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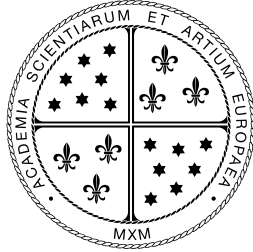
RAZLIČNI VIDIKI DOJEMANJA DOSTOJANSTVA V STAROSTI
DIFFERENT ASPECTS OF DIGNITY PERCEPTION IN OLD AGE

Uredili/Edited by: Peter Seljak, Jana Goriup



SOCIALNA GERONTOLOGIJA/ SOCIAL GERONTOLOGY

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— PRESS —

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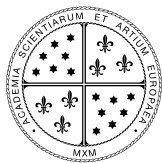
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izr. prof. dr. Jadranka STRIČEVIĆ

Fakulteta za zdravstvene vede; Univerza v Mariboru

Znanstvena monografija Katedre za socialno gerontologijo na univerzi Alma Mater »RAZLIČNI VIDIKI DOJEMANJA DOSTOJANSTVA V STAROSTI«,« sistematično in vseobsežno obravnava vprašanje družbenih sprememb z aktualnih stališč in zatečenih spoznanj socialne gerontologije in širšega družboslovnega zornega kota, vključujoč intersubjektivno doživljanje procesov transformacij življenja starejših odraslih, v katerem so se doživljanje, ohranjanje pa tudi kršenje dostojanstva kot ogrožanja varnosti starejših odraslih izkazala kot pomemben dejavnik ohranjanja in vzpostavljanja varnega načina njihovega življenja. Ker vsebina monografije izpostavlja ustrezno zaznano in povsem upravičeno skrb ob doživljanju takih disjunktivnih procesov, glede na pomembnost pojava in na pomen ohranjanja dostojanstvenega in varnega življenja starejše populacije v nepredvidljivi postmodernosti, v luči preseganja socialne odtujenosti in izolacije starejših odraslih, je ta še kako aktualna. Še posebej zaradi pomanjkanja tovrstnih raziskav in razlag.

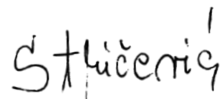
Avtorji problematizirajo doživljanje dostojanstva starejših odraslih kot individualno, ker je vsebina obsežna, povezovalna, korelativna, a mestoma celo različna, in kot obliko socialnega priznanja ter občutkom lastne sposobnosti, moči, vrednosti, pomembnosti. In, ne nazadnje; odnosom starejših do sebe.

V tej luči avtorji v predloženem besedilu ugotavljajo in opozarjajo na vprašanje družbeno odgovornih v nastalih spremembah, ki so očitno za starejše odrasle nove, težko prepoznavne in mestoma zanje celo ogrožajoče. Ob tem je avtorjem skupno še, da zagovarjajo tezo, da so v primeru, ko pride do določenih zlorab, omejevanja in kršenja, prepričani, da so prav tu pomembna socialno-gerontološka spoznanja in moč socialne gerontologije za (do neke mere) v premagovanju le-teh. Izpostavljajo pa tudi, da vedno obstoji možnost, da se tudi za starejše odrasle vzpostavi nov, drugačen in bolj ustrezen sistem ohranjanja varnosti in dostojanstva. Pomembno je tudi njihovo spoznanje, da ko bodo navedene vsebine obravnavanega problema dobile zadostno ne-le socialno in splošno družbeno, pač pa tudi (in predvsem) pravno podporo, redefinirale obstoječo fluidno vsebino napredka v življenju in obravnavi starejših odraslih. In, posledično, v nadaljnjem poteku in smereh slovenske družbe v obravnavi zadanega globalnega problema dostojanstva in varnosti v starosti kot vsestranskega problema za aktivno participacijo tako v obstoječem zoženem socialnem pa tudi globalno-družbenem okolju.

Ocenjujem, da poglavja v znanstveni monografiji izvirno obravnavajo aktualne probleme s področja socialne gerontologije, s posebnim poudarkom na vlogi in

obvladovanju dostojanstva in varnosti v življenju starejših odraslih. Poglavja v znanstveni monografiji so ustrezno metodološko in didaktično zasnovana, etično sprejemljiva, jasna in razumljiva, primerno oblikovana in zanimiva tako za širši krog strokovne in laične javnosti in predvsem za študente. Zaradi navedenega priporočam njeno publiciranje.

izr. prof. dr. Jadranka Stričević

Handwritten signature of Jadranka Stričević in black ink.

doc. dr. Danijela LAHE*Filozofska fakulteta, Univerza v Mariboru*

Intenzivno staranje v postmodernej družbi je izziv, ki ga je potrebno preučiti z različnih vidikov. Katedra za socialno gerontologijo na Univerzi Alma Mater Europa se je odzvala na doživljanje zatečenega in aktualnega dogajanja s predlagano znanstveno monografijo »Različni vidiki dojemanja dostojanstva v starosti / Different aspects of the perception of dignity in old age«,

ki obravnava doživljanje dostojanstva v sicer različno doživljanjih procesov staranja in starosti, zdravja in bolezni in nege, s posebnim ozirom na najbolj subtilno in ranljivo populacijo – t.j. starejše odrasle. Iz predloženega besedila je razbrati, da obravnava problem življenja starejših odraslih v povezavi z nezadržnimi procesi različnega (ne)razumevanja dostojanstva starejših odraslih, ki je vrednost, lastnina posameznika, ki pride do izraza v medsebojnih odnosih, v katere slednji vstopajo. Kot tako, tako izhaja iz vsebine predložene znanstvene monografije, je dostojanstvo del človekove osebnosti. Predstavlja pretežno nezaveden občutek notranje vrednosti, ki dobi svojo zavedno obliko v odnosu z drugimi ljudmi. Za vsakega človeka je doživljanje lastnega dostojanstva drugačno. Po drugi strani je dostojanstvo starejših odraslih njihova individualna vrednota, ki se je oblikovala skozi življenjska obdobja in je povezana s samospoštovanjem in samoocenevanjem starejših odraslih.

Posebna vrednost znanstvene monografije se kaže v obravnavi dostojanstva starejših odraslih kot vedenje ali nastop, ki je resen, miren in nadzorovan, kot lastnost, ki je vredna spoštovanja in kot občutek lastne pomembnosti, kar starejšim odraslim omogoča tudi občutenje varnosti.

Ker predlagano besedilo izpostavlja pomen doživljanje, občutenja in vzdrževanja dostojanstva v luči aktivnega in produktivnega staranja z več vidikov, na izvirni in imanenten način aktualizira vprašanja naraščajočega pomena zavedanja in udejanjanja pomena dostojanstva s ciljem premagovanja s kršenjem le-tega starejšim odraslim v povezanih negativnih procesih (npr. zanemarjenosti, osamljenosti, socialne izoliranosti, revščine idr.) v luči trajnostnega razvoja starejših odraslih in zagotavljanja varne starosti.

Avtorji, ki obravnavajo zadano področje življenja starejših, se zavedajo pomena izobraževanja in usposabljanja starejših za premagovanje tesnobnih občutenj ob ogroženi osebni integriteti, za ohranjanje stikov z zanje pomembnimi ljudmi in za potrebno sodelovanje in medgeneracijsko, delovno in življenjsko prepletanje med njimi kot starejšimi in drugimi, mlajšimi generacijami.

Tako so avtorji v svojih prispevkih ugotovili, da je potrebno stalno ozaveščanje in opolnomočenje starejših, izhajajoč iz skupinske identitete različnih ravni in vrsti dostojanstva, za premagovanje njihove socialne izolacije, avtonomnosti in

(z)možnosti kritičnega presojanja ter zoperstavljanja kršenja obeh: tako dostojanstva kot varnosti.

Kot taka, predložena znanstvena monografija v marsičem predstavlja prve raziskovalne podatkov o doživljanju specifičnih razmer, v katerih so se znašli starejši odrasli v situacijah kršenja dostojanstva in ogrožanja njihove varnosti. Še posebej ob doživljanju osamljenosti in socialne izoliranosti.

Navedeno me zato navaja v sklep, da bo predloženo besedilo znanstvene monografije služilo tako v študijske kot nadaljnje znanstveno raziskovalne namene. Zato izid le-te toplo priporočam.

Znanstveno monografijo »Različni vidiki dojetanja dostojanstva v starosti« kot celoto ocenjujem kot odlično in priporočam njen izid, saj s svojo širino in interdisciplinarnostjo obravnava aktualna področja starosti in staranja ter daje nove raziskovalne dimenzije za reševanje problematike dolgožive družbe. Prav tako pričujoča znanstvena monografija pomembno vpliva na izhodišča za nadaljnje razprave in raziskovanja s področja socialne gerontologije in hkrati snovalcem politik na področju starosti in staranja prebivalstva ponuja nov pogled na obravnavano problematiko.

doc. dr. Danijela Lahe



DIGNITY AND SATISFACTION: DIFFERENCES IN RESIDENTS' PERCEPTIONS WITHIN CARE HOMES FOR SENIORS ON ISLANDS IN PRIMORJE – GORSKI KOTAR COUNTRY

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ABSTRACT

Resident satisfaction is monitored through the E-Qalin system, a quality management framework for senior care institutions. Key factors influencing satisfaction include home environment, nutrition, activities, staff attitudes, and care quality.

This study aims to examine whether statistically significant differences exist in the quality of care homes for seniors on islands, based on their size and accommodation capacity. The research was conducted on a sample of elderly residents of both sexes, divided into two groups, using anonymous self-assessment questionnaires developed by the Fabrika Group. Satisfaction was measured using a Likert scale, and data were analyzed using a t-test.

The findings indicate significant differences in certain satisfaction domains, with residents in smaller care homes reporting higher satisfaction. These results provide insights into areas for potential quality improvements based on best practices observed in higher-rated facilities.

Keywords: care homes for seniors, quality of life, quality control, social care, user satisfaction

INTRODUCTION

Elderly individuals generally prefer to age and even pass away in their own homes. However, due to the decline in physical and cognitive abilities, or the inability of the family to care for them, some elderly individuals must be placed in nursing homes (Matarese et al., 2022). With the extension of life expectancy, there is an increasing need for providing care to the elderly, and one of the most crucial indicators of care quality is user satisfaction. Person-centered care planning is a challenge in nursing homes, and assessing user satisfaction is necessary to implement such care. User satisfaction results can reveal areas of service improvement (Vassimon-Barroso et al., 2021). User satisfaction is influenced by various factors, with the most significant factors in institutional care being the

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physical environment and institutional characteristics, accessibility, continuity and outcome of care, and the quality of interpersonal relationships (Bhattacharyya et al., 2022). To ensure the satisfaction of elderly individuals in care facilities, the environment should resemble a home rather than a hospital. Resident rooms should be spacious with private bathrooms, and common areas should resemble residential spaces. Residents should be allowed to bring personal items that remind them of their own homes (Matarese et al., 2022). If we want residents of nursing homes to feel content, it is essential to work on the perception of their needs. This means viewing them not merely as patients but as individuals who still desire to live in accordance with their own wishes and capabilities for further development, regardless of the decline in cognitive and physical abilities (Matarese et al., 2022). Dignity is a fundamental concept in the care of older adults, particularly for those residing in elderly care homes. Personal autonomy and respect are critical factors in maintaining dignity. Residents in care homes often feel that their autonomy is compromised due to dependency on staff for daily activities. Personal autonomy and respect are critical factors in maintaining dignity. Residents in care homes often feel that their autonomy is compromised due to dependency on staff for daily activities (Fekonja et al., 2022). When staff respect residents' autonomy and involve them in decision-making, it fosters a sense of dignity. For example, providing choices in daily routines or involving residents in their care plans can enhance their perception of dignity (Kaplan & Bentwich, 2023). Social interaction and support from staff and family members play a significant role in maintaining dignity. Residents who feel isolated or neglected may experience a loss of self-worth, which can undermine their dignity (Oosterveld-Vlug et al., 2014). Supportive social networks and respectful interactions with staff can enhance residents' dignity. For example, residents who receive emotional support and understanding from care providers are more likely to feel valued and respected (Sunzi et al., 2023).

PURPOSE AND GOALS

This study seeks to answer the following research question: Are there statistically significant differences in resident satisfaction based on the size and accommodation capacity of care homes for seniors on islands?

Based on this, the study tests the hypothesis that: Smaller nursing homes have a more positive impact on resident satisfaction.

METHODS

This study was conducted on a total of 100 residents of nursing homes located on islands in the Primorje-Gorski Kotar County, including 22 residents from a small nurs-

ing home on the island of Rab and 88 residents from a large nursing home on the island of Krk. The data collection period lasted from October 1 to October 31, 2023.

Participants were recruited based on their residency in the selected nursing homes, with the inclusion criterion being their ability to provide informed responses to the questionnaire. Residents with a higher degree of independence, receiving lower-intensity care, completed the questionnaire independently. Those with a lower degree of independence and requiring more intensive care received assistance from specially trained volunteers who were not employees of the nursing home, thereby reducing potential bias. Participation in the study was voluntary and anonymous, and all participants were informed about the study's purpose and their right to withdraw at any time. To ensure ethical compliance, ethical approval was obtained prior to data collection. A quantitative research approach was applied, using the standardized E-Qalin questionnaire developed by the Fabrika Group. This questionnaire is used annually to monitor resident satisfaction and assess the quality of services provided in nursing homes. E-Qalin is a widely recognized quality assessment tool, covering various aspects of care, including infrastructure, professional staff, communication, activities, nutrition, healthcare, and other essential services. The questionnaire consisted of 23 questions, divided into two sections. Resident Satisfaction Assessment (18 questions): Residents rated their satisfaction using a Likert scale (1 - very dissatisfied, 2 - dissatisfied, 3 - neutral, 4 - satisfied, 5 - very satisfied). The following domains were assessed: cleanliness of the facility, nutrition, activities within the facility, employee-resident relationships, care and provision of services. General Resident Information (5 questions): This section gathered demographic and contextual data, including length of stay in the facility, level of physical ability, type of room occupied, overall satisfaction with the facility, additional comments or suggestions. The study was designed as a cross-sectional study. Resident satisfaction scores for each domain were calculated by summing the values for all items within that specific domain. Only respondents who completed all questions within a given domain were included in the statistical analysis. To determine statistically significant differences, an independent samples t-test was used to compare satisfaction levels between residents of smaller and larger nursing homes. While the E-Qalin questionnaire is a standardized tool, limitations are also possible. Some residents may have hesitated to provide negative feedback. This was mitigated by ensuring anonymity and using non-staff volunteers to assist with responses. Residents with cognitive impairments may have faced difficulties in completing the questionnaire. To address this, assistance was provided while ensuring that volunteers did not influence responses. The sample was unevenly distributed between the two nursing homes (22 vs. 88 residents), which may affect result generalizability. The t-test was used

to control for this discrepancy. By addressing these limitations, the study aimed to provide an objective and reliable assessment of resident satisfaction across different types of nursing homes.

RESULTS

Arrangement and cleanliness of the facility

Table 1 shows basic descriptive statistics for the variable of tenant satisfaction with the arrangement and cleanliness of the facility for each household

Table 1. Arrangement and cleanliness of the facility

Facility	N	Miss	Min	Max	Med	\bar{x}	SD
DSO Krk	78	15	4	20	15	14.6	3.2
DSO Rab	22	1	12	20	19	18.0	2.6

N – number of respondents, Miss – number of missing values, Min – minimum value, Max – maximum value, Med – median, \bar{x} – mean, SD – standard deviation

Result of t-test: | Method/Variiances | DF | t Value | Pr > |t| |-----|-----
|-----|-----| | Pooled/Equal | 82 | -4.39 | <.0001 | | Satterthwaite/Unequal
| 42.696 | -4.91 | <.0001 |

The p-values for both methods are less than 0.0001, indicating a statistically significant difference.

At the significance level of $\alpha=0.05$, there is a statistically significant difference in the satisfaction with the arrangement and cleanliness of the facility between residents of large and small homes ($p\text{-value} < .0001 < 0.05$). Residents of small homes are more satisfied with the orderliness of their homes (higher mean value $\alpha \bar{x}$).

Nutrition

Table 2 displays basic descriptive statistics for the variable of tenant satisfaction with the nutrition in the home for each household

Table 2. Nutrition

Facility	N	Miss	Min	Max	Med	\bar{x}	SD
DSO Krk	78	4	2	10	8	7.9	1.8
DSO Rab	22	0	3	10	9	8.3	1.9

N – number of respondents, Miss – number of missing values, Min – minimum value, Max – maximum value, Me – median, \bar{x} – mean, Sd – standard deviation

Result of t-test: | Method/Variiances | DF | t Value | Pr > |t| |-----|-----
|-----|-----| | Pooled/Equal | 94 | -0.91 | 0.3657 | | Satterthwaite/Unequal
| 34.304 | -0.91 | 0.3713 |

At the significance level of $\alpha=0.05$, there is no statistically significant difference in the satisfaction with nutrition between residents of large and small homes (p -value > 0.05).

Activity in the nursing home

Table 3 displays basic descriptive statistics for the variable of tenant satisfaction with activities in the home for each household.

Table 3. Activity in the nursing home

Facility	N	Miss	Min	Max	Med	\bar{x}	SD
DSO Krk	78	26	3	15	11	10.9	2.8
DSO Rab	22	4	4	15	13	11.6	4.1

N – number of respondents, Miss – number of missing values, Min – minimum value, Max – maximum value, Me – median, \bar{x} – mean, SD – standard deviation

Result of t-test: | Method/Variiances | DF | t Value | Pr > |t| |-----|-----
 |-----|-----| | Pooled/Equal | 68 | -0.71 | 0.4791 | | Satterthwaite/Unequal
 | 22.699 | -0.59 | 0.5594 |

At the significance level of $\alpha=0.05$, there is no statistically significant difference in tenant satisfaction with activities in the home between residents of large and small homes (p -value > 0.05).

Employee relation

Table 4 displays basic descriptive statistics for the variable of tenant satisfaction with employee relations in the home for each household.

Table 4. Employee relation

Facility	N	Miss	Min	Max	Med	\bar{x}	SD
DSO Krk	78	12	3	15	12	11.8	2.9
DSO Rab	22	2	8	15	14.5	13.3	2.2

N – number of respondents, Miss – number of missing values, Min – minimum value, Max – maximum value, Me – median, \bar{x} – mean, SD – standard deviation

Result of t-test: | Method/Variiances | DF | t Value | Pr > |t| |-----|-----
 |-----|-----| | Pooled/Equal | 84 | -2.03 | 0.0460 | | Satterthwaite/Unequal
 | 40.695 | -2.34 | 0.0244 |

At the significance level of $\alpha=0.05$, there is a statistically significant difference in tenant satisfaction with employee relations in the home between residents of large and small homes (p -value < 0.05). Residents of small homes are more satisfied with the relationship with the employees (higher mean value \bar{x}).

Care and support

Table 5 displays basic descriptive statistics for the variable of tenant satisfaction with care and support in the home for each household.

Table 5. Care and support

Facility	N	Miss	Min	Max	Med	\bar{x}	SD
DSO Krk	78	34	12	30	26	25.1	4.5
DSO Rab	22	4	12	30	29	24.5	6.6

N – number of respondents, Miss – number of missing values, Min – minimum value, Max – maximum value, Me – median, \bar{x} – mean, SD – standard deviation

Result of t-test: | Method/Variiances | DF | t Value | Pr > |t| |-----|-----
 -|-----|-----| Pooled/Equal | 60 | 0.40 | 0.6913 | | Satterthwaite/Unequal
 | 23.876 | 0.34 | 0.7352 |

At the significance level of $\alpha=0.05$, there is no statistically significant difference in tenant satisfaction with care and supply in the home between residents of large and small homes (p -value > 0.05).

Statistically significant differences exist in the arrangement and cleanliness of the facility and employee relations. Those in the small facility are more satisfied.

DISCUSSION

Of the five examined criteria (arrangement and cleanliness of the facility, nutrition, employee relation, and care and support), residents of smaller homes are statistically more satisfied in two (arrangement and cleanliness of the facility and employee relations). Many studies support the higher satisfaction results of users in smaller facilities. Regarding the difference between small and large nursing homes for the elderly and frail, one study showed that the size of nursing homes is the most significant predictor of user satisfaction, with smaller nursing homes associated with higher satisfaction levels (Vassimon-Barroso et al., 2021). The study from Poland was conducted in nursing homes that were divided into two groups (up to 100 residents - small homes and with more than 100 residents - large homes). Residents of small homes had higher average life satisfaction scores than those in large homes (Trybusińska & Saracen, 2019). The study showed that users who moved to small homes experienced a decrease in anxiety levels, unlike those who stayed in larger homes. This study illustrates that transitioning from a large-scale facility to a smaller-scale environment can enhance a dimension of quality of life by indicating a decrease in anxiety (Kok et al., 2018). The size of the nursing home and the amount of activities offered to residents were identified as strong predictors of satisfaction in a study conducted in small Swedish homes. The study demonstrated that residents in smaller homes gave

higher satisfaction ratings than those in larger nursing homes. The presence of fewer staff turnovers in smaller homes was identified as a causal mechanism. The model of small homes was described as providing greater choices for users, a homely atmosphere, a positive sensory environment, and close relationships. Given the higher satisfaction ratings from residents in smaller homes, consideration should be given to organizing larger institutions into smaller units within larger facilities (Spangler et al., 2019). Research results indicate that larger institutions have a lower staff-to-resident ratio and prioritize profit development over care quality (Frey et al., 2019). The working model resembling large hospitals should be replaced with a home-like model, meaning adapting the organization of daily activities to user needs while respecting freedom of choice and residents' personal habits (Matarese et al., 2022). Findings have confirmed that transforming the physical environment, such as adopting small home models or small community models and empowering staff, is positively associated with resident satisfaction and quality of life. Nursing homes that implemented small community models had significantly higher satisfaction scores in the environmental, care, and food domains (Duan et al., 2022). Shortcomings in placing elderly individuals in small homes indicate limited resources in terms of care quality. Larger institutions have better opportunities for staff education, and single rooms are available, which can positively impact resident satisfaction. Therefore, small homes are in a less favorable economic position. Average costs are higher in institutions with 50-100 beds compared to those with 100-199 beds (Frey et al., 2019).

The environment should be well-adjusted to the needs of the elderly for their health and quality of life. Rural communities have unique characteristics, such as a small population, large distances, and limited economic resources, which can result in a lack of human resources such as a quality workforce and necessary infrastructure (Jonk et al., 2021).

In order to achieve the best results in customer satisfaction, the greatest investment should be in employees (Boscart et al., 2019). Social support has proven to be a crucial factor in satisfaction, and elderly individuals in urban areas have less social support than those living in rural areas. Residents of nursing homes lose close ties with their families, leading to less satisfaction than those who stay in their own homes. One possible reason for the higher satisfaction of older individuals living in their own homes is a stronger connection to their place. Changes in the environment can produce different cultural and individual changes related to their life experience (Lin et al., 2020). The participants' life satisfaction and perception of social support vary based on sociodemographic variables. Additionally, there is a robust and positive correlation observed between life satisfaction and the perception of social support (Assoc. Prof., Department of

Health Management, Istanbul Medeniyet University, Faculty of Health Sciences, Istanbul, Turkey et al., 2020). If we want residents of nursing homes to feel content, it is essential to work on the perception of their needs. This means viewing them not merely as patients but as individuals who still desire to live in accordance with their own wishes and capabilities for further development, regardless of the decline in cognitive and physical abilities (Matarese et al., 2022). Studies have shown that differences in the satisfaction of elderly individuals in nursing homes exist concerning the level of social support. There is also a correlation between the lack of support and the occurrence of feelings of loneliness (Zoranić et al., 2022). Key factors influencing the satisfaction of older individuals, residents of nursing homes, include the assurance of services for the elderly, the facility's amenities, and the staff working in the institution. Only high-quality staff can perform their duties well, ensure quality service to users, and create a quality environment (Wan et al., 2019). Good leadership, formal interactions, and organized staff recruitment are associated with a lower prevalence or incidence of specific clinical conditions among residents (Duan et al., 2024). One research indicates that elderly individuals placed in nursing homes show lower levels of satisfaction compared to those who remain in their own homes (Lin et al., 2020). The research findings indicated that individuals expressing a preference for residing in a nursing home exhibit greater health perceptions and life satisfaction compared to those who prefer living alone at home. In this context, it can be inferred that the environment of a nursing home, facilitating socialization and the opportunity to make friends, counteracts the experience of loneliness compared to living alone at home, thus contributing to an enhanced sense of life satisfaction (Altay et al., 2023).

Assessing user satisfaction in elderly care homes holds significance for various reasons. Firstly, it serves as a valuable tool for enhancing the quality of care by providing insights through feedback, pinpointing areas that require improvement. Secondly, user satisfaction is intricately linked to the well-being and quality of life of elderly individuals, serving as a reflection of their overall satisfaction with the services and support they receive. Moreover, the examination of user satisfaction can contribute to shaping policies and decision-making processes, ultimately enhancing the delivery of care in elderly care homes. Lastly, user satisfaction stands as a pivotal indicator of the effectiveness and success of these homes in meeting the needs and preferences of their residents, ensuring that they experience a sense of value, respect, and support in their daily lives. Various factors contribute to the satisfaction of elderly individuals in nursing homes, encompassing the quality of care delivered, the working conditions for nursing home staff, the availability of training programs for staff, the physical surroundings of the nursing home, and the size of the facility. The quality of

care, including aspects such as staffing levels and personalized care processes, directly influences the contentment of residents. The work environment, involving relationships with colleagues and opportunities for decision-making, also plays a role in satisfaction. Training programs for nursing home workers exhibit a positive association with satisfaction, while the physical environment and size of the nursing home can additionally impact satisfaction levels. Collectively, these factors contribute to the overall satisfaction of elderly individuals in nursing homes. One of the key limitations of this study is the small sample size and the restriction of the research to only two islands, which limits the generalizability of the findings to broader populations. Additionally, the study does not account for potential variations in the quality of services within different nursing homes, which may influence resident satisfaction levels. The socio-economic background of the residents, their previous living conditions, and personal expectations regarding care quality could also serve as confounding factors that impact satisfaction levels. Furthermore, environmental and cultural differences between urban and rural settings may contribute to the perception of care quality. The availability of healthcare professionals, infrastructure, and community support systems differs significantly between small and large nursing homes, which could introduce bias in satisfaction ratings. Additionally, the study primarily relies on self-reported data, which is susceptible to response bias, as participants may provide socially desirable answers or have difficulty accurately recalling past experiences. Another limitation concerns the lack of longitudinal data, making it challenging to assess long-term satisfaction trends or the effects of transitioning from a larger to a smaller facility. Future research should consider incorporating a more diverse sample, conducting comparative studies across multiple regions, and utilizing mixed-method approaches to mitigate these limitations and provide a more comprehensive understanding of factors influencing satisfaction in nursing homes.

CONCLUSION

Based on the conducted research and the obtained results, the following conclusions can be drawn:

- Residents of smaller homes are statistically more satisfied in two key criteria: the arrangement and cleanliness of the facility and employee relations.
- The most common feedback from respondents regarding ways to improve satisfaction included increasing staff numbers and improving facility organization.

The research findings confirm the initial hypothesis and suggest that small homes have a positive impact on resident satisfaction. These findings suggest the need to explore transforming large institutions into smaller, community-based liv-

ing environments to enhance resident well-being. From a practical perspective, these results highlight the need for policy changes and investments in nursing home models that prioritize quality of care over economic efficiency. While smaller homes may face financial constraints, they provide a more personalized, homely atmosphere, which has been shown to enhance the overall satisfaction and well-being of residents. Decision-makers in elderly care should consider strategies such as restructuring large institutions into smaller units, increasing staffing levels, and implementing more resident-centered care models to improve satisfaction and quality of life. Future research should explore the justification for constructing smaller nursing homes, given the higher satisfaction levels reported, despite potential economic challenges. Moreover, further studies are needed to fully understand the influence of external environmental factors, such as rural versus urban settings, on resident satisfaction in nursing homes.

LITERATURE

1. Altay, B., Karaca Biçakçı, N., Altin, A., & Arslan, L. (2023). The relationship between health perception and life satisfaction of elderly people living in nursing homes. *Caucasian Journal of Science*, 10(1), 49–66. <https://doi.org/10.48138/cjo.1210594>
2. Yanik, A., Saglam, Y., & Arslan, L. (2020). Evaluating the perception of life satisfaction and social support of elderly individuals. *Sağlık Bilimleri ve Meslekleri Dergisi*, 6(3), 501–512. <https://doi.org/10.5152/hsp.2019.552657>
3. Bhattacharyya, K. K., Molinari, V., & Hyer, K. (2022). Self-reported satisfaction of older adult residents in nursing homes: Development of a conceptual framework. *The Gerontologist*, 62(8), e442–e456. <https://doi.org/10.1093/geront/gnab061>
4. Boscart, V. M., Sidani, S., Ploeg, J., Dupuis, S. L., Heckman, G., Kim, J. L., d'Avernas, J., & Brown, P. (2019). Neighbourhood team development to promote resident-centred approaches in nursing homes: A protocol for a multi-component intervention. *BMC Health Services Research*, 19, 922. <https://doi.org/10.1186/s12913-019-4747-0>
5. Duan, Y., Hoben, M., Song, Y., Chamberlain, S. A., Iaconi, A., Choroschun, K., Shrestha, S., Cummings, G. G., Norton, P. G., & Estabrooks, C. A. (2024). Organizational context and quality indicators in nursing homes: A microsystem look. *Journal of Applied Gerontology*, 43(1), 13–25. <https://doi.org/10.1177/07334648231200110>
6. Duan, Y., Mueller, C. A., Yu, F., Talley, K. M., & Shippee, T. P. (2022). The relationships of nursing home culture change practices with resident quality of life and family satisfaction: Toward a more nuanced understanding. *Research on Aging*, 44(2), 174–185. <https://doi.org/10.1177/01640275211012652>

7. Fekonja, Z., Kmetec, S., Lorber, M., Lavrač, J., McSherry, W., & Mlinar Reljić, N. (2022). Experiences with dignity among older people confined to beds living in a nursing home: A qualitative descriptive study. *Journal of Nursing Management*, 30(7), 2362–2369. <https://doi.org/10.1111/jonm.13689>
8. Frey, R., Balmer, D., Robinson, J., Gott, M., & Boyd, M. (2019). The effect of residential aged care size, ownership model, and multichain affiliation on resident comfort and symptom management at the end of life. *Journal of Pain and Symptom Management*, 57(3), 545–555.e1. <https://doi.org/10.1016/j.jpainsymman.2018.11.022>
9. Jonk, Y., Thayer, D., Mauney, K., Croll, Z., McGuire, C., & Coburn, A. F. (2021). Acuity differences among newly admitted older residents in rural and urban nursing homes. *The Gerontologist*, 61(6), 826–837. <https://doi.org/10.1093/geront/gnaa183>
10. Kaplan, F., & Bentwich, M. E. (2023). Do differences exist in cross-cultural caregivers' respect for the autonomy/dignity of people with dementia? Real-time field observations in nursing homes. *Dementia*, 22(5), 935–963. <https://doi.org/10.1177/14713012231158410>
11. Kok, J. S., Nielen, M. M. A., & Scherder, E. J. A. (2018). Quality of life in small-scaled homelike nursing homes: An 8-month controlled trial. *Health and Quality of Life Outcomes*, 16, 38. <https://doi.org/10.1186/s12955-018-0853-7>
12. Lin, Y., Xiao, H., Lan, X., Wen, S., & Bao, S. (2020). Living arrangements and life satisfaction: Mediation by social support and meaning in life. *BMC Geriatrics*, 20, 136. <https://doi.org/10.1186/s12877-020-01541-8>
13. Matarese, M., Mauro, L., Notarnicola, I., Cinque, A., Bonacci, S., Covelli, G., & Casciato, S. (2022). Can we help older adults to feel at home in a residential care facility? What we can learn from health care personnel. *JBI Evidence Synthesis*, 20(12), 2824–2825. <https://doi.org/10.11124/JBIES-22-00418>
14. Oosterveld-Vlug, M., Pasman, H. R. W., van Gennip, I. E., Muller, M. T., Willems, D. L., & Onwuteaka-Philipsen, B. D. (2014). Dignity and the factors that influence it according to nursing home residents: a qualitative interview study. *Journal of Advanced Nursing*, 70(1), 97–106. <https://doi.org/10.1111/JAN.12171>
15. Spangler, D., Blomqvist, P., Lindberg, Y., & Winblad, U. (2019). Small is beautiful? Explaining resident satisfaction in Swedish nursing home care. *BMC Health Services Research*, 19, 886. <https://doi.org/10.1186/s12913-019-4694-9>
16. Sunzi, K., Li, Y., Zhou, X., & Lei, C. (2023). How do the older adults in nursing homes live with dignity?: A qualitative evidence synthesis. <https://doi.org/10.21203/rs.3.rs-2694897/v1>
17. Trybusińska, D., & Saracen, A. (2019). Satisfaction with the lives of elderly nursing home residents. *Nursing in the 21st Century*, 18(4), 220–227. <https://doi.org/10.2478/pielxxiw-2019-0029>

18. Vassimon-Barroso, V., Pantoni, C. B. F., Zazzetta, M. S., Ferreira, D. L., Vasilceac, F. A., & Ansai, J. H. (2021). User and family satisfaction with nursing homes: A systematic review. *International Journal for Quality in Health Care*, 33(1), mzaa160. <https://doi.org/10.1093/intqhc/mzaa160>
19. Wan, G., Shieh, C., Pu, G., & Huang, G. (2019). Factors in residence satisfaction of elderly from nursing homes: Evidence from China. *Revista de Cercetare si Interventie Sociala*, 65, 26–35. <https://doi.org/10.33788/rcis.65.2>
20. Zoranić, S., Sajko, M., Županić, M., & Knežević, G. (2022). The influence of social support on life satisfaction of elderly people in care homes. *Collegium Antropologicum*, 46(2), 129–138. <https://doi.org/10.5671/ca.46.2.7>

SHORT BIO

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COMMUNICATING WITH OLDER ADULTS USING DIMINUTIVES DOES NOT PRESERVE THEIR DIGNITY: A SYSTEMATIC LITERATURE REVIEW

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ABSTRACT

Theoretical framework: Nurses learn how to communicate with older adults in a respectful, open, relaxed, clear, and proactive manner. While this confident communication style builds good and lasting relationships, too often we see condescending conversations, elder speak, and last but not least, the use of diminutives when speaking with older adults. Research shows that young, middle-aged, and even older adults have negative stereotypes about older adults that are strongly embedded in society and affect intergenerational communication. Early social scientists were the first to identify the elderspeak, estimating that 20% of communication in nursing homes is elderspeak.

Methodology: A literature search was performed, the search was limited to the period between 2005 and 2022 (Sage Journals), and research articles were included. 3 databases were searched: PubMed, Web of Science, and Sage Journals. 4 studies were included.

Results: From the included studies we defined: that elderspeak is prevalent in nurse-patient communication (including chiropractic); implementation of evidence-based communication strategies in nursing education programs improves communication with older adults; this demonstrates the need for continued reinforcement of staff training in appropriate communication; a brief training program can improve person-centered communication and reduce elderspeak.

Conclusion: Future research in nursing education and social gerontology is needed, especially in the area of communication. Both should review and revise their conceptions of the dignity of older adults. It is inappropriate to speak to older adults, even if they need help from health care providers with activities of daily living, as we do to children, using diminutives.

Keywords: communication, nurse, diminutive, older adults.

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INTRODUCTION

The Encyclopaedia Britannica defines communication as the act or process of using words, sounds, signs, or behaviors to express or exchange information or to communicate ideas, thoughts, feelings, etc. to another person (Britannica 1994). The term „communication“ was derived from the Latin „communis“, which means „together“. Communicate“ therefore means „to do together“ „inform“, or „share“ and includes verbal, non-verbal, and electronic means of human interaction (Velentzas and Broni 2014, 117). The functionality of communication skills, (Light and McNaughton 2014, 2) i.e., the effectiveness of skills (or lack thereof), depends on the communication demands that exist in the individual's environment, whether at home, at school, at work, and/or in the community. Culture has a major impact on the perception of respect, and the way respect is shown can take different forms in different cultures. It can be communicated verbally (e.g., through appropriate word choice), nonverbally (e.g., through appropriate touch in greeting), and paralinguistically (e.g., through appropriate intonation when asking questions). Often, it is not a single instance of disrespectful communication that damages a relationship, but a „constellation of interactional features“ in cultural practices that convey disrespect (Bailey 1997, 329).

Elderspeak has based on the stereotype that older adults are less capable, i.e., younger communicators simplify their communication, attempt to clarify the communication, and change the emotional tone of the message when communicating with older adults (Ryan et. al. 1995). As Ryan et. al. (1995) identify strategies for improving communication to overcome and reverse age-related communication difficulties (in both the older adult and the communication partner), we should consider the roles of both the interlocutor (the patronizer) and the older adult (the patronize), as well as the environment or space in which the interaction took place. "Elderspeak is a form of communication overaccommodation used with older adults that: is evidenced by inappropriately juvenile lexical choices and/or exaggerated prosody; arises from implicit ageist stereotypes; carries goals of expressing care, exerting control, and/or facilitating comprehension; and may lead to negative self-perceptions in older adults and challenging behaviors in persons with dementia." (Shaw and Gordon 2021, 13).

We have always known that there are universals in the semantics of the diminutive, especially with respect to children, affection, and contempt. Here it was argued, first, that the diminutive as a construction has a surprisingly high degree of semantic coherence in interlinguistics, and that we can often expect a partitive, similarity, gender, approximation, and hedging by scaling in addition to affection and contempt, and that these relations can be captured by the radial category model. Second, it was shown that the diminutive of grammatically un-

ambiguously real global property, size, is a marker of proximity and hedging, and trans-related to the social and value sphere - is compatible with contemporary theories of unidirectionality in meaning change (Jurafsky 1993, 433). The implicit message of elder speak is the incompetence of older adults. When used in nursing homes, residents may be withdrawn, have low self-esteem, or be depressed and enact their own stereotypes but assume frail older adults with similar behaviors are dependent. Because of the implicit nature of older adults' language, caregivers may not be aware of the impact of aging on stereotypes, prejudice, and discrimination among older adults. For example, question marking and reflexive interfere with residents' right to choose, and diminutives and collective pronouns are demeaning and do not demonstrate mutually respectful relationships. Raising awareness of the phenomenon of language for the elderly and how it can influence older adults is important for improving care in nursing homes and other long-term care facilities (Williams et al. 2017, 19).

Purpose and goals

The purpose of the systematic literature review was to answer the question of whether nurses and other healthcare professionals communicate in a professional, understandable, and friendly manner when communicating with older adults.

Research Question: Do caregivers use appropriate communication with older adults and does the way they communicate impact older adults' well-being?

The goal is to answer the question of the level of communication with older adults in light of a review of the relevant literature - scholarly articles that address the topic of interest.

METHODS

Search strategy: databases were searched: Web of Science, PubMed and Sage Journals. The advanced search was used with the keywords in English: „communication' AND ,nurse' AND ,diminutive' AND ,older adults“: 2 hits in WoS, 1 hit in PubMed, 31 articles were found in Sage Journals with the restriction: publication years between 2005 - 2022. This was followed by a review of abstracts and a restriction to a selection of 9 full-text articles, from which we removed a further five articles after the full-text review because they did not thematically meet the inclusion criteria.

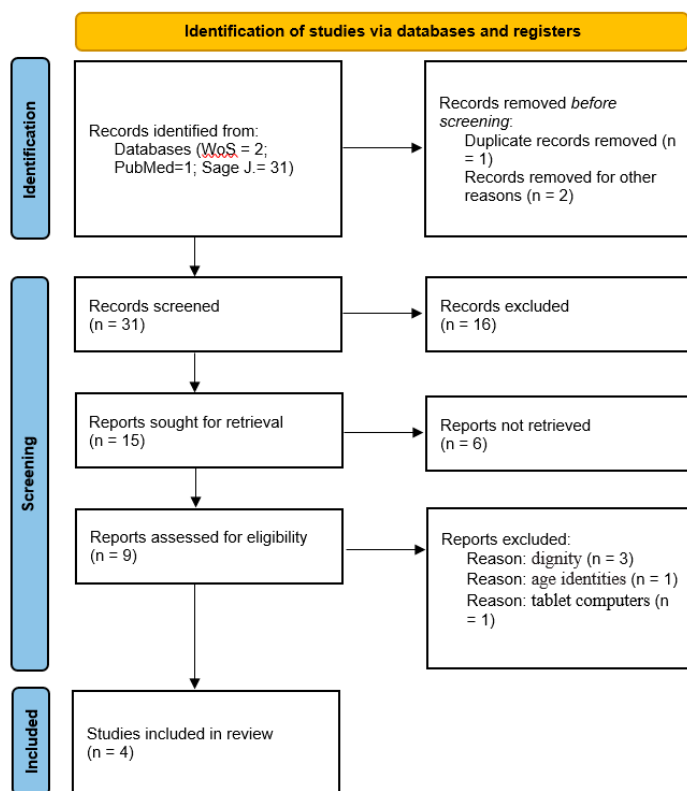
The priority reporting points of the literature review (PRISMA) and the exclusion/inclusion criteria (PICO) were implemented and are listed below.

Table 1: Inclusion and exclusion criteria in PICOS format

Criteria	Inclusion	Exclusion
Population	Studies comprised older adults	Studies comprised of population younger than 65
Interventions	Communicating with older adults using diminutives	Communicating with older adults without using diminutives
Comparators	Is communicating using diminutives demeaning to older adults?	
Outcomes	Communication between care staff and older people is at a professional level	Inadequate communication
Study design and publication type	Research scientific articles, Randomized controlled trials, Clinical trial	Systematic/literature reviews, Meta-analysis, Non-peer-reviewed studies
Publication years	2005 - 2022	Before 2005
Language	English	Languages other than English

(Jensen 2018)

Fig. 1: Flowchart of the study selection process.



The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021

RESULTS

The 4 original articles were conducted in the United States and Germany. The studies used a variety of methodological approaches, including a randomized controlled trial, a single-group repeated measures design, quantitative research, and a cross-sectional mixed method. Studies were conducted in hospitals, universities, and nursing homes. Data were collected using focus groups, group interviews, and individual interviews.

Understanding elderspeak. Communication has become even more important in the patient-care provider relationship. Positive, person-centered communication leads to trust between providers and patients, shared goal setting for treatment plans, and increased patient engagement or a holistic approach and individualized treatment. Focusing on four categories of elderspeak: diminutives, the substitution of collective pronouns, tag questions, and reflexive statements showed that elderspeak is present in simulated chiropractic sessions (Cockrell 2020, 4). Both cognitive and functional impairments play an important role in predicting probable harmfulness, as well as hybrid features of elderspeak were partially supported. Functional impairments were expected to be significantly associated with greater use of diminutives, lower grammatical complexity, and slower speech (Schnabel, Wahl, and Streib 2020, 423). The data (Grimme, Buchanan, and Afflerbach 2015, 47) clearly showed that all participants had experience with the language of older people - a finding that is consistent with the existing literature and suggests that older people's language remains prevalent in long-term care settings. The specific aims of the current study were to find out more about the intended function that older people speak and to identify contextual variables beyond those described in the existing research literature that may increase or decrease the likelihood that elderspeak will be used. The younger individual is also faced with linguistic choices regarding over-fitting, conformity, politeness, and/or respect. Many studies have found that the above language is too flexible and is perceived as condescending by socially and cognitively active older adults. Therefore, this tactic can lead to negative cognitive appraisals of reinforcing negative age stereotyping and avoidance in older people who have less positive feelings about them, subjective well-being, reduced strength, and a diminished sense of aging well. In contrast, friendly and polite language choices lead to exactly the opposite results (Keaton and Giles 2015, 5). Elderspeak can be described as an over-adaptation of speech to the elderly, mirroring similar adaptations made when speaking to children (McLaughlin 2020, 6).

Communication training. Older adults' language and changes in care, respect, and control go beyond the recommended changes in the language used by caregivers in caring for older adults. For example, using the term of endearment

requested by the family is appropriate, while generalizing terms of endearment to all users in the home crosses the line between respect and disrespect. Teaching caregivers to express genuine care and respect and to overcome controlling messages may require internalizing the basic principles of compassion, care, and respect, which cannot be taught in a brief intervention. A greater emphasis on emotional tone can help staff internalize these care values and reinforce and prolong the impact of the communication training intervention (Williams 2006, 131). The 2006 parent study (Williams 2006) conducted a study testing the effects of the Changing Talk (CHAT) program to reduce elderly language use among residents with dementia. The program CHAT instructs staff to improve person-centred communication, specifically by reducing the use of diminutives (a condescending language similar to baby talk). However, in the present study (Williams et al. 2017), behavioral coding was used to demonstrate that reducing staff use of diminutives resulted in fewer behavioral symptoms in nursing home residents with dementia. Williams et. al. (2022), in a study, show that educating health care providers about elderspeak and its potential negative effects on older adults may reduce elderspeak use by staff in nursing facilities. It is hypothesized that minimizing elderspeak will improve communication, potentially contributing to improvements in residents' cognitive and functional abilities and increased satisfaction with life in the nursing home.

Table 2: Overview of included studies

Author, year, country	Type of survey	Purpose of survey	Sample	Main findings
Williams, 2006 USA	A single group repeated measures design	This study evaluated an intervention to improve communication between staff and residents in three nursing homes.	n = 38 (nursing staff)	Regarding psycholinguistic measures, the use of language by older workers has continued to decline, but improvements in care, respect, and supervision have declined, indicating the need for continued reinforcement of training.
Williams et.al., 2018 USA	A randomized controlled trial	The purpose of this study was to 1) apply four different methods of communication analysis to assess changes in caregivers' communication with people with dementia after communication training, and 2) discuss the differences and implications of the four methods in assessing person-centered communication.	n = 49 (residents) n = 39 (nursing assistants)	Results show that analyses of communication behavior, psycholinguistics, content, and emotional tone are useful criteria for person-centered communication. Since each strategy covers different aspects of communication, they cannot substitute for each other.
Schnabel et.al., 2021 Germany	Quantitative research	The study investigates the extent to which nurses in acute care hospitals are likely to use harmful as well as hybrid features of elderspeak.	n = 34 (registered nurses) n = 106 (patients)	The study suggests that functional impairment may be a more important trigger of stereotype activation than cognitive impairment and that elderspeak deserves more attention in acute hospital settings.

Cockrell, 2020 USA	A cross-sectional mixed method	The study aimed to determine whether »elderspeak« was observed during simulated encounters between healthcare providers and patients in a chiropractic education program.	n = 60 patients Participants were Year 1 and Year 2 preclinical chiropractic students	The results showed that the chiropractic profession is receptive to the voice of the elderly. Understanding the voice of the elderly is important to prevent older adult patients from being impacted by age-related behaviors in the future and to improve their health outcomes.
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DISCUSSION

The systematic review of the literature was based on personal experience of doing the job. In care homes, staff all too often use doubles and diminutives when communicating with older people. The heterogeneity of the studies included in this review limits the comparability and generalisability of our results. The limitation to studies published in English could also lead to bias.

The process of information exchange for nursing home residents includes three elements: (a) the primary sources of information, (b) the primary means of information exchange, and (c) the content of the communication (Kolanowski et al. 2015, 53). Speaking to the older adults, initially referred to as baby talk (Caporael 1981, 877), involves slow speech, exaggerated intonation, increased pitch and volume, simple vocabulary, reduced grammatical complexity, changes in affect, the substitution of collective pronouns, diminutives, and repetition.

When it comes to elderly people entrusted to their care, the care providers use inappropriate communication, diminutive forms, and language more suitable for children. This undermines the dignity of the elderly. Fortunately, programs and communication strategies can be found in the literature that teaches staff how to communicate more appropriately with older adults. By considering cultural and linguistic norms, as well as the sensory and cognitive abilities of individuals, caregivers can become familiar with how often they repeatedly use the elderspeak and thus become aware of the use in everyday activities with older adults (McLaughlin 2020, 6).

The literature review provided an answer to the question of the adequacy of communication between health care and nursing facilities in the care of older adults. Inappropriate communication occurs wherever caregivers and older adults meet, but the research was conducted primarily in nursing homes and hospitals. A large gap exists regarding the presence of elderspeak in home care, where more research is needed in the area of communication and defining a professional, empathetic attitude of caregivers in home care, a communication attitude that allows for the dignity of the older person to be maintained.

CONCLUSION

Communication is a life skill that accompanies every person - healthy, sick, or disabled. Every person, from the first moments of his life, through all his beautiful and difficult experiences, until the end, when his expression suddenly, as in the beginning, stops forever. And in nursing, communication is this companion that always accompanies us, in our relationships with colleagues, patients, and residents, as well as with their relatives. We could add and introduce new dilemmas related to the ethics of communication that lead to various concerns and prejudices. Communicating with diminutives, addressing by personal name, and being too loud when communicating with older adults are just a few examples where we raise the question of the ethics of communication while respecting the dignity of the older adult who is often at our mercy.

And we must not forget that every older adult we help to maintain basic and supportive life activities is a mother, a father, a brother, and a daughter - in short, he has lived an independent life up to the time he came into the care and support system. He deserves respect, helps to maintain his dignity, and above all, he does not need communication that destroys his integrity as an individual who has been through a lot, and survived a lot. Reasons for caregiver irregularities are frequently changing work environments, burnout, dissatisfaction with working conditions, stress, and lack of gerontological expertise (Habjanič 2011, 44), which is not and should not be an excuse for inadequate communication. It would be useful to include the learning of appropriate communication in primary school, and special emphasis should be placed on the development of empathy and communication in secondary vocational education. We are aware that the shortage of carers in care homes makes it difficult to find well-trained and skilled staff, but it is unacceptable to deprive older adults in need of care of their dignity.

LITERATURE

1. Bailey, B. "Communication of respect in interethnic service encounters." *Language in Society*, 1997: 327-356.
2. Britannica, The Editors of Encyclopaedia. *The Britannica Dictionary*. 1994. <https://www.britannica.com/dictionary/communication> (accessed januar 19, 2023).
3. Caporael, L. R. "The Paralanguage of Caregiving: Baby Talk to the Institutionalized Aged." *Journal of Personality and Social Psychology*, 1981: 876-884.
4. Cockrell, M. D. "Provider-Patient Interaction: Exploring Elderspeak in Simulated Preclinical Chiropractic Student Encounters." *Gerontology & Geriatric Medicine*, 2020: 1-6.

5. Grimme, T. M., J. Buchanan, and S. Afflerbach. "Understanding Elderspeak from the Perspective of Certified Nursing Assistants." *Journal of Gerontological Nursing*, 2015: 42-49.
6. Habjanič, A. "Zdravstvena nega v domovih za starejše z vidika stanovalcev, sorodnikov in negovalnega osebja." *Obzor Zdrav Neg.*, 2011: 39-47.
7. Jensen, K. A. "EBSCO." *Health Notes*. 9 januar 2018. <https://www.ebsco.com/blogs/health-notes/seven-steps-perfect-pico-search> (accessed februar 15, 2023).
8. Jurafsky, D. "Proceedings of the Nineteenth Annual Meeting of the Berkeley Linguistics." *Berkeley Linguistics Society*, 1993: 423-436.
9. Keaton, S. A., and H. Giles. "Subjective Health: The Roles of Communication, Language, Aging, Stereotypes, and Culture." *International Journal of Society, Culture & Language*, 2015: 1-10.
10. Kolanowski, A., K. Van Haitsma, J. Penrod, N. Hill, and A. Yevchak. "'Wish we would have known that!' Communication Breakdown Impedes Person-Centered Care." *The Gerontologist*, 2015: 50-60.
11. Light, J., and D. McNaughton. "Communicative Competence for Individuals who require Augmentative and Alternative Communication: A New Definition for a New Era of Communication?," *Augmentative and Alternative Communication*, 2014: 1-18.
12. McLaughlin, K. "Recognising elderspeak and how to avoid." *Evidence & practice / communication*, 2020: 1-6.
13. Ryan, E. B., M. L. Hummert, and L. H. Boich. "Communication Predicaments of Aging: Patronizing Behavior toward Older Adults." *Journal of Language and Social Psychology*, 1995: 144-166.
14. Schnabel, E-L., H-W. Wahl, and C. Streib. "Elderspeak in Acute Hospitals? The Role of Context, Cognitive and Functional Impairment." *Research on Aging*, 2020: 416-427.
15. Shaw, C. A., and J. K. Gordon. "Understanding Elderspeak: An Evolutionary Concept Analysis." *Innovation in Aging*, 2021: 1-18.
16. Velentzas, J., and G. Broni. "Communication cycle: Definition, process, models and examples." *Recent Advances in Financial Planning and Product Development*, 2014: 117-131.
17. Williams, K. N. "Improving Outcomes of Nursing Home Interactions." *Research in Nursing & Health*, 2006: 121-133.
18. Williams, K. N., et al. "Person-Centered Communication for Nursing Home Residents with Dementia: Four Communication Analysis Methods." *Western Journal of Nursing Research*, 2018: 1012-1031.

19. Williams, K., et al. "Voicing Ageism in Nursing Home Dementia Care." *Journal of Gerontological Nursing*, 2017: 16-20.
20. Williams, K., S. Kemper, and M. L. Hummert. "Improving Nursing Home Communication: An Intervention to Reduce Elderspeak." *The Gerontologist*, 2022: 242-247.

SHORT BIO:

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IS CULTURAL COMPETENCE REQUIRED IN THE FIELD OF (SOCIAL) GERONTOLOGY?

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ABSTRACT

Introduction: Cultural competence includes behaviors, attitudes and policies that ensure a system, agency or an individual to function effectively and appropriately in a variety of diverse interactions and environments. This paper aims to explore the need for cultural competence in the field of gerontology.

Methods: A rapid literature review using PRISMA model was performed. Article search was executed in the SCOPUS database of the gerontology field, using the cultural competence and social gerontology as key words, in the time period from 2017 to 2022.

Results: From initial 92 articles we have limited the number to 41 by choosing open access articles only. We have furtherly eliminated 26 articles reading the abstracts, which were not applicable to our purpose. 15 relevant articles were finally identified, all addressing the need for cultural competence when dealing with older adults. Most articles pointed out the necessity for cultural competence when dealing with older adults with dementia, especially members of minority communities. Other addressed the needs for cultural competence when dealing with underserved older adults, older adults from ethnic minorities and older member of LGBT communities. Several articles explored the general need for cultural competence in gerontology and gerontology education, stipulating cultural competence as one of the key competencies in healthcare and socialcare professionals, working with older adults.

Conclusion: Cultural competences are widely recognized in today's diverse society as key competences in healthcare and socialcare. To address the needs of older adults, which are as diverse as the rest of society, cultural competencies need to be trained and acquired also in the field of gerontology.

Keywords: cultural competence, social gerontology, diversity, older adults

INTRODUCTION

Our modern world is marked by cultural diversity. Diversity not only relates to various ethnic, linguistic, geographical and religious backgrounds - it encompasses also spiritual, material, intellectual and emotional characteristics of an individual, society or social group, as well as lifestyles, value systems, traditions and beliefs (UNESCO 2009, 20-21). Diversity also characterises the older generation, as is increasingly recognised in research and society: nevertheless, it remains a vague term that is difficult to support with rigorous empirical evidence (Enßle and Helbrecht 2022, 2397).

Cultural competency is one of the key competences that enable individuals and organisations to better serve diverse populations and promote equality and inclusion (Brottman et al. 2020). Cultural competence is important in areas such as social work, medicine and nursing (Chiarenza 2012, 66). There are several definitions of cultural competence, but the most commonly cited is the 1989 definition by Cross et al (1989). They have defined cultural competence a set of congruent behaviors, attitudes, and policies that enable system, agency or professionals to work effectively in cross-cultural situations (Cross et al. 1989). Although this definition has been slightly modified over the last 15 years, the key concepts and principles advocated by this framework have remained unchanged and are considered universally applicable. A group of experts examining 34 different definitions of cultural competence found that most of them contain components of self-awareness, knowledge of different cultures, and specific interpersonal and professional skills that enable effective provision of services. All definitions also include references to cultural competence as a continuous, never-ending process of self-reflection and skill acquisition (Tehee et al. 2020).

In the light of these findings, this paper aims to identify the needs for cultural competence in the field of gerontology, and in particular to identify areas within this field where cultural competence is especially important.

PURPOSE AND GOALS

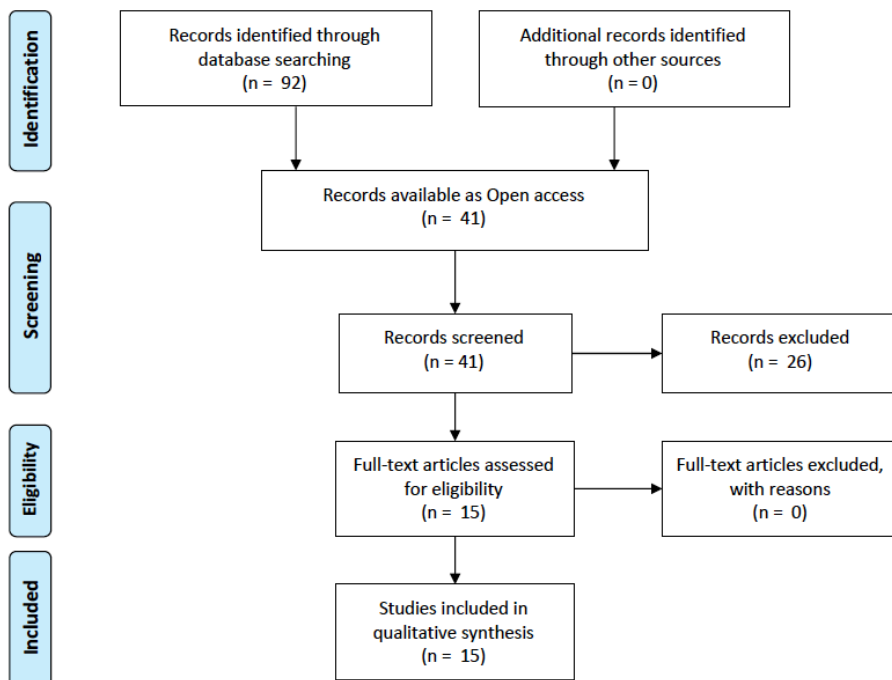
The goal of this paper is to explore the need for cultural competence in the field of gerontology and highlight the areas where cultural competence is particularly relevant. Our aim is also to draw attention to the importance of cultural competence in the increasingly diverse world of older adults and get an insight into the importance of cultural competence in addressing this diversity, therefore we posed the following research question:

In which areas of gerontology is cultural competence of particular importance?

METHODS

A qualitative research approach in form of a rapid literature review, following PRISMA guidelines, was conducted. In a rapid review, methods are simplified and procedures are speeded up to complete the review more quickly (Garritty et al. 2021). Our rapid review was performed in the SCOPUS database of the gerontology field, using the cultural competence and social gerontology as key words. We have included articles in the time period from 2017 to 2022 in English language. Our further inclusion criteria was availability of the articles as open access. Upon finding the articles with these inclusion criteria, abstracts were read for the relevance to our research question and non-relevant articles were excluded. Detailed process of the literature review is shown in the table 1.

Table 1: Prisma Flow diagram



Source: Moher et al. 2009.

RESULTS

15 relevant articles were identified as addressing the need for cultural competence when dealing with older adults. The main characteristics of the articles are presented in table 2.

Four articles addressed the need for cultural competence in the relation to the lesbian, gay, bisexual and transgender (LGBT) older adults. One of them focused on LGBT older adults experiencing cognitive impairment, Alzheimer's disease, or other dementias, as well as on their caregivers and families, identifying the key components of culturally competent care (Fredriksen-Goldsen et al. 2018). Another study stipulated that culturally competent care can prevent isolation for LGBT older adults and has potential reduce health disparities in this group (Yang et al. 2018). In a study by Puntey et al, it was demonstrated that LGBT older adults face many fears, including dependence on healthcare providers, dementia, mistreatment, and isolation, which may lead to identity concealment and psychological distress, including suicide thoughts. They conclude that there is critical need for health professionals to receive LGBT cultural competence training (2018). Holman and colleagues have studied the efficacy of such training in a senior living facility and demonstrated a significant increase in LGBT content knowledge after the training (2020).

Three studies, excluding the already mentioned study on LGBT older adults experiencing cognitive impairment, have focused on dementia. An African American case study has shown that access to dementia services as well as utilization of care and supportive services is influenced by cultural competence of healthcare professionals (Clark et al. 2018). The study by Nielson et al has focused on barriers in access to dementia care in minority ethnic groups in Denmark. They have demonstrated that cultural factors significantly impact the amount of barriers in access to dementia care and that there is a need to develop culturally appropriate dementia care options (2021). This was further demonstrated by Duran-Kıraç et al in 2022. They have performed a scoping review of the European literature and explored the barriers to dementia services for ethnic minority people. Their recommendations for better access to healthcare for this group is strengthening of healthcare professionals cultural competence.

Several other studies addressed minority elders. One study demonstrated that they face challenges related to their cultural and linguistic difference and stereotypes. Authors highlighted the need for culturally competent communication training (Likope et al. 2018). A scoping review on physical activity among medically underserved older adults, performed by Hu et al, also revealed that it is important to consider age- and race/ethnicity-specific barriers and facilitators, and use culturally adapted materials to meet the needs of different racial/ethnic or socioeconomic status groups (2019). Another scoping review by McGilton et al investigated the health and social care needs of a specific minority group - Indigenous older adults with multiple chronic conditions and their caregivers. They emphasised the importance of cultural competence to improve accessibility of culturally relevant health and social services (2018).

We have also identified several articles with focus on building culturally competent workforce in gerontology. Karasik and Kishimoto performed a survey among gerontology educators, exploring the use of anti-racist pedagogy. They have suggested that greater attention to issues of race, ethnicity, and multicultural diversity throughout the gerontological curriculum is required (2018). Also the European core competence framework for health and social care professionals working with older people incorporates several aspects of cultural competence, specifically, understanding of the diversity of the older population (expert role) and displaying of an awareness of diversity and cultural differences (professional role) (Dijkman et al. 2017). Developing and improving curriculum in interprofessional and cultural competency skills is as well one of the key recommendations by Spetz and Dudley in their consensus-based recommendations for an adequate workforce to care for people with serious illness (2019). Training in cultural competent and respectful care of diverse patients and implementation of culturally and linguistically appropriate services is also the recommended strategy to overcome ageism and bias of professionals toward diverse older adults (Periyakoil 2019). Finally, McGovern suggests that fresh pedagogical approaches are needed to improve undergraduate competence in multicultural gerontology practice (2019).

Table 2: Cultural competence and gerontology

Authors and year	Year published	Article Title	Study design	Conclusion
Fredriksen-Goldsen, Karen I., Sarah Jen, Amanda EB Bryan, and Jayn Goldsen	2018	Cognitive Impairment, Alzheimer's Disease, and Other Dementias in the Lives of Lesbian, Gay, Bisexual and Transgender (LGBT) Older Adults and Their Caregivers: Needs and Competencies	Systematic reviews, data analysis	Key competences to ensure culturally relevant care for LGBT older adults experiencing cognitive impairment, Alzheimer's disease, or other dementias, as well as their caregivers, families, and communities are identified. Culturally competent practice encompasses developing an awareness of the context of LGBT older adults' lives and relationships, the importance of early detection and support, and the development of policies and practices that promote community-level advocacy and education.
Yang, Jie, Yoosun Chu, and Mary Anne Salmon	2018	Predicting Perceived Isolation Among Midlife and Older LGBT Adults: The Role of Welcoming Aging Service Providers	Needs assessment survey	Cultural competence in serving midlife and older LGBT adults is pivotal. Culturally competent service provider cannot only reduce perceived isolation for LGBT older adults but may also increase their likelihood of accessing services, therefore potentially reduce the health disparities that this group of older adults face compared with their heterosexual counterparts.
Nielsen, T. Rune, Dorthe S. Nielsen, and Gunhild Walde- mar	2021	Barriers in access to dementia care in minority ethnic groups in Denmark: a qualitative study	Interviews	Care practices and perceived consequences of dementia in minority ethnic communities were heavily influenced by cultural factors leading to a number of persisting barriers to accessing dementia care services. There is a simultaneous need to raise awareness about dementia and the existence of dementia care services in minority ethnic groups, to reduce stigma, and to develop culturally appropriate dementia care options.

Holman, Elizabeth Grace, Laura Landry-Meyer, and Jessica N. Fish	2020	Creating Supportive Environments for LGBT Older Adults: An Efficacy Evaluation of Staff Training in a Senior Living Facility	Pre- and post training surveys	Staff's cultural competence affected their perceived readiness to address LGBT elders' needs. LGBT training resulted in significant increase in LGBT content knowledge and a significant decrease in perceived preparedness when working with LGBT elders.
Clark, Jennie Leeder, Sarah Phoenix, Ann Choryan Bilbrey, Terese McManis, Kristel Anne Escal, Rohini Arulanantham, Tiana Sisay, and Rita Ghatak	2018	Cultural competency in dementia care: An African American case study	Case study	As the older adult population becomes more diverse, it is increasingly vital to strengthen cultural competency among healthcare providers, thus maximizing access to and utilization of care and supportive services. The cultural competence of medical professionals can impact patient quality of care and health outcomes.
Hu, Yi-Ling, Kristin Junge, An Nguyen, Kelsey Hiegel, Emily Somerville, Marian Keglovits, and Susan Stark	2019	Evidence to improve physical activity among medically underserved older adults: A scoping review	A scoping review	To maximize the effectiveness of leisure physical activity interventions, researchers should consider age- and race/ethnicity-specific barriers and facilitators, and use culturally adapted materials to meet the needs of different racial/ethnic or socioeconomic status groups.
Likupe, Gloria, Carol Baxter, and Mohamed Jogi	2018	Exploring health care workers' perceptions and experiences of communication with ethnic minority elders	Interviews	Ethnic minority elders face particular challenges, including cultural differences, different language and stereotyping of care due to misunderstanding of their needs. The diversity of older people needing care in nursing homes and the community calls for training in culturally competent communication.
McGilton, Katherine S., Shirin Vellani, Lily Yeung, Jawad Chishtie, Elana Commisso, Jenny Ploeg, Melissa K. Andrew et al	2018	Identifying and understanding the health and social care needs of indigenous older adults with multiple chronic conditions and their caregivers: a scoping review	A scoping review	The study highlighted the need of Indigenous older adults for access to services and information, building community capacity, social support, preservation of cultural values in health care, and wellness approaches. The findings emphasise the importance of local Indigenous knowledge and perspectives to improve accessibility of culturally relevant health and social services.
Duran-Kıraç, Gözde, Özgül Uysal-Bozkir, Ronald Uittenbroek, Hein van Hout, and Marjolein I. Broese van Groenou	2022	Accessibility of health care experienced by persons with dementia from ethnic minority groups and formal and informal caregivers: A scoping review of European literature	A scoping review	Multiple barriers were experienced in access to care for ethnic minority people with dementia. Barriers on the side of professionals included communication skills; cultural and social factors influencing the professionals' attitudes towards ethnic minorities; and lacking competencies to work with people with dementia from ethnic minority groups and informal caregivers. Health care professionals need to strengthen their competencies in order to facilitate access to health care for this group.
Karasik, Rona J., and Kyoko Kishimoto	2018	Is gerontology ready for anti-racist pedagogy? A survey of educators' practices and perspectives	Survey	Respondents were generally unfamiliar with the anti-racist pedagogy, but many indicated that their current teaching practices employed select components of it. The findings suggest that greater attention to issues of race, ethnicity, and multicultural diversity throughout the gerontological curriculum is needed and wanted.
Putney, Jennifer M., Sara Keary, Nicholas Hebert, Lisa Krinsky, and Rebekah Halmo	2018	"Fear Runs Deep:" The Anticipated Needs of LGBT Older Adults in Long-Term Care	Focus groups	LGBT older adults seek an inclusive environment where they will be safe and feel connected to a community. They fear dependence on healthcare providers, dementia, mistreatment, and isolation. These fears can lead to identity concealment and psychological distress, including suicide ideation. This underscores a critical need for health professionals to receive LGBT cultural competence training.

Dijkman, Bea, Lidwien Reehuis, and Petrie Roodbol	2017	Competences for working with older people: The development and verification of the European core competence framework for health and social care professionals working with older people	Literature review, Delphi	The competence framework describes roles and competences that students in health and social care programs need to learn in order to provide good care and support for older people. Understanding of the diversity of the older population (expert role) and display of an awareness of diversity and cultural differences (professional role) are among the competencies required in work with older people.
Spetz, Joanne, and Nancy Dudley	2019	Consensus-Based Recommendations for an Adequate Workforce to Care for People with Serious Illness	Consensus	The lack of an adequately prepared workforce is a critical barrier to delivering high-quality care for older and seriously ill populations. Developing and improving curriculum in interprofessional and cultural competency skills is one of the key recommendations.
Periyakoil, Vyjayanthi	2019	Building a Culturally Competent Workforce to Care for Diverse Older Adults: Scope of the Problem and Potential Solutions	Narrative review	Diverse older adults face many barriers in accessing health and support services. Among them are clinician-related barriers: ageism, conscious and unconscious bias, the lack of training in the principles and practice of providing culturally respectful care. Recommended strategies include training in cultural competent and respectful care of diverse patients and implementation of culturally and linguistically appropriate services.
McGovern, Justine	2019	Improving undergraduate competence in multicultural gerontology practice with fresh pedagogies: A digital storytelling case example	Project evaluation	Fresh pedagogical approaches that expand core social work constructs can improve outcomes for diverse older adults by promoting multicultural gerontology practice competence. Social work faculty should be encouraged to provide opportunities for experiential learning across the curriculum of multicultural gerontology.

Source: Own research 2023.

DISCUSSION

The aim of our study was to explore the needs for cultural competence in gerontology, including in the social gerontology field. The fact is, that demographic and social changes require more training in providing culturally appropriate services and research (McCall et al. 2017). This is widely recognised also by professional bodies, such as The International Federation of Social Workers (IFSW), who called for promotion and expansion of gerontological, geriatric, and cultural competency education and training for all social workers and other health, mental health, and social service providers in their Policy Position Statement already in 2014. Social gerontologists should also focus on diversity and inequalities in different domains and examine the needs of diverse age, ethnic and social groups across the life course. It should not be forgotten that social gerontology, as a discipline, does not focus only on older adults, but studies all generations and stages of the life course, as ageing can only be understood in a holistic way (Putney et al. 2005, 100). In our study, we had identified several articles, addressing the need for cultural competence in the field of institutional long-term care. Nursing homes are be-

coming increasingly diverse, not only in terms of residents but also in terms of staff, which will be exacerbated in the future due to the shortage of staff and thus the need to 'import' staff. Developing cultural competence is therefore crucial for such institutions (EAN 2021, 16).

Several articles addressed the needs for integration of cultural competence training in the training of health care and social care professionals. One of them specifically pointed out the need to combat ageism and bias with this strategy. Also older studies have already addressed this point. For example, a study of nursing students found that cultural competence was strongly associated with positive attitudes towards older people, with students with higher levels of cultural competence being 12 times more likely to have positive attitudes than those who did not (Beard et al. 2004). However, a survey of organisational cultural competence in ten US nursing homes indicated a multitude of problems with the lack of such competence - including lack of knowledge about the diversity of older people, communication barriers, minimisation and generalisation of differences, covert discrimination, and inadequate organisational responses to problems. A range of strategies to improve cultural competence were cited as solutions, with educational activities at all organisational levels as the first priority (Parker and Geron 2007). In Norway, however, a culturally sensitive and competent approach by health and social care professionals has been identified through case studies as the most important factor in ensuring the dignity of older people (Minde 2015). Such an approach is particularly important in the management of people with dementia (Dilworth-Anderson et al. 2012; Antelius and Plejert 2016), which we could also identify with our review.

In short, our rapid review identified three main areas where cultural competence is of particular importance - namely in the fields of dementia care, care of the LGBT community and care of ethnic minorities.

Our rapid review didn't identify all the gerontology fields where cultural competence has to be applied. This can be explained by the nature of rapid review itself, using the narrow choice of the key words, limited time span of publications, only one data base and English language articles. However, rapid reviews are a fitting alternative to time intensive comprehensive systematic approaches, if reviewers intention is to get a general insight into the research question (Mikolajewicz and Komarova 2019). The next limitation is the complexity of the concept of cultural competence, which has many definitions and vague terms, therefore requiring an extensive key words search. On top of this, field of social gerontology, gerontology in general and geriatrics are highly interlinked, intertwined and inconsistently referred to, so it would make sense to conduct review in all those areas. For example, our search didn't identify palliative care, which may belong to all three fields. The development and nurturing of cultural competence is surely very important in this area, as beliefs, values and experiences influence perceptions of dying and

death (Chettih 2012; Saccomano and Abbatiello 2014; Martin and Barkley 2016). There is a great need for sensitivity and understanding of cultural differences in palliative care, and healthcare organisations should do more towards respecting and providing culturally competent care for the dying (Bloomer et al. 2019).

CONCLUSION

The importance of cultural competence in the healthcare of older people is supported by a large body of research. Our rapid review has highlighted some of the key areas, where cultural competence is of outmost importance, but an extensive systemic review would surely identify many more areas. However, we could show that cultural competence is one of the key competences that can address numerous challenges and barriers in long-term care, such as ageism, prejudice, cultural blindness and discrimination. In the light of these findings, we recommend educational strategies to develop cultural competences as early as possible, and certainly no later than in gerontology study programmes. Education, awareness-raising and reflection must also continue in the workplace and be lifelong, as the acquisition of cultural competences is a never-ending process.

LITERATURE

1. Antelius, Eleonor, and Charlotta Plejert. 2016. Ethnoculturally-profiled care: Dementia caregiving targeted towards Middle Eastern immigrants living in Sweden. *Anthropology and Aging* 37(1): 9–26.
2. Beard, Holly, Ann Marie Kopitzke, R. S. Benjamin-Coleman, Carolyn Rutledge and Laurel S. Garzon. 2004. Does the level of cultural competence influence positive attitudes towards the elderly? *The Gerontologist* 44(1): 594–595.
3. Bloomer, Melissa J., Mari Botti, Fiona Runacres, Peter Poon, Jakqui Barnfield and Alison M. Hutchinson. 2019. Cultural considerations at end of life in a geriatric inpatient rehabilitation setting. *Collegian* 26(1): 165–170.
4. Brottman, Melissa R., Douglas M. Char, Robin A. Hattori, Rachel Heeb, and Steven D. Taff. 2020. Toward cultural competency in health care: a scoping review of the diversity and inclusion education literature. *Academic Medicine* 95(5): 803–813.
5. Chettih, Mindy. 2012. Turning the lens inward: cultural competence and providers' values in health care decision making. *The Gerontologist* 52(6): 739–747
6. Chiarenza, Antonio. 2012. Developments in the concept of cultural competence. In *Inequalities in health care for migrants and ethnic minorities 2*, eds. Ingleby, David, Antonio Chiarenza, Walter Deville and Ionna Kotsioni, 66–81. Antwerp: Garant Publisher.

7. Clark, Jennie Leeder, Sarah Phoenix, Ann Choryan Bilbrey, Terese McManis, Kristel Anne Escal, Rohini Arulanantham, Tiana Sisay, and Rita Ghatak. 2018. Cultural competency in dementia care: An African American case study. *Clinical gerontologist* 41(3): 255–260.
8. Dijkman, Bea, Lidwien Reehuis, and Petrie Roodbol. 2017. Competences for working with older people: The development and verification of the European core competence framework for health and social care professionals working with older people. *Educational Gerontology* 43(10): 483–497.
9. Duran-Kıraç, Gözde, Özgül Uysal-Bozkir, Ronald Uittenbroek, Hein van Hout, and Marjolein I. Broese van Groenou. 2022. Accessibility of health care experienced by persons with dementia from ethnic minority groups and formal and informal caregivers: A scoping review of European literature. *Dementia* 21(2): 677–700.
10. Dilworth-Anderson, Peggye, Geraldine Pierre and Tandra S. Hilliard. 2012. Social justice, health disparities, and culture in the care of the elderly. *The Journal of Law, Medicine & Ethics* 40(1): 26–32.
11. EAN (European Ageing Network). 2021. *Promoting well-nutrition in elderly care - A guide to organising the nutritional journey in elderly care settings*. Tabor: Asociace poskytovatelů sociálních služeb České republiky. Available at: <https://european-nutrition.org/good-practices/ean-guideline-promoting-well-nutrition-in-elderly-care/> (20th Jan 2023).
12. Enßle, Friederike, and Ilse Helbrecht. 2021. Understanding diversity in later life through images of old age. *Ageing & Society* 41(10): 2396–2415.
13. Fredriksen-Goldsen, Karen I., Sarah Jen, Amanda EB Bryan, and Jayn Goldsen. 2018. Cognitive impairment, Alzheimer's disease, and other dementias in the lives of lesbian, gay, bisexual and transgender (LGBT) older adults and their caregivers: Needs and competencies. *Journal of Applied Gerontology* 37(5): 545–569.
14. Garritty, Chantelle, Gerald Gartlehner, Barbara Nussbaumer-Streit, Valerie J. King, Candyce Hamel, Chris Kamel, Lisa Affengruber, and Adrienne Stevens. 2021. Cochrane Rapid Reviews Methods Group offers evidence-informed guidance to conduct rapid reviews. *Journal of clinical epidemiology* 130: 13–22.
15. Holman, Elizabeth Grace, Laura Landry-Meyer, and Jessica N. Fish. 2020. Creating supportive environments for LGBT older adults: An efficacy evaluation of staff training in a senior living facility. *Journal of gerontological social work* 63(5): 464–477.
16. Hu, Yi-Ling, Kristin Junge, An Nguyen, Kelsey Hiegel, Emily Somerville, Marian Keglovits, and Susan Stark. 2019. Evidence to improve physical activity among medically underserved older adults: A scoping review. *The Gerontologist* 59(4): e279–e293.

17. IFSW (International Federation of Social Workers). 2014. *Ageing and older adults*. Available at: <http://ifsw.org/policies/ageing-and-older-adults/> (2nd Feb 2023).
18. Karasik, Rona J., and Kyoko Kishimoto. 2018. Is gerontology ready for anti-racist pedagogy? A survey of educators' practices and perspectives. *Gerontology & Geriatrics Education* 39(1): 3–20.
19. Likupe, Gloria, Carol Baxter, and Mohamed Jogi. 2018. Exploring health care workers' perceptions and experiences of communication with ethnic minority elders. *Quality in ageing and older adults* 19(3): 180–190.
20. Martin, Elisha M. and Thomas W. Barkley Jr. 2016. Improving cultural competence in end-of-life pain management. *Nursing* 46(1): 32–41.
21. McCall, Mary E., and Ulrika Börjesson. 2017. Integration or specialization? Similarities and differences between Sweden and the United States in gerontology education and training. *Gerontology & Geriatrics Education* 38(1): 47–60.
22. McGilton, Katherine S., Shirin Vellani, Lily Yeung, Jawad Chishtie, Elana Commisso, Jenny Ploeg, Melissa K. Andrew et al. 2018. Identifying and understanding the health and social care needs of older adults with multiple chronic conditions and their caregivers: a scoping review. *BMC geriatrics* 18: 1–33.
23. McGovern, Justine. 2019. Improving undergraduate competence in multicultural gerontology practice with fresh pedagogies: A digital storytelling case example. *Gerontology & Geriatrics Education* 40(4): 508–518.
24. Mercer, Lorraine. 2019. Intercultural gerontology curriculum: Principles and practice. *Gerontology & Geriatrics Education* 40(3): 371–392.
25. Mikolajewicz, Nicholas, and Svetlana V. Komarova. 2019. Meta-analytic methodology for basic research: a practical guide. *Frontiers in physiology* 10:1–20.
26. Minde, Gunn-Tove. 2015. A culturally-sensitive approach to elderly care. *Journal of Gerontology and Geriatric Research* 4(5): 1–5. Available at: <http://dx.doi.org/10.4172/2167-7182.1000241> (11th Jan 2023).
27. Moher, David, Alessandro Liberati, Jennifer Tetzlaff, Douglas G. Altman, and the PRISMA Group*. 2009. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of internal medicine* 151(4): 264–269.
28. Nielsen, T. Rune, Dorthe S. Nielsen, and Gunhild Waldemar. 2021. Barriers in access to dementia care in minority ethnic groups in Denmark: a qualitative study. *Ageing & mental health* 25(8): 1424–1432.
29. Parker, Victoria A., and Scott Miyake Geron. 2007. Cultural competence in nursing homes: Issues and implications for education. *Gerontology & Geriatrics Education* 28(2): 37–54.

30. Periyakoil, Vyjeyanthi S. 2019. Building a culturally competent workforce to care for diverse older adults: scope of the problem and potential solutions. *Journal of the American Geriatrics Society* 67 (S2): S423–S432.
31. Putney, Jennifer M., Sara Keary, Nicholas Hebert, Lisa Krinsky, and Rebekah Halmo. 2018. Fear runs deep: The anticipated needs of LGBT older adults in long-term care. *Journal of gerontological social work* 61(8): 887–907.
32. Putney, Norella M., Dawn E. Alley and Vern L. Bengtson. 2005. Social gerontology as public sociology in action. *The American Sociologist* 36(3–4): 88–104.
33. Saccomano, Scott J., and Geraldine A. Abbatiello. 2014. Cultural considerations at the end of life. *The Nurse Practitioner* 39(2): 24–31.
34. Spetz, Joanne, and Nancy Dudley. 2019. Consensus-Based Recommendations for an Adequate Workforce to Care for People with Serious Illness. *Journal of the American Geriatrics Society* 67(S2): S392–S399.
35. Tehee, Melissa, Devon Isaacs and Melanie M. Domenech Rodríguez. 2020. The elusive construct of cultural competence. In *Handbook of Cultural Factors in Behavioral Health: A Guide for the Helping Professional*, eds. Lorraine Benuto, Frances Gonzalez and Jonathan Singer, 11–24. Cham: Springer International Publishing.
36. Yang, Jie, Yoosun Chu, and Mary Anne Salmon. 2018. Predicting perceived isolation among midlife and older LGBT adults: The role of welcoming aging service providers. *The Gerontologist* 58(5): 904–912.

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POMEN INTERVENTNIH UKREPOV PRI ZAGOTAVLJANJU MEDGENERACIJSKEGA SODELOVANJA

THE IMPORTANCE OF INTERVENTION MEASURES IN ENSURING INTERGENERATIONAL COOPERATION

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POVZETEK

Dobra komunikacija in razumevanje med različnimi generacijami je ena izmed najpomembnejših tem moderne družbe. Ugotavljamo, da so v zadnjem obdobju sodobne družine in posledično tudi odnosi med družinskimi člani različnih generacij podvrženi velikim spremembam, ki jih zaradi velikih izzivov sami velikokrat niso sposobni razreševati. Članek se osredotoča na spremembo različnih vedenjskih vzorcev družinskih članov in raziskuje dejavnike, ki igrajo pomembno vlogo pri izzivih medgeneracijskega sodelovanja. Cilj interventnih ukrepov je ozavesiti družinske člane različnih generacij o pomembnosti spremembe načinov vedenja za dobro in uspešno medgeneracijsko sodelovanje. Članek predstavi tudi dve raziskavi o interventnih ukrepih, pri katerih smo ugotavljali dejavnike, ki vplivajo na reševanje medgeneracijskega prenosa vedenjskih vzorcev. Cilj prve raziskave je bil ugotoviti, ali so interventni ukrepi pomemben dejavnik pri ozaveščanju in razreševanju medosebnih simptomatičnih družinskih interakcij, z drugo raziskavo pa smo na podlagi dejansko izvedenih interventnih programov želeli ugotoviti, ali so pri reševanju različnih izzivov starejših odraslih kot tudi medgeneracijskega sodelovanja psihosocialni pristopi pomembni in ali so jim udeleženci naklonjeni oziroma ali se jih udeležujejo.

Pomen psihosocialnih pristopov za izboljšanje družinskih odnosov in medgeneracijskega sodelovanja osvetljuje izzive, s katerimi se soočajo družine in posamezniki pri vključevanju v programe pomoči. Rezultati obeh raziskav so potrdili, da so interventni ukrepi pomemben dejavnik pri ozaveščanju družinskih članov o razreševanju globoko ukoreninjenih načinov vedenja, mišljenja in čutenja, kot tudi pri uspešnem izvajanju medgeneracijskega sodelovanja.

Ključne besede: medgeneracijsko sodelovanje, vedenjski vzorci, družina, interventni ukrepi, starejši odrasli

ABSTRACT

Good communication and understanding between different generations is one of the most important topics in modern society. It has been observed that contemporary families and, consequently, relationships between family members of different generations have undergone significant changes in recent times, which they are often unable to resolve on their own due to substantial challenges. This article focuses on the changes in various behavioral patterns among family members and explores the factors that play a key role in the challenges of intergenerational cooperation. The goal of intervention measures is to raise awareness among family members of different generations about the importance of changing behavioral patterns for effective and successful intergenerational collaboration.

The article also presents two studies on intervention measures that examined factors influencing the resolution of intergenerational transmission of behavioral patterns. The aim of the first study was to determine whether intervention measures are a significant factor in raising awareness and resolving interpersonal symptomatic family interactions. Through the second study, based on implemented intervention programs, we sought to identify whether psychosocial approaches are important in addressing the challenges faced by older adults as well as intergenerational cooperation and whether participants are receptive to or engaged in such programs.

The significance of psychosocial approaches for improving family relationships and intergenerational cooperation highlights the challenges families and individuals face in engaging with assistance programs. The results of both studies confirmed that intervention measures are a significant factor in raising family members' awareness about addressing deeply rooted patterns of behavior, thinking, and feeling, as well as in successfully implementing intergenerational collaboration.

Key words: intergenerational cooperation, behavioral patterns, family, intervention measures, older adults

UVOD

Medgeneracijski dialog in sodelovanje sta ključna za gradnjo vključujoče, povezane in solidarne družbe. Ozaveščanje o pomenu medgeneracijskega sodelovanja omogoča ne le krepitev razumevanja med generacijami, temveč tudi izboljšanje kakovosti življenja. Programi medgeneracijskega sodelovanja združujejo mlajše in starejše posameznike, da bi spodbujali odnose med različnimi generacijami, ki koristijo tako posamezniku kot družbi nasploh. Medgeneracijski prenos lahko opredelimo kot prenos vzorcev vedenja in različnih prepričanj iz starejše generacije na mlajšo. Prenašajo se različna prepričanja, norme, vrednote, stališča in vedenja, značilna za družino, ali pa se odražajo sociokulturne, verske in

etnično ustrezne prakse in prepričanja neke družbe (Capaldi in dr., 2003; Martin-Matthews in Kobayashi, 2009; Kaplan in dr., 2020). Pojavlja se veliko raziskav, ki kažejo, da ti programi spodbujajo dobro počutje posameznika in socialno povezanost; zmanjšujejo generacijske stereotipe ter izboljšujejo sodelovanje in rezultate v izobraževalnih in socialnih okoljih (Laging in dr., 2022). Medgeneracijski dialog ima pomembno vlogo tudi pri gradnji bolj vključujoče in solidarne družbe, kjer različne generacije ne tekmujejo, ampak sodelujejo in se podpirajo. Medgeneracijski ukrepi ustvarjajo tudi priložnosti za mlajše in starejše člane družbe, da sodelujejo v družbenih ukrepih in državljanskem udejstvovanju na načine, ki prispevajo k socialno trajnostnim in starostno vključujočim skupnostim (Greenfield in Buffel, 2022; Steward in dr., 2023; Webster in dr., 2024).

Država ima pri tem pomembno vlogo, saj lahko s svojimi politikami, zakonodajnimi okviri in financiranjem aktivnosti spodbuja povezovanje med generacijami. Podpora programom in iniciativam, ki temeljijo na medgeneracijskem sodelovanju, omogoča ustvarjanje priložnosti za prenos znanja, izkušenj in vrednot, kar je ključno za obvladovanje sodobnih družbenih izzivov, kot so staranje prebivalstva, socialna izključenost in digitalni razkorak.

Ponavljajoči se vzorci odnosov v človeškem doživljanju, kot navaja Gostečnik (1997, str. 142), torej doživetja iz zgodnje mladosti in predvsem temeljni afekti, oz. temeljne emocije, ki so bili ustvarjeni na osnovi primarnega odnosa s pomembnimi drugimi v zgodnji mladosti, se ponavljajo ter prenašajo iz generacije v generacijo. Določenih vedenjskih vzorcev se torej nezavedno učimo predvsem od pomembnih odraslih, s katerimi živimo. Rečemo lahko, da je od tega, kako uspešno so npr. konflikte obvladovali oni, odvisno, kako uspešno jih bomo reševali tudi mi (Seles 2008; Iršič 2004). Omenimo lahko, da je npr. razveza staršev povezana s povečanim tveganjem za razvezo potomcev, še posebej, če so žene ali oba zakonca doživela razpad zakonske zveze svojih staršev (Amato, 1996).

Različni avtorji, ki jih navaja Gostečnik (2019) se osredotočajo na prikrite patološke transakcije in prenose nerazrešenih ter večkrat zelo bolečih mentalnih vsebin na določenega posameznika, ki jih nezavedno sprejme in se z njimi celo identificira. Tak posameznik nehote ponavljanja osnovne vzorce medosebnih interakcij in način komunikacije, čeprav so zanj in za celo družino nesprejemljivi. V družini dobi otrok temeljne vzorce, pravila za obnašanje, čustvovanje, osnove jezikovne kulture ter sposobnosti izražanja in mišljenja (Cvetek, 2005). Zato lahko rečemo, da je pozitivna komunikacija in razumevanje ter sodelovanje med generacijami oziroma medgeneracijski dialog pot k boljšim medosebnim odnosom in spremembi simptomatičnih vzorcev medosebnih interakcij.

Ne glede na uspešnost reševanja težav so lahko vzorci vedenja funkcionalni ali pa tudi ne, vendar jih kljub temu prenašamo naprej v svojem življenju, še posebno v

družinskih odnosih. Če želimo zagotoviti kakovostne družinske odnose in medgeneracijsko sodelovanje, je pomembno, da bi družinske člane vseh generacij ozaveštili o pomenu novih znanj in veščin za spremembo in opustitev neprimernih globinskih vedenjskih vzorcev. Vsekakor moramo poudariti, da pridobljene vzorce lahko spremenimo in jih izboljšamo ter jih ozaveštimo, pri tem pa si lahko pomagamo s strokovno psihosocialno pomočjo. Tudi Demšar Pečak in Ovsenik (2012) omenjata, da morajo biti družinski člani pripravljeni na ozaveščanje, spreminjanje vedenjskih vzorcev in prevzemanje odgovornosti za svoja dejanja in čustva, kajti šele takrat lahko razvijejo zavestni medosebni odnos in/ali zavestno starševstvo.

Zaradi razširjenega nepoznavanja možnosti iskanja strokovne pomoči pri medgeneracijskem prenosu simptomatičnih vzorcev medosebnih interakcij, smo naslovili različne interventne ukrepe, s katerimi je družinskim članom različnih generacij zagotovljena brezplačna psihosocialna podpora in pomoč. Namen različnih programov podpore in pomoči je, da bi družinske člane ozaveštili in informirali o pomembnosti dobrih in zdravih družinskih odnosov in jim nudili znanja in veščine pri spremembi globoko ukoreninjenih neustreznih vedenjskih vzorcev in jim pri tem nudili psihosocialno svetovanje.

TEORETIČNA IZHODIŠČA

Ko govorimo o spreminjanju globinskih vzorcev vedenja, čustvovanja in mišljenja, se s tem osredotočamo predvsem na vzorce starega, družinskega modela iz mladosti (odnos mati-otrok), saj je ves nadaljnji emocionalni, kognitivni in interrelacijski način doživljanja in mišljenja ter odzivanja v veliki meri odvisen prav od tega primarnega odnosa (Gostečnik, 2019). Kot primer lahko omenimo, da partnerji pogosto razvijejo partnersko življenje, ki je podobno partnerskemu odnosu njihovih staršev, vendar ne zaradi dednosti, ampak preprosto sledijo družinskim vzorcem, ki jih poznajo (Hendrix, 1999; Gostečnik, 2019). Gre za generacijski prenos vedenjskih vzorcev oziroma načinov vedenja, ki se kompulzivno prenašajo iz generacije v generacijo.

Omenimo lahko nekaj najpomembnejših modelov, ki prevladujejo, in ti so, kot navaja Gostečnik (2011, str. 5) „t.i. *strateški* (Haley, 1987), *strukturni* (Minuchin, 1981), *medgeneracijski* (Framo, 1992), *kontekstualni* (Boszoromenyi-Nagy, 1986, 1991) in *Bowenov* (1978) *model*“. V teh modelih omenjeni avtorji posameznika opredeljujejo kot del celotne družine, v kateri je odraščal oziroma iz katere izhaja, saj se v družinah zelo učinkovito prenašajo vedenjski vzorci, vrednote, miti in včasih tudi sramotni afekti. Zanimivo dejstvo je, kot omenja pionir te problematike Framo (1981), da določeni vzorci ali družinske teme preskočijo cele generacije, nato pa se skrivnostno zopet naselijo v novi generaciji, ki sploh ne ve, od kod prihajajo te boleče vsebine. Ugotavljal je kako lahko preteklost vpliva na

sedanjost in tudi kako lahko „družina skozi več generacij razvije nefunkcionalne vzorce vedenja, čutenja, mišljenja in predvsem medosebnih interakcij“ (Gostečnik, 2011, str. 180).

Omeniti je treba, da pridobljene vzorce vedenja lahko postopoma spreminjamo, vendar pa moramo najprej ozavestiti določeno neprimerno ali konfliktno situacijo, h kateri nato zavestno pristopimo in jo z naučenimi veščinami in znanji začnemo konstruktivno reševati. Cilj interventnih pristopov je kratkoročno gledano usmerjeno na spreminjanje stališč in vrednot posameznika, dolgoročno pa na spremembo vedenja npr. celotne družine ter spodbujanje k sprejetju novih, želenih vzorcev načina vedenja. Proces sprejemanja novega načina vedenja od posameznikov zahteva opustitev starih navad ter sprejetje in ohranjanje novih. Spremembe stališč in vrednot sodijo med najtežjo obliko intervencij, saj gre pri posameznikih za spremembo globoko ukoreninjenih prepričanj, to pa pri njih povzroči velik odpor in stres, kar še posebno velja za starejše odrasle (Demšar Pečak, 2014).

Tudi Ule (2009, str. 135) navaja »da imajo pri oblikovanju stališč posebno pomembno vlogo primarne skupine, kot so družina, podporne in prijateljske skupine. V teh skupinah se spletejo tesne čustvene vezi in zato imajo tako močan vpliv na človeka. Če so te skupine za človeka tudi referenčne skupine, torej tiste skupine, katerih vrednotni sistem človek najbolj sprejema, in se z njimi identificira, je njihov vpliv še posebej velik«. Na podlagi omenjenega lahko vidimo, da spremembo načina vedenja vedno spremlja tudi sprememba stališča. V določenih primerih lahko družinski člani hitro in brez večjih težav sprejmejo novo stališče, včasih pa novo stališče zelo težko sprejmejo, ali pa se celo zgodi, da ga zaradi prenosa globoko ukoreninjenih simptomatičnih medgeneracijskih vzorcev sploh ne zmorejo sprejeti. Za kakovostne medosebne družinske odnose je pomembno aktivno udejstvovanje na različnih delavnicah, psihosocialnih svetovanjih, predavanjih strokovnjakov o problematiki medosebnih odnosov ter veščinah dobre in uspešne komunikacije itn. S temi različnimi psihosocialnimi interventnimi pristopi lahko družinski člani pridobijo različne informacije, veščine in znanja o zdravih družinskih odnosih, zaradi česar zmorejo tudi prevzeti odgovornost za reševanje nastalih težav in konfliktov.

Kot učinkovit psihosocialni pristop k boljšemu medgeneracijskemu sodelovanju lahko omenimo socialnovarstvene programe, ki so namenjeni starejšim odraslim in njihovim svojcem. Ministrstvo za delo, družino, socialne zadeve in enake možnosti (v nadaljevanju: MDDSZ) vsako leto v okviru Javnega razpisa za sofinanciranje socialnovarstvenih programov izbere izvajalce različnih interventnih socialnovarstvenih programov. Omenjeni programi posežejo na področje problematike starejših odraslih, ki potrebujejo podporo in pomoč v vsakodnevnem življenju ali pa tvegajo socialno izključenost. Programi vključujejo vsebine in aktivnosti skupin za samopomoč, za pomoč osebam z demenco in pomoč njihovim

svojcem, vsebine in aktivnosti prostovoljskega dela starejših ter zagovorništvo za starejše. Nekateri programi naslavljajo starejše odrasle, ki si želijo aktivno preživljati prosti čas in jih zanima medgeneracijsko druženje. Eno izmed ciljnih skupin predstavljajo tudi starejši odrasli, ki so socialno izključeni in potrebujejo pomoč pri širjenju socialne mreže, so materialno in finančno prikrajšani, imajo zdravstvene ali pravne težave, so gibalno ovirani, doživljajo nasilje, zlorabe in zanemarjenost ali potrebujejo pomoč pri urejanju svojega vsakodnevnega življenja ter usmerjanje. V programe na področju starejših odraslih se največ uporabnikov vključi preko svojcev, prijateljev in znancev ter preko drugih socialno-varstvenih programov, medijev ali promocijskih gradiv.

Omenimo lahko še, da od leta 2020 dalje v okviru socialnovarstvenih programov niso več financirani programi medgeneracijskih središč, saj so namesto tega sofinancirani interventni ukrepi za boljše medgeneracijsko sodelovanje v sklopu Večgeneracijskih centrov+ (VGC+), katerih namen je druženje, povezovanja in učenje različnih generacij. Projekti se izvajajo v okviru Javnega razpisa za sofinanciranje projektov večgeneracijskih centrov+, ki ga je objavilo MDDSZ, financirajo pa se iz Evropskega socialnega sklada plus. Pomembna vloga večgeneracijskih centrov je v dostopnosti in dosegljivosti aktivnosti, zato so enakomerno razpršeni po celotnem območju Slovenije. VGC+ predstavljajo pomembno središče družbenega dogajanja in socialnega vključevanja različnih ciljnih skupin vseh generacij (MDDSZ, 2024).

V nadaljevanju bomo predstavili rezultate raziskave o pomenu različnih interventnih pristopov pri ozaveščanju in reševanju medosebnih družinskih simptomatičnih interakcij, kot tudi rezultate spremljanja izvajanja programov za starejše in njihove svojce, ter jih smiselno povezali med seboj.

METODA

Za spremljanje prve raziskave je bila uporabljena kvantitativna metodologija (Demšar Pečak, 2014). Kot merski instrument smo za raziskavo uporabili anketni vprašalnik, ki je bil sestavljen iz dveh delov. Prvi del vprašalnika je vseboval demografska vprašanja (spol, starost, izobrazba...), drugi del vprašalnika pa je vseboval vprašanja, ki so se nanašala na interventne pristope v povezavi z osebnim doživljanjem težav v medosebnih družinskih in partnerskih odnosih. Uporabljena je bila Likertova lestvica. Anketiranci so na lestvici od 1 do 5 označili, v kakšni meri so po njihovem mnenju omenjeni dejavniki pomembni pri načrtovanju interventnih pristopov. K raziskavi je bilo povabljenih 200 posameznikov, od tega jih je 176 anketirancev anketo v celoti in pravilno izpolnilo (88% vseh anketirancev, od tega jih je bilo 100 ženskega in 76 moškega spola). Anketiranci so se opredeljevali o pomembnosti različnih oblik interventnih

pristopov pri reševanju medosebnih družinskih situacij. Na podlagi teoretičnih izhodišč smo v raziskavi ugotavljali možni prispevek interventnih pristopov pri reševanju medgeneracijskega prenosa vedenjskih, miselnih in čutenjskih modelov posameznikov, ki se srečujejo s težavami v družinskih odnosih. Za raziskavo je bila uporabljena Likertova lestvica. Anketiranci so na lestvici od 1 do 5 označili, v kolikšni meri so po njihovem mnenju omenjeni dejavniki pomembni. Za opis značilnosti spremenljivk smo predvideli opisno statistiko, za dokazovanje veljavnosti merskega instrumenta faktorsko analizo, za dokazovanje zanesljivosti merskega instrumenta smo predvideli Cronbach alfa (ang. Cronbach alpha), za ugotavljanje občutljivosti merskega instrumenta asimetrijo (ang. Skewness) in sploščenost (ang. Kurtosis), za ugotavljanje normalnosti porazdelitev Kolmogorov-Smirnov test in za ugotavljanje razlik med posameznimi vzorci oziroma spremenljivkami ter za potrjevanje hipotez, smo predvideli χ^2 test, t-test in Wilcoxonov test (ang. Wilcoxon test). Med samo raziskavo se je izkazalo, da določenih omenjenih metod ni bilo moč smiselno uporabiti. Na primer, faktorska analiza zajema redukcijo odgovorov velike množice posameznih spremenljivk na bistveno manjše število, torej na manjše število, kot je bilo merjenih spremenljivk. V tem primeru se nam je, glede na naravo spremenljivk, faktorska analiza zdela nesmiselna, zanesljivost merskega instrumenta pa smo preverjali s Cronbach alfo. Tako smo dejansko za opis značilnosti spremenljivk uporabili deskriptivno oziroma opisno statistiko in izračun srednje vrednosti. Po končanem anketiranju smo opravili analizo zanesljivosti (ang. Reliability) oziroma konsistentnosti vprašalnika, da bi lahko izključili trditve, ki bi imele nizko vrednost interne konsistentnosti (nizko vrednost α), torej manjšo od 0,50 ($\alpha < 0,50$). Z analizo zanesljivosti smo preverjali mere zanesljivosti posameznih sklopov vprašanj.

Za pregled spremljanja druge raziskave (Kovač in dr., 2024), so bili zajeti podatki izvedbe socialnovarstvenih programov namenjenim starejšim odraslim. Uporabljena je bila kombinacija kvalitativnih in kvantitativnih analiz podatkov, pridobljenih iz obrazcev za končna poročila izvajalcev. V analizo so bili zajeti programi za starejše odrasle, ki so bili izbrani na Javnem razpisu za sofinanciranje socialnovarstvenih programov za leto 2023. Za potrebe analize programa so bili uporabljeni osnovni podatki o programih, njihovi regionalni razpršenosti, podatki o financiranju programov, o kadrovskih virih ter o potrebah uporabnikov in komentarjih. Kot že omenjeno je analiza večinoma kvantitativna, le v tistem delu vsakega poglavja, ki se nanaša na ciljno skupino uporabnikov, so navedeni rezultati kvalitativne analize.

Pri analizi kvantitativnih podatkov so bile uporabljene univariantne statistične analize, torej tiste, s katerimi je bila istočasno analizirana le ena spremenljivka. Uporabljene so bile statistike: 1) število enot analize (N), 2) povprečje

oz. asimetrična sredina (AS), 3) maksimum, enota z najvišjo vrednostjo (MAX), 4) minimum, enota z najmanjšo vrednostjo (MIN) in 5) in preračun odstotkov (%). Odprta vprašanja oziroma kvalitativni podatki so bili združeni in povzeti po vsebini. Zajem podatkov je tako 100 %. Gre za popolno zajetje podatkov na ravni poročevalskih enot. Za potrebe pričujoče analize so bili tako zajeti sklopi poročil, in sicer finančno poročilo izvajalcev, podatki o izvajalcu in vsebini programa, podatki o uporabnikih programa ter kadrovski zasedbi (zaposleni in prostovoljci v programu).

REZULTATI

Na podlagi teoretičnih izhodišč smo v prvi raziskavi (Demšar Pečak, 2014) ugotavljali možni vpliv interventnih ukrepov pri reševanju medgeneracijskega prenosa vedenjskih, miselnih in čutenjskih vzorcev družinskih članov. Namen prve raziskave je bil torej preučiti dejavnike, ki igrajo pomembno vlogo pri ustreznem razreševanju medgeneracijskega prenosa simptomatičnih vzorcev vedenja. Anketirance smo povprašali o tem, ali bi bili po njihovem mnenju različni interventni psihosocialni pristopi, kot so različne delavnice, treningi, usposabljanja, svetovanja ipd., lahko pomemben dejavnik pri ozaveščanju in razreševanju medosebni simptomatičnih družinskih interakcij. Kot že omenjeno smo za dokazovanje zanesljivosti merskega instrumenta opravili analizo zanesljivosti (ang. Reliability) oziroma konsistentnosti vprašalnika, da bi lahko izključili vse trditve, ki bi imele nizko vrednost interne konsistentnosti (nizko vrednost α), torej manjšo od 0,50 ($\alpha < 0,50$).

Tabela 1: Preverjanje mere zanesljivosti posameznih sklopov vprašanj

Zanesljivost		
št.	Cronbach's Alpha (α)	N
V1	0,892	7
V2	0,897	2
V3	0,907	9

Merski instrument kaže na zanesljivost vprašanj, saj koeficient Cronbach alfa presega vrednost 0,50, in sicer dosega vrednost $\alpha = 0,89$ pri vprašanju št. 1, vrednost $\alpha = 0,89$ pri vprašanju št. 2, ter vrednost $\alpha = 0,90$ pri vprašanju št. 3.

V nadaljevanju smo za ugotavljanje občutljivosti merskega instrumenta opravili analizo za asimetrijo (ang. *Skewness*) in sploščenost (ang. *Kurtosis*) za spremenljivke v sklopih omenjenih vprašanj.

Tabela 2: Koeficient asimetrije in sploščenosti

Opisna statistika		N	Skewness koeficient asimetrije	Kurtosis koeficient sploščenosti
V1	Spremembe globinskih vzorcev vedenja, čustvovanja in mišljenja.	176	-0,794	0,124
V3	Preventivni, strokovno/izob. programi	176	-0,585	0,227
V4	Usposabljanje/trening za uspešno komunikacijo (med družinskimi člani)	176	-0,777	-0,346
Skupaj		176		

Podatki v Tabeli 2 kažejo, da so vrednosti koeficienta asimetrije manjše od 0, torej kaže bolj v levo. Vrednosti koeficienta sploščenosti so blizu ali pod ničlo, kar nakazuje, da podatki nimajo izrazitih ekstremnih vrednosti ali močno koničaste oblike porazdelitve, saj so bolj razpršene.

Anketirane smo povprašali tudi o tem ali so do zdaj že kdaj poiskali kakšno psihosocialno obliko pomoči in podpore družini. Rezultati kažejo, da se je največ anketirancev udeležilo individualne strokovne pomoči ali svetovanja na centru za socialno delo in v drugih sorodnih institucijah. Od vseh anketiranih je individualno pomoč pri svetovalcih oziroma različnih terapevtih poiskalo skupaj 33 ali 18,8 % anketirancev, 22 ali 12,5 % jih je pomoč poiskalo v različnih skupinah za samopomoč.

Tabela 3: Iskanje različnih oblik strokovne pomoči

	Odgovor	Število (N)	Delež v %
Iskanje strokovne pomoči na CSD	ne	172	97,7
	da	4	2,3
Iskanje str. pomoči/skupine zasamopomoč	ne	154	87,5
	da	22	12,5
Skupaj (število partnerjev)		176	100,0

Anketirance smo, kot že rečeno, povprašali o tem, ali menijo, da imajo različne oblike psihosocialnih pristopov, kot so npr. različne individualna, družinska svetovanja, skupine/delavnice za pomoč družinam v stiski itd., treningi uspešne komunikacije pomembno vlogo pri ozaveščanju in reševanju izzivov v družinskih odnosih in medgeneracijskem sodelovanju.

Tabela 4: Frekvenčne tabele odgovorov na posamezna vprašanja

Pomembnost različnih oblik psihosocialnih pristopov	Število (N)	Odstotek (%)
Spremembe gl. vzorcev vedenja, čustvovanja in mišljenja		
nepomembno	5	2,8
malo pomembno	14	8,0
srednje pomembno	35	19,9
močno pomembno	67	38,1
zelo močno pomembno	55	31,3
Usposabljanje/trening za uspešno komunikacijo		
nepotrebno	3	1,7
malo potrebno	18	10,2
srednje potrebno	32	18,2
močno potrebno	51	29,0
zelo močno potrebno	72	40,9
Preventivni, strokovni oz. izobraževalnih programi		
nepomembno	5	2,8
malo pomembno	12	6,8
srednje pomembno	51	29,0
močno pomembno	73	41,5
zelo močno pomembno	35	19,9
Skupaj (število partnerjev)	176	100,0

Analiza podatkov je pokazala, da je pri vseh spremenljivkah vidna porazdelitev odgovorov v prid mnenja, da so različne oblike psihosocialnih pristopov močno ali zelo močno pomembne, torej imajo pomembno vlogo pri ozaveščanju in reševanju izzivov v družinskih odnosih in medgeneracijskem sodelovanju. V raziskavi smo ugotovili, da podatki niso porazdeljeni normalno, kar smo preverili tudi statistično s Kolmogorov-Smirnovim testom za en vzorec in Shapiro-Wilkovim testom. Oba testa sta bila narejena hkrati in namenjena preverjanju normalnosti porazdelitve.

Tabela 5: Test normalne porazdelitve

		Kolmogorov-Smirnov		Shapiro-Wilk	
		Statistika	Stopnja značilnosti	Statistika	Stopnja značilnosti
V1	Sprem gl. vzorcev vedenja, čustvovanja in mišljenja	0,243	0,000	0,855	0,000
V2	Usposabljanje/trening za uspešno komunikacijo	0,239	0,000	0,831	0,000
V3	Preventivni, strokovnih izobraževalnih programi	0,241	0,000	0,877	0,000

Oba testa kažeta, da podatki niso normalno porazdeljeni ($p < 0,05$), zato smo za analizo elementov v nadaljevanju kot srednjo vrednost uporabili mediano.

Tabela 6: Stopnja pomembnosti različnih oblik psihosocialnih pristopov

Deskriptivna statistika	Št. (N)	Min.	Maks.	Mediana (Me)	Standardni odklon (SE)
Spremembe gl. vzorcev vedenja, čustvovanja in mišljenja v partnerski zvezi.	176	1	5	4,0	1,036
Usposabljanje/trening za uspešno komunikacijo med generacijami.	176	1	5	4,0	1,077
Preventivni, strokovnih/izobraževalnih programov.	176	1	5	4,0	0,952
Skupaj	176				

Rezultat mediane kaže, da anketiranci oblike psihosocialnih pristopov ocenjujejo najmanj kot zelo pomembne, na podlagi tega pa lahko ugotovimo, da so anketiranci izpostavili pomembnost različnih oblik psihosocialnih pristopov pri reševanju medosebnih simptomatičnih družinskih interakcij. Na podlagi teh ugotovitev sklepamo, da je za kakovostne družinske medgeneracijske odnose pomembno udejstvovanje na različnih organiziranih srečanjih, delavnicah ali individualnih svetovanjih ipd., saj lahko na teh srečanjih družinski člani pridobijo znanja in veščine za spremembo globinskih vzorcev vedenja, čustvovanja in mišljenja ter primerne načine za uspešno medgeneracijsko komuniciranje in sodelovanje.

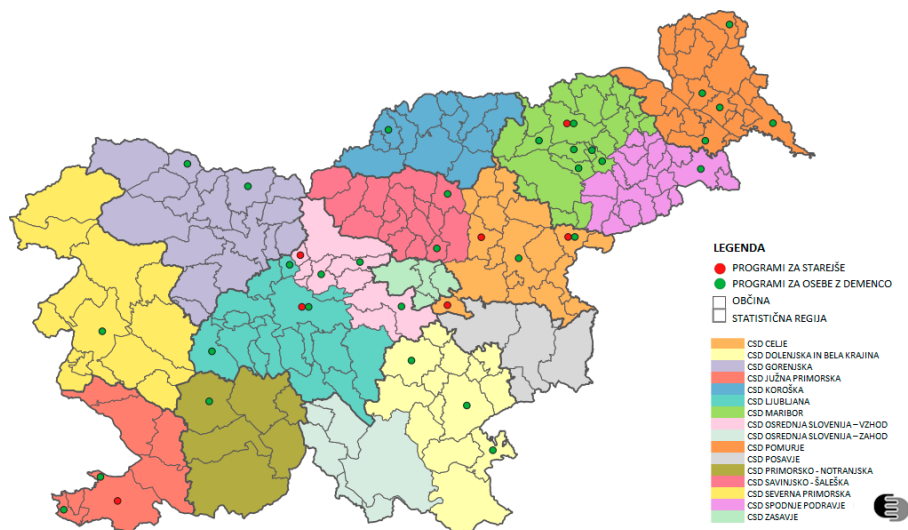
Namen druge raziskave (Kovač in dr., 2024) je bil nasloviti interventne ukrepe in udejstvovanje starejših odraslih ter njihovih svojcev v programih namenjenih starejšim in ugotoviti so pri reševanju različnih izzivov starejših odraslih kot tudi medgeneracijskega sodelovanja psihosocialni pristopi pomembni in ali so jim udeleženci naklonjeni oziroma ali se jih udeležujejo. V letu 2023 je MDDSZ sofinanciralo devet socialnovarstvenih programov za starejše odrasle, od tega je bilo šest javnih socialnovarstvenih programov (vključenih v sedemletno sofinanciranje na MDDSZ) ter trije razvojni socialnovarstveni programi (vključeni v enoletno sofinanciranje na MDDSZ), ki se izvajajo po celotni Sloveniji.

V programih za starejše je MDDSZ (so)financiral skupaj 22 zaposlenih oseb, in sicer v obsegu 14,67 zaposlitve. Največ sredstev je MDDSZ namenilo financiranju zaposlitev strokovnega kadra, poleg teh je sodelovalo še 98,4 % oz. 4.435 prostovoljcev, ki so skupaj opravili skoraj 730 tisoč ur prostovoljnega dela. Večina je opravila med 100 in 500 ur dela. Med prostovoljci je bilo 3.825 oz. 86 % žensk. Večina prostovoljcev je opravljala drugo delo, npr. druženje z uporabnikom. Programi namenjeni starejšim in dementnim so največ sredstev pridobili od MDDSZ, in sicer slabo polovico (46,6 %) vseh pridobljenih sredstev v letu 2023, delež ostalih sofinancerjev pa je bil bistveno nižji. Ker MDDSZ pri razpisih, kot lastni materi-

alni vložek organizacij upošteva tudi ocenjeno vrednost prostovoljskega dela in brezplačnih najemnin, je bilo za 78.000 EUR brezplačnega najema prostorov (4,3 %). Skupna vrednost pridobljenih sredstev za izvedbo omenjenih programov je bila v letu 2023 1.846.782,08 evra.

V nadaljevanju prikazujemo pokritost s programi po mreži CSD in na zemljevidu po občinah. Programi za starejše se izvajajo po celotni Sloveniji, programi za osebe z demenco in njihove svojce pa se izvajajo v pomurski in podravski regij.

Slika 1: Dostopnost programov za starejše



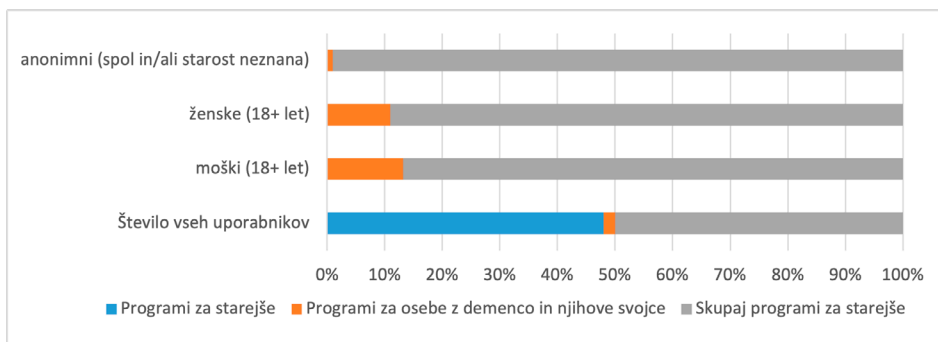
Vir: Kovač in dr. 2024.

Opomba: Trije izvajalci programov za starejše (Zveza društev upokojencev Slovenije – ZDUS, Inštitut Antona Trstenjaka za gerontologijo in medgeneracijsko sožitje, Zveza društev za socialno gerontologijo Slovenije) svoje programe za starejše izvajajo po celotni Sloveniji, zato so na zemljevidu prikazani le sedeži teh organizacij.

Za primerjavo lahko izpostavimo, da je bilo v letu 2022 v programe za starejše odrasle vključenih 65.000 oseb, v letu 2023 jih je bilo vključenih že skoraj 70.000 oseb, to pomeni, da absolutno povečanje znaša približno 5.000 oseb. Tudi v podprogramih se je povečalo število uporabnikov, in sicer je bilo leta 2022 vključenih slabih 400 oseb, leta 2023 je bilo vključenih že 2.518 oseb, kar pomeni, da absolutno povečanje znaša 2.118 oseb, kar predstavlja izjemno rast. Medtem ko je rast vključenosti v glavne programe zmerna, je rast v podprogramih izjemna. Pri vpisu v program je možna tudi anonimnost, zato je bilo anonimnih uporabnikov 52.279 oz. 75,2 % uporabnikov takih, za katere spol in/ali starost nista znana. Tudi v podprogramih se je povečalo število uporabnikov, in sicer je bilo leta 2022 vključenih slabih 400 oseb, leta 2023 je bilo vključenih že 2.518 oseb, kar pome-

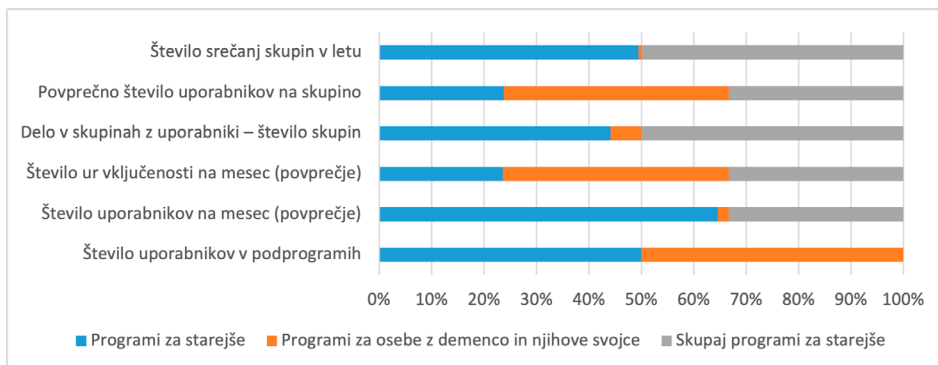
ni, da absolutno povečanje znaša 2.118 oseb, kar predstavlja izjemno rast. Medtem ko je rast vključenosti v glavne programe zmerna, je rast v podprogramih izjemna. Pri vpisu v program je možna tudi anonimnost, zato je bilo anonimnih uporabnikov 52.279 oz. 75,2 % uporabnikov takih, za katere spol in/ali starost nista znana. Če sicer opredelimo uporabnike glede na spol, med uporabniki sicer vedno prevladujejo ženske, tudi v letu 2023 je bilo v glavne programe vključenih kar 81 % žensk. V programe na področju starejših odraslih se največ uporabnikov vključi preko svojcev, prijateljev in znancev ter preko drugih socialnovarstvenih programov, medijev ali promocijskega gradiva.

Graf 1. Število uporabnikov v programih za starejše odrasle – gl. program



Vir: Kovač in dr. 2024.

Graf 2. Število uporabnikov v programih za starejše odrasle – podprogram



Vir: Kovač in dr. 2024.

Grafa prikazujeta očitno porast vključitve v programe, saj se število vključenih vsako leto povečuje. Kot možne razloge za vsakoletno povečanje vključitev v omenjene programe lahko omenimo naraščajoče število starejših odraslih za-

radi staranja prebivalstva, saj se že od leta 2012 intenzivno spreminja starostna struktura prebivalstva tako da se povečuje delež starejših (Smolej Jež in Trbanc, 2021), hkrati pa lahko omenimo tudi boljšo informiranost o programih in njihove promocije v skupnosti. Starejši odrasli se z vključitvijo v programe ognejo tveganju socialni izključenosti, ker si s tem širijo socialno mrežo, prav tako pa si zagotavljajo različne oblike pomoči, saj imajo nekateri zdravstvene ali pravne težave, so gibalno ovirani, doživljajo različne oblike nasilja, zlorabe ali zanemarjanje, nekateri pa le potrebujejo pomoč in vodenje pri urejanju svojega vsakodnevnega življenja.

Na podlagi podatkov kvalitativne analize programov za starejše odrasle (Kovač in dr., 2020; Petrič in dr., 2021; Černič in dr., 2022) ugotovljamo, da v slovenskem prostoru umanjajo programi, ki vključujejo alternativne oblike bivanja za starejše, svetovanje za prilagajanje bivalnega okolja starejšim osebam ter programi za krepitev neformalne oskrbe in dnevnega bivanja za tiste starejše, ki delno potrebujejo oskrbovanje in jim dnevno bivanje v centrih za starejše lahko omogoči, da živijo doma. Nadalje rezultati analize kažejo, da se delež osamljenih starejših ljudi izrazito povečuje, še posebno med onemoglimi starejšimi ljudmi, ki zaradi zdravstvenih težav že potrebujejo oskrbo in se torej pretežno zadržujejo doma. Kaže se tudi potreba po mreženju skupin za samopomoč, po zagovorništvu in opolnomočenju starejših. Izpostavimo lahko, da je pomembno zagotavljanje kontinuitete in stalnosti programov, geografske pokritosti in predvsem zagotavljanje brezplačne udeležbe, kar omogoča, da se starejši odrasli, vključeni v te programe, počutijo varno in sprejeto, še posebej v tej pokoronski realnosti, saj ji nekateri stežka sledijo.

RAZPRAVA

Starejši odrasli so ranljiva skupina predvsem zaradi dejavnikov tveganja za socialno izključenost, ki se s staranjem krepijo. Starejši posamezniki se soočajo tudi z občutki nevidnosti v (pre)hitri družbi. Pomemben vidik predstavljajo tudi pomanjkanje kognitivnih sposobnosti, demenca, osamljenost ter težave, ki zadevajo zdravstvene, finančne in pravne situacije (Kovač in dr. 2024). K težavam s socialno izključenostjo je v preteklih letih dodatno prispevala tudi epidemija COVID-19, zaradi katere so se starejše osebe za zaščito pred okužbo izogibale socialnim stikom. Omenimo lahko, da se ob zaostrovanju epidemioloških ukrepov (v času zaprtja) dejavnosti niso izvajale v živo, zato se je izvajanje programov preselilo v virtualno okolje. Izvajalci programov so zaradi velikega tveganja socialne izključenosti starejših odraslih v času koronakrize veliko truda vložili v usposabljanje uporabnikov programa za virtualno povezovanje, ki je večinoma potekalo povsem brez težav (Černič in dr., 2022). Zaradi povečane izolacije so se v času koronakrize naraščale tudi druge stiske uporabnikov, ki so se pojavljale na

več področjih, predvsem pa na področju duševnega zdravja. Pri starejših odraslih so opazili več apatije in odmikanje v osamo, osamljenosti, strahu, negotovosti, slabšanja finančne situacije, poslabšanje osnovnih bolezenskih stanj, poslabšanje demence. Nekateri izvajalci so zato omogočili kot posebne oblike svetovanja (telefonsko, spletno, video klic,...), povečalo se je število individualnih obravnav (Černič in dr., prav tam). Tudi avtorji (Murayama in dr., 2014; Pinazo-Hernandis in dr. 2023) navajajo, da imata osamljenost in socialna izolacija pomembno vlogo pri dobrem počutju oziroma duševnem zdravju ljudi. Število ljudi, ki jim grozi osamljenost, narašča, zato je treba še posebno zagotoviti uspešne interventne psihosocialne ukrepe. Najuspešnejše metode so tiste, ki vključujejo različne skupinske medgeneracijske intervencije, katerih cilj je ustvariti povezave med generacijami in vključevanje skupnosti. Medgeneracijsko sodelovanje ponuja močan pristop k izboljšanju življenja udeležencev z izgradnjo skupnosti in je lahko ključnega pomena za zmanjšanje osamljenosti. Medgeneracijski programi lahko služijo, kot navajajo Murayama in dr., (2014), kot ključni promotorji zdravja med starejšimi odraslimi, saj zmanjšujejo tveganje za socialno izključenost in osamljenost ter zaradi večjega občutka smisla življenja.

Pri prvi raziskavi smo ugotavljali, ali so omenjeni psihosocialni pristopi po mnenju anketirancev pomembni, pri drugi raziskavi pa smo na podlagi dejansko izvedenih delavnic ugotovili, da so pri reševanju različnih izzivov starejših odraslih kot tudi medgeneracijskega sodelovanja, psihosocialni pristopi zelo pomembni in da so jim udeleženci naklonjeni, saj se jih v veliki meri udeležujejo. Na podlagi primerjave rezultatov naših obeh predstavljenih raziskav smo lahko ugotovili, da je za kvalitetne družinske odnose in medgeneracijsko sodelovanje pomembno izobraževanje in udejstvovanje na različnih psihosocialnih programih pomoči in podpore družini, kot so na primer različne delavnice in srečanja, svetovanja, treningi dobre komunikacije itd.... Na podlagi teh ukrepov lahko družinski člani vseh generacij pridobijo znanja in veščine za spremembo in opustitev neprimerenih globinskih vzorcev vedenja, čustvovanja in mišljenja, s tem pa lahko dosežejo menjavo neustreznih utečenih vedenjskih vzorcev z novimi sprejemljivimi oblikami in posledično boljše medgeneracijsko sodelovanje.

Na podlagi obeh raziskav smo tudi ugotovili, da družinski člani, še posebno starejše generacije, ki se znajdejo v težkih situacijah velikokrat probleme zanikajo ali pa se jih celo sramujejo. Prav zato je še kako pomembno, da z različnimi pristopi, ozaveščamo in motiviramo družinske člane vseh generacij o pomembnosti iskanja različnih brezplačnih psihosocialnih programov v podporo in pomoč družini. Prav zato je pomembno, da je družini zagotovljena široka, kontinuirana in brezplačna ponudba različnih oblik pomoči in podpore ter s tem zagotovljena enakost in socialna vključenost, še posebno za najbolj ranljive družbene skupine.

Velikokrat imajo starejši odrasli ali njihovi svojci negativen odnos do različnih oblik pomoči, saj menijo, da je strokovna pomoč brez pomena ali pa menijo, da psihosocialne pomoči sploh ne potrebujejo. Zaradi problematike, ki posega v intimo družine, veliko družinskih članov svoje probleme zanika ali pa se jih celo sramuje, saj ne želijo izpostaviti svojih problemov, čeprav so v stiski (Černič in dr., 2022; Kovač in dr., 2024). Prav zato je še kako pomembno, da z različnimi, tudi promocijskimi pristopi, ozaveščamo in motiviramo družinske člane vseh generacij o pomembnosti iskanja različnih brezplačnih psihosocialnih programov, ki so namenjeni podpori in pomoči celotni družini. Pomembno je tudi to, da bi bila družini še naprej zagotovljena široka, kontinuirana in brezplačna ponudba različnih oblik pomoči in podpore ter s tem zagotovljena enakost in socialna vključenost, kar še posebej velja za starejše odrasle, ki so pra gotovo ena izmed najranljivejših družbenih skupin.

Na podlagi ugotovitev lahko naslovimo pomen nadaljnjega raziskovalnega dela za zagotavljanje dobrega medgeneracijskega sodelovanja. Kot smo že omenili, se ljudje že v otroštvu s posnemanjem njim pomembnih odraslih oseb učijo o odnosih v družini in prevzemajo njihove vedenjske vzorce. Zaradi te interakcije menimo, da bi lahko že med mladimi delovali preventivno, saj bi jih na ta način usmerjali k spreminjanju neustreznih čustvenih, vedenjskih in miselnih vzorcev, ki bi se sicer v življenju posameznika lahko ponavljali v vseh njegovih odnosih, tudi s starejšimi generacijami. Menimo, da bi bilo treba uvesti v vzgojno izobraževalne institucije vsebine, ki bi mlade ozaveščale o pomembnosti kakovostnih družinskih odnosov, kot tudi seznanjale z izzivi medgeneracijskega sodelovanja. Omenimo lahko sodelovanje pri izmenjavi znanj in veščin, na primer mladostniki bi lahko učili starejše odrasle uporabe IKT, starejši odrasli pa mladostnike različnih oblik tradicionalnih obrti.

ZAKLJUČEK

Na podlagi analize rezultatov smo ugotovili, da so za družinske člane vseh generacij različni interventni ukrepi pomembni in da so jim tudi v veliki meri naklonjeni, saj se jih kot kažejo podatki v veliki meri udeležujejo. Mreža socialnovarstvenih programov kot tudi mreža večgeneracijskih centrov je pomemben dejavnik, namenjen vsem generacijam, tudi starejšim odraslim. Gre za sistem različnih sodobnih programov namenjenih pomoči ranljivim družbenim skupinam pri dvigu kakovosti življenja ter preprečevanju zdrsa v socialno izključenost in revščino s poudarkom na krepitvi medgeneracijske solidarnosti in sodelovanju. Programi so namenjeni tudi ozaveščanju o kakovostnem, zdravem in aktivnem staranju, solidarnem sožitju med generacijami ter usposabljanju posameznikov in skupin vseh generacij za učinkovito uresničevanje teh nalog na principu samopomoči. Namen različnih programov je tudi, da bi družinske člane ozavestili in informirali

o pomembnosti dobrih in zdravih družinskih odnosov, saj je pozitivna komunikacija in razumevanje med generacijami oziroma medgeneracijsko sodelovanje ali dialog pot k boljšim medosebnim odnosom in spremembi simptomatičnih vzorcev medosebnih interakcij.

Izpostavimo lahko še, kot je omenjeno v Zaključnem poročilu o izvajanju in doseganju ciljev Resolucije o nacionalnem programu socialnega varstva za obdobje 2013–2020 (Smolej Jež in Trbanc, 2021), pomembnost povezovanja, medsebojnega informiranja in usklajenega delovanja različnih sektorjev (npr. socialnega, družinskega, zdravstvenega, prostorskega in gospodarskega), ki vplivajo na socialne razmere in položaj družin vseh generacij.

Psihosocialni programi, usmerjeni v medgeneracijsko sodelovanje, ne prispevajo zgolj k osebnemu razvoju posameznikov, temveč imajo tudi širše družbene koristi, saj krepijo povezanost, solidarnost in socialni kapital. Medgeneracijski dialog ni le cilj, temveč tudi sredstvo za doseganje bolj uravnotežene in sočutne družbe, kjer so vse generacije enakovredni partnerji v skupnem napredku. Zaključimo lahko, da ima medgeneracijski dialog ali sodelovanje pomembno vlogo pri gradnji bolj vključujoče in solidarne družbe, spodbuja empatijo in razumevanje različnih pogledov, kar vodi k večji strpnosti in sodelovanju, kjer različne generacije ne tekmujejo, ampak sodelujejo in se vzajemno podpirajo.

LITERATURA

1. Amato, P. R. (1996). Explaining the Intergenerational Transmission of Divorce. *Journal of Marriage and the Family* 58:628–641.
2. Greenfield E. A. in Buffel T. (2022). Age-Friendly Cities and Communities: Research to Strengthen Policy and Practice. *Journal of aging & social policy* https://www.academia.edu/78332569/Age_Friendly_Cities_and_Communities_Research_to_Strengthen_Policy_and_Practice
3. Capaldi, D., Pears, K., Patterson, G., in Owen, L. (2003). Continuity of parenting practices across generations in an at-risk sample: A prospective comparison of direct and mediated associations. *Journal of Abnormal Child Psychology*, 31, 127–142.
4. Cvetek, R. (2009). *Bolečina preteklosti: Travma, medosebni odnosi, družina, terapija. Celje: Društvo Mohorjeva družba.*
5. Černič, M., Smolej Jež, S., Petrič, M, in Kobal Tomc, B. (2022). Spremljanje izvajanja socialnovarstvenih programov v letu 2021. Končno poročilo. Inštitut Republike Slovenije za socialno varstvo. <https://irssv.si/institut-republike-slovenije-za-socialno-varstvo/raziskovalna-porocila/raziskovalna-porocila-otroci-in-druzine>
6. Demšar Pečak, N., in Ovsenik, M. (2012). *The Role of Social Marketing in a Communicative Partner Relationship. Informatologija*, 45 (3), 194–207.

7. Kovač, N., Černič, M., in Žiberna, V. (2020). Spremljanje izvajanja socialno-varstvenih programov za leto 2019. Končno poročilo. Inštitut Republike Slovenije za socialno varstvo. https://irssv.si/wp-content/uploads/2023/10/SVP_koncno_porocilo_za-2019.pdf
8. Kovač, N., Popovič, M. in Černi, M. (2024). Spremljanje izvajanja socialno-varstvenih programov in programov v podporo družinam. Končno poročilo. Inštitut Republike Slovenije za socialno varstvo. https://irssv.si/wp-content/uploads/2024/08/SVP_koncno_porocilo_28.6.2024_final.pdf
9. Laging, B., Slocombe, G., Liu, P., Radford, K., in Gorelik, A. (2022). The delivery of intergenerational programmes in the nursing home setting and impact on adolescents and older adults: A mixed studies systematic review. *International Journal of Nursing Studies*, 133, 104281. <https://doi.org/10.1016/j.ijnurstu.2022.104281>
10. Demšar Pečak, N. (2014). Model socialnega marketinga pri reševanju problemov v partnerskem odnosu. Doktorska disertacija. Fakulteta za organizacijske študije Novo mesto.
11. Gostečnik, Ch. (1997). Človek v začaranem krogu. Ljubljana: Brat Frančišek in Frančiškanski družinski center.
12. Gostečnik, C. (2011). Inovativna relacijska družinska terapija. Ljubljana: Brat Frančišek in Frančiškanski družinski center.
13. Gostečnik, C. (2015). Je res vsega kriv partner? Ljubljana: Brat Frančišek in Frančiškanski družinski center.
14. Gostečnik, C. (2016). Zakaj se te bojim? Ljubljana: Brat Frančišek in Frančiškanski družinski center.
15. Gostečnik, C. (2019). Relacijska paradigma in travma. Ljubljana: Brat Frančišek in Frančiškanski družinski center.
16. Hendrix, H. (1999). Najina ljubezen: od romantične ljubezni do zrelega partnerstva. Ljubljana: Orbis.
17. Iršič, M. (2004). Umetnost obvladovanje konfliktov. Ljubljana: Zavod Rakmo.
18. Kaplan, M., Thang, L.L., Sánchez, M., in Hoffman, J. (2020). *Intergenerational Contact Zones: Place-based Strategies for Promoting Social Inclusion and Belonging*. https://www.researchgate.net/publication/339391399_Intergenerational_Contact_Zones_Place-based_Strategies_for_Promoting_Social_Inclusion_and_Belonging
19. Martin-Matthews & Kobayashi (2009). Intergenerational Transmission - Cultural Transmission: Values, Norms, And Beliefs, <http://family.jrank.org/pages/917/Intergenerational-Transmission.html>
20. MDDSZ. Socialnovarstveni programi. (2024). <https://www.gov.si teme/socialnovarstveni-programi/>

21. Murayama, Y., Ohba, H., Yasunaga, M., Nonaka, K., Takeuchi, R., Nishi, M., in Fujiwara, Y. (2014). The effect of intergenerational programs on the mental health of elderly adults. *Aging & Mental Health*, 19(4), 306–314. <https://doi.org/10.1080/13607863.2014.933309>
22. Petrič, M., Smolej Jež, S., in Kobal Tomc, B. (2021). Spremljanje izvajanja socialnovarstvenih programov za leto 2020. Končno poročilo. Inštitut Republike Slovenije za socialno varstvo.
23. Pinazo-Hernandis, S., in Carrascosa, C. (2024). Effectiveness of Intergenerational Programs to Reduce Loneliness: A Scoping Review and Reflections. *Journal of Intergenerational Relationships*, 1–18. <https://doi.org/10.1080/15350770.2024.2400278>
24. Seles, V. (2008). Nezvestoba – Kako razumeti nezvestobo, se soočiti z njo in premagati njene posledice. Radovljica: Didakta.
25. Smolej Jež, S., Trbanc, M. (2021). Zaključno poročilo o izvajanju in doseganju ciljev Resolucije o nacionalnem programu socialnega varstva za obdobje 2013–2020, poročilo za obdobje 2013–2020, končno poročilo https://irssv.si/wp-content/uploads/2023/10/ReNPSV-2013-2020_zakljucno-porocilo_IRSSV.pdf
26. Steward, A., Hasche, L., Greenfield, J. C., Ingle, M. P., De Fries, C., Fix, R., King McLaughlin, J., Schilz, M., Hennig, M., in Bonatus, D. (2023). A review of participant, agency, and community outcomes of non-familial intergenerational programs. *Journal of Social Work*, 23(1), 122–142. <https://doi.org/10.1177/14680173211057436>
27. Ule, M. (2009). Psihologija komuniciranja in medosebnih odnosov. Ljubljana: Fakulteta za družbene vede.
28. Webster M., Norwood, K., Waterworth, J., in Leave, G. (2024). Effectiveness of Intergenerational Exchange Programs Between Adolescents and Older Adults: A Systematic Review. *Journal of Intergenerational Relationships* 2024, VOL. 22, NO. 4, 603–644 <https://doi.org/10.1080/15350770.2023.2267532>

THE CONSEQUENCES OF THE COVID-19 ON RESIDENTS IN ELDERLY ADULT'S HOME IN LJUTOMER

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ABSTRACT

COVID-19 posed significant challenges for nursing homes, particularly due to separation from loved ones, restrictions on visits, strict protocols, protective measures, and increased loneliness among residents and staff. Despite these measures, infections continued to rise, leading Slovenia to declare an epidemic on March 12, 2020, at 6 p.m. (Urad vlade RS, 2020). The first residents of DSO Ljutomer tested positive for the virus on March 27, 2020.

Our research was conducted as part of a master's thesis, and later, a smaller data analysis was carried out for a shorter study. The thesis was adapted to meet the requirements by incorporating new studies from researchers worldwide. Our research used qualitative content analysis to examine interview data on the consequences of COVID-19, revealing increased fear, loneliness, and social isolation among residents of the Ljutomer nursing home. The findings showed that the pandemic had a significant impact on older adults, particularly during the home's closure, when restrictive measures led to heightened loneliness and fear. The virus unpredictably disrupted social interactions, especially among the elderly, highlighting the crucial role of social gerontologists in addressing these challenges.

Keywords: older adults, social isolation, loneliness, fear, COVID-19.

INTRODUCTION

The impact of COVID-19 has been particularly significant for older adults, intensifying issues such as loneliness, fear, and social isolation, which negatively affect their well-being (Zhang & Dong, 2022). Lee et al. (2020) highlight concerns about heightened loneliness and the challenges of implementing effective measures. Social isolation during the pandemic has been a key factor in the increased sense of loneliness among the elderly (Kotwal et al., 2021).

During COVID-19, older adults experienced increased health and supportive care needs, leading to higher hospitalization rates and a decline in physical and psychological well-being (Lowthian et al., 2021). Loneliness significantly impacted longevity and overall well-being (Nguyen et al., 2020). Studies indicate that

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COVID-19 resulted in worse outcomes and higher mortality rates among older adults, particularly those with comorbidities such as hypertension, cardiovascular disease, diabetes, chronic kidney disease, and respiratory diseases (Shahid et al., 2020). Additionally, fear of falling remained a prevalent psychological concern among older adults (Xiong et al., 2024).

Noone et al. (2020) identify COVID-19 as a major factor in the decline of health and social engagement among older adults. During the pandemic, medication use, and loneliness increased significantly in this population (Wu et al., 2022). While social isolation, fear, and loneliness are often examined separately, they are distinct yet interrelated consequences of the virus (Barnes et al., 2022). Research highlights the importance of understanding these effects to develop effective measures for supporting older adults (Freedman & Nicolle, 2020). Vancampfort et al. (2019) emphasizes that physical activity plays a crucial role in reducing loneliness and maintaining quality of life in later years. Gabarrell-Pascuet et al. (2023) highlights that during the emergence of COVID-19, the medical field focused more on short-term rather than long-term effects of loneliness. Their study also notes that larger nursing homes faced higher infection risks due to greater population density. Research emphasizes the need for early intervention to mitigate the consequences of COVID-19, ensuring better conditions for the continued well-being of older adults, particularly in addressing the impact of social isolation, fear, and loneliness on health (Schrempf et al., 2019).

Altay and Çalmaz (2023) emphasize the importance of evaluating psychosocial factors to enhance life satisfaction and health in older adults. Shukla et al. (2020) define loneliness as a subjective gap between desired and actual social relationships, while Fakoya et al. (2020) describe social isolation as an objective lack of social contact that can lead to loneliness. Surkalim et al. (2022) advocate for including loneliness in general health surveillance using standardized measurement tools. Loneliness arises when social relationships fail to meet expectations (Huxhold & Fiori, 2024) and affects populations worldwide, with significant data discrepancies between high-income and lower-income countries (Surkalim et al., 2022).

Gallardo-Peralta et al. (2023) argue that aging often involves the loss of family and social relationships, contributing to loneliness—an issue exacerbated by the social restrictions of the COVID-19 pandemic. Roy et al. (2020) suggest solutions such as virtual interactions, physical activity, remote spiritual practices, and community services as effective strategies to reduce social isolation and loneliness among older adults.

METHODS

Research Questions

For the purposes of the research work, we asked ourselves research questions, as we were interested in:

RV1: What are the consequences of Covid-19 for residents in a nursing home?

RV2: How did the interviewed employees recognize loneliness in residents?

RV3: How can the interviewed residents help eliminate and prevent loneliness on their own?

RV4: What are the options for reducing the impact of the epidemic on the residents of the home?

Research methodology

Methods and techniques of data collection

In the theoretical part of our research, we employed a descriptive method to present the facts clearly, making the problem easier to understand. To summarize our findings and the results of other authors, we utilized the comparative and compilation methods. Literature was gathered from both domestic and international sources using Google Scholar, Cobiss.si, Proquest, ScienceDirect, the virtual library of Slovenia, and the Regional Library of Murska Sobota.

Description of the instruments

We conducted a semi-structured interview based on the experiences of COVID-19 among residents and employees at the Home for the Elderly in Ljutomer, informed by relevant literature. The process began with an introduction that provided basic information about the research, an invitation to participate, and written confirmation of consent. The interview included socio-demographic questions on gender, age, and address, followed by 12 main questions with sub-questions, if necessary. These questions focused on participants' experiences with COVID-19, the ongoing consequences, and how to better prepare for such situations in the future.

Description of the sample

We used a non-random sample to collect data, with interviewees ranging in age from 65 to 90 years for older adults, and 20 to 60 years for employees. We conducted interviews with 20 residents and 10 employees of the Home for the Elderly in Ljutomer.

Description of data processing

The interviews are recorded using the Voice Memos voice app on the mobile phone, with a later transcript in writing. The final time of all interviews was 2 hours, 1 minute and 1 second. For even greater confidentiality in reporting, the

interviews were encrypted with a code consisting of three units, for example: 1/20-S-F, the first unit announces the serial number of the interview for residents (1–20) and for employees (1/10), the second unit represents the resident (S) or employee (Z), and the third unit shows the gender of the interviewee (M/F) (Kordeš and Smrdu, 2015). The study separated two sets of interviews, namely interviews conducted with 20 residents, and interviews conducted with employees, of which there were 10. This makes the survey results more transparent. The semi-structured interview took place in the time from 01.12.2021 to 31.12.2021. We used qualitative content analysis to analyze the interview data of our research. The results of the research are in a descriptive form regarding the experience of consequences that cause an increase in fear and loneliness among residents in a nursing home and cohabitation of employees, as well as the categorization of records. The interviewees' responses are represented by codes, which we have divided into different categories; Later, we merged these categories into up name for all the categories and codes obtained. For example, we set fear as the main theme, and then we divided all the codes regarding fear between categories (presence of fear, absence of fear, etc.).

RESULTS

The consequences of COVID-19 have led many residents of the Ljutomer nursing home to experience difficult times, sadness, and discomfort. However, they tend not to discuss these feelings openly, often keeping them inside. There is still much work to be done, as these emotional impacts can be harmful, even potentially fatal for some individuals. The ongoing effects of the virus highlight the need for more open discussions and a proactive approach to addressing these challenges, especially in preparation for future pandemics or epidemics. Residents reported strong feelings of loneliness, distress, fear, and the negative effects of social isolation, which were reflected in their responses.

"Relationships between people were more reserved in the home, and social isolation had a big impact on that." (12/20-S-F)

"We had to be locked down because of all the measures that were issued, I felt very lonely because I didn't have the opportunity to go home to my family." (7/20-S-F)

"Given that my family and I live in a village, it wasn't that hard for me in terms of social isolation. However, working in the home during the epidemic was very demanding and exhausting. As a result, our relationships have also changed a lot." (1/10-Z-F)

The respondents overwhelmingly reported that social isolation had negative consequences for both residents and employees. Residents had not seen their families for extended periods, and due to quarantines, isolation, and professional guidelines, they were unable to socialize with each other in the dormitory.

This was a particularly difficult experience for them, as they are accustomed to sharing their feelings, both good and bad, with one another. Overall, the lack of social contact led to both physical and psychological issues, as reflected in the responses.

"During the epidemic, my life changed a lot because I lost my wife. This has had the biggest impact on my mental state. I've had a very hard time getting out of it, and yet for both of us, even though I'm alone, I have to move on." (10/20-S-M)

"The epidemic has left us residents isolated; it's been quite a big change. In our home, as elsewhere, protocols were issued that we adhered to. I didn't see my daughter, son, grandchildren and nieces for a long time, because there was no possibility of personal contact. We spoke on the phone, it meant a lot to me, because in this way I felt some warmth from my loved ones in these difficult times." (5/20-S-M)

Loneliness was largely viewed by interviewees as a significant factor that greatly impacted their lives and worsened their quality of life. Older adults, already vulnerable to loneliness, experienced an even more pronounced sense of isolation during the epidemic. According to the interviews and research conducted, one of the main consequences of the COVID-19 pandemic for both residents and employees of the Ljutomer home was fear, as reflected in their responses.

"During the epidemic, my life changed a lot as I landed in the hospital due to Covid-19. I got over it very hard, I was afraid that I wouldn't come back. The worst thing for me was that I couldn't hear anything, because I was completely deaf. At this point, I have to thank the staff at the home and at the hospital that I'm still here and alive." (2/20-S-F)

"Working during the epidemic was very demanding, I felt the greatest fear when I was in direct contact with the infected. I wasn't afraid of it if I got sick, I was most afraid that I wouldn't bring this virus home to my family, because we all live in the same house, and it would be difficult for me to isolate myself." (3/10-Z-F)

Residents and employees of the Ljutomer home consider the COVID-19 epidemic to be a very serious situation. They emphasize the importance of following the issued guidelines and measures to contain the virus, especially due to its rapid spread and the global impact of the pandemic, which affected not only Slovenia but the entire world.

"I took the situation very seriously, I stuck to everything we were told by the staff, knowing that only then would everything be resolved quickly and well." (8/20-S-F)

"The actions and instructions from the profession and the staff at the home have been well placed." (8/20-S-F)

"It was important for employees to cooperate with each other, due to the large number of infected people, the work was very difficult. Help from employees from elsewhere was hard to come by, so we had to fend for ourselves in some situations."

Above all, the guidance of the profession and our superiors in the home helped us here." (10/10-Z-F)

As people age, the likelihood of health problems increases, and the COVID-19 situation worsens and accelerated these challenges. Most interviewees reported that the virus, along with factors like lack of exercise, life changes, loneliness, fear, and anxiety, negatively impacted both their physical and mental health. The constant changes in measures and instructions led residents to feel that the epidemic and restrictions would never end, leaving them with a sense of helplessness, poor well-being, and a lack of energy and motivation. While some interviewees recovered from COVID-19, others did not, with the outcome depending on individual health conditions and how the disease progressed.

"It seemed to me that there would never be an end to all of this. It was especially hard for me when I got sick. The virus had a very negative effect on me, I was without energy, my muscles hurt, and my head hurt for the first two days. It was bad for me, because I couldn't read books because of a severe headache. That was the only thing that gave me motivation during these terrible times. When the headache passed, I first picked up a book, then everything was easier and better again." (1/20-C-F)

"I had the virus, but it wasn't that bad, it looked like a little bit of a bad cold." (15/20-S-M)

Each individual experienced and accepted the COVID-19 situation differently, influenced by their personal experiences, mindset, and psyche. A small number of interviewees stated that the measures, instructions, and the overall situation did not significantly change their lives, and they were able to cope successfully. However, they still adhered to the measures and guidelines because:

"During the epidemic, my life didn't change much, I took care of myself. I followed the measures perfectly, I knew I had to do it if I wanted to be and stay healthy and not infect anyone else if I got infected." (17/20-S-F)

"It was a tough time for the staff at home as well, having to work in challenging conditions. This is the first time we have encountered such a situation. The work itself was carried out differently and in different conditions, especially because of the OVO equipment that we had to wear to protect ourselves and the residents. I also recovered from the Covid-19 virus, but I did not allow the infection or the situation with the epidemic to negatively affect me and my life." (4/10-Z-M)

"Times have not been easy in the fight against the Covid-19 virus, and yet despite everything, with the effort and hard work of the staff, it has been contained in order. Throughout the epidemic, I remained calm despite the infection. I knew it was necessary to follow the instructions and, most importantly, to take care of yourself." (8/10-Z-F)

Only a few interviewees among the residents and employees of the Ljutomer home took the COVID-19 epidemic lightly. However, they emphasized the impor-

tance of adhering to professional measures. Despite the challenging times, their mindset remained positive.

"I've been positive throughout the Covid-19 situation because I believe it's the only way that's best for each individual." (20/20-S-M)

"I wasn't afraid, but I didn't feel lonely either. The staff helped us a lot, they also allowed us to make video calls through the tablet, so I could see my family. We also heard from our loved ones every day through my personal cell phone." (13/20-S-F)

Most residents and employees expressed in interviews that the most difficult aspect of the COVID-19 measures was the restrictions on gatherings, crossing municipal and regional borders, and the social isolation that prevented socializing and taking normal, carefree walks in nature.

"I was very sad that I couldn't hang out with my friends at home." (19/20-S-F)

"It wasn't easy to accept the fact that all of a sudden I couldn't go out for a walk because of the isolation. My day begins and ends with me going out into the fresh air and taking a lap around the park or to the city. I felt very cramped, even though I knew that this was the only way everything could be resolved as soon as possible." (18/20-S-M)

"The situation with Covid-19 has brought with it a lot of changes and adjustments, we have never before witnessed that employees in a dormitory also needed certificates from the employer to move between municipalities and regions, and we have also not witnessed that we were limited to hours for movement outside our hometown. That kind of thing has made a huge mark on us no matter how we look at it." (9/10-Z-F)

During this time, impersonal social contacts, such as correspondence, video calls, and phone chats, increased significantly. Most residents used phones as their main means of communication, with some also using tablets. As mentioned earlier, the role of the social gerontologist was crucial, particularly in facilitating video and phone calls. This was a new experience for both residents and some of their relatives, but it allowed them to see and hear each other, which meant a lot—especially since, for some, these were the last moments of connection.

"I never thought that digital technology would allow me to connect with my loved ones. With the help of a video call and a social gerontologist at home, I was able to talk to them and see them at least a little. It was very difficult for me to get through the times when we didn't have contact and that gave me a lot of strength going forward." (6/20-S-F)

"I spoke to my family on the phone a lot, we reported to each other about everything that was happening to us on one side and the other." (11/20-S-F)

In all interviews, both with residents and employees, the longest responses were given to the question about mutual relationships during and after the epidemic. Relationships with one another are crucial, particularly in preventing

loneliness among older adults and ensuring the well-being of employees. Discussing their experiences, fears, feelings, and having someone to trust acted as a form of therapy and was essential during these challenging times. This openness helped prevent individuals from becoming isolated, which could otherwise lead to further mental and physical health issues.

"I think that the relationship between people has changed, you can see that they are no longer as talkative and communicative with each other as they were before the epidemic. You also don't feel that genuine connection between them anymore." (2/10-Z-F)

"Relationships between people have changed a lot, in fact, I'll say like with whom. The epidemic has had a great impact on some, and on almost nothing. I became even closer to my neighbor in the room, and we became good friends. Just having at least one person and the right one next to you, I think you've hit the lottery of a lifetime, especially in a situation like the Covid-19 epidemic." (4/20-S-F)

"Communication between people has definitely changed, because for the most part, everything revolved around that. I think that's one of the main reasons why people have become introverted, and in a way, we can't talk to each other normally anymore." (7/10-Z-F)

"During the Covid-19 virus, people became very alienated from each other, because in a way it separated us from each other, it is very difficult to imagine life without loved ones and that is exactly what happened. Such a situation will mark us for a long time, the consequences have and will continue to show." (5/10-Z-F)

Many interviewees from both groups expressed a strong desire for a return to normal life, as it was before the epidemic, without restrictions or measures. Above all, they wanted freedom from worries and fears. Their greatest wish was to socialize with relatives and enjoy the freedom to move outside the home, attend family celebrations, and simply experience life as they once had. While the virus may not disappear quickly, caution is still necessary, with professional recommendations in place to prevent the spread of infection.

"I just want everything to pass as soon as possible and to be able to live normally again as I did before the epidemic." (14/20-S-F)

"I'm hoping that life will go back to the way it was again, because we realize how difficult it is to be in situations like this." (16/20-S-M)

The interviewed residents highlighted the importance of the employees' help, while the employees shared their experiences of working during the epidemic, including their fears and feelings of loneliness. These were very challenging times for both groups, and no one had anticipated that the COVID-19 situation would lead to significant changes in the system, work processes, and mutual relationships at the Ljutomer Nursing Home.

"The employees helped us a lot, it was not easy for them either, but they showed their maximum and fighting spirit day by day. Even though they were very tired from the hard work of all the equipment they were wearing to protect against the virus in the red zones." (3/20-S-F)

"The work of the employees was very well organized, although at the first outbreak there was a lot of help from employees from elsewhere, they also showed compassion for us and helped us as much as possible. Just to think about how difficult it was for them to get into a whole new environment and start working right away. Our employees in the Ljutomer home also proved themselves with incredible work and effort." (6/10-Z-F)

DISCUSSION

The research focused on the consequences of COVID-19 for the residents of the Ljutomer Nursing Home. It was found that both residents and employees were severely affected by the epidemic, primarily due to the lack of social contact caused by protocols, measures, and internal instructions in the institution. These major changes led to emotional distress for both groups, with fear, loneliness, and a diminished quality of life being prominent consequences during this challenging period.

Noone et al. (2020) identify the COVID-19 epidemic as a major trigger for increased social isolation and loneliness among older adults. The growing number of infections and fatalities worldwide led to significant economic, social, political, and psychosocial consequences. Billions of people were quarantined in their homes or nursing home rooms, with countries implementing social isolation measures to curb the spread of the virus (Banerjee and Rai 2020). Loneliness, a subjective sense of isolation, and social isolation, an objective lack of social contact, are serious issues, particularly for older adults, and are often underestimated as public health risks (Simrad and Volicer 2020).

Dahlberg (2021) highlights the physical distancing measures during the COVID-19 pandemic and their collateral harm, including increased loneliness, fear, and social isolation. Older adults were at higher risk of severe outcomes if infected and faced stricter restrictions on physical contact. Studies show that such moments, like the pandemic, can permanently alter worldviews and life itself (Morrissey 2020). Research indicates that loneliness and social isolation have significantly increased during COVID-19, particularly affecting older adults, and have worsened physical and mental health (Somes 2021). Schrempft et al. (2019) also found that greater social isolation in older adults, particularly women, leads to reduced physical activity and higher health risks.

Studies show that the drastic changes caused by the COVID-19 pandemic led to additional consequences, such as anxiety and depressive symptoms, alongside

fear, loneliness, and social isolation. Chronically ill and elderly individuals are particularly at high risk of serious illness and death from COVID-19 (Dziedzic et al., 2021). Schrepft et al. (2019) found that with proper understanding of loneliness in older adults and structured social distancing, we can better help them cope with future pandemic outbreaks. Elderly adults require special care due to their increased risk of experiencing severe mental and physical effects from the pandemic (Dziedzic et al., 2021). Research highlights the significant consequences for older adults during the virus and their ongoing challenges.

Review of research on the consequences of COVID-19 in residents of the Ljutomer nursing home is crucial for several reasons. It plays an important role in shaping future living conditions for older adults in the home and the work of employees. While social isolation, loneliness, and fear are distinct factors, they are deeply interconnected, as the effects of COVID-19 significantly impacted the quality of life for older adults. The findings highlight the need for ongoing discussions and proactive measures to better prepare for similar situations in the event of future pandemics or epidemics.

During the COVID-19 crisis, the role of the social gerontologist in nursing homes was vital, particularly in helping to alleviate loneliness and support residents. Their work focused on engaging in conversations, strengthening the emotional well-being of older adults, providing individual treatments, and finding solutions to residents' problems. The social gerontologist also played a key role in overcoming social isolation by using digital technology, such as tablets and phones, to facilitate communication between residents and their families, ensuring ongoing connections despite restrictions.

CONCLUSION

The findings highlight the profound impact of Covid-19 on the lives of residents and the operations of staff in nursing homes for the elderly. Three key proposals are suggested for future preparation in case of another pandemic or epidemic. First, offering additional professional support to employees to cope with crises and stress, including workshops, training, and lectures. Second, creating safe spaces for visits between residents and their families, ensuring no direct contact, like practices already used in some homes during Covid-19. Finally, the importance of social gerontologists is emphasized, as their role in supporting older adults and collaborating with staff is crucial for maintaining quality of life during crisis situations.

Future research is essential to better understand and improve responses to future crises, like the Covid-19 pandemic, for both current and future situations. This moment presents an opportunity to focus on addressing the challenges faced by older

adults during and after pandemics. By leveraging new technologies, enhancing government policies, and advancing virtual healthcare solutions, we can better support older adults and mitigate the negative impacts of such crises. Focusing on these areas now can help ensure that future generations of older adults are better prepared, supported, and protected in times of similar health emergencies.

LITERATURE

1. Altay, B. in Çalmaz, A. (2023). *Perception of loneliness and life satisfaction in the elderly during the COVID-19 pandemic process*. 23(1):177-186. DOI: <https://doi.org/10.1111/psyg.12911>
2. Banerjee, D. and Rai, M. (2020). *Social isolation in Covid-19: The impact of loneliness*. DOI: <https://doi.org/10.1177%2F0020764020922269>
3. Barnes, L., T., MacLeod, S., Tkatch, R., Ahuja, M., Albright, L., Schaeffer, A., J., Yeh, S., C. (2022). *Cumulative effect of loneliness and social isolation on health outcomes among older adults*. DOI: <https://doi.org/10.1080/13607863.2021.1940096>.
4. Dahlberg, L. (2021). *Loneliness during the COVID-19 pandemic*. DOI: <https://doi.org/10.1080/13607863.2021.1875195>
5. Dzedzic, B., Idzik, A., Kobos, E., Kryczka, T., Fidecki, W., Wysokinski, M. (2021). *Loneliness and mental health among the elderly in Poland during the COVID-19 pandemic*. DOI: <https://doi.org/10.1186/s12889-021-12029-4>
6. Freedman, A. and Nicolle, J. (2020). *Social isolation and loneliness: the new geriatric giants: Approach for primary care*. DOI: <https://pubmed.ncbi.nlm.nih.gov/32165464>
7. Fakoya, O. A., McCorry, N. K. in Donnelly, M. (2020). *Loneliness and social isolation interventions for older adults: a scoping review of reviews*. 14;20(1):129. DOI: [10.1186/s12889-020-8251-6](https://doi.org/10.1186/s12889-020-8251-6)
8. Gabarrell-Pascuet, A., Garcia – Mieres, H., Gine-Vazquez I., Moneta, V. M., Koyanagi, A., Haro, J. M., Domenech-Abella, J. (2023). *The Association of Social Support and Loneliness with Symptoms of Depression, Anxiety, and Posttraumatic Stress during the COVID-19 Pandemic: A Meta-Analysis*. DOI: <https://doi.org/10.3390%2Fijerph20042765>
9. Huxhold, O. in Fiori, K. L. (2024). *Understanding loneliness in late life*. 57:101801. DOI: <https://doi.org/10.1016/j.copsyc.2024.101801>
10. Kotwal, A. A., Holt – Lunstad, J., Newmark, R. L., Cenzer, I., Smith, K. A., Kenneth, E. C., Escueta, D. P., Lee, J. M., Perissinotto, C. M. (2021). *Social Isolation and Loneliness Among San Francisco Bay Area Older Adults During the COVID-19 Shelter-in-Place Orders*. DOI: <https://doi.org/10.1111/jgs.16865>

11. Lee, E. E., Depp, C., Palmer, B. W., Glorioso, D., Daly, R., Liu, J., Tu X. M., Kim, H., Tarr, P., Yamada, Y. in Jeste, D. V. (2020). *High Prevalence and Adverse Health Effects of Loneliness in Community-dwelling Adults Across the Lifespan: Role of Wisdom as a Protective Factor*. DOI: <https://doi.org/10.1017/s1041610218002120>
12. Lowthian, A., J., Green, M., Meyer, C., Cyarto, E., Robinson, E., Mills, A., S., Hutchinson, A., Smit, V., D., Boyd L., Walker, K., Mahmoud, F., M. (2020). *Shared Loneliness During COVID-19*. DOI: <https://doi.org/10.4300%2FJGME-D-20-00320.1>
13. Morrissey, E., C. (2020). *Video calls for reducing social isolation and loneliness in older people: a rapid review*. DOI: <https://doi.org/10.1002%2F14651858.CD013632>
14. Nguyen, T. T., Lee, E. E., Daly, R. E., Wu, T. C., Tang, Y., Tu, X., Patten, R. V., Jeste, D. V., Palmer, B. W. (2020). *Predictors of Loneliness by Age Decade: Study of Psychological and Environmental Factors in 2,843 Community-Dwelling Americans Aged 20-69 Years*. DOI: <https://doi.org/10.4088/jcp.20m13378>
15. Newnham, H. and Rose, M. (2021). *Being Your Best: protocol for a feasibility study of a codesigned approach to reduce symptoms of frailty in people aged 65 years or more after transition from hospital*. DOI: <https://doi.org/10.1136/bmjopen-2020-043223>
16. Noone, C., McSharry, J., Smalle, M., Burns, A., Dwan, K., Devane, D., Morrissey, E. C. (2020). *Video calls for reducing social isolation and loneliness in older people: a rapid review*. DOI: <https://doi.org/10.1002%2F14651858.CD013632>
17. Roy, J., Jain, R., Golamari, R., Vunnam, R., Sahu, N. (2020). *COVID-19 in the geriatric population*. 35(12):1437-1441. DOI: <https://doi.org/10.1002/gps.5389>
18. Schrempft, S., Jackowska, Ma., Hamer, M., Steptoe, A. (2019). *Associations between social isolation, loneliness, and objective physical activity in older men and women*. DOI: <https://doi.org/10.1186/s12889-019-6424-y>
19. Shahid, Z., Kalayanamitra, R., McClafferty, B., Kepko, D., Ramgobin, D., Patel, R., Aggarwal, S., C., Vunnam, R., Sahu, N., Bhatt, D., Jones, K., Golamari, R., Jain, R. (2020). *COVID-19 and Older Adults: What We Know*. DOI: <https://doi.org/10.1111/jgs.16472>
20. Shukla, A., Harper, M., Pedersen, E., Goman, A., Suen, J. J., Price, C., Applebaum, J.,
21. Hoyer, M., Lin, F. R., Reed, N. S. (2020). *Hearing Loss, Loneliness, and Social Isolation: A Systematic Review*. DOI: <https://doi.org/10.1177/0194599820910377>
22. Simrad, J. and Volicer, L. (2020). *Loneliness and Isolation in Long-term Care and the COVID-19 Pandemic*. DOI: <https://doi.org/10.1016%2Fj.jamda.2020.05.006>
23. Somes, J. (2021). *The Loneliness of Aging*. DOI: <https://doi.org/10.1016/j.jen.2020.12.009>

24. Surkalim, D. L., Lou, M., Eres, R., Gebel, K., Buskirk, J., Bauman, A., Ding, D. (2022). *The prevalence of loneliness across 113 countries: systematic review and meta-analysis*. DOI: <https://doi.org/10.1136/bmj-2021-067068>
25. Urad Vlade RS. (2020). <https://www.gov.si/drzavni-organi/vladne-sluzbe/urad-vlade-za-informacijsko-varnost>.
26. Vancampfort, D., Lara, E., Smith, L., Rosenbaum, S., Firth, J., Stubbs, B., Hallgren, M., Koyanagi, A. (2019). *Physical activity and loneliness among adults aged 50 years or older in six low- and middle-income countries*. 34(12):1855-1864. DOI: <https://doi.org/10.1002/gps.5202>
27. Zhang, X. and Dong, S. (2022). The relationships between social support and loneliness: A meta-analysis and review. DOI: <https://doi.org/10.1016/j.actpsy.2022.103616>
28. Xiong, W., Wang, D., Ren, W., Liu, X., Wen, R., Luo, Y. (2024). *The global prevalence of and risk factors for fear of falling among older adults: a systematic review and meta-analysis*. DOI: <https://doi.org/10.1186/s12877-024-04882-w>
29. Wu, J., Wu, Y., Tian, Y. (2022). *Temporal associations among loneliness, anxiety, and depression during the COVID-19 pandemic period*. DOI: <https://doi.org/10.1002/smi.3076>

SHORT BIO

Urška Kunčič holds a master's degree in social gerontology and is currently a doctoral student. She began working during the COVID-19 pandemic, gaining four and a half years of experience in the social-health sector within a nursing home. She contributed to developing protocols, instructions, and guidelines for different zones, as well as for residents and their relatives. Her master's thesis focused on the consequences of COVID-19 for older adults in nursing homes. Now, she specializes in the social aspects of aging, emphasizing the third stage of life, innovative approaches, and intergenerational connections. She has participated in several conferences, including IFAC and It's About People.

ATTACHMENT A: INTERVIEW QUESTIONS

1. What is the name of the place where you currently live/work?
2. Your age in years?
3. How and in what ways did your life change during the Covid-19 epidemic?
4. Were you infected with Covid-19? If you were infected, how did you experience the progression of the virus?
5. Were you afraid? What were you afraid of? Did this fear persist throughout the day?
6. Did you feel lonely? If so, why?
7. How did you spend your time during all the measures and isolation?
8. How did the employees/coworkers help you during the epidemic?
9. Were you in contact with your loved ones during the epidemic? In what way?
10. Do you think the consequences of the epidemic significantly changed your life? How?
11. Do you think communication between people changed during Covid-19? Why?
12. Do you think the relationship between people changed during Covid-19? How?

ATTACHMENT B: CONSENT OF THE INSTITUTE TO CONDUCT THE RESEARCH

SOGLASJE ZAVODA K IZVEDBI RAZISKAVE V KLINIČNEM OKOLJU

Zdravstveni/socialni /drugi zavod: DOM STAREJSIH OBČANOV LJUTOMER

Odgovorna oseba (ime, priimek, delovno mesto): prof. Tomislav Nemec
direktor

Slovenska ulica 17, 2000 Maribor, Slovenija
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www.almamater.si

tel: 041 747 555, e-naslov: tomislav.nemec@dsj-ljutomer.si

Študentu/ki: _____ (ustrezno obkrožite):

a) Dovoljujemo opravljanje raziskave v našem zavodu in uporabo imena zavoda v zaključnem delu.
 b) Dovoljujemo objavo rezultatov raziskave v člankih in prispevkih na konferencah šole in izven
 c) Ne dovoljujemo izvedbe raziskave.

V primeru, da izvedbe raziskave ne dovoljujete, prosimo navedite razloge za vašo odločitev:

Navedite morebitne omejitve pri raziskovanju z vaše strani, predloge idr.:

Etični vidik, v primeru, da raziskava vključuje paciente (navedite sklep organa v zavodu, ki je dal soglasje k izvedbi raziskave iz etičnega vidika):

Soglasje k izvedbi raziskave je podal organ zavoda (navedite organ, številko sklepa in datum):
Dom starejših občanov Ljutomer, št. sklepa 571-08/2001-1 z dne 25.1.2001

Podpis odgovorne osebe in žig zavoda: Tomislav Nemec

Kraj in datum: Ljutomer, 6. 8. 2021

UČINKOVITOST NAČRTOVANJA ODPUSTA STAREJŠIH ODRASLIH IZ BOLNIŠNIČNEGA V DOMAČE OKOLJE PO AKUTNEM ZDRAVLJENJU: PREGLED LITERATURE

EFFECTIVENESS OF DISCHARGE PLANNING FOR OLDER ADULTS FROM HOSPITAL TO HOME ENVIRONMENT AFTER ACUTE TREATMENT: A REVIEW OF THE LITERATURE

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POVZETEK

Uvod: Mnogo starejših odraslih (≥ 65 let) se po odpustu iz bolnišnice sooča s poslabšanjem zdravstvenega stanja, potrebo po dolgotrajni oskrbi, ponovnim sprejemom v bolnišnico ali odhodom v institucionalno varstvo. Namen pregleda literature je kritični pregled sistemov načrtovanih odpustov iz bolnišnic v domače okolje ter identifikacija primerov dobrih praks.

Metode: Izveden je bil sistematični pregled literature v bazah PubMed in ScienceDirect. Pri pregledu je bila uporabljena PICO metoda, pregled je obsegal kvalitativne in kvantitativne raziskave. Vključitveni kriteriji so bili starejši odrasli, stari v povprečju ≥ 65 let, pred odpustom iz bolnišnice zaradi akutne obravnave.

Rezultati: Od 1797 člankov v obeh bazah je bilo 10 člankov relevantnih po merilih za vključitev. V analizo so bili vključeni 4 pregledni članki, 3 opisne analize in 3 randomizirano kontrolirane študije. Meritve in analize so potekale z različnimi validiranimi vprašalniki, intervjuji, študijami protokolov in pregledom literature.

Diskusija in zaključek: Pregled literature potrjuje, da načrtovanje odpusta doprineše k samostojnosti starejših odraslih oseb, minimaliziranju ponovnih sprejemov ter zmanjšanju stroškov zdravstvene blagajne, ob upoštevanju faze pred in po odpustu, aktivne vključitve uporabnika in svojcev, edukacije, komunikacije ter zadostnega prenosa informacij vseh vključenih v procesu odpusta.

Gljučne besede: načrtovani odpusti, bolnišnica, starejši odrasli nad 65 let, domača oskrba, dolgotrajna oskrba, intervencije

ABSTRACT

Introduction: Many older adults (≥ 65 years of age) are faced with worsening health conditions, the need for long-term care, readmission to hospital or institutional care after discharge from hospital. The purpose of the literature review is to

critically review the systems of planned discharges from hospitals to the home environment and to identify examples of good practices.

Methods: A systematic literature review was conducted in the PubMed and ScienceDirect databases. The PICO method was used in the review, the review consisted of qualitative and quantitative research. Inclusion criteria were older adults aged ≥ 65 years on average, before discharge from hospital for acute treatment.

Results: Out of 1797 articles in both databases, 10 articles were relevant according to the inclusion criteria. 4 review articles, 3 descriptive analyzes and 3 randomized controlled trials were included in the analysis. Measurements and analyzes were carried out through various validated questionnaires, interviews, protocol studies and literature review.

Discussion and conclusion: The literature review confirms that discharge planning contributes to the independence of older adults, minimizing re-admissions and reducing the costs of the health fund, taking into account the phase before and after discharge, active involvement of the user and relatives, education, communication and sufficient information transfer of all involved in the discharge process.

Keywords: planned discharges, hospital, older adults over 65, home care, long-term care, interventions

UVOD

Staranje prebivalstva in posledično slabšanje zdravja starejših odraslih skokovito narašča, tako lahko do leta 2050 pričakujemo, da se bo število starejših nad 60 let skoraj podvojilo (Briggs idr. 2018). Sočasno so zaradi kompleksnejših zdravstvenih težav starejših oseb bolj obremenjeni tudi različni zdravstveni sistemi, ki se soočajo ne le z akutnimi zdravstvenimi težavami pacientov, temveč tudi s ponovnimi sprejemi v bolnišnico v roku 30 dni po odpustu (Nielsen idr. 2019).

Namen pregleda literature je torej kritični pregled različnih sistemov načrtovanih odpustov starejših pacientov po akutnem zdravljenju iz bolnišnice v domače okolje, identifikacija primerov dobrih praks ter učinek načrtovanih odpustov na starejšega odraslega, njegovo družino ter stroške zdravstvenega in socialnega varstva.

Raziskovalna vprašanja, ki jih pričujoči članek pri tem naslavlja so: Ali načrtovani odpusti iz bolnišnice dejansko zmanjšujejo število ponovnih sprejemov v bolnišnico in s tem posredno vplivajo na zmanjšanje stroškov zdravstvene blagajne kot tudi ali načrtovani odpusti iz bolnišnic dejansko doprinesejo k samostojnosti starejših odraslih oseb?

Avtorji Provencher idr. ob zavedanju kritičnosti odpustov iz bolnišnice zaradi komunikacijskih vrzeli opozarjajo na to, da je pri tem lahko bistvenega pome-

na koordiniran in načrtovan odpust v domače okolje (Provencher idr. 2021). Kar potrjujejo tudi drugi avtorji., ki dodatno ugotavljajo, da je potrebno ob tem potrebno upoštevati še negativne učinke tradicionalnega odpusta kot npr. občutek zapuščenosti, tesnobe, konflikte s svojci, nezaupanje in kaos, kar so običajno vzroki, ki pripeljejo do neučinkovitega zagotavljanja oskrbe ter podaljšanega bolnišničnega zdravljenja (Mitchell idr. 2018).

Ne gre zanemariti še ostalih dejstev na katera opozarjajo tudi druge raziskave in sicer, da je načrtovani odpust odepjansko odgovornost zdravstvenih sistemov in ne le zaposlenih ter s tem usmerjajo pozornost na nujnost vključitve pacientov v načrt odpusta. Raziskave na Danskem so pri tem izpostavile primerno komunikacijo, soodločanje, čas odpusta iz bolnišnice in velikost socialne mreže (Erlang idr. 2021). V članku bo med drugimi študijami dobrih praks predstavljena tudi študija iz Švedske, kjer so avtorji iz različnih zornih kotov raziskovali na osebo naravnano oskrbo (Person-centered care – PCC) s katero so dokazovali učinkovitost načrtovanega odpusta tako iz vidika starejše osebe in njihovih svojcev, kot iz vidika preventive ter uspešnega zdravstvenega sistema (Ebrahimi idr. 2021).

Cilj je torej identifikacij dobrih praks v zadnjih petih letih ter s tem možne usmeritve za nadaljnje načrtovanje odpustov starejših odraslih iz bolnišnic v domačem okolju tudi v slovenskem prostoru.

METODE

Izveden je bil sistematični pregled literature dveh baz in sicer PubMed in ScienceDirect v času od leta 2017 do leta 2022. Pri pregledu je bila uporabljena PICO metoda, izključitveni kriteriji so potekali po prisma diagramu, pregledani članki so obsegali kvalitativne in kvantitativne raziskave. Vključitveni kriteriji so bili starejši odrasli, stari v povprečju ≥ 65 let, pred odpustom iz bolnišnice zaradi akutne obravnave.

V PubMedu je bila pregledana literatura do vključno 4.3.2022. Ključne besede so bile »planned discharges from hospital, elderly«. Zadetkov je bilo 887. Na podlagi naslovov je bilo izločenih 782 člankov, ostalo je 105 člankov, izmed katerih je bilo na podlagi povzetkov izločenih 75 člankov. Pri 30-ih člankih je bila pregledana celotna vsebina, ostalo je 9 primernih člankov, ki so umeščeni v pričujoči članek.

Dodatno je bila glede na enake izključitvene kriterije pregledana baza ScienceDirect in sicer do vključno 18.3.2022. Rezultatov na ključne besede je bilo 915, izločenih je bilo 5 duplikatov. Ob pregledu naslovov je bilo glede na izključitvene kriterije izločenih 896 članov, 13 preostalih člankov je bilo pregledanih glede na povzete, pri tem je bilo dodatno izločenih še 12 člankov. Skupno je po pregledu ostalo 10 primernih člankov vezanih na temo načrtovanih odpustov iz bolnišnice v domače okolje.

Izključitveni kriteriji so bili članki, ki so vključevali osebe mlajše od povprečno 65 let ($n=2$), članki kjer ni bila definirana starost opisane populacije ($n=4$), kjer je bil poudarek na institucionalnih oblikah ($n=6$), vsebine vezane na paliativno oskrbo ($n=3$), odpust v ali iz rehabilitacijskih centrov ($n=4$), sprejem in odpust na urgentnih centrih ($n=2$), članki, ki temeljijo na posamezni diagnozi ($n=3$), članki kjer je poudarek pretežno na družinskih oskrbovalcih ($n=3$) ter članki, ki temeljijo samo na izračunu stroškov ($n=1$).

Pregledani članki izpostavljajo različne metode raziskovanja načrtovanih odpustov iz bolnišnic v domače okolje med katerimi je tudi metoda RAMESES (Realist And Metanarrative Evidence Syntheses. Evolving Standards), katera ne preverja le učinkovitosti intervencij, temveč pomaga razumeti zakaj in kako pridemo do pričakovanih rezultatov (Provencher idr. 2021) ter randomizirana kontrolna študija v Nemčiji, ki izhaja iz oskrbnega načrtovanja, katera temelji na simptomih bolezni, oceni tveganja, potrebah, vrednotah, glede na spol, funkcionalnosti in stanju oskrbe v domačem okolju, z imenom TIGER (The Transsectoral Intervention Programme for Improvement of Geriatric Care in Regensburg), raziskava temelji na anamnezi ter različnih ocenah stanja starejših oseb vključenih v študijo (Rimmele idr. 2021).

Medtem so Karlsson idr. merili samostojnost iz vidika temeljnih dnevnih opravil (ADL), uporabljali so Barthel ADL Index, ADL Staircase in Katz ADL Index v bolnišnici in v domačem okolju (Karlsson idr. 2020). Barthel Index je bil uporabljen tudi v raziskavi na Kitajskem, kjer so pri 520 starejših pacientih v domačem okolju v času od avgusta 2017 do maja 2018 želeli identificirati samostojnost pri temeljnih dnevnih opravilih (Li idr. 2020). V Avstraliji so z deskriptivno analizo na vzorcu 400 oseb, starih v povprečju 80,5 let, pretežno žensk (61,8%) merili učinkovitost načrtovanih odpustov (HOME) pod vodstvom delovne terapevtke v primerjavi s tradicionalnim kliničnim odpustom, z namenom ugotavljanja variacij odpusta v času 3 mesecev glede na različne parametre samostojnosti pri temeljnih dnevnih opravilih (ADL) kot so hoja, soobolenja, kognitivni status idr. (Provencher idr. 2020).

Ostali pregledani članki slonijo na različnih kvalitativnih in kvantitativnih podatkih kot na primer opazovalna študija izvedena na Danskem z intervjuji oseb starejših od 60 let, pred odpustom iz bolnišnice, podatki so bili pridobljeni z elektronskimi vprašalniki obdelani s sistemom REDCap (Erlang idr. 2021). Sistematični pregled literature in meta analiza kot npr. študija izhajajoč iz Cochrane Handbook for Systematic Reviews, pa se pogloblja v raziskovalna vprašanja vezana na običajno oskrbo, nenačrtovane povratke v bolnišnico, kvaliteto življenja, funkcionalnost starejših oseb, smrtnost idr. (Lee in Cho 2022). Pomembna je tudi študija s katero so avtorji v Združenem kraljestvu želeli razviti novo ocenjevalno orodje ter raziskati vse perspektive oseb vključenih v proces odpusta v domačo oskrbo, izhajali pa so tako iz vidika pacientov, kot iz vidika zaposlenih. Evalvaciji

ja študije je potekala z randomizirano kontrolno študijo, namen pa je bil razviti orodje prilagojeno okolju v Združenem kraljestvu s katerim bi merili kvaliteto storitev pri tranziciji iz bolnišnice v domače okolje. Ob pregledu literature so uporabili bazi PubMed in EMBASE med leti 1995 in 2018 (Oikunomou idr. 2019). Kot že omenjeno, je za poglobljeno analizo odpustov iz bolnišnic v domače okolje zanimiva tudi raziskava na Švedskem v kateri so v center obravnave postavili posameznika (PCC-Person-Centered Care) ter dodatno s sistematičnim pregledom literature v bazah PubMed, CINAHL, Scopus, Psycinfo, Web of Science in Embase, med 1772 članki izločili 63 člankov v katerih so izpostavljeni načini uspešnejše zdravstvene obravnave ob odpustu iz bolnišnic v domače okolje (Ebrahimi idr. 2021).

Podobnega raziskovanja so se lotili tudi v Kanadi (Ontario) in sicer z randomizirano kontrolno študijo oseb starejših od 65 let, v kateri so z deskriptivno in kvantitativno analizo raziskovali učinke načrtovanih odpustov starejših oseb iz bolnišnic s koordinacijo medicinske sestre ter katere intervencije so potrebne, da se implementira nov način tranzicije v domače okolje (Markle-Reid idr. 2020).

REZULTATI

Na Švedskem so kvantitativni rezultati na osebo naravnanih (Person-centered care - PCC) raziskav, pokazali pomembnost razumevanja, aktiviranja in opolnomočenja starejših oseb, njihovih družinskih članov, kot tudi zaposlenih. Partnerstvo se je udeleževalo s primerno komunikacijo ter odnosom, ki je temeljil na zaupanju in deljeni odgovornosti. Prav tako so kvalitativni rezultati pokazali ključne ugotovitve, kot so pomembnost prilagojenega osebnega zdravstvenega načrta z namenom poznavanja, potrjevanja in opolnomočenja starejših oseb, ki so partnerji v timu, s čimer starejše motiviramo, dodatno pa ustvarjamo profesionalno timsko delo (Ebrahimi idr. 2021, 1). Tudi študija na Danskem je raziskovala razliko med informiranostjo in vključenostjo v odpust. Vključenost v odpust, pogovor s starejšimi pacienti, vezan na njihova pričakovanja, strahove in načrte, je dejansko pripomogel k zmanjšanju ponovnih sprejemov v bolnišnico (Erlang idr. 2021, 13).

Poleg aktivne vključenosti pacientov v odpust, tudi diagnoza ter pravočasna podpora v domačem okolju pomembno vpliva na samostojnost pri dnevni opravi po vrnitvi v domače okolje. Rezultati pacientov po zlomu kolka vključenih v randomizirano kontrolno študijo so dejansko pokazali, da je rehabilitacija v domačem okolju enakovredna rehabilitaciji v geriatričnem centru (Karlsson idr. 2020, 577).

Študije, ki podrobneje raziskujejo področje samostojnosti pri temeljnih dnevni opravi (Activities of daily living – ADL) so pri tovrstnih raziskavah toliko pomembnejše, saj kažejo na področje odvisnosti iz več različnih vidikov in ne le iz vidika diagnoze. Dokazujejo namreč, da že samo bivanje v bolnišnici povzroča določeno stopnjo oslabelosti in odvisnosti na področju ADL. V enem od člankov

tako Li in drugi avtorji na vzorcu 10.963 pacientov ADL samostojnih ob sprejetju v bolnišnico, dokazujejo, da je bilo pri odpustu iz bolnišnice 869 oseb ADL odvisnih zaradi akutnega obolenja, kar je 7,9% oseb (Li idr 2020, 6).

Rezultati študije praks različnih držav iz leta 2021 vse bolj v ospredje postavljajo tudi segment krhkosti starejših odraslih oseb. Različni strokovnjaki so tako spremljali ponovne hospitalizacije, smrtnost, fizične funkcije, pridružene zdravstvene težave, samooceno zdravja in življenjskega zadovoljstva, stroške ter zadovoljstvo z oskrbo ter krajem bivanja. V raziskavo je bil vključen čas pred odpustom iz bolnišnice, čas neposredno po odpustu ter čas do 24 mesecev po odpustu v različnih intervalih. Razvili so različne strategije načrtovanih odpustov in dokazali učinkovitost le teh, vendar pretežno iz vidika ponovnih sprejemov v bolnišnico v roku 6 mesecev, učinkovitost glede krhkosti starejših odraslih pri tem ostaja nejasna (Lee in Cho 2020, 74).

Poleg načrtovanja so za odpuste bistvene tudi strategije in protokoli odpustov ter raziskave, ki vzpodbujajo večjo interakcijo med različnimi strokami, pomagajo pri vzdržnosti različnih intervencij ter usmerjajo na različna dejstva tako iz vidika implementacije v različne stroke, kot iz vidika prihranka stroškov pristojnih institucij (Markle-Reid idr. 2020, 21), kar je vsekakor velik interes različnih držav, saj glede na demografske spremembe število starejših odraslih in s tem povezanih stroškov raste.

Prihranek na tem področju so dokazovali v študiji TIGER, kjer je načrtovanje odpustov zmanjšalo nenačrtovane ponovne sprejeme v bolnišnico v roku 12 mesecev, dodatno pa dvignilo kvaliteto življenja starejših tako iz vidika celotne oskrbene situacije, funkcionalnosti in mobilnosti, kot iz prehranjevalnega statusa, kognitivnih in gibalnih funkcij idr. (Rimmele idr. 2021, 1).

DISKUSIJA

Pregled literature z vrsto primerov dobrih praks odgovarja na predhodno zastavljena raziskovalna vprašanja in sicer, da načrtovani odpusti iz bolnišnice dejansko doprinesejo k samostojnosti starejših odraslih oseb, kot tudi k minimaliziranju ponovnih sprejemov v bolnišnico po akutni obravnavi ter s tem posledično vplivajo na zmanjšanje stroškov zdravstvene blagajne. Slednje sicer ni popolnoma potrjeno, saj so se avtorji soočali z omejitvami iz vidika težje interpretacije rezultatov zaradi različnih merskih inštrumentov, različnih oblik poročanja, premajhnega števila kvantitativnih študij, pomanjkljivih informacij o soobolenjih, ki lahko vplivajo na splošno psihofizino kondicijo starejših odraslih, pristranskost vzorčenja, precenjevanje ali podcenjevanje podatkov, subjektivni pogled raziskovalcev, domače okolje, ki lahko sproži stare navade, ki onemogočajo vpeljavo novih kot tudi jezikovne bariere oseb vključenih v študije.

Ne glede na vse pa ne gre prezreti dejstva, da so ponovni sprejemi v bolnišnico veliko breme tako za zdravstvene institucije, kot za vsakega posameznika, ki mora čez ponovni proces bolnišnične obravnave. Opravljene študije kažejo na to, da lahko z načrtovanjem odpusta le te zmanjšamo tudi do 24 %, kar je pomemben podatek za vse deležnike v procesu oskrbe. Študija iz Danske pa dodatno nakazuje tudi na možno zmanjšanje povratkov v bolnišnice (Erlang idr. 2021, 11).

Ne le, da si starejši odrasli ne želijo ponovne hospitalizacije, temveč si še toliko bolj želijo biti po odpustu ponovno aktivni pri vsakdanjih opravilih, kar ni samoumevno, saj fizična neaktivnost v času bivanja v bolnišnici doprinese k težjemu spopadanju s temeljnimi dnevnimi opravili (ADL). Slednje povišuje tveganje za slabše okrevanje, ponovne sprejeme v bolnišnico ali krizne intervencije, dodatno pa na to vplivajo tudi rizični dejavniki, kot so težave v hoji in upad kognitivnih funkcij ter pomanjkanje socialne mreže pri starejših, ki živijo sami, kar posledično pomeni visoko tveganje za ponovni sprejem v bolnišnico v roku 30 dni (Provencher idr. 2020, 2). Ob tem torej ne gre zanemariti dejstva, da je ključnega pomena pri zgodnjem načrtovanju zdravstvenih storitev in rehabilitacije, tudi motivacija želje po domačem okolju in prisotnost svojcev (Li idr. 2020, 8). V luči različnih študij je vključevanje družinskih članov v oskrbo še dodaten faktor, katerega bi bilo potrebno uvrstiti na vrh lestvice prioritet, saj so v oskrbi nemočnih družinskih članov velikokrat spregledani (Aoun idr. 2018, 8).

Rezultati pregledanih člankov kažejo na to, da vsebina načrtovanja odpustov iz bolnišnic igra pomembno vlogo, vendar pa je potrebno upoštevati tudi sodelovanje s strokovnjaki iz lokalne skupnosti, medsebojno informiranje, uvajanje sprememb ter sodelovanje vseh deležnikov, kar so ugotovili tudi Rimmel in drugi, ki so s kvantitativnimi in kvalitativnimi analizami v različnih časovnih obdobjih celostno ocenjevali starejše odrasle osebe do 12 mesecev po odpustu z geriatrično obravnavo TCM (Transitional care model), vključitvijo orodja NBA (Neues Begutachtungs Assessment) in drugimi dodatnimi vprašalniki ter na ta način poskusili celostno analizirati oskrbo geriatričnih bolnikov v Nemčiji (Rimmele idr. 2021, 10). Ob navedenih dejstvih prav tako ne gre pozabiti na pomembno vlogo zdravnikov, dodatnih zagonskih stroškov zdravstvenih organizacij za implementacijo digitalnih rešitev, izobraževanj za zaposlene, idr. Takšne spremembe namreč zahtevajo veliko osebne zavzetosti, časa in financ, kar vsekakor otežuje trajno implementacijo postopkov načrtovanja odpusta v domače okolje (Provencher idr. 2021, 15).

Razvoj novih orodij ocenjevanja, katera so ključna za kakovost prehodov v domače okolje, morajo upoštevati tudi specifiko države bivanja. Oikonomou idr. so tako razvili orodje ocenjevanja kakovosti prehoda iz bolnišnic v domače okolje pri katerem vprašalnik izhaja iz vidika pacientov pred odpustom in se je izkazal za primerne v Združenem kraljestvu (Partners at Care Transitions Meseure – PACT-M), vključuje pa vidik in sodelovanje bolnikov pred odpustom, informira-

nost in sposobnost upravljanja z zdravili, kar so tri osnovne točke identifikacije problemov v obdobju po odpustu (Oikonomou idr. 2019, 10).

Rezultati pregledanih člankov med drugim izpostavljajo različne strokovne profile, primerne za vključitev v obravnavi v skupnosti po odpustu, tako so bili v študije poleg medicinskih sester, vključeni tudi profili kot npr. fizioterapevti, socialni delavci, geriatri in delovni terapevti (Lee in Cho 2022, 66). Slednje so tudi Provencher in drugi avtorji identificirali kot uspešne v projektu HOME, katerega kombinacijo sestavlja pogovor in svetovanje v bolnišnici s postavljanjem skupnih ciljev ter dodatnimi intervencijami v domačem okolju. Raziskava je bila nasprotno od drugih, usmerjena v osebe z upadom kognitivnih funkcij in čeprav ni bilo uspešnih rezultatov na področju povrnitve samostojnosti pri dnevnih opravilih, pa se je izkazala kot učinkovita iz vidika manjših stroškov na področju ponovnih sprejemov v bolnišnico (Provencher idr. 2020, 8).

ZAKLJUČEK

Pregled člankov iz področja načrtovanja odpustov usmerja na kompleksne in večplastne pristope različnih držav. Rezultati kažejo na to, da je potrebno upoštevati tako fazo pred odpustom, kot po odpustu, aktivno vključitev uporabnika in svojcev, pri tem pa igra pomembno vlogo tudi edukacija vseh zaposlenih v procesu odpusta ter način komunikacije in zadosten prenos informacij. Kar izstopa, so različni pristopi in orodja katera se prilagajajo na okolje, diagnoze in državo bivanja ter dejstvo, da so bile skoraj pri vseh raziskavah izločene osebe s slabšimi kognitivnimi sposobnostmi zaradi težav pri reševanju vprašalnikov ali odgovarjanju pri intervjujih, v kolikor pa so bile vključene pa raziskave kažejo, da ni pomembnega učinka v primeru načrtovanih odpustov, kar bi bilo potrebno dodatno preveriti, saj takšna predpostavka temelji na premajhnemu številu člankov, da bi jo lahko potrdila. Kar preseneča je, da ob pregledu literature v bazah PubMed in ScienceDirect med 1797 člankom pravzaprav ni bilo članka, ki bi opisoval načrtovane odpuste iz bolnišnic v Sloveniji, kljub temu, da je na tem področju relativno veliko raziskav, ki govorijo o pozitivnih učinkih, kot so izboljšana zdravstvena stanja starejših odraslih, enakovredna rehabilitacija v domačem okolju v primerjavi z institucijo, ponovna samostojnost pri temeljnih dnevnih opravilih po hospitalizaciji, kot tudi bistveni prihranki v zdravstveni in socialni blagajni. Pozitivni učinki tovrstnih raziskav vsekakor odpirajo dodaten izziv za raziskovanja tega področja v Sloveniji. Glede na, da je v Sloveniji s 1.1.2024 stopil v veljavo Zakon o dolgotrajni oskrbi (ZDOsk-1 2023) bi lahko omenjeni primeri dobrih praks, navedeni zakon kakovostno nadgradili ter dopolnili s priporočili glede načrtovanih odpustov v domače okolje, saj navedenega področja omenjeni zakon ne vključuje, kar v prihodnosti ponuja možnosti dodatnih raziskav in študij vezanih na slovenski prostor.

LITERATURA

1. Aoun, Samar M, Roswitha Stegmann, Susan Slatyer, Keith D Hill, Richard Parsons, Rachael Moorin, Mary Bronson, Debbie Walsh in Christine Toye. 2018. "Hospital Postdischarge Intervention Trialled with Family Caregivers of Older People in Western Australia: Potential Translation into Practice." *BMJ Open* 8 (11).
2. Briggs, Andrew M, Pim P Valentijn, Jotheeswaran A Thiyagarajan in Islene Araujo de Carvalho. 2018. "Elements of Integrated Care Approaches for Older People: A Review of Reviews." *BMJ Open* 8 (4).
3. Ebrahimi, Zahra, Harshida Patel, Helle Wijk, Inger Ekman in Patricia Olaya-Contreras. 2021. "A Systematic Review on Implementation of Person-Centered Care Interventions for Older People in out-of-Hospital Settings." *Geriatric Nursing* 42 (1): 213–24.
4. Erlang, Anne Snoghøj, Karina Schjødt, Jakob Kau Starup Linde in Annesofie Lunde Jensen. 2021. "An Observational Study of Older Patients' Experiences of Involvement in Discharge Planning." *Geriatric Nursing* 42 (4).
5. Karlsson, Åsa, Nina Lindelöf, Birgitta Olofsson, Monica Berggren, Yngve Gustafson, Peter Nordström, and Michael Stenvall. 2020. "Effects of Geriatric Interdisciplinary Home Rehabilitation on Independence in Activities of Daily Living in Older People With Hip Fracture: A Randomized Controlled Trial." *Archives of Physical Medicine and Rehabilitation* 101 (4): 571–78.
6. Lee, Ji Yeon, Yong Sook Yang, and Eunhee Cho. 2022. "Transitional Care from Hospital to Home for Frail Older Adults: A Systematic Review and Meta-Analysis." *Geriatric Nursing* 43 (January): 64–76.
7. Li, Xiuyue, Tingting Zheng, Yaqi Guan, Hui Li, Kexin Zhu, Lu Shen, and Zhiqin Yin. 2020. "ADL Recovery Trajectory after Discharge and Its Predictors among Baseline-Independent Older Inpatients." *BMC Geriatrics* 20 (1): 86.
8. Markle-Reid, Maureen, Carrie McAiney, Rebecca Ganann, Kathryn Fisher, Amiram Gafni, Alain P Gauthier, Gail Heald-Taylor, et al. 2020. "Study Protocol for a Hospital-to-Home Transitional Care Intervention for Older Adults with Multiple Chronic Conditions and Depressive Symptoms: A Pragmatic Effectiveness-Implementation Trial." *BMC Geriatrics* 20 (1): 240.
9. Mitchell, Suzanne E., Vivian Laurens, Gabriela M. Weigel, Karen B. Hirschman, Allison M. Scott, Huong Q. Nguyen, Jessica Martin Howard, et al. 2018. "Care Transitions From Patient and Caregiver Perspectives." *The Annals of Family Medicine* 16 (3).

10. Nielsen, Louise Moeldrup, Lisa Gregersen Østergaard, Thomas Maribo, Hans Kirkegaard, and Kirsten Schultz Petersen. 2019. "Returning to Everyday Life after Discharge from a Short-Stay Unit at the Emergency Department—a Qualitative Study of Elderly Patients' Experiences." *International Journal of Qualitative Studies on Health and Well-Being* 14 (1).
11. Oikonomou, Eirini, Eleanor Chatburn, Helen Higham, Jenni Murray, Rebecca Lawton, and Charles Vincent. 2019. "Developing a Measure to Assess the Quality of Care Transitions for Older People." *BMC Health Services Research* 19 (1): 505.
12. Provencher, Véronique, Lindy Clemson, Kylie Wales, Ian D Cameron, Laura N Gitlin, Ariane Grenier, and Natasha A Lannin. 2020. "Supporting At-Risk Older Adults Transitioning from Hospital to Home: Who Benefits from an Evidence-Based Patient-Centered Discharge Planning Intervention? Post-Hoc Analysis from a Randomized Trial." *BMC Geriatrics* 20 (1): 84.
13. Provencher, Véronique, Monia D'Amours, Matthew Meneer, Natasa Obradovic, Nathalie Veillette, Marie-Josée Sirois, and Marie-Jeanne Kergoat. 2021. "Understanding the Positive Outcomes of Discharge Planning Interventions for Older Adults Hospitalized Following a Fall: A Realist Synthesis." *BMC Geriatrics* 21 (1): 84.
14. Rimmele, Martina, Jenny Wirth, Sabine Britting, Thomas Gehr, Margit Hermann, Dirk van den Heuvel, Andreas Kestler, et al. 2021. "Improvement of Transitional Care from Hospital to Home for Older Patients, the TIGER Study: Protocol of a Randomised Controlled Trial." *BMJ Open* 11 (2).
15. Zakon o dolgotrajni oskrbi (ZDOsk-1). 2023. Ur. L. RS.

SHORT BIO

Carmen Rajer je strokovna delavka za področje dolgotrajne oskrbe in vodja projekta dolgotrajne oskrbe v skupnosti Most na Centru za socialno delo Posavje, zunanja predavateljica na Ljudski univerzi Krško, pri Socialni zbornici Slovenije, na Višji strokovni šoli Brežice, habilitirana predavateljica na Univerzi Alma Mater Europaea ter raziskovalka na Fakulteti za zdravstvene vede Novo mesto in na Zavodu INRISK. Področje: Integrirana dolgotrajna oskrba in socialna oskrba starejših odraslih v skupnosti.

INTEGRACIJA PALIATIVNE OSKRBE V SOCIALNOVARSTVENIH ZAVODIH V LUČI DRUŽBENEGA IN TEHNOLOŠKEGA RAZVOJA: INTEGRATIVNA ANALITIČNA METODA PREGLEDA LITERATURE IN ŠTUDIJA PRIMERA

INTEGRATION OF PALLIATIVE CARE IN SOCIAL WELFARE INSTITUTIONS SOCIAL IN THE LIGHT OF SOCIAL AND TECHNOLOGICAL DEVELOPMENT: INTEGRATIVE ANALYTICAL LITERATURE REVIEW AND CASE STUDY

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POVZETEK

Integracija družbeno in tehnološko napredne paliativne oskrbe je v socialno-varstvenih zavodih, s ciljem ohranjanja dostojanstva neozdravljivo bolnih, nujna. Vzpodbujati je potrebno integracijo paliativne oskrbe, ki je večdimenzionalna, trajnostna in usmerjena v relacijsko avtonomijo. Pomembnost tehnologije in prilagojene arhitekture za izboljšanje kakovosti življenja v takšnih okoljih je ključna. Namen prispevka je orisati večdimenzionalni sistem integracije družbeno in tehnološko napredne paliativne oskrbe v socialno-varstvenih zavodih. Uporabljena je bila integrativna analitična metoda pregleda literature in študija primera kjer smo združili rezultate pregleda obstoječe literature z študijo primera. Na podlagi vsebinske analize sta bila predstavljena dva koncepta: družbeno in tehnološko napredna paliativna oskrba v socialno-varstvenih zavodih in koncept opolnomočenja neozdravljivo bolnih. Analiza kaže, da je integracija družbeno in tehnološko napredne paliativne oskrbe v socialno-varstvenih zavodih ključna za ohranjanje avtonomije neozdravljivo bolnih. Spodbuja se večdimenzionalni pristop k integraciji paliativne oskrbe, ki vključuje tako fizično okolje kot tudi digitalne rešitve, ter nadaljnji razvoj in implementacijo tehnološko napredne paliativne oskrbe v socialno-varstvenih zavodih.

Ključne besede: paliativna oskrba, psihosocialni koncept dela, družbeni in tehnološki razvoj, dostojanstvo, varnost.

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ABSTRACT

The integration of socially and technologically advanced palliative care in social welfare institutions, with the aim of preserving the dignity of older adults with incurable disease, is essential. Encouraging the integration of palliative care, which is multidimensional, sustainable, and focused on relational autonomy, is necessary. The importance of technology and adapted architecture for improving the quality of life in such environments is crucial. The purpose of this contribution is to outline a multidimensional system for integrating socially and technologically advanced palliative care in social welfare institutions. An integrative analytical method of literature review and a case study were used, combining the results of existing literature review with the case study. Based on content analysis, two concepts were presented: socially and technologically advanced palliative care in social welfare institutions and the concept of empowering the older adults with incurable disease. The analysis shows that the integration of socially and technologically advanced palliative care in social welfare institutions is crucial for preserving the autonomy of the older adults with incurable disease. A multidimensional approach to integrating palliative care is encouraged, which includes both physical environments and digital solutions, as well as further development and implementation of technologically advanced palliative care in social welfare institutions.

Keywords: palliative care, psychosocial concept of work, social and technological development, dignity, safety.

UVOD

Eno od ključnih vprašanj, s katerimi se sooča javno zdravstvo, je svetovni trend starajoče se družbe (Fang idr. 2020, 5). Le ta postavlja odločevalce in izvajalce oskrbe pred zdravstvene in socialne izzive. Kellehear (2018) pravi, da je skrb za konec življenja vprašanje javnega zdravja. Kljub rasti gonilnikov potreb po paliativni oskrbi pa dostop do paliativne oskrbe ostaja neskladen tudi v državah z visokim dohodkom, saj se število izvajalcev razlikuje od 5 do 680 na milijon prebivalcev (Etkind idr. 2017).

Staranje je primarni prispevek k širokemu spektru kroničnih motenj, povezanih s slabšo kakovostjo življenja starejših odraslih (Fang idr. 2020, 4). Vse več bo oseb, ki bodo potrebovale paliativno oskrbo, ki bo zadostila njihovim potrebam (Van den Block idr., 2015) in posledično izboljšala kakovost bivanja neozdravljivo bolnih starejših odraslih.

Dostop do paliativne oskrbe je globalna človekova pravica (Zadeh idr. 2018), a je dostop do nje omejen, saj jo prejme le manjšina tistih, ki jo potrebujejo (Mills 2019). Posledično so vse prepogoste izkušnje neozdravljivo bolnih slaba komu-

nikacija, simptomi fizičnega trpljenja in potisnjenost na rob družbe. Da bi izboljšali dostop do paliativne oskrbe, moramo raziskati in razumeti raven potreb prebivalstva (Etkind idr. 2017). Primarni izzivi, s katerimi se soočamo pri starejših odraslih v mnogih državah sveta, so krhkost, sarkopenija, nevrodegenerativne bolezni, neozdravljiva kronična obolenja, bolezni srca in ožilja, motnje duševnega zdravja idr. (Fang idr. 2020, 4).

Sedanje potrebe prebivalstva po paliativni oskrbi so bile ocenjene v več državah z različnimi metodami za njeno merjenje (Morin idr. 2017), in sicer na osnovi posavljenih diagnoz (Kane idr. 2015), razširjenosti simptomov in raziskav prebivalstva (Kane idr. 2015; Etkind idr. 2017).

Trenutne razmere, povezane z pandemijo COVID-19, in kadrovska problematika predstavljajo za področje integrirane paliativne oskrbe v socialno varstvenih zavodih precejšen izziv v smislu zagotavljanja kakovostne paliativne oskrbe vključenih, njihovih svojcev in družine (Bolt idr. 2021). Integracija družbeno tehnološko napredne paliativne oskrbe v socialnovarstvenih zavodih je premalo raziskana in nedorečena. Potrebujemo raziskave in konceptualne zasnove, ki bodo omogočile razumevanje, kako optimalno vključiti digitalne rešitve v obstoječe okolje paliativne oskrbe.

Namen prispevka je orisati večdimenzionalni sistem integracije družbeno in tehnološko napredne paliativne oskrbe v socialnovarstvenih zavodih. Le-ta nam pomaga razumeti ali fizično okolje in prilagojena arhitektura vključno z naprednimi tehnologijami prispevajo k vzdrževanju avtonomije neozdravljivo bolnih, ki živijo v socialnovarstvenem zavodu in posledično potrdi ali paliativna oskrba sovпада z družbenim in tehnološkim napredkom.

Zanimalo nas je ali integracija paliativne oskrbe v socialnovarstveni zavod sovпада z družbenim in tehnološkim napredkom. Raziskovalni cilj je bil razviti razumevanje vpliva digitalnih in tehnološko naprednih rešitev na kakovost paliativne oskrbe v socialnovarstvenih zavodih ter preučiti njihovo učinkovitost pri izboljšanju življenja neozdravljivo bolnih.

V prispevku sta predstavljeni dve konceptualni zasnovi, ki temeljita na pregledu literature podatkovnih baz Pub med, Cochrane in Elsevier in študiji primera.

METODE

Uporabljena je bila integrativna analitična metoda pregleda literature in študija primera kjer smo združili rezultate pregleda obstoječe literature z študijo primera s ciljem celostne celovitega razumevanja obravnavanega problema in končno orisa večdimenzionalni sistem integracije družbeno in tehnološko napredne paliativne oskrbe v socialnovarstvenih zavodih.

Pregled na osnovi katerega smo kasneje strukturirali konceptualne zasnove upoštevajoč študijo primera, vključuje kvantitativne, kvalitativne študije in študije mešanih metod, ki proučujejo paliativno oskrbo in družbeno in tehnološko napredne storitve v socialnovarstvenih zavodih. Začetno iskanje je vključevalo pregled podatkovnih baz PubMed, Chochrane in Elsevier. Po iskanju so bili vsi ustrezní članki preneseni v aplikacijo Zotero in odstranjeni duplikati.

Metoda analize pregleda literature je vključevala temeljit pregled, sintezo in povzetek ugotovitev. Pregled je sledil smernicam PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) avtorjev Page idr. (2021). Uporabljena je bila deskriptivna raziskovalna metoda s pregledom literature, indeksirane v mednarodnih bazah podatkov. Uporabljena je bila PICO strategija, kjer smo kot populacijo izbrali neozdravljivo bolne starejše odrasle, ki bivajo v socialnovarstvenih zavodih. Intervencija kot takšna je bila paliativna oskrba v primerjavi s klasično oskrbo. Kot rezultat je bila sinteza ključnih ugotovitev: kakovost življenja, opolnomočen neozdravljivo bolni starejši odrasli, družbeno in tehnološko napredno okolje, opolnomočeni izvajalci paliativne oskrbe.

Med fazo pridobivanja in sintezo podatkov smo sledili smernicam za pripovedno sintezo predlagano s strani Popay in sodelavcev (2006).

MODEL PALIATIVNE OSKRBE S Poudarkom NA PSIHOSOCIALNEM PRISTOPU V SOCIALNOVARSTVENEM ZAVODU KOT ŠTUDIJA PRIMERA

Modeli oskrbe, naravnane na osebo, ki jih opazimo tudi v Domu starejših Šentjur, so bili v svetu izjemno dobro integrirani v prakso paliativne oskrbe obolelih z demenco in neozdravljivo bolnih, tako v institucijah kot tudi v primeru oskrbe na domu (Kogan idr. 2016, 2).

Da bi olajšali pristop oskrbe, ki je bolj osredotočen na osebo, domovi poskušajo spodbujati avtonomijo svojih stanovalcev (Brownie & Nancarrow 2013, 2). Cinahl, Academic Search Premier, Scopus, Proquest, and Expanded Academic ASAP databases for studies published between January 1995 and October 2012, using subject headings and free-text search terms (in UK and US English spelling). Z namenom vzpodbuditi avtonomije neozdravljivo bolnih starejših odraslih morajo formalni oskrbovalci vzdrževati in spodbujati avtonomijo odločanja, ko je zmožnost samostojnega izvajanja zmanjšana (McCormack 2004, 31). Zato je odnos med neozdravljivo bolnim starejšim odraslim, formalnimi in neformalnimi oskrbovalci in družino eden od glavnih elementov za ohranjanje avtonomije in izboljšanja kakovosti paliativne oskrbe (McCormack 2004, 37; Boumans idr. 2019, 709).

Poznavanje življenjske zgodbe posameznika lahko privede do spremembe v odnosu formalnega oskrbovalca: le-ta poskuša razumeti dejavnike, na katerih temelji vedenje stanovalcev, osredotoča se na sposobnosti stanovalcev names-

to na slabosti in spodbuja stanovalce, da sami pomagajo pri oskrbi, kadar je to mogoče (Doyle & Rubinstein 2014, 953; Boumans idr. 2019, 711). Vsekakor pa je to eden izmed izjemno pomembnih faktorjev vnaprejšnjega načrtovanja paliativne oskrbe.

Temeljni pomen psihosocialnega koncepta dela je normalizacija življenja. Le-ta je nepogrešljiv del celovite paliativne oskrbe. Psihosocialna perspektiva se uporablja v svetu za razumevanje trpljenja in za prepoznavanje aktivnosti za lajšanje trpljenja pri starejših odraslih z neozdravljivo boleznijo (Jacobsen in Breitbart 1996, 214), zavedajoč se, da vključuje fizične, psihološke, socialne in duhovne razsežnosti človeškega bitja, kar se zrcali v večprofesionalnem skupinskem pristopu (Voumard idr. 2018, 4).

REZULTATI – DVE KONCEPTUALNI ZASNOVI

Ob sintezi ključnih ugotovitev vključenih študij in študije primera smo oblikovali dve konceptualni zasnovi: družbeno in tehnološko napredna paliativna oskrba v socialnovarstvenih zavodih in koncept popolnomočenja neozdravljivo bolnih

DRUŽBENO IN TEHNOLOŠKO NAPREDNA PALIATIVNA OSKRBA

Potreba po okrepitvi in povečanju zagotavljanja paliativne oskrbe je bila izrecno izražena že v osnutku globalne strategije Svetovne zdravstvene organizacije (WHO) o zdravstvenem varstvu (2020–2024) (Mills 2019). Če naj bodo naša prizadevanja za reševanje te potrebe uspešna, bi morali upoštevati priporočila WHO o digitalnih intervencijah, ki pokrivajo več širših področij, pomembnih za paliativno oskrbo (World Health Organization 2019).

Zadnje življenjsko obdobje obsega dolgo fazo, za katero so značilne zapletene odločitve glede zdravljenja, težko obvladljivi simptomi, psihosocialne težave, duhovne stiske (Van den Block idr. 2015; Voumard idr. 2018, 6).

Elementi negovalnih pristopov in fizičnega okolja, ki vključuje napredne tehnologije, so ključni mehanizmi zagotavljanja družbeno in tehnološko napredne paliativne oskrbe v socialnovarstvenih zavodih (Boumans idr. 2019).

Študije (Buron 2010; Moyle idr. 2013, 587; Egan idr. 2007, 24; Eritz idr. 2016; McCormack 2004, 37) poudarjajo, da formalni oskrbovalci v primerih, ko imajo o starejšem odraslem več znanja in informacij, lažje razumejo osebo za pacientom in le tako izvajajo celovito družbeno in tehnološko paliativno oskrbo (Doyle in Rubinstein 2014, str. 952).

Za starejše odrasle, vključene v paliativno oskrbo, je pomembno ohranjanje avtonomije. Ker telesna funkcija upada in simptomi bolezni vplivajo na kakovost življenja, lahko starejši odrasli v zadnjem stadiju neozdravljive bolezni doživijo številne simptome, kot so utrujenost, tesnoba, strah, jeza, pruritus, bolečine,

motnje spanja, dispneja, slabost in depresija (Zadeh idr. 2018). Posledice občutijo tudi njihovi svojci in izvajalci zahtevnejše paliativne oskrbe, zato je izjemno pomemben celosten pristop, ki vključuje vse deležnike izvajanja storitev zdravstvene nege in oskrbe in je podprt z napredno digitalno tehnologijo. Pristopi oskrbe in fizično okolje, vključno s tehnologijami, prispevajo k ohranjanju avtonomije in zagotavljanju kakovostne formalne kot tudi neformalne oskrbe (Boumans idr. 2019).

Posebej oblikovani prostori, na primer terapevtski vrtovi, metode in tehnike dela ustvarjajo aktivnosti za stanovalce, ki zrcalijo njihovo identiteto in integriteto. Uporaba tehnologij zmanjša negovalčev čas za opravljanje primarnih nalog in zato omogoči sekundarne naloge, kot je interakcija s stanovalci, svojci in ostalimi zaposlenimi. Domovi, ki želijo izvajati personalizirano oskrbo, morajo ob upoštevanju vseh vidikov zagotavljanja kakovostne oskrbe nujno uvesti tudi psihosocialne pristope, vključno s tehnologijami, ki dodatno razbremenijo kader.

KONCEPT OPOLNOMOČENJA

Opolnomočenje neozdravljivo bolnih se kaže kot interakcija med neozdravljivo bolnim posameznikom in okoljem, v katerem biva. Skrbni pristopi in fizično okolje, vključno s tehnologijami, prispevajo k vzdrževanju avtonomije in kakovostne na osebo osredotočene oskrbe (Boumans idr. 2019, str. 1). V tem segmentu je izjemnega pomena komunikacija in interakcija z neozdravljivo bolnim. Pravilen pristop opolnomoči neozdravljivo bolnega (van Corven idr. 2021). Neozdravljivo bolni morajo biti slišani in videni.

Slika 1: koncept družbeno in tehnološko napredne paliativne oskrbe v sinergiji s konceptom opolnomočenja (oblikovani konceptualni zasnovi)



Vir: Lasten vir 2023.

Opolnomočenje prispeva k prehodu z oskrbe, usmerjene na storitev s poudarkom na bolezni, na oskrbo, usmerjeno na osebo (Kitwood 1997) in na odnos (Nolan idr. 2004, str. 46). Neozdravljivo bolni bi morali svoj dan živeti z občutkom vrednosti in ohranjenega dostojanstva (van Corven idr. 2021). Opolnomočenje pomaga določiti načine interakcije med neozdravljivo bolnim in njegovim okoljem. Zagotavlja konkretne priložnosti zdravstvenim delavcem in neformalnim oskrbovalcem (van Corven idr. 2021).

Koncept družbeno in tehnološko napredne paliativne oskrbe v sinergiji s konceptom opolnomočenja temelji na integraciji sodobnih tehnologij in družbenih pristopov za izboljšanje kakovosti življenja neozdravljivo bolnih. Ta oblikovana konceptualna zasnova združuje napredne prakse paliativne oskrbe s poudarkom na individualizirani obravnavi in celostni oskrbi s podporo tehnoloških inovacij. Hkrati pa poudarja vlogo opolnomočenja, ki neozdravljivo bolnim omogoča aktivno sodelovanje pri odločitvah o svojem zdravljenju in negi, ter jim daje občutek kontrole in dostojanstva. S tem se ustvarja holistično okolje, ki spodbuja fizično, psihično, socialno in duhovno blaginjo neozdravljivo bolnih in njihovih bližnjih v zadnjem obdobju življenja.

DISKUSIJA

Paliativna oskrba sovпада z digitalnim in tehnološkim napredkom. Veliko dokazov o obremenjujočih posegih, hospitalizacijah in obiskih bolnišnice v zadnjih mesecih življenja opozarja na napake pri usklajevanju paliativne oskrbe (Gozalo idr. 2011, 1215; Voumard idr. 2018, 3; Mitchell idr. 2009, 1532) in priča o pomembnosti zavedanja sovpadanja paliativne oskrbe z digitalnim in tehnološkim napredkom. Le to bi lahko bil razlog za bistveno manj napotitev in višji nivo ohranjanja dostojanstva neozdravljivo bolnih, ki bivajo v socialnovarstvenih zavodih. Družbeno in tehnološko napredno paliativno oskrbo zagotovo razumemo kot pristop, katerega namen je izboljšati kakovost življenja starejših odraslih, ki se soočajo z hudimi življenjsko ogrožajočimi stanji ob poslabšanju bolezni. Izjemno pomembno je sodelovanje strokovnjakov paliativne oskrbe in socialne gerontologije, saj lahko le tako izvajamo celovito paliativno oskrbo, ki se osredotoča na osebo in njeno družino (Voumard idr. 2018, 3). Komplementarnost obeh strok je lahko odlično izhodišče za zagotavljanje boljše kakovosti življenja starejših odraslih.

Med številnimi izzivi na področju paliativne oskrbe starejših odraslih v socialnovarstvenih zavodih in na ostalih ravneh velja poudariti slab izkoristek tehnološkega napredka, pomanjkanje intervencij paliativne oskrbe, ki temeljijo na metodološko in etično zanesljivih raziskavah (metodološko težavne študije – vključitev starejših odraslih s težje napredovalimi boleznimi – kognitivne težave...) (Voumard idr. 2018, 4). Velik izziv predstavlja tudi sprejemanje odločitev glede zdravstvene

in socialne oskrbe ob koncu življenja. Ta proces otežuje vrsta dejavnikov: komunikacijske ovire, pomanjkljivosti v spominskih funkcijah, ki zahtevajo rekonstrukcijo pripovedi in osebnih vrednot neozdravljivo bolnih starejših odraslih, napetost med interesi neozdravljivo bolnih, ki niso sposobni samostojnega odločanja, in njihovih pooblaščenecv (Kuehlmeyer idr. 2015, 2544; Silveira idr. 2010, 1211). Skrbniki, ki odločajo v imenu neozdravljivo bolnih starejših odraslih, morajo uporabljati preudarno presojo in se izogniti dvojni pasti nezadostnega zdravljenja in prekomernega zdravljenja (Voumard idr. 2018, 4). Istočasno se poraja vprašanje ohranjanja avtonomije posameznika, osebne identitete in integritete.

Do sedaj uporabljeni inštrumenti za zagotavljanje oskrbe v skladu z željami neozdravljivo bolnega so daleč od idealnega: vnaprejšnje direktive niso tako učinkovite, kot je bilo pričakovati, in nadomestne odločevalce pogosto celo zmedejo (Shalowitz in Silveira 2010, 35). Za vključene v paliativno oskrbo so značilni številni prehodi med posameznimi nivoji zdravstvenega varstva. Tukaj predstavlja velik izziv usklajevanje oskrbe s ciljem zmanjšanja nepotrebnih prehodov neozdravljivo bolnega starejšega odraslega v socialnovarstvenem zavodu. Pomanjkanje usklajevanja je glavni vzrok za nesmotrno porabljene finančne vire, slabšanje zdravstvenega sistema in zmanjšanja kakovosti oskrbe (Berwick in Hackbarth 2012, 1513)1513. Neravnovesje med množico specialistov in pomanjkanjem kontinuirane oskrbe (Boyd idr. 2005, 716), povečano polifarmacijo in nasprotujočimi si priporočili velikokrat bolj škoduje kot koristi neozdravljivo bolnemu starejšemu odraslemu v socialnovarstvenem zavodu ali doma. Posledično govorimo o slabši kakovosti življenja.

Da bi vzpodbudili klinične raziskave na tem področju, je potrebna javna prepoznavnost, izražena s posebnimi financirani programi, akademskimi prizadevanji in prenosom znanja laični javnosti. Za doseg učinkovite podpore pri izvedbi vnaprejšnjega načrtovanja oz. odločanja je velik izziv še vedno celovita komunikacijska podpora (Mullick idr. 2013, 28). Za veliko neozdravljivo bolnih starejših odraslih, ki so že izgubili sposobnost izražanja preferenc glede oskrbe, je ključna presoja njihovih pooblaščenecv (posredniki za vnaprejšnje načrtovanje oskrbe) v sodelovanju z zdravstvenimi delavci, upoštevajoč poznavanje življenjske zgodbe in vrednot starejšega odraslega (Volicer idr. 2002, 761).

Slabo usklajevanje oskrbe je mogoče in potrebno obravnavati na različnih mestih – bolnišnica, socialnovarstveni zavod, dom. Nujno je, da oskrbo hudo bolnih starejših odraslih skrbno načrtujemo, predvidimo poslabšanja, pripravimo načrt zanje, omogočimo stalna posvetovanja strokovnjakov in zagotovimo čim manj prehodov neozdravljivo bolnega (Voumard idr. 2018, 6). Dobro usklajevanje oskrbe dejansko izboljša kakovost življenja, omejuje škodo, povezano z zdravljenjem neozdravljivo bolnega starejšega odraslega, prihrani nepotrebne stroške (prevoz, napotitve, preiskave po sprejemu, skladne s sprejemnimi protokoli, agresivno zdravljenje) in hkrati izboljša kakovost življenja družine neozdravljivi-

vo bolnega starejšega odraslega, vključenega v proces paliativne oskrbe (Tinetti idr. 2016, 261) burdensome, and of unclear benefit. An advisory group of patients, caregivers, clinicians, health system engineers, health care system leaders, payers, and others identified three modifiable contributors to this fragmented, burdensome care: decision making and care focused on diseases, not patients; inadequate delineation of roles and responsibilities and accountability among clinicians; and lack of attention to what matters to patients and caregivers (ie, their health outcome goals and care preferences).

Na področju izvajanja celovite paliativne oskrbe velik izziv predstavlja tudi digitalna povezanost programov znotraj posameznih ravni zdravstvenega varstva. Učinkovita izmenjava informacij med posameznimi deležniki bi zagotovo predstavljala velik doprinos h kakovosti življenja neozdravljivo bolnega starejšega odraslega v socialnovarstvenem zavodu in zagotovila manjšo možnost napak ter celovitejšo paliativno oskrbo. Uporaba telemedicine in ostalih tehnološko naprednih struktur je ključna za doseg te ciljev.

Omejitve, ki jih je potrebno poudariti pri našem integrativnem analitičnem pregledu literature in študiji primera so omejena količina literature, omejena raznolikost virov, omejen pogled, omejena izkušnja, heterogenost, omejenost na angleški jezik in omejena preglednost. Kljub vsem navedenim omejitvam raziskava dalje izhodišča raziskovanja zelo pomembnih segmentov paliativne oskrbe.

ZAKLJUČEK

Velik izziv pri zagotavljanju celovite kongruentne paliativne oskrbe je zagotovitev dostopnih visokokakovostnih storitev paliativne oskrbe na vseh ravneh zdravstvenega varstva. V socialnovarstvenih zavodih je potrebno spodbujati integracijo paliativne oskrbe, ki je večdimenzionalna, trajnostna in usmerjena v relacijsko avtonomijo. Strokovnjaki, ki izvajajo paliativno oskrbo, se morajo ves čas odzivati na potrebe in pričakovanja neozdravljivo bolnih starejših odraslih in njihovih družim. V tej fazi življenja starejših odraslih postanejo tesna razmerja zaupanja odločilna in se odražajo v odnosu in odgovornosti, ki se pričakuje od izvajalcev paliativne oskrbe v socialnovarstvenih zavodih.

Pomembno je spodbujanje starosti prijaznega bivalnega okolja, podprtega z digitalno tehnologijo, ki bo omogočalo ohranjanje identitete in integritete posameznika, družine in skupnosti znotraj doma. Potrebujemo nadaljne raziskave in konceptualne zasnove, ki bodo omogočile razumevanje, kako optimalno vključiti digitalne rešitve v obstoječe okolje paliativne oskrbe. Poleg tega je treba razviti strategije za opolnomočenje neozdravljivo bolnih z uporabo teh tehnologij, da bi jim omogočili večjo avtonomijo in dostojanstvo v procesu oskrbe. Ključni izzivi vključujejo oblikovanje prilagojenega fizičnega in digitalnega okolja ter

nadaljnji razvoj ter implementacijo tehnološko napredne paliativne oskrbe v socialnovarstvenih zavodih.

LITERATURA

1. Berwick, Donald M. in Andrew D. Hackbarth. 2012. „Eliminating Waste in US Health Care“. *JAMA* 307 (14): 1513–16. doi:10.1001/jama.2012.362.
2. Bolt, Sascha R., Jenny T. van der Steen, Irma Mujezinović, Daisy J. A. Janssen, Jos M. G. A. Schols, Sandra M. G. Zwakhalen, Chandni Khemai, Els P. A. G. M. Knapen, Lara Dijkstra in Judith M. M. Meijers. 2021. „Practical Nursing Recommendations for Palliative Care for People with Dementia Living in Long-Term Care Facilities during the COVID-19 Pandemic: A Rapid Scoping Review“. *International Journal of Nursing Studies* 113 (januar): 103781. doi:10.1016/j.ijnurstu.2020.103781.
3. Boumans, J., L.C. van Boekel, C.A. Baan in K.G. Luijkx. 2019. „How can autonomy be maintained and informal care improved for people with dementia living in residential care facilities: A systematic literature review“. *The Gerontologist* 59 (6): 709–30. doi:10.1093/geront/gny096.
4. Boyd, Cynthia M., Jonathan Darer, Chad Boulton, Linda P. Fried, Lisa Boulton in Albert W. Wu. 2005. „Clinical Practice Guidelines and Quality of Care for Older Patients with Multiple Comorbid Diseases: Implications for Pay for Performance“. *JAMA* 294 (6): 716–24. doi:10.1001/jama.294.6.716.
5. Brownie, Sonya in Susan Nancarrow. 2013. „Effects of Person-Centered Care on Residents and Staff in Aged-Care Facilities: A Systematic Review“. *Clinical Interventions in Aging*, januar, 1. doi:10.2147/CIA.S38589.
6. Buron, Bill. 2010. „Life History Collages“. *Journal of Gerontological Nursing* 36 (12). SLACK Incorporated: 38–48. doi:10.3928/00989134-20100602-01.
7. Corven, Charlotte T. M. van, Annemiek Bielderman, Mandy Wijnen, Ruslan Leontjevas, Peter L. B. J. Lucassen, Maud J. L. Graff in Debby L. Gerritsen. 2021. „Defining Empowerment for Older People Living with Dementia from Multiple Perspectives: A Qualitative Study“. *International Journal of Nursing Studies* 114 (februar): 103823. doi:10.1016/j.ijnurstu.2020.103823.
8. Doyle, Patrick J. in Robert L. Rubinstein. 2014. „Person-Centered Dementia Care and the Cultural Matrix of Othering“. *The Gerontologist* 54 (6): 952–63. doi:10.1093/geront/gnt081.
9. Egan, Mary Y., Sally Munroe, Camille Hubert, Trish Rossiter, Annie Gauthier, Margaret Eisner, Nicole Fulford, Marilyn Neilson, Bonnie Daros in Carmen Rodrigue. 2007. „Caring for Residents with Dementia and Aggressive Behavior: Impact of Life History Knowledge“. *Journal of Gerontological Nursing* 33 (2): 24–30. doi:10.3928/00989134-20070201-06.

10. Eritz, Heather, Thomas Hadjistavropoulos, Jaime Williams, Kristine Kroeker, Ronald R. Martin, Lisa M. Lix in Paulette V. Hunter. 2016. „A Life History Intervention for Individuals with Dementia: A Randomised Controlled Trial Examining Nursing Staff Empathy, Perceived Patient Personhood and Aggressive Behaviours“. *Ageing & Society* 36 (10). Cambridge University Press: 2061–89. doi:10.1017/S0144686X15000902.
11. Etkind, S. N., A. E. Bone, B. Gomes, N. Lovell, C. J. Evans, I. J. Higginson in F. E. M. Murtagh. 2017. „How many people will need palliative care in 2040? Past trends, future projections and implications for services“. *BMC Medicine* 15 (1): 102. doi:10.1186/s12916-017-0860-2.
12. Fang, Evandro F., Chenglong Xie, Joseph A. Schenkel, Chenkai Wu, Qian Long, Honghua Cui, Yahyah Aman, idr. 2020. „A Research Agenda for Ageing in China in the 21st Century (2nd Edition): Focusing on Basic and Translational Research, Long-Term Care, Policy and Social Networks“. *Ageing Research Reviews* 64 (december): 101174. doi:10.1016/j.arr.2020.101174.
13. Gozalo, Pedro, Joan M. Teno, Susan L. Mitchell, Jon Skinner, Julie Bynum, Denise Tyler in Vincent Mor. 2011. „End-of-Life Transitions among Nursing Home Residents with Cognitive Issues“. *New England Journal of Medicine* 365 (13). Massachusetts Medical Society: 1212–21. doi:10.1056/NEJMs1100347.
14. Jacobsen, Paul B. in William Breitbart. 1996. „Psychosocial Aspects of Palliative Care“. *Cancer Control* 3 (3). SAGE Publications Inc: 214–22. doi:10.1177/107327489600300303.
15. Kane, Pauline M., Barbara A. Daveson, Karen Ryan, Regina McQuillan, Irene J. Higginson in Fliss E. M. Murtagh. 2015. „The Need for Palliative Care in Ireland: A Population-Based Estimate of Palliative Care Using Routine Mortality Data, Inclusive of Nonmalignant Conditions“. *Journal of Pain and Symptom Management* 49 (4). Elsevier: 726–733.e1. doi:10.1016/j.jpainsymman.2014.09.011.
16. Kitwood, Tom. 1997. *Dementia Reconsidered: The Person Comes First*. 1st edition. Buckingham England ; Philadelphia: Open University Press.
17. Kogan, Alexis Coulourides, Kathleen Wilber in Laura Mosqueda. 2016. „Person-Centered Care for Older Adults with Chronic Conditions and Functional Impairment: A Systematic Literature Review“. *Journal of the American Geriatrics Society* 64 (1): e1–7. doi:10.1111/jgs.13873.
18. Kuehlmeyer, Katja, Anna F. Schuler, Christian Kolb, Gian Domenico Borasio in Ralf J. Jox. 2015. „Evaluating Nonverbal Behavior of Individuals with Dementia During Feeding: A Survey of the Nursing Staff in Residential Care Homes for Elderly Adults“. *Journal of the American Geriatrics Society* 63 (12): 2544–49. doi:10.1111/jgs.13822.

19. McCormack, Brendan. 2004. „Person-Centredness in Gerontological Nursing: An Overview of the Literature“. *Journal of Clinical Nursing* 13 (s1): 31–38. doi:10.1111/j.1365-2702.2004.00924.x.
20. Mills, Jason. 2019. „Digital health technology in palliative care: Friend or foe?“ *Progress in Palliative Care* 27 (4). Taylor & Francis: 145–46. doi:10.1080/09699260.2019.1650420.
21. Mitchell, Susan L., Joan M. Teno, Dan K. Kiely, Michele L. Shaffer, Richard N. Jones, Holly G. Prigerson, Ladislav Volicer, Jane L. Givens in Mary Beth Hamel. 2009. „The Clinical Course of Advanced Dementia“. *The New England Journal of Medicine* 361 (16): 1529–38. doi:10.1056/NEJMoa0902234.
22. Morin, Lucas, Régis Aubry, Luisa Frova, Roderick MacLeod, Donna M. Wilson, Martin Loucka, Agnes Csikos, idr. 2017. „Estimating the Need for Palliative Care at the Population Level: A Cross-National Study in 12 Countries“. *Palliative Medicine* 31 (6): 526–36. doi:10.1177/0269216316671280.
23. Moyle, Wendy, Lorraine Venturato, Marie Cooke, Julian Hughes, Sierra van Wyk in Jenni Marshall. 2013. „Promoting value in dementia care: Staff, resident and family experience of the capabilities model of dementia care“. *Aging & Mental Health* 17 (5). Routledge: 587–94. doi:10.1080/13607863.2012.758233.
24. Mullick, Anjali, Jonathan Martin in Libby Sallnow. 2013. „An Introduction to Advance Care Planning in Practice“. *BMJ (Clinical Research Ed.)* 347 (oktober): f6064. doi:10.1136/bmj.f6064.
25. Nolan, Mike R., Sue Davies, Jayne Brown, John Keady in Janet Nolan. 2004. „Beyond ‚person-Centred‘ Care: A New Vision for Gerontological Nursing“. *Journal of Clinical Nursing* 13 (s1): 45–53. doi:10.1111/j.1365-2702.2004.00926.x.
26. Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D. ... Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, 372, Article n71
27. PMID:33782057; PMCID:PMC8005924
28. Popay, J., Roberts, H. in Sowden, A., 2006. Guidance on the conduct of narrative
29. synthesis in systematic reviews. A product from the ESRC Methods Programme. Swindon: Economic and Social Research Council.
30. Shalowitz, David I. in Maria J. Silveira. 2010. „Building a Better Advance Directive: Next Steps“. *The American Journal of Bioethics* 10 (4): 34–36. doi:10.1080/15265161003650502.
31. Silveira, Maria J., Scott Y. H. Kim in Kenneth M. Langa. 2010. „Advance Directives and Outcomes of Surrogate Decision Making before Death“. *The New England Journal of Medicine* 362 (13): 1211–18. doi:10.1056/NEJMsa0907901.

32. Tinetti, Mary E., Jessica Esterson, Rosie Ferris, Philip Posner in Caroline S. Blum. 2016. „Patient Priority-Directed Decision Making and Care for Older Adults with Multiple Chronic Conditions". *Clinics in Geriatric Medicine* 32 (2): 261–75. doi:10.1016/j.cger.2016.01.012.
33. Van den Block, Lieve, Gwenda Albers, Sandra Martins Pereira, Bregje Onwuteaka-Philipsen, Roeline Pasma in Luc Deliens, ur. 2015. *Palliative Care for Older People: A Public Health Perspective*. Oxford: Oxford University Press. doi:10.1093/acprof:oso/9780198717614.001.0001.
34. Volicer, Ladislav, Michael D. Cantor, Arthur R. Derse, Denise Murray Edwards, Angela M. Prudhomme, Dorothy C. Rasinski Gregory, James E. Reagan, James A. Tulsky, Ellen Fox in National Ethics Committee Of The Veterans Health Administration. 2002. „Advance Care Planning by Proxy for Residents of Long-Term Care Facilities Who Lack Decision-Making Capacity". *Journal of the American Geriatrics Society* 50 (4): 761–67. doi:10.1046/j.1532-5415.2002.50175.x.
35. Voumard, R., E. Rubli Truchard, L. Benaroyo, G. D. Borasio, C. Büla in R. J. Jox. 2018. „Geriatric palliative care: a view of its concept, challenges and strategies". *BMC Geriatrics* 18 (1): 220. doi:10.1186/s12877-018-0914-0.
36. World Health Organization. 2019. *WHO Guideline: Recommendations on Digital Interventions for Health System Strengthening*. Geneva: World Health Organization. <https://apps.who.int/iris/handle/10665/311941>.
37. Zadeh, Rana Sagha, Paul Eshelman, Judith Setla, Laura Kennedy, Emily Hon in Aleksa Basara. 2018. „Environmental Design for End-of-Life Care: An Integrative Review on Improving the Quality of Life and Managing Symptoms for Patients in Institutional Settings". *Journal of Pain and Symptom Management* 55 (3). Elsevier: 1018–34. doi:10.1016/j.jpainsymman.2017.09.011.

TAILORING HEALTHCARE TO GENERATIONAL NEEDS: A CROSS-SECTIONAL STUDY OF HEALTHCARE PERSPECTIVES AMONG THE VETERAN AND BABY BOOM GENERATIONS

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ABSTRACT

Introduction: Given the aging population, it is necessary to tailor healthcare services to the specific needs of the largest patient groups. Therefore, this study aimed to examine the differences in expectations and preferences for healthcare between the Veteran generation and the Baby Boom generation, as well as to determine the association of these variables with age groups.

Methods: The study was conducted using a cross-sectional research design with a self-developed questionnaire. Data were collected from November 27 to November 30, 2023, in a nursing home and a home healthcare institution. Mann-Whitney U test, chi-square test, and Spearman's correlation coefficient were used for the analysis.

Results: The study included 72 participants. A statistically significant difference between the generations was found in the preferences for the use of technology ($P < 0.05$). Additionally, a statistically significant negative correlation was identified between age and comfort in asking questions and expressing needs to healthcare providers, as well as between age and the rating of accessibility of information about one's health status ($P < 0.05$).

Conclusion: The research indicates that members of the Baby Boom generation exhibit a greater inclination toward using modern technologies in healthcare, whereas the Veteran generation prefers more traditional approaches. The findings provide a basis for developing tailored communication strategies and innovative healthcare models to better meet the needs of older patients.

Keywords: expectations, preferences, healthcare, Baby Boom generation, Veteran generation.

INTRODUCTION

The current demographic environment for aging populations is marked by a global rise in life expectancy along with a decline in fertility rates (Busetta and Bono 2021). As a result, the age composition of the population is shifting toward a larger proportion of elderly individuals, leading to significant changes in overall demographic structure (Wu et al. 2022). It is anticipated that by 2050, the

number of individuals aged 65 and older will reach 1.5 billion, making up 16% of the world's population (Fakhro 2018; Busetta and Bono 2021; Gnanasabai et al. 2020). Among older adults, two particularly notable cohorts are the Veteran generation—comprising those born before World War II—and the Baby Boom generation, whose members were born between 1946 and 1962 (Appelbaum et al. 2004). A key factor that differentiates these groups is their social values.

Ullrich (2017) reports that Baby Boomers generally hold more progressive views on social issues and demonstrate greater tolerance toward racial, gender, and familial diversity, whereas the Veteran generation tends to favor conservative principles and traditional customs. Differences are also evident in digital engagement; while Baby Boomers grew up during a period of rapid technological innovation, the entry of the Veteran generation into the digital realm was largely influenced by their socioeconomic status and educational background (Lissitsa et al. 2022). Despite being more adept with digital technology, Baby Boomers seem to trail behind the Veteran generation in adopting healthy lifestyles and in their self-perceived health (Shen 2019). Davis and Roberts (2010) express concerns over physical inactivity, obesity, and low vegetable consumption among Baby Boomers, which have contributed to an increased prevalence of chronic conditions. Consequently, it is expected that the healthcare expectations of the Baby Boom generation will differ from those of the older Veteran generation (Gill and Cameron 2022).

Understanding the varied healthcare expectations of both the Baby Boom and Veteran generations highlights the necessity of tailoring healthcare services to the distinct characteristics of each group. However, despite the significance of this issue, research exploring the expectations and preferences of these generational cohorts within healthcare remains scarce. This study aims to bridge that gap by elucidating differences in healthcare needs and by aligning services with individual preferences and expectations. Ultimately, the goal of this research is to lay the groundwork for developing customized healthcare strategies that enhance both the quality and efficiency of healthcare services in addressing the unique needs of older populations.

Literature Review

The evolving landscape of healthcare for older adults is marked by notable differences and overlaps in the challenges faced by distinct generational cohorts. In the United States, for instance, the Baby Boom generation—comprising over 73 million individuals (U.S. Department of Health and Human Services 2019)—has increasingly come under scrutiny for its healthcare needs. Despite common perceptions of superior health, Badley et al. (2015) argue that no convincing evidence exists to suggest that Baby Boomers are healthier than their predecessors.

On the contrary, investigations by Luo and Gao (2020) and Ramage-Morin and Polsky (2020) have documented elevated rates of chronic diseases and disabilities among these older adults. Chronic conditions, including diabetes, cardiovascular diseases, and obesity, persist as ongoing concerns, necessitating continuous medical attention (Xiong et al. 2020). This trend not only shifts the balance toward specialized over primary care—as noted by Canizares et al. (2016)—but also portends rising healthcare expenditures.

In response to these challenges, Fiorillo and Gorwood (2020) emphasize the importance of tailoring healthcare services to meet the specific needs of aging Baby Boomers. This generation is uniquely characterized by its proactive and resourceful approach to health management. As Pelok (2023) highlights, Baby Boomers are both goal-oriented and confident, frequently leveraging online resources to inform their health decisions. Nevertheless, as Lissitsa et al. (2022) and Gill and Cameron (2022) point out, they still value confirmation from trusted healthcare professionals. This blend of self-assurance and collaborative decision-making—further elaborated by Kahana and Kahana (2014) and Seale et al. (2019)—underscores a shift toward more informed, yet shared, medical choices.

In contrast, the Veteran generation, whose members were born before World War II, confronts a different set of challenges as they advance in age. Individuals over 85 represent one of the fastest-growing segments in developed countries (Motl and McAuley 2010), and projections indicate that by 2030, the U.S. will be home to approximately 19.5 million people over 80 years old (Gjonça and Calderwood, 2003). Characterized by a stoic resilience and a capacity for adaptation (Ulrich 2017), this group nevertheless experiences significant age-related health declines. For example, research by Bermejo Boixareu et al. (2023) on centenarians with frail hip fractures revealed high rates of dementia and institutionalization, predominantly among women. Yet, in a somewhat paradoxical finding, Araújo and Ribeiro (2011) observed that many in this generation rate their health more favorably than expected despite evident physical decline.

Beyond the challenges of advanced age, members of the Veteran generation face a spectrum of health issues—including cognitive impairment, depression, anxiety, and an array of physical ailments such as musculoskeletal problems, sensory deficits, insomnia, and dental issues (Lee et al. 2020). The compounded effects of cognitive decline and reduced daily functioning further underscore the need for integrated health and social care (Gosney 2009; Bhattarai, 2014). Moreover, entrenched traditional values often predispose these individuals to favor a more guided, less autonomous role in their healthcare decisions, as evidenced by the work of Reed et al. (2008) and Black et al. (2011). This inclination toward a simplified decision-making process is associated with higher reported satisfaction with their healthcare services and fewer access issues (Banerjee, 2015).

Together, these insights highlight the necessity for healthcare systems to adapt dynamically to the varied needs of aging populations. By acknowledging the distinct yet interrelated profiles of both Baby Boomers and the Veteran generation, providers can better navigate the balance between fostering patient autonomy and offering the structured support required for optimal health outcomes.

PURPOSE AND GOALS

Objectives

The research objectives were as follows:

1. Explore differences in expectations and preferences for healthcare between the Veteran generation and the Baby Boom generation.
2. Determine if there is a statistically significant correlation between age group membership and expectations and preferences for healthcare.

Hypotheses

- H1. There is a statistically significant difference in expectations and preferences for healthcare between the Veteran generation and the Baby Boom generation.
- H2. There is a statistically significant correlation between age group membership and expectations and preferences for healthcare.

METHODS

Study Design

The study employed a cross-sectional research design to determine differences in expectations and preferences for healthcare between the Veteran generation and the Baby Boom generation, as well as correlations between age and the mentioned variables. The research was conducted from November 27 to November 30, 2023, at a Nursing Home and a Home Healthcare Institution.

Sample

To participate in the study, participants had to meet the following criteria: (1) belong to the Veteran or Baby Boom generation, (2) be willing to participate in the research, and (3) have preserved cognitive functions. Sampling was carried out using age-stratified methods, limiting inclusion to individuals born in precisely defined periods—between 1925 and 1945 for the Veteran generation and between 1946 and 1964 for the Baby Boom generation. Potential participants were recruited in collaboration with the administrators of the nursing home and the home healthcare institution. Researchers personally approached candidates and provided detailed explanations regarding the purpose, procedures, duration of the study, and participation requirements. Before inclusion, participants were

given a comprehensive overview of all study aspects and provided opportunities to ask questions and receive further clarification. This process ensured voluntary participation and full informed consent, confirmed by signing the consent forms.

Ethical Considerations

Participants provided informed consent to participate, and all research procedures were conducted in accordance with the ethical principles outlined in the Helsinki Declaration. Anonymity and confidentiality of data were ensured through appropriate measures to protect privacy and data security. Ethical approval for the study was obtained from the ethics committee of the LEKIĆ Healthcare Institution and the Nursing Home for the Elderly and Disabled in Varaždin. Prior to participation, all participants were informed both in writing and verbally about the purpose and procedures of the study, their rights, and the voluntary nature of participation, and they confirmed their consent by signing the informed consent forms.

Instrument

Data were collected using a self-developed questionnaire consisting of three sets of questions. The first part of the questionnaire addressed sociodemographic data (age, gender, marital status, education level, and place of residence). The second part comprised ten questions regarding participants' expectations about healthcare provision, while the third part contained eight questions focusing on their preferences for healthcare. Seven questions were closed-ended, allowing selection from provided options, while participants expressed their level of agreement or disagreement on eleven questions using a five-point Likert scale. Although the questionnaire was tailored to the specific needs of the study, its validity and reliability were not previously tested in a pilot study. This represents a potential limitation of the research, as the instrument's measurement accuracy is unconfirmed, which may affect the interpretation of the results. Therefore, further verification and possible adaptation of the questionnaire are recommended for future studies.

Statistical Analysis

After reviewing and organizing the data, statistical analysis was performed using STATISTICA 12 statistical software. Response structures to survey questions were presented in tabular form using absolute and relative frequencies. Numerical values were represented using medians as central values and interquartile range as an indicator of deviation from the mean. Mann-Whitney U test and chi-square test were applied to examine statistically significant differences in expectations and preferences for healthcare between the Veteran generation and the Baby Boom generation. Spearman's correlation coefficient was used to determine statistically significant associations between age group membership and expectations and preferences for healthcare. An alpha level of $P < 0.050$ was considered statistically significant.

RESULTS

Sample Characteristics

There were 40 female participants (55.56%), constituting 1.25 times the representation of male participants, who numbered 32 (44.44%). Regarding marital status, the majority of participants were widows/widowers, totaling 34 (47.22%), which is 4.86 times more than the representation of unmarried individuals, numbering 7 (9.72%). There were 37 participants from the Veteran generation (51.39%), representing 1.06 times more than the Baby Boom generation participants, who numbered 35 (48.61%). In terms of education level, the majority of participants completed at least secondary vocational education, with 33 (45.83%), which is 3.67 times more than those with at least a college or higher education degree, numbering 9 (12.50%). Regarding the place of residence, the majority of participants were from urban areas, totaling 43 (59.72%), which is 1.48 times more than the representation of participants from rural areas, numbering 29 (40.28%) (Table 1).

Table 1. Sociodemographic Characteristics of Participants

Gender				
	n	%	χ^2	P
M	32	44,44	0,89	0,346
F	40	55,56		
Marital Status				
unmarried/single	7	9,72		
married	31	43,06	18,25	<0,001
widower/widow	34	47,22		
Generation				
Veterans	37	51,39	0,06	0,814
Baby Boom	35	48,61		
Education Level				
completed elementary school (4, 6, or 8 years)	30	41,67		
completed high school or vocational education	33	45,83	14,25	0,001
completed college or higher education	9	12,50		
Place of Residence				
city	43	59,72	2,72	0,099
village	29	40,28		

* χ^2 test

Testing hypotheses

H1. There is a statistically significant difference in expectations and preferences for healthcare between the Veteran and Baby Boomer generations.

Among respondents from the Veteran and Baby Boomer generations, high expectations were observed regarding the importance of traditional values in healthcare provision (Mdn = 5.00), the flexibility to choose their own healthcare services while receiving care (Mdn = 5.00), the emotional support from healthcare providers during care (Mdn = 5.00), and trust in current healthcare providers (Mdn = 5.00). However, the study did not find a statistically significant difference ($P > 0.050$). Additionally, Veteran generation respondents rated the importance of participating in decision-making about their own healthcare one point higher than Baby Boomer generation respondents, but this difference was not statistically significant ($Z = 1.13$; $P = 0.258$).

Among Baby Boomer generation respondents, a two-point higher level of comfort in asking questions and expressing needs during conversations with healthcare providers was observed compared to Veteran generation respondents; however, this difference was not statistically significant ($Z = 1.84$; $P = 0.065$). Similarly, Baby Boomer respondents rated the accessibility of information about their health condition provided by current healthcare providers one point higher than Veteran respondents, but this difference was also not statistically significant ($Z = 1.77$; $P = 0.076$). The importance of open communication with medical staff about their health condition was extremely low and did not differ between the two groups ($Z = 1.50$; $P = 0.133$). Finally, Baby Boomer respondents rated the importance of involving family in the decision-making process regarding their own health plan one point higher than Veteran respondents, yet this difference was not statistically significant ($Z = 0.68$; $P = 0.494$).

The importance of medical staff's use of technology to improve the quality of healthcare was rated as moderate (Mdn = 3.00) and did not differ between Baby Boomer and Veteran generation respondents; the study did not find a statistically significant difference ($Z = 0.22$; $P = 0.827$). Among Baby Boomer generation respondents, there was a one-point higher rating for the necessity of receiving continuous healthcare from the same providers compared to Veteran generation respondents, but this difference was not statistically significant ($Z = 1.88$; $P = 0.061$). The obtained results are succinctly presented in Table 2.

Table 2. Expectations and preferences among members of the Veteran and Baby Boom generations (Mann-Whitney U test)

	Veterans			Baby Boom			U	Z	P
	n	Mdn	IQR	n	Mdn	IQR			
1. How would you rate the importance of traditional values in providing healthcare?	37	5,00	(4,00-5,00)	35	5,00	(4,00-5,00)	594,50	0,68	0,496
2. How important is it for you to participate in making decisions about your own healthcare?	37	5,00	(4,00-5,00)	35	4,00	(4,00-5,00)	558,00	1,13	0,258
3. How important is it for you to have flexibility in choosing while receiving healthcare?	37	5,00	(4,00-5,00)	35	5,00	(4,00-5,00)	605,00	0,54	0,591
4. How important is the emotional support from healthcare providers during the delivery of healthcare?	37	5,00	(4,00-5,00)	35	5,00	(4,00-5,00)	619,50	0,37	0,709
5. How comfortable do you expressing your needs when talking to a healthcare provider?	37	1,00	(1,00-4,00)	35	3,00	(1,00-5,00)	492,50	1,84	0,065
6. What is your level of trust in current healthcare providers?	37	5,00	(4,00-5,00)	35	5,00	(4,00-5,00)	597,50	0,63	0,528
7. How would you rate the about your health condition from your current healthcare providers?	37	2,00	(1,00-4,00)	35	3,00	(2,00-4,00)	493,50	1,77	0,076
9. How important is open communication with medical condition to you?	37	1,00	(1,00-2,00)	35	1,00	(1,00-4,00)	535,50	1,50	0,133
10. How would you rate the importance of involving your family in the decision-making process in your health plan?	37	1,00	(1,00-3,00)	35	2,00	(1,00-4,00)	590,50	0,68	0,494
17. How important is it to you that medical staff use technology to improve the quality of healthcare?	37	3,00	(1,00-4,00)	35	3,00	(2,00-4,00)	628,00	0,22	0,827
18. How essential is it for you to receive continuous healthcare from the same healthcare providers?	37	1,00	(1,00-3,00)	35	2,00	(1,00-5,00)	494,00	1,88	1,88

*Mann-Whitney U test

Among respondents belonging to the Baby Boom generation, the most common expectation was that healthcare providers would be available for emergencies only during working hours. This attitude was 1.06 times more common among Baby Boom respondents compared to those from the Veteran generation, with no statistically significant difference found ($\chi^2 = 0.07$; $P = 0.791$). Additionally, Baby Boom respondents most frequently preferred to have individual consultations with healthcare professionals about their health once a month—a preference that was 1.29 times more common than that of Veteran generation respondents, although no statistically significant difference was observed ($Z = 0.05$; $P = 0.961$).

Respondents from the Baby Boom generation most often prioritized quick access to healthcare providers in response to their health condition ($n = 19$; 54.19%), whereas members of the Veteran generation most often prioritized clear guidelines ($n = 23$; 62.16%). However, no statistically significant difference in priority assignment regarding their health condition was found based on generational affiliation ($\chi^2 = 1.34$; $P = 0.248$). Additionally, respondents from the Baby Boom generation most frequently preferred a personalized approach to their own healthcare ($n = 19$; 54.29%), a preference that was 1.43 times more common than that among members of the Veteran generation; nevertheless, this difference was not statistically significant ($\chi^2 = 1.96$; $P = 0.162$).

The preference for classical forms of communication with healthcare professionals was 1.36 times more common among surveyed members of the Veteran generation compared to members of the Baby Boom generation. A statistically significant dependence on the preferred form of communication based on generational affiliation was found ($\chi^2 = 9.29$; $P = 0.002$).

Members of the Veteran generation stated that they would most often be unwilling to use information and communication technology to monitor their own health status and communicate with healthcare professionals. This attitude was 1.47 times more common than among members of the Baby Boom generation. A statistically significant dependence on the preference for using information and communication technology based on generational affiliation was found ($\chi^2 = 6.18$; $P = 0.013$).

Additionally, members of the Veteran generation expressed a more frequent preference for obtaining paper reports rather than online access, with this preference being 1.64 times more common than among surveyed members of the Baby Boom generation. A statistically significant dependence on the preference for paper reports based on generational affiliation was found ($\chi^2 = 10.92$; $P < 0.001$). The obtained results are summarized in Table 3.

Table 3. Expectations and Preferences among Veterans and Baby Boom Generation Members (χ^2 Test and Mann-Whitney U Test)

		Veterans		Baby Boom		χ^2	P
		n	%	n	%		
8. How much do you expect your healthcare provider to be available for emergencies?	24/7	3	8,11	5	14,29	0,07*	0,791
	only during working hours	20	54,05	20	57,14		
	only as needed	14	37,84	10	28,57		
11. How often would you like to have individual consultations with healthcare professionals about your health status?	I don't need consultations	5	13,51	2	5,71	0,05**	0,961
	once a month	14	37,84	17	48,57		
	once a week	14	37,84	14	40,00		
	every day	4	10,81	2	5,71		
12. What do you consider a higher priority in the response of healthcare professionals about your health status?	priority of quick availability of healthcare providers	25	67,57	19	54,29	1,34***	0,248
	detailed consultation with healthcare providers	12	32,43	16	45,71		
13. Do you prefer clear and simple guidelines from healthcare professionals during healthcare provision, or are you more inclined towards an adapted approach?	simple guidelines	23	62,16	16	45,71	1,96***	0,162
	adapted approach	14	37,84	19	54,29		
14. Do you prefer traditional forms of communication with medical staff or would you rather use modern technologies such as telemedicine?	traditional forms	36	97,30	25	71,43	9,29***	0,002
	telemedicine	1	2,70	10	28,57		
15. Would you be willing to use information and communication technology to monitor your own health status and communicate with healthcare professionals?	yes	6	16,22	15	42,86	6,18***	0,013
	no	31	83,78	20	57,14		
16. Would you prefer to have online access to your health records or do you prefer traditional paper reports?	paper reports	33	89,19	19	54,29	10,92***	<0,001
	online access	4	10,81	16	45,71		

* χ^2 test; divided into 2 groups, where group 1 = during working hours, group 2 = outside working hours

**Mann-Whitney U test

*** χ^2 test

After conducting the study, the conclusion was drawn that H1—which assumes a statistically significant difference in expectations and preferences for healthcare between the Veteran and Baby Boom generations—is accepted only for preferences regarding the application of technology. This indicates that a higher preference for the use of modern technologies was identified among Baby Boom generation respondents.

H2. There is a statistically significant correlation between age and expectations and preferences for healthcare.

The study found the presence of a statistically significant negative correlation between age and comfort in asking questions and expressing needs during conversations with healthcare providers ($\rho = -0.20$; $P = 0.045$). This indicates that with aging, there is a decrease in comfort when asking questions and expressing needs during conversations with healthcare providers. Furthermore, a negative statistically significant correlation was identified between the age of respondents and the rating of the accessibility of information about their own health condition from current healthcare providers ($\rho = -0.21$; $P = 0.038$), suggesting that with aging, there is a decrease in the rating of accessibility of information about their own health condition from current healthcare providers.

No correlation between age and other observed indicators of expectations and preferences was identified ($P > 0.05$). The mentioned results are presented in Table 4.

Table 4. Correlation between expectations and preferences for healthcare and age group

	N	rho	t(N-2)	P
1. How would you rate the importance of traditional values in providing healthcare?	72	0,03	0,22	0,413
2. How important is it for you to participate in making decisions about your own healthcare?	72	0,16	1,33	0,094
3. How important is it for you to have flexibility in choosing your own healthcare services during receiving healthcare?	72	0,09	0,76	0,226
4. How important is the emotional support from healthcare professionals during the provision of healthcare for you?	72	-0,05	0,40	0,346
5. How comfortable do you feel asking questions and expressing your needs when talking to a healthcare provider?	72	-0,20	1,72	0,045
6. What is your level of trust in current healthcare providers?	72	0,02	0,14	0,444
7. How would you rate the accessibility of information about your health status from your current healthcare	72	-0,21	1,81	0,038
9. How important is open communication with medical staff about your health status to you?	72	-0,14	1,17	0,123

10. How important do you consider the involvement of family in the decision-making process regarding your health plan?	72	-0,04	0,33	0,370
17. How important is it to you that medical staff use technology to improve the quality of healthcare?	72	0,04	0,35	0,364
18. How essential is it for you to receive continuous healthcare from the same healthcare providers?	72	-0,16	1,38	0,087

After conducting the study, it can be concluded that hypothesis H2, which assumes a statistically significant correlation between age group and expectations/preferences for healthcare, is supported only for the comfort in asking questions and expressing needs to healthcare providers, as well as the rating of accessibility of information about one's health condition by current healthcare providers.

DISCUSSION

This study aimed to explore differences in expectations and preferences for healthcare between Veterans and the Baby Boom generation and determine whether there is a statistically significant correlation between age group and expectations/preferences for healthcare. The study contributes to understanding generational differences in healthcare provision, providing a broader context for adapting healthcare approaches, aligning with technological trends, and improving the quality of healthcare.

One significant result of the study indicates that Baby Boomers express a greater preference for the use of modern technologies in healthcare compared to Veterans. This aligns with the findings of LeRouge et al. (2014), who identified that Baby Boomers value technological innovations such as email, automated call centers, medical video conferencing, and messaging to improve communication with healthcare professionals for managing their chronic conditions more effectively. This preference may be attributed to their daily environment, where they were exposed to rapid technological advancements, having grown up in a period of rapid rise in information technology, fostering a greater inclination towards its integration into various aspects of life, including healthcare.

On the other hand, according to Lissitsa et al. (2022), the Veteran generation showed less use of internet search engines compared to the Baby Boom generation, which was defined by socioeconomic status, education, and the later entry of the Veteran generation into the digital world. This is consistent with the results of this study, which show that Veterans are less willing to use information and communication technology for monitoring their health and communicating with healthcare professionals. This is also supported by Paige et al. (2018), who identified a lower level of trust among Veterans towards e-health resources and their own digital skills. This may be explained by their strong traditional beliefs, yet in this study, a high impor-

tance of traditional values in healthcare provision was identified for both generations (Mdn=5.00). However, the preference for classical forms of communication with medical staff was 1.36 times more common among Veteran respondents, suggesting that they prefer direct contact with healthcare providers and receiving paper reports on their health condition rather than online access.

According to a study by Reed et al. (2008), the Veteran generation prefers fewer options in decision-making about their healthcare compared to younger generations. Therefore, it is understandable why respondents from the Veteran generation in this study prioritize clear guidelines in response to their health condition, while Baby Boomers prioritize the fast availability of healthcare providers. Gill and Cameron (2022) argue that Baby Boomers are more likely to independently determine which services and information they receive and from whom, using their well-developed skills and relying on their resourcefulness. In a qualitative study they conducted with experienced Baby Boomer caregivers, they identified five key characteristics that significantly influence their expectations in healthcare: resourcefulness, independence, openness, assertiveness, and insightfulness. These characteristics suggest that Baby Boomers plan to actively participate in managing their healthcare services, preferring an approach that highlights their autonomy. This is confirmed by qualitative research conducted in Quebec, Canada, which found that Baby Boomers have high expectations of healthcare services and perceive care as a partnership with professional services (Guberman et al. 2012).

Therefore, the results of this study, show that Baby Boomers give higher ratings to the necessity of receiving continuous healthcare from the same healthcare providers and that they most often want to have individual consultations with healthcare professionals at least once a month and a personalized approach in their healthcare, are not surprising.

However, the results of this study also showed that high expectations of Baby Boomers regarding healthcare are not always accompanied by a high level of comfort in asking questions. The research found that with aging, there is a decrease in the comfort of asking questions and expressing needs during conversations with healthcare providers and a decrease in the rating of accessibility of information. The decline in these variables concerning age was most pronounced in the Veteran generation, followed by older Baby Boomers, while it was least pronounced in the youngest Baby Boomers. This can be interpreted as a reduction in cognitive resources associated with aging and the need for Veterans to cognitively unload. This result also confirms the preference of the Veteran generation for a smaller number of options in making decisions about their healthcare. Additionally, the results are in line with the assertion of Torres and Cao (2019) that the Veteran generation in healthcare values recognition, respect, and care the most, unlike Baby Boomers who have a more liberal approach. Therefore,

in both cases, healthcare providers need to recognize these aspects to adapt to the needs of older patients and ensure fair access to healthcare information and services during healthcare provision.

However, despite the valuable insights, there are certain limitations in the study that could affect the interpretation of the results. Primarily, the instrument used in the research – namely, the self-developed questionnaire – was not pre-tested in a pilot study. This means that its validity and reliability have not been confirmed, which may lead to variations in the interpretation of questions among participants. Additionally, the questionnaire may be subject to subjective interpretations, particularly in the formulation of certain questions, which could affect the consistency of the data obtained.

Furthermore, the method of sample recruitment, although conducted in collaboration with the administrators of the nursing home and the home healthcare institution, may have been influenced by specific environmental factors. For example, the presence of staff and researchers might have affected the honesty of participants' responses, representing a potential confounding factor in the data collection process. Moreover, the limited number of participants (72 individuals) may restrict the generalizability of the results to a broader population, especially when dealing with generational groups that exhibit significant socio-demographic and cultural differences.

CONCLUSION

This research contributes to a deeper understanding of generational differences in the perception of healthcare, opening up new possibilities for tailoring healthcare approaches and improving the quality of services provided. Key findings indicate that members of the Baby Boom generation show a greater inclination to integrate modern technologies into healthcare, likely due to their exposure to rapid technological advancements during their formative years, while the Veteran generation prefers more traditional approaches, such as direct contact with healthcare providers and receiving paper-based health reports.

The practical application of these findings is reflected in the potential to develop tailored communication strategies and organizational models within the healthcare system. Healthcare providers could implement technological innovations aimed at younger older patients, while for older patients, more traditional forms of communication and information dissemination might be maintained. Furthermore, the results suggest the need to develop systems that enable a personalized approach to healthcare decision-making, thereby increasing patient satisfaction and the effectiveness of the services provided.

For future research, it is recommended to conduct pilot studies to validate the questionnaire, expand the sample size to enhance the generalizability of the findings, and further investigate the influence of socio-cultural factors, as well as changes in technology and digital literacy, on the healthcare habits of different generations. These guidelines can contribute to an even better understanding of the needs of older patients and facilitate the implementation of more effective strategies to improve the overall quality of healthcare.

LITERATURE

1. Appelbaum, Steven H., Maria Serena, and Barbara T. Shapiro. 2004. Generation X and the Boomers: Organizational Myths and Literary Realities. *Management Research News* 27(11/12): 1–28.
2. Araújo, Lia, and Óscar Ribeiro. 2011. Incapacity Paradox of Very-Old People. *Acta Medica Portuguesa* 24: 189–196.
3. Badley, Elizabeth M., Mayilee Canizares, Anthony V. Perruccio, Sheilah Hogg-Johnson, and Monique A.M. Gignac. 2015. Benefits Gained, Benefits Lost: Comparing Baby Boomers to Other Generations in a Longitudinal Cohort Study of Self-Rated Health. *The Milbank Quarterly* 93(1): 40–72.
4. Banerjee, Sube. 2015. Multimorbidity—Older Adults Need Health Care That Can Count Past One. *The Lancet* 385(9968): 587–589.
5. Bermejo Boixareu, Cristina, Cristina Ojeda-Thies, Ainhoa Guijarro Valtueña, Bernardo Abel Cedeño Veloz, María Gonzalo Lázaro, Laura Navarro Castellanos, Rocío Queipo Matas, Paloma Gómez Campelo, Ana Royuela Vicente, Juan Ignacio González-Montalvo, and Pilar Sáez-López. 2023. Clinical and Demographic Characteristics of Centenarians Versus Other Age Groups Over 75 Years With Hip Fractures. *Clinical Interventions in Aging*: 441–451.
6. Bhattarai, Balkrishna. 2014. Preparedness of health care of older people. *Health Renaissance*, 12(3), 147-148.
7. Black, Ashly D., Josip Car, Claudia Pagliari, Chantelle Anandan, Kathrin Cresswell, Tomislav Bokun, Brian McKinstry, Rob Procter, Azeem Majeed, and Aziz Sheikh. 2011. The Impact of eHealth on the Quality and Safety of Health Care: A Systematic Overview. *PLoS Medicine* 8(1): e1000387.
8. Busetta, Annalisa, and Filippa Bono. 2021. Demographic Aspects of Aging. In *Human Aging*, 13–34.
9. Canizares, Mayilee, Monique Gignac, Sheilah Hogg-Johnson, Richard H. Glazier, and Elizabeth M. Badley. 2016. Do Baby Boomers Use More Healthcare Services Than Other Generations? Longitudinal Trajectories of Physician Service Use Across Five Birth Cohorts. *BMJ Open* 6(9): e013276.

10. Davis, Gary L., and William L. Roberts. 2010. The Healthcare Burden Imposed by Liver Disease in Aging Baby Boomers. *Current Gastroenterology Reports* 12: 1–6.
11. Fakhro, Mohammed Ali. 2018. What's really happening among the elderly population?. *Lancet* 388(10053), 1603-1658.
12. Fiorillo, Andrea, and Philip Gorwood. 2020. The Consequences of the COVID-19 Pandemic on Mental Health and Implications for Clinical Practice. *European Psychiatry* 63(1): e32.
13. Gill, Liz, and Ian D. Cameron. 2022. Identifying Baby Boomer Service Expectations for Future Aged Care Community Services in Australia. *Health & Social Care in the Community* 30(2): 726–734.
14. Gjonça, Edlira, and Lisa Calderwood. 2003. Socio-Demographic Characteristics. In *Health, Wealth and Lifestyles of the Older Population in England*, edited by Michael Marmot, James Banks, Richard Blundell, Carli Lessof, and James Nazroo. London: Institute of Fiscal Studies.
15. Gnanasabai, Gnanamani, Mohan Kumar, Chithra Boovaragasamy, and Mujibur Rahman. 2020. Socio-Demographic and Morbidity Pattern of Geriatric Population in Rural Area of Puducherry: A Community-Based Cross-Sectional Study. *International Journal of Community Medicine and Public Health* 7(9): 3393.
16. Gosney, Margot. 2009. General care of the older cancer patient. *Clinical Oncology* 21(2), 86- 91.
17. Guberman, Nancy, Jean-Pierre Lavoie, Laure Blein, and Ignace Olazabal. 2012. Baby Boom Caregivers: Care in the Age of Individualization. *The Gerontologist* 52(2): 210–218.
18. Kahana, Eva, and Boaz Kahana. 2014. Baby Boomers' Expectations of Health and Medicine. *The Virtual Mentor* 16(5): 380.v.
19. Lee, Hee Yun, William Hasenbein, and Priscilla Gibson. 2020. Mental Health and Older Adults. *Encyclopedia of Social Work*, August 27. Available at: <https://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1355>.
20. LeRouge, Cynthia, Craig Van Slyke, Deborah Seale, and Kevin Wright. 2014. Baby Boomers Adoption of Consumer Health Technologies: Survey on Readiness and Barriers. *Journal of Medical Internet Research* 16(9): e200.
21. Lissitsa, Sabina, Ester Zychlinski, and Maya Kagan. 2022. The Silent Generation vs Baby Boomers: Socio-demographic and psychological predictors of the "gray" digital inequalities. *Computers in Human Behavior* 128.
22. Luo, Guangxiang George, and Shou-Jiang Gao. 2020. Global Health Concerns Stirred by Emerging Viral Infections. *Journal of Medical Virology* 92(4): 399.

23. Motl, Robert W., and Edward McAuley. 2010. Physical Activity, Disability, and Quality of Life in Older Adults. *Physical Medicine and Rehabilitation Clinics* 21(2): 299–308.
24. Paige, Samantha R., M. David Miller, Janice L. Krieger, Michael Stellefson, and JeeWon Cheong. 2018. Electronic Health Literacy Across the Lifespan: Measurement Invariance Study. *Journal of Medical Internet Research* 20(7): e10434.
25. Pelok, Scott D. 2023. Pharmacotherapeutic Challenges for Treating the Baby Boomer Cohort. *Special Care in Dentistry* 43(3): 328–335.
26. Ramage-Morin, Pamela L., and Jane Y. Polsky. 2020. Health-Related Concerns and Precautions During the COVID-19 Pandemic: A Comparison of Canadians With and Without Underlying Health Conditions. *Health Report*: 3–8.
27. Reed, Andrew E., Joseph A. Mikels, and Kosali I. Simon. 2008. Older Adults Prefer Less Choice Than Young Adults. *Psychology and Aging* 23(3): 671.
28. Seale, Deborah E., Cynthia M. LeRouge, Jennifer E. Ohs, Donghua Tao, Helen W. Lach, Keri Jupka, and Ricardo Wray. 2019. Exploring Early Adopter Baby Boomers' Approach to Managing Their Health and Healthcare. *International Journal of E-Health and Medical Communications (IJEHMC)* 10(1): 94–117.
29. Shen, Anyuan. 2019. Religious Attendance, Healthy Lifestyles, and Perceived Health: A Comparison of Baby Boomers With the Silent Generation. *Journal of Religion and Health* 58(4): 1235–1245.
30. Torres, Stacy, and Xuemei Cao. 2019. Improving Care for Elders Who Prefer Informal Spaces to Age-Separated Institutions and Health Care Settings. *Innovation in Aging* 3(3): igz019.
31. U.S. Department of Health and Human Services. 2019. By 2030, All Baby Boomers Will Be Age 65 or Older: 2020 Census Will Help Policymakers Prepare for the Incoming Wave of Aging Boomers." U.S. Census Bureau. Available at: <https://www.census.gov/library/stories/2019/12/by-2030-all-baby-boomers-will-be-age-65-or-older.html>.
32. Ullrich, Helen E. 2017. The Silent Generation: 1964. In *The Women of Totagadde*, 15–45. New York: Palgrave Macmillan.
33. Wu, Huai-Wen, Prashant Kumar, Chuck Wah Yu, and Shi-Jie Cao. 2022. A Global Challenge for Smart and Healthy Care Homes for the Elderly. *Indoor and Built Environment* 31(7): 1733–1737.
34. Xiong, Tian-Yuan, Simon Redwood, Bernard Prendergast, and Mao Chen. 2020. Coronaviruses and the Cardiovascular System: Acute and Long-Term Implications. *European Heart Journal* 41(19): 1798–1800.

SHORT BIO:

Danijela Sopić is a Master of Nursing and a doctoral student in Social Gerontology at Alma Mater Europaea University. Her research focuses on improving health-care and social support for older adults, with an emphasis on understanding health and social dynamics in aging populations. She actively contributes to professional associations and conferences.

ATTITUDES OF BJELOVAR MEDICAL SCHOOL STUDENTS TOWARD EUTHANASIA

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ABSTRACT

Euthanasia is regulated by specific laws that define the exact conditions and circumstances under which it can be performed. In Europe, the Netherlands, Belgium, Luxembourg, Spain, and Portugal were among the first to introduce such legislation. Switzerland is also widely recognized for its stance on euthanasia. In Croatia, passive euthanasia—defined as the refusal of treatment and advanced life support—is legally permitted, whereas active euthanasia remains prohibited.

This study aimed to examine the attitudes of students at the Secondary Medical School Bjelovar, specifically those training as nurses/general care technicians, regarding the implementation of active and passive euthanasia. The research was conducted using an anonymous questionnaire survey, including 100 students. The questionnaire consisted of sociodemographic questions and sections addressing medical, ethical, moral, and spiritual aspects of euthanasia. Statistical analysis included descriptive statistics, the chi-square test, and graphical data representation.

The findings indicate that students pursuing a profession centered on care and patient well-being are statistically more opposed to euthanasia.

These results highlight the importance of ethical education in shaping future healthcare professionals' attitudes toward euthanasia. Further research should explore the role of cultural, religious, and educational influences on students' perspectives. Developing comprehensive ethics training in medical education could help students better navigate complex end-of-life dilemmas.

Keywords: active euthanasia, passive euthanasia, medical school students, student attitudes, life support.

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INTRODUCTION

Every patient has the right to make decisions based on their own beliefs and values, a concept defined as autonomy, which represents one of the fundamental human rights and ethical principles in healthcare (Beauchamp & Childress, 2019; Morrell, 2011). In the context of medical procedures, decision-making is a complex process that involves the patient, whose wishes and preferences regarding treatment and care should be respected (Payne, 2016). This principle is especially significant in palliative and end-of-life care, where healthcare professionals are often confronted with difficult ethical dilemmas, including the question of euthanasia (Quill et al., 2016; Morrell et al., 2019).

The increasing availability of information and the legalization of euthanasia in certain countries have contributed to growing public awareness and debate on this topic. Euthanasia is legally regulated in Switzerland, Belgium, the Netherlands, Luxembourg, Spain, and Portugal, where specific legal frameworks outline the conditions under which it can be performed (Pereira, 2011; Deliens & van der Wal, 2003). The decision to accept a request for euthanasia is made in consultation with a physician and follows strict legal and ethical guidelines, ensuring that the procedure is conducted under continuous medical supervision (Evenblij et al., 2019). Requests for euthanasia are most commonly made by patients suffering from malignant diseases, severe neurological conditions, or mental disorders that significantly impact their quality of life (Rietjens et al., 2012; Emanuel et al., 2016).

Despite the legal acceptance in some countries, euthanasia remains a controversial and highly debated issue, particularly within the healthcare profession. Nurses, as primary caregivers, play a crucial role in palliative and end-of-life care. Their ethical responsibilities include not only pain relief and symptom management but also supporting patients and their families emotionally and psychologically (Balaguer et al., 2016; Hagan et al., 2018). Studies have shown that palliative care, when effectively integrated into patient management from the time of diagnosis, can significantly reduce the desire for euthanasia by improving the overall quality of life (Radbruch et al., 2020; Pastrana et al., 2008).

Given their central role in patient care, nurses' attitudes toward euthanasia are essential in shaping healthcare policies and practices related to end-of-life decisions (Wagner et al., 2012). Medical students, particularly those studying to become nurses and general care technicians, represent the future of healthcare. Their education and training influence their ethical reasoning, clinical decision-making, and approach to patient care (Jahn et al., 2021). Understanding their attitudes toward euthanasia is crucial in designing educational programs that address ethical dilemmas and prepare them for real-life scenarios in professional practice (van Bruchem-Visser et al., 2020).

This study aims to examine the attitudes of students at the Secondary Medical School Bjelovar, specifically those in the nurse/general care technician program, regarding active and passive euthanasia. By analyzing their perspectives, this research seeks to provide insights into the factors that shape future healthcare professionals' views on end-of-life care and to contribute to the ongoing discussion on ethical decision-making in medical education.

METHODS

This study employed a cross-sectional research design to examine the attitudes of students at the Secondary Medical School Bjelovar regarding euthanasia. The research was conducted over a one-month period, from October 1, 2023, to October 31, 2023. The study sample consisted of 100 students enrolled in the nurse/general care technician program. The selection of participants was structured to include students from different demographic backgrounds to ensure a representative sample.

The inclusion criteria for participation required students to be enrolled in the final years of the nurse/general care technician program and to voluntarily agree to participate in the study. Prior to completing the survey, all students provided informed consent, ensuring that participation was entirely voluntary and that anonymity was guaranteed. This approach was taken to encourage honest and unbiased responses.

Data collection was conducted using a self-administered, anonymous questionnaire, which was specifically designed for this study. The questionnaire consisted of 26 closed-ended questions and was divided into two sections. The first section focused on socio-demographic variables, including age, gender, religious affiliation, and place of residence. The second section explored students' attitudes and knowledge about euthanasia, addressing various medical, ethical, moral, and spiritual perspectives. In order to ensure the clarity and reliability of the instrument, the questionnaire was pre-tested on a small group of students who were not included in the final analysis.

Surveys were administered in a controlled classroom environment under supervised conditions, ensuring a standardized response process. Students were informed that they could withdraw from the study at any time without any consequences. Ethical principles were strictly followed throughout the research, with confidentiality and anonymity of responses being fully respected.

For data analysis, both descriptive and inferential statistical methods were applied. Descriptive statistics were used to summarize frequency distributions and percentages of categorical variables. Additionally, the chi-square (χ^2) test was employed to examine potential associations between different variables,

particularly differences in attitudes based on religious beliefs and demographic factors. To enhance data visualization, the results were also presented through tables and graphical representations.

All statistical analyses were performed using SPSS software (version X.X), with the significance level set at $p < 0.05$. This ensured that the findings were interpreted with statistical rigor, allowing for meaningful conclusions to be drawn from the collected data.

RESULTS

Survey on students' attitudes toward euthanasia was conducted on a sample of 100 students. Table 1 provides the response frequencies for each question included in the survey questionnaire.

Table 1. Response Frequencies for Questions in the Questionnaire

		Frequency	%
Age	18	41	41.00
	19	56	56.00
	20	3	3.00
Gender	Male	16	16.00
	Female	84	84.00
Grade level	4	48	48.00
	5	52	52.00
Place of residence	City	37	37.00
	Village	63	63.00
Affiliation with a religious community	Catholic Church	70	70.00
	Orthodox Church	10	10.00
	Atheist	15	15.00
	Other	5	5.00
How many people do you live with in your household?	2	2	2.00
	3	20	20.00
	4	55	55.00
	5	17	17.00
	6	6	6.00
How many people in your household do you consider to be elderly?	0	60	60.00
	1	16	16.00
	2	21	21.00
	3	3	3.00

		Frequency	%
In your opinion, at what age is a person considered old?	50-59	5	5.00
	60-69	46	46.00
	70-79	38	38.00
	80-89	11	11.00
How many years do you expect to live?	60-69	18	18.00
	70-79	43	43.00
	80-89	29	29.00
	90 and more	10	10.00
Do your grandparents live with you in the household?	Yes	28	28.00
	No	72	72.00
Do you consider yourself a religious person?	Yes	68	68.00
	No	32	32.00

		Frequency	%
You are familiar with the concept/definition of euthanasia.	Yes	100	100.00
Do you believe that quality of life is more important than length of life?	Yes	100	100.00
One of the fundamental human rights is the right to life	Yes	100	100.00
One of the fundamental human rights is the right to death	Yes	74	74.00
	No	26	26.00
Every adult has the possibility to refuse or accept therapy and/or medical-diagnostic procedures	Yes	100	100.00
The goal of treatment for incurable diseases in the final stage of life should focus on reducing suffering and pain, ensuring a dignified death	Yes	96	96.00
	No	4	4.00
A person in the final stage of illness may not be able to rationally assess and make decisions about their health condition	Yes	46	46.00
	No	54	54.00
Euthanasia should not be allowed due to the possibility of abuse	Yes	53	53.00
	No	47	47.00
Euthanasia should not be allowed because there is a possibility of medical error in determining the final diagnosis	Yes	52	52.00
	No	48	48.00
A person in the final stage of illness has the right to decide how they want to die and when they want to die	Yes	87	87.00
	No	13	13.00

		Frequency	%
Pain is one of the main symptoms contributing to increasing requests for euthanasia	Yes	91	91.00
	No	9	9.00
Providing information and/or instructions about euthanasia to a person with the intention of allowing them to end their life is acceptable	Yes	57	57.00
	No	43	43.00
Administering medication to a person with the intention of ending their life is acceptable	Yes	37	37.00
	No	63	63.00
Physicians should be allowed to withhold life-sustaining measures at the request of the patient	Yes	43	43.00
	No	57	57.00
Have you heard of painless death? It is about a euthanasia capsule where a person can painlessly and independently end their life in less than a minute	Yes	65	65.00
	No	35	35.00

All respondents declared that they are familiar with the concept of euthanasia. Everyone agrees that one of the fundamental human rights is the right to life and that the quality of life is more important than the length of life. The vast majority of respondents believe that every adult has the possibility to refuse or accept therapy or medical-diagnostic procedures (100%), that the goal of treatment for incurable diseases in the final stage of life should focus on reducing suffering and pain and ensuring a dignified death (96%), and that pain is one of the main symptoms contributing to the increasing requests for euthanasia (91%).

An equal number of respondents believe that euthanasia should not be allowed due to the possibility of abuse (53%) and that euthanasia should not be allowed because there is a possibility of a medical error in determining the final diagnosis (52%). In addition to concerns about abuse and the possibility of medical errors, which most respondents consider reasons against euthanasia, 63% of respondents believe that administering medication to a person with the intention of ending their life is not acceptable, and 57% believe that physicians should not be allowed to withhold life-sustaining measures at the request of the patient.

On the other hand, a significant 87% of respondents stated that a person in the final stage of illness has the right to decide how they want to die and when, 57% believe that providing information and instructions about euthanasia to a person with the intention of allowing them to end their life is acceptable, and finally, 54% of respondents believe that a person in the final stage of illness is still able to rationally assess and make decisions about their health condition.

Below, we will provide tabular summaries of statements for and against euthanasia for which the majority of respondents expressed their views:

Table 2. Statements in favor of euthanasia that the majority of respondents agreed with

Statement	%
A person in the final stage of illness has the right to decide how they want to die and when they want to die	87%
A person in the final stage of illness is able to rationally assess and make decisions about their health condition	54%
Providing information and/or instructions about euthanasia to a person with the intention of allowing them to end their life is acceptable	57%
One of the fundamental human rights is the right to death	74%

Table 3. Statements against euthanasia that the majority of respondents expressed views on

Statement	%
Euthanasia should not be allowed due to the possibility of abuse	53%
Euthanasia should not be allowed because there is a possibility of medical error in determining the final diagnosis	52%
Administering medication to a person with the intention of ending their life is not acceptable	63%
Physicians should not be allowed to withhold life-sustaining measures at the request of the patient	57%

In the following tables, using the χ^2 test, we will examine whether there are statistically significant differences in responses to statements from Tables 2 and 3 between students who consider themselves religious and those who do not.

Table 4. Association Between Religious Belief and Attitudes Toward End-of-Life Decision-Making

Do you consider yourself a religious person?	Physicians should be allowed to withhold life-sustaining measures at the request of the patient		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	68 100.00 78.16	0 0.00 0.00	68
No	19 59.38 21.84	13 40.63 100.00	32
Total	87	13	100

p-value<.0001

In Table 4, a p-value $< .0001 < 0.05$ indicates that we can accept that both observed variables (Do you consider yourself a religious person and A person in the final stage of illness has the right to decide how they want to die and when they want to die) are independent, i.e., responses to one statement do not depend on the response to the other statement. The responses are statistically significantly different.

Table 5. Association Between Religiosity and Perceived Decision-Making Capacity in Terminal Illness

Do you consider yourself a religious person?	A person in the final stage of illness is NOT able to rationally assess and make decisions about their health condition		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	46 67.65 100.00	22 32.35 40.74	68
No	0 0.00 0.00	32 100.00 59.26	32
Total	46	54	100

p-value<.0001

As seen in Table 5, all respondents who do not consider themselves religious individuals stated that the statement „A person in the final stage of illness is NOT able to rationally assess and make decisions about their health condition“ is not correct.

Table 6. Association Between Religiosity and Acceptability of Providing Information on Euthanasia

Do you consider yourself a religious person?	Providing information and/or instructions about euthanasia to a person with the intention of allowing them to end their life is acceptable		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	57 83.82 100.00	11 16.18 25.58	68
No	0 0.00 0.00	32 100.00 74.42	32
Total	57	43	100

p-value<.0001

All respondents who do not consider themselves religious individuals stated that providing information and/or instructions about euthanasia to a person with the intention of allowing them to end their life is not acceptable.

Table 7. Association Between Religiosity and the Belief That the Right to Die Is a Fundamental Human Right

Do you consider yourself a religious person?	Jedno od osnovnih ljudskih prava je pravo na smrt		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	68 100.00 91.89	0 0.00 0.00	68
No	6 18.75 8.11	26 81.25 100.00	32
Total	74	26	100

p-value<.0001

Table 8. Association Between Religiosity and Concerns About Euthanasia Due to Potential Abuse

Do you consider yourself a religious person?	Euthanasia should not be allowed due to the possibility of abuse		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	53 77.94 100.00	15 22.06 31.91	68
No	0 0.00 0.00	32 100.00 68.09	32
Total	53	47	100

p-value<.0001

Table 9. Association Between Religiosity and Opposition to Euthanasia Due to Potential Diagnostic Errors

Do you consider yourself a religious person?	Euthanasia should not be allowed because there is a possibility of medical error in determining the final diagnosis		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	52 76.47 100.00	16 23.53 33.33	68
No	0 0.00 0.00	32 100.00 66.67	32
Total	52	48	100

p-value<.0001

Table 10. Association Between Religiosity and Acceptability of Administering Life-Ending Medication

Do you consider yourself a religious person?	Administering medication to a person with the intention of ending their life is acceptable		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	37 54.41 100.00	31 45.59 49.21	68
No	0 0.00 0.00	32 100.00 50.79	32
Total	37	63	100

p-value<.0001

Table 11. Association Between Religiosity and Support for Physicians Withholding Life-Sustaining Measures

Do you consider yourself a religious person?	Physicians should be allowed to withhold life-sustaining measures at the request of the patient		
	Yes	No	Total
Frequency Percentage in row Percentage in column			
Yes	43 63.24 100.00	25 36.76 43.86	68
No	0 0.00 0.00	32 100.00 56.14	32
Total	43	57	100

p-value < .0001

The students or participants in this study grant the right to a person in the final stage of illness to decide how they want to die and when they want to die. They believe that these individuals are capable of rationally assessing and making decisions about their health condition and acknowledge their right to a dignified death. However, they are against the implementation of euthanasia due to the potential for its abuse and for medical, moral, and spiritual reasons.

DISCUSSION

Euthanasia is a term defining the intentional termination of life by healthcare professionals. The process is carried out through the administration of medications that enable the patient to end pain and suffering and can be performed with or without the patient's consent. Consent-based euthanasia is voluntary and legally regulated in the Netherlands and Belgium. Involuntary euthanasia, performed without the prior approval of the patient, is prohibited worldwide (Quill et al., 2016). The decision for euthanasia is often driven by the patient's fear of the manner of their death, particularly evident in patients exposed to severe suffering, further influencing their inclination to make such decisions. Attitudes towards euthanasia also depend on societal and cultural norms within a community (Pereira, 2011). Globalization and advancements in communication and information technologies have significantly altered societal perceptions and attitudes towards euthanasia, making it a subject of global public debates (Pereira, 2011).

CULTURAL INFLUENCES ON ATTITUDES TOWARD EUTHANASIA

Cultural background plays a critical role in shaping attitudes toward euthanasia. Various studies indicate that religious affiliation, traditional values, and societal norms significantly impact opinions on end-of-life decisions (Gielen et al., 2009; Cohen et al., 2014). In predominantly Catholic countries, such as Croatia, Italy, and Poland, euthanasia is largely opposed due to religious teachings that emphasize the sanctity of life and suffering as part of the human experience (Sulmasy & Mueller, 2017). In contrast, more secular societies, such as the Netherlands and Belgium, tend to have more permissive attitudes toward euthanasia, often viewing it as an extension of individual autonomy and the right to die with dignity (Deliens & van der Wal, 2003). Additionally, within multicultural societies, attitudes toward euthanasia may vary even within the same country, depending on ethnic and religious diversity. For instance, studies have shown that Muslim and Orthodox Christian populations tend to oppose euthanasia more strongly compared to Protestant or non-religious communities, reflecting the moral frameworks inherent in these traditions (Bülow et al., 2008; van Bruchem-Visser et al., 2020). Cultural attitudes toward euthanasia also influence medical professionals' perspectives, as healthcare providers working in culturally diverse environments may have differing ethical views on end-of-life care, affecting their willingness to participate in euthanasia or assisted suicide (Evenblij et al., 2019).

In the context of Croatia, where the majority of the population identifies as Catholic, opposition to euthanasia is frequently framed through moral and religious arguments rather than legal or ethical concerns. This cultural influence was reflected in this study, where students with strong religious beliefs were more likely to oppose euthanasia than their non-religious peers. Similar findings have been reported in studies conducted in other religiously affiliated countries, reinforcing the idea that cultural and spiritual beliefs continue to shape attitudes toward euthanasia (Gielen et al., 2009).

ETHICAL AND PROFESSIONAL CONSIDERATIONS

Ethical arguments regarding euthanasia are linked to the concept of assisted suicide, where physicians play a role in alleviating suffering while also respecting patient autonomy. Advocates of euthanasia view it as an act of compassion and a means of honoring a patient's right to die with dignity (Payne, 2016). However, opponents argue that euthanasia violates the fundamental medical ethics principles of non-maleficence and beneficence. The act of ending a life, even at the patient's request, is seen as contradicting the role of healthcare professionals in preserving life and alleviating suffering through means that do not involve hastening death (Quill et al., 2016; Sulmasy & Mueller, 2017).

This ethical dilemma is further complicated by the role of palliative care, which aims to reduce suffering and improve quality of life for terminally ill patients. Some studies suggest that access to high-quality palliative care can significantly reduce requests for euthanasia, as patients may no longer perceive death as the only escape from suffering (Balaguer et al., 2016; Radbruch et al., 2020). In this regard, enhancing palliative care education among nursing students and future healthcare professionals could play a crucial role in addressing end-of-life concerns without resorting to euthanasia.

STUDY LIMITATIONS

Despite the valuable insights gained from this study, several limitations must be acknowledged. One of the primary limitations is the relatively small sample size (N = 100), which may not fully represent the broader population of nursing students in Croatia. Future studies should aim for a larger and more diverse sample to ensure greater generalizability of the findings.

Another limitation is the potential influence of social desirability bias, where students may have provided responses they believed were socially acceptable rather than their true opinions. Given that euthanasia is a controversial topic, particularly in a predominantly religious society, some respondents may have been reluctant to express pro-euthanasia attitudes, leading to a possible underestimation of actual support for euthanasia among nursing students.

Additionally, the study relied on self-reported data, which may be subject to personal bias and misinterpretation of questionnaire items. Although efforts were made to ensure clarity in survey questions, individual variations in understanding and interpretation could have influenced responses.

Lastly, the study did not explore longitudinal changes in students' attitudes. As students progress in their education and gain more clinical experience, their perspectives on euthanasia may evolve. Future research should consider conducting longitudinal studies to track changes in attitudes over time, particularly as students transition into professional practice.

CONCLUSION

This study highlights the complex interplay between ethical, cultural, and professional factors in shaping nursing students' attitudes toward euthanasia. The findings suggest that religious beliefs and cultural background significantly influence perspectives on end-of-life decisions, with students from religious affiliations being more likely to oppose euthanasia. Additionally, the ethical dilemma surrounding euthanasia underscores the importance of integrating palliative care education into nursing curricula to ensure that future healthcare professionals are equipped to navigate these difficult conversations.

Future research should focus on expanding the sample size, exploring the impact of clinical experience on euthanasia attitudes, and investigating potential interventions—such as ethics training programs—that could help students develop a well-rounded perspective on end-of-life care.

CONCLUSION

Medical ethics is a field that encompasses the responsibilities of healthcare professionals toward patients and society, often carrying greater moral significance than legal regulations. Healthcare professionals are required to adhere to ethical norms and principles, with particular emphasis on beneficence, non-maleficence, autonomy, and justice in medical treatment. These ethical principles serve as the foundation of patient care, guiding decision-making processes in complex medical situations. Euthanasia, as a practice that involves the intentional ending of life, raises profound ethical dilemmas and is often viewed as fundamentally incompatible with the role of healthcare professionals. The risks associated with euthanasia, particularly the possibility of abuse, misdiagnosis, and violation of the right to life, highlight the importance of well-defined legal and ethical frameworks to govern its practice.

The ongoing global debate on euthanasia reflects the inherent tension between ethics, law, and medical practice. While some societies advocate for euthanasia as an extension of patient autonomy and the right to die with dignity, others perceive it as a violation of the sanctity of life. This study has shown that nursing students largely support the idea that terminally ill patients should have autonomy in making end-of-life decisions, including the right to refuse treatment. However, many students express opposition to euthanasia due to concerns about potential misuse and ethical conflicts, particularly from a medical, moral, and spiritual perspective. These findings are consistent with studies in other predominantly religious societies, where euthanasia remains a controversial topic.

Despite the strong ethical and legal arguments against euthanasia, it is essential to recognize that patients requesting euthanasia often experience extreme suffering and pain, which could be mitigated through improved palliative care, psychological support, and ethical medical practices. Strengthening palliative care systems and increasing healthcare professionals' awareness of alternative end-of-life care strategies may reduce the demand for euthanasia and provide terminally ill patients with greater comfort and dignity.

Given the complexity of euthanasia as an ethical issue, further research should focus on expanding the sample size to include medical students from different regions and educational backgrounds to better understand the diversity of opinions. Future studies should also explore the impact of clinical experience on

attitudes toward euthanasia, as hands-on patient care may significantly shape students' perspectives on end-of-life decision-making.

Another important direction for future research is the role of ethics education in medical and nursing curricula. There is a growing need to develop structured ethics training programs that prepare students to navigate ethical dilemmas they may encounter in their professional careers. Research should examine effective teaching methods for bioethics, such as case-based learning, simulations, and interdisciplinary discussions, to determine the most effective strategies for fostering ethical decision-making skills.

Additionally, longitudinal studies tracking how students' attitudes toward euthanasia evolve over time could provide valuable insights into the influence of professional experience, religious beliefs, and exposure to end-of-life care scenarios. Investigating how cultural and societal factors shape ethical perspectives on euthanasia across different populations would further contribute to the global discussion on this complex issue.

Ultimately, the integration of ethics, palliative care, and patient-centered decision-making into medical education is crucial to ensuring that future healthcare professionals are well-equipped to address the challenges of end-of-life care with compassion, integrity, and ethical responsibility.

LITERATURE

1. Balaguer, Albert, Cristina Monforte-Royo, Josep Porta-Sales, Alberto Alonso-Babarro, Rogelio Altisent, Amor Aradilla-Herrero, Mercedes Bellido-Perez, William Breitbart, Carlos Centeno, Miguel Angel Cuervo, Luc Deliens, Gerrit Frerich, Chris Gastmans, Stephanie Lichtenfeld, Joaquín T. Limonero, Markus A. Maier, Lars Johan Materstvedt, María Nabal, Gary Rodin, Barry Rosenfeld, Tracy Schroeffer, Joaquín Tomás-Sábado, Jordi Trelis, Christian Villavicencio-Chávez, and Raymond Voltz. 2016. „An International Consensus Definition of the Wish to Hasten Death and Its Related Factors.” *PLoS ONE* 11 (1): e0146184.
2. Beauchamp, Tom L., and James F. Childress. 2019. *Principles of Biomedical Ethics*. 8th ed. Oxford: Oxford University Press.
3. Bülow, Hans Henrik, Charles L. Sprung, Konrad Reinhart, Shirish Prayag, Bin Du, Anastasios Armaganidis, and Maurice Levy. 2008. „The World's Major Religions' Points of View on End-of-Life Decisions in the Intensive Care Unit.” *Intensive Care Medicine* 34 (3): 423–430.
4. Cohen, Joachim, Paul Van Landeghem, Nele Carpentier, and Luc Deliens. 2014. „Different Trends in Euthanasia Acceptance Across Europe: A Study of 13 Western and Eastern European Countries.” *Journal of Medical Ethics* 40 (10): 621–624.

5. Deliens, Luc, and Gerrit van der Wal. 2003. „The Euthanasia Law in Belgium and the Netherlands.“ *The Lancet* 362 (9391): 1239–1240.
6. Emanuel, Ezekiel J., Bregje D. Onwuteaka-Philipsen, John W. Urwin, and Joachim Cohen. 2016. „Attitudes and Practices of Euthanasia and Physician-Assisted Suicide in the United States, Canada, and Europe.“ *JAMA* 316 (1): 79–90.
7. Evenblij, Kirsten, H. Roeline W. Pasma, Agnes van der Heide, Trynke Hoekstra, and Bregje D. Onwuteaka-Philipsen. 2019. „Factors Associated with Requesting and Receiving Euthanasia: A Nationwide Mortality Follow-Back Study with a Focus on Patients with Psychiatric Disorders, Dementia, or an Accumulation of Health Problems Related to Old Age.“ *BMC Medicine* 17 (1): 39.
8. Gielen, Joris, Stef Van den Branden, and Bert Broeckaert. 2009. „Religion and Nurses' Attitudes to Euthanasia and Physician-Assisted Suicide.“ *Nursing Ethics* 16 (3): 303–318.
9. Hagan, Teresa L., Jiaun Xu, Ruth P. Lopez, and Toby Bressler. 2018. „Nursing's Role in Leading Palliative Care: A Call to Action.“ *Nurse Education Today* 62: 216–219.
10. Jahn, Stefanie, Anne Börner, Matthias Fegg, and Martin Führer. 2021. „Attitudes Toward Assisted Suicide and Euthanasia Among Medical Students at German Universities.“ *BMC Medical Ethics* 22 (1): 12.
11. Morrell, Travis, Konda Sailes, and Jane M. Grant-Kels. 2019. „Response to a Letter to the Editor Regarding 'The Ethical Issue of Cherry Picking Patients'.“ *Journal of the American Academy of Dermatology* 80 (5): e127.
12. Pastrana, T., S. Jünger, C. Ostgathe, F. Elsner, and L. Radbruch. 2008. „A Matter of Definition—Key Elements Identified in a Discourse Analysis of Definitions of Palliative Care.“ *Palliative Medicine* 22 (3): 222–232.
13. Payne, Richard. 2016. „Racially Associated Disparities in Hospice and Palliative Care Access: Acknowledging the Facts While Addressing the Opportunities to Improve.“ *Journal of Palliative Medicine* 19: 131–133.
14. Pereira, Jamie. 2011. „Legalizing Euthanasia or Assisted Suicide: The Illusion of Safeguards and Controls.“ *Current Oncology* 18 (2): e38–e45.
15. Quill, E. Timothy, L. Anthony, and Susan D. Block. 2016. „Responding to Patients Requesting Physician-Assisted Death: Physician Involvement at the Very End of Life.“ *JAMA* 315: 245–246.
16. Radbruch, Lukas, Liliana De Lima, Felicia Knaul, Roger Wenk, Zaheer Ali, Shivnath Bhatnagar, and Tania Pastrana. 2020. „Redefining Palliative Care—A New Consensus-Based Definition.“ *Journal of Pain and Symptom Management* 60 (4): 754–764.

17. Rietjens, Judith A. C., Paul J. van der Maas, Bregje D. Onwuteaka-Philipsen, Johan J. M. van Delden, and Agnes van der Heide. 2012. „Two Decades of Research on Euthanasia in the Netherlands.“ *Bioethical Inquiry* 9 (3): 239–252.
18. Stolz, Erwin, Hannes Mayerl, Peter Gasser-Steiner, and Wolfgang Freidl. 2017. „Attitudes Toward Assisted Suicide and Euthanasia Among Care-Dependent Older Adults (50+) in Austria: The Role of Socio-Demographics, Religiosity, Physical Illness, Psychological Distress, and Social Isolation.“ *BMC Medical Ethics* 18: 71.
19. Sulmasy, Lois Snyder, and Paul S. Mueller. 2017. „Ethics and the Legalization of Physician-Assisted Suicide: An American College of Physicians Position Paper.“ *Annals of Internal Medicine* 167: 576–578.
20. van Bruchem-Visser, R. L., A. M. van Dijk, E. A. Giezeman, and J. Zwaveling. 2020. „Medical Students' Ethical Development and Their Attitudes Towards End-of-Life Decisions.“ *Medical Teacher* 42 (7): 753–760.
21. Wagner, Barbara, Julia Müller, Andreas Maercker, and Stefan Forstmeier. 2012. „Death Wishes in Older Adults: Examining a Psychosocial Model.“ *Aging & Mental Health* 16 (3): 329–337.
22. Yang, Y. Tony, and Farr A. Curlin. 2016. „Why Physicians Should Oppose Assisted Suicide.“ *JAMA* 315: 247–248.

SHORT BIO:

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VPLIV IN DOPRINOS MEDGENERACIJSKEGA TURIZMA *IMPACT AND CONTRIBUTION OF INTERGENERATIONAL TOURISM*

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POVZETEK

Staranje prebivalstva je pojav sodobne postmoderne družbe, ki pa, navkljub negativni konotaciji, prinaša tudi nove priložnosti, med drugim tudi na področju krepljenja medgeneracijskih odnosov. Že v aktualni sodobni družbi lahko opazimo porast medgeneracijskih skupin in centrov, ki dokazujejo, da imajo tovrstna medgeneracijska druženja zares pozitiven učinek na psihofizično stanje ljudi, sicer različnih generacij, obenem pa spodbujajo socializacijo, širjenje obzorij ter prenašanje izkušenj med generacijami. Vedno večji pomen dobivata tudi turizem za starejše odrasle in medgeneracijski turizem, ki ob dobrem poznavanju ciljne skupine in upoštevanju njihovih potreb in želja predstavljata velik potencial za turistični sektor in posledično tudi za gospodarstvo, tako na lokalni kot tudi na državni ravni. Tovrstne turistične aktivnosti spodbujajo aktivno staranje, hkrati pa prinašajo številne psihosocialne koristi in krepijo vezi med različnimi generacijami, ki pomembno vplivajo na kakovost življenja pa tudi staranja. V empiričnem delu smo s pomočjo anketnega vprašalnika raziskovali vpliv medgeneracijskega turizma na vzpostavitev tesnejših medsebojnih vezi med starimi starši in vnuki, hkrati pa smo s tem tudi preverjali, kako pomembni so medgeneracijski stiki za mlajšo generacijo, ki ima drugačne vrednote in navade kot starejša generacija veteranov in generacija Baby boom. Ugotovili smo, da je večina anketirancev s starimi starši v dobrih odnosih, obenem pa smo s pomočjo dobljenih empiričnih rezultatov potrdili zastavljeno raziskovalno hipotezo, saj so anketiranci ocenili, da skupno udejstvovanje v turističnih aktivnostih s starimi starši ugodno vpliva na njihove medsebojne odnose in na pogostost stikov ter da prihaja do prenosa pomembnih življenjskih izkušenj.

Ključne besede: starejši odrasli, medgeneracijski odnosi, turizem za starejše odrasle, medgeneracijski turizem, krepljenje medsebojnih odnosov

ABSTRACT

The aging of the population is a phenomenon of modern postmodern society, which, despite its negative connotation, also brings new opportunities, including in the field of strengthening intergenerational relations. Already in the current modern society, we can see the increase of intergenerational groups and

centers, which prove that this kind of intergenerational gatherings really have a positive effect on the psychophysical state of people, otherwise of different generations, and at the same time they encourage socialization, broadening of horizons and transfer of experiences between generations. Tourism for older adults and intergenerational tourism are also gaining more and more importance, which, with a good knowledge of the target group and taking into account their needs and wishes, represent a great potential for the tourism sector and, consequently, also for the economy, both at the local and national level. This type of touristic activity encourages active aging, and at the same time brings many psychosocial benefits and strengthens the ties between different generations, which have a significant impact on the quality of life as well as aging. In the empirical part, with the help of a questionnaire, we investigated the impact of intergenerational tourism on the establishment of closer mutual ties between grandparents and grandchildren, and at the same time we also checked how important intergenerational contacts are for the younger generation, which has different values and habits than the older generation of veterans. and the Baby Boom generation. We found that the majority of respondents have good relations with their grandparents, and at the same time, with the help of the obtained empirical results, we confirmed the set research hypothesis, since the respondents estimated that joint participation in tourist activities with grandparents has a beneficial effect on their mutual relations and on the frequency contacts and that there is a transfer of important life experiences.

Keywords: older adults, intergenerational relations, tourism for older adults, intergenerational tourism, strengthening mutual relations

UVOD

EkspONENTNO staranje prebivalstva je fenomen sodobne družbe, ki bo v prihodnosti imel vedno večje socialne in ekonomske posledice, ki bodo zahtevale drastične spremembe znotraj našega sistema (Dimovski 2011, 37). Demografske spremembe tako prinašajo nove izzive na področju dolgotrajne oskrbe; potrebne bodo številne prilagoditve, pomanjkanje aktivnega ukrepanja na tem področju namreč čutimo že danes. Staranje prebivalstva hkrati ponuja cel spekter možnosti in priložnosti, med drugim tudi na področju krepljenja medgeneracijskih odnosov, ki ugodno vplivajo na počutje vseh generacij, ki so vanje vključene, tudi pri gradnji socialnega in družinskega kapitala znotraj ožje in razširjene družine (Schänzel in Yeoman 2015, 145).

Že v današnjem času lahko opazimo porast medgeneracijskih skupin in centrov, ki v praksi preko različnih projektov in organiziranih dogodkov dokazujejo, da imajo tovrstna medgeneracijska druženja zares pozitiven učinek na psihofizično stanje

(med drugim tudi na stanje najranljivejših skupin, torej otrok in starejših odraslih), obenem pa spodbujajo socializacijo (spoznavanje novih ljudi, deljenje skupnih interesov) in nudijo prostor za povezovanje ter prenašanje izkušenj med generacijami.

Vzporedno z medgeneracijskimi skupinami vedno večjo razsežnost dobivata tudi pojma turizem za starejše odrasle in medgeneracijski turizem, ki pa poleg psihosocialnega vidika prinašata tudi številne ekonomske priložnosti za lokalno gospodarstvo oziroma gospodarstvo na sploh (ponudba različnih storitev: prevozi, gostinstvo, nastanitve, muzeji, galerije...). Kajti starejše prebivalstvo predstavlja tudi velik trg, saj imajo starejši veliko kupno moč, sorazmerno višjo od mlajših skupin (Alén idr. 2016, 303). Medgeneracijski turizem in turizem za starejše spodbujata tudi aktivno staranje. Aktivnosti, ki jih ponujata, krepijo vezi, povezave znotraj družine in skupnosti, spodbujajo medsebojno spoštovanje, razumevanje drug drugega in omogočajo izmenjavo znanj in izkušenj, hkrati pa sodelovanje v tovrstnih dejavnostih pripomore k fizičnemu in duševnemu zdravju, ki pomembno vplivata na kakovost življenja/staranja.

Namen prispevka je raziskati, kakšen pomen ima turizem za starejše odrasle, posebej medgeneracijski turizem, kjer lahko omenimo tudi družinski turizem, v današnji, postmoderne družbi, za katero je značilen hiter in odtujen življenjski slog. Prav v medgeneracijskih turističnih aktivnostih se namreč skriva obilica priložnosti za ponovno vzpostavitev povezav med različnimi generacijami, ki se pod vsakodnevnimi pritiski vedno bolj oddaljujejo druga od druge, obenem pa ponuja tudi priložnosti za izmenjavo dragocenih življenjskih izkušenj in odkrivanje novih, skupnih interesov, ki samo še bolj krepijo medgeneracijske odnose. Schänzel in Yeoman (2014, 357) prav zato napovedujeta, da se bo družinski turizem razvijal hitreje kot ostale oblike turizma.

Naši cilji so bili:

- opredeliti pojem staranja prebivalstva,
- opisati potrebe in ovire starejših odraslih na splošno,
- raziskati turizem za starejše in z njim povezano aktivno staranje,
- opisati pomembnost medgeneracijskih stikov,
- raziskati pozitivne učinke in priložnosti družinskega in medgeneracijskega turizma
- ter v sklopu raziskovalnega dela poiskati oziroma potrditi povezavo med vzpostavljanjem tesnejših vezi med vnuki in starimi starši ter skupnim udejstvovanjem v turističnih aktivnostih.

STARANJE PREBIVALSTVA

Staranje prebivalstva je zadnjih nekaj let tema, ki ima velik pomen v družbi (Goriup in Lahe 2018, 32; Dimovski in Žnidaršič 2009, 38). V Sloveniji se je staranje

prebivalstva začelo najprej s padanjem rodnosti (Šircelj 2009, 22), nato še z generacijo baby boomov, ki je dosegala (in še dosega) upokojitveno starost, ter s povečanjem človeške dolgoživosti (Dimovski in Žnidaršič 2007, 2–15). Staranje prebivalstva, ali njegovo »sivenje«, kot ga nekateri imenujejo, je proces brez primere ter brez vzporednice v zgodovini človeštva. Prebivalstvo se stara, ko rastoči delež starejših oseb (osebe starejše od 60 let) spremljata zmanjševanje deleža otrok (mladostniki pod 15 let) in upadanje deleža oseb v delovni dobi (osebe stare od 15 do 59 let) (United Nations 2009).

Pri staranju prebivalstva (SURS 2023) lahko govorimo o posamezniku ali skupini ter prebivalstvu. V Sloveniji z besedo starejši odrasli običajno označujemo osebe, stare 65 ali več let. Med letoma 1991 in 2023 je zrasel za 10,6 odstotne točke, tj. z 10,8 % leta 1991 na 21,4 % letos. Dviguje se tudi povprečna starost prebivalstva: na začetku leta 1991 je bila 35,9 leta, na začetku leta 2023 pa 44,0 leta ali za več kot 8 let višja. Naraščanje starejših odraslih ljudi je zadnje časa pogosta tema raziskav. Starostna doba se zvišuje in to lahko pripelje do družbenega problema. Že sedaj prihaja do pomanjkanja kadra pri socialnih zavodih, ki skrbijo za starejše odrasle in tudi tam je povprečna starost zaposlenih 45 let in več. V Sloveniji je trenutno 2.117.674 prebivalcev, od tega imamo večji delež starejših kot mladih (SURS 2023).

Na svetovni ravni je pričakovano trajanje življenja ob rojstvu leta 2019 doseglo 72,8 leta ali skoraj 9 let več kot v 1990. Po upadu v letih 2020 in 2021, ko se je stopnja umrljivosti zaradi pandemije covid-19 zvišala, se povprečna življenjska doba znova podaljšuje – po napovedih Združenih narodov naj bi v drugi polovici sedemdesetih let tega stoletja svetovno pričakovano trajanje življenja ob rojstvu preseгло 80 let (SURS 2023). Delež oseb, starejših od 65 let, v celotnem prebivalstvu je bil lani največji v Italiji (23,8 %), najmanjši pa v Luksemburgu (14,8 %). Povprečje EU-27 je bilo 21,1 %, enako kot v Sloveniji (SURS 2023).

Po projekcijah prebivalstva naj bi se število prebivalcev Slovenije do leta 2100 zmanjšalo za 7,8 %. Povečalo pa naj bi se število starejših od 65 let, in sicer za 37,7 %; število starejših moških za 59,2 % in število starejših žensk za 21,1 %. Delež oseb te starosti v celotnem prebivalstvu naj bi leta 2100 narasel na 32,1 %; med moškimi naj bi bilo starejših od 65 let 31,1 %, med ženskami pa 33,2 % (SURS 2023). Staranje prebivalstva je predvsem posledica dolgotrajnega padanja stopnje rodnosti in podaljšanja pričakovane življenjske dobe (dolgoživosti), pri čemer slednje odraža številne različne dejavnike, vključno z zmanjšanjem umrljivosti otrok, napredkom v javnem zdravstvu, z razvojem tehnologije, z večanjem ozaveščenosti o povezanih koristih in zdravem načinu življenja, z odmikom od težkega dela v smeri terciarnih poklicev ter z izboljšanjem življenjskih razmer (Eurostat 2020, 8).

TURIZEM ZA STAREJŠE ODRASLE

Turizem je gibanje in interakcija ljudi znotraj in izven njihovega vsakdanjega okolja (Juvan idr. 2021, 39). Število turistov se čez leta povečuje, na kar opozarjajo nekateri avtorji (Peceny Starc idr. 2019, 51), tudi na račun starejših turistov.

Pomen starejših odraslih

Staranje prebivalstva je torej eden največjih demografskih trendov na svetu, ta trend pa ima posledično vedno večji vpliv tudi na različne sektorje, med drugim tudi na področje turizma (Raspor in Macuh 2021, 157).

Dandanes se turističnih aktivnosti poslužujejo že vsi, tudi vedno več starejših odraslih, predvsem zaradi višjega življenjskega standarda, naraščanja življenjske dobe ter dostopnosti zdravstvenih storitev. Starejši odrasli so tudi bolj finančno sposobni kot v preteklosti. Sorazmerno z vedno večjim deležem upokojenega prebivalstva narašča tudi zanimanje za turistične storitve, kar pa prinaša številne nove poslovne priložnosti (Macuh in Raspor 2017, 414–415).

Aktivno staranje

V zadnjih letih se vedno več govori tudi o aktivnem staranju, ki spodbuja telesni, duševni in socialni dobrobit starejših odraslih. Aktivno staranje jim omogoča, da ostanejo družbeno dejavni ter da sodelujejo v različnih aktivnostih, na različnih področjih (Hung in Lu v Raspor in Macuh 2021, 158). Aktivno staranje je možno projicirati tudi na turizem.

Turizem v tem vidiku veliko doprinese k aktivnosti starejših odraslih, prinaša namreč ogromno psihofizičnih koristi, potovanja pa obenem tudi obogatijo njihova življenja, v njih vzbujajo dobre občutke in jih izpopolnjujejo. Marsikateri starejši ob upokojitvi išče aktivne izlete in potovanja, turistične aktivnosti pa dojemajo tudi kot nagrado ob koncu več desetletij dolge delovne dobe (Hung in Lu v Raspor in Macuh 2021, 157).

Medarič idr. (2016, 114–116) so poudarili pozitiven vpliv turizma na različne življenjske vidike:

- na socializacijo (potovanja spodbudijo druženje in socialno interakcijo; to je zelo koristno za tiste, ki se soočajo z osamljenostjo),
- na zdravje (raziskave so pokazale povezavo med udejstvovanjem v turizmu in funkcionalno sposobnostjo starejših),
- s pomočjo turizma starejši odrasli tudi širijo obzorja (turizem ima veliko pozitivnih učinkov, med drugim so pridobivanje novih znanj, spoznavanje novih ljudi, krajev, kultur, običajev, širjenje izkušenj).

Turizem za starejše odrasle

Raspor in Macuh (2021, 163) trdita, da ima turizem za starejše v naši družbi ogromen potencial, Jang in Wu (2006, 306) pa dodajata, da je večje zanimanje za trg potovanja starejših zdaj postal svetovni fenomen. Ugodni rezultati in zadovoljstvo turistov izhajajo predvsem iz poglobljenega razumevanja ciljne skupine. V primeru turizma za starejše je torej treba dobro razumeti »način razmišljanja in vedenja starejših v njihovem prostem času« in v udeleževanju v turističnih aktivnostih (Hung in Lu v Raspor in Macuh 2021, 158). Bai idr. (2001, 163) pa napovedujejo, da se bo z večanjem deleža starejših, večal tudi delež starejših turistov.

Raspor in Macuh (2021, 158) sta navedla, da je »starejši turist običajno oseba, starejša od 50 oziroma 55 let«, pri čemer moramo upoštevati tudi Ramovšev (2014) delitev starostnih obdobj. V zgodnji starosti (od 66. do 75. leta) so starejši navajajo na življenje v pokoju, ki je aktivno in z obilico prostega časa. V srednji starosti (od 76. do 85. leta) je že prisotno usihanje zdravja, s tem obdobjem povezano pa je tudi pomanjkanje želje po pridobivanju novih izkušenj. V pozni starosti (po 86. letu starosti) je starejši odrasli večinoma že odvisen od tuje pomoči, »izvaja samo še osnovne življenjske naloge« (Raspor in Macuh 2021, 109).

Starejši odrasli se med seboj, tako kot vsi ljudje, zelo razlikujejo; so izredno heterogena ciljna skupina. Razlike so prisotne v življenjskem slogu, v preferencah, željah, zdravstvenem in finančnem stanju. Vse to je potrebno upoštevati pri oblikovanju turističnih ponudb. Pri oblikovanju turističnih ponudb se je tako treba zavedati, da veliko starejših ne mara novosti, sprememb, spontanosti, po drugi strani pa obstajajo tudi starejši odrasli, ki počitnice radi preživljajo aktivno in se veselijo novih izkušenj (Raspor in Macuh 2021, 158).

Macuh in Raspor (2017, 415) sta opozorila, da so upokojenci »po navedbah turističnih agencij ena najzahtevnejših skupin«. Starejšim turistom je zelo pomembna kvaliteta turistične storitve, gastronomska ponudba, zanesljivo in kvalitetno vodenje, po drugi strani pa ne marajo doplačil za storitve in nenadnih sprememb programov.

Zavedati se moramo diskretnosti: čeprav starejši turisti želijo, da se pri turističnih ponudbah upošteva njihove potrebe, želijo, da so te prilagoditve storjene na diskreten način, brez javnega izpostavljanja besed, kot sta »stari« in »seniorji« (Mikola 2004, 38).

Pri starejših turistih so priljubljene naslednje oblike turizma: mednarodna in domača tekmovanja za seniorje, enodnevni izleti za seniorje, posebni večdnevni paketi za seniorje, aktivne počitnice za seniorje, gastronomski turizem, mestni turizem, kulturni turizem, karavanning, zdraviliški in zdravstveni turizem, planinski turizem, rekreativno pohodništvo, križarjenja za seniorje, kolesarski turizem, religiozni in romarski turizem, izobraževalni turizem, zgodovinski turizem, nakupovalni turizem, ter lovski in ribiški turizem (Ivanuša-Bezjak v Kežman 2021, 25).

Omejitve in prilagoditve starejših odraslih

Starejši odrasli se med sabo razlikujejo, razlikujejo pa se tudi njihove potrebe, ki so odvisne predvsem od načina staranja. Nekateri starejši so na primer v tem življenjskem obdobju še zelo aktivni, se udeležujejo pristočasnih aktivnosti, izletov, nekateri so še celo delovno aktivni. Po drugi strani so tukaj tudi starejši odrasli, ki imajo različne zdravstvene težave in potrebujejo pomoč pri opravljanju vsakodnevnih aktivnosti (Raspor in Macuh 2021, 107). Starejši so danes v boljšem zdravstvenem stanju kot so bili v preteklosti, imajo višje prihodke, več časa za potovanja in visoko tendenco po potovanjih na daljše razdalje (Litrell idr. 2004, 349–350).

Marsikateri starejši odrasli bi se udeleževali v različnih turističnih dejavnostih, če ne bi imel zdravstvenih težav in drugih omejitev. Številni starejši odrasli imajo posebne omejitve glede mobilnosti, hkrati pa je pri njih prisoten tudi strah pred neizidoma, na kar vpliva tudi omejen dostop do zdravstvene oskrbe na turističnih destinacijah. Nekateri se na primer od doma ne odpravijo tudi zaradi osamljenosti ob izgubi bližnjega. Potovanja tako starejšim odraslim, ki se soočajo z izgubo, predstavljajo tudi priložnost za socializacijo in vzpostavljanje novih družbenih stikov (Raspor in Macuh 2021, 158). Pri starejših odraslih, ki imajo posebne omejitve, lahko omenimo še starejše odrasle z različnimi oblikami demence. Demenca običajno vpliva na orientacijo, tako časovno kot prostorsko, bolniki z demenco pa imajo posledično še bolj omejene možnosti za uživanje v turističnih ponudbah kot ostali, z drugimi omejitvami (Lipar v Raspor in Macuh 2021, 160–161). Kot navajata avtorja, so »pristopi za vključevanje tovrstnih bolnikov dokaj specifični«. Bolniki z različnimi oblikami demence zahtevajo turistična območja, ki so varna, pod nadzorom, kjer ni tveganja, da bi se izgubili, hkrati pa je zelo spodbudno, da »jih peljemo v kraje, kjer so že bili v preteklosti, saj jim bo podoživljanje okolja izboljšalo zdravstveno stanje« (Raspor in Macuh 2021, 161).

Raspor in Macuh (2021, 157) trdita, da starejšim odraslim na izletih oziroma potovanjih največje težave povzročajo spremembe »klimatskih pogojev, časovnih pasov, kulturnih navad, prehrane« ter tudi večji fizični napori, kot je dolgotrajna vožnja ali pa hoja.

V turizmu bi tako morali nameniti še večjo pozornost prilagajanju storitev potrebam starejšim odraslim, obenem pa zagotavljati, da se starejši odrasli na potovanjih ali drugi turističnih dejavnostih zares počutijo varno. Vedno bolj se govori tudi o tako imenovanemu dostopnemu turizmu, ki omogoča dostopnost turističnih aktivnosti in neodvisno koriščenje teh storitev tudi osebam z različnimi omejitvami: omejitvami v mobilnosti, senzornimi omejitvami (vid in sluh), intelektualnimi ali kognitivnimi omejitvami, psihičnimi omejitvami ter raznimi občutljivostmi, na primer na hrano ali kemikalije (Buhalis in Darcy 2011, 5).

Večji poudarek bi bilo v bodoče treba dati tudi prilagojenemu transportu in dostopni turistični infrastrukturi, torej dostopnosti turističnih atrakcij in drugih storitev, ki jih turisti koristijo, dostopnim hotelskim sobam, restavracijam z dostopnimi toaletami, dostopnim potem, športnim površinam in parkirnim mestom (UNWTO 2016, 45). Le na takšen način lahko zares dosežemo, da ne pride do izključevanja posameznih skupin in da vsi turisti v polni meri izkusijo turistične storitve ter da se bodo turisti konec koncev na destinacijo tudi vračali.

TURIZEM IN STAREJŠI ODRASLI

Popolnoma neaktualno je mnenje, da je turizem priložnost za mlade in za samo zdrave ljudi. Podatki kažejo, da bo v Evropi do leta 2030 več kot polovica prebivalstva starejšega od šestdeset let. Gre torej za najštevilčnejšo skupino ljudi, ki bo imela največ prostega časa in največ potreb po različnih storitvah, večinoma takšnih, kakršne bo zagotavljala turistična dejavnost. Pri tem govorimo o ponudbi naslednjih storitev: turizma dogodkov, rekreativnega turizma, podeželskega, kulturnega, termalnega, zdraviliškega in zdravstvenega turizma (Veljković in Colarič-Jakše 2014, 12). Tako Jang in Wu (2006, 314) ugotavljata, da so zdravi starejši bolj notranje motivirani za potovanje.

Demografski dejavniki so ključnega pomena v turizmu, saj so del profila turistov, ki ga pri načrtovanju turistične ponudbe destinacij nujno moramo poznati. Kot se spreminja demografska slika neke populacije v nekem okolju, se z njo spreminjajo nakupovalni vzorci, vedenje turistov, zahteve po turističnih aktivnostih, rekreaciji in športu. Starejši v sodobnem času se zaradi različnih razlogov vedejo drugače od starejših pred 50 leti. K temu seveda prispevajo napredki in spremembe v medicini, tehnologiji, delavski zakonodaji in na drugih področjih (Vodeb 2010, 131).

»Demografske spremembe so pomembne za trženje turističnih destinacij. Upad rodnosti oz. število otrok, naraščanje deleža starejših ljudi in spreminjanje družinskih vzorcev vpliva tudi na izbiro turističnih destinacij. Družbeni položaj pove, kakšen položaj zaseda potrošnik v družbi, in vpliva na vedenje potrošnikov. Družbeni položaj je določen z dejavniki kot so dohodek, premoženje, izobrazba, poklic, družinski ugled, uveljavljenost doma in v tujini« (Nemec Rudež in Zabukovec Baruca 2011, 56).

V prihodnje je pričakovati povečanje deleža starejših ljudi in zato večje povpraševanje po kvalitetnih, primernih in varnih ponudbah, enostavnih prevozih, sproščujočih aktivnostih, po produktih za eno osebo v izven sezonskih mesecih in s poudarkom na udobju. Śniadek (2006, 103–105) zato trdi, da obstaja več razlogov, zakaj mora turistična in počitniška industrija resno upoštevati trg starejših. Tendenca staranja prebivalstva se posebej pričakuje v evropskih državah, kar bo povečalo socialne imigracije. Po drugi strani pa lahko Evropa pri migracijah pričakuje ti. »podnebno« imigracijo. Gre za ljudi, ki zaradi nevzdržnih

podnebnih razmer v kraju rojstva ali prebivanja zapuščajo določena geografska območja (npr. Afrika) in se naseljujejo tam, kjer lažje živijo (Veljković in Colarič-Jakše 2014, 215–216).

Veliko je turistov iz tretjega življenjskega obdobja, ker se daljša življenjska doba in ker imajo na splošno boljše zdravstveno stanje. Prihajajo po upokojitvi, turizem jim je finančno dosegljiv, imajo prihranke. Veliko ljudi si v starosti želi še kaj videti in doživeti, ker so se spremenile vrednote in življenjski slog. Veliko si jih želi okrepiti zdravje, mnogo se jih želi družiti. Zanje imajo prednost organizirana potovanja in organizirane počitnice, tudi vikendaštvo. Všeč jim je tudi krajši izletniški turizem. Potovanja pa ne smejo biti predolga in ne najbolj naporna (Pogačnik 2008, 188).

Za starejše odrasle je zanimiv še zdravstveni, potovalni, kulturni in verski turizem. Večinoma ne marajo avanturističnih, športnih in mladinskih oblik turizma. Všeč jim je družinski turizem. Starejši obenem ne marajo hrupnih krajev in krajev, kjer so množice turistov. Iščejo kraje, kjer je varnost in higiena. Radi imajo tople obmorske kraje in toplice, radi obiskujejo galerije in kulturne prireditve, všeč so jim nakupi in ogledi parkov. Obiskujejo promenadne koncerte, kavarne in slaščičarne. Topli obmorski kraji ali topliški kraji, ki zanimajo starejše, ne smejo biti zelo oddaljeni in morejo biti dobro uveljavljeni. Ne smejo biti izpostavljeni visokim vročinam. Starejši turisti imajo radi vodene ogledne. Priljubljena dejavnost starejših je tudi kopanje. Zagotovljeni morajo biti ogrevani bazeni in wellness centri. Velika turistična središča naj imajo prostorsko ločene, mirnejše, zelene in kulturno bogate predele, ki privlačijo starejše. Prisotna mora biti zdravstvena pomoč in možnost hitrega prevoza v bolnišnico (Pogačnik 2008, 188).

Pri načrtovanju turizma za starejše pazimo na prostorske ureditve. Te morajo olajšati njihovo gibanje. V poštev pridejo krajše promenade in terase. Pešpoti naj bodo manj strme in opremljene z ograjami in klopami. Kolesarske poti naj bodo blage. Na voljo naj jim bo javni prevoz, taksiji, turistični vlakci, vzpenjače itd. Do gradov, kraških jam, strmih obal, kjer so večje višinske razlike, naj bodo na voljo dvigala. Do zgodovinskih in naravnih znamenitosti naj bodo na voljo varne poti z ograjami, tudi počivališča (Pogačnik 2008, 188).

V prihodnosti bo turizem starejših splošno naraščal. Vključenih bo vse več slojev ljudi, prihajalo pa bo tudi vse več turistov iz tretjega sveta. To je treba upoštevati pri načrtovanju turizma (Pogačnik 2008, 188).

MEDGENERACIJSKI ODNOSI

Stari starši so običajno vnukom prva izkušnja medgeneracijskega sožitja. Ta izkušnja daje v povprečno zdravem sožitju otroku dve pomembni izkušnji. To sta ljubezen in naklonjenost, ki se od starševske razlikujeta z vidika miru in spokojne potrpežljivosti. Stari starši predajajo tudi zrelo življenjsko izkušnjo, predvsem da

se da živeti tako v ugodnih kot neugodnih življenjskih razmerah ter da je življenje brezpogojno smiselno. Nekateri stari starši so dandanes zaradi svojega imetja pomemben materialni vir za odraščanje vnukov. Zelo pogosta je vzgojna moč starih staršev mladi družini: vnuke varujejo, jih vodijo v vrtec, skuhajo kosilo in s tem pridobivajo na odnosu, zaupanju, spoštovanju in sprejetosti (Lipar in Ramovš 2013, 48–49). Za medgeneracijsko sodelovanje je potrebna vseživljenjska medgeneracijska vzgoja (Ramovš 2012, 25).

V starosti je še posebej pomembno zadovoljstvo s svojim življenjem. Upokojitvena življenjska inventura pa obsega tudi kompostiranje slabih življenjskih izkušenj. Ta omogoči, da ne zastrupljajo človekovega zadovoljstva s svojim življenjem in še veliko več: da se slabe življenjske izkušnje spremenijo v »gnojilo« za kakovostno staranje in sožitje med lastno in mlajšima generacijama (Lipar in Ramovš 2013, 48–49). Coall in Hertwig (2010, 11) pa poudarjata, da medgeneracijski prenosi niso nujno enosmerni.

Mnogi podatki kažejo na to, da v današnjem svetu vedno več ljudi doživlja samoto in osamljenost, tako starih kot mladih. Osamljenost starejših ljudi je ena izmed zagotovo najbolj perečih stisk današnje tretje generacije. Na prihodnost je treba gledati kot na izziv, s katerim se bomo morali soočiti in skupaj z vsemi generacijami ustvariti dobre pogoje za življenje v družbi in medsebojno solidarnost. Razvoj socialne vključenosti oziroma socialnih mrež bi morala iti v smeri:

- težišče kakovostnega sožitja med starimi in mladimi generacijami, na medgeneracijsko povezovanje;
- usposabljanje in pridobitev veščin za medgeneracijsko sožitje, komunikacijo itd.,
- delovanje civilnih socialnih mrež po principu samoorganizacije, samopomoči in solidarnosti na področju skrbi za stare (Ramovš 2006).

Dobri odnosi so temelj socialnega vključevanja in povezovanja različnih generacij, kar bo vplivalo na prenos življenjskih izkušenj, vrednot in tradicij. Musek (2014, 33) ob tem dodaja, da medgeneracijska nestrpnost in nesolidarnost načinjata integriteto človekove eksistence. Zelo pomembno je, da starejše spodbujamo k povezovanju v socialne mreže, medgeneracijsko sodelovanje in socialne vključenosti na različnih ravneh. Zelo pomembno je, da jih spodbujamo k samostojnosti in vključenosti v vsakdanje stvari (Ramovš 2006).

DRUŽINSKI TURIZEM

Pomen druženja, še posebej druženja z družino, je v življenju vsake osebe zelo kritično in pomembno. Znotraj družine so kompleksne povezave in odnosi, ki ogromno prispevajo h kakovosti življenja posameznika. Pozitivni družinski odnosi poleg doprinašanja k fizičnemu in psihičnemu zdravju družinskega člana vzpodbujajo pristne odnose sodelovanja, spoštovanja ter deljenja izkušenj, vrednot in

znanja (Tech-Roemer idr. 2002). Družina, kot ugotavlja Goody (2003, 211), je bila vselej osrednje žarišče človekovega življenja.

Pomembnost družine in medgeneracijskih odnosov je prepoznala tudi turistična industrija. Za potrebe ohranjanja te družinske povezanosti in družinskih vezi se je začela usmerjati v družinski turizem, ki trenutno predstavljajo zelo velik in rastoč trg (Schänzel in Yeoman 2015, 141–147). Družina lahko skozi turistične aktivnosti in počitnice pozabi na pritiske vsakdanjega življenja, šole ali službe. Družinske počitnice so tako ovrednotene kot simboličen in ne vsakdanji čas, skozi katerega se ustvarjajo dolgoročni spomini, ki so mnogokrat vrhunec otroških spominov (Shaw idr. 2008). Družinski turizem tako pripomore v vlaganje v doživetja in ne v materialnost in s tem k deljenju pozitivnih spominov med družinskimi člani, ki je lahko kasneje uporabljeno za izogibanje ali zmanjšanje konfliktov, spreminjanje stališč, ustvarjanje novih čustveno bogatih trenutkov ter tudi kreiranja načrtov za prihodnost (Wood idr. 2023). Družinska potovanja lahko tudi z obiski prijateljev in sorodnikov krepijo odnose ne samo znotraj ožje, temveč tudi širše družine. S tem so prav tako bolj odporna od drugih oblik turizma, saj ljudje mnogokrat potujejo iz razloga, da bi ponovno vzpostavili stike (Schänzel in Yeoman 2015, 141–147). Vendar pojem družine se je skozi desetletja spreminjal ter danes obstajajo različne oblike družin, ki imajo svoje edinstvene lastnosti in potrebe. Zato je iz strani turistične industrije potrebno obravnavati raznolikost družinskih struktur in oblik družin ter stremeti k bolj inovativnim in ustvarjalnim ponudbam, ki bodo zadovoljile vse novonastale potrebe (Schänzel idr. 2012).

MEDGENERACIJSKI TURIZEM

Daljša življenjska doba in manjše jedrske oblike družin so vplivale na to, da se vse večkrat opazuje večja vertikalnost, kot horizontalnost družine (Schänzel in Yeoman 2015, 141–147). Z dodatkom naraščajočih delovnih obveznosti in namenjanju več časa in energije karieram s strani staršev dobijo v življenju otrok dodatno pomembno vlogo stari starši. Stari starši prav tako zaradi trenutne daljše življenjske dobe preživijo veliko več časa z vnuki kot v prejšnjih desetletjih in se tako vključujejo ne samo v varstvo vnukov, temveč tudi v preživljanje prostega časa in turističnih dejavnosti z njimi (Durko in Petrick 2016). Tako so postala večgeneracijska oziroma medgeneracijska potovanja naraščajoč in zelo pomemben del družinskega turizma (Hapsari in Santoso 2022, 284).

Potovanja, ki so pogosto dojemana samo kot sprostitev ali priložnost za pobeg iz vsakdanjega življenja, dobijo z vključevanjem medgeneracijskega turizma dodatni pomen (koristi za družino in odnosi med družinskimi člani) (Durko in Petrick 2013). Vpeljevanje tretje generacije k družinskemu turizmu je pokazalo, da imajo velik vpliv na več vidikov v sami turistični dejavnosti. Ti vidiki so izbira

destinacije, nastanitve, prevoza, načrtovanja urnika ter trajanje počitnic ali dejavnosti (Hapsari in Santoso 2022, 284).

Stari starši lahko svoji družini z njihovimi prihranki, pokojnino, dohodki iz različnih naložb in drugih sredstev privoščijo potovanja in najrazličnejše turistične izkušnje (Bai idr. 2001, 148). Turistične organizacije v Afriki poročajo o kar 20-odstotnem povišanju rezervacij safari ogledov s strani starih staršev, ki želijo omogočiti sebi in svoji družini nepozabna »bucket-list« doživetja (Long 2023).

Na splošno bolj mobilna in zdrava starejša populacija trenutno želi na zabavne načine preživeti čas s svojimi vnuki in družino, katera je za starejše odrasle še tako neizmerljivo pomembna (Gurung in Ghimire 2014, 15). Danes imajo starši tudi manj otrok, kar pripomore k ustvarjanju še toliko močnejših vezi med stari in vnuki (Herlofson in Hagestad 2012).

Odnos med stari in vnuki je pa še tako posebna povezava, polna življenjskih izkušenj in zgodb. Stari starši imajo v družbi pomembno vlogo z vidika prenašanja znanja, vrednot, kulture in tradicije na svoje vnuke, pri čemer pomaga tudi medgeneracijski turizem. S skupnim udejstvovanjem v kulturnih turističnih dejavnosti, na festivalih in v običajih ne obogatijo samo kulturno pripadnost in identiteto vnukov, temveč na splošno ohranjajo njihovo kulturo in vrednote, kar je ključen vidik medgeneracijskih odnosov (Shavanddasht 2018).

Kljub temu, da turistična industrija prepozna medgeneracijski turizem kot do nose n segment, ostaja to področje slabo raziskano (Yang idr. 2020). Učinkovito trženje medgeneracijskega turizma je s strani turistične industrije težko (Hapsari in Santoso 2022). Vsaka generacija se vključuje v turizem na edinstven način, zato je s strani turističnih organizacij in industrije potrebno razviti učinkovito marketinško strategijo za večgeneracijski trg, ki bo ujel pozornost vseh starostnih skupin (Williams idr. 2010).

Marketinška sporočila se bi morala osredotočiti na družinsko povezanost, prikazovanje generacijskih vrednot ter vključevanje starih staršev in otrok v promocijski material, ki prikazuje povezanost in srečne trenutke med generacijami (Hapsari in Santoso 2022, 284). V turizmu se bi lahko vpeljala podoba družbe brez starostnih omejitev, kjer se bi ljudje opredeljevali bolj po dejavnostih, v katerih sodelujejo, kot pa po svoji starosti. Danes so lahko stari starši stari 45, 65 ali 85 let, in prav tako stremijo k bolj avanturističnim aktivnostim, na kar se mora prilagoditi turistični trg (Williams idr. 2010).

PRIMERI MEDGENERACIJSKEGA TURIZMA

Medgeneracijsko sodelovanje in odnosi skozi medgeneracijski turizem imajo ogromen doprinos ne le na posameznikovo življenje, temveč tudi za državo, družbo in njeno kulturo. Kot produkt globalizacije in množičnega prenašanja

drugih kultur se izpodrivajo ukoreninjene tradicije in kultura posameznih družb, kar lahko privede do dokončne izgubljene identitete. Tukaj pridejo v poštev starejši odrasli, ki lahko nudijo mnogo znanja, ki bo izginilo, ko jih ne bo več med nami (WalkAStory 2019).

Stari starši lahko delujejo kot varuhi tradicije, vrednot in kulturne dediščine. Zelo pomembno jim je, da se le te prenesejo na naslednje generacije. Iz teh namenov se izvaja in se je izvedlo mnogo projektov, ki skozi medgeneracijsko sodelovanje in medgeneracijski turizem želijo okrepiti tako ohranjanje kulturne dediščine kot tudi spodbujanje zdravega načina življenja. Eden izmed takšnih projektov je bil »Walk a story« ali »Prehodi zgodbo«, financiran s strani Evropske komisije in Erasmus + programa. Projekt je skozi inovativni turizem in sodelovanje promoviral zbiranje kulturne dediščine skozi medgeneracijske sprehode starih staršev, vnukov in njihovih vrstnikov. Te sprehode so vodili stari starši in med sprehajanjem razlagali vnukom in njihovim sovrstnikom dejstva o njihovem kraju in znamenitosti znotraj mesta. S projektom so tako spodbujali družbeno povezanost in krepljenje kulturne identitete mlajše generacije (WalkAStory 2019). Skozi medgeneracijske centre in univerze za tretje življenjsko obdobje je prav tako mnogo priložnosti za udeleževanje v medgeneracijski turizem, kjer se prirejajo potovanja in projekti.

EMPIRIČNI DEL

Na osnovi teoretičnih ugotovitev smo področje raziskali še z empiričnega vidika, zato smo si za namen našega prispevka zadali, da raziščemo, ali ima medgeneracijski turizem (skupno udeleževanje v turističnih aktivnostih: preživljanje počitnic, obiskovanje toplic, kulturnih in športnih prireditev, obiskovanje kulturnih in naravnih znamenitosti ipd.) pozitiven učinek na odnose med starimi starši in vnuki, torej da se med starimi starši in vnuki s pomočjo skupnega udeleževanja v turističnih dejavnostih posledično vzpostavljajo in krepijo tudi tesnejše vezi. Zanimala nas je interpretacija medsebojnih odnosov v odvisnosti od medgeneracijskega turizma tistih, ki so se s starimi starši udeleževali v turističnih aktivnostih, kot tudi interpretacija tistih, ki se niso.

Pri tem smo si za cilj zadali, da z anketnim vprašalnikom pridobimo podatke, da ugotovimo, v kakšni meri se mlajša generacija s svojimi starimi starši udeležuje v turističnih aktivnostih, ter da s pomočjo analize ugotovimo, v kolikšni meri imajo skupne turistične dejavnosti pozitiven učinek na vzpostavitev še tesnejših vezi in pogostost stikov med vnuki in starimi starši.

Za potrebe prispevka smo postavili tudi hipotezo, in sicer H1: Medgeneracijski turizem krepi vezi med starimi starši in vnuki (stari starši in vnuki, ki so se skupaj udeleževali turističnih dejavnosti, imajo tesnejše vezi in bolj trdne medsebojne odnose kot tisti, ki se niso). Krepitev vezi smo definirale kot: več medsebojnega

spoštovanja, boljše razumevanje drug drugega - druge starostne skupine, boljša komunikacija, poiskani so bili skupni interesi, izmenjale so se izkušnje in znanje...

Uporabili smo kvantitativno metodo z anketnim vprašalnikom. Za namen raziskave smo uporabile anketni vprašalnik z zaprtim tipom vprašanj (zbiranje empiričnih podatkov, urejanje in obdelava podatkov, prikaz in analiziranje podatkov). Anketni vprašalnik je v celoti obsegal 15 vprašanj (pri vprašanju »Ali se udeležujete turističnih aktivnosti/dejavnosti s starimi starši?« se je vprašalnik glede na izbran odgovor razdelil na dva dela). Anketiranci so do njega dostopali na spletu, in sicer med 1. in 5. 11. 2023. Naša raziskava je zajela manjši vzorec, v anketi je sodelovalo 87 ljudi. Pri izbiri vzorca smo uporabile metodo snežne kepe (metoda progresivnega podvajanja), vzorčenje je bilo torej naključno (vzorec je bil krajevno/regijsko dokaj razpršen).

Omejitev raziskave predstavlja manjši vzorec, saj le-ta ni reprezentativen, tako da posplošitev ni mogoča in naše ugotovitve ne veljajo za celotno populacijo. Obenem je anketni vprašalnik zajemal vprašanja dokaj subjektivne narave.

Anketa je bila zastavljena za anketirance, ki imajo še živeče stare starše, saj smo v raziskavi ugotavljali, kako medgeneracijski turizem vpliva na trenutne odnose in pogostost stikov s starimi starši; zanimalo nas je trenutno stanje. Anketni vprašalnik je bil namenjen posameznikom, rojenim med letoma 1997 in 2012, torej generaciji Z. Za to ciljno skupino smo se odločili, saj menimo, da generacija zaradi svojih značilnosti, kot so poznavanje tehnologije in razumevanje digitalizacije, zavedanje o hitrem načinu življenja in izobilje, najbolj izstopa in se najbolj razlikuje od današnje (naj)starejše generacije, torej generacije veteranov in generacije Baby boom. Generacija Z ima tudi drugačne vrednote, navade in poglede na življenje kot današnja starejša generacija. Pri generaciji Z pogosto naletimo na ignoranco do starejših in na pomanjkanje sočutja, zato je bilo še posebej zanimivo raziskovati njihove odnose s svojimi starimi starši.

Rezultati

V prvem delu ankete smo anketirancem postavili splošna in demografska vprašanja, nanašajoč se na trenutno stanje, s katerimi smo ugotavljali, kako blizu/daleč živijo njihovi stari starši, kako pomembni so zanje medgeneracijski stiki, kako bi ocenili njihove odnose s starimi starši, kako pogosto se srečujejo s starimi starši, ključno vprašanje za našo raziskavo pa je bilo vprašanje, če se udeležujejo turističnih dejavnosti s starimi starši.

V drugem delu se je anketa na podlagi odgovora na vprašanje »Ali se udeležujete turističnih aktivnosti/dejavnosti s starimi starši?« razdelila na dva dela. Tisti posamezniki, ki so na vprašanje odgovorili z da, so odgovarjali na vprašanja o pogostosti izvajanja skupnih turističnih dejavnosti in vplivu le-teh na njihove odnose s starimi starši ter o pridobivanju življenjskih izkušenj na izletih, potovanjih... Tisti posamezniki, ki so na vprašanje odgovorili z ne, pa so bili povprašani o njihovem mnenju, če bi

skupno udeleževanje v turističnih aktivnostih pripomoglo k izboljšanju njihovih odnosov s starimi starši in bi vplivalo na pogostejše stike. Eno vprašanje se je nanašalo tudi na pomembnost življenjskih izkušenj, pridobljenih v sklopu takšnih aktivnosti.

Tabela 1: Razdalja bivanja starih staršev

Odgovor	Število anketiranih	Odstotek anketiranih
Živimo skupaj	29	33,3 %
Živijo v istem kraju	25	28,7 %
Živijo v isti regiji	17	19,5 %
Živijo v drugi regiji	12	13,8 %
Živijo v tujini	4	4,6 %

Vir: lastna raziskava 2023

Tretjina anketirancev živi skupaj s starimi starši (29 ali 33,3 %), nekoliko manj jih živi v istem kraju kot stari starši (25 ali 28,7 %), najmanj starih staršev anketirancev pa živi v tujini (4 ali 4,6 %).

Tabela 2: Pomembnost medgeneracijskih stikov

Odgovor	Število anketiranih	Odstotek anketiranih
Zelo pomembni	23	26,4 %
Pomembni	44	50,6 %
Niti pomembni niti nepomembni	10	11,5 %
Nepomembni	2	2,3 %
Zelo nepomembni	8	9,2 %

Vir: lastna raziskava 2023

Več kot polovica anketirancev je odgovorila, da so zanje medgeneracijski stiki pomembni (44 ali 50,6 %). Na tretjem mestu so anketiranci, ki jim odnosi s starimi starši niso niti pomembni niti nepomembni (10 ali 11,5 %). Najmanj anketirancev je odgovorilo, da so zanje medgeneracijski stiki nepomembni (2 ali 2,3 %).

Tabela 3: Splošna kvaliteta odnosov s starimi starši

Odgovor	Število anketiranih	Odstotek anketiranih
Zelo dobri	40	46 %
Dobri	32	36,8 %
Zadostni	12	13,8 %
Slabi	1	1,1 %
Zelo slabi	2	2,3 %

Vir: lastna raziskava 2023

Največ anketirancev se je opredelilo, da so njihovi odnosi s starimi starši zelo dobri (40 ali 46 %). Kar nekaj jih je mnenja, da so dobri (32 ali 36,8). Samo en anketiraneec je odgovoril, da so odnosi s starimi starši slabi (1,1 %).

Tabela 4: Pogostost stikov s starimi starši

Odgovor	Število anketiranih	Odstotek anketiranih
Dnevno	25	28,7 %
Večkrat tedensko	15	17,2 %
Tedensko	19	21,8 %
Mesečno	16	18,4 %
Letno	12	13,8 %

Vir: lastna raziskava 2023

Največ anketirancev je odgovorilo, da imajo stike s starimi starši dnevno (25 ali 28,7 %). Na drugem mestu so tisti, ki imajo stike tedensko (19 ali 21,8 %). Najmanj anketirancev je odgovorilo, da imajo stike s starimi starši letno (12 ali 13,8 %).

Tabela 5: Udejstvovanje v turističnih aktivnostih s starimi starši

Odgovor	Število anketiranih	Odstotek anketiranih
Da	33	37,9 %
Ne	54	62,1 %

Vir: lastna raziskava 2023

Večina anketirancev se ne udejstvuje v turističnih aktivnostih s starimi starši (54 ali 62,1 %), ostali se udejstvujejo (33 ali 37,9 %).

Ker nas je v nadaljevanju zanimalo, kako je z anketiranci, ki se udejstvujejo turističnih aktivnosti s starimi starši, smo v nadaljnjo analizo vključili samo tiste anketirance. Teh je bilo 33 ali 37,9 % (tabele od 6 do 11).

Tabela 6: Pomembnost MG turizma za krepitev vezi

Odgovor	Število anketiranih	Odstotek anketiranih
Zelo pomemben	11	33,3 %
Pomemben	16	48,5 %
Niti pomemben niti nepomemben	4	12,1 %
Nepomemben	0	0
Zelo nepomemben	2	6,1 %

Vir: lastna raziskava 2023

Večini anketirancev se zdi medgeneracijski turizem pomemben za krepitev medsebojnih odnosov med vnuki in starimi starši (16 ali 48,5 %) ali zelo pomemben (11 ali 33,3 %). Nikomur se ne zdi medgeneracijski turizem za krepitev odnosov med vnuki in starimi starši nepomemben (0 ali 0 %), manjšini pa se zdi zelo nepomemben (2 ali 6,1 %).

Tabela 7: Pogostost udeještvojanja v turističnih aktivnostih s starimi starši

Odgovor	Število anketiranih	Odstotek anketiranih
Tedensko	0	0
Večkrat tedensko	1	3 %
Mesečno	8	24,2 %
Večkrat mesečno	2	6,1 %
Letno	22	66,7 %

Vir: Lastna raziskava 2023

Anketiranci se tedensko ne udeležujejo turističnih aktivnosti s svojimi starimi starši (0 ali 0 %), le redki večkrat tedensko (1 ali 3 %). Večina se jih udeležuje letno (22 ali 66,7 %) in mesečno (8 ali 24,2 %).

Tabela 8: Izboljššan stik s starimi starši na račun skupnega turističnega udeještvojanja

Odgovor	Število anketiranih	Odstotek anketiranih
Da	18	54,5 %
Ne	1	3 %
Mogoče	14	42,4 %

Vir: Lastna raziskava 2023

Anketirance smo vprašali, če imajo občutek, da se je s pomočjo skupnega udeještvojanja v turističnih aktivnostih med njimi in starimi starši vzpostavil tesnejši stik, torej, da so s starimi starši bolj povezani. Večina jih meni, da se je izboljšal stik (18 ali 54,5 %), najmanj pa jih je mnenja, da se na račun skupnega turističnega udeještvojanja stik ni spremenil (1 ali 3 %).

Tabela 9: Vpliv skupnih turističnih aktivnosti na pogostost stikov

Odgovor	Število anketiranih	Odstotek anketiranih
Da	20	60,6 %
Ne	5	15,2 %
Mogoče	8	24,2 %

Vir: Lastna raziskava 2023

Večina anketirancev meni, da bi skupno udejstvovanje v turističnih aktivnostih privedlo do boljšega stika s starimi starši (20 ali 60,6 %), nekateri v to niso prepričani (8 ali 24,2 %), najmanj pa jih to zanika (5 ali 15,2 %).

Tabela 10: Pridobivanje izkušenj posamezne generacije

Odgovor	Število anketiranih	Odstotek anketiranih
S starimi starši	18	54,5 %
Z vrstniki/prijatelji	15	45,5 %

Vir: Lastna raziskava 2023

Večina anketirancev meni, da s starimi starši dobijo več izkušenj ob skupnem turističnem udejstvovanju kot z vrstniki (18 ali 54,5 %), ostali menijo obratno (15 ali 45,5 %).

Tabela 11: Koristnost pridobljenih izkušenj v skupnem medgeneracijskem turističnem udejstvovanju

Odgovor	Število anketiranih	Odstotek anketiranih
Da	28	84,8 %
Ne	0	0
Mogoče	5	15,2 %

Vir: Lastna raziskava 2023

Večina anketirancev meni, da jim izkušnje/znanja, ki so jih pridobili z udejstvovanjem v turističnih aktivnostih skupaj s starimi starši, koristijo (28 ali 84,8 %). Nihče od udeležencev naše ankete ni odgovoril, da izkušnje/znanja, ki jih je pridobil z udejstvovanjem v turističnih aktivnostih s starimi starši, ne koristijo v življenju (0 ali 0 %), nekaj pa jih ni povsem prepričanih (5 ali 15,2 %).

V zadnjem delu so nas zanimali še mnenje in izkušnje tistih anketirancev, ki se s starimi starši ne udeležujejo v skupnih turističnih aktivnostih. Teh je bilo 54 ali 62,1 %, zato bomo v nadaljnjo analizo vključili samo te anketirance (tabele od 12 do 15).

Tabela 12: Pomembnost MG turizma za krepitev vezi

Odgovor	Število anketiranih	Odstotek anketiranih
Zelo pomemben	3	5,6 %
Pomemben	17	31,5 %
Niti pomemben niti nepomemben	26	48,1 %
Nepomemben	3	5,6 %
Zelo nepomemben	5	9,3 %

Vir: Lastna raziskava 2023

Med anketiranci, ki se ne udeležujejo medgeneracijskih turističnih aktivnosti s svojimi starimi starši, jih večina ni prepričana, če je to udejstvovanje pomembno za krepitev medsebojnih odnosov (26 ali 48,1 %), nekoliko manj pa jih trdi, da je pomembno (17 ali 31,5 %). Manjšini se zdi zelo pomembno (3 ali 5,6 %), nekaterim pa nepomembno (3 ali 5,6 %) in zelo nepomembno (5 ali 9,3 %).

Tabela 13: Želja po skupnem udejstvovanju v turističnih aktivnostih s starimi starši

Odgovor	Število anketiranih	Odstotek anketiranih
Da	15	27,8 %
Ne	15	27,8 %
Mogoče	24	44,4 %

Vir: lastna raziskava 2023

Delež anketirancev je trdil, da bi si želeli skupnih turističnih aktivnosti s svojimi starimi starši (15 ali 27,8 %), delež pa je trdil, da si jih ne želi (15 ali 27,8 %). Skoraj polovica bi si mogoče želela skupnih turističnih aktivnostih s starimi starši (24 ali 44,4 %).

Tabela 14: Vpliv skupnega turističnega udejstvovanja na kvaliteto medgeneracijskega odnosa

Odgovor	Število anketiranih	Odstotek anketiranih
Da	26	48,1 %
Ne	7	13 %
Mogoče	21	38,9 %

Vir: lastna raziskava 2023

Večina anketirancev meni, da bi se s pomočjo skupnega udejstvovanja v turističnih aktivnostih med njimi in starimi starši vzpostavil tesnejši stik, torej, da bi se s starimi starši bolj povezali (26 ali 48,1 %), manjšina se s tem ne strinja (7 ali 13 %), nekateri pa menijo, da mogoče (21 ali 38,9 %).

Tabela 15: Koristnost pridobljenih izkušenj v medgeneracijskem turizmu

Odgovor	Število anketiranih	Odstotek anketiranih
Zelo pomembne	5	9,3 %
Pomembne	23	42,6 %
Niti pomembne niti nepomembne	13	24,1 %
Nepomembne	8	14,8 %
Zelo nepomembne	5	9,3 %

Vir: lastna raziskava 2023

Večina anketirancev meni, da so izkušnje, ki jih pridobijo s starimi starši z udeleževanjem v turističnih aktivnostih, pomembne (23 ali 42,6 %) ali zelo pomembne (5 ali 9,3 %). Nekateri se ne morejo opredeliti o pomembnosti tovrstnih izkušenj (13 ali 24,1 %). Manjšina anketirancev pa trdi, da so nepomembne (8 ali 14,8 %) ali zelo nepomembne (5 ali 9,3 %).

RAZPRAVA

Medgeneracijski turizem ima ogromno potenciala in prinaša številne koristi, zato nas je v raziskovalnem delu zanimalo predvsem to, kako na medgeneracijski turizem gledajo predstavniki generacije Z, hkrati pa smo želeli izvedeti, če se mlajše generacije zavedajo pomena dobrih odnosov in povezav s starimi starši.

V sklopu prvega dela anketnega vprašalnika smo želeli pridobiti splošne informacije o tem, kje živijo stari starši anketirancev, v kakšnih odnosih so s svojimi starimi starši in kako pogosti so medsebojni stiki (v odvisnosti s prebivališčem starih staršev). Raziskava je pokazala, da približno tretjina anketirancev živi s svojimi starimi starši, zato lahko sklepamo, da bi lahko ta podatek vplival tudi na rezultate o pogostosti stikov (če živijo s starimi starši, se najverjetneje z njimi vidijo zelo pogosto), posredno pa bi lahko podatek vplival tudi na rezultate o medosebnih odnosih in vezeh.

Iz rezultatov je razvidno, da se več kot polovici anketirancev medgeneracijski stiki zdijo pomembni, približno tri četrtine anketirancev pa je v dobrih ali zelo dobrih odnosih s svojimi starimi starši. Razbrali smo torej, da se velik del našega vzorca zaveda, kako pomembno je medgeneracijsko sodelovanje in kakšne koristi prinašajo dobri medosebni odnosi tako eni kot tudi drugi generaciji.

Presenetljiv je bil tudi podatek, da se več kot polovica anketirancev dejansko ne udeležuje v turističnih aktivnostih s starimi starši, pričakovali smo namreč ravno obratno. Naša pričakovanja lahko pripišemo našim osebnim izkušnjam.

V nadaljevanju anketnega vprašalnika smo pridobili podatke, s katerimi smo lahko potrdili zastavljeno hipotezo (medgeneracijski turizem pripomore h krepitvi stikov med vnuki in starimi starši). Iz rezultatov smo lahko razbrali, da posamezniki, ki se udeležujejo v turističnih aktivnostih s starimi starši, dajejo medgeneracijskemu turizmu večji pomen kot tisti, ki se ne. Vsekakor pa moramo poudariti tudi ugotovitev, da večina anketirancev, ki se sicer niso udeleževali v turističnih aktivnostih s svojimi starimi starši, vseeno sklepa, da medgeneracijski turizem vpliva na vzpostavitev tesnejših vezi med vnuki in starimi starši in doprinese k izmenjavi življenjskih izkušenj.

Na podlagi pridobljenih rezultatov lahko sklepamo, da si posamezniki, ki so s starimi starši v slabih odnosih, ne želijo skupnega udeleževanja v turističnih aktivnostih in medgeneracijski odnosi zanje mogoče niso tako pomembni.

V nadaljevanju raziskave bi bilo smiselno raziskati še poglede in stališča starih staršev o medgeneracijskem turizmu, ter tudi pri njih preveriti, kakšne izkušnje imajo. V nadaljnjo raziskavo bi lahko vključili tudi vprašanja, ki povprašujejo po vrstah turističnih dejavnosti oziroma za katere oblike turizma se vnuki in stari starši najpogosteje odločajo, hkrati pa bi lahko preverjali tudi pomembnost in pogostost medgeneracijskega turizma v zvezi z nekaterimi splošnimi značilnostmi, kot je na primer spol, izobrazba, regija...

Menimo, da bi bilo treba dati medgeneracijskemu turizmu in medgeneracijskemu sodelovanju še večji pomen v turističnem sektorju in predstaviti različnim generacijam, koliko pozitivnih učinkov ta oblika turizma dejansko ima (tako psihične, kot tudi fizične ter socialne).

Na državni ravni bi bila implementacija medgeneracijskega turizma v pravem pomenu besedne zveze mogoča preko turistične politike, ki bi morala svoje aktivnosti in finančna sredstva bolj ciljno usmeriti tudi v razvoj in promocijo medgeneracijskega turizma. Pri definiranju smernic bi morale biti upoštevane tudi karakteristike, želje in potrebe različnih starostnih skupin (varnost, dostopnost, udobje). Medgeneracijski turizem bi se na trgu bolje uveljavil tudi s pomočjo sodelovanja različnih ustanov in ponudnikov, kot tudi s pomočjo spodbujanja turističnih ponudnikov pri uvedbi medgeneracijskih turističnih paketov. Medgeneracijski turistični paketi bi s pomočjo tržnih kampanj, prilagojenih različnim ciljnim skupinam, nagovarjali ljudi in obenem promovirali družbene koristi, preživljanje skupnega časa, prenos vrednot in tradicije ter krepitev medosebne vezi, ki jo prinašajo skupna doživetja. Ključnega pomena je tudi to, da se implementacija takšne oblike turizma ozavešča že na povsem lokalni ravni, skozi različne kulturne turistične ponudbe, prireditve in druga doživetja. Medgeneracijski turizem torej vsekakor prinaša številne poslovne priložnosti, ki bi jih gospodarstvo, tako na lokalni kot na državni ravni, lahko izkoristilo.

ZAKLJUČEK

Staranje prebivalstva je demografska sprememba, ki v sodobni družbi pridobiva vedno večji pomen. Starejši odrasli danes imajo mnogo več prostega časa, relativno boljše zdravje in razpoložljiva sredstva, da kvalitetno preživijo prosti čas in s tem lahko tudi bolj učinkovito krepijo svoje telesno in duševno zdravje ter tudi socialno mrežo ali že obstoječe odnose s svojimi otroki in vnuki. Turistična industrija se je z ustvarjanjem ponudb v smeri družinskega in medgeneracijskega turizma odzvala na povpraševanje po tovrstnih dejavnosti in s tem omogočila, da lahko celotna družina pridobi mnogo na področju spoštovanja in sodelovanja, v smeri priložnosti deljenja izkušenj, znanja, kulture in vrednot ter kreiranja dolgoročnih spominov. Še tako pomemben je medgeneracijski turizem za odnose med vnuki in starimi starši, ki jim želijo predati tradicije in veščine. Turistični trg se kljub rastočemu pomenu

medgeneracijskega turizma le temu slabo prilagaja; turistični trg bi se moral usmerjati v raziskovanje pomembnosti, doprinosa in smisla. Večji pomen bi morali dati tudi dostopnemu turizmu, ki omogoča dostopnost in neodvisno ter pravično koriščenje turističnih storitev tudi tistim ciljnim skupinam, ki imajo različne omejitve.

V prispevku smo ugotovili, da se več kot polovica naših anketirancev zaveda pomena, ki ga imajo medgeneracijski stiki, kljub temu pa se mnogi ne udeležujejo v skupnih turističnih dejavnosti. Rezultati so pokazali, da tisti, ki se v skupnih turističnih aktivnostih niso udeleževali, vseeno menijo, da imajo le-te velik pomen in vpliv na vzpostavitev tesnejših stikov med vnuki in starši. Anketiranci, ki od samega začetka nimajo dobrih odnosov s starimi starši, so potrdili, da jim medgeneracijski odnosi niso pomembni in se niti ne bi želeli udeleževati v turističnih aktivnostih s starimi starši.

Na podlagi ugotovitev raziskave lahko torej sklepamo, da več kot polovica ljudi še vedno ceni medgeneracijske odnose kot tudi vse, kar se znotraj takšnih povezav izmenja (prenos znanja, bogate izkušnje...). Ker je pomen medgeneracijskih stikov še vedno dobro ukoreninjen v naši družbi, bi bilo torej pri oblikovanju turističnih politik in oblikovanju turističnih ponudb skoraj da nujno upoštevati primarne vrednote ljudi (medosebna povezanost, druženje, družina...), kot tudi njihove značilnosti, ki pa se generacijsko močno razlikujejo. Pomemben je celosten pristop, ki zajema potrebe in želje celotne populacije, ki je zelo heterogena. Vsekakor je pri oblikovanju takšnih medgeneracijskih ponudb treba upoštevati njihove preference in omejitve, obenem pa zagotavljati dostopnost do storitev (prostorske prilagoditve (interior, eksterior), prevozi...).

S pomočjo raziskave smo pokazali, da ima medgeneracijski turizem ogromno pozitivnih koristi za vse generacije (medgeneracijsko povezovanje je koristno tudi z vidika premostitve generacijskih razlik). Menimo, da bi mu morali v prihodnosti dajati še večji poudarek v turističnem sektorju in izkoristiti priložnosti, ki jih prinaša, med drugim tudi v smislu gospodarske rasti.

LITERATURA

1. Alén, E., N. Losada in T. Domínguez. 2016. The impact of ageing on the tourism industry: An approach to the senior tourist profile. *Social Indicators Research* 127(1): 303–322.
2. Bai, B., S. S. Jang, L. A. Cai in J. T. O'Leary. 2001. Determinants of travel mode choice of senior travelers to the United States. *Journal Of Hospitality and Leisure Marketing* 8(3/4): 148.
3. Becker Digital 2023. Tourism Marketing Strategies for Multiple Generations. Dostopno na <https://www.becker-digital.com/blog/tourism-marketing-multiple-generations> (25. januar 2023).

4. Buhalis, D. in S. Darcy. 2011. *Accessible Tourism: Concepts and Issues*. Bristol: Channel View Publications. Dostopno na: Google Books.
5. Coall D. A. in R. Hertwig. 2010. Grandparental investment: past, present, and future. *Behavioral and Brain Sciences* 33: 1–19.
6. Dimovski, V. 2011. Age management. *HRM revija* 9(42): 37–40.
7. Durko, A. M. in J. F. Petrick. 2013. Family and relationship benefits of travel experiences: A literature review. *Journal of Travel Research*. 52: 720–730.
8. Durko, A. M. in J. F. Petrick. 2016. The Benefits of Travel: Family and Relationships Review of Literature. *Travel and Tourism Research Association: Advancing Tourism Research Globally* 16.
9. Eurostat. 2020. *Ageing Europe: Looking at the Lives of Older People in the EU*. Dostopno na: <https://ec.europa.eu/eurostat/documents/3217494/11478057/KS-02-20-655-EN-N.pdf/9b09606c-d4e8-4c33-63d2-3b20d5c19c91?t=1604055531000> (6. december 2023).
10. Ghurung, S. in S. Ghimire. 2014. *Role of Family in Elderly Care*, 15.
11. Goody, J. 2003. *Evropska družina: zgodovinsko-antropološki esej*. Ljubljana: Založba / *cf.
12. Goriup, J. in D. Lahe. 2018. *Poglavja iz socialne gerontologije*. Maribor: AMEU – ECM, Alma Mater Europaea Press.
13. Harlofson, K. in G. O. Hagestad. 2012. Transformation in the role of grandparents across welfare states. *Contemporary Grandparenting: Changing Family Relationships in Global Context*, ur. S. Arber and V. Timonen, The Policy Press.
14. Haspari, V. A., S. Wijaya. in T. Santoso. 2022. Multigenerational travel: A qualitative study of holiday decision making process of Indonesian family. *Contemporary Research on Management and Business* 284.
15. Jang, S. in C. E. Wu. 2006. Seniors' travel motivation and the influential factors: An examination of Taiwanese seniors. *Tourism Management* 27: 306–316.
16. Juvan, E., M. Lesjak, E. Podovšovnik in J. Jurgec. 2021. A Destination's Social Sustainability: Linking Tourism Development to Residents' Quality of Life. *Academica Turistica* 14 (1): 39–52.
17. Kežman, M. 2021. *Vloga medgeneracijskega turizma v prenosu vrednot med generacijami v slovenski družbi*. Doktorska disertacija. Maribor: Alma Mater Europaea.
18. Lipar, T. in J. Ramovš, 2013. Gerontološko izrazje. *Kakovostna starost* 16(4): 48–49.
19. Litrell, M. A., R. C. Paige in K. Sung. 2004. Senior travellers: Tourism activities and shopping behaviours. *Journal of Vacation Marketing* 70(4): 348–362.

20. Long, A. 2023. 2023 summer travel trends: why multi-generational travel is booming. Dostopno na: <https://www.thedrum.com/opinion/2023/07/26/2023-summer-travel-trends-why-multi-generational-travel-booming> (4. november 2023).
21. Macuh, B. in A. Raspor. 2017. Turisti na potovanja kot oblika aktivnegapreživljanja prostega asa starostnikov vslovenskih domovih za starejše. V *Modern Management Tools and Economy of Tourism Sector in Present Era*, ur. Snežana Štetić idr., 411-428. Beograd: Association of Economists and Managers of the Balkans. Dostopno na: ResearchGate.
22. Medarić, Z., J. Gabruč in M. Sedmak. 2016. Social Tourism Benefits for Senior. *Academica Turistica* 9 (2): 113–117. Dostopno na: Digitalna knjižnica Slovenije.
23. Mikola, N. 2004. *Turizem in starejše skupine prebivalstva*. Diplomaska naloga. Maribor: Ekonomsko-poslovna fakulteta.
24. Musek, J. 2014. *Psihološki temelji družbene prihodnosti*. Ljubljana: Inštitut za etiko in vrednote Jože Trontelj.
25. Nemeč Rudež, H. in P. Zabukovec Baruca. 2011. *Trženje turističnih destinacij*. Koper: Univerza na Primorskem.
26. Peceny Starc, U., S. Mokorel in T. Ilijaš. 2019. Turizem 4.0: Izzivi in priložnosti za lokalno skupnost. *Uporabna informatika* 27(2).
27. Pogačnik, A. 2008. *Prostorsko načrtovanje turizma*. Ljubljana: Fakulteta za gradbeništvo in geodezijo.
28. Ramovš, J. 2012. *Za kakovostno staranje in lepše sožitje med generacijami*. Ljubljana: Inštitut Antona Trstenjaka za gerontologijo in medgeneracijsko sožitje.
29. Raspor, A. in B. Macuh. 2021. *Trajnostno naravnani dostopni turizem*. Dolga Poljana: Perfectus, Svetovanje in izobraževanje.
30. Schänzel, H. A. in I. Yeoman. 2014. The future of family tourism. *Tourism Recreation Research* 39(3): 343–360.
31. Schänzel, H. A. in I. Yeoman. 2015. Trend in family tourism. *Journal of Tourism Futures* 1(2): 141 – 147
32. Schänzel, H. A., I. Yeoman. in E. Zentveld. 2012. *Family Tourism: Multidisciplinary Perspectives*.
33. Shavanddasht, M. 2018. Grandparent's segmentation by the tourism motivation: travelling with or without grandchildren. *Young consumers* 19(2): 141-158.
34. Shaw, S. M., M. E. Havitz. in F. M. Delamere. 2008. I decided to invest in my kids' memories: family vacation, memories, and the social construction of the family. *Tourism Culture & Communication* 8(1): 13-26.
35. SURS (Statistični urad RS). 2023. *Število prebivalcev lani zraslo*. Dostopno na: <https://www.stat.si/StatWeb/News/>

36. Šircelj, M. 2009. Staranje prebivalstva v Sloveniji. V *Starejši ljudje v družbi sprememb*, ur. Valentina Hlebec, 15–43. Maribor: Aristej.
37. Śniadek, J. 2006. Age of seniors—a challenge for tourism and leisure industry. *Studies in physical culture and tourism* 13(1): 103–105.
38. Tesch-Roemer, C., A. Motel-Klingebiel. in H. Kondratowitz. 2002. Importance of family for quality of life of the elderly in a social and cultural comparison. *Zeitschrift für Gerontologie und Geriatrie* 35(4): 335-42.
39. UNWTO. 2016. Manual on Accessible Tourism for All: Principles, Tools and Best Practices - Module I: Accessible Tourism – Definition and Context. Madrid: World Tourism Organization.
40. Veljković, B. in L. M. Colarič-Jakše. 2014. Turizem: *Uvod v osnove in teorijo turizma*, Maribor: Fakulteta za turizem.
41. Vodeb, K. 2010. *Turistična destinacija kot sistem*, Portorož: Fakulteta za turistične študije.
42. Walk a story. 2021. Dostopno na: <http://www.walkastory.com/news.html> (4. November 2023)
43. Williams, K., P. Robert., A. Petrosky. in E. Hernandez. 2010. Multi-Generational Marketing: Descriptions, Characteristics, Lifestyles, and Attitudes. *Journal of Applied Business and Economics*. 11. 21-36.
44. Wood, E., M. Kinnunen, J. Moss. in L. Yanning. 2023. Shared Festival Tourism Experiences: The Power and Purpose of Remembering Together. *Journal of Travel Research* 1-18
45. Yang, M., C. Khoo-Lattimore. in E. C. L. Yang. 2020. Three generations on a holiday: Exploring the influence of Neo -Confucian values on Korean Multigenerational Family vacation decision making. *Tourism Management*. 78.

DOSTOJANSTVO IN OHRANJANJE KOGNITIVNIH SPOSOBNOSTI STAREJŠIH ODRASLIH S POMOČJO ART TERAPIJE - FRAKTALNE RISBE

DIGNITY AND PRESERVATION OF COGNITIVE ABILITIES OF THE OLDER ADULTS WITH THE HELP OF ART THERAPY - FRACTAL DRAWING

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POVZETEK

Staranje prebivalstva prinaša s seboj številne izzive, s katerimi se soočajo starejši. Z leti se vse manj vključujejo v družbene aktivnosti in se pogosto znajdejo na robu družbene izključenosti. Osamljenost je eden največjih problemov starejših. Hkrati pa se ob daljši življenjski dobi soočamo tudi z upadanjem kognitivnih sposobnosti in intenzivnim naraščanjem števila diagnoz demence, ki je po svetu že presegla 50 milijonov primerov. Ob postavitvi diagnoze demence se posameznik pogosto sooča tudi z upadom dostojanstva. Fraktalna risba je oblika art terapije, za katero so značilni številni pozitivni učinki. Zato nas je zanimalo, kako lahko s pomočjo art terapije – fraktalne risbe – spodbujamo kognitivni razvoj starejših, zmanjšamo tveganje za nastanek demence in hkrati ob vključevanju v aktivnosti zmanjšamo njihovo osamljenost. Z vključevanjem v družabne aktivnosti in ohranjanjem kognitivnih sposobnosti starejši ohranjajo tudi svoje dostojanstvo. V ta namen smo izvedli osem sklopov delavnic za starejše, stare 60 let in več. Vključenih je bilo 117 udeležencev. Učinke vključevanja v delavnice in samostojnega dela doma smo merili pred začetkom in ob zaključku delavnic. Ugotovili smo, da se je pri udeležencih, ki so se udeležili vseh delavnic, izboljšala socialna komponenta. Rezultati so pokazali tudi izboljšanje pozornosti, fokusa in fine motorike, povečala se je umirjenost ter se izboljšali nekateri drugi vidiki. Na podlagi ugotovitev lahko sklepamo, da art terapija – fraktalna risba – prispeva k razvoju kognitivnih sposobnosti starejših in s tem zmanjšuje tveganje za nastanek demence, hkrati pa pripomore k ohranjanju njihovega dostojanstva. Ker učinkovitega zdravila za demenco še vedno ne poznamo, so alternativni pristopi za zmanjšanje tveganja njenega nastanka toliko bolj pomembni. Prispevek pa je pomemben tudi z vidika iskanja novih metod na področju preventive demence.

Ključne besede: starejši, osamljenost, dostojanstvo, kognitivne sposobnosti, fraktalna risba

ABSTRACT

The aging population brings with it numerous challenges that older adults face. With age, they become less involved in social activities and often find themselves on the verge of social exclusion. Loneliness is one of the most significant issues among the elderly. At the same time, with increasing life expectancy, we are also witnessing a decline in cognitive abilities and a sharp rise in dementia diagnoses, which have already surpassed 50 million cases worldwide. A dementia diagnosis often leads to a loss of dignity for the individual. Fractal drawing is a form of art therapy known for its numerous positive effects. Therefore, we aimed to explore how art therapy—specifically fractal drawing—can promote cognitive development in older adults, reduce the risk of dementia, and simultaneously decrease their loneliness through participation in activities. By engaging in social activities and maintaining cognitive abilities, seniors also preserve their dignity. To this end, we conducted eight workshop sessions for older adults aged 60 and above. A total of 117 participants were included. The effects of participating in the workshops and independent work at home were measured both before and after the sessions. We found that participants who attended all the workshops experienced an improvement in their social interactions. Additionally, the results showed enhancements in attention, focus, and fine motor skills, as well as increased calmness and improvements in other areas. Based on our findings, we conclude that art therapy—fractal drawing—contributes to the cognitive development of older adults, thereby reducing the risk of dementia while also helping to maintain their dignity. Since there is still no effective cure for dementia, alternative approaches to reducing the risk of its onset are becoming increasingly important. Furthermore, this study is significant in terms of exploring new methods for dementia prevention.

Keywords: elderly, loneliness, dignity, cognitive abilities, fractal drawing

UVOD

Staranje je pogosto opredeljeno kot fiziološki proces, ki se začne z rojstvom in konča s smrtjo. Pri staranju prihaja do sprememb v organizmu, celicah ter njihovem delovanju in obnavljanju, saj se ljudje staramo vse življenje (Ramovš 2014, 45). Danes vse pogosteje govorimo o starajoči se družbi. Ko več kot deset odstotkov prebivalcev preseže starost 65 let, govorimo o zelo starem prebivalstvu. Med takšna območja spada tudi Slovenija (Hovnik Keršmanc 2009, 9). Podatki Statističnega urada RS (SURS 2023) kažejo, da v Sloveniji delež prebivalcev, starejših od 65 let, presega 21 %. Projekcije prebivalstva kažejo, da se bo trend staranja prebivalstva nadaljeval, še posebej intenzivno pa bo naraščalo število najstarejših prebivalcev. Do leta 2100 se bo število stoletnikov povečalo s 314 na

7551 (SURS 2023). Demografske spremembe so ena od stalnic v človeški družbi (Webster in Ivanov 2020). Staranje prebivalstva pa prinaša tudi nove izzive, saj so posledice demografske dinamike že opazne (Reynaud in Miccoli 2019, 8-9).

PREGLED LITERATURE

Biološko staranje je naravni del življenjskega procesa, njegov sestavni del, tako kot rojstvo, rast, reprodukcija in smrt. Organizem sčasoma usiha, saj se njegove možnosti za nadaljevanje življenja zmanjšujejo. Telesne sposobnosti se postopoma slabšajo s starostjo (De Beauvoir 2018; Pratama in Setiati 2018). Staranje je povezano s kopičenjem številnih sprememb, ki povečujejo tveganje za različne bolezni (Baghel idr. 2019). Približno 8,5 % svetovnega prebivalstva je starejšega od 65 let, pri čemer okoli 40 % te populacije trpi zaradi blage kognitivne okvare. Takšna starostno povezana kognitivna okvara vpliva na različna področja, kot so pozornost, zaznavanje, sklepanje, odločanje, izvajanje nalog, govor in jezik (prav tam).

Kognitivne sposobnosti se z normalnim staranjem zmanjšujejo. Tekoče sposobnosti, kot sta hitrost in reševanje problemov, upadajo že od zgodnje odraslosti, medtem ko kristalizirane sposobnosti, kot sta znanje in strokovnost, naraščajo do visoke starosti (Anstey in Low 2004). Po drugi strani lahko zdrav življenjski slog prispeva k upočasnitvi kognitivnega upada in k ohranjanju zdravega staranja (Baghel idr. 2019).

Tadayon idr. (2020) trdijo, da človeško inteligenco lahko razdelimo na fluidno in kristalizirano inteligenco, pri čemer vsaka vključuje ločene kognitivne sposobnosti. Raziskava je pokazala, da je boljša uspešnost pri fluidni inteligenci povezana s širjenjem korteksa na območjih, povezanih z delovnim spominom, pozornostjo in vizualno-prostorsko obdelavo, medtem ko je kristalizirana inteligenca povezana s tanjšim korteksom in večjo površino korteksa v omrežjih, povezanih z jezikom. Horn (1982) trdi, da fluidna inteligenca vključuje biološko določene spretnosti, ki so neodvisne od izkušenj ali učenja, ter zajema sposobnosti, kot so prostorska orientacija, abstraktno sklepanje, induktivno mišljenje in verbalna fluentnost. Kristalizirana inteligenca pa se nanaša na znanje in spretnosti, pridobljene skozi izobraževanje in življenjske izkušnje, ter vključuje razumevanje besednih pomenov, asociacije in socialno presojo (Tadayon idr. 2020).

Pri starejših je pogosto prisotno stanje blagega kognitivnega upada, ki ga opredeljujejo kot klinični prehod med normalnim staranjem in zgodnjo demenco. Oseba s to diagnozo kaže blage, a merljive kognitivne spremembe, ki so večje od pričakovanih za njeno starost, vendar manj vplivajo na sposobnost opravljanja vsakodnevnih aktivnosti v primerjavi z osebami, ki že imajo diagnosticirano demenco (Astell idr. 2018, 183). Pri demenci ne gre le za progresivno upadanje kognitivnih sposobnosti, temveč tudi za nevrodegenerativni proces (Duraković idr. 2007, 389),

pri čemer je demenca tretji najpogostejši vzrok smrti, takoj za boleznimi srca in rakom (James idr. 2014, 1045). Raziskovalci so ugotovili, da nekatere starejše osebe niso dementne, vendar tudi nimajo povsem normalnega kognitivnega funkcioniranja. Ta pojav so prvič poimenovali blagi kognitivni upad (MCI – mild cognitive impairment) leta 1988 na Univerzi v New Yorku (Reisberg idr. 2008, 24). MCI lahko poveča tveganje za demenco, zato je njegova zgodnja prepoznava ključnega pomena pri preventivi demence (Astell idr. 2018, 185). Nekateri posamezniki s tem stanjem napredujejo v demenco, drugi ostajajo stabilni, pri nekaterih pa se stanje celo izboljša (Lopez 2013, 411). Kljub temu število diagnoz demence strmo narašča – leta 2015 je bilo po svetu skoraj 47 milijonov primerov demence, danes (2024) jih je že več kot 55 milijonov. Napovedi kažejo, da bo leta 2030 število primerov naraslo na skoraj 75 milijonov, do leta 2100 pa na kar 131 milijonov (WHO).

Ob upoštevanju teh dejstev postaja vse bolj pomembno zdravo in aktivno staranje, ki vključuje tudi vseživljenjsko učenje. Tam (2012) ugotavlja, da aktivno učenje pripomore k izboljšanju kakovosti življenja starejših. Kežmanova (2019, 51) dodaja, da aktivno in kakovostno staranje temelji na vključevanju v različne dejavnosti. Ramovš idr. (2016, 8) poudarjajo, da je starejša oseba, ki nima rednega stika z bližnjimi, osamljena, ne glede na to, koliko ljudi jo obdaja. Havighurst (1961, 8) v okviru teorije dejavnosti ugotavlja, da sta socialna vključenost in aktivnost bistveni za srečno in zadovoljno staranje. Wilson idr. (2002, 742) so povezali ta spoznanja z demenco, saj so ugotovili, da obstaja pozitivna povezava med pogostostjo sodelovanja v kognitivno stimulativnih dejavnostih in zmanjšanim tveganjem za razvoj Alzheimerjeve demence v kasnejših letih.

Scarmeas (2001, 2236) ugotavlja, da je redna udeležba v prostočasnih dejavnostih povezana z zmanjšano pojavnostjo Alzheimerjeve bolezni in drugih oblik demence. Wang idr. (2012, 482) so analizirali devet študij o vplivu miselnih dejavnosti na tveganje za kognitivni upad in razvoj demence. Vse študije so potrdile, da imajo miselne aktivnosti preventivni učinek na kognitivni upad in demenco. Wang idr. (2012, 489) zaključujejo, da trenutni dokazi kažejo, da lahko prostočasne dejavnosti – zlasti miselne in telesne – delujejo kot zaščitni dejavnik pred kognitivnim upadom in demenco. Zato se v zadnjih desetletjih vse več raziskav osredotoča na vlogo prostočasnih dejavnosti kot zaščitnega dejavnika pred demenco.

Demenca predstavlja izjemno breme za zdravstveni sistem, hkrati pa vpliva tudi na dostojanstvo osebe, ki se je z diagnozo srečala, ter tudi na njene svojce. Prepoznavanje zaščitnih dejavnikov ali učinkovitih preventivnih strategij zato lahko vodi do znatnih koristi (Stern in Munn 2010, 2). Ker se prebivalstvo stara in število ljudi, ki živijo z demenco ali blago kognitivno okvaro še naprej narašča, je ključnega pomena prepoznati ustvarjalne in inovativne načine za podporo in izboljšanje kakovosti njihovega življenja (Astell 2018, 189). Eden izmed teh je lahko tudi art terapija – fraktalna risba.

Art terapija je namenska uporaba vizualnih umetniških materialov in medijev pri intervenciji, svetovanju, psihoterapiji in rehabilitaciji ter se uporablja pri posameznikih vseh starosti in skupin (Malchiodi 2020, 15). Tomić idr. (2019, 63) v njej vidijo tudi krepitev potencialov. Ena izmed metod art terapije je tudi metoda fraktalne risbe, ki je inovativna in kreativna metoda, temelječa na principih art-terapije, Brain Gyma, kromoterapije, grafo motoričnih vaj in nevro znanstvenih konceptov, za katero so značilni enostavnost, sproščujoč učinek delovanja na tistega, ki riše, razvoj in krepitev kognitivnih funkcij, pozornosti, koncentracije, kreativnosti, samozavesti in motivacije za delo (Hundrić 2019, 275).

Fraktalna risba spada v kategorijo oblikovalskih tehnik, saj gre za odsev notranjega stanja osebe in nezavedne komponente psihe (Vavilkiņa 2018). Učinkovitost metode je zaznana skozi prepuščanje prosti neprekinjeni črti, moči barv in korekciji obojega (Muck in Kosec 2018). Liberman (2009) trdi, da svetloba prihaja skozi oči in pride do možganov v obliki valovanja, nato en del informacij oz. svetlobe gre po celotnem živčnem sistemu in nam omogoča proces samozdravljenja.

Metoda fraktalne risbe je sestavljena iz dejstva o povezanosti motorike roke in človekovih psihofizičnih stanj ter ima diagnostični in terapevtski učinek. Postopek risanja fraktalne risbe je precej enostaven in je sestavljen iz spontanega risanja ene neprekinjene črte z zaprtimi očmi in barvanja nastalih presečnih polj. Metoda se uporablja za individualno ali skupinsko risanje in je neodvisna od predhodnega znanja in sposobnosti risanja (Hundrić 2019, 275).

Ob vseh zgoraj navedenih spoznanjih smo želeli združiti zavedanje naraščanja upadanja kognitivnih sposobnosti v vse bolj starajoči se družbi in učinke fraktalne risbe ter spoznanja vnesti v prakso. V ta namen smo se prijavili na evropski projekt Erasmus+. Z inovativno metodo smo skušali na različne načine spodbujati starejše k aktivnemu staranju, ozaveščanju o demenci ter zmanjšati tveganje za upadanje kognitivnih sposobnosti ter za nastanek demence, predvsem s spodbujanjem kognitivnega razvoja s pomočjo fraktalne risbe. V ta namen smo organizirali cikle več delavnic za starejše v Sloveniji in na Hrvaškem, izvedli mentorski program in pripravili priročnik za nadaljnje delo, da lahko dosežemo trajnostni učinek ter pripravili več razstav izdelkov udeležencev – fraktalnih risb. Zanimalo pa nas je tudi, kakšen učinek imajo tovrstne aktivnosti na udeležence. V ta namen smo naredili tudi empirično raziskavo.

METODOLOGIJA

Na podlagi teoretičnih ugotovitev smo zadani problem prispevka raziskali še z empiričnega vidika. V teoretičnem delu smo se najprej lotili raziskovanja literature na podlagi ključnih besed (staranje, kognitivne sposobnosti, demenca, prostočasne aktivnosti, art terapija, fraktalna risba) v relevantnih in pomembnih

znanstvenih podatkovnih bazah. Pri tem smo uporabili deskriptivno metodo, metodo sinteze, analize, komparacije in kompilacije. V empiričnem delu smo uporabili vprašalnik in na izbranem vzorcu uporabili kvantitativni pristop. Zbrane podatke smo analizirali in statistično obravnavali v programu SPSS for Windows.

Pri anketiranju smo vprašalnike razdelili udeležencem delavnice na vsaki delavnici (skupno na 8 delavnicah), na zadnji in prvi delavnici pa sta bila anketna vprašalnika obsežnejša. V prvem delu smo udeležence spraševali po socio demografskih podatkih, drug del pa je bil namenjen vrednotenju počutja na vsaki posamezni delavnici in učinka vseh delavnic. Na Likartovi lestvici od 1 do 5 so udeleženci ocenjevali počutje oziroma strinjanje z danimi trditvami.

Namen prispevka je ugotoviti, ali kontinuirano risanje fraktalne risbe vpliva na izboljšano počutje ter kakšni so bili učinki risanja fraktalne risbe. Cilj prispevka pa je opredeliti vidik staranja skozi upadanje kognitivnih sposobnosti in funkcij, opisati prostočasne aktivnosti skozi njihov vpliv, proučiti art terapijo s fraktalno risbo, raziskati pozitiven vpliv fraktalne risbe na počutje, izboljšanje pozornosti in zmanjšanje stresa.

V ta namen smo si zastavili tri hipoteze

H1: Risanje in barvanje fraktalne risbe pozitivno vpliva na počutje udeležencev.

H2: Udeleženci so z risanjem izboljšajo pozornost.

H3: Risanje fraktalne risbe zmanjšuje stres pri udeležencih.

V empiričnem delu smo uporabili kvantitativno metodo. Uporabljen je bil anketni vprašalnik, ki je bil sestavljen iz treh delov (socio demografska vprašanja, vprašanja o splošnem počutju in o učinkih delavnic). Udeleženci so na vsaki delavnici ocenjevali počutje pred in po delavnici (skupaj je bilo vsaj 8 delavnic za vse udeležence). Udeleženci so po navodilih reševali vprašalnike. Vsak vprašalnik so označili s šifro, tako smo lahko zagotovili anonimnost vprašalnika. Podatke smo zbirali od januarja do decembra 2023.

Dobljene podatke smo nato analizirali in pri tem uporabili deskriptivno metodo za analizo opisne statistike. Pri primerjavi počutja pred in po delavnici smo uporabili parni T test, pri čemer smo signifikantnost preverjali skozi doseganje ustrezne vrednosti kritične vrednosti t , skozi ustrezen interval zaupanja in statistično značilno povezanost p .

V vzorec smo vključili starejše, stare 60 let ali več, ki so obiskovali cikel delavnic Spodbujanje kognitivnih sposobnosti starejših s pomočjo art terapije - fraktalne risbe. V delavnice je bilo vključenih preko 130 udeležencev, a jih je nato 117 zaključilo celoten cikel in te smo nato tudi vključili v raziskavo. Pri zastavljenih socio demografskih vprašanjih so nas zanimali spol, starost, leta upokojitve, izobrazba in oblika bivanja.

Tabela 1: Demografija anketirancev

Spremenljivka	Število odgovorov	%
Spol anketiranca		
moški	10	91,5
ženska	107	8,5
Stopnja izobrazbe		
OŠ ali manj	9	7,7
Srednja šola (2-3 leta)	11	9,4
Srednja šola (4-5 let)	42	35,9
Višja ali visoka strokovna šola	29	24,8
Univerzitetna izobrazba	22	18,8
Magisterij ali doktorat	4	3,4
Oblika bivanja		
Živim sam/a	37	31,6
Živim z možem/ženo ali partnerjem/partnerico	38	32,5
Živim v večgeneracijski družini	26	22,2
Živim v skupnosti	16	13,7

Vir: lasten vir

Vzorec je zajemal 117 udeležencev, starih med 60 in 94 let. Njihova povprečna starost je bila 70 let. V večini so bile ženske, teh je bilo 107 ali 91,5 %, moških je bilo veliko manj, zgolj 10 ali 8,5 %. V povprečju so bili upokojeni dobrih 11 let (med 0 in 40 let). Pretežno so imeli 4-5 letno srednješolsko izobrazbo, teh je bilo 42 ali 35,9 %, najmanj, 4 ali 3,4 % jih je bilo z magisterijem ali doktoratom. Pri načinu bivanja jih je najmanj živelo v skupnosti, teh je bilo 16 ali 13,7 %, medtem ko jih je 38 ali 32,5 % živelo z možem ali z ženo oziroma s partnerjem ali partnerico. Le eden manj, 37 ali 31,6 % jih je živelo samih.

REZULTATI

V nadaljevanju smo opravili deskriptivno statistiko merjenih spremenljivk o učinkih risanja fraktalnih risb. Zanimalo nas je, kako udeleženci ocenjujejo, kakšen vpliv je nanje imela fraktalna risba. Rezultate prikazujemo v tabeli 2.

Tabela 2: Deskriptivna statistika učinka risanja fraktalnih risb

	Vzorec (N)	Povprečje (M)	Standardni odklon (SD)
Risanje in barvanje sta me sproščala.	117	4,56	0,547
Risanje in barvanje sta me pomirjala.	117	4,54	0,565
Z risanjem sem izboljšal svojo pozornost.	117	4,48	0,664
Ob risanju sem čutila več samozavesti.	117	4,20	0,757
Ob risanju je fraktalna risba imela name pozitiven učinek.	117	4,51	0,610
Skozi risanje sem spoznavala nove stvari o sebi.	117	4,26	0,781
Risanje fraktalov je zame meditacija.	117	4,32	0,786
Z risanjem se mi je izboljšala motorika roke.	117	4,11	0,828
Fraktalna risba je zame koristno porabljen čas.	117	4,62	0,583
Na delavnicah ob risanju sem uživala.	117	4,79	0,465

Vir: lasten vir

Iz tabele 2 lahko vidimo, da so skupno vse podane spremenljivke ocenjene precej visoko, saj udeleženci v povprečju ocenjujejo, da ima fraktalna risba največji vpliv na uživanje na delavnicah, saj je povprečje pri tej spremenljivki $M=4,79$. V najmanjši meri so izrazili učinek na izboljšanje motorike roke, a je ta vrednost še vedno zelo visoka, saj je v povprečju $M=4,11$.

V nadaljevanju so nas zanimali rezultati počutja pred in po vsaki posamezni delavnici. Vsaka delavnica je bila namenjena določenemu področju, ki smo ga povezali z demenco. Prva delavnica je bila namenjena splošnemu ozaveščanju o demenci in prepoznavanju svojih notranjih značilnosti in vzorcev, druga je bila namenjena valovitim linijam in fleksibilnemu delovanju. Tretja delavnica je bila namenjena ravnim linijam in fokusnemu delovanju. Četrta delavnica je bila namenjena iskanju ravnovesja ter povezovanju leve in desne možganske polovice. Peta delavnica je bila namenjena krepitvi pozornosti in koncentracije. Šesta delavnica je bila namenjena zapolnjevanju praznine in vzpodbujanju kreativnosti. Sedma je bila namenjena organizaciji, redu in strukturi. Osmo delavnica pa je bila namenjena medsebojnemu povezovanju in sprejemanju različnosti. Rezultati počutja pred in po vsaki posamezni delavnici so prikazani v tabelah 3 in 4.

Tabela 3: Statistika parnega t testa počutja pred in po delavnici

Delavnica		Vzorec (N)	Povprečje (M)	Standardni odklon (SD)
1	Počutje pred delavnico 1	104	3,90	0,770
	Počutje po delavnici 1	104	4,66	0,568
2	Počutje pred delavnico 2	107	4,01	0,807
	Počutje po delavnici 2	107	4,58	0,583
3	Počutje pred delavnico 3	108	3,82	0,852
	Počutje po delavnici 3	108	4,57	0,599
4	Počutje pred delavnico 4	106	3,88	0,739
	Počutje po delavnici 4	106	4,44	0,757
5	Počutje pred delavnico 5	98	3,85	0,854
	Počutje po delavnici 5	98	4,50	0,750
6	Počutje pred delavnico 6	92	4,02	0,889
	Počutje po delavnici 6	92	4,59	0,698
7	Počutje pred delavnico 7	97	4,06	0,761
	Počutje po delavnici 7	97	4,67	0,535
8	Počutje pred delavnico 8	111	4,13	0,752
	Počutje po delavnici 8	111	4,83	0,465

Vir: lasten vir

Tabela 4: Parni test počutja pred in po delavnici

	M	SD	95 % interval zaupanja		t	df	p
			Spodnji	Zgornji			
Počutje pred delavnico 1 Počutje po delavnici 1	-0,760	0,744	-0,904	-0,615	-10,414	103	0,000
Počutje pred delavnico 2 Počutje po delavnici 2	-0,570	0,660	-0,697	-0,444	-8,930	106	0,000
Počutje pred delavnico 3 Počutje po delavnici 3	-0,750	0,810	-0,905	-0,595	-9,619	107	0,000
Počutje pred delavnico 4 Počutje po delavnici 4	-0,566	0,905	-0,740	-0,392	-6,438	105	0,000
Počutje pred delavnico 5 Počutje po delavnici 5	-0,653	0,886	-0,831	-0,475	-7,294	97	0,000
Počutje pred delavnico 6 Počutje po delavnici 6	-0,565	0,700	-0,710	-0,420	-7,743	91	0,000
Počutje pred delavnico 7 Počutje po delavnici 7	-0,608	0,771	-0,764	-0,453	-7,767	96	0,000
Počutje pred delavnico 8 Počutje po delavnici 8	-0,703	0,782	-0,850	-0,556	-9,473	110	0,000

Vir: lasten vir

S parnim t testom smo ovrednotili počutje udeležencev pred in po vsaki delavnici fraktalnega risanja. Rezultati so pokazali signifikantno zvišanje ocen udeležencev po vsaki posamezni delavnici.

Povprečno je pri delavnici 1 bilo največje zvišanje rezultata ($M=-0,760$) s 95 % intervalom zaupanja v razponu od $-0,904$ do $-0,615$, pri čemer je t višji od kritične vrednosti, p je nižji od 0,05 in oba intervala (spodnji in zgornji) sta negativna in ne vsebujeta 0. Rezultati so ovrednotili signifikantno zvišanje ocen udeležencev pred udeležbo na delavnicah ($M=3,90$, $SD=0,770$) in po delavnicah ($M=4,66$, $SD=0,568$), $t(103)=-10,414$, $p=0,000$.

Povprečno je pri delavnici 6 bilo najnižje zvišanje rezultata ($M=-0,565$) s 95 % intervalom zaupanja v razponu od $-0,565$ do $-0,700$, pri čemer je t višji od kritične vrednosti, p je nižji od 0,05 in oba intervala (spodnji in zgornji) sta negativna in ne vsebujeta 0. Rezultati so ovrednotili signifikantno zvišanje ocen udeležencev pred udeležbo na delavnicah ($M=4,02$, $SD=0,889$) in po delavnicah ($M=4,59$, $SD=0,698$), $t(91)=-7,743$, $p=0,000$.

RAZPRAVA

V raziskovanje učinka fraktalne risbe na določena področja delovanja starejših, ki vplivajo na kognitivno upadanje sposobnosti starejših smo vključili 117 udeležencev, starih 60 let in več. Baghel idr. (2019) ugotavljajo, da se s staranjem povečuje tveganje za različne bolezni. Tudi na račun upadanja kognitivnih sposobnosti, ki lahko vodijo do manj uspešnega opravljanja vsakodnevnih aktivnosti, posebej pa se poslabša pri ljudeh, ki imajo diagnosticirano demenco (Astell idr. 2018, 183). Le ta predstavlja v sodobni družbi velik problem, saj število starejših narašča, prav tako tudi pogostost demence. In ta trend se bo po napovedih tudi nadaljeval v prihodnosti (SURS 2023; WHO). Na drugi strani je znano, da imajo prostočasne aktivnosti pozitiven vpliv na razvoj kognitivnih sposobnosti. Saj kot trdijo Wilson idr. (2002, 742) obstaja pozitivna povezava med pogostostjo udeležbe pri kognitivno stimulativnih dejavnostih in zmanjšanem tveganju za nastanek AD (Alzheimerjeve demence) v kasnejšem življenjskem obdobju. Ena izmed odličnih prostočasnih aktivnosti je tudi oblika art terapije – fraktalna risba, ki je po menju Hundričeve (2019, 275) inovativna in kreativna metoda, ki temelji na principih art-terapije, Brain Gyma, kromoterapije, grafo motoričnih vaj in nevro znanstvenih konceptov, za katero so značilni enostavnost, sproščujoč učinek delovanja na tistega, ki riše, pomeni pa razvoj in krepitev kognitivnih funkcij, pozornosti, koncentracije, kreativnosti, samozavesti in motivacije za delo. Gre torej za prostočasno aktivnost, ki spodbuja in krepi kognitivne funkcije. Kežmanova (2023) pa ugotavlja, da ima risanje fraktalne risbe pozitiven vpliv tudi v času stisk kot so se pojavljale ob pojavu covid 19.

Rezultati so pokazali statistično značilne razlike v počutju pred in po delavnicah ($p < 0,05$), kar potrjuje hipotezo, da risanje in barvanje fraktalne risbe pozitivno vpliva na počutje udeležencev. T-vrednosti so bile pri vseh delavnicah visoke in signifikantne, interval zaupanja pa je v vseh primerih pokazal, da izboljšanje ni bilo naključno. To je skladno z ugotovitvami Wilsona idr. (2002), ki so pokazali, da kognitivno stimulatивne dejavnosti zmanjšujejo tveganje za Alzheimerjevo demenco. Hipoteza 2, ki trdi, da so udeleženci z risanjem izboljšali pozornost, je bila potrjena na podlagi povprečne ocene $M=4,48$. To je skladno z raziskavo Baghela idr. (2019), ki ugotavlja, da mentalna stimulacija pomaga pri ohranjanju kognitivnih funkcij. Hipotezo 3, ki trdi, da uporaba fraktalne risbe zmanjšuje stres, smo potrdili z analizo odgovorov udeležencev. Ocene ($M=4,56$ za sproščanje, $M=4,54$ za pomirjanje in $M=4,32$ za meditativni učinek) kažejo močno korelacijo med aktivnostjo in občutkom umirjenosti. To je skladno z raziskavami Malchiodija (2020), ki navaja, da vizualna umetnost pozitivno vpliva na duševno zdravje.

Kljub pozitivnim ugotovitvam ima raziskava nekatere omejitve. Prvič, vzorec udeležencev ni bil naključno izbran, saj so se delavnic udeležili tisti, ki jih metoda že zanima. Drugič, raziskava temelji na samoocenjevalnih vprašalnikih, kar pomeni, da obstaja možnost pristranskosti pri poročanju. V prihodnje bi bilo smiselno vključiti objektivne teste kognitivnih funkcij pred in po intervenciji. Poleg tega bi bila koristna longitudinalna raziskava, ki bi spremljala učinke fraktalne risbe na daljše časovno obdobje in preverjala trajnost njenih učinkov. Nadaljnje raziskave bi se lahko osredotočile tudi na primerjavo z drugimi oblikami art terapije ali na vpliv specifičnih barv in vzorcev na kognitivne funkcije.

ZAKLJUČEK

Upad kognitivnih sposobnosti in demenca predstavljajo v sodobnem svetu velik izziv. Iskanje rešitev, s katerimi bi upočasnili ali zmanjšali upad kognitivnih sposobnosti je zato nujno. Posebej ob dejstvu, da se naša družba stara in da se v prihodnosti napoveduje še intenziven porast postavljenih diagnoz demence. Ob tem so inovativne metode še kako dobrodošle. Metoda fraktalne risbe pa je zagotovo ena izmen njih. Tokrat smo se dotaknili osmih področij, ki so tesno povezana z dejavniki tveganja za nastanek demence. Ob tem smo prepoznali pozitivne učinke in izboljšano počutje skozi vsako posamezno srečanje. Naša raziskava je pokazala, da fraktalna risba pozitivno vpliva na počutje, pozornost in zmanjšanje stresa pri starejših, kar lahko prispeva k zmanjšanju tveganja za demenco in izboljšanju kakovosti življenja. Vendar je polje raziskovanja in učinkov metode fraktalne risbe še kljub dani raziskavi precej prazno. Zato bi morda bilo smiselno narediti tudi primerjavo učinkov fraktalne risbe s drugimi metodami art terapije (npr. mandalami, terapevtskim slikanjem) ali pa raziskovati nevrofiziološke spremembe pri udeležencih s pomočjo EEG ali MRI metodologije ter predvsem

dolgoročno spremljanje udeležencev za preverjanje trajnosti učinkov fraktalne risbe na kognitivne sposobnosti. Dosedanje ugotovitve potrjujejo potencial metode fraktalne risbe kot inovativnega pristopa k preprečevanju kognitivnega upada in ohranjanju dostojanstva starejših, vendar je potrebnih več raziskav za njeno širšo znanstveno utemeljitev.

LITERATURA IN VIRI

1. Anstey, K. J. in L. F. Low. 2004. Normal cognitive changes in aging. *Australian Family Physician* 33(10).
2. Astell A. J., S. Czarnuch in E. Dove. 2018. System Development Guidelines From a Review of Motion-Based Technology for People With Dementia or MCI. *Front Psychiatry*. Dostopno na: <https://pubmed.ncbi.nlm.nih.gov/29867610/> (24. januar 2024).
3. Baghel, M. S., P. Singh, S. Srivas in M. K. Thakur. 2019. Cognitive Changes with Aging. *In Proceedings of the National Academy of Sciences India Section B - Biological Sciences*. Dostopno na: <https://doi.org/10.1007/s40011-017-0906-4> (22. januar 2024).
4. De Beauvoir, S. 2018. Starost. *Andragoška spoznanja* 25(2): 103-105.
5. Duraković, Z. idr. 2007. *Gerijatrija-medicina starije dobi*. Zagreb: C T Poslovne informacije d.o.o.
6. Havighurst, R. J. 1961. Successful Aging. *The Gerontologist* 1(1): 8-13.
7. Horn, J. L. 1982. The Theory of Fluid and Crystallized Intelligence in Relation to Concepts of Cognitive Psychology and Aging in Adulthood. V *Aging and Cognitive Processes*. Advances, ur. F.I.M., Craik in S. Trehub, 237-278. Boston: Springer.
8. Hovnik Keršmanc, M. 2009. Staranje prebivalstva. V *Gorenjski bilten javnega zdravja*, ur. I. Grmek Košnik, 2(20): 9-12. Dostopno na <https://www.nijz.si/sites/www.nijz.si/files/uploaded/bilten20.pdf> (15. december 2023).
9. Hundrić, V. 2019. Primjena metode fraktalnog crteža u socijalnopedagoškom radu. *Kriminologija & socijalna integracija : časopis za kriminologiju, penologiju i poremećaje u ponašanju* 27(2): 275-314.
10. James, B. D., S. E. Leurgans, L. E. Hebert, P. A. Scherr, K. Yaffe, D. A. Bennett. 2014. Contribution of Alzheimer disease to mortality in the United States. *Neurology* 82: 1045-1050.
11. Kežman, M. 2023. Učinki fraktalne risbe na starejše ljudi v času pandemije covid-19. V *Starejši odrasli v času epidemije covid-19 v luči družbenih sprememb in digitalizacije*, ur. Jana Goriup, Barbara Grintal in Peter Seljak, 143-153. AMEU – ECM, Alma Mater Press: Maribor.
12. Kežman, M. 2019. Učinek kreativne delavnice Risanja mandal za starejše. *Kakovostna Starost* 22(2): 50-59.

13. Liberman, J. 2009. *Svijetlost lijek budućnosti*. Zagreb: AGM.
14. Malchiodi, C. 2020. *Trauma and Expressive Arts Therapy: Brain, Body and Imagination in the Healing Process*. Dostopno na: https://books.google.si/books?hl=en&lr=&id=PvNPDwAAQBAJ&oi=fnd&pg=PP1&dq=info:Ewb-z6302RzIJ:scholar.google.com&ots=OrV9FHylJu&sig=yx1yT2bUo6PAJqX_Onw0EePU5Gk&redir_esc=y#v=onepage&q&f=false (24. januar 2024).
15. Muck, D. in M. Kosec. 2018. *Pot ljubezni – pot k sebi*. Ljubljana: Fraktalnost.
16. Pratama, I. K. in S. Setiati. 2018. Correlation between hand grip strength and functional mobility in elderly patients. *Journal of Physics: Conference Series* 1073.
17. Ramovš, J. 2014. Staranje. *Kakovostna starost* 17(1): 45–46.
18. Ramovš, J., M. Rant in T. Lipar. 2016. Pripravljenost za medgeneracijsko prostovoljstvo. *Kakovostna starost* 19(4): 3–24.
19. Reisberg, B., S. H. Ferris, A. Kluger, E. Franssen, J. Wegiel, M. J. de Leon. 2008. Mild cognitive impairment (MCI): a historical perspective. *Psychogeriatr* 20(1): 18–31.
20. Reynaud, C. in S. Miccoli. 2019. Population ageing in Italy after the 2008 economic crisis: A demographic approach. *Futures* 105: 17–26.
21. Scarmeas, N., G. Levy, M. X. Tang, J. Manly in Y. Stern. 2001. Influence of leisure activity on the incidence of Alzheimer's disease. *Neurology* 57(12): 2236–2242
22. Stern, C. in Z. Munn Z. 2010. Cognitive leisure activities and their role in preventing dementia: a systematic review. *Int J Evid Based Healthc* 8(1):2–17.
23. SURS. 2023. *Statistični urad RS*. Dostopno na: <https://pxweb.stat.si/SiStatData/pxweb/sl/Data/-/05C1006S.px> (2. novembra 2023).
24. Tadayon, E., A. Pascual-Leone in E. Santarnecchi. 2020. Differential contribution of cortical thickness, surface area, and gyrification to fluid and crystallized intelligence. *Cerebral Cortex* 30(1).
25. Tam, M. 2012. Active aging, active learning: Elder learning in Hong Kong. V *Active aging, active learning: Issues and challenges*, (ur.) Gillian M. Boulton-Lewis in Maureen Tam, 163–174. Dordrecht, The Netherlands: Springer.
26. Tomić, Ž., S. Uljančić in M. Kosec. 2019. Art terapija - utjecaj boja na ljudsko zdravlje i raspoloženje. *World of health* 2: 63–68.
27. Vavilkina, N. G. 2018. The use of fractal drawing in psychology tutorials with students at technical university. *Modern Science* 11: 165–168.
28. Wang H. X., W. Xu in J. J. Pei. 2012. Leisure activities, cognition and dementia. *Biochim Biophys Acta* 1822(3):482–491.
29. Webster, C. in S. Ivanov. 2020. Demographic change as a driver for tourism automation. *Journal of Tourism Futures*. Dostopno na: <https://www.emerald.com/insight/content/doi/10.1108/JTF-10-2019-0109/full/html> (5. januar 2022).

30. Wilson R. S., C. F. Mendes De Leon, L. L. Barnes, J. A. Schneider, J. L. Bienias, D. A. Evans in D. A. Bennett. 2002. Participation in cognitively stimulating activities and risk of incident Alzheimer disease. *JAMA* 287(6):742-748.
31. WHO. World Health Organization. *Global Dementia Observatory*. Dostopno na: <https://apps.who.int/gho/data/node.dementia> (17. januar 2024).

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