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Cover Photo: Migrants on the border at Dobova, 2016
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devoted to a pioneer of social work
in Central Europe

Dr. Antonio Srholec

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Original Articles

Guest Editorial: Clinical Social Work Spring 2016

Springtime is the season for the renewal of body, mind and spirit for nature and more importantly for humanity. But not every human being shares in this rebirth? One of the reasons for this deficiency is the immorality and injustice in the world economy. In mid-April 2016 the Pontifical Academy for Social Sciences convened an international conference at the Vatican marking the 25th anniversary of Pope St. John Paul II's landmark social encyclical *Centesimus Annus* on the 100thanniversary of Pope Leo XIII's *Rerum Novarum on* social matters in the world of 1891.

Vatican Radio reported that "Centesimus Annus was written at a moment of massive change and upheaval in politics and economics in the wake of the collapse of the Soviet Union, and in the midst of an unprecedented increase in wealth and standards of living across the globe that were threatened by corrupt and exploitative interests. Its purpose was to welcome a vision of morally ordered liberty in the service of the human person. Scholars, policymakers and political leaders from around the world gathered in the Vatican to take stock of political, economic and cultural changes since the release of *Centesimus Annus* , and to offer a critical appraisal of Catholic social doctrine's engagement with the world over the same period and into the future".

Among the speakers was Bernie Sanders candidate the Democratic nomination for President in the USA. He flew from New York City to the Vatican to give a 10 minute address entitled *The Urgency of a Moral Economy* (available on the web). Sanders met the pontiff briefly and discussed the need to inject morality and justice into the world economy.

Perhaps one vision of the present diminishing economic-social situation in the world can be viewed through Hegel's thesis-antithesis-synthesis dialectic. Capitalism (thesis) is in serious diminishing chaos - maybe its demise. Communism (antithesis) has already risen and fallen. Distressed human beings all over planet earth in myriad cultures are crying out in helplessness, hopelessness and powerlessness threating extreme political dictatorship. Is the new emerging synthesis democratic socialism? Whatever human evolution brings us, Social Workers are hearing the cries and are at the forefront in their dedication to helping. Is it through Social Workers that the morality and justice of this democratic socialism (synthesis) will be birthed?

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Regarding the economic factor in a globalized society James R. Olechna and Dr. Daniel J. West, Jr. from the University of Scranton in Scranton, Pennsylvania, USA address the question: *Physician migration from developing Central and Eastern Europe to more developed English speaking Western Nations: what are the factors, causes, and potential solutions?* The answer in most cases to this "brain drain" of essential medical professions to perceptibly affluent societies - is economic. Here is scientific proof from 2009 data retrieved from the WHO for the dictum "Follow the money!" Investigating the claim of Slovak

Social Work demise - that it simultaneously disappeared with the fall of Communism in the Czechoslovak Republic, J. Levická, K. Levická reveal the morphing faces of Social Work and Social Care in their illuminating and even intriguing study: *Social Work in Slovakia in the period after 1945.* An often overlooked group of socially challenged are prisoners who are often participatants in the social environment themselves and their families. That is why Eva Zacharová's study *The quality of health care from the perspective of the client in prison* is so important for Social Workers to be aware of. Guidelines are irrelevant because National Laws precisely control how healthcare is provided for the prison population. Child abuse is a major public health issue worldwide. The next paper takes us to the balmy Caribbean where Dr. Emmanuel Janagan Johnson and Chrissie Jamie Paula Worme-Charles expose the tragic failure of Social Services in the health risk yet resilience lived by a sexually abused girl - a school dropout facing challenges in her life with her own family in their investigation: *Case analysis of child abuse and neglect in Trinidad.* An increasing cultural challenge in Europe is the refugee and immigration some see as a multi-cultural invasion. As American song writers Richard Rogers and Oscar Hammerstein so powerfully lyricized "Hatred and Fear must be carefully taught!" Martina Cichá and Andrea Preissová Krejčí delve into how multi-cultural attitudes and values shared by teachers and students are being "carefully taught' in their eye-opening study: *Prevention of marginalized social problems in Czech schools: a starting point for educational Social Work.* Examining another cultural disaster, I. Bartošovič sheds light on: *Some aspects of the health status of homeless people.* This study reveals that 40% of homeless people report at least one chronic health problem including nutritional deficiencies, infectious diseases, tuberculosis, trauma, health care, hospitalization, health status, ageing ending in death. As with hatred and fear Social Caring with compassion and empathy "must be carefully taught!" Populations worldwide are aging and with age one of the most impactful patterns the elderly experience is loneliness. The triumvirate O. Kabátová, S. Puteková and J. Martinková teamed up to look at this major challenge to health and wellness: *Loneliness as a Risk Factor for Depression in the Elderly.* Social isolation and living alone may lead to cognitive decline; increased need for help physically and emotionally; use of health services, if available and affordable - early institutionalization. What is the role of left-handedness in human evolution? This study of the history of left-handedness by Gabriela Ručková and Ľubica Varečková is relevant to recognize the functions and dependence of neurotic behavior on emotional lability, instability and possible dependency on personality characteristics and amazing creativity impacting and impacted by specific social dimensions. Love your left-handed friends! Patients with specific medical pathologies such as multiple sclerosis (MS) can experience varying qualities of life. Viera Hancinova and Ladislav Simor have made an *Analyses of measuring tools comparing the quality of life in patients with multiple sclerosis.* Readers will gain a comprehensive understanding of MS and the challenges MS patients must deal with on a daily basis and, may provide Social Workers to assist patients dealing with the challenges to the quality of life of other diseases as well. Concluding this Spring Issue of CSW*,* the quartet *of* Mrosková, S., Lizáková, Ľ., Mašterová, V. and Čuríková, A. bring us an essential study concerning the *Social environment and its impact on selected aspects of children's health.* These include quality of saturation needs of the child's families by analyzing the influence of the social environment on child morbidity; length of breastfeeding; child development; incidence of hospitalization. The role of Social Workers is alertness for assessment and elimination of risk factors in the family environment

to support children surviving a "socially disadvantaged background" such as poverty; social exclusion; marginalization; social inequality; social differentiation; stratification of society; identification of differences in the incidence of hospitalization after Social Worker intervention in children at risk needing social protection.

And so, all of these topics in this Spring issue of CSW bring us back to one of the biggest obstacles facing Social Workers in the pursuit of their highest purpose to help humanity. That obstacle is the money – never enough to solve all the challenges of immorality and injustice from economic inequality. May each of the following studies bring a lightness of insight into your Springtime.

Few words from the Edition in Chief

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

Students want to grasp both: theoretical knowledge and also the practical models used in social work. And it is our obligation to present and help students understand the theory of social work as well as showing them how to use these theoretical findings in evaluating the current social situation, setting the right goals and planning their projects.

This is a multidimensional process including integration on many levels. Students must respect client's individuality, value the social work and ethics. They must be attentive to their client's problems and do their best in applying their theoretical knowledge into practice.

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

Finding answers and solutions to these problems should be a part of a free and independent discussion forum within this journal. We would like to encourage you – social workers, students, teachers and all who are interested, to express your opinions and ideas by publishing in our journal. Also, there is an individual category for students' projects.

In the past few years there have been a lot of talks about the language suitable for use in the field of the social work. According to Freud, a client may be understood as a patient and a therapist is to be seen as a doctor. Terminology used to describe the relationship between the two also depends on theoretical approach. Different theories use different vocabulary as you can see also on the pages of our journal.

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

Michael Olah
Peter G. Fedor-Freybergh
Edition of journal

Migration of physician from developing central and eastern Europe to more developed english speaking western nations: What are the factors, causes and potential solutions?

J. R. Olechna, D. J. West, Jr.

Original Articles

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Abstract:

As information and economic growth continues to flourish in the developed nations, these developing nations are beginning to rise to the challenge of globalization. As these nations begin to develop economies of scale and start competing in the world marketplace, there are both positive and negative manifestations. While their policy makers and social sectors become more successful, there is evidence of a "brain-drain" in these developing nations. There are many suggestions as to why this is occurring, such as, but not limited to: economic; and social mobility; gender and race/ethnic disparities; culture clashes; academic integrity and advancement; career development. The issue at hand is not whether or not a "brain drain" is in effect, but to recognize this problem and offer solutions to address it. The purpose of this paper is to come up with potential suggestions and solutions, using evidence based research in relation to the four largest developed English-speaking countries: United Kingdom, Australia, United States, and Canada.

Introduction

The United States with a population of approximately 316.6 million people or roughly 5% of the world's population employs 11% of the globe's Physicians - and its demand is growing at an unprecedented rate. Today, 25% of US Physicians are international medical graduates, and the number is even higher in the UK, Canada, and Australia. These numbers may be shocking, that's because they are. There are significant issues that arise when a country relies heavily on professionals from another. Many of these graduates come from poor countries with high disease burdens - precisely those nations that can least afford to lose their professionals. (Chen, 1850).

The idea of "brain drain" is not a new issue that has just been unearthed. Brain drain can be defined as the migration of health personnel in search of a better standard of living and quality of life, higher salaries, access to advanced technology, and more stable political conditions in different places worldwide. This trend has led to concerns that the outflow of Healthcare Professionals is adversely affecting the healthcare system in developing countries. Hence, adversely affecting the health of the population.

United States Equivalent

The United States has its own national equivalent to this global idea of brain drain. Healthcare professionals tend to migrate from less populated rural areas to more densely populated urban or metropolitan areas for various reasons often monetary. The healthcare systems in these rural areas are adversely affected by the migration of Healthcare Professionals, thus the population of the rural areas are adversely affected.

International migration first emerged as a major public health concern in the 1940s when many European professionals emigrated to the UK and USA. In the 1970s, the World Health Organization (WHO) published a detailed 40-country study on the magnitude and flow of the Health Professionals. According to this report, close to 90% of all migrating Physicians, were moving to just five countries: Australia, Canada, Germany, UK, and USA (Dodani, 487)." This is also an issue that does not seem to be diminishing. The question then is where are these Health Professionals coming from and what can be done to reduce the astronomical statistics.

In 2003, a study by Wendy Hansen from the Maastricht Economic Research Institute on Innovation and Technology (MERIT) found that "the US, Canada and Australia continue to draw talent from the European Research Area (ERA) (Grigolo, 118)." This is not something that the European Union took lightly and further research was conducted. Upon further investigation it was concluded that the research may have been exaggerated and the results were not as drastic as depicted. This does not mean that this trend is not occurring but not at the rate specified.

Methods

It is difficult to quantitatively measure Physician emigration on a global scale because there is not a universal protocol in place. Therefore, a variable must be chosen in order to get a better grasp and understanding of how these Physicians are moving throughout developing Central and Eastern Europe and the aforementioned developed English speaking Western Nations. The variable of Physician demographics seemed a fitting method of measurement.

Results

The following 2009 data was retrieved from the WHO:

It can be seen that in 2009, four of the European nations examined have a higher indication of Physicians per 10,000 population, with the exception of Poland.

The following 2011 data was retrieved from the Organization for Economic Co-operation and Development (OECD):

It can be seen that in 2011, three of the European nations examined have a higher indication of Physicians per 10,000 population, with the exception of Hungary which is lagging behind Australia, and Poland.

When compared side by side, the data shows an intriguing depiction:

It can be seen that when 2009 data is compared with that of 2011, all of the nations examined, with the exception of the United States, represent an increase in Physicians per 10,000 population. There can

be many explanations as to why the United States shows a decrease in Physicians per capita such as medical school graduates or, the perpetual aging and utilization of healthcare resources by the baby boomer generation, but that is not within the scope of this paper.

Upon reviewing the literature, measuring the Physician demographic data for 2009 and 2011, and comparing the results side by side, there is no significant evidence that suggests there is a mass exodus of Physicians from Central and Eastern Europe to English speaking Western Nations. Although the data does not prove movement within the aforementioned regions, there may be movement within the European Union. This can be seen as a positive notion by the EU by virtue that their idea of open borders is effective. A trend is seen that Eastern Europeans tend to move into the expanding EU nations. This may give an indication that the EU may face similar problems of brain drain like that of the US in the future.

The next question to ask is if the international medical graduates being employed by the four leading English speaking countries are not from Central and Eastern Europe, where are they coming from. Evidence suggests that many Physicians are mostly migrating from sub-Saharan Africa, and Southeast Asia. Countries such as Ghana, Uganda, Sudan, India, Pakistan, and the Philippines are held victim to the brain drain trend.

It is a basic human right for individuals to move freely as they please and to live where they choose. Therefore, it is unethical to force Health Professionals to remain in their native lands. Because developing nations have a higher demand for these professionals, it is unlikely that they will make it more difficult for them to migrate or explore efforts to reduce the influx. Hence, the responsibility lies with the nations that they are migrating from. “Only when health staff, whatever their cadre, have the tools they require to do their job, training opportunities, a network of supportive colleagues, and recognition for the difficult job they do, are they likely to feel motivated to stay put when opportunity beckons from elsewhere (Dodani, 490).” The nations held victim must train, retain, and sustain their professionals.

There are some limitations to this study. Firstly, only research in English was examined. The data presented does not break down the Physicians into specialty or Board Certification. Physician demographics, while an effective variable for this study, may not be the most ideal variable and another must be created in order to measure Physician migration. This study also does not measure movement within the European Union.

Conclusion

In conclusion, brain drain is a global health concern, but there is not enough evidence that suggests a significant migration of Physicians from developing Central and Eastern Europe to more developed English speaking Western Nations. There is significant evidence upon reviewing the literature that suggests brain drain from Africa and Asia. Source countries must learn to train, retain, and sustain their health professionals. Further research must be conducted globally and especially in the countries suffering from brain drain.

References

Arah, Onyebuchi A, Uzor C. Ogbu, Chukwadi E. Okeke (2008) *Too Poor to Leave, Too Rich to Stay: Developmental and Global Health Correlates of Physician* Migration *to the United States, Canada, Australia, and the United Kingdom.* American Journal of Public Health 98.1 148-54.

Chen, Lincoln C, M.D., Jo Ivey Boufford, M.D. (2005) Fatal Flows - Doctors on the Move. The New England Journal of Medicine 353.17 1850-52.

Dodani, Sunita, Ronald E. LaPorte (2005*) Brain Drain from Developing Countries: How Can Brain Drain be Converted into Wisdom Gain?* Journal of the Royal Society of Medicine 98.11 487-91.

Dovlo, Delanyo (2005) *Taking More Than a Fair Share? The Migration of Health Professionals from Poor to Rich Countries*. PLoS Medicine 2.5 0376-0379. Dwyer, James (2007) *What's Wrong with the Global Migration of Health Care Professionals? Individual Rights and International Justice*. The Hastings Center Report 36-48.

Grigolo, Michele, Matthieu Lietaert, Ramon Marimon. (2010) *Shifting From Academic 'Brain Drain' to 'Brain Gain' in Europe*. European Consortium for Political Science 9 118-30.

Loh, Lawrence C, Cesar Ugarte-Gil, Kwame Darko (2013*) Private Sector Contributions and their Effect on Physician Emigration in the Developing World*. Bull World Health Organ 91 227-33.

The Metrics of the Physician Brain Drain. The New England Journal of Medicine 353.17 (2005): 1810-18.

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Social Work in Slovakia in the period after 1945[1]

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Original Articles

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Abstract:

This article reflects the development of Slovak Social Work in the context of the political development of the country. The Authors searched for answers to the following questions: Was Social Work really abolished in Slovakia after 1951? Is there evidence casting doubt upon that assertion? The aim of this article is to contribute to overcoming the claim that after 1951 there was a violent abolition of Social Work in the former Czechoslovakia and point out the consequences for the development and current state of Social Work in Slovakia brought on by ignoring events in the given period.

Introduction

The diversity of problems which Social Work responds to in the long run raises the question as to whether it is possible to build common consensus in defining it (Core 2003; Askeland, Payne 2001; Asquit, Clark, Waterhouse 2005, etc.). Initially theoretical discussion was later expanded to include research focused on the issue of Professional Identity (e.g. Dewe, Ferchhoff, Sherr, Stüwe 1995; Canavan, 2009; Tamm 2010; Leigh 2013; Lorenzetti 2013). The identity of the Profession is presented as a baseline of the nature of the Profession influenced by several internal and external factors allowing varied understanding. In the Slovak environment, the situation is complicated by two factors. The first is that the Profession has not been developed in a straight line. The second is that, so far, the history of Slovak Social Work has not been adequately compiled. As part of the ongoing research focused on the identity of Slovak Social Work, we also focused on revealing

an historical context for the development of the Profession in Slovakia because the identity of the Profession is to a significant extent affected by its own history and social status (Emmerson 2010). Knowledge of the history of one´s own Profession reinforces a sense of professional pride which not only facilitates the creation of a professional identity but is also a prerequisite for personal satisfaction with one´s own work and chosen career (Remley a Herlihy 2007).

Our contribution is a response to the claim that the Profession of Social Work was abolished in Czechoslovakia in 1951 (Majchráková 1990; Řezníček 1995) and its renewal came only in 1990 (Matoušek 2001, Žilová 2000, Strieženec 1996, 1999). Based on the reading of events in Social Work in the reporting period (1951 to 1990), we observe that although the development of the Profession was slowed down it was not abolished.

Methods

In creating this study we used the concept of an identity as a product of social and political action (Brubaker, Cooper 2000). A similar view is shared by Remley and Herlihy (2007) according to whom understanding of the current state of Social Work presupposes a good knowledge of the historical context of the development of the Profession. The aim of the study was to find out how the Slovak Social Work really was developing in the period 1951 to 1990. In order to meet this goal, we searched for answers to the following questions:

What happened with Social Work in Slovakia after 1951?

Was at least one area of the Profession continued?

Was education of Social Workers abolished at all levels?

What was the preparation for the career of Social Workers?

What were the publication and research activities about Social Work in that period?

How did the missing information influence the current state of the Profession?

The historiographical method was the main research tool used which is based on concrete and critical reflection of absolute claims referring to events from a historical-political perspective (Kocka 1990, Hendel 2005). The subjects of the research were primary and secondary sources dealing with Social Work, Social Services etc. The analyzed sources were books, magazines, legislative standards, methodical materials of the Ministry, etc. Analysis of the practical role of Social Work in Slovakia would be interesting but would not explain the developments in Social Work as a Science and Profession after 1990. For this reason, events associated with education in Social Work and its development in the Slovak Academic environment became the subject of our analysis.

Findings

In order to be able to analyze what happened in Social Work in Slovakia after the year 1945 first, we have to take a brief glance at the previous era when Social Work was established as a Profession in the former Czechoslovakia.

Historical and political background to the establishment and development of Social Work in Slovakia

The origins of Social Work in the territory of today´s Slovakia are associated with the Austro-Hungarian Empire of which Slovakia was a part until 1918. The attention of the nascent Profession still within Austria-Hungary was mainly focused on the problems of poverty, disability, children and

families at risk of social pathological phenomena, lonely elderly people, the suppression of socio-pathological phenomena, etc.. In 1918, the common state of Czechs and Slovaks called the Czechoslovak Republic was founded but whose co-existence was interrupted in the period 1939 to 1945. In 1945, after World War II the Czechoslovak Republic was restored. The termination of the joint State of Czechs and Slovaks came in 1992. Since 1 January 1993, an independent Slovak Republic was founded. Slovak history of Social Work should therefore be examined in the context of the three state units:

The first years of the common state were marked with enthusiasm because of the acquired freedom and desire to build a modern democratic state. The overall state infrastructure was built upon Public Authorities including Ministries, Health, Economics, Education, etc.. In this atmosphere in Czechoslovakia, Social Work also began to develop. The public sensitively perceived the gravity of existing problems the solutions of which were sought by the young Professionals. Therefore, Social Work in Czechoslovakia commanded respect although the term "Social Work" was rarely used during that period.

The very experience gained in the common Austro-Hungarian Empire proved to be an advantage. We would like to mention just a few:

- Slovak women studied at the Viennese ***Vereinigte Fachkurse für Volkspflege,*** the first school of Social Work in Austria-Hungary (Mais, 2011; Levická, J., Levická, K. 2015);
- Personal contacts with key representatives of Social Work abroad which were maintained by e.g. Alice Masaryková, Marie-Krakešová Došková and others (Levická J. 1999, Levická *et al*. 2015, Kodymová, 2013, Brnula, Kodymová, Michelová 2014);
- Entrance of personalities including Juraj von Schulpe, Lew Winter and others in Social Work (Botek, 2009; J. Levická 1999).

Shortly after the establishment of Czechoslovakia, Schools that educated future Social Workers were opened. Already at the stage the possibility of Pre-graduate Studies in the University environment began to be discussed. In the 1930s, the ***Organization of Social Workers*** – an umbrella of Social Workers in Czechoslovakia was founded.

Situation after 1945

In the following part of this article, firstly, we explain the events within the Profession in the years 1945 to 1990, and then point out the consequences of ignorance of the historical context for the development of Social Work in Slovakia after 1990. In this analysis, we pay specific attention to how Social Work Education took place; research and publication background of the then period; or other important events that occurred for Social Work in the territory of the former Czechoslovakia in the years 1945 through 1990.

As a result of World War II, the renewed Czechoslovak Republic was in the so-called Soviet Zone which was shortly after 1945 also reflected in the political direction of the country. Changes being implemented in the country gradually undermined the democratic character of the Republic which finally in 1948 resulted in an open regime change. That regime change was naturally carried over into the total life of society, hence to Social Work. In the area of education policy, the impact of the new policy orientations only gradually became apparent.

Immediately after World War II, part of the Professional Community became active and attempted to bring back Education for

Social Work which at the time was mainly Sociologically oriented. Based on this initiative, Decree No. **140/1945** was issued which established the ***Prague University of Political and Social Sciences.*** It was a four-year Non-University curriculum. The School had a total of three faculties one of which was Social Science. The School was established as a theoretical and practical workplace with the following mission:

1. Freedom of research to study and cultivate Political, Social and Journalistic Sciences.
2. Provide its audience (students) with thorough theoretical and practical knowledge and skills in order to teach them to navigate in society and to work for society; and thus educate not only Scientists, but also practical experts for the above mentioned disciplines.
3. Submit Certificates to the Government and the National Council (in terms of expert´s opinions) and proposals on Political, Social and Journalistic matters.

It was assumed that the University would prepare expert´s opinions for the Government and National Assembly. Prominent Czechoslovak Sociologists were involved in the teaching staff and Rector of the School was J.S. Rouček, American Sociologist of Czech origin. One part of the School was Social Science which should have prepared experts for the Social sphere. The study included subjects such as Sociology; Social Policy; Social Stratification; Social Psychology and Criminology; Sociology of Families; Children and Marriage; and Social Pathology. The second and third year were focused on Social Work and therefore there were lecture subjects such as ***Psychogenesis of a Social Case, Methods of Social Work and Social Policy***. In 1949, the name was changed to the ***College of Political and Economic Sciences***, and four years later in 1953 it was abolished (Levická 1999, Kodymová 2013).

The ***University of Political and Social Sciences*** had one remote branch in Brno from which later the ***College of Social Studies*** was profiled and established by **Law No. 124/1947 Coll.** Unlike the Prague School, it was focused more on practical performance. It aimed to train personnel for National Committees, experts for Social and Health Administration and Secondary School Teachers. Rector of the Brno College of Social Studies was Arnošt Inocent Bláha and possibly it was his initiative that the study, in addition to Sociologically oriented subjects, also included Social Pathology, Social Policy or Psychology.

In 1949, the ***Masaryk Medico-Social State School*** was abolished. Detailed reasons for its abolition are not known, but it is thought that its abolition occurred precisely because of the establishment of Higher Education. However, in 1951, it was decided to abolish Higher Education of Social Workers. Students were allowed to complete their study, thus the last graduates finished studies at both colleges in 1953.

After 1953, the training of Social Workers was implemented at a Secondary School in Prague which had opened in 1948 and operated until 1959 (Sociální Práce 1996). The original name of the School was the ***Vocational School of Social and Health Studies.*** The name of the School was subject to frequent changes. In 1952, the School received the name of the ***Higher School of Social Studies in Prague,*** which continued until the Academic Year 1959/60 when it was **reorganized into a two-year post-secondary curriculum;** the School again changed its name to ***Secondary School of Social and Law Studies.*** This change came as a result of the evaluation of four-year Pre-graduate Study where poorly trained but personally mature graduates were leaving to practice.

Although the school year 1959/60 opened a two-year post-secondary program, students who began study at the four-year school were allowed to complete their study. The last A-level Exams at that School took place in 1962. The extension studies spread to other cities and were basically of two types – focused on Social, or Social and Law Studies.

The resumption of University Studies focused on Social Work came in the years 1987/88, but only as a Specialization in the Study Programs of Sociology and Andragogy. An independent University Study Program was opened only in 1990 (Sociálna práca 1996; Levická, J. 1999; Kodymová 2015).

If the development of the Profession on the basis of these facts is evaluated, it must be recognized that ending the Education of Social Workers in Universities has slowed the development of the theoretical basis of Social Work. The fact that Social Work Education in the years 1951 to 1990 in Czechoslovakia was not situated exclusively within Universities does not entitle anyone to claim that Social Work as a separate teaching discipline did not exist at all in the then circumstances.

The presence of Social Work in Czechoslovak Society in the period under review is shown by the existence of several scientific research units which began to be built in the First Republic while several were established as a Ministerial Department. Their activities continued beyond 1948 albeit sometimes in a modified form. Prior to 1945, there were Research Departments in Czechoslovakia: ***Masaryk Academy of Work*** (1920); ***Social Institute of Czechoslovakia*** (1920); ***Psychotechnical Institute*** (1921); ***Central Counseling on Professions in Slovakia***, 1928); ***Institute of Human Labor*** (1939) (Kodymová 2015; Krajčovičová 2009; Bystrický, Zemko 2004; Tomeš 1996).

After World War II, the following Research Institutes operated in Czechoslovakia:

- *Czechoslovak Institute of Labor*
- *Regional Institute of ČSÚP for Slovakia* (1948)
- *Research and Training Institute for Occupational Safety* (1954) in 2003 it was incorporated into the new organization: *Center for Study of Work and Family*
- *Scientific Research Center in the State Wage Commission*
- *Czechoslovak Research Institute of Labor (*1964)
- *Research Institute of Living Standards* (1965)
- *Research Institute for Social Development and Labor*
- *Czechoslovak Institute of Labor and Social Affairs* (1974)
- *Research Institute for Social Development and Labor* (1984)
- *Research Institute of Labor and Social Affairs* established in Bratislava in 1991. In 1992 its name was changed to the *Research Institute of Labor, Social Affairs and Family*

The results of these reorganizations remained unnoticed after 1990 because after restoring the Pre-graduate Training of Social Workers at the Universities problems on which they focused did not present as interesting to Educators. Only Strieženec (1999; 2006) and Tomeš (1996; 2010) paid attention to them. Both of these Authors staunchly understood that Social Work was a practical exercise of Social Policy.

The cause of this factor can be seen particularly in the strong focus of Czech and Slovak Social Work on the Therapeutic or Counseling Paradigm under Navratil´s (2001) curriculum. Only over the last decade have the numbers of Authors who are more engaged in Social Work in the context

of this reform paradigm gradually increasing. In the production of British or American Social Work the paradigm is quite often discussed by Authors including Jane Adams (1922), R. Bailey, M. Brake (1975), Jan Fook (2002), Lena Dominelli (1998, 2002), Neil Thompson (2012) and others. The Academic Community of Social Work being created in the SR did not feel the need for orientation in the area of any reform paradigm as the problems the foreign Authors were coping with were only seen as examples from history at that time. Moreover, in the period immediately after November 1989 in the Czech and Slovak Federative Republic a strong anti-Socialist sentiment prevailed. It was easier and "Socially safe"[4] to navigate for the Therapeutic and Counseling Paradigm. Then there only had to come up arguments that during Socialism Social Work suffered an extinction and it was not developed theoretically after 1951; the Authors identified themselves with this claim. This was the main reason that for a long time Slovak and Czech Authors did not deal with the development of Social Work in the period 1951 to 1990.

Another unaddressed area from which we could learn more about the development of Social Work in Slovakia are publications, including articles in Departmental Journals such **as '*Social Security*'** – a monthly of the Ministry of Labor and Social Affairs. In 1968, in the Annex to this magazine, a paper was published entitled ´***Social Worker:*** **Methodical Annual**´ which also stated that ***"The study "Social Services" of Bohumir Šmyd, published by the Research Institute of Social Security in 1966 defines Social Work as a set of activities, the purpose of which is direct efforts, immediately affecting man or his family, to preserve his relationship to society, to his nearest environment, to education, to work, etc. It can be characterized as Socio-diagnostic, Consultative, and Educational Work and Work providing Social Services (organized or directly provided) in particular cases..."*** (Sociálny Pracovník 1968 p. 3). Although it is subtle material in scope, it is full of surprises in the context of the argument that Social Work was absolutely stagnant in the period after 1951. It reads, for example: ***The Social Worker is intended solely for socio diagnostic activities in families. Other tasks cannot distract him from his work. Consequently, he does not carry out any Administrative duties: neither does he have the power to make decisions, but only to propose"*** (Sociálny Pracovník 1968, p. 6).

In addition to the above report by B. Smid (1966), in this period papers were published such as ***Job Content of Regional Head Nurse in Social Services*** (Majchráková 1957), ***Job Content of Nurses for Social Services in a Medical Institution for Tuberculosis*** (Majchráková, Vašečková 1958); ***Social Service*** *(auxiliary textbooks issued for internal use)* ***Study Purposes of Nurses for Social Services, ZS, DS, ŽS, Head Nurses and Chief Nurses in Medical Facilities*** (Majchráková 1971 and repeatedly until 1987); ***Forms and Methods of Social Work*** (*auxiliary textbooks*)

[4] For neutral evaluation of the period 1951-1989 (if possible) socio-political atmosphere was not appropriate. At a time when society refused everything that was somehow associated with the previous regime it was literally unwanted to talk about some positives that actually happened during that period. Therefore, we used the term "Socially safe" which indicates that in some of the teachers there were (though unfounded) fears related to the freedom of speech; as if they still did not manage to believe that the academic ground is free and open space for critical discussion. We believe that 25 years is enough of a time gap prerequisite for an objective assessment of that period.

(Majchráková 1981); ***Tasks of Social Workers in Alcoholism Treatment Centers (****textbooks)* (Skála, Maťová 1973); ***Methods for Working with the Elderly*** by Schimmerlingova (1972)'; a two part work on ***Educational Therapy*** by Krakešova (1973); ***Problems of Families and Family Therapies*** by Fiso (1980); ***Methods of Social Work I and II*** by Chravatova and Brabcova which were published repeatedly (1975, 1985,1991). The Ministry issued many interesting methodical materials and guides on the tasks of Social Workers such as ***Caring for Socially Inadaptable People.*** A methodological tool for the staff of National Committees (1983); ***Work with the Gypsy Population*** (1976); ***Care for Citizens with Reduced Capacity to Work*** (1987); ***Proposed Principles for Completion of a Comprehensive System of Post-prison Care*** (1985); etc. In preparing these materials Authors also included Anglo-Saxon literature, as our Social Work maintained links to Social Work implemented mainly in the US and UK. After 1969, the *Sociálna/ Sociální Politika Journal* published many good articles focusing on current issues in Social Work.

The above publications are only examples, illustrative in nature, in which we want to substantiate our claim that ***Social Work in the Territory of Slovakia, or Bohemia, also developed in the period 1951 to 1989.*** At the same time, it is illustrated by the selected examples that these studies were created in each decade of the reporting period.

In practical terms, Social Work developed most within the Health Service. Ironically, it is in this field of Social Work where the roots of the claims about termination of Social Work after 1951 can be found. According to the claims of one of the most important representatives of Social Work in the Health Service, Helena Majchrákovek (1990 p. 7*) wrote* ***"Due to this simplified looking at Environmental and Social needs of human beings, in 1951 healthcare abolished: a) the branch of Social Nurses; b) the concept of Social Services; c) the statistical number of Social Nurse.... Professional literature with Social issues ceased to be issued"***. However, the truth is that already in 1952 instead of Social Nurses, Nurses for Social Services appeared with the consent of the Ministry of Health, so there was only a change in job title. Another paradox is that shortly after the abolition of Higher Education for Social Work and Education conducted at Universities, the Ministry of Health initiated the establishment of a post-A-level Curriculum in Health-Social Work.

The allegation of termination of Social Work in Czechoslovakia as a consequence of the onset of Socialism was associated with the termination of the Ministry of Labor and Social Affairs in 1957. The Ministry, with a new name Ministry of Labor, Social Affairs and Family, was restored only in 1968.

It is interesting that after the restoration of that Ministry in 1968, the activities of ***The Society of Social Workers*** were restored. The revival of the Society was initiated by its former members who operated either in direct practice with clients or at secondary schools specialized in Social Care. In the same year, the Society began to develop activities aimed at the resumption of higher education for Social Workers (Sociální Práce, 1996).

Developments in the Field of Education of Social Workers after 1990

In the Slovak literature on Social Work there can be found allegations that after Social Work had been abolished in the Czechoslovak Socialist state it was rebuilt after 1990. Based on our findings in recent years, however, we object to this claim and suggest to talk ***about the reconstruction of the Social Work Profession after 1990.*** There is no doubt about the fact that the abolition

of Vocational and Higher Schools of Social Work slowed the development of the Profession in its Theoretical and Practical Levels, however, did not mean its extinction.

The Education of Social Workers at Public Universities was reopened in 1990. During the next five years, the study programs gradually opened at the Pedagogical Faculty of the Comenius University in Bratislava; the Faculty of Arts of Prešov University; the Faculty of Nursing and Social Work, Trnava University (in 1997, they changed the name of the faculty to Faculty of Health and Social Care); the Faculty of Social studies of Constantine the Philosopher University in Nitra; at the Pedagogical Faculty of Matej Bel University in Banska Bystrica. Later, these were joined by other Public (State) Universities, which opened Study Programs in Social Work.

Increased interest by young people in this study of Social Work immediately also stimulated the emergence of some Private Universities of which the most famous include the University of St. Elizabeth in Bratislava and Danubius University in Sládkovičovo.

The development of Higher Education for Social Workers is also linked to the need for the preparation of University textbooks, monographs, study texts, which are closely related to research oriented Social Work. Gradually, there appeared also works assessing the development of the Profession in the period 1945 to 1990 (Majchráková 1990; Novotná, Schimmerlingová 1992; Řezníček 1995 and others); and these publications allege that after 1951 the extinction of Social Work in Czechoslovakia occurred. This claim was subsequently adopted by a variety of Authors (Strieženec 1996, 1999; J. Levická 1999, 2002; Matoušek 2001, 2005; Brnula 2012; Navrátil 2001; Oláh, Schavel, Ondrušová 2008 etc.) and greatly influenced the development in the Profession in Slovakia and the Czech Republic.

Based on the results of content analysis focused on the period after 1990, we conclude that ignoring the nearly 40 years of Social Work in Czechoslovakia caused a weakening of identity and Social status of Social Work. Social Work even today is seen by a part of the public as work which does not need any Professional training.

For the first decade (1990 to 2000) reconstruction of the Social Work Profession is characterized by its building "from the outside" which was the result of lack of Academics and Researchers in Social Work. Among Teachers who contributed to Education of Social Workers in Slovakia in that period there was not one Teacher who had studied Social Work. Therefore, they did not have even necessary theoretical knowledge in the field of Social Work. The persistent claim that

> ***anyone can do Social Work*** was complemented by the argument that ***Social Work can be taught by anyone***.

An emerging change in this area can be registered around 2000 when the first graduates of the Study Program in Social Work were accepted for Doctoral Studies[5]. These Doctoral Students were internally strongly identified with Social Work and eager to develop the theoretical basis of the Profession

[5] The first doctoral program for Social Work opened at the Faculty of Nursing and Social Work (now the Faculty of Health and Social Work) of Trnava University, which also housed the first Doctoral Committee for the whole Slovakia. Chairman and Members of the Committee were appointed (or dismissed) by the Minister of Education. Members of the Committee could have been proposed by individual Departments so as to be represented and participate in the activities of the Committee.

thanks to which new publications focused on Social Work emerged.

Inadequately nurtured at a local level seems to be a natural consequence of the situation. Critically, it must be admitted that the so-called Post-secondary Schools, which had implemented Post-A-level Studies focused in Social Work for years in the early 90s graduated better prepared Teachers for Social Work compared to Universities. However, Teachers from these schools were not interested to work in a University environment, which requires Scientific Studies. The vast majority of classical, academically oriented University Professors dedicated their Scientific attention to areas in which they worked before 1990, for example Medicine, Psychology, Law, Education, Sociology and so on. Only some of them decided to change their Professional orientation, and therefore, the first years of the building of Social Work at Slovak Universities were marked by an intense familiarizing with Social Work. Individual Social Work Departments gradually recruited Practitioners who complemented their Education. In the first decade of renewal of Higher Education in Slovakia you will hardly find any research focused on Social Work if qualifying studies are not taken into account.

In Slovakia, consensus on the theoretical basis of the Profession had been absent in the long run, which was already demonstrated in discussions about the content of the curriculum for future Social Workers. Study Programs reflected the more subjective interests of some Teachers than the real needs of students and the requirements of Practice. The absent consensus on what should constitute a curriculum for Social Work was reflected not only in the lack of pertinent literature but also in the underdeveloped theoretical basis of Social Work. Joint development of minimum training standards for the qualifying Social Workers and their acceptance by the Ministry of Education in 2003 also was positively reflected in the creation of Professional literature, where a qualitative shift can be observed in recent years (e.g. Balogová 2011; Brnula 2012; Gabura 2012; Gabura, Mydlíková 2004; Levická *et al*. 2012; Levická, J., Levická, K. 2015; Matulayová, Musil 2013; Mátel 2010; Mydlíková 2013; Rusnáková, Szaboová 2013; Vaska 2012 and others.).

Conclusion

Between 1950 and 1989, the Social Work Profession was not abolished, but its development was strangled. Stopping University Education was reflected in the development of theoretical foundations for Social Work. Paradoxically, although there was a strong emphasis on labor, labor conditions of workers and the like, research activities were not stopped in our country. Research activities showed comparable activity with similar Research Institutions abroad. It is indisputable that during this period Social Work continuously developed in the Health Sector and State Administration. Also, the requirements for the Education of Social Workers in connection with this were changed. Some activities carried out by Social Workers before that period were gradually taken over by other Professions, particularly Psychologists and Clinical Social Scientists (Majchráková 1990; Balogová 2002; Brnula 2012; Levická 1999, 2002a; Oláh *et al.* 2008, 2009; Strieženec 1996, 1999; Tokárová *et al*. 2002; Žilová 2000).

In the recent period, Authors focused on Social Work have recognized the urgent need for regular reflection on the impact of differences between Theory and Practice in the development of the Profession. In each area there are natural differences between Theory and Practice. In the case of Social Work, however, the differences exceeded the normal rate. This situation was caused by the fact that in the Educational Process

students were familiarized with the Theory and Practice implemented in significantly different environments. Educators strove to transfer the "current state of knowledge in the world " which is unquestionably a duty of University Teachers, but, in many cases, with the lack of reflection on domestic reality. Students, especially part-time students, accepted only with difficulty different pictures of Social Work which they were discovering in Theory and in Practice. They did not understand the too great differences between "Scientific" and "Practical" Social Work which evoked feelings, on a part of some students that theoretical knowledge was unusable in practice. These differences further blurred the identity of the Social Work Profession, a situation which persisted for more than ten years before it began to gradually change.

Despite best efforts it has failed to create a clear picture of the Profession**.** The public does not know what is under the name of Social Work and what can realistically be expected from Social Workers. We confirm the validity of the argument that the characterization of Social Work as a Profession aims to help a person in a difficult situation, blurs, rather than clarifies, the image of the Profession (Gelles, Clark *et al.* 2007, Maron 2003). The increase in field offices preparing future Social Workers contributed to the unclear picture of Slovak Social Work. This trend peaked around 2000. The official cited reasons for their opening was to bring University Education closer to poorer regions in order to save travel costs for students. These offices were opened by Public and Non-public Universities and Colleges. Due to the short period of time during which they were established, in several cases, there were no quality teaching collectives; the learning ***in some offices*** was not always in line with the latest knowledge in the field of Social Work. Moreover, these offices only rarely employed knowledgeable individuals who would pursue Scientific as well as Educational Work.

Orientation on the quantity of curricula for Social Work has resulted in the number of Graduates who flooded the labor market in a short time did not correspond with the needs of Practice; moreover, a relatively large number of these Graduates received a diploma without the knowledge corresponding with standard requirements for the training of Social Workers[6]. The media have brought information on the number of students who graduate from Universities each year and the lack of experts in Practice. This information is often associated with questioning the legitimacy of the Profession, claiming that students finishing their studies are not actually interested to carry on the Profession and so on.

There has been a lack of reliable information on the causes of this situation. The unilaterally targeted information ***strengthen the vague idea of the Profession***, ***tasks, objectives and responsibilities of its representatives.***

The status of Social Work in the Slovak public, following the introduction of Higher Education has paradoxically worsened compared to the period before 1990 which is partly caused by the fact that Social Work is the worst paid Profession with a University Degree required in the Slovak Republic.

[6] Developments in Pre-graduate Studies in Social Work after 2000 require quality secondary analyses in order to draw valid conclusions. For this reason, and also due to the sensitivity of the issue, we do not provide specific identifying information through which specific work places could be identified.

References

1. ADDAMS, J. (1922) *Peace and Bread in Time of War.* [online]. New York: Macmillan. [cit.2013-11-4]. https://archive.org/details/peacebreadintime22adda
2. BAILEY, R.; BRAKE, M. (1975) *Radical Social Work* New York: Pantheon Books
3. BALOGOVÁ, B. (2002) *Introduction to Social Work. Prešov University of Prešov*
4. BALOGOVÁ, B. (2011) *The meaning of life.* Beograd: Academy of Serbian Orthodox Church
5. BOTEK, O. (2009) *Social policy for social workers*. Piešťany: PN, 2009
6. BRNULA, P. (2012) *Social work. History, theory and methods.* Bratislava: IRIS
7. BRNULA, P.; KODYMOVÁ, P.; MICHELOVÁ, R. (2014) *Marie Krakešová pioneer Theory of Social Work in Czechoslovakia.* Bratislava: IRIS
8. BYSTRICKÝ,V., ZEMKO, M. (Eds.) (2004) *Slovakia in Czechoslovakia*. Bratislava: Since
9. DOMINELLI, L. (2002) *DeProfessionalising Social Work Anti-oppressive practice, Pcompetencies and postmodernism.* In: British Journal of Social Work, 26, 2. p. 153-175
10. DOMINELLI, L.(1998) *Sociology for Social Work.* Basinstoke: Macmillan
11. EMERSON, C. H. (2010) *Counselor Professional Identity: Construction and Validation of the Counselor Professional Identity Measure.* [online]. Dissertation thesis. Greensboro: FGS, University of Norths Carolina, 274pp. [cit.2015-01_03]. http://libres.uncg.edu/ir/uncg/f/emerson_uncg_0154d_10396.pdf
12. FOOK, J. (2002) *Social Work: Critical Theory and Practice.* London Sage Publication Ltd
13. GABURA, J. (2012) *Theory families and the process of working with the family.* Bratislava: IRIS
14. GABURA, J., MYDLÍKOVÁ, E. *et al*. (2004) *The management of social case.* Bratislava: ASSP
15. GABURA, J., PRUŽINSKÁ, J. (1995). *Counseling process.* Prague: Slon
16. GELLES, R.; CLARK, E. *et al*. (2007) *Scattered Image: Perspectives on Social Work's Identity Challenge,* Social Impact Magazine, 2007 Washington University in St. Louis. HALL, N., HEALY, L.M. (2007) *'International Organizations in Social Work',* In WAGNER.L., LUTZ, R. (eds) *Internationale Perspektiven Sozialer Arbeit [International Perspectives in Social Work], pp. 223–42.* Frankfurt: IKO-Verlag.
17. HEALY, L. M. (2008) *International Social Work: Professional Action in an Interdependent World.* 2nd ed. New York: Oxford University Press
18. HENDEL, J. (2005) *Qualitative research. Basic Methods and Applications.* Praha: Portál, 408 s.
19. CHARVÁTOVÁ, D., BRABCOVÁ, V. (1975) *Social Work Methods I-II.* Praha: SPN
20. KOCKA, J. (1990) Geschichte wozu? In HARDTWIG, W. (Hg.). 1990. Ùber das Studium der Geschichte. München: Deutcher Taschenburg Verlag, s.427-443
21. KODYMOVÁ, P. (2013) *Czech history of social work in the years 1918 - 1948.* Prag: Karolinum, 132 s.
22. KOVÁČIKOVÁ, D. (2000) *Basic questions of history of social work.* Žilina: Žilinská univerzita, 101 s.
23. KRAJČOVIČOVÁ, N. (2009) *Slovakia towards democracy*. Bratislava: HÚ SAV
24. KRAKEŠOVÁ-DOŠKOVÁ, M. (1946) Psychogenesis social case. The emergence of social abnormality. Prague: A New Awareness 1946. 343 s.
25. KRAKEŠOVÁ, M. (1973) Educational therapy. Part I and II. Prague: MPSV 10.1177/0020872814547438
26. LEVICKÁ, J. (1999) *Outline history of social work . Trnava*: SAP 104 s.
27. LEVICKÁ, J. (2002a) *Theoretical Aspects of Social Work.* Trnava: ProSocio, 2002, 283 s.

28. LEVICKÁ, J., LEVICKÁ, K. (2015) Case Social Work - the creation and development. Hradec Králové: Gaudeamus
29. LEVICKÁ, J., LEVICKÁ, K., HANZALÍKOVÁ, V., BÁNOVČINOVÁ, A. (2012) *Ekosociálne approaches in social work.* Trnava: Oliva, 2012
30. LEVICKÁ, J. ZEMAN, K. (1999) *Social protection of children and young people.* Bratislava: Faculty of Nursing and Social Work TU v Trnave
31. MACHAČOVÁ, M. (1969) *Social and legal protection. Fundamentals and Methods - General section. Prague* : SPN, 2.přepr. vyd. 126 s.
32. MACHAČOVÁ, M. (1966) *Social and legal protection. Methods - part special. Prague*: SPN, 2.vyd. 1966. 112 s.
33. MAIS, M. (2011) *Ilse Arlt – The Austrian Pioneer of Poverty and Welfare Research Based Social Work Theory and Practice.* In: Social Work and Society International Online Journal, 9, 2011, 2
34. MAJCHRÁKOVÁ, H. *et al.* (1990) *Social services and health-social care population.* Martin: Osveta
35. MÁTEL, A. *et al.* (2010) *Ethics of social work. Bratislava: University of Health and Social Work, st. Elizabeth*
36. MATOUŠEK, O. *et al.* (2001) *Basics of Social Work.* Prague: Portál
37. MATOUŠEK, O. *et al.* (2005) *Social work in practice.* Prague: Portál
38. MATULAY,S., MATULAYOVÁ.T. (1998) *Social Work - Selected Chapters*. Nitra: UKF MATULAYOVÁ, T., MUSIL, L. (2013) *Social Work, Education and Postmodernity. Theory and Studies in Selected Czech, Slovak and Poish Issues.* Liberec: Technical University of Liberec
39. MYDLÍKOVÁ, E. (2013) Family in the context of cognitive-behavioural theories. Warszawa: Wydavnictwo Naukowe PWN 112 s
40. NAVRÁTIL, P. (2001) *Theory and Methods of Social Work.* 1. vyd. Brno: MZ, 2001. 162 s. NOVOTNÁ, V., SCHIMMERLINGOVÁ, V. (1992) Social work, its development and methodological procedures. Prague: Karolinum
41. OLÁH, M.; SCHAVEL.M.; ONDRUŠOVÁ, Z. (2008) Introduction to the study of history and social work. Bratislava: University of Health and Social Work, st. Elizabeth
42. REMLEY, T .P., HERLIHY, B. (2007) *Ethical, Legal and Professiola Issues in Counseling.* New Jersey: PearsonMerrill Prentice Hall
43. RUSNÁKOVÁ, M., SZABÓOVÁ, M. (2013) Parenting from the perspective of young adults from children's homes. Libreria Ateneo Salesiano (LAS)
44. ŘEZNÍČEK, I. (1995) *Methods of Social Work. Prague*, SLON 1995. 75 s.
45. *SOCIAL WORK. Manual social worker (1996) Prague: MPSV Society for Social Workers Social Work (1968) Methodological Guide. It occurred as a supplement monthly "Social security". Bratislava: Press and publicity department MPaSV*
46. *Social worker. (1968) Methodological Guide. Completion. It occurred as a supplement monthly "Social security". Bratislava: Press and publicity department MPaSV*
47. STRIEŽENEC, Š. (1996) *Dictionary social worker.* Trnava: AD
48. STRIEŽENEC, Š. (1999) *Introduction to Social Work.* Trnava: AD 215 s.
49. THOMPSON, N. (2012) *Anti-Discriminatory Practice. Equality, Diversity amd Social Justice.* 5th ed. London: Palgrave Macmillan
50. TOMEŠ, I. (2010) Introduction to the theory and methodology of social policy. Prague: Portál
51. TOMEŠ, I. (1996) *Social policy - theory and international experience. Prague: Socioklub*
52. TOKÁROVÁ, A. *et al.* (2002) Social work. Chapters from the History, Theory and Methodology of Social work. Prešov: FiF PU 2002. 572 s.

53. VASKA, L. (2012) *Theoretical aspects of starting supervision of social workers. Bratislava*: IRIS
54. ŽILOVÁ, A. (2000) *Chapters from the theory of social work.* Žilina: Edis

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Prevention of social problems facing marginalized groups in Czech schools – a starting point to educational social work

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Original Articles

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Dental infectious are one of major health care issues in Sub Saharan Africa

Abstract:

This study focused on educational social work practice consequences, specifically prevention of xenophobia and racism in Czech primary and secondary schools. The findings are from a research conducted among teachers and students of both primary and secondary schools in Zlín, Olomouc and Moravia-Silesia Regions from September 2014 to June 2015. The aim was to explore on the attitudes of teachers and young students to the ideas of multiculturalism. The presented results focus on the way multicultural education is conceived and understood. With regard to the current migration situation, the approach of both teachers and the young students to members of ethnic or religious minorities, from which Roma were the most often reflected by the two groups, seems of key importance as well.

Introduction

This study focused on educational social work practice consequences, specifically prevention of xenophobia and racism in Czech primary and secondary schools. The basis for this study is the concept of educational social work by Mária Machalová (2013). Machalová highlights the intersection of the aspects of social work related to the pedagogical sciences: social education and social andragogy. The intention of educational social work is to interlink the educational process, as well as lifelong learning, while solving social problems (Machalová, 2013, p. 21–23). An inspiration may be provided by critical pedagogy

of Paulo Freire (1986), which has a profound social dimension. In his work *Pedagogy of the Oppressed,* he suggests the ways in which teachers and social workers can strengthen and liberate the people oppressed by political, economic, social or ideological power structures (Janebová, 2014, p. 71). Educational process in relation to the socially disadvantaged ones, e.g . Roma children, children of foreigners and the like, is the most important for this topic. If we want to improve the lives of socially disadvantaged people, it is also significant to work with the majority society. In this direction, developing multicultural education at Czech schools seems to be obvious. Young students and their teachers meet in person or through a delegated experience through their parents or more and more often through the media with excluded or otherwise weakened groups – e.g. refugees, immigrants, ethnic minorities, drug addicts and so on (Hrdá, Šíp et al., 2011, p. 7).

Multiculturalism in school practice

The starting point for social prevention in the context of social work in the educational process rests in the assumption that social events and social issues are more visible because of the challenges in the educational process of the client, therefore social problems are educationally determined (Machalová, 2013, p. 27). The most important attribute of a multicultural society is difference of individuals and groups. These may or may not be reflected in terms of physical differences, but always in terms of cultural differences. Members of different cultures have more or less different customs and habits, traditions, symbols, ceremonies and rituals, religion, as well as different languages, dialects, different ways of nonverbal communication, a different value system, etc. They are characterized by specific cultural patterns, i.e. using learned, more or less mandatory schemes in the form of specific customs, morals, laws and taboos for behavior in standard situations. Their knowledge, especially knowledge of intercultural differences in general is important for pedagogy. It is therefore possible to argue that multicultural education involves overcoming ignorance.

Ignorance is considered a factor that plays an important role in the creation and formation of prejudice. Measures that are not based on knowledge of life of those in concern have only a little chance for success (Giddens, 1999, p. 28). In the words of Geertz (2000, p. 24), „to understand the culture of other people is to reveal their normality, while keeping in mind their uniqueness“.

A key issue of the multicultural education at Czech schools is use of stereotypes and prejudices among teachers and their students. Prejudices and stereotypes are not a product of direct experience of the individual, they are irrational mostly adopted negative attitudes maintained by tradition directed toward someone or something. The subject of prejudice can be anything – a person or group of persons, things or events (Nakonečný, 1999, p. 223). In our society, a considerable amount of prejudice is related to Roma people.

Attitudes are generally internal dispositions of individuals to react to certain objects. By this term we mean sympathy or antipathy – affection or aversion towards objects, persons, groups and situations or other identifiable aspects of the environment, including abstract ideas and social policy (Atkinsonová, Atkinson et al., 1995, p. 727, Průcha, Walterová and Mareš, 2003, p. 171). Due to attitudes, we react in certain relatively stable manner. But it is essential that it should be possible to influence attitudes. The main and at the same time the most demanding

educational goals influence values and attitudes.

The main aim of this investigation was to determine teachers and students attitudes towards people of different cultures. This was attained by examining educational programs that lead to conflict-free and peaceful co-existence of various groups with different cultures, ethnicity, religious beliefs, and others. It is however difficult to reveal the true attitudes of the respondents, especially when it comes to the attitudes towards people of different ethnicity and culture. The main research question was stated as follows: What are the attitudes of students and teachers in primary and secondary schools in Zlín, Olomouc and Moravia-Silesia Regions towards different ethnics, nationalities or cultural differences?

Methodology

This study used a descriptive survey design to examine the attitudes of students and teachers towards people of different ethnics, cultures and nationalities in Zlín, Olomouc and Moravia Silesia Regions. Gay (1981) defines descriptive survey design as a study where variables that exist have already occurred with non-intervention of researcher. Questionnaires were the main tools used for data collection in this study. Semi-structured interview guides were used to collect supplementary qualitative data from the teachers. A total of 228 and 915 questionnaires were successfully responded to by the teachers and students respectively. This quantitative data was cleaned and coded into statistical package for social sciences (SPSS) for analysis. SPSS was used to generate descriptive statistics such as frequencies, mean and standard deviation. Free answers of the respondents presented an addition to the quantitative research where the „hard" data met its limits considering the fact that the answers to the questions were not the only information the interviewer should record (Disman, 2008, p. 163; Švaříček, Šeďová et al., 2014; Skutil et al., 2011).

The qualitative part of the data collection involved 30 teachers. Although the topic of the interviews was given in advance, as the selected technique of the semi-structured interviews suggests, teachers had the opportunity to express themselves to address individual questions. All the interviews were recorded on a dictaphone and then transcribed into a text document. A subsequent analysis was carried out in software for processing qualitative data *Atlas.ti.* Here, the transcribed conversations were subjected to open coding. Code groupings were then categorized according to their internal relationships, similarity or continuity and created 10 subcategories, from which 3 main categories were developed within the process. These include the categories of *Multicultural Education, Roma* and *School and Influences Outside School.*

The results of the qualitative part of the research

Teachers understand multicultural education primarily as an education to tolerance in relation to other cultures. Almost all teachers considered this topic highly relevant in our society, because, according to them, we would meet members of various ethnic groups more and more often in the Czech Republic. Teacher18 expressed the opinion as follows: „*By the way the world gets smaller, more global and more and more people emigrate and come into contact with people of different faiths, different races*". However, some teachers do not share this opinion, for example Teacher 29: „*I think it is generally understood as the coexistence of different nationalities, eventually races in some countries. This does not concern us. It concerns our country in limited extent in comparison with, for example,*

America". This view, however, occurred rarely in the interviews. There is a general consensus among teachers that with the help of multicultural education, the relations among various cultures should develop.

Teacher 16: „*Because* I think *that our society is extremely xenophobic, not only to the Roma, but in general to other nationalities, we are bothered by the Vietnamese because they take our jobs, as well as the blacks with whom we are not satisfied, etc.*",other respondents view the Czech society as intolerant as well. In their opinion, this situation could change slowly with the younger generation, which has more opportunities to meet people from other countries and cultures than there were before. Some topics may be seen as controversial because young students use the opinion background from their families, which can be significantly questioned within the discussion. The Roma issue may serve as a specific example. In some of the regions where the interviews were implemented, the young students meet members of the Roma ethnic group more often, they have personal experience with them, or an intermediated experience provided by family or friends, which motivates them discuss this topic with the teachers more often. On the other hand, the motivational element is often a source of problem for many teachers, because they are not sure how to approach this issue, as they have learnt it contradicts the opinions and personal experience of young students.

For example, Teacher 1 analyzes the young students' opinion of the Roma, which is in his view strongly negative. „*98% of their opinions are negative. It can be very difficult to react to this at the lessons, because almost all of them have had some negative experience*". When questioned about how the teacher could respond this situation, the response sounded like this: „*Well look, I come into contact with them here, let's say, for two hours a week, and they live there among the community 24 hours a day, except for the time they are at school. So it is very difficult to interpret it.*"

Teacher 5 is of opposite opinion, he sees multicultural education as a tool to combat stereotypes in the case of young students. „*The young students are aware of living in a greenhouse constructed by their parents, in certain stereotypes, and we must always learn to somehow overcome the stereotypes. Unfortunately, we are part of a globalized world, so this is a sort of biggest advantage of any kind of teaching of multiculturalism or simply learning discussion on certain issues.*" But, like most teachers, he also adds that the central motif of multicultural education at schools should be „*learning tolerance*".

Most often, teachers agree that the main mission of multicultural education should be to encourage young students to learn about different cultures, which according to them have other features than the culture in which the young students grow up. Firstly to provide for a shift of their attitudes and values towards development of their tolerance and respect when concerned with the phenomena of otherness. Physical difference of ethnics is considered the most important feature of otherness by teachers. The accented groups which must be learned to tolerate are most often in the views of teachers Roma and Vietnamese. Other ethnics and nationalities are not considered to be as interesting from the teacher's perspective. They are represented by the concepts of „other cultures", „foreigners" and the like.

Roma as the topic of multicultural education were detected in all the interviews, we can therefore conclude that the understanding of multicultural education by teachers is closely linked to the topic of inclusion of young Roma students to schools, and generally of Roma into society. In this respect, the issue of the so-called socially excluded localities and impact on the coexistence of

majority vs. minority that is perceived as problematic, due to the different social levels of marginalized population was mentioned.

On the other hand, teachers almost did not mention other ways of otherness with which students can meet, the diversity of genders, issues of different sexualities, physical differences caused by, for example, illness, or even the simple differences between the young students, which may be caused, for example, by different social background or other education. These need to be seen as separate individuals (cf. intercultural approach in Sleeter, Grant, 2009, p. 33; Banks, Banks, 2009, p. 22–23; Dom-Nwachukwu, 2010, p. 5).

The results of the quantitative part of the research

From the theoretical basis of the suggested issue resulted the following research questions, which should confirm or disprove the following hypotheses:

- Coexistence of the majority with the Roma minority is problematic.
- Otherness is seen as a source of xenophobia and racism.
- The most common form of otherness reflected as a negative stigma is the Roma origin of its bearers.

The research questions were dealing with the challenges of the demand for a description of various forms of diversity in our population, namely foreigners, representatives of religious minorities and ethnic minorities in our country. The previous studies were implemented primarily by identifying value orientation and attitudes of young students and their teachers.

Values of young students and teachers in relation to otherness

In one of our closed scale questions, there was examined the importance of the submitted values. Our aim was to compare the result of the value orientation of the respondents with the answers we obtained in reaction to the issues relating to otherness.

The young students chose *Friendship and fellowship* as the most important values in 71.6% and as rather important in further 19.8%. Furthermore, the respondents chose the value of *Love and partnership* as the most important in 66.6% and rather important in 22.2%. *Tolerance to different sexual orientation* was mostly categorized as of little importance in 10.8% and in 8.2% as the least important.

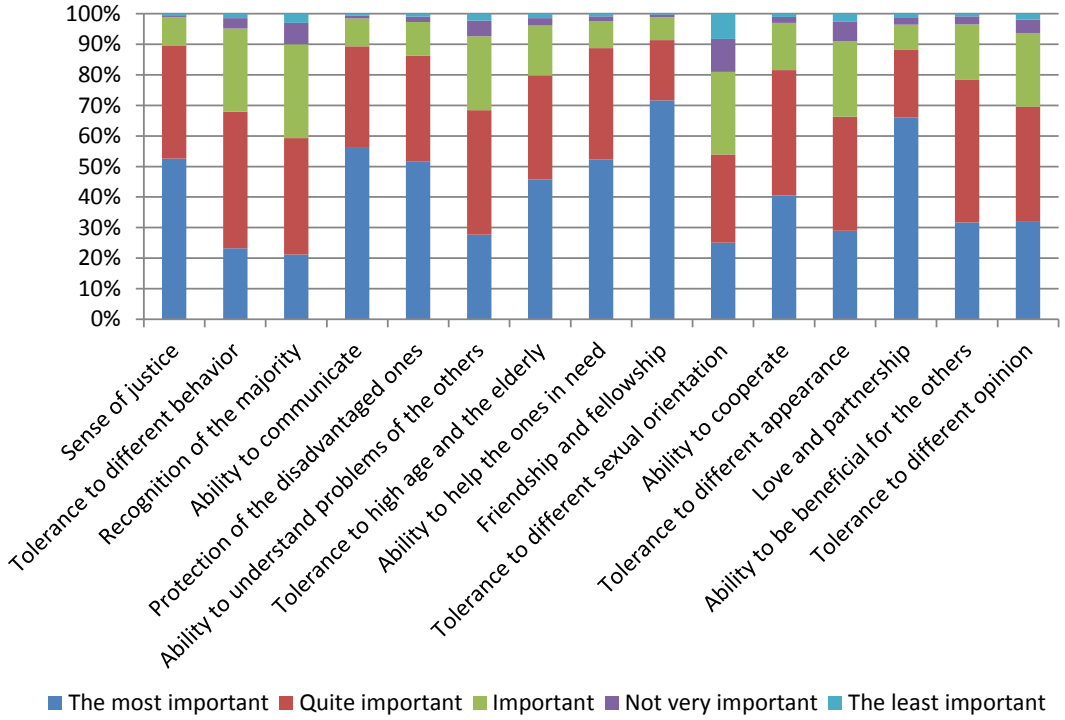
Teachers marked mostly *Love and partnership* (63%), *Sense of justice* (60.8%) and *Friendship and fellowship* (55.5%) as the most important values. The most preferred values also included the *Ability to communicate* (the sum of the answers the most important and quite important amounted to 95.2%), the *Ability to help the ones in need* (92.9%), *Tolerance to high age and the elderly* (91.1%), and *Protection of the disadvantaged ones* (89.8%). The categories *Recognition of the majority* (17.9%), *Tolerance to different sexual orientation* (8.9%) and *Tolerance to different appearance* (8%) were marked as of little or the least importance.

In the case of teachers, as well as in the case of young students, all the evaluated values relate to personal relationships among individuals. Less appreciated values appear to be related to general tolerance to otherness, unique identity of persons and their mutual differences, which include different sexual orientation, different appearance and so on.

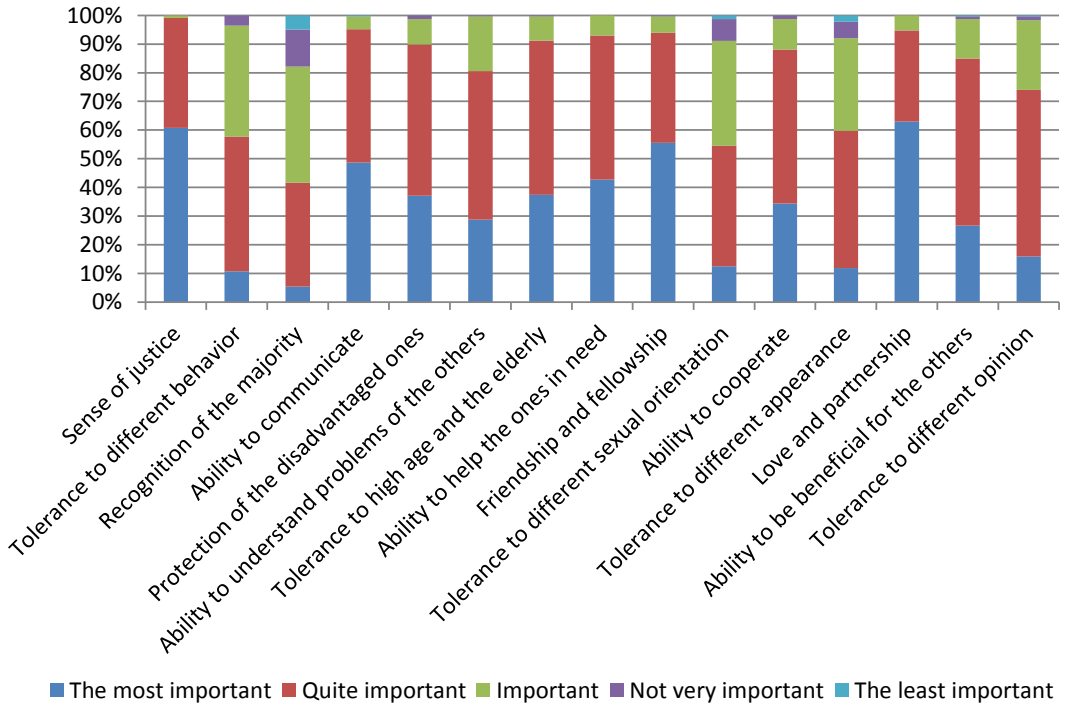
The relationship of respondents to otherness

We asked our respondents by the means of a semi-closed question about their personal relationship to various ethnic or cultural groups.

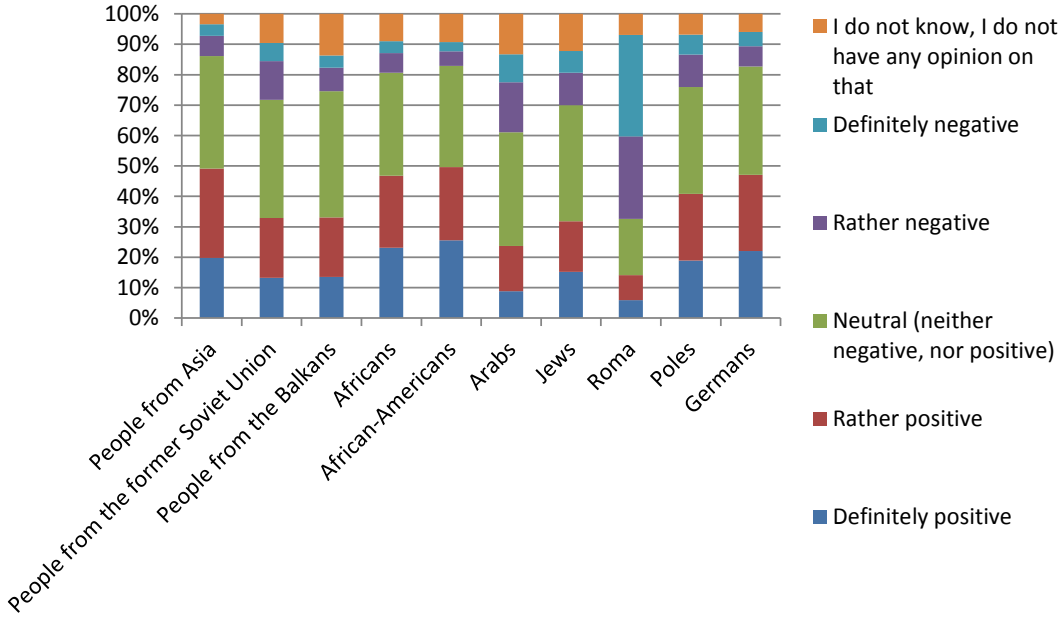
Graph 1: The importance of values in the case of young students



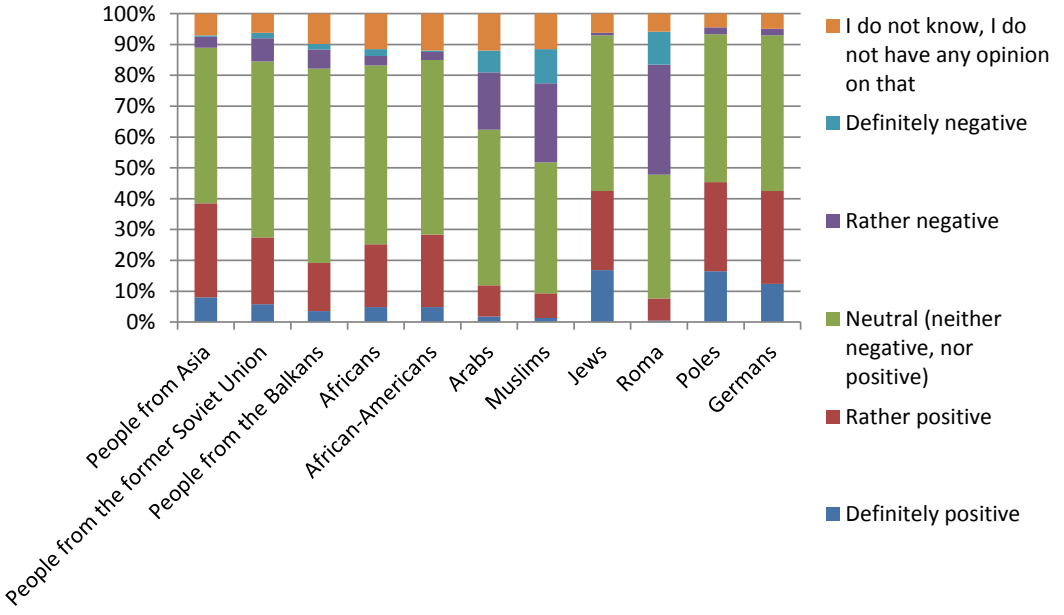
Graph 2: The importance of values in the case of teachers



Graph 3: The relationship of young students to different ethnic groups



Graph 4: Relationship of teachers to different ethnic groups



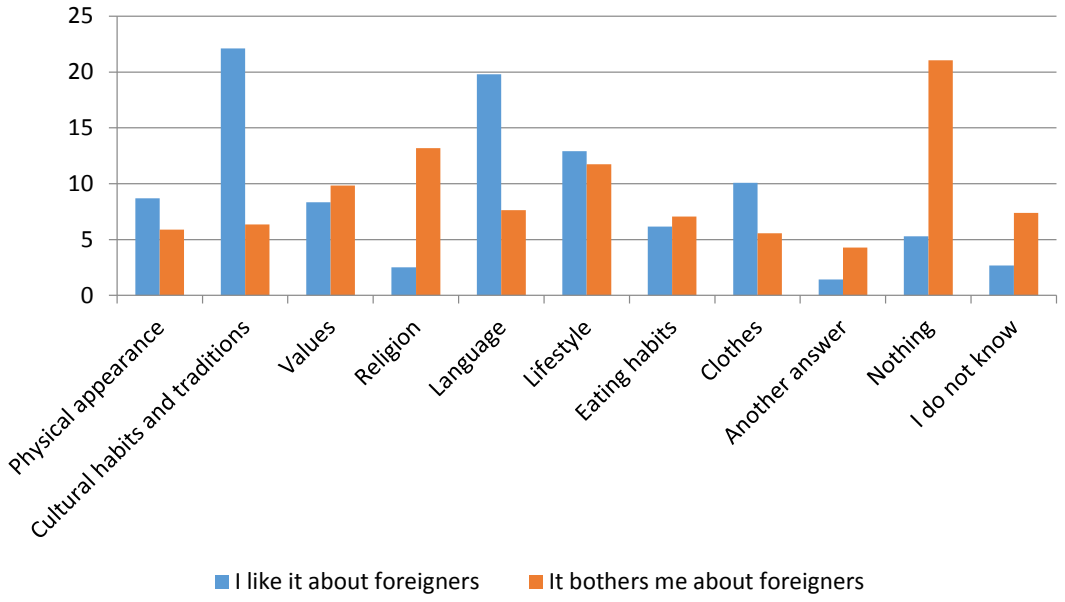
In the case of young students, it is quite obvious that the neutral and positive attitude to the relevant ethnic groups prevails over the negative ones, with one exception, which is the Roma. Also in the case of Arabs, the ratio of positive responses is one of the lowest ones.

Teachers evaluated their attitudes to the majority of the groups in relation to which they could express their opinions mostly as neutral and positive ones (although it occurred in a lesser extent than in the case of young students), which outweighed the negative ones. They usually justified their attitude by lack of knowledge of the group in concern or its members as the reason why they could not opt for one of the more clear-cut answers.

Our respondents evaluated their personal relationship to different ethnic groups in general in a very similar way. Young students chose a neutral standpoint in 46.2% of cases, the quite positive one in 17.1% and 13.3% chose the option that they had no opinion. Teachers marked their relationship with members of other ethnic groups or cultures as neutral in 60%, positive in 29.3% and negative in 8.8% of cases. The question was designed as a closed one with reasoning in the form of verbal commentary. In the respondents' answers there occurs a particularly prevalent emphasis on the willingness of different ethnic groups to adapt, to behave according to the regulations acknowledged in the Czech Republic („*It depends on the behavior, the willingness to adapt*"). These responses constitute 22.1% in the case of young students. 34.3% of teachers inclined to the opinion that it depends on the behavior of individual people. Respondents then usually reflected their personal experience in their decisions, even if it was absent (21.9% of teachers and 8.1% of young students). Especially young students frequently expressed their disinterest in the issue.

Relationship of adolescents to otherness is also documented within the statements of respondents related to what they consider attractive about foreigners and on the contrary, what bothers them about foreigners. Mainly cultural customs and traditions

Graph 5: What I like about foreigners /what bothers me about them



(22.1%), language (19.8%) and lifestyle (12.9%) were evaluated positively.

A similar question was also used to define the extent to which young students' fear of foreigners was justified. The opinion that fear of foreigners is justified prevailed in the highest frequency here, foreigners seems to denote certain danger to our society, or the few is at least understandable to a large extent.

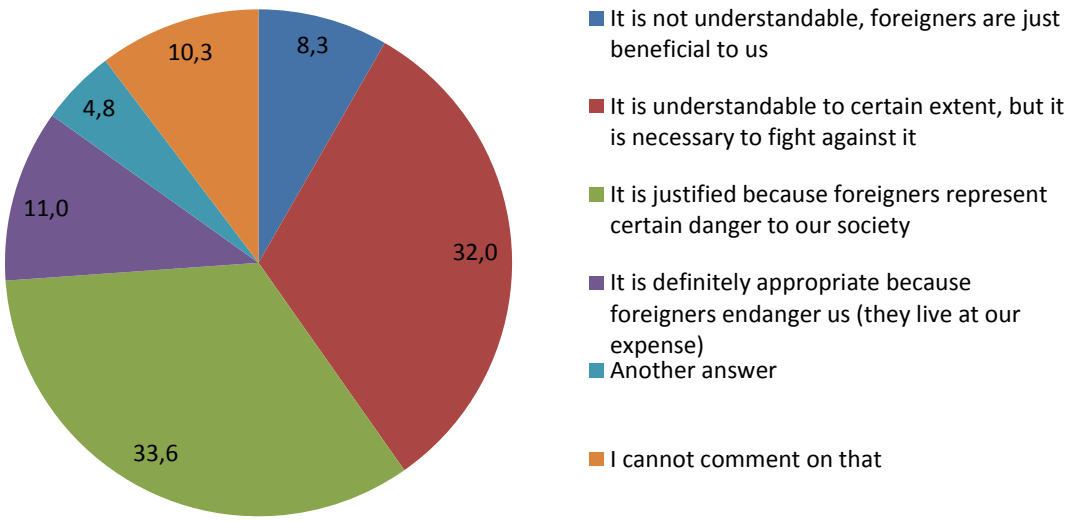
Teachers were also asked if they considered foreigners beneficial to our society, or not. Neutral answers prevailed over the positive or negative statements in the case of teachers. Nevertheless, approximately 40% of the respondents consider foreigners beneficial to our society, which is in correlation with the fact that 44% of teachers do not consider foreigners a risk to our society.

The respondents' answers absolutely obviously show that neutral and positive attitude to the relevant ethnic groups prevails over negative attitudes, even in case of Arabs, where the ratio of positive responses is almost the lowest one. Questionnaires administered to the young students targeted their attitudes as well as that of their families towards the Muslims. The answers show that the young students consider the attitudes of their families and friends to Muslims to be neutral. In both cases, the neutral value possibility was chosen by more than 50% of respondents. In the case of personal views on Muslims, which respondents presented in an open question, 41.3% corresponded with the category of „*I do not know, I do not have any opinion on that*". Another 27.1% of respondents expressed a neutral attitude and 24.0% negative or rather negative one.

An exception, in which the evaluation was not mainly neutral and positive, concerned only one group, the Roma, in the case of which our respondents chose more often quite negative, or clearly negative attitude.

In 29.9% of cases, they talked about the behavior of the given group, as was in the case of a young student: „*It depends on who they are and how they behave*". In other cases, respondents refer directly to the specific

Graph 6: Fear of foreigners



the behavior of the Roma as such, most often with negative connotations: „*I think they don't have any manners and I don't like their behavior*". 21.1% of respondents explained their attitudes by writing that the given group of people simply bothered them and in most cases without giving any reason, as it is evident here: „*And you ask why??? Yuck*," wrote a young student.

Conclusion

From the results of our research, it is apparent that teachers at Czech schools may not function sufficiently as assistants and guides to the young students – individuals or groups, who need social assistance because they belong to a marginalized group that is excluded or socially impaired – on their way to adapt to the mainstream society of the white majority. It seems that a space for a social worker as a social educational advisor (according Machalová) or social teacher (according Gulová, Hrdá, Šíp etc.) is open here. Our assumptions were confirmed in the case of a lower degree of tolerance of adolescents to the Roma minority compared to the other ethnic or cultural minority groups. The assumption that teachers and young students perceive coexistence of the majority with Roma minority as problematic has been confirmed. The research shows that attitudes declared by both young students and teachers may to some extent reflect the inclination of their bearers to xenophobia and racism as the stigmatization of the Roma in the public space of the Czech Republic is widely shared.

Based on our research, we may conclude that the values and attitudes of adolescents focused on their perceptions of members of different cultures and ethnicity is entirely different from the values and attitudes of their teachers.

Different ethnic groups are generally perceived as homogeneous entities culturally distinct from the majority and thus bearing the hallmark of „otherness" closely associated with stereotypical notions about the members of these groups. Such an approach is problematic because it goes against the spirit of multicultural education, which should eliminate stereotypes.

It is the very misunderstanding and unwillingness to try to understand the „normality of otherness", as well as a lack of effort not to designate otherness as something special, that significantly are the source of the ambivalent attitude of our respondents towards the members of minority groups.

References

ATKINSON, R. L. – ATKINSON, R. C. et al. (1995) *Psychology*. Prague: Viktoria Publishing, 1995.

BANKS, J. A., BANKS, C. A. M. (2009) *Multicultural Education: Issues and Perspectives*. 7th Ed. San Francisco: John Willey & Sons, 2009.

DISMAN, M. (2008) *How To Make Sociological Knowledge*. 3rd Ed. Prague: Karolinum 2008.

DomNWACHUKWU, Ch. S. (2010) *An Introduction to Multicultural Education*. Lanham: Rowman & Littlefield Publishers, 2010.

FREIRE, P. (1986) *Pedagogy of the oppressed*. 3rd Ed. New York: Continuum, 1986.

GAY, L, R. (1981) *Educational research*; *Competencies for analysis and application*. 2nd Ed. Columbus, OH: Charles e. Merrill, 1981.

GEERTZ, C. (2000) *The Interpretation of Cultures: Selected Essays*. Prague: SLON, 2000.

GIDDENS, A. (1999) *Sociology*. Prague: Argo, 1999.

HRDÁ, M. – ŠÍP, R. et al. (2011) *Identity in Social-Pedagogical Research*. Brunn: Masaryk University, 2011.

JANEBOVÁ, R. (2014) *Critical social work*. Prague: Gaudeamus, 2014.

MACHALOVÁ, M. (2013) *Preventive*

Social Work. Educational Paradigm in the Social Work. Presov: University of Presov, 2013.

NAKONEČNÝ, M. (1999) *Social psychology*. Prague: Academia, 1999.

PRŮCHA, J. – WALTEROVÁ, E. – MAREŠ, J. (2003). *Pedagogical Dictionary*. 4th Ed. Prague: Portal, 2003.

SKUTIL, M. et al. (2011) *Basics of Educational-Psychological Research for Students of the Teaching Profession*. Prague: Portal, 2011.

SLEETER, Ch. E. – GRANT, C. A. (2009) *Making Choices for Multicultural Education. Five Approaches to Race, Class, and Gender*. 6th Ed. New York: John Willey & Sons, 2009.

ŠVAŘÍČEK, R. – ŠEĎOVÁ, K. et al. (2014) *Qualitative Research in Pedagogical Sciences*. 2nd Ed. Prague: Portal, 2014.

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Some aspects of the health status of homeless people

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Original Articles

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Homeless, nutrition, infectious diseases, tuberculosis, trauma, health care, hospitalization, health status, ageing, death.

Abstract

Spectrum of infections and non-infections diseases among refuges from Syria/Iraq to Hungary/Austria in September 2015 is analyzed. Respiratory isolates from patients with pneumonia were obtained from respiratory tract secretions and tested for antimicriobial susceptibility. Majority of ID were upper and lower respiratory tract infections, scabies and other skin and soft tissue infections. However, infections represented only about one half of cases seeking medical help – the rest 40-60% were hypertension, exhaustion, depression, diabetes, neuropsychiatric disorders.

Abstract

40% of homeless people report at least one chronic health problem. Some medical problems are particularly prevalent such as chronic obstructive pulmonary diseases, arthritis and musculoskeletal disorders. Trauma is a significant cause of disability and death. Homeless people are predisposed to infections because of their poor physical state and lack of hygiene; hence outbreaks of contagious diseases are more prevalent in the homeless. Tuberculosis is an important health problem among the homeless. Homeless people are at high risk of bloodborne infections and disproportionately suffer from mental illness and substance use disorders. Homelessness negatively impacts child health and development. There are a number of internal and external barriers to providing health care for homeless persons. Hospitalizations are more frequent and they take a longer time. The homeless are not registered with their Doctor and try to get health assistance by using emergency services. They have problems with health system or social insurance. The health status is substantially worse than in other population. Homeless people have a greatly

increased risk of death. Problems of providing health care to the homeless depend in every country on the existing health policy and the economy. Insufficient care for homeless people means not only aggravation of their health state but it could have negative impacts on the health of the broader group of people.

Background

Definitions of homelessness vary across countries (1). In line with its simplified definition homeless people are the human beings living on the street with no roof above their heads and no place to stay even for a short time (2). In 2005, a typology named ETHOS (European Typology of Homelessness and Housing Exclusion) worked to serve the needs of the European Union. This typology was elaborated by another national organization called FEANTSA (Fédération Européenne d´Associations Nationales Travaillant avec les Sans-Abris) (3). ETHOS classifies people according to their living situation:

- rooflessness (without a shelter of any kind, sleeping rough),
- houselessness (with a place to sleep but temporary in institutions or shelter),
- living in insecure accomodation (threatened with severe exclusion due to insecure tenancies, eviction, domestic violence),
- living in inadequate housing (caravans, unfit housing, extreme overcrowding) (4).

The exact number of homeless pople is unknown. In the whole of the European Union an estimated 4.1 million people have a homeless episode in a year (5). Czech Republic estimates to have about 100,000 homeless people; a census of homeless people in Prague identified 3,096 people in this category (6). Slovakia accounts for about 30,000 homeless people living mostly in Bratislava (approximately 3,000 people – data from 2006) (7, 3).

Reasons leading to homelessness are *Objective* and *Subjective*.

Objective (structural) *factors* including the general social situation, e.g. employment policy;

housing policy; relationship of society to these marginal groups.

Subjective (individual) *factors* are represented by material factors (e.g. loss of home, loss of

job, insufficient incomes, loss of a property, etc.);

Relationship factors (e.g. family or marital problems, divorce, split up of a family, violence

in a family, loneliness);

Personal factors (e.g. mental or somatic disease, disability, alcoholism and other addictions); *Institutional factors* (release from hospital or prison, departure from children's home) (6).

To conclude: negative personal relations; work or housing problems; financial problems; administrative-legal problems; health problems belong to the most serious problems facing homeless people (6, 8).

Chronic Diseases and Nutrition

40% of homeless persons report at least one chronic health problem. These chronic illnesses may be silent until late in their courses and, because of limited medical attention, often go under recognized and untreated. Even if the condition is detected and treated, lack of compliance with consistent follow-up often results in disease progression, disability, morbidity and premature death (9). A Slovak study made in a homeless shelter demonstrated that 42.5% of homeless people suffered from infectious diseases (mostly respiratory and urinary

infections), while 57.4% of homeless people suffered from non-infectious diseases; the most frequent being ischemic heart disease and hypertension (10). Epilepsy belongs to the frequent diseases, as well. Prevalence of active epilepsy (8.1%) in a French study is markedly higher than that estimated in the general population (< 1%). When alcohol-related seizures (ARS) are included, 14.5% of a study population had a history of seizures (11). Some medical problems are particularly prevalent with homeless persons; chronic obstructive pulmonary diseases, arthritis and musculoskeletal disorders. Hypertension, diabetes and anemia are often insufficiently controlled and may be unrecognizable for a long period of time. Hygiene and tooth care are at a low level (12).

The way of life of homeless people results in problems respecting the so-called healthy lifestyle regimen. We can hardly speak of a healthy way of living in a situation when people are able to satisfy their biological needs just occasionally and/or in a substitute way (13). Homeless persons depend substantially on food from municipal and charitable shelters, fast-food restaurants, delicatesssens and garbage bins (14). Most studies report a high prevalence of inadequate or imbalanced nutritiment, vitamin and mineral intake placing the homeless at risk for nutrion-related disorders and contributing to the increased prevalence of poorly controlled diabetes, hypertension and cholesterol; all risk factors for cardiovascular diseases (15). Diets of homeless people are often high in saturated fats and cholesterol and inadequate in essential nutrients contributing to adverse lipid profiles (15).

Trauma

Trauma is a significant cause of disability and death. The homeless are particularly at risk because life in the city streets is unsafe and they may choose hazardous sleeping accommodations and suffer from burns caused by fires used for warmth (16). In a study of 581 homeless female veterans 99% of participants endorsed at least one trauma item; the homeless women reported being exposed to a mean of 7.40 different types of trauma and a median of 31 total events (17). The rate of traumatic brain injury varied across studies, ranging from 8%-53%. Homeless men are more likely to have traumatic brain injury than homeless women (1, 18). Hwang and colleagues found a high prevalence of traumatic brain injuries that are 5 or more times greater than the lifetime prevalence rate of the general population in the United States. The history of traumatic brain injuries was strongly associated with seizures, mental health problems, drug problems, and poorer physical and mental health states (19).

Infectious diseases

Homeless people are predisposed to infections because of their poor physical state and lack

of hygiene; hence outbreaks of contagious diseases are more prevalent in the homeless (20). Skin problems are the main reason why the homeless seek medical attention, and these commonly include scabies, pediculosis, tinea infections and impetigo (20). The louse transmitted bacteria *Bartonella qiuntana* has been found to cause clinical conditions in the homeless such as urban trench fever, bacillary angionmatosis, endocarditis, and chronic afebrile bacteriaemia (20). Foot problems are a major cause of illness and may represent up to 20% of the medical complaints of homeless people. The main cause of foot lesions is minor repetitive trauma because the homeless often walk in inappropriate shoes. Other factors are venous stasis and leg edema; cold (frost bite) and moisture (immersion foot); peripheral neuropathy; high

prevalence of hypertension; heavy tobacco use; lack of hygiene.

The combination of trauma, stasis and ischemia in the feet promotes infections which may result in osteomyelitis, cellulitis and gangrene and necessitate amputation of the limb (20).

Respiratory diseases are very frequent. Common viral respiratory diseases are easily transmitted from person to person. Crowded shelters and food lines provide the ideal circumstances for the spread of respiratory infections (16). Minor upper respiratory infections have been found to be twice as common in homeless children and represent 40% of the acute medical complaints of the homeless (20). Homeless persons are at high risk of serious pneumococcal infections. In Toronto, the incidence of invasive pneumococcal disease in homeless adults was 273 infections per 100,000 persons per year compared to 9 per 100,000 persons in the general adult population. Homeless persons with invasive pneumococcal disease were younger than other adults, more likely to be smokers, to abuse alcohol and to use intravenous drugs. The proportion of patients with recurrent disease was five times higher in case of the homeless than with other adults (12% vs. 2.5%) (21).

Tuberculosis

Tuberculosis is an important health problem among the homeless. Persons living in shelters are at high risk of tuberculosis and also pose a potential public health problem (16). In systematic review and meta-analysis (43 eligible surveys with a total population of 59,736 homeless individuals) authors reported that estimates of tuberculosis prevalence range from 0.2% to 7.7% (22). Tuberculosis in Prague increased from 2.1% in 1999 to 15.1% in 2008 (23). In 2002-2006, the homeless suffered from tuberculosis on average 10 times more often than the other population (24). Tuberculosis in the homeless has some specific features:

- mainly men are affected;
- ill people in a productive age of 40-60 years significantly prevail;
- tuberculosis is found in its symptomatic state only, active search is applied just with difficulties;
- a high percentage of tbc is found in moribund state or with dead homeless persons;
- multi-resistent forms of tuberculosis also appear among the homeless (23).

Bloodborne Infections

Homeless people are at high risk for bloodborne infections. HIV infection, viral hepatitis B, viral hepatitis C occur more often than in other populations due to more frequent prostitution to earn money to survive and/or get a daily drug dose. Homelessness is also an important risk factor for acquiring HIV infection. Data from the USA showed that higher intravenous drug use, prostitution or “survival sex“ and multiple sexual partners contribute to increased HIV prevalence (20). AIDS and homelessness co-occur at very high rates: AIDS is nine times more prevalent among the homeless in Philadelphia than in the general population, and homelessness is three times more prevalent among people with AIDS than in the general population. Among the homeless, being male, having a substance abuse problem and having a severe mental disorder were all significant risk factors for AIDS (25). In the above- mentioned review the prevalence of hepatitis C virus infection ranged from 3.9% to 36.2% (22). The prevalence of hepatitis B and hepatitis C are significantly higher among street youth than among non-street persons of similar age. A study of the prevalence of hepatitis B infection in street youth in Montreal found that 9.2% of the participants had markers

of the infection. Risk factors such as older age (> 18 years); injection drug use; sexual partners with history of unspecified hepatitis, ≥ 1 tattoo and body piercing were the factors associated with HBV infection (26). In the survey of hepatitis B and C prevalence amongst ninety-eight individuals of the Prague homeless community, the authors found that prevalence of both VHB and VHC achieved 26.5%. Risk factors were current or past intravenous drug users, higher age (21 years and older) and sharing paraphernalia (equipment used in the preparation of drugs for injection, e.g. spoons, filters and foil) (27).

Mental Disorders and Addictions

Homelessness can be both a cause and a consequence of mental illness (31). The homeless disproportionately suffer from mental illness and substance use disorders. In one survey, 81% of patients had a major mental illness; 69% had a substance-use disorder. Over 50% had co-occuring major mental ilness and substance-use disorder. (28). In systematic review and meta-analysis of 29 eligible surveys with 5,684 homeless individuals from seven countries, authors reported that prevalence estimates of psychotic illness range from 2.8% to 42.3%; major depression from 0.0% to 40.9%; personality disorder from 2.2% to 71%; alcohol dependence from 8.5% to 58.1% and drug dependence from 4.7% to 54.2%. The most common mental disorders appeared to be alcohol and drug dependence with random effects pooled prevalence estimates of 37.9% and 24.4% respectively (29). From a sample of 266 hostel dwellers in Glasgow, 82% had cognitive impairment and 78% were drinking hazardously. The prevalence of alcohol-related brain damage (spectrum of amnesic disorders including Wernicke´s Encefalopathy and Korsakoff´s Psychosis) was 21% (30).

Smoking

Tobacco use is common in homeless populations: approximately three quarters of homeless adults are cigarette smokers – a prevalence 4 times that in the U.S. adult population and 2.5 times that among impoverished Americans in general (32, 1). Results from the Prague homeless population are very similar. The authors found the prevalence of smoking to be significantly higher among homeless men (93%) and women (83%) compared to the general Czech population, men 38% and women 35% (33). A Slovak study implemented in an asylum home showed that 89.4% of 226 homeless people were smokers while 60.6% of them consumed too much alcohol (34).

Homeless Children and Youth

Homelessness negatively impacts child health and development in many ways (35). Children have shown higher rates of acute and chronic health problems (36). Homeless children were 2.5 times as likely to have health problems and 3 times as likely to have severe health problems as housed children (37). Children without a stable home have increased rates of multiple infections, respiratory, gastrointestinal and dermatologic diseases. The prevalence and severity of asthma are increased; they suffer from higher rate of accidents and injuries. Homeless children are at increased risk of abuse; exposure to violence; suffer from higher rates of malnutrition, stunting and obesity (36). Street youth (teenagers and young people below the age of 20-25 years) are exposed to a number of factors that affect their health. Risk of hepatitis B, hepatitis C and HIV infections are higher among street youth than among non-streeet youth. The prevalence of mental health problem, pregnancy and high levels of violence is greater among homeless youth (38).

Access to Health Care

There are a number of *Internal* and *External barriers* to provide health care for homeless persons. *Internal barriers* include the denial of health problems by many homeless persons and the pressure to fulfill competing non-financial needs such as for food, clothing and shelter. *External barriers* include unavailable, fragmented and costly health care services; prejudices and frustrations on the part of Health Profesionals who care for homeless persons (9). Despite a system of Universal Health Insurance, health care access can remain a problem for homeless people. There are *financial* and *non-financial barriers* to obtain health care. *Non-financial barriers* may include general mistrust of health care providers and lack of access to a primary care provider (39). Homeless individuals have high rates of acute health-care use, including Emergency Department visits and Inpatient Admission to hospital (1). 44.91% of homeless Veterans Affairs (VA) service users were emergency department users, which is nearly three times the rate of domiciled VA Services users (40). In Slovakia, we have similar experience. Hospitalizations of the homeless are more frequent and they last a longer time. The homeless are not registered with their Doctor and try to get health assistance by using emergency services. They have problems with any health system or social insurance (3). The most frequent problems of the health care for homeless are:

- unclear relations between the homeless person, health insurance company and health care providers,
- missing continuity of the health care,
- consequent treatment following hospitalisation,
- chronically ill homeless persons with demanding treatment,
- higher homeless morbidity of some diseases (3).

Older Homeless and Geriatric Syndromes

In the USA, the authors call the phenomena “aging of the homeless population”. The median age of the homeless in San Francisco increased by an average nine years over the 14-year period 1990-2003: this aging rate far exceeds that of the general population. The median total time homeless increased from 12 to 39.5 months. This trend may reflect provider changes or shifts in service utilization (41). The trend in aging of the homeless population will lead to higher need and consumption of health care for the homeless. The American survey compares two groups: younger homeless persons (18 to 49 years old) and older homeless persons (50 years and older). Older homeless persons were 3.6 times more likely to report a chronic medical condition; 2.8 times more likely to not have health insurance. Among medical conditions reported, older homeless respondents were significantly more likely to report having hypertension and arthritis or other musculoskeletal disorders, but comparable rates of chronic respiratory conditions, including asthma and chronic obstructive pulmonary disease (42). At the same time, geriatric syndromes among younger homeless appear more frequently. In a recent study, the authors compared a group of 247 homeless adults (mean age 56.0 years with 765 community adults (mean age 78.1 years) in three population-based cohorts. 30.1% of homeless people reported difficulty performing at least one activity of daily living; 53.2% fell in the prior year. Cognitive impairment defined as Mini Mental State Examination score < 24 was present in 24.3% of participants, impaired executive function was present in 28.3% of participants. Self-reported hearing and visual impairment was present among 29.7% and 30.0%, respectively. Urinary incontinence was reported by 49.8% of subjects. The study shows that

older homeless adults have higher rates of most geriatric syndromes compared to the general population (43).

Mortality

The health status of homeless persons is substantially worse than in other populations. Homeless people have a greatly increased risk of death (12). Among men using shelters for the homeless in Toronto, mortality rates are 8.3 times higher than the mean for 18-24 year olds; 3.7 times higher than the mean for 25-44 years olds; 2.3 times higher than the mean for 45-64 years old (44). In another study the average age at death was 47 years (median, 44 years (range 18 to 86 years). The acquired immunodeficiency syndrome (AIDS) was the leading cause of death among persons 25 to 44 years of age; homicide a leading cause in persons 18 to 24 years of age; heart disease a major cause of death in homeless persons 45-64 years of age. For men 25 to 44 years of age the rate of death from heart disesase was more than threefold higher than in the general population (45). Increased cardiovascular mortality rates in the homeless are attributable to a complex interplay between risk factors. These risks include psycho-social stressors of the daily battle for the necessities of life including food, shelter; safety which along with a decrease in diagnostic, preventative and remedial care results in an increased prevalence and poorer control of risk factors and the co-morbidities (15). Mortality of street youth is about 11 times the expected rate based on age and sex and is mainly caused by suicide and drug overdose (38).

Conclusions

Problems of providing health care to the homeless depend in every country on the existing health policy and economy (13). Given the raising number of homeless people, our Physicians will more often also have to deal with problems pertaining to diagnostics, treatment and prevention of diseases among the homeless. All of us should be aware that insufficient care for the homeless people means not only aggravation of their health state but it could have negative impacts on health for a much broader group of people passing by with no concern (13).

References

1. Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. Lancet 2014; 384 (9953): 1529-40.
2. Vereš M. The most frequently causes of homelessness among the seniors. Kontakt 2008; 10 (2): 326–333.
3. Gogoláková P, Dostálová K, Somogyiová E, Vladárová M, Moricová Š. The homeless – a problem from the public health view. Verejné zdravotníctvo 2010. http://www.verejnezdravotnictvo.sk
4. Feantsa. ETHOS – European Typology on Homelessness and housing exclusion. 2005. http://www.feantsa.org/spip.php?article120&lang=en>
5. European Comission, Comission staff working document. Confronting homelessness in The European Union. Brussels: European Comission, 2013: 48 p. http://www.ec.europa.eu
6. Barták M. Homelessness in Czech Republic: the health status of homeless people and it´s determinants. Ústí nad Labem: Univerzita J.E.Purkyně, 2011: 200 s.
7. Karvaš B. The situation of the homeless persons in Slovak Republic. Sociálna politika a zamestnanosť 2006; 2: 13-14.
8. Schwarzová G: The social work with the homeless. In: Matoušek O, Koláčková J, Kodymová P (eds.): Social work in practice. Praha: Portál, 2005: 315-330.
9. Plumb JD. Homelessness: care, prevention and public policy. Ann Intern Med 1997; 126 (12): 973-5.

10. Bošňáková M: Risk factors of homelessness and most frequent infectious and noninfectious diseases among the homeless. Acta chemotherapeutica 2004; 13 (5): 72-80.
11. Laporte A, Rouvel-Tallec A, Grosdidier E et al. Epilepsy among the homeless: prevalence and characteristics. European Journal of Public Health 2005; 16 (5): 584-586.
12. Hwang SW. Homelessness and health. CMAJ 2001; 164 (2): 229–33.
13. Šupková D, Pešek J, Trnka L, Vidovičová H, Volná J. The health care for the homeless. Praha: Grada Publishing, 2007: 64 s.
14. Luder E, Boey E, Buchalter B, Martinez-Weber C. Assessment of the nutritional status of urban homeless adults. Public Health Reports 1989; 104 (5): 451-457.
15. Jones ChA, Perera A, Chow M, Ho I, Ngyuen J, Davachi S. Cardiovascular disease risk among the poor and homeless – what we know so far. Current Cardiology Reviews 2009; 5: 69-77.
16. Brickner PW, Scanlan BC, Cinanan B et al. Homeless persons and health care. Ann Intern Med 1986; 104: 405-409.
17. Tsai J, Rosenbeck RA, Decker SE, Desai RA, Harpaz-Rotem I. Trauma experience among homeless female veterans: correlates and impact on housing, clinical, and psychosocial outcomes. Journal of Traumatic Stress 2012; 25 (6): 624-32.
18. Topolovec-Vranic J, Ennis N, Colantonio A. et al. Traumatic brain injury among people who are homeless: a systematic review. BMC 2012; 12: 1059.
19. Hwang SW, Colantonio A, Chiu S et al. The effect of traumatic brain injury on the health of homeless people. CMAJ 2008; 179(8): 179-84.
20. Raoult D, Foucault C, Brouqui P. Infections in the homeless. The Lancet Infectious Diseases 2001; 1(2): 77-84.
21. Plevneshi A, Svoboda T, Armstrong I et al. Population-based surveillance of invasive pneumococcal disease in homeless adults in Toronto. PloS One 2009; 4(9): e 7255. doi:10.1371/journal.pone.0007255.
22. Beijer U, Wolf A, Fazel S. Prevalence of tuberculosis, hepatitis C virus, and HIV in homeless people: a systematic review amd meta-analysis. Lancet Infect Dis 2012; 12: 859-70.
23. Kubín M, Kalina P, Jágrová Z, Švandová E. Foreigners and homeless – new epidemiological and social factors in the control of tuberculosis in Prague. Prakt Lék 2010; 90(6): 352-7.
24. Trnka L. The prevalence of tuberculosis in 21th century and problem of homeless in Czech Republic. In: Health care for homeless people in Czech republic. [Šupková, D. a kol. - eds]. Praha: Grada Publishing, 2007: 44-50.
25. Culhane DP, Gollub E, Kuhn R, Shpaner M. The co-occurence of AIDS and homelessness: databases for AIDS surveillance and public shelter utilisation in Philadelphia. J Epidemiol Community Health 2001; 55(7): 515-20.
26. Roy E, Haley N, Lemire N, Boivin JF, Leclerc P, Vincelette J. Hepatitis B virus infection among street youth in Montreal. CMAJ 1999; 161(6): 689-93.
27. Volf V, Marx D, Pliskova L, Sumegh L, Celko A. A survey of hepatitis B and C prevalence amongst the homeless community of Prague. European Journal of Public Health 2007; 18 (1): 44–7.
28. Wolfson IS. Homelessness and health. Medicine and Health Rhode Island 2006; 89 (10): 336-8.
29. Fazel S, Khosia V, Doll H, Geddes J. The prevalence of mental disorders among the homeless in Western countries: systematic review and meta-regression analysis. PLoS Medicine 2008; 5(12): e 225. doi:10.1371/journal.p.med.0050225.
30. Gilchrist G, Morrison DS. Prevalence of alcohol related brain damage among homeless hostel dwellers in Glasgow. European Journal of Public Health 2005; 15(6): 587-8.

31. Perry J, Craig TKJ. Homelessness and mental health. Trends in Urology and Men´s Health 2015; 6 (2): 19-21.
32. Baggett TP, Tobey ML, Rigotti NA. Tobacco use among homeless people – addressing the neglected addiction. N Engl J Med 2013; 369(3): 201-4.
33. Kubisová D, Adámková V, Lánska V, Dlouhý P, Rambousková J, Anděl M. Higher prevalence of smoking and lower BMI, waist circumference, cholesterol and triacylglyceride levels in Prague´s homeless compared to a a majority of the Czech population. BMC Public Health 2007; 7: 51.
34. Kasanová A, Turček K. A look on unwanted habits and other mental morbidities of residents of asylum houses. Alkoholizmus a drogové závislosti (Protialkoholický Obzor) 2004; 39 (4-5): 211-6.
35. Weinreb L, Goldberg R, Bassuk E, Perloff J. Determinants of health and service use patterns in homeless and low-income housed children. Pediatrics 1998; 102 (3): 554–562.
36. Council on Community Pediatrics. Providing care for children and adolescent facing homelessness and housing insecurity. Pediatrics 2013; 131(6): 1206-10.
37. Berti LC, Zylbert S, Rolnitzky L. Comparison of health status of children using a school-based health center for comprehensive care. J Pediatr Health Care 2001; 15 (5): 244-250.
38. Boivin JF, Roy E, Haley N, Galbauld du Fort G. The health of street youth. CJPH 2005; 96 (6), 432-7.
39. Hwang SW, Ueng JJM, Chiu S. et al. Universal health insurance and health care access for homeless persons. Am J Public Health 2010; 100(8): 1454-61.
40. Tsai J, Rosenbeck RA. Risk factors for ED use among homeless veterans. Am J Emerg Med 2013; 31(5): 855-59.
41. Hahn JA, Kushel MB, Bangsberg DR, Riley E, Moss AR. Brief report: the aging of the homeless population: fourteen–year trend in San Francisco. J Gen Intern Med 2006; 21: 775-778.
42. Garibaldi B, Conde-Martel A, O´Toole TP. Self-reported comorbidities, perceived needs, and sources for usual care for older and younger homeless adults. J Gen Intern Med 2005; 20(8): 726-730.
43. Brown RT, Kiely DK, Bharel M, Mitchell SL. Geriatric syndromes in older homeless adults. J Gen Intern Med 2011; 27 (1): 16–22.
44. Hwang SW. Mortality among men using homeless shelters in Toronto, Ontario. JAMA 2000; 283: 2152-7.
45. Hwang SW, Orav EJ, O´Connell JJ, Lebow JM, Brennan TA. Causes of death in homeless adults in Boston. Ann Intern Med 1997; 126 (8): 625-628.

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Loneliness as a Risk Factor for Depression in the Elderly

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Original Articles

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Elderly. Depression. Loneliness. Risk factor. GDS scale

Abstract:

The aim of the study was to determine the impact of loneliness on the emergence of depression in the elderly. The sample consisted of 168 elderly living in their natural social environment. The depressive symptomatology was examined by the Geriatric Depression Scale (GDS). The impact of loneliness on depression development has been assessed by the non-parametric Kruskal Wallis and Chi-square Tests. The study found that up to 60.7% of seniors suffer from some degree of depression: 32.1% reporting mild; 28.6% manifesting full depression. We also have found a relationship between loneliness and depression development of the elderly.

Introduction

The current demographic trends show increases in aging population within all countries. Statistics clearly show that the number of people in senior age is continuously increasing and our population is getting older. Rabušic (2002) states that in 2030 the number is expected to increase from 23% to 25% and in 2050 seniors will represent 33% of our population. Depression is the most common affective disorder in old age. It affects 7%-15% of the population over 65 living in the community. The prevalence of hospitalized seniors and seniors in long-term Nursing care tends to be higher in 20% to 30% (Topinková 2010). Weber (2000) states that every sixth senior who comes to a Physician is diagnosed with varying degrees of depression. Because of the difficulty of depression determination in old age and the presence of severe somatic diseases, a significant number of depressives in old age remains undiagnosed. Loneliness is common among older people. It is related to several characteristics that impair the quality of life of older people: like depressive symptoms and decreased subjective health (Tilvis *et al*. 2000; Victor *et al*. 2000; Cohen Mansfield, Parpura-Gill 2007). Loneliness may lead to cognitive decline, increased need of help and use of health services, as well as early institutionalization (Geller *et*

al. 1999; Tilvis *et al*. 2000). Loneliness is a multi-faceted concept. In the Nursing literature, the terms loneliness, feeling lonely or alone often have been used interchangeably (Karnick 2005). In addition, the concepts of social isolation and living alone have been equated with loneliness (Victor *et al.* 2000).

Patients and Methods

The aim of this study was to verify whether loneliness affects the development of depression of the elderly. In this case, we defined loneliness as marital status in which senior lives alone. The overall research sample consisted of 168 seniors. The sample selection was purposive and the inclusion criteria for selection were as follows: age 65 and over; willingness to cooperate; none of the respondents has been diagnosed with depression and treated by antidepressants at the time of research. For data collection we used a standardized Questionnaire GDS – short form. The short form of the GDS Questionnaire contained 15 questions. The evaluation of answers was done in the following way: an examined individual received 1 point for a so-called depressive answer, which means "yes" for Questions Number 2, 3, 4, 6, 8, 9, 10, 12, 14 and 15, and 1 point for "no" for the remaining Questions 1, 5, 7, 11 and 13 (Weber *et al*. 2000 p. 131). The GDS is a simple Questionnaire which is easy to use in practice. There are only two options (Yes/No) which are associated with receiving 1 point for each answer depending on the Question. It is capable of evaluating the current state of an elderly person and differentiating three groups of people:

without depression, with minor symptoms, and those in need of a psychiatric intervention.

Questions are designed to focus on symptoms of depression typical for the elderly (Sheikh, Yesavage 1986). The GDS is a useful screening tool used in clinical practice in order to simplify the diagnosis of depression among the elderly. More than 5 points obtained in the GDS should be a reason for psychological examination of that particular individual.

Results and Discussion

The prevalence of depression among the elderly is high. The present study found that in a sample of 168 elderly people, as many as 60.7% of them suffered from some degree of depression; of those 32.1% suffered from only a mild type; 28.6% suffered from severe depression (Table 1).

Due to the low number of the compared groups, the difference in scores of depression related to family status we verified by the non-parametric Kruskal- Wallis test. Results are listed in Table 2. It can be seen that the difference in depression among patients single, married, and widowers is statistically significant ($p < 0.01$) where comparing to the average the highest depression score demonstrated widowed, and the lowest

Tab. 1 The prevalence of depression among the elderly

Form of depression	**Relative frequencies**	**Absolute frequencies (%)**
Normal affect without depression	66	39.3
Mild depression	54	32.1
Severe depression	48	28.6
Total	**168**	**100**

Tab. 2 Marital status and the occurrence of depression – Kruskal Wallis test

Marital status		N	Average order
Depression	Single	12	61.00
	Married	14	31.86
	Widowed	142	92.26
	Total	**168**	
Chi-square	11,494		
df	2		
Sig.	.003		

married seniors. The assumption has been accepted. Marital status is associated with depression in the elderly.

We verified an assumption of significant differences within the occurrence of depression among the categories of single, married and widowed seniors by the Chi-square Test. Table 3 shows $p<0.05$, which indicates that the differences are statistically significant in relation to the anticipated frequencies. We can state that widowed seniors equally represent the incidence of depression in categories – no depression: 32.4%; mild depression: 35.2%; severe depression: 32.4%. In the category of married seniors there is markedly higher number of respondents without depression – almost three quarters; the rest demonstrate only mild depression. In the group of elderly singles n= 6, the total of 5 respondents did not demonstrate depression (83.3%).

Aging is a specific long-encrypted biological process of functional changes that occur in an adult based on advancing age (Otomar 2011). The onset of the changes occurring in the ontogenesis of an individual at different times and progress. The progress of aging of an individual is genetically coded; at the same time is influenced by environmental factors and life-style (Weber *et al*. 2000). Good condition in old age is a state of good physical and mental condition and related ability to lead a full independent and quality life. On the other hand, it must be accepted that old age is a period when some of the diseases and disorders occur more often (Holmerová *et al*. 2007). Depressive symptoms are not an attribute of physiological old age, yet depressive conditions are often attached to aging by elderly themselves, their surroundings, even by their physicians (Drástová, 2006). Depression is one of the so-called "geriatric" which can be understood as a geriatric key concept and a priority of Geriatric Medicine that significantly affect the diagnosis and treatment of standard diseases (Kalvach *et al*. 2008).

Depression is a pathological condition with the predominance of sad mood acting on perception, cognition and emotional experience (Topinková 2010). It is a morbid mood change: a long-term sadness; bad mood of which reasons are often not known. Sadness and low mood persists long term and are accompanied by feelings of hopelessness, abandonment, meaninglessness (Holmerová *et al.* 2007). One of the most characteristic risk factors for the development of depression is loneliness. It quite often leads to serious health problems. Green *et al.* (1992) state that loneliness is the third most important risk factor for development of depression, and also is a significant cause of suicides and attempted suicides. A study conducted by Hansson *et al.* (1987) found out that loneliness is related to a poor mental state of

Tab. 3 Marital status and the occurrence of depression – Chi-square

			Depression-category			Total
			No depression	Mild depression	Severe depression	
Marital status	Single	Freq.	10	0	2	12
		Expected freq.	4.8	3.8	2.4	12.0
		%	83.3%	0.0%	16.7%	100%
	Married	Freq.	10	4	0	14
		Expected freq.	5.6	4.6	4.0	14.0
		%	71.4%	28.6%	0.0%	100%
	Widowed	Freq.	46	50	46	142
		Expected freq.	55,6	45,6	40,6	142,0
		%	32,4%	35,2%	32,4%	100%
Total		Freq.	66	54	48	**168**
		Expected freq.	66,0	54,0	48,0	168%
		%	39.3%	32.1%	28.6%	100%
		df	Sig.			
Chi square	10.488[a]	4	.033			

a person; unhappiness within the family; bad social relationships. Another cause of loneliness at the older age is widowhood. A study carried out by Holmer *et al*. (2006) found a significantly higher occurrence of depression among the elderly without children or those without a spouse. In this case, it is important to distinguish loneliness from living alone. A study conducted by Prince *et al.* (1997) found that elderly who live alone but have neighbors and friends have a lower risk of developing depression than those without relationships. According to Grešš Halász & Tkáčová (2015), Advanced

Nursing Practice could bring positive and accurate outcomes in assessment and care of clients suffering from loneliness. Because of this finding, the marital status was added to the set of factors analyzed in the present study. The results show that the marital status is associated with the development of depression since the widowed individuals tend to suffer from depression more frequently than the others. By contrast, the elderly living with their spouses demonstrated the lowest incidence of depression. The results confirm that widowhood belongs to the significant risk factors for development of depression in the elderly.

Conclusion

The study found that 60.7% of the elderly have some degree of depression, of which 32.1% showed mild and 28.6% showed severe depression requiring examination and treatment. Normal affect without depression was found in 39.3% of respondents. Results also confirmed our assumption that senior's marital status has an impact on the incidence

of depression. The higher incidence of depression was found in widowed – in our understanding of seniors living alone. Based on these results we suggest mapping depression risk factors of the elderly, and in primary prevention focusing particularly on seniors living alone. Further studies could specifically focus on the role of Nurses in the community that could bring quality care in terms of prevention as well as treatment of loneliness of elderly.

References

COHEN-MANSFIELD J, PARPURA-GILL A. *Loneliness in older persons: a theoretical model and empirical findings.* Int Psychogeriatr 2007; 19: 279-94.

DRÁSTOVÁ, H. *Depression in old age*. In Medicine for practice, 2006. 5:241 – 243.

GREEN BH, COPELAND JR, DEWEY ME, SHAMRA V, SAUNDERS PA, DAVIDSON IA, SULLIVAN C, MC WILLIAM C. *Risk factors for depression in elderly people: A prospective study*. Acta Psychiatrica Scandinavica.1992;86(3):213–217.

GREŠŠ HALÁSZ, B., TKÁČOVÁ, Advanced practice nurses. In *Road to modern nursing XVII. - Reviewed proceedings of the expert conference with international participation* [CD-ROM]. Prague: University Hospital in Motol, 2015, p. 19- 25. ISBN: 978- 80- 87347- 20-1.

GELLER J, JANSON P, MCGOVERN E, VALDINI A. *Loneliness as a predictor of hospital emergency department use*. J Fam Pract 1999; 48: 801-4.

HANSSON RO, JONES WH, CARPENTER BN, REMONDET JH. *Loneliness and adjustment to old age*. International Journal of Human Development.1987;27(1):41–53.

HOLMEROVÁ I, VAŇKOVÁ H, DRAGOMIRECKÁ E, JANEČKOVÁ H, VELETA P. *Depressive syndrome in the elderly, an important and hitherto unrecognized problem.* Psychiatry to practice. 2006;7(4):175-177.

HOLMEROVÁ, I. et al. *Selected Chapters from Gerontology*. Prague: Gerontologic center, 2007. 145 pp. ISBN 978-80-254-0179-8.

KALVACH, Z. et al. *Geriatric syndromes and geriatric patient*. Prague: Grada, 2008. 336 pp. ISBN 8024724904.

KARNICK PM. *Feeling lonely: theoretical perspectives*. Nurs Sci Q 2005;18:7-12; discussion 6.

OTOMAR, K. et al. *Medical physiology*. Prague: Grada, 2011. 800 pp. ISBN 978-80-247-3068-4.

PRINCE MJ, HARWOOD RH, BLIZARD RA, THOMAS A, MANN AH. Social support deficits, loneliness and life events as risk factors for depression in old age. The Gospel Oak Project VI. Psychological Medicine. 1997;27(2): 323-332.

RABUŠIC, L. *Aging population as a disaster or as a social challenge?* [online]. Available on the Internet: http://www.vupsv.cz/Starnuti_populace.pdf. [cited 2011-02-12].

TILVIS RS, PITKÄLÄ KH, JOLKKONEN J, STRANDBERG TE. *Social networks and dementia.* Lancet 2000; 356: 77-8.

SHEIKH JI, YESAVAGE JA. *Geriatric Depression Scale* (GDS). Recent evidence and development of a shorter version. Clinical Gerontologist: A Guide to Assessment and Intervention. NY: The Haworth Press, Inc.1986;5(1/2):165-173.

TOPINKOVÁ, T. *Geriatrics.* Prague: Society of General Medicine ČLS JEB, 2010. 24 pp. ISBN 978-80-8698-37-4.

VICTOR C, SCAMBLER S, BOND J, BOWLING A. Being alone in later life: loneliness, social isolation and living alone. Rev Clin Gerontol 2000; 10, 407-17.

WEBER, P. et al. *Minimum of clinical gerontology*. IPVZ Brno, 2000. 151 pp. ISBN 80-7013-314-7.

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Left-handedness preferences, functions and dependence on neurotic behavior limited by specific social dimensions

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Original Articles

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social dimension, laterality, lateral preference, emotive lability, neuroticism, school age

Abstract

Studies show that 10 to 12 percent of the population in every culture worldwide is left-handed. Our main motivation was to seek general and specific knowledge of this lateral phenomena, left-handedness, mainly in terms of Psychology and Neuropsychology. We concentrated on lateral preference, function relations and investigation; their dependence on emotional lability, that is instability and possible dependency on personality characteristics. Chosen methods were strictly divided into two independent areas: lateral preferences and social characteristics of personality. For detection of lateral and preferential conditions the Test for Measuring Lateral Preferences and the Questionnaire of Social Perspectives were used. Neurotic symptoms were examined through Eysenck´s Questionnaire B-JEPI, and for the more complex view and incidence of neuroticism the computerized form of Bourdon´s Test was used, applied in the distraction conditions aimed at confirming, respectively the act of a disproving personality and social variables.

Introduction

The majority population of the planet is right-handed, which is commonly known as a right-oriented society. The existence of left-handedness dates back in the history. During the Stone Age people executed their tools both for the right as well as the left hand. Since the Bronze Age specifically differentiated tools have been found.

The above mentioned phenomenon can be the most markedly seen during the process found in grapho-motoric habits or writing. Considering the fact that genotypic left-handed dispositions are not in accordance with right-sided tendencies of significant numbers of people, but the form of left-hand preference may be of pathological character as well. The first years of left-hand mentoring are probably becoming the most prominent ones, and in disorders such as dysgraphia, dyslexia, dyscalculia, they have wide etiology or cause of inception or

beginning to happen. It is known that the influence of non-crystallized left-hand lateral preference is not insignificant. Several empirical studies suggest have proven that left-handed children being strongly forced to a right-sided behavior and/or environment encounter higher incidences of neurotic symptoms.

Which hand is or will be used for writing? This problem of left-handed preference with an enhancing solution cannot be completed just by answering this question because the problem is considerably deeper; not just remaining within the preference of the upper limb arms and hands, but involving the entire body – respectively the twin body parts. The term pair functions can be understood as functions occurring in the body in pairs, and having the same functional focusing, generating quantitatively and with subtle differences qualitatively different activities. Mental functions arising under such pair-mating activities are therefore, in their core, having base-pair characteristics (I. Papousek, G. Schulter 2006). Lateral preference can be included among pair-based features. The unevenness of pair functions can be seen in Physiological and Psychological context (Smith 2007) which is expressed by relatively better performance of one of the paired organs in neuro-psychical regulation of behavior. It depends on which function is the leading one and which is the cooperative one (ocular dominance, footedness, handedness...). Every single individual has a part of the paired organ developed differently; i.e. a visual analyzer tends to be greater in its dimensionality than the other side: further one upper limb tends to be stronger; blood vessels in one hand are more branched than in the second hand; similarly, we can talk about facial mimic muscles.

During 1960s and 1970s there was significantly increased work done on laterality. One of the most important monographs in Czechoslovakia was M. Sovák's research entitled *Laterality As A Pedagogical Problem* (1962) with summarized findings of earlier perception of laterality derived from observations in Psychology, Anthropology, Science and Medicine and further compared with classical concepts of left-handedness. According to M. Sovák, the 1960s, 15% of non-practiced genotypic left-handers and 85% of phenotypic right-handers were found; 50% were inborn and 35% were left-handers but genotypically practiced as righties.

Various recent global statistics record the left-handed population at about 10%. In 2007, Scientists identified LRRTM1; a gene whose occurrence increases likelihood of left-handedness; however, inheritance of lateral preference remains questionable. S. Ekaldi (1999) points out that if both parents are with left hand dominance, they give their child a chance also to be left-handed (about 26%). Concerning that, it should be pointed out that the right-handed environment is appropriate for any level of right-handedness. Inborn right-handedness is supported from early childhood by education and personal development. On the contrary, we distinguish between natural (or genetic) left-handers and taught left-handers, identified by Giannini (1984) on the basis of right hemisphere preference related to speech and language. The trained left-handers usually write with their left hand (usually poorly) and have dual hemispheric activation with tasks aimed at speaking verbal processes.

Research, Methods, Results

Professor D. Kováč, from the Institute of Experimental Psychology of the Slovak Academy of Sciences, created a team of Slovak Experimental Researchers G. Horkovič, I. Ruisel, K. Jariabková, L. Arbeit J. Stempelová, I. Brezina etc., and Czech collaborators – experts, headed by A. Kučera

and M. Sovák, who devoted more than ten years of research to left-handed preference. However, this lateral preference is not well understood in society due to social and other problems. That is the reason we want to follow the experiments launched by D. Kováč and G. Horkovič where their starting point was a construction of a Questionnaire based on their evident experience and furthermore individual awareness of several lateral-preference issues where individuals know about them and are able to talk about them. There is no doubt that lateral preferences are manifested not only in real life performance, but also in the experiential realm, and therefore can be further explored based on own personal statements about it.

We collected and processed data using a combination of M.B. Denckla´s (1998) Neuro-motor Test for Children (6-15 years) and D. Kováč and G. Horkovič's (1969) Test on Orientation of Individual and Overall Lateral Preference. Next the revised version of the B-JEPI Personality Questionnaire of the Eysenck Questionnaire E.P.Q Junior (HJ Eysenck, Eysenck JGB, arr. J. Senka 1994) and the Bourdon BOPR Test computer program made on the basis of the original Test were used. During the BHD testing respondents had to record two different sounds (250 Hz and 650Hz) randomly applied from the speakers. The two mentioned Tests gave us data on possible neurotic behavior which recently can be recognized as a major conflict factor and can be applied on a reactive basis with various disposals and higher nerve activity.

The experimental sample was limited to the school-age period. Conflicts and arising neuroticism have more reasons to occur during this developmental period; mainly grouped in the school environment as a primary problem of this age. Part of the conflicts arise primarily between an Educator and a child especially if at least one of them is a less adaptable person. Quite often we also encounter conflicts between a Teacher and a child that arise through a parent. Another conflict occurs through a reduced intellectual capacity level bound with school demands and a child's ability. The impact of a team, where a child directly belongs or is forced to go, plays an important role in conflict and subsequent neuroticism. Important dispositions for creating conflicts that lead to neurotic symptoms and to neurosis are bound with inappropriate education; general fatigue; behavioral dispositions (partial psychic infantilism); encephalopathy (especially perinatal) which are important and not to be forgotten. In response to these mentioned conflicts some neurotic symptoms occur: children process problems in different ways depending on the dimension of the conflict and the overall mental development of each individual (Ručková 2013)

If it was possible to see noticeable personal qualities of a child before, then they are strongly emphasized under the loading influence. Loading compensation in school age is bound with the so-called level of imagination and at the same time directly related to reality. M. Vágnerová (2000) says that with more complex cases under long-term stressful situations in the school environment come character deformations.

Our research cohort consisted of 578 respondents; 291 boys and 287 girls aged 10 to 15.5 years. Included were pupils of basic schools from 5th to 9th grade. The respondents were examined in twenty-five groups; each group keeping order for maintaining the tests and their administration (Ručková, 2013).

Measurement of Lateral Preferences – Side Preference Questionnaire (DSP)

Results from the DSP (the Questionnaire which is aimed at finding a general lateral preference, subjectively evaluated

by the individual) verify the general lateral preferential conditions of an individual in his or her organism, we decided to divide the Questionnaire score into three equal intervals, which gave us the following lateral-preferential groupings:

1st Group – group with the most significant lateral-preferential relations (VL-PV)

2nd Group – group with moderately significant lateral-preferential relations (SVL-PV)

3rd Group – group with the least-significant lateral-preferential relations (NVL-PV)

Lateral-preferential conditions are specifically manifested with boys and girls. It would be ineffective to analyze individual lateral-preference groups, regardless of sex. Therefore, we divided each group into subgroups of boys and girls. (Table No.1)

The incidence of respondents after their division into different lateral-preference groups was:

Finally, we formed a separate group of lefthanders consisting of 34 students – 5.88 % of the total respondents.

Totally, we can say that our experimental groups can be characterized by lateral-preference ratios, whilst the sub-groups will be characterized by sex and age.

The relationship of DSP Lateral reference Questionnaire to sex and age (age = grade) is in Graph No.1. The independent variable in this case is age from the fifth to the ninth grade of Elementary School (10 to 15.5 years). The dependent variables are the scores achieved in these grades. The achieved scores and appropriate deviations of the DSP Questionnaire are mentioned in Table No. 2.

As it is visible from Graph No.1, the clear-cut lateral-preference cases of boys and girls has an analogous development. The girl's curve has a higher overall score of the general lateral preference which indicates a higher degree of lateral-preference.

Table No. 1

	1st Group VL-PV	**2nd Group SVL-PV**	**3rd Group NVL-PV**
Boys	138-47.42% Of total amount of boys	119-4.89% Of total amount of boys	15-5.15% Of total amount of boys
Girls	129-44.95% Of total amount of girls	126-43.90% Of total amount of girls	16-5.57% Of total amount of girls
Total	267-46.19% Of total amount of respondents	245-42.39% Of total amount of respondents	32-5.53% Of total amount of respondents

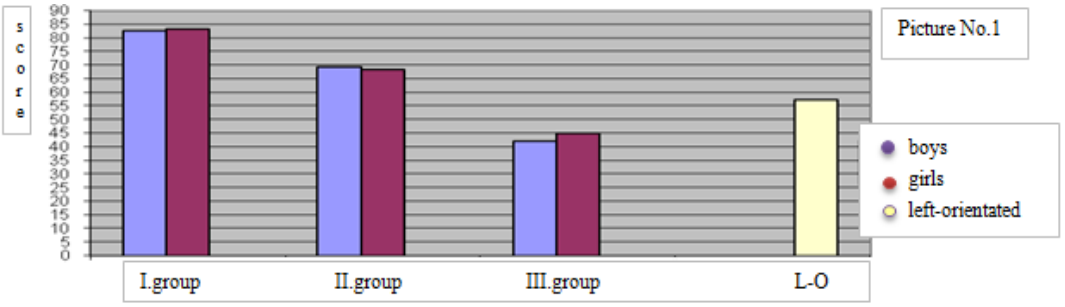
Table No.2

		V Grade	**VI Grade**	**VII Grade**	**VIII Grade**	**IX Grade**
Boys	AM	81.41	73.26	75.28	75.62	73.59
	б	13.5	14.79	9.75	9.77	9.21
Girls	AM	86.9	83.21	85.57	85.43	82.7
	ǐб	11.83	15.18	15.88	15.29	13.87

Graph No. 1 The general lateral preference (DSP), depending on age and sex

Presented results come from the occurrence of DSP score in each of the lateral-preference groups. The average score of general lateral preference (measured by DSP Questionnaire) are based on subsets of boys and girls selection given in picture No.1.

Picture No. 1 DSP-Average value score in the individual lateral-preference groups



The cross-sex differences which are visible in the Graph strongly retain their size with each grade (only mitigating differences are in the fifth grade). Both with girls and with boys it is seen in a down-warding of the clear-cut of lateral preference. This finding must be taken from the aspect of general lateral-preference relations, because the DSP-Questionnaire has a more or less general lateral preference aim.

Considering that "n" respondents in the individual subgroups are not mentioned in the pictures we comment them in the text. In the first group, and with the most prominent lateral-preference relations, are 143 boys and 135 girls. In the second group with moderately well-defined lateral-preference relations are 24 boys and 131 girls. In the third group with the least-significant lateral preference relations are 15 boys and 17 girls.

Achieved scores as well as the standard deviations of DSP Questionnaire and the subgroups of boys and girls in each lateral-preference groups are mentioned in

It is not important to state much to the scores distribution of DSP-Questionnaire in each lateral-preference groups because it is artificially constructed. The average incidence of DSP- Questionnaire score is slightly higher in the subgroup of girls than in the boys subgroups. The exception creates the group with moderately significant lateral-preference relations. The cross-sex differences cannot be mentioned at all (Table No. 4). Highly distinctive differences are seen in the inter-group relations. It is not important to add any comment to

this data as we mentioned earlier that the lateral-preference groups were built precisely according to the traced reference score of DSP Questionnaire.

Table No.3

		I Group	II Group	III Group	Left-oriented	
					AM	Б
Boys	AM	82.68	69.52	42.01	57.35	17.65
	Б	4.87	5.72	8.29		
Girls	AM	83.1	68.46	45.03		
	Б	4.68	6.64	6.63		

	B I Group	B II Group	B III Group	G I Group	G II Group	GIII Group
B I Group	–	19.375***	33.023***	0.513	–	–
B II Group	-19.375***	–	20.084***	–	0.859	–
B III Group	-33.023***	-20.084***	–	–	–	0.467
G I Group	-0.513	–	–	–	22.542***	29.269***
G II Group	–	-0.859	–	22.524***	–	16.458***
G III Group	–	–	-0.467	-29.269***	-16.458***	–

Neurotic Symptoms Measurement B-JEPI

As was already mentioned, the lateral preference conditions affect the personal characteristics of an individual. We would like to deal in the following pages with the results of neuroticism, as one of the personal characteristics, its curves and dependence on age and relationship of neuroticism to the lateral-preference ratio.

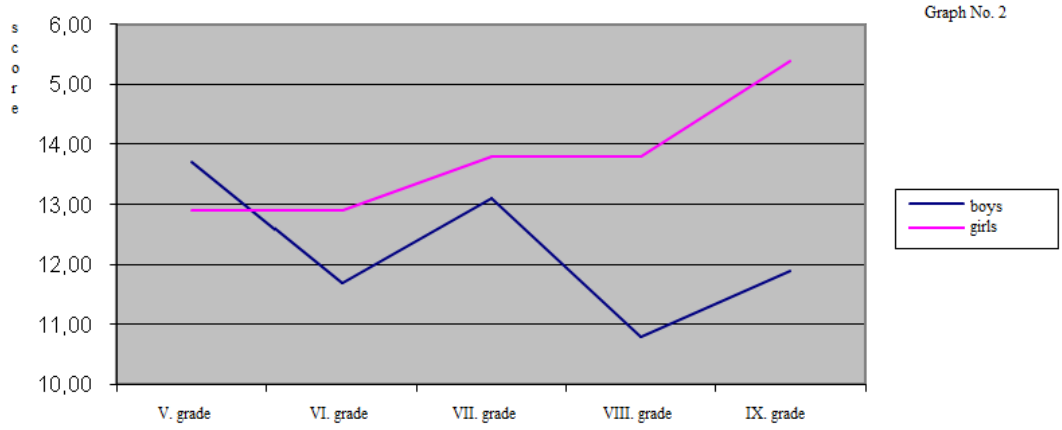
Relevant neuroticism score and its standard deviation can be seen in **Table No.5.**

Graph No.2 shows neuroticism dependence by sex and age of examined samples.

This graph visualizes the extensive sex differences. Development of the neurotic average score, connected with age has the so called scissor character that means that the average incidence of neurotic score with girls increases significantly with age, on the contrary with boys it decreases. This finding could be possibly justified by the statement that the requirements and demands on the child are generally increasing with age. Boys are more adjustable; the loading does

		V grade	VI grade	VII grade	VIII grade	IX grade
Boys	AM	13.70	11.70	13.10	10.80	11.90
	Б	4.02	4.03	3.92	3.83	4.16
Girls	AM	12.90	12.90	13.80	13.80	15.40
	Б	3.82	3.96	3.96	3.90	3.48

Graph No.2 shows neuroticism dependence by sex and age of examined samples.



not play such a role as for girls who are able to cope with the requirements, but the outcome can be marked by neuroticism.

Remarkable results were gained in the analysis of neurotic symptoms and their occurrence in each lateral-preference groups.

Picture No. 2 shows the average neurotic scores of age subsets of boys and girls from the examined sample. Relevant neuroticism score of a particular group of boys or girls is shown in the picture as well as in Table No. 6.

and disadvantaged, and even in that case, when they are not adapting they remain the extreme cases for the rest of population.

Further as it is seen from the picture, differences between subgroups of boys and girls in individual lateral-preference groups are important (Matrix t-distribution neuroticism Table No.7). Less important (at the border with meaning importance) are only differences in less-defined lateral-preference cases (Third Group). Regarding the

Picture No. 2 Neuroticism – average score in individual lateral preference groups

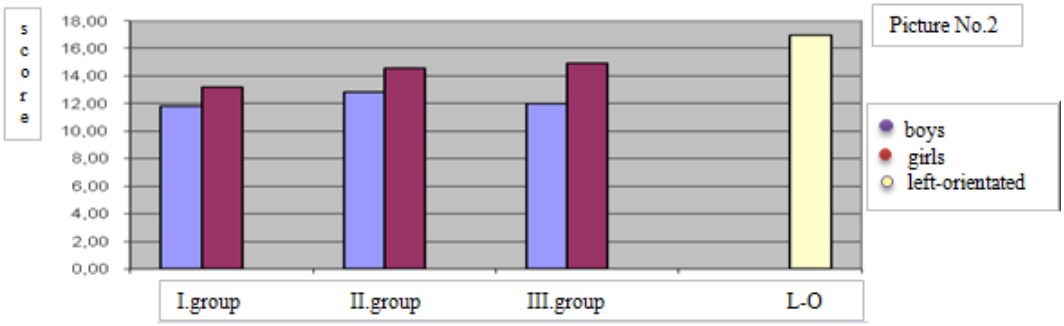


Table No. 6

		I. group	II. group	III. group	Left-oriented	
					AM	Б
boys	AM	11,84	12,84	12,00	17,00	2,48
	Б	4,25	4,37	4,64		
girls	AM	13,17	14,58	14,94		
	Б	4,89	4,12	4,16		

The picture shows, that the group with the highest well-defined lateral-preference relations (Group 1) scores with low levels of neuroticism.

Left-oriented respondents, as an independent group gain the highest average scores for neuroticism. This fact is probably bound with the influence of the right-hand oriented environment that handicaps left-oriented individuals to such an extent that they are marked by neurotic symptoms. Considering the fact that they are forced to adapt it is assumed that they are frustrated

cross-group differences, important is the occurrence between groups with high and medium significantly prominent lateral-preferential relations.

The left-oriented group have not undergone the t-test because it is a less numerous group and it is rather than orientation in comparison with the other lateral-preference groups. Distinctions of left-oriented compared with the other groups is expected from Picture No 2 which expresses the occurrence of neuroticism in the groups who achieved high scores and with relatively

Table No. 7

	B I Group	B II Group	B III Group	G I Group	G II Group	G III Group
B I Group	–	2,070*	0,268	2,738**	–	–
B II Group	-2,070*	–	0,914	–	2,953**	–
B III Group	-0,268	-0,914	–	–	–	2,101*
G I Group	-2,738**	–	–	–	2,191*	1,363
G II Group	–	-2,953**	–	-2,191*	–	0,420
G III Group	–	–	-2,101*	-1,363	-0,420	–

low standard deviations. (Table No 6).

Based on further results during the correlation matrixes analysis we present boys and girls subgroups with the highest well-defined lateral-preference relations in the group with moderately well-defined lateral-preference relations and the important positive correlation between neuroticism and the load tolerance. Furthermore, also was found (p 0.05) a positive correlation between neuroticism and anxiety which is on the border of importance. The group with the least-significant lateral preference relations (III group) stands independently. The boys from this group gain important positive correlation of neuroticism with anxiety (p 0.05). In the subgroup of girls there is not an important correlation relation with anxiety while there is positive correlation only with the grade.

BDN – Bourdon test

We involved the second diagnostic sensitive test for neuroticism – Bourdon Test – into our experiment for concentration and burden. We do not state our assumption that the test will be diagnostically sensitive to neuroticism to such an extent that it will become its specific indicator. The differences between the Test and re-Test will try to the find out more about the loading tolerance as one of the primary forms of neurotic symptoms. The Graph No. 3 shows dependence of the Bourdon Test Score (loading tolerance) by age and sex of the selected sample. The score of independent variables gained in this test are given in Table No.8 together with the respective standard deviations.

As it is seen from the graph both boys and girls have generally increasing score

Graph No. 3 Tolerance to burden dependet in sex and age

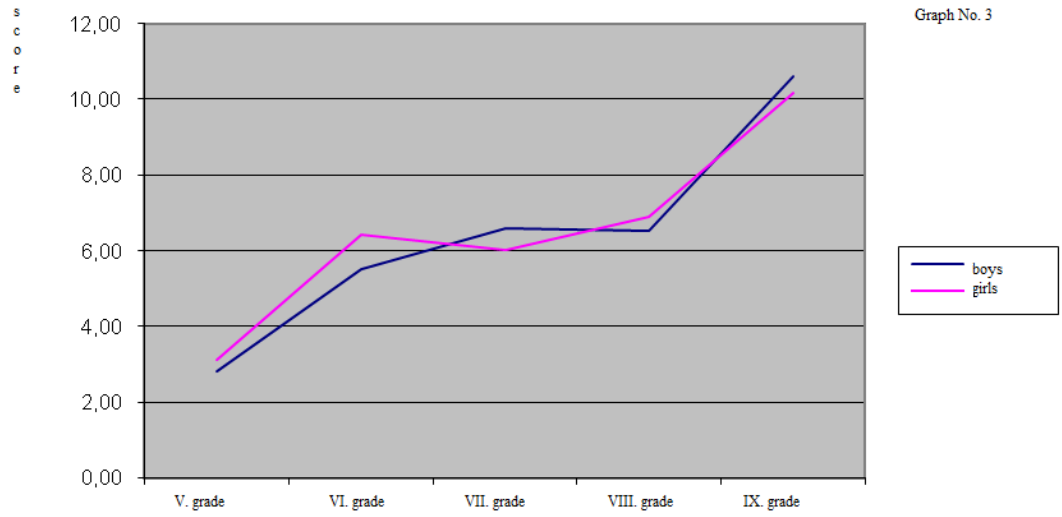


Table No. 8

		V Grade	VI Grade	VII Grade	VIII Grade	IX Grade
Boys	AM	2.83	5.53	6.61	6.54	10.62
	Б	1.32	2.36	2.64	2.52	3.47
Girls	AM	3.11	6.41	6.00	6.91	10.17
	Б	1.08	3.21	2.71	2.73	4.11

Table No. 9

		I Group	II Group	III Group	Left-oriented	
					AM	**Б**
Boys	AM	22.61	22.47	21.24	28.08	10.75
	б	8.63	8.49	7.61		
Girls	AM	22.60	24.47	24.82		
	б	8.48	8.71	8.40		

characteristics of load tolerance. Both sexes score in this test without major cross-sex differences and almost with the same trend. Some cross-sex differences occur between the sixth and seventh grades when the girls score decreases so that in the seventh grade it is slightly lower than with boys scores. From the seventh to eighth grade the score falls just with boys while the girls´ score rises until the ninth grade. After the eighth grade the boys load tolerance continue with rising characteristic which was kept up till the seventh grade.

It is visible that the girls have an analogous course of load tolerance changing with age development of neuroticism level. With boys the load tolerance decreases with the stage of lateral-preference groups. From the findings we can assume that the sensitivity of this test to neurotic symptoms is greater with girls.

It should be also noted that important cross-sex and cross-group differences are not present in the whole sample (matrix t-distribution of the load tolerance, Table No.10).

Similarly as with neuroticism the most important load tolerance score is gained by left-oriented individuals. Connected with them, it is important to mention relatively high standard deviations, however these occur at the examined personality traits with the other groups, too.

Furthermore, in the experiment we evaluated the correlation matrices of individual lateral-preference groups. We provide the results as illustration. In the first group (with significant lateral-preference relations) with subset girls as well as with subset boys we report expected positive correlations to the load tolerance and also positively important correlations with neuroticism and anxiety (p 0.01). In the boys subgroup with moderately-defined lateral-preference relations the load tolerance gains positively important correlations with neuroticism and anxiety. In this group it is also important to mention a significantly negative relationship with extraversion (p 0.05). In the second lateral-preference subset girls the load tolerance correlates positively with neuroticism and the grade as the age representative (p 0,01). In the third group (the least-defined lateral-preference relations) were not found any important correlation.

Picture No. 3 is the average score load tolerance measured by the Bourdon Test with the subsets of boys and girls of the examined sample. Individual Test Scores are together with the standard deviations mentioned in Table No.9.

Picture No. 3 Load tolerance average score in individual lateral preference groups

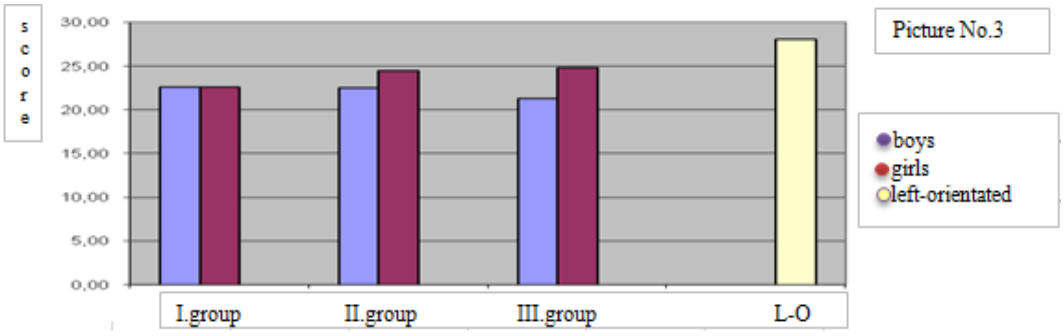


Table No. 10

	B I Group	B II Group	B III Group	G I Group	G II Group	G III Group
B I Group	–	0.095	0.653	0.270	–	–
B II Group	-0.095	–	0.730	–	1.734	–
B III Group	-0.53	-0.730	–	–	–	1.443
G I Group	-0.270	–	–	–	1.607	0.923
G II Group	–	-1.734	–	-1.607	–	0.152
G III Group	–	–	-1.443	-0.923	-0.152	–

Conclusion

One of the main assumptions which was verified by our work was that the right-oriented civilization condition the neurotic symptoms with generally left-oriented individuals and it becomes sub-optimal for them. Based on contemporary knowledge of genetics there are more individuals of this type than in the phenotypic manifestation. D. Kováč, G. Horkovič (1967) as well as Bishop (1990) state that the prevalence of genotypic left-handedness was very slowly created during the development of mankind, while the right-sided civilization developed rapidly and almost exclusively. The following results can deduced from our social inquiry: Allow optimal conditions for development of left-handed individuals and lateral-preference orientation. These conditions should be related not only to school education (acquiring writing habits) but also in daily activities of the children. Here appeals can be made to Industrial and Engineering Psychologists to take the lateral-preference of the clear-cut staff into account. As we found out, these results cannot just be applied to 5-12% of left-handed population, but, they also concern other common people in many varying degrees with not clear lateral-preference. We can say, these not clear individuals with certain personality characteristics are more disadvantaged than left-oriented individuals. In our opinion this reality comes from the fact that these people have no clear lateral-preference neither expressly left-oriented nor optimally right-oriented, which means that they have no sufficiently strong

personality profile of their lateral preference which is obviously necessary for overbridging disadvantageous positions. These facts suggest that it is necessary to pay as much attention to the individuals with weak lateral-preferences as to the left-oriented although it can be expected that their number may decrease with age. Lateral issue relates to a broader range of Professionals, especially Psychologists, Psychiatrists, Neurologists and Defectologists. It is a multi-disciplined problem so insisting on one apparent scientific approach to the problem can lead to failure and error. The results of our work are therefore only a small contribution to examination and detection of optimal lateral-preference relations of an individual in society.

References

1. BISHOP, D (1990) Handedness and Developmental Disorder. London,. MacKeith Press.
2. DENCKLA, M. B (2008) Development of Motor Co-ordination in Normal Children. Developmental Medicine & Child Neurology, New York 16/6, 729-741.
3. ELKADI S, Nicholls ME, Clode D (1999) Handedness in opposite and same-sex dizygotic twins: testing the testosterone hypothesis. NeuroReport. 10 (2) 333–336.
4. GIANNINI, M.E., Barringer, M.C., Giannini, R.H (1984) Lack of relationship between handedness and intuitive and intellectual (retionalistic) modes of information processing. Journal of General Psychology 111:31-37.
5. KOVÁČ, D (1977) Lateral Preference: Five years of concentrated study in the Institute of Experimental Psychology. Prague, Czechoslovakia Psychology.
6. KOVÁČ, D (2007) Psychology Towards Meatanoia. Bratislava Veda ISBN 978-80-224-0965-0.
7. KOVÁČ, D (1967) Horkovič, G Lateral preference, presence and perspectives. Bratislava Studia Psychologica.
8. PAPOUSEK, I., Schulter, G (2006) Individual differences in functional asymetries of the cortical hemispheres .Revital of laterality research in emotion and psychopathology. Cognition, Brain, Behavior, Graz 2/X, 269-298, ISSN: 1224-8398.
9. RUČKOVÁ, G (2013) Parameters of lateral and preference functions with their dependence on neurotic behavior within the limited developmental stage QUAERE Vol. III Hradec Králové, ISBN 978-80-905243-7-8. - S. 2133-2143 [CD-ROM].
10. VÁGNEROVÁ, M (2000) Development Psychology. Prague Portál. ISBN 80-7178-308-0.

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Analyses of measuring tools comparing the quality of life in patients with multiple sclerosis

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Original Articles

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Abstract

Multiple sclerosis (MS) is an autoimmune disease affecting the central nervous system (CNS). It is characterized by degeneration of axons and axal demyelination. Prevalence of multiple sclerosis is 30 per 100 000 people in the world. In this article we aim to analyze and compare the selected measuring tools evaluating the quality of life in patients affected by MS. The studied measuring tools are: the Multiple Sclerosis Quality of Life Inventory (MSQLI), the Health-Related Quality of Life Questionnaire for Multiple Sclerosis (HRQOL-MS), the Multiple Sclerosis Quality of Life (MSQOL), the Functional Assessment of Multiple Sclerosis (FAMS), the Multiple Sclerosis Impact Scale (MSIS), the Multiple Sclerosis Functional Composite (MSFC), the Multiple Sclerosis International Quality of Life (MUSIQOL). Based on the selected studies we aim to compare the quality of life in MS patients. This article is directed towards the patients affected by MS and the specialist public. It aims to facilatate the navigation between the measuring tools evaluating the quality of life with multiple sclerosis.

Introduction

Multiple sclerosis (MS) is an autoimmune disease affecting the Central Nervous System (CNS). It is characterized by degeneration of axons and axal demyelination (22). The charecteristic features of MS are multiple inflammatory infiltrates located in the CNS particularly within white matter. These inflammatory infiltrates contain activated T-lymphocytes, macrophages and to a lesser extent B-lymphocytes. Additionally, the defects of the hematoencephalitic

barrier are found in the acute focuses in CNS. As the MS is a multi-factorial disease, hence the exact determination of causing factor/s is difficult. With stroke occupying first place, Multiple sclerosis is positioned in second place (together with Parkinson's Disease) on the list of most debilitating diseases. Even though the main characteristic of MS is the lesion located in the white matter, in recent years with the development of new ways of screening techniques and specialized histopathological studies, research has been focusing more on the degeneration and lesions of grey matter. In particular, some research has shown that the grey matter lesions may lead to extended progression of physical disability; cognitive deficit; exhaustion; even epileptic seizures (4, 9). The MS treatment and symptom management is predominantly based on treatments of attacks through immuno-modulation (prophylactic) treatment to influence the natural progression of the disease and its rehabilitation (11). The latest clinical trials which showed positive effects of marijuana in MS treatment are not yet clear (21). In recent years, the treatment of MS has markedly progressed accentuating the necessity of early diagnosis, early subsequent treatment using new MS medication allowing for the natural progression of disease (12).

The prevalence of multiple sclerosis is 30 per 100 000 people in the world (Slovak Republic 128 per 100 000), predominantly young individuals between 20 – 40 years of age, with women being twice as often afflicted as men (14). In recent years, the incidence of MS has grown mainly in the countries of the northern and middle geographical areas. The least affected people with MS are in the area of the Equator with the prevalence of 2 -15 per 100 000 people (19).

Quality of life is an important consideration for patients with a chronic disease such as multiple sclerosis. In the latter period, the focus of many medical disciplines evolve around the term quality of health care (23) and quality of life. Quality of life within the medical field contains aspects of physical and psychological health of an MS patient mainly related to the term "health related quality of life". However, quality of life has a multi-dimensional character and is affected by many factors e.g. nutrition (20); physical; emotional; sexual; racial; economic; work; family; cultural; social. In general, in understanding of the quality of life, no less important is subjective valuation of quality of life by MS patients themselves. This subjective valuation stems from the unique and personal cognitive make up of each patient with the importance being given to patient's adaptability to life events and the support of their close ones.

In this article, we analyzed and compared the selected measuring tools evaluating the quality of life in patients affected by MS. The studied measuring tools are: the Multiple Sclerosis Quality of Life Inventory (MSQLI); the Health-Related Quality of Life Questionnaire for Multiple Sclerosis (HRQOL-MS); the Multiple Sclerosis Quality of Life (MSQOL); the Functional Assessment of Multiple Sclerosis (FAMS); the Multiple Sclerosis Impact Scale (MSIS); the Multiple Sclerosis Functional Composite (MSFC); the Multiple Sclerosis International Quality of Life (MUSIQOL).

The measuring tools evaluating quality of life in patients with MS

Tests used to evaluate clinical symptoms of MS fall into two categories: those that measure impairments of body function and body structures; those that measure activity limitations and restrictions. Among the tests in the first category are e.g. the Expanded Disability Status Scale and the Multiple Sclerosis Functional Composite. Examples of tests in the second category are

the MSQOL, the Multiple Sclerosis Quality of Life Inventory.

The Multiple Sclerosis Quality of Life Inventory MSQLI is a battery consisting of 10 individual scales providing a quality of life measure that is both generic and MS-specific. The MSQLI was developed by the Consortium of Multiple Sclerosis Centers (CMSC) Health Services Research Subcommittee. It was designed to supplement but not replace traditional MS outcome measures. The MSQLI includes the medical outcome study short form-36 (SF-36) and 9 symptom-specific scales. The first 7 scales of the symptom-specific scales that complete the MSQLI address fatigue; pain; sexual satisfaction; bladder control; bowel control; visual impairment; perceived cognitive deficits. For these 7 scales higher scores indicate more severe problems in each of these areas. For the last 2 scales, which assess mental health status and perceived social support, higher scores are indicative of better mental health status and a stronger social support system respectively. If the standard longer forms are used the MSQLI takes approximately 45 minutes to administer. Using all 5 of the short forms the time can be reduced to approximately 30 minutes (6). The MSQLI is a commonly used HRQOL Instrument in MS studies.

The Health-Related Quality of Life Questionnaire for Multiple Sclerosis is a multi-dimensional construct that includes aspects of life quality or function affected by health status such as physical health and symptoms; psychosocial factors; and psychiatric conditions (7). This construct provides a broader measure of disease burden than physical impairment or disability level approximating the World Health Organization's definition of health as including physical; mental; and social well-being and not just the absence of disease or infirmity. Chronic illnesses such as MS have multi-dimensional impacts affecting physical and social functions as well as emotional well-being. Measures of HRQOL record patient's perceptions of their overall health and how their health affects their daily lives. A study of QOL measures in MS research found that the use of QOL Questionnaires provided a more comprehensive measure of the impact of MS than relying solely on assessments of physical impairment or disease activity and its effects. People with MS tend to rate aspects of their HRQOL lower than do people in the general population and even those with other chronic conditions (10, 3).

Multiple Sclerosis Quality of Life is a multi-dimensional health-related quality of life measure that combines both generic and MS-specific items into a single instrument. This 54-item instrument generates 12 subscales along with two summary scores, and two additional single-item measures (Table 1). The subscales are: physical function; role limitations-physical; role limitations-emotional; pain; emotional well-being; energy; health perceptions; social function; cognitive function; health distress; overall quality of life; sexual function. The summary scores are the Physical Health Composite Summary and the Mental Health Composite Summary. The MSQOL-54 is a structured, self-report questionnaire that the patient can generally complete with little or no assistance. It may also be administered by an interviewer. However, patients with visual or upper extremity impairments may need to have the MSQOL-54 administered as an interview. Interviewers should be trained in basic interviewing skills and in the use of this instrument. There is no single overall score for the MSQOL-54. Two summary scores – Physical Health and Mental Health – can be derived from a weighted combination of scale scores. In addition, there are 12 subscales: physical function; role limitations-physical; role limitations-emotional;

pain; emotional well-being; energy; health perceptions; social function; cognitive function; health distress; overall quality of life; sexual function. There are also two single-item measures: satisfaction with sexual function and change in health (16).

The Functional Assessment of Multiple Sclerosis is one of the disease-specific quality of life instruments available. It has been described as the best instrument for assessing quality of life of patients with MS as it covers many of the quality of life domains relevant to patients with MS and has shown good convergent validity. The FAMS Instrument was developed in Chicago to be included in clinical trials and clinical processes. FAMS relates to six domains: mobility; symptoms; emotional wellbeing (depression); general contentment; thinking/ fatigue; family/ social wellbeing. The final version comprises 59 statements where the respondents are asked to indicate how true each statement has been for them during the past 7 days using the following 5 categories: not at all; a little bit; and somewhat; quite a bit; very much. The scoring algorithm for the FAMS assigns a value between 0 and 4 to each response category. The scores of negatively worded statements are reversed so, a high score consistently reflects good functional status/quality of life. The scores are added within each of the six subscales and then aggregated into a total FAMS score. One subscale (thinking/ fatigue) has a range of 0 – 36, while the others have a range of 0 – 28. The total FAMS score ranges between 0 and 176. In the case of missing response items a subscale score is derived based on the valid responses and adjusted so that the score maintains its full range (15, 24).

The Multiple Sclerosis Impact Scale is a disease-specific health-related quality of life instrument developed using the patient's perspective on disease impact. It consists of two subscales assessing the *physical* (MSIS-29-PHYS) and *psychological* (MSIS-29-PSYCH) impact of MS. Although previous studies have found support for the psychometric properties of the MSIS-29 using traditional methods of scale evaluation. The Multiple Sclerosis Impact Scale is a new measure of the physical and psychological impact of MS from the patient's perspective. It was developed using the standard psychometric approach of reducing an item pool generated *de novo* from people with multiple sclerosis (MS). Psychometric evaluation of the scale was conducted in two large independent postal surveys of randomly selected, geographically stratified members of the Multiple Sclerosis Society. In those samples, the MSIS-29 satisfied all recommended psychometric criteria for rigorous measurement. However, the psychometric properties of health measurement instruments are sample dependent and cannot be established in a single study (18).

Another important instrument is the Multiple Sclerosis Functional Composite which was developed by the MS Society's Clinical Assessment Task Force as an additional clinical measure of MS disability progression. The MSFC comprises quantitative functional measures of three key clinical dimensions of MS: leg function/ambulation; arm/hand function; cognitive function. Scores on component measures are converted to standard scores (z-scores), which are averaged to form a single MSFC score. Preliminary analyses confirm that the three clinical dimensions of the MSFC are relatively independent the MSFC is sensitive to clinical changes over 1- and 2-year intervals and the MSFC has acceptable criterion validity (i.e., predicts both concurrent and subsequent EDSS change). The advantages and potential limitations of incorporating quantitative functional outcome measures such as the MSFC into collaborative databases are discussed.

The Multiple Sclerosis International Quality of Life provides a global index score which is calculated as the mean of the individual dimension scores. The MUSIQOL Questionnaire comprises 31 questions in 9 dimensions (subscales): activities of daily living; psychological well-being; symptoms; relationships with friends; relationships with family; sentimental and sexual life; coping; rejection; relationships with the healthcare system (Table 2). The index score is computed as the mean of these subscale scores. All 9 dimensions and the index score are linearly transformed and standardized on a 0 to 100 scale where 0 indicates the worst possible level of quality of life (QOL) and 100 indicates the best level. Differential item functioning analysis were performed in the initial validation study showing satisfactory results across countries (2).

Table 1. Validated health-related quality-of-life Instruments (1)

	Multiple sclerosis – specific instrument								
	HRQOL-			**MSQOL-**		**MSIS-**	**MUSI-**		
	FAMS	MS	LMSQOL	54	MSQLI	29	QOL	PS	RAYS
Sexual function				**X**	**X**		**X**	**X**	
Cognition	**X**			**X**	**X**			**X**	
Communication									
Emotional well – being	**X**		**X**	**X**	**X**		**X**		
Fertility									
Global QOL or VAS				**X**			**X**		
Health perception or distreee			**X**	**X**					**X**
Mental health		**X**	**X**	**X**	**X**			**X**	
Mobility	**X**	**X**		**X**	**X**				
Overal functioning					**X**		**X**		
Pain				**X**	**X**				
Physical function		**X**		**X**	**X**	**X**	**X**		**X**
Psychological function	**X**	**X**	**X**			**X**	**X**		**X**
QALY									
Self-care		**X**		**X**					
Sensations									
Sleep									
Social function	**X**		**X**	**X**	**X**		**X**		**X**
Spasticity								**X**	
Symptoms	**X**						**X**	**X**	
Visual function					**X**			**X**	
Vital or energy		**X**	**X**	**X**	**X**			**X**	
Instrumen length[a]									
short			**X**				**X**	**X**	
moderate	**X**	**X**				**X**			
long				**X**	**X**				**X**

Abbreviations: FAMS – Functional Assessment of Multiple Sclerosis, HRQOL-MS – Health Related Quality of Life in Multiple Sclerosis, LMSQOL – Leeds Multiple Sclerosis Quality of Life, MSIS-29 – Multiple Sclerosis Impact Scale, MSQLI – Multiple Sclerosis Quality of Life Inventory, MSQOL-54 – Multiple Sclerosis Quality of Life–54, MUSIQOL – Multiple Sclerosis International Quality of Life, PS – Performance Scales, QOL – quality of life, RAYS – RAYS scale

[a] Short, <10 minutes; moderate, 10–44 minutes; long, ≥ 45 minutes.

Table 2. Description of MS-specific instruments used in the assessment of health-related quality of life (1)

Instrument	MSQOL-57	MSQLI	MUSIQOL
Description	5 unchanged dimensions from the SF-36, 3 altered SF-36 dimensions, and 4 new MS-specific dimensions	SF-36 and disease specific measures	9 disease specific measures
Number of items	54	138	31
Approximate time to complete (min)	11-18	45	10-11
Dimensions	**SF-36** Emotional well-being Health perceptions Physical function Role limitations – emotional Role limitations – physical	**SF-36**	-
	Modified/altered SF-36 Energy/fatigue Pain Social function	**Disease-specific measures** Blader Control Scale Bowel Control Scale Impact of Visual Functioning Scale Mental Health Inventory Modified Fatige Impact Scale MOS Modified Social Support Scale MOS Pain Effects Scale Perceived Deficits Questionnaire Sexual Satisfaction Scale	**Disease – specific measures** Activity of daily living Copins Psychological well – being Relationship, health- care system Relationship, family Relationship, friends Rejection Sentimental and sexual life Symptoms
	New		
	Cognitive function		
	Health distress		
	Overall quality of life		
	Sexual function		

Abbreviations: MOS – Medical Outcomes Study; SF-36 – Medical Outcomes Study 36-item Short Form Health Status Survey

Comparing several selected studies evaluating the quality of life in patients with MS (MSQOL); the differences in overall quality of life were found to be minimal. The overall quality of life in patients was evaluated as 50.50 (5), 59.39 (8), 58.20 (13) (Table 3).

Conclusion

In this article we have compared and analyzed several measuring tools evaluating the quality of life in patients with MS. Two principal and one complex measuring tools within a multi-dimensional construct evaluating the quality of life are: the MSQOL, the HRQOL and the MUSIQOL respectively. The MSQOL is a multi-dimensional health-related quality of life measure that combines both generic and MS-specific items into a single instrument. The HRQOL is a multi-dimensional construct that includes aspects of life quality or function affected by health status such as physical health and symptoms; psychosocial factors; psychiatric conditions. The MUSIQOL evaluates the quality of life in 9 dimensions (subscales): activities of daily living; psychological well-being; symptoms; relationships with friends; relationships with

Table 3. Comparing several selected studies, evaluating the quality of life in patients with MS

Indicator	Tripoliti et al. 2007 (25)	Casetta et al. 2009 (5)	Forbes et al. 2006 (7)	Patti et al. 2007 (17)	Füvesi et al. 2008 (8)	Miller et al. 2005 (13)
FAMS						
Mobility	26.16					
Symptoms	71.07					
Emotional well being	61.86					
Contentment	51.52					
Thinking and fatigue	49.51					
Family well being	73.57					
Total	55.61					
MSQOL						
Overall Quality		50.50			59.39	58.20
Cognitive Function		78.75			75.88	73.30
Health Distress		65.00			52.94	58.50
Sexual Function		89.25			73.36	72.90
Sexual Function		75.00			59.16	62.20
MSIS						
Physical impact			57.20			
Psychological impact			46.20			
QoL SF-36						
Physical functioning				49.00		
Role physical				46.00		
Role emotional				58.00		
Social functioning				67.00		
Bodily pain				69.00		
Mental health				60.00		
Vitality				48.00		
General health				46.00		

family; sentimental and sexual life; coping; rejection; relationships with a healthcare system.

References

1. BANDARI, DS, VOLLMER, T., KHATRI, BO *et al*. (2010) *Assessing Quality of Life in Patients with Multiple Sclerosis.* Int J MS Care, no. 12 p 34-41.
2. BAUMSTRACK, K, BUTZKUEVEN, H, FERNANDEZ, O *et al*. (2013) *Responsiveness of the Multiple Sclerosis International Quality of Life Questionnaire to disability change: a longitudinal study.* Health Qual Life Outcomes, no. 11 p 1-9.
3. BUCHANAN, RJ, HUANG, C, KAUFMAN, M (2010) *Health-Related Quality of Life Among Young Adults with Multiple Sclerosis.* Int J MS Care, no. 12 p 190-199.
4. CARNICKA, Z, KLOBUCNIKOVA, K, SIRIAK, P *et al*. (2013*) Epilepsy in patients with multiple sclerosis (in Czech).* Neurol prax, 14 no. 2 p 86-89.
5. CASETTA, I, RIISE, T, NORTVEDT, WM *et al*. (2009) *Gender differences in health-related quality of life in multiple sclerosis.* Mult Scler, 15 no. 11 p 1339-1346.
6. FISCHER, JS, LAROCCA, NG, MILLER, DM *et al*. (1999) *Recent developments in the assessment of quality of life in multiple sclerosis (MS).* Mult Scler, 5 no. 4 p 251-259.
7. FORBES, A, WHILE, A, MATHES, L *et al.* (2006) *Health problems and health related quality of life in people with multiple sclerosis.* Clin Rehabil, 20 no. 1 p 67-78.
8. FÜVESI, J, BENCSIK, K, BENEDEK, K *et al*. (2008) *Cross-cultural adaptation and validation of the 'Multiple Sclerosis Quality of Life Instrument' in Hungarian.* Mult Scler, 14 no. 3 p 391-398.
9. *HORAKOVA, D, KALINCIK, T, DUSANKOVA, JB et al*. (2012) *Clinical correlates of grey matter pathology in multiple sclerosis.* BMC Neurol no. 12 p 1-10.
10. ISAKSSON, AK, AHLSTROM, G, GUNNARSSON, LG (2005) *Quality of life and impairment in patients with multiple sclerosis.* J Neurol Neurosurg Psychiatry no.76 no.1 p 64-69.
11. KLIMOVA, E, CVENGROSOVA, A, DANOVA, M *et al.* (2015) *Medical management of patient with highly active relapsing/remitting multiple sclerosis (RRMS) and pregnancy. Case report and discussion (in Slovak).* Neurologia, 10 no. 2 (Suppl) p 5-9.
12. KLIMOVA, E (2008) *Clinicaly isolated syndrome and sclerosis multiplex (in Slovak).* Ambulantná terapia, 6 no.1 p 28-32.
13. MILLER, A, DISHON, S (2005) *Health-related quality of life in multiple sclerosis: psychometric analysis of inventories.* Multiple Sclerosis, 11 no. 4 p 450-458.
14. MULTIPLE SCLEROSIS INTERNATIONAL FEDERATION (2013) Atlas of MS 2013. *Mapping multiple sclerosis around the world*. London: MSIF p 1-28.
15. NICHOLL, CR, LINCOLN, NB, FRANCIS, VM *et al.* (2001) *Assessing quality of life in people with multiple sclerosis.* Disabil Rehabil, 23 no. 4 p. 597-603.
16. NATIONAL MULTIPLE SCLEROSIS SOCIETY (2015) *Multiple Sclerosis Quality of Life Inventory (MSQLI)*. Atlanta: NMSS.
17. PATTI, F, AMATO, MP, BATTAGLIA, MA *et al.* (2007) *Caregiver quality of life in multiple sclerosis: a multicentre Italian study.* Mult Scler, 13 no. 3 p 412-419.
18. RIAZI, A, HOBART, JC, LAMPING, DL *et al.* (2002) *Multiple Sclerosis Impact Scale (MSIS-29): reliability and validity in hospital based samples.* J Neurol Neurosurg Psychiatry, 73 no. 6 p 701-704.
19. ROSATI, G (2001) The prevalence of multiple sclerosis in the world: an update. Neurol Sci, 22 no. 2 p 117-139.
20. SAMOHYL, M, LISY, L, JURKOVICOVA, J (2014) The impact on nutrition in treatment of multiple sclerosis (in Slovak). Neurologia, 9 no. 1 p 46-49.

21. SAMOHYL, M, LISY, L., RAMS, R *et al* (2015) Active ingredient of marijuana has no effect on the multiple sclerosis progression (in Slovak). Neurologia, 10 no. 1 p 7-9.
22. SAMOHYL, M, LISY, L, RAMS, R *et al*. (2015) The nutritional factors affecting epigenetic regulation in the multiple sclerosis pathogenesis (in Slovak). Neurologia, 10 no. 2 p 69-73.
23. SAMOHYL, M (2014) Quality of health care (in Slovak) Postgradualni med, 16 no. 8 p 887-892.
24. SØRENSEN, J., BAY, J, DAMSGAARD, T **et al.** (2011) Validation of the Danish Version of unctional Assessment of Multiple Sclerosis: A Quality of Life Instrument p. 1-8.
25. TRIPOLITI, E, CAMPBELL, C, PRING, T *et al* (2007) Quality of life in multiple sclerosis: Should Glinicians trust proxy ratings? Multiple Sclerosis 13 no. 9 p 1190-1194.

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Nursing care for migrants in a refugee camp Dobová - Slovenia

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Original Articles

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Abstract:

The aim of the study was to map the range of the most frequent nursing diagnoses in migrants migrating through Slovenia to Austria and Germany. Data collection took place in the refugee camp in Dobová (Slovenia). We found out that the largest number of migrants suffered from acute pain, fatigue, hyperthermia, diarrhoea, impaired skin integrity, lack of sleep, impaired gait and reduced volume of body fluids. Frequent nursing diagnoses related to psychological problems were hopelessness and helplessness, resulting from difficult life situations.

Introduction

Nursing is not only an extremely demanding work, but also a stimulating and joyful mission, which combines professional performance with a willingness to help people and work towards their benefit. Linking knowledge and practical skills with deep altruism inherent in the loving care is a typical feature of contemporary nursing. Nursing is science and art at the same time. A good nurse is a gift of God; fulfils several functions and missions (Novotny, 2006). A nurse must be prepared to perform tasks professionally, theoretically and practically in favour of a recovery and health promotion. A nurse is able to find new creative approaches in the provision of nursing care and to gain new experience within the profession (Wiczmándyová & Tkáčová, 2010). From 25th to 27th, December, 2015 our main mission was to provide care for people with difficult destiny – migrants from both somatic and psychological aspects.

Patients and Methods

The main objective of the study was to map the most common nursing diagnosis for migrants migrating through Slovenia to Austria and Germany. Migrants coming to our refugee camp in the village of Dobová in Slovenia from Syria, Afghanistan and Iraq. Daily 3000 - 5000 migrants register in Dobová, which is the main crossing point on the Slovenian-Croatian border,

from where most of them are transported to the village of Šentilj in northeast Slovenia by train- near this village is a major railway border crossing to Austria. After registering, humanitarian aid workers provide food, clothing and medical care. Data collection took place from 25th to 27th, December, 2015, during which in two 12-hour night shifts we treated about 250 people aged from 2 days to 67 years. Nursing diagnoses were specified on the basis of taxonomy NANDA International 2012-2014.

Results and Discussion

Help and assistance to migrants in the camp Dobová was provided by organizations such as the UNHCR which provides legal security and counselling, the Red Cross which provides social welfare, and civil protection unit, which provides functioning of the camp (electricity, benches, tents, tables). Medical assistance is provided by St. Elizabeth College of Health and Social Work´s Tropic Team and its volunteers as doctors, nurses and medical students. Volunteering and nursing are linked since ancient times. The emergence of volunteering in Slovakia historically falls into the Middle Ages and was formed in first orphanages, hospices and shelters. Even then, the selflessly devoted religious helped the abandoned, the sick and dying (Dudeková, 1998). This period is defined as a charity nursing. Today's professional nursing broaden and improve the nursing process, which is the base of a detailed assessment of the patient and determination of the appropriate current or potential nursing diagnoses. Assessment of the patient is the cornerstone of nursing, of which the aim is to lead a systematic and integrated review (Martinková, 2015). Nurses who apply their knowledge and advanced experience as well as they cooperate with multidisciplinary and transdisciplinary teams, play a very important role in accurate assessment outcomes (Grešš Halasz & Wiczmándyová, 2015). Table 1 shows the range of the most common nursing diagnoses occurring at the time of our operation in the refugee camp. In connection with the diagnosis of acute pain, the most frequent problem was headache, neck, abdomen and lower limb pain. The diagnosis impaired verbal communication mainly meant the language barrier. Within nursing assessment, we measured basic vital signs (blood pressure, pulse, body temperature, O2 saturation), blood glucose, treated wounds, focused on hydration of the patient, administered drugs orally, into ears, eyes, administered subcutaneous (insulin) and intramuscular injections or provided infusion therapy. Individual nursing interventions were carried out either on the basis of indications or in collaboration with a doctor.

Tab. 1 The range of the most common nursing diagnoses in migrants

Nursing diagnoses (NANDA)
Inefficient care for own health (00078)
The risk of unstable glucose levels (00179)
Reduced volume of body fluids (00027)
Constipation (00011)
Diarrhoea (00013)
Lack of sleep (00098)
Impaired gait (00088)
Fatigue (00093)
Impaired verbal communication (00051)
Hopelessness (00124)
Powerlessness (00125)
Fear (00148)
The risk of infection (00004)
Impaired integrity of the skin (00046)
Impaired integrity of tissues (00042)
Hyperthermia (00007)
Acute pain (00123)
Nausea (00134)

According to a study Krčméry et al. (2015), the most common medical diagnoses in migrants are infectious- origin inflammations of the upper respiratory tract, pneumonia, skin and soft tissues damages including wounds and insect bites, scabies; MRSA as a cause was found only in one case. Non-infectious diseases included hypertension, insomnia, diabetes, total exhaustion of the body, depression and neuropsychiatric disorders related to long-term stress.

Conclusion

The issue of refugees is a new social phenomenon which will require increased attention of social and health workers. Nurses play an important contributing role of a multidisciplinary team that appreciates patient with his religious beliefs, life values, customs, and aims to create conditions that meet individual´s needs within care they provide. Therefore, in the context of migration and volunteering, multicultural nursing care is increasingly gaining prominence.

References

GREŠŠ HALÁSZ, B. WICZMÁNDYOVÁ, D. *Advanced practice nurses in the context of multidisciplinarity, interdisciplinarity and transdisciplinarity*. In A multidisciplinary cooperation in health: Proceedings of professional and scientific work. SKSaPA High Tatras. 2015, p. 122- 125. ISBN 978-80-89542-49-9.

KRCMERY, V. et al. *Respiratory infections after camping in free nature are the current diseases in Migrants to Austria and Germany via Hungary in September 2015: Experience from Röszke and Vámoszabadi*. Clinical Social Work. 2015. 2, 5: 39-41.

MARTINKOVÁ, J. *Physical assessment of the Elderly.* In X. national conference nurses working in internal medicine. - Bratislava: Slovak Chamber of Nurses and Midwives, 2015. - ISBN 978-80-89542-47-5. - CD-ROM; S. 21.

NOVOTNÝ, J. *Nursing as humanitarian science.* In Nursing. 2006. 8: 1 – 200.

NANDA INTERNATIONAL. *Nursing diagnoses - Definition and classification 2012 – 2014*. Prague: Grada. 584 pp. ISBN 978-80-247-4328-8.

DUDEKOVÁ, G. *Voluntary association in Slovakia in the past.* Edition third sector and volunteering 4/1998, Bratislava: S.P.A.C.E. - Centre for the analysis of social policy.

WICZMÁNDYOVÁ, D., TKÁČOVÁ, Ľ. 2010. *The socio-economic aspect of migration of nurses.* And training in non-medical odboroch-Proceedings of the 4th International Scientific Conference. Bratislava: SZU, 2010. ISBN 978-80-89352-47-0, p.62-70.

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Social environment and its impact on selected aspects of children's health in Prešov region

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Original Articles

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Socially risk environment, morbidity of children, breastfeeding, hospitalization of children, caseworker

Abstract:

*Aim.*Child Health is greatly determined by the social environment (quality of saturation needs of the child families). The aim was to analyze the influence of social environment on child morbidity, length of breastfeeding, child development, incidence of hospitalization. *Design.* Retrospective analysis of medical and social documentation in the years 2011-2013 in J.A.Reimana Hospital in Prešov. *Methodics.* Children (n-450) were classified in two categories: children at risk of social environment (RSE children, 65.6%) children without endangering social environment (without RSE children, 34.4%). At the same time we assessed children's morbidity, length of lactation, incidence of hospitalization of children. *Results.* Children RSE you found a significantly higher likelihood of gastrointestinal disorders (OR: 4.694, p = 0.000), respiratory tract (OR: 5.21, p = 0.000), skin disorders (OR: 7.154, p = 0.000), delays in Psychomotorics (OR: 3.184, p = 0.000), and neglecting the child (OR: 14.687, p = 0.000) in comparation with children without RSE. Children without RSE were breastfed longer (M – 3.64, SD – 3.32) than children RSE (M – 1.94, SD – 3.23) (p = 0.000). We found that the child admitted to the hospital after the intervention of social workers occurred in 12.4% of children without RSE and in 87.6% of children RSE (p = 0.000). *Conclusion.* Social environment can negatively affect the health of the child. The role of social workers is the assessment and elimination of risk factors, family environment.

Introduction

The major determinant affecting the health of the child is sufficiently stimulating social environment. Taking into account the fact that human health is at 20% -Tachov participates environment (including social) and 50% -Tachov lifestyle (Kozierová et al. 1995), which is initially formed family, the family and social environment surrounding the child plays an important role in health promotion and disease prevention of the child. The family has a role in enhancing

the childs‘ growth, development, health of the child and satisfying their needs of vital importance (Fischer, Škoda 2009). The dependence of the child‘s family is quantitatively greater than in adults. Without the cooperation of the family it is not possible to promote the health of the child (Dunovský 1999).

In the literature we meet various alternatives term „socially disadvantaged background“ such as poverty, social exclusion, marginalization, children at risk of social protection, social inequality, social differentiation, stratification of society (Kovalčíková, Džuka 2014). In hospital practice, children from such environments are known as „casus social“. Law no. 245/2008 Coll. in Slovak republic on education defines socially disadvantaged environment as an environment where social, family, economic and cultural conditions insufficiently encourage development of mental, emotional and volitional qualities of man. Such an environment does not support the socialization of the child and does not provide sufficient incentives for optimal development (Rosinský, Klein 2008). Since there is no uniformity in the definition of the term „socially disadvantaged background“ likewise, there is no uniformity in the criteria that should be taken into account in its analysis. The common criteria are zaradzované: families who do not fulfill their basic functions, poverty and material deprivation, lack of education for the child‘s parents, poor living and sanitary conditions, the language other than the language which the child at home say, segregated Roma families, social exclusion community (Machálková 2007; Rosinský, Klein 2008).

Dluholucký and Šváč (1988) created a “scoring system of social traits“, which integrates the 12 monitored criteria (tab. 1). This system should be preferred over the traditional concept of „casus social“. The common denominator criteria included in the scoring system is to interact at the same time contribute to the quantity and quality of meeting all the needs of the child‘s family, health promotion and disease prevention.

Objectives

- To assess the influence of social environment on child morbidity, length of breastfeeding, child development, incidence of hospitalization and placement of the child after discharge from hospital.
- Identify differences in the incidence of hospitalization after the intervention of social workers in social environment of the child.

Methodology

Design.

The research was conducted through retrospective analysis of health and social documentation. Family data for hospitalized child were profiled so that the children could be classified into two categories:

- children at risk of social environment (children RSE),
- children who are not at risk of social environment (children without RSE).

The categorization were prepared based on “scoring system of social traits“ (SSST) (Dluholucký, Šváč 1988), which is a method of at-risk children. SSST can be used by pediatricians, nurses and social workers. The system integrates the 12 regions (Table 1), the scoring is based on a binary response (symbol present / absent). The presence of ≥ 3 points is a clear risk.

Documentation for the selection criteria were established:

- Including – health for the child (0-19 years) hospitalized at the Department of Pediatrics or neonatal of the hospital J.A.Reimana in Presov.

Table 1 Areas „scoring system of social traits"

SSST area	scoring
alcoholism in the family	1 = present one character = one alcoholic parent 2 = present characters both parents are alcoholics
housing conditions	present sign = poor housing conditions
Roma families	present character = family of Roma origin
many children	present sign = fourth child and more
death of children in the family	present sign = exit child in the family
intelligence mother	present sign of low intelligence = mother
marital status of mother	present sign = living alone (single, divorced)
punish parents	present sign = punishing parent
children in institutional care	present the = child in institutional care
maternal age	present sing = less than 18 years
interest of the child	present sing = lack of interest hospitalized child
„other"	present sing = other relevant factors included in other areas (in the case of research, we present as a feature included neglect of a child)

- in the years 2011-2013, and health and social status of the child require the intervention of a social worker in hospital,
- Negative – not including medical records documenting the social worker.

Sample

In the years 2011-2013 was at the Department of Pediatrics at the University Hospital JAReimana 11,413 hospitalized children, and assessment of social workers subject to 455 children (3.98%). The analysis was scrapped five dossiers. The research sample consisted of 450 respondents – parents and their children.

The average age of mothers of hospitalized children was 32.75 years (SD – 9.83, range: 14-60). 30.2% of mothers are unemployed, 43.2% in receipt of parental allowance, 19.5% of employment and 3.6% of mothers are schoolgirls.

The average age of fathers of children bolt 35.8 years (SD – 9.63, range: 18-59). 59.3% of fathers are unemployed and 20.9% of the employed.

Parents have averaged 4:52 of children (SD – 2.96, range: 1-16). The average age of children was 13.4 years (SD – 5:00, range: newborns up to 18 years). 204 children (45.3%) were female and 246 (54.7%) males.

Data collection

The research was conducted during the period February 2014 to June 2014. Documentation processing was carried out with the approval of the Ethics Committee Hospital JAReimana Prešov.

Data analysis

For statistical data processing SPSS 17.0 software was predominantly used. In assessing the odds ratio (OR) occurrence of the same phenomenon we chose logistic regression with 95% confidence intervals (CI).

For statistical comparison of average values was used Mann-Whitney test. Relationships between variables were tested by Spearman correlation coefficient. For the identification of occurrence of the phenomenon between two categorical variables, we chose Chi-Quadrat test. The level of significance was $p < 0:05$.

Table 2 Areas „scoring system of social traits in the research sample

SSS region in the research sample	n (%)
one alcoholic parent both parents are alcoholics	123 (27.3%) 47 (10.4%)
bad housing conditions	183 (41.7%)
family of Roma origin	332 (73.8%)
≥ four children in the family	241 (53.6%)
death of children in the family	34 (8.6%)
low intelligence, including mother‘s mental illness mother	112 (25.0%)
mother living alone in households (= single, widow, divorced)	62 (13.9%)
punishment / parents	9 (2.0%)
children in institutional care	40 (8.9%)
maternal age less than 18 years	18 (4.0%)
hospitalization of a child without parents interest of the child: regular visits interest of the child: an occasional visits interest of the child: No visit	448 (99.6%) 123 (27.3%) 123 (27.3%) 202 (44.9%)
neglect of a child found in the day hospital	189 (42.0%)

Results

Using SSST we found that 295 (65.6%) children are at risk of social environment and 155 children (34.4%) without endangering social environment.

Data analysis showed significantly more likely to develop gastrointestinal disorders (OR: 4.694), respiratory tract (OR: 5.21), skin disorders (OR: 7.154), delays in psychomotorics (OR: 3.184), and neglecting the child (OR: 14.687) in RSE group of children in comparation with children without RSE (tab 3).

The average length of breast-fed infants was 2:52 months (SD – 3:36, range: 0-12 months). 48.4% of children were not breastfed at all ≤ breastfeeding for six months, we have identified in 41.1% of children and breast-feeding 7-12 months in 10.5% of children. Children without RSE were breastfed on average 3.64 months (SD – 3.32), while children RSE 1.94 months (SD – 03.23). Observed differences are statistically significant (p = 0.000). Children without RSE in the current year (ie. 2011, 2012, 2013) 1:35 hospitalized times (SD – 0.96), while children RSE 2:43 times (SD – 2.28) (p = 0.000). We further found that children were without RSE during their lifetime hospitalized an average of 2.28-fold (SD – 3.27) and children RSE 3.84 times (SD – 4.48), the differences are analyzed significantly (p = 0.000). The correlation between the risk of endangering the child‘s social environment and the length of suckling pointed out that with increasing degree of endangering a child decreases the length of breastfeeding (r: -0,419). Also rising risk to the child‘s social environment leads to an increase in frequency of hospitalization of a child in a given year (r: 0.380) and increases the total number of hospitalizations child during their lifetime (r: 0.322). The correlations are statistically significant (tab.4). We can say that an increasing number of negative elements in the social environment of the child reduces the length of breastfeeding of children and increases the frequency of hospitalization in a hospital.

Most children (n – 449, 99.7%) before hospitalization lives with his biological parents respectively. relatives. This

Table 3 Analysis of morbidity, lagging behind in development and neglect of children due to social environment

	OR (95% CI)	sig.
	GIT disease	
children without RSE children RSE	1 4.694 (2.780 – 7.925)	**<0.000**
	diseases of the respiratory character	
children without RSE children RSE	1 5.212 (2.685 – 10.116)	**<0.000**
	disease VVCH	
children without RSE children RSE	1 1.194 (0.659 – 2.162)	0.559
	skin disorders	
children without RSE children RSE	1 7.154 (4.005 – 12.778)	**<0.000**
	diseases of the blood	
children without RSE children RSE	1 2.524 (0.714 – 8.921)	0.151
	CNS disease	
children without RSE children RSE	1 1.159 (0.552 – 2.434)	0.696
	intoxication	
children without RSE children RSE	1 0.736 (0.390 – 1.388)	0.343
	accident in the home	
children without RSE children RSE	1 0.918 (0.264 – 3.184)	0,892
	delays in psychomotorics	
children without RSE children RSE	1 3.184 (1.873 – 5.411)	**<0.000**
	child neglect	
children without RSE children RSE	1 14.687 (8.090 – 26.664)	**<0.000**

Note. reference group – children free of that disease, trauma, lagging in development, neglect

Note. RSE without children – children without endangering social environment; RSE children – children at risk of social environment

effect is predominantly observed after hospital discharge (n – 357, 80.5%). 87 children (19.6%) had a change of placement of the child after discharge from hospital and in terms of the child‘s removal from the original family (parents, relatives) to inpatient / emergency care (n – 86, 19.4%). The change of location of the child after discharge from hospital, we identified in 13.8% of children without RSE and in 86.2% of children RSE (p = 0.000). After the intervention of a social worker readmissions child was present in 97 cases (21.6%). Rehospitalization child after the intervention of social workers was identified in 12.4% of children without RSE and in 87.6% of children RSE (p = 0.000).

Table 4 Correlation between the risk of endangering the child's social environment and the descriptive variables

	length breast-feeding	frequency of hospitalization of a child in a given year	the total number of hospitalizations child
risk to the child social environment	-0.419**	0.380**	0.322**

Note ** Correlation is significant at the 0.01 level.
Note 2. Risk to the child‘s social environment was expressed by the number of characters present in 12 areas SSST

Discussion

Social workers work with hospitalized child focuses on the social causes and consequences of child illness (Navratil, Musil 2000). Social worker at the hospital uses a wide range of interventions conducted directly with the child and his family. In the survey sample, we have seen many negative phenomena in child‘s family environment, which can be determined by his health. Although the mean age of mothers was almost 33 years, 4.0% of mothers were juveniles. Without partner was 13.9% of mothers of children. Substandard housing conditions were identified in up to 36.9% of families at what can be clearly involved a high proportion of parents who are unemployed (30.2% of mothers and 59.3% of fathers) or just receive different allowances from the state.

The vast majority of families were Roma ethnic group (73.8%). According to the Infostat (2002), the proportion of Roma in the Slovak population will increase from 7.2% (2002) to 9.6% (2025). Population density Slovak Republic, the Roma population is not homogeneous, the highest number of Roma population is in eastern Slovakia (Slovak Statistical Office, 2001). The Prešov region in the years 1997-2011 slightly increased birth rate of Romani children (from 2,632 to 2,908 children), while the Slovak ethnic birth rate has fallen more strongly. Despite the same time, higher infant mortality Roma ethnic group (Kovaľ, Mrosková Schlosserová, 2012a), roma families have a higher number of children, which is confirmed by our research data. The Roma families had four children ≥ 60.5% of households, while non-Roma families have a higher number of children identified in 33.9% of families. The Roma population is both younger children component is strongly represented in it (Vaňo 2004). The Roma population is specific accumulation of many negative criteria such as low education, high share of unemployment, poor housing conditions, low hygiene standards, a greater share of abuse (Infostat 2002). From the above it can be assumed that Romani children, where there is no change and the ability to access their parents in meeting their needs, they will be in a hospital environment represent a significant proportion of hospitalized children and will require the intervention of a social worker.

It is necessary to differentiate whether the parents can, are unable or whether they want their children to take care (Machálková 2007). The inability to take care of children may be involved in the intelligence condition of the mother as the primary carer of the child. Simplex state was found in nearly ¼ of mothers (23.9%). If childcare in terms of financial resp. psycho-social one parent (eg. in the exercise of parental punishment – in the sample was a 2.0% mom living without a partner / husband – 13.9%) can lead to the fact that the parents can not or can not adequately take care of the children. The result of these phenomena is usually that some

children are placed in institutional care (in the study was a 8.9% of children), there is the child‘s death (8.6%), or parent does not seem adequate interest of the child during his hospital stay (almost half of the parents even once not visited their child in a hospital environment). Data on the interest of the parents of the child are social workers important, but it is necessary to consider the objectivity of reasons for the under interest of the child in hospital by their parents (eg. Poor financial situation, which may be a problem with commuting to the hospital every day, a greater number of children in particular, young age, serious health problems parents intentional lack of interest of the child and his health).

The frequency of hospitalization of children is significantly determined by the social environment and to the detriment of children RSE, which was higher frequency of hospitalization ($p = 0.000$). At the same time, we found that with the deteriorating social environment (ie. On a greater number of positive elements in SSOD) increases the number of hospitalizations. These results suggest that inappropriate social environment increases the risk of various diseases requiring hospitalization.

The probability of digestive diseases, respiratory tract and skin was higher in children RSE in comparation with children without RSE. Respiratory diseases include nationwide for the most common diseases in childhood (110,038 cases in 2012), followed by skin diseases (37,556 cases) and gastrointestinal system (27351) (National Health Information Center 2013), as well as the dominant reasons for hospitalization of children for pediatrics clinic at the University Hospital JAReimana in Prešov (Koval, Pochová, Čuříková 2010). On the high incidence of respiratory disease contributes mode of transmission (droplet infection) of many diseases of the respiratory system, underdeveloped immunity at an earlier age, children RSE come into consideration other factors: inadequate housing conditions, cold, malnutrition, a higher number of people living in one room. Diseases of the digestive system may be associated with poor nutrition (Šašinka, Šagát, Kovácz 2007), with the absence of drinking water and sanitation, and particularly in segregated Roma groups (Matyšák 2015). Kovaľ et al. (2012b) indicate qualitative differences in diet composition of Roma children (low share of fruits, vegetables, dairy products, high proportion of sweets, meat, meat products, the low number of meals during the day). Skin disorders, specifically dermatitis, psoriasis, intertrigo, louse hair, insect bites, festering wounds of the skin, are related primarily to very low hygiene standards in families, the high number of people living in a small living space, which creates conditions for their rapid and repeated dissemination. The dominant negative determinant of health of the Roma is the low level of education triggers an insufficient level of health awareness (= health awareness), followed by low personal and communal hygiene, low standard of living and unhealthy eating habits (Hanobik 2014).

Social environment has no impact on the incidence of central nervous system disorders, congenital developmental defects, diseases of the blood. Although in children RSE is likely to develop these diseases slightly higher in comparation with children without RSE did not show statistically significant differences. The etiology of these disorders is multifactorial and has no clear and exact correlation with the social environment of the child. Terms of factors such as heredity, diet pregnant women, the quality of nutrition of the child (Šašinka, ~~Saga~~ Šagát, Kovácz 2007), which can occur in families of different social nature. The smallest differences were identified intoxication. In children, the likelihood of intoxication RSE somewhat lower than those without RSE (p

= 0.343). The intensive care unit Pediatrics Clinic Hospital JAReimana in Prešov in the years 2003-2007 was hospitalized for severe alcohol intoxication 129 children (2-18 years). By ethnicity they were more often intoxicated „non-Roma“ children (91%) as Roma children (9%) (Kovaĺ et al. 2007). Alcohol intoxication is becoming increasingly frequent problem but does not specifically connected with the social environment. Intoxication is for larger children and adolescents importance influence of friends, parties, breakup with a boyfriend / girlfriend (Vágnerová 2004).

Passive form of child abuse is its neglect (Vágnerová 2008). Neglect is usually based on ignorance of parents about what is appropriate care for the child, or inability Planning (Kohut 2008). In the research we have a group of neglected children on admission to the department included only neglect „ physical“ for example, children dirty, with insufficient ensure hygiene, inappropriate clothing malnourished. We found almost 15 times more likely (OR: 14.687) (p = 0.000) neglecting the child from RES in comparation with children without RSE

Growth and development of children are important indicators of child health (Šašinka, Šagát, Kovács et al., 2007). For healthy development is an important right for the stimulation of the child (Vágnerová 2008), the functioning of the nervous system, supply nutrients and oxygen to the brain, the quality of nutrition (Nevoral et al. 2003). Probability lagging behind in development, according to data from the study three times higher in children RSE in comparation with children without RSE (p = 0.000). Also in this case it can be expected that a higher incidence of falling behind in development among children RSE is mainly related to insufficiently stimulating environment from parents. In clinical practice remains a problem even parents who do not respond to warning doctors about the child‘s retardation attending a medical examination which it is possible to change this situation (Vágnerová 2004).

An integral part of a healthy growth and development of the child is **breastfeeding.** The average length of breastfeeding in children was two and a half months (M – 2.52, SD – 3.36) and almost half of children (48.4%) was not breastfed at all, which we assess as a negative approach to maternal health of their child. Breastfeeding is seen as the most ideal way of nutrition during the first months and is an effective form of protection against many diseases of civilization (Agostoni et al. 2009), especially diseases of the respiratory and digestive systems (Duijts et al. 2010; Story Parish 2008). Research has shown that children be breastfed RSE almost one and a half months shorter than in children without RSE while a deteriorating social environment decreases the length of breastfeeding. And it is children from unsuitable environments, as already mentioned, had a statistically higher chance of suffering from respiratory and digestive system. Shorter duration of breastfeeding (p = 0.004) and a higher incidence of respiratory diseases (p = 0.000) showed a Mrosková al. et (2012) in a group of children environmental hazards. However, it should be pointed out that as children RSE perceived by children of Roma origin, has therefore applied a different methodology in the categorization of children. Details of the length of breastfeeding in disadvantage of Roma children do not correspond to results of research conducted on 657 Roma families (even distribution in Slovakia), where Roma children were breast-fed at a higher rate than the total population of children (Popper, Szeghy Šarkózy in 2009).

At the same time, we analyzed the incidence of re-hospitalization of a child after the intervention of social workers. After the intervention of social workers did not

need to re-hospitalization, 78.4% of children. For nearly ¼ of children (21.6%) after the intervention of repeated hospitalization, and the children were dominant RSE (87.6% versus 12.4% in the group of children without RSE). The data obtained on the one hand, the importance of the work of a social worker in a hospital environment, since most of the children after the intervention or re-hospitalized. However, for children from disadvantaged social environments we have seen, in spite of the social worker, a statistically higher incidence of rehospitalization child. It can be assumed that the problems in the families of these children have complex character and unless dealt with community social workers, family environment will continue to negatively affect the child's health and will interact on his re-hospitalization. For increasing the efficiency of social workers by the social field their scope should include not only the hospital and the community environment (Levická 2005), with the necessity of their mutual overlapping.

The most important task in assessing the situation of the family is deciding whether a child is at risk (Levická 2004). One of the most extreme measures is Social and child protection in terms of its placement in foster care (Machálková 2007). To 99.7% of children were placed in front of the hospital with their biological parents / relatives. However, during hospitalization in 19.6% of children were found significant problems in the family environment, which at the end of hospital care threatened the health of the child, so these children were chosen for alternative forms of care (this was a dominant inpatient care). Changing the placement of the child at the end of their stay in the hospital was predominantly carried out on the basis of recommendations of the social worker in children RSE compared to children without RSE ($p = 0.000$).

Conclusion

Based on the results of the research summary, we can conclude that inappropriate social environment has a negative effect on the health of the child and that the intervention of a social worker in a hospital environment can prevent re-hospitalization of children, ie. his work in the hospital is justified. At the same research results (in)directly) point to the importance of the work of community social workers and the importance of establishing secondary and tertiary prevention. Social workers work with families creates space for change of terminology the term „disadvantaged social environment" to "unfavorable social environment." While the former term refers to the steady state, the second emphasizes that social environment may not have ireparibilný character (Kovalčíková, Džuka 2014), and it is possible to influence the work of social workers to change. The findings of the study seem to suggest proper intervention of community social workers would minimize chances of re-hopitalization through improved social environment at places of residence and/ or at the household. This is a more cost effective response than dittaching the child from parental care to institutionalized centres, hence the need to target 'unfavourable social environment'.

References

AGOSTONI, C *et al*. (2009) Breast-feeding: A Commentary by the ESPGHAN Committee on Nutrition. *Journal of Pediatric Gastroenterology and Nutrition*. 47(1):112-125.

DLUHOLUCKÝ, S, ŠVÁČ, J (1988) Score Social endangering a child. *Czechoslovak Pediatrics.* 3:172-174.

DUIJTS, L *et al*. (2010) Prolonged and Exclusive Breastfeeding Reduces the Risk of Infectious Diseases in Infancy. *Pediatrics*. 126(1):e18-e25.

DUNOVSKÝ, J *et al.* (1999) *Social*

Paediatrics - Selected Chapters. Prague: Grada Publishing, 284 p.

FISCHER, S, ŠKODA, J (2009) *Social Pathology: Analysis of Cause and Influence serious socio-pathological phenomena.* Praha: Grada Publishing, 224 p.

HANOBIK, F (2014) Epiphenomena of Marginalization and Discrimination of Roma in Contemporary Society. *Clinical Social Work.* 5(2):122-135.

INFOSTAT (2002) *Prognosis of the Roma population in Slovakia in 2025.* [online]. [cited 12/30/2011]. Available at: <http://www.infostat.sk/vdc/pdf/prognoza2025rom.pdf>.

KOHÚT, P. *Social work with abused persons.* In TOKÁROVÁ, A., MATULAYOVÁ, T. (2008) Social Education, Social Work and Social Education for Adults - current issues of theory and practice. Proceedings of the scientific conference with international participation. Prešov, p. 302-305.

KOVALČÍKOVÁ, I, DŽUKA, J (2014) Conceptualization of the concept of socially disadvantageous environment. *Pedagogy.* 1:5-27.

KOVAĽ, J, HAVRILLA, R, KORDOVANOVÁ, J, BALÁŽ, J. (2007) Alcohol intoxication - modern trend of youth. *Pediatrics.* 6:333-338.

KOVAĽ, J, POCHOVÁ, D, ČURIKOVÁ, A. (2010) *Children's health at risk to environmental factors.* Kosice: EQUILIBRIA.

KOVAĽ, J, MROSKOVÁ, S, SCHLOSSEROVÁ, A (2012a) Natality and infant mortality in Roma children in the Presov region. *Medycyna* Środowiskowa - *Environmental Medicine*. 15(2):92-102.

KOVAĽ, J, MROSKOVÁ, S, MAGUROVÁ, D (2012b) Nutrition of the Roma children and its impacts on same indicators of health. *Medycyna Środowiskowa – Environmental Medicine.* 15(1):69-74.

KOZIEROVÁ, B, ERBOVÁ, G, OLIVIEROVÁ, R (1995) *Nursing 1*. Martin: Osveta, 1474 p.

LEVICKÁ, J. *et al*. (2004) *Social work with family I. Trnava: Faculty of health and social work TU.* 177 p.

LEVICKÁ, J (2005) *Basics of Social Work.* Trnava: ProSocio. 170 p.

MACHÁLKOVÁ, Z (2007) *Social work in pediatric patients*. In Conference proceedings providers of social services to families with children. Trnava, p. 21-29.

MATYŠÁK, P (2015) Social problems in the Roma community in the Slovak republic. *Clinical Social Work.* 1(1):97-108.

MROSKOVÁ, S, SCHLOSSEROVÁ, A, REĽOVSKÁ, M. (2012) Impact inappropriate social environment on children's health. *MOLISA. Medical – nursing sheets of Saris*. 9:142-146.

National Health Information Center (2012). *Outpatient care for children and adolescents in Slovakia 2012th*. Bratislava, 36 p.

NAVRÁTIL, P, MUSIL, L (2000) *Social work with members of minority groups*. Proceedings of the Faculty of Social Studies of the University of Brno. Social Studies 5. 37 p. [online]. [cited 10/25/2015]. Available at: <http://socstudia.fss.muni.cz/ papers/080404095539.pdf>.

NEVORAL, J *et al.* (2003) *Nutrition in Childhood.* Prague: H@H, 420 p.

POPPER, M, SZEGHY, P, ŠARKOZY, Š (2009) *Rome population and healt*. *Analysis of the situation in Slovakia*. Bratislava: A.D.I. Partners for Democratic Change Slovakia, 97 p.

ROSINSKÝ, R, KLEIN, V (2008) *The definition of socially disadvantaged backgrounds*. In TOKÁROVÁ, A., MATULAYOVÁ, T. Social pedagogy, social work and social Adult Education - current issues of theory and practice. Proceedings of the scientific conference with international participation. Prešov, p. 313-316.

STORY, L, PARISH, T (2008) Breastfeeding Reduces Risk of Respiratory Illness in Infants. *The Internet Journal of Allied Health Sciences and Practice*. 6(3):1-5.

ŠAŠINKA, M, ŠAGÁT, T, KOVÁCS, L *et al*. (2001). *Pediatrics*. Bratislava: HERBA, 740 p.

Statistical Office of the Slovak Republic. *Census and Housing in 2001*. [online]. [cited 12/30/2011]. Available at: <http://portal.statistics.sk/showdoc.do?docid=5835#Obsah>.

VAŇO, B (2004) *Roma children in terms of demography*. In Roma children in Slovak schools. Bratislava, Slovak Governance Institute: ADIN, p. 25-32. [online]. [cited 2/12/2014].

Available at: <http://www.governance.sk/assets/files/ romske-deti_v-sk-skolstve-www.pdf>.

VÁGNEROVÁ, M (2004) *Psychopathology for helping professions.* Prague: Portál, 870 p.

VÁGNEROVÁ, M (2008) *Developmental psychology I. Childhood and growing up.* Prague: Karolinum, 467 p.

Law No. 245/2008 Z. *z.* on education and training (Education Law) and on amendment certain laws.

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Case analysis of child abuse and neglect in Trinidad

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Abstract

Child abuse is a major public health problem. This article exposes the health risk faced by a sexually abused child who was a school dropout facing challenges in her life with her own family. This case study critically analyzed the struggle of a female child, whose unfortunate experience was compounded by many gaps within the country's social support systems. On the other hand, the case explored her resilience and will to be successful against all odds. The authors identified a resilient approach which examines and guides the review of the risk; protective factors and resilience in the client's life; the impact of Cognitive Behavioral Therapy that helps her to identify her distorted thinking were discussed.

Introduction

Whether child abuse is defined socially, legally or clinically reflects poor parenting skills on the part of the parent/caregiver to protect the child. For the purpose of this paper a child is defined as "any person under the age of 18". Child sexual abuse "is a form of child abuse in which immature children are exploited through non-violent or violent molestation, pornography, prostitution and/or incest. Non-violent molestation involves adult non-violent sexual contact with a child and may include kissing or touching, voyeurism, exhibitionism, genital fondling and urogenital contact. Violent molestation includes rape, which is defined as attempted or successful penetration of the vagina or labia with the use of force or threat or force. Oral and anal intercourse or vaginal abuse may be violent or non-violent. The use of children as pornographic photography and/or prostitution also constitutes child sexual abuse" (Ellerstein 1981 as cited by Ministry of Social Development and Family Services, 132).

Indicators and Impacts of Child Abuse on Health

Child abuse can lead to negative externalizing and/or internalizing behavior on the child's health. The impacts of which, if not dealt with appropriately, can lead to maladaptive behaviors (Gelles 1976, Sharpe 2012, UNICEF 2006 and Bell 2005). There are many indicators of child maltreatment some include, regressive communication patterns (e.g. speaking childishly); hostility toward authority figures; lack of trust in others amongst others; can lead to insomnia, depression, fear; will affect the growth of the child.

Interaction of Risk Factors Protective Factors and Resiliency in Outcomes

Current literature underscores the interplay of risk factors, protective factors and resiliency with the characteristics of the child, parents and contexts, as major influences in the outcome for child maltreatment and neglect (Stagner and Lansing 2009, and Durlak 1998). Some examples of risk factors are but not limited to frustration tolerance; trauma; difficulty learning and understanding; poor ability to problem solve; family violence; high family conflict; low family bonding. Protective factors act as buffers to the effects of risk factors some examples are hopefulness; physical health; high monitoring and supervision; stable housing; positive role models; parental involvement (Durlak 1998, Paxson and Haskins 2009, Daro 1998, Kugler 1988).

Theoretical Framework

An integrative combined approach of Cognitive Behavioral Therapy and Ecological Theories were used as the resources of choice. Research indicates that "…treatment strategies involving multi-faceted approaches may be more useful than the narrow approaches that have characterized the field in the past" (Lutzer 1984, Lutzer, Mcginsey, Mc Rae, Campbell 1983 as cited by Morris and Braukmann 1987, 291). Child Maltreatment is considered to be multi-faceted with many environmental textures, treatments which warrant a multi-faceted approach (Moursund and Kenny 2002, Coulshed and Orme 2012, Zastrow 2003 and Hamilton 1967).

Methods

Protecting the rights of clients is a critical element in Social Case Work as such; ethical considerations guided the process for this case (York 2009). In research and case studies, it is important to protect the client; start where the client is; and principles of positive self-regard and self-determination observed (Kadushin and Kadushin 1997, York 2009 and Padgett 2008).

Use of Open Ended Questions Guided by Empirical Research Theory

The questions asked in the interview were guided by Eco-behavioral Theoretical Frameworks. The series of questions transitioned from the easiest to more complex. The questions were open ended and were mainly qualitative. Padgett (2008) encouraged case worker/researchers to capture elements of resilience in aspects of their research; hence, questions also explored how the client persevered from her experience.

The stages of Cognitive Behavioral Therapy as highlighted by Coulshed and Orme (2012)

were utilized. The stages were: engagement; problem focus; problem assessment; teaching client a cognitive principle; challenging the assumptions of the client; encouraging client's self-disputing; setting behavioral homework; completion.

Case Analysis

The client is a fifteen year old female survivor of child abuse, neglect and

a witness to parental abuse. To date, she has lived in eight different communities. At the age of 10, she was raped by an adult male family friend who is currently serving an eight year prison term for this crime. She stated that she received no counseling, psychological support or intervention from any Human Services Agency after the abuse. In 2012, two years after the rape, she was detained in the country's lone prison for allegedly causing the death of a 17 year old male school mate (herein after referred to as 'the incident') on the school's compound. While in prison, she stated that she saw the man who raped her. According to her this left her feeling emotionally drained. She feels frustrated, depressed and angry. She regrets committing the incident and stated that it was not intentional. Notwithstanding, she is hopeful that her situation can help someone who may be encountering similar feelings or experiences. She openly expresses feelings of sadness, frustration and anxiety towards this situation and doesn't understand the reason the Ministry of Education cannot place her in any formal public or private educational setting. She is willing to go to different schools to speak out on violence and looks forward to resuming her education. Presently, she is out of prison, assigned to a probation officer, doing community service, on a curfew and serving a bond.

Discussion

Social/Emotional Functioning

Notably, her pattern of responses is a cause for concern. The relationship with her parents seems to be deteriorating. Her overall pattern of responses demonstrates that her emotional functioning is impaired. Data suggests that adjudicated delinquent female adolescents who experienced particularly high rates or exposure to sexual and other forms of abuse tend to be very aggressive and have self-regulatory issues (Bell 2005). On examining Bronfenbrenner's Ecological System Theory (1979) one can further gain insight into the clients present behavior. The Ecological model postulated that an individual's growth and development is based on contextual factors. A young person's development is affected by the interaction of five types of environmental systems.

The first Micro-system which examines her immediate environment: for instance the relationship she has with her mother and their communication patterns.

The second, Meso-system, looks at her interaction with peers, school and immediate persons around her. However, in the present situation, interactions in her Meso-system seemed curtailed. She is still out of school; breaks the bond; stays out late; spends most of her time with anti-social young adults; enters into communities with high incidences of crime. This raises concerns for this stage in her developmental pathway: exposure to positive attributes from school; pro-social peers; clear rules and consequences are all encouraged because they can help reinforce positive behavior. Interestingly, although she interacts with persons who presumably have negative behaviors, this has not affected her determination to re-enter the school system and succeed, she holds firm to what she wants.

The third, Exo-system, consists of structures that may not be directly in her path but affect her immediate setting. She expressed anger towards her mother's unemployment status. She thinks her mother is lazy, nags her too much and should find a job. She doesn't like to remain home whenever her mother is there.

The fourth, Macro-system examines concrete structures in the society: for example, the cultural beliefs of the society. It examines the cultural expectations of young women in the Trinidad culture and their implications. Her father complainss about her dress code protesting that it is too revealing for a 'young lady'. Talking to her about her dress code yielded no result; she does not believe that she has to dress to please people; the way she dresses is her identity. This view may be consistent with Erik Erikson's (1993) developmental stage of identity versus role confusion.

The fifth, Chrono-system examines her behavioral consistency over time; the environment in which she lives; the impact of the incident on her psychological functioning; the effects of her parent's divorce. The literature stated that girls like this are at risk for the development of aggression and delinquency come mainly from disadvantaged circumstances such as parental stress (parent's tumultuous relationship) and disrupted parenting. Additionally, parent-child conflict relates to aggression and delinquency in girls.Further, internalizing and externalizing problems such as her withdrawal and aggression towards her mother indicate that she is at risk. Disengagement or exclusion from school may well precipitate offending by young women. Bell (2005) noted that absenteeism/expulsion from school is known to have an indirect pathway to crime.

Risk and resilience

To examine and guide the review of the risk, protective factors and resilience in her life, Bronfenbrenner's (1979) Ecological Systems Theory and risk protective framework were utilized. Bronfenbrenner's (1979) multi-system approach was used to understand environmental and individual factors that influenced her. The framework posited that behavior and possible outcomes of persons along their developmental pathway are shaped by the interaction of multiply risk and protective factors.

Durlak (1998) defined protective factors as influences or variables that buffer the effect or reduce the probability of a maladaptive outcome stemmig from risk factors. Examples of protective factors may include: individual's good problem solving skills; access to support networks; parents who are supportive and attentive; school climate that fosters positive growth and development. In contrast, Durlak (1998) stated that risk factors are factors that increase the possibility of negative undesirable outcomes for a child. Examples of risk and protective factors include: elements such as characteristics or qualities of individuals; experiences; relationships; contexts; institutions.

Resilience offers a framework to gain insight on the various ways in which a child does well in an adversarial situation. A resilient child is one who develops normally despite of difficult circumstances in the past and/or present (Luthar S. 2000). Resilience is also characterized and influenced by the interactions and outcomes derived from familial and environmental factors (Schoon 2006). Resilience examines how the child process respond in the onset of the adversity (Rutter 2007). Other researchers concluded that resilience in girls can be measured along six or eight domains of functioning criteria of: employment; homelessness; education; social activity; psychiatric disorder; substance abuse (Bell 2005). Bell *et al*. (2005) stated that 22% of abuse and neglected children followed into adulthood met the criteria for resilience.

The client also expressed her frustration with the system: she gets bored easily and resents being inside for long bouts of time based on the conditions of the bond. She is becoming restless, her father claimed that

she doesn't attend counseling anymore and the counselor was in the process of terminating their sessions. In the presenting case, her risk factors include: poor parental supervision; being exposed to family relationship conflict and parental abuse; prohibition from school; lack of adequate social support networks, community violence and crime; exposure to adult criminals in prison. Enduring risk factors may include social isolation; aggressive behavior; mother's failing health; underlying all of this is the family's new economic status having used up savings for her legal fees. Other underlying risk factors: caregiver childhood adversity and violence in the neighborhood.

Protective Factors: enduring protective factors: father and mother constantly support her although the relationship is strained with her mother; the mother still continues to pledge her support for her daughter; father continuously supports her financially and emotionally; her siblings constantly support her; give her lessons; speak to her; has bonded with her infant sister who gives her a sense of purpose and fulfilment. Spiritually, she believes that God is going to make a way for her through all of the adversity.

Cognitive Behavioral Therapy

Cognitive Behavior Therapy assumes that most people can become conscious of their own thoughts and behaviors and then make positive changes to them. Behavior Therapy assumes that all behaviors occur as a result of internal and/or external stimuli (Zastrow 2003). Further the client can benefit from what the Therapy has to offer. Within the Therapy, she can move towards overcoming the difficulties by changing her problematic behavior and the emotions experienced over the incident. This therapy will also allow her to change unhelpful thinking and confront her feelings, reframe and restructure some of her thoughts, especially about the abuse. It should also help her to identify her distorted thinking; relate better with her mother; in the long restore her back to proper emotional functioning.

Social Work Intervention

"A culturally specific definition of child abuse and neglect in the Caribbean is needed to avoid inappropriate intervention, infringements of parents rights and inconsistencies in interpretation of who is the at-risk child and who is the abused child (Ministry of Social Development and Family Services 1989 p 34)."

Long term commitment is needed to help the client through this tumultuous time; she needs consistent and committed workers helping her along. This will bring some level of stability to her life as she tries to successfully complete her developmental milestone. She can benefit from weekly counseling sessions with an emphasis on a Cognitive Behavioral Therapeutic approach. Intervention in the home is critical.

Strengths Based Approach

The focus of the helping process is on consumer's strengths interests and abilities, not upon weaknesses, deficit or pathologies. (Coulshed and Orme 2012, 163).

Against this background interventions for the client should focus on empowerment, resilience and the Social Work value of individualization. It is also suggested that an intervention surrounding positive activities that she loves should be encouraged. Asset-enhancing activities like playing pan and interacting with people can be used as an opportunity for her to develop pro-social skills and a channel through which the Case Worker can develop trust and build rapport. The client though experience issues has resources within her that have not been utilized. A multi-sectorial approach can also be

used as an intervention strategy to capitalize on what each social partner can contribute to her holistic development. It is clear that there are major gaps within the systems in which she interacts. As such, interventions should focus on strengthening protective factors within the family such as the skill set of her parents. This should have a positive impact should improve the family's overall interactions.

Gaps Within the Social Service Delivery

Notably, child abuse is a complex problem that requires a continuum of culturally and gender relevant assessment and intervention to secure prevention of child maltreatment and neglect. For the purposes and issues arising out of this study, the gaps in three human service providers: Child Protection Authority (CPA), Law Enforcement and Child Care Homes will be reviewed in the country of Trinidad. There are many gaps within the service delivery that contribute to the prevailing risk factors for victims of abuse.

Child protection authority

The Child Protection Authority is the agency for child protection in Trinidad. Though its vital role cannot be understated, its fragmented approach in dealing with child abuse has left many gaps. Although the Child Protection Authority was designed to prevent child abuse, the response to accomplishing this feat seems to be difficult. The multi-sectorial approach as proposed has not entirely lived up to expectations. The roles and responsibilities of various sectors and agencies are not clearly defined, as such, duplication and negligence of duties may be forth coming issues. Public trust and confidence in the Authority has been a major challenge in some instances it even may be termed as jeopardized. This mistrust may be a result of a pattern of inefficiency and unreliability in responses when clients reach out for help. Sensitization: lack

of public awareness of the rights of the child and the access to social support agencies continue to be a gap that leaves the victims of abuse isolated from protective services that should buffer the effects from the inclement risks. Preventative strategies, more reactive than preventative, take on a medical model, more on intervention focuses on victims and their family not on strengthening the support units and gaining support from the wider community. Lack of physical, human and financial support are issues that compromise the quality of services the agency can provide. Though the Authority has made strides to remedy this problem, it is still concurrent. There isn't training and capacity building to fulfil the child protection mandate.

Law Enforcement Agency

A significant aspect of the roles of Law Agency Workers in the Caribbean lies with the protection of human rights. Included in their mandate is the protection of children against maltreatment and abuse (Ministry of Social Development and Family Services 1989). Delay in initial responses and lack of trained officers in the area of child abuse investigations broadens the gap to effective management of this crime. Widening the gap even further is the issue of a cohesive response towards abuse. Grenada is cash strapped and as a result may not have the resources to invest in many human and physical resources. As such, the need for coordinated multi-sectorial approaches between the police and other child protection agencies heightens. Although significant strides were made along the years, the problems still persist, officers are not always readily available to respond to the victims of abuse.

Conclusion

Every child has a right to a harm free life. As a professional working directly with children, it is very disheartening to encounter victims of abuse. Policies and Laws are there to protect, but until the gaps are bridged, children will forever be vulnerable. The case of Xalima Hood is one in many. The focus on the on child abuse in the past has now changed to encompass a resilient approach. An approach that focuses on the strength of the child to withstand the perils of unfortunate circumstances is an excellent one to undertake in Grenada. Children are resilient they are strong and they have the capacity to survive.

References

Bell, Deborah J., Foster, Sharon, L., Mash, Eric, J,(2005) *Handbook of Behavioral and Emotional Problems in Girls* New York: Kluwer Academic/Plenum Publishers

Bronfenbrenner, Urie. (1979) *The Ecology of Human Development: Experiments by Nature and Design* Massachusetts: Harvard University Press

Coulshed, Veronica, and Joan Orme (2012) *Social Work Practice*: Palgrave Macmillan. London

Daro, Deborah (1998) *Confronting Child abuse*: New York: Free Press

Duncan, Neville, C. (2005) *World fit for Children in the Caribbean Beyond 2002*. Christ Church: UNICEF,

Durlak, J.A. (1998) *Common risk and protective factors in successful prevention program American Journal of Orthopsychiatry*: 512-520.

Erikson, Erik, H.(1993) *Childhood and Society* New York: WW Norton,

Gelles, Richard J. (1976) *Demythologizing Child Abuse*: *The Family Coordinator,* Vol. 25, No. 2, 135-141.

Gordon, Hamilton (1967) *Theory and Practice of Social Case Work*: New York: Columbia University Press,

Kadushin, Alfred, and Goldie Kadushin (1997) *The Social Work Interview A Guide for Human Service Professionals* New York: Columbia University Press,

Kugler Karen, Hansson Robert (1988) *Relational Competence and Social Support among Parents at Risk of Child Abuse Family Relations* Vol. 37, 328-32.

Luthar S, Cicchetti D & Ecker, B. (2000) *The construct of resilience: A critical evaluation and guidelines for future work* Child Development 71, 543-562.

Luthar, S., Cicchetti, D. & Becker, B. (2000*) The construct of resilience: A critical evaluation and guidelinnes for future work.* Child Development 71, 543-562.

McCoy, Monica,L, & Stefanie,M Keen (2009) *Child Abuse and Neglect,* Psychology Press, NY

Ministry of Social Development and Family Services, UNICEF Caribbean Regional Conference on Child Abuse and Neglect (1989) Conference Report, Port of Spain: Ministry of Social Development and Family Services & UNICEF,

Morris, Edward, K, & Curtis, J Braukmann (1987) *Behavioral Approaches to Crime and Delinquency* A Handbook of Application, Research, and Concepts New York: Plenum Press,

Moursund, Janet & Maureen C. Kenny (2002) *The Process of Counselling and Therapy*. Prentice Hall, New Jersey

Padgett, Deborah, K. (2008) *Qualitative Methods in Social Work*. Sage Publication, Inc. California

Paxson, Christina & Ron Haskins (2009*) Introducing the Issue* Preventing Maltreatment Vol.19, No.2, 3-18

Riley, Akilah (2010) *The Secret that Everyone Knows: Exploring the Experiences and Perspectives of Social Workers who intervene in Child Sexual Abuse Cases in Trinidad and Tobago* Caribbean Journal of Social Work Vol10, 42-73.

Rutter, M. (2007) *Resilience competence and coping* Child Abuse and Neglect 31 (3), 205-209

Schoon, I. (2006) *Risk and Resilience: Adaptation in Changing Times* Cambridge University Press, Cambridge

Sharpe, GIlly (2012) *Offending Girls Young women and youth justice*. Rutledge New York,

Stagner, Matthew, Wand, and Jiffy Lansing (2009) *Progress toward a Prevention Perspective* Preventing Child Maltreatment vol.19 no.2, 19-38.

York, Reginald, O. (2009) E*valuating Human Services* A Practical Approach for the Human Service Professional Allyn & Bacon/Pearson, Boston

Zastrow, Charles, H. (2003) *The Practice of Social Work: Applications of Generalist and Advanced Content.* Brooks/Cole-Thomson Learning, California

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