the longest, the most enduring and the most solid relationship, created in the course of our life. According to Lamb (2010), were earlier researches in this area focused mainly on differences of the mother and the father. Recent researches refrain from unilateral perspective and the researchers realized that mothers and fathers significantly and similarly affect their children. Their warmth, parental care, closeness and safety, secure relationship with the child and form the major part of positive relationship performance between them.

When studying the literature, we mainly faced area solving the chronic disease problems of the child and its impact on the parents. We noticed the lack of research or studies in the opposed problem, how the child copes with a chronic disease of the own parent. As it is known, the relationship of a parent and a child changes throughout the life, but in most cases we still talk of a lasting and stable relationship. It is clear that chronic disease of a parent will differently affect the child in preschool or school age and other the adult child.

For our research we chose a group of adult children. Our aim was to determine the difference of selected constructs between the adult children and their parents who are diagnosed with non-specific chronic disease, further the adult children whose parents are diagnosed with a chronic disease and are hospitalized, and compare them with the adult children with healthy parents.

The aim of work and research results

The whole research is focused on determination of differences in selected constructs of the group of children and their parents who are diagnosed with nonspecific chronic disease and of the adult children whose parents are not diagnosed with any serious illness.

Within the research we set the following research objectives:

1. Determine the level of anxiety and anxiousness for participants, who have a parent with a chronic disease and compare it with participants who have a parent without any diagnose of chronic disease, that means a healthy parent.
2. Identify the level of anxiety and anxiousness with participants whose parent is chronically ill, compared with participants whose parent is chronically ill and currently hospitalized in a medical facility.

Research material and methodology

The research sample initially had 100 participants, but 12 administered questionnaires could not be included in research because of their incompleteness or improper fulfilment. From total amount of 88 questionnaires, the research sample consisted of 61 women and 27 men, with the average age 35.6. The selection of participants was based on the following criteria: age over 20 with both alive parents. Further was the sample group divided to three groups.

- S1 – 42 adult children (47,7%), whose parents are healthy,
- S2 – 24 adult children (27,3%), whose parents are diagnosed with nonspecific chronic disease,
- S3 – 22 adult children (25%), whose parents are diagnosed with nonspecific chronic disease and recently hospitalized at the Teaching Hospital in Trnava or at the Hospital with Policlinics in Nové Mesto nad Váhom at one of the departments (oncology, neurology, internal, long-term ill).

For the research we used STAI (The State - Trait Anxiety Inventory) questionnaire - by Spielberger, Gorsuch, Lushene, Vagg, Jacobs (1983), to measure the level of anxiety and anxiousness, which was developed as a method for anxiety assessment (it can be defined as anxiety, fear or discomfort caused by different situations that are perceived as danger for individuals, and this type of anxiety is considered as temporary), and anxiousness (bound with feelings of tension, fear, restlessness experienced in everyday life. This type is long-lasting and steady for individuals).

Based on the STAI questionnaire collected data, we conducted the descriptive analysis (Table No.1), where we calculated minimum and maximum ranges of the raw scores of individual scales x-1 and x-2, the average sum, and standard deviation.

Descriptive analysis of STAI Questionnaire

Table No.1

Dimension	N	Min	Max	Average	SD
x-1 anxiety	88	27,00	72,00	43,70	10,763
x-2 anxiousness	88	26,00	67,00	40,70	7,889

Hypothesis, interpretation and discussion

We assume that adult children with healthy parents (S1) have lower levels of anxiety, as adult children whose parents are diagnosed with nonspecific chronic disease (S2) and / or are diagnosed with nonspecific chronic illness and hospitalized (S3).

Based on the test of normality and data distribution we decided to choose a non-parametric Kruskal-Wallis H-test, because within the groups was not found normal distribution of values. The resulting significance of Kruskal-Wallis H-test shows that among the groups exist the significant differences in the level of anxiety ($\chi^2(2) = 13.181, p = 0.001$). On the basis of shown significant differences in Kruskal-Wallis H-test in the level of anxiety, we further used the Mann-Whitney U-test for finding the differences among S1 and S2, S3 and S1, S2 and S3. The resulting significance was achieved in the Mann-Whitney U-test, where were the results compared to the adjusted significance level by the Bonferroni corrections. The results are shown in Table No.2

Mann-Whitneyho U-test of H1research hypothesis

Table .No 2

Group	N	Average score	Mann-Whitneyho U-test	Exact significance
S1	42	28,26	284,000	0,003
S2	24	42,67		
S1	42	27,40	248,000	0,002
S3	22	42,23		
S2	24	24,19	247,500	0,717
S3	22	2,75		

Results of Mann-Whitney U-test showed, that there is significant difference in the level of anxiety of a group of adult children whose parents are healthy (S1) and the group of adult children whose parents are diagnosed with nonspecific chronic disease (S2), where S1 has significantly lower level of anxiety, than the group S2 ($U = 284.000$, $p = 0.003$). Furthermore, we demonstrated a significant difference in the anxiety level of the group of adult children whose parents are healthy (S1) and a group of adult children whose parents are chronically ill and currently hospitalized (S3), S1 have lower level of anxiety than S3 ($U = 248,000$ $p = 0.002$). So the hypothesis was confirmed.

From the results can be concluded that the objectives of our work were met, it means we detected a difference in some constructs of adult children with parents diagnosed with a chronic disease and adult children with healthy parents. The assumption is that adult children with healthy parents (S1) have lower levels of anxiety, than the adult children whose parents are diagnosed with nonspecific chronic disease (S2) or diagnosed with nonspecific chronic disease and recently hospitalized (S3), was confirmed, and it is clear from the above mentioned results. We managed to prove that there is a significant difference of the adult children whose parents are healthy and the adult children whose parents are diagnosed with nonspecific chronic disease. There is also a significant difference in the level of anxiety of adult children whose parents are healthy and whose parents are chronically ill and hospitalized at the same time.

The hypothesis was set based on our knowledge. The chronic diseases we considered as difficult life situations and these type of situations are often accompanied by anxiety feelings. Nakonečný (1997) defines anxiety as a negative emotion that a person experiences as a feeling of threat, which has no its specific source and is accompanied by internal tensions. It is a feeling of insecurity and worry about somebody. Chronic disease of a parent is the entire situation that strongly influences the family. Family, especially children, experience a long period of time with unclear end, fear, whether the parent state remains in a long-term remission or the relapse can occur. In case of relapses, and necessity of a parent hospitalization, the family is getting into a new situation, when it is necessary to adapt to a new situation, without the presence of the patient at home, divide his tasks and handle household with the patient's absence. If the child has own family and does not live in the same household with the chronically ill parent, the concern about the state of the parent may be higher and often must be suppressed because of urgent obligations related to job or education of own children. Such a person may experience anxiety, whether from remorse, that is not around their parents or because is unable to help the parent, or facilitate disease.

Researchers have demonstrated higher rates of anxiety in patients with chronic disease. As an example can be mentioned the study, dealing with biomedical and psychological factors of coronary heart disorders and their interconnection. The team of authors in the study focuses, except for the other things, on the level of anxiety of the patients with chronic disease. The result

of this study is that people with heart failure scored significantly higher level of anxious and depression survival (Skorodenský al., 2007). Further study proved the presence of anxiety in patients with chronic disease, high level of anxiety occurrence, over 20%, of patients with cancer. The authors of the study also point to the fact that patients utilizing cognitive coping strategies aimed at patient's problem, reach higher anxiety score levels (40% of patients) (Wu, Li-Min et al., 2013).

Confirmation can also come from the other side. The above mentioned studies demonstrated presence of anxiety in patients with chronic diseases. Within our research, these patients play the role of parents in their everyday life. From various studies come out, that children of parents, who suffer from symptoms of anxiety and anxiety disorders, have a higher probability of anxiety disorders development than the children of parents who have never suffered from this disorder or have never had the symptoms. Furthermore, the studies suggest that parents, usually women with children diagnosed with anxiety disorders, reach higher level of anxiety, in comparison with the parents of children without anxiety symptoms (Perier et al., 2014). From the above mentioned comes out the possible explanation and confirmation of our hypothesis, that the relationship between parent and child is as strongly linked as the feelings and anxiety states are able to pass from the parent to the child and vice versa.

To sum up we can state, that based on our mentioned results, the adult children with healthy parents have lower anxious level than the adult children of parents with diagnosed nonspecific chronic disease and hospitalized.

Within the comparison of groups of adult children whose parents are diagnosed with a chronic disease and a group of adult children whose parents are chronically ill and hospitalized, we found no significant difference in the level of anxiety ($p = 0.002$). The group of adult children whose parents are diagnosed with chronic disease reaches, based on the questionnaire, higher level of anxiety, as a group of adult children whose parents are chronically ill and hospitalized.

Conclusion

In conclusion we have to mention, that the results offer a new perspective on chronic disease, but not from the patient viewpoint, but from the perspective of the relatives, their children, who play a very important and significant role in the course of treatment. For general validation of results and demonstration of interconnection of parent chronic illness is required further subsequent examination. Our next aim is to extend the research oriented at detection the differences in experiencing the survival of subjective well-being with adult children whose parents suffer from chronic illness and the adult children who have healthy parents.

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