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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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Guest Editorial

The science of the social work is a complicated one, with so many layers and dimensions. Those, who work at this field, meet numerous sorts of problems and challenges. Our colleges have to keep up with the financial, cultural, political and social processes in the particular society as well as to be ready to alleviate the problems given by the biological nature of a human being. The client most likely fights with extreme life situations in so many levels: struggles the body pain; tries to maintain a healthy psychological balance while suffers the burden of material and financial hardship – maybe even desperate loneliness and hopelessness. His/her micro and macro environment changes rapidly – this is why those who devote their lives to help, must be ready to adapt their skills and knowledge to the actual state of reality. For the social worker, learning is not an option, but it is a lifetime duty indeed!

The collection of the following treatises offer a great opportunity for those interested in social work. Every one of them shows a new and exciting glimpse to the depths of the social sphere. Their authors are excellent associates, professors and students of the workshops belonging to Saint Elizabeth University of Health and Social Sciences. They essays have been born in cooperation with our colleges from illustrious institutions in the USA; like the Scranton University or the University of North Carolina – but also with other European, and Asian specialists and experts.

The first one comes from the pen of *Robert J. Sawyer and Daniel J. West*, with the title: **Out-of-pocket spending and its effect on public health in the Slovak Republic**. The study examines the Slovak healthcare system from the economical perspectives: particularly the out of pocket spending on medical services and pharmaceutical products. It follows the changes in the country's healthcare reforms from the beginning of the new millennia; and the transformations of the former socialistic system to a modern one. The work shows the changes and reforms of public expenditures on health, and the individual's expenses on drugs and services. It also reveals the benefits of the rationalization of out of pocket spending, but also the burdens on specific social groups as well it puts on. One of the major goals of the work is to prove, that this way of healthcare financing helps to improve the state of the population health.

The word **justice** is used almost on daily basis. But what does justice mean in social work? Justice is what we consider to be the foundation of the social state, human rights and democracy. But how the society determines what justice is, and what the person things of it? Is it an objective reality or is it viewed differently by everyone? How could we approach the question of justice at social work, and how psychology shapes the opinion about it – this is the topic of the treatise of *Ms. Dagmara Lendelova*, from the Department of Psychology of Trnava University.

The age, we live in, is incredibly fast paced and restless. Our way of life is a perfect birthplace of many diseases and psychological disorders, which are revealing about the civilisation we built... One of these disorders is the so called hyperactivity – scientifically known as **HDAD symptom**. The HDAD is a worldwide growing problem, developing in the very early stages of the human life. *Mr. Mieczyslaw Dudek* from Warsaw researches the impact of the symptom on the high school students: particularly how the HDAD affects their social

skills and their integration to the social environment, he also writes about the importance of recognizing the HDAD in time, its treatment and possible disadvantages of undiagnosed hyperactivity in the adulthood.

Mr. Patrick Casterline gives the reader another objective to look on the healthcare of the Central Europe countries – namely the evolution of the **Healthcare Ethics Committees**. The author analyses the structures and work of these committees in Slovakia, Czech Republic, Hungary, Poland and Croatia. *Mr. Vladimir Masaryk* from Central Military Hospital Ruzomberok, takes a different turn: he lets us visit the field of medicine, with his work, titled **Muscular disbalance of the neck muscles**. The deformity of the muscular structure of the neck is the result of the changed patterns of our physical activities – thanks to the time; we spend on sitting in front of various screens. The researcher comes to the conclusion, that the comprehensive physiotherapy is important for the problem combat: with kinesiotherapy and physical therapy as well.

The couple of researchers, *Ms. Soňa Šrobárová* and *Ms. Slanicayová*, with the support of medical doctor Jiřina Kafková from the St. Bakitha Clinic in Nairobi, are dealing with the **importance of social support in difficult life situations**. Their work is not only about the general social help – they are targeting a special group, with special needs: namely the former members of the Armed Forces of Slovak Republic, who lost their jobs because of severe, irreversible illnesses or accidents.

The issue of *Ms. Elena Gažíkova*'s study is surprising end quite disturbing. We all know that the most endangered social group is the group of youngsters and teenagers. They are the primal target of drug dealers; also they are the most susceptible of bad habits and abusing the addicting substances. Ms. Gažíková shares her thoughts and experiences with smoking habits of children and young adults in orphanages. She describes the social environment, the psychological needs, and the client's supportive behaviour towards each other's self destructive attitude in Slovakia's similar institutes.

The quality of healthcare from the perspective of the client in prison is the title of the next essay, by *Ms. Eva Zacharová*. She takes us amongst the habitants of the Czech jails, and gives us a picture about the coverage against health damaging factors.

One of the most vulnerable age group is the group of seniors and elders. The next two studies deal with them in the treatises **Survey of quality of life of seniors and their readiness for a period of Old Age**, created by a team with numerous researchers; and from *Mr. Radoslav Micheľ* who is signed under the study **Satisfaction with the provision of seniors social services**. Finally, *Mr. Peter Matyšák* tries to shed some light on a timeless problem of the Eastern European countries: why the *Romany* community is not able to integrate to the society? Why they live in poverty, how their culture forms their attitude towards the majority; and mostly who is responsible for the failure of every attempt to integrate them?

I highly recommend this collection of essays to all social workers or those who are in some way involved in activities of humanitarian support – professionals and volunteers alike. I believe the following studies are rich in knowledge, information and up to date facts. No one, who has vocation to help our fellow human beings in need, should avoid the opportunity to read them!

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ORIGINAL ARTICLE

OUT-OF-POCKET SPENDING & ITS EFFECT ON PUBLIC HEALTH IN THE SLOVAK REPUBLIC

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Abstract

The purpose of this paper is to evaluate Slovakia's healthcare payment structure reforms over the past decade in regards to co-payments. The research seeks to answer whether co-payments for healthcare services have any effect on public health. Out-of-pocket spending plays a significant role in the financing of healthcare services in the Slovak Republic. In 2010, out-of-pocket expenditure represented 27% of total expenditure on health – well above the OECD average of 19.4% Pharmaceutical costs are a major driver for increased out-of-pocket expenditures for healthcare; 70% of out-of-pocket expenses are for pharmaceuticals. Co-payments are continually rising for healthcare services. Yet macro public health indicators, namely mortality rates, seem to be steadily improving. It is important for policy makers to be aware of impact co-payments have on healthcare utilization patterns, public health, and the equity.

Key Words: Healthcare Expenditure, Co-payments, Out-of-Pocket, Pharmaceuticals, Public Health

INTRODUCTION

Healthcare reform has played a significant role in the utilization of healthcare in Slovakia, amongst the „Visegrád" group, over the last decade. During the communist period, patient co-payments were not required to receive healthcare services. Only some services required co-payments on the part of the patient following the change in regimes (emergency care, dental services, food, and transport), leaving hospital services and physician services free of charge. Slovakia attempted to implement further co-payments in 2003 for physician visits, and per-day hospital stays. However, these co-payments were abolished in 2006. Regardless, co-payment structures have and continue to place financial pressures on individuals receiving healthcare services.[1] Additionally, policy discussions are concerned with the equity of care, which points to potential financial burdens of out-of-pocket payments for low income

groups.[2] The purpose of this paper is to examine the current healthcare payment structure in Slovakia, particularly the out-of-pocket payments healthcare services and pharmaceuticals, and compare this structure to macro- public health indicators, namely mortality rates. The research attempts to address the following question: Do out-of-pocket payments for healthcare negatively effect public health? The hope for healthcare policy is that it can provide more efficient healthcare – quality, safety, and cost – without sacrificing the public health.

HEALTHCARE EXPENDITURE

Slovakia's total health expenditure in 2009 and 2010 was 9.2% and 9.0%, respectively (as a share of the GDP). These values are significantly higher then previous years *(Table 1)*. From 2003 to 2004, Slovakia experienced a 1.4% increase in total healthcare expenditure, a 14.5% decrease in public expenditure, and 7.5% increase in out-of-pocket expenditure. These dynamic changes are the direct result of bailouts and year-on-year rises in private expenditure – the effect of financial reforms of 2003.[1,5]

The total health expenditure per capita for Slovakia in 2010 was significantly higher than the other three „Visegrád" countries at $2,094.50, as the Czech Republic, Hungary, and Poland reported $1884.40, $1,656.20, and $1,394.90, respectively. Out-of-pocket payments per capita are also concerning for Slovakia: $541.80 in 2010; compared to the „Visegrád" group, in 2010, the Czech Republic, Hungary, and Poland had out-of-pocket payments of $280.00, $435.10, and $308.50, respectively.[3] The most visible trend in the expenditure data is the continuously increasing share of out-of-pocket payments.

Table 1: Slovakia Healthcare Expenditure

Year	**Total Expenditure on Health** (as % GDP)	**Public Expenditure on Health** (as % total expenditure on health)	**Out-of-Pocket Expenditure** (as % total expenditure on health)
2000	5.5	89.4	10.6
2001	5.5	89.3	10.7
2002	5.6	89.1	10.9
2003	5.8	88.3	11.7
2004	7.2	73.8	19.2
2005	7.0	74.4	22.6
2006	7.3	68.3	25.9
2007	7.8	66.8	26.2
2008	8.0	67.8	25.2
2009	9.2	65.7	25.6
2010	9.0	64.5	25.9

(OECD Health Data 2013)

HEALTHCARE STRUCTURE

Healthcare cost is a significant concern, especially in a difficult economy with much reform. In 1993, the Bismarck System of Social Health Insurance began through the National Insurance Fund. Multiple reforms from 2002-2006 were intended to respond to the financial instabilities of the system, providing a tighter budget and addressing utilization concerns. Economically, the 2002-2006 reforms were effective in stabilizing the country's financial debt, restructuring market mechanisms from a hierarchical, centralized system to a contractual, decentralized system. Starting in 2003, investments on part of the Ministry of Health budget decreased capital purchases, allocating funds to insurance companies for greater decentralization and flexibility.[5] Meanwhile, the Ministry of Health continues to oversee the universal SHI (Slovakia Health Insurance) system, and to ensure regulation; further, its Reimbursement Committee establishes co-payments, and sets criteria and policy.

CO-PAYMENTS

A major factor in these reforms was the introduction of co-payments – an out-of-pocket expense per primary/secondary physician visit, per prescription, per each hospital day stay, and emergency services. A co-payment's function is to decrease the utilization and demand on a healthcare service, which was successfully achieved through this reform. There was a significant drop in physician visits, especially in primary care (reduction of 10% between 2002 and 2003).[5]

According to a survey, FOCUS (2004), co-payments were regarded as a „serious or very serious financial burden" on families, representing 27% of respondents; these burdens were most revealed in the elderly and by single mothers. 6 Low public support for co-payments and political debate eventually led to the abolishment of some fees in 2006, while others were modified. Eliminating co-payments for physician and hospital visits brought the number of patient-physician visits in 2007 back to the number of visits in 2002 *(Figure 1)*. However, co-payments for emergency care remained at €2, and pharmaceutical co-payments were reduced from €0.67 to €0.17.

As previously noted in *Table 1*, healthcare co-payments continue to rise. According to the *Data from Statistical Office of the Slovak Republic* (2008), Slovaks spend about €200+ annually out-of-pocket for co-payments. Between 2002 and 2009, out-of-pocket payments as share of total health expenditure rose 15% (10.9% to 25.9%, respectively).[5] Taking a closer look at the distribution of out-of pocket expenses, the main driver is pharmaceuticals.[1]

PHARMACEUTICALS

Pharmaceutical expenditure represents 30% of total healthcare expenditure for insurance companies – the most significant cost compared to 7% on primary care, 11% on ambulatory secondary care, and 27% on inpatient „tertiary" care.[5] While expenditure on pharmaceuticals continues to rise, the volume of prescriptions has been relatively stable. Co-payments for pharmaceuticals are increasing at a greater rate than public expenditures.[4,7] More than 70% of out-of-pocket payments are for pharmaceuticals and medical devices, while the share of out-of-pocket payments for other healthcare services is very low.[1] The fi-

nancial burden of continuing drug therapy may hinder the benefits of a physician visit. The introduction of generic drug substitutes in 2005 sought to relieve the financial burdens of expensive drug therapies and introduce a new market.

The reimbursement practices in Slovakia are mainly derived from reference pricing. Drugs are divided into three reimbursement categories[1]: (1) essential drugs that are fully reimbursed (100%) through insurance – oncology, antibiotics, cardiovascular, etc. Approximately 33% of drugs are in this category, requiring a co-payment of €0.17; (2) partially subsidized drugs – based on reference pricing, where the patient is responsible for the difference between the reference price and the actual cost of the drug[5]; (3) no subsidy at all. As of 2011, there are no exemption categories for drug co-payments. The Reimbursement Committee, based on a therapeutic and social value analysis, develops drug pricing and reimbursement for SHI benefit packages.

PUBLIC HEALTH

Macro public health indicators were reviewed, including those available through the OECD health data website. Given the data, overall health status has improved, especially in life expectancy. As noted above, the 2002-2006 healthcare reforms attempted to decrease utilization of the system, yet total life expectancy improved from 73.6 to 74.2 (2001 to 2005, respectively) *(Table 2)*. Both men and women life expectancy rates are improving, but a growing gap between the rates is apparent. Infant mortality rate slightly increased during this same time, however; from 2001 to 2003, infant mortality rate increase from 6.2 to 7.9. Yet, compared to 2011, it has improved significantly to 4.9.3 The main causes of death can be attributed to life-style effects, including cardiovascular related (59.9%), cancer (22.1%), gastrointestinal (5.9%), respiratory (5.5%).[3]

Table 2: Slovakia Health Status

	2001	**2003**	**2005**	**2007**	**2009**	**2011**
Life Expectancy (Females)	77.7	77.7	78.1	78.4	79.1	79.8
Life Expectancy (Males)	69.5	69.8	70.2	70.6	71.4	72.3
Life Expectancy (Total)	73.6	73.8	74.2	74.5	75.3	76.1
Infant Mortality Rate (per 1,000 live births)	6.2	7.9	7.2	6.1	5.7	4.9

(OECD Health Data 2013)

CONCLUSION

Health status of the population is continuing to improve, yet do not meet the OECD averages in many categories. As seen in the history of Slovak healthcare reforms, there is

much opposition to increased co-payments for healthcare. A recurrent concern addressed in literature focuses on the equity of healthcare services – that of which relies on Slovakia's healthcare policy. Co-payments for healthcare services have the potential to have adverse effects on the health of the population that cannot utilize the system due to the financial burdens of out-of-pocket payments.[1] It is important for policy makers to be mindful of the effects such policies may have on public health, especially for the lower class. Especially in pharmaceuticals, it is important for healthcare leaders to continually revisit the reimbursement structures to ensure public health equity and overall improvement.

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SPECIFICS OF THE PSYCHOLOGICAL UNDERSTANDING OF JUSTICE IN THEORETICAL-EMPIRICAL ANALYSIS

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Key words: Evaluation of justice/injustice, understanding of justice, human values and value orientations.

Abstract

This review research study is based on an analysis of a broad range of domestic and foreign literature. It is organised according to the logical division of different approaches to the inquiry of the evaluation of meanings of justice and injustice by the participants.

This review study is divided into three parts: 1. Partial approaches to the understanding of justice (factorial, situational, content, alternative). 2. A more comprehensive (holistic) approach to understanding of justice. 3. Discussion of the results from the research done by the author.

Our method falls under the holistic approach and it is based on a cognitive-emotional inquiry of the understanding of justice/injustice among young adults.

INTRODUCTION

The issue of justice has been a subject of interest of many scientific disciplines for decades, since it is one of the most critical values which determines and secures human rights, order, desirable behavior and relationships among people. The beginnings of research of justice in the field of psychological sciences date back to the 1960s. Depending on the principium divisionis that is applied, we can divide distinct psychological approaches into four categories.

1. Partial approaches to the understanding of justice

As implies from the following, they include factorial, situational, content and alternative approaches.

a/ Factorial approaches answer the question of whether and how a person evaluates justice vs. injustice. This has been well researched in relation to various psychological con-

ORIGINAL ARTICLE

structs such are well-being, neuroticism, egocentrism and locus of control (Ďuroška, Lovaš, 2002; Fatima, Suhail, 2010; Hafer, Correy, 1999; Schmitt, Dörfel, 1999). Factorial approaches are psychological approaches that consider the analysis of how people react when facing injustice. Most of the research in this field has been based on the issue of the re-establishment of justice (Hogan, Emler, 1981; Exline, et. al., 2003).

Another approach to the research of justice is to look at the intensity of justice/injustice and analyze its object, i.e., the fate of people, the world as such, rewards and punishments. In cases where the object of evaluation is the world and functioning in it, authors of the studies ask the participants about the degree of their belief in a just world where justice is understood as a reward. Individuals assessed their level of agreement about justice according to which everybody gets what they deserve and deserve what they get (Dalbert,1999). In other works, the subject of evaluation is the final justice of the world defined as **a reward**, as well as justice that goes beyond this world and earthly life. Other studies place an emphasis on the goal of resolving the problem of the sensitivity of justice as „strictness" in the evaluation of the behavior of others towards an individual (Gollwitzer et. al., 2005; Hafer, Olson; 2003; Lovaš, 1995; Lovaš, 2001).

b/ The situational approach to the evaluation of justice vs. injustice attempts to determine what individuals consider as just under the specific conditions of a given situation. For instance, Lernera (1977); Sabbagh, Dar, Resh, (1994), and Wagstaff (1994) point to the diverse understanding of justice depending on the goal. If the goal is an individual's good, profit or material goals, justice is served when those who contribute to society the most get the most. If the goal is the welfare of the majority, justice is served when everyone has equal rewards. On the contrary, if the goal is a reduction of suffering, as well as personal good and the development of the members of a society, justice is served when the one we identify with has rewards that correspond with his/her anticipated primary and secondary needs (Deutsch, 1975; Lerner, 1977; Sabbagh, Dar, Resh, 1994).

These studies consider the understanding of justice from a contextual point of view where justice is not universal but rather changes in time, context and situations across different societies and preferences of individuals. Even more so, these studies focus on the individual's understanding of justice based on someone else's definition of justice. Respondents, in a sense, are thus forced to apply the principle of justice as defined by the authors of the study and not themselves.

The approaches we have discussed so far imply issues that occur when an approach omits the free specification of justice by the individuals or when it focuses on an analysis of the understanding of justice by the individuals indirectly through the given definition of injustice. Even in cases when individuals can choose from a list of preferred reactions to instances of injustice, these options are designed to capture a level of experienced anger as the criteria for injustice (Mikula, Schlamberger 1985, Mikula; Petri, Tanzer, 1990). This is problematic, because if the criterion for injustice is a level of experienced anger, the question remains whether a lack of anger automatically presupposes justice. Furthermore, if an individual can overcome injustice through forgiveness and does not experience anger or a need for revenge, does it mean that it was not injustice?

c/ The understanding of justice through content specifies justice indirectly and derives from an evaluation of specific situations pointing to preferences of principles of justice. An evaluation from the participants' point of view in some studies is determined by evalu-

ating justice exclusively through one principle (e.g., the balance of costs and gains) to which the authors of the study incline (Adams, 1965; Lerner, 1977; Dalbert, 1999; Maes, Schmitt, 1999). Respondents give their answers in terms of their agreement or disagreement with the specific understanding of justice. In other studies, respondents have a choice of several preferences for an understanding of justice (principle of equality, balance of costs and gains) however, again only from the options provided by the authors (Deutsch, 1975; Lerner, 1977; Sabbagh, Dar, Resh, 1994; Sabbagh, 2001).

A problem arises when people use the same name for justice (denotation) in substantially different situations while attributing different content (connotation) to it.

In other words, what people call justice can in fact mean essentially different things and what they consider just can have a crucial impact on their behavior. For instance, Correia et al, (2001) determined that victims who are judged to be innocent are more liked and helped by observers than victims who are not judged to be innocent.

Other findings show that when people evaluate justice based on future rewards, such approach is associated with a better understanding of other people in difficult life situations (Maes, Schmitt, 1999) and increased solidarity (Maes, Kals, 2002). If an individual faces injustice in his/her own life and believes in compensation in the afterlife, he/she shows better signs of adjustment, well-being and a greater willingness to forgive than the one who does not (Exline et al., 2003).

The evaluation of justice through the principle of need is associated with a higher sense of responsibility towards others, indulgence and the development of close relationships (Sabbagh, Dar, Resh, 1994). Justice evaluated through the principle of equality is connected to higher loyalty to the group, as well as appreciation and cooperation (Deutsch, 1975). In cases of the understanding of justice through the principle of the balance between costs and gains, according to which it is just to give everyone a reward based on their contribution to society, there is a link with low interpersonal attraction when dealing with concurrence (Lerner, 1977). Thus, one may assume that it is not important to know only to what extent an individual evaluates a situation but mainly why he/she does so, what values he/she chooses and what connotation he/she attributes to justice (see Popielski, 2005).

d/ Alternative objective and subjective approaches to justice vs. injustice feature the domination of dialectics and subjectivism (Váross, 1970). There is a tendency to understand justice as a result of functions, activities of individuals and societal norms (Adams, 1965; Deutsch, 1975; Lerner, 1977). Another tendency is the understanding of justice as a result of one's mental state and how one feels. (Mikula, Schlamberger 1985, Mikula; Petri, Tanzer, 1990; Lovaš, 1995). The origin of justice and its principles can be found in society or individuals where the norm is utilitarianism, according to which just is what is useful for humankind (Tondra, 1994).

In a majority of studies, justice is defined as contextual or situational. Universal justice is mentioned only in the equity theory (Adams, 1965) which defines justice through the principle of costs and gains as an equally applicable rule for protecting the rights of different people. In other studies, we found situational definitions of justice throughout diverse assessments of conflict situations when the individual assesses justice according to what is important for him/her as well as learned norms of society. Justice is thus pluralistic and not universally applicable (Deutsch, 1975; Lerner, 1977; Lovaš, 1995).

A situational understanding of justice reflects the postmodern phenomena of the dis-

appearance of objectivity from an evaluation of justice at the expense of immutable human values. To what extent are human values justifiable and who is entitled to what is determined by the individual (Klčovanská, 2009)? In a contemporary understanding of justice in psychological sciences, except for its definition as forgiveness (Exline et al., 2003), there is a lack of a universal approach to looking at justice as an objectively given fact, where justice would be understood as an ontological foundation and unchangeable truth (Váross, 1970).

2. More comprehensive approaches to the understanding of justice

More comprehensive approaches are represented by the cognitive-existential schools of thought. This part of our work proceeds from our research analysis. Although psychology, as an empirical science, describes a phenomenon that can be observed, it is not fully competent to define what justice is or should be. It also means that psychology is not competent to create norms of justice, since we know that authors of studies, whether they acknowledge it or not, always choose a specific philosophical and axiological starting point as their preference projected into their approach to the inquiry of human values (Klčovanská, 2005). For this reason, psychology is helped by philosophy, theology, law, economics and others (Popielski, 2005).

Our work features the use of a theoretical framework of Catholic social philosophy and theology and the search for inspiration in a cognitive-existential approach that is in concord with Catholic social philosophy and looks at human values as objectively given facts. Thus the approach we use for studying justice can be called holistic and tends to point to a comprehensive, universal understanding of justice applicable in all areas of life and respecting the specificity of situations. We understand justice broadly as a term covering the field of studies of morality, mainly as they relate to human relationships and societal functions (Tondra, 1994; Léon-Dufour Xavier, et al, 2003).

Such justice is in general understood as a moral and spiritual value that goes beyond legal and societal norms „by giving to everyone what is due to him even though it is not determined by customs or legal norms." (Léon-Dufour Xavier a kol., 2003; p..803). The sovereign objective norm of justice is the Creator and the Decalogue established by Him or Natural Law inscribed in every human being (Tondra, 1994; Léon-Dufour Xavier, et al, 2003; Benedikt XVI., 2009; Wolf, 2011). Justice is thus one of the highest moral and spiritual values which puts in hierarchical order other values aiming at the final goal which is a meta-value, the absolute and the Creator. Justice in this understanding protects moral rights for the objective good and values which are directed towards the meaning and the Absolute, and helping the individual and others in becoming a human person in its all aspects (see Popielski, 2005, Frankl, 2006). Only if justice protects the rights which are ordered towards the Absolute, can a human be fully actualized (Benedikt XVI., 2009; Popielski, 2005).

The cognitive-existential approach that we have just outlined has its roots in theological and philosophical tradition and views man as a personal subject and a psycho-bio-spiritual whole. This three-dimensional understanding of personality is not only comprised of the biological and psychological dimensions personality is determined by, but by a spiritual (noetic) dimension in which freedom and responsibility can be fully actualized as qualities exclusively belonging to human beings.

Three existential dimensions can be linked with specific values. The biological di-

mension includes values that are self-focused (e.g., material goods, hedonistic and others). The psychological dimension is a compound of natural values (final values, allocentric, normative) and noetic values are understood as self transcendent (spiritual and moral values) (see Dedová, 2009, Klčovanská, 2009). Justice, as a spiritual and moral value, is a noetic value from the three-dimensional point of view. Content understanding of noetic value from an individual's point of view can be reduced to a psychological or biological quality (Klčovanská, 2009).

Justice is driven by the virtue of charity and the equally transcendent human dignity which are unconditional in the spiritual meaning and belong to the noetic dimension (Popielski, 2005). The aim of justice is as much the societal good as the individual good. Justice can be a noetic and moral value only when it protects the noetic understanding of rights respecting transcendental human dignity and the actualized noetic virtue of charity.

3. Summary of the most important research results

a/ Research problem, objectives and methodology In connection with the demonstrated different consequences of justice for society and human relations, and moral (or on the contrary immoral) actions, as well as with regard to the fact that we have not yet met with literature in which an understanding of justice through a content and objective approach to its analysis would be clearly defined, the following problems appeared to us from the empirical perspective: We will try to briefly describe them in relation to the previous connections of the outlined three-dimensionality of values, how young adults understand justice in our Central-European, in particular, Slovak population.

We subsequently implemented the stated results from the aspect of a cognitive–existential approach. Based on the stated facts, we will try to present:

1. An understanding of justice by respondents on the basis of their cognitive judgment.

2. An evaluation of the addressed ethical situations by respondents (hereinafter referred to only as the ES) which, in addition to cognitive judgment, also capture their emotional preference and in general existential living.

We conducted research from November 2012 to February 2013. The research sample consisted of 127 participants between the ages of 18 and 30 (M = 21.8; SD = 2.1). They were university students of different disciplines (psychology, law, economics, theology, etc.) from Bratislava and Trnava. 40 men (31.5%) and 87 women (68.5%) participated in the research. With regard to our research goals, we chose a quantitative and qualitative method. Within this method we applied two research methodologies which we developed on the research sample. The methodology aimed at:

1. an understanding of justice through content

2. an evaluation of ethical situations.

Ad 1. We discovered an understanding of justice through content by means of a questionnaire we developed, in which we identified the first variable based on the answers to the open question: „What do you understand by the term, justice?".

Ad 2. We approached the assessment of ethical situations and the justification of such an assessment on two levels. **The first level** represents the numerical expression of the perceived justice/injustice of a player's behavior in an ethical situation on a scale from 1 - 7.

The second level represents the justification of a numerical evaluation, which for a researcher is dominant with regard to the possibility of a deeper knowledge of a participant's experience in relation to the value. For illustration we introduce one part of this methodology.

„EVALUATION OF ES"

In the following part we offer you several situations in the form of stories. Under each situation, there are questions about your evaluation of the justice/injustice of the behavior of a particular person. First, always read the situation carefully and answer on the basis of the submitted questions. In the evaluation of the story always take into account only those facts which are stated in the story; do not add or remove individual facts from the content.

SITUATION 1

A mother whose only child was left paralyzed after being hit at a crossing by a young drunk driver demanded from the court the highest possible limit of the penalty for the young driver.

Questions to the above-stated situation:

1. State (by circling one of the numbers from 1-7) to what extent in your opinion the **behaviour of the mother towards the young driver** was fair/unfair?

very	quite	rather	equally fair	rather	quite	fair
unfair	unfair	unfair	and unfair	fair	fair	fair
1	2	3	4	5	6	7

2. **Why** do you consider the behaviour of the mother towards the young driver to be fair/unfair?

b/ Results The initial qualitative analysis of the examined variables from the perspective of the three-dimensionality of existence by means of the Popielski interpretation table and adapted categorization device (Popielski 2005; Klčovanská, 2005) allowed us to identify and classify the understanding of justice through the content as well as the justification of the ES on noetic, psychological and biological levels. After encoding the main categories, we made a quantitative analysis using the SPSS 13.0 statistical program which allowed us to compare the frequency of the individual groups.

Particular features of understanding justice in terms of content. From the total number of 119 participants who answered the open question of how they understood justice in terms of content, as many as 81.5% attached the connote of a psychological dimension to justice. Only 16.8% percent of young adults understand justice in terms of content on the noetic level, i.e., on the one which corresponds to it. Only 2 (1.7%) of the participants reduce justice to a biological level (Table 1).

Tab. 1: Contingency (description) of the level of connote of justice

Level of connote of justice	Frequency	Percentages
Noetic	20	16.8 %
Psychological	97	81.5 %
Biological	2	1.7 %
Total	119	100%

Justification of the evaluation of ethical situations (Table 2) In the total analysis of all ES, we found in general that, similar to the case of cognitive judgment on the understanding of justice through content, the preference of justifications pertaining to a psycho-

logical level is shown. Of the total number of 588 justifications discovered within all five ES, as many as 45.2% of young adults understand justice „in practice" also psychologically. The second largest group includes the noetic justifications of ethical situations which have a slightly higher representation than in the cognitive judgment (12.4%). The same is true for justifications which are neutral.

Note: In this case, the participants could not decide between two values.

Tab. 2: Profiling of justification of the evaluation of five ES from the perspective of three-dimensionality on 5 ES.

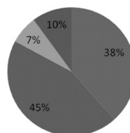
	Noetic		Psychological		Biological		Neutral		Total	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
ES 1	13	11.0 %	94	79.7 %	-	-	11	9.3 %	118	100%
ES 2	7	5.9%	**97**	82.2%	3	2.5%	11	9.3%	118	100%
ES 3	**73**	62.4%	-	-	32	27.4%	12	10.3%	117	100%
ES 4	**76**	64.4%	19	16.1%	2	1.7%	21	17.8%	118	100%
ES 5	4	3.4%	56	47.9 %	**36**	30.8 %	21	17.9 %	117	100%
Total	173	29,4	266	45,2	73	12,4	76	13	588	100%

* ES = ethical situation

Review of the results from the aspect of understanding versus evaluation. The results show us that *from the point of view of their connote of justice, young adults do not justify the evaluation of ethical situations in accordance with their cognitive judgment.* Even if they attach the noetic connote to justice, they mostly understood it psychologically in individual ES. From a total of 99 possible noetic justifications of the participants who added the noetic connote to justice, it was only understood noetically in practice in 38% justifications. Most justifications (45%) belong to the psychological dimension (Graph 1).

Graph.1: Justification of evaluation of ES in noetic understanding of justice

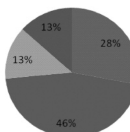
■ Noetic ■ Psychological ■ Biological ■ Neutral



In the group of *participants who understood justice psychologically*, from a total of 479 possible psychological justifications of the ES, the largest representation is comprised of psychological justifications (46%). The second largest group of justifications was the group of noetic justifications (28%)

Graph.2 : Justification of evaluation of ES in psychological understanding of justice

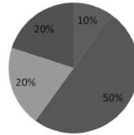
■ Noetic ■ Psychological ■ Biological ■ Neutral



Those who *understood justice biologically* from a total number of 10 possible biological justifications of ES, mostly justify the ES psychologically (50%) (Graph3).

Graph. 3: Justification of evaluation of ES in biological understanding of justice

■ Noetic ■ Psychical ■ Biological ■ Neutral



c/ Discussion The results of the study show that the young adults who formed our research sample mostly understand the noetic value of justice psychologically. Similarly, it is in justifying the evaluation of ES that justifications of the psychological quality once again dominate. A discrepancy arises when analyzing the justification of ES in accordance with their understanding of the aspect of justice in terms of content. Those who theoretically understood justice noetically mostly understood it psychologically in the justifications. The only concord between „theory" and „practice" is shown in participants who understood justice psychologically.

The largest concord of a psychological understanding of justice on the theoretical (cognitive judgment) as well as practical (relationship, experience in evaluation of EC) levels confirms the findings of Klčovanská (2005), Dedová (2009), who point out that contemporary young people reduce noetic values to psychological and sometimes to biological levels. The prevailing discrepancy between an understanding of justice on the theoretical level and in practice seems to us to be in concord with the findings of Grác (2008), who states that knowledge is not virtue but the first necessary cognitive condition for virtue. Knowledge itself does not mean its recasting into practice. At the same time, these findings are also consistent with a new phenomenon of the situational understanding of values, according to which an empiric definition of justice is not unified; at one time, one value is preferred, at another time another value (Klčovanská, 2009).

d/ Conclusion The results from this research study on our sample of 127 young adults clearly demonstrate a content reduction of a noetic understanding of justice, especially when it concerns its mostly situational understanding. It has been demonstrated that when approaching and understanding a content understanding of justice as well as other values, it is not only necessary to make a more comprehensive psychological profile of the individual, but at the same time to analyze the adequacy of previously reported background theories of the understanding of justice. Since the harmonization of justice in human interaction is a necessary condition for conflict-free co-existence not only of individuals, but entire nations, it is also desirable to continue with the clarification of this issue.

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INTENSIFICATION OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) SYMPTOMS AND SOCIAL MALADJUSTMENT OF THE MIDDLE SCHOOL THIRD YEAR STUDENTS

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ORIGINAL ARTICLE

Abstract

The purpose of the article is to examine the relationship between ADHD and social maladjustment of the middle school's final year students. This problem is very important from the point of view of scientific research on the ADHD syndrome and pedagogical practice. The study was conducted among 354 middle school's final year students. The behavior, which is the effect of the process of social derailment resulting from the lack of therapy of people suffering from ADHD and educational errors in the family and school environment, is often intensified at this age.

Key words: diagnosis, ADHD, social maladjustment, interdependence.

Characteristics of the ADHD syndrome

In recent years, there have been a lot of works devoted to Attention Deficit Hyperactivity Disorder in Poland. This is accompanied by a huge amount of courses and trainings. There may be no such school in Poland, where trainings on ADHD would not be conducted for Teachers' Councils. The large interest in the ADHD syndrome is accompanied by a large amount of conflicting information. There is still insufficiency in the teachers' awareness regarding the ADHD diagnosis model; knowledge of diagnostic methods and techniques;, and forms of work with a student suffering from the syndrome. For many teachers, a simple diagnosis, a finding that a child is psycho-motorically hyperactive is sufficient. They often treat the ADHD student's problems frivolously, presupposing that the student is difficult, dangerous, naughty, bad and socially maladjusted. They are not able to distinguish two separate syndromes, i.e. Attention Deficit Hyperactivity Disorder and social maladjustment.

The basic misconception of some authors is that the children slowly grow out of ADHD. This position proves a total confusion and sometimes a misunderstanding of the ADHD essence and its effects on the development of the individual. Such views are conducive to the attitude that it is sufficient to be patient, wait a bit and the child's behavioral problems will automatically disappear with age. Indeed, with age some of the external ADHD symptoms are slowly fading, but the problem itself remains. The author is of the opinion that the people affected by the syndrome have simply learnt to live with it and disguise its external symptoms. However, the problem itself has not disappeared, because people with ADHD continue to reveal specific living difficulties resulting from the essence of this syndrome. This applies to everyday problems, such as forgetfulness of performing duties determined by certain principles; distraction; rashness in thinking; problems with concentration of mind; etc.

Previous studies of the author (Dudek, 2003; 2009) conducted among primary school final year students prove a strong relationship between the severity of ADHD symptoms and problems associated with social maladjustment of primary schools final year students. Ten years later, the author decided to conduct re-examination in a group of middle school senior years students. The main research problem in this paper is the question whether and to what extent middle school students with varying severity of ADHD symptoms have problems with social maladjustment.

3. Methodology of Own Studies

The studies were conducted in 2009 and 2010 among urban (Lublin, Kozienice) and rural (Ludwin, Cyców) middle school students. The total number of examined students was 354.

The studies were conducted with the use of two research tools:

ADHD Rating Scale; Conduct Disorder Scale (CDS).

3.1. ADHD Rating Scale According to DSM-IV Diagnostic Criteria

In order to measure psychomotor hyperactivity symptoms, the ADHD Rating Scale according to DSM-IV Diagnostic Criteria was used. The Scale consists of 18 items, which contain the description of behavior. According to DSM-IV criteria included in the revision of APA's (American Psychiatric Association) DSM-IV manual disease, the first 9 of them refer to attention deficit and the other 9 – to hyperactivity.

One may note that the basic psychometric properties of the ADHD Rating Scale have been verified by Dudek (2003). For this purpose, one checked the integrity of two teacher's independent estimation by the means of calculating Kendall's Tau Coefficient. To calculate the internal consistency of the entire scale and two of its constituent subscales, i.e. attention deficit and hyperactivity, Cronbach's α Coefficient was used.

The integrity of two teacher's independent estimation tested on a population of 58 fifth year students generally ranged from 0,60 to 0,79 for particular items (Kendall's Tau). The internal consistency of the entire scale and two of its constituent subscales, i.e. attention deficit and hyperactivity is very high. The Cronbach's α Coefficient is 0,97 for the entire scale, 0,96 for attention deficit subscale and 0,97 for hyperactivity subscale (Dudek, 2003).

3.2. Conduct Disorder Scale

To examine the middle school students' adaptation problems, one used the scale, which contains the diagnostics criteria of conduct disorder (CD) syndrome, interchangeably called the conduct control disorder (DSM-IV). These criteria may be found in the DSM-IV Manual, developed by the American Psychiatric Association (APA). Conduct disorders include models of behavior observed in individuals, who temporarily or permanently break the legal rules and violate the privileges and privacy of other people (DSM-IV). It should be emphasized that conduct disorders are treated as a harbinger of Anti-Social Personality Disorder (Radochoński, 2000). According to the DSM-IV Manual, the following description of 15 behaviors is listed among the basic diagnostics criteria of conduct disorders (DSM-IV, p. 66-68).

For the data operationalization purpose, like in the description regarding behaviors of students with ADHD symptoms, a 4-point scale of the symptoms frequency was applied in relation to the Conduct Disorders Scale:

1) did not occur,
2) occurs at the low level,
3) often occurs, 4) occurs commonly.

According to the diagnostics criteria included in DSM-IV, in order to establish the conduct disorder, it is necessary that these behaviors were of repeated and persistent behavioral pattern, which involves the violation of the fundamental rights of the others and the norms and principles of social coexistence. To determine the occurrence of conduct disorder it is necessary that at least three of these symptoms occurred in the past 12 months, with at least one of them being seen in the past 6 months. According to Radochoński (2000) the Conduct Control Disorder syndrome is equivalent to antisocial behaviors and it is characterized by symptoms, which are crime manifestations or lead to crime.

2.3. Calculation of the results

The study used a comparative analysis model. For this purpose, the descriptive statistics, and particularly such measures as the arithmetic mean and standard deviation were used.

Data from own research concerning social maladjustment in groups of students with diagnosed ADHD, with severe ADHD symptoms and with no significant features of this syndrome were subject to the statistical analysis by the means of:

- one-way analysis of variance (ANOVA);
- LSD multiple comparisons tests.

Statistical processing of empirical material has been developed with the use of Statistical Package for Social Sciences (SPSS for Windows).

3. The study results

All students, who were the involved in the examined groups, were the middle school third year students. It should be emphasized that the surveyed students were characterized by a small age range. The vast majority, i.e. 342 (96,6%) students are 16 years old and only 12 (3,4%) students are 17 years old. The average age of students is 16,03 years old.

The surveyed students were divided into three groups. The criterion of the students

selection was the severity of ADHD symptoms measured with the means of ADHD Rating Scale. In accordance with the diagnosis principles two teachers from each class (the so called independent judges) with a good knowledge of the students completed the ADHD Rating Scale questionnaire (see: Table 1). Thus, there were chosen three groups, each of which had a different ADHD symptoms severity:

Studied vari / Results in A	Result of the analysis of variance (ANOVA)		GR	Average	SD	Groups compari-son	p in LSD test
Rating Scale	F	P				n	
Severity of sympto	1,522	n.r.	A=96	2,4896	0,753	A – B	n.r.
			B=129	2,3125	0,801	A – C	n.r.
			C=72	2,3836	0,810	A – D	<0,052~
			D=57	2,2281	0,866	B – C	n.r.
						B – D	n.r.

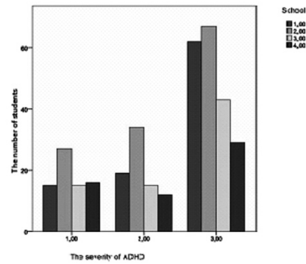
**p<0,05 when df = 3; n.r. – not relevant statistically; ~ close to statistical significance*

Group A – consisted of 73 students with diagnosed ADHD, who meet the DSM-IV criteria, i.e. they received an assessment of 4 or 3 in at least 6 items of the ADHD Rating Scale.
Group B – with marked ADHD symptoms, which included 80 students receiving an assessment of 3 or 4 in 3 to 5 items of the ADHD Rating Scale.
Group C – without significant ADHD symptoms, consisted of 201 students, who received not more than 2 in particular items.

The severity of ADHD at students from the surveyed schools

First, it was examined whether there are differences in the ADHD occurrence among students from the compared schools (Table 1.). According to the accepted research model, to determine the differences in the ADHD occurrence among the students of each school environments the analysis of variance (ANOVA) was applied in four schools simultaneously, and the LSD post test was applied to compare the pairs of groups (dyads). Comparing the arithmetic means and standard deviations with the use of the analysis of variance, in general, indicates no significant differences in the occurrence of ADHD problems in the compared schools. The value of the F test is far from the statistical significance. Only in the case of comparisons in each dyads some trends to diversify group A (Cyców rural school students) and Group D (Kozienice Urban School) are visible.

Table 1. The severity of ADHD in the surveyed groups (A-school in Cyców, B-school in Lublin; C-school in Ludwin; D-school in Kozienice. Number of students: A= 96; B= 129; C= 72; D= 57)
Figure 1. Results in the ADHD Rating Scale obtained by students in each of the surveyed schools



3.2.The Severity of ADHD and Social Maladjustment

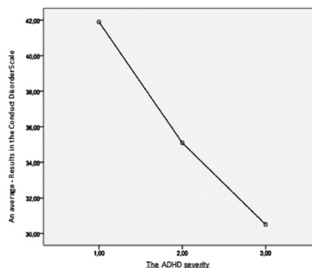
The rich literature on the subject indicates the major problems of people with ADHD in social adjustment (Vitelli, 1997, 1998; Bartkowicz, 1998). In the context of the above considerations it was considered necessary to examine differences in adaptation problems among groups distinguished because of the severity of ADHD symptoms. For this purpose there were compared arithmetic means and standard deviations of the results obtained by students from different groups with the use of Conduct Disorder Scale (compare Table 2 and Figure 2).

Table 2. Comparison of arithmetic means and standard deviations obtained in the Conduct Disorder Scale by the students with the severity of ADHD symptoms (Group A- students with diagnosed ADHD syndrome; Group B- students with the severity of the syndrome; Group C- students without significant ADHD symptoms)

**p<0,001 when df = 2; n.r. – not relevant statistically*

Studied vari / Symptoms of social maladjustment	Result of the analysis of variance (ANOVA)		GR	Average	SD	Groups comparison	p in LSD test
	F	P					
Results in th duct Disorde	128,268	<0.000	A=73	2,4896	0,753	A – B	n.r.
			B=129	2,3125	0,801	A – C	n.r.
			C=72	2,3836	0,810	A – D	<0,052~

Figure 2. Average results obtained in the Conduct Disorder Scale by students with the severity of ADHD symptoms



The comparison of the three groups at the same time with the use of F test indicates a huge difference in the severity of maladjustment problems measured in the Conduct Disorder Scale among groups of students distinguished because of the severity of ADHD symptoms (F=128,268; p<0,000). The severity of these problems depends proportionally on the severity of psychomotor hyperactivity symptoms. The comparison of the groups with the use of LSD test indicates a clear dominance of adaptation problems among students with diagnosed ADHD (Group A) in relation to students with the severity of the syndrome (Group B) as evidenced by a high degree of statistical significance being at the level of p<0,000. Similarly, students with the severity of ADHD symptoms (Group B) manifest adaptation problems more often than their colleagues from Group C (no significant ADHD symptoms), where the value of statistical significance is comparatively high at p<0,000.

The results confirm previous reports on high correlation between the occurrences of ADHD and conduct disorder symptoms (defined as social maladjustment) (Radochoński, 2000).

Discussion on the results:

In the description of the behavior of people with psychomotor hyperactivity, the coexistence of the following features is often emphasized: explosiveness, quarrelsomeness, prone to fight and bully colleagues, lack of discipline, unwillingness to comply with colleagues and adults (Barkley, 1997; Biederman et al., 1996; Loeber, et al. 1997; Ratey, et al. 1997). Based on many years of his experience in work with children with ADHD, Barkley (1983) comes to the conclusion that the children are generally more aggressive, stubborn and less mature in relations with siblings and peers. Similar views are announced by Ramirez et al. (1997), who, based on their insightful observations and comparative studies, indicate a strong correlation of ADHD symptoms and trends in anger severity, large (social and interpersonal) adaptation problems, emotional liability and other mental problems.

Hallowell, Ratey (2004) indicate that problems associated with the ADHD issue may equally interfere with social life, at work and at school. Reactions and messages from the environment are usually unintelligible to people affected by ADHD because they are unable to properly receive them. No ability of reading the subtle signals from the environment (such as winking eyes, raising eyebrows, slight changes in the tone of voice, tilting head, etc.) is a main reason of committing several social blunders or overall feeling of alienation. This is very important, particularly during adolescence, when social contacts are turbulent. A lack of insight into a social situation resulting from the basic ADHD features, i.e. absentmindedness and impulsivity often make acceptance of this person impossible as well as prevent from the friend's understanding (Hallowell, Ratey, 2004).

Rozenham, Seligman followed up on 101 sixteen-year olds, who evidenced the ADHD features in their childhood. It turned out that almost half of them (45%) experienced conduct disorder and drug abuse, while in the control group the problem affected only one in six (16%) adolescents (Rosenham, Seligman, 1994).

In Polish conditions, as yet, few researchers have taken an attempt of comprehensive analysis of the social maladjustment phenomenon among people with ADHD. The research results of such authors as Orwid and Pietruszewski (1996), Radochoński (2000) and Dudek (2003;2009) are of a particular importance in the context of the problem.

Orwid and Pietruszewski (1996, s.74) emphasize that antisocial personality develops in one quarter (25%) of respondents in adolescence and adulthood. Another researcher, Radochoński (2000), has taken an attempt to clarify the role of selected environmental and personality factors in the formation of antisocial personality disorder. In his research he demonstrates a strong correlation between antisocial behaviors and psychomotor hyperactivity. The studies, conducted by Radochoński, concerned the environments of adult recidivists.

The results of the studies, conducted by Dudek (2003;2009) among 301 primary school final year students, clearly indicate a strong relationship between the severity of ADHD symptoms and the features of social maladjustment. This means that the adaptation problems are arranged proportionally to the ADHD severity: the largest ones are in the group with diagnosed ADHD, slightly smaller ones in the group with significant ADHD symptoms and definitely the smallest ones in the group with few ADHD symptoms. At the same time the author emphasizes the importance of gender in the manifestation of the ADHD and social maladjustment features. It turns out that girls with ADHD manifest problems in the area of social maladjustment less often than boys (Dudek, 2009).

According to Panas (2010), studies, conducted among juveniles referred by the courts to Family Diagnostic Centers, until recently indicated a significant predominance of ADHD features among boys. Currently, the differences become blurred, which proves that minor girls manifest ADHD features as much as boys.

In the characteristics of the attention deficit hyperactivity disorder there are emphasized huge adaptation difficulties of people affected by this syndrome. Typically, individuals with ADHD have difficulties in task situations, which require planning and attention, adaptation to the school rules, the rules of social life, etc. People affected by ADHD, by virtue of their behavior, are called difficult people, and by some – socially maladjusted. The irritating way of these people functioning causes aversion among their colleagues and teachers. Educating and raising students with ADHD cause a lot of difficulties for teachers and parents. Students with ADHD come into frequent conflicts with adults and peers. In the teachers' opinion these students do not follow the school rules, violates Basic rules of the social life, and they are often supposed to be malicious and to act deliberately. Teachers are often of the opinion that children with ADHD syndrome may become criminals in the future. This occurs despite the increasing awareness of teaching and social environment in Poland regarding the ADHD syndrome itself, its main characteristics, influence on individual and social ways of functioning, methods of diagnostics and therapeutic possibilities.

These reports seem to indicate the existence of a development cycle in terms of the antisocial tendencies in the individual's life, the initial stage of which is psychomotor hyperactivity and the final stage – antisocial personality (Vitelli, 1998; Radochoński, 2000).

Previous experience indicates a modest effectiveness of any corrective treatments, where the subject is only the child manifesting certain symptoms of behavioral disorders. Similarly, there is little significance of the analysis of isolated, small fragments of reality, which are a part of a larger social entity and analyzed in a linear manner (e.g. in the family – mother-child, father-child dyad, at school – teacher-student, student-student dyad). It becomes necessary to look at the problem of the pathology of human behavior in a holistic manner, which consists of examining and understanding the psychosocial relationship between a man and his social environment, with which he remains in constant and direct interactions. This means that social prevention must be directed not only at the individual, but

also (some believe that mostly) at his social environment. In the integrated system of prevention the emphasis is put on eliminating and reducing the causes of behavioral disorders. For this purpose the early multilateral diagnosis is used. Interventions aimed at reducing problems are concentrated on the basic social groups, such as: family, peers, school or others, which are the source of disorders or perpetuate them.

One should remember that the full diagnosis must be multifaceted. The need of conducting multifaceted diagnosis makes it necessary to engage a diagnostics body consisting of specialists in various fields. For this purpose, the presence of a Psychologist, a Pedagogue, a Physician and a Social Worker is necessary. Each of them, individually or in consultation with others makes a particular aspect (fragment) of the diagnosis. The Psychologist is responsible for the formulation of a clinical diagnosis model. The Pedagogue seeks to combine the pedagogical diagnosis with the information on psychological diagnosis into a logical entirety. The Physician answers questions of a medical nature. And the Social Worker collects information on the social environment and formulates a social diagnosis.

The diagnosis of social maladjustment of students with ADHD is so important because, in practice, it is difficult to distinguish behaviors arisen from the nature of the syndrome from behaviors resulting from the process of social derailment, which is the effect of parenting and school environment errors.

As the practice indicates, students' educational problems are the main cause of conversations and analysis of teachers and other staff. Interventions and increasing contacts of parents and guardians with the schools' representatives are the consequence of this situation. The staff expects parents' intervention in order to eliminate or decrease a number of difficult and hazardous behaviors. Parents attempt to protect children, not always understanding the quantity and quality of objections raised to their children. As a result, the parents get a sense of misunderstanding, loneliness, bitterness. This state potentially affects the quality of family life and relationships within the entire family system.

The basic condition of effectiveness in work with a child affected by ADHD is early diagnosis and intervention. Systematic work with a child can teach him to deal with ADHD results, making his life less problematic and more joyful. On the contrary, the lack of diagnosis and the lack of relevant treatment condemn student with the syndrome to multiple problems, suffering and failure. This situation calls into question the conscience of all those, who raise the child with ADHD syndrome every day.

Conclusion

The results of the study presented in the article very clearly demonstrate a strong relationship between the severity of ADHD symptoms and problems with the Middle school students' social maladjustment. This proves that with age the situation of people affected by ADHD has not improved, but even become worse. There are nominally increasing numbers of people with ADHD (comparing to the previous studies among the primary school final class students), who AT the same time are perceived by teachers as socially maladjusted individuals. One may, therefore, raise questions:

- What happened in lives of adolescents that result in growth of people affected by ADHD?
- Is there a real system of support for students with ADHD syndrome?
- What do the teachers do to help students with ADHD?

These are the elementary research questions, which also relate to the Polish schools realities. The answer to these questions is of a great importance from the research, but also organizational point of view. The existing provisions on psycho-pedagogical help are a good start to organize a support system for students, but will not replace the good will of Pedagogues and their need of understanding people affected by ADHD syndrome.

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THE ORGANIZATION AND STRUCTURE OF HEALTHCARE ETHICS COMMITTEES IN CENTRAL EUROPE: PROMOTING AND INHIBITING FACTORS OF EVOLUTION

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ORIGINAL ARTICLE

Abstract

Within the past thirty years, Central Europe has experienced the establishment and implementation of Healthcare Ethics Committees, which are in the process of continual evolution. Healthcare Ethics Committees were first recommended, then required internationally, and now differently regulated nationally in Croatia, Czech Republic, Hungary, Poland, and Slovakia.

This article analyzes the legal requirements for the organization, meaning the manner of operation, and the structure, meaning who can and must participate, in research and Hospital Ethics Committees. This includes ways in which regulations promote and inhibit the evolution of such Committees. This will be analyzed in a top-down manner, from international recommendations and regulations, to national regulations on organization and structure. Although research and Hospital Ethics Committees have different purposes and tasks, their organization and structure are too similar. Additionally, although such regulations are optimal for Research Ethics Committees, they limit the power of deliberation in hospital Ethics Committees. This implicates that there are areas of improvement in the overarching top-down regulations of Healthcare Ethics Committees. In conclusion, fewer legal regulations will allow for a continual positive evolution of Healthcare Ethics Committees in Central Europe.

Key words: healthcare commitee, international regulation, hospital ethics

INTRODUCTION

Within the past thirty years, Central Europe has experienced the establishment and implementation of Healthcare Ethics Committees, which are in the process of continual evolution. Healthcare Ethics Committees were first recommended, then required internationally,

and now differently regulated nationally in Croatia, Czech Republic, Hungary, Poland, and Slovakia. Ethics Committees are the driving force for patient-centered Healthcare. They act on their duty to "protect the dignity, rights, safety and well-being of [individuals]" (2). In this sense, Ethics Committees act for the rights on individuals, and in the process also act for the benefit of community health, with the ultimate goal of health improvement. The evolution of medicine has coincided with the development of sound ethical practices, and Committees to guard those Ethics. In addition, Ethics Committees act as national Healthcare indicators to different cultural implications, stances on technology, stages of development, and the direction of Healthcare in the future. This article analyzes the legal requirements for the organization, meaning the manner of operation, and the structure, meaning who can and must participate, in research and Hospital Ethics Committees. This includes ways in which regulations promote and inhibit the evolution of such Committees. This will be analyzed in a top-down manner, from international recommendations and regulations, to national regulations. The reason to study structure and organization of such Committees is that these factors drive their function and outcomes. In addition, Healthcare Ethics Committees will be categorically split into Research Ethics Committees (RECs) and Hospital Ethics Committees (HECs) in order to analyze their unique structure and function. This study utilizes a top down approach to studying Healthcare Ethics Committees by first analyzing the structure and function imposed by European Council Recommendations and Compliance, then European Union Requirements, then Research Ethics Committee Practices, and lastly Hospital Ethics Committees. In addition to impose requirements for their formation, this study is concerned with additional manifestations of practice, which stem from initial requirements and recommendations.

EUROPEAN RECCOMENDATIONS AND REGULATIONS

The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the application of Biology and Medicine (Oviedo Convention), laid the groundwork for Ethics Committee legislation to occur. The commission focused on establishing precise ethical rules regarding research practices concerning human subjects and individual human rights. As seen in Table 1 (2), Croatia, Czech Republic, Hungary, Poland, and Slovakia all signed that they would abide by the principles laid out. Every country but Poland also ratified their signature, making it officially valid, and entered the principles established into force (2).

The next significant landmark in European Healthcare Ethics Committees occurred in 2001 as part of the European Commission Directive 2001/20/EC. This directive was primarily concerned with implementing good clinical practice in clinical trials, and established requirements for research screening by RECs. The requirements established a loose structure for Ethics Committees „consisting of Healthcare professionals and non-medical members" (3), meaning there were no requirements for the members themselves. Simply, Committees are to consist of Healthcare professionals and non-medical members. Conversely, the directive formulated strict organizational requirements for the function of Ethics Committees. For example, Committees were provided with specific Committee protocols and directives, specific timelines and due dates, and application requirements from research institutions. These requirements standardized the manner in which research Ethics Committees practice, forcing

Committees act in a very specific manner, with little room for ethical deliberation. In addition, the Commission Directive 2005/28/EC established increased requirements for the national organization of Ethics Committees. This implemented regulations on national provisions by establishing that each Ethics Committee shall adopt the relevant rules of procedure necessary to implement the requirements. This established further structural regulations, basically forcing nations to adopt laws that embody commission directive protocols (3).

On the national level, Research Ethics Committees (RECs) aim their focus on the review of medical research involving human subjects. As a representation of European recommendations and regulations, such Committees are organized strictly in order to follow European Union Protocols. Which means they follow a strict method of analysis and interpretation medical research in order to meet the needs of analysis. REC structure, instead, is loosely regulated internationally. Consequently, nations have developed their own regulations and a certain level of consistency in their structure. As seen in Table 2: National Structures of Ethics Committees (7, 8, 9, 10 & 11), RECs are implemented either regionally or nationally, with differing numbers of members related to the how many Committees the nation has as a whole. In addition, when most recently studied, all Committees out of the five countries that included a layperson and three out of five nations also included an ethicist in their Committees. Without an empirical measure of effectiveness, it is difficult to judge which structural requirements work best, however, ethicists, laypersons, and training programs can act as an initial measure of effectiveness, meaning there is some room for improvement in their structure.

Hospital Ethics Committees (HECs) primarily focus on the moral issues in patient care. This includes ethical case analysis and policy guideline formation. HECs are unrequired and unregulated internationally in Europe. However, HECs are required by law in Croatia, Czech Republic, Hungary, and Slovakia. Polish law does not require them, however, some Polish hospitals still implement HECs. HECs tend to follow the structure of RECs. This was especially seen in Slovakia and Croatia, where HECs generally followed protocols similar to RECs and often times performed similar tasks (6). This relationship can be seen in Table 3: Average frequency of Tasks over a 12 year period in Croatian HECs (1). This table looks into the frequency of different tasks performed by Croatian HECs over a 12 year period. Over this time, 37% of tasks dealt with analysis of research protocols, so one third of the time, HECs were performing REC tasks. In addition, Hospital Ethics Committees were performing their tasks similarly in organization to RECS (1). The overall structural formation of the five countries studied can be seen in Table 1: Types of Regulation in Hospital Ethics Committees. This table demonstrates the central and strict regulation of Ethics Committees. Central, meaning that the Committees function in relation to a standard overarching organization nationally, and strict, meaning that Committees act by following strict protocols with little room for deliberation.

LIMITATIONS OF THE STUDY

One major limitation in this study was its English literature based nature. In this sense it was difficult to determine the amount of missed literature on the subject matter. In addition, there has been little empirical research done concerning HEC practices and effectiveness. There is a need for continual study within the topic of Healthcare Ethics Committees. More empirical research must be done on HEC operations and perceived success, meaning the

Committees ability to determine all ethical implications involved and come to the most appropriate conclusion. By studying how Committees operate and when they are perceived to be successful, countries can begin to form their own standardization of successful organization and structure. Ethics Committees act as a unique yet important entity within hospitals. In order to make them maximally effective, nations need to know the amount of, or lack there of regulations to impose on Committees.

ANALYSIS, FINDINGS & PREDICTIONS

The organization and structure of HECs and RECs are similar, although they have different purposes and tasks. Although such regulations are optimal for Research Ethics Committees, they may limit the power of deliberation in Hospital Ethics Committees. This implicates that there are areas of improvement in their overarching top-down regulations. Over the past decade, RECs have been successfully implemented in all five Central European countries studied. In all five cases, each country now has its own laws set in place to ensure compliance with European Union regulations. In addition four of the five countries have taken additional steps to ensure HECs are also implemented by law. Now that each country has implemented Ethics Committees, the same top down regulation needs to ensure their evolution and improvement by lessoning international regulations and allowing for variability in structure and organization. Fewer legal regulations will allow for a continual positive evolution of Healthcare Ethics Committees in Central Europe. With the goal of protecting human rights, HECs in particular must be formatted in better setting for ethical deliberation, which would make Committees more ethically effective. In addition, Ethics need to have the proper amount of power to act on their ethical effectiveness. This principle pertains especially to Catholic Ethical Principles. In order to appropriately apply Principles, HECs must maintain less strict organization to ensure ethical deliberation.

In conclusion, there is room for improvement in the organization and structure of Ethics Committees in Central Europe. In order to continue their evolution, Ethics Committees need to be studied further and allowed less international regulations. Only by doing so will Healthcare Ethics Committees continue to evolve in their success related to the protection of human rights.

Table 1: Compliance with Convention Protocols (2

Council State	Signature	Ratification	Entry into Force
Croatia	7/5/1999	28/11/2003	1/3/2004
Czech Republic	24/6/1998	22/6/2001	1/10/2001
Hungary	7/5/1999	9/1/2002	1/5/2002
Poland	7/5/1999	-	-
Slovakia	4/4/1997	15/1/1998	1/12/1999

(Convention for the protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine)

Table 2: National Structure of RECs (7, 8, 9, 10, & 11)

	National or Regional RECs	Number of Members	Do RECs include Layperson/ Ethicist?	Who appoints members of Committee?	Specified training program available?
Croatia	Single	19	Yes/Yes	Minister of Health	No
Czech Republic	Multiple	6-25	Yes/No	Head of institution	No
Hungary	Single	20	Yes/No	Minister of Health	Yes
Slovakia	Multiple	5-9	Yes/Yes	President of regional state authority	Yes
Poland	Multiple	11-15	Yes/Yes	Rector or	No

Table 3: Average Frequency of Tasks over a 12-year period in Croatian HECs (1)

Functions	Frequency	Percentage
Analysis of approval of research protocols	56	37%
Education of the members of the Ethics Committees and hospital staff	12	8%
Policies and guidelines formation	11	7%
Ethical case analysis	37	25%
Review of the complaints made by patients and physicians	35	23%

Figure 1 Organization and Structure of Hospital Ethics Committees (6)

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MUSCULAR DISBALANCE OF THE NECK MUSCLES

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ORIGINAL ARTICLE

Abstract

Background: Muscle imbalance is developed as a consequence of shortened and weakened muscles and results in disorder of movement patterns and muscle coordination.

Material and methods: We conducted clinical research, where respondents were filled in the classification by method of deliberate choice. The group consisted of 50 respondents in the age group 24-52 years. Main criterion for inclusion was neck pain. First group had kinesiology as a treatment and the second group had kinesiology plus physical therapy.

Results: Mean value of the shortening of muscles at the beginning of therapy is greater than at the end of therapy in patients in both groups.

Conclusion: Comprehensive physiotherapy is important as far as shortened muscles are considered. Reduction of pain can be achieved not only by kinesiotherapy, but also with physical therapy. Their combination is accelerating the releasing of shortened muscles, thus improving the overall position of the head, neck, and shoulder blades.

Key words: Neck pain. Shortened muscles. Weakened muscles.

1. Introduction

Physiologically, we are programmed for active life. But nowadays, when we all prefer cars instead of walking, TV instead of sports activities and on top of that we have sedentary work, this all contributes to the fact that our bodies are overloaded and must work in disharmony (6). Computers, air conditions and the ever-present stress on the shoulders contributes to the occurrence of pain and disease in the cervical area. We can see increase in the incidence of vertebrogenous cervical disease in rehabilitation clinics and neurological and orthopedic clinics as well. Therefore, we can consider this condition as a lifestyle disease, caused by lack of exercise or poor movement patterns learned which cause pain and restriction of movements, thus reducing quality of life.

2. The methodology of work and research methods

Clinical research was conducted in outpatients of Physiotherapy and Rehabilitation Department in Bratislava. The study was composed of 50 patients who reported pain in the neck with and were diagnosed with Vertebrogenous algic syndrome (VAS) of cervical, cervico-brachial or cervico-cranial area of innervation. We divided participants into two groups of 25 patients. First group, 14 (56%) women and 11 (44%) men, received only kinesiotherapy. Second group, consisted of 19 (76%) of women and 6 (24%) of men, received also physical therapy in addition to kinesiotherapy.

3. Objective and Results

The objective is to determine the possibility of affecting the nuchal muscle pain by selected methodologies of physical therapy and to map the potency of selected methodologies of physiotherapy on the top cross-over syndrome. We have set the hypothesis of assumption, that in the majority of patients with selected targeted physiotherapy techniques, the muscle imbalance in terms of cross-upper syndrome (VAS) is reduced or removed.

VAS is developed by weakened and shortened muscles in the neck and shoulders. For confirmation of diagnosis, we investigated abbreviated m. trapezius - upper fibers, m. levator scapulae and m. pectoralis major. Deep neck flexors and lower blades fixators were chosen for investigation from weakened muscles. Group 1 we present levels of shortened muscles found and point values of weakened muscles. (Table 1 and 2)

Table 1: Shortened muscles, group 1

	Entrance examination						Conctrol examination					
	Right			Left			Right			Left		
	0	1	2	0	1	2	0	1	2	0	1	2
m. trapezius – upper strings	0	6	19	0	5	20	9	13	3	7	14	4
m. levator scapulae	0	10	15	0	11	14	8	14	3	10	13	2
m. pectoralis major	0	15	10	0	14	11	7	17	1	9	16	0

Table 2: Weakened muscles, group 1

	Entrance examination										Control examination									
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
Deep neck flexors	0	0	2	5	8	3	5	2	0	0	0	0	0	0	1	2	5	4	7	6
lower blades fixators	0	0	3	5	6	8	3	0	0	0	0	0	0	0	0	4	6	7	6	2

The average value of the level of shortening during the examination of the upper fibers of m. trapezius before therapy was 1.78 degree and 0.82 degree after therapy, the m. levator scapulae 1.58 degree of shortening before therapy, after 0.74, and the mean degree of shortening of m. pectoralis major before therapy was 1.42 and after therapy 0.7. (Table 3)

Table 3: The average values and standard deviations of the degree of shortening of the neck muscles - group 1

	Entrance examination		Control examination	
	Right	Left	Right	Left
	Average ± standard deviation		Average ± standard deviation	
m. trapezius – upper strings	1,76 ± 0,44	1,80 ± 0,41	0,76 ± 0,66	0,88 ± 0,67
m. levator scapulae	1,60 ± 0,50	1,56 ± 0,51	0,80 ± 0,65	0,68 ± 0,63
m. pectoralis major	1,40 ± 0,50	1,44 ± 0,51	0,76 ± 0,52	0,64 ± 0,49

In the first group of patients, average point value of the weakened deep neck flexors during the examination was 5,4 points before therapy and 8,28 after therapy. The average value of points in examination of lower blade fixators before therapy was 5,12 points and 7,84 after therapy. (Table 4)

Table 4: The average values and standard deviations of points of muscle weakness - group 1

	Entrance examination	Control examination
	Average ±standard deviation	Average ±standard deviation
deep neck flexors	1,76 ± 0,44	1,76 ± 0,44
lower blade fixators	1,76 ± 0,44	1,76 ± 0,44

To confirm the presence of cross-upper syndrome in group 2 patients we present the measured values of shortened and weakened muscles. (Table 5 and 6).

Table 5 Shortened muscles in patients - group 2

	Entrance examination						Control examination					
	Right			Left			Right			Left		
	0	1	2	0	1	2	0	1	2	0	1	2
m. trapezius – upper strings	0	13	12	1	9	15	7	17	1	8	16	1
m. levator scapulae	0	10	15	0	11	14	7	18	0	8	17	0
m. trapezius – upper strings	1	12	12	0	14	11	11	14	0	12	13	0

Table 6: Weakened muscles in patients - group 2

	Entrance examination										Control examination									
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10
deep neck flexors	0	1	4	5	4	7	3	1	0	0	0	0	0	0	2	2	4	5	8	4
lower blade fixators	0	2	2	2	8	5	5	1	0	0	0	0	0	0	3	1	3	7	7	4

In group 2, the average value of the level of shortening during the examination of the upper fibers of m. trapezius before therapy was 1,52 degree and 0,74 degree after therapy, the m. levator scapulae 1.58 degree of shortening before therapy, after 0.7, and the mean degree of shortening of m. pectoralis major before therapy was 1.44 and after therapy 0.54. (Table 7)

Table 7: The average values and standard deviations of the degree of shortening of the neck muscles - group 2

	Entrance examination		Control examination	
	Right	Left	Right	Left
	Average ± standard deviation		Average ± standard deviation	
m. trapezius – upper strings	1,48 ± 0,51	1,56 ± 0,58	0,76 ± 0,52	0,72 ± 0,54
m. levator scapulae	1,60 ± 0,50	1,56 ± 0,51	0,72 ± 0,46	0,68 ± 0,48
m. pectoralis major	1,44 ± 0,58	1,44 ± 0,51	0,56 ± 0,51	0,52 ± 0,51

In group 2, average point value of weakened deep neck flexors improved from 5.0 points before therapy to 8.08 points after, and the average value of points in examination of lower blade fixators improved from 5.24 points to 8.04 points after therapy. (Table 8)

Table 8: The average values and standard deviations of points of muscle weakness - group 2

	Entrance examination	Control examination
	Average ±standard deviation	Average ±standard deviation
deep neck flexors	5,00 ± 1,55	8,08 ± 1,50
lower blade fixators	5,24 ± 1,59	8,04 ± 1,54

To confirm the presence of cross-upper syndrome in the whole group of patients, we present investigated value of shortened and weakened muscles. (Table 9 and 10)

Table 9: Shortened neck muscles in the whole set of patients

	Entrance examination						Control examination					
	Right			Left			Right			Left		
	0	1	2	0	1	2	0	1	2	0	1	2
m. trapezius – upper strings	0	19	31	1	14	35	16	30	4	15	30	5
m. levator scapulae	0	20	30	0	22	28	15	32	3	18	30	2
m. pectoralis major	1	27	22	0	28	22	18	31	1	21	29	0

Table 10: Weakened muscles in the whole set of patients

	Entrance examination									Control examination								
	2	3	4	5	6	7	8	9	10	2	3	4	5	6	7	8	9	10
deep neck flexors	0	1	4	5	4	7	3	1	0	0	0	0	0	2	2	4	5	8
lower blade fixators	0	2	2	2	8	5	5	1	0	0	0	0	0	3	1	3	7	7

In all patients included, the average value of the level of shortening during the examination of the upper fibers of m. trapezius before therapy was 1,65 degree and 0,78 degree after therapy, the m. levator scapulae 1.58 degree of shortening before therapy, after 0.72, and the mean degree of shortening of m. pectoralis major before therapy was 1.43 and after therapy 0.62. (Table 11)

Table 7: The average values and standard deviations of the degree of shortening of the neck muscles - whole set

	Entrance examination		Control examination	
	Right	Left	Right	Left
m. trapezius – upper strings	1,62	1,68	0,76	0,8
m. levator scapulae	1,6	1,56	0,76	0,68
m. pectoralis major	1,42	1,44	0,66	0,58

Average point value of weakened deep neck flexors improved from 5.2 points to 8.18 points. A mean value points for examination lower blade fixators improved from 5.18 points to 7.94 points. (Table 12)

Table 12: The average point value of weakened muscles in the whole set of patients

	Entrance examination	Control examination
deep neck flexors	5,2	8,18
lower blade fixators	5,18	7,94

From the above investigated values we can conclude that there was a partial removal of muscle imbalance in terms of upper-cross syndrome (VAS). To confirm this hypothesis we used paired t - test for both groups. Our zero hypothesis (H0) was to verify whether the mean (μ) degree of shortening of the muscles before therapy and degree of muscle shortening after therapy were identical (H0: μ1 = μ2). For the muscles with a tendency to the reduction (H1) we verified the alternative hypothesis, that the mean value of the pre-treatment reduction of the muscle is greater than the mean value of the reduction of muscle after treatment (H1: μ1> μ2). For the muscles with a tendency of a weakening we verified the alternative hypothesis, that mean value point of weakness before therapy is less than the mean value point of weakness after treatment (H1: μ1 <μ2).

Comparison of differences of mean values of the degree of muscle shortening with tendency to the reduction in the first group of patients at the beginning and at the end of therapy are presented in the tables 13,14,15, for m. trapezius - upper strings, m. levator scapulae and the m. pectoralis major.

Table 13: Comparison of differences of mean values of shortening m. trapezius

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	1,76	0,76	1,8	0,88
Standard deviation	0,43589	0,663325	0,408248	0,665833
The coefficient of variation	24,7665%	87,2796%	22,6805%	75,6628%
Minimum	1,0	0,0	1,0	0,0
Maximum	2,0	2,0	2,0	2,0
Range	1,0	2,0	1,0	2,0
Obliquity	-2,64687	0,617282	-3,26087	0,273598
Taperness	-0,360943	-0,624698	0,605111	-0,568474
$H_0: \mu_1 = \mu_2$	$H_1: \mu_1 > \mu_2$			
test characteristics: t	6,29941		5,8897	
P-value	4,36617E-8		1,84693E-7	
Conclusion	Accepting H_1		Accepting H_1	

Table 14: Comparison of differences of mean values of shortening m. levator scapulae in Group 1 patients

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	1,6	0,8	1,56	0,68
Standard deviation	0,5	0,645497	0,506623	0,627163
The coefficient of variation	31,25%	80,6872%	32,4758%	92,2298%
Minimum	1,0	0,0	1,0	0,0
Maximum	2,0	2,0	2,0	2,0
Range	1,0	2,0	1,0	2,0
Obliquity	-0,887496	0,412471	-0,525537	0,70515
Taperness	-2,01704	-0,489898	-2,15325	-0,538359
$H_0: \mu_1 = \mu_2$	$H_1: \mu_1 > \mu_2$			
test characteristics: t	4,89898		5,45753	
P-value	0,0000056812		8,35153E-7	
Conclusion	Accepting H_1		Accepting H_1	

Table 15: Comparison of differences of mean values of shortening m. pectoralis major in Group 1 patients

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	1,4	0,76	1,44	0,64
Standard deviation	0,5	0,522813	0,506623	0,489898
The coefficient of variation	35,7143%	68,7912%	35,1821%	76,5466%
Minimum	1,0	0,0	1,0	0,0
Maximum	2,0	2,0	2,0	1,0
Range	1,0	2,0	1,0	1,0
Obliquity	0,887496	-0,60242	0,525537	-1,26812
Taperness	-2,01704	-0,00791936	-2,15325	-1,79852
$H_0: \mu_1 = \mu_2$	$H_1: \mu_1 > \mu_2$			
test characteristics: t	4,42345		5,67581	
P-value	0,00002780015		3,90559E-7	
Conclusion	Accepting H_1		Accepting H_1	

Comparison of differences of mean point values of weakened deep neck flexors and lower blade fixators in group 1 patients are presented in Table 16.

Table 16: Comparison of differences of mean point values of deep neck flexors and lower blade fixators in group 1 patients

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	5,4	8,28	5,12	7,84
Standard deviation	1,44338	1,45831	1,23558	1,21381
The coefficient of variation	26,7292%	17,6124%	24,1325%	15,4823%
Minimum	3,0	5,0	3,0	6,0
Maximum	8,0	10,0	7,0	10,0
Range	5,0	5,0	4,0	4,0
Obliquity	0,44271	-1,08571	-0,501542	0,0555819
Taperness	-0,838287	-0,615196	-0,889845	-0,887292
$H_0: \mu_1 = \mu_2$	$H_1: \mu_1 > \mu_2$			
test characteristics: t	-7,01813		-7,85196	
P-value	3,44867E-9		1,84416E-10	
Conclusion	Accepting H_1		Accepting H_1	

Table 17: Comparison of differences of mean values of shortening m. trapezius upper strings in Group 2 patients

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	1,48	0,76	1,56	0,72
Standard deviation	0,509902	0,522813	0,583095	0,541603
The coefficient of variation	34,4528%	68,7912%	37,3779%	75,2226%
Minimum	1,0	0,0	0,0	0,0
Maximum	2,0	2,0	2,0	2,0
Range	1,0	2,0	2,0	2,0
Obliquity	0,174052	-0,60242	-1,91151	-0,312833
Taperness	-2,21874	-0,00791936	-0,00279175	-0,353815
$H_0: \mu_1 = \mu_2$	$H_1: \mu_1 > \mu_2$			
test characteristics: t	4,9295		5,27756	
P-value	0,00000512259		0,0000015566	
Conclusion	Accepting H_1		Accepting H_1	

Table 18: Comparison of differences of mean values of shortening m. levator scapulae in Group 2 patients

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	1,6	0,72	1,56	0,68
Standard deviation	0,5	0,458258	0,506623	0,476095
The coefficient of variation	31,25%	63,6469%	32,4758%	70,014%
Minimum	1,0	0,0	1,0	0,0
Maximum	2,0	1,0	2,0	1,0
Range	1,0	1,0	1,0	1,0
Obliquity	-0,887496	-2,13034	-0,525537	-1,6777
Taperness	-2,01704	-1,01812	-2,15325	-1,47718
H_0: $\mu_1 = \mu_2$	H_1: $\mu_1 > \mu_2$			
test characteristics: t	6,48745		6,32892	
P-value	2,24788E-8		3,9344E-8	
Conclusion	Accepting H_1		Accepting H_1	

Table 19: Comparison of differences of mean values of shortening m. pectoralis major in Group 2 patients

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	1,44	0,56	1,44	0,52
Standard deviation	0,583095	0,506623	0,506623	0,509902
The coefficient of variation	40,4927%	90,4684%	35,1821%	98,0581%
Minimum	0,0	0,0	1,0	0,0
Maximum	2,0	1,0	2,0	1,0
Range	2,0	1,0	1,0	1,0
Obliquity	-0,886367	-0,525537	-0,525537	-0,174052
Taperness	-0,68328	-2,15325	-2,15325	-2,21874
H_0: $\mu_1 = \mu_2$	H_1: $\mu_1 > \mu_2$			
test characteristics: t	5,69622		6,3996	
P-value	3,63674E-7		3,0656E-8	
Conclusion	Accepting H_1		Accepting H_1	

Comparison of differences of mean point values of weakened deep neck flexors and lower blade fixators in group 2 patients are presented in Table 20.

Table 20: Comparison of differences of mean point values of deep neck flexors and lower blade fixators in group 2 patients

	Right		Left	
	Before	After treatment	Before	After treatment
No. of patients	25	25	25	25
Average	5,0	8,08	5,24	8,04
Standard deviation	1,55456	1,49778	1,5885	1,54056
The coefficient of variation	31,0913%	18,5368%	30,3149%	19,1612%
Minimum	2,0	5,0	2,0	5,0
Maximum	8,0	10,0	8,0	10,0
Range	6,0	5,0	6,0	5,0
Obliquity	-0,147646	-1,29136	-1,01363	-1,51295
Taperness	-0,810288	-0,414022	-0,197925	-0,168337
H_0: $\mu_1 = \mu_2$	H_1: $\mu_1 > \mu_2$			
test characteristics: t	-7,13391		-6,32671	
P-value	2,29233E-9		3,96518E-8	
Conclusion	Accepting H_1		Accepting H_1	

On this basis, we rejected the null hypothesis (H0) and we adopted alternative hypothesis H1. Based on the fact that in all the cases we have seen the lowest possible level of significance to reject the null hypothesis given P-value less than 0.05 we can talk about statistically significant differences. The hypothesis was confirmed.

Discussion and conclusion

For modifying muscle imbalances we have used mainly Brugger methodology, functional stabilization and mobilization of the spine according to Smisek and rehabilitation according to Pilates Medical concept. For each exercise, we have emphasized the correct starting position, adjusting the spine and correct exercise demonstration. It is important to maintain physiological status of the cervical spine and head during exercise, as well as provide static and dynamic work the muscles with exercise that support the most upright position of the body (1). The flexibility and muscle balance in the cervical spine are important for that we are able to resist gravity and other harmful external influences [2].

When using Brugger methodology exercises, we gave emphasis on exercises with theraband. One of the practical rehabilitation principles when working with patients, who have sedentary job, is to ensure an upright sitting position, where one example of practicing proper seating is Brugger seat [3]. Pilates medical exercise is based on rehearsed basic settings of important parts of the body, which are called pilot positions, for each exercise [4]. Functional stabilization and mobilization of the spine according Smisek (SM system) is a

selection of exercises that activate muscle systems of the body with creating strong musculature. The main principle is the necessity of stabilizing the movement during its implementation. SM system includes releasing shortened muscles, strengthening weakened muscles and incorporating new situation to management programs in the brain. With slow exercises with little power in the proper position, this system is able to perform musculoskeletal repair of man at once, in both levels (in terms of strengthening and releasing muscles). The principal value of symmetrical upper limbs exercises is that compensates for muscle imbalance in the shoulder girdle [5].

By selecting appropriate methodologies and adherence to the principles we have managed to reduce or even eliminate muscle imbalances in the neck and shoulder girdle.

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SOCIAL SUPPORT AND ITS IMPORTANCE IN DEALING WITH DIFFICULT LIFE SITUATIONS

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Abstract

The authors, in the presented paper, are dealing with Social Work's view of social support and its importance when dealing with difficult life situations. They put an emphasis, however, especially on social support, which is understood to be one of the most important positive factors modifying the effect of difficult life situations experienced by individuals. In this paper, they also list the availability and the adequacy of social support, studied through a survey, among professional soldiers with a severe change of medical status, who for this reason are losing their jobs in the Armed Forces of the Slovak Republic.

Key words: Social support. Difficult life situation. Social assistance

ARTICLE

1. INTRODUCTION

Social support is understood to be one of the most important positive factors modifying and moderating the adverse impact of various negative life situations on the mental and physical health status of a person, his/her well-being and the quality of his/her life (Křivohlavý, 2001). The importance of social support as an important protective factor that mitigates the consequences of adverse life events is documented by a wide range of research claims.

The actual impact of social support is a complex construct and it can be understood in different ways. Křivohlavý (2001), mentions two possible ways of understanding the impact of social support, and that is the general impact and the specific impact, which distinguishes social support as the presence of favorable social relations compared to support in stressful and distressing situations. (Šolcová, Kebza, 1999). Another aspect that puts social support into a more specific context is its direction. This is reflected by the fact that social support is either anticipated or received (Kebza, Šolcová, 2003).

2. FROM SOCIAL NEEDS TO SOCIAL SUPPORT AND SOCIAL REATIONS

Social needs are classified into the category of the so called higher or psychological needs; they thus represent a deficiency in the social human being. The need for social support is closely related to the existence of social needs and their satisfaction, or dissatisfaction. An effort to satisfy these needs greatly affects the social behavior of an individual.

Social support can be provided, received, expected and rejected. Many authors consider satisfaction with social support as the most important factor, or its subjectively perceived adequacy. Žiaková (2005), points out that when examining social support, in addition to the subjective perception of the client, its objective observation is also very important. Alan Vaux et al (1986, p. 196), created a concept, which understands social support as a meta construction, with three different components:

– **resources of the support network -** a set of relationships, through which an individual is granted assistance,
– **supporting behavior -** the area of procedures, widely known as the effort to help someone,
– **subjective evaluation of support -** a subjective assessment regarding the resources of social support and the supporting behavior that takes place within these relationships.

2.1 Social support is an important part of social relations.

A person has a natural tendency to unite, thus to live in relationships; according to this, she/ he creates his world. Each lives in the so-called social environment which is formed by people and their mutual relationships, their common activities, or products of such activities and relationships. Individuals, who are well integrated in their community, live longer, are able to better and faster recover from any illness and vice versa - social isolation is a significant health risk (Kožený, Tišanská, 2003).

According to A.R. Laireiter (1997), persons providing social support can be divided into three groups (in Kebza, 2005):

– family and friends,
– people, who strongly resemble by their characteristics (e.g.: gender, age, education, the same type of illness and so on),
– persons who are familiar with the relevant stressor and its situational context (e.g.: healthcare providers, socialcare providers, counselors, therapists, etc.).

A common feature of the aforementioned persons is a certain range of possibilities towards the alleviation of a difficult situation in life. The closest community, in which we live, is our family. It may be a simple relationship between partners or spouses, or family, whether a nuclear one or a secondary one. It turned out that people who live in a satisfactory marriage; have close friends; a branched supportive social network; feel satisfied with their jobs are happier and more satisfied, have better physical and mental health and live longer, than people who are missing these aspects in their life (Kebza, Šolcová, 2003). If in our vicinity, not only within a close family, but also extended by friends, classmates or colleagues, we can find individuals who in an emergency are able to create a supportive atmosphere for us; a feeling we are not alone with all the problems called relationships, social networking.

A person in a state of separation from their loved ones is experiencing many stressful, negative psychological situations, where it is important to know the risks and support factors. One of the important supporting factors is also access to social and community networks (Antolová, 2011, p. 35). Similarly, Kebza (2005) says that sources of social support are part of the social relations of the individual; according to him a social network or social support resources include six main components:

– family,
– close friends,
– neighbors,
– co-workers,
– community,
– professionals (Kebza, 2005).

To have good relationships with the people around you is one of the best and most important values in life. The inclusion of a person into the social structure, significantly affects her/his well-being and overall health. Thanks to this inclusion, a person acquires and builds social relationships and expands his social network.

A person, who is surrounded by close people and is experiencing both, joy and worries with them, fulfils his life with positive emotions and overall he feels stronger knowing that he is not alone. This implies that people with a high level of positive social relationships are not subject to as much stress factors; are able to cope better with illnesses, such as depression, arthritis, cardiovascular diseases etc. (Kebza, 2005).

When we imagine that we are suffering from some more serious illness, probably most of us in such a situation would be happy to rely on some close person; would welcome an opportunity to make a clean breast from our feelings and thoughts to someone else; just feel the interest of the other person about us. The fact that we perceive the possibility that we have somebody to rely on significantly contributes to the psychological well-being and, therefore, we dare to say that it favorably influences the course of the illness.

According to Štefáková, among life situations addressed in Social Work which require intensive social support and the involvement of not just immediate family, is the care for a terminally ill family member (Štefáková, 2014). The aforementioned example is a standard example of the need for the combination of individual and institutional social support, which we shall discuss in the next part of the article.

2.2 Individual and institutional social support

Individual social support is provided by a particular person, as an independent person, when the aim is to help another person in a difficult life situation.

Institutional social support is associated with assistance, which is covered by a formal organization, also here, of course, the support is provided by individual people, but generally as employees of these institutions, their supporting action is connected with the performance of their profession. In this respect, we can distinguish direct and indirect forms of institutional social support.

Direct form - is primarily targeted to the individual.

Indirect form - is aimed at creating favorable conditions for the solving of a difficult life situation (Kebza, 2005).

The loss of health and, on that basis, job loss, leads to profound changes in an individual's life and can cause a crisis situation. According to Špániková (2013b), already common situations that are caused by the natural decline of physical performance after 50 years of age, during persistent mental performance, means a change of attitude of an individual towards their planning for the future; in the area of the further professional path; towards one's own health. From the perspective of an individual, an organization and also the State. One of the solutions considered to reduce the risk of job loss in this target group is the implementation of so called age management the aim of which is to create conditions that take into account age in the management of work processes; in the area of the physical and social environment. These approaches, however, cannot be used in every kind of organization. One of the specific organizations is the Armed Forces of the Slovak Republic (hereinafter referred to as the Armed Forces) and the profession of a professional soldier. Therefore, in the following chapter we have focused precisely on the issue of the availability and adequacy of social support among professional soldiers in difficult life situations such as discharge from the Armed Forces, due to unsatisfactory medical fitness.

3. SURVEY OF ACCESSIBILITY AND ADEQUACY OF SOCIAL SUPPORT AMONG PROFESSIONAL SOLDIERS, IN A DIFFICULT LIFE SITUATION

Basic assumptions of the survey

One of the basic conditions for the acceptance of a citizen into the civil service of being a professional soldier, is the medical fitness of the citizen - this means that the citizen is „mentally competent and physically fit" (Act No. 346/2005, § 13) to perform the civil service of being a professional soldier. The content focus of a psycho-diagnostic examination and the standards of movement performance and physical fitness are contained in the Decree of the Ministry of Defense, No. 495/2005.

The medical fitness of a professional soldier is essential throughout the whole performance of the civil service. The majority of people consider a severe change of health status to be a difficult situation. If to the loss of health we also add the loss of employment[1] the situation becomes even more difficult and could turn into a crisis. Social surroundings and support have significant potential for helping people in a difficult life situation. Social support represents an important pillar of mental and physical health, increases a resistance to burdens and the will to also survive life's losses and crises. Social support can be provided, received, expected and rejected. Many authors (e.g. Křivohlavý, Kebza, Baštecká), consider the most important factor to be the satisfaction with social support, or its subjectively perceived adequacy.

The subjects of this survey are professional soldiers, who are, due to a severe change of their health status, assessed with a medical disability; for the performance of the civil service of a professional soldier; and who are, according to this change, discharged from the Armed Forces.

[1] Another psychologically significant factor, which compared to civilian occupations affects the professional soldier is, according to Špániková (2013a, 295), the application of a non-uniform approach towards breaking the law, in the form of stricter penalties for breaking the law - especially in order to maintain discipline, or in the area of complying with labor relations. Also in these cases which lead to a discharge from the Armed Forces of the Slovak Republic sufficient social support is important.

The main objective of our survey is to determine the availability and adequacy of social support (from different sources) for professional soldiers in difficult life situations.

Through an analysis of theoretical knowledge and practical experiences, we have set the following **exploratory issue:**

„Does a professional soldier in a difficult life situation, concerning his overall loss of health and loss of employment, have adequate social support?"

3.1 The method of the survey

The method of the survey was the questionnaire. Its first part consisted of questions regarding the purpose of the investigation, and when compiling the questions in the second part of the questionnaire, we worked with the test, The Multi-Dimensional Support Scale (MDSS). The MDSS is a test that measures the availability and adequacy of social support from various sources.

3.2 Characteristics of the survey sample

Professional soldiers (hereinafter „respondents") came from all over Slovakia, since the scope of the examination commission of The Ministry of Defence of the Slovak Republic (hereinafter The Ministry of Defence), is for the whole territory of the Slovak Republic. The largest representations were respondents from Eastern Slovakia, which was 44 (38%). There were 37 (32%) respondents from Central Slovakia and 34 (30%) from Western Slovakia. The respondents were further divided, according to their years of service in the Armed Forces into three groups; the same as in the previous case.

Group 1, 34 (30%), consisted of respondents who worked in the Armed Forces less than 5 years and thus they are not eligible for payment of a pension or a retirement allowance.

Group 2, 49 (43%), consisted of respondents who worked in the Armed Forces more than 5 and less than 15 years and are entitled to a retirement allowance.

Group 3, 32 (28%), worked in the Armed Forces more than 15 years and are entitled to a retirement pension.

From the total number of respondents, (97%) are men and (3%) are women. As the group of women was statistically insignificant those respondents have not been distributed,.

3.3 An interpretation of the results of the survey

The results of the processed data are presented in tables, which include the absolute and relative frequencies of responses, to the individual questions.

At the outset of the questionnaire we included questions relating to the actual performance of the civil service of being professional soldiers in the Armed Forces. We were interested in how professional soldiers evaluate (hereinafter respondents) the performance of the civil service of being a professional soldier.

Table 1. The opinions of the respondents on the demands of the performance of the civil service of being a professional soldier in the Armed Forces

Answer	n_i	f_i
Hypothesis No. 1: Especially very demanding mentally	42	37%
Hypothesis No. 2: Especially very demanding physically	20	17%
Hypothesis No. 3: Equally demanding, both physically and mentally	37	32%
Hypothesis No. 4: Physically and mentally un-demanding	16	14%
Total (n)	**115**	**100%**

Based on the table representation, we can conclude that up to 99 (86%) of the respondents considered the civil service of being a professional soldier, as demanding. 16 (14%) of the respondents considered the performance of the civil service of being a professional soldier as both physically and mentally undemanding.

Table 2. Agreement of the respondents with the statement „I consider the change of my health status as a difficult situation."

Answer	n_i	f_i
Hypothesis No. 5: Yes	55	48%
Hypothesis No. 6: More yes than no	41	36%
Hypothesis No. 7: I do not know	2	2%
Hypothesis No. 8: More no than yes	10	9%
Hypothesis No. 9: No	7	6%
Total (n)	**115**	**100%**

The answer to the question of whether a professional soldier perceives the change of his health status as a difficult life situation; based on the table representation, we can conclude that up to 96 (84%) of respondents consider the change of their health status, as a difficult situation (of which 41 (36%) stated more yes than no). 7 (6%) of the respondents do not perceive the change of their health status as a burden.

Table 3. Agreement of the respondents with the statement „I perceive the loss of employment in the Armed Forces, as a difficult situation."

Answer	n_i	f_i
Hypothesis No. 10: Yes	65	57%
Hypothesis No. 11: More yes than no	31	27%
Hypothesis No. 12: I do not know	2	2%
Hypothesis No. 13: More no than yes	10	9%
Hypothesis No. 14: No	7	6%
Total (n)	**115**	**100%**

Based on the table representation, we can conclude that up to 96 (84%) of the respondents consider their departure from the civil service of being a professional soldier in the Armed Forces, as a difficult situation. 7 (6%) of the respondents do not perceive leaving the civil service as a burdensome situation.

4. VERIFICATION OF THE HYPOTHESES

In our previous survey, we focused on examining the availability and adequacy of social support among professional soldiers, who had been, due to severe changes in their health status, assessed on their medical fitness for the civil service of being a professional soldier and who were, on the basis of this change, discharged from the Armed Forces. The survey sample consisted of 115 professional soldiers. We could verify the hypotheses of the survey, by numeric evaluation and by a statistical analysis of individual results.

People consider health to be very important, even to be the greatest wealth that they have. Its change or loss may mean a heavy burden for a person, indeed perhaps even a crisis situation (Bratská, 2001). In the survey we conducted in 2008, we found that professional soldiers perceive the change of their health status to be a difficult life situation. At that time, 85% of respondents expressed themselves as we already mentioned, one of the most important conditions for the acceptance of an individual into the civil service of being a professional soldier is his physical and psychological condition. Individuals have to pass a selection process which has high standards of both physical and mental fitness. Only a few citizens, who choose to enter into the professional army, meet these criteria. It is lot more difficult is for the individual to accept the fact that he is ill; that he can no longer do what he has been doing before.

According to Žiaková (2005, p. 217), „the main features of the patient are restrictions and dependencies, conditioned to illness and therapy." 95% of respondents certified that the change of their health status is limiting them in some things. Respondents considered the biggest limitation, related to the changes in health status to be deterioration in the quality of their lives.

The development of illness also effects to a large extent how the ill person experiences

the illness. Žiaková argues that „it is in the first place, the way in which a person experiences the illness as to how the illness affects his self-esteem, self-confidence and self-realization." (Žiaková, 2005, p. 81). Within the survey, we found that respondents are seeking, in particular, for effective strategies for coping with a difficult situation in such a way that they try to resist an illness; get as much information about treatment options; as well as get as much information about the illness itself.

In the survey, we have, in Hypothesis No. 1, suggested that „more than 80% of professional soldiers, unfit to perform the civil service of being a professional soldier, perceive a change of their health status, as a difficult life situation." This hypothesis was verified by Questionnaire item No. 6 We found that up to 91 (84%) of the respondents perceive a change of their health status as a difficult life situation. We can conclude that **Hypothesis No. 1 was confirmed.**

If a change in the health status of the professional soldier is severe enough that he is assessed by an investigation commission as being incapable to perform the civil service, he would be discharged from the Armed Forces.

Dismissal from the civil service can be understood as a crisis period of life, but also of the professional career of the professional soldier which is characterized by an interruption of their professional path through changes of social status and by the loss of a social role. In common practice, most attention is paid especially to the economic side of unemployment, and the psychosocial effects that unemployment leaves on people is underestimated. Work is at a relatively high position in the scale of values of an adult person. An individual devotes a lot of vital energy to work; work being scope for self-realization and self-actualization (satisfaction with self-realization in the Armed Forces was reported by 64 (55%) of the respondents; satisfaction with the social status of the professional soldier was reported by 91 (79%) of the respondents. An individual suddenly loses all of this; that which was meaningful in his life and valued by the family, by the social environment and, not least, by himself, is suddenly gone. „For fully committed individuals, this sudden loss of employment may mean a kind of social death" (Žiaková, 2005, p. 99).

87% of respondents in the survey considered departure from the civil service to be a difficult life situation. In Hypothesis No. 2, we assumed that „more than 80% of professional soldiers unfit to perform the civil service of being a professional soldier, perceive leaving from the civil service as a difficult life situation." Hypothesis No. 2 was verified by Questionnaire item No. 7. Despite the fact that only 99 (96%) of the respondents evaluated the performance of civil service in the Armed Forces as challenging, the departure from the civil service was perceived by 96 (84%) of the respondents as a difficult life situation. Based on the aforementioned, we allege that **Hypothesis No. 2 was confirmed.**

In the survey, we further found that for professional soldiers the loss of employment in the Armed Forces especially means financial problems. A reduction or a loss of income is reflected in a reduction in the amount of choice and a restriction for overall consumption. Unemployed people feel not only a lack of personal items, but also a loss of the possibility to confirm, through their expenditure, their social status. They fall to a lower level; cannot afford what others from their social class can (http://www.saske.sk/cas/4-2003/fedakova-std.html, cit. 2010-03-01). The biggest concerns of respondents between 31-40 years of age about financial problems related to the loss of employment indicated that they are worried about existential problems relating to finances and about the living standards of their family.

We think that this is related to the fact that in our society the traditional family model in which the male is the breadwinner still prevails. If there are two members in the family without work, as is often the case in regions with high unemployment, the stress operating on the family is often compounded and the family living standards plummet. This finding corresponds with another finding that 82 (72%) of the respondents are satisfied with the financial evaluation of the Armed Forces (Table 3). If professional soldiers serve less than 15 years in the Armed Forces, they do not have an entitlement to a retirement pension, according to the Act on Social Security.

The older age group reported that they are concerned whether they will find a new job as a civilian. From the research of the adaptation of former professional soldiers to civilian employment there are fundamental causes of a low attractiveness of the labor force of professional soldiers in the labor market within the civilian sector:

– older age
– narrow specialization of professional focus of activity
– low confidence and negative relationship on the part of the civilian social
– environment towards former professional soldiers (a lack of interest in the soldiers, prejudices, envy because of the amount of military retirement pension, etc.)
– overall negative development of employment
(http://www.mosr.sk/dokumenty/kariera/brozura2006.pdf., 2010-03-01).

A considerable potential for helping people, who find themselves in a difficult life situation is the social environment and its help and support. Theoretically, we define social support as „an activity, which makes a stressful situation, in a certain way, easier for the person in distress." (Křivohlavý, 2001, p. 94). Quantitative indicators of social support are the extent of the social networks; the qualitative side can thus be expressed by the satisfaction with the social support (Koubeková, 2001).

In our survey, we relied on Vaux's concept that understands social support as a meta construction with three distinct components.

The first component is the sources of the support network. In the questionnaire, we described three groups of people according to Laireiter:

Group 1 - is confidential, the respondents were asked to imagine two or three people who are most important for them.

Group 2 - people who are equal, similar to our respondents in something; they could be collaborators, people of the same age or people with the same illness.

Group 3 - people, who have official status; who represent some authority for the respondent, such as a Commander, a medical professional, an employee of the Labor Office and so on.

In **Hypothesis No. 3**, we assumed **„that for the professional soldier, unfit to perform the civil service of being a professional soldier, social support is more available from a group of confidential people (the first group of people), than social support from a group of people with official status (the third group of people)."** We found out that respondents consider social support that they acquire from the first group as more available (the highest score 4.42 - practical support, the lowest score 3.81 - support through appraisal, a total score of 3.96), than social support that they acquire from the third group (the highest score 1.96 - active listening, the lowest score 1.82 - support through appraisal, a total score of 1.84). **Hypothesis No. 3 was confirmed.**

The second component of Vaux's concept is **support behavior**. In the Questionnaire, we described individual types of social support: **emotional; practical; informational support; support through appraisal; active listening.**

We found out that respondents consider the most available to be practical support from the first group of people; conversely respondents consider the least available to be practical support from the third group of people. Respondents also consider practical support to be most available from the second group of people. According to the respondents from the third group, the most available is active listening. Respondents consider support through appraisal to be the least available from the first group of people.

Another component of Vaux's concept is a **subjective evaluation of the support**, a perceived adequacy of the social support. Each of the Questionnaire items included, in addition to the availability, also the adequacy of the social support which was expressed by the respondents' satisfaction with the availability of the social support „I would like it to be - much more often, more often, it's just right".

In the survey, we found that, 95% of the respondents were satisfied with the help and support that their family gives them, and vice versa, 81% of the respondents expressed dissatisfaction with the help and support that their wider social environment gives them.

An interesting finding in the survey was that 51% of the respondents were satisfied with the help and support from their employer. We think that it corresponds with the fact that the social security of professional soldiers is in many ways much more favorable than civilian social security (Act 328/2002 Coll.). As an example, we can say that the Armed Forces mediate assistance also for professional soldiers who leave the service of being a professional soldier, through the department of support for professional soldiers leaving the service.

In the current survey, we have assumed in Hypothesis No. 4 **„that a professional soldier, incapable of performing the civil service of being a professional soldier, is more satisfied with the social support provided to him in stressful situations by a group of confidential people (Group 1), than the social support provided to him in stressful situations by a group of people with official status (Group 3)"**. We can conclude that **Hypothesis No. 4 was confirmed.** We found that the respondents really perceive social support received from the first and second groups of people - thus a group of confidential people, as more appropriate.

Interesting is the fact that the subjectively perceived adequacy of the availability of social support is in all three groups of people almost the same (the average score is different only by tenths). **For example:** respondents considered the least available social support from Group 3. The question of how often people with official status help them in practical matters, up to 56 (49%) of the respondents answered, never; 34 (30%) of the respondents answered, rarely. Despite the fact that up to 66 (57%) of the respondents perceive it as **appropriate** - they replied, **„it's just right"**

In the survey, we found that our respondents were convinced that they may at any time refer to their family to ask for help while they classified the wider society into last place.

This finding was reassuring for us because for all individuals (whether in a crisis or not), family is very important. In addition, the principle of subsidiarity applies in social policy according to which every individual is obliged to help himself, and if he cannot, his

family must help him; when the family is unable to help, a number of institutions, authorities and the State have to. On the other hand, the role of the State is to take care of the creation of such conditions so that everyone can help themselves by their own efforts (Tokárová, 2003).

5. CONCLUSION

The survey findings showed that professional soldiers, addressed by us, perceive a change of their health status as a difficult situation. They consider the loss of their employment as a difficult situation. Difficult life situations in which individuals find themselves, threaten their mental health; it is therefore necessary to have comprehensive psychosocial support secured.

Social support has significant potential for helping people in a difficult life situation. The source of social support is the social network of an individual: that means around the individual and not just within the close family, but also in the wider surroundings of friends or colleagues we find people who in an emergency create a supportive atmosphere and a feeling that the individual is not alone with all his problems. However, if an individual does not receive social support from natural sources, the helping professionals can come, who can help by supporting the natural systems of social assistance or they can offer their own advice.

Below, we present a proposal of forms of assistance within social work, which could help professional soldiers, but also other individuals, to solve their difficult life situation.

Social Work with an individual and with the family:

a) for individuals to develop the potential and ability to cope with difficult situations,
b) to teach individuals to take responsibility for their lives,
c) to strengthen in individuals a consciousness that the family is indispensable to them,
d) to lead individuals to the establishment of self-help groups or lead individuals to enter into self-help groups, which are already operational,
e) to focus on the remediation of family in the case of its dysfunction,
f) to cooperate with the family of a client in need,
g) to understand the family as an indispensable member of the multidisciplinary team,
h) to expand the social network of an individual to people who can be helpful in dealing with difficult situations.

Institutional assistance within Social Work

a) through **social therapy**, to provide the development or the maintaining of the social skills of individuals and support the social inclusion of individuals in difficult life situations into society, to provide clients with psychotherapy, social therapy etc,
b) through **social counseling** to help clients in the use of commonly available services and information sources,
c) through **employment services** to provide under an active policy - the support of employment, increasing employment, and through a passive policy - to ensure unemployment compensation among the clients,
d) to ensure **social assistance**, to address the social need for a citizen with a severe

disability, or for the compensation of a severe disability,
e) to ensure **material assistance** for individuals in material need.

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THE RATE OF TOBACCO SMOKING PREVALENCE IN CHILDREN IN ORPHANAGES

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Abstract

We consider smoking a type of risk behavior in children. The paper discusses the rate of tobacco smoking prevalence in children in orphanages. The research carried out so far in the Slovak Republic did not focus on children in orphanages. Considering hard fate of children in orphanages and with regard to their needs that are not satisfied in an orphanage environment it comes as no surprise that the rate of smoking prevalence in children in orphanages is higher than in children growing up in families.

Key words: orphanage, smoking, risk behavior, children's needs

Introduction

„Risk behavior may be defined as behavior the result of which is unclear and brings balancing between the possibility of negative results (loss) and positive results (profit). All forms of risk behavior generally include a compromise between a short-term profit and potential long-term negative consequences" (Orosová et al., 2007, p. 32-33). Macek (2003) divides risk behavior into two groups – first, behavior that in some way damages physical or psychological health and second, behavior associated with negative effects and harm to others, i.e. dangerous for society.

Labáth (2001) sees riskiness of humans from several points of view – a personal, somatic, health, social point of view and the point of view of skills and behavior. These definitions do not differ from each other in their essence and consider risk behavior primarily a threat to psychological and social development of a child.

Excessive use of alcohol and drugs, smoking, poor hygiene and nutrition lead to several diseases (Mojtová et al. 2013). Tobacconism belongs to socially tolerated types of drug addiction. Tobacco smoke contains thousands of chemicals, nicotine apparently being the only one that is addictive. Besides strong psychological dependence, also nicotine causes physical dependence.Nešpor and Csémy (In Hroncová, 2006) mention negative effects of

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tobacco smoking which, besides malignant tumors and heart diseases, also lead to diseases of the respiratory system, vascular diseases, damage to the stomach, decrease of potency in men, risk of damage to fetus in pregnant women, etc.

According to Verešová (2004), consumption of legal drugs such as alcohol, tobacco, and medicines increasingly become part of people's everyday life and that's why children also become involved in situations related to consumption of alcohol, smoking tobacco products, or free use of medicines, as passive observers at first and as active experimenters later.

„The most consumed drugs in our country (SK) are alcohol and tobacco products followed by marijuana, heroin, methamphetamine, ecstasy, and other drugs" (Hroncová, 2006, p. 252).

The drug contained in tobacco cigarettes – nicotine – is along with alcohol a gateway drug for adolescents. Alcohol and nicotine are more harmful to children and youth. These legal drugs act as a poison; disrupt a developing organism; decrease resistance to diseases; using them makes the habit stronger. Nicotine causes the decrease in the levels of monoamine oxidase enzyme, which is a gateway to using other drugs. According to gateway drugs theory, smoking, in particular in youth, later leads to the use of illegal drugs (Souza – Markou, 2011). As drugs represent a problem that extends to numerous areas of life, they cannot be dealt with separately, but must be based on cooperation among several government departments and institutions because cooperation among various sections of society is necessary. The following should be involved in preventive activities: peers; government; parliament; local authorities; prominent personalities; health facilities; facilities for treatment of addiction; media; institutions providing education and training; cultural facilities; pedagogical and psychological support centers; church and its facilities; social services providers; third sector institutions; police; courts; army (Mojtová, Gažiková, 2013).

First and foremost prerequisite for the fulfillment of children's needs is a home and a family that children in orphanages miss the most. A family of a child with court-ordered institutional care is often not functioning and threatens a child and already before entering the orphanage, the child's development is shaped in a different way in an often dysfunctional family (Němec, Vojtová, 2009).

Institutional care environment is most often associated with psychological deprivation characterized by Langmeier and Matějček (In Kovařík et al., 2004) as a psychological state that arises when basic psychological needs of a child are not satisfied for a specific longer period of time. Consequences of such a psychological state may manifest themselves in later development of an individual „through specific particularities and bring certain risky psychological circumstances into social relationships" (Kovařík et al., 2004, p. 110).

Children's needs that can't be satisfied in the conditions of institutional care are the following:

- the need for a meaningful world; as an orphanage is an artificial world in a way that has different rules and does not train a child for real life as a family and natural social environment does.
- an orphanage can't offer a child any certainty and life perspective in the future,
- the need for an open future is filled with considerable uncertainty without permanent support, alone and with a so-called independence,
- life in an orphanage leads to anonymity of a child rather than to creation of their own identity. Thus, the development of identity is considerably limited and

self-evaluation is often negative, which leads a child to destructive behavior towards themselves and the environment.

- a child in an orphanage doesn't have enough opportunities for personal initiative and responsibility; their personal time is considerably organized,
- a child growing up in an orphanage has disorders of attachment, i.e. has difficulties forming healthy and stable emotional ties in their childhood and particularly in their adulthood (Náhradná starostlivosť, 2011).

Research goal and hypotheses

Based on theoretically described motives, the following research goals were defined: Identification of the rate of tobacco smoking prevalence in children in orphanages and comparison of the rate of tobacco smoking by gender.

We ask the following research questions (RQ):

RQ1: What is the rate of tobacco smoking prevalence in children in orphanages?

To achieve the goal described above, we formulated hypotheses based on the Final report on TAD (Tobacco-Alcohol-Drugs) survey in pupils of elementary and secondary schools and their teachers in 2010 (Nociar, 2011).

This final report contains findings from 1994 to 2010 both in pupils of elementary and secondary schools.

Comparison of smoking cigarettes by gender:

RQ2: Are there any differences in the availability of cigarettes between boys and girls in orphanages?

H1: We suppose that boys in orphanages had smoked more cigarettes during their lifetime than girls in orphanages.

H2: We suppose that boys in orphanages had smoked more cigarettes during the last 30 days than girls in orphanages.

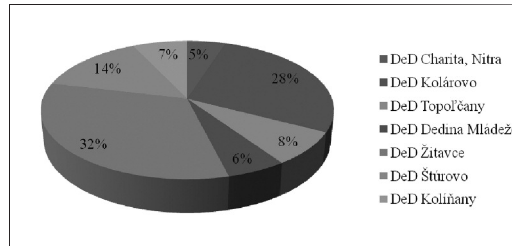
H3: We suppose that boys in orphanages start smoking at an earlier age than girls in orphanages.

Sample

The sample consisted of 141 children in orphanages (DeD) in the Nitra Region. We obtained data from seven orphanages (Graph 1), specifically from DeD Charita in Nitra (n = 7), DeD Kolárovo (n = 39), DeD Topoľčany (n = 11), DeD Dedina Mládeže (n = 8), DeD Žitavce (n = 46), DeD Štúrovo (n = 20) and DeD Kolíňany (n = 10). These orphanages were contacted intentionally and children from 11 to 19 years of age were selected in each of them.

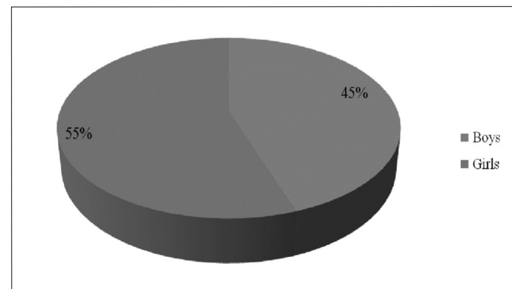
Graph 1. The composition of the sample by the location of the orphanage

In our research, the children in orphanages were of the mean age of 15.24 years, the minimum age limit was 11 and maximum age limit was 20 years. As for the representation of boys and girls in the sample, out of 141 respondents, 78 were girls (55 %) and 63 were



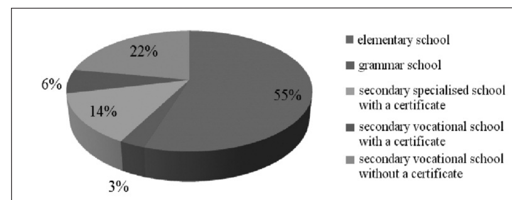
boys (45 %). This composition is shown in Graph 2.

Graph 2. The composition of the sample by gender



As for the currently attended school, in our sample we recorded 77 children attending elementary school and 63 children attending secondary school. Out of children attending secondary school; 4 children attended a grammar school; 19 children attended a secondary specialized school with a school-leaving certificate; 9 children attended a secondary vocational school with a school-leaving certificate; 31 children attended a secondary vocational school without a school-leaving certificate (Graph 3).

Graph 3. The composition of the sample by the type of school attended



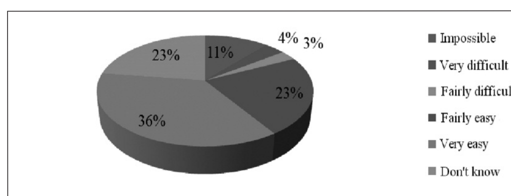
The data was collected using the ESPAD Questionnaire. ESPAD is the European School Survey Project on Alcohol and Other Drugs. It began in the first half of the 1990s from the initiative of Swedish Researchers of the Swedish Council for Information on Alcohol and Other Drugs (CAN). The main purpose of this international study is to collect standard, mutually comparable information on the overall prevalence of smoking, alcohol drinking, and the use of illegal drugs in European youth. Once collected, the data was statistically analyzed using univariate and bivariate analysis. During univariate analysis, we worked with frequencies, percentage, median, arithmetic average, and standard deviation. During bivariate analysis, we used Pearson's Chi-square test for the comparison of nominal variables and Mann-Whitney U Test for the comparison of ordinal variables.

Tobacco smoking in children in orphanages

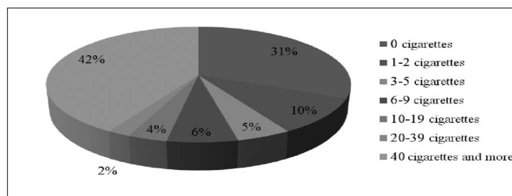
In this area, we asked the following question:
When asked about the number of cigarettes smoked so far during their lifetime, the highest percentage of children (42%) reported 40 cigarettes and more. In contrast, 31% of children reported 0 cigarettes smoked during their lifetime. 10% reported 1-2 cigarettes; 5% reported 3-5 cigarettes; 6% reported 6-9 cigarettes; 4% reported 10-19 cigarettes; and 2% of children reported 10-39 cigarettes smokes so far during their lifetime (Graph 5).

RQ1: What is the rate of tobacco smoking prevalence in children in orphanages?
Primarily, we asked about the availability of cigarettes in children in orphanages. When asked how difficult it would be to obtain cigarettes if children wanted to, 36% found it very easy; 23% fairly easy; 11% impossible; 4% very difficult; 3% fairly difficult; 23% responded „Don't know" (Graph 4).

Graph 4. The availability of cigarettes if a child is interested

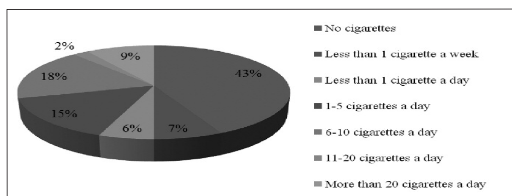


Graph 5. The number of cigarettes smoked during the lifetime



With regard to the number of cigarettes smoked, we were also interested in the number of cigarettes smoked during the last 30 days, where regularity of smoking could be observed in responses. 43% of children in orphanages reported that they had not smoked any cigarettes during the last 30 days; 7% had smoked less than 1 cigarette a week; 6% less than 1 cigarette a day; 15% had smoked 1-5 cigarettes a day; 18% 6-10 cigarettes a day; 2% 11-20 cigarettes a day; 9% had smoked more than 20 cigarettes a day during the last 30 days (Graph 6).

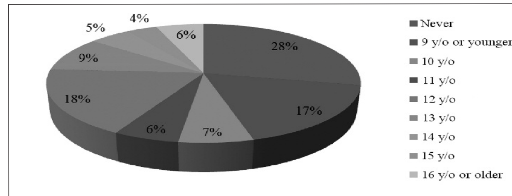
Graph 6. The number of cigarettes smoked during the last 30 days



Furthermore, we asked about the age when children in orphanages smoked their first

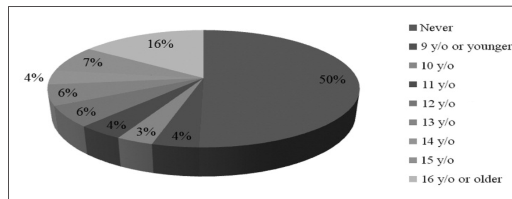
cigarette. 28% reported they had never smoked a cigarette; 17% were 9 years of age or younger; 7% at the age of 10; 6% at the age of 11; 18% at the age of 12, 9% at the age of 13; 5% at the age of 14; 4% at the age of 15; 6% of children were 16 years of age or older (Graph 7).

Graph 7 The age of smoking the first cigarette



When asked about when they started smoking on a daily basis, 50% of children in orphanages reported that they had never started smoking on a daily basis; 4% started smoking at the age of 9 or younger; 3% at the age of 10; 4% at the age of 11, 6% at the age of 12 and, likewise, 6% at the age of 13, 4% at the age of 14, 7% at the age of 15; 16% at the age of 16 or older (Graph 8).

Graph 8. The age of starting smoking on a daily basis



Cigarette smoking in children in orphanages by gender

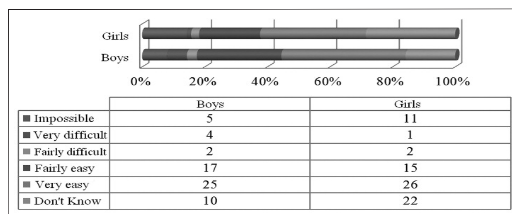
In this area, we primarily focused on the availability of cigarettes and asked the following research question:

RQ2: Are there any differences in availability of cigarettes between boys and girls in orphanages?

Graph 9 shows responses to the question about the availability of cigarettes by gender. 10 boys and 22 girls responded with „Don't know"; 5 boys found it impossible; 4 boys very easy; 2 boys fairly difficult; 17 boys fairly easy; 25 boys very easy to obtain cigarettes.

Girls responded as follows: 11 girls found it impossible; 2 girls fairly difficult; 15 girls fairly easy; 26 very easy to obtain cigarettes.

Graph 9. The availability of cigarettes if a child is interested by gender



	Boys	Girls
Impossible	5	11
Very difficult	4	1
Fairly difficult	2	2
Fairly easy	17	15
Very easy	25	26
Don't Know	10	22

Based on the results of Pearson's Chi-square Test, we conclude that there is no statis-

tically significant difference ($p > 0.05$) in the availability of cigarettes between boys and girls if interested in obtaining them (Table 1).

Table 1 Comparison of the availability of cigarettes if a child is interested by gender

	Value	Degrees of freedom	Significance
Pearson's Chi-square	7.368	5	0.195

We also compared responses about the number of cigarettes smoked during the lifetime. The hypothesis was formulated as follows:

H1: We suppose that boys in orphanages had smoked more cigarettes during their lifetime than girls in orphanages.

Median scored by boys was 5, i.e. 10-19 cigarettes, and 3 in girls, i.e. 3-5 cigarettes during their lifetime. Based on the Mann-Whitney U Test results (value: 1981, significance: 0.05), we conclude that there is a statistically significant difference in the number of cigarettes smoked during the lifetime between boys and girls in orphanages and that boys had smoked more cigarettes during their lifetime (Table 2).

Table 2 Comparison of the number of cigarettes smoked during the lifetime by gender

	Median	Mann-Whitney U test	Significance
Boys	5	1981	0.049
Girls	3		

The following hypothesis formulated by us was concerned with smoking during the last 30 days.

H2: We suppose that boys in orphanages had smoked more cigarettes during the last 30 days than girls in orphanages.

Table 3 shows results in relation to the number of cigarettes smoked during the last 30 days. Boys scored the median value of 4, i.e. 1-5 cigarettes a day; girls scored the median value of 1 – not a single cigarette. There is a statistically significant difference ($U = 1968.5$; $p < 0.05$) in the number of cigarettes smoked during the last 30 days between boys and girls in orphanages. Boys in orphanages had smoked more cigarettes than girls in orphanages.

Table 3. Comparison of cigarettes smoked during the last 30 days by gender

	Median	Mann-Whitney U test	Significance
Boys	4	1968.5	0.045
Girls	1		

The last hypothesis in relation to age was concerned with the age of starting smoking.

H3: We suppose that boys in orphanages started smoking at an earlier age than girls in orphanages.

Table 4 below presents results of the comparison of boys and girls in orphanages by the age of smoking the first cigarette. Both groups scored the median value of 3, which corresponds to 10 years of age. Based on the testing using the Mann-Whitney U Test, the value

of which equaled 2094.5 and the significance level was higher than 0.05, we conclude that there is no difference between boys and girls in the age of smoking the first cigarette.

Table 4. Comparison of the age of smoking the first cigarette by gender

	Median	Mann-Whitney U test	Significance
Boys	3	2094.5	0.268
Girls	3		

We also examined the difference between boys and girls by the age of starting smoking on a daily basis. Boys scored median 4 – 11 years of age, and girls scored median 1 – never. Based on the results of Mann-Whitney U Test we conclude that there is a statistically significant difference ($U = 1463.5$; $p < 0.05$) in the age of starting smoking on a daily basis between boys and girls in orphanages. Boys in orphanages started smoking on a daily basis at the age of 11 while girls in orphanages never started smoking (Table 5).

Table 5 Comparison of the age of starting smoking on a daily basis by gender

	Median	Mann-Whitney U test	Significance
Boys	4	1463.5	0.029
Girls	1		

Our first research question aimed to determine *the rate of tobacco smoking prevalence in children in orphanages (RQ1)*. According to the findings of Pétiová (2009), 7.9% of children aged between 13 and 16 years old smoked on a daily basis and the age of children starting smoking is 12 years. As much as 23.2% of children in secondary schools smoked on a daily basis and 10.2% of them smoked every now and then. 66.6% of secondary school children identify themselves as non-smokers.

In our research, 36% of children in orphanages found it very easy and 23% fairly easy to obtain cigarettes. Only 7% found it difficult and only 11% impossible to obtain cigarettes. 31% of children reported that they had not smoked a single cigarette during their lifetime and the rest had already smoked at least one cigarette during their lifetime. In the latter group (69% of children) as much as 42% had smoked 40 cigarettes or more during their lifetime.

During the last 30 days, 43% of children had not smoked a single cigarette. The rest of children had smoked at least one cigarette. Regular smoking of at least one cigarette a day was found in 44% of children.

The age when children start smoking was represented the most (18%) in children that started smoking at the age of 12. 28% of children reported that they had never smoked.

As Pétiová (2009) found in her research, 82.9% of elementary school girls and 66.6% of secondary school boys were non-smokers. If we compare it with our results, we find that more than 50% of children in orphanages smoked when the focus was on the last 30 days.

Smoking is a part of everyday life of children in orphanages; children even have no problem admitting that they smoke. Cigarettes are generally easily obtainable for them, which is also supported by the fact that they receive monthly pocket money enabling them to buy them. Children support each other in smoking; offer a „support network" to each other; are willing to give cigarettes to those who currently don't have financial means to buy them provided that they will give them cigarettes in return in case of an „emergency".

Psychological deprivation of children in orphanages in the sense of the need for compensating unmet needs can also be considered one of the reasons for an increased rate of smoking in children in orphanages.

In the second research question we asked *if there were any differences in the availability of cigarettes between boys and girls in orphanages (RQ2)*. According to our findings, there are no differences in the availability of cigarettes between boys and girls in orphanages.

Overall, it can be said from the results of Pétiová (2009) that considerably more boys than girls belong to regular smokers; however, girls more often reported smoking only sometimes or not at all. Therefore, formulated hypotheses about the number of cigarettes smoked were in favor of higher number in boys.

The first formulated hypothesis had to do with the number of cigarettes smoked during the lifetime and we supposed that *boys in orphanages had smoked more cigarettes during their lifetime than girls in orphanages (H1)*. Based on statistical testing, we came to a conclusion that there was a statistically significant difference in the number of cigarettes smoked during the lifetime between boys and girls in orphanages and boys had smoked more cigarettes during their lifetime. Therefore, we accept the hypothesis H1. These differences were corroborated also by Nociar (2011) in the Final report on TAD Survey, with boys scoring higher than girls of the same age in the smoking prevalence during the lifetime, which was also confirmed by Pétiová (2009). Thus, there are no differences between children in orphanages and children living in a family in this respect.

The second hypothesis was concerned with differences in the number of cigarettes smoked during the last 30 days, where we supposed that *boys in orphanages had smoked more cigarettes during the last 30 days than girls in orphanages (H2)*. The difference between boys and girls was confirmed also in the case of cigarettes smoked during the last 30 days and that is why we accept the hypothesis H2 and state that boys in orphanages had smoked more cigarettes during the last 30 days than girls. Likewise, the given difference was corroborated also in children not living in an orphanage (Nociar, 2011).

In the hypothesis H3, we supposed that boys in orphanages start smoking at an earlier age than girls in orphanages. As for the age of starting smoking, the differences between boys and girls were not confirmed by statistical testing and therefore we reject the hypothesis H3 and state that there is no difference in the age of smoking the first cigarette between boys and girls, the given age being 10. However, if we compared responses to the question about the age of starting smoking on a daily basis, the differences were confirmed. The average age in boys was 11, while girls rather responded with „Never".

Looking at the results of other research, we can observe that researchers found differences - according to their findings, boys tried smoking for the first time mostly before the age of 12, while girls rather at the age of 12 to 15 years (Pétiová, 2009). Nociar (2011) also corroborated differences in the age of smoking debut between boys starting earlier and girls starting later. Children in orphanages try their first earlier than children not living in orphanages, which, however, does not necessarily mean that they start smoking from this age. Boys regularly smoke on a daily basis after a year from having their first cigarette, while it is not the case in girls.

Conclusions

The issue of children in orphanages is unexplored in many aspects. Even though several authors deal with this area, the issue of prevalence of risk behavior in children in orphanages is not given enough attention. It is necessary to implement social policy measures, focus on creation and implementation of preventive programs with regard to specific needs of children in orphanages, and involve volunteers, civic associations, and non-profit organizations in order to support meaningful use of free time and capture and develop talents of children in orphanages. However, we consider it to be of the highest importance that a child has at least one contact person in an orphanage to whom they are strongly attached, who they respect, and who sets a good example for them, which could lead to gradual elimination of risk behavior.

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THE QUALITY OF HEALTHCARE FROM THE PERSPECTIVE OF THE CLIENT IN PRISON

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ARTICLE

Abstract

Healthcare in the detention centers as well as in prison facilities has a specific form where it must follow the law NMS4/2008 (1). Healthcare provided in prisons has to achieve the same quality as the healthcare provided in other healthcare facilities. In the Czech Republic prisoners have the same rights to healthcare as other citizens outside prisons. The quality of healthcare influences the quality of the whole treatment process. In this article the quality of healthcare provided in one of the prison facilities was determined by a quantitative survey. The general and specific objectives of the survey as well as the recommendations to clinical practice are presented in the conclusion of the article.

Key words: Healthcare. Imprisonment. Convicted. Quality. Client.

Introduction

Healthcare in custody and in prison has its own specifics. Working with inmates as the general practitioner Doctor differs from the work of Nurses who carry out their work with people who are not in prison. Convicted persons have certain rights but they are limited and totally dependent on the medical and health services provided in prisons which care for their overall health state. Prisoners are not entitled to the right to their free choice of a Doctor, a clinical psychologist, medical facilities and transport services. Therefore, it is the duty of the Prison Service in spite of these limitations to ensure the quality of healthcare through qualified healthcare personnel. Healthcare is carried out by Nurses registered in the Register of Health Workers who are eligible to exercise their professional services without professional supervision, as well as by Doctors certified in the field of General Medicine. The quality of healthcare in the Prison Service is provided according to standards, for which these standards were created by the Prison Service. Healthcare is focused on the sick but also a large emphasis is aimed at preventing the spread of infectious diseases, maintaining the health conditions of the prison environment, and also on the transfer of sufficient infor-

mation on preventive measures to limit the occurrence of the disease among inmates (6). The provision of healthcare to prisoners with health workers in the Prison Service is to a greater extent than other population groups associated with persons who suffer from mental disorders, behavioral disorders and drug addiction. These people require a specific nursing approach with appropriate communication. Therefore, it is important to ensure sufficient education of healthcare professionals and in greater depth.

Objective of the survey

The main objective of the survey was to chart, with the help of Czech and foreign studies, the issues and quality of healthcare in prisons and through a quantitative investigation to determine and compare the client satisfaction with healthcare facilities in the selected facilities.

Sub-objectives

1. To determine if the patient is provided with privacy during examination by medical personnel.
2. To determine whether the communication and access to the client is on a professional level.
3. To determine whether the clients are sufficiently educated and informed.
4. To determine the availability of healthcare in acute conditions.
5. To determine to what extent the clients' needs are satisfied in times of illness.

File and Methods

The survey was conducted by a quantitative non-standardized questionnaire. Some questions included were taken from a questionnaire compiled for the project „Quality through the eyes of patients" and its guarantor was RN Dr. Tomas Raiter (Questions 1, 3, 5, 6, 7, 8, 9, 11, 15). Questions 2, 4 and 29 were newly created due to the specifics of healthcare in prisons. The questionnaire consisted of 30 questions, one of which was open allowing respondents to answer in writing. Other questions were closed where they had only one possible answer to choose from a choice of answers. Participation in the survey was anonymous and voluntary. The survey was conducted in the fourth quarter of 2014. After the questionnaires were completed they were processed and evaluated. The survey was carried out in selected facilities of the Moravian-Silesian Region with permission from government authorities. Questionnaires were distributed to 132 prisoners by mentors in the various departments.

In October 2014 a pilot survey was conducted to verify the clarity of the questionnaire to a sample of 15 respondents. Questionnaires were handed back in a short time with a 100% return. No changes were made to the questionnaire and the data was retained. Microsoft Office and Excel 2007 software were used for the data processing. Data was inserted into pie charts and tables with relative and absolute frequency. The relative frequency is shown in %.

Results and Discussion

The main objective of this work was to determine the quality of healthcare in prison from the view of the client through an anonymous questionnaire. Work was also addressed by determining whether the patients' needs are met in times of illness, their access to medical

staff and communication to clients regarding their access to healthcare. Questions 1, 2 and 3 were focused on socio-demographic characteristics. espondents were only men despite the fact that in the chosen prisons there are also women serving sentences. Questionnaires were distributed to men only because of the division into two prison buildings, a prison for women and a prison for men, wherein each of them there are other healthcare personnel, and the results would therefore not be objective. The survey found that most of the convicted men aged from 19 years to 30 years old did not graduate from secondary school.

Sub-objective 1 is focused on the client's privacy when providing medical care. Questions 4, 5, 6 and 7 helped to determine the first goal in the questionnaire. The question about whether clients are familiar with the identity of the medical staff who treated him, and who is entrusted with important information about the health problems of the client, could be evaluated incorrectly. The names of the medical staff present and other personnel are not shown or stated. When the patient examination is performed by a Doctor there is always a General Nurse present, and if the Doctor requires it, then there is also a Prison Warden present. Of upmost importance is the safety of medical staff which is why the investigation was evaluated to determine if privacy during examination or discussing the health status with your Doctor is partial or not. In a study conducted in 2013 (in Washington) by Luong, he states that privacy in the treatment of prisoners and communicating the information regarding the state of health is at a very bad level (3). Prison guards are an integral part of the medical team, the medical staff is in some cases dependent on the submission of information through the guards. In a study from 2008 (in England) Plugge, Douglas and Fitzpatrick questioned women prisoners and found the lack of privacy, both in the administration of confidential information, as in the actual examination (4). A Nurse can solve common medical problems in public places in prisons in the presence of others. The results of all these studies showed that clients in prisons have no privacy when communicating their health problems and when examined by a Doctor, so it is necessary to deal with this problem in the future. **Objective 1 is met.**

Sub-objective 2 determines at what level the professional communication is provided to the prisoners. This issue is addressed in Questions 8, 9, 10, 11 and 12. Professional communication is an important part in providing care by Doctors and Nurses. Information about health problems and the needs of clients is obtained by using communication and this must be on a professional level. The investigation found that communication by Doctors and Nurses is at a good level. Communication to the medical staff is based on willingness and answers to the medic's questions were in most cases answered comprehensibly. This objective was also set by Luong in a study in 2013 (3). The survey showed that communication between prisoners and medical staff is unprofessional, and ironically the approach to the prisoners was cold. The result of the 2008 study, undertaken by Plugge, Douglas and Fitzpatrick, showed that the communication level by medical personnel was bad and unprofessional (4). This is not a professional attitude and prisoners had the impression that medical personnel do not have sufficient competency to exercise their profession. Clients appreciate a compassionate and kind approach but in the case of this survey only a small amount of respondents answered. Foreign studies agree and at the same time are different from studies which were conducted in the prison, where the survey was conducted. **Objective 2 is met.**

Sub-objective 3 is concerned with whether the prisoners are adequately educated and informed of health conditions, therapies and other procedures. Questions 13, 14, 15, 16, 17, and 18 dealt with this particular objective. The respondents' answers found that clients are

clearly informed about their health status, course of treatment, possible complications or further examination required by a specialist or other procedures related to the treatment of diseases. They were not always educated on further examinations. Feedback was provided to the prisoner. In a study in 2013 (in India) Kumar and others examined the prisoners health and medical care provided in the largest prison in central India (2). They found that the healthcare is at a very poor level, which means a large number of prisoners are sick. Sick prisoners are not informed about their health condition, treatment or educated on further examinations and follow-up care. These two studies disagree on the provision of information as well as the education towards the prisoners. **Objective 3 is met.**

Sub-objective 4 dealt with the access to healthcare in the acute stage of the client and was evaluated in Questions 19, 20 and 21. Healthcare is provided to prisoners 8 hours a day on weekdays. Medical care is limited to two times per week in the morning hours when a Doctor is employed and available during these times. The Head Doctor of the health department is not in the prison building for men but is always available to the Head Nurse via telecom-munications. Healthcare in the Doctor's absence is provided by a general Nurse who provides treatment to prisoners in case of an accident, sudden illness and other reasons. In a survey a small number of respondents answered that they had the opportunity to take advantage of every day health services and that they could be treated outside of office hours. Acute care is provided, according to the patient's condition, by a transport escort service to the hospital or by calling the ambulance. The question about the possibility of providing healthcare in acute situations in the absence of medical staff found that 57% of the prisoners do have the opportunity to travel to hospital for healthcare via a transport escort service. Access to healthcare was evaluated as average. In 2008, Plugge, Douglas and Fitzpatrick found in their qualitative study that the availability of basic healthcare, even in times of illness, is bad (4). Female prisoners who require medical attention must complete a form where they describe their health problems and the reason for treatment. A Nurse, and in some cases a Prison Warden, decides who will be treated by a Doctor. Convicted women are not informed where they will receive medical care. In a study conducted in 2010 (in England) Powell and others declared that access to healthcare is difficult (5). Since this is the same country as mentioned in the previous research, prisoners requesting healthcare are asked in the same way to complete a form. A Nurse goes through a large number of applications and decides who will be treated by a Doctor. They stated that patients with acute illness are entitled to treatment. If prisoners have a common disease they could have access to surgery 24 hours a day. In a study in 2013 (in Washington) Luong found that healthcare in the prison, where the research was conducted, is easily available (3). If a prisoners' condition requires specialized medical care or treatment that cannot be done within a healthcare facility in the prison, then the prisoners are transported to hospitals or other clinics, where they are under guard for several hours or days. Access to healthcare was published from different studies. You can only compare studies from England where apparently the health system works the same way. **Objective 4 met.**

Sub-objective 5 in this study is the ultimate goal and deals with the needs of the satisfaction of the client needs during sickness. For this objective we refer to Questions 22, 23, 24, 25, 26, 27, 28, and 29 with Question 30 being the last question in which clients can express their views towards improving health services in prisons. The provision of healthcare is in first place towards meeting the needs of patients. Timely treatment is an important need of the client during time of sickness despite the fact that the prisoner does not have their own

resources to buy drugs. The survey found that more than half of the respondents were issued drugs on the same day which they were prescribed by a physician. It also depends on an assessment of the health status of the patient. Some clients seek to purchase drugs for pain, even though their health condition does not require it. In the event that a prisoner has no funds to pay for drugs and it is for a one-time assistance, the client can be offered medicine in the form of injections. Prisoners can be issued drugs in a single original packaging to be used when required but psychiatric medicines are dispensed in one-day doses with controlled use. Another need of patients is their satisfaction with the care provided. From the survey it was found that clients are more satisfied with the care provided by a Nurse than that from a Physician but in both cases the respondents indicated that they were satisfied with the care provided. The studies showed that the prisoners need to be more involved in decisions about their treatment and have more time to discuss their health and medical problems with a Physician. The study has found that the client trusts the prison medical staff and patient care is comparable to the patient care provided outside the Prison Service. In an open question the clients could express what they would like to improve in the provision of healthcare and thus satisfy even their own needs. The question found that clients require greater options of prescription medications without a Doctor's visits, and without the frequent presence of a Doctor. A minimum percentage of respondents have a need for better communication and information and more privacy. In a study in 2013 by Luong it was found that although prisoners are granted healthcare they are not always ensured the therapy (3). Many prisoners are addicted to drugs, benzodiazepines and other drugs, because they are all medicines issued by the Nurse. Prisoners are not happy with the medical staff during examinations and with the delivery of drugs. This research expressed dissatisfaction with the needs of patients. A study conducted by Plugge and others in 2008 showed that in addition to the difficult access to healthcare personnel there is also poor accessibility to medicines that prisoners have the need to use (4). Many of the prisoners were receiving important drugs prior to their imprisonment. In prison, their treatment was interrupted. The medical staff was unaware of the reasons or they were given insufficient reasons by the prisoners why the prisoners could continue to use those drugs. In prison, where the study was conducted, there was great dissatisfaction with healthcare. Like in the previous study from England conducted in 2010 by Powell and others, the provision of drugs is unsatisfactory for patients (5). The issuing of large amount of drugs was time consuming for Nurses. Providing only vital drugs is important. Nurses pick up the medication in pharmacies. Conclusions from the studies disagree. **Objective 5 met.**

Recommendations for Practice:
Management Facility

• Continuously explore and improve awareness of clients' facilities according to the lecture on the theme of „Healthcare in custody and imprisonment".
• Promote and expand Supervision in the field of healthcare.
• Provide regular professional development of the health workers.

Healthcare Professionals

• Observe the principles of effective communication and professional conduct with a client.
• Ensure the timely introduction of healthcare to clients in custody and imprisonment.

Conclusion

The contribution on the quality of healthcare from the perspective of the client in prison was aimed at determining the level of customer satisfaction with the healthcare in prisons and performance of the Prisons and Institute for Security Detention in the Moravian-Silesian Region. Healthcare in custody and prison has its own specifics, which is governed not only by legislative documents from the Ministry of Health but also by the Ministry of Justice and applicable laws. Healthcare provided to prisoners must have the same level of quality as the healthcare provided outside the prison because prisoners have the same rights to healthcare as patients who are not in prison like everyday citizens. The quality is viewed differently by professionals as by that of the clients. Quality nursing care is achieved not only by contributed expertise but also by personal skills of health professionals.

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SURVEY OF QUALITY OF LIFE OF SENIORS & THEIR READINESS FOR A PERIOD OF OLD AGE

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ARTICLE

Key words Quality of life of seniors, old age, aging, changes in the elderly, social care, health

Summary

In the article authors focus on the results of the survey which have investigated factors influencing the quality of life of seniors and seniors' level of preparedness for their new period of life - old age. A basic set of 300 respondents were seniors - patients hospitalized in geriatric clinics at the Hospital in Podunajské Biskupice in Bratislava, at the Internal Clinic of the University Hospital Ružinov, the Hospice Clinic in Bratislava Ruzinov, in Iinternal Department in Povážská Bystrica and Geriatric Department in Trencin. Authors have set four goals and four exploratory working hypotheses which were checked by questionnaire items. The main method of the survey was a questionnaire of own design, consisting of five demographic items and 15 questionnaire items. In the conclusion authors evaluated working hypotheses and proposed several recommendations for the practice.

Research problem

The aim of our survey was to determine the factors influencing the quality of life of seniors and how ready they are for the period of their "new life" - the period of old age.

Objectives of the survey

O1: To determine whether seniors are ready to old age and if they are satisfied with their current life situation.

O2: To determine what is the attitude of seniors to social service facilities.
O3: To find out if seniors know the possibilities of social assistance.
O4: To determine what is currently the most important for seniors.

Working hypotheses of the survey
H1: We expect that the majority of seniors are balanced and content with old age.
H2: We assume that seniors are satisfied in their domestic environment and have a negative attitude towards social service facilities, despite the fact that they begin to depend the help of other people.
H3: We expect that the majority of seniors do not know all possibilities of social assistance which can be provided in the old age.
H4: We assume that the most important for most seniors is to be healthy and self-sufficient in order not to be burden to the family and their children.

Method of survey
Main method of survey was a questionnaire of our own design which consisted of 20 questionnaire items (16 of which were closed and 4 items were open).

Characteristics of the basic sample
A basic set of respondents consisted of patients hospitalized in Geriatric Clinics at the Hospital in Podunajské Biskupice in Bratislava, at the Internal Clinic of the University Hospital Ružinov, the Hospice Clinic in Bratislava Ruzinov, in Internal Department in Považská Bystrica and Geriatric Department in Trencin
Number of respondents: 300

Demographics
Table 1: Age

Answers	n	%
50 - 60 years	60	20,0
66-80 years	140	46,7
over 80 years	100	33,3
N	300	100

Table 2: Gender

Answers	n	%
male	220	73,3
female	80	26,3
N	300	100

Table 3: Education

Answers	n	%
elementary	60	20,0
secondary	160	53,3
college	80	26,7
N	300	100

Table 4: Marital Status

Answer	n	%
single	20	6,7
married	180	60,0
divorced	10	3,3
widow, widower	90	30,0
N	300	100

Table 5: Number of Children

Answers	n	%
childless	20	6,7
1 child	30	10,0
2 children	110	36,7
3 children	100	33,3
more then 3 children	40	13,3
N	300	100

The results of our empirical analysis
Table 6: You live in:

Answers	n	%
family home (3)	150	50,0
apartment building (2)	130	43,3
retirement home (1)	20	6,7
N	300	100

Graph 1: You live in:

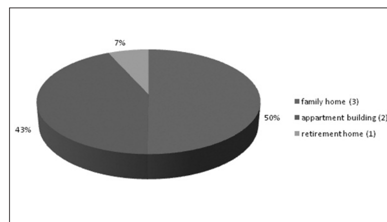


Table 7: With whom you live

Answers	n	%
alone (1)	70	23,3
with wife, husband (2)	190	63,3
with children (3)	40	13,4
with grandchildren	0	0
N	300	100

Graph 2: With whom you live

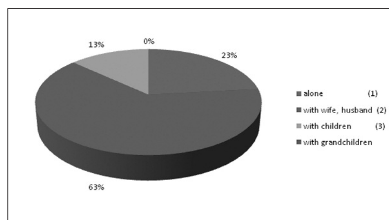


Table 8: When did you retire

Answers	n	%
after reaching the retirement age	140	46,7
later	160	53,3
to answer later – how many years (from – to)	2 – 12	In average 5.2 years
N	300	100

Graph 3: When did you retire?

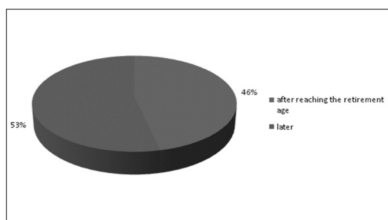
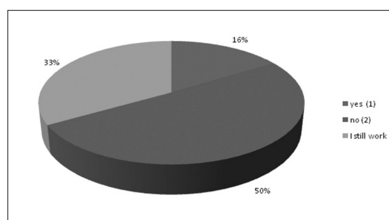


Table 9: Do you miss your job?

Answers	n	%
yes (1)	120	16,7
no (2)	180	50,0
I still work (3)	40	33,3
N	340	100

Graph 4: Do you miss your job?



In item 5 we asked for what reasons respondents still they still worked & what has led them to do it?

Table 10: Why still worked?

Answers	n	%
financial reasons (1)	20	16,7
I liked my job (2)	60	50,0
I miss contact with people (3)	40	33,3
N	120	100

Graph 5: Why still worked?

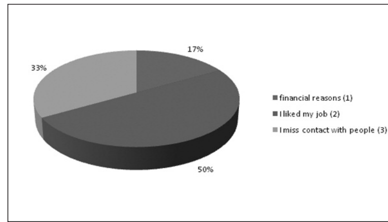


Table 11: Do you depend on the help of your family?

Answers	n	%
yes	90	30,0
no	150	50,0
yes, financially	10	3,3
I do not ask for help but sometimes Is would be helpful	50	16,7
N	300	100

Graph 6: Do you depend on the help of your family?

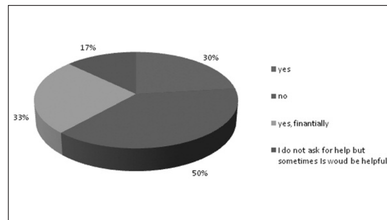
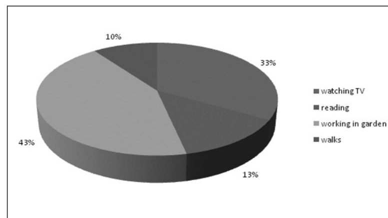


Table 12: How do you spend your free time?

Answers	n	%
watching TV	100	33,3
reading	40	13,3
working in garden	130	43,4
walks	30	10,0
N	300	100

Graph 7: How do you spend your free time?



In item 8 we asked whether respondents would like to spend their free time also in different ways.

Table 13: How would you like to spend your free time?

Answers	n	%
I am satisfied	120	40,0
more time to spend with children	80	26,7
if I was a healthy I would spend more time in nature	60	20,0
go to holidays	40	13,3
N	300	100

Graph 8: How would you like to spend your free time?

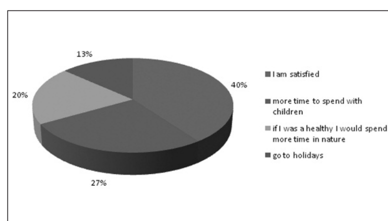


Table 14: How do you imagine your life in old age?

Answers	n	%
in good state of health	120	40,0
with my closest relatives	180	60,0
N	300	100

Table 15: How do you perceive aging?

Answers	n	%
positively	30	10
negatively	30	10
as a natural part of life	240	80
N	300	100

Graph 10: How do you perceive aging?

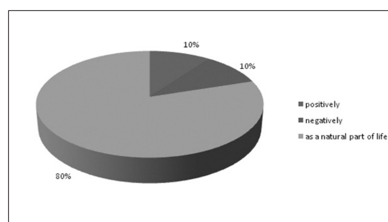


Table 16: What influences the quality of life of seniors in the higher age?

Answers	n	%
bad state of health	200	66,7
poor financial situation	30	10,0
bad interpersonal relations	70	23,3
N	300	100

Graph 11: What influences the quality of life of seniors in the higher age?

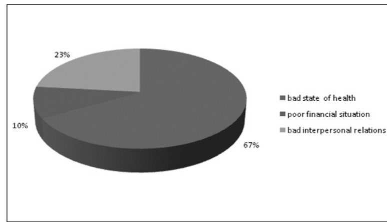
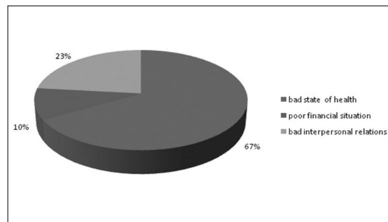


Table 17: The most important values affecting the lives of seniors

Answers	n	%
health	100	33,3
family	60	20,2
partnership	80	26,7
friends	40	13,3
finances /money/	20	6,7
N	300	100

Graph 12: The most important values affecting the lives of seniors



Item 13 we asked whether seniors have information about social facilities for the Elderly

Table 18: Do you know of social facilities for the Elderly?

Answers	n	%
yes, of some	190	63,3
no	40	13,4
no, because I have no interest in them	70	23,3
N	300	100

Graph 13: Do you know of social facilities for the Elderly?

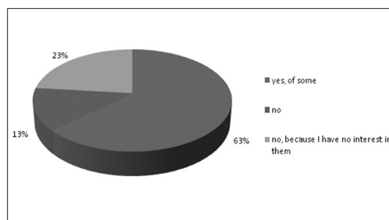


Table 19: How did you learn about social facilities for the Elderly?

Answers	n	%
I myself found out	20	10,5
I read about them	90	47,7
I learned from friends	50	26,3
my children informed me	20	10,5
social nurse informed me	10	5,0
N	190	100

Graph 14: How did you learn about social facilities for the Elderly?

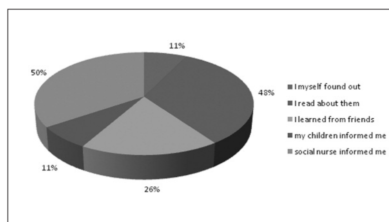
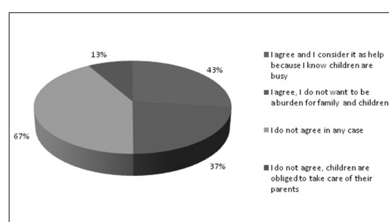


Table 20: Feedback on placement in the social facilities for seniors who cannot take care of themselves

Answers	n	%
I agree and I consider it as help because I know children are busy	130	43,3
I agree, I do not want to be a burden for family and children	110	36,7
I do not agree in any case	20	6,7
I do not agree, children are obliged to take care of their parents	40	13,3
N	300	100

Graph15: Feedback on placement in the social facilities for seniors who cannot take care of themselves



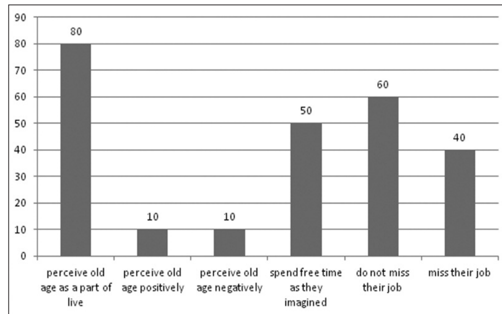
Discussion

In the working hypothesis **H1**, we assumed that the majority of seniors are balanced and reconciled with old age. In research, we found that 80% of respondents perceived it as a necessary part of life: 10% of respondents perceived aging positively and 10% negatively. Half of the respondents replied that their free time is spent according to their preferences.

60% of respondents expressed that they do not miss their jobs; 40% that they miss their jobs. This shows that seniors are ready to go to a retirement pension and are glad that

can make their hobbies to which they did not have any time in the period when they were employed.

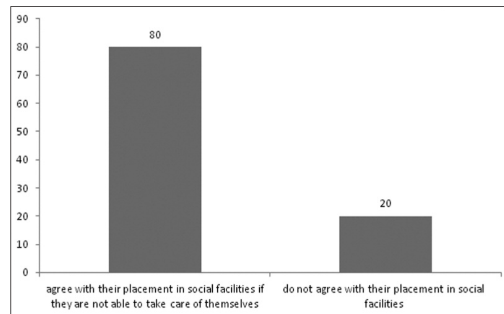
Evaluation of the working hypothesis H1



Based on the above, we can conclude that the working hypothesis H 1 was confirmed.

In the working hypothesis **H2**, we assumed that seniors are satisfied in their domestic environment; have negative attitude to social facilities although they begin to be dependent on the help. In research, we found that 80% of respondents would in case they could no longer care for themselves, agree with their placement in social facilities because they would not like to become a burden to family and children. 80% of respondents should not have the opposition to social facilities and perceived it as required assistance. 20% would never disagree with their location in the social facilities.

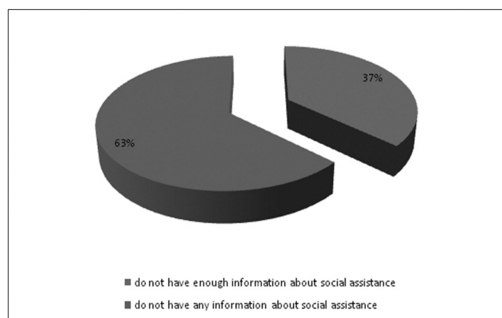
Evaluation of the working hypotheses H2



On this basis we can conclude that working hypothesis H 2 was not confirmed.

In the working hypothesis **H3**, we assumed that the majority of seniors do not know all possibilities of social assistance, which can be provided to them in old age. In research we found that 63.3% of respondents have the lack of information on the possibilities of social assistance which they might use and 36.6% of the respondents stated that they do not know any social facility.

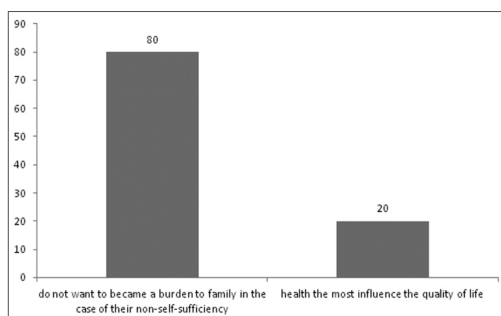
Evaluation of the working hypothesis H3



Based on the above, we can conclude that working hypothesis H3 was confirmed.

In the working hypothesis **H4**, we assumed that most important for seniors is to be healthy and self-sufficient in order not to be burden to their family or children. Confirmation of this hypothesis was the most likely of all hypotheses. It proves that for 75% of respondents health is the value which in a higher age which most affects their quality of life. Although almost everyone would like live the period of old age in a circle of their closest relatives, 80% expressed that, in the case of their non-self-sufficiency, they would not like to became a burden and agree with their placement in the social facilities.

Evaluation of the working hypothesis H4



Based on the above we conclude that working hypothesis H 4 was confirmed.

Conclusion

The issue of the Elderly is often moved into the back row of our interest, and therefore, should be given increased attention. In the 21st Century, a significant increase in the proportion of seniors in the population still takes place. To it, contributes progress of Medical Science and rising of the standard of living and quality of life. To this change, however, our society /Ministries of Health, work and family or Social Affairs are not sufficiently prepared as evidenced by the lack of social facilities. The aim of society should be to establish a comprehensive network of social and health services and promoting the activities of non-state, ecclesiastical and charitable organizations; also, to create conditions for seniors which they deserve for their lifelong labors. Based on our survey, we concluded that seniors are ready

for old age and they want to live it actively in the company of their closest relatives. Although the quality of life is often affected by a poor financial situation and bad interpersonal relations, the most common obstacle to live life fully according to their preferences and to spend their leisure time, due to their age, are health and financial situation. It depends on all of us to allow seniors, after taking up a retirement pension, peacefully and with dignity to survive the Autumn of their lives because we also all become seniors; so keep it in mind!

Recommendations for Practice

Based on our survey we concluded that it is very important to provide help and support to seniors to be able to remain as long as possible in their domestic environment. Institutional care is to be provided only when it is necessary. The role of society should also be to support seniors and to help them integrate into society even in retirement age. We should find ways to actively engage in their lives - visit pensioners clubs, sightseeing tours, etc., to familiarize them with the possibilities of further education at the Universities of the third age. It is very important for society to be sufficiently prepared for an increase in the proportion of seniors in the society. The primary role should be to coordinate health and social services; expand services of home nursing care agencies; promote activities of non-state, ecclesiastical and charitable organizations. To create conditions to seniors which reflect their all-life hard work. It depends on all of us to allow seniors after taking up a retirement to survive the Autumn of their lives peacefully and with dignity.

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SATISFACTION WITH THE PROVISION OF SENIORS SOCIAL SERVICES

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Abstrakt

It is important to highlight the importance of social services to improve and maintain overall bio-psycho-social health of seniors. Under the provision of social services is of paramount importance-care and positive attitude of staff to senior citizens.

Key words: Unfavorable social situation. Nursing service. Social service. Aging. Old age.

ARTICLE

INTRODUCTION

The main objective of social services is to ensure and protect social welfare, so a certain level of quality of life for all seniors, which is reflected in the official social policy. The company plays a dual role, both as a source of jobs on the one hand, being a productive factor, and on the other hand, allows you to support seniors in social need in the direction of ensuring its integration into society.

The importance of social services is not only important in view of the number of people who need it, but mostly because without its existence, part of the seniors had the opportunity to participate in social life would not be possible to exercise their human and civil rights, and this will cause their social exclusion.

SOCIAL SERVICES

According to § 2 para. 1 of Act no. 448/2008 Coll. on social services, social service is a professional activity, operator action or further action or set of actions aimed at:

a) prevention of unfavorable social situation, solution of unfavorable social situation or mitigate adverse social situation of an individual, family or community,

b) the maintenance, restoration and development of the ability of individuals to lead independent lives and to promote the social inclusion,

c) ensuring the necessary conditions to meet basic needs individual,

d) addressing critical social situation of the individual and the family,

e) prevention of social exclusion of the individual and the family."

Levicka (2002) characterizes social services as a set of activities that focuses on meeting the needs of individuals and groups manner other than material goods. These are activities aimed at ensuring adequate living conditions for the people creating such conditions in order to avoid negative social phenomena, creating support activities that seek to limit the adverse development of human society as a whole. To conventional forms of social services include:

- Institutional care for the sick, elderly, handicapped,
- homeless shelters,
- nursing care,
- organization of mass catering.

Modern forms of social services are:

- pension plan,
- Home care services
- intermediately, poloinštitucionálne forms of care (day stays for children, youth and adults alike handicapped)
- street worker,
- transport services
- Personal Assistant - Personal Assistant, as new quality of care services (Levicka, 2002).

„Social work is a professional discipline that special working methods to secure the social care on a professional basis. It based on the knowledge of many social sciences and applied scientific knowledge into practical action. It deals with the optimal functioning social institutions aimed at care, security and assistance to individuals, groups or communities" (Strieženec, 1996, p. 161).

Basics of working with the elderly social worker to establish a relationship, which will be based on trust. The client should have when communicating with a social worker a sense of security, certainty, be a landmark among seniors and the wider world, which will lead him and help him keep his life under control (Matousek et al., 2005).

Social service includes activities to satisfy not only the individual, but also the collective needs and it is not just about material possessions. Social services are important for clients that will help them cope with the adverse social or material need, on the part of state policy is a difficult economic assistance. In planning and shaping the social services are paid humanistic social criteria, as well as economic criteria, for this reason, each State has the services generally contained in a legal norm (Kasanova, 2008).

Social services are provided to people socially disadvantaged to improve their quality of life. Social services take into account the user's person, his family, the group to which it belongs, or the interests of the wider community (Matousek et al., 2007).

Law no. 311/2001 Coll. Labour Code, as amended, and which amending certain laws, § 151 paragraph. 1).

According to § 2 paragraph of Act no 1. 448/2008 Z. z. on social services, unfavorable social situation under this Act is a threat to an individual social exclusion or limitation of its ability to be socially integrated and solve their own problems:

a) on the ground that it has secured the necessary conditions to meet basic needs,

b) for their living habits and the way of life,

c) to severe disability or poor health,
d) on the ground that she has attained the age required for entitlement to a pension under a special regulation 1) (hereinafter referred to as „retirement age"),
e) the performance of babysitting natural persons with severe disabilities,
f) the threat to the performance of other individuals or
g) because she was a victim of human trafficking.

By Cornanicova (1998) is aging slowly flowing process of change that is the body, but are so named at a later age. These changes are reflected significantly to an advanced age.

„While aging is an inevitable biological process, old age is the last period of life, and it always ended in death." (Krajcík, 2000, p. 20).

According Švancaryho ,,Ageing is not the lesions but normal biological processes taking place in the unstoppable flow of development" (In Krivohlavy, 2011, p. 19).

Age itself is not a disease state, but during aging there is a summation of adverse effects, resulting in a higher number of sick people. Each individual during his lifetime overcome many diseases that affect the somatic functions. An essential feature of the disease in old age is polymorbidity, this means that, a person suffers a greater number of different diseases simultaneously. Older people just do not bother somatic diseases but also mental, that is not always correctly diagnosed (Vagnerova, 2000). They remain hidden, or are considered response to somatic disease or environmental burden.

The social worker must take into account the social practice of a specific (different) social characteristics of clients, such as: various interests, needs, opinions, etc. (Michel, 2013).

According to § 41 paragraph. 1 of Act no. 448/2008 Z. z. on social services,, nursing service is a social service provided by a natural person who:
a) is dependent on the assistance of another person and the degree of care, at least according to II Annex. 3 and,
b) is dependent on self-servicing assistance in transactions, acts of care for your home and basic social activities."

According to § 41 paragraph. 3 of Law no. 448/2008 Coll. on social services,, care service can not be provided to individuals:
a) which provides year-round residential care,
b) who is cared for by a natural person, which provides cash benefit for care under a special regulation, 11) unless provided otherwise,
c) which provides cash allowance for personal assistance under a special regulation, 11),
d) which is prescribed for quarantine suspected of being infected with a communicable disease and diseases of the disease.

The existence and development of human society is associated with various forms of social relations. Every form of community creates scope for action, which takes relations in and also affect the functioning of the various forms of mutual assistance (social services) (Hanobik, 2011).

Michel (2010, p. 90) states that everyone has the need to be a full member of society. It is important for people to create space for social self-expression and self-esteem.

It is important that each procedure was also consistent with a conscience. It is also necessary to take into account the consequences of the decision for the employees and the organization (Vansac In Beno, Andrejiova, Sramka, 2012).

There are also important implications and impacts of modernization trend of the economic efficiency of social work, which is associated with marketization. This is closely related to the economic dimension of social services, important sector of the public sector, the financing is carried out mainly from the state budget.

The fundamental basis of quality of life issues include the socio-political context. During the 20th century, will improve the protection of social rights, environmental standards, the development of health and psychosocial care showed the need to measure quality of life. Basically, there are three perspectives: objective measurement indicators, subjective estimate of the total life satisfaction and subjective estimation of satisfaction with various aspects of life. All perspectives are relevant for marketing in social services, whereas the quality of life value. The latest marketing concept is emphasized irreplaceability values at strategic and tactical marketing. We consider it important to accentuate current trends in marketing, whereby the aim of marketing effort to create a real value for the customer. We expect a close link with the trend of increasing the quality of services offered (Matulayová In Marketing social services as a subject of research in social work). The current marketing aims to meet the needs of the seniors who wishes to live a satisfying life.

Poor seniors in society Their position still, but 21st century should try to reduce people's reliance on social assistance or social services, through scientific and social progress (Bujdova, Dancak, 2011).

SURVEY PART

SATISFACTION SURVEY RECIPIENTS OF SOCIAL SERVICES

Custom research was conducted from 09. 08. 2013 to 27. 09. 2013 by questionnaire. Of the 182 questionnaires have been properly completed and returned 170 questionnaires in research, representing a 93,4 % return usable questionnaires. These 170 respondents consisted of exploratory sample (the sample). The basic sample consisted of randomly addressing seniors in Bardejov, which were distributed 170 questionnaires.

In September and October 2013 Department of Social Municipal Bureau implemented anonymous satisfaction survey addressed to individuals (seniors) who use social services provided by the City of Bardejov. The basis for obtaining information on the satisfaction questionnaire was anonymous.

The questionnaire is considered as a research tool aimed at the mass and relatively rapid identification of information about the views and attitudes of the actual situation. The questionnaire was personally delivered through employees of social Municipal Office in collaboration with various social service facilities so that individual beneficiaries of social services allowed to fill out a questionnaire. Collection and processing of questionnaires were provided by staff of Bardejov. The survey evaluated the nursing service, professional staff in the provision of care services that help improve the city offer social services in Bardejov in subsequent periods.

SURVEY RESULTS

Table 1: Evaluation of Social Services (in %)

Evaluation of Social Services	**Number**	**%**
Sufficient for all older	22	12,9
Partially sufficient	43	25,3
Are not sufficient	**87**	**51,2**
There are don´t exist	20	11,8
Total	**170**	**100,0**

Question 1: How do you assess the overall social services that are available to you in your town?
Source: Department of Social City Office

The data in table 1 shows that only 51,2 % of respondents answered that social services are inadequate for 25,3 % of the respondents social services partially satisfactory. 12,9 % of seniors was the view that social services are sufficient for all seniors. 11,8 % of respondents answered that social services in Bardejov there.

Table 2: Problems in the provision of social services (in %)

Problems in the provision of social services	**Number**	**%**
Financial problems	86	50,6
Expensive services and low pensions	42	24,4
Bureaucracy in handling	23	13,2
Congestion nurses	11	6,5
Lack of information on social services	10	5,7
Total	**170**	**100,0**

Question 2: Where do you see the biggest problem in the provision of social services in your town? (possibility of multiple answers)
Source: Department of Social City Office

Based on the results shown in table 2, we found that only 50,6 % of respondents considered the biggest problem in the provision of social services in Bardejov financial problems, 24,4 % of seniors said that they are expensive to service and low pensions, 13,2 % of respondents said „bureaucracy in dealing with." 6,5 % of respondents considered the biggest problem in the provision of social services in Bardejov overload nurses, 5,7 % of seniors reported „ignorance of social services."

Table 3: Satisfaction seniors with nursing (in %)

Satisfaction with nursing in its provision	**Number**	**%**
Very satisfied	23	13,5
Satisfied	52	30,6
I can not judge	**69**	**40,6**
Dissatisfied	23	13,5
Very dissatisfied	5	2,9
Total	**170**	**100,0**

Question 3: Are you satisfied with nursing homes in your town? (possibility of multiple answers)
Source: Department of Social City Office

The data in table 3 shows that only 40,6 % of respondents were unable to assess satisfaction with nursing. 30,6 % of seniors were satisfied with nursing, 13,5 % of respondents were very satisfied with the nursing home, just 13,5 % of seniors were dissatisfied with nursing, 2,9 % of seniors were very dissatisfied with nursing.

Table 4: Satisfaction seniors with the approach of staff (in %)

Satisfaction with the approach of staff	**Number**	**%**
Very satisfied	32	18,8
Satisfied	**63**	**37**
I can not judge	52	30,6
Dissatisfied	21	12,4
Very dissatisfied	4	2,4
Total	**170**	**100,0**

Question 4: Are you satisfied with the approach of the staff in the provision of care services in your town? (possibility of multiple answers)
Source: Department of Social City Office

The data in table 4 shows that 30 % of respondents were satisfied with the approach of the staff in the provision of care services. 30,6 % of respondents were unable to assess satisfaction with the approach of the staff in the provision of care services. 18,8 % of seniors were very satisfied with the approach of staff, 12,4 % of respondents were dissatisfied with the approach of the staff, 2,4 % of seniors were very dissatisfied with the approach of the staff.

Table 5: The need for care services in self-service activities

The need for care services in self-service activities	Number	(%)
Personal Hygiene	**41**	**24,1**
Dressing, undressing	15	8,8
Mobility	20	11,8
Toilet, emptying	13	7,6
Houseworks	36	21,2
Catering	18	10,6
Drinking regime	4	2,4
Shopping, house maintenance	23	13,5
Other	0	0,0
Total	**170**	**100,0**

Question 5: In which the activities necessary self-care service? (possibility of multiple answers)
Source: Department of Social City Office

From the data shown in Table 5 shows that of the total 170 respondents (100,0%) and 41 elderly (24,1%) needs assistance with personal hygiene, 36 elderly (21,1%) needs care service on housework, 23 respondents (13,5%) needed help with buying or building maintenance, 20 respondents (11,8%) need help in improving mobility, seniors 15 (8,8%) needs care service in dressing and undressing, 13 respondents (7,6%) need help in emptying, 4 seniors (2,4%) needs care service in receiving fluids.

Table 6 Seniors dissatisfaction with the activities of the carer

Dissatisfaction with those of seniors caregiver	Number	(%)
Communications	43	25,3
Responsivenes	25	14,7
Expertise	20	11,8
Assistance with self-service activities	**63**	**37,1**
Fulfillment of personal wishes	19	11,2
Total	**170**	**100,0**

Question 6: In which activities carer you least satisfied with? (possibility of multiple answers)
Source: Department of Social City Office

From the data shown in Table 6 it shows that only 63 respondents (37,1%) are dissatisfied with the assistance of a carer at a self-service activities. 43 seniors (25,3%) were dissatisfied with communication caregiver. 25 respondents (14,7%) were dissatisfied with the willingness caregiver. 20 seniors (11,8%) reflected the dissatisfaction with expertise caregiver. 19 respondents (11,2%) were dissatisfied with the performance of their personal wishes and requirements from the carer.

Table 7: Complications with the processing of nursing services

Complications in handling day-care	Number	(%)
Lack of funding municipal office	**58**	**34,1**
Lack of nurses	48	28,2
Reluctance in handling	27	15,9
I am unable to service / s to pay	37	21,8
Other complications	0	0,0
Total	**170**	**100,0**

Question 7: Specific complications in connection with the course of dealing with requests for attendance allowance? (possibility of multiple answers)
Source: Department of Social City Office

Based on the results shown in Table 7, we found that up to 58 respondents (34,1%) felt most common complications associated with the lack of funding municipal office for care services. The other frequently mentioned complication is the shortage of nurses, it provides 48 seniors (28,2%). 37 respondents (21,8%) as a complication emphasizes the cost of care services, seniors are not COPD it from its own resources. With an overall reluctance of workers municipal authorities to deal brought together 27 (15,9%) of the elderly.

RECOMMENDATIONS FOR PRACTICE

a) it is very important to focus care service from different areas of self-service operations including the proposition personal care for the elderly,
b) it should be a greater focus on increasing satisfaction with the elderly by caregivers in self-service activities,
c) under the care services provided to the elderly, it is important to increase the number of nurses.

CONCLUSION

Social services are an essential part of improving the bio-psycho-social quality of life of seniors. For this reason it is necessary to improve the level of social services and professional staff access to older people.

Social services are a necessary condition for a decent life in old age. Social services are an instrument of social policy geared towards enhancing the bio-psycho-social health of seniors.

An important focus of social services are: to take into account the individual needs of the service recipient, activate it by its possibilities and capabilities necessary to provide the service professional level, together with his family, relatives and the community.

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SOCIAL PROBLEMS IN THE ROMA COMMUNITY IN THE SLOVAK REPUBLIC

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Abstract

Our society is currently experiencing very serious economic problems. Another problem that presently appears on the surface of daily reality is the coexistence of the Slovak Republic majority and Roma ethnic minority. Roma community, for its different way of life, culture, customs, and way of thinking and racial characteristics, has been left out on the edge of society.

Key words: Roma ethnic group, social problems, education, unemployment

ARTICLE

INTRODUCTION

Although the Roma ethnic group is the most represented in population in the Slovak Republic, the situation has not changed. The majority population has a negative attitude towards this ethnic group. In Slovakia there are still significant regional differences in poverty, unemployment and average wages rates, as well as in education and health indicators. Conditions in Roma villages suggest that there is an overlap between these islands of poverty and many lives of Roma people. Why is there this poverty? Doesn't everybody, Roma or not, supposedly deserve the right to live? Right to education, employment and good housing...?

One of the key factors influencing living conditions in many ways is education. There is a connection between education, behavioral patterns, successful integration and advantages of being part of labor market such as employment, work quality, bonuses, quality of housing and so on. There is also a connection between low qualification for labor market status as well as higher risk of being excluded from the labor market. Statistics reveal that most of the registered unemployed population comes from a group of professionally trained people; from people with complete primary education; or no education at all. Citizens with a low education degree are a group most often in danger of losing their jobs and hence low incomes.

As part of creating this paper, we performed a small research, which was conducted among university students. The sample was selected randomly. Questionnaire was completed by 100 respondents with 100% return. The only condition was age over 18 years. The research was focused on accurate information, so I asked each respondent to carefully express their opinion. Respondents' opinions are shown graphically with comments; graphs are created by the author of the article.

Poverty of Roma community

Striženec (1996, p. 75) defines poverty as

„a state characterizing the lack of basic means of life and access to services. Individual, family, or social group are not able to satisfy the most urgent life necessities through with their own resources. Therefore they need assistance from other Social Services (state, municipality, NGOs, charity, etc.). Poverty is a situation where income is insufficient to cover minimum wage."

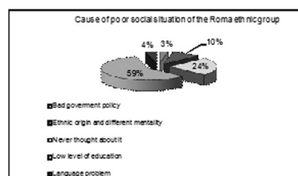
Due to the limited amount of quantitative data we rely on qualitative indicators and observations. Absolute or material poverty refers to the lack of adequate housing, clothing, food, access to basic infrastructure and utilities - such as roads, running water, electricity and sewage system as well as healthcare. Studies have found that poverty in Roma and non-Roma population in Slovakia is of a different nature. Poverty in Roma settlements is closely linked with living conditions, and more specifically, the level of integration or segregation. Poverty among Roma is closely related with four factors (Report, entitled Chudoba Rómov a sociálna starostlivosť o nich v Slovenskej republike 2002 [Poverty of the Roma and Social Care for them in Slovak Republic 2002], p. 13)

- Economic conditions in the region
- Size and concentration of Roma population in the settlement
- Proportion of the Roma in settlement
- Degree of geographical integration or segregation of the settlement and its distance from the nearest town or village

Poverty does not focus only on narrow aspects of material consumption or resources. It includes many other aspects, such as social exclusion; lack of access to Social Services; vulnerability; psychological dimensions. In this context, social exclusion is understood as the inability to participate in social, economic, political and cultural life.

„Implicating the Roma are more affected in segregated areas, which is actually a typical problem of Roma settlements in Slovakia" (Radičová, 2001, p. 443).

Chart 1: Cause of poor social situation of the Roma ethnic group



According to 59% of respondents, low education is the reason for bad social status of the Roma; 10% because of ethnic origin and different mentality; 4% in languages; 3% to poor government policy; 24% never even thought about this problem.

UNEMPLOYMENT OF THE ROMA

Unemployment generally means under-utilization of the population that is capable of work, and that seeks employment. Being unemployed doesn't necessarily mean being inactive because also people with disabilities, who can't work, belong to this group. The existence of unemployment is a phenomenon of a free and democratic society based on the principles of free market economy.

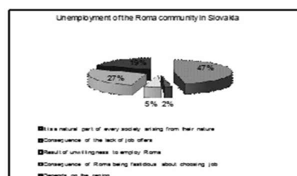
„Unemployment is generally perceived as a socio-economic phenomenon, of mostly negative character (especially when it becomes massive), associated with the existence of the market in this case the labor market." (Sotník. A., 2009, p. 15)

Unemployment is a social problem because it has significant effect on the psyche of an individual; the trauma of losing one's job is transferred to other family members and close friends. In periods of high unemployment, the economic misery deepens and influences human destinies and lives of families.

According to EUROSTAT definition *„unemployed are people between ages 15 and 64, which, by ILO (International Labor Organization) definition, are: without work, with no relevant reasons preventing them from working; so they are able to work during next two weeks and were actively seeking employment for the last four weeks"*. (Martincová.M., 2008 p. 11)

According to Zeman (2006, p. 123) unemployment among the Roma is 80%. Looking at the demographic situation of the Roma in Slovakia there is a large difference. The number of children per family in the Roma population is 4.2 children while the number of children in the non-Roma family is 1.51.

Chart 2: Unemployment of the Roma community in Slovakia



The highest percentage of respondents, 47% thinks that unemployment is a natural part of every society arising from their nature; 27% because Roma are being fastidious about choosing a job; 19% that it depends on the region; 5% that this is due to unwillingness to employ a Roma; and only 2% that this is due to lack of jobs .

Employment Dimension

The National Action Plan for Social Inclusion 2004-2006 describes Roma as the most vulnerable group facing double marginalization. Their gathering in marginalized regions indicates a minimum employability and ability to liberate themselves from the social aid network, simultaneously they are unplaceable in the labor market for various reasons; either their entry into the labor market is more difficult due to a working disadvantage or because of social exclusion. The position of Roma in the labor market during the transition period has changed dramatically, causing a huge increase in unemployment and inactivity.

„Work as a legitimate source of income provides citizens with the highest rates of economic independence and self-realization; one can assume that the restricted access to the labor market is globally one of the most important factors in risk of poverty." (Loran In: Vašečka 2002, p.265).

Because the Roma people are long-term or permanently unemployed, they are becoming dependent on social support benefits provided by institutions of the state social policy.

The result is extremely high long-term unemployment leading to intergenerational reproduction of this status. Report, entitled Poverty of the Roma and Social Care for them in Slovak Republic (2002, p. 31) states that *„many Roma consider racial discrimination as a serious obstacle to their employment despite the fact that Slovakia has a valid anti-discriminatory legislation corresponding to the conventions concluded within the International Labor Organization"*.

Hidden forms of discrimination against Roma by employers, as well as the stereotypes and prejudices of the majority society, are some of the factors that increase the risk of Roma unemployment and thereby deepen their marginalization in the labor market. The high rate of Roma unemployment presents one of the most significant issues concerning the Roma community and its position within the entire society.

Extreme unemployment in the Roma population leads to other social impacts; strengthening tendencies toward criminal activity aggravating conditions for upbringing and education of the younger generation and we can assume that it can be one of the reasons for negative attitudes towards the majority society. Many officially unemployed Roma actually work illegally, which is often tolerated by the local authorities because they consider it more reasonable than complete apathy. Orientation towards the illegal work, however, has many negative impacts.*„In addition to direct consequences such as lack of job security, there are indirect but important repercussions. The contracts for undeclared work are not legally enforceable, so workers often lose their earnings"*. (Hůlová, Steiner, 2005, p.14)

Long-term unemployment reduces the ability of personal growth and causes the loss of working habits. Other factors that maintain marginalized and excluded status of Roma in the labor market include their low level of education and qualification; inferior housing status and living conditions; inadequate health status as well as prejudices and latent discrimination against Roma by potential employers.

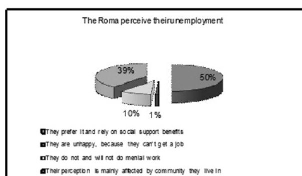
Long-term unemployment of Roma reaches 70-85%, and it's a result of:

- Small number of unqualified work offers, which is, for most Roma,so far the only possible form of legal livelihood due to their level of education.
- Wrong benefit system, which doesn't considered that the Roma can permanently sustain far lower standard of living than the rest of the citizens, and are more easily satisfied with life on the „social support" that doesn't motivate them to obtain work, qualify or re-qualify themselves.
- Commonly known poor work ethic, dishonesty and unreliability of Roma staff.
- Latent and refined racism; for example discrimination in hiring process when an employer doesn't verify the soundness of the candidates, but rejects them right away, because they are of Roma origin. (Hůlová, Steiner, 2005, p.14 - 15)

We asked the next question because despite the fact that it seems to reflect the perception of the Roma ethnic group, in fact, it tells us about the perception of the employed people.

50% of respondents chose the answer that they prefer social benefits. A more conciliatory response, 39% that their perception is mainly affected by the community where they live. Thirdly, 10% that they do not and will not do menial work. Lastly, only 1% believes that they are unhappy because they are not able to find a job.

Chart 3: The Roma perceive their unemployment



HEALTH OF THE ROMA POPULATION

It is well known that the health status of the Roma population is worse than that of the majority population. According to Vašečka (2002), the average life expectancy of Roma men in Slovakia is 55 years, which is about 13 years less than the average life expectancy of non-Roma men. The average life expectancy of Roma women in Slovakia is 59 years. This is approximately 17 years less than the life expectancy of non-Roma women. The main factors affecting the poor health of Roma population are unhealthy lifestyle, especially incorrect eating habits, smoking and high alcohol consumption, as well as inadequate housing conditions. This situation is particularly alarming in isolated and segregated settlements where the residents have insufficient access to drinking water or clean water and sanitation.

Some studies have found a different approach to healthcare for Roma people. Healthcare is in some cases different, some diseases are managed within the community and others require Public Health System Services. Affiliation with the Public Health Sector in some cases depends on cultural factors. For some Roma, a stay in hospital indicates death.

This belief can lead to rejection of some forms of healthcare. Health Workers, without understanding this context can see it as irresponsibility. As main determining factors affecting lower quality of the health status of the Roma population considers Vašečka (2002, p. 258), in particular:

- lower level of education, possibly causing insufficient level of health and social awareness,
- low standard of personal hygiene,
- low standard of communal hygiene,
- low standard of living and hazardous environment that relates to polluted and devastated environment (especially alarming is the situation in isolated Roma settlements where the quality of housing often doesn't meet basic sanitation requirements,
- the problem of the bad economic situation in many families is also connected with bad eating habits, impossibility to purchase needed medication or to seek adequate medical assistance,
- increasing rates of alcohol and tobacco consumption,
- relatively large genetic burden of the Roma nation associated with a high incidence of congenital diseases.

Access to healthcare among Roma from settlements is negatively affected by geographic distance of these settlements from urban areas as well as poor communication between Roma and members of the medical institutions and widespread discrimination. Due to poor condition of roads, ambulances in emergencies often have difficulties to arrive in geographically isolated areas.

THE LEVEL OF EDUCATION OF ROMA IN SLOVAKIA

„Every child without any limitation due to race, nationality or religion, shall have the right to an education, directed to the promotion and development of the child's personality, talents and mental and physical abilities to their fullest potential." (UN Universal Declaration of Human Rights - 10. 2. 1948)

At this moment, the question of education of the Roma is a debatable issue. Linked to the integration and inclusion issues, legislation is also contributing. Legal Standards guarantee the right to education for every child (individual). Area of education is a priority for Roma integration, but must go hand in hand with the development of job offers and the fight against discrimination in accessing the labor market. Lack of education and professional competencies are two of the main reasons for high Roma unemployment.

„Education can be characterized as a deliberate acquiring of knowledge and habits, closely associated with development of cognitive, emotional and liberal growth, heading towards socially desirable behavior and actions of the individual." (Šimoník, 2005 s. 41)

Professional literature often referrers to Roma disinterest in education which results in unwillingness to adapt to the educational system. Šotolová (2000, s.96) writes: *„...among many objective reasons obstructing Roma children the access to education, one is subjective, the internal regard of the Roma for education that doesn't represent more important role in their value system."*

The educational path compared with the majority is significantly qualitatively (type of school) and quantitatively (level of educational attainment) below average. Up to 35% of Roma did not complete elementary school; among 36.6% of the Roma this is the highest obtained level of education; only 15.2% of the population has completed secondary education. Inevitable result of this educational structure is that alarmingly only 0.2% of Roma with education higher than the secondary one (Filadelfiová, 2006, p. 62). The causes of this phenomenon are, according to Filadelfiová (2006, p.62), diverse due to a general failure in educational process and we can classify them as follows:

- absence of pre-school attendance,
- poor housing conditions and lifestyle,
- differences in the value system of the Roma population, especially
- different meaning ascribed to the value of education,
- hostile attitude towards the school institutions,
- absence of social and communication skills (which are essential at schools)
- language barrier (Roma children's insufficient knowledge of teaching language)
- different psychic characteristics of the Roma children

The fact that the Roma are less educated than the majority population and that the Roma children have significantly worse grades at school is influenced by several factors. The bad social situation influences the education of the Roma and their children from seg-

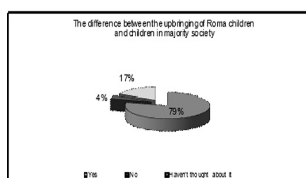
regated settlements mostly in marginalized regions of Slovakia. Children from segregated settlements are already disadvantaged in many ways when entering school.

The reason is absolute poverty of their parents; children are missing basic abilities; hygiene and social habits; basic communication skills; because large part of the Roma community doesn't speak Slovak and communicates with their children only in Romani language at home. Therefore, the problem lies in ignorance of the language, which is a significant barrier in poor readiness to adapt to conventions of the majority population and in low education among Roma. These children also lack any support from family and immediate environment. At the same time, Roma children have high absence at school, explained most commonly by insufficient clothing; unavailability of transport to school; responsibility to care for younger siblings; disease (Musilová Mačkinová, 2012).

„Roma children from separated and segregated settlements are disadvantaged several times: first, when entering elementary school, second, during the admission exams for secondary schools. Considering their chances if they decide for secondary education, they usually prefer vocational schools (most important factor being the availability - distance from their residence) and there is the third limitation they face." (Radičová, 2001, p. 67).

Despite the fact that we can speak of a lower level of education among Roma compared to the majority population, it is not possible to approach the issue of education as a one-dimensional phenomenon. The aim of this part was to particularly emphasize the heterogeneity of the Roma population and demonstrate the differentiation of attitudes towards education. These positions are determined more by the social situation in which Roma live, than by the traditional values. Low level of education of parents, long-term unemployment and poor living conditions that do not allow adequate preparation of Roma children for school, shape the Roma point of view on the education of their children (Mačkinová – Musilová, 2012).Without the active participation of Roma in education, acceptance of their opinions and attitudes, we cannot achieve success in any projects aimed to increase their level of education.

Chart 4: The difference between the upbringing of Roma children and children in majority society



As shown in the chart, most respondents 79% see the difference in upbringing of Roma children and the upbringing of children of majority society. When answering yes, they had the opportunity to state where they see this difference. They stated that the upbringing of Roma children is too benevolent; parents don't lead their children towards education, order and responsibility. 17% have not thought about this and 4% doesn't see this distinction.

HOUSING AS A SOCIAL PROBLEM OF ROMA PEOPLE

The way of living is the most important indicator of economic and cultural maturity of individual, as well as the nation. Among Roma it's a reflection of their specific lifestyle, value scales, but also their social and economic status.

Labaj's (1993, p. 12) understanding of the term residing is, a person's implementation of the set of activities in an apartment or residential area, because a person's life does not happen just in the apartment, but also in its surroundings. From a sociological point of view, residing also means living in a particular community, with a sense of fellowship, safety and security, resulting from the integration in this community and a certain degree of identifiability with it. Housing of the majority Roma population visible on the outside does not differ substantially from the average housing of the general population.

However, on the inside, they maintain many traditional customs, way of living and family life. Furnishing the interiors has its specifications among Roma. Their sense of color is reflected in the vibrant wall patterns accompanied by various ornaments, such as framed hand painted photos and paintings with religious themes.

„Furthermore, some Romani families also adopt various negative habits from their environment, which they generally want to avoid." (Davidová, 1995, p.167)

One of the most important factors affecting the way Roma live is their territorial distribution, respectively the degree of their concentration in individual regions. An integral part of Roma living is the nature of their settlements, i.e. residential (urban) types. Characteristics of the Roma housing issue by Miller:

- concentration of Roma inhabitants in inadequate, old housing complex owned by the state,
- segregation practices of municipalities
- forced segregation, impossibility to rent an apartment in another location because of frequent racial prejudice of the tenants
- formation of ghettos,
- illegal occupation of flats, living in flats without a lease,
- abuse of the owners of houses and apartments, inability of part of the Roma community to navigate in official bureau procedures and a tendency to agree with an offer considered beneficial in the present situation, but in the longer term usually unfair.

Roma settlements

Mušinka (In: Vašečka, 2002, p. 632-633) divided and defined Roma settlement as follows:

a) Completely segregated Roma settlements- are independent urban units that are physically separated from the village and in fact constitute an individual unit, often isolated from the village by several kilometers. These settlements often lack basic infrastructure such as electricity, gas, water, sewer system and street lighting.

b) Segregated settlements- residential units which are physically separated from the village, but actually in its vicinity. Separating element is mostly natural formations (most common are streams or fields), road or railway. Current Roma settlement consists of dwellings, each with individual type and style, determined by economic status of families as well as their cultural and historical customs. Dwellings are characterized

by their minimum standard of the living space. The decisive factor is the large kitchen allowing preservation of traditional, coherent Roma way of life. Thus the hut is spatially separated. One part consists of space where Roma sleep and the other living area of the house (hut) consists of the kitchen. Kitchen and bedroom are separated. Roma living in huts have terrible hygienic conditions and are dependent on using dry toilets, which are near their hut.

c) Separate residential units within municipalities - are mostly separate streets or neighborhoods that are urban sections of village but socio-culturally form separate entities. A typical example might be a settlement in the village, which is located in the lower part of the village separated on an island between two streams, where the Roma concentrate on an individual street.

d) The scattered communities - These are municipalities in which Roma live scattered among the majority population. A typical example would be a village where the majority of Roma live scattered and is fully integrated between non-Roma citizens and their homes are no different from non-Roma ones. However, the dispersion of the Roma community in the municipality doesn't necessarily mean its integration into majority society.

e) Roma settlements - the so-called urban ghettos: Especially in the 70s, in some city agglomerations in Slovakia, there was a boom of modern „Romani Multi Dwelling Units (MDU)". An example is Košice's MDU Luník IX that was built as a separate housing estate where all of the Roma families had been relocated. This isolated housing estate built by the city thus became „Roma Multi Dwelling Unit settlement". (Davidová, 1995, p. 169)

Segregation of Roma into these urban areas is associated with their reliance on social benefits. Reduction of the social benefits results in inability to fulfill their obligations related to housing and thus increasing the number of late payers and problems connected to this, such as disconnection of electricity, drinking water supply or forced evictions in case of long-term non-payment. It has been shown that the large concentration of mutually distinct Romani groups was a big mistake, having impact especially on the Roma themselves. This failure is blamed on shortcomings in the social assistance system and incorrect actions taken to solve housing problem of the Roma people.

Jakoubek (2004, p.117) describes Roma settlements primarily as islands of traditional culture that was once passed down from generation to generation. He describes the Roma settlement as a set of specific practices of families living in one place at a certain time. This means that if one family leaves the settlement, the whole culture of Roma settlements changes, because the family takes away part of it with them. Hence, the Roma settlement is a set of families rather than specific area in space.

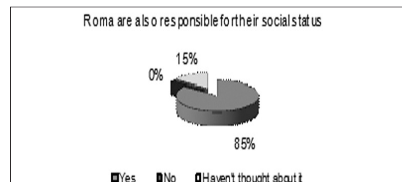
Roma settlements in Slovakia have different sizes. Members of one Roma families usually live in one settlement. They're mutually supportive and help each other.

Nowadays, the basic unit in Roma settlements is closer family - man, woman and their children, closely linked by family and wider community of their distant relatives and consequently the whole Roma settlement. The authority and respect for the elders, women's respect for men was, and still is the basic requirement for functioning Roma settlement.

A specific problem of life in town is the so-called „housing estate phenomenon". For Roma people, life in such a place is even more complex than for the majority society because

of self-identification position and social hierarchy. In a Roma settlement, they were used to communicate with their environment; with the people; with their living space. They were accustomed to interaction with this space not just of its acceptance. Housing estate plans with their artificially created symbolism by foreign and majority society and their typical town anonymity and isolation, did not help with the coexistence of Roma and non-Roma majority. *„In addition to these problems given by strong contrast between the way of life in Roma settlements and Roma life in urban and village housing estates, there still exist many problems related to the value scale of the Roma people."* (Blažek, B., 1998, S.184).

Chart 5: Roma are also responsible for their social status



Regarding the social situation of the Roma, up to 85% people questioned think that Roma are responsible for their own social status. 15% haven't thought about this issue. Not one respondent chose the negative answer.

SURVEY RESULTS

Based on the gathered findings, we have come to the following conclusions:Questionnaire survey has shown that the Roma in Slovakia are not discriminated, on the contrary, the majority thinks they're being favored. The position of the majority society towards Roma minority can originate from, on the one hand, increasing number of the Roma in the total population majority, and on the other, that the Roma minority either does not want to or engages only with great difficulty in processes that are inherent to the majority. The causes of differences of opinion are not only specific manifestations of the Roma ethnic group, which are partly based on historical origins and experiences, but also the approach of majority society.

Other research results showed that racial intolerance in the majority society, according to our respondents, does not dominate. My subjective opinion is that this idea is created by major media outlets. Thought, racial intolerance is a very sensitive issue, opinions about it depend on age, education and social status of individuals in community.

Young people, who are informed and educated, do not desire to be racists or xenophobes. They do not mind living next to a Roma and other people from different states, who settled in Slovak Republic. They only want them to behave properly, and that they adapt to the conditions of our society.

Most of our respondents think that the involvement of Roma citizens in Public Services should help solve social problems of the Roma. Public media rarely promote positive examples of educated Roma, who are figures in social, political and cultural life.

Roma suffer from a lack of positive information about joint activities of the Roma and non-Roma communities. Specifically joint activities will help improve mutual coexistence between the majority society and Roma ethnic group. In the process of forming public

opinion and removing negative attitudes towards their own ethnicity; in addition to Roma intelligence also Romani media should be active.

Results from our survey indicate, that the majority of Roma do not wish to be employed. In every society, there have always been and always will be people, who do not want to and avoid work. The same is true for Caucasians as well as Roma. But the reality is that many Roma, who want to work, have smaller chances that they will find a work compared with majority. The reasons are usually prejudice and low level of education of Roma. An important role plays the fact that Roma settlements are generally located in areas of greatest unemployment in Slovakia.

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