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**SCIENTIFIC ABSTRACTS
AND ARTICLES**

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ABSTRACTS

INTERPROFESSIONAL COLLABORATION IN HEALTHCARE: ADVANCING QUALITY, SAFETY AND PATIENT-CENTERED CARE

Fernanda Sofia Brandão^{1,2}

¹Escola Superior de Saúde do Vale do Ave (ESSVA), in the Instituto Politécnico de Saúde do Norte (IPSN), from the Cooperativa de Ensino Superior Politécnico e Universitário, CRL (CESPU)

²The Health & Human Movement Unit (H²M)

Introduction. The World Health Organization (2010) recognizes collaborative practice as an essential strategy for strengthening workforce effectiveness and improving the responsiveness of healthcare systems. Interprofessional collaboration (IPC) has become increasingly important in promoting high-quality, safe, and patient-centered care. IPC refers to the process through which healthcare professionals from diverse disciplines work collaboratively with patients, families, and communities to provide integrated and comprehensive care. The growing complexity of healthcare demands, influenced by aging populations, chronic illnesses, and rapid technological developments, has further highlighted the need for collaborative approaches. According to the World Health Organization, IPC contributes to improved health outcomes and more efficient health systems, particularly within hospital and primary healthcare environments (Reeves et al., 2017).

Aim of the Work. This presentation aims to examine the theoretical foundations, practical implementation, and measurable outcomes of interprofessional collaboration across clinical and community healthcare contexts.

Materials and Methods. A narrative literature review was conducted focusing on interprofessional collaboration, interprofessional education, educational strategies, value-based healthcare, professional engagement, and patient satisfaction.

Results. Effective interprofessional collaboration is grounded in shared values, mutual respect, effective communication, role clarification, and collaborative decision-making. Successful implementation is strongly influenced by organizational culture, leadership commitment, and communication infrastructures that support teamwork. Healthcare organizations that encourage psychological safety and participatory decision-making tend to demonstrate enhanced team functioning and improved professional relationships. Evidence indicates that collaborative interprofessional teams contribute to lower rates of clinical errors, higher patient satisfaction, and increased professional well-being among healthcare providers.

The principles of IPC are closely associated with interprofessional education, which equips future healthcare professionals with essential collaborative competencies. The Interprofessional Education Collaborative (2016) identifies four key competency domains: values and ethics for interprofessional practice, understanding of roles and responsibilities, interprofessional communication, and teamwork. These domains provide a framework for integrating collaborative practices within healthcare settings. Nevertheless, barriers such as hierarchical organizational structures, poorly defined professional roles, and ineffective communication continue to challenge the implementation of IPC. As healthcare systems increasingly adopt value-based care models, interprofessional collaboration is becoming a critical component of effective healthcare delivery.

Conclusions. Interprofessional collaboration represents a strategic pathway for aligning educational practices, healthcare policies, and organizational leadership with collaborative competencies. Strengthening IPC can support sustainable improvements in healthcare quality, patient outcomes, and population health.

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ATTITUDES TOWARD SUFFERING AND PSYCHOLOGICAL RESILIENCE: INSIGHTS FROM STOICISM AND ALBERT CAMUS

Edita Budrytė

Utenos kolegija Higher Education Institution, Utena, Lithuania

Introduction. Psychological resilience and a person's reaction to stress and suffering largely depend on the flexibility of thinking and the ability to look at the difficulties experienced with philosophical wisdom. Suffering is an integral part of human life, therefore it is important to develop philosophical thinking that would help overcome suffering and increase psychological resilience. Based on the analysis of philosophical sources, it is possible to determine what approach to suffering helps a person find spiritual support and the meaning of life in the face of suffering.

Aim of work is to analyze how the Stoics' and Camus' approach to suffering can help a modern person increase their psychological resilience when experiencing suffering.

Materials and methods. This study is based on theoretical analysis of philosophical and scientific literature, including interpretative and comparative analysis of Stoic philosophy and Camus' existential approach to suffering.

Results. The philosophy of Stoicism emphasizes a person's responsibility for their reaction to difficulties and events that cause suffering. Stoics claim that a person can achieve inner freedom from external events and changes in fate if they do not become attached to the circumstances of their life: wealth, social environment, social status, etc. Stoics emphasize the need to prepare for life's difficulties in advance, developing one's virtues, and peace of mind is provided by a wise approach, in which the most important values are thinking, honor, focusing on one's moral attitudes, and the concept of good and evil. Interpreting Camus's essay "The Myth of Sisyphus", it can be stated that a person should not be attached to one meaning of life, because overcoming difficulty and suffering in itself gives meaning to life. Camus described Sisyphus as a hero who has many Stoic traits: the ability to live with suffering without giving in to it. One can raise a discussion question about how seeing reality without distortions and thinking errors is related to developing psychological resilience in the context of modern psychology and the concept of the meaning of life in suffering presented by the Stoics and Camus. The answers lie in the ability to purify one's approach, which leads to the intersections of psychology and philosophy.

Conclusions. Stoicism and Camus's approaches to overcoming suffering are similar, because one can see one important connecting link – inner freedom, as independence from external circumstances and the perception of personal

responsibility. For a modern person, the approach to suffering is how to develop one's inner freedom and responsibility for one's reaction, giving a wise response to current life circumstances and difficulties can become an internal resource that helps develop psychological resilience.

STRESS, ANXIETY, AND DEPRESSION IN CESPU GROUP EMPLOYEES: ASSOCIATION WITH SOCIODEMOGRAPHIC AND PROFESSIONAL VARIABLES

Ana Coelho^{1,2}, Gabriela Brochado^{1,2}, Sofia Lopes^{1,2,3,4}, Ágata Vieira^{1,2,3,5}, Mariana Leite¹, Luísa Gonçalves^{1,2}, Timothée Vanpouille¹, Simon Leroy¹, Paula Rocha^{1,2}

¹Departamento de Tecnologias de Diagnóstico e Terapêutica, Escola Superior de Tecnologias da Saúde do Tâmega e Sousa, Instituto Politécnico de Saúde do Norte (IPSN), 4585-116 Gandra, Portugal

²H2M—Unidade de Investigação em Saúde e Movimento Humano, Instituto Politécnico de Saúde do Norte, CESPU, CRL, 4760-409 Vila Nova de Famalicão, Portugal

³Centro de Investigação em Reabilitação (CIR), Escola Superior de Saúde, Instituto Politécnico do Porto, Rua Dr. António Bernardino de Almeida, 400, 4200-072 Porto, Portugal

⁴ESS, Escola Superior de Saúde, Instituto Politécnico do Porto, Rua Dr. António Bernardino de Almeida, 400, 4200-072 Porto, Portugal

⁵Departamento de Fisioterapia, Escola Superior Saúde Santa Maria, Trav. Antero de Quental 173/175, 4049-024 Porto, Portugal

Introduction. Mental health in the workplace, particularly in higher education institutions, has attracted growing interest, given that psychosocial factors can contribute to high levels of stress, anxiety, and depression (SAD). Sociodemographic and professional variables can influence this risk. However, evidence regarding these associations in the Portuguese university context remains limited.

Aim of work. To assess the levels of SAD among employees from a higher education institution and to examine their association with sociodemographic and professional variables.

Materials and Methods. A cross-sectional study was conducted on 55 employees, who completed an online sociodemographic and professional characterization questionnaire and the 21-item Depression Anxiety Stress Scales (EADS-21). Participation was voluntary, and informed consent was obtained prior to questionnaire completion. Only 44 met the eligibility criteria. Statistical analysis was conducted using IBM SPSS Statistics, with a 5% significance level ($p < 0.05$).

Results. The sample consisted predominantly of women (75%), with a mean age of 45.3 ± 12.5 years. Most participants considered their workplace adequate (93.2%) and did not report work-related pain (56.8%). The majority presented normal levels of stress (81.8%), anxiety (88.6%), and depression (81.8%). A statistically significant positive correlation was observed between the number of hours spent sitting per day and anxiety levels ($\rho = 0.335$; $p = 0.026$), as well as between lunch break duration and depression levels ($\rho = 0.303$; $p = 0.046$). Unmarried individuals had significantly higher levels of anxiety (Median = 4.0; AIQ = 5.5; $p = 0.006$) and depression (Median = 3.0; AIQ = 9.5; $p = 0.045$) compared to married individuals (Median = 0.0; AIQ = 2.0 and Median = 0.0; AIQ = 4.0, respectively). Furthermore,

the presence of work-related pain or discomfort was associated with higher levels of anxiety (Median = 4.0; AIQ = 6.0 pain report vs. Median = 0.0; AIQ = 2.0 no pain report; $p = 0.026$).

Conclusions. Most employees presented normal levels of SAD. However, certain factors such as the number of hours spent sitting, marital status, and discomfort at work were associated with higher levels of anxiety. In this sample, the length of the lunch break and marital status influenced levels of depression.

STRENGTHENING INTERCULTURAL APPROACHES TOWARDS BLENDED INTENSIVE PROGRAMMES IN HIGHER EDUCATION

Elisete Diogo¹, Tatiana Casado²

¹Portalegre Polytechnic University, Portalegre, Portugal

²Universitat de les Illes Balears, Palma, Spain

Introduction. Internationalisation efforts are expanding in higher education institutions (HEIs). These institutions have become multicultural environments, and key sites for cultivating intercultural understanding (Gonzalez, 2010), and for developing intercultural competences of students as future professionals (Deardorff, 2006; Deardorff & Jones, 2022).

In the current European context, there is an opportunity to enhance intercultural approaches in the field of higher education through the introduction of innovative pedagogical methods. One potential path for this are the implementation of Erasmus+ Blended Intensive Programmes (BIP). These are short, intensive programmes that use innovative ways of learning and teaching, with two components – physical mobility and digital cooperation. These programmes include challenge-based learning, where transnational and transdisciplinary teams work together to tackle societal challenges (European Commission, 2025).

In the 2023/2024 and 2024/2025 academic years, two BIP were organised for European social work students on the topic of migrations – counteracting hate speech, and collaborative practices with migrants. Students from the following countries participated: Estonia, Germany, Latvia, Lithuania, Portugal and Spain.

Materials and Methods. An exploratory qualitative multiple case study approach was employed. The objectives of this ongoing study are to identify and understand the effects of these BIP on the participants' knowledge and competencies in dealing with migration and diverse environment demands. The study also examines their contribution to professional identity formation and practice-oriented learning. The results may determine guidelines to improve future projects and higher education. The content generated in both courses, including all materials, assessments and reflections of lectures and students ($N = 56$), was analysed to determine useful elements to maintain, and improvements for future formative proposals.

Results. The findings of the study highlighted several impactful insights, namely:

- 1) an increased awareness of other individuals and their respective backgrounds;
- 2) the acquisition of effective intercultural competences; and
- 3) an increase in self-motivation for individuals aspiring to become social workers and to pursue a career in the field of migrations.

Participants also reported transformative learning experiences linked to experiential activities, international group work and close academic support. Informality and close support from staff are important enablers, while the differences in the study programmes of each university require a detailed contents' preparation.

Conclusions. The conclusions of the study indicate that the international BIP is a suitable approach for enhancing the intercultural competencies of undergraduate students, particularly in the context of migration and diversity. The programme has also been found to be effective in increasing academic motivation among students.

Keywords: Social Work Education; International migrations; Erasmus Programme; Competences; Intercultural approach.

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IDENTIFYING GENERAL PRACTICE WORKFORCE PATTERNS IN ENGLAND: MACHINE LEARNING TO SUPPORT EVIDENCE-BASED HEALTH AND SOCIAL CARE POLICY

Goran Erfani¹, Bryan Burford², Anthony Montgomery³, Nawaraj Bhattarai⁴, Eleanor Hoverd⁵, Ko-Le Chen⁶, Megan Brown⁷, Alison Steven⁸, Gillian Vance², Marco Tomietto¹

Additional authors: Sophie Park⁵, Matthew Lievesley⁹, Peter Van Der Graaf¹, Tim John Rapley¹⁰

¹School of Healthcare and Nursing Sciences, Faculty of Health and Wellbeing, Northumbria University, Newcastle upon Tyne, United Kingdom

²School of Medicine, Newcastle University, Newcastle, United Kingdom

³School of Psychology, Northumbria University, Newcastle upon Tyne, United Kingdom

⁴Health Economics Group, Population Health Sciences Institute, Newcastle University, Newcastle upon Tyne, Tyne and Wear, United Kingdom

⁵Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford, United Kingdom

⁶School of Design Arts and Creative Industries, Newcastle upon Tyne, United Kingdom

⁷School of Medicine, Newcastle University, Newcastle upon Tyne, United Kingdom

⁸School of Healthcare and Nursing Sciences, Faculty of Health and Wellbeing, Northumbria University, Newcastle upon Tyne, United Kingdom

⁹School of Design Arts and Creative Industries, Northumbria University, Newcastle upon Tyne, United Kingdom

¹⁰School of Communities and Education, Faculty of Health and Wellbeing, Northumbria University, Newcastle upon Tyne, United Kingdom

Background. General practices in England continue to face increasing workload pressures, recruitment and retention challenges, and inequalities in healthcare provision. Analysing national workforce composition and workload patterns is critical for informing health and social care policy decisions, and resource planning and allocation. This study applies machinelearning methods to national workforce data to identify distinct clusters of general practices based on skill mix and workload. The aim is to generate an evidence base to inform strategic primary care planning.

Methods. Publicly available NHS workforce, demographic, and geographic datasets were used to conduct a cross-sectional secondary analysis of 6,202 general practices across England. After excluding practices with missing workforce data, 5,846 practices were included. The Skill Mix Index was calculated using Shannon Entropy across five direct care roles (GPs, nurses, pharmacists, physician associates, paramedics), while the Workload Index measured patient demand relative to workforce capacity. Both indicators were standardised before applying K-means clustering. A three-cluster solution was identified, followed by ANOVA and chi-square tests to examine differences in socio-demographic, geographical, and

workforce characteristics. The geographical distribution of these clusters across England is illustrated in Figure 1.

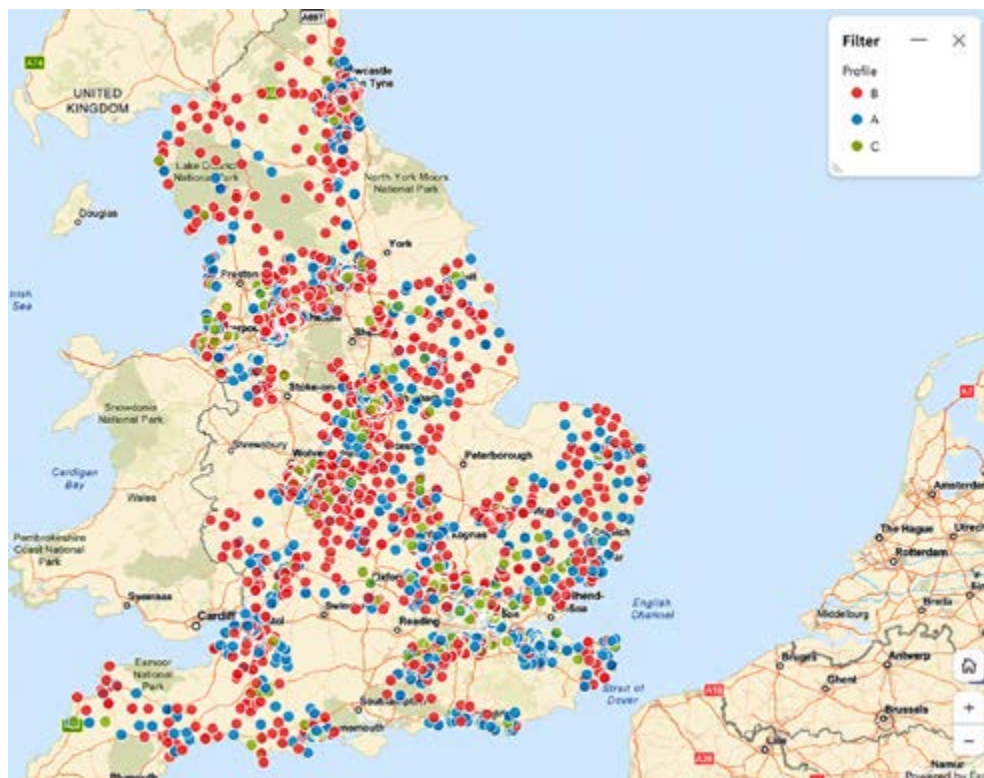


Figure 1. Geographical distribution of identified general practice profiles across England

Results. Three workforce clusters emerged. Cluster A ($n = 1,628$) had the highest skill mix (Mean = 0.60) and a low–moderate workload (Mean = 0.30), representing large, well-resourced practices with broad multidisciplinary skill sets. Cluster B ($n = 2,916$) had the lowest skill mix (Mean = 0.35) but lowest workload (Mean = 0.28), characterised by mid-sized practices with high proportions of GP FTE and the largest rural share. Cluster C ($n = 1,302$) showed a low–moderate skill mix (Mean = 0.38) combined with the highest workload burden (Mean = 0.69), predominantly located in highly urban areas with high patienttoGP ratios and the lowest appointment rates.

Conclusions. This study provides useful insights to develop primary care-tailored policies. Cluster A practices are comparatively resilient and well-resourced, with broad, multidisciplinary teams that serve as a benchmark for effective workforce configuration. Cluster B shows relative stability but signals the need for continuityofcare and GP retention strategies, particularly in mixed

rural settings. Cluster C practices are under a substantial burden and require prioritized policy action, including investment in workforce expansion, deployment of multidisciplinary roles, enhanced appointment capacity, and recruitment incentives. These insights can inform the NHS Long Term Workforce Plan by guiding decisions on staffing skill mix, improving access in high-demand urban areas, and strengthening resilience in mid-sized practices. The machine-learning approach offers a scalable, repeatable national framework for monitoring workforce patterns, enabling early identification of emerging pressures and supporting more dynamic, data-driven resource allocation.

Keywords: General practices, England, Cluster analysis, Healthcare workforce planning, Workforce sustainability

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FROM THE CULTURE OF SILENCE TO THE CULTURE OF VOICE: THE ROLE OF PLAY THERAPY IN TRANSFORMING CHILDREN'S SOCIAL EXPERIENCE

Lina Garšvė

Šiauliai State Higher Education Institution, Šiauliai, Lithuania

Introduction. The field of social work continually seeks innovative methods to enable children to change their social reality through practical activities. Play therapy is a progressive method that supports the development of children's cognitive, motor, and intellectual abilities. This therapy is based on building a relationship between the child and the adult, a foundation of successful social work. Unequal power relations in society often create a "culture of silence" that leads to passive self-perception in children (Freire, 1967). By using play as an educational tool, children develop critical thinking and awareness that help them overcome social exclusion (Acar, 2020).

In international practice, play therapy is increasingly recognized as an effective psychosocial treatment method. In the US, Canada, and South Africa, play therapy is a widely recognized social work method for working with children. In the Lithuanian scientific community, play therapy is regarded as a method that helps children who experience peer isolation, are prone to deviant behavior, or have relationship problems with family members overcome social disorders and develop social resilience. Although play therapy is recognized as an effective method for strengthening children's social skills and emotional well-being.

The study aims to analyze how applying game theory in a children's day center can help change children's social reality, identify their needs, strengthen social resilience, and encourage critical thinking and social participation.

Methods. Semi-structured interviews and observation methods were used in the study. The study was conducted at a children's day center that employed a token-reward system. Tokens are points earned or lost based on a person's behavior. During the study, social workers and children aged 18 or younger attending the day care center were observed. The sample consisted of 22 children aged 7 to 18 (with the consent of their legal representatives). Event sampling was chosen as the observation model.

Conclusions. The study findings revealed that the use of game-based elements and a token system enables social workers to more effectively identify children's individual needs and address inappropriate behavior. Play therapy in children's day centers helps to transition from a culture of "silence" to a culture of "voice" providing children with a safe space to vocalize their experiences, strengthen their self-esteem, and develop critical awareness. This method develops emotional self-regulation, empathy, and constructive conflict resolution, preparing children for

independent living and social responsibility. By using game elements and token systems, social workers can more effectively identify children's needs, address inappropriate behavior, and encourage adherence to social norms. Sociocultural activities and therapeutic play reduce digital addiction and social exclusion, thus fostering long-term resilience in children to negative environmental influences.

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AGGRESSION AND EMOTIONAL INTELLIGENCE AMONG PREHOSPITAL EMERGENCY MEDICAL PERSONNEL

Angelīna Kašuba

P. Stradins medical college of the University of Latvia, Jūrmala, Latvija

Introduction. The prehospital emergency medical care environment is characterized by high work intensity, uncertainty, and increased emotional burden. Medical personnel regularly encounter verbal and physical aggression from patients and their relatives, which may be associated with acute medical conditions, substance use, or mental health disorders.

Research indicates that aggression toward healthcare workers is a significant risk factor for professional burnout and psychological stress (WHO, 2002). Emotional intelligence (EI), defined as the ability to perceive, understand, and regulate emotions (Mayer et al., 2004), may serve as a protective factor in managing aggressive situations and promoting professional resilience.

Aim of the Study. To investigate the prevalence of aggression in the prehospital setting and to analyse the relationship between emotional intelligence and medical personnel's ability to effectively manage aggressive situations.

Materials and Methods. The study included 97 (100%) prehospital emergency medical service specialists who work in the Emergency Medical Service (certified physician assistants). A quantitative research design was applied. Data were collected using an anonymous structured questionnaire assessing experiences of verbal and physical aggression during the past year, as well as a standardized self-report emotional intelligence scale based on the ability model (Mayer et al., 2004).

Data analysis included descriptive statistics and Spearman's correlation analysis to determine the relationship between EI level and self-assessed ability to manage aggressive situations. The study was conducted from March 2024 to August 2024. The survey was distributed within the State Emergency Medical Service via the website www.visidati.lv and in a closed social media group for emergency medical personnel.

Results. The findings indicate that 85% ($n = 82$) of respondents experienced verbal aggression during the past year, while 30% ($n = 29$) reported experiencing physical aggression. A higher level of EI was statistically significantly correlated with greater confidence in conflict resolution and lower perceived stress during aggressive situations ($p < 0.05$). Respondents with higher EI scores more frequently used de-escalation communication strategies and reported emotional exhaustion less often.

The majority of respondents indicated having encountered verbal aggression in their professional practice, and a considerable proportion reported experiencing physical aggression. The analysis revealed a statistically significant negative

correlation between experience of physical aggression and the interpersonal factor of emotional intelligence ($p < 0.05$). This suggests that higher interpersonal EI is associated with less frequent experiences of physical aggression or more effective de-escalation of such situations. Respondents with higher interpersonal EI scores more often reported confidence in communication and the ability to manage conflict situations constructively.

Conclusions. Aggression in the prehospital setting is prevalent and significantly affects the professional performance and psychological well-being of medical personnel. Emotional intelligence represents an important resource in managing aggressive situations and reducing stress. The results support the need to incorporate emotional intelligence and conflict management training into professional development programs for emergency medical service personnel.

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CONCEPTUALIZING DIGITAL OVERUSE IN HIGHER EDUCATION: EXPERT PERSPECTIVES FROM ESTONIAN UNIVERSITY SETTINGS

Helen Kool¹, Riin Seema²

¹*Institute of Service Economy, TTK University of Applied Sciences, Tallinn, Estonia*

²*Tallinn University, Institute of Educational Sciences, Tallinn, Estonia*

Introduction. Teaching and learning in the university setting have fundamentally changed due to digitalization, a shift significantly accelerated by the COVID-19 pandemic which forced both academic and social interactions into cyberspace (Zhang et al., 2022; De' et al., 2020). Students now spend excessive amounts of time online for both learning and socializing, often leading to a normalization of constant digital engagement (Singh and Singh, 2019). This environment has increased the risk of digital addiction, which is positively associated with depression, anxiety, and sleep disturbances, compromising student well-being and academic success (Hou et al., 2019; Hussaini and Akachukwu, 2025). Despite these global trends, there is a lack of research regarding the prevalence and specific impact of digital overuse within Estonian higher education institutions (Käosaar and Purre, 2021). DigiComp (2025) draws attention to the need to use digital technologies in ways that support wellbeing and inclusion and minimize risks to wellbeing while using digital technologies. For balance, offline activities to support wellbeing are suggested (Cosgrove and Cachia, 2025). The latest report of Human Development in Estonia brought out that there is a growing need to support mental health and wellbeing because constant technology use is linked to increased anxiety and stress for both students and educators (Kindsiko, 2026).

Aim of work. Primary aim is to create an instrument to measure healthy vs unhealthy digital use, investigate the prevalence and correlates of digital addiction among Estonian university students and to explore institutional strategies for developing a digital wellness framework to support student success.

Materials and methods. This research utilize a mixed-methods design conducted in two phases. The first phase – developing the instrument – consists of a qualitative study using semi-structured interviews with experts (8), including psychiatrists, psychotherapists, student counselors, lecturers and students, to detect experiences with student struggles and perceptions of excessive technology use. In this presentation the focus is on the findings from this first part of the study.

Results. Qualitative results from the first phase indicate that digitalization has created a distraction in the classroom. Lecturers report that students are frequently “*smiling to their devices*” instead of engaging with the material, requiring instructors to put in significantly more effort, even doing “*stand-up*” to maintain attention. Counselors observe a rise in social disconnection, reporting weekly sessions

specifically focused on teaching students how to find friends. Students express significant struggles with self-regulation, noting they are often unable to sleep without their phones and frequently eat meals alone while using digital devices.

Conclusions. The first part of the study reveals a self-reinforcing cycle where digital overuse during lectures leads to reduced knowledge and poor-quality input in group assignments. This results in social exclusion from collaborations, creating conflicts that further diminish student motivation and well-being. The findings highlight that managing screen time has become difficult, therefore we need institutional “digital harm minimization” policies and a comprehensive digital wellbeing framework to protect the autonomy and academic success of our students (Cain, 2018; Carras et al., 2024).

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MINDFULNESS, HAPPINESS, AND WELL-BEING AS PREDICTORS OF WORK ENGAGEMENT AND QUALITY OF CARE IN HEALTHCARE PROFESSIONALS

Sara Lima^{1,2}, Francisca Pinto^{1,2}, **Fernanda Sofia Brandão**^{3,4}

¹*Escola Superior de Enfermagem do Tâmega e Sousa, Instituto Politécnico da Saúde do Norte (IPSN-CESPU), Penafiel, Portugal;*

²*Innovation in Health and Well-Being Research Unit, IPSN-CESPU, Penafiel, Portugal;*

³*Escola Superior de Saúde do Vale do Ave, IPSN-CESPU, Vila Nova de Famalição, Portugal;*

⁴*The Health & Human Movement Unit (H²M), IPSN-CESPU, Vila Nova de Famalição, Portugal*

Introduction. Healthcare professionals are frequently exposed to high emotional demands, time pressure, and complex clinical decision-making. Promoting psychological well-being is therefore essential not only for professionals' health but also for sustaining high-quality care. Positive Psychology focuses on the study and observation of positively deviated behaviors, outcomes, and processes at the individual, collective, and societal levels of analysis (Seligman, 2002). This domain of Psychology, advocate for the understanding of how an individual's happiness and well-being influence his or her productivity and optimal functionality to fully achieve his or her potential in life (Seligman and Csikszentmihalyi, 2000) based on the idea of developing and increasing skills and tools to promote well-being and optimal human functioning. Mindfulness and happiness have increasingly been identified in the literature as key constructs to consider when assessing and promoting healthcare professionals' well-being and work engagement (Coo & Salanova, 2018; Chamblers, et al., 2023). The literature indicates that fostering mindfulness, happiness, and engagement among healthcare professionals is not only beneficial for their personal well-being but also has meaningful implications for the quality and effectiveness of the care they provide (Muturi et al., 2020, Hafeez, 2024).

Aim of work. To examine the role of mindfulness and happiness in promoting healthcare professionals' well-being and work engagement.

Materials and Methods. A cross-sectional quantitative study is going to be conducted with healthcare professionals from a hospital setting. The sample includes physicians, nurses, physiotherapists, social workers, psychologist, and radiographers. Sociodemographic variables collected include age, gender, years of professional experience, professional category, and type of clinical department. Participants will complete validated measures of mindfulness, happiness, psychological well-being, work engagement. Correlational and regression analyses will be conducted to examine predictive relationships.

Results. Based on previous research, it is expected that mindfulness will be positively associated with happiness and overall well-being. Higher levels of happiness and well-being are anticipated to predict greater work engagement. In

turn, work engagement is expected to be positively associated with perceived quality and safety of care. Differences across professional groups and levels of experience may emerge, with engagement potentially functioning as a mediating mechanism between psychological well-being and care outcomes.

Conclusions. The study is expected to reinforce the importance of promoting mindfulness, happiness, and well-being as strategic resources to enhance engagement and support high-quality healthcare delivery. Organizational initiatives focused on strengthening these psychological dimensions may contribute to professional sustainability and promote the mental health of these professionals.

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EMBRACING DIVERSITY IN SELF AND OTHERS: TEACHING CULTURAL COMPETENCE FOR HELPING PROFESSIONS IN SOCIAL WORK

Liesma Ose

University of Latvia, Riga, Latvia

Introduction. Across Europe, helping professions are increasingly required to deliver rights-based, equitable services in culturally, linguistically, and socially diverse settings. Policy conceptions of diversity emphasise differences in values, cultural perspectives, beliefs, ethnicity, gender identity, sexual orientation, skills, knowledge, and lived experiences (EIGE, 2018). Latvian monitoring suggests that practitioners may experience uncertainty when supporting people with migration experience, minority religions, Roma communities, former prisoners, and sexual minorities—an uncertainty that may translate into uneven service quality if cultural competence is not systematically developed (Ministry of Welfare of the Republic of Latvia, 2023). This presentation argues that the lecturer’s cultural competence is a decisive mechanism through which professional readiness for anti-discriminatory practice is cultivated in social work education.

Aim of work. To examine how lecturers’ cultural competence and cultural humility shape students’ development of culturally competent, ethically accountable, and anti-discriminatory practice readiness in social work and adjacent helping-profession programmes.

Materials and methods. A qualitative design combines:

- 1) desk research synthesising Latvian and EU policy documents and professional guidance on diversity, discrimination risks, and culturally competent practice; and
- 2) autoethnography grounded in the author’s reflective teaching practice. Autoethnographic materials include structured reflective memos, course artefacts (case materials, learning tasks, and assessment rubrics), and observations of classroom dialogue.

Data were analysed thematically, with attention to how pedagogical decisions operationalise values of dignity, equity, participation, and accountability.

Results. Desk research indicates a persistent implementation gap between normative equality commitments and reported uncertainties in work with particular client groups. Thematic analysis of the autoethnographic materials identifies four pedagogical levers that most strongly support competence development:

- a) scaffolded self-reflection on positionality, implicit bias, and professional power;
- b) rights- and ethics-based case analysis focusing on discrimination mechanisms and risk assessment;

- c) communication skills training for practice under uncertainty (e.g., culturally responsive interviewing and conflict-sensitive dialogue); and
- d) assessment criteria that make anti-discriminatory accountability explicit and measurable (NASW, 2015).

The lecturer's cultural competence is most visible in the capacity to facilitate psychologically safe dialogue while naming power dynamics and normalised assumptions without moralising or silencing students.

Conclusions. Cultural competence should be treated as a core educational quality criterion rather than an elective topic. The combined evidence suggests that lecturers who model cultural humility—lifelong self-reflection and deliberate attention to power relations (Tervalon and Murray-García, 1998)—can strengthen students' readiness to provide respectful, equitable, and effective support in diverse communities, thereby reducing discrimination risks in everyday practice.

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HELPING OTHERS WITHOUT FORGETTING ONESELF – THE PROBLEM OF PROFESSIONAL BURNOUT FOR A SOCIAL WORKER WHEN WORKING WITH FAMILIES AT SOCIAL RISK

Neringa Povilaitienė

*Šiaulių valstybinė kolegija / Higher Education Institution
Health Care Faculty, Šiauliai, Lithuania*

Introduction. Social work is a practice-based profession and academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. A study conducted in Northern Ireland revealed that 30% of respondents experience mild emotional exhaustion in their work environment, 37% of respondents identified themselves as experiencing moderate emotional exhaustion, and 7% of respondents identified themselves as experiencing severe symptoms of depression (Maddock, 2024). Social workers provide a variety of support to individuals and families facing a range of life challenges and problems. From working in the care system to supporting service recipients and their family members. However, while providing support to many people, social workers can experience professional burnout due to fatigue and stress. Timely recognition of risks helps prevent professional burnout or minimize its negative effects (Ferguson et al., 2021).

Aim of work. to identify the expression of professional burnout in the professional activities of a social worker with families at social risk.

Methods of collecting and processing research data: structured interviews, written surveys, and qualitative content analysis.

Sample of the research. Eight social workers participated in the research; they had obtained qualifications in social work, worked with families experiencing social risk, and had varying levels of professional experience. All participants were women belonging to different age groups. The participants work in different cities of Lithuania. The subjects were selected using a criterion-based sampling method. All social workers who participated in the study work with families experiencing social risk; this was the main criterion set for selecting participants.

Results. The results showed that professional burnout among social workers worsens their health, reduces motivation and the quality of their work, and affects the organization of assistance to service recipients and the provision of services. Professional burnout is mainly determined by the lack of motivation and aggressive behavior of service recipients, unwillingness to cooperate and insufficient cooperation between institutions.

Conclusions. The results of the research revealed that social workers experiencing burnout are characterized by an apathetic state, a devaluation of themselves and their professional activities, difficulty in performing usual motivational tasks, and work no longer provides motivational satisfaction.

Research has shown that when working with families, social workers encounter complex situations with service recipients, which usually cause significant emotional stress and fatigue. This is associated with the constant need to help families, the inability to step back, and the constant desire to take on too many responsibilities for other people. These factors inevitably affect the risk of professional burnout.

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MOTOR CONTROL AND CERVICAL AND LUMBAR FUNCTIONAL DISABILITY IN CESPU GROUP EMPLOYEES

Paula Rocha^{1,2}, Sofia Lopes^{1,2,3,4}, Ana Coelho^{1,2}, Ágata Vieira^{1,2,3,5}, Nuno Nogueira^{1,3,4}, Mariana Leite¹, Pedro Pinto¹, Jorge Carneiro¹ & Gabriela Brochado^{1,2}

¹*Departamento de Tecnologias de Diagnóstico e Terapêutica, Escola Superior de Tecnologias da Saúde do Tâmega e Sousa, Instituto Politécnico de Saúde do Norte (IPSN), 4585-116 Gandra, Portugal*

²*H2M—Unidade de Investigação em Saúde e Movimento Humano, Instituto Politécnico de Saúde do Norte, CESPU, CRL, 4760-409 Vila Nova de Famalicão, Portugal*

³*Centro de Investigação em Reabilitação (CIR), Escola Superior de Saúde, Instituto Politécnico do Porto, Rua Dr. António Bernardino de Almeida, 400, 4200-072 Porto, Portugal*

⁴*ESS, Escola Superior de Saúde, Instituto Politécnico do Porto, Rua Dr. António Bernardino de Almeida, 400, 4200-072 Porto, Portugal*

⁵*Departamento de Fisioterapia, Escola Superior Saúde Santa Maria, Trav. Antero de Quental 173/175, 4049-024 Porto, Portugal*

Introduction. Cervical and lumbar pain have a high prevalence in the adult population and are often accompanied by functional disability. Scientific evidence has increasingly highlighted the role of deep stabilizing muscles, namely the deep cervical flexors and the transversus abdominis, in pain modulation and functional preservation. Motor control of these muscle groups may influence functional disability in symptomatic individuals.

Aim of work. This study aimed to analyze the levels of self-reported functional disability among participants and their association with motor control performance of the cervical and lumbar musculature.

Materials and Methods. A cross-sectional study was conducted on a sample of 54 participants, employees of a higher education institution. Data collection included online questionnaires with sociodemographic and occupational data, as well as functional disability indices (Neck Disability Index (NDI) and Oswestry Disability Index (ODI)). Subsequently, data on motor performance were collected in person using the Pressure Biofeedback Unit (PBU). All statistical analyses were conducted in IBM SPSS Statistics at a 5% significance level ($\alpha = 0.05$). Chi-square tests were used to evaluate the association between PBU-assessed motor control and self-reported disability outcomes (NDI and ODI).

Results. In the study sample, 14 participants (25.9%) self-reported minimal disability and 1 participant (1.9%) moderate disability in the lumbar region. Regarding the cervical region, only 1 participant (1.9%) presented with mild disability. Furthermore, 93% of individuals with good transversus abdominis muscle endurance demonstrated minimal disability, and this association was statistically significant ($p = 0.008$). In contrast, no association was identified between levels of cervical disability and the endurance of the deep cervical flexors ($p = 0.362$).

Conclusions. The results suggest that better motor control of the deep lumbar muscles may be associated with lower levels of functional limitation.

HOME-BASED INTEGRATED CARE AS A BUFFER AGAINST SYSTEMIC CRISIS: PATIENT EXPERIENCE EVIDENCE FROM LITHUANIA

Patricija Strašunskaitė

Šiauliai State College, Šiauliai, Lithuania

Introduction. For many people living with chronic illness or functional limitations, receiving care at home is closely linked to a sense of dignity, familiarity and security. In recent years, health systems have increasingly explored ways to organise care beyond institutional settings, seeking models that ensure continuity of services beyond patients' everyday environments. Home-based nursing, when delivered through interdisciplinary collaboration, is increasingly viewed as one of the approaches capable of supporting both patient well-being and the sustainability of health care systems.

Aim of work. To analyse the experiences of patients and their relatives receiving ambulatory home nursing services and to examine how these services are perceived within the context of integrated care provided in the patient's home environment.

Materials and methods. A quantitative survey was conducted between June and August 2021 at the Family Medicine Clinic of the Lithuanian University of Health Sciences. The study involved 137 respondents receiving ambulatory nursing services at home or their relatives participating in the care process. Data were collected using a structured questionnaire assessing satisfaction with services, perceived quality of care, communication with health professionals and expectations regarding specialist involvement. Descriptive statistics and comparative analysis were applied.

Results. Respondents assessed home nursing services positively, with 62.77% evaluating the quality of services as very good. Particularly favourable evaluations were observed among respondents without formally identified special care needs (76.5%). Communication with health professionals emerged as an important dimension of patient well-being. After consultation with a specialist, women reported a statistically significantly greater improvement in well-being compared with men (67.7% vs. 39%; $p = 0.002$). Respondents aged 80 years and older more frequently indicated that specialists addressed their complaints attentively during visits compared with younger respondents (87.2% vs. 72.9%; $p = 0.035$). Expectations expressed by respondents also reflected a broader understanding of care at home: alongside nursing services, patients highlighted the value of visits from other professionals, social workers, nursing assistants and physiotherapists, suggesting that home-based care is perceived not only as medical assistance but also as comprehensive support within everyday life.

Conclusions. Patients and their relatives evaluated ambulatory nursing services at home positively and associated them with improved communication with health professionals and better well-being. The findings underline the importance of interdisciplinary collaboration when providing home care. Home-based integrated care may therefore serve not only as an alternative to institutional services but also as a way of maintaining humane, continuous care while responding to increasing demands placed on modern health systems.

SIMULATION OF FUNCTIONAL LIMITATIONS AS A FACTOR IN STRENGTHENING PROFESSIONAL EMPATHY IN SOCIAL WELFARE PRACTICE

Danguolė Šakalytė, Edmundas Vaitiekus

Utenos kolegija / Higher Education Institution, Utena, Lithuania

Introduction. Professional empathy is an essential component of high-quality of social welfare services. The ability to understand a person's physical and sensory vulnerability determines not only the quality of the relationship with the client or patient but also the adequacy of decisions made in complex situations. However, empathy is often developed at a theoretical level during the study process, and students do not always have the opportunity to experience the impact of functional limitations in their own lives. Experiential simulation can serve as a tool for strengthening emotional awareness and professional attitudes when working with vulnerable people.

Aim of work. To evaluate the impact of simulation of functional limitations on the empathy and professional attitudes of future social welfare professionals.

Materials and methods. This quantitative study employed a pre- and post-intervention design. Thirty students from the Social Work study programme participated in the research. The intervention consisted of a simulation of functional limitations using a gerontological simulation suit (GERT) that imitates sensory, physical, and coordination limitations.

Students' experience was assessed using a 9-point semantic differential scale, recoded into an interval from -4 to +4, where 0 indicated a neutral assessment and positive values indicated a stronger simulation effect. Five areas were assessed: sensory, physical, psychological, and coordination limitations, as well as changes in empathy and professional attitudes. Data analysis was performed by calculating mean scores and comparing the results obtained before and after the intervention.

Results. The results showed that the simulation had a clear effect on students' perception of functional limitations. In the area of sensory limitations, mean scores indicated a moderate effect, while in the areas of physical limitations and coordination, the effect was more pronounced. Psychological impact indicators revealed a tendency toward emotional discomfort and a reduced sense of control.

The greatest change was observed in the areas of empathy and professional understanding. After the simulation, students rated their ability to understand the experiences of people with functionally limitations significantly higher and reported stronger professional motivation to take their needs into account in practice.

Conclusions. Simulation of functional limitations is an effective experiential learning tool that strengthens the professional empathy of future social welfare professionals.

Quantitative findings indicate that experiential intervention increases awareness of functional limitations and promotes a deeper emotional response, which is associated with more positive professional attitudes.

Simulation may be considered an educational strategy that contributes to the development of higher-quality, more sensitive professional practice and more sustainable service provision in the social welfare sector.

COMPLIANCE WITH INFECTION CONTROL REQUIREMENTS IN THE CLINICAL PRACTICE OF THE DOCTOR'S ASSISTANT STUDY PROCESS

Jeļena Urbēna, Janeta Strazdiņa, Maira Lāce

P. Stradins Medical College of the University of Latvia, Jūrmala, Latvia

Introduction. More than 35,000 people die each year in Europe from multidrug-resistant infections, 70% of which are healthcare-associated (HAI), although most are preventable through effective infection control (ECDC, 2022). Infection control is essential for healthcare quality and patient safety, and inadequate compliance increases HAI risk. Therefore, adherence to infection control requirements must be emphasized already during healthcare professionals education, as it shapes their future competence and attitudes.

Aim of work. To determine compliance with infection control requirements in the clinical practice of the doctor's assistant study process.

Materials and methods. A quantitative sample data analysis was conducted to assess the implementation of infection control requirements during clinical practice of doctor's assistant students in the 2024/2025 academic year. Data were collected using an author developed survey questionnaire administered via Google Forms and processed in Microsoft Excel. The respondents were 1st and 2nd year students of the P. Stradins Medical College of the University of Latvia study program "Medicine" enrolled in the course "Professional Technical Skills" at the Jūrmala and Rēzekne branches. All 48 students ($n = 48$; 100%) participated anonymously, reporting on their clinical practice based on observations and personal actions. Research period – 30.05.2025. to 30.06.2025.

Results. The results of the study showed that during practice, healthcare staff did not always act in accordance with the guidelines, as indicated by 38% ($n = 18$) of respondents. 15% ($n = 7$) of respondents indicated that staff did not always change gloves when performing procedures that may involve contact with the patient's body fluids, while 21% ($n = 10$) did not always disinfect reusable equipment after each procedure. 8% ($n = 4$) of respondents indicated that staff used gloves without hand disinfection when performing such procedures, while 13% ($n = 6$) of respondents indicated that staff sometimes used the same gloves on multiple patients. 21% ($n = 10$) of respondents indicated that staff did not always perform hand hygiene during patient care.

Conclusions. In over one third of cases, healthcare staff did not consistently follow guidelines, including lapses in hand hygiene, glove changing, and equipment disinfection, highlighting the need to strengthen infection control measures in clinical practice.

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AUTOMATED CAPILLARY REFILL TIME AS A NOVEL TOOL FOR MICROCIRCULATION ASSESSMENT IN INTENSIVE CARE

Una Undine Zelca¹, Mara Klibus², Edgars Laksa³, Andris Grabovskis³, Zbignevs Marcinkevics¹

¹Department of Human and Animal Physiology, Faculty of Biology, University of Latvia, Riga, Latvia

²Department of Anaesthesiology, Intensive Care and Clinical Simulations, Riga Stradins University, Riga, Latvia

³Faculty of Science and Technology, University of Latvia, Riga, Latvia

Introduction. Microcirculatory dysfunction is central to sepsis and shock and may persist even when systemic parameters appear normal. Because these microvascular abnormalities directly affect tissue oxygenation, assessing microcirculatory perfusion at the bedside is important for early detection of inadequate tissue perfusion and for guiding timely interventions (Falotico et al., 2020). Manual capillary refill time (mCRT) is a simple, noninvasive test in which the fingertip is briefly compressed until blanching, and the time to color return is measured (Guven et al., 2020). Although widely used, manual CRT depends on subjective visual estimation and is influenced by technique, lighting, and skin temperature, limiting its precision, reproducibility, and usefulness for serial monitoring. Automated CRT (aCRT) aims to standardize the compression maneuver and incorporate optical sensing to quantify the refill curve objectively (Kawaguchi et al., 2019; Sheridan et al., 2017). By providing stable, repeatable values, aCRT may improve consistency across caregivers, enhance trend detection over time, and support more informed decisionmaking when adjusting treatment strategies.

Aim. To introduce an automated CRT device and report early feasibility and discriminative performance in a small series of healthy adults and septic ICU patients.

Materials and methods. A fingertip prototype delivering standardized compression with optical reflectance sensing was developed to compute CRT automatically; local skin temperature was recorded in parallel. Six participants were enrolled: three healthy adults and three septic ICU patients. Bedside measurements were performed, and descriptive statistics summarized acquisition success and group differences.

Results. All measurements were completed without adverse events. Healthy adults had short aCRT values (mean 1.53 ± 0.40 s). Septic ICU patients showed prolonged, more variable times (mean 6.78 ± 5.2 s), with two of three exceeding 3 s. Longer aCRT values coincided with cooler fingertip temperature (~ 26 °C), consistent with impaired perfusion. Hemodynamic findings were normal in healthy adults and altered in septic patients.

Conclusions. This feasibility series shows that automated CRT is practical, rapid, and reliably standardized at the bedside, and in this small cohort it clearly distinguished healthy adults from septic ICU patients. aCRT is designed to support and complement clinicians' assessments, providing an objective measurement alongside routine bedside evaluation. Larger studies are needed to evaluate agreement with established perfusion markers, assess repeatability, and determine how best to integrate aCRT into everyday clinical workflows.

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ARTICLES

GROUP SESSIONS AS A RESOURCE FOR IMPROVING INTERACTION SKILLS IN THE WORK OF SOCIAL REHABILITATION SPECIALISTS WITH PERSONS WITH INTELLECTUAL DISABILITIES

Inese Eņiņa, Kristīne Vītoliņa

P. Stradins Medical College of the University of Latvia, Jurmala, Latvia

Introduction

The social inclusion of persons with mental health disorders and the improvement of their quality of life is a priority of Latvian social policy and healthcare. The aim of social rehabilitation is to restore the abilities of individuals to integrate into society. One of abilities is interpersonal skills, which are very significant factor in keeping emotional and psychological balance, integrating into society, promoting the development of self-confidence, and improving quality of life. As said in the regulatory documents and guidelines of the Ministry of Welfare of the Republic of Latvia in the social field (Ministry of Welfare of the Republic of Latvia, 2017), special emphasis is placed on the importance of social rehabilitation services for persons with mental health disorders. These services promote the social functioning, independence, and inclusion of persons in society. The guidelines provide for the development of structured, high-quality group programmes and sessions oriented toward the acquisition of practical skills and everyday competencies. One of competencies is interpersonal skills, which are important for employment, emotional well-being, and quality of life improvement. The relevance of the topic is determined by several factors. In recent years, considerable attention in Latvian policy regulations and programmes has been devoted to the social rehabilitation approach and the development of services, showing the necessity to evaluate and improve methods used in practice (Ministry of Finance of the Republic of Latvia, 2025). Research materials of the Saeima of the Republic of Latvia (Saeima of the Republic of Latvia, 2022) indicate that a lack of interpersonal and communication skills is one of the significant barriers in social integration.

In the context of social work, communication plays a particularly significant role, as it is considered one of the most essential instruments of professional

practice. Effective communication ensures not only the exchange of information but also promotes the development of trust, strengthens a sense of security, and fosters mutual respect and understanding. The importance of effective communication is mentioned in the publication *Social Work with Cases* (Roga-Vailza, et al., 2021). Effective communication is a multidimensional process that includes both verbal and non-verbal expression. It encompasses the ability to speak or convey information, to listen actively, to perceive and interpret what another person says, as well as to understand non-verbal signals. A lack of effective communication may create misunderstandings, distorted feeling of information, and negatively affect interpersonal relationships, including in the professional environment. In communication, not only the content of information is important but also the manner of its presentation, the choice of language, symbols, and context. In social work practice, these aspects are particularly important, as professional relationships are based on trust, empathy, and mutual understanding. Good oral and written communication is one of the fundamental elements of social work, ensuring effective help, correct identification of needs, and purposeful planning of support (Ministry of Welfare, 2019). Martinsone and Sudraba (Martinsona un Sudraba, 2019) write down that if the relationship between the doctor/healthcare professional and the patient is formed while respecting the patient's autonomy, self-determination, decision-making capacity, and active participation (Delbanco et al., 2001), then such a patient-centred approach can yield superior results. The effectiveness of such an approach is also confirmed by research results showing that it influences patient adherence and satisfaction with the treatment process and outcome. To implement this cooperation model, both doctors and other healthcare professionals must develop educational and psychological competence alongside specific professional knowledge and skills. This enables them to assess possible psychosocial risks of the patient and provide the necessary support (Martinsona un Sudraba, 2019).

One of the tasks of a social rehabilitator is to work with or lead small groups. The aim is to develop the communication skills and cooperation abilities of group participants, as well as to restore or strengthen social interaction. The authors of the study "Social Group Work with Adults Having Intellectual Disabilities," Sinu Ezhumalai and Ranganathan Marimuthu, emphasize that group work helps support the abilities of persons with mental health disorders in everyday life, learning, and social functioning and is used as an effective rehabilitation method. Group work or sessions provide an environment in which individuals can practice social skills through practical activities, receiving feedback from other group participants and the leader (Ezhumalai and Marimuthu, 2021). Group sessions help reduce social isolation and promote social interaction.

Methods

In contemporary practice, social rehabilitators increasingly require evidence-based and effective methods that facilitate the social inclusion of persons with mental health disorders and enhance their quality of life. Group sessions represent a particularly significant resource in fostering the development of clients communication skills, self-confidence, and collaborative abilities. Participation in group work provides clients with an opportunity to express their thoughts and emotions within a structured, safe, and supportive environment. Furthermore, group-based interventions contribute to the development of empathy, as participants are exposed to diverse experiences and perspectives in various situations. Such interventions play an essential role in reducing social isolation and strengthening a sense of belonging, which is especially important for individuals with mental health disorders.

Within the framework of the qualification thesis, the author developed a cycle of five sessions intended for adults with mental health disorders. By developing a structured cycle of group sessions, it is possible to ensure purposeful development of clients skills and systematic observation of results, providing professional support to the social rehabilitator. The sessions are structured sequentially and purposefully so that the client can gradually express emotions and improve interpersonal skills.

The cycle begins of emotion cards, which help the client become aware of, recognize, and name emotions. At this stage, the client is more involved in conversation; however, structured support is still provided to ease emotional expression. Emotion cards serve as a mediator in conversation, helping to formulate feelings and share experiences with other group participants. The emotion cards are developed based on the principles of cognitive behavioural therapy (CBT) and mindfulness practice (Eniņa, 2024). This combined approach promotes mental health and well-being by enabling clients to better understand their emotions and moods. Working with the cards provides a simple and structured way to find, explore, and reflect on different emotional states. Each card has questions on the front to help analyse a specific emotion and an affirmation on the reverse side to promote positive thinking and mood. The cards are used in group sessions, where participants choose the emotion card that resonates with them most and answer the question or read the affirmation to promote a positive emotional state. In total, the set consists of 42 emotion cards, ensuring recognition of various emotions and moods while developing self-awareness and emotional regulation skills.

The next session involves the use with collage creation, which is a safe and indirect form of self-expression that allows the client to visually reflect thoughts, feelings, and inner experiences without direct verbal communication, thereby reducing tension. Collage creation is a visual art therapy method that promotes emotional expression through symbols, images, and visual associations. In art therapy, the creative process is considered a significant means that helps clients become aware of inner emotions and experiences, especially when verbal expression

is limited (Martinson, 2011). Collage creation develops creative thinking, sensory interaction (vision, touch, and movement), self-assessment and positive self-esteem, fine motor skills, and sustained attention.

The third session is planned as a workshop using natural materials. In this session, clients promote creativity and cooperation. Working with natural materials helps relaxation, fosters a connection with nature, and trains patience and cooperation skills. It develops tactile and visual senses and promotes hand-eye coordination. Communication in this session occurs both verbally and non-verbally, allowing clients to feel more comfortable interacting with others.

The fourth session is a board game session. It helps develop social skills such as rule-following and patience. During board games, clients promote mutual communication, learn to control their emotions, and accept both victory and defeat. Board games help train thinking, attention, cooperation, emotional resilience, and social contact formation. In this session, the client feels more secure and is ready to engage more actively in joint activities and cooperation with other group participants.

The cycle concludes with a cooking session, in which participants prepare a meal together. It is planned to prepare cinnamon sticks from puff pastry. This session combines practical activity, cooperation, and acquisition of useful everyday skills. Cooking together helps persons with mental health disorders strengthen practical skills, stimulate the senses (taste, smell, touch, sight), develop self-confidence as a visible result is achieved, and gain emotional satisfaction and joy from shared time. While preparing food together, participants learn to divide responsibilities, help one another, and communicate in a relaxed, informal atmosphere. In this session, previously bought interpersonal skills are reinforced, and participants can recognize their sense of belonging to the group. Overall, the session cycle is designed so that participants gradually feel more secure, become more open in expressing emotions, and develop the social skills necessary for everyday life (Jonathan et al., 2024) also mention skill development and its importance, saying that the main aim of rehabilitation services is to find and purposefully develop individuals' skills and strengths. A significant role in individual skill development belongs to the social rehabilitator, who considers the client's individual abilities and opportunities. The social rehabilitator promotes the development of social, emotional, and functional skills and encourages participation in various activities using diverse methods. One of the aims of my qualification thesis was to create a session cycle whose content promotes the maintenance or improvement of clients' interpersonal and communication skills. Such a developed session cycle is significant in the work of a social rehabilitator because it ensures a purposeful and transparent work process.

Results

The implementation of the developed five-session cycle for seniors with mental health disorders yielded positive and professionally meaningful results in emotional, social, and functional domains. During the session process, participants were open, interested, and willingly engaged in the proposed activities. Already at the first meeting, a cautious but positive attitude toward the creative process was seen, while in later sessions participant involvement became increasingly active and confident.

The use of emotion cards eased emotional expression. Participants learned to find, name, and describe their emotions based on structured questions. The card format served as a safe mediator in communication – it was easier for participants to speak about emotions by referring to a specific card rather than formulating thoughts spontaneously. Some seniors openly shared personal feelings within the group for the first time. Reading affirmations also created a positive effect, promoting a more optimistic mood and strengthening self-esteem.

During the collage session, participants proved the ability to represent emotions and subjective experiences. The visual self-expression method reduced initial tension and insecurity often characteristic of verbal self-disclosure. Some participants who are usually more reserved and less communicative were able to reveal feelings through collage. The creative process promoted concentration, activation of fine motor skills, and satisfaction with completed work. Group participants examined each other's works with interest, forming initial elements of mutual interaction.

High engagement and emotional responsiveness were seen in the natural materials workshop. Working with natural elements created a calm and harmonious environment that promoted relaxation and reduced signs of anxiety. Communication occurred both verbally and non-verbally, which is particularly important for persons with limited verbal expression abilities. Positive emotional dynamics were seen – smiles, mutual aid, and spontaneous praise for other participants.

In the board game session, social skills developed particularly prominently. Participants learned to follow rules, wait for their turn, and accept both victory and defeat. Initially, some seniors had trouble controlling disappointment when losing; however, with the support and structured explanations of the social rehabilitator, emotional self-regulation was promoted. The game process encouraged communication, shared emotions, and mutual encouragement. Activation of thinking, attention, and memory processes was seen, as well as a positive influence of the competitive element on motivation.

In the final cooking session, participants proved a proficient level of cooperation. Preparing cinnamon sticks from puff pastry together created a practical and emotionally fulfilling experience. Participants helped each other and communicated in a relaxed atmosphere. The senses – taste, smell, sight, and touch – were stimulated, creating an added positive emotional experience. The visible and tangible

result strengthened the sense of self-efficacy and self-confidence. Sharing the meal created a sense of belonging to the group and concluded the cycle with an emotionally positive experience. Overall, a gradual increase in participants openness, communication, and involvement was seen from the first to the fifth session. Seniors with mental health disorders became more confident, engaged more actively in conversations, and started interpersonal contact more often.

Discussion

Summarizing the obtained results, it can be concluded that the sequence of sessions – from indirect, creative self-expression to active cooperation and practical collaboration – promotes gradual trust-building and increased social openness. Such a methodological structure allows clients to develop communication skills step by step while reducing anxiety and insecurity. It is important to mention the use of diverse methods (visual art, emotion cards, natural materials, board games, and practical life skills), which ensure a comprehensive approach to client development. Cognitive, emotional, and social functions are stimulated while keeping a motivating and positive work environment.

The positive results confirm that seniors with mental health disorders can actively take part in group work, develop communication skills, and experience emotional satisfaction when provided with a supportive and safe environment. The session cycle promotes increased self-esteem, a sense of belonging, and expansion of social contacts. Interview results confirm the usefulness of the session cycle from a professional perspective. The positive evaluation of social work specialists shows that the developed programme corresponds to the aims of social rehabilitation and can be integrated into everyday practice. The structure of the session cycle is particularly significant as it ensures a transparent and systematic work process.

Conclusions

In conclusion, the developed session cycle is a significant and structured support instrument in the professional activity of a social rehabilitator. It ensures a clear framework for work organisation, transparent goal setting, and systematic observation of client development dynamics. Such a purposefully planned and structured group work process allows evaluation of achieved results, flexible adaptation of activities to clients' individual needs, and professionally grounded implementation of rehabilitation. At the same time, the session cycle promotes maintenance and improvement of socio-emotional skills, strengthens self-confidence, and encourages more active participation in the social environment, thereby improving social functioning and quality of life, particularly in work with seniors with mental health disorders.

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PHYSICAL ACTIVITIES FOR SENIORS IN THE SOCIAL REHABILITATION PROCESS

Sanda Lapuķe, Ina Viksniņa

P. Stradins Medical College of the University of Latvia, Jurmala, Latvia

Introduction

In Latvia, over the ten-year period from 2015 to 2025, the total population has decreased from 1.98 million to 1.86 million, of which seniors aged 65 and over account for 19.4 % in 2015 and 21.87 % in 2025 (Centrālā statistikas pārvalde, 2026a). Similarly, recent years in Latvia have been marked by declining birth rates, indicating negative natural population growth (Centrālā statistikas pārvalde, 2025), and a substantial share of the population (440 396 residents between 2004 and 2024) has emigrated abroad (Centrālā statistikas pārvalde, 2026b). These demographic trends indicate a decline in population and the relevance of the ageing of society.

As people age, various changes occur. The main age-specific feature is the ageing process of the body, which is accompanied by certain age-related changes in the body, as well as cognitive, personality, and psychological features. The personality of a senior is characterised by his or her status in society, value system and profession (Jansone and Dambe, 2009). Therefore, it is important to understand the physical, cognitive and social features typical of the senior life stage, which is crucial in the social rehabilitation process.

According to the Law on Social Services and Social Assistance a long-term social care and social rehabilitation institution is a social institution which provides a person who cannot take care of himself or herself due to old age or state of health, and also orphans and children left without parental care with housing, full care and social rehabilitation (Sociālo pakalpojumu un sociālās palīdzības likums, 2002). Therefore, the majority of clients of long-term social care and social rehabilitation institutions are seniors.

One of the professional duties of a social rehabilitator is to promote a physical active lifestyle for clients (Sociālā rehabilitētāja profesijas standarts, 2021).

Data published in the Central Statistical Bureau database indicate that in 2022 a total of 6183 people aged 62 and over were living in long-term social care and social rehabilitation institutions (hereinafter referred to as institutions), in 2023 – 6758, and in 2024 – 7087 (Centrālā statistikas pārvalde, 2026c). These data indicates that the number of clients living in institutions has been increasing in recent years.

The above-mentioned analysis reveals that mentioned clients should be provided with social rehabilitation services, including promoting a physical active lifestyle and ensuring meaningful leisure activities.

The recommendations developed by the Ministry of Health on promoting physical activities among Latvian residents emphasize that, when planning the promotion of physical activity in society, it is important to pay attention to the involvement of seniors and people with disabilities. One of the most important factors for these target groups is the opportunity to socialise, which can be promoted through appropriate physical activities (LR Veselības ministrija, 2019).

It is well known that physical activities and movements have a significant role in strengthening health, preventing diseases and reducing the risk of death, especially for seniors. Physical activities for seniors is a vital element in the social rehabilitation process, which not only promotes seniors' physical functioning, but also improves their independence, autonomy in everyday life, increases self-care skills and creates positive emotions, promotes socialisation and integration into society, ensures the maintenance of communication skills and a sense of belonging, as well as helps seniors maintain an active lifestyle and provides meaningful leisure activities. These positive benefits reduce the risks associated with social ageing, which are closely linked to cognitive features and physical changes at the senior stage of life. In addition, physical activities for seniors during the social rehabilitation process promotes active ageing, which is the foundation of life quality and healthy longevity. The above analysis highlights the topicality of this theme.

The aim of study is to study the physical activities for seniors in the social rehabilitation process.

Methods

This study uses both qualitative and quantitative research methods, providing deeper understanding of seniors' physical activities in the social rehabilitation process. This holistic approach is essential for developing conclusions based on the data and the opinions of experts – social work specialists.

The following research methods were used to achieve the study aim:

1. Descriptive statistics and statistical data analysis methods to reflect demographic trends and the relevance of the ageing of society in Latvia, as well as to summarise and analyse survey results.
2. Analysis of literature and information sources to describe the senior stage of life, to analyse seniors' physical activities in the context of an active lifestyle, and highlight the significance of seniors' physical activities in the social rehabilitation process.
3. The survey was developed to find out the opinion of social work specialists on the physical activities of seniors in the social rehabilitation process.

The survey for social work specialists was previously approved by the Ethics Committee of P. Stradins Medical College of the University of Latvia.

The study was conducted in eight long-term social care and social rehabilitation institutions that provide social rehabilitation services to seniors, and permission

to conduct the study was obtained from these institutions. These institutions are registered in the Register of Social Service Providers (Sociālo pakalpojumu sniedzēju reģistrs, 2026). Four institutions are located in the Riga municipality, one of which is the largest institution in Riga municipality in terms of the number of clients (Gailezers, 2026), two are non-governmental institutions and one is a private institution. The study also involved the largest municipal institution in terms of the number of clients from Tukums municipality (Rauda, 2026), two non-governmental institutions from Bauska municipality, one of which is the largest institution in terms of the number of clients served (Derpele, 2026), and one largest municipal institution in terms of the number of clients from Talsi municipality (Lauciene, 2026).

The authors of the study conducted a survey of social work specialists from the aforementioned institutions, which complies with the qualifications of the respondents (Sociālo pakalpojumu un sociālās palīdzības likums, 2002).

The aim of the expert – social work specialists – survey within this study is to obtain expert opinions on physical activities for seniors in the social rehabilitation process.

At the beginning, the experts from institutions were informed about the purpose and the context of the study. The expert survey was conducted using a questionnaire method, employing the Microsoft Forms tool available online and an in-person survey. 24 respondents completed the Microsoft Forms online survey and 5 respondents completed the in-person survey, for a total of 29 respondents. Survey period – February to March 2026. The survey includes closed, partially closed, and multiple-choice and two open-ended questions, as well as one Likert scale question, for a total of 19 questions. With regard to the Likert scale question, it should be noted that it provides four response options, excluding the neutral response option, as its impact on this study is not significant (Armstrong, 1987). The results obtained from the survey were compiled, processed and analysed using Microsoft Excel.

The structure of the survey was developed to include several logical sections. At the beginning of the survey, information about the qualifications and professional experience of social work specialists in working with seniors is included. Then, the types of physical activities for seniors, their availability and frequency are clarified. Opinions on motivating seniors and getting them involved in physical activities are being identified, and limiting factors are being clarified. The positive benefits of physical activities for seniors in the social rehabilitation process are explored. The final part of the survey included 2 open-ended questions to ascertain the experts suggestions for improving physical activities among seniors and motivating them to participate in physical activities offered by the institution in the context of the social rehabilitation process.

Results

Respondent description. 29 respondents ($n = 29$) participated in the survey, of whom 4 indicated that they were senior social workers, 9 social workers, 8 social rehabilitators and 8 social workers. After evaluating the professional experience in working with seniors of experts involved in the study, it was concluded that the majority of respondents had up to 5 years of working experience (15 respondents), 11 respondents had 6-10 years, and 3 respondents had 11 or more years of working experience.

29 respondents ($n = 29$) answered questions about the types of physical activities most common among seniors, their availability, and how frequently they were provided in institutions. They were asked about the availability of activities and their frequency (every day, 1 to 4 times a week, 1 to 2 times a year, 3 or more time a year, seasonally). The data showed that all of respondents point to the possibility of walking on the institutions territory (within a 50 m radius of entrance doors), and in most cases (21 respondents) daily. With regard to walks outside of the institution's territory, for example, in nature – in nearby park or forest, 7 respondents indicate that these occur only few times a year or not at all. Walking in the urban environment is even less common, with only 8 respondents indicating that this activity occurs from every day to 1 or 2 times a week. The data analysis shows that not all institutions offer Nordic walking classes. Only 8 respondents had mentioned Nordic walking, which occurs couple times a year. Morning exercises and gymnastics classes for seniors are relatively common physical activities in institutions, taking place either every day (8 answers regarding to morning exercises and 10 gymnastics) or up to 4 times a week or more (11 answers regarding to morning exercises and 19 gymnastics), although not all institutions offer morning exercises (9 respondents). With regard to gym access, it should be noted that in some institutions they were available every day (13 respondents), or couple of times a week (4 respondents), while in other institutions they are not available, as indicated by 12 respondents. Fine motor skills classes are one of the most frequently organized activities and take place in all institutions. This was followed by the use game elements (for example standing or siting in a circle and not letting the balloon touch the ground, etc.) in the social rehabilitation process, which takes place as often as fine motor skills classes. Seniors in institutions also have access to social dancing, such as dancing to music, including a senior disco, which, according to respondent's answers, take place almost evenly – either a couple times a week (14 answers) or a couple times a year (12 answers). On the other hand, movement and dance therapy and the use of its elements in social rehabilitation process are available a few times a year (9 respondent answers in each activities), not available in institution (9 respondents for movement and dance therapy, 10 respondents answers regarding the use of movement and dance therapy elements) or occurs 1 to 2 times a week (11 respondents for movement and dance therapy, 10 respondents answers regarding the use of movement and dance therapy

elements). In institutions, board games (chess, Novus, pool) are often offered in daily basis (17 respondents). However, boccia is much less commonly available – based on responses, it is offered 1 to 2 times a year according to 7 respondents, 3 times a year according to 1 respondents, once a week according to 9 respondents, or not at all according to 12 respondents. The majority of respondents indicated that their institutions organize sports games for seniors, which mainly take place a few times a year (18 respondents). Similarly, in institutions, various gardening and greenhouse work activities are available to seniors, which, as respondents indicated, are carried out together with a gardener, caretaker, social worker, and only when the weather is warm enough for the season and the health conditions allow (15 respondents). In addition to the mentioned activities in the survey, others include spring-cleaning, mushroom picking, and fishing (2 respondents). One respondent indicated that swimming in the lake and sea was provided with specialised wheelchairs for seniors who use wheelchairs or other mobility aids.

Analysing the data from the perspective of gender of seniors who are most active and most willing to attend physical activities offered by the institution, it can be concluded that women are the most active (14 respondent's answers). A very close result was also obtained, showing that both genders are active and willing participate in physical activity classes (13 respondent's answers). In contrast, 2 respondents indicated that only men participate in physical activity classes.

It was also important to find out whether a physiotherapist was available in all institutions. Most respondents indicated that a physiotherapist was available at the institution, providing therapeutic exercises individually and in groups (20 respondents), 2 respondents noted that only individual physiotherapy was available, while 7 respondents noted that no physiotherapist was available at the institution.

With regard to availability of physical activities in institution (morning exercises, gymnastics), 18 respondents indicated that these take place in groups and individually. Meanwhile, 9 respondents noted that activities take place only in groups, and 2 respondents indicated that they take place individually.

When analysing which groups of seniors regularly attend the physical activity classes offered by the institution (morning exercises, gymnastics), respondents could select up to 5 answers from 8 options provided. The authors of the study have summarized and arranged the results in Figure 1.

According to the data in Figure 1, it can be concluded that in institutions there are many seniors who need to be invited or reminded to participate in physical activities, as shown by 25 responses from respondents to multiple-choice questions.

It was also established that physical activities at the institution are almost adjusted to all seniors, including those with functional impairments (23 answers), while the outdoor environment of the institution (within a 50 m radius of the entrance) is even better adopted (27 answers).

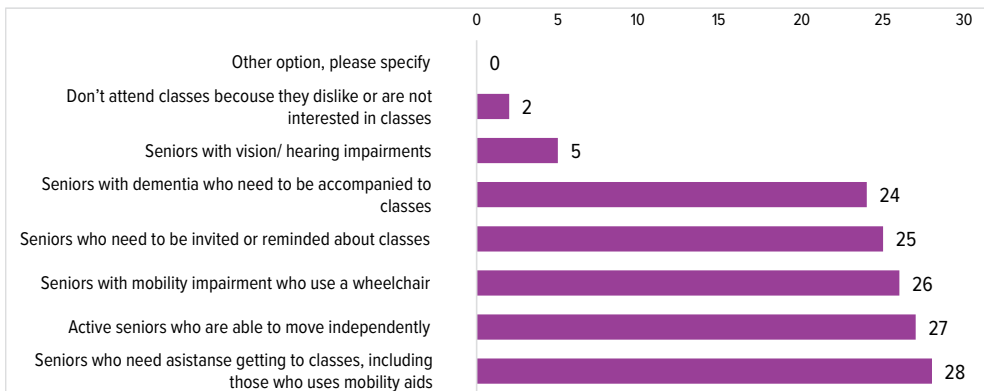


Figure 1. Senior groups, who regularly attend physical activities provided by the institution

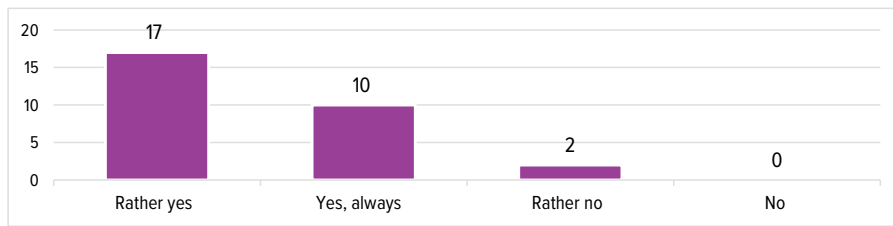


Figure 2. Respondents' opinion on whether seniors should be invited and encouraged to attend physical activities

The study continues by identifying options on motivating seniors and involving them in physical activities, which are important in social rehabilitation process. Respondents were asked whether seniors should be invited and encouraged to attend physical activity classes. The answers are based on Likert scale with 4 options: “yes, always,” “rather yes,” “no,” “rather no,” excluding the neutral option in order to clearly determine respondents’ option on the motivation of seniors to attend physical activity classes as “yes” or “no.” The data obtained is shown in Figure 2.

The data shows that more than half of the respondents (17 respondents) think that seniors should be invited to physical activity classes, and 10 respondents answered “yes, always” seniors should be invited and spoken to, while only 2 respondents think that seniors should rather not be encouraged to attend physical activity classes. No respondents selected the option “no.” In the context of the Likert scale, this means and allows to conclude that 27 respondents answered “yes” to this question, confirming that seniors should be invited and encouraged to attend physical activities.

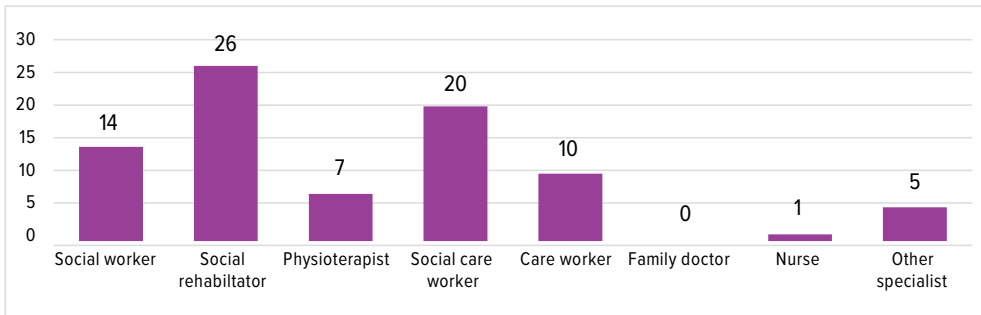


Figure 3. Respondents' answers as to which of the institution's specialists motivates seniors to attend physical activities

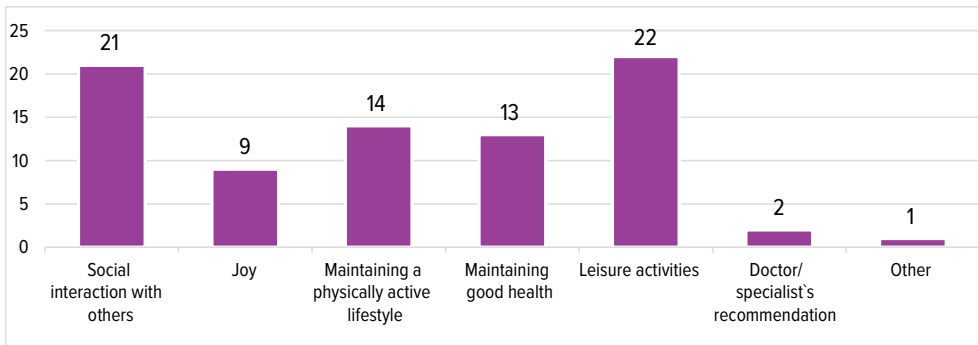


Figure 4. Respondents' answers, which motivate seniors to participate in physical activities

Figure 3 clearly shows which social work specialists in the institution motivate seniors to attend physical activities, allowing respondents to select up to 3 answers from 8 provided options.

The data in Figure 3 clearly shows that the main specialist who motivates seniors in institutions is a social rehabilitator (26 answers), followed by social care worker (20 answers) and a social worker (14 answers). With regard to the other specialists mentioned, it should be pointed out a class tutor who does not have a social work qualification (4 answers) and a cleaner (1 answer) were mentioned.

It was also important to identify the opinion that most often motivates seniors to participate physical activity classes, allowing respondents to select up to 3 answers from 7 options provided (see Figure 4).

According to the data in Figure 4, most respondents marked the answers related to leisure activities (22 answers), noting that leisure activities most often motivate seniors to participate in physical activities. The 21 responses from respondents pointed to social interaction with others. Meanwhile, 14 respondents noted maintaining a physically active lifestyle, following by maintaining good

health as motivation for seniors to participate in physical activities. Positive emotions such as joy were mentioned by 9 respondents, which is very important aspect of seniors' cognitive health and their willingness to participate in activities offered by institutions.

In order to ensure a detailed analysis, it was important to identify the factors that most often limit or hinder the participations of seniors in physical activities, allowing respondents to select up to 5 answers from 8 options provided. The limiting factors were identified in following order: health limitations (26 responses), lack of motivation (24 responses), physical functional impairments (mobility, vision, hearing impairments) (14 responses), mental disorders (psychiatric disorders, including dementia, depression) (14 responses), lack of staff workload (no staff availability to take them to activities) (9 responses) and institutional limitations (space, facilities) (4 responses). As can be seen, lack of motivation ranks second, which is a high indicator and confirms both the findings of Likert scale question and the conclusions drawn from Figure 1 that there are many seniors in institutions who need to be invited and reminded about physical activities in order for them to attend regularly.

A similar result was obtained in the next question of the survey, "Should seniors be encouraged to go for walks outside?", allowing respondents to select up to 5 answers from 7 options provided. The most popular answer was "yes, they go outside if they are invited and motivated" (26 responses), taking first place in the multiple-choice question and confirming once again that seniors need to be motivated, approached, and invited to participate in the physical activities offered by the institution. In second place is the response "go outside without being invited" (24 responses), which shows that these seniors are independent and active lifestyle enthusiasts. In third place, the analysis data shows that "going outside is only possible with an assistant" (18 responses), which indicates the limited and other functional problems of seniors. In fourth place, respondents noted that seniors "do not want to go outside, even though they are able to" (17 responses), which is immediately followed by responses that seniors "do not want to go outside because they prefer to spend time indoors watching TV" (11 responses), or "do not want to go outside" (11 responses) at all. The last three responses indicate that many seniors have sedentary lifestyle and lack motivation and interest.

It was important to identify 3 to 5 **main benefits for seniors** from the physical activities offered by the respondent institutions. Respondents marked 3 to 5 answers from the 13 options provided (see Figure 5). The option "other" does not appear in Figure 5, as nothing was entered in it.

According to the data in Figure 5, the main benefits of physical activity for seniors are listed in the following order: Opportunity to spend leisure time (24 responses), socialising (18 responses), maintaining a physically active lifestyle (16 responses), joy (15 responses), and physical health (12 responses).

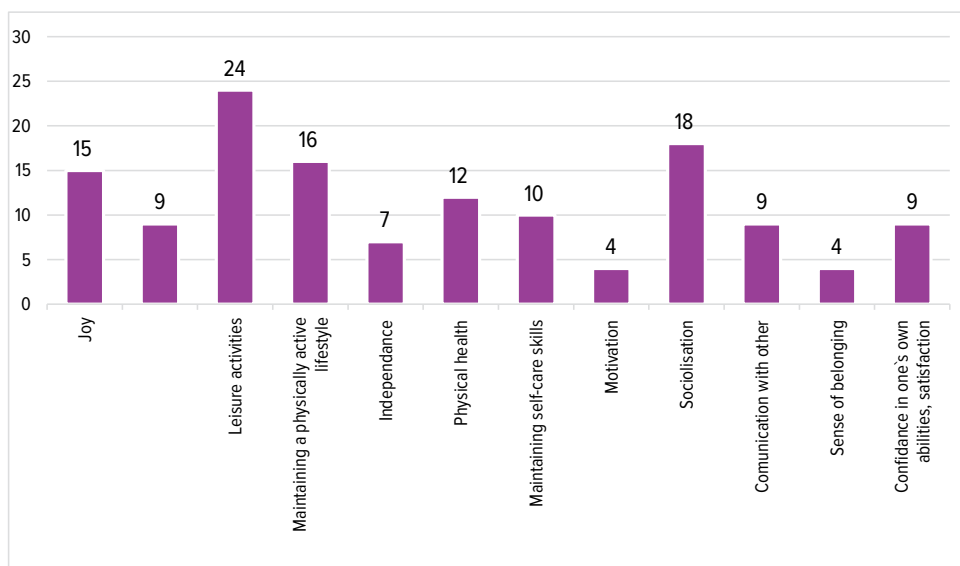


Figure 5. Respondents' answers about the main benefits seniors gain from physical activities offered by the institution

When asked whether seniors participate in sports games at the respondent's institution, only 4 respondents answered that seniors do not participate in sports games. However, from the 25 respondents who answered that seniors participate in sports games at their institution, volume of participants was: 10–19 seniors (12 respondents), 20 or more seniors (8 respondents) and 6-10 seniors (5 respondents).

Discussion

Ageing is not a disease. Despite the physical changes that occur in old age, every person is unique. The universal problem of old age, namely a slowing of psychomotor speed, can be mitigated through exercise, training specific activities, and engaging in active physical and cognitive activities reduces or at least temporarily halts the physical and cognitive decline expected in old age (Sebre and Miltuze, 2022). Social ageing, on the other hand, reflects the interaction of seniors with society as their influence in the social and economic spheres declines (Liepiņa, 1998). Norwegian researchers have found that physical activities provides a positive experience, gives meaning to everyday life, and at the same time is a challenge (Telenius et al., 2022). Seniors who are more physically active have higher quality of life indicators in terms of physical health, psychological well-being, social relationships, and environment (Rétsági, 2020). To avoid loneliness, seniors need to be involved in social activities, and social rehabilitators can give seniors a new meaning in life by offering them various activities (Jansone un Dambe, 2009). During exercise activities, seniors are

also taught counting skills to keep their minds active, and at the end of the activities, seniors perform positive self-affirmations (Botsford, 2009).

According to the results obtained from the survey, it can be concluded that daily, low-intensity physical activities are more accessible and regularly provided to seniors in institutions that activities outside the institution or specialised activities, e.g., movement and dance therapy, Nordic walking, and visits to the gym. Walks on the territory of the institution are the most widely available physical activity, which is available every day. This shows that institutions provide mobility opportunities for seniors by using available institutions territory. Activities organised on the institution's territory, such as exercise activities, fine motor skills, and board games, are also available. This means that seniors are provided with regular functional maintenance and development classes, which are necessary for both daily functioning and meaningful leisure activities. Activities organised outside the institution (walks in nature, in the city, Nordic walking) are much less frequent and subject to weather conditions. The analysis data indicates that Nordic walking as a targeted activity for seniors is not widely integrated into the daily practice of institution, as this activity only takes place a few times a year. Not all of the institutions that responded have a gym available. Which may be due to a lack of free space, costs, gym maintenance, and staff capacity. Specialised physical activities (movement and dance therapy, boccia) are provided unevenly. The absence and non-use of movement and dance therapy in the social rehabilitation process indicates a limited availability of specialists (art therapists), especially in the regions, or a lack of financial resources to attract such specialists. However, in the institutions where movement and dance therapy is offered, one respondent noted that the institution holds musical activity classes with seated dance elements once a week, and that the project always involves movement and dance, drama or art therapists who conduct 4 to 10 sessions per year, or that the aforementioned specialists work with seniors as part of their study practice. 4 respondents indicated that volunteers are involved in promoting a physically active lifestyle among seniors by providing various activities. One respondent noted that schoolchildren also visit the institution. One respondent emphasized that seniors are more physically active during the summer and want to go outside more often. Overall, it can be concluded that there are differences between institutions in the variety, accessibility, and regularity of physical activities, which indicates differences in the objectives, planning, resource availability and attraction, infrastructure, and staff capacity of social rehabilitation services.

The study identified, processed, and summarised the proposals of experts – social work specialists (16 respondents answered an open-ended question) – on improving physical activity for seniors in social rehabilitation process. The results show that improving physical activity for seniors in the social rehabilitation process is linked to strengthening human resource capacity and ensuring an individual approach, especially for seniors who are unable to attend group activities on their own and cannot be outside the institution alone. Experts emphasise the need

for additional staff, including social rehabilitation workers, to provide constant assistance to seniors both during activities and when accompanying them activities and outside the institution. Great importance is attached to individual adapted activities in accordance with the health condition and functional abilities of seniors. At the same time, emphasis is placed on motivating seniors and encouraging their regular participation classes or activities offered by the institution that involve physical activity. It is worth including small physical activities in the content of each social rehabilitation class, both to focus on the class and to promote physical activity. The use of games and varied physical activities are mentioned as effective methods for maintaining seniors' interest and promoting engagement. This is similar to what was mentioned in Botsford's (2009) publication. Experts also point to the need for larger and more suitable spaces that would allow for safe, diverse physical activity classes adapted to the individual abilities of seniors. The focus is on ensuring competitive salaries in order to reduce risk of professional burnout and promote higher quality of social rehabilitation services.

The conclusion of the study summarises the suggestions of experts (15 answers from respondents to an open question) on motivating seniors to participate in physical activities offered by institutions in context of social rehabilitation process, emphasising the importance of both professional competence and organisational resources. The experts emphasise that the skills of social workers are important-persistence, the ability to encourage and establish motivational communication based on individual conversations, regular conversations, and positive reinforcement, especially for small achievements. At the same time, it is pointed out that seniors who already have an interest in physical activities often do not need additional motivation, while those who have not developed an experience of physical activities in their lifetime, building motivation is gradual and purposeful process. An effective approach includes individual communication, explaining the importance of a physically active lifestyle, regular reminders, as well as offering passive involvement, such as simply observing the class, thereby reducing psychological resistance. Experts also emphasise the importance of an emotionally positive environment when working with seniors, using fun tasks, game elements, and musical accompaniment that promote engagement and create an enjoyable experience. As with improving the physical activity of seniors, motivating seniors also highlights the need for an adequate number of social rehabilitators and the involvement of students to bring new ideas and a more creative and diverse approach to the social rehabilitation process when working with seniors.

The results obtained in the study are very valuable in terms of the physical activities of seniors in the social rehabilitation process, and experts have provided significant feedback. The study confirmed that promoting a physically active lifestyle for seniors in institutions is important part of the social rehabilitation process, highlighting the social context of physical activity. The findings of study can be uses in the work of long-term social care and social rehabilitation institutions with

seniors with seniors within the framework of social rehabilitation services and their diversification, improvement, and development.

Conclusions

Promoting a physically active lifestyle is one of the most important elements of social rehabilitation in maintaining and preserving the functional abilities of seniors. Physical activity promotes independence, emotional well-being, and social inclusion. When planning physical activities for seniors, social rehabilitation specialists must adapt activities to each individual. Social rehabilitation specialists can be guided by the recommendations of healthcare professionals. Physical activities for seniors can be a successful element of the social rehabilitation process when combined with emotional and cognitive aspects.

The surveyed social work specialists emphasised the importance of physical activity for seniors within the social rehabilitation process. The study identified three main benefits for seniors from the physical activities provided by the institution: opportunity to enjoy leisure time; Socialisation; Maintaining a physically active lifestyle. These benefits also aligned with the factors motivating seniors to participate in physical activities.

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MEDICAL COLLEGE SUPPORT SYSTEM IN THE CONTEXT OF STUDENT WELL-BEING

Aelita Koha, Mārīte Saulīte

P. Stradins Medical College of the University of Latvia, Jurmala, Latvia

Introduction

In recent years, the well-being of students and young people in the context of education has been increasingly studied in Latvia and around the world. The theoretical framework of the concept of well-being is analysed from several aspects, however, in the study of academic environment and student well-being, along with several others: (e.g. *wellness, welfare, satisfaction with life* etc.) two concepts are more commonly used: *Student well-being* – a broader term that encompasses the emotional and physical state of students during the learning process and *Academic well-being* – specific, a term describing academic well-being that focuses on a student's well-being in relation to academic achievement, motivation, and prevention of burnout risks (Koļeņņikova, et al., 2023).

In medical education, academic well-being is closely linked to students' ability to cope with high academic workloads and avoid burnout (Salmela-Aro & Read, 2017). In Latvian higher education institutions, student well-being is measured by assessing both emotional resilience and social skills. (Dūdiņa & Martinsone, 2024; Perepjolkina et al., 2020).

In turn, learning support in the academic environment is defined as a set of resources, strategies and measures that help students overcome learning difficulties and fully engage in the study process (Simpson, 2012; Tait, 2000).

The Latvian research space emphasizes that student well-being is closely linked to the development of socio-emotional skills and the availability of support mechanisms at the university (Dūdiņa & Martinsone, 2024; Koļeņņikova, et al., 2023). Considering the specifics of medical studies, which require not only academic discipline but also emotional resilience, it is necessary to evaluate how the support system works at the college level.

It is noteworthy that not only in education, but also in the latest medical research in Latvia (Nagle, Reine, & Naglis, 2025) and around the world, the concept of well-being and the reduction of potential stress risks for medical professionals are being highlighted. The need for continuous monitoring of employee well-being is emphasized, promoted by a holistic approach, balancing work demands with sufficient resources, in addition to providing support for emotional, physical and

psychosocial well-being. Organizations that actively care about employee well-being are reported to create healthier and more productive work environments.

Purpose: to identify and analyse the components of a medical college support system in the context of student academic well-being.

Methods

The study used theoretical and empirical research methodology.

In theoretical analysis, academic well-being is viewed as a four-dimensional construct that includes study vigour, burnout, satisfaction with studies, and self-efficacy (Salmela-Aro & Read, 2017). The conceptual framework of well-being is formed by Seligman's (2011) PERMA model, which includes positive emotions, engagement, relationships, meaning, and achievement in medical studies. In turn, the assessment of student autonomy or self-determination is based on Self-Determination Theory (SDT) to determine how students' autonomy, competence, and sense of belonging affect their well-being in universities (including medical college) (Ryan & Deci, 2017).

Promoting well-being in the educational environment and student support is analysed based on the findings of Baiba Martinsone, a leading researcher at the University of Latvia (Martinsone, 2016; Dūdiņa & Martinsone, 2024). Learning support in medical college is analysed as a two-dimensional model: on the one hand, it is the pedagogical skills and structured resource offer emphasized by Harden (2017), and on the other hand, the experiential learning identified by Dornan (2007), which is based on qualitative feedback and emotional support in clinical work.

The empirical study was conducted as a quantitative cross-sectional design study using a structured anonymous survey, with the aim of evaluating the medical college support system and its relationship with student well-being and perceived stress levels during the study process.

The study included 80 first- and second-year medical college students ($n = 80$). The sample was drawn based on convenience, involving students who voluntarily agreed to participate in the study. Before completing the survey, students were informed about the purpose of the study, the use of data for scientific purposes, and the voluntary nature of participation. Completing the survey was considered as providing informed consent to participate in the study.

The research instrument was developed in the form of a structured questionnaire. The questionnaire included: 2 demographic questions (age, course of study); 8 statements about general well-being and the study environment; 14 statements about stress, its causes and effects; questions about types of support received; questions about the biggest challenges during studies; questions about the use of college support services; and 2 open questions about necessary improvements in the support system.

A five-point Likert-type scale (1 – completely disagree, 5 – completely agree) was used to assess well-being and stress. Higher scores indicated higher levels of well-being or stress, depending on the wording of the statement.

Quantitative data analysis was performed using descriptive statistical methods. Frequencies, percentage distributions, as well as mean values and standard deviations for Likert scale questions were calculated.

Additionally, possible relationships between student well-being indicators, perceived stress, and types of support received were analysed. The answers to the open-ended questions were analysed using thematic content analysis, identifying common themes and proposals for improving the support system. Statistical significance was considered at $p < 0.05$.

Results and discussion

When evaluating the survey data, low internal consistency was found for the well-being question block (Cronbach's $\alpha = 0.39$), which indicates that the statements included in the questionnaire reflect several different dimensions, rather than a single construct. Therefore, the results were analysed in thematic blocks rather than creating an overall well-being index (see Table 1).

Student well-being and assessment of the study environment (Cronbach's $\alpha = 0.71-0.78$ – average good):

When analysing students' self-assessment of well-being in the study environment, a positive trend was found, as 40 students (50%) completely agreed with the statement that they generally feel good in their study environment, while 28 students (35%) tended to agree. Only 10 respondents (12.5%) tended to disagree with this statement, while 2 (2.5%) chose a neutral answer.

Regarding emotional support, 41 respondents (51.3%) tended to agree, while 20 (25%) completely agreed that they receive sufficient emotional support during their studies. 10 students (12.5%) gave a negative rating, while 9 (11.3%) were neutral.

A significantly positive assessment was also given to the support of academic staff — 47 students (58.8%) completely agreed, while 14 (17.5%) rather agreed that they receive sufficient support in the study process.

A particularly high rating was found for the balance of the study load — 65 respondents (81.3%) fully agreed that the study load is balanced with the students' capabilities.

At the same time, the results show a significant presence of stress in the study process, as 27 students (33.8%) completely agreed, while 30 (37.5%) rather agreed that studies cause excessive stress. Only 20 respondents (25%) strongly disagreed with this statement.

Regarding the psychological stress caused by practical classes, 25 students (31.3%) completely agreed, 15 (18.8%) rather agreed, and 20 (25%) were neutral. 20 students (25%) gave a negative rating.

Table 1. Students' self-assessment of general well-being and study environment (n = 80)

Criteria	1 – I completely disagree	2 – I tend to disagree	3 – I neither agree nor disagree	4 – I rather agree	5 – I completely agree
I generally feel good in my study environment		10	2	28	40
Studying causes me excessive stress	20		3	30	27
I have sufficient emotional support during my studies	10		9	41	20
I am able to balance my studies and personal life	10	10	11	9	40
Practical classes create increased psychological stress	8	12	20	15	25
I feel safe and respected in my study environment	29	1	5	5	40
Academic staff provides sufficient support in the study process	9	5	5	14	47
The study load is balanced with the students' capabilities	5		5	5	65

Cronbach's $\alpha = 0,39$

Maintaining a balance between studies and personal life was assessed differently – 40 students (50%) completely agreed that they were able to maintain a balance, while 20 respondents (25%) rather or completely disagreed.

The results of the study reveal a generally positive assessment of the study environment, but at the same time indicate significant psychological stress among students.

Although most respondents feel good in the study environment and are positive about the academic staff and emotional support, more than 70% of students admit that studies cause excessive stress. This contradiction may indicate that the organizational structure of the study is appropriate, but the emotional load, intensity of demands, or individual factors are causing increased stress.

The polarization of feelings of security and respect attracts particular attention. The high proportion of negative responses (36.25%) may indicate individual problem situations or uneven student experience in the study process. This aspect should be analysed in more depth in future studies.

The psychological stress caused by practical classes, which is acknowledged by half of the respondents, shows that the practical part of studies can be a significant source of stress. This may be due to high demands, a grading system, or the level of responsibility.

Interestingly, despite the high stress level, the study load is assessed as balanced. This may indicate that stress is not directly related to quantitative load, but rather to qualitative factors – emotional tension, exam anxiety or individual adaptive abilities.

The following is an analysis of respondents' statements about stress, its causes and effects, as the analysis of the results in Table 1 reveals a pronounced polarization of opinions, which may be related to individual differences in time planning, extracurricular employment or personal circumstances, and indicates an existing contradiction between a balanced study load and a high level of stress.

The stress question block showed high internal consistency (Cronbach's $\alpha = 0.96$), which confirms the reliability of the measurement instrument. The results show very high levels of stress among students. More than 90% of respondents indicate that they experience high levels of stress during the semester, and almost 70% admit to a significant increase in stress during the session.

Particularly worrying is the data on the impact of stress on sleep (95%) and concentration (87.5%). This indicates a potentially negative impact on mental health and the quality of learning.

Exams and study load are the main sources of stress identified, while there is a marked difference in experience regarding deadlines and the grading system. This may indicate individual adaptive abilities or different study strategies.

Interestingly, not all students experience stress reducing motivation. This may indicate that stress acts as a mobilizing factor for some respondents.

Overall, the results confirm that stress is a systematic and significant phenomenon in the study process, affecting both emotional and academic functioning. There is a pronounced polarization of opinions in terms of the impact of motivation and attitude towards deadlines, therefore, in the support system model, there is a need for effective stress reduction and psychological support strategies in the study process.

When evaluating the results of the answers from both blocks, it is clear that students are not unanimous in their assessment – some feel very confident, while others feel the opposite, while there are few answers in the middle position, which indicates a polarization of the statistical results. Therefore, the following analysis combines the assessment of the study environment (Table 1) and the assessment of stress experiences (Table 2) to determine the interrelationships between the study environment and psychological strain.

Table 2. Students' self-assessment of stress, its causes and impact on the study process (n = 80)

Criteria	1 – I completely disagree	2 – I tend to disagree	3 – I neither agree nor disagree	4 – I rather agree	5 – I completely agree
I often feel stressed during my studies		5	5	2	68
My stress level is high during the semester		5	1	4	70
My stress increases significantly during the session	5	10	10	2	53
Exams cause me a lot of anxiety	10	10	2	10	48
A large amount of studying causes me stress	10	10	10	5	45
Short deadlines for submissions increase my stress	55	5			20
The grading system creates pressure and stress	30	5	10	2	33
I find it difficult to balance multiple study tasks at the same time	15	15	8	20	22
Stress negatively affects my sleep	4			4	72
Stress makes it harder for me to concentrate	10			20	50
Stress reduces my motivation to study	10	25	10	10	25
Stress is affecting my academic results	10		10	25	25
I experience physical fatigue or health problems due to stress	20	15	15	15	15

Cronbach's $\alpha = 0,96$ (excellent internal consistency)

The results of the comparative analysis were analysed in thematic blocks:

1. Study environment and general well-being

The results show that the study environment is generally evaluated positively. Most students indicate that they: feel good in the study environment (85%), receive sufficient emotional support (76.25%), positively evaluate the support of academic staff (76.25%), and consider the study load to be balanced (87.5%). These indicators indicate a relatively stable and structured study environment. However, there is a strong polarization on certain issues, especially in the aspect of safety and respect, where a significant proportion of students indicate negative experiences.

2. Stress level and its dynamics

Despite the positive assessment of the study environment, a very high level of stress was found among respondents: 87.5% often feel stressed; 92.5% feel high stress

during the semester; 68.75% admit that stress increases significantly during the session. This indicates that stress is a systematic phenomenon in the study process, not just the result of individual situations.

3. Main sources of stress

Data analysis shows that the most significant stress factors among respondents are exams (72.5% feel anxious), a large amount of studying (62.5%), and performing multiple tasks simultaneously (52.5%).

However, the results regarding deadlines and grading systems are polarized – for some students they create pressure, for others they do not. This may indicate individual differences in adaptation abilities and time management skills.

4. The impact of stress on functioning

Medical College Support System In the context of student well-being, indicators on the effects of stress are particularly important, with 95% of respondents admitting that stress negatively affects sleep, 87.5% indicating difficulty concentrating, and 62.5% believing that stress affects academic performance.

In turn, polarization is observed when it comes to motivation – for some students, stress reduces motivation, while others maintain it or even mobilize it.

Summarizing the results of the comparative analysis, a significant contradiction can be seen: the study environment is assessed as positive and supportive, but at the same time a very high level of stress has been detected among students. The aforementioned contradiction can be explained based on several aspects of theoretical research:

1. The structural and emotional dimensions are different.

The study organization may be balanced, but the emotional load (responsibility, self-demands, competition) creates high psychological stress. (Koļesņikova, et al., 2023; Ryan and Deci, 2017).

2. Acute or chronic stress.

Stress increases especially during the session, which may indicate intermittent but intense tension (Martinsonsone, 2016; Dūdiņa & Martinsone, 2024)

3. Individual differences.

Polarization on several issues shows that student experiences are not homogeneous – some adapt successfully, while others experience significant difficulties. (Salmela-Aro & Read, 2017)

4. Functional impact.

The effects of stress on sleep and concentration can have long-term consequences for academic performance and mental health. (Perepjolkina et al., 2020).

The results of the questions about receiving support during the study process and recommendations for improving support, as well as answers about challenges and planned discontinuation of studies, are planned to be analysed more extensively in future publications. But in the context of the work objective, these results show that the main providers of support for students are teachers (31.25%), family

and friends (31.25%), which points to the importance of two types of support, institutional support (academic staff) and emotional support outside the study environment.

In turn, the dominant challenges in the study process are time planning (68.75%) and the stress of practical classes (60%). This indicates that the main difficulties are not only the content of the course, but also the intensity and schedule of studies, the emotional and psychological burden of practical work, as well as the balancing of multiple responsibilities.

Most students (87.5%) have not considered quitting their studies due to stress or burnout. This indicates relatively stable psychological resilience and overall sufficient adaptation to the study environment. However, it is significant that 12.5% of students (one in eight) have considered dropping out of their studies due to stress or burnout. In the context of higher education, this is an important indicator, as even a small percentage can signal potential risks to the quality of studies and student well-being.

Conclusions

1. The results of the study indicate a pronounced contradiction between the overall quality of the study environment and the emotional well-being of students, because despite a structurally balanced study framework, there is a pronounced polarization of experience and high emotional tension, which indicates the need to improve support mechanisms to strengthen student well-being.
2. The student support system is primarily based on informal and direct communication channels — feedback from lecturers and private social networks (family, friends). In contrast, structured support tools, especially the institute of group tutors, currently provide the least tangible contribution.
3. Most students have not considered dropping out, which indicates a generally stable study environment, however, 12.5% of students have considered dropping out due to stress or burnout, which is a significant risk indicator. Therefore, it is necessary to continue to strengthen the emotional support system and improve workload organization to reduce the risk of student burnout and improve academic well-being.
4. The results of the study show that although the study environment is formally organized and supportive, it is necessary to strengthen psychological support mechanisms and stress reduction strategies, especially during sessions and exam periods, which should definitely be included in the medical college support system development model.
5. Overall, the results of the study show that the study load is academically well-balanced, however, the intensity of practical classes and time planning challenges create significant psychological stress for some students. Therefore,

to improve the support system model in medical colleges and student well-being, it is recommended to strengthen the support system for stress management and time planning, provide more flexible study options in the implementation of practical classes, and continue regular feedback collection to identify at-risk student groups.

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BURNOUT RISKS IN PODOLOGIST WORK

Mārīte Saulīte, Aelita Koha

P. Stradins Medical College of the University of Latvia Jurmala, Latvia

Introduction

Today's changing socio-economic developments, information flow, and rapid digitalization processes in the medical industry increase the risk of burnout for healthcare professionals. Global (Denning & Goh, et al., 2021; Riethof, et al., 2020) and Latvian research (Paudere-Logina, 2023; Paudere-Logina, 2020) data show, that medical professionals are at greater risk of burnout syndrome than other professions, which is determined by the specifics of the work environment – work intensity, medical ethics dogmas, bureaucratic burden and close daily contact with people (with patients, their relatives and colleagues). In recent years (Riethof, et al., 2020), research has suggested a hypothesis that the clinical symptomatology of burnout syndrome is associated with alexithymia, as well as with symptoms of depression and traumatic stress, which can be both risk factors and consequences for the development of burnout syndrome.

Literature (Fumis, et al., 2017; García-Campayo, et al., 2016) analysis data shows that burnout syndrome is characterized by three main indicators – emotional exhaustion, depersonalization, and a low sense of personal achievement or self-realization. It should be added that the concept of “burnout” is identifiable from stress, which, unlike burnout, is a temporary reaction of the body to a high load, however, if stress is not adequately managed, it can lead to burnout (Burčėna & Skrupska, 2025). Therefore, it is important to identify burnout risk factors in healthcare workers (including podologists) to ensure early intervention in stressful situations and improve work performance. This describes the relevance of the topic, as it is also necessary to identify the risk factors for burnout syndrome in the work of a podologist.

Purpose: to identify the risk factors for burnout syndrome in the professional work of podologists.

Method

The study used theoretical and empirical research methods. The theoretical research uses the results of theoretical analysis of scientific sources and research results. In turn, a quantitative research method was used to conduct the empirical study – a survey of podologists practicing in Latvia. The practical study was

conducted in 2024, as part of the LUPSK qualification work “Factors contributing to burnout syndrome in the work of a podologist” (Negriņa & Saulīte, 2024).

150 practicing podologists from various medical institutions in Latvia were invited to participate in the study. Sixty-six podologists ($n = 66$) responded to the study and completed valid and analysable questionnaires. Although the number of respondents did not exceed half of the number of individuals invited, the amount of data obtained was considered sufficient to formulate initial conclusions, considering the diversity of the sample and the geographical spectrum covered.

The obtained data were collected, systematized and analysed using MS Excel software. Descriptive statistics were used for statistical analysis of the data. Since the burnout syndrome risk factors analysed in the study are expressed as proportions (the number of respondents who marked the relevant factor), a 95% confidence interval (Confidence Interval-CI) for the population proportion was calculated for each indicator.

Considering the sample size ($n = 66$), the amplitude of the data confidence intervals (CI) is approximately $\pm 11-12\%$, which is considered acceptable in social science research and ensures sufficient reliability of the results. The results are presented using descriptive statistics and graphical visualization of data – diagrams.

Results and discussion

The results of theoretical research (Burčeņa & Skrupska, 2025; Paudere-Logina, 2023; Denning and Goh, 2021) show that burnout syndrome is characterized by symptoms such as fatigue, a feeling of exhaustion at work, demotivation, an inability to be productive, a higher sense of stress in everyday life, difficulty focusing, sleep disturbances, as well as difficulty falling asleep and bedwetting. The individual becomes more careless – makes more mistakes, is unable to organize work and plan time. Duties are postponed until later; it is more difficult to complete them on time and meet deadlines. Furthermore, the symptomatic recognition of burnout syndrome is difficult, as it also underlies several other psychosomatic illnesses. (Ābeltiņa, 2023; Riethof, u.c., 2020). However, the main difference is that burnout risks are fundamentally related to the impact of working conditions.

In turn, the empirical research data reflects the risk factors for burnout syndrome in the work of podologists, the most characteristic subjective complaints, and the number of burnout episodes in the professional activities of podologists.

The study sought to determine whether respondents understood the concept of burnout syndrome in the work context and associated its development with prolonged stress. Respondents were given three answers that correspond to the theoretical description of the concept (Geģere & Merkulova, 2018; Ābeltiņa, 2023), as well as the opportunity to express their opinion in the section – other answer (see Figure 1).

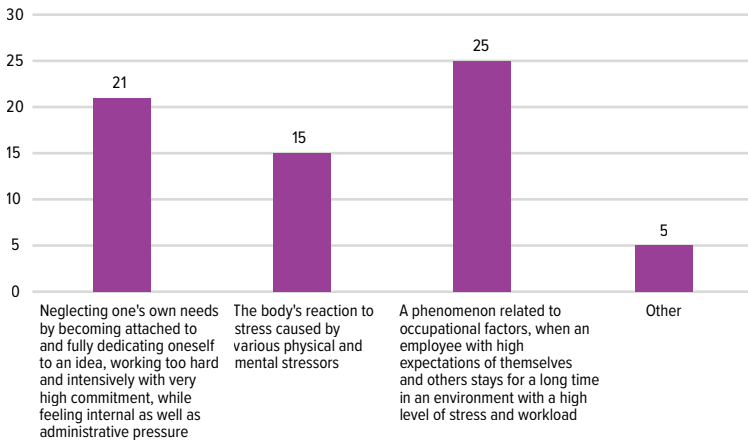


Figure 1. Understanding of the concept of “burnout syndrome” among respondents

The results show that 2/3 of respondents ($n = 46$) associate burnout syndrome with their professional activities, intense dedication, and high demands on themselves under conditions of intense workload. In turn, 15 respondents associate burnout syndrome with the body’s response to physical and mental stressors. Respondents ($n = 5$) who provided an answer to the open-ended question mentioned that they disagreed with the explanation of the concept provided in the survey ($n = 2$), as well as emphasized physical and emotional exhaustion ($n = 2$), and workload as a stress factor ($n = 1$). The answers show that respondents generally understand the concept of burnout syndrome and associate it with their professional activities, which suggests that podologists, when faced with such a situation in a real work environment, will be able to react and initiate early preventive measures to reduce the risk of burnout.

In order to determine the respondents’ perceptions of possible burnout risk factors, a question was asked, to which it was possible to provide multiple answers, as well as express one’s opinion. The total number of responses received is 169 from $n = 66$. The diagram (see Figure 2) shows that respondents noted a large amount of work as the most significant possible risk factor for the development of burnout syndrome ($n = 49$), while the second possible risk factor mentioned ($n = 28$) was excessive dedication and conscientiousness. Respondents also noted working with people ($n = 26$) and practicing idealism ($n = 25$) as significant potential risk factors. In turn, respondents ($n = 4$) who expressed their opinion in the “other” section point to a lack of balance between work and rest (essentially the same workload associated with a large amount of work). It is noteworthy that one respondent indicated routine as a possible risk factor for burnout syndrome, as the literature (Åbeltiņa, 2023) also describes this type of burnout, which is associated with an individual’s feeling of being stuck in unimportant routine tasks and untapped potential.

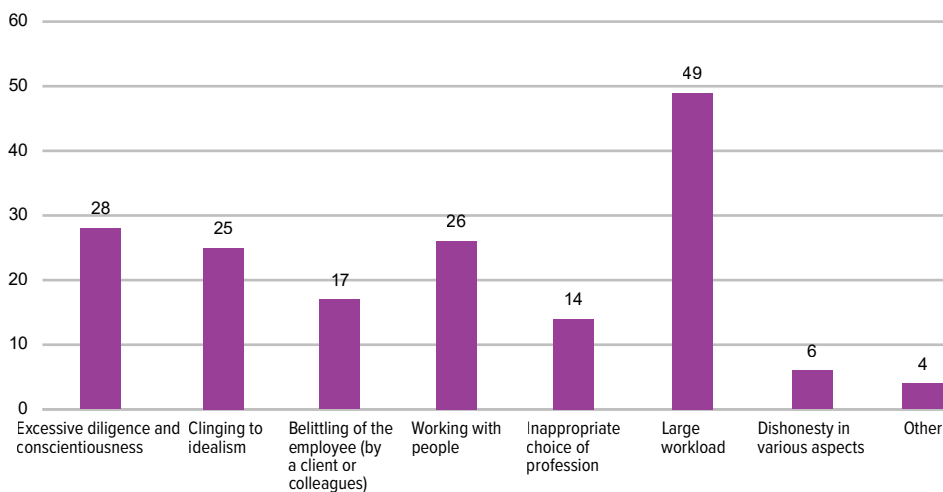


Figure 2. Possible risk factors for burnout syndrome from the respondents' perspective

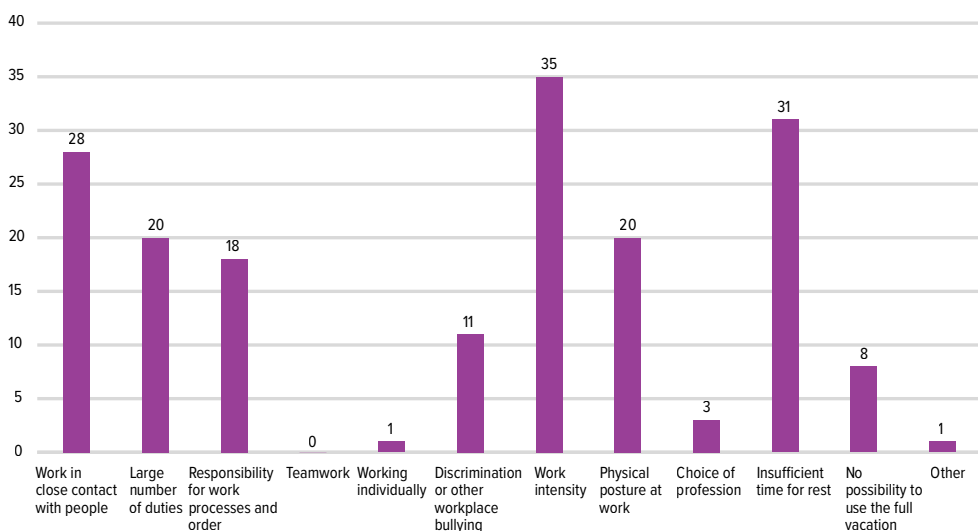


Figure 3. Risk factors for developing burnout syndrome in the work of a podologist

In order to determine which of the risk factors for the development of burnout syndrome mentioned in theoretical sources are directly attributable to the professional activities of a podologist, a question was asked, the answers to which are reflected in Figure 3. Here too, respondents were given the opportunity to mark several answers and express their opinion.

The results show that from the offered answer options, professionals see the following as the most significant risk factors for burnout syndrome in the work of a podologist: work intensity ($n = 35$), insufficient time for rest ($n = 31$), and work in

close contact with people ($n = 28$). The analysis of theoretical research (Burčena & Skrupska, 2025; Denning & Goh, 2021; Riethof, et al., 2020) on the burnout risks of medical professionals also shows similar results, where the most frequently mentioned risk factors are the length of working hours and the inability to control workload.

It is noteworthy that respondents did not note teamwork as a possible burnout risk factor, while individual work was noted by one respondent, which is probably related to the specifics of a podologist's work, as podologists most often perform their professional activities individually and work in a team only as subordinates. Thus, by organizing your work individually, it is possible to control the intensity of work and distribute the amount of work to be done, which is more difficult to do in large healthcare institutions.

The respondents' opinions on the possible risk factors for burnout syndrome (Figure 2) and the risk factors for the development of burnout syndrome directly in the work of a podologist (Figure 3) coincide. Therefore, a 95% confidence interval (Confidence Interval-CI) was calculated for the respondents' answers shown in both figures, which is reflected in the tables (see Table No. 1 and Table No. 2). It should be noted that respondents had the opportunity to choose multiple answers, therefore each risk factor was analysed as a separate binary characteristic (checked / not checked).

The calculated confidence intervals show that the most statistically convincing risk factor for burnout syndrome in the opinion of podologists is a large workload, as the lower limit of the confidence interval exceeds 60%. For the other risk factors, the confidence intervals overlap, so the significance of these risk factors cannot be statistically convincingly arranged.

Table 1. 95% Confidence Interval-CI for possible risk factors of burnout syndrome in the opinion of respondents ($n = 66$)

Risk factors	<i>n</i>	%	CI
Large amount of work	49	74.2%	63.6% – 84.8%
Excessive dedication and conscientiousness	28	42.4%	30.4% – 54.4%
Work with people	26	39.4%	27.7% – 51.1%
Idealism	25	37.9%	26.3% – 49.5%

Table 2. 95% Confidence Interval-CI 95% for risk factors for developing burnout syndrome in podologist's work ($n = 66$)

Risk factor	<i>n</i>	%	CI
Work intensity	35	53.0%	41.0% – 65.0%
Insufficient time for rest	31	47.0%	35.0% – 59.0%
Working in close contact with people	28	42.4%	30.4% – 54.4%

The calculated confidence intervals show that the most statistically significant risk factors for burnout syndrome in the professional activities of podologists are work intensity and insufficient time for rest, as their proportions exceed the 40% limit within the CI. The confidence intervals for the other risk factors partially overlap, indicating that there is no statistically significant dominant factor among them, however, workload aspects generally show a higher likelihood of burnout risks.

Health monitoring data conducted in 2020 by Benu Aptieka in collaboration with the market and public opinion research centre SKDS shows that 86% of Latvian residents have experienced prolonged fatigue, lack of motivation, as well as physical and mental exhaustion, while 79% of Latvian residents have experienced increased anxiety in the last year. In addition, the majority, or 59%, of the population have not addressed the problem and have not sought help from a specialist (Paudere-Logina, 2020). Therefore, the study investigated whether podologists have encountered any subjective feelings characteristic of burnout syndrome in their daily lives, whether they have experienced burnout episodes, and whether respondents have sought help from a specialist. It should be noted that respondents were given the opportunity to choose one or more answers. The results obtained are summarized in Tables 3–5.

Summarizing the results, it can be seen (see Table 1) that subjective feelings characteristic of burnout syndrome, such as chronic fatigue, were noted by half of the respondents (33 out of $n = 66$) and increased daily stress by 30 respondents. Among the most frequently mentioned answer options, respondents noted increased irritability in everyday life (27 out of $n = 66$) and sleep disorders (26 out of $n = 66$), as well as headaches or migraines (21 out of $n = 66$) and demotivation (20 out of $n = 66$). The results obtained indicate a high risk of burnout in the work of podologists, however, when comparing the obtained data with other research results on burnout among medical professionals (Riethof, et al., 2020; Paudere-Logina, 2023), the situation is similar, which once again proves the relevance of the study.

Table 3. Subjective feelings characteristic of burnout syndrome among respondents

Subjective feelings characteristic of burnout syndrome	Number of positive responses 197 from $n = 66$
Headaches or migraines	21
Increased irritability without objective motive	27
Digestive system problems – stomach pain, increased secretion of gastric juice (feeling of sour juice in the mouth, throat area)	17
Sleep disorders – difficulty falling asleep, poor-quality sleep, bedwetting	26
Demotivation	20
Difficulty focusing	13
Inability to perform work duties qualitatively (sloppy work)	10
Chronic fatigue	33
Increased stress in everyday life	30

Table 4. Burnout episodes experienced by respondents

Burnout episodes	Number of positive responses <i>N</i> = 66
I haven't thought about it	21
Not once	5
1 time in a lifetime	12
More than once in a lifetime	25
Another answer	3

Table 5. Seeking help from a specialist among respondents

Help from a specialist	Number of positive responses <i>N</i> = 66
I have not consulted a psychologist or medical professional with such complaints	45
Once in a lifetime	6
More than once in a lifetime	9
"Burnout syndrome" has not been confirmed	4
Another answer	2

The survey identified burnout episodes experienced by respondents, the results (Table 4) show that a third of respondents ($n = 21$) have never thought about it, but only 5 respondents have never encountered this problem. So, the rest of the $n = 66$ have had one or more burnout episodes in their professional lives. A study on the prevalence of burnout syndrome among medical professionals (Paudere-Logina, 2023) also noted that burnout syndrome was observed in 52–61% of pharmacists and 1/3 of doctors. Therefore, it is determined whether respondents have sought help from a specialist.

When asked whether the respondents had been diagnosed with burnout syndrome by a psychologist or other medical professional (see Table 5), 45 respondents indicated that they had not consulted a medical professional. Considering that in the previous question (see Table 2), more than half of the respondents noted that they had experienced burnout syndrome at least once ($n = 12$) or several times in their lives ($n = 25$), these results indicate that professionals are not turning to medical professionals, and this can be assessed as a worrying trend. It should be noted that the study did not investigate in depth the severity of the burnout syndrome (this issue could be explored in a separate study), however, scientific literature indicates the need to involve a medical professional in the recovery process, where techniques for identifying stressors are learned, as well as models for solving the situation are developed to reduce the possibility of recurring burnout syndrome in the future.

Conclusions

Based on the aim of the study – to identify the risk factors for burnout syndrome in the professional activities of podologists, the following conclusions can be drawn:

1. The concept of burnout syndrome is currently viewed in the context of the work environment, linking its development to prolonged stress in professional activities. Podologists understand this concept by also emphasizing physical and emotional exhaustion, and workload as a stress factor in the development of burnout syndrome.
2. There are several significant risk factors for burnout in the professional work of a podologist, the most significant of which are work intensity, high workload, and insufficient time for rest. These factors directly affect the physical and emotional well-being of professionals.
3. Work in close contact with patients, which requires high emotional involvement and constant concentration, has also been recognized as a significant risk factor, thus increasing the risk of emotional exhaustion.
4. Individual personality factors – excessive dedication, high self-demands and idealism – significantly increase the likelihood of developing burnout, especially under conditions of intense workload.
5. The subjective feelings indicated by the respondents (chronic fatigue, increased stress, sleep disorders, irritability) indicate that the risks of burnout among podologists are not only theoretical but are practically relevant and are already manifested in everyday professional life.
6. A large proportion of respondents have experienced one or more burnout episodes, however, most have not sought professional help, which indicates insufficient problem solving and a possible risk of burnout syndrome becoming chronic.
7. Overall, the study confirms that the podologist profession is exposed to a high risk of burnout, which is determined by both organizational (workload, working time structure) and individual (personality traits, sense of responsibility) factors.
8. The study did not determine the degree of burnout syndrome among respondents, nor did it specify whether the burnout occurred while performing the duties of a podologist or other professional activities previously, therefore the research problem should be expanded more widely in future studies. This would allow the development of targeted preventive measures to reduce the risk of burnout and promote professional well-being.

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SOCIAL REHABILITATION OR “SOCIAL” AND REHABILITATION

Iluta Bērziņa

P. Stradins Medical College of the University of Latvia Jurmala, Latvia

Introduction

“To see the world in a grain of sand” is a quote by the English thinker William Blake, which could be used to illustrate how, by tracing the development of one element of a system, one can arrive at the conceptual basis of the system itself. In other words: in the beginning there was an idea, a word. This was followed by action, and successive actions created a process we all are a party to.

In this case, the grain of sand is the profession of social rehabilitator. After studying the process of its creation and development, the author comes to the conclusions presented below, that, perhaps, can serve as a basis for discussion among those who will feel addressed. One of the aspects of the discussion is the use of concepts, which gives direction to everything that follows from a specific concept. It is not just a word or words, but a framework that gives consistency and a specific trajectory to the actions taken by those who are involved.

The choice of the topic of the work was initiated by the author's observations in education and practice, taking into account the responsibility that the public expectations and funding aspect of both entails.

Initial goal is to identify the stage of development of the social rehabilitator profession with an orientation towards its further possible development – in order to plan where we move next, it is useful to know where we stand.

During the research process, a secondary goal came to the fore – to contribute to an in-depth discussion that allows us to look at everyday issues in a broader context. One of the contexts might be the fact that in February 2017, World Health Organisation launched initiative ‘Rehabilitation 2030’, which aims to unite stakeholders in the field of rehabilitation and to include rehabilitation in the list of political priorities **under one universal understanding of rehabilitation and its role among stakeholders.**

Methods

It is important to emphasize, that the research process, taking into account its long-term goal – the development of the profession as true added value for society within everchanging system, can hereby be considered as just begun. To prepare the analytical and theoretical part of the initial study, theoretical and research literature,

internet resources and publications, as well as regulatory acts have been widely analyzed. Additional information like statistics, facts about historical development etc. from information sources (institutions, individuals) has been collected, as well as first survey of 103 social rehabilitators has been conducted.

The profession of social rehabilitator – creation and development

In January 2020, 241 social rehabilitator was employed in Latvia, but in October 2025 – 333. The number of people working in the profession is steadily increasing by an average of 17 every year (State Revenue Service, 2025). In turn, 532 people have obtained the qualification of a social rehabilitator between 2018 and 2025, or an average of 66 people per year (Ministry of Education, pers. communication., 22.12.2025).

Social work as an education began to be offered in Latvia in 1991 by a private educational institution – the Management and Social Work University *Attīstība*. In 1993, the first graduation took place, in which graduates received diplomas after completing the two-year professional higher education social work study program. Ten years later – in 2003, the professional higher education study program Social Rehabilitation was licensed for the first time, and a year later it was accredited, which gave the institution the right to issue a state-recognized document for the acquisition of a specific educational program (*Attīstība*, 2025). Currently, it can be acquired at 3 higher education institutions.

In November 2002, the Ministry of Education and Science approved the first Social Rehabilitator Professional Standard. According to it, “a social rehabilitator works in welfare system institutions that provide **health care, rehabilitation and social rehabilitation services in an institution or at the client’s place of residence.**” (Professional Standard. Social Rehabilitator., 2002). In 2015 and later in 2021, the professional standard is being revised. The professional standard approved in 2021 already differs significantly from the initial version, and it is also determined that a social rehabilitator is employed **only by a social service provider** (Social Rehabilitator. Professional Standard., 2021).

In Latvia, within the system of Soviet Union, social support was partly provided within the framework of health care, and also in the 1990s, the health and social spheres were unified – under the jurisdiction of the Ministry of Welfare. After the 8th elections, the newly elected government, determining its priorities, decided to transfer some of the functions of the Ministry of Welfare to separate institutions. In 2003 – a year after the approval of the first Professional Standard mentioned above, the Ministry of Health was re-established (Ministry of Welfare, 2025).

In the atmosphere of the 15th Saeima elections, a political party “New Unity” proposes merging the Ministry of Health and the Ministry of Welfare again as stated by Health Minister Hossam Abu Meri: “I do not see healthcare as separate

from welfare, the social sphere. They must be together. Latvian residents, thank God, live longer, but we also live with several problems, several diseases, and its social component comes together with health, it cannot be divided,” says Abu Meri (LSM, 2026).

From the above, it follows that the social rehabilitator profession has developed within various systemic frameworks – namely, it was established at a time when the health and welfare sectors were integrated, while real practice began after the redistribution of the aforementioned sectors between the ministries. And it is highly possible, that system will be changed again. Although the first professional standard for a social rehabilitator was based on a **rehabilitation approach**, the Social Services and Social Assistance Law adopted in 2003, which, among other things, established social work for the first time, defined a social rehabilitator as one of **the social work specialists**.

The discussion of whether the profession of social rehabilitator will truly grow to the status of a profession within the existing framework, and whether with the existing content it has the potential to grow to that point, is one of the goals of this article.

A profession (auth. not as a statistical category) is a systematized set of knowledge and skills that gives a person the right to receive remuneration or make a profit in the relevant sphere, but not only. In connection with a professional occupation, the term career is also used, which is not used in connection with, for example, the occupation of a bricklayer or mechanic. The concept of career is centered on a certain attitude towards work, which is professional. A career is a calling, not just a means to an end – it is the end itself. Professional activity, or the service provided with a certain impact on society, is a value in itself. A professional performs his services mainly for psychological satisfaction and only then – for monetary compensation (Greenwood, 1957).

E. Greenwood, in an article published in the Journal of Social Work (Sage), describes 5 characteristics of the profession – systematized theory, professional authority, public approval, code of ethics and professional culture.

In summary, it must be concluded that in order for the profession of social rehabilitator to qualify for the status of a profession, it would be necessary to identify what the service provided or value is, what the systematized theory on which the service is based is, as well as conceptualize those issues related to authority, ethics and professional culture.

“Over the past 20 years, some experience has been accumulated, some practice has developed, but we still need to seriously work on the identity of the profession and its professional boundaries,” admits lecturer at P. Stradins Medical College of the University of Latvia Dace Erkena (pers. communication. 02.05.2025). It should be noted that since the beginning of the 20th century, when social work professions were being formed, answers have been sought to questions of the identity of the social work profession, namely, how the professional field of social work differs

from other helping professions and what is the research field of social work (Zemīte, 2003). The search for answers is largely related to the action or inaction of the professionals themselves, thus they could be considered internal challenges, and their identification requires additional research, for example, by surveying those employed in the profession.

The concept of 'social rehabilitation'

To paraphrase the mid-20th century Austrian philosopher Ludwig Wittgenstein, the challenge is not to say more than we know. He did apply this to philosophy. However, saying much more than we know is a phenomenon of our time. Language is used to attract attention or, on the contrary, to avoid it, and it requires the same thing – to use as many words as possible.

The concept of 'social rehabilitation' is made up of two words. 'Social' is used in a wide variety of contexts, in which it carries the same basic idea, which stems from the etymology of the word. The word 'social' is derived from the Latin noun 'socius', which means 'companion, friend, ally'. So, the basic meaning of this term includes some kind of civilized relationship between two or more people, where at least two are involved: 1) the person who has a companion, and 2) the companion. In every context in which the term 'social' is used, it has this basic meaning. Depending on the context in which 'social' is used, it carries with it additional meanings, the purpose of which is to indicate more precisely the nature of these relationships (Bowdery, 1942.).

Bowdery distinguishes 3 additional meanings of the word 'social': 1) one that corresponds to the standard of "higher society", is generally recognized as the most optimal; 2) one where the use of the term 'social' involves an ethical, evaluative element (according to a certain moral or ethical system, i.e. social vs. antisocial); 3) as well as one that considers verifiable knowledge about the mutual relations of individuals (auth. social roles, social norms, socially, behavior acquired as a result of socialization, etc.).

The modern Latvian dictionary indicates that the word 'social' means 'related to human life and relations in society, characteristic of them'. Thus, the basic meaning of the word refers to the sphere of society, human relations and living conditions.

When looking at the word 'social' philosophically, one must also look at 'individual', and according to the dictionary, it is something that is characteristic only of an individual; something that belongs to one; separate.

The State Language Commission (pers. communication. 01.12.2025.) explains that in Latvian the word 'social' denotes areas in which activity is related to a person's social needs and support for social functioning. This applies to professions and services whose aim is to support a person's integration into society, etc., therefore in concepts such as 'social work', etc. the word 'social' indicates a professional field.

At the same time, the author would like to point out that the word 'social' is used much more widely. Although from a linguistic point of view, semantically the word 'social' does not mean 'state-financed', 'state-provided', 'belonging to the public sector' or 'one that the state provides at its own expense', in the use of the word it is often understood that way.

Also in social rehabilitation practice, the word 'social' can denote different understandings of the focus of practice, which could be viewed on a spectrum – with closed and absolute at one end and open and relative at the other. In the most absolute approaches, the client is considered a deviant (i.e., defective, incapable) person and therefore requires “social rehabilitation”, and his/her adaptation to standard societal norms appears as the focus of practice. In contrast, in the open and relative interpretation, the community, environment, or social structure is also in the center of attention, and changes in these areas are also considered an essential part of practice (Kataja et al., 2022).

Although the seemingly 'social' element of the concept does not contain any risk or contradiction, its use would be debatable, and it may indicate significant semantic differences in ideas and approaches.

According to the Modern Latvian Language Dictionary (from the medieval Latin 'rehabilitatio'), 'rehabilitation' refers to a process or set of measures to restore working capacity, health (after illness, injury, etc.), as well as in jurisprudence – to restore previous rights, including the previous honorable social status (*Tēzaurus*, 2025). So, the focus is on the recovery of something lost.

'Rehabilitation' entered medicine at the end of the 19th century. As an integral part of the recovery process to reduce disability after injury, it was recognized at the beginning of the 20th century, after the First World War. At that time, rehabilitation mainly focused on the physical and practical aspects of recovery.

During 1920s and 1930s of the 20th century services for people disabled by war and other injuries developed. World War II brought renewed attention to the need to actively treat the consequences of disability caused by illness and injury. Around this time, people with spinal cord injuries, burns, and head injuries were recognized as needing more than just rehabilitation. Emphasis was placed on working-age men, and while it was recognized that some people would not return to the open labor market, employment remained the primary goal. Special employment services were developed for disabled soldiers, sailors, and airmen.

A new development in rehabilitation was brought about by George Engels's biopsychosocial model of illness, published in 1977. J. Engels notes that the biomedical model “leaves no room within its framework for the social, psychological, and behavioral aspects of illness” (Wade, 2017). The WHO acknowledges the biopsychosocial model included in the International Classification of Functioning, Disability and Health as the basis for the definition of rehabilitation (Cieza, pers. communication, 2026).

In 1969, the World Health Organization defined rehabilitation as “combined and coordinated medical, social, educational and vocational interventions aimed at restoring the individual’s capabilities to the highest possible level” (WHO, 1969).

In turn, 12 years later, the WHO definition no longer distinguishes between the various aspects of rehabilitation and states that “rehabilitation includes all measures aimed at reducing the impact of disability and the conditions that cause disability and at enabling people with disabilities and those with disabilities to achieve social integration” (WHO, 1981).

Over time, and in response to global (i.e., not just one country or region) public health and demographic trends, in February 2017, WHO launched the initiative ‘Rehabilitation 2030’, which aims to unite stakeholders in the field of rehabilitation and to include rehabilitation in the list of political priorities **under one universal understanding of rehabilitation and its role among stakeholders.**

The report of the initiative’s launch meeting states that “with the increasing prevalence of non-communicable diseases and injuries and the aging of the population, there is a significant and growing unmet need for rehabilitation. [...] Given its goal of optimizing functioning, rehabilitation provides support to people with health problems so that they can maintain as much independence as possible, participate in education, be economically productive and fulfill meaningful life roles (WHO, 2017, p. 15)”.

The report explains that rehabilitation is a multidisciplinary field, involving specialists from both health care and other sectors (such as education and vocational or employment). In order to effectively scale up rehabilitation services, close cooperation between these sectors is necessary. **However, health care systems should take the lead in strengthening rehabilitation services, as rehabilitation is a health strategy that is needed for people with health problems at all levels (primary, secondary and tertiary), throughout the care process and throughout the life course** (WHO, 2017, p. 35).

Alarcos Cieza, Head of the WHO Department of Non-Communicable Diseases and Mental Health, continues the theses set out in the WHO initiative in 2019 and writes – “Rehabilitation is care that is needed when a person has or is likely to have limitations in daily functioning due to aging or a health condition, including chronic diseases or disorders, injuries or trauma. [...] Examples of limitations in functioning include difficulties in thinking, seeing, hearing, communicating, moving, forming relationships or maintaining employment. [...] Changing health and demographic trends associated with the increase in the prevalence of non-communicable diseases and the aging of the population are already contributing to a rapid increase in the number of people worldwide whose functional abilities are deteriorating.”

At the same time, she points out that **“To move things forward and ensure that rehabilitation becomes a political priority, based on a single message, rehabilitation stakeholders need to unify the different portraits of rehabilitation according to the concept of functioning.”**

Describing the current situation, A. Cieza says “there is currently no common understanding of rehabilitation and stakeholders portray it in different ways depending on the context. Rehabilitation can be portrayed as a development issue, a disability issue, a health issue, a human rights issue, a social security issue or a substance use issue, to name just a few.”

Derick Wade shares a similar view, noting that “over time, many new words and terms have been introduced as labels that essentially refer to processes and services that cannot be distinguished from rehabilitation. [...] The reasons for this explosion of terminology are primarily political.” (Wade, 2023).

In 2020, the WHO defines rehabilitation as “a set of interventions designed to reduce disability and optimize functioning for individuals with health problems in their interactions with the environment. [...] “Health status” refers to a disease (acute or chronic), disorder, injury or trauma. A health status can also include other conditions, such as pregnancy, aging, stress, congenital anomalies or genetic predisposition. The goal of rehabilitation is to maximize a person’s ability to live, work and learn” (WHO, 2020).

In summary, it can be concluded that rehabilitation has emerged as a health care strategy and has been generally recognized as an integral part of the recovery process, which, moreover, includes a wide variety of health aspects – from physical to self-realization. From the process of development and development of rehabilitation described so far, the following stages can be identified:

- 1) physical medicine with a focus on the physical aspects of the disease,
- 2) a biopsychosocial approach, along with the physical aspects of recovery, also recognizing the social and psychological, i.e. a unified approach that includes all measures aimed at achieving social integration and focusing on the functioning of the person
- 3) a (global) health care strategy that aims to maximize the ability of every person to live, work and learn, and to do what is important in their lives.

‘Social rehabilitation’ in Latvian regulatory acts and official sources, and in practice

If the explanations of the individual aspects of the concept ‘social rehabilitation’ – namely ‘social’ and ‘rehabilitation’, can be traced, then their combination – ‘social rehabilitation’, is viewed and explained very differently – depending on the source and context in which it is used.

The law ‘On social assistance’ adopted in 1995 states that “social rehabilitation, along with material assistance and social care, is a type of social assistance, and it is a complex of measures aimed at restoring and improving a person’s social functioning abilities, restoring social status, and integrating into society and includes the restoration of physical, intellectual, psychological and professional abilities” (Law on Social Assistance, 1995).

In turn, the current, i.e. the ‘Social Services and Social Assistance Law’ adopted in 2003, stipulates that a social rehabilitation service is “a set of measures aimed at restoring or improving social functioning abilities in order to ensure the restoration of social status and inclusion in society, and includes services at the person’s place of residence and social care and social rehabilitation institution or at the person’s place of residence or social care and social rehabilitation institution” (Social Services and Social Assistance Law, 2023).

Namely, the law does not create an understanding of the concept, but states that **social rehabilitation is a service that includes services**, and does not provide clarity about the content of these services, instead emphasizing the place of receipt of services.

One of the explanations of the concept of social rehabilitation is available in the Dictionary of Social Work (Ministry of Welfare, 2023). It positions the concept as general – as one that includes all forms of rehabilitation and relates to the improvement of a person’s social functioning. **The aforementioned explanation contradicts, for example, the WHO approach, which defines rehabilitation as one that encompasses all its specific aspects.**

If we return to the profession of social rehabilitation – a profession whose name is directly borrowed from the concept, a serious challenge can be identified, which arises from the fact that a social rehabilitator as a professional is not an expert in all forms of rehabilitation.

The Ministry of Welfare, in turn, explains on its website that “social rehabilitation means the restoration or improvement of a person’s social abilities in order to return a person to social and working life, restoring or training in those skills that have been lost due to various circumstances”. This explanation also includes a challenge for the profession, because it covers a very wide professional field.

At the same time, there are institutions and organizations, including those outside the social services system, that offer social rehabilitation programs, but they can be provided without the participation of a social rehabilitator. An example is the State Probation Service.

There are also social service providers who offer social rehabilitation as a service and process that includes practicing a certain lifestyle with the aim of restoring social functioning. With the same goal as set by social rehabilitation service providers registered in the Social Services Register of the Ministry of Welfare, therapeutic communities are offered, for example, for people who have suffered from addiction problems (Ministry of Welfare, 2020), who are not registered in the relevant register.

In addition, similar opportunities are offered by various creative associations and folk applied art studios, which not only do not focus on providing social services, but do not associate themselves with the social sphere in any way.

If we look at social rehabilitation as a social service in accordance with the regulation adopted in Latvia, the opportunities are those provided by social service providers registered in the Register of Social Service Providers. In turn, if we look at the essence – a significantly wider range of organizations sought to support the social functioning of individuals in accordance with their sphere of activity, including organizations that do not identify themselves with either the social sphere or the public sector.

In summary, it can be concluded that social rehabilitation in Latvia is formally designated as a ‘type of social assistance’, ‘complex of measures’ and ‘set of measures that include services’; it is recognized as a general concept that includes all forms of rehabilitation and, more narrowly, is applied to specific services related to the acquisition of skills.

Taking the above into account, in the author’s opinion, it would be valuable to discuss whether social rehabilitation as a concept in its use in Latvia has lost its connection with its origins, its affiliation with rehabilitation as a health strategy; whether, by separating it out as a separate service provided by organizations from a wide variety of spheres, social rehabilitation has not become a ‘synonym’ for inclusion; whether the use of the concept has not become so general that there is a risk of losing the professionalism in services appropriate to each sphere.

‘Social rehabilitation’ in theory

Analyzing the theoretical and research literature in English, it can be concluded that there is no single, generally accepted theoretical basis and approach to social rehabilitation, however, as a concept that denotes a certain process, approach and practice, it exists in a number of countries, but with a tendency to abandon it. One example is Estonia, where the Ministry of Social Affairs made a decision in 2024 to discontinue the social rehabilitation service, justifying that it does not meet people’s needs, partially overlaps with health care and educational support services, and thus does not provide clear added value (Voltri, 2024).

In various sources and various publications where the concept is mentioned, similar features can be found, but the number of publications in which the concept is mentioned, according to the author’s observations, is even smaller.

The absence of a theoretical basis, according to the author’s opinion, has created a tendency in Latvia, including when educating new specialists, to rely not on international trends, to search for new approaches, but on the regulatory framework created by themselves and thus to repeat historically established practice with little potential for change.

Within the framework of this work, one comprehensive study was identified – a meta-analysis, which, in the author’s opinion, provides valuable insight into the use of the concept of social rehabilitation. The study was conducted in Finland,

within the framework of the study “Social Rehabilitation in Practice” funded by the European Social Fund.

A team of authors from the University of Eastern Finland and the University of Lapland conducted a qualitative study on what is meant by the term social rehabilitation, what are the client groups, physical environment and types of services in social rehabilitation practice, and what are the essential assumptions underlying the needs, focus and goals of social rehabilitation.

The research summary was first published in 2020, and in 2022 – in the *Journal of Social Work*, which has been published in English since 2001. The *Journal of Social Work* is published by Sage Publishing, which was founded in the United States, in New York in 1965. During its first decade, the publishing house established an office in London, which is the beginning of its international presence. Sage prides itself on its independence and is known for its commitment to supporting the social sciences.

The authors of the aforementioned study concluded that policy-level discussions on the social aspect of rehabilitation have taken place since the 1960s, and the social significance has strengthened over time due to these discussions. Namely, researchers have already initially recognized and defined social rehabilitation as an aspect of rehabilitation.

They found that studies focusing on the social aspect of rehabilitation contain many references, for example, to social interaction, participation in society, fulfilling or maintaining social roles, or understanding the social demands of the environment. **However, in these studies, the potential client groups, forms, and goals of social rehabilitation include so many variations and interpretations that its practical implementation is difficult.** They point out that discussions on the very concept of social rehabilitation and its meaning have remained insufficient.

The results of the study show that within the framework of social rehabilitation, three client groups are discussed: health-related (e.g. injuries or illnesses), behavior-related (behavior that violates social norms) and life-course-related (elderly people). Regarding the physical environment of social rehabilitation, three different systems were also distinguished: social rehabilitation institutions, community-based services or programs, and other institutions (e.g. prisons). In turn, regarding the practice of social rehabilitation itself, the authors conclude that it includes a very wide range of services, such as social assessments and therapy, counseling and coaching, education, vocational training, solving communication problems, and recreational activities. Thus, the study illustrates the client groups, the physical environment of social rehabilitation provision, and its content.

Regarding the concept itself, the authors point out that “social rehabilitation should not be understood as a one-dimensional, fixed form of social care (in Latvia it is defined as a service), but as a constantly changing set consisting of several transforming components. The set approach conceptualizes social rehabilitation as a phenomenon determined by material, economic, technological, political and

cultural influences. It conceptualizes values such as ‘humanity’, ‘health’, ‘well-being’ and ‘satisfaction with life’ in relation to surrounding regularities and influences.”

‘Social rehabilitation’ or inclusion?

When analyzing how the term ‘social rehabilitation’ is used in Latvia, the question was raised above, **what is the unifying professional activity of the mentioned service or ‘the service provided with a certain impact on society’, which is a value in itself.** As concluded, the spectrum of parties involved in the provision of the service is wide – from formal to informal; from state institutions and social service providers that identify themselves with ‘social rehabilitation’, to therapeutic communities and cultural heritage practitioners who do not consider themselves providers of this service.

The clue to the answer, according to the author’s point of view, can be identified in policy planning documents. Thus, the long-term development direction of Latvia is determined by the Sustainable Development Strategy of Latvia until 2030 “Latvija2030”, while the medium-term development is determined by the National Development Plan (NDP).

The NDP for 2021–2027 provides for five priorities. The first of them – “Strong families, healthy and active people” includes four lines of action – person-centered health care; psychological and emotional well-being; strong families across generations; social inclusion. The objective of the line of action ‘social inclusion’ states: “social support is individualized, person-centered, and it is offered to everyone who needs it or might need it most”. **So, social support, or the social sphere in the sense of this work, is subordinated to the line of action ‘social inclusion’.**

It is explained that “in Latvia, there is a relatively large proportion of people who, due to incapacity for work, age or other reasons, do not earn income from paid work. Among them are persons with disabilities, people who are subject to premature loss of working capacity due to physical or mental health disorders, seniors, as well as family members of dependent persons, who are often forced to interrupt their active work careers in order to care for their loved ones if the range and availability of care services is not adequate for the needs of the dependent person. The social and economic **inclusion** of these people is largely the responsibility of the public sector.” (Latvian National Development Plan 2021–2027, 2020)

Along with other social work and other public sector professions, the social rehabilitator profession represents the public sector mentioned above in the NAP, and according to the Dictionary of Social Work, a social rehabilitator (social rehabilitator*) is a social work specialist employed in the Latvian social security system who promotes the **inclusion** of individuals into society, plans, manages and organizes the work of social activation of individuals. The Law on Social Services and Social Assistance states that a social rehabilitator plans, manages and organizes

social activation work in such a way as to promote the **inclusion** of individuals into society.

It should be noted that 'social inclusion' is not the task of just one profession, but, as stated in the NAP, the task of the public sector. In the author's view, it could be a more accurate indication of the unifying professional activity or 'services provided with a certain impact on society' or value of 'social rehabilitation' as it has been practiced in Latvia so far.

A.Cieza (pers. communication, 05.02.2026.) points out that there is a significant conceptual difference between the 'social' aspect of rehabilitation and inclusion. While rehabilitation aims to optimize the functioning of an individual in relation to their health status and immediate environment, inclusion aims to design environments and systems so that differences in functioning do not limit participation.

Rehabilitation focuses directly on the individual. Its aim is to optimize the health, abilities and autonomy of the person in the context of their health status or impairment and their immediate environment. Conceptually, rehabilitation is about:

- improving or maintaining functioning (physical, sensory, cognitive, psychological);
- reducing the impact of health conditions on daily activities;
- supporting people to achieve the highest possible level of independence by working with their body and immediate environment;
- working mainly through health and rehabilitation services.

In short: rehabilitation focuses its practice on the interaction between the person and their immediate environment, with a particular emphasis on the person's functioning.

Inclusion, on the other hand, focuses on society and systems, **rather than on changing the individual**. Its goal is to ensure that everyone can fully and equally participate in social, economic, cultural and political life. Conceptually, inclusion means:

- removing barriers (physical, social, institutional, attitudinal);
- ensuring equal opportunities, rights and participation;
- adapting the environment, policies and systems to the diversity of people;
- is based on human rights and social justice.

In short: inclusion works on the wider environment and society, not on the person and the immediate environment.

A. Cieza explains that there is a connection between rehabilitation and inclusion – namely, rehabilitation is often a tool that can support inclusion. However, it is not sufficient in itself. Inclusion does not require rehabilitation as a prerequisite – that is, a person can be included without rehabilitation, and it is necessary to distinguish between what is needed primarily – inclusion, or rehabilitation, and whether rehabilitation is chosen as a compensation mechanism for non-existent inclusion.

Without inclusion, the benefits of rehabilitation may not be translated into real life participation. Without rehabilitation, some people may still face preventable participation restrictions.

Conclusions

Tracing the trajectory of the development of the social rehabilitation profession, it must be concluded that it has been formed within various systemic frameworks – namely, the idea and need arose in a healthcare-based public administration model, while real practice has already begun in a system where social work declares its presence.

The differences between the initial conceptual and theoretical framework belonging to rehabilitation and the real practice belonging to social work most likely create a number of challenges. It would probably be valuable to analyze whether the social sphere in Latvia is based on current policy planning priorities or still functions as a redistributed component of the previous unified health/welfare system, as this affects how the professional responsibilities of those involved in the social sphere are defined.

The use of the term ‘social rehabilitation’ in Latvia is very general, and at the same time there are no identifiable comparative examples in other countries. A wide range of stakeholders outside healthcare identify themselves with ‘social rehabilitation’ as a service, which contradicts, for example, the WHO’s vision of rehabilitation. This leads to the idea that in Latvia ‘social rehabilitation’ refers to the process and services based on the need for social inclusion, which in turn means a completely different focus.

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