DOI https://doi.org/10.32782/2956-333X/2025-3-4

THE ROLE OF A SOCIAL WORK IN WORKING WITH A CLIENT WITH ALZHEIMER'S DISEASE

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Summary. The aim of the study was to examine families' awareness of Alzheimer's disease and their preparedness to provide care in the home environment, emphasizing both cognitive and emotional dimensions of caregiving readiness. The research aimed to evaluate the level of understanding regarding the nature and progression of the disease, the perception of early symptoms, and families' ability to navigate health and welfare systems in order to access appropriate professional and community-based support. Particular attention was paid to assessing attitudes towards caregiving, recognition of care burden, and coping strategies adopted by relatives providing day-to-day assistance.

The study focused not only on measuring knowledge about disease progression but also on identifying the availability, accessibility, and effectiveness of formal and informal networks of professional, psychological, and social support. The analysis incorporated factors such as socioeconomic status, previous caregiving experience, and intergenerational perspectives within households that included elderly persons with cognitive impairment. It is hypothesized that both family members and the general public possess a general awareness of Alzheimer's disease and are capable of identifying basic sources of support, yet their understanding of long-term care requirements and specialized interventions remains limited.

The findings are expected to contribute to assessing families' readiness to assume caregiving roles, revealing areas in which systematic education and social infrastructure are insufficient. Results may inform public health policies and community-based programs aimed at empowering families through training, counseling, and integrated care pathways. The study ultimately underscores the need for a coordinated approach involving medical, psychological, and social services to strengthen family competence and resilience in managing Alzheimer's disease in home-based settings.

Keywords: Alzheimer's disease; family care; awareness; caregiving; social support.

1. Introduction

Dementia is one of the most common mental disorders in old age, but it can also occur earlier in life and is not uncommon even among people in their forties. Alzheimer's disease is a progressive degenerative disorder of the brain, manifested by a gradual loss of memory and reasoning to such an extent that it affects an individual's everyday life.

"Nowadays, the number of mental disorders among people is increasing. To a large extent, this is manifested mainly through dementia. Dementia is a general term used to describe the loss of memory and cognitive abilities. In recent years, the dementia syndrome has become a health and social phenomenon in industrially developed countries, primarily affecting seniors, while seriously impacting their family members, caregivers, and society as a whole" (Ferťalová, 2012, p. 29).

Alois Alzheimer was a significant physician who contributed to describing the disease that was eventually named after him. He was a German psychiatrist and neuropathologist. His colleague, Emil Kraepelin, was the first to describe the symptoms of the disease now known as Alzheimer's disease. In 1901, Alzheimer observed the condition in a female patient and, following her death, published the autopsy findings of her brain in 1906 (Izakovičová, 2025).

"The incidence of Alzheimer's disease shows a growing trend, the main cause of which is population aging. This disease is associated with psychological, social, and physical impairments in patients and at the same time represents a serious economic problem" (Majerníková et al., 2012).

Early diagnosis of this disease is sometimes difficult, as it mostly affects the elderly, and its symptoms are often perceived as normal signs of aging. Modern medicine continues to make progress in seeking solutions for people affected by diseases for which no cure, vaccine, or effective treatment has yet been found. Although no cure for Alzheimer's disease currently exists, many medications can slow its progression, alleviate its consequences, and contribute to improving the quality of life of affected individuals.

Certain preventive measures may also delay the onset of the disease by several years. Maintaining psychological well-being in later life, memory training, solving crosswords, and reading all have a beneficial effect. Emphasis is also placed on proper nutrition, complemented by foods rich in micronutrients and vitamin E. If there is suspicion that a person shows symptoms of Alzheimer's disease, it is necessary to consult a specialist–neurologist, psychiatrist, or geriatrician (Casnovská, 2025).

"Although no cure has yet been discovered, certain studies within ongoing research provide hope for people affected by this disease. There are measures that can help prevent cognitive decline, which for many years was considered by experts to be inevitable and irreversible. Therapeutic programs have been developed to halt mental deterioration and to restore the ability to remember, think, and live a healthy life again. By following these guidelines, individuals can reverse cognitive decline that burdens their lives. For the first time in history, hope goes hand in hand with Alzheimer's. The reason lies in a groundbreaking discovery–Alzheimer's disease does not arise because the brain does something it should not, as in the case of cancer, which results from uncontrolled cell proliferation, or heart disease, which stems from clogged arteries. Rather, Alzheimer's develops as a result of an internal, naturally occurring reduction program targeting the brain's extensive synaptic network" (Bredesen, 2018, p. 114).

People diagnosed with Alzheimer's disease or another form of dementia are affected not only psychologically and mentally but also physically. Depending on the stage of the disease, these impairments vary and may manifest differently in each individual. Physical limitations gradually lead to complete immobility, leaving individuals dependent on others for care, either at home or in social care facilities. The progression of Alzheimer's disease may last from 8 to 20 years, depending on social conditions as well as the individual's overall health status (Callone et al., 2008).

The symptoms of this disease include:

- Short-term memory loss – declining ability to manage daily activities, forgetting family members, failing to recognize neighbors.
- Difficulties performing routine tasks – inability to cook meals as before, repetitive cooking, or problems using the telephone.
- Speech difficulties – forgetting words, replacing them with others, resulting in incomprehensible speech.
- Disorientation in time and space – inability to find the way home, confusion about the day or year.
- Misplacing objects – placing keys in the refrigerator.
- Mood and behavioral changes – frequent mood swings.
- Personality changes – suspicion, fear.
- Loss of initiative – lack of interest in activities, passivity (Casnovská, 2025).

Dementia – Alzheimer's disease – can in its early stages be characterized primarily as progressive dementia accompanied by memory loss, cognitive decline, and speech disorders.

This dementia is generally divided into three stages:

Early stage – lasting 3–5 years. The first brain area affected by neuronal death is memory. If social skills, logical reasoning, and judgment remain intact, individuals may compensate for memory loss by developing substitute strategies. Most people can still perform several daily activities, but require assistance in organizing them. This stage is marked by disorientation even in familiar environments, feelings of depression, sadness and anxiety, communication difficulties, and forgetting names, people, or appointments.

Moderate stage – lasting 2–10 years. Neuronal death spreads throughout the brain. Individuals struggle with dressing, orientation, and recalling the use of common household objects. They may experience evening restlessness, confusion, anger, distrust, difficulties in expressing themselves, and problems understanding others.

Advanced stage – lasting 1–3 years. At this point, individuals are dependent on others for daily activities, sleep more often, communicate less, and may not respond to caregivers at all. Some experience delusions, hallucinations, emotional lability, aggression, incontinence of stool and urine, ataxia (gait disorder, loss of coordination), and apraxia (inability to perform complex tasks such as dressing or unlocking doors). Apraxia represents a loss of learned abilities (Bartko et al., 2008).

The duration of these stages varies among individuals. Some experience rapid disease progression, while in others stages last longer. Factors influencing progression include treatment, participation in therapy, the level of family support, and the quality of care received. Alzheimer's disease manifests differently across individuals, including variations in onset. Less common is early-onset Alzheimer's disease (before the age of 65), typically characterized by rapid onset and progression. More common is late-onset Alzheimer's disease (after 65 years), which progresses more slowly and is often mistaken for normal age-related forgetfulness (Majerníková et al., 2012).

Individuals with Alzheimer's dementia face multiple difficulties that progressively limit them physically and psychologically. In the early stages, impairments appear gradually, but later they become completely dependent on others. "Not all individuals exhibit identical symptoms or progress through the disease at the same rate. The system developed by Barry Reisberg, M.D., clinical director of the Dementia Research Center in New York, identifies seven stages of Alzheimer's disease: 1. No impairment. 2. Very mild decline. 3. Mild decline. 4. Moderate decline. 5. Moderately severe decline. 6. Severe decline. 7. Very severe decline" (Memory Center, 2025).

These stages describe the problems associated with the disease and the challenges faced by affected individuals and their relatives.

Stage 1. The person shows no memory problems, and medical examination does not reveal any symptoms of dementia.

Stage 2. The person experiences minor memory lapses, such as forgetting familiar words or the location of everyday objects. However, no clear signs of dementia are detected during medical examination.

Stage 3. Relatives and others begin to notice difficulties, and clinical evaluation identifies problems with memory and concentration. The person struggles to find the right word or name, to remember the names of new acquaintances, often misplaces belongings, and has difficulties with planning and organizing tasks.

Stage 4. Medical examination reveals clear signs of the disease. The person forgets recent events, has difficulty with numerical tasks, loses track of personal experiences, and often becomes moody and withdrawn.

Stage 5. Memory and cognitive deficits become obvious, and assistance with daily activities is required. The individual cannot recall personal details such as address or phone number, becomes disoriented in space, cannot choose appropriate clothing, and while still remembering important details from the distant past, increasingly depends on help with eating and toileting.

Stage 6. Significant memory deterioration and personality changes occur, with the individual requiring help in daily functioning. The person forgets recent events and surroundings, remembers their own name but struggles with personal history, recognizes faces but not names, has difficulty dressing appropriately, experiences disrupted sleep cycles, needs help with toileting, and may lose bladder and bowel control. Personality changes are evident, and wandering or getting lost may occur.

Stage 7. In this final stage, the person loses the ability to respond to the environment, communicate, or move independently. Repetitive speech or phrases may occur. The individual requires daily assistance with eating and toileting. Reflexes become abnormal, muscles stiffen, and swallowing is impaired (Memory Center, 2025).

2. Clinical social work with a client with Alzheimer's disease

As the number of older people continues to rise, including those with Alzheimer's disease who are placed in institutional healthcare facilities and depend on the assistance of others, it is necessary – and indeed essential – to establish the position of the clinical social worker, who is able to adequately address the issues of patient care. Many authors highlight the societal demand of our time, which lies precisely in the development of clinical social work. This specialized form of social work focuses on mental health and is carried out by social workers who must acquire specific professional knowledge, complete specialized training, and undergo supervised practice. The primary aim of clinical social work is to assess, and above all positively influence, the overall functioning of affected individuals, their families, and their environment (Ptáček, Pemová, 2012).

In everyday life, multiple factors affect an individual's health and psychological well-being. To ensure harmony and provide comprehensive assistance when problems arise, it is crucial to approach problem-solving holistically. In clinical social work, social care overlaps with healthcare, thus becoming an integral part of nursing and therapeutic processes. For care to be comprehensive, it must also include support in addressing patients' social issues. In healthcare facilities, the role of the clinical social worker is indispensable, as they assist patients in adapting to a new environment and ensure both social and healthcare support, taking into account the individual's health status and age – especially in situations where the patient cannot manage independently, or where the family is unable or unwilling to provide sufficient support.

Clinical social work emphasizes an individual approach to each patient; since every client is unique, care must be tailored to their specific problems. Human beings must be perceived holistically, with attention given to the entire bio-psycho-social entity. In practice, the clinical social worker is guided by a holistic model, meaning that care is directed not only at the client but also at their family, helping to address their problems, meet their needs, and strengthen mutual relationships (Mojtová et al., 2013).

"A clinical social worker must be aware of their own competencies and, through self-reflection and awareness of their abilities, is able not only to plan more effectively but also to carry out work with others. In this way, helping professions are responsible for activities aimed at meeting both their own needs as well as those of clients and patients" (Kutnohorská et al., 2011, p. 34).

3. Communication with a client with Alzheimer's disease

Every sick person is much more sensitive and receptive to the external environment. He often has trouble coping with his diagnosis, his feelings, his pain, or how he should continue to function. It is important that he is then provided with information that will help him process these sensations. It is difficult to cooperate with a client who often rejects all this himself, therefore, for these reasons, it is very necessary for the staff of the facilities to have professional education, but also empathy, patience, the ability to work with people, especially the elderly, to be able to empathize with their thinking and way of acting, to listen not only with their ears, but also with their heart, but on the other hand, the ability to detach from work problems and not transfer them to personal life. It is extremely difficult and not everyone is able to work in such an environment and with mentally disabled clients. It is very important for a social worker to master communication with disabled clients, especially with clients affected by mental illness – dementia, Alzheimer's disease.

The client often has a damaged part of the brain, is at different stages of the disease, and therefore reacts differently to our stimuli and conversations. The client is not able to change the way he communicates, but the social worker is responsible for how he conducts this communication. It is up to him to provide the client with understanding and satisfaction. The social worker, but also other professional staff, should be especially empathetic – because empathy heals. The client feels that if he is accepted as he is, it has a better impact on his life and behavior.

Communication with the client can be verbal and non-verbal. People with Alzheimer's disease have difficulty communicating by remembering what was said, they often deviate from the topic of the conversation, repeatedly ask the same questions, they keep going back to the past because their short-term memory is not working for them, they have trouble remembering names, people, they get lost in space and time. The social worker then becomes the moderator of the conversation and tries to lead the conversation and the entire communication in the right direction so that the client feels good about it and is not distracted or embarrassed. He uses his knowledge of how to communicate properly with the client – he addresses them by name, sits at the level of the client he is talking to, speaks slowly, clearly, makes sure that the client understood him, if the client gets lost, reminds him of what he just said. The client needs to be allowed to process what was said. However, if the client moves from topic to topic, it is necessary to follow it even if it does not make sense. Nonverbal communication is also important in communicating with a client with Alzheimer's disease. It remains functional even when verbal communication fails and there are problems with it. The worker or relative must pay attention to gestures, facial expressions and what the client is showing in order to better understand what the client wants to say. It is the responsibility of the social worker, or anyone who is talking to a disabled client, to stop, look and listen, to try to find meaning in every communication, especially if the client is upset or frightened. It is important to know the real meaning of the words or actions that the affected person expresses and only then to react correctly. For example, behind the sentence "I want to go home" or "I want my mother" is a desire for love and security. It is then that it is important to know how to react correctly and provide that security and feeling of love to the client. Incorrect answers or statements that "mother died" or "where do you want to go, you are at home here" will only make the client uneasy, and aggression may even manifest when he wants to assert his own. It is necessary to pay attention to the client's feelings and gradually divert his attention by providing him with some other interesting activity – offering him tea, playing a game he likes. In communication with the client, we also use books with pictures or large letters, photos that remind him of times he likes to return to, or various memory aids (Janečková, 2005).

It is very important that a clinical social worker has the skills necessary to be able to establish contact and recognize the needs of the client, to create a correct relationship with him, based on trust, security and safety, and at the same time to be able to work with the client's family (Sedgewick, 2014). A social worker must adhere to ethical principles and respect basic human rights in his work.

4. Social services

Social services and their provision are regulated by Act 448/2008 Coll. – the Act on Social Services and on Amendments to Act No. 455/1991 Coll. on Trade Licensing. This Act regulates legal relations in the provision of social services, the Act also regulates the care of people who are dependent on these services. All these social services can be used by those who are dependent on them, whose quality of life, whether physical or mental health, has changed, and it is through social services that life situations can be facilitated and improved.

Social services are provided to clients for a certain period of time, or, if necessary, for an indefinite period of time. The type, form and scope of social services are determined by the unfavorable social situation or the degree of dependency of the client on the help of a third party (Act No. 448/2008 Coll. on social services).

Social service providers may be public and non-public providers.

Public providers: Local government (municipality, city), Legal entity established or founded by a municipality.

Non-public providers: Catholic Charity. Slovak Red Cross. Evangelical Diaconia. Private persons (Act No. 448/2008 Coll. on social services).

"A non-public provider of a service to support the reconciliation of family and work life is any other person (natural person or legal entity) who is a subject of private law and who, based on a free decision, expresses an interest in providing this service and, upon registration in the register of social service providers, is authorized to provide this service (Ministry of Labor, Social Affairs and Family of the Slovak Republic)." Another person – means a legal entity or natural person – a civic association, a non-profit organization, a registered church, an entrepreneur registered in the Commercial Register, a natural person conducting business under the Trade Licensing Act, a limited liability company, a joint-stock company. A non-public provider of a social service can also be a family member – a wife, husband, children, parents (Act No. 448/2008 Coll. on social services, 2025). An important part of the work of providers is their financing. For public providers, the majority of costs are covered by the budget of the municipality or city, which is why prices for public providers are lower than for non-public ones. Prices for services provided by public providers are determined by the VZN – General Binding Regulation.

5. Social services in the home environment and types of services

Every person feels best in their natural home environment. Familiar surroundings, family, and loved ones contribute to a person using their potential to overcome the obstacles that their illness brings. They better tolerate discomfort and limitations that their disability causes. Social services provided in the home environment also contribute to ensuring that the disabled client can stay in their home environment for as long as possible. The client's relatives can use them to relieve their share of caring for the disabled family member. Care often requires professional intervention that family members are unable to do themselves.

In such a case, it is desirable for the family to use the possibilities of social services and thus overcome the problems and obstacles that limit their family life. If a person is interested in the provision of a social service provided within the scope of their competence by the municipality and a higher territorial unit, they shall submit a written request to these providers to ensure the provision of social services. This application must have its own requirements, which are the name and surname of the applicant, the name of the social service provider, the type of social service, the expected start of the service provision, a valid decision on dependency on social services, if issued.

Social services may be combined as necessary – for example, home care services, transport services, relief services, provision of aids and the like (Act No. 448/2008 Coll. on social services)." For the care of a person in their home environment, a field form of social service is used. It is very good for the client that they do not have to go to services outside the home, but the caregiver comes to the client's home and provides them with the necessary help and support there.

Care service is included in §41 of Act No. 448/2008 Coll. "Care service is provided to a person who:

– is dependent on the help of another natural person and their degree of dependency is at least II.

– is dependent on help with self-service, household care and basic social activities.

Care service cannot be provided to a person:

– who is provided with year-round residential social service.

– who is cared for by a person who is provided with a cash allowance for care under a special regulation.

– who is provided with a cash allowance for personal assistance.

– who is ordered to quarantine (Act No. 448/2008 Coll. on social services). " Care service is performed on the basis of a care contract. The scope of actions based on social assessment activity is determined by the municipality in hours – it must not be lower than the minimum scope corresponding to the degree of dependency of the person. This social assessment activity is performed by a social worker of the municipality or a higher territorial unit. The result of social assessment activity is a social assessment, which contains a list of actions and activities for which the person is dependent on the help of another person.

Based on the health and social assessment, a report on dependency on social services is prepared. A citizen who applies for care services in the home is obliged to pay a social service fee to the social service provider. For the purpose of paying the social service fee, the income of the assessed person, as well as that of the spouse, is assessed and counted together. The law also includes the obligation of the municipality to provide financial support for citizens dependent on care services (Act No. 448/2008 Coll. on social services)."

The most common providers of home nursing care include ADOS – the Home Nursing Care Agency, which provides comprehensive home nursing care to patients of all ages in the comfort of their own home. The service is provided by nurses and is intended primarily for immobile and severely mobile patients after discharge from hospital, after injuries, operations, strokes, chronically ill and oncological patients. The service is free of charge for patients and is fully covered by public health insurance.

ADOS and its nurses help patients and their families with professional care for the patient, perform health-promoting activities and contribute to the prevention of deterioration of health. They are a solution for patients who cannot independently go to medical facilities for treatment or rehabilitation. In the case of serious health conditions, they help to live out their last moments with dignity in the circle of family and the comfort of home. It primarily provides medical care. The service must be recommended by the attending physician and requested by the patient. In addition to visits and care, ADOS o the client in the home environment also provides the loan of medical supplies – such as a positionable bed, portable toilet, rollator and various aids that will help the client overcome his health limitations.

Another form of care includes a care service – the caretaker provides clients with social tasks – assistance with self-service activities, necessary household chores, contact with the social environment, and accompaniment to the doctor. This service is provided based on a decision on dependency on social services issued by the municipality. The transport service provides clients with the possibility of transportation to medical facilities.

Respite service provides the possibility of care in the event that the person providing care to the disabled client cannot take care of the client for a short time for various reasons – due to illness, hospitalization, spa treatment. In such a case, they can request this service so that the disabled client is taken care of and provided with care during their absence.

The care service is provided in the client's home environment and has its advantages, but although it doesn't seem like it – and its disadvantages. Advantages of care services:

– The client can stay in their home environment, surrounded by their family, a familiar environment – an old person is like an old tree – if they get too carried away – they die.

– The client's socialization is ensured so that the quality of their life is maintained to the highest possible extent – all available activities and techniques are used.

– Contact with the social environment is not interrupted.

Provision of respite care – if a caregiver who is with the person being cared for for a long time needs to rest, is hospitalized – this respite service is provided to them, which will give them the assurance that the person being cared for is well taken care of. This service is provided for whole days – a maximum of 30 days a year.

Disadvantages of caregiving services:

– The caregiver enters not only the family environment of the person being cared for, but also into the life of his family, his loved ones and often becomes part of their lives, often has a dilemma as to how far he can enter their personal lives.

– He often witnesses the resolution of family problems, disagreements; dilemma – to what extent he should replace the social counselor.

– Long-term time spent alone with the client: he must solve all the problems – to what extent he should be able to replace a doctor, psychologist, psychiatrist; burnout – caregiver burnout syndrome, supervision of caregivers is important.

– Unsatisfactory housing conditions of the person being cared for – barrier-free apartment, missing medical devices, neglected client; dilemma – how should the caregiver enter into solving this situation, which requires a period of time, although the client needs help immediately.

– Time stress of the caregiver – if he has more clients, he often cannot devote enough time to the person being cared for.

– Manipulation of the client's financial cash and material property – distrust of people; dilemma – how to carry out these activities so that the caregiver does not affect the client's autonomy and dignity.

– Manipulation of the client so that the caregiver performs activities beyond the scope of the contract (Bušová, 2025).

6. Empirical part

The main goal of the research was to determine whether the family, which includes a person diagnosed with Alzheimer's disease, has sufficient knowledge about this disease and skills to provide care in the home environment.

The goal of the research was also to determine how informed people are about Alzheimer's disease, whether people know who and how can help them and provide advice if necessary, but also to determine what form of care families with a disabled person prefer.

Based on the set goals, we present preliminary hypotheses:

Hypothesis No. 1: We assume that people in today's society have sufficient information, knowledge and skills about Alzheimer's disease even before its diagnosis.

Research questions:

1. When were you diagnosed with Alzheimer's disease?
2. Did you already have any information about this disease before the diagnosis of a loved one?
3. What feelings and emotions accompanied your life when you learned about it?

Hypothesis No. 2: We assume that family members have sufficient information on how to provide help and care to their loved ones who are affected by Alzheimer's disease.

Research questions:

4. Did you know who you could turn to if necessary?
5. Did the doctor provide you with professional advice on how the disease would progress?

6. Did you have knowledge about possible help within the framework of social services and social assistance?

The research group consisted of 12 participants – a person affected by Alzheimer's disease and a person who cares for them, as well as 2 caregivers who provide care to people with Alzheimer's disease. We created an audio recording of the interview. The participants agreed to the focus group method. We used fictitious first names of the participants.

By evaluating the interview, we generated preliminary hypotheses through analytical induction.

Preliminary hypothesis No. 1: We assume that people in today's society have sufficient information, knowledge and skills about Alzheimer's disease even before it is diagnosed.

To question no. 1 – when did they encounter the diagnosis of Alzheimer's disease, they answered: Peter knew about this diagnosis from various magazines and television discussions, but he did not expect to know its consequences in his own life. Two years ago, when his wife was diagnosed with this disease, he encountered it for the first time in his family. Zuzana said that although she had heard about this diagnosis, she did not pay attention to it, she thought that it did not concern her, because no one around her suffered from this disease. Her mother told her about it for the first time when a specialist doctor in a psychiatric clinic informed her about it. Dagmar reacted similarly, she also had information about this diagnosis from the media, but she did not think that this disease would ever affect someone close to her. It has now been 15 years since her mother was diagnosed with this disease and since then she has had enough information to use in caring for her mother. On the other hand, Karin, whose father suffers from this disease, has already encountered this diagnosis in the past. Her grandfather was also affected by Alzheimer's disease and she already knew at a young age what consequences this disease causes. When her father was diagnosed with this disease two years ago, she was theoretically prepared for what awaits them in the future, although she knows that the manifestation of the disease may not be the same. Milan has had information about this disease for a long time, as he works in the social sphere. He currently works in administration, but in the past he worked as an occupational therapist in a specialized facility for clients affected by various forms of dementia. As a graduate of the social work department, he encountered this diagnosis already at school as part of his studies. Paulína also encountered this diagnosis personally only when her father was diagnosed with this disease. It was a while ago, she took care of him at home for six years, but six months ago she placed him in a specialized facility in Stropkov because she herself has health problems. Jana, who has been working in Austria as a caregiver for ten years, also joined the conversation. During this period, she took care of clients who were affected by some form of dementia, mostly Alzheimer's or Parkinson's disease. She first encountered this diagnosis in practice in her own practice. While working abroad, she also completed a dementia course, which significantly helps her in her work and care for clients.

To question no. 2 – whether clients had any information about Alzheimer's disease at the time of diagnosis, they mostly answered by shaking their heads that they did not. Peter knew the disease by hearsay, but he did not pay attention to it, he was not interested. Zuzana smiled slightly, saying that she was full of worries about her children and did not think that she would ever take care of a person affected by this disease. Dagmar, who only knew about the disease by hearsay, reacted similarly. Karin knew about this diagnosis earlier, as she was present when she took care of her grandfather and thus already had practical experience. Milan had sufficient information about this disease, not only theoretical, but also practical. He knew what awaited him in the future, although the course of the disease in his father may be different. Paulína replied that at the time her father fell ill, she had not thought at all about the possibility that someone close to her might be affected by Alzheimer's disease. Based on these findings, we can reformulate the preliminary hypothesis into the final hypothesis no. 1.

Final hypothesis no. 1: We assume that people in today's society mostly do not have sufficient information, knowledge and skills about Alzheimer's disease before it is diagnosed.

Preliminary hypothesis no. 2: We assume that family members have sufficient information on how to provide help and care to their loved ones who are affected by Alzheimer's disease. Our participants expressed their attitude to the information in their responses that before the diagnosis of the disease they mostly did not have information and did not know how to care for a person with Alzheimer's disease, 2 knew the possibility of whom to turn to from the past, 4 did not know at first. All 6 answered positively that after the diagnosis they found help and support from doctors, whether specialists – psychiatrists, neurologists, but also general practitioners who were helpful and gave them all the necessary information about the disease, about what awaits them in the coming months and years, how the health and psychological state of their loved ones will change, what possible situations they may encounter. 4 respondents were not aware of the possibility of using social services and social assistance, but they responded positively to the help of state authorities ÚPSVaR, Charity and ADOS, who gave them a helping hand and informed them about the options they could use. Only 2 had knowledge of these options right at the beginning of the disease. However, as the disease progressed, all those present expressed that they had acquired all the necessary information they needed for care. 6 participants did not have practical experience and skills on how to care for their loved ones, but similarly to theoretical information, this practical experience came gradually with the progression of the disease. By evaluating the answers, we came to the conclusion that although the participants did not have enough information on how to provide help and care at the beginning, everything was explained to them after diagnosis and they currently have enough of this information. Based on these answers of the participants of the qualitative research, we can establish the final hypothesis No. 2. Similar conclusions are drawn in palliative care research, where education has been identified as the key tool for empowering caregivers and ensuring the quality of multidisciplinary care (Šimek, 2024).

Final hypothesis No. 2: We assume that family members have sufficient information on how to provide help and care to their loved ones who are affected by Alzheimer's disease.

By evaluating the research, analyzing the results and determining the fulfillment of the objectives, we propose the following recommendations for practice in connection with the issue of Alzheimer's disease:

– increase public awareness of Alzheimer's disease, through professional articles in magazines, telling real stories of clients, on the Internet,

– arouse interest in people to show greater interest in their mental health, increase preventive activities and activities,

– create space for the activities of support groups for clients affected by Alzheimer's disease and thus increase their quality of life,

– organize courses for family members to better master the skills necessary for home care for a disabled client, As Šimek (2024) emphasises, without structured and systematic education it is impossible to secure effective multidisciplinary coordination and high-quality care, whether in palliative or long-term Alzheimer’s care.

– increase support for families who take care of a client affected by Alzheimer's disease in home care.

Alzheimer's disease affects an increasing proportion of the human population, so it is necessary to pay more attention to prevention and spreading awareness in the future so that people have basic information about this disease even before the disease is diagnosed. It is a form of dementia that brings many limitations to the lives of those affected and their families, so greater awareness is needed about where and who to turn to if necessary. It is also necessary to have information about where to acquire the skills needed for home care.

7. Conclusion

Modern man lives in a hectic time, full of new challenges. This fast-paced lifestyle affects each of us and is manifested not only in a decrease in physical fitness, but especially in the psychological area. A person lives in uncertainty, in fear of the future, is afraid of losing his job, is accompanied by problems in the family, and often also a lack of understanding of his surroundings. This hustle and stress affects the overall health of a person. In an effort to provide for their families economically, people devote a lot of time to work and often ignore the symptoms of diseases, do not pay attention to changes in the body. This is how Alzheimer's disease often creeps into life, slowly and secretly. It does not choose its victims, but affects people regardless of gender or education. Since it is often a part of life, we wanted to point out in our work and find out what it brings to people's lives, whether they are at least theoretically prepared for it, what knowledge they have.

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