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Author: Michal Olah

The impact of the Environment on a person's mental and social Health

Original Articles

- ✓ THE IMPACT OF THE ENVIRONMENT ON A PERSON'S MENTAL AND SOCIAL HEALTH
- ✓ A CHILD WITH A PARENT SERVING A PRISON SENTENCE AND ITS IMPACT ON THE SCHOOL ENVIRONMENT
 - ✓ FACTORS AFFECTING AND SHAPING THE PERSPECTIVES AND EXPERIENCES OF WOMEN LIVING WITH HIV/AIDS
- ✓ SOCIAL (PASTORAL) SERVICES AND ITS IMPACT ON THE CITIZENS OF THE CZECH REPUBLIC
- ✓ PEOPLE LIVING WITH HIV/AIDS IN THE KIBERA INFORMAL SETTLEMENT IN NAIROBI CITY, KENYA: IS THERE ANY GENDER DIFFERENCE IN FACTORS RELATED TO ANTIRETROVIRAL THERAPY?
 - ✓ NARCISSISTIC PRIVACY AS A BARRIER TO SOCIALIZATION
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 - ✓ SELF-EVALUATION AND SELF-ESTEEM IN CHILDREN WITH TYPE 1 DIABETES MELLITUS
- ✓ BURNOUT SYNDROME AS AN INSTABILITY INDICATOR OF PROFESSIONAL MEANINGFULNESS WITH A SPECIAL FOCUS ON THE PROFESSION OF GENERAL PRACTITIONERS FOR ADULTS IN THE POSTMODERN AND POST-COVID ERA
 - ✓ AN INVESTIGATION INTO THE ROLE OF EARLY MARRIAGE IN DEVELOPING SUICIDAL IDEATION AMONG GIRLS IN DIR, KHYBER PAKHTUNKHWA, PAKISTAN
- ✓ HOMELESSNESS AND SUICIDALITY: HOW DO NEW EMIGRANTS CONFRONT THE DILEMMA? EVIDENCE FROM EXISTING RESEARCH CONDUCTED IN CANADA
- ✓ REFUGEE CRISIS IN THE EUROPEAN UNION COUNTRIES: PROBLEMS AND CONSEQUENCES
 - ✓ PSYCHOSOCIAL RISK MANAGEMENT OF EMPLOYEES FROM THE PERSPECTIVE OF MANAGERS OF SOCIAL SERVICE FACILITIES, CASE 5P
- ✓ THE IMPACT OF THE SYNDROME BURNOUT OF PROFESSIONAL WORKERS IN FACILITIES SOCIAL SERVICES

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Editorial

The impact of the Environment on a person's mental and social Health

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The Journal of Clinical Social Work and Health Intervention remains an essential resource for utilizing updated research by social scientists, policymakers, and practitioners. The journal is committed to intellectual rigor, diversity, and relevance and has solidified its position as a leading journal in innovative and rigorous research in the field of social sciences. With its diverse range of articles, in-depth analysis, and commitment to interdisciplinary dialogue, this journal has become an indispensable resource for scholars and practitioners alike. As one of the top scholarly journals that publish high-quality research in social work and related fields, adhering to worldwide publication standards, the current volume No. 15, Issue 3, October 2024 includes papers from various parts of the world and thus has maintained diversity. The first study examines the situation of a child whose parents are incarcerated and how such incarceration affects the school setting, where children spend the majority of their time after their homes. This article identifies the stress that children experience when their parents are incarcerated. The second paper examines the variables influencing and moulding the viewpoints and encounters of females suffering from HIV/AIDS in Pakistan where the paper specifically deals with the relationship between studying the sociocultural and religious factors in shaping the perspectives and experiences of women living with HIV/AIDS and how it shapes gendered perspectives in the locality. Further, the socio-cultural and religious domain of cultural beliefs, traditions and religious practices have been investigated which influence the experiences of women affected by HIV/AIDS.

Similarly, the paper on Social (Pastoral) Services and its Impact on the Citizens of the Czech

Republic examines social services and their impact on the citizens of the Czech Republic from the point of view of the present time and analysis has been made on important concept of social services in the networking of religious institutions in the Czech Republic using a quantitative representative sample. Similarly, the issue of people living with HIV/AIDS in the Kibera informal Settlement in Nairobi City, Kenya using gender differences in factors related to antiretroviral therapy are associated with identifying gender differences in behavioural factors and treatment-related fact of ARV therapy as a predictor of treatment, adherence using cross-sectional study design. Besides, Narcissistic Privacy as a Barrier to Socialization, a study provided in the journal deals with the trends and changing dimensions of a democratic society which has created tensions between private and public interests while passing through different stages of change. This has also posed a serious threat to the functionality of society by making it a complex whole.

Besides, the research regarding The View of Social Work on the Sexuality of Persons with Health Disadvantages – Mental Disabilities deals with a description of attitudes towards the issue of sexuality of persons with mental disabilities and the individual attitudes towards sexuality of people with mental disabilities have also been investigated. The study on Self-evaluation and Self-esteem in Children with Type 1 Diabetes Mellitus which is the most common childhood endocrine disease was investigated through self-evaluation on the degree of compensation in children with Type 1 DM using a self-assessment questionnaire and statistical methods. Similarly, the article on Burnout Syndrome as an instability indicator of professional meaningfulness with a special fo-

cus on the profession of general practitioners for adults in the postmodern and post-COVID Era focuses on the Burnout Syndrome, the importance of its causes and ways to overcome debated in the post-COVID era in the medical profession. Further, the paper on an investigation into the role of early marriage in developing suicidal ideation among girls in Dir, Khyber Pakhtunkhwa, Pakistan is about the association between early marriages and suicidal ideation, the relationship between suicidality and early marriage is thoroughly investigated through a mix-method research design. The issue of homelessness and suicidality: how do new emigrants confront the dilemma? evidence from existing research conducted in Canada was also investigated under a systematic review design for extracting specific evidence and confirming how homelessness is associated with suicidality among new immigrants to Canada. The Refugee Crisis in the European Union Countries: Problems and Consequences were taken into consideration and the negative impact of the European migration crisis on various spheres has been debated. The research identifies the current problems of Ukrainian migrants, assessing the socio-economic situation of EU citizens, the impact of the migration crisis and identifying mechanisms for reducing its negative impact using sociological and expert survey methods. Besides, the psychosocial risk management of employees from the perspective of managers of social service facilities, case 5p aims to find out the importance of supporting the management of psychosocial risks of mental health in helping professionals from the view of managers of social service facilities using qualitative analysis through a pilot pre-research probe from the Head manager of the Social Services Home.

In conclusion, this journal has established its reputation through excellent research in the field as specified. My special congratulations to the editorial team's dedication to maintaining quality and relevance in the publications. As the journal is evolving, it is hoped that future contributions to this journal will shape the landscape of research in clinical social work.

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A Child with a Parent Serving a Prison Sentence and its Impact on the School Environment

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Original Article

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Abstract:

The school environment is where a child spends the second most amount of time (after the family environment). Leskova (2018, p. 52) claims that “the school and the school environment also play an irreplaceable role in the formation of a child.” Professional authors are largely inclined to claim that having a parent in VTOS has a negative impact on a child’s school results. „The stress caused by a parent being in prison or in VTOS can affect a child’s school performance. Strong emotions and the actions associated with them can result in problems in the classroom and social isolation“ (Chil-

dren of Incarcerated Parents Toolkit, 2022, p. 6). This problem is then the subject of social work, and as Planka et al. (2024, p. 1) state, we use the means of social policy in the school system, which leads “by providing for the social needs of the population and creating conditions for improving the living conditions of individuals and groups.” Having a parent VTOS can affect the child in several areas:

- **Mental health.** The child loses physical contact with the parent, which can be reflected on the psychological side of the individual. Children may experience different feelings such as guilt and sadness. As a result, mental problems in the form of depression and anxiety are created.
- **Social relations.** These relationships can be influenced by the family environment as well as the school environment. In the family environment, the whole family suffers and the child can sense instability in the home environment. Discrimination and ridicule from classmates can occur at school
- **School achievements.** The previous two areas can affect the school area. The family situation can lead to absence from school or failure to fulfill school duties.

According to Slavin (2000, In: McMahan, 2002, p. 5), “children with incarcerated parents are at increased risk of poor school performance, dropping out of school, gang involvement, early pregnancy and drug abuse.” In some cases, the departure of a parent to VTOS can have the opposite, i.e., positive effect on the child. Some children, as well as families, are relieved after the departure of a parent or family member to VTOS. However, as Planka and colleagues (2024, p. 119) point out, whether the situation has improved or deteriorated after the parent’s departure, there must always be communication between the child, the family and the parent in VTOS. “Communication as a process of mutual understanding plays a huge role in all aspects of life - private life, the work environment and interpersonal relationships.” Matejkowski, Johnson and Severson (2014, [cit. 2024-05-22]) add that this fact can also leave children with clinical problems, such as depression and anxiety, problems with attention, disruptive behavior, poor results at school, disruption at home and a reduced likelihood of dealing with anxiety and stress in the future.

Organization and management of research

The main part of the presented professional article is the research part. In our empirical part, we decided to follow the guidelines laid out by Bačíková and Janovská (2018):

1. research objective,
2. research problem and research questions,
3. research sample,

4. research method,
5. data collection and processing,
6. interpretation of the detected data.

Among the first steps, even before the actual implementation of the research, we recommend gaining knowledge from professional literature in addition to knowledge of the researched topic. Theory is important for the implementation of the research part, so the researcher must become

familiar with the topic and the professional literature when writing the theoretical part. Based on the professional literature, we continue with the empirical study, where we define the research problem, the research objective and research questions. Following this is the selection of the research sample or population. The research sample is represented by people who meet the criteria determined by the researcher. The researcher determines the number of people who will make up the sample. After choosing a suitable research sample, we deal with the choice of research methods. As stated by Hendl (2005), the choice of the research method depends on several aspects, namely the acquisition of the necessary information, the selection of suitable persons and the situation under which it will be carried out.

Based on the decision of the selected research (quantitative/qualitative research), the selection of an appropriate method is developed. We most often associate the questionnaire method with quantitative research, which according to Gavor (2010) „is one of the most frequently used methods in research,“; with qualitative research we recommend performing interviews, for example. Eventually we get to the main part of the research, which is data collection and processing. It is necessary to establish contact with the respondents either in person or online - depending on the chosen research method and the topic being researched. We prefer in person meetings when performing interviews, as they allow us to notice other aspects like the behavior of the respondent. We consider it necessary to inform each of the respondents both verbally and by getting informed written consent about the processing of their personal information and the anonymization of data obtained in the interviews. All of the interviews are transcribed. According to Bačiková and Janovská (2018, p. 132), the “transcription of records (e.g., the audio recording of an interview) is usually lengthy, but necessary for further work. The most common form of transcription is verbatim transcription. Its advantage is that no information is lost, and it is available at any time during the analysis. In this way, it is possible to record, for example, peculiarities in the participant’s expression.” We evaluate the obtained data with the help of open coding.

Research objective

Our research objective is as follows. Through the teachers we want to learn what the consequences are of having a parent in VTOS, how it affects the functioning of the child in the educational system, and if these children have the same life experiences.

A research problem

When defining a research problem, it is necessary to pay attention to brevity, clarity and concreteness, as research questions and goals also develop from it. We can say that the entire process of scientific investigation is built on the research problem; it is necessary to constantly stick to the research problem, as Gavora (2010) claims that “only a specific research problem can be investigated”. In the event that the course of our research changes or it is necessary to change it, a change in the research problem is considered. *The research problem in our research is the life experience of three children who have a parent in VTOS. We want to know in which areas teachers see changes in the children. At the same time, we are interested in whether the fact that the children’s parents are in VTOS has an impact on the overall functioning of the given child in the school environment.*

From our research problem, we set the following research question:

How did the family environment (or parent’s imprisonment) affect the functioning of the child in the school environment?

The research sample

Due to the sensitivity of our topic, we decided not to conduct the research with the children themselves, all of whom have a parent in VTOS. We also decided against carrying out the research by dealing with the parents who take care of the children. Therefore, as previously mentioned, the subjects of our research are primary school teachers who can tell us about children with a parent in VTOS. According to Lee Smith (2021), it is important that educators or staff in the school environment had knowledge about the mental health of pupils and the impact mental health has on their performance. The mentioned primary school is located in the district of Malacky.

Considering the strategy of our research and the general lack of information about children with a parent in VTOS, we decided to look for our research sample directly in the given school. We had unverified information about 3 students with a parent in VTOS, and we went to verify this information directly with the given school. The information was confirmed by the teachers. When choosing the people under investigation, we were guided by certain selected criteria:

- at least one of the student's parents must be, or have been in VTOS,
- the intensity of the teacher's contact with the child whose parent is in VTOS,
- the teacher should have gotten to know the student before the parent left for VTOS, and the teacher is also in contact with the student after the parent has left for VTOS.

For the reason mentioned above, the names of the respondents are not mentioned in our research, and the names of the children are fictitious. The respondents in this research will be referred to as: Teacher 1, Teacher 2, Teacher 3, Teacher 4 and Teacher 5. The children in our research will be referred to as Daniel, Sofia and Ema.

Research method

We chose the method of qualitative research, namely interviews. According to Bačíková and Janovská (2018, p. 122), "it is verbal (and non-verbal) interaction between two or more actors." Since there are several types of interviews, we decided on semi-structured interviews, which, according to Gavor (2008), are a compromise between completely scheduled interviews (structured interviews) and free interviews (unstructured interviews). In a semi-structured interview, basic questions are set, and additional questions are also asked during the interview. When conducting our interview, we

followed the recommendations of Bačíková and Janovská (2018):

- plan the place, date and time of the interview,
- plan the areas of interest and interview questions,
- at the beginning of the interview, create a friendly and, above all, trustworthy atmosphere, inform the respondent of the reason for the meeting and briefly introduce the researched topic,
- observe the basics of verbal and non-verbal communication, the questions must be understandable, do not interrupt the respondent...,
- decide on the method of recording the interview,
- at the end, ask the respondent if they have any other information not mentioned so far that they consider important to inform the researcher, thank them for the interview, offer contact and say goodbye.

Collection, processing and analysis of data

Data collection was carried out at one primary school in the district of Malacky. Based on an agreement about the researchers meeting with the respondents, personal meetings were planned at the school. We came to the meeting with the teachers with pre-prepared questions for our research. Before conducting the actual interview, we got to know each teacher and briefly introduced them to the goal of our diploma thesis and the goal of the research. We also familiarized them (as we mentioned above) with the processing of the obtained data.

In the following Table 1, we provide information about the children that the respondents, the educators, told us in our semi-structured interview. Two children - Daniela and Sofia are united by two phenomena; both are in second grade, and each of them has a mother in VTOS. Ema is in first grade and her father is in VTOS.

Table 1 Description of children who met our criteria

Name	Age	The class	A parent who is/was in VTOS
Daniel	14 years	9th grade	mother
Sophia	12 years	6th grade	mother
Emma	8 years	2nd class	father

Source: own processing

Table 2 Description of respondents (educators) who met our criteria

Child's name and case number	Respondent (Teacher)	Number of years of experience of teachers	The length of the child's contact with the teacher	Length of contact of the child with the teacher after the parent leaves the VTOS	The school subject he teaches
Daniel Case no. 1	Teacher 1	44 years	5 years	3 years	Slovak language and the pupil's class teacher
	Teacher 2	5 years	4 years	3 years	biology and geography
Sophia Case no. 2	Teacher 3	35 years	6 years	1 year	art education and physical education
	Teacher 4	2 years	2 years	1 year	mathematics and class teacher
Ema Case no. 3	Teacher 5	6 years	2 years	1 year	class teacher, mathematics, reading, writing

Source: own processing

We divided the children into cases. For better understanding, see Table 2. We had interviews with 4 teachers about Daniel and Sofia. Because they are in second grade, they come into contact with several teachers. Ema is in first grade, so she most often meets her class teacher.

After obtaining the necessary data from the teachers, we could start processing the data. We recorded the data by uploading it to a mobile device. Subsequently, we began to transcribe the interviews verbatim. We analyzed the data using open coding, which according to Kalash et al. (2011, p. 24) is "a key method of qualitative analysis that is applicable to a variety of research styles." Open coding is data analysis that draws attention to concepts and phenomena and then labels and categorizes them through their relatedness and similarity (Strauss and Corbinová, 1999). For this reason, our goal in analyzing the data was to create categories. In our research, we first chose areas of research interest - phenomena that interested us based on the research questions, the research problem, and anything that was revealed to us when studying the transcribed interviews. Based on the resulting phe-

nomena, categories were formed. On the following pages, we will focus on individual cases and analyze the categories that appeared to us while studying the interviews. The categories are:

- behavior
- benefit
- problems

Based on the categories, we will describe each question from the interview, with each teacher and in each case. Category names are indicated by a number, and phenomena are indicated by a letter.

1st category —> **Phenomena/factors**

behavior

A - changes in behavior

B - communication

C - spending breaks

D - relationships with peers

2nd category —> **Phenomena/factors**

benefit

A - changes in benefit

B - class activity

C - readiness for classes

3rd category —→ **Phenomena/factors**
 problems
 A - absenteeism
 B - dependencies
 C - psychological problems

The results

Based on the stated research question and research objective, we evaluated the conclusions of our qualitative research based on the individual cases. *We were interested in which aspects the respondents (educators) see the change that occurred in the children after the parent left for VTOS.*

Case number 1 (Teacher 1, Teacher 2, Daniel)

Based on the statements of Teacher 1, *changes in behavior occurred.* Daniel liked to be the center of attention, had teasing remarks and had conflicts with one classmate that sometimes resulted in fights. Teacher 2 commented that *the changes in behavior* occurred only because Daniel likes attention. Both teachers said that *there were no changes in the benefit* and they consider Daniel to be lazy. Teacher 2 added that Daniel could have 1's and 2's and could use his potential more. Based on the answers of Teachers 1 and 2, we came to the conclusion *that the most critical area for Daniel from the teachers' point of view is clearly behavior*, since there were no changes in his achievement. According to Teacher 1, the departure of Daniel's mother to VTOS *affected Daniel's school attendance*, which was shown by how he neglected the morning lessons. He came to school *tired, and Daniel seemed to have been slightly neglected when it comes to his care.* Teacher 1 also added that Daniel played computer games often, and the reason for this may be that no one paid attention to Daniel during his mother's VTOS. Teacher 2 added that Daniel smokes, but he does not think it is related to his mother's VTOS.

Case number 2 (Teacher 3, Teacher 4, Sofia)

According to the statements of Teacher 3, *the behavior and benefit have not changed.* This is because Ema's grandparents took care of her even when her mother was free. Sofia comes to class prepared, is active and has friends with whom she also spends breaks. Teacher 4 noticed that Sofia had *a sad period* that lasted for about a month, adding that she was *behaving like other children* her age. Teacher 3 also noticed periods

of crying, which he classified as psychological problems. According to Teacher 4, her *benefit is unchanged.*

Through Teachers 3 and 4, we learned that *Ema's achievement and behavior are unchanged.* According to both educators, the behavior was different when Ema was sad and had crying periods.

Case number 3 (Teacher 5, Ema)

According to the statements of Teacher 5, there were no changes in the behavior of Ema after the father's departure to VTOS. Her behavior was specific, but according to the teacher, Ema had this behavior before. Ema never excelled in her grades, and she repeated the first grade twice. *Yet, according to Teacher 5, Ema's father's VTOS affected her grades in a negative way, meaning that this area is more critical.* Teachers 3 and 4 agreed that the grandparents are devoted to Sofia to a great extent. They took care of Sofia even when her mother was not free. Therefore, there were no *fundamental changes in Sofia's school environment.* According to the statements of both teachers, Sofia only had a sad period. Sofia is an exemplary student. She has minimal absences and her grandparents, who look after her, cooperate with the school and are interested in Sofia's work. We encounter a negative influence on the child in the school environment, which is visible especially *when it comes to benefit and absence.* Teacher 5 commented that care is neglected in the family, and this fact *affects Ema at school as well* because she often comes *unprepared* and *absenteeism* is frequent. After the father's departure to VTOS, no one has been *informed about Ema's work at school.* In this case, we can conclude that the family environment affects the child at school.

If we start from the theoretical framework of our study, most authors agree that a child with a parent in VTOS will react negatively, and this can negatively affect their results at school (*Children of Incarcerated Parents Toolkit*, 2022, Slavin, 2000, In: McMahan, 2002). In professional literature, we did not come across a positive statement about the school area of a child with a parent in VTOS.

Considering our qualitative research, we come into conflict with other authors. This is because it is not a rule that a parent in VTOS has

a negative impact on a child in the school environment. In cases 1 and 2, we did not encounter fundamental changes in the children. Sofia had short crying periods and Daniel only showed changes in his behavior. In the last case, we encountered the opposite problem. The VTOS of the father affected the child (Ema) in a negative way.

In our research, we came across the fact that having a parent in VTOS does not necessarily affect the child in a negative way in the school environment. We are of the opinion that if the family environment and ties in the family are firmly established, the child is carefully taken care of and has someone to lean on, there might not be such a threatening impact on the individual. Also important is the fulfilment of family functions that affect family stability - see case 2 (Lehoczka, Zatkova, 2021). According to Šrobárová and Slanicayová (2015), the fulfilment of needs has a significant impact on an individual's social behavior. In case 3 there were strong family ties between Ema and her father, who went to VTOS. The father was the one Ema could lean on. In this case we encounter two problems. The first is the departure of a caring parent and the second will be the return of this parent from VTOS. As Lešková and Haburajová Ilavská (2023) claim, when a convict returns to society, various obstacles arise that the convict must overcome, and one of them is rejection by society. Based on these facts, we conclude that this is the reason for Ema's negative behavior at school at that time. Important aspects include the fulfilment of family functions but also the fulfilment of the child's individual needs, which are largely fulfilled by the family.

Conclusion

The fact that someone from the family is in VTOS is not an easy situation for adult family relatives. It is hard to imagine how their children process this situation and what they are going through. A parent in VTOS can cause vulnerabilities to emerge in children, which may continue to accompany them. Czirák (2022, p. 236) states that social maturity plays a big role here. "Social maturity is a global indicator of how competent an individual is to enter into social interaction and deal with social situations. While social competence is understood as a general human

characteristic, the concept of social maturity is understood as a synthesis of the assessment of social competence attributes in terms of social independence and responsibility."

We think that society forgets about children with this type of fate, and maybe the reason is the low awareness people have about these problems in families. From the point of view of professional literature, only foreign literature deals with the issue of a child with a parent in VTOS to a large extent. So as to not only be negative about this issue, there are organizations and people who try to help, and they have understanding and empathy for these children. Among other things, we recommend cooperation between schools and parents. Children should receive support not only in the family environment, but also in the school environment. This support can mitigate negative impacts and help children to have a better chance of achieving success in school.

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Factors affecting and shaping the Perspectives and Experiences of Women living with HIV/AIDS

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Original Article

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Abstract:

This paper explores the relationship between studying the socio-cultural and religious factors in shaping the perspectives and experiences of women living with HIV/AIDS. The study aims to deeply investigate the socio-cultural and religious domain of the Pakhtun culture of Malakand District, Pakistan, and to know how cultural beliefs, traditions and religious practices influence the experiences of women affected by HIV/AIDS. Through a qualitative research approach, this study engages in-depth interviews with the participants, participant observations and field notes to gain profound insights into the challenges these women face. The research objectives comprise a comprehensive exploration of the complex relationship between socio-cultural and religious factors that

influence the experiences and perspectives of women living with HIV/AIDS. The analysis of field data has been thematically analyzed and is presented in the form of themes and a discussion that is supported by theoretical data as well as data from field observations, field notes and personal data of the respondents. However, for the presentation of the personal data, ethical consideration of the research and field data coding was strictly observed.

Introduction

Human Immunodeficiency Virus (HIV) is a widely known and feared disease across the world. HIV attacks the immune system of the body and gradually weakens the ability of the immune system to fight against infection and diseases (Willman, 1994), and it can progress to acquired immunodeficiency syndrome (AIDS), making the body highly susceptible to different opportunistic infections and diseases (Campbell, Ni, & Lim, 2019). HIV can be transmitted various ways, such as the exchange of body fluid from an infected person through sexual contact, exposure to infected blood, the sharing of needles or injectable equipment, and from mother to child (during pregnancy, childbirth, and breastfeeding). Further, the primary mode of HIV transmission worldwide is still sexual contact, as exposure to infected blood can also transmit the virus (CDCP, 2021). An estimated 38 million people were living with HIV/AIDS at the end of 2019. This number includes 1.7 million new infections that year, and there were approximately 690,000 AIDS-related deaths that year as well.

Although significant progress has been made in HIV/AIDS prevention, treatment and care, many people living with HIV/AIDS still face significant barriers to care and treatment, particularly in low- and middle-income countries. Unfortunately, this topic does not receive attention in the school curriculum (UNAIDS Report, 2020, Ihsan *et al* 2019). In Pakistan, HIV/AIDS is a growing concern. Poverty, gender discrimination, a lack of awareness about the disease, risky healthcare practices and cultural barriers to condoms make women vulnerable to HIV/AIDS (Bonnell, 2000; Mall, S., *et al.*, 2015; Sana Ulla and Naz, 2019). Gender-based power imbalances and women's subordination within societies contribute to their increased vulnerability to HIV/AIDS (Shacham *et al.*, 2009). However, in Pakistan, although the prevalence of HIV is rel-

atively low with approximately 220,000 individuals having HIV/AIDS in 2019 (NACP, 2020), addressing the HIV/AIDS epidemic in Pakistan is challenging due to socio-cultural and religious factors. These aspects result in limited access to prevention, inadequate testing and treatment services, and insufficient funding for HIV/AIDS programs (UNAIDS, 2020; Ullah, Naz, Khan, Khan, Gul, Khan, Khan 2019).

Protection from the disease becomes more difficult for marginalized and vulnerable communities because of their lack of access to appropriate healthcare facilities (Hargreaves and Boler 2006). Unequal access to healthcare facilities is also dependent on the description of gender roles, certain given responsibilities in societies and the status of gender discrimination. Moreover, in a society with gender discrimination, women's access to healthcare, assistance and treatment services, as well as their ability to manage the disease, all become more difficult (Population Council Report, 2009). It is important to understand the specific needs and challenges faced by women in the cultural context that are important for effective HIV/AIDS prevention and control in Pakistan (Abdool Karim *et al.*, 2010).

In the context of Khyber Pakhtunkhwa, a province in Pakistan, HIV/AIDS prevalence and healthcare access persist, with only 18% of women having access to Antiretroviral Therapy (ART) compared to 47% of men due to socio-cultural and religious factors (Azim *et al.*, 2008). Socio-cultural and religious factors have strong impacts on reducing the prevalence of HIV/AIDS among women and marginalized gender and sexual orientation communities in the region, as only 14% of HIV-positive women are registered, according to the National AIDS Control Program (NACP) Pakistan. The rest of them remain unregistered and untreated, as cultural and societal values restrict women from

talking about the disease, pushing them to conceal the fact that they have it instead (NACP, 2020).

Study Rationale

Within the socio-cultural and religious domain of Pakhtun culture, existing research has investigated how cultural beliefs, traditions and religious practices influence the experiences of women affected by HIV/AIDS. The region has high poverty levels (Sana Ullah, Arab Naz, Muhammad Asghar Khan, Muhammad Hamayun Khan, 2021), experiences gender inequalities, possesses limited awareness of the disease, practices risky healthcare practices and additionally there are cultural barriers to condom use, making women more prone to becoming infected with HIV (Agha, 2019). Although research has been done on various aspects of HIV/AIDS studies in the context of gender and HIV/AIDS, these aspects have not yet been explored specifically in the Pukhtoon culture. The existing study is based on an investigation of the socio-cultural and religious factors in shaping perspectives and experiences of women living with HIV/AIDS in the Malakand division. This is indeed a challenging and sensitive issue, but at the same time it has far-reaching effects on the lives of women living in a society as conservative as the Pakhtun culture. The study is guided by research questions such as *What are the different sociocultural factors that create gender disparity?* and *What are the sociocultural and religious factors influencing the perspectives and experiences of women living with HIV/AIDS?* The data was collected to explore the socio-cultural and religious factors shaping the perspectives and experiences of women living with HIV/AIDS. In addition, the goal is to understand the experiences of women facing gender-based stigma, medical stigma and discrimination, and its impact on their access to healthcare facilities.

Methodology

The study was delimited to two selected districts of Malakand Division i.e., District Dir Lower and District Swat. This choice was based on the fact that District Dir Lower has a higher number of HIV/AIDS patients in the province after District Peshawar, and District Swat was selected based on current reports about the

spread of HIV/AIDS in the district, particularly in the capital city Mingora (Express Tribune Report, 2017). Primary data was collected from a sample of 25 females (with HIV/AIDS) with equal representation of both districts. There were 10 other stakeholders including the organizational head, doctors and key informants. The researchers used observations, field notes and key informants, and they developed case studies during various interactive sessions with respondents. The collected information was qualitatively analyzed following Braun and Clarke's (2006) six-step thematic analysis model, and a report was subsequently generated. Looking at the sensitive nature of the study and to protect the anonymity of the respondents, various codes consisting of alpha-numeric words and figures were employed. These codes were developed due to ethical considerations, serving as identification markers while maintaining confidentiality. By meticulously organizing, coding and analyzing qualitative data, thematic analysis uncovered meaningful patterns and themes, providing valuable insights into the research topic. The major themes that emerged from the data were: socio-cultural and religious influences on women's perspectives and experiences of HIV/AIDS, followed by sub-themes of social stigma, medical-based stigma and discrimination, gender disparities, religious beliefs and practices, socio-cultural and religious influences on women's perspectives, and experiences with HIV/AIDS.

Study Results and Analysis

In many societies worldwide, HIV/AIDS has a devastating impact that goes beyond its medical implications. Socio-cultural and religious factors play a significant role in shaping the perspectives and experiences of women affected by the disease (Parker et al., 2003; Mahajan et al., 2008). Similarly, the analysis of the existing research data reveals that socio-cultural and religious factors have a strong influence on women patients living with HIV/AIDS, and they develop fear and distress that shape their perspective about the disease. One interviewee shared her views accordingly:

„Culturally, a woman is considered to be pure and pious, while the disease is thought of as an outcome of immoral relations between a man

and women that results in the suspicion of and rejection of a woman.“ (WP112)

The primary data collected shows a strong link between the negative societal attitudes towards HIV/AIDS patients and feelings of rejection by society that hurt their health-seeking behaviors. Social and cultural norms have a strong connection with the health-seeking behavior of HIV/AIDS patients. This is especially true for women in Pakhtun culture, where the only cause of the disease is considered to be immoral action. This way of thinking, in connection with religious unawareness and misinterpretation, can put the lives of women at risk in terms of rejection by society. It can even threaten their lives, as honor killing is still practiced in some of the areas. Moreover, social stigma associated with HIV/AIDS, specifically the stigmatization of women, can hinder their access to testing, treatment and support services (Li et al., 2010). Such fear restricts women from talking about their illness and receiving medical assistance. Data collected through personal observations and focus group discussions revealed that fear of social isolation and rejection compel women to remain silent and not disclose the disease. This not only puts their lives in danger, it can also threaten the lives of others by allowing for the transmission of the disease in different ways. Secondly, prevailing societal norms surrounding masculinity imply that men are expected to have more extensive sexual knowledge and experience compared to women. These expectations often cause young men to underestimate the risks associated with sexual behavior, leading to a lack of awareness about preventive measures (UNAIDS, 2013). This unawareness about the disease among women leads to a high prevalence of HIV/AIDS. The analysis of field notes indicates that the majority of the respondents had no clear information about the disease, its transmission routes and treatment. The major issue when it comes to asking for information or guidance about HIV/AIDS was the social disapproval for discussing such issues both in person and in general. Mostly the respondents shared during focus group discussions that they can't ask for any information about the disease because if anybody initiates such a discussion, people perceive her as being shameless and immodest. This is due to the fact that this kind

of discussion is related to sexual relations and contacts.

Similarly, low literacy levels and educational disparities also impact women's knowledge and understanding of HIV/AIDS, potentially increasing their susceptibility to infection (Duff, 2012). The field data also demonstrated that a lack of knowledge has adverse effects on the prevalence of the disease. During the individual interviews, it was said by an interviewee that she had been transferred the disease through unscreened blood. Another one of the cases highlighted the death of a 22-month-old child because of a blood transfusion.

Moreover, the supportive literature also shows that despite the socio-cultural factors, stigma is also associated with misinterpreted religious beliefs, especially when HIV/AIDS is considered sinful or immoral (Khawja & Motlagh, 2016). The field data explored that misinterpretation of religious beliefs also causes stigma and discrimination. During the data collection from women participants, many of the interviewees expressed experiencing feelings of social isolation, lacking family support and facing stigma after being diagnosed with HIV/AIDS. One woman said:

„I felt helpless, and my behavior changed a lot after getting this disease. I couldn't control my anger, and everyone treated me with hatred. I was blamed for having this disease, even though I wasn't at fault. There was nobody who showed sympathy, and I couldn't share my pain and worries with anyone.“ (WPI02)

This quote portrays the emotional distress and desperation experienced by women living with HIV/AIDS facing stigma and discrimination. The stigma surrounding HIV/AIDS often leads to social exclusion, discrimination and negative attitudes towards those affected by the disease. Women, in particular, face additional challenges due to existing gender norms and societal expectations. Stigmatizing beliefs and a misunderstanding of HIV/AIDS contribute to fear, shame and silence, preventing individuals from seeking testing, treatment and support services (Parker et al., 2013; Mahajan et al., 2008). This stigma can have severe psychological and emotional impacts on women, increasing feelings of isolation and adding to the burden of living with HIV/AIDS. As another interviewee expressed,

„I cried for many days, and I thought, ‘If I die, I can escape from this insulting life.’“ (WPI05)

It highlights the impact of stigma on their mental well-being that causes strong emotional distress and desperation. This results from stigma and discrimination, which create significant barriers to seeking support, accessing healthcare services and adhering to treatment.

Similarly, religious teachings also play a strong role in shaping women’s perspectives about the disease. During a focus group discussion, it was concluded that religion has both negative and positive impacts on women living with HIV/AIDS. It was said by one participant that religion has a positive and sympathetic approach toward HIV/AIDS patients. She supported her point with the argument:

„In Islam, it is taught that if you have a disease that can be transmitted to others, you should treat yourself and protect others from it. If I have this disease, I should not keep it a secret and should take all precautions to keep others safe.“ (WPI03)

This interviewee, reflecting on Islamic teachings, emphasizes the importance of taking responsibility for one’s health and preventing the transmission of the disease to others. In contrast to the stigma and secrecy often associated with HIV/AIDS, religious aspects related to the disease promote openness, compassion and a sense of communal well-being. The misconception and misinterpretation of religious teaching regarding the disease create a social stigma around the disease, as one of the participants highlighted during a focus group discussion. She mentioned that people assume the infected person is a wrongdoer or had extra-marital relations. Islam does not allow physical relations before marriage, which is why people behave in an insulting way to such patients, and this also may have a drastic effect on the psyche (Humera Ali, Ayesha Gul, Mohammad Yousaf, Rahim Changezi, Arab Naz, 2019). Personal observation and field notes explore the religion-based stigma associated with HIV/AIDS. Due to the lack of coordination and cooperation between religious leaders and the health department, HIV/AIDS is mostly interpreted religiously as the outcome of extra-marital relations, which are not allowed in Islam. Other transmission routes

of the disease are not very known to people and among the religious community.

Social Stigma, Medical Stigma and Discrimination

The broader theme of socio-cultural and religious influences on women’s perspectives and experiences with HIV/AIDS sheds light on the challenges faced by women living with the disease. Social stigma and discrimination highlights the negative societal attitudes, discrimination and restrictions imposed on individuals with HIV/AIDS. To investigate the problem, in-depth interviews and focus group discussions took place, and in some places, participant observations were carried out and field notes were taken. Women who were HIV/AIDS positive were encouraged to share their feelings of being stigmatized by society. The majority of the interviewed shared that they face social stigma and discrimination because of their disease, which aligns with supporting literature that emphasizes the significance of social stigma and discrimination as the main hurdle in the prevalence of the disease. According to Nyblade, MacQuarrie and Canales (2001), women living with HIV/AIDS are often subjected to stigmatization due to societal gender norms. During the interviews, one of the interviewees shared similar experiences and stated:

„Women’s lives are dependent on men, and women are more stigmatized in society. Even if she has gotten the disease from her husband, she will be treated very harshly.“ (WPI03)

This statement discloses social inequality based on gender. The discriminatory attitude towards the interviewee highlighted that although she is not guilty of any wrongdoing, she was still facing the stigma for it. This shows that in her case, men are not held responsible for wrongdoing or perceived for wrongdoing, but the women’s status in society is always very vulnerable to social stigma. Furthermore, Herek, Capitanio and Widaman (200; Hardy, Vansac, Benca, Palun, Gallova, Susta, & Kimuli,(2018). highlight that the detrimental impact of social stigma on the well-being of individuals with HIV/AIDS is very high, and this restrains them from sharing their feelings about the illness. They argue that negative social behaviors and discrimination can be more harmful than the disease itself. This

aligns with the emotional toll expressed by an interviewee during an in-depth interview:

„It’s all about social issues; a person may not die of the disease but will die of the negative behavior of people.“ (WPI03)

It is evident from this interviewee quote that the illness is curable, but the negative behaviors of the people make them suffer more. This also shapes their perspectives, making them more vulnerable to the disease because of the social pressure they face along with the disease.

Another important factor highlighted during field data collection was the concealment of the disease, which is a potential threat to the lives of healthy people. The majority of the respondents discussed that they are not sharing the information with relatives or people outside of the family, and they might not even share their HIV/AIDS status during minor medical procedures. In such cases, the healthcare structure, which is already not following proper medical protocols, and malpractice are very prevalent in rural communities, can pose a threat when it comes to HIV/AIDS prevalence. In rural areas, deliveries are normally dealt with by traditional birth attendants at home in the absence of advanced medical techniques and procedures. This can increase the prevalence of the disease if the patient hides their HIV/AIDS status. Similarly, one of the patients said that because of social rejection and isolation, she does not share her illness with people, and if this is done on a large scale, it can create healthcare issues for the wider population.

„Aw aghoi ta ptha da, kho za cha ta der nawym da kor na bahar zaka khalak der nafrath kai da dasi mareez na, awal ki za dera parehsana wam chi kor ki rana khalko yaredo da khabaro atharo na aw khwa ki kenaastho na, kho ro ro poha sho chi da pa khwa ki kenasto na lagi.“

Translation: Yes, they know, but I don’t share it outside of my family because people hate such patients. In the beginning I was very disturbed when people at home were reluctant to talk with me or sit near me, but slowly they understood that it’s not transmitted by touching“.

This fear doesn’t allow them to talk about their illness outside of their family, and this fear hinders their access to healthcare facilities as well, which can increase the prevalence of the disease.

Mahajan, Sayles, Patel and Remien (2008) explore the stigma, as healthcare providers have been known to bar women from receiving treatment for HIV/AIDS. Similarly, field data collected from women living with HIV/AIDS also highlighted that they face medical-based stigma when it comes to healthcare services. The collected data further differentiated the medical-based stigma and showed that hospitals that have specialized places for HIV/AIDS treatment are very cooperative and patients don’t experience negative behavior there. However, when patients initially tried to get treatment from a hospital that doesn’t have an HIV/AIDS specialized staff, they were neglected and treated with hatred. This is an important factor because there is a lack of medical healthcare facilities in rural areas, where routine treatment is provided in an improvised manner. This means that in such cases HIV/AIDS emergency needs cannot be provided sufficiently. Additionally, the stigmatizing behavior shapes women’s perspectives and restrains them from receiving medical services. The impact of stigma and discrimination on the quality of care provided is evident in one interviewee’s statement about what happened when she took her 22-month-old HIV/AIDS-positive child to the hospital:

„Their behavior suddenly changed with us, the doctor who had a long beard asked me not to rest her on the bed. The nurses were also avoiding me.“ (WPI04)

In conclusion, the interviewee’s statements align with the findings of supporting literature, including Nyblade et al. (2001), Herek et al. (2002), Campbell et al. (2007), Aggleton and Parker (2002), Mahajan et al. (2008) and Earnshaw and Chaudoir (2009). These insights underscore the urgent need to address social stigma, promote acceptance and challenge discriminatory practices to ensure the well-being and rights of those living with HIV/AIDS. By connecting the interviewee’s statements with the supporting literature, this article highlights the significance of social stigma and discrimination and provides a basis for understanding and addressing these issues.

Sociocultural Factors and Gender Disparities

The study and analysis of sociocultural factors and gender disparities are crucial in understanding the health status of communities

and identifying underlying health inequalities among different sub-populations (Marmot & Wilkinson, 2000). However, in the context of women living with HIV/AIDS, gender inequality persists due to discriminatory cultural and behavioral practices, both at home and within the community. These practices have given rise to considerable health obstacles for women that are driven by social disparities among different groups, thereby amplifying the difficulties confronted by women living with the disease (Nyblade *et al.*, 2004). Research shows that inequalities experienced by women living with HIV highlight the negative societal attitudes, discrimination and barriers to accessing healthcare and support (Earnshaw & Chaudoir, 2009; Khanna, & Patil, 2020).

First-hand data collected through in-depth interviews, focus group discussions, personal observations and case studies highlighted that woman living with HIV/AIDS face negative responses and discrimination in their communities. Moreover, the social restrictions imposed on women hinder their access to healthcare services. During data collection, it was highlighted that women face discrimination at the family level because of the cultural and societal status designated to women, and this further exacerbates their access to treatment services for HIV/AIDS. One of the interviewees highlighted that her health issues are not taken seriously at home and she has a lack of social support from her family. Socially, women are not empowered to live their lives according to their will, and they are bound to follow the cultural norms that restrict their social mobility and don't allow them free movement.

In the Pakhtun cultural context, women are not allowed to go to hospital without the support and approval of a man, and this can result in delays in treatment. Field data explored the fact that women can't receive health services on a regular basis because of the unavailability of family members to be at every checkup. One of the interviewees expressed the challenges faced by women in seeking timely healthcare due to cultural or logistical factors:

„I go to Peshawar after months, but most of the time I just take medicines from Peshawar and do not meet with a doctor every month.“ (WPI02)

This finding aligns with the research conducted by Campbell *et al.* (2003), who discuss the cultural and logistical barriers faced by individuals in accessing regular healthcare services:

„Aw wali na, zmong kor ki kho nor sok nish-ta, khwand me bahar day, plar mi boda day kho gharib rala gham kai aw pa wakht rala golai rawri zka pa day ki qaza kawal nshta.“

Translation: „Why not, there is nobody at home. My husband is abroad, and my father is an elderly person. But he still arranges medicine for me in a timely way because we can't skip it.“ (WI02)

Social and cultural factors play an important role in accessibility to healthcare services. In the cultural context of Pakhtun society, women are kept less empowered and lack access to income-generating activities that could result in economic dependency and impact their health status. The majority of the respondents shared that they don't have the financial resources to make free decisions about their health issues. Such problems have been highlighted by the majority of women, and one of the respondents shared:

„They are providing it free of cost in Lady Reading Hospital, and there is now a separate ward for HIV/AIDS patients. This is provided by an international NGO, that's why it's free. If it was not free of cost, nobody would be able to afford the treatment, and normally women's illnesses are not taken seriously in our society. So for AIDS patients, it's more difficult, as people hate them.“ (WPI03)

Socially and culturally, women's health issues are given less importance, which shows the discrimination they face in society. This finding aligns with the literature, as studies conducted by Nyblade *et al.* (2004) showed that women's illnesses are often not taken seriously in society, leading to difficulties in accessing healthcare services. Additionally, Earnshaw and Chaudoir (2009) discuss the barriers faced by women in accessing HIV/AIDS services and emphasize the importance of addressing social stigma and discrimination. Parker *et al.* (2005) explored the stigma experiences of individuals affected by HIV/AIDS and emphasized how perceived immoral behavior and blame contribute to negative attitudes towards them. Another interviewee shared her experience of being treated in a very

hateful way, isolated from her community and subjected to discriminatory practices:

„My in-laws were treating me in a very insulting way. They separated their kitchen items from me. I was not supposed to hug or kiss my children, and even my shoes were kept at a distance from theirs.“ (WPI02)

The social status of women affects their mental health, as they are blamed for bearing the disease even though they are not guilty. This highlights the unjust and discriminatory treatment of women by society. During focus group discussions, women discussed the negative behavior of the family and relatives, who tried to convince them to keep their relations limited to close family members. One of the respondents shared:

„doi wayi sa ghalat kar ba yi karay yi. Allah kho da khpal banda ghalyani hm maaf kai kho khalak kho k da cha qasoor hm na yi bad warta gori.“

Translation: „They think that we might have done some kind of immoral act. Allah forgives sin, but people don't forgive even if they are not guilty. They still treat them badly.“ (WPI01)

This finding aligns with the research conducted by Mahajan et al. (2008), which examines the social and cultural dimensions of HIV/AIDS stigma. The study highlights how societal norms and practices can contribute to the stigmatization and discrimination faced by individuals with the disease.

In conclusion, the findings from the interview quotes, which are supported by relevant literature, highlight the profound impact of sociocultural factors and gender disparities on the perspectives and experiences of women living with HIV/AIDS. The interview quotes provide valuable insights into the challenges faced by women, including societal attitudes, discrimination and restrictions on access to healthcare.

Religious Beliefs and Practices

A lack of religious education emerged as a prominent theme from the interviewees. Religious beliefs and practices are pivotal in shaping perceptions and responses to HIV/AIDS, with their impact influenced by cultural contexts and interpretations (Agadjanian, 2005; Campbell et al., 2011). Some religions emphasize values like compassion, understanding and support for in-

dividuals affected by the disease, fostering empathy and community (Pargament et al., 2004).

The majority of respondents talked about the misinterpretation of religious teachings by society. They pointed out that people don't deeply study the Quran, as it restricts them from blaming others without knowing the reality of the situation. According to them, if people treated others according to religious teachings, their lives would be less difficult, and the spread of diseases like HIV/AIDS would be minimized. During the gathering of field notes, it was observed that HIV/AIDS is not openly discussed; it is only mentioned in personal meetings due to the fear of religious interpretations of the disease. Misconceptions about the disease and a lack of knowledge limit the understanding of its actual causes. In focus group discussions, it was noted that the general perception of the disease is that it results from deviating from Islamic limitations and it is perceived that the transmission of the disease is the result of extramarital relations that leads to this infection, which is not accurate.

In stakeholder interviews, doctors discussed that hospitals lack proper waste management facilities, leading to the potential reuse of needles and syringes by drug addicts and contributing to the prevalence of AIDS. The community tends to overlook these factors as causes of HIV/AIDS prevalence. The absence of proper knowledge among religious leaders hinders their ability to address the issue effectively and promote accurate understanding within their communities.

This lack of cooperation and information-sharing among stakeholders, including religious leaders, further exacerbates the misconceptions and stigma surrounding HIV/AIDS. The interviewees commented about the religious teachings regarding HIV/AIDS:

„In Islam, it is taught that if you have a disease that can be transmitted to others, you should treat yourself and protect others from it. If I have this disease, I should not keep it a secret and should take all precautions to keep others safe.“ (WPI02)

It demonstrates how certain religious teachings, like those in Islam, promote compassion, care and prevention, leading to positive attitudes and reducing stigma within religious communities. Moreover, another interviewee stated that,

„Culturally, people will talk about the religion of the woman, not of the man“ (STK01), underscoring the unique challenges and stigmatization faced by women living with HIV/AIDS. It emphasizes the need for targeted support and understanding within the community, taking into account the intersection of religious beliefs, gender dynamics and cultural norms. One participant mentioned that „People don't have much religious education. In our village, the younger generation is receiving education, but older people are mostly uneducated. They don't know about this disease, and it is discussed in such a negative way that nobody likes to ask about this disease“ (WPI03). This lack of education becomes a barrier to raising awareness, dispelling misconceptions and addressing HIV/AIDS openly. Additionally, societal opinions often overshadow religious teachings, perpetuating stigma and discrimination.

In summary, the interviewee's responses highlight the influence of religious beliefs, education levels, societal opinions and cultural norms on perceptions and responses to HIV/AIDS. Accurate education, respectful interpretation of religious teachings, challenging societal opinions and addressing gender disparities are crucial in combatting stigma and providing comprehensive support for individuals affected by HIV/AIDS (Bharat, Aggleton, & Tyrer, 2001; Pew Research Center, 2014). These findings directly contribute to achieving the objective, which aims to explore the socio-cultural and religious factors shaping women's experiences with the disease. The alignment between these findings and the objective underscores the critical role of sociocultural and religious factors in shaping the experiences of women affected by HIV/AIDS.

The field data collected through interviews strongly supports the notion that socio-cultural and religious factors shape perspectives and the experiences of women living with HIV/AIDS when it comes to accessing healthcare services. The field data provides valuable insights into the pervasive social stigma and discrimination faced by individuals affected by the disease, particularly women that are restricted from having doctor visits, and whose fear of social isolation never allows them to talk about their disease. Such social behaviors are prevalent in society because

of the access to information about disease and the social norms that restrict the dissemination of information on HIV/AIDS. Through a comprehensive analysis of themes, gender-related and medical-based stigma and discrimination, power imbalances, cultural norms, religious factors and socioeconomic constraints, the study explored the complexities that create barriers to accessing healthcare services and contribute to the HIV/AIDS epidemic.

Conclusion

In conclusion, the study results emphasize the urgent need for interventions to address these interconnected barriers. Educational programs that challenge harmful cultural norms and promote gender equality can empower women to make informed healthcare decisions. Economic support, accessibility to healthcare services, transportation assistance and free medical treatment supplies at the village level can alleviate the burden of socioeconomic constraints, enabling women to access and receive treatment and prevention services. The study's findings have broader implications for advocacy, policy and awareness efforts. This is not only true at the community level, but also religious scholars and clerics must get on board to help overcome the negative impacts of social stigma and discrimination and to encourage women to talk about the disease and the available healthcare services. These aspects would help to reduce the risk of HIV/AIDS prevalence in the conservative Paktoon culture of Malakand Division. It is also important to initiate a comprehensive program that can provide trained medical staff with medical facilities and provide counseling to patients and their families about the disease, as well as volunteering for testing for HIV/AIDS. For the successful implementation of an HIV/AIDS program, it is more important that all stakeholders have strong communication and coordination, including religious leaders.

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Social (Pastoral) Services and its Impact on the Citizens of the Czech Republic

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Original Article

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Abstract:

The article examines social services and their impact on the citizens of the Czech Republic. This is not only important from the point of view of the present time, but also for the acute needs of the localized places of the studied area. The main objective of the study was based on this aspect in line with the main research question: *How important is the concept of social services in the networking of religious institutions in the Czech Republic?* The quantitative representative sample

(online) consisted of 858 respondents from the Czech Republic, of which 59% (N = 506) were women and 41% (N = 352) were men. Age group representation was balanced across the five main categories, with the 41-59 age group dominating at 41% (N = 351). Two-thirds of respondents 67% (N = 575) reported having a college or high school education. The research sample identified 54% (N = 465) of participants who identified themselves as atheists in terms of religious beliefs. Almost half of the 48% (N = 413) surveyed identified having the Ústí nad Labem region as their place of residence, which can be considered a positive given the current social issues in the North Bohemian territory. In turn, we see a balanced view of our respondents in the five marked groups in relation to the size of the place of residence. From the research results, we can conclude that the social sphere plays an important role in the Czech Republic, where we see a significant role in the connection of religious institutions. It is from these religious places that our respondents expect the greatest amount of „social attention“.

Introduction to the topic

A society can be defined as a stable network of relationships between men and women based on their mutual behaviors that are manifested among specific people based on established positions. One of these positions holds the dimension of “social friendship”, where we discover the recognition of the values of each human person in the dimensions of human greatness. The present theme aims to point to the need for social (pastoral) service in favor of the most needy, so that the humane level of universal fraternity is shown precisely to them. For this group we have in mind children and teenagers in detention centers, people on the margins of society (homeless people), individuals at social and deviant risk, the seriously ill, the elderly and the dying. It is in these groups that we recognize, above all, those who are often above the level of human misery and who are so close to God’s plan, even though they have never known his teaching (cf. *Mt 9:13*). We are aware that this is the very open space of the “outstretched palms”, which in their misery point to the open wounds of the crucified Savior.

There is a whole range of dynamic processes that can be employed to help those in need in the social assistance continuum. It happens, for example, through appropriate pedagogical and clerical outreach (1,2), but, above all, it comes about through the witness of a life based on neighborly love. Today’s covid period in par-

ticular offers a wide range of possibilities for maintaining the right direction in relation to other people (3,4,5). The duty that we have towards ourselves, that is, the restoration of the social good (6,7,8), can also be developed through the spiritual values (9,10,11) we discover in various religious institutions (12). It is in them that we can point to the various examples of the holy friends of God (13,14,15,16) who drew their inspiration from the previously mentioned divine purpose (17,18).

It is good to note that, despite being in a civilized Central European environment like the Czech Republic, we also find here a whole range of “social attention”, as well as a desire not to forget those who are not receiving it. We must not forget that we can also imagine this charitable activity nowadays through various managerial-economic factors (19,20) and social-media means (21,22), which, especially in the 21st century, set the trend for new possibilities related to the culture and ethics of education (23,24).

Objective of the study

The main objective of the study was to answer the question:

- How important is the concept of social services in the network of religious institutions in the Czech Republic?

Sub-goals (hypotheses) examined using the Pearson chi-square test:

- Do the answers of women and men differ significantly?
- Do the answers differ significantly according to the age of the respondents?
- Do the answers to questions depend on whether the respondents come from a village, a small town or a big city?

Methods

Research design

The research design of the study was chosen to target the available measurement methods. We chose a non-experimental research plan – a comparative study – and analyzed the results obtained from the measurements using basic descriptive and inferential statistical methods. The research set was obtained by deliberate selection. We selected residents of the Czech Republic as the target research groups to compare. The research took place for three months from May to July 2021, online and by distributing access data to the research questionnaire.

Methods of statistical processing

The results were examined through descriptive statistics, contingency tables and a contingency table variability test. The variable independence test assumes that the random variables X and Y are independent, so the values of one variable do not affect the values of the other variable. The dependence between variables can be either one-sided (asymmetric) or mutual (symmetric), where both variables interact with each other. Pearson’s chi-square test was used to test the independence of two categorical variables in the PivotTable, regardless of the direction of their dependence. The null hypothesis of this test assumes that both variables are independent of each other. We tested the null hypothesis at the determined level of significance α , that the variables are independent, as opposed to the alternative that there is a dependence between the variables. We write the hypotheses as follows:

$$H_0: n_{ij} = \frac{n_{i.} * n_{.j}}{n}$$

$$H_1: n_{ij} \neq \frac{n_{i.} * n_{.j}}{n}$$

when n_{ij} indicates the frequencies in the PivotTable where $i = 1, 2, \dots, r$ denotes the categories of the variable X and $j = 1, 2, \dots, s$ denotes the categories of the variable Y.

The test criterion χ^2 is defined as:

$$\chi^2 = \sum_{i=1}^r \sum_{j=1}^s \frac{(n_{ij} - n'_{ij})^2}{n'_{ij}}$$

where $\chi^2 \approx \chi^2 [(r-1) (s-1)]$. The larger the differences between the categories of the examined variables, the larger the test criterion χ^2 .

The prerequisite for using this test is that theoretical frequencies where there are less than 5 observations make up less than 20% of the PivotTable fields. Individual categories of variables can be combined to meet this assumption. The data were processed using the statistical program SPSS (version 23) and MS Office Excel.

Research file

Data was collected between April and July 2021. A total of 858 respondents were surveyed, of which 41% were male (N = 352) and 59% were female (N = 506).

Age	(N)	(%)
up to 18 years	99	12%
18-25	121	14%
26-40	168	20%
41-59	351	41%
60 and over	119	13%

Religious confession	(N)	(%)
No religion	465	54%
Christian	352	42%
Eastern religions and similar	20	2%
Jewish	1	0%
Other	20	2%

Permanent residence - region	(N)	(%)
Usti	413	47%
Karlovy Vary	83	10%
Prague	65	8%
South Bohemia	62	7%
Middle Bohemia	61	7%
Olomouc	35	4%
South Moravia	31	4%
Pardubice	25	3%
Moravian-Silesian	24	3%
Plzeň	18	2%
Hradec Kralove	14	2%
Liberec	14	2%
Zlin	9	1%
Vysočina	4	0%

Size of place of residence	(N)	(%)
village	202	24%
a city of up to 10,000 inhabitants	174	20%
a city of 10,000 to 50,000 inhabitants	287	33%
a city of 50,000 to 100,000 inhabitants	95	11%
a city of over 100,000 inhabitants	100	12%

Highest completed education	(N)	(%)
Primary education	102	12%
Secondary educ. without matriculation	80	9%
High school with high school diploma	246	29%
Higher vocational school	58	7%
Higher education	328	38%
Higher education postgraduate	44	5%

Measuring instruments

We did not use standardized questionnaires in our research. We created a sociometric questionnaire that also included requirements for basic demographic data. Participants answered eleven questions, one of which was open-ended.

Result

In the following section, we present the data in frequency tables:

A) How would you express, in percentage terms, the need for social services in the society in which you live?

	(N)	(%)
0% - 10%	36	4%
11% - 25%	166	19%
26% - 50%	261	30%
51% - 75%	241	28%
76% and more	154	19%

B) Which group of people, in your opinion, deserves the most „social attention“?

	(N)	(%)
children and teenagers in detention centers	368	43%
the seriously ill	125	15%
the elderly	114	13%
homeless people	81	9%
individuals at social and deviant risk	76	9%
all those groups	35	4%
other	59	7%

C) What do you see as the main cause of socially deviant behavior of some people?

	(N)	(%)
the family environment (poor upbringing)	440	51%
media age	114	13%
genetic factors (innate predispositions)	97	11%
the absence of religious influence	60	7%
a delinquent group of „friends“	55	7%
the absence of God	3	0%
other	89	11%

D) Which form of assistance, in your opinion, is the most effective support for these socially vulnerable people?

	(N)	(%)
family background	348	41%
professionalism	261	30%
a change of environment	113	13%
spiritual help	73	9%
other	63	7%

E) In your opinion, does the social-pastoral service of religious organizations play any social role?

	(N)	(%)
to some extent	353	41%
yes	313	36%
no	66	8%
I do not know	126	15%

F) Have you observed people in your environment who belong to a church institution and who have actively participated in the social assistance of others?

	(N)	(%)
noted/observed	300	35%
partly noted	296	34%
partly have not noted	245	29%
have not noted	17	2%

G) Can you briefly describe a personal experience or the experience of people close to you in the area of social services? If yes, please describe it... (open question)

Only 5% of the respondents did not answer the question at all, and 20% stated they had no such experience.

- Other common answers:
- Helping seniors, children, the ill 8%
- Caring for the elderly and ill 6%
- Donating things, money 4%
- Hospice care 5%
- Charity 5%

H) How would you evaluate the quality of social services in the society in which you live?

	(N)	(%)
very good	85	10%
rather good	586	68%
rather bad	173	20%
very bad	14	2%

I) How could the performance of social services be improved?

	(N)	(%)
personal approach to others	560	65%
emphasis on professionalism	113	13%
offer spiritual help	53	6%
I do not know	51	6%
nothing can be improved	42	5%
in another way	39	5%

J) Should the state, religious institutions or other associations participate more in the form of increased funding for this area?

	(N)	(%)
definitely yes	336	40%
rather yes	405	47%
rather no	97	11%
definitely no	20	2%

K) Do you yourself participate in any way in the development and benefit of social services?

	(N)	(%)
definitely yes	103	12%
rather yes	263	31%
rather no	402	47%
definitely no	90	10%

Dependency results

Comparison by gender

For the question *Have you observed people in your community affiliated with a religious institution who have actively participated in social assistance to others?:* There was a gender de-

pendency at the 1% level of significance (P-value of the Pearson chi-square test: 0.002). Men were most likely to respond: I have observed quite specific acts by believing Christians. The second most frequent response was noted but only marginally. Women most frequently reported having observed, but only marginally, and as the second most frequent response they reported not having observed.

For the questions *How would you express, in percentage terms, the need for social services in the society in which you live?*; *Which group of people, in your opinion, deserves the most "social attention?"*; *What do you see as the main cause of the socially deviant behavior of some people?*; *Which form of help, in your opinion, is the most effective support for these socially vulnerable people?*; *In your opinion, does the social-pastoral service of religious organizations play any social role?*; *How would you evaluate the quality of social services in the society in which you live?*; *How could the performance of social services be improved?*; *Should the state, religious institutions or other associations participate more in the form of increased funding for this area?*; and *Do you yourself participate in any way in the development and benefit of social services?*, no statistically significant gender dependence was found at the 5% level of significance.

Comparison by age

For the question *Which group of people, in your opinion, deserves the most "social attention"?*: There was a statistically significant dependence on age at the 5% level of significance (P-value of the Pearson chi-square test: 0.014). All age groups reported the youngest and most vulnerable (children and teenagers in detention centers) most often. Age groups under 25 years reported seriously ill as the second most common option. Age groups over 26 years reported seniors as the second most common option.

For the question *Which form of assistance, in your opinion, is the most effective support for these socially vulnerable people?*: There was a statistically significant dependence on age at the 5% significance level (P-value of the Pearson chi-square test: 0.026). Age groups over 26 years old reported family background as the most common. Age groups under 25 years reported the same number of responses for the

family background and professional expertise options.

For the question *In your opinion, does the social-pastoral service of religious organisations play a social role?*: There was a statistically significant dependence on age at the 1% level of significance (P-value of the Pearson chi-square test: 0.001). The age groups under 25 years old most often mentioned the option of a partial role because, like any other institution, they are also responsible for other matters (education, care of cultural monuments, pilgrimages, etc.). The age groups over 26 were most likely to say yes, because this area is one of their priorities.

For the question *Did you notice people in your neighborhood who belong to a religious institution and who were actively involved in the social assistance of others?*: There was a statistically significant dependence on age at the 1% level of significance (P-value of the Pearson chi-square test: 0.000). The age group under 25 years old most often reported the option of not having noticed. Age groups from 26 to 59 years were most likely to report the option noted but only marginally. The 60 and over age group most frequently reported having observed very specific actions by believing Christians.

For the question *Should the state, church institutions or other associations be more involved, including through increased funding for this area?*: There was a statistically significant dependence on age at the 5% level of significance (P-value of the Pearson chi-square test: 0.011). The age group up to 59 years old most frequently reported the option rather yes. The age group 60 years and over most frequently reported definitely yes.

Comparison by town or village size

For the question *What do you see as the main cause of the socially deviant behaviour of some people?*: Gender was found to be significant at the 1% level of significance (P-value of the Pearson chi-square test: 0.009). All groups cited the family environment (family upbringing) most often. Respondents from a city of over 100,000 inhabitants cited genetic factors (innate predispositions) as the second most common answer. Conversely, respondents from smaller areas cited the media production environment as the second most common option.

For the question *Which form of assistance, in your opinion, is the most effective support for these socially vulnerable people?*: It was found to be dependent on gender at the 5% level of significance (P-value of the Pearson chi-square test: 0.038). Again, the other groups were outperformed by respondents from cities of over 100,000 inhabitants, who most frequently reported professional expertise. Other groups most frequently reported family background.

For the question *Do you yourself participate in any way in the development and benefit of social services?*: There was a gender dependence at the 5% level of significance (P-value of the Pearson chi-square test: 0.016). Respondents from cities with a population of over 100,000 were most likely to report yes, while respondents from areas with smaller local authorities were most likely to report no. Respondents residing in rural areas were most likely to say rather no and definitely no.

For the questions: *How would you express in percentage the need for social services in the society in which you live?*; *Which group of people, in your opinion, deserves the most "social attention"?*; *In your opinion, does the social-pastoral service of religious organizations play any social role?*; *Have you observed people in your neighborhood who belong to a religious institution and who actively participate in the social assistance to others?*; *How would you evaluate the quality of social service performance in the society in which you live?*; *How could the performance of social services be improved?*; and *Should the state, religious institutions, or other associations become more involved, including through increased funding for this area?*, no statistically significant relationship was found for the size of the place of residence at the 5% level of significance.

Discussion

Based on the research, we perceive an important element that shows an interesting fact among the respondents in terms of religion. Although the greater half did not identify with any religious denomination 54% (N = 465), through their responses we see their humanistic dimension. This demonstrates the fact that the men and women of the Czech Republic are not indifferent to the sphere of human good, even in the connection of church institutions. Two thirds of the re-

spondents 77% (N = 666) believe that social and pastoral service occupies an important element of social life. We find some surprises at this point in the Western economic-managerial world (25). Even the church environment, which is more or less exposed to a public-critical view, is evaluated by the Czechs in a more or less positive way. In response to the question *Have you observed people in your environment who belong to a church institution and who have actively participated in the social assistance for others?*, again, a significant 69% (N = 596) responded positively. Czech society expects a greater call for a personal approach from church institutions in the connection of humanitarian activities, as around 65% (N = 560) answered in this direction to the question *How could the performance of social services be improved?* It is precisely in this direction that we can perceive the dimension of further new evangelisation efforts (26,27,28).

Conclusion

In conclusion, we found that through the main research question in the linking thesis objective, we have established through quantitative research that social service connected to religious institutions holds an important place in the Czech Republic. There is room for deeper research here by focusing on the categories that our respondents noted most in their answers (children and teenagers in detention centers, the seriously ill and the elderly) (29,30). In this context, we should not neglect the factor of the family environment (poor upbringing) and media age, which the respondents identified as the main causes of socially deviant behavior of some people. After all, since ancient times the family has held the most basic position in the operation of the individual in connection with society as a whole (31,32). It is in this media-technological (post-industrial) progressive society, to which we are all connected today through various systems (33,34), that we see not only the dangers already identified, but also the wide-ranging positive possibilities affecting our chosen topic (35,36,37,38).

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People living with HIV/AIDS in the Kibera informal Settlement in Nairobi City, Kenya: Is there any gender difference in Factors related to antiretroviral Therapy?

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Abstract:

Objective: To identify gender differences in behavioural factors and treatment related factors of ARV therapy as a predictor to treatment adherence.

Design: Cross-sectional study.

Methods: A quantitative study using a standardized PLWHA questionnaire was conducted in the Kibera informal settlement in the capital, Nairobi, Kenya. Data were collected by community health volunteers during home visits in cooperation with ART health facilities.

Results: The observed sample consisted of a total of 272 persons living with HIV/AIDS in the Kibera informal settle-

ments, of which 64.3% were women and 35.7% were men. We found a significantly higher rate of the behavioural risk factors cigarette smoking and alcohol drinking in men compared to women. There was no significant difference in the factors of patients' medical history between men and women. A significant difference was found in the source of ARV treatment therapy, travelling costs to ARV treatment facilities, loss of income due to visiting an ARV treatment facility and extra costs related to ARV treatment between the men and women in our study group. Another significant difference was observed in disclosure related factors - the HIV status of the current sexual partner, and the current sexual partner being on ARV therapy and disclosing this information to the current sexual partner.

Conclusion: Alcohol drinking and smoking cigarettes were the most common behavioural risk factors and were more prevalent in men. Women significantly dominated in treatment related factors of ARV therapy.

Introduction

We refer to the epidemiological situation of HIV in Kenya as a generalised epidemic, which means that the virus is present in all population groups and geographical areas of the country. The prevalence of HIV/AIDS in Kenya has decreased over the past 30 years, but is still relatively high compared to other countries in the world. In terms of HIV/AIDS incidence, we therefore rank Kenya among the countries with the highest incidence. According to UNAIDS data, it is estimated that in 2020 there were more than 1.6 million infected (of which 910,000 were women), with the number of new cases being 78,000, representing 1.62 cases per 1,000 inhabitants of the country. In 2020, the prevalence of HIV/AIDS among adults in Kenya was at 4.9% [1].

The prevalence of HIV/AIDS varies by region of the country. For some areas, such as Nyanza province and the coastal region, higher prevalence values of the disease are typical. Urban areas, especially the capital Nairobi, are well above the national average. Nairobi is an area with a large contribution to the burden of HIV/AIDS on the public health population. As the capital of the country, it hosts a highly mobile incoming and outgoing population due to internal migration [2]. Another reason is that the population groups such as single mothers, orphans living on the street, sex workers, men who have sex with men and injecting drug users, who are at a significantly higher risk of contracting

HIV/AIDS, are most concentrated in the main city of the country. Reasons are the rapid urbanisation of the Nairobi metropolis, the level of poverty, the ever-growing informal settlements, the language barrier, stigma and discrimination in the community [3]. Approximately 60% of the population of Nairobi are slum dwellers. Kibera is the largest informal settlement in terms of area and population. Nongovernmental organisations have provided estimations of a population of 600,000 – 800,000 thousand living in an area of approximately 2.5 square kilometres [4].

The Kibera informal settlement is administratively organised into 13 villages, which are characterized by ethnic and tribal specificities. Accurately quantifying the occurrence of HIV/AIDS in Kibera is quite difficult due to the constant movement of the population. However, it is estimated that the value of the predicted prevalence of HIV/AIDS is in the range of 14-21%, which is several times higher than the prevalence in Nairobi city (5.8%) and the country level (4.7%) [1].

Kenya has made progress in improving access to ARV therapy for people living with HIV/AIDS. The government, in collaboration with international partners, has expanded ARV therapy programs to ensure that those in need have access to life-saving treatment free of charge [5]. The timely and consistent treatment of ARV is critical to achieving optimal health outcomes for people with HIV. However, there are several known barriers to accessing and adhering to

ARV treatment for HIV/AIDS. These barriers may vary depending on individual, social and systemic factors, and one of these is gender differences. Gender can increase personal vulnerability to HIV depending on gender-related social and cultural norms, and it can influence a person's ability to access information about preventive measures, care and treatment. Standing on the WHO and UNAIDS strategy to achieve the Sustainable Development Goals (SDGs), it is essential to focus strategies using a gender perspective to integrate them into development programs, interventions and policies affecting the care and treatment of people affected by HIV and AIDS.

In some countries with available HIV/AIDS treatment, women are less likely to access it than men, due in part to cultural norms that prioritise men's treatment [6]. According to the International Community of Women Living with HIV/AIDS [7] and some previous research [14], gender inequality within families means a barrier to women's access to information and treatment. In terms of this, gender inequality is an important factor related to effective care and treatment. Among the available studies conducted in Asia, Latin America and some African countries, only few have specifically captured gender-related factors [6].

Based on this, we conducted a study to identify gender differences in behavioural factors and treatment-related factors of ARV therapy as a predictor of treatment adherence.

Methods

The study group consisted of people living with HIV/AIDS in the Kibera informal settlement. Data collection was coordinated by the Kenyan Regional Ministry of Health - Nairobi County, Langata Subcounty. Its regional scope also includes the area of the Kibera informal settlement. All health facilities (governmental, private, faith-based facilities and NGOs) that provide antiretroviral therapy as part of their services provided a list of registered patients living in Kibera. There was no misuse of personal data. Subsequently, community health volunteers coordinated by the Kenyan Regional Ministry of Health conducted data collection as part of their work activities during routine home visits. Data collection took place in the PLWHA's home en-

vironment, where confidentiality, privacy and comfort for the study participants were guaranteed. In this way, their anonymity was ensured, and unwanted disclosure of their HIV status and whether the patient was on ARV treatment was avoided. Community health volunteers were trained for data collection by the local Kenyan partner of the Faculty of Health Care and Social Work, Trnava University in Trnava, the community based organization Amani Kibera under the supervision of sub-county medical officer for health, Dr. Asma Adwah. Data collection took place from March to April 2021. The inclusion criteria for the study participants selection were their willingness to cooperate, the presence of the HIV/AIDS disease, an age of 18 years and above and their place of residence being Kibera. The participation of a minimum of 200 persons living with HIV/AIDS in Kibera was required to achieve a representative sample so that the findings of the study could be generalized to the entire population of PLWHA. A total of 272 persons living with HIV/AIDS in Kibera participated in the study.

The data needed to fulfil the objectives were obtained using a standardized PLWHA questionnaire. The questionnaire consisted of 7 sections: socio-demographic characteristics, risk behaviour, personal history and treatment-related factors, disclosure of HIV status and stigma, family and social support, non-adherence to treatment and reasons for re-integration into the ARV therapeutic regimen. Questionnaires are well-established in the research community and used worldwide. Questionnaire data collection was carried out electronically using the Google Forms tool.

The obtained data were evaluated using descriptive statistics methods. To determine the influence of the independent categorical variable (gender) on the dependent categorical variables, a chi-square test was used, as well as Fisher's test with a frequency lower than 5. R-project, version 3.4.2017, was used to process the data analysis with the level of statistical significance $p < 0.05$.

Results

The observed sample consisted of a total of 272 persons living with HIV/AIDS in the Kibera informal settlements, of which 64.3% were

Table 1 Socio-demographic characteristics of the observed group of PLWHA, Kibera, 2021, n=272.

Age	
Average	39.53 ± 10.18 years
Range	18-70 years
18-25 years	17 (6.3%)
26-50 years	216 (79.4%)
≥51 years	39 (14.3%)
Sex	
Female	175 (64.3%)
Male	97 (35.7%)
Religion	
Roman Catholic	43 (15.8%)
Protestant/Pentecostal	198 (72.8%)
Muslim	17 (6.3%)
Other	10 (3.7%)
None	4 (1.5%)
Education level	
None	5 (1.8%)
Primary	149 (54.8%)
Secondary	117 (43.0%)
Higher education	1 (0.4%)
Marital status	
Single	47 (17.3%)
Married/living together	110 (40.4%)
Separated/divorced	66 (24.3%)
Widowed	49 (18.0%)
Children	
Do not have children	24 (8.8%)
Not living with them	43 (15.8%)
Living with them	205 (75.4%)
1-2 children	44 (21.5%)
3-5 children	112 (54.6%)
6 and more children	49 (23.9%)
Monthly income	
Less than 3,000 KES	89 (32.7%)
3,000- 5,000 KES	92 (33.8%)
5,000- 10,000 KES	77 (28.3%)
More than 10,000 KES	14 (5.2%)
Occupation	
Employed	169 (62.1%)
Unemployed	103 (37.9%)
Retired	0 (0%)
Health insurance	
Yes	35 (12.9%)
No	237 (87.1%)

women and 35.7% were men. The mean age of PLWHA in the observed group was 39.5 ± 10.2 years. The youngest study participant was 18 years old and the oldest was 70 years old.

The most frequently represented religions were the Protestant/Pentecostal religion (72.8%) and the Catholic religion (15.8%). Primary education was reported by most PLWHA in the observed group, around 54.8%. Higher professional education was reported by one study participant.

In the observed group of PLWHA, 40.4% of the respondents were married or in a permanent relationship. There were 8.8% childless study participants, 15.8% stated that they do not live with their children and 75.4% of respondents live in the same household with them. Most study participants (54.6%) had 3 to 5 children.

When monitoring the amount of monthly income, we observed that most PLWHA in the observed group had an income of between 3,000 and 5,000 Kenyan shillings, namely 33.8% and 32.7% reported a monthly income of less than 3,000 Kenyan shillings. At the same time, 62.1% of the study participants were employed. 12.9% of PLWHA in the observed group had health insurance, and 87.1% were without health insurance (Table 1).

In the observed group of PLWHA in the Kibera informal settlement, we followed the occurrence of behavioural risk factors and observed whether there is a significant difference by gender. Behavioural risk factors are strongly associated with ARV therapy adherence. Alcohol drinking (11.8%) and starting fistfights (11.0%) were the most common behavioural risk factors in our study group.

Using the chi-square test, we found significant differences in cigarette smoking between women and men ($p < 0.05$), while there was a significantly higher rate of smoking among men (12.4%) compared to women (0.6%).

There were also significant differences in alcohol drinking between women and men ($p < 0.05$), and there was a significantly higher rate of drinking in men (24.7%) compared to women (4.6%) (Table 2).

Adherence to antiretroviral therapy is strongly correlated with the suppression of human immunodeficiency virus, reduced rates of drug resistance, increased survival and improved

Table 2 Behavioural risk factors in the observed group of PLWHA, Kibera, 2021, n=272.

	Total (n=272) n (%)	Women (n=175) n (%)	Men (n=97) n (%)	p-value; X
Smoking cigarettes	13 (4.8)	1 (0.6)	12 (12.4)	<0.05; 19.093
Alcohol drinking	32 (11.8)	8 (4.6)	24 (24.7)	<0.05; 18.262
Substance addiction	9 (3.3)	5 (2.9)	4 (4.1)	NS 0.313
Betting to earn some money	6 (2.2)	3 (1.7)	3 (3.1)	NS 0.458
Starting a fistfight	30 (11.0)	19 (10.9)	11 (11.3)	NS 0.015

quality of life. After CD4 lymphocyte count, antiretroviral adherence is the second strongest predictor of progression to AIDS and death. Another goal of this paper is to quantify the treatment-related factors and observed difference in women and men. To fulfil this goal, we observed factors of medical history of PLWHA in the Kibera informal settlement and factors of ARV treatment itself.

We observed a lack of food in the past 14 days, the nutritional status, if they were too sick to work in the past 3 months, their functional status, tuberculosis treatment, the number of years since the first HIV detection, the mode of HIV diagnosis and the mode of HIV transmission in our study group of PLWHA in the Kibera informal settlement. There was no significant difference in these patients' medical history between women and men (Table 3).

When observing the ARV treatment-related factors, we found statistically significant differences in the source of the ARV treatment, traveling costs for a visit to an ARV treatment facility, a loss of income due to visiting an ARV treatment facility and extra costs as results of taking ARV treatment in women and men.

There was a significant difference in the usual health facility as a source of ARV treatment in our study group of PLWHA in the Kibera informal settlement. Most of the women (44.0%) preferred government dispensaries, while most of the men preferred NGOs (54.6) ($p<0.05$).

Another significant difference was observed in the traveling costs to visit an ARV treatment facility. Men in our study group reported a high-

er rate of travelling costs (86.6%) compared to women (76.6%) ($p<0.05$).

We found a significant difference in the loss of income due to visiting an ARV treatment facility in our study group of PLWHA between women and men. A higher rate of income loss was reported by men (79.4%) compared to women (62.9%) ($p<0.05$).

A significantly higher rate of extra costs as a result of taking ARV treatment was observed in women in our study group (37.7%) compared to men (20.6%) ($p<0.05$) (Table 4).

Adherence to ARV treatment varies according to the population context, individual factors, treatment factors and, above all, the environment of the patients.

We investigated if there were significant differences of disclosure related factors in PLWHA in the Kibera informal settlement in women and men. These factors strongly correlate to ARV therapy adherence.

We found a significant difference in knowing the HIV status of the current sexual partner in the women and men in our study group. Most women (42.9%) reported a positive HIV status and most men reported a positive HIV status (64.9%) ($p<0.05$).

There was a significant difference in knowing if the current sexual partner was on ARV treatment by gender in our study group of PLWHA in the Kibera informal settlement. Most women (38.3%) reported being unsure of whether they were on ARV therapy (38.3%), while most men reported their current sexual partner was on ARV treatment (57.7%) ($p<0.05$).

Table 3 Medical history of patients in the observed group of PLWHA, Kibera, 2021, n=272.

	Total (n=272) n (%)	Women (n=175) n (%)	Men (n=97) n (%)	p-value; X
Lack of food in past 14 days	236 (86.8)	151 (86.3)	85 (87.6)	NS 0.098
Nutritional status				
Green	249 (91.5)	158 (90.3)	91 (93.8)	NS 1.974
Yellow	11 (4.0)	7 (4.0)	4 (4.1)	
Red	12 (4.4)	10 (5.7)	2 (2.1)	
Too sick to work in past 3 months	122 (44.9)	79 (45.1)	43 (44.3)	NS 0.017
Functional status				
Working	243 (89.3)	157 (89.7)	86 (88.7)	NS 0.073
Ambulant or bed lid	29 (10.7)	18 (10.3)	11 (11.3)	
Tuberculosis treatment				
Current	4 (1.5)	1 (0.6)	3 (3.1)	NS 5.975
In the past	137 (50.4)	96 (54.9)	41 (42.3)	
Never	131 (48.1)	78 (44.5)	53 (54.6)	
Number of years since first HIV detection				
<1 year	6 (2.2)	3 (1.7)	3 (3.1)	NS 1.317
1-3 years	49 (18.0)	33 (18.9)	16 (16.5)	
3-7 years	45 (16.5)	31 (17.7)	14 (14.4)	
>7 years	172 (63.2)	108 (61.7)	64 (66.0)	
Mode of HIV diagnosis				
Couple HIV counselling and testing	62 (22.8)	18 (10.3)	44 (45.4)	---
Prevention of mother to child transmission testing	70 (25.7)	70 (40.0)	0 (0.00)	
Diagnosis testing	112 (41.2)	73 (41.7)	39 (40.2)	
Community based screening	28 (10.3)	14 (8.00)	14 (14.4)	
Mode of HIV transmission				
From husband/wife	149 (54.8)	105 (60.0)	44 (45.4)	---
Having sex with HIV positive man	55 (20.2)	55 (31.4)	0 (0.0)	
Having sex with HIV positive woman	46 (16.9)	0 (0.0)	46 (47.4)	
Mother to child transmission	13 (4.8)	10 (5.7)	3 (3.1)	
Blood transfusion	7 (2.6)	5 (2.9)	2 (2.1)	
Shared needles	2 (0.7)	0 (0.0)	2 (2.1)	

Table 4 Treatment factors in the observed group of PLWHA, Kibera, 2021, n=272.

	Total (n=272) n (%)	Women (n=175) n (%)	Men (n=97) n (%)	p-value; X
Currently on ARV treatment	272 (100.0)	175 (100.0)	97 (100.0)	----; ----
Total no. of tablets/day				
1-2 tablets/day	255 (93.8)	159 (90.9)	96 (99.0)	NS 5.368
3 tablets/day	14 (5.2)	13 (7.4)	1 (1.0)	
More than 3 tablets/day	3 (1.1)	3 (1.7)	0 (0.00)	
Frequency of taking tablets/day				
Once- twice/day	271 (99.6)	174 (99.4)	97 (100.0)	NS 0.185
Three times and more	1 (0.4)	1 (0.6)	0 (0.0)	
Source of ARV treatment				
Government dispensary	101 (37.1)	77 (44.0)	24 (24.7)	<0.05; 11.215
Government sub-county hospital	43 (15.8)	27 (15.4)	16 (16.5)	
Private clinic	1 (0.4)	1 (0.6)	0 (0.00)	
Faith-based health facility	10 (3.7)	6 (3.4)	4 (4.1)	
NGO	117 (43.0)	64 (36.6)	53 (54.6)	
Distance to ARV treatment facility				
Less than 10 minutes	11 (4.0)	11 (6.2)	0 (0.0)	NS 5.803
10-30 minutes	161 (59.2)	96 (54.9)	65 (67.0)	
More than 30 minutes	100 (36.8)	68 (38.9)	32 (33.0)	
Traveling costs for a visit to ARV treatment facility				
No	54 (19.9)	41 (23.4)	13 (13.4)	<0.05; 3.943
Yes	218 (80.1)	134 (76.6)	84 (86.6)	
average	117.16± 60.87 KES			
median	100 KES			
mode	100 KES			
range	30- 350 KES			
Loss of income due to visiting an ARV treatment facility				
No	85 (31.2)	65 (37.1)	20 (20.6)	<0.05; 7.932
Yes	187 (68.8)	110 (62.9)	77 (79.4)	
average	345.08± 217.05 KES			
median	300 KES			
mode	300 KES			
range	30- 3000 KES			
Extra cost as a result of taking ARV treatment				
No	186 (68.4)	109 (62.3)	77 (79.4)	<0.05; 8.436
Yes	86 (31.6)	66 (37.7)	20 (20.6)	

Table 5 Disclosure related factors in the observed group of PLWHA, Kibera, 2021, n=272.

	Total (n=272) n (%)	Women (n=175) n (%)	Men (n=97) n (%)	p-value; X
Current sexual partner HIV status				
Positive	138 (50.7)	75 (42.9)	63 (64.9)	<0.05; 19.130
Negative	36 (13.2)	21 (12.0)	15 (15.5)	
Unsure	83 (30.5)	65 (37.1)	18 (18.6)	
No partner	15 (5.5)	14 (8.0)	1 (1.0)	
Current sexual partner is (was) on ARV treatment				
Yes	118 (43.4)	62 (35.4)	56 (57.7)	<0.05; 17.299
No	50 (18.4)	32 (18.3)	18 (18.6)	
Unsure	89 (32.7)	67 (38.3)	22 (22.7)	
No partner	15 (5.5)	14 (8.0)	1 (1.0)	
Disclose to a current sexual partner				
Yes	183 (67.3)	102 (58.3)	81 (83.5)	<0.05; 19.037
No	74 (27.2)	59 (33.7)	15 (15.5)	
No partner	15 (5.5)	14 (8.0)	1 (1.0)	
People in community know my HIV status even though I did not tell them				
Yes	51 (18.8)	31 (17.7)	20 (20.6)	NS 0.346
No	221 (81.2)	144 (82.3)	77 (79.4)	
Have you ever been treated differently due to your HIV positive status?				
Yes	27 (9.9)	17 (9.7)	10 (10.3)	NS 0.025
No	245 (90.1)	158 (90.3)	87 (89.7)	

Another significant difference was observed in the disclosing of this information to a current sexual partner. The men in our study group reported a higher rate of HIV status disclosure (83.5%) compared to women (58.3%) ($p < 0.05$) (Table 5).

Discussion

HIV/AIDS has continued to be a leading public health problem globally. Particularly, low income countries such as those in sub-Saharan Africa are challenged with this widespread virus and the socio-economic crises brought about by it. Globally, in the previous era, many efforts were made to fight against the worldwide HIV epidemic. The rate of new infections and HIV/AIDS related morbidity and mortality declined significantly. Scaled-up accessibility of ARV treatment has saved around

2.5 million lives from HIV-related deaths in low income countries since 1995 [8].

The level of adherence to ARV can vary based on the population context, and it is affected by individual, service, and therapy-related factors, such as substance abuse, psychiatric problems, the inability to disclose HIV status, a lack of psychosocial support, stigma, drug side effects, pill burden, poor quality service delivery and unexplained treatment costs [9]. With a better understanding of the reasons for treatment adherence and defaulting, interventions can be designed that improve treatment retention and ultimately, patient outcomes. The aim of this study was to identify gender differences in behavioural factors and treatment-related factors of ARV therapy as a predictor of treatment adherence in Kibera, because such knowledge is absent.

Behavioural risk factors can affect the antiretroviral therapy adherence of people living with HIV/AIDS. Alcohol drinking (11.8%) and starting fistfights (11.0%) were the most common behavioural risk factors in our study group. When comparing if there were differences in behavioural risk factors between women and men, we found a significantly higher rate of alcohol drinking and cigarette smoking in men. In a quantitative study evaluating the prevalence of behavioural risk factors related to ARV adherence, the most common factors were a positive history of drug abuse (74.8%) and a positive history of injection drug use (68.8%). All the observed behavioural risk factors increased non-adherence to ARV therapy [10].

We examined the medical histories of the patients in our study group. Research evaluating determinants of adherence to clinic appointments for people living with HIV in South Africa found that with patients coinfecting with tuberculosis, only 17.4% attained good ARV therapy adherence. It is vital to reinforce public health interventions that would enhance sustained adherence to clinic appointments and mitigate its impact on ARV treatment adherence and patient outcome [11].

With people living with HIV/AIDS in Kibera, we found significant differences in the source of ARV treatment therapy, travelling costs to ARV treatment facilities, loss of income due to visiting an ARV treatment facility and extra costs related to ARV treatment between the men and women in our study group. A study measuring the ARV therapy adherence of HIV-positive patients found that higher travelling costs and a distance of reaching ARV therapy centre being more than 40 km were strongly associated with poor treatment adherence [12].

A study evaluating the influence of social support characteristics in people living with HIV/AIDS in Zambia with a study design similar to ours brought similar results. Community-related factors such as disclosing one's HIV status to a sexual partner and a sexual partner being on ARV therapy are significantly associated with full treatment adherence [13].

There are some limits in our study. The quantification of ARV treatment adherence in the study sample should be performed. Additionally, recall bias may occur in our study since we assume that study participants do not accurately

remember a past event or experience, or leave out details when reporting about ARV treatment related factors.

Conclusion

The study findings show that alcohol consumption and smoking were the most common behavioural risk factors with a higher rate in men compared to women. These behavioural risk factors limit their social and economic situation and support from their families; they ultimately affect their ability to successfully adhere to ARV treatment.

Women significantly dominated in treatment related factors of ARV therapy, such as travelling costs to the ARV treatment facility, extra costs related to ARV treatment and loss of income due to visiting an ARV treatment facility. This acquired knowledge is an important predictor of adherence to ARV treatment based on gender differences. In countries with low income, the man is usually the head of the family, and the woman cannot go for ARV treatment without his permission. In addition, the man is the one who gives her money for travel costs and additional expenses related to ARV treatment. The woman will also be limited when it comes to travelling to distant health centres due to her demanding domestic duties. Consequently, the health of these women is likely to be affected by the inability to attend scheduled facility visits and limited time for rest.

Keeping people living with HIV/AIDS in the informal settlement on ARV treatment is extremely important for the successful outcome of antiretroviral treatment. It requires work with the patient, their family, the community and also at the level of the healthcare delivery system in health facilities. Interventions to strengthen the assessment of adherence and integration, making treatment facilities available and strengthening the family environment, friends, communities and social organisations appear to be effective steps in the Kibera informal settlement.

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Ethical approval of the research

This study received ethics approval from the Ministry of Health, Nairobi County, Langata sub-county. All data have been de-identified and were not attributable to individual patients.

Conflict of interest

There is no conflict of interest.

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Narcissistic Privacy as a Barrier to Socialization

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Abstract:

A democratic society is characterised by tensions between private and public interests. At different stages of a society's development, the emphasis shifts to one side or the other within the dialectic of both aspects of the functioning of society. We believe that the degree of disharmony between the two can result in problems and phenomena that ultimately pose a serious threat to the functionality of society as a complex whole. This study focuses on the phenomenon of privacy in relation to human socialization in a changing open society. We are convinced that in the last decade and especially in the post-pandemic period we are experiencing an unhealthy assertion of private interests that stem from the narcissistic mental world-setting of contemporary man. We seek to highlight the causation and manifestations of a narcissistic culture, part of

which is a lifestyle of dominance of privacy curved in on itself, and the implications associated with it – especially in the realm of social interest and interpersonal socialization.

Introduction: The threat of narcissism

Christopher Lasch's 1979 book „The Culture of Narcissism“ raised the issue of narcissism as a phenomenon in which Western society is stuck. Although the core content of this book was mainly reached for by psychologists and psychiatrists in the context of medical research, Lasch uncovered a movement of thought and values in his society whose unfortunate consequences can only now be identified with relative clarity: „It is true that a „present-oriented hedonism,“ as Riesman went on to argue, has replaced the work ethic „among the very classes which in the earlier stages of industrialization were oriented toward the future, toward distant goals and delayed gratification.“ But this hedonism is a fraud: the pursuit of pleasure disguises a struggle for power. Americans have not really become more sociable and cooperative, as the theorists of other-direction and conformity would like us to believe; they have merely become more adept at exploiting the convention of interpersonal relations for their own benefit“ (1). Alongside the medical connotations of Lasch's analysis, his voice warning of the gradual loss of interest in the future in the name of present experience and immediate gratification according to purely subjectivist preferences has somehow disappeared. In our work, we draw more attention to the very aspect of narcissism that obliterates teleological reasoning as Lasch implied. It is here that we see the core of the threat of narcissism.

The future is not only a philosophical question, but also a psychological factor, a sociological stimulus and a political-economic factor. If the future as a concrete mental project were to disappear from our temporal perspective, we would have to face a number of serious problems. While in the recent past there has been a discourse about the shape and form of the future and the ways to get there, in the present we see the problem lies elsewhere: in the loss of interest in the future as such. For if one loses interest in the future, one loses motivation for wider social interaction. As a consequence, one loses the soft skills needed to communicate and manage any project oriented towards a *'telos'*, where

the *'telos'* represents a temporal projection of the anticipation of the participating subjects present at that anticipation and planning time. However, if he does not develop his soft skills and even begins to lose them, his ability to communicate and coordinate solutions to problems that are bound to emerge over time will deteriorate. Given these preconditions, the death spiral of society and the entire ecosystem begins to unfold, consisting in the loss of coherence of the social complex.

Narcissism is a complex phenomenon of extreme solipsism, whose unambiguous definition has not yet been accepted in the ongoing professional discourse (2); this is perhaps because by its very nature it represents a paradoxical phenomenon in which we observe emerging characteristics that are not negative in themselves, while in a certain constellation of these characteristics, negative socio-pathological manifestations occur (3). Narcissism is on the rise in contemporary culture when it comes to the perception of the world as well as in lifestyles. The culture of narcissism poses a serious challenge that is currently being addressed by the global scientific community in an interdisciplinary discourse. Narcissism affects the whole of human existence, making it a form of spirituality. Its essence lies in the fact that man is attached to his own ideas about himself, life and the whole ecosystem to such an extent that he loses his sense and feeling for community and the integrity of the functioning of the social entities of which he is a part. He longs for love, admiration and acceptance, he wants to mean something and to be respected, but his growing need for recognition and admiration is not met. The future he dreams of thus becomes a projection of his illusory desire rather than a realistic teleological project growing out of the foundations of purposefulness, critical thinking, a healthy spirituality and a true knowledge of the world. (4). At the heart of the problem is the self-referential trap into which the human mind is swept and trapped. The self-centered, twisted world of anthropocentrism, coupled with the possibilities offered by digital technology, becomes the catalyst for extreme self-preoccupation, which brings nega-

tive concomitants into the life of the individual (5) and the whole society in the form of undesirable psychological and sociological phenomena.

Among others, the human world, characterized by significant 'human insecurity,' is influenced, for example, by the media. They boldly, directly, and loudly showcase new worlds, values, mentalities, traditions and religions. Moreover, they are established in society as opinion creators and shapers of public opinion (6). Another catalyst for extreme self-preoccupation, with many negative concomitants, is over-sharing content on the Internet (7) or completely reshaping the way interactions between people occur within the online environment (8). This also contributes to shaping the self-centred and twisted world of anthropocentrism (9).

Nutrition for narcissism

One factor that has contributed to the amplification of narcissistic culture is the philosophical shift that occurred with the advent of postmodernism. According to Hassan (10), modernists perceived the world deterministically with some certainty; postmodernists perceive the world in its indeterminacy. Modernism emphasized the goal and intention of things; postmodernism emphasizes movement, processes and opportunities. With modernism there was a development of hierarchy; postmodernism cultivates anarchy. Modernity favored typology, and postmodernity foregrounds mutation and variation. Modernism emphasized the importance of logos as a unifying principle of the universe that can be captured by language; postmodernism gives way to silence, rejecting the meaning of words as well as the word in the sense of the biblical narrative.

The postmodernist concept of creativity with its emphasis on the moment and the intensity of the experience itself, without a broader context beyond the temporal and social horizon of the moment, naturally reinforces man's solipsistic tendencies. „Whereas in the past the critique of reason was accompanied by an alternative foundation (e.g., imagination), postmodernism tends to abandon any metanarratives that might legitimize a foundation for postulating truth; what's more, it claims that we don't even need them, and they are no longer of any use“ (11). Postmodernism thus becomes a worldview that denies all other worldviews. It becomes a path

to extreme subjectivism for which no normative is relevant and no way out of the impasse is justified.

The second factor is the presence of digital technologies and their impact of cyber-reality on the human brain. In video games, for example, participants can fly, pass through matter, disappear and reappear, create their own cities, islands, civilizations, governments, communities and at the same time they can afford to take risks knowing that „it's no big deal“. With respect to the phenomenon of narcissism, these possibilities correlate with risk-taking imagination, a false perception of freedom and the empowerment of a grandiose ego. Research studies (12) focusing on the behavioural effect of cyber-culture on humans confirm that, despite the extensive communication in the online world, people paradoxically do not experience real *face-to-face* communication – one of the reasons is the absence of non-verbal communication, which makes people captive to their own world of ideas about what communication is and what it is not. He or she creates his or her own concept of understanding communication, which is, however, separated from the real world. As a result, the person may feel lonely, misunderstood and experience states of sadness that lead to a deepening of social isolation and, consequently, to the strengthening of narcissistic tendencies.

The third factor is the culture of the entertainment industry as an extreme form of anthropocentric philosophy of life and perception of the world. Social networks resonate with the human desire to show off in a better light, to display for admiration the often-fabricated stories and realities of one's own life just to keep one's virtual friends, and possibly to make new ones. The entertainment industry, according to Winter (13), offers various benefits and financial advertising opportunities for the user, who can thus become a virtual celebrity, influencer and in-demand personality. Not infrequently, this involves a kind of voyeurism, the sharing of racy details from other people's private spheres, absurd interpretations of events and extremist arguments. We believe that the growing problem of the increasing influence of conspiracies, trolls and hoaxes is a natural consequence of entertainment culture and part of a world in which anthropocentrism has become the exclusive interpretation of hu-

man existence. The absence of absolute norms and the displacement of metaphysical reasoning thus naturally creates a space for moral action in which autonomous ethical principles become dominant at the expense of heteronomous ethics.

Friendships on social networks are formed on the basis of a priori mutual affinities based on value preferences, fashion tastes, political opinions, personal goals or leisure hobbies. In such discussion threads, the spectrum of opinion is greatly reduced, and individuals who would cross it are blocked. The group of so-called friends is thus formed by participants whose attitude is indifferent or sympathetic to the views of the „creator“ of the group. In most cases, especially among children and adolescents, there is a mirroring effect of the opinions, comments and ideas presented by the group creator on social networks. If the discussants do not want to be blocked, they refrain from expressing their real opinion. Lesková points out that one of the consequences of the mirroring effect in a media-saturated society is the absence of deeper discussion on status threads in the digital environment, thus weakening the ability to think critically and cultivate interpersonal relationships (14). The culture of the virtual world fosters individualism and weakens the mental abilities and social skills needed to form sustainable interpersonal connections in the sociologically diverse entities in which one finds oneself.

On the contrary – a healthy community environment is characterized by the dynamics of diversity of personality types, age dispersion, cultural and opinion differences, intellectual equipment, etc., of those who create it. Tensions of opinion and the ability to manage them are related to physical proximity, which encourages, and in a way forces, individuals to interact with each other, no matter how intense their friendship relationships. We can call this a kind of corrective mechanism of reciprocity of social interactions that is constituted by the variety of communication techniques, the variability of signals, experiences and skills that take place directly – face-to-face. According to Kondrla, it is the corrective mechanism that plays an important role in the upbringing of children, the educational process, as well as in other formative activities, such as sports and art groups, where one is forced to adapt to the collective, to accept

authority and cope with pain and suffering and the differences of opinion occurring in natural social relationships. In their study, Hlad et al. explicate the importance of physical proximity and the presence of addressing diversity of opinion and values within a social entity for progressive personality modelling of its members (15,16).

The privacy phenomenon

According to Habermas (17) the public sphere constitutes a key platform for the functioning of a democratic society, since it is here that public debates, the exchange of ideas and the formation of attitudes and value orientations take place, and they are translated into the institutional expression of the character of a given society. It is in the public sphere that the public authority is born that will promote these values, ideas, goals and ethical frameworks. In general, the public sphere is an open arena for all participants coming from the private sphere (family life and private space of existence) who create its form and character. The dynamics of the relationship between the private and public spheres are complex and may change over time, but the importance and place of the private sphere in the long term is unquestionable. In the case of totalitarian regimes, the influence of the public sphere, controlled by the ruling power, is dominant and interferes in the private sphere in often unwanted ways. It can even trigger political movements in the private sphere that develop into revolutionary processes. In the case of a democratic society, by the very nature of democracy, the private sphere becomes a decisive factor that will determine the shape and character of the entire open society.

The private sphere is the realm of the family and the home, which in theory should be free and independent from the direct influence of government and other social, economic and political institutions. The private sphere has its own dynamics, organisation, values and ethical frameworks, for which the citizen, the individual and those who make up the private sphere are responsible. It is clear that the boundary between the private and the public is a vague, shifting, permeable and is always evolving. As OECD research and sociological surveys of the V-4 countries show, interest in the public sphere, elections, and active participation in public affairs

has been declining significantly over the last decade. We believe that one of the reasons for this is the narcissistic nature of the private zone. If processes of mutual disconnection between the private and public spheres begin to take place, any efforts on the part of the public sphere to improve skills and revitalise the instruments of public functioning of society will be limited by the degree of disinterest in public affairs on the part of the private sphere (18). The strengthening of narcissistic culture in the space of the private sphere will have a natural consequence in that the citizen's interest will curve into their own bubble and consequently not only their interest but also the ability to interact with the environment will be significantly weakened. The loss of coherence of the public sphere is then an inevitable consequence of these narcissistic processes.

Current indications of private narcissism

When it comes to any initiative from the public, the typical question for an ordinary person in our society is: what will I get out of it? What good will it do me? How will I benefit from it? What will it cost me? How does that limit me?, etc. The very nature of these and similar questions in itself would not be problematic if it were not an expression of refusal to participate in public and society-wide matters. A typical example can be the characteristics of people's attitudes during the covid-19 pandemic (19,20,21) that emerged not only in e-learning processes, as can be found in Kobylarek's (22) work, but also in post-pandemic pastoral activities as reported by Kralik in his study (23) and similarly by Caban in his research study (24) devoted to the area of family life. Truth and reasonableness presented in public, no matter how scientifically proven, shatters into strictly guarded boundaries of one's own freedom and limitations within the private sphere. If the public interest is disadvantageous from the private point of view, if it collides with private rules and preferences, then any rationality and rule benefiting the public becomes unacceptable and is usually rejected. Naturally, the question arises as to how it is possible to promote interests beneficial to the majority in such a society – issues of safety, ecology, economy, health, etc. – if the public discourse is not even able to reach the level of professional sci-

entific sharing and listening, because prejudices from the environment of privacy will a priori reject the concept of general benefit? In addition, as from the very nature of some phenomena, e.g., collective immunity in the field of health prevention, private and public interest can be mutually exclusive. Narcissism leads a person to one-sidedness, in which he prefers his own interest at any cost. He perceives his surroundings and thus the public interest one-sidedly, i.e., from the point of view of how it can help himself. In such a perception of the world, there is no room for private self-restraint in the interest of the public, for renouncing one's own advantages for the benefit of the whole.

The change in the relationship between public and private also has an impact on the formation of the identity of the contemporary person. The possibilities offered by his economic independence are almost unlimited in the environment of an open society. A narcissistic person will look for his authentic self-expression in all dimensions of his life – from choosing a vacation to the way he dresses and the design of his own apartment or house. „The other“ and „the interest of others“ disappear from his perception of the meaning of life and the perspective of the future. Everything revolves around a person being authentic, creative, progressive and successful – but in the sense of narcissism, that is – according to egoistic preferences and ideas of what progress, success, creativity and authenticity are. In such a view of a person's self-actualization, interest in the other person is lost. Public interest is denied. Any request from the neighbourhood is perceived as a threat. Only those who share the same values, opinions, preferences and lifestyle as the narcissist are accepted into the narcissist's world. Those „others“ should adapt to his private sphere, otherwise he will label them as „non-adaptable“ and perceive them as a threat.

Artificial intelligence and digital technologies play a significant role in the dynamics of narcissistic privacy, especially with regard to marketing and the online economy. The point is that the highly personal and specific characteristics of the individual, which are manifested in the online space where he enters, will begin to be mirrored thanks to AI, and business companies will quickly include the person with offers that

express his world. The same applies to his opinion preferences, which, if expressed in the online space, will trigger an avalanche of „information sources“ whose rationality and ethical quality are more than questionable. In a world where truth is not objective but has become a commodity that is produced and sold, a person becomes defenseless against hoaxes and conspiracies. His private world is subsequently filled with toxic content, which increasingly weakens the position of man and his relationship with the public. In the environment of the growing influence of cyber warfare (25), the negative consequences of narcissistic privacy cannot be overlooked or underestimated.

Today's entertainment culture is dominated by „stories.“ This can be seen in the advertising industry, where the product offered must have a „story“ (26). Likewise, the „story“ is encountered in show business and in almost all entertainment shows, educational programs and benefit concerts – everywhere there is a key story to which the client, sponsor, listener or consumer of the sophisticatedly offered commodity relates. The congruence of the individual with the „story“ has come to the forefront of narcissistic culture in the sense that the „story“ being offered „outside“ fits into my own story „inside“ my own and unique bubble. The object of interest thus ceases to be the search for truth, but is instead about the selection of the stories offered based on how they fit with my story. A narcissistic sense of inner well-being and existential security comes when the events, facts, findings and discoveries offered fit into our own story. This creates an inner conviction that we understand the world properly and we can handle the challenges of life, regardless of whether we have bought into the illusion, the hoax or the conspiracy.

If rationalism rejected the Judeo-Christian story of understanding the world, then postmodernism rejected the need for any meta-story as a prerequisite for knowing the world and maintaining the coherence of a society in which diversity is preferred to the unity of the elements that make up the system. Narcissism brings about the domination of the individual story over all other stories and thus pushes philosophical pluralism to an extreme position: one ceases to look for a unifying platform for „diversity“

but the postmodern concept of *unity in diversity* begins to disintegrate into mutually unrelated entities. Zacharias emphasizes the need to search for the point of reference that would safely anchor this diversity and bring back the unity and interconnectedness into the fore: „Where there is no coherence, there is no meaning. We look for coherence between law and life. We look for coherence between word and deed. We look for coherence between promises and fulfilments. We look for coherence between love and trust. In short, there is a longing to find a connectedness in life“ (27,28,29).

A person lost in narcissistic privacy has no real interest in the objective world around him – in the public sphere. He loses real connection with his surroundings. He ceases to understand it and does not care to influence it. One thus loses the ability to socialize and form relationships with one's surroundings, since encountering otherness – and the surroundings of one's own bubble are indeed different – is painful, uncomfortable and brings discomfort to the narcissist.

Conclusion

International research and comparative studies show that people close themselves off into their own private world, not only in an economic sense, but especially in a philosophical (theological) and psychological sense (30,31,32). Interest in public affairs is steadily declining. One of the reasons for this trend is the influence of digital technology and the online space, which allows a person to create their own bubble according to their own specific and highly individualistic preferences. We are convinced that extreme forms of solipsism at the individual level create a narcissistic culture that ultimately weakens social ties on a civic basis and also the authority of institutions and the state. Interdependence is fading, but independence is on the rise. As a result, the willingness and ability to agree, accept compromise, voluntarily limit oneself for the benefit of another, be willing to change one's opinion and respect the authority of another, and other relationship-building skills are lost. We perceive the following as remedies:

- purposeful leisure activities tied to the physical meeting of people of all ages;
- education about the benefits and risks brought about by the online space and AI;

- appeal to the media and cultural institutions to create a balanced field of information and an artistic space in which commerce and the mainstream will not have the highest preferences;
- a renaissance of basic philosophical questions in the field of knowing the truth and searching for the meaning of life;
- strategic preventive influence towards the private sphere in favour of the public;
- a public discourse that will openly and relevantly address the narcissistic; manifestations of the present culture and lifestyle and will look for ways out and solutions;
- purposeful support of the activities of communities and institutions that introduce the values of love, friendship, mercy, self-sacrifice for the benefit of the whole, teamwork and respect for others (33,34,35).

The narcissism of the private life of society is a serious problem that negatively affects the whole dynamic of the relationship between the private and social spheres in a democratic society and thus threatens its proportional functioning (36,37). The aim of this study was to contribute to the discourse on the issue of socialization in today's disintegrated society (38,39,40,41). Here, too, there are more reasons behind it. One of them, however, is the growing importance of the private sphere and the crisis of direction and functioning of the public sphere.

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The View of Social Work on the sexuality of Persons with health Disadvantages – Mental Disabilities

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Abstract:

The research article deals with a description of attitudes towards the issue of sexuality of persons with mental disabilities. As part of this issue, we often encounter the fact that there is still a widespread myth in society that people with mental disabilities do not need or cannot establish partnerships. However, the opposite is true.

Aim of the research: The main aim of the research was to find out individual attitudes towards the sexuality of people with mental disabilities in society from the point of view of

social work. **Research sample and setting:** The research sample consisted of six professionals (staff working with people with mental disabilities) and lay people (parents of people with mental disabilities and someone who has no major experience with a person with mental disabilities). The research participants were informed about the purpose of the research study.

Research analysis: Due to the nature of the topic, it was appropriate to use the advantages of qualitative research, which allows for the examination of phenomena in the natural environment and provides the possibility to studying processes and establish theories. Semi-structured, in-depth interviews and the procedure of grounded theory were used, and an inductively derived theories from the investigated phenomenon are presented.

Introduction

All relationships are irreplaceable in the life of each of us and significantly affect the quality of human life in society. The need for belonging and love is one of the most important human needs, without distinction. However, we believe that little attention is still paid to the individual and specific relationships of people with various health disabilities. In our case, the focus is on those with mental disabilities. The relationships of an individual with a medical disadvantage are important from early childhood. They connect them with parents, siblings and extended family, and later with peers and friends. "The family is the basic unit/cell that makes up our society. The family ensures the existence of the society, it brings new members into the society, and through it the child is integrated into the society" (Čulenová, Mačkinová, Nowak, 2023, p. 1). Partner relationships also have their place. Due to disabilities, the connections can be more difficult and have their own specific characteristics. If there is a misunderstanding in the creation of pathological relationships (e.g., non-acceptance of the child by the parents, abuse, domestic violence), the individual may be negatively affected in social interactions throughout their life. The development of an individual and the establishment of relationships is related to the manifestation of sexuality, which is always individual and probably different from peers. It is important that the individual has support and understanding from the family or experts when going through psychosexual development. Suppressing or denying sexuality is not a solution; on the contrary, it is the beginning of great complications.

All of us, even people with a health disadvantage, and in our case those with an intellectual disability, need warm, functioning relationships in order to lead a happy life. Due to the limits in different areas, which are the result of their disadvantage (disability), they may require different levels and different types of support. We can find this support in social work, which as a professional discipline helps people based on specific methods with a professional foundation. Individual and specific aspects of social work are based on many social sciences, especially psychology, sociology and special pedagogy (Laca, P. 2011).

Social work with people with health disabilities, i.e., with mental disabilities, has its own specifics, which differ from social work with other target groups. Social services that work with the target group of people with mental disabilities usually set the goal of involvement in everyday life in their mission (Laca, S. 2021). With terminally ill patients, "social workers try to help clients fulfill 4 kinds of wishes that I try to address before death" (Mačkinová - Okech, 2017, p. 75). "The current ideal is to aim for people with mental disabilities to be able to use common resources, i.e., institutions that provide services to the public. This means that they live in the local community in a way that corresponds as much as possible to the life of other people without disabilities" (Matoušek, 2005, p. 113). Ways of working with people with mental disabilities are always individual. Every person is different, and this fact affects the level of mental, human and physical support needed. As Mačkinová (2014, p. 463) puts it, "Sedentary lifestyles and unilat-

eral work put a strain on an individual's musculoskeletal system." This medical condition also adversely affects the mental health of individuals with intellectual disabilities.

Methodology – Research Design

The goal was to answer the main research objective, which was **to find out individual attitudes towards the sexuality of people with mental disabilities**. A partial goal was to clarify the difference between the attitudes of experts and laymen on this issue. Due to the nature of the topic, it was appropriate to use the advantages of qualitative research, which allows for the investigation of phenomena in the natural environment and provides the possibility to study processes, establish theories and respond flexibly to local situations and conditions (Hendl, 2016). Furthermore, the procedure of grounded theory was used, and an inductively derived theory from the investigated phenomenon is presented. The theory is revealed, created and preliminarily verified by systematically gathering information about the investigated phenom-

enon. This is followed by the analysis of these data (Strauss & Corbinová, 1999). Semi-structured, in-depth interviews were chosen as the research method.

The following research questions were used to answer the main research objective:

- What are the differences between the attitudes of experts and laymen?
- What is the attitude of the environment of people with mental disabilities towards sexuality and partnerships of people with a mental disability?
- What is the opinion of society about the parenting of people with mental disabilities?
- How does society feel about the sexuality of people with mental disabilities? What experience do they have?

As it follows from the research objective and research questions, the aim of the research was to find out individual attitudes towards the sexuality of persons with mental disabilities. Therefore, participants were approached from the ranks of professionals (those that work with people with mental disabilities) and lay people

Table 1 Overview of participants

Participants	Age	Achieved education	Occupation	Experience with people with mental disabilities
Participant 1	39 years old	higher professional education	SP in ambulatory care and field social service	from employment
Participant 2	30 years old	secondary school education with high school diploma	PvSS in ambulatory care and field social service (previously in residential service)	from work and personal life
Participant 3	27 years old	higher professional education	SP – public guardian	from employment
Participant 4	56 years old	bachelor education	SP in field social service	from personal life and from work
Participant 5	43 years old	secondary school education with high school diploma	accountant	from personal life
Participant 6	43 years old	bachelor education	unemployed	none

(parents of people with mental disabilities and those who have no major experience with a person with mental disabilities). Another criterion for the selection of participants was age – they needed to be at least 21 years old. A total of six participants were approached, and all of them agreed and wanted to know the interview questions in advance. During the research, ethical principles were maintained. Before arranging the interviews, all participants were familiarized with the essence and purpose of the interview, and for reasons of personal data protection, the names of all the participants were changed. All the participants agreed to record the interview on a dictaphone so that the data could be processed as best as possible. After the completion of data collection, all the interviews were transcribed and analyzed using the open coding technique. Open coding involves operations by which data are broken down, conceptualized and composed in a new way. Individual interviews were coded, and a list of existing codes was created. Then came their systematic categorization according to similarity or internal connections (Švaříček et al., 2014).

Research Results

When analyzing and interpreting the collected data (recordings), we approached individual categories and subcategories, that is, we analyzed and decoded semi-structured interviews. Subsequently, we arrived at the following six categories and subcategories, which we present in Table 2.

Experience with people with mental disabilities

All of the 6 participants had personal **experience with people with mental disabilities**. Participant no. 2: *“I actually met people with mental disabilities in elementary school. In first grade I actually had a girl with a mental disability among my classmates, and then a boy. So actually, for me, they are completely normal, full-fledged citizens.”* Participant no. 5: *“Hmm, I have a disabled daughter at home. We were at a camp two years ago, and it was difficult for me there. Because there were actually, there were more disabled people than my daughter, and it was actually uncomfortable for me to be in a group of so many people with mental disabili-*

Table 2 Overview of categories and subcategories

Categories	Subcategories
experience with people with mental disabilities	experience with people with mental disabilities
	experience with the sexuality of people with mental disabilities
	experience with parenting people with mental disabilities
access to people with mental disabilities	emotions associated with the sexuality of people with mental disabilities
	approaches to people with mental disabilities
sexuality of persons with mental disabilities	manifestations of sexuality
	views on sexuality
	sexuality in people with mental disabilities in practice
parenting of persons with mental disabilities	parenting of persons with mental disabilities
	opinions on the parenting of persons with mental disabilities
	contraception in people with mental disabilities
enlightenment	sexuality education of people with mental disabilities
	education in the field of sexuality
professional help to people with mental disabilities in the field of sexuality	multidisciplinary cooperation
	social services in the field of the sexuality of people with mental disabilities in practice

ities. *Even though I have a disabled daughter myself, because it was so concentrated there, it was not easy for me.*"

In the subcategory of **experience with the sexuality of people with mental disabilities**, it is important to mention that the participants perceived the concept of sexuality differently and an incomplete understanding of the concept could have influenced their answer. Five participants spoke about this subcategory. Participant no. 4: *"So I perceive that they have certain needs as well, but based on the fact that this person has a moderate mental disability, those needs take place somewhere, that there just might not be any physical sexual contact at all, right? That even some hugs, caresses or touches will be enough, but that's probably all, I dare to say. Because I can't say for sure that it is. But I've known her for some time, and so far she hasn't shown any greater desire to get to know something more."* Participant no. 3: *"I met someone during a court hearing when the client was actually mentally disabled and was not aware of the consequences. So he started exposing himself sexually. But I also solved various problems, as it were, with regard to motherhood and the like."* Participant no. 6: *"Hey, come on. I haven't come into contact with this issue, well, in person. But I must have seen some reports on this topic. Or as I know that it is a problem, that actually there are various like... various kinds of complications... That before it was actually prohibited, right? And those people have this sexuality normally or have such a need sometimes, maybe I would say an increased one."*

With the subcategory of **experience with parenting people with mental disabilities**: If they encountered the parenting of people with disabilities, it was more likely a physical disability. For example, participant no. 2 had positive experiences with parenting people with MP: *"Hmmm, I actually met, like my parents, two couples in my neighborhood. There are people with mild mental disabilities who have children. A great deal of support is definitely needed there, certainly from an early care perspective, and so on in general. But actually how it works, I think that those children are provided with basic needs, but I'm not sure if they actually lack some mental skills, like the abilities of those parents. If I'm saying it correctly."* On the contrary,

participant no. 4 talked about a personal experience with a young lady with a mental disability who could not handle parenthood: *"And you can say that she is actually my daughter's friend who had a need for sexuality different than my daughter. She has a one-and-a-half, maybe two-year-old little girl today. I've known this girl for five years, maybe seven, and I know that... She was also in our family, so I know that... So somehow I dare to say what she can handle, what she can't handle. She is simply a grown child. And she can't take care of her daughter at all, so she was actually put on trial. The grandma does everything, so her mom and dad take care of her. And the parents of the boy, who is also disabled, in some way, I don't know exactly how."* The question remains whether the participants have much experience with parenting people with MP due to the fact that this topic is still taboo in our country, or whether preventive measures are taken so that people with MP do not become parents. The reason could also be the nature of the social services in which the participants work, or the stage of life they are in.

Access to people with mental disabilities

All participants talked about equal access to people with mental disabilities, but their emotions regarding the issue of sexuality were different.

It was clear from the interviews that **the emotions associated with the sexuality of people with mental disabilities** are diverse. For participant no. 2, the first confrontation with sexuality was a shock, but he perceives it as being completely natural. Participant no. 4's manifestations of sexuality in their daughter did not come as a surprise, but on the contrary. Participant no. 5 hopes that he will never have to deal with his daughter's sexuality, and this topic causes him great concern. Participant no. 4: *"But for example, with my daughter... She is still very childish, even though she is thirty. So she prefers holding hands, caressing and squeezing, kisses. So it didn't surprise me that much."* Participant no. 5: *"That's how we sweep it under the carpet and hope that it never comes out. It's like, I can't imagine how I would fight with that."* From the interview with participant no. 6, it turned out that he perceives sexuality as a very intimate topic, but it should certainly not be muffled and

suppressed. Participant no. 6: *"I don't need to see it like this or like that, because I don't need to see it or anyone else's sex, except my own. But I think that it really shouldn't be suppressed.* Participant no. 3 thinks that the sexuality of people with mental disabilities does not want to be seen by the public.

In the sub-category **approaches to people with mental disabilities**, there were answers containing equal access and an individual approach. Participant no. 6 talked about sympathies and concerns about whether he would be able to treat people with mental disabilities correctly. Participant no. 1 perceives people with mental disabilities completely naturally: *"And I perceive them like all other people. They just probably have some specific needs and you need to talk to them a little differently."* Participant no. 3 fully respects people with mental disabilities, but he knows from his experience that working with this target group is not the right one for him. *"Nooo, it's not my target group that would be close to my heart. I respect them, I understand them, but it is not a target group that I would like to be with in the future... Maybe I should focus on it, and so on."* The attitude of participant no. 5, who, despite the fact that he has a daughter with a mental disability, feels uncomfortable in a group where there are more people with a mental disability: *"Because there were actually, there were more disabled people than my daughter, and it was actually uncomfortable for me to be in a group of so many people with mental disabilities."*

Sexuality of persons with mental disabilities

As already mentioned, it can be assumed that the participants' answers regarding **manifestations of sexuality** could affect different understandings of the concept of sexuality. Participant no. 1 perceives sexuality only as sexual intercourse and the satisfaction of sexual needs: *"Well, probably some sexual needs, some manifestations of those needs and satisfaction."* Participant no. 2, participant no. 3 and participant no. 6 perceive sexuality as a much broader concept. Participant no. 2: *"When I thought about it, I definitely don't see it as sexual intercourse as such, it's more like self-expression, and it's definitely related to intimacy. Actually, it is certainly related to something like relieving stress or*

tension in the body...and knowing one's own body." Inadequate perception of the concept of sexuality may be the reason for the participants' answers that they have no experience with the sexuality of people with mental disabilities.

Opinions on sexuality are very similar to the participants' approach to people with mental disabilities. It was often mentioned that it is bad that sexuality is not talked about much and also that sexuality in people with mental disabilities is completely normal and natural and it's okay. Participant no. 4: *"I see it as actually every person, whether they have a mental disability or not, let's say a healthy person, has certain sexual manifestations, needs... And I think that's okay."* From all the interviews, it was clear that participant no. 5 has a different opinion, and for this person the whole topic of sexuality is difficult and unpleasant.

Participant no. 2 has many positive experiences with the **sexuality of people with mental disabilities in practice**. His answers indicate that if someone has experience with the sexuality of people with mental disabilities, they are less afraid of this issue and do not perceive it as taboo. *"Yeah, whether it was simply the partnership of people with mental disabilities, or actually some sort of autoeroticism, which I knew took place in those rooms, I mean, quite normally. Actually, not only the partnership of people, but also as a matter of fact as sexual intercourse and as with mental disabilities with each other."* Regarding the answer of participant no. 3: *"I had a client like this who actually maintained a relationship with her partner and fortunately decided to undergo sterilization based on that."* The word "fortunately" is to be emphasized. Can it be interpreted in such a way that the participant would perceive it as a misfortune if the client he is talking about became a mother?

Parenting by persons with mental disabilities

It was clear from the interviews that **parenting by persons with mental disabilities** is not as common in our country as, for example, parenting by people with physical disabilities. The participants often had no personal experience and could not even imagine what parenting could look like in this kind of situation. In most of the answers, it was agreed that people with

mental disabilities need support to cope with parenthood. Participant no. 4 is fundamentally against parenting by people with mental disabilities. He had a clear opinion that they cannot be full-fledged parents and that every child has the right to parents, to a full-fledged life. *“So I always say to myself, when I hear somewhere that simply everyone has the right, they have the right to have children, I think to myself, but the child has rights too... where does the child have their rights... they has the right to have a full life, and not have to be raised by their grandmother and grandfather. They just needs to have parents. This is a terribly sensitive topic.”* The answers confirmed that this is a very sensitive and controversial topic among experts and lay-people. Even for experts, it is still a topic that is unexplored and very tricky due to its sensitivity. The majority of participants did not claim that it could not work, but perceived the risks and questions associated with it.

In the subcategory **opinions on parenting by people with mental disabilities**, human rights activists say that everyone has the right to found a family, to be a parent. Participant no. 1: *“Well, I think that it is a basic human right to found a family. So they just need some more support and to simply work with them from the beginning, and then I believe that it can work.”* Participant no. 2 had an interesting and enlightening view that parenting is very individual, just like for people without disabilities. Unfortunately, even among healthy parents there are very bad parents. *“I think that just like there are good and bad parents among people without disabilities, it will be the same with these people, completely normal. Because there are some parents without disabilities, I think they can be much worse than parents with disabilities.”*

The topic of **contraception for people with mental disabilities** is very controversial, and the opinions of the participants differed significantly. Participant no. 1 is against the fact that an individual has to use contraception if they are unable to understand it. *“Well, it will probably always depend on the depth of the disability and what and how they are able to understand as people, but I am certainly against giving something to someone without them knowing what it is and why it is. So, try to talk about it mainly, to somehow simply explain it clearly,*

to offer possibilities, so that it is really obvious what the consequences will be.” Participant no. 2 also disagrees with the preventive use of contraception and unfortunately has experience with this happening. On the contrary, participant no. 4 is a supporter of people with mental disabilities using contraception on the basis of someone else’s “order” even if they do not understand it and cannot decide for themselves. *“Well, I would be very much in favor of that. Because even though I perceive sexuality as very natural, I have to say I am very much against people with disabilities having children. Because I see it as one big problem, and I would be like... Yes, I would just give them everything, to have sexuality, so that they simply have a partner, to enjoy life, to experience it. But without children. This means that I would definitely be in favor of contraception.”* Participant no. 3 has a similar opinion, which supports sterilization in addition to lighter forms of contraception. *“I think that in some cases, if it is a mild disability, the person is able to manage it. But if it’s actually worse, it’s probably better to solve it radically. When a person is not able to take care of themselves and actually agrees with it.”*

Enlightenment

The participants agreed that **education about the sexuality of people with mental disabilities** is insufficient. Participant no. 1 talked about the fact that sexuality is talked about little and only superficially. *“Hmm. Well, I think that it should be talked about more. And maybe mainly more in depth. It is dealt with in such a terribly superficial way, as if it exists, something should be done about it, but actually, there should simply be, I don’t know, more stories published about it or something like that, I don’t think so.”* Participant no. 2 pointed out that people with mental disabilities are not educated in the field of sexuality. *“It’s just that a person with a mental disability simply doesn’t have as much awareness about how to actually handle their sexuality. So maybe if there were more, mmm, actually more workers who could work with those people and maybe at least tell them in the beginning how to do it, then there wouldn’t be such prejudices in society.”* Participant no. 3 did not encounter enlightenment either: *“Well, I personally did not encounter enlightenment here on that topic*

at all. Yeah, me personally somehow. Maybe I'm not looking for it, it didn't even come to me at work. So I don't dare say how it is in society at all. It is possible that they have little awareness of it, and that is why they have such prejudices."

In the sub-category of **education in the field of sexuality**, answers regarding the absence of education in the field of sexuality are summarized. Participant no. 2 talked about the fact that he does not know who he could turn to for education, even though he has been working in social services for several years. "Well, I can't seem to think of anyone to turn to. Maybe some organization or something like that. Nothing comes to mind." This points to the fact that it is still an unexplored area, and there is a lack of services and organizations that deal with this issue. Similarly, participant no. 4, who, if he did not know about the problem due to his job, would not know where to turn as a parent. "Well, of course, if I didn't work in it, I would look for some sort of help in a psychological counseling center, where they would surely direct me further. But that I would... I don't think that I would know that there is a counseling center dealing with the sexuality of people with disabilities." Participant no. 1 and participant no. 5 talked about the fact that education about people with mental disabilities in the field of sexuality is insufficient or even non-existent in schools. Participant no. 1: "No, not that. So we were for a long at the Jedlička Institute, where there are also schools, and there, I think, the school should deal with something like sex education and things like that, and actually talk about it with them. Well, I'm not sure about the Jedla." Participant no. 5: "I have no idea if I have ever talked about it. Maybe, if ever, at my primary school in Říčany. But I think not even in such a form as natural history - a description of organs. But only as boys, girls, well..."

Professional assistance to people with mental disabilities in the field of sexuality

Participant no. 3 spoke about the importance of **multidisciplinary cooperation from his experience**. He has experience cooperating with doctors from the fields of sexology, gynecology and psychiatry. "Well, I'm more for ensuring if there is any problem, it is up to doctors to handle it. All possible ones. So we place the client in an

institution so that they are under permanent supervision and then it is up to the workers there." Participant no. 2 and participant no. 5 talked about the lack of cooperation with the school the teenage daughter attends.

The subcategory of **social services in the field of sexuality of people with mental disabilities in practice** also includes answers regarding which of the participants come across the topic in their jobs within social services and who does not. It was clear from the answers that the biggest topic is residential social services, or field services. Based on the interviews, it is important to mention that there is a great lack of services that work with the sexuality of people with mental disabilities or support them in parenthood. We believe that the lack of these services is related to a lack of awareness and fear of working with this issue. Participant no. 2: "Well, I would say that probably not. I think that initially, even in our area, some kind of early care works quite well. But it ends one day, yes, and then, I think it's harder for those families to get support from the surrounding area. Maybe they don't even often ask for it themselves, because due to their mental abilities, it actually doesn't even occur to them. And at the very least, when I think about my surroundings, it's probably hard to find that support." Participant no. 4 talked about a situation where a young lady with a mental disability (a friend's daughter) became pregnant in the residential service, and therefore perceives the residential services as very risky if the lady does not use contraception. "So they took her from one social service situation, put her somewhere else, in a completely different residence ... I would say a freer one, and that's where it happened that the daughter was actually not protected and kept wanting boys, boys... Until she really got pregnant."

Conclusion of Research Results

In conclusion, we will try to answer the main research goal, which was to **find out the attitudes of the environment towards the sexuality of people with mental disabilities** through answers to four research questions.

The answer to the first research question, **What are the differences between the attitudes of experts and laymen?**, can also be found in the above-mentioned examples of answers. It is not

possible to say unequivocally that experts hold one position and laypeople another. Interviews with participants revealed that attitudes differ regardless of whether the participant works with people with mental disabilities, is the parent of a child with mental disabilities or has no experience with them. An important factor is the participant's personal settings and life experiences. All participants agree that people with mental disabilities are equal citizens, but the degree of affection varies. Attitudes towards the sexuality of people with mental disabilities are also very diverse, and again it is not possible to clearly determine whether experts hold one opinion and laypeople another.

The research question *What is the attitude of people around people with mental disabilities towards sexuality and partnerships of people with mental disabilities?* is closely intertwined with the first question. After summarizing the interviews, we cannot establish one specific position here either. Attitudes towards sexuality differ among participants based on their experience. Four participants perceive sexuality completely naturally, one participant respects it but does not want to see it, and for one participant, the sexuality of people with mental disabilities is taboo and he hopes that he will never have to deal with it.

For the third research question, *What is the opinion of society about the parenting of people with mental disabilities?*, there were the biggest differences in the participants' answers. Three participants have experience with parenting by people with mental disabilities and have a clear opinion that with the necessary support they can function and be good parents. One participant does not have a strong opinion. In his practice, he encounters the fact that it can work, but also that it really does not work and radical interventions are necessary. However, he realizes that this cannot be said across the board, and it always depends on the individual abilities and possibilities of the individual, or on the type and possibilities of natural and professional support. One participant has the opposite opinion and does not agree with the fact that people with mental disabilities should be parents. It is based on his personal experience, and he became convinced that people with mental disabilities cannot take care of a child. Someone else has to take

care of the child, and every child has the right to parents and a full life.

And the last question, *How do the surrounding people feel about the topic of sexuality of people with mental disabilities? What experience do they have?*, it was possible to find the answer in the sample answers. It is possible that the answers could have been distorted by a wrong understanding of the concept of sexuality. For example, participant no. 5 talked about the fact that he has no experience with sexuality (because he perceives sexuality only as sexual satisfaction), but then he described the manifestations of sexuality in his daughter. Only one participant had no experience with sexuality among people with mental disabilities. The participants' feelings about sexuality differed according to their experience with this issue. Most of the participants perceive sexuality as completely natural. One participant respects it, but does not want to see it. Feelings about sexuality from participant no. 5 vary depending on whether it is his daughter's sexuality or someone else's.

Due to the nature of qualitative research, it is not possible to apply the results to society as a whole. However, the results of the research investigation are beneficial for everyone who deals with the issue of the sexuality of persons with mental disabilities in their professional or personal life. They can serve as a summary of information, and the opinions of the participants can be used by experts dedicated to the issue of education in this area. The elaboration of this topic in a quantitative form would certainly be very beneficial because we would learn opinions on the issue from different points of view.

Conclusion

The research results show that society has taken a big step in integrating people with mental disabilities into society. As Mačkinová, Keketiová and Vavrčáková (2014, p. 987) say, "knowing personal identity is important for each of us." Nevertheless, the sexuality of people with mental disabilities is still a very sensitive topic that is not talked about much, and this may be due to insufficient awareness of the topic, which the participants mentioned. It is not possible to clearly determine which positions are taken by experts and which ones are taken by laymen. It

is evident from the research results that the nature of the opinions do not depend only on profession, but mainly on experience and personal attitude. Another topic that often appeared in the research is education.

We know from practice that the topic of sexuality is appearing more and more often in social services, and there are still not too many options on how to effectively support workers and how to comprehensively prepare them to work with this issue at all levels. Education for the lay public, which could contribute to removing prejudices, also deserves attention. It is very good that in recent years the number of professionals in social work and other areas who educate and support people with mental disabilities in the field of sexuality has been increasing. Society is thus at least one step closer to accepting people with disabilities as full-fledged citizens.

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Self-evaluation and Self-esteem in Children with Type 1 Diabetes Mellitus

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Original Article

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Abstract:

Background: Diabetes mellitus (DM) is the most common childhood endocrine disease. Treatment of the disease is complex and includes lifestyle modification, self-monitoring, insulin administration and regular physical activity. After starting school, children gradually become aware of their differences from their peers, which together with other factors can affect their self-evaluation. Hence, in the present study we focused on the influence of self-evaluation on the degree of compensation in children with type 1 DM.

Methods: The sample consisted of 64 parents of 6-12-year-old children that are regularly treated in the Diabetology Out-patient Clinic of the Children's Diabetes Centre. To obtain the data, a self-assessment questionnaire was used. To verify the hypotheses, statistical methods were used: the chi-square test (verifying the relationship between nominal data and verifying the differences between the compared groups), the Student's t-test (a comparison of mean values), and the F-test (a comparison of variances).

Results: The relationship between children's difficulties at school and the occurrence of acute complications was found in the sample of this study. The relationship between difficulties at school and the frequency of hospitalisations of children with type 1 DM was confirmed.

Conclusions: The present study suggests there is a relationship between difficulties of children with DM in the school environment and the occurrence of acute complications or hospitalisations of children with DM. Thus, nursing interventions should be aimed at improving self-esteem to achieve the desired compensation of DM.

Introduction

Diabetes mellitus (DM) is defined as a group of metabolic diseases characterised by hyperglycaemia that are caused by absolute or a relative deficit of insulin. The disease can be manifested at any age. The highest incidence in our population is recorded between 9-14 years of age. There has been an increase in its incidence in children from birth to five years of age (1). Diagnosis of the disease brings significant changes to children's lives. The changes influence the children's daily routine significantly, and children are also affected by more frequent separation during hospitalisations, isolation from their peers and changes in relationships with peers. School-age children with type 1 DM gradually start to compare themselves with their peers and realise they are different, which may influence their self-evaluation (2).

Self-evaluation, as a concept, was defined for the first time by the American psychologist William James in his book "Principles of Psychology", which is considered the first American textbook on psychology by professionals. James characterises self-evaluation as a certain self-image that allows us to appreciate or not appreciate who we are, what we do and what we achieve (3).

Zelina (4) states that self-evaluation is a result of comparing oneself and pronouncing

a "judgement" about oneself, how a person perceives oneself as good or bad, wise or unwise, etc.

Self-evaluation develops and changes continually throughout a person's life. In general, it is high in childhood and decreases significantly with the beginning of adolescence. It is affected by multiple factors, including family support, parents' education, economic factors, peer relationships, age, growth and development (5). However, children's self-evaluation also relates to the fact how their opinions are accepted and how their roles at home or school are perceived (6).

In the present study, we focused on identifying the effects of self-evaluation on the compensation of DM in children.

Sample and methods

A questionnaire method was used to obtain relevant data about the studied phenomena. We filled in the questionnaire in cooperation with children's parents. The sample included 64 parents of 6-12-year-old children with type 1 DM. The exclusion criteria were insulin pump treatment in the child and an intercurrent disease. The respondents' willingness to participate and anonymity were respected when filling in the questionnaires. The response rate was 100%. Statistical methods of quantitative research were used, and the data were statistically processed.

To verify the hypotheses, we used various types of statistical tests. The chi-square test was used to verify the differences between the compared groups. To compare cardinal data, we used the F-test, and to compare variances, the Student’s t-test was used to compare mean values. We found the relationship between the cardinal variables by calculating the correlation coefficient and testing for the nullity of the correlation coefficient.

Results

To find out the effects of self-evaluation on the compensation of diabetes, we asked the respondents about the self-evaluation of their children and the parents’ relationships to their diabetic children.

We analysed the relationships between the parents and their children, and the extent of cooperation between them. The parents were asked to choose one option rating their cooperation with their children.

Table 1 Cooperation with children

	N	%
Very good	31	48%
Rather good	27	42%
Rather bad	6	9%
Bad	0	0%
Total	64	100%

Almost half of the parents, 31 (48%), stated that their cooperation with their children was very good. Another group, almost the same size, 27 (42%), rated their cooperation with their children as rather good. Six (9%) parents considered their cooperation with their children to be rather bad than good. None of the parents rated their cooperation as bad.

Regarding the cooperation between the parents and their diabetic children, a very good or good atmosphere prevailed between them in their families (Table 1).

We asked the parents which attitudes they used in the attempt to comply with the treatment regimen. They were asked to choose if they preferred each attitude or not.

We found out that the parents, in their attempt to comply with the treatment regimen of their diabetic children, preferred reasoning their decisions, as was stated by 58 (91%) respondents. Almost the same number of respondents, 57 (89%), used cautions too. Approximately one third of the parents admitted they also used not very suitable methods in their attitudes towards their diabetic children. Too high requirements for their children were reported by 25 (39%) respondents, and 19 (30%) parents protected their children excessively (Table 2).

The children’s self-evaluation was significantly affected by their health. They may feel different from other children or even excluded by others because of their disease. Therefore, we were interested in how the parents supported their children’s self-evaluation.

The parents from the sample stated most frequently that they gave their children adequate work (M = 3.58). However, we perceive certain shortcomings by the parents in supporting the self-evaluation of children with type 1 DM. They largely stated they were critical towards their children and blamed them for their failures. On the other hand, they often did not realise that positive evaluation was important for children. They paid very little attention to children’s success (M = 0.98). Showing respect (M = 2.59) and esteem (M = 2.44) towards the child was not a matter of course either. We also studied whether parents’ support for their child’s self-esteem changed with age (Table 3). We compared the

Table 2 Attitudes towards complying with the treatment regimen

	Yes		No		Total
	Number	%	Number	%	
Cautions	57	89%	7	11%	64
Excessive protection	19	30%	45	70%	
Reasoning the decisions	58	91%	6	9%	
High requirements	25	39%	39	61%	

Table 3 Supporting children's self-evaluation

Supporting children's self-esteem		
	M	SD
Adequate work	3.58	0.79
Being critical towards the child	3.36	0.91
Blaming for failures	3.33	0.77
Criticism of work, not the child	3.30	0.78
Respect	2.59	1.30
Esteem	2.44	1.33
Attention to success	0.98	1.12

answers about children's ages with the answers about support for children's self-esteem. We found out that the age of the child with type 1 DM and support of self-evaluation by parents had strong correlation between the studied characteristics. The correlation coefficient was negative ($r = -0.33$); thus, it is indirect correlation. It means that the parents supported their children's self-evaluation less as the children got older.

In addition to usual activities that are expected from healthy children, children with type 1 DM must also cope with activities related to compliance with the diabetic regimen. It can cause negative pressure that is manifested by various difficulties. Therefore, we asked the parents which difficulties were manifested in their children and to what extent.

The parents rated anger outbursts as the most frequent difficulty in children with type 1 DM.

Table 4 Children's difficulties

	M	SD
Anger outbursts	2.55	1.37
Self-deprecating	2.17	1.24
Difficulty talking about the disease	1.56	1.31
Sensitive reactions to criticism	1.47	1.38
Child's isolation	1.44	1.41
Child's sadness	1.22	1.32
Does not give an opinion	1.06	1.34

The average rating of the degree of this difficulty was 2.55, which can be interpreted as a moderate to high level of difficulty. Self-deprecating ($M = 2.17$) was also a very frequent phenomenon in the children. The children had difficulty talking about their disease to a moderate degree ($M = 1.56$). Similarly, the difficulties were manifested in sensitive reactions to criticism ($M = 1.47$) or a child's isolation ($M = 1.44$). According to the parents, sadness and not giving an opinion ($M = 1.22 - 1.06$) caused the slightest difficulties from the offered options (Table 4). Higher standard deviations were in all the studied items. It suggests that children's difficulties varied. Furthermore, we examined if there was a relationship between age and manifestations of difficulties in children. We compared the answers about children's age and the answers about manifestations of difficulties in children. We verified the validity of relationships by testing for the nullity of the correlation coefficient.

The relationship between the age and occurrence of difficulties in children was found using statistical tests. Thus, in general, we can state that difficulties occur more often in older children than in younger ones.

Besides the difficulties that are manifested primarily by behaviour towards close persons in family or friends, children can experience difficulties at school too. Therefore, in the questionnaire we asked about difficulties that children experienced most frequently at school or among peers.

The parents stated that most of the difficulties at school occurred with their children only to a small extent. According to our findings, ex-

Table 5 Difficulties at school

	Mean	Deviation
Excessive fatigue	1.63	1.34
Difficulties concentrating	1.20	1.24
Rejecting after school groups	0.97	1.32
Rejecting common activities	0.81	1.41
Difficulties learning	0.64	1.37
Criticism from teachers	0.45	1.38
Non-acceptance by classmates	0.31	1.31

cessive tiredness (M = 1.63) caused the largest difficulties for children. Difficulties concentrating (M = 1.20) followed. Rejecting common activities and rejecting after school groups by children (M = 0.81 – 0.97) occurred less frequently. Difficulties learning, criticism from teachers and non-acceptance by classmates (M = 0.64; 0.45; 0.31) occurred to the smallest extent.

As in the assessment of children’s difficulties, higher values of standard deviations are also observed here. Thus, it means that difficulties of the diabetic children at school also occurred to various extents.

We tried to find out if the occurrence of difficulties in the school environment related to more frequent hospitalisations due to the inadequate compensation of diabetes in individual children. We used the respondents’ answers to the questions where the parents stated to what extent their diabetic children experienced difficulties at school and the answers about the reasons for hospitalisations. In the sample, 38 children were hospitalised in the previous year. The parents stated the most frequent reasons for hospitalisation: diagnosis of the disease (17%), inadequate compensation (16%) and ketoacidosis (11%).

We processed the answers to those questions by entering data for the Student’s t-test.

The differences in the compared groups are very large and cannot be attributed to random effects. The test results confirm that difficulties at school occurred in the group of children hospitalised for decompensation much more frequently than in the second group. We found out there was a relationship between the number of hospitalisations due to decompensation

in the children and their difficulties at school. Thus, we also focused on detecting a relationship between children’s difficulties at school and the occurrence of acute complications in the previous two years. We compared the answers from the question about the extent to which the diabetic children experienced difficulties in the school environment and the answers about types of acute complications experienced by the children in the previous two years.

We found moderate correlation (r = 0,475) between children’s difficulties at school and the occurrence of complications. The relationship between children’s difficulties at school and the occurrence of acute complications in the sample was confirmed.

Discussion

Vlachioti et. al. (6) pointed out that parents’ education also has an influence on the self-evaluation of children with type 1 DM. Several studies implied that family plays an important role in compliance with treatment for diabetic children in all stages of development. The family that provides support in coping with a disease relates to a higher level of self-esteem in the child. Furthermore, it was proved that children have a higher self-evaluation in the period after being diagnosed, because in that time they are supported by the education process and get the necessary family and social support. Also, the present study implies there is a relationship between children’s age and support for self-esteem provided by parents. We found out that the parents paid less attention to supporting self-evaluation in older children than in younger ones.

Table 6 Relationship between the occurrence of school difficulties and hospitalisations of children

Occurrence of school difficulties		
Hospitalised for inadequate compensation		Without hospitalisations for the stated reasons
Mean	7.77	3.04
Variance	18.69	13.04
Number	13	51
T stat	4.05	
T crit	2.00	T stat > T crit
p-value	0.000145	p-value is very low

We also studied a relationship between the age and parents' attitudes towards complying with the treatment regimen. No relationship was found in this case.

Several authors studied the impact of the chronic disease on the self-evaluation of children. The objective of the study by Vlachioti et. al. (6) was to evaluate negative effects of diabetes on the self-evaluation of children and young people. A group of 144 patients with DM was compared with a group of 136 healthy children. The study authors found out that the self-esteem of diabetic children was primarily affected by age, level of physical activity and family support. However, the analysis of the data obtained by them showed that the self-evaluation of the children with DM did not differ from the self-evaluation of the healthy children. Similarly, Boeger, Seifge and Roth (7) found out that the self-evaluation of the young people with type 1 DM and the young adolescents did not differ significantly.

Hoare and Mann (8) studied self-esteem and behavioural disorders in children with chronic diseases. The sample included 8-15-year-old children. The first group consisted of 64 children with epilepsy; the second group consisted of 91 children with type 1 DM. Their study implied that the children with epilepsy had lower self-evaluation and more behavioural disorders than the diabetic children.

In the present study, we asked the parents what difficulties their children experienced at school or among peers. We focused on the existence of a relationship between difficulties at school and children's hospitalisations because of complications. We compared the group of children who were hospitalised because of inadequate compensation with the group of children who were hospitalised for other reasons (for example: hospitalisation for the diagnosis of DM) or children who were not hospitalised at all. We found that the group of patients hospitalised for decompensation experienced difficulties at school much more often than the children in the second group. Furthermore, the relationship between children's difficulties at school and the occurrence of acute complications was confirmed.

Children of a younger school age have sufficiently developed cognitive skills to be able to understand their diseases. Furthermore, they start to realise their differences from their peers.

In this period, children often compete and try to achieve success both in and out of school. If children fail, it can affect their self-evaluation. Children's failures can be caused by multiple factors, such as tiredness, frequent absence from school because of hospitalisations and insufficient concentration (2).

Based on their study, Pek et al. concluded that children with type 1 DM had a higher self-evaluation in the period after being diagnosed because in that period the children were supported by the education process and got the necessary family and social support (8).

Therefore, it seems important to continuously educate children so they can understand "what is happening to them". Individual education is an ideal choice because it allows nurses to focus on the specific needs of children and their families (9). Information can also be supplemented by various brochures or books (2). Telenursing could also be an effective tool for supporting and educating children with DM. When providing nursing care, telenurses use systems that allow them to monitor patient data and their physiological parameters (for example: glucose levels). They can also use telephone or video consultations to solve nursing problems that arise during the management of diabetes (for example: how to administer insulin correctly, and many others) (10). Furthermore, it is suitable to include children in all activities. Family and peer support groups also have irreplaceable roles (2).

Conclusions

The occurrence of acute complications and the frequency of complications in children with type 1 DM is related to children's difficulties at school. Therefore, it is necessary to focus on supporting children and their parents through education sufficiently so that their occurrence is reduced to minimum. Education should be directed in support of modern trends in the treatment of children with type 1 DM, the possibility of using telemonitoring, and consultations with physicians and nurses (11) to achieve the maximum compensation of DM.

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Burnout Syndrome as an instability Indicator of professional Meaningfulness with a special Focus on the Profession of general Practitioners for Adults in the postmodern and post-COVID Era

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Abstract:

Burnout syndrome (WHO, 2019), especially in the post-COVID era, seems like a pandemic of the 21st century. Burnout is often the result of prolonged stress in the workplace (Butz et al., 2024). Identifying the syndrome itself and pointing out the importance of its causes and ways to overcome it is essential in many professions. It mainly affects the so-called helping professions, the group in which the medical profession and doctors belong. There is a crisis in the health sector (in the Slovak Republic), but little attention is paid to the instability of the medical profession. However, if there is a crisis of general values within our postmodern society, which would be supported to a large extent by the post-COVID era,

then the primary focus of the medical profession – to help and heal, which means to give the whole of oneself for the good of others – is being questioned as a value. At the same time, doctors are not satisfied with their professional fulfillment. For the stabilization of the medical profession, it would certainly be helpful to rediscover the profession of a doctor as a person who performs an art instead of doing a craft, and as one who practises his/her profession instead of doing business (Stavdal, 2023). In addition, the rediscovery and subsequent development of a gratitude culture in the workplace could be a proper substitution for the culture of careerism and rivalry.

Among physicians, general practitioners for adults represent one of the most endangered groups for burnout (Tidy, 2023). This paper deals with the burnout syndrome etiology, which is based on the essence of human beings, meaning a human-being focused on self-transcendence and on creating values. Therefore, the causes of burnout syndrome cannot only be narrowed down to the amount of work. In comparison to non-post-communist countries, building a company philosophy within clinics is an important element in the still recently established institution of GP clinics for adults as companies. It is based on the principal question: Why is working in a GP clinic for adults important? This question is legitimate not only for workers (healthcare workers), but also for clients – patients. The answer to this question should be based on values.

The paper also analyses symptoms, such as anticipatory anxiety, loss of creativity, loss of authenticity and the ability to relax, as well as resignation to innovation and inefficient functioning of clinics consisting of just one doctor and one nurse. These symptoms are generally mentioned less frequently among both the lay public and professionals. However, they seem to be essential indicators of burnout syndrome. For this reason, their proper recognition is also very important in solving the problem of burnout. Last but not least, we identify the uncertainty regarding the profession of a doctor in the framework of postmodern instability. We assume that the anchoring of the position of a doctor as the bearer of the profession, which has a self-transcending and unquestionably altruistic dimension, is the way to find professional stability as a prerequisite for a sense of fulfillment. Feeling the satisfaction from job fulfillment is a protective factor against burnout.

1 Complexity of the conditions for the emergence of burnout syndrome

Burnout syndrome is a complex health condition. It is dependent not only on the amount of work, but also on many other conditions. As a matter of fact, people are not only workers. Their lives are not only determined by their work, but also by other variables that are of the same importance as one's working life.

In 2023 at the Sydney Medical Congress, the president of the International Organization of General Practitioners for Adults (WONCA), namely A. Stavdal, quoted the eminent physician Sir William Osler (1849-1919) when she said: „The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head“ (Stavdal, 2023).

Doctors do not meet their patients in a vacuum. However, they are embedded in a socio-economic context. The rapid development of technology can represent both a boon and a stressor factor at the same time. Every medical record is stored in a software application called Electronic Health („E-health“), meaning that doctors' work can be immediately checked and monitored. In addition, doctors are dependent on technologies. For example, when applications for electronic drug prescriptions or electronic sick leave do not work, it becomes an insurmountable obstacle for doctors to do their job. Technological progress and an emphasis on telemedicine was strongly accentuated during the COVID-19 pandemic. This required many doctors to make rapid changes in the usual running of outpatient clinics.

1.1 Generational continuity

In the postmodern era (Aylesworth, 2015), certain general values are being questioned, some of which have already been pointed out in *Slovak Historic Tales for Young and Old* by Pavol Dobšinský in a story called „O troch grošoch“ [About three pennies]. These values include, for instance, generational continuity, social cohesion, a functional family and a supportive wider community. It was Albert Einstein who expressed his feelings in a similar way, when he said:

„How strange is the lot of us mortals! Each of us is here for a brief sojourn; for what purpose he knows not, though he sometimes thinks he senses it. But without deeper reflection one knows from daily life that one exists for other people... A hundred times every day I remind myself that my inner and outer life are based on the labors of other men, living and dead, and that I must exert myself in order to give in the same measure as I have received and am still receiving“ (Popova, 2012).

Moreover, certain „-isms“ tend to appear in the public sphere (Weir, 2023, p. 36). One of them is ageism, which means age discrimination. Every day, we can witness the accentuation of discrimination against the older generation. Unfortunately, older people are no longer being perceived as those who represent „the bearers

of wisdom and life experience“, but instead as an unproductive part of society. Such a society emptied of the stability of traditional values is increasingly focused on success, image, money and youth, which are in contradiction with the altruistic profession of a doctor.

1.2 Acting in accordance with the human heart

Doctors have to face the fact that while performing medical practice there are fewer and fewer opportunities for them to act in accordance with what they feel in their heart, meaning in accordance with the innermost motives of the doctor's personality. The famous writer L. N. Tolstoy succinctly described the possibility to act according to one's heart in his novel *Anna Karenina*. It states:

„The more often it occurred to him that the ability to act for the public welfare, which he seemed to have completely been lacking, may not even be an advantage, but on the contrary, it is a certain disadvantage in the form of deficiency – however, it is not the lack of good, honest, and noble desires or tendencies, but the lack of life force, of that abstract thing we understand by the term heart, and also of that specific effort which forces a person not only to choose exactly one life path from all countless paths life offers us, but also to desire only that one already chosen path. He noticed that public servants were not drawn to this work by their hearts, but by the fact that they rationally came to conclusion it was the right thing to do - to deal with public welfare and to take part in its creation. This assumption was also confirmed by Levin's brother's opinion that issues related to the public welfare... should be taken so seriously as a game of chess or the ingenious mechanism of a new technology machine“ (Tolstoj, 2019, pp. 323 – 324).

Furthermore, it is important to mention a statement by professor Špidlík: „A person is dissatisfied if he does not act in accordance with his/her heart“ (Špidlík, 2005, p. 105). Many of the „ars curandi“ that make a doctor a person who treats, heals and applies his/her knowledge in practice, result from the mentioned setting of

a doctor's heart. Patients feel such qualitative differences significantly. When examined by doctors who act from the „heart“, they perceive their professional interest, which is subsequently reflected in patients' compliance to treatment (Mir, 2023). However, if patients are examined by doctors with different personal values, patients' compliance is much lower, and, in turn, so is the therapeutic success. This is how a reciprocal therapeutic relationship is created (Suchman & Matthews, 1988), in which the doctor's interest in a patient provides the doctor with positive feedback regarding the patient's compliance and satisfaction.

Nowadays, it is quite problematic for doctors to be and stay patient-oriented. This mainly boils down to the fact that this altruistic dimension of their profession is losing its social prestige more and more. Therefore, the motivation of many young people – future doctors – is then reduced only to the financial aspect of the profession.

1.3 A profession or a job

From everything that has been mentioned above, a logical question has arisen about whether being a doctor is more of a profession than a job, or vice versa. Moreover, if we define a job as an activity due to which a person secures material goods for his/her life, it is also true that such an activity is interchangeable with any other activity providing him/her with necessary material goods. Based on this concept, a doctor could easily be engaged in business or hotel management as well. However, if we consider being a doctor not a job, but a profession, it is important to mention purpose, meaningfulness and heart as the centre of the human personality. It is true that a person is dissatisfied if he/she does not live in accordance with his/her heart. In this context, we understand heart to mean the whole abstract human inside that characterizes each individual personality, with all his/her feelings, temperament, character and will (Mojzeš, 2011, pp. 85 – 92).

After more than 30 years of professional medical practice, Doctor Anne Malatt from the USA reflected on medicine as a profession when

she stated: „People's health care starts with us. The fact is that we can only care for other people as deeply as we care for ourselves“ (Malatt, 2022).

1.4 Self-reflection

When talking about being a doctor, the focus is put on human existence itself. In that case, it is almost impossible to avoid asking who a doctor is and how he/she reflects his/her existence. Knowing yourself, i.e., the self-reflection of one's being, is a necessary prerequisite for running a successful medical clinic.

„Medicine is a lifelong journey, immensely rich, scientifically complex, and constantly developing. It is characterised by positive, fulfilling experiences and feedback, but also involves uncertainty and the emotional intensity of supporting colleagues and patients. It is characterised by positive, fulfilling experiences and feedback, but also involves uncertainty and the emotional intensity of supporting colleagues and patients.“¹

Nowadays, the speed of life is so fast that many people do not have time for self-reflection. Some people do not manage to do it during their whole lifetime, and others just do not want to do it. For this reason, personality mechanisms come to the fore (Bailey & Pico, 2023) – I see myself as I want to see myself. Such a trap also waits for doctors. Both society's and doctors' own expectations lead them towards a pedestal of infallibility, and they are finally put on it. This situation is very dangerous for the doctor profession in general, as well as for the maturation process of a doctor's personality.

1.5 Dubito ergo sum – I doubt, therefore I am

Descartes's statement „dubito, ergo cogito, cogito ergo sum“ (I doubt, therefore I think; I think, therefore I am) is being oppressed. As a result, another urgent question has arisen: „Is a doctor allowed to doubt?“ „A growth mindset combined with the recognition of failure is es-

¹ The reflective practitioner - guidance for doctors and medical students (2021). [online] [Retrieved December 4, 2023] Available at: https://www.gmc-uk.org/-/media/documents/dc11703-pol-w-the-reflective-practioner-guidance-20210112_pdf-78479611.pdf

sential for a successful medical practice“, says Dr. Franz Wiesbauer. As British actor Damian Lewis said, „fallible characters are ultimately more interesting than superheroes“ (Wiesbauer, 2017). The crystallization of thought processes represents one of the biggest obstacles to creativity and leads to an increased number of mistakes in professional performance.

1.6 Authenticity

Only a doctor who is capable of professional self-reflection can succeed in the authenticity test when being judged by colleagues, patients or him/herself. The subject matter of authenticity goes along with admitting limits, which leads all human beings towards the willingness to overcome them. Moreover, it is authenticity that leads us to the possibility of creating a functional therapeutic relationship. Simply prescribing pills is definitely not enough for treatment. The role of a professional medical worker can be demanding, hectic and sometimes even unappreciated, and it is important to admit that being a medical worker is never going to be easy. However, staying loyal to one's patients and duties is of the utmost importance. Authenticity in medical professions means being natural to yourself in your role as a healer, a counsellor and a message-bearer to your patients every day (Ramalingam, 2021).

1.7 A holistic approach towards patients

Analysing what it means to be a doctor involves defining a doctor as a person. However, we must not forget about the dimension of human beings in their self-transcending context. Doctors themselves truly do have that feature. Furthermore, only in relation to it can they meet another person who also has a self-transcending dimension. In summary, patients expect doctors to be mature, self-reflective, authentic and self-transcending people. They are able to recognise a doctor's approach to them. From a holistic point of view, doctors see patients as people who dispose of all the personal attributes mentioned above, not just as objects suffering from diseases.

If it is really true that a positive approach to

others makes people feel good and that a feeling of fulfillment is an inseparable part of professional practice, then the feeling of job satisfaction could not exist without this important holistic approach to the patients that involves the acceptance of all patient modalities. To be more specific, a holistic approach involves patients not only being seen as objects suffering from diseases, but as people with all the attributes we have already mentioned. Nevertheless, such an approach puts much greater demands on doctors. If a doctor's personality in all its complexity is separated from the factors that influence it, then reducing burnout symptoms down to each individual symptom in relation to professional practice does not describe the issue entirely. A healthy person is defined by self-awareness, which can be significantly impaired when it comes to burnout syndrome. For this reason, it is also necessary to apply a holistic approach when it comes to doctors.

General practitioners for adults as „gate keepers“ encounter a wide range of diseases and health problems much more often than any other medical specialty. They also become patients' first listeners in various life troubles, not necessarily only when it comes to solving their health problems. In addition, the spectrum of health problems is as wide as medicine itself. After years of medical practice, we dare to say that general practitioners encounter all medical and psychological diseases and are burdened by the need to differentiate the severity and etiology of diseases. Furthermore, at the same time, they have to apply a holistic point of view and see each patient in his/her socioeconomic, cultural, environmental and spiritual context (Mojzešová & Mojzeš, 2018).

1.8 General practitioners for adults and burnout syndrome

Among all medical professions, general practitioners for adults are considered the most threatened by the risk of burnout syndrome (Karuna et al., 2022). In spite of the fact that burnout affects individuals, it strongly depends on the level of healthcare system functionality.² Doctors doing outpatient care encounter inef-

² What is physician burnout? (2023). [online] [Retrieved December 4, 2023] Available at: <https://www.ama-assn.org/practice-management/physician-health/what-physician-burnout>

efficient functioning of the healthcare system on a daily basis. Firstly, during medical studies at universities, and after that, during specialization studies, student doctors and doctors have only limited opportunities to interact with institutions. Therefore, they are not prepared enough for their role as an outpatient care manager. A lot of doctors who feel the calling to be a general practitioner cannot identify themselves as a limited company director. Possible restrictions and the gradually increasing pressure of controlling authorities, not to mention insurance companies, coupled together with patients' demands, which are often accompanied by complaints, make it quite frustrating for every doctor. The forensic implication of a physician's work that looms over every decision he or she makes is a substantial variable that contributes to burnout development. On the contrary, therapeutic success and the establishment of a satisfactory and deep therapeutic relationship between the doctor and his/her patient that best fits the general practitioner belong among the concepts that help to prevent burnout syndrome. However, doctors' necessary interaction with administrative institutions often causes doctors to have a fear of failure and a sense of threat.

In medical practice, doctors encounter unpredictable events that result from the nature of their profession, which in this case refers to doctors' interactions with patients and their health. Professional books describing characteristic symptoms of many diseases form the levels of doctors' expertise and knowledge only to a certain extent. The ability to perceive possible relations among diseases, think of new ones and sense the right direction for determining the correct diagnosis differentiates good doctors from the rest of the group. Even though medicine has always been evidence-based, the ability to both creatively diagnose and creatively treat is one of the essential skills that characterizes a good doctor. However, a doctor's creativity is one of the most burnout-threatened qualities. We noticed this with doctor's abilities to respond creatively and efficiently to unpredictable events, such as the one brought about by the COVID-19 pandemic.

1.9 Several selected symptoms as indicators of burnout syndrome

In this article, we do not want to deal with the symptoms of burnout syndrome, as they have already been published comprehensively in different publications (Akkayagorn, 2023; Casarella, 2022; Tavella et al., 2021). We want to point out certain aspects that are less often mentioned that also contribute significantly to burnout syndrome development.

When it comes to less-known symptoms, we decided to focus on the symptom of anticipatory anxiety.³ It is defined as a state in which a person feels anxious and stressed about situations in advance for no specific reason. In terms of patient health, it can be the fear of the necessity of going to visit a doctor. In a private group of over 400 general practitioners for adults on one social network, a question appeared asking whether doctors felt uncomfortable on Sundays about going to work the following day, even if they already had many years of medical practice. The vast majority of doctors answered that they felt anxious.

Loss of creativity is one of the prominent symptoms in the diagnosis of burnout syndrome. As a matter of fact, creativity is a strong burnout-protective factor, and its loss signals a serious threat of burnout syndrome development. Creativity, referring to independent thinking about concepts, requires a moment of quiet silence and an open-minded doctor. A person under the pressure of all the medical fears and anxiety is hardly able to create such mental conditions for his/her intellect. Creativity requires energy, peace of mind and a vision of perspective. Burnout takes away all of these elements. Mental exhaustion destroys creative sparks, and then problems seem insurmountable (Razzetti, 2020).

2 How to overcome burnout

Human beings have a self-transcending dimension, and they naturally suffer if they cannot let this aspect fully develop. The symptoms of burnout syndrome lead towards existential loneliness as a result of one's social and emotional isolation. On the contrary, being open to the out-

³ Cf. 15 Tips for Nurses to Deal with Pre-Shift Anxiety (2023). [online] [Retrieved December 11, 2023] Available at: <https://www.floatcare.net/post/tips-for-nurses-to-deal-with-pre-shift-anxiety>

er world for relationships, inspirations, innovations, life visions and the occasional introspection, which requires a certain personal distance, protect people against burnout syndrome.

Generally, art leads to self-transcendence. A person participating in an artistic experience enters a reality that is the result of art reflecting an innovative point of view, whether it be visual, acoustic or in the form of a written story. To give more arguments to support this need, we can mention numerous doctors who, besides their medical professions, are also active artists, painters, writers or musicians (Subramanian & Brooks, 2022).

2.1 Bibliotherapy

The key point of bibliotherapy lies in a person's full concentration on a narrative story. The experience of being immersed in a story can enhance the sense of well-being. Mental transportation from our physical surroundings can provide an escape or an opportunity for meaningful contemplation. Bibliotherapy is well-established. Reading books and other written materials help to improve mental health and well-being; however, the question remains, what types of books are the most essential to recommend reading (McNicol & Brewster, 2018). Some doctors even record real anonymous stories from their outpatient clinics based on their experiences with different patients and illnesses. Thus, writing stories not only becomes therapy for doctors themselves, but also for their patients (Mojžešová, 2021; Mojžešová, 2022).

2.2 Innovation – minds playing with concepts. Active idleness

Albert Einstein once said that he had never made any of his discoveries through the process of rational thinking, and that a new idea had always come to his mind suddenly and in a relatively intuitive way. However, he considered intuition nothing else but the result of previous intellectual experience.⁴

In the sense of active idleness, creativity, i.e., the ability of the mind to play with concepts when we let associations related to our

profession flow freely, can often lead to finding innovative solutions. These can be such things as a vision for developing an outpatient clinic, a way to improve work organization or anything that becomes a new element and helps to improve the clinic microenvironment. The mind playing with concepts can be done during both active and passive relaxation. This can happen while sitting in a favourite armchair during an afternoon rest, or even during such activities as swimming in the pool. The aspect of active rest increasingly comes to the fore in direct proportion to the difficulty of medical work done under the time stress factor and the burden of possible forensic consequences due to incorrect diagnostics.

In addition to what was mentioned previously, we can mention some examples of famous people and their ways of active resting. Albert Einstein took breaks from his mental scientific work by playing the violin. Beethoven preferred long, vigorous walks, during which he always had a pencil and blank sheet music with him. Mahler, Satie and Tchaikovsky all believed in the power of a regularly scheduled midday walk.

Even nowadays, different people rest in different ways. Some prefer walks and breaks during the day. Others spend their free time developing skills in fields they are deeply interested in, but which are completely different from their profession. It usually varies from music to painting. Pursuing creative endeavours can help people discover and also connect what they already know with what they have been longing to know.⁵

Stress, which ultimately isolates people and makes them closed in themselves, does not allow people to have open minds and let associations flow freely, and thus be creative. This can be one of the first signs of incipient burnout, since creativity itself is considered a strong protective factor of this syndrome.

2.3 Education

A study conducted among Danish general practitioners showed a positive correlation between life-long learning and the prevention of

⁴Albert Einstein's Unique Approach to Thinking (2017). [online] [Retrieved January 4, 2024] Available at: <https://evernote.com/blog/einsteins-unique-approach-to-thinking>

⁵Ibid.

burnout syndrome (Brøndt et al., 2008). Life-long learning not only provides satisfaction from the fulfillment of doctors' professional requirements, it also leads to greater diagnostic and therapeutic certainty. We are of the opinion that even during medical studies at the Faculty of Medicine, emphasis should be placed not on the amount of knowledge, but on understanding the principles. With such an approach, when a medical practice is interrupted by parental leave, doctors are able to return back to work with self-confidence very quickly and can easily continue building onto knowledge they have already acquired. Forms of life-long learning then become continuing steps in already gained education and provide doctors with appropriate argumentative skills when offering patients possible treatments and building compliance towards the treatments. If doctors are able to obtain a patient's compliance, they also gain feedback in the form of satisfaction from reaching the therapeutic goal. In addition, a doctor's erudition is important from a credibility point of view, and it results from the intersection between a doctor's expertise level and his/her character features.

2.4 The transfer of medical competencies

The feeling of irreplaceability experienced by doctors in outpatient clinics becomes a significant predisposition to burnout syndrome development. The working model of a clinic consisting of just one doctor and one nurse seems to be outdated. It is expected that many healthcare activities that do not necessarily have to be performed by doctors will soon be transferred to mid-level health workers or nurses, who will then acquire higher competencies within the clinic and the health sector in general. In each outpatient clinic, a director should be a person with a specific vision of clinic development, and to fulfill that vision, he or she needs to be able to motivate other workers. It is necessary to define clear competences for all workers. Moreover, we consider it of high importance to implement adequate team building activities with the clinic workers themselves as well as general practitioners from different clinics, analogously to Balint groups (Kabát, 2018). Similarly, when it comes to nurses and their prevention of burnout syndrome, we focus predominantly on those nurses working in outpatient clinics of general

practitioners for adults. Taking that into consideration, their profession includes such a wide range of medical and administrative duties, probably more than any other kind of specialist; therefore, it is necessary for a doctor to have the opportunity to transfer medical competencies among the workers (Bassi, 2023). It even seems to be very beneficial to interchange those competences among them at certain time intervals. For example, taking care of patients in the waiting room would be assigned cyclically to all nurses from the clinic. It is necessary for doctors in the Slovak healthcare system to give up the feeling that they are irreplaceable and to learn how to create the correct conditions in outpatient clinics to transfer many of their current duties to middle-level health workers and nurses. Furthermore, it is important to create a model of an outpatient clinic with two doctors. In such a model, doctors do not compete with each other, but create conditions for a more efficient allocation of working time and the possibility for relaxation. In addition, it would help them to prevent the fear of being absent from the clinic, and thus of not meeting the demands of their patients. In this way, a doctor would be available for the patients of his/her clinic at all times. Planned examinations would not have to be postponed, and medical work would not accumulate during the time period of a doctor's absence from the clinic. It is definitely extremely difficult to run an outpatient clinic where, even within the framework of subsidiarity, all workers, whether doctors or nurses, feel appreciated and perceive the value of their job position. Collegiality and common visions among doctors in one clinic would become the rare variable necessary for building a model of one clinic with two or more doctors.

2.5 The ability to be awed

George Vaillant describes seven concepts of positive mental health: effective functioning, character strengths, maturity, positive emotional balance, social-emotional intelligence, life satisfaction (genuine happiness) and resilience (Cloninger, 2012, p. 103). In our opinion, the ability to be awed belongs to the above-mentioned personal qualities as well. A lack of this in human lives is one of the subtle initial symptoms of possible burnout syndrome development. Awe is the ability to perceive the beautiful,

extraordinary and impressive part of everything that surrounds us. Many people associate awe with immaturity. Therefore, when they grow up, they think they are too old, sensible or intelligent to be amazed. Beauty is something that a person appreciates or admires without any concern for personal gain. If we use this definition, we can understand why it is so difficult to perceive beauty. Unfortunately, today's society is focused on „What is in it for me?“ and „How does it benefit me?“ (Snow, 2017).

People who are interested in new facts not only suffer less from burnout, but also live longer. The ability to be awed is a true indicator of a functional mental state. Only people who are not focused on their own anxious experience are capable of feeling awe and amazement. In other words, it is only these people who are capable of getting excited about something. Awe provides a cleansing, cathartic experience and transfers the focus of human attention to an object that is „wonderful“ and therefore deserves to be admired. The ability to perceive goodness, beauty and other generally positive values could be therapy as well as an indicator of psychological health.

2.6 A culture of gratitude

Negative emotions such as „a priori“ disagreement lead to feeling intrapersonal tension. Learning to agree, praise and see the good in colleagues, situations and patients is medicine for the doctor's soul (Svačina, 2012).

The impact of gratitude on employee motivation cannot be underestimated. When employees feel appreciated for their work, they are more likely to put in extra effort and show increased loyalty towards their employer and institution they work for. The power of gratitude lies in boosting morale, increasing job satisfaction and reducing turnover rates. Employees who feel appreciated stay longer and perform better (McKinney, 2023).

Currently, more and more healthcare organizations are coming to the conclusion that a culture of gratitude is good for their employees, and therefore also good for their patients (Bozena, 2018).

2.7 Mental resilience

The current importance of the topic we are dealing with in this paper can be confirmed by

an interview in Forbes magazine with Zuzana Čmelíková, an expert on ethical leadership and resilience. Among other things, she mentioned that in today's era, which is characterized by constant change, pressure to do one's best and unclear rules in society, psychological resistance—resilience—plays an absolutely important role (Okšová, 2023). The Czech neuropathologist František Koukolík describes mental resilience as a key feature that is important for people living in the 21st century. However, resilience was also discussed during the times of great philosophers like Plato and Aristotle. As Martin Seligman, the father of positive psychology, says, resilience should not only be about ways of overcoming problems, but also about how to live meaningfully.

The most important prerequisite for mental resilience is self-awareness. The most resilient people are those who are aware of who they really are. Despite all personal traumas and failures, they manage to maintain meaningfulness in their lives. From other necessary prerequisites we can mention critical thinking, self-regulation, the ability to build healthy relationships, tenacity, perseverance and, last but not least, good energy management. Based on these seven key competencies, a resilience quotient is determined that is evaluated similarly to IQ and EQ. Using the proper resilience tests, we can determine the level of the aforementioned competencies and start working on them.

The question of how to have a good balance between work and personal life is important. Many people focus on how to recharge their batteries physically, but they find out it is not enough. We need to gain energy in other ways as well. During the day, we need to have enough stimuli to bring us joy and have people around us who we can look forward to seeing, whether at work or at home. Last but not least, we need to feel the meaningfulness of what we do. Sometimes we find it in material things, but it becomes a much greater driving force when we feel it through our relationships. It can also be found in our relationship to work. If we feel joy in what we do, we maintain some inner curiosity and enthusiasm, and therefore are better at finding solutions to problems. The key is to always look for ways to cooperate with other people and find out how to get along and form a strong bond

with them. However, leaders should allow employees from their team to experience even less standard situations so that they get to know each other better on different occasions and, despite their character differences, manage to create a stable basis for a bond to arise among them. For this reason, it is important for companies to organise experiential empirical team building events at which people can get to know each other in different situations and gradually start to form stronger relationships (Okšová, 2023). All of this helps to overcome burnout syndrome.

2.8 Company philosophy – focus on values

As a post-communist country, Slovakia is still in the stage of building company philosophies. It is characterised by a principled question about each company's values that can be asked both by employees and clients, meaning patients. It should be remembered that this question is not only legitimate, but also necessary. Not only does it create a framework, bring stability and reflect a company's vision, in case of an incipient crisis, it is a key point for all company leaders and employees. To be more specific, the answer to such a principled question in our outpatient clinic is the very name of the clinic itself with all of its contextual meaning—*Salus animarum, Ltd.*—which means health (in Latin, also the salvation) of souls. Furthermore, the full Latin text says *Salus animarum suprema lex*, meaning the health (salvation) of souls is the highest law. We even consider building this kind of company philosophy essential in outpatient clinics of general practitioners for adults.

Conclusion

The existence of burnout syndrome in the medical profession with general practitioners for adults is a real fact in both global and local meanings in the Slovak context. It was strongly accentuated in the post-COVID era. However, it is necessary to take into consideration the devaluation of this profession as such resulting from the values of instability of postmodern societies. For this reason, we agree with the statement that although burnout affects individuals, it is strongly dependent on the level of healthcare system functionality as a whole. In addition to common burnout symptoms, of which detailed analysis can be found in many other publications, we have

focused on some specific indicators of burnout syndrome that can also be considered very early or subtle indicators of this syndrome. Their identification contributes to burnout prevention and helps its treatment. These symptoms include the loss of creativity, the ability to be awed and a desire to continue life-long learning. This topic appears to be very current and needs to be further developed (Verhoef & Blomme, 2022).

It is of the same importance to build a culture of gratitude within outpatient clinics of general practitioners for adults in order to develop doctors' abilities to have mental resistance, which is also referred to as mental resilience.

Creating a list of personal value rankings as the framework for successfully running an outpatient clinic and building a company philosophy this way is still appropriate to be remembered and developed in the healthcare system of general practitioners for adults in the Slovak Republic.

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An investigation into the Role of early Marriage in developing suicidal Ideation among Girls in Dir, Khyber Pakhtunkhwa, Pakistan

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Abstract:

Early marriage is a common practice in African and Asian regions, including Pakistan. For females, early marriages have numerous adverse consequences, including those that are mental, physical, social and educational. However, so far, the association between early marriages and suicidal ideation and behaviours haven't been well researched. Therefore, this study aims to explore the relationship between suicidality and early marriage. This study was conducted in Chakdara and Ouch region, Khyber Pakhtunkhwa, Pakistan. This study is framed under a mix-method research design and is cross-sectional. Sampling for the study was done in multiple phases. First,

girls were identified who were married before 18 years of age, and second, there was an identification of girls who were not happy in marital life. A total of 120 girls were identified as a target population, and 92 were sampled through the Uma Sekaran sample size table. Third, 2 completed suicides and 4 uncompleted suicide attempts were identified, comprising a total of 6 cases among girls. An SIQ questionnaire devised by William M. Reynolds was utilized for judging suicidal ideation among the 92 sampled girls. Informal interviews were carried out for the 6 cases of completed and uncompleted suicides from key informants (family members and nearby people). The information collected was analysed quantitatively (data collected through the SIQ questionnaire), descriptive and inferential statistics were used, and data collected through informal interviews was transcribed and narrated. Findings show that suicidal ideation prevails among girls that are married before 18 years of age, and in some cases, it leads to suicide attempts. The most notable causes of suicidal ideation and suicide attempts among girls married early include stress due to an inability to take care of the husband and his family in the expected way, the burden of household responsibilities, relationship issues with the husband and/or his family, mental changes with pregnancy and rejection by parents.

1.1. Background of Study

In Pakistani society women face many problems (Gul et al., 2019). Early marriage is a commonly prevailing practice in many countries (Worldatlas, 2017). Pakistan is on the list of countries with high numbers of early marriages. So far, a bulk of research studies have been carried out about the practice of early marriages exploring numerous causes and consequences of them (The Express Tribune, 2013). Similarly, in Pakistan the causes and consequences of early marriages have been well researched. The key consequences of early marriage among females include poor sexual and physical health (ICRW, 2012; Save the Children, 2004), an impact on education, such as absenteeism, poor test and exam performance, discontinuation of education (Ababa, 2006), and fear (Carranca, 2013). Another key consequence includes increased household responsibilities, e.g., cooking, helping the mother-in-law, taking care of the husband and after some time the children as well (Yardley, 2006; UNFPA, 2012).

Regarding the relationship between early marriage and suicidal ideation, very few studies have been carried out. Among such studies, a study conducted by Gage in one African region

revealed that girls who are married between 10-17 years of age are at increased risk of having suicidal ideation compared to girls who are not. The risk increases because of mental health issues resulting from marriage at a very young age, and this is due to increased tension, stress and depression because of dependency and pressure resulting from marital responsibilities (Gage, 2013).

A study in Syria revealed that a total 13 cases of suicide among under-aged girls was reported during a six-month period. Responsibilities and depression are some of the common factors contributing to suicide among girls married before adulthood. The reasons for depression also include strict familial norms (of the husband's home), rejection by one's own parents after marriage in case of issues with the husband and his family, and social stigma in case of fear of divorce (Arfah and Yahya, 2017). Another study revealed that forced marriage is linked with suicidality (Pridmore and Walter, 2013); however, the study wasn't about early marriage. But it should be kept in mind that many early marriages are forced and are therefore a source of stress, depression and marital issues later, which can contribute to suicidality. The main

reason for suicidality among females married forcibly is to *escape from pain*.

1.2. Statement of the Problem

Majzoub (2018) reported that a young girl aged 16 attempted suicides in Lebanon. The girl was married at the age of 14 and was recently divorced by her husband. She further illustrated that so many cases of young girls attempting suicide soon after marriage goes unreported in Lebanon. Globally, the association between early marriage (among females) and suicidality hasn't been well researched. Only a few studies are available regarding the association between early marriage and suicide. Although early marriage is a common practice throughout the developing world, specifically in African and Asian regions, suicides still haven't been researched. The consequences of early marriage among females are a well-researched area. The common consequences include an increased burden of household responsibilities, poor educational performance and dropping out of school, pregnancy and health related issues, mental illness, etc. However, its association with suicidality is not well researched and documented.

1.3. Theoretical framework

A wide range of theories explains the social nature of suicide (Bak et al., 2019). This research work is guided by liberal feminism, specifically the work of Jessie Bernard. According to Jessie Bernard, there are two aspects in one marriage: first, a man's marriage, and second, a woman's marriage. For a man, marriage comprises of authority, independence and a right to domestic, emotional and sexual service by the wife. Whereas for a woman, marriage corresponds with powerlessness, dependence, an obligation to provide domestic, emotional and sexual services, and a gradual „*dwindling away*“ of the independent young person she was before marriage. Therefore, marriage for women is a source of stress, and many studies have shown the physical consequences of it, such as heart palpitations, fear, anxiety, sleepiness and insomnia (see Ritzer 2012 for further details).

1.4. Objectives of the Study

- To find out about suicidal thoughts prevailing among females married before 18 years

- To investigate the prevalence of suicide attempts among females married before 18 years
- To explore the factors responsible for suicide attempts among females married before 18 years

1.5. Methodology

This study is framed under the mixed-method research design. Mixed-method design was chosen to provide the researcher with maximum flexibility to investigate the problem, as the aims and objectives of the study are sensitive in many ways. First, the issue of suicide is often not discussed openly in the studied area. Secondly, Pakhtunwali prevails in the study area. Norms in Pakhtun culture are very sensitive when it comes to any aspect or dimension related to females.

Keeping in view the objectives of the study, there were two types of potential samples for the current study: first, girls who are married before 18 years of age (to judge the suicidal ideation among them); and second, girls who attempted suicide and were married before 18 years of age. Identifying individuals and families where females were married earlier wasn't a difficult task, as early marriage is practised commonly and is a culturally and socially accepted practice in the studied area. In this regard, a short survey helped the researchers to identify girls who were married before 18 years of age, and a total of 249 such girls were identified. 229 girls were accessed, and the rest were not accessible. Among the 229 girls, 120 girls stated that they were happy in their marital life, and therefore were not potential samples for judging suicidal ideation due to early marriage. From 120 girls, 92 girls were sampled based on an Uma Sekaran sample size table. Therefore, 92 girls were sampled to judge suicidal ideation due an early marriage.

The identification of girls who were married before 18 years of age and who attempted suicide (whether completed or not) was carried out by asking friends and relatives. Some samples were identified easily as they belonged to nearby areas where the researchers reside. It is important to mention that this issue came into consideration with such reports. In this context, 2 complete suicides and 4 uncompleted suicide attempts were identified, comprising a total of 6 cases. Only in one case was the person directly

accessed, whereas for the rest, family members and relatives were interviewed.

For assessing suicidal ideation, a questionnaire was adopted that was developed by William M. Reynolds. The questionnaire was reprinted upon his permission and is available online. The questionnaire contains 15 items related to thoughts and ideas about suicide that the respondents had over the last one month. The questionnaire was used for the 92 sample respondents, i.e., girls who were married before 18 years of age. The questionnaire is provided at the end of this paper. Informal interviews were carried out to collect information about familial and personal issues confronted by females married before 18 years of age who attempted suicide. Only one respondent was directly accessed, whereas for the rest, family members and relatives were questioned.

Data was analysed accordingly, and descriptive and inferential statistics were applied to the

data collected through the SIQ questionnaire. The data collected through interviews was analysed thematically.

1.6. Data Analysis

Table 1 is an illustration of the eligibility for judging suicidal ideation among the population of interest, i.e., early married girls. In this regard, the first basic question is whether the girl who was married before 18 years of age was happy with her marital life or not. If she was happy, then she was not eligible. Whereas if she was not happy, she was included among the potential samples for further investigation. In this regard, out of the 229 identified girls married before 18 years of age, 109 (47.59 %) stated that they were happy with their marital life, meaning that they were ineligible for further investigation. 120 respondents (52.41%) said that they were not happy with their marital life, making them eligible for further investigation. As per Uma Sekaran

Table 1 Eligibility for Suicidal Ideation

Are you happy in your marital life?	Frequency	Percentage
Yes	109	47.59
No	120	52.41
Total	229	100
If no, then please explain.		
Note: The information below was collected from 92 respondents. 120 respondents were eligible for further investigation, and 92 were sampled based on the Uma Sekaran sample size table.		
Household responsibilities	Frequency	Percentage
To some extent	26	28.26
To a greater extent	66	71.74
Total	92	100
Relationship issues with husband and/or his family	Frequency	Percentage
To some extent	44	47.82
To a greater extent	48	52.18
Total	92	100
Physical and mental health issues, including pregnancy	Frequency	Percentage
To some extent	76	82.61
To a greater extent	16	17.39
Total	92	100
Rejection by parents after marriage	Frequency	Percentage
To some extent	16	17.39
To greater extent	76	82.61
Total	92	100

Table 2 Uni-variate Description of Suicidal Ideation among Early Married Girls

S. No	Statement	6	5	4	3	2	1	0	Mean Score
1.	I thought it would be better if I was not alive	4.3%	8.7%	22.8%	13%	33.7%	4.3%	13%	2.72
2.	I thought about killing myself	7.6%	8.7%	6.5%	9.8%	8.7%	29.3%	29.3%	1.91
3.	I thought about how I would kill myself	6.5%	5.4%	7.6%	14.1%	17.4%	25%	23.9%	1.99
4.	I thought about when I would kill myself	13%	5.4%	12%	13%	28.3%	20.7%	7.6%	2.70
5.	I thought about people dying	7.6%	3.3%	21.7%	23.9%	19.6%	9.8%	14.1%	2.70
6.	I thought about death	20.7%	27.2%	25%	8.7%	4.3%	7.6%	6.5%	4.02
7.	I thought about what to write in a suicide note	3.3%	3.3%	00%	00%	2.2%	2.2%	89.1%	0.42
8.	I thought about writing a will	3.3%	3.3%	00%	00%	2.2%	2.2%	89.1%	0.42
9.	I thought about telling people I plan to kill myself	13%	3.3%	23.9%	15.2%	28.3%	5.4%	10.9%	2.98
10.	I thought about how people would feel if I killed myself	13%	19.6%	26.1%	9.8%	6.5%	18.5%	6.5%	3.41
11.	I wished I were dead	22.8%	19.6%	21.7%	15.2%	8.7%	6.5%	5.4%	3.91
12.	I thought that killing myself would solve my problems	19.6%	21.7%	15.2%	12%	13%	15.2%	3.3%	3.64
13.	I thought that others would be happier if I was dead	25%	5.4%	16.3%	16.3%	14.1%	17.4%	5.4%	3.37
14.	I wished that I had never been born	23.9%	14.1%	10.9%	22.8%	12%	14.1%	2.2%	3.64
15.	I thought that no one cared if I lived or died	29.3%	33.7%	6.5%	15.2%	5.4%	4.3%	5.4%	4.32
0: I never had this thought; 1: I had this thought before but not in the past month; 2: About once a month; 3: A couple of times a month; 4: About once a week; 5: A couple of times a week; 6: Almost every day									

sampling table, a total of 92 respondents were sampled. The further description is based on the responses of the 92 sample respondents.

Regarding the eligible respondents, 26 (28.26%) respondents said that they were unhappy to some extent because of the burden of household responsibilities, and 66 (71.74%) respondents replied they were unhappy to a greater extent. 44 (47.82%) respondents stated that to some extent that they were unhappy in their marital life because of relationship issues with the husband or his family members, and 48 (52.18%)

respondents marked to a greater extent. Further, 76 (82.61%) respondents to some extent and 16 (17.39%) to a greater extent said that they were unhappy in their marital life because of physical and mental health issues they were confronted with after marriage, such as stress, pregnancy, fatigue, etc. Lastly, 76 (82.61%) respondents marked to some extent and 16 (17.39%) to a greater extent that they are unhappy in their marital life because of parental rejection due to issues with the husband, his family, health problems and the burden of household responsibilities.

The tabular information indicates that in lower albeit considerable numbers of respondents, suicidal ideation prevails in a severe form, e.g., 20.7% of respondents thought about death almost every day; 22.8% of respondents wished for death every day; 23.9% of respondents wished that had never been born; and 29.3% of respondents thought that no one would care if they lived or died every day. Similarly, a small but considerable number of respondents thought about death a couple of times a week; 21.7% of respondents thought that killing themselves would solve their problems, and 33.7% of respondents thought that no one would care if they lived or died a couple of times a week. 22.8% of respondents thought it would be better if they were not alive about once a week; 21.7% of respondents thought about people dying about once a week; 23.9% of respondents thought about telling people that they were planning to kill themselves about once a week; and 28.3% of respondents thought about telling people that they were planning to kill themselves about once a month. 13% of respondents thought almost every day about how people would feel if they killed themselves, and 26.1% of respondents thought about it about once a week. 22.8% of respondents thought about wishing to be dead almost every day, and 21.7% of respondents thought about wishing to be dead about a couple of times a month. 19.6% of respondents thought that killing themselves would solve their problems almost every day, and 21.7% of respondents thought the same about a couple of times a week. 25% of respondents thought al-

most every day that people would feel happy if they were dead. 23.9% of respondents wished almost every day that they had never been born. 29.3% of respondents thought almost every day and 33.7% a couple of times a week that no one would care if they lived or died.

Correlation analysis was conducted between the judging association between suicidal ideation and early marriage in the four categories of issues identified among the samples, including household responsibilities, relationship issues with the husband and/or his family, physical and mental health issues including pregnancy, and rejection by parents after marriage. In this context, the burden of household responsibilities among girls married before 18 years of age were found to be significantly associated with suicidal ideation ($r= 0.91, p=0.001$; and *mean score*=3.82, $p=0.001$). Relationship issues with the husband and/or his family among girls married before 18 years of age were found to be significantly associated with suicidal ideation ($r= 0.88, p=0.001$; and *mean score*=3.18, $p=0.001$). A significant association was found between physical and mental health issues, including pregnancy and early marriage ($r= 0.84, p=0.001$; and *mean score*=2.88, $p=0.001$). A significant association was found between rejection by parents after marriage and early marriage ($r= 0.89, p=0.000$; and *mean score*=3.95, $p=0.000$).

Part-II

This research reveals that early marriage is one of the reasons for suicide attempts among females. Cases of attempted and complete sui-

Table 3 Pearson Correlations of the Problems after Early Marriage Score with Suicidal Ideation among the Study Samples

Scale	Household responsibilities		Relationship issues with husband and/or his family		Physical and mental health issues including pregnancy		Rejection by parents after marriage	
	R	P	R	P	R	p	R	p
Total mean score of problems with early marriage	0.91	0.001	0.88	0.001	0.84	0.001	0.89	0.000
Total mean score from SIQ	3.82	0.001	3.18	0.001	2.88	0.001	3.95	0.000

cide have been reported in the study area among girls married before 18 years of age. Suicidal ideation, suicide attempts and completed suicides can be explained because of early marriage among females. Field information collected through interviews and informal discussions indicates that early marriage is not directly associated with suicidal ideation, and a suicide attempt is the outcome of the situation and other consequences of early marriage among females. For example, it is evident from many research studies that early marriage increases household responsibilities on teenage females. Research further illustrates that increased responsibilities paves the way for developing suicidal ideation among individuals. Samaritans (2013) stated that failure to fulfill responsibilities leads to stress, and stress significantly correlates with suicide-related behaviours. In this regard, one extract is:

„..... Teenage girls are unable to take appropriate care of the husband's family (including the husband, father-in-law, mother-in-law, brothers, and sisters of the husband, etc.), but in this culture they are expected to do so. Due to their age and immaturity they often are unable to do so. This creates extra pressure on such girls. This pressure causes tension, and in that case, I observed this was the situation. The girl couldn't cope with the responsibilities, and this led to relationship issues with the husband's family, and later she committed suicide....“

A respondent stated that:

„..... Married girls, whether teenager or adult, are considered responsible for taking care of the husband's family. This is particularly difficult for girls to marry at a very young age. They are unable to take proper care, leading to stress among them. Sometimes it leads to relationship problems with the husband's family members, and this is dangerous when considering suicide and related behaviours....“

The brother of a deceased girl, who committed suicide, said that:

„..... My sister had issues with her mother-in-law and the sisters of her husband. The issues primarily started due to household work, such as washing clothes, cooking, cleaning the home, etc. My sister was just 16

years old, and they were exerting pressure on her as she was not good at that. She told us many times, but in this society, we can't do anything about it....“

Relationship (particularly intimate) issues contribute to suicidal ideation and attempts. This is evident from the current study as well. Relationship issues with the husband and his family are one of the key causes of the prevalence of suicide attempts among teenage married girls. In one case a key informant illustrated that:

„..... It had been told to us by our wives that she (referring to girl who died by suicide) didn't like her husband. She was married against her consent. She left her husband's home 2 times, but her parents' exerted pressure and brought her back to the husband's home. In the end, she could not find a way out and hanged herself....“

Health problems, particularly problems about pregnancy, are difficult to cope with at a very young age. Fear, stress and altered emotions are very common among females when pregnant because of hormonal changes. One unique case has been reported in this regard as well in the study area. The family members of a girl who died by suicide stated that her behaviour turned strange when she became pregnant. She was complaining of fear and screamed many times during sleep. In addition, she started reacting aggressively and was stressed for two weeks. Her husband said that:

„..... I told her many times to control herself and took her to a doctor. The doctor told us to take care of her; as a medicine prescription at such a time can harm the child within the womb. After a few days she fought with my mother about an unimportant issue and committed suicide. She was behaving in a strange manner, but we were not expecting such an extreme act....“

Key informants also illustrated that rejection by parents after marriage is common in cases where girls do not have good relationships with the husband or his family. Society stigmatizes parents who support their daughters (married) not having good relationships with their husband or his family. Parents are expected to exert pressure upon their daughters to maintain good relationships with the husband and his family. In rare cases girls get parental support if they have

issues with the husband and his family. Therefore, girls get more stressed when they are having issues with their husbands and/or his family because pressure or rejection also comes from their own parents. A key informant stated that:

„..... *People don't like parents who do not exert pressure on their daughters to maintain good relationships with their husband's family. If a girl (married) does not like her husband or his family members, parents are expected to taunt their daughters for that. So it creates more stress for girls. I had a lot of information about Ms. X (not mentioning the name of the girl) that she was not happy, but her parents were also rejecting her. I was told by my wife that her parents told her not to come to their home if she had another fight with her husband. And after a few days, I heard the sad news that she had hanged herself....*“

1.7. Discussion and Conclusion

The results from the sample population indicate that a particular portion of girls married before 18 years of age are vulnerable to developing suicide and related behaviours. It is important to mention that suicidal ideation among girls married at earlier ages is linked with other socio-economic factors and is not an outcome of the marriage. Therefore, populations where other causative indicators are missing are not considered. Such factors or indicators include the pressure of household responsibilities, relationship problems with the husband's family, health problems (stress and behavioural issues with pregnancy) and rejection by parents.

In the target population, it is evident that early marriage can develop suicidal ideation among girls who are married before 18 years of age. In Pakhtun culture there are numerous expectations from girls who are married, and these particularly come from the family of her husband. The expectations include taking care of the husband and his family members, helping the mother-in-law cook and other household responsibilities, etc. However, girls who are married at a very young age often are unable to meet such expectations, leading to tension, stress and issues with the husband and/or his family members, in addition to rejection by and stress from parents. In some cases, it leads to mild to moderate levels

of suicidal ideation, and in rare cases suicide attempts.

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Homelessness and suicidality: How do new emigrants confront the dilemma? Evidence from existing research conducted in Canada

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Original Article

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Abstract:

Framed under a systematic review design, this study aimed to extract specific evidence of how homelessness is associated with suicidality among new emigrants to Canada. A database search strategy was adopted, and biasness in the selection of studies was avoided by consulting with two independent reviewers. 18 studies were sampled purposively. It was concluded that migration to Canada is an important component of Canadian society. However, like other social processes, there are certain cons of migration to Canada. The newly emigrated individuals confront economic vulnerability, and homelessness is one of the possible outcomes. Homelessness is directly and indirectly associated with suicidality.

Introduction

Migration to Canada (emigration) is one of the hallmarks of Canadian society. Individuals from Arab and Asian regions have found Canada to be a place of opportunity due to its acceptance and tolerance for different cultures, nationalities, etc. However, emigrants still face significant problems upon their arrival, specifically those who move to Canada for employment. They face numerous problems, but one important issue is homelessness. Homelessness in Canada is common among new emigrants, but even emigrants in Canada who have been settled for years face this issue. Homelessness and mental health problems are linked. This systematic review focuses on homelessness as a precursor for mental health problems, leading to suicide and related behaviors.

Material and Methods

This is a systematic review based on searching using keywords in standard databases. Bias was avoided by sending the selected papers to 2 independent reviewers who were working as professors at universities in the field of sociology. The databases included Sociological Abstracts (showing 870 results), EBSCO host (showing 21 results) and Academic Search Complete (provided 3 highly specific publications). 18 studies were sampled purposively. The criteria for the studies included a) the research must have been conducted in Canada b) the research should be specific to homelessness and mental health c) the research must be focused on suicidality as an outcome of homelessness directly or indirectly.

Results and Discussion

P. Kissoon (2010) found that emigrants are one of the most vulnerable social groups to be homeless in Canada. Higher levels of poverty contribute significantly to homelessness among emigrants. Emigrants, specifically those who are new to Canada and the United Kingdom, are often dealt with by welfare organizations. Often times, even for many years they find themselves unable to have their own residence or have a place to rent. For some, homelessness becomes a whole life issue.

P. Miller *et al.* (2004) carried out research that is specific to homelessness in Canada. The study shows that homelessness is very common

in Canada among young persons, as most emigrants are young persons. The percentage of homeless youth is as high as 24% in Calgary. The purpose of emigration is to search for better employment and education. The experiences of emigrants to Canada are often negative and include, for example, negation, stress, a lack of sleep, food scarcity, and so on. This puts them on the brink of having psychological issues as well. The authors describe the issues associated with homeless youth in Canada. For instance, homeless youth are at high risk of becoming victims of violence and exploitation. The researchers refer to numerous studies that demonstrate the connection between mental disorders and homelessness by comparing homeless and non-homeless youth. Life on the streets is a sort of nightmare for homeless individuals in Canada.

C.H. Lindquist *et al.* (1999) explained that emigrants are vulnerable to many health-related complications. Most of them are psychological in nature; however, physical illnesses and symptoms also prevail. New emigrants are vulnerable to stress and anxiety, which in many instances lead to depression. The reasons for this include unmet needs, unemployment and homelessness. Suicide is a global concern. There is no country where the dilemma of suicide does not exist. However, suicide is relative, and the numbers vary; the causes and patterns also vary.

L. Sher (2010) investigated the socio-cultural determinants of suicide in Canada. This research is significant in terms of framing suicide in Canada under economic theories and frameworks. However, social variables, indicators and attributes are also framed under economic variables. For example, the social aspects are theorized under economic frameworks. First, gender is conceptualized in terms of unemployment rates. It is evident that higher unemployment rates put men at higher risk of mental illness and suicidal ideation. Masculinity may attribute to and be a mediating factor in this connection, as men are expected to earn and take care of the family. The failure to do so may lead to stress, mental illness and even suicidality. Secondly, the author found that per capita income affects mental health. For instance, widespread unemployment and mental health indicators are significantly correlated. The less the per capita income, the worse the mental health indicators. Intriguingly, research

also indicates that societies with less per capita income and higher unemployment rates have higher levels of alcohol consumption. Alcohol consumption, on the other hand, is linked with mental illnesses and concomitant suicide. For emigrants starting out, the unemployment rate is high, and therefore low per capita income and alcohol consumption is evident. This may be an important indicator for suicidality among emigrants. Third, scientists mention risk-taking behaviors, and suicide is included in such kinds of behavior. There is no doubt that having a low income is linked to risk-taking behaviors, and it is true for emigrants, at least in the early days of migration. Scientists refer to the role of occupational stress in mental illness leading to suicidality. Cyclical fluctuations in income are highly evident in the lives of emigrants, and in Canada it is certain that this leads to mental illness that may result in suicidality. For emigrant individuals, low incomes and occupational stress are significant risk factors that are in addition to lacking integration, such as not having friends or family. Furthermore, policies are also important for emigrants, and there is evidence that Canada's migration policies are not that friendly. This makes the situation worse for them in terms of income, occupational stress, alcoholism and mental illnesses. The author mentions Canada's suicide prevention policies as well, for example, its failure to implement the United Nation's guidelines.

Homelessness and problems in life are connected. Unmet needs, stigma and mental health are also connected (Khan and Naz, 2023). C.F. Wong *et al.* (2016) found that homelessness is significantly correlated with mental health problems. Stress and anxiety are common minor issues, while depression and bipolar disorders are major ones. S. Gutwinski *et al.* (2021) illustrate that homelessness is a concern for many European countries, specifically due to higher emigration rates. There is substantial evidence that the mental health of homeless people is poor compared to the non-homeless. In psychiatric wards, visits by homeless people are significant, and homelessness is labelled as a major indicator for both minor and major mental health problems.

Homelessness is a global issue; however, certain social groups are more vulnerable to being homeless, and emigrants belong to this group.

Conceptualizing homelessness is also important. Homelessness is a situation or condition whereby there is a not regular and/or fixed place to sleep at night. Next, we can look at the numbers. About 0.7 percent of the general population in Canada and the United States are homeless, yet as many as 33% of new emigrants are homeless for the 1st month of their migration. This means that 33% of emigrants are vulnerable to mental illness in the U.S. and Canada. But there is another sort of relationship as well: illness among emigrants leads to homelessness. Stress is the most common culprit. Stress and depression are linked to decreased interest in work. This is often the result of living away from their families, which may lead to mental illness and loss of work in another country, which in turn simply means homelessness. Therefore, there is a two-way relationship; first, emigrants remain unemployed for some time, leading to homelessness; second, mental illness affects their work performance, leading to unemployment and homelessness. Homelessness and emigration are linked by the mediating factor of mental illness. In between are the different attributes, including drug use, loneliness, a lack of social support, stress, social stigma, negation, and so on (Nishio *et al.*, 2017).

Bipolar illnesses and disorders significantly affect an individual's ability to control and express emotion, and one can say that there is a lack of balance between control and expression - at least there is a lack of balance when compared to the general population. This situation is a problem of its own, and it affects the relationships and interaction patterns of individuals. This affects familial life, but the biggest impact is on work life. Family and friends are more adoptive in terms of taking care of and avoiding behavior issues, whereas at the workplace there is often a lack of blood relationships, and the emotional attachment associated with it. In addition, loss of energy and a lack of concentration are also the outcomes of bipolar mood disorders, and they cause job loss for many people. Simply put, mental illness is one of the causes of homelessness in Canada, and it is also evident that mental illnesses are common among emigrants. Therefore, there is a two-way relationship. Statistically, it is evident that there is a 4-fold higher probability of mentally ill people becoming un-

employed, which may lead to homelessness (Oh *et al.*, 2015).

One's mental health is also connected with physical health. Poor mental health leads to poor physical health; it is a simple hypothesis that has been proven by a bulk of research studies. Poor physical health related to mental health leads to exacerbating situations at the workplace and often results in job loss. Job loss for a certain few individuals means homelessness. Routine social interaction and finding and maintaining ways to get a permanent or relatively steady source of income is a challenge for people with mental illness, and this also affects their physical health (Bacciardi *et al.*, 2017).

There is another important attribute and mediating factor between mental illness and homelessness, which is a fear of being homeless. Homelessness is the outcome of a population explosion or an unplanned demographic process. In recent times, as is evident from research, fear and anxiety of being homeless is an important aspect in mental health studies. Many people become mentally ill because they predict that their job or profession is not steady, and they can become homeless at any time. When such stress is exacerbated, it can lead to suicidal ideation as well. This is evident among very few individuals, but it still must be taken into consideration. For the people who had predicted they would become homeless, and they do become homeless, the life stressors are exacerbated. They already have fears and anxieties, and the stress levels are exacerbated because additional stressors in their lives, such as feeling unsafe and social stigma, also start circling around them. This adds to problems, such as isolation and scarcity of food, and for many people, getting help to have enough food is a significant stressor (Fitzpatrick *et al.*, 2007).

The work of M. Pinillo (2020) is significant regarding mental illness and homelessness. Homeless people are highly vulnerable to assaults in Canada. For example, statistics show that 56.9 percent of people who are homeless have been confronted with some type of violence. This number is extremely high compared to the general population. Simply said, homeless individuals are vulnerable to crime. The author found that individuals confronting crime, seeing crimes and being victims are more vulnerable to

mental illness and therefore developing suicidal ideation. However, one attribute that is important is the duration of homelessness. The lengthier it is, the higher the probability of mental illness and suicidality.

S. Fitzpatrick *et al.* (2013) make an important argument. For scholars, homelessness plays a significant role in avoiding social activities, as most individuals cannot bear the burden of social stigma associated with homelessness. Some specific mental illnesses are evident in the case of avoiding social activities due to social stigma resulting from homelessness, and these include cognitive deterioration and depressive symptoms. Statistics reveal that approximately 60% of homeless people exhibit some sort of depressive symptoms. The most common reason among these people (referring to the homeless) is avoidance and withdrawal from societal obligations. The authors suggest a solution of social integration, whereby communal and governmental responsibilities play a crucial role. The more efforts made to integrate homeless people into society, the lower the probability of mental illness and suicidal ideations.

K.J. Hodgson *et al.* (2014) found that depressive symptoms among homeless people are also connected with routine and daily troubles. The most notable of these are meeting food-related needs, a lack of privacy, the overcrowding of stay facilities, and feelings of being unsafe and unwanted. It has been found that individuals confronting these problems are at a 3-fold higher risk of developing suicidal ideation following mental illness.

C.F. Wong *et al.* (2016) found that self-harming behaviors are commonly found among homeless individuals. In England many studies confirmed that homelessness has been one of the causes of deliberate self-harm. R. Eynan *et al.* (2002) investigated different aspects of homelessness contributing to suicidality. In this regard, for example, the duration of the homelessness period was an indicator. The correlation is simple: longer durations of homelessness go along with an increased risk of suicide and related behaviors. The mediating factor was mental illness. If homelessness leads to mental health issues, it can lead to suicidal ideation. Further, the study produced intriguing results in the contexts of gender, homelessness and suicidality.

For example, men are found to be at higher risk of developing risks of suicidal behaviors compared to women. One factor in this connection was the percentage of men being homeless, and for example, there is a higher number of homeless people who are emigrants in Europe. Mental illness was found to be the most important indicator for suicidal ideation.

E. Lau *et al.* (2017) specifically investigates depression, emigration and suicidal ideation. Situations confronted by emigrants are the root cause of mental illnesses that lead to suicidality. Difficulties in life, specifically at the early stage of emigration, are significant. If the duration of difficulties faced is lengthy, there is a higher probability of poor physical and mental health. Poor physical and mental health is strongly correlated with suicidal ideation among new emigrants. The authors conceptualized the emigration stress. Emigration stress includes a broad range of variables. Leaving the family behind exacerbates stress levels. Interacting with new people in the destination country creates new stressors. Loss of social position and having the status of being an emigrant lead to burdensomeness. Being homeless adds to this condition, leading to higher stress levels that often develop into minor or major depression. Both minor and major depression are significant indicators in terms of the development of suicide and related behaviors.

Homelessness is the outcome of financial problems. Without a doubt, financial problems are a key concern for immigrants (Khan *et al.*, 2021, Husna Noor, Naila Hussain, & Maryam, 2024). For most emigrants, financial problems are inevitable. This is one of the reasons for homelessness, and homelessness creates stress, stigma and an inferiority complex, which may lead to suicidality. There is another sort of connection between emigration, homelessness and suicidality. Another indicator is substance use and abuse. The stressors in the lives of emigrants compel them to relieve their stress by using substances, and it is evident from research that emigrants are at risk of substance abuse. The feeling of being alone and away from one's family combined with life without one's own home leads to a feeling of burdensomeness, leading to suicidal ideation.

Linking suicide and related behaviors with homelessness among migrants is a key area of

research for social researchers. In this regard, T. Okamura *et al.* (2014) display that emigrants who are homeless have an increased risk of attempting suicide; this suicidal ideation is as high as 41%. 17% of such people suffer from serious suicide and related behaviors. However, scholars also add other attributes that play a moderating and mediating role when it comes to emigration, suicidality and homelessness. They include the previous history of suicidal thoughts, gender and previous life experiences, such as painful events in life. Gender specifically plays an important role. It is a fact that most emigrants are men, and therefore rates of suicide attempts among men are higher compared to women. Another factor found was the fact that men often remain homeless for longer periods. This is due to the societal response of gendered perceptions leading to relatively quick responses to get women out of poverty and homelessness; whereas men, being masculine, are tough and receive a minimal societal response in similar situations. As with previously mentioned studies, the authors also assert that homelessness leads to suicidal ideations. However, the relationship is not a direct one, as mental illness is the precursor.

C. Lee *et al.* (2017) found that schizophrenia is one of the mentionable mental illnesses found among homeless people, particularly those remaining homeless for 5 years or more. 10 percent of individuals who have been homeless for more than 5 years are reported to have schizophrenia symptoms, which is quite high compared to the general population.

J.H. Hammer *et al.* (2013) assert that Canada's government hasn't been successful in dealing with suicide as a public health issue. Since 1920, suicide has been continuously reported in Canada, and the statistics display the situation getting worse instead of improving. The suicide prevention strategy is there, but it needs to be applied to special populations, such as emigrants, the elderly, individuals with mental illness, etc.

Conclusions

In conclusion, emigrants are one of the social groups most vulnerable to homelessness in Canada. Higher levels of poverty significantly contribute to homelessness among emigrants. Homelessness is very common in Canada among young persons, as many emigrants are young

persons. The percentage of homeless youth is as high as 24% in Calgary. Emigrants are vulnerable to many health-related complications, both physical and psychological. This is because of their socio-economic status. Like homelessness, suicide is a global concern. There is no country that is free from the issue of suicide. However, suicide is relative, and the numbers vary, as do the causes and patterns. There are numerous socio-cultural determinants of suicide in Canada. They range from an individual level to a group level. For emigrants, the situation is the same, and one's personal status and socio-economic status lead to suicidal ideation. For emigrants in Canada, key causes of suicide include low per capita income, unemployment, occupational stress and cyclical fluctuations in income. Such an economic situation among emigrants in Canada is linked with homelessness, and homelessness leads to mental illness. Mental illnesses among emigrants are inevitable facts in Canada. Mental illness among emigrants is the outcome of the socio-economic conditions they deal with, which are poverty, social negation, social stigma, an uneasy life routine, etc. Thus, homelessness creates mental illnesses, and stress, anxiety and depression are culprits for suicide and related behaviors. The synthesis of the review is that there is a three-way relationship: mental illness is common among emigrants and leads to suicidality; homelessness is common among emigrants and leads to suicide and related behavior; therefore, the socio-economic conditions of emigrants can lead to homelessness and mental illness, both of which are associated with suicide and related behaviors.

Conflict of Interest

The author declares no conflict of interest.

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Refugee Crisis in the European Union Countries: Problems and Consequences

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Abstract:

The article presents the results of a study of the negative impact of the European migration crisis (European refugee crisis) on various spheres of European society and the societies of individual EU countries (using the examples of Germany and Poland). The research methodology involves identifying current problems of Ukrainian migrants, assessing the socio-economic situation of EU citizens, assessing the impact of the migration crisis and identifying mechanisms for reducing its negative impact using sociological and expert survey methods. A comparative analysis of the features of the European migration crisis of 2015-2016 and the crisis caused by the war in Ukraine in 2022 was carried out. The main negative consequences of the migration crisis for Europe are identified as: a gradual decline in the economy and inflationary processes, rising prices and housing rents, and overloading of the social

security system, social services, healthcare and the labor market. It is noted that, on one hand, the socio-cultural proximity and similarity of democratic, humanistic values Ukrainians and Europeans share contribute to the integration of Ukrainian refugees in host countries. On the other hand, the positive attitude of national governments and citizens towards Ukrainian refugees can strengthen the process of intolerance towards other refugees of culturally different countries, therefore acting as a factor of internal political and inter-ethnic conflicts. The following mechanisms have been identified to reduce the level of the negative impact of the migration crisis on the EU: economic (redistribution of the EU budget in accordance with the number of refugees in the host country, investing in the restoration of Ukraine after the war); international legal (improving international legislation regarding refugees); political (updating and developing a strategy for the EU migration policy); social mechanisms aimed at social support for refugees.

Introduction

In the scientific circles of European and Ukrainian scientists, the problem of migration and refugees in the European Union has remained relevant for 2-3 decades. At the same time, there are two options for the terminological interpretation of this multidimensional phenomenon. The absolute majority of Ukrainian scientists use the term „European migration crisis“, and among European scientists (and even more politicians and journalists) the term „European refugee crisis“ is very often used [1,2,7,12,13]. However, despite differences in terminology, the European migration crisis („European refugee crisis“) is a negative socio-economic, socio-cultural and socio-political phenomenon that has led to a disruption in the functioning and governance of the European Union as a whole. Additionally, it has entailed a threat to political, socio-economic and security components of stability in individual EU countries.

To date, the greatest migration crisis in Europe occurred in 2015-2016 due to an increase in the flow of refugees from zones of armed conflicts and humanitarian disasters (Syria, Afghanistan, South Sudan, Venezuela, etc.) [6,9].

At that time, the European Union was not ready for such challenges - there was no consensus strategy for the EU migration policy that had been approved by all countries. For Europeans, the „European migration crisis/European refugee crisis“ turned out to be not only a humanitarian and socio-economic crisis, but also as

a crisis of governance in the European Union; it became a real threat to the integrity and stability of the EU as a geopolitical entity [2, p.39]. This was due to problems with the legal foundations of European migration policy, the determination of migrant quotas for EU countries, the determination of the legal status of refugees (although it is based on the 1951 UN Convention relating to the Status of Refugees), and the emergence of security threats from smuggling and terrorism. But the greatest threat to the stability of the EU, according to scientists, was the negative socio-cultural consequences, which in the scientific and political space were called „Islamization“ and the creation of „Eurabia“ (political neologism, English Eurabia), the transformation of European Christian values and a threat to Western civilization that would be brought about using Islamic ideology [1,4,8]. As a result of the integration of Muslims into the Western European community, problems with assimilation, the erosion of democratic values and fundamental traditions of indigenous Europeans, as well as their rights being neglected, have intensified, leading to violations of the legal and democratic structure of the EU.

The full-scale war that began on February 24, 2022, in Ukraine has had a significant impact on European Union countries: firstly, there are socio-economic consequences associated with financial, humanitarian and armed support for Ukraine; the energy crisis and restrictions as a result of sanctions against the Russian Feder-

ation; secondly, security consequences, the essence of which is that the threat of aggression and the example of the use of force against a neighbouring country creates an unstable situation in the region, affecting political relations between European countries; and, most importantly, the migration consequences caused by a large number of refugees from Ukraine to European countries, which in turn requires socio-economic, humanitarian and psychological support from European states and societies (according to Eurostat data as of mid-August 2023, regarding the number of refugees from Ukraine, the number of people who had temporary protection status in the EU reached 4.7 million, and there were a total of 5.88 million refugees from Ukraine in Europe) [3].

Therefore, the purpose of this study is to identify the problems, consequences and mechanisms for reducing the negative impact of the European refugee crisis in the context of the full-scale Russian-Ukrainian war.

Methodology

The pilot study is aimed at identifying the problems and consequences of the European refugee crisis in the context of the full-scale Russian-Ukrainian war, as well as identifying mechanisms for overcoming the socio-economic and socio-cultural consequences of the migration crisis in Europe. The methodological basis of the study is general scientific and it employed empirical methods of knowledge, making it possible to identify the following research objectives: 1) identify current problems of Ukrainian immigrants in host communities of European Union countries; 2) assess the socio-economic situation of EU citizens in connection with the increase in the number of refugees from Ukraine (using the examples of Germany and Poland); 3) assess the impact of the Ukrainian refugee crisis in the EU; 4) identify mechanisms for reducing the negative impact of the socio-economic and socio-cultural consequences of the migration crisis in the countries of the European Union hosting Ukrainian refugees.

Participants

The study involved 580 participants. Of these: 1) 80 were experts in the field of political science, economics, psychology or sociology, or

they were scientists working on the problems of people affected by armed aggression; 2) 200 internally displaced persons from Ukraine who received temporary protection status in Germany and Poland (the average age of the respondents was 39.8 years, of which 74% were women and 26% were men); 3) 300 people living in Germany and Poland and are citizens of those countries (the average age was 42.8 years, of which 64% were women and 36% were men; 41% were citizens of Poland, 59% were citizens of Germany). The study among Ukrainian refugees in Europe and citizens of Germany and Poland was conducted from June-August 2023 together with volunteer organizations and specialists who provide primary psychosocial services to displaced people.

Methods

According to the specific objectives of the pilot study, we used the following methods: 1) to identify the current problems of Ukrainian immigrants in host communities of the European Union countries - a mass sociological survey (random sampling); 2) to assess the socio-economic situation of EU citizens in connection with the increase in the number of refugees from Ukraine - a mass sociological survey of German and Polish citizens living in host communities (random sampling); 3) to determine an assessment of the impact of the Ukrainian refugee crisis in the EU and identify mechanisms for reducing its negative socio-economic and socio-cultural consequences - an online expert survey. To process the research results, methods of mathematical statistics (using SPSS 17.0 software) and a method of content analysis of respondents' answers to open questions were used.

Results

To identify current problems facing internally displaced persons in the EU, 200 internally displaced persons from Ukraine who received temporary protection status in Germany and Poland were interviewed (in Germany there are 28% of such persons of the total number in the EU, in Poland it is 24% [3]). The problems faced by refugees from Ukraine indirectly indicate the general state of the social and economic sphere of societies in European countries (Fig. 1). It is also important to assess the attitude towards

Figure 1 Current problems of Ukrainian refugees in EU countries (several options could be selected)

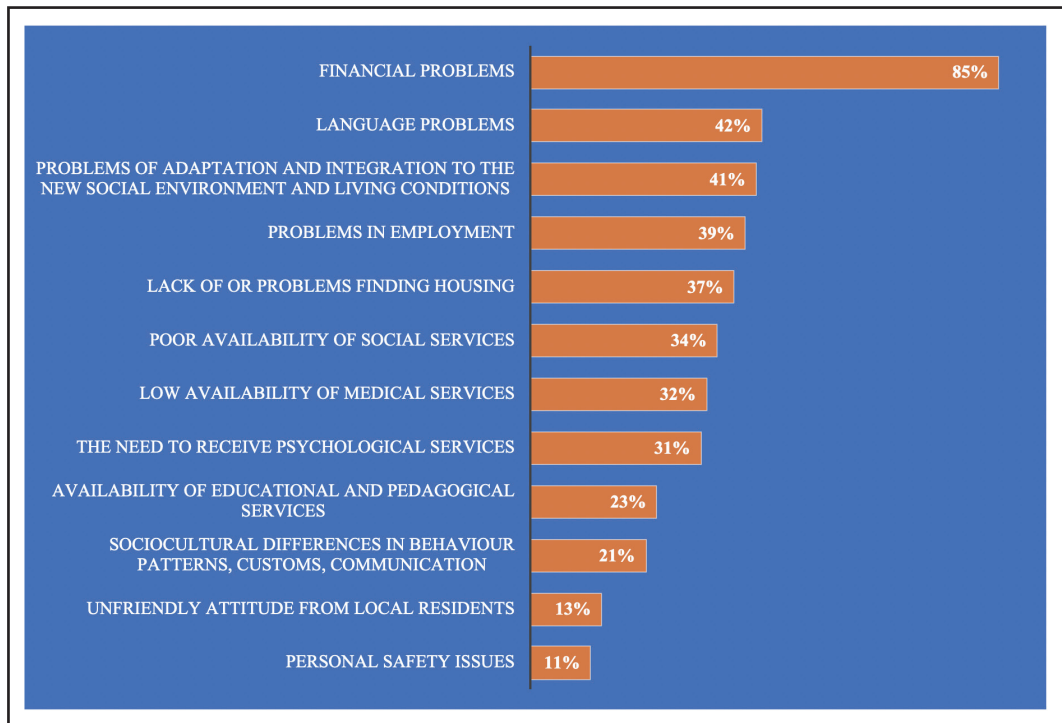
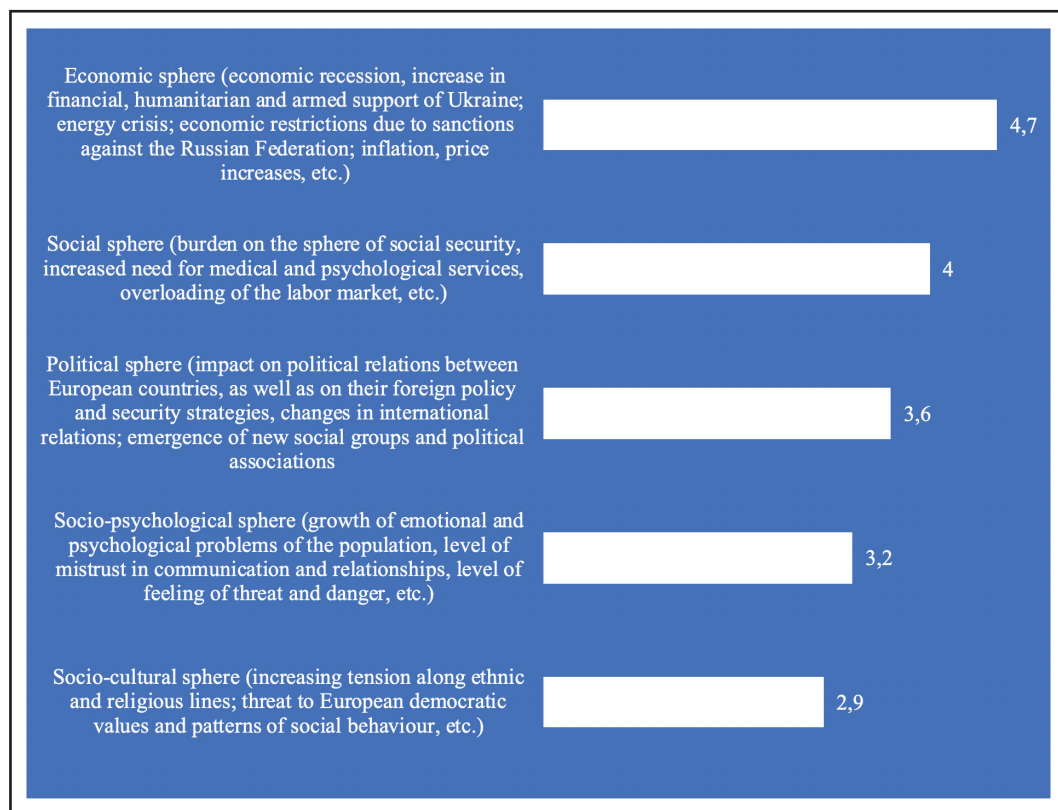


Figure 2 Assessment of the socio-economic situation by EU citizens in connection with the increase in the number of refugees from Ukraine (several options could be selected)



Figure 3 Assessing the negative impact of the migration crisis in the EU on different areas of society

Ukrainian refugees on the part of citizens of host countries: 79% of Ukrainians noted local residents having a positive attitude towards them (according to Gradus Research Plus [5]).

As can be seen from the diagram, the main problems of internally displaced persons from Ukraine are: financial and material (a lack of funds, a lack of housing, job search); adaptation problems that may be associated with unfamiliarity with the language of the host country; accessibility of social, medical and psychological services. Sociocultural differences do not have a significant impact on the social and psychological well-being of Ukrainians abroad.

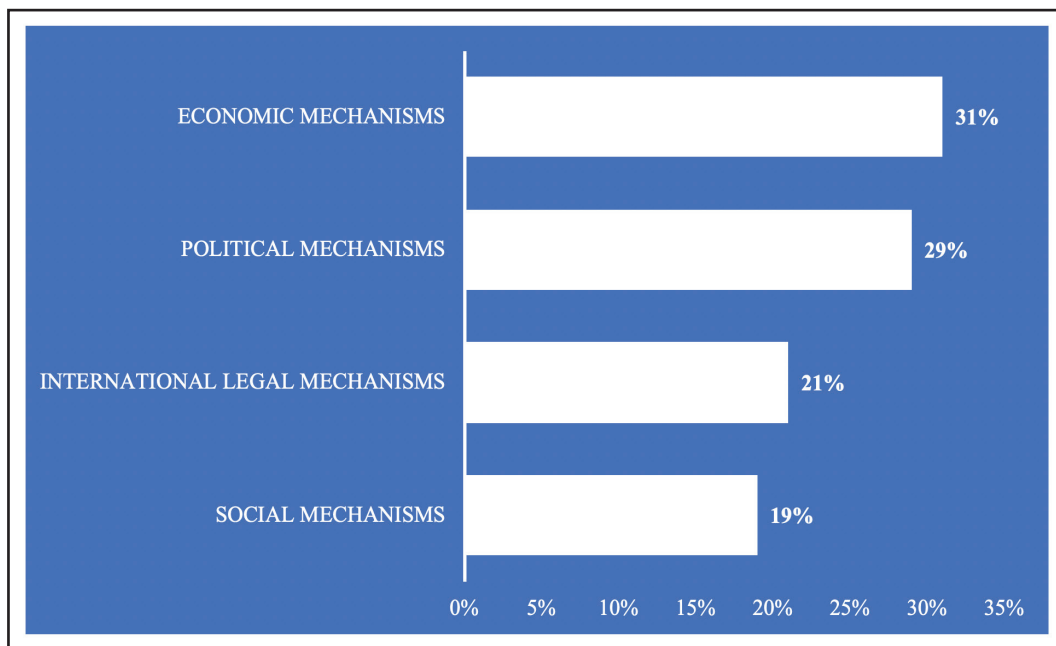
To assess the socio-economic situation of EU citizens in connection with the increase in the number of refugees from Ukraine, 300 respondents – citizens of Germany and Poland – were interviewed. In general, 84% of respondents had a positive attitude towards refugees from Ukraine, and 81% supported the EU migration policy on providing asylum and temporary protection status. Fig. 2 presents the results of an-

swers to the question: „What, in your opinion, was most influenced by the war in Ukraine and the increase in the number of Ukrainian refugees in the EU?“

According to the survey results, the greatest problems brought about by the influx of refugees from Ukraine are socio-economic – rising prices, inflation and job search, although the impact of the global economic downturn should be noted. Respondents also noted a significant burden on the sphere of social protection and social services (21%). It is interesting that the increase in sociocultural and interethnic tension was noted by 14% of respondents. This represents a positive trend compared to the migration crisis of 2015-2016, which was associated with the increase in refugees from Muslim countries [6,10].

Using an online expert survey (80 Ukrainian and European scientists in the field of political science, economics, psychology and sociology), an assessment was made of the impact of the migration crisis in the EU in connection with the war in Ukraine. The experts were asked to rate

Figure 4 Mechanisms for reducing the negative impact of the European migration crisis (results of content analysis)



the negative impact on different areas of society on a 5-point scale (Fig. 3).

According to these experts, the migration crisis has had the greatest negative impact on the economic sphere (4.7 points), which in turn affects the general well-being of the population of European countries. Following this is the social sphere (4 points), which in European welfare states (social states) is a system-forming feature and is associated with a significant burden on the provision social, medical, psychological and pedagogical services. The negative impact on the political sphere (3.6 points) should also be noted, and it is manifested in threats to the integrity and political stability of the EU as a political entity, the radicalization of political views and positions, and tension in political relations between European countries (Western Europe, Central-Eastern Europe, South Europe, Balkan countries, Baltic countries). According to experts, the sociocultural (2.9 points) and socio-psychological (3.2 points) spheres have experienced a lower level of negative impact.

Experts also suggested identifying the most effective mechanisms to reduce the negative impact of the European migration crisis (European refugee crisis). A total of 164 responses from the

surveyed experts were received (answers to an open-ended question). Using the content analysis method, groups of mechanisms were identified and united by semantic and content similarity (Fig. 4).

The content of the selected categories of content analysis is as follows:

- Economic mechanisms (31% of all statements). The semantic content of the category is represented by the following typical answers: „creation of new jobs“, „development of a strategy for the restoration of Ukraine after the war“, „redistribution of the EU budget depending on the number of refugees accepted“;
- International legal mechanisms (29% of all statements). The semantic content of the category is represented by the following typical answers: „improving international legislation regarding refugees“, „involving the countries of North America and the Global South in solving the problems of Ukrainian refugees“;
- Political mechanisms (21% of all statements). The semantic content of the category is represented by the following typical answers: „updating and developing a strategy for EU migration policy“, „political and economic

support by Western European countries for the Baltic countries and Central-Eastern Europe“, „implementation of the idea of common European responsibility for solving migration problems“;

- Social mechanisms (19% of all statements). The semantic content of the category is represented by the following typical answers: „increasing spending on social work and social services“, „ensuring the basic needs of the most vulnerable groups of refugees and people in need of protection“, „social programs for the integration of refugees into host societies“, „involving specialists from other countries, from Ukraine in particular“, „support for public and volunteer organizations“, etc.

Discussion

An analytical review of publications on the European migration crisis and the results of this study of the problems and consequences of the growing number of refugees from Ukraine identified several controversial issues.

Firstly, despite the fact that the majority of migrants and local residents show a positive, friendly attitude towards each other, financial and material problems and problems with the provision of social, medical and psychological services come to the fore. The war in Ukraine affected not only the financial and material losses of Ukrainian refugees in the EU (they became recipient countries of the European Union, which provides social assistance to ensure a minimum standard of living), but also the economies of European countries, whose budgets require additional funds to provide for Ukrainian refugees; this is reflected in rising prices and inflationary processes. On the other hand, Ukrainian refugees competed in the labor market with other categories of refugees who acquired this status before the start of the war in Ukraine. Taking into account such features of the Ukrainian mentality as hard work, education and tolerance, they have an advantage in employment over refugees from the Middle East, Africa and Asia. This could create tension and radicalization among other ethnic communities living in the EU. In addition, there is a significant burden on the social security and social protection systems, social services and the healthcare system, which do not have the resources to cover and provide

services for all the categories of refugees and the local population.

Secondly, if the European migration crisis of previous years (especially 2015-16) contributed to the emergence of such a phenomenon in socio-political opinion as „Islamization“, the signs of which were a threat to democratic values and the foundations of multiculturalism, Ukrainian refugees do not fit into the typical category of those arriving in EU countries during previous migration flows. The similar sociocultural values of Ukrainians and European residents helped improve integration processes [14,15]. This situation poses a threat to the values of multiculturalism, the basis of which is a tolerant attitude towards cultural differences. However, in practice, the crisis of 2015-2016 showed the reluctance of refugees from Muslim countries to integrate into European society and comply with the principles of the rights and freedoms of citizens, as they created their own ethno-national and religious communities (notable examples are France, Germany and Sweden). As a result of the coexistence of different cultural groups in a single socio-economic and political space, it gives rise to problems that force many European countries to abandon the policy of multiculturalism and change their migration legislation. The positive attitude of national governments and citizens towards Ukrainian refugees can strengthen the process of intolerance towards refugees from other, more culturally dissimilar countries, and therefore act as a factor in internal political and inter-ethnic conflicts.

Thirdly, a controversial issue among experts is determining the level of negative impact of the refugee crisis on various spheres of EU society and its national societies, as well as the mechanisms for reducing and overcoming such an impact. As we noted and revealed from the results of the study, most experts agree that the crisis has had a significant impact on the EU economy, especially on the less developed countries of the European Union. Therefore, the main mechanisms for reducing the level of negative impact should be economic ones. Yet, despite the agreement of experts on the decline of the economy and some decline in well-being, there is no unity in determining effective economic mechanisms. Two aspects can be highlighted here: On one hand, many experts consider the most effective

mechanism for overcoming the migration crisis to be the return of refugees to Ukraine after victory in the war. This involves EU investment in the restoration of Ukraine and the creation of favourable socio-economic conditions for the existence and development of citizens. On the other hand, it requires a redistribution of the EU budget in accordance with the number of refugees in host countries and the level of their GDP. In our opinion, such a mechanism is only possible if appropriate political decisions are made and it is the political will of EU national governments.

Conclusion

Based on the results of the study, the following conclusions were drawn: 1) For Ukrainian refugees, the most pressing problems are financial and material difficulties, difficulties with employment, and inaccessibility to social, medical and psychological services. Problems of integration may be associated with ignorance of the language of the host country; 2) Surveyed citizens of Germany and Poland determined that the war in Ukraine and the migration crisis had the greatest impact on the economy and well-being, the labor market, the sphere of social services and social security; 3) Sociocultural proximity and the similarity of the democratic, humanistic values of Ukrainians and Europeans contribute to the integration of Ukrainian refugees in host countries; 4) Experts believe that the migration crisis has the greatest negative impact on the economic and social sphere, and the main mechanisms for reducing or overcoming the negative impact are economic, international legal, political and social mechanisms.

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Psychosocial risk Management of Employees from the perspective of Managers of social service Facilities, case 5P

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Original Article

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Abstract:

Objective: The aim of the research was find out the importance of supporting the management of psychosocial risks of mental health in helping professionals from the view of managers of social service facilities.

Design: Qualitative analysis, pilot pre-research probe.

Participants: Head manager of the Social Services Home for Adults in Zavar, in the Trnava district, creator of an authentic support project, and head manager of the Social Services Home for Children and Adults in Pastuchov, in the Hlohovec district, a participant in the activities of the project.

Methods: At the beginning stage of the preparation of the pre-survey project, the authors designed semi-structured interviews to be carried out with social workers in management

positions with many years of managerial experience in social service facilities.

Results: The intention was to find out what the baseline situation is when it comes to the perception of the importance of mental healthcare. The results of the pilot study aimed at recognizing the authenticity of the 5P support project and reflecting the positive effects of employee participation in preserving one's own mental balance. The source of the greatest benefit is individual self-development.

Conclusion: The case of 5P has become an exemplary model of effective subvention of psychosocial mental health risk management in helping professionals.

Introduction

Exposing important psychosocial factors fundamentally affects the work and power of social and healthcare staff. The accumulation of tasks, the nature of them, and the scale of the workplaces' high demands on professional and human availability can be stressful and affect the mental balance of social and healthcare workers. The priority of the work of the helping professions in the field of social services is the universal benefit for the client. The social worker, as a manager of a social service facility, provides mental healthcare for their staff. This is a current, timeless value and a human resource development benefit; one significant quality benefit is improved access to clients. It is the unique responsibility of the management of social service facilities to create an optimal model of functioning of care for the clients of social services and to eliminate stressogenic factors in this environment that would negatively affect the professional intervention of the helping professions. This process cannot be completed without the application of programs to strengthen the mental health of employees. Social work plays an integral role in setting up support for mental health projects, and this is not only true for social workers.

The aim of this paper is to qualitatively analyze the professional exposure of mental healthcare of social and healthcare staff in social service facilities from the perspective of human resource management and the importance of the elimination of risk factors (so-called psychosocial factors) that determine the mental health of employees of social service facilities. This is a pilot pre-survey and a search for partial answers, which will form the primary research

framework for further scientific research. The authors intended to highlight the significant interaction between mental healthcare and subjectively perceived job performance. A suitable self-relationship of an employee of a social service facility positively profiles the interaction with a social work client. In this context, Bočáková et al. (2023) state that in view of the development of social services, the priority tasks, among others, are a quality guarantee, humanization and deinstitutionalization. In the Slovak area, the pioneering support project 5P of mental health in social services represents a significant advancement in the fulfilment of these tasks in the form of prevention for those who work professionally in social services homes.

Methods

The basic method of the qualitative research, interviews, was used. As this is a relatively unstructured way of gathering data, the following information was presented through content analysis. Interviews have the advantage of exploring a phenomenon in its natural setting while responding to local situations and conditions (Hendl, 2016). The interviews were done with managers of social service facilities who are involved in the implementation of applied mental healthcare into practice among employees in the helping professions of social services.

Pavlicek and Dobrikova (2007) indicate that qualitative research is a process of seeking understanding based on different methods of investigation for a given social or human problem. The researcher builds a comprehensive picture, analyzes information and the views of research participants, and conducts the investigation in natural conditions. The researcher may change

or add questions during the course of the research; the research design may also be changed. We consider these factors to be essential in the decision to use the suggested basic research.

Science considers postulated statements to be true if they are also adopted by others unconditionally and if they are perfectly non-contradictory. We use the consensus theory of truth, which considers a statement to be true when it is accepted by all reasonable participants in a conversation or dialogue (Ondrejkoovič, Ma- jerčíková, 2012).

The basic research concept focuses on the area of maintaining mental balance in the practice of helping professions. At the beginning stage preparation of the pre-survey project, the authors designed semi-structured interviews to be carried out with social workers in management positions with many years of managerial experience in social service facilities in the Trnava self-governing region. The intention was to find out what the baseline situation is in the perception of the attributed importance of mental healthcare. What was of interest was their managerial experience, particularly in the field of human resource management.

Based on the knowledge of theory, observation and social interaction, the premise that there are fundamental differences in the approach of the management of social service facilities to the elimination of psychosocial risks of the work of social and healthcare staff was developed. A key role is represented by the individual availability and erudition of the manager to adapt psycho-hygienic intentions into the management process. Another important aspect is the support of the founder of the social service facilities in the creation of innovative social work methods in the field of mental health maintenance.

The design of the pilot pre-research probe is part of an intended research investigation in which we plan to use a mixed design to gather relevant data on the issue. To understand the essential connections between mental health and psychosocial risks, we contacted erudite social service managers with more than 20 years of experience in management positions. In addition to the length of managerial experience in social services management, additional criteria were determined as education in social work, the location of performance (social services facilities

in the Trnava self-governing region) and participation in the 5P support project.

Results

The first 5P support project started to take form in the context of post-covid rehabilitation of the helping professions in the facilities of the Trnava County in the Centre of Social Services in Galanta. Primarily, it was addressed only to approximately 250 employees after overcoming a viral illness in 21 social service facilities, all of which were founded by the Trnava Self-Governing Region. The purpose was and remains the prevention and support of the recovery of mental balance and the elimination of physical and mental consequences of post-covid syndrome in people who take care of clients of social service institutions on a daily basis. As part of the original 5P project aimed at preventing burnout through psycho-hygiene and a holistic view (body, soul, mind) of the person, there were also additional mental health support modules for the helping professions. Trnava County as a self-governing body offers these services as a non-material benefit for its employees in social services. As of 2019, more than 1,500 employees of social service facilities in the Trnava region had participated in psycho-hygienic rehabilitation (Navzám lepši, 2023).

The role of the 5P support project is to introduce a new perspective into the social service provision system and provide tools and techniques for the psycho-hygienic care of providers. The project, which was created by the management of the social services facility in Zavar, is mainly focused on social service providers themselves, their education and psycho-hygiene. The aim is to provide prevention from the emotional and psychological stress helping professionals have to deal with. This objective leads to improvements in well-being, efficiency, the quality of work and working conditions.

Management practice has shown that for the qualitative development of social service facilities, it is essential to promote a balance between the work and personal life of employees. This is especially true in helping professions. This concept has become a basic part of the management intervention in our selected facilities. It is a broad view of an approach to life that points to the need for self-reflection. Self-reflection is

important for understanding opportunities in the workplace and in personal life. Holistic optics emphasize that the individual components in life form a whole. If we don't have balance in one part, it will naturally manifest itself in other areas. For example, the lack of balance from the area of providing material needs goes to the level of personal development and self-fulfillment.

The project employs an authentic model that is based directly on the needs of social service providers. Every single course is „tailor-made“ for the participants and aims to start a change in each individual. The uniqueness of the project lies in its focus on human individuality and the development of teamwork and synergy as an important requirement for growth in personal and professional life (Pavlovičová et al., 2021).

The partial goals of the project include the detection of one's own experience, reactions and behaviour, the discovery of inner motivation, and the path to internal change. In other words, to find the dimension of inner leadership - the ability to lead others, which helps to guide people effectively and to perform better with minimal energy output.

Psychosocial risk management by social services managers

Part of the delimitation of stressogenic factors in the work of social and healthcare staff is the management of psychosocial risks by the managers of social services facilities. According to Žul'ová and Skolodová (2021), expert studies identify the following as risk factors with an impact on employees' mental health (the so-called psychosocial factors):

- job description,
- workload, work pace,
- working time and its distribution,
- scope for decision-making, control,
- working environment and equipment,
- the culture and function of the organisation,
- interpersonal relations at work,
- position in the organisation,
- career development,
- violence, bullying, harassment,
- the interface between work and home.

Employers are expected to effectively manage individual psychosocial risks and promote the mental health of employees in the workplace. The final product of these managerial activities is work conditions and an atmosphere in the workplace that is stimulating, satisfying, pleasant and safe. In this context, it is essential for the employee to have the opportunity to contact an available professional in the event of an acutely perceived threat to mental health. Current European approaches to counselling suggest that the role of professionals is to guide, motivate and provide relevant information to assist individuals on their journey through life and to facilitate their decision-making. The new approach includes counselling as a continuously available service to all. These factors are also part of the profiling of the support center in the case of our research survey. Being with the client in a way that facilitates his or her personal growth and potential is part of biodimensional counselling (Woolfe, 1999).

In managing psychosocial risks to mental health, the social services manager can build on aspects of biodimensional counselling, which consist of counselling about relationships, trust and a specific form of communication aimed at optimising and stimulating personal development.

Emphasis is placed on the clients taking an active approach to their own life and taking responsibility for themselves in decision-making and problem solving. The content and form is personalized and socialized learning. It includes education, upbringing and training (Hargašová, 2009).

Authentic outcomes qualitative analysis

Managers of selected social service facilities in the Trnava district (Social Services Home for Adults in Zavar and the Social Services Home for Children and Adults in Pastuchov) perceived the risk factors of mental health threats almost identically based on their long-standing practice. In the focus of their own managerial function, they perceived serious psychosocial risks, in particular: workload, working time and its distribution, work pace and interpersonal relationships. Managers at both social services homes identified threats to mental balance in subordinate social and medical staff as follows: work-

load, work pace, work environment and equipment, and interpersonal relationships at work. In the context of managerial risk management, expert studies identify workload as a source of risk in the sense that employee mental discomfort can be caused by a lack of job variation, short work cycles, fragmented or meaningless work, the underutilization of an employee's skills and high levels of uncertainty.

A positive relationship with people is one of the requirements for psychological balance and success at work and in the personal lives of those who help. Social or physical exclusion, isolation, poor relationships with superiors, interpersonal conflicts and a lack of social support are perceived as psychosocial dangers. The priority of social services management is to eliminate them and employ the support of teamwork through educational impulses. Members of a functional work team are aware of belonging to a group; achieving goals is a shared affair. They can identify with their work and the goals to be achieved because they themselves participated in their creation. Each member contributes with knowledge to the correct formulation of the task. An atmosphere of trust encourages the open expression of opinions, disagreements and feelings. Communication should be open with an effort to understand each other. In a functional team, members are encouraged to make the most of their knowledge and skills (Hambálek, 2010).

The head manager of the Social Services Home for Children and Adults in Pastuchov detected specific psychosocial risks in the social or health profession in a broader evaluation concept: „It is a demanding mental and physical job, which is reflected in the lack of staff and interest in the positions. Insufficient salaries also play a role. Another individual risk is the continuous increase in the demands of specific work with clients. In view of managerial risk management, unsatisfactory diagnosis of clients and the lack of specialised facilities providing this type of social service are often a problem.“

In addition to the selected risks, the manager of the Social Services Home in Zavar, who created the design of the project in the individual focus group, registers an enormous burden and unsolved question marks: „For the helping professions in particular, deciding whether to be a person first - a woman, a mother,... or a 'role'

- doing an expected behaviour. It exposes the enormous pressure on just the professional role from society - criteria, standards, inspection... From a manager's point of view, I realise there are many absent common sense and realistic horizons. The helping professions in social services are often looked down upon in society, and there is a lack of decency, respect and increased arrogance, even though social and health workers are the people who look after the most difficult group of clients, who often no one is interested in.“

Stress creates one of the so-called challenging life situations, which are usually unpleasant events causing all sorts of difficulties and activating considerable efforts to cope with them (Nakonečný, 2015). Therefore, the managers of the selected facilities agreed that the workplace is an appropriate place for mental health interventions for employees. The manager of a facility in Zavar explains the innovative attitude of the management of social service facilities about the mental healthcare of employees: „In the horizon of changes and many concepts of social services after the adoption of Act No. 448/08 Coll. on Social Services and its revisions, it is the view of mental health that has changed significantly in a positive way. Since 2019, the Trnava self-governing region has been very actively caring for all its employees in the helping professions with the 5P project, which is comprehensively based on a holistic view and supports all provider resources. An interactive book has been published with coaching tools under the title 'Better Together'. Approximately two thousand employees of social service institutions in the Trnava self-governing region have been trained. We are preparing a Mental Health Institute. The 5P project is innovative and directly 'tailored' to the needs of the helping professions, taking into account the topicality of the times, post-covid rehabilitation and three-day therapeutic stays offered to maintain and develop mental health. „It should be remembered that the project involves all employees in social service institutions, regardless of their profession.

Discussion and conclusion

The reason why the management of social service facilities should attend to the mental health issues of their own employees comes

Table 1 SWOT analysis of potential psychosocial risks

S - Potential internal forces	W - Potential internal weaknesses
<ul style="list-style-type: none"> • strong and receptive management • regular supervision • positive interaction between manager versus social and healthcare worker • self-management of the manager 	<ul style="list-style-type: none"> • staff fluctuation • lack of qualifications in some positions • interpersonal relations in the workplace • communication barriers
O - Potential external opportunities	T - Potential external threats
<ul style="list-style-type: none"> • founder's support • own project and educational program in the field of mental health • the use of therapeutic stays aimed at removing stressogenic factors 	<ul style="list-style-type: none"> • uncertain financing perspectives • low wages and employee benefits compared to similar positions in other sectors • lack of funds for investment

(Source: author's own processing)

from the primary managerial task, which is to guarantee the effective functioning of the organisation. To do this, management emphasizes that personal goals are achieved through individual efforts and organisational goals require collective action. Managers achieve goals by influencing other people (Dravecký, 2015).

In the pilot pre-research probe, it resonated with both managers: „In our case, effective psychosocial risk management can only happen if management and staff support each other, listen to each other and bring new things to the table that will be put into practice.“

Positive group behaviour, which occurs as a result of a positive team of working people in work groups, plays a role here. Group ideology and cohesion, communication channels and identification with the group can significantly affect the mental balance of an individual in both positive and negative ways. The dysfunctionality of a group is caused by an unnatural and formalised atmosphere, frequent discussions that lead nowhere and healthy discussions being obstructed by dominant members of the work team. Employees do not listen to each other, and decisions are not made together or are not justified. They do not feel free to express their opinions. Employees do not know the goals and standards of the facility, and individuals on the work team avoid work or let others do the work for them (Armstrong, 2009).

The management of the social services home that created the project and another one that is

part of the implementation of different modules of mental health support see the essential positive aspects brought about by the participation of their staff in them. The exposed evaluations of the managers of the social service homes were united in the intersection of the necessary evaluation of the social area of human resource management, which mainly follows:

- creating the conditions for job satisfaction, job content and the work environment,
- the internal working climate, building employee loyalty to the organisation, the use of appropriate motivational tools
- appropriate development of incentive programs to encourage skill development, creativity and initiative to solve the organisation's problems (Vaverčáková, Hromková, 2018).

On the basis of the internal knowledge of the selected social service institutions and their managerial management, we profiled the evaluation construct of psychosocial risk delimitation in the performance of managerial, social and healthcare professions with regard to both opportunities and weaknesses by means of a SWOT analysis in Table 1.

The consensus of the results of a pilot study aimed at recognizing the authenticity of the 5P support project reflects the positive effects of employee participation in preserving their own mental balance. The source of the greatest benefit is individual self-development. The real source of long-term and lasting change is invest-

ment in education and therefore the development of the human potential of employees. The added benefit of social service management's concern for staff mental health development consists of a change in perception and a holistic view of the social service provider. Teamwork, creativity, self-expression, willpower, self-confidence and self-satisfaction are found in the social and health professions.

It is necessary to establish a formal mechanism to provide tools for management to consult with employees about issues of mutual concern. The exchange of views and the sharing of knowledge and experience in a partnership system emphasises the mutual benefit and importance of cooperation between the manager of a social service facility and those in the helping profession.

The manager has the opportunity to design a counselling program focused on psychosocial skills oriented to interpersonal relationships, mental balance and self-development. The helping professions must be saturated with opportunities for personal development in effective communication, openness and willingness to accept feedback, in basic group counselling techniques and procedures, in learning a new concept of life and healthy action, i.e., assertiveness.

The results of the research study in the regional conditions of the Trnava self-governing region clarify that successful management of psychosocial risks among employees of social service institutions includes individual consultations, coaching in the area of self-confidence, self-satisfaction, the elimination of discomfort, the fear of responsibility and authority, effective communication, improvement at work (employee) and partner relationships.

It has been shown that the concrete implementation of mental health support programs is largely dependent on the supporting material, in this case the Integration Centre in Galanta. Psycho-hygiene support includes conferences, inspirational stays, holistic health festivals, community, walking, tea at five, and others. Improving individual resilience in European workplaces will be crucial in the future to minimize the risk of burnout and increase the well-being of employees (Butz, Mrazova, Deaconu, Czirfusz, 2024).

In addition, we reflect on the fulfilment of the vision of making the social services facility

a holistic centre of mental, spiritual and physical balance. It is encouraged not only by the managerial expertise, but also by the social worker's conceptual equipment to create active living programs. Social workers themselves must humanely walk the way of responsibility and prevention towards mental health as a result of inner balance. However, it is highly strategic for them to implement and develop comprehensive and innovative programs. This not only increases the working efficiency of human resources, but above all exposes the qualitative development of interpersonal relationships in the workplace. This is especially true for the necessary activism in the work of the social and health professions.

Helping professions in social services are in continuous contact with clients. They are often exposed to their negatively accented attitudes or feelings, which disturbs the psychosocial balance and in the long term leads to burnout syndrome. Other factors posing psychosocial hazards to mental health include an excessive or insufficient workload, a machine-like pace of work, high levels of time pressure and constant exposure to deadlines.

Prevention is important. Zaskodna et al. (2023) say for example, that personal engagement, particularly the emotional engagement of individuals who take care of a dependent member of the family, can result in a caregiver burden, specifically manifested by stress. The purpose of this paper is to emphasize positive approaches and theories in the context of a selected psycho-hygiene practice that is applied to eliminate psychosocial risk factors in social work practice, specifically in social service staff. The role of managers of social service facilities is to provide support for the staff and the clients themselves and to promote the profile of the integrated personality.

Part of coping with psychosocial risks is taking a constructive approach to the value of mental health in the management of a particular facility. It should respect the principles of salutogenesis, i.e., perceiving individual sources of health and a whole, holistic understanding of the human being as a bio-psycho-social and spiritual entity with unique needs.

Kováčik and Imrovič (2019) explain there is a growing problem with the lack of skilled labor

in some sectors of the economy. This also applies to social services.

The case of the 5P project clearly showed that it is not only in the helping professions that we need to change our attitude to life and look for a sense of integrity. This especially goes for the coherence of meaningfulness, the perception of the manageability of tasks and the ability to understand what happens around us as a comprehensibility measure. In a fundamental way, this builds the resilience of the helping profession along the lines of self-awareness, self-regulation, critical thinking, realistic optimism, perseverance, relationships and energy management. The case of the 5P project has naturally become an exemplary model of effective subvention of psychosocial mental health risk management in helping professionals.

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The impact of the Syndrome Burnout of professional Workers in facilities social Services

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Abstract:

This study is focused on the effects of the syndrome burnout in professional workers in helping professions. The study presents the importance of professional workers in helping professions. It describes prerequisites, roles, obstacles, risks and problematic situations closer specified professions. Next solves the theoretical and practical starting points of the syndrome burnout. Aims to the causes syndrome burnout and diagnosis. It characterizes the consequences impacts on professional workers. Next with deals with the research methodology and states the established research questions and the goal research. Describes the time plan, presents the research plan set, sets criteria and lists collection techniques data. The

study presents the overall results of standardized MBI and BM questionnaires and their evaluation. Throughout the creation of qualitative research proceed according to ethical rules and the anonymity of the participants is respected participants. Main goal study is acquisition, analysis and evaluation information at finding out impacts syndrome burnout in professional workers in helping professions in facilities social services.

Introduction

Today's modern times record the development of the syndrome burnout. They contribute to this state increasing with demands on work performance and accelerating with the pace of life. Continuous occurrence of the syndrome burnout is increasing. It is caused the present time, which is characterized by fast life style and everywhere those present by stress. Syndrome burnout is basically a state of chronic stress and is a danger in life for people with a very high workload pace and workload. This condition leads to physical, mental and emotional exhaustion, cynicism, detachment and even feelings of imperfection and inferiority. He discovers with mainly among workers in assisting professions who they don't have to indifferent to his work approach. It has harmful consequences not only for its so-called victims, but also causes a deterioration in the quality of care provided in facilities social services.

When with syndrome burnt out is coming, you are no longer able to effectively function on a personal or professional level. However, burnout does not happen suddenly. You won't wake up se and you will not find out that you have the syndrome burnout. His nature is much more insidious, syndrome burnout with creeps very slowly, which is a lot harder to recognize Syndrome burnout is not just a random feeling of tiredness after working a difficult day. This is a deep chronic state of exhaustion, which is rooted in the psyche man. The dominant characteristic is above all how we are already they mentioned psychological exhaustion, which it mainly manifests in the field of cognition, motivation and emotions. It affects and affects the attitudes, opinions, performance and entire patterns of the professional behavior and actions. Effects of the syndrome burnout with they do not only concern the work sphere. They disrupt personal relationships, leisure activities and the

overall quality of life. People resistant to various stressful situations with they are characterized by having balanced eigenvalues. They focus on yourself, family and friends. If this is not the case, an internal conflict arises, which is emotional burdensome and exhausting. That's why it's important attach a less important role to a permanent partner relationship in life and are satisfied to the family.

In submitted studies we will focus on the effects of the syndrome burnout among professional workers in facilities social services. Studies we focus on professional workers in helping professions. We deal with the characteristics of these professional workers and we describe assumptions, roles, obstacles, risks, conflict situations, problematic behavior, mobbing, bossing and staffing. This is a situation, se by which with these workers are most often at work environment they meet Next with we pay attention to stress and define its burdens. Next with we dedicate syndrome burnout, we will introduce theory domestic and foreign authors who with deal with this issue. We will explain risk factors and describe perspectives on the causes of burnout. We describe the differences of the syndrome burnout from negative psychological.

In the empirical part studies with we deal with research methodology, in which we present the established research questions and objective research. We describe the time schedule for the creation of qualitative strategy and we present the characteristics of research file, in which we set the selection criteria research file. We define collection techniques data by which are ethical research rules, secondary data analysis, semi-structured interviews with open questions and standardized MBI and BM questionnaires. A sample of empirical research brings us closer to our own research investigation, which we carry out at twenty four participants that device social services. We dedicate with analysis and

coding of semi-structured interviews. We all of them directions, we proceed according to ethical rules qualitative research.

In conclusion with we devote to the overall summary of the questionnaire survey and describe the discussion. We deal with answers to one main research question question and amount goals. Subsequently, we define recommendations for practice.

1. Professional workers in facilities social services

Social work is in constant development and is implemented through social services. It is important in order to respond flexibly to social problems which with daily solves and to be solved well, it is needed have enough quality professional workers. In part studies we will focus on professional workers in helping professions, to define the concepts of helping professions, state prerequisites and role of professional workers in helping profession. Next we will describe obstacles and risks of the work of experts in helping professions and workplace conflicts.

Ideal helping the worker is according to Nettles (2006) prosocially oriented mature a personality that is aware your own of life direction. A personality without neurotic and psychopathic traits and with an assumption the art of independent decision-making and action. This is a group of professions whose the aim and content is, as stated Hartl and Hartlová (2010), providing help and support with the principal focusing on the individual needs individuals.

Workers in helping professions they have own specific features. These features distinguish them from others profession. Kopřiva (2013) points out the most essential and that is relationship and trust between client and professional worker in helping profession. In this created relationship with assumes, as stated Nakonečný (2021) above all with a high degree of empathy, helpfulness, understanding and assurance of trust that arises between client and professional worker in helping profession. Between helping profession we rank according to Malíková (2020) doctors, nurses, medical workers, caregivers, psychologists, psychiatrists, therapists, social workers, but also special pedagogues and educators. In a broader view, less often to help by profession pedagogues, physiotherapists and

masseurs also assign. They didn't have to we would forget the individual main components of the Integrated Rescue System, which they include the fire brigade, the medical rescue service and the police.

Carrying out work in this industry it is not easy and it is not suitable for everyone. It is mentally and physically very demanding. To eat could worker in helping profession perform effectively, it should have certain prerequisites. Matoušek (2021) describes that one that basic assumptions which they are for performing work in helping important in professions is intelligence, fitness, ability and will to try with to constantly expand and enrich their knowledge with new theories and practical techniques that could to be more effective at solution theirs working tasks. This work, as Malíková (2020) points out, is based on mainly on the relationship between professional worker and client. In helping professions is necessary and important teamwork and holistic approach of the whole multidisciplinary team. Social work enables people increase the quality of life. The quality of care is in the foreground interest professionals and the public.

1.1 The role of professional workers in helping profession

The tasks of professional workers in helping professions is above all according to Mlýnková (2017) direct client care, medical care, health care, social care, rehabilitation care and care on the part of occupational therapists and activators workers. This care with each other connects. Therefore, the cooperation of the entire team is important workers. Main goal workers is improving the quality of life of clients who are in facilities social services they live.

The role of the doctor in the facility social services

Medical care is provided through contractual doctors in the facility. In case device social services these are external employees and doctors occurs at agreed regular intervals. Very narrowly they cooperate with the head nurse and social workers workers.

Doctors they provide professional medical care care and closely they cooperate with others specialists in the relevant fields. Performs

income of new clients to the facility social services, comprehensively assess the health status of clients in the facility social services. They make entries in the documentation. They recommend next intervention, according to which the multidisciplinary team is progressing. In the team, each member has his own responsibility expertise and at the same time everyone brings your own view of the matter.

The role of the general nurse in the facility social services

The content of the job consists of good knowledge in the field of complex nursing care that is provided mainly for the purpose of support, restoration of health, bio-psycho-social and spiritual satisfaction needs. Malík- Holasová (2014) further states that the general nurse participates in development and preservation existing self-sufficiency clients. Another activity of the general nurse is the diagnostic-therapeutic task, which includes activities related to interventions based on indications doctor with subsequent observation clients. The role of general nurse is needed include the manager activity where the nurse is responsible for the quality of nursing care provided care. However, as expressed by Mačkinová, Masaryk and Musilová (2014, p. 463), “A sedentary way of life and monotonous one -sided work burdens the movement system of an individual.” This health condition is not good it also affects mental health.

The role of the social worker in the facility social services

The basic role of a social worker is the effort to integrate knowledge, values and skills into practice. A social worker should have a general overview and ability mobilize human and material resources in benefit clients as stated Matoušek (2021) and should not specialize only for one method. Thanks methods recognizes and maps the problems of unfavorable ones situations needs and resources of the client. Performs social investigation. It is discussed interested parties social services. He is looking for opportunities to work with his family. Follows ethical principles.

Social worker as advisor ensures social and socially legal consultancy according to the statutory legislation, which it is related to the ap-

plication of the right to financial or material possibilities of support and assistance. It helps clients get insight into their attitudes, feelings and ways negotiations. Handles applications for care allowances and negotiates contributions to medical devices. It solves guardianship matters. He participates meeting at the authorities at processing guardianship, property and inheritance settlement, notary's agenda. Preparing provision contracts social services.

As a methodologist, he creates procedures and fillings work activities for other workers. It evaluates the provided social service. Drafts internal documents of the organization. Processes and updates internal regulations to standards of the quality of care provided. Performs evaluation questionnaires satisfaction and fulfillment goals for clients and employees. Records, solves and evaluates complaints. Updates individual planning. Methodically leads the key workers.

The social worker is the main one participant communications between client and family, client and guardian, organization and guardian or family. Contacts guardians and family members at changes in the client's life, at changes in the services provided. Maintains correspondence with family members. Ensures consent signatures and processes powers of attorney. At terminally ill patients, “social workers try to help clients fulfill 4 kinds of wishes which with I strive solve before death.” (Mačkinová – Okech, 2017, p. 75)

The role of the caregiver in the facility social services

The caregiver's activities are described by Mlýnková (2017), they are focused on the performance of direct service care for clients . These are hygiene care, general baths, changes incontinent aids, care of the bed and personal belongings, dressing, putting on shoes, prevention of pressure ulcers and positioning. Caregivers they are responsible for the distribution and serving of food, for the correct one administration of specified diets. Prudká (2015) characterizes other activities which they are important in the care of clients in facilities social services. Between these activities include practicing simple daily activities, supporting self-sufficiency, creating basic and social contacts and satisfaction psychosocial needs. Each individual has his

own needs. Between the most famous theory needs we can sort Maslow's hierarchy of needs. (Čulenová, Nowak, Mačkinová, 2021)

1.2 Obstacles and risks in helping professions

Professional worker in helping professions with can in professional life encounter obstacles and risks, which over time could lead to a disruption of the balance, as he states Mátel (2019) and negatively affect the quality of his work. The most common problems, with by which professional workers meet, there are conflicts at the workplace, problematic behavior at the workplace, mobbing, bossing, staffing, stressful burden and syndrome burnout.

2. Syndrome burnout

In the second part studies with we devote to theoretical knowledge syndrome burnout. Most often they are hereby phenomenon reached professional workers in helping professions. This phenomenon represents a metaphor characterized by Gazdíková (2017) from the English verb to burn, which means to burn, while in phrase burnout it is an expression to burn out, to burn out, to go out. In individuals who they are disabilities symptoms syndrome burnout, precedes initial fierce burning fire, symbolizing strong motivation, extreme interest, excessive activity with extreme by deploying in a state of burnout, extinction and burning.

Actually in other words, a uniform definition syndrome burnout does not exist to this day. Illustrative metaphorical example syndrome burnout states Rush (2004), which this phenomenon compares to candles. When man it lights both ends of the candle, so to speak acquires more lights, but a candle faster burn out. A brief description is also provided by Stock (2010), according to which is a syndrome burnout explicitly conditional consequences of chronic stress. An idea about the syndrome burnout states Nešpor (2007), who defines it as a state of maximum physical and mental exhaustion. In practice, we could also label this state like emotional exhaustion. In humans there is a massive loss of physical strength, gradual extinction all of them body strength, loss of energy and general loss of desire to exercise any work activity. Röhr (2013) also points out that an insufficient sense of self-

worth significantly complicates the lives of many of us and large I will fall syndrome burnout on a person are frequent depression, anxiety, psychosomatic diseases and in the worst case different forms of addiction. Collective authors Matoušek, Kodymová and Koláčková (2005) define the term syndrome burnout like a set of typical symptoms which with occur in professional workers.

2.1 View of the causes of the syndrome burnout

They are common features, according to which we can have generalized look at the causes syndrome burnout. It gives a brief description Prieß (2015), which indicates that the real cause syndrome burnout is the occurrence of a health deficit relationship to oneself and the environment. With such a one a person who lives in a stereotyped way develops a dislike for living. The main ones triggers syndrome burnout they are according to Honzák, Cibulka and Pilátová (2019) chronic stress, permanent time pressure and high emotional tension. It's a reaction body and above all mind for long-term mental exhaustion, intense preoccupation with a certain task and everyday stress. We must not forgetting that the professional staff in the facilities social services they very often encounter challenging and critical situations. It depends on their handling Mačkinová and Musilová (2017) suitable to use the development of human personality using the bibliography method.

2.2 Diagnosis of the syndrome burnout

Superhuman performance they are situation, when and how to convince the person who very much well known to visit a specialist and let himself in detail investigate. Why investigate? Because we suspect that he suffers from the syndrome burnout. We have been observing certain characteristics of this phenomenon for a long time. As stated by Kopecká (2011), such an affected person man can to be almost without preview. In his thinking prevails belief that he definitely does not suffer from the syndrome burnout. However, as Mačkinová, Keketiová and Vavrčáková (2014, p. 987) say, "knowledge of personal identity is important for each of us."

As stated Študentová (2016) are most often used questionnaires based on observation

scales. For one of the basic diagnostic methods are considered detailed personal anamnesis, where the subjective one is followed experiencing and perceiving individual symptoms. Another diagnostic method is a somatic examination. Most importantly further objective diagnostic methods is considered series special psychological examinations, which they are directly designed for the diagnosis of the syndrome burn out and are objectively accurate.

Simple method is according to Kurucová (2016) orientation questionnaire, which compiled authors Dno Hawkins, Frank Minirth, Chris Thursman and Paul Maier. This method is based on cognition approaching with the condition of the syndrome burnout. It is suitable for anyone who wants to find out, evaluate and reveal your own relation to the syndrome burnout. The questionnaire is made up of 24 items and participants mark answers to dichotomous questions yes or no. The more positive answers are marked, the more is signaled by the syndrome burnout. On the other hand, negative answers tend towards denial syndrome burnout.

Another one very much acquaintances the questionnaire is a standardized MBI questionnaire (Maslach Burnout Inventory), which serves as stated authors Kebza and Šolcová (2003) to findings degrees syndrome burnout in the emotional area. This questionnaire was for the first time published by the authors Christine Maslach and Susan Jackson in 1981 and later modified in 1986. The questionnaire consists of 22 statements, each of which focuses on one of the three dimensions of the questionnaire. Nine questions is focused on emotional exhaustion. Five questions are focused on depersonalization and the rest eight questions directed to the area personal satisfaction.

Emotional Hřebíčková (2011) considers exhaustion to be the most authoritative indicator syndrome burnout. It describes a person who experiences emotional states exhaustion, loss of zest for life, lack of strength and negative motivation for some activities. In depersonalization there is a loss any respect for other people. Most often with occurring in helping professions. People suffering depersonalization they have feelings of inadequacy reverse bonds, breed becomes cynical, disappears with respect and very much quickly they become bitter (Poschkamp, 2013).

3. Empirical part

Main goal this research studies was acquisition, analysis and evaluation information at finding out impacts syndrome burnout in professional workers helping professions in two selected devices social services. We carried out the research specifically in two devices social services - for study purposes named device social services A a device social services B.

In ours qualitative research we are due to the sensitive topic mainly used individual method collection data, as in semi-structured interviews as well as when filling out standardized MBI and BM questionnaires. Based on main goals research and within implementation qualitative research we set the main research question and the secondary one research questions.

HVO: They have sociodemographic data of participants that device social services influence on the possible effects of the syndrome burnout?

VO1: What is the incidence rate of the syndrome burnout according to standardized MBI questionnaire for professional staff in the facility social services A in comparison with device social services B?

VO2: What is the rate of occurrence of psychological exhaustion according to standardized BM questionnaire for professional staff in the facility social services A in comparison with device social services B?

Collection technique data

For collection data we used the method secondary data analysis, method semi-structured interview with open questions and standardized MBI questionnaires (Maslach Burnout Inventory) and BM (Burnout Measure). Based on we implemented these techniques and created record sheets for twenty-four participants from among professional workers that of the two device social services who provided us with this valuable data. Throughout the creation of qualitative research we followed the ethical rules of research.

3.2 Research file

Participants for qualitative research studies we are they chose method intentional selection. File participants for the research studies formed in total twenty four professional workers in helping professions, ze two device social services. At

intentional selection participants that two device social services we are with they focused on the basic criteria, which were the number of years of experience in the field at the facility social services, education of participants and age category participants.

4. Interpretation of the obtained data

In this one parts studies we are dealt with the results of the collection data from the implemented standardized questionnaire MBI and BM and marked them in the following table no. 1. In the table we are tried to be concise and clear characterize and divide research file participants according to device social services, which these professionals perform my own profession. Next we characterized the age participants, education, number of years of experience in helping profession, standardized results psychological burnout questionnaires (BM), standardized results MBI questionnaires from the areas of emotional exhaustion (EE), personal satisfaction (PA) and depersonalization (DP).

Table 1 Overall results of the BM and MBI questionnaires from device A and device B

Participant (+ mark ZSS)	Age (years)	Education	Practice (Years)	BM	MBI EE	MBI PA	MBI DP
P1 F (A)	43	Trained	16	3.23	43	24	17
P2 M (A)	61	University	21	1.57	33	34	17
P3 F (A)	53	Primary	22	3.81	36	37	24
P4 F (A)	48	University	10	2.80	47	33	19
P5 F (A)	41	Trained	12	4.09	43	30	20
P6 M (A)	50	Trained	8	4.46	36	31	18
P7 F (A)	44	Secondary	6	4.29	40	28	15
P8 F (A)	41	Higher Vocational	3	4.00	46	31	20
P9 F (A)	42	Trained	7	2.78	37	28	20
P10 F (A)	44	University	25	3.23	33	32	19
P11 F (A)	43	Trained	8	3.29	40	27	17
P12 F (A)	52	Trained	7	2.63	41	30	21
P13 F (A)	61	University	18	2.62	49	29	19
P14 F (B)	39	Trained	2	3.33	32	29	18
P15 F (B)	47	Primary	15	3.47	46	33	20
P16 F (B)	51	Higher Vocational	24	2.63	38	37	19
P17 F (B)	43	Primary	4	3.48	43	30	13
P18 F (B)	48	Secondary	6	4.08	37	32	20
P19 F (B)	46	Secondary	20	2.68	42	36	13
P20 F (B)	41	Trained	5	3.88	46	33	20
P21 M (B)	47	Primary	25	3.88	36	33	22
P22 F (B)	41	Trained	9	4.08	44	35	20
P23 F (B)	49	Secondary	15	4.34	37	34	9
P24 F (B)	46	Secondary	13	3.04	36	37	4

Source: own processing

4.1 MBI questionnaire

Standardized Maslach questionnaire Burnout Inventory - MBI belongs between the most frequently used professional methods at research syndrome burnout. We decided with use the Czech version standardized MBI questionnaire. Its individual items are comprehensible and filling it is not time consuming. The MBI questionnaire belongs between the most used methods for expert examination syndrome burn out and find out basically three factors (Žídková, 2013).

The first is the EE factor (emotional exhaustion) - emotional exhaustion. It manifests with loss of zest for life, lack of it strength for any activity, zero motivation for any activity. EE is considered basic and most authoritative symptoms syndrome burnout. For evaluation emotional exhaustion applies, the greater it is the measured value, the higher the degree of measure evaluation. The second is the DP factor (depersonalization) - it manifests with loss of respect for other people as to human beings. This factor is clear in people with a large the need for reciprocity. This means that they need a positive response from people who with dedicate. For evaluation degrees depersonalization applies the same principles as with the previous one. This means that the higher the measured value, the higher the degree of measure burnout. The third is the PA factor (personnel accomplishment) - reduction of performance. With this factor with we will meet mainly in people with a low level of healthy self-esteem and self-confidence. They have lack of energy to coping with stressful situations. The higher the value, the better the result more positive. And the lower the measured value, the higher degree of burnout higher.

There are nine in the MBI questionnaire questions focused on the emotional exhaustion. Five questions are focused on depersonalization. Eight questions is aimed at reducing performance. In this questionnaire, feelings are evaluated on the scale of frequency of occurrence and on the scale of occurrence of intensity and strength. The total score of individual factors is evaluated. In practice it is more suitable use only one of the indicators. Mostly with uses strength feelings.

Table 2 Results of the standardized MBI questionnaire from ZSS A and ZSS B

Professional workers in helping professions	Degrees of burnout of ZSS A			Degrees of burnout of ZSS B				
	MBI	Low	Moderate	Total	MBI	Low	Moderate	Total
Doctor	EE	1			EE	1		
ZSS A:1	DP	1			DP	1		
ZSS B:1	PA		1		PA		1	
Nutritional therapist <small>(She was not present in ZSS A)</small>	EE	-	-	-	EE	1		
ZSS A:0	DP	-	-	-	DP	1		
ZSS B:1	PA	-	-	-	PA	1		
Nurses	EE		1	2	EE	1		3
ZSS A: 3	DP			3	DP	2		2
ZSS B:4	PA		1	2	PA		2	2
Caregiver/Caregiver	EE	2		5	EE			4
ZSS A: 7	DP	1	1	5	DP	1	1	2
ZSS B:4	PA	2		5	PA		3	1
Social worker	EE		1		EE			2
ZSS A: 1	DP	1			DP	2		
ZSS B: 2	PA	1			PA	1	1	
In total		9	5	22		12	8	16

Source: own processing

We are in the table no. 2 with devoted to the description of the results standardized MBI questionnaire according to degrees burnout collectively for items emotional exhaustion (EE), personal satisfaction (PA) and depersonalization (DP).

Of the total number of twelve participants that device social of services A was one doctors, three nurses, seven caregivers and one social worker. According to there are nine of the results of the questionnaire survey participants that all of them three items standardized MBI questionnaire present low degree of the syndrome burnout. At five of participants is present mild degree of the syndrome burnout. Twenty-two participants have a high degree of the syndrome burnout. At the device social there were twelve B services participants, which consisted of one doctor, one nutritional therapist, four nurses, four caregivers - caregivers and two social worker. For 12 participants we noted a low degree of the syndrome burnout, 8 participants moderate degree and 16 high degree of the syndrome burnout.

4.2 Questionnaire BM

Authors standardized BM questionnaire (Burnout Measure) are Dr. Ayala Pines , PhD., and Dr. Elliot Aronson , PhD. The questionnaire was created in 1980. It is a test of psychological burnout. This method looks at the syndrome burnout that three aspects. First aspect is the feeling of physical exhaustion. The second aspect is feeling emotional exhaustion. The third the aspect is the feeling of the mental exhaustio . For its high internal consistency and reliability

is very important popular (Zámková, Rigorous Thesis 2018, In: Melgosa, 2001). We used this standardized questionnaire to findings degree of psychological burnout. Participants filled in the marked boxes for 21 questions with numbers indicating according to the key below strength feelings that they usually experienced.

Strength feelings : 1. never, 2. once in a while, 3. rarely when, 4. sometimes, 5. often, 6. usually, 7. Always.

The questions are deal with by the degree of fatigue, physical and emotional exhaustion, feelings of happiness and energy, feelings of anxiety, fear , worthlessness and hopelessness. After that with according to the given formula calculated the value of BQ which indicates of peace threat syndrome burnout. These BQ values were divided into five groups and a certain rate was assigned to them threat syndrome burnout. The lowest BM values (i.e. BQ = 1.9 and below) indicate a very good result. The individual is not at risk at this time syndrome burnout. If BM = 2 to 2.9, the condition is satisfactory. If the resulting BM value is between 3.0 and 3.9, then with recommends to think over life and work, over style and meaningfulness own life. If the overall result is BM = 4.0 to 4.9, it can be considered presence syndrome of psychological exhaustion beyond the proven . If the result is higher than BM = 5.0 or higher, it is necessary considered as a distress signal. It is present in the individual syndrome burnout with fully developed symptoms. (Zámková, Rigorous Thesis, 2018, In: Venglářová , 2011).

By method of the standardized BM questionnaire were investigating rate of psychological burnout in twenty four participants that two device social services. Equipment we are divided into devices social services A a device social services B. Each device was represented twelve participants. The questions in this standardized questionnaire se deal with by the degree of fatigue, physical and emotional exhaustion, feelings of happiness and energy, feelings of anxiety, fear, worthlessness and hopelessness. After that with according to the given formula calculated the value of BQ which indicates of peace threat syndrome burnout.

Table 3 Overall evaluation of the BM questionnaire by the participants that device A a device B

BM values Range	Frequency of participants from ZSS A	Frequency of participants from ZSS B
2 and less	1	2
2,9	4	4
3.0-3.9	4	4
4.0-4.9	3	1
5, 0 and more		1
In total	12	12

Source: own processing

In this one table we marked the overall results from two devices social services, which we are carried out collection data in the form of standardized BM questionnaires. Of these tables you can compare results between by these devices social services. According to submitted results from the table we are found that larger representation in higher values from the BM questionnaire, participants have ze device social services A. There are three of them participants in which we are they measured moving values with in the range of 4.0 to 4, 9. In tables no. 4 and no. 5 we are described the results that standardized BM burnout questionnaire according to length of professional experience of the participants .

Table 4 Results of the BM questionnaire from device A according to length of professional experience of the participants

Length of professional experience of participants from ZSS A						
Number of years of experience in ZSS A	1-5	6-10	11-20	21-30	30+	in total
BM						
2 and less				1		1
2,9	2	2				4
3.0-3.9	1	1	2			4
4.0-4.9	1		1	1		3
5, 0 and more						
In total	4	3	3	2		12

Source: own processing

After evaluation sums that standardized BM psychological burnout questionnaires we are in the table described the results that device social services A by length of professional experience. According to of the results of the questionnaire we found a result value of BM 2 or less in one participant with professional experience of twenty one to thirty years. At four participants she was measured value up to 2.9. And that for two with professional experience in the range one to five years and two participants with expe-

rience from six to ten years. At these participants this is a very good to satisfactory result. At four participants with the BM values ranged between 3.0 and 3.9. Which is on the border of psychological exhaustion. These participants would already they had think about style to reassess your life and your priorities.

This is one participant with experience in the range one year to five years, another is one with experience in the range six to ten years and two participants with experience in the range eleven to twenty years. We recorded a BM result of 4.0 to 4.9 in a total of three participants. For one with professional experience in the range one year to five years. For one with professional experience in the range eleven to twenty years and one with twenty one to thirty years of experience. At these of participants is according to results of BM syndrome of psychological exhaustion proven . A BM result above the value of 5.0 is not.

Table 5 Results of the BM questionnaire from device B acc length of professional experience of the participants

Length of professional experience of participants from ZSS B						
Number of years of experience in ZSS B	1-5	6-10	11-20	21-30	30+	in total
BM						
2 and less			2			2
2,9	2	3				5
3.0-3.9	1	1	1			3
4.0-4.9		1				1
5, 0 and more			1			1
In total	3	5	4			12

Source: own processing

In submitted table we recorded the results of standardized BM psychological burnout questionnaires in participants that device social services B according to length of professional experience. According to the overall results from the questionnaires we are found in two participants with professional experience in the range eleven to twenty years the resulting value of BM 2 and less. At five participants she was measured value up to 2.9. And that for two with professional experience in the range one to five years and three participants with experience from six to ten years. At these participants this is a very good to satisfactory result. At three participants with ranged BM values between 3.0 and 3.9. Which is on the border of psychological exhaustion. These participants would already they had think about style of his life. This is one participant with experience in the range one year to

five years, another is one with experience in the range six to ten years and one participant with experience in the range eleven to twenty years. We recorded a BM result of 4.0 to 4.9 in a total of one participant with professional experience ranging from six to ten years. The BM result was above 5.0 recorded in one participant who works in the range eleven to twenty years – psychological burnout syndrome.

Discussion

Main the aim of this research was acquisition, analysis and evaluation information at finding out impacts syndrome burnout in professional workers in helping professions in two selected devices social services. For acquisition valid ones information from participants who were the largest source at collection data, three criteria were essential. The first the criterion set by us was the number of years of experience in the facility social services and in the relevant field. The 2. criterion was the highest achieved education participants. The 3. criterion was age.

In the following table no. 6 we are tried according to results from individual levels of EE - emotional exhaustion, PA - personal satisfaction and DP - depersonalization of the standardized MBI questionnaire to allocate the number of participants with the highest measured values.

Table 6 Results of the occurrence of the syndrome burnout with the highest values

Results of occurrence of burnout syndrome in participants with the highest values MBI and BM questionnaires. Levels, criteria and total number of participants with the highest measured values and incidence of burnout syndrome from ZSS A and B							
ZSS A			Participants	ZSS B			Participants
EE	Practice	11-20	3	EE	Practice	6-10	4
	Education	Learned	3		Education	Medium	3
	Age	41-50	4		Age	41-50	4
PA	Practice	11-20	3	PA	Practice	1-5	1
	Education	Learned	3		Education	Medium	1
	Age	41-50	4		Age	31-40	1
DP	Practice	11-20	3	DP	Practice	6-10	1
	Education	Learned	3		Education	11-20	1
	Age	41-50	4		Education	vs	1
BM	Practice	1-5	1	BM	Practice	1-5	2
	Education	Learned	1		Education	Medium	1
	Age	41-50	2		Education	Learned	1
EE	Practice	11-20	1	EE	Practice	6-10	1
	Education	Learned	1		Education	11-20	1
	Age	41-50	1		Education	VOS	1
PA	Practice	11-20	1	PA	Practice	6-10	1
	Education	Learned	1		Education	Medium	1
	Age	41-50	1		Education	Basic	2
DP	Practice	11-20	1	DP	Practice	31-40	1
	Education	Learned	1		Education	41-50	1
	Age	41-50	1		Age	41-50	1

Source: own processing

Next we are described, in which device social services has the highest incidence of the syndrome burnout. Also we are described the results of the standardized BM questionnaire according to selected criteria, which were essential at qualitative research.

Submitted results of the level (EE) of emotional exhaustion that of the MBI standardized questionnaire proved the highest values overall for seven participants that device A and at three participants with a length of professional experience of eleven to twenty years. Of device B we are found a high degree of EE according to length of professional experience in total for nine participants. From the given table you can summarize that according to four participants with a high degree of EE who they have been working in the field for six to ten years. We are in facility A measured a high degree of EE according to education a total of seven participants. From the given table you can to confirm that according to education high EE values occur in three participants with an apprenticeship. He was in facility B a high degree of EE was found in a total of nine participants. The highest the EE rate was found in three participants with high school education. The highest degree of EE was recorded in four participants that device A in age range of forty- one to fifty years. A was in device B the highest representation in the field of emotional exhaustion in four participants in age range of forty- one to fifty years. From the results we are found that the occurrence of the syndrome emotional burnout depletion is higher in device B.

For results from the level (PA) of personal satisfaction from of the standardized MBI questionnaire in facility A, we recorded a high level in a total of seven participants and three with a length of professional experience of eleven to twenty years. From the given table you can confirm that according to education high EE values occur in three participants with an apprenticeship and in age range of forty- one to fifty years. We are in facility B found a high degree in a total of three participants and one participant with professional experience in the range one year to five years, for one participant in the range six to ten years and more one participant with professional experience in the range eleven to twenty years. According to at most achieved

a high level of education is present in three participants. This high degree was represented by one participant with a higher education, by one participant with high school by education and for one trained participant. There was a high degree of PA evaluated in three participants and that in age range thirty one to forty years for one participant. Furthermore, for one participant in age range forty- one to fifty years and in one participant in age range fifty one to sixty years. From the results we are found that the occurrence of the syndrome burnout in the area of personal satisfaction is higher in facility A.

Overall evaluation results degrees depersonalization (DP) from standardized MBI questionnaire with the highest values in facility A we are found a high degree in eight participants. The biggest representation was found in three participants with eleven to twenty years of professional experience. According to at most achieved a high level of education is present in three participants with an apprenticeship. There was a high degree of DP recorded in four participants and that in age range forty one to fifty years. The measured values showed the overall occurrence of a high degree of DP from the point of view length of professional experience in four participants that device B. This high degree we are found in two participants with professional experience in the range one year to five years. In the table we pointed to the results in the field of education and found out we that the high degree of DP was measured four in total participants. For one participant with a higher vocational school, for one with secondary school, one with an apprenticeship and one with basic education. High degree DP acc age was evaluated a total of four participants. The highest representation in we have a high degree of DP found in two participants and that in age range thirty one to forty years. From the overall results we are found that the occurrence of the syndrome burnout in the area of personal satisfaction is higher in facility A.

After evaluation sums that standardized BM psychological burnout questionnaires according to length of professional experience in facility A we are found results with the highest values of BM 4.0 to 4.9 in total in three participants. For one with professional experience in the range one year to five years. For one with professional experience in the range eleven to

twenty years and one with twenty one to thirty years of experience. After evaluation sums that standardized BM psychological burnout questionnaires according to the highest achieved education in facility A, we recorded results with the highest BM values of 4.0 to 4.9 in total for three participants, one with a university degree, one with a university degree with secondary school and one trained participant. Overall highest result BM 4.0 to 4.9 ze standardized BM psychological burnout questionnaires according to age category we recorded a total of three participants. There were two participants in age category forty- one to fifty years and one participant in age category fifty one to sixty years. In submitted table we recorded the results of standardized BM psychological burnout questionnaires in participants that device B acc length of professional practice. We recorded a BM result of 4.0 to 4.9 in a total of one participant with professional experience ranging from six to ten years. The BM result was above the value of 5.0 recorded for one participant who works in the facility social services in the range eleven to twenty years. BM values of psychological burnout 4.0 to 4.9 according to the highest achieved education we recorded a total of three participants, one with a higher vocational school and two with basic education. The BM result was above the value of 5.0 recorded in one participant se high school education. Of the evaluated sums that standardized BM psychological burnout questionnaires we are they found out result of BM 4.0 to 4.9 in one participant in age category thirty one to forty years. The BM result was above 5.0 recorded in one participant in age category forty one to fifty years. At these of participants is according to results of BM syndrome of psychological exhaustion proven. Out of a total of twenty four participants that two we are devices A and B measured BM values of 2 or less in three participants. Values of 2.0 to 2.9 were measured in eight participants. The results of the BM questionnaire in the range between 3.0 and 3.9 were measured a total of eight participants. We recorded BM values of 4.0 to 4.9 in a total of four participants. The BM result was above the value of 5.0 recorded in one participant. From the overall results we are found that the occurrence of psychological burnout is higher in facility A.

Conclusion

Professional workers in the field of helpers professions what kind they are doctors, general nurses, direct workers care and social workers are those who suffers the most from today's phenomenon, such as the syndrome burnout. The work that carried out, them on one side brings joy and satisfaction, but on the other hand can cause painful suffering on mental and physical health. It's not just that they are able to manage various burdensome situation and stress, but that he tries to put a lot of effort and emotion into his work. To help at all costs, to manage everything at the expense of one's abilities. But theirs the biggest the risk is that these workers who they are used to only giving, they will be in the future deal with the fact that they will care need too. Syndrome burnout can have on workers fatal consequences and leave traces that they won't go simply remove.

Based on the main research question "They have sociodemographic data of participants that device social services A a device social services B influence on the possible effects of the syndrome burnout?" we note the following. From the results standardized MBI, BM questionnaires and outputs from semi-structured ones conversations that we realized at twenty four participants that two device social services, we are determined the occurrence of the syndrome using three criteria burnout and occurrence of psychological burnout. They found out we are that the occurrence of the syndrome burnout it is related to the length of professional experience, education and age participants.

The consequences of work stress have emotional, cognitive and behavioral effects - what finally will cause syndrome burnout. Employers would they had more focus on mental health support. In the first series we would recommended that employers and colleagues at work pay more attention to their own colleagues and perceived warning signals in time. Okay proposed preventive measures they can prevent many complications. First and foremost by interest employers should be a good creation of programs that should have positive influence on the personal development of employees. Next we would recommended teamwork, work consultancy, fitness programs and supervision. Work should not to be monotonous and stereotypical. They should

more organize training and events and seminars on the topic of communication development skills, self-control, exercises for assertiveness and solutions conflicting situations. To give bigger spaces for self-realization. It would be appropriate to acquire information about satisfaction workers in the form of anonymous questionnaires, where they could be revealed in time causes excessive mental and physical loads and stress factors.

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