

The Quality of Life in the Contexts Health and Illness

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INTRODUCTION

Quality of life represents a category that is recently very frequent, often as a subject of research or an interpretative starting point for a range of problems. Quality of life is a term which is used in many disciplines and it has got into medicine, psychology and pedagogy through economy and sociology, when by researching, for example a life level, it has been shown that qualitative criteria are more decisive than quantitative ones.

Quality of life is an interdisciplinary term, thus it is very convenient everywhere we deal with human problems in a wider aspect. Quality of life researching, in a way, enriches and extends health researches, which have been recently the centre of attention in social medicine and in quickly developing health psychology and pedagogy. Health category has become one of central conception of materials and programs of World Health Organisation; while in health research attention was paid also to subjective variables, it was better to interpret them within quality of life. Certain disadvantage in quality of life researching is a wide conception of this term and often different understanding by diverse specialists; on the other hand it is a term, which is adequately perceived also by the public and it is easy to work with in practice.

We do not want to deal with the theory here; the reader can find it further in the book. We only want to give notice that we do not research the quality of life only in patients, but quality of life is a very favourable term also in investigation of “normal” individuals or society groups. Basically we always pursue maintenance or increase of quality of life, when we are aiming at the human personality and at those its components that we are able to successfully develop in a certain situation as these issues are being offered by contemporary positive psychology.

The presented publication shows plenty of knowledge that can be divided into reports usable in the clinic sphere (especially in ontological patients) or in the domain of personality and social load situations (such as unemployment, age) and furthermore the research of quality of life in the school system. Theoretical questions are solved here and research results from different observations of the quality of life domain are presented as well. We assume that, in the conception of the whole publication, authors' effort to show individual aspects of quality of life research is evident and, in the diversity of approaches, conceptions and results, ambiguity, interdisciplinarity and wide field of usable possibilities of the quality of life examination are also shown.

The impulse for publication of this collective monograph was a seminar meeting held on 25th April 2008 in Brno with the same title QUALITY OF LIFE IN THE CONTEXTS OF HEALTH AND ILLNESS; we are offering this publication as a starting point for further discussion about this interesting and important issue.

Brno, October 2008

Oliva Řehulková, Evžen Řehulka

HEALTH - RELATED QUALITY OF LIFE PARADOXES (HRQL)

Jiří MAREŠ, Jana MAREŠOVÁ

Introduction

Contemporary medical science does not only contemplate offering health care to the ill and **prolonging** human life or saving it (no matter whether towards its beginning or its end) It begins to devote more and more time to thinking about the **quality** of the months and years added, as advanced scientific knowledge, increasingly sophisticated technologies, revolutionary treatment and surgery procedures and new medicaments allow to save human lives even in the cases that would have been deemed fatal a few years ago. It is little to be wondered that ethical aspects of health care and nursing are being discussed on a wider scale and recommendation *guidelines* are being set up.

On the other side, health care institutions more frequently meet complaints (either justified or not justified) about the poor quality of their care made by patients and their families. There have also been legal suits and law courts investigate whether, while providing care, health care workers neglected or did not neglect their duties.

Arising problems are also viewed from a different perspective now. The dominating professional-centred approach is now supplemented with patients' opinions and adjusted by the patients themselves and their families, and ,in case of small children, by their parents. Concrete objective health care results yielded are, as a standard procedure implemented in developed countries, combined with the patients' subjective views on the quality of the health care provided, and, especially , on the **after-treatment quality of life**.

Generally speaking, we can say that health-related quality of life concerns mainly **professional health care** and becomes an important **result indicator** of provided **care** (Wilson, Cleary, 1995).

In a document by the American Ministry of Health (Guidance, 2006), methods examining health-related quality of life are ranked among the methods used by the **patient** to refer about the health intervention impacts known and are known as *patient-reported outcomes measures*. They report for example about positive treatment effects or about its side effects, which often hold unpleasant consequences for the patient. Three of the document's main arguments supporting the necessity to ask patients rather than health care workers are:

- some clinical research outcomes in new medicament testing are only known to the patient

- it is desirable to know patient's opinion on total treatment effectivity
- systematical and standardized procedures in assessing patients' views can bring precious information likely to be lost if verification is based only on doctor-conducted clinical interview

Extensive research into health-related quality of life has not only offered a vast number of useful theories, many research and diagnostics instruments and valuable clinical data, but also some surprising discoveries – paradoxical findings.

This review study **objectives** can be summarized into three points: 1. to investigate in detail the term *health-related quality of life* and its clinical use, 2. to characterize the term *paradox* 3. to describe and explain the five paradoxes discovered while exploring the quality of life that is related to health.

Term Definition

It is not easy to define the general category called *quality of life*, as it did not originate as a scientific term. It gradually spread into use in many branches of science and started to acquire specific nuances.

The term *quality of life*, applied throughout health care generally and in individual branches of medical science specifically, is labelled **HRQL** - *health-related quality of life*. It could be said that HRQL coverage is more *narrow* than in case of *quality of life* (Spilker, Revicky, 1996; Epstein, Stinson, Stevens, 2005) and that is why it is more suitable for use while considering wider contexts in providing health care (Strand, Russell, 1997).

However, theoretical defining of the term is not unified. There are numerous approaches to how to define this term. We drew inspiration from an overview chart created by researchers centred around E. Davis (2006), as the table struggles to give definition cores. We added more information as seen in Table 1, which was created by us.

Tab. 1 Diverse definitions of health-related quality of life, especially in children and adolescents. (modified according to Davis et al., 2006, p. 315; Mareš, Marešová, 2006, p. 30-31).

Definition Core	Definition Example	Authors
Overall being (total existence)	Overall being (total existence) of an individual or a group including various positive health aspects	Lindström, Kohler (1991) *
Functioning	It includes somatic functioning, emotional and social functioning, as well as role functioning	Varni, Burwinkle, Seid et al., (2003)
	Multidimensional construct covering three main domains: somatic functioning, psychological and social functioning	Speith, Harris (1996); Bouman, Koot, van Gils et al. (1999)
Functioning and its subjective assessment	It is usually defined as an individual's subjective quality functioning assessment and satisfaction or distress linked to it	Graham, Stevenson, Flynn (1997)
	Multidimensional term including a broad area of functional state, psychological and social well-being as well as perceived health and symptoms related to a disease and its treatment	Aaronson et al. (1991) *

Disease impact; objective and subjective assessment of its influence	Objective and subjective impairment effects on somatic, psychological and social aspects of quality of life affected by an individual's disease and its treatment	Strand, Russell, (1997) *)
Disease impact and its subjective evaluation	Functional effects of a disease and its subsequent treatment on the patient as seen by patients themselves	(Schipper, Clinch, Olweny, 1996) *)
	Patient's subjectively perceived impact of his or her illness on their everyday life, somatic functioning, psychological and social functioning and well being	(Reflection paper, 2005) *)
Functioning and well-being	Multidimensional construct including somatical, emotional, psychical, social and behavioural components of well-being and functioning as perceived by patients and/or individual patient feelings related to health	Ravens-Seiberer, Gosch, Abel, et al. (2001)
State of health	An individual's state of health as a continuum with increasing complexity of patients' outcomes; it can be assessed on five levels: biological/physiological factors, symptoms, functioning, perceived overall health and total well-being or quality of life	Wilson, Cleary, (1995) *)
State of health and perceived feelings about the state of health	It is a combination of state of health and affective reactions to problems with health	Vogels, Verrips, Verloove-Vanhorick et al. (1998); Fekkes, Theuissen, Brugman et al. (2000); Rosenfeld, Goldsmith, Tetlus et al. (1997)
A component of health	A component of overall quality of life primarily determined by an individual's health and can be affected by clinical interventions	Mishoe, Baker, Poole et al. (1998); Juniper (1997)
Value assigned to life	The value assigned to life during its course as modified by impairments, functional states, perceptions, and social opportunities that are influenced by disease, injury, treatment or policy	Feeny, Furlong, Boyle et al. (1995); Patrick, Erickson (1993); Furlong et al. (2005) *)
Life satisfaction	The level of personal satisfaction with the life aspects that can be influenced by disease impact and its treatment	(Brouwer, Maillé, Rovers et al., 2005) *)

Explanatory notes:

*) Quotations marked with an asterisk were supplied to the original Davis et al. overview by us.

Just taking a short glance at Table 1 suggests that authors usually perceive HRQL as the influence of a disease on an individual's functioning, on various aspects of their lives, on their state of health, on health and components of life as assessed by the individuals themselves.

Empirical research participating authors do not devote their time to discussing

its theoretical basis and various ways how to define it, as we found out for ourselves in empirical research works on quality of life in Czech and Slovak juvenile patients (Mareš, Marešová, 2006).

Taking into account the facts given, the renowned research worker M. Rapley (2003, p. 140) recommends using the definition formulated by the American Disease Prevention and Treatment Centre. Further, he calls attention to the fact that HRQL as a scientific category is suitable for use not only on the individual level, but also for groups of people and even for whole populations.

HRQL includes the aspects of the total quality of life which can be clearly related to being health influenced, both by somatical health and mental health. It is perceived somatic and mental health, including further factors of influence like health hazards and conditions, functional state, social support and socioeconomic status. On the community level, HRQL includes resources, conditions, health policy and practical procedures that influence a population's perceived health and its functional state (Centers, 2000).

HRQL in Clinical Branches

Health-related quality of life is a significant component of medical and nursing care and its apt quality indicator. This fact is utilized both in clinical experiments (Fayers, Hays, 2007), and in clinical practice.

Russak, Croft, Furst et al. prepared a basic thesis review for clinical applications (2003, p. 575- 577).

HRQL importance for clinical experiments:

- Data on patients' quality of life collected from the questionnaires filled in by patients in clinical experiments can show changes in their state of health as effectively as a physical or clinical examination.
- Health-related quality of life data discriminate better active therapy effects from placebo effect than using joint controls.
- Methods used for finding about health-related quality of life should be included in the set of methods used for assessing clinical experiments.

HRQL importance for clinical practice:

- Methods used for finding about a patient's health-related quality of life bring information important both for the doctor and for the patient
- Multidimensional questionnaires finding about a patient's health-related quality of life yield further information not available from traditional questionnaires.
- Data outcomes brought by the methods investigating a patient's health-related quality of life represent significant predictors of a patient's functional state, health care costs, work absence and premature mortality.
- Methods finding about a patient's health-related quality of life are reliable and valid for group diagnostics of patients.
- Methods finding about a patient's health-related quality of life can help improve the health care documentation for the care provided to the patient.

Jenkinson et al. (1993) explicitly notes the following possibilities:

- Methods finding about a patient's health-related quality of life allow for quality monitoring of the care provided to the patient.
- They improve the doctor-patient interaction.
- Generic methods allow for comparing treatment effectivity in different diseases; in other words, they help compare quality of life improvements while being used in various patient groups and so help in deciding about treatment focus priorities.

Paradox as a Term

People intuitively understand paradox as a term. They perceive it as something that contradicts their common sense. In ancient Greece and Rome, paradoxes were logical tricks of mind – carefully thought out statements leading to contradictions. Later on, a paradox was a controversy between two statements, which were both based on factual or logical proofs; nevertheless, as a whole, they could not be valid both at the same time.

The term *paradox* in our study will be used to describe an unexpected or peculiar antagonism in that part of quality of life which is related to health and five of these antagonisms shall be presented here.

HRQL Paradoxes

The paradox hidden in the title. The term definition (health-related quality of life) both in original works and their Czech translations^{1*)} says unambiguously that it is related to the health of an individual, a group or a population. As a matter of fact, it is a well-established description, which is, however, not very accurate, as far as the dominating research subject is concerned. As a rule, authors are interested in the quality of life in people suffering from some kind of a disease (Veenhoven, 2000; Mareš, Marešová, 2005). In other words, HRQL measures are predominantly the measures of *negative* health (Veenhoven, 2000).

European medical institutions also hold this opinion when they state that HRQL represents a *patient's* subjective perception of their *illness* and its treatment influence on their everyday life, somatic, psychological and social functioning and their well-being (Reflection paper, 2005). The official definition by the American Ministry of Health and other institutions dealing with quality of life clinical research states: HRQL is a term covering many area – it is multidomained. It expresses a patient's overall perception of how the *illness* and its treatment influence their health. It depicts a patient's functioning at least on three levels – somatic, psychological (including emotional and cognitive one) and social. (Guidance, 2006, p.31).

One of the exceptions truly accentuating the category of health is the definition by Lindström and Kohler (1991), which understands HRQL as total being (overall existence) of an individual or a group, including numerous positive health aspects.

^{1*)} Quality of Life: as related to health (Sláma, 2005), from health point of view (Křivohlavý, 2002), influenced by health (Hnilicová, 2005), health-conditional (Kalová, Petr, 2004; Bukertová, 2006), concerning health (Vadurová, 2006), related to health (Džuka, 2004; Mareš, Marešová, 2005; Sláma, 2005).

Health Impairment Positive Effect Paradox. Research studies have shown that ill people state the same or even a higher quality of life than healthy people. One of the first researchers to identify this phenomena was Cassileth et al. He found that five patient groups suffering from a chronic disease (arthritis, diabetes, oncological diseases, kidney failure and dermatological disorders) were unexpectedly *not* different in the perceived quality of life from the surrounding healthy population. His study outcomes suggested that psychological adaptation in chronic patients to living with their disease is extraordinarily efficient and, in fact, independent from the type of the chronic disease (Cassileth, Lusk, Strouse et al., 1984).

Similar findings were observed by Albrecht and Devlieger (1999) in patients suffering from spinal cord impairments, cerebral palsy, orthopedical impairments, multiple sclerosis, HIV/AIDS, chronic obstructive lung disease, diabetes and chronic pain. They asked themselves a question – why do many people seriously ill or with a long-term health impairment claim that their quality of life is good or excellent, when most *outside observers* would consider their everyday life hard and certainly not desirable? To describe the discrepancy between the objective proofs of a serious diagnosis and its grave impacts as seen by the outside observers, including health care professionals on one side and by the subjective high rating of quality of life by those with serious diseases on the other side, Albrecht and Devlieger chose the term *disability paradox*. Although there were partial objections to the term (for example Koch, 2000; Albrecht and Devlieger, 2000), it was coined.

Nowadays it is used not only in people with a *disability*, but it is also used in people with a serious disease. Let us mention a recent study in women after a myocardial infarction. Their indicators were lower in the somatic domain and they were less satisfied with their state of health, but their quality of life was no different from the psychological and social domains observed in healthy women population (Norekvål, Wahl, Fridlung (2007).

The above mentioned discrepancy of the positive effects of a disease can be, according to Albrecht and Devlieger, explained by the theory of balance. Many people who are seriously ill are able to balance the somatic, psychical and spiritual components of their life. They are also helped by the positive influence of the surrounding environment, no matter whether the environment is natural or social. On the other hand, seriously ill people who claim that quality of their life is bad, are not able to create such balance and/or they are not helped by the environment.(Albrecht, Devlieger, 1999).

So far, our comparisons were based on ill people and healthy people commenting on their quality of life. The question is: what is the situation like if we compare how the ill individual views himself or herself and their doctor's point of view? In some cases, we find out that objectively ill people (aware of their illness) feel quite all right. Old people after femur neck fractures belong to the group stating palpable improvement in quality of life, although objective examinations showed they should be having problems. The authors hold the opinion that this finding shows how important *subjective factors* are in assessing therapy quality and their influence on HRQL assessment. A successful therapy that can be objectively documented is not primary and decisive for a patient-stated improved quality of life (HRQL), whereas subjective assessment is (Papadopoulos et al. , 2007).

Successful Treatment Difficulty Paradox. An objectively cured individual sometimes encounters various difficulties as 'going back to normal' is not easy and can mean complications. Wilson et al. (Wilson, Bladin, Salin, 2004) observed epileptic patients after a surgery (temporal lobectomy), which removes the cause for epileptic attacks. She found out that the outcome is a paradox situation: the cured patients did not view this fact as a purely positive event and they mentioned problems that complicates their everyday life they had been adapted to. The problems overview is seen in Table 2.

Tab. 2 Clinical demonstrations of the 'burden of normality' (modified according to Wilson et al., 2004, p.19)

Psychological Aspects	Behavioral Aspects	Emotional Aspects	Social Aspects
Missing one's illness	Celebrating new freedom	Mood improvement and feeling of being cured	Changes in family relationships and in established ways of family life
Growing expectations by the patients themselves and by their environment, too	Excessive activity: in body movements and sports, at work and social one, too	Deeper anxiety states	Inclinations to rebel against excessive mothering
Trying to catch up with the 'time lost'	Increase in sexual activities	Depressive states with psychotic spells	Higher inclinations towards divorce
	Inclination to higher alcohol and drug consumption	Higher probability of post-surgery treatment in psychiatric wards	Difficulties in finding new job perspectives
	Sleep deprivation		Difficulties in adopting new social skills necessary for 'new life'
	Disobeying medical advice given by the doctor after the surgery		

Table 2 shows that patients are likely to have problems at least in four areas: psychological, behavioral, emotional and social one. As a result, they miss the time when they were ill, which is totally incomprehensible for the people around them.

Positive Posttraumatic Effect Paradox. Going through a very serious disease can improve an individual's life truly significantly in comparison with the time when they were healthy. As it can be seen here, a serious life event does not only have to bring negative impact. Positive impact on the individual can be observed immediately or after some time and he or she can rate their quality of life higher than in the time before the illness or trauma.

There are several descriptions and theories dealing with this paradox in more detail, for instance *perceived benefit* (Calhoun and Tedeschi, 1991, McMillen, Fisher, 1998), *flourishing* (Ryff and Singer, 1998), *positive illusion* (Tailor, Brown, 1988), *adversarial growth* (Linley, Joseph, 2004), *stress-related growth* (Park, Cohen, Murch, 1996) or *posttraumatic growth* (Tedeschi, Calhoun, 1996, Calhoun, Tedeschi, 2006). Most authors in the recent review monography (Calhoun, Tedeschi, 2006) tend to use the last term in the listing.

Literature defines posttraumatic growth as a significant positive change in an individual's cognitive and emotional life, which can also be manifested outwardly by changes in the individual's behaviour. By the growth here we mean such a change that takes the individual above their original level of adaptation, psychological functioning and life perception (Tedeschi, Park, Calhoun, 1998, p. 3). Moreover, by growth we mean both the process and its outcomes, which can manifest months, years or even decades later.

Posttraumatic growth is probably the result of an individual's attempts for a psychological survival; it can coexist with residual distress caused by the trauma (Tedeschi, Calhoun, 2004, p.5). In other words, the existence of posttraumatic growth does not mean that an individual's pain or other distress disappear. As a rule, it is not accompanied by changes in the individual's view on the crisis, loss or trauma itself as on something desirable. Serious life events themselves are not considered favourable, necessary or welcome – only the certain good originating from them takes a positive form (Tedeschi, Calhoun, 2004, p.6-7).

Hobfoll et al. (2007) suggests that the **real** posttraumatic growth should be defined not only as a cognitive process or an intellectual exercise leading to event reframing, but also as salutogenesis taking form of an *active development*. Individuals put into practice their ideas about the event benefits or make their illusions concrete via an action. So, it is not sufficient if looking for a new sense in a trauma is only cognitive. If no complementary action or deeds follow, it can result in negative consequences. People are more likely to take a concrete action after a crisis in health.

Petty events or common illnesses are not enough to start changes for better. The set of unfavourable factors must represent a serious threat to the individual's life up to date to make a positive change possible (Tedeschi, Calhoun, 2004; Janoff-Bulman, 2006). The key element in defining whether the change has actually taken place is a destruction or wrecking of their life up to the event; people talk about what their life was like 'before' and 'after'. If posttraumatic growth is to take place, the individual must be put under severe distress. It is possible to speak about a 'minimum dosage' here. On the other hand, if the dose is too high, it will not aid growth as it, among many other things, disturbs cognitive mechanisms necessary for an individual to process the event (Calhoun, Tedeschi, 2006). Based on what is said above, growth happens if trauma impact on the individual remains within a certain optimum scope.

Adult research states that posttraumatic growth is not universal experience and does not influence all people who were subject to a traumatic event. Posttraumatic growth prevalence seems to have two peaks – at 30-40 % and at 60-80 % of the population in research. Occurrence depends on (excluding trauma types, personality diversities and social environment) the diagnostics method used, and thus on the growth defining domains and on the limit which was set as a marker of a change for better.

Ethnic Minority Health Paradox. Based on common assumptions, the state of health is determined by four main factors – biological factor (genetically influenced; immunity), by individual styles of life (healthy or unhealthy life style), by the environment (health-supporting or harmful) and by the health care access and its quality. In the last twenty years, there has been growing empirical evidence of sociocultural influences as well.

As early as in 1986, Markides and Coreil stated that Hispanic community in the USA (especially the first immigrant generation) shows on average signs of better health than the majority Caucasian population. According to Moralese et al. (2002), Hispanics:

- on leaving Mexico, they lose the social support system they enjoyed while still living there
- they have a lower socioeconomic status as opposed to majority society
- language and cultural barriers complicate their access to necessary social service
- health care access is very difficult
- they are not likely to have health insurance coverage
- acculturation can lead to greater stresses and significant problems in the psychosocial sphere
- young Hispanics often report discrimination because of their origin

Despite all the above mentioned facts, their state of health is better than in majority population (measured by morbidity and mortality) and their perceived quality of life is higher.

This phenomena is called *Hispanic health paradox* (Markides, Coreil, 1986). Though, at the moment, there is no widely accepted single interpretation, there are several hypotheses. One of them claims that Hispanics are better at stress-related coping than majority community, use more suitable strategies, have lower life expectations and receive greater social support in their wide families.

Studies in African American population show similar ethnical diversities. For instance, Ohldin and colleagues (Ohldin et al., 2004) carried out an extensive research in Vietnam war veterans. She was interested in the veterans who suffer from ischemic heart disease and are treated in outpatient wards. She stated that although there is a bigger number of cardiac risk factors and significantly lower satisfaction with ischemic heart disease treatment, in quality of life in ill veterans there are remarkable differences between African Americans and Caucasian majority. When processing the collected data and after adjusting it for the original state of the disease, education, marital status, personal income, comorbidity, smoking and place of residence, African American veterans still reached more favourable figures in physical functioning, perceived bodily pain and vitality; they showed worse outcomes in emotional functioning. Their ischemic heart disease was more stable and their state of health deteriorated less often.

Conclusion

This review study characterized the term *health related quality of life* (HRQL). Based on a work by Davis, Waters, MacKinnon, 2006 it described in detail 14 diverse approaches to defining the term. Our study showed that this term is useful for clinical experiments and it is especially suitable for clinical practice. It enables us to assess living with an illness from the patient's point of view, and not only as it is seen by doctors, nurses and other helping professionals. We learn how patients perceive intervention effects and how they assess their own efforts. The means used for this process are procedures collectively known as *patient-reported outcomes measures*.

However, the study did not focus on individual instruments used for assessing quality of life. It was interested in those specific cases when the reported outcomes were contradictory to what both professionals and wide public anticipated, sometimes even contradicting common sense. The study gathered and described five paradoxes of this kind: the paradox included in the term HRQL itself, health impairment positive effect paradox, successful treatment difficulty paradox, positive posttraumatic effect paradox and ethnic minority health paradox.

Apparently, while investigating the quality of life which is seemingly strongly biologically and somatically determined (HRQL), we find out that psychological, social, cultural and ethnic factors play a very significant role. Should these factors be disregarded, then professionals striving to help their patients might take the wrong path of oversimplification and will not be able to understand the paradoxical effects of an illness, impairment, trauma or other handicap.

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QUALITY OF LIFE ISSUES - BASED ON PREVIOUS RESEARCH RESULTS

Oliva ŘEHULKOVÁ, Evžen ŘEHULKA

Quality of life is a very frequent topic in contemporary research and it can bring new and interesting results to various research areas. This category has a lot of advantages for practical psychological research: it is interdisciplinary, it has an objective and subjective side and is richly interpretable.

Initial debates on quality of life started probably in economics in the twenties of the last century; it was discovered in well-developed states that the indicator of well-being and welfare is not only a plenty of consumption goods but a subjective experience of current conditions with decisive personal cognitive and emotional appraisals. By means of sociology the term ‘quality of life’ came in medicine; here keeping adequate quality of life has become an important aim e.g. in geriatrics, psychiatry or oncology (Hnilicová, H., Bencko 2005). Křivohlavý (2002) quoted the work published by A. L. Strauss in 1975; he considered it to be one of the first monographies dealing with quality of life; the work was focused on assessment of quality of life of chronically ill patients and seniors. Here the care was aimed not only at keeping alive but mainly at providing for dignified and meaningful life directed to experience of human happiness and well-being. Those propositions were embodied into a stimulating program also for psychology; consequently psychology of health and positive psychology have been developed in related intentions.

Paradigm for researching quality of life has been changed in our contemporary world in a certain way because of shifting an interest from ill people to healthy individuals. Therefore it is not studied how seriousness of disease can reduce life capability of an individual but a view is preferred on the people who are healthy and can go through their life more completely, more intensively, more meaningfully i.e. in a higher quality.

However, quality of life is not, unfortunately, specified exactly, due to its interdisciplinary character and various methodological approaches to its interpretation and investigation. In such situation we consider the concepts of the World Health Organization (WHO) to be the most suitable, although they can be also debatable sometimes but they offer relatively the most frequent interpretation facility for professional communication.

Here it is necessary to start with the known definition of health by WHO: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity“. By D. Seedhouse (1995) health of a certain human being is closely connected with quality of his/her life. In 1996 WHO stated that “quality of life is defined as an

individuals' perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns". In the newest materials of WHO "Health 21 – Health for all in the 21st century" quality of life can be seen in feelings of individuals or groups of citizens that their needs are satisfied and that they are not put off from opportunities to reach happiness and life fulfilling. Comprehensiveness in understanding "quality of life" can be well seen in the document of WHO Quality of Life Group (1993) quoted by J. Mareš, J. Marešová (2004) and J. Mareš (2006); the authors emphasise that quality of life reflects an individual perception and complete subjective evaluation of own position in relation to a given culture, values and future expectation in this direction; quality of life comprehensively includes somatic health, mental status and also social relationships. When working with quality of life we must be aware that it is not a synonym of „health status“, „living satisfaction“, „mental status“ or „personal well-being“.

We can see that in general quality of life is an experience, a lived-through relationship and reflection of own existence. Many theories and models of quality of life often work also with spiritual dimension and pay attention to relevance of spirituality. Here we would like to mention D. Kováč (2001, 2004) who created his model of quality of life with three levels:

- 1) Basally-panhuman level of quality of life
- 2) Individually-civilisational level
- 3) Cultural-spiritual level

Those three dimensions are controlled by a meaning-of-life-factor; the author interpreted this factor as follows: „Meaning of life being found and being developed is a top psychic regulator of individual components of quality of life and it is also the most effective source of permanent satisfaction with the individual's life, an origin of continuing well-being; it is a platform where moments of happiness can also appear sometimes“ (D. Kováč 2007).

Such listing of theoretical concepts of life could be more elaborated but our study is not targeted at this overview; in the above mentioned paragraphs we would like to introduce only basic ideas essential for our results given below.

x x x

In the last about five years we have dealt with quality of life of healthy people and the studied people were usually teachers and women teachers respectively. We paid our research attention to this profession from psychological viewpoint (see the list of literature at the end of this article). This view proved to be very interesting and we suppose that it could bring some new information for understanding this profession, previously discussed in a few works (J. Průcha 2002). We focused several investigations on understanding quality of life of adults (O. Řehulková, E. Řehulka 2006).

Here we would like to present our results and summarize them in more general conclusions. Our investigations were often specific in relation to investigated persons (hereinafter IPs) because we used respondents participating in teaching, training or lectures that dealt with quality of life issues (e.g. lessons on psychohygiene or psychology of health); our IPs were oriented in the basic issues, which had to be taken into account by making conception of the research and interpretation of the results.

x x x

In our first attempt (E. Řehulka, O. Řehulková 2005b) we chose a simple analysis of free texts; IPs were asked to describe their own quality of life, based on their information on quality of life issues. Each of them worked with one A4 piece of paper in time interval of 40 minutes maximally (the average time used was 28 minutes). IPs were here separated in four groups differing by age.

1. group: students of Faculty of Education and Faculty of Medicine in the age from 18 to 28 years (46 respondents)
2. group: graduates of high schools and universities, employed in school and health care systems in the age from 29 to 45 years (56 respondents)
3. group: graduates of high schools and universities, employed in school and health care systems in the age from 46 to 60 years (31 respondents)
4. group: U3A students, graduates of high schools and universities in the age from 61 to 70 years (26 respondents).

All respondents, i.e. 159 IPs (110 women and 49 men) were quite well-grounded in basic quality of life issues, therefore we expected a certain informed self-reflection from them in this direction. Overall the respondents were currently in a good health status, so they were not limited in working performance or in spending leisure time.

The obtained written materials were analyzed by three psychologists; they evaluated the content of reflections of own quality of life by using the scale with seven degrees between the following polarity categories:

Future	versus	Past times
Large self-reflection		Small self-reflection
Responsible verbalization		Lax verbalization
Certainty		Uncertainty
Activity		Passivity
Contentment		Discontentment
Systematicness		Accidentalness
Orderliness		Disorderliness
High self-criticism		Low self-criticism
Strong self-confidence		Weak self-confidence

In our evaluation the results showed that in the given dimensions the following trends can appear from the aging point of view, as indicated by describing his/her own quality of life:

From future	To past times
From small self-reflection	To large self-reflection
From lax verbalization	To responsible verbalization
From certainty	To uncertainty
From activity.	To passivity
From discontentment.	To contentment
From systematicness.	To accidentalness
From disorderliness	To orderliness
From low self-criticism	To high self-criticism
From strong self-confidence	To weak self-confidence

Then we can say that by describing his/her quality of life, the younger IPs are more focused on future times, the older IPs are more directed to the past; a small self-reflection is characteristic for the younger IPs and a large self-reflection of the older IPs can be seen; the older IPs formulate their thoughts more responsibly and use more general terms in comparison with the younger IPs who are in their expressions more certain; the younger IPs express more indicators of activity by describing their quality of life in comparison with the older IPs who demonstrate far less activity; the younger IPs are discontent with their own quality of life in larger measure than the older IPs; the younger IPs look after a certain plan for quality of life whereas the older IPs see more accidentalness; but the younger IPs are not able to organize their life facts as the older IPs do; the older IPs are, in comparison with the younger IPs, more self-critical and they have a weak self-confidence while the younger IPs characterize their own quality of life with a stronger self-confidence.

The discovered trends can be understood as a common characteristics of self-reflection; they need not be valid individually but we suppose that the trends enable the interpretation by which the description and perception of own quality of life is influenced by age and certain relationships can be found here. So we can state that quality of life changes with age.

x x x

Our next experiment (E. Řehulka, O. Řehulková 2005b) was aimed at an attempt to express quality of life by means of a relatively exact formula.

We worked with the same set of IPs. After one lecture we asked participants to evaluate their quality of life by using integer numbers from 1 to 10. Consequently we prepared simple clinical discussions guided by the authors, physician or nurses. By means of those discussions we obtained information on whole health, mental and social statuses of IPs and on possible psychosomatic complaints, which was again evaluated by using the same scale. Then we informed individual participant on the results that were discussed briefly. Finally we asked IPs to evaluate that “objective“ information by using the above mentioned scale according to their subjective importance.

In this way we obtained three types of data:

1. subjective own evaluation of quality of life (QoLs)
2. objective data on quality of life (QoLo)
3. whole subjective view after interpretation of QoLo (QoLo/s)

The data were processed by using the following formula:

$$\frac{\frac{\text{QoLo} + \text{QoLo/s}}{2} + \text{QoLs}}{2} = \text{QoL}$$

We suppose that this simple mathematical expression can appropriately show subjectivity of quality of life category but besides, it takes into account as a whole also health, mental and social statuses of IP.

If we had shown the results of this research part, they would seem to be vague in essence, but they could be taken also interesting in this direction. Age groups proved to be

almost identical in sense of statistical significance in the values obtained by using the above mentioned processing, i.e. the age is not the factor to determine quality of life directly if it should be expressed quantitatively.

Still, it is evident that quality of life changes somehow with age and it is possible to suppose that the changes are qualitative, or in other words the structure of quality of life and its individual components go through changes with age, which was demonstrated in the previous project.

X X X

In another research we dealt with development of quality of life, again for teaching profession (O. Řehulková, E. Řehulka 2007b). The research was realized with participants of several one term courses specialized in psychohygiene. Our IP set was formed from 148 women teachers of elementary schools, 31 women - students of teaching and 14 women teachers - students of U3A. We used a simple questionnaire to get information on working load volume that was split as follows:

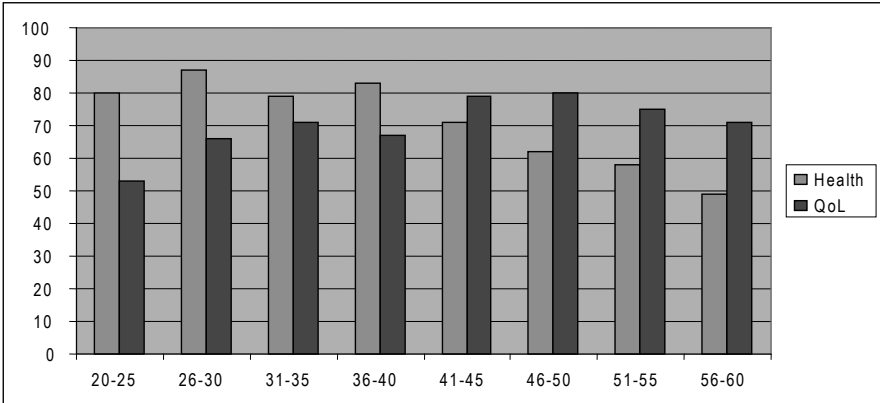
- a) positive load (tasks that are accepted willingly, IPs understand work difficulties and they dare to cope with them with a certain effort and strain; accomplishment of those tasks evokes satisfaction, IPs consider the tasks to be a part of personal improvement)
- b) negative load (tasks that must be fulfilled but they are considered useless, getting-down, noncreative and dull).

For evaluation of subjective health status we used Symptomatology Inventory (E. I. Kasielke, S. Möbius, Ch. Scholze), for assessment of quality of life the method SEIQoL was applied.

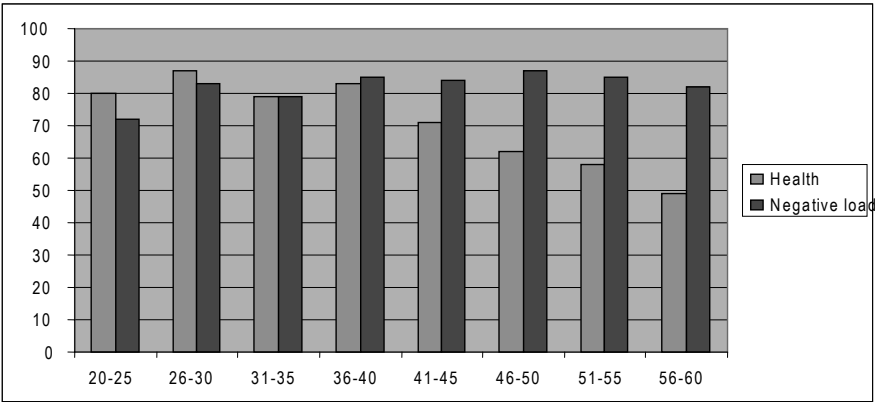
The SEIQoL methodology (O'Boyle, McGee, and Joyce, 1994) is based on a structured discussion in which IP must define five life goals, efforts or values (the so called cues) that he/she consider to be the most important for himself/herself. For each of those five goals their "importance" must be given (the sum for of all five cues must be 100%) and "extent of contentment" (for each cue it is from 1 to 100). Simple arithmetical processing gives the numeric individual value of quality of life. In our country this method was introduced and interpreted by J. Krivohlavý (2001).

Example:		
IMPORTANCE	LIFE GOAL, VALUE, CUE	CONTENTMENT
15%	e.g. career	80%
25%	family	95%
10%	money	70%
20%	knowledge	75%
30%	self-realization	70%
Σ 100%		from 1 to 100%
EVALUATION:		
In each line multiplication of "importance" times "contentment", the products are added and divided by 100		
EXAMPLE:		
sum of five products is 7875 divided by 100 is Qol 78,75		

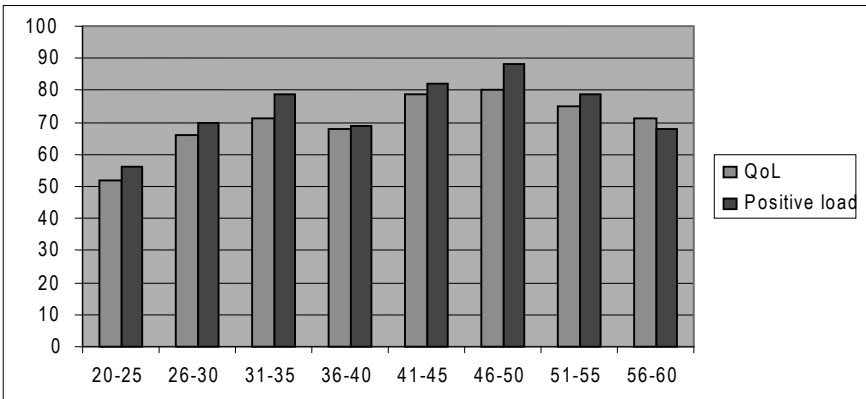
Obtained results were divided by age criterion (IPs in quinquennial age groups) and are displayed in the following tables.



Tab. 1 Relationship between self-evaluation of health status and QoL by age groups



Tab. 2 Relationship between self-evaluation of health status and negative load by age groups



Tab. 3 Relationship between self-evaluation of health status and positive load by age groups

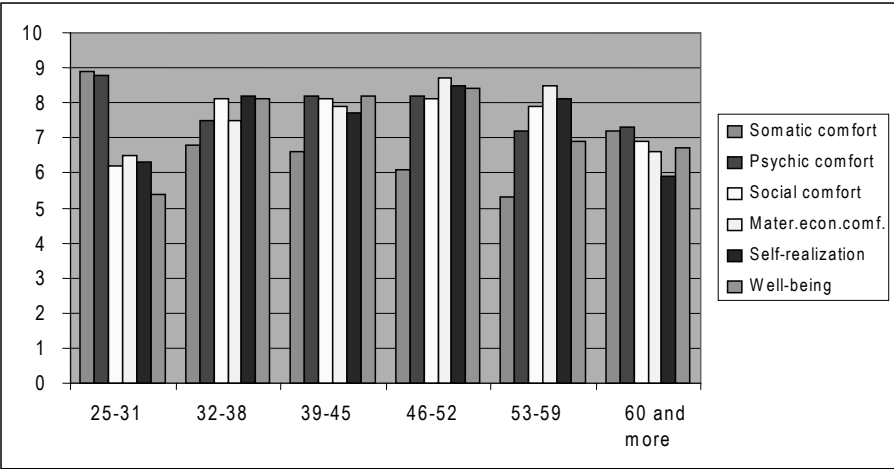
If we try to formulate some conclusions from the above given graphs we can say that quality of life of our IPs has increased in their higher age while their self-evaluation was getting worse, negative load was on increase for IPs of higher age and their positive load resulted in increasing quality of life.

x x x

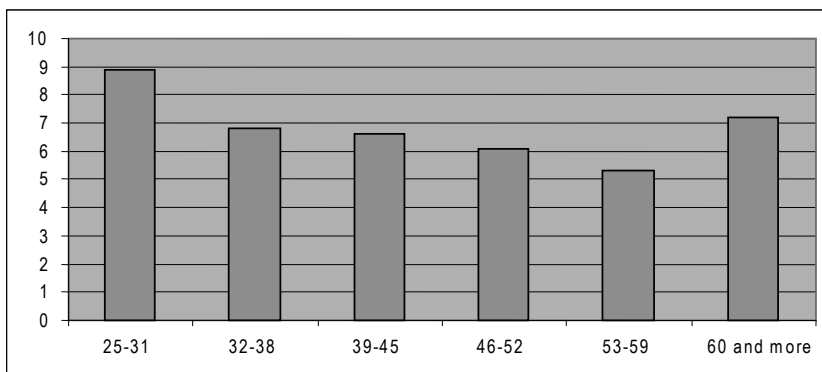
While continuing our quality of life research (E. Řehulka, O. Řehulková 2007) we returned to the theme of quality of life structure because we proceeded from our previous findings that quality of life is not usually changed by aging but its structure is changed. Based on various theoretical concepts on quality of life and our previous studies of the so called healthy personality (E. Řehulka 2000, 2006) we formulated the following components of a quality of life construct:

- Somatic comfort
- Psychic comfort
- Social comfort
- Material-economic comfort
- Level of self-realization
- Experiences of well-being, joy and happiness

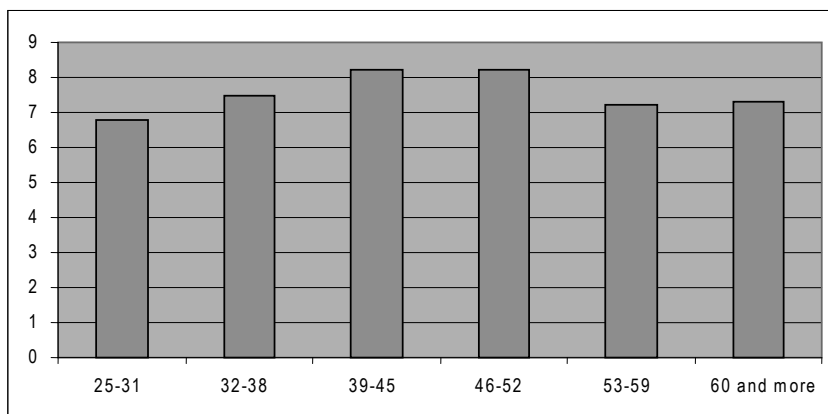
By this concept we designed a non-standardized questionnaire for the mentioned quality of life structure, with scaled answers. By using this method we examined 519 elementary school women teachers in the age from 25 to 63 years. The obtained results are displayed in the next tables.



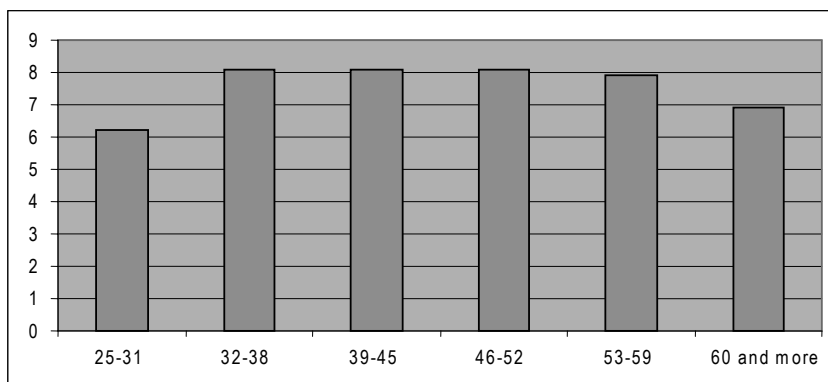
Tab. 4 Development of QoL in individual components



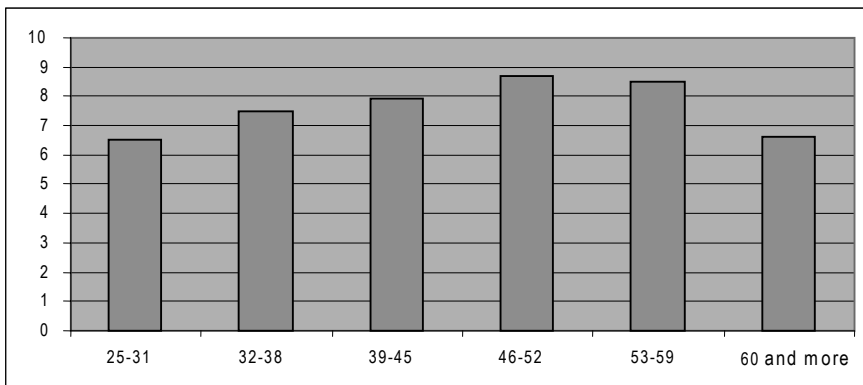
Tab. 5 Somatic component of QoL



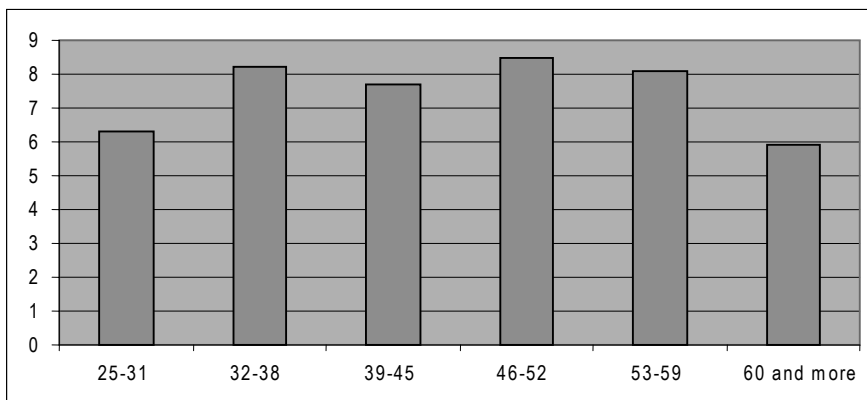
Tab. 6 Psychic component of QoL



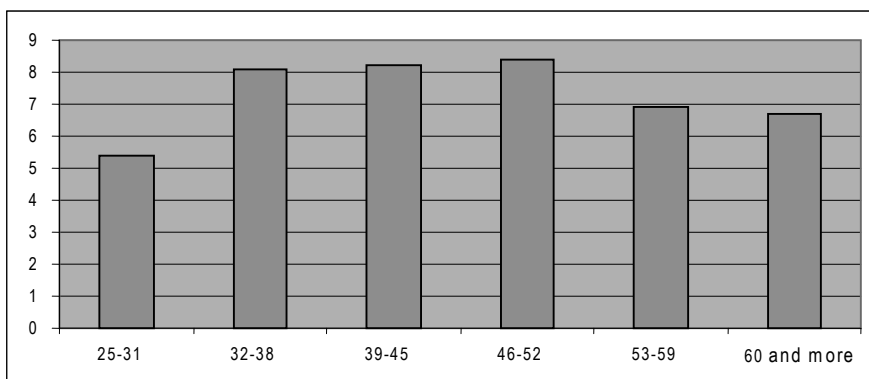
Tab. 7 Social component of QoL



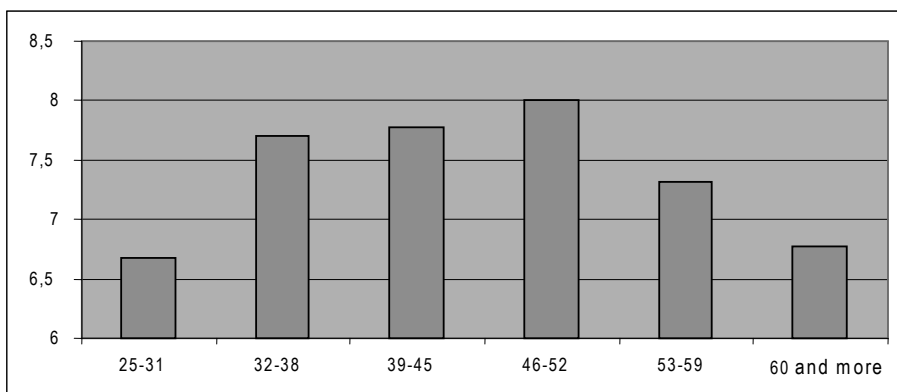
Tab. 8 Material-economic component of QoL



Tab. 9 Self-realization as QoL component



Tab. 10 Well-being as QoL component



Tab. 11 QoL during professional development

These tables demonstrate that individual components of quality of life are developed differently in the course of a teacher's professional life and his/her quality of life culminates generally in the second half of life. The course of the overall quality of life is most closely connected with those components of quality of life that we characterize as "psychic comfort" and "material-economic comfort".

x x x

Here we would like to continue with more concrete information obtained from the SEIQoL method that we used as characterized above. Now we bring more detailed results based on using this method (E. Řehulka, O. Řehulková 2003). 43 women teachers were investigated by the SEIQoL method. This set of IPs was formed randomly; usually the IPs participated in some of educational courses for teachers where the authors were in the role of lecturers. The youngest woman teacher was 27, the oldest one 56, the average age was 36.2 years. All of them had passed five-year practice minimally, the average time of practice was 16 years; in time of our investigation the IPs worked actively and nobody of them was aware of more serious health problems. The investigation was performed in the year 2002 and the results are summarized in Tab. 12.

Cues	Frequency (f) /	Importance	Contentment
1. health	43 / 100	24,2	72,6
2. family	30 / 69,7	28,6	72,5
3. happiness	25 / 58,1	15,7	45,6
4. children (own)	24 / 55,8	27,2	77,1
5. partner relationships	16 / 37,2	13,1	45,6
6. money	13 / 30,2	22,7	30,0
7. love	11 / 25,6	18,6	54,5
8. freedom, independence	11 / 25,6	12,1	62,7
9. friendship	9 / 20,9	19,4	67,7
10. serenity, well-being	8 / 18,6	16,9	47,5

11. work (at school)	5 / 11,6	16,1	76,1
12. sex, erotic	5 / 11,6	12,2	70,0
13. production, creativeness	4 / 9,3	13,8	67,5
14. meaning of life, being	4 / 9,3	10,8	55,0
15. culture (participation)	3 / 6,9	13,3	73,3
16. parents (care for them)	2 / 4,7	27,5	75,0
17. career	2 / 4,7	22,5	75,0
			Ø 62,8

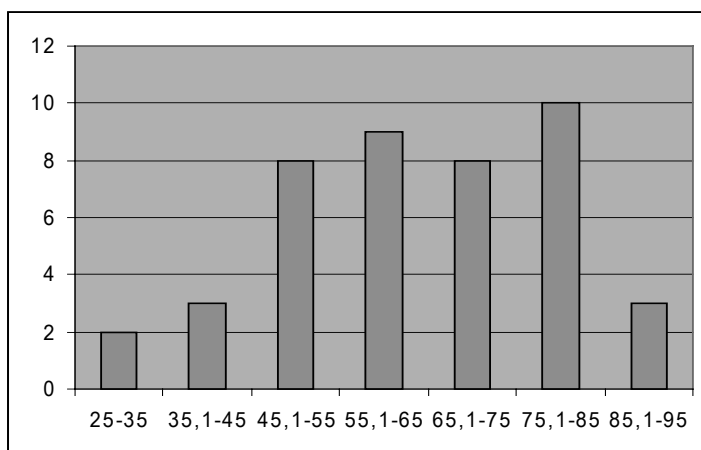
Tab. 12 Quoted life goals in the SEIQoL method - for women

First of all, 17 life goals (cues) were detected; among them “health“ was quoted by all IPs (100%). Then “family”, “happiness”, “own children” etc. follow, see Tab. 12. The first ten quoted life goals can be characterized as common or egocentric goals because they are related only to personal feelings of well-being. Pedagogical work as a life goal took only the 11th position.

If we observe importance of individual life goals, we see that more than 20 points is assigned to the life goals “health”, “family”, “own children”, “money”. Then “care for parents” and “career” were also mentioned - only by two IPs . Relatively least importance was assigned to “freedom, independence” and “sex and erotic”.

When we watch in Tab. 12 how our women teachers are satisfied with realization of their life goals, we can see their highest contentment with “own children”, another interesting fact is that the next high value belongs to “work at school”. It can be said that the IPs, who indicated “work at school“ as one of their life goals, consider this work important. Relatively high values are for average contentment with “health”, “family”, with “participation in culture” and with “sexual life” - the last life goals were mentioned only by several respondents. The lowest but evident discontentment is with “money”, which is a rather expectable result characteristic for our school system.

Distribution of individual results of quality of life of our IPs is displayed in Tab. 13. The most IPs (10) reached numeric value of quality of life between 75.1 and 85 points.



Tab. 13 Distribution of QoL results for women teachers

It is interesting to mention the resulting value of quality of life obtained by the SEIQoL method. In the following Tab. 14 we see, in comparison with the results of Irish researchers quoted by J. Křivohlavý (2002), that quality of life of our probed women teachers is significantly lower. Interpretation of this fact is not easy. Probably a certain role is played by a rather substantial load which is characteristic for teaching profession; but contemporary we must stated that the main life goals expressing quality of life of our IPs are more connected with their private life than with factors connected directly with their pedagogical profession. We can also speculate that the increasing quality of life – if it would be by increasing contentment – would refer to the values connected more with a certain personality than with working realization. In this sense we can understand the results as a confirmation of our assumption that a permanent cultivation and personal growth are basic factors for successful performance of teaching profession.

Results of Quality of Life Measurements			
	Average value	Permissible deviation	Volume
<i>Irish research</i> Healthy elderly people	82.1	12.2	47.3-100
<i>Irish research</i> Young people	77.4	9.5	52- 95.3
Our research	64.3	15.27	30- 92

Tab. 14 Results of QoL measurements

x x x

A lot of new knowledge on quality of life can be obtained by studying this category in community of adolescents (J. Mareš 2006, 2007); this view can also enrich information on this age group. Quality of life is perceived differently in adolescent age, in early adulthood, in middle and later age, especially before going to retirement - because the senior age has its specific features of quality of life when considering normal psychophysiological states and recognition of a special quality of life category of ill people.

We performed our research of quality of life for adolescents (O.Řehulková, E. Řehulka 2006), based on assumption that quality of life is in a very close relation with different development stages of each individual person. Quality of life is a multidimensional term and it is necessary to remind that it results in a subjective evaluation realized in a certain cultural, social and environmental context and so it is not identical with the terms “health status“, “life contentment“, “mental status“ or “personal well-being“.

Relationship between well-being and quality of life is often interpreted in various ways. Most often the personal well-being is taken as a part of quality of life. The term of “well-being“ can be also found in the known definition of health issued by WHO: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. Well-being can be also taken as a term which can connect a quality of life concept and a health concept.

In our concept, especially for research of adolescents, we paid attention to the following spheres:

1. HOW I AM HEALTHY objective quality of life - objective information on health status
2. HOW I LIVE style of life
3. HOW I FEEL MYSELF subjective well-being - current emotional evaluation of own life
4. HOW I EXIST subjective quality of life - individual cognitive evaluation and life experience from view of personal perspective

In the research of our respondents (number = 140; the age: 10 to 20 years; half-and half of boys and girls, all respondents were healthy) we used information from the basic health investigation, the questionnaire dealing with health complaints, the questionnaire on quality of life and data of methods used for getting information for the above mentioned four spheres. Besides that the SEIQoL method was used as characterized above.

The data on health status of adolescents are quite satisfactory. In our research set there were no IPs with a reduced working capability and the IPs' current health status gave no signs of problems, we did not register any serious health disorders. We found out only allergy well compensated by medicaments or light orthopaedic defects - consequences of sport activities without limiting mobility. Also components of mental health did not show more serious problems, maybe sometimes only a slight neuro-vegetative instability and several neurotic symptoms appeared (stage fright, light emotional instability, higher sweating etc.). Overall we can say that, in this quality of life dimension, the health status measure of our adolescents is in average 87%.

A more complicated picture appeared by investigation of the life style of the adolescents. Quality of the life style can be evaluated positively only for 55% of IPs. Very often the adolescents do not eat a proper diet, they are insufficiently informed on healthy nutrition components; if they have such information they underestimate them substantially. Harmfulness of alcohol is underestimated (the alcohol addiction was not proved in our IP set), and also tobacco smoking - 29% of IPs marked themselves as smokers, often only with a sporadic frequency; 62% of IPs indicated some experience with drugs but pathological drug addiction was not proved in our set. Considerable deficiencies are evident also in organization of work and relaxation; errors in that organization can be hidden, thanks to their compensation by a good health capacity. Work, relaxation and sleep are organized spontaneously according to random life circumstances, stress situations are solved incoherently, with an inappropriate contribution of energy and ineffective actions.

In contrast to that, the adolescents bring hardly themselves to admit negative aspects of their life and their subjective well-being is rather high, 73% by our method.

The adolescents see an existence experience of their own life mainly in more valuable social relationships, more stable emotional contacts with contemporaries, parents and teachers and particularly in finding better attachment to himself/herself. This question is for adolescence rather characteristic but in our research it seemed to be a factor decreasing quality of life. We suppose that quality of life of our adolescents is influenced in the present time negatively by low values of factors that could be called

spiritual; those factors are here characterized with absence of a concrete life plan, pursuit of stable development, with inclination to commercial values and simple material experiences, with naivety in searching for transcendent values. Here the subjective quality of life resulted in the average value of 51%.

In fact the results correspond also with the data obtained by the SEIQoL method used for quantitative evaluation of quality of life, which showed values about 65% in our research sample, without substantial differences by age and sex.

It is necessary also to note that, with exception of data on health, all other three dimensions of quality of life had a large dispersion for average values and for different measurement during the research.

1. OBJECTIVE QUALITY OF LIFE (how I am healthy).....	87 %
2. STYLE OF LIFE (how I live).....	55 %
3. SUBJECTIVE WELL-BEING (how I feel myself).....	73 %
4. SUBJECTIVE QUALITY OF LIFE (how I exist)	51 %

Tab. 15 Positive values of QoL components for adolescents

We can conclude that the value on health status is here high, as expected, while quality of life is very variable, most probably in dependence on a relevant social-psychological status, which is demonstrated mainly with qualitative analysis of the data. The variable values of quality of life of the young people can imply a certain danger because they can be later projected to health status changes. One proposal follows from this finding for education of adolescents - paying attention to adolescents' quality of life in this age period because their health status is not the only sufficient component. We should also deal with such issue, namely how quality of life, as a category of a largely subjective experience, could be influenced pedagogically, by self-education or by therapy.

Conclusions

- In the course of life, individual components of quality of life are developed differently.
- In the course of life, quality of life changes more qualitatively than quantitatively.
- In the course of life a conscious rational understanding of quality of life is growing, with occurrence of higher content of self-reflection and lower self-confidence at the same time.
- In average it is demonstrated that increasing quality of life of our respondents by getting higher contentment with their chosen life goals is accomplished by satisfying their own values connected closely to their individual personalities.
- From the life goals point of view, the most frequent cue seems to be "health" that is in average considered to be relatively very important for our IPs who are with their health in average quite satisfied.

- In self-evaluation of “healthy“ individuals during their professional life there is not basic correspondence between their health status level and quality of life level.
- Generally, quality of life of women teachers culminates in the second half of their professional development.
- The first and the last professional decades of women teachers are complicated from the quality of life point of view.
- The average value of quality of life seems to be relatively low for our women teachers in comparison with research results from abroad.
- Fluctuating values of quality of life found for adolescents can be a signal of a health peril in later age periods.
- The structure of quality of life can be characterized by features that can be influenced by education, self-education or by therapy.
- Thus, “quality of life“ can be (must be) advisedly influenced by suitable programs.

QUALITY OF LIFE VIEWED IN TERMS OF EMPIRICAL DATA

Jitka ŠIMÍČKOVÁ-ČÍŽKOVÁ, Bohumil VAŠINA

Introduction

From the psychological viewpoint, quality of life (QoL) is seen as a subjective phenomenon without general validity. This is why methods of determining quality of life are based on an individual's subjective perception of his/her quality of life, or the way in which the individual understands or defines QoL. One of the methods for representing this subjective perception is SEIQoL (Schedule for the Evaluation of Individual Quality of Life), which identifies an individual's QoL priorities.

The SEIQoL method is based on the identification of five areas that are of key importance for a particular individual because they give his/her life meaning and represent life goals and tasks. (Křivohlavý, 2001) Drawing on this conception, we are dealing with the 'basis' for the life satisfaction of an individual. Although there are certain changes in priorities during the course of an individual's life – affecting the priorities that form the core of the SEIQoL method – it appears that an individual's priorities measured by this method remain relatively stable compared with some situational factors. In addition to the factors presented by SEIQoL, there also exists a range of other factors that may exercise a current or time-limited influence over QoL by means of merely reducing or increasing the degree of an individual's experience and evaluation of QoL. These factors, which fluctuate over time, may influence the current experience of QoL as well as dynamicity and variability in its evaluation. These aspects are more clearly projected into the evaluation of overall life satisfaction and QoL using a second type of method: graphic and numerical scales which see QoL as a monolithic entity. Evaluation of QoL using a third type of method – offering the respondent choices from various goals and situations – may help the respondent to select answers, and it is highly probable that the goals/situations will include those from SEIQoL plus those linked with the respondent's current situation. This type of method is used e.g. in the WHOQOL questionnaire. However, a disadvantage of this method is the subjective way in which the respondent may be guided to select factors which are not currently important for him/her, and which would probably not have been chosen if the subject was not reminded of their existence. We expect that this type of method for evaluating QoL will incorporate the advantages and drawbacks of both of the other types.

Problem

This paper presents a comparison of various methods and techniques for diagnosing quality of life. We set out to answer this question: to what extent does the evaluated degree of QoL and life satisfaction depend on the method used to measure these variables? The following methods were examined:

- SEIQoL;
- Multi-item scales in which individual factors are named;
- Methods used for the evaluation of overall life satisfaction as a monolithic entity, on both graphic and numerical scales anchored verbally at the extreme points.

Another area of interest was the relation of evaluated QoL with other important factors, such as the subjective perception of the individual's state of health, evaluation of work-related stress, resilience against psychological stress, and social support.

Methods used

1. SEIQoL questionnaire, giving five life goals and stating the level of life satisfaction on a graphic scale (QLG) anchored verbally at the extreme points. The graphic scale is generally part of SEIQoL.
2. WHOQOL questionnaire – 30 QoL-related items. For each item, the respondent evaluates (on a scale of 0–6) the importance of the item and their satisfaction level with regard to that item. The resulting WHOQOL value is the sum of the scores for each individual item for importance and level of satisfaction.
3. One numerical scale used is part of the ŠSS set – the SS8 scale evaluating overall life satisfaction. This 7-point scale is anchored at extreme points.
4. A symptomatological questionnaire capturing health complaints (Kasielke, Möbius & Scholze). This study used the following scales: physical problems (FO), psychological problems (PO) and neurasthenic-psychasthenic problems (NP).
5. Evaluation of work stress (D. J. Abramis), including the following stressors: uncertainty roles (RN), internal conflict (KR1), external conflict (KR2), depression (DE), anxiety (UZ), anger (ZL), technical performance (TeV), social performance (SoV), application of creativity (Tvoř), personal satisfaction (SPOK), work stress (ZAT).
6. Hardiness questionnaire (S. Kobasa), including the following items: control – powerlessness (HCO), identification – alienation (HCM), challenge – threat (HCO).
7. Social support scale PSSS (J. A. Blumenthal), including the following: level of overall social support – SP, support from significant other – SPA, support from family – SPB, support from friends – SPC.
8. Work stress evaluation (HPZ) using a graphic scale (HFI) verbally anchored at extreme points (I feel no stress – stress is exceptionally high).

Data set

Data was collected using the available sample method. Completed questionnaires were used from 108 respondents. The respondents were female teachers at level 1 of primary schools.

Results

Table no. 1 shows the relation between the evaluation of QoL a) by using the SEIQoL method and b) by marking the importance of 30 items in the WHOQOL questionnaire. The connections were monitored on the basis of respondents' stated perception of their QoL level and the results of the numerical scale of the SS8 life satisfaction questionnaire. The table captures the closeness of the mutual relations expressed via Pearson's correlation coefficient. The correlations are relatively low (from $r=0.428$ to $r=0.117$). The level of significance is marked with asterisks. SEIQoL correlates on a statistical significance level of 0.01 with the graphic scale and WHOQOL. The relation between SEIQoL and the numerical scale is statistically insignificant. The graphic scale correlates significantly with WHOQOL and the numerical scale.

CORRELATION MATRIX OF RESULTS N = 104				
Variable	SEIQoL	Graphic scale	WHOQOL	SS8 numerical scale
SEIQoL	1.000	0.347**	0.333**	0.117
Life satisfaction (graph. scale)		1.000	0.204*	0.428**
WHOQOL			1.000	0.154

* $P = 0.05$ ** $P = 0.01$

Table no. 1 Correlation matrix of results N=104

Statistically significant relations to overall levels of health complaints (SDC), physical problems (FO), psychological problems (PO) and neurasthenic-psychasthenic problems (NP) were captured only using the graphic scale. The numerical scale correlates significantly only with neurasthenia and psychasthenia. The higher the level of life satisfaction, the lower the levels of these problems. The graphic scales are more sensitive to the respondent's subjectively perceived state of health.

QUALITY OF LIFE AND HEALTH COMPLAINTS Correlation matrix N = 104				
Variable	SDC	FO	PO	NP
SEIQoL	-0.159	-0.189	-0.097	-0.061
Graphic scale	-0.193*	-2.208*	-0.139	-0.262**
WHOQOL	-0.098	-0.097	-0.090	-0.183
SS8 – numerical scale	-0.165	-0.115	-0.081	-0.312**

Table no. 2 Quality of life and health complaints

Psychological resilience (hardiness) measured using the questionnaire by S. Kobasa displays a relation between this scale and the SEIQoL questionnaire, but also between Kobasa's method and life satisfaction expressed via the QLG graphic scale. The results positively correlate with the ability to control the situation (HCO), identification (HCM), acceptance of stress as a challenge (HCA) and overall level of hardiness (H). The 'control of situation' variable shows a strong correlation with SEIQoL and

with overall hardiness (H). The strongest connections were found between the graphic scale and all subfactors of hardiness as well as overall H. WHOQOL correlates only with identification with stimuli received (HCM), which expresses a need to feel that an activity is worth doing. Life satisfaction expressed via the SS8 numerical scale is shown to be independent of hardiness.

QUALITY OF LIFE AND HARDINESS (Correlation matrix) N = 104				
Variable	HCO	HCM	HCA	H
SEIQoL	0.209*	0.228*	0.073	0.200*
Graphic scale	0.226**	0.338**	0.283**	0.316**
WHOQOL	0.171	0.239*	0.078	0.169
SS8 – numerical scale	0.057	0.114	-0.055	0.111

* P = 0.05 ** P = 0.01

Table no. 3 Quality of life and hardiness

A further tested factor was the level of perceived work stress (HPZ), which shows a statistically significant correlation with QoL measured via SEIQoL and life satisfaction measured using SS8. This is an indirectly proportional relationship. Social support and the variables tested in this study show that this factor or at least one of its aspects (support from significant other – SPA, support from family – SPB, support from friends – SPC) correlate with all variables. SEIQoL significantly correlates with SPA, SPC and overall support (SP). Life satisfaction measured using the graphic scale is in a statistically significant relationship with SPA, SPB and SP. WHOQOL correlates with social support from SPA and SP. The SS8 numerical scale shows no significant relation with social support.

The level of work-related stress (HPZ) correlates only with the SS8 numerical scale and with SEIQoL. The other items show no significant relation.

QUALITY OF LIFE AND WORK STRESS (measured using HFI), SOCIAL SUPPORT (Correlation matrix) N = 104					
Variable	stress HFI	SPA	SPB	SPC	SP
SEIQoL	-0.206*	0.259**	0.186	0.226*	0.274**
Graphic scale	-0.021	0.229*	0.352**	0.111	0.298**
WHOQOL	0.056	0.225*	0.185	0.121	0.237*
SS8 – numerical scale	-0.336**	0.025	0.057	0.045	0.057

Table no. 4 Quality of life and work stress, quality of life and social support

Work-related stress measuring using the HFI scale shows a significant correlation only with SEIQoL and the SS8 numerical scale. The correlation is negative, with an indirectly proportional relationship between the variables. The higher the stress, the lower the value of SEIQoL and the lower the life satisfaction measured via the SS8 numerical scale. Overall social support SP correlates significantly with SEIQoL and with life satisfaction evaluated on the graphic scale. It also shows a significant correlation with.

FACTOR ANALYSIS					
Variable	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
FO – physical problems	0.9290				
PO – psychological problems	0.8819				
NP – neurotic symptoms	0.8819		-0.2545		
H – total hardiness	-0.6308				0.3485
SP – total social support					0.9419
COPE 9 turning to faith				-0.9319	
SEIQoL	-0.2487	0.8265			
Graphic scale	-0.2366		0.4827	-0.5006	0.3769
WHOQOL		0.7769	0.3273		
SS8 – life satisfaction			0.9401		
Variation %	18.73%	11.90%	9.92%	6.92%	6.65%
	Health	Core QoL	Current QoL	Choice COPE 9	Social support

Table no. 5 Factor analysis

The first factor has been termed ‘health’, as it is saturated mainly with subjective health-related problems – physical, psychological and neurotic. This factor is also negatively saturated with SEIQoL and the graphic life satisfaction scale. Another variable negatively saturating this factor is total hardiness.

The second factor is primarily the variable SEIQoL and WHOQOL. Other variables do not contribute significantly to this factor. Both SEIQoL and WHOQOL are based on the evaluation of important values for each respondent. WHOQOL is based on the evaluation of up to 30 aspects which exercise a major influence on quality of life, and SEIQoL is based on the respondent stating his/her 5 most important life goals and the degree of their importance for the respondent. It is our opinion that these two methods – especially SEIQoL – represent the core basis of QoL with a lower dynamic of change. We expect that the list of 30 goals includes some of the goals and values used in the SEIQoL method.

The third factor is saturated mainly by the evaluation of life satisfaction as a monolithic entity and measured via graphic and numerical scales, as well as – to a certain degree – evaluated via the WHOQOL method. The fourth factor is saturated by the rejection of coping of the type ‘turning to faith’ and low levels of life satisfaction on the graphic scale. The fifth factor could be termed ‘high level of social support’ and is saturated by the level of overall life satisfaction on the graphic scale and by the overall hardiness level. It could also be seen – though this would be somewhat imprecise – as the level of resilience.

Conclusions

1. Methods based on the evaluation of the importance and level of satisfaction of individual QoL factors capture precisely what has here been termed the ‘core’ QoL. This applies most of all to the SEIQoL method, based on the selection of only five items that are considered of key importance by the individual.
2. Graphic and numerical scales evaluating the overall level of life satisfaction as a

monolithic entity are probably influenced not only by what is most important for the individual, but also by the current situation and satisfaction-related factors linked with this situation. These factors may exercise a positive or negative influence over the evaluation of life satisfaction. Factor analysis of the existence of two QoL factors confirms this fact.

3. Currently, the authors are compiling a much larger data set based on a larger sample of respondents, who will provide data using all four of the methods used to date, plus other variables that can be used in the evaluation of QoL and life satisfaction. The results given here are to be seen as suggesting hypotheses that will be confirmed or rejected in the course of further ongoing research.

Translated by Hopkinson, Christopher, Mgr., B.A.

EFFECTS OF CHILDHOOD MALIGNANCY TREATMENT ON QUALITY OF LIFE: PRELIMINARY RESULTS OF THE QOLOP PROJECT

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Scope of the problem

Due to remarkable advances in the treatment of cancer in children and adolescents about 80% of patients reach long-term remissions today (Ries et al., 2007) as compared with less than 30% of childhood cancer survivors in 1960s. This population of children and young adults who were previously treated for childhood malignancy requires specialized care. Enhancing chances of survival of diseases that were previously considered as incurable is one of the greatest achievements of modern medicine. Expectations of both professional and lay public in the field of pediatric oncology shifted from the focus on quality palliative and symptomatic therapy to anticipation that the child will be cured and live to adult age. Therefore, *quality of life* comes into focus today. The new paradigm that defines success rate of contemporary oncological treatment of childhood malignancy is not to achieve only survival, but also *balance* between anti-cancer activity and toxicity, or late adverse effect of the therapy (Oeffinger, Robinson, 2007).

Two thirds of childhood cancer survivors suffer from at least one chronic health problem, approximately half of which are serious or even life-threatening conditions (Geenen et al., 2007, Oeffinger et al., 2006, Mladosičevičová, Kaiserová, Foltinová 2007). Only one third of survivors have no health problems. The most common health problems of patients who underwent childhood malignancy treatment are psychosocial and cognitive disorders that affect up to 40% childhood cancer survivors (Geenen et al., 2007). Understanding of these problems and adequate interventions can significantly enhance quality of life of patients.

Patients' awareness about the therapy and its possible long-term risks is usually poor (Oeffinger, Robinson, 2007, Kreitler, Ben Arush, 2004). However, many late effects can occur long after the therapy was finished (even after decades). The aim of

centers of comprehensive oncological care is therefore enhancement of awareness about the incidence of late effects of the therapy.

The “Qolop” Project (*Quality of Life Longitudinal Study of Oncology Pediatric Patients*)

The “qolop” project is a prospective longitudinal quality of life study of oncology pediatric patients, commenced in Brno in autumn 2006 (www.qolop.eu). The research is conducted by the Pediatric Oncology Clinic at the Children’s Hospital, FN Brno, in collaboration with the Institute of Psychology of the Academy of Sciences of the Czech Republic (ASCR) and the Institute of Psychology at the Faculty of Arts, Masaryk University (FF MU).

The main purpose of the project is to identify the areas of reduced quality of life in children with cancer, including both the objective indicators (mobility, function of sense organs, social involvement), and the subjective well-being (emotional experience, life satisfaction). The identification has been based on the comparison between the children with cancer, the healthy population and the children with chronic non-cancerous disease. In the longitudinal perspective, the collected data will be used for the study of the treatment’s late effects and identification of significant antecedents of the quality of life in adulthood.

Children aged 8 – 18, two to five years in the remission period at the time of examination, enter the study on a continuous basis. In April 2008, when this study was in its preparatory stage, 73 cancer survivors, 263 clinically healthy elementary school children and 30 chronically diseased children were examined. For more details see the project’s website www.qolop.eu or a survey study designed by Blatný et al. (2007).

Goal of the study

For now, control sample of elementary school children is available only. Therefore only data from 37 cancer survivors falling into this age category can be analyzed. Considering the sample size, we decided to compare only significant life domains of cancer survivors and healthy children. Particularly, the study focused on conventional involvement, parent-child interactions, depressiveness and satisfaction with individual life domains.

Method

Sample

The sample consisted of 37 childhood cancer survivors aged 8 to 14 who had been in the remission for 2 to 5 years at the time of examination. Analyses were done for the entire sample and then separately for age category of 8 to 12 year (27 persons, 10 boys / 17 girls) and 13 to 14 years (10 persons, 6 boys / 4 girls). Out of 263 healthy children, pupils of elementary schools in Brno, a control group of children was created with adequate age and gender characteristics.

Methods

Degree of involvement in after-school activities was determined using a Conventional Involvement scale from SAHA questionnaire (Weissberg, 1991). Frequency of individual activities is ranked by children on a 5-point scale ("How many times a week?" 0x, 1x, 2-3x, 4-5x, 6-7x; scale range is 0-4), overall involvement in after-school and leisure activities is expressed by means of an average score.

Relationships between children and parents (parenting aspects) were determined by Parent-child interactions scale taken again from SAHA questionnaire that focuses on the following four parenting aspects: parental involvement, warmth, control and inconsistency of parenting. Children evaluated behavior of their parents on a 4-point scale (never – rarely – sometimes – often; 1-4). Degree of individual parenting aspects is again expressed by an average score.

Degree of depressiveness was measured by means of The Children's Depression Inventory (CDI; Kovacs, 1992). The inventory consists of 27 items, each of them is divided to three options that should express seriousness of depressiveness symptoms (1-3). Children chose options that best corresponded with their feelings. Although the inventory has five sub-scales (Negative Mood, Interpersonal Problems, Ineffectiveness, Anhedonia, Negative Self-Esteem), we worked only with overall degree of depressiveness that is expressed by an average score.

Personal value of individual life domains and well-being in these domains were identified by the SQUALA method (Dragomirecká et al., 2006) that was modified to suit childhood age and extended to include items concerning life domains that could be affected by the consequences of the therapy (e.g. physical self-sufficiency). The questionnaire covers 30 life domains in total, both material (toys, home environment) and psychosocial (friendship, fairness). Children use a 5-point scale to define the importance of individual domains for them and then assess their satisfaction with these domains. This method is used above all to monitor changes of sources of well-being over time.

Differences between healthy and diseased children in the monitored characteristics were analyzed by nonparametric Mann-Whitney test.

Results

Descriptive statistics describing involvement in after-school activities, depressiveness degree and parenting aspects, and statistics identifying differences between the groups are demonstrated in Table 1. The results of test for modified SQUALA are described only verbally due to a large number of scales and relatively small number of significant differences.

		All		8-12 years		13-14 years	
		m(SD)/median	U	m(SD)/median	U	m(SD)/median	U
Conventional Involvement	Onco	0.58(0.40)/0.50	1898.0	0.60(0.42)/0.50	893.5*	0.53(0.35)/0.50	182.5
	Contr	0.73(0.47)/0.67		0.80(0.48)/0.83		0.56(0.39)/0.50	
Depressivness	Onco	1.30(0.21)/1.26	1902.0*	1.34(0.22)/1.30	1203.5	1.18(0.13)/1.19	67.0**
	Contr	1.44(0.30)/1.41		1.43(0.32)/1.37		1.46(0.27)/1.41	
Parenting	Involv.	Onco	2356.0	3.06(0.50)/3.17	1236.0	2.92(0.66)/3.08	185.5
		Contr		2.88(0.68)/2.83		2.84(0.54)/2.75	
	Warmth	Onco	2226.5	3.67(0.36)/3.60	1150.5	3.51(0.43)/3.50	170.0
		Contr		3.41(0.64)/3.60		3.33(0.59)/3.40	
	Control	Onco	2517.0	2.81(0.62)/2.75	1226.0	2.93(0.54)/2.94	171.0
		Contr		2.94(0.68)/3.00		2.76(0.59)/2.87	
	Incons.	Onco	2243.0	2.14(0.78)/2.00	1209.0	2.16(0.49)/2.30	147.5
		Contr		2.29(0.68)/2.40		2.42(0.69)/2.60	

* $P < 0.05$; ** $P < 0.01$

Table 1: Healthy children (Cotr) vs. children with cancer (Onco)

Childhood cancer survivors involve less in social activities (after-school, leisure time) than children from control group. This result was significant in 8 to 12 years age category. Childhood cancer survivors show significantly lower degree of depressiveness than children from control group – significant difference was found in 13 to 14 years age category. No significant differences were observed between cancer survivors and control group in self-perception of child-parent interaction.

As far as the importance of individual life domains is concerned, cancer survivors gave more weight to values “to have leisure time activities” (children aged 13 to 14) and “to be able to go to school” (children aged 8 to 12 years), and are more satisfied with their health and belief (8 to 12 years), ability to attend school (8 to 12 years) and their own appearance, as compared with children from control group.

Discussion

Lower involvement of childhood cancer survivors in social activities is no surprise, as it can be caused by (1) the effects of the therapy itself such as increased fatigability or higher sickness rate, (2) weakened social competencies due to a long-term isolation from peers and lack of contact with people under normal living conditions or, importantly, (3) increased protectiveness by parents who worry about their child’s health.

No significant differences between cancer survivors and control group were found in the children’s view on the quality of parent-child interaction. This result can be interpreted as the positive finding that parents of cancer survivors do not tend to consider their children as sick patients. The abovementioned protectiveness is probably limited to domains where increased control of behavior and certain forethought can be only useful.

The finding that childhood cancer survivors show less depressiveness symptoms than children from control group was rather unexpected. However, it is almost sure

that this result was not accidental, as it was observed also in our previous study on the effect of chemotherapy on cognitive function in children and adolescents (Neurocognitive functioning in children cancer survivors, Czech Science Foundation – GACR, No. 406/05/0603, 2006-2008) where cancer survivors showed lower degree of depressiveness as compared with general population.

There are several explanations of this result that will have to be further investigated in future studies. First, exceptional life experience associated with anti-cancer therapy could strengthen children's psychical hardiness. Second, criteria of perception of mental strain in childhood cancer survivors have changed, which means that what other children see as stressful situation causing negative reactions, cancer survivors perceive as non-stressful circumstances. Third, it could be the act of dissimulation: children fear that the disease could recur, so they suppress potential negative signals such as mood swings, anhedonia, fatigability etc. Fourth, cancer survivors can be on antidepressants which are indicated in certain diagnoses as part of anti-cancer therapy. Although they are gradually discontinued (six months after the therapy at the latest), some children can go on using antidepressants prescribed by their pediatrician.

As far as the importance of individual life domains is concerned, cancer survivors gave more weight to values "to have leisure time activities" (group of children aged 13 to 14 years) and "to be able to go to school" (8 to 12 years). Here, specific experience of children who were isolated from normal life for a long time is clearly reflected, as they emphasize values that can seem normal (ordinary, everyday) to healthy children. Cancer survivors were also more satisfied with individual life domains, namely their health and belief (8 to 12 years), ability to attend school (8 to 12 years) and their own appearance, as compared with children from control group. Higher well-being in these domains can be interpreted as the contrast to the experience of disease.

Conclusion

Differences in self-perceived quality of life between childhood cancer survivors and healthy population reflect specific experience of children treated for an oncological disease: cancer survivors less involve in social activities (hobbies, leisure time) than children from control group, give more weight to values "to have leisure time activities" and "to be able to go to school", and are also more satisfied with their health, belief and ability to attend school. No significant differences were observed between cancer survivors and control group in self-perception of child-parent interaction.

The only unexpected finding was that childhood cancer survivors show less depressiveness symptoms than children from control group. Several explanations are suggested: strengthened psychic hardiness of cancer survivors, changed criteria for perception of strain, dissimulation (fear of the disease relapse) or taking antidepressants. However, these explanations require further research.

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QUALITY OF LIFE OF CANCER CHILDREN CAREGIVERS

Helena VAĎUROVÁ

Current Situation

Oncology is one of the fields experiencing the fastest development in the last few years. New treatment methods brought about bigger chances of survival¹ for cancer patients and cancer became a chronic disease. On the other hand, cancer is still a disease with severe impact on the patient as well as his/her family and close friends. The number of survivors and people with cancer symptoms under control is increasing and therefore the research in their quality of life gains more and more importance as well. Current research is dealing with the question: “What kind of life is dignified and worth and to what extent can a patient’s health status predominate over one’s subjective well-being in a situation of a fatal illness. In other words, nowadays the question of quality of life arises aside quantity of life and success of treatment.

Children cancer is a relatively rare condition, however, as much as 7-10% of children suffer for some kind of chronic illness (Řičan, 1995: 79). Cancer is unique because of the depth and seriousness of its impact on the ill child and its family. The quality of life of ill children is considerable compromised due to pain arising from the illness itself as well as aggressive treatment procedures, loss of energy and possibilities to enjoy common everyday activities, inability to maintain contact with peers in education and social sphere and in older children also with fear of future.

Cancer does not affect the particular person (in our case a child) in isolation, but the whole family. Behaviour and role patterns are disturbed by the illness and family members have to cope with a new and demanding situation and in many cases change their social roles or even leave some of them and take up new ones.

Research outcomes support the evidence that the success of treatment is to a large extent (up to 20%, University Hospital Brno, 2006) influenced by one’s family, it means its preparedness and ability to cope with stressful situations, cooperate with doctors and nurses, make decisions about future treatment and offer physical and

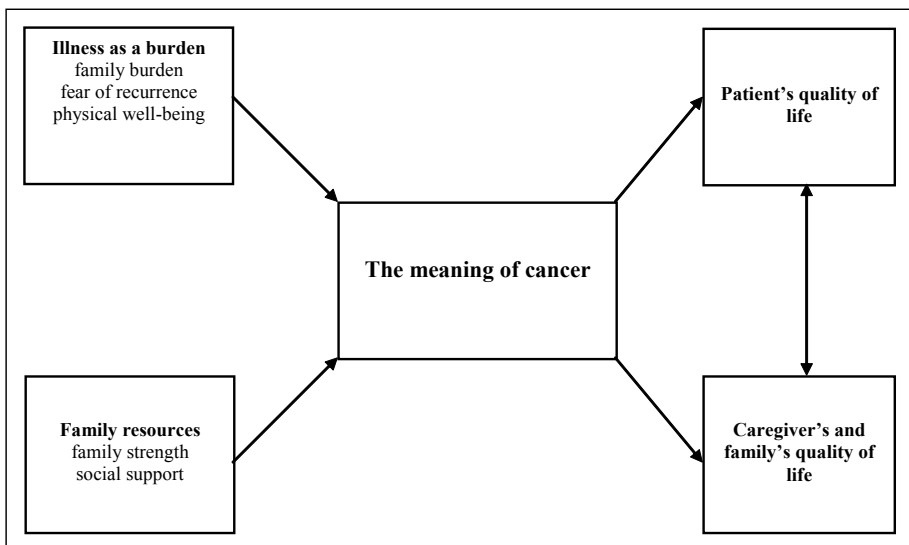
¹ The prognosis of children cancer has improved tremendously (up to 75% of disease-free survival in five years after treatment) in the last few years (Cancer Research UK, 2004, Available at: <<http://info.cancerresearchuk.org>>).

emotional support to its child². Quality of life of a family influences overall well-being and treatment of its child.

Factors Influencing Quality of Life of Caregivers and Families

Northouse et al. (2006) created a “*family survivorship model*” based on evaluation of the impacts of cancer on family. There are three variables included in the model: fear from recurrence of the illness, family burden, physical well-being (especially important for the patient). Other factors identified as important for coping with cancer are: family strength, social support and meaning of the illness.

The family-survivorship model of a cancer patient (pict. 1) shows interconnectedness of its parts and its influence on the overall quality of life of the whole family.



Pict. 1: Family-survivorship model of cancer patients by Northouse et al. (2006)

When talking about quality of life, we have to mention one very important factor – shortening of hospital stays and the preference of out-patient and home care. Patients are released to home care as soon as possible. This approach is convenient from economic point of view as well as for the patient him/herself (especially when talking about a child),

² This fact has been reflected by professional in western countries as well. An approach called Family-Centred Care has been put into practice in the United Kingdom and the USA. This approach puts family in the centre of all decision making and discussions. It is not only medical personnel who are taking care of the child and its parents. There is a wide range of non-medical services offered. Their aim is to help parents and children with problems arisen due to the illness and thus enhance their subjective quality of life. The offer of non-medical services has been improving and widening in the last few years. Nowadays, we can take advantage of services of psychologist, social worker, special education teacher, counselling workers and therapists from NGOs and an offer of supporting services (such as accommodation in hospital).

who is cared for in known and pleasant environment. In the case of cancer patients, home care might mean long months of bed rest. The caregiver burden thus persists and becomes his/her new lifestyle. The result of this new trend is rising importance of informal caregivers who are responsible for a patient's care in home care.

Most frequently mothers are forced to change their lifestyle considerably because they accompany the ill child during hospital as well as home care. Fathers usually continue working and take care of the household and healthy children in mother's absence. In comparison with mothers, the fathers' life more resembles the normal one (before the illness). However, they also are affected by the disease and should not stay out of professionals' focus. Therefore, the current interest of scientists focuses not only on quality of life of the ill child but also quality of life of persons who take care of it or keep close contact, so called primary caregivers.

Lim et al. (2004) made an analysis of 19 studies focused on particular aspects of cancer caregiver's quality of life. Based on this analysis they published the following list of areas most influenced by cancer:

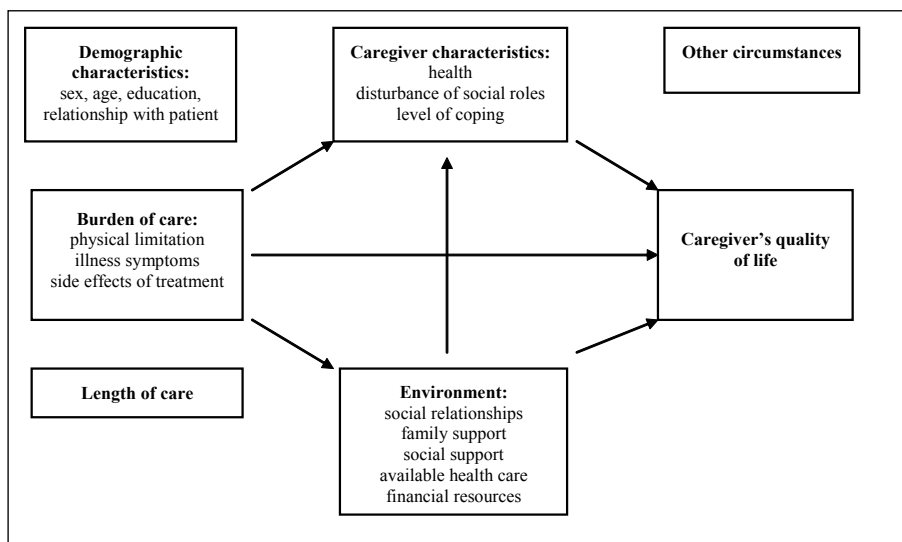
- Ill person characteristics – functional state, age, sex, psychological well-being, type of cancer, pain, symptoms (seriousness of illness)
- Caregiver characteristics – age, sex, physical state, monthly income, QOL at the beginning of treatment, education, health care, psychological well-being, anger, anxiety
- Primary burden – objective context, demands on caregiver, seriousness of illness, length of care giving, recurrence, caregivers overburden, degree of patient's dependence, intensity of care
- Secondary burden – subjective context, care giving demands, role change, responsibility, caregiver's experience, disruption of lifestyle
- Evaluation of burden – evaluation of situation, feeling of control, difference in understanding of situation (patient and caregiver)
- Coping strategies
- Social support – quality and appropriateness of social support, social network and social life, family life (quality of relationships), loneliness, family resources (psychological, social, interpersonal, material), formal support

This overview offers all dimensions mentioned by different authors. Every model of quality of life assigns different level of importance to particular dimensions. It could be supplied with the point of view of professional distinguishing between quality of life in curative and palliative care.

Model of Quality of Life in Cancer Children

Different aspects and factors influencing caregivers' quality of life were taken into account in the model of caregiver quality of life created by White et al. (2004) (pict. 2). Their study focused on caregivers of stroke patients; however, the basic dimensions can be applied to the situation of cancer children caregivers as well. The basic dimensions are the same for both, there are differences only in specific impacts of illness and relationship with the patient.

The model of White et al. adopted for the specific situation of cancer children caregivers can be found below.



Pict. 2: Concept of quality of life of cancer children caregivers

This model clearly shows multidimensional character of caregiver quality of life as well as interconnectedness of particular dimensions of caregiver's social role and his/her quality of life. This concept has a great complexity; therefore, it is not possible to narrow a measurement to measuring of a single dimension (Mayo, 2002).

The concept of caregiver quality of life has the major dimensions identical with general public, however, their importance and sub-dimensions will differ.

We will use Weinitzer et al. model of quality of life used in generic questionnaire SF-36 to demonstrate the specific aspects of cancer caregivers. Dimensions identified by SF-36 are as follows: physical functioning and social roles, physical pain, overall health, vitality, social relationship (functioning in society), emotional well-being, spirituality.

Among the *physical aspects* of QOL we can include tiredness, sleep problems, loss of appetite and need to rest. The most important form *psychological aspects* are emotional burden, stress, fear for the patient, nervousness, anger, feeling of destruction and depression (Kornbith et al., 1994), confusion, lack of information about the situation, feeling of hopelessness (Vaďurová, 2007). In the study of patients after bone marrow transplantation Boyle et al. mentions the following *social relationship* aspects: family support, change of responsibility distribution in the family, persistent, long-term demands on care. *Spirituality* is according to Matthews et al. (2004) the most highly rated dimension in cancer survivor caregivers. This dimension includes spiritual well-being, feeling of spiritual support, utility, hope, feeling of sense and overall satisfaction with life. This dimension is important also to parents of cancer children in active treatment (Vaďurová, 2007).

Measuring Quality of Life of Cancer Caregivers

Measuring quality of life in medicine, e.g. Alzheimer disease has a long tradition and a number of tools has been developed. However, this is not true for cancer caregivers; there are only a few measurement tools, for example:

- Quality of Life Tool (QoL Tool)
- Caregive Quality-of-Life Index (CQoL-Index)
- Caregiver Quality of Life Index-Cancer (CQOLC)³
- Care-related quality of life instrument (CarerQol Instrument)
- Scale of Quality of Life of Caregivers (SQLC).

Caregiver Quality-of-Life Index (CQoL-Index)

CQoL-Index has been developed by McMillainem and Mahonem (Deeken et al., 2003). it is a simple tool evaluation caregiver's quality of life in four dimensions: physical, psychological, social and financial. A visual-analogue scale from 0 to 100 is used for an answer indication.

One disadvantage of this tool is low inter-correlation and low sensitivity to change in time (Decken et al., 2002: 947).

Quality of Life Tool (QoL Tool)

A 20-item questionnaire QOL Tool was developed by Ferrel et al. in 1995. It also uses a visual-analogue scale from 0 to 100 for answer indication. In comparison with CQoL Index this tool is more detailed as all four measured dimensions (physical, psychological, social and spiritual) contain further sub-dimensions. Ferrel et al. focused on the impact of cancer patient pain on caregiver quality of life. The disadvantage of this questionnaire is its narrow focus on the pain experience (Decken et al., 2002: 947).

Caregiver Quality of Life Index-Cancer (CQOLC)

One of the most widely used tool is CQOLC by Weinitzer et al. (1997). It is a self-evaluation questionnaire. Every item is evaluated by a respondent on a Likert scale from 0 (not at all) to 10 (absolutely). The overall score is given by the total value of individual items. The highest socre possible is 140, higher score means better quality of life (Rhee, 2005).

Care-related quality of life instrument (CarerQol Instrument)

Care-related quality of life instrument (CarerQol Instrument) is one of the newest tools for measurement of quality of life. It was developed by Brouwer et al. in 2006. The questionnaire focuses on quality of life of informal caregivers. The authors evaluate care giving from economic point of view and state that informal caregivers very often leave their jobs and care giving is thus economically demanding. Despite this fact, economists do not satisfactorily consider care giving as a financial burden and a reason for special allowance. therefore, the authors attempted to develop a tool to measure economic impact of certain treatment methods.

³ Decken et al. used abbreviation CQoL-Canc, more widely used is CQOLC, used by the author himself (M. A. Weitzner).

Quality of Life of Cancer Children Caregivers

The following information is based on a research carried out by the author in 2007.

Nowadays, there is no standardized and widely used tool for measuring quality of life of caregivers of cancer children in active treatment or finished treatment. The questionnaires usually focus on caregivers as such⁴, caregivers of adult cancer patients⁵ or caregivers of terminally ill children or adults⁶.

For the purposes of this research, we modified the already existing questionnaires to suit our specific situation and aims of our research.

The basis of our questionnaire is formed by variables influencing caregiver quality of life created by White et al. (2004):

- burden of care – physical, psychological, emotional situation of caregiver, length of care
- caregiver characteristics – sex, age, education
- environment variables – social support, economic situation.

These variables are to a large degree identical with dimensions of QOL identified in generic questionnaire SF-36. This questionnaire is used for a wide range of respondents and numerous foreign researches use it for measuring caregiver quality of life⁷ as well. The dimensions of SF-36 are mentioned above. The dimension “physical pain” has been omitted as it is not relevant when not measuring a patient’s QOL. On the other hand, we have added the dimension “economic situation”, this is being emphasised by contemporary studies⁸ and also introductory demographic information (based on White et al., see above). The situation of cancer children caregivers is very variable and depends on the treatment and health status. Therefore, items measuring psychological and emotional well-being ask about situation in the last 4 weeks⁹.

The use of a set of questions from foreign researches allows a partial comparison with results of foreign researches. However, this questionnaire was also supplied with original questions to develop a questionnaire that is relevant for our cultural background, specific situation and research goals.

The questionnaire measured subjective quality of life of cancer children caregivers in active treatment and shortly after the end of the treatment. Among the most important factors belong a respondent’s characteristics. The average respondent of the research was a woman aged 25-36, having two children, with secondary school education and living in a village. The child would be treated for the period of 7 to 12 months.

⁴ CarerQOL instrument (Brouwer et al., 2006), Caregiver Activity Survey, Caregive Quality-of-Life Index (CQoL-Index), Scale of Quality of Life of Caregivers (QLC), etc.

⁵ Caregiver Quality of Life Index-Cancer (CQOLC) (Weitzer et al., 1997)

⁶ QOLLI-F (Cohen et. al)

⁷ Patti et al., Caregiver quality of life in multiple sclerosis: a multicentre Italian study, 2007, Jönsson et al., Determinants of Quality of Life in Stroke Survivors and Their Informal Caregivers, etc.

⁸ Glozman (2004), White et al. (2004)

⁹ The questionnaire SF-36 usually uses the scope of one month (University of Wollongong: review SF-36, 2004). A time frame was employed also by Cohen et al. in their questionnaire QOLLI-F for caregivers of terminally ill patients. With respect to this specific situation, the time frame was set on 48 hours.

Seven dimensions of quality of life in a 14-item questionnaire were evaluated. The particular dimensions reached different summary score (scale 1-5, 1=max.; overall health – 3; vitality – 3; emotional well-being – 3,6; physical functioning and social roles – 3,3; social relationships – 2,9; spirituality – 3,4; economic situation – 3,1). The total score of cancer children caregiver quality of life reached 3,18 (median = 3,16; scale 1 – 5; 1 = max.). When expressed verbally it means considerably good quality of life. The outcome of our research corresponds with the research of Dutch team of Brouwer et al. (2006, CarerQoL-VAS) who came to the score 5,7 (median= 6; scale 0-10).

Therefore, we can state that the *overall quality of life of cancer children caregivers in our research is not considerably compromised the illness*. However, *individual dimensions are affected to different extends*.

Discussion

Cancer caregiver quality of life is a concept that is slowly becoming more central to professionals working with cancer children and their families. At present, there is no standardized and widely used tool for measuring QOL of cancer children caregivers in active treatment respecting their specificity. Quality of life and evaluation of its particular dimensions offers a very precise picture about caregivers' needs, the appropriateness, coverage and quality of services for them.

A MEANING OF A GAME SPECIALIST WORK WITH A KINESIOLOGY THERAPEUTICS SPECIALIZATION BY ONCOLOGY SICK CHILDREN

Marie BLAHUTKOVÁ, Jana DLOUHÁ

Introduction

A stay of a child in a hospital means all the time a significant psychical stress, above all if a child is seriously sick. This stress is represented by lots of pain, a fear from “white coats” (from time to time it broke out into a phobia), an unexpected loneliness, a fear from the future, and sometimes food intake disorders (that are corresponding with facts mentioned above) – especially dysorexia. All of these causes result into a progressive change of a child’s personality. It is often happening that from a previously “happy” person is becoming a pensive, gloomy, distressful human that generally looks older than is his or her biological age. An illness is mostly becoming unexpectedly and if evolves – it is often becoming a reason for formation of negative emotions, stress, and frustration. Sometimes elements of anxiety are appearing even in a child age. These manifests are evident by serious children’s diseases in which oncology diseases belong in. The treatment in hospitals is essential by oncology patients. Even if today’s hospitals enable parents to stay with their children and they are trying to shortened a hospitalization time, a stay in such places is all the time stressful for a child including medical treatments. There might some negative own experiences from medical treatments or form inadequate information distribution occur by children patients that are causing fear even if the information are not based on the truth. A child is so that brining lots of information into a hospital that he or she accumulated in previous years (Křivohlavý, 2002). The hospital staff is contributing to treatment processes with lots of nontraditional approaches that could not be realized in hospitals before. Only the modern approaches to patients have helped in implementation of game specialist indicatives that might cope with children all the time in hospitals. A game specialist should be present in every child’s department and his or her obligating is a presence by children’s beds and preparation of activities during the treatment. The main element is a game. Lots of game specialists went trough training in kinesiotherapy, especially in psychomotoric activities that might be applied during a hospitalization.

A phenomenon “psychomotoric” represents especially a close connection of psychical (spiritual processes) and motoric (body processes) aspects. This mutual relationship might be observed nearly continuously on oneself and on other people, e.g. body posture, facial expression etc. (Hermová, 1994). The psychomotoric is a form of a movement activity that is based on an experience from a movement. It leads to recognition of own body, of the environment and experience from movement activities. It is effecting through simple game activities; activities with equipment and tools, contact elements, and various relaxation techniques (Blahutková, 2001). The psychomotoric is equally developing physical, psychical, and social aspects of every human. It has in view an optimization of psychophysiological state of human through game movement activities. It is a form of an active relaxation, a process of regeneration, and an adequate activity for mental stress compensation (Adamířová, 2000). The aims of movement activities from an empirical sphere are a direct experience of joy from a movement, from a game, and from physical exercises and creation of bio-psycho-social-spiritual balance of the human (Blahutková, 2003). A part of psychomotoric activities are relaxation techniques, massages, and psycho stimulations. Psychomotoric games are different from common games in a usage of nontraditional tools, nontraditional approaches, relaxation components; they respect a personality potential, and they are also different in a fact that there are no winners and losers. The winner is simple everyone who participates (Hermová, 1994). A game is affecting very positively, especially in a child age and its incidence might be also observed by sick children. The psychomotoric games are affecting on negative emotions of children through positive approaches and positive experience; the negative emotions are often weakened through the games. During the game there is a relaxing atmosphere – children are losing barriers and their personalities are coming forward, they are expressing their experience, they are not afraid to be opened towards their environment, they are more communicating with hospital staff, they are better accepting the treatment. After the game activities the children are able to cooperate on better level, they trust more to the environment, they are gaining better tolerance to the stress, and therefore the hospitalization time is shortened as well.

The psychomotoric has a significant influence on a positive way of living of a sick child and it is supporting in an optimistic way during the whole treatment process (especially in a relation to the future). For an optimistic harmonizing process, from a causal point of view, it might be counted with a fact that an expiation ease of actual issues and creates positive conditions for reparation seeking process and its application. It is therefore a part of a treatment (Matějček, 1992). These principles are contributing to the escalation of a sick child’s quality of life – especially in these situations, when a parent or both parents are systematically taking a part in cooperation with a game specialist and they are able to react on sick child’s needs that are lately contributing to a faster recovery.

Chosen casuistry

We were asked for cooperation from a side of a sick girl’s family that had felt ill in her ten with leukemia diagnoses. The cooperation started to realize after

a communication barrier that created a misunderstanding from a hospital management's side. After recognition of family anamneses and after an opening communication with the parents, permission for visitation of hospital was granted to us. We were gladly welcomed by the hospital staff including the attending physician and the head physician. She agreed with the cooperation; she showed an interest about methods of game specialist's work; however a condition was an agreement from a hospital's director. He showed no willingness to cooperate, so that we had to stop the opening experiment. During the hospitalization period of the child we had implemented only an opening interview and then we were cooperating on an external base just with parents and grandparents. The cooperation was difficult; primarily because of the fact that a father left the family and got divorce with the wife – we had to consult them separately. Because the sick girl was a part of a class that we had psychologically tested on personality, we had an opening research available and results from personality's tests (from a time, when the girl was in a good health condition). After ending of the first hospitalization we were visiting the girl in a home environment, we implemented the same psychological analyses using the same test's range and we started to use psychomotoric games. We founded out that there were some total changes in several characteristics of the personality. The girl lost her interest about the environment, she was not communicating at all, she did not want to meet anyone, she stopped eating, and she was crying most of the time. Our first intervention was targeting the family. The cooperation with the family was on a very good level and already after the first month, the girl started to regain an interest about her previous hobbies. The second hospitalization was then realized and afterwards a transplantation of a bone marrow (it was a significant psychical stress for the family). We were cooperating with the family during the whole period; lately we got a possibility to visit the girl with the parents. We led parents and grandparents to the bed only after an agreement with an attending physician, after their pacification, and we were strongly requesting only a positive approach. An ability to cope with such approaches was very difficult that was a reason, why was our intervention in this period targeting also the closer psychological family profile. After ending of the second hospitalization of the girl, we were continuing very carefully in psychomotoric activities and in further cooperation in the family environment. The cooperation was shielded all the time by the same person. In this period we were again contacted by the attending physician with a request for cooperation with other patients. With regard to the unwillingness of the hospital management, we were trying to find a way to the sick children. This mean of cooperation was enabled thanks to a headmistress of a hospital school that had already met game specialists' projects during her practice. Chosen students that showed an interest about the work of voluntary game specialist, started to cooperate with the hospital staff and with the sick children.

At that time, our sick girl was passing trough a chemotherapy that she was taking very hardly. But a very close relation was established between us and she was able to speak about her troubles. We were facing a solid frankness in the family as well; the father was visiting the girl even at home; the former husband and wife started to communicate again. We managed to stabilize the situation and after ending of the chemotherapy we classed the girl into a psychomotoric course within education sche-

me of Pedagogic faculty for special pedagogy students. The courses were attending accompanied by parents or the grandmother and at that time the personality of the girl started to change again. During this period the girl was attending regular classes, a pedagogue was visiting the family and the attending physician agreed with the psychomotoric courses. In the closing lesson of the course (there was the father presented with the girl), the girl took the floor and presented all opening and actual feelings, experience, and impressions. This information was so significant that we were forced to publish the whole cooperation and, after an agreement with the family, present it openly. At the present the young miss is sixteen, she is attending a high school, and she is healthy, still under a medical supervision. The father returned to the family and married the mother again. The family is working.

Research

The aim of our work was in identification of game specialist's influence on personality changes by oncology patients in areas of temperament, extroversion and neuroticism, aspiration and attention, and identification of an influence on some oncology sick children's areas of life; above all on their quality of life, interpersonal relations, and on a development of communication skills. A testing range of personality tests used in the research was affected with the entrance data from the class, in which was the sick girl lately classed. That was the reason why we used the same personality tests:

- J.E.P.I. (Eysenck, 1973)
- Temperament test (Belov, 1971)
- Quotient of aspiration level (Meili, 1965, Blahutková, 1996)
- Attention (Bakalář, 1993).

We consequently assigned to these testes:

- SEQoL (Křivohlavý, 2001)
- Stress test (Selye, 1993).

Our results show that an influence of a game specialist on a positive development of oncology sick child's personality is significant, but also on a contribution of this work on a children's quality of life. We are mentioning only partial results of our work in temperament and aspiration areas.

During the diseases by the oncology sick children occurs a significant shift to neuroticism; the girl turned into her self, she stopped to communicate, she was very frequently crying, and she was refusing a communication with the hospital staff. The main contribution, in a positive shift, is seen in an interest of the family, in cooperation with a psychiatrist and therefore an interest to help during the child's treatment. An essential element during the treatment was an interest of the father (that was no longer staying with the family). During the cooperation with a game specialist a very positive relation (as far as a friendship) was established and therefore there were some possibilities to regulate some approaches in the treatment and currently the communication with the hospital staff was improving (see figure n. 1). The sick girl started to

express herself as a melancholic in the temperament area without any interest about the environment; her outgoing mood was occurring very rarely. She was not able to cooperate, not even establish some relations with sick children; she did not pay any attention to the environment or her self, she turned her interest to the meetings with her father. The very strong relation was established between the girl and her father that was lately recognized by the mother and therefore she enabled father's visits at home. After ending of the chemotherapy and after the next intervention of a game specialist, the girl started to communicate and started to pay an attention to the society – she established some new relationships and she found her previous hobbies again (see figure n. 2).

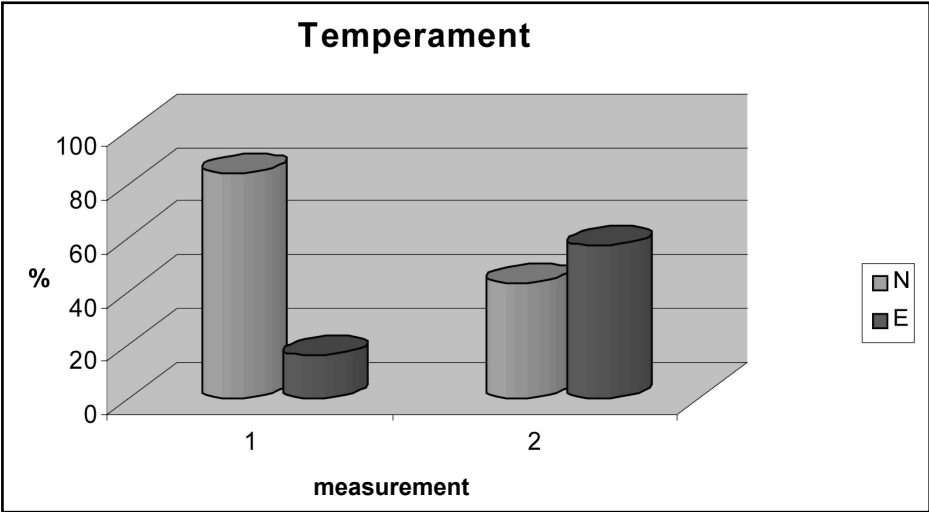


Figure 1: Personality changes by a chosen person during an influence of a game specialist

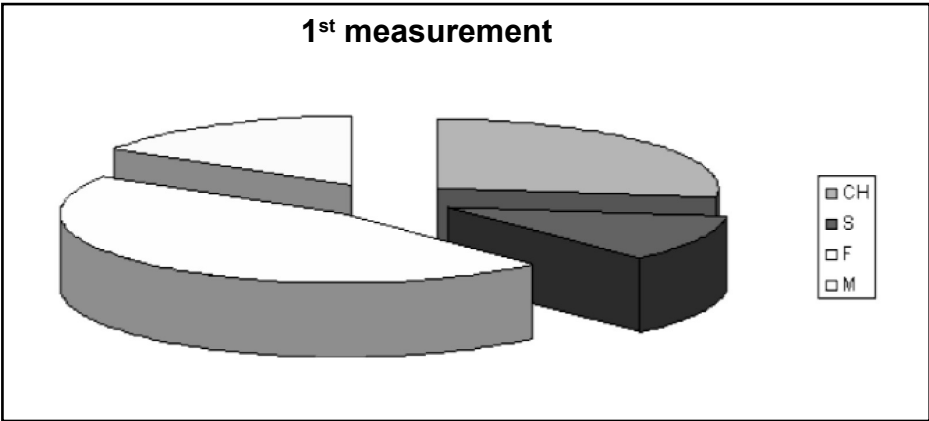
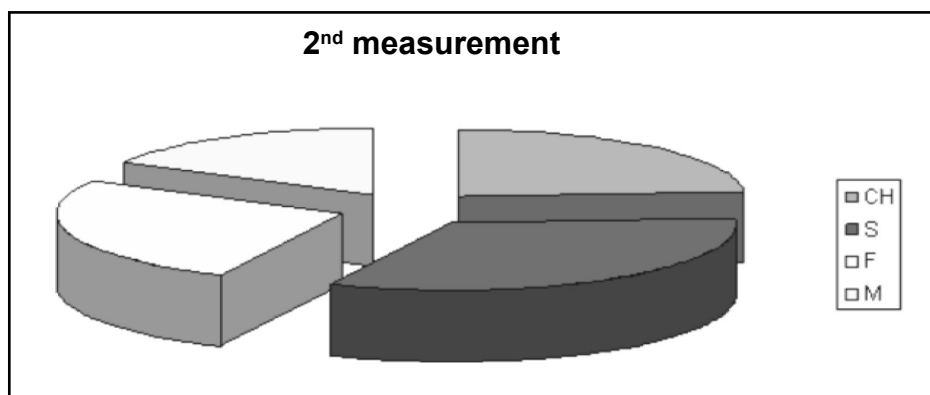


Figure 2: Changes in the temperament during an influence of a game specialist



We noted the biggest difference in an aspiration area. The sick girl did not try to achieve any results at all; she was not disposed to talk even about possibilities of her recovery. The world was fading away for her; she was blaming her self from the diseases; she was trying to find the mistake in herself and she showed no interest about herself and about the environment. During the cooperation we were focusing a significant part of game activities on recognition development of oneself and on recognition of the environment and we paid the main attention to self reflections (e.g. during the chemotherapy hair loses occurred and the girl refused to identify herself with the reflection in a mirror). But after the psychotherapy she started to accept herself. The turning point was observed during the ending of the chemotherapy and during the home game activities – the girl's family bought several psychomotoric tools; a sponsor's gift (psychomotoric trolleys) also helped. After an ending of the treatment, the aspiration is progressively getting better (see figure n. 3).

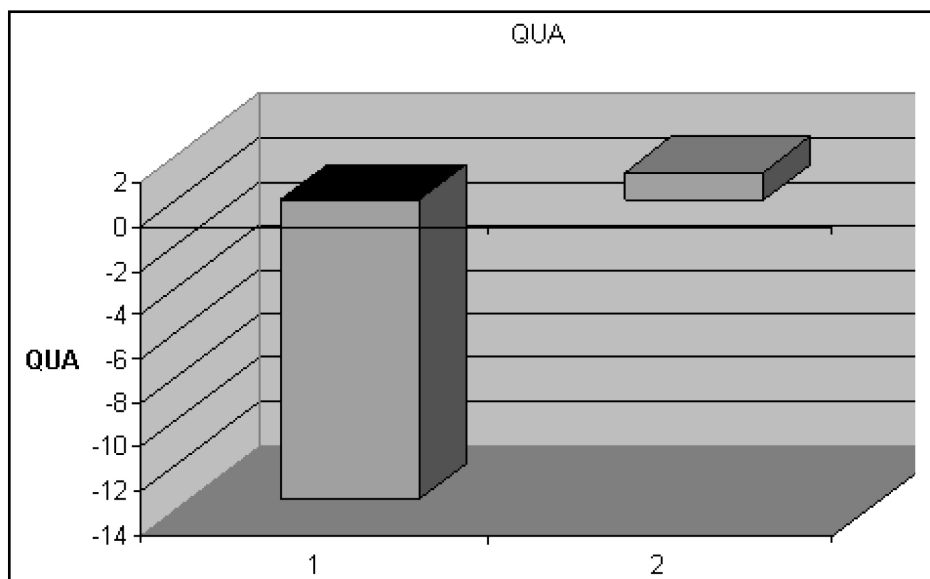


Figure 3: Changes in a sick child's aspirations

Conclusions

Our work brought lots of conclusions that might be relevant for a further usage. Therefore we would like to present them to wider public; especially to doctors, pedagogues, schoolmasters, psychiatrists, but also to hospitals management, so that we can support an improvement process of the health care quality of oncology sick children. The basic aim of the work was experimentally proven and we found out that a game specialist work by oncology sick children has a great meaning. The contribution of a game specialist's work is also seen in a support of a family, during communication with hospital staff, but also during the work with a child's environment (wider family, other patients, and friends). Other contribution of our work is also in current possibilities of cooperation with a hospital school; where we enable students' practices directly in a hospital environment to some beginning game specialists and therefore we help pedagogues in their formidable work. Currently, a positive cooperation with doctors and hospital staff (that are interested in this work and that are praising the positive approaches of children patients, but even of their relatives during the hospitalization) is being observed.

AN INFLUENCE OF EDUCATIONAL PROCESS IN HOSPITAL PRIMARY SCHOOLS ON SICK CHILDREN'S QUALITY OF LIFE

Jana DLOUHÁ, Marie BLAHUTKOVÁ

For sick or healthy weakened children and pupils in hospitals there are nurseries and primary schools at hospitals established (school law 561/04 Coll., Not. 62/07 Coll.). In these schools there can be health weakened or longititude sick pupils educated if it is enabled based on their health condition. Primary schools might provide consultation in common educational subjects even to pupils of high schools located in such institutions. An enlistment in hospital schools is based on an attending physician and an agreement of a pupil's legal representative. A range and organization of pupils education assigns a headmaster of school based on an agreement with attending physician (Coll. 73/05 Not., §4).

The educational process in hospital schools is based on a pupil's health condition that is affected by a state of disease in which a patient is in. Michalickova (1961) mentions three stages of a disease:

- *Acute stage* – beginning of disease, time during a surgery and immediately after it, etc. A child needs an absolute quiet in this stage. The more is disease difficult, the more significant is this requirement. A child is generally lying or sleeping, a child is not caring about people or things. So that any pedagogical intervention steps back.
- After an acute stage comes a stage when *a child is not fully recovered, but a first stadium of disease is successfully overcome*. Improvement of a health condition is basically shows in fall of temperature, increase in appetite, and interest in environment. At this time it is already possible to begin with the educational process, e.g. helping with tidying up a bad table, borrowing a book or a toy. It is still necessary to keep in view a fact that a child can be still quickly tired and needs a rest.
- With a withdrawal of a disease comes the third stage, *the last stage*, in which a child is again involved in the educational process, whereas a time and a range are based on a doctor's decision. A cooperation of a doctor and a pedagogue in hospital is more than desirable. A pedagogue's observation of a pupil behavior and his or her remarks might help to an appropriate diagnosis of a pupil.

Establishment of a contact with a sick child

An establishment of a personal contact with a sick child is a solution of every single pedagogical work in hospital children departments. By hospitalized children it is basically difficult to establish such connections because patients are situated in a new unknown environment. Here can appear the abnormal psychical reactions in a form of *hospitalism* that is slowing down a treatment process, even despite of all effort of hospital staff and other specialist pedagogues, game specialists, etc. There can be two outer variants of behavior in a child society and in an approach to work in school established: stay in an opposition – a child is not involving in work and express him or herself as a disturbing element or as an opposite extreme – ingrown state when a child is suffering alone. A fact when a pedagogue is able to gain a child interests or not is significantly affecting a child further stay in department.

Some children are surprised by a pedagogue presence in a hospital. From the beginning even disappointed (“I am ill so that I do not need to study”). Others are, on the other hand, kindly surprised when a suspected doctor turns into a pedagogue from whom there is no threat of any painful treatments. The pedagogue is for a child a person that is much more familiar than others and he or she can become a mediator between a child and hospital staff. If a pedagogue manage to established a close personal relation to a sick child, it is expressed not only in a pupil’s approach to the work, but it is also a child relation to the treatment significantly affected – a child is more patient, brave, better cooperating (Sasín, 1965).

Education and teaching as a part of a medical treatment

Education and teaching in hospital schools is not an independent and freelance process. Its specifications lies in a fact, that it is a part of a medical treatment. The education has to be under any circumstances realized in a way that it is appropriately affecting a child state, thereby contributing to a positive development of a health process. Several ground conditions is affected by a doctor (child enrolment in the education, canceling the education, a stress rate, creating groups possibilities, submission of the education in a day program, etc.).

The main meaning of hospitalization is a treatment. The main influence in a workplace has medical staff. Every single step of a school, no matter how it is affecting an established way of work, children’s regime or a workplace modification, has to be discussed with a hospital management in advance. That is way the school innervations can not be independent and direct, but they have to be subordinated to the treatment itself.

An air in the children departments is full of negative emotions: homesickness (if there are no parents with a child), a desire of returning into a former environment, an anxiety from medical treatments, and a fear of hospital. An intensive balancing of these emotions by diversity and optimism is a specialty of pedagogue’s work in a hospital. There are significant requirements posed on a pedagogue’s personality – his or her balance, relation to children of every age level – from children of pre school age to teenagers (Hiblbauer, 1963). A pedagogue in a hospital school is, from a very first meeting with a pupil, facing a problem how to currently observe and educate, diagnose and

measure. Therefore a good special pedagogue has to have not only a solid experience and knowledge, but even a fantasy and a pedagogical intuition. He or she has to be able not only a solid observation, but also a pedagogic improvisation, have an ability to feel what is desirable at a certain moment (Sasin, 1970).

Educational and didactic work is effective only then if a pedagogue is able to understand to personal problems of a child, if he or she can promptly adopt age differences, and if he or she is successful in an establishing of relations process. This presumes a good knowledge of sick children psychology (Hiblbauer, 1963). Important roles play sensitive individual approach with a solid amount of tolerance and understanding of every single issue of a sick child. To teach children not only a new knowledge and stabilize gained knowledge, but to teach them a mutual tolerance, help to each other. This leads to good relations between the younger and the older, between the boys and the girls, etc. Relaxation and pleasant atmosphere of relationships is the best that can be added to pills and injections (Čížková, 1978).

The education is, without any doubt, one of the best forms of activity for a sick child. It helps to return to a common way of living, it brings a feel of joy, self-confidence, and will to pull oneself together. The education divers, in a good way, a child thinking about a disease, focuses a child thoughts to working tasks, keep a child fresh and in a working activity. It also benefits to a fact that a child, in a hospital environment, meets a similar regime like a former one (learning in the morning, homework and entertainment in the afternoon – reading, games, TV, visits, etc. (Kalendová, 1985).

Hospitalized pupils are educated only in the mornings, but often hospital schools are not limited to only the morning education. It is connected with afternoon activities in a public nursery that is a part of the whole day educational-medical system. An effort of schoolmistresses working in a public nursery is establishing such an environment that is the most similar to a family environment. Children can do, to a certain extent, activities according to their hobbies and ways of interest. They have their favorite toys from home, on several departments some instruments – if they do not want to miss music lessons. In the most children departments there are libraries available with a child literature, lots of social games, TVs, and DVD players in a common room or directly in the rooms of small patients, and various materials for working and art education.

Cooperation of a hospital school pedagogue with a home school of a pupil

A pedagogue in a hospital school might be significantly supported by a pedagogue from a child home school. If a pupil is hospitalized for a several days, it is sufficient to get information about studying matter from the pupil or from parents. If the pupil is hospitalized for a longer period, a hospital school pedagogue contacts a home institution and asks for sending of the studying matter (e.g. by fax or by email). If a class master or mistress is familiarized in advance with a fact that his or her pupil is ahead of hospitalization (no matter if for several days or weeks), it is good to provide a pupil with all needed materials. Also a good contribution is seen in sending in a studying

matter roster that would be suitable to cover during a hospitalization. A hospital school pedagogue is then spearheaded an investigation what a pupil knows and what not, and what is expecting from him or her after returning into a school. Some hospital schools (Pardubice, Ústí nad Orlicí, Hradec Králové) arrange for children from public nurseries and from lower levels of primary schools projects focusing on prevention of fear from a hospital environment, i.e. from a hospitalization - „Come and have a look how nicely might ailment be at our place”. Pedagogues with children may visit a hospital where are the environment and conditions presented. Children have a chance to peep into hospital rooms, to have a chat with sick friends, to find out a little bit about their experiences from a hospital environment, and on revenge, they can draw nice pictures with a kind greeting to their friends back in the hospital.

Organization of hospital school education

Teaching of school aged children takes place in a study room or directly in a hospital room of a concrete pupil. The advantages of teaching in **class rooms** are among others that school aged children are presented. If there are in a same department pupils of the same year hospitalized, a group teaching is suitable and a closed class room is at least partly clear of a hospital rush (Plevová, 1997).

Not an every department can provide a separate room for teaching of hospitalized pupils using for only this purpose in the morning. If there is such a room available, generally pedagogues with pupils are sharing such a place with secondary doctors that are using these rooms for meetings. A more frequent variant is either teaching in a game room or directly in hospital rooms. Pupils are generally working by a table; they can help each other, which is usually a positive motivation.

Teaching in hospital rooms is taking place by a dinning table or by a hospitalized pupil's bed. Except for unique cases, it is an individual teaching in a time range of 20 minutes. For administrative needs of the hospital school, only pupils with longer period of hospitalization than 3 weeks are registered, nevertheless pedagogues' interest is focusing even on children that are staying in a hospital for a shorter period.

Often, especially by older school aged pupils, when a pedagogue is working with a one pupil, the others are unobtrusively watching from their beds and they often join the solution process of an educational issue. Even if it is, for example, a studying matter from lower classes, such a form is a benefit for a pupil, but even for a roommate that is watching the teaching. This leads a pupil to an activation that serves not only for a repetition of former studying matter, but within focusing on a task or help to a friend with a studying difficulties, it serves to free oneself from thoughts on a diseases and on a time of a possible ending of hospitalization. A cooperation of older pupils with the younger or with pupils thought according to General educational program (RVP) for a basic teaching, modified for a pupils with a light mental disability, has a priceless pedagogic effect and it is a concrete realization of the education in praxes. By a high school aged pupils a request for a consultation is generally initiate by a pupil him or herself. His or her questions are addressing to studying matters that are not fully clear and that are related to profile or graduation's subjects.

Didactics aspects of sick children education

In the nineties, a survey shielded by Amsterdam hospital school was realized in European hospital schools. In the survey, through a questionnaire, 19 European countries were addressed including the Czech Republic. The survey oriented on pedagogical and didactical aspects in the sick children education issue, i.a. questions and answers in which ways is the education different in hospital schools from a regular teaching in common schools. A continuity of educational process was observed; prevention and elimination of learning issues, prevention of isolation feelings from the hospitalization, perspective in the future, and an assistant to children with their returning in home institutions.

The survey results pointed out that a minimalization of isolation feelings and returning of a child into a home school are among priorities (see figure 1). Other objectives are seen by respondents nearly with the same priority; the lowest priorities get the offer of future perspective and the elimination of learning issues (these are evidently seen by respondents among other articles).

<u>Educational objectives</u>	<u>Number of answers</u>
Learning issues prevention	69
Assisting in returning process into home institutions	75
Educational process continuity	73
Learning issues elimination	65
Future perspective offer	67
Isolation feelings minimalization	74

Figure num. 1. Identification of educational objectives in hospitals (*Knol, Courlaner, 1993*)

In the Czech Republic, according to Plevova (1997), there is implicitly seen the educational objectives, i.e. objectives mentioned in the table in the first four rows (Learning issues prevention, assisting in returning process into home institutions, educational process continuity, learning issues elimination). No less important objectives are seen in a so called psychotherapeutics category, i.e. sustenance of a good psychical condition, overcoming of a critical period during a hospitalization, sustenance of a psychic development level, and returning back home and back into a home institution.

The principle of **the education of hospitalized child theory** is consisted of a selection and a modification of the educational content with regard to educational objectives. By hospitalized pupils, modification of studying matter content is necessary with regard to a pupil health condition and with regard to an allowed time for learning by an attending doctor. The front place in an educational plan takes a Czech language education, including language and literature parts, mathematics, and foreigner languages. A ground education is seen as an assisting subject in the first level, later on a homeland study and general science; in the second level there are social subjects seen in the same way such as civics, history, and general science's subjects – chemistry, physics, natural science, and geography. Working, graphic education, and partly musi-

cal education take place in the afternoon activities (in a conformity with the school reform and with the school law 561/2004 Coll). From a school year 2007/2008 all the hospital schools educate their pupils according to their own educational programs (ŠVP) that had been created a year before.

In ŠVP schools generally do not fulfill a time dotation, not even a minimal time dotation for single educational sections in RVP. The length of a teaching hour and number of teaching hours in a day and in week are determinate after a discussion with an attending doctor in a relationship with a day regime actual for single children departments.

In interaction with educational plans that were created based on Educational programs of primary schools schema, in educational programs of hospital schools according to an actual RVP for a basic education and ŠVP of single schools, there are not all educational sections submitted, but an education of other sections is intensified. The main stress is upon an education in a language section, mathematics and its application, whereas there are not some of their parts included based on an environment, material equipment, and above all on a health condition of a pupil. There is also no second foreigner language included in the educational program. A choice of sectional themes into hospital schools schemas is based on concrete conditions and time possibilities of a particular school.

In a case of a hospitalization of pupils with disabilities, specific learning alienations, behavioral alienations, and with an autism diagnosis, a pedagogue is closely cooperating with the hospital staff, with parents that are, in many cases, hospitalized with their children, and with a home school. A health and a mental condition of a child are carefully observed. An educational program of such a pupil is strictly individual based on an agreement with a home school and with parents. Based on this cooperation it is possible to educate pupil in subjects from a different year or help a pupil to confirm gained knowledge, or eventually to catch up on missed studying matter.

A specific pedagogical care is targeting even genius pupils. Even here it is necessary to ensure a close cooperation with parents and with a home school pedagogue. A pedagogue can proceed faster in teaching, set more complicated homework, puzzles, quizzes, etc. A pupil's work might be sending into various regional or whole republic competitions. Even theses pupils are lead towards an adequate approach to less talented friends, to tolerance, and to a willingness to help younger, eventually disabled friends.

With regard to a fact that it is all about the education of hospitalized pupils, it is adequate to dedicate more interest to an educational section – Human and Health, and to its section – Health education. The education deals about prevention, protection and responsibility for own health, fixation of hygienic, catering, and working habits, injuries prevention, and foreseen of risk situations.

Into the educational section – Human and health – it is adequate to integrate **an explanation of children disease fundamentals, medical treatments and procedures** that a child is meeting during the hospitalization. This explanation generally goes through parents - hospital staff explains to the parents, whose know the child the best, what is ahead of their child and it is upon them how they explain it to the child. Some of hospital departments employ game specialists. Their job description is to fulfill a leisure time of sick children, but first of all preparation of a child on procedures, explanation what is

ahead of a child in a hospital, and an attendance at treatments. If a department has a game specialist and a pedagogue, a school is fully focusing on primary objectives, i.e. ensuring a continuity of the education and teaching of children and enable smooth return to a home institution. Pedagogues are still one of a solid support and confidants of small patients and parents. The explanation of medical treatments is then upon game specialist. If a department has no game specialists, an integral parts of a pedagogue's job description are even activities including a psychotherapeutic child preparation for medical treatments. The aim of these activities is to free a child from a fear of medical treatments.

Older children may use "working pages" – cards, where are detail descriptions of medical treatments. Pedagogues and game specialist, after a discussion with the hospital staff, are taking a part in cards production process.

The main methods using for the explanation of diseases to a small patients are game activities and demonstrations – a child is explained a procedure on a doll of a boy or a girl (adequate to a child age, mental level, and psychic state), which parts of the body are involved in the injury or in the disease and what methods will be used for a full recovery. By means of manipulation a child can all alone try what is going to happen with a child's body and the fear from an unknown procedure might be "lived" in advance. Except the dolls, there are even puppets used for the demonstrations. Mistress teacher can borrow real instruments from doctors, e.g. phonendoscope, ORL mirror, injections etc. By older children there can be educational method used – a discussion by an opened anatomy book, photo documentation, video projection of a treatment etc.

A pedagogue has to act carefully and sensitively. Every single child is the individuality. Not every child is able to absorb some information about treatments from psychological point of view. There should be even a shame taken in an account, especially by older children. Therefore, the one (a pedagogue or a game specialist) that is discussing a medical treatment with a child has to choose a strictly individual approach with a preservation of privacy and discreteness. There are some parents that from a religious or others reasons do not want to a child to be informed (by whom a presentation of a treatment might have a contra productive effect). All the factors have to be considered carefully in advance.

An evaluation of an issue understanding and a managing of a treatment has to be form a psychology point of view only positive - a compliment for a child effort and bravery (even in the cases when a child did not cope with the situation). The positive reaction of a pedagogue brings an assurance that even a child gave in the pain and the fear, a pedagogue do not damn a child; a pedagogue keeps a trust in him or her and that there is still hope and will to cope with the situation. Training of such an approach that teach a child to not give up, even despite of a self failure to be able to set the teeth, and believe that a child relatives do not damn him or her, is for a child a priceless device in to the future; not only for a school work, but above all for a live itself - for future relationships, professional realizations and for a role of parents.

The theory of hospitalized pupils education deals about what methods, forms, and tools seem to be the most adequate for the education of hospitalized pupils; in a period when a child becomes a pupil in a hospital school, or from a moment, when an attending doctor allows a child to participate in the education until the time, when a patient is returning back home.

A pedagogue makes sure him or herself about a state of pupil's knowledge through a repetition of studying matter and based on a health condition he or she can move on. During the teaching a pedagogue explains a new matter and enters homework. The homework is solved out independently. During the teaching a pedagogue is checking the work; if some troubles appear a teacher will recheck the work and practice it again (Vítková, 2006).

An every day question, that pedagogues of sick pupils ask him or herself, is what should be chosen as the most effective approach in the educational process to meet the educational and teaching objectives; i.e. balance in an adequate way a choice of the most effective methods in a relation to the objectives and to a content, with regard to the pupil's abilities and skills (Janiš, 2006). For needs of educational process in hospital schools it is necessary to take in account an actual health condition of pupils, their psychic conditions, actual knowledge, hobbies etc. We result from a procedural aspect or from a summary of educational methods from Mojžíšek (1988):

Motivational methods

An education in hospital schools is specific in fact that a vision of teaching is motivation on its own. The school education is a variegation of a monotonous hospital regime; an opportunity to focus on other thoughts than on diseases and homesickness; a touch of a "normal" reality in an adverse environment that a pupil is in during a hospitalization. The pupils, especially from a first level of primary school, are keen to show off their knowledge to a pedagogue and they make an effort to continue in teaching. Pupils from higher years are often afraid of a possibility of missing the studying matter and they welcome a school work with a hope that "it will not be so bad after returning back to a home institution." The pedagogues are of course taking in account changes in a health condition, based on which they put adequate requirements on their pupils.

Thanks to an individual approach the pupils are often achieving better results than in their home institutions.

It is managed to hold a pupil interest with a little footsteps, free her or his thoughts from the pain and fear, and return a hunger for learning and gathering new information. Pupils of an older age are often choosing a studying matter on their own, which they missed or did not understand properly in their home institutions. A self confidence of a child is often returning back even after a long time missing cooperation between a home institution's pedagogue and parents; the motivation and a positive approach to the education is again developed. If the reactions of the children on a school work are positive and integration into educational activities is spontaneous - it reflects that the methods are effective and adequate.

An individual work with an every pupil is subsequently enchanted and extended by work in a group; where is a varied age-class distribution, pupils from different schools and different domiciles are meeting with each other. Thanks to the cooperation, support and motivation there are more easily accepting new knowledge; they are behaving in more open way and they are more tolerant, they learning how to respect others and how to be respected (http://skola-uohospital.hostuju.cz/o_nas.html).

From other motivation methods seems as a suitable the “protracted” motivation – in the ending of a lesson of an exposure type, a pedagogue is using some attractive items to evoke an interest about next studying matter in a next lesson. A pupil is looking forward to a next lesson and in a free time he or she can find some information about the subject thanks the internet in advance.

Information of a didactic aim as a motivation is generally advised in the education of older pupils, but here it has its foundation by all age-classes, of course information adequate to a mental and age level of a pupil. Pedagogues are often listening from their pupils if it is necessary to study in a hospital, for how long, what subjects, and why. An explanation what studying matter will be discussed and presentation of an approximate pupil’s schedule bring a light into these questions and might be motivating into a school work.

In the motivation methods there can be even examples from praxes included. In the hospital environment these examples might be implicated to a day regime and to situations that a child is usually found in and that a child is usually solving.

For example – during a mathematic lesson, during teaching percentage and fractions, a discussion might be touching a snack; how to split an apple, a cake or ice-cream cake for two, three or more friends in a room, in the way that all of them will have the same piece. What piece will eat a child in a room where are four children? And what if some impolite child will eat a piece belonging to his friend? Etc.

A thankful motivation factor, especially by young children, is a ritual. It brings a certain feeling of security in an unknown environment that is connected with a lot of pain, stress, and anxiety. The ritual might be a concreted signal whit that a pedagogue is knocking on the room doors of their pupils and he or she is in such a way announcing an arrival. It might be a greeting that is used between a pedagogue and pupils as a mutual welcome in the beginning. Next ritual might be a song or a poem that is entering or ending a lesson.

Not only by preschool aged children, but even by first school level pupils, it seems very effective a usage of thematic “leitmotivs”; topics, that are fading into all subjects in certain time intervals, most common in a week or in a fortnight. These topics are generally planed in the beginning of the year in a skeleton plan. It deals about the year seasons usage and related changes in the nature, traditions, public holidays, anniversaries, etc. The education in such a section is then fulfill with e.g. the fore spring theme, spring flowers, etc.; the sections might be also vitalized with nontraditional activities – mask production, balls organization, etc. These activities have to be consulted with an attending doctor, in some departures, e.g. immovable patients; these activities are not suitable at all.

A motivation for participation in the education and for a smooth communication with a pedagogue is an emotional support of children – expression of a frank interest of a pedagogue about a child’s problems and his or her school results, smiles, caresses, cheers, a promise of a small material prize. This might a candy – of course based on a child’s health condition, furthermore a picture, stickers, puzzles, sudoku; it is based on a child age, gender, and hobbies.

Exposure methods

The most frequent exposure methods used in hospital schools are *verbal* methods, whether monological or dialogical.

Especially by younger school aged children a method of *narration* it is suitable. Besides a fact that the method is effecting as a motivator, it strikes children with its emotional elements and it has ability to establish a close social interaction a pedagogue – a pupil. This method might be suitable supported by pictures demonstration, by photos or didactics tools.

Demonstrative methods are especially pleasant, because they clearly show a principle of an issue or a studying matter. A good assistant during the explanation of studying matter and during a further practicing is adequately chosen *teaching tools*. However they have to be suitable for specific conditions of work in hospital schools. It is advisable to have same or similar teaching tools, which are the pupils using in home institutions.

The tools variegating the education have to meet following criteria. Above all the have to be suitable form a hygienic point of view – the most suitable are some tools in transparent washable covers made of plastics, pictures, graphs, tables, surveys etc. If a pedagogue is preparing some tools, the most common are some papers or cards from paper; it is suitable to laminate them, namely not only because of hygiene, but even because of durability. A next criterion during a preparation of the tools is their size. In contrast to a teaching in a common class it is necessary to use tools of smaller size, especially by lying pupils. The tools should be also light, easily portable; it is also necessary to take a notice of a child safeness, so that a child will not be harmed by a manipulation with them (Kalendová, 1985).

During the teaching in hospital rooms there is no possibility to use blackboards. It is advisable to use, for a better clearness of a teaching subject, mentioned graphs, tables, etc. (especially by older pupils) – for a longer durability again laminated in a transparent cover. A good tool for a work with a bedridden pupil is a washable writing table with markers.

The most suitable tools are generally those, which based on manipulation lead to thinking, decision making process, acting, and to support an activity of a child. By younger pupils it is necessary to keep in view game and entertainment factors than information; that is why there should be more frequent those tools that are enabling “game occupation”. Among these tools might be various social games that a pedagogue is preparing on him or her own. Their usage is very broad; they will serve for an exposure of a new studying matter as well as during repetition and practicing of an older studying matter. A game might be played with a one pupil during an individual teaching as well as with more pupils by a table in a room or in a playroom or in a classroom. It might be made as a play ground where the players are moving their figures in certain boxes and they fulfill tasks prepared on cards. A topic and a way of elaboration is based on a pedagogue fantasy and on a didactic objective, i.e. what is a game meant for (exposure, fixation, concrete subject or concrete studying matter). Elaborating of such a tool takes a solid amount of a pedagogue time; if it is already elaborated it might be use for a long time period. After a certain time spends in a hos-

pital school a creative pedagogue has several pieces of these nontraditional teaching tools – so that he or she creates a special-interest portfolio. Expect of the games that are function on playing boxes, figures, playing dices bases; there are also often used games on pexeso, domino, and puzzle bases.

Elaboration of nontraditional activities and connected elaboration of tools and preparation for teaching put great demands not only on a pedagogue fantasy and creativity. A pedagogue do not need to be alone in these activities; ideas on elaboration of adequate tools and their realization might be entrusted to students (especial in faculties hospitals in cities) that are on pedagogical praxes or other specialist that are participation on leisure activities scheme of sick children (e.g. high schools students specialized in social work etc.). Pupils might also assist at elaboration of such a game during a leisure time or during a time spent in a pubic nursery. They might be drawing according to a model, cutting out cards, painting pictures, etc. Pupils of the older school age and high school students may come with valuable ideas how to improve and complete the pedagogue's own didactic games and tools.

A significant toll in education of hospitalized patients is a computer. Today, nearly every single children departure has some – in a playroom, or in a classroom, in a hall, or directly in a patient's room. Some hospital schools use notebooks in the work with bedridden patients. The work with a computer brings a broad spectrum of possibilities for educational work of a pedagogue.

If a computer is connected to the internet, there might be some information found relevant to a studying matter (e.g. for homework). A role of computers and the internet can not be overestimated, at time pupils are spending more time than is desirable using the internet – as a tool for a longitude fulfillment of a leisure time, this tool can not be recommended. In a hospital environment a computer has lot of positives. Thanks this tool children can find not only some information relevant to the educational process, but they might be in a contact with the outside world. They can email to friends from home and from a school, receive emails form parents, and chat with close persons.

Expect a classical demonstration, there can be also a *comparative demonstration* used. This method might be predominantly used with pupils that are educated in groups within various competitions. For example in art education – pupils are drawing pictures on a concrete motive, final works are collected, and they alone choose the bests that will be used for a decoration of halls or directly of patient's rooms.

A longitude observation method might be used occasionally in a hospital school environment, with regard to a fact that a time of pupils' hospitalization is shortened as much as possible. Its place is so that in children sanatoriums and in medical institutions, or in classes of day stationeries at faculty hospitals.

Fixation methods

An initiative to fill in gaps of pupils in a studying matter, catch up missing matter, and keep up with a home institution might take priority over an interpretation than over a recapitulation. A significant amount of time is anyway dedicated to fixation methods that are focusing on the repetition and the training, especially knowledge repetition methods. The most frequent are questions and answers methods – the form of question

during studying matter exposition and after it – in the end of a pedagogue interpretation and in the end of a class.

For the repetition serves also homework – in this case not “home”, but work set by a pedagogue to a pupil in the end of classes that should be prepared to a the next lesson. In a home environment supervision upon this process is in parent’s hands; a pupil is elaborating them under parent’s supervision, or parents just only confirm them with their signature that the pupil elaborated homework. In a hospital school this is not possible; children older than 6 years are not usually hospitalized with their parents, pupils are so that lead to an independent work.

There broad possibilities for an independent work of pupils in this type of schools. This fact comes from the educational conditions, especially from a chronicle absence of time for a direct pedagogic work. It takes only a fragment of time; it is followed with an individual work of children that is significant thanks highly productive peaces of the educational process. A pedagogue hast to very carefully think about the individual work of their pupils and there have to be a very good organization. A variance in a longitudinal lack of the direct educational time and in a potential excess of a pupil’s study time can not be solve out with extensive homework after an opening instruction. Children have no possibility to check the homework if they are right or not; a feedback is missing. The experience shows that pupils are losing their motivation and confidence during a continual work and a level of results has a decreasing tendency (Sasín, 1970).

The individual work has nothing in common with such a work when pupils are only occupied thanks activities, or remaining silence, or order in a departure is not disturbed. Individually pupils may work:

- during educational process itself,
- during elaboration of homework into next classes,
- during other activities that are under a supervision of a pedagogue, mistresses in a public nursery, but even of the hospital staff (Ochrymčuk, 1962).

Thanks to the individual work a pupil is stabilizing and deepening a new studying matter. A pupil is also trained in an individual thinking and he or she is learning how to use gained knowledge. This work has also a significant educational and educational-technique meaning – a pupil is learning how to study.

It is really hard for a pedagogue to prepare for the pupils’ individual work such tasks that would bring not only the new knowledge, but also that would entertain them and occupied them, and that would help them to overcome a boredom, homesickness, and unpleasant medical treatments and diseases. That is why is so necessary to choose different entertaining and various forms of the occupation for the pupils’ individual work. By older pupils a basement of the individual work is remaining in studying books, textbooks, or other text. A pupil must be well oriented in a textbook and a pupil must know how to use it.

The direct teaching is connected to the previous individual work of a child and it is again setting new tasks for the next individual work. Form the beginning a pedagogue is submitting easier tasks and subsequently the tasks are getting harder. But the individual tasks have to be chosen carefully (ask form pupils only the knowledge that they know and that they can manage elaborate).

During the direct teaching a pedagogue has to think of an adequate procedure for the individual work; lead a pupil towards an adequate work organization. These abilities and habits are valuable for the individual and active work and a pupil has to consequently master them. Abilities and habits of the individual work are conditional on volitional qualities of a pupil. The quality of the individual work affects predominantly: self-discipline, endurance, determination, discipline, as well as concentration of an attention (Kalendová, 1985).

Special pedagogical diagnostics in hospital schools

During pupil's knowledge verification process unsubstantial place occupies the criteria pedagogical diagnostics – a pedagogue is verifying what level of knowledge a pupil can manage (i.e. studying matter that had been though in a home institution before hospitalization). During educational process in a hospital school the criteria diagnostics is supplemented by an individual diagnostics. During this diagnostics a pedagogue is observing progresses of a pupil from the very first meeting. Results form the individual diagnostics serve for speed and quality diagnoses of knowledge adoption process during the pedagogical intervention (Zelinková, 2001). For pedagogues in hospital schools the individual diagnostics and the individual approach are significant. In the very first place stands a success of an individual and self confidence support of young patients. Children are able to risk more during the individual teaching even for a high price – a failure. They are often surprise thanks to theirs achievements and therefore they are becoming more self confident and independent (<http://www.sweb.cz/szs/>).

The individual diagnostics is also a good tool for an auto evaluation of a pedagogue – revision of an approach to a pupil, usage of a pedagogical and special-pedagogical methods, forms, and instruments. The individual diagnostics may serve for a support of a pupil's positive approach to the school – e.g. highlighting results that a pupil achieved during the stay in a hospital school. There might be found a collision between the criteria diagnostics and the individual diagnostics systems during a classification process.

Educational plans represent criteria that a child should be meeting and according to a level of fulfillment a child is classified. If a pedagogue for classification of a pupil (weakened by a longitudinal diseases and with a restricted time that can be devote to the school by treatments and examinations) is using only the criteria approach without an emphasis of the individual achievements, there might be expected a motivation lost, lack of interest, even some disciplinary issues might occurred or ingrown of a pupil in his or herself, and an invariability or a degradation of a child's health condition.

A pedagogue in a hospital school sees his or her pupil from a wider perspective. A child is not subjecting to the family and home institution influence; a pedagogue often sees a child in intimate situations, sees a child's relation and behavior to other patients, hospital staff, and to the school work. These observations enable a complex view on a pupil and the pupil is unwittingly unfolding his or her cause of failure and causes of conflicts in behavior (Dvořáková et al., 1975).

A sick pupil classification

A classification of a sick pupil is a responsible and difficult task. A pupil can not be classified insensitively without taking in account a health condition. On the other hand a pupil has to be classified objectively, so that a pupil will not abuse his or her health condition in classification process. Usually is classified mastered studying matters and as a bet's form of classification is seen an oral formulation (Vítková., 2006).

After ending of a hospitalization, a hospital school is sending to a home institution a personal file of a pupil with an evaluation of behavior and relation to the education, the last studying matter, and a classification proposal (only if a health condition was at least for a month or longer on an adequate level). The record is elaborated by a responsible pedagogue and it is signed by a head of a school. In the case of a shorter hospitalization, a pupil is informed about the classification continuously, as same as in a case of a pupil hospitalized for a longer period; the meaning of classification is arranged with a pedagogue individually. The personal file of a pupil is established even in this case, but it does not contain the classification.

Legitimate representatives of pupils, if they are hospitalized with their children, are continuously informed about educational outcomes after an agreement with a pedagogue; in other cases information handover is made during visits in a hospital, by a phone, or by emails.

A part of a complex classification in hospital school is **a pupils' self classification**. It develops self-respect and self-confidence of pupils, if it is observed and revised by a pedagogue it helps to develop a pupil's personality; it brings to a pupil an overview on her or his achievements and usage of educational styles. It teaches a pupil how to cope with failures and mistakes that are occurring during a school work – to accept them as a natural part of the process. Pedagogues are discussing the mistakes with their pupils and the pupils might also correct some of their work. A pupil is led onwards to the state when he or she is able to discuss his or her performance and results, try to describe what is on sufficient level and what is not, and how to continue in the work. It is desirable to establish so called teaching diary – written remarks are not as passing as oral comments, they might be recalled. There might be some experience from a hospital mentioned in such a dictionary – experiences from a day to day routine in a department, from extraordinary activities – hospital jesters' visits, trips outside a hospital – zoo, etc. The dictionary might be filed in with some pictures or photos from these actions. After returning back home, this might serve as a memory; If a pupil is asked to present the stay in a hospital to classmates – experience and experiences, or classmates and friends are curious about the stay in hospital, the dictionary enables a better recollection and photos can underline the experiences.

For a class teacher of home institution the evaluation of pupil's work is the most valuable output (exercise books and work sheets) that enables a complex point of view on a state of studied matters in a hospital school.

Hospital schools pedagogues count with a variant that a pupil after hospitalization may remain home for a longer time period. Already during a pupil's stay in a hospital they are trying to prepare the pupil on this fact and explain subject matter in advance. Some hospitals schools are also offering a possibility of consultations, when a child

during a check up is coming to consult the subjects (http://www.skolaftn.cz/zakladni_skola.html).

Others are offering a professional assistance to home institutions pedagogues during teaching provision or during returning of a pupil in a home institution in the way that obligations from the school law about an attendance and about a teaching of a longitudinal sick child would be fulfilled. For example – The special primary school at the Child hospital on Černopolní 9 in Brno, elaborated a project “Home teacher” focusing on longitudinal sick children that are not able to attend classes during a whole year in a home institution and they have to usually interrupt studying because of a health condition; or after the returning they have to pass an exam from a half-year or whole-year’s subject matter. A home institution pedagogue is usually starting to attend a pupil after a half of the year absence.

To ensure the same conditions for these children as their contemporaries have, there is preparing a project called “Integrational home education”.

A home pedagogue is used the most by children with oncology diseases, cardiac, children with immunity disorders, and chronically sick children (<http://www.ahojškola.cz/docs/domaciucitel.pdf>). A care about bedridden pupils is usually shielded by a home institution.

It would be definitely desirable if a home institution, after a concrete time period from returning of a pupil from a hospital or from a home therapy, would send a report about a pupil’s re-integration in to an educational process; this is however happening very rarely. Children after moving off a hospital, with an exception in children that are hospitalized regularly, are literally “disappearing” and feedbacks that would certainly bring significant outcomes about pedagogical fruitfulness of pedagogues in hospital schools are lost.

Conclusion

The school education is without any doubt belonging between one of the best occupation of a sick child. It helps a child to return to a common life, it brings joy, self-confidence, and a will to recover. It indisposes a child attention from a disease, focuses child thoughts on homework, and keeps a child fresh and in a stable working activity. It also contributes to a fact that a child in a hospital environment, usually unknown environment, meets a regime similar to a former one (education in the morning, after the rest homework and entertainment in the afternoon – reading, games, TV, pleasant visits, etc.).

A pedagogue in a hospital school is facing an issue from a first meeting with a pupil – how to simultaneously observe and educate, do diagnostic and compare. A good special pedagogue has to have not only solid experience and knowledge, but he or she should be characterized by fantasy and pedagogical institution. In present days it is necessary to be not only a pedagogue but also a manager; with the regard to distribution of a financial support from grants on nontraditional activities, play rooms and class rooms’ equipments, purchase of didactical tools, etc., coordination of voluntary’s activities, cooperating with a game specialists (if a specialist works in a department).

A hospital school pedagogue occupation is specific thanks to a need of a careful consideration what didactics methods, forms, and tools should be used for a concrete department, a group of pupils, or for an individual work with a concrete pupil. During a pedagogical work with hospitalized pupils knowledge of special pedagogy didactics and its application during a teaching of sick children in a hospital environment is necessary; but also a solid sense for a pedagogical improvisation – an ability to react flexible on hectic changes consequent from a hospital environment – new patients incoming, unexpected leaving of pupils in the middle of teaching because of medical examinations and treatments – returning of a friend back home or transfer to an another department, spoiled visits, disappointments from not receiving a post, etc.

The presented text tried to discuss some spheres from the educational process in hospital schools' area and from hospitalized children didactics; that is only a small part from problematic spheres in somatopedy; or its part that is dealing with the educational and teaching issue of hospitalized children. This problem is closely connected to a sick children quality of life and its correct solution enables a faster process of recovery. There are lots of other tasks ahead of it, demanding further elaboration. Spheres dealing not only about the educational issue and teaching in a hospital school, but spheres discussing a fact, what part plays hospital teaching in a complex health care about children with regard to a today's technological advance in medicine, trend in shortening of hospitalization, and a newly occurring phenomenon focusing on a psychical support of children and on quality leisure time – voluntary activities, application of expressive forms of psychotherapy, hospital jesters, games specialist, etc.

LEISURE TIME OF CHILDREN IN HOSPITAL AND QUALITY OF LIFE

Jana DLOUHÁ, Marie BLAHUTKOVÁ

A leisure time might be characterized as an opposite of a required work and responsibilities. A time when a man can choose his activities optionally and they bring a feeling of satisfaction and relaxation (Pávková et al., 2005). These activities restore and develop his or her physical and spiritual abilities at the same time. In this time a human is becoming a one's own man, he or she belongs one's own the most. All the activities that are carried on, even a man is undertaking them for himself or for others, based on an inner initiative or on an interest (Němec et al., 2002).

A leisure time of children in a hospital is a time, when children are not expecting any examination, operations or treatment procedures. When they do not need to fulfill any school duties, it is a time when a child can dispose of activities freely, based on a child judgment to a certain extent – based on an environment a child is in and based on an actual patient mood and a psychical state.

If a child in a leisure time in a hospital is left “just so”, without any notice, a leisure time becomes an empty time, in which will be a solid space for a boredom state and for bothering. But based on an environment and on a situation the child is in, even for nostalgia, an anxiety, and for inquietude. To not let this happened the children in their leisure time are under a supervision not only of hospital staff, but even under a supervision of professionals from other supporting professions such as social pedagogues, schoolmasters in hospital schools, psychologists, game specialist, and volunteers: high school and university students, hospital jesters etc.

Since 1994 a survey of Endowment Fund Key has been carried out in a children departure in hospitals. All the children departures in the Czech Republic have been questioned. The questionnaires were filled in by responsible employees of a certain department. The text containing their answers and it is therefore their presentation of an actual state of children departments in the Czech Republic. Concrete results of this survey are available from 29.10.2007 on web sites www.detivnemocnici.cz. (www.klicek.org/index2.html). From the results is obvious that a majority of children departments allow parents to be hospitalized together with their children and a minimal restriction in visitation. Generally, it is recommended to not bring in a very young children (infant or toddler) and refrain of visiting to people suffering actual infective diseases. A matter of fact is lately becoming a reality that a child is seen as a partner. Adequate to a child age, mental level, and psychical stability it is presented what is ahead of a child in a hospital.

On a question how is the children leisure time shielded in hospital, doctors and nurses named partly material equipment: televisions in bedrooms and in playrooms, videos, DVDs, etc. An important part of the leisure time was attributing to hospital schools, to a role of playing specialists and volunteers, and to special activities (theater performances, visiting of zoo, etc.).

From parents of sick children point of view is at the very first place a child health state, a quality of medical treatment, and a fast recovery, so that all what is closely connected with their quality of life. A somatic aspect is significantly affected by a good psychical condition that participants on the leisure time usage. In hospital schools can play pedagogues, game specialists, and hospitals jesters an important role. Well, a duty of hospital school is not only a continual educational process of children, but even a concern for a child soul and for a making a stay in hospital pleasant.

Today, hospital schools can be found primarily in cities in the Czech Republic. According to region institutions' files of the Czech Republic (in a school year 2007-2008) there are 26 hospital schools established, 4 sanatorium schools, and 20 children medical institutions schools (resource: web pages of single region institutions; and <http://www.ped.muni.cz/wsedu/index.php?p=op-somatopedie-zdravotnicka-zarizeni&id=f6db5e5124f7b180a123758b03eee663>).

A function and possibilities of the leisure time defines Opaschowski (2001). As a ground functions he sees recreational functions – recovery and relaxation; compensative – disappointments and frustration elimination; pedagogical and further educational, contemplation - seeking for a meaning of life and its spiritual development; communicational – social contacts; participation – participate in society running process; integration – family life stabilization and in growth into society organisms; en cultural – cultural development of one's own, creative expressions trough art, sport, and other technical activities.

From a hospitalized child point of view *a recreational function*, i.e. recovery and relaxation after medical treatments, examinations, procedures, and even after school duties. On the other hand even a fulfillment of school duties and elaboration of home works might have, under certain circumstances, a recovery character. Family visits and a time spend with relatives might be a part of a relaxation; on the other hand it might be exhausting even if a visit is nice and welcome.

Exhaustion state might occurs when an organism is weakened; a child can be easily tired out; during a visit an arguing might occurs, at this case the visit just deepens stress and frustration from a longitudinal stay in a hospital.

A recreational function (passive or active form) might be filling with a movement, e.g. callanetics by teenage girls, computer games or websites searching, mobile phone games, communication between patients etc.

The most frequent controlled activities, in a category of leisure time activities of children in hospitals, are graphic activities that contribution is highly rated among hospital staffs. For example a head nurse in Masaryk town's hospital in Jilemnice, Janouskova Marie pointed out that pedagogues of a hospital school put a great pressure on working activities; *they create a lot of bright products, children are coloring their t-shirts, so that they have good experiences from a hospital environment even back home. Even during a school age child acceptance process that is staying in a department without*

parents, from time to time a tear is dropped, during a planning of replacement some-time can be hearted "I do not want to go home yet, I must finish the picture." Sometimes children even do not have a time for parents' visits (http://www.detivnemocnici.cz/seznam/1/1_d03.html).

A game specialist is significantly involved in fulfillment of a leisure time in a hospital with an aim in securing a rest and a recovery of sick children, if a hospital has a game specialist or schoolmistresses available. They are trying to create a homelike environment for children, occupy them, and not let them think about their injuries. The occupation in a public nursery is closely related to a school work, also it is securing a full spiritual activity of a child, and it is developing a spare time activity in graphic, esthetic, musical, and working education.

Situations that are evoking a frustration or a disappointment might occur very easily: a child is informed about unpleasant news. The child is afraid of examinations or of painful operations. Despites of an effort of hospital staff, pedagogues, game specialist, and the others, the child is stressed thanks to: staying in hospital, not improving or upsets of physical condition, the stay in a hospital is extended, leaving of friends back home – roommates or visitors, spoiled visits of parents or relatives, homesickness etc.

To compensate a disappointment and a stress help activities mentioned above. Its role plays even friends between patients, behavior of hospital staff, and lots of other people and activities.

A great joy brings for example a brief or an email from home – from friends, from schoolmates, and from a class teacher.

Pedagogical and educational functions in a leisure time fulfill homework from teachers; if it is on a volunteer base and it is not forced – it might be supported with a teacher's personality and sympathy of a student to a teacher, form of homework, help to younger friends etc.

By *contemplation* an age of children is the most important. By believing children it is dealt about e.g.: a prayer – alone, with a friend, brothers and sisters, parents. An issue might occur in a specific stressful situation by hard sick patients e.g.: oncology diseases. In such cases a psychologist is significantly involved.

For a *communication function* of the leisure time it is essential to keep in touch with a family and with peers. This fact is support with a trend of losing visiting hours of hospital departments, a possibility for parents to stay with their children during hospitalization.

Regarding *the participation* – children are participating on running process of a hospital, e.g. decoration of departments' walls with own drawn pictures. For example in the Region hospital in Pardubice, decoration of a permanent character is consisted of wooden sculptures – especially in halls. Maternal rooms are decorated with cloth sculptures. In small patients' rooms there are some webs installed, that are decorated with own pupils work form a hospital school (http://www.nem.pce.cz/NemPce_odd_det_hra.htm). The pupils also assist at preparing of various actions in a hospital or in a hospital school – trips, competitions, projects etc.

An *integrative function*, form a hospitalization point of view, is to a certain extent lowered, but thanks to segregation it is possible to partly eliminate this issue based on shortening of hospitalization length and based on a presence of family. In some depart-

ments e.g. psychiatry, a music therapy is held. This therapy, besides a therapeutic effect, allows a cultural development of children patients – *creative realization through arts*. Children creativity is also developed through listening of quality music, active singing or playing some instrument, e.g. while walking in a hospital park.

Children patients are mainly allowed to leave a hospital area, especially those with a hard sickness that have to stay in beds under a continual supervision of hospital staff. That is not encouraging them at all in their moods and psychical condition that are so essential for a faster recovery and returning back home. That is the reason why some “good souls” are trying to bring some pieces of the outside world in - through a nice visit that will bring in an entertaining program, presents, sweets etc.

A trip outside a hospital is highly welcome if there is permission from doctors. This fact has already realized several employees from Brno’s zoo and prepared an innovative activity as a trip for small patients of Faculty hospital Children hematology in Cerna Pole on the 1st of June, 1997 – Day of children, along with their parents accompanied by hospital staff. As Linhartová (2007) pointed out, the action had a remarkable response. It brought lost of joy and relaxation to all the participants. It helped to relax children, ease their stress, and involve them more in a treatment process. After the first success from a one-time action became a tradition. Children became regularly – every first Tuesday in a month – visiting animals in the zoo situated on Monks Mountain in Brno. A leaflet with “a tiger’s invitation” gets children regularly for more than ten years.

Children are tolerating much better a hospitalization thanks to the trips to the animals. Thanks to the effect of stay in fresh air the children have a better appetite that is very significant by oncology patients. By drawings pictures next day after trips, children can recall experiences from the zoo visits and pleasant moments spent outside a hospital are again recalled. A children good mood is infectious; it is transmitted to parents and medical staff (Dlouhá, 2006).

An idea to give a piece of leisure time to several volunteers and professionals even of different specializations (oncologists, university pedagogues, zoologists, nature lovers), had an external employee of Brno’s zoo prof. MVDr. Dagmar Ježková, CSc. She argued a director of the zoo MVDr. Martina Hovorku, Ph.D., a head of Children oncology clinic prof. MUDr. Jaroslava Štěrbu, Ph.D., and several others into the realization of this project participating up till today (Linhartová, 2007).

In to the drawing of pictures, children parents are also often involved, especially mothers. They are recalling animals that they met a day before. They are trying to capture details of a favorite animal and afterwards they are comparing their work. Students’ visits are also a pleasant relaxation even for family members that have as well as their children a chance to relax, change thoughts, and least for a little while forget hardships connected with a hospital of their kin (Dlouhá, 2006).

During these meetings in Brno’s zoo, there are not offered only a zoo attraction, but “*an extraordinary kindness was handed out, a leisure time of some volunteers, even some sweets from a zoo budget for enjoyment, a joy for oncologist children patients were offered*” (Linhartová, 2007, p. 74). And it is offered not only to the children, but even to their parents and medical staff. A trip to the zoo meets definitely a relaxation function (meeting the animals, meeting their way of living and behavior), pedagogic-

educational function (listening to a soft splashing of water by seals' pool, watching exotic fishes bustling in aquarium in the tropical kingdom) is an ideal scene for contemplation. If sick children are accompanied by their family or health brothers and sisters, the visit has a communicational and an integration contribution. As Linhartová, V., 2007 pointed out, satisfied parents and grandparents of sick children that are involved in these activities are often confirming these facts in interviews with the hospital staff.

Thanks to graphic activities with pedagogic faculty students the children are also involved in the running process of departments – the pictures partly decorate children rooms and hospital halls, but what is significant, they are sending towards Mrs. Jensenova in Norway within in a frame of Stonožka project. The pictures are distributed in to the whole world from Norway and gains from the project are used for buying all sorts of equipment for sick children.

Thanks to graphic activities children also develop their creativity and an ability to capture details of an observed phenomena or a memory on it trough drawings, batiks, linocuts, and other graphic techniques. It also contributes to their en-cultivation – a culture development of their own trough arts.

On simulative meaning of animals behavior in zoo for sick children, drew attention colluviums - About not dying (may 2005) and About tiger's invitation (may 2007) held in a lecture hall of Brno's zoo. Their psychotherapeutics benefits for all that are involved in zoo visits appreciated prof. MUDr. Jiří Vorlíček, CSc., prof. MUDr. Jan Žaloudík, CSc. and others.

In today's sick patients medical care theories, especially in children age, there is a main principle in a complex treatment involving all complicated processes going along with a child from a beginning of medical process to the end of treatment (in an ideal state to the complete recovery). In this conception of the medical care not only a doctor is involved, but even other professionals from assisting professions and ordinary persons that are trying to keep a child in an adequate psychic condition and that are trying to ensure a child a quality utilization of leisure time. Do not expose a child to homesickness and dark thoughts on own pain and diseases and throughout this effort contribute to a faster return into a common life.

All the leisure activities for sick children prepared and realized with an agreement and supervision of attending doctor and nurses, characterize a solid amount of devoted work motivated by compassion on the pain and suffering.

It is necessary to highly appreciate and support them in their work, because thanks to them children are getting an opportunity to variegate the medical treatment. They bring joy and relaxation, so that a psychical condition is improved, a quality of life is affected, and in such consequences, even a health condition.

Conclusion

The leisure time of children in hospital is a time when there is no medical examinations, medical procedures or treatments are not head of a child. It is a time when a child needn't to fulfill school duties and it is a time that a child can, to a certain extent (based on an environment a child is in, physical a psychical condition of a child), spent freely based on an own discretion. To not let a child be alone in unhappy thoughts about

a stay in hospital and about a separation from family and friends, hospital staff and other specialists (special pedagogues, schoolmasters, psychologists, game specialists, volunteers students from high schools and universities, hospital jesters etc.) are taking care about the leisure time of children in hospital.

Hospital staff, in a way of complex approach to the sick children treatment and seeing the treatment as bio-psycho-socio-spiritual wellbeing, welcomes these activities. Whereas it is a matter of fact that nothing should be affecting the process of treatment and all that are involved in improving tendency of the time when is a child in a hospital have to respect a treatment mode and all instructions of the attending hospital staff.

A good example of an extraordinary initiative of decoying a child from a diseases and from unpleasant experiences that is highly welcome from hospital staff and where is the staff even taking apart, are trips of oncology diseased children from Faculty hospital Brno in Cerna pole. These activities are being held for more than ten years. In this period more than 280 children together with their parents and hospital staff participated in. The trips in to the zoo contribute to a higher quality of leisure time of sick children and they have a significant psychotherapist meaning for them.

QUALITY OF SCHOOL LIFE FROM THE PUPILS' PERSPECTIVE - RESEARCH THESIS

Věra VOJTOVÁ

Introduction

There is a relatively broad consensus among the general public that education plays a decisive role for the quality of life in adulthood. People usually associate the quality of education with efficiency, success, high qualification..., with the school. On the other hand, one often forgets the pleasure gained from learning, shared experience and success, and from the other pleasant personal aspects of school life. Nevertheless, specialists pay a lot of attention to these aspects. They are believed to influence the activity of pupils, their integration and functioning within process of education (cf. WHO, 2001) and they can be crucial for school performance (Hollenweger, Haskell, 2002, Booth, Ainscow, 2002). Positive school life experience and positive signals associated with learning initiate pupils' motivation to self-development (RVP, 2005). These aspects seem to be relevant for the quality of education.

We present a tool, which makes this dimension of "pupils' school life perspective" accessible to teachers, making them more aware of some negatively perceived aspects and allowing them to actively work and develop positive environment for all pupils. The requirement of high quality school environment for all pupils closely relates to the inclusive trends of the contemporary education (UNESCO, 1993, 1994, 2005). Within the inclusive concept (WHO, 2001, 2002, 2003), individual learning problems and failure in schoolwork are believed to hinder good quality of life (Walker, Severson, 2002, Booth, Ainscow, 2002).

Delimiting the research problem

Our long-term research aims at verifying the usability of the "School life" questionnaire as a tool for the identification of risk areas of school life, which have a negative impact on the active involvement of all pupils in learning and education. We specifically focus on pupils with behaviour disorders, for whom the risk of exclusion from school and education is very high (Jahnukainen, 2001, Wearmouth, Glynn, Berryman, 2005). In this contribution we present the first results of our research, which is a part of research intent "Education of Pupils with Special Educational Needs" of Masaryk University Pedagogical Faculty.

The first phase of the research aimed at verifying the usability of a scale for measuring the quality of school life from pupils' perspective. In particular, our goal was:

- to translate and modify the "Quality of school life" questionnaire (Williams, Batten, 1981) and verify its usability in the Czech environment;
- to verify the reliability of a scale and suggest further steps;
- to analyze and describe pupils' attitudes towards the quality of school life.

The empirical research was conducted at elementary schools in the Czech Republic in the years 2007 and 2008.

We characterize the *quality of school life* in terms of individual and contextual connections of the school environment. It is defined as a list of scales which are used in the questionnaire of the evaluation of school life (cf. Ježek, 2006). Positive assessment of school life by pupils themselves is relevant for their motivation in education and corresponds to the current school concept (cf. UNESCO, 2005) and is an important factor affecting pupils' approach to learning and education (cf. Booth, Ainscow, 2002). Negative attitudes, on the other hand, contribute to the development of problem behaviour (cf. Sørli, 1997, Wearmouth, Glynn, Berryman, 2005) and increase the risk of school drop-out (Jahnukainen, 2001). The importance of understanding the attitudes of pupils themselves in the context of school environment is accentuated by many researchers (cf. Ježek, 2006); attitudes typically involve the aspect of assessment, whether explicitly or implicitly; pupils' attitudes capture the implicit curriculum as a "didactic" aspect of class or school life, which is used to instill the pupils with certain knowledge or skill (cf. Daniels, Garner, 2000, Wearmouth, Glynn, Berryman, 2005).

Selected findings

There is a number of studies concerning the influence of school environment on the performance of pupils. In this section we describe a few examples, which are relevant for our own study. One of the first large-scale research of school life quality, specifically focused on pupils' attitudes towards the school environment was published by Epstein and McPartland in 1976. On the sample of 4266 pupils (10–18 years old) they observed the significance of pupils' emotional experience for the development of their motivation to learn. Pupils that were *happy at school turned out to have a more positive attitude* towards other areas of school life, they performed and behaved better at school, and were altogether more successful (Epstein, McPartland, 1976). Williams and Batten (1981) took up with their „Quality of school life“ research. They determined the latent structure of indicators and shortened the questionnaire from the original 71 to 29 questions. The usability of this version of the questionnaire, as well as its independence of culture and nation specific factors, was tested and verified in a number of international studies (Binkley, Rust, Williams, 1996, p. 197). This international research, conducted in 8 countries of the European region, serves as an inspiration for our own study. Linnakylä with team (1996) proved the *significance of the impact of school life on the forming personal and social identity* of pupils; they

identified *school life experiences as important determinants in the process of learning, their future education, as well as in the overall attitudes towards long-life learning*. Henderson and Fisher (2008) investigated a group of 157 11–12 years old pupils of non-study classes; they were interested in the correlation between how pupils perceive the teacher-pupil interaction and how successful they are at school. They found out that pupils' perception of the *teacher-pupil interaction plays a decisive role in pupils school performance. Clear guidance and instruction are showed to support friendly behaviour and the feeling of freedom at schoolwork, which in turn increase pupils' motivation to learn*. Dinkes, Forrest, and Lin-Kelly (2007) arrived at similar results after they analyzed data about the criminality of 12–18 years old pupils and students in the school environment and on their way to and from school. The data spanned a 10-year long period. They concluded that *school criminality and indiscipline at class work directly correlates with school failure and low level of schoolwork*. In 2000, the European Commission ordered a research on the quality of school life in the European region. This research was conducted by an international group of experts, which identified 16 indicators of school quality clustered into 4 areas: *level of knowledge, opportunity to success, education process monitoring, tools and structure of teaching*. The UNESCO experts proved a direct correlation between a bad guidance and school failure (2005). Johnson and Asera (1999) studied the relation between school quality and pupils' school success. They conducted the research in 9 schools with pupils at risk of social disadvantage. They focused on systemic aspects, functionality and strategies of school environment. Five years before the research was conducted, all these schools registered a notable improvement of pupils' school success. This was exemplified by the shift in scores at national tests, where these schools moved from bad results to results comparable with the nation's best schools. Johnson and Asera (1999) concluded that the observed improvement in pupils' school success as well as in their contentment and mutual relations is to be attributed to a *school environment with clearly defined competences and responsibilities of both teachers and pupils*. The way pupils perceive teacher's *assessment* of their own *behaviour* and the *respect* with which they are treated were pointed out as important determinants of desirable models of behaviour for all pupils of the schools in the survey. In addition, the *opportunity of teamwork, peer support and mediation* were identified as important factors for fulfilling the educative goals of the school.

As regards the Czech research activities, a number of authors occupy themselves with the context of school environment and the ways it influences pupils' attitudes towards school performance and self-evaluation. A study of Helus and Pelikán from 1984 investigates the impact of teachers' *preference attitudes* on pupils' performance at school, their self-reflection, self-evaluation, and auto attribution. They pointed out that teachers tend to project their subjective view of objective reality into the evaluation of pupils. A high amount of subjectivity (in the sense of under- or over-evaluating the performance of a certain pupil) was identified as a risk factor affecting the motivation to learn, the formation of pupils' self-confidence, and pupils' relationship to the teacher and the subject they teach. It can also induce negativistic attitudes in the behaviour of pupils. Novotný (1997) studied how teachers' attitudes towards pupils influence the school performance.

He pointed out that authoritarian teachers emphasize disciplinary requirements at the expense of educative requirements and aims. Vojtová (2001) compared pupils' and teachers' attitudes to certain selected phenomena of the school environment, focusing on the issues of pupils' behaviour. She observed the tendency of teachers to perceive pupils' attitudes in a more positive way than pupils themselves and to undervalue the work with disciplinary rules and a fair assessment of pupils' performances. School environment and its context has further been investigated by Mareš, 2003, 2007; Ježek, 2003, 2006; Smékal, 2007; and others. These authors emphasize the wide range of these problems (Mareš, 2003) and the multitude of possible approaches to the context of school environment and climate (Ježek, 2006). They stress the point that there is no universal general concept of climate which would be appropriate for solving all problems in the context of school education (cf. Mareš, 2003, 2007, Ježek, 2003, 2006).

Findings of the first research phase

The first phase of our research aimed at determining the usability of a scale for measuring pupils' attitudes towards school. In what follows we present elementary school pupils' attitudes towards education and quality of life in school. The data were extracted from the process of verifying the used scale. The background assumptions of our research come from Williams and Batten (1981) and Binkley, Rust, and Williams (1996). Our goal was:

- to translate and modify the "Quality of school life" questionnaire (Williams, Batten, 1981) and verify its usability in the Czech environment;
- to verify the reliability of a scale and suggest further steps;
- to analyze and describe pupils' attitudes towards the quality of school life and education by using a descriptive analysis.

This study does not include an analysis of the differences in attitudes of pupils with problem behaviour. We leave this for future research phase. The data have already been collected. Currently we are adding new data concerning distinct target groups.

Questionnaire

As we mentioned the construction of our questionnaire was inspired by the "Quality of school life" questionnaire by Williams, Batten (1981). Given the specifics of the Czech school environment (cf. Mareš, 2003, 2008), the questionnaire was not merely translated but also modified. We arrived at a set of 35 questions. We used the theory of Binkley, Rust, Williams (1996) and divided the questions into six topical dimensions: (i) the overall satisfaction with school, (ii) the perception of one's own success and opportunity in learning, (iii) negative experience, (iv) the teacher-pupil relationship, (v) the school status of pupils, (vi) the formation of identity.

The dimension of the *overall satisfaction with school* was delimited by the indicators: I really like going to school; I like most of the subjects; I am

usually satisfied with what I do; I know what the teacher wants from me; teachers don't take my mistakes ill of me when they see that I make effort; learning is fun; I am happy in school. The dimension of *success and opportunity* involved the following indicators: I can reach good results; I like learning; I am curious; I learn a lot; teachers show interest in my opinions and thoughts. The *negative experience* dimension made use of the indicators: I am often nervous; teachers like some pupils more; I am afraid when I hear my name; I feel lonely; teachers don't like me; I am afraid of vexation. The *teacher-pupil* dimension focused on: I can speak to the teacher when I have a problem; teachers are fair at assessment, punishment, and praise; teachers help me when I don't know how to proceed with an assignment; teachers listen to what I say; teachers help me achieve good results; teachers evaluate me appropriately. The *school status* dimension was delimited by the following indicators: people respect me; others think a lot about me; pupils with disability are showed the same respect as others; I learn to take others the way they are; schoolmates help me when I don't know how to proceed with an assignment; I feel that I am important. The *formation of identity* dimension was determined as follows: I know about many things which I do well; meeting other people helps me understand myself; I learn to understand schoolmates with different opinions; I learn more about myself; I learn to understand being a person with handicap. The respondents answered on the basis of a six-level Likert scale. The questionnaire exploits the method of self-report. This method was also used in the original research (cf. Binkley, Rust, Williams, 1996) and is still widely used in investigations of school context. It is believed to provide reports of implicit influences in the school environment (cf. Ježek, 2006, Klusák, 2004).

Data collection

A pilot study was conducted in the third quarter of 2007 on 64 respondents – 7th and 8th grade elementary school pupils, who formed a group heterogeneous as for both school performance and behaviour. The first quarter of 2008 was devoted to data collection. The fieldwork was conducted by administrators who were trained for that at two seminars.

Examined data

The examined data consists of 2069 randomly selected pupils, with an even proportion of both sexes. The data were collected in 39 schools and residential school institutions; most of them were schools and institutions from the region of South Moravia; the respondents were between 12 and 17 years old, which age-span corresponds to the original research. The smallest files of respondents (5 to 10 children) were from residential children's homes. The files from elementary schools consisted of 30 to 100 pupils. The survey included also one upper secondary school of the gymnasium type; however, only students from lower years of the more-year study program (still in the compulsory school attendance age) took part in research as respondents. In this first phase of the research we concentrate

on the file of elementary school pupils. Other files of respondents are now only considered for purposes of comparison but will get into the centre of our attention in upcoming research phases. Table 1 summarizes the characteristics of the full file of respondents.

	numbers of respondents	number of institutions	representation (%)	gender man/woman in %	mean age
elementary school	1649	22	79,7	52/48	14,2
upper secondary school	103	1	5	50/50	14,1
residential childrens homes	101	12	4,9	49/51	14,9
special chool/residential school institution	216	4	10,4	69/31	15,8
Total	2069	39	100	54/46	14,4

Comment: pupils attending lower grades than 6th have been excluded from the analysis; total number in presenting analysis N covers 1596 respondents

Table 1: Full file of respondents – basic characteristics

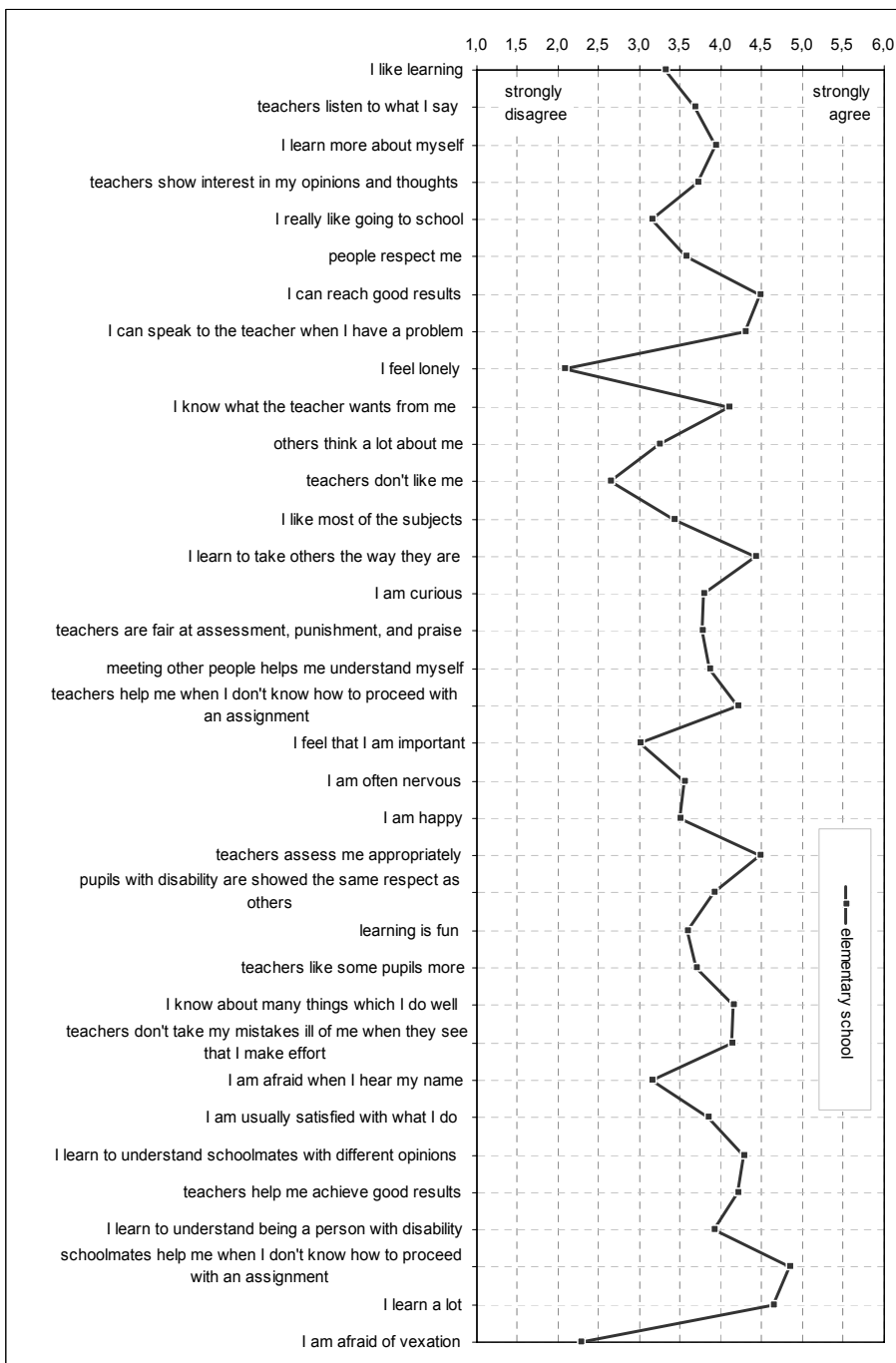
Analysis and interpretation of selected findings

In this study we focus on the first phase of analysis: we describe the distribution of the data onto particular questions concerning the school environment, looking at the file of elementary school pupils (graph 1). We summarize the mean scores in the scales of school life assessment, using the basic tools of descriptive statistic analysis. The obtained data serve for the verification of validity and reliability of the scale. The second phase of analysis will concentrate on the internal logical consistency and cohesion of choices at particular items of the scale. The third phase will focus on testing the external validity and relations between both used scales.

School life evaluation scale

The battery of school life evaluation (*School is a place where...*) consisted of 35 items. Pupils expressed their opinion about each of them via a six-level scale: from 1 = definitely false to 6 = definitely true. Graph 1 gives a summary of the mean score of all evaluated items. The evaluation profile is different for each type of school.¹ Elementary and upper secondary school respondents agree with the following statements to a great extent: *School is a place where my schoolmate helps me when I don't know how to deal with an assignment*. The biggest disagreement was expressed with the statements *where I feel lonely* and *where I am afraid of vexation*. Graph 1 summarizes the mean scores of all evaluation items in the same order as in the questionnaire. The evaluation profile is different for each type of school.

¹ Elementary schools represent the largest and the main examined data set. If not stated otherwise, the data interpretation relates to this set. Other data sets are included for comparative purposes.



Graph 1: Evaluation profile of school life elementary school

Interpretation of selected findings

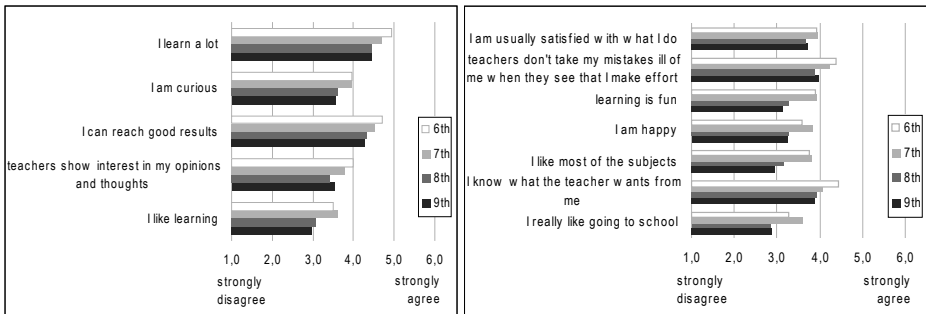
Elementary school pupils associate school with the opportunity to learn, they realize the possibilities and opportunities that school offers. Their attitude to school as a place where they like to learn is unclear; school is not a place “*where they really like to go*”. They understand the conditions and rules well and perceive school as a place where they get an opportunity and offer to develop their competences. What we find interesting and pleasing is the finding that pupils do not experience fear of failure and perceive the possibility of a repeated opportunity in case of failure. Teachers’ attitudes are generally evaluated positively.

School environment evaluation in the file of elementary school pupils

In what follows, we present the elementary school data. Answers will be compared on the basis of school years.

Evaluation in dimension A – success and opportunity and C – overall satisfaction

Graph 2 presents items from the success and opportunity dimension. On average, all items are evaluated positively, except for “*school is a place where I like to learn*”. The evaluation in the overall satisfaction dimension is close to the centre of the scale, making the data more ambivalent. Teachers’ attitude is evaluated positively in general, however, school is not a place “*where I really like to go*”. Moreover, there is a systematic decrease in the evaluation of this item with higher school years.



Source: file elementary school pupils 6th – 9th grade; N = 1596

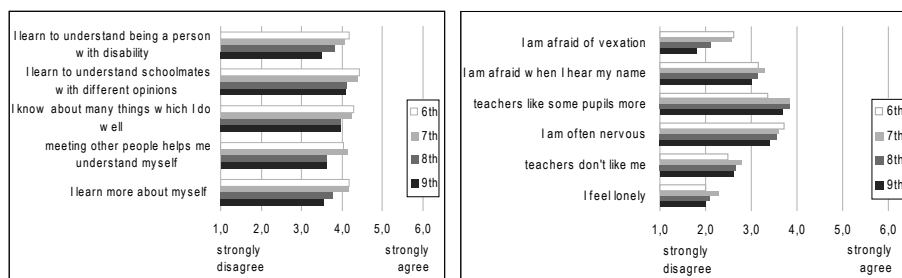
Graph 2 Evaluation profile in dimension A - success and opportunity and C - overall satisfaction

Pupils associate school with the opportunity to learn, they are aware of the possibilities and opportunities that school offers. They understand the conditions and rules well and perceive school as a place where they get an opportunity and offer to develop their competences. What we find interesting and pleasing is the finding that pupils do not experience fear of failure and perceive the possibility of a repeated opportunity in case of failure. What is worrying is the finding that as pupils grow older (and go to higher school years), their satisfaction and positive evaluation of school is decreasing. The data also suggest that the joy from learning and going to school is not

very high, with 8th and 9th year pupils even getting into negative scores. Nevertheless, it is positive that pupils experience school as a place where they are happy.

Evaluation in dimension I – formation (support) of identity and N – negative experience

In the dimension of *identity formation* (Graph 3 on the left), the evaluation is ambivalent at all items. It is again the case that the mean score decreases with higher school years and that pupils in lower years tend to evaluate items more positively. The evaluation in the *negative experience* dimension is reversed, compared to other dimensions; higher scores translate to a negative evaluation of school. Interestingly, the trend witnessed so far, namely that older students evaluate school more negatively, is not attested in this case. In some cases, most significantly in the item “*where I am afraid of vexation*”, the trend is even reversed. This is due to the fact that the oldest pupils are threatened relatively less. Another item where the score improves with age is “*where I am nervous*”. On the other hand, the item “*teachers like some pupils more*” appears to be problematic for pupils. Nevertheless, the evaluations in this dimension are generally relatively low, which is a positive result.



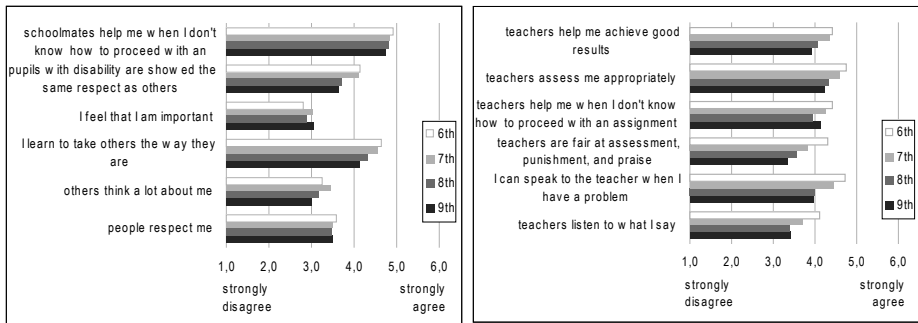
Source: file elementary school pupils 6th – 9th grade; N = 1596

Graph 3 Evaluation profile in dimension I formation (support) of identity and N – negative experience

Pupils feel safe in school, they do not feel particularly lonely or threatened by vexation, these items receive the lowest scores, accordingly. Arguably, this is due to the efficiency of prevention programs which have been systematically carried out at schools and which aim at the increase in pupils' awareness and resistance to vexation and violence exposure (cf. Peňázová, Vojtová, 2008). It is also encouraging that pupils perceive school as a place where they learn to accept different opinions and different dimensions of human life, in the sense of health and handicap (cf. RVP, 2005, UNESCO, 1996). The positive evaluation of teachers' attitudes towards pupils and the opportunity to develop shows a shift in the overall approach to learning in school. It appears that pupils are more confident about their possibilities to reach good results in learning (cf. Vojtová, 2001).

Evaluation in dimension S – school status and T – teacher-pupil relationship

Similarly to the *negative experience* dimension, the differences in evaluating the *school status* items are significant. While the item “*where my schoolmate helps me when I don’t know how to deal with an assignment*” is the highest evaluated in the whole 35-item battery, the statement “*where I feel that I am important*” is evaluated rather negatively. The feeling of importance slightly grows with age. Two other items are age-independent and others follow the general pattern of older pupils’ more negative evaluation. The *teacher-pupil relationship* item is evaluated in a balanced way and slightly positively. Negative evaluation is only witnessed in two items, where older pupils are skeptic towards how fair teachers are and how much attention they pay to pupils.



Source: file elementary school pupils 6th – 9th grade; N = 1596

Graph 4 Evaluation profile in dimension S – school status and T – teacher-pupil relationship

The findings from this battery of questions lead us to the interpretation that social networks in school environment are perceived positively by pupils. One’s importance, on the other hand, appears to be undervalued by pupils – they generally feel as unimportant, the attention that they receive is felt to be insufficient, especially in higher school years. Given the plans for future research, this finding is rather significant, as it points to pupils’ undervaluation of confidence in oneself and one’s own competences. We have reasons to believe that pupils that are unsure or weakened in areas that are important for a successful social interaction do not get enough opportunity in school to strengthen (compensate for) these weak points.

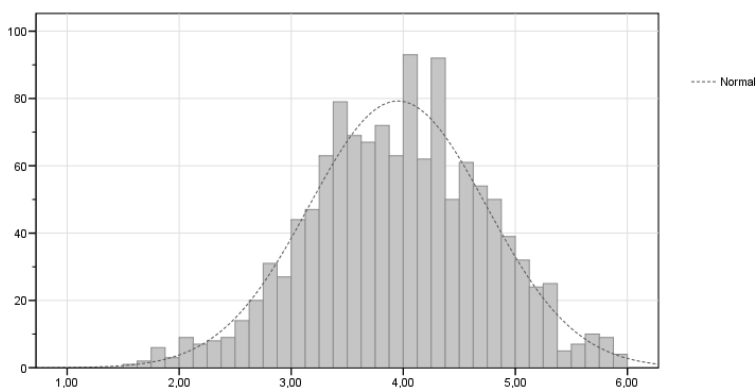
Histogram of the overall evaluation of school life

We also investigated the overall distribution of the used scale of school life evaluation, i.e. the sum score of the whole battery of questions. By summing the results of all items we arrived at a scale where each pupil can receive an amount of 35 to 210 points. The overall value was divided by the number of questions, in order to return to the original scale: 1 to 6.² The lowest score (1,0) would correspond to a pupil whose evaluation of school is extremely negative. The highest score (6,0), on the other hand, reflects an unconditionally positive view of school. The actual lowest score in the file of elementary schools is 1,57 and the highest 5,97.

² Recall that all scales consisted of 6 levels, the maximal score is therefore 6x35. In order for the summing to work properly, it was necessary to reverse the scale in the dimension *negative experience*.

The overall mean score is 3,95. Graph 5 presents the distribution of values on the scale, with a curve representing the normal distribution. The whole distribution is shifted towards the right side of the scale, which corresponds to the slight predominance of positive evaluation. **Except for a few slight deviations, the form of the actual distribution corresponds the normal curve**, which is also confirmed by other graphical and statistical tools.³ The distribution of values therefore exhibits some usual properties: the score of 68 % of all pupils is located within the ± 1 standard deviation from the average, i.e. within the span 3,15 - 4,75; the score of 95 % of pupils is not below 2,35 or above 5,55 (± 2 of the standard deviation, whose value is 0,8 in our case). If we treat the file of respondents as representative, the same holds for all pupils from 6th – 9th elementary school years.

Pupils perceive school as a place associated with happiness and feel safe in school: the feelings of being threatened by vexation and loneliness are items that appear to be the least problematic. It is also encouraging that pupils perceive school as a place where they learn to accept different opinions and different dimensions of human life, in the sense of health and handicap (cf. RVP, 2005, UNESCO, 1996). The positive evaluation of teachers' attitudes towards pupils and the opportunity to develop shows a shift in the overall approach to learning in school. It appears that pupils are more confident about their possibilities to reach good results in learning (cf. Vojtová, 2001). One's importance, on the other hand, appears to be undervalued by pupils - they generally feel as unimportant, the attention that they receive is felt to be insufficient, especially in higher school years. Self-confidence and the perception of one's own importance are crucial for a successful social interaction and integration. Our survey shows that compensating for these weaker sides by introducing opportunities in the educative process is not a usual strategy in schools. The predominance of **slightly positive attitudes in the overall scale of school life evaluation** is positive. The support of pupils' individuality and specificity with the emphasis on individual contribution to learning and teaching is an area which deserves more investigation.



Source: file elementary school pupils 6th – 9th grade; N = 1596
Graph 5 Histogram of the overall evaluation of school life

³ The normality of the distribution is controlled graphically by the so-called Q-Q graph. Statistically, we test the distribution normality hypothesis with the help of the Kolmogorov-Smirnov test, which yields the value 0,20 in this case (it must be above 0,05).

Extreme values appear less with increasing distance from the average. The scale can therefore predict the proportion of pupils with very low evaluation in a given group (population, school, class). (Normal distribution of the school life evaluation scale is also attested in other subsets – secondary schools, children's homes, and special institutions.) The distribution of the overall school life evaluation scale suggests a latent structure of the scale of pupils' evaluation of attitudes to school life in the Czech environment. Further on, we verified the tests of scale usability, its validity and reliability by factor analysis and Cronbach's α . The factor analysis, using all the items in the battery, indeed identifies 6 factors, which explain more than 52 % of the variance of the original variables.

Summary

In the first phase of our research we aimed at verifying the test of a measuring tool suitable for learning about subjective school evaluation. The pupils answer 35 questions, which are ex post divided into six dimensions, characterizing various aspects of school environment. The data set consists of 1596 elementary school (6th – 9th year) pupils. The results suggest that the internal consistence of the scale in particular dimensions is satisfactory, which in turn implies an unproblematic internal validity. The scale as a whole exhibits a normal distribution, which is a significant advantage for its further statistical assessment. The normality of the distribution is good to verify in any potential future research.

Pupils generally perceive their school environment in a positive way. The most highly evaluated statement is *School is a place where my schoolmate helps me if I do not know how to deal with an assignment*. This finding reveals that pupils perceive school as a place of social (peer) support.

PSYCHOTRAUMATIZING OF PUPILS, STUDENTS AND TEACHERS AT CZECH SCHOOLS

Rudolf KOHOUTEK, Eva FILIPKOVÁ

Introduction

Psychical traumas experienced by pupils, students or teachers at Czech schools don't usually have a character of extreme *macrotraumas* (such as primary life or health threat), but more likely of less remarkable *microtraumas*. Somatic macrotraumas at schools are not mostly caused on purpose (e.g. injuries at sports). For the most part the macrotrauma like this is a trauma both for the afflicted and the one who caused it unwillingly. *Psychic microtraumas* (experiences of unsuccessfulness, verbal aggression, insulting, humiliation, muck-raking), especially those with chronicity, may have severe impact on personality development, psychical, social and physical health.

Our entry of psychical traumatizing partly results from contemporary academic and scientific literature and partly from the action research of collaborationist focal university students' group, (57 men and 94 women), who gave over their remembrances and experiences from nursery, primary, secondary school and university attendance, which may have threaten their psychical and social health and adequate personality development. (In total 15 % surveyed students mentioned that uncomfortable experiences at school belonged to their most serious actual traumas).

We have chosen the action research because it is focused on cognition, evaluation and improvement of working experience (teaching working experience at all school types, too).

In the research students and pupils most often complained of humiliation on teachers' part and teachers' „choleric“ or someone else's cold-livered way of dealing with students. „Cholericity“ was too little differentiated term, though. It involved e.g. teachers' choleric temperament, eventual personality disorders, increased neuroticism, neuroses and perhaps even other psychopathological tendencies.

A half of students surveyed described teachers' vexation (bossing) and classmates' bullying (mobbing).

Types of psychical traumatizing

Both macrotraumatizing and microtraumatizing may be classified into four types - primary, secondary, tertiary and quarternary. Nevertheless, more common is primary

psychotraumatizing (concerning the individual himself) and secondary psychotraumatizing (concerned other persons).

There is another possible classification – we distinguish individual and group traumatizing, which is quite typical for educational system.

Not only individuals are traumatized, but also the whole classes of students.

Primary psychical traumatizing means a situation, in which a student or a teacher himself is a victim of bullying, corporal punishment (maybe originally intended to someone else), humiliation or he is experiencing emotional stress (e.g. anxiety, dismay, humiliation, disgrace), helplessness, unsuccessfulness, hostility on the part of other people, aversion, feeling of injustice (e.g. in virtue of criticism, reproach or lowered demerit), mockery, irony, flippancy, scoring off, power manipulating, persecution. Children at nursery schools are often traumatized with compulsion to eating up meals they don't like.

Sometimes there is an individual victimized both by teachers and classmates. Occasionally some of the victimized pupils must undergo longlasting mental treatment.

Primary psychotraumatizing (among other types of traumatizing) is being experienced in the most intense way. It harms psychic and emotional health the most.

It may be effected intentionally or not.

One of the university students gives an illustrative example of primary psychotraumatizing of secondary school pupils:

*„At grammar school we had a physics teacher who was an author of publication about physics. He forced all students to buy the publication and to memorize it. He liked oral examinations and if we didn't answer properly before he counted to three, we got **two F's**. He multiplied the bad grades but the good ones stayed single. If we didn't understand something or couldn't formulate something correctly, he asked us if we wanted E or F and he added with the mocking smile that he didn't like giving F's. Once he said during a student's evaluation: „show your mug“ and after he looked him through, he said loudly: „you can't get a good grade with a face like this“. He had also his favourite sentence: „Take a little walk, you have a mental blockage“. Once he said to a classmate that he had never seen such an imbecile and that he was „a serious genetic mistake of the mankind“. He liked tearing students' exercise books. He complained that it is terrible to be a teacher when students are so dull. From time to time he threw his keys at pupils and he slapped them. He often said over: „There's a God, then me, then nothing for a long time, then Mr. schoolmaster, then nothing for a long time, a few stacks of dung and then are you. If you are not quiet, I'll throw someone out of the window“. He did not try to remember students' names, so he called everyone Hurvínek or Fridolin.*

He set tests dates saying: „Boys will understand it and girls will learn it by heart.“ I started to hate that teacher, but also physics as a subject, said the student in conclusion. “

Let us mention an example of primary psychotraumatizing of teachers: currently, teachers often travel abroad with the whole classes, which is sometimes very traumatizing.

During a journey abroad pupils and teachers were embarking the ferry after the midnight.

Teachers recommended sleepy children to bring with only the most necessary things from the bus and to board quickly. They accommodated children in cabins four by four and checked number of children. In one of the cabins a teacher found only three boys. He asked where the fourth one is and he was told that the student was having a shower. In the morning all of them met at breakfast. Students were counted several times over. One student was missing. After a while his classmates confessed that a pupil of the fourth grade, Kuba, hadn't been in his cabin all night long. After teachers' unsuccessful search for Kuba withing the board, stressed and traumatized teachers called in the police. Some classmates, especially girls, started flapping, crying and despairing. Neither the police found the pupil.

Time to go back to the bus was drawing nearer. Teachers' and pupils' stress was increasing and intensifying. On the way to underdeck they met one of their bus drivers, who told them excitedly that he had found a sleeping student under the bus seat. It was a big relief for the traumatized teachers. How it happened? Children initiated a special sleeping system during the bus trip. One slept on the two-seat and the other one slept under. While they were leaving the bus and boarding the ferry, Kuba, sleeping under the seat, didn't wake up and noone noticed him under the cover, not either the drivers.

Fortunately, Kuba was a stoic, took it in good part and didn't even mind that he missed tasty breakfast aboard.

The boy's classmates were reproved that they had concealed Kuba at night. Teachers felt greatly exhausted, but on the other hand happy that all came right.

Secondary psychotraumatizing is for example a situation when pupils, students or teachers are not traumatized themselves, they are not primary victims, but they were witnesses of primary traumatizing of someone close, e.g. a classmate, friend, relative or colleague. They are experiencing intensively their traumatizing, which negatively influence their own mental condition.

This is mostly less intensive than the primary traumatizing.

There is an example of a first-grader Pavlik's classmate traumatizing: his classmate watched a situation when Pavlik asked a teacher if he could go to the toilet. It was ten minutes to the break. A teacher got angry, she shouted at him that he must hold out and he wasn't allowed to go to the toilet. And Pavlik wet. He started crying. A teacher told him off for the incident and made fun of him in front of the whole class. Classmates didn't lough though. They were sorry for him. A teacher left him sitting at the desk till the break and after the lesson she took him to the headmaster's room with dislike. Some pupils were stressed by the situation, although they were not concerned primarily.

Tertiary psychotraumatizing means such a situation when pupils, students or teachers are witnesses of traumatizing people who they hadn't known before and hadn't had any close relationship with them. Nevertheless, they feel stressed. Tertiary traumatizing is generally less intense than primary and secondary traumatizing.

An illustrative example may be brush-up for state exams of two students (fri-

ends), who decided to study at campus. Their revision was disturbed by tertiary psychotraumatizing, when an angry husband, whose wife cheated with a student, arrived to the campus,. Her husband came to punch a student, so that a student was bloodily. Studying friends didn't know the beaten student, but the experience disturbed their next study for the exam.

Quarternary psychotraumatizing means such a situation when pupils, students or teachers are notified of psychotraumatizing other (unknown) people viva voce or visually (e.g. through a film). If it concerns a sensitive or even hypersensitive personality, this kind of traumatizing may have a negative influence on his mental condition. This traumatizing is generally the least intensive.

We give an example of a viewer, who leaves TV news:

Why do I leave TV news? I leave it because during TV news we are mainly provided informations with negative examples. During the programme we are presented criminals, politicians' quarrels and abuse, someone who offended, rises in prices etc. I think that not only TV news lacks balance between negative and positive examples.

Pupils', students' and teachers' symptoms of psychotraumatizing

The most frequent symptoms are **hyperarousal**, hyperexcitation, hypervigils, psychic tension, panic, permanent expectation of danger, conflict, stress, frustration. They may be situational, short-term or long-term. It seems that in some teachers there is such a reactivity a steady state, typical for their behaviour, by reason of their personality and temperament disorders or profession deformation. According to pupils and students, teachers have „choleric behaviour“ or temperament, going together with shout, abuse, mockery, irony, self-will, corporal punishments, humiliation of the students regarded as „difficult“ by the teacher.

Of sorts, teachers with stabilized hyperexcited behaviour consider this behaviour to be a useful deterrent customizing technique, which reduces a great part of hyperactivities, assertivities and agressions in active and self-confident pupils and students, because it evokes anxious reactions or fear of a teacher.

The second frequent symptom of psychotraumatizing is **intrusive** behaviour, including annoying, persistent and obsessional feelings, resulting from psychotraumatizing, sometimes even with inclination to compulsions. Continual imagining of traumatic situations and thinking about what had happened, often go along with so called flashbacks, leading to the similar experiences that were evoked by the original traumatic situation.

The third common symptom of psychotrauma is so called **psychic constriction**, sort of inner psychic constriction, immobilizing „choke“, which may have either acute or chronical character. It concerns deformed reception which has a character of passive defence customizing mechanism. It causes sort of temporary anesthesia against experienced psychotrauma. It is an avoidance reaction.

Pupils and students often mentioned these symptoms of their psychotraumas.:
reduction of their confidence when their intelligence, appearance, weight, way of dressing were mocked,
aversion against a teacher or a subject,
reasoning block,
chronic fear of „choleric“ teacher behaviour,
fear or phobia of examining and unfair evaluation,
headaches,
dyssomnia,
abdominalgia, emesia,
bowel symptoms,
nausea, swoon,
generally increased neuroticism.

Level of pupils´, students´ and teachers´ psychic vulnerability

All people, both children and adults, don´t have the same level of psychical vulnerability, (actual and long-term).

Some people are more resistant, other people are sensitive or even hypersensitive. Stress hardiness, personality immunity and peevishness should be trained and developed. We should take this fact into account especially in educational system.

Psychotrauma-prone are sensitive or hypersensitive people, run-down after suffering from diseases, injuries or surgeries, people with low self-confidence.

To a certain extent it may be related to the inherent, genetic matter.

Sensitive personality even experiences psychotrauma if he had traumatized someone else, though unwillingly, not on purpose.

Phases of psychotraumas being experienced at school

The first phase of adaptation syndrom, according to H. Sely, is an **alarm**, emergency phase. It shows symptoms of strong excitation, hyperarousal.

The second phase of adaptation is a **resistance**.

An organism tries to get used to traumatizing, to adapt. There often occur obsessions and intrusions during this phase.

The third phase of adaptation is **exhaustion**, which is a complex, holistic failure of adaptive and regulating organism mechanisms. It may results in a serious health or life threat.

Prevention and therapy of psychotraumatizing at schools

Primary prevention of psychotraumatizing at school

Teachers and parents should be well-informed how to prevent from mental difficulties and disorders of pupils, students and even teachers themselves, and how to build

healthy lifestyle and communication skills. Education promoting healthy lifestyle is very important.

Secondary prevention of psychotraumatizing

Here belongs right diagnosis of difficulties and disorders caused by psychotraumatizing at school, their remedies. Early diagnosis of psychosocial problems is a condition of their adequate remedy. We recommend properly applied debriefing, crisis intervention, counselling and psychotherapy.

Tertiary prevention of psychotraumatizing

The point is to prevent from further deterioration of the developed difficulty or disorder, nevertheless, we should take into account that complex recovery is either very difficult or impossible. There is also emphasized self-help, self-care, resocialization and sociotherapy.

Quarternary prevention of psychotraumatizing

It involves identification of the developed and chronic difficulty or disorder, which is not possible to correct totally, but at least it is possible to reduce some results. What is important is a well-informed self-care and supportive social communication.

Psychosocial and pedagogical support and help after acute psychotraumatizing detection

First of all it is necessary to enable a traumatized person **defusing**, i.e. a chance to confide to someone, to unbrace spontaneously in the interview, to free of accumulated explosive emotions. It may even be laic social support of friends, classmates, colleagues or relatives. Both a child and an adult, who experienced acute psychotraumatizing, should have possibility to weep out, cry out, complain, swear, relax. It is not suitable to persuade him that he should be brave, so that he can help himself without crying and help of others.

An example of defusing, provided by an older sibling after a strong conflict of a first-grader with her teacher. The pupil was told off because she prompted to her classmate during a maths test. During the break she went to his brother, who was in higher grade of the school. She told him everything while she was crying. Her brother stilled her and told her: „Kačka, in the morning teacher got upset over something and unfortunately, you caught it. Don't bother about it. Everything is going to be all right again. Just breathe deeply“. He accompanied her to the classroom and helped her to prepare teaching aids for the following lesson. After the break he went to his classroom. Kačka expected the conflict to continue but a teacher behaved as if nothing had happened, which suprised Kačka pleasantly.

Another suitable way is to enable traumatized persons **debriefing**, i.e. one-shot official counsel (often group), where the traumatizing event is analysed and adequate antitraumatizing intervention or corrective professional care are proposed.

Sometimes it is even necessary to provide professional and specialized **antitraumatizing intervention**.

It involves long-term professional counselling or psychotherapeutical care, which is realized by psychologists, psychiatrists, special and social educators. Sometimes a solution may be to change a class or a school.

QUALITY OF LIFE OF THE LONG-TERM UNEMPLOYED¹

Božena BUCHTOVÁ

Introduction

Initially, quality of life used to be examined from the perspective of health and illness. Strauss' monograph (1975) dealing with the quality of life of the chronically ill and aged people was one of the first studies dealing with the subject. Methodologically, scholars concentrated in particular on the effectiveness of healing methods for patients' quality of life and tried to establish intervention approaches (Bergsma, Engel, 1998; McGee et al. 1991; O'Boyle, McGee, 1992; Browne et al., 1994; Browne et al. 1997). It was only later that a broader human life perspective began to be taken into account when studying the quality of life (Emmons, Diener, 1985; Ryff, Keys, 1995; Oishi, 1999; Džúrová, Dragomirecká, 2000; Hnilica, 2000). It became apparent though that quality of life was not determined solely by a set of identifiable external factors, but also – and substantially – by the individual perception of life's meaningfulness (Zika, Chamberlain, 1987; Frankl, 1994; Thompson, Janigian, 2000; Halama, 2000; Balcar, 1995c; Machovec, 1967; Šmajš, Krob, 2003). The findings and experience acquired from measuring the quality of life have shown the following:

1. Rather than a system of values set and evaluated externally, an individual's own perception of the priorities concerning quality of life is relevant for evaluating his or her quality of life.
2. Various quality of life dimensions have different levels of importance for every individual.
3. The importance of the quality of life dimensions changes during an individual's life span as a result of his or her going through different stages of life and facing various situations.
4. Personal approach to the quality of life is closely related to expressing satisfaction with achieving goals and fulfilling plans.

Our approach derives from the above-mentioned findings as well as from the

¹⁾ The study was completed with a grant aid from GAČR Reg. No. 406/02/1562 and grant aid from ÖSI, branch Brno in 2001 and 2002

Statistical data processing: PhDr. Tomáš Urbánek, PhD, Psychologický ústav ČSAV Brno

Technical assistance: Viktor Kulhavý, student of the Faculty of Economics and Administration of the Masaryk University in Brno

approach to the quality of life issue by the Irish psychologists C. A. O'Boyle, H. McGee and Swiss doctor C. R. B. Joyce (1994, p. 160): „Quality of life should be defined individually depending on how the person has determined it“. Their method called SEIQoL (Schedule for the Evaluation of Individual Quality of Life)² currently belongs among the most frequent methods of evaluation. As the sources available to us suggest, we are unique in using SEIQoL for examining the quality of life of the long-term unemployed. Our inquiry was built on the following presumptions:

- Loss of work is a serious milestone in an individual's life with significant effects on his/her quality of life and its evaluation.
- Long-term unemployment has negative effects on the overall quality of life as well as on the composition and importance of the different aspects of life.
- For the long-term unemployed their quality of life is strongly influenced by age, sex, education and duration of the unemployment.
- Long-term unemployment negatively impacts the meaningfulness of life for the afflicted individuals.

Data and methodology

The inquiry took place in 2001 and 2002, there participated 1957 respondents, who were divided into four sub-sets:

- 1. The unemployed** (N= 966; 558 women and 408 men, average age 34.5 years, aged between 17 and 65. 6% of the respondents had primary education, 19% had completed apprenticeship, 60% had secondary education, 2% had attended colleges and 13% had university degrees. On average, they had been unemployed for 19.63 months).
- 2. The employed** (N=949; 528 women and 421 men, average age 35.7, aged between 19 and 73. 2.7% of the respondents had primary education, 6.3% had completed apprenticeship, 59% had secondary education, 2% had attended colleges and 30% had university degrees).
- 3. Homeless** (N=22; 22 men, average age 42.2, 12 men with primary education, one with completed apprenticeship, 7 with secondary school. On average, they had been unemployed for 47 months).
- 4. Unemployed mothers** after maternity leave (N=20; average age 34 years, 19 had secondary education and 1 had university degree. In average, they had been actively seeking jobs for 9 months).

The respondents participated in the inquiry on a voluntary basis. Those from the first two sets (the employed and the unemployed) were spoken to by trained inquirers throughout the territory of the Czech Republic. The homeless were interviewed in the Brno region while the mothers after maternity leave at workshops for the unemployed in the Nový Jičín district.³

²⁾ A Czech translation of the SEIQoL method was published in the Czech Republic by J. Křivohlavý (2001, 2002)

³⁾ The homeless were interviewed by PhDr. Aleš Sekot, CSc., the mothers after maternity leave by Mgr. Marta Pavelcová. PhDr. Katka Křivá largely contributed to the interviews with the unemployed. They all deserve our acknowledgment.

We used the SEIQoL method to examine the quality of life of the unemployed. The concept published by C. A. O'Boyle, H. M. McGee and C. R. B. Joyce in 1994 in the *Advances in Medical Psychology* (5, p. 159-180) is based on a subjective individual's evaluation of the quality of life. In a structured interview the individual freely contemplates his/her system of values without any previously set criteria. The individual evaluates which aspect of life he/she currently considers to be the most important one and to which of the five aspects of life he/she attributes the greatest importance. For a better understanding of the statement and for an adequate interpretation, the respondents refer to the chosen aspects of life in a descriptive manner rather than just in keynotes; they use free associations and explain what each aspect means for them. The aspects of life considered to be substantial in their current status are assessed in terms of their relevance, i.e. their relative importance for the particular individual. Subsequently, the individual contemplates on his satisfaction with the given aspect of life and whether he or she manages to meet the demands and objectives of his current life situation. For the purpose of the data evaluation, the importance of each aspect of life (given in per cent from 0 to 100) is multiplied by the level of satisfaction (also given in per cent from 0 to 100 where 0 per cent represents the lowest level of satisfaction and 100 per cent represents complete satisfaction). The resulting quality of life figure is a sum total of all the five products divided by 100 to give a number from 0 to 100. The resulting quality of life profiles and the final quality of life scores for the individuals and groups are accompanied by data reflecting the meaningfulness of life in their current stages of life. The individual assessment of the meaningfulness of life is marked by a cross on a sloping line (rising from left to right in a 45° angle) where the bottom is entitled "life is absolutely meaningless" and the top "life is truly meaningful".

The outcomes of the inquiry were processed using the descriptive statistics methods, correlation analysis (Pearson's correlation coefficient, Spearman's rank correlation) as well as the t-test, the Kruskal-Wallis test, the median test and the ANOVA (Univariate Analysis of Variance) method.

Research outcomes, discussion

For each respondent group, we processed the following:

- a) sequence of separate life aspects arranged in the order of importance for their lives and for the establishing of an individual's **quality of life (QL) profile**.
- b) sequence of the separate life aspects evaluated by the respondents **based on their satisfaction levels** (in a scale from 0 to 100) with the particular aspects

The following tables give averages and standard deviations for the different groups of respondents concerning the identified quality of life aspects and their satisfaction with these aspects. Apart from the five most important life aspects we specified also other life aspects for each group that were referred to as less important.

Aspect of life

	Aspect of life	Average QL	Standard deviation
1.	Family	27,44	17,01
2.	Health	20,79	15,29
3.	Work	9,33	13,4
4.	Peace of mind	6,32	9,02
5.	Interpers. relations	5,67	8,42
6.	Hobbies	4,64	7,49
7.	Personal improvement	4,52	7,91
8.	Money	1,07	4,74
9.	Housing	0,28	2,26

Satisfaction

	Aspect of life	Average satisfaction	Standard deviation
1.	Family	64,51	33,30
2.	Health	58,41	33,75
3.	Work	30,13	37,80
4.	Interpers. relations	26,96	35,41
5.	Peace of mind	26,60	35,06
6.	Hobbies	24,57	34,07
7.	Personal improvement	18,41	29,48
8.	Money	3,41	13,72
9.	Housing	0,87	7,41

N=949; significance levels *p ≤ 0.05. **p ≤ 0.01

Table 1 The employed. Quality of life (QL) profile and the level of satisfaction with the particular life aspect

Aspect of life

	Aspect of life	Average QL	Standard deviation
1.	Family	25,28	17,04
2.	Health	20,12	15,11
3.	Work	9,70	14,36
4.	Peace of mind	5,70	8,88
5.	Interpers. relations	5,65	8,47
6.	Hobbies	5,50	8,36
7.	Personal improvement	5,06	9,21
8.	Money	2,13	8,14
9.	Housing	0,44	3,18

Satisfaction

	Aspect of life	Average satisfaction	Standard deviation
1.	Family	58,03	35,14
2.	Health	53,18	34,23
3.	Work	28,81	36,77
4.	Interpers. relations	25,71	34,35
5.	Peace of mind	20,54	30,44
6.	Hobbies	16,82	27,83
7.	Personal improvement	8,60	18,86
8.	Money	3,09	11,90
9.	Housing	1,16	8,50

N=966; significance levels *p ≤ 0.05. **p ≤ 0.01

Table 2 The unemployed. Quality of life (QL) profile and the level of satisfaction with the particular life aspect

Note Given the numbers of the respondents involved, statistical tests could only be performed between the groups of the employed and the unemployed. Where statistically significant differences were identified, the average figures are given in bold.

The same life aspects are important for the quality of life of the employed and the unemployed respondents, in the following order – family, health, work, peace of mind and interpersonal relations. We identified only one statistically significant difference between these two groups - the “family” value, which was a more important aspect in the life of the employed than in the life of the unemployed, and the employed were also more satisfied with this particular life aspect. While the employed showed significantly

higher satisfaction with their work and health, the unemployed reported hobbies and interests as the life aspects providing them more satisfaction in their current status.

Family

From the judgment analysis we have concluded that family has almost identical meaning for both the employed and the unemployed respondents. 1. Family as a symbol of understanding, satisfaction and fellowship 2. Family as a psychological support (a symbol of security, background and safety) 3. Family as the most important value in life (to have someone to live for) 4. Family as a background where children can be brought up 5. Family as giving life its meaning (self-fulfillment).

However, obvious differences were apparent between both groups in the relative frequency of the family meanings and their ranking by the frequency of reports. Among the unemployed respondents family was primarily associated with a major psychological support during the unemployment. In their families the unemployed reclaim psychological balance, which was previously shattered by the involuntary loss of work and even more by the unsuccessful attempts to find a job. Family often restores mental balance of the unemployed. The employed respondents associate family with the peace of mind, harmony, coherence, and understanding among the family members, and only then it comes as a place of security, safety and backup. This seemed to confirm what we had learned during our previous research: long-term unemployment is a test of the interpersonal relations in a family and is better coped with by those who have close people to rely on and to speak with openly about their situation (B. Buchtová et al., 2002 pp.107, 8).

In addition, we identified differences between the employed and the unemployed in the frequency of reporting family as something that gives meaning to one's life and provides personal self-fulfillment. By losing their jobs, people experience a shift and transformation of their vital energy from work to family, which is an alternative with a changed arrangement from the perspective of roles. Especially for unemployed women family is an alternative working field providing self-fulfillment and easing the burden of the unemployment (B. Buchtová et al., 2002 p.100). The psychosocial burden on the unemployed men responsible for the livelihoods of their families is much heavier than that on the unemployed women.

Health

Health was reported to be one of the primary life qualities by all the four groups of respondents. Semantically, health was most frequently associated with the following:

1. the highest value in life, 2. a value people become aware of only after they have lost it (increased care for health as a result of illness or injury), 3. a prerequisite for achieving a lasting employment (a prerequisite for productive life), 4. healthy lifestyle (healthy food, physical exercise – care for physical health), 5. a source of physical and mental comfort (with a focus on harmony between mental and physical health resulting in the satisfaction with life), 6. a guarantee of self-reliance (independence from others, in particular in the old age, not being a burden on others), 7. care for the health of family members and close people.

Health is a supreme value from which a number of other fulfillments stem in the quality of life of both the employed and the unemployed respondents. It is also seen (as was frequently reported) as a prerequisite for getting and retaining a job. Health is the most valued asset in today's labor market. The chance of people with disabilities to find jobs is decreasing as a result of the increasing focus on the productivity of work and performance. In general, the period of time they are registered at job centers exceeds that of the healthy individuals many times.

A number of researchers describe in their studies the connection between unemployment and a decline in health. In our studies as well (B. Buchtová, 1992, 1999, 2000), more than a half of the long-term unemployed repeatedly reported subjective symptoms of neurotic complaints such as anxiety, unease, irritation, headache, insomnia, exhaustion. After losing jobs, both men and women experienced worsening of the existing health problems – hypertension, stomach ulcers, heart disease, spinal cord problems, asthma, etc. Many people in the Czech labor market live in fear of job loss due to being employed for a definite period of time or as they observe the constantly increasing numbers of the unemployed in many regions. Foreign investors recently resorted to large-scale lay-offs as the Czech labor force has become less profitable. Apart from having an impact on those who have lost their jobs, unemployment also influences the behavior and health of the employed. They either experience anxiety and strain from the anticipated loss of work or they have to work in uneasy conditions. It is obvious that the quality of peoples' emotional comfort represented by health is influenced by the changed economic climate whether or not the individual directly experiences the unpleasant job-related events.

Work

Work was ranked in the third place by the respondents considering the quality of their lives. Work was most frequently related to the following needs: 1. self-fulfillment (employing one's abilities, knowledge and skills) 2. financial independence (material support for the family, means of independence) 3. security in life (certain future) 4. ordered life (daily program, time spending, everyday routine) 5. social background (interpersonal relations in the workplace, friendship, celebrations, common eating facilities), 6. emotional response, emotional appreciation (need for success, appreciation, acknowledgment).

A statistically significant difference between both groups was identified in their satisfaction with work. While the employed respondents reported remarkable satisfaction, the unemployed tend to fill in this life aspect with hobbies and interests.

A generation gap is identifiable in the responses of the unemployed respondents. While young people believe they will find a job soon, they strive for self-fulfillment and have plans for the future, older individuals place the basic needs of their families first. Men more often reported age discrimination in the labor market. Repeated failure to find a job leads to depression, feeling inferior, losing confidence. In family life, the unemployed feel like "parasites", men believe unemployment is the reason for their inability to satisfy the basic needs of their families. It is obvious that the importance of labor in human life changes, which has an effect on experiencing and coping with the loss of work.

The employed respondents showed a statistically significant satisfaction with work as well as aspirations to get even a better job facilitating their further strive for better education (in particular as computer literacy and language skills are concerned). Work is conceived as an important place in human community, as a place of fellowship with colleagues, as a second “family”.

During the inquiry we detached two specific, less numerous groups from the set of the respondents – the homeless people and the unemployed mothers after maternity leave.

Homeless (N=22; significance levels $*p \leq 0.05$; $**p \leq 0.01$)

Among the unemployed homeless people **family** was ranked as low as fourth among the values. Most frequently, the respondents associated family with a desire to establish a functioning family or with a desire to be again with the partner who had left them because of their own excessive alcohol abuse, criminality or imprisonment. Some homeless people do not wish to change anything in their current status. These individuals tend to live alone and freedom is of utmost value for them.

Health achieves the highest average figure in the quality of life rating among the homeless people. Health is often a critical aspect in their lives. It tends to be weakened by staying overnight in the open, by the irregular and low-quality food supply and often by excessive alcohol abuse. Most homeless people associated health with improved health or at least with not worsened health.

Work is characterized by the homeless’ desire to find a permanent job, although toned with resignation. Those who would really like to work are aware at the same time that the homeless status gives them poor prospects. More than a half of the respondents do not see work as a relevant subject – they are happy with living on the edge and providing for their livelihood in legally dubious ways.

Unemployed mothers after maternity leave (N=20; significance levels $*p \leq 0.05$; $**p \leq 0.01$)

In the group of the unemployed mothers after maternity leave, **family** and satisfaction with family show the highest average figures in the quality of life in comparison with the other three groups of respondents. The assessment is compatible with the mothers’ view of their current life status, which is also related to the average rating of and satisfaction with the aspect of peace of mind. Unemployed mothers consider **their own improvement efforts** to be important (some women had been at home for several years with their children). These efforts, which include not only acquiring new knowledge and skills (all the women were at the time of the inquiry attending a retraining program), also require a new view of lifestyle, organization and program of the day. Even though a quarter of the women were single parents, finances were not rated as an important life aspect. Low average rating of **work** seems to correspond with their current status, but on the other hand preparations for the resumption of employment are taken seriously. This happens in spite of the fact

that the particular region showed a high rate of unemployment and the chances for employment were therefore slim.⁴

For average values of the other life aspects among the unemployed mothers after maternity leave and their satisfaction with them see Table 4.

The following part of our research was focused on comparing the average quality of life among the individual groups of respondents. For results see Table 3.

	QL average	Standard deviation	Number of respondents
unemployed	60.3	20	966
employed	70.6	15.8	949
homeless	33.1	19.6	22
mothers after maternity leave	62.3	18	20
Total	56.6	18.35	1957

Table 3 Comparison of quality of life averages for different groups of respondents (in per cent)

The individual evaluation of the quality of life is highest among the employed in all groups of respondents. It is apparent that a loss of employment represents a major milestone in human life, it has a significant effect on the quality of life and impacts mostly negatively the other life aspects and personal goals.

Quality of life aspects and satisfaction with them by age and gender

We have verified the assumed relationships between the quality of life aspects, satisfaction with them and the age and gender variables using the Pearson's correlation coefficient. The results of the statistical testing of correlations between the variables in question confirmed the major links.

The results suggest that among **homeless** people the importance of housing (0.615**) and family (0.487*) increases with age while satisfaction with the importance of income decreases (-0.472*).

Among the unemployed **mothers after maternity leave**, satisfaction with the peace of mind significantly decreases with age (-0.493*).

Among the **unemployed respondents** the importance of health (0.222**), family (0.129**) and finances (0.071*) increases along with the age, while the importance of personal improvement decreases as well as satisfaction with it (-0.168**); the same

⁴⁾ The conclusions from the inquiry administered to the homeless sample and the unemployed mothers after maternity leave are but preliminary. In order to confirm them, we would need a larger sample from different regions of the Czech Republic.

holds true for interpersonal relations (-0.097**) and peace of mind (-0.079*). In the same group of respondents, satisfaction with family proved to be statistically significant (0.080*) as well as housing (0.081*).

Among the **employed respondents** the age variable positively correlated with the values of family (0.157**) and peace of mind (0.073*) and also with the satisfaction with both. Negative correlation was identified in the importance of and satisfaction with the personal improvement (-0.134**; -0.129**).

		Homeless		Mothers after mat. leave		Unemployed			Employed		
		men	total	women	total	women	men	total	women	men	total
Quality of life	Family	6.11	6.11	39.25	39.25	28.82**	20.59	25.33	29.31**	25.20	27.50
	Health	28.33	28.33	13.50	13.50	20.55	19.64	20.16	22.35**	18.91	20.83
	Work	5.00	5.00	1.75	1.75	11.69	8.27	9.70	11.12	7.94	9.33
	Hobbies	0.00	0.00	2.25	2.25	4.12	7.41**	5.52	3.54	6.06**	4.65
	Interpersonal relations	0.83	0.83	5.00	5.00	5.89	5.36	5.67	6.33**	4.85	5.68
	Money	13.61	13.61	0.00	0.00	1.75	2.65	2.13	0.89	1.31	1.07
	Housing	5.56	5.56	0.00	0.00	0.27	0.66	0.44	0.25	0.32	0.28
	Personal improvement	0.00	0.00	8.15	8.15	5.68*	4.24	5.07	4.90	4.06	4.53
	Peace of mind	0.56	0.56	8.25	8.25	6.11	5.16	5.71	6.73	5.84	6.34
Satisfaction	Family	3.89	3.89	61.50	61.50	65.69**	47.88	58.15	67.99**	60.40	64.64
	Health	30.00	30.00	36.50	36.50	56.63**	48.74	53.29	62.00**	54.16	58.54
	Work	5.00	5.00	2.50	2.50	8.90	8.41	8.60	32.66	28.23	30.13
	Hobbies	0.00	0.00	7.50	7.50	23.51	36.15**	28.86	20.71	29.57**	24.62
	Interpersonal relations	2.78	2.78	26.25	26.25	26.58	24.66	25.77	31.25**	21.67	27.02
	Money	18.89	18.89	0.00	0.00	2.85	3.43	3.10	3.08	3.84	3.41
	Housing	10.28	10.28	0.00	0.00	0.74	1.74	1.16	0.92	0.80	0.87
	Personal improvement	0.00	0.00	28.75	28.75	19.21**	13.65	16.85	20.84**	15.42	18.45
	Peace of mind	1.11	1.11	33.25	33.25	22.24*	18.33	20.58	29.08*	23.58	26.66

N=1957; 851 men, 1,106 women; significance level *p ≤ 0.05; **p ≤ 0.01

Table 4 Average values of life aspects in the quality of life and satisfaction with them from the perspective of gender in all four groups of respondents.

The results show that in terms of gender, both the unemployed and the employed women are more satisfied with family and health life aspects than both groups of men.

In case of both the employed and the unemployed men, there is a positive correlation with the hobby life aspect, which is not observed in women.

Employed women tend to be more satisfied with their interpersonal relations (31.25**) than employed men (21.67). Among unemployed men and women no statistically significant differences in satisfaction with this variable was found.

Both the unemployed and employed women tend to be more satisfied with their personal improvement and piece of mind than both groups of men.

We tested the differences between the groups of the employed and the unemployed men and women in preferences of the life aspects and the satisfaction with them using the Pearson's correlations and testing the individual variables for the different groups (N=1915; unemployed =966, employed =949; significance level * $p \leq 0.05$; ** $p \leq 0.01$)

The figures suggest that from the gender perspective family is a more important life aspect for women, both unemployed and employed than for men (-0.239**; 0.120**) and women tend to be more satisfied with it than men.

The value of health and interpersonal relations is considered to be more important by employed women than by employed men (-0.112**; -0.088**) and the employed women tend to be more satisfied with these aspects (-0.116; - 0.134**). Between the unemployed men and women gender differences were not confirmed.

The value of work and hobbies is statistically more significant for the employed (0.121**; **0.167**) and the unemployed men (0.117**; 0.194**) than for women. Both the employed and the unemployed men find more satisfaction in their hobbies (0.129**; 0.170**) than both groups of women.

Satisfaction with personal improvement and satisfaction with peace of mind is statistically more significant among both the unemployed and the employed women than among men.

Personal improvement is statistically more significant for the unemployed women (-0.077*) than for the unemployed men. Employed women are apparently more satisfied with their interpersonal relations than employed men. Differences between genders in this value were not confirmed between the unemployed men and women.

For the other life aspects, no statistically significant differences between men and women were discovered.

Quality of life aspect and satisfaction with it according to the achieved education

We checked the relationships between the quality of life aspects, satisfaction with them and the achieved level of education using the Spearman's rank correlation. The results of the statistical testing of the variables in question have revealed significant relationships (N=1915; unemployed =966, employed =949; significance level * $p \leq 0.05$; ** $p \leq 0.01$). A positive correlation means that the higher education the higher the quality of life or satisfaction in the given area; negative correlation – the higher education the lower the quality of life or satisfaction in the given area.

The results suggest that the higher the level of education in the unemployed group, the lesser the importance of hobbies (-0.089**), value of money (-0.084**) and

work (-0.076*), while the importance of personal improvement increases with education (0.094**), just like that of peace of mind (0.079*).

In the employed respondents' group, the importance of money in their quality of life decreases with the achieved level of education (-0.113**), while the importance of personal improvement increases (0.107**).

More educated unemployed people showed a statistically significant increase in satisfaction with their personal improvement (0.118**) and peace of mind (0.085**) (they better cope with the loss of work) as well as with health (0.065*). On the other hand, their satisfaction with money decreases (-0.095**) along with the satisfaction with hobbies (-0.077*) and housing (-0.064*).

Among the employed people satisfaction with their personal improvement increases with education (0.114), while satisfaction with money decreases (-0.113**).

Quality of life aspects and satisfaction with them according to the unemployment duration

We tested the expected relationships between the quality of life aspects, the satisfaction with them and the duration of the unemployment using the Pearson's correlation coefficient (N=988; homeless=22, unemployed=966; significance level *p ≤ 0.05; **p ≤ 0.01).

Note: In the homeless group some correlations could not be calculated due to the variables being invariable.

The data suggest that the longer a person is unemployed, the more importance he or she attributes to his or her family (0.081*). At the same time, satisfaction with the work aspects decreases (-0.067*).

Among homeless people the importance of housing significantly increases along with the extending period of unemployment (0.566**).

Relationship between the duration of unemployment and education

Having divided the duration of the unemployment into 5 categories (up to 0.5 year, 0.5 to 1 year, 1 year to 1.5 years, 1.5 to 2 years and more), we calculated the Spearman's correlation of duration of the unemployment with education. The resulting correlation was -0.226, statistically significant at 1%. The selected sample of respondents confirmed our assumption that **the higher the level of the achieved education, the shorter the duration of the unemployment.**

These results are documented in the table below showing the different frequencies and percentages in lines, columns and throughout the table. **In bold** there are shown the figures that are more frequent, in a statistically significant manner, than we would assume from the hypothesis of the variable independence, ***bold italic*** refers to figures significantly less frequent.

Education	up to ½ year	½ to 1 year	1 to 1½ year	1½ to 2 years	over 2 years	Total
primary	10	8	3	9	38	68
apprenticeship	58	62	46	27	64	257
secondary	145	137	81	50	72	485
FE college	5	5	3	1	2	16
university	54	27	25	6	15	127

N=953; primary=68, apprenticeship=257, secondary=485, FE=16, university=127

Table 5 Duration of unemployment by education

Note: The relationship between the duration of the unemployment and the achieved level of education could be examined only in 953 respondents, in thirteen of the total 966 respondents education was not specified unambiguously.

The relationship between the achieved level of education and the duration of the unemployment is, similarly as in the Spearman's correlation above, statistically significant: $\chi^2=94.309$, $df=16$, $p=0.000$

As the table suggests, the most frequent combination consists of unemployed people with a secondary education who were jobless for less than half a year (145 persons) and a ½ to 1 year (137 persons).

Significant relationships in the individual categories: people with lower education are significantly more often unemployed for a period exceeding 2 years (primary education and apprenticeship), people with higher education for a period up to 1 year (secondary and university education) – see the figures in **bold**. On the contrary, combinations of short unemployment and low education as well as long-lasting unemployment and higher education are significantly less frequent – see the figures in **bold italics**.

Quality of life aspects for men and women and satisfaction with them

We further examined in our inquiry the question as to how the average QL figures differ for the different life aspects and the satisfaction with them between men and women (regardless of their employment status) and between the employed and the unemployed men and women. We used the ANOVA (Univariate Analysis of Variance) method for data processing. Respondent group sizes: 1106 women, 851 men, 966 unemployed, 949 employed.

FAMILY. Results of statistical processing show that the average QL figures differ in the FAMILY aspect for men and women regardless of their employment status. Specifically (see the table containing the descriptive statistics), women show an average of 29.06 and men 22.92. The average QL figure for the FAMILY aspect is statistically significantly higher for women than for men.

While the average QL for the FAMILY aspect is roughly the same for the unemployed (28.82) and the employed (29.31) women, in men – whose QL aspect for FAMILY is generally lower than in case of women – there is a great difference between the unemployed (20.59) and the employed (25.2). Among the employed men, the FAMILY aspects shows a statistically significantly higher value than among the unemployed men.

Among the employed men and women, the average satisfaction with FAMILY is higher (64.64) than that among the unemployed men and women (58.15), while women tend to be more satisfied with their families (66.82) than men (54.21) within the whole set of respondents.

In the average satisfaction with family there is no significant difference between the employed (67.99) and the unemployed women (65.69), although among men certain significant differences were discovered. Unemployed men are significantly less satisfied (47.88) with their families than employed men (60.4).

HEALTH. As far as the quality of life is concerned, the average figure for the HEALTH aspect is higher for women (21.43) – both employed and unemployed – than for the employed and the unemployed men (19.27).

In case of both the employed men and women the average satisfaction with health is higher (58.54) than in case of the unemployed men and women (53.29). Women are more satisfied with their health than men (51.48) across the entire set of respondents (59.25). The highest average figure for the satisfaction with health is in the group of the employed women (62.00).

WORK. The average quality of life figure for the WORK aspect is statistically significantly higher for men (11.40) than for women (8.11) across the entire set of respondents.

As was anticipated, satisfaction with the WORK aspect is statistically higher among employed men and women (30.19), than among unemployed men and women (8.62).

PEACE OF MIND. No statistically significant differences between the employed and the unemployed and between men and women in the average quality of life figures for the PEACE OF MIND aspect were discovered among the respondents.

The average satisfaction with PEACE OF MIND is statistically more significant among women (25.58) than among men (20.99). Employed men and women are more satisfied with it (26.66) than the unemployed (20.58).

Employed women show the highest average satisfaction with the PEACE OF MIND aspect (29.08).

INTERPERSONAL RELATIONS. Women tend to be more satisfied with the INTERPERSONAL RELATIONS aspect (28.85) than men (23.15) across the entire set of respondents.

The average quality of life for the INTERPERSONAL RELATIONS aspect is statistically higher among women (6.11) than among men (5.1) regardless of their employment status.

While the average satisfaction with the INTERPERSONAL RELATIONS aspect is roughly the same for both the employed and the unemployed men (21.67; 24.66), for women, who generally show a higher average value in the INTERPERSONAL RELATIONS, there is a statistically significant difference between the employed (31.25) and the unemployed (26.58) ones. Employed women are more satisfied with their interpersonal relations than unemployed women.

HOBBIES, INTERESTS. The average quality of life for the HOBBIES and INTERESTS aspect is statistically higher among men (6.73) than among women (3.84) and is higher among all the unemployed men and women (5.52) than among the employed men and women alike (4.65). Among the unemployed men and women you can see a higher satisfaction with this aspect (28.86) than among the employed men and women (24.62). The highest average quality of life figure for the HOBBIES and INTERESTS aspect appears for the unemployed men (7.41) who also feature the greatest satisfaction with it (36.15).

PERSONAL IMPROVEMENT. The average quality of life figure for the PERSONAL IMPROVEMENT aspect is statistically more relevant for women (5.3) than for men (4.15).

Across the entire set of respondents, women are statistically more satisfied with their personal improvement (20.00) than men (14.55).

MONEY. As the table shows, the average quality of life figure for the MONEY aspect is statistically higher for men (1.97) than for women (1.33). An obvious difference also exists between the unemployed (2.13) and the employed (1.07) men and women.

The average figure for the MONEY aspect is statistically most significant among the unemployed men (2.65).

The ANOVA results did not provide statistically relevant differences between the average satisfaction figures for the MONEY aspect between men and women and between the employed and the unemployed.

HOUSING. The average quality of life and satisfaction figures for the HOUSING aspect did not confirm statistically significant differences either between the employed and the unemployed or between men and women.

Meaningfulness of life and long-term unemployment

Our inquiry on the quality of life of the long-term unemployed included an evaluation of the meaningfulness of their lives. First we processed an analysis of the average meaningfulness figures reported by the different respondent groups.

	Average (in %)	Number of respondents	Standard deviation
Homeless	52.286	22	21.389
Mothers after maternity leave	83.590	20	17.057
Unemployed	65.261	966	22.969
Employed	81.270	949	16.137
Total	73.072	1957	21.515

Table 6 Analysis of the average meaningfulness figures in the different respondent groups (in per cent)

As the table shows, mothers after maternity leave found more meaningfulness in their lives (83.590) than any other group. The lowest average meaningfulness was reported by the homeless people (52.286). The average figure across the entire sample (1957) was 73.02%. The average figures indicate remarkable differences between the unemployed (65.261) and the employed (81.270) respondents in their perceiving their lives as meaningful.

We checked the differences in meaningfulness of life between the employed and the unemployed respondents using the t-test.

The difference between the meaningfulness figures for the employed and the unemployed men and women groups is statistically significant. Work brings meaning and order to human life. No activity is a fair replacement for a lost job.⁵

We further compared the meaningfulness of life in all the respondent groups using the Kruskal-Wallis test and the median test.

The results of the test showed that the differences between the respondent groups in their meaningfulness of life evaluation are statistically significant.

We further examined as to whether the meaningfulness of life evaluation is influenced by the duration of the unemployment, gender and age and we also examined the differences between the employed and the unemployed.

	Unemployed	Employed
Duration of unemployment (in months)	-0.111**	.
Gender	-0.158**	0.038
Age	-0.130**	0.056

N=1915; unemployed 966, employed 949; significance level * $p \leq 0.05$; ** $p \leq 0.01$

Table 7 Pearson's correlations between the meaningfulness of life evaluation and duration of the unemployment, gender and age.

As the data in the table show, relationships are statistically significant for the unemployed group where the meaningfulness of life evaluation slightly decreases with

⁵⁾ For more details refer to J. Šmajs, 2002; M. Machovec, 1968

the increasing duration of the unemployment (-0.111**). The same holds true for men (-0.158**) and for older people (-0.130**). The results suggest that older men who are unemployed for a long time represent a "risk" group suffering worst from the loss of employment.

Conclusion

Our inquiry has not only clarified our understanding of how a loss of a job is experienced by the unemployed, but also our understanding of work and its role in the contemporary life. The notion of the "Quality of Life" arose in the early 1970s as a sociological term referring initially to the amount of positive changes brought into the human life by the social and scientific progress. Later, even the negative effects of illnesses and old age were incorporated into the concept, and one of our conclusions is that the notion will need further theoretical treatment and a better definition.

The classic idea of the Age of Enlightenment that human life can be improved through culture was built on a confidence that although human nature has a mysterious biological element, the elastic social (socio-cultural) element is determining and more important. It was believed that man shapes his own nature about as much as he creates an artificial cultural environment. Yet this optimistic understanding of man and human nature is supported neither by the biological sciences nor by human and social life itself. Just like other mammals, today's human beings are a highly conservative biological species. Any information an individual receives from his environment during his ontogenesis and later life in culture can only be recorded in his current neuronal memory. Although we understand what culture is with our intellect, our genetic adaptation to culture is as slow and blind as was our ancestors' adaptation to the animate and inanimate nature. Hence today's cultural environment also has solely physical and chemical effects on this conservative memory. Again and again, generations of people are born with a necessity to employ physical and intellectual exertion in fighting for survival and in coping with the resistance of their environment. This predicts extinction to the illusion that live human work could be completely replaced by dead work using production and other technology as well as it implies that a return to employing human forces in a well-thought and productive way is not a step back, but rather a perspective solution of the existing stalemate unemployment situation in the technically developed countries. So far however, technical progress in combination with the market and relentless demand for profit steal jobs from thousands and tens of thousands of people every day.

Those who loose paid work through no fault of their own bear a similar load as if suffering from a long-lasting illness. This is why we tried to employ a method in our inquiry which had been used to measure changes in quality of life before and after interventions to ill and old people.

We chose the evaluation of individual quality of life in the unemployed and employed people because the individual feelings from the loss of job are rather resistant to purely objective perspective. Furthermore, the Schedule for the Evaluation of Individual Quality of Life gives the individual a possibility to specify those areas of life he or she considers to be the most important in their lives and to give a percentage weight to

their importance. SEIQoL is a method which, unlike traditional approaches, takes into account mainly the individual perspective.

Although we are well aware that we have to be careful in drawing conclusions from our inquiry, we are confident that it has lead to several substantial findings:

1. Paid work in our young liberal market economy, which did not experience unemployment and its effects for two generations, will be increasingly valued in our lives.
2. Family is not a fading away category with just religious, ethical and educational relevance, but rather a category still important from biological, social and existential perspectives.
3. Even the transformed lifestyles due to increased consumption, traveling and massive expansion of the consumer products such as cars, televisions and computers, cannot make for or litigate the loss of the beneficial effect of work on human satisfaction and health.
4. Should the standard structure of the human psyche, which was formed in the deprived and for people physically demanding Hunting-Gathering and Neolithic cultures, be reproduced even in future, it will be necessary to face not only the extremely consumer life-style of people but also to create conditions for a relevant load on the human body by means of a socially useful, productive labor.

THE TASK OF SPIRITUALITY IN LIFE QUALITY AND LIFE SATISFACTION IN YOUNG PEOPLE

Irena OCETKOVÁ

Main investigation issues

1. Is there a coherency between a spirituality level and life quality expressed in the sensation of subjective wellbeing?
2. Is there a coherency of the spiritual level in relation to relevant sociodemographic variables (differences between men and women, between the younger and older, differences between the secondary-school and university students, differences in the state of health, differences between town and country population, membership or non-membership in youth organisations, and finally the differences between the religiously practising and non-practising)?
3. What is the interaction of the above mentioned sociodemographic variables and the importance given to individual spheres of life (such as physical, material, spiritual and psychosocial wellbeing)?
4. What is the satisfaction in the individual observed spheres of life in men and women, in the younger and older, in the respondents in regard to the type of school, state of health, place of residence, membership in church or religious movement, membership in youth organisations, practising or non-practising religious regulations and duties?
5. In what spheres of life and in what variables regarding the quality of life is the difference between young people with a higher level of spirituality and those of a lower level of spirituality?

Set of respondents

The set of respondents was formed from 445 persons, 213 men and 212 women, at the age of 16 – 35, 216 persons were younger (age 16 – 21) and 229 older (age 22-35). The average age was 21.14 years. All participants were present student or graduates of secondary schools (156 persons) or present students or graduates of universities (289 persons).

Data collection, methods, statistical data processing

Data collecting was performed in May and June by following questionnaire methods: (SQUALA questionnaire, Questionnaire of personal sense by M. Soudková

(Wong, 1998), Bern questionnaire for detecting subjective wellbeing of adolescents (Grob, Luthi, Kaiser, Flammer, Makinnon, Wearing, 1991, according to Lukášová, 1994), Self-Esteem Scale (Rosenberg, 1965 according to Lukášová, 1994)).

The respondents filled the questionnaires anonymously. The statistical data processing was performed by means of the program SPSS 14. For detecting the dimensional structure of the questionnaire of personal sense was performed a factor analysis of all 67 items.

For testing the differences among more than two groups was used the scatter analysis. For qualifying the differences between the means of two groups a t-test was used. For qualifying statistical significance of the results was used the usual significance level $p = 0.05$ or $p = 0.01$.

The investigation dealt with

1. a) detecting the sensation of the importance of individual spheres of life wellbeing,
b) detecting the satisfaction in the spheres,
c) detecting the spirituality level and personal sense,
d) detecting the life satisfaction and self-esteem, two dimensions of subjective wellbeing in individual respondents.
2. We looked for the differences in individual items
 - a) according to the sex
 - b) according to the age
 - c) according to the type of school the respondents study or graduated
 - d) according to the life standard of the family the persons live in
 - e) according to the state of health
 - f) according to the place of living
 - g) between the believers and non-believers
 - h) according to the membership in a church or in a religious movement
 - i) according to the membership in a youth or another organisation
 - j) between those who follow or do not follow religious rules and duties
3. We identified the items in which the respondents with higher and lower spirituality differ

Summary of the investigation results

One of the important results of the investigation data processing was the identification of three spirituality factors on the basis of the factor analysis of the questionnaire on purposefulness of life, which were further exploited in interpretation as self-contained spiritual dimensions (1) pro-social orientation (life for others), (2) purposefulness of life and (3) universal spirituality.

Spirituality was not understood in a narrow religious meaning but as an integrating component of the personality.

The investigation results in:

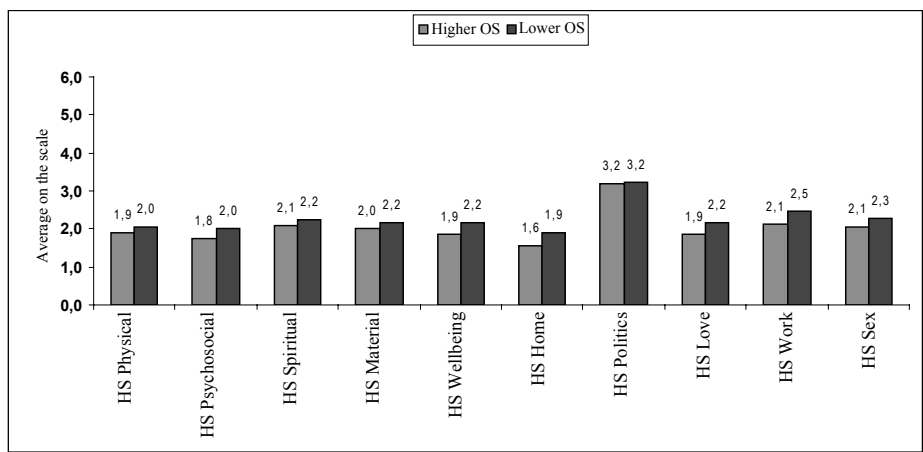
1. Young people participating in the research are aware of a free space in the sphere of spirituality of their own personality, which is not filled by positive contents. Young people feel rather happy in their common life (the average value of life satisfaction of all investigated persons on a six-point scale is 2.78).

2. Young people in the investigation set judged themselves as rather more spiritual without regard to age and sex (the average value on a six-point scale was 2.87). They realise their spirituality particularly in commonly good mutual relations to other people (the average value of the pro-social orientation without regard to age and sex on the six-point scale was 2.47. The average value of the purposefulness of life on the six-point scale was 2.97. The lowest value of the three spirituality factors was measured the value of eco-spirituality, i.e., the ability to perceive and experience a transcendence, an overlap of common reality to anything which is positioned “above it” (the average value on the six-point scale was 3.53).
3. The height of spirituality is not influenced by the age of the persons but the spiritual fulfilment is related to age (the older respondents (age 22 – 35) were statistically more satisfied in the sphere of spiritual wellbeing than the younger ones (16 – 21)).
4. The educational level does not influence the height of spirituality but the university graduates, as evidential by statistics, are more satisfied in the sphere of spiritual wellbeing than secondary school students.
5. Women, as proved by statistics, are more oriented towards other people and perceive their lives as more purposeful than men.
6. Membership in church or religious movements and also membership in youth or other organisations has positive influence on the spirituality level of a young person.
7. Spirituality and inwardness expressed in living a experiencing the purposefulness of one’s own life and realised in relations and in pro-social devotion, improves these persons’ sensation of their own state of health.
8. Belief and following religious regulations and duties bring the believers and followers statistically evident feeling of a higher life satisfaction, feeling of satisfaction and wellbeing in the sphere of belief, justice, freedom, beauty and art and truth and a higher satisfaction in the material sphere and in the spheres of love and work.
9. Material satisfaction and the emphasis and orientation onto material satisfaction in life is indirectly proportional to the spiritual orientation and life satisfaction.
10. Neither a low nor a high standard of living agrees with spirituality very much.
11. The differences between the respondents in the groups with a higher and lower spirituality and personal sense in regards to the satisfaction in stated spheres of life, are given in graph No. 1.
12. The differences between the groups with a higher and lower spirituality and personal sense (OS) in total feeling of subjective wellbeing (WB), in life satisfaction (LS), in self- esteem (SE) in pro-social orientation (FA1), in experiencing the purposefulness of life (FA2) and in universal spirituality, are given in graph No. 2.
13. Statistically significant differences between the groups of respondents with higher and lower spirituality in the individual monitored spheres are given in Table 1.

Graph 1.

The differences between the groups with higher and lower spirituality and personal sense (OS) with regard to the satisfaction in the stated spheres of life on a four-point scale (very unsatisfied = 4, rather unsatisfied = 3, rather satisfied = 2, very satisfied = 1); HS Physical = average value of life satisfaction in the physical sphere, HS Spiritual = average value of life satisfaction in the spiritual sphere, HS Material = average

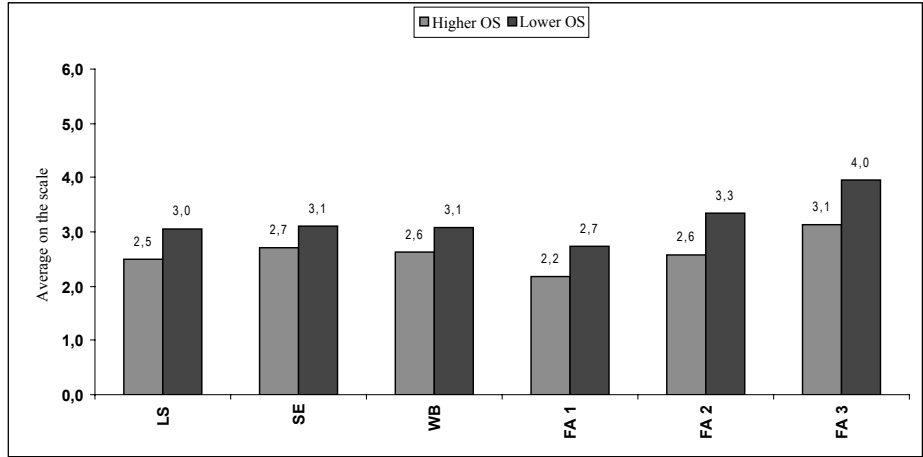
value of life satisfaction in the material sphere, HS Psychosocial = average value of life satisfaction in the psychosocial sphere, HS Home = average value of life satisfaction in the sphere of environment and home, HS Love = average value of life satisfaction in the sphere of love, HS Sex = average value of life satisfaction in the sphere of sex, HS Politics = average value of life satisfaction in the sphere of politics, HS Work = average value of life satisfaction in the sphere of work).



Graph 1

Graph 2.

The differences between the groups with higher and lower spirituality and personal sense (OS) in a total sensation of the subjective wellbeing (WB), in life satisfaction (LS), in self-esteem (SE), in pro-social orientation (FA1), in experiencing the purposefulness of life (FA2) and in universal spirituality (FA3) on a six-point scale (definite disagreement = 6, disagreement = 5, rather disagree = 4, rather agree = 3, agreement = 2, total agreement = 1)



Graph 2

Group of young people with higher spirituality	Group of young people with lower spirituality
More women than men	More men than women
More believers than non-believers	Less believers than non-believers
More members of churches or religious movements	Less members of churches and religious movements and more non-members than in the group with higher spirituality
More religious followers	Less followers and more non-followers than in the group with spirituality
Consider the sphere of spiritual wellbeing (belief, justice, freedom, beauty and art, truth) more important in life than respondents with lower spirituality	Consider the spiritual sphere as less important than persons with higher spirituality.
Value the sphere of psychosocial wellbeing (family, interpersonal relations, children, hobbies, safety) as more important in life than young people in the group with lower spirituality	Value the sphere of psychosocial wellbeing as less important than respondents with higher spirituality
Give higher importance to the sphere of psychic wellbeing in life than persons with lower spirituality	Consider the sphere of psychic wellbeing as less important than the respondents with higher spirituality
Consider the sphere of environment and home in life as more important than the persons with lower spirituality	Value the sphere of environment and home as less important than those with higher spirituality
Value the sphere of love as more important in life than those with lower spirituality	
Value the sphere of politics as less important than those with lower spirituality	Consider the sphere of politics as more unimportant even meaningless than the respondents with higher spirituality
Are more satisfied in the sphere of physical wellbeing, i.e., in the spheres of health, physical self-sufficiency, sleep, personal care and rest than respondents with lower spirituality	Value themselves as less satisfied in the sphere of physical wellbeing than those with higher spirituality
Are more satisfied in the sphere of psychosocial wellbeing, i.e., in the spheres of family, interpersonal relations, children, hobbies and safety than persons with less spirituality	Value themselves as less satisfied in the sphere of psychosocial wellbeing than those with higher spirituality
Are more satisfied in the sphere of spirituality, i.e., in the spheres of belief, justice, beauty, arts and truth than those with lower spirituality	Value themselves as less satisfied in the sphere of spirituality than those with higher spirituality
Are more satisfied in the sphere of material wellbeing in their lives (money, food) than those with lower spirituality	Less satisfied than those with higher spirituality
Are more satisfied in the sphere of psychic wellbeing	Less satisfied in the sphere of psychic wellbeing than those with higher spirituality
Are more satisfied in the sphere of home environment	Less satisfied
Are more satisfied in the sphere of love than those with lower spirituality	Less satisfied
Are more satisfied in the sphere of work than those with lower spirituality	Less satisfied

Are more satisfied in the sphere of sex than those with lower spirituality	Less satisfied
Value themselves as generally more satisfied than persons with lower spirituality and personal sense	Generally less satisfied
Have more positive attitude to life than younger people with lower spirituality and personal sense	Less positive attitude to life
Have higher self-esteem than persons with lower spirituality and personal sense	Lower self-esteem

Table 1.

Statistically significant differences between groups of respondents with higher and lower spirituality.

Conclusion

We found coherence between spirituality on one hand and quality of life and life satisfaction on the other in the context of further relevant variables. The results found in the realised investigation verified that a developed spirituality is an important component of a high-quality and satisfactory life of young people.

QUALITY OF LIFE IN THE OLD AGE

Vladimír SMĚKAL, Hana HOBZOVÁ

Introduction

The old age has been called the „third age“ from the point of view of social politics and sociology. The psychologists talk about the eighth or even ninth age. For illustration, let us take a look at several categories of human evolution stages during the ontogenesis.

Since when a human being is old?

Pythagoras thought

- that the following periods of our lives correspond to the four seasons as follows:
- forming (to 20 years),
- youthfulness (to 40 years),
- strengths heyday (to 60 years),
- old age (after sixty years of age).

According to the Indian tradition, life has been divided according to predominate values to four stages too:

- In childhood and youthfulness it is an ambition for satisfying desire.
- In young adulthood it is an effort to achieve wealth or power or successes.
- In mature adulthood it is pointing to responsibility, a desire to fulfill one's duties.
- In an old age it is an effort to break out of desires, longing for liberation and finding a sense of being.

In Old China life was divided to:

- youthfulness (to 20 years),
- age for getting married (to 30 years),
- age of fulfilling social duties (to 40 years),
- age of seeing own faults (to 50 years),
- last possibility of creative life (to 60 years),
- age of wisdom (to 70 years),
- old age (after seventy years of age).

Even in 19th century someone noticed that there is a scale of predominate live problems and tasks connected to age whose objective urgency and subjective experience depend on how we had managed them.

- To 25 years it is spoken about the age of qualification that changes into the age of unsettling down in case of failure;
- to 35 years it is an age of career that in case of failure changes to the age of decline;
- to 45 years it is an age of authority (results) that in case of failure changes to the age of disappointment;
- to 50 years an age of action (position) is supposed, in case of failure an age of envy;
- a career can be characterized to 60 years as an age of grades that changes to an age of resignation in case of failure;
- to 65 years an age of dignity is possible that changes into an age of cynics if the personal expectations are not met;
- after 65 year of age there follows an age of wisdom, which can thwart into the age of bitterness.

Kajka'ús (1021 - 1099), a Persian thinker, poet and writer, wrote in his *"Book of guidance"* thousands years ago:

A man to thirty four years every day gets powers and competency and to forty stays without any change like a Sun when it gets the zenith, slows down its way.

From forty to fifty a human being every day notices a disease he/she had not suffered from in the past year;

from fifty to sixty he/she every month finds a deficit he/she did not notice a month ago;

from sixty to seventy he/she every week finds a disease he/she did not know about a week ago;

and from seventy to eighty he/she finds a new malady every day.

And if he/she gets older than eighty, each hour brings a new pain and new sufferings.

The boundary, to which a man has an enjoyment of life, is forty years. When this age comes, it is like you sit on the topmost traverse of a ladder and the way you climbed, you have to get down.

These days this considerably pessimistic description of life course is not that valid. New findings about brain ageing are a source of moderate optimism.

Is it possible to put off the changes caused by ageing? - Yes, if we start in youth.

What role is played by lifestyle in the change dynamics? - Great.

The results by neuropsychologists confirm that active spiritual and intellectual life as well as health lifestyle can compensate even possible influence of genetic disposition.

The publication *"Paradoxes of wisdom"* by American neuropsychologist E. Goldberg (2006) dedicated to specialists as well as to broader public says that ageing of a brain does not necessarily mean the decrease of mental functioning. The author engages in this problem in many aspects - historical, cultural, psychological and neurological and he fills it in the examples from the lives of historical persons. He deals with the functions of both hemispheres; and compared to existing affirmation emphasizes a new scientific finding that even encephalic cells restore. The end of the publication brings topics that help to slow down or even suppress ageing of brain.

The psychology brings many evidences that the course of life and its final stages - ageing and old age - are not so much dependent on the date of birth as on the biological and psychological age.

Psychology generally accepts distinguishing of the life path into eight stages (by E. Erikson, 1999). Ageing and old age are the eighth phase for which an evolutionary task is reaching wisdom. It is a result of fight between an effort for integrity and destructive powers of health, social and mental troubles. If the integrity is not achieved, despair and hopelessness fixes in the senior's personality, which has often been processed by the vicinity in the displays of lack of interest and disdain that even fix these feelings. The seniors need positive experience with the world's status and the demonstrations of the vicinity's interests in their opinions. If they have an opportunity to meet positively thinking coevals, it is a great source of comfort for them.

Bodily, health, social and psychical changes that threaten the quality of life

Bodily and health changes

physiological

- vision degradation,
- hearing degradation,
- problems with balance,
- problems with mobility - osteoporosis,
- incontinence,
- degradation of health problems neglected in the previous periods - rheumatism, diabetes.

Social

- feelings of loneliness and desolation (nobody talks to them and listens to them),
- demands on attention and interest of the vicinity in their problems,
- leaving family by adult children (syndrome of the left nest),
- change of place for living (moving), or moving to the facilities for seniors (old people's home, rest home, boarding houses, houses with the day care, etc.),
- death of the partner, coevals, friends,
- diseases of an old age.

psychological

- changes of thinking,
- changes of memory,
- changes in values,
- opinion adherence,
- rigidity in relationships,
- suspiciousness and mistrust (the vicinity must count with paranoia),
- often comprehensible gullibility,
- communication topics are mainly negative and repeating,
- the problem is in mental acceptance of restrictions given by the age,
- wisdom is rare, but magnificent (E. Goldberg).

What the seniors demand from their vicinity

Talk to them

Listen to them

State politics towards seniors

The euro deputy Zuzana Roithová presents an EU project to the Czech public named “Common AAL program“ that should among others contribute to introducing smart assistants to the seniors’ households. She says that thousands projects in European countries are dedicated to improving the quality of life in adulthood. The common research program of assisted living is however interesting in the fact that it concerns research and development of informational and communication technologies oriented on elder people – the aim is not to directly support old people’s homes, but to provide a space to development of such information technologies that will ensure quality of life to elder people even in their households.

Contemporary government reacts to demographic data about the age becoming longer and initiates creating measurements that support the quality of life. It is not only continuous increasing of pension support amounts, but also creating conditions so that the senior could stay in his/her home environment. Thus it supports programs that allow dwelling and dignified life in home environment as long as possible according to the person’s own wish. It is connected with the need of interlacing the terrain workers in the area of health and social works who visit the seniors, and providing sufficient amount of such people.

However, this needs modifications of law measurements in the area of social services. The contemporary system of social services allows the seniors to draw the contribution to support in four grades from 2,000 to 11,000 Czk. In 2006 the ČSSD government invested in social services 13 billion CZK, in 2007 it was instead of 16.5 billion 6 billion more and in 2008 it will be 25 billion CZK. This law is however insufficiently effective and needs changes. These finances cannot escape from the system and must be devoted to real care.

There is a new significant service for seniors – community centers and stationeries, where the family can leave the senior during the day. These centers will provide seniors and families support and flexible services.

There are also thoughts about improving the system of terrain sisters and doctors who will visit the seniors in their homes.

Special trainings in the geriatrics are planned. A new law has been planned that will allow fast changes in the patient’s regime depending on whether he/she needs health or social care or not.

There has already been the quality control of institutional care running. Many beds in the medical institutions for the patients with ill health will be transformed to specialized geriatric departments with higher quality of services for the seniors.

Introducing the contribution of children for long-term stay of their parents in nursing homes is thought, whose level will depend on the financial situation of the family. As the survey shows, 56% of the seniors contribute to their children from their pension, while 72% children have never contributed to their parents.

Strengthening inter-generation solidarity has been desirable in the cases, when the family is not able to take care of the senior in their home environment.

Tax deductions for working pensioners should be introduced, support measurements for employing elder workers and tax advantage for part time jobs.

Findings of the survey on the seniors' quality of life

Examining the quality of life and life satisfaction of seniors from the psychological point of view has been important for contribution to carrying out the measurements for seniors' life at home as well as in social welfare facilities and medical institutions for people with ill health. The dissertation by H. Hobzová (2005), written under my supervision, brought many findings of which we further state the most inspiring.

The survey has shown that the people living in the old people's homes attribute smaller importance to self-care, care about the environment, and physical self-sufficiency because of relatively worse health condition of this group of respondents, as well as because of smaller level of autonomy and self-sufficiency accompanying living in the old people's homes. Greater emphasis put on the task of belief corresponds to the presumption that with degradation of health and reducing basic needs the interest of an ageing person shifts to higher level of the quality of life fulfilled e.g. by the spiritual interests of the respondents.

Also the life satisfaction that is closely connected with the quality of life according to the correlation analysis, is different at individual groups of respondents. However, while the total highest scores in the quality of life were achieved by the respondents living at home, in case of the overall life satisfaction, higher levels of satisfaction were asserted by the respondents living in the boarding houses for seniors. This finding can in fact appear false and influenced by non-representative selection of the respondents, however within the study it shows to be significant. Possible interpretation is connected with the fact that institutions like boarding houses for the seniors ensure its inhabitants help in everyday matters, at the same time they provide the seniors with high level of autonomy together with the possibility of finding social contact with other inhabitants. These positives then probably come through higher life satisfaction of the people living in the boarding houses.

Low values in the items „My way of life almost completely matches my ideal“ and „My life conditions are great“ at two groups of respondents – living in the old people's homes and charitable facilities also show that staying in these institutions has not been perceived as wanted and desired. Moving to a facility of an institutional type has usually been accompanied by worsening health condition and isolating from natural environment of an old man. It is connected with loss of existing social contacts as well as contacts with the family, which leads to lower current life satisfaction, but also to lower satisfaction with the areas of the quality of life. For example evaluating of the item “Quality of the environment and living” that is connected with the way how the respondent lives is significantly lower for people who live in the old people's homes than at respondents who live at home and in the boarding houses.

The congruity and continual nature of evaluating the importance of life areas correspond to the image of the stable ladder of values and images about world at the

minds of the elder people. These values form potential sources of finding a sense of life in an old age, which is suggested by the result of comparing the questionnaire “Profile of personal importance”, in which no differences were found between individual samples of respondents. Thus the sources of life sense in the adulthood probably stay the same for all the seniors, however with regard to individual differences. Finding and accomplishing the sense of life as a whole appears as an independent component of life in adulthood. There are some observable differences on lower level, in individual dimensions of the “Profile of personal importance”, particularly in the dimension of acquiring the sense of life and relationships with the others. The dimension of intimacy, at which also its lower satisfaction could have been supposed with the group of respondents living in the *old people’s homes*, does not achieve significant difference. The gathered result can however be influenced by lower number of filled questionnaires “Profile of personal significance” in the group of old people’s homes inhabitants.

The nature of relationships among three concepts of life evaluation: quality of life, life satisfaction and sense of life suggest that they are quite close to each other (the value of the coefficients moves between 0.423 to 0.567) and state their linear interdependence. Thus we can say that a fair quality of life leads to satisfactory life and more successful finding of life sense sources. Or another point of view: finding the sense of life leads to higher evaluation of the quality of life and satisfaction with life, regardless the objective barriers.

If the four sub-samples of respondents are compared, a very convenient way of living appears to be a boarding house for the seniors. Its inhabitants despite their higher age and higher level of health problems achieve scores in all the concepts of research scores higher than the inhabitants of old people’s homes and charitable facilities, very similarly like the respondents who live in their households. Development of this type of social care institutions for seniors could therefore lead to more satisfactory and successful ageing of more seniors than so far.

How to keep the quality of life despite the negative results of changes in the old age?

Whenever the seniors are in personal physical, mental, spiritual or social crisis, they should know that it is not possible to prevent increasing age by the movement in time. **The important fact is however, how we go through our age, what attitude to the years of our lives we have. Therefore it is necessary to learn how to:**

- relax,
- recall the memories to experiences and events full of well-being,
- communicate with unconditional basis of our personality (the God) through prayer and meditation,
- recall the old oriental adage: To see roses on thorny tree than to concentrate on the thorns on rose tree.

In many studies we can find the summary of conditions for well-being and dissatisfaction of the seniors. Let us look on the outline by J. Krivohlavý (2004):

When people feel good?

The characteristics of the personal goals that lead to good subjective status

- particularly defined, achievable goals (to be decently dressed, to talk slowly and clearly...),
- the goals suggesting getting closer to the dominant, highest, whole-life orientation,
- goals defined in the terms of spiritual dimension of life (spiritual goals),
- goals with the characteristics of the group affiliation,
- goals focused on increasing the intimacy in the narrowest relationships,
- generative goals,
- goals coming out of own personal decision of given person (intrinsic goals),
- goals typical with higher level of devotion to selected activity.

When people do not feel well

The characteristics of the personal goals that lead to bad subjective status:

- power goals (defined in terms of using to abusing the power),
- ambivalent (contradictory) goals,
- goals given to a person from the vicinity (extrinsic goals),
- conflict goals (choosing the goals that collide with other goals already selected),
- too abstract goals (to be 100% honest, to think only about positive things...),
- attempts significant with the desire to dissociate (take away) from something.

Top ten for handling the accompanying phenomena of ageing and old age

1. Reject the numbers that are not very important for having luck - unimportant data like age, blood pressure or cholesterol level. Leave care on their optimal level on the doctors.
2. Contact optimists - people who spread well-being and good mood. If possible, avoid snivelers, sourpusses and eternal grumblers who spread bad mood. If you cannot avoid them, show them positive aspect of life at all circumstances. Joy even ordinary, everyday and seemingly routine things.
3. Always learn something new, discover new things. Learn for example working with computer, handmade something, work in the garden. Let neither your body, nor your brain idle. „*Lazy mind is a work of devil and the devil's name is Alzheimer.*“ And remember – it is better to do needless things than nothing.
4. Do not be ashamed for laugh, laugh often and aloud. Laugh so much that you start split your sides with laughter. Visit cinemas or watch comedies on TV.
5. Even tears are beneficial and release tension. Do not be afraid of venting legitimate fear, but try to find any meaningful activity or help to the others. And realize that you are always with yourself. Agree to life, however difficult it is.
6. Surround yourself with things you like – grow flowers, get a pet, collect something. Create in your house a refuge against the outer world.
7. Take care of your health. Do not neglect prevention. Choose healthy lifestyle. If you have health problems, do not hesitate to contact a doctor.
8. Do not try to escape using alcohol or drugs. Instead of drinking or having troubles at home it is better to set out among people - to a shopping centre for example.

If possible, go for walks. Go to package tours, but select such that correspond to your physical condition. Find a center of regeneration activities for seniors.

9. Keep saying to people that you care for them and like them, do not impose yourself to them, but show it in your helpful and hearty behavior.
10. String in you an interest in a spiritual life that becomes with astonishment and enthusiasm even with ordinary gifts of life. Develop belief, hope and love in the relationship to the sense and values of life against ignorance, fear and selfishness that present the biggest evil in individuals as well as nations.

*According to the foreign sources prepared by
Vladimír and Ema Smékal*

The conclusion of study

Examining the components and determinants that participate on the quality of life, life satisfaction, feeling luck, hope or wisdom, has not been a common part of traditional psychological researches among seniors. However it appears in the past decades together with the development of research in the scope of positive psychology paradigm that tries to fill in and develop the existing psychological knowledge.

The interest in positive aspects of human life has so far focused only for their content definition, clarification of definitions, or creating the models. Only in the recent time it focuses on possible shift and development during the human life. Part of this effort is also a presented dissertation that tries to map the development period of adulthood, to summarize its biological, social and psychological aspects and to clarify some topics coming out of the positive view on an old age.

Selected positive components of living in the old age that are discussed at theoretic and research part of this dissertation, concern the quality of life, life satisfaction and experienced meaningfulness of life. They are confronted with involution changes that cannot be separated from biological process of getting old. One of the losses accompanying the process of getting old can be changes of sensoric functions, decreasing adaptability, loss of physical or mental strengths and many others whose enumeration would be very broad. A man getting old must know how to adapt to these changes so that he can consider his/her life satisfactory and happy in future. The opposite to given losses in adulthood are important gains that the old age brings, mainly the deepening wisdom, patience or stability of opinions and views on world.

The evaluation of gains and losses in the adulthood is reflected in the subjective evaluation of the quality of life and life satisfaction. Interconnection of these aspects in the course of the whole life is obvious, however in adulthood it gains certain specifics. When the old people evaluate their lives, they often use retrospective, they tend to link the quality of their lives to their current evolution and assess their current states from this point of view. However, the subjective methods of examining the quality of life and life satisfaction in an old age are the only possible, for objective assessment would suppose also objective criteria that cannot be exactly captured for the last evolution period of an old age.

The objectivity of evaluating the quality of life and life satisfaction in an old age should not be the goal, but on the contrary. The process of getting old is individually

variable and the existence of outside physical restrictions does not necessarily influence the satisfaction with an own life. Rather it depends on the attitude taken by a person to the process of getting old and only it is connected with the evaluation of life in all its components. An optimistic attitude to own adulthood has not been a commonplace and its searching can be very difficult. If it is successful, it usually means a parallel finding of those sources of life satisfaction and sense of life that is not linked with the biologic envelope, but has an enjambment to the mental and spiritual component of the personality.

Older people usually find the sources of satisfaction and quality of life in the areas of family, children, mental welfare or belief. They are gathered from broader social contacts and they are less and less interested by public life or politics. The general importance of life areas however has not changed too much with age, but the basic needs like health, physical self-sufficiency or satisfactory environment and living remain. With increasing age they are however fulfilled with more difficulties and thus lower satisfaction with them is reflected in declining life satisfaction. It means that the components of life that are not dependent on these basic needs are accented, like the transcendence or accepting self, that lead to finding the sense of life in the old age.

In my opinion, investigating the difficult and complex topic of the quality of life and life satisfaction in the old age should be contributing not only for closer understanding of this evolution stage, but it goes beyond broader opinion on the society. The quality of life and life satisfaction could become possibilities for looking at a human life in the course of its whole development.

Further broader investigation of these concepts is necessary. The dissertation only suggested possible topics concerning the quality of life, life satisfaction and sense of life. Further elaborating could be done in the direction of searching and adapting the most suitable methods that can be applied to older people, or lead to deeper understanding, why the evaluation of the quality of life and life satisfaction at various groups is different and what particular details fulfill it.

The possibility of exercising the results gathered in the dissertation is also in their including to prepared publication about the quality of life and the SQUALA method getting out from the researches carried out by Eva Dragomirecká, PhD. within the activities by the Prague psychiatric center.

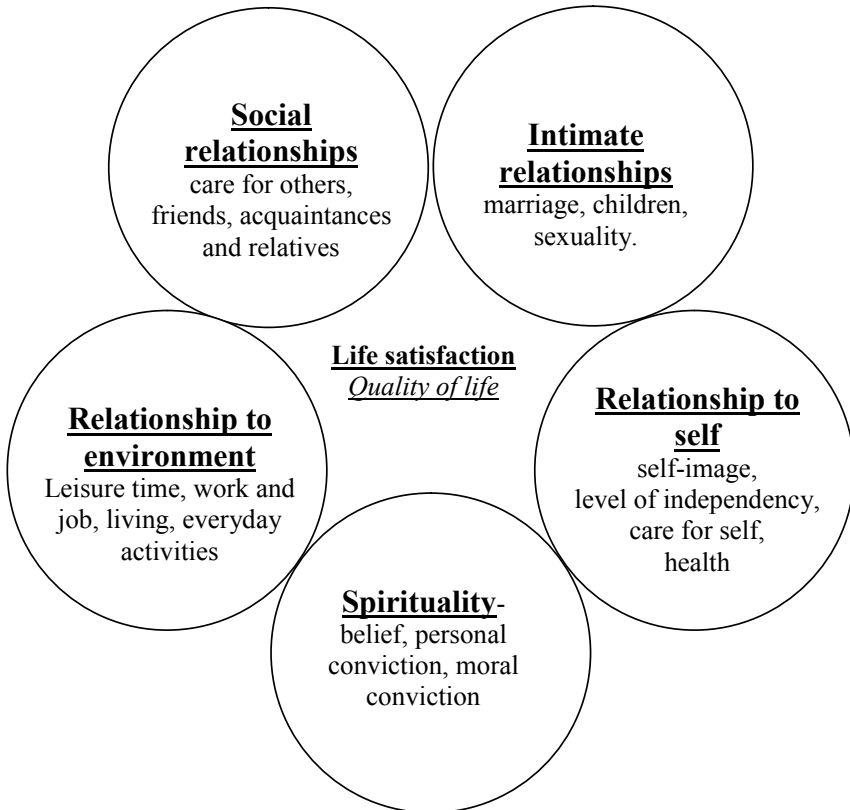
Areas of life as sources of life satisfaction

by C. Hawis, J. Fahrberg,WHO

Please put the number into each circle that evaluates the level given life area satisfies you.

Use the scales 1 – 9, where 1 means the minimum, 9 the maximum:

Low level of satisfaction	Middle level of satisfaction	High level of satisfaction
1 - 2 - 3	4 - 5 - 6	7 - 8 - 9



ABSTRACTS

Health - Related Quality of Life Paradoxes (HRQL)

Jiří MAREŠ, Jana MAREŠOVÁ

Abstract: This review study aims at covering the following three points: 1. To describe in detail the term 'health-related quality of life' and its clinical use, 2. To characterize the term 'paradox', 3. To describe and explain five paradoxes discovered while investigating the quality of life related to health. The term 'quality of life' applied in health care generally and in separate medical branches individually has its specific name – HRQL (health-related quality of life). Generally speaking, HRQL is a more narrow term than 'quality of life' and it is suitable for use while having in mind wider contexts of health care providing. When examining health-related quality of life, psychological, social, cultural and ethnic factors play a significant role.

Key words: quality of life, health-related quality of life, quality of life paradoxes

Quality of life issues - based on previous research results

Oliva ŘEHULKOVÁ, Evžen ŘEHULKA

Abstract: In this article several research studies are summarized dealing with examination of quality of life for women teachers of elementary schools and adolescent youth. In the presented results the quality of life structure is emphasized that is changing qualitatively with age; by interpretation of the data on quality of life it is appropriate to consider the age; the quality of life depends specifically on health and on development of a pedagogical career; several quality of life characteristics of the young age can signal a health peril for some later time. The quality of life can be influenced by education, self-education and psychotherapy.

Key words: quality of life, quality of life structure, quality of life dynamics, teaching profession, adolescent youth

Quality of life viewed in terms of empirical data

Jitka ŠIMÍČKOVÁ-ČÍŽKOVÁ, Bohumil VAŠINA

Abstract: This paper presents a comparison of various methods and techniques for diagnosing quality of life. We set out to answer this question: to what extent does the evaluated degree of QoL and life satisfaction depend on the method used to measure these variables?

Key words: SEIQoL, multi-item scales, overall life satisfaction, graphic and numerical scales, quality of life

Effects of childhood malignancy treatment on quality of life: Preliminary results of the QOLOP project

Marek BLATNÝ, Tomáš KEPÁK, Irena VLČKOVÁ, Martin JELÍNEK, Petra NAVRÁTILOVÁ, Milan PILÁT, Šárka KÁROVÁ, Alena SLEZÁČKOVÁ, Hana HRSTKOVÁ, Jaroslav ŠTĚRBA

Abstract: The most common health problems of patients who underwent childhood malignancy treatment are psychosocial and cognitive disorders. The project QOLOP (Quality of Life Longitudinal Study of Pediatric Oncology Patients) is a prospective longitudinal study whose purpose is to identify areas of reduced quality of life in children with cancer, including both objective indicators (mobility, function of sense organs, social involvement), and subjective well-being (emotional experience, life satisfaction). This study analyzes data from 37 childhood cancer survivors aged 8 to 14 years that were compared with data obtained from control group, pupils of elementary schools in Brno, Czech Republic. The study focused on the following four life domains: conventional involvement, parent-child interactions, depressiveness and self-perceived quality of life. Compared to children from control group, childhood cancer survivors showed lower involvement in social activities, lower degree of depressiveness and higher satisfaction with their health, belief, appearance and ability to attend school. No differences between child-parent interactions were found between the groups. Certain results were unexpected (such as lower depressiveness in cancer survivors) and are discussed in detail.

Key words: child's carcinology, quality of life, incidence treatment, psychosocial and cognitive disorders

Quality of Life of Cancer Children Caregivers

Helena VAĎUROVÁ

Abstract: The article deals with the concept of quality of life of cancer children caregivers, it focuses on individual aspects influencing subjective quality of life and presents current models of caregiver quality of life as well as ways of its measurement. Furthermore, the article deals with current situation in non-medical services provision for caregivers (psychologist, social worker, special needs teacher, non-government organizations, spiritual services, accommodation during in-patient treatment, etc.) in the Czech Republic. The article also presents partial outcomes of a research from 2007 which analyzed the quality and appropriateness of the current range of non-medical services and their influence on the caregiver quality of life.

Key words: cancer, caregiver, quality of life, coping, caregiver quality of life, factors influencing caregiver quality of life, coping, measuring quality of life

A meaning of a game specialist work with a kinesiology therapeutics specialization by oncology sick children

Marie BLAHUTKOVÁ, Jana DLOUHÁ

Abstract: A stay of a child in a hospital means all the time a significant psychical stress, above all if a child is seriously sick. This stress is represented by lots of pain, a fear from “white coats” (from time to time it broke out into a phobia), an unexpected loneliness, a fear from the future, and sometimes food intake disorders (that are corresponding with facts mentioned above) – especially dysorexia. All of these causes result into a progressive change of a child’s personality. The work of game specialist in kinesiotherapy improves communication level with the hospital staff, cooperation with a family, and also affects sick children’s quality of life.

Key words: kinezioterapy, child’s carcinology, psychomotor, Psycho - stimulation

An Influence of Educational Process in Hospital Primary schools on sick children’s quality of life

Jana DLOUHÁ, Marie BLAHUTKOVÁ

Abstract: The paper deals about an educational process in hospital schools because the education and teaching in hospital schools is not an independent process, but it is a part

of a medical treatment. The paper deals about an establishment of personal contacts with sick children as an essential solution of educational work in children departments, followed by a necessity of teachers cooperation in a hospital school with a home school of the pupil and with organization shielding educational process of hospitalized children. The main part is devoted to didactics of hospitalized children – an educational theory, i.e. a necessary modification of a grammar content and range based on a pupil health state and based on a fact for how long is the pupil allowed to study from medical point of view. It is pointed out that a possibility – based on newly accepted ŠVP – of integration of children diseases principles and treatments presentation by which a child is exposed during staying in a hospital. In the hospitalized children education theory the authors deal about what educational methods, forms, and instruments are the most acceptable for the education needs of pupils from hospital school: specialties of hospitalized children's educational methods – motivational, exposal with a focus on didactic tools, fixative, and a roll of an independent work and classification of sick children, including self-classification of pupils.

Key words: hospital primary schools, educational theory, teaching theory, education and teaching as a part of a medical treatment, teaching organization, didactics of hospitalized children, structure of education in hospital schools, didactic methods.

Leisure Time of Children in Hospital and Quality of Life

Jana DLOUHÁ, Marie BLAHUTKOVÁ

Abstract: The article is concerned with the issue of the leisure time of the sick children in hospital. The author describes the specific of sick children free time in hospital settings. There is an account of the activities, which contributes to the relaxation of the sick children, to the compensation of their stress and anxiety of the course of the medical treatment and the personality development of the children in hospital. The text refers to an importance of the hospital teachers and the tutors in the connection of the influencing of the hospitalized children. The attention is devoting the role of the volunteers and untraditional activities for small patients, especially to the trips out of the hospital area – concretely the visits to the zoo for child oncology patients and their parents.

Key words: the leisure time, sick children's free time in hospital, the functions of the free time, school in hospital, untraditional volunteer's activity.

Quality of school life from the pupils' perspective - research thesis

Věra VOJTOVÁ

Abstract: This article presents a pedagogical tool for investigating elementary school pupils' attitudes towards the quality of school life. In this contribution we present the first results of our research. We aimed at determining the usability of a scale for measuring pupils' attitudes towards school. Quality of school life within the inclusive school was the framework for our research. We interpret data received from 1596 respondents. Pupils associate school with the opportunity to learn, they are aware of the possibilities and opportunities that school offers. School is not seen as a place where "they really like to go". One's importance, on the other hand, appears to be undervalued by pupils – they generally feel as unimportant, the attention that they receive is felt to be insufficient, especially in higher school years.

Key words: quality of school life, risk of exclusion, school for all, inclusive education, quality of life concept..

Psychotraumatizing of pupils, students and teachers at Czech schools

Rudolf KOHOUTEK, Eva FILIPKOVÁ

Abstract: Our entry deals with various kinds of psychotraumatizing during school attendance. Based on research in primary, secondary school and university students, we have discovered the most frequent stress factors, which we have categorized. The most frequent complaints were humiliation, teacher's personality disorders (neuroticism, choleric behaviour) and victimizing between a teacher and a student and between students. We have identified symptoms of psychotraumatizing and outlined ways of prevention and therapy at schools. In our entry we bring in a few examples of microtraumas, influencing negatively school achievement and pupils' mental and social development.

Key words: psychotrauma, microtrauma, stress factors, prevention of psychotrauma

Quality of life of the long-term unemployed

Božena BUCHTOVÁ

Abstract: The aim of the study was to examine the relationship between the long-term unemployment, quality of life and the variables of age, gender, education and unemployment duration. The SEIQoL (Schedule for the Evaluation of Individual Quality of Life) method developed by C. A. Boyle, H. McGee and C. K. B. Joyce was used to measure the individuals' evaluation of the quality of life. A sample of 1957 respondents was inquired, including 966 long-term unemployed, a control sample of 949 employed people, 22 homeless and 20 unemployed mothers after maternity leave. Structured interviews with the first two groups were conducted throughout the territory of the Czech Republic, while the interviews with the homeless people and the unemployed mothers after maternity leave were performed in the Moravian and Silesian regions. The results of the inquiry showed that: 1. Remarkable similarities exist in the ranking by importance of the quality of life profile in both the employed and unemployed respondents – family, health, work, peace of mind and interpersonal relationships. In case of the homeless people and the unemployed mothers after maternity leave, a different ranking of the quality of life aspects was preferred, due to their current status. 2. As a result of a job loss, the important aspects are assigned different relative frequencies of semantic meanings as well as different ranking. 3. Long-term unemployment has a negative effect on the overall individual evaluation of the quality of life, satisfaction with the individual quality of life aspects and views of life's meaningfulness. 4. Correlation analyses have statistically confirmed the significant relationships between the quality of life aspects and satisfaction with them and the variables of age, gender, education and duration of the unemployment among both the employed and unemployed. 5. Duration of unemployment has a significantly negative correlation with education (-0.226 ; $p \leq 0.01$). With education, the time of unemployment decreases, while the importance of personal improvement increases and satisfaction with life and peace of mind increase. Educated people “better” cope with job loss. 6. Unemployed men find coping with the worsened financial status more difficult than women. They significantly more often compensate for the lost work by interests and hobbies. 7. In case of older men, experiencing unemployment has a heavier impact on the meaningfulness of life along with the extending unemployment period than in case of any other unemployed group. 8. ANOVA results discovered statistically significant differences in the average quality of life figures for the individual aspects – family, health, work, peace of mind, interpersonal relations, hobbies, interests, personal improvement, money, housing – as well as in satisfaction with them, both between men and women in general (regardless of their employment status) and between the unemployed men and women.

Key words: quality of life, aspects of life, meaningfulness of life, SEIQoL, work, unemployment

The task of spirituality in life quality and life satisfaction in young people

Irena OCETKOVÁ

Abstract: The contribution deals with the task of spirituality in life satisfaction and life quality of young people. The theme commenced from the fact that spirituality and everything what is related to religious life of people is a part of the culture of mankind, and from the knowledge of the history of psychosocial and spiritual culture, that the spiritual life is connected with both positive and negative impacts at personal wellbeing and life quality of man. In the first part there is a brief review of existing knowledge and spiritual components of life as religiosity, belief, conscience, religious practices and spiritual non-consciousness, all connected in professional studies and in a tradition with life quality and life satisfaction in a broad sense of the word. In the second part there are the results of the realised explorative heuristic investigation the goal of which was to find existing coherency between spirituality on one side and life quality and life satisfaction on the other in the context of other relevant variables. .

Key words: spirituality, transcendence, purpose of life, belief, religion, religiosity, life wellbeing, life quality, life satisfaction, sensation of subjective wellbeing

Quality of Life in the old age

Vladimír SMĚKAL, Hana HOBZOVÁ

Abstract: The old age has been called the “third age” from the point of view of social politics and sociology. The survey focused on the quality of life has shown that the people living in the old people’s homes attribute smaller importance to self-care, care about the environment, and physical self-sufficiency because of relatively worse health condition of this group of respondents, as well as because of smaller level of autonomy and self-sufficiency accompanying living in the old people’s homes. Greater emphasis put on the task of belief corresponds to the presumption that with degradation of health and reducing basic needs the interest of an ageing person shifts to higher level of the quality of life fulfilled e.g. by the spiritual interests. The quality of life and life satisfaction could become possibilities for looking at a human life in the course of its whole development.

Keywords: old age, hope, wisdom, satisfaction, quality of life, spiritual and mental life

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