St. Elizabeth University of Health and Social work Bratislava, Slovak Republic

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Interdisciplinary research

Social work, education, social development

St. Elizabeth University of Health and Social work, Bratislava, Slovakia
College of International Business ISM Slovakia in Presov
Universytet Rzeszowski Wydzial Socjologiczno - Historyczny

2020

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ISBN: 978-615-00-7752-9

Publisher:
St. Elisabeth University of Health Care and Social Work

Printing: Budapešť; Expharma

EDITORS:
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Number pieces: 100

Number of pages: 157

Year of publication: 2020

Method of issue: book publication

CONTENT:

SOCIAL SERVICES AND THEIR SIGNIFICANCE FOR THE ROMA PEOPLE IN THE SLOVAKIA NOWADAYS

ANDREA GÁLLOVÁ

Abstract:
Nowadays social services are significant part of activities and actions performed by public as well as non-public providers of social services in Slovakia. Current state of social services provision in Slovakia is based on the legislation frame, social policy of the state, development of the countries in the European Union and societal development of our country. Social services are usually perceived as services of various subjects focused on social needs of the people who would find themselves in a state of social distress if not provided with social services.

Keywords: social services, Roma ethnicity, social and economic factors, Senior´s homes.

Introduction:

Currently applicable Law Act No. 448/2008 Coll. on Social Services governs legal relationships within providing social services, financing social services, and supervising provision of social services by public and non-public social services providers. Performance of social service activities is guaranteed by specialized, operating and other activities.
The framework policy of the development of social services provisions in the Slovak Republic is based on and takes into account respect for basic human rights, also stated in the Universal Declaration of Human and Civil Rights, and the European Convention for the Protection of Human Rights and

Fundamental Freedoms, and developing a common approach to the contents of the European Social Charter, pursuant to which disabled people have the right to independence, social integrity and participation in social life and also all other people reliant to help of another natural

person, or retired people, as well as individuals, groups or communities being in unfavourable social-economic situation. The government of the Slovak Republic has the goal to integrate the Romani people into the society at all its levels. In Slovak context there is a high extent of social distance in connection to the Roma people and their low extent of emancipation connected with poverty and negative economic impact on overall quality of their life, which are two factors preventing creation of functional multicultural society.

Social services are based on the matter of social services, which is a personal relationship arising between providers of social services and their recipients. It is important to motivate citizens in modern and postmodern society to personal involvement in social services. Social services constitute a mechanism, which can improve individual´s social skills and widen every single individual´s sources of social environment. In the sphere of social service it is necessary to direct individual, family or group towards the most important social values.

Currently, recipients of social services are expected not to be objects receiving social services, but they are expected to be subjects participating in organization activities, i.e. to be active recipients of social services.

Quality of social services derive from important rules and principles, which provide adequate quality of living standards and provision of social services along with acceptance of individual and group needs of the receivers without any

differences. Quality social services relating to the receiver are those solving the citizen´s social situation, where at the same time the recipient takes position of being satisfied with them.
A quality service then means a social service enabling the recipient to live a normal life (complexity of services), it takes into consideration the needs of an individual and protects their rights and interests.

Methods

The scientific research was performed in Banskobystrický Region, the research file consisted of the facilities for senior citizens, year-long form of stay, public establishments providers, higher territorial unit, town, municipality, non-public providers and the Romani ethnic group citizens living in Banskobystrický Region. The main goal of the research was to find out the significance of social services provision to the Romani people and the extent of the interest in social services provision, to which factors significance is attributed when being or not being interested in placement in the facilities for senior citizens. Research method: quantitative, qualitative. Research instrument: questionnaire, dialogue. The examined population and basic examined file consisted of directors and social workers in the facilities for senior citizens and the Romani ethnic group citizens in all 13 districts of the region mentioned.
We addressed all 61 registered facilities for senior citizens, where there were placed 1776 clients, our questionnaires were completed by 40 of them, where there were 1165 clients placed, which meant 65.6% participation.
The age structure of the clients ranged from 60 years to 100 years. We addressed 300 Romani people to be engaged in our dialogue, out of which 253 participated, which is 84.33% participation. Within the frame of the research paradigm we

set social and socioeconomic factors, which we assessed using statistical methods. Our main goal was to find out the significance of services provision to the Romani people through the extent of the interest or disinterest by the help of social and socioeconomic factors.

On the basis of the research we wanted either to confirm or contradict Adelfer´s ERG theory. We applied statistical counting methods: Chi-Square test, Wilcoxon test, Spearman´s and Pearson´s correlation coefficient.

The research was based on looking for answers to five essential questions, the main goal was divided into nine partial goals and we determined seven hypotheses.

Result

On the basis of the results of our research we unambiguously proved validity of the dual theory.

The results confirmed the two-factor theses in the part saying that exclusively the social factors are the source of interest in placement into a facility for senior citizens coming from the Romani ethnic group and exclusively socioeconomic factors are the source of not being interested in placement into the facility. We found out that substantial problems of current state of this difficult and responsible social work area is a socio-economic factor: segregation, gender, age, human rights, social involvement, integration and having information.

Disinterest is shown in the following socioeconomic factors only: social involvement, life style, integration and segregation, having information, work migration, mobility, discrimination, human rights, relations between the Romani and non-Romani citizens, success, participation, political representation, social recognition. As it was proved in the research part of our work, the interest in being placed in a facility for senior citizens is influenced by social factors,

which are dynamic, and disinterest in being placed in a facility for senior citizens is influenced by socioeconomic factors.

Two-factor theory and socioeconomic factors significantly contributed into knowing and understanding the nature of the Romani people´s the interest in being placed in a facility for senior citizens. Its main benefit, finding out a practical significance within the provision of social service, originates from emphasising the fact that the interest in placement in a facility for senior citizens is connected with social factors.

We confirmed this fact by means of our research results. Disinterest of a Romani ethnic group senior citizen originating from socioeconomic factors, which creates a very strong moment, is established in their attitudes, family environment, and conditions supporting them.

Expected output and benefit for everyday practical life is measuring and evaluation of the degree of interest along with partial factors of interest and also overall interest in being placed in a facility for senior citizens.

Through the research we emphasized that the interest in being placed in a facility for senior citizens, as part of overall life comfort of a Romani senior citizen, is significant not only from the view point of their individual experiencing the autumn of life, but undoubtedly it influences also their current mental condition, emotional state, self-confidence, or ability to resist stress and support active entering into difficult situations whereby it consequently influences the quality of life in a facility for senior citizens.

At the same time we came to the result concerning the factors which respondents consider to be most important and that creates an opportunity to implement the measures which would reduce or even remove their disinterest in being placed in a facility for senior citizens.

Conclusion

The results of the research: the most important factor supporting the interest is education and similarly the most important role in disinterest originating is played by education. The most powerful negatively diverging factor is segregation. The results of the research are useful either for employees in leading positions in state or public institutions, directors of facilities providing social services, and also for supervisors in various areas of their work as well as for the Romani ethnic group.

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Zákon č. 219/2014 Z. z. o sociálnej práci a podmienkach na výkon niektorých odborných činností v oblasti sociálnych vecí a rodiny.

Všeobecná deklarácia ľudských práv, Všeobecná deklarácia ľudských práv prijatá a vyhlásená rezolúciou Valného zhromaždenia OSN, 217 A (III) z 10. decembra l948, 5 s.

Listina základných práv a slobôd: Úplne znenie Ústavného zákona c. 23/1991 Zb. (znenie aktualizované k 7. 6. 2004), 15 s.
Národný program aktívneho starnutia 2014 – 2020, MPSVaR SR, 2014
Národné priority rozvoja sociálnych služieb na roky 2015 – 2020, MPSVaR SR
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The importance of compulsory screenening programe for congenital and acquired hearing loss applying toae

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Abstract

According to the Guidelines of Ministry of Health for Healthcare Professionals has been newborn hearing screening (NHS) in Slovak Republic compulsory since 2006. It is realized in neonatology departments applying examination of Transient Evoked Otoacoustic Emissions (TEOAE). The reason for such early diagnosis and proper correction of hearing loss is that it improves child´s psychomotor development, mainly speech development. Before the establishment of newborn hearing screening was hearing loss in children diagnosed later. The optimal schedule for the screening program is so called 1-3-6 rule, according to which a hearing impaired infants up to the age of 6 months wear hearing aid. Following WHO more than a half of the cases of individualizing hearing loss can be prevented by public health measures. Screening is effective if it

is universal. At present the Central Register of Hearing Loss does not receive screening results from all neonatology facilities. Therefore we do not know the numbers of examined newborns and complex hearing screening results. The legislative obligation of screening and further diagnostic procedure is inevitable in order to make the 1-3-6 rule working in clinical practice, since the consequences of late deafness diagnostics are underdevelopment of speech, lagged cognitive skills and mental development.

Key words: screening, TEOAE, deafness, newborn Aims and definition of the newborn screening

One of the key methods of secondary prevention in medicine is screening – an active search for hidden diseases. Newborn screening is an important preventive program covering whole area of population. Positive screening in the population of healthy newborns means suspicion for selected diseases, the ones that meet the criteria of WHO *(Chovancová, 2007)*. Basic principles for screening were formulated in 1968 by Mr. Wilson and Mr. Jungner *(Andremann, 2008*). Their aim was not only to detect the congenital disorder, but also to take measures, leading towards the improvement of its clinical manifestations, meaning early treatment. Diseases searched by screening are of high incidence in the population and the screening is aimed on its early, asymptomatic stage for which shall be accessible, reliable diagnostic test and existing effective treatment. At the same time is taken in consideration financial benefit coming from the difference in the costs spent on screening examination and the costs necessary for the detection of a disease in a newborn *(Lysinová, 2015).* Screening test detects individuals with a certain probability for the given disease. In part of these patients is the result falsely positive,

despite that they represent healthy group of newborns. In their cases is the disorder excluded by more exact diagnostic test with the higher sensitivity. Screening must not provide falsely negative results as these would mean undiagnosed ill individual *(Kerruish, 2005)*. The term screening program covers screening test, diagnostic test and provision of an early treatment for a patient *(Elliman, 2002)*. Newborns detected by screening program can have full quality life, or can have their life prolonged with improved quality; program helps to prevent permanent effects of diseases *(Lysinová, 2015).*

Newborn screenings in Slovakia currently covers screening of congenital metabolic diseases, screening of congenital cataracts, hip dysplasia screening, hearing screening applying TOAE along with recommended USG screening of obstructive uropathies. Further there exists selective screening, which is only realized on a part of newborns, with the increased probability for a certain disease, disorder or complication. This group includes brain ultrasound examination and the examination of eye background conducted by ophthalmologist in prematurely born children, or hypoglycemia screening in a newborn of diabetic mother, prematurely born children, hypotrophic or resuscitated newborns *(Chovancová, 2007).*

Organization of the whole area covering screening of congenital metabolic disorders is defined by Guidelines of Ministry of Health for Healthcare Professionals of Slovak Republic (GMH) no. 42 from 2012. Sampling of dry blood drop from heel is realized between 72^{nd} and 96^{th} hour of life of a newborn regardless of their maturity, food intake and health condition. The material is sent to the newborn screening centre in Banská Bystrica, where is the sampled blood examined for congenital hypothyroidism, cystic fibrosis, congenital adrenal

hyperplasia and since 2013 other ten inherited metabolic diseases *(Lysinová, 2015)*.

Second mentioned is screening of congenital cataract, realized following GMH journal from 2006. Congenital cataract significantly affects incidence of blindness in children. Early diagnosis is crucial, because the vizus of a child depends on the early surgical treatment. Surgery has to be conducted and sight has to be corrected within the first 6 to 8 weeks after birth. Screening is performed by provoking so called red reflex by lightening the eye using ophthalmoscope placed approximately 30 centimeters far from a child's eye, preferably conducted in a dark room. In case of unclear result, respectively, absence of the red reflex is the child examined by an ophthalmologist *(Chovancová, 2007)*.

The next mentioned is congenital dislocation and dysplasia of hip joints as the severe impairments of locomotor system with possible permanent effects. These are having high occurrence in our population. Screening of them is performed following GMH from 2000. For the condition are defined three degrees of screening. At the beginning is clinical examination of hip joints performed on the third to fifth day of life, so called Ortolani maneuver; followed by ultrasound examination up to the one month after birth. In case of resistant pathology is as the third degree performed orthopedic examination *(Chovancová, 2007)*.

Another disorder searched by screening is hearing loss. The importance of screening lays in the early detection and proper correction of congenital or acquired hearing loss which improves child´s psychomotor development, mainly speech development. The disorder is detected by hearing screening applying TEOAE examination, which is according to the GMH, realized before the discharge of a newborn from maternity hospital. A trained nurse examines a child using a special aid. Even a healthy child is not always detected as healthy, this

occurs when there is liquid in their inner ear or earwax in the auditory canal, respectively a child cries during the screening examination. In such case can TEOAE be refer and the examination is repeated and later followed by other tests conducted by the specialists, making sure that the exact diagnosis has to be established up to the 3rd month of child´s age. Because even in case of severe bilateral disorder is possible early treatment using hearing aid; in the indicated cases is performed cochlear implantation *(Chovancová, 2007)*.

The next mentioned were other recommended screening examinations of kidneys and uropoetic system sonoghraph. This focuses on the diagnosis of congenital developmental defects on kidneys or on other parts of excretory system, mainly obstructive uropathy, which, if not early detected can cause renal insufficiency. The examination is conducted on the third day after birth, due to the necessity of adequately hydrated child. Pathologic findings are further observed by child´s urologist and nephrologist; if the obstructive uropathy is of severe degree the newborn is immediately sent to a pediatric urologist *(Chovancová, 2007)*.

The last mentioned screening is not a routine in all newborns - ultrasound brain screening performed through large fontanel. It is recommended as an additional examination in newborns under 2 500 grams and strongly recommended in newborns with the birth weight under 1 500g, since one of the main causes of mortality and morbidity in prematurely born children are ischemic and hemorrhagic lesions in the brain. If the acute worsening of clinical condition, signaling intracranial bleeding, does not occur in the newborn, the USG examination is recommended between 4th to 7th day of life, further examinations in regular intervals. Prognostically is important the period corresponding with the planned birth date *(Chovancová, 2007)*.

Hearing loss in children

According to Slovak Health Organization is total deafness, after mental impairment, considered the second most severe impairment of an individual. It occurs in one out of thousand born children *(Šebová, 2018)*. Before the establishment of Universal Hearing Screening (UHS) was hearing loss in children diagnosed later, approximately at the age of year and a half, when a toddler starts walking and moves further from the source of sound – often speaking mother. Today are children with diagnosed hearing loss rehabilitated through hearing aids even before the development of speech – ideally at the age of half a year of life *(Hošnová, 2018)*. The development of sensory organs is completed postnatal. A newborn delivered in 30^{th} gestational week catches high tones in contrast to a full term newborn that catches spectrum of tones in the same range as an adult. A healthy child is born with functional inner ear and developed, but not sufficiently myelinated, auditory pathways and nerve. Their maturation takes place during the first year of life. For maturation of auditory cortex are important acoustic impulses from the outer environment. Spatial hearing is in a healthy child developing at the age of two years; gradually a child understands speech better even at the presence of disturbing noises. The speech development depends on development of hearing. Deaf children without auditory rehabilitation up to 7^{th} year of life remain mute. Therefore all the children born with the hearing loss require early intervention *(Šebová, 2018)*.

Hearing loss is in 60% of cases congenital, remaining 40% originate from the perinatal period or arise during the life *(Hownová, 2018)*. Congenital hearing loss is genetically determined, caused by damage on developing hearing system during embryonic development or it occurs due to unknown reasons *(Držata, 2015)*. The most sensitive

period for fetal hearing loss is approximately 20th day of pregnancy; etiological agens can be infectious agents such as rubella, measles, syphilis, CMV, ototoxic preparations or X-rays. The most frequent congenital defect of hearing development is otapostasis without the hearing loss, however, if the earlobes are underdeveloped or significantly malformed, then the otapostasis can be associated with atresis or stenosis of outer auditory canal. Other causes of hearing defects are determined by anomalies of inner ear – incompletely developed or absent inner ear cavity, deviations in auditory ossicles. Membranous labyrinth in the inner ear is affected in 80% of cases, changes on which can only be proven histologically. In one fifth of the cases is the malformation of osseous labyrinth proven radiologically using HRCT. Especially rare is impairment of auditory nerve. However individual anomalies may occur in mutual combination *(Hošnová, 2018)*.

Clinical division of hearing disorders is to non-syndromic, where the hearing loss is isolated and syndromic, where the condition is associated with other anomalies and the impairment is of greater extent. Within genetically determined hearing loss is the most frequent type of inheritance autosomally recessive type. Genetic defect is present in approximately half of the patients, autosomally recessive type in 75 – 80% of non-syndromic hearing loss. Prevailing mutation (50%) in this type of inheritance is mutation on the gene for connexin 26, which is a part of intracellular connection in membrane of hair cells. It is manifested by severe prelingual sensorineural hearing loss; patients are the candidates for cochlear implantation. Among the other defects belong EVA syndrome and Mondini dysplasia, which may also appear as syndromes. Roughly 20% of auditory defects are transmitted autosomal dominant, in this case is the loss

typically milder, postlingual, but progressive. A small percentage is binded on chromosome X or the mitochondrial inheritance, where the loss of hearing can occur after aminoglycoside antibiotic treatment *(Hošnová, 2018)*.

20 – 30% of hearing losses are syndromic. Transmission hearing loss is of secondary origin, it arises from craniofacial malformations associated with chronic secretory otitis or clefts, as in cases of Down, Turner or Pierr-Robin syndromes. Transmission hearing loss occurs primarily in case of hearing canal atresia or malformations of middle ear, examples are Goldenhar syndrome or osteogenesis imperfecta. In case of perceptual syndromic hearing loss is sometimes hearing loss recognized as a first symptom. Jervell and Lange – Nielsen syndrome is associated with prolonged QT interval in EKG and can be manifested suddenly as a collapse and exitus. Also severe is Usher syndrome, where are at the same time present sight and hearing impairments of various degree up to deafblindness. One of the most frequent syndromic sensomotoric hearing losses is Pendred syndrome, often related to Mondini or EVA malformations (*Držata, 2015)*.

Among the causes of perinatal hearing loss belong fetus immaturity, birth weight less than 1 500g, hypoxia and asphyxia. The hearing nerve can be impaired, i.e. retrocochlear impairment. In case of risky perinatal anamnesis is as a part of newborn screening, except to the TEOAE examination, also recommended screening of brainstem auditory evoked potential. In case of retrocochlear impairment are acoustic emissions pass, since cochlea hair cells are functioning and the diagnosis is not established early *(Zeleník, 2015)*.

After diagnosing the hearing loss is important to search its etiology; this serve anamnesis, objective and laboratory imaging and other examinations. When recording the anamnesis we ask questions about the course of pregnancy,

overcame infections and drugs. From perinatal anamnesis are important: term of delivery, birth weight, birth circumstances and neonatal jaundice. Since considerable number of hearing losses is congenital, family anamnesis cannot be omitted. If child´s siblings suffer hearing loss, but other relatives and parents hear normally, we suspect autosomally recessive type of inheritance. While dominant inheritance is suspected when more generations are affected. Postnatal hearing loss can be caused by sepsis, administration of ototoxic drugs, it can occur after mumps or cerebral membranes inflammation (meningitis). Each child, who overcame meningitis, has to have their hearing examined. If congenital infection is suspected, added are serology examinations for CMV, toxoplasmosis and syphilis. With suspected Alport syndrome are examined urine and kidneys; thyroid gland is affected in Pendred syndrome. In some cases can be helpful immunology examination, which may detect autoimmune impairment of inner ear. Examination performed by ophthalmologist is helpful in syndromes with concomitant sight impairment, e.g. Usher syndrome. In case of positive family anamnesis is added genetic examination. This is also justified in case of congenital hearing loss, when in a mother or in a newborn is not present any possible cause of the impairment. Examined is mutation of GBJ2 – connexin 26 - in children and parents, since inheritance can be recessive. Orthopedic examination can help with diagnosing Klippel – Feil syndrome, where is present anomaly of cervical spine. In case of syndromic disorders has its justification also cardiologic examination *(Jakubíková, 2008)*.

A child is after birth affected by other factors, which may lead to transmission and sensorineural hearing loss (of cerumen, acute and chronic inflammations). The most frequent causes of perceptual hearing losses in children are defects of inner ear originating from autoimmune processes and viral infections

(Držata, 2014). Severe disease with irreversible damage on inner ear is purulent labirinthitis as a consequence of meningitis, when the labyrinth ossifies; necessary is an early cochlear implantation *(Hošnová, 2018)*. Further may occur hearing loss caused by ototoxic substances like aminoglycosides or cisplatin; younger children treated by these are at the higher risk of hearing loss *(Hošnová, 2015)*.

Among the main negative consequences of hearing loss belong limited or totally impossible communication with hearing people. Moreover in these children is endangered speech development and inclusion in between peers. In case of unnoticed hearing loss can occur worsening of school grades. Therefore an early treatment and intervention are inevitable *(Hošnová, 2018)*.

Newborn hearing screening

Central Newborn Hearing Screening (CNHS) has been compulsory in Slovakia since 1th May 2006, by GMH number: 25940-7/2005-OZS – for early diagnosis of hearing loss in newborns and children. Already in 1955 was published Resolution about hearing loss prevention by World Health Organization (WHO). They recommended processing national programs focusing on regulation and definition of causes for preventable hearing loss for individual countries as well as programs for early detection of unknown impairments in newborns, children and adults. In 1998 was in Milan accepted European consensus about the newborn hearing screening. This document considers CNHS in maternity hospitals more effective than the usage of behavioral methods. It recommends training to the staff and the same time assessment of screening effectivity. The schedule considered as optimal is so called 1-3-6, rule, which is the key protocol for CNHS in the maternity hospitals; in case of positive screening result is hearing loss further diagnosed up to the age of 3 months and the hearing

rehabilitation starts up to half a year. In indicated cases is rehabilitation followed by cochlear implantation at the age of 12 – 24 months *(Šebová, 2018)*.

WHO resolution – Deafness and hearing loss prevention, accepted two years ago at the World Health Assembly declares, that the individualized hearing loss suffer 32 million children worldwide. It also presumes that in over half of the cases (60%), is possible to prevent the loss mainly by the public health measures, since the cause of one third of the losses are infections, some of which are preventable by vaccination – mumps, measles, rubella *(Šebová, 2018c).*

Recommended procedure for suspected hearing loss Selected newborn departments and ENT facilities in Slovakia started TEOAE examination in 1998. GMH from March 2006 provides that every newborn has to undergo hearing screening at the neonatology department by TEOAE test, before discharge from the hospital up to 3 days after birth. In risk children is examination realized up to 1 month of age; the results of the examinations have to be written down in their health documentation. TEOAE is performed by a trained nurse using screening aid for hearing testing *(Šebová, 2018c).*

Hearing loss suspicion occurs when a newborn´s TEOAE is refer. A neonatologist recommends a child to otoscopy and thympanometry, which are conducted by ENT physician. Repeated TEOAE examination is performed at the age of a month, in risk newborns a month later after the previous screening. If the result is corresponding to the first examination, a child is recommended to test brainstem auditory evoked potential. Patients with diagnosed impairment are entitled for the hearing aid. Deaf patients and children with severe bilateral hearing loss are recommended an examination in Bratislava in the centre for cochlear implantation. In spite of realized screening, General Practitioner for Children and

Adolescents (GPCHA) is obliged to monitor speech development and possible hearing loss subjectively.

Hearing loss may not be present at birth inevitably, no matter if it is acquired or congenital with later manifestations; example is congenital CMV infection or toxoplasmosis. In these, and other cases such as if children were treated by ototoxic preparates, overcame meningitis or sepsis, it is recommended to undergo objective hearing test *(Šebová, 2018c).*

If the hearing loss is confirmed, a child shall be reported to Children Otorhinolaryngology Clinic in Bratislava - the central register. Facility is reported patient´s personal data and auditory threshold. The data from central register are provided to Ministry of Health of Slovak Republic and the central European database for early diagnosis of hearing loss. However the instructions of GMH have not been fully performed in clinical practice by today and that causes organizational problems of various origins. First of all, in the Slovak area are for newborn screening used 2 types of aids, their various specificity can to some extent account for part of falsely positive results, therefore the data sent to the register are burdened with high error rate. With this is related the problem that facilities, whose role is to further diagnose hearing loss in children, can be partially overwhelmed by patients with falsely positive results. Another problem is that in near future, is terminating the contractual service for the aids, which are used for refer TEOAE, and for preservation of CNHS operation is necessary to buy new aids to all the facilities *(Šebová, 2018c*).

In 2015 was in Children Otorhinolaryngology Clinic of Comenius University Medical Faculty and National Institute for Childhood Diseases (NICHD) in Bratislava established the register of children with the hearing loss in order to collect data of the incidence of hearing loss in children. Its secondary function is further qualitative management of hearing

screening. Nowadays register gets screening reports from 2/3 of all Slovak newborn departments. In case of repeatedly refer TEOAE, the patient has to be send to one of the six selected ENT facilities (Table 2), for hearing diagnosis and therapy in children. Once the hearing loss is confirmed, the facilities are obliged to report individual cases to the register. Due to the rare reports from selected ENT facilities is worsen qualitative CNHS output; children with hearing loss are lost in the system and despite the diagnosed disease they are not provided adequate rehabilitation in time *(Šebová, 2018).*

Central register was established late, almost 9 years after accepting GMH for early diagnosis of hearing loss in newborns and children. Neither today do all the neonatology facilities send the screening results. Therefore we do not know the numbers of examined newborns and the complex CNHS results. This implies that in Slovakia does not exist whole area controlling qualitative management of newborn hearing screening. GMH from 2006 does not oblige facilities to report register with the numbers of all examined patients, only the children with hearing loss – without the obligation to include the solution for hearing loss. Therefore we do not know the relevant data about the incidence of deafness and hearing loss in children in Slovakia, so as a consequence the Ministry of Health and the European database cannot be reported required data. Recommended schedule for examination of children with hearing loss is not always followed in clinical practice due to the various reasons and as a consequence, children are not rehabilitated on time, or not rehabilitated at all. Here again the guidance does not deal with the obligation for phoniatrist to allocate hearing aid on time *(Šebová,2018c)*.

Currently (year 2018) is central register reported data about newborns examined under CNHS and about refer TEOAE by 32 out of 56 facilities in Slovakia. For year 2016 was register

reported 658 newborns, almost a half (47%) with bilateral refer TEOAE, 22% left, 24% isolated right and a part of reports stated incomplete data, which could not be followed. In 40% of children with suspected hearing loss based on the CNHS results was diagnosis excluded by further examination. Unilateral hearing loss was confirmed in 2% of children. Atresia and stenosis of external auditory canal were reported in 0,5% of patients. The course of examination was due to various reasons, not fully followed in over 50% of children. Here plays important role the social situation, which is sometimes the reason for not attending the examinations. Out of the system are children with syndromes including hearing loss, where hearing loss remains a side problem due to other more severe health problems associated with the syndrome. Sometimes are newborn´s parents with refer TEOAE recommended check up late, for example at the age of 12 months. Assessment of the results of central register for year 2017 has not been completed yet.

A newborn with pass TEOAE is observed by GPCHA. A child, with positive screening results, also in case of refer unilateral emissions, has to undergo further examination by ENT physician till the establishment of final diagnosis. Repeated TEOAE test should be performed within one month since the realization of newborn screening at the same facility. If the check up examination is all right, the child is further observed by a pediatrician. Repeatedly refer emissions are considered finding of hearing loss. In this case is a pediatrician obligated to report a child to the central register of hearing loss. Such patient has to be examined by regional ENT physician, who adds otoscopy, thympanometry and acoustic reflex test. Or a child is send directly to one of above mentioned facilities responsible for further diagnosis of hearing loss in children. If a child is first examined by the regional otorhinolaryngologist,

they still have to be send for screening examination in one of the six ENT facilities before the age of two months. Otorhinolaryngologist sends children to the selected facility for specific appointment. Risk newborns – premature, with hyperbilirubinemia, newborns after ototoxic antibiotic treatment, newborns with the higher genetic risk for hearing impairment – with refer TEOAE, have to be send straight to the centre in order to further diagnose hearing loss using more precise objective diagnostic methods – BERA, A-BERA, SSEP. If GPCHA has in care a child born in foreign maternity hospital that did not undergo CNHS, this also has to be send to screening examination immediately. If the parents deny CNHS a child is monitored by a pediatrician using behavioral methods *(Šebová, 2018c)*.

Out of the total number of liveborn children in Slovakia in one year is the focus of the newborn screening search 110 – 220 children. Ensure 100% attendance on screening is not possible – for example home births. We wish for attendance of 95% of live born children *(Šebová, 2018)*.

In the world was introduced experimental hearing loss screening in 80s of 20th century. Already in 1999 American Academy of Pediatrics (AAP) had identified the importance of hearing screening in newborns. If the screening is not realized covering the total area of population one third of the cases remains uncovered. That is why the goal is to make screening universal and therefore effective. Also helpful is legislative obligation of screening and further diagnostic procedure, to make 1-3-6 rule feasible in clinical practice. Since the consequence of late diagnosis of deafness is underdeveloped speech, lagged cognitive abilities and mental development *(Jakubíková, 2011)*.

The effective screening shall cover whole population, including all newborn departments; it shall also be instantly accessible.

Of the same importance is the system of results processing and data passing from lower facilities to the workplaces responsible for diagnosis and treatment of hearing loss in children and data collection in centre in order to control the whole system and sending the feedback to the newborn departments. Upper stated conditions are not currently met in Slovakia. Current situation can be improved by aids for TEOAE testing, which would directly send screening data to the hearing loss register. Costs necessary for purchasing the mentioned aids and finances for their operation would be recovered to the society in the form of early diagnosed children with following appropriate treatment and effective rehabilitation leading to the full private and professional lives of affected children *(Šebová, 2018)*.The effect of CNHS on early diagnosis of hearing loss in Slovakia

The screening is universal if hearing screening is defined by country´s legislation and if it is undergone by 95% of newborns *(Aurelio, 2010)*. Generally accepted methods for hearing screening in newborns are otoacoustic emissions and examination of brainstem evoked potential *(Choo, 2010)*. Hearing loss is present at birth in over 80% of affected children. One child per thousand liveborns is born deaf and in other three newborns is present uni or bilateral hearing loss. In case of bilateral impairment should a child start using hearing aid by the age of six months, since in deaf child without the correction of hearing defect will not develop speech and they will lag in psychomotor development *(Jakubíková, 2011)*.

In 1998 Slovakia started with hearing screening in newborns in chosen ENT facilities in cooperation with neonatology departments; since 2005 the screening has been realized in large neonatology departments – undergone by 42% of newborns. Since 1th May 2006 has existed legislation giving obligation of screening to all newborns; in that year were

examined 66% of newborns, a year later 94,9% of newborns *(Jakubíková, 2009)*.

Before the onset of whole area covering hearing screening was in Slovakia diagnosed bilateral perceptual hearing loss in 0,588 per 1 000 newborns. In 2008, as shows Table 1, the number of detected losses risen to 1,168 per 1 000 newborns. After CNHS establishment was the number of detected hearing losses in newborns increased by 50%, simultaneously was decreased the average age of diagnosing from 12 months to the half of a year. The incidence of bilateral hearing loss in children born in 2008 is comparable with the data from other countries. Except for the universal hearing screening in newborns applying TEOAE are for the early diagnosis of hearing loss in infants of the same importance other objective diagnostic audiologic examinations *(Jakubíková, 2011)*.

Possibilities for hearing examination in newborns and children

Pedaudiology is a science focusing on the examination of hearing impairments in children population. Prelingual and paralingual deafness include hearing defects formed before development and fixation of speech. These, as we have already mentioned, cause impairments in development of speech and cognitive abilities in children *(Držata, 2015)*. In clinical practice of suspected hearing loss had most of them been formed in newborns with repeatedly refer TEOAE, the examination which they had undergone first time as a part of CNHS in neonatology department. The other group of children is those, who were suspected by first contact pediatrician, parents or teachers as a consequence of the inadequate speech development or reactions for the auditory stimuli *(Šebová, 2018b).*

The pedaudiologic examination is most often performed through interviewing parents and search for various information like the result of newborn hearing screening,

course of pregnancy, the afterbirth period and information about overcame diseases – meningitis, rubella, CMV infection, listeriosis or toxoplasmosis along with the questions about the ototoxic preparation treatment.

An important element is further information about the family and social anamnesis – hearing loss and associated syndromes in parents, siblings and other relatives, social situation and the integration of a child. In patients where child´s age allows interview, are these asked questions aiming at the observation of hearing and speech development, followed by ENT examination, important part of which is otoscopy and aspexy of outer ear, searching for anatomic anomalies in shape or size. For valid TEOAE examination is necessary the accurate auditory canal patency. In young and non-cooperating children are used objective methods for testing of their hearing *(Šebová, 2018b).*

OAE is one of the objective examination methods. It is used for determination of functionality of outer hair cells of the inner ear. The examination does not detect central and retrocochlear causes of deafness. During the course of examination a child must be unsleeping, but calm, since crying or restless patient can affect its result. For pass of emissions is necessary the correct function of cochlea, middle ear and auditory canal – presence of an obstacle. At the end of the examination the aid evaluates hearing function, using the term PASS, in case of recall TEOAE, or in contrary, REFER if indicating possible hearing loss. The risk newborns are advised to add examination of hearing evoked potential, since in certain less frequent causes of hearing loss can occur pass TEOAE. TEOAE can measure threshold of hearing up to 30 decibels, special distortion OAE is used for measuring of hearing loss up to 50 decibels *(Šebová, 2018b)*.

Thympanometry, measuring the acoustic resistance or so called ear transmission impedance, serves for identification of the proportion of transmission impairment in the total hearing loss. The result is a thympanogram, showing three types of curves – A, B, C. Crucial condition for thympanometry is free hearing canal with a sufficient width. In infants aged up to six months is due to their narrow outer hearing canals risk of false results – B curves, highfrequency tympanometry is used. Using thympanometry can be diagnosed liquid content in the middle ear, negative pressure, perforated eardrum and it helps assessing the functionality of Eustachian tube. Other method is provoking reflex musculus stapedius, being a congenital, involuntary and bilateral reflex, serving for the protection of inner ear against excessive noise. The reflex is recall if the auditory pathways and facial nerve are functioning. To make reflex working is inevitable airy middle ear cavity, supple and intact eardrum and free auditory canal *(Šebová, 2018b)*. Tympanometry is used for exclusion of severe perceptive hearing loss.

So called AABR examination, or in other words screening hearing stem potential, is an additional examination to otoacoustic emissions, or a method of choice in risk newborns. AABR verifies the functionality of auditory pathway and retrocochlear part of inner ear, it also allows establishment of auditory threshold. The examination is performed at rest, preferably at sleeping, because motor unrest may record falsely positive results. The objective threshold audiometry aims at establishment of patient´s auditory threshold. Among the used methods belong stem evoked hearing potentials BERA and steady state evoked potentials ASSR. The methods are further divided in frequency specific and non specific; according to the possibility to determine auditory threshold for the individual frequencies. BERA produces curve with 5 – 7 waves, each of

them representing certain anatomic structure, which needs to be considered for the assessment of record. In ASSR, the instrument itself identifies the probable hearing threshold by analyzing the EEG signal. This general examination method does not allow examination of hearing neuropathy *(Šebová, 2018b).*

Among other hearing examination methods in children belong subjective methods; the extent of their application depends on the age of a patient and the question examined. The examiner has to be capable of motivating a child to cooperate and at the same time, judge to what extent they can bother the patient with the test. The result of the examination has to be interpreted individually, there also have to be recognized various answers as recognition of auditory impulse – for example grimaces, and accelerated breathing. These methods are burden for a patient and often need to be repeated. In newborns and infants during the first months of their lives is used reflex and reactive audiometry. Patients are examined conscious, but motorically calm. We can record the quick movement of an eyelash – acousticpalpebral reflex or a grimace, or when using the impulse with high intensity also Moor reflex. This examination method can be used from the age of three months up to half a year, when the reflexes disappear. In neonatal period is not possible to differentiate healthy and a deaf child without particular examinations because even when newborn´s hearing is all right, they are not aware of acoustic impulses. Up to the end of newborn period are in a child without hearing defect observed responses to the acoustic impulses. Later an infant imitates surrounding sounds and at around the age of 12 months says first words. If the speech development is not adequate we can pronounce suspicion to the potential hearing defect. This is usually pronounced by a parent or first contact pediatrician.

That is why it is important to observe child´s responses to acoustic impulses during the hearing test.

The other subjective method is a visually supported audiometry. This is used mainly in infants and toddlers within the age from 6 to 24 months. This examination combines acoustic and visual stimulation. A child sits alone or with the mother by the audiometric table. The speakers are placed at the distance of approximately one meter far from them; speakers play sounds alternately from different places and with various intensity. If the patient responds to the impulse, they are rewarded by visual stimulation – e. g. short movie, dance, toys. An erudite nurse can distinguish, which reactions are the answers to the auditory impulse, forming the threshold curve. Based on the infusion of these two types of impulses is formed conditioned reflex. In little older children can be used audiometry by game, which requires patient´s concentration and some practicing. A child responds to the acoustic impulses by an action – e. g. places the toy in the basket. The examination sometimes has to be repeated. Part of preventive medical examinations performed by a pediatrician is orientational hearing test of a child in the form corresponding to their age. Within the first months of life are tested conditioned reflexes, for example through squeaking toys. Later, since seventh month of life is checked directional searching reaction. In toddlers is possible to use age corresponding verbal test – repeat the words, answer the command. At the age over three years is used classic verbal test, assessing the adequacy of speech development corresponding to child´s age. A pediatrician has to be familiar with hearing screening programs – CNHS as well as hearing screening in children at pre-school and school age *(Šebová, 2018b).*

Nowadays exist various possibilities for compensation of hearing defects in the children. Therefore it is of crucial importance to assess a patient individually and choose the correct procedure. Management of hearing impaired child is in the hands of interdisciplinary team, which members are – a neonatologist, a local pediatrician, an otorhinolaryngologist, a phoniatrist, a neurosurgeon, a surdopedy specialist, a clinical speech therapist and a special pedagogue, a psychologist and others. A child with hearing impairment needs to be detected on time, and for their diagnosing has to follow the 1-3-6 rule along with the observation of their speech development especially in children during the toddler period *(Strutz, 2017)*.

Conclusion

Already in 1999 AAP identified the justification of newborn hearing screening. However, the consequence of not covering the whole population means approximately one third of the cases left undiagnosed. Therefore in order to make the screening effective must be ensured its universality – legislatively given with the coverage of 95% examined newborns. After the establishment of CNHS was the number of identified hearing losses in newborns increased by 50% along with the decrease of average age of diagnosis from 1 year to 6 months. Central register of hearing loss was established 9 years after the acceptance of GMH for early diagnosis of hearing loss in newborns and children. Not even today do all neonatology facilities send their screening results. Therefore we do not know the numbers of examined newborns and complete CNHS results. This implies that in Slovakia we do not have whole population controlling qualitative management of newborn hearing screening. Guidance of Ministry of Health from 2006 does not oblige facilities to report the register with the numbers of all examined patients, only the children with hearing loss. That is why we do not know the relevant data about the

incidence of deafness and hearing defects in Slovak children and the results cannot be further send to the Ministry of Health and to European database. Slovakia today, needs national standard for diagnostics and treatment procedure, which would specifically define algorithm and treating procedure of hearing loss in newborns and children, by which the 1-3-6 rule would be feasible in clinical practice. In spite of the whole population covering hearing screening, the hearing loss is not diagnosed early in part of patients or, due to various reasons some children remain with incomplete examination. While thanks to the early detection and correct rehabilitation of hearing is possible full personal and working life of hearing impaired person. In contrary as a result of late diagnostics of deafness is underdevelopment of speech, lagging of cognitive abilities and mental development of an individual associated with the dependence on the state social system.

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Social Services and Counselling – Innovation in Education in the Field of Social Work

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Abstract
The purpose of the contribution is to point to the creation of a new study programme within the field of Social Work. We draw attention to current social issues. Further, the need to concentrate the attention on the whole spectrum of social services. At the same time, we will point out the importance of counselling in solving social problems of clients. The aim of the paper is to introduce some key content frameworks of the study programme, to outline the profile and application of graduates of the social services study programme and counselling in practice.

Key words
Counselling. Graduate profile. Social services. Study programme.

Introduction
The study field social work is in higher education established as a social science discipline since 1990. Over this period, it has undergone its development. The content of education in the field has being created, which was oriented to the universal forms of education. Currently, in identifying the whole spectrum of social problems is a reason to consider the need for a closer focus with respect to the needs of society and the social clients. The reason of the inevitable reasoning about this change are also links to the social practice and the challenges for the professional preparation of social workers

centred by the area of closer focus in the study field of social work. Such a challenge is also the education for the social services and counselling. The provision of social services has its own specific features depending on the target groups of clients and the difficulty of providing effective counselling on a variety of social issues.

Social services as part of the higher education

In every advanced society is a part of the social policy of the state also the provision of social services to those who are in a particular area and to a certain extent depend for help by other people in everyday lifes. The practical provision of social services can be understood as a professional activity that enables individuals or groups to eliminate personal or group social problems. Similarly, as the other components of social policy, social services have also gone through their development, depending on how the society was being developed. We could say that the social services represent a special set of activities concentrated on satisfying of individual or collective needs of the citizens.

The aim of a particular social service is the security and protection of a certain level of quality of life of beneficiaries of social services, which is expressed in the official social policy of the state. In our environment social services are provided according the Legal Act No. 448/2008 on Social Services, which defines tho social service as a professional activity handler activity or the next activity or set of these activities, which are focused on:

a) the prevention of formation of unfavourable social situation, solution of unfavourable social situation or mitigation of unfavourable social situation of a natural person, family, group or community,

b) preservation, restoration or development of the abilities of the natural person to lead a self-dependent life and to support its integration into the society

c) ensuring the inevitable conditions to meet the basic needs of the natural person;

d) resolution of the crisis social situation of the natural person and family;

e) prevention of the social exclusion of the natural person and family.

Social services according this Legal Act are provided by public and non-public social service providers. A corporate body established by a municipality constituted by a higher territorial unit shall be considered a public provider. A non-public provider is a legal or natural person providing social services under the Social Services Act, which is registered.

From the point of view of providing a social service for citizens who are dependent on a social service, to define the obligation to provide a social service is an important asset. This obligation is imposed on the municipality or higher territorial unit according to the type of social service required. The relevant municipality or higher territorial unit shall provide social service within its scope or in its facility, if it has available capacities.

It follows a relatively demanding procedure related to the provision of social services in terms of their establishment. We could say that in this case the preparation of graduates of the social service and counselling study program in the field of social work could be beneficial. Graduates of this program could have included topics such as public administration, social administration and knowledge of the functioning of self-governing units, municipalities and towns.

This is also related to the assumption of increasing the authority of the founders of social services entities from the

point of view of decentralization of social assistance according the Legal Act no. 416/2001 Coll. on the transfer of certain powers from state administration bodies to municipalities and higher territorial units. In accordance with this Act, the transfer of competences was transferred to the founding powers of municipalities and higher territorial units by the state.

On the other hand, the Social Services Act also introduces a new philosophy of providing social services, which consists mainly of:

• guaranteeing the provision of social services by municipalities, higher territorial units or non-public social service providers,
• greater variability of social services,
• client activation through an individual development plan
• new types of social services and professional activities;
• community planning;
• in improving the quality and expertise in the provision of social services;
• supervising the provision of social services;
• increasing the objectivity of assessing a citizen's reliance on social services.
• guaranteeing a financial contribution to a non-public social service provider if it provides the service at the request of a municipality or a higher territorial unit.

This trend increases the need for qualified training of professionals in order to graduate their professional competence in the context of higher education. At the same time, these plans create conditions for improving the quality of social services provided. According to Brichtová (2014), who continuously occupies with the quality standard of social service provision, the standardization of quality has gone through three stages of development. The first stage is

referred to as the rational - conservative stage. The quality of social services provided in this period is understood as one of many functions of the organization and is intended for professionals. This is mostly about the quality of the product or service, but not the quality of the process it achieves. The second stage is called the integral stage. During this period, quality becomes a standalone feature that is integrated into all other device features. In practice, each area of social services provided produces quality, its content may still be unclear and fragmented. The third stage is the pragmatic stage for the development of social service quality standards. Quality becomes a category that is superior to all other functions of the institution. All employees of the institution are guided to achieve quality, and the quality of the product is actually the result of the quality of each individual's work, the quality of the process and hence the quality of the organization or institution itself.

To define the model for introducing the quality of services provided, we could define three stages, defined according to the concept from which the quality was approached in individual periods. In the first period, also called the intiutively - informalized stage (1988 - 2008), quality was approached intuitively, without a specific name, based on its perception as a natural intrinsic quality of service. Thus, the quality was promoted towards the recipients of social services, by providing them themselves, without a binding system of evaluating clients' satisfaction with the services provided.

The second stage is called the framework conditions formulation stage (2009-2013). Since 2009 effectiveness of Act no. 448/2008 Coll. on social services has become part of the legal system in Slovakia assessment of quality conditions

of social services provided. For the first time, the concept of quality was legalized in social services.

The framework conditions should have contributed in two ways to assessing the quality of social services:

a) by standardizing the functional aspect of social services; i.e. by identifying what government policy considers important in terms of quality;

b) by program standardization; i.e. by evaluation of quality by the relevant public authority, which is the Ministry of Labor, Social Affairs and Family of the SR.

The third stage is called the standardization stage (since 2014). At this stage, the adoption of the other amendment to the Social Services Act created the legislative prerequisites for defining quality in social services as a standard whereby the achieved results are compared with the expected results set as a standard. In the practice of social service facilities this meant the formulation of standards for individual quality conditions, their subsequent projection into a set of indicators, thus creating the basis for measurability of social service quality conditions.

The area of providing social services quality is conditioned by good managerial abilities that are related to the content of provided social services, their process and staff. In our opinion, managerial skills must be linked to the nature of the institution, its mission, the content of its activities and the specifics of every social service subject. Therefore, we consider it important that a good manager has not only managerial skills but also professional potential within the provided social services. In this case, we confirm again the relevance of the training of future professionals at the second stage of higher education not only in the field of social services but also in the management of their direction.

We see another professional framework in the provision of social services in the humanization itself of the provision of social services in social services facilities, which directly affects the quality of life of clients. Nowadays, there is no generally accepted definition for thr quality of life, and equivalent or related terms such as sustainability, human happiness, standard of living and others are often used for this term. A comprehensive view of the issue should be based primarily on the study of human interaction on the environment and vice versa. This human-environment interaction seems to be crucial in terms of quality of life creation. Similarly, according to Mühlpachr (2002), the quality of life is very subjective and individual - representing different things for different people and at different times. Even in the context of the provision of social services, the author points out that the individual pace of aging leads to greater differentiation of the quality of life, especially in the post-productive age. In addition to age, health, physical and mental performance, other factors such as gender, family situation, standard of living, educational level, acquired socio-professional status, etc. are reflected in the quality of life assessment. In this respect, we could rely on WHO quality of life indicators as follows:

1. Physical health - energy and fatigue, pain and discomfort, sleep and development depend on it.
2. Mental health - expresses image, negative and positive feelings, self-esteem, way of thinking, learning, attention (concentration).
3. Level of independence: movement, daily activities, work capacity, drug dependence.
4. Social relations - personal relationships, social support and support, sexual activity.

5. Environment - access to financial resources, freedom, security, healthy environment and social care, home, access to information, participation in recreation, travel, physical environment.
6. Spirituality - personal belief and belief, value orientation.

Fulfilling or ensuring the subjective satisfaction of clients within individual quality of life indicators requires professionals not only an adequate social service but also a good orientation in the provided social services, the ability to provide advice and communicate effectively in order to motivate clients to participate in fulfilling their quality of life.

Counselling as part of university education in the social services and counselling curriculum

The department of work, social affairs and family has an important place in assessing the social problems of the population. This department provides counselling services through some institutions which, through their counselling activities, contribute to a positive change of people who are in material or social need, in collisional situations of life, while they are not able to ensure the change of the state by themselves. In addition to the resort itself, non-profit organizations and municipalities are also involved in solving clients' social problems. In this context, we think that the university preparation of advisers for dealing with clients 'social problems should be concentrated mainly in addressing the social contexts of the clients' problems. E.g. if the family is falling apart due to the unfavorable socio-economic situation, the counselor should address in particular the areas of material need, unemployment, indebtedness, family budget, debt repayment, childcare, housing and the provision of basic family life needs. After the divorce of the parents, of course, entrusting the child to the care of one of the parents, or alternatively counselling in the field of alternating care. The

counselor should not focus on the personality frameworks of individual family members and the resolution of family conflicts, which should be the domain of psychologists. Resolving these adverse situations requires the advisor to have sufficient counselling skills to deal with some situations when working with an aggressive, non-cooperating, resigned, manipulative, etc. client. It is paid just a little attention to these areas of counselling in university education in the field of social work. In social counselling, social counselors play an important role in minimizing disproportionate expectations of the client, offering them active participation in solving the problem, while the social counselor should support, inform, educate, create the conditions for change, it should help the client to see the different possibilities and alternatives of constructive change.

The basic precondition of the social counsellor's approach to the client is to respect the authenticity of the client, accepting their differences, empathizing with their current situation, motivating and encouraging the client to change, common searching for optimal patterns of behaviour and functioning in the world.

Schavel (2016) alerts that counsellor is interested in detail in the relationships that are applied in the client's environment, which influence them, influence their behavior and actions. He considers all possibilities that could and also caused a collision, social event, state of emergency, whether material or social. counsellor- client cooperation can be of a long-term character. The consultant tries to motivate the client to actively cooperate and participate in solving the problem. These assumptions also significantly affect the differentiated approach to solving social problems of clients.

In the context of the study program social services and counselling, it would be possible to identify current

counselling problems and at the same time to profile students of this field for their competent solution. It is true that the basic orientation in the problems of social clients is also mediated by students of the social work department, which is more of an orientation, often superficial information about counselling, counselling skills rather than prerequisites for providing effective counselling. There are departments of social work in Slovakia that do not include the subject of social counselling, counselling process or training in counselling skills. This deficit is absurd mainly because we consider counselling to be the most frequently used method of social work.

The issues that could be included in the content of counselling can be:

• problems in social relations,
• deficits in social skills,
• problems in relation to social institutions and other organizations,
• problems in performing social roles (role of parent, partner) , employee, citizen, etc.),
• problems with dealing with social change (loss of family, employment, health problems),
• social insufficiency (missing home, lack of money, etc.)
• social adaptation problems
• social problems (unemployment, socio-economic problems, health problems, severe disability)
• problems in the area of socio-pathological phenomena

If we should name the specifics of social counselling, then among the most basic, i.e. those that significantly differentiate social counselling from other types of counselling could include:

• target group of clients and their range of social problems,

• the client himself with his peculiarities, character traits, mental level and degree of socialization,
• environment, external conditions in which social counselling is provided,
• character of the institution, which creates the framework to provide social services (state administration bodies, self-governments, public institutions and civic associations within the third sector, but also private-law advisory bodies),
• knowledge, skills, but also the personal framework of the social counsellor.

We consider social counselling as a tool of social assistance, which on the one hand allows clients to participate in decision-making and on the other hand obliges the social advisor to act appropriately and taking into account the specific problem and autonomy of the client. These parts of the counsellors' professional competences can only be adequately secured as part of the rigorous training of future professionals - counsellors.

If we wanted to come out of a description of the branch of study of social services and counselling, we could look for inspirations for a study program of a similar name, and we could generally state that a graduate of bachelor's degree commands the basics of the theory and practice of social services and counselling, has knowledge of state administration tasks , self-governing bodies, non-state entities and non-profit organizations in the field of social policy and is ready to perform:

• social-consulting activities,
• first contact social-legal counselling,
• social prevention,
• crisis intervention,
• negotiating and representing clients in tangible and social need

• establishing, coordinating and organizing various social services;
• organizing leisure activities and active therapies.

We consider important the orientation in the system of functioning of social services at the level of self-government of higher territorial municipalities. Kuzyšin - Legdan (2014) consider it important to use art therapy with the prerequisite to provide students at the bachelor's level with an amount of knowledge about projective techniques used in activity therapies. This assumption is also related to the equipment of educational entities for individual educational activities, such as art therapy, music therapy, drama therapy, etc. This deficit in terms of activation of clients in residential care is also important in terms of leisure activities, but also in the diagnosis of the whole spectrum of social problems of clients (Kuzyšin, 2014). In the content of the study it would be necessary to pay attention to socio-legal counselling (similarly as in the Czech Republic) and in this case it would be more about providing basic counselling on the level of information and distribution of clients. The graduate of the master's degree should know theoretical concepts of social services and methods of social counselling intervention. They have managerial skills in the field of social services, they control the parts related to the skills in ensuring the counselling process when working with the client. They know methods of social services management and are able to:

- design and implement a solution to the whole spectrum of social problems, social collisions and adverse social events of clients, cooperate with involved subjects of state administration and self-government,
- perform basic and specialized social counselling depending on the client's social problems, • solve problems of minority ethnic and social groups

- solve problems of family life in the area of social and legal protection of children and social guardianship,
- provide and carry out counselling in the field of socio-pathological phenomena (delinquency, various types of addiction, domestic violence, prostitution, etc.); socio-economical problems related with financial literacy and economic instability, budget management and debt,
- plan and organize social services and counselling activities;
- plan and organize activities in the field of social services and counselling
- be competent to manage social services entities,
- participates in the conceptual plans of effective social services,
- be knowledgeable in the field of social services marketing,
- in the context of counselling, control the counselling process in its individual phases.;

A bachelor's degree graduate in the Social Services and Counselling program could work effectively as a social work assistant in social service entities and facilities, social and legal guardianship of children, institution for elderly citizens, education and re-education facilities, asylum-type institutions, non-profit and non-governmental institutions.

Graduates of the study program Social Services and Counselling in the master's degree are able to work as a social worker in state and public administration, as well as an independent specialized social counselor in social, family counselling, counselling in the process of re-socialization, etc. Furthermore, as a social worker in social services facilities, social and legal protection of children and social guardians, in institutions for seniors, educational and re-education facilities,

asylum-type institutions, non-profit and non-governmental organizations

Conclusion

Demographic indicators and the social policy of the state create inevitable prerequisites for creating and developing the whole spectrum of social services. This phenomenon raises the need for qualified work of social subjects managers, but also of professional employees as implementers of various activities when working with clients. It is necessary to continuously increase the professional competence of employees in social services at the level of their advisory activities, as well as leisure activities and elements of social rehabilitation. Social Service and Counselling study program within the Social Work Department could sufficiently fulfill these prerequisites. It is also necessary to realize the necessity of profiling graduates of social work for individual areas of their professional activities. Social Service and Counselling curriculum could meet this need for such educational segments. Although the paper is not based on empirical findings, it points to some perspectives and the need for innovation in the education of social workers. Rather, it is an incentive to the conceptual intention of effective education that corresponds to the needs of social practice.

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Social-ethical illness of present society

Jozef Kutarňa

Abstract

In the article, the writer's focus is on the pride of man, which is at the beginning of all wrong doing and it has become a social-ethical illness. If a person does not see or does not want to see deformities resulting from a cult of his ego, it changes him into a person who is a serious danger in politics, economy, and social institutions. An absence of humility in society is causing different levels of social problems. The actions of politicians, who should guarantee common good, are today characterized by a maximalist search for self-interest. Sense for justice is being lost, with a rising crisis on different levels. Justice and righteousness seem to be unknown terms. Humility is the key element in man's advance. The key step towards a real humility is intellectual humility.

Dear audience, allow me to present my own personal view on the revived phenomenon, which has adverse impact on a personal life and public life, as well. We live in an individualistic western society, in which among the most appreciated values are subjective rights, autonomy, self-realization, and professional success. Unfortunately, many representatives and leaders, on various levels, do not see, or do not want to see thedeformities resulting from a cult of ego, which deforms life of people of our time. „Tolerant leniency, cult of individualism, and respect for principle that everybody can do whatever he wants, undermine established structures of society.“[1]

[1] HEYWOOD, A.: *Politické ideologie*, Aleš Čeněk, Plzeň 2008, s.111.

Not long time ago, I read in anewspaper that politics without humility leads to hell.The author emphasized that „Humilityitself does not make aman good politician, however absence of humility certainly makes a man bad politician. “[2]Humility is very oftenconnected to Christianity;however, it does not belong to church only.I'm persuaded that identical rules apply to the area of social work, and the whole society as well. Lack of humility may result in unjustified high valuation of yourself, which is the first step leading to pride, overvaluation of yourself, and loss of authentical humanity.

Daily events are leading us to thoughts about the pride of man, which is at beginning of all wrongdoing, and today it becomesa social-ethical illness, which causes damage and is serious danger in politics, economy, and social institutions.

Pride is rooted inside of man, who seeks for and asserts himself and his views without their human or scientific substantiation.

He regards his own views as exceptional, and irrespective of others he enforces them as his own ego to „yield“ or benefit himself only.Regrettably, proud people put into center of attention just themselves and with no intention for primary welfare and benefit for others. Even if pride has varied forms, it always focuses on superiority of himself, or prioritization of himself before others in thoughts, propositions, and resolutions.

[2] ONDRÁŠEK , Ľ.M.:*Politika bez pokory vedie do pekla*, *Denník N,* 20. februára 2019.

Demonstration of pride in various surroundings

Such situation is visible in many surroundings: in daily life, starting with family, where husband or wife, son or daughter, brother or sister want their views and resolutions to be dominantly put through. Sometimes in such degree, that they cause distress to relatives, or close relatives.

Also, school is place where pride is visible already among pupils. It is not a simple problem for „proud individuals“ only. In the past, smart pupils were strikingly modest and schoolmates respectfully „acknowledged“ theknowledge and ability of the pupil. Today? Those smarts are conceited and those others are doing all possible to somehowlower their ability or knowledge. The best one„terrorizes“ hissurrounding with his views and showy exceptionality, and the rest reciprocates with wrath, envy, and arrogance. Loosely said – such classroom is literally hell, where is always somebody who thinks that he is better than the rest, and with his views and arrogance terrorizes others. At the same time, it’s not the matter of competition, but possibly only a dominant self-assertion in the group.In this case empathy becomes an important preventive element. This understanding of empathy leads the pupil to concentrate on what he actually experiences.[3]If this is not the case, then in work groups we are witnessing conceited behaviorof those who are ambitious for personal success. Not rarely, they would like to profit to the detriment of their colleagues, sometimes also without

[3]FULKOVÁ, E. – REIMER, T.: *Netradičný prístup k vyučovaciemu procesu*. In: *ACTA facultatistheologicaeUniversitatisComenianaeBratislaviensis.* XV, 1/2018, s. 35.

accreditation of colleagues' work, and the worst is that with the use of fraud and untruth.

The actions of politicians, who should guarantee common good, are today characterized by an elaborate search for self-interest, and at the same time they openly show opposition to all who are not members of „their locally dominant party." Unfortunately, other people who do not belong among the „privileged" play a small part only. Only rarely, they come out from the crowd and point at the overfulfilled limits and bohemianism from hoarded pride. Such environment is place, incubator of deceptions. To the detriment of society, winning is lie, manipulation and falsification,because pride warrants those less able to occupy leading positions and by all means to create space for their own ego, which is based on ambitions, graspingness, and mainly deception.

These realities, as described, are basis of beginning of social problems, formation of opposition, bringing to light misrepresentation and trample of rights of citizens. Simultaneously with that,the carefulness for common good is neglected.Sense for justice is being lost; with anescalating crisis on different levels, justice and righteousness seem to be unknown terms. It is not to be wondered that with such state of democracy all those lately rich have no respect for courageous work. Weare getting to the „higher phase" in which those lately rich negate also human dignity of those who connect their existence with principles of liberty, democracy, culture, and solidarity.

I am convinced that it is possible to change the present situation with our permanent humility, truth, fairness, and persistence as well. We recognize the misery of poor man, however,as well as the cruel misery of rich man.

Intellectual humility

For life and for work we need **intellectual humility** which does not tolerate rudedistorted truth. Humility is not an abstract ethical call. It is the most basic skill for life in the world today, which we live so fast that we can easilyget intouncertainty, situations which we've never expected. Instantly, all our certainties can be destroyed. Without real humility it will be very difficult to „rise" again.

The truth is that sooner or later everybody will be dealing with hard reality of life and will face decision: learn from yourown mistakes and grow, or stay unconscious (withinyour own pride) and rely on yourself. Initially, it seems to be obvious, but common sense it telling that it is necessary to begin again, even if from a „high-level" position, even if it will be very challenging. But that's the privileged moment when we can find our own inner voice, clarify our own values and expand inside authentic and genuine way of life.Just such moments in our life can lead us to humiliation, which is transforming us; these are the moments which initiate positive changes which lead to a person becoming more authentical, truthful, and finally more capable.

In situations where man is humiliated, he is becominga humble person. And humility is the key part of man's growth. Suffering may bevery effective teacher. Almost all biographies of great leaders include at least one failure, which at the end made them stronger, more aware of others' needs. Steve Jobs – the co-founder, chief executive and chairman of Apple Computer, after he was laidoff from the company he co-founded, said „I didn't see it then, but it turned out that getting fired from Apple was the best thing that could have ever happened to me."

All that has its value only if we are adequately humbled, to be able to comprehend and learn from experience. Intellectual humility is the key step towards a real humility. In recent years, Google requires intellectualhumility as one of the five basic characteristics for new hires. „Without humility" a top manager said „you cannot learn anything. "

In recent studies about attributes of successful leaders in the digital age, humility is revealed as the key factor. Not only as generic personal characteristic, but more specifically, it was named as „humility through learning," respectivelyas intellectual humility. This has great meaning in this constantly changing world, where it is not easily possible for a leader to know all information and all answers. To be opened to new ideas requires active listening to others, gatheringinformationextensively and not allow that any prejudices are restricting our thoughts. Recent psychological studies revealed that „intellectually modest people" are more willing to accept their own mistakes, are more opened to new evidence, by which wrong opinionsare removed[4].

Intellectual humility means to realize that we do not know everything – and that what we know is not for our own benefit only. Quite contrary, we accept that we are influenced by our convictions and we should search for new information which we are missing.Intellectual humility is characterized by our pledge to search for answers and willingly accept new ideas. Otherwise, it is a mental arrogance only – double wrath of excessive self-confidence. Such arrogance always arises from egocentric partiality, tendency to overestimate own abilities or importance,and to ignore an influence of others on our life.

[4]DEFFLER, LEARY, HOYLE:*The Psychology of Intellectual Humility, In: Journal of Personality and Individual Difference*, 2016, vol 9).

Thinking of yourself less

Clev Staples **Lewis** (*„klajvstejplslujs“)* – Irish writer, poet, scholar, literary critic, distinguishedChristianapologist, and one of the most famous authors of fantasy (genre covering social and political problems, with focus on human values) used to say that „humility is not thinking less of yourself, but thinking of yourself less.” We should try to apply this concept towards intellectual humility, and from the ethical platform transform it into practical one.Successful leaders, who accomplished a lot, spend less time dwelling on what they already know, „what is in progress,“ however, they spend proportionally more time to search for new concepts and ideas. In other words, humility is helping me to focus more on what is in front of me, rather then what I’ve already achieved. Researchers must be always willing to abandon their theories for the sake of new and more precise explanations, with the goal to keep-up with incessantinnovations.Albert Einsteinsupposedly said that „without humility we cannot learn,“ or also: „As a human being, one has been endowed with just enough intelligence to be able to see clearly how utterly inadequate that intelligence is when confronted with what exists.“

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WHAT SHALL SOCIAL WORKER KNOW ABOUT OBESITY, DIABETES AND NON - ALCOHOLIC FATTY LIVER DISEASE

MÁRIA BELOVIČOVÁ

Abstract:
NAFLD - Non- Alcoholic Fatty Liver Disease - is characterized by the presence of hepatic steatosis - by excess accumulation of fat in liver, which is associated with insulin resistance (IR). The risk factors for development of NAFLD include: obesity, type 2 diabetes mellitus (DM), hypertriglyceridaemia. NAFLD is a major European health burden due to its high prevalence, capacity to progress to liver cirrhosis and liver cancer, and because it is associated with a greater risk of cardiovascular disease and other cancers. It is supposed that NAFLD, mainly associated with type 2 DM and the metabolic syndrome, is the most common chronic disease worldwide affecting 15-40% of the world population. The goal of treatment of NAFLD / NASH patients is to slow down, or stop disease progression, perhaps the development of liver fibrosis / cirrhosis and subsequent serious complications. The most effective treatment of obesity and NAFLD appears to be non-pharmacological (diet, physical activity, cognitive behavioral therapy, education, or their combination).

Key words: Non-Alcoholic Fatty Liver Disease (NAFLD), NASH . Non-Alcoholic Steato-Hepatitis, Diabetes mellitus, obesity, metabolic syndrome, treatment

NAFLD - Non- Alcoholic Fatty Liver Disease - is characterized by the presence of hepatic steatosis - by excess

accumulation of fat in liver, which is associated with insulin resistance (IR).

NAFLD is considered benign, non-progressive form of the disease, while **NASH - Non-alcoholic steatohepatitis** - is a progressive form with the development of fibrogenesis, with high risk for liver cirrhosis and hepatocellular carcinoma of the liver.

NAFLD is a major European health burden due to its high prevalence, capacity to progress to liver cirrhosis and liver cancer, and because it is associated with a greater risk of cardiovascular disease and other cancers.

NAFLD is the most common liver disease in economically developed countries.Over the past 20 years, the incidence of NAFLD has doubled worldwide, while the number of other chronic liver diseases has remained without significant changes (EASL – EAS –EASO, 2016).

More than half of adults and one third of children in Europe are classified as overweight or obese, with the highest proportion coming from lower socioeconomic groups where NAFLD is prevalent.

For the future, we have to face not only the increase of absolute number of affected patients, but more important fact is, that the number of patients with advanced liver fibrosis will increase. Fibrosis is the most important predictor of overall and hepatic mortality.

The prevalence of NAFLD increases with age because patients of higher age have more risk factors for metabolic syndrome. It is generally considered that the progression of NAFLD into steatohepatitis or into fibrosis results rather from the associated diseases and their duration than from the age itself. ***The risk factors for development of NAFLD include: obesity, type 2 diabetes mellitus (DM), hypertriglyceridaemia.*** However, NAFLD may be present in

7% of those who do not suffer from obesity. In this case, the accumulation of visceral fat must be present (EASL –EAS – EASO, 2016, Holomáň, J. – Szántová, M. – Zima, M. et al., 2017).

In most cases, **obesity** is a multifactorial determined disease, in which the interaction of environmental factors and genetic predispositions leads to a positive energy balance that results in excessive accumulation of adipose tissue.It is usually defined by body mass index (BMI - weight in kg / height in m^2). *The World Health Organization (WHO) speaks about the global epidemic of obesity.*

In the development of obesity, the localization of fat itself is extremely important - most harmful it is in abdominal area and in individuals with sudden weight gain. Abdominal obesity is responsible, for example, for 21% of IHD - ischemic heart disease, arterial hypertension, dyslipidemia, non-alcoholic steatohepatitis, osteoarthritis, arthritis, gall bladder disease, sleep apnea syndrome, some types of oncological disease (8-42%).

In the 21st century,obesity is becoming one of the most serious public health problems. By 2025, the WHO expects 1.5 billion people in the world to be overweight and about 500 million to be obese (Belovičová, M. – Belovičová, L., 2015)..

According to the IASO (International Association for the Study of Obesity) data in 2002 45% of Slovak women and almost 60% of Slovak men were overweight and obese, 14% of women and 16% of men were actually obese. In 2009 in OECD countries, including Slovakia, the average appearance of obese individuals was around 16,9%, which is appearance that our country also reaches. In 2012, the incidence of obesity in Slovakia was 25.6%, the incidence of diabetes mellitus (DM) was 6.3%.

Diabetes mellitus is a disease of civilization that negatively affects and threatens our society. The nature of this disease is everincreasing and thus becomes a serious and global social problem that can not be overlooked. The hazard of this disease can also be seen in the disproportionately fast increasing number of new patients in all age categories of the population (Krahulec, B.- Fábryová, Ľ – Holéczy, P. et al., 2013).

According to the International Diabetes Federation, in 2015, 415 million patients worldwide (1 in 11 adults) suffered from DM, out of which 90-95% had type 2 DM. The number of patients with DM is expected to reach 642 million by 2040.

According to the National Health Information Center (NHIC), at the end of 2016, 368 084 patients with treated diabetes were registered in the Slovak Republic, and 21752 new patients were added. Patients were most often dispensarized for type 2 diabetes mellitus (91%), 83% were diabetes patients over 50 years of age. The epidemic increase in the number of diabetes patients is associated not only with prolonged life expectancy, but also with an obesity epidemic and unhealthy lifestyle.

The incidence of DM increases both with the body mass index (BMI) and with the waist circumference itself. The incidence of diabetes and obesity cumulatively increases worldwide, gaining global pandemic dimensions, and therefore the term *„**diabesity**"* is also commonly used. Our entire population lives in a diabetogenic environment. It is known that up to 9 out of 10 newly diagnosed type 2 diabetes patients have excess body weight (Krahulec, B.- Fábryová, Ľ – Holéczy, P. et al., 2013).

According to literature data, that are being recently available, about 70-80% of patients with type 2 DM probably have

NAFLD (Brúha, R., 2015). **Applying this to Slovakia, it means that approximately 234469 diabetic patients have NAFLD and 35170 patients have advanced liver fibrosis and a risk of cirrhosis.** In patients with type 2 DM, the diagnosis of NAFLD should be set independently of liver enzyme activity, as the progression of the disease is significantly higher in these patients.

Unfortunately, **liver steatosis and NASH** are still perceived as benign conditions, the severity of which is often being questioned.Approximately 25-30% of NASH patients have advanced liver fibrosis at the time of diagnosis, 10% -15% of them even have cirrhosis. **The risk of death from liver disease is increased 10-20-fold in NASH patients.**Recent studies have pointed out that patients at all stages of NASH, including advanced fibrosis and cirrhosis, may have values of the liver function tests within the reference range. The activity of aminotransferases in NAFLD is not an indicator of disease activity. Some predictive value may have the increase in GGT (gamma-glutamyltransferase) activity that is typical in NAFLD patients (Belovičová, M. - Adamcová-Selčanová, S., 2017).

It is supposed that NAFLD, mainly associated with type 2 DM and the metabolic syndrome, is the most common chronic disease worldwide affecting 15-40% of the world population (Brúha, R., 2015)**.**

As for the metabolic syndrome, it is important to focus attention not only on the risk factors for its development, but also on the possibility of inducing a change in the risk behavior of an individual in their social environment before this behaviour in the integration with inherited vulnerability causes the development of the metabolic syndrome.

Cirrhosis in NAFLD was once marked as cryptogenic. Today it is the third most common indication (after alcoholic

cirrhosis and chronic hepatitis C cirrhosis) for liver transplantation. It is assumed it will dominate the indications for liver transplantation (Belovičová, M., 2018).

Epidemiological studies have shown that patients with NAFLD have higher total mortality than the general population has. It is not only affected by cirrhosis, but especially by cardiovascular diseases and extrahepatic malignancies (colon and breast carcinoma). **Therefore, active screening for cardiovascular diseases in patients with NAFLD, independent of the presence of risk factors, is needed. The monitoring of adolescent and pediatric patients with NAFLD and monitoring of metabolic risk factors require close attention** (Zarebska – Michaluk, D., 2018) **.**

Therefore, in patients with diagnosed metabolic syndrome it is necessary to specifically look for liver disease at the same extent as is now being looked for the other complications of diabetes.

Detection of advanced fibrosis or cirrhosis is essential for the futureof a patient with type 2 DM - at least in the fact that the patient may be included in the program for screening for hepatocellular carcinoma (HCC) and the risk esophageal varices (Brúha, R., 2015). The cumulative incidence of NAFLD related-HCC is 10-fold higher in patients with obesity and type 2 DM. NAFLD is the second leading indication for liver transplantation in HCC patients. Diabetic patients with liver steatosis have a significantly higher incidence of ischemic heart disease, stroke, peripheral vascular disease compared to diabetic patients without steatosis. Liver diseasesare the 4th leading cause of mortality in patients with diabetes.

NAFLD is considered a slowly progressive chronic liver disease in adults and in children. In 20% of cases fibrosis

progresses rapidly. The rate of *progression* corresponds to 1 fibrosis stage *every* 14 *years* in NAFLD, and every 7 years in NASH, being doubled in patients with coexisting arterial hypertension. NASH is associated with increased standardized mortality ratio compared with the general population (EASL – EAS – EASO, 2016). **Liver diseases are considered to be the third most common cause of death (after cardiovascular diseases and cancer).** NAFLD in children is considered to be a significant problem because of the serious complications associated with liver diseases. Cases of NASH-related cirrhosis have already been reported in eight-year-old children (Belovičová, M., 2018).

The goal of treatment of NAFLD / NASH patients is to slow down, or stop disease progression, perhaps the development of liver fibrosis / cirrhosis and subsequent serious complications. **The treatment strategy for NAFLD** is mostly based on **regime arrangement and treatment of the individual components of the metabolic syndrome.** It has been proved that weight loss of 10% over 6-12 months improves both insulin resistance and histological findings in the liver in patients with NASH. A 4-14% weight loss leads to a statistically significant reduction in triglycerides in liver of 35-81%.The rate of their reduction depends on the weight loss. Of course, regular physical activity is also needed to support the weight loss efforts and help maintain thereduced weight. It has been proved that NASH patients have less than half the physical activity compared with controls. However, patients should be advised that rapid weight loss (e.g., on a very low calorie diet) may increase the risk of liver disease progression and even lead to liver failure (Holomáň, J. – Szántová, M. – Zima, M. et al., 2018).

Energy expenditure and food intake are the two main components that create the body energy balance. From the

point of view of the NAFLD and associated increased body weight treatment, the goal is initially to achieve a negative energy balance that leads to a reduction in excess weight. In the second, long-term phase of treatment, the goal is to induce a new energy balance and maintain the achieved weight loss. Calorie restriction should be individualized, taking into account nutritional habits, physical activity, co-morbidity, experience with and tolerance of previous dietary practices. Prescribing energy-restricted diets may require an intervention of a dietitian. Most often it is recommended to reduce the current energy intake by 500-1200 kcal / day. Often, reduction can be achieved by revising patient's dietary report in the sense of a healthy diet (Belovičová, M., 2015).

Physical activity is important not only in the treatment of NAFLD but also in its primary prevention. Physical activity promotes the formation of active body mass, prevents unwanted reduction of muscle mass during a reduction diet, reduces diet-induced decline in resting energy expenditure, positively affects the amount of postprandial energy expenditure, increases the mobilization of fats from fat stores. Physical activity reduces the severity of NAFLD even if it does not lead to weight loss; it reduces hepatic fat content and improves insulin sensitivity.

Regular physical activity helps to reduce weight and improve metabolic complications associated with NAFLD: improves cardiovascular function, reduces blood pressure (both systolic and diastolic pressure by 2.5-10 mmHg), deepens breathing, prevents osteoporosis, improves fat and sugars metabolism - increases HDL cholesterol, lowers values of total cholesterol, triglycerides, LDL cholesterol. However, a greater volume of physical activity is required to increase HDL-cholesterol.

Regular physical activity reduces the risk of stroke by 27%, type 2 diabetes mellitus by 58%, Alzheimer's disease by about

40%, colon cancer by 60%, lung cancer by 20-24%, breast cancer - about 50 %, risk of falling by 30%. In addition, regular physical activity prevents depression and obesity.

In obese patients with type 2 diabetes, physical activity leads to an improvement in glycemic profile. In complex lifestyle interventions,physical activity also reduces the incidence of newly developed type 2 diabetes mellitus in individuals with impaired glucose tolerance. In an American study „Diabetes Prevention Program" (2002) and a Finnish study,,Finnish Diabetes Prevention Study", an intensive intervention, including diet and physical activity, resulted in weight loss and a 58% reduction in incidence of newly developed type 2 diabetes compared to the control group. In addition, physical activity has considerable positive impact on one´s mental health (Belovičová, M. – Belovičová, L., 2015).

In overweight / obese NAFLD patients, 150-200 minutes of physical activity per week at higher intensity (50-80% of maximum heart rate) is recommended *to achieve a beneficial health effect* (increase fitness, improve metabolic profile indicators).

When reducing weight in patients with NAFLD, physical activity of moderate intensity with a duration of 250-300 minutes per week (40-70% of maximum heart rate) is recommended. Exercise units should last 30-45 minutes. When physical activity is combined with a low energy diet, weight loss is increased. However, to *maintain weight loss*, more physical activity is required - 400-500 minutes per week. In general, in treatment of NAFLD, *aerobic activity* is recommended. In severely obese patients,swimming or cycling are suitable physical activities, as these types of sports do not put any extra pressure on weight-bearing joints. *Walking is the most effective physical activity while being the easiest one to do.*

When recommending aerobic physical activity, it is necessary to characterize the intensity of the activity, the duration of the exercise unit and its frequency. *In clinical practice, the recommendation of physical activity must be adapted to the individual characteristics of an obese patient.* During physical activity, the following symptoms should be noted in the patient: weakness, lightheadedness, excessive shortness of breath, rhythm disorders, chest pain (Belovičová, M. – Belovičová, L., 2015).

This will allow the patient to comply with the physical activity program, minimize their risks and help maximize the effect.

Just as important as the exercise itself is to *limit the sedentary way of spending leisure time.* Sedentary lifestyle and low cardiorespiratory fitness belong to the most significant independent predictors of premature mortality.

We are living in a period of gastronomic revolution and the chronic "overload" of calories is a trend of the time. Food prices have fallen, calorie richness has increased (from 1800 to 2000, the consumption of simple carbohydrates has risen 500-fold worldwide!). It is assumed that caloric intake has increased by more than 500 kcal per person per day over the past five decades. On the other hand, energy expenditure in connection to employment fell by nearly 150 kcal (National Health and Nutrition Examination Survey).

Obesity significantly increases morbidity and mortality, impairs quality of life and brings serious socio-economic problems.In the European region, obesity is underestimated and under-diagnosed public health challenge with rapidly increasing prevalence. In many economically developed countries it has even reached pandemic level.

For the evaluation of the health consequences of obesity **years-of-life lost** (**YLIs**) are being used. These are the

differences between the life expectancy for persons in various categories of BMI. Another indicator that is used to evaluate the quality of life of obese individuals are quality-adjusted life-years (**QALYs).** These allow the assessment of the overall burden caused by obesity.Increased morbidity of obese patients is reflected in the increased costs spent on health care. Meta-analysis of cross-sectional and prospective studies confirm that obesity is a risk factor for the short and long term sick leave. Obese people had four extra days of sick leave each year. Most long-term sick leave cases were caused by chronic comorbidities of obesity. The most effective method in preventing obesity is targeted intervention aimed at improving eating habits, increasing physical activity and changing lifestyle.

In the last 30 years due to the epidemic of obesity and metabolic syndrome, NASH has become serious health problem. The disease NAFLD / NASH is considered to be the organ / hepatic manifestation of metabolic syndrome, and probably plays a key role in the pathogenesis of systemic atherosclerosis (Belovičová, M. – Balážová, I., 2016).

The most effective treatment of obesity and NAFLD appears to be non-pharmacological (diet, physical activity, cognitivebehavioral therapy, education, or their combination) (Belovičová, M – Belovičová, L., 2015)..

The fight against NAFLD / NASH, obesity, requires the involvement of society as a whole, not only at national, regional and local level, but also at global level, including food businesses, which should maintain ethical standards when advertising to children, provide clear information for consumers, support education and prevention programs as part of the corporate social responsibility strategy, and modify recipes to reduce the amount of indredients that contribute to the rise of NAFLD and obesity.

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Ehe und Familie im Gerichtsaal?

Pavol Tománek

Abstrakt:
Der Beitrag beschäftigt sich mit dem Phänomen der Partnerschaft versus der Ehe heutzutage. Immer mehr junge Menschen heiraten nicht, weil sie nicht heiraten wollen und keine Heiratsurkunde haben. Anderere Seite, homosexuelle Partnerschaften diesen Ehebrief sehr wollt. Wenn eine Ehe oder Partnerschaft getrennt wird, die Kinder oft getrennt großgezogen werden. Der Beitrag beschäftigt sich mit den Möglichkeiten der Sozialhilfe in einer Zeit, in der sich die Familie in einer Krise befindet.
Schlüsselwörter: Familie, Ehe, Erziehung, Sozialisation, Krise, Restriktion.

Einleitung

Leute verwenden Wortschatz, den sie oft nicht verstehen. Das Böse nennen sie Tugend, Unsittlichkeit erhöhen sie auf einen Kult, Sünde wird durch Ästhetik entschuldigt. Wir sind Zeugen von neuen Typen des familiären Zusammenlebens, wie single, mingle, patchwork Familien, homosexuelle Familien etc. Immer öfter treten viele heterosexuelle Paare nicht in die Ehe, weil sie Ehe für unnötige Formalität halten, mit der Äußerung, dass „*sie keine Papiere dafür brauchen, dass sie sich lieben*“. Wir können reflektieren, dass das traditionelle Verständnis von Entstehung der Familie (wir denken an heterosexuelle Ehe) „*Papiere zur Legalisierung ihres Verhältnisses*“ nicht braucht, wobei die neuentstandenen Formen des ehelichen (wie auch des familiären) Zusammenlebens „diese Papiere“ verlangen. Wir fragen deshalb, warum bestimmte Gruppen diese „Papiere“ nicht mehr brauchen, und andere sie verlangen? Andere Sicht auf die ganze Problematik der Ehe bietet der Fakt, dass

heutzutage die jungen Paare Bedürfnis haben, vor der Eheschließung zusammenzuleben, damit sie ausprobieren, wie ihre Beziehung funktioniert, aber Paradox ist es, dass nur wenige von diesen Paaren nach der Eheschließung den 3-5. Jahrestag feiern. Dabei ihre Eltern, Großeltern, die vor der Eheschließung nicht zusammengelebt haben, sehr wohl einen 20., 30. 40. Jahrestag der Eheschließung feiern. In der Gesellschaft macht es dann einen Eindruck, dass sich die Leute direkt in die Augen lügen, bzw. anders gesagt, sie entschuldigen eigene Schritte, Entscheidungen insofern, dass sie auch Schwäche zur Tugend, Unsittlichkeit zu einem Kult und zu einem Modell des Modernismus erhöhen, und eigene Fehltritte verschieben sie von der Kategorie der Geschmacksverirrung in die Kategorie der Ästhetik.

In der Gesellschaft entsteht ein Mythus über die Ehe, dass es sich um eine überholte Form des Zusammenlebens handelt, die durch Freiheit der kohabitierenden heterosexuellen/homosexuellen Beziehungen ersetzt werden soll. Wichtiger ist aber Tatsache, dass aus solchen atomisierten und „gebogenen" Familien Kinder in die Welt kommen, die nicht immer gut für sie vorbereitet ist. Und so enden viele solche Kinder bei Pflegefamilien, in Kinderheimen oder paradox bei neuen Familien, wo sie zwar einen neuen Vater und Mutter erleben, aber oft erst nach einigen Abwechslungen bzw. Austauschen (single, mingle, patchwork Familien, oder homosexuelle Familien).

Wir fragen also, ob in den imaginären „Gerichtssaal" der Gesellschaft, wo die Existenz der Ehe und Familie gehandhabt wird, in der Folge auch Kinder kommen, die zwar Eltern haben, aber erst nach einem bzw. mehreren Umtauschen.

Wir gewinnen die Überzeugung, als ob die Gesellschaft des 21. Jahrhunderts solche familiäre Gruppierungen kreieren und

gutheißen würde, welche selbstdestruktiv sind aus dem soziologischen, pädagogischen, psychologischen bzw. rechtlichen Gesichtspunkt?!

1. Die Familie und die Familienerziehung

Die Familie ist eine Umgebung, in der die primäre Sozialisierung realisiert wird. Eheliche Lebensgemeinschaft, Zusammenarbeit und Hilfe, Toleranz und gemeinsame Kommunikation – dies´ sind oft die charakteristischen Merkmale dieser bedeutsamen Institution. *Aus der Sicht der Pädagogik und Psychologie gehören zu ihren Grundfunktionen die langfristige Kinderpflege und ihre Erziehung, und zwar im Umfang des Personalbeziehungsrahmens „ich und du". Gerade in diesem Rahmen wird nicht nur ihre emotionale Funktion am besten erfüllt, sondern es wird hier die Umgebung voller Liebe, emotionaler Unterstützung, Annahme, Sicherheit und Stabilität angeboten* (Mátel, 2011, S. 219). Obwohl die Beziehungen in der Familie nicht immer als ideal scheinen, muss die Atmosphäre im Familienkreis wohlbedacht sein, weil es sich hier nicht nur um gegenseitige Eltern-Kind-Beziehungen handelt, sondern werden hier auch die Grundlagen für alle anderen zukünftigen Beziehungen gebaut. Daraus ergibt sich, dass das Kind neue Beziehungen gerade nach dem Vorbild der Beziehungen in seiner eigenen Familie sucht und bildet, dies geschieht aber nicht nur in der Umgebung, wo es aufwächst. Laut L. Stašová (2001, S. 78) wird die Familie charakterisiert als *eine institutionalisierte Sozialformation der mindestens drei Personen, zwischen deren es elterliche, verwandtschaftliche und eheliche Bindungen gibt.* Sie beruht auf der dauerhaften Partnerschaft und Elternschaft zwischen Personen des anderen Geschlechts.

Die Familie ist die älteste Gesellschaftsinstitution und der wichtigste Faktor, der den Verlauf und die Ergebnisse der

Erziehung (=Edukation) in bedeutsamer Weise beeinflusst. Die Familie ist die erste Umgebung, in die das Kind eintritt. Deswegen zählt sie zu den primären Erziehungsumgebungen. Obwohl die Familie derzeit dem postmodernen Liberalismus ausgesetzt ist, hält sie in der Slowakei dauerhaft ihr Kredit, ihre Wert und Stichhaltigkeit. Sie wird als die Grundzelle der Gesellschaft definiert. Was bedeutet das in Wirklichkeit? Jede Familie entsteht durch die Eheschließung. Die Ehe wird im slowakischen Rechtssystem als durch allgemein gültige, meist gesetzliche Regel gefestigte Lebensgemeinschaft der Eheleute verschiedener Geschlechter definiert (die einzelnen Schritte vor der Eheschließung werden laut § 27-30 des Gesetzes Nr. 154/1994 der Gesetzessammlung des Nationalrates der slowakischen Republik geregelt), wobei sie versprechen, die aus ihrer Ehe entstandenen Kinder anzunehmen. Vom Kompositum *„Grundzelle“* auskommend bedeutet der zweite Teil des Wortes *„Zelle“*= Leben, weil nur das Lebendige schafft es, das Leben weiterzugeben und der erste Wort *„Grund“* = Basis, *Elementar*- bedeutet auf einer Seite etwas, was durch etwas anderes nicht ersetzbar sein darf, auf der anderen Seite etwas, was der Teilung fähig ist; fähig das Leben weiterzugeben. Den Schwerpunkt der Sozialisationswirkung in der Familie stellt die Erziehung dar und ihr erstrangiges Ziel ist die allseitige Entwicklung der Persönlichkeit. Die Persönlichkeitsentwicklung fängt in der Familie, bzw. mit der Familienerziehung an.

Die Erziehung (Edukation) stammt aus dem lateinischen „*educare“= erziehen*, *ausbilden* und *educere = mitkommen*, begleiten (Zelina, 2004, S. 27). Unter dem Begriff *Edukation* kann man gewöhnlich die bewussten und unbewussten erzieherischen Auswirkungen auf die Persönlichkeit verstehen, wobei sie die qualitativen Änderungen der Persönlichkeit als Folge hat. Laut M. Zelina (2004, S. 28) ist

die Familie *„professionelle, fachliche und zielbewusste Aufrechthaltung, Erweiterung und Entwicklung der positiven und funktionellen Möglichkeiten eines Menschen“.* Die Erziehung kann in einer slowakischen Altersweisheit mit einem an den Baum gefesselten Stab verglichen werden, der dem jungen Baum hilft, richtig zu wachsen, wobei er ihn unterstützt, nicht abzubrechen und mit der Zeit fähig zu sein, viele Früchte zu tragen.

Die Familienerziehung kommt aus dem pädagogischen Familienfeld. Pädagogisches Familienfeld ist, im Grunde genommen, die Theorie und Methodologie einer Familie. Im Allgemeinen widerspiegelt die Familienerziehung alles, was sich in der Familie abspielt. Sie widerspiegelt die Familienverhältnisse, die aufgrund der Persönlichkeits- und Wertqualität der Eltern und ihrer gegenseitigen Kommunikation entstehen. Weiter werden in ihr sowohl die sozial-ökonomische Situation als auch die Gesellschaftsentwicklung widerspiegelt. Laut H. Rozinajová (1996, S. 12) kann *„die Familienerziehung als Prozess der absichtlichen Übergabe von gesellschaftlich-historischen Erfahrungen an junge Generation* aufgefasst werden. Sie setzt fort: „*Diese Erfahrungen sollen junge Generation auf ein ordentliches Familienleben und auf die Arbeit in neuen Gesellschaftsbedingungen vorbereiten.“* Heutige Familienerziehung wird auf einer Seite als Institution voller Liebe charakterisiert, auf der anderen hört sie aber auf, die Erziehungsziele festzulegen. Es ist oft befremdlich, wenn die Kinder diese Erziehungsziele ihren Eltern durch ihren Trotz und Widerrede, usw. auferlegen. Die Erziehung in der Familie geht durch die gesellschaftlichen Turbulenzen durch. Woran liegt das Problem dieser Gesellschaftsturbulenzen? Es liegt an der Erziehung selber, bzw. an der Kinder- und Jugenderziehung. Unsere Gesellschaft hat den Kindern und

Jugendlichen erlaubt ihre Rechte auf Rechnung ihrer Pflichten zu betonen. Die Kinder und Jugendlichen von heute haben keine fest definierten Grenzen des wohlanständigen Verhaltens, bzw. die Grenzen gehen verloren. Die Kinder und Jugendlichen wissen nicht oder wollen nicht wissen, was richtig und was nicht normgerecht ist. Sie werden auf der Straße, durch Medien und mit Hilfe des Internets, bloß nicht von ihren Eltern großgezogen. Die Eltern sind von der Stellung der Erzieher auf die Stellung der Versorger, Behüter abgeschoben worden. Trotz dieser Tatsache- der stürmischen und schweren Zeit, die darstellt, für die Eltern außer Behüter auch der Erzieher zu sein- muss man nicht in Trostlosigkeit verfallen. Wie G. Barberis (1897, S. 3-8) sagt: "*Es gibt noch einen Rettungsplan, und zwar die Kinder- und Jugenderziehung.“*

2. Ehe - und Familienkrise

Auch dank dieser Aspekte gibt es oft Meinungen, laut denen sich die Familien der Gegenwart und die mit ihnen zusammenhängende Erziehung in Krise befinden. Die Wahrheit verbirgt sich doch irgendwo weit näher. In der Ehe. Menschen der heutigen Welt genießen „das Gute“ der Ehe, doch sie lassen sich nicht sehr oft in die Eheschließung ein, stattdessen suchen sie andere Alternativen (z. B. Konkubinat, homosexuelle Beziehungen u. ä.), die prinzipiell das Ehewesen und letztendlich auch die Familie, was die Kinderzeugung betrifft, nicht erfüllen können. Diese Tatsache betrifft nur die homosexuellen Partnerschaften. Jeden Tag sind wir über den ethischen Normenverfall der Gesellschaft, über den Ehe-, Familienverfall, Brutalität und Gewalt informiert.

Die Gesellschaft verliert schrittweise die Kontrolle über ihre Gefühle. Sie verfällt der Einsamkeit, in eine gewisse Teilnahmslosigkeit und Rücksichtlosigkeit nicht nur in den

Familien-, sondern auch in den Arbeitsverhältnissen. An der Familie hat der Markt das erstrangige Interesse. Unsere Familien sind sowohl dem furchtlosen, „aggressiven" als auch dem unausgeglichenen, gefühlinstabilen Held aus der virtuellen Welt (Gálik, 2003, S. 16) ausgestellt. Durch Medien wirbt der Markt für offene Beziehungen, homosexuelle Partnerschaften, die fordern, die Eherechte und gemeinsames Wohnen mit mehreren Personen zu haben (Beispiel: US-amerikanischer Sitcom Friends), usw. Die Forschung, die im Jahre 2006 M. Manková (2006, S. 3) durchgeführt hat, beweist die oben genannten Tatsachen. Kinder und Jugendlichen im familiären Rahmen:

- 89% der Kinder und Jugend langweilt sich, verbringen ihre Freizeit verbringen,
- 83% sehen fern,
- 76% lernen/studieren,
- 69% treiben Sport,
- 60% spielen Computer (Šoltésová, 2004, S. 26-27),
    - 46% verbringen die Zeit im Gespräch mit ihren Eltern.

Der letzte Punkt (46% der Kinder und Jugendlichen sprechen mit ihren Eltern) warnt uns. Die Familie darf nicht zulassen, dass ihre primäre Erziehungsfunktion Medien oder Multimedien übernehmen.

Der Kern dieser Probleme besteht im / in der (Tománek, 2019)**:**

- **Liebemangel zwischen den Eheleuten, Familieninstabilität**. Kinder haben größere Probleme, die Elternliebe wahr- und aufzunehmen, weil sie keine Liebe zwischen ihren Eltern sehen und spüren können,

- **Zeitmangel ihrer Eltern** (Ferrero, 2007, S. 64) sich den Kindern geduldig, systematisch, vollwertig und mit der „vernünftigen Aufklärung“ zu widmen. Die Erwachsenen haben keine Zeit, ihren Kindern viele Sachen beizubringen, den Prozess der einzelnen Tätigkeiten und Ursachen für alles, was geschieht, zu erklären. Sowohl die Kleinen, als auch die Großen sind im alltäglichen Wirbel mit riesiger Pflichtmenge überlastet. Es gibt eigentlich kaum bis keine Zeit für die Kinder,
- **Situation der breiten Religionsindolenz** in der ganzen Gesellschaft; in der Situation des praktischen Atheismus / der religiösen Pluralität. Platz für die Religion in den Köpfen der Jugendlichen und Erwachsenen, denen es allein um Wohlstand, Geld und Erfolg geht; die Begeisterten für die Fernsehpropaganda und Werbung, die in ihren persönlichen Wünschen und in ihrer persönlichen Sehnsucht nicht beschränkt sein wollen.

3. Ehen vs. Partnerschaften in eu? Heterosexuelle vs. Homosexuelle partnerschaft?

Ehe? Institution der Ehe ist vertreten fast in allen Ländern auf der ganzen Welt, ob in Form einer standesamtlichen oder kirchlichen Eheschließung (Tománek, 2019):

- **Rechtlicher Aspekt:** Es ist Vertrag zwischen Mann und Frau,
- **Sozialer Aspekt:** der „verursacht“, dass sich Mann und Frau in ein „Leib“ verbinden für die Dauer ihres ganzen Lebens. (*Consorttium Totius Vitae) oder* für gewisse Zeit ihres Lebens
- **Natürlicher Aspekt:** Ehe baut auf der Natürlichkeit des Menschen. Ziel dieser Gemeinschaft ist das Wohl der Eheleute, Zeugung und Erziehung der Kinder (Gesetz von der Familie)

- **Kultureller, religiöser Aspekt**: traditionelle Ehe wird verstanden als eine Beziehung eines Mannes und einer Frau (Gleichstellung: katholische, evangelische, orthodoxe, jüdische Religion; Ungleichstellung bzw. Kastengesellschaft: Budhismus, Shintuismus, Hinduismus, Konfuzionismus)

Und das Partnerschaft? Phänomen einer legalisierten Partnerschaft ist kein moderner Hit des 21. Jahrhunderts). Offen wurde zum ersten Mal über legalisierte Partnerschaften schon (oder erst) auf der Wende des 19. und 20. Jhdts gesprochen, wobei Phänomen der Homosexualität hat sich deutlich auf der Wende des 17. und 18. Jhdts präsentiert (Tománek, 2019):

- **Rechtlicher Aspekt:** Rechtlicher Aspekt in Ländern wo es keine legalisierte Partnerschaft gibt, entweder fehlt, oder ist in großem Ausmaß atomisiert, bzw. aus dem partnerschaftlichen Bund entstehen keine Verpflichtungen, d.h. wenn sich das Paar trennt, folgen keine rechtliche Sanktionen.
- **Sozialer Aspekt:** Beziehungen Mann/Frau (Kohabitation), Mann/Mann oder Frau/Frau (homosexuelle Verbindungen), sind statistisch gesehen weniger dauerhaft.(s. Tab. Später)
- **Natürlicher Aspekt:** fehlt…
  - **Kultureller, religiöser Aspekt**: es geht um ein alternatives Verständnis von der Ehe. Ehe, lat. *Matrimonium*, wir übersetzt als mater (Mutter) und unus oder nunus (Aufgabe, Berufung). Homosexuelle Beziehung kann also aus dem etymologischen Gesichtspunkt kann immer nur als Partnerschaft bezeichnet werden. In Staaten (Niederlande), wo es

legislativ eine homosexuelle Ehe gibt, wird momentan durch das Verfassungsgericht Beschwerden wegen des „etymologischen Paradoxes“ verhandelt. Keine Religion gutheißt offiziell homosexuelle Verbindungen (nur toleriert).

4. Zussamenleben

Homosexuelles partnerschaftliches Zusammenleben erfüllt nicht einmal die grundlegende Reproduktionsfunktion. Homosexuelle Partner können „Eltern“ werden, nur durch (Tománek, 2017):

- **Form der Adoption** (wenn wir an Beziehungen Mann – Mann denken), oder
- **Form der geraden Linie** (z.B. wenn die Frau oder Mann aus der ersten heterosexuellen Beziehungen in die homosexuelle Beziehung eigenes Kind mitbringt, oder das sie in die Obsorge bekommen haben.

Aber, in der Gesellschaft notieren wir 5 Etappen von Aneignung der homosexuellen Kultur. Es geht um diese Schritte (Tománek, 2017, 2019):

- **1. Schritt: Toleranz:** also Recht unangefochten zu sein. Man sagt dazu auch Antidiskriminierungspolitik, z.B. auf der Basis der sexuellen Orientierung (z. B. einige EU Länder, USA…)
- **2. Schritt: Ansuchen um Gleichstellung**: in USA gibt es eine Organisation mit dem Namen *Human Rights Campaign*, also Kampagne für die Menschenrechte, die in die ganze Welt LGBTI Thematik verbreitet und bemüht sich, dass es in einzelnen Staaten, Ländern nicht nur zur Gleichstellung kommt, sondern dass es gestraft wird, wenn jemand nicht mit der Homosexualität einverstanden ist. Homosexualität wird als

Menschenrecht dargestellt. In UK (London) gibt es wiederum das Tavistov‘s institut for human rights. Seine Existenz reicht in die Zeit des II. Weltkrieges. Das Institut sollte eine Würdigung der Menschenrechte sein, aber heutzutage wurde es zu einem Verbreiter der LGBTI Thematik. Gegründet war es schon im Jahr 1924 als eine Klinik, erst nach dem 2. Weltkrieg wurde es zu einem Institut, nachdem das Memorandum des gegenseitigen Verständnisses durch Persönlichkeiten wie Rokefeler, Tavistov und Rolling, unterschrieben wurde. Der Hauptgedanke dieses Instituts ist Veränderung des menschlichen Verständnisses, Schaffung neuer Kultur in neuer Zeit. Es geht um Propaganda der Bewegung New Age, bzw. heutzutage bereits Next Age. Propaganda wurde vor allem durch das Projekt Heapes ersichtlich. **3. Schritt: Bekenntnis**: d.h. es reicht nicht nur Toleranz und Gleichstellung, aber es wird auch Bekenntnis zu diesen Werten verlangt.

- **4. Schritt: verpflichtende Teilnahme**: Homosexualität wir als persönlicher Weg gesehen.
- **5. Schritt: Straffe**: jeder, der gegen Homosexualität ist, wird gestraft, sanktioniert, z.B. in einigen Staaten der USA jeder, der gegen die Homosexualität ist, begeht eine Straftat.

5. Soziale Faktoren versus Herausforderungen und perspektiven für das Institut der Ehe und Familie

Wo sind die grundliche Probleme?:

- Sozial-wirtschaftliche Probleme,
- Geschwächter Einfluss der Kirchen,
- Massenmedien,
- Ehebetrüger,
- Voreheliche Verträge,

- „ich will ein Kind– aber keinen Mann“ (single Familien)...,
- Weniger Eheschließungen und Geburten,
- Heiratsmarkt,
- Kohabitationen (Tománek, 2019, Škoviera, 2007).

Und wie weiter?

- Staaten, in denen bislang keine heterosexuelle/homosexuelle Partnerschaften legalisiert wurden, werden oft ausgelacht, dass sie rückschrittlich , traditionell und konservativ sind.... Aber wie stellt Pastor (2012, S. 268) in seiner Forschung fest: „Nicht alles Moderne ist zugleich auch gut und ethisch“.
- Laut schweizer und deutscher Untersuchungen (2010-2011), in die 20.000 Homosexuelle einschlossen waren, sind sogar **68 % der Homosexuellen BISEXUELL!**...allerdings, laut *R. Uzel*, tschechischen Sexuologen, existiert keine Bisexualität, es ist nur eine Art eines eigenartigen Verhaltens… Es taucht aber die Frage auf, was Homosexualität in der Tatsache ist, und welchen Standpunkt soll man dazu einnehmen?
- **Wenn A, dann auch B:** Länder, wo die homosexuelle Partnerschaft legalisiert ist (z.B. in der Niederlande ist es schon länger als 12 Jahre) lösen sie gerade Frage, was passiert mit den Kindern, die durch homosexuelle Partner erzogen wurden? 57 % der Kinder aus homosexuellen Familien haben psychische und soziale Probleme. Warum? Haben nicht ähnliche Probleme auch Kinder, die aus heterosexuellen Familien stammen? Die Antwort lautet ja, aber nicht in solchem Verhältnis. Wie Pastor in seiner Untersuchung anführt (2012, S. 268) geht es um 74% Kinder stammend aus homosexuellen Familien und 26% der Kinder stammend aus heterosexuellen

Familien. Warum? In heterosexuellen Beziehungen kommt es zu einer größeren Krise, die oft zur Scheidung führt zw. 5-7 Jahr des gemeinsamen Ehelebens, aber in den homosexuellen Beziehungen ist es zw. 1,5-3,5 Jahr des Zusammenlebens (Pastor, 2012, 262-268). Das heißt, dass in den homosexuellen Beziehungen zu einer Abwechslung 2 bis 3 Mal früher als in heterosexuellen Beziehungen kommt. Nicht auszuschließen ist die Tatsache der eigentlichen Kindererziehung (auf die biologische oder adoptive Art), die durch oftmalige Trennungen der „Eltern" die Stabilität einer jeglichen Beziehung verlieren.. (es geht z.B. um Niederlande, Australien, Großbritannien)

- **Jede Minderheitsgruppe, die „auf den Markt" kommt** (z.B. neue Religion, Sekte, Ehealternative…?) , muss etwas vorweisen, wodurch sie für die Gesellschaft nützlich ist. Was bietet die heterosexuelle/homosexuell Ehe?
- **Frage des Konkubinats** (Kohabitation): *concubine* bedeutet Gesellschaftsdame, Prostituierte. Es geht um ältere Bezeichnung für heterosexuelles Zusammenleben der Partner. Von diesem Wort stammt der Ausdruck Konkubinat. Pastor (2012, s. 265-268) zitiert deutsche Forschungen aus dem Jahr 2008, in denen angeführt wird, dass Ehen, die nach einem vorherigen Zusammenleben entstanden sind, werden innerhalb von 10 Jahren nach der Eheschließung geschieden.

6. Phänomen Scheidung und die Argumentation

- **Phänomen Scheidung** (Tománek, 2019, Škoviera, 2007): die Gesellschaft wird immer öfters belügt mit „Fakten" über die Scheidungsrate in der Slowakei. Die Scheidungsrate in der Welt resp. EU solle ca. 52% der Ehen sein. Wir fragen von welchen? Standesamtlichen,

kirchlichen Ehen? Oder gesamt? Die Leute schließen die Ehen am Standesamt oder in Kirchen und kirchlichen Räumlichkeiten jener religiösen Gemeinschaften, die in der Slowakei mit der slowakischen Republik einen gegenseitigen Vertrag haben. Aber in Kirchen oder am Standesamt werden die Ehen nicht geschieden. Scheidungen erfolgen am Gericht, und diese können klar definieren, welche Beziehungen bei Scheidung standesamtlich und welche kirchlich beschlossen waren. Warum? Laut unseren Untersuchungen endet jede 2-3 standesamtliche Ehe mit einer Scheidung wobei jede 5-7 kirchlich (und in religiösen Gesellschaften) geschlossene Ehe mit einer Scheidung endet! Warum wird in der Slowakei nicht auch über diese Tatsachen gesprochen? Aus den Scheidungen wurde ein Trend. In der Vergangenheit haben sich Leute für die Scheidung geschämt, jetzt rühmen sie sich durch diese.

- **In der Krisenzeit,** die zum Zerfall der Familie führt, lösen Erwachsene mit Priorität ihr eigenes Problem – vernachlässigen das Kind, wodurch es emotionell und sozial verunsichert wird. Das zeigt sich vor allem durch:
- **Erhöhtes Risiko der sozialpathologischen Erscheinungen** (Schule schwänzen, Erfahrungen mit Drogen, Schikane, aggressives Handeln usw.)
- **In Angstzuständen, Flucht in eine Krankheit, Selbstzerstörung, Selbstanschuldigung** (es ist „der Grund“ der Krise)
- **In erhöhtem Misstrauen gegenüber der „Welt“ der Erwachsenen**.

In der Zeit des Verlassens der Familie durch einen Elternteil (z.B. *single Familie)* oder Scheidung (z.B. *mingle, patchwork Familie)*:

- Erlebt das Kind ein Identitätstrauma – wenn die zwei nicht zueinander gehören, kann ich zu beiden gehören?
- Das Kind ist „Handelsgegenstand“,
- Auf der sozialen Ebene verliert es praktisch eine Beziehungs- und Modellperson,
- Im Falle des abwechselnden Sorgerechts geht es einerseits um Adaptierungsballast, andererseits um Problem, „wo hat es eigentlich sein Zuhause“???

Schlusswort

In der Zeit nach der Scheidung steht im Vordergrund Unsicherheit des Elternteiles gegenüber dem Kind, seine Unfähigkeit dem Kind angemessene Anforderungen zu stellen:

- Oft Schuldgefühle und Bemühungen den anderen Elternteil zu „ersetzen“
- Verlust eines der Einkommen führt die Mütter dazu, sich eine zweite Arbeit zu suchen und zur Materialisierung der „Erziehung“, das Kind verbringt viel Zeit ohne Aufsicht – Risiko der Cliquen
- Das Kind lernt, die Schwachstellen beider Eltern auszunutzen, manipuliert, erpresst – „ich gehe zu dem Vater“
- Lehnt neuen Partner ab: „Du hast mir nichts zu sagen – du bist nicht mein Vater!“
- Schwächt die Beziehung als Institution ab, Mädchen – erhöhtes Risiko von promiskuiten Beziehungen.

Zu diesen Lebensphasen können wir auch andere soziale Einflüsse an das Kind einordnen, wie:

- In einer unvollständigen Familie wird die Führsorge um kranke und ältere Familienmitglieder kompliziert, ihre Funktion des primären sozialen Netzes wird geschwächt.

- Anforderungen an staatliche finanzielle Hilfe – Beihilfe wachsen (es ist Unterschied, falls ein Elternteil in einer vollständigen oder unvollständigen Familie arbeitslos wird).
- Suche eines „Ersatzes" für den anderen Elternteil – „Ruf" in der Öffentlichkeit, andere wirtschaftliche und soziale Probleme (meine Kinder + deine Kinder + unsere Kinder)– sog. patchwork Familie, oder sogar homosexuelle Familie.
- Langfristiges Risiko der rechtlichen und wirtschaftlichen Konflikte mit dem anderen biologischen Elternteil.

Man sagt, dass derjenige, der hoch bauen will, muss zuerst in die Tiefe gehen. Wir müssen eine Basis schaffen, auf der wir bauen können. Familie, Gesellschaft kann doch nicht „hohe" Beziehungen auf seichten Grundlagen bauen. Reife einer erwachsenen Person wird doch durch die Qualität der Beziehungen gemessen, und nicht durch ihre Quantität. Wenn ein Mensch beginnt „verdorbene" Familien, Beziehungen abzulegen… verstreicht dann nicht aus der Gesellschaft Verzeihung, Annäherung, Ehrfurcht und Respekt gegenüber den anderen, was eigentlich Zeichen einer reifen ausgeglichenen Persönlichkeit sind, die nützlich für die ganze Gesellschaft sein kann? In meinem Vortrag habe ich versucht, die Familie und Ehe als Institutionen dazustellen, die immer ihren speziellen und wichtigen Platz in der Gesellschaft haben, ohne Rücksicht auf die Schnelligkeit dieser Zeit, eingeritzte Tradition oder Diversität in der Kultur.

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"Technology-Dependent Children" and Paediatric Palliative Care – The Future of Today's Reality?

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Introduction

In recent decades, medicine has observed a significant development in terms of pharmaceutical industry and new technology. Medical research as well as sophisticated and often extremely costly treatment procedures (new drugs, technology, and equipment…) have significantly improved the life expectancy of children suffering from acute as well as chronic diseases including extremely immature newborns. Besides life expectancy, also prognoses have improved for children suffering from severe diseases such as solid tumour, hematologic malignancy, or cystic fibrosis. Some of these children's lives depend upon different levels of technological support.

The meaning of the term "Technology-Dependent Children"

„Technology-dependent children“ (TDCH) has been defined by the United States Congres OTA (Office of Technology Assessment) as early as in 1987 as a children using medical equipment that compensates for a lost vital bodily function, who requires long-term health care to prevent death or further damage.

Some of these children only need a single aid/device, however, 2/3 of them depend on multiple types of technology. The most frequent devices include nebulisers, dialysis machines and catheters, feeding pumps and tubes, long-term intravenous catheters, oxygenators, ventilators, and others. The frequency of their use is variable and depends on the child's diagnosis and their degree of disability (e.g. peritoneal dialysis for 8 hours a night, 6–7 times per week, artificial nutrition in 90-minute intervals during the day and continually at night, permanent artificial lung ventilation, etc.). The terms „high-tech“ (e.g. child using permanent ventilation) and "low-tech" dependent child are also used (e.g. child with colostomy, temporarily dialysed child...). Figures 1 and 2

Basic categorisation:

1. ALV (artificial lung ventilation) dependent children
2. children requiring long-term parenteral nutrition or intravenous treatment,
3. children requiring respiration or nutritional support,
4. children requiring cardio-monitoring, dialysis treatment, children with stomas and permanent urine catheters.

How many children are there whose existence depends upon medical technology?

The data on the TDCH numbers are insufficient. The relevant data provided by the OTA study in the US are more than 20 years old. According to those findings, there were 50,000

technology-dependent children in the US (approx. 5 children per 100,000 citizens) out of which 2,000 children required permanent ventilation support. In Utah, the number of children requiring home ventilation increased 25 times over 20 years! A similar increase was observed in England; in 2001 there were 6,000 TDCH recorded out of which 141 were on permanent ventilation. In 2008, 933 children were on permanent ventilation, i.e. their number increased 6 times over 8 years. There are no relevant data on TDCH in Slovakia, however, according to the data provided by health insurance companies, 61 patients on home lung ventilation were registered as of 31 December 2012. Table 1

The current trends in TDCH care

These children receive care in:

- hospitals,
- hospices,
- at home.

Home care is significantly preferred in many states; from the viewpoint of the state and health care system, it represents a major decrease in the health care costs and transfers the responsibility to the family and relatives. For instance, yearly costs for a home-ventilated child in England represent £100–250,000. Health care provided to such children at an ICU would cost £750,000 a year (almost €900,000; authors' note – in our conditions the costs are almost 40 times lower).

The basic preconditions for TDCH care at home include:

- free will and ability of the parents to provide the care,
- relatively stabilised child,
- equipping the home with the necessary technology (aids, devices),

- availability of professional health care staff (continually, daily, intermittently) according to the disease severity and technology used,
- possibility of resolving unexpected complications including urgent transport into a health care facility, etc.

Despite initial enthusiasm in the family and among relatives, caring for a disabled child brings many unexpected events, which may seriously affect the family life. According to the relevant literature, the consequences of TDCH home care can be divided as following:

- ✓ Normalisation efforts – the effort to emphasize equal development and opportunities for the both disabled (TDCH) and healthy children. However, after some time, parents begin to realize the inexorable reality, e.g. that the child's movement is restricted by the technology that keeps them alive. The presence of medical devices and monitors itself as well as frequently visiting health care professionals in the home environment significantly affect the normality of the child's life. Another serious factor that affects the family life is noise generated by the operation of devices (ventilator, oyxgenator) and of course, monitor and device alarms in case of fault or another event.
- ✓ Social isolation – another consequence of living with a TDCH affects the child, family as a whole, and also its members as individuals. Social isolation negatively influences not only the mental health of the child or young person whose life depends on technology, but also their parents.

- ✓ Emotional burden – emotional and physical load accompanying the effort to provide the best TDCH care as possible may bring severe consequences. According to the relevant literature, as many as 50% mothers caring for TDCH suffer from depression. Interestingly, the incidence of depression correlates rather with the child's technological dependency rather than their disability level – it increases along with higher technological dependency. Further emotional burden results from the many painful procedures the parent must perform for their child and the fear that their child could suddenly die at home.
- ✓ Financial and other deprivation – naturally, one of the parents has to accept full time TDCH care at home, which means temporary or permanent loss of employment along with income. Another possible problem is the loss of privacy as the specialised nursing staff is often present.

TDCH and the paediatrician of first-contact

As previously mentioned, TDCH care is performed in a hospital, hospice, or at home. Each possibility has both pros and cons. In Slovakia, there is no specialised hospice or ward where TDCH would be provided as long-term care; their role is substituted by hospitals. Certain hospice-type mobile devices provide children with complex palliative care, but their performance is limited mainly by the willingness of the family to cooperate, their availability, and distance. However, not every TDCH requires palliative care! A large group of these children have relatively good prospects and there is a possibility they can return to normal, fully-fledged life (e.g. child undergoing peritoneal dialysis awaiting kidney transplant).

Every doctor of first contact, whether a GP or paediatrician, has a patient dependent on a certain level of technological support. It is important that a TDCH is cared for at home by an experienced, educated family whose members are managing basic and specialised nursing care well. In cooperation with the "mother" workplace usually represented by a regional clinic/paediatric anesthesiology and intensive medicine ward, parents provide quality and safe health care in the home environment. An important part of care is provided by the GP specialising in children and youth who ensures prevention, observes the child's mental and motor status/development, helps resolve certain technical issues, and in case of need, orders early hospitalisation of the child based on clinical/laboratory examination.

Palliative care

Palliative medicine is a specialised field that deals with diagnostics and treatment of patients suffering from incurable chronic diseases and actively progressive diseases with limited life expectancy. Its goal is to maintain as high a quality of life as possible until the patient's death.

Not every patient who depends on a technology to some level is receiving palliative care. Technological devices are often used only for bridging or resolving the given situation. For instance, a dialysed child can live a completely normal life after receiving a kidney transplant and does not need elimination treatment.

If the patient receives palliative care, the following principles should be observed:

1. Patient's own will (besides situations specified in points 5 to 7).
2. Rejection/cessation of liquids and nutrition supply is not acceptable.

3. Before stopping the life-sustaining therapy, the main doctor must be consulted.
4. Each decision on a further treatment procedure must be documented in writing.
5. Prescription/application of painkillers/discomfort reducing drugs in high dosage to a patient in the terminal stage of their illness that causes death is forbidden and will be prosecuted.
6. Despite the patient's wish to accelerate their process of dying, this (euthanasia) is forbidden.
7. Assisted suicide is forbidden and it is necessary to be aware of the valid legislation.

Conclusion

Despite the lack of data pertaining to Slovakia, it can be assumed that the number of children whose lives depend upon different levels of technological support (temporary or permanent) is increasing. The current trend abroad – TDCH home care – is also observable in this country. However, not all parents are able to manage home care for such children as it is extremely physically and psychically demanding. The day-to-day reality of home care accompanied by the effort to normalise the child's life may result in negative issues such as social isolation of both the child and family; emotional and physiological stress; loss of privacy; and financial deprivation, which negatively affects the whole family. There are people who refer to caring for their technology-dependent children as "living on the edge." Despite the presented negative aspects, TDCH home care also provides positive results – certain families draw energy from the unequivocal positive influence of the home environment on the disabled child; some parents have been able to adopt a positive attitude

to life, personal strength, and become more empathetic and communicative.

A large number of these children are permanently committed to standard or intensive care paediatric wards, infants' homes and other asylum facilities, which are unable to provide TDCH with complex care due to obvious reasons. It seems that the medical authorities together with the general public must create pressure to initiate the establishment of a specialised paediatric hospice-type facility(ies) for children who cannot benefit from home care due to a variety of reasons. It will also be important that the families who decide to "live on the edge" and accept all the positives and negatives, which accompany TDCH home care, receive the necessary psychological and economic support.

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COUNSELLING FOR THE CLIENTS OF SOCIAL WORK PROVIDED BY THE ASSOCIATION FOR SOCIAL DEVELOPMENT AND SUPPORT FOR THE CITIZENS OF THE SLOVAK REPUBLIC

ANDREA GÁLLOVÁ

Introduction

The Universal Declaration of Human Rights adopted on 10 December 1948 in its Article 23 declares that "Everyone has the right to work, to free choice of employment, to just and favourable conditions of work and to protection against unemployment." The right to work belongs among the most essential rights of man in society. The right to work is found in a lot of international and national legal documents, such as The Universal Declaration of Human Rights, International Covenant on Economic, Social and Cultural Rights adopted by the United Nations in 1966, which entered into force in 1976, also Encyclical Laborem Exercens (about human labour) dated 14 September 1981.

Counselling for the unemployed is perceived as a specific professional activity, as a process of help using existing sources and possibilities of individuals to handle current problems in their lives. Identification of the problems serves to determine the contents and focus of the counselling, which may be of a legal, economic, psychological, health and social nature.

Clients must be active part participating in solving their problems and not only a passive participants who just receive the instructions and directions given by the adviser. In the Integration Centre of Social Assistance the Association for

Social Development and Support for the Citizens provides free legal, financial and social counselling for citizens.
Specialists are comprehensively engaged with citizens and their individual problems, but also with groups and communities at local and municipality level. Active cooperation with all social parts at regional and state level contributes to a better employability of the unemployed in the labour market and also to a better tackling socio-economic problems in society and removing socio-pathological problems in families.
The role of the Integration Centres of Social Assistance consists in active participation in tackling socio-economic field of regions and this way to contribute to increasing the quality of life of the citizens living in individual regions.
Their role is to actively develop qualitative level of cooperation with state, public institutions, towns´ and municipal self-administrations, enterprise sector, the third sector, legal and physical entities at the regional level. Solving the issues of social problems of the citizens within a region is perceived as a need to help at the level of individual society segments, where a segment / some segments are not functional / are failing.
This is a phenomenon, which requires intervention not only for the benefit of an individual but also for the benefit of a whole group or community in a certain region. All these activities lead to the promotion of development of client´s / group´s /community´s potential, among which there is also the issue of unemployment and its reached level in individual regions, which is alongside others considered to be priority social issue needed to be perceived separately, individually and to base it on specific needs, possibilities of individual regions / regions most affected by unemployment as an undesirable social phenomenon.

The activities of a preventive character, which are realized at the centre level: in relation to clients / users / citizens, in relation to a social problem of inhabitants within a region (edifying, prevention, search activity), active participation in resolving social events, contribution to social guarantees, social cohesion, establishment and consolidation of social segments through development of active social communication with all concerned subjects in a given region.

Promotion of social functioning of clients: consists in the help to renew or acquire such capabilities and information which enable clients to cope with the requirements within the environment or to influence those demands of the environment which are inadequate or problematic for the client. In these terms, social workers, specialists of helping professions are persons implementing the changes in society, but also in individual´s, family´s, community´s life in a given region.

To support clients and help them to be self-sufficient: professionals of the Centre support clients´ responsibility for their lives, lead them to be self-sufficient and give them an opportunity to use their own power and abilities to overcome the situation in which their clients are, where the professionals undertake a certain degree of responsibility, participation in resolving and preventing clients´ social problems through being directly involved in the happening and solving all social processes and social events, to which unemployment issues primarily belong.

On the basis of that the professionals and workers of the Integration Centres of Social Assistance: can provide emotional support, they help clients to identify their strengths and weaknesses, they can clarify clients´ rights and manners how to exercise these rights, they help clients with making decisions, undertaking responsibilities, they support clients to

obtain and enlarge information, abilities and skills which reinforce clients´ self-sufficiency, renewal of working habits and skills which strengthen their self-sufficiency, renewal of working habits and skills, development of individual and team abilities and enlarging individual possibilities within social competence, social participation, they act in clients´ interests, defend and explain their legitimate interests, create and develop partner relationships in the frame of active cooperation and based on the principles of mutual trust, deference, respect and qualitative human relations.
The Integration Centres of Social Assistance also provides for maximum level support, care, protection and control, the professionals are involved in prevention, they pursue a search activity towards institutions, organizations, enterprise sector, town and municipal self-administrations, non-profit sector, legal and physical entities within a given region.

The mission of the Integration Centres of Social Assistance within their work with families is perceived at the following levels:

a) at the level of understanding family as client´s (individual´s) environment. Social work is focused on removing or alleviation of social problems of an individual through a family system, which constitutes one of possible sources of origin and solution to the client´s problem,

b) at the level of understanding the whole family as a client. Social work is mostly focused on the change of family system functioning or on adaption of a whole family to new conditions.
The professionals of the Centre must assess the client´s situation globally from the point of view of the client as well the environment in which the client lives and which

influences the client. On the client´s side there might exist number of barriers which limit the social functioning. It is the task for the professionals to consider which of these factors are the key ones.

Adequate help is always influenced by particular situation in which clients currently find themselves.

Another significant attribute is recognition of the fact that on the one hand the task of the Association for Social Development and Support for the Citizens is to help clients, but on the other hand they must respect social requirements based on which they follow, build and strengthen social bonds, social partnership and lead social dialogue with all social segments for the purpose of solving social problems. It is to say that society provides a certain normative frame for granting aid. It creates rules and standards which must be respected by the Integration Centres of Social Assistance.

Therefore it requires more effective cooperation of all assisting professions, which is in this case a guarantee that problems within families may be prevented more effectively.

The mission of the Association for Social Development and Support for the Citizens is: to associate professionals, solve, assist and through professional activity participate in the fields which aim to reach social well-being, social guarantees, quality of life, social justice, equality, social freedom, employability, social development, democratization, humanization, respect for and promotion of human rights and civil liberties and support for the citizens in the territory of the country, to allow, assist, activate and form a place for effective and meaningful communication and cooperation, lead social dialogue and develop social partnership, take part in solving social problems at local, regional and nation-wide level, solve existing social problems at local, regional and nation-wide levels and this way contribute to enhancement of

living conditions and life quality of all citizens within the entire society.

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PATIENTS BEING TREATED WITH DIALYSIS AND THE PROBLEM OF POVERTY

Martina Vnučáková

ABSTRACT:

The contribution is dealing with the problematic of poverty as a social phenomenon from the health point of view. It presents results of the survey focused on the views of patients with chronic kidney disease, treated with dialysis on the problematic of poverty in the dialysis centre B. Braun Avitum s. r. o. Trstená. The survey was performed in November 2016. The sample consists of 34 respondents. When performing the survey part, we used the empiric research, quantitative methodology. The data were obtained by means of a narrative interview extended of a questionnaire method. Based on our own results, we hereby present proposals for improving social and economic situation of dialysis patients.

Keywords: Patient on dialysis . Poverty. Health.

Poverty is not a problem of an individual only, but also an economic, social, cultural, political, ethical, and health problem. Poverty is classified as a negative social phenomenon with adverse impacts on the overall length of one's life and its quality. Social exclusion, discrimination, and poverty also affect the group of older citizens. From the aspect of the social work and help for the patients on dialysis., the problematic should be talked about and analysed and we should study its various forms, causes, impacts, and, most of all, search for methods of solution and elimination of its consequences. Diseases have never been an isolated phenomenon. They have always had social associations,

consequences, and often also causes. When providing a complete healthcare, it is therefore impossible to ignore social associations of a disease. The increasing ageing index and average age of the population together with the expected growth of costs for the social care and healthcare represent a great challenge for the current society. Prospectively, seniors and children are the most relevant marginalized, disadvantaged, and vulnerable groups of citizens.

End Stage Renal Disease (ESRD) the worst stage of chronic HYPERLINK "http://www.kidney-symptom.com/chronic-kidney-disease/" HYPERLINK "http://www.kidney-symptom.com/chronic-kidney-disease/"kidney HYPERLINK "http://www.kidney-symptom.com/chronic-kidney-disease/" HYPERLINK "http://www.kidney-symptom.com/chronic-kidney-disease/"disease significantly changed the life of an individual, since it cannot be cured.

The patient is reliant on dialysis, on the medical team Since the kidney failure is a life threatening condition, the long-term dialysis is an inevitable solution for the patient. As resulting from the aforementioned facts, the care of persons enrolled in the regular course of long-term dialysis should be viewed from the overall point of view, i.e. through the healthcare, social care, social assistance, and psychological and spiritual assistance.

In 2014 we had 75 active dialysis centers or workplaces with 856 beds for adults and 9 for children. 4,302 patients were maintained by chronic dialysis.; this is the highest number within the monitoring period of ten years.

The highest number of patients (34 %) belong to the group of **70** and more years, 31 % of patients belong to the age group from **60 to 69** years, and 19.4 % belong to the age group from 50 to 59 years. 24 patients (0.6 %) at the age of

less than 18 years were on dialysis. (National health information center)

Disadvantaged or vulnerable or marginalized communities are the groups of citizens that, due to various objective or subjective reasons, have not the equal access to education, healthcare, employment, and other areas of the social life. Disadvantaged groups of citizens include, for example, disabled persons, unemployed, homeless people, children and young people from socially deprived and one parent families, seniors, and Roma communities living in separated and segregated dwellings. Being a part of a disadvantage group of citizens means, first of all, living in poverty.

“ The government of the Slovak Republic has the goal to integrate the Romani people into the society at all its levels. In Slovak context there is a high extent of social distance in connection to the Roma people and their low extent of emancipation connected with poverty and negative economic impact on overall quality of their life, which are two factors preventing creation of functional multicultural society.” (Gállová, 2017, p. 120)

Survey methodology and characteristics of the survey sample

The quantitative survey was performed using the questionnaire method in dialysis centre B. Braun Avitum Trstená. For performing the survey part, we used the empiric research, quantitative methodology. Respondents filled out the questionnaire at the presence of the inquirer. The data were obtained by means of a narrative interview extended of a questionnaire method. The basic group consisted of the patients treated with haemodialysis.

Selection criteria were chosen as follows:

- medical diagnosis chronic renal failure N 18.5 and the treatment applying haemodialysis, peritoneal dialysis, transplantation
- age range from 20 to 90 years

The entire survey was performed in the dialysis centre B. Braun Avitum s. r. o. Trstená in November 2016. The survey sample consisted of 34 respondents representing the rate of return of 100 %. The overall number included 47 % of women and 53 % of men. The average age of women was 61.31. years and of men 61.11 years. 14.70 % represented persons living alone; 85.30 % of respondents have lived with their families. 4 respondents were obliged to provide maintenance and care of children.

Incomes of respondents

Financial income is an important component of the household budget. In the case of our respondents, the greatest part of incomes was represented by disability pensions (35.30 %), old-age pensions (58.80 %), and sickness benefits (5.90 %). The overview of income amounts are stated in the following tables.

Table 1: Monthly incomes of dialysis patients

gender	male	female	sickness benefit
Pension in EUR	384.44	295.44	235

Source: Own survey

The at-risk-of-poverty rate from the income point of view seems to be higher at females than at males. The amount of pensions is also relating to education. In our survey, 26.47 % of females had the primary education only.

Table 2: Education of dialysis patients

	primary	secondary school	secondary specialized school/leaving examination	University
education	13	10	10	1

Source: Own survey

People living alone represent a special risk group, since it is expensive for them to cover costs for their households and medicines. They cannot afford buying new clothes and shoes. They have problems with extraordinary costs: fees for electric power, water, maintenance and purchase of electrical appliances. They are then forced to borrow money. From the age point of view, 70- and more-than-70-years-old respondents felt being at risk of poverty. It was an interesting finding that the groups younger than 60 years had no financial problems with covering the most basic needs, but they felt being at risk of poverty mainly in the case of a loss of their relatives.

The process of transferring from the perfect health condition of working-age patients to the dialysis treatment represents a great financial burden in the case of the sickness leave that could last quite a long. If a patient is a family provider, the risk group also includes his/her family.

Expenses for medicines and healthcare are of especially great significance at patients suffering from chronic diseases.

Table 3: Monthly expenses for medicines of dialysis patients

	up to 44 years	45-59 years	60-74 years	75 years	average
expenses for medicines /EUR	20	36.11	47.77	53.33	39.3

Source: Own survey

From the age point of view, seniors seem to be a risk group threatened by higher costs for medicines. Social disadvantaging of seniors is supported by special features of diseases at higher ages, chronic diseases

We were interested in impacts thereof on financial requirements for households.

Table 4: Do you have financial problems with covering monthly expenses for household services?

	town	**village**	**SHs**
seldom	1	13	1
sporadically	2	9	
often	6	1	
always	1		

Source: Own survey

It is easier to cover financial requirements for households for respondents living in villages. It is also given by the fact, that households in villages include more household members to the contrary with towns with a higher share of the respondents who live alone. In villages, expenses for food and heating represent savings, since the respondents are able to cover them from their own resources.

Possible savings and reduction of expenses are stated in the following table.

Table 4: Elimination of expenses

	completely eliminated	**partially eliminated**	**not eliminated**
heating in households	12	18	4
water consumption	12	18	4
meat consumption	14	14	6
fruit and vegetable consumption	21	12	1

Source: Own survey

Subjective perception of poverty is based on feeling insufficiency at those who rates poverty upon their own experience; they are not satisfied with the existing condition. Subjective or situation or factor poverty may be concerned here.

Table 5: Opinions of respondents regarding their feeling of being at risk of poverty

low pensions	61.80%
high costs for households	44.11%
high costs for medicines	72%
inflation	20.58%
health condition	85.29%
lack of information of means of help	14.70%

Source: Own survey

Suggestions and recommendations

In the contribution presented we tried to give an idea of perceiving poverty by dialysis patients. Findings of our survey point to several areas to be known for being able to provide assistance to such patients. Work with seniors, work

with families, lonely individuals, the area of education and awareness.

In the case of a social worker and social work with a patient on dialysis.:

Create conditions for the development of social work in the health sector

Social work with seniors suffering from chronic renal failures

Social work with families

Social advisory area

Tasks and responsibilities at the political level at the acts preparation

Now I would like to quote prof. Bielova, who has taught us that health was not only "*the condition of absolute biopsychosocial well-being"*. (WHO, 22 July 1946) As she believes, such health perception might tend to the fitness idolatry (adoration of physical condition and hedonism unable to process diseases and sufferings); she quoted to us the anthropologic-personological definition of health and tried to make us accepting it, because acting in compliance therewith was conductive to the whole social system. I'm offering the quotation in this part of my contribution, because it holds the mirror up to the society oriented on the economic performance and profit only, which are insufficient if built on other foundations than respect to humans, their value, and natural principles of justice that are far away from justice as wanted by the will of the powerful and wealthy. *"The true health is the direction towards the project of truth and filling every human being with humanity. It is harmonization and integration of every kind of human, physical, psychical, and spiritual power and energy. It is the ability to daily respond to one's own mission, giving in every situation one's best."* Karl Barth, the dogmatitian adds: *"It is the power to be a human."* In spite

of the lapse of time of more than half a century, there's nothing obsolete in the Barth's statement. To the contrary.

Tasks and responsibilities at the social level

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KNOWLEDGE OFTHE TARGET GROUPOF POTENTIAL PARENTS AS ONE OF BASIC CONCEPTS OF THEPREVENTION OFSOCIAL PATHOLOGY OF FAMILIES

Miroslava Jagelčáková Schifferdeckerová

Ján Šuvada

ABSTRACT

The paper is inspired by agroup of young people – high school students in the Orava region,withwhomwehavebeenvividly discussing thei rvisions of marriage and family, their fears, positive experiences and disappointments from the irown families.These debates were also the startingpo int for the creation of therese archintention, of which wepresent some of there sults.Wecon sider it important to focus attentionon preventin gundesirable phenomenain the family through primary and secondary social prevention aim edat secondary schol students, eitherthroughhigh-quality,direct and follow- up education for marriage and parenting, butals othrough school social work, which also has a preventive character .

ÚVOD

“Family experiences are becoming the basis for developing attitudes to different areas of life. The child perceives things in their simplicity and considers what they are experiencing in their family as the norm. ” (Ruttmarová, 2006, str. 3).

Young people have a great potential that needs to be developed and directed so that their actions and decisions are in line with the essential values that must be respected and maintained for society to function.

In this context, we see a great need to communicate with young people about marriage and family. Nowadays, several phenomena can be observed in connection with marriage and parenting education. On the one hand, sexuality is no longer taboo, it can be discussed, which could be a prerequisite that marriage and parenthood education and sex education as part of it can be presented in truth and greater sincerity. (Augustyn, 1998). This requires dialogue: dialogue between parents and children and dialogue between teachers and their students. On the other hand, it depends very much on what environment young people come from. Whether it is an environment that relativizes values and offers "instant" solutions that often lead to fatal decisions in relation to the partner, its value and new life, or it is an environment that respects natural law and values. In 2011, we conducted a research aimed at finding out the status of value orientation towards the institute of marriage and family among young people in the Orava region. In 2018, we continued this idea and repeated the research. This gave us two sets of data that inspired us to reflect on some facts about the prevention of socio-pathological phenomena in the family.

1 CHARACTERISTICS OF METHODS AND TARGET SAMPLE

The target sample consisted of third year students of all secondary schools operating in the Orava region. 300 respondents were included in the target sample in 2011/2012 and in 2017/2018,. The ratio of boys and girls and the ratio of type of school of the total number of third-year students in the Orava region was kept. We used a multi-stage stratified sampling to respect the set objectives and overall research intent. Of the total number of questionnaires distributed to us in 2011/2012 returned 280. Of these, we excluded 21

questionnaires for incompleteness. We evaluated 278 questionnaires in 2017/2018.

53.67% of boys and 46.33% of girls were represented in the sample in 2011/2012,. 85.33% lived in acomplete family, and 14.67% lived in a single-parent family but the reasons for which the family is incomplete have not been investigated, but a detailed analysis of data from individual questionnaires revealed that it is most often the death of one parent or divorce. We collected the data through the questionnaire we created. The questions in the questionnaire were created taking into account studies that have already been carried out taking into account the specificities of the target sample.

When sorting the collected questionnaires we also sorted the questionnaires according to the type of education. Taking into account the needs of the qualitative analysis and the objective in particular, we have created three categories of school: **grammar school, secondary technical school with leaving examination, apprenticeship**.

The obtained data were processed in two phases:

1) Descriptive statistical processing.

2) Qualitative analysis of open questions

The overall analysis is very extensive, so let us choose only a few key ideas that relate to the topic of our contribution. We will focus on cohesion of the family. We will approach the group of respondents with low family cohesion, which may be a potential risk factor and briefly summarize the basic findings that were decisive in formulating proposals for the marriage and parenting education or for school social workers.

2 RESULTS

Cohesion in the family, as conceived in our research, does not presuppose the complete eradication of differences in family hierarchy and natural differences arising from

family roles. We start from the knowledge that social cohesion in society means trying to create a peaceful coexistence of a community whose members have different characteristics, reducing disparities and guaranteeing social justice. The society is making efforts to ensure that these differences do not widen and become the basis for instability in society.

"*The natural family is a place where, even in modern times of technical wonders,goods are allocated, distributed according to need, not merit. Nevertheless, every functional family understands this as justice, not harmfulness, because one of the criteria is the future and the responsibility for it. "* (Bielová, M. 2005)

The family counterbalances the functional system by providing its members with inclusion as complete persons.

"When family members stand together in good and bad terms and help each other, they solve a number of social problems themselves." (Fórumkresťanskýchinštitúcií, 2018)

Cohesiveness in the family also expresses a sense of belonging. Individual answers can be seen as an expression of the respondents' individual relationship to their own family.

According to Plaňava (1994), family and marriage can be characterized by four basic components: family structure, personal autonomy, values and attitudes, and intimacy.

Intimacy means emotional qualities, feelings and awareness of mutual proximity, expressions of interest, warmth, cohesion (cohesion), support and interdependence. (Plaňava, 2000).

In our research, we focused on the cohesion of the family, which the said author included in the field of intimacy. Cohesion in the family is many times a weak link in families. Very little is invested in building positive

relationships between family members, even though they are the key to a quality happy family life. We surveyed respondents' attitudes towards their own family. Individual questions related to family relationships: between father and child; between mother and child; between parents; between respondents and siblings. We also focused on family environment (relationship ...).

In evaluating, we assigned each option a value (3-0), descending (except for question 6.15, there we assigned it ascending (0-3).

We summed the values of each question and the score is divided into four groups:

1) 0- 20 => Lowest score 2) 21- 31; 3) 32-42 43-51 => Highest score

In 2011/2012, the lowest score had 5.79% of respondents and 45.95% of respondents had the highest score. In 2017/2018, 2.78% of respondents had the lowest score and 24.60% of respondents had the highest score. . This means that the number of respondents between the firstand the third quartile, which are the imaginary center, has increased.

For respondents with the lowest score, however, we see room for intervention. They are boys and girls most endangered by external influences and other factors, so we devote a separate subchapter to them.

2.1 RESPONDENT FAMILY CHARACTERISTICS WITH THE LOWEST SCORE

The reasons for the reduced score are different - missing mom / missing father in the family, not answering all the options. For others, the score was lower especially for items related to parent and sibling relationships. Girls and boys from this group are more reserved in their responses. Less often, they express their feelings with the answer "I

agree". This was reflected in almost all the answers. After analyzing the individual answers, we can conclude that the weaknesses are from the respondents' point of view in the following areas:

o **The lack of interest of parents, especially the father.**

o **Disturbed relationships:**parents / children / siblings.

o **Impaired need for belonging** (they do not trust their problems, they relax best outside the family, they are not able to talk in the family about things that interest them and about plans for the future ...).

On the other hand, these respondents have sufficient material needs. 90% of respondents in this category were positive about *"I have always received the necessary food, clothing, housing and pocket money in my family"*.

Satisfying material needs does not mean that there are no problems. Families with a lack of love and belonging should be the subject of increased attention. They are the children of these families who often struggle with problems that affect their view of the outside world.

Boys and girls are aware of the need for proximity to their parents, and despite external manifestations, which may sometimes speak to the contrary, they need emotional ties with their parents. Respondents' experience of parental love affects their direction. Education in love, the environment in which one is accepted, teaches, among other things, the ability to give oneself in relationships while respecting oneself. Boys and girls who have the opportunity to experience the unconditional love of parents and have good "emotional contact" with them (Augustin, 1998, p. 16) are emotionally stable and balanced with their femininity and masculinity.

Families characterized by a lack of love and a lack of need for belonging should be the subject of increased attention,

although this is not a large sample. The children of these families struggle many times with problems affecting their relationship to themselves, experiencing their own sexuality and their interpersonal and partnership relationships. This evaluation represents the client's subjective feelings and his / her attitude towards his / her own family. He/she also speaks about the position he/she holds in his/her family. For this reason, it would not be correct to say that the sense of belongingand cohesiveness of the family in no way affects the attitude to marriage among respondents. We consider this information important in case of individual work with a young person, resp. working with a small group.

3 DISCUSSION

High school students have revealed their view of marriage and family. What is a very valuable starting material, which indicates to us the possibility of focusing marriage and parenting education. We have formulated a number of areas that need to be given increased attention.

3.1 SOME CURRENT NEEDS IN RELATION TO EDUCATION FOR MARRIAGE AND PARENTING

If we want to get closer to young people, we must first listen to them. Young people are very creative and interested in topics that concern them. However, they need to be motivated to be willing to express themselves. Excessive directive leads to passivity. On the other hand, we are aware of the limited space due to the density of study plans. Where there is will, space will be found, and we will see that in contact with many enthusiastic high school teachers. Therefore, we present a number of topics for discussion that could inspire teachers and educators in dialogue with students.

- **The need to talk about your feelings, opinions, express**

them and know how to listen to others

The key problems arethe communication with the other sex, understanding its way of thinking, feeling and the way it expresses its love, needs, disagreement or consent. How to resolve conflicts and burdens.

It is necessary to choose from the offer of organizations and experts that could contribute to this goal. It is possible to invite a psychologist, a married couple or other experts. There are also communities that have trained young people who can discuss with young people about relationships in a married couple, about differences between a man and a woman, and about the perception of the world. Experience activities allow young people to realize these differences and the need to respect and accept another person. On the lessons of religion, ethics and civics, classroom lessons, or other social science subjects, there would certainly be a space for activities of this kind.

Special attention is required for boys of apprenticeship study field, who are much slower to develop their orientation and attitudes in relation to their future marriage and, above all, the role of paternity compared to girls. Boys are often unable to talk about their feelings and opinions and often lack adequate vocabulary. It is necessary to work with the group and give everyone the opportunity to express themselves. A discussion that could be preceded by a survey among the target group of students could help. Preliminary statements of exempted answers provided by students could be discussed, or other youth research could be an inspiration.

- **The need to target young people from a family environment marked by the crisis**

The young person also confronts his own family in shaping his attitude towards marriage and parenthood. The critical view of the family is natural at this age, so it is necessary to

perceive signals that indicate problems in the family and to work with these students in an appropriate way.

3.2 USE OF RESEARCH RESULTS FOR SOCIAL WORK

A family founded by marriage is a natural institution that protects the good of its members. It fulfills important functions that no other institution can fully replace and has therefore always been at the center of social work. The research results show inspiration for social work with the family in three areas:

1) Prevention of unwanted phenomena in the family, especially in the field of communication and intimate relationships.

Through youth programs, eg. also in cooperation with the school and other experts, respectively institutions could be done regular activities in an experiential form focused on the issues of intimate relationships, interpersonal communication, self-esteem and respect for others. In this context, Augustin (1998) emphasizes the complexity of sex education, which is an integral part of marriage and parenthood education. Those working with young people, educators, psychologists, social workers, priests and parents should try to create opportunities to talk about these topics. It is advisable, through publications, films, television programs, to create an environment that is open and encourages education for accountability for oneself and the family, including intimate relationships.

2) **Counseling and accompanying of families with adolescents.**

Adolescence is a challenging process not only for the children themselves, but also for parents and their surroundings.

3) Social work with the children from problem families.

We also perceive the increased need to address children from incomplete and disrupted families, who also sincerely show

interest in this topic but do not have positive patterns of spouses and parents in their neighborhood. . They are shy and have no one to lead the discussion on topics related to intimate relationships, marriage and family. Children from problem families also need to experience a secure receiving environment where they could open topics of interest to them without fear of being misunderstood, or rejected.

CONCLUSION

Young people are interested in topics related to relationships between men and women, marriage and family. Research has shown us areas that need to be strengthened with these students. It is mainly the area of communication, its content and external expression. Young people incomplete and broken families are also at risk.

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ACCULTURATION STRATEGIES

MONIKA NOVÁ

Annotation

The author (Ms Monika Nová) provides a review of effective and ineffective strategies employed by society to integrate migrants and pursued by migrants to integrate into society. The strategies are described in the light of the relevant theory, but also practical experience in working with the target group of foreigners. Having conducted a qualitative research based on her practice and supported by a focus group of intercultural workers, the author chose to split the strategies into effective and ineffective. When examining the theme of acculturation, she treats the subjects of integration, assimilation, marginalization, separation and segregation. In discussion the author looks at determinants, i.e. factors affecting the process of acculturation.

Key words: Acculturation. Determinants. Strategies.

Effective strategies of acculturation

Integration

Used as a strategy, integration might appear very promising, but it requires that certain initial conditions are met. In the process of integration people maintain their traditional culture but at the same time they seek contacts with new groups, try to enter them and become established in them (Berry *et al*., 2006, p. 306). Regrettably, the integration is impossible, unless the receiving society is favorably disposed to accept the members of also other groups, unless it is open to cultural diversity and does not hold any deep-seated prejudices. Concurrently, the newcomers have to be ready, at least to a degree, to identify themselves with the new group (Berry,

1997, p. 11). With these conditions met, a harmonious relationship between the already established dominant group and the newly coming group / groupscan develop - this development can then be regarded as one indicator of a successful integration.

In America, the result of integration is metaphorically depicted as the "salad bowl", where each piece of fruit or vegetable can add its unique taste to the overall taste of the dish. In effect, while the cultural heritage and integrity of people are properly respected, they can successfully establish and cultivate their relationships with the dominant society(Advani & Reich, 2015, p. 3).

In consequence, effective integration will be easier in multicultural communities already accustomed to the diversity of cultures and, therefore, better prepared to absorb members with different cultural backgrounds.

Assimilation

Assimilation is another strategy available for beneficial acculturation of people in a new society. The process of assimilation can be defined as a "method attaching just a marginal importance to maintaining the original culture whilepreferringblending into the new society" (Berry *et al*., 2006, p. 306). As obvious, assimilation tries to make the people "merge into the background" through espousing new habits and behavioral patterns in all walks of life (e.g. eating habits; greeting; leisure time activities). The relationship thus being built is apparently a one-way street where the newcomers try to adjust their ways to the dominant community.

The term assimilation is connected with the expression "melting pot" which conveys the idea of dissolving the newcomers in the dominant group.

This metaphor holds good especially for American environment wherein this phenomenon has shaped the national identity. At first sight the process of melting could spell the end of any specific features of cultural heritage pertaining to the newcomers, but it is not completely true. The process of "melting" may blur the specific features, but it may not annihilate them totally, since the society as a whole becomes more and more homogenous.

This concept is not likely to find favor with proponents of the traditional Anglo-Saxon paradigm of the melting pot who maintain that the pot contains a hard core of American national identity to which everybody must bow or at least try to bow (Orosco, 2016, p. 13).

A more conservative view of the concept is represented by a fusion model which accepts the existence of American national identity, but the identity is seen as fluid. When wedded, the Dominant and the New engender a unique identity which goes through an unending process of changing and reshaping (Orosco, 2016, p. 16).

Returning to assimilation we can say that (as opposed to the mechanism of integration whose changes in structure target entire groups) assimilation is rather a choice of an individual (Berry, 1997, p. 11). Still, even in the case of assimilation, the dominant culture may be found unprepared. While integration requires the absence of deep-seated prejudices, the same can be said about assimilation (Nguyen, 2012, p. 51). If the newcomers suffer discrimination, they may tend to reject the dominant culture and choose to separate or segregate from society, as described below. (Pavelková, 2016)

Ineffective strategies of acculturation

Marginalization

Marginalization belongs to the summary of ineffective acculturation strategies. This phenomenon is typical of just a

feeble effort put into maintaining own culture accompanied by a little interest in forging new relationships with the new culture (Berry, 1997, p. 9). Researches indicate that individuals opting for this strategy are in the worst mental condition (Socolov*et al*., 2017, p. 45) and most prone to develop problems associated with the acculturation stress, both also possibly related to insufficient social support (Berry, 1997, p. 24).

As a rule, marginalization is not a strategy chosen voluntarily (Mareš in Jarkovská, 2015, p. 171). Quite the opposite - it is often imposed on the individuals who then feel deserted by their own culture and discriminated against by the dominant culture (Berry *et al.*, 1987, p. 495). Attempts at assimilation, frequently guided andaccompanied by off-putting behavior of the majority, may induce the people to give up their previous culture without trying to embrace the new one (Berry, 1997, p.19).

Separation

A different example of ineffective acculturation strategy is separation. In this case the people avoid contacts with individuals from the dominant culture and cling to their own (Berry, 1997, p. 9). Separation, however, should be adopted voluntarily. No matter how strange it may sound, Berry *at al.* (2006, p. 328) believe that government policy allowing foreigners to choose whether or not they wish to blend in with the dominant society appears to be more successful than policy "compelling them to assimilate, for example by denying them their ethnic, cultural and/or language rights, or encouraging them to move out of their own community".

Segregation

Segregation is based upon the same premises as separation - the individuals stick to their own culture and do not contact the people of the new culture, but this time the situation, i.e.

segregation, is imposed on them by the dominant society (Berry, 1997, p. 10).

Determinants of acculturation

Kosteleckáat *al.* (2017, p.25) postulates two major categories of determinants involved in the process of migrant acculturation. The first category encompasses social determinants that find expression on the level of the entire country, e.g. migration traditions; government migration policy; quality of integration mechanisms; social and political climate; and the degree of discrimination and prejudices against immigrants. The second category contains personal determinants, e.g. socio-economic factors (inclusion in labor market; access to education; socio-economic status); socio-cultural factors (attitudes; values; language skills; relations with members of the dominant culture); and psychological factors.

Kosteleckáat *al.* (2017) alludes to the determinants of acculturation only when she is on the subject of integration.

Below, you will find the determinants analyzed through the eyes of authors who also addressed this theme.

Ideally, both the newcomers and the members of the receiving community should strive to coexist in respect of each other and, inevitably, to adjust to each other. Berry (2001, p. 619) observed that "this strategy requires that immigrants adopt the main values of their new society, but the society should be ready to adapt its national institutions so that they are better suited to the needs of all groups living within the plural society". The institutions to be thus adapted are primarily those providing education and health-care, but also those dispensing justice, and forgotten must not be a vast network of authorities.

The search for better understanding different integration strategies is associated with the concept of cultural identity,

i.e. a "set of notions and attitudes that people have of themselves as members of a cultural community" (Berry, 2001, p. 620).What is at issue here is whether or not, and to what extent, certain individuals are able to identify with their own ethno-cultural group and whether or not, and to what extent, they are ready to identify with the dominant group. In case a person is capable of identifying with both the groups, he or she can be successfully integrated. If, conversely, he or she feels attached to neither, the likely result shall be marginalization. Identification lopsided in favor of just one of the groups will produce assimilation or separation, depending (respectively) on whether the person favors the new group or the old one.

When going through factors that rule the acculturation of people in a new community, we cannot disregard the acculturation stress which many newcomers have to handle in their early contacts with the new culture. Berry *et al*. (1987, p. 492) define the stress as "caused by stressors attributable to the process of acculturation", i.e. stress rooted in meeting a new culture and driven by fears of coexistence with strangers. Such stress can translate into worsened mental health (e.g. confusion, anxiety, depression), feelings of exclusion and the overall loss of identity. All these problems can damage also other aspects of life and deteriorate the process of acculturation.

On the other hand, the acculturation stress may not develop at all, since some individuals are able to see the stressors as opportunities, or they can employ a better strategy of acculturation learning. Rudmin (2008, p. 118) depicts four major methods of acculturation learning: (1) seeking information on the new culture; (2) following given instructions (e.g. from authorities); (3) imitating the ways of individuals at home in the new culture; and (4) receiving

guidance from a person knowledgeable about the new culture and willing to provide this kind of social support.

Not surprisingly, a person knowledgeable about the new culture and providing expert guidance can streamline the entire process, impart information and help to establish social contacts.

Conclusion

The attitude that the dominant society takes towards migrants will depend on its type, but also on the manner of the migrants´ acculturation, i.e. on whether or not they want to retain their own cultural identity, on how they relate to their new society and how they share in its life.These factors are decisive for the form of inclusion in the new community - integration, assimilation, marginalization, separation or segregation. Berry *at al.* (1987, p. 492) identified one more factor: the type of individuals and/or groups that come to a new society. He then split the type into five categories: (1) immigrants (expected to stay longer); (2) refugees; (3) indigenous peoples; (4) ethnic groups; and (5) sojourners (expected to remain in contact with the new culture only temporarily). It is supposed that "those who enter the process of acculturation voluntarily, e.g. migrants, can experience less problems than those who were given no choice, e.g. refugees" (Berry *et al.*, 1987, p. 494) - our hands-on experience allows us to confirm this conclusion. The truthfulness of this supposition can be ascribed to the fact that immigrants coming voluntarily are open to changes and possibly even welcome them. Moreover, keen embracing of acculturation can pursue specific goals (Gibson, 2001, p. 20). Our qualitative research and practical experience lead us to believe that refugees fleeing from war could choose their destination only out of peaceful countries and could not consider any other factors - and they might be in for an unpleasant surprise.

We should not be unmindful of the fact that the success of integration stems also from the character traits of each individual as well as other demographic, social and psychological factors. Successful acculturation requires strategies effective in coping with stress and emotional burden. A certain role can also be played by education, age, sex, cognitive faculties and/or previous experience with an alien culture. Gibson (2001, p. 20) adds to this list of factors a socio-economic status, which she believes to influence where a person settles and what people he or she meets.Author Matejová says that the family needs help because the members are not able to solve problems or conflicts in the family, have a specific problem, or are unable to cope with the new situation.

Acknowledgements

Thetheme and researchofthispaper**„*Acculturationstrategies*“** wasrealizedfromtheproject: ***Právní a společenské aspekty migrace a problémy postavení menšin - Progres Q05*** and project***VEGA 1/0192/18 Formovanie postojov generácie Y v geografickom priestore V4 k problematike migrantov prostredníctvom digitálnej komunikácie na sociálnych sieťach.***

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RELIGIOSITY AND QUALITY OF LIFE IN THE ELDERLY IN SENIORS HOMES

Andrea Gállová

Abstract:
Nowadays, social services are significant part of activities and actions performed by public as well as non-public providers of social services in Slovakia. Current state of social services provision in Slovakia is based on the legislation frame, social policy of the state, development of the countries in the European Union and societal development of our country. Currently applicable Law Act No. 448/2008 Coll. on Social Services governs legal relationships within providing social services, financing social services, and supervising provision of social services by public and non-public social services providers.

Key words: Senior´s homes, senior, religiosity, spirituality, quality of life.

Introduction:

Contribution emphasises meaning of religiosity and quality of life of the elderly in the Senior´s homes. The theoretical part deals with the general conceptions againg and old age.

Satisfaction with the provision of social services in instititutions providing social services in Slovakia is one of the important indicators of quality, which determines the structure of the existing network of social services and demand for social services. Increasing life expectancy and ageing of population importance of examining factors is increasing. These factors affect ageing and quality of life in old age. Current state of social services provision in Slovakia is based on the legislation frame, social policy of the state,

development of the countries in the European Union and societal development of our country.

Currently applicable Law Act No. 448/2008 Coll. on Social Services governs legal relationships within providing social services, financing social services, and supervising provision of social services by public and non-public social services providers.

Life quality of seniors depends on their physical health, degree of independence, psychical functioning, adaptation on dominating emotional experiencing, psychical and social support, as well as on spirituality and religiosity in Senior´s homes.

We have determined the stage of research and implementation, research methods and in the end we will collect and process all the results of our research. This research has go two phases: qualitative phase (interview), quantitative phase (questionnaire).

In the reasearch part we will deterrmine the research problem, the research goal, the research questions and the hypotheses. Using the Squal subjective quality of life questionnaires and the Swedish Religious Orientation Scale (SROS) we identifily statistical indicators of research. We verify the normality of data distribution using the Kolmorov – Smirnov (KS) test and Sharipo – Wilkov (-W) normality test.

Methods

The research was focused on the attributes of religiosity and quality of seniors´ life in the facilities for seniors operated by public and non-public providers in the Region of Banská Bystrica.

The research intention is based on subjective approach concerning the detection of the quality of life of seniors placed in the facilities by means of questionnaire SQUALA.

In order to identify the religiosity we applied the Swedish scale SROS, my means of which we measured the dimensions of religious orientation. The method for the data collection was implemented by means of a questionnaire.

We circumscribed three types of the research problems: Descriptive (periphrastic) research problem, leading to the description of the reality, situation or phenomenon, asking about the importance values to which seniors living in the facilities for seniors attribute significance when searching the quality of life, values of satisfaction and the values from the scale of religious scale which influence religiosity dimensions.

The relationship research problem, focused on asking about the relation between certain phenomena, factors, agents, features and within the research we rose the questions whether there is a relation between the searched phenomena – a relation between seniors´ quality of life and measured values of the interiorized religiosity, measured values of external religiosity and also the relation between measured values of the retrieval and the relation between interiorized religiosity and the quality of life in dependence on the gender of seniors.

Basic research question was split into four partial questions and we were looking for the answers: Is there a connection between the dimensions of religiosity and quality of life in seniors living in facilities for seniors?

Result

The main goal of the research was to attest the set hypotheses and find out whether there is a connection between the religiosity and the quality of life in seniors living in a facility for seniors. The main goal was split into partial goals of the research, through which the relations between all other variables (dimensions of religiosity and dimensions of life quality) were revised in exploration way.

The complete group consisted of 489 respondents seniors at the facilities for seniors, 293 women and 196 men. The youngest respondent in the sample was 60-year old and the oldest was 91-year old. The studied group was not created through random selection.

We addressed all targeted available participants – providers of social services in the facilities for seniors in the self-governing region of Banská Bystrica as follows: at eight studied facilities for seniors operated by public providers, three facilities for seniors operated by non-public providers and two facilities established by municipality.

We electronically and personally distributed 649 pieces of questionnaires in to the selected facilities for seniors and 486 questionnaires were returned back to us from the respondents, which means 75.35 %.

At the beginning, the Folstein Test of cognitive function was used to evaluate the seniors´ abilities to answer the questions included in the questionnaires of life quality SQUALA and religious orientation SROS.

Consequently, the seniors who scored 24 – 30 points in the Folstein Test of cognitive function, which is considered to be a standard, were asked to fill in the questionnaires.

On the basis of the questionnaire we found out the extent of the importance and happiness of the respondents.

The SQUALA questionnaire included 21 areas of Squala 1,2,3,4,5. The instrument for the collection of the religiosity in seniors at the facilities for seniors was the questionnaire called the Swedish Religious Orientation Scale, which was supplemented with the dimension of searching. The scale SROS consists of 28 indicators in total.

Conclusion

On the basis of the research results we confirmed the assumptions concerning the connections between the religiosity and life quality at the facilities for seniors, the connections between the interiorized religiosity and overall quality of life in the entire studied group were confirmed – Pearson´s correlation coefficient 0.265 and the value of the coefficient of determination is 7.02 % and between the external religiosity and overall quality of life in the entire studied group - Pearson´s correlation coefficient was 0.182 and the value of the coefficient of determination is 3.31 %. A positive relation between the interiorized religiosity and subjectively assessed quality of life was revealed in seniors living at the facilities for seniors. We did not find out any connections between the dimension of searching and overall quality of life in the entire studied group – Pearson´s correlation coefficient 0.092, trivial value. The quality of life of seniors living at a facility for seniors is also influenced by social relationships, special circumstances, which play an important role when subjectively evaluating the factors of the dimension Squala 1,2,3,4,5. When the health care staff, professional employees in health care and social work fields and assisting professions understand the religiosity of the seniors living in seniors facilities, they will able to provide a better social and health care of a higher quality and the religiosity may be a very important factor or additional element in their treatment because in our research the life quality dimension squala2 health factor in seniors is a very important indicator. The results of the research indicate a positive influence of the religiosity on the indicator health and behaviour of the seniors, which confirms that the religiosity raises the overall quality of life in seniors facilities.

The research emphasised that if the function of the quality of life dimension squala1,2,3,4,5 with the factors of life quality in the interaction with religiosity dimensions is correctly understood, the work of professional as well assisting staff may be positively influenced in their provision of health, social services in stated institutions, which absolutely leads to overall well-being in seniors.

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Czech Republic minorities coming from south-eastern Asia

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Annotation

The paper introduces a target group of foreigners coming to the Czech Republic from south-eastern Asia in search of work. The scope of the paper dictates that the range of nationalities be restricted to just the Mongolian minority. The paper´s author exemplifies both good and corrupt practices. Relying on her own hands-on experience with the target group of Mongolian minority now living in the CR, she specifies the economic and social determinants of their migration and presents her research results.

Key words: adaptation, majority, minority, Mongolians

Introduction

In the relatively recent past Mongolia had to cope with pressure exerted by its two powerful and influential neighbors: Russia and China. Despite now being a sovereign state, Mongolia cannot boast of fully eliminating their restraining influence. If we choose to embrace Huntington´s division of world into different civilizations, the role played by Mongolia could be just opposite - the country could become a borderline between two civilizations: Western (as represented by Russia) and Chinese. Naturally, each will be keen to promote its own interests - it remains to be seen whether only to the detriment of the other party or also to the detriment of Mongolia itself. In point of fact, since the downfall of communism in Mongolia, China has been establishing a dominant economic position there. In so doing, China has replaced the gradually disintegrating Soviet Union.

Early in the 1990s Mongolia started to employ procedures which could be described as "westernization".

Given that Mongolia has no workable infrastructure and a greater part of goods has to be imported, the future might see the country fully dependent on its powerful neighbors. Even in the present, the Mongolian population has to face frequent price rises. Let us take bread as an example: a loaf of bread costs the equivalent of 70 CZK, while a clerical worker at the Municipal Authority of the country´s capital city earns no more than 200 dollars, i.e. approx. 4100 CZK. True enough, the official sources put the unemployment rate at 12.8% for 2018, but as follows from interviews with MsErdenebat, a member of Mongolian community, the reality is closer to 18 - 20 percent (Erdenebat, 2019). Personal experience gained by the author of this paper (Ms Monika Nová) shows that many a family has therefore decided to send at least one of their members to seek work abroad. Factually, these trips abroad in search of work have recently been taken by entire families, including their elders.

Though the destinations of preference are South Korea and Japan, where Mongolians try to win jobs, the recent years have witnessed the people traveling more and more often to also European countries, primarily the west European ones. All the target countries feature advanced economies troubled by a shortage of certain type of labor, particularly unskilled labor, which can suitably be remedied by hiring Mongolian blue-collar workers. Migrational movements prompted by such uneven distribution of economic attributes are treated by the neo-classical economic theory. The theory is based on two chief factors: the "push" factor which drives the population out of their home country; and the "pull" factor which attracts the people to a foreign country (Drbohlav in Šišková,

2001:19). In the case of our interest the "push" factor rests in the high unemployment rate, while the "pull" factor is represented by a better standard of living and, first and foremost, by the demand for foreign workers from major companies operating in Czechia.

Reaching the desirable destinations is anything but cheap and quite a few Mongolians have found that the Czech Republic is a convenient point of entry. After joining the European Union in 2004, the Czech Republic has become a welcome alternative route to the west-European countries, not less because the CR entry visas can be obtained for about half the fee that is charged for visas to the west-European states. Moreover, the Czech Republic enjoys considerable popularity in Mongolia, a fact attributable to mutual cooperation within Comecon when CR was still a communist country.

1. Adaptation

History tells us that Mongolian population has never found it difficult to adapt itself to a variety of environments. Frequent raids on territories far beyond the border of the Genghis Khan Empire testified to the prowess of Mongolian troops as well as to the speed with which they were able to cover vast distances. Mongolians were thus typical nomads who traveled from place to place and moved their homes as circumstances demanded. Since that times the world has dramatically changed - not just in terms of technologies but also in the ways of life - and Mongolians, moving with the times, can today hardly be considered nomads in the classical sense of the word. Most of them now live in towns, though some vestiges of their traditional ways of life still survive. Moreover, they have never lost what could be called "wanderlust" and hence their tendency to migrate. No matter

how strong their economic reasons might be, a minor role in the process of decision-making is certainly played also by their desire to see faraway countries (cizinci.cz, 2019).

Adaptation *per se* may assume a multitude of forms and social adaptation may be affected by several key factors. Out of these the most important are physical and cultural similarities and/or differences between the majority and minority populations. The practical relevance of such similarities & differences will then depend (among other things) on the country´s policy of integration. The policy should be designed not so much to handle conflicts already existing as not to allow new conflicts to emerge. Most importantly, both parties, the minority and the majority, must wish to get along with each other (Pavelková, 2016). Considered should therefore be both the society´s attitude to immigrants and the immigrants´ willingness to integrate into their new social environment. Other factors worth mentioning are the distance between the source country and the target country; the extent to which the ethnic group of interest historically migrated or still migrates; or the size of place where the people live (village, town) and even their specific lodging conditions (Drbohlav in Šišková, 2001:23).

Mongolians differ from Czechs not just in their physique but also culturally. In terms of the cultural differences Mongolians are industrious and modest, and it is particularly their adaptability that often contributes to mutual toleration. These and some other properties make them highly attractive to Czech employers, seeing that Czech workers cannot perform on their jobs so well as their Asian colleagues (migration.cz, 2019).

Helping professions are characterized by cooperation with people of different age and social groups. One of the preconditions for the effective pursuit of these occupations is specific personality prerequisites, which may also influence personal engagement (Leczová, Barkasi, Lachytová, 2017, p.163-175).

Adaptation course

June 2008 saw introduced (for the first time in CR) a project undertaken jointly by the Bridge for Human Rights and the Foxconn company - an Adaptation course. The project targeted primarily Mongolian and Vietnamese nationals and was intended to familiarize its participants with their new cultural environment. The course was structured into three blocks: the first one treated the industrial & labor relations, emphasizing the company´s process of manufacture; the second block provided basic information on the Czech Republic, the regions and towns where the newcomers would live - attention was also paid to enhancing the participants´ elementary communication skills; the third block offered practical advice on specific towns, the local shops and services, the offices of different authorities and on the system of municipal transportation.

Language adaptation

At least a partial command of the local language is one of the most important steps in adapting to the new environment. Adequate language skills will make the newcomers´ life easier, helping them to communicate with authorities, at their workplaces, in shops... These skills are of special importance in case there is no *lingua franca* which would allow them to make themselves understood in communication with the locals.

Middle-aged and older Mongolians possess a very satisfactory knowledge of Russian - to all intents and purposes many of them are bilingual. In contrast, people of the younger generation who can speak Russian are relatively few and far between. More often they can offer English, but even this is not exactly a rule - depends on their education. Paradoxically, Mongolians are reputed for being competent learners of foreign languages (Grollová, Zikmundová, 2000, p. 35). Their insufficient command of languages can thus be ascribed rather to the recently observed poor performance of the Mongolian system of education than to their unwillingness to learn.

The decision on learning or not learning the Czech language will be a matter of individual discretion, and of the importance that the people may attach to the language. Even skeleton Czech will help the newcomers find their way in Czech environment, where no other language is spoken, and their attempts at speaking Czech will also endear them to the locals (cizinci.cz. 2019).

2. The minority

As opposed to a greater part of other ethnic minorities living in the Czech Republic, Mongolians have not created such a close-knit community as, for example, the Vietnamese, Chinese and Ukrainians. While the Vietnamese prefer life in communities, Mongolians are rather inclined to live individually. Still, we have personally witnessed situations in which Mongolians sought advice from other members of their community, not knowing where else to turn to. Certain cohesion does exist even among Mongolians, but their community is not hierarchized as is the case of the Vietnamese, whose contacts with the general public are mediated by only a few chosen individuals in their capacity as

interpreters, foremen and intermediaries in job negotiations. The special Mongolian features can be explained by different mentality and, at least partially, also by the relatively short history of Mongolian continuous residence in the Czech Republic. The influence of social networks is only beginning to be felt (migration.cz, 2019).

Massive immigration of Mongolians to the CR started in 2010. In 2014 alone the CR Mongolian community doubled (Ministry of Labor & Social Affairs, 2018). The exodus was prompted particularly by stressful economic situation in Mongolia. The cost of the transfer was prohibitive, and to cover it, the people had often to sacrifice a major part of their worldly possessions - obviously, their desire to get to Europe was really strong. Regrettably, their gullibility made them an easy prey for dishonest job mediators whose activities were left almost uncontrolled by the state administration. Considering that legal residence is conditional on being employed, the loss of employment would defeat the purpose of the residence and thus void the residence permission, unless a new job would be found within 2 months (cizinci.cz, 2018).

3. Empirical section

Opinions on Mongolian minority held by the inhabitants of *MladáBoleslav* were surveyed using questionnaires and the method of choice was quantitative. The survey, conducted in March 2019, covered 84 respondents aged 25 to 64, all of them residents of the city. The respondents were asked: (1) What do you think about Mongolian minority settled in your city? (2) Can you tell a Mongolian from e.g. a Vietnamese or Chinese?

We wished to find out what was the majority´s attitude to the Mongolian community; whether the city dwellers were able to recognize its members at all; and where they met them most frequently. The questionnaire responses indicated that 35% of locals found the community objectionable, but out of these only 62.5% felt certain they could recognize a Mongolian. Out of all the respondents, this certainty was claimed by 46%. The latter value can be rather misleading since some respondents obviously equated Mongolians with Asians generally. As could be expected, overwhelming majority (74%) encountered Mongolians in streets, shops and the means of municipal transportation. Never ever the locals met the foreigners during cultural activities and/or at social events (theatres, dances, discos and other cultural encounters organized by the city hall).

Conclusion

The quantitative method we chose was applied in the form of questionnaires to be completed by the members of local majority - not only those in close and/or frequent contacts with Mongolians but also those city dwellers who meet the foreigners in everyday urban environment. Altogether, the questionnaire was given to 84 citizens of *MladáBoleslav*. The results, when interpreted to reveal how the municipal majority related to the Mongolian minority, can inspire further hypotheses and surveys to be performed in also other towns and cities of the Czech and/or Slovak Republics.

Considering the research results, the paper´s author is fully convinced that municipalities should assemble stable teams of intercultural workers capable of working professionally with both the groups - the majority *and* the minority. Particular attention must be devoted to working with local media, since they invariably exert significant influence on the regional

and/or municipal majority. Preschool facilities, primary and secondary schools should organize seminars and workshops for their pupils and students, where the subject of coexistence with local minorities would be properly discussed. These activities will offer some ground for "intercultural workers" - a specialization newly included in the National Register of Vocations.

Acknowledgements

Thetheme and researchofthispaper „*Czech Republic minoritiescomingfromsouth-easternAsia*“ wasrealizedfromtheproject: *NAKI II DG18P02OVV064 Právní, historické a společenskovědní aspekty nových a tradičních menšin v České republice*

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ISBN: 978-615-00-7752-9

Publisher:
St. Elisabeth University of Health Care and Social Work

Printing: Budapešť; Expharma

Number of pages: 157

Number pieces: 100

Year of publication: 2020

Method of issue: Book publication