

# CONFLICT MANAGEMENT AND ITS DIAGNOSTICS IN SOCIAL STRUCTURE RELATIONSHIP NETWORKS

## INTRODUCTION

Society's historical security depends on its management of a mix of the economy's most important risk factors. These risk factors include the following sectors: health, banking, enterprises, insurance system, pension funds, social networks, media, space management and regulative sectors. In the culture of the functional imperative which is focused on maximising the profit of enterprises, class and social structure can constitute either a firewall or open the doors to the performance of cultural obligations in the society. If social structures are poorly integrated, the maintaining of their stability and the stability of social order is put in danger. According to the World Health Organization, average life expectancy in the period between the years 1999 and 2000 was 61.4 years, while forecasts for the years 2020-2025 expect its increase to 71.6 years. It is anticipated that the entire population of developed countries will increase by 94% whilst the population of people that are 60 years or older will increase by 240%. This of course, definitely means that there will be a significant shift in age proportions toward the growth of the elderly population (Walden-Gałaszko de 2008: 3) and it constitutes a crucial argument in the societal discussion concerning health, disease, and long-term health care standards. Problems related to health-treatment, long waiting times for an appointment with the doctor, difficulties concerning accessing distant specialised health centres (clinics), existing information deficit on where and how to look for all kinds of support, paralysing stress, periodical lack of life-saving drugs, *non-caring* inhumane regulations, the loss of income in the family – all of the above-listed are just some of the problems faced by families taking care of family member who are suffering from cancer. Society's major task as far as the development of palliative care is concerned is not only the permanent acquisition of families to perform care for the cancer-stricken patients but also investing in perfecting the caregivers' skills that are vital especially in consequences arising after oncological treatment, such skills include those needed in combating pain, and skills necessary for palliative care. The main point of society's departure from the

reductionist biomedical model towards the epidemiological model results in a significant reduction in mortality due to chronic diseases (such as cardiovascular disease, stroke, diabetes and cancer). Nowadays this has led to an increase in the population of people living day by day with chronic disease, and consequently has led to an increase in demand for long-term care and long-term community support. One of the major challenges faced by medical science was the development of new evaluation parameters used for assessing the efficiency of medical care. Parameters include more than objective indicators of care (such as percentage decrease in mortality). Another challenge involves moving towards inclusion of the patient's perspective on the care provided (patient-centered outcomes) (Tobiasz-Adamczyk 2002: 41). When economic transition accelerates, the rebuilding of social organisation and social consciousness does not keep pace with the speed of the changes. In such conditions *people that are left to themselves, no longer know what is possible and what is impossible, what is fair and what is unfair; what hopes and revindications they are entitled to, and those in which they are going too far* (Szacki 2006: 392). In this situation, necessary measures on behalf of the state must be taken to foster a family capable of taking care of the ill. It is very important to protect *the healthy family* which incidentally happens to be in a situation of crisis due to a family member's grave illness. There is a strong need to support the family in the implementation of tasks related to their caring function and tasks related to meeting the basic needs of the ill family member. Family must be perceived from a broader perspective. We must examine it, as at a *healthy family* which incidentally, due to family member's sickness, happens to be in a crisis situation. With the introduction of a *social support strategy for the family as a unit of care*, a possible reduction in the number of hospitalisations may take place and there also may be an increase in the independence and autonomy of the families. There will be an increase in a family's ability to resolve everyday problems, to rebuild the necessary social support networks, and to improve the quality of care for sick members of the family.

### **FAMILY SOCIAL SUPPORT STRATEGY FOR PROVIDING ASSISTANCE TO A PERSON WITH AN ONCOLOGY RELATED DISEASE**

The family (social) support strategy for providing assistance to a person with an oncology related disease consists of dialogue and directness and also the mobilisation of a social network to reduce deficits in the family with respect to the *unit of care*. It does so through a sequence of rational actions in cooperation with a multidisciplinary team of palliative caregivers. The sup-

port is targeted to meet the informational, medical, psychological, social and/or spiritual needs of a family based on a diagnosis of the social status of the family and a number of integrated activities by public institutions, such as the law, knowledge and financial means.

The family support strategy for providing assistance to a person with an oncology related disease aims at:

1. ensuring permanent monitoring, control and evaluation of provided support depending on the needs of the family during the progression of the illness;
2. inclusion of multi-disciplinary (multi-professional) palliative care teams and inclusion of social workers (established by a decision of the governor on the basis of the law of medical rescue, maintained by resources from the state budget and aided by counties. Multi-disciplinary palliative care teams enable the creation of a registry of recorded patients, documenting the kind of support being provided, (e.g. nurse visits, receipt of documentation concerning the need for support and assistance, coordination of assistance actions with other social services, creation of a national registry of volunteers who offer individual support based on their similar past experiences and information sharing);
3. raising awareness about home care for a patient with oncology-related disease through the establishment of a number of professional courses, and educational training for caregivers and also volunteers in counties, and providing online assistance for coping with chronic stress. This will reduce the cost of home care, decrease anxiety, and will positively affect the development of home hospices;
4. developing local social networks, cooperating with nongovernmental organizations, volunteers, and social workers. This will enable the creation of stable and lasting social contacts (interactions) for the ill family members and their families who may feel isolated and lonely.

The inclusion of a social worker into the family support strategy for providing assistance to a person with an oncology related disease comes from the need to involve the family itself in seeking alternative measures in this situation of severe distress, a situation that can be evaluated as too burdensome or too difficult to manage.

It is crucial to design, in the patient's presence, a *care plan* for family members. It must be a plan that will acknowledge and respect the patient's autonomy and freewill throughout the cancer treatment.

It is important to coordinate actions by informing and pointing out where one can seek support and how to plan future actions. In a situation where the family does not want to, or cannot take care of the patient any longer, activities that block families as *care units* must be left out.

The major task of local administration here is the inclusion of public administration, local government and third sector institutions in the support strategy. Their implementation of tasks connected with information and support stems from the institutions' abilities and obligations.

Step one: in accordance with the proposed strategy the first step at the municipal, voivodeship, and state level is presenting available web links to social service portals, medical, local and non-government organisations, providing links filled with up-to-date information concerning short and long-term home care, prevention, medical, social, financial, and legal aid. Web links that identify offices, hospitals, pharmacies, clinics, nongovernmental organisations, lawyers, volunteers, nutritionists, rehabilitation experts, point out all places where a family can receive help and support.

Step two: The next task is to share a local register of volunteers who offer personal support, and establishing a register of available hospices, daycare facilities, associations, places with training and educational courses concerning home care, palliative care, effective coping with chronic stress, and improvement of problem solving skills.

Step three: the family support strategy implies the integration and synchrony of actions taken by public service and local government institutions such as hospitals, clinics, municipal and county social welfare centres, regional centres for social policy, nongovernmental organizations, and the Professional Paramedic Unit.

It is possible to incorporate a Specialist Paramedic unit into the county paramedic aid system which is led by GPS and a communication platform (both educational and rescue) with the transmission of information to the dispatcher. The Emergency Department's tasks include the transport of patients, medical aid, and if necessary, the right to send information to the Municipal Social Welfare Centre about the need for a social worker's intervention and also the need for the necessary inclusion of a social palliative care coordinator into the family.

Step four: the family support strategy indicates the possibility of including the religious ministry in assisting the family of cancer patients. The task of the ministry (Roman Catholic Church and other churches) is the organisation of support groups and hospices. Other tasks include finding youth volunteers, and organising meetings for caregivers and families. The purpose of the meetings is to exchange care experience.

The implementation of a support strategy for the family results in a quick and action-oriented analysis of the needs of people affected by cancer. It determines both the weak and strong sides of care, lists threats faced by the family and opportunities which arise while providing assistance. It provides

an evaluation and assessment of the status of the family as a unit of care. The individual approach to the family aims to diminish the feeling of deprivation that many families have and aims to improve health care in accordance with EU standards.

The introduction of this strategy makes the monitoring of community support networks possible. The multidisciplinary team of palliative care can plan appropriate action when solving family problems related to caring for the sick.

### **THE INTEGRAL SOCIAL WORK APPROACH TO FAMILY AS A UNIT OF CARE IN ONCOLOGY-RELATED DISEASE**

The term *active community support* means the possible interaction which activates a social agent (either an individual, a group, or an institution) to enhance the level of family care. It depends on the process of the reconstruction of the physical, emotional and intellectual characteristics that enable effective coping in a crisis situation. Its aim is to help reach the support network and to maintain the well-being of the family thanks to a gradual introduction of three assistance stages.

The information about the family and the situation of the cancer patient is collected. A social worker contacts the family and determines whether there is a problem in the family with providing palliative care for the patient. The important thing at this point is that the social worker must accept the family's point of view, jointly with the main family caregiver, and must analyse in detail and plan subsequent steps concerning care for the ill family member. By enabling wider access to related information, the social worker activates families and supports them in their search for solutions. The social worker should also assist in lowering the anxiety level and their actions should also lessen the feeling of deprivation and isolation that families experience.

The palliative care the social worker attempts to alter the dysfunctional behaviour of the family. The social worker focuses on avoiding possible conflicts and tries searching for new solutions. Intervention in family members' dysfunctional patterns/ways of behaviour takes place. In this phase the family is made aware of possible alternative forms of assistance such as online support and educational training. It is important to find alternative behaviours within the family and to improve long and short-term care skills which will later positively affect the quality of everyday life.

The main family caregiver is informed of the date and details of meeting with a multidisciplinary team of palliative care specialist. This is a team that proposes the short and long-term tasks connected to future care.

In this phase the main caregiver consults future tasks with an expert. The aim of the tasks is to encourage other family members to relieve caregivers in the care process, thus not only significantly reducing the risk of the main caregiver's burnout but also lowering the potential costs of the patient's hospitalization.

An essential feature of the support strategy is enabling the family to rebuild its resources and to improve the conditions of the patients' recovery in cooperation with social services (both medical and nonmedical ones). This short-term and long-term strategy increases the chance of helping the socially isolated elderly calls in an emergency situation as a result of a patient's sudden worsening of health condition. During this call by way of a communication platform (educational and paramedic) paramedics may now be able to inform the Municipal Social Welfare Centre of the address of a family that is in need of immediate support and assistance.

These actions will enhance the support of the elderly who fall victim to cancer. They will bring a new quality to social work, raise the prestige of the social worker and paramedic profession, and teach adaptive behaviours during a crisis situation in the local community. The integrated social work approach is used to plan care in the subsequent stages of the progression of a disease. What families need most is support and assistance, primarily in the first phase of the sickness, immediately after learning of the diagnosis of the terminal illness, secondly when the illness strikes back, and lastly when active pharmacological treatment is ceased.

According to the experiences of health care professionals, it is essential in these three phases that the family and the sick be understood and treated seriously. It is in these phases that providing support is most effective.

In addition, institutional support is necessary under the following conditions: when there is a lack of initiative and perseverance in care for cancer patients, after the collapse of the aid system, when the main caregiver's ability is limited due to senility, and when other serious family problems coexist.

Due to the nature of the problem, the process of informing the family about possible sources of support to fight cancer must be done gently. It is important to choose the right place and an adequate way and means of communication. Furthermore, the knowledge of what is involved in treatment and what forms of treatment are available should be aptly conveyed. We must note that the boundaries and limitations of support must be clearly defined at this point to avoid learned helplessness in the family. The creation of new frames of community support must also take place depending on the progression of the disease and the adaptive skills of the family itself.

Social work's prime interest in this matter is the possible impact of the palliative care social worker planning and solving a family's problems which

they formulate in collaboration with a multidisciplinary (multi-professional) team of palliative care professionals. This strategy aims to reduce conflicts which occur in the family. Such conflicts arise due to a fear of taking up new roles, the loss of the breadwinner's income, impossibility or inability to ensure high standards of care. As Robert Merton remarks, such persistent conflict within the set of roles might be big enough to seriously interfere with the proper execution of roles by individuals having a particular social status. It might be assumed that malfunctioning sets of roles are the most common life situation (Merton 2002: 420).

According to Peter Blau, superficial altruism permeates social life. People want to perform services and be able to reciprocate what they receive, yet at the root of this apparent altruism and selfishness egoism can be discovered. The willingness to assist others is motivated by people's expectation for social rewards. The basic reward that people are seeking is social approval. Being selfish and disregarding others prevents them from receiving this award (Blau 2009: 39).

There are also other reasons for having an interest in the support strategy. The strategy should be perceived as part of bigger plan directed at society, since the strategy directs societal attention to social problems such as social numbness, anomie, dehumanisation of social life, an increase in pathology, a reduction of the financial means aimed at cancer treatment, and an increase in social tension.

This strategy is designed to enhance the quality of cancer care and takes into account the individual needs of the patient which change over time due to the progression of the illness and the burnout of family members. This project involves constructing and/or restructuring social community support networks and educating the family with the necessary adaptive skills and modifying behaviour. And it is certainly true that the theoretical synthesis concerning health and disease, treatment and care, and support and assistance are an expression of a tendency present in medical and social sciences pursuing intellectual revival on which humanities base their tradition.

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### **Summary**

There is a strong need to support the family in the implementation of tasks related to their caring function and tasks related to meeting the basic needs of the ill family member. Family must be perceived from a broader perspective. We must examine it as a healthy family which incidentally, due to family member's sickness, happens to be in a crisis situation. With the introduction of a social support strategy for the family as a unit of care, a possible reduction in the number of hospitalisations may take place and there also may be an increase in the independence and autonomy of the families. There will be an increase in a family's ability to resolve everyday problems, to rebuild the necessary social support networks, and to improve the quality of care for sick members of the family.

**Key words:** family, hospitalization, social support, relationship