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Original Articles

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Slovakia, excluded Roma community in Slavosovce

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Editorial

Evolving Paradigms in Social Work: Investigating Emerging Theories and Practices

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Introduction

In recent years, the *Journal of Clinical Social Work and Health Intervention* has emerged as one of the foremost scholarly publications in the field of social work, earning recognition for its academic rigor and substantial contribution to advancing the discipline. This prominence can be largely attributed to the editorial board's deliberate and strategic emphasis on publishing original research, particularly studies that explore innovative, novel, and non-traditional phenomena within the broad scope of social work and intervention practices. These scholarly inquiries are grounded in the mission to enhance the well-being of individuals, families, and communities, with a notable focus on populations in Central Europe, addressing the region's unique social challenges and needs. The journal's impact is further solidified through its collaborations with distinguished scholars and emerging practitioners, whose expertise extends beyond the European Union, thereby offering a global perspective and deepening the journal's relevance and scope within the international academic community. Each issue is a carefully curated compilation of peer-reviewed articles that collectively engage with a central, cohesive theme to foster a rich, dynamic, and interdisciplinary scholarly dialogue that is both timely and impactful in advancing social work as a field.

This particular issue gathers an eclectic group of scholars and academic collectives, each critically analyzing and interrogating the multifaceted challenges confronting individuals across various social, educational, and age-related contexts. The contributions presented herein tackle some of the most urgent and complex issues facing contemporary societies, including homelessness, the educational struggles of younger generations, the increasing demands for comprehensive and compassionate elder care, and the transformative role that digital technologies play in reshaping the effectiveness of social work interventions. By addressing these pressing issues, this collection underscores the necessity of adopting interdisciplinary approaches to tackle the growing complexity of social problems, reinforcing the need for holistic and sustainable responses to address these challenges. The articles highlight how emerging technologies, evolving social structures, and shifting cultural paradigms intersect with and influence the traditional role of social work, prompting a critical reexamination of current methodologies, ethical frameworks, and intervention strategies.

Furthermore, this issue underscores the urgency of collaboration across disciplines in creating evidence-based solutions that are not only effective but also ethically sound, demonstrating how social work practice can evolve in response to a rapidly changing global landscape. Through a careful balance of theoretical exploration and practical application, the contributions to this issue reflect a commitment to advancing social work practices that are adaptable, inclusive, and equipped to respond to both current and future societal needs. Ultimately, this collection seeks to enhance the discourse surrounding the role of social work in addressing contemporary issues, ensuring that the profession remains at the forefront of developing innovative strategies for the betterment of individuals and communities worldwide.

The Integration of Spirituality in Social Work Practice: Implications for Theory and Intervention

Within academic discourse, there is widespread agreement on the importance of a holistic approach to social work and healthcare that integrates physical and mental health, community engagement, and social services into a unified framework (2). This journal adopts a complementary methodology, wherein research papers with distinct yet interconnected focal points collectively offer a more comprehensive understanding of these critical issues. This approach not only broadens the scope of the discourse but also highlights the growing interest in spirituality as a fundamental element in enhancing human well-being and fostering resilience (3).

The concept of *holistic social work* is grounded in the integration of multiple disciplines to provide comprehensive support for individuals (4). From a medical perspective, holistic care ensures that biological, psychological, and social factors are incorporated into treatment (4). From a sociological viewpoint, it aligns with theories that emphasize the interconnectedness of individuals within their communities (5). In this context, the biopsychosocial model underscores the necessity of a multifaceted approach to address the complex interplay between biological, psychological, and social dimensions of health (6).

Spirituality has been shown to play a significant role in an individual's resilience and coping mechanisms, particularly during times of crisis (7). It is essential for social workers to develop the competencies required to recognize and respect the spiritual dimensions of mental well-being (8). Research indicates that spiritual practices contribute to reduced stress levels and enhanced psychological health (9). Integrating spiritual considerations into social work practices not only fosters greater client engagement but also supports holistic healing.

Synthesizing research from various academic domains remains crucial to advancing a deeper understanding of the evolving landscape of social work and healthcare. This includes emphasizing the significance of innovative strategies and ethical considerations in the development of policies and practices that uphold human dignity and promote social justice (10).

Navigating the Challenges of Digital Technologies in Social Work Practice: Ethical and Practical Considerations

The proliferation of digital technologies has significantly transformed social work practice, enhancing both operational efficiency and accessibility. The integration of artificial intelligence (AI) and machine learning has generated data-driven insights that improve case management, intervention strategies, and predictive analytics, enabling more precise and targeted support for vulnerable populations (11). However, the increasing reliance on augmented reality (AR), virtual reality (VR), and AI, particularly among Generation Z, has fostered a culture where digital identities often overshadow authentic social interactions (12). Research suggests that excessive engagement with these technologies contributes to the development of narcissistic behavioral traits, as social validation becomes increasingly driven by algorithms rather than genuine interpersonal connections (13). The phenomenon of 'self-curation,' facilitated by AI-powered filters and VR-enhanced experiences, has led to distorted self-perception and a sense of social detachment (14).

In response, the field of social work must adapt to address the psychological and sociological consequences of these digital realities. This adaptation should involve the development of intervention strategies that emphasize digital literacy, critical media consumption, and emotional resilience to counteract the negative effects of hyper-reality. For instance, virtual reality has been successfully employed in therapeutic settings to support individuals dealing with trauma, anxiety, and social skills deficits, offering immersive experiences that complement traditional therapeutic methods (15). Moreover, telehealth and digital platforms have expanded the reach of remote counseling services, improving accessibility for individuals in underserved and rural areas.

Nevertheless, it is imperative that ethical considerations—such as data privacy, algorithmic biases, and the preservation of human empathy in digital interactions—are carefully addressed

(16). The development of comprehensive ethical frameworks, ongoing professional development, and policies that ensure technology enhances, rather than undermines, human-centered social work practices are essential to effectively navigating these challenges.

The Expanding Role of Family Systems in Social Work: Theoretical Perspectives and Practical Implications

The family unit is universally recognized as a cornerstone of support within the field of social work. Research consistently demonstrates that strong familial networks contribute significantly to emotional stability and positive health outcomes (17, 18). However, contemporary social dynamics are increasingly shaped by the pervasive influence of digital technologies, media saturation, and shifting cultural paradigms. The rise of online harms, such as harassment and digital addiction, presents substantial challenges to family cohesion and individual well-being (19, 20). Furthermore, the emergence of a social media-driven youth culture—often promoting superficial validation and narcissistic tendencies—complicates traditional social work interventions.

It is crucial for social workers to develop innovative strategies that address the psychological implications of these phenomena while simultaneously reinforcing the importance of authentic human connection and emotional resilience within family systems (21, 22, 23). The incorporation of digital literacy, ethical social media use, and cyber safety education into social work practice is essential to mitigating the adverse effects of these cultural shifts and strengthening the role of family as a stabilizing force in an increasingly complex digital age.

Conclusion: Advancing Social Work in a Complex Global Context

In the evolving landscape of social work, the continued integration of a holistic approach remains vital for providing effective support to individuals. The combination of medical, sociological, and psychological frameworks enhances the discipline's ability to address multifaceted social issues (24). Additionally, recognizing the importance of spirituality, reinforcing family support systems, and leveraging digital innovations presents new opportunities for advancing social work practices (25, 26, 27).

However, it is essential to recognize and navigate the ethical challenges that arise in these domains, ensuring that the core humanistic principles defining social work are upheld. Moreover, the growing global instability, marked by political shifts and conflicts, has exacerbated widespread fear and uncertainty, further underscoring the need for adaptive social work strategies (28). The proliferation of cyber threats and the pervasive influence of media-driven youth culture, which fosters narcissistic behaviors and digital dependencies, calls for continued research. Future inquiries should focus on the psychological impact of geopolitical crises on vulnerable populations, the ethical use of AI in social work, and the development of resilience-building frameworks within communities. By addressing these emerging concerns, social work can evolve in ways that promote the well-being of individuals and societies in an increasingly complex and interconnected global environment.

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The Impact of Labelling on Roma Integrity

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Abstract:

Objective. This study aims to explore the impact of labelling on the integrity and social status of Roma communities, focusing on how these labels influence their identity, social relations, and experiences of discrimination.

Methods. We employed a qualitative study that included 68 Roma people living in communities to analyze the impact of labelling. The impact of labelling on Roma integrity is a multifaceted issue that significantly affects their social status, identity, and overall well-being. Labelling often results in stigmatization and reinforces stereotypes that contribute to systemic discrimination against Roma communities.

Results. The findings indicate that labelling significantly contributes to the stigmatization of Roma individuals, reinforcing negative stereotypes and social exclusion. Participants reported experiences of discrimination in various domains, including education and employment, leading to

a diminished sense of identity and belonging. Quantitative data highlighted that higher levels of perceived discrimination correlated with increased feelings of alienation, poor housing and job opportunities, and lower self-esteem among Roma individuals.

Discussion: The discussion contextualizes these results within broader societal and historical frameworks, emphasizing the role of systemic discrimination in perpetuating negative labelling. The homogenization of diverse Roma identities under the single label of "Roma" obscures their unique cultural practices and experiences, further entrenching barriers to social integration and equity. Comparisons are drawn with studies from other marginalized groups to illustrate common themes of labelling and its consequences.

Conclusion: This research underscores the urgent need for policies that recognize and celebrate the diversity within Roma communities rather than perpetuating harmful stereotypes. It advocates for educational and social interventions aimed at combating discrimination and promoting the integrity and dignity of Roma individuals.

Introduction

For many years, Roma families have been unable to socialize and integrate into the culture of Slovaks. Unemployment and crime rates are high, and education is at a low level. The housing of some Roma resembles anything but decent housing for a person. We wonder whether this is caused by the Roma themselves, or whether we are helping them to live in an unsuitable environment. Various claims are spread about Roma people. Labels they have been given state that they are lazy to work, uneducated, unmotivated, musically talented, and so on. We know various stereotypes and prejudices about Roma people, but we do not know which ones are true and which ones are fiction and conjecture. The aim of our research is to find out whether stereotypes and prejudices against the Roma interfere with their lives. The behavior of prejudiced people can ruin a spontaneous acquaintance. It can determine the treatment of a person against whom we have prejudices. We will learn how prejudices can degrade good intentions. Prejudices are close to the attitudes we adopt. We can pretend that nothing has happened, and by doing so we deepen our attitude towards the Roma. Therefore, in that case, it can happen that in the future we will not want to cooperate with them, creating an attitude of disinterest in the situation.

Theoretical background

Stereotypes are fixed and ingrained types, ideas, and patterns that a person refers to in order to justify a positive or negative prejudice. Even though these types, ideas, and patterns are promoted, it is difficult to find out their origin and what they are based on. Stereotypes lack factual support. The function of a stereotype is to justify and defend some kind of behavior or attitude. If a stereotype is negative, it helps to sort and select only negative connotations, and this subsequently defends the negative selection or antipathy. For these reasons, a stereotype is not a prejudice, but a tool for rationalizing supposedly permanent values, thinking, and behavior. In most cases it is a set of unflattering ideas about members of social groups, classes, ethnic groups, etc., based on racial and social prejudices (Allport, 2004).

We live in a world full of stereotypes. Because of them, we dare to say that cohesion, unity, and understanding among people are not growing. We have a high tendency to separate ourselves from everything that is a little different from what we ourselves are used to accepting.

Our stereotypes and negative opinions can lead to hatred and contempt for individuals, communities, and their faith. Due to the long-term persistence of the way of life led by Roma, the stereotypical Roma way of life has been deeply embedded in people's consciousness and continues to spread. Their opinions about the Roma community are heavily laden with emotions. Many of these attitudes still persist and are taken from their environment without a rational basis. Negative attitudes and opinions can have varying degrees of intensity - from negative group simplification to openly extremist attitudes.

Stigmatization and the sharing of stereotypes among Roma people contribute significantly to social exclusion, discrimination, and a diminished sense of identity within the community. These negative labels often lead to internalized stigma, causing individuals to begin to accept and embody the negative perceptions associated with their ethnic group (Budayová, Ludvigh Cintulová, 2023). Authors Rýc and Ludivgh Cintulová (2021) state that most people with a gypsy background confirmed that the labelling started when they were at school. Roma children frequently face discrimination in schools, leading to lower educational attainment and reduced future opportunities.

One study highlights how these experiences create an environment where Roma students internalize negative labels, which can diminish their self-esteem and lead to disengagement from the educational system (Ludvigh Cintulova L, Budayova Z, Brédová S, 2022). Furthermore, Hancock (2020) emphasizes that these early negative experiences can contribute to a cycle of disadvantage, where limited educational attainment affects future employment opportunities and perpetuates social exclusion.

The connection between the health issues faced by Roma people and the concept of labelling is significant. Labelling, particularly in educational and social contexts, can have profound implications on the identity and self-perception of marginalized groups, including Roma. When individuals from the Roma community are labelled as "deviant" or "problematic" due to their ethnic background, it can lead to systemic discrimination, social exclusion, and stigmatization, impacting their access to essential services like healthcare.

Health Disparities and Labelling

The study by Ludvigh Cintulová et al. (2023) highlights how stigma and negative stereotypes associated with Roma culture contribute to health disparities. This stigmatization often starts in educational settings, where Roma children may face discrimination from peers and teachers. Such early labelling can lead to diminished self-esteem and a sense of hopelessness, which in turn affects mental health and willingness to seek care (Ludvigh Cintulová et al., 2023; Finkelstein et al., 2020).

Labelling is one of many social determinants that shape the experiences of Roma individuals. The authors argue that to effectively address health disparities, policy interventions must consider the unique cultural and social contexts of Roma communities. This includes recognizing how negative labelling impacts both the health-seeking behavior and the quality of care received by Roma individuals (Vladár & Szabó, 2019; Stojanovic & Toma, 2022).

Cultural Competence in Healthcare

An emphasis on cultural competence training for healthcare providers is crucial in mitigating the effects of labelling. By understanding and addressing the specific challenges faced by Roma, healthcare professionals can foster an environment that reduces stigma and promotes better health outcomes. Training can help practitioners avoid biases that may arise from societal labels, leading to more equitable care (Kovács et al., 2021; Zólyomi & Berényi, 2022).

Reasons for labelling

The Roma community has faced centuries of marginalization, leading to entrenched stereotypes that view them as outsiders and deviants. As noted by Budayová (2019) and Budayová & Ludvigh Cintulová (2021), these stereotypes are often internalized within a society, influencing how Roma individuals are perceived and treated. This historical baggage complicates contemporary interactions, as many people remain unaware of their biases.

Stereotypes form a crucial part of social identity, influencing group dynamics and perceptions of "the other." The tendency to categorize individuals based on group membership can foster an "us vs. them" mentality, where Roma people are viewed through a lens of difference rather than inclusion. This dynamic can lead to exclusionary practices in areas like employment, education, and housing. The socioeconomic challenges faced by many Roma individuals, including poverty, limited access to education, and unemployment, often feed into negative stereotypes. When society views these challenges through a biased lens, it leads to further labeling and stigmatization (Ludvigh Cintulová et al., 2020).

Many people remain uninformed about Roma culture and history, which can exacerbate misunderstandings and perpetuate myths. Educational efforts aimed at increasing the awareness of Roma contributions to society and dispelling common misconceptions are often insufficient. The absence of culturally competent training in institutions, including healthcare and social services, further alienates Roma individuals from mainstream society. Research has shown that teacher attitudes significantly influence students' educational experiences. If teachers hold biases against Roma culture or have preconceived notions about Roma students, they may unconsciously treat these students differently. This can manifest itself in disciplinary actions, participation opportunities, and overall encouragement in the classroom, contributing to higher dropout rates among Roma youth (Rác, L Cintulová, 2021).

1. Socioeconomic Factors: Economic disparities play a significant role in the marginalization of Roma communities. Many Roma individuals experience poverty, limited access to education, and inadequate healthcare, which reinforces negative stereotypes and creates a cycle of discrimination and exclusion. The ongoing socioeconomic challenges faced by Roma populations often lead to their further stigmatization, as societal narratives may frame these challenges as inherent to their identity rather than the result of systemic inequality (Ludvigh Cintulová, Budayová, Oláh, 2024).

Mental health

Roma students often face negative stereotypes that label them as troublemakers and underachievers. "Analysis of mental well-being of Roma due to labelling" by Radková, Ludvigh Cintulová, Brédová, and Budayová (2022) focuses on the mental health challenges faced by the Roma community, particularly concerning the impacts of societal labelling. The study highlights how negative stereotypes and discrimination contribute to mental health issues among Roma individuals, affecting their overall well-being. Key findings suggest that labelling not only perpetuates social stigma but also exacerbates mental health problems, leading to increased anxiety and depression among those affected. The stigma associated with being Roma can extend beyond the classroom, impacting students' relationships with peers and their broader community. This can further alienate them from the educational experience, leading to lower participation and success rates and worse mental health. The constant experience of discrimination linked to labelling can create chronic stress. This stress can manifest in various ways, including anxiety disorders, depression, and other mental health issues. The relentless pressure of navigating a world that views them through a stigmatized lens can severely impact their overall mental health (Ludvigh Cintulová et al., 2023). Labelling can result in social isolation and exclusion from mainstream society. When Roma individuals are marginalized, they may withdraw from social interactions, leading to loneliness and increased anxiety. The sense of not belonging can exacerbate feelings of depression and hopelessness (Budayová, 2019).

Methodology

The qualitative method included interviews with 68 Roma people about labelling through in-depth, semi-structured interviews. The objective of these interviews was to gather personal narratives and insights about their experiences with labelling. After collecting interview data, we used thematic analysis to identify and analyze recurring themes in participants' responses. This method allowed for a deeper understanding of how labelling affects the mental and social

well-being of Roma individuals. The qualitative research aimed to explore the concept of labelling as experienced by 68 Roma individuals. The study employed a descriptive and interpretative approach, focusing on personal narratives to understand the complexities of labelling in their lives. A total of 68 Roma participants were selected through purposive sampling, ensuring a diverse representation of experiences and backgrounds. Participants were chosen based on their engagement with different aspects of life affected by labelling, including education, housing, and employment.

The interviews included open-ended questions that prompted participants to discuss their perceptions of labelling, its origins, and its impact on their lives. One interview took 30 minutes, with categories consisting of the impact of labelling on Roma life in the field of education, housing, and employment. The research revealed that labelling has profound implications for the mental and social well-being of Roma individuals. Themes that emerged included the internalization of negative stereotypes, barriers to accessing quality education and employment opportunities, and social isolation stemming from discriminatory practices. The insights gained from this study contribute to a deeper understanding of the systemic issues affecting Roma communities and underscore the need for targeted interventions to combat labelling and its repercussions.

Results

Roma people say the start of labelling is mostly in the school environment and in the media. The media casts a negative light on Roma people in their articles. Crime is one of the most frequently mentioned topics. Roma commit crimes and theft due to unemployment and are forced to obtain wood and other necessities by stealing. This does not apply to every Roma, as is the rule. However, when the media constantly reports on Roma thefts, the Slovak population adopts the idea of thieving Roma who steal and will not and cannot do anything else. This is how negative stereotypes about thieving Roma are born. The reason for the theft does not matter to anyone because they have already made a judgment and a decision within themselves that Roma steal. The more this is pointed out, the more the truth of this statement is confirmed for many people. Residents, consumed by negative news and prejudices about Roma, have already condemned any coexistence or cooperation because it had already been decided to integrate Roma before assistance began.

Open Coding of Roma Responses on the Impact of Media Labelling

1. **Code: Origin of Labelling:**
   - School Environment: Roma individuals identify schools as a primary setting for the initiation of labelling, indicating early exposure to stereotypes and biases.
   - Media Influence: The media is perceived as a significant contributor to the labelling process, shaping public perception negatively from a young age.
2. **Code: Negative Media Portrayals:**
   - Focus on Crime: Media frequently highlights crime-related stories involving Roma, creating a narrative that predominantly associates the community with criminality.
   - Stereotyping: Articles often present the idea that Roma are inherently criminal, emphasizing theft and unemployment as defining traits.
3. **Code: Perpetuation of Stereotypes:**
   - Confirmation Bias: Continuous reporting on thefts leads to a reinforcing cycle where the majority of the population adopts and perpetuates the stereotype of the "thieving Roma." Additionally, based on media presentations, the majority of the majority population holds the opinion that Roma are uneducated, poor, have many children, are dependent on state assistance, and violate the law much more often than members of the majority society.
   - Judgment Formation: The community feels that the reasons behind these acts (e.g., economic hardship) are overlooked, resulting in a rigid and prejudiced view of Roma individuals.
4. **Code: Societal Impact:**
   - Prejudiced Coexistence: The pervasive negative narratives in the media foster a hostile

environment where the majority population feels justified in their biases, often preemptively rejecting integration efforts.
- Barrier to Cooperation: There is a sense that the negativity surrounding media portrayals has already condemned any potential for coexistence or collaboration with Roma communities.

Open coding: The Impact of Labelling

The lives of Roma are not only influenced by stereotypes, but also by the real problems this minority group faces in areas such as housing, employment, and education. These areas are often stigmatized, and Roma have to cope with them in an environment where prejudices and negative opinions prevail.

Code: Housing

Roma people often face difficulties in securing housing that have been brought about by poverty and social exclusion. In many cases, mayors avoid granting permanent residence to Roma due to pressure from other residents, making it difficult for them to integrate into local communities. This problem not only limits their opportunities to find stable housing, it also deepens their social isolation and increases their marginalization. The housing situation for Roma communities often reflects broader issues of poverty and social exclusion. Roma individuals frequently encounter significant barriers to securing stable housing due to a combination of systemic discrimination and societal prejudice.

Key Points:

1. **Difficulties in Securing Housing -** Many Roma face challenges in finding adequate housing options. This situation is exacerbated by their socio-economic status, which limits access to the financial resources necessary for renting or purchasing homes.
2. **Discrimination from Local Authorities -** Local officials, including mayors, may refuse to grant permanent residence permits to Roma families, often due to pressure from non-Roma residents who may harbor negative attitudes towards them. This bureaucratic hurdle effectively isolates Roma from fully integrating into local communities.
3. **Social Isolation and Marginalization -** The lack of stable housing not only hinders Roma's ability to find employment and access education, it deepens their social isolation. Being denied housing can lead to increased marginalization, making it difficult for Roma to participate in community life and access essential services.
4. **Impact on Community Relations** - The avoidance of granting housing rights to Roma contributes to tensions between Roma and non-Roma communities. It fosters an environment of distrust and reinforces stereotypes, further alienating Roma individuals.

Code: Employment

The view of Roma employment is often distorted by stereotypes that portray them as unemployed and unwilling to work. Although many Roma are trying to find employment and improve their situation, barriers such as discrimination, a lack of education and skills, and employer reluctance make it difficult.

Coding answers of participants:

- **Perception of discrimination**: "We feel that we are looked at differently." - The statements show that respondents feel that they are treated differently from the majority society in everyday situations, such as when visiting shops or restaurants.
- **Unfavorable treatment in employment**: "We were interviewed, we did everything, but you don't fit in." - This takes into account the feeling of rejection and non-acceptance based on ethnicity.
- **Stereotypes and generalizations**: "They put us all in the same bag." - This expresses how Roma are often perceived as a homogeneous group, regardless of individual differences.
- **Ethnic discrimination in the labor market**: "A white person gets a job, but a Roma person doesn't." - This points to systemic discrimination that stems from prejudice based on skin color.
- **Barriers to employment**: "Even if he shows his papers, they won't hire him." – The state-

ment reflects a sense of helplessness and frustration at not being able to find a job, even when meeting the qualifications.

- **Changes in social norms**: "Some Olašskis have a white wife.", "Yes, I'm for change, times are different. We used to be able to do nothing. Now women can dress differently too." - This reflects developments in social norms and acceptance among different ethnic groups.

Do Roma consider education important for jobs? "Some do and some don't. They say that he will go to a special school and learn something. My little one will go to a regular school. If I could do it over again, I would do all the schools, but I had parents who didn't send me to school. We feel the need for education because workers are immediately asked about school. The grandparents didn't consider school necessary. Life was different. Now you can't get a good job without a good school. Young Roma have to learn if they want to live well. The view of Roma people is bad, and that doesn't motivate them to learn much. They do not understand it is important in the future, and they do not think so much about the future and getting a job. Money is important for them, and they think only their hands are enough to get a job. We know that there are smart Roma in parliament. That boxer really pulled himself together. He had an opportunity. I know they were very poor. Roma are progressing slowly, and we are looking forward to it," said Roma participant 48.

Open Coding: Do you have problems finding a job and housing?

Participants answers: "Yes, we do, most of us. When they find out that you are Roma, nothing can be done. They won't give you a job. And you can even have school papers. We won't get a chance. My sons go to school. They can read, write, they are young, and they haven't been taken away. They are trying to find a job. They treat all of us the same. They see Roma and they only think negative things. Nobody will give them a chance."

1. **Discrimination**: The statement highlights the systemic barriers Roma face in securing employment due to their ethnic background. The participant feels that being identified as Roma immediately disqualifies them from job opportunities, regardless of their qualifications or educational background.
2. **Lack of Opportunity**: There is a strong emphasis on the absence of opportunities for Roma individuals, suggesting a feeling of hopelessness. The participant states that despite their sons' educational achievements, they are still unable to find work, indicating a disconnect between education and employment prospects.
3. **Negative Stereotypes**: The participant notes that the perception of Roma people is overwhelmingly negative, which affects their chances of being hired. This reflects broader societal attitudes and prejudices that stigmatize Roma, creating barriers to integration in the workforce.
4. **Education vs. Employment**: The statement illustrates a significant disconnect between educational attainment and employment opportunities for Roma individuals. Despite having skills and educational qualifications (e.g., reading and writing), the participant's sons are still denied opportunities based solely on their ethnicity.
5. **Collective Experience**: The use of "nás" (us) emphasizes a shared experience among Roma individuals, suggesting that the challenges faced are not isolated incidents but part of a broader societal issue affecting the entire community.
6. **Desperation for Change**: There is an underlying tone of frustration and despair in the participant's words, reflecting a desire for change and acknowledgment of their potential. The sentiment that "nobody gives us a chance" signifies a call for more equitable treatment and opportunities.

This research reveals the deep roots of discrimination and stigmatization that Roma face at various levels. Respondents often feel marginalized and perceive negative stereotypes that affect their employment opportunities and interactions with the majority society. Many believe that their ethnic identity plays a key role in how they are evaluated and what opportunities they have. Labeling has a significant impact on the employment of Roma, and it is reflected in various aspects of their lives and education. These

factors can be divided into several main areas that prevail until the Roma reach adulthood. Roma children may face prejudice from a young age, which affects their school and later employment opportunities. The parental background and culture can contribute to stigmatization that is transmitted to their children. Conflicts that arise in the school environment are often caused by prejudices against the behavior of Roma children. These conflicts can lead to their segregation and placement in special schools, which fundamentally affects their education and reduces their future employment opportunities. Access to quality education is crucial for Roma children. Individualized care and understanding from teachers are necessary to eliminate stigmatization, but many children end up in special schools, thereby missing out on the chance for a quality education. The segregation of Roma in the education system is a form of discrimination, even though the law prohibits segregation as a principle of education. This situation contributes to the fact that Roma have limited employment opportunities due to their low education level. After graduating from a special primary school, Roma have minimal skills, such as reading and writing, which significantly hinders their chances of getting a good job.

Category: Education

Education is another area where Roma face discrimination. Parents often fear that their children will be stigmatized and harassed at school, leading some children to not enroll at all or to drop out early. These factors contribute to perpetuating the cycle of poverty and limit Roma's future opportunities.

Code: Low expectations

"Teachers do not expect much from us, as they automatically assume that there will be a problem with learning. Low expectations do not motivate Roma to learn much because appropriate demands are not made of them, or vice versa, a Roma child often fails at school because he does not understand the curriculum due to cultural and language barriers." Teachers' low expectations of Roma students can lead to poorer results. So can prejudice, a lack of understanding, and individual support. All of this reinforces the real or perceived decline in the quality of education, which can lead to an intensification of the so-called "white flight."

According to the results of our study, there is a connection between low expectations of teachers and poorer educational results of Roma students. These factors contribute to the perpetuation of negative stereotypes and the marginalization of Roma communities in the education system. Teachers often assume that Roma students will have problems with learning, leading to them make low demands on them. This approach can affect the motivation of Roma students to learn and improve because they feel as if no one expects them to perform. Roma students face challenges related to cultural and linguistic differences, which can lead to misunderstanding the curriculum. These barriers can make students feel isolated and discouraged, further reinforcing stereotypes about their abilities. Low expectations from teachers can lead to a lack of motivation among Roma students. If appropriate demands are not made, students may lose interest in learning because they feel that their success is not important.

Code: Insufficient individual support

"There are many students in the class, and there is no time to pay attention to everyone individually", "you are unlucky if you are slower, and individual help is missing", "learning is not the parents' business in the Roma family, there are no positive role models, but also knowledge is lacking." The lack of tailored support and resources for Roma students reduces their educational opportunities and outcomes.

Code: Lack of interest in mixed classes

"Whites don't want to be in the classroom with our children", "There is still exclusion. Ideally, Roma children would be in their schools, that is the majority opinion." Non-Roma parents are afraid to let their children go to school with Roma children. The fears are obvious and justified, but often exaggerated and hasty. Teachers themselves have prejudices and label Roma children as unable to keep up with non-Roma children. They assume that they will learn the

curriculum slowly, and non-Roma children will pay for it with poor education. They are afraid of the influence of children from settlements and the problems that could arise. The upbringing of Roma children is different from that of the majority, which is why parents of non-Roma children are afraid to let them be in a class with Roma children.

Code: School system

The school system in Slovakia is not sufficiently prepared for the education of Roma children. Teachers are not trained to teach children from the Roma community, and this has a negative impact on their educational outcomes. In order for Roma children to achieve good results in school, it is necessary to provide them with individual care and adapt educational methods to their needs. Many of these children face cultural and linguistic barriers and therefore do not have the same opportunities as their peers. In settlements, children rarely learn about the Slovak language or other basic subjects, which increases their distance from the majority society. Outside the settlement, they are faced with a completely foreign world, which can lead to feelings of failure and frustration. The consequence of this situation is that many Roma children end up in special schools where they have limited opportunities for a quality education. Without adequate education, it is difficult for them to find a good job, which only deepens the cycle of poverty and stigmatization from which it is difficult to escape. While some experts suggest segregation as a possible approach to improving the educational outcomes of Roma children, such a move would be against the law and could be considered discriminatory.

Discussion

The perspectives of Roma individuals regarding education reveal a complex interplay of cultural beliefs, historical contexts, and contemporary challenges. While some Roma recognize the necessity of education for securing better job opportunities and improving their social standing, others remain skeptical, influenced by their upbringing and historical attitudes towards schooling. Many participants expressed a desire for educational advancement, reflecting an awareness that a good education is increasingly essential in today's job market.

However, the prevailing attitudes towards education among some Roma communities are hindered by past experiences and socio-economic conditions. The acknowledgment that education was not prioritized by previous generations, particularly grandparents, contributes to a cyclical pattern where the value of schooling may be diminished. Despite these challenges, there is growing recognition among younger Roma that education can be a vital pathway to a more prosperous future.

Participants also pointed out that external perceptions of Roma culture, often marked by negative stereotypes, can demotivate individuals from pursuing education. The belief that societal views are often dismissive can overshadow the intrinsic motivation to learn, making it difficult for many to envision a long-term future in education. Overall, while there is a notable shift towards valuing education within the Roma community, this transformation is gradual. Addressing these complex dynamics will not only require increased access to quality education, but also broader societal changes that recognize and support the educational aspirations of Roma individuals (Svoboda et al., 2024; Makap et al., 2023).

The lack of tailored support and resources for Roma students in schools has a negative impact on their educational opportunities and outcomes. The situation where there are many students in the classroom and teachers do not have time to pay attention to each one individually leads to some students, especially those who need more attention, being left without help (Tyrol et al., 2023). Roma students often encounter prejudice and low expectations from teachers, which further aggravates their situation. Various studies and scholarly contributions point to the need for an individual approach and adaptation of teaching to take into account the cultural and linguistic barriers that many Roma children face (Budayová, 2019; Ludvigh Cintulová, 2021). It is also important to ensure that teachers receive adequate training and support in cultural compe-

tence so they can better respond to the needs of all students. Without these changes, existing stereotypes and inequalities in education are likely to be perpetuated.

Conclusion

It is important to examine and change stereotypes on both sides because their transformation can have a significant impact. Stereotypes often claim that no aid is effective and that any investment is just a waste of money. Many believe that nothing will change and that efforts to improve are just a waste of time and resources. Proper education about the success of projects in Roma communities can provide important insights and help uninvolved people understand the importance of changing stereotypical thinking towards Roma. Having a common understanding and goal among the majority are key steps to bringing about change to the lifestyle of Roma and their integration. Projects targeting marginalized communities have positive results and contribute significantly to improving the situation.

Although progress has been made in many areas of Roma life in recent years, negative stereotypes and stigmatization persist and affect their daily lives. To improve the situation, it is necessary to raise awareness of cultural and social differences and support initiatives that seek to integrate Roma into society. Eliminating prejudices and providing equal opportunities in areas such as housing, employment, and education are key steps towards improving their living conditions.

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The Functioning of Centers for Children and Families Within the Slovak Republic from the Perspective of a Social Worker

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Original Article

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Abstract:

Centers for children and family consistently monitor and ensure compliance with the rights of children, ensure the necessary protection of children for their well-being, healthy development, and growth, and respect their best interests. The Ministry of Labour, Social Affairs and Family of the Slovak Republic characterizes the goal of the measures as follows: "The basic goal of measures of the social and legal protection of children and social guardianship is to provide necessary assistance to families so children can grow up in the care

of their parents." If this goal cannot be achieved, other legal options and aspects of care come into play and are employed until the situation in the family improves. This option is the placement of the child in a center for children and families, which ensures the child is in a healthy environment for their development and benefit. In the presented study, we focus on these centers and their basic functioning, as well as on the basic aspects of child upbringing.

Institutional care versus deinstitutionalization

In line with the global trend of systematically phasing out institutional, segregated care—traditionally provided to individuals with long-term dependency, such as people with severe disabilities, the elderly, and children in foster care—and replacing it with community-based services and social guardianship measures within the natural social environment, the Government of the Slovak Republic adopted the Strategy for the Deinstitutionalization of the System of Social Services and Foster Care in the Slovak Republic by Resolution No. 761/2011 on 30 November 2011. This shift in the care model aligns with the objectives of EU policy on social inclusion and disability and also reflects the Slovak Republic's commitments within the framework of the international human rights agenda. These include:

- The European Disability Strategy 2010-2020,
- European social guidelines for the transition from institutional to community-based care,
- Tools for using structural funds for the transition from institutional to community-based care,
- The United Nations Convention on the Rights of Persons with Disabilities and the Optional Protocol to that Convention,
- The UN Convention on the Rights of the Child,
- The European Social Charter.

The development of the National Action Plan for the Transition from Institutional to Community-Based Care in the Social Services System for 2012–2015 (hereinafter referred to as the "National Action Plan for DI") was one of the basic tasks of the Strategy for the Deinstitutionalization of the Social Services and Alternative Care System in the Slovak Republic (hereinafter referred to as the "DI Strategy"). Both the DI Strategy and the National Action Plan for DI were prepared with the help of a broad working group of experts in the field of social services and alternative care (MPSVR, 2016). "The basic objective of the National Action Plan for DI was to support the deinstitutionalization of the social services system by implementing pilot projects and creating additional support mechanisms in legislation, financing, and organization of the DI process" (MPSVR SR, p. 3).

The main principles that guided the pilot phase of the DI social services system were:

- respect for human rights,
- demedicalization,
- self-realization,
- self-help,
- self-advocacy /advocacy,
- removing barriers,
- examples of good practice,
- a cross-sectional approach.

According to WHO, an institution is "any setting in which persons with disabilities, seniors, or children live together outside their family; an environment where people do not have control over their own lives and daily activities" (MPSVaR In: World Health Organisation, The World Bank, World Report on Disability, 2016, p. 8).

The main features that characterize institutional culture are:

- depersonalization – insufficient respect for personal property, as well as for signs and symbols of one's own uniqueness and humanity,
- rigid, stereotyped, and routine activities – fixed time and structure of activities, a lack of respect for personal needs,
- flat-rate treatment and professional procedures – social service recipients are worked with en masse, without respecting their privacy or individuality,

- social distance and paternalism – the different status of staff and clients,
- segregation from the local community – the location of the social services facility is eccentric, distant from the local community, and services are concentrated in one place,
- learned passivity – passive behavior of social service recipients that they have acquired and their helplessness,
- underdeveloped social relations. (MPSVaR In: Report of the Ad Hoc Expert Group on the Transition from Institutional to Community-based Care, European Commission, 2016).

Institutional care provides social services, which include:

- recipients being isolated from the wider society and forced to live together,
- having no power over their lives and the decisions that affect them,
- the tendency to prioritize the requirements of the organization itself over the individual needs of individual recipients of social services (MPSVR, 2016).

Deinstitutionalization is based on a fundamental value-based change in the relationship to people who are dependent on the help of society. It represents a process of change (transformation) of the system, form, structure, and content of social services, which is manifested in a departure from the model of traditional care that was applied in classic facilities with an institutional culture. It moves from a passive model to an active model, which requires a change in the approach to clients, especially by respecting them as individuals and holders of rights (MPSVR, 2016). Oláh et al. (2008, p.240) characterized deinstitutionalization as "an influential trend in contemporary social work that promotes, in all cases where possible, non-constitutional forms of care that are easily accessible to the client and do not tear the client out of their natural environment, i.e., care provided within the community."

The overall transition was based on the following recommendations of the DI Ad-hoc Group Report:

- respect the rights of beneficiaries and their involvement in decision-making processes,
- prevent institutionalization ,
- create community services,
- close institutions,
- limit investments in original institutions,
- human resources development,
- the efficient use of resources,
- quality control,
- a holistic (comprehensive) approach,
- continuous awareness raising (MPSVR, 2016, p. 10).

The amendment to Act No. 305/2005 Coll. on the social and legal protection of children and social guardianship on 1 January 2019 brought about significant legislative changes. The biggest change concerned the transition of children's homes, crisis centers, and resocialization centers into a new type of multifunctional facility called centers for children and families (CDR). This involved the transformation of spatial conditions, personnel structure, educational conditions, and economic conditions. If a home transformed into separate groups is compared with a boarding school type, at first glance the transformed homes appear more advantageous. When it comes to the quality of housing, project design, the functionality of premises, and equipment, the position of separate groups is almost unshakable (Škoviera, 2006). Škoviera (2006, p.74) offers us another perspective, namely, "if we add a standard home environment to the comparison and choose as a criterion what can be called the "truthfulness" of the environment (we understand it as the relationship between what the environment really is and what it is declared to be externally), the outcome in favor of family types is not so clear." The author explains his statement:

- A true home is a home without any need to declare it outwardly, it is defined by the emotional and legal relationship between parent and child.
- The boarding school declared itself to be an alternative solution, but did not create the illusion of a real home.
- The so-called family type - if aspirations are to replace a real home - only creates the illusion of a real home.

Empirical verification of the functionality of deinstitutionalization

The purpose of the survey we conducted was to determine the general public's view of the

centers for children and families, what knowledge the public has about how they function, the nature of the services provided, and its clientele, and whether they are aware of the legislative changes from 2019, especially regarding the transformation of former children's homes into centers for children and families. We asked them specific questions that gave them the opportunity to express their views on the topic using a questionnaire.

We set the following hypotheses:

Hypothesis No. 1: We assume that the public thinks that children who grow up in centers for children and families are unable to start a family and live an organized family life because they did not grow up in a classic family environment and did not have a role model.

Hypothesis No. 2: We assume that the public believes that children of Roma origin are overrepresented in centers for children and families compared to children of non-Roma origin.

Hypothesis No. 3: We assume that the public believes that children who leave a center for children and families are sufficiently prepared for life and can integrate into society without major problems.

Hypothesis No. 4: We assume that the public believes parents continue to have contact with a child placed in a center for children and families after the child has been removed from their care.

Organizational requirements for the survey

We used Survio, an online platform for creating and distributing questionnaires that also provides tools for comprehensive response analysis. We chose this method for its advantages as a quantitative research tool, such as:

- **anonymity** – in our case, anonymity was provided in terms of the answers to the questionnaire questions. The sample we addressed were respondents we know personally, but the questionnaire was filled out anonymously, without personal contact and without knowing which of the respondents had filled out the questionnaire at all,
- **time to think** – the time period for completing the questionnaire was from 09/2023 to 10/2023. However, the time respondents devoted to completing it was their personal choice,
- **the number of respondents** – a large number of respondents can be addressed.

We primarily used closed-ended questions in the questionnaire to reduce hesitation in completing it, especially if respondents found the questions too open-ended. The questions were designed to elicit clear responses, either in the form of a yes/no answer or by offering three or more specific choices.

The questionnaire began with 3 identification questions, where respondents indicated their age, gender, and education, thus providing us with basic demographic data. Respondents then answered 19 questions. As mentioned, we avoided leading questions so the data obtained would not distort the survey results.

In total, we addressed 310 respondents, and we excluded the following from the survey sample:

- children and youth under 18 years of age
- CDR employees
- other interested persons in this issue
- children placed in CDRs

In our case, the questionnaire was completed by a larger number of women than men, 71.5% women and 28.5% men, namely 143 women and 57 men. The selection was not targeted, but random. The largest representation was in the age category 35-44 years with a total of 72 respondents, or 36% of the total number. The second largest group was the age category 18-24 years with 38 respondents, 19.0% of the total number. The age groups 25-34 and 45-54 years both accounted for 17.0% of the respondents, or 34 individuals each, placing them in third position. The smallest group of respondents was the age group 55-64 years, with 22 respondents, or 11.0% of the total number.

When determining the level of education, the respondents provided the following data. The largest number of respondents was represented by those who had graduated from a secondary vocational school and completed their studies with a high school diploma. The number of respondents with a high school diploma was 86, or 43.0% of the total number of respondents. This was followed by respondents with a second-level university degree, there were 40 of them, representing 20.0% of the total number of respon-

dents. This was followed by 25 respondents with a secondary vocational school without a high school diploma, 12.5% of the total number. The next group, with 20 respondents and a 10.0% representation, were respondents with a 1st-level university degree. There were 17 respondents with a high school diploma, 8.5% of the total number. The next group consisted of respondents with a primary school degree, amounting to 12, or 6.0% of the total number. We also mentioned the possibility of using the "other" group, which the respondents did not use.

Research part

We asked the question: *Did you know that since January 1, 2019, the name center for children and families has been used and the original name children's home has been discontinued?* By asking this, we were investigating whether the public had noticed the changes effective from January 1, 2019. 67% of the respondents (134 respondents out of 200) did not know about the change. The remaining 66 respondents (33%) knew about the change, but it cannot be concluded that they actively use the new name. It is unclear whether they continue to refer to the institution by its older name, children's home, which has been in use for a longer period and is more deeply ingrained in the public's memory. It is also not possible to deduce from these answers that the respondents who noticed the change also understood the content change (the merging of functions, etc.).

Table 1 Did you know that since January 1, 2019, the name center for children and families has been used, and the original name, children's home, has been discontinued?

ANSWER	ANSWERS	SHARE
yes	66	33.0%
no	134	67.0%

Table 2 Children placed in centers for children and families (CDRs)

ANSWER	ANSWERS	SHARE
orphans	76	38.0%
half-orphans	35	17.5%
they have both parents	89	44.5%

The table refutes the myth that there are only children in CDRs who do not have parents, commonly referred to in the past as orphanages. 89 respondents, or 44.5% of the total number of respondents, chose the answer that the children have both parents. The answer orphans was chosen as an option by 76 respondents (38%). A total of 17.5%, or 35 respondents, think that children in CDRs are half-orphans.

Table 3 The biological family contacting children is permitted

ANSWER	ANSWERS	SHARE
allowed anytime	105	52.5%
only allowed a few times a year	61	30.5%
not allowed at all	34	17.0%

As displayed in the table above, we learned from our respondents that more than half of the total number of 200, 105 respondents or 52.5%, think the biological family can visit the child at any time. Of course, court orders, agreements with the CDR on visits, etc., must also be taken into account. 61 respondents (30.5%) are convinced that children can only be visited a few times a year. The rest of the respondents, 34, totaling 17.0%, answered that children are not allowed visitation at all.

Table 4 Do you think that children are sufficiently prepared for real life after leaving CDRs and can integrate into society without major problems?

ANSWER	ANSWERS	SHARE
yes	43	21.5%
no	157	78.5%

Our hypothesis no. 3 is also related to this question: We assume that the public thinks that children who leave centers for children and families are sufficiently prepared for life and can integrate into society without major problems.

As the table shows, 157 respondents think that the problem occurs when integrating into society (78.5%), and only 43 respondents out of the 200 think the opposite (21.5%).

Table 5 Do you think the statement that the majority of children in CDRs are of Roma origin is true?

ANSWER	ANSWERS	SHARE
yes	122	61.0%
no	78	39.0%

This question was very important for us because it is the basis of our hypothesis. 61% of the respondents answered that the statement is true, and 39% disagreed with the statement.

Hypothesis no. 2: We assume that the public believes that children of Roma origin are more represented in centers for children and families than children of non-Roma origin.

Table 6 Do you think that children who leave CDRs are able to start a family and live an organized family life, despite the fact that they did not grow up in a classic family environment and did not have a role model?

ANSWER	ANSWERS	SHARE
yes	180	90.0%
no	20	10.0%

This question was key for us because it is linked to hypothesis no. 1: We assume the public thinks that children who grow up in centers for children and families are not able to start a family and live an organized family life because they did not grow up in a classic family environment and did not have a role model. So far, this is the biggest difference between two answers because 180 respondents, 90%, chose yes, and just 10% of the total number, 20 respondents, chose no.

Table 7 Do the biological parents from whom the child was taken maintain contact with the child in the CDR?

ANSWER	ANSWERS	SHARE
yes, often	11	5.5%
less often	172	86.0%
they don't contact their child at all	17	8.5%

Another key question related to hypothesis no. 4: We assume the public believes that parents maintain contact with a child in a CDR who has been taken away from them.

We offered 3 possible answers to the question we asked. There were also striking differences in the answers. The answer "less often" was chosen by 172 respondents out of 200 (86%); the answer "they do not contact their child at all" was chosen by 17 respondents (8.5%); and the answer "yes, often" was chosen by a total of 11 respondents (5.5%).

Discussion

Table 6 in the study corresponds to hypothesis number 1, where respondents were given the option to choose from two answers. This question stood out in the entire questionnaire due to the significant disparity in responses, with a distribution of 90% to 10%. Specifically, 180 respondents believed that children who leave a CDR are capable of starting a family and living an organized family life, despite not growing up in a traditional family setting or having a role model. Our hypothesis was **not confirmed**. We claimed the public thinks these children are not capable of this.

Hypothesis number 2 is related to Table 5 in the study, where we asked the public the following question: "In your opinion, is it true that the majority of children in CDRs are of Roma origin?" We hypothesized that the public believes that children of Roma origin are more prevalent in centers for children and families than children of non-Roma origin. Respondents were given the option to answer either "yes" or "no." The results showed that 122 respondents (61% of the total) believed that children of Roma origin make up the majority in CDRs, while 78 respondents (39%) disagreed with this statement. This means that our assumption was **confirmed.**

In the third hypothesis, we investigated whether the public believes that children are sufficiently prepared for life and can integrate into society without major difficulties after leaving a center for children and families. The questionnaire results clearly show that 157 respondents, or 78.5%, do not believe that children are ready for real life after leaving a CDR and will be able to integrate into society, as they answered no. Only 43 respondents, or 21.5% of the total, expressed confidence that these children are prepared for life and can successfully integrate into society. We can therefore conclude that hypothesis no. 3 is **unconfirmed.**

The final hypothesis, stated as "We assume that the public believes that parents maintain contact with the child in the CDR that was taken away from them," was examined using the data presented in Table 7. Respondents could choose from three answers. The first answer "yes" was chosen by 11 respondents. The answer "less often" was chosen by 172 respondents, representing 86% of the total number of respondents. The last option, " they do not contact their child at all," was chosen by 17 respondents. This leads to the only conclusion: the hypothesis is **unconfirmed.**

Hypothesis No. 1 – unconfirmed – We assumed that the public thinks children are not capable of starting a family and living an organized family life because they did not grow up in a classic family environment and did not have a role model. The public's answer was yes, they are capable of it (90%).

Hypothesis No. 2 – confirmed – We assumed the public believes that children of Roma origin are more represented in centers for children and families than children of non-Roma origin. The public's answer was yes, the majority of children are Roma (61%).

Hypothesis No. 3 – unconfirmed – We assumed the public thinks that children are sufficiently prepared for life and can integrate into society without major problems after leaving a center for children and families. The public's answer was no (78.5%).

Hypothesis No. 4 – unconfirmed – We assumed the public believes that parents maintain contact with a child in a CDR who was taken away from them. The answer "yes, often" was only chosen by 5.5% of respondents.

Conclusion

When comparing hypotheses 1 and 3, a contradiction becomes apparent. While 78.5% of respondents believe that children leaving a CDR are not able to integrate into society, 90% believe they are capable of starting a family and living an organized family life. These views are somewhat conflicting because we think a person who cannot integrate into society also has a problem finding a life partner and thus starting a family. It's important to recognize that these children often come from environments that are not ideal for their physical, psychological, and social development, and it can have lasting effects. Not all children can process traumatic events quickly, if at all. Our goal and mission is to work with both the child and their family to eliminate shortcomings, problems, and complications so the child can return to their own biological family. During their stay in a CDR, we strive to create an environment that closely resembles a true home.

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Centers for Children and Families as a Subject of the Social-Legal Protection of Children and social Guardianship

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Abstract:

The study focuses on centers for children and families (CDR) as key entities of the social and legal protection system for children and social guardianship in Slovakia. It discusses their legislative anchoring, objectives, forms of measures, and practical implementation in accordance with the current legal regulation. It describes various interventions – residential, field, outpatient – and specialized programs, principles of work with children, documentation systems, and financial security. The study also includes a public opinion poll, which revealed the population's partial awareness of how centers for children and

families function, especially regarding pocket money, meals, and allowances. The results point to the need to improve public awareness and a take more sensitive approach in the diagnostic phase. The work offers a comprehensive view of CDRs as a tool for protecting the best interests of children in situations where remaining in their natural environment is not possible.

Legislative grip

Act No. 305/2005 Coll. characterizes the measures of social and legal protection of children and social guardianship (SPODaSK) that are implemented in centers for children and families. These measures are as follows:

a) measures temporarily replacing the child's natural family environment or substituting the family environment based on a court decision ordering institutional care, an urgent measure, or imposing an educational measure (court residence measures),
b) educational measures imposing an obligation to undergo social counselling or other professional counselling; obligations imposed to ensure the purpose of an educational measure, pursuant to a special regulation or urgent measures imposing such an obligation (outpatient educational measure),
c) measures to prevent the emergence, worsening, and recurrence of crisis situations for a child in a natural or substitute family environment, as well as to prevent the child from developing psychological, physical, and social disorders due to problems in the natural or substitute family environment, the social environment, and in interpersonal relationships,
d) specialized programs for children who are victims of human trafficking, maltreatment, sexual abuse, or other acts that threaten their life, health, or psychological, physical, and social development,
e) resocialization programs to support the social integration of a child or adult addicted to alcohol, drugs, or pathological gambling.

The Social and Legal Protection of Children and Social Guardianship Authority has established centers for children and families as budgetary organizations. Centers for children and families may also be established by:

- a village,
- a higher territorial unit.
- legal or natural persons.

Act 305/2005 Coll. states that "measures under this Act may be carried out or participated in by a natural person or legal entity by implementing various methods, techniques, and procedures on the basis of the granted accreditation, unless otherwise provided by this Act." In point 3, it further states that "an accredited entity shall not carry out measures under this Act for the purpose of making a profit." Overall, the above-mentioned Act deals with accreditation in Sections 77 to 86, where it specifies the implementation of measures by accredited entities, the conditions for granting accreditation, the accreditation procedure, and the termination and cancellation of accreditation.

The Ministry of Labour, Social Affairs and Family of the Slovak Republic reports the following number of centers for children and families in Slovakia, as seen in the Table 1. The data was updated as of 1.1.2017.

Table 1 The number of state and non-state CDRs by region

	CDR – state	CDR – non-state (accredited)
Banská Bystrica Region	12	5
Košice Region	14	2
Trenčín Region	6	1
Trnava Region	7	3
Žilina Region	6	4
Bratislava Region	5	4
Nitra Region	9	3
Prešov Region	8	4
TOTAL	**67**	**26**

Centers for children and families provide services through residential, field, and outpatient formats. These forms of intervention can be effectively and appropriately integrated to maximize their impact. Act No. 305/2005 Coll. § 46 para. 1 states for whom CDRs implement measures in its residential form. These include:

a) a child based on
   - agreements with the parent or person who personally cares for the child,
   - the child's requests,
   - court decisions on the order of institutional care, on the order of an urgent measure, and on the imposition of an educational measure,

b) an adult natural person
   - who is participating in a resocialization program,
   - who is a young adult, after the court's residence order ends upon the child reaching the age of majority,

c) a pregnant woman, a woman after childbirth, and her child.

Internal standard No. IN – 012/2019 issued by the Central Office of Labour, Social Affairs and Family (2019) states that when implementing SPODaSK measures in CDRs, the following applies:

- the principle of the primacy of the natural family environment,
- the principle of priority for placing children who cannot grow up in their natural family environment in alternative personal care, or if this is not possible, in foster care,
- the principle of priority for placing children and, if necessary, children with their parents, in a CDR on the basis of an agreement, if possible and expedient, before placing a child in facilities on the basis of a court decision,
- the principle of priority for placing children in CDRs based on a court decision in professional families over other organizational units of this facility,
- the principle of priority of implementing a court decision in separately organized groups established in separate houses or apartments, if it is no longer possible to place the child in a professional family,
- the principle of preserving sibling relationships and not separating siblings,
- the principle of placing children as close as possible to their natural family environment,
- the principle of integrating children who require special or increased care.

Ďurková Fábryová, in her methodological guidelines for the education sector at centers for children and families, defines the target group she works with as follows:

- a child
  - based on an agreement with the parent or person caring for the child,
  - which is in the facility upon request,
  - based on a court decision,
- an adult natural person
  - who is participating in a resocialization program,
  - a young adult, after the court's residence order ends upon the child reaching the age of majority.

All centers must have their own program for children and families. Decree 103/2018 Coll. in § 1 clearly lists the essentials of the program that must be included. These programs must be published on the CDR website and available to everyone for study. Essentials that must be included are, for example, contact details, the purpose of the center, the type of measures implemented, the form of the implementation of measures, a description of the target group, the total number of places, the number of buildings, a description of internal and external spaces, the number of employees, professional work methods, a description of healthcare provision, a description of school attendance, and other essentials. The legislation mandates the inclusion of 25 essential elements; however, it does not prescribe a specific graphic format, only that these elements must be present.

The maximum number of groups in one family house or one building of the center that is not a family house can be two. The total number of groups allowed in one apartment is one.

The number of separately organized groups in one family house is at most two, if one of them is a specialized separate group. If it is an

apartment, the maximum number is one. If it is a building that is not a family house or an apartment, there can be at most two groups (Decree 103/2018 Coll. § 13). The number of children in one group is 10.

For each child, a social worker establishes a file. This obligation is imposed by law. Specifically, Decree 103/2018 Coll. in Section 31 details the maintenance and requirements of the file, which must include:

- the decision on a residence order by the court,
- the child's birth certificate,
- report cards,
- a social report on the child prepared by the social and legal protection of children and social guardianship authority prior to admission to the center,
- a comprehensive assessment of the child's situation and its updates, including the conclusions of psychological diagnostics and recommendations of a psychologist, an assessment of the child's social situation and other professional assessments, reports, examination results, and necessary information about the child's health status to assess the child's situation,
- a video recording of the child; the video recording is updated at least once every six months,
- video recordings and audio-visual recordings documenting significant events in the life of a child who is kept in the register of children who need to be placed in foster care or adoption,
- records of the child's psychological, physical, and social development,
- an individual plan for the development of the child's personality, an individual plan for implementing measures regarding a residence, or an individual resocialization plan and evaluations and updates,
- records of parental visits and other visits,
- records of leaving the center when unauthorized to do so, accidents, and other risky situations,
- other requirements necessary for the implementation of measures and monitoring the fulfillment of their purpose.

Additionally, the center prepares and maintains the following documentation, depending on the purpose and form of the implemented measures:

- an individual plan for the child's personality development,
- a plan for implementing measures regarding the child's residence– based on an agreement,
- a plan for preparing a young adult for independence,
- a plan for implementing residential care measures for the child – in a specialized program,
- an individual resocialization plan,
- a plan for implementing measures in an outpatient or field form (Act No. 305/2005 Coll. Section 45, paragraph 9).

Centers for children and families whose purpose is to implement a residence measure based on a court decision must develop an individual plan for the development of the child's personality in cooperation with the SPODaSK authority, and if possible with the child himself/herself. The abbreviation IPROD is used for the individual plan for the development of the child's personality. It is a set of partial plans for the implementation of professional activities in the center, in particular:

- a social work plan – a partial plan, developed by a social worker that contains:
  - the degree of risk to the child, a description of the determination procedure,
  - an assessment of the child's situation,
  - cooperating entities in creating a social work plan,
  - the goals of social work at the center,
  - specific tasks to achieve the goals
  - criteria for evaluating task completion and the deadline for re-evaluating the task,
  - the result of the reassessment of task performance and the level of threat,
  - other crucial facts that could help in fulfilling social work.
- an educational work plan with a child – the activity of the educator in direct contact with the child; the educational plan is evaluated in such a way as to capture the child's development. The plan includes:

- sub-goals that follow on from IPROD,
- specific tasks to achieve the goals,
- other crucial facts and significant events related to the child's life.

- the main tasks of the psychological activity carried out by the center's psychologist – The psychologist shall, upon the child's arrival at the facility, provide psychological intervention aimed at stabilizing the child's immediate emotional reaction to the stressful situation of transitioning to a new environment, and subsequently monitor the child's adaptation process,
- a comprehensive nursing care plan if the child's health condition requires it - This is developed in centers where there are specialized separate groups and children whose health conditions require special care based on a medical opinion. These are children:
  - with a mental disability,
  - with a physical disability,
  - with a sensory impairment,
  - with a combination of disabilities.

Educator documentation refers to the parts of the file documentation listed below that may also contain outputs processed by educators. They are as follows:

- a comprehensive assessment of the child's situation and updates (Pedagogical diagnostic report and recommendations),
- an individual plan for the development of the child's personality, an individual plan of measures in the form of residential care, an individual resocialization plan with evaluations and updates,
- a plan for educational work with the child,
- a record of the child's mental, physical, and social development,
- half-yearly reports on the child,
- the book of life,
- records of pocket money, gifts in kind, and the child's valuables,
- records of parental and other visits,
- records of leaving the center without authorization, accidents, and other risky situations,
- other significant events in the child's life are recorded. (Ďurková Fábryová)

G. Kriglerová (2015) draws attention to a certain situation when a child comes to a CDR and goes through a diagnostic phase, which serves as a basis for developing individual plans for the development of their personality. However, diagnostic methods are often not sensitive enough to ethnocultural differences among children and the specifics of the environment from which they come. The fact that adaptation to a different language environment can distort the child's performance in tests is not taken into account. The overall behavior can be classified as problematic because it does not correspond to the norms of behavior in the facility. For example, regarding Roma children from segregated localities, this is their first contact with a formalized institution in the non-Roma world, so the adaptation process is more difficult for them. Gradually, they realize that their behavior is not unmanageable, but is just a reaction to a new life situation and not their personality trait. However, these reactions also have an impact on the helping staff. As Mačkinová and colleagues (2024, p. 1) state, "the burden and resilience of helping professions have a significant impact on workers in this field." Mačkinová describes helping workers as irreplaceable and important forces (2020, p. 10). "Their skills, professional qualifications, their passion for the cause and, last but not least, the ability to cooperate and collaborate with all parties are important."

In the case of a professional's inability to cope with the workload, supervision is an important aspect, as it serves as a type of prevention. As Nowak and Planka (2024, p. 7) state, "supervision is oriented towards teaching, guidance, reflection, feedback, and, in a certain sense, support for the supervisee. Through supervision, we prevent burnout, control and monitor the procedures used, and receive feedback."

Centers for children and families provide various financial contributions. The amount of contributions depends on changes to the subsistence minimum. The subsistence minimum is always reassessed on July 1 of a given year. The financial contribution also increases on this date. The official website of the Ministry of Labour, Social Affairs and Family of the Slovak Republic states that "as of July 1, 2020, the subsistence minimum amounts were established by the Measure of the Ministry of Labor, Social Affairs and Fam-

ily of the Slovak Republic No. 174/2020 Coll. The subsistence minimum of a natural person or natural persons whose income is assessed is considered to be the sum or total of the amounts:

- €214.83 per month, if it concerns one adult natural person,
- €149.87 per month, if it is another jointly assessed adult natural person,
- €98.08 per month if it is a dependent child or a dependent minor child."

Act 601/2003 Coll. on the subsistence minimum and on amendments and supplements to certain acts in Section 1 defines the subsistence minimum as follows: "This Act establishes the subsistence minimum as a socially recognized minimum income limit of a natural person, below which a state of material need occurs."

As was mentioned, the subsistence minimum set by the Ministry of Labour, Social Affairs and Family of the Slovak Republic, in our case is €98.08 per month. All contributions provided are therefore based on this basic amount.

Contributions to ensure the purpose of the court's residence order and contributions are as follows:

- food allowance,
- pocket money,
- gifts in kind,
- contributions to independence.

Food allowance

The amount of food units is regulated by the Decree of the Ministry of Social Affairs and Health of the Slovak Republic No. 103/2018 Coll. in Section 8, paragraph 1. It states that food shall be provided according to the food units per day. It can be provided for a child, a minor mother, a child of a minor mother, a young adult, and an adult natural person. The food unit is determined as a percentage of the subsistence minimum. The exact data is provided in the Table 2.

The food units can be increased to cover food and raw material expenses:

- by 25% if dietary food is provided for a diabetic diet, a protein diet, a nutritional diet, or a special diet,
- by 8% during non-working days, except Sundays and public holidays (in 2020 it was specifically 06.01, 10.04, 13.04, 01.05, 08.05, 15.09, 01.11, 24-25-26.12),
- by 5% during recreational activities provided by the center for children and families,
- by 7.2% during recreational activities when collecting food from other natural or legal persons.

Decree 103/2018 Coll. in Section 9, paragraph 1 states that the food unit per day is determined according to the number of meals taken as a percentage of the amount calculated according to Section 8, which is

a) with a rational diet, a sparing diet, and a low-salt diet:
   1. breakfast 12%
   2. morning snack 9%
   3. lunch 40%
   4. afternoon snack 9%
   5. dinner 30%
b) for diabetic diets, protein diets, nutritional diets, and special diets:
   1. breakfast 11%
   2. morning snack 8%

Table 2 Food units per child in CDR

		Age category	% of the subsistence minimum
Pursuant to the Decree of the Ministry of Labour and Social Affairs of the Slovak Republic No. 103/2018 - Section 8, paragraph 1	FOOD UNIT	0 - 3 years	2.2 - 3.4%
		3 - 6 years	2.3 - 3.6%
		6 - 10 years	2.4 - 3.9%
		10 - 15 years	2.6 - 4.2%
		15 - 18 years	2.7 - 4.4%
		18 years and over	4.4 - 5.3%

3. lunch 40%
4. afternoon snack 8%
5. dinner 27%
6. second dinner 6%

The CDR director has the authority to reduce or increase the percentages in the provision of meals, but only while staying within the range of the total meal units per day specified by law.

The Table 3 shows, as an example, the specific processing of the financial contribution for meals, where CDRs set the % of the subsistence minimum within the range set by law while retaining the number of meals and their percentage division from the amount set by law.

Pocket Money

A child placed in a center for children and families pursuant to a court-ordered residence decision, as well as a young adult undergoing measures while preparing for a profession, is legally entitled to receive pocket money. This allowance is provided on a monthly basis and is determined according to the rates specified in the Table 4, calculated as a percentage of the subsistence minimum.

Act 305/2005 Coll. Section 66 in paragraphs 2, 3, 4, 5, and 8 further states that:

- The child decides how to use the pocket money, but the child may be provided with assistance that takes into account their age and mental maturity,
- Pocket money can also be provided in several installments per month, if it is purposeful and appropriate. Or with the child's consent, pocket money or part of it can be kept for a certain period of time,
- Due to educational reasons, the amount of pocket money can be reduced for the child. The difference can be paid in the next round of pocket money, or the amount corresponding to this difference can be deposited into the child's personal account,

Table 3 Example of processing food units in CDRs

		Breakfast	Morning snack	Lunch	After-noon snack	Dinner	
% of the amount of the CDR	Age category	12%	9%	40%	9%	30%	Total EUR
2.8%	0 to 3	€0.33	€0.25	€1.10	€0.25	€0.82	€2.75
3.0%	3 to 6	€0.36	€0.26	€1.18	€0.26	€0.88	€2.94
3.3%	6 to 10	€0.39	€0.29	€1.30	€0.29	€0.97	€3.24
3.6%	10 to 15	€0.42	€0.32	€1.41	€0.32	€1.06	€3.53
3.8%	15 to 18	€0.45	€0.34	€1.49	€0.34	€1.11	€3.73
5.0%	over 18	€0.59	€0.44	€1.96	€0.44	€1.47	€4.99

Table 4 Pocket money for a child in a CDR

Pursuant to the Decree of the Ministry of Labour and Social Affairs of the Slovak Republic No. 103/2018 - Section 23, paragraph 1	POCKET	Age category	% of the subsistence minimum	Amount
		6 - 10 years	8%	€7.85
		10 - 15 years	12%	€11.77
		15 years and over	30%	€29.42

- Pocket money can be used to create savings for the child, with their consent,
- The amount of pocket money established for a month is reduced by the proportional amount of pocket money for those days when the child left the CDR (escaped) and stayed outside the center without permission.

Financial literacy is a very important topic these days. Even with a child in a CDR, it is necessary to address this topic and not avoid it. Pocket money is a great tool for teaching children how to handle money. A child does not yet have a general idea of the value of money and cannot recognize what an adequate price for a good or service is. When communicating, it is necessary to take into account the child's age and intellectual maturity. If a child's pocket money has been reduced for educational reasons, it is necessary to explain this to the child and give them space to express themselves. Subsequently, the decision must be evaluated to see if it has achieved its purpose, and the child must be informed.

Gifts in kind

Gifts in kind are provided on important life events of children and young adults. These include, for example, birthdays, name days, significant religious events, sporting achievements, school achievements, and other achievements in other areas of social life. Act 305/2005 Coll. § 67 further states that the amount due on such an event is at least 25% of the subsistence minimum for a dependent child.

Independence allowance

A one-time allowance is provided to a young adult to facilitate their independence. It is used to provide housing and housing-related items. The allowance is provided upon leaving the center, no later than the day of their departure. It is provided only once and:

- in cash,
- in a tangible form,
- in a combined form.

It provides a set amount, up to a maximum of

Table 5 Gifts in kind for a child in a CDR

Pursuant to Act No. 305/2005 of the Ministry of Labour and Social Affairs of the Slovak Republic - Section 67	GIFT IN KIND	% of the subsistence minimum	Amount
		at least 25%	€24.52

Table 6 What is the financial value (how many €) of meals for one day that should be allotted for the breakfast, morning snack, lunch, afternoon snack, dinner and drinking regimen for 10-15 year old children?

ANSWER	ANSWERS	SHARE
€1 - €2.53	3	1.5%
€2.54 - €3.53	21	10.5%
€3.54 - €4.54	47	23.5%
€4.55 and more	129	64.5%

Table 7 How much does the state contribute to clothing for a child in a CDR, regardless of the child's age?

ANSWER	ANSWERS	SHARE
€100 per year (€8.33 per month)	57	28.5%
€200 per year (€16.67 per month)	71	35.5%
€300 per year (€25.00 per month)	48	24.0%
€400 per year (€33.33 per month)	24	12.0%

Table 8 Do children in CDRs receive pocket money?

ANSWER	ANSWERS	SHARE
yes	120	60.0%
no	80	40.0%

15 times the subsistence minimum for a dependent child. The allowance is not granted if, upon the termination of the court-ordered placement due to reaching the age of majority, the young adult is residing outside the center without its consent, or is serving a prison sentence or held in custody (Act 305/2005 Coll., Section 68). However, the law does not mention one item that is also financially demanding: clothing for the child.

Empirical anchoring of the topic

The aim of our survey was to gain a comprehensive understanding of public perceptions regarding the operation of centers for children and families, including the level of public awareness about their activities, the services they offer, and the nature of their clientele. Respondents were presented with targeted questions to express their opinions on these topics. A questionnaire served as the primary research instrument and was administered through the Survio platform, which facilitated both the distribution of the survey and the detailed analysis of the collected responses.

A total of 310 respondents participated in the survey. However, specific groups were excluded from the sample – namely children and youth under 18, CDR employees, persons directly interested in the issue, and children placed in CDRs.

More than half of the respondents, a total of 129, chose the fourth answer, €4.55 or more. There were 47 respondents who chose the second highest value, representing 23.5%. As the offered amounts decreased, so did the number of respondents. The option €2.54 - €3.53 was chosen by 21 respondents (10.5%), and the option €1 - €2.53 was selected by three respondents (1.5%).

We offered 4 possible answers to this question. The respondents chose the following order – €200, €100, €300, then €400. The distribution of answers, as can be seen from the table, was quite even.

The respondents were divided into two groups. The numerically larger group consisted of respondents who answered yes. There were 120 of them, or 60% of the total number. 40 respondents (40%) believed that children in CDR did not receive pocket money.

Discussion

The survey results suggest that while the public demonstrates a general awareness of the role and activities of centers for children and families (CDRs), there are notable gaps in understanding the specific operational mechanisms of these institutions. Many respondents accurately estimated the amount allocated for children's meals, indicating a basic familiarity with the topic. However, a significant portion—up to 40%—believed that children in CDRs do not receive pocket money, highlighting a lack of awareness regarding the social benefits available to these children. The survey also revealed that public perceptions regarding the amount of state contributions for clothing are inconsistent, suggesting a lack of transparency and limited media coverage of specific support measures. These findings highlight the need for more systematic and accessible public communication about the operations of centers for children and families, including their legislative framework and the practical aspects of the services they offer. Moreover, the results raise important questions about how public awareness and attitudes may influence levels of support for, or distrust of, these institutions.

Conclusion

Centers for children and families play a vital role in Slovakia's system of social and legal child protection, ensuring comprehensive care when a child cannot remain in their natural family environment. The study revealed that both the legislative framework and practical implementation of measures are extensive and differentiated, with

a strong emphasis on individualized care, the protection of children's rights, and their gradual reintegration into society. Nevertheless, ongoing challenges remain, particularly in addressing ethnocultural sensitivity and ensuring adequate public awareness. The empirical findings suggest that while public familiarity with CDRs exists, there is significant potential to enhance this through educational and informational campaigns. For these institutions to continue operating effectively, it is essential not only to ensure robust legislative and professional support but also to foster greater public trust and engagement.

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The Impact of Tele-education on the Mobilization of mothers post Cesarean Section

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Original Article

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Abstract:

Starting points: When it comes to nursing, the incorporation of information and communication technologies represents a tool for improving the availability of nursing care, reducing costs for its provision, reducing disparities in the provision and access to nursing care, and, last but not least, the development of nursing as a scientific field. One rapidly developing nursing service abroad is, for example, telenursing, and in the

Slovak Republic it is tele-education.
Objectives: The objective was to create and implement a tele-education program for physical activity that was intended for respondents who had undergone a cesarean section. The program should be accessible using a QR Code created in Microsoft Sway, and the outcome should be the ability to analyze the impact of the tele-education program on the early mobility of postpartum women and the prevention of postpartum and postoperative complications.
Research sample and methods: The research sample consisted of 411 respondents from an obstetrics and gynecology clinic. The average age of the respondents was 31 years. It was a quasi-experiment. A self-constructed questionnaire was used for data collection. Statistical tests, including the Chi-square test and Cramer's V, were used for data analysis.
Results: We found statistically significant strong relationships between completing the tele-education program and the early mobility of respondents after a cesarean section in favor of its completion: an earlier start of exercise (V=0.571); getting out of bed with less assistance after surgery for the first time after 24 hours (V=0.428); more stable and confident walking 3 days after the surgery (V=0.386).
Conclusion: The development of various mobile platforms in the 21st century indicates the interest in tele-education and its positive impact on health and illness.

Introduction

Similar to the implementation of telemedicine across medical fields, tele-nursing can also be applied to all age categories and in several nursing domains. These areas include tele-education and remote counselling. Based on the WHO Health 21 document, the National Health Promotion Program of Slovakia includes the preparation and implementation of educational programs for individuals, families, and communities on the topics of health and illness. It also promotes the development of technologies and services supporting healthcare. Digital technologies in nursing and its applied fields, including gynecological and obstetric nursing, contribute to alleviating the concerns, biases, and prejudices of puerperal women and to close collaboration within nursing teams. Physical activity and the overall mobilization of postpartum women are significant components of therapeutic approaches aligned with nursing care and interdisciplinary collaboration in implementing non-pharmacological treatments. Prokešová (2018) points out the fact that without subsequent postpartum exercises with a longer interval, the function of pelvic floor muscles would be compromised, leading to pelvic organ prolapse, the development of stress incontinence with manifestations of sexual dysfunction, and lumbopelvic pain. Nursing care and physiotherapy complement each other, and therapeutic approaches and procedures are implemented to support, maintain, and restore health. Information and communication technologies can assist healthcare institutions in addressing the shortage of nurses. These technologies have emerged at a time when patients suffering from chronic illnesses require expanded consultations and services. This represents an opportunity for educated nurses to "go virtual" and enhance their value as healthcare professionals (Fadhila, Afrian, 2020). Trends in the development of nursing care in the 21st century are expanding the nurse's role to include the provision of tele-nursing through

information and communication technologies whenever physical distance exists between a patient and a nurse.

Goal

The goal was to implement the tele-education physical activity program for mothers after a cesarean section that was embedded in a QR code and to analyze its impact on the physical condition of the mothers – more specifically, their mobility. Through deliberate, methodical guidance and the repetition of selected exercises, we aimed to support the function of a specific organ system in postpartum women. We hypothesized tele-education would have a significant impact on the physical activity of the experimental group of respondents compared to the control group. We assumed there would be more significant differences in selected indicators of physical condition among respondents who completed the tele-education program compared to respondents after a C-section who did not complete the program: verticalization after 24 hours, walking stability, turning over in the bed, sitting after 24 hours, and self-sufficiency in daily activities.

The Sample

The sample consisted of 411 respondents who underwent obstetric surgery with the medical diagnosis of cesarean section according to ICD-10 code O82.0. They all expressed their consent to participate in the tele-education program and complete the provided questionnaire. The average age of the respondents was 31 years. The inclusion criteria were respondents after a cesarean section and having undergone general anesthesia. Out of the total number of respondents, 138 mothers (33.6%) voluntarily completed the tele-education program, 113 mothers (27.5%) partially completed the program, and 160 mothers (38.9%) did not complete the tele-education program. The age distribution of the sample is practically identical in the group that participated in the program and the group that did not participate in the program ($p = 0.943$).

Methodology

This was a quasi-experiment. Respondents were divided into control and experimental groups based on their expressed interest in participating in the tele-education program. To examine the established methodological phenomena, we used methods of analysis and synthesis to observe the relationships between various variables and the effect of the application of tele-education. An online self-constructed questionnaire and the Get Up and Go evaluation and measurement scale (Libová et al., 2020) were used for data collection. The questionnaire contained 26 items that identified the physical condition of mothers, specifically their mobility in relation to tele-education. Descriptive statistical characteristics were used for data analysis: n – frequencies, % – relative frequencies with first-degree and second-degree classification tables. To evaluate the individual objectives and compare the groups, we used the Chi-square test of homogeneity with a significance level of $\alpha=0.05$. The test assesses the overall statistical significance of differences in response options among examined subgroups.

To assess the strength of the relationship between the examined variables in conjunction with the Chi-square test, we used the value of Cramer's V. A V-value around 0.50 indicates a relatively strong relationship, while a value greater than 0.60 indicates a strong or very strong relationship.

The collection of empirical data was carried out at the Faculty Hospital in Nitra at the obstetrics and gynecology clinic in the postpartum department from June to November 2022 with written consent from the ethics committee. The tele-education program was created using the online presentation tool MS Sway. The content included an educational-instructional program on the principles of physical activity after cesarean delivery. The tele-education was structured for the first three days post-C-section, starting within the first two hours after delivery, with the aim of early mobilization and recovery. After completing the tele-education program, respondents filled out an online questionnaire that was part of a series of 10 instructional physical activity procedures to be done over time. Pilot testing was conducted in June 2022 at the Faculty Hospital in Nitra. Awareness of the tele-education program was promoted in the postpartum

department at the Faculty Hospital in Nitra with the help of nurses and midwives, who informed the respondents about the QR code that was laminated and placed in each room.

Figure 1 QR code of the tele-educational physical activity program (Source: author)

We implemented the physical activity tele-education program embedded in a QR code (Figure 1). Subsequently, we examined the impact of the tele-educational physical activity program on the early mobility of mothers after cesarean section.

The results

We present the responses to selected questions from the questionnaire and compare different areas in terms of completion, partial completion (experimental group), and non-completion (control group) of the tele-education program for mothers after C-section. We investigated when the respondents started exercising after the C-section in relation to their participation in the program. The results are presented in Table 1.

We found a statistically significant difference in exercising, specifically the start of exercising after the surgery in relation to participation in the tele-education program ($\chi^2(8)=267.7$, $p<0.001$; $V=0.571$, $p<0.001$). The relationship between the variables can be considered large ($V=0.571$).

We also analyzed a statistically significant difference in getting out of bed for the first time after the C-section in relation to participation in the tele-education program (Table 2).

We found a statistically significant difference in getting out of bed for the first time after the surgery in relation to participation in the tele-education program ($\chi^2(4)=150.6$, $p<0.001$; $V=0.428$, $p<0.001$). The relationship between the variables can be considered large ($V=0.428$).

Table 1 Differences at the beginning of exercise due to the completion of the TP

Exercise:		yes	partially	no	overall
2 hours after C-Section	n	65	6	5	76
	%	47.10%	5.30%	3.10%	18.50%
6 hours after C-Section	n	54	23	18	95
	%	39.10%	20.40%	11.30%	23.10%
12 hours after C-Section	n	16	21	23	60
	%	11.60%	18.60%	14.40%	14.60%
Later	n	3	59	49	111
	%	2.20%	52.20%	30.60%	27.00%
I did not exercise	n	0	4	65	69
	%	0.00%	3.50%	40.60%	16.80%
Overall	n	138	113	160	411
	%	100.00%	100.00%	100.00%	100.00%
			Value	df	P
		χ^2	267.7	8	<0.001
		Cramer V	0.571		<0.001

We also examined the difference in walking three days after the surgery in relation to participation in the tele-education program (Table 3).

We found a statistically significant difference in walking three days after the surgery in relation to participation in the tele-education program ($\chi^2(4)=122.2$, $p<0.001$; $V=0.386$, $p<0.001$). The relationship between the variables can be considered large ($V=0.386$).

We also investigated differences in turning over in bed three days after the C-section based on the completion of the tele-education program (Table 4).

We found a statistically significant difference in turning over in the bed three days after the surgery in relation to participation in the tele-education program ($\chi^2(4)=80.1$, $p<0.001$; $V=0.312$, $p<0.001$). The relationship between the variables can be considered moderately large ($V=0.312$).

Table 2 Differences in the first movement - getting out of bed after 24 hours in relation to the completion of the tele-education program

Getting out of bed for the first time:		**yes**	**partially**	**no**	**Overall**
Without any help	n	52	4	3	59
	%	37.70%	3.50%	1.90%	14.40%
With the help of hands	n	78	85	72	235
	%	56.50%	75.20%	45.00%	57.20%
With the help of medical staff	n	8	24	85	117
	%	5.80%	21.20%	53.10%	28.50%
Overall	n	138	113	160	411
	%	100.00%	100.00%	100.00%	100.00%
			value	df	p
		χ^2	150.6	4	<0.001
		Cramer V	0.428		<0.001

Table 3 Differences in walking three days after surgery in relation to the completion of the tele-education program

Walk:		**yes**	**partially**	**no**	**Overall**
Steady	n	83	17	19	119
	%	60.10%	15.00%	11.90%	29.00%
Unsteady	n	50	63	70	183
	%	36.20%	55.80%	43.80%	44.50%
Unstable	n	5	33	71	109
	%	3.60%	29.20%	44.40%	26.50%
Overall	n	138	113	160	411
	%	100.00%	100.00%	100.00%	100.00%
			Value	df	P
		χ^2	122.2	4	<0.001
		Cramer V	0.386		<0.001

We also analyzed a statistically significant difference in sitting up three days after the C-section in relation to the completion of the tele-education program (Table 5).

We found a statistically significant difference in sitting up three days after the surgery in relation to participation in the tele-education program ($\chi^2(4)=65.3$, $p<0.001$; $V=0.282$, $p<0.001$). The relationship between the variables can be considered moderately large ($V=0.282$).

We also investigated a statistically significant difference in the assessment of self-sufficiency in daily activities based on the completion of the tele-education program. The results are presented in Table 6.

We found a statistically significant difference in the assessment of self-sufficiency in daily activities based on the completion of the tele-education program ($\chi^2(4)=113.7$, $p<0.001$; $V=0.372$, $p<0.001$). The relationship between the variables can be considered large ($V=0.372$).

Table 4 Differences in turning over in the bed three days after the C-section based on the completion of the tele-education program

Turning over in the bed		yes	partially	no	Overall
Certain	n	27	13	2	42
	%	19.60%	11.50%	1.30%	10.20%
Uncertain	n	106	66	85	257
	%	76.80%	58.40%	53.10%	62.50%
Significantly uncertain	n	5	34	73	112
	%	3.60%	30.10%	45.60%	27.30%
Overall	n	138	113	160	411
	%	100.00%	100.00%	100.00%	100.00%
			value	df	p
		χ^2	80.1	4	<0.001
		Cramer V	0.312		<0.001

Table 5 Differences in sitting up three days after surgery based on the completion of the tele-education program

Sitting up in bed:		yes	partially	No	Overall
Without any help	n	40	10	4	54
	%	29.00%	8.80%	2.50%	13.10%
With the help of hands, leaning	n	92	76	112	280
	%	66.70%	67.30%	70.00%	68.10%
Significantly uncertain, help needed	n	6	27	44	77
	%	4.30%	23.90%	27.50%	18.70%
Overall	n	138	113	160	411
	%	100.00%	100.00%	100.00%	100.00%
			value	df	p
		χ^2	65.3	4	<0.001
		Cramer V	0.282		<0.001

Discussion

The aim of the study was to compare various aspects of mobility based on the completion, partial completion, and non-completion of the implemented tele-education program among mothers after cesarean section. Maskalová (2018) highlights the most common problems faced by mothers, such as getting out of bed and surgical scar pain. Libová et al. (2020) emphasize the objective assessment of a patient's condition, the application of new scientific knowledge, and effective nursing procedures for patients after surgery. In the context of investigating the impact of the tele-education program (TP) on the mobility of mothers, we evaluated the relationship between the tele-education program and the variables of physical activity immediately after 2, 6, and 12 hours post-C-section, categorizing the impact as significant. Out of 411 mothers, 14.6% to 27.0% used each of the online physical activity time options, clearly indicating that mothers who completed the TP, or even partially completed it, began exercising earlier after the cesarean section compared to mothers who did not participate in the TP at all. We found a statistically significant difference when getting out of bed for the first time after the operation with regard to the completed program. Mothers were significantly more capable of standing up without assistance if they completed the entire TP. Conversely, only a small number of mothers who partially completed or did not complete the program were able to stand up without assistance. After completing the TP, a greater proportion of mothers had a stable walk on the third day post-operation. In contrast, those who did not complete the program continued to experience unstable walking on the third day post-operation. The relationship between the variables concerning turning over in the bed can be considered moderate. The difference was most noticeable in the evaluation of turning as significantly uncertain; very few mothers who completed the program exhibited this, whereas nearly half of those who did not complete the program did. Approximately 1/3 of the mothers were able to sit up without assistance if they completed the TP. Regardless of program completion, about 2/3 of the mothers used hand support or leaning to sit up. Mothers required more significant assistance in sitting up even after 3 days, with about 1/4 of the mothers who did not complete or partially completed the program needing assistance. The largest statistically significant difference favors the group that completed the entire TP, as mothers were self-sufficient and independent in 63% of these cases. Conversely, in the group that did not complete the program, self-sufficiency was at the level requiring substantial assistance in nearly 1/3 of cases. The results indicate relative-

Table 6 Differences in self-sufficiency in daily activities based on the completion of the tele-education program

Self-sufficiency:		yes	partially	no	Overall
I am self-sufficient and independent	n	87	16	22	125
	%	63.00%	14.20%	13.80%	30.40%
I need minimal help	n	46	72	90	208
	%	33.30%	63.70%	56.30%	50.60%
I need a lot of help	n	5	25	48	78
	%	3.60%	22.10%	30.00%	19.00%
Overall	n	138	113	160	411
	%	100.00%	100.00%	100.00%	100.00%
			value	df	p
		χ^2	113.7	4	<0.001
		Cramer V	0.372		<0.001

ly strong relationships between the early mobility of mothers and completing the implemented TP. The tele-education on breathing, vascular gymnastics for arms and legs, gradual verticalization, and exercises for sitting and lying down were confirmed to have a significant effect on the mobility of mothers, and this was directly targeted by individual studied variables. Jingru et al. (2020) conducted a prospective randomized study implementing ERAS, including lateral rotation within 6 hours and post-operative verticalization within 24 hours. Movement was assessed using the VAS scale on the first and the second day postpartum. The VAS scale was also used to evaluate the satisfaction of mothers, showing that the satisfaction of the group using the ERAS protocol was significantly higher and included various therapeutic approaches in contrast to the control group. Research has shown that delayed mobilization, functional recovery, and breastfeeding difficulties have a significant impact on pain and postoperative complications. Sancho et al. (2015) conducted a cross-sectional experimental study in Portugal investigating the impact of abdominal exercises on mothers after cesarean section (CS). The intervention involved three abdominal drawing-in exercises. Subsequently, ultrasound produced three images of the abdominal wall above and below the umbilicus in JPG format, concluding that the exercise results were more effective below the umbilicus than above it. Laronche et al. (2017) characterized early mobilization within 6-8 hours post cesarean section in a comparative multicenter prospective study. Their assessment included sitting ability, early fluid intake, light food intake within 8 hours, infusion therapy lasting less than 12 hours, the removal of the urinary catheter within 12 hours, and oral analgesics limited to the first day post-operation. The study found higher satisfaction among mothers and lower pain scores on the third day in the group using Enhanced Recovery After Surgery (ERAS) programs, which has been confirmed. Boden et al. (2018) investigated the impact of physiotherapeutic care, breathing exercises, and early mobilization on the health of mothers. The results favored physiotherapeutic care, which prevented postoperative complications and improved physical health compared to mothers receiving standard nursing care. Physiotherapy is an effective and cost-effective treatment with minimal harm to mothers. Breathing techniques and the effects of core exercises post C-section were also reviewed by Gürsen et al. (2016), who evaluated this through muscle and abdominal tests after 4 weeks. Mothers' problems decreased, and postpartum complications were eliminated. Based on the results of our study, exercises added through the TP are more effective than the exercise alone.

In a study by Chermak et al. (2016), the benefits of incorporating physical activity into comprehensive post-C-section care management to improve treatment outcomes and alleviate surgical procedure consequences were confirmed. The purpose of the randomized controlled study by Weerasinghe et al. (2022) was to examine the effectiveness of personalized physiotherapy training and education for mothers undergoing a C-section. They similarly assigned benefits to physical activity, breathing techniques, and postural care, which reduced the immediate pain associated with the surgical incision and difficulties in functional activities, as we also presented in our research. Mothers who completed the tele-education program had significantly better outcomes compared to the group receiving standard nursing care, suggesting that physical activity can be a beneficial adjunct in improving postpartum recovery.

Conclusion

In Slovakia, the utilization of tele-nursing is still in its early stages. Physical activity represents a significant part of therapy in both prenatal and especially postnatal periods. Movement and vitality among the current "digital" generation of mothers are declining sharply, making it appropriate to focus mothers' attention on a new way of delivering and presenting nursing care online via QR codes. We identified the positive impact of an online tele-education program on the mobility of respondents after a cesarean section. Mobile platforms are currently used across all sectors; therefore, it is desirable to implement them in various applied fields of nursing, including preoperative and postoperative patient care. Tele-education interventions in

physical activity that were tailored to the needs of mothers, creative, and engaged nurses in information and communication technologies and tele-nursing contributed to the postpartum health of respondents.

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Women with HIV/AIDS and healthcare Stigma: An Analysis of challenges to Women with HIV/AIDS in Malakand Division Khyber Pakhtunkhwa

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Abstract:

This research paper explores the dual impact of social and healthcare-based stigma on women living with HIV/AIDS in Pakhtun society, focusing on their access to healthcare services in the Malakand region of Khyber Pakhtunkhwa Province of Pakistan. Pakhtun society, which is characterized by strict gender norms and an emphasis on honor and modesty, intensifies the challenges faced by HIV/AIDS-positive women. Social stigmas include discrimination, isolation, and psychological distress, which strongly affect their lives and willingness to seek medical care.

Healthcare-based stigma manifests discriminatory attitudes and practices exercised by healthcare providers and exacerbates their lack of access to necessary treatment and support. The study is guided by the research question of how social and healthcare-based stigma impact the access of women living with HIV/AIDS to healthcare services in the Malakand Division within the cultural context of Pakhtun society. The study was conducted through a qualitative approach using an interview schedule, focus group discussions, field notes, case studies, and observation. Though the study was challenging in terms of the cultural restrictions regarding accessing women living with HIV/AIDS, an effort was made to gain deep insight into the impacts of social and healthcare-based stigma on access to healthcare facilities in the Malakand Division. Field data was thematically analyzed and is presented in the form of themes. The discussion is also supported by data from the field and is reinforced by available literature, observation, and field notes. However, for the presentation of personal data, the ethical consideration of the research and field data coding was strictly observed.

Introduction

The prevalence of human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) is still a tremendous challenge to public health authorities globally, particularly in developing countries (Campbell et al., 2017; Paraskevis et al., 2011; Bonovas and Nikolopoulos, 2012). The disease can progress to acquired immunodeficiency syndrome (AIDS), making the body highly susceptible to different opportunistic infections and diseases (Campbell, Ni, & Lim, 2019; Gul A, et al., 2024). It can be transmitted through different routes, including the exchange of body fluid from an infected person to a healthy person through sexual contact, exposure to infected blood, sharing needles or injectable equipment, and from mother to child (during pregnancy, childbirth, or breastfeeding). As a chronic disease, AIDS seriously affects public health around the world, and the mortality caused by AIDS is much higher than other diseases transmitted through sexual contact (STDs) (Li et al., 2014). Even though HIV/AIDS programs are efficiently making efforts to control the situation, still an estimated 38 million people were living with HIV/AIDS at the end of 2019. Additionally, 1.7 million new infections and approximately 690,000 AIDS-related deaths were recorded that year.

Although significant progress has been made in HIV/AIDS prevention, treatment, and care programs, many people living with HIV/AIDS still face significant barriers to care and treatment services, particularly in low- and middle-income countries; there has been no attention given to school curriculums, the involvement of religious leaders, and communities in minimizing its prevalence (UNAIDS Report, 2020; Ihsan et al., 2019). In developing countries like Pakistan, the situation becomes graver as poverty, gender discrimination, a lack of awareness about the disease, social and healthcare-based stigma, risky healthcare practices, and cultural barriers to the use of condoms make women more vulnerable to HIV/AIDS (Bonnel, 2000; Mall, S., et al. 2015; Sana Ulla and Naz, 2019). Gender-based power imbalances, social stigma, women's subordinate status within society, and cultural observance towards women's health having low importance contribute to their increased vulnerability to HIV/AIDS (Shacham et al., 2009).

However, although the prevalence of HIV in Pakistan is relatively low, with approximately 220,000 individuals living with HIV/AIDS

in the same year (NACP, 2020), this figure has the potential to increase. This is due to the cultural norms and values in the Khyber Pakhtunkhwa region, a province of Pakistan that does not allow women free access to testing services, as it is considered contrary to the cultural traits of honor and dignity to consider the possibility of HIV/AIDS in women. There is a misconception about the disease that it might have been transferred through extramarital sexual relations, which is strongly prohibited in the culture and results in honor killing and disputes in society.

Due to this fear, addressing HIV/AIDS testing and treatment is challenging in Pakistan; this results in limited access to prevention and treatment services, which is exacerbated by insufficient funding for HIV/AIDS programs (UNAIDS, 2020). Protection from the disease becomes more difficult for marginalized and vulnerable communities because of the lack of access to appropriate health healthcare facilities (Hargreaves and Boler, 2006; Bahadar Ali, Muhammad Humayun, Parveen Gul, Suhail Shahzad & Arab Naz, 2023). Low economic conditions also contribute to unequal access to healthcare facilities, which prioritize healthcare needs based on gender and provide the less accessibility to healthcare for women compared to men. Furthermore, this gender discrimination and social and cultural barriers in women's social mobility decrease women's access to healthcare, assistance, and treatment services (Population Council Report, 2009). It is important to understand the specific needs and challenges faced by women in this cultural context for effective HIV/AIDS prevention and control in Pakistan (Abdool Karim et al., 2010).

The existing study focuses on the impacts of social stigma and healthcare stigma on women's access to healthcare services in the Malakand Division to understand the conditions of women living with HIV/AIDS in Khyber Pakhtunkhwa. HIV/AIDS prevalence and healthcare access data show that only 18% of women have access to antiretroviral therapy (ART) compared to 47% of men, which is due to socio-cultural, economic, and religious factors (Azim et al., 2008). Moreover, in Khyber Pakhtunkhwa, access to health services is not equal due to gender differences, highlighting that access to treatment services for HIV/AIDS is affected by aspects of gender discrimination and that gender-based inequalities tend to negatively affect women's health. This inequity indirectly impacts women's contributions to economic activities, as culturally women's access to education, jobs, and income-generating activities is very low. Thus, the women in Pakhtun culture are more prone to poverty, increasing their economic dependency on their male counterparts and limiting their role in making decisions about their health issues (Ahmad & Ali, 2020). Thus, the impact of social stigma on women is very serious because of their subordinate role in society, which makes them more fragile and vulnerable when it comes to accessing healthcare services for HIV/AIDS (Silvester et al., 2005).

Moreover, socio-cultural and religious factors also contribute to the prevalence of misconceptions about HIV/AIDS. These misconceptions result in social stigma in this society that bring about negative impacts on women's health in Pakhtun culture. A lack of trained medical staff, awareness, and education about HIV/AIDS within the health structure also contributes to healthcare-based stigma that affects women's access to healthcare services (Shah & Zaman, 2022). Furthermore, insufficient health facilities for the disease and an unavailability of treatment services at the nearest location are also factors that affect women's access to healthcare services. Women in Khyber Pakhtunkhwa have restricted social mobility because of cultural restrictions, and in such cases, it becomes more difficult for women to access healthcare services because stigma is associated with the disease (Ahmad & Ali, 2020).

Hence, healthcare-based stigma and social stigma have impacts on women's accessibility to healthcare services for HIV/AIDS, as only 14% of HIV-positive women are registered, according to the National AIDS Control Program (NACP) in Pakistan (NACP, 2020). The rest of them remain unregistered and untreated, preferring to conceal the fact that they have it since the cultural and societal values restrict women from

talking about it. Within the domain of Pakhtun culture, existing research investigated how social stigma and healthcare-based stigma affect the access of women living with HIV/AIDS to healthcare services. The region has high poverty levels (Ullah. S, Naz, A. Khan, M.A. Khan, H.M, 2021), experiences gender inequalities, possesses limited awareness about the disease, practices risky healthcare practices, and additionally, cultural barriers to condom use expose women to HIV infection (Agha, 2019). The social stigma associated with certain health issues often leads to healthcare-based stigma, which results in discrimination and prejudice faced by patients within the healthcare setting (Shaikh & Hatcher, 2005). The focus of the present study is to deeply explore the impacts of dual stigma on women living with HIV/AIDS, paying special attention to the Pakhtun cultural background's effect on accessing healthcare services in the Malakand Division.

Statement of the problem

Although research has been done on various aspects of HIV/AIDS, the interconnectedness of these stigmas, where healthcare-based stigma overlaps with social stigma, has not been thoroughly explored. Existing research tends to focus separately on social and healthcare-based stigma, addressing their combined effect on women's health outcomes and access to care (Khan & Khan, 2012; Roomaney & Van Wyk, 2018). There is a pressing need for studies integrating these two dimensions to better understand how they collectively impact women's health-seeking behaviors and access to healthcare services in Pakhtun culture in the Malakand Division. This integrated approach is crucial for developing effective interventions and policies that address the specific needs of women in stigmatized communities. This study is guided by research questions, such as: What are the impacts of social stigma and healthcare-based stigma on the access of Pakhtun women living with HIV/AIDS to healthcare facilities? Data was collected to explore the impacts of social stigma and healthcare-based stigma on women living with HIV/AIDS when it comes to accessing healthcare facilities.

Methods and procedure

The study was delimited to two selected districts of the Malakand Division, District Dir Lower and District Swat. The choice was based on the fact that District Dir Lower has a higher number of HIV/AIDS patients in the province after District Peshawar. District Swat was selected based on the 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) and gave equal representation to both districts. 10 other stakeholders included an organizational head, doctors, and key informants. The researcher used in-depth interviews, observations, case study field notes, and key informants to develop deep insight into the problem. The collected information was qualitatively analyzed following Braun and Clarke's (2006) six-step thematic analysis model. Due to 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. Thanks to fastidious organizing, coding, and analyzing qualitative data, thematic analysis uncovers meaningful patterns and themes, providing valuable insights into the research topic.

Results and discussion

Women living with HIV/AIDS in Pakhtun society encounter significant barriers to accessing health services. Healthcare-based stigma and social stigma hinder women's accessibility to treatment services for HIV/AIDS in the Malakand Division. These stigmas are deeply linked with cultural, societal, and institutional norms that discriminate and exclude. Social stigma and discrimination highlight the negative societal attitudes and restrictions imposed on individuals with HIV/AIDS. Healthcare-based stigma occurs when healthcare professionals have prejudiced or discriminatory behavior towards patients with a certain disease (Hatzenbuehler et al., 2013). Healthcare providers' negative attitudes towards individuals with HIV/AIDS lead

to substandard care or the avoidance of treating these patients (Kleinman & Hall-Clark, 2009). Data was collected through different tools like in-depth interviews, focus group discussions, participant observations, and field notes. Though it was very challenging to reach out to female HIV/AIDS patients due to the given cultural sensitivity, the researcher's previous experience in working in different organizations and links with different departments were utilized to develop contact with female HIV/AIDS patients. Interviewees were assured of the confidentiality of their provided information and the consent form was explained to them. Analysis of the data shows that women who are HIV/AIDS positive face social stigma and healthcare-based stigma, which result in psychological and emotional distress that bar them from accessing available health care services. Major themes that emerged from the analysis of the data are below.

Fear of Rejection and Health Services Access

The majority of the interviewed women 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 in developing patients' fear of rejection by society. This stigma and fear restrict them from talking about their illness, and ultimately they hide it from their own family and people outside their family. This is the main hurdle in accessing health services and a contributing factor to the prevalence of the disease. Women living with HIV/AIDS are often subjected to stigmatization due to societal gender norms (Nyblade, MacQuarrie, and Canales, 2001; Nasar Khan, Arab Naz, 2023). Primary data also support the relevance of gender norms and societal pressure on HIV/AIDS patients, as 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 HIV/AIDS patients is highlighted by the interviewee. Although she is not guilty of any wrongdoing, she still faces the stigma. In her case it shows that men are not held responsible for wrongdoing or perceived as doing wrong, but the woman's status in society is always very vulnerable to social stigma. This is specifically true in Pakhtun culture, where she is considered a source of honor and shame for a man. Furthermore, Herek, Capitanio, and Widaman (2002) highlight that the detrimental impact of social stigma on the well-being of individuals with HIV/AIDS is very high, which 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 the personal quote of the interviewee that the illness is curable, but the negative behaviors of the people make them suffer more. This shapes their perspectives, making them more vulnerable to disease because of the social pressure they face in addition to the disease. The same feeling shared by another respondent validates that social pressure and rejection create fear among those affected by the disease:

"They misconceive them for wrongdoings. Allah forgives his followers, but people don't, even if they have not done anything wrong." (WPI01)

The analysis of the data aligns with the available literature and concludes that the patients develop fear because of the social stigma they face at the family level and in society, making them more vulnerable and having negative impacts on their health-seeking behaviors. Women prefer to avoid seeking access to healthcare services because of this fear of rejection and the hatred they face. This creates hurdles in forming an HIV/AIDS control program that aims to diagnose, treat, and control the spread of the disease.

Concealment of the disease

Another important theme that emerged during primary data analysis was the conceal-

ment of the disease, which is a potential threat to public health. Most of the respondents stated that they do not share the information with relatives or people outside of the family, and they possibly might not even share their HIV/AIDS status during minor medical procedures. Therefore, in a developing country such as Pakistan, where the standard of health facilities is not sufficient and medical protocols are neglected or avoided, treatment due to injuries from the earthquakes in rural communities and can pose threats to the spread of HIV/AIDS (Ahmed & Mahmood, 2018).

In rural areas of the Malakand Division, baby deliveries are normally dealt with by traditional birth attendants at home in the absence of advanced medical techniques and procedures, and the concealment of one's HIV/AIDS status can pose a threat to the spread of disease (Farooq et al., 2020). Similarly, one of the interviewees said that because of social rejection and isolation, she does not share her illness with people, which can both affect her health and increase the prevalence of the disease. Because of the fear of the social stigma associated with the disease, the fear of rejection and isolation don't allow them to talk about their disease, as one of the respondents shared:

"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." WPI6

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."

Social stigma has strong effects on the lives of women living with HIV/AIDS, both at the family level and outside their families. They refrain from disclosing their HIV/AIDS status to others, as one of the respondents shared:

"I received the disease from my husband, who was in Saudi Arabia. My in-laws were treating me very badly, they separated their kitchen, they separated their prayer mat (janamz), and I was sitting alone and crying all the time. I wanted to hug my children, but I could not. I felt as if I had committed sin although I received it from my husband, but nobody was talking against him. I never told this to anybody outside the family. Otherwise they would also keep their distance from me." (WPI 9)

Another important aspect of the concealment of the disease was the fear of honor killing in Pakhtun culture, which was discussed indirectly in focus group discussions due to the sensitivity of the issue. It was said that in some places, women are involved in extramarital relations that cause HIV/AIDS. However, because of the fear of honor killing, it is always kept secret. It is evident from the interviewees' responses that social stigma has far-reaching effects on the lives of women living with HIV/AIDS, both in their private lives and in their social lives, which does not allow them to make their health status public.

The fear of rejection and isolation is so strong that women living with HIV/AIDS put their lives and those of others in danger by concealing their HIV/AIDS status. They normally avoid seeking health services because of the fear that people will discuss them in bad ways or perceive them as wrongdoers because of the misperception and lack of awareness about the disease. The available literature and analysis of the data reflect on the relationship between social stigma and the access of women living with HIV/AIDS to healthcare services. Cultural rigidity towards the disease and misperceptions about the transmission of the disease are the main factors preventing women from talking about their problem, which can lead to the spread of HIV/AIDS among healthy people.

Healthcare-based Stigma

Healthcare-based stigma refers to negative attitudes and discriminatory behaviors exercised by healthcare providers to individuals living with HIV. In Pakhtun culture, women's roles and responsibilities are subjected to patriarchal norms and values, and a high value on the family reputation, known as *Ghairat* (honor), is attributed to women's behavior and control over mobility. She

is expected to uphold the family's honor through modesty, obedience, and limited interaction with males, particularly with family males (Ahmad & Ali, 2020). In a cultural context, when a woman is diagnosed with HIV/AIDS in Pakhtun culture, she faces social stigma that is multiplied by healthcare-based stigma that restricts her from receiving healthcare services available for the disease. Different research shows that women living in strict Pakhtun culture where the presence of a man is considered important during her mobility face difficulty in accessing healthcare facilities (Roomaney & Van Wyk, 2018; Tariq & Hussain, 2018). They are reluctant to access healthcare services because of the impacts of social stigma and discrimination in society and culture; in such cases, the negative and hateful attitude of healthcare providers makes them more vulnerable when accessing healthcare services (Roomaney & Van Wyk, 2018). This stigma can manifest in various ways, including substandard care, breaches of confidentiality, and overt discriminatory practices that bar women from accessing healthcare services for HIV/AIDS (Shaikh & Hatcher, 2005; Zakar et al., 2011; Mahajan, Sayles, Patel, and Remien, 2008)

Primary data aligned with the available literature and showed that healthcare-based stigma has far-reaching effects on women's access to healthcare services. During interviews, the patients shared their experiences at healthcare facilities, displaying that patients face both social stigma and healthcare-based stigma, both of which have significant impacts on their access to treatment and healthcare facilities. The collected data further differentiated the healthcare-based stigma and showed that hospitals with specialized places for HIV/AIDS treatment are very cooperative and don't discriminate or behave negatively. However, when they initially tried to get treatment from a hospital without a specialized HIV/AIDS staff, they were neglected and treated with hatred. This is a major problem in developing countries that have limited healthcare facilities, a lack specialized centers for HIV/AIDS, and certain services only available in main cities. The impact of stigma and discrimination on the quality of care provided is evident in this interviewee's statement:

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

A case study of a child aged 22 months who passed away during the period of this research also shows that her mother suffered from healthcare-based stigma, and the doctors' and nurses' hateful and discriminatory attitude was a main factor in the delayed treatment of the child.

Healthcare-based stigma has a strong negative impact on access to healthcare facilities. Women dealing with HIV/AIDS mostly face a lack of attention and social support from their families because they depend on their males to receive treatment. In such cases, the fear of healthcare-based stigma discourages women from visiting healthcare facilities for HIV/AIDS treatment because of the fear of being ashamed and disgraced (Nyblade et al., 2001; Herek et al., 2002; Campbell et al., 2007; Aggleton and Parker, 2002). 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 interviewees' statements with supporting literature, this article highlights the significance of social stigma and discrimination and provides a basis for understanding and addressing these issues. This study highlights the pervasive impact of the fear of rejection and stigma on women living with HIV in Pakistan. Addressing both healthcare-based and social stigma is essential for improving access to health services. Future research should explore targeted interventions to reduce stigma and support women in seeking necessary care.

Interplay Between Healthcare-Based Stigma and Social Stigma

The interaction between healthcare-based stigma and social stigma results in a serious threat to the available healthcare services for HIV/AIDS in culturally sensitive environments. The role of social stigma in general has a very strong effect on women's lives in Pakhtun culture, where forced marriages and honor killings exist; in such a scenario, a woman's HIV/AIDS

status is a very sensitive issue to handle (Ali et al., 2011; Zakar et al., 2011). This compounded stigma in the cultural context of Pakhtun society diminishes women's capacity to talk for themselves in healthcare settings, further restricting their access to care.

Conclusion

The study concluded that social stigma and healthcare-based stigmas have significant and far-reaching impacts on Pakhtun women living with HIV/AIDS regarding their access to health services in the Malakand Division. The complex web of social norms that emphasize honor and modesty increase the challenges faced by these women, leading to discrimination, social exclusion, isolation, and psychological distress. The pervasive stigma in healthcare settings in addition to social stigma further complicates their situation, resulting in delayed or denied access to necessary medical care and treatment services. Women living with HIV/AIDS in Pakhtun culture are often reluctant to seek medical support due to fear of exposure, judgment, mistreatment, and the hateful and prejudiced attitudes of healthcare providers at healthcare facilities. This fear leads to a refusal to test, late diagnoses, inadequate and incomplete regular treatment, and overall poorer health outcomes. In Pakhtun culture, women not only face restricted mobility and autonomy, but also a lack of awareness and misconceptions about HIV/AIDS, leading to further stigma and discrimination.

Recommendations

To address these challenges, there is a need for comprehensive interventions that can not only reduce societal stigma but also promote supportive and non-discriminatory healthcare environments. Efforts should be focused on educating healthcare providers about HIV/AIDS and its related protocols and implementing policies that protect patient confidentiality and privacy to build trust and confidence in healthcare services. During the study, it was observed that the disease is also prevalent because of the absence of proper screening facilities at healthcare facilities. Modern techniques must be applied while screening blood so transmission of the disease is prevented. It is very important to include community religious and political leaders in education and awareness programs related to HIV/AIDS to create awareness and support for affected people. Community-level initiatives can reduce misconceptions and stigma associated with the disease. These initiatives have the potential to both provide support to the affected population and encourage testing for HIV/AIDS. It is important to educate the youth about the spread and prevention of the disease by adding information at the curriculum level. Treatment facilities should be close enough to women to increase accessibility and the chance of survival. This would also address issues of delays in continuing medication because of the unavailability of drugs. The availability of local healthcare services could also help women overcome their fear of leaking information about the disease and encourage them to talk about their health issues. During the study, it was observed that the disease is also prevalent because of the absence of proper screening equipment available at hospitals, which also needs to be addressed.

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On the Problem of the Common Good and Paternalism in the Current Political Context

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Abstract:

Aim. The aim of this article is to explore and analyze the tension between the individual rights of citizens and the demands of the common good in the context of the modern democratic state, focusing on the paternalistic measures taken during the COVID-19 pandemic. The article seeks to clarify how crisis situations reveal the limits of liberal democracy in balancing personal freedom and the public interest.

Concept. The article (1) explores the tension between the personal interests of individuals and the common good; (2) analyzes relevant philosophical categories, such as freedom, moral autonomy, and the common good; (3) draws on the discourse of political and moral philosophy to identify the theoretical limits and practical consequences of paternalism towards individual rights in the modern democratic state; and

(4) focuses on the paternalistic measures taken during the COVID-19 pandemic as examples of situations in which the principles of liberty and autonomy come into conflict with the declared public interest.

Results and Conclusion. The article highlights the conflict between personal interest and the demands of the common good in democratic states, which was fully manifested during the COVID-19 pandemic. The theoretical-methodological analysis shows how paternalistic measures restrict individual freedom and how they are applied to protect public health in crisis situations. The conclusions emphasize that democratic societies must be willing to seek practical compromises in political decision-making.

Itroduction

The tension between the personal interest of individual citizens on the one hand and the common good (or public interest) on the other can be characterized as a problem of the modern democratic state. It is a latent and subtle problem that normally stands in the background and only comes to the surface in times of crisis - most recently very explicitly during the COVID-19 pandemic (2020-2022). However, it is also reflected less intensely in the context of long-term problems, such as the environmental crisis and the conditions of sustainable development.

In a liberal democratic order, freedom and individualism are traditionally placed on a pedestal, which in practice means that each person has the right to determine his or her own course and to decide about their own life and happiness, without unnecessary interference from the state or other authorities. Principles such as individual rights, personal responsibility, moral autonomy, and the need for self-fulfillment are highlighted, emphasizing the importance of personal identity. The normative framework is based on a plurality of forms of the good life, which shapes the value neutrality and the uniqueness of each person. However, political decision-making in a liberal democracy also takes into account the interests and needs of society as a whole.

These two currents can conflict when personal interests prove incompatible with the common good or public interest. For example, when it comes to public health issues such as vaccination, the state may restrict some individual rights for the sake of protecting the population, and, conversely, interfere with individual liberty through paternalistic measures by commanding or nudging. Conflicts between autonomy and paternalism often arise in the field of bioethics and medical ethics, specifically in cases such as refusing treatment that can save a patient's life, intervening in suicide attempts, and lying to patients about their health status, when a doctor insists on withholding certain information from the patient for the patient's own good (1, pp. 4-5).

In this article, we focus on specific paternalistic measures applied during the COVID-19 pandemic in the Slovak and Czech political space. These and similar practices within the framework of declaring a state of emergency in a democratic society open up the problem of ambiguity and the necessary revision of basic categories of political and moral philosophy, such as, above all, freedom, moral autonomy, the common good, and the public interest.

The problem of the relationship between individual interest and the common good

Political and moral philosophy discusses, among other things, whether individual interest and the common good (or social utility) are mutually supportive or contradictory. Strauss characterized it by stating that "for political philosophy, or political science is based on the premise that political things are in a class by themselves, that there is an essential difference between political things and things which are not political or that there is an essential difference between the common good and the private or sectional good" (2, p. 132). Even in the second half of the 18th centu-

ry, J. J. Rousseau rightly observed that these two quantities can be in conflict with each other, since it usually happens that the "advantage of one party is the detriment of the other, and private interest is almost always contrary to the public" (3, p. 31). As a suitable example of the manifestation of this conflict, let us take the text of the *Declaration of the Rights of Man and of the Citizen*, the content of which, as solemnly proclaimed by the Constituent National Assembly, was inspired by many of Rousseau's ideas (first version of 26 August 1789). The preamble to this important historical document declares that the purpose of every political institution is to preserve the natural, inalienable, and sacred rights of man. However, it also states that the demands of citizens, as long as they are based on simple and undeniable principles, should always be directed toward the preservation of the Constitution and the good of all people. The first idea requires that individual rights be protected regardless of the circumstances, but the second idea suggests the possibility of modifying or limiting citizens' rights in the interest of the common good.

This problem resonates further in the very first established articles of the Declaration – Art. 1: *Men are born and remain free and equal in rights. Social distinctions may be founded only upon the general good;* Art. 2: *The goal of any political association is the conservation of the natural and imprescriptible rights of man. These rights are liberty, property, safety, and resistance against oppression.;* and Art. 6.*: The law is the expression of the general will. All the citizens have the right of contributing personally or through their representatives to its formation*. Apart from the fact that the first three articles of the Declaration inscribe the slogan of the French Revolution "*Liberté, Égalité, Fraternité*" (although in this case the primacy of equal rights over liberty is evident), it emphasizes that all people are to be free and equal in rights. However, social differences can undermine this ideal, since the definition of the "general good" is vague and therefore easy to manipulate. Moreover, the right to resist oppression may conflict with existing laws and power, creating the risk that individual freedom and rights will be suppressed in the name of protecting the *general will*. Therefore, this definition is paradoxical - a law that is meant to protect the rights of individuals may serve to violate them when it comes to the question of the general good.

The above problem would immediately disappear if we accepted that the satisfaction of personal interests directly leads to the common good. This could, for example, happen through the market, as first described by B. de Mandeville in *The Fable of the Bees* (1714), from which comes the famous phrase "private vices, public benefits." Selfish individualism, as one of the ideas of liberalism presented in Mandeville's satire, assumed that individuals pursuing their own interests create a positive effect for the whole society, so that society is actually an "aggregation of self-interested individuals necessarily bound to one another neither by their shared civic commitments nor their moral rectitude, but, paradoxically, by the tenuous bonds of envy, competition, and exploitation" (4, p. 1). Mandeville supported in principle the concept that was later designated in political economy as *laissez-faire*. These social conditions create *the best of all possible worlds* in the Leibnizian sense, where all state intervention and moral prohibitions are unjustified, and all considerations of the creation of the common good are, in short, completely unnecessary (5, pp. 111-112).

This consideration also inspired A. Smith, who wrote in *The Wealth of Nations* that an individual focused on his own benefit is "led by an invisible hand to promote an end which was no part of his intention," and "by pursuing his own interest he frequently promotes that of the society more effectually than when he really intends to promote it." The individual, on the other hand, (also naturally) does not take into account "promoting the public interest, nor knows how much he is promoting it" (6, p. 456). Here, Smith's "invisible hand" serves as a metaphor for a special kind of rationality, where the personal interests of individuals spontaneously contribute to the general good without any need for intervention.

Smith outlined this concept in an earlier work, *The Theory of Moral Sentiments*, where he characterized the invisible hand as one of several possibilities of unintentional "motivations that lead to conduct serving the public good although

they don't involve any thought of doing such a thing." According to Smith, rich people "in spite of their natural selfishness and rapacity (...) make nearly the same distribution of the necessaries of life, (...) and thus without intending it, without knowing it, advance the interest of the society, and afford means to the multiplication of the species" (7, pp. 184-185). However, in the next paragraph he immediately stated, "when Providence divided the earth among a few lordly masters, it neither forgot nor abandoned those who seemed to have been left out in the partition – these last too enjoy their share of all that it produces" (7, p. 185). This means that this concept refers to God's will or God's plan and contains a religious element – the common good arises even without intervention as a natural order arranged by God, and individual personal interests contribute to the common good (8, p. 54). In other words, satisfying the selfish interests of the rich also contributes in a special way to the well-being of the poor and thus benefits the entire society.

The rationality of the "invisible hand" was shared in a similar vein by modern political economy - the common good is the product of activities that are not themselves aimed at the common good (9, p. 315). Economists such as M. Friedman and F. A. von Hayek argued that market mechanisms and individual decision-making are capable of creating economic prosperity and efficient distribution of resources without the need for central planning. Additionally, they believed that the common good is actually a by-product of individual effort and competition. As long as individuals focus on personal interest (satisfying selfish needs), market mechanisms simultaneously create positive conditions for each individual member of society – paternalism is not only unjustifiable, but also ineffective because the market is spontaneous and self-regulating. State intervention regulating the market or enforcing moral norms disrupts this spontaneous process and causes crisis, stagnation, and inefficiency. The normative model of society weakens the role of the state in socio-economic issues and assumes that individuals pursuing their own interests produce public goods and services themselves, thus minimizing the need for intervention.

However, the pursuit of personal interests can stand in contrast to the common good, as G. Hardin demonstrated in the essay *Tragedy of the Commons* (1968). This is the concept of a model situation where individuals with access to public resources act exclusively in their own interests, inevitably leading to the depletion of resources and a deterioration in the quality of life for all. According to Hardin, A. Smith "contributed to a dominant tendency of thought that has ever since interfered with positive action based on rational analysis, namely, the tendency to assume that decisions reached individually will, in fact, be the best decisions for an entire society" (10, p. 1244). The gradual exploitation of common resources (such as forests, ponds, and air) to maximize personal interest leads to the deterioration and ultimately to the destruction of resources. In this equation, this causes a disadvantage for everyone, as everyone's personal interest is reduced. Additionally, this footprint also affects future generations, so it is an ethical problem of the common good par excellence.

Hardin made an apocalyptic claim: "Ruin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons, freedom in a common brings ruin to all" (Ibid). Here the invisible hand truly takes on a religious dimension, this time in the sense of a pious wish. Hardin argued that the "tragedy of the commons" can be applied to all cases where a set of unregulated personal interests does not promote the common good in the use of public resources - including the case of unregulated traffic in a city where there are no signs or traffic lights because, by some invisible logical principle, it is a priori expected that the personal interests of drivers will spontaneously cause the self-regulation of traffic.

In the current discourse on the relationship between personal interest and common good, communitarianism plays an important role as one of the directions of political philosophy that criticizes liberal individualism. This is primarily because it does not take into account the connection of an individual's identity with their social environment and the values that this community represents because personal decisions are large-

ly influenced by cultural norms. Communitarianism represents an ideological opposition to the liberal tradition represented by philosophers, such as J. Rawls and R. Nozick, who emphasized the value of justice and individual rights (both from completely different and incompatible positions). This conflict between communitarianism and liberalism is based on the definition of concepts such as "freedom" and "responsibility."

While liberalism defines freedom as the absence of obstacles or constraints (i.e., negative freedom, see 11), communitarianism defines it as the ability to act in accordance with the values and goals of the community, which leads to the question of how individual rights can be balanced with the requirement of personal responsibility towards society. Ideally, individual choice contributes to the common good, while always taking into account the cultural and ethical context in which these decisions are made. In this regard, M. Sandel criticized liberalism in his work *Justice: What's the Right Thing to Do?* He emphasized that justice is not only about protecting personal interests but also about seeking the common good. In exploring various ethical theories, including utilitarianism, deontology, and virtue ethics, he pointed out that shared values form the basis of moral autonomy (12). In *After Virtue*, A. MacIntyre criticized contemporary moral pluralism, which leads to a division of ethical opinions and a weakening of social solidarity – values and virtues are rooted in historical and cultural traditions, which means that individuals cannot fulfil their moral obligations without taking into account their community and tradition (13).

We will also briefly discuss political theory from the period of classical ancient philosophy. In his work "The Republic," Plato clarified whether achieving personal good is compatible with the common good, or whether they are one and the same. He explicitly problematized this relationship because "the difficulty would disappear if the common good were identical with the private good of each" (14, p. 91). Plato assumed that most people naturally care only about personal interest, and for them "the common good is derived from the private good via calculation" (14, p. 82). However, there are also "team players" who care about the benefit of the community, and they are the ones who should rule because they "prefer the common interest to their private interest and to the objects of their passions" and are able to "discern in each situation what is the noble or right thing to do, do it because it is noble and right and for no ulterior reason" (2, p. 55). In a just community, where everyone does what is most appropriate for them and what corresponds to their abilities and nature, the common good also arises. Harmony between different parts of the community is key to the common good, as everyone contributes by belonging to the individual tasks of the community. Justice appears here as the "art of assigning to each what is good for his soul and as the art of discerning and procuring the common good" (14, p. 91). In a just community, the sum of personal interests equals the common good.

Although Plato's political theory tends to be characterized as idealistic, his proposal for the division of the community is strongly realistic – the view that some people simply would not be good rulers because they prioritize personal interest over the common good is pragmatic, and it would be idealistic to dismiss it with an argument about universal human nature (such as the zoon politikon as a feature of human identity in Aristotle). Moreover, there was a strong belief among the Sophists at that time that "there is an insoluble conflict between the good of the individual and the common good" (14, p. 88). In "The Republic," this idea is supported by Thrasymachus, who explicitly denied the existence of the common good (15, p. 95). Plato's response to this "unresolvable conflict" is his emphasis on the necessity of a just community built upon the principle that justice arises when each individual performs the role for which they are best suited. This notion reflects Plato's metaphysical belief in the harmony of the soul, where justice within the individual is mirrored in the just ordering of society as a whole (16). Plato's starting point for the "unresolvable conflict" was the establishment of a just community. But is it possible? According to Plato, yes, but first it is necessary for the general public to be indoctrinated with the so-called "noble lie"; but even before that,

"it will take a great art of speech to make anyone believe it" (17, p. 126). If the subjects had accepted the Phoenician story as a historical fact or as a revealed truth, the rulers would have been able to enforce a noble political goal and, according to Plato, this would have "the good effect of making the citizens care more for the community and for each other" (17, p. 127). Plato's demand can be classified as the first (and also special) case of paternalism.

Paternalism

The etymology has roots in the Latin pater or patronus and refers to an approach, principle, or policy demonstrating concern and care for those who cannot help themselves. It is reminiscent of a relationship in which a parent cares for their children, but also has supervision and control over them. It is applied either in an effort to do good to those who are subordinate to the state, or in an effort to prevent harm to them, even in the case of self-harm. Examples include laws that prohibit drug use and require the wearing of seat belts while driving. It is characteristic of the weak version that those who are exposed to it at least broadly agree with it. For the strong version, consent is usually irrelevant and is often associated with authoritarianism. A strong version of paternalism is sometimes justified by the fact that intelligence and experience are not evenly distributed in society, so those in positions of authority or rulers know more than anyone else what is best for others (18, p. 99).

Paternalism, as a concept that focuses on interfering in individuals' decision-making in order to protect them from potential harm, can be oriented both towards the personal interest of the individual and towards social benefit, with both variants pursuing different intentions and having different ethical implications.

Self-interest-oriented paternalism assumes that individuals may not have sufficient information or the ability to properly assess what is best for them. This variant of paternalism focuses on protecting the individual from themselves and is often present in legislation in the form of regulations that restrict the choices of individuals in the name of their own protection, such as laws on the mandatory use of seat belts while driving and safety helmets while cycling. These measures raise ethical questions about interference with personal freedom, moral autonomy, and dignity.

On the other hand, paternalism oriented towards social utility is based on the belief that individual decisions can have a negative impact on society as a whole. An example of this paternalistic variant is environmental protection regulations that seek to limit pollution and ensure sustainable development (here we can also include the above-mentioned "tragedy of the commons"). Likewise, in the area of public health, measures that restrict the sale of unhealthy foods or tobacco are considered paternalistic, as their aim is to protect the health of the population and reduce healthcare costs. Building upon these foundations, contemporary forms of paternalism have expanded into digital and technological domains. During the pandemic, the internet emerged as a crucial platform not only for disseminating guidance and essential information (19), but also for enabling individuals to express opinions (20) and emotions (21) publicly on their terms through social media. Moreover, digital paternalism became evident through increased parental controls to protect children from oversharing and harmful online content (22) and through addressing the psychological impacts of technology use on children's self-esteem and critical thinking (23). Similarly, benevolent oversight was extended, for example, to seniors, as emphasized by Tkácová et al. in their research (24). These modern instances illustrate how paternalistic practices evolve to navigate the ethical tensions between safeguarding individuals and respecting their autonomy in an increasingly digital world.

An important critique of paternalism can be found in I. Kant in several respects. According to him, in civil society it is necessary to ensure that the government does not enforce paternalistic measures because this presupposes authoritarianism: "paternalistic government is the greatest conceivable despotism – subjects are like minors who cannot discern what is truly beneficial or harmful to them, so they are forced to behave only passively and can only expect the determination of the way in which they are to be happy

from the judgment and benevolence of the ruler, since he is concerned for their welfare" (25, p. 69). Kant's critique rested on the assumption that if we deny an adult the right of free choice, even though he may make unreasonable choices, then we are treating him as a means to his own good, but not as an end in itself, which contradicts the second formulation of the categorical imperative, "so act that you use humanity, in your own person as well as in the person of any other, always at the same time as an end, never merely as a means" (26, p. 91). Paternalism violates people's rights as rational beings to determine their own goals. Moral autonomy, as a combination of freedom and responsibility, means that an autonomous person must not be subordinated to the will of anyone else (27, p. 14).

Kant also rejected paternalism in the form of merciful lies when he stated that we should not lie even to a person who knocks on our door and is about to murder a person hiding in our house. This is because if we tell him a lie and the murderer happens to meet this person, we are "responsible for all the consequences" because "whoever then tells a lie however good his intentions may be, must answer for the consequences of it" (28, p. 363). Kant did not allow any exception, because a lie "always injures another; if not another individual, yet mankind generally" (28, p. 362). This also applies to any paternalistic merciful lies, because they are "condemned as a wrong even by external laws" (28, p. 362). Paternalism opposes the categorical imperative (as an external law) and denies moral autonomy in the sense of submission to laws that man has established for himself (17, p. 14).

An ambivalent attitude can be seen in J. S. Mill's works. In *On Liberty* he promoted the view that "neither one person, nor any number of persons, is warranted in saying to another human creature of ripe years, that he shall not do with his life for his own benefit what he chooses to do with it" (29, p. 140), and therefore every individual has the right to decide about their own life as they see fit. Paternalism deprives a man of personal responsibility and of gaining experience from autonomous decisions, which a priori also implies erroneous decisions because "all errors which he is likely to commit against advice and warning, are far outweighed by the evil of allowing others to constrain him to what they deem his good" (29, pp. 140-141). If a third party thinks that the choice is harmful to the individual, they may offer "considerations to aid his judgment, exhortations to strengthen his will"; in any case, it must respect that "he himself is the final judge" (Ibid). Mill was aware that it can be difficult to look at someone who is outwardly making a wrong choice and not hinder their choice. Interfering with moral autonomy is undignified. This extra work by a third party that looks like caring is harmful to the individual because everyone knows best what their needs or desires are, and "he is the person most interested in his own well-being" (Ibid). Personal experience is most important for individual development, which also contributes to the development of society.

However, paternalism is justifiable as long as one wants to sell oneself into slavery because it is a radical choice that inevitably leads to the abdication of freedom, and intervention against such an act is not only justified but also necessary (29, pp. 163-164). It also applies to all cases of protection of freedom from a personal decision, the consequences of which would irrevocably lead to a loss of freedom (1, p. 27). Other exceptions are children, avoiding neglect by parents (30, pp. 78-79), those that are incompetent and irrational, those taken care of (31, p. 230), and "backward states of society in which the race itself may be considered as in its nonage," where Mill defended despotism as a legitimate form of government: a "ruler full of the spirit of improvement is warranted in the use of any expedients that will attain an end, perhaps otherwise unattainable" (29, p. 81). Moreover, Mill also understood paternalism as a form of despotism if the individuals being guided would later recognize that paternalistic intervention protected them and that the authority was right.

Contemporary discourse in political and moral philosophy problematizes the relationship between the protection of individuals and respect for personal freedom and moral autonomy. Supporters of paternalism, such as J. Rawls, A. Sen, and M. Nussbaum, argue that interventions can contribute to levelling inequalities and

ensuring fair conditions for all citizens – social programs to support education and minimum living standards can help vulnerable groups that would otherwise find themselves on the margins of society. Paternalism is a way to empower individuals and allow them to fully develop their potential where there are systematic obstacles that the individual cannot overcome on their own. Critics, such as F. A. von Hayek, A. Rand, and R. Nozick, point out that paternalism leads to the undermining of personal responsibility and the restriction of an individual's freedom to make decisions about their own lives (cf. 32, p. 139). Paternalism often involves interference in private decisions, leading to a loss of motivation and creativity for individuals, as it reduces their ability to learn from their mistakes and take responsibility for the consequences.

Nozick, in his book *Anarchy, State, and Utopia*, took an anti-paternalist position by arguing that anyone "may choose to do to himself anything, unless he has acquired an obligation to some third party not to do or allow it" (33, p. 58). The concept of a minimal state as a night watchman does not allow paternalism because "anyone might come up with the pattern of life you would wish to adopt, since one cannot predict in advance that someone won't" (33, p. 50). In addition, he stressed that "it is in your self-interest to allow another to pursue his conception of his life as he sees it; you may learn from his example" (Ibid). This implies that moral autonomy is not only legitimate, but also has an educational function (34, pp. 8-9 & 11). However, it should be noted that paternalism (e.g., bans on drug use or compulsory contributions to retirement savings) is also exercised for the protection of third parties, and if drug use leads to criminal activity, paternalism is legitimate for the protection of society (35, p. 138). Paternalism not only protects individuals from their own decisions, but also from the wider public by protecting individuals from the harmful decisions of other individuals (variant B paternalism).

"Nudge theory" as a weak version of paternalism

It is clear from the above definitions that the phrase libertarian paternalism evokes an oxymoron. But such a term exists, and it is a doctrine of behavioral economics, which was established by American economists R. Thaler and C. Sunstein.

Table 1 Vaccination

Laissez-faire	voluntary vaccination (individual choice)
Traditional paternalism	compulsory vaccination (regulation)
Libertarian paternalism	voluntary but socially preferred vaccination
Intervention	launch of the vaccination campaign, benefits for vaccinated people
Goal	achieving the highest possible vaccination coverage of the population (+60%)

Table 2 Lockdown

Laissez-faire	no lockdown (individual choice in health protection)
Traditional paternalism	lockdown for all (government regulation)
Libertarian paternalism	lockdown for the unvaccinated
Intervention	imposing an exception to lockdown
Goal	achieving the highest possible vaccination coverage of the population (+60%)

According to the authors, the term seems on the surface to be internally contradictory, but as they explain, the libertarian viewpoint is that each individual should generally retain "freedom of choice," and the paternalistic viewpoint is based on the claim that it is legitimate for certain "architects of choice" to seek to influence and regulate the behaviour of individuals to help them improve the quality of their own lives. Individuals are therefore free to choose between all possible alternatives, but at the same time they are directed by the default choice architecture towards a choice that they themselves are highly likely to consider in hindsight to be better than if they had not been directed from above/outside.

The authors built this doctrine on the observation that many individuals often make incorrect or irrational choices that they probably would not have made if they had been better informed, had more developed cognitive abilities, or had better self-control. Therefore, they later regret the choice. This is a weak version of paternalism because the choice itself is not distorted or blocked. If individuals want to smoke, eat unhealthily, or choose retirement savings that are disadvantageous to them, libertarian paternalism will not prevent them from doing so. Despite this, it is a paternalistic approach because choice architects attempt to track the expected decisions of individuals and, at the same time, want to gently move them in a direction that improves the quality of their lives (according to the judgments and expectations of a higher authority). The authors refer to this as a so-called "nudge" (36, pp. 5-6).

A nudge refers to any aspect of the choice architecture, or intervention, that changes individuals' behaviour in a predictable way without prohibiting any options or significantly manipulating economic incentives. Commands, orders, and prohibitions are not considered to be a nudge. If the state ensures that fruit in stores is placed at eye level, this can be considered a nudge, but if the state prohibits the sale of unhealthy food, then we are not talking about a nudge in that case. The basic premise of nudging is that it must guide individuals to decisions that are better for themselves as well as for society. The role of nudging is to direct an individual towards a certain goal. Seemingly insignificant or minor details can greatly influence people's behaviour and decision-making. According to this doctrine, people need a nudge in situations where they don't know the right response or have nowhere to learn it. The authors emphasize the importance of nudges being transparent, not exceeding personal freedom, and complying with ethical principles. The intention is to create an environment in which people can make informed decisions, while at the same time drawing on insights from behavioral economics about the way people often deviate from rational decision-making.

Paternalistic measures during the COVID-19 pandemic

In 2021, the Ministry of Health of the Slovak Republic introduced a vaccination support campaign. Several politicians, scientists, artists, publicists, and athletes advocated for vaccination as the only way out of the COVID-19 pandemic. This campaign used notorious slogans, such as the vaccine is the solution, the vaccine is the way out of isolation, the vaccine is a step towards victory over the pandemic, the vaccine is the goal that moves us towards victory, and others.

Table 3 Non-infectivity

Laissez-faire	voluntary vaccination (individual choice)
Traditional paternalism	compulsory vaccination (government regulation)
Libertarian paternalism	voluntary but state-preferred vaccination
Intervention	statement by the Czech government that those vaccinated and who have overcome are infection-free
Goal	achieving the highest possible vaccination coverage of the population (+60%)

The goal was to create the impression that vaccinating as large a proportion of the population as possible was the best solution to combat the disease, as the effect of the vaccine is primarily preventive. Additionally, in the event of infection with the virus, it alleviates symptoms and protects not only the vaccinated, but also indirectly the unvaccinated by creating collective immunity.

The crisis staff pushed through a proposal that public enterprises could only be visited by persons belonging to the VR (vaccinated and recovered) regime instead of the VTR (vaccinated, tested, and recovered) regime under the pretext of public interest in protecting and promoting health - this was intended to apply primarily to the unvaccinated, who were more vulnerable to the disease. This regulation also applied to such unvaccinated individuals whose interest was not personal health protection through vaccination, but whose freedom of movement was nevertheless restricted by government regulation to prevent infection of the general public. Part of the population considered this a repressive and discriminatory measure. Although this was an effort to increase the number of vaccinated by imposing an exemption from the lockdown, the unconditional introduction of compulsory vaccination was also considered.

According to biologist L. Valášek, the Czech government exerted pressure on the unvaccinated by claiming that they were responsible for transmitting the disease, and government politicians and some scientists purposefully spread the information that if someone is vaccinated or has overcome the disease, they are automatically infection-free, "as if they had some kind of protective shell around them." Such a principle, in his view, completely denied logic and negated science. According to him, the government was spreading lies to persuade unvaccinated people to get vaccinated. Paternalism manifested itself in the effort to vaccinate the largest possible proportion of the population, which is a scientifically proven means of protecting the population from infection. According to him, this caused the COVID-19 disease to be largely transmitted by the vaccinated and recovered who believed the government authorities when they said they were infection-free and that transmission of the disease did not affect them. However, in the end, the blame for this was solely on the unvaccinated.

Conclusion

We focused on examining the relationship between personal interest and the demands of the common good in a modern democratic state, paying particular attention to paternalistic measures taken during the COVID-19 pandemic (37). This crisis showed how the principles of liberal democracy - especially freedom and moral autonomy - can come into conflict with the need to protect public health and safety. We analyzed cases in which the state interfered with personal freedoms, such as compulsory measures and restrictions on the freedom of movement, opening a broader discussion about the possibilities and limits of paternalism in a democratic society. As part of the theoretical and methodological analysis, we pointed out the current problem of a modern democratic state, which must face balancing individual rights and the common good in a way that respects the values of the democratic system while responding to the needs of modern society, especially during crisis situations. Paternalistic interventions, as we saw during the pandemic, reveal the need for deeper reflection on traditional values such as autonomy, freedom, and the common good.

Finally, it is necessary to emphasize that society is held together neither by the common good nor by an abstract general will, but by politics itself as a process in which different individuals and social groups find practical compromises. The common good is the result of this negotiation, not something objective or timeless that exists independently of politics (38, p. 24). What is important is not agreement on abstract principles, but rather the practical will to seek solutions that are acceptable to the majority within the limits of possibilities. The essence of a modern democratic society is not uniform agreement, but precisely the possibility of diversity, which enables the search for compromises between conflicting interests. "Politics is the art of the possible," the statement attributed to O. von Bismarck, seems to be particularly apt

in times of crisis, new challenges, and states of emergency.

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The Formation of Psychological Stability of Scientific and Pedagogical Teams of Higher Education Institutions in the Conditions of the Russian-Ukrainian War

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Original Article

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Abstract:

The article examines the peculiarities of the psychological stability formation of scientific and pedagogical staff of higher educational institutions in the conditions of the Russian-Ukrainian war. The significance of the psychological stability of scientific and pedagogical staff of higher educational institutions was analyzed. The factors included the ability to overcome life and professional challenges and maintain and strengthen physical and mental health.

The object of the research is the psychological stability of scientific and pedagogical staff of higher educational institutions in the conditions of the Russian-Ukrainian war. The subject is the peculiarities of the psychological stability formation of scientific and pedagogical staff of higher educational institutions. The goal is to determine the peculiarities of the psychological stability formation of scientific and pedagogical staff of higher educational institutions.
The goal is to determine ways to increase the level of psychological stability and preserve the physical and mental health of scientific and pedagogical workers of higher education institutions. The importance of the formation of psychological stability for scientific and pedagogical workers in a period of social challenges and upheavals for the development of professional self-regulation and preservation of national identity is highlighted.
The concept of the "psychological stability of scientific and pedagogical staff of higher educational institutions" is revealed as the ability of specialists to maintain a stable level of professional activity in conditions of physical, psychological, socio-pedagogical, and personal discomfort. The components of the psychological stability of scientific and pedagogical staff of higher educational institutions in the conditions of the Russian-Ukrainian war are substantiated. The results of the diagnostics of factors affecting the psychological stability of 25 scientific and pedagogical workers of 5 higher educational institutions of Ukraine in modern realities are presented. A program for forming the psychological stability of scientific and pedagogical staff of higher educational institutions in the conditions of the Russian-Ukrainian war is proposed.

Introduction

In the conditions of the Russian-Ukrainian war, scientific and pedagogical teams of higher education institutions in Ukraine are facing unexpected challenges, and they need to set an example of psychological stability for the subjects of the educational process and the global educational and scientific communities. The activation of internal potential, the mobilization of resources, and the search for tools to provide their own psychological stability have become challenges for all educators in Ukraine.

According to the Law of Ukraine "On Scientific and Scientific and Technical Activity" dated 26.11.2015 N 848-VIII, "a scientific and pedagogical worker is a scientist who professionally carries out pedagogical and scientific or scientific and pedagogical activity" (1).

A culture of behavior sets social norms, expectations, and ways of interaction between individuals. Emotional culture then influences the way people experience and express their emotions, how they cope with stress, and what their emotional regulation strategies are (2).

Currently, scientific and pedagogical teams of higher education institutions are not only specialists in their fields. First of all, they are a creative, professional team and a group of like-minded people. Each representative makes their own individual contribution to collective activity and the development of education and science.

In the conditions of the modern reality in Ukrainian society, the scientific and pedagogical teams of higher education institutions need to form psychological stability due to the negative

impact of the Russian-Ukrainian war on physical and mental health. A scientific and pedagogical team of a higher education institution having psychological stability means it has the ability to maintain a safe and effective educational space for each of its subjects.

The purpose of the study is to form the psychological stability of the scientific and pedagogical team of higher education institutions in the conditions of the Russian-Ukrainian war and determine methods for preserving and strengthening physical and mental health.

To achieve this goal, **the following issues** were considered: revealing the essence of the concept of "psychological stability of the scientific and pedagogical teams"; the determination of the content and organizational aspects of the psychological stability formation of scientific and pedagogical teams; clarification of the diagnostic results of the factors influencing the psychological stability of the scientific and pedagogical teams of higher education institutions in the conditions of the Russian-Ukrainian war; the development of a program for the psychological stability formation of scientific and pedagogical teams of higher education institutions in the conditions of the Russian-Ukrainian war.

Study Rationale

The problem of psychological stability in individuals has been considered in many domestic and foreign studies by scientists and practitioners. In particular, in foreign works the topic of psychological stability was considered by authors (10-18).

During their professional lives, the scientific and pedagogical staff of higher education institutions repeatedly experience stressful situations that leave an imprint on their physical and mental health (10, 19). "The accumulation of tasks, the nature of them, and the scale of the workplaces' high demands on professional and human availability can be stressful" (20, p. 108). Therefore, to work effectively, an employee must be resilient and able to cope with stress (21, 22).

Workplace stress is a state of physical and mental tension that arises in the scientific and pedagogical staff of higher education institutions due to the influence of adverse circumstances of professional activity, everyday life, and extreme situations (11). For example, this is influenced by the fact that academic staff at higher education institutions under martial law often experience anxiety and even depression. This is exacerbated by interaction with higher education students who are also experiencing such psychological disorders (23, 24). When carrying out one's teaching duties in addition to research activities, an employee sometimes has to overcome internal weakness, a lack of knowledge, doubts, a lack of sleep, exhaustion, a lack of time, underfunding, etc. (25). The person experiences "fear and trembling" and is responsible for choosing and solving issues while dealing with their own life (26, 27). A person acts in accordance with their own moral standards, moral principles, and based on their spirituality (28-31). This creates stressful situations when there is an internal conflict between personal beliefs and real circumstances (e.g., the inability to meet the expectations of colleagues or the educational institution's administration, or when giving partially undeserved or motivating grades) (32).

Internal crises are exacerbated by external crises: the Russian-Ukrainian war; the difficult economic situation in Ukraine; the threat of nuclear war; professional challenges (for example, ensuring quality interaction in an inclusive environment) (33); working with students who are experiencing stress; particularly during social adaptation (34, 35); cooperation with students with post-covid syndrome (36), etc. Professional ambitions, aspirations, competition, goals, situations of uncertainty, defeats, and the search for new solutions are examples of factors contributing to the psychological stability of the scientific and pedagogical team of higher education institutions (37).

The very nature of these and similar questions would not be problematic if it were not an expression of refusal to participate in public and society-wide matters (2).

Psychological stability is an integrative property of a person that is characterized by the interaction of emotional, volitional, intellectual, and motivational components of mental activity to ensure the successful achievement of a goal in

difficult circumstances (13, 38). It is worth considering that psychological stability determines the mental and somatic health of a person, protects them from disintegration and personality disorders, and creates the basis of internal harmony (17).

The psychological stability of scientific and pedagogical teams of higher education institutions refers to the ability to provide qualitative resistance to negative external influences and stresses, recover after crises, and successfully develop in circumstances that are rapidly changing, with the best possible outcome for themselves.

Purpose of the study

The goal of the study was to determine the features of psychological stability formation of scientific and pedagogical staff of higher education institutions in the conditions of the Russian-Ukrainian war.

Methodology

The study employed the questionnaire method, a comparative analysis based on collected data during the empirical study of determining the features of psychological stability formation of scientific and pedagogical staff of higher education institutions in the conditions of the Russian-Ukrainian war. The online tool "Google Forms" was chosen for data collection. The study was conducted on a sample of scientific and pedagogical employees of higher education institutions in Ukraine. The questionnaire consisted of fifteen open-ended questions, to which the participants gave detailed answers. This questionnaire was used to determine the factors influencing the psychological stability of scientific and pedagogical staff of higher education institutions.

Study Results

In order to study the factors influencing the psychological stability of scientific and pedagogical staff of higher education institutions, a survey was conducted among 25 scientific and pedagogical workers from 5 higher education institutions in Ukraine (Taras Shevchenko National University of Kyiv, State Higher Educational Institution "Donbass State Pedagogical University," Petro Mohyla Black Sea National University, Mykhailo Drahomanov Ukrainian State University, Western Ukrainian National University).

According to the results of the survey, the following indicators and factors influencing the mental stability of scientific and pedagogical teams of higher education institutions were identified (Table 1): an increased level of personal anxiety (25 respondents (100%)), disruption of the phases of cheerfulness and rest (22 respondents (88%)), permanent stressful situations

Table 1 The results of the survey

Factors (indicators) of influence on the mental stability of scientific and pedagogical staff of higher education institutions	Respondents (scientific and pedagogical staff)	Percentage
Increased level of personal anxiety	25	100
Disturbance of phases of cheerfulness and rest	22	88
Permanent stressful situations	20	80
Reduced or increased need for communication	22	88
Mood swings	24	96
Disrupted intellectual activity	22	88
Unsatisfaction or partial satisfaction of physiological needs	25	100
Reduced level of professional productivity	25	100
Deterioration of physical and mental health	24	96

Source: own research

(20 respondents (80%)), a decrease or increase in the need for communication (22 respondents (88%)), mood swings (24 respondents (96%)), disruption of intellectual activity (22 respondents (88%)), unsatisfied or partial satisfaction of physiological needs (25 respondents (100%)), a decreased level of professional productivity (25 respondents (100%)), deterioration of physical and mental health (24 respondents (96%)).

The determined indicators of the impact on the mental stability of scientific and pedagogical staff of higher education institutions made it possible to schematically depict the factors influencing the mental stability of the scientific and pedagogical staff of higher education institutions in the conditions of the Russian-Ukrainian war (Figure 1).

The results of the diagnostics made it possible to determine the components of the psychological stability of scientific and pedagogical teams of higher education institutions. The psychological stability of scientific and pedagogical teams of higher education institutions in the conditions of the Russian-Ukrainian war involves the presence of four basic components: existential, emotional, cognitive, and behavioral. The existential component is the awareness of the goals and objectives of the scientific and pedagogical team; the emotional component is ways of responding to events and supporting the scientific and pedagogical team; the cognitive component is the beliefs of the scientific and pedagogical team; the behavioral component is the actions of the scientific and pedagogical team (Fig. 2).

The existential component involves a tangible sense of isolation, strengthening professional stability and personal beliefs, and the presence of a goal in one's professional field. The emotional component involves the resource emotional states of the scientific and pedagogical team, positive emotional moods, emotional stability, the ability to understand and control emotional states, the ability to empathize, and compassion. The cognitive component involves the cognitive flexibility of the scientific and pedagogical team, reducing the assessment of the threat to health and life, and maintaining positive self-esteem and positive beliefs (60, 61). The behavioral component involves the social competence of

Figure 1 Factors influencing the mental stability of scientific and pedagogical staff of higher education institutions

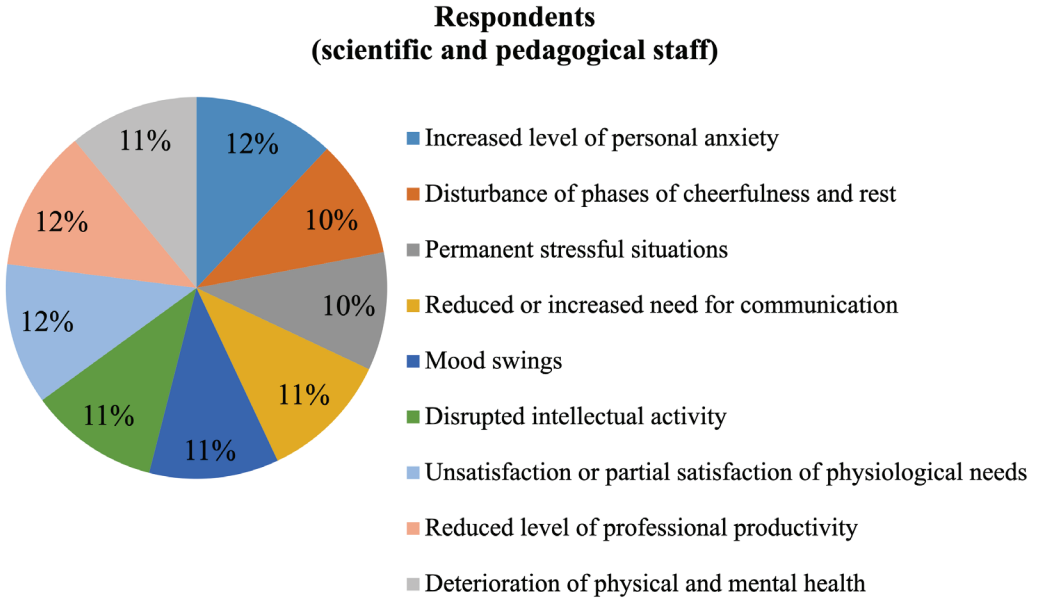
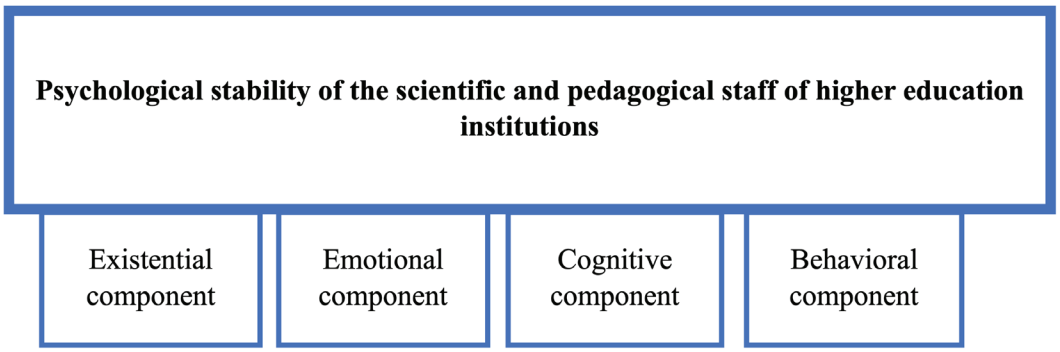


Figure 2 Components of psychological stability of the scientific and pedagogical staff of higher education institutions



the scientific and pedagogical staff, a search for resources among social ties, active coping strategies, the presence of social support from society and the higher education institution, support for physical and mental health, and the advantages altruistic behavior brings.

One key aspect of psychological stability formation of the scientific and pedagogical staff of higher education institutions is the creation of a socio-psychological support program aimed at providing the necessary assistance and psychological, social, educational, and legal support to restore physical and mental health.

Such a program must take into account the best practices in the field of social work and the needs and capabilities of the target audience.

The purpose of the developed program is to provide effective psychological support to reduce negative consequences, promote social and educational adaptation, and ensure safety and support in the conditions of the Russian-Ukrainian war.

The main components of the program:

– Psychological support: individual consultations with a psychologist to reduce stress, anxiety, and depression, as well as to restore self-esteem and psychological stability;
– Social support: consultations with a social worker on issues of social and legal protection;
– Rehabilitation support: group classes for support and exchanges of experience, all with an aim of improving the psychological stability of the scientific and pedagogical staff in higher education institutions;
– Educational support: consultations on the organization of the educational process in the conditions of the Russian-Ukrainian war (Table 2).

It is necessary to explain why it is important to implement all the components of the program.

Providing effective psychological support to academic staff is crucial due to the significant emotional and mental pressure caused by the Russian-Ukrainian war in daily life during wartime that, in addition to military personnel, also affects civilians (39, 40, 41). The war, like any other destructive phenomenon, leads to increased levels of stress, anxiety, and depression, and it exacerbates professional burnout (42, 43). Individual consultations with a psychologist, which can be provided on a paid or volunteer basis, help reduce these negative effects, process difficult emotions, and lower stress levels (44). Such sessions help restore self-esteem and maintain psychological stability, which is especially crucial for educators as they must maintain high professional standards and interact with students. Improving mental health through consultations also enhances work efficiency, reduces errors, and improves adaptation to stressful conditions (45).

Social support for the academic staff of higher education institutions during the Russian-Ukrainian war is essential for protecting their rights, ensuring a stable working environment, and adapting to challenging conditions. It is important to note that social support for individuals has always been relevant and important

in difficult periods of history. This is true both now (first during the Covid-19 pandemic and now during the war) and in the past (for example, back in the days of early Christianity) (46, 47, 48). It is provided by social workers who work in various state, public (including religious), and international institutions to implement social services (49). Today, consultations with a social worker on socio-legal protection help educators understand their rights, access social benefits, and address issues related to forced displacement and financial assistance (50). The consultations also contribute to preventing professional burnout, which is an indicator of instability in professional meaningfulness, adapting to new working conditions, and maintaining the quality of education, making them an integral element of support for educators during times of crisis

Table 2 Program of socio-psychological support of the psychological stability of scientific and pedagogical staff of higher education institutions

Month 1	Weeks 1-2	Overview and introduction to the program of socio-psychological support of the psychological stability of scientific and pedagogical staff of higher education institutions
		Individual consultations with a psychologist and social worker to identify key needs and problems
		Group session to get to know each other, define goals and objectives
	Weeks 3-4	Individual consultations with a psychologist to develop an individual plan for the formation of psychological stability
		Group classes to develop stress management skills and improve self-awareness.
Months 2-3	Weeks 5-8	Individual consultations with a psychologist to assess progress and adjust the support plan
		Group class on developing social skills and interacting with others
	Weeks 9-12	Individual consultations with a psychologist and social worker to discuss opportunities to obtain socio-legal support
		Group session for support and exchange of experiences among program participants
Months 3-4	Weeks 12-14	Individual consultations with a social worker to address specific problems and find ways to solve them
		Group class on developing self-awareness and self-esteem
	Weeks 15- 18	Individual consultations with a social worker to support them in difficult work situations and develop a positive attitude towards the future
		Group class on developing social adaptation and support skills
Months 5-6	Weeks 19-22	Final individual consultations with a psychologist and social worker
		Group session on evaluating results and planning further steps towards building psychological stability
	Weeks 23-24	Final group session with feedback and summarizing the program
		Assessing the effectiveness of the program and preparing for further steps towards building psychological stability

Source: own research

(51, 52). Interestingly, this can only be achieved if the consultant is empathetic and insightful, knows how to listen, and formulates specific questions (53, p. 197).

Rehabilitation support for the academic staff of higher education institutions during the Russian-Ukrainian war helps educators maintain emotional balance, cope with stress, and adapt to challenging conditions. "Problems are inevitable in the subtleties of organizational communication, but it does not mean confronting them is uncontrollable" (54, p. 30). Group sessions for support and experience-sharing help strengthen psychological resilience by creating a space for open communication, mutual support, and the development of effective strategies to overcome emotional exhaustion. They help reduce feelings of isolation and foster a sense of unity and professional solidarity, all of which are especially crucial in wartime. Such activities enhance work motivation, support psychological well-being, and contribute to maintaining the efficiency of the educational process, making them an essential element of comprehensive support for academic staff.

Educational support for the academic staff of higher education institutions during the Russian-Ukrainian war is important as it helps educators effectively adapt to new teaching conditions while maintaining the quality of the educational process. Consultations on organizing the teaching process during the war allow for the development and implementation of optimal teaching methods, such as distance or blended learning, that meet the demands of the current situation. For this purpose, computer technologies are actively used, especially in the context of the digitalization of various social spheres, including education (55, 56, 57). Such consultations help address issues related to organizing classes, assessing student performance, and adapting teaching materials to the realities of wartime. This should be based on modern scientific research on the implementation of education under martial law and should consider, for example, the protective mechanisms of participants in the educational process from military influences and their need for self-realization, as well as the extended duration of time spent in the digital environment due to distance or blended learning formats (58, 59). This support helps maintain the professionalism of the teaching staff, ensures the stability of the educational process, and reduces stress for educators. All of this, in turn, contributes to preserving a high quality of education during a crisis.

A key element of the effective implementation of the socio-psychological support program for the psychological stability of scientific and pedagogical staff of higher education institutions is partnership cooperation. Such cooperation provides a comprehensive approach to solving the problem and covers all levels of assistance and support on the way to forming the psychological stability of scientific and pedagogical staff of higher education institutions.

Conclusion

As a result of the study, it was found that the problem of forming the psychological stability of scientific and pedagogical staff of higher education institutions is multifaceted and requires a comprehensive approach. The analysis of theoretical aspects allowed us to identify the main factors influencing the formation of psychological stability, as well as their impact on physical and mental health. The main problem remains the need to increase the effectiveness of measures to form psychological stability.

Discussion

The developed program to provide social and psychological support for the psychological stability of scientific and pedagogical staff of higher education institutions includes a comprehensive approach to solving a problem in ways that include psychological, social, rehabilitation, and educational support. An important aspect of the program is partnership cooperation on the way to forming the psychological stability of scientific and pedagogical staff of higher education institutions. To form said psychological stability, it is advisable to introduce comprehensive assistance programs into the educational process and ensure access to them for scientific and pedagogical staff of higher education institutions. A step such as this is especially significant in the conditions of the Russian-Ukrainian war.

Prospects for further research

Prospects for further research are to identify and develop tools for forming the psychological stability of scientific and pedagogical teams of higher education institutions and to search for resource strategies for the psychological stability of scientific and pedagogical workers in the conditions of the Russian-Ukrainian war.

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Triple Pelvic Osteotomy in the Treatment of pincer type Femoroacetabular impingement Syndrome Triple Pelvic Osteotomy for FAI

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Abstract:

Purpose: Femoroacetabular impingement (FAI) syndrome is a dynamic contributor to hip arthritis. It is frequently identified in young adults with no other underlying reasons for hip discomfort. The pincer type of FAI, which is the focus of this study, is usually observed in inactive middle-aged women. This study aimed to assess our group of patients who underwent surgical treatment for pincer or combined types of FAI, examining their clinical and radiological outcomes, as well as any complications arising from the surgery.
Methods: Eighteen patients identified with pincer or combined

type FAI underwent triple pelvic reverse osteotomy from 2011 to 2020, and their progress was tracked in a prospective study for both clinical and radiological assessment. The average age of the patients was 37.3 years, with a range of 28.0 to 45.0 years. Follow-up assessments were conducted at mid-term. MRI scans were utilized to accurately assess the retroversion of the acetabulum both pre- and post-surgery. Subjective evaluations were carried out using Harris Hip Scores (HHS), Visual Analog Scale (VAS) scores, and Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC) scores, with Wilcoxon tests applied for paired samples (the significance level was set at 95%, $p<0.05$). A comparison of preoperative and post-operative data was conducted to assess clinical outcomes.

Results: Statistically significant improvement was observed in MRI measurements after triple pelvic osteotomy for the treatment of pincer or combined-type FAI. The HHS improved from 55.1 to 91.4, with preoperative MRIs showing a median retroversion of 5.35 degrees and post-operative MRIs indicating anteversion at 26.35 degrees. WOMAC scores were at a median of 69.9 prior to surgery and increased to 94.15 afterward, with a statistically significant result ($p<7.629$ x 10-6). After surgery, 22% (4 out of 18 patients) showed signs of clinically relevant posterior pelvic femoroacetabular impingement (FAI), although this finding was not considered significant due to the small sample size, which was a limitation of our study.

Conclusion: This surgical approach is a safe method for restoring hip mobility. For patients with pincer or combined-type of FAI, the authors recommend performing surgical pelvic osteotomy rather than hip arthroscopy, as it is an extra-articular operation and may be more effective in addressing intra-articular arthritis.

The authors declare no conflicts of interest.

All experimental protocols were approved by the Ethics Committee of the Faculty Hospital Bulovka.

Introduction

Femoroacetabular impingement (FAI) is characterized by an abnormally shaped hip joint, which can lead to hip arthritis. Pain occurs during certain hip movements, particularly flexion, adduction, and internal rotation, and it is displayed during the anterior impingement test. FAI can have multiple causes, including developmental conditions, hip joint trauma, and changes in the angles of the proximal femur due to osteotomy. Pincer FAI is more common in active, middle-aged women and is caused by extra bone growth on the acetabulum, resulting in overlap between the acetabulum and the femoral head. Combined FAI is a combination of pincer and CAM types. It is the most common type of FAI and is diagnosed by X-ray. In this study, the authors found that pelvic osteotomy is favorable for treating pincer types of FAI.

Treatment options for femoroacetabular impingement (FAI) include lifestyle modifications, over-the-counter pain relievers, physical therapy, and surgical intervention. When conservative measures fail to alleviate pain or if joint

damage is present, surgery is advised. Patients with minor joint and cartilage damage can often undergo arthroscopic procedures, whereas more extensive cases may require open surgery, pelvic osteotomy, or total hip replacement.

The purpose of this study was to assess a series of patients who underwent surgery for pincer or combined-type FAI, examining their clinical and radiological outcomes, along with any surgical complications. We hypothesize that the redirectional triple pelvic osteotomy will correct acetabular retroversion as seen on MRI scans and will lead to improved clinical results in our patient group. We also believe this anatomical correction will not negatively impact joint arthritis.

Materials and Methods

Our patient cohort consisted of consecutive cases from our institution over a specific period. All participants were diagnosed with pincer or combined FAI. These patients had undergone a reverse triple pelvic osteotomy for the treatment of pincer/combined-type FAI at the Orthopedic Clinic, Faculty Hospital Bulovka in Prague between 2011 and 2020. A total of 18 consecutive patients completed the midterm follow-up (1-9 years). The average age of the patients was 37.3 (28.0-45.0) years. All the specifications of the patients are disclosed in Table 1. All the patients were unilateral cases and were sequenced successively.

Patients with clinically symptomatic anterior femoroacetabular impingement, characterized by groin pain and decreased hip flexion, abduction, or internal rotation, were recruited for this study. Most of these patients also tested positive on the anterior FAI test. Initially, they were managed non-surgically through activity modifications; specifically, they were advised to avoid painful activities such as horse riding or motorbiking that could exacerbate symptoms.

Table 1 Patients prior to surgical intervention. Patients experienced pain during activities that involved abduction and flexion, such as ice skating and horse riding. The degree of retroversion was assessed using X-rays, following the methodology outlined by Siebenrock et al. MRI scans were utilized to measure the most retroverted side of the acetabulum.

Patient no.	Sex	Pain VAS during movement	ROM			X-ray retroversion	MRI retroversion
			Sagittal	Rotational	Abd./Add.		
1	M	5	0-0-120	10-0-10	30-0-20	x	5.5°
2	F	6	0-0-120	10-0-0	30-0-10	x	6.9°
3	F	5	0-0-120	10-0-10	30-0-20	x	7.0°
4	F	5	0-0-120	10-0-10	30-0-20	x	6.5°
5	M	7	0-0-110	10-0-0	30-0-10	x	5.2°
6	F	8	0-0-100	10-0-0	20-0-10	x	6.5°
7	F	5	0-0-120	10-0-10	30-0-20	x	5.1°
8	F	5	0-0-120	10-0-10	30-0-20	x	4.8°
9	F	6	0-0-110	10-0-10	30-0-10		3.9°
10	M	6	0-0-120	10-0-10	30-0-10	x	5.2°
11	F	7	0-0-110	10-0-0	20-0-10	x	6.1°
12	F	8	0-0-110	10-0-0	20-0-10	x	6.3°
13	F	9	0-0-110	10-0-0	20-0-10	x	6.0°
14	F	10	0-0-100	10-0-0	20-0-10	x	6.2°
15	F	7	0-0-120	10-0-10	30-0-10	x	3.4°
16	F	7	0-0-120	10-0-10	30-0-10		3.2°
17	M	7	0-0-120	10-0-10	30-0-10	x	5.0°
18	M	5	0-0-120	10-0-10	30-0-20		3.4°

This treatment period is often not limited, frequently extending beyond a year, until patients begin to experience progressive or intolerable pain that limits daily activities and ultimately leads to a surgical indication. All patients were evaluated using the Harris Hip Score (HHS) before and after surgery. Additionally, X-rays and MRI scans were performed to assess the acetabular retroversion—either focal or global—and to distinguish between retroversion and anterior rim prominence [21]. Pre- and post-operative X-ray measurements were compared following Siebenrock's criteria [20] (see Figures 1, 7, and 8). Retroverted acetabulum was identified based on three signs: 1) a crossover sign with a retroversion index over 30%, 2) a posterior wall sign, and 3) an ischial sign. These same radiographs were used to evaluate pincer FAI. Figure 3 il-

Figure 1 The typical crossover sign observed in combined FAI cases. A: Indicates focal retroversion of the acetabulum accompanied by a crossover sign. B: Shows the frontal edge highlighted in red and the reverse edge in yellow.

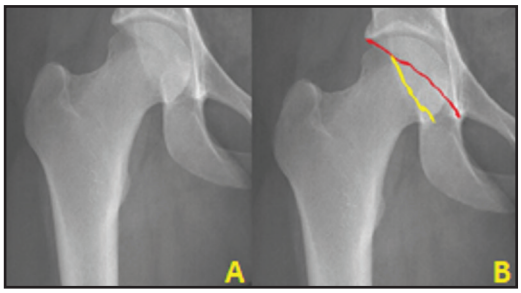


Figure 3 An image of the osteotomy procedure. It illustrates a triple pelvic osteotomy as a treatment for pincer femoroacetabular impingement (FAI) syndrome. The osteotomy lines are highlighted in yellow.

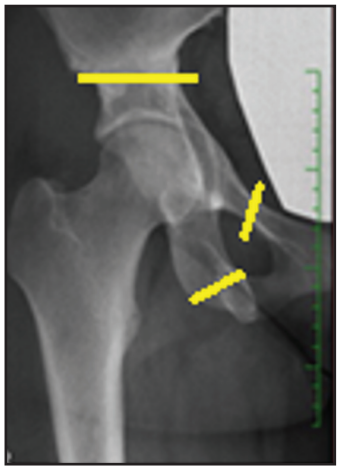
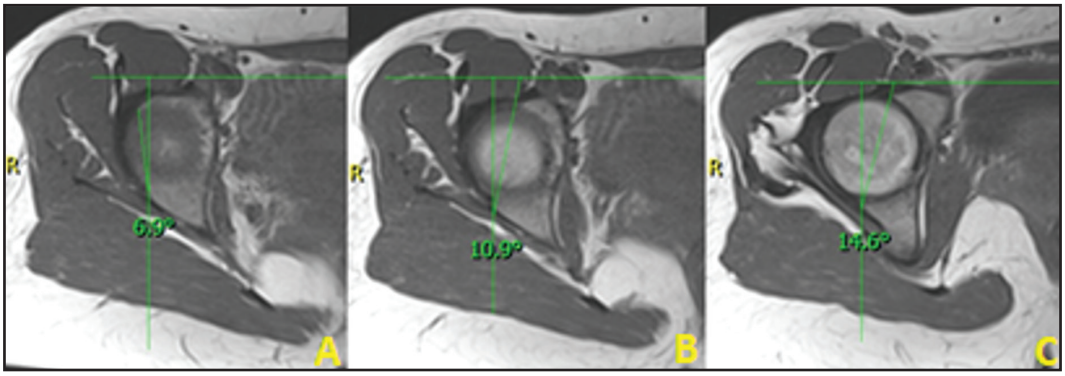


Figure 2 Transverse MRI sections of the acetabulum at various levels prior to surgery A: Focal retroversion measuring 6.9°. B: Middle portion of the acetabulum exhibiting an anteversion of 10.9°. C: Caudal part of the acetabulum in anteversion 14.6° [13]. A transverse cut of the acetabulum was performed preoperatively to accurately assess acetabular retroversion and pincer FAI and to ensure there was no damage to the cartilage.



lustrates the osteotomy lines and the post-operative X-rays. Follow-ups occurred at 6 and 12 months, then annually.

Anteversion/retroversion of the acetabulum were measured on transverse T1 MRI scans before surgery and when the osteotomy (OT) were healed. All MRI scans were done on the same MRI machine in our hospital using the same protocol. The highest measured angles were used (Fig 2 and 4).

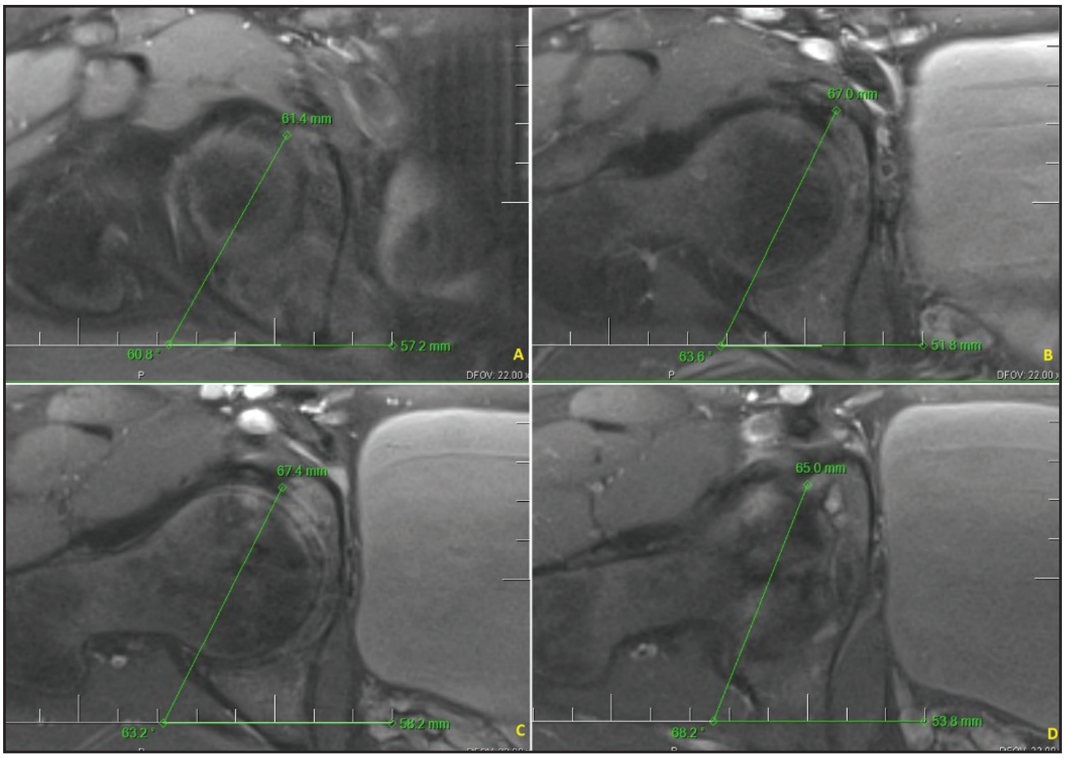
MRI scans were also used to determine the status of the cartilage and signs of arthritis before and after surgery and at the last follow up (Figure 2).

The surgical technique of a triple pelvic osteotomy, as described by Steel, is performed to change the orientation of the acetabulum. Retroversion of the pelvic bone, as identified on preoperative MRI scans, is usually performed to prevent posterior FAI clinical signs. This surgery only involves the reorientation of the acetabulum, so no bone graft was used (as in another pelvic osteotomies) and there was no lower-leg prolongation. During the operation, an extraction of part of the bone was performed from the os ischii (segment of 0.5 cm). An internal rotation of the acetabular segment of approximately 30 degrees was also performed (see Table 2 for exact values of each retroversion) with Kirschner wire fixation. The amount of inner rotation was approximately 30 degrees. Since there are no standardized reference points for degree measurements, we estimated angles based on the MRIs to achieve acetabular anteversion between approximately 10 and 20 degrees (±15 degrees).

Surgical intervention was only indicated for patients with symptomatic pincer or combined FAI that were unresponsive to conservative therapy, especially if radiographic signs of joint degeneration were present.

We opted for this extra-articular procedure to effectively address intra-articular arthritis, with

Figure 4 Transverse MRI scans of the acetabulum at various levels post-surgery. There is no retroversion present at any level.



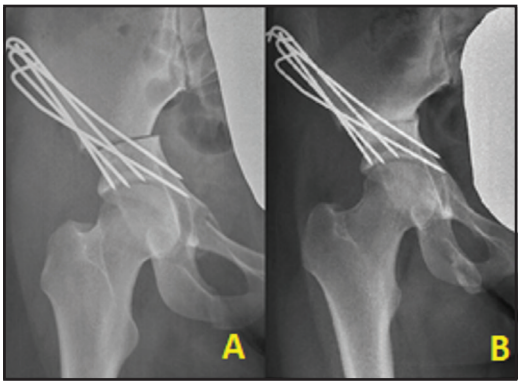
the operation typically lasting around 90 minutes. Post-surgery, patients were advised to begin physiotherapy immediately to prevent periarticular adhesions. Recommendations included continuous passive motion, using two crutches for at least 8 weeks, and limiting hip flexion to 70° for 3 to 6 months.

Cartilage damage was monitored via MRI during follow-up. X-rays were examined for signs of non-union at osteotomy sites (Figure 5).

Once complete bone healing was confirmed after two years, the Kirschner wires were removed from all patients (Figure 6A). At the 3-year follow-up, we checked for any signs of femoral head damage or necrosis (Figure 6B).

By the end of this study, patients had been followed for up to 9 years post-surgery. We analyzed the follow-up data for patients in their middle age, focusing on HHS as a clinical outcome. Additionally, frontal and dorsal impingement tests were repeated to assess the surgical results, along with X-rays and MRIs to evaluate surgical success. MRIs specifically assessed whether the osteotomy had healed and the displayed the positioning of the reverted acetabulum without using classification tests.

Figure 5 X-rayimages taken after the osteotomy. A: The postsurgical view of the pelvis after the procedure. B: The pelvic X-ray one year after the surgery indicates that proper alignment has been maintained, with no Kirschner wires observed in the joint during passive hip movement.



Results

The average retroversion was 5.34 degrees (details are in Table 2). Postoperative MRI scans were used to assess the orientation of retroversion. Patient satisfaction was measured using the Visual Analog Scale (VAS), rating pain during daily activities from 0 (no pain) to 10 (the worst pain) [12]. The Harris Hip Score (HHS) evaluated pain, gait, daily activity function, deformity absence, and range of motion, with scores categorized as poor (<70), fair (70–79), good (80–89), and excellent (90–100) [9]. The WOMAC [11] score was also recorded (Table 3).

Figure 6 X-ray images of the pelvis after the removal of the Kirschner wires. A: Taken two years post-surgery when the wires were extracted. B: Taken one year after their removal, demonstrating no defects in the femoral head, no signs of necrosis, and proper alignment. The yellow lines in the final image illustrate the technique used for the triple pelvic osteotomy.

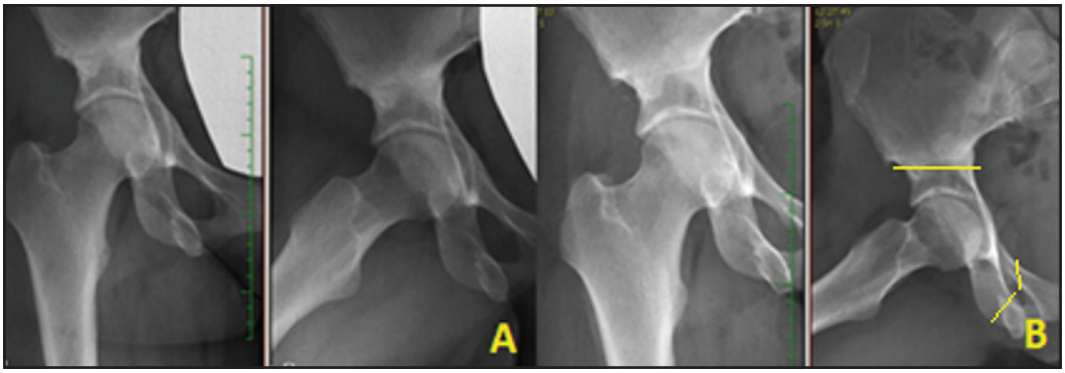


Table 2 MRI findings prior to the operation revealed an average acetabular retroversion of 5.34°, measured at the most prominent edge of the acetabulum. After the operation, the average anteversion was recorded at 26.75°.

Patient no.	MRI before operation	MRI after operation
1	5.5°	29.2°
2	6.9°	26.4°
3	7.0°	26.8°
4	6.5°	25.8°
5	5.2°	25.2°
6	6.5°	26.3°
7	5.1°	27.2°
8	4.8°	26.3°
9	3.9°	25.7°
10	5.2°	26.3°
11	6.1°	25.9°
12	6.3°	26.2°
13	6.0°	27.3°
14	6.2°	28.2°
15	3.4°	28.1°
16	3.2°	25.3°
17	5.0°	27.2°
18	3.4°	28.1°
Statistics		
average	5.34	26.75
median	5.35	26.35

Table 3 Statistical analysis was conducted using the Wilcoxon test for paired samples on the WOMAC scores. Statistical analysis showed that the scores before and after the operation were not identical. With a confidence level of 95%, the analysis indicated that the post-operative WOMAC scores were significantly improved compared to the preoperative scores ($p<7.629*10-6$).

Patient no.	WOMAC before operation	WOMAC after operation
1	67.2	96.9
2	62.5	94.5
3	64.5	89.8
4	74.2	93.5
5	68.3	95.3
6	71.9	95.2
7	73.4	93.0
8	60.8	92.7
9	71.8	95.3
10	75.0	95.3
11	68.0	92.2
12	72.7	93.5
13	69.5	96.9
14	79.7	95.3
15	71.1	94.5
16	68.0	93.8
17	70.3	93.0
18	69.5	93.8
Statistics		
average	69.91	94.14
median	69.90	94.15

Overall, all patients improved into the excellent HHS category, with scores rising from an average of 55.1 to 91.4 (Figure 7).

Hip impingement tests showed no signs of anterior impingement or pain similar to preoperative symptoms. Some patients experienced mild discomfort during prolonged walking, but overall, there was complete relief from painful hip movements (Figure 9).

We observed a significant reduction in clinically positive signs for ventral FAI, regardless of the surgical approach. All patients exhibited positive signs for ventral FAI before surgery, and postoperative treatment reduced clinically positive FAI tests to less than 1%. This outcome suggests that conservative therapy was beneficial for all patients. In our cohort treated with triple pelvic osteotomy, 22% (4 out of 18 patients) exhibited clinically relevant rear pelvic FAI post-operation, which is a limitation of our study. Our goal was to correct the retroversion of the acetabulum, as measured by post-operative MRIs. Changes to the labrum or cartilage defects were not assessed since all patients were considered too young to have such complications and did not report any arthritic issues.

When we look more precisely at the version levels of acetabulum before and after surgery (Figure 10), we can clearly see a significant of difference preoperative and postoperative MRI measurements, expressed in degrees.

Figure 7 Data on median Harris Hip Scores (HHS) for patients after reverse pelvic osteotomy

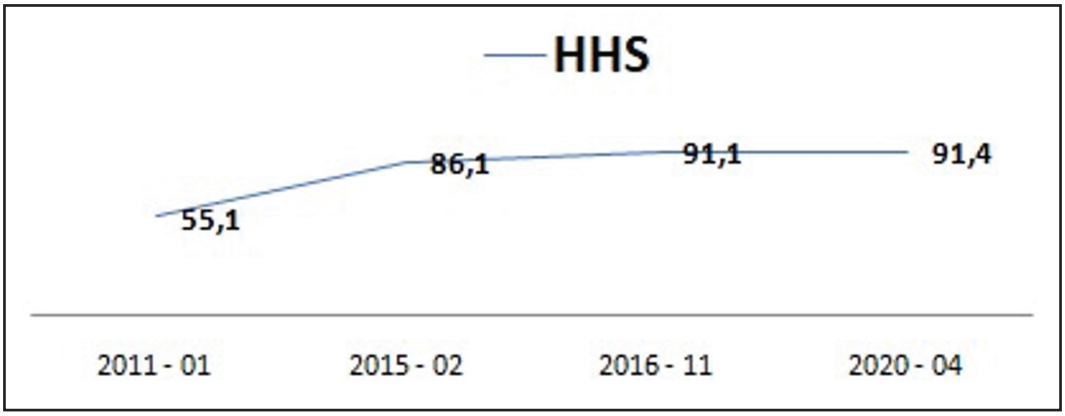
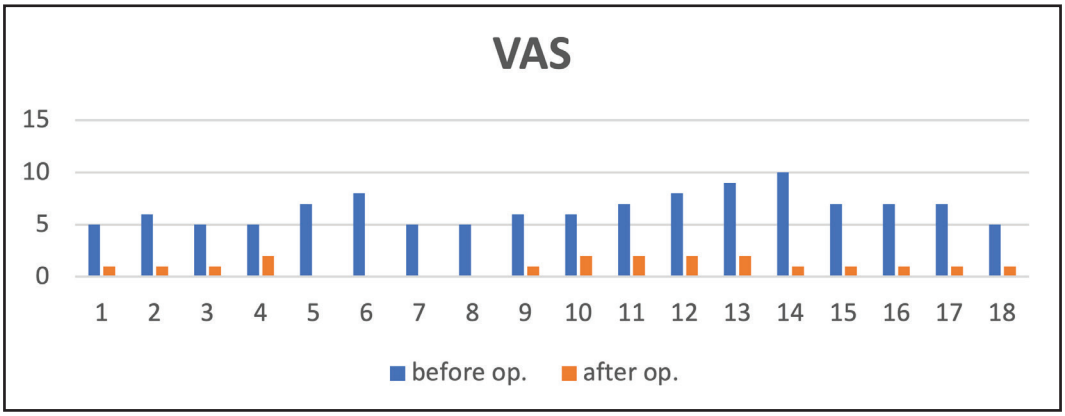


Figure 8 The average Visual Analog Scale (VAS) scores for the participants. Measured before the operation (blue line) and one year after (red line), clearly showing the benefits of the surgery.



Discussion

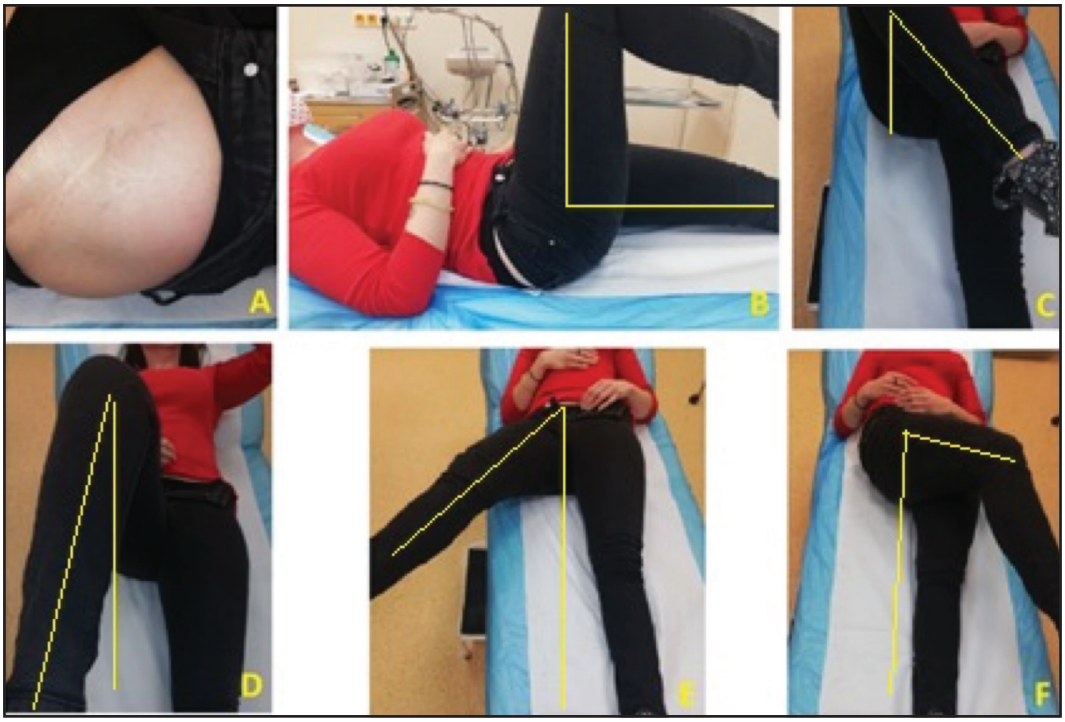
Since FAI is a dynamic factor contributing to hip arthritis, accurate diagnosis and timely treatment are crucial. Surgical intervention is indicated when patients have persistent symptoms, characteristic FAI radiographic features, and evidence of labral or cartilage damage [2]. For cases of only pincer FAI with total or global retroversion of the acetabulum, we opted for a primary reverse pelvic osteotomy, as it is the only technique capable of altering the acetabular orientation.

Various surgical options exist when a prominent anterior rim is present—these include hip dislocation with rim abrasion and redirectional pelvic osteotomy if retroversion is identified. Our findings suggest that significant acetabular retroversion in young (up to age 35) symptomatic patients with pincer FAI is most effectively treated with anteverting periacetabular osteotomy. Kirschner wires were used to stabilize the bones during the healing process. At the one-year follow-up, all the hips remained properly aligned, indicating no osteotomy displacement or femoral head necrosis. The majority of the participants were women (73%).

Siebenrock et al. [21] previously reported that 90% of patients who underwent periacetabular osteotomy for acetabular retroversion correction experienced excellent results. We built upon these findings and performed osteotomies to correct FAI before considering total hip replacement. Furthermore, we avoided surgical hip dislocation as an intra-articular procedure to prevent intra-articular complications.

It is crucial to position the patient correctly (with inner rotation and flexion) during the osteotomy, as improper positioning can lead to secondary rear FAI. Additional capsulotomy and

Figure 9 A clinical photograph of a patient taken eight years post-surgery (March 2020). A: The access point to the hip. B: Complete hip flexion (90 degrees) without pain. C: Hip outward rotation (30 degrees). D: Slight limitation in inward rotation (10 degrees). E: Hip abduction (40 degrees). F: Hip adduction (20 degrees).



enhancement of the anterior head-neck offset are generally not performed [20].

In our patient group, no total hip replacements were required during the follow-up period. Most studies report no complications related to femoral head necrosis, and our patients experienced clinical relief, as evidenced by the reduction in the VAS scores. Our ongoing long-term follow-up will yield further insights. The early correction of FAI appears to enhance hip function, and we aim to explore how often this correction prevents arthritis in future studies.

Surgical hip dislocation [6] was the initial technique described for femoroacetabular osteoplasty (FEO) and labral repair. However, due to its relatively high complication rates, long learning curve, and complexity, numerous alternative surgical approaches have emerged [14, 16]. Ultimately, addressing the acetabular abnormality remains the critical goal, tailored to the source and etiology of the impingement [8]. This aligns with the primary aim of any hip preservation surgery, which is to prevent, or at least delay, total hip arthroplasty while allowing patients to maintain the symptom-free function of their native hip.

The literature describes reverse periacetabular osteotomy (PAO) as an effective method to correct underlying deformities, improve hip pain and range of motion, and achieve favorable outcomes [19, 18]. Combined FAI, which includes true acetabular retroversion and associated cam lesions, can be treated with reverse PAO. In such scenarios, the incision is extended distally for anterior hip capsulotomy, femoral head-neck osteoplasty, and the management of labral pathology [19]. It is essential to correct the reoriented acetabulum while carefully avoiding an increased lateral edge angle or a negative Tonnis angle during the anteversion maneuver of the mobile fragment. Overcorrection of the acetabular fragment must be avoided to prevent excessive anteversion, posterior acetabular impingement, and suboptimal clinical results [18].

Peters et al. [17] previously noted that the failure rate of hip preservation procedures increases by 4% per year. While our findings show a decreasing incidence rate with extended follow-up, this inconsistency may be clarified in future studies.

We propose that significant acetabular retroversion in young symptomatic patients (up to 35 years of age) is best managed with triple pelvic osteotomy. Generally, the outcomes of acetabular rim trimming for treating retroversion appear to be inferior to those of pelvic osteotomy. Since acetabular retroversion results from malorientation rather than excessive anterior rim and insufficient posterior rim, reorienting the acetabulum is a more logical approach. Rim trimming could potentially lead to inadequate acetabular coverage [20].

Figure 10 A box diagram of the medial 50% of the difference in degrees of retroversion and post operative anteversion, a dotted line of the minimum and maximum levels.

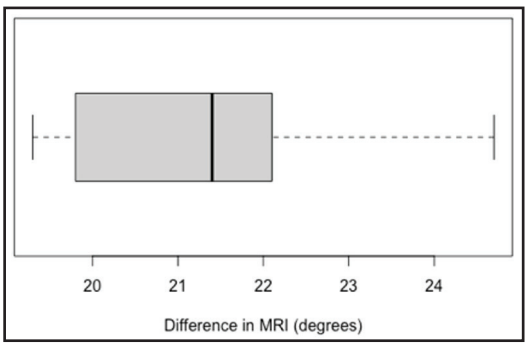
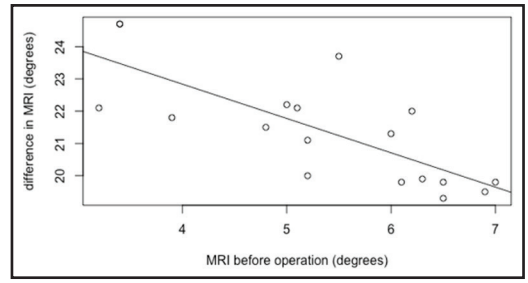


Figure 11 Displays a regression model of the differences in MRIs (degrees) based on MRIs before surgery (degrees), Shapiro-Wilk test – p=0.68, Breusch-Pagan test – p=0.23. This is a statistically significant relationship.



Conclusion

The triple pelvic osteotomy represents a favorable option among various surgical treatments for pincer/combined FAI of the acetabulum without affecting intra-joint arthritis. One advantage of this procedure is that it is the only method capable of changing the acetabulum's orientation. It is also simpler to perform than periacetabular osteotomy. However, our study's limitations include a small sample size, necessitating a larger cohort over a longer duration. Additionally, the middle-aged follow-up is another area for improvement, with 22% of patients in our control group testing positive for rear FAI, indicating that one in five patients displayed this issue. Nonetheless, the management of rear FAI with triple pelvic osteotomy is uncommon, which may be of interest to the hip preservation surgical community.

Declaration

Ethics Approval and Consent to Participate: All procedures were conducted in compliance with applicable guidelines and regulations. The experimental protocols received approval from our institution for postgraduate orthopedic surgery. Informed consent was secured from all participants.

Consent for Publication: This study does not require consent for publication.

Availability of Data and Materials: The datasets utilized and/or analyzed during this study are available from the corresponding author upon reasonable request.

Competing Interests: There are no competing interests to disclose.

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An Investigation into the Impact of Social Media Addiction on Cognitive Failures Among Young Adults: A Cross Sectional Study

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Abstract:

This mixed-method cross-sectional research investigated the impact of social media addiction on cognitive failures among young adults in Pakistan. The study employed a correlational technique, using the Social Media Addiction Scale-Student Form (SMAS-SF) and the Cognitive Failures Questionnaire (CFQ) to assess social media addiction and cognitive lapses, respectively, among Islamabad-based university students (n=636) for predictor and criterion variables. At the same time, an exploratory case study was conducted to gather qual-

itative insights from the sample regarding their understanding of the potential risks associated with social media addiction, strategies to counter it, and the cognitive failures it may result in. The findings of the study highlighted a significant positive correlation between social media addiction and cognitive failures, suggesting a strong positive impact of predictor variables on criterion variables. The research further explored the idea that young adults with a higher tendency to be addicted to social media experience greater cognitive lapses, including attention deficits, short-term memory loss, and disruptions in routine tasks. The findings also underscored the need to raise awareness about the potential risks associated with social media addiction and suggested the need for targeted interventions to mitigate its impact on cognitive performance in the educational context.

Background

Social media is an integral part of people's lives in this digital age, as it facilitates digital connectivity, communication, entertainment, business, and jobs. Quoting Walsh (2022), Ahmed et al. (2023) view Snapchat, Instagram, TikTok, and Facebook among many others as the social media platforms that have nurtured global connectivity and communication. However, alongside the benefits of social media use, concerns have arisen about social media addiction and its potential impacts on the psychological and physical health of individuals. The impacts include perseverative thinking, changes to cognitive functioning, inferiority complexes, figure paralysis, and others. In Pakistan, access to social media, particularly through smartphones, has rapidly expanded. Siddiqui (2024) reported that Pakistan was ranked 10th globally in terms of hours spent on smartphones, as Pakistanis spent about 99 billion hours on their digitally-connected devices in 2023. The potential psychological and physical harms associated with heavy social media use underscore the importance of an academic inquiry into the phenomenon. Hence, the current study attempts to understand the impact of social media addiction on cognitive failures and psychological disorders among young adults in Pakistan.

Introduction

Social media addiction is referred to as a behavioral pattern marked by compulsive and excessive engagement with various social media platforms (Jameel et al., 2024; Maccarrone-eaglen & Schofield, 2023) that bears negative consequences on various aspects of users' lives, including personal and social relationships, academic performance, professional routines, and psychological well-being (Pellegrino et al., 2022). A combination of technological, social, and psychological factors contribute to the reinforcement of compulsive and addictive social media usage patterns. This addiction is fueled by the gratification obtained from social media interactions, statuses, validation, and social media features, such as likes, reactions, comments, and shares, all of which lead to feelings of satisfaction and pleasure and increase addictive behaviors (Bhatiasevi, 2024). Furthermore, social media platforms tend to be highly engaging due to features that include notifications, scrolling, and tailored content algorithms that encourage individuals to spend more time on them. Social media addiction may also arise from an individual's desire for social connectivity, belongingness, and peer-acceptance (Angelo et al., 2023). People also use social media to maintain digital relationships, seek social support, and/or compare themselves to others. Excessive reliance on social media for social interactions may lead to social isolation, feelings of loneliness, and fear of missing out, driving social media users to engage in compulsive use to lessen these undesirable emotions (Smith et al., 2021).

Addiction to social media is facilitated by us-

er-friendliness and the ubiquitousness of digital devices, particularly smartphones, that enable unremitting digital connectivity. Smartphones, as modern tools for communication and information access and dissemination, have become instrumental to contemporary high-tech life, offering instant global connectivity and supporting work and entertainment. Equipped with features like social media applications, navigation, e-commerce, and e-banking, these digital devices have reshaped societies. As of December 2023, 85.74% of the global population, translating to 6.92 billion individuals, own smartphones (Bankmycell, 2023). In addition to the widespread use of smartphones and the convenience they bring, numerous potential risks for individuals and society have also been identified. Excessive smartphone use may cause diminished real-world interactions, leading to social isolation, disturbed sleep patterns, anxiety, and stress (Škařupová et al., 2016). A severe decline in productivity in the professional and personal lives of those addicted to smartphones has been reported by many researchers (Lee et al., 2018; Tams et al., 2018; Wang et al., 2022)descriptive analysis, t testing, one-way analysis of variance (ANOVA. Among the challenges a smartphone addict may face are cognitive failures, defined as lapses in cognitive functions that may affect routine activities, ranging from absent-mindedness and forgetfulness to poor attention and misperception (Karishma et al., 2023).

Such failures can be situational, transient, or chronic, and they often manifest in different forms, including forgetting someone's name, misplacing things, and/or having difficulty concentrating (Tirre, 2018). While possibly everyone encounters such failures infrequently, chronic and critical lapses indicate an underlying problem that warrants a thorough investigation. The cognitive processes affected by smartphone use and potential addiction involve attention, memory, and executive functions. The compulsive behavior of checking notifications, engaging with various apps, and multi-tasking leads to divided attention and hinders smartphone users' ability to concentrate on different tasks. Furthermore, the widespread reliance on digital devices to seek information contributes to a dependence on external memory sources that potentially impacts internal memory recall (Mrazek et al., 2021).

Attention deficits are among the significant cognitive failures that involve difficulty maintaining focus or sustaining attention on any particular task (Spaccavento et al., 2019) evaluating the influence of the side and site of the brain lesion, the time from stroke, and the concomitant presence of aphasia or neglect. We assessed 204 patients with a first unilateral brain lesion and 42 healthy individuals with three subtests of the Test of Attentional Performance (TAP. Attentional lapses may lead individuals to have impaired task performance, increased errors, and decreased vigilance, especially in situations that require sustained concentration and attention. Factors that contribute to attention deficit include information overload, boredom, distraction, and fatigue, as they disrupt attentional processes and restrict task performance (Hobbiss & Lavie, 2024). Memory lapses can be counted as another form of cognitive failure that are marked by difficulties in receiving, encoding, storing, and retrieving information (Miller, 2021). These lapses range from minor memory slips to significant memory failures, including forgetting imperative tasks, appointments, and deadlines. Factors that influence memory lapses include multitasking, anxiety, stress, depression, fatigue, and aging-related cognitive functional changes that affect memory processes, such as consolidation, encoding, and retrieval. Similarly, perceptual errors refer to sensory processing and perceptions that may lead to misperceptions and misinterpretations of stimuli (Zaman et al., 2021). Executive function disorders are cognitive failures involving higher-order cognitive functions, including planning, decision-making, and problem-solving, often resulting in difficulties monitoring, organizing and initiating goal-directed behaviors (Colautti et al., 2022). The repercussions of cognitive failures can be of great significance and affect different aspects of life, from academic and professional performance to interpersonal relationships. Furthermore, cognitive failures can lead to self-doubt, frustration, and embarrassment, particularly in critical situations.

The current research seeks to add to the existing body of literature by investigating the impact of social media addiction on cognitive failures among young adults in Pakistan. It focuses on university students in Islamabad, the federal capital of Pakistan. To explore this impact, the study employed a cross-sectional, mixed-method approach, using both quantitative and qualitative methodologies concurrently. The quantitative part of the research employed standardized measures, using the Social Media Addiction Scale-Student Form (SMAS-SF) and the Cognitive Failures Questionnaire (CFQ) to measure the levels of social media addiction and cognitive failures among the respondents. Simultaneously, the researchers collected qualitative data through an exploratory case study. Open-ended questions were embedded in the quantitative survey to gather deeper insights into individuals' perception of social media addiction and potential strategies to mitigate the effects on the cognitive functioning of social media users.

By examining the interplay between social media addiction and cognitive failures, this research aims to contribute to the growing body of literature on the psychological consequences of excessive social media use. Furthermore, the findings of this study have practical implications for educators, policymakers, and mental health professionals in Pakistan, and they highlight the importance of awareness-raising campaigns and targeted interventions to address social media addiction and its impact on the cognitive performance of young adults. Ultimately, this research endeavors to inform evidence-based strategies to foster healthy social media habits and enhance cognitive well-being in the digital age.

Objectives of the Study

The study was driven by the following research objectives:

1. To measure the relationship between social media addiction and cognitive failures among young adults (university students) in Pakistan.
2. To document individual experiences of young adults in Pakistan (Islamabad-based university students) regarding the risks linked with social media addiction and strategies to mitigate its impact on cognitive function.
3. To examine the implications of social media addiction on the cognitive performance of university students in educational settings and suggest interventions to address the dilemma.

Research Hypotheses (Quantitative Part)

The current research devised the following hypotheses for the quantitative survey:

H1. There is a significant positive relationship between social media addiction and cognitive failures among young adults (university students) in Pakistan.

H2. There are significant differences among gender and age groups of young adults (university students) in Pakistan on the variable of cognitive failures and social media addiction.

Research Questions

The exploratory case study was guided by the following research questions:

RQ1. What are the individual perceptions and experiences of the Islamabad-based university students regarding the hazards of social media addiction?

RQ2. How do the Islamabad-based university students understand the impact of social media addiction on their cognitive performance?

RQ3. What are the suggested strategies by the Islamabad-based university students to mitigate the undesirable impact of social media addiction on their cognitive performance?

Research Methodology

a. Research Paradigm: The current study was designed using pragmatism as research paradigm. Johnson and Onwuegbuzie (2004) view pragmatism as the valid philosophy for studies adopting mixed-method research designs.

b. Research Design: The current study, as guided by pragmatism philosophy, adopted a concurrent mixed-method design by employing both quantitative and qualitative approaches to simultaneously collect data from the study participants. The concurrent mixed-method design guides researchers in real-time data

collection for the quantitative and qualitative parts (Dawadi et al., 2021), but the data gathering stands independent of any influence from the other phase (McCrudden et al., 2021; Şahin & Öztürk, 2019).

c. **Research Method (Quantitative)— Cross-sectional, Correlational Survey:** The current mixed-method research employed a cross-sectional, correlational, non-experimental survey method to measure the correlation between social media addiction and cognitive failures among young adults in Pakistan (university students). Such surveys help researchers understand the perceptions, behavior, and opinions of the study population (Lin et al., 2018).

d. **Research Method (Qualitative)— Exploratory Case Study:** This mixed-method study employed an exploratory case study to document the participants' perspectives on the potential risks of social media addiction and identify mitigation strategies/interventions to counter the impacts on university students' cognitive performance in academic settings. Qualitative case studies help scholars conduct in-depth investigations within the given context (Rashid et al., 2019).

e. **Population of the Study:** The population for the study comprised young adults (university students).

f. **Study Participants:** Since the study was related to young adults, the researchers selected university students as study participants.

g. **The Sampling Technique and the Sample:** Due to resource and accessibility considerations, the study employed a purposive convenience sampling technique. The researchers approached more than 1,000 Islamabad-based university students who actively used social media platforms. Of the students approached, 636 agreed to participate in the quantitative survey and simultaneously respond to the open-ended (qualitative) case study questions.

h. **The Instrument:** The current study measured the relationship between social media addiction (predictor variable) and cognitive failures (criterion variable). The researchers adopted the Social Media Addiction Scale-Student Form (SMAS-SF), which was devised and validated by Cengiz (2018) to measure the level of social media addiction (predictor variable) among study populations. The researchers also used the Cognitive Failures Questionnaire (CFQ), developed and validated by Broadbent et al., 1982), to measure the extent of cognitive failures among the study population. The study measured the correlation between the predictor and criterion variables, taking gender and age into consideration.

Data Analysis (Quantitative)— Cross-sectional, Correlational Survey

Table 1 shows the frequencies and percentages of the demographic characteristics of the sample. The study considered age in two categories: 18-24 years and 25-30 years. Similarly, the genders male and female were documented. It was noted that 359 (56.4%) respondents fell into the age group of 18-24 years, and the other 277 (43.6%) study participants were between 25-30 years of age. Moreover, 373 (58.6%) respondents were male, and 263 (41.4%) were female.

Table 2 illustrates that the reliability of the scales is in the good to excellent range, with Cronbach Alpha (α) values of .92 for the Social Media Addiction-Student Form (SMAS-SF) and .88 for the Cognitive Failures Questionnaire (CFQ). Similarly, the Cronbach Alpha values for Virtual Tolerance (VT), Virtual Communication (VC), Virtual Problem (VP), and Virtual Infor-

Table 1 Frequencies and Percentages of the Demographic Characteristics of the Sample (n=636)

Variables	Categories	(f)	(%)
Age	18-24 Years	359	56.4
	25-30 Years	277	43.6
Gender	Male	373	58.6
	Female	263	41.4

mation (VI), the subscales of the Social Media Addiction-Student Form (SMAS-SF), were also recorded as .77, .74, .87, and .76, respectively. Moreover, the Cronbach Alpha values for Forgetfulness (FG), Distractibility (DT), and False Triggering (FT), the subscale of the Cognitive Failures Questionnaire (CFQ), were documented as .81, .74, and .83, respectively. As all of the above-mentioned Cronbach Alpha (α) values fall in the expected range of reliability for any research study, the researchers applied further statistical tests to measure the correlation between social media addiction and cognitive failures among the study population. Table 2 also presents the means, standard deviation, and minimum and maximum ranges for each scale.

Table 3 shows the correlation between the Social Media Addiction Scale-Student Form

Table 2 Reliability Analysis of the Study Scales Used (n=636)

	No. of items				Range	
		(α)	M	SD	Minimum	Maximum
SMAS-SF	29	.92	92.46	20.39	46	145
VT	5	.77	8.79	3.77	5	25
VC	9	.74	18.37	5.86	12	45
VP	9	.87	27.89	7.91	10	45
VI	6	.76	20.67	4.66	9	30
CFQ	25	.88	44.36	14.67	23	83
FG	8	.81	13.91	5.95	6	28
DT	8	.74	15.90	6.25	9	28
FT	8	.83	13.08	5.94	4	28

Note. SMAS-SF=Social Media Addiction Scale-Student Form, VT=Virtual Tolerance, VC=-Virtual Communication, VP=Virtual Problem, VI=Virtual Information, CFQ=Cognitive Failures Questionnaire, FG=Forgetfulness, DT=Distractibility, FT=False Triggering

Table 3 Pearson Product Moment Correlation between the Social Media Addiction Scale-Student Form and its Subscales and the Cognitive Failures Questionnaire and Its Subscales (n=636)

		1	2	3	4	5	6	7	8	9
1.	**SMA**	1	.822**	.904**	.902**	.742**	.967**	.891**	.468**	.926**
2.	**VT**		1	.686**	.674**	.491**	.793**	.735**	.386**	.753**
3.	**VC**			1	.737**	.600**	.880**	.819**	.417**	.845**
4.	**VP**				1	.534**	.861**	.796**	.406**	.825**
5.	**VI**					1	.734**	.653**	.383**	.704**
6.	**CF**						1	.861**	.574**	.925**
7.	**FG**							1	.106**	.974**
8.	**DT**								1	.248**
9.	**FT**									1

*Note:** Correlation is significant at the 0.01 level (2-tailed). SMA=Social Media Addiction, VT= Virtual Tolerance, VC=Virtual Communication, VP=Virtual Problem, VI=Virtual Information, CF=Cognitive Failures, FG=Forgetfulness, DT=Distractibility, FT=False Triggering*

and its subscales, as well as the Cognitive Failures Questionnaire and its subscales. The resulting statistics revealed a significant positive correlation between social media addiction and cognitive failures among the study population. The result supported Hypothesis 1, proposing a significant positive relationship between social media addiction and cognitive failures among young adults (university students) in Pakistan.

Table 4 demonstrates the impact of social media addiction on cognitive failures among young adults (university students) in Pakistan. The R^2 value of .83 revealed that regarding social media addiction, the predictor variable caused 83% variance in the cognitive failures. The criterion variable was F=8853.99, $p<.01$. The findings discovered that social media addiction positively predicted cognitive failures (β=.86, $p<.01$).

Table 5 shows the application of an independent sample *t*-test that indicated statistically significant differences between male and female gender groups on the variables of social media addiction, cognitive failures, and their respective subscales. The statistics presented in Table 5 also revealed that the male study participants scored higher on the variables of social media addiction and cognitive failures compared to their female counterparts. This suggests that they suffered from social media addiction, and ultimately cognitive failures, more than the female participants of the study. This also supported Hypothesis 2, proposing significant differences among gender

Table 4 Regression Coefficient of Social Media Addiction on Cognitive Failures

Variable	B	β	SE	F
Constant	.15		1.11	8853.79
SMA	2.35	.86	.028	
R^2	.83			

Note: N=636, P<.01, SMA-SF=Social Media Addiction

Table 5 Independent Sample t-test Analysis between Male and Female Groups of the Sample on the Variables of Social Media Addiction and Subscales, and Cognitive Failures and Subscales (n=636)

	Male (n=373)		Female (n=263)		T	P	95% CI	
Measures	**M**	**SD**	**M**	**SD**			**LL**	**UL**
1. SMA	95.17	21.77	88.62	17.60	4.181	.000	3.470	9.616
2. VT	16.48	4.91	15.64	4.03	2.366	.018	.143	1.539
3. VC	28.61	6.95	26.58	6.04	3.926	.000	1.016	3.050
4. VP	28.76	8.20	26.65	7.32	3.410	.001	.897	3.331
5. VI	21.31	4.87	19.76	4.19	4.301	.000	.845	2.264
6.CF	46.93	14.85	40.72	13.66	5.440	.000	3.966	8.445
7. FG	14.77	5.94	12.68	5.75	4.460	.000	1.169	3.012
8. DT	16.39	6.38	15.21	5.99	2.370	.018	.203	2.150
9. FT	14.26	5.72	11.41	5.86	6.090	.000	1.931	3.767

Note. P>.05, SMA=Social Media Addiction, VT=Virtual Tolerance, VC=Virtual Communication, VP=Virtual Problem, VI=Virtual Information, CF=Cognitive Failures, FG=Forgetfulness, DT= Distractibility, FT=False Triggering

and age groups of young adults (university students) in Pakistan on the variable of cognitive failures due to social media addiction.

Table 6 reflects the application of an independent sample *t*-test that revealed statistically significant differences between the age groups of the study sample on the variables of social media addiction, cognitive failures, and their respective subscales. The results show that that the study participants in the age group of 25-30 years scored higher on the variables of social media addiction and cognitive failures compared to the respondents in the 18-24 category, suggesting that the older age group (25-30 years) suffered from social media addiction, and ultimately cognitive failures more than those in the 18-24 age bracket. This also supported Hypothesis 2, proposing significant differences among gender and age groups of young adults (university students) in Pakistan on the variable of cognitive failures due to social media addiction.

Results (Thematic Analysis) of the Exploratory Case Study

The questions for the exploratory case study revolved around respondents' perceptions and experiences regarding social media addiction hazards, their understanding of the impact of social media addiction on their cognitive performance, and self-adopted/suggested mitigation strategies/interventions to counter the undesirable impact of social media addiction on their cognitive performance. The responses yielded three main themes: social media addiction hazards, social media addiction's impact on cognitive performance, and the mitigation of social media addiction's impact on cognitive performance. A detailed thematic analysis of the responses from the study participants is as follows:

Theme 1: Social Media Addiction Hazards

The first theme identified from the responses of the study participants was "social media addiction hazards." This theme was further comprised of three sub-themes: Academic Performance, Mental Health Issues, and Disrupted Social Interactions.

Table 6 Independent Sample t-test Analysis between Age Groups on the Variables of Social Media Addiction and Its Subscales, and Cognitive Failures and Its Subscales (n=636).

	18-24 (n=359)		25-30 (n=277)		t	P	95% CI	
Measures	M	SD	M	SD			LL	UL
1. SMA	91.26	19.960	94.02	20.871	-1.685	.093	-5.98	.46
2. VT	15.84	4.436	16.51	4.745	-1.793	.074	-1.39	.06
3. VC	27.36	6.411	28.30	6.945	-1.757	.079	-1.99	.11
4. VP	27.92	7.912	27.84	7.930	.126	.900	-1.16	1.32
5. VI	20.13	4.725	21.36	4.500	-3.354	.001	-1.96	-.51
6.CF	43.32	14.657	45.71	14.624	-2.037	.042	-4.68	-.08
7. FG	13.26	5.774	14.75	6.068	-3.147	.002	-2.43	-.56
8. DT	16.08	6.462	15.67	5.958	.817	.415	-.57	1.37
9. FT	12.40	5.881	13.96	5.915	-3.312	.001	-2.49	-.64

Note. P>.05, SMA=Social Media Addiction, VT=Virtual Tolerance, VC=Virtual Communication, VP=Virtual Problem, VI=Virtual Information, CF=Cognitive Failures, FG=Forgetfulness, DT= Distractibility, FT=False Triggering

a. **Sub-theme 1 — Academic Performance:** The sub-theme Academic Performance highlighted two main aspects: distraction and procrastination, and a difficulty to focus on studies due to social media addiction. It was noted that social media addiction distracts individuals from focusing on their studies and may lead to distress that can impact cognitive performance.
b. **Sub-theme 2 — Mental Health Issues:** The sub-theme Mental Health Issues was defined by social media addicts as being anxiety, stress, low self-esteem, and irrational comparison with others. It was documented that those who use social media in excess (to the level of addiction) have very low self-esteem and suffer from anxiety and stress. Such individuals are also in the habit of irrationally comparing themselves with others.
c. **Sub-theme 3 — Aggrieved Social Interactions:** The sub-theme Aggrieved Social Interactions was based on a decline in face-to-face interactions and the impact on meaningful relationships due to social media addiction. It was observed through the responses of the study participants that individuals who suffer from social media addiction face troubles in their social relationships. They avoid face-to-face interactions, and if they have them, they have them reluctantly. Similarly, social media addicts also suffer from troubled marriages and other social relationships due to their spending a lot of time in the virtual world and not paying attention to real-life relationships and the factors associated with them.

Theme 2: Social Media Addiction Impact on Cognitive Performance

The second theme identified among the responses of the study participants was Social Media Addiction's Impact on Cognitive Performance. This theme was further comprised of three sub-themes: Focus and Concentration, Memory and Retention, and Cognitive Fatigue.

a. **Sub-theme 1 — Focus and Concentration:** The sub-theme Focus and Concentration highlighted two main aspects that are brought about due to social media addiction: increased distractions and trouble concentrating. It was observed from the responses that social media addicts were unable to concentrate on their routine real-life activities, particularly academic activities and studies, as they were distracted by the illusion of the virtual world created by social media and smartphones.
b. **Sub-theme 2 — Memory and Retention:** The sub-theme Memory and Retention comprised forgetfulness, memory lapses, and difficulty retaining information. The respondents recognized that they suffered memory lapses and often forgot important tasks due to being continuously engaged with smartphones and social media. They acknowledged that the tasks they once considered manageable had become more challenging and that they often struggled to retain information and stay focused during class lectures and other academic sessions.
c. **Sub-theme 3 — Cognitive Fatigue:** The sub-theme Cognitive Fatigue included feeling mentally exhausted and having decreased cognitive abilities. It was observed that the respondents suffered mental fatigue due to constant exposure to social media. They reported a decline in their critical thinking skills and problem-solving abilities, attributing it to an overload of information coming from social media platforms, which led to mental overburdening and ultimately cognitive fatigue.

Theme 3: Mitigation of Social Media Addiction Impact on Cognitive Performance

The third theme identified from the respondents' answers to questions about counter-strategies to mitigate the undesirable impacts of social media addiction on their cognitive performance was comprised of individual routines and limitations, conducive learning environments, and mindfulness and self-care.

a. **Sub-theme 1 — Individual Routines and Limitations:** The sub-theme Individual Routines and Limitations was comprised of suggestions by the respondents regarding specific times of social media usage and utilizing digital well-being applications to track and limit screentime. In addition to acknowledging the unavoidability of smartphones and so-

cial media, the respondents agreed that people should use a timetable for social media usage and limit screentime. They also suggested using various digital media usage trackers and applications available for smartphones and other digital devices to ensure their mental well-being, which in turn will help reduce the amount of memory lapses and cognitive failures. They also highlighted the importance of spending as much time socializing with family and friends as possible as a step that could also help individuals counter cognitive fatigue.

b. **Sub-theme 2 — Conducive Learning Environment:** The sub-theme Conducive Learning Environment comprised suggestions including managing smartphone and social media use during physical class lectures, minimizing notifications and distractions, and establishing quiet spaces that could facilitate studying and academic discussions. On one hand, the respondents suggested that individuals could mitigate the hazardous impact of social media, particularly cognitive failures, by reducing their dependence on social media during class lectures. On the other hand, they demanded strict rules by the academic institutions to restrict social media usage during academic discussions. They agreed that smartphone usage should not be allowed in classrooms. The respondents also suggested that academic institutions should encourage study circles and academic debates and establish more study-friendly spaces to counter social media addictions and cognitive failures.

c. **Sub-theme 3 — Mindfulness and Self-Care:** The sub-theme Mindfulness and Self-Care comprised strategies like engaging oneself in mindfulness rituals like meditation and expanding leisure hobbies and activities to counter social media addiction and cognitive failures. The respondents viewed mindfulness practices like deep-breath exercises and meditation as helpful in regaining focus and countering cognitive fatigue and failures caused by addictive social media usage. Similarly, individuals should consciously make efforts to diversify their leisure activities, spend time with family and friends, plan outdoor activities, read books, and exercise to minimize their reliance on smartphones and social media.

Findings of the Study (Quantitative Part)

a. It was found that the scales used: the Social Media Addiction Scale-Student Form (SMA-SF) and the Cognitive Failures Questionnaire (CFQ) for the current study (quantitative part) were reliable.

b. It was found that a significant positive correlation between social media addiction and cognitive failures exists among young adults in Pakistan. Another finding was that social media addiction positively predicts cognitive lapses among the study population. Hypothesis 1, which proposed a significant positive relationship between social media addiction and cognitive failures among young adults (university students) in Pakistan, was supported.

c. It was noted that male respondents and those with an older age (25-30 years) tend to display a greater degree of social media addiction and cognitive failures compared to the female group of respondents and individuals in the younger age group of 18-24 years. Hypothesis 2, which proposed significant differences among gender and age groups of young adults (university students) in Pakistan on the variable of cognitive failures due to social media addiction, was supported.

Findings of the Study (Quantitative Part)

a. Social media addiction causes distraction, procrastination, trouble focusing, and negatively affects cognitive performance. This addiction leads to stress, anxiety, low self-esteem, and irrational comparison with others. It also results in minimal interpersonal interactions and disturbed relationships.

b. Social media addiction leads to increased distraction and reduced concentration, especially in the context of academic performance. Social media addicts often experience cognitive fatigue and failures, including memory lapses, forgetfulness, and reduced cognitive abilities, particularly in retaining information, due to constant exposure to social media.

c. The respondents suggested that social media use should be scheduled. Individuals should install and use digital well-being apps. People should spend time with their family and friends to counter cognitive fatigue. Academic institutions should manage social media use during class lectures, minimize distractions, and create quiet study circles (spaces). Furthermore, engaging in leisure pursuits, practicing mindfulness, and participating in outdoor activities are recommended strategies to counter cognitive failures associated with social media addiction.

Conclusion

The current research explored the significant positive correlation between social media addiction and cognitive failures among young adults in Pakistan. It also found that social media addiction positively predicted cognitive failures among the study populations. Furthermore, the male respondents and individuals falling in the age group of 25-30 years displayed a greater degree of social media addiction and cognitive failures than their female counterparts and younger individuals aged 18-24 years. Moreover, the study showed that social media addiction resulted in distraction, procrastination, poor interpersonal interactions, disturbed relationships, stress, anxiety, and low self-esteem. The findings revealed that social media addicts may also suffer from cognitive fatigue, memory lapses, and reduced cognitive performance. The respondents proposed several strategies to mitigate social media addiction and cognitive failures, including scheduled use of social media, the use of digital well-being apps, engaging in leisure time and outdoor activities with family and friends, regulating social media use during class lectures to minimize distractions, establishing dedicated study circles within academic institutions, and incorporating mindfulness practices.

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A Social Worker's Case Study on Forgiveness in a Senior Care Facility: Reflections on Alzheimer's, Trauma, and the End of Life

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Original Article

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Abstract:

Typical symptoms also include depression, a distorted perception of reality, anxiety, paranoia, and disorientation in time and space. This is because the brain cannot cope with abnormal clusters of proteins that form during the disease. It cannot degrade them, so it tries to "store" them and gradually stops functioning properly. The public often perceives Alzheimer's disease as a normal part of aging, but that is a mistake. Although its occurrence is associated with age, it is not an automatic consequence of getting older. Ordinary forgetfulness or slight disorientation in old age does not necessarily indicate pathological changes in the brain. More than forty-six million people

worldwide suffer from the "disease of forgetting." In Slovakia, there are approximately sixty thousand diagnosed patients, and that number is increasing. The condition is increasingly affecting younger people, including those in their fifties.

Digital Dementia of Middle Age

Well-known Bratislava-based geriatrician Peter Belan has pointed to a new form of "digital dementia" among middle-aged individuals. Over the past twenty years, he has observed a decline in their ability to remember everyday things that people used to recall with ease. "Thanks to technology—especially mobile phones—we are becoming mentally lazy. Our cognitive skills are weakening, and we stop training our memory. I cannot yet estimate the consequences of this phenomenon, but I suspect it will result in a higher incidence of dementia in the coming decades," explains the doctor, who has more than fifty years of experience treating various forms of dementia. He adds, "Society is unfair when comparing young and old people. When a young person forgets something, it's called absent-mindedness. But when an older person forgets, people immediately suspect dementia."

Risk factors for the early onset of Alzheimer's include being overweight, obesity, diabetes, high blood pressure, and a sedentary lifestyle. On the other hand, protective factors—besides a healthy lifestyle—include personal success and life optimism. Genetics play a key role. Alzheimer's disease has a significant social impact. In the home environment, each affected person typically requires care from two people. In social service facilities in Slovakia—where around thirty thousand seniors live—about half of the residents suffer from Alzheimer's disease or a similar form of dementia. Some senior homes report up to two-thirds of clients with Alzheimer's. The real number of people affected by pathological "forgetfulness" is unknown. Often, the disease is only definitively confirmed by autopsy. An increasing number of experts are linking Alzheimer's directly to unresolved trauma.

A Desire to Die

Mrs. Jana was admitted to the senior care facility of the Evangelical Diaconia Center on Palisády Street in Bratislava on her 80th birthday—over ten years after she began forgetting and experiencing frequent disorientation. She had been a widow for fifteen years. Her two daughters brought her to the center. The whole family had good social standing and appeared happy and well-adjusted. "Learning a person's entire story from birth is part of the process of accepting a senior," explains social worker and director of the retirement home, Beáta Dobová.

Everything seemed fine. Jana had five children, all with university degrees and stable jobs. All of them described their mother as a caring and family-oriented woman. However, in recent years, she had started reacting to men with uncontrollable aggression as her memory faded and her disorientation grew. No male caregiver or maintenance worker could approach her without it ending in screaming. When a social worker asked her daughters about any past negative experiences their mother might have had with men, they both shook their heads, claiming she had lived a good life.

In her first months at the facility, Jana was still able to communicate, walk, and eat independently—until her condition suddenly began to deteriorate rapidly. She no longer recognized her own children, stopped speaking, and remained bedridden in a fetal position, needing to be fed through a syringe. This vegetative state, in which people usually pass away within weeks, lasted over two years for her. Something was preventing her from dying.

This unsettled Mrs. Dobová, who once again urged the family to have an open conversation about their mother's life. That's when a well-guarded family secret finally came to light. For forty years of marriage, Mrs. Jana had been brutally abused by her husband every night. By day, they appeared to be the perfect, deeply religious family. By night, it was hell at home. Jana lived two separate lives. According to her children, she never wanted to talk about the domestic violence. Her problems with mem-

ory and disorientation began shortly after her husband's death fifteen years earlier.

"The human mind searches for ways to cope with trauma. A person suppresses painful, unresolved experiences and gradually forgets, until they forget the whole world—and die," explained a physician in relation to how different forms of dementia may arise. The care workers began communicating with Jana more through touch, whispering into her ear, gentle caressing, and expressions of empathy—all techniques from the validation therapy approach developed by American social worker Naomi Feil. "After a few days, she began responding with her breath and coughing. She was in the fourth and final stage of dementia. We told her that life is hard, and that we need to forgive," explains the director of the facility. Within four weeks, Jana passed away peacefully.

What a Therapeutic Lie Can Do

Older people are physically and mentally fragile. They are like icebergs in the ocean—what we see is just the tip, while everything essential is hidden beneath the surface. This is true both for healthy seniors and for those who are disoriented, lost, and tucked away in their own world—a world they retreat to in search of memories, joys, and the past. The need to come to terms with different life stages—childhood, youth, middle age, marriage, parenting, work, and interpersonal relationships, which are often filled with crises and traumas—is a natural part of aging.

If a senior remains well-oriented in time and space, if their mind and memory still function, and if they are capable of reflecting on their life, naming experiences, evaluating them, and—most importantly—offering or asking for forgiveness, they have a great chance to live to a good old age. However, disoriented people, especially those in the middle stage of Alzheimer's disease onward, are locked in their inner world of memories, stories, and traumas. This world is hard to access from the outside. Yet, just like healthy seniors, they need to process their lives, give meaning to their life stages, come to terms with loss, and gradually let go of past certainties.

Seventy-eight-year-old Vladimír arrived at the social care facility on Bratislava's Palisády Street accompanied by his son. He had held high-ranking positions in Slovak healthcare all his life, which is why his name, like those of all the other residents of the Evangelical Diaconia Center, has been changed. He was disoriented and diagnosed with Alzheimer's disease in its early stage, when people can still use their intelligence to mask memory gaps and disorientation. For example, if he forgot whether he had already had lunch, he would go to the head nurse and ask what program he had left for the day.

Over his two-year stay at the facility, Vladimír progressed through the second and third stages of Alzheimer's, and then his condition suddenly worsened. He began bleeding from body openings without any apparent cause. Even the paramedics had never seen anything like it. The bedsheets were always soaked in blood. They were only ever able to help temporarily. Like Mrs. Jana, he couldn't die.

Vladimír's son visited him every day. During a conversation with a social worker, he revealed that Vladimír also had another son who had completely cut ties with their father years ago. He blamed him for the premature death of their mother. The bad relationship with his estranged son tormented Vladimír deeply. Despite the social worker's pleas, the angry son repeatedly refused to visit.

"We didn't know what to do—Vladimír was deeply troubled, so we decided to use a therapeutic lie," the social worker explains. "We told him his son had called, that he wanted to see him but couldn't come because he was abroad, and that everything was now okay between them." Vladimír began to cry—and died within a week. He experienced the feeling of forgiveness and reconciliation.

Unresolved Trauma

The staff of the Evangelical social care facility are trained to communicate with disoriented individuals suffering from various forms of dementia. As part of their program, they talk with clients about difficult life experiences and emphasize the importance of forgiveness—toward themselves, toward others, and, for those

who believe, even toward God. They all agree on one thing: the hardest form of forgiveness is forgiving God.

American social gerontologist Naomi Feil claims that if people are helped to process their traumas, it can slow down—or even stop—the accelerated progression of dementia. "A good outcome of working through a senior's trauma can be a good death. We are not a hospital where people are treated—we help people in the final and most difficult stage of life come to terms with this phase," explains the facility's head nurse, Marta Takáčová.

In her research and years of experience working with seniors, Feil found that when individuals carry unprocessed trauma through each stage of life and into old age—like a heavy backpack—these unresolved burdens can lead to a faster onset of disorientation and forgetfulness in later years. The inner turmoil, conflicts, and crises that are never resolved remain like unfinished tasks, accumulating until the final stage of life. At that point, people can no longer resolve them on their own.

Painful emotions that were once suppressed or ignored become more intense in old age. Seniors lack the strength to process them, and instead of experiencing a "blessed old age," they face memory loss and a quicker death. If we do not consciously deal with our problems, the unconscious eventually takes over. According to staff at social care facilities, disoriented people with dementia often have multiple life stages unresolved, not just one.

"We don't become disoriented if, at every stage of life, we find an effective way to process conflict," says Beáta Dobová. "For an aging person, Naomi Feil argues, it's easier to escape the most difficult final stage of life into gradual forgetfulness than to confront unprocessed trauma."

As we were leaving, we spent a little time with Iveta, an 86-year-old former clerk from Slovenská sporiteľňa bank, originally from Vranov nad Topľou, and Alena, an 89-year-old former waitress from Levoča. Both suffer from moderate Alzheimer's disease. Most of our questions were met with a smiling "I don't know." They said they weren't taking any medications, hadn't eaten yet, didn't know what time or day it was, and felt troubled by forgetting their grandchildren's names or the actors in TV shows.

They no longer really wanted to visit their children or grandchildren at home. They had found their home in the care facility, where they are looked after, talked to often, and loved. Sometimes, when they feel like going somewhere, they sit at a replica bus stop with printed arrival and departure times for trolleybuses number 203 and 207 that is located by the facility's exit. After a while, caregivers, nurses, or social workers come and sit with them, talk about their wishes, worries, and needs. Then the women usually get up and either go lie down or take part in one of the therapeutic activities.

The Nun Study

American social worker Naomi Feil built on findings from the well-known "Nun Study" led by neurologist David Snowdon. The study involved 678 nuns from the School Sisters of Notre Dame congregation, aged between 75 and 107 years. It sought to explore the connection between lifestyle factors and aging, with a special focus on Alzheimer's disease and dementia.

All the nuns kept diaries for over twenty years, which researchers were allowed to access, and they also agreed to post-mortem brain examinations. The study revealed a surprising finding: a large group of nuns whose autopsies confirmed brain damage typical of Alzheimer's disease had shown no signs of disorientation, memory loss, or other Alzheimer's symptoms during their lifetime. In contrast, another group of nuns—whose brains showed no pathological changes—had behaved in a disoriented manner and exhibited symptoms of dementia.

Based on the autopsy results and analysis of the diaries—where the women recorded their life attitudes and how they coped with personal suffering—Feil concluded that those who did not suppress their problems, but addressed them, talked about them, named them, and above all, practiced forgiveness, showed no symptoms of dementia, even when their brains were physically damaged. Conversely, nuns who did not work through their issues exhibited signs of confusion and disorientation, despite having healthy brains.

According to Dr. Belan, Alzheimer's disease is, in a way, nature's act of mercy toward humans. It helps them forget pain and trauma they are unable to resolve. "I've never seen a dementia patient suffer a breakdown or a sudden health collapse upon receiving tragic news, such as the death of a partner or child," the geriatrician explains. "There is sorrow, of course, but not a collapse. It points to the body's regulatory mechanisms, which protect people from further pain during major losses near the end of life. It filters everything heavy into forgetfulness. I have treated several people who survived concentration camps. Despite experiencing immense trauma, they lived full lives into their nineties or even past one hundred, with full mental clarity. What they had in common was that they were able to process that pain within themselves—even if they couldn't always talk about it."

In conversations with healthcare professionals, social workers, psychologists, and special educators across several senior care homes, one key word consistently surfaced when discussing dementia: forgiveness. This seemingly "simple" act is a vital key to a healthy mental life. It is a universal response to unresolved life issues within each of us.

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Monitoring the quality of the endoscopic reprocessing technique by a nurse in gastroenterology

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Abstract:

Introduction: Gastrointestinal endoscopy is an effective and safe method designed for screening, diagnosing, and treating digestive tract diseases. However, nosocomial infections are a serious problem. Therefore, many countries are revising guidelines for the reprocessing of endoscopes, with the goal of preventing nosocomial infections. It is crucial for endoscope reprocessing to be conducted in accordance with the latest recommendations.
Objective: To monitor the quality of endoscope decontamination by nurses and compare the quality of the endoscope decontamination after automatic and manual reprocessing through indicator tests. Based on the results, recommendations will be proposed for routine reprocessing control by nurses in practice.

Methodology: The research took place from January to September 2022 in the Department of Gastroenterology at the Faculty Hospital in Trnava. The quality of manual and automatic reprocessing was compared using 1,108 rapid indicator tests. This was routine testing of endoscopes using rapid tests to detect protein and blood residues. Gastroscopes, colonoscopes, and duodenoscopes were tested. In total, 277 control procedures were performed by nurses after the manual and automatic reprocessing of endoscopes. The results were assessed using the T-test and Chi-square test.
Results: The rapid tests showed 31.8% (with manual) compared to 15.5% (with automatic) contamination after endoscope reprocessing. In the case of manual reprocessing, there were 58 (42%) positive protein tests and 5 (7%) positive blood tests out of all the reprocessed endoscopes. With automatic reprocessing, there were 41 (28%) positive protein tests and 1 (0.7%) positive blood test out of all the reprocessed endoscopes. The average time for carrying out reprocessing with quality control of disinfection was 31.8 ±10.2 min compared to 29.9 ±10.0 min without control.
Conclusion: We demonstrated the justification for the implementation of rapid tests after endoscope reprocessing. We proposed a pilot set of recommendations for practice for routine reprocessing control by nurses that are tailored to the needs of a tertiary care facility. We attempted to create a basis for other facilities in Slovakia where endoscope reprocessing is carried out.

Conflict of interest - We are not aware of any conflict of interest concerning the work presented.

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Introduction

The first generation of flexible endoscopes was introduced into practice about 50 years ago, and it triggered a revolution in the clinical practice of gastroenterology. They significantly improved diagnostics, and endoscopic screening prevented many cancer-related deaths. National and international endoscopic societies supported the employment of nurses, research, and proposed guidelines to support internal auditing and quality assurance in the proper handling of endoscopes. Advances in instrument design and the production of new accessories improved endoscopic techniques and their capabilities while increasing patient comfort and safety. The risk of infections associated with the use of endoscopes is never zero, and with the increase in the number of endoscopic procedures, nosocomial infections began to appear. Therefore, endoscopic societies introduced very high-quality protocols and guidelines for endoscope disinfection to minimize the risks of infectious agent transmission (Axon, 2020). An increasingly serious problem in healthcare facilities is the growth of nosocomial infections with multidrug-resistant strains. Standards for the reprocessing of flexible endoscopes in gastroenterology should be regularly updated by a group of experts working in the field, including nurses, microbiologists, infection prevention and control specialists, and other relevant professionals. The goal is to maintain high-quality reprocessing to minimize the risk of infection transmission based on findings and the

subsequent development of professional guidelines for endoscope decontamination practices in specific workplaces.

We are witnessing a constant increase in endoscopic and surgical procedures, and therefore, also the risk of infectious complications, which are associated with the potential transmission of infectious agents. The constant increase in diseases and examinations leads us into an era of quantity. It is essential to use all the available options to ensure patient health. In recent years, disposable medical devices have become preferred in healthcare practices. The use of disposable medical devices offers clear advantages, a trend that has also been embraced in endoscopy. Disposable devices facilitate and speed up work. In some countries, disposable endoscopes are already firmly established in clinical practice, basically a given. However, the current situation regarding the climate is alarming. We are destroying our ecosystem with irresponsible and indifferent human behavior, consumerism, and the burning of disposable instruments. Endoscopy is also a major contributor to this. The production of waste, namely plastics, increases greenhouse gases (Rodríguez De Santiago et al., 2022). Endoscopic examinations carry a certain risk of infection transmission, but with thorough endoscope disinfection carried out by professional specialized staff, the risk of transmission to patients, staff, and the workplace can be significantly reduced.

The problem with biofilm formation inside or on the surface of an endoscope may stem from the following: repeated exposure of the instrument to microorganisms (mechanical transfer during the handling of the endoscope), insufficient cleaning procedures from various unclassified causes, and ultimately the modernization of the technical execution of the instruments and their structural complexity. Therefore, a nurse's role requires a comprehensive understanding of the entire reprocessing process, including mechanical cleaning, disinfection, drying, and the proper storage of endoscopes.

Methods

Currently, there is a lack of data on the transmission of nosocomial infections through endoscopic instruments from endoscopy centers in Slovakia. Information about the epidemiological situation and the activities of epidemiology departments in the Slovak Republic from 2010 - 2019 report an average positivity of tested instruments as being 18% (9 out of 50 tested) (Annual Epidemiological Reports, 2020). However, they do not provide further information about what infections were involved and where the highest risks were. Therefore, it is essential to obtain this information and develop further procedures to prevent infection transmission. In Slovakia, the most recent professional guidelines on performing endoscope decontamination were issued in a bulletin published in 2000. On July 1, 2000, the Ministry of Health of the Slovak Republic, through the Chief Hygienist, issued "professional guidance on performing endoscope decontamination" effective from September 1, 2000. This guidance was issued according to §19 letters h) and i) of the NS SR Act No. 277/1994 Coll. on the protection of human health as amended by Act NR No. 290/1996 Coll. to prevent and limit the spread of communicable diseases. This guidance was supplemented on May 15, 2021, by two standards that were our motivation for research. However, these standards were not derived from verified data or practical experience. They are more of a theoretical framework, and to this day these standards have not been implemented. Workplaces often struggle independently and use European standards to manage their facilities.

Organization and realization

The organization and realization of the research took place at the Gastroenterology Outpatient Clinic of the Faculty Hospital Trnava, which is the final provider of institutional healthcare for the catchment area of the Trnava region. Approximately 25,000 patients are hospitalized annually in FN Trnava in 638 beds, and roughly 2,380 invasive procedures are performed on an outpatient basis.

The research was carried out from January 2022 to September 2022 in cooperation with the staff of the Department of Hospital Hygiene and Epidemiology FN Trnava. Our sample of respondents reflects the number of on-site rapid indicator tests conducted to detect the presence

of protein residues or blood in patients undergoing endoscopic examination in gastroenterology at FN Trnava. The result of an on-site rapid test is available within 15 seconds. If a rapid test was repeatedly positive despite repeated reprocessing, ATP testing was then conducted. The endoscopic device to be tested must first be decontaminated, either manually or automatically. Automatic decontamination involves the use of both manual decontamination and decontamination in an automatic disinfector. In the event of a positive indicator test result, the ATP method was carried out, i.e., testing for residual adenosine triphosphates to detect the presence of microorganisms. The method is based on the fact that when ATP reacts with d-luciferin, light energy is produced, which is then quantitatively measured by a luminometer in relative light units. ATP detection was measured after the completion of the decontamination process using a portable luminometer (3M Clean-TraceTM). Protein detection was determined by a Resi test, and blood detection was carried out using HemoCheck-S. Repeated routine testing of positive indicator tests either confirmed or refuted staff errors in reprocessing. The ATP method yielded a positive result in one case following a change in the disinfection protocol after switching from glutaraldehyde preparations to peracetic acid-based ones. The elimination of the issue was confirmed after the switch. Another case of ATP occurred at the very beginning of the project itself, when the technique was verified and calibrated on a non-reprocessed endoscope. Due to the low sample size, we did not statistically process this method. In principle, the basic steps of the reprocessing description were based on valid legislation. After examining the patient, the endoscope was reprocessed by the nurse at the endoscopy workplace according to the current standards of the Ministry of Health of the Slovak Republic for the manual and automatic reprocessing of instruments. After both manual and automatic reprocessing, quality control tests using indicator tests were performed, and the quality of each reprocessing performed by the nurse was evaluated and compared. According to amendments to the law, the task of a nurse is to verify the quality of the reprocessing (and thereby eliminate the risk of infection transmission) by carrying out an indicator test after performing both manual and automatic reprocessing. Our set consisted of 1,108 indicator tests. We focused on selected types of endoscopes (colonoscope, duodenoscope, gastroscope), as they have been the most commonly used in clinical practice for a long time, and the method of disinfection used (manual vs. automatic reprocessing). If the selected "on site" tests yielded positive results, a higher level quantitative test was performed, specifically the ATP bioluminescence method using a luminometer. This was always conducted in the presence of a staff member of the Department of Hospital Hygiene and Epidemiology FN Trnava. If the ATP sample was positive, corrective measures were taken and immediate re-education of the staff took place to improve the effectiveness of the decontamination and disinfection process. In addition to the primary goal of verifying the reprocessing quality using rapid tests, the secondary objectives were to assess the total time required for thorough endoscope decontamination by the nurse and to use indicator tests to evaluate the entire decontamination process.

Objective

The Slovak Republic ranks among the countries with the highest incidence of colorectal cancer. 3.8% of deaths stem from rectum and colon cancer, and approximately 1.6% from pancreatic cancer (OECD, 2021). Through screening and early detection, the alarming numbers of colorectal cancer incidence can be actively prevented. Endoscopy plays an indispensable role in modern healthcare. Our objective is to contribute to the proper functioning of endoscopic facilities in Slovakia and to promote the overall health of the Slovak population.

The main objective of the work is to monitor the effectiveness of endoscopic equipment decontamination performed by nurses in gastroenterological outpatient practices. The results will be used to analyze the factors regarding the adjustment and testing of endoscopic devices, ultimately contributing to the development of a practical standard for nursing practice in Slovak endoscopic facilities. Our goal is to assess the practical feasibility of implementing the

new recommendations issued by the Ministry of Health of the Slovak Republic for nurses regarding the routine disinfection control of medical devices and to compare different methods of detecting contamination. We will develop proposals and recommendations for practice on the routine control of reprocessing in gastroenterological outpatient clinics in Slovak healthcare facilities. At the same time, various aspects and impacts of reprocessing quality control in practice will be analyzed.

The sample selection criteria were set as follows: endoscopes used in examinations of patients at the gastroenterology outpatient clinic of the University Hospital Trnava. The research was carried out in cooperation with the Department of Hospital Hygiene and Epidemiology of the University Hospital Trnava. Resi tests were used to detect residual proteins and Hemo-Check-S tests were used to detect residual blood. If a result was positive, we proceeded with the ATP method. The endoscopes were decontaminated using manual and automatic processes. The tested endoscopes were 3 colonoscopes, 3 duodenoscopes, and 3 gastroscopes. Additionally, we processed and analyzed the time unit (the duration of the test itself and the total reprocessing time).

Statistical Methods

Statistical tests were carried out in the R Project 4.1.3 program, and a significance level of $p < 0.005$ was chosen. If at least one indicator test was positive, the decontamination process was assessed as unsatisfactory. We graphically represented the comparison of time using box plots. The Student's T-test was used to compare the two mean values. The Chi-square test of independence was used to compare categorical variables.

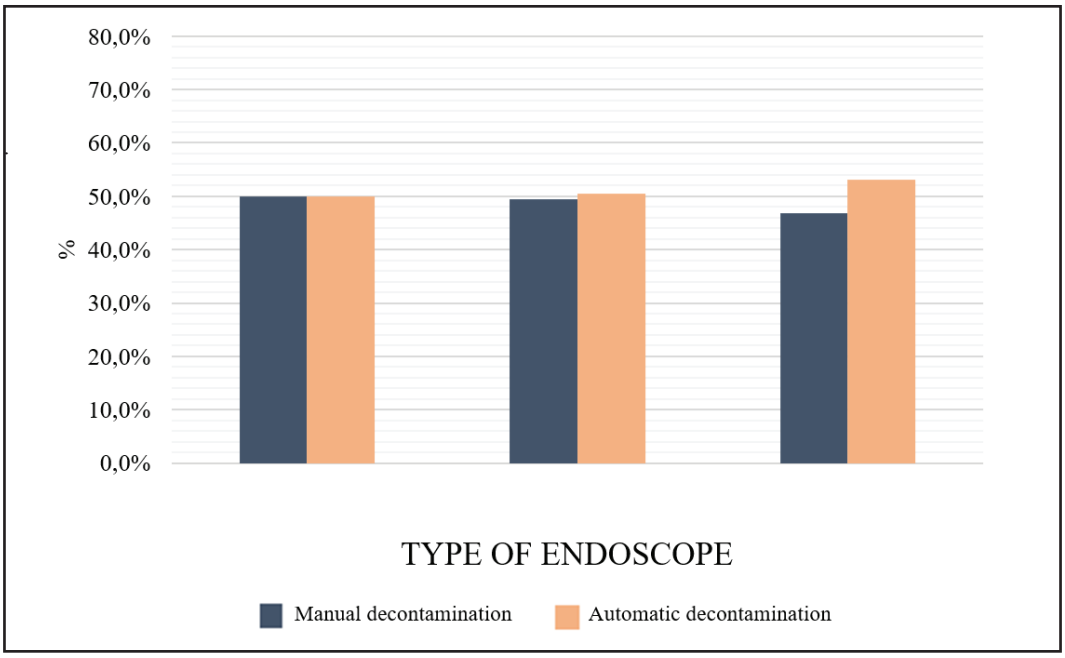
Research Results

During the research period, a total of 277 decontamination checks of endoscopic instruments were performed using 1,108 indicator tests. The tests were designed to detect residues of proteins and blood in the internal channels and outer casing of the endoscope. Testing was done after the manual and automatic decontamination of the endoscopic instruments. We divided the sampling sites for indicator tests into external and internal sections. In the external testing, we took a swab from the casing of the endoscope, the screws, and the distal end of the endoscope. The internal parts consisted of the suction and working channel and the distal end of the working channel. A different kind of testing was done with duodenoscopes, as a swab was also taken from the elevator wire channel. There were 88 (31.8%) checks on colonoscopes, 93 (33.6%) checks on gastroscopes, and 96 (34.7%) checks on duodenoscopes. According to the method of decontamination, 135 (48.7%) checks were performed purely after manual decontamination, and 142 (51.3%) checks were performed after automatic endoscope reprocessing.

The results of the control of the endoscopic reprocessing technique performed by manual decontamination

A total of 135 endoscopes were tested using indicator tests (540 tests) after being decontaminated and disinfected by the manual technique, of which 65 tests (48.1%) were positive. Out of 44 tested colonoscopes, 19 indicator tests (43.2%) were positive. The most common positive tests were for the presence of proteins in the working channel of the colonoscope, with 12 cases (27.3%). Out of the total number of 46 gastroscopes tested after manual reprocessing, 25 tests (54.3%) were positive. Similarly, the most common positive tests were for the presence of proteins in the working channel of the gastroscope, with 15 cases (32.6%). The manual reprocessing technique was performed on 45 duodenoscopes, of which 21 (46.7%) tested positive. Again, the most frequent positive tests were for the presence of proteins in the internal part of the duodenoscope channels, with 12 cases (26.7%). The results include values for endoscopes that were repeatedly tested following the detection of positive results during routine testing, specifically during the transition from glutaraldehyde preparations to Persteril.

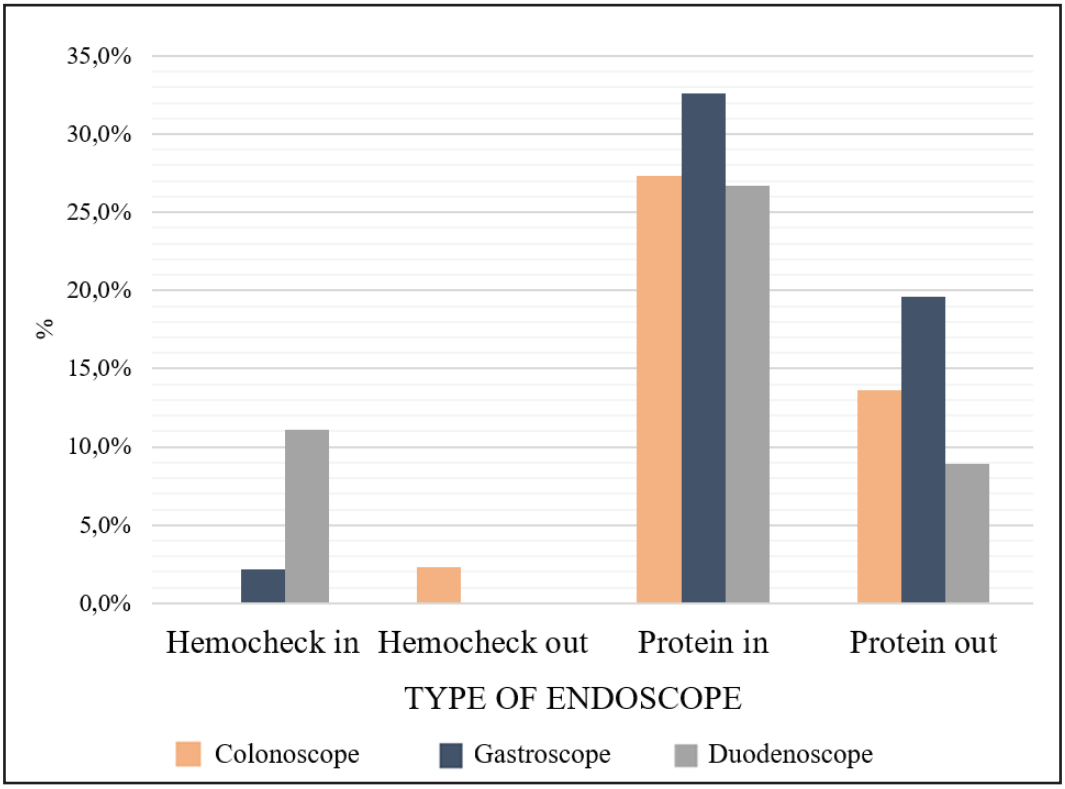
Graph 1 The number of performed inspections according to the type of endoscope and method of decontamination



Results of the inspection of reprocessing endoscopic techniques performed by manual decontamination

A total of 135 endoscopes were decontaminated using the manual technique, with 540 indicator tests conducted. Of these, 65 tests (48.1%) yielded positive results. Out of the 44 tested colonoscopes, 19 indicator tests (43.2%) were positive. The most frequent positive tests were due to the presence of proteins found in the inner part of the colonoscope, with 12 cases (27.3%). Out of the 46 gastroscopes tested after manual reprocessing, 25 tests (54.3%) were positive. The most frequent positive test results were due to the presence of proteins found in the inner part of the gastroscope, with 15 cases (32.6%). The manual reprocessing technique was performed on 45 duodenoscopes, of which 21 (46.7%) tested positive. Again, the most frequent positive tests were for the presence of proteins found in the inner part of the duodenoscope, with 12 cases (26.7%).

Graph 2 The number of positive controls after conducting manual decontamination according to the type of endoscope.

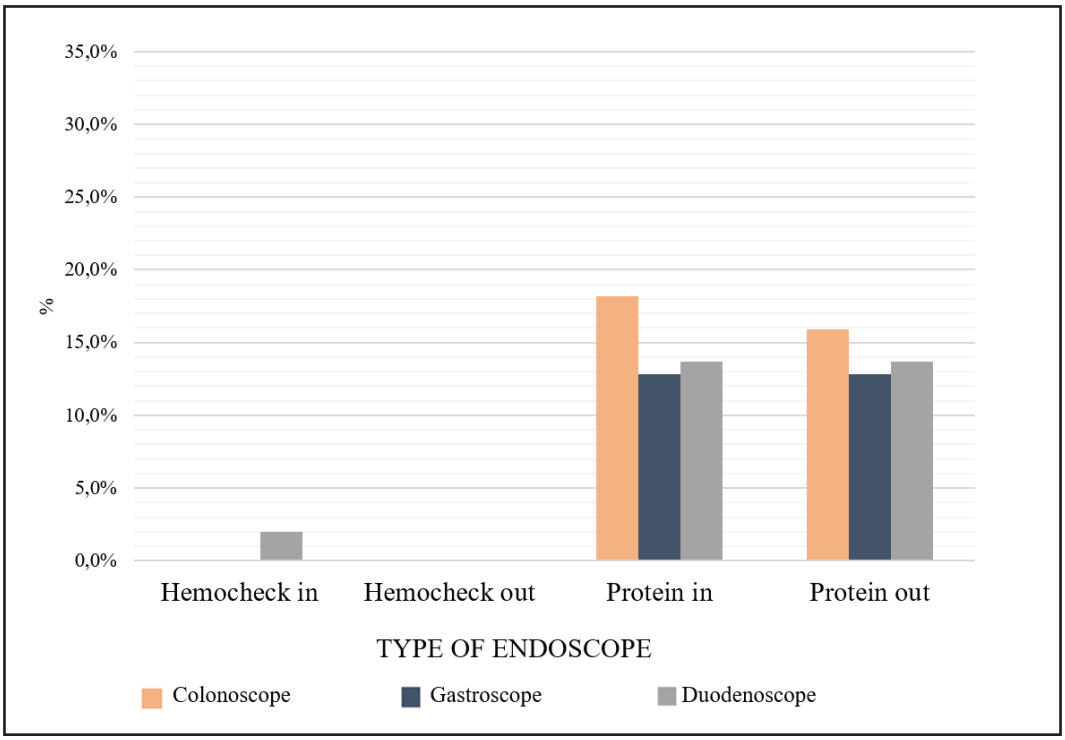


Results of the inspection of reprocessing endoscopic techniques performed by automatic decontamination

A total of 568 tests were performed automatically and 142 endoscopes were inspected. Out of the total number of 44 tested colonoscopes, 15 (34.1%) tests were positive. The most frequent positive tests were due to the presence of proteins. In the case of colonoscopes, all the performed tests were negative for the presence of blood. Out of 47 tested gastroscopes, a total of 12 tests (25.5%) were positive. The most common errors were detected in the control for the presence of proteins detected on the exterior and interior of the gastroscope, with 6 cases (12.8%). Tests for the presence of blood were negative for gastroscopes decontaminated using the automatic technique. The 51 tested duodenoscopes yielded 15 (29.4%) positive tests. The most frequent reasons for the positive tests were the presence of proteins detected on both the exterior and interior of the duodenoscope, with 7 cases (13.7%). Only one duodenoscope was positive for the presence of blood, as indicated by indicator tests, on the exterior part of the duodenoscope.

It is necessary to mention, however, that the positivity of the rapid test itself does not mean gross inaccuracy or failure of the disinfection process. The tests are semi-quantitative "rapid tests" and are intended to capture the presence of possible biological (whether protein or blood) contamination on the endoscope after reprocessing. To detect the infectivity of the endoscope for the patient, we would have to use methods for culturing microbial colonization, which are carried out in collaboration with the department of hygiene and epidemiology of the institutional facility (founder) or regional public health offices, which would not be within our competence.

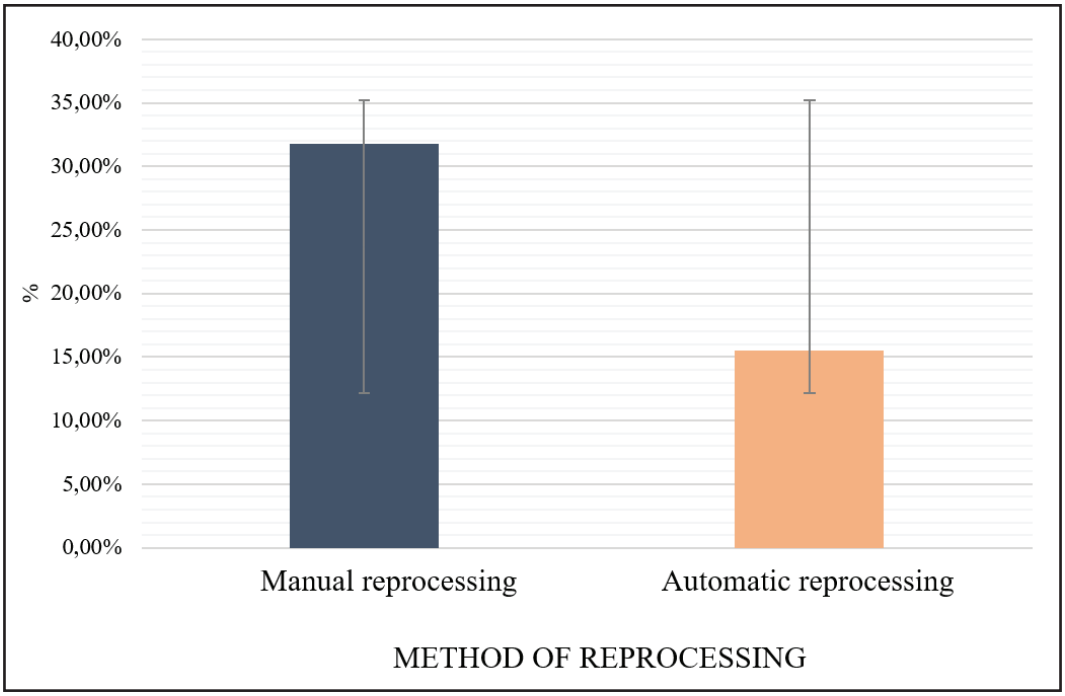
Graph 3 The number of positive controls after performing automatic decontamination according to the type of endoscope.



Comparison of the quality of endoscopic decontamination techniques after performing manual and automatic reprocessing

Out of the total number of 135 checks carried out after manually reprocessing endoscopic equipment, 43 (31.8%) endoscopes tested positive. With automatic reprocessing, 22 endoscopes (15.5%) out of a total of 142 tested positive. Statistical research shows that there is a statistically significant difference between the occurrence of errors in the reprocessing of endoscopic techniques according to the method of decontamination (p=0.0021).

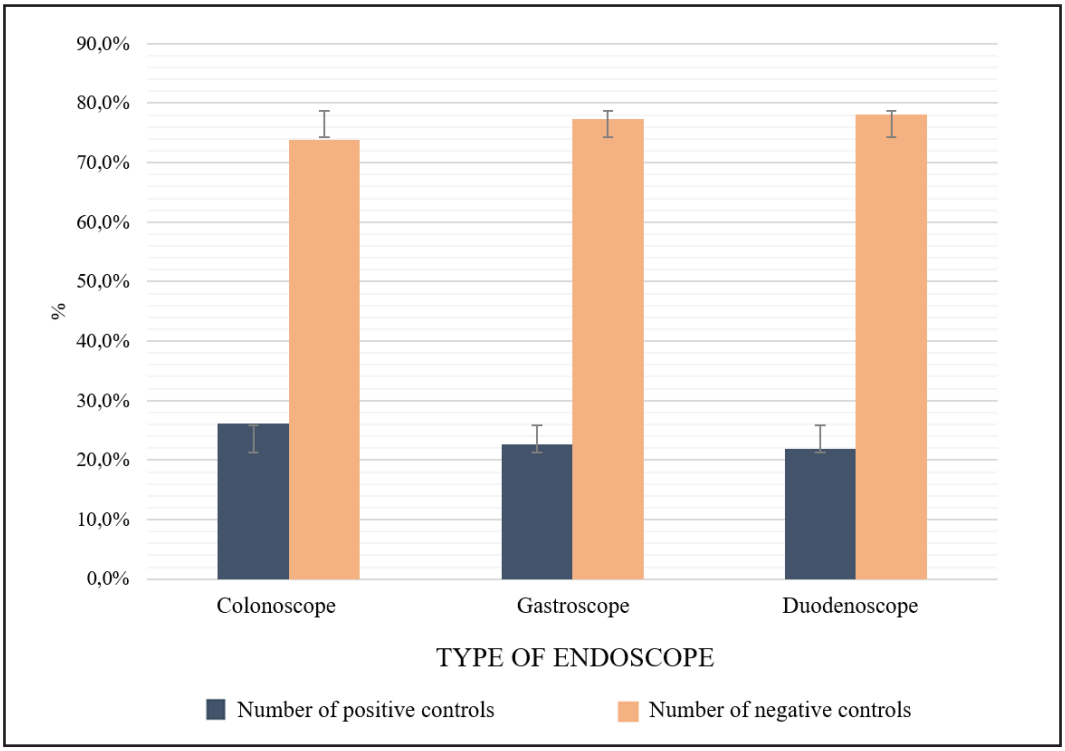
Graph 4 A comparison of the detected errors in manual and hand reprocessing



Comparison of the quality of decontamination of endoscopic equipment after performing manual and automatic reprocessing according to the type of endoscopic equipment

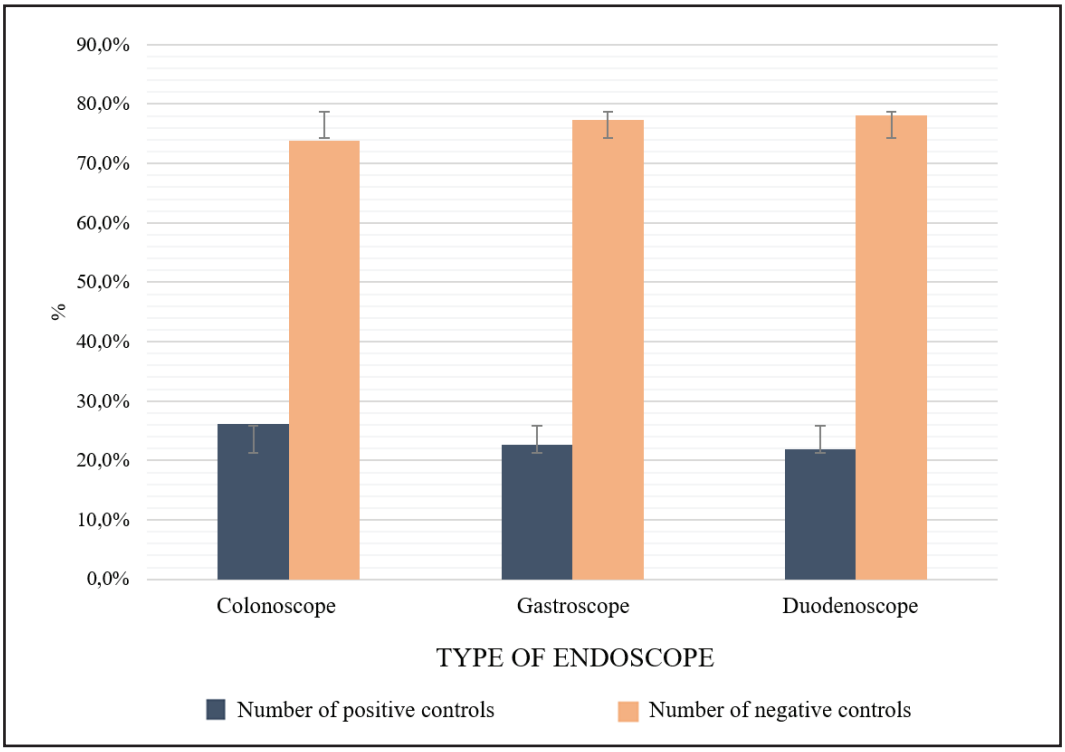
From the total number of 277 endoscopic equipment checks, 96 duodenoscopes were tested for the presence of proteins and blood, out of which 21 (21.9%) tested positive. After reprocessing, a total of 88 colonoscopes were tested, with positive results detected in 23 of them (26.1%). 93 gastroscopes were checked in total, and positive results were detected in 21 of them (22.6%).

Graph 5 A comparison of the number of endoscopes that tested positive after reprocessing according to the type of endoscope



In statistical testing, we verified whether there is a statistically significant difference in the number of detected errors according to the individual type of endoscope. This relationship was not statistically confirmed; there is no significant difference in the number of detected errors after reprocessing according to the type of endoscope (p=0.769).

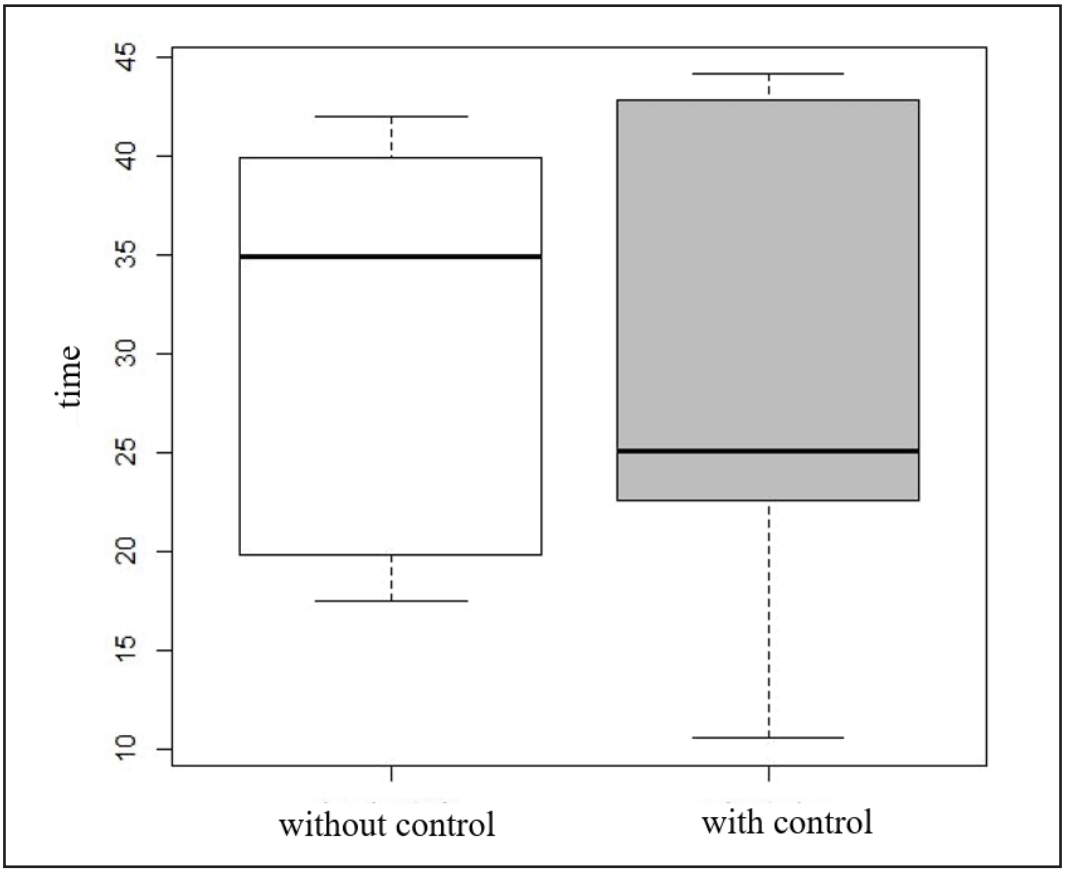
Graph 6 The results of endoscope reprocessing controls according to metho



Average time required to carry out endoscopic technique reprocessing

The average time required to perform endoscopic technique reprocessing without a control check was 29.9 ± 10.0 minutes. Reprocessing, during which the quality control of the decontamination of the endoscopic technique was also performed, lasted on average 31.8 ± 10.2 minutes (p=0.0218). Statistical testing shows that there is a statistically significant difference in the time of decontamination of endoscopic technology depending on whether the decontamination was performed with the quality control of decontamination using indicator tests and without control.

Graph 7 A comparison of endoscope decontamination time without and with testing by indicator tests



Graph 7, presented in a box plot, shows the comparison of the time required to perform reprocessing with the quality control of decontamination and without control, based on quartiles.

Discussion

This study emphasizes the primary objective of verifying the accuracy of the reprocessing procedure, which was statistically validated. Rapid tests showed a 31.8% positivity rate during manual reprocessing compared to 15.5% contamination of the endoscopes that underwent automatic reprocessing. Manual decontamination was conducted in 135 cases of endoscope cleaning, and 43 endoscopes tested positive. This represents a percentage expression of 31.8%. In contrast, the rate of positive rapid tests was reduced by half when decontamination was performed using an automatic reprocessor. This value represents higher rates of endoscope positivity testing compared with automatic reprocessing, where we detected positivity in 22 endoscopes, totaling 15.5%. **The results demonstrated the existence of a connection between the occurrence of errors in automatic versus manual decontamination, as identified by rapid tests.** Rapid tests are discussed with regard to their application in routine testing or contamination monitoring. For proving infectivity, it is necessary to carry out a cultivation examination in collaboration with the department of hygiene and epidemiology. Certain individual tests were positive due to human error, time factors, or complications of the patient's epidemiologic state. However, it should be noted that the positivity of the protein test itself does not mean gross inaccuracy or a failure

of the disinfection process. This is because the mentioned tests are semi-quantitative "rapid tests" and are meant to detect the presence of potential biological (either protein or blood) contamination on the endoscope after reprocessing. It was proven that with a second reprocessing, the rapid test yielded a negative result.

In decontamination, manual cleaning is a key component. The author Wo (2021) compared mechanical, or manual, decontamination with high-level disinfection using an automatic endoscope reprocessor. He describes sufficient and proper decontamination as difficult to achieve due to the technical complexity and the possibility of human error. The risk of contamination associated with different decontamination methods was assessed by detecting the presence of proteins and carbohydrates, thereby confirming endoscope contamination. The sample consisted of 48 examinations conducted with duodenoscopes. Out of those, 21 endoscopes were manually cleaned according to the given standards under the supervision of hygiene workers, and 27 were cleaned with HLD. Contamination was proven after manual cleaning in 4 out of 21 cases (19%). As this study concludes, manual cleaning has pitfalls and is more prone to error. HLD appears to be an automated cleaning technology that is suitable as an alternative to replace manual cleaning (Wo et al., 2021).

In 2019, study results on cleaning, disinfection, and high-level disinfection were processed. It is possible that only discussions on this topic occurred during this period in Slovakia. Slovak standards are not supplemented with these new recommendations. Rutala et al. (2019) recommend employing high-level disinfection or, alternatively, single-use sterile endoscopes—particularly for procedures involving duodenoscopes.

In 2020, Mark et al. addressed the issue of duodenoscope decontamination using HLD. Endoscopes were cleaned according to recommended practices and standards for automatic decontamination. A total of 140 cleanings were performed on 280 samples. This extensive study highlights the importance of obtaining information about decontamination as an option for further decisions regarding the fate of endoscopes. It was found that HLD is not always effective at eliminating contamination. For contaminated duodenoscopes, it is beneficial to reprocess the duodenoscope through three decontamination cycles using HLD as the type of decontamination (Mark et al., 2020).

In Brazil, they analyzed the cleaning process of 22 endoscopes, including gastroscopes, colonoscopes, and duodenoscopes. The analysis consisted of 60 samples that were used to determine the cleaning effectiveness of the endoscopes. The cleaning results revealed significant gaps in the cleaning and thorough removal of heavy contaminants from the endoscopes. The author provides an overview of the error rates, highlighting that by preventing these errors, the retention of proteins or blood in endoscopes can be avoided, even after automatic or mechanical reprocessing (de Oliveira, Madureira, 2022).

Our research did not find a correlation between the selection of endoscopes and the error rates in disinfection, specifically among endoscopes (gastroscopes, colonoscopes, and duodenoscopes). This hypothesis was not supported by our study. However, its conclusions are significant for clinical practice. It is largely derived from other studies with larger sample sizes that indicate duodenoscopes are more prone to disinfection failures compared to standard endoscopes. One of the studies talks about a sample that tested 309 duodenoscopes and 63 other endoscopes for comparison. The authors demonstrated the presence of contamination after reprocessing in 54 duodenoscopes and 9 endoscopes. In this case, the length of use of the duodenoscope (the age of the endoscope) was not associated with the contamination risk. The result is an increased risk of contamination for patients undergoing examination with a duodenoscope, particularly during ERCP, with 66% at risk of microbial transmission, as outlined in this study (Rauwers et al., 2020).

In 1993, one American company estimated the rate of infection associated with endoscopy at 1 case per 1.8 million procedures. In 2013, a new estimate was made on the rate of infection transmission during endoscopic procedures. Over the years, world organizations have monitored and conducted various studies to find the actual data.

The author talks about substantial evidence and results. High-level disinfection (HLD) alone cannot remove all contamination from duodenoscopes, and this is due to the presence of biofilm on the duodenoscope. The risk is estimated to be present in up to 10% of all procedures, or 1 in 1,765 ERCP procedures. Therefore, it is essential to continuously strive to improve the cleaning and inspection process in cooperation with relevant departments, such as hygiene, microbiology, etc. (McCafferty et al., 2018).

Duodenoscopes with a removable distal cap were compared to those with a solid, non-removable distal cap to assess the presence of bacterial infection after HLD processing, followed by testing using the ATP method. They identified the presence of bacteria in the two different types of duodenoscopes. It was confirmed that in the sample of 54 duodenoscopes with a removable distal cap there is a lower risk of the presence of bacteria compared to the solid distal end of a duodenoscope. The removable part of the duodenoscope represented a 37% presence of the risk of bacteria, and for the non-removable part, there was a 95% risk. The removable end provided easier access to the cleaning brush from Albaran's bridge, which led to effective cleaning of the endoscope and reduced the risk of the presence of bacteria (Ridtitid et al., 2020). I n examining the time required to perform endoscope control checks using indicator tests after automatic reprocessing, whether mechanical or not, we made the following assumption: we assumed a correlation between time consumption and the performance of endoscope control during reprocessing, with and without control. The average time required to reprocess endoscopic equipment without conducting indicator tests was 29.9 ± 10.0 minutes. Reprocessing, during which a quality control of the decontamination of the endoscopic technique was also performed, lasted on average 31.8 ± 10.2 minutes (p=0.0218). **After obtaining the time data, statistical testing displayed a statistically significant correlation in the decontamination time of endoscopic equipment depending on whether the decontamination was carried out with quality control of decontamination using indicator tests or without control.**

Many global recommendations, such the one from the World Association of Endoscopy Nurses, had already developed a recommendation for reprocessing testing in 2007 (Loquai et al., 2008). Many other places and facilities have adopted these recommendations into practice. The importance of detecting contamination after endoscope reprocessing in the workplace was confirmed through our research, where we repeatedly identified positive tests, thus preventing recontamination. Causes can be human factors, time, routines, and other factors that limit proper decontamination. The method of testing individual endoscopes once a week proved to be a sufficient method for detecting blood and proteins inside the channels on the surface of endoscopes. Our objective was to examine the correlation between time consumption and the implementation of endoscope reprocessing tests to inform practical recommendations and estimate the additional time this process would require in endoscopic facilities.

The time required for endoscope decontamination is divided into the time for manual processing, mechanical decontamination, and the time needed for automatic reprocessing. Unfortunately, current European guidelines lack clearly defined and uniform standards for testing endoscopes following reprocessing. It suggests the necessity of routine endoscope testing or doing so after each use. However, the interval between endoscope testing should be no longer than three months. In 18 out of 20 countries, automatic disinfectors are used, and endoscope testing is carried out in 12 out of 20 states. Many of these countries recommended testing within three months (Loquai et al., 2008).

Researchers who analyzed the time healthcare workers spent on endoscope processing developed a workflow that not only measures the time required for endoscope reprocessing but also identifies issues related to human factors and ergonomics. The sample of respondents consisted of 341 individuals. 69 of them performed manual processing and manual cleaning of endoscopes in under 10 minutes on average. Approximately 16-30 minutes were dedicated to automatic reprocessing. The respondents described time pressure during cleaning and the need to work faster (Sivek, 2022).

Conclusion

In addition to providing nursing care to patients, gastroenterology units require nurses to properly reprocess endoscopes. Reprocessing involves more than just cleaning; each step must be meticulously executed and followed by thorough verification of endoscope cleanliness through appropriate testing. Indicator tests, used to verify the presence or absence of endoscope contamination, also function as a quality control measure for nurses. However, consistent and effective use of these tests can only be ensured through standardized guidelines for all nurses working in gastroenterology units across Slovakia.

After processing our results, we found different results can be expected based on the type of endoscope reprocessing. The subject of our study were tested endoscopes that were cleaned after patient examination. The nurses reprocessed them, and then the endoscopes were tested for the presence of blood and proteins. Based on our findings, we recommend the implementation of indicator tests in gastroenterology facilities, as their use has proven effective for quality control during reprocessing. We also recommend carrying out controls, which are not time-consuming for nurses or healthcare facilities. However, we are still talking about routine testing and monitoring for contamination. For proving infectiousness, a culture examination is necessary in cooperation with the department of hygiene and epidemiology. We recommend using an automatic reprocessing process for endoscopes in workplaces, regardless of the type of endoscope. The duodenoscope, due to its construction, is a more complex endoscope. Therefore, it is essential to be vigilant in the first phase of cleaning and to comply with all recommendations to ensure the proper operation of gastroenterological facilities.

We have informed certified nurses, nurses, and practical nurses about the results. The information included how to manually clean the endoscope itself. During reprocessing, the pre-cleaning phase is the most important step, as solid particles that remain in the channels of the endoscope can infect the endoscope in all subsequent reprocessing phases. Automatic endoscope reprocessing methods are preferred over manual methods, as they reduce staff workload and demonstrate superior outcomes in quality control for high-level disinfection. After reprocessing, indicator tests should be utilized to test for blood and protein. Testing with indicator tests should be performed by a certified nurse who is trained in the form, type, and method of testing. The entire reprocessing process should be thoroughly documented, including the result of the indicator test. Newly hired staff should be trained on effective reprocessing and its importance, and the regular retraining of nurses and staff performing endoscope reprocessing should be carried out every 2 years. It is important to point out the benefits of using automatic reprocessing, using automatic disinfectors, and testing with indicator tests to nurses.

Gastroenterology departments should be equipped with all the necessary resources to ensure high-quality endoscope reprocessing in compliance with established hygienic and microbiological standards. After regular revisions, maintenance, and new endoscopic equipment installations, it is necessary to carry out testing with indicator tests before using the technology. Using indicator tests to check for proteins and blood residues should be carried out for all types of endoscopes on average once a week when using automatic disinfectors, and this is sufficient for regular endoscopies. Testing should be conducted on all types of endoscopes after each use when manual reprocessing is employed. For high-risk or clearly infectious patients, an indicator test should be performed following every examination. Despite our findings, based on the results of other studies, we strongly recommend heightened supervision during the reprocessing of duodenoscopes, particularly at the Albaran bridge, which has been identified as a potential risk site.

We recommend fostering interdisciplinary collaboration to conduct endoscope testing using indicator tests during repeated corrective actions and instances of positive results. In such cases, the hospital hygiene and epidemiology department should be consulted. Additionally, the ATP method and microbiological testing should be employed when relevant. It is essential to es-

tablish conditions that facilitate the adoption of adjusted recommendations in collaboration with the hygiene and epidemiology departments.

Thanks to the results of this work, the findings of other authors, and our practical experience of working nurses in gastroenterology, I believe that this information will be beneficial for all workplaces and for practice. Effective collaboration between gastroenterology clinics, alongside the professionalism of the staff, is a critical factor in ensuring patient satisfaction within these healthcare facilities.

Acknowledgement

I would like to express my gratitude to the Faculty Hospital in Trnava for the opportunity to conduct research at the Gastroenterology Department. I would also like to express my gratitude to the staff of the Gastroenterology Department, as well as to the Department of Hygiene and Epidemiology, whose support facilitated the funding of the tests and the implementation of the ATP method through collaboration.

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Abbreviations

ATP - Adenosine triphosphate residue testing
ERCP - Endoscopic Retrograde Cholangiopancreatography
HLD - High-level disinfection
FN - University Hospital
FNTT - University Hospital Trnava

Structural Deficits in the health care of Prisoners: Results of a cross-sectional Analysis from German Prisons

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Original Article

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Abstract:

Healthcare in prisons offers key opportunities and challenges for public health management. This study analyzes the prevalence of chronic diseases, health differences between prisoners with and without a migration background, care deficits, and preventive measures in German prisons. Based on a nationwide survey of 62 prisons (36% response rate), the results show that 41-50% of prisoners have at least one chronic illness, with significantly higher rates of depression (21-30%) and hepatitis C (11-20%) compared to the general population. Prisoners with a migration background also have a higher prevalence of infectious diseases and drug addiction. While the availability of medication is predominantly rated as good, there are deficits in the updating of positive lists and

in transition management. Prevention was rated as effective, but challenges remain in the transition to extramural care. The results emphasize the need for targeted reforms in the prison system, including culturally sensitive approaches, improved prevention, and aftercare and the integration of prisons into the public healthcare system.

Introduction

Prisons are places with unique challenges in the area of healthcare. In Germany, medical care for prisoners is based on the principle of equivalence, which aims to ensure that prisoners receive medical care that is equivalent to that of the general population (§2 StVollZG; WHO, 2007). However, studies show that the health situation of prisoners is often already worse than that of the general population when they enter prison due to socio-economic disadvantages and risky behavior such as drug abuse (Opitz-Welke et al., 2018). At the same time, specific prison conditions, such as isolation and a lack of stimuli, contribute to exacerbating health problems (Fazel et al., 2017). This applies, in particular, to chronic illnesses, infectious diseases and mental disorders, which occur at a significantly higher prevalence among prisoners than in the general population (RKI, 2021).

However, imprisonment also offers the opportunity to implement targeted health measures in order to improve the health of prisoners while at the same time protecting society from the spread of disease ("Prison Health is Public Health", WHO, 2003). Despite these potential opportunities, the reality in German prisons shows structural deficits in the provision of resources, prevention, and intramural healthcare (Keppler et al., 2010).

This publication examines healthcare in German prisons from the perspective of public health management and sheds light on the connections between healthcare, the prevalence of illnesses, and resocialization measures. The aim is to identify starting points for improved care and sustainable resocialization through targeted public health measures. The analysis is based on data from a nationwide survey of German prisons and a comparison with data from the general population and international studies.

Methodology

This study is based on a nationwide survey that was sent to all 172 prisons in Germany. The aim was to systematically analyze the state of health, the care situation, and the preventive measures in the facilities. A total of 62 prisons took part in the survey, which corresponds to a response rate of 36%.

Study design and data collection

Data was collected using a standardized questionnaire that covered the most important areas of healthcare in the prison system. The questionnaire was divided into four main areas:

1. **Prevalence of chronic diseases:** The prevalence of selected diseases, such as depression, obesity, hepatitis C, and addictions, was estimated and compared with data from the general population.
2. **Cultural differences:** The health situation of detainees with and without a migration background was analyzed in a differentiated manner.
3. **The supply situation:** Questions were asked about the availability of medication, the frequency of updates to the positive lists, and the quality of the treatment regime.
4. **Prevention and aftercare:** The effectiveness of preventive measures and the challenges in the transition from intramural to extramural care were analyzed.

The survey was aimed at the medical directors of the prisons. In order to ensure the comparability of the data, closed response formats were used, such as percentages and Likert scales (e.g., "very good" to "not sufficient"). The complete questionnaire can be found in Appendix I of the paper.

Evaluation and statistical analyses

The data was analyzed descriptively, whereby frequencies and percentages were calculated. The Mann-Whitney U test was used to compare

different subgroups (e.g., German prisoners vs. prisoners with a migration background). This test was chosen because the response scales were ordinal and the sample sizes were limited. Results with a p-value <0.05 were considered statistically significant.

Data basis and limitations

The data collected represents around a third of German prisons, which provides a solid basis for analysis. Nevertheless, it must be taken into account that the response rate does not cover all facilities across the board, meaning that distortions due to self-selection cannot be ruled out. In addition, some of the information provided by respondents is based on estimates and subjective perceptions, which can limit the validity of individual results. Despite these limitations, the study provides a comprehensive insight into healthcare and prevention in prisons and offers important starting points for further public health measures.

Results

The results of the survey provide a comprehensive insight into the health situation, care, and prevention in German prisons. The key findings include the prevalence of chronic illnesses, cultural differences between prisoners with and without a migration background, the care situation, and the evaluation of preventative measures.

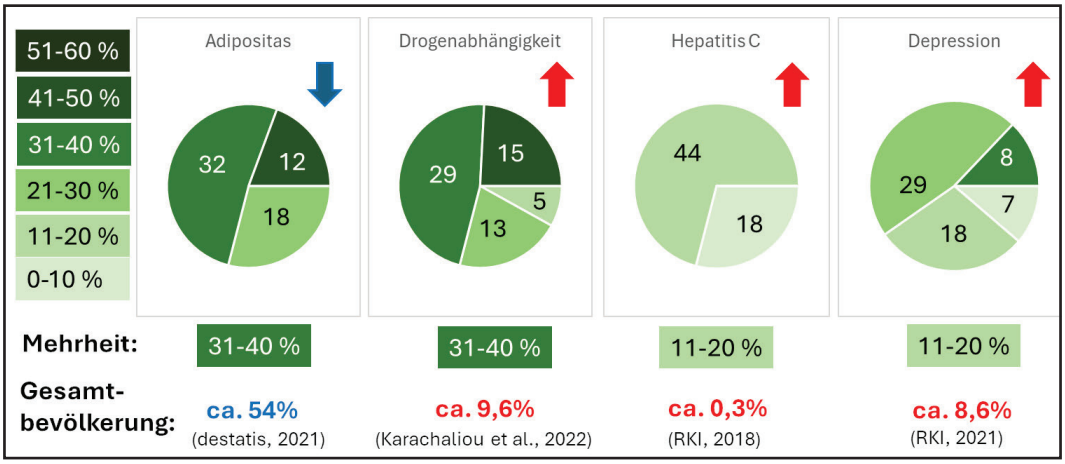
Prevalence of chronic diseases

The survey revealed that 41-50% of prisoners have at least one chronic illness. This figure is comparable to the general male population, in which around 46.4% have at least one chronic illness (RKI, 2021). However, certain illnesses occurred significantly more frequently: Depression was estimated to occur in 21-30% of inmates, compared to 8.6% in the general male population. At 11-20%, hepatitis C also had a significantly higher prevalence than in the general population (0.3%) (RKI, 2021). Obesity, on the other hand, was less common among prisoners (31-40%) than in the general population (54%) (Federal Statistical Office, 2024). A summarized presentation can be found in Figure 1.

Cultural differences and health inequalities

Prisoners with a migrant background showed poorer health scores than German prisoners in several categories. In particular, infectious diseases, such as hepatitis C (19-30% vs. 11-20%) and drug addiction (41-50% vs. 31-40%), were

Figure 1 Summarizing the most important differences between the frequency of certain diseases in prisoners and in the (male) general population in Germany. The numbers in the diagrams describe the number of votes cast by the prisons for this spectrum (n=62).



more common among prisoners with a migrant background. These differences were underpinned by the statistical analysis. The Mann-Whitney U test showed a p-value of <0.0001 for hepatitis C, indicating a statistically significant difference between the two groups. A significant difference was also found for drug addiction ($p = 0.013$), with detainees with a migration background showing significantly higher prevalence rates. These differences are shown in Figure 2.

However, no significant differences were found for other diseases, such as cardiovascular diseases and diabetes ($p > 0.05$), which indicates that these diseases are evenly distributed in both groups. The results emphasize that health inequalities in the prison system are particularly pronounced for infectious diseases and addictions. These inequalities highlight the need to develop culturally sensitive approaches and targeted prevention programs for prisoners with a migrant background.

The supply situation

The availability of medication was rated as "very good" or "good" by 80% of the facilities surveyed, while 20% rated the supply as "limited." New medications are only added to the positive lists in most institutions every few years, which limits the timeliness of treatment options. The assessment of the treatment regime for specific illnesses showed a mixed picture: While addiction disorders were often perceived as better treated than outside prison, care for cancer and depression was more often rated as worse. A graphical summary can be found in Figure 3.

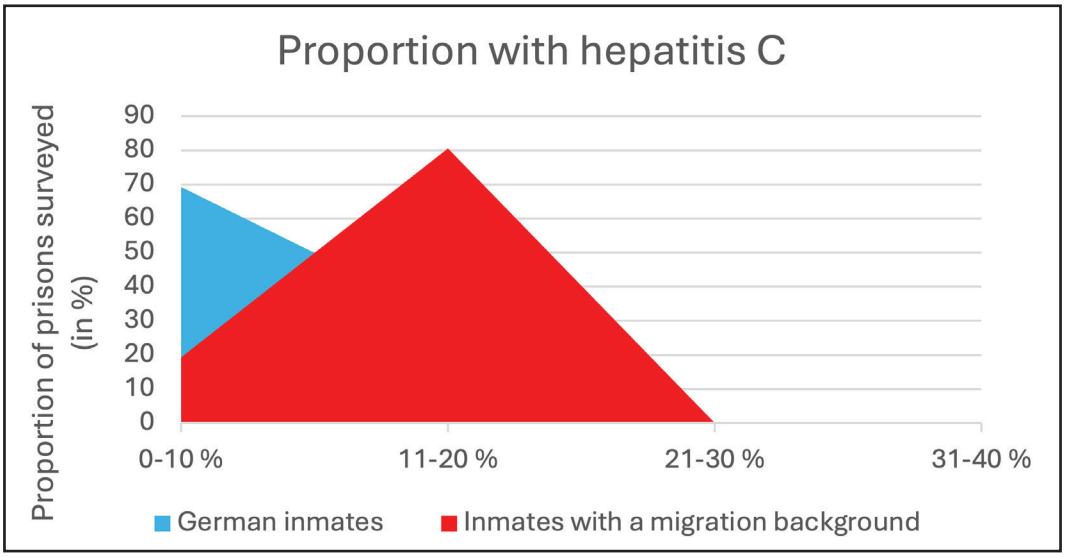
Prevention and state of health on release from prison

The majority of prevention measures in prisons were rated as "effective" (35%) or "very effective" (52%). However, many facilities reported problems with the transition from intramural to extramural care after release. Common difficulties included a lack of continuity of medical care (88.7%), social and financial problems (83.9%), and insufficient coordination between facilities (88.7%). The state of health on release from prison was assessed as "unchanged" or "worse" in 71% of the facilities, which indicates existing deficits in intramural care and aftercare.

Discussion

The results of this study provide valuable insights into the health situation, care conditions,

Figure 2 Cultural differences in the incidence of hepatitis C (top) and drug addiction (bottom) among prisoners in Germany (in both cases p<0.05; surveyed prisons: n=62).



and prevention in German prisons. In the following section, the most important findings are categorized and discussed in the context of existing literature, and implications for public health management are derived.

Prevalence of chronic diseases

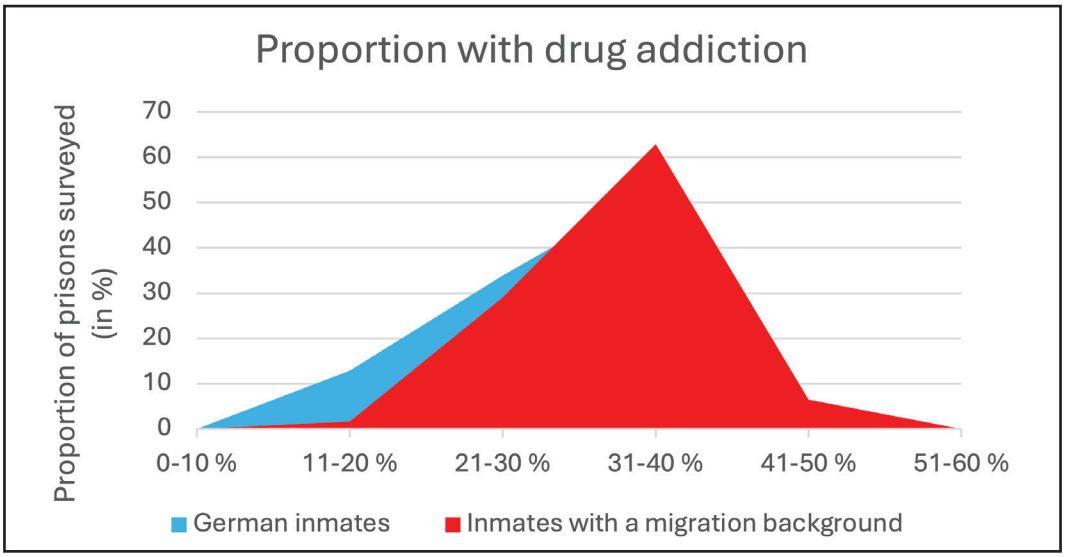
The results show that the proportion of prisoners with at least one chronic illness (41-50%) is comparable to the general male population (46.4%) (RKI, 2021). This similarity could be due to the comparable age structure of the two groups, although older people are underrepresented in prisons (approx. 5% of prisoners are over 60 years old) (Statista, 2023). However, the higher prevalence of specific diseases, such as depression (21-30% vs. 8.6%) and hepatitis C (11-20% vs. 0.3%), illustrates that prisoners are disproportionately affected by socioeconomic stress and health risk factors (Fazel et al., 2017).

The high prevalence of depression is supported by studies that point to the psychological stress caused by prison conditions, such as isolation, a lack of social support, and stigmatization (Opitz-Welke et al., 2018; Bedaso et al., 2020). There is also a lack of adequate psychotherapeutic services in many prisons, which further increases the discrepancy with the general population. Hepatitis C also shows a significantly higher prevalence among prisoners, which is linked to risk factors such as intravenous drug use and inadequate preventive measures at the start of imprisonment (WHO, 2023).

Cultural differences and health inequalities

Analyzing the differences between German prisoners and those with a migrant background revealed significant differences in the prevalence of certain diseases. Hepatitis C and drug addiction were significantly more common among detainees with a migrant background, which was confirmed by the results of the Mann-Whitney U test ($p<0.0001$ and $p=0.013$, respectively). These findings are in line with international literature, which points to socioeconomic burdens and limited access to medical services as the main causes (Lungu-Byrne et al., 2020; Fazel et al., 2017). At the same time, the study shows that language and cultural barriers can make access to healthcare even more difficult. Culturally sensitive approaches, as proposed by Kosendiak et al. (2022), could provide a remedy here.

Figure 3 A summarized comparison of the assessment of treatment regimens inside and outside prison for defined illnesses (n=62).



Supply situation in the prisons

There are considerable deficits in medical care in prisons. Although the availability of medication was rated as "good" or "very good" in 80% of the facilities, the delayed inclusion of new medication in the positive lists remains a problem. These limitations could contribute to the fact that the care of certain diseases, such as depression and cancer, is perceived as poorer compared to the general population (Opitz-Welke et al., 2018). At the same time, care for addiction was rated as better in many facilities, which could be due to targeted programs such as therapeutic communities (Richardson & Zini, 2020).

Human resources in correctional centers also pose a challenge. A shortage of specialists and the limited availability of specialized treatment services have been identified as key obstacles (WHO, 2023). Urgent measures are needed here to ensure the equivalence of care in line with the principle of equivalence.

Prevention and aftercare

The effectiveness of preventative measures in the prisons was predominantly rated positively, but the data also shows clear gaps, particularly in the transition to extramural care. A lack of continuity of medical care and social problems such as financial insecurity were cited as key challenges by over 80% of the facilities. This is in line with the literature, which identifies the transition from intramural to extramural care as a critical point for the health of ex-prisoners (Fazel et al., 2017; WHO, 2023). The introduction of standardized discharge preparation and health passports could help to reduce these deficits and improve aftercare.

Implications for public health management

The results presented here make it clear that prisons play a central but often neglected role in the healthcare system. Their importance lies not only in the care of a particularly vulnerable population group, but also in their influence on public health. Targeted public health management measures are needed to address the identified deficits in care and prevention.

Improving preventive measures

The high prevalence of certain infectious and addictive diseases among prisoners, such as hepatitis C and drug addiction, underlines the urgency of comprehensive prevention programs. The World Health Organization (WHO) emphasizes that prisons are "epidemiological hotspots" for the spread of communicable diseases and calls for the introduction of regular testing upon entry into prison and standardized vaccination programs (WHO, 2021). Studies show that systematic testing and treatment programs for hepatitis C in prison not only improve individual health, but can also reduce the spread of the disease after release (Kouyoumdjian et al., 2016). In the area of addiction, therapeutic communities and substitution programs offer effective approaches that should be promoted more strongly (Richardson & Zini, 2020). At the same time, psychosocial interventions should be integrated to prevent relapse and support resocialization. Pilot projects in European prisons have shown that a combination of medical care and psychosocial support significantly increases treatment success (McLeod et al., 2020).

Ensuring adequate care

Treatment in German prisons suffers from structural deficits that include a limited availability of modern medication and staff shortages. Delayed access to innovative therapies due to infrequently updated positive lists is a significant problem. As emphasized by Keppler et al. (2010), regular revisions of these lists are essential to ensure the equivalence of care in accordance with the equivalence principle.

In addition, the shortage of specialists, especially psychiatrists, is a key obstacle to optimal care (Stöver, 2008; Stöver, 2015). Better remuneration and specific training programs for medical staff could create incentives to increase the attractiveness of this field of work. At the same time, the increased use of telemedicine could help to bridge supply bottlenecks. Initial projects in the UK have shown that telemedicine consultations can significantly improve access to specialists (Valentim et al., 2023).

Improving the transition to extramural care

A smooth transition from intramural to extramural care is essential in order to avoid relapses and deterioration in health after imprisonment. The frequently reported problems, such as a lack of continuity of care and social difficulties, make it clear that existing structures are inadequate. The introduction of standardized discharge preparations, such as the creation of "health passports," could help to ensure continuity of care and facilitate access to external healthcare facilities (WHO, 2021). Greater involvement of community health services in the release process could also help to close the care gap. In Canada, collaboration between prisons and community health centers has proven to be an effective model for improving aftercare and facilitating reintegration into society (Kouyoumdjian et al., 2016).

Integration of the prison system into the healthcare system

The prison system should not be viewed in isolation, but as an integral part of the public health system. Prisons offer a unique opportunity to address health inequalities and provide medical care to hard-to-reach populations ("Prison Health is Public Health", WHO, 2007). To achieve this, greater cooperation between justice and health authorities is necessary. The implementation of national health strategies that explicitly include the prison system could help to standardize care and improve it in the long term.

Conclusion

The results of this study make it clear that prisons play a central role in public health management. Despite comparable prevalence rates of chronic diseases to the general population, prisoners show significantly higher rates of infectious diseases and mental illnesses, particularly hepatitis C and depression. At the same time, deficits in care, prevention and the transition to extramural care reveal the urgent need for targeted reforms. Prisons offer a unique opportunity to address health inequalities and strengthen public health. Greater integration of the prison system into the healthcare system, culturally sensitive prevention approaches, and systematic transition management can utilize this potential in the long term.

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Empirical Typology of the Realization of the personal Potential of gifted Adolescent Children

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Abstract:

The article presents the results of a cluster analysis of data. The results of the study are based on the following 5 psychodiagnostic methods: "Identification of personal resources" by N. Vodopyanova and M. Shtein; "Indicator of coping strategies" by D. Amirkhan; "Motivation for success and fear of failure" by Rean; the author's questionnaire "Identification of motivation to study"; and "Self-actualization test" by E. Shostrom. The analysis of the results was carried out based on the number of observations in each cluster, the chronology of interactions, and the differential variations between the initial and final centers of the clusters. The first typological

group included 660 subjects, and the second had 109 subjects. The typology based on the object of the researched problem is substantiated, namely: motivated-realization and unmotivated-realization types of the personal potential of gifted youth according to appropriate scales.

Introduction

The topic of self-realization remains highly relevant today, and our research uniquely focuses on exploring this issue from a motivational perspective in gifted boys and girls, which represents the novelty of our study.

The purpose of our study is to empirically investigate the typology of personal potential realization of gifted children of adolescent age based on a number of developed or undeveloped motivational tendencies.

Research hypothesis: The typology of the personal potential realization of gifted youth will depend on the justification of the research sample, the revealed number of clusters, and differential differences in the initial and final centers of clustering.

Research methods

The empirical validation of the typological characteristics of personal potential realization in gifted individuals is an unresolved issue.

In previous publications, we used theoretical methods to theoretically substantiate the problem of the typology of the personal potential realization of gifted children of adolescent age, including analysis of the used literary sources, systematization, and classification. To determine the types of personal potential realization, we selected the following psychodiagnostic methods: "Definition of personal resources" by N. Vodopyanova and M. Shtein; "Indicator of coping strategies" by D. Amirkhan; "Motivation of success and fear of failure" by Rean; the author's questionnaire, "Identification motivation to study"; and "Self-actualization test" by E. Shostrom (Sadova M.A., 2022).

In our study, we present empirical findings based on a cluster analysis of data related to the research problem. This statistical method allowed us to classify participants into two contrasting groups (personality types). These groups were named in accordance with the identified clusters, ensuring that the defined scales and statistical outcomes accurately reflect the study's results.

Table 1 presents the results of the data analysis of the observations included in each of the selected clusters.

Table 1 Number of observations in each cluster

Cluster	1	660.000
	2	109.000
are valid		769.000
missed		0.000

Based on the distribution of **769 subjects**, 2 clusters (2 groups of subjects) were determined by cluster typology. **The first group included 660 subjects, and the second had 109 subjects.** The number of missed indicators and valid indicators is 769.

Table 2 Chronology of interactions

Iteration	Changes in cluster centers	
	1	2
1	0.511	23.263
2	0.000	0.000

Convergence is achieved with little or no change in cluster centers. The maximum change in the absolute coordinate of any center was 0.000. The current iteration is 2. The minimum distance between initial centers is 71.399.

Changes in the centers of clusters correspond to the normal distribution of the subjects under the determined scales of the questionnaire tests.

Research results

Taking into account the fact that we consider motivational aspects as the realization of personal potential, it is appropriate to name the corre-

sponding types as follows: motivated-realization and unmotivated-realization types of personal potential.

At the theoretical level, we substantiate the types of personal potential realization of gifted young men and women based on the following scales: Motive of satisfaction, Motive of professional realization, Social motive, Identification of external positive motives, Identification of external negative motives, Identification of the social significance of the pupil (student), Identification of prestige motivation, Disciplines by profession, Literature, Language (linguistics), Creative disciplines, Time Orientation Scale, Support Scale, Value Orientation Scale, Behavior Flexibility Scale, Sensitivity Scale, Spontaneity Scale, Self-Esteem Scale, Self-Acceptance Scale, Perceptions of Human Nature Scale, Synergy Scale, Scale Acceptance of Aggression, Contact Scale, Cognitive Needs Scale, Creativity Scale, Problem Solving Scale, Social Support Scale, Problem Avoidance Scale, Failure Motivation, Success Motivation Scale, and Resources.

We used a parallel method to compare the initial and final centers of clustering according to each of the scales proposed above. In the second stage, we compare the results of the first and second cluster studies in parallel.

Table 3 shows the statistical indicators of the initial and final centers according to the two detected clusters.

The initial and final centers of the clusters provide an opportunity to see, according to each of the selected scales, at which stage the motivation of the personal and realization potential the gifted youth will be more vividly expressed.

The Motive satisfaction scale is characterized by both the expressed intra- and extrinsic motivation to the general activity. The difference according to this scale falls only on the final centers of the clusters, which increase the indicators (0.00 - 2.48).

The Motivation for Professional Realization scale is aimed at the active and correct choice of profession in youth. These indicators increase at the initial centers of clusters (1.00 - 2.79). Such results are characterized by the fact that gifted children in high school can happily choose a profession.

The Social motive scale increases in the initial centers of the clusters and decreases later on in its dynamics (2.00 - 0.56). Such data are characterized by the fact that it is very important for first-year students to adapt to new educational institutions.

The scale Identification of external positive motives is aimed at extrinsic motivation, which depends on the external approval of the student and the evaluation of their completed tasks at the appropriate level. It manifested itself more clearly in the initial clusters (4.07 - 1.01).

The scale Detection of external negative motives manifested itself more in the initial clusters (3.00 - 2.54). An example of such motivation can be a demonstrative manifestation of one's individuality (where peers, especially teenagers, begin to ridicule and show disrespect and contempt for others).

Identification of the social significance of the pupil (student) is a scale that manifested itself more vividly between clusters than between the initial and final centers (0.79; 2.91 – 1.30; 2.40). Such results testify not to the dynamics of the motivational process, but to the motivational typology, which we laid down experimentally in the study.

With Identification of prestige motivation, the scale at the initial level (12.54 - 13.00) was more clearly revealed. After all, this scale is related to the choice of a profession, particularly as it relates to socio-cultural factors.

Disciplines by profession is the scale for those subjects who study a relevant specialty that they like (12.54 - 13.00), and this clearly displayed itself.

Literature as a choice of profession was more evident in elementary schools (8.00 - 7.21).

For Language (linguistics), the centers differ with a very wide gap, and the final one showed itself the most (18.39 - 9.00). For example, for admission to master's or doctoral studies, in addition to specialization, students must pass a foreign language exam.

Creative disciplines showed themselves more according to the scale at primary centers (22.14 -24.00).

The Orientation in time scale measures a person's ability to combine, accept the past/present/

Table3 Statistical indicators of initial and final centers by clusters

End centers of clusters			Initial centers of clusters		
	Cluster			Cluster	
	1	2		1	2
Pleasure motive	0.00	2.48	Pleasure motive	0.00	0.00
Motive of professional implementation	1.00	2.79	Motive of professional implementation	1.00	1.00
Social motive	0.00	0.56	Social motive	0.00	2.00
Identification of external positive motives	1.00	1.00	Identification of external positive motives	1.00	4.07
Identification of external negative motives	9.00	2.54	Identification of external negative motives	9.00	3.00
Identification of the social significance of the pupil (student)	0.79	2.91	Identification of the social significance of the pupil (student)	1.30	2.40
Identifying prestige motivation	9.00	12.54	Identifying prestige motivation	9.00	13.00
Disciplines by profession	9.00	12.54	Disciplines by profession	9.00	13.00
Literature	7.00	7.21	Literature	7.00	8.00
Language (linguistics)	42.00	18.39	Language (linguistics)	42.00	9.00
Creative disciplines	54.00	22.14	Creative disciplines	54.00	24.00
Orientation in time scale	6.00	25.67	Orientation in time scale	6.00	6.00
Scale of Support	4.00	5.68	Scale of Support	4.00	6.00
Scale of value orientations	9.00	11.15	of value orientations	9.00	13.00
Behavior flexibility scale	6.00	8.90	Behavior flexibility scale	6.00	6.00
Sensitivity scale	8.00	6.00	Sensitivity scale	8.00	8.34
Spontaneity scale	3.00	5.00	Spontaneity scale	3.00	3.89
Self-esteem scale	4.00	4.95	Self-esteem scale	4.00	2.00
Self-acceptance scale	7.00	13.00	Self-acceptance scale	7.00	9.71
Scale of Ideas about human nature	10.00	11.35	Scale of Ideas about human nature	10.00	12.00
Scale of Synergy	7.00	8.00	Scale of Synergy	7.00	7.49
Acceptance of aggression scale	5.00	6.78	Acceptance of aggression scale	5.00	6.00
Contact scale	9.00	15.00	Contact scale	9.00	12.80
Cognitive needs scale	42.00	48.30	Cognitive needs scale	42.00	45.00
Creativity scale	5.00	7.33	Creativity scale	5.00	8.00
Problem Solving scale	0.00	3.58	Problem Solving scale	0.00	0.00
Scale of Social Support	0.00	0.00	Scale of Social Support	0.00	1.61
Problem Avoidance scale	0.00	0.00	Problem Avoidance scale	0.00	0.39
Motivation to fail	0.00	0.00	Motivation to fail	0.00	0.32
Motivation to succeed scale	0.00	0.71	Motivation to succeed scale	0.00	3.00
Resource	0.00	2.00	Resource	0.00	0.99

future, and understand that all these time dimensions are an integral part of a person's life. This showed itself very brightly at the final stage (25.67 - 6.00).

The scale of Support of family, relatives, and friends showed itself more at the initial level of admission to higher education (5.68 - 6.00). After finishing school, children are not used to living independently and making important strategic decisions about their lives, so the scale is considered much more relevant at the age of 16-17, in contrast to the older student audience.

The scale of Value Orientations was also more pronounced at the initial level if we take into account value orientations in professional self-determination and the formation of a gifted personality (11.15 - 13.00).

The Flexibility of Behavior scale showed itself more in the final center than in the initial one (8.90 - 6.00). The results indicate that gifted children, when placed in unfamiliar conditions, can demonstrate flexibility in adapting to unpredictability; however, this adaptation often comes at a cost, as it initially triggers maladjustment. Nevertheless, after a period of adjustment, they tend to recover more quickly and navigate challenging situations more effectively.

The Sensitivity scale manifested itself more at the initial center (8.34 - 6.00). The results show that gifted participants in the educational process, if they don't know the group in which they are studying, are more anxious to make an impression, show their strengths, to prove themselves to be at a decent level.

The Spontaneity scale at the initial level showed itself less, in contrast to the final one (5.00 - 3.89). The corresponding scale describes quick decision-making without additional thinking. The subjects who were older and those who belonged to the category of creatively gifted could express themselves more freely, casually, and unpredictably.

The Self-Esteem scale also increases according to indicators in the final centers of significance, in contrast to the initial ones (4.95 - 2.00). We argue this result is because a person respects themselves more in adulthood due to the results of their activity (educational, professional, and creative).

The Self-acceptance scale manifests itself more in the final center in contrast to the initial one (13.00 - 9.71). It is logical that as self-esteem increases during the youth of gifted students—compared to their adolescent counterparts—the self-perception scale reflecting their potential for creative or academic abilities follows a similar distribution.

The Synergy scale reflects the ability to integrate physical and spiritual dimensions, balance academic learning with creativity, and harmonize recreation with productivity—particularly relevant for gifted student youth. According to the cluster analysis, this ability is more strongly expressed in the final clusters compared to the initial ones (8.00 - 7.49).

According to E. Shostrom, the Acceptance of Aggression scale indicates the extent to which a gifted personality understands that aggression can manifest itself in a positive direction, as opposed to a negative one. In order to reveal and realize personal potential, you need to overcome psychological barriers by setting goals. In the final centers, the results are higher compared to the initial ones (6.78 - 6.00).

The scale of Contactness describes the degree of entry of a gifted personality into the social environment, namely to what extent the person can find and approach to others. It manifested itself more in the final centers, in contrast to the initial ones (15.00 - 12.80)

The scale of Cognitive Needs showed itself with very high indicators (48.30 - 45.00). Such results may indicate that the largest number of subjects were academically gifted (grade certificates) as opposed to intellectually or creatively gifted.

The Creativity scale indicates the level of performance of assigned tasks in non-traditional ways. This scale describes the creative component of a gifted participant in the educational process, which is revealed through divergent thinking (several options for solving a task). It manifested itself more in the initial clusters (7.33 - 8.00).

The Social Support scale showed itself more in primary centers because teenagers and first-year students really need it from relatives and friends, especially when they are not yet used to a new social environment (0.00 - 1.61).

The scale Motivation to Succeed manifested itself better compared to the previous scale and was revealed more successfully in the final centers compared to the initial ones (3.00 - 0.71). Motivation for success increases when a gifted person sees the results of their activities (learning, creativity).

The Resource scale in gifted students increased from the initial to the final centers (2.00 - 0.99), which indicates activity and motivation in educational and professional activities.

Now we will briefly justify the typology we defined in practice.

Cluster 1 - The unmotivated-implementation type of personal potential of a gifted person is characterized by significantly lower indicators in motivational trends in contrast to the motivated-implementation type. According to the relevant indicators, this type indicates a very low level on 11 scales: Motive of satisfaction (0.00), Social motive (0.00), Motive of professional fulfillment (1.00), Detection of external positive motives (1.00), Detection of social significance of the pupil (student) (0.79), Solving problems (0.00), Social support (0.00), Avoiding problems (0.00), Motivation for failure (0.00), Motivation for success (0 .00), and Internal resources (0.00).

The following 16 scales were found to be at the average level: Detection of external negative motives (9.00), Detection of prestige motivation (9.00), Disciplines by profession (9.00), Literature (7.00), Support (4.00), Value orientations (9.00), Flexibility of behavior (6.00), Sensitivity (8.00), Spontaneity (3.00), Self-esteem (4.00), Synergy (7.00), Acceptance of aggression (5.00) , Contact (9.00), Creativity (5.00), Time Orientation (6.00) and Self-Acceptance (7.00).

Only 4 scales worked at a high level: Concepts of human nature (10.00), Language (42.00), Creative disciplines (54.00), and Cognitive needs (42).

Cluster 2 - The motivated-realization type of a gifted person's personal potential has significantly higher indicators compared to the previous type.

Low scores were found on only 2 scales: Avoidance of problems (0.00) and Motivation to fail (0.00). Such scales only confirm the motivated-realization type because high indicators of the corresponding scales indicate the opposite - a low level of motivation.

Medium-high indicators were found on 20 scales: Motive of satisfaction (2.48), Social motive (2.00), Motive of professional realization (2.79), Identification of external positive motives (4.07), Identification of the social significance of the student (2.91), Solving problems (3.57), Social support (1.61), Motivation for success (3.00), Resources (2.00), Identifying external negative motives (3.00), Literature (8.00), Support (6.00), Flexibility of behavior (8.90), Sensitivities (8.34), Spontaneity (5.00), Self-esteem (4.95), Synergies (8.00), Acceptance aggression (6.78), Creativity (8.00), and Problem Solving (3.58).

10 scales worked at a high level: Identification of prestige motivation (13.00), Disciplines by profession (13.00), Value orientations (13.00), Self-acceptance scale (13.00), Scale of ideas about human nature (12.00), Contact (15.00), Orientation in time (25.67), Language (linguistics) (18,39), Creative disciplines (24), and Scale of Cognitive Needs (48).

Comparing the results of the first and second clusters, we see significant differences in motivational trends regarding the personal potential of gifted youth. A significantly larger number of scales increased in the motivated cluster at high and medium-high levels, in contrast to the unmotivated one. Also, a large number of scales dominate the unmotivated type in relation to the low level of motivation of gifted adolescent youth.

Discussion

An empirical typology of the personal potential realization of gifted youth has not been studied by scientists.

The relevant research problem is included in the list of topics of the Institute of the Gifted Child of the National Pedagogical Academy of Ukraine and the international grant of experimental developments of the Faculty of Psychology of the Pan-European University (M.A. Sadova, 2022).

The problem of implementation potential has its origins in the humanistic direction of psychology. In particular, the following foreign scientists made significant contributions to development and self-realization: Katelein Barbier,

Vincent Donche, Karin Verschueren (7), Weihua Fan, Cathy Williams (12), and others.

Aspects of the motivational structure and typology of the personal potential of gifted youth have become debatable issues in the scientific works of Sadova M., both at the theoretical (Sadova M.A., 2023) and empirical levels (Sadova M.A., 2022).

At this stage, the problem was substantiated by reviewing and analyzing foreign studies from the past 5 to 8 years that explore motivational aspects within the structure of personal potential in gifted adolescents (Mann, R. V., 2020). For the corresponding problem, we relied on the research of foreign scientists and organizations. Over the past decade, modern foreign scientists have considered the factors and components of motivation in the structure of the personal potential of gifted youth (Worrell F. C. et al., 2012). In studies by I. V. Samokhin, M. G. Sergeeva, E. V. Tabuyeva, T. G. Stanchulyak, E. G. Kolesina (Samokhin I. at al., 2018), and I. L. Yakymova. (Yakymova I.L., 2021), the essence of the components of extra- and intrapunitive motivation, which lead to the disclosure of the personal potential of gifted children of adolescent age, is described (1). The works of Sternberg R. (Sternberg R., 2016), Vorel F. K., Sharko Y. E., and Gabelko N. Kh. (Worrell F. C. et al., 2012) highlight the study of the positive and negative attribution of success and failure of gifted people (Sternberg R., 2016). Danchenko O. B., Palchynska M. V., Ajaman I. A., and Telychko N. A. (Danchenko O. B. at al., 2020) investigated the failure of gifted children from low-income families (Ellen D. Fiedler, 1999).

Conclusions

Summarizing the above, it is worth noting that motivation is a dynamic process of realizing the personal potential of gifted youth.

The results of the cluster analysis is based on the number of observations within each cluster, the chronology of interactions, and the differential variations between the initial and final centers of the clusters. The empirically derived typology related to the core issue identifies two types of personal potential realization in gifted youth—motivated-realization and unmotivated-realization—based on the relevant assessment scales. In particular, according to the motivated-realization type, 10 scales worked at a high level: Identification of prestige motivation (13.00), Disciplines by profession (13.00), Value orientations (13.00), Self-acceptance scale (13.00), Perceptions of human nature (12.00), Contact (15.00), Orientation in time (25.67), Language (linguistics) (18.39), Creative disciplines (24), and Scale of cognitive needs (48). According to the motivated-non-fulfillment type, 11 scales worked at a very low level: Motive of satisfaction (0.00), Social motive (0.00), Motive of professional realization (1.00), Identification of external positive motives (1.00), Identification of social significance of the pupil (student) (0.79), Solving problems (0.00), Social support (0.00), Avoiding problems (0.00), Motivation for failure (0.00), Motivation for success (0. 00), and Internal resources (0.00).

Therefore, according to typological trends, the types of motivational formations play an important role for youth when choosing a profession, forming a personality, and realizing gifted youth in various spheres of activity.

Future research should focus on developing the motivational structures of gifted individuals, as only 109 out of the 769 participants studied demonstrated motivation.

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Digital Benefits to Sustainable Presence: A Qualitative Study on Seniors' Use of Social Networks to Support Their Social Participation

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Abstract:

The article focuses on seniors' sustainable presence and social participation with the use of digital tools. The research consists of a qualitative exploration of how seniors, often referred to as "silver surfers," leverage social networks to support their social status, i.e., their social presence and participation. Semi-structured interviews, which enabled control over the direction and content of the interviews, were conducted with twenty-eight seniors in Slovakia. The starting point of the research findings was knowledge levels as reported by the

seniors, which created a thought-provoking research context. The research highlights the potential for technology to a) catalyze positive change and socially empower seniors, as well as b) the involvement of seniors in the processes of the digital era for a more sustainable future. The advancement of the digital competencies of seniors requires building skills and a deeper knowledge level of using social networks.

Introduction

Scholars identify three distinct types of aging: biological, social, and chronological. Biological aging involves physical and psychological changes, such as muscle deterioration and memory decline, which impact an individual's overall well-being. Social aging refers to shifts in an individual's social roles and lifestyle, often influenced by new responsibilities and status changes, such as becoming a senior. These social changes can affect an individual's social presence and participation, with technology playing an increasingly significant role in sustaining social connections. Continuing to work and maintaining social contacts are crucial factors for avoiding loneliness and enriching seniors' lives (1).

Chronological aging, on the other hand, is determined by reaching a specific age threshold. As Janet Roebuck noted in 1979, chronological age is often used to define old age based on biological aging, even though these two measures may not align. This discrepancy is evident in the varying definitions of old age across different contexts—while the United Kingdom has historically considered old age to begin at fifty (2), in the United States, individuals are legally recognized as seniors at 65 and older (3).

In Slovakia, the term "seniors" is commonly used to describe older adults aged between 60-65 and 75, after which the following stage is classified as "old age" (4). This classification aligns with the United Nations, which, along with most researchers studying population aging, defines older individuals as those aged 60 or 65 and above based on chronological age (5, p. 5). Similarly, institutions such as the Organisation for Economic Co-operation and Development (OECD) and the World Economic Forum consider the elderly population to consist of individuals aged 65 and over (6, 7). These distinctions in aging categories underscore the importance of understanding how different life stages influence seniors' social participation, particularly in the context of digital tools that support a sustained presence and engagement.

Recent research in Slovakia revealed that 63% of individuals aged 15-79 use social networks daily, marking an all-time high. This increase in social media engagement has been observed across all age groups, with a notable rise in the online activity of women. While men's usage has remained relatively stable, women's higher engagement with social networks and other digital platforms is a pattern observed across generations and cultures. Interestingly, A. R. Hochschild has pointed out that creating and maintaining social networks, both online and offline, are traditionally seen as female competencies as they focus on fostering connections with family, friends, and neighbors (8). For seniors, these platforms become essential tools for their social presence and social participation. Additionally, the increasing technological literacy among seniors in Slovakia, driven in part by the shift from traditional mobile phones to smartphones, highlights how digital tools are empowering this demographic.

According to Slovak online marketing expert Tony Dúbravec, the overall increase in internet usage across all demographics, regardless of age or gender, is influenced by greater internet accessibility, the expansion of social networks, and the shift of media consumption from physical and print formats to digital platforms. Specifically, according to Dúbravec, the rising online activity of seniors in Slovakia is also linked to the transition from traditional push-button mobile phones to smartphones, which has contributed to both increased digital engagement and greater technological literacy among seniors (9).

Moreover, we consider the latest findings

in the context of Slovakia intriguing. These findings declare that the total number of social network users over the age of 60 is only slightly increasing, but we notice a more significant increase in the number of daily users among seniors. Seniors' interaction with social networks on a daily basis is already approaching 40% (10). In 2014, it was less than 10% in Slovakia, and in 2020, the number of seniors on social networks grew to almost 20% (11). Just to illustrate, we present a comparison of seniors in Slovakia with seniors in America, where similar findings were measured in 2009. In America too, although five years earlier than in Slovakia, the increase in the intensity of the use of social networks was significant; while in 2009 only 10% of aging Americans reported using social networking sites daily, a year later it was already one in five (20%) seniors (12). We can see that even in America, social networks have gained popularity relatively quickly in the lives of older Americans. Currently, up to 80% of older Americans are online at least six hours a day. As an additional comparison, the results are similar among seniors in Israel, with a slight increase of between 10%-20% in the use of social networks in 2024, depending on which site and its use (13). The researchers refer to them as "digital seniors," recalling the reasons for their daily digital existence. These reasons include, for example, keeping in touch with friends and family, organizing finances, and improving health and well-being (14).

This research aims to qualitatively explore seniors' knowledge, motivations, and perceptions of using social networks to support their social presence and participation. The following research questions guide this study: 1) What are seniors' perceived digital literacy levels regarding social networking sites? and 2) What benefits do seniors derive from using social networking sites in the context of social participation and sustainable presence?

We believe that the research findings can help researchers and policy makers identify gaps in knowledge and support their understanding of what might be needed to properly support older people in fully enjoying the benefits of social media use, while doing so safely.

The role of technology in enhancing social participation among seniors

Accoriding to experts, the increase in the intensity of social network use contributes to the increasing adaptation of seniors to technology (10, 15, 16, 17, 18, 19). Experts even deny that the increase in social network use is caused by an influx of young people. As Adam Kršiak stated, based on findings by the Statistical Office of the European Union, "it is the older generation that tries and learns to use the internet and modern technologies" (9). The indicated trend opens the question of the degree of adaptation of seniors to technology as well as the question of the benefits and positive consequences that follow from it.

Technology plays a pivotal role in enhancing social participation among seniors by facilitating connections that might otherwise be limited due to physical or geographical constraints. Kondrla et al. highlight that seniors' desires for the future often revolve around a few basic needs, particularly family needs (20). In this context, increasing the use of digital platforms becomes essential, as it enables seniors to stay socially engaged, combat isolation, and maintain active involvement in family life and the broader community (21). Social networks offer a convenient and accessible medium for maintaining relationships, sharing experiences, and staying informed. Such platforms have been proven to help improve mental well-being because they allow seniors to maintain and build their social capital (22).

Moreover, technology not only improves connectivity, but also supports seniors' social roles and interactions. Research has demonstrated that seniors who are active in online communities experience better social inclusion and engagement in societal matters, both online (23) and in the offline environment (24). Thus, researchers have confirmed that social networks foster a sense of belonging and purpose, particularly when seniors engage in group activities that correspond to their specific needs and interests (25).

Interestingly, the ability of social networks to enhance seniors' well-being extends to fostering intergenerational connections because they bridge the age gap (26). Platforms like so-

cial networks and messaging apps allow seniors to interact with their peers and younger family members, thereby improving communication and reducing generational divides. These platforms often facilitate conversations that might not happen otherwise. They strengthen relationships and encourage social and emotional benefits (27), i.e., benefits that are essential for everyone, including individuals with problematic life situations (28) or illness. These conversations contribute to maintaining social relationships, overcoming isolation, and fostering meaningful engagement in society (29). This aligns with the fundamental notion that humans are inherently social beings who rely on the company of others for their well-being and development (30).

On the other hand, while technology facilitates social participation, the digital divide remains a significant barrier. Not all seniors have equal access to or are comfortable with digital tools. Additionally, research has shown the need to protect seniors, perhaps even more so than younger users.

According to experts, seniors should take protective measures for the following reasons:

a) Low digital literacy (31);
b) Limited computer self-sufficiency (32);
c) Less knowledge and lower confidence in performing protective behaviors compared to younger users (33);
d) Higher susceptibility to certain cyberattacks, such as consumer fraud (34);
e) Lagging behind younger users in internet security awareness, confidence, and knowledge (35, 36, 37).

Morrison, Coventry, and Briggs therefore state that seniors appear to be the type of users who do not show a willingness to fully follow the challenges in the field of cyber security. According to these researchers, this is the result of a combination of their "low computer self-efficacy, mistrust, and lack of awareness" (36, p. 1034).

The dangers associated with the use of social networks can also have an impact on the mental well-being of seniors. The rapid evolution of digital tools can create frustration and a sense of exclusion among seniors; experts even speak about the so-called "grey digital divide," which highlights the growing gap between younger and older generations in their ability to access and effectively use digital technologies that often leads to social exclusion and reduced well-being among seniors (38). Similarly, the pressure to keep up with trends and popular culture on social media can create a feeling of inadequacy or a "Fear of Missing Out" (FOMO), leading seniors to have unwanted stress (39). This pressure to constantly stay connected or respond quickly to messages and posts can also induce stress, particularly if seniors feel overwhelmed by the demands of online engagement (40). Additionally, seniors may experience cognitive overload from the constant flow of information, making it harder to focus or make informed decisions (41). Moreover, exposure to toxic content, misinformation, media manipulation, and fake news can lead to confusion (42, 43) or even radicalization, as seniors may have difficulty distinguishing credible sources from misleading content (44).

Seniors themselves acknowledge the psychological strain associated with online engagement. Many report experiencing fear, anxiety, and a lack of personal control over online processes, often stemming from ignorance about existing services and the potential pitfalls of using them (45). They associate these negative feelings with a range of digital tools and platforms, including online banking (46, 47), tablets (48), smartphones (49, 50), and even regular websites (51). These experiences highlight the need for comprehensive digital literacy programs tailored to seniors to help them navigate the online world with confidence and security.

In this context, a more optimistic perspective is noteworthy. Despite challenges, technology brings significant benefits for seniors, particularly in boosting their social participation and well-being (21, 52, 53). One example is a study from the University of Missouri that highlighted the positive impact of social network use on seniors' well-being. Interestingly, in the study, social media generally contributed to a sense of connection and engagement. While the risk of depression was noted in individuals who used social media for self-comparison, many seniors experienced positive emotions, such as happiness and a sense of belonging through on-

line interactions. If seniors used social media to maintain contact with other people, the risk of depression dropped sharply (54). Other research findings have confirmed from a sample of retired seniors in the US that internet use also reduced the odds of depression by one-third (19).

It seems that tailored digital literacy programs can significantly enhance seniors' ability to utilize technology effectively and safely, increasing their social participation and well-being (55). Educating seniors on digital platforms improves their connectivity and empowers them to maintain active social roles in an increasingly digital world (56). This emphasizes the importance of equipping seniors with the necessary skills to thrive in the digital age (57) and ensuring that they continue to have high social value in the digital environment as well (58).

Finally, an international comparison of Slovaks in all age groups has found that seniors not only lag in digital skills and media literacy compared to the rest of the population, but there is also a lack of broader and representative media research on the group of current Slovak seniors (59). In addition, there is no database of knowledge concerning the use of new means of communication among this population group, and there is no clear overview of the level of their media skills. The lack of research on seniors in the Slovak population also leads to a lack of information on, for example, the level of critical thinking and the ability to understand media products (60). This article also wants to respond positively to the research conclusion of Ľubica Gálisová, who focused on the status and life of older Slovaks. She found that seniors in Slovakia "feel like they are on the margins of society" (61, p. 2). It is a long-term problem in Slovakia, which T. Hangoni, D. Cehelská, and M. Šip also drew attention to more than ten years ago (62, p. 4).

Methodology

This study explores how seniors use social networks to maintain their social participation and how these platforms contribute to their sustainable presence in the digital era. Specifically, the research examines seniors' perceived digital literacy levels, motivations, perceived benefits, and challenges associated with using social networking sites.

The goal is to understand how technology can enhance seniors' social connections and involvement in society while identifying potential barriers to their engagement.

Research questions

The following research questions guided this research:

Q1: What are seniors' perceived digital literacy levels regarding social networking sites?

Q2: What are seniors' perceived benefits of social networking sites?

Research approach

The study employed a qualitative research design, utilizing semi-structured interviews to gain in-depth insights into seniors' experiences with social networking sites. This approach allows for flexibility in responses while ensuring consistency in addressing key research themes. The researchers aimed to clarify how respondents "come to an understanding of what is happening, why they act in a certain way, and how they organize their everyday activities and interactions" in their everyday environments (63, p. 52).

By focusing on seniors' personal narratives, the study captures the complexities of their engagement with social networking sites and the broader implications for their social participation.

Participants

The study included twenty-eight seniors from Slovakia that were selected through purposive sampling to ensure a diverse range of experiences with social networking sites. The participants varied in age, prior digital experience, and frequency of social network use, allowing for a comprehensive exploration of their engagement with these platforms.

Digital literacy assessment

To assess seniors' perceived digital literacy levels regarding social networking sites, a self-evaluation scale was applied based on

school grades from 1 to 5, where 1 represented the highest level of digital literacy and 5 indicated minimal familiarity. The scale was structured as follows:

1 — I am very digitally literate in using social networking sites;
2 — I am digitally literate in using social networking sites;
3 — I have some digital literacy regarding social networking sites;
4 — I am aware of social networking sites but do not have much digital literacy;
5 — I have almost no digital literacy regarding social networking sites.

This self-assessment method provided valuable insights into seniors' confidence and perceived competence in navigating social networks. These factors were then analyzed based on their usage patterns and reported benefits.

Research method

This study employed a qualitative research approach using semi-structured interviews to explore seniors' experiences with social networks. Semi-structured interviews allow researchers to guide discussions and provide participants with the freedom to express their perspectives in detail, ensuring that key themes are covered while allowing for new insights to emerge (64). Semi-structured interviews are particularly valuable as they offer a balance between structure and flexibility, allowing for both in-depth exploration and the possibility of new insights to emerge naturally during conversation (65). Compared to structured interviews, semi-structured interviews offer a deeper understanding of participants' motivations, experiences, and perceived challenges, making them a valuable tool for qualitative inquiry (64, 66).

Data collection

The data were collected through semi-structured interviews conducted over several weeks from September - December 2023, both in person and online to accommodate participants' preferences. The interviews focused on topics such as digital literacy levels, motivations for using social networks, perceived benefits, and challenges encountered.

Data collection process

Participants were asked eight open-ended questions designed to capture their motivations for using social networks, the benefits they perceived, and the challenges they encountered. Examples of questions included: Why do you use social networks? What benefits have you gained from using social networks? What features do you find most useful or difficult to navigate? How do you learn to use new features on social media? Who do you turn to for help when using social media when needed? How important is it for you to stay connected with others via social media? Have you noticed any changes in your social participation and well-being since you started using social media? A semi-structured format using open-ended questions ensures that a broad range of topics is covered systematically. At the same time, it allows participants to express personal experiences and perspectives in detail and give detailed and personal insights into their social media experiences, all of which are essential for capturing rich qualitative data (64, 65, 66).

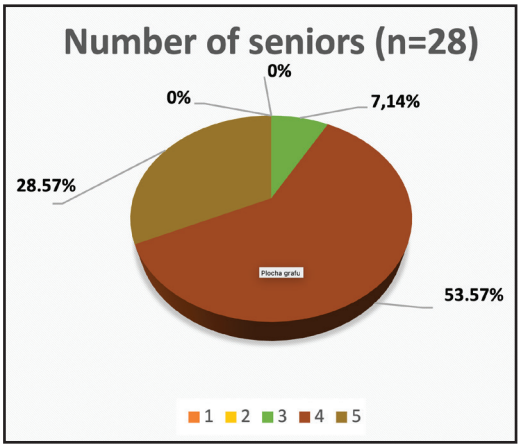
Results

The results section presents findings from an analysis of seniors' perceived digital literacy levels regarding social networking sites and the benefits these platforms provide. Likewise, the findings provide insights into areas where seniors may need further support.

Perceived digital literacy levels of seniors regarding social networking sites (Q1)

Graph 1 shows the results of the seniors' perceived digital literacy levels concerning social networking sites among the respondents of our study.

Graph 1 Self-reported social networking sites knowledge level (n = 28)



Source: Own research.

As we can see in Graph 1, among the 28 seniors surveyed, most rated their digital literacy as a 4, indicating that while they were aware of social networking sites, their ability to navigate them remained limited. A total of 15 participants (53.57%) selected this rating. Notably, no respondent rated their digital literacy as 1 (very high) or as 2 (digitally literate), and only two rated themselves as 3 (moderate digital literacy), comprising 7.14% of the group. Conversely, 8 participants (28.57%) reported having almost no digital literacy regarding social networking sites (rating 5). Despite these self-assessments, all respondents expressed a willingness to engage with social networking sites, reflecting a notable gap between digital literacy levels and the motivation to participate in online interactions.

The data further revealed that many seniors linked their digital literacy to their immediate needs. One respondent stated, "I use social networks to eliminate boredom when I rest in the afternoon and can't fall asleep," emphasizing a practical approach. Others highlighted the importance of family support in overcoming digital barriers, as expressed by one participant: "Whenever I get stuck, my grandson helps me. He even made me a small guide on paper." These insights suggest that while many seniors may not feel confident in their digital literacy, they rely on family members to navigate them in the digital environment.

Additionally, some respondents reported feeling comfortable using basic social networking features, but they required assistance for more advanced functions. One participant shared, "I can scroll through posts and comment, but I don't know how to post pictures." Another stated, "I mostly use Facebook because I'm familiar with it, but I don't understand other social networks like Instagram." These responses highlight varying levels of digital literacy, as some seniors engage with social networking sites at a basic level, while others avoid unfamiliar features altogether.

Several seniors also described their engagement with social networking sites as being motivated by social and emotional connections. One participant noted, "I use social networks mainly to stay in touch with my family and friends. It makes me feel included in their lives." Another shared, "Sometimes I just scroll through posts to pass the time and see what's happening in the world." A different respondent expressed, "Even though I don't know all the functions, I enjoy reading my children's and grandchildren's posts and seeing their pictures." These findings indicate that while digital literacy levels among seniors may be limited, social networking sites play a significant role in maintaining their social presence and emotional well-being.

Perceived benefits of social networking sites for seniors (Q2)

As we saw above, social networks motivate seniors to foster connections and communicate by providing a platform for their various activities. The following are some of the most often expressed benefits of using social networks according to the seniors in our research (n = 28). Similarly, we present the order of benefits from the most important to the least important in our research sample.

- Communication and the company of other people — The most valuable benefit of social networks among the respondents of our research is staying connected with family members, friends, and distant relatives. Thus, seniors not only receive but also share updates, photos, and videos, comment on posts, and engage in real-time conversations through messaging and video calls. As they stated, all of these possibilities help them combat social isolation and solitude. Respondents speak about maintaining meaningful connections as the main reason for using social networks.
- Entertainment and boredom buster — A big benefit of social networks is that they offer a wide range of entertainment options for elderly individuals. Respondents follow pages and groups related to their favorite hobbies, engage in discussions, and do shopping. This provides them with an important source of enjoyment and, as several of them stated, "It helps alleviate boredom."
- Finding and joining interest communities — Social networks provide a platform for seniors to find and join interest-based groups. Whether it's a hobby, a recreational activity, or a cause they are passionate about, they can connect with like-minded individuals, share experiences, and engage in discussions related to their interests. According to respondents, when many people are dying in real life, it is positive to meet new people who share interests with them.
- Health and well-being support — Social networks are a good tool for seeking advice, information, and support related to health and well-being. Seniors in our research sample stated that they join groups focused on specific health conditions. In these online groups, in addition to specific web sites, respondents find resources and tips for healthy living. Seniors also participate in discussions on topics such as nutrition, herbs, and exercise. Moreover, in our research sample, social networks are not only a popular tool for seeking advice, information, and support. Respondents also talked about the mutual support and encouragement they receive from other users. This confirms the importance of relationships and connections that develop on the basis of reciprocity in the social network environment. A parallel phenomenon is the strengthening of the social role and personal meaning of each user.
- Information and education — Social networks are utilized by respondents as a platform for seeking information. Some of the seniors in this research spoke about using internet tools for their education and continuing education. As we can see, for them social networks serve as sources for other websites where education takes place; i.e., education is not directly a benefit of social networks, although social networks create a connection with educational content, online courses, and webinars. Thus, with the use of social networks, respondents can find information and increase their knowledge.
- Memory presentation allows them to engage with loved ones — Social networks serve as a digital platform for seniors to preserve and share memories. Our respondents are not primarly users who actively upload new video content or create photo albums. The seniors in our research sample use social networks to preserve and share memories (especially by uploading and sharing photos on social networks). They do it especially because they want to share their memories and allow family and friends to engage with their memories.
- Learning from life experiences of others — Social networks provide a space for the seniors in our research group to share their life experiences, wisdom, and stories with a wider audience. Our respondents create posts and engage in discussions on various topics. In doing so, they are exposed to and learn from conversations, experiences, and others' perspectives.

- An aid and a tool to save effort — Experts point out that the adaptation of older people to changes related to aging is not always natural and problem-free. The situation is also complicated by the accumulation of losses in several different spheres of life (e.g., the loss of professional status, the loss of social contacts, etc.) (58). Attempts by seniors to satisfy their own needs also appear problematic if they have no help. In that case, seniors most often do not even reach out to services that would solve their difficulties (67). Social networks, as shown in our research, represent a suitable way for respondents to help. In the words of one respondent, social networks are often the place where he tends to "look for what he needs to improve his own situation or solve a problem." Respondents talk about getting help promptly using easily available information thanks to the use of social networks. An accompanying phenomenon is the subsequent support of independence that the internet gives to older users.
- A stimulator for human discussions, personal intelligence, and memory — Respondents refer to social networks as "fast newspapers that change every moment." They appreciate learning new information that turns out to be interesting to others: "I'm glad that when I talk to my granddaughter or daughter, I always have something to talk about! I realised that some of the topics in our conversations are topics that I know from the social network." In this context, participating seniors also point out another benefit, the training of personal intelligence and memory, which is then fully manifested during conversations with other people. One respondent stated: "I have difficulty remembering what I wanted to say if I don't say it immediately. However, if the information (from the social network) is also interesting for me, I find that I not only remember the main idea better, but also many details related to the information." This benefit naturally also supports the quality of seniors' discussions with other people.
- The use of social networks and their impact on structuring the day — Similar to television, seniors are used to watching "their programs" broadcast at "their time." Thus, their time on the internet is scheduled in advance. One respondent stated, "I'm used to watching TV starting at half past five because my favorite show is on." After that, I have dinner and sit down to watch TV again at seven when the news comes on. I watch social networks exclusively on my mobile phone during the afternoon break, as I can't sleep but I need to rest and straighten my back." Another respondent described herself as an "all-day viewer of televison." She keeps the TV on all day so she doesn't feel alone. She said, "I go to Facebook in the evening, but only on those days when my series is not on TV." Television is the dominant medium among the participants that largely determines how seniors structure their day. However, it seems that the use of the internet and social networks also has its place in the daily routines of the research group members.

Discussion

By 2050, the United Nations projects that one in six people will be aged 65 or older, signaling a growing global aging population (5). With this demographic shift, a crucial challenge is the perception of quality of life and life satisfaction among seniors (68, 69, 70, 71, 72). Experts emphasize that the use of digital tools can positively impact seniors' well-being, fostering a more optimistic outlook. These tools not only enable them to stay connected, they also contribute to a better sense of purpose and fulfillment. Moreover, this demographic shift further underscores the importance of addressing the social participation and well-being of seniors in the current digital era.

Despite assessing themselves as having low perceived digital literacy when it comes to social networking sites, the seniors in our study actively engage with these platforms, demonstrating the digital benefits that support their sustainable presence and social participation. Many respondents acknowledged difficulties in navigating social networking sites beyond basic functions (Q1). However, this self-perception does not necessarily prevent them from leveraging social networks to maintain social connections, access

information, and participate in online communities. This finding is significant in our sample and aligns with other similar studies where participants mentioned that they primarily rely on social networks to stay in touch with family and friends (21, 22, 23, 24, 25, 26, 52).

Other respondents noted that they learn through trial and error and seek assistance from younger family members when needed. This suggests that while seniors may view their digital skills as weak, their motivation to stay socially connected and informed fosters their continued use of social networking sites. Our findings join those of many experts highlighting the role of digital tools in promoting social inclusion and sustainable engagement in the digital era (27, 53, 56, 57).

Finally, although education is not perceived as a direct benefit of social networks, respondents acknowledged that users can gain valuable information and expand their knowledge through these platforms. The observations of the respondents recorded in this research are consistent with the views of other experts who argue that computer technologies can be an integral part of innovative learning methods, as they help students better absorb material and develop critical thinking skills (73).

The set of ten benefits we identified in the research set within the second research area (Q2) point to several interesting aspects:

a) The benefits of using social networking sites positively affect seniors' personal experiences with these sites. In our research group, it is primarily about the benefits of experiencing communication and the company of other people, enjoying entertainment, using it as a boredom buster, and finding and joining communities of interest. The identification of benefits also correlates with research findings of other experts (54, 74, 75). However, let us recall what has already been said: although social networks can contribute to socialisation, according to experts, "everyday use of technology changes the perception of other people so that an individual sees others as something technical and technological" (76, p. 40). Finally, although social networks can contribute to socialisation, we believe that they will not solve loneliness that is brought about due to the loss of contact with other people. Using the internet is not enough to solve this problem. The risk is, for example, that younger relatives will meet less physically with seniors and will make up for it only with online communication. This can also be understood as a negative consequence or the flip side of the apparent benefits of seniors using social networks.
b) Adopting social media sites seems to be a rather hard job for seniors, but comes with daily mental health benefits and well-being. All respondents also perceived social networks as an aid that helped them accomplish various needs and daily tasks. They realise that the greatest impact of social networks is shown in their participation in social life, despite the fact that it is an online space, and this gives them a sense of joy and usefulness. Many repeatedly say that social networks make them feel better and less sad. These qualitative findings align with the observations of other experts who state that strengthening social ties helps seniors not only fight loneliness, but also helps them stay healthier and happier (54, 77). Maintaining existing ties and creating new ties also brings well-being (19, 78, 79, 80) because it helps reduce stress, anxiety, and sadness that is caused by social isolation and loneliness (11, 74).
c) It seems that for seniors, social networks are a welcome and utilized age-friendly place. Being a part of an online community of seniors enables the realization of social interaction with individuals of the same age, who, may or may not belong to the closest circle of family and friendship. Moreover, our research sample shows that social networks acting as age-friendly places where seniors meet acquaintances in many cases really not only complement, but even replace non-existent, past, and dysfunctional ties within the family.
d) As an age-friendly place, social networks also create space for online life and thus enable older people to continue active social life and participate in the life of the community, which many evaluate very positively. According to respondents, active participation in an

online community and the opportunity to contribute to or influence this community leads to a sense of happiness. Other experts also confirm this statement (19, 77, 78, 79, 80).

Future research worthy of attention could be comparative research of a representative layer of those seniors we consider active and those who can be understood as passive in relation to social networks; it is necessary to examine, for example, their digital skills, their understanding of digital security, and other elements of digital citizenship. We think it is important to pay attention to both groups because their members can be socially isolated, which can have a very negative effect on them. The use of the internet, social media, and specifically social networks, can, among other things, help them strengthen interpersonal relationships (e.g., 11, 74, 77, 78), improve their cognitive functions like the ability to concentrate, remember, and learn (e.g., 74, 81, 82), and improve their subjective well-being (e.g., 19, 75, 78, 79, 80). Finally, we believe that the comparative research of active and passive seniors could also confirm our qualitative research observation that the quality of life of seniors can be significantly influenced by the quality and possibilities of social networks.

Conclusion

In this study, we explored how seniors use social networks to maintain their social participation and how these platforms contribute to their sense of presence in an increasingly digital world. We aimed to understand their knowledge levels, motivations, benefits, and difficulties while engaging with these platforms.

The findings show that although seniors may perceive their digital literacy as limited, they continue to use social networks to stay connected, entertained, and informed. Despite challenges navigating beyond basic functions, their motivation to remain socially engaged drives their active participation. This aligns with the broader focus of this research that emphasizes the importance of enhancing digital competencies among seniors to ensure their sustainable presence in society.

The study revealed that seniors' personal experiences with social networks have led to significant benefits. Communication, social interaction, entertainment, and joining interest-based communities were identified as noteworthy advantages. These benefits highlight the role of social networks in supporting seniors' social and emotional well-being. Importantly, social networks serve as valuable tools for accomplishing daily tasks and addressing practical needs, making them a crucial part of seniors' daily routines.

In conclusion, while "silver surfers" may face challenges in their digital literacy, their engagement with social networking sites demonstrates their commitment to maintaining social connections and participating in the digital world. Thus, empowering seniors with enhanced digital skills will foster their inclusion and well-being and help them navigate the digital era safely and confidently.

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